EXHIBIT A: OFFEROR'S CHECKLIST

The Offeror must complete the Offeror's Checklist. The Offeror's Checklist must be submitted with the Proposal and shall be the initial pages of the Proposal. The Offeror's Checklist includes all submission requirements for the Proposal. It is the Offeror's responsibility to ensure it has submitted all requirements in the RFP notwithstanding the items included in the Offeror's Checklist.

In the column titled "Offeror's Page No.," the Offeror must enter the appropriate page number(s) from its Proposal where AHCCCS may find the Offeror's response to the specified requirement. Refer also to the **Submission Requirements** outlined in RFP Section H: Instructions to Offerors.

OFFEROR'S CHECKLIST		
Submission Requirement	**RFP Section**	**Indicate Offeror's Bid Page Number(s)**
Offeror's Bid Choice Form	RFP Section I, Exhibit B Refer to Bidders' Library	3
Offeror's Completed and Signed RFP Solicitation and Offer Page	RFP Section A Refer to Bidders' Library	4-5
Offeror's Signed Signature Page(s) for **each** Solicitation Amendment	Refer to Bidders' Library	6-7
Capitation Non-Benefit Costs Bid Submission		
Signed Agreement accepting capitation rates	RFP Section H, Instructions to Offerors	8
Non-Benefit Costs Bid Submission workbook	RFP Section H, Instructions to Offerors	9-14
Actuarial Certification(s) of the non-benefit costs (administrative and UW gain bids)	RFP Section H, Instructions to Offerors	15-21
Executive Summary and Disclosure		
Executive Summary	RFP Section H, Instructions to Offerors	22-24
Moral or Religious Objections	RFP Section H, Instructions to Offerors	25
Narrative Submission Requirements		
1.	RFP Section I, Exhibit C	26-27
2.	RFP Section I, Exhibit C	28-34
3.	RFP Section I, Exhibit C	35-39
4.	RFP Section I, Exhibit C	40-46
5.	RFP Section I, Exhibit C	47-51
6.	RFP Section I, Exhibit C	52-56
7.	RFP Section I, Exhibit C	57-63
8.	RFP Section I, Exhibit C	64-68
9.	RFP Section I, Exhibit C	69-73
10.	RFP Section I, Exhibit C	74-78
11.	RFP Section I, Exhibit C	79-83
12.	RFP Section I, Exhibit C	84-88
Narrative Submission Requirements Continued		

OFFEROR'S CHECKLIST		
Submission Requirement	**RFP Section**	**Indicate Offeror's Bid Page Number(s)**
13.	RFP Section I, Exhibit C	89-93
14.	RFP Section I, Exhibit C	94-98
15.	RFP Section I, Exhibit C	99-103
16. A (North) *If applicable*	RFP Section I, Exhibit C	104-106
16. B (South) *If applicable*	RFP Section I, Exhibit C	107-109
17.	RFP Section I, Exhibit C	110-114
18.	RFP Section I, Exhibit C	115
Oral Presentations		
Names and Titles of Participating Individuals	RFP Section H, Instructions to Offerors	116
Resumes of Participating Individuals	RFP Section H, Instructions to Offerors	117-136
A.R.S. §35-393.01 Attestation		
Completed and Signed Attestation	RFP Section I, Exhibit D Refer to Bidders' Library	137
Affiliated Organization Attestation		
Completed and Signed Attestation	RFP Section I, Exhibit E Refer to Bidders' Library	138
State Only Pregnancy Termination Agreement		
Completed and Signed Agreement	RFP Section I, Exhibit F Refer to Bidders' Library	139-141

EXHIBIT B: OFFEROR'S BID CHOICE FORM

AHCCCS COMPLETE CARE RFP YH19-0001 OFEROR'S BID CHOICE FORM

BID CHOICE FORM - PART 1

Magellan Complete Care of Arizona, Inc. **is bidding on the AHCCCS Complete Care Program in the GSA(s) checked below:**

OFFEROR'S NAME

Offerors bidding in all three GSAs shall also identify below GSA priority preferences for award by indicating (1st choice, 2nd choice, 3rd choice) in the Priority Choice by GSA Column.

	GSA	Priority Choice
☒	**Central**: Maricopa, Gila, and Pinal Counties	1
☒	**North**: Mohave, Coconino, Apache, Navajo and Yavapai Counties	2
☒	**South**: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties	3

James R. Stringham — Authorized Signature

1-3-18 — Date

James R. Stringham — Print Name

CEO, Magellan Complete Care of Arizona, Inc. — Title

BID CHOICE FORM - PART 2

Offerors requesting to participate in the evaluation for expansion of services as described in *RFP Section H, Instructions to Offerors, Paragraph 20*, shall indicate their request for participation below. An Offeror must complete the Bid Choice Form - Part 2 in order to be considered for participation in the future expansion of services. **Failure to complete the Bid Choice Form shall preclude the Offeror from participation in the future expansion of services.**

Magellan Complete Care of Arizona, Inc. **is requesting to participate in the evaluation for expansion of unique services in the GSA(s) checked below:**

OFFEROR'S NAME

	GSA
☒	**Central**: Maricopa, Gila, and Pinal Counties
☒	**North**: Mohave, Coconino, Apache, Navajo and Yavapai Counties
☒	**South**: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties

James R. Stringham — Authorized Signature

1-3-18 — Date

James R. Stringham — Print Name

CEO, Magellan Complete Care of Arizona, Inc. — Title

SECTION A: SOLICITATION AND OFFER PAGE

Chief Procurement Officer
Meggan Harley, CPPO, MSW
Chief Procurement Officer
AHCCCS
701 E. Jefferson, MD5700
Phoenix, Arizona 85034

Telephone: (602) 417-4538
E-Mail: ICRFPYH19_Questions@azahcccs.gov
Issue Date: November 2, 2017

LOCATION: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION (AHCCCS)**
Procurement Office (First Floor)
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

DESCRIPTION: **AHCCCS COMPLETE CARE PROGRAM CONTRACT FOR CONTRACTORS**

PROPOSAL DUE DATE: **January 25, 2018** **AT 3:00 P.M. ARIZONA TIME**

A Pre-Proposal Prospective Offerors' Conference has been scheduled for Wednesday, November 8, 2017 starting at 9:00A.M. Arizona Time. The Conference will be held in the following location:

AHCCCS
Gold Room, Third Floor
701 E. Jefferson Street
Phoenix, AZ 85034

QUESTIONS CONCERNING THIS SOLICITATION SHALL BE SUBMITTED TO THE PROCUREMENT OFFICER NAMED ABOVE, IN WRITING, VIA E-MAIL, AS SPECIFIED IN SECTION H, INSTRUCTIONS TO OFFERORS. QUESTIONS MUST BE SUBMITTED ON THE RFP YH19-0001 QUESTIONS AND RESPONSE TEMPLATE LOCATED IN THE BIDDERS' LIBRARY. ANSWERS TO QUESTIONS WILL BE POSTED IN THE AHCCCS WEBSITE IN THE FORM OF A SOLICITATION AMENDMENT FOR THE BENEFIT OF ALL POTENTIAL OFFERORS.

In accordance with A.R.S. §36-2906, which is incorporated herein by reference, competitive sealed Proposals will be received by AHCCCS in accordance with the instructions in this solicitation document until the time and date cited. Proposals received by the correct time and date will be opened and the name of each Offeror will be publicly read.

Proposals must be in the actual possession of AHCCCS on or prior to the time and date in accordance with the instructions in this Solicitation document.

Late Proposals shall not be considered.

All Proposals must be typewritten. Additional instructions for preparing a Proposal are included in this solicitation document.

Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting the person named above. Requests should be made as early as possible to allow time to arrange the accommodation.

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION

AHCCCS Arizona Health Care Cost Containment System	NOTICE OF REQUEST FOR PROPOSAL
	SOLICITATION # YH19-0001
	AHCCCS COMPLETE CARE CONTRACT FOR CONTRACTORS

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and final Proposal revisions (if any). Signature also certifies Small Business Status.

NPI No. (*optional*)

45-5337737

Federal Employer Identification No.:

NA for Offeror; Parent (Magellan Health, Inc) = 04-969-7332

Dun and Bradstreet (DUN) No.

E-Mail Address: **jrstringham@magellanhealth.com**

Magellan Complete Care of Arizona, Inc.

Company Name

4800 N. Scottsdale Rd. Suite 4400

Address

Scottsdale, AZ 85251

City State Zip

For clarification of this offer, contact:

Name: **James Stringham**

Title: **CEO**

Phone: **602 / 572-5955**

Signature of Person Authorized to Sign Offer

James R. Stringham

Printed Name

CEO

Title

CERTIFICATION

By signature in the Offer section above, the Offeror certifies:

1. The submission of the offer did not involve collusion or other anti-competitive practices.
2. The Offeror shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 2009-09 or A.R.S. §§41-1461 through 1465.
3. The Offeror has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.
4. The Offeror ___ is / X is not a small business with less than 100 employees or has gross revenues of $4 million or less.
5. The Offeror is in compliance with A.R.S. §18-132 when offering electronics or information technology products, services, or maintenance; and
6. The Offeror certifies that it is not debarred from, or otherwise prohibited from participating in any contract awarded by federal, state, or local government.

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

Your offer, including all exhibits, amendments and final Proposal revisions (if any), contained herein, is accepted. The Contractor is now bound to provide all services listed by the attached Contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by AHCCCS. The Contractor is cautioned not to commence any billable work or to provide any material or service under this Contract until Contractor receives written notice to proceed.

This Contract shall henceforth be referred to as Contract No. YH19-0001

Award Date: _____

MEGGAN HARLEY, AHCCCS Chief Procurement Officer

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

SOLICITATION AMENDMENT #1		
YH19-0001 AHCCCS Complete Care	Solicitation Due Date: **January 25, 2018** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: ICRFPYH19_Questions@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

This Solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME: James R. Stringham	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: CEO	TITLE: Chief Procurement Officer
DATE: 1-3-18	DATE:

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

SOLICITATION AMENDMENT #2		
YH19-0001 AHCCCS Complete Care	Solicitation Due Date: January 25, 2018 3:00 pm Arizona Time	Chief Procurement Officer: Meggan Harley Email: ICRFPYH19_Questions@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

This Solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: SIGNATURE ON FILE
TYPED NAME: James R. Stringham	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: CEO	TITLE: Chief Procurement Officer
DATE: 1-3-18	DATE:

CAPITATION NON-BENEFIT COSTS BID SUBMISSION

All Capitation Non-Benefit Costs Bid Submission files are located in the folder of the same name, per the RFP instructions, as follows:

- Signed Agreement accepting capitation rates – **Page 8**
- Non-Benefit Costs Bid Submission workbook – **Pages 9-14**
- Actuarial Certification(s) of the non-benefit costs (administrative and UW gain bids) – **Pages 15-21**

Executive Summary

Magellan Complete Care of Arizona, Inc., (MCCAZ) is pleased to submit its response to the AHCCCS Complete Care Program Contract for Contractors (Solicitation #YH19-0001) for all three GSAs. We are capable and interested in the potential option to expand service provisions including: physical health (PH) and behavioral health (BH) services for members determined to have a serious mental illness; and BH services for members in the DCS/CMDP program, Crisis Services, and SAMSHA Grants and other Non-TXIX/XXI funded services. We have direct experience coordinating care for these complex populations as well as adhering to the Arizona system values and guiding principles. MCCAZ is uniquely positioned to exceed the expectations of AHCCCS by supporting member choice in the delivery of the highest quality care while addressing the whole health needs of our members and improving the member experience.

Magellan Healthcare (Magellan) has been a committed member of the Arizona healthcare community and a partner to AHCCCS for more than 10 years. We are an Arizona-based company with national corporate headquarters and executive leadership in the Phoenix area; with nearly 900 employees across Arizona. We have deep roots serving Arizona Medicaid populations as the Regional Behavioral Health Authority (RBHA), providing complex specialty, pharmacy, and BH services to over 700,000 Arizonians; including many of the members and services that will be integrated as part of this transformative program.

> Magellan Complete Care of Arizona provides a truly integrated solution by managing all required services without partnership agreements or joint ventures making us solely accountable to AHCCCS.

Since 2010, Magellan Rx Management (MRx) has designed and implemented the Medicaid preferred drug list (PDL) and supplemental rebate services for the State. We understand the nuances of service delivery across the State and in each GSA; including the needs of Arizona's tribal members. Magellan has been active in thought leadership across the state – participating on the Governor's Opioid Task Force, providing guidance on the statewide suicide initiative, serving on the Board of the Arizona Chamber, and participating in a number of healthcare conferences and taskforces focused on key issues surrounding the health delivery system.

Nationally, Magellan has built on its experience and learning in Arizona, and elsewhere, to completely transform into an innovative, fully-integrated health plan. Today, we operate Medicaid and Medicare Advantage health plans for populations similar to the AHCCCS Complete Care Program in multiple states including Florida, New York, Virginia, and Massachusetts; as well as targeted specialty plans in Louisiana, Wisconsin, Wyoming, Pennsylvania, Virginia, Montana, and Florida. When designing our integrated health plans, we believe that most national Medicaid managed health plans all essentially follow the same model. Instead, we utilize our deep experience working in BH, pharmacy, and in our member's homes and communities to drive a different approach. This perspective led us to design MCCAZ as something different; a far more specialized, intensive, and family-centered health plan. With key members of the Leadership Team already in place for the AHCCCS Complete Care contract, MCCAZ's goal is to serve Medicaid members far more effectively than the traditional health plans do today. MCCAZ's ***person-centered, community-focused, evidence-based*** approach provides complete care coordination tailored to the individual's PH, BH, and social needs.

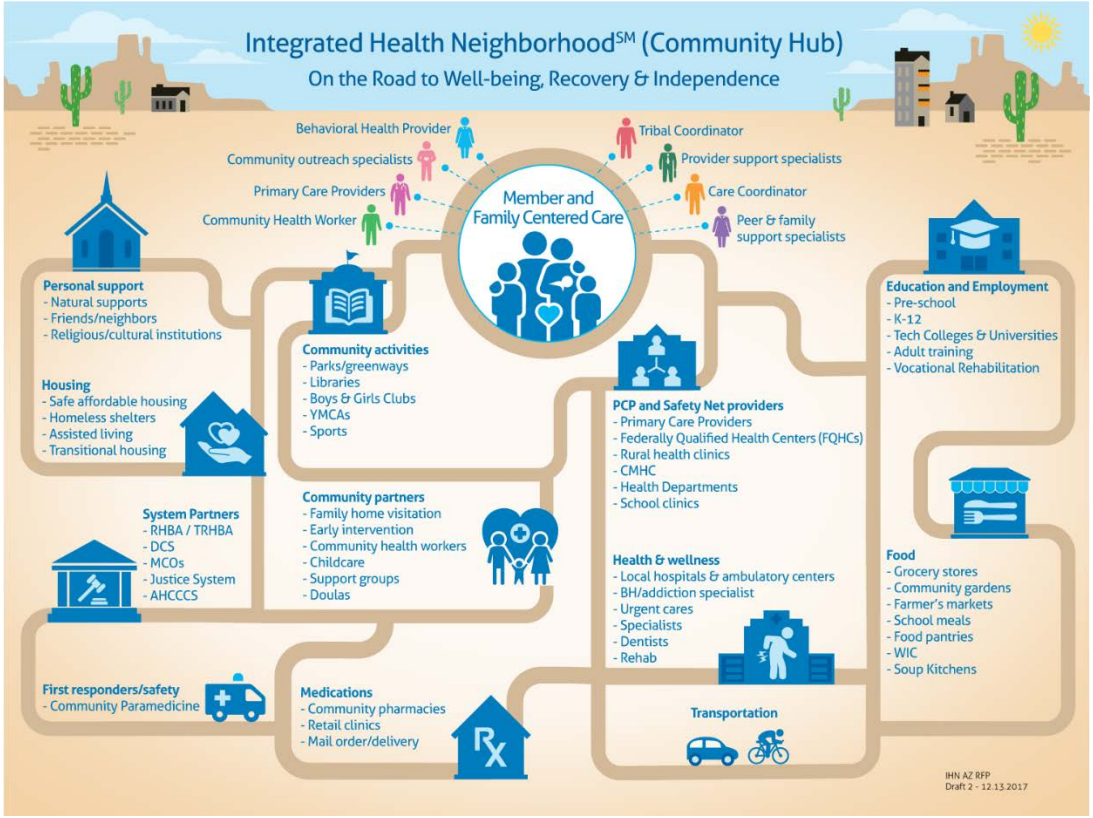
Approach to the AHCCCS Complete Care Program: We recognize that AHCCCS is looking for system transformation by further integrating care delivery systems and properly aligning incentives to improve health outcomes, enhance member satisfaction, and better manage costs. Magellan has direct experience re-shaping the delivery of health care services in other markets – taking a once fragmented system and creating a fully-integrated system of care. Unlike traditional MCOs that serve a broad demographic with a focus most often on responding to routine and acute needs, Magellan redesigned the traditional MCO by first serving the most complex Medicaid populations and applying those principles to deliver superior outcomes for more general populations. We fully integrate these capabilities that have been in-house for decades, which further sets us apart from other health plans that often outsource critical services to third party vendors, such as BH and pharmacy.

We were innovators in integrating care for special populations in Arizona with our successful launch of Integrated Health Homes (IHH). We previously partnered with the State to develop an IHH for approximately 20,000 individuals with serious mental illness. We helped providers prepare for the evolutionary change in payment models, enabling several to obtain FQHC designation and offer a broader suite of integrated services.

In Florida, we built on these concepts to launch the nation's first Medicaid health plan specifically designed to fully integrate services for individuals with serious mental illness. Our plan re-imagined and re-designed the member journey and system of care; including processes, policies, and care models to truly integrate PH and BH care while addressing social determinants of health, such as housing, employment and transportation.

MCCAZ's approach uses community-focused coordination through the **Integrated Health Neighborhood℠ (IHN)**, as shown in **Figure ES-1**. Our mission is to partner with our members, one person at a time, through individualized, community-based, data-informed and technology-assisted approaches to healthcare delivery and care coordination. MCCAZ's goal to improve members' care, quality of life and health outcomes is achieved within the context of where the members live – within neighborhoods and local communities. This helps minimize member disruption through use of familiar local provider networks and support from trusted community organizations. Our IHN model naturally bridges language and cultural barriers. Our regionally-based IHN Team lives and works within the communities where our members reside and have first-hand knowledge of GSA and community-specific strengths, resources and available services.

Figure ES-1. Integrated Health Neighborhood



We incorporate Magellan-owned programs such as pharmaceutical management through **Magellan Whole Health Rx,** and ancillary management through **Magellan Specialty**, which are specifically focused on contracting, clinical, and cost outcomes for those two increasingly high-cost categories. These solutions are instrumental in identifying and targeting savings opportunities in both pharmaceutical spend and high-cost specialty services. Also, we leverage Magellan's innovative technology driven suite of tools called **Magellan Virtual Care Solution**, which provides individualized treatment and early interventions on phones and tablets to reduce escalation to higher levels of care.

Our provider and community partnerships, key elements of the IHN, are built with a shared commitment to person-centeredness, evidence-based treatment, robust communication, and teamwork. We work closely with our tribal, provider, and community partners to strengthen connectivity of Health Information Technology (HIT) to exchange the information needed to coordinate care and improve health outcomes. Within the IHN, MCCAZ's system of care includes:

- Engaging members through the IHN
- Serving the whole member – PH, BH, and social needs
- Investing in technology to fully integrate care management and simplify program administration
- Strengthening coordination between Indian and non-Indian health providers for American Indian members
- Monitoring of HEDIS metrics, EPSDT, birth outcomes, and preventable events

- Committing to provider collaboration supported by the unique value-added role of the **Provider Support Specialists**, who are licensed clinicians that facilitate practice-level system transformation
- Establishing relationships with advocacy and community-based organizations
- Creating a culture of innovation, highlighted by Magellan's Virtual Care Solution and mobile platforms
- Hiring local and culturally competent staff who are rooted across GSAs to best serve our neighbors.

