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

A. RESPONDENT BACKGROUND/EXPERIENCE

No SRCs in this Category for MMA.

B. AGENCY GOALS

MMA SRC# 1 – Potentially Preventable Events (Regional):

The respondent shall describe its organizational commitment to quality improvement as it relates to reducing potentially preventable events. More specifically, the respondent shall describe its overall approach and specific strategies that will be used to ensure a reduction in potentially preventable hospital admissions and readmissions, a reduction in the use of the emergency department for non-emergent/urgent visits, and a reduction in the use of unnecessary ancillary services during hospitalization and outpatient visits. The respondent’s approach shall also include:

- A description of the respondent’s assessment (using available data sources) of hospital utilization rates and the potential for improvement;
- A description of performance benchmarks for each area of focus;
- A description of incentives that will be implemented for providers and enrollees aimed at diverting care to more appropriate and cost-effective settings; and
- A description of evidence-based interventions and strategies that will be used to target super-utilizers, particularly related to pain management and behavioral health conditions.

Response:

OVERVIEW

Magellan Complete Care is an innovative health plan focused on delivering fully-integrated, physical health and behavioral health care to one of the most complex and vulnerable Medicaid populations in Florida, individuals with serious mental illness (SMI). Individuals with SMI face many challenges in managing their health and maintaining compliance with care plans and guidance for self-care. Even when enrollees have established relationships with primary care and specialty providers, they often feel more comfortable and accepted in environments such as emergency rooms. For these reasons, individuals with SMI are often designated super-utilizers by health plans and delivery systems. Social vulnerability, such as housing and food insecurity, and incarceration can also destabilize both behavioral and physical health, increasing the likelihood of inpatient admissions and readmissions. These characteristics and issues make management of preventable events challenging. Our entire model of care is directed at minimizing those risks, increasing enrollee stability, recovery and resilience, and reducing the likelihood that enrollees will require higher acuity services in an inpatient setting or the ER.
CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT IDENTIFIED SPECIFIC

Magellan Complete Care is constantly analyzing local and statewide utilization and enrollee risk patterns to develop broad-based programs to manage care and inappropriate utilization across all populations, as well as targeted interventions focused on specific enrollee risks or inappropriate patterns of use. As a fully-integrated physical health and behavioral health plan, each of our interventions is focused on managing the health of our enrollees across the continuum of care, including both physical health and behavioral health conditions. We regularly analyze enrollee risk factors to determine key drivers of utilization and the effectiveness of specific interventions in limiting inappropriate use.

As an example, we recently completed a detailed analysis of our overall enrollee population and a separate analysis of our child and adolescent enrollees to identify those factors influencing inpatient and ER utilization. Those analyses, which were based on Magellan Complete Care claims, care management, and encounter data identified sickle cell disease, cancer, pregnancy, substance use disorder (SUD), lack of compliance with BH medications or use of four or more psychotropic medications, and homelessness as significant predictors of inpatient utilization. We also identified that enrollees residing in Regions 4, 6, 7, and 11 were more likely to be admitted and that lack of engagement with a primary care provider increased the risks that enrollees would have difficulty managing their chronic illnesses.

In response to that and other analyses, we have implemented a number of programs to address those issues, and which are described in this response. Those interventions include: development of specialty care management programs targeting enrollees with sickle cell disease; new delivery system solution including an Integrated Behavioral Health Program (IBHP), targeting drug use; continued enhancement of our OB program; expansion of our highest-acuity integrated care management program targeting enrollees with high IP and ER utilization; and development of Integrated Health Home (IHH) programs with local CMHC and FQHC providers in Regions 4, 6, 7, 11 to improve engagement in primary care, and management of gaps in care.

Magellan Complete Care recognizes that many of our enrollees fall into the “super-utilizer” category, and are responsible for driving higher rates of preventable admissions, readmissions, and ER use. The Magellan Complete Care population is even more complex than most. All of our enrollees have at least one SMI. Fifty percent of our enrollees are living with two or more co-occurring behavioral health and/or physical health diagnoses. More than 30 percent of our enrollees have two or more physical health diagnoses in addition to SMI. This combined complexity means that Magellan Complete Care must use every available enrollee touchpoint to influence enrollee behavior and engage the enrollee to manage his or her health and utilization of health care services. That also means that no single solution will fully address the variables driving higher rates of preventable events. Interventions may vary based on the needs of enrollees and the nature of the delivery system in each region.

1.1 Programs Encompassing All Regions

To address the issues and factors contributing to high rates of preventable events across all regions, Magellan Complete Care has developed solutions that include:

1.1.a Provider Incentives and Disincentives
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MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

> Provider incentives to encourage increased enrollee engagement in primary physical and behavioral health care, and closure of care gaps that may increase ER and inpatient usage

> Value-based reimbursement programs specifically targeted at reducing preventable events, including bundled payment to encourage delivery of care in the most appropriate setting

> Provider disincentives to avoid inappropriate services. Magellan Complete Care also uses selected disincentives to discourage inappropriate utilization. This is accomplished primarily through benefit design and payment policies. Key programs that we have put in place include:

>> Prudent layperson: Magellan Complete Care has implemented this policy in application to ER claims for services. This policy is directed at limiting inappropriate billing for non-emergent services, and delivery of unneeded services.
>> Radiology utilization management
>> Non-payment for non-medically indicated Cesarean section and early elective delivery

1.1.b Enhanced Care Management
> Enhanced care management and care coordination programs (ICCM) specifically targeting our highest utilizing enrollees, with lower care manager to enrollee staffing ratios, and health guide and other supports

> Targeted specialty care management programs, such as our sickle cell program or our Integrated Behavioral Health Program (IBHP), targeting specific illness categories driving high rates of preventable events

> For enrollees who have presented in the emergency room, Magellan Complete Care’s ICCM’s also facilitate a post-ER assessment to review the purpose of the visit to the ER, to determine if another level of care may have been appropriate, identify any barriers to the enrollee receiving care in an alternate setting, and to determine if ER utilization is an indication of increasing enrollee risk or destabilization. This assessment also allows the enrollee to receive education on what conditions can be safely and effectively treated in other settings, including the benefit of ongoing, regular PCP or psychiatric visits.

> Use of long-acting-injectable (LAI) for psychotropic medications, reducing risks of enrollee destabilization due to medication non-compliance

> Integrated Discharge Planning (managed by Utilization Management Professionals (UMP) and coordinated by 32 hospital-based Health Care Guides)

1.1.c Utilization Monitoring and Management
> Ongoing monitoring of utilization: Magellan Complete Care has robust, ongoing monitoring of real-time and near-real-time utilization. Key elements of that approach include:
>> Use of the Florida HIE ENS system for ADT notification
>> Real-time notification of ER use for hospitalists
>> Hospitalists programs in most major inpatient facilities allowing us to effectively manage enrollee utilization for individuals who present at those hospitals
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Enhanced gap-in-care monitoring, reporting and management: Magellan Complete Care takes HEDIS, EPSDT and care management gaps-in-care seriously. We have developed robust reporting and monitoring programs for internal and provider use, and have aggressive gap outreach and closure programs in place, including an innovative program on HEDIS gap closures for enrollees in inpatient settings.

1.1.d Care Line Support
All Magellan Complete Care enrollees also have access to 24/7, toll-free care and crisis lines. This service is staffed by mental health and nursing professionals who work directly for Magellan Complete Care. The Care Line professionals triage calls, provide appropriate interventions based on the nature of the care, and assist enrollees in identifying the correct level of care based on symptom presentation. They will also assist enrollees in accessing the correct level of care if necessary.

1.1.e Social Supports
Magellan Complete Care also provides an integrated, and comprehensive system of care management and social supports for our enrollees, with a goal of increasing community tenure and minimizing inappropriate use of higher acuity services. In addition to more traditional types of providers, our integrated systems of care incorporate a housing program, food security, “feet on the street” outreach through our own community team members and our partners such as Integra, and use of Rapid Response Teams to address difficult to manage enrollees. One of the unique elements of Magellan Complete Care’s integrated program is our Integrated Health Neighborhood (IHN). The IHN customizes our system of care by region, with the goal of improving enrollees’ 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. IHN team members are an important linkage to our enrollees in each region to educate them on the appropriate use of services; support them in the removal of barriers that may prevent them from engaging lower acuity services; assist in the removal of social vulnerabilities such as homelessness, which Magellan Complete Care’s own internal data shows as a significant contributor to higher rates of preventable events.

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. The following enrollee success story provides an example of the value of these interventions in supporting enrollees in the appropriate use of care.

~~Enrollee Success Story: Dave (name changed to protect privacy)~~
"Thank you Magellan Complete Care for helping me, when at times I felt I didn't even deserve it. I am striving to stay clean with your support, thank you!" – Dave

Dave has a history of homelessness, substance use and frequent hospitalizations. His lack of stable housing made it difficult for him to attend follow-up appointments and take his medications. His Health Guide helped him get into a residential treatment center, apply for supportive housing and connect with his providers.

He has now found housing and will obtain a sponsor. He is now on the road to recovery, he takes his medication regularly, and his readmission rates have decreased significantly. Dave has the support he needs and is motivated to stay healthy and achieve sober living.

Magellan Complete Care also continuously monitors and analyzes utilization in all settings to identify the factors driving inappropriate use, or indications of the need for additional interventions, including daily inpatient UM reviews and coordination with Case Management in evaluating and managing preventable admissions. As we identify the need for new solutions, we will continue to work with AHCA to develop and implement those programs.

1.2 Region-Specific Interventions
Magellan Complete Care also has additional initiatives currently underway, or being launched that target the needs of enrollees in specific regions. Each of those initiatives is specifically targeted at reducing the risks of preventable events, including admissions, readmissions, and inappropriate ER use. Those specific programs include:

1.2.a Urgent care clinics: Magellan Complete Care has contracted with urgent care centers throughout Florida, but primarily in the major metropolitan communities where many of our enrollees are located, and where unplanned utilization is greatest. This includes Tampa, St. Petersburg, Orlando, Jacksonville, and south Florida.

1.2.b Road-to-Recovery Program: This program is currently primarily targeted at the northern regions of the state, where enrollees often have more limited access to routine services, resulting in higher rates of admissions and readmissions. This program is specifically focused on managing enrollee transitions from inpatient settings, ensuring timely access to after care. It includes the use of telehealth services through our provider-partner IMPOWER, as well as provider incentive payments for timely delivery of required post-discharge services. The program is specifically targeted at reducing readmissions. Although it is currently focused on BH admissions, the second phase of the program will incorporate PH admissions as well.

1.2.c Integrated Health Homes (IHH): Magellan Complete Care is currently working with our CMHC and FQHC provider partners to implement Integrated Health Homes to provide services and management of both physical health (PH) and behavioral health (BH) conditions in an integrated solution with a single site of care. Development of this solution is specifically targeted at those regions where we have our largest concentrations of enrollees and our highest rates of preventable events, including Regions 5, 7, 9, 4, and 10. The program includes provider incentives for the management of gaps in care, and reductions in preventable events.

1.2.d MY LIFE program for adolescents and young adults: The MY LIFE program, which is currently implemented in Orlando, with plans to expand to other regions, is community-based
program to engage adolescents and young adults with SMI and substance use, through social networking, social supports and peer support programs. The program specifically targets a population which has been shown to be higher utilizers of ER services.

1.2.e Telehealth Solutions: Magellan Complete Care has been systematically expanding its use of telemedicine services for our enrollees, with a focus on increasing access to these services for primary care and behavioral health, as well as increasing the availability of these services in specific regions. This has resulted in significant increases in Regions 2, 4, 5, 6, and 7, and we believe it will be particularly important for reducing preventable use of the ER. We are very excited about the potential for expanding the use of this technology (particularly for Regions 9, 10, and 11) to support crisis intervention, similar to the model currently being employed by Manatee County, and expect to expand its use in some of our regions with higher numbers of enrollees and resulting higher rates of preventable events.

1.2.f Crisis Intervention Teams: Magellan Complete Care has recently launched a new Crisis Intervention Program specifically targeting enrollees in Tampa and South Florida. These teams, which will include community-based mobile clinical staff will be deployed for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially deleterious behavioral health condition, episode or behavior. Our goal is to support stabilization of the enrollee to prevent unnecessary inpatient admissions, readmissions, or emergency room encounters. Enrollees can either be treated on-site or transferred to other more appropriate, lower acuity sites of care. When needed, a trained behavioral health professional will respond to the enrollee’s location, assess the crisis situation, provide an appropriate intervention to the crisis, and follow up with Magellan Complete Care’s care coordination team after the crisis has been resolved. Teams can be deployed to multiple sites, including inpatient facilities and assisted living facilities which may find it challenging to deal with an enrollee’s destabilization.

1.2.g Specialty Centers of Excellence: Magellan Complete Care has already established a number of specialty care management programs targeted at specific chronic illness categories with high rates of inpatient and ER use. This includes our Sickle Cell Program, targeting a category of enrollees which accounts for significant rates of preventable admissions and ER use. That program has already demonstrated a 41 percent reduction in total costs, a 58 percent reduction in IP utilization, and a 29 percent reduction in ER utilization. We are currently working with our provider partners in Broward County to expand that program to a facility-based, center of excellence which would provide comprehensive care for these enrollees. This will allow an expansion of the program to serve a larger number of individuals and should significantly reduce inpatient and ER usage rates for these individuals.

1.2.h Integrated Behavioral Health Program (IBHP): We have recently launched our first IBHP program with Baycare Health serving Regions 5 and 6. This innovative program integrates behavioral health, substance use treatment, and physical health services in a single site of care. Many of our enrollees experience co-occurring substance use, which often contributes to high rates of ER and inpatient use. Early results for this program have been extremely promising, demonstrating more than a 50 percent reduction in IP costs, and a 40 percent reduction in ER costs. We believe this innovative, integrated program will be effective in reducing those rates, and will be evaluating its effectiveness for further expansion throughout the state.
1.2.i Hospitalists: Magellan Complete Care has implemented hospitalist programs in those regions with our highest density of enrollees. This includes Regions 4, 5, 6, 9, 10 and 11. The use of hospitalists has proven effective in reducing unnecessary admissions, and in planning and managing enrollee discharge and transitions of care. We anticipate an expansion to all regions as well as increased use of hospitalists to evaluate enrollees who present in the ER. Not only will this afford the opportunity to educate enrollees on appropriate use of the ER, but we believe it will be effective in reducing inappropriate admissions from that site of care. Behavioral health hospitalists also support our follow-up after discharge program, targeted at reductions in preventable readmission.

1.2.j Homeless Housing Initiative: Magellan Complete Care’s Homeless Housing initiative is an effective and important tool for supporting our homeless enrollees with finding and securing stable housing. Our own analysis of our enrollees has shown that lack of housing often leads to much higher rates of both inpatient and ER utilization. Our program, which is primarily focused in Miami-Dade, Broward, and Orange counties, has demonstrated a near 40 percent reduction in totals costs, and reductions in IP use of nearly 30 percent.

1.2.k Jail In-Reach Program: Magellan Complete Care recently launched its Jail In-Reach Program in Miami-Dade County. This program, which provides care coordination services to enrollees while incarcerated also supports enrollee transitions back into the community. This program is patterned after similar efforts employed by Magellan in other states, and which have demonstrated significant reductions in IP and ER usage while enrollees are incarcerated, as well as post-release. We are very excited about demonstrating the value of this type of program in Florida, with the goal of expanding it to other regions of the state.

Each of the programs described above, is a part of our larger fully-integrated system of biopsychosocial care delivery and care management program, all of which are directed at improving overall health outcomes for our SMI enrollees, and reducing preventable admissions, readmissions, and ER usage.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES SPECIFIC CARE...

Magellan Complete Care has built an entire system of care and utilization monitoring, care interventions, and incentives to support targeted reductions in preventable events and management of super-utilizers. This comprehensive system of health is focused on minimizing preventable events through interventions and solutions that incorporate physical health management, behavioral health management and social supports to maintain enrollee stability and manage the risks of preventable events. That system includes the following key elements:

> Enhanced predictive modeling: We have developed enhanced predictive modeling systems that allow us to more accurately predict (more than 80 percent predictive accuracy) the likelihood of increased enrollee health risk and inappropriate utilization of inpatient and ER services. Key elements of the enhanced predictive modeling model include:
  >> Modified ImpactPro
  >> Identification of emerging risks
  >> Expanded health risk assessment tool
  >> Post utilization analysis and reporting of preventable events: Although Magellan Complete Care continuously monitors and manages utilization for its enrollees, the monitoring of
preventable events, as defined by AHCA, requires the same technology currently used by AHCA. To address that gap, we have purchased the same 3M Grouper software used by the state. We are currently implementing that solution and building monitoring and reporting around its use.

As described in other sections, we have developed a robust risk stratification and segmentation model that focuses on key drivers of utilization as well as predictors of health risk. [MMA SRC #01, Attachment 1: Magellan Complete Care Risk Stratification Model] provides an overview of our risk stratification model in a graphical representation. The development of our stratification and segmentation model is driven by regular and ongoing analyses of our enrollees, their utilization patterns, interventions and intervention effectiveness, and quality and utilization outcomes. We also specifically analyze super-utilizers, high-utilizers and enrollees with patterns of inappropriate utilization to understand the key drivers of that utilization, characteristics of those enrollees, and the impact of specific interventions in addressing that utilization.

As part of our ongoing analyses we 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 ScoreTM (SBS).

Design of our stratification and segmentation model is iterative and continually refined as we learn more about our enrollees and what influences their behavior. Currently enrollees are stratified into the following key categories, and assigned to levels of care management or wellness and prevention management based on those risks. Note, that the ultra-high risk and high-risk categories of enrollees are often super-utilizers and are thus assigned the highest level of care management, care coordination, and monitoring. Our specific stratification groupings are as follows:

- **Ultra-high risk**: Inpatient or likely to admit within 90 days
- **High risk**: Multi-morbid with uncontrolled BH or PH diagnosis
- **Monitor risk**: High-risk or ultra-high-risk, but unwilling to be engaged; and, indications of rising risks (e.g. ER utilization, medication non-compliance, new medication therapy, significant chronic illness gaps-in-care)
- **Moderate risk**: Stable single physical health diagnosis (in addition to BH diagnosis), gaps-in-care, limited PCP engagement
- **Low risk (includes Wellness and Prevention)**: BH diagnosis, without physical health comorbidity

Engagement in care coordination and case management (CC/CM) varies depending on the risk stratification of an enrollee. Our goals are three-fold:

- **Stabilize enrollees who are demonstrating instability and significant utilization**
- **Reduce instability and improve management of chronic disease to prevent unnecessary future utilization**
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>Monitor enrollee risk, support self-care, and reduce likelihood of destabilization for enrollees with chronic PH diagnoses
>Manage health and prevention for healthier enrollees (BH diagnosis, with no PH diagnosis)

Our highest risk enrollees, which are typically considered super-utilizers, are engaged in intensive integrated care coordination and case management (ICCM), which includes physical health, behavioral health and psycho-social support. Those enrollees may also be supported by our recovery support team which is responsible for supporting stable and effective community re-integration, and/or they may receive support from our homeless housing staff, if they demonstrate housing instability.

High-risk enrollees are engaged in less intensive case management. However, they also have access to the social support programs mentioned above, and may be enrolled in one of our specialty care management programs directed at case management for specific diagnoses. These include: sickle cell disease, CHF/hypertension, COPD, diabetes, high-risk pregnancy, schizophrenia, and first-episode psychosis (adolescents and young adults).

Moderate-risk enrollees are enrolled in some level of disease management (DM), with the level of management varying based on enrollee level of stability. For enrollees with less effectively controlled chronic illness, or indications of increasing instability such as medication non-compliance or ER utilization they are managed through our enhanced DM program which includes light case management and support from wellness and outreach specialists. More stable enrollees are provided with self-care education and support, medication therapy monitoring and management, and focused engagement to monitor and close gaps-in-care. Magellan Complete Care is also developing a community health worker (CHW) program to outreach to, and engage enrollees in this category who may be demonstrating indications or rising instability or increasing risks.

Moderate-risk and low-risk enrollees are all actively monitored for indications of increasing risk. These may include lack of medication adherence; high total number of medications (particularly psychotropic medications); new medication protocols; lack of primary care engagement; routine/preventive gaps-in-care; ER usage; co-occurring SUD: indications of drug-seeking behavior; and, housing instability. Magellan Complete Care’s goal is to intervene with these enrollees either directly or through their providers, to mitigate that increasing risk before it leads to inappropriate utilization.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES STRATEGIES ...
Magellan Complete Care providers have access, through the Connect Portal and the Provider Portal, to patient utilization information, care plans and related information. In addition, providers receive gap-in-care reporting for their patients on a monthly basis. Gap in care reporting is provided through rosters and providers can also log into the system at any time to view information for their patients. Providers are also encouraged to actively participate in care management activities for their patients, including case rounds with our care management team.

Magellan Complete Care currently captures inpatient and ER encounter notifications using the state Health Information Exchange (HIE) Electronic Notification System (ENS). This supports near real-time notification of utilization. Magellan Complete Care receives up-to-date information when
an enrollee presents to an ER or is admitted for inpatient services. This capability is used in our Hospitalist program in Regions 4, 5, 6, 9, 10, 11. The notification allows Magellan Complete Care staff to put into action a supportive and coordinated response for the enrollee. Depending on the nature of the notice, staff coordinate internally with the ER staff, hospital staff, PCP, and psychiatrist to give the enrollee the best opportunity for a positive outcome. Care coordination staff inform the PCP or Primary Behavioral Health Provider (PBHP) for enrollees utilizing ER services. Using information in our care management systems, we also have the ability to limit duplication of services by sharing labs and test results. At this time, we also encourage and assist the enrollee in arranging follow up care with the PCP or PBHP after an ER visit.

Magellan Complete Care’s TruCare care management platform also includes update alerts for enrollees who have high ER or inpatient utilization (super-utilizers). When an enrollee or the enrollee’s provider contact Magellan Complete Care, the frequent utilizer flag alerts the enrollee case owner that the enrollee or the enrollee’s provider may need additional support or the care coordination staff may need to be contacted to intervene to limit future inappropriate utilization.

As discussed previously, Magellan Complete Care is also launching targeted Crisis Intervention Teams in Tampa and South Florida. Dispatch of those teams will rely on electronic sharing of information between emergency response teams and the Crisis Teams. We anticipate that the teams will also have telemedicine linkages for additional clinical support and consultation as needed. This type of program has proven very successful in other locations throughout the country and is currently being employed in a more limited form in Manatee County. The model has proven very effective in reducing preventable events.

Finally, our Road to Recovery program, referenced earlier in this document and currently deployed to the Tallahassee area, includes the use of telehealth to connect recently discharged enrollees with providers for their required after-care. We plan continued expansion of this program as well as additional programs focused on remote monitoring of high-risk enrollees. Those programs will included automated exchange of information for regular and ongoing illness management and should have a significant impact on preventable events. Existing programs are already available through hospital systems in the northern part of the state, including Tallahassee and Jacksonville, which we anticipate will provide a platform for those programs.

CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT PLANS…
As noted above, Magellan Complete Care currently uses AHCA’s Event Notification System (ENS) to capture admissions, discharge, transfer (ADT) information, and ER encounters. We encourage all providers to participate in the system to maximize its accuracy and effectiveness, and are constantly evaluating new opportunities to use this information to more effectively manage care.

Magellan Complete Care uses information from this system to identify enrollees who have been admitted, for purposes of engaging our ICCM staff as well as our Hospitalists. Discharge planning for our enrollees starts at the point of admission, with the goal of ensuring that transition is safe and optimizes the enrollee’s chances for a long community tenure. Once notified of admission, our ICCM staff also uses this opportunity to close any enrollee gaps in care, and to secure updated contact and health risk information for our enrollees. The timely availability of this information
through the ENS system is an important tool in managing enrollee health both during and after an encounter.

We are also currently assessing opportunities to use this information to provide real-time notification to our behavioral health and physical health hospitalists for any of our enrollees who present in the ER. Our goal is to use this mechanism to prevent unnecessary inpatient admissions resulting from that ER encounter, and educate enrollees about appropriate ER use, if necessary. Information gathered from the ENS is used to monitor and manage ER and inpatient utilization, and to monitor and plan transitions of care for our enrollees. Data from the ENS is loaded to our TruCare system and supports our staff in managing our enrollees.

CRITERIA 5: THE ADEQUACY OF THE RESPONDENT’S DESCRIPTION…
Magellan Complete Care uses the same, statistically and clinically-valid methods to evaluate the effectiveness of all interventions, including those targeted at super-utilizers. We use a Plan-Do-Study-Act (PDSA) model, which starts with statistical analysis of the key drivers of clinical outcomes. Our care and quality management teams then design interventions directed at affecting those key drivers, and the methods that will be used to assess their effectiveness. Once the intervention has been implemented we allow the intervention to be run for an adequate period of time which is ideally one-year, but may be three to six months if there is significant urgency associated with the intervention.

We evaluate enrollee outcomes and utilization for the intervention period and compare that to enrollees who were enrolled in Magellan Complete Care for the same duration, continuous period prior to the intervention. Typically, we assess standard utilization metrics such as inpatient admissions, readmissions, ER encounters, engagement and activation with case management, closure of gaps-in-care, etc. The nature of the metrics used to assess intervention efficacy will vary based on the area of clinical focus. We perform statistical analyses of the data gathered to determine whether the impact of the intervention is significant. Based on these analyses we may enhance or modify the intervention, or potentially abandon the intervention if it appears to be ineffective. The following provides an example of our analysis of a specific intervention targeting high-utilizing populations with sickle cell:

>Sickle Cell Enrollees Completing CM: 10
>> Overall Cost Savings: 41 percent
>> IP Admits: Decreased 58 percent
>> ER visits: Decreased 29 percent

>Sickle Cell Enrollees Still in CM: 21
>> Overall Cost Savings: Flat, thus far
>> IP Admits: Decreased by 31 percent
>> ER visits: Decreased 20 percent

>Sickle Cell Enrollees Not Engaged: 59
>> Overall Cost: Increased 250 percent
>> IP Admits: Increased 1350 percent
>> ER visits: Increased 1283 percent
On an ongoing basis, Magellan Complete Care monitors all key managed care utilization indicators, including:

- Inpatient admissions
- Average length of stay
- Seven-day readmissions
- Thirty-day readmissions
- Ninety-day readmissions (all and readmissions for the same diagnosis)
- ER encounters
- Primary care encounters
- Primary behavioral health care encounters
- Medication adherence and adverse reactions

We also continuously monitor gaps-in-care related to specific enrollee diagnoses, using that data for outreach to enrollees and for reporting to providers. This allows us to target interventions with enrollees before they become destabilized and encourage engagement with primary care to minimize preventable events.

As mentioned previously, Magellan Complete Care also recently purchased the same 3M Grouper technology used by AHCA to analyze preventable events. We are currently evaluating and defining the elements of our program to use this tool which will be used to effectively mirror the analyses being performed by AHCA.

CRITERIA 6: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES FINANCIAL...
Magellan Complete Care currently has provider incentive programs targeting management of specific clinical outcomes and closure of gaps-in-care, including those for EPSDT and HEDIS. These programs allow us to incentivize primary care and specialty providers to deliver appropriate care in a clinic setting, thereby limiting enrollee utilization of ER or experiencing a destabilization of a chronic illness that results in an unplanned admission. We also use targeted provider incentives for closure of high-priority gaps-in-care identified through our quality management program. Our Road-to-Recovery program also includes provider incentives for follow-up care after discharge, with a goal of limiting readmissions.

Magellan Complete Care also has a number of new incentive programs that are discussed in greater detail in other sections of this ITN response. These programs include:

6.1 Incentivize Integrated PH-BH Primary Care to Increase Enrollee Engagement and Access to Care: The goal of this program is to increase overall primary care engagement and associated outcomes.
- Targeted Providers: Primary care and primary behavioral health care
- Program Features: This program will focus on the implementation of Integrated Health Homes (IHH) which will combine both physical health and behavioral health services in a single site of care. This model is built on CMS-SAMHSA models for fully integrated care delivery and management. IHH’s have been demonstrated to achieve significant reductions in overall costs of care, with particular benefits for reductions in preventable ER usage. Magellan Complete Care is currently actively negotiating with CMHC and FQHC providers throughout the state for the development of IHHs.
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> Quality Improvement Goals: Overall reduction in ER usage; Improvement in overall basket of HEDIS metrics at or above annual minimum threshold. HEDIS metrics to be determined collaboratively in consultation with our provider partners.

6.2 Partner with High-Quality Providers to Create Fully-Integrated Programs for Targeted Disease Categories (Centers of Excellence)
> Targeted Providers: Hospitals and hospital systems

> Program Features: Hospital “center of excellence” responsible for all care (physical, behavioral and social supports) for high-risk, high-complexity enrollees with specific targeted diagnoses (e.g., sickle cell, CHF, COPD, etc.). These programs will be designed to complement our specialty care management programs targeted high-risk/high-cost disease categories. Our initial program focus has been on sickle cell disease, which is a disease category that is one of our greatest contributors to preventable events. Magellan Complete Care has already had preliminary discussions with key providers for the creation of this program. We continue to work with our provider partners and AHCA to develop reimbursement proposals for this program.

> Quality Improvement Goals: Overall reduction in costs of care; overall reduction in ER usage, I/P admissions, and 30 and 90-day readmission rates. Goals to be set annually, in conjunction with our provider partners.

6.3 Incentivize Specialty Providers to Reduce Preventable ER Usage
> Targeted Providers: Specialists

> Program Features: Specialty professional capitation, with participation in shared savings pool. May include additional capitation for enrollee care management. Our initial specialty targets would be those chronic disease categories which are most common among our SMI enrollees, including diabetes, CHF, and COPD. Participating specialty providers would be responsible for managing the overall care and health of the assigned enrollees, similar to what is done in chronic illness health homes. Magellan Complete Care has already had initial discussions with one of our FQHC partners for implementation of this type of program focused on diabetes.

> Quality Improvement Goals: Overall reduction in costs of care; overall reduction in ER usage for specialty-related diagnoses (e.g., diabetes, asthma, CHF, etc.); improvement in specialty target HEDIS measures at or above annual improvement goals. The goal of this program will be to engage these physician partners in the active monitoring and management of individuals with specific higher-acuity/higher-complexity chronic diseases.

6.4 Incentivize Providers to Reduce Preventable Admissions and Readmissions
> Targeted Providers: Hospitals and hospital systems

> Program Features: This program would be specifically targeted in improving quality outcomes and reducing preventable hospital admissions and readmissions. It would include bundled payments for total episodes of care, including readmissions within specific timeframes post-discharge. Payment bundles would also include costs for transitions of care. Program features would follow similar models in use for Medicare, which we believe will reduce provider resistance. One key difference in our proposed program would be the creation of payment bundles for behavioral health admissions, which are key for Magellan Complete Care achievement of
significant reductions in preventable events. As noted in the initial section of this SRC response, we anticipate this program will require lengthy negotiation and development of details with our hospital partners.

>Quality Improvement Goals: This program will specifically target reductions in preventable admissions and readmissions. The program will include specific targeted reductions similar to that for the Medicare program. Metrics will be developed collaboratively with our provider partners. We believe that each of the programs proposed above will be instrumental in driving significant reductions in preventable events for our enrollees. They have been specifically designed to support the targeted reductions we have agreed to as part of our ITN response.

CRITERIA 7: THE EXTENT TO WHICH THE RESPONDENT PROPOSED LOCAL...
Magellan Complete Care identification of regional improvement targets is driven by several considerations, including:

>Enrollment density and the number of enrollees per region
>Presence of strong hospital partners to support improved outcomes
>Availability of strong non-hospital provider partners capable of delivering integrated care
>Regional utilization rates of selected services

In the last 12 to 18 months Magellan Complete Care has implemented a number of targeted initiatives that we believe will support the reduction of preventable events in all regions. This includes significant enhancements to programs for management of enrollee gaps-in-care and timely notification of inpatient admissions and ER encounters.

7.1 Reducing potentially preventable hospital admissions and readmissions, and
7.2 Reducing use of the emergency department for non-emergent/urgent visits

We have proposed the implementation of several new provider incentive programs and value-based reimbursement programs that will further reduce inappropriate utilization. This has allowed us to target a FIVE PERCENT REDUCTION IN PREVENTABLE ADMISSIONS, READMISSION, AND AVOIDABLE ER ENCOUNTERS ACROSS ALL REGIONS IN THE NEXT 18 MONTHS. Achievement of these goals will bring Magellan Complete Care rates below the state FFS rate in all regions.

We also believe, several targeted initiatives will allow us to further reduce preventable admissions, readmissions, and ER usage in several select regions. These initiatives include the development of integrated health homes for management of both physical and behavioral health. Initial launch of these programs will affect Regions 6, 10 and 11. Expansion to other regions is planned over the next year. Additionally, as mentioned previously, we have implemented a dedicated sickle cell program in Region 10 and a hospital home program in Region 11. We believe each of these programs will support significant reductions in preventable hospital admissions and readmissions, as well as reductions in ER usage in these regions. Recognizing that, WE ARE TARGETING AN ADDITIONAL FIVE PERCENT REDUCTION IN PREVENTABLE ADMISSIONS, READMISSIONS, AND ER ENCOUNTERS FOR REGIONS 5, 6, 7, 9, 10, AND 11. We believe these additional reductions will take slightly longer, with a goal of achieving these benchmarks within 24 months. Achievement of this goal will allow us to bring our rates of preventable events within line of several of the current standard Medicaid plans. This is significant given the higher risk profile of our enrollees.
7.3 Reducing the use of unnecessary ancillary services during hospitalization and outpatient visits

In addition to the targeted reductions in admissions, readmissions, and ER usage already identified above, we believe we can target additional reductions in inappropriate ancillary utilization by focusing on radiology-related services, a program which was discussed previously. We believe we can also reduce laboratory utilization through reduced duplication and unnecessary testing resulting from our integrated health home programs being developed throughout the state. Recognizing the benefits of these programs, we have set a benchmark for a FIVE 5 PERCENT REDUCTION IN ANCILLARY COSTS IN THE NEXT 18 MONTHS.

One of the most significant challenges associated with management of preventable events is that determination of whether an event is preventable is largely retrospective. Recognizing this, the focus of Magellan Complete Care’s efforts at controlling this inappropriate utilization is directed at:

- Managing overall rates of inpatient and ER utilization
- Providing appropriate post-discharge support to enrollees to minimize risks of readmissions
- Monitoring and closing enrollee gaps in care to minimize risks of destabilization
- Enhancing access to primary and specialty care in non-hospital settings
- Monitoring and controlling inappropriate provider services delivery

We have recently purchased the same 3M Grouper software used by the state in its analyses of preventable events. The availability of this software will allow us to regularly monitor, report and analyze utilization data in the same way that AHCA does. We will then be able to more effectively identify and intervene with both enrollees and providers who may be driving this inappropriate utilization.

Magellan Complete Care is committed to being an important and influential partner with AHCA in understanding the factors that influence preventable events and developing interventions that are effective reducing those trends. We recognize that the SMI population we manage often has disproportionate impacts on overall rates for Medicaid populations. We also recognize that influencing the behavior of the population can be challenging, and are committed to demonstrating the value of our fully-integrated model of enrollee management to achieve those goals.

**Evaluation Criteria:**

1. The extent to which the respondent identified specific localized opportunities for improvement in achieving a reduction in potentially preventable events and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care (i.e., medical, behavioral health).

2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify super-utilizers.

3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for high-risk enrollees, using specific local examples.
4. The extent to which the respondent plans to include the use of the Agency's Event Notification System as a means to extract relevant data from hospitals.

5. The adequacy of the respondent's description of specific indicators or measures that will be used to evaluate the effectiveness of evidenced-based programs and interventions that target super-utilizers.

6. The extent to which the respondent describes financial and non-financial provider and enrollee incentives that are aimed at diverting care to more appropriate and cost-effective settings (e.g., incentives for primary care providers that agree to extended or after-hours clinic care for their Medicaid patients).

7. The extent to which the respondent proposed local performance benchmarks for:
   (a) Reducing potentially preventable hospital admissions and readmissions;
   (b) Reducing use of the emergency department for non-emergent/urgent visits; and
   (c) Reducing the use of unnecessary ancillary services during hospitalization and outpatient visits.

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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MMA SRC# 2 – Birth Outcomes (Statewide):

The respondent shall describe its organizational commitment to quality improvement as it relates to pregnancy and birth outcomes. More specifically, the respondent shall describe its overall approach, and specific strategies, that will be used to address prematurity prevention, improve perinatal outcomes, and reduce unintended pregnancies, including:

- A description of performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries;
- A description of incentives that will be implemented for providers and enrollees aimed at improving birth outcomes; and
- A description of strategies to decrease unintended pregnancies (e.g., increase in the use of long acting reversible contraceptives).

Response:

OVERVIEW

Magellan Complete Care is committed to supporting Agency and Federal goals of improving birth outcomes for pregnant enrollees and women of child-bearing age. This includes limiting risks of pre-term birth, unnecessary cesarean sections, early elective deliveries, and unplanned pregnancies. We have well-designed programs, and a specific care management team focused on enrollees who are pregnant or who have recently delivered. The Magellan Complete Care programs include screening for pre- and post-partum depression, drug and alcohol use, and smoking, in addition other high-risk physical health comorbidities that are common in our SMI enrollees. Magellan Complete Care, through our Magellan Rx organization, has also recently embarked on a collaboration with Bayer pharmaceuticals to increase provider and enrollee understanding of safe contraceptive alternatives and to promote their use. In Magellan Complete Care offers an expanded set of intensive BH and addiction services for pregnant enrollees. Where services may not be offered or authorized for a non-pregnant enrollee (i.e. IP services, intensive services), they would be offered for the pregnant enrollee recognizing the significantly greater risks of pregnant enrollees and the importance of maintaining their stability during pregnancy.

Though pregnancy is not considered a disease state, the unique requirements for our pregnant enrollees, who all have at least one SMI, demand the kind of dedicated, fully-integrated program focus Magellan Complete Care maintains to identify and manage our enrollees who are pregnant or may become pregnant. These programs also serve to support the Agency’s goals to improve birth outcomes. We have an OB/GYN Psychiatrist on staff to oversee management of these enrollees. She is triple-boarded in OB, adolescent psychology, and addiction medicine, and is an OB/GYN Associate Professor at a Florida based medical school. She participates in our weekly clinical rounds for these enrollees. We also maintain a dedicated Obstetric Integrated Care Case Managers (OB-ICCM) Team, which includes an RN and four (4) case managers.

Management of pregnancy and post-partum care can present particular challenges for SMI enrollee medication therapy management. Recognizing that potential complication, a clinical pharmacist participates in weekly OB clinical rounds as needed. The OB ICCM team members consult with the clinical pharmacist who reviews the enrollee’s medication profile, contraindications and drug interactions and makes recommendations as appropriate. A risk-
benefit assessment must be performed initially and throughout pregnancy and the post-partum period to the needs of the enrollee regarding initiating, continuing, or discontinuing medications. Ideally, women with SMI should obtain a consultation before, during and after pregnancy 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 during pregnancy and the postpartum period
> Ongoing monitoring, as medications may have to be adjusted and/or discontinued

Magellan Complete Care’s Enrollee Website also includes information focused on the special needs of individuals with SMI, including a guide to medications, self-management, empowerment tools, enrollee success stories and links to national and local resources

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT IDENTIFIED OPPORTUNITIES...
All Magellan Complete Care pregnant enrollees have complex health and social issues, risks due to the treatment for their SMI, high-rates of co-occurring substance abuse and smoking, and co-morbid physical illness. As an example, 25 percent of our pregnant enrollees also have a substance use disorder, versus 16 percent for our overall enrollment. Many of our enrollees also experience chronic homelessness and other social support challenges that may make the management of pregnancy risks difficult. Our programs specifically focus on overcoming those challenges and are built on our commitment to continual improvement in key indicators for improvement of birth outcomes.

Magellan Complete Care is continually focused on improvements in birth outcomes for our population of women of child-bearing age. In addition to our targeted pregnancy management program described below, strategies to reduce early elective deliveries are two pronged: provider collaboration and enrollee education. We plan to post the ACOG and Joint Commission indications for a medically necessary delivery prior to 39 weeks on our provider website along with medical indications checklist tools to ensure all providers are clear on medical appropriateness. We use modifiers for better reporting and tracking of deliveries and are exploring the possibility of related alternate payment systems. Provider Support Specialists provide training and dissemination of best practices regarding the reduction of early elective and C-section deliveries and available tools.

Member awareness campaigns for pregnant enrollees include the importance of a full-term pregnancy for the health and well-being of the baby and related risks of elective deliveries. We have adopted the March of Dimes education campaign: “Healthy Babies are Worth the Wait” including toolkits for enrollees and provider education focused on elimination of non-medically indicated (elective) deliveries before 39 weeks.

We use every available means to identify, engage and support our pregnant enrollees, and connect them to care. Magellan Complete Care has developed a “First 12 Weeks” educational outreach program that targets all women of childbearing age. The program raises awareness of the importance of early prenatal care and options for what to do if an enrollee suspects she might
be pregnant. We include a “Signs and Symptoms of Pregnancy” guide, and a guide to free pregnancy testing sites.

Recognizing the unique risks factors in our enrollee population, we have also developed the following key programs aimed at improving all key birth outcomes for pregnant enrollees, and enrollees of child-bearing age:

> Comprehensive OB/GYN care management program for all pregnant enrollees. Since all of our enrollees have SMI, we consider all pregnant enrollees to be high-risk, requiring case management.

> We have recently launched a program specifically focused on increasing use of contraceptives, include Long-Acting Reversible Contraceptives (LARC).

> Our benefit design is specifically directed at enhancing birth outcomes and mitigating known risks for our SMI enrollees.

> Our program includes both provider and enrollee incentives to encourage required pregnancy-related care, as well as participation in other programs to limit birth outcome risks.

> We make extensive education and support materials available to our enrollees through our website and, printed materials and reminders to our enrollees as part of our expanded population health and wellness programs. This includes information on routine gynecological exams and prevention, routine screening for STIs and cancer, and information on contraceptives and their use (targeted for women with SMI).

> We have specific provider training and education programs to assist in understanding the requirements of simultaneously managing pregnant enrollees with SMI.

Magellan Complete Care also has specific programs targeted at increasing breastfeeding among our enrollees. These programs help to overcome misconceptions on the part of both enrollees and providers about the safety of breastfeeding for women being treated for SMI. The Mother and Baby Connection program includes breastfeeding education; individual lactation consultation by a lactation consultant; and equipment rentals.

****Trade secret as defined in Section 812.081, Florida Statutes****

The Magellan Complete Care (MCC) Mother Baby Connections Program is a perinatal program that is a specialized and an integral element of the AHCA approved and NCQA compliant Magellan Complete 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. Our 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.

Approximately 1,046 Magellan Complete Care enrollees were pregnant and delivered in 2016. Of these enrollees, a portion received at or above 81 percent of their recommended prenatal care in a timely fashion (FPC measure). Our preliminary 2017 HEDIS rate result is based on claims data only, and placed the FPC measure at 40.15 percent. This reflects steady improvement from a final 2016 rate (based on 2015 data) of 32.6 percent. The PPC1 measure for timeliness of prenatal care, has also shown improvement, from 59.37 percent in 2015 (for 2016 measure) to 64.96 percent in 2016 (for 2017 measure), <<which exceeds the overall rate for Florida (63.3 percent>>). Finally, the PPC2 measure for postpartum care increased from 32.6 percent to 39.17 percent over the same period.

Our data shows that pregnant women in our health plan are significantly more likely to have substance abuse, and urological and risk drivers, along with infectious disease (excluding TB, hepatitis and HIV) and mood disorders (both bipolar and depression). On average, our pregnant enrollees have been enrolled for 10 of the last 12 months (not necessarily continuously), and have spent an average of $7,996 per case, with $1,046 of that being on pharmacy. The average age of our total enrollee population is 40, while pregnant women have an average age of 26. Of our pregnant enrollees, 145 cases are below 18 years of age and two are 13 years of age. Although, they are less likely to have psychosis, schizophrenia, diabetes, hypertension, or cardiac risk drivers, than the experience in our broader population, those risk factors do exist. This compares to our non-pregnant population, which has been eligible for an average of nine months, and has spent $5,605 per case, in total, but $1,663 on pharmacy.

1.1 Care Management Programs
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.

Women are at greatest risk of developing a psychiatric disorder during the childbearing years, between the ages of 18 and 45. Many women may experience the symptoms of their illness for the first time during pregnancy and the postpartum period. Women with histories of these disorders are at increased risk for relapse during pregnancy and/or in the postpartum period. As a result, pregnant women with serious mental illness are likely to present more often to the
emergency room and experience more frequent admissions to the inpatient settings. In addition, 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, substance use/abuse, lack of physical activity and poor nutrition. Pregnancy can make a difference in long term recovery and provide the incentive to make changes to adopt a healthier lifestyle. 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.

The Mother Baby Connections program includes intensive coordination of care and services provided to pregnant enrollees who have multiple health care needs including pregnancy, serious mental illness (SMI) and/or co-occurring and/or co-morbid conditions and/or lifestyle risks requiring extensive and prolonged use of resources. MCC uses a holistic and integrated approach
to deliver case management services to those individuals with complex behavioral and physical health care needs. Due to the complexities of pregnancy combined with the diagnosis of SMI and related treatments, all pregnant enrollees are considered high risk. The program is an opt-out program where all eligible enrollees have the option to participate or decline participation. Additional, more detailed information on our programs for pregnant enrollment can be found in [MMA SRC #02, Attachment 2: Mother Baby Connection Program].

Magellan Complete Care’s Mother Baby Connections program offers comprehensive ongoing education and support to all pregnant enrollees from preconception through the first year of her newborn’s life. Our program incorporates our IHN model of care. The IHN is built on our understanding that a pregnant woman’s ability to have a healthy pregnancy and newborn is intrinsically tied to multiple factors outside of health, namely the social determinants and physical conditions in her environment. Our goal to improve care and outcomes can only be achieved within the context of where our enrollees live – in Florida’s neighborhoods and communities. Relationships and collaborations with community partners enable us to effectively coordinate care with the community supports and services that the enrollee knows and trusts (e.g., Resource Mothers, Nurse Family Partnership, WIC, and CenteringPregnancy, which is currently available in selected regions of the state).

The Magellan Complete Care program offers culturally sensitive, high-touch interventions designed to assist the enrollee and her baby to remain healthy. Magellan Complete Care supports each pregnant woman living with severe mental illness (SMI) individually based on her unique needs. It involves comprehensive assessment of the enrollee’s health status; determination of available benefits and resources; and development and implementation of a case management plan known as the Care Coordination Plan, documentation of the assessment and plan within the care coordination documentation system, individual and program level performance goals, monitoring and follow-up.

Magellan Complete Care provides complex case management and education services to help enrollees achieve their optimal health and recovery and become more self-directed in managing their health care. Complex case management services are delivered by Magellan Complete Care’s Care Coordination Team which includes Obstetric Integrated Care Case Managers (OB-ICCM), a clinical Pharmacist, Peer Specialists and Health Guides. The enrollee, the enrollee’s family supports, and the enrollee’s providers are encouraged to be part of the Care Coordination Team and be active participants in the process and plan of care. Emergency department (ED) diversion and hospital care transition services are offered to pregnant enrollees. The case managers and care team proactively assess and plan for potential risk factors which could result in an unnecessary ED visit or hospital admission/readmission.

Obstetric Integrated Care Case Managers are registered nurses or masters level licensed professionals who provide systematic pregnancy and behavioral health-related assessments and coordination of care and services using evidence-based clinical guidelines (EBG). They are available to coordinate complex care arrangements and connect high risk enrollees to the services they need while maximizing the use of their benefits. OB-ICCMs support and empower enrollees and their caregivers (natural supports) to effectively manage their ongoing condition(s) and prevent complications by supporting the provider/patient relationship, adhering to treatment and medication regimens, adopting a healthy lifestyle, and care coordination with behavioral health and medical providers. Magellan Complete Care provides intensive case management
service throughout pregnancy and up to eight weeks’ post-partum. If the enrollee has a continuing need for complex case management, her care will be transitioned to an ICCM.

**CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES SPECIFIC CARE COORDINATION PROTOCOLS...**

All Magellan Complete Care enrollees have co-occurring behavioral health conditions, since each has at least one SMI. Because of the potentially complicating nature of pregnancy for individuals with SMI, we identify all pregnant enrollees to be either high-risk or ultra-high risk. Ultra-high risk enrollees are those who are inpatient, or likely to admit within 90 days, as identified through our predictive modeling analytics, which considers known risk factors such as co-occurring substance use disorder, lack of engagement with primary care, etc. Enrollees who are designated as ultra-high risk receive integrated complex care coordination, our highest level of CC/CM until they are determined to have stabilized enough to be moved down to the high-risk category.

Magellan Complete Care customizes enrollee interventions to meet the pregnancy care and behavioral health coordination needs of each individual. Each pregnant enrollee is assigned to an Obstetric Integrated Care Case Manager (OB-ICCM) who is supported by a Care Coordination Team consisting of Health Guides, Peer Support Specialists, Care Coordinators support staff, Medical Directors and Clinical Pharmacists. The Obstetrical (OB) Provider oversees the prenatal, intrapartum and postpartum services that the enrollee receives to ensure they are medically appropriate and coordinated with the behavioral health provider and other specialists. Depending on the complexities of the enrollee’s conditions, care may be provided in consultation with a Maternal-Fetal Medicine physician.

Magellan Complete Care’s internal OB consultant is Board Certified in Obstetrics and Gynecology, Psychiatry, and Addiction Medicine. Areas of focus include high-risk obstetric patients with co-morbid psychiatric and substance use disorders. The primary Behavioral Health Provider (PBHP) is responsible for overseeing the delivery and quality of the behavioral health services that the enrollee receives in collaboration with the OB provider. Additional provider specialists may participate on the Care Coordination Team when the enrollee has a complex condition that requires specialist input and consultation (e.g. endocrinologist). The ICCM team responsible for managing our pregnant enrollees includes:

>-OB-ICCM: The OB-ICCM monitors and coordinates the pregnancy treatment plan with the OB provider, PBHP, and other providers, and maintains frequent, high-touch interventions for enrollees based on individual enrollee needs. The case manager provides ongoing assessments, pregnancy education, enrollee empowerment strategies, and engages the health guide and peer support specialist as indicated for additional support for behavior risk reduction, resource linkage, and coordination of services from the first trimester through the post-partum period. The case manager will make referrals to and coordinate care with the Healthy Start program, immunization programs, and referral to the Special Supplemental Nutrition Program for Women, Infants, and Children. We provide cultural competency education for OB/GYN practice staff so that they understand the special needs of their patient with SMI.

>-Health Guide: The Health Guide is the enrollee’s advocate and helps the enrollee navigate through the delivery system. 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.

>Peer Support Specialist: The Peer Support Specialist is a Certified Peer Support Specialist who is trained in applying resiliency and recovery principles and tools such as wellness recovery action plans, 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.

>Clinical Pharmacist: The clinical pharmacist participates in the weekly OB clinical rounds as needed. The OB-ICCMs 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 the 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:

>>The 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 during pregnancy and the postpartum period

>>Ongoing monitoring, as medications may have to be adjusted or discontinued.

2.1 Special Programs

Magellan Complete Care offers additional special programs directed at our pregnant enrollees with SMI. These include:

>Preterm Labor/17P (alpha-hydroxyprogesterone caproate): The Mother Baby Connections program, through a preferred relationship with Optum, offers high-risk OB home health services for certain enrollees with a history of preterm birth. Qualifying enrollees include women with a documented history of spontaneous preterm delivery at less than 37 weeks gestation in a previous pregnancy, and current pregnancy at a minimum of 16 weeks gestation confirmed by ultrasound and less than 28 weeks gestation, with no known major fetal anomaly. Magellan Complete Care OB home care services includes in-home obstetric nurse administration of 17P, education about the risk factors and signs and symptoms of preterm labor, weekly assessments and 24/7 nurse-line support. The goal of the program is to increase the likelihood that the enrollee will deliver a full or near-term baby resulting in improved health status for the baby.

>Opioid Dependence in Pregnancy: Due to the unique challenges of caring for pregnant women diagnosed with an SMI condition and with a co-occurring addiction to prescription narcotics or heroin, the perinatal program OB-ICCMs receive special training in opioid-assisted therapy for pregnant women. MCC pregnant enrollees with opioid dependence face additional complex medical and psychosocial needs and risks factors including inadequate nutrition, inadequate prenatal care, self and fetal exposure to fluctuating blood levels of drugs, and exposure to HIV, HCV, and other blood-borne pathogens associated with injection drug use. OB-ICCMs assist with coordination of care working closely with the enrollee’s OB often in consultation with a perinatologist, primary behavioral health specialist, and the local addiction medicine specialist at
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

the treatment program for opioid addiction with an appropriate Authorization to Use and Disclose (AUD) is in place.

The current standard of care for pregnant women with opioid dependence is referral for opioid-assisted therapy with methadone, but emerging evidence suggests that buprenorphine also should be considered. Methadone Maintenance Therapy (MMT) results in a decreased likelihood of preterm birth, low birth weight and other perinatal complications. The dosage may need to be adjusted throughout pregnancy to avoid withdrawal symptoms, especially in the third trimester. Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise. If a woman refuses to undergo methadone or buprenorphine maintenance, the OB-ICCM will work with providers to ensure access to a medically supervised withdrawal program.

During the postpartum period, the OB-ICCM continues to coordinate care to prevent postpartum relapse and a risk of overdose, and to ensure adequate contraception to prevent unintended pregnancies. Opioid-assisted therapy is compatible with breastfeeding. Magellan Complete Care will also work with the enrollee to support the new mother upon admission to the Newborn Intensive Care Unit (NICU) for babies identified as substance exposed (SEI). We work with the new mother to encourage parental attachment, including Kangaroo Care if available, breastfeeding, and use of pacifiers. Our OB-ICCM team supports education of the new mother, including referrals for ongoing treatment, and home visitation if needed.

>Smoking Cessation: Smoking is the leading preventable cause of fetal and newborn morbidity and mortality including complications of premature birth, certain birth defects, and infant death related to preterm birth or Sudden Infant Death Syndrome (SIDS). Pregnant women, including pregnant women with SMI, are more motivated to stop smoking during pregnancy. However, pregnant women with SMI may find it more difficult to stop smoking.

The Mother Baby Connections program leverages the Magellan Complete Care Healthy Behaviors Smoking Cessation program as well as our innovative online Clickotine smoking cessation tool. The program uses the Tobacco Free Florida smoking and tobacco cessation program that follows the Centers for Disease Control and Prevention’s Best Practices for Comprehensive Tobacco Control Programs. Enrollees who enroll in the Tobacco Free Florida smoking and tobacco cessation program will receive coaching sessions, self-help materials and quit aids from either a telephonic Quit Coach, an online Web Coach, or attend local face-to-face group sessions. The program will assist enrollees by addressing the physical, psychological, and behavioral issues of smoking and tobacco. The program will educate enrollees on the triggers of tobacco use, quit tips, overcoming withdrawal symptoms, and the benefits of quitting. After enrollees complete one month of the smoking and tobacco cessation program, they will receive a $15 pre-paid Walgreen’s gift card incentive. When enrollees self-report they have met the goal of two months with no tobacco use, they will receive a $15 pre-paid Walgreen’s gift card reward. Clickotine employs the concepts of Computerized Cognitive Behavioral Therapy to support enrollees through a step-wise smoking cessation program. The program, which has been certified by the FDA, has been demonstrated to be clinically effective through multiple scientific studies.

>Residential Care/Intensive Outpatient Therapy (IOT) for Substance Abuse: Magellan Complete Care offers IOT as an expanded benefit. Enrollees with SMI benefit from a continuum of community-based behavioral health and substance abuse treatment options and wrap around
services. This comprehensive continuum of care with its additional supports is critical for enrollees to live and participate in their communities. These services are also associated with reduced emergency room utilization and inpatient admissions. Services such as self-help, community support, and ambulatory detoxification provide flexible services for enrollees with SMI allowing for personalized treatment options that are cost effective and consistent with principles of recovery and resiliency.

The Mother Baby Connections program OB-ICCMs coordinate care continuum of community-based behavioral health and substance abuse treatment options including IOT and residential treatment centers to serve our pregnant enrollees. OB-ICCMs assist with coordination of care working closely with the enrollee’s OB often in consultation with a perinatologist, primary behavioral health specialist, and the treatment center staff with an appropriate Authorization to Use and Disclose (AUD) is in place.

>Home Visitation Programs: The Mother Baby Connections program OB-ICCMs refer appropriate enrollees to the Florida funded home visitation programs to provide family and parenting support for our enrollee’s. Florida has chosen three proven models for implementation by communities based on local needs including:
  >>Nurse-Family Partnership
  >>Parents as Teachers
  >>Healthy Families Florida.
Programs are implemented by local Healthy Start Coalitions, hospitals, federally-qualified health centers and other community-based organizations. These programs provide: parent education, child development, developmental screening, playgroups and service coordination to link families to other available services.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES STRATEGIES TO IMPROVE DATA EXCHANGES…
Early identification of pregnant enrollees and early prenatal care is critical to improve the outcome of high risk pregnancy. Since many pregnancies are unplanned or not known to us, Magellan Complete Care uses multiple tools and strategies to identify pregnant enrollees to engage them in prenatal care as early in pregnancy as possible.

We require all contracted primary care providers (PCPs), primary behavioral health providers (PBHPs) and other providers to notify us via the Case Management referral form within one week of identifying an enrollee as being pregnant. Once a form is received, it is forwarded to the OB-ICCM team for enrollee outreach or engagement. OB providers are required to submit a prenatal notification form within three (3) days of the enrollee’s first prenatal care visit. As part of our ongoing data analysis and predictive modeling activities, we are also constantly monitoring claims and diagnostic data for indications of pregnancy among our enrollees. We identify pregnant patients through claims, including claims for pregnancy tests, procedures or medications which indicate pregnancy, including ER visits. In addition, we also track ante-natal depression, pre-term labor, and other outcomes. This multi-pronged strategy supports active identification and outreach by our ICCM team.

Magellan Complete Care also makes use of the States HIE ENS system and enrollee demographic and diagnosis information from the State’s enrollment systems. We maintain automated interfaces to provider electronic medical record (EMR/EHR) systems for a number of
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our highest volume providers, as well as our laboratory partners. Each of these data sources provides important information for identification of pregnant enrollees, as well as utilization and treatment patterns.

Magellan Complete Care’s provider partners have access to extensive information for their pregnant enrollees through our Provider Portal and Connect Portal. The data provided on those sites includes care plans and care management results, gaps in care, risk assessment data, and other clinical information that is very useful to providers in delivering and managing care for our enrollees.

As part of our expanded telemedicine strategy, we are also evaluating the use of telehealth services for management of particularly high-risk enrollees. This strategy has proven very effective in managing this type of enrollee in a number of states and we believe it can be successfully implemented in Florida as well.

Magellan Complete Care requires the OB provider to offer Florida’s Healthy Start Services including but not limited to: prenatal risk screening to each pregnant enrollee as part of the first prenatal visit and to submit a copy to the County Health Department and to the enrollee; a referral to Florida WIC program medical referral; HIV counseling and offer HIV testing; Hepatitis B surface antigen screening (HBsAG) during first prenatal visit and a second test between 28 and 32 weeks of pregnancy; and report to the CDC findings as appropriate and make additional referrals as needed. We educate providers on these requirements through our contracting process, provider newsletters, provider handbook, and web-based educational materials and as part of our case management process. In addition, the required prenatal notification form is used to ensure that providers are addressing all of the State requirements with each pregnant enrollee.

Program goals of the Mother Baby Connections program include:

> Delivery of a healthy, full-term infant at 37 weeks or greater

> Stabilization of co-morbid/co-occurring conditions during the pregnancy for 80 percent of enrollees enrolled in maternity program as evidenced by decreased or absence of inpatient utilization

> Optimizing the health and safety of the pregnant enrollee by promoting compliance with at least 10-14 prenatal visits based on gestational age and stage of pregnancy as promoted by ACOG guidelines

> Compliance with at least one postpartum appointment within 56 days of delivery.

Enrollee Outreach and Enrollment: MCC provides general awareness about Mother Baby Connections program through:

> Education by MCC staff including Customer Service and Health Services who view an alert in MCC systems

> Information available on the MCC Florida website
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>Information provided by Nurse Line 24/7 staff when a pregnant enrollee calls in with questions or concerns. The system flags pregnant enrollees

>Information in the Enrollee Handbook. Targeted engagement activities for enrollees identified as pregnant also occurs through:

>Mailing of the perinatal program welcome kit to enrollees upon identification of the pregnant enrollee with information about enrollment in the program

>OB-ICCM outreaches to the enrollee to complete an initial clinical assessment and inform her about the program. If after two attempts the OB-ICCM is not able to reach an enrollee by telephone:
>>An “unable to reach” letter will be mailed. The letter includes information about the program
>>A referral will be made to the Health Guide to attempt a home visit where appropriate
>>A referral will be made to a vendor in regions where we partner for assistance in locating difficult to reach enrollees
>>Enrollees have the right to refuse enrollment in the Program.

CRITERIA 4: THE ADEQUACY OF THE RESPONDENT’S DESCRIPTION OF SPECIFIC EVIDENCE-BASED PROGRAMS AND INTERVENTIONS…
Magellan Complete Care embarked on a very exciting program in 2016 that included a partnership with Bayer pharmaceuticals and is directed at increasing knowledge of contraceptive options and increasing usage of safe and effective methods. Study results for program interventions during 2016 showed a 54.3 percent increase in LARC usage over 2015. The program, Magellan Method, is a contraceptive outreach educational program and includes the following key elements:

1. Initial provider outreach
   a. Educate providers regarding the initiative: PCPs are provided education on contraceptive options, usage, and administration of LARCs if needed.
   b. Discuss patient-specific opportunities: Magellan Complete Care communicates with providers to share data on enrollee contraceptive usage and adherence.
   c. Identify barriers to providers utilizing LARC or other contraceptive methods: Additional education provided if desired, or OB/GYN referral information shared. Magellan Complete Care provides 100% reimbursement to providers through pharmacy buy-and-bill program.

2. Initial member outreach
   a. Discuss current contraception therapy: Education is available to enrollees through multiple sources, including written materials, case management, etc.
   b. Educate enrollees on all contraception types, including LARC: Providers given educational materials, talking points, etc.
   c. Facilitate enrollee follow-up for contraception evaluation

3. Closing the loop
   a. Provider follow-up to relay enrollee interest in contraception: Magellan Complete Care provides outreach through its clinical management and outreach staff.
   b. Enrollee follow-up to ensure office visit is scheduled: Members are provided with appropriate support to schedule and attend provider visits as needed.
Providers within the Magellan Complete Care network are being targeted for inclusion if they are OB/GYNs and PCPs with potential patient candidates for contraception therapy based on the following:

- Females of childbearing age (18-45 years old)
- Poor adherence to oral contraceptive therapy per claims-based data analysis demonstrating a PDC <0.8 since 1/1/2015
- No claims for a LARC, IUD, or subdermal contraceptive therapies

We have identified more than 1,500 potential provider participants to target the more than 16,000 enrollees of child-bearing age. The program has been specifically designed to allow us to measure the effectiveness of specific strategies for achieving higher rates of engagement and compliance. Evaluation methods include the following:

1. We are conducting pre- and post-intervention telephonic provider surveys. Outreach messaging is being tailored to prescribers to assist in navigating barriers to contraceptive usage.
2. We are conducting baseline and post-implementation data analysis to test the effectiveness of interventions.
3. Telephonic outreach is being conducted with providers to understand the barriers that persist. Information is also being gathered to assist in determining the number of patient-specific opportunities for contraceptive therapy that exist.
4. Provider follow-up through ICCM and Provider Support Specialists (PSS) to identify education and support required by providers, and/or barriers to be addressed.
5. Fax materials are also provided, including contraceptive order forms and enrollee letters.

In addition to this recently launched program, Magellan Complete Care provides reimbursement for immediate post-partum insertion of LARCs. Magellan Complete Care specifically incentivizes providers for placement of LARC by reimbursing for their use outside the delivery bundled payment. This separate payment helps to overcome provider resistance to their use post-delivery, due to their substantial cost.

We also provide enrollees with comprehensive family services which allows enrollees to make informed decisions about contraception, pregnancy and childbirth. Magellan Complete Care supports intentional family planning and the use of Long Acting Reversible Contraceptive (LARC) as a means of effective birth control. We have adopted the recommendations of the Office of Population Affairs (US Department of Health and Human Services) and CDC evidence-based Quality Family Planning Guidelines 2014, and make this available on our provider web site. Specifically, we provide education to our providers on the safety and efficacy of LARC and encourage postpartum inpatient LARC insertion. Our Provider Support Specialists (PSS) provide training on current guidelines and approaches. For primary care practices, training incorporates “One Key Question – would you like to become pregnant in the next year?” approach. In this enrollee-centered approach, a response of “no” can lead to further discussion about the enrollee’s reproductive life plan. Providers are encouraged to use a tiered approach to the discussion of contraception starting with LARC because an initial comparative review of all options can be overwhelming. PSSs also provide focused education and tools based on the American Academy of Pediatrics Bright Futures regarding how to work with teens to prevent teen pregnancy.
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Magellan Complete Care educates our enrollees about unintended pregnancy, the importance of spacing pregnancies at least 18 months apart, and the benefits and ease of use of LARC. We work with enrollees of childbearing age to promote the use of the CDC’s “My Reproductive Life Plan” and “Show Your Love” pre-conception health app. We offer health education for parents/guardians/caregivers on how to talk to their teens. We raise awareness of teen activities (e.g. use of social media to know where they are and what they are doing).

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES FINANCIAL AND NON-FINANCIAL PROVIDER AND ENROLLEE INCENTIVES...

Magellan Complete Care employs both provider and enrollee incentives (financial and non-financial) to encourage evidence-based practices aimed at improving all birth outcomes. We have already described our contraceptive intervention programs, as well as our many programs for enrollee and provider supports above. In addition to those already described. We offer the following important incentives.

5.1 Enrollee Incentive Program: Magellan Complete Care offers an incentive program to pregnant enrollees in the program and when established milestones are achieved. These milestones are based on the HEDIS measures, Prenatal and Postpartum Care and Frequency of Prenatal Care The incentive milestones are as follows:

1. Upon enrollment in the program, enrollees will receive a $10 Walgreen’s or BabiesRUs gift card through the mail.
2. For established MCC enrollees who become pregnant, a $10 Walgreen’s or BabiesRUs gift card will be mailed after completion of the first prenatal visit within the first trimester; OR,
3. For enrollees who are already pregnant when joining MCC, a $10 Walgreen’s or BabiesRUs gift card will be mailed when the enrollee attends their prenatal visit within 42 days of enrollment with the plan.
4. For enrollees who keep 100 percent of their prenatal care visits, according to the ACOG visit schedule, a $20 Walgreen’s or BabiesRUs gift card will be mailed.
5. For enrollees who keep their postpartum follow up appointment within 21-56 days of delivery, a $10 Walgreen’s or BabiesRUs gift card will be mailed.

All incentive milestones are independent of each other; an enrollee does not need to achieve milestone #3 to receive incentive #4. However, each milestone must be met in full to receive the incentive. A claim for the provider visits must be received by Magellan Complete Care for the incentive to be paid. In addition to these incentive programs, as previously mentioned, Magellan provides additional benefits and programs including the Pre-term 17P program, additional supports and access to expanded benefits for the treatment of substance use disorder (SUD) and in-home supports. All are aimed at supporting enrollees in achieving healthy, full-term deliveries and healthy babies.

5.2 Physician Incentive Program: In addition to the enrollee incentive programs noted above, Magellan Complete Care has a Provider Incentive Program (PIP) which is specifically focused on the Frequency of Ongoing Prenatal Care (FPC) and Postpartum Care (PPC). Participating providers that meet the eligibility requirements must meet the following criteria to qualify for the financial incentive program:
>HEDIS: Frequency of Ongoing Prenatal Care (FPC). - Rate of patients with ≥81 percent of expected visits must be at or above the Medicaid 50th percentile as calculated by NCQA using 2016 HEDIS specifications above the National Medicaid Mean as calculated by NCQA using 2016 HEDIS specifications

Payment is made using an enhanced, bundled payment based on the Medicare rate for each delivery. This incentive excludes some providers, including those without a delivery in the measurement period, non-participating providers, FQHCs, RHCs, and county health departments. Payment to all providers is made through an enhanced per member per month (PMPM) capitation rate. Quality measures are reported and paid on a quarterly basis. For each quarter, four measures will be evaluated.

As noted earlier in this document, additional provider supports include education and support for managing enrollees with SMI, through our Provider Portal and published educational materials. It also includes specific outreach and support programs such as our Contraceptive Outreach and Education Program noted above. As part of this ITN response, Magellan Complete Care is also proposing expansion of its provider incentive programs and value-based purchasing programs to include additional metrics tied to healthy birth outcomes. Although the final program design will require Agency approval, additional performance metrics and incentives would include areas such as increased contraceptive use; and, screening and testing for maternal risk factors such as STIs, intimate partner violence, obesity, hypertension and diabetes.

Additionally, Magellan Complete Care has proposed expanded physician incentives to drive further improvements in key birth outcomes. Notably, our proposed program includes an expanded focus on key metrics tied to maternal health, which is known to affect infant mortality and overall health. Specifically, we are proposing a shared savings incentive program for our non-capitated providers. The primary objective of this program will be to incentivize:

>- Increased enrollee accessibility and engagement for OB and primary care
>- Increased utilization of primary care to reduce preventable events
>- Improved access to provider electronic medical record (EHR/EMR) data for monitoring and management of gaps in care
>- Participation in programs to close gaps in care for assigned enrollees.

We propose that non-capitated providers would participate in a shared savings pool and incentive program for their enrollees, which would allow them to share in savings in total costs of care based on their performance in each of the areas noted above. In order to qualify for participation, providers would first need to agree to allow Magellan Complete Care to establish electronic access to the provider’s electronic medical record system, if available, for purposes of capturing and reporting quality and gap in care data. Providers without EMRs would not be excluded from participation. Providers would then participate in a shared savings pool for their assigned enrollees. Payouts from that pool would be based on total savings generated and would be driven by:

>- Encounter rates per enrollee, within range for annual target rates per enrollee
>- Provider gap closure rates for key target HEDIS/EPSDT/CHCUP metrics
>- Reductions in all-cause admissions for assigned enrollees
>- Reductions in 30 and 90-day readmissions for assigned enrollees
>Reductions in ER encounter rates for assigned enrollees.

The key objective of this program would be to increase access and use of primary care, with the goal of reducing preventable events and closing gaps in care. We would work with our capitated providers to further define and enhance the programs as needed to gain support and acceptance of the program.

In addition to the specific metrics included in Magellan Complete Care’s existing MPIP program, we are targeting quality improvement in additional areas tied to improving birth outcomes. We propose additional incentive payments to OB/GYNs for the following types of services:

>Screening for substance use
>Screening for sexually transmitted diseases (STIs)
>Family planning visit
>Cervical Cancer Screening (CCS) Cervical Cancer Screening
>Pap smear
>Mammogram.

The details of these incentive programs will be developed in consultation with our OB/GYN providers. Note that the incentives for family planning visits are in addition to current incentives for insertion of Long-Acting Reversible Contraceptives (LARCs) post-delivery. Currently, Magellan Complete Care provides reimbursement for immediate post-partum insertion of LARCs. Magellan Complete Care specifically incentivizes providers for placement of LARC by reimbursing for their use outside the delivery bundled payment. This separate payment helps to overcome provider resistance to their use post-delivery, due to their substantial cost. In addition to the other incentives identified above, we propose continuing this program.

CRITERIA 6: THE ADEQUACY OF THE RESPONDENT’S PROPOSED PERFORMANCE BENCHMARKS...

Our entire OB/GYN management program is directed at supporting improvements in clinical outcomes for our pregnant enrollees and those of child-bearing age as identified in the Federal governments Healthy People 2020 goals and as defined by NCQA. Those goals include: a) improved access and frequency of perinatal and post-partum care; b) improved management of pregnancy risk factors; b) limiting elective Cesarean-sections and early elective deliveries; reducing rates of unintended pregnancies (including among teens and youth); and, increased use of effective contraceptive methods. We also embrace the goals established by the Center for Medicaid and CHIP Services (CMCS) Maternal and Infant Health Quality Goals, as they apply to the Magellan Complete Care enrollee population (please note that we do not cover enrollees below the age of 5).

The specific improvement goals we have set include:

> Increase by 10 percentage points, the rate of post-partum visits over a three (3) year period.

<<Note that, although still not at desired rates, Magellan Complete Care’s PPC2 HEDIS measure for postpartum care increased from 32.6 percent to 39.17 percent between 2016 (2015 data) and 2017 (2016 data) --- a 20 percent improvement.

> Increase by 15 percentage points, the use of moderately effective contraception, over a three year period
In addition to the goals noted above related to post-partum care and use of contraceptives, Magellan Complete Care has established specific improvement goals in each of the following areas:

>Reductions in pre-term deliveries. Note that Magellan Complete Care already achieves a low percentage of pre-term deliveries of 2.48 percent, versus 10.4 percent as reported by the Center for Medicaid and CHIP Services and 9.63 percent for all populations in 2015 as reported by the CDC. We are targeting an additional 5 percent improvement in that performance.

>Increase by 10 percentage points the percentage of enrollees meeting NCQA standards for prenatal care visits (timeliness and frequency --- first trimester, ongoing)

>Additional 10% reductions in cesarean section rates (Leapfrog Group Maternity Care Expert Panel Target of 23.9 percent as identified in Federal Government Healthy People 2020 goals, and 32 percent cesarean section rate in 2015 for all populations as reported by the CDC). <<Magellan Complete Care averaged for all cesarean sections was 28.45 percent of all deliveries between 2015 and 2017>>

We believe these birth outcome performance improvement targets are achievable given our strong programs and commitment to managing birth outcomes for our enrollees. Although Magellan Complete Care is responsible for a very complex, high-risk SMI population, our results in managing birth outcomes speak to the effectiveness of our programs and the ability to achieve further reductions in non-medically indicated cesarean sections and early elective deliveries. It is important to note that Magellan Complete Care does not pay for delivery prior to 39 weeks gestation of either Cesarean- section or induction, unless there is a documented medically reason for early delivery. We work very closely with both our providers and enrollees to maximize our rates for full-term deliveries, and to provide both with additional training and interventions in instances in which clinical goals are note being achieved.

We collect data on an ongoing basis, identifying the number of elective deliveries, method of gestational determination (ACOG criteria used), and indications for delivery. Where non-compliance with clinical protocols is identified, we identify enrollee and provider barriers to compliance, provide education, and implement solutions to overcome those barriers. We contract with board-certified OB/GYNs who have met all the pre-defined measures standards for prenatal care, frequency of ongoing prenatal care, postpartum care, and who do not exceed the overall Florida Medicaid Cesarean-section rates. Our provider incentive programs, as described above, further incentivize achievement of the planned improvements.

In addition to our ongoing focus on provider education, quality improvement and outcomes, we provide enrollee education materials, including our “Beginnings Pregnancy Guide” that define “full term” and emphasize the importance of 40 weeks gestation. The importance of this goal is further emphasized throughout our engagement with the enrollee through our case management programs.

CRITERIA 7: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES ITS EXPERIENCE...
Magellan Complete Care’s OB program approach is comprehensive in addressing both non-medically indicated cesarean sections (C-section) and early elective deliveries. As described
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earlier in this response, our approach is comprehensive and supports full engagement and
coordination between the enrollee, provider, our ICCM team, and community systems and
supports through our IHN team members. These programs are reinforced by proactive and data-
driven identification of pregnant enrollees at the earliest points of their encounters with the health
care system. We also rigorously, and continuously analyze and report the results of our program
using statistically valid methods, and use that data to improve and refine our programs. We have
incorporated the goals related to C-section and early elective deliveries within our perinatal
program and as a part of our daily approach with enrollees and providers. The Magellan Complete
Care leadership reviews data and works with the analytics team to identify providers with higher
rates of C-sections or pre-term delivery rates and work to educate providers when issues are
identified.

Our OB management program shows compelling results, pointing to the success of these
interventions. As noted previously, our C-section rates are low when compared to Medicaid
program performance, at approximately 28.45 percent for all deliveries between 2015 and 2017.
This is significantly below the rate experienced by Medicaid populations throughout the country.
Our results for pre-term delivery are also very low, at 2.48 percent versus a 10.4 percent rate for
Medicaid populations throughout the country. The benefits of our program are particularly evident
when comparing pre-term delivery rates for participants in our program, at 1.2 percent versus a
2.1 percent pre-term delivery rate for non-participants in the program.

Our OB management program also shows promising results in other areas as well. For example,
there is very little inpatient utilization for pregnant women in the six months following their delivery
date, while proportionally more women who are not enrolled in the program have at least 1
inpatient stay. A similar trend is seen in ER use. Notably, of the women with ER use, 61 percent
were not enrolled in our program. Although there was some ER use among enrolled women, the
majority of those encounters were for physical trauma. Though the cause of trauma among this
group is not clear, we are evaluating that trend to determine whether it is tied to intimate-partner
violence and will be enhancing our programs to address these issues if that turns out to be the
case. In addition to these very favorable outcomes in clinical indicators, we are also very pleased
with some of the patterns we are seeing in program enrollment. Most significantly, nearly 40
percent of program participants are African-American, a Medicaid sub-population that
experiences much poorer birth outcomes across the country.

In addition to the data already cited above for improved pregnancy outcomes, we have also
achieved a 54.3 percent increase in use of LARCs from that successful program, contributing to
the goals of both AHCA and the Federal government to reduce the rates of unintended
pregnancies. However, Magellan Complete Care is committed to continual enhancements of our
programs to take advantage of new programs and approaches to support healthy birth outcomes,
and culturally-sensitive differences in pregnancy care. Specifically, our ongoing analysis of birth
outcomes shows that participation in our programs is much lower for our Spanish-speaking
enrollees. In an effort to address that issue, and expand access to culturally-sensitive care, we are
exploring the use of Doulas as part of our pregnancy program, allowing us to work more
closely with Florida’s very robust Doula networks to enhance outreach and engagement with the
Spanish-speaking community. In addition, we are looking forward to the potential to work with the
CenteringPregnancy programs in use in other regions throughout the state. CenteringPregnancy,
which is a CMS-sponsored initiative with proven clinical effectiveness, brings pregnant women
together in a group setting for their care. It provides a relaxed environment to learn about healthy
pregnancy and share the parenting journey. In addition to providing participants with recommended prenatal care, it also encourages active engagement of the mother-to-be in pregnancy self-care. We believe that this group setting might also provide needed social connections and support for our SMI enrollees who often experience social isolation. We are very excited about the potential for adding these additional programs to our interventions to drive even better outcomes for our pregnant enrollees.

**Evaluation Criteria:**

1. The extent to which the respondent identified opportunities for improvement in achieving the benchmarks and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care.

2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify high-risk pregnancies (including enrollees with co-occurring behavioral health conditions).

3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for pregnant enrollees that are determined to be high-risk.

4. The adequacy of the respondent’s description of specific evidenced-based programs and interventions that will be used to decrease the number of unintended pregnancies and the associated indicators or measures that will be used to determine their effectiveness.

5. The extent to which the respondent describes financial and non-financial provider and enrollee incentives for evidence-based practices that will contribute to hitting the benchmarks.

6. The adequacy of the respondent’s proposed performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries.

7. The extent to which the respondent describes its experience implementing successful strategies that resulted in a reduction in non-medically indicated cesarean sections and early elective deliveries. In order to receive all points for this component, the respondent must include outcome data on specific performance metrics.

**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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MMA SRC# 3 – Patient Centered Medical Homes (Regional):

The respondent shall describe its experience with patient centered medical homes (PCMHs) including the respondent’s efforts toward the solicitation of PCMH-recognized practices to improve access, facilitate care integration and improvement in quality measures. Specifically, the respondent shall describe programs and initiatives utilizing PCMHs to promote the Agency’s goals.

Response:

OVERVIEW
Magellan Complete Care shares the AHCA’s commitment to the advancement of the Patient Centered Medical Home (PCMH) model for its beneficiaries. Working together, we are uniquely positioned to ensure improved access, coordinated and integrated care, and improved outcomes for individuals enrolled in Florida MMA. As the specialty plan serving individuals with serious mental illness (SMI), our primary focus is the promotion and facilitation of integrated care through an expanded PCMH model – Integrated Health Homes.

In our response to the 2013 SMI Specialty Plan ITN, we sited Integrated Health Homes in the PCMH response and specifically titled it “PCHH” (Patient Centered Health Home). At the time, we described the Integrated Health Home as our specialized, tailored approach, as an expansion of PCMH. We established this as our standard and intention years ago in Florida. We have held true to that commitment and developed a statewide Integrated Health Home approach as well as other targeted health homes for more complex enrollees.

We fully recognize the value of PCMH and continue to work with them in pursuit of integrated care models and to provide primary care for our enrollees. Magellan Complete Care currently holds provider contracts with 44 PCMHs throughout the state of Florida. Many of our federally-qualified health center (FQHC) partners seeking to develop integrated health homes are already certified or working on becoming a PCMH. Our parent company, Magellan Health, Inc., has a national PCMH team with an in-house PCMH specialist to help guide the local Provider Support Specialists who work with providers working on PCMH certification.

As we work with our PCMH partners, we promote or capitalize on the Collaborative Care Models already in place to expand services and supports for our enrollees who need additional integrated intensive and “wrap around” services. Today, two of our initial four Integrated Health Home partners are FQHCs certified as PCMHs (more detail in section 1.2 below). Magellan Complete Care’s goal is 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 PCMH/Integrated Health Home model.

The foundation of our regional approach to the development of Integrated Health Homes is our understanding that each enrollee’s ability to achieve and maintain a healthy and vibrant life is tied to multiple factors beyond healthcare, namely social determinants of health, including housing, poverty, education, and access to transportation and healthy food. Improved overall health and wellness can only be achieved where enrollees live – in Florida’s neighborhoods and communities. That’s why we developed and implemented Integrated Health Neighborhoods™ in
Florida. We help enrollees stay connected to their families, friends, neighbors, and resources in their communities to achieve optimal health and well-being.

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 – Miami or Tallahassee. The Integrated Health Neighborhood model works in rural underserved areas and in urban areas.
For more information, please refer to [MMA SRC #01, Attachment 1: Integrate Health Neighborhood Overview, Flowchart, and Flyer].

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT’S DESCRIPTION DEMONSTRATES EXPERIENCE THAT INCLUDES...

1.1 Experience with PCMH in Our SMI Specialty Plan Provider Network in Florida
We have prioritized the contracted PCMH's in our provider engagement model by having our Provider Support Specialists foster partnerships with 44 traditional PCMH providers in every Florida Region we serve to impact access, quality, enrollee and provider experience, and cost; and to close gaps in care for our enrollees. Many of our PCMH partners have achieved PCMH level three recognition. Most are accredited with NCQA while others have pursued Accreditation Association for Ambulatory Health Care (AAAHC) accreditation. The Provider Support Specialist 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 act as a facilitator to create connections between the PCMH and behavioral health providers to coordinate and integrate care to achieve improved quality outcomes.