VBP Strategies where Provider Collaboration Fuels Provider-led Change: We are committed to exceeding AHCCCS threshold goals of 25 percent value-based purchasing (VBP) reimbursements by 2020. When designing VBP strategies, we collaborate with providers to better understand their needs and preferences while partnering to develop solutions for common implementation challenges. Our VBP strategy has a proven effect on total cost of care. By focusing heavily on improvements in clinical outcomes and access to services, we partner with providers to efficiently deliver services that engage members, increase member satisfaction, and positively bend the cost curve. We have Letters of Agreement and Memorandums of Understanding with several providers with VBP initiatives; including bundled payment, shared savings and provider incentives. In New York, we have partnered with the State and long-term care providers to move nearly 70 percent of capitation into a VBP model.

Solutions to Reduce Opioid Use Disorders and Opioid-related Deaths: Opioid addiction in Arizona, and across the rest of the United States, has reached epidemic proportions. There were 679 opioid-related deaths in Arizona in 2015 alone. The CDC reports that the epidemic is especially centered outside cities and among Native Americans. Over the last sixteen years, deaths rose by 325 percent in rural areas, and by more than 500 percent among Native Americans. Magellan brings a unique approach to combat the opioid crisis; which has been leveraged by national committees (e.g., National Quality Partners, AHIP, and Shatterproof), state and local government organizations, and commercial health plans across the country. Our advanced analytics, clinical expertise, education resources, and pain management approaches provide many innovative ways to address the opioid problem—at any stage during an individual's experience having an opioid problem to accelerate the time to recovery.

Successful Experience Operating 4.5 Star Medicare Advantage D-SNPs: MCCAZ is prepared to provide Medicare benefits to Medicaid members who are also enrolled in Medicare (dual eligible members) through a state-contracted D-SNP for all counties of the awarded GSAs; effective January 1, 2019. We will provide care coordination as well as data reporting as required by AHCCCS, and as detailed in its Medicare Advantage D-SNP Health Plan Agreement with AHCCCS, consistent with 42 CFR 422.107, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), and the Affordable Care Act. We look forward to collaborating with AHCCCS in developing and implementing additional strategies to enhance alignment of dual eligible members enrolled in our D-SNP and our companion Complete Care Plan. We have submitted our Notice of Intent to Apply and received Medicare State Certification through the Arizona Department of Insurance. We are preparing the D-SNP application for submission to CMS in February.

Nationally, Magellan already operates Medicare Advantage D-SNPs. Our Massachusetts D-SNP received an Overall Star Rating of 4.5 Stars for 2018. It serves as the Medicare Center of Excellence for our New York D-SNP, which was ranked one of the highest rated Medicare Advantage health plans in the state for CAHPS member satisfaction.

Conclusion: MCCAZ has been a member and proven partner of the Arizona healthcare community since 2007. We understand the nuanced regional GSA differences that drive healthcare challenges in Arizona and we are operationally ready. We administer fully-integrated Medicaid health plans for similar populations in multiple states. Most importantly, we offer a customized system of care that goes beyond the standard offering of other organizations to deliver person-centered, community-focused, and evidence-based solutions for all children and adults in the Complete Care Program.

Our long-standing partnership with AHCCCS, deep Arizona experience, proven Medicaid health plan capabilities, and unique track record serving some of the most vulnerable Arizonians, provides the foundation for a seamless implementation and innovative program administration. We look forward to collaborating with AHCCCS to build a one-stop system of care in Arizona to reduce fragmentation, expand the availability and use of health information technology, and partner with providers to develop reimbursements that incentivize quality outcomes. We are uniquely positioned to administer a holistic, fully-integrated care delivery system to improve health outcomes and enhance member satisfaction; while better managing healthcare costs and other limited resources.

MORAL OR RELIGIOUS OBJECTIONS

Magellan Complete Care of Arizona, Inc. has no moral or religious objections to providing or reimbursing for a covered service.

1. Experience managing healthcare delivery systems similar to the AHCCCS Complete Care Program.

Magellan Complete Care of Arizona, Inc., (MCCAZ) is a fully-integrated physical health (PH) and behavioral health (BH) plan with demonstrated experience implementing programs similar to AHCCCS Complete Care in several states, including Florida and New York. We have delivered over 30 programs in 11 states on behalf of 4.3M members on Medicaid, Medicare, and CHIP, including polychronic, acute care, and post-acute medical care.

Our original Maricopa County Regional Behavioral Health Authority (RBHA) contract served over 700,000 Arizonians, including many of the members and services that will be integrated as part of this transformative program. This program was transitioned from the incumbent within 60 days, which speaks to our ability to implement the AHCCCS Complete Care Program.

Table 1-1. Cited Contracts

Magellan Healthcare Contract	Special Populations (Adults and/or Youth)					
	Justice Involved	COT/ COE	High Needs/Cost	SUD	DCS Removal Risk	Transition from CMDP
Magellan of AZ	●	●	●	●	●	●
MCC of FL	●	●	●	●	●	●
SWH of NY	●	●	●	●		

MCCAZ's parent company, Magellan Healthcare (Magellan), manages specialty health services on behalf of 24.5M individuals nationwide; focusing on providing clinically- and cost-effective solutions in high cost areas such as pain management, diagnostic imaging, and physical medicine. Our clinically supported medical management programs improve quality while holding cost trend lines. We offer fully-integrated, in-house pharmacy benefits management (PBM) services through Magellan Rx Management, Inc., (MRx), our wholly-owned PBM, and indeed holds a Medicaid Preferred Drug List (PDL) contract with AHCCCS today. In keeping with RFP requirements, we describe Magellan's Arizona (Magellan of AZ) experience, as well as two additional contracts, which closely mirror AHCCCS' transformational vision – Magellan Complete Care of Florida (MCC of FL), and Senior Whole Health of New York (SWH of NY). **Tables 1-1 and 1-2** provide a summary of experience across our cited contracts.

Table 1-2. Summary of Experience

Contract	Geographic Coverage	Population Served and Enrollment	Physical Health and Behavioral Health Integration Status	Years; Current Status
MCC of FL	8 of 11 Medicaid regions within FL	70,000 members – including children and adults in low-income families with children; pregnant women; children on CHIP Title XXI; youth in foster care/adoption; and children with special needs	MCC of FL is a fully-integrated Medicaid Medical Assistance Plan with special designation for individuals with serious mental illness (SMI); full Medicaid PBM services to members on medical assistance program through our affiliate company MRx; dental, vision, and transportation services	3.5 Active
SWH of NY	6 counties within NY	14,230 members – including individuals who are eligible for both Medicare and Medicaid services and who choose to enroll in a D-SNP or FIDA (integrated duals eligible) program; Managed Long Term Care Services (MLTSS) for individuals >20 years of age	SWH of NY is an Article 44 HMO that provides 100% integrated PH, MLTSS, BH, long-term care; dental, vision, and transportation services to eligible members; 4.5 Star Medicare Plan	6 Active
Magellan of AZ	Maricopa Pinal County (Central GSA) within AZ	715,100 members – including infants, children, and adults in low-income families; pregnant women; children in foster care/adoption; children with special needs; teens who are uninsured	Magellan of AZ was the RBHA; established an Integrated Health Home (IHH) initiative for ~20K individuals with SMI; implemented a co-located Joint Venture with a local health plan to serve >1,800 individuals with both PH and BH diagnoses	6.5 Complete

Magellan Complete Care of Florida (MCC of FL): Implemented in 2014, the first licensed Medicaid HMO (Medical Assistance Health Plan) to be granted special designation for individuals with SMI. MCC of FL worked with the Florida Medicaid Agency to transform a carve-out BH model to a fully-integrated PH and BH program focused on individuals with SMI and those with multi-system complex needs, including children with autism spectrum disorder; individuals that were justice-involved; children at risk of out-of-home placement; substance use disorder; and those with diverse and specific linguistic and cultural challenges. In Florida, we developed a capitation model with PCPs that has routinely served approximately 70 percent of members in some form of value-based reimbursement, primarily capitation for primary care arrangements focused heavily on improvements in HEDIS/EPSDT and gaps in care closure. The focus of these programs has been PCPs, pediatricians, and OB/GYNs; with whom we have worked to increase Child Health Check-Up visit rates, increase Adults' Access to Preventive/Ambulatory Health Services (HEDIS AAP), and closed HEDIS gaps in care for hypertension management, breast and cervical cancer screening, and diabetes.

Senior Whole Health of New York (SWH of NY): A licensed HMO in six New York counties, SWH of NY began operating in 2011 and offers three products, a Medicaid Long Term Care program (MLTC); Dual Eligible Special Needs Plan (FIDE SNP); and a Dual Advantage (FIDA) program; all of which deliver fully-integrated PH and BH services. SWH of NY is distinguished by its leadership implementing VBP initiatives; overall 70 percent of the 2017 total medical capitation at the plan in New York is in a VBP. SWH of NY favors two models: (1) a home care quality VBP program that rewards home care providers for Medicaid long term care and personal attendant services (98% of all home care providers who meet VBP criteria hold a contract with SWH of NY); and (2) a primary care quality VBP program that generates bonus payments to IPAs that achieve risk-adjusted medical care targets (20% of total claims expense are under a primary care VBP arrangement). SWH of NY consistently meets high quality standards and achieves a high ranking among health plans in New York. The New York Medicare Advantage membership, including clinical/administrative policies, procedures and best practices, is managed through SWH of NY's Center of Excellence in Cambridge, MA; a 4.5 Star Medicare Plan.

Magellan of Arizona (Magellan of AZ): Magellan of AZ served as the Central GSA RBHA for almost seven years, beginning in 2007. Under Governor Jan Brewer's leadership, we partnered with stakeholders to develop an Integrated Health Home (IHH) for approximately 20,000 individuals with SMI. We helped providers prepare for the evolutionary change in payment models; enabling several to obtain FQHC designation and offer a broader suite of integrated services. In a joint venture with a local Medicaid health plan, we co-located services physically with the plan; delivering truly integrated care for more than 1,800 individuals with both PH and BH diagnoses. Through our efforts, we secured 710,000 nights of shelter for people experiencing homelessness, helped more than 1,600 homeowners avoid foreclosure, and connected almost 3,000 people to Permanent Supportive Housing programs and services. In addition, we reduced the number of children in residential care from 149 to 41 in just four years, and partnered with service providers to reduce substance use by young people in the juvenile justice system; earning a prestigious Science and Service Award from SAMHSA in 2011. Moving forward, MCCAZ is committed to developing transformational provider reimbursement models to serve vulnerable populations; we agree with AHCCCS that working closely with community-based social resources and employing data exchange and analytics are critical to this effort.

Magellan Rx Management (MRx): Currently, Magellan provides Medicaid partial PDL pharmacy services to the State of Arizona through a contract that began in 2015. Our staff participate in the AHCCCS Pharmacy & Therapeutics (P&T) meeting on a quarterly basis and leads PDL recommendation discussions with their P&T Committee; recently awarded a PDL contract extension from AHCCCS. Through 3Q 2017, MRx generated over $50M in supplemental rebate savings for the State through this program.

Magellan's RBHA experience as an early proponent of integrated care in Arizona, together with the best practices developed in fully-integrated PH and BH programs like Florida, and managed long-term care/duals programs in New York, strongly positions us to support the transformation vision for the AHCCCS Complete Care Program.

2. Implementing critical components and principles of behavioral and physical health services delivery while maintaining and high standard of care.

Magellan Healthcare (Magellan) has been a committed member of the Arizona healthcare community and a partner to AHCCCS for over 10 years. We are an Arizona-based company with our national corporate headquarters in Scottsdale. We employ nearly 900 across Arizona. We have deep roots here, previously serving Arizona Medicaid populations as the Regional Behavioral Health Authority. We have reached over 700,000 Arizonians in providing complex specialty, pharmacy, and behavioral health (BH) services; including many of the members and services that will be integrated as part of this transformative program. Since 2010, Magellan Rx Management (MRx) has designed and implemented the Medicaid preferred drug list (PDL) and supplemental rebate services for the State. Magellan has been active in thought leadership across the state – participating on the Governor's Opioid Task Force, providing guidance on the statewide suicide initiative, serving on the Board of the Arizona Chamber, and participating in a number of healthcare conferences and taskforces on key issues surrounding the health delivery system.

MCCAZ End-to-End Integration

- Integrated, Evidence-Based Program Design
- Integrated Health Neighborhood
- Integrated Member/Family Outreach & Engagement
- Integrated Provider Support/System Transformation Supported by VBP
- Integrated, Broad Network Design
- Integrated Care Management Continuum from Population Health to High Risk Case Management & Utilization Management
- Integrated Pharmacy Benefit Program
- Integrated Systems & Technology
- Integrated Benefit Design including Enhanced Benefits
- Integrated Quality Improvement
- Integrated Data and Analytics
- Integrated Customer Service

Magellan Complete Care of Arizona (MCCAZ) has unique qualifications and experiences to exceed the expectations of AHCCCS for implementation of high quality physical health (PH) and BH service delivery through a fully-integrated managed health plan. MCCAZ's rich history in Arizona has informed our understanding of the AHCCCS PH and BH populations. We have remained closely informed of the stepwise changes that AHCCCS has made toward reaching a fully-integrated program. Our involvement in co-location and coordinated models of care was followed by the movement of Children's Rehabilitative Services (CRS) into a specialty health plan. We have followed the movement of dual eligible members into the managed care health plans, and the integrated program for individuals diagnosed with serious mental illness (SMI). Magellan Complete Care of Florida is the nation's first fully-integrated health plan for individuals with SMI, and the work of Magellan's Senior Whole Health in New York is closely in sync with the direction that AHCCCS has taken to ease the navigation of PH and BH services; creating single points of accountability in the health care system, aligning incentives among all providers, and streamlining care coordination to avoid duplication and misdirection of services.

Integrated, Evidence-based Program Design: The demonstrated efficacy at the heart of our member-centered service delivery stems from the systems-level integration of PH and BH services and incorporates our deep understanding of the impacts of the social determinants of health (SDoH). Interventions and solutions are built around the Substance Abuse and Mental Health Services Administration's (SAMHSA) Four-Quadrant model for the management and delivery of integrated PH-BH solutions, and the Collaborative Care delivery design concepts. These include a continuum of care delivery and care management solutions based on the complexity and risks of PH and BH comorbidities. Building on these concepts, we seek to direct member care to the best, and most appropriate site of services, and direct targeted interventions based on that complexity and risk. We use specific models for coordination, integration and support of care management through a continuum of solutions such as Team-based care models, Primary Care Medical Home (PCMH), Collaborative Care, Integrated Health Homes (IHH), and Magellan's **Integrated Behavioral Health Program (IBHP).** As the leading BH plan provider in the country, our strengths-based approach shares in SAMHSA's establishment of the resiliency and recovery-oriented systems of care (ROSC) to enhance prevention, treatment, and recovery services. These elements are incorporated throughout our health plan design and programs and are integrated as part of our broader outreach and member support efforts. Our well-honed techniques, such as motivational interviewing, have proven integral to address PH and BH comorbidities.

Magellan maintains unique specialty care management Teams and Centers of Excellence for members with more acute PH-BH comorbidities such as sickle cell anemia with co-occurring substance use, or bipolar disorder with diabetes, or chronic pain with substance use disorder (SUD) or depression. We bring expertise in the intensive management of physical disease, BH diagnoses, and often co-occurring drug use.

Integrated Health Neighborhood: The foundation of MCCAZ is our **Integrated Health Neighborhood℠ (IHN)**. We established the IHN based on our understanding of the importance of community partnerships; our experience in working collaboratively to strengthen the local system of care; our desire to facilitate system change by supporting our providers in adopting integrated models of care; and ultimately to do a better job of engaging our members in a holistic way that supports what they need to lead healthier lives. Our IHN approach will reflect a statewide infrastructure working across the health and social services systems in Arizona to support and enhance the relationships among members and their families, their providers, and, community partners. The IHN informs all aspects of our health plan design including integrated programs, staffing, network development, community partnerships, and system transformation activities. The approach reflects the best of our depth of experience, passion for serving our members where they live, and our commitment to bring best-in-class service to our Arizona partners.

The IHN is built on our understanding that each member's ability to achieve and maintain a healthy and vibrant life is tied to factors that affect PH and BH, including SDoH and environmental conditions, such as housing, poverty, food insecurity, health literacy, education, justice-system involvement, and access to transportation. Improving care and outcomes can only be achieved where our members live – in Arizona's neighborhoods and communities. Relationships and collaborations with community partners enable us to effectively coordinate care with the community supports and services that the member knows and trusts e.g., churches, schools, RBHAs. The IHN is MCCAZ's innovative solution that allows us to "think locally" as we customize our programs in each region to deliver locally-focused, integrated, and culturally responsive solutions to meet members where they are. As we strive to eliminate health disparities, the beauty of our IHN neighborhood-based program design is that it naturally bridges language and cultural barriers regardless of region. The model works in rural, underserved areas like Gila County and as well as in urban areas like Phoenix or Tucson.

In addition to the local program design, we enhance the model with "feet on the street" staff who live and work in the communities they serve to enhance and extend the reach of local public health systems. These Teams have first-hand knowledge of community strengths, resources, PH and BH services, service gaps, and experience in engaging community-based organizations, advocacy groups, faith-based organizations, and other community resources. Our **Provider Support Specialists (PSS)** and **Community Outreach Specialists (COS)** assume a facilitative role connecting PH and BH providers, community-based agencies, and community members to promote comprehensive integrated services for our members. The PSS are clinicians who support dissemination of evidence-based practices and integrated models through training, technical assistance, and data sharing. The COS will establish partnerships with State agencies and community organizations e.g., department of health, DCS, school based clinics, parish and school nurses, RBHAs, Inter Tribal Council of Arizona, home visitation programs, Community Action program offices, and the criminal justice system; including Drug Courts.

The COS in each region completes a community health assessment and asset mapping within the neighborhoods they serve and develops a "Road Map to Recovery" to help direct the IHN Clinical Team to the most impactful interventions and impactable members. This allows the Team to recognize the uniqueness of each community, its strengths, and best positioning of our resources to support the local system of care. Our COS Team customizes **Aunt Bertha Community Connections**, our geocoded repository of community resources – to the unique needs of our members to address SDoH and leverage non-traditional services in their neighborhoods. With Aunt Bertha's intuitive interface, it can easily access members and their supports, providers, IHN care management, and MCCAZ Customer Service Associates. These data are also used to inform our annual System Transformation Plan for community partnerships and network development decisions, where issues such as housing, school programs, court and correctional programs are, and how they contribute to health. For our high risk members, our locally-based care management Teams and community-based model is designed to meet the needs of the whole person.

Team members include **Care Managers (RN's, LSWs), Community Health Workers (CHW), promotoras, Recovery Support Navigators, Family Support Specialists, Housing and Employment Specialists**, **Jail Liaisons**, **Doulas, Indian Health Services (IHS) Community Health Representatives, Tribal Coordinators, and community partners.** The Teams provide additional needed support and coordination to assist our members in navigating the health care and social supports systems to get needed care and services. For high volume providers who need staffing support, we support a Team-based model and co-locate staff in the practice setting.

Active Member/Family Engagement: Core to the effective implementation of critical components of PH and BH service delivery is active engagement of our members and/or their families or caregivers. Our program empowers members with actionable health information and tools that inform, enable, influence, and incentivize member engagement for self-management. Our goal is to connect each member to a health/medical home and provide them with the tools they need to engage in self-care to ensure their health and social needs are met. We encourage our members to choose a primary care provider (PCP). For those who do not choose a PCP, MCCAZ assigns a PCP process based on preferred providers, available care mdoels (e.g., PCMH, IHH, Collabrative Care), geographic location, and quality of care indicators. In Florida, we assign a primary BH provider (PBHP). MCCAZ will explore this option in Arizona.