As an example, in Region 9, our Provider Support Specialists were able to add value to a PCMH provider facilitating a connection made to the local mobile crisis unit. During the Provider Support Specialist’s routine visit to a practice site, the practice manager at that rural location explained the need for education and resources when a behavioral health crisis occurs in the PCP clinic. The Provider Support Specialist was able to connect the PCMH to the Community Mental Health Center (CMHC) nearby who has a Mobile Crisis team. The Provider Support Specialist was able to coordinate a “meet and greet” between the PCMH and CMHC to conduct a training and overview of the Mobile Crisis Unit, the services and supports they provide, and how the PCMH can leverage them in times of crisis to support the immediate needs of the enrollees and maintain safety of all involved.

Please see [MMA SRC #03, Attachment : PCMH Map] for a graphical depiction of collaborations and between Magellan Complete Care, PCMH’s and IHH’s in Florida.

1.1 Additional Experience Developing Specialized Health Homes
In addition to our experience with PCMH network providers as the SMI Specialty Plan, we have experience working with the provider network with additional models and programs to demonstrate (a) enhanced access; (b) coordinated and/or integrated care; and (c) achievement of improved quality, including:
1.1.a Medical/Health Home Options through the Provider Partnership Program

In 2015, Magellan Complete Care established the Provider Partnership Program (PPP) 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 triple aim of healthcare. It is Magellan Complete Care's SMI-specific version of the very successful programs for primary care transformation used throughout the country.

Magellan Complete Care Provider Support Specialists targeted providers who were PCMH, as well as FQHC, and community mental health centers (CMHC) interested in developing integrated care models. We started with Health Resources and Services Administration (HRSA) funded health home programs in Florida, CMHCs with a co-located primary care provider (PCP) and FQHCs that offer behavioral health services. Our Provider Support Specialists provide practice facilitation as provider groups work towards or maintain their PCMH/Integrated Health Home status or 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, actively use the handbook to guide their processes with providers and have developed Magellan Complete Care specific provider materials and tools to support Practice Facilitation activities.

Several key activities which help to drive the process:

>Identification of Providers to Participate: This is a twofold process: (1) data analysis, and (2) qualitative input from the Provider Support Specialists assigned to the provider. We look at enrollee assignment, risk category and provider engagement to target which provider to prioritize into the program.

>Provider Engagement: Learning about the providers, their capabilities and goals. Gathering 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 Specialists 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 Specialists conduct on-site practice observations at all practice locations. They follow and observe the general patient experience from end to end. The Provider Support Specialist take copious notes to identify best practices, strengths and areas of improvement. The goal of these observations is to listen, learn and understand how the practice is operationally functioning.

Develop Workflows and Practice Integration Assessment: After conducting all practice observations, the Provider Support Specialists compile work flows for each step of the patient experience to thoroughly illustrate how effective the processes are functioning and supporting the organizations goals related to patient care and outcomes. The Provider Support Specialists also completed a practice integration assessment which focuses on: 6 Levels of Collaboration (SAMSHA tool) and Readiness for Change (based on Motivational Interviewing). There is also a short summary for the Provider Support Specialists to provide narrative feedback to the practice about the overall observation. This information is then shared and presented during a meeting with the practice organization.

Collaboratively Create a Practice Plan: Once the practice has reviewed the information, the Provider Support Specialists team 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, the practices growth goals and align with addressing the triple aim of health care.

1.1.b Integrated Health Homes
Magellan Complete Care has maintained its commitment to the Integrated Health Home Model set forth in our 2013 SMI Specialty Plan proposal. Integrated Health Home is nationally recognized by the Joint Commission and cited in the Affordable Care Act as an integrated approach to address “whole person health” for complex populations such as SMI. Our statewide Integrated Health Home program is built around an integrated service model that provides coordination between behavioral health and medical services, employing a unique team-based approach for delivering whole-person, patient-centered services coordinated for all situations in life and transitions of care to produce an integrated system of healthcare practices. The Magellan Complete Care Integrated Health Home program seeks to establish collaboration and co-location between CMHCs and FQHCs with shared incentives. The Integrated Health Home is designated as the enrollee’s Primary Behavioral Health Provider (PBHP) to serve as the behavioral health support hub for the assigned enrollees. This model provides an additional layer of support for enrollees to include both the PCP and PBHP to address the complex needs of the enrollees and promote an integrated model of care. Integrated Health Homes are perfectly designed and tailored for our membership.

These models are designed to be specifically responsive to Mauer’s “Four Quadrants of Clinical Integration Based on Patient Needs”. The Four Quadrant construct recognizes the need for different models of care integration, collaboration, and coordination based on degree of enrollee behavioral health and physical health complexity. We have worked with the Florida provider community to build medical/health home models that are more comprehensive in their scope, but also targeted at the specific high-risk needs and challenges faced by our enrollees. All of our models leverage our deep understanding of Florida providers and the neighborhoods where our enrollees live.
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The models also reflect the strong partnerships developed over our many years as the Prepaid Mental Health Plan (PMHP) in the state and strengthening relationships since the launch of Magellan Complete Care. Each model incorporates the concepts of integrated biopsychosocial care delivery and coordination of care for individuals with SMI. They support the enrollee in establishing an ongoing relationship with a PCP to provide first contact; continuous and comprehensive care; whole-person orientation; enhanced access; integrated and/or coordinated care; quality and safety. Each model builds on the concepts of provider-health plan-enrollee collaboration and focuses on prevention; and closing gaps in care minimizing potentially preventable events; and improving outcomes, including birth outcomes.

The co-location of physical and behavioral health care in specific, targeted settings increases the access and continuity of care. Many enrollees with SMI do not have a regular source of physical health care and do not feel comfortable going to PCP offices. In some cases the PCPs do not feel comfortable, or appropriately trained to manage the care of enrollees with SMI and find their behaviors unsettling to their other patients. By locating primary care where the enrollee and provider feel most comfortable we are able to address all of our enrollee’s health care needs more effectively and efficiently.

Core activities of Integrated Health Home programs include comprehensive care management; care coordination and health promotion; medication reconciliation; comprehensive transitional care from inpatient to other settings; appropriate follow up; peer support to help individuals set and reach recovery and wellness goals; individual family support, which includes authorized representatives; referrals to community resources and social support; and use of health care technology to share clinical information and to identify and address gaps in care.

Magellan Complete Care has identified key metrics that will drive meaningful shift away from unnecessary deep end services, reduce instances of preventable events and help to increase community tenure and long term recovery for our enrollees. The Integrated Health Home providers will be measured and incentivized through a creative value based system to:

- Increase enrollee engagement
- Increase medication adherence
- Increase access to services
- Increase access and coordination with primary care
- Increase delivery of community-based services.

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 Community Mental Health Centers throughout the state and have received support and commitment from them to move in this direction.

Starting in Q1 of 2018, Magellan Complete Care launch phase II by introducing an incentive program based on the above metrics as well as reduction in preventable events. Magellan Complete Care will continue to work hand in hand with the provider to share savings 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.
1.1.c Collaborative Care Model
The Collaborative Care Model is an evidence-based approach for integrating physical and mental health care in Medicaid Health Homes to improve health care of high-need, high-cost Medicaid populations. The integration of physical and mental health care is an important aspect of the Medicaid health home model. Collaborative care programs are one approach to integration in which primary care providers, care managers, and psychiatric consultants work together to provide care and monitor patients’ progress. These programs have been shown to be both clinically-effective and cost-effective for a variety of mental health conditions, in a variety of settings, using several different payment mechanisms.

Magellan Complete Care is uniquely qualified to organize the delivery system to support the integrated Collaborative Care model through clinical expertise and scalable solutions as primary care is able to bill for this as an expanded value-add benefit. Collaborative Care is a specific type of integrated care approach developed by the University of Washington that treats common mental health conditions. The key principles of the model include the following:

> Team care
> Evidence-based
> Measurement-guided
> Practice-tested
> Population-based
> Accountable care.

Magellan Complete Care integrated models, programs, and initiatives to promote the AHCA’s goals include the following:

1.1.d Integrated Behavioral Health Home Pilot Program
The Integrated Behavioral Health Program (IBHP) is a Magellan Complete Care innovation aimed at delivering immediate access to integrated, comprehensive, enrollee-focused care through community-based health homes. The IBHP has been launched with two strategic provider partners and mirrors the foundational elements of the evidenced based ACT model (Assertive Community Treatment) with more intensity and an additional layer of support provided through collaboration with our Care Coordination team to ensure positive quality outcomes. The IBHP addresses the behavioral health and physical health needs, as well as social determinants, of enrollees to improve quality, improve the enrollee experience, and decrease costs.

Another important element, and differentiator of IBHP is the focus on recovery. Magellan Complete Care believes that recovery is possible for all enrollee not matter the diagnosis or condition. IBHP put the enrollees’ voice and choice at the forefront of care planning and service delivery to ensure their recovery goals drive the process. As part of the IBHP program, Magellan Complete Care included peer support services as a requirement and will provide resources, training and education to the provider partners to help build and grow their capacity to deliver this valuable service.

The Integrated Behavioral Health Program multidisciplinary teams are made up of: Licensed Clinical Social Worker, Psychiatrist, PCP, Case Manager, Peer Support Specialist, and our Care Coordination team. IBHP was built on a foundation of collaboration and partnership with the providers. Over a period of six months, Magellan Complete Care leadership met with the provider
Leadership teams to develop, refine and operationalize the intensive “Florida Assertive Community Treatment (FACT)-like” model. IBHP was created based on several key principles:

> How can we better support enrollees with complex needs?
> What is missing in the continuum of care today?
> What are the gaps? And how can we work to close them to improve the wellness and quality of life for the enrollees?

The goal of IBHP is to provide person centered services for our enrollees with the most complex needs to increase community tenure, provide expedited access to critical outpatient services, address social determinants and promote long term recovery. The objectives are to deliver coordinated, community-based outpatient behavioral health services connected with primary care services, to ensure that the enrollee’s end-to-end healthcare clinical needs are met, reduce any barriers to treatment, improve the quality of services, and provide expedited access to critical services to support the enrollees in the communities for which they live. Additionally the IBHP model gives flexibility to the provider partners so they are able to employ creative methods to care delivery such as community navigation, crisis interventions and real time, same day access to psychiatrists and MDs.

Built on our Integrated Health Neighborhood model, we deployed an intensive Rapid Response Team “feet on the street” approach integrating community partners to address the enrollee’s social determinants, including housing, food deficiencies, familial, and social needs, and give the enrollee a voice in their recovery pathway. From a clinical perspective, we created access and availability to a team of professionals who understand the complex needs of the enrollee and have the dedication and tenacity to help the enrollee build a healthier future. The IBHP is a community-based, intensive outpatient model that is that is recovery oriented and person centered, reverse integrating primary care into behavioral health care delivery. It is also specifically focused on reducing preventable events such as readmissions or ER utilization for ambulatory care sensitive admissions, by providing enhanced care management, care coordination and access to critical outpatient services in the community where the enrollee’s feel comfortable and included.

Peer Support Services is a critical role on the IBHP team to ensure lived experience is included into the model. Each provider has included peer services as a contracted part of the model to highlight enrollee voice and choice, help empower enrollees through a shared experience and work collaboratively on recovery goals through Wellness Recovery Action Plans (WRAP), an evidence-based practice to support individuals living with SMI). Through the ongoing data analysis process, we identified enrollees with high inpatient and ER utilization, uncoordinated care, and multiple chronic and complex behavioral, physical and psychosocial challenges. These enrollees experienced 20 or more behavioral health admissions within a year and additional ED visits totaling an average of one facility visit approximately every nine days annually with little utilization of outpatient services or pharmacy benefits. We designed the dedicated IBHP with our provider partners to meet their complex needs and help to intensively support them and remain in the community.

The IBHP model provides flexibility through a creative funding arrangement, case rate, 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 do not exist in the FFS environment and helps to support “non-traditional services” that are critical for long term recovery. IBHP is also designed to help build enrollee positive coping skills and support systems to reduce unnecessary reliance on facility-based care and increase connection to community-based outpatient services. The program is focused on CMHCs that have embedded or have established partnerships with physical health providers, as well as FQHCs that have done the same with behavioral health providers.

Magellan Complete Care program outcomes include reductions showing 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 CCM at all risk levels when compared to a control group.

Magellan Complete Care conducts collaborative trainings between the IBHP provider teams and our care coordination teams to ensure an environment of partnership. We continue to meet on a weekly basis with the provider teams to review the individual enrollee needs, clinical concerns and program operations. Additionally Magellan Complete Care leadership and the providers’ executive leadership meet monthly to discuss the strategic direction for the program. For example, we are working to coordinate housing options within this program in the Miami-Dade area, to include specialized ALFs.

For more detail, please refer to [MMA SRC #03, Attachment 3: Magellan Complete Care and Jackson Health System: Integrated Behavioral Health Program.]

1.1.e Medicaid Health Home (Sickle Cell Program)
Magellan Complete Care’s Medicaid Health Homes are both physical and “virtual health homes” specifically targeted at serving enrollees with high-risk chronic illnesses such as sickle cell anemia, diabetes, congestive heart failure, COPD, high risk pregnancy, schizophrenia, and mood disorders. Our first Medicaid Health Home has been launched with Broward Health and focuses on sickle cell disease. We will be rolling out additional Medical Homes in other locations and other conditions throughout 2017 and 2018. The Medicaid Health Homes are based in health system centers of excellence for each specific disease, incorporating integrated (behavioral health-physical health) case management, care coordination, enhanced access and enrollee support services.

Magellan Complete Care’s approach to Sickle Cell Care Management is different from that found in traditional coaching programs. We address 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. While population-based, our Sickle Cell Care Management Program 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.

Magellan Complete Care’s Sickle Cell Care Management Program is offered to all eligible Enrollees diagnosed with sickle cell. This 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.

For high volume practices or health homes, Magellan Complete Care will designate resources including case managers who will work with providers and their patients. For enrollees who have sickle cell and other chronic conditions or special needs requiring ongoing care from a specialist, Magellan Complete Care will provide authorization for “standing referrals” to reduce any barriers or administrative burden for the provider and the enrollee. The measures used to evaluate the Magellan Complete Care Sickle Cell Care Management Program are population-based, and will be analyzed in comparison to benchmarks or goals, based on available industry standards.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT’S DESCRIPTION OF RECOGNIZING PCMHS...
We recognize the value that health home models such as PCMH’s and Integrated Health Home’s bring to address potentially preventable events. Magellan Complete Care has invested resources to build specialty health homes and leverage the contracted PMHC’s in our network to target potentially preventable events through incentivizing: preventive care, expedited access to outpatient treatment, using telehealth as a method to deliver critical services, community-based services, non-traditional supports such as community outreach and navigation, and peer support services. Additionally, we have developed funding mechanisms to support outcome-based care focusing on keeping enrollees safe in their communities and achieving healthy, vibrant lives.

Our Integrated Health Neighborhoods are an important linkage to our enrollees in each region to educate them on the appropriate use of services; support them in the removal of barriers that may prevent them from engaging lower acuity services; assist in the removal of social vulnerabilities such as homelessness, which our internal data shows as a significant contributor to higher rates of preventable events.

In addition to these roles, Magellan Complete Care is evaluating the use of Community Health Workers for inclusion as enrollees of our Integrated Health Neighborhood teams. The Community Health Workers 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. Although Florida’s Community Health Worker networks are still emerging, we believe they can serve an important role; particularly in prevention, wellness, and enrollee self-care education.

Once the core capabilities are in place, Magellan Complete Care works with providers to ensure that each enrollee has an on-going relationship with at least one provider of choice such as an Integrated Health Home or PCMH depending on their individualized needs. In most cases this will be a behavioral health provider with whom the enrollee already has a relationship. This provider takes a whole person orientation to care and ensure the enrollee has a physical health provider.

Magellan Complete Care includes activity related metrics aimed at reducing “potentially preventable events” (PPE) as performance measures in our Integrated Health Home program description and contract Scope of Work with providers. As a function of the program oversight, Magellan Complete Care uses data and analytics to track/trend PPE “hot spots” and shares this information with Integrated Health Home providers.
Activity based metrics include:

- Increased enrollee engagement
- Increased medication compliance
- Improved access to follow-up care
- Increased connection to PCP care
- Increase in community delivered services.

We provide ongoing data, technical assistance and support to our Integrated Health Home partners to support a reduction in PPEs; examples include:

- Sharing Electronic Notification System (ENS) data to ensure provider follow up after an ER visit or inpatient stay. Our Care Coordination team works with our Integrated Health Home providers on discharge planning and transitions. Providing actionable information to our providers in order to reduce PPEs. Our secure online ImpactPro® 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 Provider Support Specialists 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).

- Facilitating Integrated Care Coordination Team meetings (ICCT) to discuss enrollees with particularly complex situations. The meetings help to address readmissions, ER utilization and other enrollee concerns that require a team based approach. When AUD’s are in place, Magellan Complete Care will provide useful information including gaps in care, utilization and medication history to these rounds providing a level of clinical, enrollee specific support to address complex needs, barriers or difficulties impeding the enrollee’s recovery and success.

- Monitoring inappropriate prescribing patterns that could lead to PPEs through our “Whole Health Rx” program. Whole Health Rx uses advanced proprietary clinical algorithms to identify psychiatric prescription patterns that are inconsistent with evidence-based, best practice guidelines. Magellan Complete Care reaches out to the primary care or behavioral health provider to engage in a multi-modal personalized consultation.

- Connecting the Integrated Health Home to our local Care Coordination team. For high volume practices, Magellan Complete Care may embed a Case Manager or Health Guide within the practice.

Related to potentially preventable conditions, the Magellan Complete Care medical/health home models address four major components that are persistently problematic within our population:

1) Reduce unnecessary or inappropriate ER admissions, both physical health and behavioral health;
2) Increase outpatient services;
3) Increase community tenure for enrollees as identified by enrollee driven surveys of the providers we implement; and,
4) Decrease use of multiple psychotropic medications.
2.1 Incentives to Manage Outcomes, Including Potentially Preventable Events

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 value-based purchasing. 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 encourage 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, performance based incentives, 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.

The Integrated Health Home and Road 2 Recovery programs are good examples of how we have combined payment methods to provide the flexibility of a bundled model and front end fee for service enhancement, in addition to back end incentives driven by activity based performance metrics. The back end metrics help to shape the direction of care to ensure access, availability and quality, while providing additional revenue to the provider for achieving success. We have adapted different payment structures to support positive outcomes for the enrollee population we serve.

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.
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If needed and as appropriate, our Network staff may include provisions within provider agreements for incentives or increased fees to certain providers for accepting enrollees and ensuring timely access to needed services.

We know that providers have many demands on their time. We recognize that providers are at varying degrees of readiness and that moving to and sustaining a medical/health home model takes time and persistent effort. We have structured our incentive programs to reward movement towards becoming a medical/health home. Our reimbursement protocols align provider payments and incentives based on the level of integration, care coordination programs, appropriate utilization and improved outcomes. Reimbursement models range from case rates and pay for performance models to outcomes based tiered payments and gainsharing.

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. This includes achieving outcomes and performance in multiple settings, including CMHCs, FQHCs, hospitals, and free-standing provider practices.

Magellan Complete Care currently has provider incentive programs targeting management of specific clinical outcomes and closure of gaps-in-care, including those for EPSDT and HEDIS. These programs allow us to incentivize primary care and specialty providers to deliver appropriate care in a clinic setting, thereby limiting enrollee utilization of ER or experiencing a destabilization of a chronic illness that results in an unplanned admission. We also use targeted provider incentives for closure of high-priority gaps-in-care identified through our quality management program. Our Road 2 Recovery program also includes provider incentives for follow-up care after discharge, with a goal of limiting readmissions.

A new program called Incentivize Integrated PH-BH Primary Care, will incentivize integrated physical and behavioral health primary care to increase enrollee engagement and access to care. The goal of this program is to increase overall primary care engagement and associated outcomes, with targeted primary care and primary behavioral health providers. Program features include a focus on the implementation of Integrated Health Homes to combine both physical health and behavioral health services in a single site of care. This model is built on CMS-SAMHSA models for fully integrated care delivery and management. Integrated Health Homes have demonstrated significant reductions in overall costs of care, with particular benefits for reductions in preventable ER usage. Magellan Complete Care is actively negotiating with CMHC and FQHC providers throughout the state for the development of Integrated Health Homes. Overall reduction in ER usage; improvement in overall HEDIS metrics at or above annual minimum threshold is the quality goal. The HEDIS metrics will be determined collaboratively in consultation with our provider partners.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT’S DESCRIPTION OF RECOGNIZING PCMHS ADDRESSES METHODOLOGIES...
Magellan Complete Care offers our Mother Baby connections program as a “wrap around” to our current Integrated Health Homes. Integrated Health Homes often do not have obstetric providers in their practice. If the practice does not include an obstetric provider, our Provider Support Specialists facilitate the relationship between the Integrated Health Home and that provider.
Magellan Complete Care provides education for providers on potential complications and issues associated with SMI medications; safe and appropriate management of enrollees with SMI and pregnancy; and, comprehensive monitoring and collaborative case management for our pregnant enrollees through our OB/GYN Care Management program. That includes regular monitoring of our pregnant enrollees and birth outcomes, including C-Section, vaginal delivery rates, and deliveries at less than 39 weeks gestation.

Due to the complexity of our pregnant enrollees and the potential complications associated with their ongoing medication therapy and behavioral health treatment, our enrollees require intensive case management and care coordination and often consultation with specialists and subspecialists. For this reason, Magellan Complete Care has developed innovative programs and partnerships to ensure that our enrollees receive the necessary care and support during pregnancy and the postpartum period. We have well-designed programs, and a specific care management team focused on enrollees who are pregnant or who have recently delivered. We include screening for pre- and post-partum depression, drug and alcohol use, and smoking; in addition other high-risk physical health comorbidities that are common in our SMI enrollees.

We have an OB/GYN Psychiatrist on staff to oversee management of these enrollees. Dr. Ross-Roussos is triple-boarded in OB, adolescent psychology, and addiction medicine, and is an OB/GYN Associate Professor and leads our weekly clinical rounds for these enrollees. We also maintain a dedicated OB/GYN Integrated Care Case Management team, which includes an RN and four Case Managers and a clinical pharmacist who participates in weekly OB clinical rounds as needed. Magellan Complete Care, through our Magellan Rx Management affiliate, has also recently embarked on a collaboration with Bayer Pharmaceuticals to increase provider and enrollee understanding of long-acting reversible contraception (LARC) and to promote their use.

Our Mother Baby Connections Program offers comprehensive ongoing education and support to all pregnant enrollees from preconception through the first year of her newborn’s life. Our program interfaces with PCMH/Integrated Health Neighborhoods and incorporates our Integrated Health Neighborhood model of care. The Integrated Health Neighborhood is built on our understanding that a pregnant woman’s ability to have a healthy pregnancy and newborn is intrinsically tied to multiple factors outside of health, namely the social determinants and physical conditions in her environment. Our goal to improve care and outcomes can only be achieved within the context of where our enrollees live – in Florida’s neighborhoods and communities.

Relationships and collaborations with community partners enable us to effectively coordinate care with the community supports and services that the enrollee knows and trusts (e.g., Resource Mothers, Nurse Family Partnership, WIC, and CenteringPregnancy).

The Magellan Complete Care Mother Baby Connections Program addresses the special needs of pregnant women with SMI, 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 primary goal of the 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.

For practices with Obs on staff, we offer the Provider Incentive Program (PIP) targeting on the Frequency of Ongoing Prenatal Care (FPC) and Postpartum Care (PPC). Participating providers that meet the eligibility requirements must meet the following criteria to qualify for the financial incentive program:

>HEDIS: Frequency of Ongoing Prenatal Care (FPC) – Rate of patients with ≥81 percent expected visits must be at or above the Medicaid 50th percentile as calculated by NCQA using 2016 HEDIS specifications.

>Payment is made using an enhanced, bundled payment based on the Medicare rate for each delivery. This incentive excludes some providers, including those without a delivery in the measurement period, non-participating providers, FQHCs, rural health clinics, and county health departments.

>Payment to all providers is made through an enhanced per enrollee per month (PMPM) capitation rate. Quality measures are reported and paid on a quarterly basis. For each quarter, four measures are evaluated.

For details, please refer to [MMA SRC #04, Attachment 4: Physician Incentive Program for Board Certified OB/GYNs.]

3.1 Improving Prenatal Care and Birth Outcomes through the Patient-Centered Specialty Practice

Many specialists in Florida are initiating the process of transforming their practices to a NCQA Patient-Centered Specialty Practice (PCSP). This program seeks to improve access to care and enhance communication between the patient, the patient’s specialist and PCP. We identify OB practices recognized as or in the process of becoming a PCSP and explore opportunities for a partnership to better serve our enrollees. We work collaboratively with these practices on appropriate reimbursement methods for the enhanced services. This program recognizes specialty practices that successfully coordinate patient care and communicate with their primary care colleagues, other specialists and patients. Like NCQA’s PCMH program, PCSP recognition has specific expectations for providing timely access to care and continuous quality improvement. Practices who earn recognition have made a commitment to providing high quality patient-centered care.

3.2 Improving Prenatal Care and Birth Outcomes through the Maternity Care Home or Pregnancy-Centered Health Home Pilot

We are exploring a pilot with an OB provider to establish a Pregnancy-Centered Health Home with Kay Roussos Ross in Gainesville if we are selected statewide as the SMI Specialty Plan. This enhanced prenatal care model will include psychosocial support, education and health promotion, in addition to prenatal care. The Center for Medicare and Medicaid Innovation (CMMI) Strong Start initiative is currently testing a Maternity Care Home model with providers across the country as a promising model of coordinated care and integrated patient-oriented systems of care. We believe Centering Pregnancy and Centering Parenting would be a perfect fit for this model.
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We define Pregnancy-Centered Health Homes broadly to enable local innovation based on local
needs and resources. Features in common across all models should include:

>Continuity of care from a primary clinician who accepts responsibility for providing and/or
coordinating all health care and related social services during a woman’s pregnancy, childbirth,
and postpartum period
>Commitment to continuous quality improvement, patient safety, and evidence-based practice
>Commitment to woman-centeredness and a positive experience of care
>Timely access to appropriate care and information.

Magellan Complete Care will work collaboratively with the pilot provider on appropriate
reimbursement methods for the enhanced services. Reimbursement could include per-enrollee
lump sums paid up front or incentives that reward reporting and improvement on performance
measures. Magellan Complete Care is committed to a strong, collaborative partnership with our
Florida provider community. Each of the programs detailed above continue to evolve as providers
continue to develop capabilities and capacity to serve our SMI enrollees within the requirements
and expectations for integrated, whole-person care under a health home model. We will continue
to work with the AHCA, our provider partners and our enrollees to refine these programs and
enhance enrollee outcomes and satisfaction.

Evaluation Criteria:

1. The extent to which the respondent’s description demonstrates experience that includes
contracts with patient centered medical homes in the network serving populations similar
to the target population of this solicitation and demonstrates:

   (a) Enhanced access;
   (b) Coordinated and/or integrated care; and
   (c) Achievement of improved quality outcomes.

2. The extent to which the respondent’s description of recognizing PCMHs addresses the
reduction of potentially preventable events for enrollees assigned to a PCMH for their
PCP.

3. The extent to which the respondent’s description of recognizing PCMHs addresses
methodologies and processes to improve prenatal care and birth outcomes for enrollees
assigned to a PCMH as their PCP.

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.
MMA SRC# 4 – Telemedicine (Regional):

The respondent shall describe its overall approach to utilizing telemedicine services to promote the Agency’s goals, in particular as it relates to enhanced access to the following providers within the plan’s network:

a. Primary Care;
b. Licensed mental health clinicians;
c. Psychiatrists;
d. Cardiologists;
e. Pulmonologists;
f. Endocrinologists; and
g. Internists.

The respondent shall describe any limitations placed on telemedicine services within its network and the percentage of providers with the network that are authorized to provide telemedicine services for the specialty types referenced above and those actually providing telemedicine.

Response:

OVERVIEW

Magellan Complete Care and our parent company, Magellan Health, are committed to expanded use of telemedicine across medical specialties (including behavioral health) and across all regions of Florida. We recognize that telemedicine, in all its forms, is an important mechanism to enhance access, improve engagement and outcomes for enrollees, and reduce preventable events across all geographies. This is particularly the case for enrollees who may be in rural communities, or who have limited access to transportation or may experience other barriers affecting their access to physical sites of care. Telemedicine is also an important solution for individuals with SMI such as Magellan Complete Care’s enrollees. Telemedicine has proven to be an important and useful mechanism for overcoming the stigma of behavioral health care by allowing individuals to seek care in the privacy of their own home, resulting in significantly higher uptake of telemedicine by behavioral health providers. Magellan Complete Care, and our parent company, Magellan Health, have been in the forefront of that trend, expanding our use of telemedicine services in Florida and across the country. We also know that telemedicine is a viable and important solution for our SMI enrollees who may experience barriers to accessing care, and is an effective tool to reduce unnecessary use of higher acuity services.

Magellan Complete Care has developed a strategic approach to further develop our telemedicine footprint and expand services as the availability of those services increases in Florida. Our goals are to expand access to primary physical and behavioral health care and increase enrollee convenience in accessing that care; enhance crisis management to target reductions in preventable ER use and readmissions, particularly for super-utilizers; improve remote care delivery and management of chronically ill enrollees and high-risk pregnancy; and improve access to routine care and health education throughout all regions of the state. Magellan Complete Care has strategies in place to increase the availability of telemedicine services, has established standards for the use of these tools, and currently reimburses providers for these services throughout the state. Each of these elements supports the goals of improving ease of use and
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efficiency for our provider partners and increasing access for our enrollees, particular for underserved communities or specialties.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES AN APPROACH...
Magellan Complete Care recognizes that telemedicine can take many forms and that enrollees may have barriers to accessing telemedicine at home due to broadband availability, data limitations, and connectivity issues or access to required hardware. Magellan Complete Care’s approach to telemedicine recognizes those potential limitations, as well as the significant potential that telemedicine provides for expanding access to care, improving outcomes, and reducing preventable events. Our approach to telemedicine includes an expansive definition of telemedicine to embrace its use on multiple platforms, including mobile technologies, and in varied delivery models, including individual enrollee encounters; remote monitoring and care management; remote consultations and telemedicine hubs to expand presentation sites; telemedicine supported mobile-crisis response; etc.

Magellan Complete Care fully supports the use of telemedicine services, and is focused on incorporating this technology platform to support and maintain the continuum of care, in a manner that supports the complex, multi-dimensional needs of the our SMI enrollees. Magellan Complete Care sees telemedicine as an important element of our delivery system design and delivery system transformation efforts to support integration of physical and behavioral health services and expand access to “whole person” care throughout the state. That includes supporting our enrollees in maintaining a behavioral health provider relationship to serve as the hub for coordinating care and neighborhood supports, with ease of access through telemedicine. It also includes a focus on expanding access to services in geographically underserved communities and for underserved medical specialties. We recognize those priorities include filling access gaps in some of the more remote areas of the state, as well as addressing gaps in the availability of behavioral health services both within Florida and nationally.

Magellan Complete Care’s specific goals for expansion of telemedicine services by different specialties and geographic areas of the state, are as follows:

> Routine primary physical and behavioral health care: Expand access to routine services for all Medicaid regions, with initial focus on serving more remote and rural regions, including Regions 1, 2, 3, and 4.

>Specialty care: Expand access and reduce wait times for rural and underserved regions through creation of telemedicine hubs and specialty presentation sites. This includes Regions 1, 2, 3 and 4 for all key specialties, with likely expansion to include Regions 6, 7, and 8 for selected specialties.

>Remote monitoring and management for chronic illness: Establish remote monitoring programs for high-acuity enrollees in high-priority disease categories, with initial focus in more remote and rural regions. Initial focus would be on Regions 2 and 3, and portions of Region 9. We are specifically focused on expanding use of remote monitoring and management for high-risk pregnancies, CHF, COPD, and acute diabetes and related complications. This model has already been successfully used for each of these illness categories and in Medicaid programs throughout
the country. Additionally, there are already hospital and clinic providers in Florida already providing these services, or who have expressed interest in providing those services.

Telemedicine-assisted behavioral health crisis support: Establish telemedicine behavioral health crisis support services for use across all regions. We expect that the use of these services would vary based on region. For Regions 1, 2, 3, 4, and 8 we would seek to provide access to basic behavioral health crisis management services to first responders, clinics and hospital staff. For the remaining more urban regions of the state (Regions 5, 6, 7, 9-11) we would use telemedicine to provide access to more specialized behavioral health services as part of our strategy to establish behavioral crisis management teams in each of these regions.

Magellan Complete Care is committed to expanding access to these increasingly accepted technology solutions for care, and we are actively seeking to expand telemedicine relationships with providers in Florida with already established capabilities. This includes hospitals and hospital systems, primary care and specialty practices and clinics, behavioral health practices and clinics, and public agencies. We believe that telemedicine is a particularly important solution for our enrollees who may experience various barriers for access and appropriate use of care.

We summarize the accessibility and use of these services in our current Provider handbook, which has been reviewed and approved by AHCA, and we support the following agency goals:

Reduce 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

Magellan Complete Care’s standards for the use and delivery of telemedicine services by our providers, allow for a great amount of flexibility for the technology and types of solutions implemented by providers. Those standards include the following:

Interactive and real-time synchronized multimedia (audio and video) transmission. Remote camera control is preferred. The provider must have a dedicated secure line and utilize an acceptable method of encryption.

The provider must provide a platform and evidence that it is secured and HIPAA compliant

The originating site (location of the enrollee) must have telemedicine support staff able to assist the enrollee with the technical equipment and connection. A protocol must be in place to access emergent or urgent clinical care if the designated telemedicine support staff are not clinicians. The enrollee site should be a room that provides privacy.

Providers should have completed basic training on telemedicine equipment, provide the same rights to confidentiality and security of clinical information as provided in face-to-face services, and must include in the enrollee’s clinical record that the service was provided via telemedicine.

The contracted organization must provide an updated roster or list of providers who will be rendering the services to ensure they are credentialled and loaded appropriately in our systems.
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The contracted organization must also provide a copy of their policies and procedures for use of telemedicine to ensure operationalization and use of telemedicine and delivery of related services.

Services delivered via telemedicine are subject to the same standards and quality review requirements as non-telemedicine services. As we reference in our current provider handbook, Magellan Complete Care’s Provider Support Specialists (PSS) function as the point of contact for all providers interested in providing telemedicine services in any form. Our PSS are trained to assist providers with adding any addenda to their contract regarding telemedicine services.

Magellan Complete Care does not have a proprietary telemedicine platform or solution that providers must use. We believe this approach supports maximum flexibility on the part of our provider partners to develop and implement telemedicine solutions. This approach also support Magellan Complete Care’s goal of delivery system transformation and the development of integrated systems of care. Our strategy is to support our provider partners in developing and owning telemedicine capabilities themselves, rather than requiring that they use a platform that we have defined.

Magellan Complete Care’s strategy for telemedicine adoption and use is technology agnostic as long as certain basic criteria and standards are met (e.g., provider submits our national telemedicine attestation). This allows providers to select a HIPAA-compliant platform of their choice, and that best meets their practice needs. In fact, we provide education to providers on selecting telemedicine platforms as well as telemedicine clinical guidelines. If the telemedicine service is for a covered benefit, providers can simply submit a claim with the telemedicine GT modifier and Magellan will pay the claim at the same CPT fee schedule. By not mandating a specific technology, we allow providers to make decisions that are in the best interest of their practices and patients.

Magellan Complete Care also has telemedicine incentive programs available to support selected providers (in identified provider shortage categories, currently limited to behavioral health) in implementing telemedicine capabilities. As part of this ITN response we are also proposing new enrollee incentives to encourage telemedicine use and our proposed model for value-based-reimbursement also encourages use of telemedicine as part of the delivery model to improve outcomes.

Magellan Complete Care currently contracts for telemedicine services with providers throughout the state, including for use in our Road-to-Recovery (R2R) program that is specifically directed at post-discharge follow-up care and reducing readmissions. The Road-to-Recovery Program is a great example of how Magellan Complete Care has employed an innovative solution to leverage telemedicine and statewide provider relationships to improve enrollee access to care and outcomes. R2R takes standard follow up to a new level by providing two follow up opportunities within five days of behavioral health discharge. First with a licensed clinician and the second with a psychiatrist or ARNP to address medication needs which is currently serious shortage in Florida and nationally. The providers deploy a case manager to the enrollee’s home for both types of follow up appointments to meet the enrollee where they are, in the community or home setting. This specialized type of follow up program is funded through an incentive program so that the participating providers are able to support the community activities.
Our approach to telemedicine is to continue expanding its use, particularly for solutions with the potential to expand access to care in medically underserved areas, and for programs that have the potential to reduce unnecessary ER usage, support delivery of care in home settings, and reduce unnecessary admissions and readmissions.

Magellan Complete Care is particularly interested in partnering with innovative programs such as:

>Manatee County Community Paramedic Model, which is part of a growing number of telemedicine mobile crisis response solutions being implemented throughout the country
>Tallahassee Memorial Healthcare home monitoring programs for such illnesses as CHF and COPD, and specifically targeted at reducing readmissions; and, their telemedicine consults program to expand access to specialty care
>Diabetes management programs currently being developed by several of our FQHC partners
>Continued expansion of telemedicine services with many of our CMHC partners
>University of Florida (UF) – Jacksonville Family Medicine and UF-Gainesville telemedicine program specifically targeted at expanding access to children’s health services.

Magellan Complete Care’s approach to telemedicine is focused on continuing to expand both provider availability and enrollee access to care, incorporating the use of telemedicine as an additional site of care for a variety of services. Our organizational philosophy is focused on providing the right care at the right time. Incorporating a range of digital solutions helps deliver on that philosophy.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES THE METHODOLOGY IT WILL USE...

In support of our goals for expanded telemedicine access, Magellan Complete Care continues to inventory the availability of telemedicine solutions among providers in Florida, and to work with those providers, as well as community organizations such as the Florida Partnership for Telehealth to expand the availability of these services.

Magellan Complete Care sees telemedicine as a core solution to improving the healthcare delivery system in Florida. As such, we have developed a Florida specific methodology to grow our current capacity as well as build capabilities within the provider network to support a long term, systemic change.

2.1 Partnerships with statewide provider organizations

In support of our goals for expanded telemedicine access, Magellan Complete Care will work collaboratively with statewide provider based associations such as: The Florida Council for Community Mental Health, Florida Hospital Association and Florida Association for Community Health Centers. The goal of these large scale partnerships will be to engage providers statewide to better understand their current applications and future development goals to identify opportunities to leverage their approaches and support innovation in their inception. Focusing on an expansive group of industry leaders will position Magellan Complete Care at the forefront of telemedicine program expansion with key specialties and applications such as ER, substance abuse and OB/GYN services. We will also be able to effectively understand and address barriers from the provider perspective early on to reduce possible issues in the future. As noted previously, we are also specifically interested in partnering with providers in certain regions of the state that
have shown particular leadership in developing and expanding use of telemedicine. This includes providers in Regions 2, 4, and 6 which each have programs they have already developed which are consistent with our targeted areas for expansion. We are particularly interested in the opportunity for working with these partner organizations to act as hubs for the expansion of their services to other regions of the state.

2.2 Identification of enrollee needs through data
The core of what we do is proactively identifying the enrollee’s needs and developing creative solutions to improve the experience and outcomes for our enrollees. We would follow this same strategy for expansion of telemedicine services throughout the state. The second layer of our telemedicine growth methodology is data driven. Leveraging our analytics engine, claims data, and clinical insight from our health services team, we will identify those areas where enhanced access to care would benefit from opportunities to expand telemedicine. This would include key specialties, and regions of the state to ensure seamless access and reduce barriers for enrollees. Predictive analytics, trending utilization data and trends for single case agreements will provide a direction so that we are building a telemedicine program that makes sense for the enrollees and has a significance in the market. This information will help to shape “telemedicine hubs” which bring together critical specialty care to address access issues in a multitude of settings.

2.3 MCC Physician Advisory Board
We also will be establishing a telemedicine subcommittee of our existing Physician Advisory Board in 2018 to specifically work on telemedicine across specialties (we currently have pulmonologists, psychiatrists, PCP, addiction specialists and other specialists on this committee). This sub-committee will be responsible for developing a provider-supported approach for the expanded use of telemedicine throughout the Magellan Complete Care network.

2.4 Evaluate and Replicate Successful Programs Currently in Place in Other Medicaid Programs
Magellan Complete Care and our parent company, Magellan Health, Inc. are already conducting reviews of successful telemedicine programs in use for Medicaid populations throughout the country. Many of our current proposed strategies are patterned on those programs. We plan to continue expanding our review of those programs and completing evaluations of each based on the unique market conditions, enrollee population characteristics, and provider characteristics in Florida. Further expansion beyond those areas already identified would be based on that review.

2.5 Partner with AHCA to Understand and Fill Care Gaps
Magellan Complete Care is particularly interested in collaborating with AHCA and key stakeholder groups to develop telemedicine solutions for behavioral health, addiction medicine, and crisis management. Our company not only has the deep expertise we have developed through our time as the State’s SMI Specialty Plan, but we also bring decades of experience in providing behavioral health services to millions of public and private sector enrollees across the country. Improved access to behavioral health services has been demonstrated to benefit overall management of health and to drive reductions in unnecessary use of higher acuity services. Magellan Complete Care is excited about the potential for partnering with the State in developing solutions to make these services more broadly available to all Floridians.

Particular areas of focus for each of these efforts are those services and specialties of high need and limited availability among our enrollees. These include:
<Expanded access to mental health services, including children’s services and substance use, throughout all regions of the state

<Expanded access to specialty services, including specialty consults, focused on hypertension/congestive heart failure (CHF), diabetes and endocrine management, chronic obstructive pulmonary disease (COPD) and asthma management, and high-risk pregnancy management

<Expanded use of remote monitoring for high-risk patients to prevent unnecessary admissions and readmissions

<Expanded use of telemedicine-assisted mobile crisis response teams to reduce unnecessary ER use and preventable admissions

As the availability of telemedicine-enabled solutions become more broadly available throughout Florida, we will continue to work with a broad range of providers, AHCA, and our enrollees to expand its use.

The increases in telemedicine use among our providers in the last year speaks to this trend, with usage having increased by more than 100 percent.

Our Provider Support Services (PSS) and contracting staff are actively engaged in identifying providers for these programs, and will work with providers to address requirements and overcome any barriers they may encounter. We individually train our providers on setting up and using the required equipment, practice ethics, fraud and abuse detection procedures, and best practices of delivering care online. This ensures that enrollees can be matched with specialists who meet their needs regardless of the enrollee's or a provider’s geographic location. We ensure that enrollees always have a choice to access services through a face-to-face or telemedicine-based encounter. As noted earlier in this response, Magellan Complete Care also can provide incentives for selected providers to implement telemedicine programs.

Magellan Complete Care is aware of, and has also participated in the State’s efforts to promote increased access to telemedicine services. For these reasons, we have, and will continue to pursue a multi-pronged strategy to enhance access using multiple platforms and delivery models. We are particularly interested in supporting and partnering with the provider community to promote their development and launch of these services. This principle serves as a backbone of our efforts.

Providers in many regions throughout Florida have established, or are in the process of establishing telemedicine capabilities, allowing them to expand their reach to enrollees. Magellan Complete Care has established standards for clinical management and protection of enrollee privacy to support the expanded use of telemedicine throughout our network.

Magellan Complete Care currently has approximately 25 providers actively billing for telemedicine services, and the number of new providers seeking to establish those capabilities continues to grow. Since these numbers primarily reflect clinic and multi-specialty locations the actual number of individual providers delivering these services is even higher. In addition to CMHCs in our network who are already well-advanced in the development of their telemedicine capabilities, a
number of FQHCs in our network are currently developing their telemedicine capabilities for direct delivery of care as well as remote monitoring and management of chronic illnesses such as diabetes.

Our experience with one of our providers, IMPOWER offers a perfect example of this kind of partnership. IMPOWER is a progressive Behavioral Health organization providing psychiatric evaluation, medication management, outpatient therapy, and targeted case management for all ages of enrollees. IMPOWER seeks to improve access to care by offering enrollee choice of service delivery through community-based TCM/Outpatient services, office based and/or telemedicine. IMPOWER has been providing services for over 3 years and has data to support its efficacy in terms of both quality and consumer satisfaction. Access to psychiatric services is of particular concern in many areas of the state. This organization is demonstrating success in addressing these needs.

Magellan Complete Care and IMPOWER have collaborated on a number of projects and continue to work to address care gaps specifically regarding Bridge and 7 day follow up. One Brevard County Pediatric provider wanting to provide integrated BH services on site is actively working with IMPOWER to provide on-site access. IMPOWER is also actively involved in working with providers in Regions 9 and 11 to develop a plan/workflow to increase 7 day follow up and support the connection of enrollees from inpatient to outpatient community services. Their “Just in Time” scheduling model ensures enrollees a scheduled appointment within the week before their prescriptions need to be refilled.

This quote from Amy-Erin Blakely, MBS/HCM, Vice President Behavioral Health Operations speaks to the strength and results of this partnership.

~~Quote from from Amy-Erin Blakely, MBS/HCM, Vice President Behavioral Health Operations~~

“Magellan has been an innovative partner promoting the use of HIPAA-compliant telemedicine psychiatric and mental health services. In doing so, gaps in service have been identified and the partnership between Magellan and IMPOWER has allowed for solutions despite the severe crisis caused by the shortage of practitioners. Through the Magellan/IMPOWER partnership for telemedicine, members are able to participate in services (within 0-3 days of referral) from the privacy of their own homes on their smartphones, tablets, or computers.”

During early 2017, another one of our key provider partners in Tallahassee, Apalachee Center, reached out to Magellan Complete Care in a serious, urgent situation. Due to unexpected circumstances, they had lost several psychiatrists and were looking at a significant capacity issue for people in Region 2. The CEO expressed his concerns regarding the situation including: impacts this will have on current clients needing care, newly identified clients needing follow up care, and access issues for rural areas on Region 2 as the psychiatrists he did have would need to be based in the high volume locations. The CEO of Apalachee requested that he allow their center to implement a telemedicine program to be fully operational as soon as possible. The Magellan Complete Care team (CEO, COO, and CMO, Sr. Director of Systems of Care) worked together with the Apalachee team to ensure this was possible to avoid any negative impact to the enrollees. Within the same week, Magellan Complete Care turned on the telehealth function in our system and gave Apalachee the green light to go live with telehealth at all of the centers they requested.
The key telehealth delivery programs that we currently have in place, are developing, or will be contracting include:

> Enrollee telemedicine portals: This model provides enrollees with the ability to directly connect with a provider either through secure messaging, video chat, or similar mechanisms. Magellan Complete Care already has these capabilities in place with select providers and is continuing to expand these services. Specific initiatives are discussed later in this section.

Mobile integrated crisis support: This model is a telemedicine-assisted model that includes access to specialty services, and integrates field-based triage; behavioral health urgent care; substance use; and other services into a crisis response model targeting super-utilizers and similar populations. The Manatee County Community Paramedic model referenced earlier is an example of a program currently in place in Florida, although there are numerous additional examples in use in other parts of the country.

> Computer supported direct delivery of care: This model, for which Magellan Health has been a pioneer, supports enrollees in self-directed care which is computer aided. The best known of these solutions is Computerized Cognitive Behavioral Therapy (CCBT). This solution, which has been shown to be effective in the treatment of many behavioral health conditions, is really the new frontier for remote delivery of care. Again, specific initiatives are discussed later in this section.

> Telemedicine specialty hubs: Access to specialty care is a known problem for Medicaid enrollees across the country, as is the lack of adequate broadband access in more remote areas of many states. A solution pursued by many programs has been the creation of telemedicine hubs which are created in existing clinics, physician’s offices or hospitals. It’s important to note that this is the model of care delivery supported by Medicare, making it more likely to be available among specialty providers. Many of these hubs are associated with medical schools and academic medical centers, and their effectiveness has been demonstrated particularly for OB (including high-risk pregnancies), dermatology, ophthalmology, etc. In fact, the State Telehealth Advisory Council report detailing telemedicine availability in Florida indicated that 45 percent of Florida hospitals have some form of telemedicine capability (citation: “Florida Report on Telehealth Utilization and Accessibility”, Agency for Health Care Administration, December 2016, p. 4). Leaders for these types of services in Florida include Tallahassee Memorial Healthcare, University of Florida Health in Gainesville, and University of Florida Jacksonville. Our goal is to partner with these, or similar organizations in the state to expand the availability of these programs.

Interestingly, that same study found that the most common uses of telemedicine services in the state were for behavioral health, primary care, home health remote monitoring, neurology/stroke care, radiology, chronic disease/cancer, pediatrics/pediatric specialty care, intensive care, dermatology, prescribing, and emergency/trauma care. Magellan Complete Care is already employing telemedicine services in a number of those categories including behavioral health and primary care. The more specialized categories (pulmonology, endocrinology and cardiology) are less well-established in Florida, suggesting that it will take longer to develop these capabilities with providers. Magellan Complete Care is currently developing initiatives for use of telemedicine hubs which we believe may be a solution for this deficit. In spite of these obstacles we are already maximizing the State’s significant efforts in this area, expanding on existing telemedicine
development programs being driven by the State’s Telehealth Advisory Council, of which we are a participant.

Magellan sees telemedicine as a solution to address access and capacity issues that create unnecessary barriers for our enrollees statewide and to enhance the quality of care and care management for those enrollees. Access to primary care, behavioral health, and specialty providers is both a national, and a Florida problem. Most counties outside the major metropolitan areas in Florida include at least some medically-underserved areas (MUA), as designated by the Federal government. The Kaiser Family Foundation has estimated that nationally the average amount of demand for behavioral health services met in any given region is only 44 percent, with the vast amount of behavioral health needs going unmet. The Foundation also notes that 165 regions within Florida are designated as Mental Health Care Professional Shortage Areas. According to that same data, those shortages are even more acute for primary care providers in Florida, with the state having 258 shortage areas in that category.

Magellan Complete Care’s annual network plan includes the processes to develop, maintain and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this Contract. To this end, we maintain precise data identification and trend analysis programs that along with our Florida market knowledge, enables our Network development team to identify gaps where the application of telemedicine services can add value to our network coverage. Where these gaps and related telemedicine opportunities exist, our network management field staff engage community mental health centers, federally qualified health centers, facility-based and individual providers about their interest and capability in providing telemedicine services. For those centers, facilities and providers that express an interest in telemedicine, we work with them and their technology team(s) to coordinate telemedicine services that meet the State’s telemedicine regulations as well as our service delivery policies and procedures. We also provide training on how to setup and use telemedicine equipment, review best practices of delivering online-based care, and techniques for documenting services and methods for identifying fraud and abuse.

There are significant shortages of providers to meet growing needs, with specific additional shortages being driven by increasing numbers of individuals seeking proactive and ongoing treatment for behavioral health needs. Telemedicine is increasingly seen as a solution to address these shortages; improve convenience and access to services; as well as improving the management of chronic illness through rapidly evolving tools for symptom and treatment monitoring, health education, self-care support, and remote monitoring of symptoms. Magellan Complete Care embraces these solutions to address those needs.

>FQHC Telemedicine Expansion: An idea to address physical health telemedicine access is through our FQHC/PCMH providers. Many of them have developed or are in the process of developing educational programs that address disease management. These are not standard health care services, but rather patient self-management and population health geared programs. An example—an FQHC in Region 9 has a telemedicine diabetes management program in partnership with FAU (Florida Atlantic University) to deliver patient education related to diabetes via telemedicine. Programs like this are popping up statewide through FQHC’s and PCMH’s as chronic disease management is a focus. As telemedicine continues to gain momentum and application statewide, Magellan Complete Care plans to leverage the FQHC network as a major hub to increase access to telemedicine and enrollee self-management programs to address
health conditions and increase enrollee engagement into the healthcare process. Through our provider engagement model, we are able to identify innovative programs within our network of FQHC’s that employ best practices for population management and education via telemedicine. We have the opportunity to understand the local FQHC’s programs that will have a positive impact on our enrollees and share that with the Magellan Complete Care enrollee-facing care coordination team to promote referrals and access to the programs. It also allows Magellan Complete Care an opportunity to continue building meaningful provider relationships and highlight best practices throughout the state.

>Telemedicine Hubs: In addition to solutions for delivering care remotely to enrollees, Magellan Complete Care is interested in working with providers to develop telemedicine hubs. As noted earlier, this type of solution can be particularly effective for expanding access to specialty care, such as cardiologists, pulmonologists, and endocrinologists identified in this section. Again, this solution requires the availability and participation of qualified providers, but we know that it has been an effective solution in other parts of the country and for Medicaid populations. We plan to work collaboratively with selected providers to invest in the infrastructure, equipment and software for the use of telemedicine hubs in provider offices with particular emphasis placed on high-need and high-utilizer availability. Use of telemedicine holds the promise of expanding the availability and accessibility of services for enrollees with limited resources, transportation barriers, or who may live in the rural communities. We believe that much of the real value of telemedicine will be in its use for expanding access to select specialty services through the development of telemedicine hubs in selected provider clinic locations. This model has been successfully and extensively used in Medicaid programs in other states such as Arkansas and California for management of high-risk pregnancy and to expand access to ophthalmology, dermatology, etc.

We propose contracting with at least three specialty hubs in the first 18-months of our contract. These may be existing programs such as that provided by Tallahassee Memorial Healthcare, or similar providers. Provider Support Specialists would work with providers to identify those willing to serve as hubs (typically hospitals, FQHCs, RHCs, and multi-specialty groups) in regions of the state with specialty shortages. We would provide support and training to providers for required infrastructure and practice implementation. <<Note that the infrastructure would also be available for provider use in delivering services to other payers>>. Program performance would be measured based on use of specialty telemedicine services. We may also link measurement of performance to HEDIS screening and treatment rates in areas such as diabetic screenings.

In addition to these more traditional forms of telemedicine service, Magellan Complete Care also currently provides access to additional behavioral health services using our innovative Computerized Cognitive Behavioral Therapy (CCBT) tools. These include:

>Cobalt: Cobalt is a broad-based platform that supports enrollee self-care and is coupled with Smart Screener technology, and a provider platform to monitor and support the enrollee’s care. It is part of Magellan’s Virtual Care Solution (VCS). We have invested carefully and deliberately in technology to empower individuals and their Primary Care Teams. This accomplishes short- and long term goals while improving access to care and lowering costs. We worked with FQHCs to design and implement a VCS that accomplishes several things: 1) it links enrollees to screening tools so that they and their providers know their risks and diagnoses, 2) it links them directly with proven tools such as (CCBT), telemedicine, text, and chat and 3) is setting the stage for ongoing additions of new resources and tools through the platform. The system currently includes
programs for OCD, depression, anxiety disorder, substance use disorder and pain management. We are also currently launching an opioid management program. The advantage of the Cobalt platform is that it supports screening for behavioral health conditions and delivery of care through the primary care or specialty provider’s office. It significantly increases screening efficiency and assessment of enrollee acuity and risk, allowing the provider to refer the enrollee to the self-directed care programs if appropriate for their level of risk, or to refer him or her to more specialized care if appropriate. Cobalt is available throughout all regions served by Magellan Complete Care.

>Cobalt: Cobalt is another CCBT solution that is specifically directed at smoking cessation. As AHCA is aware, SMI enrollees across the country have much higher rates of smoking and resulting health related risks, including asthma and COPD. Cobalt, which has been certified by the FDA as a clinically validated intervention, is an effective solution for providing access to smoking cessation programs in a location and format that embraced by enrollees.

>Clickotine: Clickotine is another CCBT solution that is specifically directed at smoking cessation. As AHCA is aware, SMI enrollees across the country have much higher rates of smoking and resulting health related risks, including asthma and COPD. Clickotine, which has been certified by the FDA as a clinically validated intervention, is an effective solution for providing access to smoking cessation programs in a location and format that embraced by enrollees.

>PsychTrac: Psych is a new CCBT solution that is being implemented by Magellan Complete Care. PsychTrac, which is being used in a number of states for Medicaid and jail diversion programs, has been shown to be particularly effective for achieving compliance with individuals with SUD and who may have been mandated into care through the correctional system. We are currently developing plans to implement the program for use in a similar fashion. We anticipate that it may demonstrate much broader use for remote monitoring and management of enrollees with other diagnoses as well.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT HAS ALREADY MADE SIGNIFICANT ACHIEVEMENTS...
We will continue to develop creative telemedicine solutions to meet network adequacy demands and improve enrollee outcomes across our entire network. For those geographic areas where there are limited numbers of providers, including PCPs, specialists and behavioral health providers, Magellan Complete Care employs a variety of methods to deliver services and recognizes the benefit of telemedicine as a means of improving access to services. The benefits of telemedicine include:

>Improved access to specialists
>Improved quality of care through specialty evaluation and diagnosis
>Decreased wait time for evaluations
>Reduced need to transport children/adolescents to other locations for treatment

Though the availability of telemedicine services in Florida is in the early stages of development, the interest expressed by providers, and their development of these capabilities is expanding rapidly. We anticipate rapid, continued growth in the availability of these services in our network. Current availability and use is described below.

3.1 Percentage and Type of Providers Currently Authorized to Provide Telemedicine Services
All providers are currently authorized to provide telemedicine services to Magellan Complete Care enrollees, although they must meet the minimum requirements of our program as noted earlier in this section. Once a provider has submitted the required documentation certifying that they meet
Magellan Complete Care requirements for their telemedicine platform, security of enrollee information, etc. they may begin delivering telemedicine care.

The data provided below shows the current percentage of providers in the Magellan Complete Care network by provider type that CURRENTLY can provide telemedicine services to our enrollees. We note that our overall percentage of Magellan Complete Care network providers who are authorized to provide telemedicine services is 7% (527 providers), which exceeds the percentage of physicians identified in AHCA’s telemedicine survey. We have included this information overall and by region, demonstrating our strategy of focusing on addressing gaps in specific specialties and regions. The availability of telemedicine providers currently authorized to deliver services by each specialty included in this SRC are as follows:

3.1.a Primary Care
>Overall percent of providers: 4 percent
>>Region 2 providers: 17 percent
>>Region 4 providers: 1 percent
>>Region 5 providers: 12 percent
>>Region 6 providers: 1 percent
>>Region 7 providers: 10 percent
>>Region 9 providers: 1 percent

3.1.b Licensed Mental Health Clinicians
>Overall percent of providers: 12 percent
>>Region 2 providers: 19 percent
>>Region 4 providers: 22 percent
>>Region 5 providers: 46 percent
>>Region 6 providers: 4 percent
>>Region 7 providers: 6 percent
>>Region 8 providers: 2 percent
>>Region 9 providers: 3 percent
>>Region 10 providers: 2 percent
>>Region 11 providers: 14 percent

3.1.c Psychiatrists
>Overall percent of providers: 10 percent
>>Region 2 providers: 11 percent
>>Region 4 providers: 31 percent
>>Region 5 providers: 44 percent
>>Region 6 providers: 1 percent
>>Region 7 providers: 15 percent
>>Region 8 providers: 2 percent
>>Region 8 providers: 5 percent

3.1.d Cardiologists
>Overall percent of providers: 0 percent

3.1.e Pulmonologists
>Overall percent of providers: 0 percent
3.1.f Endocrinologists  
>Overall % of providers: 0 percent

3.1.g Internal Medicine  
>Overall percent of providers: 4 percent  
>>Region 7 providers: 42 percent

Most of our existing telemedicine relationships are with clinics, with multiple providers per site and multiple sites. The data provided above reflects that.

3.2 Percentage and Type of Providers Currently Authorized to Provide Telemedicine Services  
The data provided below shows the current percentage of providers by provider type that are CURRENTLY PROVIDING telemedicine services to our enrollees. We have included this information overall and by region, demonstrating our strategy of focusing on addressing gaps in specific specialties and regions. The availability of telemedicine providers currently delivering services by specialty included in this SRC are as follows:

3.2.a Primary Care  
>Overall percent of providers: 3 percent  
>>Region 2 providers: 17 percent  
>>Region 4 providers: 1 percent  
>>Region 5 providers: 7 percent  
>>Region 6 providers: 1 percent  
>>Region 7 providers: 10 percent

3.2.b Licensed Mental Health Clinicians  
>Overall % of providers: 3 percent  
>>Region 2 providers: 19 percent  
>>Region 4 providers: 3 percent  
>>Region 5 providers: 8 percent  
>>Region 6 providers: 2 percent  
>>Region 7 providers: 6 percent

3.2.c Psychiatrists  
>Overall percent of providers: 3 percent  
>>Region 2 providers: 11 percent  
>>Region 4 providers: 6 percent  
>>Region 5 providers: 7 percent  
>>Region 6 providers: 1 percent  
>>Region 7 providers: 15 percent

3.2.d Cardiologists  
>Overall percent of providers: 0 percent

3.2.e Pulmonologists  
>Overall percent of providers: 0 percent
3.2.f Endocrinologists
>Overall percent of providers: 0 percent

3.2.g Internal Medicine
>Overall percent of providers: 4 percent
>>Region 7 providers: 42 percent

Most of our existing telemedicine relationships are with clinics, with multiple providers per site and multiple sites. In addition, Magellan Complete Care is actively engaging and adding new providers to these programs, including for primary care and physical health specialties, with the result that we expect a significant expansion of these programs over the next 12 to 18 months. As noted earlier in this response, use of telemedicine services by our provider partners, as measured by number of encounters submitted, INCREASED by 102 percent in the last 12 months. As enrollees get more experience with use of these services, we expect use of this technology to increase significantly.

3.3 Behavioral Health Providers
Magellan Complete Care currently employs telemedicine solutions primarily for remote access to behavioral health services, a specialty which experiences chronic capacity constraints across the nation. As an SMI specialty plan, we are also acutely focused on ensuring that our enrollees have the kinds of access to these services that they require to manage their health. We currently have telemedicine relationships with the following providers:

>IMPOWER (Region 7)
>New Horizons of the Treasure Coast (Region 9)
>Banyan (Regions 10 and 11)
>Jerome Golden Center (Region 9)
>Apalachee (Region 2)

IMPOWER is currently a participant in our Road-to-Recovery program, which is directed in providing timely post-discharge access to care for enrollees discharged for behavioral health services. As our provider partners continue to expand their capabilities in these areas, we expect to support those efforts.

In addition, Magellan Complete Care is deploying the Road to Recovery program, which will expand our telemedicine support to enrollees, via provider-based case managers who are deployed in the field to meet the enrollee at home. These case managers will bring the necessary technology to provide clinical and psychiatric services. Our initial focus of this effort will support HEDIS seven-day follow-up after behavioral health hospitalization. We will then examine how to extend this capability to other levels of care and services.

Magellan Complete Care is also working with IMPOWER as a collaborative partner to deploy their telemedicine technology (WebMD) throughout the state utilizing the enrollee’s mobile technology. Magellan Complete Care is working with the national Safelink program to explore upgrading current flip phone technology with more advanced smartphone technology. In addition, we are exploring strategies with Safelink to address deployment challenges, e.g., homeless enrollees, which currently is a condition that precludes successful participation with the program. Finally, Magellan Complete Care is exploring enhanced data plan coverage and select application data
limit bypass to support the video data exchange needed for telemedicine engagement while still maintaining and supporting an enrollee’s general data use.

3.4 Pediatric Specialists
Magellan Complete Care’s Provider Network Policy on Network Standards also specifically acknowledges and supports telemedicine services for pediatric specialists. This section of our policy states:

“For pediatric specialists not listed the Managed Medical Assistance Provider Network Standards Table, the Managed Care Plan may assure access by <<providing telemedicine consultations>> with participating pediatric specialists, at a location or via a PCP within sixty (60) minutes travel time or forty-five (45) miles from the enrollee’s residence zip code. Alternatively, for pediatric specialists not listed in the Managed Medical Assistance Provider Network Standards Table, for which there is no pediatric specialist located within sixty (60) minutes travel time or forty-five (45) miles from the enrollee’s residence zip code, the Managed Care Plan may assure access to that specialist in another location in Florida through a transportation arrangement with willing participating pediatric provider(s) who have such capability.”

Two of our largest current telemedicine providers, IMPOWER and Apalachee, currently use telemedicine services to serve pediatric enrollees. Furthermore, we expect the use of telemedicine to be an important element in our Integrated Health Home model which is currently being implemented. This will drive significant additional expansion of the use of telemedicine for all enrollees, including the many pediatric enrollees served in these settings.

Magellan Complete Care is enthusiastic and very supportive of the expansion of telemedicine services throughout the state. We believe telemedicine is a particularly useful solution to expand access, increase enrollee engagement, and enhance health outcomes for our SMI enrollees who often face transportation challenges, or might find more traditional care delivery settings uncomfortable. We believe our network of telemedicine providers, and the scope of services available to our enrollees will continue to expand as the growth of programs continues in Florida. We look forward to working with AHCA and with our provider partners to drive the development and adoption of these solutions.

Evaluation Criteria:

1. The extent to which the respondent describes an approach on the use of telemedicine services within its provider network that supports achievement of the Agency’s goals.

2. The extent to which the respondent describes the methodology it will use to identify providers eligible for participation, limitations/barriers in its proposed use of telemedicine and proposed strategies to overcome those limitations/barriers.

3. The extent to which the respondent has already made significant achievements in the deployment of telemedicine within its network as evidenced by:

   (a) The percentage of providers authorized to provide telemedicine services for the provider types referenced; and
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

(b) The percentage and type of authorized providers that provided telemedicine services during the 2016 calendar year.

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.
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 5 – Provider Network Development (Statewide):

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to primary and specialty care services, necessary to promote the Agency’s goals, including:

a. Identification of network gaps (time/distance standards, after-hours clinic availability, closed panels, etc.);

b. Strategies that will be deployed to increase provider capacity and meet the needs of enrollees where network gaps have been identified;

c. Strategies (including a description of data sources utilized) for measuring timely access to appointments with the following provider types:

1. Cardiologists (pediatric and adult);
2. Pulmonologists (pediatric and adult);
3. Endocrinologists (adult);
4. Internists (adult);
5. Psychiatrists (pediatric and adult);
6. Obstetricians/Gynecologists (adult); and
7. Licensed mental health clinicians (pediatric and adult).

d. Strategies for recruitment and retention efforts planned for each provider type, including the quality and/or performance metrics that will be used to determine a provider’s success in making progress towards the Agency goals.

Response:

OVERVIEW

As the specialty managed care plan serving individuals with serious mental illness (SMI) in Florida, Magellan Complete care has tailored our network to meet the unique and complex needs of our enrollees while exceeding AHCA’s network requirements, which ensure timely access to primary and specialty care services. Our successful strategies and overall approach are now being leveraged in the other regions (1, 3, and 8) where we are seeking to operate a statewide SMI specialty plan.

We facilitate our model of care by deploying teams with first-hand knowledge of community strengths, resources, and service gaps to all regions of the state. Our Integrated Health Neighborhood approach enables us to think locally as we work with providers in each region to meet enrollees where they live. Participating providers play an integral role within our Integrated Health Home and the overall delivery of high quality 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.

At the regional level, each city, town, and county presents unique provider compositions and variations in how enrollees seek health care services. These variations direct our tactical actions and inventive approaches, which include developing alternative payment arrangements with primary care providers (PCPs) and pediatricians, and embedding Provider Relations managers at the practice level to engage and integrate with our plan. We also offer Provider Support
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Specialists/licensed clinicians who promote care delivery advances, including integrated care models, and who teach practices to thrive within managed care environments.

Beyond traditional use of geographic access data analytics and mapping technology, we configure our networks to align with how enrollees access care, including the extent to which enrollees are presenting for care at Community Mental Health Centers (CMHCs) or using in-network versus out-of-network care. We take into account the percentage of available providers within a county as well as the number of providers accepting new patients. This knowledge helps us recruit the right providers to advance our provider-to-enrollee ratios as well as minimize travel time and travel distance for enrollees.

Magellan Complete Care currently has 32,245 credentialed network providers serving approximately 70,000 individuals with SMI in 86,185 locations. In addition to the credentialed network providers, Magellan Complete Care provides our online Community Resource Guide, a comprehensive listing of more than 4,000 community-based resources to help support the social needs of our enrollees. Our community-based teams continually expand on existing relationships in each region to help identify these valuable community resources.

Magellan Complete Care Network team collaborates with quality and operations staff to develop the Network Development and Management Plan, which is submitted to AHCA annually. This plan guides our process for developing, maintaining, and monitoring an appropriate provider network that is sufficient to provide adequate and compliant access to all required health care services covered under the Contract. The Network Development and Management Plan includes the following key components:

> Network Adequacy and Accessibility Standards, appropriate to the number of providers and related geographic displacement to time and distance to access such providers as it pertains to specialty designation, qualifications, and training
> Network configuration of providers in support of Medicaid enrollment
> Expected patterns of utilization of covered services by enrollees
> Provider credentialing and re-credentialing requirements
> Anticipated change in network configuration and demographic changes
> Providers open to accepting new patients
> Providers with closed panels
> Provider network standards and procedures
> Provider contract and network compliance
> Provider termination and continuity of care
> Provider diversity and cultural competency

[MMA SRC #05, Attachment 1: Network Development and Management Plan] is provided for more detail.

CRITERIA 1: THE ADEQUACY OF THE RESPONDENT’S METHODOLOGY FOR IDENTIFYING AND RESOLVING...

The Magellan Complete Care Network Development and Management Plan addresses identifying and resolving barriers and network gaps, including ongoing activities for network development based on identified gaps and future needs projections.
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1.0 Identifying Barriers and Network Gaps
Magellan Complete Care uses several methods and sources to determine network barriers and
gaps in each region to ensure our network meets the needs of our enrollees. Examples of these
methods and sources follow:

> Evaluation of geographic access: to effectively measure and monitor network adequacy at the
highest level, we track provider locations in relation to enrollee locations using Quest Analytics
Geographic Network Analysis reports, density analysis, current and anticipated enrollment
> Monitoring of physician compliance with AHCA accessibility standards for appointment wait time,
telephone, and after-hours accessibility
> Evaluation of PCP-to-enrollee ratio using PCP capacity and panel status
> Evaluation of specialist contracting for significant specialties
> Examination of service utilization data
> Projections of future membership growth and service utilization
> Demographic data including cultural and linguistic needs
> Utilization data, grievance, and appeals data
> Satisfaction surveys, stakeholder participation in committee structure, input from AHCA
> Provider onsite reviews and surveys of appointment availability and treatment record reviews of
high volume providers
> Quality of care delivered to enrollees
> Feedback from quality improvement (QI) committees and stakeholder participation in other
committees
> Notification of a gap from a care manager or customer service representative

1.1 Resolving Barriers and Network Gaps
Magellan Complete Care continuously monitors and adjusts our regional provider network, and
we implement innovative solutions to ensure that we offer enrollees choices and a full array of
providers and services. We continually assess the availability and accessibility of care and
services to maintain appropriate enrollee access to specialty care and behavioral health care
services. Once it’s determined that a gap in provider coverage is emerging, network managers
quickly engage network contractors to expand the provider network in a respective provider
specialty to avoid a gap in provider coverage being created.

In our experience, barriers and gaps can exist in a region based on a variety of reasons including
the lack of providers in rural areas, provider panels being full, providers’ refusal to accept Medicaid
or their desire to work with a limited number of managed care plans, providers exclusion of
individuals with SMI from their practice, a limited number of providers to meet the needs of a
culturally diverse population, or a limited number of board-certified providers in a community.

As issues are identified in an area, we take appropriate action to address and quickly resolve any
barriers or gaps including:

> Working with existing providers to expand their hours, service locations and/or staffing by such
means as using advanced practice nurses
> Negotiating/renegotiating terms, conditions, and/or reimbursement to continue or deepen
provider participation
Contracting with advanced practice nurses. We also maintain a contract with Advance Health to send nurse practitioners to our enrollee’s home or residence to improve access or for enrollees who are difficult to engage in care or do not want to leave their home.

Working with our current provider network to become “champions” of Magellan Complete Care as a means of recruiting or recommending providers that work closely together for contracting.

Encouraging the use of telemedicine.

Facilitating the use of mobile services.

Contracting with public health departments, urgent care clinics and retail clinics.

Using in-person interpreters to help bridge language/cultural barriers.

Using a Single Case Agreements (SCA) to ensure immediate access and ongoing adequacy.

Using non-emergency medical transportation to transport an enrollee to another county.

The Magellan Complete Care Network managers work closely with quality and health services staff to develop an active provider plan that addresses provider interface and outreach, incorporates provider orientation and ongoing training, and identifies opportunities for providing ongoing support to providers and support of quality initiatives to ensure an adequate and accessible network of health care providers.

Our flexibility and open dialogue with providers has proven results, as the following two examples demonstrate:

1. Broward Health: Innovative contracting that aligns provider incentives with appropriate utilization and clinical and quality outcomes results in improved access to care and care coordination. In October 2015, the Broward Health System requested a significant increase in their reimbursement structure with Magellan Complete Care that was inconsistent with most reasonable and ordinary cost analysis. We proposed an alternative reimbursement approach that focused on mitigating the high costs tied to frequent emergency room visits and readmissions of our enrollees with sickle cell disease. We established a sickle cell “medical home” with Broward’s Sickle Cell Clinic and PCPs. In exchange for a broader collaboration with the health system, the improved access to this center of excellence avoids unnecessary emergency room visits, increases the speed by which medication is dispensed, and adds to the number of available practitioners for all SMI specialty plan enrollees.

2. OB ultrasound: The unique requirements of our pregnant enrollees demand the kind of dedicated focus that Magellan Complete Care maintains to identify and care for our enrollees who are pregnant. Due to the potential for co-occurring substance use, smoking, medication therapy, and their SMI symptoms, we view every pregnant woman as at high risk. For that reason, our obstetric providers often perform ultrasounds throughout pregnancy to monitor fetal growth and detect issues. Our obstetric providers provided feedback on their hesitancy to accept our pregnant enrollees because of our requirement for a prior-authorization after three ultrasounds – it became an administrative burden. As a result, we no longer require a pre-authorization for this service, which has improved access for our pregnant enrollees.

1.2 Ongoing Strategies for Network Development to Meet Enrollee Needs based on Identified Gaps and Future Needs Projection

Magellan Complete Care Network staff collaborates with quality, health services and operations staff to develop an annual Magellan Complete Care Network Development and Management Plan. The plan addresses identifying and resolving barriers and network gaps, includes ongoing...
activities for network development based on identified gaps and future needs projection, provides details regarding provider engagement and outreach, incorporates provider orientation and ongoing training, and identifies opportunities for the provision of ongoing support to providers on quality initiatives. As established in the Network Development and Management Plan, Network staff continuously monitor, report, and adjust network sufficiency as appropriate. We support the evolving network needs through our localized Integrated Health Neighborhood structure, which is designed to leverage the knowledge of the regionally based teams to ensure the network is able to meet the needs of the enrollees.

As the current SMI specialty plan, Magellan Complete Care has already implemented various methods to identify and resolve barriers and network gaps, including ongoing activities or network development based on region-specific identified gaps and future needs projection. To make sure the needs of our enrollees are met, we employ the following ongoing strategies for network development:

> Development of programs and initiatives to help close gaps such as telemedicine and mobile services
> Facilitation of enrollee care coordination by ICCM and Health Guides
> Communication through Network management and Provider Relations teams
> Outreach to community providers by the Chief Medical Officer
> Continuous provider network expansion statewide
> Participation in local medical and provider associations as well as patient advocacy groups
> Relationships with state medical schools and graduate medical education programs
> Ongoing joint operating committee (JOC) sessions with provider partners
> Designated Provider Support Specialists to assist the delivery of patient care
> Designated Provider Support Specialists to assist with office administration
> Hospital Advisory Board
> Physician Advisory Board

We are pursuing the following ongoing programs and initiatives:

1. Telemedicine: We recognize that telehealth, in all its forms, is an important mechanism to enhance access and to improve engagement and outcomes for enrollees. We have established a multi-pronged telehealth strategy to enhance access using multiple platforms and delivery models. Providers in many regions throughout Florida have established, or are in the process of establishing, telehealth capabilities that allow them to expand their reach to enrollees. This includes a number of CMHCs with which Magellan Complete Care has already contracted to provide telehealth services. We are particularly interested in supporting and partnering with the provider community to promote the development and launching of these services.

Telehealth is a viable and important solution for our SMI enrollees who may experience barriers to accessing care or who may often feel more comfortable accessing care remotely. When necessary, we work with enrollees to overcome barriers to accessing telehealth at home due to broadband, data limitations, and connectivity issues or access to required hardware.

2. Integrated Health Homes: Magellan Complete Care has maintained a unique framework to meet the needs of the population we serve. Caring for individuals living with SMI requires a specialized approach — Integrated Health Homes — to meet the enrollees where they live and
where they feel most comfortable accessing healthcare services. Integrated Health Homes are “reverse integrated” by placing the CMHC as the care leads and embedding primary care into the CMHC structure. The purpose of Integrated Health Homes is to deliver integrated, comprehensive, enrollee-focused care through a community-based setting. Integrated Health Homes address behavioral and physical health needs as well as the social determinants of health, which are critical factors influencing the recovery process. The aim of Integrated Health Homes is to reduce barriers for the enrollees as well as the providers to improve the overall system of care and quality of life outcomes for enrollees. We launched a plan to develop Integrated Health Homes statewide to improve enrollee access to preventative behavioral health and physical health (BH and PH) care, partner with CMHCs to ensure quality services, and improve the overall enrollee experience by creating a healthcare access point with the enrollees’ needs as the central focus.

Magellan Complete Care has established a robust plan which supports the implementation of the Integrated Health Homes and the growth of the model using a phased approach. Phase one focuses on targeting existing fully integrated CMHCs throughout the state to build on their current capacity and expertise. Following an approach similar to that which guides 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.

Several key activities are employed to optimize the Integrated Health Homes 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 a central principle of the Integrated Health Home model to open up pathways to care when the enrollees need it most.

> Care Coordination – Different than traditional behavioral health case management, the Integrated Health Home facilitates communication between all treatment providers, connects enrollees with annual preventative care, works with enrollees to collaboratively develop a plan of care, and educates the enrollee and providers when needed to ensure the highest quality of care.

> Enrollee Navigation/Outreach – Our enrollees’ recovery needs go beyond standard clinical services. The social determinants of health exemplify the additional factors that affect healthcare outcomes. Integrated Health Home supports system navigation activities and outreach to address those needs by walking hand-in-hand with enrollees to help meet their housing, food, educational, economic, and community needs.

3. Assistive Technologies: Rising demand and limited health care services throughout rural counties statewide highlight a range of valuable technologies and interventions such as using mobile X-ray services, remote monitoring by practitioners and patients themselves, advancing home health technologies aimed to improve enrollees’ adherence to medication regimens, or use of emotion sensors as a means to monitor and measure enrollees with certain behavioral health conditions to fill critical service gaps; which afford practitioners more opportunities to manage patients.
4. Centers of Excellence: From our early beginning as the State’s SMI specialty plan, we recognized the unique value in anchoring our network of providers around the State’s numerous hospitals. As institutions attempt to remain providers of choice as they are faced with declining reimbursement and revenue challenges, Magellan Complete Care is advancing our Center of Excellence continuum with hospitals and a multidisciplinary team approach to meet patient needs from diagnosis to discharge in a seamless, coordinated manner. Our work with the Broward Health System for example, identified barriers to care experienced by our enrollees with sickle cell disease and sickle cell disease traits by establishing a disease-based medical management program to both interdict this chronic-type condition for efficacy and superior outcomes but also to rectify a deficiency in network accessibility.

5. Providers who limit Medicaid: We are tackling the issue of providers who do not want to participate in Medicaid head on. Providers may fear that by working with managed care organizations, they could lose control and autonomy in their professional practices. We practice open dialogue and avoid strict guidelines, inflexible policies, and low payment rates to highlight our willingness to work with providers. The dialogue that occurs within our regional and local meetings and the Provider Advisory Committee all guide our policies and influence care through an interactive process to enhance the provider and patient relationship. We participate in provider association meetings, one-on-one health system meetings, AHCA forums, and other forums. Through our current Florida experience, we have learned that provider reluctance can often be effectively addressed when our staff engage directly with providers. We deliver ongoing support/technical assistance and keep communication open and accessible through our hands-on provider engagement approach.

In addition, our local Integrated Health Neighborhood 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 enrollee navigate these systems and supports, facilitating their access to community-based resources on the road to well-being. This integrated model ties providers together to facilitate communication among various provider types for more effective communication.

Please refer to [MMA SRC #05, Attachment 2: Integrated Health Neighborhood] for more details. To demonstrate our ongoing strategy of successfully communicating with our provider network as a way of building strong relationships, we include the following letter of support from Rafael Guzman, LCSW, Memorial Regional Hospital (Region 10) as [MMA SRC #05, Attachment 3: Provider Letter of Support (1)]; and from Jerome Golden Center for Behavioral Health (Region 19) as [MMA SRC #05, Attachment 4: Provider Letter of Support (2)].

CRITERIA 2: THE ADEQUACY OF THE RESPONDENT’S PLAN TO MEET THE NEEDS OF ENROLLEES...
As part of our network monitoring and accessibility capacity measurement process, we use industry accepted Quest Analytics Geographic Network Analysis mapping that appropriately evaluates membership detail against a set of defined network access standards required for each line of business.
We establish provider-to-enrollee ratios by specialty type based on the populations served throughout our service regions. We place strong emphasis on network adequacy and accessibility evaluation elements to include the following:

> Ongoing active evaluation of network additions and terminations, including identifying trends or particular providers through Provider Relations and Clinical teams

> Appointment access standard reviews; our provider contracts outline requirements to comply with appointment access standard timelines. Providers are educated on the standards, and compliance is measured through appointment test cases and other random sampling techniques

> Results of our annual provider satisfaction surveys incorporate feedback from network participants on satisfaction of available providers

> Evaluation of Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results that evaluate enrollee satisfaction with access to care

> Review of physician panel size and capacity to serve challenging enrollees.

If an enrollee is unable to access care or needed service within our network, we take appropriate action to address and resolve issues to ensure sufficient capacity and enrollee choice, including the following steps:

> Immediate interventions to address network gaps and resolve barriers: We have a clear and standard process to resolve immediate access issues in an expedited manner. Integrated Care Case Managers (ICCM) are responsible to oversee the process to resolve issues for an enrollee. ICCMs are RNs (Bachelor’s or Master’s degree level; LMHC, LCSW or LMFT (all are Master’s level licensed clinicians) who are educated and trained in all aspects of case management practice and in caring for individuals in specialized populations along with person-centered assessment and planning principles, processes, and requirements. Our ICCMs and the other members of the care team live in the communities where enrollees live and have relationships with local providers and community resources. If the ICCM identifies a unique need during rounds with the medical director, they reach out to providers who have accepted SCAs to see if they can provide the care needed. If there are no network providers who can fill the need, the health services staff enlist the support of our Network staff to expand the search for a provider who is willing to provide the care for the enrollee. When the request is sent to the Network team, they treat it as a priority, where the initial response is required by end of the day and updated the following day if it takes longer to find a qualified provider.

>> Encourage the use of telemedicine if appropriate and available.
>> Single Case Agreement (SCA): Our Health Services staff initiate the SCA with an out-of-network provider based on clinical needs of the enrollee. The Network team executes the SCA to ensure immediate access for an enrollee and ongoing adequacy until specified provider types and/or locations can be contracted. The SCA process allows us to establish relationships with providers throughout the various regions which often results in their willingness to contract.