As soon as a member is assigned to MCCAZ, we reach out to them to welcome them to our plan. We want our members to understand their benefits and feel empowered and involved in their health care. Building on our experience in Arizona and other states, we use a "no-stone-unturned" approach using traditional and innovative strategies to find and engage our members. In addition, our integrated information platform, which incorporates data from the AZ HIE, Health Current, includes alerts to help customer service, care coordination, and outreach staff identify hard to reach members. We meet members where they are by using outreach strategies including phone calls, face-to-face interaction, written materials, online tools, mobile, and social media platforms. These strategies have evolved as we have learned how to best communicate in a person-centered, culturally appropriate, and health literate way. Through a Member Advocacy Council (MAC) that includes representation of council members that reflects the population and community served, we solicit input on communications and check for health literacy, cultural awareness, and readability of our member materials. We engage regional and local staff to better understand the unique needs of each community as they reach out to members, including the use of the following:

- **Onboarding Materials:** In addition to the Welcome Call, we provide written materials that include: ID card, Member Handbook, PCP assignment, provider and prescription search instructions, and care manager assignment (if applicable). The Member Handbook serves as the Evidence of Coverage and outlines covered benefits and programs.
- **Member Experience:** MCCAZ also uses internal reports (e.g., call center trends) to identify member confusion. We address issues by tailoring member materials or creating new materials to eliminate confusion and increase clarity. For example, MCCAZ's **Passport to Care** is a personal health record that helps members track their PH and BH care needs to help self-manage their conditions.
- **Population Health:** MCCAZS uses a population health management system to identify members with gaps in care or who could benefit from disease or chronic care management programs; it also provides the platform through which MCCAZ administers public health campaigns.

Provider Support/System Transformation: Our goal is to work with providers to ensure every member receives the very best outcomes. We deeply value our provider partnerships and have developed meaningful relationships to support them in the care of our members. As we do today in other states, we will work with providers to bring about system change. Our goal is to support a comprehensive approach to integrated care in any care setting in which an AHCCCS member receives services to enhance addressing whole-person needs. MCCAZ believes that ongoing provider engagement and support fosters healthcare integration at the system and service level by ensuring collaboration and communication with providers and caregivers across the member's entire care continuum. Our MCCAZ licensed clinical PSS are proof of our commitment to our network providers and to provider-led system change in Arizona. MCCAZ's goal is to support AHCCCS in the transformation of the system of care and, with our continued support and our effective use of technology and innovation, shift care coordination and quality improvement resources to the point of care. Using the principles of practice facilitation, the PSS leverage their clinical and public health knowledge, along with their deep understanding of the neighborhoods they serve, to provide consultation, training, and technical assistance to help

providers develop integrated care solutions. Working with providers at their locations, the PSS simplify programmatic changes by conducting analyses of their needs and readiness to change, reviewing workflows to identify opportunities for improved services, and identifying the potential for creating additional network access. Our PSS work to adopt evidence-based practices, facilitate relationships between PH and BH providers, transform data into actionable information, support value-based purchasing (VBP) initiatives, and establish learning collaboratives. We have found that the PSS role is a unique position to our management approach that other health plans do not employ. The PSS approach is well received by the povider community and is very effective in managing system transformation, integrating PH and BH, and positively impactacting outcomes and healthcare spend.

VBP and alternative-payment-models (APM) are important elements in promoting and achieving integrated models of care. MCCAZ's approach incorporates a multi-tiered and appropriately paced implementation of VBP, built on concepts of collaboration, assessment of provider readiness, and support to minimize disruption and risks for our provider partners. Our VBP strategy focuses heavily on improvements in clinical outcomes and access to services; with proven effects on total costs of care, and provider and member satisfaction.

MCCAZ incorporates additional support and tools for the provider community to support the integration of PH and BH care, incorporating the SDoH, and bending the cost curve, including:

- Data analytics/provider detailing to share patient information regarding quality metrics and service utilization
- Primary care integration of BH screening and SBIRT (Screening, Brief Intervention, and Referral to Treatment)
- Integration of health risk assessment and scale-based interventions into clinical practices and settings
- Enhancing access to treatment through **Magellan's Virtual Care Solution (VCS)** including our **SmartScreener™** technology, **Digital Cognitive Based Therapy (dCBT)**, and **Clickotine™** apps (description below)
- Enhancing access to PH or BH services through telemedicine
- PSS support to advance models such as PCMH, IHH, Collaborative Care, co-location, and virtual integration
- Programs and incentives for providers to integrate PH and BH services in their practices
- Comprehensive provider orientation and training in programs and protocols for integrated PH-BH care and SDoH.

MCCAZ providers play a critical role in program oversight, strategic planning, and program initiatives. For that reason, we are establishing **Provider Advisory Committees** (PAC) within each GSA upon Contract award. The PAC provide feedback on new Quality Improvement initiatives, provide insight into local population health concerns, review program evaluation and Performance Improvement Project results, and provide guidance on new initiatives to achieve health improvement goals. The PAC will also represent the provider network by providing ideas and feedback on innovative strategies to transform the health delivery system and consider VBP programs for MCCAZ.

Broad, Integrated Network Design: We are expanding our existing extensive and experienced Arizona provider network to deliver high quality PH and BH care. Delivery of quality healthcare to AHCCCS members is dependent on a diverse, comprehensive, and competent network of acute care hospitals, children's hospitals, BH providers, social support providers, and specialists (including but not limited to endocrinology, dermatologist, orthopedic surgeons, nephrologists, gastroenterologists, cardiology, oncology, OB/GYN, allergy, specialized healthcare providers for medically fragile, and chronically ill infants, children, and young adults, and an array of pediatric specialists and sub-specialists). Given our existing PH and BH network, our deep knowledge of the needs/challenges facing AHCCCS populations, and our proven local and national experience building networks for children and adults requiring preventive (e.g., EPSDT) acute, and complex PH and BH services, we are uniquely positioned to deliver a comprehensive and effective provider network to ensure the critical PH and BH services are delivered while maintaining a high standard of care. Our contracting strategies concentrate on recruiting existing PCMHs, IHHs, and other practices that incorporate integrated care models including Collaborative Care and co-location. MCCAZ is not hospital-system-based health plan – we contract with all willing providers and health systems to offer broader access to services other than high-cost inpatient settings and emergency departments (ED). Our network is built on existing RBHA delivery system capabilities and innovative integrated care elements, including crisis clinics, step-down services, post-crisis navigators that includes safety net providers and a range of integrated models such as IHH in clinics, FQHCs, RHCs, and CMHCs.

We have established relationships with Indian Health Services (IHS), tribal nations, Urban Indian Health Facilities (I/T/U) and engagement and partnership with Native American providers. We ensure that members can access services through tools such as the use of single case agreements, technological advances in tele-doc/telehealth, non-emergency transportation, and provider incentives to ensure members have sufficient access to providers. In order to ensure access to critical services and minimize the risk of a crisis, we make extensive use of enhanced access models, including community paramedicine and dCBT.

Integrated Care Management: Supporting our IHN model is a robust model of service delivery and care management that is fully-integrated from the initial point when a beneficiary becomes a MCCAZ member. Our integrated care management programs – including staffing and interventions – are designed to support a whole-person approach meet the member's PH and BH needs, as well as SDoH. We work with our members to complete our enhanced risk screening tool, which incorporates assessment of PH, BH, and SDoH to determine member risks and needs. Based on our deep experience with BH conditions, Magellan has modified its predictive modeling capabilities to incorporate BH conditions. The proprietary tool also considers census-tract level SDoH to stratify all members by his or her combined biopsychosocial risk and complexity, and assign the member to care management categories ranging from well/prevention to ultra-high risk.

MCCAZ's care coordination/care management staff are trained in PH and BH clinical program requirements and work as integrated Teams to coordinate member care. As part of our recruiting and staffing strategy, we look for Case Managers with certification in both disciplines. Our Care Coordination/Care Management Leadership Team includes both a PH and BH Medical Director under the same roof; who are in joint collaboration. Our care management platform, is a fully-integrated PH-BH solution to manage all member engagement from enrollment, population health, utilization management (UM), and all care management through transitions of care and advanced illness management and end-of-life care. We also maintain a 24/7 integrated nurse advice line with clinical staff trained in both PH and BH to address member questions and concerns. MCCAZ uses the AHCCCS Medical Policy Manual, Milliman Care Guidelines (MCG), medical society guidelines (e.g., American Academy Pediatrics), American Society of Addiction Medicine (ASAM) criteria, and AHCCCS policies to guide integrated care. We build on Magellan's expertise in areas such as dCBT and motivational interviewing in the design of our population health, disease and care management programs to enhance member participation and outcomes. MCCAZ adheres to the EPSDT guidelines and supports care through screening to treatment and ongoing care. Our individualized reviews are conducted by pediatric reviewers. No service provided to a child under EPSDT is administratively denied as out-of-network and/or experimental or non-covered, unless specifically noted as non-covered or carved out.

Integrated Pharmacy Benefit Program: MCCAZ's pharmacy benefit program provides a unique solution to pharmacy benefits management (PBM) for our members, in that Magellan owns and operates our PBM - Magellan Rx Management (MRx). Since 2010, MRx has designed and implemented the Medicaid preferred drug list (PDL) and supplemental rebate services for Arizona. Additionally, MRx has extensive experience providing services for 25 Medicaid programs. Through a broad network of pharmacies, MRx functions as an integrated component of our health plan and plays an integral part in our holistic approach to caring for our members. This allows timely focus on poly-pharmacy, management of drug-drug interactions, adherence, and monitoring for evidence of substance abuse. We offer highly specialized programs including pain management, treatment for opioid addiciton, and use of long-acting injectables (LAI) to promote adherence to antipsychotic medications. We utilize tools such as prior authorization, step-edits, dose optimization, specialty pharmacy programs, Medication Therapy Management (MTM), and other programs effective at controlling costs. The Magellan **Whole Health Rx program** uses advanced proprietary clinical protocols to screen pharmacy and medical claims with the purpose of identifying prescribing patterns that are inconsistent with evidence-based, best practice guidelines for individual diagnoses and co-morbid PH-BH conditions. Based on these findings, our Clinical Pharmacist provides targeted clinical consultative services with providers and staff and connects PCPs, BH providers, and nurse practitioners to identify and resolve gaps in care and inappropriate prescribing. MCCAZ's formulary provides evidence-based therapeutic options to meet the unique PH and BH needs of our members.

Integrated Systems and Technology: MCCAZ information systems are integrated to ensure the delivery and reimbursement of all PH and BH benefits in accordance with eligibility groups. Appropriate care is delivered and paid

through our robust integrated platforms; including enrollment/claims, member services, and clinical systems, all of which are configured according to the unique benefit packages established by AHCCCS in accordance with the member's eligibility category. We operate on a single platform across all clinical areas, providing a seamless, continuous record of member services, interventions, care gaps, and other supports. This information is available to members, providers, and internal staff in one place; providing a single comprehensive 360-view of the member's overall health. We configure our payment system based on medical benefit policies derived from our experience and AHCCCS clinical and policy requirements. Policies reside in our compliance management system Compliance 360 and updated at regular intervals and any time AHCCCS issues new communications; which trigger updates to provider manuals, contracts, technical manuals, and outbound memos. Requirements for our claims system are built upon these policies and system indicators detail the UM and claims payment workflows. As we manage care, we recognize limits or constraints and work with the member to find alternatives that are acceptable and within covered or enhanced benefits.

Integrated Benefit Design: One of the most important elements of national health care reform is the expansion of coverage for those with mental health disorders and SUD, and the commitment to mental health parity. MCCAZ offers enhanced benefits to augment AHCCCS benefits evaluating the AHCCCS covered benefits and populations, while focusing on each underlying high-needs group e.g., pregnant women, children and youth including children with special needs like foster care/adoption assistance youth, and individuals with BH care needs. Based on our experience in Arizona, Florida, and in other markets, we include a unique array of benefits that are proven to positively impact health outcomes. These enhanced benefits are listed below in the innovations section.

Integrated Quality Improvement: Continuous quality improvement (CQI) programs are woven into all parts of our operations to drive ongoing refinement. This includes regular, comprehensive assessment of program interventions and outcomes to ensure they are serving the best needs of our members and AHCCCS priorities. We also conduct a variety of surveys and listening sessions. All of this is enhanced by our "lived" IHN experience. The performance of our integrated programs is validated on an ongoing basis and includes a focus on both PH and BH gaps in care, HEDIS metrics, AHCCCS performance metrics, EPSDT, birth outcomes, and preventable events tied to treatment of both PH and BH conditions. MCCAZ uses expanded outcomes metrics that our experience in other states has shown to be important for monitoring and managing combined PH-BH outcomes. In addition to sharing practice- and member-specific data through provider detailing, our providers have online access to gap-in-care reports and member Individualized Service Plans (ISP); as we collaborate to conduct outreach to close those gaps. Through MRx, we conduct analysis of pharmaceutical usage, flag and follow up for poly-pharmacy issues and members who are late to refill prescriptions. Our MRx Whole Health Program supports providers in understanding the appropriate use of both PH and BH medication therapies, risks of drug-drug interactions, and management of pharmaceutical therapies for members with PH and BH comorbidities.

Our Continuous Quality Improvement (CQI) model incorporates the concepts of Plan-Do-Study-Act (PDSA), which are used to design, test, and evaluate our member intervention programs using statistically valid health research methods to assess efficacy and modify program design where necessary. MCCAZ maintains a dedicated unit within our organization, Advanced Health Analytics and Solutions, which is primarily focused on analyzing the outcomes of our programs; understanding the characteristics of our member population and the key drivers of service utilization and outcomes; refining health assessment and predictive modeling tools; and, assisting with the design of program interventions to achieve targeted outcomes and statistically valid results. MCCAZ incorporates NCQA-standards and best practices in our operations and will seek will seek NCQA certification. All staff will participate in rigorous, ongoing training in federal, State, and AHCCCS program standards and requirements; as well as evidence-based practices, clinical guidelines and quality and outcome standards. UM staff are measured on inter-rater reliability, and the performance of care management staff receive regular review and assessment by senior clinical staff. Activities of care management staff are overseen by our Medical Directors who are board-certified physicians in areas such as internal medicine, psychiatry, pediatrics, and OB/GYN. Many of our Medical Directors are double- and triple-board-certified (peds/adult psych/child psych) in some combination of those disciplines. Our Quality Team has oversight over member complaints regarding quality of care. This process is well-defined in our policies and procedures to bring resolution to members, while maintaining due process for providers. Finally, our Quality Team takes the lead on HEDIS reporting, and participates in clinical and operational strategies to support HEDIS metrics. Related to HEDIS are our efforts for maintenance of NCQA accreditation.

Past implementation of these concepts and other innovative strategies under this contract.

Nationally, Magellan has built on our experience and learning in Arizona and elsewhere to completely transform into an innovative, fully-integrated health plan. Today, we operate Medicaid and Medicare Advantage health plans for populations similar to AHCCCS Complete Care; including children and women eligible under the Temporary Aid for Needy Families (TANF), Aged, Blind and Disabled (ABD), foster children, and Children's Health Insurance Program (CHIP), in multiple states including Florida, New York, Virginia, and Massachusetts. Magellan also has targeted specialty plans in Louisiana, Wyoming, Wisconsin, Pennsylvania, Virginia, Montana, and Florida. MCCAZ innovative strategies are based on successes and lessons learned in Arizona and other markets, identifying the needs of AHCCCS beneficiaries, and selecting solutions that are impactful and make a difference in our member's lives. We take a population health management approach to incorporating innovations into our programs. We evaluate our target population while focusing on each underlying high-needs group. Based on our past implementations discussed throughout this response, in addition to the IHN, MCCAZ will implement the following innovations and enhanced benefits:

BH Self-direction: Given our national leadership in self-directed care, we plan to leverage our family-centered approach toward an emerging field within self-directed services. Our holistic program builds on the tenets of long-term services and supports (LTSS) self-directed programs, but extends the principles to members who want to build a plan that will integrate supports for PH, BH, housing, and employment—extending well beyond the typical focus of activities of daily living.

Specialty BH Care Management Programs: We offer integrated specialty care management programs targeting high-acuity, high-complexity BH conditions, including First-Episode Psychosis (adolescents and transition-age youth), bipolar disorder, schizophrenia and schizoaffective disorder, and chronic pain management. Our targeted programs integrate the management of PH comorbidities and co-occurring SUD.

VCS: A technology driven suite of tools to improve access to care and drive member engagement through a virtually-organized, multilingual ecosystem of digital health tools. VCS integrates tested and proven online clinical programs packaged in a seamless user experience accessible on cell phones, tablets, and other personal computing devices, including:

- **SmartScreener**, to screen for common BH conditions, substance abuse, and insomnia
- **dCBT**, providing online and app-based cognitive therapy for depression, anxiety disorders, substance abuse, chronic pain, and insomnia
- **Clickotine**, an app-based smoking cessation tool
- **ClickHeart**, an app-based program for persons with heart disease.

IBHP: To further meet the needs of this complex and high utilizing membership, MCCAZ will explore provider partnerships for implementation of IBHP.This collaborative model co-locates MCCAZ care coordination staff within the provider clinics to support whole person care management of our members.

IHH/PCMH: Building on our experience in Arizona and other states, MCCAZ will continue to advance this model through the support of our PSS; pursuing models for members with SMI, SED, SUD, as well as chronic PH conditions.

Collaborative Care Models: MCCAZ also facilitates the adoption of this evidence-based model which supports full collaboration between the Care Team in an integrated practice.

Homeless Housing Program: MCCAZ maintains a program to support homeless members to find and secure stable housing. Through our previous experience in Arizona and in our Florida SMI Specialty Plan, we have found that lack of housing is often a key driver of high ED and inpatient utilization. Lack of secure housing also decreases the likelihood that members can maintain their health. We plan to be actively engaged to collaborate with State and local partners, organizations, and our members, to address this issue.

***Magellan Youth Leaders Inspiring Future Empowerment (MY LIFE)*:** Our **MY LIFE** program targets transition-age youth, with particular focus on youth experiencing SUD or BH issues. Programs are built around social engagement and peer support and are integrated with community agencies, schools, social services, and family support agencies, etc.

3. Effectively self-monitoring to ensure members are able to access and receive needed services post-implementation; Managing the delivery system transition

Magellan Complete Care of Arizona, Inc. (MCCAZ) understands the complexities of successfully managing the delivery system transition and will ensure that providers, members, community partners, and key stakeholders are well-informed of the changes, through regular, easily accessible means for communication, proactive identification of problems, and rapid problem solving when the unanticipated occurs. Our transition management strategy and mechanisms required to plan, execute, monitor, and control implementation, are integrated throughout our response to ensure consistent and effective application across all key functions and activities. We bring a strong history of successful system transitions to managed care and for implementing new programs within even the most aggressive timeframes and most complex landscapes. Our existing infrastructure, implementation management, and operational readiness capability is built on decades of experience in Medicaid. We have a well-designed project management structure and process, active and early engagement of MCCAZ leadership and staff, and active senior leadership oversight and commitment. Our approach includes best practices in agile project management and lessons learned from launches in other markets. We know that our combined capabilities and experience will ensure a smooth member and program transition.

Key Features

- Community outreach and engagement to understand and address member and stakeholder issues and concerns
- Provider outreach and engagement to understand requirements for success and readiness for change
- Provider education and support to facilitate transformation
- Provider Support Specialist Team for ongoing provider support
- Early planning to ensure continuity of care and smooth transition of operations
- Senior leadership involvement and oversight, with active engagement of our executive "SWAT" Team to quickly address and mitigate issues

Implementation Strategy: Magellan Healthcare's (Magellan) successful implementation track record is a reflection of our Team's skills and determination and the corporate support provided to each project we undertake. Our approach for planning and managing program transitions reflects our experience and lessons learned managing similar changes in Florida, Arizona, New York, and many other states and programs. Our guiding principle is to minimize potential for harm to members, providers, and key stakeholders; with an overriding objective of improved experience and outcomes. Our planning and implementation management starts at the point of bid development and continues for at least six-months after go-live.

Pre-Implementation Community Outreach and Engagement: MCCAZ recognizes a program transition like the one contemplated by this RFP, may mean significant changes for members, providers, other payers, and key stakeholder groups. Recognizing the potential for disruption and resistance to these changes, we begin outreach and engagement in the communities we will be serving well before go-live. Our goal is to establish strong, lasting relationships with key organizations, stakeholder and advocacy groups, local agencies, local offices of state agencies, and potential members with whom we will be working. We develop detailed communication plans, plan one-on-one meetings, host member forums and listening sessions, facilitate small group meetings to listen to issues and concerns, and develop approaches to mitigate issues. Prior to go-live, we establish locally-based Teams as part of the formation of our **Integrated Health Neighborhood℠ (IHN)**; which becomes the foundation for ongoing community engagement, outreach and support after implementation; includes member and provider support staff and community outreach staff. This approach allows us to develop a more in-depth understanding of underlying community needs. The IHN Teams also provide a local connection to members, providers, and key stakeholders for rapid outreach and problem solving during and after the transition.

Provider Outreach, Engagement, and Education: We conduct early, extensive outreach to providers, including those for the Indian Health Services (IHS), tribal nations, Urban Indian Health Facilities (I/T/U), through one-on-one meetings and provider forums to understand concerns, secure support, and collaborate on solution development. We also form our Provider Advisory Council early for ongoing feedback, direction on planning, and actions needed to support successful transition. We recognize solutions must be designed collaboratively to be responsive to underlying market conditions and provider and member needs to support evolution toward a model of seamless integration across all practice areas; including claims, network, reimbursement, and incentives.

Through our **Magellan Learning Alliance** we provide extensive, ongoing training to ensure readiness, with special focus on providers who may not have already developed integrated practices or may not be familiar with integrated care concepts. This training includes education on new requirements; principles and practices for integrated care; integrated care clinical materials; reporting requirements; billing or other administrative tasks; and, answering questions for providers. Our provider portal access is established early so providers and their staff can be familiar with AHCCCS requirements. We also emphasize establishing strong connections with clinically-trained **Provider Support Specialist (PSS)** staff, who we believe were key to our successful implementation of our specialty health plan in Florida, and who will be an important source of ongoing provider support. **Table 3-1** shows our approach and key activities for successful program implementation.

Table 3-1. Summary Implementation Approach and Activities (Illustrative)

Key Phase	Key Activities
Pre-Bid Planning	▪ Contract comprehensive network and assess provider readiness to support integrated care ▪ Conduct community, member and provider outreach and listening sessions ▪ Assess infrastructure and systems readiness and verify ability to support all requirements ▪ Finalize organization structure, key positions, hiring, and staff training ▪ Complete concurrent filing process for all D-SNP applications and requirements
Readiness Planning	▪ Establish Arizona-specific Implementation Command Center and functional Teams ▪ Establish executive SWAT Team and senior leadership oversight ▪ Establish key member, provider, and stakeholder advocacy/advisory committees ▪ Conduct provider and stakeholder training and transformation support activities ▪ Conduct community, member and provider outreach and listening sessions ▪ Finalize all contracting, governance, staffing and training ▪ Finalize AHCCCS-specific clinical programs and processes ▪ Finalize AHCCCS-specific operational programs and processes ▪ Finalize AHCCCS-specific coordination and activities with other agencies, payers and providers ▪ Prepare and/or verify all required readiness documentation ▪ Complete integrated testing of all systems, processes and key activities and address/correct issues ▪ Verify coordination and key activities with other agencies, payers, and providers ▪ Complete mock readiness review
Readiness Review	▪ Complete readiness review ▪ Address/correct gaps or issues and finalize preparations ▪ Complete mock go-live testing of key operations, activities, transactions, and processes ▪ Verify coordination and key activities with other agencies, payers and providers ▪ Address/correct remaining operational issues ▪ Establish final implementation monitoring, oversight and reporting ▪ Complete SWAT Team verification of go-live for all key areas
Go-Live	▪ Begin accepting enrollment
Post-Implementation Monitoring	▪ Conduct daily, weekly, monthly operations and performance reviews (months 0-6) ▪ Conduct monthly advisory committee meetings and identify required corrections/improvements (months 0-6) ▪ Conduct monthly coordinating reviews with other agencies, payers and providers, identify and address issues ▪ Review performance reporting and identify required corrections/improvements ▪ Design required interventions to address issues and concerns ▪ Implement required interventions and test to assess effectiveness

Implementation Planning and Oversight: Planning and organizational readiness preparation starts as soon as we began developing our response to the RFP. Functional reviews are already underway, with project plans for each area. Through

our established project management organization (PMO) we establish a **Command Center** and **Local Implementation Team**. Key activities in all areas are overseen by our executive-level **SWAT Team** that has the ability to quickly evaluate and resolve issues as they arise. We apply our well-tested process including rigorous and detailed readiness review; with testing of all operations, infrastructure, systems and interfaces, and notification and coordination requirements prior to go-live. Our PMO establishes implementation Teams for all key areas and transition phases, from readiness to post-go-live support. We conduct daily operational calls for each key area and with the **Command Center** to ensure seamless transition preparation, implementation, and ongoing monitoring.

Continuity of Care: Even under the most stable conditions, many individuals find the healthcare system confusing and difficult to navigate. These issues are often magnified by social determinants of health and environmental factors or significant PH or BH conditions, or combinations of conditions. For individuals with significant BH conditions, these challenges are often that much more complicated. Our approach to this transition recognizes and plans for these vulnerabilities. Our on-the-ground Arizona Clinical Team and executive-level clinical leadership monitor continuity of care on a daily, weekly, and monthly basis with the goal of identifying issues before they occur and with rapid mitigation. We clearly define programs and operational solutions to ensure continuity of care, including medication therapies and ongoing treatments, and continuation of existing provider relationships for members undergoing active treatment. We establish common standards and guidelines for grandfathering and single case agreements; criteria for utilization management (UM) staff to expedite priority cases; closely monitor authorizations and claims disputes to prevent unnecessarily burdening members/providers; and, support expedited loading of non-par providers.

Ongoing Communication: We continue to conduct outreach and listening sessions during the transition period to solicit member and stakeholder input. We also form our Member Advocacy Council as quickly as possible after we begin receiving enrollment, and continuously monitor member, provider, and stakeholder complaints. This allows us to quickly capture issues as they arise and respond rapidly. We make information for members broadly available through multiple sources; ensuring newsletters, printed communication, website and automated phone systems have clear, easily accessible and regularly updated information about the transition for members, providers, and key stakeholder groups.

Proactive Member Needs Assessment: Our approach to managing member transitions during this period is not purely dependent on inbound communication from members. Immediately upon receiving enrollment and historical claims files, we match that data with data in the State's Health Current HIE through secure file transfer. That data, along with any other clinical data passed by the State, and eligibility and beneficiary classification data, will run against MCCAZ's proprietary risk stratification and predictive modeling tools to risk stratify all members and assign them to our care management categories. This includes all high priority and vulnerable members identified by AHCCCS. We also use this information to assign the member to a PCP based on existing relationships and treatment patterns. Our systems prioritize for outreach and engagement based on risk category and immediacy of need. This information, along with any information obtained through inbound calls from members, completion of risk assessments, or receipt of member transition plan information from another payer or provider, is used by care management staff for outreach and engagement with care coordination. We also maintain a dedicated Team that follows similar procedures to manage member pharmacy transitions with detailed procedures to prevent lapses in medication therapies.

Active Outreach and Engagement Based on Member Need: Care management and outreach staff begin outreach for priority and high-risk populations for engagement to ensure continuity of care, establish Individualized Service Plans (ISP), and verify providers, current medications or other therapies. For dual members, we communicate with providers to help them understand benefits, who pays for what, and requirements for serving members. We specifically outreach to members who cross programs, are in targeted special populations or in DCS or correction system programs to ensure inter-agency coordination of services and treatment. For members receiving active treatment from a provider who is not in our contracted network, we reach out to add the provider to our network or secure single case agreements, as required under AHCCCS and NCQA guidelines. The member will also be given the option of switching providers, if appropriate. If the provider is unwilling to enter into an agreement with MCCAZ, they will be "grandfathered in" based on State requirements, member treatment needs, and NCQA continuity of care standards. For hard-to-reach, high-priority members (including AHCCCS priority categories), we will attempt to engage the member in-person through the IHN.

Member Onboarding: Our goal is to make the transition process as uncomplicated and supportive as possible for members and their families. We use multiple communication methods at member enrollment; including printed materials, welcome calls, posting information on our website, and on social media, all members receive:

- **Welcome Packet:** We include a link to the Member Handbook and information to request a printed version. Materials are culturally, developmentally, literacy-level appropriate, and disability accessible. Welcome Packets also include our expanded NCQA-compliant health risk screen and instructions for completing it.
- **Welcome Call to All Reachable Members:** Our Member Services call center staff help members choose a different PCP if they are not happy with the one assigned during our automated matching; make appointments; complete health screening telephonically; and, answer any questions or address any concerns.
- **Additional Outreach Calls:** If a new member has not completed their health screening within 30 days, we conduct additional outreach calls within 90 days of enrollment, or sooner for members with increased risks and in specified eligibility categories, and attempt face-to-face engagement for priority and high-risk members.

Surge Capacity: Immediately prior to, and for a period following initial start-up, we staff our call centers and 24/7 Care Line with surge capacity to ensure reasonable wait times for members and providers. Our multilingual call center staff is well-trained in the unique features and requirements of a fully-integrated health plan, as well as the typical challenges and questions members may have. They are able to make warm-handoffs to care management or other staff, as needed to connect members with an appropriate, supportive resource; including escalation of issues if the member's need is urgent. During this transition period, we also provide extra staffing within our care management department to answer questions, gather ISP, provider and other information, and support members in arranging appointments. This includes super-users to support staff day-to-day and identify enhancements that could improve efficiency and integration of UM and CM through rounds to improve services. We work with providers and community resources to try to fast-track appointments for members with urgent or near-term needs. If needed, we also place Care Managers in high-volume facilities where we anticipate a significant number of members.

Oversight and monitoring of member transitions, access and outcomes

We set performance milestones for each operating area; continuously monitor outcomes during the transition process, tracking activities and results on a daily basis; and, maintain a key performance indicators (KPI) dashboard for monitoring and reporting outcomes, issues and trends. Our goal is to maintain a "no-wrong-door" process for capturing and compiling information on our performance and feedback from members, providers and key stakeholders. We maintain an ongoing issues log to capture and manage risks, engage in detailed reviews at 1-week, 1-month, 3-month, and 6-month intervals to assess results and make required changes or enhancements as needed. Our executive-level **SWAT Team** reviews implementation performance and results daily through the first month, weekly during months two and three, and monthly during months four through six. They are also available to address and mitigate critical issues which have been elevated by the **Command Center**, within 24 hours of notification. Immediately prior to, and for a period after the transition, we maintain a dedicated Transition Team to meet daily, in-person or by video conference staff located throughout the State, including the following:

- IHN staff who provide results and outcomes from members and providers on a day-to-day basis, including complaints, issues with accessing services, provider support issues, etc.
- Administrative operations staff who monitor operational metrics, including call center volume, call times, key issues identified through contact with members, providers, or key stakeholders, electronic files such a member eligibility, medical and pharmacy claims, PA TAT, billing issues, or other administrative concerns
- Clinical program staff monitor, report, and track key clinical results; including outreach and engagement for health screening, for targeted member categories, high-risk members, inter-agency coordination for members that cross programs, issues with member access to care, and members requiring additional transition support
- Provider contracting and support staff to monitor provider or network issues, secure new contracts or agreements and educate providers on ongoing requirements
- RBHA Transition Team responsible for coordination with the RBHA and RBHA staff and providers, and addressing need for coordination, or member, provider, or other issues that arise
- Community outreach and engagement staff to identify and address key issues with stakeholder groups

- Analytics and reporting staff to monitor member experience, complaints/grievances and appeals, outcomes and needs and identify new requirements or modifications that may be required.

Monitoring of outcomes and performance for new delivery system

Our programs and approach for monitoring outcomes and performance follows models we have employed in Florida and New York. We have key metrics and performance indicators to monitor outcomes and performance during the transition process and quickly transition to ongoing monitoring and management; allowing us to quickly assess program performance and modify programs or interventions as needed. For the first one to three months after receiving our first members, our focus is on continually monitoring operating efficiency and compliance, and clinical indicators measuring access and continuity of care. Senior local and national clinical and operational leadership are actively involved in monitoring performance and developing solutions to mitigate results not at target throughout all implementation phases. Initial monitoring allows us to establish baseline measures of performance at the three-month mark. We then establish performance improvement targets for each of those benchmarks, with targets for three-month, six-month, and one-year marks. These performance improvement goals are integrated into our Quality Monitoring/Quality Improvement (QM/QI) Plan for continuous monitoring and improvement through our quality committee structure. Finally, we ensure members have adequate access to services by doing provider surveys and secret shopper calls to monitor how quickly members can get an appointment for different types of care. **Table 3-2** shows KPI.

Table 3-2. Key Performance Indicators

Area	Key Indicator
Operational Monitoring	▪ Call volumes and wait times, including type and key groupings ▪ BH crisis intervention call rates ▪ Member and provider complaints by type, volume, location ▪ PCP-assigned members ▪ Members in priority populations assigned to and in active care management ▪ Members assigned for cross-agency/cross-payer coordination ▪ UM and claims processing times, including by key groupings ▪ Claims denial and pended rates, including by key groupings ▪ Single-case and “grandfather” agreements ▪ Primary care and specialty encounters/1000, including key groupings and member categories ▪ ED encounters/1000, including key groupings and member categories ▪ ED holds, including groupings and member categories ▪ IP admissions/1000, including key groupings and member categories ▪ IP length-of-stay (ALOS), including key groupings and member categories
Clinical Performance	▪ Adults access to ambulatory/preventive health services (HEDIS AAP) ▪ Children and adolescents access to primary care practitioners (HEDIS CAP) ▪ Well child visits in the first 15 months of life (HEDIS W15) ▪ Well child visits in the third, fourth, fifth and sixth years of life (HEDIS W34) ▪ Adolescent well care visits (HEDIS AWC) ▪ EI screening, referral and timeliness rates ▪ Timeliness of prenatal and postpartum visits (HEDIS PPC) ▪ Diabetes monitoring for people with cardiovascular disease and schizophrenia (SMD) ▪ Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC) ▪ Use of multiple concurrent antipsychotics in children and adolescents (HEDIS APC)

MCCAZ is prepared to successfully manage the delivery system transition and will ensure that providers, members, community partners, and key stakeholders are well-informed of the changes. Our transition management strategy and mechanisms required to plan, execute, monitor, and control implementation, are integrated throughout our response to ensure consistent and effective application across all key functions and activities.

4. Integrating the delivery of behavioral and physical health care under a single entity. Successfully administering integrated benefits to improve individual health outcomes and enhance care coordination and member outcomes; and our role in care management and coordination.

Magellan Complete Care of Arizona, Inc., (MCCAZ) has unmatched experience and expertise coordinating and administering integrated benefits to improve Medicaid outcomes. Through our first-of-its-kind integrated Medicaid health plan for individuals with serious mental illness (SMI), we are coordinating physical health (PH) and behavioral health (BH) services for more than 70,000 adult and child members in Florida. This model, which was built on many of the Maricopa RBHA concepts designed in conjunction with AHCCCS and our provider partners, has already demonstrated its value. In the three years since we started accepting members, we have achieved a 15 percent decrease in total PMPM costs, and improvements in quality outcomes well beyond those of our competitors. We have used that expertise to design an Arizona-specific system of care that actively engages the community and our provider partners, including Integrated Health Home (IHH), Patient Center Medical Home (PCMH), and Centers of Excellence (COE) providers and programs. This system of care supports transformation, delivering person- and family-centered, community-focused, evidence-based solutions for both PH and BH care. Key elements of our model include the following:

Integrated System of Care

- IHN meets the member where he or she lives, to deliver person-centered, local, culturally-responsive solutions
- Fully-integrated biopsychosocial care management and care coordination bridges the services continuum; incorporates NCQA and AHCCCS standards and the SAMHSA Four Quadrant Clinical Integration Model
- GSA-based care teams are accessible and flexible to meet local differences
- Interventions are proactive, targeted, and based on known member needs, including the use of technology and social media
- Providers and family are important team members to support member needs
- Systems and continuous quality monitoring are integrated to drive outcome improvement

Integrated Health Neighborhood℠ (IHN): The IHN is the foundation of our system of care, reflecting our commitment to our members' ability to live vibrant, healthy lives and to sustain PH and BH recovery and resiliency. It reflects our understanding that achieving those goals is often intrinsically tied to environmental and social factors beyond traditional health and wellness; including social determinants (SDoH). More than 40 years of experience providing integrated PH and BH services has shown us that sustained improvement in member health is best achieved within the context of where members live and the services and supports available in their community. **Our IHN is designed to be person, family, and community-centered to support Arizona's regional GSA needs.** It is built around relationships with local community partners enabling effective coordination and customized solutions with community supports and services that members know and trust. IHN Teams bridge language and cultural barriers to facilitate access to services to support AHCCCS members and families where they live, learn, work, and play. The IHN builds on existing, statewide infrastructure, working across health and social services systems in Arizona to support and enhance relationships among members, their families, caregivers/guardians, providers, and community partners. Our system of care management and care coordination aligns with AHCCCS goals and guiding principles, with active management of member services and coordination of total health.

Best Practice Integrated System of Care: Our care management and care coordination approach includes system-level integration of PH and BH services; disease- and condition-specific programs; and population health for primary care, prevention, and wellness. Ours is a true biopsychosocial system combining a disciplined, data-driven approach to CC/CM with innovative strategies to combat SDoH. We support the needs of all AHCCCS members, including addressing its most vulnerable target populations in a proactive and holistic fashion. Our programs are based on best practices and are consistent with accreditation standards of the National Committee for Quality Assurance (NCQA): and, are in compliance with AHCCCS scope of work requirements. They include fully-integrated systems, policies, procedures, and tools, supporting members to ensure provision of primary PH and BH services, coordinated care, and access to specialty care services and providers. Integrated care management starts from member enrollment; including locally-defined, integrated engagement and delivery through our IHN. Targeted interventions/supports are based on member bio-

psycho-social risk, complexity and needs, enhanced member risk assessment, segmentation and stratification, fully-integrated PH-BH clinical protocols, integrated care management Teams, and, programs specifically designed for high-risk populations and members with special needs. MCCAZ CM staff are certified, trained, and experienced in both PH and BH disciplines. Our system of care focuses on improving total member health while developing family- and peer/recovery-centered care management approaches, engaging members/caregivers in their healthcare, and partnering with providers. Our IHN, which is designed to work across settings, also brings together community resources and nontraditional services to support diverse needs.

Integrated Care Management: Our integrated care model stratifies members using a multi-step process to provide members with services and supports tailored to their individual risk, complexity, and needs. Our model recognizes that a member's PH, BH, or SDoH needs change as they progress through life stages. At the same time, their requirements for social connectedness and education to support optimal health and wellness may vary over time. All members have access to the care management supports and services they need; including transitions of care, utilization management (UM), or linkages to non-health plan supports and services. Our programs are robust and comprehensive incorporating: population wellness and prevention; disease management (DM) for stable chronic illness, care management for unstable PH or BH conditions; care coordination for multi-morbid PH and/or BH conditions; advanced illness; and end-of-life/palliative care. Our comprehensive care transitions program incorporates nationally recognized best practice approaches and measures; based on key components of the National Transitions of Care Coalition, Eric Coleman's Care Transitions Program, and the Camden Coalition's work with super-utilizers to reduce preventable hospital readmissions. Care coordination/care management Team members have certification, training, and experience in PH and BH disciplines, care management, and UM. In addition to standard clinical guidelines such as MCG, we employ Magellan integrated care coordination/care management guidelines that consider PH and BH conditions, the unique interplay between each and, integrated management of both. We have programs specifically targeting special needs and priority populations; including members who are dually eligible for Medicare and Medicaid.

Figure 4-1. Integrated Care Model

Dedicated GSA-based IHN Teams: MCCAZ leverages the IHN to provide regionally-based GSA care Teams, ensuring members are advised of the Team's role for contact and support, working telephonically and in-person within the GSA. The Interdisciplinary Care Team (ICT) includes the member or caregiver; Care Coordination/Care Manager (CC/CM) and/or MCCAZ Medical Director (depending on risk level); primary treating providers (including PCP and/or BH provider (if applicable); and, community and a recovery/social support resource. Team composition and intensity of services provided to the individual member flexes based on member need and reflects the expertise of a broader GSA-specific Team. CC/CMs are community-based and have the person-centered background, experience, and resources to assist members in navigating the local landscape. MCCAZ employs experienced CC/CMs with demonstrated commitment to establishing trusting relationships while serving vulnerable AHCCCS communities and subpopulations.

Segmentation and Stratification*:* MCCAZ assigns members to care coordination/care management programs based on member condition, situation, risk, and complexity with CC/CM engagement based on member need. **Table 4-1** depicts our proposed MCCAZ care management risk level segments.