>> Telemedicine: We arrange care and services via telemedicine if appropriate and available.
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>>Transportation: If geographic accessibility issues are present, we provide transportation to the
necessary provider type within the closest proximity, as appropriate. We arrange transportation
to transport an enrollee to another county or region:
>>>Advance Health: We schedule an Advance Health nurse practitioner visit if appropriate.
>>>Use in-person interpreters to help bridge language/cultural barriers.

>Short-term interventions to address network gaps and resolve barriers: We proactively and
continuously work to ensure access to needed services. Our Network staff review adequacy
reports and other trended requests monthly to ensure we do not have any access issues.

When it is necessary to do SCAs with providers, the Network team follows up with the provider to
see if they are willing to contract and join Magellan Complete Care’s network.
>>Referrals from In-Network Providers: We engage current provider partners to become
“champions” of Magellan Complete Care as a means of recruiting those MDs that work closely
together and who could close the network gap. As a result, various FQHCs and provider groups
have been instrumental in allowing us to achieve this, whether by recommending various
specialists throughout the community which they have used in the past, or by facilitating
contractual talks to expand the already existing network.
>>Work with Current Network Providers: We work with existing providers to expand their hours,
current panel size if appropriate. We conduct a targeted analysis to identify and resolve any
provider inaccessibility issues due to a provider’s non-compliance with access standards such as
closing their panel to new patients, maintaining a disproportionate provider-to-enrollee ratio or
exceeding stated appointment wait times.

>Longer-term interventions to fill network gaps and resolve barriers:
>> Work with Current Network Providers: We continue to work with existing providers to expand
their hours, service locations and/or staffing by such means as using advanced practice nurses.

>Contracting strategies:
>>When necessary due to an inadequate number of specialists or in rural areas, we
negotiate/renegotiate terms and/or reimbursement to continue or deepen provider participation
>>In areas with inadequate numbers of specialists, we continue to pursue contracts with regional
provider groups. In some cases this requires contracting from outside the immediate area. We
may need to work with provider groups to import those specialists into the area to offer those
specialty services
>>Contracting with advanced practice nurses
>>Facilitating the use of mobile services
>>Contracting with public health departments, urgent care clinics and retail clinics
>>Customer Service forwards provider “leads” for contracting to the network team based on
feedback from enrollee requests
>>SCAs: If necessary to ensure access, we use SCAs until a provider type and location can be
contracted. These, coupled with enrollee network expansion requests, have allowed us to
facilitate services as needed in a prompt manner.

As mentioned above, we continue to establish relationships with out-of-network providers and
providers who do not want to participate in Medicaid. We practice open dialogue. Our Provider
Advisory Committee advises us on strategies for enhancing our network. We participate in
provider association meetings, one-on-one health system meetings, AHCA forums, and other forums.

~~Enrollee Example of Collaboration with an Out-of-State Provider~~

The Magellan Complete Care ICCM provided care coordination for a 25-year-old female enrollee diagnosed with anorexia nervosa, major depressive disorder, and a history of adverse childhood experiences (ACE) from trauma related to child sexual abuse. Her family was no longer part of her support system, so she relied on the therapeutic support of the ICCM, the peer support of the Recovery Support Navigator (RSN), and the community support of her Targeted Case Manager (TCM) from a CMHC.

Her Care Coordination team connected the enrollee to behavioral health and primary care providers specializing in eating disorders. Nevertheless, the enrollee continued to be admitted to inpatient facilities either due to her low weight and distressing vitals or because she had reported suicidal ideations and a plan. When outpatient care proved inadequate to meet the enrollee’s needs, the ICCM convened SWAT meetings with Utilization Management, Account Management, and Medical Leadership teams to explore higher level of care options as well as to consider appealing to the AHCA for support in managing the high cost and high needs of the enrollee.

Throughout the next 15 months the enrollee was admitted into five residential treatment facilities in Regions 2, 6, 10, and 11 as well as in Connecticut and one inpatient facility in New Jersey for her eating disorder needs. The ICCM, RSN, and TCM worked to continuously engage the enrollee in treatment but the enrollee would often be admitted to the residential facility and be discharged due to non-compliance with treatment program’s structure and guidelines. The ICCM enlisted the support of the enrollee’s mother who became re-engaged in the enrollee’s treatment.

CRITERIA 3: THE ADEQUACY OF THE RESPONDENT'S APPROACH FOR MEASURING TIMELY ACCESS...

The Magellan Complete Care network development and maintenance goal is to ensure timely access to quality health care services for all enrollees. We adapt and modify our proven methodology to meet the unique needs of our specialty care enrollees across each of the regions we serve. Since the SMI Specialty Plan Program inception in 2014, we have successfully conducted the assessments to measure timely access by provider type and communicated the results to AHCA.

Magellan Complete Care’s QI Department is responsible for overseeing the process used to verify compliance with PCP and applicable provider specialties for appointment access requirements. As part of the QI program, Magellan Complete Care uses industry standard data collection, monitoring, and reporting tools to continuously evaluate providers pursuant to requirements set forth in the provider agreement.

One of the ways this is accomplished is through conducting an annual survey of providers (as described above) to evaluate the average number of calendar days for appointment and availability. Variables measured include the number of hours for crisis, urgent, and routine appointments; status reported in currently accepting new enrollees; in office wait time; and any barriers to scheduling appointments with enrollees.

Starting October 1 of each contract year, we conduct a statistically valid sample of network providers, including PCPs’ appointment wait times with specific emphasis on the following
standards: (a) average wait time for an urgent appointment; and (b) average wait time for a routine appointment. This is to ensure appointment access is in compliance with Attachment II, Section VII, Provider Network, Item F., Appointment Waiting Times and Geographic Access Standards, and report the results to the responsible committees in the format specified, in accordance with Attachment II, Section XII, Reporting Requirements. (See 42 CFR 438.206(c) (1) (IV), (v) and (VI).

When performance indicators, quality reviews, or internal data suggest the need for a focused review of provider performance, targeted reviews are initiated and conducted by clinical reviewers or compliance auditors. Any issue related to lack of access, limited availability, complaints, quality of care concerns and potential fraud, waste, and abuse (FWA) requires ad hoc review. These reviews are conducted to ensure the safety of enrollees and to ensure best practices and established policies and procedures are being followed.

Monitoring and tracking of findings from these reviews can inform essential provider education and re-training to a more severe issuance of a Provider Improvement Process (PIP), along with system interventions, which are then monitored for improvement as noted in the corrective action as well as for continued network participation suitability.

Results of monitoring activities are reported to the QI Committee to develop appropriate interventions in response to any identified areas of sub-optimal performance, including ongoing monitoring for the implementation of interventions to support continuous improvement. The Magellan corporate QI Department collects access measurement data per the QI Work Plan. We measure timely access continually for all provider types the same and use the same reports to monitor network opportunities. Our network development plan does not vary between adult and pediatrics.

Magellan Complete Care annually measures compliance of its network providers and facilities with appointment access and availability standards. We administer a survey questionnaire at least annually to determine the extent to which our network provides and maintains appropriate enrollee access to primary care, high volume and high-impact specialty care, and behavioral health care services. Results of annual performance evaluation are conveyed to AHCA by February 1 of each contract year. Providers not meeting the appointment standards are notified and asked to submit an improvement plan to ensure compliance with appointment standards.

Data sources used in this assessment include:

>Geographic-access and density reports assessing provider availability
>Enrollee experience data, including satisfaction and complaints regarding the availability of and access to services
>Primary care practitioner self-report regarding access to regular, routine, urgent and after-hours care
>Behavioral health practitioner self-report regarding access to emergent, urgent, routine care, and follow-up to routine care
>High volume and high-impact specialty practitioner report regarding appointment access.

The purpose of this survey is to monitor network providers’ compliance with the timely appointment access standards, reinforce areas of compliance, and identify patterns of non-
compliance with timely access requirements for further investigation and intervention. Our provider availability monitoring is performed using a focused practitioner self-report survey, analysis of complaints and grievances specific to provider availability, and information derived from enrollee feedback on either the CAHPS or Magellan Complete Care behavioral health enrollee experience surveys.

These various data sets strive to measure the appointment access standards listed below as well as enrollee satisfaction with their access to care for each practitioner category (PCP, Behavioral Health, and Specialist). The Provider Appointment Access and Availability Survey questionnaire was faxed or emailed to all Magellan Complete Care network providers by the following process:

>A fax/email blast function within the distribution list’s database delivered the questionnaires to each provider according to their fax or email contact information

>Providers were instructed to complete the survey online or fax it to Magellan Health’s ASD Survey Operations Department.

Provider respondents returned questionnaires to the ASD Survey Operations Department in 2016. The ASD Survey Operations Department. They sent out reminder messages to non-responding providers and scanned questionnaires upon receipt into database designed for statistical analysis (SPPS). We analyzed the following data:

>Primary Care Practitioner Availability: We ensure our primary care network provides ample availability for enrollees. This is accomplished by establishing quantifiable and measurable standards for the number and geographic distribution of each type of practitioner providing primary care. Performance is analyzed at least annually:

>>Standards for Number of Primary Care Practitioners: Required standards are defined in the Managed Medical Assistance Provider Network Standards Table in the AHCA Contract. The information below presents our actual results compared to the established standard for each primary care practitioner type:

Practitioner Type: Family Practice
Measure: Practitioners to enrollees
AHCA Standard: 1:1,500
Magellan Complete Care Actual Standard: 1:56

Practitioner Type: General Practice
Measure: Practitioners to enrollees
AHCA Standard: 1:1,500
Magellan Complete Care Actual Standard: 1:161

Practitioner Type: Internal Medicine
Measure: Practitioners to enrollees
AHCA Standard: 1:1,500
Magellan Complete Care Actual Standard: 1:50

Practitioner Type: Pediatrics
Measure: Practitioners to enrollees
AHCA Standard: 1:1,500
Magellan Complete Care Actual Standard: 1:50

Practitioner Type: Pediatric & Family Practice
Measure: Practitioners to pediatric enrollees
AHCA Standard: 1:1,500
Magellan Complete Care Actual Standard: 1:13

>>Performance Analysis: As the information above shows, we significantly exceed the established performance goal for practitioner-to-enrollee ratios for all primary care practitioner types.

>>Standards for Geographic Distribution of Primary Care Practitioners: Standards for Magellan Complete Care are defined in the Managed Medical Assistance Provider Network Standards Table, which is part of the AHCA Contract. The following presents our results compared to established performance goal:

Practitioner Type: Family Practice
Measure: 1 within 20 miles
AHCA Performance Goal: 95%
Magellan Complete Care Actual: 100%

Practitioner Type: General Practice
Measure: 1 within 20 miles
AHCA Performance Goal: 95%
Magellan Complete Care Actual: 100%

Practitioner Type: Internal Medicine
Measure: 1 within 20 miles
AHCA Performance Goal: 95%
Magellan Complete Care Actual: 100%

Practitioner Type: Pediatrics
Measure: 1 within 20 miles
AHCA Performance Goal: 95%
Magellan Complete Care Actual: 100%

>>Performance Analysis: As the information above shows, Magellan Complete Care’s primary care network meets the geographic distribution performance goal, providing a PCP to all of its 56,199 enrollees within 20 miles of their home. This is possible due to a 100% compliance with all geographic distribution metric goals. No opportunities for improvement are identified.

>>Actions: Though we continues to meet and exceed expectations, Provider Optimization Delivery System (PODS) Directors and their staff continue to enhance the network to ensure it remains robust so that enrollees have sufficient a selection of practitioners to provide primary care services.
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> High Volume and High Impact Specialty Care Availability: We ensure that its specialty care network provides sufficient availability for its enrollees. This is accomplished by defining the types of practitioners that serve as high volume and high impact specialty care practitioners (SCPs) and then establishing quantifiable and measurable standards for the number and geographic distribution of each type of high volume/high impact SCP. Performance is measured annually.

> Identification of High Volume and High Impact SCPs: A review of 2016 claims volume identified the top 10 high volume and high impact specialties listed below. Due to the SMI specialty plan population, there is significant overlap of high volume and high impact specialists. Designations for each are indicated below:

  >> Allergy – high volume
  >> OB/GYN – high volume
  >> Cardiology – high volume
  >> Endocrinology – high volume and high impact
  >> Neurology – high impact
  >> Infectious Disease – high volume and high impact
  >> General Surgery – high volume
  >> Pulmonology – high impact
  >> Nephrology high volume and high impact
  >> Hematology/Oncology – high volume and high impact
  >> Optometry – monitored per contract
  >> Gastroenterology – monitored per contract

> Standards for Number of SCPs: Standards are defined in the Managed Medical Assistance Provider Network Standards Table in the AHCA Contract. The information below compares the Magellan Complete Care standards to actual results:

Practitioner Type: Allergy
Measure: Practitioner to enrollees
AHCA Standard: 1:20,000
Magellan Complete Care Actual: 1:835

Practitioner Type: OB/GYN
Measure: Practitioner to enrollees
AHCA Standard: 1:1,500
Magellan Complete Care Actual: 1:123

Practitioner Type: Cardiology
Measure: Practitioner to enrollees
AHCA Standard: 1:3,700
Magellan Complete Care Actual: 1:136

Practitioner Type: Endocrinology
Measure: Practitioner to enrollees
AHCA Standard: 1:25,000
Magellan Complete Care Actual: 1:847
Practitioner Type: Neurology  
Measure: Practitioner to enrollees  
AHCA Standard: 1:8,300  
Magellan Complete Care Actual: 1:227

Practitioner Type: Infectious Disease  
Measure: Practitioner to enrollees  
AHCA Standard: 1:6,250  
Magellan Complete Care Actual: 1:368

Practitioner Type: General Surgery  
Measure: Practitioner to enrollees  
AHCA Standard: 1:3,500  
Magellan Complete Care Actual: 1:175

Practitioner Type: Pulmonology  
Measure: Practitioner to enrollees  
AHCA Standard: 1:7,600  
Magellan Complete Care Actual: 1:362

Practitioner Type: Nephrology  
Measure: Practitioner to enrollees  
AHCA Standard: 1:11,000  
Magellan Complete Care Actual: 1:360

Practitioner Type: Hematology/Oncology  
Measure: Practitioner to enrollees  
AHCA Standard: 1:5,200  
Magellan Complete Care Actual: 1:518

Practitioner Type: Optometry  
Measure: Practitioner to enrollees  
AHCA Standard: 1:1,700  
Magellan Complete Care Actual: 1:73

Practitioner Type: Gastroenterology  
Measure: Practitioner to enrollees  
AHCA Standard: 1:8,333  
Magellan Complete Care Actual: 1:221

Performance Analysis: As the results show, we exceed established standards for all practitioner types for both high volume and high impact specialists. The specialist network exceeds the accessibility requirements from as little as 10 times the standard to as much as 37 times the requirement, as is seen in the Hematology/Oncology and Gastroenterology specialties respectively. We continue to improve the ratios of specialists to enrollees through a continuous contracting process. At this time there are no opportunities for improvement noted.
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

> Standards for Geographic Distribution of High Volume and High Impact SCPs: Standards are defined in the Managed Medical Assistance Provider Network Standards Table in the AHCA Contract with performance goal compared to actual shown below:

Practitioner Type: Allergy
Measure (Urban/Rural) AHCA: 1 within 60/75 miles
Performance Goal: 95%
Magellan Complete Care Actual: 99%

Practitioner Type: OB/GYN
Measure (Urban/Rural) AHCA: 1 within 35/60 miles
Performance Goal: 95%
Magellan Complete Care Actual: 100%

Practitioner Type: Cardiology
Measure (Urban/Rural) AHCA: 1 within 35/60 miles
Performance Goal: 95%
Magellan Complete Care Actual: 100%

Practitioner Type: Endocrinology
Measure (Urban/Rural) AHCA: 1 within 75/90 miles
Performance Goal: 95%
Magellan Complete Care Actual: 100%

Practitioner Type: Neurology
Measure (Urban/Rural) AHCA: 1 within 45/60 miles
Performance Goal: 95%
Magellan Complete Care Actual: 96%

Practitioner Type: Infectious Disease
Measure (Urban/Rural) AHCA: 1 within 75/90 miles
Performance Goal: 95%
Magellan Complete Care Actual: 100%

Practitioner Type: General Surgery
Measure (Urban/Rural) AHCA: 1 within 35/60 miles
Performance Goal: 95%
Magellan Complete Care Actual: 100%

Practitioner Type: Pulmonology
Measure (Urban/Rural) AHCA: 1 within 45/60 miles
Performance Goal: 95%
Magellan Complete Care Actual: 96%

Practitioner Type: Nephrology
Measure (Urban/Rural) AHCA: 1 within 60/75 miles
Performance Goal: 95%
Magellan Complete Care Actual: 100%
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Practitioner Type: Hematology/Oncology
Measure (Urban/Rural) AHCA: 1 within 60/75 miles
Performance Goal: 95%
Magellan Complete Care Actual: 99%

Practitioner Type: Optometry
Measure (Urban/Rural) AHCA: 1 within 35/60 miles
Performance Goal: 95%
Magellan Complete Care Actual: 100%

Practitioner Type: Gastroenterology
Measure (Urban/Rural) AHCA: 1 within 45/60 miles
Performance Goal: 95%
Magellan Complete Care Actual: 94%

Performance Analysis: We have improved the enrollee access to practitioners through a continuous contracting process. Geographic access met or exceeded the established performance goal across all specialties. The one high volume specialty that was slightly below the goal of 95% was gastroenterology at 94%, one percentage point below goal. A drill down by region shows this is driven by a shortage of this provider type in Region 2. This can be attributed to an inability to maintain an adequate patient panel in this rural area in addition to practitioners wanting to be closer to a greater expanse of medical services. All regions exceed established goals for all practitioner types with the exception of Region 2, which in addition to gastroenterology is below goal for neurology and pulmonology practitioners.

Actions: PODS Directors continually look for contracting opportunities to improve availability in areas with identified geographic coverage deficiencies by targeting the pertinent specialist(s). However, in certain rural areas, targets are limited.

Behavioral Healthcare Availability: We ensure our behavioral healthcare network provides ample availability for enrollees. This is accomplished by defining the types of practitioners that serve as high volume behavioral healthcare practitioners (BHPs) and then establishing quantifiable and measurable standards for the number and geographic distribution of each type of high volume BHP. Performance is measured at least annually.

Identification of High Volume BHPs: A review of 2016 claims shows the following five High Volume BHPs:
>>>Psychiatrist
>>>Mental Health Counselor
>>>Licensed Social Worker
>>>Child/Adolescent Psychiatrist
>>>Clinical Psychologist

Standards for Number of BHPs: Standards for practitioner to enrollee ratios are defined in the Managed Medical Assistance Provider Network Standards Table in the AHCA Contract and presented in the information below:

Practitioner Type: Psychiatrist
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Measure: Practitioner to enrollees
AHCA Standard: 1:1,500
Magellan Complete Care Actual: 1:71

Practitioner Type: Mental Health Counselor
Measure: Practitioner to enrollees
AHCA Standard: 1:1,500
Magellan Complete Care Actual: 1:35

Practitioner Type: Licensed Social Worker
Measure: Practitioner to enrollees
AHCA Standard: 1:1,500
Magellan Complete Care Actual: 1:83

Practitioner Type: Child/Adolescent Psychiatrist
Measure: Practitioner to pediatric enrollees
AHCA Standard: 1:7,100
Magellan Complete Care Actual: 1:60

Practitioner Type: Clinical Psychologist
Measure: Practitioner to enrollees
AHCA Standard: 1:1,500
Magellan Complete Care Actual: 1:218

>>Performance Analysis: As the actual results show, we significantly exceed the established performance goal for practitioner–to-enrollee ratios for all behavioral health provider types. No opportunities for improvement are identified at this time.

>>Standards for Geographic Distribution of BHPs: Standards for geographic distribution are defined in the Managed Medical Assistance Provider Network Standards Table in the AHCA Contract as noted below:

Practitioner Type: Psychiatrist
Measure (Urban/Rural) AHCA: 1 within 20/45 miles
Performance Goal: 95%
Magellan Complete Care Actual: 100%

Practitioner Type: Mental Health Counselor
Measure (Urban/Rural) AHCA: 1 within 20/45 miles
Performance Goal: 95%
Magellan Complete Care Actual: 98%

Practitioner Type: Licensed Social Worker
Measure (Urban/Rural) AHCA: 1 within 20/45 miles
Performance Goal: 95%
Magellan Complete Care Actual: 96%
Practitioner Type: Child/Adolescent Psychiatrist
Measure (Urban/Rural)  
AHCA: 1 within in 20/45 miles
Performance Goal: 95%
Magellan Complete Care Actual: 99.8%

Practitioner Type: Clinical Psychologist
Measure (Urban/Rural)  
AHCA: 1 within in 20/45 miles
Performance Goal: 95%
Magellan Complete Care Actual: 97%

>>Performance Analysis: We exceed the performance goal for geographic access for all behavioral health practitioner types. It should be noted that Childhood/Adolescent Psychiatrists were calculated against the child/adolescent population and met the standard based on that calculation.

>>Actions: Although we meet the performance goals, Network staff continue to work to meet the last outstanding gaps in our behavioral health provider network. PODS Directors assess and monitor their respective networks and work with their staff to identify potential providers with whom to contract to further decrease the gaps.

3.1 Summary and Next Measurement Period
Magellan Complete Care has made improvements in practitioner availability during 2016, and we currently meet or exceed all of the practitioner availability performance standards and goals with the exception of gastroenterology, which is one percentage point below the established threshold goal of 95 percent.

Where deficiencies have been identified, the Network Management team continues to work to recruit targeted providers to fill existing gaps. However, as noted earlier, there are limited targets available in the rural areas which make recruitment efforts difficult.

The Network Management Team continues to discuss strategies to improve collection and tracking of provider race/ethnicity and language data to better assess the network’s ability to meet the cultural needs and preferences of the membership. We will review practitioner availability again during Q4 2017 and will analyze deficiencies and identify potential interventions.

To see the actual survey, please refer to [MMA SRC #05, Attachment 5: Provider Appointment Access and Availability Survey.]

CRITERIA 4: THE EXTENT TO WHICH THE RECRUITMENT EFFORTS OUTLINE THE FREQUENCY AND...
Our goal is to build a provider network that not only meets, but exceeds the AHCA minimum access requirements. We do this by continuously monitoring our provider recruitment using various tools, including Quest Analytics software, which provides both access and adequacy reports based upon time, distance and quantity of providers. We build specific reports to meet both the urban and rural county access standards, ensuring that we continue to build a dense and diverse pool of providers to meet enrollees’ primary care and specialty care needs.
We evaluate our network accessibility reports to identify gaps in enrollee access to care and services, on a weekly basis or as issues arise, such as when new gaps are identified or a provider terminates from the network. We provide reports to AHCA through its Provider Network File submission, which furnishes the quantity, type, time and distance analysis of all required providers and practitioners throughout the service area and is attested by the plan's executive officer as adequate.

Additional data-points and reports are reviewed monthly by Magellan Complete Care Network Strategy and Oversight and Quality Improvement Committees in addition to the Network Contracting team. These analyses include health care providers and subcontracted networks such as vision and dental. Specific measures used to determine the need to deploy recruitment activities include:

- Projected changes in membership growth or the demographics of the membership
- Evaluation of the PCP-to-enrollee ratio using PCP capacity and panel status
- Monitoring of physician compliance with AHCA accessibility standards for appointment wait time standards, telephone and after-hours accessibility
- Evaluation of service utilization trends
- Examination of Quest Analytics Geographic Network Analysis reports based on travel time and distance using AHCA network standards
- Review of provider terminations from the network
- Review of trends in enrollee complaints and grievances
- Identification of new gaps in the network based on input from the enrollee, provider, care coordination, stakeholder, Provider Advisory Committee or other sources.

On an annual basis, the Network team collaborates with the quality and other cross-functional teams to update the Network Development and Management Plan, including the process for continuous monitoring of network sufficiency and access to services. In addition to the above measures, the plan is informed by additional data such as provider audits, provider surveys, enrollee surveys, and input.

4.1 Strategies for Recruitment Efforts for Each Provider Type

Magellan Complete Care has made strategic investments in the development of our network for individuals with SMI over the past several years. Because our enrollees require immediate services, we have dedicated Network staff who focus on the management and expansion of the network every day. We have also supplemented our Network team with not only pure contractors, but also with Provider Support Specialists with a clinical background, who work with our providers and their office staff.

The Provider Support Specialists strive to meet the needs of the provider to effectively manage and provide services to the SMI population. We make available onsite one-on-one education on the unique needs of enrollees with SMI, provider tools, and the best practices that providers and office staff should follow to work most effectively. We have office consulting to assist providers in becoming more effective serving the SMI enrollees through practice facilitation activities focused at addressing the Triple Aim of healthcare and support an integrated care model. Magellan Complete Care offers quality incentive contract models for providers that are designed to enhance patient experience and quality outcomes. We collaborate directly with our providers to identify
quality metrics, mechanisms to be used for measuring and tracking patient outcomes, and payment mechanisms to drive provider performance and improve patient quality outcomes.

In addition, our network contains more than just the traditional provider types – we also have a network of more than 4,000 non-traditional community organizations and supports. These relationships have been cultivated over the years and complement our current network design. As industry innovators, we understand the need to address social and emotional needs that go beyond standard healthcare services to ensure the enrollees’ success and recovery.

Magellan Complete Care continuously calibrates the network and makes investments to keep the network where it needs to be. Our staff members have the expertise and training to work with the provider community. Together, we successfully work to meet the needs of an SMI population.

Please see [MMA SRC #05, Attachment 6: Provider Support Specialist Letter of Support] from Oswald Williams, MD Medical Director of Maturity Medical in St. Petersburg, Florida.

CRITERIA 5: THE EXTENT TO WHICH THE RETENTION EFFORTS OUTLINE...
Successful provider engagement is achieved by building accountable and responsive relationships, which drive provider satisfaction. 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 improving the provider experience through a high-touch provider engagement model and continuous improvements to streamline provider management processes and improve the quality of care for our enrollees.

We have the executive commitment and staffing model to support that commitment. Our field-based representative model includes dedicated provider relations managers (PRMs) and Provider Support Specialist staff in each region to ensure real-time, personalized support. Our integrated provider engagement approach offers a hybrid of onsite, personalized support within each Florida region, as well as virtual, self-service and technology-based support capabilities. We believe this fosters healthcare innovation, integration, community inclusion and collaboration with all providers and caregivers across the enrollee’s entire care continuum.

Our retention approach includes the foundation that we do not want to terminate any provider – we continue to proactively create and develop a different approach to retaining providers based on our processes, staff, and technology to successfully support our SMI population. Magellan Complete Care submits a Provider Network Verification file each week to AHCA. The provider retention rate for 2017 is 92.3 percent.

Magellan Complete Care’s successful retention approach to keeping providers satisfied and in good-standing are detailed in the following components:

> Network Development team Support
> Reimbursement structure/Incentives
> Provider Initiative – Provider Partnership Program
> Physician Advisory Board
> Provider Satisfaction Surveys
5.0 Network Development Team Provider Support
Our PRM serves as the primary contact to providers and manages the overall support needs of their assigned region. This role also includes managing provider issues and concerns, as well as ensuring that these issues are addressed in a timely manner. The PRM serves as the local hub for resolving provider challenges and coordinating among other internal Magellan Complete Care departments to ensure cross-departmental involvement and support.

Provider relations managers coordinate training and technical support to providers and their staff including:

- Orientation to Magellan Complete Care
- Claims submission, payment and dispute process
- Understanding and applying provider handbook policies

5.1 Provider Support Specialist Team
Our Provider Support Specialists are committed to our providers and work to establish a positive experience with Magellan Complete Care. They are proof of our commitment to ensure our providers remain in favorable standing. The Provider Support Specialist team consists of licensed behavioral health clinicians or RNs with significant behavioral health experience. As a participant of the regional Integrated Health Neighborhood team, the Magellan Complete Care SS facilitates and supports our partnerships with providers to develop and improve quality of care and integrated care models. These highly trained and qualified clinicians, who are expert at working with enrollees living with SMI, enable us to be more effective with providers and their office staff.

Provider Support Specialist staff coordinate training and technical support to providers and their staff, including the following:

- Provide orientation to Magellan Complete Care Model of Care
- Provide education and support to facilitate best practices and cultural competency
- Assess provider readiness for integration
- Deliver clinical trainings to educate the network on the unique needs of our enrollee population
- Implement provider practice-based quality initiatives—(e.g., patient registries, P4P programs, provider scorecards)
- Distribute and review various Magellan Complete Care reports.

It is important to providers and their staff to have a direct contact with the health plan to address their provider agreement, their credentialing application, or resolving underpayment and overpayment claim for payment issues, as well as when they experience issues surrounding understanding covered services, the authorization process or ensuring an enrollee’s eligibility, and assisting in managing bad debts from enrollees. Magellan Complete Care has placed Network team members in the same community of providers that they represent. We believe this approach better equips the provider community to trust and depend upon the network representative who happens to live and work within the same community in which they represent.

By embedding the Network team in this manner, we empower our Provider Support Specialists to expedite coordination across practitioners, community stakeholders, advocacy groups, and local providers of care.

As licensed clinicians, the Provider Support Specialist staff build positive and engaged rapport with network providers. The Provider Support Specialist team facilitates trainings with specific emphasis on improving quality, best practices modeling, medical record reviews, implementation
of our clinical initiatives and processes from the viewpoint of a clinician with a focus on the characteristics of an SMI population.

5.2 Reimbursement Structure/Incentives
Magellan Complete Care understands and supports AHCA’s goal to ensure that providers are reimbursed at levels at least consistent with Medicare, including through increased compensation for physicians, using funds achieved through savings from effective care management, as specified by Section 409.967(2)(a), Florida Statutes. Though many of our primary care and behavioral health care providers are capitated, we have designed several incentive programs that are specifically focused on outcomes and incentive payments through shared savings strategies. Magellan Complete Care currently has several provider incentive programs in place, all of which are tied to improvements in specific outcomes, including the following:

> OB/GYN Incentive Program
> Pediatric Incentive Program
> HEDIS/EPSDT/CHCUP Gap Closure Incentive Program
> Road 2 Recovery Program for Post-Discharge Follow-Up Care
> Integrated Health Homes
> Integrated Behavioral Health Program (IBHP)

We work collaboratively with providers to define meaningful reimbursement methods and incentives, as well as the non-financial supports that Magellan Complete Care provides. This may include support for practice transformation, grant writing, hiring of key staff, etc. Magellan Complete Care’s Value-Based Payment (VBP) strategy focuses on population health management; improving quality of care while efficiently delivering clinical and provider services that engage our enrollees, reducing overall costs, for both the enrollee and the plan, and most importantly, increasing enrollee satisfaction and improving outcomes.

In addition, we are focused on supporting providers operationally and financially as they transition from fee-for-service to value-based payment or alternative payment models (APM).

5.3 Provider Initiative – Provider Partnership Program
As part of our commitment to our providers, we work closely with our innovative providers to break new ground related to integration of care. The purpose of the Provider Partnership Program is to partner with valued providers who support an integrated model of care to increase the quality and access to care as well as to promote a positive enrollee experience. The process involves understanding provider organizations, practices, and operations to build provider efficiencies, capacity and support.

The Provider Support Specialist staff begin with an observation of the practice processes and work flows tailored to reflect the uniqueness of a practice. Based on the observation, we collaboratively develop a practice plan to reflect the goals of the practice, including strategies and improvement efforts that drive practice transformation.

The outcomes of the 2016 Provider Partnership Program include the following:

> Increased PCP utilization
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

> Increased closed HEDIS gaps year-over-year
> Increased score for the Coordination of Care items on medical and behavioral health record reviews
> Improved overall provider office workflows
> Several providers implemented or expanded population health activities and/or chronic conditions

Since 2016 we have had 315 high/ultra-high risk enrollees and 7,847 moderate and low risk enrollees engaged in the project within nine PCPs/ FQHCs and eight CMHCs. Please see [MMA SRC #05, Attachment 7: Provider Partnership Program.]

5.4 Physician Advisory Board
The Magellan Complete Care quarterly Physician Advisory Board provides a venue to solicit provider input regarding our policies and procedures, communications and administrative practices, incentive programs as well as clinical and quality programs.

The Physician Advisory Board includes key stakeholders in both primary and specialty community care and leaders from Magellan Complete Care, including the chief medical officer, the senior director of health services, the chief operating officer, chief executive officer, and other clinical leaders.

The Physician Advisory Board has been instrumental in the genesis of several quality-of-care programs at Magellan Complete Care, including those designed to decrease preventable emergency room and admissions. The continuing input of these stakeholders has been instrumental to the development of the Integrated Behavioral Health Program (IBHP), the Integrated Health Home, the Road 2 Recovery, and the Health Home.

5.5 Provider Satisfaction Surveys
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. For 2016, the overall satisfaction result of 85.1 percent is 5.1 percentage points above the established performance threshold goal of 80 percent.

After review and discussion of the survey elements, the Magellan Complete Care Satisfaction Survey Workgroup determined to evaluate all elements not meeting a threshold goal of 80 percent for opportunities for improvement. As part of our ongoing commitment to QI, provider satisfaction, and engagement; a quality improvement plan was established to address areas of areas of opportunity so that the provider’s feedback was responded to in a meaningful, collaborative manner. We are then able to convey the changes/improvements that were made as a result of their feedback by leveraging the strength of our field-based Integrated Health Neighborhood structure. This ensures that providers are aware of the positive changes being implemented.

CRITERIA 6: THE EXTENT TO WHICH THE QUALITY AND/OR PERFORMANCE METRICS IT WILL USE...
Magellan Complete Care is committed to offering tools and resources to our providers to help improve enrollee outcomes. Magellan Complete Care publishes the performance metrics AHCA
uses to gauge our plan progress on our provider website. In addition, we develop and disseminate tip sheets and trainings related to performance improvement. We offer self-service tools including the Impact Pro Connect Portal to support performance improvement efforts.

To safeguard enrollees and ensure that best practices and established policies and procedures are being followed, we conduct the following reviews:

- Targeted Reviews: When performance indicators, quality reviews, or internal data suggest the need for a focused review of provider performance, our clinical reviewers or compliance auditors initiate and conduct targeted reviews.
- Ad Hoc Reviews: Any issue related to lack of access, limited availability, complaints, quality of care concerns and potential FWA requires ad hoc review.

Monitoring and tracking findings from these reviews inform essential provider education and re-training to a more severe issuance of a Provider Improvement Process (PIP), along with system interventions. These issues are monitored for improvement and continued suitability for network participation as noted in the corrective action plan. Network staff also collaborates with the quality department and the quality director to develop an annual provider monitoring plan, which addresses provider accessibility and availability to required health care services. When Network staff identify an accessibility, availability or related quality of care issue through its monitoring activities, such staff promptly report their findings to the quality director and adjust network development, provider training, expanded monitoring or corrective actions to maintain network adequacy standards.

6.0 Real-time Access to Provider Progress in Achieving Quality and/or Performance Metrics

Provider Support Specialist staff use Magellan Complete Care provider portal self-service tools, including the Impact Pro Connect Portal, to support provider performance improvement efforts. The Connect Portal assists and informs providers about improved care management, identification of enrollee gaps in care, and performance comparisons to quality benchmarks. We offer real-time access to gap in care data about their assigned enrollees. 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.

Our Provider Support Specialists offer training and technical assistance on the availability and use of our tools and information as well as strategies and support to improve performance. Provider support specialists meet one-on-one with providers to share and review performance metrics as well as data from audits, surveys, and enrollee feedback.

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. The Provider Support Specialists and PRMs use Salesforce, our customer relationship management platform, which helps inform their provider performance outreach efforts. Salesforce is a cloud-based application used for the purpose of managing network providers, resources, and stakeholder relationships as well as the daily tasks of each team's preparation, planning, research, outreach, follow up, tracking, and reporting of data. We have tracked all interfaces with providers for the last two years, including phone contacts, email messages, and in-person meetings.
All major clinical initiatives are specifically documented and tracked in Salesforce so that our PRM/Provider Support Specialist 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. The Provider Support Specialist team conducts onsite medical record reviews with providers in partnership with our quality department. This team also arranges and plans the monthly regional meetings across the state with all departments. The Provider Support Specialist team documents all of the provider outreach, engagement, and communication on the Salesforce platform. This platform serves as a key connector enabling transparency, real-time support, and enhanced customer service.

Please refer to [MMA SRC #05, Attachment 8: Provider Portal Screenshots] to see screenshots of the Provider Portal where providers have real-time access to gap in care data.

**Evaluation Criteria:**

1. The adequacy of the respondent’s methodology for identifying and resolving barriers and network gaps; including ongoing activities for network development based on identified gaps and future needs projection.

2. The adequacy of the respondent’s plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.

3. The adequacy of the respondent’s approach for measuring timely access for the specified provider types and the extent to which the respondent’s approach includes clear methodology for determining the following:

   (a) Average wait time for an urgent appointment; and

   (b) Average wait time for a routine appointment.

4. The extent to which the recruitment efforts outline the frequency and specific measures to be used to track the need to deploy recruitment activities for the provider types listed.

5. The extent to which the retention efforts outline the approach to keeping providers satisfied and in good-standing with the respondent.

6. The extent to which the quality and/or performance metrics it will use to gauge progress toward the Agency goals are transparent to providers, including the frequency with which providers will be able to access their progress.

**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.

5 additional points will be awarded to respondents who demonstrate that providers shall have real-time access to their progress in achieving quality and/or performance metrics.
MMA SRC# 6 – Provider Network Agreements/Contracts (Regional):

The Agency has identified some of the key network service provider types that will be critical in order for the respondent to promote the Agency’s goals.

The respondent shall demonstrate its progress with executing agreements or contracts it has with providers in the region by submitting Exhibit A-4-b-1, Provider Network Agreements/Contracts (Regional):

Response:

Magellan Complete Care understands the importance of maintaining a regional and statewide network of providers in sufficient numbers to meet the access standards for specific medical services for all enrollees in the plan. We fully intend to promote AHCA’s goals by continuing to exceed the requirements in accordance with s. 409.967(2)(c)(1).

As the Serious Mental Illness (SMI) specialty plan since 2014, Magellan Complete Care will continue to leverage and broaden our existing provider network in Florida. Through our ongoing geographical access analysis, we have continued to refine the network construct, while establishing a provider network that supports our enrollees’ needs.

In addition, our network contains more than the traditional provider types; we also have a network of more than 4,000 community organizations and supports that complements our current network to support individuals with SMI.

We understand how to determine additional key network provider types to support the unique needs of our membership as we continue to grow and refine our network.

Magellan Complete Care demonstrates its depth and breadth of its network via the executed agreements or contracts it has with providers in the region by submitting [Exhibit A-4-b-1, Provider Network Agreements/Contracts].

Evaluation Criteria:

For each service provider type the respondent may receive up to 20 points as described below. Points for each service provider type will be awarded as outlined in the table below:

<table>
<thead>
<tr>
<th>Percentage of agreements/contracts for each service provider type</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>1.0% - 25%</td>
<td>5</td>
</tr>
<tr>
<td>25.1% - 50%</td>
<td>10</td>
</tr>
<tr>
<td>50.1% - 75%</td>
<td>15</td>
</tr>
<tr>
<td>75.1% or greater</td>
<td>20</td>
</tr>
</tbody>
</table>
Score: This section is worth a maximum of 240 raw points based on the above point scale.
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
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MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide):

The Agency has designed the MMA Physician Incentive Program with the expectation that Managed Care Plans should be able to increase compensation for physicians, using funds achieved through savings from effective care management, as specified by Section 409.967(2)(a), Florida Statutes. The respondent shall describe its plan for ensuring physician compensation rates are equal to or exceed Medicare rates for MMA covered services. Specifically, the response shall include detailed descriptions of quality initiatives the respondent intends to implement or maintain that produce savings by promoting the Agency’s goals, as well as other areas where the respondent has evidence that a potential for savings and increased quality exists.

Response:

OVERVIEW

Magellan Complete Care understands and supports AHCA’s goal to ensure that providers are reimbursed at levels at least consistent with Medicare, including through increased compensation for physicians, using funds achieved through savings from effective care management, as specified by Section 409.967(2)(a), Florida Statutes. At present, more than 70 percent of Magellan Complete Care enrollees are assigned to primary care physicians who are reimbursed on a capitated basis. Our capitated rates have been set at a level which we believe is at or above Medicare reimbursement based on the average number of encounters per enrollee for each provider. We do recognize that some providers may not be consistently submitting $0 claims, which may be skewing these results, however, our goal is to ensure providers receive the higher Medicare reimbursement levels. Magellan Complete Care also currently participates in the AHCA’s MPIP program, which targets quality improvements for pediatricians and OB/GYN, providing additional reimbursement to those providers for key services. As part of this response, we are also proposing selected expansion to that program as well as implementation of new quality incentive programs for other areas, and which will further increase reimbursement for both non-capitated and capitated providers. Each of these proposed programs is tied to specific quality and outcomes improvement goals for both AHCA and Magellan Complete, including programs to close gaps in care, and incentives to enhance access with the goal of reducing preventable events. Most have also been specifically tied to the generation of savings, resulting from those improvements in outcomes, allowing Magellan Complete Care to share the results of those improvements with our provider partners.

Magellan Complete Care understands and appreciates the importance of a strong and supportive provider network to ensure timely and appropriate access to services for our enrollees, to drive improved outcomes for our enrollees, and to generate potential savings. Achieving those goals is critical for delivering the quality of services we strive to deliver for our SMI enrollees, and for supporting our goals for reducing preventable events and timely closure of gaps-in-care for HEDIS, EPSDT, birth outcomes and care management. The programs we are proposing support those goals as well as the AHCA’s objective of provider reimbursement at or above Medicare through both enhanced reimbursement for specific activities as well as programs to share quality-driven savings with our provider partners.
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT’S PROPOSAL TO IMPROVE ...
Magellan Complete Care has a well-designed, integrated Continuous Quality Improvement process. Quality initiatives included in that process each require demonstrated effectiveness to drive improved outcomes, often including reductions in costs of care. Most are specifically targeted at closing gaps-in-care that, if left unaddressed drive preventable events in inpatient settings and the ER or may negatively impact birth outcomes, and result higher costs of care. Engagement of our provider partners, and where necessary, incentives to encourage that engagement, are important elements in our strategy. Those incentive programs also allow Magellan Complete Care to deliver higher overall rates of reimbursement at or above Medicare, while tying payment to value through improved outcomes for our enrollees and AHCA.

Among our physician providers, we have both capitated and non-capitated reimbursement. Programs to incentivize quality improvement for each of these groups must reflect those differences in reimbursement. As noted above, based on current utilization, we believe our capitated providers are currently receiving reimbursement at or above Medicare rates. However, given the large number of enrollees assigned to these providers, it is still important to engage them to support quality improvement initiatives and drive reductions in costs of care. We describe our approach to incentivize these providers later in this section.

Magellan Complete Care also has a large number of providers that are currently reimbursed on a fee-for-service basis at rates below Medicare. Our program goals for those providers is to provide them with reimbursement at or above Medicare through value-based incentive programs that are specifically tied to improvements in quality and outcomes for our enrollees. Through multiple programs, which we describe below, we will directly increase overall reimbursement to achieve rates that are equal to or exceed Medicare. These incentive programs include participation in the existing MPIP program which has been submitted to, and approved by AHCA. However, in addition, 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. The specific improvements targeted, 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 both our capitated and non-capitated providers. Performance metrics and targeted outcomes will be different for each group, recognizing differences in reimbursement and goals we are trying to achieve.

The specific programs we are proposing for each group of physicians is as follows:

1.1 Capitated Providers:
The primary objectives of our quality improvement incentive programs for our capitated providers is to incentivize:

> Increased claims/encounter submission ($0 claims) for gap in care reporting and monitoring
> Improved access to provider electronic medical record (EHR/EMR) data for monitoring and management of gaps in care
> Increased enrollee accessibility and engagement for primary care
> Increased utilization of primary care to reduce potentially preventable events; hospital admission, readmissions and emergency department use
We propose that capitated providers would participate in a shared savings pool and incentive program that would allow them to share in savings in total costs of care based on their performance in each of the areas noted above. Participating providers would include PCPs, pediatricians, and OB/GYNs. To qualify for participation, providers would first need to agree to allow Magellan Complete Care to establish electronic access to the provider’s electronic medical record system for purposes of capturing and reporting quality and gap in care data. Providers that allow that access would then participate in a shared savings pool for their assigned enrollees. Payouts from that pool would be based on total savings generated and would be driven by improvement in each of the categories below, at a level at or above minimum improvement thresholds to be set collaboratively with providers on an annual basis:

- Provider increases in $0 claims submission/patient encounter rates
- Provider gap closure rates (same gaps used for non-capitated providers)
- Reductions in all-cause admissions for assigned enrollees
- Reductions in 30- and 90-day readmissions for assigned enrollees
- Reductions in ER encounter rates for assigned enrollees

The key objective of this program would be to increase access and use of primary care, with the goal of reducing preventable events and closing gaps in care. We would work with our capitated providers to further define and enhance the programs as needed to gain support and acceptance of the program.

1.2 Non-Capitated Providers
We propose a program of incentives for our non-capitated providers that incorporates multiple additional elements. Participation may require a minimum panel size for participation in the shared savings pool, if needed from program execution. However, our goal will be to establish community-wide groups of providers based on community referral patterns. All non-capitated providers within that community pool would then participate in the benefits of savings generated. All providers would, of course, have the opportunity to reserve enhanced reimbursement for activity-specific incentive programs such as the existing MPIP program. Specific program elements we propose include:

- Existing MPIP program which has been submitted to, and approved by AHCA
- Additional quality incentive payments tied to our annual HEDIS and EPSDT/CHCUP gap in care closure initiatives
- Participation in a shared savings pool similar to that described for capitated providers that includes potentially preventable events related to hospital admission, readmissions and emergency department use.

These combined programs allow non-capitated providers to secure additional reimbursement for specific services tied to Magellan Complete Care quality programs, allowing them to secure reimbursement at rates at or close to Medicare rates, when combined with existing reimbursement. We believe that the addition of a shared savings program will allow these providers to move to levels of reimbursement at or above Medicare rates through participation in the savings generated through increased access to primary care services and reduced use of higher cost ER and inpatient services.
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1.2.a Existing MPIP program for Pediatrics and OB/GYN
Non-capitated providers will continue to participate in our existing MPIP program targeting gap in care closure around specific HEDIS and EPSDT/CHCUP metrics. Those incentive payments are available for both OB/GYNs and pediatricians. That program is not tied to specific redirection of costs to pay higher provider reimbursement rates, but are specifically tied to quality initiatives. The details of those programs are described below in the section of this response for initiatives tied to birth outcomes.

1.2.b HEDIS/EPSDT/CHCUP Gap Closure Incentive Program
This program provides for enhanced reimbursement for providers for encounters tied to closure of specific gaps in care. Specific target metrics for this program vary each year based on the key HEDIS/EPSDT/CHCUP gaps being targeted by Magellan Complete Care. This program is not tied to any redirection of costs to pay increased reimbursement. Details of that program are described later in this response in our discussion of additional quality incentive programs.

1.2.c Shared Savings Incentive Program
As with our capitated providers, we are proposing a shared savings incentive program for our non-capitated providers. Participating providers would include PCPs, pediatricians, and OB/GYNs. The primary objective of this program will be to incentivize:

> Increased enrollee accessibility and engagement for primary care
> Increased utilization of primary care to reduce preventable events
> Improved access to provider electronic medical record (EHR/EMR) data for monitoring and management of gaps in care
> Participation in programs to close gaps in care for assigned enrollees

We propose that non-capitated providers would participate in a shared savings pool and incentive program for their enrollees, which would allow them to share in savings in total costs of care based on their performance in each of the areas noted above. In order to qualify for participation, providers would first need to agree to allow Magellan Complete Care to establish electronic access to the provider’s electronic medical record system, if available, for purposes of capturing and reporting quality and gap in care data. Providers without EMRs would not be excluded from participation. Providers would then participate in a shared savings pool for their assigned enrollees and within their geographically defined referral pool. As with our capitated providers, performance on key metrics for each provider would need to meet or exceed minimum improvement thresholds, which would be established annually in collaboration with our provider partners. Payouts from that pool would be based on total savings generated and would be driven by:

> Encounter rates per enrollee, within range for annual target rates per enrollee
> Provider gap closure rates for key target HEDIS/EPSDT/CHCUP metrics
> Reductions in all-cause admissions for assigned enrollees
> Reductions in 30 and 90-day readmissions for assigned enrollees
> Reductions in ER encounter rates for assigned enrollees

As with the program described above for capitated providers, the key objective of this program would be to increase access and use of primary care, with the goal of reducing preventable events
and closing gaps in care. We would work with our capitated providers to further define and enhance the programs as needed to gain support and acceptance of the program.

1.3 Telemedicine Incentive Program
Finally, Magellan Complete Care is also proposing its incentive program for provider use of telemedicine. Consistent with the goals of AHCA, we believe the expanded use of telemedicine, particularly for primary physical and behavioral health care, is an important element in redirecting costs to lower cost sites of care, and reducing preventable events, particularly those tied to inappropriate use of the ER. Additionally, we believe that telemedicine can serve to increase access to care particularly for medically underserved areas (MUAs) and for known provider specialties, as well as pediatrics.

We currently have incentive programs for the implementation and use of telemedicine for behavioral health providers, including psychiatrists and licensed mental health providers, which has been effective in expanding use of these services. We propose expansion of that program to include the following additional physician categories which is consistent with the priority categories identified by AHCA, but also includes pediatrics, which Magellan Complete Care considers a priority for expansion. The specific additional physician specialties we propose include:

> Primary care (including internists)
> Pediatrics
> OB/GYN
> Cardiologists
> Pulmonologists
> Endocrinologists
> Internists

As with our current program targeting primary care providers, we propose an initial incentive payment to providers in these categories for the implementation of a Magellan Complete Care-compliant telemedicine platform. (We currently pursue a technology-agnostic strategy for implementation of telemedicine, requiring only that the telemedicine platform and use of the platform meet requirements for enrollee confidentiality, security, etc. We believe this strategy allows providers greater flexibility to choose a platform that works for their practice, thereby increase the rate of uptake of this important delivery system solution.) Once a qualified provider has completed their first telemedicine encounter and received payment for their first claim using that platform, the provider would then receive a second incentive payment.

Magellan Complete Care believes that increasing provider and enrollee use of telemedicine will be effective in redirecting costs from other higher acuity sites of care, while simultaneously increasing rates of enrollee engagement with their physician providers. The combined effect should be improved clinical outcomes and overall reductions in the costs of care for our enrollees.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT INCORPORATES QUALITY INITIATIVES THAT WILL RESULT IN REDIRECTING COSTS...
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Magellan Complete Care maintains a robust, organization-wide model for quality improvement across all our operations. Our goal is to enhance clinical outcomes and enrollee experience, while partnering with AHCA to drive greater value for the program and the State. This includes efforts to increase the use of electronic data and data sources, streamlining and reducing duplication in all operational areas, and robust quality and clinical outcomes improvement programs that are data-driven and targeted to improve the health of our enrollees with SMI.

Our quality improvement programs have been specifically designed to drive improvements in HEDIS/EPSDT/CHCUP and care gap closures, and have been adapted to the unique circumstances our enrollees face. Our results demonstrate the strength of this model. We have achieved improvements in our scores that exceed those for the four other largest health plans in the program.

Our care management programs have also been specifically designed to deliver fully-integrated biopsychosocial management of our enrollees, with similarly impressive results. Through these programs, we have reduced total admissions per 1,000 by 18 percent, reduced total per-enrollee-per-month (PMPM) costs by 15 percent and emergency department costs by 27 percent. We achieve similar results in our administrative functions where, as an example, we exceed AHCA benchmarks for provider dispute resolution and claims, grievances, and appeals.

However, Magellan Complete Care is driven to demonstrate outstanding performance across all programs and to demonstrate overall health and clinical outcomes for individuals with SMI that are equal to or better than those for other Medicaid beneficiaries. The incentive programs we have proposed will support those objectives.

2.1 Shared Savings Program
As described above, we are proposing shared savings programs that are specifically directed at increasing use of primary physical health and behavioral health services, and reductions in usage of unnecessary ER and inpatient utilization. The program has been specifically designed to redirect the benefits of those improvements to our provider partners, allowing for enhanced reimbursement to achieve AHCA goals. We believe this program will reduce preventable events, particularly tied to inappropriate ER usage resulting from issues of access to primary care. Additionally, the inclusion of metrics tied to the closure of gaps in care should drive greater stabilization of enrollee health for key conditions, which we believe will reduce the rates of preventable admissions.

2.2 Road-to-Recovery Program for Post-Discharge Follow Up Care
Magellan Complete Care has also established a separate program specifically tied to activities required for successful transitions of care, with the goal of reducing preventable readmissions and unnecessary ER use. This program is specifically directed at incentivizing providers to ensure that enrollees discharged from an inpatient setting receive required post-discharge follow up in specified timeframes. Providers can receive enhanced reimbursement for specific post-discharge activities. The first phase of this program is directed at follow-up care after discharge for a behavioral health diagnosis, a high-priority area for reducing preventable events. The specific incentives for this program are as follows:

> Incentive Payments for Follow-up with Licensed Clinician:
>> Incentive when completed within the expected guidelines and timeframes
Payments tied to specific post-discharge activities

This program also incorporates the use of telemedicine services for post-discharge encounters. We are currently implementing this program in specific regions of the state, with the goal of assessing its impact on increasing post-discharge follow-up and reducing preventable events. Based on the results of this more limited program we expect to expand to other regions, as well as use of the program for non-behavioral health transitions of care.

As is evident from each of the programs described above, each offers the potential for significant increases in reimbursement for well-performing providers. This program is also specifically directed at reducing preventable readmissions. Currently the program is directed at our behavioral health providers with the goal of reducing our rates of psychiatric readmissions. We are also expecting that it may reduce our Baker Act admissions which are specifically tied to our higher-than-expected rates for preventable psychiatric admissions.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT INCORPORATES QUALITY INITIATIVES...

As noted earlier, Magellan Complete Care currently participates in AHCA’s MPIP program which provides targeted incentives to OB/GYN providers and pediatricians. We understand AHCA’s goals of improving birth outcomes by:

> Increasing rates of full-term deliveries
> Reducing rates for cesarean sections
> Improving fetal health by focusing on reduction of maternal risks
> Reducing rates of unplanned pregnancies

Magellan Complete Care has robust care management programs for our SMI enrollees who are pregnant. Early and regular prenatal care, screening for risks of comorbid conditions, and screening for co-occurring substance use are critically important for supporting those programs and ensuring favorable birth outcomes for our enrollees. Post-partum care is equally important, given the potentially destabilizing effects of giving birth for our SMI enrollees.

We have a strong commitment to work with, and incentivize our providers to assist in meeting these expectations for our programs. As noted above, we are proposing continuation of our existing OB/GYN incentive programs tied to prenatal and post-partum care. However, we are also proposing an expansion of our programs to include prenatal episodes of care and have also included incentives for initiation of substance abuse treatment. In addition, through our existing LARC (long-acting reversible contraceptives) program physicians receive additional supports for purchase of that product (100 percent reimbursement for buy-and-bill), training in its use, and assistance in identifying and conducting outreach to enrollees with limited use of oral contraceptives. Use of LARC, as well as other oral contraceptives, has been shown to reduce rates of unplanned pregnancies, an important goal for AHCA. This program also has the benefit of increasing reimbursement for providers through fees associated with insertion of the device.

Magellan Complete Care currently achieves relative low rates of cesarean sections, and pre-term deliveries. For those reasons, our incentive programs are addressed at increasing care in other areas tied to improved birth outcomes. We propose a continuation of existing incentive programs, with the addition of expanded metrics tied to other areas of focus for improving birth outcomes.
The additional metrics and incentive payments that we propose are specifically directed at addressing care requirements for our pregnant enrollees with SMI. Those specific metrics are discussed later below.

3.1 Existing MPIP OB/GYN Incentives
The following is a brief overview of the incentives for each current program:

<<OB/GYN Incentive Program>>: Incentives are tied to provider performance in closing gaps in care for HEDIS rates of ongoing prenatal care, and HEDIS post-partum care (FPC and PPC). Payment is at the appropriate Medicare rate, as determined by AHCA. Payments to fee-for-service providers are made using an enhanced bundled payment, equivalent to the Medicare rate, for services provided related to each delivery during the payment period.

>Non-Participating providers- providers without a contractual arrangement with the plan are currently excluded from this program.
>Federally Qualified Health Centers (FQHCs)- Services provided in an FQHC may not be included in the MMA Incentive Program, regardless of whether or not the service is billed by the FQHC as an FQHC service or by the rendering provider using their own Medicaid ID.
>Rural Health Clinics (RHCs) - Services provided in an RHC may not be included in the MMA Incentive Program, regardless of whether or not the service is billed by the RHC as an RHC service or by the rendering provider using their own Medicaid ID.
>County Health Departments (CHDs) - Services provided in a CHD may not be included in the MMA Incentive Program, regardless of whether or not the service is billed by the CHD as a CHD service or by the rendering provider using their own Medicaid ID.

3.2 Expanded Metrics and Incentives Tied to Birth Outcomes
In addition to Magellan Complete Care’s existing MPIP program, we are targeting quality improvement in additional areas tied to improving birth outcomes. We propose additional incentive payments to OB/GYNs for the following types of services:

>Screening for substance use
>Screening for sexually transmitted diseases (STIs)
>Family planning visit
>Cervical Cancer Screening (CCS) Cervical Cancer Screening
>Pap smear
>Mammogram

The details of these incentive programs will be developed in consultation with our OB/GYN providers. Note that the incentives for family planning visits are in addition to current incentives for insertion of Long-Acting Reversible Contraceptives (LARCs) post-delivery. Currently, Magellan Complete Care provides reimbursement for immediate post-partum insertion of LARCs. Magellan Complete Care specifically incentivizes providers for placement of LARC by reimbursing for their use outside the delivery bundled payment. This separate payment helps to overcome provider resistance to their use post-delivery, due to their substantial cost. In addition to the other incentives identified above, we propose continuing this program.
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CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT IDENTIFIES OTHER AREAS...
Magellan Complete Care believes that each of the incentive programs we have proposed will support improved outcomes for our enrollees, increase physician reimbursement to levels at or above Medicare, support our quality improvement initiatives, redirect costs to more appropriate sites of care, and improve efficiency for our providers. Our proposed telemedicine incentive program is also specifically directed at improving access while simultaneously increasing the efficiency of provider practices.

Magellan Complete Care also has many programs in place that are specifically targeted at supporting the complex needs of our enrollees. As an example, we have adopted the full set of expanded benefits proposed by AHCA, as well as a number of additional benefits that we believe are important to ensure the recovery and stability of our enrollees, such as post-discharge meals. We also cover, and incentivize the use of Long-Acting Injectable (LAI) psychotropic medications to support increased medication adherence, and Long-Acting Reversible Contraceptives (LARC) with the goal of reducing unplanned pregnancies. Enrollees can also receive medication refills on an emergency basis. We also have expansive programs to support our enrollees in the community including homeless housing support and jail in-reach programs. We work collaboratively with our providers and the community on these programs with a goal of increasing enrollee stability and reducing inappropriate and unnecessary use of more acute services.

Magellan Complete Care also maintains extensive and comprehensive programs for provider education on requirements and best practices for fully-integrated physical and behavioral health care for our enrollees. Our Provider Support Staff (PSS) are also available and actively engaged with providers in practice development and practice improvement activities to develop their capabilities to deliver best outcomes for this complex population. This is in addition to our active and robust programs of provider and enrollee outreach and engagement for HEDIS/EPSDT/CHCUP and care gap closure. All providers, also have access to information for their patients online through our Provider and Connect portals, and receive gap-in-care reports to assist in managing patient outcomes.

However, in addition to all of these features, and the programs we have already described, we propose the following additional programs tied to other quality improvement initiatives. These programs are specifically tied to quality improvement initiatives for Magellan Complete Care, with many tied to our HEDIS/EPSDT/CHCUP gap closure programs. They are supported by a system of ongoing monitoring, outreach to providers and enrollees, education, and support to remove barriers to gap closure and support provider success. The specific, additional programs we propose are described below.

4.1 Existing MPIP for Pediatricians
We propose the continuation of our existing MPIP program directed at our pediatric providers.
<<Pediatric Incentive Program>>: Incentives are tied to provider performance in closing gaps in care for HEDIS Weight Assessment and Counseling – BMI (WCC) and HEDIS Adolescent Well Child Visit (AWC). Payment to all providers is for services rendered by qualified providers to enrollees under age 21. Payments are made at the group level unless the provider is a solo practitioner.
4.2 HEDIS/EPSDT/CHCUP Gap Closure Incentive Program
This program includes incentives for both primary care and specialty providers. The targeted
metrics and incentives will vary each year, based on gap closure goals and targets. Note that as
currently conceived, each program only applies to our non-capitated providers. Note that these
programs are directed at closing specific high-value gaps-in-care for our enrollees. We provide
examples below of the targeted metrics we currently propose.

>Primary Care: All incentives are in addition to normal reimbursement. Incentive payments would
be provided for the following, tied to gap closure:
  >>Well Visit
  >>Pap Smear
  >>Mammogram
  >>Lab Test
  >>BMI
  >>Immunizations
  >>Adult Wellness Visit
  >>Antidepressant Medication Management (AMM) Effective Acute Phase Treatment
  >>Diabetes Screening for People with Schizophrenia or Bipolar Dis Who are Using Antipsychotic
  Meds
  >>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Initiation Total

>Specialty Care: All incentives are in addition to normal reimbursement. Incentive payments
would be provided for the following, tied to gap closure:
  >>Specified high-priority lab tests
  >>Diabetic Retinal Exams (DRE) exam
  >>Road-to-Recovery Program (described in preceding section)

>Pediatrics: All incentives are in addition to normal reimbursement. Incentive payments would be
provided for the following, tied to gap closure:
  >>Early and Periodic Screening, Diagnostic, and Treatment Participation Rate (EPSDT)
  >>Weight Assessment & Counseling for Children
  >>Adolescent Well Care Visit
  >>Screening for substance use
  >>Medication reconciliation (MTM)

4.3 Reporting to Support Provider Efficiency for Improving Outcomes
Finally, Magellan Complete Care will be developing additional expanded reporting to support
providers in closing gaps in care, improving outcomes, and achieving success through our
proposed incentive programs.

Currently, we provide providers with gap in care reports for their enrollees, and which can be used
to monitor, track, and close quality measures. Those reports are available to providers in written
form, and online through the provider portal. We propose enhancing that reporting to specifically
tie gap closure to provider incentive opportunities. This information will provide additional direction
to providers for how they can increase their reimbursement while simultaneously supporting plan
goals to address quality and outcomes gaps and improvement initiatives. As is currently the case, we also propose continuation of our provider support programs performed by our Provider Support Staff (PSS). These include ongoing support for providers in identifying gaps in care, educating providers on program requirements, and supporting them in practice transformation and redesign to enhance their ability to achieve success in these programs.

Magellan Complete Care believes the combination of each of these incentive programs supports our providers in securing higher rates of reimbursement as well as assisting in the delivery of improved outcomes for our enrollees. We are committed to working with our provider partners and AHCA to further develop the details of these programs for use across our network.

**Evaluation Criteria:**

1. The extent to which the respondent’s proposal to improve quality can be tied to redirecting costs to pay higher physician rates.

2. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by reducing potentially preventable events.

3. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by improving prenatal care and birth outcomes.

4. The extent to which the respondent identifies other areas for quality initiatives or efficiencies that will result in potential cost savings.

**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.
C. **RECIPIENT EXPERIENCE**

**MMA SRC# 8 – Primary Care Providers (PCP) Assignment (Statewide):**

The respondent shall describe its overall process of assigning enrollees to primary care providers (PCPs), including its assignment algorithm. The response shall include the quality and/or performance metrics used to determine high quality PCPs, and the timeframes associated with processing an enrollee’s request to change PCPs.

**Response:**

**OVERVIEW**

Magellan Complete Care’s primary focus is to preserve existing enrollee and provider relationships whenever possible to facilitate seamless continuation of care. To ensure effective and efficient PCP connections for those we serve, Magellan Complete Care maintains written policies and processes for assigning and changing a PCP. Our processes meet all applicable regulatory and contractual requirements of AHCA (see [MMA SRC #08, Attachment 1: Assigning, Changing and Reinstatements to PCPs Policy]).

Our experience shows that enrollees often require highly specialized primary care services to address the complex needs associated with serious mental illness (SMI) potentially combined with substance use disorders (SUD) and/or co-morbid chronic conditions. Our approach to PCP assignment is to link enrollees to the PCP who is best suited to meet their needs and who offers the highest quality of care.

<<PCP Assignment Process>>

For newly enrolled or reinstated non-dual eligible enrollees, Magellan Complete Care ensures assignment of a PCP by their effective date. Our auto-assignment algorithm uses a hierarchy to match to the enrollee’s previous PCP at any service location within the area, if the appropriate scope of practice (age, pregnancy, etc.) and restrictions (panel size/panel hold) still apply.

If the enrollee does not have a PCP, or the scope of practice of the prior PCP does not currently match that enrollee’s needs, a PCP is auto-assigned (see more information in Criterion #2). From the beginning of operations of our SMI specialty plan in 2014, Magellan Complete Care established an assignment process based on preferred providers to ensure consistent care for our enrollees; more information about our preferred provider construct is included below.

In a limited number of cases, such as when the previous PCP has closed their panel, an enrollee is not assigned to a PCP through the auto-assignment process. In those cases, a report is issued to the Customer Service Department. Depending on the reason the enrollee was not auto-assigned, a trained customer service representative can reach out to the provider to override their panel limit, to the enrollee to choose a new PCP, or can manually assign a PCP if the enrollee can’t be reached.

We communicate PCP assignment in the welcome letter that is mailed to the new enrollee along with the welcome packet and Enrollee Handbook within 5 days following the receipt of the X12-
834 enrollment file from AHCA. During the new enrollee welcome call, Magellan Complete Care provides an opportunity for the enrollee to change their PCP. The enrollee may choose a specialist as the PCP in certain cases e.g. an OB/GYN for pregnant enrollees. The letter and handbook provide the enrollee with instructions on how to call our toll-free customer service help line in order to request a new PCP or make a change in their PCP at any time. The assigned PCP is integrated into our operating systems including our clinical system, TruCare, and our enrollee/provider services system, TMR.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT’S DESCRIPTION INCLUDES HOW QUALITY AND/OR PERFORMANCE METRICS ARE DEFINED AND UTILIZED IN THE ASSIGNMENT PROCESS.

The Magellan Complete Care primary care provider assignment process aligns with our commitment to achieve the Institute of Healthcare Improvement’s triple aim. That is, our process for assigning PCPs supports (i) improving the enrollee experience of care, including quality and satisfaction (ii) improving the health of populations and (iii) reducing the per capita cost of healthcare.

In addition, Magellan Complete Care has broadened the triple aim construct by adding a fourth element, the provider experience (including quality and satisfaction), resulting in a “quadruple aim.” We believe provider participation is an integral and essential addition to this comprehensive framework. We fully understand the important role providers play in achieving the goals of our enrollees, AHCA, and Magellan Complete Care.

In support of our dedication to quadruple aim, we strive to ensure that our enrollees receive the right care in the right setting, at the right time, and by the right provider. This is reflected in our approach to incorporating quality to our PCP assignment process as well as our ongoing efforts to improve upon this approach.

From the beginning of our business operations as an SMI specialty plan in 2014, Magellan Complete Care established an assignment process based on preferred providers to ensure accessible and high-quality care for our enrollees. As a new health plan, Magellan Complete Care defined preferred providers as providers who offer comprehensive care coordination, quality programs, “one-stop shop” and wrap around services. These providers are largely federally qualified health centers (FQHC), FQHC “look-alikes” or other large safety-net facility based practices. By definition, FQHCs are required to provide comprehensive services and have a robust quality assurance program in order to receive ongoing funding. These requirements ensure that an FQHC will address, among other things, clinical services and management, as well as measurement, tracking, and reporting of key quality indicators on annual basis.

FQHCs serve underserved areas and/or populations, very much consistent with the mission and operation of Magellan Complete Care in serving the population of our enrollees living with SMI across the state. As community-based organizations that provide comprehensive primary care and preventive care, including physical and behavioral health/substance abuse services to persons of all ages, FQHCs are a critical component of Magellan Complete Care’s health care safety net for our enrollees. They are governed by a board of directors, a majority of whom receive care at the FQHC.
Since that time, and based on three years of data, we are now able to advance our methodology for establishing preferred providers based on quality and cost. The Magellan Preferred Provider Quality Rating (MPPQR) is designed in such a way that it evolves over the length of time a PCP is contracted with Magellan Complete Care and allows each physician the opportunity to meet the standard of a preferred PCP. More specifically, providers will be ranked and categorized into one of three tiers: “preferred”, “select”, and “no select” (assignment frozen) for assignment.

The development of the MPPQR approach is well under way. Subject to any required regulatory approval from AHCA, we anticipate being fully operational with the approach by the end of 2017. In the initial phase of MPPQR, providers will be ranked using quality of service and quality of care metrics:

>Quality of service is based on complaints, grievances and issues related to the provider and their practice. Each provider receives an aggregate quality of service score based on the number and severity of complaints and issues. Physicians with no complaints or quality issues are assigned a perfect score, and physicians who have had complaints/issues have a proportionately lower score based on established benchmarks and thresholds. In keeping with our current practice, we will not assigned new enrollees to any provider who is subject to peer review based on the number and/or significance of quality complaints/issues about that provider..

>Quality of care metrics will align with our AHCA performance measures, our provider incentive programs, and value-based purchasing (VBP) agreements and the quality of service provided. In the next phase of MPPQR, the Magellan Complete Care ranking process will include industry standard tools and methods such as the 3M value index score (VIS) and total cost of care (TCOC) combined with a process for attribution and risk adjustment for illness burden.

A provider’s tier placement may be adjusted to reflect access concerns related to geographic location and capacity or to recognize highly specialized providers/facilities serving unique populations or conditions/procedures. Magellan Complete Care will continue to monitor individual practice patterns and trends including timeliness of services, grievances, and the enrollees' experience with care. Negative trends or practice patterns will directly affect a provider’s tier and preferred status.

We partner with our providers to facilitate improvements related to negative trends or practice patterns. On an ongoing basis, Magellan Complete Care provider support specialists (clinicians) provide training and technical assistance to practices to improve access to high quality of care providers in all regions for our enrollees.

Ranking will be updated biannually. The effectiveness of this new PCP assignment process will be reviewed at least semi-annually by the Magellan Complete Care Network Strategy and Oversight Committee, co-chaired by representatives from our Network and Quality Departments. Also, the Provider Advisory Committee will continue to be consulted for input and feedback. As further evaluations of effectiveness are conducted and lessons are learned, other key quality-related measures may be included in the PCP assignment process and algorithm.

Magellan Complete Care provides tools and information to empower enrollees to take responsibility for and exercise choice in their healthcare. Accordingly, we plan to post our provider
tiering on the secure enrollee portal to provide an opportunity for our enrollees to make informed choices; this in turn has the potential to reduce costs and improve enrollee satisfaction and quality.

CRITERION 2: THE EXTENT TO WHICH THE RESPONDENT’S ALGORITHM INCLUDES ASSIGNMENT OF ENROLLEES TO HIGH-QUALITY PCPS.
Magellan Complete Care incorporates a “preferred provider” status into our PCP assignment algorithm. As described above and beginning in 2018, a preferred status will be defined through a three-tier scoring and stratification process. Each PCP is assigned a designation of “preferred” (first tier), “select” (second tier), and “no select” (third tier - assignment frozen) for assignment; this designation is based on performance scoring associated with select quality of service (complaints, grievances and other service issues) and quality of care (tied to AHCA performance metrics including HEDIS) measures.

At the time of enrollment, our auto-assignment algorithms use a hierarchy to preserve the enrollee’s prior relationship with his or her PCP and matches to the enrollee’s previous PCP at any service location within the area, if the appropriate scope of practice (age, pregnancy, etc.) and restrictions (panel size/panel hold) still apply. If the enrollee does not have a PCP, or the scope of practice of the prior PCP does not currently match their needs, a PCP is auto-assigned.

More specifically, Magellan Complete Care automatically assigns a PCP based on an established algorithm, taking into consideration the following:

> Past relationship: as stated above
> Geography: accounting for adherence to travel time and distance requirements with assignment to the closest PCP to the enrollee’s address noted on the 834
> Age: accounting for a distinction between adults and children/adolescents
> Gender: for certain conditions and provider specialty, i.e., pregnancy and OB/GYN
> Family: accounting for PCP assigned to other family members enrolled in Magellan Complete Care, with an attempt to keep children/adolescents within the same family with the same PCP
> Linguistic/cultural needs: if known (specified in eligibility file), assignment to PCP who is or with office staff linguistically and culturally competent to communicate

> Preferred provider status: all things being equal above, the preferred provider is chosen first by our logic If no preferred provider is available for assignment, the enrollee will be assigned to a “Select” (second tier) provider based on the provider-tiering process. A report will be generated of all second tier assignments to allow tracking and follow-up with those providers by a provider support specialist.

CRITERION 3: THE EXTENT TO WHICH THE RESPONDENT CAN PROCESS REQUESTS FOR PCP CHANGES WITHIN THREE (3) BUSINESS DAYS.
Magellan Complete Care allows enrollees to change their PCP at any time effective within 24 hours of the time the enrollee requests the change. We aim to remove any potential barriers to care and ensure that our enrollees can receive necessary services when they present for care. For this reason, we allow an enrollee to seek care from any in-network PCP and will process the claim without an authorization or referral.
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This approach is documented in Magellan Complete Care internal policies and procedures. In addition, it is also included in training for our staff, including our customer service, health services, and network teams, who most often interface with enrollees who may be interested in or need to make a PCP change. Our enrollees are aware of the process through the Enrollee Handbook, newsletters, and tip sheets; they are also advised when they call customer service to request a change in their PCP.

Evaluation Criteria:

1. The extent to which the respondent’s description includes how quality and/or performance metrics are defined and utilized in the assignment process.

2. The extent to which the respondent’s algorithm includes assignment of enrollees to high quality PCPs.

3. The extent to which the respondent can process requests for PCP changes within three (3) business days.

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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MMA SRC# 9 – PCP Timely Access Standards (Statewide):

The respondent shall describe the process and monitoring plan it uses to ensure compliance with the timely access standards as defined in Exhibit B-1, Managed Medical Assistance (MMA) Program, Section VIII., Provider Services Item A., Network Adequacy Standards, Sub-Item 8., Timely Access Standards. The respondent shall also describe the process and methodology it uses for determining whether a PCP has the capacity to accept new patients.

Response:

OVERVIEW
Magellan Complete Care, in administering its Primary Care Provider (PCP) network, will comply with timely access standards defined in Exhibit B-1, Managed Medical Assistance (MMA) Program, Section VIII., Provider Services, Item A., Network Adequacy Standards, Sub-Item 8., Timely Access Standards. Indeed, we already maintain policies, procedures, and processes consistent with these requirements to ensure this compliance, to include but not limited to exercise of ongoing monitoring protocols, identification of potential gaps, and as necessary, planning and implementation of corrective action.

Magellan Complete Care is committed to timely access to all medically necessary and covered services for our enrollees. As a specialty plan for individuals with serious mental illness (SMI) our goal is to remove barriers to care and ensure prompt access to services when our enrollees are ready to engage in care. We know and understand that individuals 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. To meet our commitment, Magellan Complete Care’s dedicated Network staff are equipped with the tools and systems they need to build and maintain a responsive provider network best suited to meet the needs of our enrollees and assure timely access to care.

Magellan Complete Care already has extensive experience in establishing and delivering upon a fully contracted and completely credentialed network of health care service providers that meet AHCA’s network adequacy and accessibility criteria and in accordance 42 CFR 438.206. We are uniquely positioned to meet the needs of individuals with SMI due to our deep understanding of their utilization patterns and specials needs. Based on our experience in Florida, we will meet all of the requirements of the ITN, and more specifically, maintain the capacity to serve the expected number of enrollees as we have been doing since the inception of our SMI Specialty Plan.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT’S PROCESS AND MONITORING PLAN ENSURE...
Magellan Complete Care has established and maintains a comprehensive provider network oversight set of policies and procedures, process, and monitoring plan. This plan ensures, among other things, that Magellan Complete Care enrollees have timely access to routine, necessary non-urgent care and even more importantly, immediate and unimpeded access to care that is urgent, all in accordance with AHCA requirements, including those defined in Exhibit B-1, Section VIII, Item A, Sub-Item 8. Our current Florida experience prepares us to anticipate our MMA enrollment, enrollee utilization patterns, and practice experience of our providers in order to better inform our policies, procedures and, as needed, interventions with facilities and practitioners to
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
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guarantee ready access to all care services but most importantly, urgently needed care. Because of our established relationships within the provider community, we have partnered with our providers to effectively define and shape key improvements in provider responsiveness and enhance our providers’ understanding of the unique needs of our enrollees with SMI.

We continuously evaluate actual/expected enrollment and its composition, in the context of the AHCA contract and NCQA accreditation requirements, as well as our SMI enrollees’ health care experiences, including frequently co-occurring conditions and how that translates to accessing care delivery differently. We therefore know that access demands intensive coordination and dependable availability in each care service our enrollees’ need. Our extensive appreciation for and experience in making certain that these SMI enrollees get the services they need when they need them informs and continuously refines our monitoring approach and shapes our future practices to secure appropriate accessibility for enrollees and improve upon it on an ongoing basis.

Monitoring the Magellan Complete Care network, and in particular, adherence to appointment standards by medical and behavioral health practitioners in PCPs, OB/GYN’s, Pediatricians, Mental Health counseling and Hospitals, ensures that beyond adequacy and accessibility, Magellan Complete Care can safeguard enrollees access to health care services during emergencies and sudden peril. As the recent Hurricane Irma demonstrates, when anticipating hurricanes, loss of electrical power, city-wide street flooding, and closures of businesses, Magellan Complete Care prepares our providers through well planned activities and communications. These activities may include temporary changes to our policies and procedures to allow for exigent circumstances and urgent communication of these changes to providers; examples include reviewing any updated information with providers as to how to contact our staff for assistance and providing instructions on how enrollees can get their medications quickly and without interruption.

These policies, procedures, and practices are the hallmark by which Magellan Complete Care has consistently met AHCA’s contract standards since the inception of SMI Specialty Plan. A key ingredient to our success in this regard is that we diligently and actively monitor provider compliance against these standards and where necessary, take corrective action to address noncompliance and guarantee access to crucial health care services whether routine in nature or urgent and immediate.

These policies, procedures, and practices are the hallmark by which Magellan Complete Care has consistently met AHCA’s contract standards since the inception of the SMI Specialty Plan. A key ingredient to our success in this regard is that we closely monitor provider compliance against these standards and take corrective action to address noncompliance.

The Magellan Complete Care Enrollee Access Process and Monitoring Plan, a pivotal aspect of our approach to assuring an adequate and accessible network as well as provider compliance, includes:

> The development of a robust and responsive PCP network;
> Provider contracting and communications; and
> Continuous monitoring and improvement.
Robust and Responsive PCP Network: Ensuring network PCP accessibility begins by determining the number of providers needed by a number of factors, including: age; geographic proximity to where an enrollee resides; the quality and type of practitioners’ capacity for new patients; acuity and utilization patterns of our enrollees; accessible hours available; accommodations for individuals with disabilities; and any barriers in communication. We also account for provider adequacy measures including the number of PCPs, by region, accepting new Medicaid patients and the percentage of PCPs offering after-hours appointments and responsiveness to urgent care matters. Magellan Complete Care has the advantage of an adequate and accessible provider network carefully established in the regions where we currently operate. The effective strategies we have utilized in our network development and management approach within these regions will be leveraged in the other regions where we are seeking to expand operations of the SMI Specialty Plan.

Key to our approach, Magellan Complete Care Network staff collaborates with Quality and Provider Support Specialists teams to develop an annual Network Development and Management Plan. An essential component of this Plan is the continuous and routine monitoring of network sufficiency and access to urgent and non-urgent services. Results of ongoing network sufficiency analyses help ensure that service types and capacity meet system needs including culturally diverse priority populations and enrollees with special needs.

When deficiencies or gaps in the number of providers or accessibility based on time, distance or appointment setting requirements are identified, Magellan Complete Care deploys result-oriented initiatives to ensure enrollees can access critical primary and specialty care services through the recruiting of new providers, the use of single case agreements with out of network providers, use of Advanced Practice Nurses, non-emergency transportation, and provider incentives – all so that generous appointment times are readily available.

1.1. Provider Contracting and Communications

Magellan Complete Care has established specific requirements in its provider agreements and developed extensive provider education and training around such requirements to ensure practitioners will abide by Magellan Complete Care policies and standards of performance. For example, providers are contractually obligated and by instruction in the Provider Handbook and Network field training, to demonstrate an understanding and strict adherence to the following: providing 24/7 availability for enrollee access to health care services and supplies; maintaining established hours of operation, including after-hours physician coverage; and meeting requirements for scheduling patients requesting routine well care appointments, needing an appointment set within seven days for when reporting as sick and even seeing a patient on the same day for urgent care. Through our contracting and training processes, access standards are explicitly outlined and carefully reviewed with providers. Primary Care Providers are educated on state requirements and the importance of limits on panel size of enrollees, including why such standards ensure reasonable and necessary access to health care services. Through periodic and recurring network staff site visits, provider trainings, orientations, webinars and educational bulletins, contract requirements are thoroughly reinforced.

1.2 Continuous Monitoring and Improvement
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

The annual Network Development and Management Plan includes the process for continuous monitoring of network sufficiency and access to urgent and non-urgent services. Magellan Complete Care’s Quality Improvement (QI) department is responsible for evaluating the process used to verify compliance with the PCP appointment access requirements. As part of our QI program, Magellan Complete Care utilizes industry standard data collection, monitoring, and reporting tools in order to continuously evaluate providers pursuant to requirements set forth in the provider agreement. Results are reported to the Magellan Complete Care QI Committee and the Network Strategy and Oversight Committee, for oversight review and follow-up. When performance indicator reviews or quality data on a trended basis suggest the need for a focused review of provider performance, targeted reviews are initiated and conducted by QI clinical reviewers. Issues that include (but are not limited to) lack of access and limited availability are triggers for ad hoc reviews.

Magellan Complete Care routinely monitors provider adherence to these standards through:

a. Provider audits
b. Enrollee and CAHPS surveys
c. Enrollee grievances
d. Enrollee Advisory Board
e. Other data points

a. Provider Audits: We conduct a statistically valid sampling of PCPs (and other specialties) quarterly to evaluate appointment availability and average wait times. On an annual basis, we measure additional variables including the number of hours for crisis, urgent, and routine appointments; status reported in currently accepting new enrollees; in office wait time; and any barriers to scheduling appointments experienced by enrollees. As needed, Magellan Complete Care performs ad hoc “mystery shopper” calls or site visits in response to a complaint or other information about a provider practice.