Table 4-1. Risk Level Segments

MCCAZ Care Management Program – Risk Level Segments			
Ultra High Risk (UHR)	**High Risk (HR)**	**Moderate Risk**	**Low Risk**
Population Includes: ▪ Complex Risk Level (scoring at a UHR level) requiring intensive, high touch, community-based interventions ▪ Members engaged with an IHH, PCMH, or COE Program ▪ Member assigned to a primary MCCAZ CM & engaged with the MCCAZ GSA based IHN & ICT staff	Population Includes: ▪ *Unstable* DM or Chronic Condition Management Needs (PH & BH Needs) ▪ Members typically engaged with an IHH or COE program ▪ Member assigned to a primary MCCAZ CM & other IHN/ICT Team members/engagement activities	Population Includes: ▪ *Stable* DM or Chronic Condition Management Needs (primarily PH conditions) ▪ Members typically engaged in a PCMH program ▪ Members requiring short-term care management ▪ Members assigned to a MCCAZ Wellness Specialist	Population Includes: ▪ Healthy Population with Focus on Wellness/ Prevention ▪ Members with stable Health & Wellness status

Coordinating the Services Continuum: CC/CMs contact providers, set up timely appointments, facilitate transportation, and, ensure PCPs receive documentation from referring providers. If members have problems obtaining timely appointments, CC/CMs contact other providers in the network. CC/CMs prevent duplication of services and unnecessary/avoidable benefit utilization through careful review, coordination of care, and collaboration with other health plans, community agencies, and providers. Through our previous experience partnering with AHCCCS, we have demonstrated expertise in coordinating care for members receiving community-based services by Community Mental Health Centers (CMHC) and addiction and recovery service providers. We also have experience working with early intervention programs including high-risk prenatal and infant programs. Our IHN stresses the importance of strong connections with community-based health care and social systems; including for example, housing services, family supports, other public programs, safety net providers, local health departments, RBHAs, FQHCs, and RHCs to address the full spectrum of member needs.

Our CC/CMs anticipate member needs and communicate with providers and other health plans to recommend and authorize necessary services. For example, for the dual eligible membership, our CC/CMs are aware of the high incidence of home safety concerns and are able to recommend/authorize/coordinate a home physical and occupational therapy evaluation; including a comprehensive home environmental assessment and recommendations. We work in a highly localized manner to develop creative solutions for member services, support, or resources that are not otherwise a covered benefit. Our Teams include the member, Community Health Workers (CHW) Recovery Support Navigators (RSN), and Family Support Specialists, who have expertise and experience to engage community-based organizations, advocacy groups, faith-based organizations, and other community resources. We solicit member feedback and incorporate member ideas and suggestions regarding local community resources and maintain a comprehensive listing of referral resources and community-based services.

MCCAZ member communication and education materials incorporate input from focus groups and our Member Advocacy Council (MAC). We embed member and family voice at all levels of our operations and in our communications, and we review all member materials to consider member satisfaction feedback; member physical and cognitive abilities, level of literacy and linguistic proficiency, and, culturally responsiveness. Members with limited English proficiency are offered interpreter services and we accommodate other communication needs to ensure services, supports, resources, and, if applicable, Individualized Service Plan (ISP) are understood. Members and providers have 24/7 access to care coordination/care management staff. MCCAZ also offers 24/7 member Care Line services; including member health information and BH crisis assistance and services. MCCAZ employs ASAM trained addiction specialists who provide members with access to addiction and recovery treatment services 24/7.

Proactive Member Needs Assessment: We use enhanced risk-stratification algorithms to identify vulnerable populations, high-risk, and emerging-risk members early to expedite our member outreach and engagement activities. We analyze enrollment data for eligibility and assigned benefits, along with PH, BH, and pharmacy claims data to create a list of potential diagnoses, prescribed medications, and to calculate predictive risk scores. Our analytic software and

stratification incorporates information on non-medical member characteristics and SDoH to categorize members into "personas" tied to key drivers of health and utilization, and responsiveness to care coordination/care management interventions. We use this to predict future outcomes and behavior, stratify members for enrollment into necessary programs, and provide personalized, motivational messaging for self-management, prevention, and wellness. Our model of care and supporting systems ensure coordination of care, follow members through episodes of care, and streamline transitions to ensure positive health outcomes. The MCCAZ clinical documentation system houses fully accessible and viewable member information from the point of enrollment and through the member's tenure with our health plan. Our initial analytically-driven screening and stratification is supplemented by our proprietary health risk screening and assessment tool (HRA) which comprehensively identifies PH, BH, substance use, safety, social risks, and needs. Our HRA meets NCQA Health Plan Accreditation and AHCCCS Program requirements for content and timing of engagement and completion. All notification attempts and results are uploaded into our care management system. We attempt to complete initial screenings for all members, either by the member, or telephonically by an outreach worker. Screening tools are available via the member portal and in hard copy, and members are eligible for an incentive payment for timely completion. We use a variety of methods to encourage member participation in screening and care management. If not completed within 30 days, we make calls within 90 calendar days of enrollment or 60 calendar days for target populations. Our CHWs, or RSN may also attempt to engage members. Unreachable members are sent a letter requesting a return call to schedule screening. Members who are located but decline to be screened, assessed, and/or engaged in care coordination/care management, are flagged for ongoing monitoring and periodic follow up. For members with limited English proficiency, CMs have access to a real-time Language Line for interpreter services. We also recruit, employ, and train community-based, culturally competent CMs who are versed in the second-most common languages spoken in the GSA. Screening information is used to further define member needs for assignment to sub-populations, care level and, to identify gaps in care.

Intensity of care coordination/care management activities varies based on member needs; ranging from members receiving email/mail/messaging, reminders and health coaching, to intensive community-based, face-to-face visits between the CC/CM and the member. The assigned CC/CM has access to and utilizes the initial comprehensive assessment in addition to a variety of condition specific branching assessments and tools all housed within the care management system. This proactive, targeted approach allows us to identify immediate PH and/or BH needs requiring expedited follow up. Based on member need or corresponding triggers identified during screening, a warm transfer and/or referral to care coordination/care management may be made for more comprehensive assessment. MCCAZ's clinical documentation system informs each MCCAZ staff member on current member information; including alerts and triggers which may be placed in the system. Each member encounter/activity is documented within the system. In the case of an escalated need, the member is immediately assigned a CC/CM. For highest complexity members, an Integrated CC/CM (ICCM) is assigned. This approach reflects our extensive experience in identifying PH, BH, and psycho-social needs of members, as well as SDoH. The CC/CM is responsible for assessing, reviewing, analyzing, and prioritizing member needs in collaboration with the member, authorized representative, family members, caregivers and guardians, to develop an ISP. We use intelligent assignment to match members with CC/CMs. Members with a primary BH condition and/or SUD are assigned to Teams specializing in those conditions, and a Registered Nurse (RN) or Licensed Clinical Social Work (LCSW) professional with BH expertise.

Care Planning, Monitoring, and Care Conferencing: CC/CMs assist the member/caregiver in developing an ISP that includes prioritized goals, using a person-centered approach to develop meaningful and appropriate strategies to maximize member independence, control, and autonomy. Throughout the process, we ensure members and caregivers are actively involved and the plan reflects member's goals as stated by them, preferences, values, strengths, challenges, family situation, social circumstances, and lifestyle. Care plans are updated as often as required when trigger events/significant changes occur in the member's condition, or at least annually. Findings are discussed in individual supervision meetings. The CC/CM Team monitor member plan success and attainment of defined goals, and identify barriers or issues that may impact member progress. The CC/CM communicates with the member and providers and ensures that communication between members and providers is occurring as needed. CC/CMs select "task dates" to re-evaluate goals from a drop-down menu in our fully-integrated, automated system. Standard interventions are pre-populated in the system, but can be customized to meet unique needs of the member.

Care conference/case review Team members, including PH and BH physicians, care coordinators, clinical pharmacist, and UM professionals, offer input both formally and ad hoc to assist the member and primary CC/CM.

Proactive Provider Engagement: MCCAZ includes the member's primary care provider (PCP) and BH provider in all aspects of our wellness and prevention programs; including the member at the center of those solutions. MCCAZ encourages members to choose their PCP and our staff assist members with this process. For members who do not choose a PCP, they are assigned to a PCP based on prior utilization, underlying diagnosis(es), geographic proximity, and other matching criteria. Members can change PCPs at any time by contacting MCCAZ. Our goal is to align members with a PCP appropriate for his or her health needs and conditions. We use proactive strategies to encourage use of integrated care settings for members with combined PH and BH comorbidities. For members without chronic or acute illness (PH or BH), we focus on PCPs with enhanced access and high quality scores. For members with well-managed chronic illness and no complex comorbidities (including non-complex BH diagnoses), we try to link the member to a PCMH or IHH, which can assist in management of the member's illness. For members in tribal communities this may be an American Indian Medical Home. Members with chronic illness, including complex BH comorbidities, are linked to an IHH with capabilities for integrated management of the member's PH and BH conditions. Members with complex, multi-morbid conditions are linked to either PCMH or IHH, depending on their conditions, or they may be linked to a COE specializing in that illness. We actively engage providers in care planning with our care Teams as well as invite their participation for committees and discussion to develop clinical programs and targeted interventions. They receive ongoing education on integrated PH-BH care, and are supported by our **Provider Support Specialists (PSS)** to assist in assessing readiness and transforming their practices to deliver integrated PH-BH care if they desire. Providers at each level may participate in value-based purchasing (VBP) incentive programs for outcomes improvements. PCPs are incentivized and reimbursed for BH screening and referrals. BH providers are incentivized to complete PH screenings if their practice and licensing support it. MCCAZ fully supports innovative CM approaches (especially in rural areas) including on-site CC/CM support at high volume practices, clinics, and EDs, and leveraging practice/clinic-based staff to assist with CC/CM activities.

Ensuring Access to Clinically Qualified Providers: MCCAZ has established referral policies which promote CC, integration, and access to high-quality, timely healthcare services; including all covered medical conditions as of effective date of coverage under the program, regardless of the date on which the condition arose. We provide access to a full spectrum of adult and pediatric PH and BH providers, OB/GYN, midwives, specialty and sub-specialty providers for timely access to qualified providers, and referrals to specialty care for the full range of benefits available within the AHCCCS Complete Care Program. If needed, the Provider Relations Team may include provisions in provider agreements for incentives or increased fees to accept members and ensure timely access to services. CC/CMs follow up on high risk referrals to assure services were provided as planned and as appropriate. In support of the Triple Aim *(Berwick DM, Nolan TW, Whittington J. Health Aff (Millwood). 2008 May-Jun;27(3):759-69. doi: 10.1377/hlthaff.27.3.759.),* MCCAZ 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. We fully understand the important role providers play in achieving the member's, MCCAZ's and AHCCCS' program goals. The fact that MCCAZ is not a provider-based health plan allows us to maintain a broad network and direct members to the site of care and services that best meets their needs. In remote, rural GSAs of the State, we flex the model to place greater emphasis on the use of CHWs/promotoras or Indian Health Services (IHS) Community Health Representatives for outreach to members, midwives, telemedicine for delivery of care, tele monitoring for complex conditions, and community paramedicine, sheriff and police staff to assist members in crisis and prevent inpatient admissions. In more urban areas like Phoenix and Tucson, our model allows us to make greater use of BH Crisis Centers, IHHs, and Centers of Excellence for delivery of care, and Post-Crisis Navigators to reduce ED holds and support timely access to follow-up care.

All federal, State, AHCCCS, and NCQA UM standards will be followed to ensure appropriate authorizations are secured for services. We consider benefits configuration, administration, and education a fundamental capability and take a proactive approach to ensuring member privacy. A MCCAZ dedicated Health Analytics Team will continuously monitor and analyze program interventions and outcomes; and make refinements as needed to support outcome goals. We monitor PH and BH HEDIS metrics, EPSDT, birth outcomes, preventable events, and AHCCCS-specific integrated program metrics as part of our programs; with regular reporting of gaps-in-care both internally and to providers, with emphasis

on members with special health care needs. We conduct regular outreach to providers and members to close gaps or identify and close barriers to receiving required care. Integrated continuous quality improvement (CQI) programs are in place throughout all programs and functions and analytics, program and intervention assessment and redesign programs are based on the well-established Plan-Do-Study-Act (PDSA) framework for program development and refinement, and incorporate statistically valid health outcomes research principles. Moving forward, MCCAZ is committed to developing transformational provider reimbursement models to serve vulnerable populations; we agree with AHCCCS that working closely with community-based social resources and employing data exchange and analytics are critical to this effort.

Administering integrated contracts, improved quality outcomes, and new strategies for members.

Magellan of Arizona (Magellan of AZ) served as the Central GSA RBHA for almost seven years, beginning in 2007. We partnered with State agencies and stakeholders to develop an IHH for approximately 20K individuals with SMI. We helped providers prepare for the evolutionary change in payment models; enabling several to obtain FQHC designation and offer a broader suite of integrated services. In a joint venture with a local Medicaid health plan, we co-located services physically with the plan; delivering truly integrated care for more than 1,800 individuals with both PH and BH diagnoses. Through our efforts, we secured 710,000 nights of shelter for people experiencing homelessness, helped more than 1,600 homeowners avoid foreclosure, and connected almost 3,000 people to permanent supportive housing programs and services. In addition, we reduced the number of children in residential care from 149 to 41 in just four years, and partnered with service providers to reduce substance use by young people in the juvenile justice system; earning a prestigious Science and Service Award from SAMHSA in 2011.

Magellan Complete Care of Florida (MCC of FL) is our fully-integrated Medicaid MCO for individuals with SMI. This first-of-its-kind plan manages health (including vision, dental, and transportation) for approximately 70K members including children and adults in eight of the State's eleven regions, and was developed in partnership with the State. MCC of FL worked with the state Medicaid agency to help transform the delivery system from the existing carve-out BH model to a new, fully-integrated PH/BH model. During the three years since MCC of FL started accepting members, it has reduced hospital admissions by 18 percent, total PMPM costs by 15 percent, PMPM ED costs by 27 percent, and PMPM Rx costs by 7 percent. Clinical outcomes have also improved in multiple areas, including primary care engagement at nearly twice the rate for members with SMI nationally and improvements in 90 percent of agency quality scores, a level of improvement considerably greater than that for our three competitors.

Senior Whole Health of New York (SWH) is a Medicaid Managed Long-Term Care which covers Managed Long Term Care Services (MLTSS) for individuals 21 years of age and up. It is a fully-integrated Dual Eligible Special Needs Plan (DSNP) responsible for all benefits including medical, MLTSS, BH, long-term care, dental, vision, and transportation. The plan manages approximately 13K members across seven counties in New York; with consistent growth in the plan. The plan has improved quality scores each year since inception and is projected to earn a quality bonus in 2017 for 2016 results. SWH has achieved the highest quality-tier ranking for the state. The company also achieves utilization metrics that exceed dual eligible metrics across all measures.

Engaging members and improving outcomes through the use of technology and social media

MCCAZ will make extensive use of member data available through the State's HIE for early identification of member diagnoses and ongoing treatment at the point of member enrollment. Early capture of that information, combined with active multi-channel outreach, allows us to quickly identify and monitor member risks and provide appropriate care management support and access to required providers and services. Access to the HIE also allows us to target programs such as use of hospitalists, active engagement with facilities for discharge planning, and to identify members who have received care in the ED and may require outreach from the MCCAZ IHN Team. As we identify groups of members in particular geographies, among particular communities, or with specific conditions, we develop new programs directed at assisting those members in achieving targeted results incorporating the use of technology and social media.

MCCAZ has well-designed, comprehensive programs for population health and wellness, closing gaps in care, incorporating member engagement activities through a multi-channeled approach. MCCAZ utilizes technology and social media whenever possible and appropriate; along with utilizing non-technology approaches based on individual member need and preference. We incorporate and comply with NCQA population health management standards and guidelines.

Our goal is to keep members as healthy as possible, minimizing the chances of developing chronic or acute illness, including BH conditions. Our IHN actively engages members through regular member outreach, coordination with community resources, peer support, and other features. We also actively monitor members who are coming up for Medicaid redetermination, and work through AHCCCS programs and supports to minimize member loss of coverage and lapses in treatment; which can destabilize or degrade member health adding to poor outcomes and higher costs. All members have access to our online wellness library with information on prevention, managing their illnesses, and accessing services. We make use of telemedicine services; including remote care delivery, tele-consults, store and forward, and remote monitoring (including virtual Centers of Excellence). Magellan's own BH telemedicine solution expands existing capacity, and our technology-agnostic telemedicine program supports providers who are interested in delivering telemedicine solutions; requiring only that they meet Magellan standards for online privacy, security, and clinically-derived standards of care. **Table 4-2** below describes the current scope of our rapidly-expanding technology tools.

Table 4-2. Member Technology Tools

Tool	Solution Description
Magellan Virtual Care Solution (VCS)	▪ **Digital Cognitive Based Therapy (dCBT)**; providing online and app-based cognitive therapy for depression, anxiety disorders, substance abuse, chronic pain, and insomnia: ▪ **SmartScreener™**, providing self-guided screening for common BH conditions, substance abuse, and insomnia ❖ SmartScreener app programs have shown to be just as effective as traditional face-to-face CBT, and the cost per patient (with the same outcome) is approximately 45% to 90% lower ▪ **Click Therapeutics**, including **Clickotine™** for smoking cessation and **ClickHeart™** for persons with heart disease ▪ PsychTrac™ for treatment and monitoring of members in jail diversion or Court-ordered Treatment ▪ MCCAZ online and mobile member portal allows member screening, access to health and wellness tools, and member messaging ▪ Mobile pharmacy access through MagellanRx.com, which provides secure sign-on and role-based access to prescription information, health resources, and user-group specific applications for members ▪ Live Chat with a clinician to address urgent issues and receive coaching
Telehealth	▪ MCCAZ works with community providers to provide access for direct delivery of care (PH and BH) as well as remote monitoring of care and member health through all provider-defined platforms that meet Magellan clinical and security standards and are HIPAA compliant
Self-Management Tools	▪ Healthwise™ interactive wellness and health management courses ▪ Text4Baby™ and Wildflower™ for pregnancy management ▪ Glucose Buddy™ diabetes tracker ▪ My Asthma Pal™ children's asthma tracker ▪ **Aunt Bertha Community Connections**, a mobile and online platform and community to support members in identifying and securing community-based services
Mobile Phones	▪ We provide members with access to SafeLink Smartphones; used to remind members of appointments and required prevention and screenings
Social Media	▪ Facebook, Twitter, Microsite, and blog are all used to communicate with members, providers, and the community

Our **Mobile Member Engagement Program** provides Smartphones, mobile applications (apps) and texting for education and communication. For example, with pregnancy apps similar to Wildflower, we are able to send appointment reminders and tailor our health messages and education. The app helps members track symptoms, monitor key milestones, read health tips, and view benefits. Texting allows us to monitor symptoms easily and quickly resolve any barriers to care (e.g., transportation). We use social media (e.g., Facebook, Twitter, Snapchat, and YouTube) for education and to push messages and/or information; including HEDIS reminders, healthy tips, community events, and appointment reminders. Facebook also allows us to receive member feedback and opinions (unsolicited).

5. Managing care to achieve the best outcome for the member.

Please see **Table 5-1** below for the member demographic profile for "Kim" that sets the stage for her Individualized Service Plan (ISP).

Table 5-1. Kim's Demographic Profile

Meet Kim: 54-year-old female, resides in Phoenix		
▪ **Conditions**: schizophrenia, opioid use disorder (including IV heroin use), brittle diabetes, and chronic pain due to peripheral neuropathy ▪ **Environmental & Social Factors**: Unemployed, homeless, poor comprehension/socialization, low literacy, no regular meals/poor eating habits, inconsistent checking of blood sugar & medication compliance, poor glucose control, missed primary care, psychiatric, and specialist appointments, and estranged from her family and friends ▪ **Supports**: Emergency department (ED) utilization, community mental health center (CMHC), PCP out of network		
Key Assumptions	▪ Kim desires to be safe and obtain stable housing and food ▪ Kim desires to feel better, stay connected to her care providers ▪ Kim desires to stop using heroin ▪ Kim desires to be reconnected with her family and friends ▪ Kim is motivated to change	
Key Components of Care	▪ Assess readiness to change and facilitate member-provider relationship to improve adherence ▪ Address and treat immediate care needs while in ED ▪ Assess and treat schizophrenia ▪ Address and treat IV heroin use and withdrawal management/use Medication Assisted Therapy (MAT) ▪ Address and treat immediate care need related to pain management, peripheral neuropathy with use of non-opioid pain medications, and unstable diabetes management ▪ Address and facilitate immediate social determinants of health (SDoH) needs; including housing and food insecurity ▪ Partner with Kim to better understand, treatment plan/service plan, written materials, and connect her to community supports to promote optimal general and health literacy	
Timeline	▪ **Day 1:** Kim's effective date with MCCAZ – CM, "Susan" initiates outreach to Kim but is unable to locate/unable to reach ▪ **Day 2-14:** CM, Susan outreaches to Kim 4 times without success, places an alert in the clinical documentation system, contacts Kim's pharmacy for updated contact information ▪ **Day 12:** MCCAZ's on site ED CM, "Dolores" is notified of Kim's ED visit/3-day observation stay ▪ **Day 12-14:** Dolores conducts Kim's initial comprehensive assessment while Kim is in the ED/3-day observation stay ▪ **Day 14-15:** Dolores, Susan, and a Recovery Support Navigator work with Kim and the ED CM Team to prepare/assist Kim with discharge planning	▪ **Day 15-30:** Kim is discharged from the ED/3-day observation stay and is followed by the intensive Comprehensive Community Health Program; Kim agrees to placement at Transition Point, a short-term step down program ▪ **Day 30-90:** Interdisciplinary Care Team (ICT) meets in person and via Zoom video conferencing at Transition Point ▪ **Day 90:** Kim is stable enough to transition to permanent housing ▪ **Months 4-6:** Kim is successfully engaged in her MAT program and outpatient PH and BH services ▪ **Month 7-12:** Kim stays opioid free for one year and stays fully engaged in her outpatient treatment / therapy; she begins to re-unite with her family

Enrollment and Engagement: Magellan Complete Care of Arizona (MCCAZ) learns of Kim as she is auto-assigned by AHCCCS to MCCAZ as of 10/1/2018 and her enrollment information is received on the AHCCCS enrollment file. MCCAZ loads the AHCCCS enrollment file into its eligibility system and the data is fed downstream to a variety of systems including MCCAZ's care management system and viewable by the Health Services Team. The selection and assignment of a Care Manager (CM) with matching expertise via MCCAZ's intelligent assignment process occurs to ensure timely engagement and assistance for members like Kim, who have complex physical health (PH), behavioral health (BH), and social needs.

For example: Members with a primary BH condition or SUD are assigned to Teams specializing in those conditions, and to a Registered Nurse (RN) or Licensed Clinical Social Work (LCSW) professional with BH expertise. A CM, "Susan", is assigned to Kim's case. Susan reaches out to Kim within the first week of her enrollment. Susan is initially unsuccessful at trying to reach Kim as the telephone number and address provided are inaccurate. Susan follows the MCCAZ Engagement and Unable to Reach Process, which includes telephonic and field-based outreach. Susan attempts face-to-face outreach four times within the first week of Kim's enrollment; including outreach to Kim's PCP of record, and most recent pharmacy visit.

In addition, due to Kim's long-term history of homelessness, MCCAZ leverages its value-based partnership with the PATH Outreach Team to attempt to locate her in areas where homeless individuals tend to frequent. All attempts at locating Kim are unsuccessful. Susan documents and places an alert within the clinical documentation system and the member services system to notify other staff if there is activity of any kind on Kim's case. With Kim's ED visit at Maricopa Medical Center (County Hospital) on October 12th, Susan was notified by the MCCAZ high volume ED CM Dolores, who is based at Maricopa Medical Center. In addition, Susan was notified of Kim's ED visit via the HIE ED notification system. MCCAZ participates in direct message exchange regarding members like Kim who are identified on MCCAZ's roster. Susan immediately begins communicating and working with Dolores, the hospital's ED staff, the hospital's utilization management (UM) staff, the pharmacy Kim uses, and Kim's PCP to explore previous contact with Kim. In addition, Susan works with all of these sources to ensure that Kim's immediate needs are addressed utilizing a very tactical approach.

Initial Comprehensive Assessment and Key Findings: Kim has been in an ED observation for three consecutive days because the inpatient beds are full. Due to Kim's immediate needs, Dolores, who is trained in PH and BH chronic condition management and member engagement strategies, visits Kim in the ED and conducts an initial comprehensive assessment of her PH, BH, psychosocial needs, functional status, and social supports; including reviewing hospital assessments and screenings. Dolores reviews Kim's ED stay and collaborates with the ED in educating them on proactive MCCAZ programs that promote avoidance of extended ED stays. For members of the MCCAZ health plan, the MCCAZ Team works hard at mitigating the risk of members like Kim unnecessarily returning to the ED.

Dolores, obtains all of the appropriate consents during her visit with Kim and proceeds with Kim's assessment; while obtaining information from Kim's providers. For Kim, the Initial Clinical Assessment is completed with immediate enrollment into MCCAZ's Ultra High Risk Care Management Program. Dolores collaborates with the ED staff and focuses on the highest risk areas. Dolores identifies that Kim's literacy level is low in general. Dolores works with Kim in a clear, supportive way to help her understand the information to maximize Kim's overall comprehension. Dolores observes that Kim's schizophrenia is symptomatically stable. Kim's detox has just begun and will require further and ongoing assessment and close monitoring once she is released from the ED. Kim is a good candidate for a Medication Assisted Therapy (MAT) program including opioid treatment combined with behavioral therapy and medications to treat her substance use disorder (SUD). Kim does not have a safe place to live and requires assistance in obtaining immediate housing, medications, education for medication use; along with getting food. Kim's peripheral neuropathy pain is under poor control and is addressed with non-opioid pain medications. Kim's blood sugar level is very high; requiring adjustment in her diabetes medications along with additional blood sugar monitoring. Kim is agreeable to all of the care and support she is receiving and understands the seriousness of her immediate situation. Please see **Table 5-2** for Kim's assessment findings.

Table 5-2. Kim's Assessment Findings

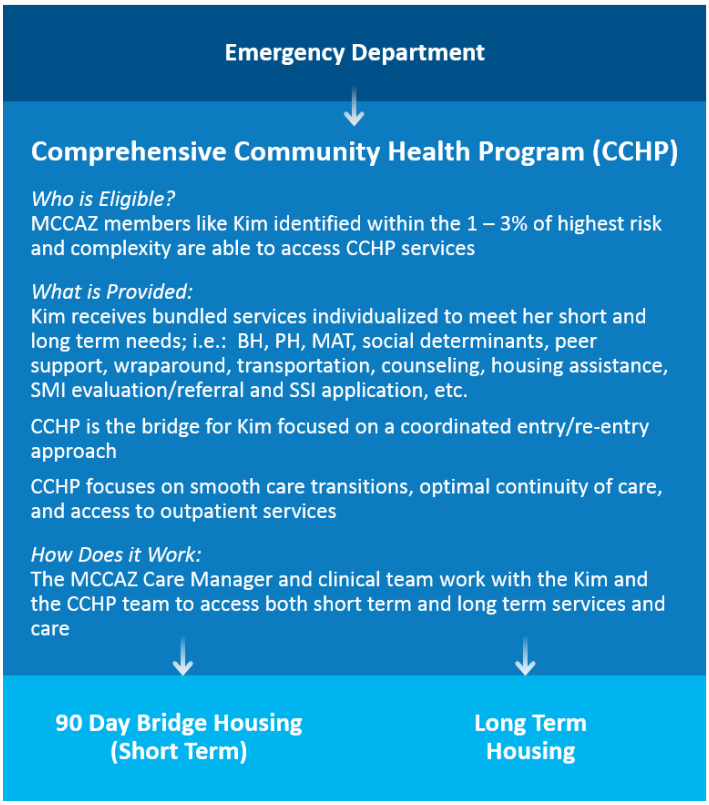
Assessment Findings		
Conditions	**Potential Risk Outcomes**	**Strengths**
Readiness to change	Difficulty coping with homelessness and estrangement from her family	▪ Kim agrees to work with the MCCAZ Team and her outpatient providers to engage in her treatment plan and IHN supports ▪ Kim agrees to receive necessary health screens and follow up including Hep C, Hep A, HIV, GYN/STD, oral care, foot care, hypertension, and nutrition monitoring

Assessment Findings		
Opioid use disorder	Increased risk for additional withdrawal and relapse	▪ Kim is willing to stop using IV heroin and opioids and to engage in her new treatment plan ▪ Kim understands that she may have additional withdrawal symptoms and may need further withdrawal treatment ▪ Kim agrees to a MAT program ▪ Kim wants to see her family once she is fully clean
Inadequate diabetes care	Increased risk for complications due to uncontrolled diabetes	▪ Kim has a PCP and is willing to see the Endocrinologist to get her diabetes under better control ▪ Kim is agreeable to get all pertinent diabetes lab work, medications and supplies once released from the ED
Uncontrolled schizophrenia and inadequate care	Risk of poor decision making and chronic homelessness	▪ Kim is agreeable to working with her outpatient BH providers to receive therapy and medications ▪ Kim is agreeable to receiving long acting injectable medications ▪ Kim is agreeable to stay in short-term housing once released from the ED
Uncontrolled pain due to peripheral neuropathy	Increased risk for further drug seeking behavior, including abuse of opioids and IV heroin use if pain control is unaddressed and uncontrolled	▪ Kim is agreeable to improving wellness self-management behaviors

Dolores assesses Kim's current and past supports within her immediate family, friends, and **Integrated Health Neighborhood℠ (IHN)**. Kim is tearful when talking about her estrangement from her family. Dolores explains to Kim that she and the MCCAZ Team will assist in getting the help Kim needs. Dolores also emphasizes that the MCCAZ Team will support Kim's full participation and self-direction in all aspects of her care and treatment. Ultimately, Kim will decide where she wants to live and where she wants to receive care.

Dolores educates Kim on MCCAZ's IHN approach and creating an individualized service plan (ISP) around the immediate care and service options in a familiar neighborhood where Kim agrees to live. Kim is considered medically and psychiatrically stable enough to be released from the ED. Therefore, the MCCAZ and hospital Teams work collaboratively with Kim to establish the safest plan within the local Phoenix community that offers several options to choose. Dolores recommends an intensive crisis transition and follow-up program for Kim within the Phoenix area, and an outpatient Integrated Health Home (IHH) provider and Comprehensive Community Health Program (CCHP); described in **Figure 5-1**, within an IHN familiar to Kim.

Figure 5-1. Comprehensive Community Health Program



MCCAZ's unique contracting with CCHP providers offer services to members like Kim (identified within the 1-3 percent of highest risk and complexity), benefitting from a full suite of bundled services, including BH, PH, MAT, social determinants, Recovery Navigator Support, Wrap Around, transportation, counseling, housing assistance, SMI

evaluation/referral, and SSI application, etc. The CCHP is a bridge of support for Kim that is focused on a coordinated entry/re-entry approach. CCHP offers assistance with smooth care transitions, optimal continuity of care, and access to needed outpatient services.

Interdisciplinary Care Team (ICT): Dolores recommends that a formal ICT is scheduled after Kim's release from the ED; Kim agrees. Dolores addressed Kim's immediate needs with Kim, the ED Team, and outpatient providers. Dolores explains to Kim that once she is released from the ED, Susan will be her primary CM to work with the MCCAZ Team within Kim's immediate community to ensure her needs are met. Kim is agreeable and appreciative of the help and support. Kim's initial ICT meeting will include Kim, Susan, Dolores, MCCAZ Recovery Support Navigator, MCCAZ Medical Director, MCCAZ Pharmacist, outpatient IHH providers, and CCHP representative. Kim understands that some Team members will attend in person and others by telephone. A Recovery Support Navigator with the CCHP Provider Team, meets Kim at the hospital to assist with discharge and re-entry into the community. It is determined that Kim would benefit from a short-term stay at a "Transition Point" step-down facility; which provides stabilizing care in a residential setting for three to five days; including bringing in a Nurse Practitioner who continues to monitor Kim's diabetes and peripheral neuropathy pain. This short-term less-restrictive/costly setting allows for initial steps in the short-term treatment plan to be put into place; while Kim is still in a stable setting. The ICT meeting occurs at the step-down facility. With assistance of the MCCAZ Clinical Team, Kim is able to successfully define her immediate goals and interventions as outlined in her ISP below in **Table 5-3**.

Table 5-3. Kim's Top Priorities with Specific Interventions

Action	Responsibility
Kim's Priority: I want a place to live.	
▪ Assist Kim with readiness to change and facilitate the member-provider relationship to improve successful completion of service plan goals; initially assist Kim more intensively upon discharge with all aspects of her care and treatment and build toward self–determination ▪ Assist upon discharge from the hospital; the CCHP Recovery Support Navigator picks Kim up from the hospital, transports Kim, and accompanies Kim as she completes the intake to enter short-term housing ▪ Facilitate move to new Phoenix Bridge Housing Program (90-day short-term bridge housing) upon discharge from the Transition Point ▪ Develop transition plan to achieve goals and reduce risk of repeat ED visits, chronic homelessness, and unsafe living situation ▪ Coordinate referral to the intensive CCHP ▪ Coordinate community supports within the IHN ▪ Complete the VI-SPADT assessment (CCHP Team) – Kim scores high (13) resulting in eligibility for expedited Housing-First housing resources via the Continuum of Care Coordinated Entry System; based on Kim's history, VI-SPADT results and wrap-around support services offered through CCHP, Kim qualified for a City of Phoenix Section-8 Voucher ▪ Assist Kim with move into permanent housing and work directly with local housing authority to locate housing options to meet Kim's preferences/needs; complete housing eligibility paperwork, and transport Kim to housing program briefings and potential home visits ▪ Provide intense wrap-around support to aid Kim's transition into housing to maximize safety and independent living skills	▪ Kim ▪ Susan (MCCAZ CM) ▪ Dolores (MCCAZ Onsite ED CM) ▪ CCHP Team ▪ MCCAZ Recovery Support Navigator ▪ Housing Coordinator
Kim's Priority: I want to feel better.	
▪ Obtain signed Authorization to Use and Disclose form which permits sharing of Kim's health information among treating providers ▪ Confirm Kim's treatment for schizophrenia, substance use/withdrawal/detox, diabetes, peripheral neuropathy, and chronic pain to ensure an immediate and appropriate treatment plan per MCCAZ's evidence-based clinical practice guidelines (CPGs); share service plan/CPGs with Kim's providers and educate Kim on all aspects of her care, treatment, and contingency planning	▪ Kim ▪ Susan (MCCAZ CM) ▪ Dolores (MCCAZ Onsite ED CM) ▪ MCCAZ Recovery Support Navigator ▪ CCHP Team

Action	Responsibility
▪ Initiate MAT; use of targeted opioid medication and BH therapy utilizing Suboxone; monitor Kim closely for any further substance use/withdrawal symptoms immediately post discharge; coordinate ▪ Accompany Kim (Recovery Support Navigator) for first few outpatient visits to keep her engaged in detox/substance use program; keep Naloxone on hand post discharge with establishment of contingency planning potential relapse ▪ Arrange and facilitate outpatient appointments within IHH utilizing the CCHP Team for PH, BH, and social health services and care; establish and find PCP, endocrinologist, BH provider, housing coordinator, etc.; focus on diabetic preventive care, blood sugar control, blood pressure management, gynecologic screening, and risk factors, if any ▪ Coordinate with Magellan RX Management (MRx), MCCAZ Team, and Kim's CCHP Team during hospital transition to ensure medication obtainment, adherence, and overall management into the outpatient setting; coordinate pharmacy lock in program use ▪ Discuss the use of long-acting BH injectables to address Kim's non-adherence history ▪ Confirm follow-up appointments are in place ▪ Review strategies to promote adherence to medication therapies; provide self-care education regarding schizophrenia, diabetes, peripheral neuropathy, nutrition, SUD, and treatment adherence	▪ MCCAZ Pharmacist ▪ MCCAZ Medical Director ▪ PCP ▪ Endocrinologist ▪ BH Provider
Kim's Priority: I want to reconnect with my family.	
▪ Partner with Kim to co-create a plan to reconnect with family to establish positive and rewarding relationships to enhance quality of life; including family services e.g., support groups as needed	▪ Kim ▪ Susan (MCCAZ CM) ▪ Recovery Support Navigator ▪ CCHP Team

Ongoing Care Management and Reassessment: **(Initial 1-4 months)** Once Kim is settled into the Phoenix Bridge Housing, Susan remains in close contact with Kim by telephone and face-to-face weekly meetings to monitor status. This includes ensuring Kim receives a Phoenix Section 8 Voucher through the CCHP Program, and maintains stable housing through a Housing-First approach. Susan and Kim's Recovery Support Navigator verify that a crisis plan is in place, and confirm Kim is attending scheduled appointments, obtaining medications, overcoming any potential obstacles to her recovery, self-managing her chronic conditions, and achieving her life goals. Kim is successfully engaged in her MAT program and is responding positively to the treatment plan. Kim's community of support helps her cope and thrive. Relationships and collaborations with community partners enable Kim to effectively coordinate care with the supports and services that she knows and trusts like Church on the Street, St. Kim's Food Bank, City of Phoenix Family Service Center (CAP Office), and the Human Service Campus.

(5-12 months) As Kim's recovery progresses and her symptoms improve, Kim gradually becomes more connected with her community and family. Along with an improved insight into Kim's treatment adherence, Susan gradually reduces the frequency of her contacts to monthly and ICT meetings to quarterly, and verifies that the CCHP Team is taking the lead ensuring that Kim is engaging in treatment and is complying with all aspects of her service plan. The MCCAZ Team and Kim participate in quarterly audits of her service plan with the CCHP Team and Kim's PCP to verify that the service plan reflects Kim's evolving needs; such as exploring employment and educational goals as her recovery continues. Through transition planning that links all treating providers and uses evidence-based best practices, Kim engages in treatment and keeps her appointments, improves her medication adherence, and enhances her overall health. Kim's housing provides the stability and confidence that she needs to engage in self-care and rehabilitation activities, and supports her recovery.

Kim has no further ED visits and does not require crisis services or inpatient admissions.

6. Manage care to achieve the best outcome for the member.

Please see **Table 6-1** below for the member demographic profile for "Marie" that sets the stage for her Individualized Service Plan (ISP).

Table 6-1. Marie's Member Profile

Meet Marie, 18-year-old female, resides in Phoenix		
▪ **Conditions:** Pregnant, sickle cell anemia, intermittent opioid use, mild depression ▪ **Social Factors:** Teen pregnancy, no prenatal care prior to incarceration, plans to keep baby, recently released from jail, trying to finish high school ▪ **Environmental Factors:** Lives in Flagstaff, unemployed, unsafe neighborhood ▪ **Supports:** Lives with grandmother, best friend Michelle, father of baby not involved		
Key Assumptions	▪ Marie is motivated to care for her baby and finish school ▪ Marie is assigned to MCCAZ prior to incarceration ▪ Marie's depression is mild ▪ Sickle cell crisis triggers opioid use	
Key Components of Care	▪ Care co-managed locally with consults from tertiary centers in Phoenix ▪ Member education and support re: pregnancy, pain management, diet, and parenting ▪ Alignment of PH, pharmacy, BH, and community resources and services	
Timeline	▪ **Day 1:** Marie's effective date with MCCAZ; 3 months pregnant ▪ **Day 2:** OB CM, Pam, outreach to Marie in jail ▪ **Day 3:** Our Justice Liaison works with jail to allow Pam to meet Marie ▪ **Day 7:** Pam meets Marie - completes initial assessment ▪ **Day 14:** Karla, Recovery Support Navigator, begins visits ▪ **Day 60:** Team meeting in correctional facility to plan Marie's re-entry	▪ **Day 90:** Marie released from jail – 6 months pregnant ▪ **Day 96:** Interdisciplinary Care Team meets at North Country ▪ **Month 5:** Chloe is born – 4 lbs/6oz; Marie takes active role in her care and Chloe's care ▪ **Month 7:** Marie passes GED ▪ **Month 9:** Marie begins University of Arizona online classes ▪ **Month 10:** Chloe enrolled in AzEIP and Early Head Start ▪ **Month 12:** Marie stays opioid-free for 1 year; Chloe shows signs of improvement

Enrollment and Engagement: Marie is auto-assigned to Magellan Complete Care of Arizona (MCCAZ) through the AHCCCS auto-assignment process. MCCAZ's automated enrollment processes use the files from AHCCC, identify Marie as pregnant, and categorize her as high risk due to her age and sickle cell disease (SCD) diagnosis. She is automatically enrolled in the MCCAZ **Mother Baby Connections** high risk pregnancy program and assigned to "Pam" - an integrated Obstetric Care Manager (OB CM) who is Master's degree prepared with high risk pregnancy background. Our Mother Baby Connections program is designed to engage our members using a high touch person-centered integrated approach; customized to the specific, often complex needs of pregnant women like Marie.