In addition, we on-site audits, initially prior to credentialing and then periodically thereafter, using the Magellan Complete Care Appointment Access and Availability Tool [See MMA SRC #09, Attachment 1: Practitioner Office Site Evaluation Tool]. Including a host of regulatory requirements and other performance standards to which a provider must adhere, this Tool is used by our Network staff to verify timely appointment access standards for urgent, routine and preventative care, among other things, as outlined in Section III, pages 6-7 of this Tool. Any findings from these audits as well as the need for a follow-up visit, and updates to the provider’s demographic and contact information are entered into Salesforce.

Salesforce is Magellan Complete Care’s Provider Support Specialist (PSS) and Community Outreach Specialist (COS) team’s Customer Relationship Management Platform. This application is used to manage and document information about Magellan Complete Care’s providers, community resources, and stakeholder relationships, as well as the daily tasks of each team’s preparation and research, outreach and follow up, and tracking and reporting of data. Provider profile information input and updated in this application includes access and availability, i.e., accepting new enrollees, after-hours appointments, urgent appointment availability, and same day availability.
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For all provider types, including but not limited to PCPs, data sources utilized in this assessment and auditing activity include:

> Geo Access and Density Reports assessing provider availability;
> Enrollee experience data, including satisfaction and complaints regarding their availability of and access to services;
> PCP self-report regarding access to regular, routine, urgent and after-hours care;
> Behavioral health practitioner self-report regarding access to emergent, urgent, routine care, and follow-up to routine care; and
> High volume and high-impact specialty practitioner report regarding appointment access.

b. Enrollee and CAHPS surveys: Magellan Complete Care uses the results of enrollee surveys including the CAHPS survey to identify opportunities for improvement and track progress toward our goals. Annual CAHPS results are reviewed and year over year comparisons made to monitor improvement. The results and analysis are shared with a CAHPS Improvement Workgroup and an action plan is developed and implemented. The results are also shared with all Magellan Complete Care quality sub-committees and QIC. The key questions that capture enrollee satisfaction with access are given special attention and improvement strategies are put in place to address the areas of concern. The composite results for survey questions related to access demonstrate improvement, as show below.

> NCQA CAHPS Composite Results (Global Proportion) Adult
  >> Getting Needed Care (Q14 & Q25)
  >>> 2016 = 2.15  2017 = 2.16  Improved  2016-2017=1%
  >> Getting Care Quickly (Q4 & Q6)
  >>> 2016 = 2.24  2017 = 2.31  Improved  2016-2017=7%

> NCQA CAHPS Composite Results (Global Proportion) Child
  >> Getting Needed Care (Q14 & Q28)
  >>> 2016 = 2.36  2017 = 2.31  Decreased  2016-2017=-5%
  >> Getting Care Quickly (Q4 & Q6)
  >>> 2016 = 2.58  2017 = 2.59  Improved  2016-2017=1%

c. Enrollee grievances: The Quality Improvement Department and Quality Improvement Committee (QIC) review negative trends regarding access to services and 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.

Appointment access is a specific complaint/grievance type tracked through Magellan Complete Care’s complaint and grievance process. Our Customer Service staff files a complaint on behalf of the enrollee when an access to care issue is reported. Each issue submitted is tracked in our complaint/grievance tracking system and an investigation is coordinated by the Complaint/Grievance Coordinator. On a quarterly basis, the Quality Improvement staff prepares trended reports of all enrollee complaint/grievance cases. The category of access is further analyzed and findings, as well as planned follow-up, are shared with the Enrollee Services Committee, Network Strategy & Oversight Committee, Vendor Oversight Committee and the QIC.
d. Consumer Advisory Group: The Magellan Complete Care Consumer Advisory Group (CAG) is convened to obtain input from enrollees concerning various aspects of our healthcare program. The Magellan Complete Care CAG meets, at a minimum, semi-annually. Some of the functions of the group include:

> Review and comment on the provider accessibility and availability standards, conclusions, recommendations, and actions taken
> Review enrollee experience and provider satisfaction survey annual results & action to address, including satisfaction with the UM process and practitioner access
> Review of and comment on Magellan Complete Care procedures for customer complaints and appeals and/or frequent complaints/ appeals

The feedback gathered is shared with the Enrollee Services Committee and the QIC for evaluation and further follow-up.

5. Other data points: Magellan Complete Care may discover access issues through Magellan Complete Care staff including the call center, care coordination or network staff and through data-mining e.g. volume of out-of-network authorizations.

Gap in Access: A Gap in Access (GIA), defined as an enrollee’s inability to access contracted providers, is referred directly to the Network Department. GIAs are monitored on a per-provider basis each week and categorized to identify early trends and patterns in patient care delivered to enrollees. On a bi-weekly basis Network and Health Services discuss access and availability challenges to proactively address, even where Magellan Complete Care has met adequacy and availability requirements.

Since the SMI specialty plan program inception in 2014, we have successfully conducted regular assessments to measure timely access by provider type, including, but not limited to, PCPs, and communicated the results to AHCA. Magellan Complete Care and its PCPs have been consistently in compliance. Of note, our Network Development and Management team reviews each PCP’s average wait times to ensure compliance with the required Timely Access Standards at least yearly. This annual review is included in [MMA SRC #09, Attachment 2: Network Adequacy Standards Policy].

2016 Survey: We faxed and emailed 18,057 surveys. The data was analyzed to prepare this report:

> Well Care (PG3 = 31 days): 98.8%
> Routine Office Visits (NCQA = 10 business days): 90.6%
> Sick Care (PG2 = 7 days): 89.9%
> Urgent Care (PG1 = 1 day): 91.8%
> Urgent Care (NCQA = 48 hours): 95.2%
> After Hours Care (NCQA = 6 hours): 40.1%
> Non-Life-Threatening Emergency Care (NCQA = 6 hours): 71.9%

As mentioned above, we take very seriously our responsibility to ensure our primary care network enables full availability and access for our enrollees. Magellan Complete Care has demonstrated
appropriate PCP availability during 2016 and meets or exceeds the availability performance standards and goals. More specifically, we analyzed and reported on the following:

>Standards for Number of Primary Care Practitioners: Required standards are outlined in the Managed Medical Assistance Provider Network Standards Table in the Statewide Medicaid Managed Care Contract with AHCA (Contract). The following presents our actual results compared to the established standard for each primary care practitioner type:

**Family Practice**

<table>
<thead>
<tr>
<th>Measure: Practitioners to Enrollees</th>
<th>AHCA Standard: 1:1500</th>
<th>Magellan Complete Care Actual: 1:56</th>
</tr>
</thead>
</table>

**General Practice**

<table>
<thead>
<tr>
<th>Measure: Practitioners to Enrollees</th>
<th>AHCA Standard: 1:1500</th>
<th>Magellan Complete Care Actual: 1:161</th>
</tr>
</thead>
</table>

**Internal Medicine**

<table>
<thead>
<tr>
<th>Measure: Practitioners to Enrollees</th>
<th>AHCA Standard: 1:1500</th>
<th>Magellan Complete Care Actual: 1:50</th>
</tr>
</thead>
</table>

**Pediatrics**

<table>
<thead>
<tr>
<th>Measure: Practitioners to Enrollees</th>
<th>AHCA Standard: 1:1500</th>
<th>Magellan Complete Care Actual: 1:50</th>
</tr>
</thead>
</table>

**Pediatric & Family Practice**

<table>
<thead>
<tr>
<th>Measure: Practitioners to Pediatric Enrollees</th>
<th>AHCA Standard: 1:1500</th>
<th>Magellan Complete Care Actual: 1:13</th>
</tr>
</thead>
</table>

**Performance Analysis:** As this table indicates, Magellan Complete Care significantly exceed the established performance goal for practitioner to enrollee ratios for all primary care practitioner types; thus, no improvement opportunities are identified.

>Standards for Geographic Distribution of Primary Care Practitioners: Standards for Magellan Complete Care are defined in the Managed Medical Assistance Provider Network Standards Table, which is part of the Contract. The following presents our results compared to the established performance goal:

**Family Practice**

<table>
<thead>
<tr>
<th>Measure: 1 within 20 miles</th>
<th>AHCA Performance Goal: 95%</th>
<th>Magellan Complete Care Actual: 100%</th>
</tr>
</thead>
</table>

**General Practice**

| Measure: 1 within 20 miles | AHCA Performance Goal: 95% | Magellan Complete Care Actual: 100% |
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>>>AHCA Performance Goal: 95%
>>>Magellan Complete Care Actual: 100%

>>Internal Medicine
>>>Measure: 1 within 20 miles
>>>AHCA Performance Goal: 95%
>>>Magellan Complete Care Actual: 100%

>>Pediatrics
>>>Measure: 1 within 20 miles
>>>AHCA Performance Goal: 95%
>>>Magellan Complete Care Actual: 100%

>Performance Analysis: As this table shows, Magellan Complete Care’s primary care network meets the geographic distribution performance goal, providing a PCP to all of its then 56,199 enrollees within 20 miles of their home. This is attributable to full (100%) compliance with all geographic distribution metric goals; thus, no opportunities for improvement are identified.
>Actions: Though we continue to meet and exceed expectations, our Provider Optimization Delivery System (PODS) Directors and their staff continue to enhance the network to ensure it remains robust so that enrollees have sufficient selection of and access to practitioners to provide primary care services.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT’S MONITORING PLAN INCLUDES SPECIFIC MITIGATION...
Magellan Complete Care relies on established and standardized means of network monitoring through key data analysis in order to identify where a network accessibility to care or a barrier in the network adequacy of practitioners is likely to occur, within a single region or across multiple regions. Such analysis is essential to ensure our network of participating providers meets/exceeds accessibility requirements and assures that health care delivery of services to our enrollees is effective. Although numerous data sources are used in the ongoing monitoring and evaluation of the provider network, a few of the most important elements we utilize are as follows:

>Geo-access analysis of our network to evaluate the number of and time distance relationship of enrollees to providers

>Evaluation and tests of a physician’s compliance with Magellan Complete Care and AHCA accessibility requirements for appointment wait time standards, physician on-call and after hours accessibility

>Enrollee-to-PCP ratios to substantiate access compliance and capacity for new enrollees

>Projections of future enrollee growth, anticipating where network capacity should expand

>Demographic data, such as cultural and linguistic requirements, to include providers sensitive to such differentiators
>Enrollee use data, grievances, and appeals that highlight where providers may need to be educated or removed

> Satisfaction surveys, stakeholder participation in committee structure, input from AHCA

> Provider onsite reviews and surveys of appointment availability and treatment record reviews of high volume providers

> Feedback from QI committees and stakeholder participation in other committees

Each of these data sources inform our judgement as to where the network of providers is meeting or exceeding our requirements, as well as where network participation may need to be enhanced. These key evaluations afford Magellan Complete Care a sophisticated and nearly 360-degree view of how the network is operating relative to provision of care delivery. In addition, Magellan Complete Care has found benefit in listening to our enrollees who notify their care manager or contact a customer service representative to report restrictions or barriers they are encountering in getting timely access to their providers for their health care. Once we have such intelligence, Magellan Complete Care engages the Network contracting team, Provider Support Specialists, and the Provider Relations staff to conduct a short-term intervention to guarantee that the enrollee can access covered services while at the same time, soliciting where the network may need to increase the number of providers or expand within a region, based on time and distance access.

As part of monitoring the provider network, we assess the availability and access to care, services and even to needed supplies. These barriers and gaps can exist in a region based on a variety of reasons including: lack of providers in rural areas; provider panels are full; providers refuse to accept Medicaid or want to work with a limited number of managed care plans; providers do not want or do not feel comfortable with individuals with SMI in their practice; limited providers to meet the needs of a culturally diverse population; or limited number of board certified providers in a community.

In the event it is determined that a gap in provider coverage is emerging, network managers quickly engage their contractors to expand the network to increase the number of primary and behavioral health care specialties. As issues are identified in an area, we take appropriate action to address and quickly resolve any barriers or gaps including:

> We often discover in speaking with providers that we can improve accessibility by expanding the hours, or the servicing to secondary locations and/or staffing increases through use of, for example, Advance Practice Nurses, Physician Assistants and other practice care givers;

> Negotiating/renegotiating terms, conditions and/or reimbursement in contract provisions to continue or enhance provider participation;

> Contracting with Advance Practice Nurses, Physician Assistants, working with Urgent Care facilities in use of Primary Care, in order to create a means to extend network accessibility by sending a practitioner to an enrollee’s home or residence, particularly for those who are difficult to engage in care or do not want to leave their home; and
Leveraging advancing technological opportunities in telemedicine, use of mobile services such as x-ray and diagnostic and imaging services thru partnerships with public health departments, urgent care clinics, rural clinics and community mental health clinics.

As previously described, to ensure our provider network is responsive to the needs of our enrollees, we conduct annual access surveys, as well as scheduled and periodic audits. We also use direct assessment and secret shopper approaches as well as online tools for measuring primary care, family planning, pediatric, obstetrics and gynecology practitioner access and wait times. These mechanisms are leveraged to understand where providers are accepting new patients, the quantity of PCP office hours available for routine visits, sick, urgent care and crisis appointments, and in-office wait times. In addition, we monitor PCP accessibility on an ongoing basis via our Quality Committee structure, particularly through the Magellan Complete Care Network Oversight and Quality Improvement Committees.

If we identify an accessibility issue for an enrollee or a PCP is otherwise out of compliance with the provider agreement or policies and procedures set forth in the Provider Handbook, our first priority is the enrollee. In that case, our Care Coordination team will conduct initial follow-up to ensure the enrollee is connected promptly with other Magellan Complete Care PCPs before any other actions are initiated.

Once assured the enrollee receives PCP access and necessary services, a focused review of provider performance is initiated by our Network team. As necessary, the Network team will coordinate closely with Provider Support Specialists, clinical reviewers or compliance auditors to isolate the root cause for limited PCP access, constricted availability reported by case managers and care coordination staff, enrollee feedback and complaints. At the same time, we look carefully at the quality of care, potential fraud/waste/abuse to construct a comprehensive view of the practice and PCP.

The findings from this type of review and analysis will lead to any one or a combination of network interventions, ranging from provider education and training that addresses a specific provider’s issue in detail, a review of the provider agreement—including emphasis on the potential consequences of failure to comply—and further instruction in administration of provisions described in the Provider Handbook related to panel size, panel limitations, reporting and adherence.

These findings, as well as Magellan Complete Care expectations/recommendations and the timeframe within which the provider must take corrective action, are communicated to the PCP in writing; they are verbally reemphasized in follow-up meetings with the practice. Oversight is conducted by Network and Quality Improvement to ensure compliance.

In the event that a material deviation from established standards is identified, the PCP and practice may be required to participate in a Process Improvement Plan (PIP) to remediate the issue and otherwise rehabilitate a PCP and practice to achieve adherence as quickly as possible. In the most extreme situation in which Magellan Complete Care cannot successfully correct noncompliance by the provider or depend upon their adherence to standards as required, a formal referral to the Network team, as well as the Quality Improvement and Credentialing Committees for contractual censor or termination may occur.
As mentioned, the Magellan Complete Care Network team collaborates with the Quality Improvement Department to develop an annual provider monitoring plan to address provider accessibility and availability and to initiate corrective actions where identified provider improvement is warranted. As an additional aspect of this collaboration, our Quality Improvement department will align closely with Network to modify policies and procedures in the Network Development and Management Plan, provider agreements, and the Provider Handbook to ensure maximum compliance with expectation. Through this work, Magellan Complete Care can effectively anticipate network accessibility issues and deploy network initiatives as noted to demonstrate compliance with network adequacy and accessibility requirements and even more importantly, safeguard enrollee’s access to the care the need when they need it.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT’S PROCESS AND METHODOLOGY FOR DETERMINING PCP CAPACITY...
We follow a well-defined process and prescribed methodology to determine PCP capacity to accept new patients. Due to the complexities related to our enrollees’ diagnosis of SMI, potentially combined with comorbid and co-occurring conditions, we establish conservative target ratios to assure appropriate access. Our PCPs agree to carefully manage their enrollee panel size, not to exceed 1,500 enrollees per physician. But at Magellan Complete Care, our PCP panels are generally limited to 1,000 enrollees. We have learned that one size does not fit all, and with a fragile SMI population, a PCP’s time devoted to a patient tends to be higher; therefore, a smaller panel size than customary allows a PCP and his or her practice to better manage their Magellan Complete Care patients and thus account for better outcomes.

Panel size can be influenced by several factors when considering the entirety of the provider’s practice. For that reason our network team takes the following steps and uses the data points outlined below in analyzing how a PCP and their practice is best managing their patients, particularly taking accessibility and timeliness into account when setting, monitoring, and modifying panel limits for PCPs.

- The panel for the provider’s entire practice (accounting for all payers) does not exceed 3,000 active enrollees and as defined by the unique patients who have seen that PCP (physician, NP or PA) in the last 18 months. Because their patients may have seen multiple providers in a practice, the patient should be attributed to the PCP they have seen the most.
- The acuity of the patients in their overall practice (e.g., well children versus Medicare).
- Number of appointments/patients seen per day.
- Number of days the provider is available per year.
- Average number of visits per patient per year.
- Direct feedback from enrollees on accessibility and appointment wait times. A key aspect of our PCP monitoring and wait time intervention approach includes the Magellan Complete Cares online provider directory, specifically the Find a Provider feature. This option may be utilized by enrollees to provide us with for instant and real-time provider feedback on any issues encountered within a PCP practice, such as inability to get an appointment (whether for a routine appointment, for a reported sick visit or an urgent care appointment) when the provider directory indicates acceptance of new patients.

Informed by these data points, we conduct direct and focused discussion with a provider to set the correct panel limit and document the agreed upon panel size in the provider agreement. These
limits are reviewed with the provider on an annual basis and throughout the year as a matter of routine practice during on-site reviews with PCPs by our Network team. Network also advises our networking contract team in the event additional PCPs appear to be needed to maintain necessary access. A PCP’s panel limit is set in our system when that provider is loaded to ensure that PCP auto-assignment does not conflict with established panel size limitations.

As with PCP adherence to timely access standards, if our internal monitoring of a PCP’s panel size, particularly as it relates to accessibility and wait times, indicates a concern, a Network team member is dispatched to conduct a review with the PCP and the practice. Corrective action will be initiated as needed.

In determining network capacity, we monitor and evaluate providers distinguishing PCPs with an open panel (capacity to accept new patients) from PCPs who exhibit a closed panel (not able to accept new patients) when they have reached the prescribed limitation. When a PCP notifies Magellan Complete Care of their intention to close their panel, we validate the appropriateness of this action through an exhaustive analysis of the data points noted above and through interviews with the PCP. In doing so, we ensure that Magellan Complete Care standards are met; that is, the panel closure is consistent with the terms of their provider agreement, comports with policies and procedures as set forth in the Provider Handbook, and is in accordance with AHCA requirements. In addition, we verify that a PCP who requests a panel closure for Magellan Complete Care likewise includes enrollees from other Medicaid plans that the PCP accepts as part of the determination of panel size and panel limitations before we grant the PCP’s panel closure.

Another means of testing and validating appropriate PCP panel size is the day-to-day practice of our Customer Service team to validate a provider’s practice information, including patient panel size. We believe that this anecdotal but recurrent review of practice information supplements our more formal monitoring through periodic and semi-annual audits. As a Customer Service Representative has an opportunity to engage with a provider, our Representative will address with the provider a series of questions, which include policies described in the Provider Handbook. Importantly, the Representative will ascertain the provider’s knowledge of these policies and general understanding on how to administer them within the context of an office setting and with regard to patient care. As a pointed example, one question is whether the provider understands and conforms to a PCP-to-enrollee limit of 1:1,500 Magellan Complete care enrollees (as well as a limit of total panel size of 3,000 enrollees) in accordance with our policy and AHCA standards. Others would be whether the practice understands and has ever allowed a physician extender (ARNP or PA) to increase panel size by 750 patients or a provider has applied access and availability requirements to include 24-hour coverage, coverage during absence, appointment wait times, timeliness for a medical evaluation and even how a provider and their office actively comply with the American with Disabilities Act. Finally, our Customer Service Representatives are trained to evaluate a provider and practice on many of these requirements while assisting enrollees with scheduling or attempts to schedule an appointment with that provider. In the event the Customer Service Representative identifies a deviation from the requirements as indicated above or recognizes a need for improvement with the office and/or its practitioner, a report is completed, documented in our system and referred to the Network team for their direct intervention.
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Offering providers a suite of online services makes it possible and easy for a provider to self-report updates and corrections to practice and provider information that impact reporting, monitoring of provider network accessibility, and panel changes. Providers can avail themselves of our provider survey where a provider may inform Magellan Complete Care of an addition of a new provider to the practice, closure or re-opening of the office to new enrollees, or offering information about patients living with a SMI. Another important on-line feature providers are apt to use is our online provider portal, which as mentioned previously, allows PCPs and other network facilities and practitioners to update Magellan Complete Care regarding their practice, whether they are accepting new patients, and/or their current appointment availability. An effective means by which we assure and enhance validation of provider and practice information is our requirement that the provider review and attest that practice information is accurate, up-to-date, and complete, as requirement by the terms of their provider agreement and the provider handbook. To the extent that certain information impacts payment of claims, enrollee accessibility, and display of demographic information to the on-line provider directories, this attestation has proven to be helpful authentication.

Our Provider Relations and Provider Support Services teams meet periodically with PCP’s, high-volume providers, safety net providers in FQHCs and CMHCs, hospitals and clinics, on both a scheduled and un-scheduled basis. Building rapport and strengthening relationships with those tasked with care delivery to our enrollees is a priority in making these visits. But in addition to offering support and services to their practice, we also conduct on-site assessments of a provider’s adherence to all policies, procedures - including the required accessibility and availability standards for panel size, patient wait time(s), and requirements defined in the provider agreement and provider handbook.

To evaluate and determine ongoing compliance with Magellan Complete Care’s provider policies and procedures, we may also conduct an even more formalized and comprehensive on-site audit using the Magellan Complete Care Appointment Access and Availability Tool [See MMA SRC #09, Attachment 1: Practitioner Office Site Evaluation Tool], as the situation dictates and based on review of a host of data sources described earlier. Included in this critical assessment tool is a review of reports, including patient self-reporting, provider self-reporting, access and appointment wait time summary(ies); among other essential purposes, this Tool is used by our Network staff to validate whether the provider is accepting new patients (see Section III, page 7 of this attachment).

Any findings from this audit and updates to the provider’s demographic and contact information are entered into Salesforce, which as previously described, serves as the Magellan Complete Care Relationship Management Platform. Provider profile information input and updated in this application includes access and availability (i.e., accepting new enrollees, after-hours appointments, urgent appointment availability, and same day availability) to assure a provider’s status is current using data with integrity.

Evaluation Criteria:

1. The extent to which the respondent’s process and monitoring plan ensure that enrollees have access to urgent or non-urgent services within the timely access standards defined in Exhibit B-1, Managed Medical Assistance (MMA) Program, Section VIII., Provider Services, Item A., Network Adequacy Standards, Sub-Item 8., Timely Access Standards.

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2. The extent to which the respondent’s monitoring plan includes specific mitigation steps it will take if there is a potential accessibility issue identified.

3. The extent to which the respondent’s process and methodology for determining PCP capacity clearly outline the steps and data used for determining whether a PCP has the capacity to accept new patients.

**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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The respondent shall describe how it will address the transition of care between service settings, including transitions from hospital to nursing facility rehabilitation and from hospital or nursing facility rehabilitation to home. Identify specific methodologies for ensuring that transition planning ensures appropriate primary care and behavioral health follow up, where appropriate. Provide an example of an effective transition plan.

Response:

OVERVIEW
Magellan Complete Care of Florida (Florida MHS, Inc. d/b/a Magellan Complete Care) was created for the sole purpose of developing, delivering, and managing state-of-the-art integrated medical and behavioral health services for individuals living with SMI. Our Integrated Care Case Management (ICCM) model incorporates best practice for that integration, treating the transition of care and the planning and management of those transitions as components of the overall enrollee care plan and support for enrollee recovery, stability and resiliency.

We understand that a care transition occurs when an enrollee moves from one care or residential setting to another due to a planned choice, change in health status, circle of support, or living circumstance, or as a result of moving in and out of the judicial system. In addition to planning for the enrollee’s transition, any enrollee undergoing a transition is evaluated for level of behavioral health and physical health complexity and risk, and the enrollee is stratified into the appropriate level of case management based on complexity. Magellan Complete Care understands and assesses the impact of social determinants of health that each of our enrollees faces each day. We consider those social determinants along with other behavioral and physical health factors in determining whether enrollees can safely be discharged into the community. We also consider the effects of those issues on successful transition of care and needs for mitigation. These issues, along with physical and behavioral health assessment and needs, are managed as integrated elements in the enrollee’s overall case management and care coordination process. As an SMI specialty plan, we also have a special appreciation of the need to protect enrollee confidentiality in managing the transition of care process while still supporting the requirements of a successful transition process. Enrollee confidentiality and requirements for appropriate releases and authorizations are important parts of transition planning and execution.

Any planned or unplanned care transition that enrollees experience requires diligent planning and follow up to avoid unnecessary emergency department utilization, potential readmissions to acute care settings, and hasty placements into potentially inappropriate institutions. The care transitions approach used with our enrollees aims to:

> Ensure continuity between settings while including the enrollee’s choice, preference, and goals
> Assist the enrollee and caregivers to improve health literacy and learn self-management skills to ensure that his or her safety, behavioral, and physical health needs are met
> Provide adequate support for the enrollee to return to the setting of his or her choice
> Minimize risks of adverse outcomes from the transition

Magellan Complete Care understands that effective and properly executed transitions of care are essential for limiting unnecessary complications, preventable emergency room (ER) use, and
readmissions. Our transition of care programs are structured with those goals in mind, while protecting enrollee confidentiality and safety needs.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT’S PROCESS AND EXAMPLE ADDRESS...

1.1 Transitions of Care Program Overview
Magellan Complete Care’s Transitions of Care programs address all of the key domains for successful transition management and the key issues identified by AHCA in this section. Our approach is proactive, with the goal of preventing unplanned, unmanaged, and unsuccessful transitions for our enrollees; and it includes the following key elements:

>Timely and proactive identification for transition management
>Assessment criteria to make sure enrollee can be safely served in the community
>Collaboration with providers
>Referral and scheduling assistance
>Coordination with PCP and behavioral health providers
>Processes to prevent unnecessary hospital or nursing facility readmissions
>Appropriate protections of enrollee privacy and data security

To support the enrollee, we assign a case manager with both mental health and physical health experience to support the enrollee's choices, manage the transition, identify potential care/service gaps, enhance communication among providers, and ensure safer outcomes. The case manager communicates with all relevant parties involved in the transition and supports the enrollee in the least restrictive and safest environment.

We recognize the highly complex nature of our enrollee population and their specific vulnerabilities in managing transitions from different care settings, levels, locations, as well as 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 emergency department (ED) utilization, potential readmissions to acute care settings, hasty placements into potentially inappropriate care settings, or destabilization of physical health or behavioral health comorbidities. A care transition occurs when enrollees move from one health care or residential setting to another due to a planned choice, change in health status, circle of support, or living circumstance, or as a result of moving in and out of the judicial system.

Our Transitions of Care Program addresses movement to and from:

>Hospitals
>Other Institutional Settings
>Assisted Living Facilities
>Crisis Stabilization Unit,
>Statewide Inpatient Psychiatric Program
>Home

Our transition of care policies, procedures, and practices have been developed with our enrollees’ special vulnerabilities in mind, focusing on ensuring:
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>Enrollee Safety:
>>Enrollees have a safe and appropriate setting into which they can be discharged or transferred, and that a comprehensive assessment of enrollee and family caregiver needs has been completed
>>Enrollee has appropriate transitional supports in place, including such items as meals, stable housing, transportation to appointments, access to home care services, etc.
>>Enrollee/caregivers are assisted in learning self-management skills to ensure their safety, behavioral, and physical health needs are met
>>Enrollee/caregivers are supported in working with existing community transition programs to build a circle of support within their community or neighborhood to ensure a safe transition plan

>Continuity of Care/Utilization Management:
>>Enrollee choice, preferences, and goals are considered and included in plans to ensure continuity between settings
>>Enrollee is engaged with a utilization management professional (UMP) and is supported in ensuring that appropriate follow-up appointments have been scheduled and that enrollee has the support required to ensure those follow-up appointments occur
>>Enrollee is supported by the UMP in ensuring that discharge medications have been reviewed and reconciled with existing medications and medication therapy regimens and that appropriate providers have been engaged to resolve conflicts and discrepancies
>>Enrollee is supported by the UMP in ensuring that information has been provided for current and new providers, care settings, or health plan, with documented approval of the enrollee, or legal designate
>>Enrollee is supported by the UMP in establishing a physical and behavioral health home if one does not exist

>Care Management:
>>Enrollee is engaged with care coordination staff and understands the support that is available to provide a safe, healthy, and successful transition to the new care setting or to a safe living situation
>>Enrollee is supported by care coordination staff (nurses, social workers, and/or health guides) and case management processes in setting enrollee-specific, prioritized goals to close gaps in care and promote coordinated care, reduce preventable readmission, institutionalizations, and adverse outcomes
>>Enrollee and families are provided one point of contact and accountability
>>Enrollee is educated on use of the 24/7 Nurse Line and Enrollee Services line

1.2 Assessment and Planning Process and Criteria for Making Sure the Enrollee Can Be Safely Served in the Community
The care transition assessment process starts with the case manager and the UMP reviewing cases for enrollees who have been admitted, as part of our daily case review conferences. The case review session allows for a medical director-led interdisciplinary team of Magellan Complete Care staff to review cases to ensure that the highest level of quality care and follow up is being provided for the enrollee. On-site discharge planning visits are made by a Care Transitions Health Guide (HG) to further assess the enrollee’s needs, support discharge planning between care episodes, and proactively focus on key activities to prevent avoidable hospital admissions, readmissions, and ED visits. The UMP oversees the Care Transitions HG activities at all times.
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Any post-discharge requirement for durable medical equipment (DME), home health, community outreach, community agencies, adjunct support systems, medication assistance/reconciliation, or community mental health services are identified as early as possible before or during an enrollee inpatient stay to ensure availability for a timely and safe discharge. If an enrollee is admitted for medical (physical health) reasons, the UMP ensures that the enrollee receives a psychiatric evaluation prior to discharge to ensure that the enrollee is stable on the prescribed psychiatric medications and treatments. If an enrollee is admitted primarily for a psychiatric (behavioral health) reason, the UMP will ensure that the enrollee is seen by a medical doctor prior to discharge to ensure that his or her medical conditions are stable, including medication adherence, compliance, and treatment understanding. Obtaining safe and reliable housing support and skilled nursing facility (SNF) placement is often a challenge for our enrollees. Magellan Complete Care staff collaborate with all members of our Integrated Health Neighborhood (IHN), partnering with the enrollee and community supports to ensure timely and safe living and care arrangements. A comprehensive transition assessment and plan is completed proactively by the UMP and ICCM upon hospital admission as well as when they receive notification that the enrollee is in, or has been discharged from the ER. An assessment may also be completed when an enrollee is identified by the 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).

1.2.a Criteria for Making Sure the Enrollee can be Served Safely in the Community
Discharge transition care planning follows a standard care planning process where there is a comprehensive assessment driven by the enrollee’s circumstances and condition, identification of needs and problems, identification of care transition goals, and the development of the interventions and activities which will ensure goals are achieved. Magellan Complete Care staff carry out a comprehensive assessment, including information gathered as part of the Utilization Management and Case Management process e.g., looking at the enrollee’s electronic medical record (EMR), talking to the hospital discharge planning and care delivery professionals.

In examining whether the enrollee can safely be discharged to the community, we evaluate the following:

1. Is there a safe site to which the enrollee can be discharged?
2. If the enrollee does not have a site for safe discharge, have arrangements been made for discharge to an alternate setting?
3. Does the enrollee and/or the enrollee’s caregiver understand the enrollee’s plan of care and requirements for follow up?
4. Is the enrollee or the enrollee’s caregiver able to manage enrollee post-discharge care needs? If not, have alternate arrangements been made?
4. Have enrollee transition needs been evaluated and addressed (e.g., in-home care, meals, transportation for follow-up care, etc.)?
5. Has an assessment of the enrollee’s medications been completed, and does the enrollee understand medication and after-care requirements and have the ability to follow them? If not, have barriers been identified and remediated?
6. Has the enrollee’s care plan been updated, and is the ICCM engaged for transition and care management?
7. Has the enrollee’s provider(s) been informed of enrollee’s transition and discharge summary, and has required follow-up care been scheduled? If the enrollee has barriers for timely, required follow-up care, have they been identified and remediated?
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8. Is the enrollee stable enough (both PH and BH) to be safely transitioned back into the community?

Our TruCare system includes all key requirements for assessing whether the enrollee can be safely discharged to the community. Specific areas assessed as part of Transition of Care management include each of the following items that are completed as part of our Transitions Checklist:

1.2.a.1 Completion of discharge planning activities:
> Admission Start date?
> Inpatient (IP) Authorization Review Completed?
> Readmission?
> Coordination with UM Reviewer to Obtain Discharge Plan?
> Coordination with ICCM to Identify Trigger for Admission and Plan Interventions?
> Enrollee Meets Criteria for Complex Case Management (CCM)?
> Enrollee Contact Scheduled?
> Facility Contact Scheduled?

1.2.a.2 Assess need for planned discharge interventions:
> Assist With Care Coordination?
> Assist With Follow-up Appointment?
> Housing?
> Identify Support System?
> Obtain AUD
> Obtain Updated Contact Information?
> Post Discharge Meal Discussion?
> Teach Back Discharge Plan?
> Other, Describe: _____________________

1.2.a.3 Complete discharge planning for behavioral health and physical health:
> Behavioral Health Discharge Planning:
>> Active Targeted Case Management (TCM) Authorization Found?
>> New TCM Referral Needed?
>> Coordinate with ICCM on TCM referral?
>> Home Health authorization needed?
>> Medication needs identified (Including LAI coordination)?
>> 7-Day FAH Appointment verified prior to discharge?
>> Has task been created to the Follow-Up Queue to verify 7-Day FAH?
>> Transportation to FAH scheduled?
>> Barriers to 7-DAY FAH?
>> Enrollee support system?

> Complete physical health discharge planning:
>> Home Health authorization needed?
>> DME Needs?
>> Medication needs identified?
>> Transportation scheduled?
>> SNF placement recommended?
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>>Barriers identified?
>>7-day follow-up appointment with PCP/specialist verified
>>Enrollee support system?

1.2.a.4 On Day 2 we complete a Welcome Home Assessment, which is due 48 hours post-discharge. Documentation completed at that time includes addressing any identified barriers and required interventions:
>Document attempt to complete (1st, 2nd, 3rd attempt)
>Assess whether enrollee requires post-discharge meals or other supports
>Create tasks to schedule additional supports

1.2.a.5 Complete field visit:
>Field Visit Completed?
>>If yes, document details in the fields below:
>>Location of Field Visit: (IP facility, at-home, other)
>>Assess and document results of visit and additional needs, if any, identified
>Create tasks to schedule additional supports

1.2.a.6 Complete 7-day post-discharge follow up:
>>Identify post-discharge needs (such as PCP, BH etc.) requiring case owner follow up
>>Task case owner for follow up post 7 days if needed
>>Ensure ICCM coordination is established

1.2.a.7 Additional contacts completed:
>>Facility - (Document date of contact, intervention, and response)
>>UM Team - (Document date of contact, intervention, and response)
>>Hospitalist - (Document date of contact, intervention, and response)
>>Enrollee - (Document date of contact, intervention, and response)
>>Provider - (Document date of contact, intervention, and response)
>>Additional Comments

Magellan Complete Care initiates the transition of care process at the earliest possible point to allow us to address the complex needs of our enrollees. Identification of enrollees requiring transition of care begins with the Concurrent Review nurses who have periodic contact with facility discharge planning staff and/or receive notification through the TruCare system to develop a discharge plan including the coordination of needed services after discharge. In collaboration with the case manager, the assigned UMP and Care Transitions HG conduct a detailed assessment for discharge readiness, preparation of the home environment, safety considerations, and post-hospital follow-up needs. The distinguishing feature of our approach is that in every step, behavioral and physical health needs are considered together. Inpatient Coordinators assist with the clerical work of setting up services and putting authorizations in the system.

We have adopted and adapted evidence-based content from our proprietary behavioral health management tools and from the discharge assessments contained in Milliman Care Guidelines. Adaptations include the use of Magellan Complete Care’s Integrated Care Guidelines, which provide clinical considerations for condition/condition (such as schizophrenia and diabetes) and drug/condition interplay in scenarios typical for the SMI population.
We have also adapted medication management protocols to address the particular issues often seen in individuals living with SMI who undergo transitions in levels or settings of care, including the frequent practice of a new provider adjusting psychiatric medications without insight to past history and the potential effect on physical health conditions.

Care Coordination and UMP/HG staff complete a customized Discharge Plan Summary Assessment with the enrollee or the enrollee’s authorized representative that involves multiple domains, including social determinant, to assess the appropriateness of the next level of care.

Once the enrollee has been discharged, the HG conducts welcome home calls (WHC) to enrollees within 48 hours of discharge from the inpatient setting. The WHC can be in the form of a home visit. At the home, the HG will evaluate the safety of home environment and evaluate the need for additional support in the home. As part of the WHC, we review the following with the enrollee and/or enrollee’s caregiver:

> Review discharge instructions
> Review treatment plan and who to call if symptoms get worse
> Review medication adherence
> Review DME and/or supply needs
> Assess home environment and caregiver needs

If needed, we also support the enrollee in attending follow-up appointments with Behavioral Health/Medical Provider and Primary Care Physician or Specialist.

If the enrollee meets criteria to be designated by Magellan Complete Care as High or Ultra High Risk, the HG assigns a task for the ICCM to complete an additional Welcome Home call to be made on day 7 to determine if there are any other discharge follow-up needs and/or barriers that need to be addressed. The handoff to the ICCM may also be documented in the discharge planning assessment. The ICCM will complete Day 7 WHC or other assessments or interventions as needed.

If the enrollee does not meet criteria for High or Ultra High Risk, the HG will assign a task to his or herself for the 7 day WHC, if needed and document post-discharge follow-up with case owner. The HG will queue the following tasks for a Follow up Specialist (FUS) to ensure consistent and timely completion of required activities:

>Activity: “Hospital Discharge Follow Up.”
>Due Date: 8 days post-discharge from Hospital
>Description: Confirm attendance to OP appointments.
>Health guide or case owner may also confirm attendance at follow-up appointment. If this step is completed, task to FUS Queue is not needed. The FUS calls each follow-up provider to confirm enrollee attended the follow-up appointment and, if the appointment was kept, documents completed follow-up appointments the enrollee’s key metrics screen in TruCare: Clinical -> Key Metrics Summary -> Follow Up After Hospitalization – Medical or Clinical -> Key Metrics Summary -> Follow Up After Hospitalization For Mental Illness. If the enrollee did not keep a follow-up appointment, FUS documents in a General Progress Note that the appointment was not kept and what was done to secure another appointment and address any barriers the enrollee may have for keeping the appointment.
The HG/ICCMs contact established providers (physical or behavioral depending on the reason for admission) to update the enrollee’s treatment plan to account for crisis management and to prevent a readmission.

As noted above, the ICCM or HG, depending on risk level, completes the 7 day WHC and notes the outcome in the WHC Assessment and Initial Clinical Assessment. If the enrollee is newly assigned to the High Risk Category as a result of this review, the Care Plan is updated and reminders are placed for ICCM to ensure enrollee will attend follow-up appointment.

1.3 Collaboration with Providers’ Discharge Planning Staff
The initial evaluation for discharge transition planning begins at the time of notification of ED visit and/or inpatient admission and continues along the entire continuum of care. The UM team and care/case manager review complex cases during the daily case review conferences.

The Care Transitions Program actively monitors inpatient admissions and has established relationships with inpatient and community-based setting staff. Care Transition team members have a number of specialized tools to support them in the transition planning process. In addition to the Care Coordination and Transitions Policies and Procedures, team members have access to the following tools, including: Discharge Planning DTP, Discharge Planning Summary Assessment, and Discharge Planning SIPP.

Magellan Complete Care has a complete 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 care coordination, utilization management, case management and continuity of care protocols for the following transition of care activities.

Magellan Complete Care identifies four main types of care coordination transitions between specific care settings. The procedures in place for each are described below and are carried out by the Care Transitions HG and UMP who also communicate and collaborate with the primary ICCM at all times:

1. From hospitals (acute/psychiatric discharge) or other institutional settings to:
   >Community (Home):
     >>Before discharge, arranges inpatient onsite case conferences for transition/community discharge planning, conducts assessments, and generates a transition plan/care plan that includes enrollee goals, preferences, clinical and living status
     >>The care plan reflects logistical arrangements, coordination among care/service providers, identifies and documents enrollee/caregiver education and additional community resources
     >>As needed, arranges additional services (including behavioral and telehealth) and peer/parent/family support
     >>Ensures that the care plan is shared and monitors for community repatriation at the earliest opportunity
   >Nursing Facility (skilled or custodial) or Assisted Living Facility (ALF):
     >>Coordinates with the Nursing Facility (NF) or ALF Admissions Coordinator and enrollee’s support system
>>Before discharge, arranges onsite care conferences, explores community transitions/next steps, collects enrollee goals, preferences, assesses status, agrees to a care plan, arranges services, and coordinates supports among entities to ensure a successful transition

>Crisis Stabilization Unit (CSU):
>>Coordinates with CSU Admissions Coordinator and enrollee’s support system
>>Prior to discharge, arranges an onsite care conference, explores community transitions/next steps, collects enrollee goals, preferences, assesses status, agrees to a care plan, arranges for additional services, and coordinates supports among other involved entities to ensure a successful transition
>>As needed, arranges additional services (including behavioral and telehealth), peer/parent/family support, intensive community treatment or possible transitional housing between care settings to ensure adequate treatment and support

>Statewide Inpatient Psychiatric Program (SIPP):
>>Coordinates with SIPP Admissions Coordinator and enrollee’s support system
>>Prior to discharge, arranges an onsite care conference, explores community transitions/next steps, collects enrollee goals, preferences, assesses status, agrees to a care plan, arranges for additional services, and coordinates supports among other involved entities to ensure a successful transition
>>As needed, arranges additional services (including behavioral and telehealth), peer/parent/family support, intensive community treatment or possible transitional housing between care settings to ensure adequate treatment and support

2. From communities to:
>Hospital or other institutional setting:
>>Ensures continuity of care by notifying providers, assisting with medication reconciliations, sharing the current care plan
>>Before and during admission, arranges inpatient onsite case conferences for transition planning, conducts assessments, produces a transition plan/care plan that includes enrollee goals, preferences, clinical and living status or assesses feasibility of continuation of current care plan
>>The care plan reflects logistical arrangements, coordination among care/service providers, identifies and documents enrollee/caregiver education and community supportive resources
>>Ensures information is shared among involved parties, including current care plan, enrollee preferences, and current service providers

>Nursing Facility or ALF:
>>Coordinates with the NF/ALF Admissions Coordinator and enrollee’s support system
>>Ensures continuity of care by participating in onsite care conferences and sharing the enrollee’s current care plan
>>Regularly visits the enrollee and participates in case conferences
>>Plans and assesses feasibility to return to the community by conducting assessments, working with the enrollee to develop a transition plan/care plan with enrollee goals, preferences, clinical and living status

>Crisis Stabilization Unit (CSU):
>>Coordinates with CSU Admissions Coordinator and enrollee’s support system
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>>Prior to admission, arranges an onsite care conference to collect enrollee goals, preferences, assesses status, agrees to a care plan, and arranges for additional services and coordinates supports among other involved entities to ensure a successful transition

>>As needed, arranges additional services (including behavioral and telehealth), or peer support to ensure adequate treatment and support

>>The care plan/transition plan reflects logistical arrangements, coordination among care/service providers, identifies and documents enrollee/caregiver education and community supportive resources

>>Ensures information is shared including current ICP, enrollee preferences, and monitors the earliest opportunity for repatriation to community

>Statewide Inpatient Psychiatric Program (SIPP):
>>Coordinates with SIPP Admissions Coordinator and enrollee’s support system
>>Prior to admission, arranges an onsite care conference, collects enrollee goals and preferences, assesses status, agrees to a care plan, arranges for additional services, and coordinates supports among other involved entities to ensure a successful transition
>>As needed, arranges additional services (including behavioral and telehealth), peer/parent/family support, intensive treatment to ensure adequate treatment and support

Magellan Complete Care provides the following example for the elements included in the development of an effective transition plan. Care plans are based on NCQA and include evidenced-based elements to support the enrollee’s safe and successful transition. We include an enrollee story as an example of this process at the end of this section.

Key elements include:

To support collaboration with provider discharge planning staff, we manage care transitions by gathering, sharing, and acting upon information about any hospital or emergency room visit of which it is notified. The same applies to transitions into or out of nursing homes or rehabilitation centers.

Licensed clinical staff (UMPs and case managers) are responsible for assessing the enrollee’s needs and will develop and facilitate a plan to transition the individual smoothly across levels of care and back into the community or to a new care location in collaboration with other team members, providers, the enrollee and family.

The HG shares information with the admitting or discharging organization, the behavioral health provider, and PCP to prevent any gaps in treatment that could result in a break in continuity or a readmission. To facilitate timely and effective transitions from inpatient and long-term settings to the community, we maintain collaborative relationships with hospital emergency departments; medical and psychiatric units of local hospitals, nursing homes, home care agencies, and other applicable settings. We provide formal and informal training for these entities’ staff in meeting the special needs of individuals who are living with SMI in general, and specifically, the strengths and sensitivities of our enrollee who is receiving transition support.

The Care Transitions HGs work at facilities to ensure that there is coordination of care and services for the enrollee upon discharge. In addition, the Magellan Complete Care health plan medical director or the behavioral health medical director are available for consultation and review of discharge plans.
The Magellan Complete Care UMP contacts the Facility Discharge Planner, telephonically or on site, to gather the enrollee's discharge needs, including physical and behavioral health service needs, home environment, social/transportation, community support services and substance abuse service needed. This can be done telephonically or on site.

The UMP completes the discharge note section tied to the authorization. The discharge note will document the discharge plan with prescribed follow-up orders and appointments, and it will contain the following details:

- Actual Discharge Date
- Discharge Status
- Discharge Disposition
- Diagnosis (if additional or different from admitting diagnosis)
- Discharge Medications
- Home Health orders
- DME orders
- Follow-up appointment (include provider name and contact information; date/time)
- Other discharge needs identified

The Magellan Complete Care Heath Guide reviews the IP authorization including the discharge note and initiates the Discharge Plan Summary Assessment in TruCare. The HG uses the Discharge Plan Summary Assessment to collect all discharge planning and follow-up activities. The Discharge Plan Summary Assessment guides the HG in discharge planning by requiring completion of activities specific to Physical Health and Behavioral Health discharge planning including:

- Scheduling follow-up contacts with enrollee and providers
- Transportation Confirmation
- Home Services Required
- DME Required
- Medications Prescribed Upon Discharge
- Enrollee Referrals for Additional Services
- Scheduling Follow-up Appointments
- Identification of Support System
- Planning of discharge interventions
- Coordination of Post Discharge Meals
- Completion of Welcome Home Calls

1.4 Referral and Scheduling Assistance
The Magellan Complete Care enrollee services team assist enrollees with the bulk of routine referral and scheduling assistance activities. This also includes identifying and addressing any barriers to completion of that care, such as transportation. In addition, our UMPs and case managers are available as an extension of the enrollee services team to facilitate referrals, authorizations, and scheduling of medical and clinic appointments, transportation, community and clinical services such as home care, DME, medical supplies, and Meals on Wheels if indicated, especially when more complicated or complex situations arise. Should a question arise about the treatment plan, the case manager will engage other members of the Magellan Complete Care
team, including the medical director or clinical pharmacist, as needed. Magellan Complete Care has developed a detailed desktop procedure that outlines the call handling process, including how the enrollee is assisted with referrals and scheduling.

1.5. Coordination with PCP and Behavioral Health Providers to Ensure Appropriate Follow-Up Care Has Been Provided
Within the Magellan Complete Care ICCM model, complex case management is defined as the intensive coordination of care and services provided to a subset of enrollees who have multiple health care needs, or who have experienced a critical event (e.g., admission, discharge or transfer) or a diagnosis that requires the extensive or prolonged use of resources. Given the fragile and complex nature of our enrollees living with SMI, this often includes enrollees undergoing a care transition. Many of these enrollees will be identified for enhanced care coordination and identified as “ultra-high risk” because of the risk of readmission within 90 days. These enrollees receive our highest level of integrated case management, as well as the management of their specific care transition(s).

The Magellan Complete Care Transitions and Emergency Department Follow-Up Program activities are integrated within each area/level of the care coordination program. The program promotes physical and behavioral health comprehensive care transition management, proactively while an enrollee is enrolled in a care management program as well as when an emergency department visit or hospital admission/readmission occurs. The ICCM, UMP, and Care Transitions HG work collaboratively and are actively involved with the enrollee at times of care transition, including during planned and unplanned admissions, frequent ED visits, transfer to other institutions and facilities, and crisis stabilization units. This team also works in conjunction with the enrollee’s HG to ensure care plan communication between all providers and of the enrollee’s Care Coordination Team.

Discharge Planning is a key element of the Care Transitions program and specifically focuses on safely transitioning enrollees from an inpatient admission in an acute care, skilled nursing facility, or ED 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 HGs 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 ED visit and/or inpatient admission and it continues along the entire continuum of care, up to and including getting the enrollee safely placed back home or in an alternate facility or living situation.

1.5.a Policies and Procedures
Magellan Complete Care has developed policies and procedures that address the following transition of care requirements:

a. Assessment criteria for making sure the enrollee can be served safely in the community;
b. Collaboration with providers’ (e.g., hospitals, institutional settings, assisted living facilities, crisis stabilization unit, and statewide inpatient psychiatric program) discharge planning staff;
c. Referral and scheduling assistance;
d. Coordination with PCP and behavioral health providers to ensure appropriate follow-up has occurred; and
e. Processes to prevent unnecessary hospital or nursing facility readmissions.
1.5.b Transition of care policies and procedures include the following functions:

> Appropriate support to UMPs, HGs, case managers, and as needed to enrollees and caregivers for referral and scheduling assistance for enrollees who require specialty health care, transportation or other service supports

> Determination of the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting with assistance, as needed, by AHCA. Transfer of medical/case records in compliance with HIPAA privacy and security rules

> Documentation of referral services in enrollee medical/case records, including follow-up resulting from the referral

> Monitoring of enrollees with comorbidities and complex medical conditions and coordination of services for high utilizers to identify gaps in services and evaluate progress of case management

> Identification of enrollees with hospitalizations, including emergency care encounters and documentation in enrollee medical/case records of appropriate follow-up to assess contributing reasons for emergency visits and to develop actions aimed at reducing avoidable emergency room visits and potentially avoidable hospital admissions

> Transitional care coordination/care management that includes coordination of hospital/institutional discharge planning and post-discharge care, including conducting a comprehensive assessment of enrollee and family caregiver needs including social determinants of health, coordinating the patient’s discharge plan with the family and hospital provider team, collaborating with the hospital’s or institution’s care coordinator/case manager to implement the plan in the patient’s home, and facilitating communication and the transition to community providers and services

> Ensuring 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

> Support to the UMP, HG, case manager, and as needed to enrollees and caregivers for referral and scheduling assistance for enrollees who require special health care, transportation or other service supports, including those identified through CHCUP screenings

Magellan Complete Care designates Care Coordination Teams (CCT) made up of care coordination, case management, and utilization management staff who are qualified by training, experience and certification/licensure to carry out procedures required in care transition management, care coordination, complex case management, and other related care management programs.

The CCT includes the enrollee and/or designated representative, the primary behavioral and medical treating providers, a HG, and an Integrated Care case manager, and UMP if indicated by the enrollee’s circumstances. A clinical pharmacist, peer recovery support navigator, and medical directors (with physical and behavioral health expertise) are also available to the CCT at all times. Enhanced care coordination processes and staffing requirements are applied for medically complex and medically fragile enrollees under the age of 21 who are receiving services in a skilled
nursing facility or who are receiving private duty nursing services in their family home or other community-based setting. Specialized complex case management also applies for individuals transitioning to or from long-term care program services.

Our enrollee’s plan of care supports and closely integrates any type of transition in care. All transitions fully comply with the Americans with Disabilities Act and Florida Statutes. Magellan Complete Care fully supports and requires that individuals with disabilities be given opportunity to “receive services in the least restrictive setting appropriate to their needs.”

The Care Transition HG assists the enrollee to schedule services, follow-up appointments, transportation, order DME supplies and arrange back-up plans.

Magellan Complete Care Transitions Staff collaborate and communicate as appropriate with the enrollee, the enrollee’s providers and supports as authorized by the enrollee to ensure a safe and successful transition to the new care setting. Processes for ensuring privacy and confidentiality include:

> Consent obtained to share information
> Care planning process always identifies who the enrollee has authorized to be a part of the care process

Case managers, UMPs, and HGs always obtain consent (including the AUD) from enrollees or their representatives before sharing PHI across providers, including providers in the new service setting, and information on how sensitive information (e.g. BH, SUD) is communicated (or not) through the care plan. In addition, the team verifies with the enrollee whether he/she has an advance directive in place. If the enrollee has an advance directive in place, the Magellan Complete Care team member requests a copy of the form and scans it into the TruCare system. If the enrollee does not have an advance directive, the team offers education on the advance directive topic as needed.

Activities to ensure that the enrollee receives required post-discharge care begin while the enrollee is in the discharging facility. The HG meets with the enrollee on the hospital unit or telephonically, depending on individual enrollee needs, volume, regional coverage, and timing/logistics. Activities of the HG include:

> Complete the Health Risk Assessment (HRA)
> Collaborate with the UMP and case manager in assessing the root cause for hospital admission
>> Collaborate with the UMP and case manager in conducting additional clinical assessment specific to the enrollee’s chronic condition and social needs
> Review the Follow-up Screens in TruCare to gain knowledge of the discharge plan and instructions; this is entered into TruCare by the Concurrent Review (CCR) team
> Identify any social supports for the enrollee (friends, family, and neighbors) who may be able to assist in supporting the enrollee and involve, with an executed AUD, the circle of support to assist enrollees as needed
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> Identify enrollees who have had a 30-day hospital readmission and who now meet the defined criteria for high or ultra-high risk case management and forward the case to a regional ICCM
> Confirm with the Magellan Complete Care licensed utilization management professional or assigned ICCM that all physical health-related items within the discharge orders and plan have been addressed, including but not limited to ordering home health services, durable medical equipment, supplies, transportation, infusion therapy, etc.

> Call to confirm the enrollee’s follow-up appointments with both physical and behavioral health providers

> Reinforce the importance of obtaining preventive health visits and screenings whenever possible

> Request and attend bridge appointments, whether face to face or through telehealth, when available

> Confirm that the enrollee knows how to fill post-discharge medications and ensure arrangements for any post-discharge injections have been made

> Follow up with the pharmacy to ensure that there are no barriers to filling discharge medications; become knowledgeable of pharmacies that deliver medications; resolve barriers to enrollee filling prescriptions

> Recognize which stage of change the enrollee is in and use motivational interviewing techniques to help move enrollee to next stage; gather a sense from the enrollee of his or her level of commitment to adhere to the follow-up plan; coordinate with region peer specialist to meet with enrollee on the unit to assist with motivation

> For high utilizers and readmissions: If enrollee is not likely to follow up on his or her own, HG immediately offers to attend the appointment with the enrollee; if enrollee is not in agreement, HG offers to make to make a home visit for the 2 day welcome home call to discuss joint attendance further. The HG will then coordinate with the peer specialist for the enrollee’s region, to attend home visit as well.

> Distribute Passport to Care and assist in completing as much as possible

Activities of the Community-based HG: The Designated HGs meet with select enrollees in the field, either at home or at the provider’s office, according to the following criteria:

Home Visits: Within 2 days of discharge for enrollees who are reluctant or ambivalent about attending the 7 day follow-up appointment
At the home visit, HG (and peer if needed) will:

> Reinforce the importance of continuing progress made during the inpatient period
> Re-educate enrollee about alternative levels of care to get health care needs met
> Reinforce the importance of obtaining preventive health visits and screenings whenever possible
> Re-educate enrollee how to avoid letting behavioral or physical health conditions get to the crisis point at which ER or inpatient is needed; use tip sheet of ER vs. PCP vs. UC
EDUCATE ENROLLEE ON IMPORTANCE OF KEEPING ALL OP APPOINTMENTS; HOW TO GET THE MOST OUT OF THE OP APPOINTMENT
> Educate enrollee on the benefits of improving health literacy and using other services like TCM, PSR, Individual therapy and PCP
> Educate enrollee on benefits of a bus pass for appointments and ability to use the pass all month for other needs

Behavioral Health Provider Visits with the enrollee: To the 7-Day appointment
> For enrollees who have missed previous 7 day appointments
> For enrollees new to OP Care or first appointment at new provider office

At the provider visit, HG will:

> Mentor and coach enrollee throughout visit, using appropriate language, volume, tone, professionalism, assertiveness when appropriate, and patience
> Advocate for enrollee’s needs (with enrollee permission) as identified by inpatient admission, HRA, enrollee self-report
> Advocate for timely next appointment for continuing medication management, obtainment of prescriptions depending on how many days of meds are left, fast-tracked referral to other programs such as TCM, PSR, and therapy
> Empower enrollee to advocate for self needs, via wellness plans, to stay out of the ER and hospital

HG completes 7 day WHC for moderate and low risk enrollees. HG tasks to ICCM the completion of the 7 day WHC. The ICCM then manages the case moving forward. The designated HG manages the moderate and low risk enrollees after the 7 day WHC call.

1.6 Processes to Prevent Unnecessary Hospital or Nursing Facility Readmissions
As a key component of our IHN, we work with existing community transition programs to further ensure a safe transition plan for each enrollee. Magellan Complete Care case managers and HGs understand how coordinated health care improves the behavioral, social, and medical care of the enrollee, and they incorporate these activities into the care plan and assign accountability. The HG helps the enrollee make and keep appointments with behavioral and physical health providers, provides follow-up after appointments, and coordinates with community agencies, adjunct support systems, and other resources. Others on the team provide their special clinical and functional expertise to the process as needed. For example, peer specialists model and assist enrollees in making lifestyle improvement and self-management of ongoing medical conditions through treatment and medication adherence. Housing specialists may work with the enrollee and community agencies to assist in securing stable, safe housing.

The case managers and HGs coordinate care for the enrollee by focusing efforts on proactive care management interventions. They maintain the responsibility and continue to be the primary advocate in ensuring the enrollee’s well-being across multiple care settings. Whenever possible, the case manager communicates with all relevant medical and behavioral health care entities, including hospital emergency department), inpatient, outpatient settings (residential services, day treatment programs, case management, therapy, medication management) as well as specialized nursing home facilities from the time of initial involvement through the discharge period. The case
manager ensures that the highest quality of health care is delivered to the enrollee in each of the health settings.

We incorporate nationally recognized best practice approaches and measures, and those outlined by AHCA. These approaches are based on key components of the National Transitions of Care Coalition (NTOCC) and Eric Coleman’s Care Transitions Program®, and the Camden Coalition's work with hot spotting of super-utilizers to reduce preventable hospital readmissions. The Magellan Complete Care team focuses on the super-utilizers through a high touch, community-based approach (sometimes referred to as hot-spotting). This approach further assists the enrollee in staying safe and stable within his or her own neighborhood.

Our program assists enrollees presenting with complex care needs and their caregivers/family members to learn self-management skills that will ensure their needs are met during the transition from hospital to home. This is a low-cost, low-intensity evidence-based intervention made up of a home visit and three phone calls.

We have incorporated key aspects of the Coleman model into our Care Transitions approach. The Coleman Model focuses on the Four Conceptual Domains referred to as Pillars. This model assists in: Improving Quality and Safety during Hand-Offs. The focus of the Care Transitions intervention encourages enrollees and family caregivers to assert a more active role during care hand-offs.

The four Pillars include:
1. Medication self-management
2. Use of dynamic patient-centered record, the Personal Health Record
3. Timely primary care/specialty care follow-up
4. Knowledge of red flags that indicate a worsening in condition and understanding of how to respond.

On a national level, enrollees who receive this program were significantly less likely to be readmitted to the hospital, and the benefits were sustained for five months after the end of the one-month intervention. In contrast to traditional case management approaches, Coleman’s model is a self-management model.

The model draws from principles of adult learning and uses simulation to facilitate skill transfer to enhance self-management. As many of these enrollees are likely to experience another transition in the near future, the Care Transitions approach aims to address both the enrollee’s current and future needs.

Using qualitative techniques, the Magellan Complete Care team listened carefully to enrollees and family caregivers to identify and understand the key self-management skills needed to assert a more active role in their care. The role of the Magellan Complete Care - Care Transitions HG was introduced to help impart these skills and help the individual and the family caregiver become more confident in self-care. The Care Transitions HG works closely with the UMP to carry out the care transitions intervention.

The program consists of the following three components:
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1. A meeting with a Care Transitions HG in the hospital or discharging/transferring site of care (where possible—this is desirable but not essential) to discuss concerns and to engage enrollees and their family caregivers in the Care Transitions intervention.

2. The Care Transitions HG collaborates with the Magellan Complete Care UMP and primary ICCM ensuring that all transition elements are being addressed.

3. Set up the Care Transitions HG in home follow-up visit and accompanying phone calls designed to increase self-management skills, facilitate personal goal attainment, improve health literacy, and provide continuity across the transition.

The Care Transitions HG is key to encouraging the enrollee and family caregiver to assume a more active role in his or her care. The Care Transitions HG assists the enrollee in modeling and facilitating new behaviors, skill transfer, and communication strategies for enrollees and families to build confidence that they can successfully respond to common problems that arise during care transitions.

The Magellan Complete Care Transitions and Emergency Department Follow-Up Programs are an integrated part of our overall care coordination model. Our program is focused on the goal of limiting risks for the enrollee’s health and plan of care, as well as successfully transitioning the enrollee safely back into the community or to a new care setting. Activities are integrated with each area/level of the care coordination program and provided by various members of the care coordination team, including RN and SW case managers, HGs, and UMPs. This team works within the Integrated Health Neighborhood assisting the enrollee in accessing necessary supports and services necessary for a safe transfer between health care settings and home.

The transition of care planning process starts long before the enrollee has 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 the enrollee’s family or caregivers.

The Utilization Management Program and UMPs monitor transitions of care including movement of the enrollee 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 are based on enrollee need. Specific criteria have been developed and are used by each of the enrollee-facing areas to facilitate placement and referral to the appropriate care coordination program.

A key component of care coordination and care management is a focus on community-based assistance to enrollees and providers during transition of services. Magellan Complete Care has standards and protocols that detail support for planned and unplanned transitions from one level of care or service to another and across settings. These transitions are particularly challenging for those living with SMI as they may have multiple health concerns and struggle with changes in their treatment environment, medications, and/or treatment.

Enrollees undergoing these transitions have a special need for well-coordinated services, and they face numerous challenges including inefficient, duplicative care caused by the compartmentalization of behavioral health and physical health care systems. Magellan Complete Care has extensive experience in supporting Florida residents with transitions, and we maintain relationships with providers and many community agencies, some formalized in linking
agreements. For example, in working with enrollees, our case managers often find needs for housing, financial assistance, and services not covered by the benefit structure.

Reducing unnecessary readmissions is a high priority case management focus. To reduce readmissions and facilitate stability post-hospitalization, enrollees receive a Welcome Home Call or visit within 48 hours of discharge. As described earlier, our Care Transitions approach and corresponding processes are very detailed and comprehensive as the risk of our SMI population in experiencing unnecessary hospital readmissions is very high. We know that our enrollees present with very complex social issues along with both behavioral and physical health issues. All of our rigorous care transitions processes have been developed to try and mitigate the risk of our enrollees experiencing unnecessary hospital readmissions. Our hands on approach is carried out to ensure that the treatment plan is being followed, planned supports are in place, and all psychosocial, medical, and behavioral health needs are addressed.

When a gap in the discharge plan is identified, including non-adherence to an agreed upon discharge plan, a member of the care coordination team will work with the enrollee to identify obstacles and potential solutions. The enrollee’s family and other support systems will be evaluated to identify medication concerns, untapped family or support system strengths, as well as family or support system resistance to discharge plans. When indicated, a peer recovery support navigator or HG is able to visit an enrollee’s home to assist with family and support system support of discharge plans.

The enrollee’s physical and behavioral health providers will be notified of an enrollee’s discharge and after-care plans including hospital discharge medications. When gaps and/or non-adherence to discharge plans are identified by the team, providers will be notified with the goal of activating all caregivers to achieve the post-discharge stabilization of the enrollee.

If indicated, the team will also organize a care review conference with team members and the enrollee’s providers of care to examine reasons for post-discharge concerns and develop a coordinated plan to address the concerns, including a review of medications and the need for additional community and adjunct systems support services.

One strategy we have found to be helpful for enrollees who are frequently readmitted is the use of a wellness recovery action plans (WRAP®). The WRAP is a peer-led, evidence-based model. It features specific elements related to pre-crisis support, crisis mitigation, and post-crisis self-management. We engage the enrollee and his or her family along with the full team to help identify the triggers for admission. As a group, the causes and possible solutions are discussed. We partner with the enrollee to help shape the support he or she needs and to ensure that the interventions are put in place.

The 24/7 Nurse Line is informed of the plan and provides around-the-clock crisis support according to the plan. In some situations, the crisis plan needs to be tried and refined a few times, but it often breaks a negative cycle almost immediately.

Magellan Complete Care provides case management for enrollees who transition to and from homeless shelters or jail and prison settings. These are difficult situations and readmissions – or new transitions among settings – can be frequent. These situations are particularly challenging and require additional planning. When appropriate, we work with designated agencies for referral.
to Florida Assertive Community Treatment (FACT) teams to provide greater stability and support within the community.

Magellan Complete Care uses each instance of readmission as an opportunity to improve the system as well as our processes. We engage in root cause analysis and invite the enrollee to help us in understanding what could be done differently.

In addition, our program incorporates the following innovative elements:

<<Road to Recovery Program>>: Our newly implemented Road to Recovery Program also provides enrollees who are undergoing care transitions with additional supports and services to increase their engagement with their community providers and supports. It includes enhanced supports to access required follow-up services, access to telehealth if needed, and provider incentives to complete required after-care.

<<Integrated Health Neighborhood>>: The Integrated Health Neighborhood (IHN) is also an important element supporting the enrollee’s safe and successful transition. Our IHN team members live and work within the communities where our enrollees reside. These team members have first-hand knowledge of community strengths, resources, services and service gaps. IHN team members include ICCMs, HGs, peer recovery support navigator, and community outreach specialists supported by housing specialists, employment specialists, clinical pharmacists, medical directors and others.

<<Homeless Housing Program>>: Enrollees are also supported by our unique Homeless Housing Program and our Justice System Programs, which are both directed at overcoming what is often a significant barrier for enrollees living with SMI who are transitioning back into the community. Our goal is to support successful transition that minimizes risks of destabilization of the enrollee’s physical health or behavioral health condition, protecting against the risks of readmission, and increasing enrollee community tenure.

<<Expanded Telemedicine>>: Magellan Complete Care has expanded its use of telemedicine services to enhance enrollee access to care and the timeliness of that care. We have integrated the use of telemedicine into our Road to Recovery program noted above, and we have worked with our CMHC and FQHC providers to expand its use and availability for other specialties. Access to these services has been shown to reduce risks of readmissions as well as inappropriate use of the ER. We are also currently developing programs for use of telemedicine in crisis management for enrollees outside the facility setting.

<<Telehealth Remote Monitoring>>: As part of our expansion of telehealth throughout our delivery network, we have also developed programs for remote monitoring of both chronic illness and post-discharge follow-up and management. We have already identified several hospital and FQHC partners with interests in implementing these programs, and we believe they will be instrumental for supporting successful transitions of care for our complex enrollees.

We offer the following enrollee story as an illustration of our transitions of care programs and their success in achieving successful outcomes.

~~ Enrollee Story: Alan (name changed to protect privacy)~~
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Our enrollee Alan had several inpatient admissions in 2015 due to lack of housing. As a result, he was experiencing depression, isolation, lack of motivation in daily activities, and difficulty following up with his providers. He had reported that he felt he wasn't presentable and was ashamed to go to his provider. Alan had at least ten admissions in 2015 due to suicidal ideation. The Magellan Complete Care HG followed up with the discharge planner in the hospital to help Alan with housing and discharge planning. The HG communicated with hospital staff about the barriers Alan was facing, including not being able to go to his follow-up appointments due to being displaced and the shame he felt walking into an office to get the help he needed from his behavioral health provider and primary care physician. Hospital staff assisted with filling out Homeless Declaration forms and medical records supporting his current situation, indicating that if Alan remained homeless he would be at risk of self-harm, and his life expectancy would be shortened without permanent housing. Magellan Complete Care assisted Alan with housing, which took about a month to solve. Since that time, he has not been inpatient in a hospital and has been able to follow up with all his outpatient providers.

Alan is now actively involved in his health needs and currently going to AA meetings on a weekly basis. He has not been to an emergency room or in an inpatient hospital setting in the past 4 months. Alan has expressed that he is happy, fulfilled, actively involved in the community, and finding enjoyment in his day-to-day activities. His obtaining housing was very important for his recovery, and for his overall psychiatric and medical needs. Alan was very much at risk for self-harm and death, if permanent housing was not made available to him.

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

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT’S PROCESS AND EXAMPLE ENSURES...
In the process of coordinating care, Magellan Complete Care ensures that each enrollee’s privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164 that specifically describe the requirements regarding the privacy of individually identifiable health information.

Magellan Complete Care has a policy and procedure to ensure compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with 42 CFR, Part 431, Subpart F.

During transition planning, Magellan Complete Care ensures that the enrollee or authorized representative signs and dates an AUD release form before any clinical/case records are released to another party. We understand and comply with clinical/case record release in accordance with state and federal law. Magellan Complete Care has developed a formal AUD process that is used by the care team on a daily basis.

Except as otherwise permitted or required by law, Magellan Complete Care does not use or disclose an enrollee’s PHI without first obtaining a valid AUD form from the enrollee:
> We use a standard AUD form consistent with applicable federal regulations.
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MMA SUBMISSION REQUIREMENTS
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> If the standard AUD form is modified, prior approval is obtained from the Compliance Department. A valid AUD form may contain additional elements or information provided that such additional terms are not inconsistent with, and do not conflict with, the existing items.

> If presented with a written authorization form other than Magellan Complete Care’s standard AUD form, prior approval must be obtained from the Compliance Department before any PHI is used or disclosed pursuant to such form.

We obtain a completed AUD form prior to using PHI for purposes other than treatment, payment, or health care operations. In some instances, we obtain and/or require an AUD form for activities that qualify as treatment, payment, or health care operations.

General guidelines for disclosing PHI pursuant to an AUD include the following:

> When we obtain or receive an AUD form for the use or disclosure of PHI, such use or disclosure must be consistent with the terms and conditions set forth in the form.
> Prior to disclosing PHI pursuant to an AUD form, staff checks the form for completion of the required elements.
> If any of these required elements are missing, the form is not valid, and any disclosure pursuant to the form would constitute a breach.
> Staff assists enrollees to complete the form accordingly.
> A description of the information to be used or disclosed that identifies the information in a specific and meaningful way.
> The name or other specific identification of the person or class of persons authorized to make the disclosure. This should indicate “Magellan Complete Care,” or the appropriate Magellan entity name, in some fashion.
> The name or other specific identification of the entity, person, or class of persons to whom the information may be disclosed.
> A description of the purpose of the disclosure. If the disclosure is being made at the request of the enrollee, or if the enrollee elects not to provide a statement of the purpose, the purpose section may read, “at the enrollee’s request.”
> The signature of the individual and the date.
> The bracketed information in Section 7 of the AUD must be customized for Magellan Complete Care.

An AUD form is invalid if it has any of the following defects:
> The AUD form has not been filled out completely and correctly.
> The AUD form is known by Magellan Complete Care to have been revoked.
> The AUD form is combined with any other document to create a compound authorization.
> Magellan Complete Care knows that material information in the AUD form is false.

For any use or disclosure of psychotherapy notes, which should be exceedingly rare, a valid AUD form must always be obtained:

> An enrollee may revoke authorization at any time if this request is made to us in writing.
> Revocation will not include action that we have taken based on a previous authorization.
> We document the presence of an AUD form in the clinical system, and we retain all signed AUD forms for at least 6 years or longer if required by state law.
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MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

The enrollee has a right to receive a signed copy of the AUD form. The AUD form directs the enrollee to retain a copy, if he/she is sending a signed copy to us, and also informs the enrollee of how to request a copy from us.

If the AUD is signed by a personal representative of the enrollee, the representative must provide a description of his or her authority to act on behalf of the enrollee in making decisions related to healthcare:

We may request a copy of the relevant legal documentation granting such authority.

Copies of all written or electronic communications or forms are maintained in Magellan Complete Care’s designated record set. All statements supporting any action or activity identified in this policy that require documentation are documented in Magellan Complete Care's designated record set.

Magellan Complete Care tracks its requests for records (date, provider, record types requested, when received) to manage and organize provider communications, and ensure timely access, including:

Members of the Health Services team are responsible for requesting and managing medical records used in health plan activities.

Duplicate requests for information from enrollees or providers are avoided whenever possible.

Storage of physical records is performed in accordance with corporate policies.

All employees including directors, officers, and the Compliance Officer, must complete annual trainings on HIPAA Privacy and Security.

Providing a safe and secure environment that protects an individual's privacy is a critical element for success with individuals who are living with SMI conditions. Magellan Complete Care staff will ensure enrollee’s privacy in a manner that is consistent with all State and federal regulations.

Upon enrollment to the health plan all enrollees will be asked to complete an Authorization to Use and Disclose form that permits communication with treatment providers. Staff will carefully explain the purpose of the authorization, the providers of care who will be contacted, and the goal of coordinating care to improve the enrollee’s health. In addition, the enrollee is able to complete the AUD form at any time including during hospital or facility admission.

Magellan Complete Care’s clinical information system provides comprehensive capabilities to maintain and store clinical records in accordance with state and federal requirements while supporting the sharing of information among permitted providers.

Magellan Complete Care stores and maintains clinical information in an electronic format so that staff has computer access to the records. Magellan Complete Care complies with HIPAA privacy standards including:

All enrollees’ paper medical records are stored in a locked room with access limited to key personnel who retrieve the files on an as-needed basis only.

Role-based computer access limits what users can view according to their job duties within the organization. This access includes read-only or read/write capabilities.
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

>A secured e-mail system is maintained within Magellan Complete Care, as well as automated encryption of e-mails sent outside Magellan Complete Care that contain protected health information.

>Clinical staff discuss and share details of a case only with those who are involved, such as the enrollee’s treating providers, medical director, and physician advisors.

>Staff keep the enrollee up to date on what transition communications have occurred and the purpose of the communications.

Network providers are contractually obligated to maintain the confidentiality and to safeguard all information regarding covered services provided to enrollees in accordance with any applicable laws and regulations, including the provisions specified in 42 CFR 438.224 and 42 CFR Part 431F, Subpart 4, the Health Insurance Portability and Accountability Act:

>Provider acknowledges that in receiving, storing, processing, or otherwise dealing with information from Magellan Complete Care about enrollees, it is fully bound by all laws governing the confidentiality of medical records

>Subject to all applicable laws governing the confidentiality of medical records:
>>We have the right, at times reasonably acceptable to the provider, to review enrollee records to determine compliance with our policies and procedures, and compliance with the provider’s obligations under the agreement; and
>>HHS, the Comptroller of the United States, CMS, AHCA, DCF, the External Quality Review Organization (EQRO), any other applicable state or federal agencies or authorities, and their authorized representatives, have the right to inspect, review, and copy enrollee records, on prior written notice during normal business hours, to monitor and evaluate the quality, appropriateness and timeliness of services provided under the Agreement or to investigate enrollee grievances or complaints.
>>DHHS, AHCA, the MPI, MFCU and CMS and any other applicable state or federal agencies or authorities and their authorized representatives, have the right to inspect, review, evaluate, audit and copy any pertinent books, financial records, medical records, documents, papers and records of Provider involving any records pertinent to this agreement.

Network providers are contractually obligated to maintain enrollee medical records in a secure manner and to adopt reasonable measures to prevent their unauthorized disclosure:

>Information about medical record practices is included in the Provider Handbook and covered during provider orientation
>Assess medical record practices in site visits for network providers as well as in the Medical Record Review for sampled providers.
>Our provider relations staff addresses any issues with providers, such as trends showing providers consistently sending records late.

The following enrollee story is an example of how this integrated process, and securing appropriate authorizations was used to support one of our enrollees in the transition of care.
~Enrollee Story: Tim (name changed to protect privacy)~

Our enrollee Tim has a long history of chronic homelessness, and frequent readmissions to different hospitals in Broward County area. He was wheelchair-bound due to left leg amputation. Due to homelessness and life situations, Tim was unable to regularly follow up with his outpatient providers and take medication prescribed by his psychiatrist and attending PCP. Tim’s life situation also contributed to exacerbation of symptoms of depression resulting in suicide attempts. He also has a severe eye problem interfering with his ability to read and fill out forms. In addition, he had no access to a phone, was very difficult to reach once discharged from the hospital, and had an inadequate support system.

The Magellan Complete Care Discharge Health Guide (DCHG) met with Tim at the hospital, worked in the Intervention plan, and connected our enrollee with an ICCM for complex case management engagement. Our DCHG was able to assess barriers and needs to create the intervention plan for the enrollee. Tim agreed to participate in the Complex Case Management Program and was open to receiving assistance from our care coordination team. Our DCHG secured all necessary AUDs from the enrollee to allow coordination of required services. He was then referred to a peer support specialist, linked with medical and psychiatric providers, and provided with transportation. Our DCHG also coordinated placement for Tim in an independent living facility where he currently resides.

Before Tim was discharged, our DCHG coordinated referral for a new wheelchair, because his old one was in bad condition and made it difficult to ambulate. Tim was placed in a transitional home and was referred to a community mental health agency for services including therapy, group sessions, medication management and targeted case management services, psychosocial rehabilitation services, individual therapy and medication management. A SafeLink application for a free cell phone was completed and submitted, and Tim received his cell phone.

Tim was linked with a primary care physician and an eye specialist. The DCHG ensured that the enrollee was picked up by the transitional house manager so as to make it to a safe environment. Two days later, the DCHG visited Tim and assisted him with transportation to attend all his appointment. Referrals to an orthopedist and optometrist were coordinated with the PCP by our DCHG and ICCM. Tim is now living in a safe environment and receives three meals a day. His TCM applied for Supplemental Nutrition Assistance Program (food stamps) and Section 8 housing vouchers benefits, which were approved (Tim's goal is to live independently). Our DCHG and ICCM personally picked up eye glasses for Tim, and the DCHG took the glasses to him. Tim obtained a new wheelchair, and he now has his prosthetic leg. The DCHG also completed a referral with Footprints for Success so that Tim could get assistance finding a job after he obtained his prosthetic leg. Tim is now complying with all his medical and PCP appointments, and he hasn't been admitted since receiving housing placement. Tim is still waiting for his Section 8 housing voucher, which should be received in 2 months.

“My self-esteem fly high because of Magellan and [my DCH] and once I have my prosthetic leg my goal is to find a job.” --- Tim

Magellan Complete Care is committed to successful transitions of care for all our enrollees, and we have built a comprehensive and integrated program that supports successful transitions. Our program is built on solid and well-established programs for care transition management, and it incorporates key elements to assess and manage enrollee safety while protecting enrollee
privacy. We accomplish this while integrating behavioral and physical health providers, social services, and requirements for supports. Through these elements we are able to achieve integrated management of our enrollees’ care.

**Evaluation Criteria:**

1. The extent to which the respondent’s process and example address the following transition of care requirements:
   
   (a) Assessment criteria for making sure the enrollee can be served safely in the community;
   
   (b) Collaboration with providers’ (e.g., hospitals, institutional settings, assisted living facilities, crisis stabilization unit, statewide inpatient psychiatric program) discharge planning staff;
   
   (c) Referral and scheduling assistance;
   
   (d) Coordination with PCP and behavioral health providers to ensure appropriate follow up has occurred; and
   
   (e) Processes to prevent unnecessary hospital or nursing facility readmissions.

2. The extent to which the respondent’s process and example ensures the protection of the enrollee’s privacy consistent with confidentiality 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.
MMA SRC# 11 – Provider Network – Network Development Plan (Regional):

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to the following services:

- Physical therapy (pediatric);
- Speech-language pathology services (pediatric);
- Occupational therapy (pediatric);
- Private duty nursing services (pediatric);
- Intermittent skilled nursing (pediatric and adult);
- Early intervention services;
- Compounding pharmacies; and
- Specialized therapeutic foster care.

The respondent’s approach shall include at a minimum:

a. Identification of network gaps (time/distance output reporting, after-hour clinic availability, open/closed panels, etc.);

b. Strategies that will be deployed to increase provider capacity where network gaps have been identified;

c. Strategies for ensuring timely access to services by measuring the time in-between when services are authorized and when they are received; and
d. Strategies for updating the network development and management plan, including the data that will be used to inform improvements to increase access to services.

Response:

OVERVIEW
The Magellan Complete Care Serious Mental Illness (SMI) Specialty Plan Network Development and Management Plan is customized for each region in order to demonstrate a sufficient number of facilities, practitioners and related service locations to provide covered services to enrollees. Given regional variations in provider and enrollee demographics, Magellan Complete Care collaborates with providers to evolve network understanding and acceptance of individuals challenged with SMI as well as anticipating how and where our enrollees need access to covered services.

As the current SMI Specialty Plan across the State of Florida, Magellan Complete Care meets and exceeds AHCA’s minimum access requirements as well as supports the network construct to support enrollees with SMI. We have developed and submitted a Network Development and Management Plan to AHCA annually. In addition, we have customized our systems and/or processes to address AHCA’s specific concerns/interests. Magellan Complete Care’s Network Development team ensures that all services and tasks related to the provider contract are performed in compliance with the terms of the Provider Agreement.
We built a robust provider network that has taken years to properly calibrate, which dates back to our experience managing the AHCA Pre-paid Mental Health Program in Areas 2, 4, 9, and 11, beginning in 2006. This was done through continuous monitoring of our provider network, recruitment activities, and leveraging technology like Quest Analytics software; thereby providing accessibility and adequacy reports to ensure Magellan Complete Care’s success in building a dense and diverse pool of providers to meet enrollee’s primary and specialty care needs.

Magellan Complete Care currently has 32,245 credentialed network providers serving approximately 70,000 SMI Specialty Plan enrollees in the SMI Specialty Plan in 86,185 locations. In addition to the credentialed network providers, Magellan Complete Care also provides additional support through community engagement, offering an online Community Resource Guide to share information about our more than 4,000 non-traditional providers available as support resources across the state.

[MMA SRC #11, Attachment 1: Network Development and Management Plan] is provided for more detail.

CRITERIA 1: THE ADEQUACY OF THE RESPONDENT’S METHODOLOGY FOR IDENTIFYING AND RESOLVING...

1.1 Methodology for Identifying and Resolving Barriers and Network Gaps

Identifying and resolving barriers and network gaps can exist in any region based on a variety of reasons including: lack of providers in rural areas, provider panels are full, providers refusal to accept Medicaid or want to work with a limited number of managed care plans, and providers do not want or do not feel comfortable with individuals with SMI in their practice. All of these barriers can pose a risk to maintaining an accessible network.

As part of our network monitoring and accessibility capacity measurement process, we use industry accepted Quest Analytics and GeoAccess mapping standards that appropriately evaluate membership detail against a set of defined network access standards required for each line of business. We establish provider-to-enrollee ratios by specialty type based on contractual requirements and the populations served throughout our service regions. More importantly, as the SMI Specialty Plan, we support that some ratios should be more extensive than the Managed Medicaid requirements to increase the number of participating providers and to recognize that Regions 1, 3, and 8 need every Medicaid-registered provider to accept Managed Care enrollees. Magellan Complete Care has used this strategy in Region 1 with the Sacred Heart Health System to not only include their facilities in our network but their specialists as well.

Effectively managing against barriers to care and network gaps in provider accessibility rests upon anticipating where such a barrier or gap is most probable to occur. Continuous monitoring, short to long-term interventions, and the capacity to develop key relationships with all participants across the health care continuum are central to Magellan Complete Care’s strategy.

Beyond our network contracting strategies, we rely on additional policies and tactics for monitoring network adequacy and accessibility, some of which include the following as interventions:
Ongoing active evaluation of network additions and terminations, including identifying trends or particular providers through Provider Relations and Clinical Teams

Appointment access standard reviews; our provider contracts outline requirements to comply with appointment access standard timelines – providers are educated on the standards, and compliance is measured through appointment test cases and other random sampling techniques.

Results of our annual provider satisfaction surveys incorporate feedback from network participants on satisfaction of available providers.

Evaluation of Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results that evaluate enrollee satisfaction with access to care.

Review of physician panel size and capacity to serve challenging enrollees.

1.2 Ongoing Activities based on Region-specific Identified Gaps and Future Needs Projection

We embed our network team where enrollees and providers are concentrated, which allows our team to understand the region, counties, cities, and towns more closely. This key strategy means that our Network team learns about issues in the provider community, within our panel of providers, and with our enrollees that affords us an advance alert to a potential network gap or barrier in accessing care. Recently, our Network Manager, who lives in Jacksonville, learned in a seminar that a provider was adding a second location, which happened to benefit our network with an important provider.

In Panama City, knowledge that a provider was gravely-ill and not likely to return to practice gave our network team the needed lead time to develop a remedy before the official change was announced. Placing network team members in the local area in which they work has been an instant gain for enrollees to maintain seamless access to their providers.

When our network contractor, who works in the Gainesville area, recognized that UF Health Shands employed specialized physicians and neonatal nurses qualified to address high risk infants and children with serious health conditions within their Regional Perinatal Intensive Care Center, Magellan Complete Care was able to stop an emerging barrier to care for an enrollee who could not wait to see his PCP.

This experience best represents a short-term intervention while amending a provider’s agreement with Magellan Complete Care resulting in a longer-term intervention by adding additional locations and practitioners. Long-term, when we think a network gap or barrier to care may persist beyond immediate and short-term solutions, or that enrollee numbers increase or concentrate as we have seen in Region 11 during the winter months, the network team sets forth contracting throughout the Region to increase the supply of available providers. This may include new contracting, renegotiating terms, conditions and/or reimbursement to continue or deepen provider participation within the network.

Sourcing alternatives with Advance Practice Nurses, Physician Assistants, and Nurse Practitioners are effective interventions in rural areas such as Regions 1, 2, 8, and 11 because bringing care to where an enrollee resides changes the dynamic by which enrollees get their care; especially individuals who are difficult to engage in care or do not want to leave their home.
environment. This is precisely why Magellan Complete Care cannot only deploy a static network of providers and expect that enrollee access is ensured because there exists at any given moment, accessibility barriers that demand novel ideas, such as the following that are increasing in their usefulness:

> Working locally in rural areas to use telemedicine
> Emphasis on mobile-based services, such as mobile X-ray
> Contracting with public health departments, urgent care clinics, and retail clinics to augment wider network access
> Using in-person interpreters to help bridge language/cultural barriers
> Using Single Case Agreements (SCA) for non-traditional providers such as long-term acute care

Although the preceding disciplines address both short and long-term interventions to network configuration and adjustments that may be needed, they also serve the role of informing Magellan Complete Care in how to anticipate network accessibility changes and developments in the future.

Preparing for an increase in enrollees for Region 1 and Region 3 required an immediate engagement and longer-term approach. For example, Magellan Complete Care contacted hospitals under contract in Region 2 and provider groups in Region 5 to expand our network of providers quickly into Region 1 to ensure access to care was available to enrollees. Managed Medicaid in Region 2 and Region 8 demanded a sustained and longer set of solutions due to larger health systems that dominate within a small urban community, the local hospital and its physicians, in particular, specialists. Therefore, Magellan Complete Care developed contracts with higher reimbursements as the key intervention to maintain and grow access. In the event we sense a need for more providers, we understand the key strategy is to work with providers through their contract rates to deepen network accessibility.

Although we experience strong and diverse population centers in Regions 5, 6, and 7 and therefore, large numbers of providers, each region can still represent the network adequacy challenge for any Managed Care Plan. A common barrier develops when facilities and provider practices are routinely challenged with a greater demand so practices tend to close their offices to new patients. Magellan Complete Care often uses a SCA for a quick remedy when access becomes restricted, and educates providers on access requirements, or enforces contractual provisions to safeguard services to our enrollees.

Interestingly, Region 4 often requires similar interventions when providers refuse to accept patients with SMI and our network team or provider support specialists have to influence providers to execute upon their contractual commitment. Magellan Complete Care relies on a comprehensive safety net provider solution in FQHCs, RHCs, and Health Departments where we increase the number of available providers by creative contracting actions to encourage continued participation with Magellan Complete Care.

We know that it is essential to collaborate with a health system such as Lee Health because of the densely populated geography with concentrated health care services in Sarasota and Lee Counties in Region 8; which amounts to greater than 46 percent of all available health care services and is the dominant pattern of care by which enrollees seek health care delivery. Magellan Complete Care has expanded its current relationship with Lee Health to include a
contractual relationship to afford this vital link to accessing hospitals, clinics, outpatient centers, and physician practices throughout the Region.

Intermediate means by which Magellan Complete Care avoids the potential for network gaps and barriers to care are by concentrating on the integration of primary care with behavioral health, emergency room diversion initiatives, and the use of disease management programs. We have found that providers prefer working with Managed Medicaid programs that improve patient care and overall network accessibility. Although infrequent, a network gap or barrier to care, anticipated or identified, in Regions 9 and 10 is intervened by working with our provider partners directly to increase capacity in their facilities and practices.

Finally, Miami-Dade Region 11 enjoys a broad and diverse panel of Magellan Complete Care providers and although it is uncommon to experience a network gap, from time-to-time a barrier to care may persist. Recently, we recognized through our monitoring and feedback from both providers and enrollees, that access to certain specialties was beginning to form and create a possible reduction in services to enrollees. Magellan Complete Care determined that the appropriate short-term intervention would be to re-direct enrollees to other network providers while over the intermediate-term, we added another health system to the network who also brought with it, several of the needed provider specialties.

Region 11 is home to Monroe County which historically is a network gap due to its isolation and lack of available providers within the county. Therefore, we use SCA, telehealth, nurse practitioners, physician assistants, and work with local agencies and provider groups for mobile clinics. As a longer term solution, Magellan Complete Care is in discussions with an FQHC and CMHC to determine how our resourcing and technology can aid their expansion into Monroe County.

Also in Region 11, for example, we recently thought it was important to contract with Baptist Health to meet our interest in stricter provider to enrollee ratios and to accommodate an influx of new enrollees to the plan but also needed the hospital in Monroe County to come online to address our practice of SCA with a longer-term and more permanent alternative.

As discussed, Magellan Complete Care recognizes that there are geographical areas within the state of Florida that may lack a sufficient number of particular specialties, especially Regions 1, 3, and 8 and in Monroe County in Region 11 where the available providers are limited. Therefore, we continue to employ strategies to address these situations through contracting, management, use of SCA, technological advances, non-emergency transportation, and provider incentives to ensure all enrollees maintain sufficient access to providers.

CRITERIA 2: THE ADEQUACY OF THE RESPONDENT’S PLAN TO MEET THE NEEDS OF ENROLLEES…

2.1 Immediate Interventions to Meet Enrollee Needs Outside of the Specialty Plan Provider Network

Our Health Services staff initiate the SCA with an out-of-network provider based on the clinical needs of the enrollee. The Network Team executes the SCA to ensure immediate access for an enrollee and ongoing adequacy until specified provider types and/or locations are contracted. The SCA process allows us to establish relationships with providers throughout the various regions
which facilitates a participating provider contract. In addition, to appropriately address an accessibility issue, we employ the use of non-emergency medical transportation to the necessary provider type within the closest proximity; as may be appropriate for an enrollee’s need. Arranging transportation may at times, include working within the established pattern of care, which may include transporting an enrollee to a neighboring county because doing so delivers the best care to the enrollee. Another key method we employ frequently is to work with Advanced Registered Nurse Practitioners, Nurse Practitioners, and Physician Assistants in urgent care facilities, as extenders in primary care settings and within safety net providers.

To validate and monitor accessibility through these immediate interventions, Case Managers verify during rounds with the Medical Director, provider staff, and through contact with enrollees, that providers who accepted an enrollee through a SCA have actually delivered the care needed. Moreover, if a Case Manager notes that the care needed is impeded, they will notify our network Contracting Director for immediate outreach to remedy the matter within the same day. We think these immediate methods to circumvent the normal contracting process ensures an enrollee has seamless access to covered services and also highlights for our network contracting department the cities and types of health care providers within our service area where provider accessibility may need heightened monitoring for rapid responses.

2.2 Short-term Interventions to Meet Enrollee Needs Outside of the Specialty Plan Provider Network

Short-term interventions to address network gaps and resolve barriers to care include proactively and continuously working with providers and office staff to ensure access to needed services is available. Our Network Staff review adequacy reports, accessibility data, feedback from our Case Managers and Care Coordination teams as well as, reports from enrollees to identify where and how network adequacy and accessibility issues are developing. The use of SCAs with providers as an immediate intervention is also utilized in a shorter and in some cases, longer term solution to maintain needed accessibility to providers. The SCA generally becomes the precursor of a participating provider agreement as the provider begins to understand how to work within a managed care setting and that Magellan Complete Care through its policies and care plans can best assist the practitioner in managing their patient.

We engage current provider partners to become “champions” of Magellan Complete Care as a means of recruiting those MDs that work closely together and who could close the network gap. As a result, various FQHCs and provider groups have been instrumental in allowing us to achieve this, whether by recommending various specialists throughout the community that they used in the past, or by facilitating contractual talks in order to expand the already existing network.

We work with existing providers to expand their hours and current panel size, if appropriate. We conduct a targeted analysis to identify and resolve any provider inaccessibility issues due to a provider’s non-compliance with access standards such as closing their panel to new patients, maintaining a disproportionate provider-to-enrollee ratio, or exceeding stated appointment wait times.

2.3 Long-term Interventions to Meet Enrollee Needs Outside of the Specialty Plan Provider Network

Long-term interventions to address network gaps and resolve barriers include expanding upon the terms, conditions, and reimbursement components of an existing SCA to go beyond an
immediate intervention to be a longer use approach. Our network Contracting Director and team work towards a participating provider agreement in replacement. Revising contracts with existing providers to expand their hours, service locations, and/or adding additional staffing or using Nurse Practitioners, Advance Registered Practice Nurses, and Physicians Assistants, within the practice for example are additional means to broaden overall access.

In areas with an inadequate numbers of specialists, we continue to expand contracts with regional provider groups to assist Magellan Complete Care in the closing of adequacy or accessibility gaps. In some cases this requires contracting from outside the immediate service area because we have identified that an enrollee with SMI may use a non-traditional pattern in seeking access to health care and thereby match their choice in access with an untraditional provider solution. Finally, we understand the value in working with provider groups beyond the classic and time-honored contracting process to think and respond beyond the norm to do what is necessary to meet access demands, some of which are highlighted below:

>Contracting with newly licensed practitioners
>Facilitating the use of mobile and telehealth services
>Bringing providers to where care is needed
>Supporting practice and provider expansion with technology, data and financing
>Expanding partnerships with public health departments, urgent care clinics and retail clinics
>Requesting providers, who are “leads” for contracting to the network team based on feedback from enrollee requests.

To ensure access, if necessary, we continue to use SCAs until a provider type and location are contracted. These, coupled with enrollee network expansion requests, have allowed us to facilitate services as needed in a prompt manner. As mentioned above, we continue to establish relationships with out-of-network providers, and providers who do not want to participate in Medicaid. We practice open dialogue. Our Provider Advisory Committee advises us on strategies for enhancing our network. We participate in provider association meetings, one-on-one health system meetings, AHCA forums, and other forums.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT’S PLAN INCLUDES STRATEGIES FOR MEASURING..
3.1 Strategies for Measuring the Time In-between When Services are Authorized and When Received
Magellan Complete Care ensures service authorizations are consistent with AHCA requirements and with the services documented on the enrollee’s plan of care, including the frequency and duration necessary to support the enrollee adequately and safely in the setting of his or her choice. Through the Health Services Department, including the Utilization Management Team, the clinical urgency of the enrollee’s case at the time of the coverage request made in TruCare, our clinical documentation and authorization system, determines whether the authorization process is conducted within an expedited or standard timeframe. This level of urgency determines how long we have to complete it for a standard, concurrent, expedited, or retrospective review. An expeditious process is conducted for coverage review of continued inpatient days.
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Once we approve the services and we verify that the approval letter was sent, measuring the time in-between when services are authorized and when they are received, includes the following strategies:

> Care Manager communication with the enrollee
> Key Performance Indicator (KPI) report used to audit authorizations
> Claims/encounter submissions
> Enrollee complaint log
> Enrollee complaints, if the enrollee did not receive the requested services they contact us
> Provider complaints, if the enrollee did not receive the requested services they contact us
> Annual enrollee and provider satisfactions survey.

When coverage for a medical or behavioral health service is requested before service is delivered per the authorization provision of the benefit, Health Services staff initiates the process by collecting information. A UM Licensed Health Professional applies the clinical criteria against the clinical features of the individual enrollee. If the UM Licensed Health Professional 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 Complete Care policy and are in compliance with state requirements. Case Managers follow up with enrollees and providers to ensure the services are completed. We review service authorizations reports daily to ensure requests are processed timely; however, the reports to review compliance with benchmark standards is reviewed monthly.

3.1.a Timeframes for Processing Requests for Authorization
Magellan Complete Care complies with the following standards, measured on a monthly basis, for processing authorization requests in a timely manner:

> Process 95 percent of all standard authorizations within 14 days
> Average turnaround time for standard authorization requests shall not exceed seven days
> Process 95 percent of all expedited authorization requests within three business days
> Average turnaround time for expedited authorization requests shall not exceed two business days.

Magellan Complete Care ensures that PCP services and referrals to specialists for medical and behavioral health services are available on a timely basis, as follows:

> Urgent Care — within one day of the request;
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>Sick Care — within one week of the request; and
>Well Care Visit — within one month of the request.

Magellan Complete Care authorizes enrollee referrals for EPSDT services to appropriate providers within four weeks of these examinations for further assessment and treatment of conditions found during the examination. We ensure that the referral appointment is scheduled for a date within six months of the initial examination, or within the time periods specified above, as applicable.

3.1.b Example: Turnaround Time Monitoring for Outpatient (pre-cert) Prior Authorization Requests for both Behavioral and Medical/Surgical Subdivisions

We use the Key Performance Indicator (KPI) Report to audit 100 percent of standard and expedited prior authorizations not processed within Turn Around Time (TAT) timeframes 48 hours for expedited and seven days for standard to determine reasons for missed TAT. The Health Services Auditor (HSA) conducts an audit to determine trends by staff or process and identifies needed interventions. The HSA reviews the KPI report monthly. If the KPI report shows pre-cert authorizations (standard/expedited) fall below 95 percent compliance of being processed within timeframe, then the HSA conducts audits to determine reasons/trends.

If audits are conducted, the HSA will analyze, assess, and report audit results on a monthly and quarterly basis. The HSA will report quantitative/qualitative results to UM Director and 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. The 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. In addition, the HSA will provide the team with authorization errors that are corrected and followed to ensure compliance with corrections. Finally, the HSA will provide audit results and analysis during quarterly Health Services Committee meetings.

CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT’S UPDATE OF ITS NETWORK DEVELOPMENT...

Magellan Complete Care updates its Network Development and Management Plan informed by multiple data sources that include the following:

4.1 Network, Clinical, and Quality Staff Input
Magellan Complete Care Network staff collaborates with quality staff and other cross functional teams to develop the annual Network Development and Management Plan. We have developed and maintained the Magellan Complete Care Network Development and Management Plan since the inception of the SMI Specialty Plan and will continue to submit this plan to the AHCA by September 1 of each Contract year.

4.2 Comprehensive Data and Feedback to Inform and Update the Plan
Our overarching network development and maintenance goal is to ensure timely access to quality health care services for all enrollees. The Plan includes processes and methods to develop, maintain, and monitor an appropriate provider network sufficient to provide adequate access to all services covered under this Contract, is included in the Plan. The Plan includes measurable targets, goals, and timelines for completion. In addition, it includes a description of the evaluation
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MMA SUBMISSION REQUIREMENTS
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of the prior year’s plan including an explanation of the method used to evaluate the network and reference to the success of proposed interventions and/or the need for re-evaluation. We gather information on an ongoing basis on the number and types (in terms of training, experience, and specialization) of providers currently delivering healthcare services to the SMI population within the state and to Medicaid enrollees. We assess provider network capacity, geographic location of providers, and, whether the healthcare sites accommodate individuals with disabilities or special needs.

As an NCQA Accredited Health Plan, Magellan Complete Care develops an annual Quality Improvement (QI) Plan that guides QI, including network, initiatives throughout the year. The scope of this program includes objective and systematic monitoring of the quality of medical, behavioral, and psychosocial care and service delivery with a focus on recovery and resiliency. The Quality program is led by the VP-Medical Director and managed by the Quality Director. Oversight of the program is provided by our Quality Improvement Committee (QIC) which meets monthly. In developing the program we track and trend complaints and grievances and actively seek input from enrollees, family members, and key stakeholders. The compliance, risk management and safety programs are also elements of the program. Through the feedback obtained by the Quality and Clinical departments, we incorporate updated changes into the Plan.

Magellan Complete Care uses multiple data sources to inform updates to our Network Development and Management Plan, for example:

>Feedback from enrollees gathered through the enrollee services line, care coordination and other Magellan Complete Care staff; satisfaction and CAHPS surveys; and Enrollee Services Committee. This includes a review of trends in enrollee complaints and grievances

>Feedback from providers gathered through our Provider Services Line, satisfaction surveys, provider complaints, Physician Advisory Board, professional organizations, Provider Support Specialists, Utilization Management or other Magellan Complete Care staff

>Feedback from AHCA through weekly account management, network file reviews or AHCA enrollee/provider complaints

>Feedback from the QIC, Credentialing Committee, Network Strategy and Oversight Committee, Compliance Committee, and other committees

>Feedback from subcontractors through joint operations meetings and vendor oversight staff.

>Feedback from community-based organizations gathered through committees, Community Outreach Specialists, or other community forums

>Input from community-based agencies gathered through committees, Community Outreach Specialists, or other community forums

>Provider audits, onsite reviews, surveys of appointment availability, and medical/treatment record reviews
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
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> Evaluation of access data including Quest Analytics GeoAccess reports; projected changes in membership growth or the demographics of the membership; PCP to enrollee ratio utilizing PCP capacity and panel status; and service utilization and cost trends.

4.3 Network Strategy Committee
The Network Strategy Committee is chaired by the Magellan Complete Care Senior Director of Network Management. The annual Network Management and Development Plan is reviewed and evaluated within this committee. The Committee reviews and approves network development and network expansion related functions, responds to provider terminations and availability and accessibility issues, plans for short and long term needs from the larger provider community.

The Committee also reviews provider claims, denial reports and percentages, reviews non participating provider utilization, and focuses on area-specific initiatives related to training and development needs. The Network Strategy Committee meets, at a minimum, quarterly.

Functions of the Network Strategy Committee include the following:

> Define network size, composition, and training needs of the network serving their membership
> Establish ongoing network maintenance and development priorities
> Evaluate the need for network membership by geographic territory on an ongoing basis, including network saturation and need for specialty practitioners and providers
> Evaluate clinical needs for special populations or diagnostic categories
> Develop service resources for all levels of care and collaborate with existing providers for expansion
> Develop strategies for filling network gaps including review of ad hoc data
> Identify continuum of care needs to facilitate improved service delivery.

Network Strategy Committee membership at a minimum, includes the following:
> Senior Director of Network Management (Chair)
> Medical Director of Behavioral Health
> Senior Area Contract Manager
> Network Regional Director
> Vice President, Chief Medical Officer
> Senior Account Executives
> Senior Director of Health Services
> Quality Director or designee

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT’S DRAFT NETWORK DEVELOPMENT AND...
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.

Magellan Complete Care addresses the delegation of provider network functions to subcontractors and the oversight of these operations in our Network Development and Management Plan. We maintain oversight authority of all subcontractors as outlined in our
Delegate and Subcontractor Contracting and Oversight Policy to ensure ongoing compliance with applicable Florida AHCA Medicaid contract and regulatory requirements.

We provide training to our subcontractors and their staff on how to communicate and interact with enrollees with SMI. Please see [Attachment MMA 11-XX: Delegate and Subcontractor Contracting and Oversight Policy] for more details.

Magellan Complete Care selected the following subcontractors to further enhance our broad network adequacy and accessibility in the delivery and implementation of the obligations in ensuring network adequacy and accessibility to include the following:

>Veyo – Transportation Services
>DentaQuest – Dental Benefits Management
>Premier Eye Care – Vision Benefits Management
>PurFoods, LLC – Home Nutrition Solutions

We continue to monitor the performance of our subcontractors to ensure contract compliance, including network development and management. This is accomplished through a dedicated Delegation Vendor Management Team, in collaboration with our Network team that focuses on mitigating timely access to care and the risks and optimizing the opportunities associated with delegation. The outcomes of delegated vendor oversight are reported to the Compliance Committee and issues are brought to the Board of Directors through the Contract Compliance Officer.

Through our oversight and auditing processes, we are able to assess the effectiveness of our subcontract programs and apply corrective actions as necessary to ensure network adequacy and accessibility for Magellan Complete Care enrollees. We continue to utilize our current contract with Global Interpreting to provide a robust network of qualified interpreter services to accompany our enrollees with limited English proficiency or hearing impairments to appointments. We work with our network providers to ensure they are aware of this resource for our enrollee appointments. Magellan does not support the use of family members and friends to fulfill this function.

In addition to 24/7 availability and no scheduling restrictions, we require vendors to have established and measurable standards and training for its health care interpreters that meet the standards currently recommended by the National Council on Interpretation in Health Care.

To provide high quality and responsive Non-Emergency Medical Transportation services, we require all third-party providers attend a mandatory Magellan Complete Care or State initiated driver training program to ensure the driver provider understand and comply with their Magellan Complete Care contracts with Veyo transportation services allowing us to meet the non-emergency transportation needs of enrollees with Mental and Behavioral Health experiences. Vehicles are required to meet Federal and State standards for vehicle safety and, including meeting the Americans with Disabilities Act (ADA) requirements.
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Magellan Complete Care ensures that all of our subcontractors are fully qualified to provide the identified services requested in our AHCA contract, and that they follow the same stringent guidelines and requirements for quality of services. The management and oversight of delegated subcontractors is the responsibility of the Magellan Complete Care Senior Director. Vendor Management is responsible for providing oversight and coordinating activities of all delegated functions to vendors.

5.1. Managing Subcontractors to Ensure Compliance with Requirements
Our approach to management and oversight of subcontractors includes our understanding that we are ultimately accountable to ensure subcontractors meet all contract requirements through our comprehensive oversight process to ensure performance. In addition, we provide technical assistance and correction measures when subcontractors are not performing. If subcontractors do not perform to our standards, we transition services to a more qualified vendor in a thoughtful and seamless manner.

Magellan Complete Care’s annual network plan includes a description of coordination between internal departments, including a comprehensive listing of all committees and committee membership where this coordination occurs. The Magellan Complete Care Vendor Delegation Oversight Committee is responsible for assessing and overseeing the quality of performance of delegated services provided by vendors in order to ensure the safety and well-being of enrollees as well as meet performance requirements and accreditation standards, including membership from the following areas:

- Vendor Delegation Oversight Coordinator (co-chair)
- Compliance Officer (co-chair)
- Vice President Health Services or designee
- Quality Director
- Director Operations
- Chief Operating Officer
- Director of Investigations

The scope of the Magellan Complete Care quality program includes all quality monitoring and oversight activities conducted by Magellan Complete Care. Quality is incorporated throughout the organization and includes comprehensive monitoring and evaluation activities and the implementation of actions to improve care and service. Prior to entering into a delegation arrangement, we audit the intended delegate for: the existence of policies and procedures, an established quality program, compliance with applicable standards, regulatory requirements, and the ability to consistently and reliably provide the services to be covered by the proposed delegation agreement, using an appropriate delegation oversight tool.

We use a formal delegation agreement and monitor delegated activities and functions regularly using a systematic process to assess compliance. Magellan Complete Care retains overall accountability for completion of the tasks delegated. We are responsible for ensuring the delegated entity’s compliance with internal Plan standards and requirements, as well as federal, State, and accreditation standards. Oversight activities include but are not limited to:

- Executing written agreements with each delegated entity that specifies the activities to be delegated and those to be retained by the Plan, including data reporting standards
>Evaluating the entity’s ability to fulfill delegation obligations through review of the entity’s 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

>Performing ongoing performance monitoring via review of submitted data reports and ensuring that corrective action is taken, in a timely manner, to address any opportunities for improvement identified

>Completing an annual formal performance review and re-approving all applicable programs, including the entity’s QI program

>Imposing sanctions or revoking delegation if the entity’s performance is inadequate.

To ensure ongoing compliance with applicable Florida Medicaid Contract and regulatory requirements, Magellan Complete Care maintains oversight authority of each vendor services subcontractor reviewing reports/data and analyses monthly, quarterly, or annually, as deemed applicable. Data/reports and analyses 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
>Staff training
>Patient safety activities
>Encounter compliance reports
>Other performance measures as identified.

5.2. Monitoring Fraud, Waste, and Abuse
Magellan Complete Care monitors the services of its subcontractors to prevent fraud, abuse, and waste through the following activities:

>Assure that the comprehensive employee training program is in place to report and investigate potential fraud

>Review of data and scheduling of audits conducted by subcontractors to identify providers who demonstrate a pattern or practice of falsified encounter or service reports, overstated reports or up-coded levels of service and fraud and abuse

>Review of audit conducted by subcontractors of providers to identify providers that alter, falsify or destroy records prior to the end of the ten year records retention requirement; make a false statement regarding credentialing; misrepresent medical information to justify a referral; failed to
provide scheduled services for enrollees; charged an enrollee for covered services and/or have or been suspected of committing fraud or abuse.

**Evaluation Criteria:**

1. The adequacy of the respondent’s methodology for identifying and resolving barriers and network gaps; including ongoing activities or network development based on region-specific identified gaps and future needs projection.

2. The adequacy of the respondent’s plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.

3. The extent to which the respondent’s plan includes strategies for measuring the time in-between when services are authorized and when they are received.

4. The extent to which the respondent’s update of its network development and management plan is informed by multiple data sources (including complaints, grievances, etc.).

5. The extent to which the respondent’s draft network development and management plan addresses the delegation of provider network functions to subcontractors and the oversight of these operations.

**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.
D. PROVIDER EXPERIENCE

MMA SRC# 12 – Provider Credentialing (Statewide):

The respondent shall describe its proposed process to credential and recredential providers (including subcontractors’ processes, if applicable), including credentialing timeframes, internal continuous quality improvement initiatives for recredentialing, transparency for providers on their application status and the steps the respondent or its subcontractors will take to ensure the respondent and the Agency have accurate provider demographic information in-between credentialing cycles.

Response:

OVERVIEW
Magellan Complete Care is dedicated to the careful selection and credentialing of healthcare professionals for the provision of the Serious Mental Illness (SMI) Specialty Plan enrollee care and treatment across the range of managed services. Our provider network construct is different from a traditional Health Maintenance Organization (HMO) network, because we serve a very complex population that has multiple service and access needs.

Magellan Complete Care leverages more than 10 years of experience credentialing and recredentialing providers in Florida, because we previously managed Florida’s Prepaid Mental Health Program (PMHP). We follow National Committee for Quality Assurance (NCQA) standards to execute our comprehensive and successful process of credentialing and recredentialing behavioral and physical health providers and facilities that meet and exceed the requirements set forth in the ITN.

Since 2014, Magellan Complete Care has built, and continues to expand an integrated contracted network of more than 32,245 providers in the State of Florida. The contracted providers include behavioral and physical health hospitals, primary care providers, a variety of specialists, behavioral health providers, and ancillary providers who deliver a full array of services to our enrollees.

Magellan Complete Care has identified best practices within the credentialing process, as a result of our extensive experience in behavioral health provider credentialing Medicaid contracts by our parent company. Coupled with our successful Florida network management experience we can leverage our accumulated knowledge and complete understanding of the following factors for SMI Specialty Plan credentialing:

>Agency for Health Care Administration (AHCA) requirements
>Comprehensive provider community necessary to provide services to the enrollee population
>Credentialing and recredentialing process
>Diversity of membership needs, especially as it relates to enrollees with SMI.

To exceed Contract requirements, we have designed the scope and objectives of the credentialing program to include the following key components:
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>Establish criteria for credentialing and participation in our provider network that consider the quality of clinical and service needs of the enrollee population, the regulatory environment, and business needs
>Establish appropriate credentialing committee structures at the corporate and regional levels to implement the credentialing program
>Establish and oversee implementation of policies and standards for network provider credentialing, quality evaluation, and network provider participation
>Ensure proper oversight of the delegation of any aspect of the credentialing program
>Establish and oversee activities and findings to support our ongoing assessment of the quality and effectiveness of provider network
>Integrate our credentialing and provider network management activities and findings into our quality improvement (QI) program.

CRITERIA 1: THE ADEQUACY OF THE RESPONDENT’S DESCRIPTION OF ITS CREDENTIALING...
1.1 Credentialing and Recredentialing Criteria
Magellan Complete Care diligently adheres to rigorous credentialing criteria, which encompass review of licensure, education, training, and other criteria that must be met for the review and selection of healthcare professionals for inclusion in Magellan Complete Care’s practitioner/provider network.
Magellan Complete Care is the first and only SMI Specialty Plan to receive full accreditation under NCQA Health Plan standards. In addition, we perform credentialing and recredentialing “in house” to control the process and to remain agile to respond to business needs.
Magellan Complete Care credentialing and recredentialing criteria include:

>Primary Care and Specialist Providers
>>Types of providers: MD, DO, DDS/DMD (dental), DPM (pediatric, OD (optometric), DC (chiropractic), behavioral health: Psychologist (PhD, EdD, PsyD)
>>Provider Participation Requirements:
>>>>Completed Standardized Provider Participation Application which contains provider’s statement regarding: any history of loss or limitation of privileges or disciplinary activity, any physical or mental health problems that may affect the provider’s ability to provide health care, any history of chemical dependency /substance abuse, any history of loss of license and/or felony convictions, and that the provider is eligible to enroll as a Medicaid provider
>>>>The application is signed and dated, as attestation to the accuracy and completeness of the information contained within
>>>>Meets AHCA’s Medicaid participation standards and completes a satisfactory level II background check for all treating providers not currently enrolled in Medicaid’s fee-for-service program
>>>>For each PCP, documentation of a good standing site survey
>>>>A National Provider Identifier (NPI) and taxonomy which can be validated via NPPES
>>Compliance with Ownership and Management Disclosure requirement at the contracted entity level
>>>>Attestation that PCP patient load is no more than 3,000 active patients
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>>Admitting privileges in good standing at an in-network hospital or alternative admitting
arrangements with a Magellan participating provider

>>>Current unconditioned, unrestricted valid license to practice in Florida or bordering state, or
certificate consistent with practitioner’s scope of service

>>>Valid DEA, CDS, as applicable

>>>CLIA certificate or number for each location where lab services are performed, as applicable

>>>Compliance with all applicable AHCA and Magellan Complete Care insurance requirements

>>>Evaluation of at least five years of work history

>>>No sanctions within the past five years, verified by a Sanction/Exclusion query to Florida
Medicare/Medicaid, Office of Inspector General (OIG)

>>>Professional liability claims history (National Practitioner Data Bank Query) – past ten years
claim review

>>>Medical specialty Board Certification, as applicable

>>>Residency or specialty training if not Board Certified

Mid-level Providers

Types of providers: Speech, Physical, and Occupational Therapist (ST, PT, OT), Nurse
Practitioner (NP), Certified Nurse Midwife (CNM), Certified Nurse Specialists (CNS) all focus
areas), Physician Assistant (PA), LPC Licensed Professional Counselor (LPC), Licensed
Clinical Social Worker (LCSW), LMSW – ACP Licensed Master Social Worker – Advanced
Clinical Practitioner (LMSW-ACP), Licensed Marriage and Family Therapist (LMFT)

Provider Participation Requirements:

>>>Completed Standardized Provider Participation Application which contains provider’s
statement regarding: any history of loss or limitation of privileges or disciplinary activity, any
physical or mental health problems that may affect the provider’s ability to provide health care,
any history of chemical dependency/substance abuse, any history of loss of license and/or
felony convictions, and that the provider is eligible to become a Medicaid provider

>>>Application is signed and dated, as attestation to the accuracy and completeness of the
information contained within

>>>Meets AHCA’s Medicaid participation standards AND a satisfactory level II background check
for all treating providers not currently enrolled in Medicaid’s fee-for-service program is
performed

>>>For each PCP, documentation of a good standing site visit

>>>National Provider Identifier (NPI) and taxonomy which can be validated via NPPES

>>>Compliance with Ownership and Management Disclosure requirement at the contracted entity
level

>>>Attestation that PCP patient load is no more than 3,000 active patients

>>>Admitting privileges in good standing at an in-network hospital or alternative admitting
arrangements with a Magellan participating provider

>>>Current unconditioned, unrestricted valid license to practice in Florida or bordering state
certificate consistent with practitioner’s scope of service

>>>Valid DEA, CDS, as applicable

>>>CLIA certificate or number for each location where lab services are performed, as applicable

>>>Compliance with insurance requirements as outlined by AHCA

>>>Evaluation of work history – minimum of five years

>>>No sanctions within the past five years, verified by a Sanction/Exclusion query to Florida
Medicare/Medicaid, Office of Inspector General (OIG)
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>>>Professional liability claims history (National Practitioner Data Bank Query) – past ten years claim review
>>>Specialty Board Certification (e.g., ANCC), as applicable.

>Organizational Providers
>>Types of providers: Hospitals, home health agencies, skilled nursing facilities, behavioral health facilities, Durable Medical Equipment (DME), and freestanding surgical centers
>>Provider Participation Requirements:
>>>Completed provider participation application
>>>Current accreditation (TJC, NIAHO, HFAP, COA, etc.) or successful site visit results for non-accredited facilities
>>>Compliance with all applicable AHCA and Magellan Complete Care insurance requirements
>>>Current State license
>>>Compliance with Ownership and Management Disclosure requirement at the contracted entity level
>>>Verification of Medicaid/Medicare certification
>>>CLIA certificate or number for each location where lab services are performed, as applicable
>>>Professional Liability Claims history
>>>No sanctions within the past five years, verified by a Sanction/Exclusion query to Florida Medicare/Medicaid, Office of Inspector General (OIG)
>>>NPI, Medicare and Medicaid numbers

>Pharmacies
>>Types of providers: Pharmacists, pharmacies
>>Provider Participation Requirements:
>>>Current unrestricted Florida license
>>>Sanction query to OIG/LEIE
>>>Verification of current liability insurance coverage
>>>Current DEA and State Controlled Substance Certificate
>>>Applicant must also provide a Medicaid ID number and National Council for Prescription Drug Program (NCPDP) number.

1.2 Certified Credential Verification Organization Processes
In addition to NCQA health plan accreditation, Magellan has been certified by NCQA as a Credentials Verification Organization (CVO). As the first managed behavioral health organization to achieve this designation, our certification encompasses all 10 verification services. Achieving NCQA CVO certification demonstrates that we have the systems, process, and personnel to thoroughly and accurately verify providers’ credentials and ensure all providers meet AHCA credentialing requirements as set forth in the ITN.

Magellan Complete Care’s credentialing structure allows us to maintain central authority and oversight of credentialing decisions. Our practices ensure compliance with NCQA standards and AHCA requirements, as well as technical support for providers, which result in an extensive and diverse network of community providers. Our Credentialing Committee maintains program oversight and ultimate authority over credentialing decisions.

1.3 Utilization of a Third Party Credentialing Vendor
Magellan Complete Care does not utilize a third party credentialing subcontractor.
CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT’S TIMEFRAMES FOR PROCESSING CREDENTIALING...
Magellan Complete Care’s credentialing timeframes are more expeditious than the industry standard. Our credentialing process needs to be fast because our enrollees having different sets of complex needs. Enrollee needs and circumstances require us to thoroughly understand the importance of continually expanding and evolving our network. We have developed an efficient and robust credentialing process as a result of years of successful network management experience and we have been able to build on all the history we have had in Florida. Our credentialing operations department has targeted and eliminated wasteful processes and barriers to successful credentialing, and can typically complete the initial and recredentialing process without provider intervention.

Our focus on a hassle-free credentialing experience results in higher than industry standard success rates and significantly lower processing times. We are pleased to report the following turnaround times for calendar year 2016:

> Practitioners:
>> Average turnaround time from completing the application through the credentialing decision is 26 days
>> 99.8% of applications are approved within 120 days of completing the application

> Organizations:
>> Average turnaround time from completing the application through the credentialing decision is 13 days
>> 99.8% of applications are approved within 120 days of completing the application.

CRITERIA 3: THE ADEQUACY OF THE RESPONDENT’S APPROACH TO PROVIDING TRANSPARENCY...
3.1 Approach to Providing Transparency to Providers
Magellan Complete Care offers providers transparency throughout the provider contracting and credentialing process. Our approach aligns with the following guiding principles:

> Strive to make Magellan Complete Care easy to work with as a partner
> Respect providers’ time by easing the administrative burden
> Offer multi-channel communication approaches

At the point of recruitment, Field Network staff ensure that providers understand all steps within the onboarding process, including provider obligations, forms, and process steps. Checklists and other documents are provided within recruitment packets and supplemental information is provided within the Provider Handbook and Magellan Complete Care Provider website to ensure critical information is accessible to providers. In addition, the Provider Service Line is staffed Mon-Fri, 8 a.m. to 7 p.m. EST to respond to provider inquiries throughout the process.

Upon receipt of a signed contract and supplementary documents, the information is fed to the correct application processing team via Magellan Complete Care’s workflow processes which leverages technology to ensure the right teams have the needed information to support processing the provider application in an accurate and expeditious manner.
Our Provider Data team ensures that demographic data are quickly and accurately entered into Magellan Complete Care’s provider data management system. The team processes the other critical forms that are required for contract execution. Examples include W-9, Electronic Funds Transfer (EFT) set up, and Disclosure of Ownership forms. Field Network associates work directly with providers in cases where required documents are missing. Our Credentialing team in most cases accesses the Provider Participation Application directly from CAQH, easing the administrative burden to the provider community.

The Credentialing team performs all required verifications in alignment with NCQA and AHCA standards. In cases where information needed to complete the credentialing review is missing, the Credentialing Operations team directly contacts the provider and provides guidance about the missing documentation and instructions for proper submission. Communication may be email, telephone, fax, and/or letter. Multi-channel outreaches increase the likelihood of successful contact.

3.1 Communication Approaches to Inform Provider of the Application Process
From the point at which the CVO is notified to begin the initial credentialing process and retrieves a CAQH application, the provider is contacted by the CVO only if incomplete or missing information is identified by the Provider Data team. During the credentialing process, we suggest that providers contact the Provider Support Line for a status update. With a complete application, the CVO median turnaround time is fewer than 30 days and the provider is notified in writing, after the Credentialing Committee reaches a final decision.

Upon completion of credentialing and validation of all other contractual requirements, the CVO returns the executed provider agreement to the provider along with a Welcome Letter officially welcoming the provider to the network and offering additional information on available resources.

Magellan Complete Care recredentials providers at least every three years. We complete provider recredentialing in a manner that is invisible to the providers, allowing them to focus on providing care to Magellan Complete Care enrollees, by eliminating any administrative burden associated with recredentialing. We limit our provider outreach to only those required items that are not found in the provider’s updated and attested CAQH application. Throughout the process, we encourage providers to use online resources, or to contact the Provider Support Line with questions or concerns.

CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT USES INFORMATION FROM PROVIDER COMPLAINTS…
Magellan Complete Care’s Credentialing Committee makes provider recredentialing decisions based on provider complaints, monitoring, and recommendations from the Magellan Complete Care Quality Improvement Committee (QIC). The Credentialing Committee reviews all available quality information, including provider complaints, ongoing sanctions monitoring, medical record reviews, and other quality studies to make recredentialing decisions. Our Chief Medical Officer chairs the Credentialing Committee and is responsible for conducting the monthly meetings and all activities related to the credentialing and recredentialing programs. The Credentialing Committee also includes the QI Director and selected QI staff. The Vice
President of Network Operations, has overall responsibility for the administrative aspects of the credentialing program.

We include available quality data in our credentialing and recredentialing process. Verification at initial credentialing may result in the discovery of education and training issues, prior adverse history related to the practitioner or facility, such as disciplinary action on the provider’s license to practice, action on privileges, and state agency action on facility licensure. This information, along with the provider’s explanation, is presented to the Credentialing Committee for evaluation of potential impact on enrollee care and safety, after which the committee makes a final credentialing determination.

Providers who complete initial credentialing are subject to performance monitoring as previously described, must cooperate with QI program activities, enrollee complaint resolution, critical incident review, medical records reviews, and respond to negative ongoing sanction monitoring findings. At recredentialing, administrative credentialing elements, such as licensure, board-certification, accreditation, and good standing with regulatory agencies (OIG, SAM) are re-verified. Once administrative reverifications are completed, Magellan collates all available quality monitoring information and quality performance information, including enrollee complaints, quality of care concerns, medical record findings, and adverse incidents and presents any findings to the Credentialing Committee for review and determination.

We emphasize a continuous approach to provider performance evaluation through QI activities, rather than conducting peer review primarily at the recredentialing event. The majority of quality-related issues are addressed or resolved proximate to their occurrence. Therefore, the recredentialing review is typically an overview of any prior performance improvement activities to ensure all issues have been, or are being addressed through a performance improvement plan (PIP) or other action, which results in a Credentialing Committee decision to recredential.

4.1 Information Sources for Recredentialing
In addition to recommendations from the QIC, Magellan Complete Care uses information from the following sources to inform the recredentialing process:

>Peer review process
>Onsite reviews
>Medical and behavioral health record reviews
>Complaints, grievances, and appeals
>Ongoing sanctions monitoring
>Provider accessibility
>Focused reviews
>Satisfaction surveys
>Credentialing policies and procedures

4.1a Peer Review Process
The peer review process evaluates provider-specific performance and clinical practices to ensure that a high level of care is maintained. The Credentialing Committee provides oversight of enrollee safety through the review of provider credentials, provider quality of care concerns, enrollee complaints, and adverse incident trends. The scope of our peer review process extends beyond credential review and includes specific cases where there is evidence of a quality deficiency in the care or a service provided, or the omission of care or a service, by a
participating health care professional or provider. We take action based on recommendations of the committee and may include consequences ranging from provider education, a request for a PIP, conducting a site visit, placing the provider on suspension or “hold” for new enrollees or referrals, to immediate termination from the network.

In addition to our minimum credentialing requirements and primary source verification activities, we review quality of care information, including recommendations from our QIC. Information related to QI activities, complaints, utilization, site visits, record reviews, and grievances and appeals obtained subsequent to the prior credentialing are included as part of the recredentialing process. Our staff perform onsite visits as needed to address quality complaints, licensing issues, accreditation, sanctions, and quality concerns that are presented to the Credentialing Committee for appropriate action.

4.1.b Onsite Reviews
Onsite provider reviews give us the opportunity to assess aspects of the quality of the care received by enrollees with SMI that cannot be determined from administrative data. Regular site visits by Provider Support Specialists afford the opportunity to engage providers with direct linkage to our staff, so business and contractual needs are addressed. We use site visits to improve the provider’s practice through education, training, and discussion of PIP, where applicable. These discussions assist us in identifying trends that indicate the need for system-wide education and/or programmatic changes. Medical Records Reviews are a component of these visits. Our staff members perform additional site visits as needed to address quality complaints, issues with licensing, accreditation, sanctions, and quality concerns that are presented to the Credentialing Committee for appropriate action.

4.1.c Medical and Behavioral Health Record Reviews
Medical and behavioral health record reviews give us an opportunity to assess the quality of care that is provided to enrollees with SMI. We monitor performance measures that require information maintained in enrollee records, and conduct medical record reviews based on contractual requirements. We perform audits at least every three years for providers who have served 10 or more enrollees in the prior 12 months. These audits include PCPs, OB/GYNs, and other high volume providers. More frequent reviews may be completed based on supplemental monitoring and evaluation data that indicate the need for closer oversight. In these cases, we conduct focused audits and site visits to ensure that deficiencies are addressed and corrected.

We consider risk factors, data from previous monitoring, service utilization, problem resolution, compliance with clinical practice guidelines, and other sources when developing the monitoring activities and schedule. We distribute our findings to providers with a request for a PIP for those who do not meet standards. Provider-specific and aggregate findings are reviewed by the Credentialing Committee. Additional action may be recommended to bring providers into compliance or to remove them from network participation.

4.1.d Complaints, Grievances, and Appeals
We maintain a process for responding to enrollee, stakeholder, or provider initiated complaints, grievances, and appeals. The process includes an evaluation of the specific complaint or appeal, as well as an analysis of the nature of these complaints on an aggregate basis. This reporting and analysis supports the determination of trends and identifies opportunities for improvement with individual providers and related systemic issues. We track enrollee
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complaints, grievances, and appeals at the provider level to identify specific patterns that may indicate that a provider is not delivering care that meets AHCA and our own standards for clinical practices, enrollee rights and responsibilities, cultural competence, and other areas of compliance.

By identifying a problem as it is emerging, we have the ability to intervene and to work with the provider to enhance their practices before the well-being of other enrollees is impacted. Provider-specific complaints are reported to the appropriate Credentialing, Network Strategy, and Vendor Oversight subcommittees. These QI subcommittees make recommendations for provider-specific, as well as network-wide improvement activities to the appropriate staff, who implement and monitor them through completion. In addition, the QIC oversees these activities to further identify Magellan Complete Care system-wide improvement.

4.1.e Ongoing Sanctions Monitoring
Our ongoing sanction monitoring process includes a review of reports from state licensing boards, the Medicaid/Medicare Sanctions report, GSA's System for Award Management, and state-specific exclusion lists. We query these sources to identify any providers whose licenses have been officially sanctioned, disciplined, or revoked as well as other actions taken against the provider. Our Compliance Officer receives and coordinates the Medicaid Program Integrity lists. The Compliance Officer sends them to the Credentialing, Network, Pharmacy, Vendor Management, and Health Services Departments for action and requires a report back on completion of the activity. Our process ensures timely review of these sources (within 30 days of release of information from the source). Results are compared to our database of network providers to identify and confirm matches and report back to our clients, as appropriate.

4.1.f Provider Accessibility
As part of the QI program, we employ data collection, monitoring, and reporting activities to continuously monitor provider compliance, ensuring that they comply with appointment access standards. Our goal is to make certain that enrollees with SMI are seen in a timely manner and that individual service plan goals are met. We have identified the following measurable activities that demonstrate provider compliance with accessibility requirements:

> Reviewing appointment logs during site visits
> Monitoring complaint indicators related to access
> Evaluating enrollee, family, parents of children and adolescents, and other stakeholder recommendations and incorporating those into the network development plan
> Identifying providers to fill service or geographic gaps, as needed

4.1.g Focused Reviews
When performance indicator reviews or quality data suggest the need for a focused review of provider performance, our clinical reviewers and compliance auditors initiate and conduct targeted reviews. Issues such as lack of access, limited availability, complaints, quality of care concerns, and potential fraud, waste, and abuse are potential triggers for ad hoc reviews. The reviews are conducted to ensure the safety of enrollees and to ensure best practices and established policies and procedures are followed. Trending and tracking of findings from these reviews can lead to a PIP, provider education, and/or system interventions, which are monitored for performance improvement and sustainability.
4.1.h Satisfaction Surveys
We use satisfaction data to assess enrollees’ experience of care and to identify improvements needed, from their perspective. We conduct CAHPS enrollee surveys and provider satisfaction surveys annually and the results are analyzed through our quality improvement process. We survey our participating network providers annually to obtain their feedback on the service they received in collaboration with Magellan Complete Care. We use the Magellan Complete Care Provider Survey questionnaire to collect provider feedback. Results of our annual provider satisfaction surveys incorporate feedback from network participants on satisfaction of available providers, for example:

- Ease of referring enrollees to other practitioners in the network = 95.0%
- Your patient’s ease of access to non-urgent lab and radiology testing = 94.6%
- Your patients’ ease of access to non-urgent behavioral health care = 94.6%
- Magellan Complete Care’s language assistance services (i.e., interpretation, translation services) = 93.4%
- The professionalism of the clinical reviewer(s) = 92.2%

4.1.i Credentialing Policies and Procedures
Magellan Complete Care provider credentialing and recredentialing policies and procedures meet NCQA Health Plan Accreditation standards as well as federal and State standards related to provider credentialing. These policies and standards apply to those providers credentialed by Magellan Complete Care, as well as those credentialed through delegation agreements with health care providers and subcontractors. Please refer to the following for more information:

- [MMA SRC #12, Attachment 1: Credentialing Program Description]
- [MMA SRC #12, Attachment 2: Network Organizational Provider Assessment Policy and Standards]
- [MMA SRC #12, Attachment 3: Provider Network: Ongoing Monitoring Policy and Standards]
- [MMA SRC #12, Attachment 4: Network Practitioner Credentialing and Recredentialing Policy and Standards]

4.2 Two Examples of Continuous Performance Monitoring and Credentialing Committee Evaluation Process
Example 1: Initial credentialing verification for a physician applying for network participation found a single licensing board action relating to wrong site procedures and/or unauthorized procedure. The physicians’ credentials and history were thoroughly reviewed by the Credentialing Committee which approved initial credentialing and began monitoring for any similar pattern or trend.

Subsequently, Magellan Complete Care’s ongoing sanctions monitoring discovered a new administrative complaint filed with the physician’s licensing board, also for a wrong site procedure. The new information was presented to the Credentialing Committee based on a potentially problematic pattern of practice.

As a result of committee discussion, requests were made to the physician for additional information pertaining to the complaints. The provider failed to respond to the Committee’s requests for explanation, despite multiple outreach attempts, and the Credentialing Committee, recommended removing the physician from participation in the Magellan Complete Care provider network.
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Example 2: A behavioral health practitioner, licensed in multiple states and in active practice in Florida, was found by Magellan’s ongoing sanctions monitoring to have received an adverse action on an out-of-state license. Although the practitioner’s Florida license had not been affected, the Credentialing Committee reviewed the practitioner’s explanation of the circumstances of the action and recommended removal from participation in the Magellan Complete Care provider network at that time.

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT AND ITS SUBCONTRACTORS INCORPORATE...

Magellan Complete Care supports AHCA’s decision to make available and promote a streamlined enrollment application – limited enrollment. This limited enrollment is available to professionals who are not enrolled as Florida Medicaid providers and need to complete basic credentialing. This initiative allows a professional to engage with a Medicaid health plan, having met basic credentialing requirements. This option is beneficial if the professional does not intend to participate in the state Medicaid FFS program.

At the time of initial interest, the Magellan Complete Care Network Team encourages eligible professionals to take advantage of Limited Enrollment to obtain a Medicaid ID. In addition to the streamlined application process offered through AHCA, a provider who obtains a Limited or Full Enrollment Agreement with AHCA may be considered to have met the Medicaid Disclosure requirements (42 CFR 455.104, 455.105, & 455.106). Access to Limited Enrollment, via the Florida Medicaid Web Portal, is found via the following link, https://flmmis.com/flpublic/Provider_Provid.

Because Magellan is an NCQA-certified Credentialing Verification Organization, we are required to meet criteria which may duplicate information provided during the Limited Enrollment process, but we always attempt to minimize the duplication of effort for a professional. Since 2013, Magellan Complete Care has built a network of more than 32,245 providers. Limited enrollment represents a valuable tool available to Florida professionals, one that Magellan Complete Care is incorporating into our contracting, provider handbook, and ongoing education communications.

CRITERIA 6: THE EXTENT TO WHICH THE RESPONDENT OUTLINES STEPS THE RESPONDENT...

Since 2016, NCQA and CMS have implemented requirements that health plans engage providers in reviewing and maintaining provider directory data. In compliance with those requirements, Magellan Complete Care utilizes various strategies to collaborate with providers to update their provider data, including asking providers to access magellanhealth.com/provider and update their information. Providers may also certify their practice information between credentialing cycles. Data elements to be updated include address, phone, office hours, availability, specialties, and product participation. This requirement extends to both our contracted network providers and contracted subcontractors.

Whether as part of a credentialing/recredentialing activity or through our online Provider Data Management Change Form, Magellan Complete Care continuously prompts our network of professionals to manage their practice data. Magellan Complete Care’s provider data are captured and maintained in the Integrated Provider Database (IPD), which contains provider demographics, credentialing, and contract-related information. This IPD database is the core repository for the data displayed on the website, and is updated daily, in real time.
Magellan Complete Care captures provider information, such as clinical expertise that 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 extracted 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, Magellan Complete Care reviews the response files to identify any records that require correction for successful transmission to AHCA.

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 validations are performed on all entries and provider types in the provider database to ensure completeness and alignment with documented data requests and state requirements. Findings of inaccurate provider data is updated after verification of the correct information.

We believe timely and accurate information about each provider is essential for enrollee access to care. We use provider information to support provider directories, claims payment, prior authorizations, and enrollee referrals to providers. Examples of this data include: provider demographic information, provider availability, provider credentials, and provider billing information. This policy supports our data validation requirements by confirming the accuracy of provider data by comparing the data to a valid, credible source. We use multiple methods to perform this validation, including credential verification, provider attestation, and periodic audits.

We use the following data sources and data validation steps to confirm and validate the accuracy of provider data:

> Magellan's Provider Gateway application for providers interested in joining the Magellan Complete Care network

> Provider's credentialing/recredentialing application

> Materials and documentation supplemental to the application as submitted by the provider

> Primary and secondary verification sources queried at credentialing events and when new information is received from the provider

> Online Provider Data Change Form available on Magellan's provider website (magellanprovider.com) used by providers to update their information and to ensure accuracy

> Appointment availability information which may be obtained from random outreach calls (as required by customer or regulatory body)

> Provider interaction with our Field Network staff and Provider Support Specialists, who regularly verify and validate provider data
Enrollee services staff validate information as they interact with providers in arranging appointments for enrollees

Enrollee feedback regarding inaccurate provider practice and provider availability information

Written communications from providers indicating changes to their practice data

Provider directory information validated through a combination of primary and secondary source verifications performed by Magellan, provider self-report, and attestation

Practitioner qualifications gathered during the credentialing process match these listings. Verification using primary sources is performed on: education, training, licensure, and specialty board certifications

Facility and organizational provider accreditation status is verified via primary source or provider-supplied copy of accreditation report, letter, or certificate

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

Provider information is revalidated at recredentialing (at least every 36 months), and, as required, whenever a provider submits new information

Practitioners are requested to review and attest to the accuracy of the information displayed on the online provider directory quarterly

Contracts with subcontractors require adherence to all AHCA requirements, which includes those related to the integrity of provider data in those cases where a subcontractor maintains a delegated network of providers. In addition, the audit tool used for the initial pre-delegation assessment and the annual audits thereafter test the “data quality process” of the subcontractor for collecting and maintaining provider information. If any of these audits identify deficiencies or opportunities for improvement, follow up with the subcontractor is held.

Given the importance of this validation, Magellan Complete Care is addressing the need for provider data accuracy through external vendor support to ensure the quarterly validation of data. A Request for Proposal (RFP) is being prepared to partner with a data validation vendor for 2018. This partnership will ensure that 100 percent of our network is continuously validated and, when necessary, data changes are incorporated into all necessary systems. Magellan Complete Care intends to ensure provider demographic and/or participation changes are reported to us at any point during the life of a provider or vendor agreement.

Evaluation Criteria:

1. The adequacy of the respondent’s description of its credentialing and recredentialing criteria, certified credential verification organization processes, and utilization of a third party credentialing vendor.
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2. The extent to which the respondent’s timeframes for processing credentialing applications is more expeditious than the industry standard processing timeline of one hundred twenty (120) days.

3. The adequacy of the respondent’s approach to providing transparency to providers throughout the credentialing and recredentialing processes, including how providers will be informed at each step of the application process.

4. The extent to which the respondent uses information from provider complaints, monitoring, and recommendations from its Quality Improvement Committee in its recredentialing process.

5. The extent to which the respondent and its subcontractors incorporate the Agency’s streamlined credentialing capability (via promotion of limited enrollment) in its credentialing and recredentialing processes.

6. The extent to which the respondent outlines steps the respondent and its subcontractors will take to ensure provider demographic or participation status changes are reported to the plan in-between credentialing cycles.

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.
MMA SRC# 13 – Value Based Purchasing (Regional):

a. The respondent shall describe the continuum of value-based purchasing (VBP) contractual arrangements available for providers, delineated by primary care, specialty care and hospital-based care.

b. The respondent shall describe the volume of contracts it expects to implement or maintain through a VBP arrangement each year for each of the next five (5) Contract years, delineated by primary care, specialty care and hospital-based care.

c. The respondent shall include specific outcomes it expects to see throughout the life cycle of the VBP continuum, delineated by primary care, specialty care and hospital-based care.

d. The respondent shall describe specific VBP arrangements it intends to implement and/or maintain in an effort to promote the Agency’s goals, delineated by primary care, specialty care and hospital-based care.

Response:

OVERVIEW

The State of Florida and AHCA are committed to supporting enrollee engagement and improved outcomes through the development of value-based purchasing (VBP) contractual arrangements for providers. Magellan Complete Care is committed to those same goals, as part of our strategy to drive delivery system transformation and the development of alternate delivery models for integrated biopsychosocial care delivery and care management for Serious Mental Illness (SMI) enrollees. Transformation of the provider reimbursement model toward value-based payment is a critical element to support those goals. However, we also recognize that transformation must be done in collaboration with our provider partners and AHCA, and must reflect provider readiness for change. The continuum of value-based purchasing arrangements, and the prioritization of providers targeted for those arrangements reflected in Magellan Complete Care’s value-based purchasing strategy is intended to support that transformation and continually improved health and outcomes for our SMI enrollees.

During Magellan Complete Care’s initial contract period as the State’s SMI specialty plan our primary focus was to expand the network of providers capable of providing integrated physical and behavioral health services to our enrollees. The concepts of fully-integrated physical and behavioral health services for individuals with SMI, though widely accepted as a desirable goal, is still being developed for broad usage across large populations. We have worked diligently to educate providers on best practices in dealing with SMI; requirements for the integrated treatment and management of physical and behavioral health comorbidities; and establishing patterns of engagement between SMI enrollee and non-behavioral health providers to overcome the nationwide patterns of low primary care utilization by individuals with SMI. That work continues. However, we now believe the provider community has achieved a level of transformation that will allow us to begin engaging our provider partners in value-based contracting arrangements to drive improved outcomes for our enrollees and AHCA. In support of those goals, we have developed a range of value-based contracting alternatives with a goal of working collaboratively with our provider partner to build trust while continuing to improve results. Magellan Complete Care is only in the 2nd year of full
measurement to create baseline. We believe this creates a launchpad for how we want to move forward.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT HAS PROVIDED THE CONTINUUM OF VALUE-BASED PURCHASING ARRANGEMENTS...
Magellan Complete Care’s strategy for value-based purchasing arrangements is specifically tied to our goals for delivery transformation to support our fully-integrated care delivery and management model for our SMI enrollees, with our provider partners as active participants in that process. It reflects our detailed understanding of current provider network capabilities and gaps that we believe must be addressed to enhance the delivery system’s ability to support improved outcomes for our enrollees. This includes incentive programs to encourage creation of integrated physical health (PH) and behavioral health (BH) sites of care that are equipped to address the complex PH-BH needs of our enrollees; comprehensive programs for fully-integrated care for enrollees with targeted illnesses; and, shared incentives to drive improvements in outcomes, with particular focus on preventable events. These transformation goals support our Integrated Care Case Management Model (ICCM), with identification and development of provider partners to support the needs of our enrollees.

Our proposed value-based reimbursement programs include:

> Primary care capitation, which is already being used for a number of our providers
> Global capitation
> Bundled case rate

These programs encompass all provider types identified by AHCA, including primary care, specialists, and hospitals. However, the programs directed at each are aimed at achieving specific outcome improvement goals we have identified for each type of provider, and therefore include different types of reimbursement to achieve those goals. Each proposed program also reflects differing accepted practices within each type of provider, provider readiness for change, and provider willingness to accept outcomes risk for our complex enrollees.

The timing of initiatives and the continuum of value-based purchasing (VBP) contractual arrangements that we are proposing are specifically directed at continuing to drive delivery system transformation in support of improved outcomes for our SMI enrollees. They are also reflect current AHCA contracting requirements and restrictions, and are at least partly driven by current our current contracted provider reimbursement arrangements. We also believe that movement toward more and more complex VBP models is an evolutionary process, as we work collaboratively with our provider partners to design programs to achieve the targeted improvements for our enrollees and all key stakeholders, and which support success for both providers and AHCA programs.

For several of the programs we already are negotiating terms for proposed arrangements, while in other instances timing and acceptance by providers is longer term. Our goal is to improve enrollee health, recovery and resiliency to support delivery of care with improved outcomes in lower acuity, more appropriate care settings, where both physical health and behavioral health are integrated to support the SMI enrollee’s unique needs.
The continuum of VBP reimbursement that we propose for our providers includes:

> Capitation (primary care, specialty care, ancillary services), with additional incentive payments tied to shared savings, quality activities, and outcome improvement
> Global capitation (all services, including facility, pharmaceuticals and ancillaries), with care management/care coordination capitation, and minimum performance requirements
> Bundled case rate, with additional payment for care management/care coordination, and minimum performance requirements

These arrangements are proposed for primary care, specialty care, and hospital providers, as required by this SRC. Our priorities for delivery system transformation, and the continuum of VBP contracting arrangements we are proposing are as follows:

1.1 Phase I: Contract Years One and Two
The initial focus for our value-based programs is directed at improving engagement for primary care services for our enrollees. This includes services delivered by PCPs, pediatricians, and OB/GYNs. Throughout the healthcare industry individuals with SMI have very low rates of primary and preventive care engagement. Though Magellan Complete Care already achieves rates of engagement for enrollees that is more than double that experienced nationwide, we are committed to achieving engagement rates that are at least as high as those for non-SMI Medicaid enrollees. We believe that achieving those higher rates is important for improving health outcomes and reducing preventable events for more acute levels of care. However, we also recognize that, based on our several years of experience working with the Florida provider community, that additional incentives and different forms of reimbursement may be required to encourage providers to fully engage our SMI enrollees who can sometimes be challenging to serve.

In addition to our focus on increasing engagement in primary care, our early focus will be directed at development of targeted “center of excellence” programs focused on specific complex illness categories, such as sickle cell disease. Many of these illness categories drive higher acuity utilization rates and require a more complex mix of services for effective management. Magellan Complete Care has already developed targeted specialty care management programs in a number of areas. As we move forward with the development of our fully-integrated SMI program our goal is to more fully integrate our provider partners in the management of these enrollees through creation of centers-of-excellence which would be reimbursed through value-based arrangements. In fact, we already have pilot programs underway.

The specific programs we propose in each of these areas are as follows:

> Program One: This program is specifically targeted at improving outcomes for those providers in traditional practice settings. Our goal is to incentivize existing PRIMARY CARE, PEDIATRIC, and OB/GYN providers to increase enrollee engagement, improve quality outcomes, and reduce total costs of care.
  >> Program Objective: Provider reimbursement would be tied to increased utilization of primary care and primary behavioral health care by our enrollees with the goal of reducing preventable hospital admissions, readmission and ER use. Provide specific incentives to close targeted
gaps in care. Providers would be required to achieve minimum utilization standards to be eligible to participate in additional incentive payments above their base reimbursement.

>>Value-Based Reimbursement Model: CAPITATION WITH INCENTIVE PAYMENTS tied to TARGETED OUTCOMES and generation of shared savings, with specific activity requirements. Additional incentive payments tied to closure of targeted care gaps for assigned enrollees.

>>Targeted Providers: Primary care providers, pediatricians, OB/GYN

>>Timing: Immediate and year one of contract term. Many current Magellan Complete Care providers receive capitated reimbursement, without outcome incentives. Magellan Complete Care will work collaboratively with providers to design incentive programs that largely focus on potentially preventable hospital admissions, readmissions and emergency department utilization and determine timing for implementation. Incentives will be funded through reductions in enrollee costs of care.

Program Two: Incentivize Integrated PH-BH Primary Care to Increase Enrollee Engagement and Access to Care. Our goal is to encourage the development of fully-integrated (BH and PH) sites of care, particularly targeted at our more complex enrollees with BH and PH comorbidities. This model of care delivery has proven successful in managing the health of enrollees with SMI. However, it requires practice transformation to achieve appropriate levels of integration. Our goal is to drive the expanded development of this model particularly with CMHCs and FQHCs throughout the state.

>>Program Objective: As noted, this program is specifically targeted at our CMHC and FQHC partners which include both PRIMARY CARE AND SPECIALTY PHYSICIANS. Enhance access to fully-integrated primary physical health and behavioral health services in a single site of care, with a goal of increasing engagement in those services and improved outcomes for our enrollees. Providers are encouraged to incorporate use of flexible delivery models, including telehealth, and other emerging solutions.

>>Value-Based Reimbursement Model: CAPITATED monthly payment for care delivery, with additional monthly reimbursement for care management/care coordination. Participating providers must meet minimum requirements for enrollee engagement and service delivery. Providers will become eligible for additional performance-based incentives as those programs are implemented. INCENTIVES WOULD BE TIED TO REDUCTIONS IN ER AND INPATIENT UTILIZATION.

>>Targeted Providers: Behavioral health providers (specialists) and primary care providers. Initially targeting CMHCs and FQHCs.

>>Timing: This program is currently being rolled-out to provider partners throughout the state. We anticipate expansion of this program during the first two years of the contract term.

Program Three: Partner with High-Quality Providers to Create Fully-Integrated Programs for Targeted Disease Categories (Centers of Excellence). This program is targeted at our HOSPITAL partners, with the goal of incentivizing delivery of all care in the most appropriate, cost-effective setting.

>>Program Objective: Establish fully-integrated, comprehensive care and delivery management programs for high-acuity, high-risk enrollees in targeted disease categories (Centers of excellence as supplement to specialty care management programs). The programs would be established in a select number of high-quality hospitals and hospital systems that have
demonstrated expertise in managing specific illness categories with high prevalence among SMI enrollees.

>>Value-Based Reimbursement Model: BUNDLED, CASE-RATE REIMBURSEMENT. Includes front-end enhanced reimbursement for care management and care coordination services. Currently includes minimum outcome and reporting requirements. May incorporate shared outcomes incentives as program experience develops.

>>Targeted Providers: HOSPITALS AND HOSPITAL SYSTEMS

>>Timing: Immediate. Magellan Complete Care has already negotiated its first agreement, and are in the process of evaluating its effectiveness for possible expansion.

1.3 Phase II: Contract Years Three through Five

>Program Four: Incentivize SPECIALTY PROVIDERS to Reduce Preventable ER Usage. Magellan Complete Care recognizes that many of our enrollees have high needs for specialty care, due to their overall complexity. However, we also recognize that specialty providers are often more reluctant to accept value based reimbursement. We propose a program that reimburses specialty providers for overall management and outcomes for our enrollees in specific illness categories which have high prevalence among individuals with SMI (diabetes, CHF, COPD), but which can be managed in non-acute settings.

>>Program Objectives: Reimburse providers to deliver and manage care for our enrollees with a single, non-complex physical health comorbidity, with incentives for delivery of care in the most appropriate setting and service mix (primary care, telemedicine and ER, BH admissions and ALF or other facility types, etc.)

>>Value-Based Reimbursement Model: SPECIALTY PROFESSIONAL CAPITATION, INCLUDING ANCILLARIES AND PHARMACEUTICALS, WITH OUTCOMES INCENTIVES. Incentive payments would be funded through shared savings, and would be tied to reductions in both inpatient and ER use.

>>Targeted Providers: SPECIALISTS

>>Timing: Year four of contract term

>Program Five: Incentivize HOSPITAL Providers to Reduce Preventable Admissions and Readmissions, through reimbursement for entire episodes of care. Our enrollees often require higher acuity services due to the complexity of their conditions. However, that complexity also demands that enrollees are stable and fully able to deal with requirements for after care once discharged. We propose the implementation of a limited number of programs tying hospital reimbursement to specific bundles of care to support our goals in this area.

>>Program Objectives: Program would incentivize providers to deliver care in the most appropriate setting through PAYMENT WHICH BUNDLES MULTIPLE SITES OF CARE. Initial focus on BH admissions and readmissions which are expected to benefit from incentives to deliver care in non-IP settings (e.g., ALFs, IOP, etc.).

>>Value-Based Reimbursement Model: BUNDLED EPISODES OF CARE, prioritized by highest diagnosis categories for Magellan Complete Care readmissions and admissions. Bundle would include multiple sites of care across the care continuum. Reimbursement may also eventually include outcomes incentives.

>>Targeted Providers: HOSPITALS AND HOSPITAL SYSTEMS

>>Timing: Year three of contract term.

Magellan Complete Care is committed to implementing VBP reimbursement solutions across our provider network and across the state. The range of options we propose, and the providers we are focused on engaging reflects our commitment to working with our provider partners to
develop solutions that drive delivery system transformation and improved outcomes for our enrollees.

CRITERIA 2: THE EXTENT TO WHICH THE RESPONDENT HAS PROVIDED SPECIFIC...
Magellan Complete Care’s goal is to have 30% of costs of care (excluding pharmacy) through value based purchasing models across Magellan Complete Care by 2020. We believe this can be accomplished given our experience in other states and our starting point for creation of value-based models with existing providers. Across Magellan Complete Care we currently have approximately 70 percent of enrollees in some form of value-based reimbursement, primarily capitation for primary care which is typically seen as the first step toward for expansive value-based payment programs. Additionally, we have already been working with these providers to strengthen and increase incentives tied to improvements in HEDIS and other outcomes measures. The success of those programs in driving improved results for both HEDIS and EPSDT cause us to be confident that our provider partners will embrace additional value-based programs. We also currently have negotiations under way with both physician and hospital providers to move toward several of the types of VBP models we’ve presented above.

Our goal is to progressively move our providers toward a VBP reimbursement model based on the following timing and expectations for outcomes:

> Short-Term key outcomes and quality drivers
  >> Access to, and engagement in primary and preventive care
  >> Access to, and engagement in condition-specific care and management
  >> Access to, and engagement in care management and transitional care
  >> Access to, and engagement in community based services and supports

> Mid-Term Key Outcomes and Goals
  >> Increase PCP use
  >> Decrease ER utilization
  >> Decrease inpatient and SNF admissions and readmissions

> Long-Term Goals and Vision
  >> Improve enrollee health
  >> Improve enrollee well-being
  >> Increase enrollee recovery and resiliency

Across the Magellan enterprise we currently have 261 contracts paying out under VBP reimbursement models and we are rapidly migrating contracts to this approach. Given that experience, we propose the following mix of VBP contracts by provider type:

2.1 Primary Care
As noted above, our rationale for projections of VBP penetration is based on current rates of capitated reimbursement in this provider category. We also have VBP and delivery transformation proposals that have been discussed with these types of providers, and are currently negotiating those arrangements. We’ve indicated that delivery transformation to facilitate integrated delivery of PH-BH services in a site of care is a top priority for our
organization. Given this emphasis on moving to these new models, we believe our projections for VBP penetration are reasonable.

>Year One (2018): 20 percent  
>Years Two and Three (2020): 25 percent  
>Years Four and Five (2022): 50 percent

2.2 Specialty Care (includes behavioral health)
As noted above, our rationale for projections of VBP penetration is based on current rates of capitated reimbursement in this provider category, specifically focused on behavioral health specialty providers. We also have VBP and delivery transformation proposals that have been discussed with these types of specialty providers, and are currently negotiating those arrangements. We’ve indicated that delivery transformation to facilitate integrated delivery of PH-BH services in a site of care is a top priority for our organization. Our behavioral health providers, particularly our CMHC partners, are an important element of that strategy. Given this emphasis on moving to these new models, we believe our projections for VBP penetration are reasonable. However, we do believe that it might take longer to move other types of specialty providers to these types of arrangement given our low, overall penetration of their practices. However, we do expect that our delivery model may support VBP for other selected categories with higher need among our population (e.g., endocrinologists, cardiologists, etc.).

>Year One (2018): 15 percent  
>Years Two and Three (2019-2020): 20 percent  
>Years Four and Five (2021-2022): 20 percent

2.3 Hospital
As noted above, our rationale for projections of VBP penetration is based on current proposals for VBP and delivery transformation that have been discussed with these types of providers. We have also recently executed one of those agreements for a limited Integrated Behavioral Health Program (IBHP) with one of our key providers. This arrangement will act as a test case for the concepts of the program, allowing us to move to VBP arrangements for additional illness categories and for additional hospitals and hospital system partners as the approach is further refined. Progress toward VBP for hospital providers has been stalled largely due to develop a program which will be acceptable to the AHCA, and which supports current State reimbursement caps. In many instances, this requires renegotiation of existing contracts with these providers. However, based on our experience to date we believe many of our hospital and hospital system providers will be very willing to enter VBP arrangements to provide greater incentives for the management of our very complex enrollees. Our rationale for expansion of these programs reflects this thinking.

>Year One (2018): 5 percent  
>Years Two and Three (2019-2020): 10 percent  
>Years Four and Five (2021-2022): 15 percent

Magellan Complete Care is very committed to working collaboratively with providers, across the care continuum and provider spectrum, to develop provider capabilities and implement incentives and reimbursement programs, consistent with AHCA regulation, limitations and guidelines. Additionally, we are committed to working with providers in the development and
implementation of incentive and reimbursement programs directed at achieving outcomes and performance in multiple settings, including CMHCs, FQHCs, hospitals, and free-standing provider practices (where they can demonstrate required capabilities).

We have indicated the proposed mix of contracts for each key category in the discussion above. We believe these proposed percentages can be supported by work already completed to date. The proposed percentages for primary care/ specialty care reflect a continuation of earlier work developed in 2017 in support of creating integrated PH-BH care delivery solutions, including our Integrated Health Home (IHH) initiative and our Integrated Behavioral Health Program (IBHP), which are either already contracted or being negotiated. In 2016, Magellan Complete Care also initiated a primary care provider incentive program directed and closing gaps in care, as part of our HEDIS/EPSDT/CHCUP improvement initiatives. We expect the reimbursement and incentive models for providers in both our IHH and IBHP model to be fully developed and in place during 2018.

As noted above, development of programs targeting hospital-based providers will take longer to develop, and our projected percentages reflect that reality. As AHCA is aware, we have previously proposed VBP reimbursement programs for some of our existing hospital providers. Approval for those programs will necessitate some re-contracting with those providers to bring reimbursement below the State’s caps. We expect that process to take longer, as indicated by a lower percentage goal assigned to that category.

Beyond those existing initiatives already underway, Magellan Complete Care has proposed a series of Provider Incentive Plans which incorporate an approach to VBP that incorporates specific quality incentives (including HEDIS, EPSDT/CHCUP, and birth outcomes), as well as shared savings incentives directed at reducing costs and preventable events. Those incentive payments are intended to be in addition existing capitated or FFS reimbursement for providers. The details of those and other incentives tied to each of these key areas are described in greater detail in the sections below.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES HOW ITS VBP...
Magellan Complete Care considers VBP as an important tool for driving improved value for our enrollees, the AHCA, and the state Medicaid program. That improved value will result from transformation of the delivery system to more effectively care for the complex SMI enrollees covered by the state Medicaid program. It also will result from the very clear linkages we have established between each of our proposed VBP solutions and improved outcomes tied to priorities defined by the AHCA. Each of the proposed VBP solutions proposed in this SRC response is specifically tied to outcomes in one or multiple areas of focus for AHCA. These include:

> Improvements in clinical outcomes tied to gaps in care (HEDIS, EPSDT/CHCUP, and enrollee care plans)
> Reductions in preventable events (preventable admissions, readmissions, and ER usage)
> Improvements in birth outcomes
> Reductions in costs of care
> Redirecting care to lower cost and more appropriate care setting, including rebalancing LTSS.
Magellan Complete Care’s goal is to support our enrollees in getting the care and services needed, in the timeframes needed, and in a manner which is accessible and convenient, resulting in improved outcomes and lower costs of care. This may mean fewer trips to the emergency room or, less time spent in the hospital. It means getting regular care and services in the physician’s office and clinic, rather than the ER or as an inpatient. When care is required in a more acute setting, it means that care is delivered in the right amounts, and in the appropriate setting that balances length of stay with preventable readmissions.

As noted by the timing of our proposed VBP initiatives, our first, and most immediate priority is implementation of VBP programs that specifically target improvements in targeted quality and outcomes measures. These initiatives tie directly to physician incentive programs we have proposed elsewhere in this ITN response, with incentive payments to be made out of shared savings pools generated through reductions in the costs of care. We believe that these programs will not only drive specific improvements in quality outcomes, but that they will also generate reductions in preventable events by creating greater engagement between primary care, pediatric and OB/GYN providers. We anticipate that these reductions in preventable events and overall utilization of higher acuity services will support reductions in costs that can be shared with our provider partners.

The specific phases of our proposed VBP programs tied to general improvements in quality are as follows (note we discuss preventable events and birth outcomes separately in the sections that follow):

3.1 Specific Targeted Improvements in Outcomes
Phase I:
> Incentivize existing primary, pediatric and OB/GYN providers to increase enrollee engagement, improve quality outcomes, and reduce total costs of care.

> Incentivize integrated BH-PH care delivery and management

> Program Features: These two programs reflect our first phase in moving our providers toward VBP and achieving greater levels of integration for both PH and BH services. Our objective with these programs is to increase engagement for primary care services, while driving improvement in quality outcomes through provider participation in incentive programs paid from shared savings pools. Funding of shared savings pools would be generated through reductions in costs of care, with incentive payments made based on physician performance on key outcome metrics for their specialty.

> Quality Improvement Objectives: Reductions in costs of care; reductions in preventable ER usage; improvements in targeted quality metrics by specialty to meet minimum quality thresholds. Note that the quality metrics proposed for each specialty below are currently recommended, but may be modified based on collaboration and joint decision making with our provider partners.

> Primary Care Quality Improvement Targets: Targets to be set annually. Provider must meet or exceed minimum threshold for shared savings payout.
>>Provider HEDIS measures improvement at or above minimum threshold with 10% improvement in target HEDIS measures annually for years 1 and 2, with 5% annual improvement in years 3 through 5 (target HEDIS measures to be defined annually)
>>Two percent annual reductions in all-cause admissions for assigned enrollees
>>Two percent annual reductions in 30 and 90-day readmissions for assigned enrollees
>>Two percent reductions in ER encounter rates for assigned enrollees
>>10 percent increase in average primary care provider encounter rates in years one and two, with two percent annual increases in years three through five at or above annual target

> Pediatrics Quality Improvement Targets: Targets to be set annually. Provider must meet or exceed minimum threshold for shared savings payout.
>>10 percent improvement annually in years one and two for Early and Periodic Screening, Diagnostic, and Treatment Participation Rate, (EPSDT). Five percent improvement annually in years three through five. Additional one percent improvement annually for the following specific measures
>>Weight Assessment & Counseling for Children (EPSDT/HEDIS)
>>Adolescent Well Care Visit (EPSDT/HEDIS)
>>Screening for substance use (HEDIS)
>>Medication reconciliation (Care gap)

> OB/GYN Quality Improvement Targets: Minimum two percent to five percent improvements in performance for target quality metrics. Performance targets to be set annually. Provider must meet or exceed minimum threshold for shared savings payout. Please note that Magellan Complete Care has separate OB/GYN incentive programs tied to prenatal and post-partum care.
>>Screening for substance use (HEDIS)
>>Screening for sexually transmitted diseases (STIs) (Care gap and HEDIS)
>>Family planning visit (Care gap tied to contraceptive use)
>>Cervical Cancer Screening (CCS) Cervical Cancer Screening (HEDIS)
>>Mammogram (HEDIS)
>>Reductions in overall cesarean section rate
>>Reductions in overall pre-term delivery rate

Phase II: Incentivize specialists and hospital providers to reduce admissions, readmissions, and preventable events

Program Features: The programs we have proposed are specifically targeted at improving outcomes for more acute care, including management of chronic illness. We incentivize both specialty providers and hospitals through bundled payment mechanisms and quality incentives.

Quality Improvement Objectives: Reductions in inpatient and ER utilization and preventable events as well as reductions in costs of care. We also target improvements in quality metrics for management of specific chronic illnesses. Chronic illness quality metrics would be defined and agreed to through collaboration and joint decision making with our provider partners.
>>Five percent annual reductions in inpatient admissions and ER encounters annually in years three through five
>>Three percent annual reductions in all preventable events (admissions, readmissions, and preventable ER use) in years three through five
Five percent annual improvement in target chronic illness HEDIS metrics in year three, and three percent annual improvement in years four and five.

3.2 Progressive Evolution of Reimbursement to VBP:
There are three variations of current contracted reimbursement that Magellan Health, Inc. can build models for: 1) capitation, 2) FFS and 3) non-capitated FQHC with wrap (or bonus payment options for providers). We are still developing programs for bundled payment, which reflects the complexity of bundling care for behavioral health services. However, the organization is committed to continued development of those programs as defined in this section. We describe some of the current elements of our programs below.

3.2.a Capitation
Under capitated contracts, Magellan would support payment to providers for activity or participation in process measures that improve encounter submissions.

a. In year one: provider payment for activity or process measures that improve encounter submissions would be weighted at 90 percent.

b. In year two: Providers paid for quality measures within their specialty type (10 percent).

To measure potential for savings and quality - need evidence that a potential for savings and increased quality exists, e.g., 1) number of members that attribute to the CMHC / Capitated Primary Care Group, 2) number of encounters submitted per attributed member, 3) set benchmarks for expected increase and encounter submission.

3.2.b. FFS
Under FFS contracts, Magellan would support payment to providers for quality performance within their specialty type. Measure targets would be increase in year two and year three. As noted previously, we propose creating provider pools for purposes of generating shared savings payments. Typically those pools would follow local referral patterns, and as a result they are also often instrumental in driving greater levels of collaboration between providers within a geography.