Pam calls Marie the next day but reaches her grandmother instead who states that Marie lives with her in Flagstaff but was arrested for possession of an illegal prescription medication (Vicodin) the previous day. Marie's grandmother is very upset; she is worried that Marie will experience a "sickle crisis" while she is in jail and "not get good medical care". Pam states she will try to meet with Marie. MCCAZ notifies AHCCCS that Marie is incarcerated. Once Marie is identified as incarcerated on the 834 file, the system indicator shows that she is "pending enrolled but inactive". This allows Pam to create care management tasks to monitor Marie through her incarceration.

Initial Comprehensive Assessment and Key Findings: Pam is very concerned that Marie is three months pregnant and in jail and is anxious to meet Marie as soon as possible. Through our "Criminal Justice Reach-In" program, our MCCAZ Jail Liaison visits Marie in the Coconino County Detention Facility. Through a Memorandum of Understanding, this program adheres to our justice system collaboration protocols; including credentialing MCCAZ Care Management and select

providers to "reach-in" to coordinate care inside the jail. Our Jail Liaison identifies that Marie would be a good candidate for Drug Court and advocates with pre-trial services to have her offered participation in the Coconino County Recovery Court. Unfortunately, the court is "full" so they require Marie to serve her full three months sentence. While disappointing, the MCCAZ Justice Liaison works with the facility to allow Pam to begin joint care coordination/care management. Pam's goal is to complete the initial assessments and screens to determine immediate needs and to work with Marie on establishing an ISP including a plan for Marie's re-entry into the community.

Within the week, Pam is able to meet Marie. Marie is relieved, expressing, "I'm worried about my baby and I am so scared here". Pam explains her role and that she will work hand-in-hand with Marie to help get the care she and her baby need. Pam chats with Marie to get to know her better and to learn about Marie's strengths, values, preferences, hopes and dreams. The father of the baby is not involved. Marie has a very close relationship with her grandmother and her best friend from high school, "Michelle". Pam provides Marie with an overview of the Mother Baby Connections program stating she will help her coordinate not only her 24/7 pregnancy, physical health (PH) and behavioral health (BH) needs, and also help connect her to resources for baby clothing, crib, housing, education, employment, and food.

After Marie signs a consent to share information with her providers and grandmother, Pam completes the initial comprehensive pregnancy assessment along with the Edinburgh depression screen and the Substance Use Risk Profile-Pregnancy scale. Our assessment includes demographic, cultural, past PH and BH history, social determinants of health (SDoH) and an "about you" section that focuses on readiness for change. Pam assesses Marie's SCD, related complications, and treatment. Please see **Table 6-2** for Marie's assessment findings.

Table 6-2. Marie's Assessment Findings

Assessment Findings		
Conditions	**Potential Risk Outcomes**	**Strengths**
Unintended teen pregnancy at 3 months; Inadequate prenatal care	▪ Increased risk - low birth weight (LBW) and intrauterine growth restriction (IUGR), preterm labor/birth, preeclampsia	▪ Receiving prenatal care in jail ▪ Lab tests completed including HIV, Hep B, VDRL, chlamydia and gonorrhea ▪ EPSDT visits/immunizations current
Sickle cell disease (SCD) with periodic sickle cell crisis	▪ Potential medical/pregnancy complications ▪ Increased risk for maternal mortality ▪ Potential sickle crisis/re-hospitalization	▪ No known chronic conditions related to SCD
Difficulty coping with sickle cell crisis & chronic pain	▪ Risk of opioid addiction & NAS ▪ Potential fetal anomalies due to first trimester opioid use	▪ Open to learning non opioid pain control techniques and medications
Mild depression no suicidal thoughts	▪ Potential bonding issues with her newborn due to depression	▪ Motivated to keep baby/get education ▪ Has been seeing a BH Professional
Teen parent	▪ Risk of repeat unintended pregnancy ▪ Risk of not getting high school degree; lost 3 months in jail	▪ Open to parenting support ▪ Grandmother supports/employed ▪ Plans to breastfeed ▪ Wants to finish high school
Incarcerated	▪ Transition from jail/recidivism risk	▪ Motivated by pregnancy to change

Pam and Marie discuss Marie's top priorities. Marie states: "I want to have a healthy baby; I don't want to have sickle pain; I want to keep my baby; and I want to finish school." Pam is encouraged by Marie's strength and motivation. Based on the "life course perspective" incorporated into our model of care, Pam understands that Marie's needs change over the course of her life. In Marie's case, pregnancy and transition to adulthood are critical milestones to address.

Because Marie's pregnancy is providing an incentive to make health and lifestyle changes, Pam's focus is to empower Marie with actionable health information and tools that enable her engagement in self-management promoting healthy

behaviors and controlling modifiable risk factors during pregnancy. Pam learns that Marie's substance use does not extend beyond her need to treat the sickle cell pain.

Pam asks Marie if she would like to meet one of our MCCAZ Recovery Support Navigators, "Karla"; who had a baby when she was 17 and experienced depression and past substance use. Marie meets with Karla the next week. Over the course of her incarceration, Karla and Pam rotate visits each week to provide support for Marie along with Marie's grandmother. Pam provides prenatal education including milestones, fetal movement, nutrition, and normal aches and pains of pregnancy. After Pam consults with our MCCAZ Sickle Cell Specialty Team, she educates Marie on self-management of her chronic SCD. Marie receives regular prenatal care and her pregnancy progresses without complications except for one hospitalization for sickle cell crisis. She is treated with rest and hydration and discharged back to jail two days later.

MCCAZ assists pregnant members to receive timely prenatal care with collaborative, engaged providers, including specialists. Pam works with Marie to prepare for her re-entry into the community. Marie identifies an OB at North Country Healthcare in Flagstaff where she sees her pediatrician and BH professional. Pam is happy because MCCAZ collaborated with North Country to implement CenteringPregnancy (group care). Since Centering is evidence-based with proven outcomes, MCCAZ pays North Country an enhanced rate. Other advantages of North Country include its close proximity to WIC and "wrap around" services including telemedicine, dental care, Health Start, HealthySteps and lactation support. Pam schedules appointments within the first few days after Marie's release with her OB, hematologist, BH, and substance use providers. Thirty days prior to her release, Pam convenes a virtual Team meeting including the correctional facility, MCCAZ's Medical Director, Karla, Marie's providers, Marie's grandmother, and Jail Coordinator to discuss needed services and resources for ongoing prenatal care and safe transition home. Due to the complexity and timing of Marie's immediate needs, Pam discusses the benefits of MCCAZ's Interdisciplinary Care Team (ICT) meetings. Marie agrees to participate and asks that her grandmother, Michelle, and Karla be included. Pam schedules a "virtual" ICT for the first week after her release. Prior to Marie's release, Pam calls each provider with an update on Marie's condition and coordinates the sharing of medical records.

Marie is Released Back into the Community: At approximately 24 week's gestation and after three months of incarceration, Marie is released. MCCAZ receives the update on the 834 and the system indicator shows her as actively enrolled. This information is ''fed" downstream to all internal systems and the web-based provider and member portals. To help with re-integration into the community, Karla and Michelle meet Marie at discharge and accompany her home to her grandmother's apartment. Karla assists with setting up transportation and plans to accompany Marie to her initial provider meetings scheduled later that week. Pam visits Marie on the following day and completes a transition assessment to determine her immediate needs and adjustment to home. Pam provides Marie with a Smartphone. Marie is very open to using the mobile applications and texting for education and communication. With the Wildflower™ pregnancy "app", we send appointment reminders and tailor our health messages and education. The app helps Marie track her symptoms, monitor key milestones, read health tips, and view her benefits. Texting allows us to monitor Marie's symptoms easily and quickly resolve any barriers to care (e.g., transportation).

Marie plans to continue to live with her grandmother. Our **Integrated Health Neighborhood℠ (IHN)** model of care is built on our understanding that Marie's ability to have a healthy pregnancy and newborn is intrinsically tied to SDoH, support, and the physical conditions in her environment. Marie's goal to have a healthy baby and stay pain-free can only be achieved within the context of where she lives – her neighborhood in Flagstaff. Marie and her grandmother need a community of support to cope and thrive with the next few months of pregnancy and parenting a newborn. Relationships and collaborations with community partners will enable Marie to effectively coordinate care with the supports and services that Marie and her grandmother know and trust; like their Church at Harbert Chapel, Flagstaff High, WIC, Flagstaff Family Food Center, and North Country.

Marie attends her first prenatal visit with her new OB two days after her release. Her OB encourages Marie to join a CenteringPregnancy group for her prenatal care because participation in group care lessens the feelings of isolation and stress while building friendships, community and support systems. Marie agrees to join and to continue to attend additional periodic visits with her OB as well. Because of the SCD, Marie's OB refers her to a Maternal Fetal Medicine (MFM) specialist at St. Joseph's Hospital and Medical Center in Phoenix for a complete maternal and fetal evaluation.

Within four days of her release, Karla accompanies Marie and her grandmother to Marie's appointments in Phoenix with her hematologist at the sickle cell program at Phoenix Children's Hospital, and the MFM specialist at St Joseph's. Her hematologist explains that if Marie experiences a severe sickle crisis, opioids are the drug of choice during pregnancy. Given Marie's history with illegal possession due to her need to self-medicate, it is critical that Marie finds ways to prevent a crisis. The MFM specialist evaluates Marie and performs an initial ultrasound and concludes that the fetus is a girl with asymmetric intrauterine growth restriction (IUGR). Marie starts to cry but the MFM specialist explains that while the baby is small for her age, in this case the head is normal size (brain is spared) and the body is small. The MFM specialist calls Marie's local OB to discuss the findings. Periodic fetal surveillance using telemedicine is scheduled.

Interdisciplinary Care Team Meeting (ICT): Within one week after Marie's release, the ICT convenes virtually at North Country Healthcare with her local OB, pediatrician, BH professional, Pam, Karla, Marie's grandmother, and Michelle. The hematologist, MFM specialist, MCCAZ's Medical Director, and an MCCAZ clinical pharmacist are invited. Pam assists Marie to define her priorities and goals, shown in **Table 6-3**. Marie and the ICT design the interventions and determines ICT responsibilities. With their support and input, Marie decides to continue her care with her local OB with support from the MFM specialist via telemedicine and on-site visits as needed. They discuss the possibility of maternal transport prior to if needed to ensure the delivery of the infant at St. Joseph's Level III NICU.

Individualized Service Plan (ISP): The ICT develops an ISP that helps Marie maximize her benefits and connections to informal and community supports. The ISP includes Marie's goals with activities and strategies to assist her in achieving a healthy pregnancy and newborn. ICT members view HIPAA-compliant data on Marie's conditions, medications, gaps in care, and the ISP, through our secure provider portal. Marie accesses the ISP through the member portal via her Smartphone. **Table 6-3** summarizes Marie's ISP.

Table 6-3. Marie's Top Priorities with Specific Interventions

Action	Responsibility
Marie's Priority: I want to have a healthy baby.	
▪ Coordinate frequent prenatal care/fetal surveillance visits including transportation, telehealth, and maternal transport if needed ▪ Continue CenteringPregnancy group care for added support ▪ Schedule visit with dentist at North Country ▪ Monitor risk/provide education on milestones, signs and symptoms of PTL/preeclampsia, and evaluation of fetal movement ▪ Begin Digital Cognitive Behavioral Therapy (dCBT) using Smartphone and MCCAZ's depression and substance use modules ▪ Report symptoms of worsening depression/complete re-screen at 28 wks/postpartum ▪ Report substance use/desire to use substances ▪ Improve nutrition/weight gain -prenatal vitamins, nutritional counseling, referrals to community supports including WIC, Farmers Markets that accept SNAP ▪ Select doula for support during labor and delivery and immediate postpartum ▪ Prepare for L&D/develop birth plan, breastfeeding, bringing baby home ▪ Tour Flagstaff OB, Special Care Nursery, St. Joseph OB, and NICU units ▪ Meet with the anesthesiologist and neonatologist	▪ Marie ▪ Pam/Karla ▪ North Country HealthCare OB/GYN (OB) ▪ St. Joseph's MFM specialist (MFM)
Marie's Priority: I don't want to have sickle pain.	
▪ Learn ways to prevent sickle crisis ▪ Develop plan to minimize/cope with pain without using opioids including dCBT using MCCAZ's pain module via Smartphone ▪ Develop a plan for L&D and postpartum pain relief	▪ Marie ▪ Pam/Karla ▪ Grandmother ▪ Doula, OB, anesthesiologist
Marie's Priority: I want to keep my baby.	

Action	Responsibility
▪ Develop plan to support breastfeeding, e.g., classes, lactation support, breast pump ▪ Coordinate parenting education/support; refer to Health Start/ HealthySteps ▪ Prepare for baby, e.g., refer to diaper bank, car seat, sleep box or free crib, clothing ▪ Learn how to keep baby safe, e.g., safe sleep, baby care, child-proofing home, car safety, how to calm a crying baby (never shake a baby) ▪ Maintain list of 24/7 resources, e.g., North Country, MCCAZ's Care Line and Crisis Line, MCCAZ's lactation support, WIC, and community resources ▪ Choose pediatrician and set up appointments immediately after the baby is born ▪ Learn about EPSDT/immunizations schedule for baby and Marie ▪ Report symptoms of worsening depression and treat if needed ▪ Report substance use or desire to use substances for pain ▪ Refer to MCCAZ's **MY LIFE** for continuing support for depression and substance use – (youth support each other in their recovery goals)	▪ Marie ▪ Doula ▪ Grandmother ▪ Pam/Karla ▪ North Country HealthCare ▪ HealthySteps
Marie's Priority: I want to finish school.	
▪ Explore alternative schools, online high school, group home settings, distance learning, or GED (MCCAZ will pay for GED) ▪ Develop plan to remove barriers after the baby is born, e.g., childcare ▪ Discuss possible inpatient LARC postpartum to avoid a second unintended pregnancy ▪ Develop a reproductive plan using the CDCs "My Reproductive Life Plan"	▪ Marie ▪ Pam/Karla ▪ Grandmother ▪ Local OB/GYN

Ongoing Care Management and Reassessment: Pam and Karla continue to support Marie through the remainder of her pregnancy. Her depression improves and she is able to prevent and/or cope with her chronic sickle pain without resorting to opioids. Three weeks before her due date, Marie experiences severe sickle pain. After stabilization at Flagstaff Medical, Pam arranges for Marie and her grandmother to stay at a hotel near St. Joseph's in anticipation of an early delivery. The MFM and hematologist decide to administer a blood transfusion to treat Marie's anemia and to help prevent a sickle crisis during labor. With the support of her doula and her grandmother, Marie delivers a healthy baby, "Chloe", at 37 weeks. Chloe is born weighing 4 pounds, 6 ounces and is admitted to the NICU. The doula supports Marie to initiate breastfeeding. Prior to discharge, at Marie's request, the delivering physician inserts Depo-Provera® (DMPA) a long acting reversible contraceptive (LARC). Marie is discharged in five days. Pam arranged for Marie and her grandmother to stay at the nearby hotel until Chloe is discharged two weeks later. The hospital staff and her doula work with Marie daily to support breastfeeding and provide infant care education in preparation for discharge.

After discharge, Pam and Karla visit Marie and Chloe to ensure a smooth transition to home, successful breastfeeding and to complete the perinatal depression screen. Marie is engaged in her own care as well as Chloe's. Marie called North Country and set up an appointment for two days after discharge with Chloe's pediatrician and an initial visit with the HealthySteps child development specialist. Marie agrees to home visits by the Health Start Community Health Worker. Marie sets up her postpartum visit for six weeks. Karla accompanies Marie, Marie's grandmother, and Chloe to the visits for the first few months.

First Year of Life: Pam continues to work with Marie on a monthly basis. Marie identifies her evolving goals and priorities: "I want my baby to grow and be healthy; I want to stay off drugs; and I want to continue my education." She develops a plan for transition to adulthood and Chloe's successful growth and development. With the help of Pam and Marie's IHN, Marie is able to pass her GED and begin online community college classes. Women at her church offer to provide childcare when Marie starts a part-time job. Over time, Chloe shows signs of developmental delays. Chloe is evaluated and enrolled in AzEIP and Early Head Start.

7. Improving member engagement, developing and implementing best practices and tracking and monitoring outcomes.

Magellan Complete Care of Arizona (MCCAZ) is uniquely qualified to assist AHCCCS, providers, and community stakeholders to address the complex needs of special populations and improve health outcomes. Our solutions build upon our Arizona-specific experience, replicating and refining those solutions and building on our fully-integrated Medicaid health plan experience in other states. We have reviewed AHCCCS' DSRIP strategies and will support and/or develop approaches that recognize the importance of collaboration in serving complex and high cost members. We will cultivate a fully sustainable integrated system of care that improves both health and financial outcomes. Our member engagement approach meets members where they are, in a respectful and dignified manner, leveraging their natural strengths and supports while addressing their unique needs. We know based on our past experience that social determinants of health (SDoH) are also critical to consider as we take a holistic approach; with heavy emphasis on working with partners and stakeholders to meet the holistic needs of members with complex needs.

We leverage the "lived-experience" of peer support including Certified Recovery Support Navigators (RSN) Family Support Specialists (FSS), e.g., both provider and MCCAZ staff, and Community Health Workers (CHW) to increase member connectivity and engagement. We also develop and utilize a variety of value-based purchasing (VBP) funding mechanisms; including pay-for-performance (P4P), integrated services bundles, and shared savings to address complex physical health (PH), behavioral health (BH), psychosocial member needs, engagement/outreach efforts, SDoH, and cross-system navigation – critical to affecting meaningful outcomes and bending the cost curve. Below we describe our robust strategy for member engagement that layers in specific interventions and best-practices designed to meet the unique needs of special populations; incorporating tailored tracking and monitoring of outcomes.

MCCAZ's approach to improving member engagement

We use a multifaceted approach to identify and work with members with complex needs. We use enrollment, benefit, claims, and HIE data, along with our proprietary health risk assessment (HRA) to quickly identify vulnerable members with complex PH, BH, and psychosocial needs; as well as members who are involved with systems such as criminal justice, DCS, and Court-Evaluation. Our HRA captures SDoH, BH, and substance use disorder (SUD) risks further informing our risk stratification and interventions. Once identified, members are flagged for outreach, additional comprehensive screening, and enrollment in our complex, ultra-high risk care management program. MCCAZ leverages a proprietary and enhanced predictive modeling and risk stratification tool, using a variety of data sources and analytics, to continuously identify, monitor, and quickly intervene with high-utilization, vulnerable sub-populations, and members identified as having emerging risk factors. This allows for intelligent identification and assignment of a Care Manager (CM) who is trained to meet the unique needs of the member; assessment of needs and goals; development of an individualized service plan (ISP); member and family education; facilitate linkages to community-based organizations; and, address SDoH, which often have a significant impact on outcomes for these sub-populations.