3.2.b.1 FFS FQHC with Wrap
Under non-capitated FQHC contracts, Magellan would support payments to providers within their specialty type similar to that of FFS.

3.3 Provider Pool & Payment Model
Magellan would achieve cost savings through the deployment of efficiency measures (ER visits per 1,000, admissions per 1,000, preventable readmissions by diagnosis). Providers who are participating in the program will fund the pool based on reduction of total cost of care spend and year over year utilization. Magellan will incentivize providers to reduce spending for their defined patient population by offering a percentage of any net savings they realize. Primary care and OB/GYN providers would participate in a shared pool, with allocation between both specialties to be determined. Pediatricians would participate in a separate pediatric pool. Providers would be eligible for payouts from the shared savings pool based on their achievement related to targeted quality improvement metrics. All providers would be required to meet minimum performance improvement goals for their specialty. Depending on how providers score on quality metrics [in aggregate] determines distribution of pool by provider type. Bonuses to providers will pay out semiannually. First payment begins at close of Q2.
Second payment reconciles and pays out final payment at close of Q4 + three months for claims run out.

CRITERIA 4: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES HOW ITS VBP…
Magellan Complete Care’s remaining VBP proposals will all support reductions in preventable events, with our early focus being on reductions in preventable ER usage. However, we hope to quickly move toward bundled payments and bundled episodes of care, which will allow us to target reductions in preventable admissions and readmissions. The specific VBP initiatives and their expected contributions to reductions in preventable events are described below.

4.1 Program One
Primary Care Quality and Engagement Incentives: Magellan Complete Care believes this program will drive reductions in preventable ER usage through increased engagement with primary care. However, the primary focus of that program will be on driving improvements in quality outcomes. Therefore, we are not citing specific reductions in preventable events for these programs.

4.2 Program Two
Incentivize Integrated PH-BH Primary Care to Increase Enrollee Engagement and Access to Care: The goal of this program is to increase overall primary care engagement and associated outcomes

> Targeted Providers: Primary care and primary behavioral health care

> Program Features: This program will focus on the implementation of Integrated Health Homes (IHH) which will combine both physical health and behavioral health services in a single site of care. This model is built on CMS-SAMHSA models for fully integrated care delivery and management. IHH’s have been demonstrated to achieve significant reductions in overall costs of care, with particular benefits for reductions in preventable ER usage. Magellan Complete Care is currently actively negotiating with CMHC and FQHC providers throughout the state for the development of IHHs.

> Quality Improvement Goals: Overall reduction in ER usage; Improvement in overall basket of HEDIS metrics at or above annual minimum threshold. HEDIS metrics to be determined collaboratively in consultation with our provider partners.

4.3 Program Three
Partner with High-Quality Providers to Create Fully-Integrated Programs for Targeted Disease Categories (Centers of Excellence):

> Targeted Providers: Hospitals and hospital systems

> Program Features: Hospital “center of excellence” responsible for all care (physical, behavioral and social supports) for high-risk, high-complexity enrollees with specific targeted diagnoses (e.g., sickle cell, CHF, COPD, etc.). These programs will be designed to complement our specialty care management programs targeted high-risk/high-cost disease categories. Our initial program focus has been on sickle cell disease, which is a disease category that is one of our greatest contributors to preventable events. Magellan Complete Care has already had
preliminary discussions with key providers for the creation of this program. We continue to work with our provider partners and the AHCA to develop reimbursement proposals for this program.

>Quality Improvement Goals: Overall reduction in costs of care; overall reduction in ER usage, I/P admissions, and 30 and 90-day readmission rates. Goals to be set annually, in conjunction with our provider partners.

4.4 Program Four
Incentivize Specialty Providers to Reduce Preventable ER Usage:
>Targeted Providers: Specialists

>Program Features: Specialty professional capitation, with participation in shared savings pool. May include additional capitation for enrollee care management. Our initial specialty targets would be those chronic disease categories which are most common among our SMI enrollees, including diabetes, CHF, and COPD. Participating specialty providers would be responsible for managing the overall care and health of the assigned enrollees, similar to what is done in chronic illness health homes. Magellan Complete Care has already had initial discussions with one of our FQHC partners for implementation of this type of program focused on diabetes.

>Quality Improvement Goals: Overall reduction in costs of care; overall reduction in ER usage for specialty-related diagnoses (e.g., diabetes, asthma, CHF, etc.); improvement in specialty target HEDIS measures at or above annual improvement goals. The goal of this program will be to engage these physician partners in the active monitoring and management of individuals with specific higher-acuity/higher-complexity chronic diseases.

4.5 Program Five
Incentivize Providers to Reduce Preventable Admissions and Readmissions:

>Targeted Providers: Hospitals and hospital systems

>Program Features: This program would be specifically targeted in improving quality outcomes and reducing preventable hospital admissions and readmissions. It would include bundled payments for total episodes of care, including readmissions within specific timeframes post-discharge. Payment bundles would also include costs for transitions of care. Program features would follow similar models in use for Medicare, which we believe will reduce provider resistance. One key difference in our proposed program would be the creation of payment bundles for behavioral health admissions, which are key for Magellan Complete Care achievement of significant reductions in preventable events. As noted in the initial section of this SRC response, we anticipate this program will require lengthy negotiation and development of details with our hospital partners.

>Quality Improvement Goals: This program will specifically target reductions in preventable admissions and readmissions. The program will include specific targeted reductions similar to that for the Medicare program. Metrics will be developed collaboratively with our provider partners.
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

We believe that each of the programs proposed above will be instrumental in driving significant reductions in preventable events for our enrollees. They have been specifically designed to support the targeted reductions we have agreed to as part of our ITN response. These include five to 10 percent reduction in preventable admissions, readmissions, and avoidable ER encounters across all regions over the next eighteen 18 – 24 months. Note that the targets and timeframes for achievement may vary by region.

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES HOW ITS VBP ARRANGEMENTS INCORPORATE...
As noted above, both our current and proposed incentive programs include specific metrics tied to improvement in birth outcomes. These include the delivery of services related to both pregnancy outcomes, reductions in unplanned pregnancy rates, and specific quality improvement activities tied to more routine care that Magellan Complete Care believes are essential for our SMI enrollees. This includes such areas as screening and referral for substance use, and screening for sexually-transmitted diseases (STI), both of which have high prevalence among our SMI enrollees. In addition to the programs described in this SRC response, Magellan Complete Care participates in MPIP program which includes incentive payments for specific activities tied to prenatal and post-partum care. The specific birth outcome oriented provider improvement programs we already have in place or have proposed elsewhere in this response include:

5.1 Existing MPIP OB/GYN Incentives
The following is a brief overview of the incentives for each current program:

OB/GYN Incentive Program: Incentives are tied to provider performance in closing gaps in care for HEDIS rates of ongoing prenatal care, and HEDIS post-partum care (FPC and PPC). Payment is at the appropriate Medicare rate, as determined by the AHCA. Payments to fee-for-service providers are made using an enhanced bundled payment, equivalent to the Medicare rate, for services provided related to each delivery during the payment period.

>Non-Participating providers: providers without a contractual arrangement with the plan are currently excluded from this program.

>Federally Qualified Health Centers (FQHCs): Services provided in an FQHC may not be included in the MMA Incentive Program, regardless of whether or not the service is billed by the FQHC as an FQHC service or by the rendering provider using their own Medicaid ID.

>Rural Health Clinics (RHCs): Services provided in an RHC may not be included in the MMA Incentive Program, regardless of whether or not the service is billed by the RHC as an RHC service or by the rendering provider using their own Medicaid ID.

>County Health Departments (CHDs): Services provided in a CHD may not be included in the MMA Incentive Program, regardless of whether or not the service is billed by the CHD as a CHD service or by the rendering provider using their own Medicaid ID.

>Expanded Metrics and Incentives Tied to Birth Outcomes
In addition to Magellan Complete Care’s existing MPIP program, we are targeting quality improvement in additional areas tied to improving birth outcomes. We propose additional incentive payments to OB/GYNs for the following types of services:

>>Screening for substance use
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

>>Screening for sexually transmitted diseases (STIs)
>>Family planning visit
>>Cervical Cancer Screening (CCS) Cervical Cancer Screening
>>Pap smear
>>Mammogram.

The details of these incentive programs will be developed in consultation with our OB/GYN providers. Note that the incentives for family planning visits are in addition to current incentives for insertion of Long-Acting Reversible Contraceptives (LARCs) post-delivery. Currently, Magellan Complete Care provides reimbursement for immediate post-partum insertion of LARCs. Magellan Complete Care specifically incentivizes providers for placement of LARC by reimbursing for their use outside the delivery bundled payment. This separate payment helps to overcome provider resistance to their use post-delivery, due to their substantial cost. In addition to the other incentives identified above, we propose continuing this program.

Magellan Complete Care maintains a robust care management program for our pregnant enrollees, all of whom are considered high-risk because of their comorbid SMI which can complicate pregnancy and pregnancy outcomes for our enrollees. That program, which is described in detail elsewhere, already achieves low rates of cesarean sections and pre-term deliveries.

However, Magellan Complete Care is committed to continued improvements in outcomes for this program. In addition to our continuing participation in the MPIP program, as noted above, we have included VBP proposals specifically targeting OB/GYN providers. To reiterate, those program features are as follows:

>Program 1: Incentivize existing OB/GYN providers to increase enrollee engagement, improve quality outcomes, and reduce total costs of care.

>>Program Features: This program reflects our first phase in moving our providers toward VBP. Our objective with this program is to increase engagement for primary care services, while driving improvement in quality outcomes through provider participation in incentive programs paid from shared savings pools. Funding of shared savings pools would be generated through reductions in costs of care, with incentive payments made based on physician performance on key outcome metrics for their specialty.

>>Quality Improvement Objectives: Reductions in costs of care; reductions in preventable ER usage; improvements in targeted quality metrics by specialty to meet minimum quality thresholds. Note that the quality metrics proposed for each specialty below are currently recommended, but may be modified based on collaboration and joint decision making with our provider partners.

>>OB/GYN Quality Improvement Targets: Magellan Complete Care is targeting 10% annual improvements in performance on these metric in years one and two, with additional five percent annual improvements in years three through five. Target metrics to be set annually. Provider must meet or exceed minimum threshold for shared savings payout. Please note that Magellan Complete Care has separate OB/GYN incentive programs tied to prenatal and post-partum care. The current target metrics we have identified for this program are as follows:

>>Screening for sexually transmitted diseases (STDs) (Care gap and HEDIS)
>>Family planning visit (Care gap tied to contraceptive use)
>>Reductions in fetal mortality rates
>>Reductions in overall cesarean section rate
>>Reductions in overall pre-term delivery rate

As noted elsewhere in this ITN in our discussion of our programs focusing on birth outcomes, we are proposing the following improvements in birth outcomes as a result of the implementation of the proposed VBP program above as well as other improvements proposed for our care management programs:

> Increase by 10 percentage points, the rate of post-partum visits over a three year period. <<Note that, although still not at desired rates, Magellan Complete Care’s PPC2 HEDIS measure for postpartum care increased from 32.6 percent to 39.17 percent between 2016 (2015 data) and 2017 (2016 data) - a 20 percent improvement.>>

> Increase by 15 percentage points, the use of moderately effective contraception, over a three year period

In addition to the goals noted above related to post-partum care and use of contraceptives, Magellan Complete Care has established specific improvement goals in each of the following areas:

> Reductions in pre-term deliveries. Note that Magellan Complete Care already achieves a low percentage of pre-term deliveries of 2.48 percent, versus 10.4 percent as reported by the Center for Medicaid and CHIP Services and 9.63 percent for all populations in 2015 as reported by the CDC. We are targeting an additional five percent improvement in that performance.

> Increase by 10 percent the percentage of enrollees meeting NCQA standards for prenatal care visits (timeliness and frequency --- first trimester, ongoing)

> Additional 10 percent reductions in cesarean section rates (Leapfrog Group Maternity Care Expert Panel Target of 23.9 percent as identified in Federal Government Healthy People 2020 goals, and 32 percent cesarean section rate in 2015 for all populations as reported by the CDC). <<Magellan Complete Care averaged for all cesarean sections was 28.45 percent of all deliveries between 2015 and 2017>>

CRITERIA 6: THE EXTENT TO WHICH THE RESPONDENT PROVIDES A BREAKDOWN...
Magellan Complete Care’s current reimbursement programs for primary care focus heavily on improvements in HEDIS/EPSDT and gap in care closure. We provide incentive payments to providers for activities tied to closure of those gaps, as well as providing capitated reimbursement to many of our primary care providers for delivery of a predefined bundle of services. These programs are consistent with Magellan Complete Care’s Value Based Payment (VBP) strategy which focuses on population health management and improving quality of care while efficiently delivering clinical and provider services that engage our members, reducing overall costs and increasing member satisfaction, all of which are specifically tied to engagement with primary care. In addition, we are heavily focused on supporting providers operationally and financially as they transition from fee for service to value based payment or Alternative Payment Models (APM). We meet each of the providers “where they are.”
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Through participation in Health Care Payment and Learning Action Network (HCP-LAN) and using Alternative Payment Models White Paper principles, we refined our internal approach to develop our strategy. We have incorporated key features cited by HCP-LAN into our model to ensure that compensation arrangements are powerful enough to affect changes in provider behavior. To implement our strategy, we provide network facilitated support and guidance for practice transformation and the development of skills required to adopt value based payment models and strategies that support the highest quality delivery. By delivering healthcare value (high quality/low cost = value), we secure member, provider, and system satisfaction on financially solid compensation models. We are committed to:

>Engaging and empowering providers, with a heavy focus on primary care providers, throughout engagement in reimbursement and delivery design and delivery system evolution

>Achieving provider participation early on by aligning value to better outcomes, employing transparency to ease compensation shift, and creating meaningful incentives to support behavior change.

Across the Magellan Health enterprise we are actively engaged in converting existing and new providers to VBP models, and we are well underway towards meeting our goal for VBP arrangements to comprise of 50 percent or more of total healthcare spend by the end of year three (3). Similar initiatives are taking place throughout Magellan, where, as an example, 26 percent of all medical spend in Pennsylvania currently comes from VBP arrangements.

Magellan has VBP experience with multiple business segments and provider types. Magellan has invested significant resources toward developing our capabilities to support providers in value-based reimbursement models and offerings, with the belief that value based incentives improve quality and reduce cost. We have experience implementing VBP arrangements targeting primary physical and behavioral care, OB/GYNs and pediatricians within Magellan Complete Care Florida. Utilizing this experience, we promote a variety of innovative compensation models with our contracted provider networks.

We support our primary care providers with engagement that focuses on education and participation to invest in and adopt new approaches to care delivery and set targets for applicable metrics. We invest deeply in people and processes to ensure capabilities and know-how to support additional payment models including: bundled payments, centers of excellence, provider stratification, risk adjusted capitation, and two-sided risk sharing.

Magellan Complete Care intends to continue to drive toward development of value-based solutions with our existing Florida provider partners. We will build on existing programs discussed above while we simultaneously build new and expanded programs to increase the number and mix of providers we have under these programs.

Magellan Complete Care is actively engaged in the development of VBP programs based on the models described in Priorities one and two above. We have recently initiated an arrangement with BayCare Health System for an Integrated Behavioral Health Program (IBHP). This program will be a bundled case rate with front-end enhancement to support non-traditional
enrollee support services, including: enrollee outreach, community based services, community navigation, hospital in-reach, jail in-reach, and care coordination.

In addition to our IBHP, Magellan Complete Care is also currently working with our CMHC and FQHC provider partners to design programs features, reimbursement models, and incentive programs for the creation of Integrated Health Homes (IHH), built on the model described earlier in this document. We are very excited about both of these programs and believe they are important steps forward toward delivery system change and improved outcomes through VBP.

7. THE EXTENT TO WHICH THE RESPONDENT DESCRIBES THE APPROACH IN SHARING...

Magellan Complete Care has robust, existing programs for information sharing with our providers, with many of them specifically tied to targeted improvements in outcomes for our enrollees. Providers have online access to enrollee utilization, care management and gap-in-care information for their patients through our Provider Portal and our Connect Portal. Information on those systems also includes enrollee risk stratification, engagement in care management, and descriptions of engagement activities and care management services. That information is extremely useful to providers, for assessing patient risk, and needs for interventions to achieve targeted outcomes improvements. Both of these systems support the provider with detailed information required by providers to manage the outcomes improvements for each of the programs we propose. Additionally, through our Physician Advisory groups we also collaborate with our provider partners to design new data and reporting required to support program goals. In addition, as part of each of the programs we have identified, we will develop and provide monthly/quarterly reporting on progress against program goals and targets for improving performance. Providers currently receive regular reporting on HEDIS/EPSDT gaps in care for their patients. This tool has proven useful for our provider partners in assisting us in achieving significant improvements in these areas. We will use that model to expand data and information sharing for these programs as well.

In addition, Magellan Complete Care seeks to work with all our providers as partners in delivery system transformation, the development of improved capabilities to deliver integrated BH-PH care, and to drive improved outcomes for our enrollees and AHCA. In pursuit of those goals, we incorporate the following key elements in support of our VBP programs and providers:

> Assess and Plan Total spend for each Alternate Payment Methodology: This is based on calendar previous year paid claims. Denominators are representative of the total dollars paid for the respective revenue codes listed by line of business, state and/or market. Numerators are representative of the total dollars paid to the respective eligible providers for revenue codes listed.

> Provider Education: We have developed a proprietary education program, the Magellan Learning Alliance, a program to support provider education through a facilitated educational curriculum, and will continue to enhance and grow the program in conjunction with these efforts.

> Readiness Assessment: We assess current and future provider readiness. To accomplish setting a baseline and developing the pace and rate of change for providers, we provide a
pre-go-live assessment of provider readiness through a web-enabled survey tool which assesses provider (type) overall ratings along a spectrum of population health and clinical management maturation. The assessment outcomes data is shared with the Advisory Committee(s) and our development team to inform design and implementation.

>Provider Advisory Council: The power of provider ownership is a key to success in value based care delivery models and providers are central to cost control and quality improvement efforts. Providers should be closely involved in planning groups and executing initiatives targeted in cost control and quality improvement areas. We develop and actively facilitate Provider Advisory Councils to represent and influence initiatives in behavioral health, Primary Care Physicians (PCPs) and specialty providers.

>Operational Support>>: The Provider Team works with providers to integrate clinical programs and practice workflows. Providers receive quality, total cost of care and pharmacy data on a routine basis (monthly, quarterly, and semi-annually) and receive support in interpreting and using the data to support VBP.

>Methods and Frequency for Collecting and Providing Quality Performance Data>>: Based on the assessment of provider readiness, we establish agreements with individual providers and provider groups that include the physician advisory supported, agreed upon quality metrics and efficiency measures. We develop and configure metric reports through the acquisition and reporting of specific data sources. For PCP/physician groups/behavioral health providers, the data sources include: historical monthly utilization (medical, behavioral and pharmacy), enrollment and encounter data, financial statistical data, medical record review, and other supporting on-site data and documentation required from our contracted providers. For utilization metrics, we provide providers performance data no less than quarterly. For quality metrics such as HEDIS, Medication Assisted Treatment, and Potentially Preventable Events (PPEs) reductions in negative outcomes, the metrics are shared annually. While performance on key metrics themselves are only calculated quarterly, the results are available continually through the provider portal. Additionally, gaps in care which assist the provider in improving against these targets are updated no less than monthly.

Magellan Complete Care’s focus in designing, developing and implementing VBP programs is initially directed at report development (quarterly), population health managers engage primary care practices to review reports and share best practices.

Partnering with local population health medical leadership and provider support staff (PSS) or population health staff 1) plays a critical role in supporting primary care practices as they focus on population health management efforts and value based care, 2) supports physicians and their office staff as they engage in population health management transformation through practice transformation, performance management support, and the clinical programs, 3) successfully services, monitors and grows strategic relationships with physicians to influence decision making and enable achievement of the triple aim- improved patient experience, improved clinical quality, and reduction in total cost of care.

Analytic support for training client clinical teams and building receptivity to quality performance data. Support monitoring and interpretation of performance, including targeted opportunity analysis and recommendations for high impact opportunities to improve network performance.
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Comprehensive review of performance across lines of business, including insights into trend drivers, and recommendations to support improved quality and cost performance. Analytic support to conduct drill down or targeted analyses related to insights delivered as part of the monthly medical economics or quarterly clinical performance review.

On-going access to analytics support team for broad ranging support in monitoring, understanding and driving program performance, to include:

> “Deep dive” opportunity identification across operations, network, quality, medical economics, clinical and population profile analysis.

> Reporting capabilities and access to create reports, dashboards and analyses (vs. run and manipulate existing.)

> Structured analyses of program performance, including comprehensive quarterly performance reports.

> Structured evaluations (where data and volume of experience can support it) of clinical program impact and outcomes.

> Facilitation of Quarterly Value meetings with an emphasis on outcomes, clinical savings and opportunities for performance enhancement.

Magellan Complete Care is committed to a strong, collaborative partnership with our Florida provider community. Each of the programs detailed above continue to evolve as provider capabilities and capacity to serve our SMI members within the requirements and expectations for integrated, whole-person care. We will continue to work with AHCA, our provider partners and our members to refine these programs and enhance member outcomes and satisfaction.

Our value-based purchasing incentive arrangements are aimed at achieving the same common goals:

> Achieving specific, targeted quality and service outcomes for our members
> Delivering coordinated and timely access to care through integration of the physical and mental health delivery systems
> Reducing the fragmentation of services often experienced by this population
> Reducing medical and behavioral emergency department visits and inpatient hospitalizations
> Enhancing the ability of enrollees to self-manage their care
> Transforming management processes to ensure a sustainable approach for continuous and comprehensive care (e.g., producing and using data to make improvements in access, service, and outcomes)

Evaluation Criteria:
1. The extent to which the respondent has provided the continuum of value-based purchasing arrangements available to network providers, delineated by primary care, specialty care and hospital-based care.

2. The extent to which the respondent has provided specific percentages of overall contracts, delineated by primary care and specialty care and hospital-based care, that it intends to implement or maintain through some type of VBP arrangement for each of the five (5) Contract years, including a rationale for the intended percentages.

3. The extent to which the respondent describes how its VBP arrangements incentivize quality improvement, including specific outcomes it expects at each stage on the continuum.

4. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for reduction of potentially preventable events.

5. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for improvement of birth outcomes.

6. The extent to which the respondent provides a breakdown of specific VBP strategies employed with its current network of primary care providers.

7. The extent to which the respondent describes the approach in sharing specific data elements with providers under a VBP arrangement and the level of respondent support offered to providers to ensure progression along the continuum of VBP arrangements.

**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.
E. DELIVERY SYSTEM COORDINATION

MMA SRC# 14 – General HEDIS Performance Measures Experience (Statewide):

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. Include in table format, the target population (TANF, ABD, dual eligibles), 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 of three (3) states for the last two (2) years.

The respondent shall provide the data requested in Exhibit A-4-b-2, MMA Performance Measurement Tool (10-2-2017) to provide results for the following HEDIS measures:

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits); and
- Timeliness of Prenatal Care.

Response:

OVERVIEW

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.

Magellan Complete Care enrollees also currently include a large number of children and young adults under the age of twenty-one. At its inception, it was not expected that the plan would be serving a significant numbers of enrollees in these age groups. 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). In teens, more frequently than in younger children, addiction, bipolar disorder, and less often, early onset schizophrenia 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 15,000 enrollees under age 21. Of those enrollees, one percent are ages 5-6, 18 percent are ages 7-12, 46 percent are ages 13-17, and 35 percent are 18-20. The complexity of addressing the physical and behavioral health needs of 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. Adverse Childhood Experiences (ACEs), which include 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, experiencing an incarcerated household enrollee has become a significant area of focus for Medicaid agencies and SAMHSA. Childhood experiences of this type can exacerbate existing illness and make engagement, treatment and management more challenging.

Recognizing these complicating issues and limitations, along with the importance of EPSDT/CHCUP services, Magellan Complete Care launched a comprehensive effort to develop targeted programs to close child and adolescent HEDIS gaps in care and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT/CHCUP) requirements, as well as other child/youth specific care management and quality interventions. In fact, Magellan Complete Care
just recently developed a newly enhanced set of programs for children, adolescents and young adults. Those programs not only focus on routine and preventive care, testing, immunizations and diagnostics for children, but also include programs focused on issues such as polypharmacy use and inappropriate prescribing of psychotropic medications in this population.

Magellan Complete Care has also put significant resources into developing a focused and well-designed program of interventions targeted at closing gaps in care for CHCUP (EPSDT). The program includes direct outreach to both enrollees and providers, and integration of HEDIS initiatives with all enrollee-facing teams within our health plan. Magellan Complete Care has also established provider incentive programs for pediatricians specifically focused on performance around key outcomes metrics, and in fact, we are proposing expansions to those incentives as part of this ITN response. Magellan Complete Care is committed to meeting and exceeding benchmarks for HEDIS and Contract-related metrics for children and adolescents.

In addition to the large number of children being served by Magellan Complete Care, we also currently have roughly 17 women enrollees of child-bearing age, with a reported 1,055 deliveries in 2016 according to the HEDIS specifications for identifying delivery for the Prenatal and Postpartum Care measure. As with our other enrollees, each of these individuals has one or more SMI’s and may have one or more physical health comorbidities. Additionally, while our overall enrollee population has rates of co-occurring substance use (16 percent, a rate higher than the general Medicaid population), our pregnant enrollees have rates that are even higher than that, at 25 percent. For these reasons, Magellan Complete Care treats all pregnant enrollees as high-risk, and attempts to enroll them in integrated case management, which focuses on closing gaps in care, as well as managing enrollee care to achieve healthy birth outcomes. The results of these programs are impressive for a Medicaid population, and especially so for a population with SMI. Magellan Complete Care currently has a cesarean-section rate of less than 29%, compared to a nationwide average cesarean-section rate among all populations, of 32% in 2015 according to the CDC. Our goal is to continue to reduce those rates to a level closer to the WHO (World Health Organization) goal of 15%. Magellan Complete Care’s pre-term delivery rate of less than 2.5 percent, compared to nearly 9.63 percent pre-term birth rates among all populations nationwide in 2015, according to the CDC. We have also shown more than a 40 percent increase in LARC usage through our targeted enrollee and provider interventions.

Magellan Complete Care is committed to supporting AHCA and Federal goals of improving birth outcomes for pregnant enrollees and women of child-bearing age, which includes ensuring that enrollees are receiving timely prenatal and postpartum care according to nationally endorsed evidence-based guidelines. Our goal is to increase access to prenatal care to ensure healthy mothers and infants, including limiting the risks of pre-term birth, unnecessary cesarean sections (early elective deliveries), and low-birth weight babies.

We have well-designed programs, and a specific care management team focused on all enrollees who are pregnant or who have recently delivered, with program goals aligned with the AHCA’s HEDIS focus on Timeliness of Prenatal Care, Frequency of Prenatal Care, and Postpartum Visit. Additionally and importantly, Magellan Complete Care programs also include screening for pre- and post-partum depression, drug and alcohol use, and smoking, in addition to other high-risk physical health comorbidities that are common in our SMI enrollees.
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 enrollees 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 enrollee 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.

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. Our HEDIS performance for reporting years 2015, 2016, and 2017, for the service period 7/1/14 – 12/31/16, is provided below for key measures related to children and pregnant enrollees, 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 Frequency of Ongoing Prenatal Care and Timeliness of Prenatal Care were reportable for HEDIS 2015. Additionally, Well Child Visits (3-6 years) was first reportable for HEDIS 2017, as the eligible population did not meet minimum denominator size for reporting for HEDIS 2016. Finally, because Magellan Complete Care requires a diagnosis for SMI for enrollment, our youngest enrollees are age 5, and we do not report Childhood Immunization Status or Well-Child Visits in the First 15 Months.

None of these measures met AHCA’s minimum benchmark of 50th percentile, however, the average percentage point improvement per measure when comparing HEDIS 2016 and 2017 was
13.09 points. In comparison, the top three MMA plans in Florida by membership had a decline of nearly one percentage point on average across the same measures, as illustrated in [MMA SRC #14, Attachment 1: HEDIS Improvement 2015-2016].

> Childhood Immunization Status (Combo 3), HEDIS 2015=NR, HEDIS 2016=NR, HEDIS 2017=NR
> Well-Child Visits in the First 15 Months (6 or more), HEDIS 2015=NR, HEDIS 2016=NR, HEDIS 2017=NR
> Immunizations for Adolescents (Combo 1), HEDIS 2015=NR, HEDIS 2016=26.11 percent, HEDIS 2017=54.01 percent*
> Well Child Visits (3-6 years), HEDIS 2015=NR, HEDIS 2016=47.62 percent
> Adolescent Well Care Visits, HEDIS 2015=NR, HEDIS 2016=23.26%, HEDIS 2017=35.04 percent*
> Frequency of Ongoing Prenatal Care (>=81%), HEDIS 2015=0%, HEDIS 2016=32.60 percent, HEDIS 2017=40.15 percent
> Timeliness of Prenatal Care, HEDIS 2015=55.30 percent, HEDIS 2016=59.37 percent, HEDIS 2017=64.48 percent*

*= year over year change

Additionally, Magellan Complete Care made significant improvements in seven additional HEDIS and EPSDT/CHCUP measures relevant to improving primary and preventive care for the population of focus for this SRC. None of these measures met the 50th percentile benchmark, however, the average percentage point improvement per measure when comparing HEDIS 2016 and 2017 was 6.52 points.

> Child Health Check-up Participation Rate, FFY 2014-15=23 percent, FFY 2015-16=28 percent*
> Child Health Check-up Screening Rate, FFY 2014-15=25 percent, FFY 2015-16=35 percent*
> Weight Assessment and Counseling for Children (BMI Assessment), HEDIS 2016=50.61 percent, HEDIS 2017=66.18 percent*
> Weight Assessment and Counseling for Children (Nutrition), HEDIS 2016=49.96 percent, HEDIS 2017=61.07 percent*
> Weight Assessment and Counseling for Children (Physical Activity), HEDIS 2016=47.69 percent, HEDIS 2017=58.15 percent*
> Appropriate Treatment for Children with Upper Respiratory Infection, HEDIS 2016=77.94 percent, HEDIS 2017=81.43 percent*
> Postpartum Care, HEDIS 2016=32.60 percent, HEDIS 2017=39.17 percent*

Across all the measures cited above, the year over year improvement when comparing HEDIS 2016 to 2017 was 10.69 percentage points due to the significant efforts dedicated to this population.

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)
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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 four 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 enrollees 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 enrollees 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, 2017.

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 Middle and East Regions exceeded the performance of Magellan Complete Care. Of note, the East Region rate for Frequency of Prenatal Care exceeded the 95th percentile, National 2016 Medicaid Quality Compass, and their Timeliness of Prenatal Care exceeded the 75th percentile.

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 a more developed community-based outreach strategy. Their algorithm to identify race/ethnicity to better tailor 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. Health disparities in birth outcomes involving race are well known, for example, and leveraging Shared Health’s expertise will assist Magellan Complete Care in continuing to improve on our HEDIS Timeliness of Prenatal Care, Frequency of Ongoing Prenatal Care, and Postpartum Visit. 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 existing community presence to reach a greater percentage of our enrollees, especially our children and adolescent enrollees, through events that focus on the entire family.

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 key 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 and outcomes results for our enrollees.

We provide our completed Exhibit A-4-b-2, MMA Performance Measurement Tool 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 scores which can be submitted, were unclear. For this response, we have submitted only results for Magellan Complete Care of Florida and have not submitted an additional spreadsheet to include the two contracts referenced in the related HEDIS/CAHPS sections of this ITN, as they are not applicable for the HEDIS metrics in this SRC.

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 70 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 60 points as described below:

Exhibit A-4-b-2, MMA Performance Measurement Tool (10-2-2017), provides for forty-two (42) opportunities for a respondent to report prior experience in meeting quality standards (seven (7) measure rates, three (3) states each, two (2) years each).

For each of the seven (7) measure rates, a total of 5 points is available per state reported (for a total of 105 points available). The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean and 1 point 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 1 point 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 60 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 105 points, the final score will be 60 points (100%). If a respondent receives 95 (90%) of the available 105 points, the final score will be 54 points (90%). If a respondent receives 10 (10%) of the available 105 points, the final score will be 6 points (10%).
MMA SRC# 15 – Failure to Meet 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.

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits); and
- Timeliness of Prenatal Care.

Response:

OVERVIEW
Magellan Complete Care is committed to meeting and exceeding benchmarks for HEDIS and Contract-related metrics for children, adolescents and pregnant women. We have focused teams in both our quality and care management (from UM to CC/CM) organizations that are specifically directed toward these important enrollee groups. We also have a focused and well-designed program of interventions targeted at closing gaps in care for EPSDT (CHCUP), which includes direct outreach to both enrollees and providers and integration of HEDIS initiatives with all enrollee-facing teams within our health plan. Magellan Complete Care has also established provider incentive programs for pediatricians and OB/GYNs, specifically focused on performance around key outcomes metrics and we are proposing expansions to both of those programs as part of this ITN response. We believe expansion of our incentive programs in these areas will support our goals of driving continued improvement for the affected populations.

CRITERIA 1: THE EXTENT TO WHICH THE DESCRIBED EXPERIENCE DEMONSTRATES THE ABILITY TO IMPROVE QUALITY...
Magellan Complete Care currently serves roughly 17,000 women of child-bearing age, with a reported 1,055 deliveries in 2016 according to the HEDIS specifications for identifying delivery for the Prenatal and Postpartum Care measure. Magellan Complete Care is committed to supporting AHCA and Federal goals of improving birth outcomes for pregnant enrollees and women of child-bearing age, which includes ensuring that enrollees are receiving timely prenatal and postpartum care according to nationally-endorsed evidence-based guidelines. Our goal is to increase access to prenatal care to ensure healthy mothers and infants, including limiting the risks of pre-term birth, unnecessary cesarean sections (early elective deliveries), low-birth-weight babies, and rates of unintended pregnancies. We have well-designed program and a specific care management team focused on all enrollees who are pregnant or who have recently delivered, with program goals aligned with ACHA’s HEDIS focus on Timeliness of Prenatal Care, Frequency of Prenatal Care, and Postpartum Visits. Additionally and importantly, Magellan Complete Care programs also include screening for pre- and post-partum depression, drug and alcohol use, and smoking, in addition to other high-risk physical health co-morbidities that are common in our SMI enrollees. In contrast to risk stratification for most managed care maternity programs, our care
management model treats pregnancy, in and of itself, as an indicator for placing our enrollees in the Ultra High Risk category. This classification makes these enrollees eligible for our maternity program, regardless of any other risk factors. We also focus specifically on our pregnant enrollees for medication therapy management (MTM). As an example, we track the utilization of Category X medications, which are contraindicated drugs to avoid during pregnancy. When women in this category are identified, that information is forwarded to Whole Health Rx for pharmacist intervention and management.

Magellan Complete Care is also currently serving a large number of children and young adults under the age of twenty-one. At its inception, it was not expected that the plan would be serving a significant numbers of enrollees in these age groups. 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). In teens, more frequently than in younger children, addiction, bipolar disorder, and less often, early onset schizophrenia may manifest. As we have discussed elsewhere in our response individuals with SMI have significantly lower rates of engagement with primary care, increasing the likelihood that these individuals will have related gaps in care.

The distribution of our population of enrollees under twenty-one (21) years of age speaks to these trends. In fact, we know, based on Magellan Complete Care’s analysis of our own pediatric population, that the presence of asthma or diabetes, along with SMI, increases the risk and complexity of managing outcomes for the enrollee. Magellan Complete Care serves approximately 19,500 enrollees under age 21 for the FL ITN program. Of those enrollees, 1 percent are ages 5-6, 18 percent are ages 7-12, 46 percent are ages 13-17, and 35 percent are 18-20. The complexity of addressing the physical and behavioral health needs of 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 suffer from conditions such as asthma and diabetes. Adverse Childhood Experiences (ACEs), which include physical, sexual and emotional abuse; physical and emotional neglect; mother treated violently; substance misuse within the household; household mental illness; parental separation or divorce; and, incarcerated household enrollee has become a significant area of focus for Medicaid agencies and SAMHSA. Childhood experiences of this type can exacerbate existing illness and make treatment and management more challenging.

Recognizing these complicating issues and limitations, along with the importance of EPSDT/CHCUP services, Magellan Complete Care launched a comprehensive effort to develop targeted programs to close child and adolescent HEDIS gaps in care and EPSDT/CHCUP requirements, as well as other child/youth-specific care management and quality interventions.

Though our HEDIS performance on the measures listed in this SRC do not currently meet AHCA’s minimum 50th percentile target, all measures have improved from HEDIS 2016 to HEDIS 2017. Due to our extensive efforts to improve the health of these populations, and the progress made
in accomplishing those goals, additional measures related to primary and preventive care for children and adolescents have also been cited in our response. We believe our success in improving outcomes in those areas reflect the extensive effort we have made to improve the health of these populations. Increased engagement with primary care is also an important goal for Magellan Complete and is instrumental for managing the overall health of our enrollees.

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 enrollees. 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 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 community presence to reach a greater percentage of our enrollees.

Magellan’s partnership with Shared Health began in 2016, when we partnered with their organization to successfully bid for the managed Medicaid Long Term Services and Supports (LTSS) contract for 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 2017. 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 to assist in developing our population health management framework, and as an expert advisor for HEDIS quality improvement.

Magellan Complete Care believes that the addition of Shared Health is an important partner in these efforts. When combined with the deep understanding of our population and the key mechanisms that drive successful interventions that we have developed in the past several years to this specialty health plan, we can continue to achieve significant improvements in quality and outcomes results for your enrollees.

1.1 Our success in improving quality and remediating failures
As the current Florida Serious Mental Illness (SMI) specialty plan contractor, Magellan Complete Care began accepting enrollees with SMI for delivery and management of fully integrated physical health and behavioral health care in July 2014. Our HEDIS performance for reporting years 2015, 2016, and 2017—for the service period 7/1/14 to 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 Frequency of Ongoing Prenatal Care and Timeliness of Prenatal Care were reportable for HEDIS 2015. Additionally, Well Child Visits (three-six years) was first reportable for HEDIS 2017, as the eligible population did not meet minimum denominator size for reporting for HEDIS 2016. Finally, because Magellan Complete Care requires a diagnosis of SMI for enrollment, our youngest enrollees are age five, and we do not report Childhood Immunization Status or Well-Child Visits in the First 15 Months. None of these measures met AHCA’s minimum
benchmark of 50th percentile, however, <<the average percentage point improvement per measure when comparing HEDIS 2016 and 2017 was 13.09 points>>. In comparison, we note that the top three MMA plans in Florida by enrollment had a decline of nearly one percentage point on average across the same measures, as illustrated in [MMA SRC #15, Attachment 1: HEDIS Improvement 2015-2016].

>Childhood Immunization Status (Combo 3), HEDIS 2015=NR, HEDIS 2016=NR, HEDIS 2017=NR
>Well-Child Visits in the First 15 Months (6 or more), HEDIS 2015=NR, HEDIS 2016=NR, HEDIS 2017=NR
>Immunizations for Adolescents (Combo 1), HEDIS 2015=NR, HEDIS 2016=26.11 percent, HEDIS 2017=54.01 percent*
>Well Child Visits (3-6 years), HEDIS 2015=NR, HEDIS 2016=NR, HEDIS 2017=47.62 percent
>Adolescent Well Care Visits, HEDIS 2015=NR, HEDIS 2016=23.26 percent, HEDIS 2017=35.04 percent*
>Frequency of Ongoing Prenatal Care (>=81 percent), HEDIS 2015=0 percent, HEDIS 2016=32.60 percent, HEDIS 2017=40.15 percent
>Timeliness of Prenatal Care, HEDIS 2015=55.30 percent, HEDIS 2016=59.37 percent, HEDIS 2017=64.48 percent*

* = year over year change

Additionally, Magellan Complete Care made significant improvements in seven additional HEDIS and EPSDT/CHCUP measures relevant to improving primary and preventive care for the population of focus for this SRC. None of these measures met the 50th percentile benchmark, however, the average percentage point improvement per measure when comparing HEDIS 2016 and 2017 was 6.52 points.

>Child Health Check-Up Participation Rate, FFY 2014-15=23 percent, FFY 2015-16=28 percent*
>Child Health Check Up Screening Rate, FFY 2014-15=25 percent, FFY 2015-16=35 percent*
>Weight Assessment and Counseling for Children (BMI Assessment), HEDIS 2016=50.61 percent, HEDIS 2017=66.18 percent*
>Weight Assessment and Counseling for Children (Nutrition), HEDIS 2016=49.96 percent, HEDIS 2017=61.07 percent*
>Weight Assessment and Counseling for Children (Physical Activity), HEDIS 2016=47.69 percent, HEDIS 2017=58.15 percent*
>Appropriate Treatment for Children with Upper Respiratory Infection, HEDIS 2016=77.94 percent, HEDIS 2017=81.43 percent*
>Postpartum Care, HEDIS 2016=32.60 percent, HEDIS 2017=39.17 percent*

Across all the measures cited above (both those in the SRC, and the additional measures), the year-over-year improvement when comparing HEDIS 2016 to 2017 was 10.69 percentage points due to the significant efforts dedicated to this population.

1.2 Maternity Quality Improvement Programs

Though pregnancy is not considered a disease state, the unique requirements for pregnant enrollees, who all have at least one SMI, demand the kind of unique and dedicated focus Magellan Complete Care maintains to identify and manage our enrollees who are pregnant or may become pregnant. These programs also serve to support tAHCA’s goals to improve birth outcomes, and
have led to the significant improvements we have seen in our HEDIS measures for Frequency of Ongoing Prenatal Care, Timeliness of Prenatal Care, and Postpartum Visit.

****Trade secret as defined in Section 812.081, Florida Statutes****

Our pregnancy program leader, [redacted], [redacted], [redacted]

The Magellan Complete Care Mother Baby Connections Program is a perinatal program that is a specialized and integral element of the AHCA-approved and NCQA-compliant Care Coordination and Complex Case Management Program that addresses the special needs of pregnant women with serious mental illness who also experience a higher incidence of substance misuse/abuse and lifestyle risks, such as obesity and tobacco use, and co-morbid psychiatric illness, and chronic conditions. Our 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 engage pregnant enrollees in recommended prenatal care and reduce and prevent pregnancy-related complications and complications related to the pregnant enrollee’s mental illness and treatment. Program goals of the Mother Baby Connections program include:

> Delivery of a healthy, full-term infant of 37 weeks or greater
> Stabilization of co-morbid/co-occurring conditions during the pregnancy for 80 percent of enrollees enrolled in our maternity program, as evidenced by decreased or absence of inpatient utilization
> Optimizing the health and safety of the pregnant enrollee by promoting compliance with at least 10-14 prenatal visits, based on gestational age and stage of pregnancy as promoted by ACOG guidelines.
> Compliance with at least one postpartum appointment within 56 days of delivery
All Magellan Complete Care enrollees who are pregnant are considered high risk and are encouraged to enroll in the program.

Early identification of pregnant enrollees and early prenatal care is critical to improve the outcome of high-risk pregnancy. Since many pregnancies are unplanned or not known to us, Magellan Complete Care utilizes multiple tools and strategies to identify pregnant enrollees in order to engage them in prenatal care as early in pregnancy as possible.

****Trade secret as defined in Section 812.081, Florida Statutes****

This allows active outreach by our ICCM team to support enrollees in engaging for recommended prenatal care.

Targeted engagement activities for enrollees identified as pregnant also occurs through:

Magellan Complete Care employs both provider and enrollee incentives (financial and non-financial) to encourage evidence-based practices aimed at improving all birth outcomes. Enrollees are offered incentives to enroll in the Mother Baby Connections Program, and for completion of their first and/or all recommended prenatal care visits and postpartum visit.
1.3 Physician Incentive Program
In addition to the enrollee incentive programs noted above, Magellan Complete Care has focused its MMA Provider Incentive Program (PIP) on performance targets for the HEDIS Frequency of Ongoing Prenatal Care (FPC), included in this SRC, and for Postpartum Care (PPC). As part of our response to this ITN we have proposed expansion of those programs to include additional indicators of maternal health tied to healthy birth outcomes.

1.4 Child and Adolescent Quality Improvement Programs
Magellan Complete Care’s programs for child/adolescent-related HEDIS measures and EPSDT/CHCUP incorporate education, motivational and emotional support, easy to read materials, and individual resources in alignment with the enrollee’s conditions, needs, and readiness for change. Our core enrollee outreach and education process incorporates analytics that result in identification of the enrollee’s caregiver, and conduct outreach and education through multiple enrollee interactions that include live calls and face to face visits.

Our program promotes self-management through personalized enrollee interventions, and requires inter-departmental referrals and community connections to meet the enrollees’ needs. Magellan Complete Care recognizes the importance of the provider’s role, and focuses significant efforts through our Provider Support Specialist team to reinforce guidelines, deliver gap in care and performance reports, and collaborate on enrollee outreach and improvement initiatives. Finally, enrollees with special health care needs are offered case management assistance to coordinate their extensive medical specialty and behavioral needs.

Efforts to outreach and educate all eligible enrollees/guardians about the importance of EPSDT/CHCUP begin at the time of enrollment and continue throughout enrollment in the plan. Outreach and education efforts include:

>Initial Outreach and Education focused on completion of the initial Health Risk Assessment (HRA) that includes a discussion of benefits, and education about the benefits of required services. When available, we use previous medical records to identify the status of required visits and enrollee gaps in care. Our enrollee handbook and Welcome Kit are promoted and include information about the importance and timing of required visits and immunizations

>Ongoing Outreach and Education includes population-based communications, such as enrollee newsletters and information on our enrollee website. Other targeted outreach focuses on enrollees with one or more gaps in care and include live calls to help schedule appointments and face to face home visits to help schedule appointments. Gap in care information has been incorporated into our customer service processes and care management programs to ensure we are educating and assisting enrollees at every touch point.
Magellan Complete Care also has a robust program to notify providers of their enrollee’s gaps in HEDIS/EPSDT/CHCUP and other care. Magellan Complete Care also provides trainings for providers to engage and assist them in efforts to increase HEDIS/EPSDT/CHCUP compliance rates. Those trainings include: discussion of services included in HEDIS/EPSDT/CHCUP; HEDIS/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 HEDIS/EPSDT/CHCUP services, lead screening and immunizations.

For high-volume providers, Magellan Complete Care uses rolling 12-month data to benchmark for each key HEDIS/EPSDT/CHCUP indicator. We also conduct annual medical record reviews on a randomly selected sample of providers to check for the presence of required HEDIS/EPSDT/CHCUP visit and HEDIS/EPSDT/CHCUP screening elements. These reviews, which are conducted by our Provider Services staff, are used as an additional training opportunity to work directly with providers and their staff where deficiencies are noted.

Magellan Complete Care is committed to continuing this upward trend in our outcomes performance. We have executive sponsorship at the CEO and CMO level to continue to invest significant resources to meet AHCA’s benchmarks. However, we also endorse the University of Southern Florida’s (USF) recommendations that enrollees with SMI require intensive community-based and specialized services. 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 believe these factors influence results for your population, and should be taken into account in assessing performance against the National Medicaid 50th percentile. We are committed to continued improvement to demonstrate the value of our fully-integrated biopsychosocial care and care management model in driving clinical and quality outcomes for individuals with SMI that meet or exceed those for the general Medicaid population.

We have invested the time, effort, and resources to understand your enrollee population, and have built and implemented a comprehensive program that will improve as a result of our commitment to ACHA’s program outcome monitoring and measurement for your enrollees who are living with SMI.
CRITERIA 2: THE EXTENT TO WHICH THE DESCRIBED EXPERIENCE DEMONSTRATES THE ABILITY TO IMPROVE QUALITY...EVEN WHEN HEDIS OR CONTRACT-REQUIRED STANDARDS WERE MET...
Magellan Complete Care is fully committed to ongoing improvement of all child and pregnant enrollee HEDIS rates identified in this SRC. As stated above, we did not meet the 50th percentile benchmark on the measures cited in this question, however, our efforts above are extensive and the improvements as a result are significant, with the average percentage point improvement of 13.09 points when comparing HEDIS 2016 rates against HEDIS 2017.

We have also described our extensive care management and outreach programs to address these issues, and believe our partnership with Shared Health will continue to push us to additional improvements. As noted earlier, HEDIS 2017 rates for the Tennessee Middle and East Regions exceeded the performance of Magellan Complete Care. Of note, the East Region rate for Frequency of Prenatal Care exceeded the 95th percentile of the National 2016 Medicaid Quality Compass, and the Timeliness of Prenatal Care exceeded the 75th percentile.

Finally, and of note, Magellan Complete Care’s efforts have been expansive. Because of the needs of our SMI population, our Mother and Baby Connections Program considers all pregnant enrollees as high-risk and program initiatives are directed to all. This commitment will continue, even once we achieve AHCA benchmarks in the prenatal and postpartum measures of focus for this SRC.

Similarly, Magellan Complete Care HEDIS improvement efforts were broadly focused in 2016, and continue to be broadly focused for all of our HEDIS initiatives, including those supporting the HEDIS measures in this SRC. Our HEDIS initiatives target all Magellan Complete Care enrollees with at least one gap in care, regardless of whether these measures met AHCA member benchmarks.

As described earlier in this response, Magellan Complete Care’s pregnant and child/adolescent population is qualitatively and quantitatively different in its needs than other populations, and our significant efforts to improve outcomes for both physical and behavioral health have been equally and meaningfully applied, even when HEDIS Contract-required standards were met. Magellan Complete Care believes in the promise of 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.
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MMA SRC# 16 – HEDIS (Data Sources) (Statewide):

The respondent shall describe:

a. The extent to which it has used the following standard supplemental data sources for its HEDIS and other performance measures:
   - Laboratory result files;
   - Immunization data in State or county registries;
   - Transactional data from behavioral healthcare vendors; and
   - Current or historic State transactional files in a standard electronic format.

b. The extent to which it has used supplemental data from electronic health record vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures.

c. The extent to which it has experience reporting HEDIS measures collected using Electronic Clinical Data Systems.

Response:

OVERVIEW
Magellan Complete Care is committed to the accurate measurement of all clinical and health related outcomes for our enrollees, including those measured through HEDIS and CHCUP/EPSDT reporting. Use of supplemental data sources increases the accuracy of our reported rates, as well as increasing the efficiency of our data collection processes, which is important for our providers, and important to reduce overall administrative costs. We currently use many standard supplemental data sources for HEDIS reporting, and are working toward increasing our knowledge, infrastructure, and capacity to better leverage electronic health record (EHR) and Electronic Clinical Data Systems (ECDS) data which is becoming increasingly important for reporting HEDIS measures for which claims and encounter data are not adequate. Regarding transactional data from behavioral healthcare vendors, Magellan Complete Care is a fully-integrated behavioral health and physical health plan, and does not contract with other behavioral healthcare vendors.

Magellan Complete Care currently maintains electronic interfaces (batch and real-time) for the following types of data:

> Laboratory results files from our two largest providers, Quest and LabCorp
> Immunization data from the Florida SHOTS (State Health Online Tracking System) registry
> Current and historic state transactional files in a standard electronic format
> Electronic health record (EHR) interfaces
> Health Information Exchange (HIE) interfaces

Magellan Complete Care recognizes the value of automated solutions to enhance care delivery and care coordination; improve quality and outcomes monitoring, reporting, and gap closure; reduce duplication of services; and enhance clinical outcomes and customer service for
enrollees, providers, and the AHCA. We are also committed to continually exploring opportunities for expanded use of these important tools.

CRITERIA 1: THE EXTENT TO WHICH THE DESCRIBED EXPERIENCE DEMONSTRATES THE ABILITY TO USE STANDARD SUPPLEMENTAL DATA SOURCES...

Magellan Complete Care recognizes the value of leveraging standard supplemental data sources to secure the most accurate measurement of the health of our enrollee population. Additionally, our dedication to continuous quality improvement is reflected in the significant investments we have made across quality initiatives which are reliant upon the accurate identification of enrollee gaps in care. Our standard supplemental data sources include lab result files from Quest and LabCorp, which comprise a portion of our total lab data; immunization data from the Florida SHOTS registry; daily hospital census data derived from the HIE Electronic Notification System (ENS); and data from State transactional files. These data are aggregated with claims and encounter data, and self-reported assessment data and used in several ways including:

> Quality monitoring and management, inclusive of annual and in-period HEDIS and EPSDT/CHCUP performance measures and clinical outcomes metrics.

> Population health management and analysis, to support risk stratification, population health assessment, and program effectiveness analyses.

> Quality improvement initiatives, by accurately identifying enrollee care gaps to support for appointment scheduling and participation in specific programs such as home visit opportunities.

> Care management, through a robust system of care management and analytic dashboards to monitor enrollees and results within specific clinical areas. Our care management system receives data from each of the data sources discussed in this section, as well as information captured through completion of health risk assessments (HRA) and enrollee engagement to identify gaps in care and support the enrollee and provider in closing those gaps.

> Provider data sharing and profiling, to ensure our providers have accurate patient gap in care reports and an accurate assessment of their performance on HEDIS and EPSDT/CHCUP measures.

The use of supplemental data sources is critical for accurate, timely, and efficient monitoring and management of quality and outcomes, but is also important for day-to-day operations. Magellan Complete Care uses all of the standard supplemental data sources referenced in the criteria for this SRC, with the exception of interfaces to behavioral health vendors. As noted previously, Magellan Complete Care is a fully-integrated physical health and behavioral health plan and adjudicates all behavioral claims on the same system as medical claims, ensuring that behavioral health claims are already fully integrated into Magellan Complete Care data sets. As such Magellan Complete Care does not require integration with vendors for carved out behavioral health services. We describe our use of each of these standard supplemental data sources below.
1.1 Laboratory Results Files
Magellan Complete Care incorporates electronic data files from both of 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. These data populate our enhanced version of ImpactPro, one of our key analytic engines for HEDIS care gap identification which drives the targeted enrollee outreach files for quality, care management, customer service, and QI vendors; the development of patient care gap lists and provider performance reports which are available to providers via online access and manually generated to be shared by our Provider Support Specialist staff; and, which feed population segmentation and stratification for care management and outcomes and clinical analysis.

These data are incorporated into our file feeds to our certified HEDIS vendor (Verscend), throughout the year to generate our in-period HEDIS performance scores, and of course, for annual HEDIS reports which are validated by our certified HEDIS vendor (MetaStar) and submitted to NCQA, and to AHCA’s External Quality Review Organization (HSAG).

1.2 Immunization Data in State and County Registries
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.

1.3 Current or Historic State Transaction Files in a Standard Electronic Format
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. This data is used to verify enrollment and determine eligible populations (i.e. administrator denominators for HEDIS and EPSDT/CHCUP measures). This data also provides us with some information on the enrollee’s eligibility classification, which can be useful care management. We also extract data from the State’s Health Information Exchange (HIE) on a daily basis, primarily for identification of admissions, discharges and transfers (ADT). This information is critically important for care management, but also informs our HEDIS inpatient intervention, which identifies and closes enrollee care gaps, including A1c or LDL tests, while enrollees are in the hospital. These data are also 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.
Data from these source systems is made available across our fully-integrated technology platform that supports customer service and enrollee engagement, quality monitoring and management, enrollee segmentation and stratification, provider engagement, care management, and our analytical engines for evaluation of enrollee interventions and effects on enrollee outcomes.

****Trade secret as defined in Section 812.081, Florida Statutes****
This data supports 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.

Engagement of providers in the sharing of quality and outcomes data, and information to drive gap closure is also essential to drive continued improvement in quality metrics and clinical outcomes. Magellan Complete Care captures data from selected providers through their sharing of EHR data, capture of traditional claims and encounter data, and the sharing of data with 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 management, in combination with quality outreach and gap reporting provided at regular intervals.

CRITERIA 2: THE EXTENT TO WHICH THE DESCRIBED EXPERIENCE DEMONSTRATES THE ABILITY TO USE SUPPLEMENTAL DATA...
Our goal is to significantly expand the use and automation of EHR solutions in succeeding years. We believe this is an important, viable and cost-effective solution for HEDIS hybrid measures, but that the applicability is also broader year around, particularly for our capitated providers. Capitated providers are responsible for submitting zero-dollar claims for all encounters, allowing Magellan Complete Care to capture critical clinical and encounter data. By having timely and accurate electronic access to EHRs, we can support more rapid and accurate capture of those data for both quality and care management activities. To that end, Magellan Complete Care is proposing new incentives for our capitated providers who increase their submission of zero-dollar claims, and for whom we achieve reductions in total costs for their enrollees. We believe this will not only increase the accuracy of encounter and quality reporting, but will also be important for reducing preventable events.

Medical record requests for providers are significant year round, but particularly in the first half of every year during annual HEDIS production. Recognizing the importance of medical record data, and the burden on our providers, as well as the administrative burden on our plan,
Collection and abstraction of medical record data is essential for accurate reporting of hybrid HEDIS rates for all measures, but particularly for measures such as Controlling Blood Pressure (CBP) and for all the HbA1c results measures for Comprehensive Diabetes Care (CDC). We are currently working on plans to expand access and engage providers again for this access for HEDIS 2018.

We are committed to decreasing the administrative burden associated with medical record collection, and also support the increased data accuracy that electronic data can add to HEDIS measurement. From a quality perspective, electronic data systems help providers deliver more consistent and evidence-based care. To that end, in our Magellan Complete Care’s current certified HEDIS vendor through HEDIS 2018 production is Verscend, which is not currently a qualified eMeasure vendor. However, our new, certified eMeasure vendor will be in place by the start of AHCA’s new contract.

CRITERIA 3: THE EXTENT TO WHICH THE DESCRIBED EXPERIENCE DEMONSTRATES THE ABILITY TO REPORT HEDIS MEASURES...

NCQA defines possible ECDS data systems to include enrollee eligibility files, EHRs, clinical registries, HIEs, administrative claims systems, electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS), and certified disease/case management registries. NCQA further indicates that data in ECDS may be structured, semi-structured, or enrollee-reported within the legal health record.

As noted previously, Magellan Complete Care has experience in using these types of data to manage quality and outcomes, outreach and engagement of enrollees, and management of care and the enrollee experience. We currently use ECDS data from the following key sources:

> Laboratory data
> Immunization registries
> Provider clinical systems (EHRs)
> Florida Health Information Exchange
> State transaction files
> Electronic data captured by our certified HEDIS quality engine

Our quality, care management, and enrollee engagement systems of delivery and management are very data-driven, allowing careful targeting of enrollees and enrollee care with the greatest
Magellan Complete Care continues to evaluate all potential sources for use of automated data and systems for the capture of quality and outcomes data, and in support of our ongoing enrollee population analysis and evaluation of the impact of care delivery and care management interventions. Robust, and accurate data collection and ease of access is critical for delivering on our goal of demonstrating the value of our integrated model for improving the health of individuals with SMI. To that end, we currently have a company-wide initiative underway for the creation of a “data lake” to support automated data capture, reporting, and analysis.

Magellan Complete Care is fully committed to increasing the use of accurate and timely electronic data from multiple sources. Our review and refinement of strategies in support of this goal is a continuous and ongoing part of our efforts to increase administrative efficiency, enrollee and provider outcomes, and satisfaction for all our enrollees and partners.

Magellan Complete Care is also committed to automating the capture and reporting of accurate data from all our provider partners and from State agencies or other key stakeholders. Automation will reduce the administrative burdens on our partners, limit duplication of services, reduce care costs, and enhance reporting for care delivery and management. Magellan Complete Care already provides for robust sharing of enrollee clinical and care management data with providers through our online Provider and Connect portals, which allow them to view care plans, gaps in care, care management activities, and utilization. The availability of additional data to enhance these portals will go a long way toward integrating the provider as a critical element in our model of care. We are enthusiastic about continued enhancements to our systems and partner interfaces in support of these goals.

**Evaluation Criteria:**

1. The extent to which the described experience demonstrates the ability to use standard supplemental data sources (lab result files; immunization data in State or county registries;
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transactional data from behavioral healthcare vendors; and current or historic State
transactional files in a standard electronic format) for HEDIS and other performance
measures.

2. The extent to which the described experience demonstrates the ability to use
supplemental data from electronic health record (EHR) vendor systems and data from
certified eMeasure vendors for HEDIS and other performance measures.

3. The extent to which the described experience demonstrates the ability to report HEDIS
measures collected using Electronic Clinical Data Systems (ECDS).

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.
MMA SRC# 17 – Coordination of Carved Out Services (Statewide):

The respondent shall describe its approach to coordinating services that are not covered by the respondent, but are covered by Florida Medicaid either through the FFS delivery system (e.g., behavior analysis services, prescribed pediatric extended care) or through a prepaid dental plan.

Response:

OVERVIEW
SMI Specialty Plan enrollees are eligible to receive some services that may not be the financial responsibility of Magellan Complete Care. These are referred to as carved out services and are covered by Florida Medicaid or the prepaid dental plan according to traditional AHCA fee-for-service guidelines. SMI Specialty Plan enrollees can obtain covered AHCA carved out services from any AHCA enrolled provider qualified to render the services. Magellan Complete Care ensures that enrollees have a seamless and easy-to-navigate system for coordination between Florida Medicaid and carved out services.

Our fully integrated model of care – the Integrated Health Neighborhood approach – is a conduit for any caregiver within the Integrated Health Neighborhood to convey and ask for Magellan Complete Care resolution for the need of care for an enrollee. If a service need is identified (covered and non-covered), our Health Services staff coordinate with service providers and community organizations to meet the needs of the enrollee.

We integrate the providers into the community aspect of our Integrated Health Neighborhood approach. 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 is to link enrollees with the appropriate service providers to address ongoing needs.

Please refer to [MMA SRC #17, Attachment 1: Member Journey Touch Points] that illustrates the Integrated Health Neighborhood approach of accessing care for an enrollee.

Enrollee engagement is critical for Integrated Health Neighborhood coordination. This process starts by sending the Medicaid Enrollee Handbook and Welcome Kit, initiating a new enrollee welcome call immediately upon enrollment, and the completion of a health risk assessment (HRA). For those enrollees that are identified as critical, we engage Integra ServiceConnect, Inc., in select communities, to engage the “difficult to engage” enrollees because of no working phone or viable address. From the results of the HRA, this specific information allows us to coordinate carved out services when needed.

Reciprocal coordination with all care providers, including carved out services, is critical in addressing enrollee needs. Through reciprocal communication, we now have the ability to identify the full continuum of care needs for the enrollee and coordinate their care as documented in their care plan.

Magellan Complete Care is in the process of establishing a solution for an enrollee-centric coordination of all Integrated Health Neighborhood care and support resources through a
sophisticated software solution that would allow coordination and exchange of the full continuum of care, which extends well beyond a referral mechanism.

CRITERIA 1: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES EFFECTIVE AND EFFICIENT PROCESSES...
All new enrollees receive the Medicaid Enrollee Handbook and Welcome Kit, a welcome call, and a request to complete the HRA. In addition, all enrollees have access to Magellan Complete Care’s enrollee portal and Customer Service. Throughout this process, we capture contact information for continued enrollee engagement.

Care coordination begins with the assessment of the enrollee’s level of functioning across many areas including medical, behavioral, social, and environmental needs, including where the enrollee is receiving services. If unmet needs are identified, e.g., a referral to behavior analysis services is needed, the Care Coordination team works in collaboration with the behavior analysis service providers and community resources to address those needs. This may include assisting the enrollee with referrals to providers, coordinating with providers to address unmet needs and adjust the treatment plan and/or service plan to account for the identified unmet needs.

The Care Coordination team completes referrals for non-covered services (residential treatment, FACT, etc) with the enrollee’s consent. The enrollee is provided education on available non-covered services and an AUD obtained for the external service provider with enrollee’s permission. These activities are tracked by Care Coordination staff within TruCare, our case management application system providing clinical systems support for case management, utilization management, health promotion, care transition, disease management, and care coordination tasks. 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. The actual referral for the non-covered services is completed based on provider requirements and stored in TruCare. The referral is sent to the provider outside of TruCare by phone/fax/email.

Our Care Coordination team is responsible for contacting the enrollee, the enrollee’s family/caregiver/legal guardian, the treating physician, and other providers as needed to collaboratively address identified health and care coordination needs. Upon referral or during outreach activities, the Care Coordination team ensures that key stakeholders are included in offering ongoing input into the assessment and care planning process as appropriate for each enrollee risk level. Magellan Complete Care employs extensive internal resources to support the enrollee’s continuum of care needs as identified during new enrollee engagement or as the enrollee engages in care, such as through physical and behavioral health care services, ED, inpatient, and outpatient services. Internal resources include, but are not limited to Integrated Care Case Management (ICCM), Health Guides, Peer Recovery Navigators, Wellness Specialists, and our enrollee and provider call center.

All of our employee resources are trained to have knowledge to connect supports within the Integrated Health Neighborhood, including carved out services. Our role is to coordinate the referral for needed continuum of care services, including carved out services along with the reciprocal care needs. Once the referrals are made, and the enrollee is engaged with all service providers to support the care plan, our Care Coordination staff monitors enrollee progress through
periodic contact with the enrollee and provider. ICCM procedures address facilitation of enrollee referrals to resources and follow-up processes to determine whether enrollees act on referrals.

In addition, Care Workers, a non-clinical staff member, are 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 protective health information, assisting with referrals, scheduling appointment, scheduling case conference meetings and assisting with other basic care coordination activities.

The Magellan Complete Care Discharge Planning team actively monitors inpatient admissions and has established relationships with inpatient and community-based setting staff. The goals of our Discharge Planning Program are focused on decreasing ED utilization, decreasing hospital admissions/readmissions, increasing compliance with the provider’s discharge plan, increasing use of appropriate pharmaceutical choices/combinations, increasing appropriate community referrals, and increasing enrollee satisfaction and health outcomes. Magellan Complete Care provides case management and care coordination with all service delivery systems including carved out services that serve enrollees in Magellan Complete Care.

As mentioned above, the Care Coordination team completes referrals for non-covered services (residential treatment, FACT, etc) with the enrollee’s consent.

1.1 Examples of Coordination of Outpatient Behavioral Health Services

Example 1: Our enrollee is a 37-year-old male with multiple hospitalizations secondary to substance use disorder. Diagnoses includes crack cocaine abuse, cannabis abuse, alcohol abuse, and major depressive disorder. On his last in-patient admission, the Discharge Health Guide contacted the managing entity to coordinate State funded treatment for substance use and co-occurring illnesses. The Discharge Health Guide completed the referrals and application for residential treatment with the enrollee’s consent. The enrollee’s application was accepted and the managing entity offered placement at Better Way of Miami, which offers residential placement for an average length of stay of 60 days. Better Way of Miami also provides enrollees with housing support services, vocational rehabilitation, and continued services to assist with transition out of residential treatment. The Discharge Health Guide and the Integrated Care Case Manager (ICCM) coordinated the transition of care during the in-patient stay and the enrollee was able to transition directly from the in-patient facility to the residential program where a bed was waiting on the day of in-patient discharge. Two days after discharge, the Discharge Health Guide and the ICCM visited the residential program to ensure the enrollee’s transition was successful. He completed the residential treatment program and has remained free of in-patient admissions for the last 90 days.

Example #2: Our enrollee is a 25-year-old male with numerous hospital visits due to mental illness and has a history of alcohol abuse, prescription medication abuse, and cocaine abuse. The enrollee was in a car accident and needed medication for pain; however, he eventually began taking his medication for recreational purposes and selling them to his friends to purchase cocaine. The enrollee attempted to enroll in the Drug Abuse Foundation (DAF) Residential Program with the assistance of the Care Coordination Team several times. After attempting to complete the program with DAF and relapsing several times, he was ultimately able to complete the program. This enrollee has been clean and sober for over 90 days and shortly after graduation went on to obtain employment and sober housing with Project Soar.
CRITERIA 2: THE ADEQUACY OF THE RESPONDENT’S APPROACH TO ENGAGE AND EDUCATE ENROLLEES…

Magellan Complete Care strives to engage and educate the enrollee of all available resources within the Integrated Health Neighborhood that can seamlessly activate recovery. Recovery Oriented Systems of Care (ROSC) illustrates the vast network of resources available to individuals living with SMI. We have learned as the SMI Specialty Plan, the importance of enrollee education related to all aspects of these systems of care, including benefits coverage and how to effectively engage these resources.

Customer Care Specialists inform enrollees about extra benefits and special programs. After-Hours staff are available from 7:00 pm to 8:00 am on weeknights. During the weekends, they respond Friday from 7:00 pm - 8:00 am Monday morning. Enrollees can also call Florida Medicaid Choice Counselors at 877-711-3662 or 866-467-4970 (TTY only), for questions about additional services that are covered directly through the Medicaid State Plan.

In addition, Personal Health Guides are also assigned to help enrollees. Health Guides also engage and educate enrollees in understanding covered benefits and the connections to support services in the community. ICCM and Wellness Specialists are also part of the Care Coordination team and available to educate enrollees in understanding the difference in covered benefits and those available through other Medicaid delivery systems.

We understand the unique value and critical role that Peer Recovery Navigators offer in enrollee education and engagement within the Integrated Health Neighborhood. Magellan Complete Care has invested internal resources and expanded external peer network development throughout Florida. The unique lived experience within each Peer Recovery Navigator, allows a personal level of engagement that connects enrollees with the neighborhood resources, including carved out resources.

Enrollees are instructed to find additional information through the Medicaid Enrollee Handbook and Welcome Kit or from the Magellan Complete Care of Florida website under the “Enrollees” tab, then “My Plan” tab to find “Benefits” or “Expanded Benefits”.

For a carved-out service such as behavioral analysis, enrollees will find a link on our website to AHCA’s website for a link to behavioral analysis service providers on the AHCA’s Recipient Support webpage under “Additional Reference Information”. Prescribed Pediatric Extended Care (PPEC) centers allow Medicaid eligible children from birth through age 20 with medically-complex conditions to receive continual medical care in a non-residential setting. When approved, children can attend a PPEC up to a maximum of 12 hours per day while receiving nursing services, personal care, developmental therapies, and caregiver training. For PPEC, enrollees or caregivers will find a link on our website to go to AHCA’s website for more information.

We also explain to enrollees that we also provide additional support through community engagement offering an online community resource guide to share the information of more than 4,000 non-traditional providers available as support resources across the state, located on our website on the “Enrollees” tab front page called “Community Resources”. Magellan Complete Care staff explain to enrollees and their caregivers that routine, out of service area care is not
covered by Magellan Complete Care. Only ED services are covered. Enrollees are instructed to call Magellan Complete Care at 800-327-8613 if they need care while out of the service area.

Eligible enrollees are encouraged to call Magellan Complete Care Enrollee Services at 800-327-8613 from 8:00 am – 7:00 pm or 711 for Telecommunications Relay Service for individuals with a hearing or speech disability. Customer Care Specialists are ready to answer questions and educate enrollees in understanding the difference in benefits covered by Magellan Complete Care and those benefits available through other Medicaid delivery systems, including benefits, in Lieu of Service benefits, carved out services, and additional expanded benefits. Magellan Complete Care’s enrollee portal is an effective resource for our enrollees, which includes the Enrollee Handbook for an overview of benefits.

The Magellan Complete Care CareLine is available to enrollees 24 hours a day/7 days a week and is staffed by Licensed Clinicians (RNs and Mental Health Professionals). Enrollees can call the CareLine anytime for assistance for symptom education, provider referrals, general health and wellness related questions, or if they are experiencing a crisis or emergency of any kind. Staff taking the call have access to a host of resources to assist the enrollee in obtaining the necessary information or in getting to the right level of care for their symptom management.

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT’S DESCRIPTION INCLUDES A PROCESS FOR...
Since the inception of the SMI Specialty Plan, Magellan Complete Care has provided comprehensive, high-quality, communications for staff, providers, and subcontractors, which includes information on services available through other Medicaid delivery systems.

Magellan Complete Care has invested in, and developed a comprehensive, well-structured onboarding program that is anchored by a comprehensive training plan through the Magellan Learning Alliance, an online learning system, for Health Services team members. The training program is custom designed to thoroughly assess knowledge, communication, and professional skills.

The training and oversight program ensures full compliance with care coordination and utilization management program requirements, including a learning module on covered services, which includes carved out services. We provide an overview of all of the services covered by fee-for-service.

Our provider and subcontractor training begins with an orientation to our network, the SMI Specialty Plan covered and non-covered services, our model of care, the Integrated health Neighborhood approach, enrollee population, and billing and claims payment processes. We also utilize our Provider Newsletter, website, conference calls, Provider Manual, and fax blasts to alert providers to programmatic changes.

Our provider support approach delivers an integrated, high touch Provider Relations Team organized for each strategic region. The model fosters healthcare integration at the systems and services level by ensuring superior collaboration and communication with all providers and subcontractors across the continuum of care. Our strategy allows us to effectively communicate with providers, with a minimum of 30 days’ notice, whenever there are programmatic changes.
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Through provider orientation, the Provider Support Specialist team and other Network Management staff educate providers on information for services available through the Magellan Complete Care SMI Specialty Plan including covered and non-covered benefits. This communication is accomplished through regular visits as well as regularly provided training sessions and found in the Provider Handbook.

Magellan Complete Care’s Health Services Department works in collaboration with other health plan departments to assist enrollees with transition of care/transition of service in the following situations: when benefits are exhausted; when newly enrolled; when transitioning between health plans or between levels of care, when a provider is terminated from the network; or when non-covered services are needed from community agencies.

Our subcontractors are contractually obligated to comply with the terms and conditions of the Florida Medicaid Contract between Magellan Complete Care and AHCA. Our subcontractors are contractually obligated to provide covered services to enrollees in accordance with the Florida Medicaid Contract, the applicable Florida Medicaid Coverage and Limitations Handbook, and applicable statutory and regulatory requirements. Magellan Complete Care’s Vendor Oversight Committee monitors the activities of all vendors against contractual requirements.

**Evaluation Criteria:**

1. The extent to which the respondent describes effective and efficient processes for reciprocal referral for needed services.

2. The adequacy of the respondent’s approach to engage and educate enrollees in understanding the difference in benefits covered by the respondent and those that are available through other Medicaid delivery systems.

3. The extent to which the respondent’s description includes a process for ensuring respondent’s staff and subcontractors are aware of and effectively communicate the appropriate information on services available through other Medicaid delivery systems.

**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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MMA SRC# 18 - Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Jose is a 15-year old male. He is diagnosed with bipolar disorder and is currently hospitalized under the Baker Act; this is his third psychiatric admission under the Baker Act in the past year. Up until six (6) months ago, Jose lived with his mother and two younger siblings, but he moved in with his father after his behavior declined and his mother was unable to protect herself and his siblings from Jose’s angry outbursts and verbal and physical aggression. His father is physically disabled from a work injury, and he is concerned about managing Jose upon release, as Jose’s behavior at home and school has significantly declined. At school, Jose is currently failing and has a notable number of absences and office referrals for altercations. Jose was diagnosed two months ago, during his second psychiatric admission, with bipolar disorder. Jose has been prescribed a low dose of Seroquel daily, but he does not take it consistently because of the side effects. He experiences drowsiness, dry mouth, and nausea. In his current admission, his laboratory testing results showed evidence of thyroid dysfunction. The hospital social worker assisted the family in completing and submitting a referral for Statewide Inpatient Psychiatric Program (SIPP) services, but the SIPP provider informed the social worker that authorization was denied. Jose’s father has called the plan’s enrollee help line for assistance with completing an expedited appeal. Jose was involved in outpatient therapy for the past six weeks. There have not been any adjustments to his medications to date. Jose has been enrolled in Medicaid since he was 5-years old. He has been enrolled in his health plan since July 2014.

The respondent shall describe its approach to coordinating care for an enrollee with Jose’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 JOSE’S PROFILE

Magellan Complete Care approaches Care Coordination/Case Management (CC/CM) through a pathway that begins with the initial identification of a new enrollee and is reviewed and updated
as changes occur with the enrollee’s individual situation. Upon identification and as changes occur, our pathway flows through intake, engagement, initial health risk assessment, CC/CM, service planning, care planning, discharge/transition planning, disease management (DM), utilization management (UM), grievance and appeals, and ongoing quality monitoring and evaluation. As the State’s only Serious Mental Illness (SMI) Specialty Plan, we currently have approximately 70,000 enrollees that have similar conditions and situations, like Jose, where we engage using a flexible, person-centered approach ranging between less intensive to very high touch engagement.

Our approach is customized to the specific, complex needs of individuals, including children and adolescents, with SMI, serious emotional disturbance (SED), and substance use disorders (SUD). We offer access to specially trained clinical staff 24 hours each day. Consistent with our day-time staff, our after-hours CareLine staff are specially trained in triaging calls, questions, and concerns from our enrollees who have SMI, SUD, SED, and physical health issues. In Jose’s situation, our staff engaged both of Jose’s parents and care providers in this process.

Magellan Complete Care’s Clinical team specializes in engagement, empowerment, and behavior change with adolescents with SMI and their families and caretakers. We do this through leveraging the integration of behavioral and physical approaches, and psychosocial health data; the “chassis” for all of our operations, field-based teams, community partnerships, enrollee needs-based program designs, and ongoing building of systems capacity and functionality. All of this leads to quality care and enrollee satisfaction, as well as increased enrollee engagement and ultimately, enrollee success in achieving improved health goals.

Jose’s profile may be fictional, but it is realistic and resonates in a very real way with Magellan Complete Care. His profile and treatment plan illustrates how we create an environment of partnership, assistance, and support with Jose, his family, caregivers, providers, and our Clinical team. We assist in applying choice, self-management, and control over the decisions affecting Joe’s life and achieve the goals he wants to accomplish (self-determination). We are focused on helping Jose and combining community supports to navigate through the challenges he experiences. We take our role very seriously and consistently strive to instill in Jose that recovery is possible.

Jose has been enrolled in Medicaid since 2014. He is eligible for enrollment in the Magellan Complete Care SMI Specialty Program due to his recent hospital admissions and diagnosis of bipolar disorder and was auto-assigned effective 8/1/2017. Upon enrollment and assessment, in addition to his significant behavioral condition, two concerning issues that may have caused Jose’s aggression were identified. First, Jose’s thyroid dysfunction could be the primary etiology of his behavioral health condition and requires immediate specialty evaluation and treatment. Second, it was recognized that his current medication, Seroquel SR, and other psychiatric medications that may have been prescribed in the past, are a possible cause of his thyroid condition.

Jose was identified to be immediately eligible for the Magellan Complete Care First Episode Psychosis Program. The Program identifies children, adolescents, and young adults in early stages of psychotic disorder development and/or upon their first or initial episode(s) of psychosis. Any individual in this age (children to young adult) with psychosis or psychotic-like features, is considered to have a “first episode psychosis.” It is well established in the literature that the earlier
in life a psychotic condition is identified, evaluated, and quickly treated, the better the life-long prognosis is for the person.

Individuals with first episode psychosis are identified through the HRA, UR teams, other clinical assessment, and through regular predictive modeling by the Clinical Analytics Team. Enrollees are then prioritized, assigned to CM, and the appropriate clinical appointments are set up with ongoing CM monitoring.

Jose’s Baker Act admissions were both voluntary and involuntary; with the most recent admission being involuntary. According to a Magellan Complete Care’s Inpatient Authorization Dashboard, 85 percent of Magellan Complete Care’s behavioral health admissions are involuntary under the Baker Act. Our Clinical team coordinates care and services for many enrollees like Jose and are very experienced in working with these individuals. According to an enrollee age profile dated March 2017, for these admissions, based on approximately 66.9K enrollees, 11 percent were between 13-17 years of age. If we include ages 9-12 (3%) and 18-21 (10%), almost a quarter of these admissions are children/adolescents/youth.

Because Jose displayed very aggressive behavior, our Clinical team had a heightened awareness to the possibility of Jose’s risk of self-injurious behavior or suicide. Based on analytics by our Clinical Analytics team, enrollees engaged in our CM program are approximately 1.5 times more likely to remain in a community setting 200 days following an inpatient hospital discharge. Outcomes improved over time, with engaged enrollees in 2016, approximately 1.25 times more likely to remain in the community setting than in 2014. A comparison of community tenure outcomes for individuals enrolled in CM indicated engagement more than 50 percent of the time as compared to enrollees not enrolled, or enrolled without engagement. Durational outcomes compare 2016 Q2 discharge results to 2014 Q4 discharge results.

Jose’s parents are divorced with joint custody and have a solid shared parenting plan. Due to the Jose’s aggressive behaviors and last admission, Jose is now living with his father. We customize Jose’s care within the context of where he and his family live – within his neighborhood and community. We facilitate our Model of Care by deploying teams who live in the communities where our enrollees live with diverse cultural and social backgrounds. With our Integrated Health Neighborhood approach, we give our team’s accountability and responsibility for a group of enrollees and providers. This allows flexibility as they work collaboratively to facilitate the best possible service options for enrollees. We augment our Integrated Health Neighborhood “lived experience” with data and analytic insights to drive our efforts. This approach takes into account social determinates of health and localized neighborhood resources and strengths.

Jose’s Integrated Health Neighborhood team includes his primary Integrated Care Case Manager (ICCM), Health Guides, Recovery Support Navigators, Community Outreach Specialists, Integrated Residential Treatment Specialist (IRTS), Wellness Specialists, Clinical Pharmacists, Child and Adolescent Psychiatry Medical Directors, and Customer Service Support. The Integrated Health Neighborhood approach promotes the building of relationships and collaborations with community partners to create a more effective and trusted coordination of, and access to, care that is familiar to Jose, his parents (custodial and non-custodial), and his clinical providers. These community partners include Jose’s school, religious organizations, and other community-based agencies and supports; allowing us to customize Jose’s care with a seamless infrastructure of services and support.
Magellan Complete Care’s Child and Adolescent Program: We assist many enrollees just like Jose – adolescents who are at a precarious crossroads in learning to manage and address their physical and behavioral health as well as their school, social network, and family. Magellan Complete Care philosophy and community-level strategy for children’s health is based on the American Academy for Pediatrics' Task Force on Mental Health. Our Child and Adolescent Program is a specialized program offering services and support for all children and adolescents enrolled in our Specialty Plan.

In this program, we offer our CC/CM programming, targeted case management (TCM), peer-support services, first episode psychosis programming, and integrated behavioral health and pediatric rounds. We collaborate with a multitude of child and adolescent partners and collaborators, including juvenile justice, county youth partnership awareness programs, school systems, emergency crisis teams, pediatricians, mental health advocacy groups, managing entities and human service agencies, which includes the department of child and family and local behavior health and physical facilities and providers.

Our Child and Adolescent Program is managed by a Child and Adolescent Psychiatrist, Pediatrician, IRTS child trained and a specialized case manager and care coordinator who specializes in assisting children. In addition, child trained, peer-support specialist also participate. Due to the complexity of Jose’s situation, he is offered and agrees to work with “Ashley”, a pediatric ICCM. Ashley is actively engaged with Jose and helps guide him to needed services and supports.

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;
Magellan Complete Care has designed its CC/CM model around a “no wrong door” approach for our enrollees to access services throughout their enrollment with our health plan and referred to appropriate programs. Each of our enrollees receive some level of CC services. For enrollees like Jose who experience a critical event, exacerbation of their illness, or a complex diagnosis, are treated by us as priority candidates for timely integrated, CCM 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 CareLine, to hospital discharge planners, providers, and to enrollee self-referral. In addition, our UM team would have been notified of Jose’s hospitalizations under the Baker Act as a request for authorization. Our Clinical team immediately begins to coordinate Jose’s discharge plan, exploring and exhausting all possibilities, including intensive wrap around services, lower level of care services, family therapy, and an individualized education plan (IEP) delivered within the school and community.

We employ an IRTS, “Rosemary”, who collaborates with our Behavioral Health Medical Director/Child Psychiatrist and Jose’s ICCM, Ashley, to coordinate and assist with care and treatment options for Jose; including Statewide Inpatient Psychiatric Program (SIPP) reviews, authorizations, denials, applications, outpatient services, and other potential lower level of care placements. Our Clinical team feels strongly that Jose’s thyroid dysfunction is a primary and
urgent medical issue requiring immediate evaluation and treatment to be followed by the development of his post discharge care plan. The Clinical team felt that a brief SIPP treatment, due to recent hospitalizations, medication adherence issues, and custodial change issues, would be beneficial for Jose. The initial SIPP request, however, was denied due to the scope and length of the requested stay. After we requested additional evaluations and medical-psychiatric work-ups, we approved a shorter SIPP stay that included a more comprehensive treatment plan.

Rosemary collaborated with the SIPP case workers and AHCA regarding the various aspects of SIPP denials, authorizations and applications. Rosemary has 14 years of experience in this area. As indicated previously, Jose’s SIPP application was denied initially by us, therefore Rosemary’s focus was on assisting Jose, the providers, and his legal guardian (his father), through the appeal process that is discussed in detail within our response. Upon provider completion of our requested additional medical-psychiatric work-up (primarily the thyroid work-up and comprehensive treatment plan), our Child and Adolescent Medical Director overturned the denial. Of note, identification of Jose as a candidate for CC/CM started at the earliest stages after enrollment with Magellan Complete Care.

Our Clinical Analytics team reviews available enrollee diagnostic information for all membership as well as available claims data to proactively sort the current Magellan Complete Care membership based on prioritized needs whenever possible. One of the alerts from the data analysis about Jose was a predictor for hospitalization in the next 90 days and the inpatient hospital identifier. This alert provided additional support for the short SIPP stay after the thyroid workup was completed and treated; and a more comprehensive treatment plan was developed.

In addition to our analytic capabilities, there is no substitution for real-time face-to-face assessment and interaction with Jose and his family to best engage and obtain the most accurate identification and risk level assignment. This assessment took place at the hospital. Also, shortly after becoming enrolled with Magellan Complete Care (within five days of enrollment), Jose and his legal guardian were sent his Medicaid Member Handbook and Welcome Kit, that included his identification card, information about his benefits, contact information, and a Provider Directory. At any point when Jose or either of his parents contacts our Customer Service team or CC/CM team, the teams always verify who they are speaking with to ensure appropriate level of consent and privacy is maintained; including teen consent and privacy authorizations.

Attention to Jose’s special needs regarding his diagnoses and recent hospitalizations would have been similarly prioritized and he or his guardian would receive a call from Ashley for further assessment and follow up. Because Jose was hospitalized, Ashley visits Jose in the hospital to conduct the Pediatric HRA and the comprehensive Initial Clinical Assessment. During this visit, as much information is gathered from Jose as possible further assessing his current physical and behavioral health status, imminent challenges, family concerns, personal concerns, and other biopsychosocial (including characterological) issues as indicated.

While in the hospital, Ashley collaborated with Rosemary to sort through the best plan for Jose, including a pending SIPP application and appeal. As indicated, Ashley conducted the pediatric HRA and Initial Clinical Assessment to ensure Jose’s physical health issues had been addressed, specifically his thyroid dysfunction. Ashley ensured that Jose’s discharge plan and SIPP placement were actively being developed, individualized, clarified, and moved forward. Through this and other processes and evaluations, as previously indicated, Jose’s initial SIPP application
was denied. In collaboration with Rosemary, Ashley, and Jose’s father, as well as our Clinical team and Child Psychiatrist Medical Director (after additional workups and treatments were complete), they appealed the denial and it was overturned. This resulted in Jose receiving a brief placement in the SIPP facility.

Ashley’s completion of the Pediatric HRA, Initial Clinical Assessment, and DM/condition-specific assessments provided important information to our Clinical team. Our pediatric SMI-tailored HRA information identifies key areas of risks and the unique needs of the SMI population who also have other complex physical and social health needs. In addition to basic clinical information, the information captured includes health habits, living situation, and social connectedness; important predictors of outcomes for individuals with SMI.

Additionally, Ashley conducted additional, more detailed condition-specific branching assessments focused on Jose’s individualized needs. These included attention to his thyroid dysfunction and possible corresponding behavior changes, medication side effects, and medication adherence issues. This assessment, problem list creation, and care planning process is described later in detail within this vignette. Globally, the Initial Clinical Assessment results in Jose’s self-disclosure of his circumstances, including verification of privacy and appropriate consents, including teen and guardian consents, review of his bipolar disorder, behavior patterns, and altered thyroid function. Jose and his father received assistance in setting up follow-up care once he transferred out of the SIPP facility. Ashley discussed specific treatment options and community resources in outpatient therapy and additional supports (school, support groups, etc.).

An example of Jose’s branching assessments include, PHQA (PHQ9 modified for adolescents), adolescent depression screen, risk assessment, and full depression assessment, thyroid disease assessment, and other behavioral assessments, as indicated, specific to Jose’s current condition.

During the face-to-face visit with Ashley, Jose and his parents asked questions about SIPP and Rosemary assisted by explaining that SIPP services typically include the following:

- Clinical assessment process
- Individual psychotherapy
- Group psychotherapy
- Family therapy
- Milieu treatment (positive behavior support, positive parenting training, structural interventions, peer government, and leadership training)
- Educational services, including psychological and neuropsychological testing, and IEP
- Vocational training
- Independent living skills
- Psychiatric and medical medication monitoring services
- Discharge and aftercare planning
- Parent resources.

We use our analytics and assessment information, clinical judgment, and team input to assign enrollees, like Jose, 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 can be used to identify and prioritize both short and long-term CC/CM needs.
Magellan Complete Care enrollees, like Jose, who present with physical health and/or behavioral health co-morbidities further complicates their ability to engage and diminishes their quality of life, as well as their ability to adhere to treatment plans. Results of our own internal analyses of our SMI 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. At the time the initial clinical assessment was completed (shortly after enrollment), Jose scored as Ultra High Risk stratification.

Ashley utilized Jose’s identification and assessment information when presenting his case at the interdisciplinary integrated care team (ICCT) meetings, and when developing Jose’s problem list and plan of care. We have a three-tiered process for both enrollee stratification/segmentation, and development of enrollee interventions, including:

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 Jose and his parents using a high touch, person-centered approach, customized to his specific, complex treatment plan. Given Jose’s aggressive behaviors, behavioral health and psychosocial support needs, Jose is considered to be in the “Ultra High Risk” category based on his current situation and on our predictive modeling and risk stratification construct. In Jose’s situation, his referral to the CCM program was prioritized to ensure that his needs were addressed and his HRA and initial assessment was completed well before the initial 30 days of enrollment.

An essential element to our CC approach is using an individualized assessment and planning process with each enrollee focused on the unique needs of those with SMI. Under the umbrella of our Child and Adolescent Program we have developed a pediatric HRA. Screening for behavioral health, SUD, social determinants of health, and physical health concerns begins at the time of enrollment using our pediatric HRA, the comprehensive Initial Clinical Assessment, and various branching assessments. If Jose experienced a significant change in condition or there is a utilization trigger, an additional HRA is carried out further assessing his needs. This assessment tool is SMI-tailored and pediatric focused, identifying key areas of risks and needs of the pediatric SMI population. 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.

The core domains of the Pediatric HRA components include:

> Living situation / social determinants of health / family dynamics
> Development screening
> School and work
> Hospital / office visit history
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

> Substance abuse history
> Social activity / social connectedness
> Preventive test history/gaps in care
> Chronic and / or acute physical and behavioral health condition history, screens, and exams
> Rating of health
> Medication review and adherence
> Supply and equipment needs

This pediatric SMI-specific HRA, along with additional data, augments the scoring of the analytics assigned level of risk, documents those risks, and stratifies enrollees for assignment to the various levels of CC/CM planned interventions. We also employ enhanced, branching assessments that cover a broad range of SMI, SUD, and SED customized for children and youth, medical, and psychosocial conditions to broaden the scope of CC/CM assessment and ensure a comprehensive and personalized plan of care. Ashley had access to 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, Ashley utilized the Bipolar, Adolescent Behaviors, and Thyroid Dysfunction chronic care guidelines when assessing Jose and developing his plan of care. In addition, Ashley communicated with the SIPP providers and incorporated their services and interventions into the plan of care.

The assessments were used to develop a problem list where each problem identified is 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/areas of focus included in Jose’s initial clinical pediatric assessment are as follows:

> Clinical history, including condition specific issues and medications
> Medication adherence / side effects
> Assessment of life planning and self-directed care activities
> Physical, psychosocial, cognitive, and functional needs
> Comorbidities
> Cultural needs assessment
> Developmental screening / child and adolescents
> PCP and specialists / recent Pediatrician visit / results / recommendations
> Recent dental visits
> Past, present and future lab work needs (e.g., thyroid dysfunction)
> Outpatient behavioral health services received / failed – can they work again in lieu of SIPP
> School or work history
> Family dynamics – father as legal guardian and mother/other siblings
> Family financial situation – vocational rehab for father and SSI for Jose
> Learning disabilities
> Police involvement
> Mental health history, past behavioral therapy visit information, and links to family situation moving forward
> Current behavioral health outpatient therapy benefit / use
> Behavioral health and substance abuse screening
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

> Social determinants
> Supply and equipment needs
> Community agencies and supports
> Ability to perform ADLs / functional ability
> Long term care needs and what services currently receiving
> Evaluate caregiver resources and social supports
> Utilization history

Planned interventions are person-centered, individualized and disease specific. For example, in Jose’s situation, his behavioral health gaps in care had different goals than his physical health gaps in care. Interventions also take into account the enrollee’s psychosocial status 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 ICCM support.

Ashley, Jose’s ICCM, conducted additional, more detailed condition-specific branching assessments focused on Jose’s individualized needs; including behavior changes, medication side effects, medication adherence issues, and thyroid dysfunction concerns. This assessment, problem list creation, and care planning process is described later in detail within this vignette. Ashley discussed specific community resources that Jose may want to tap into in the area of obtaining support. The branching assessments include, PHQA adolescent depression screen and full depression assessment, thyroid disease assessment, and other behavioral assessments specific to Jose’s current behavior changes.

Ongoing segmentation and stratification was carried out further assisting with the enrollee CC/CM assignment process. For Jose, Ashley and the CC team monitored, assessed, and reassessed his needs on an ongoing basis.

We use ImpactPro, our predictive modeling tool to capture and identify the top tier risk population monthly for possible referral to our CCM program. We have modified the tool to incorporate behavioral health conditions, social support status, and other issues that are unique to our population and with enrollees presenting as Jose did. ImpactPro assessed Jose’s potential for future utilization, and assigned 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. Ashley and the team were trained in gaps in care and specifically those which were pertinent to Jose’s individual situation. Ashley reviewed these gaps in care with each contact with Jose and documented the information within the customized
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

template within the TruCare documentation system. TruCare is Magellan Complete Care’s 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 our clinical staff to assess Jose’s needs, complete his service plan, and authorize his services.

Based on the results of these analyses and ongoing CC/CM activities, enrollees, like Jose, are stratified into several different levels of risk, with the level of support and intervention varying depending on that enrollee classification. The CC 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; with enrollees graduating to less intensive intervention levels as those goals are achieved.

All of Jose’s contacts were documented in TruCare and notes are made on all elements of the CM and services. Information sent to us by Jose’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 Jose.

System support for Jose 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 Jose’s CC program participation and case artifacts in one place. When baseline assessments were completed for Jose, the TruCare system provided the ICCM with prompts to create the service plan for Jose. The assessments and system branching offered intuitive triggers and alerts to assist Ashley as she was assessing Jose and planning for his care. The system provides a list of recommended problems and interventions for a user to select when building the individualized service plan based on Jose’s assessment responses. The problems and interventions were based on opportunity areas for Ashley to focus on when supporting Jose.

Ashley addressed questions about benefits, SIPP versus outpatient therapy, recent behavior changes, transportation issues, provider appointments, and issues Jose had with school and his family. Ashley and other members of the CC team explored services and resources within the Integrated Health Neighborhood to assist and support Jose and his father.

Within the ongoing segmentation and stratification activities for Jose, all of the described Magellan Complete Care applications interact, including claims processing, enrollee eligibility, benefits, UM data, the service plan, Jose’s profile containing a summary of his medication list, recent services, risk score, and gaps in care. Clinical reference tools were accessible to Ashley 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 Jose’s conditions, predicting and stratifying risks, reporting gaps in evidence-based care, and monitoring medication adherence. Jose’s continuity of care documents (CCDs), if available, are also displayed to users.

Magellan Complete Care’s approach to reporting and analytics embodies a strategic philosophy of ensuring that the most actionable, real-time information is available to support each individual program’s operational team using the most efficient technology possible. Our sophisticated
technology infrastructure is flexible so our operational teams can quickly access and leverage information to assist Jose with his needs. Enrollees such as Jose who have complex physical, behavioral, and social needs are identified appropriately and quickly to ensure timely engagement and assistance by the CC team.

We use this detailed understanding, and ongoing study and analysis of enrollees, like Jose, 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 Jose to the intervention and CC/CM category that is right for him, and which affords the greatest opportunity for successful engagement with him and to assist him in reaching optimal outcomes.

Given the complexity of Jose’s situation and our overall population, we are able to review segmentation of enrollee behavioral and physical health clinical stability. Enrollees, such as Jose, 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 Jose, our Clinical Analytics team also scored Jose in his propensity to enroll in CM. 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.c. Application of the respondent’s case management risk stratification protocol;
We see the continuum of care and the support provided to Jose through CC/CM as a fluid treatment pathway, where enrollees may enter at any level and be moved to more or less-intensive settings, and different levels of CC/CM as their changing clinical needs dictate. Our active, and regular engagement with enrollees in CC/CM, allows us to monitor and adjust a plan of care 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 continuous data capture, monitoring, assessment, and analysis for assignment of enrollees based on changing needs.

Since being awarded the opportunity to serve and support our enrollees in the SMI Specialty Plan, Magellan Complete Care’s dedicated CC and Medical teams have focused their efforts on fully understanding the unique needs of this very complex population. Our enrollees not only present with SMI, but also present with multiple chronic physical health conditions, co-occurring illnesses, and are often 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, and 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. This model allows us to assign enrollees 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.
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, physical health and social risks and requirements. Enrollees are assigned to CC/CM programs of interventions and supports that reflect their combined complexity and need. Our CC/CM model, referred to within Magellan Complete Care as the Integrated Care Case Management 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 ICCM use the Case Management Society of America’s Case Management Standards of Practice and National Association of Social Work Case Management Guidelines.

Jose’s SIPP denial and the observation that his thyroid dysfunction required treatment triggered Ashley, the ICCM, to request review by our Child Psychiatrist Medical Director and re-presentation in the ICCT clinical rounds where a Pediatrician and Child Psychiatrist were present. As a SMI Specialty Plan, we employ Medical Directors with specialty expertise across the medical and behavioral continuums, including physicians with multiple areas of expertise such as double training in OB/GYN and psychiatry, and triple training in pediatrics, psychiatry and child/adolescent psychiatry. Having medical leadership with these varied clinical backgrounds is unique and allows us to support our enrollees in a customized manner.

Ashley consolidated the notes and medical information and prepared a case summary to guide the discussion with our Medical Director, in this case our Medical Director who is triple-boarded as a pediatrician, adult psychiatrist, and child and adolescent psychiatrist. The ICCT meetings are a place for a group of clinicians, peer specialists, and physicians to gather and collaboratively construct a plan of care.

The hospital admission history and examination case summary Ashley prepared was as follows: Jose is a 15-year old male, with three recent admissions for physical/verbal aggression, diagnosed with bipolar disorder and treated with Seroquel to stabilize his mood disorder symptoms. He reports that over the last couple of weeks he has not been taking his medication because of side effects including drowsiness, dry mouth and nausea, prompting the most recent Baker Act Admission. He denied using any substances (and his blood and urine toxicology screens were negative). He had also experienced changes in his social situation as a consequence of his behavior – six months ago he was living with his mother and sibling. However, his mother became afraid of Jose and he moved to live with his father. He has had frequent school absences due to his symptoms, hospitalizations and now was failing in school. During the recent hospitalization, medication changes were made and SIPP services were requested. The SIPP services were denied because Jose was found to have a medical condition, thyroid dysfunction, which had not been treated. This case conference discussed the management of this complex adolescent.

During the case conference, the doctors discussed Jose’s condition and the different diagnoses which can cause it. In his experience, hyper-thyroid dysfunction alone can cause behavior symptoms of this significance. The medical management priority at this time would be to immediately obtain an endocrine consult for a thyroid workup. The attending physician indicated that he/she would obtain consult and if necessary transfer to a pediatric medical hospital for potential management of Jose’s thyroid dysfunction. The endocrinologist indicated he would call
the treating behavioral health physician to discuss the treatment plan. No transfer to a pediatric medical hospital was indicated at the time and workup occurred on the behavioral health unit.

Since we have an integrated care case management program, Jose’s ICCM, Ashley had been trained to manage both medical and behavioral conditions. She worked with the doctors to determine the management plan, and with the hospital staff to coordinate the transfer to the pediatric hospital for further evaluation and management; if it was recommended. In the background, she would have coordinated with our UM team to ensure that the authorization for the hospitalization at the pediatric hospital was seamlessly completed and transmitted to the facility.

Jose was treated by the endocrinologist and attending psychiatrist at the behavioral health hospital with medications to decrease the symptoms caused by the high levels of thyroid hormone in his blood and to treat the underlying cause of his thyroid disease. With thyroid treatment, there was a significant improvement in Jose’s mental status and feelings of aggression. Both the pediatrician and the psychiatrist believe that many of his symptoms may have been related to the thyroid dysfunction and that the thyroid dysfunction may have been caused by psychiatric medications. Bipolar disorder or a bipolar spectrum disorder continues to be a significant component of Jose’s differential diagnosis. For this, Jose’s family was thankful and optimistic that his behaviors may significantly improve. Since Jose is getting ready for discharge, Ashley began to work on Jose’s discharge plan.

Due to Jose experiencing three psychiatric admissions under the Baker Act in the past year along with his behavior, family, medication adherence, school failure, and social issues, Jose is considered “Ultra High Risk” and he and his family continued to work with Ashley and Rosemary, for a short-term admission to a SIPP program. Ashley, has extensive child and adolescent experience and collaborated closely with Magellan Complete Care’s Behavioral Health team.

Our Clinical team immediately began to coordinate Jose’s discharge plan, assisting in the overturn of the SIPP denial and admission and transfer to the SIPP program. In addition, consideration was given to repeating the neuropsychological and psychological testing after full stabilization of symptoms. Ashley asked the family to identify their recovery goals to be incorporated into the plan of care. They identify that returning to “normal” family life, returning to school and being with friends as the priorities.

1.d. Identification of Service Needs (Covered And Non-Covered) and a Description for Service Referral Processes;
The CC/CM team ensured that Jose was receiving the services best aligned with his plan of care. Ashley and the Clinical team were very knowledgeable in all aspects of covered benefits and services and had access to this information within the TruCare system. Covered service information is available on both the enrollee and provider portal and can be easily accessed by staff, providers, and enrollees. The CC team is knowledgeable and assists enrollees and providers in understanding covered services and benefits, along with assisting them in obtaining referrals and authorization for services when indicated.

Ashley worked to ensure that Jose did not receive duplicative services. She also visited Jose at the hospital and collaborated with the hospital discharge planner to identify appropriate service
needs and authorizations. In addition, our Medical Directors were available for MD to MD interaction and consultation as needed to determine the best discharge plan for Jose.

In certain situations, if an enrollee requires a service which is not a covered service, the CC team will review the case with the local Medical Director and other members of the CC team to determine how the enrollee can 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 is to link enrollees with the appropriate service providers so that the providers can address the ongoing needs of the enrollees.

In addition, the Medical Director has the ability to authorize the payment of the non-covered service given the individual enrollee circumstance, outlined in detail in applicable policies and procedures. Our medical necessity definition meets the EPSDT definition of medical necessity for individuals under the age of 21 years. We understand AHCA’s obligation of assuring the federal government that EPSDT services are provided as required. We support the EPSDT screenings according to the American Academy of Pediatrics periodicity schedule, diagnostic services, as well services identified as necessary to correct, maintain, or ameliorate any identified defects or conditions for enrollees who are under age 21.

Our CC team assists enrollees by coordinating care when third party carrier coverage has been exhausted. One recommendation may be that the enrollee choose a provider that accepts both their third party carrier’s coverage Medicaid payments. Additionally, our CC team assists the provider in the proper steps to ascertain authorization and submission of their claims for payments for enrollees.

For example, in Jose’s situation, he was denied SIPP placement and his father called us to appeal the decision. Jose and his father were notified of their right to a peer to peer review. This expedited appeal was handled over the phone and the appeals team immediately placed the information in the system to quickly get the appeal processed and resolved for Jose. This quick response positively impacted his health status and he avoided exacerbating his other health and behavior issues.

Ashley met with Jose without his father present to allow Jose the opportunity to review his problem list and goals that may differ from his father’s goals. During the discussion, Jose said that he wanted to go back to school and to see his friends. He was worried about going back because he was so far behind and would need additional help to get caught up on his work.

With this new information, Ashley developed a comprehensive plan of care, which included both the discharge transition plan and the ongoing plan of care. She worked collaboratively with the hospital discharge planner to:

- Find a SIPP placement and obtain authorization for admission
- Set up an appointment with Pediatric Endocrinology for his thyroid condition
- Set up an appointment within seven days after SIPP discharge with his behavioral health provider who served as an advocate for Jose
Establish action and crisis plans for his physical and medical conditions with parents after SIPP discharge.

Review medications and identify strategies for adherence to his medications. Jose thought that setting an alarm on his cell phone would be effective and agreed to call Ashley if it didn’t work so they could put together a new plan.

Ashley also reached out to Jose’s PCP. She wanted to update the PCP on Jose and identify information the PCP needed to follow Jose. The PCP was appreciative to get a call and wanted to see Jose within the first month after discharge.

With the SIPP discharge transition and plan of care in place, and with significant improvement in Jose’s clinical situation, he was discharged home with his father. Ashley checked in the day after discharge to make sure that medications were picked up and confirmed dates and times with Jose’s father for the follow up appointments. Jose’s father was also going to call the school to get an IEP case conference set up and asked Ashley to attend. Jose’s father also said that the TCM had been to the home to visit. Jose liked the TCM which was a great first step.

Ashley stayed in close touch with Jose, his father, and his mother during the first month after discharge to evaluate adherence with medications, appointments and therapy. Jose made great progress towards his goals, as did his parents in family therapy. Jose was able to take his medications on time, go back to school with IEP programming, improve his social skills, and reunite with his mother.

Ashley maintained contact every two weeks for the next three months and moved Jose’s risk status to medium after 120 days. Ashley continued to call the family monthly until Jose had been stable for six months and was disenrolled in CC/CM. Ashley remained available if needed. The family now felt secure with Jose’s progress and knowledgeable about his condition and treatment plan.

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 Jose mean that Magellan Complete Care must use all available touch points to assess Jose’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 Jose, 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 Jose’s evolving needs and circumstances including indications of decomposition, or instability in Jose’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 Jose included: identifying his behavioral and medical health risks, family issues, educational needs, biopsychosocial needs, chronic care needs; and closely monitoring, assessing, and reassessing Jose; designing a plan of care to proactively address his most immediate needs; engaging the ICCT; and, proactively identifying and monitoring Jose’s changes or triggers that might destabilize his illness and intervene early.
To further ensure Jose’s compliance with his plan of care, Ashley worked with Jose in reducing and eradicating some of the risk factors which were contributing to his worsening behaviors, thyroid dysfunction, etc. Ashley worked with Jose to create an individualized plan of care and to collaborate on prescriptive interventions. A sample of Jose’s plan of care, which includes a full problem list, goals, and barriers is available in [MMA SRC #18, Attachment 1: Jose’s Plan of Care].

Ashley included EPSDT and immunizations in Jose’s plan of care to ensure that Jose receives appropriate Child Health Checkup visits in accordance with nationally recognized and state specific guidelines. Jose’s EPSDT and immunization information was documented in TruCare, offering alerts and tasking activities as a tool for Ashley to use when coordinating care for Jose. Ashley reviewed the Healthy Behaviors incentive program with Jose and his parents.

1.f Application of Discharge and Aftercare Planning Protocols that Facilitate a Successful Transition;
The Magellan Complete Care Transitions and Emergency Department Follow-Up Program activities are integrated within each area/level of the CC program. The program promotes physical and behavioral health comprehensive care transition management both proactively while an enrollee is enrolled in a care management program, and when an ER visit or hospital admission/readmission occurs. The ICCM, Utilization Management Professional (UMP), and Care Transitions Health Guide work collaboratively and are actively involved with the enrollee at times of care transition, including, but not limited to planned and unplanned admissions, frequent ER visits, transfer to other institutions and facilities, crisis stabilization units, and works in conjunction with the enrollee’s Health Guide to ensure plan of care communication between all providers and of the enrollee’s CC team.

Discharge Planning is a key element of the Care Transitions program and specifically focuses on safely transitioning enrollees from an inpatient admission in an acute care, skilled nursing facility, or ER back to home, community setting, or another site of care. In Jose’s situation, the assigned ICCM, hospital team and SIPP team collaborate on all aspects of Jose’s discharge plan. Typically, discharge Planning is carried out by our UM staff and Care Transition Health Guides, however in Jose’s case, Rosemary, our IRTS and Ashley, took lead on Jose’s discharge planning activities. His SIPP placement and unique discharge plan required the subject matter experts to take lead and communicate between all providers of care and services. 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 the enrollee safely placed back home or to an alternate facility or living situation.

In Jose’s situation, there was a higher visibility and procedural triggers unique to an enrollee who was a Baker Act case. Our staff are very experienced and knowledgeable in handling Baker Act cases with ease. Each time Jose was in the hospital, our team proactively engaged him as soon as we were aware of admission. Since Jose had multiple hospital visits, very complex needs, and was Baker Acted, the CC experts in this area closely engaged and monitored him.

The assessment process starts with the ICCM and UMP reviewing complex cases and beginning the assessment and planning of these complex cases including those enrollees who have been admitted, within the case review conferences which are held daily. The case review session allows for a Medical Director led interdisciplinary team of our staff to review complex cases to
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effect that the highest level of quality care and follow up is being provided for the enrollee. Onsite discharge planning visits are made by Care Transitions Health Guide to further assess the enrollee’s needs, support discharge planning between care episodes and proactively focus on key activities to prevent avoidable hospital admissions/readmissions, or ER visits. The UMP oversees the Care Transitions Health Guide activities at all times.

For Jose, all of his discharge requirements for SIPP placement and any other needs once he was out of the SIPP setting, including as needed, equipment (DME), home health, community outreach, community agencies, adjunct support systems, medication assistance/reconciliation, community mental health services, family treatment, and coordination with educational providers, are identified by his ICCM and CC team as early as possible. For hospitalized enrollees like Jose, all of the post discharge requirements are identified before or during an enrollee inpatient stay to ensure availability for a timely discharge or placement. Jose was admitted primarily for a psychiatric reason, Baker Act, but then was evaluated for his physical health concerns, medication adherence, and his thyroid dysfunction. The ICCM ensured that Jose was seen by a medical doctor prior to discharge to ensure that his medical conditions were stable, including medication adherence, compliance, and treatment understanding. In addition, the ICCM ensured that the family was advised of and understood the risks, benefits, and side-effects of Jose’s psychiatric and non-psychiatric medications. Our staff collaborated with all members of the Integrated Health Neighborhood, partnering with Jose and community supports to ensure timely, safe living and care arrangements along with close interface with his school.

For Jose and all enrollees experiencing any type of transition, a comprehensive transition assessment and plan includes, but is not limited to, the following:

> Assessment of needs – proactively by the UMP, ICCM, and other subject matter experts as needed (Rosemary and SIPP) when an enrollee is identified by our 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.

We understand that a care transition occurs when an enrollee moves from one care or residential setting to another due to a planned choice, change in health status, circle of support, or living circumstance, or as a result of moving in and out of the judicial or state hospital system. In addition to planning for the enrollee’s transition, any enrollee undergoing a transition is evaluated for level of behavioral health and physical health complexity and risk, and will be stratified into the appropriate level of CM based on complexity. More important, we understand population health and the impact of social determinants of health that each of our enrollees face each day. These social determinants along with other behavioral and physical health factors impact each transition of care and are managed as an integrated element in the enrollee’s overall CC/CM process. For
Jose, his father and mother, these social determinants were paramount and required an in depth assessment to further determine which services and supports were needed.

Any planned or unplanned care transition that enrollees experience, including Jose’s hospital stays, require diligent planning and follow up to avoid further unnecessary inpatient utilization/potential readmissions to acute care settings, and hasty placements into potentially inappropriate institutions.

The care transitions approach utilized with Jose and all enrollees aims to:

> Ensures continuity between settings while including the enrollee’s choice, preference and goals
> Assists the enrollee and their caregivers to improve health literacy and learn self-management skills to ensure that their safety, behavioral, and physical health needs are met
> Provides adequate support for the enrollee to return to the setting of their choice
> Reduces preventable readmissions, institutionalizations, and adverse outcomes.

To prevent unplanned care transitions for our enrollees, we provide proactive CC/CM interventions, including:

> Assessment of Jose’s who would be at risk for any type of transition
> Set Jose’s specific, prioritized goals that promote coordinated care
> Address Jose’s social determinants, medical, and behavioral risk factors affecting enrollees, including family and caregiver / guardian dynamics
> Provide Jose and his family / caregivers, one point of contact for accountability
> Make and keeping specific tasks / appointments / calls / follow up with Jose
> Create a communication process for involved providers
> Facilitate Jose’s self-management capabilities and closing gaps in care
> Work with existing community transition programs to support a safe transition plan
> Educate Jose and his parents on the use of the 24/7 CareLine and Customer Services
> Establish a physical and behavioral health home if one does not exist
> Build a circle of support with Jose within their community or neighborhood
> Work closely with Jose to develop a plan for any type of transition
> Modify Jose’s existing home or locate a safe, affordable place to live
> Arrange for in-home supports.

Ashley communicated with all relevant parties involved in the transition, ensuring that the plan of care supports Jose in the least restrictive and safest environment.

We recognize the highly complex nature of Jose’s situation and our enrollee 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. A care transition occurs when enrollees move from one health care or residential setting to another due to a planned choice, change in health status, circle of support, or living circumstance, or as a result of moving in and out of the judicial system.
The CC team utilizes best practice care transition checklists, 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.

The Magellan Complete Care Transitions and Emergency Department Follow-Up Program is an integral part of our overall CC model. Our program is focused on the goal of limiting risks for the enrollee’s health and plan of care, and successfully transitioning the enrollee safely back into the community or to a new care setting. In Jose’s situation, being placed in the SIPP facility required a unique set of expertise held by Rosemary, who assisted Jose and his father with the transition. These activities are integrated with each area/level of the CC program and provided by various members of the CC team, including RNs, MSWs, ICCMs, Health Guides, UMPs, and our Child Psychiatrist Medical Director as needed. This team works within the Integrated Health Neighborhood assisting Jose in accessing necessary supports and services necessary for a safe transfer between health care settings and home.

The transition of care planning process starts long before the enrollee has been discharged or transferred from one setting to another, with active engagement with providers and staff in the discharging/transfering site of care and with the enrollee’s family or caregivers.

The UM Program and UMPs monitor transitions of care including movement of the enrollee to and from different levels, settings, types of care, and to other health plans or delivery systems. The Care Transitions approach 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 are based on enrollee need. Specific criteria have been developed and are used by each of the enrollee-facing areas to offer ease of placement and referral to the appropriate care coordination program.

Magellan Complete Care has developed a complete process for the assessment and development of transition of care planning 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 Jose are able to receive necessary services from non-covered PCPs, specialists, other service providers, and community partners. Ashley 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 an efficient streamlined 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.
Ashley and the UM staff ensure that the appropriate and necessary referrals are in place for Jose’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 Jose’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 Jose’s situation, Ashley and the CC team worked closely with him to establish which services and resources were available within his neighborhood. Jose obtained his medical and behavioral health care through the SIPP upon discharge. In addition, the Social Worker on the CC team assisted Jose’s father to obtain SSI for Jose and obtain information on vocational rehab for himself, assistance with his financial issues, food access, and follow up with Jose’s school with formal communication plans once he returns to school. Jose’s parents are active within his church where he also accesses support and services for both himself and his son. The church volunteers were available to assist Jose with home repairs and help his son with teen social activities and support groups once he was stable enough to do so.

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 Jose’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 the Agency, 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.

We worked with Jose and his parents to choose a PCP and specialists. We made recommendations based on PCP, specialist, and community partners who were best suited to meet his needs and able to offer the highest quality of care. Ashley and the Clinical team had access to updated provider panel lists which were assessed and updated on an ongoing basis by our Provider Network team to ensure that we had the right specialized services providers to meet Jose’s complex needs. Ashley kept in contact with our Provider Support Specialists, who are out in the neighborhoods collaborating with all types of providers, ensuring that provider capacity and specialized network was meeting Jose’s needs and the needs of the broader population.

When Ashley 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 Jose’s situation, we successfully matched him with a PCP, endocrinologist and a behavioral health provider nearby/within the SIPP initially and then near his home after discharge from the SIPP.

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 Jose received the right care, in the right setting, at the right time, and by the right provider.

In addition, Ashley works with her Integrated Health Network team to identify and connect Jose to all needed services and resources available in his community. Our community partnerships have culminated in the development of the Magellan Complete Care Community Resource Guide (CRG) as our customized solution to catalog over 4,000 regional and county resources and partnerships across the state. The CRG is an online searchable tool, similar to the provider directory which contains services and supports that can be searched by resource type, region, and county. The CRG contains 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.

1.i. Identification of Strategies that Promote Enrollee Self-Management and Treatment Adherence;
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 Model of Care, including our CC/CM programs, reinforced and prioritized recovery, stabilization, health maintenance, optimal safety, quality, and independence through a partnership with Jose, 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.

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

Magellan Complete Care maintains a Disease-State Specialty team for youth and adolescents at high-risk of or who have diagnoses of first episode psychosis. We are 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 partnering 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 behavioral health program approaches, including best practice protocols in the area of addiction and recovery services.

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

The full Clinical team, including the after-hours CareLine staff, are able to interact with online health information tools from Healthwise™ designed for enrollees like Jose, and used by nurses for guidelines in triaging health symptoms and providing self-care education to Jose. Ashley utilized the Healthwise information during each of her contacts and face-to-face visits with Jose. Use of the Healthwise information ensured that Jose was able to provide evidence-based disease specific health information at all times. The 24/7 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 Jose's presenting symptoms, offering immediate advice and/or referral assistance to an alternate type of follow up or care.

At all times, Ashley and the CC team circled back with Jose and his parents 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 Jose, the CC team utilized the Integrated Health Neighborhood approach to assist Jose with self-management; accessing necessary resources within the community and health care system to remove barriers and to maximize treatment adherence. Ongoing engagement and communication with Jose and his support system was essential to the success of Jose reaching optimal self-management and adherence goals. Ashley included Jose in his self-management goal setting and Jose expressed repeatedly that he needed assistance in trying to manage his conditions. Ashley and the assigned Social Worker assisted each of Jose’s parents in obtaining parenting classes at the local library.

To further assist Jose with his self-management and treatment adherence, Ashley assisted Jose in accessing some of our technology assisted therapy tools utilizing Smartphone applications. These applications include Cobalt cognitive behavioral therapy, which offers ways to help Jose reduce his stress and anxiety to focus on reaching his health and wellness goals. In addition, our pharmacy benefit management company (Magellan Rx Management) offers real-time information in the area of medication refills, providing alerts to Ashley regarding medication refills that Jose has made or missed. Specifically around Jose’s prescription for Seroquel, Magellan Rx was able to communicate with Ashley regarding warnings or information that Ashley may need to educate Jose on the medication’s side effects, indications for use, contraindications, etc.

1.j. Application of utilization management protocols (i.e., identification of the criteria that will be used, processes to ensure continuity of care, etc.);
Magellan Complete Care’s UM Program and approach is built around the unique requirements of our population, delivery system, and providers.

For Jose, 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 Jose’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 Jose. 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 Jose. 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 Jose’s services:

> Corporate support and UM experience with similar contracts and populations – enhances the experience
> Our Model of Care is unique with collaboration and integration between all departments, including physical and behavioral health staff working together
> The UM team assisting Jose was made up of a unique blend of clinicians who have medical and behavioral health backgrounds e.g., Social Workers, LPNs, RNs, child and adolescents psychiatrists, pediatricians, and other doctorate level professionals, who all understand both physical and behavioral health and the pediatric complex 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, COBs, 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 Jose.

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 Jose’s care and services. We adopted MCG guidelines as a set of national standardized criteria for the management of Jose’s physical and behavioral health services.

We also use proprietary diagnostic services criteria for imaging, sleep studies, and certain pain management procedures that Jose 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 Jose’s Integrated Health Neighborhood and local delivery system available as well as Jose specific factors, such as his
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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 Jose’s providers by hard copy upon request. The criteria used for the basis of an individual service determination for Jose was in the notice of action letters and also available upon request. The CC team who helped Jose 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 Jose, if the need goes beyond the UM clinical decision support tools, we request review from our child and adult psychiatry and pediatric Medical Directors. Magellan Complete Care has and will continue to ensure continuity of care, particularly as it relates to special needs populations. We have 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 Jose’s situation when he came onto the Specialty Plan, he was receiving prior authorized ongoing treatments with multiple providers. We were 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.

We reimbursed Jose’s non par providers at the rate they received for services rendered to Jose 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 Jose’s non par providers and coordinated with the Provider Network team to obtain a formal contract with Jose’s non par provider.

We provide continuation of MMA services until the enrollee’s PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews Jose’s treatment plan, which is no more than 60 days after the effective date of enrollment.

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 Jose. 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 use our SCA process to ensure continued services.

When Magellan Complete Care was notified of Jose’s enrollment, at minimum, the following was carried out:

> Obtained appropriate consent from Jose to share demographic and healthcare information
> Collaborated with Jose, 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 Jose 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 Jose’s treatment. One of Jose’s providers terminated from Magellan Complete Care and we notified Jose within 30 days of the effective date of provider termination without cause. This process is utilized for all enrollees, like Jose, 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 Jose, 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 Jose.

Magellan Complete Care uses the comprehensive TruCare system as the medical management platform to break down these barriers. For example, staff have the ability to view the following information for Emma in one system:

- Complete and up-to-date demographics
- Authorization request and approval/denial history
- Any HRAs performed by the CM/DM department
- Gaps in care
- Any other clinical or quality notes entered in the system.

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. Changes in protocols or guidelines are 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 service 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 Information about the Enrollee 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 Jose. 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 Jose, are documented in the system and notes are made on all elements of CC/CM processes and services. Information sent to us by Jose’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 CC/CM/UM 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 Jose 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 Jose. Magellan Complete Care’s goal is to work with both providers and subcontractors to ensure that Jose 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 Jose. We firmly commit 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 Jose’s entire care continuum. Magellan Complete Care has developed a robust statewide provider and subcontractor network to support Jose’s unique needs. Over this same period, we have developed successful approaches to engaging, supporting, and communicating with our providers and subcontractors. Data from our subcontractors is integrated into our data warehouse and various data points are populated into TruCare for real-time access to data for clinical staff.

We offered Jose, his providers, and his subcontractors’ access to specially trained clinical staff 24 hours each day. Our teams were able to access Jose’s information 24 hours each day to ensure optimal communication with Jose, his subcontractors, and his providers. Jose 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. Jose accessed the enrollee portal at least weekly.

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 Jose and his enrollment in the CCM program. Ashley and the CC team followed a defined and prioritized process for each step in Jose’s assessment and care planning process. We adhere to NCQA standards for care plan development utilizing prioritized goals and corresponding timeframes. These timeframes for completion are outlined within Jose’s service/plan of care.

The following outline describes Jose’s High Risk CCM process which encompasses identification, assessment, care planning, and ongoing monitoring with associated timeframes for completion:

1. Jose was identified as High Risk through the analytics, HRA, and assessment process and scoring, utilization reports, predictive modeling and by having special conditions, including bipolar disorder or a bipolar spectrum disorder, thyroid dysfunction, aggressive behavior, medication non-adherence etc.

2. Jose was identified as High Risk and then eventually Ultra High Risk and our Regional Manager assigned Jose to his primary ICCM, Ashley

3. Ashley became Jose’s case owner and enrolled him into the CCM program, and completed the referral screens within 24 hours of Jose’s case assignment

4. Ashley completed Jose’s Pediatric HRA, ICA, branching assessments, obtains the AUD as appropriate, and completed the plan of care within 30 days or sooner of CCM program enrollment

5. The CCM program open date in TruCare became the trigger date from which the timeframes for Jose’s outreach, engagement, assessments and care planning was based on and measured

6. Jose’s plan of care included prioritized physical/behavioral health goals, considers Jose’s goals, preferences, identifies barriers to meeting goals, and developed with Jose a plan for self-management and a plan for schedule of communication and follow up

7. Ashley documented Jose’s information in TruCare assessments/notes, uploaded all documents to the Jose’s case

Jose’s CC monitoring timeframes:

8. Ashley conducts required monthly reviews of Jose’s case as evidenced by completion of the CCM Monthly Review Note in TruCare

9. Ashley conducted as appropriate, ICCT meetings with the Health Services staff, Jose and providers
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> Ashley conducted ad hoc case conferences with Jose’s care team in-between formal ICCT meetings

> If Jose admitted to an inpatient setting, Ashley and Jose’s ICCM followed the Discharge Planning desktop procedure (DTP)

> Ashley assisted Jose and his family in accessing health services including coordination of transportation, and services on an ongoing basis

> Ashley maintained and updated Jose’s plan of care at minimum on a monthly basis during the CCM monthly review

> Ashley documented all of Jose’s activity in TruCare by updating the plan of care when needed and documenting case conferences using the Case Conference/Care Review Note type on the day the service occurred

> Ashley completed the CCM Monthly Follow-Up Note to summarize activities for the month including Jose’s progress toward his plan of care goals and updates the plan of care accordingly

> Ashley monitored the predictive modeling screen in TruCare to identify Jose’s HEDIS gaps in care and followed the process for closing Jose’s gaps in care

CRITERIA 3: THE EXTENT TO WHICH THE RESPONDENT DEMONSTRATED INNOVATIVE AND EVIDENCE...
Our Model of Care is built on the active involvement and coordination of all of Jose’s providers involved in his care. Our Clinical team recognized the important role in assisting Jose’s treating providers in their efforts to monitor and improve the quality of healthcare and service delivery for Jose.

We did not delegate any of the CC/CM functions for Jose, however we did share Jose’s clinically relevant information for CC/CM purposes with Jose’s providers and subcontractors in various ways and on an as needed basis. We shared Jose’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.

Because Magellan Complete Care has its own pharmacy benefit management company, Magellan Rx Management, Ashley and the team were able to receive information through the pharmacy system to offer additional support to Jose and his parents in the area of medication adherence, utilizing flags and review alerts across and between systems. For example, we have real-time access to our internal Magellan Rx 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 Jose’s medication over- and under-utilization.
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We ensured that Jose signed and dated a release form before any clinical/case records were released to another party. Clinical/case record release occurs consistent with State and federal law.

We are committed to offering tools and resources to clinicians to help improve enrollee outcomes. Magellan Complete care maintains provider self-service tools including the Impact Pro Connect Portal to support clinical communication. The portal provides valuable enrollee data to help inform treatment and close gaps in care. The Connect Portal assists and informs providers in improved care management; review enrollee service utilization; identify enrollee gaps in care; and provides customized reports and performance comparisons to quality benchmarks. The Connect Portal also allows providers the ability to see updated status on the plan of care as well as other clinical information such as current and historical prescriptions.

We encouraged ongoing engagement through direct and indirect information sharing to support all of Jose’s providers, including:

> ICCM communication (Ashley reached out directly to Jose’s care providers)
> Prior authorizations
> Reconciliation of medication regimens and treatments, especially at care transitions
> Plan of care
> ICCT meeting notes and agendas
> Other case conference and case review notes
> Referrals to necessary services, including his PCP and behavioral health providers.

Sharing of Jose’s information through the Provider Portal as follows:
> Jose’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 Jose’s care
> Case summaries
> HEDIS gaps in care information
> AHCA related updates.

Sharing of UM Concurrent Review:
> Hospital admission lists daily
> Admissions and discharge notification
> Transition of plan of care
> ER department notification

4. THE EXTENT TO WHICH THE RESPONDENT DESCRIBES AN APPROACH THAT SUPPORTS CARE DELIVERY...
Magellan Complete Care has enhanced its predictive modeling to specifically identify child and adolescent enrollees like Jose who are likely to go to the ER and be Baker Acted or admitted. The predictive modeling identifies specific timeframes of individuals who have complex disease specific indicators. These indicators include bipolar disorder, hyperthyroidism, and aggressive behavior among others. The predictive modeling data identified Jose with the highest probability of inpatient admission risk. His admission probability and disease condition indicators from the claims predictive model were used to guide his stratification into a High Risk and then Ultra High
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Risk case types with referral to the Magellan Complete Care Child and Adolescent Program. Ashley, who was primarily assigned to Jose, focused on ensuring that Jose received all of the supports and services he needed, along with coordinating his services in the most appropriate setting.

In addition, through the Child and Adolescent Program (as described in the introduction), we have developed child and adolescent specialty specific programs. These include the Magellan Complete Care First Episode Psychosis Program, Cobalt, our CC/CM programming, TCM, family peer-support services, and integrated child behavioral health and pediatric rounds. We employ subject matter experts and leaders who manage these programs on a daily basis. For example, Ashley is specially trained in CCM, specifically for adolescent children. Our teams use the MCG modules, including chronic condition guidelines, and CarewebQI, etc. Ashley had access to our Medical Directors on a daily basis, who were available for consultation. Ashley coordinated with our partners as indicated that included youth partnership awareness programs, pediatric dental programs, school systems, emergency crisis teams, pediatricians, mental health advocacy groups, managing entities, human service agencies, (including the department of child and family), and behavioral health and physician health providers and facilities. Ashley did this with the guidance and support of the Child and Adolescent Program team.

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 partnering 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 child and adolescent care.

CRITERIA 5: THE EXTENT TO WHICH THE RESPONDENT DEMONSTRATES EXPERIENCE IN PROVIDING.
As we have gained even more experience with our enrollees, including Jose, 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 populations we serve. This collaborative, enrollee-centered approach to develop effective solutions to manage the health of our complex child and adolescent enrollees continues and grows to the present day. This Florida-specific experience with enrollees as complex as Jose differentiates us from any other health plan.

As Magellan Complete Care has grown, our data analytics and understanding of our child and adolescent 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 children and adolescents with special health care needs.

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:

> Targeted High and Ultra High Risk enrollees like Jose focusing on his specific high risk conditions

> Expanded and defined services to meet the specialty needs of these groups of enrollees

> Enhanced predictive modeling and ER diversion

> Utilized financial models to identify and target high cost enrollee, like Jose for additional services.

  >> Focused on Jose who we identified through predictive machine modeling with a likelihood to admit to an inpatient facility within a 90 day period. The predictive model allows Ashley the opportunity of early intervention and prevention of an unnecessary inpatient admission for Jose

  >> Decreased ICCM caseloads to create more capacity for Jose to receive high touch CC and follow up.

For Jose and our current membership, individuals continue to present with complex medical, behavioral health, and psychosocial conditions. 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.

We continue to refine our strategies and improve the outcomes for the complex membership we serve. Specifically, we increased our enrollee satisfaction with the services and treatment received by children by 15% year over year – from 75 to 90% Year 1 to Year 2.

Additionally, on a satisfaction survey conducted in Year 2, 90% of respondents indicated that “it was easy to get the care I thought my child needed” in Year 2, a 14% increase over Year 1. And, 96% of respondents indicated that “staff members helped us get as much information as we needed to help us take care of our child’s illness, including possible side effects of medications”, an 8% increase over Year 1.

Caregivers also reported a 7% fewer crises for their children in Year 2, as well as a 7% increase in caregivers reporting that service times were convenient. In addition to improving the reported satisfaction with CC and provider access, we also improved enrollee’s access to primary care – for example, by a 7% improvement on compliance with children’s annual dental visits, a 16.2% increase in weight assessment and counseling for children, and a 3% improvement in metabolic monitoring for children and adolescents on antipsychotics.

5.1 Practice Guidelines
Ashley utilized applicable national evidence-based guidelines (EBG) as a basis for Jose’s assessment, evaluation, quality management and improvement, identification of care gaps, his education, provider education, key interventions and outcomes measures. Ashley had additional resources available to her including:

> Magellan’s proprietary, evidence based integrated care guidelines and medical policies which are fully reviewed and vetted through the Magellan corporate policy and procedure committee
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> Magellan’s proprietary behavioral health medical necessity guidelines
> MCG medical necessity guidelines are currently in use
> Healthwise and MCG Chronic Care Guidelines for health education materials in English and Spanish
> The American Society of Addiction Medicine (ASAM) Criteria.

Magellan Complete Care clinical practice guidelines (CPG) give guidance to providers on the evidenced based tools which support screening for behavioral health and substance use:
> CPG cover conditions such as depression, anxiety, insomnia, panic disorder, OCD, substance use/abuse, opioid use/abuse and smoking
> CPG outline the next step in clinical management based on the disease specific assessment, for example: prescription medications, referral to psychotherapy, psychiatric consultation or urgent/emergency evaluation.

For behavioral health and for use with Jose, guidelines from the American Psychiatric Association that have been adopted by Magellan Complete Care specifically for use with children and adolescents:
> Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Post-Traumatic Stress Disorder
> Practice Guideline for the Treatment of Patients with Major Depressive Disorder
> Practice Guideline for the Treatment of Patients with Bipolar Disorder
> Practice Guideline for the Treatment of Patients with Eating Disorders
> Practice Guideline for the Treatment of Patients with Panic Disorder
> Practice Guideline for the Treatment of Patients with Schizophrenia; and

CRITERIA 6: THE EXTENT TO WHICH THE RESPONDENT DEMONSTRATES A SYSTEM OF COORDINATED...

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. Ashley and her Manager collaborated with the Quality team to ensure that the quality improvement (QI) and HEDIS initiatives specific to Jose were fully integrated with Jose’s clinically appropriate/CCM programs. Ashley and Jose’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. Ashley carried out HEDIS and quality measure initiative activities encouraging and assisting Jose 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 Jose with complex care needs and has been able to demonstrate savings for the time period of 2014 to 2016:
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>15% reduction in total care expense PMPM;
>27% reduction in ER 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 Jose (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 Jose’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 Emma’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, 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 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%:

> 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 enrolled / engaged enrollees decreased by 38%
> > All readmissions were statistically significant (over time and between enrolled and not enrolled).

In adults, similar to Emma, 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 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.

Individuals like Jose 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):

Sixty-three percent of those enrolled and engaged had highly significant improvement in their health, well-being, baseline stabilization, and outcomes.

CRITERIA 7: THE EXTENT TO WHICH THE RESPONDENT DESCRIBES INNOVATIVE AND EVIDENCE-BASED STRATEGIES TO INTEGRATE INFORMATION ACROSS ALL SYSTEMS/PROCESSES INTO ITS WORKFLOWS.

Although Jose's clinical course showed significant improvement in aggressive behavior, this is not the case for many adolescents. Consequently, our Clinical team has a heightened awareness to the possibility of adolescents with behavioral health conditions potentially hurting themselves, we ensure that the risk of self-harm is assessed and re-assessed. Our Integrated Care Case Management programs are effective in keeping individuals in the community, with enrollees engaged in our CM program 50 percent more likely to remain in a community setting nine months following an inpatient hospital discharge than those who refuse CM.
Magellan Complete Care enrollees, like Jose, who present with physical health and/or behavioral health co-morbidities, further complicates their ability to engage and diminishes 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.

Planned interventions are person-centered, individualized and disease specific. For example, in Jose’s situation, his behavioral health gaps in care have different goals than his physical health gaps in care. Interventions also take into account the enrollee’s psychosocial status 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 ICCM support.

For Jose, the CC team used several different innovative and evidence-based strategies, utilizing technology and Smartphone applications connecting Jose to health and wellness information and his parents to stress reduction services. It is essential for enrollees and their families to stay as healthy as possible and the CC team helped Jose and his parents with the Smartphone technology and services. Ashley educated Jose and his parents on Magellan Complete Care’s Cobalt services (cognitive behavioral therapy), which helped Jose and his parents reduce stress, anxiety and cope better; while achieving health and wellness goals.

Because Magellan Complete Care has its own pharmacy benefit management company, Magellan Rx Management, Ashley and the team were able to receive information through the pharmacy system to offer additional support to Jose and his parents in the area of medication adherence, utilizing flags and review alerts across and between systems.

We also use our innovative TruCare care management system to connect the other applications mentioned above into one seamless system. This approach enhanced the team’s ability to coordinate Jose’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 receives data from our claims processing and provider data applications to enable Health Services staff to assess enrollee needs, complete CC plans, and authorize services.

All of Jose’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 Jose in the CCM program operated seamlessly within TruCare, establishing a single platform for Magellan Complete Care CC/CM/UM staff across the whole continuum of care (behavioral, physical, and psychosocial), and encompassing all care settings. TruCare effectively tracked Jose’s programs and case artifacts in one place. When baseline assessments were completed for Jose, the TruCare system intuitively provided Ashley with prompts to further assess or to create a CM plan of care for Jose.
The system also provided a list of recommended problems and interventions for Ashley to select when building Jose’s plan of care, based on his assessment responses. The problems and interventions were based on opportunity areas for CM to focus support.

To most effectively identify process improvements and problem solve when necessary, we structure our analytic functions to provide daily enrollee-level information to the Operational team related to Jose’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 Magellan Rx 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 Jose’s medication over- and under-utilization.

Daily extracts of Jose’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 Jose’s risk scores meant to predict the likelihood of admitting to a hospital within 90 days. The models predicts 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 Jose’s “highest risk”. The risk status is then joined to the rules engine results to extract Jose’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 Jose’s Clinical and Health Services team within Florida. This information is then reported to the Executive team within Florida, as well as to the Magellan Health, Inc., corporate Executive team.

Biweekly meetings between the Magellan Health, Inc., corporate analytic teams and Jose’s local Florida Clinical, Quality, and Health Services team, served to examine performance of the risk stratification, health segmentation, and gaps in care for Jose. The teams reviewed current enrollment of enrollees, including Jose, into CM, identify areas of emerging risk, and reviewed analytic data related to drivers of inappropriate clinical utilization patterns. Performance of Jose based upon clinical and operational designated outcomes was tracked via Tableau or the 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 Jose 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 Jose’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 Jose’s care team. This shift allowed for the
easy exchange of information important for the success of Jose’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 Jose’s risks, complexity and need
> Stratification and assignment of Jose 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
  >> CM
  >> Care transition management and supports
  >> Complex medical, behavioral and psychosocial CC
  >> Transparency of outcomes and performance, with regular reporting, analysis and refinement of programs and interventions.

An important element of managing Jose’s care and health plan experience was the Integrated Health Neighborhood team. Our goal to improve Jose’s care, quality of life, and health outcomes could only be achieved within the context of where he lived — within his neighborhood and community. Our Integrated Health Neighborhood team lives and works within the communities where Jose resides and are important participants in supporting his stability and his path to recovery. Our team has first-hand knowledge of Jose’s community’s strengths, resources, services, and service gaps. Jose’s Integrated Health Neighborhood team included Ashley (his ICCM), Health Guides, and Community Outreach Specialists, supported by Housing Specialists, Employment Specialists, Clinical Pharmacists, Medical Directors, and others. The Integrated Health Neighborhood Model of Care enables us to effectively coordinate care with the community supports and services that Jose 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 Jose, 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 Jose, his son with supports where he lives, works, and plays. In Jose’s rural area, the Integrated Health Neighborhood had the ability to use the latest telehealth and telemedicine techniques to ensure Jose received the care and services needed. Virtual health care applications were utilized by Jose at local libraries, agencies, and/or health care offices.

No less 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.
We also participate in the MY LIFE community collaborative. MY LIFE Tallahassee was established in 2011 through partnerships with The Family Café, Palmer Monroe Teen Center, Department of Juvenile Justice, Department of Children and Families, Carters Corner, and numerous other youth serving agencies. MY LIFE is a free group for youth between the ages of 13-23 who have experience with mental health, substance use, foster care and/or other challenges. The 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.

Regular meetings are the foundation of the MY LIFE model, providing opportunities for youth to come together to create a community of support, plan activities and initiatives, practice social skills, learn from presenters and provide peer mentoring. The Magellan youth festival, MY FEST, is a signature event. The free community event is organized by MY LIFE to raise awareness and reduce stigma about mental health, substance abuse, and foster care issues facing youth and young adults. It features musical acts, dance performances, art exhibits, and resources for youth and families. Twenty MY FEST events have been held nationally which have inspired and educated over 50,000 attendees. MY FEST held its 4th annual event on November 19, 2016 in Tallahassee with over 600 people were in attendance.

Magellan Complete Care continues to collaborate with Florida-based child and adolescent stakeholders to enhance access to children’s mental health services and support educational opportunities for area youth, parents and families. Provider Support Specialists attend biweekly Management Network meetings, and Clinical Outcomes Subcommittee as scheduled.

Magellan supports and will continue to support system enhancements through:

> Development of youth specific enrollee and provider facing educational materials addressing topics such as First Episode Psychosis, Suicide, Effects of Trauma / PTSD / Dissociation, Depression in Kids, Bullying, Substance Use Disorders / Alcohol / Marijuana, “What to do if” guidelines for teens, parents, caregiver; overall teen/youth emotional health, building positive relationships, etc.

> Distribution of above materials to providers, pediatricians, PCPs, behavioral health providers; community organizations such as the Boys and Girls Clubs, schools, law enforcement. Material distribution to include a resource list of ways to get connected to services i.e., 211 information resource line, and local community mental health centers (CMHC)

> Expansion of MY LIFE - implemented April 4, 2017

> Offer technical assistance and guidance for network providers interested in building certified peer services through connection to Orlando-based Florida Coalition for Peer Support Network

> Identify Magellan Complete Care vendors / contracts with resources pertinent to youth mental health and look for opportunities to share in the community (Zero Suicide, JED)

> Ensure all enrollee-facing employees have understanding of local youth and family resources, including knowledge of evidence-based practices such as Wraparound.
Transition age youth are much more likely to drop out of high school, be arrested, be bullied and/or become homeless than other youth who do not face these challenges. In most cases these young people, like Jose, need more than just traditional clinical care to help them avoid these negative outcomes and reach their recovery and life goals. Unfortunately, many organizations, systems and communities are not utilizing emerging best practices in the area of youth involvement, youth-guided care and youth peer support that are making great strides in helping to address this disparity.

We support involving youth in the process of designing and delivering behavioral health services as a relatively new practice. It is becoming more widely accepted following recommendations from the Substance Abuse and Mental Health Services Administration (SAMHSA) and other experts. Professionals are recognizing that involving youth in the systems that serve them can improve outcomes for youth by helping them develop relationships, acquire new skills, improve behavior, build self-confidence, instill positive social supports, and cultivate leadership skills. We have noted the value in providing opportunities for youth to share their opinions and ideas to help shape policies, programs and services for their own care and for the broader community. We believe that involvement not only benefits the individual youth involved, but can also be very beneficial to programs and systems that serve youth.

Magellan Complete Care utilizes Recovery Support Navigators who are certified and trained in applying resiliency and recovery principles and tools such as including wellness recovery action plans (WRAP), 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. Jose’s Recovery Support Navigator assisted Ashley, providing additional outreach to obtain access to and engage in needed services.

7.1 Grievance and Appeals

We are committed to supporting Jose and his father 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, Jose’s experience, and outcomes for our innovative specialty health plan.

Magellan Complete Care worked with Jose, his father, and his 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.

We work to resolve issues quickly to promote Jose’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 and behaviors and how to engage them with sensitivity and empathy. Enrollee satisfaction is a critical component of empowerment, and is central to the AHCA and Magellan Complete Care’s vision for recovery and health for enrollees, like Jose.
We strive to make the complaints, grievances, and appeals process as simple and user friendly as possible. Jose 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.

Jose and his father were 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. Ashley educated Jose and his father on the grievance and appeals process with each contact she made with them. Jose and his father were encouraged to register any complaints, appeals, and grievances with Magellan Complete Care when they felt it was appropriate to do so. Jose and his father were informed of the process that Magellan Complete Care follows in investigating and providing feedback on resolution.

Jose and his father were educated that if he ever needed to report a grievance or participate in the appeal process, when he contacts the Customer Service, QI Department, or the Appeals Department, the staff would take the opportunity 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, Ashley took the opportunity to inform Jose and his father on how to work with his providers to get needed documents, or to discuss how we can help them get documents on their behalf; if Jose would need this assistance.

In Jose’s situation, Ashley reviewed the grievance and appeals process with him and his father initially with the first face-to-face visit and on subsequent calls and contacts with him. Jose had no formal complaints or concerns but expressed a good understanding of what to do in the event that he needed it. There are a number of mechanisms under which Jose and his father could file a complaint/grievance: calling Customer Service, submitting a letter to a designated address, sending by electronic mailbox, asking a PCP or other provider to submit on his behalf, or asking a Health Guide/ICCM to submit on his behalf.

All written materials are written 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 Specialists 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, 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 JOSE
At this time, Jose has been an enrollee with Magellan Complete Care SMI Specialty Plan for three months. Immediately following his enrollment and subsequent hospitalization, our CC team engaged Jose, his care providers, and his family, to ensure his needs were being met and that appropriate assessment and care planning were carried out. Jose was placed in the SIPP program following his August inpatient stay, and the Magellan Complete Care Clinical team continued to partner with Jose and his family to work toward stabilization of his physical and behavioral health conditions; plus his educational, family, community and other biopsychosocial issues.

Currently, Jose’s medications are working with minimal side effects and his thyroid function and lab work are all within normal limits. Jose has not had any further anger outbursts and is progressing positively with all of his care goals. While in the SIPP program, Jose and Rosemary monitored Jose’s progress and attended care conferences and meetings to work toward the goal of transitioning back home with his father.

CM of adolescents requires special processes. Magellan Complete Care’s assessments for adolescents have one part for completion with the adolescent, and another part for completion with the parents or guardian. Ashley specifically wanted to complete the adolescent’s portion of the HRA and review the problem list with Jose and begin goal-setting; including detailing the goals Jose identified for his recovery, which may differ from the parent’s goals.

During this discussion, Jose said that he wanted to go back to school and to see his friends. He also hoped to behave better towards his mom and not scare her—and spend some time again at her apartment. He was feeling confident that he would be able to make his mother feel comfortable.

He was feeling afraid of going back to school both socially and because he didn’t know how to catch up. He was embarrassed by how much school he had missed. And, he definitively did not want to be readmitted to the hospital or go back to a SIPP program.

With this new information, Ashley developed a comprehensive plan of care which included both the discharge transition plan and the ongoing plan of care with the SIPP program. Prior to the SIPP program, she had worked closely with the hospital discharge planner to identify follow up for his thyroid condition with Pediatric Endocrinology, and an appropriate place for outpatient therapy and after-care. Ashley served as an advocate for Jose to find an alternative to a SIPP program if his condition changed. Action and crisis plans were developed for his physical and medical conditions. Ashley made sure that the hospital and the SIPP program did medication teaching with Jose and his family, and then worked with them to identify strategies for adherence to his medications and treatment plan. For medications taken once a day, Jose decided to “rope” his toothbrush and medication bottles together. For two of his thyroid medications, this would not work because they were taken twice a day. Jose set an alarm on his cell phone and he agreed to call Ashley if this method did not work.
Ashley also reached out to Jose’s PCP to bring her up to date and see what information she needed to follow Jose. The PCP was appreciative to get a call and wanted to see Jose within the first month after discharge. Ashley included EPSDT and immunizations in Jose’s plan of care to ensure that Jose receives appropriate Child Health Checkup visits in accordance with nationally recognized and state specific guidelines. Jose’s EPSDT and immunization information is documented in TruCare, offering alerts and tasking activities as a tool for Ashley to use when coordinating care for Jose. Ashley reviews the Healthy Behaviors incentive program with Jose and his parents.

With the discharge transition and plan of care in place, and with significant improvement in Jose’s clinical situation, he was discharged home with his father. Ashley checked in the day after discharge to make sure that his medications were picked up at the pharmacy. She confirmed with Jose’s father the follow-up appointments. Jose’s father was also going to call the school to get an IEP case conference scheduled and asked Ashley to attend along with Jose’s mother. Jose’s father also said that the TCM had been to the home to visit. Jose liked the TCM, so that was a great first step.

Ashley stayed in closed touch with Jose, his father and his mother during the first month after discharge. They talked at least once a week. Ashley also touched base with Jose. She checked to make sure that Jose was keeping appointments, taking medications, and going to school. She also checked in with his parents individually to get their perspective and to offer support and encouragement.

During the month after discharge, Jose made great progress towards his goals. He was able to take his medications on time and his parents were very proud of his responsibility. He met with the school and together they figured out a plan that Jose felt would work. Jose was able to visit his mom’s apartment twice for two hours and see his siblings. He followed up with the endocrinologist who was pleased with his thyroid treatment. Family therapy continued for therapeutic engagement of family issues and parenting skills.

On this basis, Ashley and the family revised Jose’s goals as he accomplished his milestones. They also agreed that they would talk every other week; knowing they could call anytime they needed something. Over the few months, Jose would meet his goals. He stayed out of the hospital. Ashley continued to call and meet with the family as scheduled and to monitor Jose for stabilization over a six month period. Jose and his family felt more secure with Jose’s progress and more knowledgeable about his condition and plan of care.
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 that the plan has in place;
   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 information about the enrollee 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 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 provide evidence of strategies utilized that resulted in improved health outcomes.

6. The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.
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7. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) 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.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK
MMA SRC# 19 - Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Jane is a 57-year old female with Type II diabetes mellitus and hypertension. Jane is compliant with her treatment plan, which consists of the following prescribed drugs: Insulin and Lisinopril. She is also compliant with her follow-up appointments with her specialists. She lives alone, but receives support from her eldest daughter who lives nearby. Jane thought she timed her follow-up visit with her endocrinologist adequately to allow sufficient time to receive a new prescription for all drugs; however, Jane realizes she only has enough insulin to last through the doses for tomorrow. Her appointment with Dr. Seem, her endocrinologist, is in two weeks. Jane calls her doctor's office who informs her that they have no availability to see her today or tomorrow and Dr. Seem will not write a new prescription without examining Jane since it has been four months since her last appointment. Jane decides to call her health plan’s member hotline for assistance.

The respondent shall describe the approach for handling Jane’s call and how the respondent would help Jane obtain her medication.

Response:

OVERVIEW: MAGELLAN HEALTH CARE’S HIGH TOUCH EXPERT CUSTOMER SERVICE

Jane’s call may be fictional but it resonates in a very real way with Magellan Complete Care’s Serious Mental Illness (SMI) Specialty Plan. This is not a unique situation for our enrollees as they commonly reach out to us for help. In 2016, the Magellan Complete Care Customer Service call center received approximately 150,000 enrollee calls. Almost 11,000 of them (7.25 percent) were about medication issues. Similarly, in 2017 from January through September, we received approximately 121,000 enrollee calls with more than 6,500 (nearly 5.5 percent) were about medication issues.

Magellan Complete Care has the experience and specialized expertise to help Jane and other enrollees through challenges; like the one described in Jane’s vignette. We take her situation as seriously as she does and are prepared to go the extra mile to help her get her insulin. Our primary goal is for Jane to get her medication in the least restrictive setting and to avoid a preventable visit to urgent care or the emergency department to receive a new prescription. We ensure Jane’s outreach to us is as supportive, seamless, and results-oriented as possible. Our call center’s commitment to support the enrollee is also demonstrated by our average call handling time at approximately 10 minutes. Our extensive Medicaid integrated behavioral health and primary care experience combined with the depth of expertise of our well-trained staff, our capacity to be flexible with call handling times allows for multi-departmental engagement allows us to provide the strongest support for our enrollees.

When Jane realizes that her insulin is running out, she knows how to reach Magellan Complete Care for assistance and support with a simple telephone call. A Magellan Complete Care Medicaid Member Handbook and Welcome Kit was previously mailed to Jane when she enrolled with Magellan Complete Care. Included in the Welcome Kit was her ID card, which
included our toll-free Customer Service number at 1-800-327-8613. When she calls this number, she reaches a well-trained Customer Service Representative in a timely manner.

CRITERIA 1. THE ADEQUACY OF THE RESPONDENT’S APPROACH IN ADDRESSING THE FOLLOWING:
1.(A) Training For Call Center Staff That Illustrates The Ability To Triage Cases Of This Nature, Including The Internal Escalation Process Available To Call Center Staff.

Magellan Complete Care’s Customer Service Center is not your typical call center – each of the Customer Service Representatives diligently engage our enrollees to best understand the true and complete purpose of the call; serving as an important information resource, collaborative advocate, and effective problem-solver. This foundational approach to our enrollees’ experience and our level of engagement is critical to meet the unique needs of our SMI enrollees and their providers.

Each Customer Service Representative has extensive cross-training to support both enrollee and provider calls, which reflects the integration of behavioral health and primary care and allows a single representative to handle any type of call. In addition, Call Center supervisors, leads, and representatives are available to support calls real-time. This team approach offers robust and effective support for all enrollees, including Jane.

1.(a).1 Extensive Customer Service Training at the Outset and Beyond
Like all Customer Service Representatives at Magellan Complete Care, the Representative helping Jane has successfully completed an extensive 4-week orientation and training program that includes nearly 100 unique training sessions and practical experience simulations that include scenarios similar to the one presented by Jane’s call.

In consultation with the Magellan Complete Care leadership team in Operations and Health Services, this training program was developed and is conducted by the Customer Services Senior Trainer, who started at Magellan Complete Care as a Customer Services Representative herself. Our Senior Trainer took the very first enrollee call when Magellan Complete Care began operating as AHCA’s first SMI Specialty Plan in 2014. Thus, she is very experienced in supporting the Representatives’ needs and has the expertise and skills to most effectively help our enrollees.

The Customer Services training curriculum includes a comprehensive set of topics covering various aspects of supporting and assisting individuals with SMI, Medicaid managed care in Florida, and Magellan Complete Care’s business operations. Every Representative is trained on, for example:

> magellan Complete Care benefits and coverage, including behavioral health and physical health integration, as well as pharmacy;

> Enrollee rights and responsibilities, including caller identity verification and use/disclosure of protected health information;

> Call handling and process flows, including tele-professionalism, dealing with difficult or crisis calls, as well as escalation and referral of issues;
Orientation to and working in the Customer Service system, Total Member Record (TMR) for call documentation, and accessing our Health Services authorization system, TruCare, for research;

Coordinating with providers on an enrollee’s behalf, including arranging appointments and providing other assistance to access services;

Care coordination programs offered by Magellan Complete Care, including those in disease management for diabetes and other specified medical conditions; and

Arranging for other enrollee supports such as interpreter services and transportation.

All training is conducted upon hire and then occurs on a topic-specific basis periodically thereafter.

By the time each of our Customer Service Representatives has completed this training, they are well equipped to help Jane. They have learned what they need to know through instructor-led education, web-based education, live sessions with subject matter experts from critical areas of Magellan Complete Care’s business, written materials including desktop procedures (DTP), tests and quizzes to demonstrate retention and understanding, hands-on practice on systems; role-playing in taking calls and creating documentation; and “shadowing” experience with high-performing Customer Service staff on live calls.

Our Representatives are trained in detailed, step-by-step procedures in call handling as a core and critical part of Customer Service training curriculum. These procedures start with a call being received by the Representative from the call center queue, through the identification of the reason(s) for the call, best approaches to assist the caller, to warm transfers to other areas of Magellan Complete Care if the Customer Service Representative cannot fully resolve the call.

This training, accompanied by documented desktop procedures and scripts, covers that which should be done to address all incoming enrollee calls. When Jane calls into our Customer Service call center, for example, our Representative has been trained to verify Jane is who she says she is, and triage the call according to Jane’s needs, by listening closely to Jane as she describes why she is calling and talking with her in a calm, capable and collected manner. The Representative has further been trained to help Jane directly, if possible, and/or warm transfer her to the appropriate department based on what must be done – no matter why Jane is calling – and to document all aspects of the call in TMR.

Handling of more specific types of calls is covered in depth within Customer Service training, with focused attention on more commonly-received calls from our enrollees, such as medication issues like the one that prompted Jane’s call to us. Magellan Complete Care receives so many calls from enrollees regarding medication questions and issues that our Customer Service training includes “Pharmacy Troubleshooting” as a core segment of the curriculum. It covers issues such as a pharmacy not being able to fill a prescription, an enrollee or provider’s question regarding whether a medication is covered, an enrollee is asking about their lock-in to a pharmacy, or as in Jane’s case, the enrollee needs an early refill. For each of these issues,
our Representatives are trained on specific actions to take to most effectively address the issue for our enrollee.

In the case of an early refill, these Representatives are instructed to gather the following information: the name of Jane’s insulin and current dosage; the date the prescription was last filled and why she needs an early refill. The Representative is trained to further try to help by contacting the pharmacy to verify the status of the prescription as well as Jane’s doctor to see if their office can assist. The Representative is trained to ultimately refer Jane (via warm transfer) to our CareLine for coordination of her care. In the event no one is available on the CareLine to speak to Jane, the Representative to whom she is speaking also knows from this training to send an email to her integrated care/case manager (if she has one) or a Health Services supervisor for follow-up.

1.(a).2 Use of Technology Supplements Customer Service Training
Our Customer Service Representatives also have real-time system access to Magellan Complete Care’s customer service shared access location, called Box, which supplements initial and periodic facilitator-led formal training. Box contains all of our desktop procedures, step-by-step guides, workflows, and other written resources to support Representative call handling.

We use this technology particularly to take advantage of the functionality offered by Box that allows a Representative to quickly search documents for information by related terms; locating all of the files that pertain to their search. This quick search functionality enables our Representatives to find what they are looking for faster and keep pace with the caller.

In addition, this technology also makes it easier to get new informational resources out to Representatives in an easy-to-share, centralized format. Because of this enhanced technology, our training becomes truly real-time and use of this system affords our enrollees and providers, a more seamless, results-oriented, and enhanced experience.

1.(a).3 Internal Escalation Response for Call Center Staff
If Jane appears to be agitated or upset at any time during the call, our Customer Service Representative has been trained to do their best to engage her in non-threatening low volume conversation to try to obtain as much information as possible, in a calm and empathetic manner. The Representative does his or her best to appropriately reassure Jane that Magellan Complete Care will help. All of our Representatives practice with a supervisor for effective listening and de-escalation techniques to make interactions with enrollees and providers as individualized and positive as possible, and they are equipped to handle even the most difficult of situations, including, for example, if Jane is upset because her prescribed Insulin is running out by the following day and she needs our help to obtain a refill.

1. (a).4 Responding to Enrollee Inquiries
There are many ways in which Magellan Complete Care can help Jane through our Integrated Care Coordination/Case Management (CC/CM) model of care. Customer Service Representatives support the model of care in many ways each and every day with our enrollees; no matter the issue, concern, or question. The Representative speaking to Jane is also trained and expected to familiarize Jane with her covered benefits such as vision, dental, and transportation.
EXHIBIT A-4-b  
MMA SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA (10-2-17)

Our Customer Services Representatives are also expected to assist the enrollee with inquiries, such as if Jane asked about a grievance or appeal she had filed. Representatives are trained on all key applications to support the enrollee during the call; such as Total Member Record (TMR), Customer Service documentation, and Resolve, our resolution application. These applications are vital to integrating information from previous calls from Jane and tracking any support follow up needed after the call. In the case of her inquiry about a grievance or appeal, for example, if there is no outcome in the case yet, our Representative would inform Jane that the matter is still in progress. If there is a resolution, our Representative reads the outcome to Jane from a copy of the resolution letter uploaded in Resolve.

1.(B) Description Of The Interventions And Strategies That Would Assist Jane In Avoiding A Visit To Urgent Care Or The Emergency Department To Receive A New Prescription.

1.(b).1 No-hold Transfer to Professional CareLine Staff

Jane may appear calm and in control when she calls the Magellan Complete Care Customer Service call center, but since she is usually so effective in self-managing her treatment, including her medications, she may be upset her Insulin is so close to running out. For Jane, she has the option to select #1 in Interactive Voice Response (IVR) if she feels in crisis. In that case, her call is routed as a priority in this queue. Our Representative promptly answers the call and sees it as a crisis from the screen. Once this Representative obtains information from Jane and appropriately determines it is a crisis (and not, for example, a misdirected call), Jane uses the no-hold conference option to bring our CareLine staff on the line consistent with our Customer Service call handling and crisis call protocols. The same would occur if Jane appears to become upset while already on the call and our Customer Service Representatives’ efforts to calm Jane do not appear to work.

The individuals staffing the Magellan Complete CareLine, available 24 hours each day, are behavioral health Licensed Clinical Social Workers and Nurses well-trained to handle calls from upset enrollees who need help with a health-related issue. If Jane is transferred to the CareLine, our Customer Services Representative stays on the call for the entire time to assure appropriate support and resolution is provided, or until the CareLine Nurse/Social Worker indicates they will assist Jane from that point.

These Nurses and Social Workers help enrollees choose appropriate medical or behavioral health care; find a provider, specialist, or hospital in their community; understand treatment options; answer health coaching and enrollee health questions; and answer medication questions. These CareLine staff are extensively trained to help enrollees like Jane from a clinical standpoint, and know how to talk with an enrollee in a comforting and soothing manner. Before they even help Jane with her medication issue, CareLine staff can work to calm Jane down and reassure her that Magellan Complete Care is there to help.

1.(b).2 Verifying the Status of Jane’s Unfilled Prescription

While there are many opportunities to support an enrollee who calls us, our priority on Jane’s call is to assure her we will try to get her refill of Insulin. Jane continues to work with our Customer Service Representative, and because there may be miscommunication and/or misunderstanding about refill status, our Representative verifies the status of Jane’s prescription. This Representative gets the names of her medications, as well as the name and contact information for Jane’s pharmacy.
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Our Customer Service Representative asks Jane if she is willing to wait on the line, while reaching out to Jane’s pharmacy to determine if a refill is left on both the Insulin and Lisinopril prescriptions. If Jane is not willing or unable to wait on the line, the pharmacy is called and the Representative calls Jane back to confirm status and next steps.

1.(b).3 Contacting Dr. Seem’s Office
If a call to Jane’s pharmacy confirms that she does not have a refill on her Insulin or Lisinopril, our Representative transfers back to Jane and explains the need to call Dr. Seem, her endocrinologist’s office, to see if the Representative can help Jane get an appointment as soon as possible.

Assuming Jane is fine with staying on the line, our Representative puts her on hold and calls Dr. Seem’s office. The Representative explains the urgency of Jane’s situation and asks if there is any opening for Dr. Seem or his colleagues to see Jane on a walk-in basis, through another patient cancellation, or other possible accommodation. Alternatively, our Representative asks the office staff to check with Dr. Seem to see if he is willing to make a one-time exception for Jane by writing prescriptions for her today; with the understanding that she has an upcoming appointment within two weeks.

If Dr. Seem’s office staff indicates they can fit Jane into the schedule, our Customer Service Representative confirms the time Jane needs to arrive. The Representative transfers back to Jane to share the new appointment time. Alternatively, if Dr. Seem is willing to write a prescription for her, the Representative shares that information with Jane. In either case, our Representative asks Jane if she has transportation to Dr. Seem’s office and/or the pharmacy. If Jane does not, our Representative would give Jane the option of calling to schedule transportation with Veyo, our non-emergent transportation (NET) subcontractor, or having the Representative assist in scheduling the transportation for her.

1.(b).4 Contacting Other Physicians/Providers
Some of Magellan Complete Care’s contracted providers do not accept patient appointments on a walk-in basis. So if Dr. Seem’s office does not accommodate a request for an appointment or is not able to provide a prescription prior to the Insulin running out, the Customer Service Representative asks Jane if she is willing to see another in-network provider. If she is, our Representative looks for another provider in Magellan Complete Care’s network near Jane, who is able to see her on an expedited basis. If Dr. Seem is not Jane’s PCP, we start there. If her PCP cannot see her or if Dr. Seem is her PCP, our Representative tries to locate another provider, via search of the Magellan Complete Care on-line directory.

In a call to the provider’s office, our Representative confirms the day and time with office staff and transfers back to share this information with Jane. It is possible that our Representatives could reach out to at least a few providers to arrange a new appointment for Jane; if for some reason, they cannot locate one, the Representative refers the case to a specialized sub-team in Customer Service for further research. This is done on an expedited basis given the time sensitivity of Jane’s situation.

1.(b).5 Health Service’s Staff Assistance
If Jane is not willing to see another provider or if our Customer Service team cannot find a provider who will see her on such short notice – or if Jane’s medication issue remains
unresolved for any other reason – our Representative advises Jane that she would like to refer Jane to Magellan Complete Care Health Services for additional assistance. Jane has been with us for some time, so she may have a Case Manager or Wellness Specialist already working with her who can assist her. Jane has done such a good job of self-managing her care in the past, she may not. In that case, a Health Guide provides assistance.

Assuming Jane is still willing to stay on the line, the Customer Service Representative tries to reach Jane’s Case Manager, Wellness Specialist or an available Health Guide who can continue working with Jane. If our Representative reaches a Case Manager or Health Guide, the Representative stays on the line for a warm-transfer to introduce Jane. If the Representative cannot reach Jane’s Case Manager, Wellness Specialist or a Health Guide, our Representative sends an email referral to them with a full description of Jane’s circumstances. All of this activity is documented in the TMR system and can be referenced by the various staff that may support Jane during this call or for any future or follow-up calls. Magellan Complete Care staff document 100 percent of calls to assure access to Jane’s history.

1.(b).6 In-house Clinical Pharmacist Assistance
If the Customer Service Representative cannot resolve Jane’s medication issue directly, our Representative transfers Jane to someone else who can help – the issue will not be left unresolved. As described above, that could be someone on the CareLine, a Health Guide, or Jane’s Case Manager. From that point, and if Jane agrees to stay on the call, our clinical staff reaches out to her pharmacy to request a medication override in real-time.

The call to her pharmacy is made by our designated in-house Clinical Pharmacist, who has more than 10 years of Medicaid managed care experience. He reviews Jane’s medication history in FirstTrax, the clinical system of record for Magellan Rx Management, to which he has complete access. If the Clinical Pharmacist had any questions regarding a narcotic or any other medication, he might, for example, consult with one of our Medical Directors, Jane’s Case Manager (if she has one), and/or a Wellness Specialist assigned to Jane if she is in a Disease Management program. The Clinical Pharmacist consults with pharmacists at Magellan Rx Management for medication issues.

In this vignette, after reviewing available pharmacy information about Jane and finding no contra-indication or other concern, and given the apparent urgency here, our in-house Clinical Pharmacist approves an override for these very critical maintenance medications.

The Clinical Pharmacist then reaches out to a Magellan Rx Management technician to facilitate the override. For non-urgent cases, he sends an email to a Magellan Rx Management mailbox maintained for this purpose. This mailbox is checked by a technician several times each day. In Jane’s case, and other cases that are clearly more urgent, our Clinical Pharmacist calls Magellan Rx Management and speaks real-time to a technician. Given that Jane’s Insulin and Lisinopril is about to run out, Magellan Rx Management reaches out to Jane’s pharmacy to indicate that an Insulin refill is authorized and the pharmacy should fill it the very same day.

At the same time, our Clinical Pharmacist advises our staff that an override has been put into place, and the Representative returns to the line to inform Jane. If for some reason Jane was not able to stay on the line, our staff calls Jane back to inform her that the refill would be available later that day.
Again, we would verify that Jane has transportation to the pharmacy and if not, would give Jane the option of calling to schedule transportation with Veyo, our NET subcontractor, herself or have Magellan Complete Care staff assist in scheduling the transportation.

1.(b).7 Arranging Transportation to Obtain Prescription
Assuming it is our Customer Service Representative who has stayed on the telephone with Jane while her medication issue is resolved, our Representative then asks Jane if she has transportation to the pharmacy to pick up the prescription. Any of our staff who talk with Jane would do the same. If Jane indicates that she does not have transportation, the Magellan Complete Care team member talking with her would first try to ascertain if Jane’s daughter can assist her. If not, our Representative outlines Jane’s transportation benefit and offers to help her arrange for transportation to the pharmacy. Jane is provided with the contact information for Veyo as well.

Our Representative asks Jane if she would like assistance contacting Veyo on a three-way call. Magellan Complete Care has agreed that Veyo will typically have a three day notice to arrange for NET. However, Veyo accommodates a request for unexpected circumstances like this one, as long as Veyo has a driver to assign to the trip. If Jane’s needs can be accommodated, Veyo’s driver schedules to pick Jane up and take her to her pharmacy, and then back home. On the three-way call, this solution is established with Jane fully engaged.

We support Jane in other ways to help make sure she does not find herself in this situation again. For example, once our staff knows there are effective arrangements in place for Jane to get an immediate refill of Insulin before her current supply runs out, our Customer Service Representative asks Jane if she needs to speak to her Case Manager, if she has one. If she does not, we work with Jane to make every attempt to prevent this issue from occurring again.

1.(b).8 Health Risk Assessment Confirmation
When our Customer Services Representative is working with Jane, she looks in TruCare, our clinical system of record, as she has been trained, and determines if Jane has completed a Health Risk Assessment (HRA). If Jane does not have a completed or current HRA, the Representative asks if she can connect Jane to a Health Guide to have the HRA completed; after Jane’s prescription refill is resolved. Alternatively, our Representative might see in TruCare that Jane already has a Case Manager. In that case, the Representative asks if she can transfer Jane to her Case Manager for additional engagement. In the event Jane has no HRA completed and no Case Manager, and a Health Guide is not immediately available, our Representative emails a Health Services Supervisor, requesting that someone contact Jane to complete a HRA as a critical intervention point to assure effective CC/CM for Jane moving forward.

This outreach regarding the HRA is accomplished by Magellan Complete Care’s subcontractor Engaging Solutions (a minority, woman-owned, small business). Engaging Solutions conducts new enrollee outreach and annual HRAs, as well as necessary follow-up outreach to all enrollees that Magellan Complete Care did not reach to complete an HRA upon initial enrollment. Even though Jane is typically able to self-manage her care needs, completion of a new or updated HRA further engages Jane to assure that we assist when necessary and as proactively and holistically as possible.
1.(b).9 Disease Management Consultation
As it turns out, Jane is enrolled in both our Diabetes and Hypertension Disease Management program and based on what is documented in the TruCare system, our Customer Service Representative asks Jane if she needs/wants to speak to the Disease Management Wellness Specialist assigned to her specifically about her diabetes and hypertension conditions. If Jane was not already in a Disease Management program, the Representative asks Jane if she is interested in a program to help manage her diabetes and hypertension. Jane is already participating in both of these disease management programs. Please refer to [Attachment 10-XX Jane’s Plan of Care.]

At Magellan Complete Care, we know that when talking to enrollees, it is important to remind them about their yearly appointments. Jane’s Wellness Specialist reminds Jane of the importance of a yearly PCP visit, yearly dental visit, yearly eye exam, yearly gynecological visit, and any of the HEDIS gap in care screenings specifically related to diabetes management and blood pressure monitoring. The Representative would also inquire and remind Jane of her breast cancer screening (mammogram) based on her PCP’s recommendation.

Because Jane has Type II diabetes, the Wellness Specialist, as part of the Disease Management program, also mentions that she should also have HbA1c bloodwork completed; and to prevent any problems with her feet, a podiatrist visit for a foot examination. In addition, the Wellness Specialist reviews with Jane hypertension management, blood pressure monitoring, and Healthwise diabetes and hypertension health information.

1.(b).10 Magellan Complete Care Provides Language Interpreter and/or Translation Services
Magellan Complete Care’s Customer Service call center employs English and Spanish-speaking Representatives. If at any time, Jane indicates that she is more comfortable speaking to Customer Service in another language, or if the Customer Service Representative otherwise determines an interpreter is necessary, our Representative places Jane on hold and contacts Pacific Interpreters, our language interpreter subcontractor, to provide an appropriate interpreter. The call is then conducted with three parties – (1) our Customer Service Representative, (2) Jane, and (3) the interpreter from Pacific Interpreters.

If Jane needed written documents translated (language or Braille), the Customer Services Representative sends a message to the Customer Services Mailbox for processing of this translation request by our Creative Services Member Relations team. The translated documents are produced and mailed to Jane.

1.(C). Evidence Of The Integration Between And Among All Relevant Departments, Including Subcontractors If Applicable, To Facilitate A Seamless Resolution.
By now, Magellan Complete Care has helped Jane with a plan to get her medications refilled without having to go to the ER or urgent care. Magellan Complete Care’s Customer Service team involved a number of internal departments and subcontractors to timely and effectively institute interventions and strategies to resolve her immediate issues. This is a critical element to our integrated and holistic approach to coordinating care and arranging for services for all of our enrollees, like Jane.

The Magellan Complete Care SMI Specialty Plan integrated and holistic approach involves the following key components:
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>24/7/365 CareLine, which is staffed with licensed clinical professionals who work with Jane in calm and in crisis to address her immediate medication issue; among other issues and concerns, even during off-hours. Customer Service Representatives are well-trained to interact, warm-transfer and seek the assistance of the CareLine team when necessary.

>Health Guides, who, as their title suggests, serve an essential role in guiding our enrollees through their “member journey” with us. More specifically, Health Guides ensure that our enrollees, including Jane, have completed HRAs and access to integrated CC/CM services, including Disease Management programs. Our Customer Service Center knows when and how to engage our Health Guides based on the extensive training they receive regarding our integrated business operations and model of care. In Jane’s case, if she was assigned to a Health Guide, our Customer Service Representative knows by looking at Jane’s profile in TruCare. The Representative engages that Health Guide, during the call with Jane or afterward, by assuring that both the issue and its resolution are fully documented. If Jane does not already have an assigned Health Guide, but could be helped by one, the Representative makes a request to Health Services.

>Integrated Care Case Managers (ICCM) act as single point of contact and engagement in the healthcare management for our enrollees. As with our Health Guides, our Customer Service Representatives know when and how to engage ICCMs for our enrollees.

>Pharmacy supports our enrollees both through a designated in-house Clinical Pharmacist available to problem-solve with clinical teams at Magellan Complete Care, and Magellan Rx Management to assure that the administration of medication issues like Jane’s is carried out to its logical and most effective resolution. The Customer Service Representative assisting Jane, after exhausting all approaches to help, reaches out to our Health Services team for consultation and resolution. Whether it is the CareLine team, a Health Guide, or the ICCM, they in turn reach out to our Clinical Pharmacist for a medication override, and other discussion as needed based on Jane’s overall health profile.

>Medical Directors for physical and behavioral health are consulted as needed by our Clinical Pharmacist and/or Jane’s ICCM, if she has one, in the event that her overall health and care management profile warranted it before authorizing a medication override.

>Engaging Solutions conducts enrollee outreach on behalf of Magellan Complete Care, including HRA assessments and HEDIS outreach in support of our QI initiatives. Our Customer Service and Health Services teams are very accustomed to working with Engaging Solutions, our subcontractor, as they have been doing so since 2014. In Jane’s case, Engaging Solutions would assist us in ensuring that Jane has a completed and current HRA; in the event that we determined this through resolution of her medication issue.

>Veyo is Magellan Complete Care’s subcontractor to provide NET to our enrollees for their medical or behavioral health appointments. Our Customer Services and Health Services teams work closely with Veyo and our enrollees to arrange for transportation. If an enrollee, such as Jane who is typically managing her own care needs in an effective manner, wants to make arrangements, they have access to Veyo’s contact information in the Welcome Kit and/or can obtain that information any time by calling Customer Service at 1-800-327-8613.
>Pacific Interpreters, which is a comprehensive language interpretation services provider, serves as Magellan Complete Care’s language line solution to eliminate language barriers for limited English proficient enrollees. Pacific Interpreters has served our SMI enrollees since the inception of the Magellan Complete Care Specialty Plan in 2014 by providing telephonic language interpretation.

Whenever our team, including Customer Service, is engaging with an enrollee who speaks a language other than English or Spanish, we help connect the enrollee to Pacific Interpreters, who has the ability to facilitate language interpretation in more than 240 spoken languages.

CONCLUSION – RESULTS FOR JANE
Upon contacting the Magellan Complete Care Customer Service Center, Jane was assisted by the Customer Service Representative who helped her successfully obtain a one-time emergency refill for both her Lisinopril and her Insulin. The Customer Service Representative was also able to assist Jane in scheduling an appointment with her PCP to get her ongoing prescriptions filled. In addition, the Customer Service Representative connected Jane to her assigned Disease Management Program Wellness Specialist who followed up with Jane in the area of both her diabetes and hypertension management. The Customer Service Representative also reviewed with Jane the importance of following up with all of her related health visits and screenings, along with instructions to access the CareLine 24/7.

Evaluation Criteria:

1. The adequacy of the respondent’s approach in addressing the following:
   
   (a) Training for call center staff that illustrates the ability to triage cases of this nature, including the internal escalation process available to call center staff.
   
   (b) Description of the interventions and strategies that would assist Jane in avoiding a visit to urgent care or the emergency department to receive a new prescription.
   
   (c) Evidence of the integration between and among all relevant departments, including subcontractors if applicable, to facilitate a seamless resolution.

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.
MMA SRC# 20 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Emma is four-years old. She currently lives in a pediatric nursing facility. At the age of two she was admitted to PICU following a respiratory arrest during an acute illness. A further complication of her condition led to her requiring a tracheostomy to support her breathing. Following an acute exacerbation of her condition, she is now unable to breathe without the support of her ventilator when she is tired, asleep, or unwell. She is fully ventilated overnight. Her difficulties are compounded by complex seizures. Emma’s doctor says Emma needs to have nurses or health care assistants with her at all times to monitor her ventilation. Emma’s most recent developmental screening indicates the presence of an intellectual disability. Emma’s condition has stabilized, but her mother is concerned about agreeing to bring her home permanently. Her mother is the sole income for their home, which includes three older siblings and Emma’s maternal grandmother. Emma’s grandmother is retired, and her ability to help the family is limited by severe rheumatoid arthritis.

To be discharged to her home, Emma’s physician has ordered a custom wheelchair that must be individually fabricated and assembled. Her physician also ordered an electronic tablet to provide cognition exercises for Emma. The tablet has a cognition exercise application that reduces the likelihood for any seizure activity that may occur with other similar tablets. Florida Medicaid does not cover the tablet nor the wheelchair, which includes a part that will make it easier for Emma to hold the tablet. Her mother is unable to bear the costs for these special service items. Further orders for Emma’s transition to home care are:

- Continuous pulse oximetry monitoring.
- Apnea monitor when she is not on the ventilator.
- A backup generator for the ventilator if the power goes out in the home.

Emma is a new enrollee. Prior to her enrollment, all services were provided through the Medicaid FFS delivery system.

The respondent shall describe its approach to coordinating care for an enrollee with Emma’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 EMMA’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, assessment, 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. As the Serious Mental Illness (SMI) Specialty Plan, we engage enrollees like Emma using a flexible, person-centered approach ranging between less intensive to very high touch engagement, customized to the specific, often complex needs of adult and pediatric individuals with disabilities, SMI, serious emotional disturbance (SED), and substance use disorders (SUD).

In addition, we have experience in coordinating care for complex children, like Emma, who present with physical, intellectual, and developmental disabilities accompanied by highly technical care needs. We offer access to specially trained clinical staff 24 hours each day. Consistent with our daytime staff, our 24/7 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 and intellectual disabilities.

Emma’s vignette may be fictional, but it resonates in a very real way with Magellan Complete Care. As complex and relatively rare as Emma’s care needs are—it is not an entirely unique situation for us to address. As a new enrollee, we want Emma and her family to count on us to collaborate care in an effective partnership, providing assistance and support. Indeed, we are privileged to help them through the plan of care laid out for Emma; with the understanding that having her in the least restrictive, but safest environment possible, is the goal. We will work with her family, her current clinical caregivers, and others in their community to ensure that the path forward is supportive. In addition, we want those closest to Emma to be as motivated, educated, and prepared as possible to meet the challenges of her complex care needs.

In applying principles of choice and control over the decisions affecting our enrollees’ lives, we work with them, in this case the family, to sustain and if possible, maintain health and wellness within the home and immediate community. We focus our efforts on integrating care, services, and supports to holistically address each of Emma’s various, separate but inter-related, complex needs.

Magellan Complete Care’s approach to assisting Emma and her family in coordinating the complex care and services she needs is achieved through our regionally-based, Integrated Health Neighborhood approach. This approach customizes Emma’s plan of care, quality of life goals, and health outcomes; focusing on achieving these things within the context of where she and her family are—within a neighborhood and community of resources, support systems, and programs. Our approach is made more “local” in that our Integrated Health Neighborhood team live and work within the same communities as our enrollees.
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The Integrated Health Neighborhood approach promotes relationships and collaborations with community partners enabling us to effectively coordinate care with the community supports and services that Emma's family and current caregivers may already know and trust, and a provider delivery system they can readily be accessed. The Integrated Health Neighborhood drives close collaboration with Emma's current facility and other community partners; allowing us to customize care for her, and to provide a seamless infrastructure of services and supports.

This approach also includes bridging language and cultural barriers, service access, and transportation challenges to more effectively and efficiently facilitate access to the high technology services that Emma needs to support her at home. Magellan Complete Care's Child and Adolescent Program is a specialized program offering services and supports for all children enrolled in our health plan who are diagnosed with SMI and accompanied with complex health care needs. In this program, we offer all of our CC/CM services and collaboration with several different county-based child collaborative programs.

Magellan Complete Care has developed its robust CC/CM program, which includes clinical approaches spanning the health and wellness spectrum, including CC, health and wellness, population health, and complex case management (CCM). We have developed and used a number of interdependent policies, processes, and protocols that support these approaches and are essential for Emma as her family accesses essential health services—physical health, behavioral health, social health, or a combination of all three.

More particularly, Magellan Complete Care will connect Emma, her family, and current caregivers with our Health Services team that have first-hand knowledge of and experience in coordinating care for children with special health care needs. The Health Services team assists in identifying specific community strengths, resources, services, as well as any potential gaps. Emma's Magellan Complete Care Integrated Health Neighborhood team includes her assigned Integrated Care Case Manager (ICCM), Health Guides, and Community Outreach Specialists, supported by Wellness Specialists, Clinical Pharmacists, Medical Directors, and others.

Due to the complexity of Emma’s situation, coordinating care for an enrollee with Emma’s profile includes, most essentially, the assignment of an agreed upon Magellan Complete Care ICCM who leads all aspects of Emma’s CC/CM activities as they continue to develop and change. Emma’s assigned ICCM is “Dolores”, who takes the lead on engagement with Emma and her family when carrying out the CM process for the aspects of care and services that Emma needs. Starting from the very beginning of our partnership with Emma, including new enrollment, Magellan Complete Care mobilizes and stays just as active all throughout the journey to support Emma and her family.

For purposes of this vignette, as the Specialty Plan, we are focused on collaborating with Emma’s pediatric facility where she receives the greater part of her highly skilled and technical care. We offer coordination of services for select items while she is in the facility. Magellan Complete Care is called in to review and assist Emma’s family and facility providers as Emma’s condition has stabilized and she may be able to go home. By partnering with Emma’s mother and extended family to assist and support them in managing Emma’s social, developmental disabilities, and physical health needs, we strive to achieve the least amount of disruption to their daily life, but to also enhance it as much as possible.
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MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Starting from the very beginning of our partnership with Emma’s mother, from the time Emma is enrolled with us, Magellan Complete Care mobilizes and stays active all throughout our journey of partnership, engagement, and support. To that end, we already have well-developed and effectively operating programs and processes, as well as highly specialized experts to consult, so we make a meaningful difference in her life.

Emma is eligible for enrollment in the Specialty Program because she has Florida Medicaid benefits and otherwise qualifies for managed care enrollment based on her disabilities. At some point in her tenure with Medicaid, she was assigned to Magellan Complete Care (or her mother chose our health plan for her). In any case, we are the perfect choice for her because of our holistic person-centered approach to getting her the services, supports, and durable medical equipment (DME) she needs.

As the Specialty Plan, we engage Emma’s mother and her current clinical caregivers, as well as any pediatric nursing facility case manager already supporting her plan of care, other health insurance and state funded program staff, and case managers, to employ a high-touch, person-centered approach, customized to Emma’s specific, often complex need. We take into account her social, as well as physical and behavioral health determinants. In her current and very complicated situation, Emma is eligible for enrollment in Magellan Complete Care’s CCM program as her risk level would score at an Ultra High Risk level based on our predictive modeling and risk stratification construct.

Given her historical and ongoing health challenges and overall needs, a pediatric health risk assessment and a comprehensive assessment of Emma is given high priority when she is enrolled, and conducted as soon as possible within the first 30 days of her enrollment. In Emma’s situation, her referral to the CCM program was prioritized to ensure that her needs were addressed; including her mother’s concern about possibly taking Emma home and coordinating all of the things she would need. For example, Emma needs a custom wheelchair, electronic tablet, continuous pulse oximetry monitoring, apnea monitor when she is not on the ventilator, and a backup generator for the ventilator if the power goes out at home. Emma’s Initial Pediatric Clinical Assessment was completed well before her initial 30 days of enrollment. Dolores communicated with the facility team who shared Emma’s current information, which was beneficial as Dolores carried out Emma’s assessment and the coordination for her home care.

Magellan Complete Care is committed to and works hard at getting Emma home with the right services and supports; while also asserting that such a plan takes time and alignment of a many people, services, equipment, and support before it is recommended and deemed safe and sound.

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;
To minimize the time between when an enrollee’s care needs are identified and when the enrollee receives services, we have multiple avenues to be considered for CC/CM services. These range from input from nurses on the telephonic CareLine, hospital discharge planners, providers, or by enrollee self-referral. In Emma’s case, we received notification that she is
residing in a pediatric nursing facility through the Children’s Multidisciplinary Assessment Team under the Florida Department of Health. We receive this notification for all enrollees under the age of 21, residing in a facility. In addition, the nursing facility typically contacts us to share pertinent and necessary information to ensure optimal coordination of benefits and services. The Magellan Complete Care UM team assigned to nursing facilities also proactively reaches out to the pediatric nursing facility to review Emma’s case. The UM team also establishes the details of covered services and payment responsibility (Magellan Complete Care, the facility, etc.). If Emma was transferred to the pediatric facility from the hospital, Magellan Complete Care is notified and invited to attend a pre-staffing and care conference meeting.

Because Emma is a child residing in a pediatric nursing facility and the request for potential discharge to home is received, Magellan Complete Care identifies Emma as meeting criteria for enrollment in the Magellan Complete Care CCM program. Dolores, Emma’s ICCM, is assigned on the same day as Emma’s case is identified. Dolores reaches out to the facility and Emma’s mother as soon as she is aware of Emma’s enrollment and schedules the initial face-to-face pediatric assessment within 14 days or less of enrollment. Dolores studies the agencies and other care providers that are involved in Emma’s care, and reaches out to them during the assessment process.

In addition, further identification of Emma as a candidate for CCM is conducted by our Clinical Analytics Team, who review available enrollee diagnostic information for all membership and any other enrollee information that is available to proactively sort the current population based on prioritized needs whenever possible. If Emma returns home and Magellan Complete Care is responsible for her covered benefits and services, the Clinical Analytics team begins to use claims data as an additional input in this identification process. One of the alerts coming out of this data analysis for Emma, is that she is a child, residing in a pediatric nursing facility, with multiple disabilities, and current ventilator use. Due to the complexity of Emma’s situation, she is prioritized for assignment and engagement to Dolores, within the CCM program. Dolores, has extensive pediatric nursing experience and collaborates closely with Magellan Complete Care’s Medical team, skilled nursing facility Nurse Specialist (who is an expert in the area of nursing facility care/authorizations, including pediatric nursing facilities), Clinical Pharmacist, and Social Worker.

Emma was auto-assigned by the Agency to Magellan Complete Care and received on the Agency’s X12-834 enrollment file. The file also contained “special needs” including the “developmental delay” and “wheelchair access” indicators. Magellan Complete Care loads the Agency’s enrollment file daily into CAPS, our eligibility system. We also received “MC Special Conditions Indicator” for Emma on the Agency’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; viewable by our Health Services team. Our sophisticated technology infrastructure is flexible so our operational teams can quickly access and leverage information to assist Emma with her care needs. Enrollees such as Emma who have complex physical, behavioral, and social needs are identified appropriately and quickly to ensure timely engagement and assistance by the CC/CM team.

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 Emma, receive outreach by an ICCM.
Once Emma was loaded into CAPS an automated process runs issuing Emma a Magellan Complete Care 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 the Agency’s X12-834 enrollment file.

Magellan Complete Care conducts a close review of its enrollment files each month focusing on new enrollees received from the Medicaid fee-for-service area with a profile similar to Emma. Once identified, we communicate with AHCA on these very complex facility-based cases. Our Analytics team reviews enrollment data identifying who is in a facility or any enrollee who has high needs, requiring a higher level of care and services.

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 engage Emma and her family using a high touch, person-centered approach, customized to her specific, complex needs, taking account of social, as well as physical and behavioral health, and the social determinants of health that reflect social factors and physical conditions of her environment. Other sources of data/information used in the assessment process include historical claims data, HRA process and scoring, 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.

Methods to screen and identify risk(s) for enrollees, specifically children like Emma, include the pediatric HRA process and scoring, utilization and Rx reports and patterns, pediatric facility indicator, direct referral, or having special high-risk conditions or social dynamics. Enrollees like Emma, who have multiple chronic conditions and disabilities, or who are medically, behaviorally, or socially unstable, are designated as Ultra High Risk, and receive complex and enhanced care coordination (ECC) services. The CC team also focuses on detecting and educating Emma’s family and facility staff to identify escalating triggers, as well as provide them with appropriate ways to manage triggers and deescalate potential crisis levels.

For example, Emma’s seizure and respiratory medications are prescribed and administered appropriately to ensure that her seizures and respiratory condition are managed effectively. Back-up medications are available in the event that Emma’s seizures or respiratory status is not controlled with her current routine medication and respiratory treatment plan. Emma’s skin care treatment plan is carried out by the facility staff and Dolores monitors Emma’s skin status and nutritional status to ensure there are no surprises or setbacks. In Emma’s situation, with her mother’s permission, Dolores communicates with her facility-based and/or outpatient behavioral health, PCPs, and specialists to ensure Emma’s plan of care and needs are communicated and addressed appropriately.

There is no substitution for face-to-face assessment and interaction with Emma and her family to best engage and obtain the most accurate identification and risk level assignment. Shortly after becoming enrolled with Magellan Complete Care (within five days of enrollment), Emma, and her legal guardian (her mom), are sent a Magellan Complete Care Medicaid Member Handbook and Welcome Kit, (including identification card, information about benefits, how to contact Magellan Complete Care), and a Magellan Complete Care Provider Directory. At any point when contacting the Magellan Complete Care Customer Service team or CC/CM team on...
Emma’s behalf, verification is made to ensure privacy and the obtainment of appropriate consent, including guardian consent and privacy authorizations.

As a result of Emma’s special needs and current hospitalization, her mother receives a call from Dolores for further assessment and follow up within 24 hours of case identification. Since Emma is in the pediatric nursing facility, Dolores visits Emma at the facility to conduct an Initial Pediatric Clinical Assessment. During this visit, as much information is gathered from Emma’s mother and the nursing facility staff; further assessing her current health status, and imminent challenges. While at the facility, Dolores collects current assessment and treatment plan information, and conducts the Pediatric HRA and Pediatric Clinical Assessment to ensure that her treatment plan is appropriate and safe to meet Emma’s complex and comprehensive care needs.

The assessments include branching into any of the DM/condition specific assessments. Our Pediatric HRA information identifies key areas of risks and the unique needs of the intellectually disabled population with other complex physical and social health needs. In addition to basic clinical information, the information captured includes health habits, living situation, complex physical and developmental needs, and social connectedness; which are important predictors of outcomes for our enrollees. Dolores utilizes and incorporates the facility’s assessment and treatment plan information into her comprehensive assessment.

In Emma’s situation, there is a request for Emma to return home with private duty nursing care. A detailed assessment is conducted with input from the pediatric nursing facility staff, Emma’s family, and the Magellan Complete Care Clinical team to ensure that all aspects of the case and potential discharge to home are reviewed and discussed. Not only is a pediatric clinical assessment conducted, but an extensive home assessment is carried out to ensure that Emma and her family are able to accommodate caring for Emma given the size constraints of their home. Emma’s equipment, safety of the electrical outlet capacity, other siblings and grandmother who reside in the home, are assessed and including in the planning. Magellan Complete Care employs a Medical Director who is also a pediatrician and an expert at caring for complex enrollees like Emma. Once Dolores collects Emma’s assessment information, she presents Emma’s case at the Magellan Complete Care interdisciplinary integrated care team (ICCT) meeting. During this ICCT meeting, the Pediatric Medical Director is present and is able to consult with Emma’s facility medical team to ensure that her treatment plan is safe and appropriate to meet her complex needs, and if it is safe and possible to take Emma home.

Dolores conducts additional, more detailed condition-specific branching assessments (seizure disorder, respiratory distress) focused on Emma’s individualized needs, including equipment needs, respiratory status, nutrition, medication list/medication side effects/medication adherence issues, tracheostomy care, skin care, intellectual disability, physical disability, and seizure concerns. The assessment, problem list creation, and care planning process is described later in detail within this vignette.

Globally, the Initial Comprehensive Assessments result in Emma’s mother and care providers self-disclosure of her current circumstances, including verification of privacy and appropriate consents, including guardian consents and review of her current health problems and concerns. Emma’s mother is reassured and is offered complete assistance in the event that Emma is
discharged to home. Dolores discusses specific and essential resources that Emma’s mother needs to obtain support.

The Pediatric HRA and Initial Comprehensive Assessment are administered within 14 days or sooner of Emma’s enrollment, 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. If an enrollee transitions from another health plan, we apply the same identification and assessment timeframes and processes, and enroll them into the appropriate Magellan Complete Care CC/CM program.

For enrollees who are receiving intensive services such as inpatient or subacute care, including subacute behavioral health conditions, they are referred to CC/CM through the transition of care process.

As described earlier, there are critical components of information that can only be provided by self-report by enrollees or their responsible party. For Emma, these include health habits, living situation, and social connectedness of her mother and family; all important predictors of outcomes. Our model uses clinical judgment and team input to assist with appropriate risk level assignment. The cultural diversity of our employee team also understands the specific needs of the Medicaid pediatric enrollees in the different regions.

Our system of care reinforces and prioritizes stabilization, health maintenance, optimal safety and quality, and independence through partnering with Emma and her caregivers, her natural supports and providers. Our sound evidence-based practice approaches have been used in the development of our program approaches. The elements of our approach to the management of high care need enrollees like Emma, include identifying health risks, biopsychosocial, and chronic care needs, assessing Emma, designing an individualized plan of care to proactively address the most immediate needs, engaging her family, supports, and the ICCT, and proactively identifying and monitoring Emma’s changes or triggers that might destabilize her illness.

Based on this ongoing analysis, we have developed targeted screenings and interventions specifically focused on:

- Children and adolescents
- Children with special health care needs (including ventilator dependent children)
- Care transitions
- Excess ER utilization
- Hospital admissions / readmissions
- Neurological – seizure disorder.

Magellan Complete Care’s own, innovative predictive modeling tools are a critical element for ongoing stratification and segmentation of enrollees 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 the SMI population 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 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.

As in Emma’s case, our goal is to identify enrollees and their family/care providers to engage them in CC/CM or CCM support before indicators of decomposition translate into poor clinical outcomes or inappropriate use of services. In addition to the more traditional predictive modeling described above, we recognize the complex drug regimens many of our enrollees are on, and the many potential issues that can arise from drug-drug interactions.

For example, when Dolores presented Emma’s case in the ICCT review meeting, all of her medications were reviewed and our Medical team offered recommendations for Emma’s seizure and respiratory care management. Our Pediatric Medical Director recommended a peer-to-peer review and call with Emma’s pediatrician and neurologist to further discuss her medications. Emma may benefit from a different combination of seizure medications; especially one that has less side effects and would be better tolerated. For this reason, we also perform regular analysis of pharmaceutical data through our Magellan Rx Management affiliate. These analyses are focused on identifying patterns of inappropriate or harmful prescribing; 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 appropriate use and make changes to therapy regimens.

This information is particularly important and useful in identifying increasing enrollee risks due to not filling required prescriptions, risks of drug-drug interactions, or inappropriate use. As an 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. As an example, 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. This type of pharmaceutical monitoring and reconciliation is critically important for enrollees with SMI given the sometime significant effects from drug-drug interactions, or increased risks of physical health side effects of these medications.

Magellan Complete Care has developed a stratification and segmentation model that is uniquely designed for our complex pediatric population, which uses data from many sources. We use our analytics and assessment information, clinical judgment, and team input to assign enrollees, like Emma, to a risk stratification and corresponding CC program that is most appropriate based on enrollee need and complexity. The pediatric HRA, ongoing clinical assessments, regular data capture, and predictive modeling, allow us to gather in-depth clinical information about enrollees 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. Dolores utilized Emma’s identification and assessment information when developing Emma’s problem list and plan of care.

We see the continuum of care and the support provided to Emma through CC/CM as a fluid treatment pathway, where enrollees enter at any level and move to a more or less-intensive setting, and different levels of CC/CM as their changing clinical needs dictate. In Emma’s situation, it is highly unlikely that she will move across risk levels given her high risk, complex care needs. Our active, and regular engagement with Emma’s mother and her care providers allows us to monitor and adjust plan of cares and the intensity of her engagement and support as enrollee health improves or degrades. Our approach to risk stratification and segmentation of our population reflects that approach to continuous data capture, monitoring, assessment, and analysis for assignment of enrollees based on changing needs.

Since being awarded the opportunity to serve and support our enrollees in our SMI Specialty Plan, Magellan Complete Care’s dedicated CC and medical teams have focused their efforts on fully understanding the unique needs of this very complex population, including children. Our pediatric enrollees, like Emma, often present with multiple chronic physical health conditions, and physical and intellectual disabilities, co-occurring illnesses. They are often faced with challenges in accessing the supports and services they need in the areas of their social determinants of health.

We have used that detailed understanding, and ongoing study and analysis of our pediatric 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 tailored to the specific risk factors of our very complex pediatric population. This model allows us to assign enrollees, like Emma, to the intervention and CM category that is right for her; which affords the greatest opportunity for successful engagement with her mother and caregivers to achieve optimal health outcomes and improvement.

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, physical health, social risks, and requirements. Pediatric enrollees like Emma are assigned to CC/CM, programs of interventions and supports that reflect their combined complexity and need. Our CC/CM model, referred to within Magellan Complete Care as the Integrated Care Case Management 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 ICCM use the Case Management Society of America’s Case Management Standards of Practice and National Association of Social Work Case Management Guidelines.

Given the complexity of the Magellan Complete Care enrollee population, our clinical Analytics team study our membership based on both their physical and behavioral health stability. Enrollees, such as Emma, who present with multiple chronic conditions and intellectual disability, 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 levels of our enrollees, our Clinical Analytics Team also scores each enrollee by the enrollee's propensity to enroll in CCM. Emma, by nature of her complex care needs and due to her age, full support of her mother and the facility staff, had a score with a high propensity to enroll in the CCM program.

Magellan Complete Care’s data warehouse collects information that includes clinical data, authorizations, claims and encounters, provider-based information, membership-related data, financial information, products, and services data.

1.d. Identification of Service Needs (Covered And Non-Covered) and a Description for Service Referral Processes,

Our CC team ensures that Emma is receiving the services that are best aligned with her plan of care. Please see [MMA SRC #20, Attachment 1: Emma’s Plan of Care]. Magellan Complete Care works to ensure that Emma receives necessary care and services and collaborates with other care providers and payers to ensure there is clarity regarding covered and non-covered services. If Emma were not currently receiving long-term care (LTC) benefits, her mother would be given education and resources to assist her with applying for additional coverage; such as those available through the Agency for Persons with Disabilities, Emma’s mother would be provided with support, education, and advocacy by the Health Services team to ensure Emma was linked to all available benefits.

In certain situations, if an enrollee requires a service which is not a covered service, the CC team will review the case with the Magellan Complete Care Medical Director and other members of the CC team to determine how the enrollee receives the required service. This is accomplished 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 is to link enrollees with the appropriate service providers so that the providers can address the ongoing needs.

For example, Dolores and the Health Services team collaborate with Emma’s mother, facility staff, and care providers as they determine what type of equipment Emma will need if she is able to go home. The custom wheelchair and the tablet are not Magellan Complete Care covered services; however the ICCM presents the case at the ICCT meeting with the multidisciplinary team present and realize that the tablet Emma needs can be provided through Emma’s local Education Department as part of her Individualized Education Plan (IEP). Dolores assists Emma’s mother by referring her to the local school system to obtain the necessary tablet for her educational needs. In addition, Dolores contacts the local Easter Seals chapter to explore their ability to provide the tablet if the Education Department is unable to do so in a timely manner. In addition, the ICCM and team discusses Emma’s need for the custom wheelchair.

Dolores will work with Emma’s PCP to obtain the necessary orders for the custom wheelchair. If the request for the custom wheelchair is outside of the current benefits, the request would be presented to the Magellan Complete Care Medical Director for review of medical necessity and approval of additional benefits. Dolores would coordinate the scheduling of appointments.
needed for Emma to ensure the wheelchair was appropriate to her size and specific needs. Due to the high cost of custom wheelchairs, as Emma grows, Dolores will continue to work with the wheelchair provider to identify custom solutions that will be transferrable as Emma outgrows her wheelchair. Dolores coordinates with the DME vendor following the approval of the wheelchair to ensure it is delivered successfully and suited to Emma’s home environment. Dolores works with her Integrated Health Network team to identify and connect Emma’s mother to all services and resources available in their community.

Our community partnerships have culminated in the development of the Magellan Complete Care Community Resource Guide (CRG) as our customized solution to catalog over 4,000 regional and county resources and partnerships across the state. The CRG is an online searchable tool, similar to the Provider Directory which contains services and supports searched by resource type, region, and county. The CRG contains forty different “resource types” identified to address a wide variety of social determinants and other needs in every region and more specifically, counties we serve. Dolores coordinates with a local agency to request the donation of a ramp for Emma’s home for convenient access. Dolores also collaborates with Magellan Complete Care’s Community Outreach Specialist to identify a donation source for a backup generator to support her ventilator if the family is unable to afford pay for it.

Dolores and the Magellan Complete Care Clinical team assess Emma’s developmental needs and obtain ongoing evaluations for Emma specific to her transition from the Early Interventions Program; exploring the possibility of home tutoring through the school system and collaborating with the schools in developing Emma’s IEP. Dolores explores and evaluates the need for Emma to receive in-home therapy – physical, occupational, speech, and perhaps even “play” therapies to enrich her days once she goes home. Even though Emma is on a ventilator, speech therapy could work with Emma on her nutrition and eating skills. Emma would need 24/7 private duty nursing care at first while at home with assessment of a possible decrease in hours if her condition stabilizes.

Dolores explores finding Emma an inter-disciplinary clinic at the local children’s hospital which would offer and provide her with “one stop shop” programs where all the specialists are in one place and can be scheduled on the same day. Likewise, Dolores explores the Prescribed Pediatric Extended Care (PPEC) services with Emma’s mother as a transition step in Emma’s care and locates a pediatrician who will make home visits once Emma is home. Dolores also finds a “caregiver support group” for Emma’s mother to help her share, interact, and learn from other caregivers in a safe, supportive environment.

Additionally, Dolores assisted Emma’s mother in understanding how the orders and arrangements are made for the other equipment and services needed in the home. Dolores explained that Magellan Complete Care had contracts with specific vendors and care providers who would be contacted to assist in meeting Emma’s needs. Dolores reached out to the respiratory and DME vendor to inquire and prepare for the ordering of continuous pulse oximetry monitoring, apnea monitoring when she is not on the ventilator, the ventilator, and a backup generator for the ventilator if the power goes out in the home.

Of important note, Dolores and team will collaborate with other covered home and community-based services to maximize what Magellan Complete Care is able to provide, cover, in addition to complimenting what the LTC services are able to provide.
If Emma were denied a requested service, Emma’s mother could call Magellan Complete Care to appeal the decision that was made. Emma’s mother would be notified of their right to a peer to peer review. This expedited appeal is handled over the phone and the Appeals team immediately places the information in the system to quickly get the appeal processed and resolved for Emma. This quick response will positively impact her health status and avoid exacerbating her other health and behavior issues.

Our local 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 Emma reach their health and wellness goals. We have established standard operating procedures to address communication with local LTC plans and accountable care organizations that address processes and timeframes for sharing information and coordinating care.

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.

Once Emma is discharged home, Dolores monitors all aspects of Emma’s plan of care to ensure that Emma receives appropriate EPSDT services and that her Child Checkup visits are carried out in accordance with nationally recognized and state specific guidelines. Dolores communicates with Emma’s pediatrician to verify the EPSDT services, including which immunizations she should receive. Emma’s EPSDT and immunization information is integrated within the Trucare system, offering alerts and tasking activities as a tool for Dolores to use when coordinating care for Emma. We review enrollee participation in our Healthy Behaviors programs and EPSDT/Childhood Checkup program results monthly to ensure that enrollees like Emma receive these necessary services. Our HEDIS clinical initiative campaigns incorporate EPSDT activities and integrate the information directly into the plan of care within the Trucare system. Dolores works with Emma’s mother to help her obtain caregiver tips and support; ensuring that she stays healthy as she supports Emma’s care at home.

The complexities of managing the pediatric population presenting with special health care needs requires that Magellan Complete Care use all available enrollee touchpoints to assess Emma’s health and deploy targeted interventions. In Emma’s situation, onsite visits no less than monthly by Dolores and other members of the Clinical team while Emma is in the facility, are carried out to ensure compliance with Emma’s service/plan of care interventions. Weekly on site visits will be made if Emma returns home until such time that she stabilized and the same schedule of onsite visits will occur once Emma returns home. Our Model of Care reinforces and prioritizes recovery, stabilization, health maintenance, optimal safety and quality, and independence by partnering with Emma’s mother and caregivers, their natural supports and providers. Our pediatric expertise and sound evidence-based practice approaches have been used to develop our Model of Care approaches, including best practice protocols related to children with special health care needs. We continually adjust interventions based on Emma’s evolving needs and circumstances including indications of decomposition or instability in her mental or physical health, which can trigger cascading effects.

As a part of our child and adolescent program, the elements of our approach to the management of high need pediatric enrollees, including Emma, includes: identifying behavioral and medical health risks; disability needs; biopsychosocial and chronic care needs; assessing
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the enrollee; designing a plan of care to proactively address the most immediate needs; engaging the ICCT; and, proactively identifying and monitoring enrollee changes or triggers that might destabilize Emma’s illness. The Magellan Complete Care Health Services team assesses and works with Emma’s family support network and other care providers to ensure that Emma has a strong in home network as the team evaluates possible transition back home for Emma.

Our Pediatric Care team seeks to fully understand why Emma may be in crisis and identify strategies to assist them on the path to safety, stability, and higher functioning. The elements of our approach include identifying health risks, biopsychosocial, and chronic care needs, assessing the enrollee, and designing a plan to proactively address the most immediate needs. An essential element to our CC approach is using an assessment and planning process keeping the enrollee’s unique needs at the center. We have a catalogue of assessments and screening tools to use with enrollees depending on their risk stratification, current conditions and past history of illness and treatment.

Data from our enrollees shows the importance of multiple forms of screening on a regular and ongoing basis. Our membership does not cluster into a limited number of diagnoses, and often presents with multiple health diagnoses.

1.f. Application of Discharge and Aftercare Planning Protocols That Facilitate a Successful Transition;
The Magellan Complete Care Transitions and Emergency Department Follow-Up Program activities are integrated within each area/level of the CC program. The program promotes physical, behavioral, and psychosocial health comprehensive care transition management both proactively while an enrollee is enrolled in a CM program, and when an ER visit or hospital admission readmission occurs. The ICCM, UM Professional (UMP), and Care Transitions Health Guide work collaboratively and are actively involved with the enrollee and their responsible party at times of care transition. This includes, but not limited to planned and unplanned admissions, frequent ER visits, transfer to other institutions and facilities, crisis stabilization units, and works in conjunction with the enrollee’s Health Guide to ensure plan of care communication between all providers and of the enrollee’s CC Team.

Discharge planning is a key element of the Care Transitions program and specifically focuses on safely transitioning enrollees from an inpatient admission in an acute care, skilled nursing facility, or ER back to home, community setting, or another site of care. In Emma’s situation, Dolores, nursing facility team and provider/DME team collaborate on all aspects of Emma’s transition plan. Typically, discharge planning is carried out by Magellan Complete Care’s UMP staff and Care Transition Health Guides. However in Emma’s case, our nursing facility UMPs and Dolores take lead on Emma’s discharge planning activities.

Emma’s unique discharge plan requires the subject matter experts (Medical team, CC/CM team and Pharmacist) to take lead and communicate between all providers of care and services. 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 the enrollee safely placed back home.

In Emma’s situation, a transition to home request has been discussed. Dolores works with Emma’s mother to help her fully understand the complexity of bringing Emma home and that a
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comprehensive assessment will be carried out both at the facility and within the home. Dolores also explains that in some situations, once the assessment is completed, there could be a decision made that does not support Emma returning home. Dolores obtains and reviews the current assessment and treatment plan that is in place at the facility and also requires about obtaining the signed physician orders for the skilled home health care, private duty nursing services, (HCFA 485 – physician plan of treatment), along with equipment, supply, and medication orders.

Dolores schedules an ICCT meeting at the pediatric facility and includes our Health Services team, our pediatric medial staff, Emma’s mother, and the facility staff to start. Dolores reviews Emma’s current care and service needs and reassures Emma’s mother that she will facilitate communication between the current treatment team and the Magellan Complete Care team to develop a safe transition plan for Emma if at all possible. Dolores explains that as she has assessed and planned for Emma’s care in the facility she will do the same once Emma goes home. First, Dolores and the team will conduct a home visit to assess Emma’s home environment, including where Emma will be cared for and by whom. A safety and environmental checklist will be carried out along with other important things described in detail below.

Emma’s mother was hesitant at first with the possibility of taking Emma home and after much contemplation and discussion with Emma’s siblings and grandmother, she decides that she does in fact want to take Emma home.

The assessment process starts with Dolores and UMPs reviewing complex cases and beginning the assessment and planning, including those enrollees who have been admitted, are in a facility, and those enrollees, like Emma, who may be able to go back home. This assessment occurs within the case review conferences held daily. The case review session allows for a Medical Director led interdisciplinary team of Magellan Complete Care staff to review complex cases to ensure that the highest level of quality care and follow up is provided for the enrollee. For acute hospital-based enrollees, onsite discharge planning visits are made by Care Transitions Health Guides, ICCMs and UMPs to further assess the enrollee’s needs, support discharge planning between care episodes, and proactively focus on key activities to prevent avoidable hospital admissions/readmissions, or ER visits. The UM and CC Team collaborate on all care transitions activities and obtain Emma’s current facility treatment plan, medication, supply, and equipment orders.

For example with Emma, while this is not an exhaustive list, all of her transition to home requirements including as needed, equipment (DME), pulse oximetry monitoring, apnea monitor, backup generator, ventilator, custom wheelchair, tablet, home health care, private duty nursing care 24 hours/day with needed personal care, respiratory therapy, peg tube feedings, community outreach, community agencies, adjunct support systems, medication assistance/reconciliation, school access, and community mental health services are identified as early as possible.

Assessment of the ability of Emma’s siblings and other family members to assist with Emma’s care will be carried out. Assessment of available support mechanisms for Emma’s mother and family members will take place and Dolores will coordinate respite and support as needed.
For enrollees like Emma, all of the discharge requirements are identified before or during an enrollee inpatient stay or transfer back to the community, to ensure availability for a timely discharge or placement. The Magellan Complete Care team will offer Emma and her family community resources through “Building Bridges” and the Agency for Persons with Disabilities as needed. Dolores will also work with the family to ensure that a land line telephone is installed at home to be used as a backup in emergency situations.

For Emma, a comprehensive transition assessment and plan includes, but is not limited to, the following:

- Assessment of needs – proactively by the UMP, ICCM, and other subject matter experts as needed 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
- Assessment of needs – when an enrollee wants to move back to their home out of a nursing facility
- 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.

We understand that a care transition occurs when an enrollee like Emma moves from one care setting to another due to a planned choice, change in health status, circle of support, or living circumstance. In addition to planning for Emma’s transition, she is evaluated for level of behavioral health, physical health, psychosocial health, special healthcare needs, complexity and risk, and will be stratified into the appropriate level of CM based on complexity. More important, Magellan Complete Care understands the impact of social determinants of health that each of our enrollees face each day. These social determinants along with other behavioral and physical health factors impact each transition of care and are managed as an integrated element in the enrollee’s overall CC/CM process. For Emma and her family, these social determinants are paramount and require in depth assessment to further determine the services and supports needed.

For Emma and her family, in order to take her home with the necessary supports and services, all aspects of her social determinants of health will need to be thoroughly assessed. For example, Emma and her family’s immediate living situation will need to be thoroughly assessed to ensure its adequacy to accommodate Emma’s equipment needs, space, electricity with a backup generator, the impact and stress of bringing Emma home on other members of her family (mother, siblings and grandmother), financial stressors, work schedule impact, stress in general with caring for Emma, and the need to bring all services into the home setting.
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Any planned or unplanned care transition that enrollees’ experience, including Emma’s nursing facility stay, require diligent planning and follow up to ensure she is placed in the appropriate setting with all necessary supports and services.

The care transitions approach used with Emma and all enrollees aims to:

> Ensure continuity between settings while including Emma’s mother’s choice, preference and goals
> Ensure safety when transitioning back home with all supports and services carefully coordinated
> Assist Emma’s mother to improve health literacy and learn self-management skills to ensure that Emma’s safety, behavioral, and physical health needs are met
> Provide adequate support for Emma to return to the setting of choice
> Reduce preventable readmissions, institutionalizations, and adverse outcomes

To prevent unplanned care transitions for our enrollees, we provide proactive CC/CM interventions, including:

> Assessment of Emma who would be at risk for any type of transition
> Set enrollee-specific, prioritized goals that promote coordinated care
> Address social determinants, medical, and behavioral risk factors affecting enrollees
> Provide Emma’s mother and their family/caregivers one point of contact/accountability
> Make and keep specific tasks/appointments/calls/follow up with Emma’s mother
> Create a communication process for involved providers
> Facilitate Emma’s self-management capabilities and close gaps in care
> Work with existing community transition programs to support a safe transition plan
> Educate Emma’s mother on use of the 24/7 CareLine and Customer Services staff
> Establish a physical and behavioral health home if one does not exist – bringing providers to Emma’s home
> Build a circle of support with the enrollee within their community or neighborhood
> Work closely with the Emma’s mother to develop a plan for any type of transition
> Modify Emma’s existing home (e.g., grab bars in bathroom) or locate a safe, affordable place to live
> Arrange for in-home supports (e.g., medical equipment and supplies, medications, home-delivered meals)

We recognize the highly complex nature of Emma’s situation and our enrollee 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.

In Emma’s situation, transitioning back home requires a unique set of expertise held by our multidisciplinary team, who are able to assist Emma and her mother with her transition to home. These activities are integrated with each area/level of the CC program and provided by various enrollees of the CC team, including RN and Social Work Case Managers, Health Guides, and UMPs. This team works within the Integrated Health Neighborhood assisting the enrollee in accessing necessary supports and services necessary for a safe transfer between health care...
settings and home. Dolores and the team will collaborate with Emma’s care providers and review and receive updated clinical orders and information uploaded to the TruCare system. The Utilization Management Program and UMPs monitor transitions of care including movement of the enrollee 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 are based on enrollee need. Specific criteria have been developed and are used by each of the enrollee facing areas to offer ease of placement and referral to the appropriate CC program.

Magellan Complete Care has a complete process for the assessment and development of transition planning 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/CM, UM, and continuity of care protocols for the following transition of care activities.

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;

Magellan Complete Care has developed a Coordination of Benefit (COB) and Single Case Agreement (SCA) approach for use in its communication and collaboration with other insurers, providers/entities or those who may require a referral, ensuring that timely coordination, authorizations and services are facilitated.

Dolores and the UM team adhere to the COB and SCA desktop procedures which clearly outline each step in the COB and SCA process.

The CC and UM teams adhere to detailed desktop procedures and processes to ensure that enrollees like Emma are able to receive necessary services from non-covered PCPs, specialists, other service providers, and community partners. 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 CC team strives to remove barriers and roadblocks that either providers or enrollees may potentially experience, when faced with a non-coverage situation.

Dolores and the UM staff ensure that the appropriate and necessary referrals are in place for Emma’s non-covered services. The team coordinates the obtainment of these 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 Emma’s need. Our clinical staff establish SCAs and encourage direct contracting and formal integration of the non-covered providers and community partners as a part of expanding our Integrated Health Neighborhood approach.
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In Emma’s situation, because she will be moving back home with skilled and private duty services and supports, Dolores and the CC team work closely with Emma’s mother to establish which services and resources are available within her neighborhood. We have extensive experience in coordinating services similar to what Emma will be receiving. Emma will obtain her medical, specialty, and behavioral health care by having the health care providers make in home visits whenever possible. We have the ability to request visiting home physicians or nurse practitioners as needed. In addition, the Social Worker on the CC team assists Emma’s mother in determining which financial supports she may need as she plans to bring Emma home. The Social Worker also helps to coordinate food access. Emma’s grandmother is active within her church; where she also accesses support and services for herself and the family. The church volunteers are available to assist Emma’s grandmother and the immediate family with needed services, supports, 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 is to preserve Emma’s existing provider relationships whenever possible allowing for seamless continuation of care. In order to assure effective and efficient PCP “connections” for Emma, we maintain 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 the Agency, 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 Emma’s PCP and specialist assignment is to link Emma to the PCP, specialist, therapists, and community partners who are best suited to meet her needs and able to offer the highest quality of care.

Dolores and our Clinical team have access to updated provider panel lists assessed and updated on an ongoing basis by our Provider Network teams to ensure that we have the right specialized services providers to meet Emma’s complex needs. Dolores keeps stays in contact with our Provider Support Specialists who are out it in the neighborhoods collaborating with all types of providers, ensuring that provider capacity and specialized network is meeting Emma’s needs and the needs of the broader population. When Dolores identifies a specific provider need or gap, she communicates directly with the Provider Network team and/or Provider Support Specialists who engage the provider in the contracting process.

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 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, we have 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, our goal is to ensure that Emma receives the right care, in the right setting, at the right time, and by the right provider.

For example, in Emma’s situation, we will successfully match her with a set of outpatient providers once she is able to return home; with emphasis on finding appropriate providers from
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a list of reliable and credentialed professionals. Whenever possible, Emma’s medical care will be provided by professionals who are able to visit within her home. Magellan Complete Care has extensive contracts with skilled home health and private duty care providers, DME, and medical supply providers, etc., all of whom will be notified and communicated with during the assessment and planning process.

1.i. Identification of Strategies That Promote Enrollee Self-Management and Treatment Adherence;
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. All of Emma’s condition specific/DM assessments and approaches are fully integrated and carried out by her primary ICCM, Dolores. She collaborates with the facility team and eventual community-based team to address all of Emma’s condition specific needs. All of these approaches are fully integrated within the TruCare system.

Our Model of Care, including our CC/CM programs, reinforces and prioritizes recovery, stabilization, health maintenance, optimal safety, quality, and independence through partnering with the enrollee, their natural supports and providers. Our company-wide recovery expertise and sound evidence-based practice approaches have been used in the development of our health program approaches. For Emma, her mother and caregivers assume the primary role for adherence to Emma’s plan of care.

Dolores and the CC team use a person-centered approach when educating Emma’s mother about available services and supports to assist in achieving optimal health, wellness, and self-management goals. Dolores and CC team enrollees also explain the support provided to the enrollee for self-direction and self-management.

As mentioned earlier and with the case of Emma, the CC team uses the Integrated Health Neighborhood approach to assist the enrollee during acute exacerbations and during more stable times with self-management, accessing necessary resources within the community and health care system in order to maximize treatment adherence. Ongoing engagement and communication with the enrollee and their support system is essential to the success of enrollee self-management and adherence. Dolores communicates and collaborates with Emma’s providers and includes Emma’s mother in self-management goal setting. Dolores collaborates with Emma’s providers to stabilize her acute health issues, medication adjustments, and then works with Emma’s mother to develop self-management goals once she was out of the facility and in her home.

In addition, the CC team assists Emma’s mother to work together on Emma’s self-management goals, including her grandmother and three siblings when appropriate. Dolores and the CC team focused on health education in all aspects of Emma’s care, including medication adherence/management of side effects. Emma’s mother agreed to attend support groups with other parents at the facility before Emma was discharged back to her home. Emma’s mother was able to meet new friends who also had children with similar health issues. They shared caregiving experiences and tips to ease the transition. Emma’s mother began to use a journal for Emma’s health information and self-management plan. The pediatric program ICCM
reviewed Emma’s self-management plan during each contact and visit. Other enrollees of the CC team reinforced different aspects of Emma’s plan during their contacts and visits. Because of the complexities and technical nature of Emma’s care, the ICCM educated Emma’s mother and caregivers on how to keep Emma as safe and as stable with her symptoms as possible.

We understand from previous experience there will also be enrollees who decline CC services. Dolores explains that her role is to support the enrollee in accessing services and supports to meet their goals. Dolores provides Emma’s mother with contact information with each interaction.

Magellan Complete Care’s UM program and approach is built around the unique requirements of our pediatric population, delivery system, and providers.

For Emma, we ensure that applicable evidence-based guidelines are utilized with consideration given to characteristics of the local delivery systems, as well as enrollee-specific factors, such as Emma’s age, co-morbidities, complications, progress in treatment, psychosocial situation, facility care, and home environment. We strive to make appropriate medical management and authorization decisions based on nationally recognized guidelines and ultimately what is in the best interest for Emma. Our UM program 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 Emma.

Emma’s 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. We bring the following strengths to the SMI Specialty Plan for authorization of Emma’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 Emma is made up of a unique blend of clinicians who have pediatric medical and behavioral health backgrounds e.g., Social Workers, LPNs, RNs, doctorate level professionals, all understand both physical health and the pediatric complex 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 staff receives addresses medical, psychosocial, and behavioral health services, COB, SCAs, service authorization protocols, community-based services, transitions of care, end of life issues, and palliative care
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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 SMI 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, in addition 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 Emma.

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 Emma’s care and services. We have adopted Milliman Care Guidelines (MCG) as a set of national standardized criteria for the management of Emma’s physical, behavioral, psychosocial and pediatric special health services.

We also use proprietary diagnostic services criteria for imaging, sleep studies, and certain pain management procedures that Emma 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.

Our medical necessity criteria are listed on our website and are also available to Emma’s providers by hard copy upon request. The criteria used for the basis of an individual service determination for Emma is in the Notice of Action Letters and is also available upon request. Emma’s staff have access to the Florida Medicaid Handbooks, MCG Guidelines, and the Magellan Healthcare Guidelines are all embedded in TruCare under “resources”.

As in the case of Emma for her specialized care and equipment needs, if the need goes beyond the UM clinical decision support tools, we request review from our Medical Directors. We have and will continue to ensure continuity of care, particularly as it relates to special needs populations. We have 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 Emma’s situation when she came onto the Specialty Plan, she was receiving prior authorized ongoing treatments with multiple providers. We are 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.

1.j.1 Ensuring Continuity of Care for a Newly Enrolled Enrollee or an Enrollee Disenrolling
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MMA SUBMISSION REQUIREMENTS
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We honor any and all continuity of care requests for a new enrollee, including Emma. We honor the authorization for 60 days and we contact the provider to ensure that no delay in services occurs. If we cannot find an in network provider, we use our SCA process to ensure that the enrollee can continue services.

When Magellan Complete Care was notified of Emma’s enrollment and any newly enrolled enrollee or an enrollee who is disenrolling from the health plan, at minimum, the following is carried out:

>Obtain appropriate consent from the Emma’s mother to obtain and share demographic and healthcare information

>Collaborate with the Emma’s mother, 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

>Request/share the most current assessment and plan of care with documentation of same in the TruCare clinical documentation system

>Assist Emma’s mother in finding in-network health and service providers whenever possible

>Assist Emma’s mother in exploring the possibility of returning to the community through formal collaboration with Magellan Complete Care transition subject matter experts

>Document 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
We provide continuity of care for the course of treatment in the event a provider agreement terminates during the course of Emma’s treatment. One of Emma’s providers terminated from Magellan Complete Care and we notified Emma’s mother within 30 days of the effective date of provider termination without cause. This process is utilized for all enrollees, like Emma, 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 Emma, who was getting active treatment with the terminated provider, with agreement of 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 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, or for utilization control, consistent with the terms of the Contract; provided the services furnished can be reasonably expected to achieve their
MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

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 our enrollees, like Emma.

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, Customer Services CRM (Call Tracker), authorization system, and CC/CM/DM system (Case Management Module).

As such, all relevant departments are working on the same system and performing all their duties in the system. Given our “all services under one roof” approach, an authorization or clinical staff have everything at their fingertips to fully assess Emma’s situation and needs to furnish the best possible service for Emma and her providers.

For example, staff have the ability to view the following information for Emma in one system:

> Complete and up-to-date demographics
> 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
> Any other clinical or quality notes entered in the system.

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 Emma’s situation and her 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 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 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 Emma’s 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 Emma. TruCare is the Magellan Complete Care application providing clinical systems support for UM, case management, 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 Emma’s mother and her caregivers, are documented in the system and notes are made on all elements of CC/CM processes and services. Information sent to us by Emma’s providers, subcontractors, facilities, and other treatment teams are able to be uploaded and attached to each enrollee’s record. This provides for a comprehensive tracking of all activities, information, services, treatment plans, plan of care, discharge plans, etc., related to the 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 that Emma’s mother or caregivers call Magellan Complete Care they are assisted by either a Customer Service Representative or assigned ICCM. These Magellan Complete Care employees have access to the TMR and TruCare systems at all time.

We view our subcontractors as essential partners to work with us to serve Emma. Magellan Complete Care’s goal is to work with both providers and subcontractors to ensure that Emma receives 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 Emma. We enhance 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 Emma’s entire care continuum. Magellan Complete Care has developed a robust statewide provider and subcontractor network to support Emma’s unique needs. Over this same period, we have developed successful approaches to engaging, supporting, and communicating with our providers and subcontractors. Data from our subcontractors is integrated into our data warehouse and various data points are populated into TruCare for real-time access to data for clinical staff.

We offer Emma’s mother, her providers/subcontractor’s access to specially trained clinical staff 24 hours each day. Our teams are able to access Emma’s information 24 hours each day to ensure optimal communication with Emma’s mother, her subcontractors, and her providers.

Emma’s mother and her providers/subcontractors are 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. Emma’s mother has accessed the member portal from time to time and asks Dolores to assist her with accessing it again to be sure she is using it to its fullest extent.

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 adheres to the NCQA assessment and care planning standards and timeframes for Emma and her enrollment in the CCM program. Dolores and the CC team follow
a defined and prioritized process for each step in Emma’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 Emma’s plan of care.

The following outline describes Emma’s Ultra High Risk CCM process encompassing identification, assessment, care planning, and ongoing monitoring with associated timeframes for completion:

>Emma is identified as Ultra High Risk as she is in a pediatric facility, through the analytics, HRA, and assessment process and scoring, utilization reports, predictive modeling and by having special conditions, including being on a ventilator, seizure activity, intellectual disability, and having overall special health care needs

>Emma is identified as Ultra High Risk and the Regional Manager assigns Emma to her primary ICCM, Dolores

>Dolores becomes Emma’s case owner and enrolls her into the CCM program and completes the referral screens within 24 hours of Emma’s case assignment

>Dolores completes Emma’s HRA, Initial Clinical Assessment, branching assessments (seizure disorder, respiratory distress), obtains the AUD as appropriate, and completes the plan of care within 14 days or sooner of CCM program enrollment

>The CCM program open date in TruCare becomes the trigger date from which the timeframes for Emma’s outreach, engagement, assessments and care planning is based on and measured

>Emma’s plan of care includes prioritized goals, considers Emma’s mother, family, and caregiver’s goals, preferences, identifies barriers to meeting goals, and develops with Emma’s mother and CC team a plan for self-management and a plan for schedule of communication and follow up

>Dolores documents Emma’s information in TruCare assessments/notes, uploads all documents to the Emma’s case

Emma’s CC monitoring timeframes:

>Dolores conducts required monthly reviews of Emma’s case as evidenced by completion of the CCM Monthly Review Note in TruCare

>Dolores conducts as appropriate, ICCT meetings with the Health Services staff, Emma and her mother, and providers weekly

>Dolores conducts ad hoc case conferences with Emma’s CC team in between formal ICCT meetings – as needed or when changes in condition occur

>If Emma admits to an inpatient setting, Dolores and Emma’s Health Guide follow the Discharge Planning DTP
Dolores assists Emma and her family in accessing services including coordination of transportation, DME, and supplies weekly or more often as changes occur

Dolores maintains and updates Emma’s plan of care at minimum on a monthly basis during the CCM monthly review

Dolores documents all of Emma’s activity in TruCare by updating the plan of care when needed and documenting case conferences using the Case Conference/Care Review Note type on the day the service occurred

Dolores completes the CCM Monthly Follow-Up Note to summarize activities for the month including Emma’s progress toward her plan of care goals and updates the plan of care accordingly

Dolores monitors the predictive modeling screen in TruCare to identify Emma’s HEDIS gaps in care and follows the process for closing Emma’s gaps in care.

Examples of other CC activities for Emma:

Emma’s mother requests a new PCP and has a demographic change, Dolores follows the desktop process for PCP/demographic change requests. Dolores completes the requested update within 24 hours

Emma has authorization needs from previous providers, therefore Dolores notifies the UM department by tasking the UM Clinical Review Queue for prior authorizations and the UM Concurrent Review Queue for concurrent requests

With each contact with Emma, Dolores works to assure she has a provider for all of her healthcare and service needs

Dolores’s contact frequency is determined by Emma’s Ultra High Risk acuity and coordination of care needs

The frequency of Emma’s contacts must occur no less than 1x/month

Emma’s Health Guide works with Emma’s mother, as needed, in conjunction with Dolores conducting home visits and other community visits based on direction from Dolores.

3. THE EXTENT TO WHICH THE RESPONDENT DEMONSTRATED INNOVATIVE AND EVIDENCE-BASED PROCESSES THAT IT HAS IN PLACE TO ENHANCE COMMUNICATION AMONG ALL SERVICE PROVIDERS AND SUBCONTRACTORS (FOR DELEGATED FUNCTIONS).

Our Model of Care is built on the active involvement and coordination of all of Emma’s providers involved in her care. The Clinical team recognizes the important role in assisting Emma’s treating providers in their efforts to monitor and improve the quality of healthcare and service delivery for Emma.
We do not delegate any of the CC/CM functions for Emma, however we do share Emma’s clinically relevant information for CC/CM purposes with Emma’s providers and subcontractors in various ways and on an as needed basis. We share Emma’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 ensure that Emma’s mother signs and dates a release form before any clinical/case records are released to another party. Clinical/case record release occurs consistent with State and federal law.

We encourage ongoing engagement through direct and indirect information sharing to support all of Emma’s providers, including:

> ICCM communication (Dolores reaches out directly to Emma’s care providers and subcontractors, including her pharmacy, customized wheelchair, ventilator and nutrition supply providers)
> Prior authorizations
> Reconciliation of medication regimens and treatments, especially at care transitions
> Plan of care and HCFA 485 physician plan of treatment for home health care and private duty orders
> ICCT meeting notes and agendas
> Other case conference and case review notes
> Referrals to necessary services, including her in home care providers, therapy services, equipment companies

Sharing Emma’s information through the Provider Portal as follows:

> Emma’s mother’s and care provider interactions are captured on the portal ensuring each member of the ICCT, including primary care and specialty health providers, have access to up-to-date information about Emma’s care
> Case summaries
> HEDIS gaps in care information
> AHCA related updates

Sharing of UM concurrent review:

> Hospital admission lists daily
> Admissions and discharge notification
> Transition of plan of care
> ER department notification
> Home health/private duty and therapy services
> Respiratory therapy services.

4. THE EXTENT TO WHICH THE RESPONDENT DESCRIBES AN APPROACH THAT SUPPORTS CARE DELIVERY...

As described earlier, Magellan Complete Care utilizes internal and external sources, including claims, predictive modeling, and direct referrals to identify enrollees, like Emma, who are likely to benefit from and require CCM services. As an additional focus within our CCM approach, Magellan Complete Care and Magellan Health, Inc., (parent of Magellan Complete Care)
national Clinical Leadership team collaborate with the Analytics team to further understand and address the needs of the highest risk Florida pediatric membership.

Specifically, predictive modeling activities have identified Magellan Complete Care enrollees who are likely to admit to the hospital within specific timeframes and enrollees, like Emma, with complex disease specific indicators. The predictive model data identifies enrollees with the highest probability of inpatient admission risk. The admission probability and disease condition indicators from the claims predictive model is used to guide enrollee stratification into High or Ultra High Risk case types. This CCM focus ensures that Emma will receive care delivery in the most appropriate setting.

In addition, we have developed specialty condition specific programs, including our pediatric program which focuses on children with special health care needs. We employ subject matter experts and leaders who carry out the components of these programs on a daily basis. Each of the specialty programs use the core basic CCM approaches in addition to specific nuances and tools pertinent to each of the designated conditions and for children with special health care needs. Our teams use the MCG modules, including chronic condition guidelines, and CarewebQI, etc. We have dedicated and specially trained pediatric and facility-based teams who fully understand the unique needs that Emma presents with and are able to assist in Emma’s transition back to her home.

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 partnering 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 behavioral health program approaches, including best practice protocols in the area of addiction and recovery services.

5. THE EXTENT TO WHICH THE RESPONDENT DEMONSTRATES EXPERIENCE IN PROVIDING SERVICES...

Magellan Complete Care’s pediatric programs along with CCM, CC/CM, and DM programs are informed by input from those most closely involved – Florida residents like Emma’s mother and her direct care providers who experience and understand the complex care needs of children with complex illnesses, families and other caregivers, and the professionals who provide behavioral and physical health treatment.

We have gained even more experience with our pediatric 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 complex enrollees continues and grows to the present day. This Florida-specific experience with enrollees as complex as Emma 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 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 children with special health care needs.

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 specific pediatric program data analytics have led to paradigm shifts within the CC team, leading to better outcomes and more effective programs overall for the pediatric enrollees.

We continue to refine our strategies and improve the outcomes for the complex membership we serve. Specifically, we increased our enrollee satisfaction with the services and treatment received by children by 15% year over year – from 75 to 90% Year 1 to Year 2.

Additionally, on a satisfaction survey conducted in Year 2, 90% of respondents indicated that “it was easy to get the care I thought my child needed” in Year 2, a 14% increase over Year 1. And, 96% of respondents indicated that “staff members helped us get as much information as we needed to help us take care of our child’s illness, including possible side effects of medications”, an 8% increase over Year 1.

Caregivers also reported a 7% fewer crises for their children in Year 2, as well as a 7% increase in caregivers reporting that service times were convenient. In addition to improving the reported satisfaction with CC and provider access, we also improved enrollee’s access to primary care – for example, by a 7% improvement on compliance with children’s annual dental visits, a 16.2% increase in weight assessment and counseling for children, and a 3% improvement in metabolic monitoring for children and adolescents on antipsychotics.

Examples of refinements we have made to our programs include the following:

> Based on 2016 data, for children and adolescents engaged in the CC/CM programs, 62% of total costs were reduced
> Targeting High and Ultra High Risk enrollees like Emma focusing on specific complex, high risk conditions
> Expanded and defined services to meet the specialty needs of children and adolescents
> Enhanced predictive modeling and ER diversion
> Utilization of financial models to identify and target high cost enrollees, like Emma, working to transition these enrollees to a more appropriate level of care
> Decreased ICCM caseloads create more capacity for Emma to receive high touch CC and follow up.

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.

5.1 Practice Guidelines
Magellan Complete Care staff use national evidence-based guidelines (EBG) as a basis for assessment, evaluation, quality management and improvement, identification of care gaps,
enrollee and provider education, key interventions and outcomes measures, including the following:

> Magellan’s proprietary, evidence-based integrated care guidelines and medical policies which are fully reviewed and vetted through the Magellan Health, Inc., corporate policy and procedure committee
> Magellan Health, Inc., proprietary behavioral health medical necessity guidelines
> MCG medical necessity guidelines are currently in use
> Healthwise and MCG Chronic Care Guidelines for health education materials are available in English and Spanish

Magellan Complete Care clinical practice guidelines (CPG) give guidance to providers on the evidence-based tools such as:
> CPG cover conditions within the child and adolescent care – physical health and behavioral health areas
> CPG outline the next step in clinical management based on the disease specific assessment, for example: prescription medications, referrals, consultation or urgent/emergency evaluation. Examples of Magellan Complete Care guidelines include:
> Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7)
> Immunizations – the Advisory Committee on Immunization Practices (ACIP) recommendations
> American Association of Pediatrics (AAP) – Periodicity Table and Centers for Disease Control
> Preventive care – United States Preventive Services Task Force (USPSTF)

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.
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. Dolores and her manager collaborate with the Quality team to ensure that the quality improvement and HEDIS initiatives specific to Emma are fully integrated with Emma’s clinically appropriate/CCM programs. Dolores and Emma’s CC team are educated on targeted quality, HEDIS, quality measures, and cost of care activities. Current and new initiatives are discussed at the cross-functional oversight and operational meetings to determine key initiatives for focus to improve key measures. Outcome measures are 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.

Dolores carries out HEDIS and quality measure initiative activities encouraging and assisting Emma in obtaining care and preventive services she needs to improve overall health and to establish a medical health home. Magellan Complete Care of Florida has a unique Model of Care that supports the needs of individuals like Emma with complex care needs and has been able to demonstrate savings for the time period of 2014 to 2016:
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

>15% reduction in total care expense PMPM
>27% reduction in ER care cost PMPM
>7% reduction in aggregate PMPM pharmacy expense
>18% reduction in total Inpatient hospitalizations
>18% reduction on 30-day readmission rates (all causes) / 1,000

To further the point that Magellan Complete Care of Florida’s unique approach reduces the high costs of complex enrollees like Emma (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 are able to demonstrate the value of our CC/CM and DM interventions in improving enrollee outcomes similar to those that Emma faces each and every day. 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 Emma’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 case management 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 Emma’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, 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 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%:
>>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 enrolled / engaged enrollees decreased by 38%
>>>All readmissions were statistically significant (over time and between enrolled and not enrolled).

In adults, similar to Emma, 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 readmissions were statistically significant (over time and between enrolled and not enrolled)

Individuals 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.

7. THE EXTENT TO WHICH THE RESPONDENT DESCRIBES INNOVATIVE AND EVIDENCE-BASED...
For Emma, the CC team utilized several different innovative and evidence-based strategies, utilizing technology and Smartphone applications connecting Emma’s mother to caregiver stress reduction services. We realized that caring for a child with the complex care needs that Emma requires is very taxing to both family and care providers. It is essential for family and caregivers to stay healthy. Dolores explained more about Magellan Complete Care’s Cobalt services (cognitive behavioral therapy), which could help Emma’s mother with caregiver stress management and the prevention of potential unnecessary ER visits and chronic illness development, including insomnia, anxiety, depression, hypertension, etc.

Because Magellan Complete Care has its own pharmacy benefit management company, Magellan Rx Management, Dolores and the team are able to receive information through the pharmacy system to offer additional support to Emma’s mother in the area of medication adherence, utilizing flags and review alerts across and between systems.
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MMA SUBMISSION REQUIREMENTS
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We use 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, 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.

All of Emma’s mother’s and caregiver contacts are documented in the system and notes are made on all elements of CC/CM processes and services. Information sent to us by the providers, facilities, and other treatment team are able to be 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 CCM 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 plan of care for the enrollee.

The system also provides a list of recommended problems and interventions for a user to select when building the plan of care, 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 Clinical Assessment that he/she often forgets to take his/her medications, a problem of “medications” is recommended for the user to select from when building the enrollee’s individualized plan of care.

Magellan Complete Care has incorporated and the Clinical team has access to MCG chronic care guidelines within the TruCare system. These guidelines are evidence-based, nationally recognized guidelines offering current and accurate assessment and care planning information to further augment the assessment and care planning process. In addition, we have adopted MCG medical determination guidelines as a set of national standardized criteria for the management of both physical and behavioral health services.

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 enrollee 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 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 medication over- and under-utilization.

Daily extracts of claim information, vendor claims, provider information, enrollee eligibility, and pharmacy claims are extracted into an input file 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 (schizophrenia and psychosis, mood disorders), potentially preventable admissions (ambulatory sensitive
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
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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 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 the Clinical and Health Services team within Florida, and are reported to
the Executive team within Florida as well as to the Magellan Health Corporate Executive team.

Biweekly meetings between the Corporate Analytic teams and local Florida Clinical, Quality and
Health Services teams serve to examine performance of the risk stratification, health
segmentation and gaps in care for enrollees. The teams review current enrollment of enrollees
into CM, identify areas of emerging risk, and review analytic data related to drivers of
inappropriate clinical utilization patterns. Performance of the enrollee based upon clinical and
operational designated outcomes is tracked via Tableau or Qlikview dashboard, and is also
reviewed bi-weekly with the Clinical and Operations teams, and monthly at the Executive team
meeting.

7.2 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 SMI Specialty Plan in
2014 and due to the dynamic and complex nature of the Magellan Complete Care enrollment,
we conducted more frequent assessments of the population to accurately determine CC/CM
focus. The information is used to refine our CC/CM models, including changes needed in clinical
programs, planned interventions, staffing mix/level, etc. Our Population Assessment analytical
map includes the following key elements:

> Data Inputs:
  >> Medical and Rx claims
  >> Enrollee demographics (age, gender, language, ethnicity)
  >> HRA and other enrollee attributes (e.g., homelessness, etc.)
  >> Fast-tracked referrals from enrollee, providers, agencies, and other stakeholders, including
    other Magellan Complete Care Departments and staff who come into contact with the enrollee

> Processing Engine and Data Mart:
  >> Available data is then driven through our proprietary processing engine that identifies: gaps in
care, enrollee risks, HEDIS gaps, key clinical dashboard metrics, etc.
  >> A detailed clinical profile for each enrollee is then made available to CC/CM and QI staff via
    reporting systems and proprietary online clinical dashboards, built specifically around this
    unique and complex SMI population.

> Reporting System:
  >> Data generated through our processing engine and data mart are made available to CC/CM
    staff in a web browser
  >> Data can be filtered at both an individual and population level
Population reports are used to stratify enrollee for intervention and to assess utilization and cost trends, etc.

We support multiple methods to segment and stratify populations for intervention and program design, including:
> Age (adults, children, adolescent, etc.)
> Language, race and ethnicity
> Geographic distribution
> Income and living situation (e.g., homelessness)
> Diagnoses (including chronic conditions, injury, type(s) of SMI, etc.)
> Prognostication of inpatient admissions within 90 days
> Potentially preventable events
> Likelihood of engagement with assigned Case Managers.

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 help. 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 Cost of Care and HEDIS initiatives.

7.3 Grievance and Appeals
We are committed to supporting our enrollees like Emma 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, 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, enrollee experience, and outcomes for our innovative SMI Specialty 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.

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 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 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 Member Handbook, enrollee newsletter, and on the Magellan Complete Care website. Enrollees 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 we follow in investigating and providing feedback on resolution.

When an enrollee contacts the Customer Service, QI Department, or the Appeals Department, staff take the opportunity 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 take the opportunity to inform 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.

In Emma’s situation, Dolores reviewed the grievance and appeals process with Emma’s mother initially with the first face-to-face visit and on subsequent visits and contacts. Emma’s mother had no formal complaints or concerns but expressed a good understanding of what to do in the event that she needed it. Emma’s mother did communicate that in the past she was having difficulty finding a dentist that would come to the facility to provide dental care for Emma given her complexities and she thought about filing a complaint.

Dolores reassured Emma’s mother that if she did file a complaint, that whomever took her 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 then we would have a different timeframe to manage. Our goal would be to get Emma the care she needed quickly to resolve any potential complaint or grievance. There are a number of mechanisms under which Emma’s mother could file a complaint/grievance: calling Customer Service, submitting a letter to a designated address, sending by electronic mailbox, asking a provider or PCP to submit on her behalf, or asking a Dolores to submit on Emma’s behalf.

All written materials are written 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 Specialists 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, 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 EMMA
Within the first two months of Emma’s enrollment with the Magellan Complete Care SMI Specialty Plan and engagement in the CCM program, Emma’s condition continued to stabilize. Magellan Complete Care’s Clinical team continued to closely collaborate with the pediatric nursing facility’s staff. Dolores led the CC team discussions and CM process pulling in and authorizing the appropriate supports and services that Emma required.

Dolores coordinated additional supports for Emma’s mother, siblings, and grandmother within Emma’s Integrated Health Neighborhood construct. At first, Emma’s mother was opposed and hesitant around the idea of possibly taking Emma home with needed supports and services; however in time, she agreed to consider the possibility of taking Emma home. Emma’s mother and siblings participated in Emma’s care at the facility and became the backup experts in understanding and providing what Emma needed.

Dolores led a comprehensive transition assessment and planning process, resulting in Emma’s safe return home after six months of enrollment in the Magellan Complete Care SMI Specialty Plan. The planning and preparation were extensive, yet well worth the effort to ensure the safety of Emma’s situation.

Once home, Emma received both skilled home health nursing and therapy services along with private duty nursing services – provided 24 hours each day. Emma’s medical supplies and DME were arranged with adequate backup in case of an emergency situation. A backup generator was donated along with an electronic tablet to provide cognition exercises for Emma. The tablet had a cognition exercise application that reduced the likelihood for seizure activity that may occur with other similar tablets.

The specialized wheelchair was authorized and customized for Emma’s use, which included an additional support that made it easier for Emma to hold the tablet. Emma’s respiratory treatments and medications were organized and supplied and were sometimes a challenge for Emma’s mother to handle during her coverage time slot. With the support of all of Emma’s providers and Dolores, Emma’s mother felt more comfortable each day in having Emma at home. Emma’s medical care was provided by the children’s hospital close to Emma’s home along with home visiting providers, including nurse practitioners. Emma’s church provided additional supports by bringing meals over and assisting with running errands, doing chores, and completing home repairs.

The CC team assisted Emma’s mother in finding additional financial resources and supports as she was the sole provider and income earner for their home, which included three siblings and Emma’s maternal grandmother. Dolores and the Clinical team continue to provide CC/CM services for Emma. The team continues to interact and stay involved with Emma and her family ensuring that the highest level of quality services and supports are in place.

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;
EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

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 that the respondent has in place;
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 information about the enrollee across the plan and various subcontractors when the respondent has delegated functions.

2. The extent to which the respondents’ workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the respondent demonstrates innovative 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 avoid 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 provide evidence of strategies utilized that resulted in improved health outcomes.

6. The extent to which the respondent demonstrates a holistic 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 strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) 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.
F. OVERSIGHT AND ACCOUNTABILITY

No SRCs in this Category for MMA.
G. STATUTORY REQUIREMENTS

MMA SRC #21 – Provider Network Agreements/Contracts Statewide Essential Providers (Statewide)

The respondent shall submit Exhibit A-4-b-3, Provider Network Agreements/Contracts Statewide Essential Providers, to demonstrate its progress with executing agreements or contracts with Statewide Essential Providers by submitting Exhibit A-4-b-3:

Response:

Magellan Complete Care understands the importance of maintaining a regional and statewide network of essential providers in sufficient numbers to meet the access standards for specific medical services for all enrollees in the plan. We fully intend to promote AHCA’s goals by exceeding the requirements in accordance with s. 409.967(2)(c)(1), and we demonstrate our progress in executing agreements or contracts with Statewide Essential Providers via Exhibit A-4-b-3.

As the Serious Mental Illness (SMI) Specialty Plan for the State since 2014, Magellan Complete Care will continue to leverage and broaden our existing provider network in Florida. Through our ongoing geographical access analysis, we have refined our network construct while establishing a provider network that supports our enrollees’ needs.

Our depth of experience maintaining regional and statewide networks includes the experience of Magellan Health, Inc., (parent company of Magellan Complete Care). Magellan began providing managed mental health and substance abuse services to the Florida Prepaid Mental Health Plan. However, membership ended April 30, 2014 as a result of the State of Florida’s Medicaid Reform process which sunset all Prepaid Mental Health Plans and launched the Specialty Plan for adults with SMI.

In addition, our network contains more than the traditional provider types; we also have a network of more than 4,000 community organizations and supports that we have cultivated to support individuals with SMI. We understand how to determine the need for additional key network provider types to support the unique needs of our membership.

Magellan Complete Care is able to demonstrate the depth and breadth of our network through executed agreements or contracts with providers in the region by submitting Exhibit A-4-b-3, Provider Network Agreements/Contracts Statewide Essential Providers.

Evaluation Criteria:

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<th>Percentage of agreements/contracts for each service provider type</th>
<th>Points</th>
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<td>0</td>
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<tr>
<td>1.0% - 25%</td>
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</tbody>
</table>
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AND EVALUATION CRITERIA (10-2-17)

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Points</th>
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<tbody>
<tr>
<td>25.1% - 50%</td>
<td>20</td>
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<tr>
<td>50.1% - 75%</td>
<td>30</td>
</tr>
<tr>
<td>75.1% or greater</td>
<td>40</td>
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**Score:** This section is worth a maximum of 40 raw points based on the above point scale.

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