The foundation of our approach to increasing member engagement and improving outcomes is our community-based model of our **Integrated Health Neighborhood℠ (IHN)**; consisting of our locally-based care management Teams designed to meet the PH and BH needs of the whole person. Team members including **CM, Licensed Social Worker (LSW), CHW, promotoras, RSN, FSS, Housing and Employment Specialists**, **Jail Liaisons**, **Doulas, IHS Community Health Representatives, and community partners,** provide additional needed support and care coordination to assist our members in navigating the PH and BH care and social supports systems to get the care and services they need. Our ultimate goal is to limit disruption and improve member's health, well-being, and overall quality of life. We hire a diverse Team of regionally-based staff who live in the communities where members live; allowing staff to customize their approach and collaboration with specialized resources and supports the member knows and trusts. The IHN reflects the best of our depth of experience, our passion for serving our members, and our commitment to bringing best-in-class service to our Arizona partners. Through the IHN we use innovative strategies, including collaborative community partnerships and resources to increase access and improve member engagement. Once identified the IHN Team quickly engages members to complete needed assessments and begin care management and coordination. For more difficult to reach members, or members who require more frequent engagement due to complex needs (such as those who are homeless), we deploy intensive outreach approaches, including provider collaboration to assist reaching members;

IHN Team ("feet on the street") to engage members in their homes and communities; collaboration with the criminal justice system, community agencies, and organizations (e.g., area agencies, Community Assistance Programs, PATH Outreach, first responders, shelters, and others); informal social networks; and digital/mobile outreach; engaging members through mobile phones; including text notifications and alerts containing health and wellness information and reminders. Our active, regular engagement with members in CM allows us to monitor progress over time and adjust ISP and the intensity of CM based on the needs of the member – leading to improved outcomes.

MCCAZ's approach to developing and implementing best practices

From our extensive history of serving complex populations in Arizona and other states, we have acquired unique insights into factors critical to successfully delivering customized member-centric care; utilizing best practices while improving outcomes and significantly reducing overall costs. **Table 7-1** references Magellan Healthcare contracts that we highlighted in **Question 1. Contracts** demonstrating similar experience with specialty populations.

Table 7-1. Medicaid Population Experience by Contract

Contract	Justice Involved	Court Ordered Evaluation & Treatment	Members with High Needs & High Costs	Members with Substance Use Disorders	Children at Risk of Removal by DCS/State Agencies	Children Transitioning from CMDP/Foster Care
Magellan Healthcare	AZ, FL, NY	AZ, FL, NY	AZ, FL, NY	AZ, FL, NY	AZ, FL	AZ, FL

Justice Involved (including probation, parole, Reach-in)

Individuals involved with the justice system face multiple factors that complicate access to care. While SDoH are an important consideration for all Medicaid members, they are especially critical for individuals who are forensically involved. In addition to housing and employment issues and limited support networks, cross-system justice factors and challenges with information sharing exacerbate barriers. Cycling in and out of jail disrupts continuity of care for existing treatment; from disruption of medications while incarcerated, suspension of AHCCCS benefits, and Medicaid reactivation upon re-entry. Individuals are often discharged from jail at less than ideal times, night-time and weekends; missing a critical opportunity for engagement. Therapeutic jurisprudence, while admirable, can also further complicate efforts; since criminal justice stakeholders may require additional treatment and reporting, that do not fit with the typical public health approach. Knowing the challenges members face, we intentionally accompany them on their journey from the justice system to ensure they have an ISP, access to needed service, and peer support to walk along-side the member as they reintegrate back into the community. MCCAZ understands the critical interface between the criminal justice system and individuals on Medicaid; incorporating compassion and knowledge about the challenges these individuals/families face. Through early identification of the Justice Involved we allow for in-reach and coordination with our preferred forensic provider network, who assist the member with a "warm" re-entry back into the community. In Arizona as the Central GSA RBHA, we partnered with the criminal justice system and developed best practices that are still in place today. As an integrated health plan, we build upon these practices and enhance them to increase opportunities for front-end diversion, identification, re-entry, and ongoing community support; while leveraging innovative technologies to assist in the management of this population. We will leverage our tested approach from our experience in Arizona and other states to offer the following best practice strategies shown in **Table 7-2**.

Table 7-2. Strategies for Justice Involved Members

Strategies for Justice Involved Best Practices	Track & Monitor Outcomes
▪ Use Health Information Technology (HIT)/data exchange links to identify members ▪ Jail/prison In-Reach care coordination for transition/discharge planning pre-release, includes completion of HRAs, schedule appts, and collaborate with probation/parole pre/post release ▪ Co-located provider-based Forensic RSN for warm-handoffs ▪ Develop collaborative protocols with justice system organizations – e.g., police, sheriff, jails, Department of Corrections, probation/parole, correctional health, courts	**Track & Monitor:** ▪ Identify and track members ▪ Pre-release reports ▪ Arrests, re-arrests (recidivism rates) ▪ Healthcare utilization ▪ Mandatory reporting **Expected Outcomes:**

Strategies for Justice Involved Best Practices	Track & Monitor Outcomes
▪ Contract with Targeted Investment (TI) providers and integrated healthcare settings at probation/parole offices; incentivize utilization of Forensic EBP Treatment ▪ Offer bundled service agreements with providers to provide a broad array of services ▪ Employ Telemedicine, **Magellan Virtual Care Solution (VCS)** – e.g., (**Clickotine™**, and **SmartScreener™** apps), and Smartphone technology, including PsychTrac™, an innovative patient-facing mobile apps for individuals in jail diversion programs and post-incarceration ▪ Offer Medication Assisted Treatment (MAT) in the community and explore innovative option of providing MAT while still incarcerated ▪ Utilize community resources – e.g., NA/AA and **Aunt Bertha Community Connections** online resource technology ▪ Collaborate with law enforcement, criminal justice and probation officer training ▪ Use a Housing First approach ▪ Use dedicated staff – Housing & Employment Specialists, Justice System Liaison, RSN	▪ Improved access/PH/BH outcomes ▪ Reduced recidivism ▪ Increased community tenure ▪ Cost savings to AHCCCS ▪ Cost savings for justice system ▪ Reduced homelessness

Court Ordered Evaluation (COE)/Court Ordered Treatment (COT)

Individuals referred for COE are often experiencing very stressful circumstances that may require involuntary confinement. Our staff will work with members and their families throughout this process to help minimize traumatic effects from this process. We meet with and coordinate person-centered plans, ensure they are aware of their rights and the COE/COT process, while ensuring appropriate access to care and follow up post release. MCCAZ has extensive experience working with members on COE/COT to improve their health outcomes. As the Maricopa County RBHA, we oversaw the COE/COT for approximately 2,000 members annually from 2007-2014, including tracking, monitoring, and compiling DBHS/AHCCCS reports. We have significant expertise with the Title 36 Process (including the protection of member's rights) and extensive experience collaborating with law enforcement, courts, and county government. We work with members throughout the process including immediate follow up at COE and throughout their court order, if placed on COT. Care coordination is particularly important for this population, with heavy emphasis on meeting the member where they are to assist with navigating the system, ensuring access to care, and helping the member remain compliant with their court order. For members placed on COT, we utilize a multi-disciplinary Team of psychiatrists, nurses, social workers, and other BH professionals who work collaboratively with the member, developing an Individualized Service Plan (ISP) that includes referrals to necessary physicians, BH agencies, and other health care professionals to ensure the best possible outcome. We will leverage our tested approach from our experience in Arizona and other states to offer the following best practice strategies shown in **Table 7-3**.

Table 7-3. Strategies for Members in Court Ordered Evaluation/Court Ordered Treatment

Strategies for Court-Ordered Best Practices	Track & Monitor Outcomes
▪ Schedule 7-day or sooner follow-up appointments post discharge ▪ Offer bundled services with providers delivering integrated services to members ▪ Ensure HIPAA-compliant access to electronic medical records with alert technology ▪ Partner and refer to integrated providers and Centers of Excellence ▪ Utilize RSN as support to members ▪ Employ provider medication monitoring; Long Acting Injectable for med adherence ▪ Coordinate serious mental illness (SMI) determination & with RBHAs, if applicable ▪ Establish collaborative protocols to ensure coordination of care and access to care – e.g., Tribal Courts ▪ Employ clinical rounds while inpatient ▪ Use dedicated staff – Court Coordinators, ICCM Team, RSN	**Track & Monitor:** ▪ Comprehensive CM system ▪ Track members COT information (dates, type, status) & build reports ▪ Monitor court-related calendar ▪ Monitor monthly appointments, med compliance & progress toward goals ▪ Monitor amended COT Requests **Expected Outcomes:** ▪ Members receive 7 & 30 day follow up after IP stays to reduce re-admissions ▪ Improved access/PH/BH outcomes ▪ Reduced risk of harm & suicide ▪ Successful completion of COT

Members with high needs and high costs

High need/high cost members often have a high incidence of complex co-morbid medical conditions (e.g., diabetes, COPD) that are poorly managed, including BH and substance abuse challenges; as well as unmet social needs that may result in preventable use of emergency department (ED), inpatient care, and other costly services. Our integrated PH and BH population health approach systematically stratifies members using a multi-step care management process to provide each member with healthcare services and supports tailored to their risk, complexity, and needs. We use advanced clinical analytics to ensure we use a scientifically valid approach for patient identification and clustering. As noted earlier, we identify vulnerable subpopulations, high-risk, and emerging-risk members early to expedite outreach and engagement utilizing a high touch, community-based approach to engage and connect with the member. Our Teams are specially trained to work with these complex members assisting them in navigating health care and social service systems. We also help them understand the importance of primary and preventive care, educate them on medication adherence and how to access and obtain needed housing, food, transportation to close gaps in care whenever possible. CMs closely monitor high risk members to ensure ISP are working; resulting in optimal outcomes and eventual member self-management. We will leverage our tested approach from our experience in Arizona and other states to offer the following best practice strategies shown in **Table 7-4**.

Table 7-4. Strategies for Members with High Needs and High Costs

Strategies for High Needs/High Costs Best Practices	Track & Monitor Outcomes
▪ Use enrollment and HIE data, along with predictive modeling to identify members who are high cost/high needs from point of enrollment and risk stratify specific members ▪ Offer bundled services with providers to provide integrated services to members (e.g., in-home), such as the Comprehensive Community Health Program (CCHP) ▪ Contract with integrated providers, FQHCs, RHCs, and Centers of Excellence, and providers who use peer support, to assist in system navigation and address SDoH ▪ Use SAMHSA Four Quadrant Clinical Integration model & promote enrollment in Disease Management (DM)/Care Management Program ▪ Use Housing-First approach ▪ Use/promote VCS, Smartphone technology and use pharmacy lock-in program ▪ Collaborate with AHCCCS and qualifying HIE organization ▪ Offer provider education, access to age appropriate screening tools, and incentives for use ▪ Use dedicated staff – Recovery Support Specialists, CHW, ICCM, DM RNs	**Track & Monitor:** ▪ Identify and track members ▪ Monthly appointments & provider-based engagement activity ▪ (Re)admissions, ED, & ambulance utilization ▪ Medical & pharmacy claims **Expected Outcomes:** ▪ Improved access/PH/BH outcomes ▪ Cost savings to AHCCCS ▪ Increased use of preventative care & reduced admissions ▪ Reduced homelessness ▪ Improved member satisfaction

Members with Substance Use Disorders

Individuals with SUD face many challenges; including higher rates of justice involvement, and higher healthcare costs. At the same time, they are frequently unable to access treatment needed to improve their overall health. MCCAZ understands that addiction is an illness, and similar to traditional PH illnesses, can often respond favorable to appropriate care; delivered through a member-centric approach that addresses member goals and uses treatment strategies that are acceptable to them, including a harm-reduction approach. We recognize it "takes a community" to address SUD, therefore we intentionally collaborate with community partners and stakeholders. This requires significant expertise and an array of service choices and evidence-based practices delivered in an integrated, member-centric approach. We have built networks and support services to meet these needs. Our 360-degree approach brings together our comprehensive PH/BH experience, integrated pharmacy benefits management, expanding models of member self-direction, and expertise in specialty healthcare to deliver solutions that positively impact quality, access, availability, and cost. We recognize that traditional health-care providers often have limited knowledge of addiction treatment.

Our approach incorporates provider training, screening tools, practice support and VBP incentives to increase SUD knowledge and screening in practice settings. These skills are especially critical as we seamlessly integrate BH services for this population and address the use of opioids and other SUD with our extensive experience; specifically in addressing opioid-related issues. In fact, Magellan Healthcare remains a thought-leader in this area and has created an

executive level committee; bringing together our addiction experts with government affairs and operational leaders to create a holistic approach to combat the opioid epidemic. MCCAZ applies a proactive approach to monitor and prevent controlled substance abuse. We also incentivize selected SUD providers to use peer support services; a SAMHSA best-practice for increasing engagement and improved outcomes for individuals with SUD. We will leverage our tested approach from our experience in Arizona and other states to offer the following best practice strategies shown in **Table 7-5**.

Table 7-5. Strategies for Members with Substance Use Disorders

Strategies for SUD Best Practices	Track & Monitor Outcomes
▪ Maintain and increase provider network of BH providers using EBP ▪ Use MAT with community navigation/transportation support – office-based opioid treatment ▪ Use peer support programs and promote self-help resources and harm reduction ▪ Use Chronic Pain Digital Cognitive Behavioral Therapy (dCBT), Chronic Pain Case Management, ▪ Use Comprehensive Prior Authorization Criteria for long- and short-acting opioids ▪ Use community resources – e.g., NA/AA, Aunt Bertha resource technology ▪ Facilitate care coordination and partnerships with integrated providers ▪ Facilitate/promote neonatal interventions and protocols for pregnant members using substances ▪ Use Centers of Excellence for adults and children ▪ Use VCS, Smartphone technology, Opioid New Start for members newly prescribed opiates ▪ Facilitate data-driven substance abuse prevention/planning to include member, provider, and community education regarding risk factors and use of outreach tools ▪ Use Magellan WholeHealth Rx (pharmacy program) to review prescribing practices; education ▪ Use our board-certified addiction medical directors and board-certified pain management medical directors to inform key stakeholder organizations, design and staff innovative programs ▪ Use dedicated staff – Chief Medical Officer (Dr. Caroline Carney) on the National Quality Partner's Opioid Task force and AZ Opioid Task Force, Recovery Support Navigators, Pregnancy and Addiction CM/DM Team; Certified Recovery Support Specialists	**Track & Monitor:** ▪ Capture SUD from assessment for tracking, monitoring and ongoing ISP planning ▪ Monthly appointments & provider-based engagement activity ▪ (Re)admissions, ED, & ambulance utilization ▪ Pharmacy claim surveillance **Expected Outcomes:** ▪ Improved access/PH/BH ▪ Decreased substance use and/or abstinence ▪ Cost savings to AHCCCS ▪ Reduced admissions ▪ Reduced overdoses ▪ Improved member satisfaction ▪ Improved functional status ▪ Improved comorbid conditions (e.g., depression, diabetes)

Children at risk of removal by Department of Child Safety (DCS)

Preventing child abuse and promoting child safety requires participation of multiple stakeholders in government, in business, and the community. We understand the statutory purpose of DCS is to protect children and assess child safety and risk as a primary responsibility. We also understand that the primary goal is to keep children in their home – when possible. Determining whether to remove a child from home is based on child safety and risk assessment practices. Several programs exist in Arizona and the nation, providing services that have the primary or secondary goal of prevention of children being placed in foster care. MCCAZ will partner with DCS and other community organizations such as Healthy Families Arizona, the Phoenix Dream Center's Foster Care Prevention program, and AZ Families F.I.R.S.T. Families in Recovery Succeeding Together (AFF), to improve care for Medicaid-enrolled children who are at risk of removal from their homes; to ensure basic needs are met, transitions are smooth, and continuity in care across providers over the continuum of the child's care is maintained. Early interventions, working with both the child and parents/family, is key to helping prevent avoidable foster care placements. MCCAZ members and families are connected with programs that provide core services such as therapy, stable and safe housing, crisis intervention, and ongoing in-home partnerships to ensure stability.

Wraparound services that focus on both child and parents, include tutoring, backpack and homework programs, and CM. By using a grassroots approach to reach out to local churches and civic groups and partnering with healthcare providers, businesses, and local programs, MCCAZ intends to prevent children from entering foster care by providing

housing, healthcare, meals, and other basic family needs. We will leverage our tested approach from our experience in Arizona and other states to offer the following best practice strategies shown in **Table 7-6**.

Table 7-6. Strategies for Children at Risk of Removal by Department of Child Safety

Strategies for Child At Risk Removal by DCS Best Practices	Track & Monitor Outcomes
▪ Facilitate Child and Family Team (CFT) participation/collaborative meetings & develop collaborative protocols with DCS; host Team decision meetings; coordinate with T/RBHAs ▪ Use **Magellan Youth Leaders Inspiring Future Empowerment (MY LIFE)** program ▪ Facilitate family support; in-home services, community resource education, and referral ▪ Use Centers of Excellence that leverages HIT to communicate within the system ▪ Use Trauma Informed Care (TIC) and support early screening for trauma ▪ Support evidence-based therapies such as Parent-Child Interaction Therapy ▪ Use staff support – Children Healthcare Administrator, Children Services Liaison, CHW, Peer, and FSS	**Track & Monitor:** ▪ Track, & monitor members ▪ Review of members monthly to discuss progress, high need **Expected Outcomes:** ▪ Decreased child removal & increased family reunification ▪ Improved coping skills ▪ Improved access and PH & BH outcomes

Children transitioning from the CMDP to the AHCCCS Complete Care Contractor

Our member engagement strategy for children transitioning from the CMDP to MCCAZ involves coordinating care through the transition from the CMDP Contractor, working closely with child/youth/young adults and their family/guardians, and ongoing monitoring and support for up to one year post transition. This partnership ensures provision of uninterrupted services and includes providing service information, emergency numbers, and instructions on how to obtain services. MCCAZ's experienced Team of professionals will promote a smooth transition that minimizes disruption for children and their families, providers, AHCCCS, and additional stakeholders. To support the member, we assign a CM with both BH and PH experience to support member choices, manage the transition, identify potential care/service gaps, enhance communication among providers, and ensure positive outcomes. The CM communicates with all relevant parties involved in the transition and supports the member in the least restrictive and safest environment. We will leverage our tested approach from our experience in AZ and other states to offer the following best practice strategies shown in **Table 7-7**.

Table 7-7. Strategies for Children Transitioning from the CMDP to the AHCCCS Complete Care Contractor

Strategies for Child Transitioning from CMDP Best Practices	Track & Monitor Outcomes
▪ Use Child and Family Teams (CFT) – e.g., member, family, schools, providers ▪ Create transition policies, procedures, and checklists that align with best practices and maintain continuity and quality of care ▪ Work with AHCCCS to ensure smooth transition of members from one Contractor to another – e.g., flexibility with authorizations to facilitate seamless transitions ▪ Provide protocols for the transfer of pertinent medical records and arrange for timely notification to members, subcontractors, or other providers, during times of transition ▪ Coordinate and collaborate with CMDP health plan; work together to ensure smooth member transitions from one Contractor to another ▪ Partner with parent advocacy organizations ▪ Use Wellness Recovery Action Plans (WRAP) & Transition Age Youth (TAY) procedures if moving to adult system; Transition to Independence Process (TIP) program ▪ Use dedicated staff –Transition Coordinator, Children's Healthcare Administrator, Multi-Disciplinary Team, RSNs	**Track & Monitor:** ▪ Flag, track, & monitor members for min. 1 year or as long as necessary ▪ Transition process & member goals **Expected Outcomes:** ▪ Improved, smooth transitions ▪ Increased member satisfaction ▪ Improved coping skills for family ▪ Family reunification ▪ Improved access & PH & BH outcomes

MCCAZ's approach to tracking and monitoring

MCCAZ recognizes the importance of identifying, tracking, and monitoring outcomes for members with complex needs.

Our robust flexible information systems, including enrollment, claims, member services and clinical systems, all operate on a single integrated platform providing a seamless, continuous record of member services, interventions, care gaps, transitions between systems, and other supports. Our ability to generate a custom scorecard for each special population allows for effective monitoring of rates and performance around operational processes, utilization, transitions, and outcomes. Our care Teams and network staff have direct access to tools to perform drill down analysis to identify immediate needs and interventions around member care, network gaps, training, and operations allowing for immediate improvement while monitoring sustained performance. Our systems allow us to identify members for reach-in care coordination; for monitor utilization and emerging risk; and for supporting HEDIS and AHCCCS monitoring. The strength of these systems is demonstrated by our significant positive outcomes working with these specific populations, as shown in **Table 7-8.**

Table 7-8. Magellan Experience and Outcomes Working with Specific Populations

Challenges	Magellan Experience and Outcomes Working with Specific Populations
Reducing Over-representation in the Justice System	▪ AZ – Used information data exchange via technology to identify and engage incarcerated members; employed full-time justice-related staff to work with jails and courts; Supported law-enforcement diverting over 12,000 members annually from criminal justice system; Operated nationally recognized CIT Program; trained over 500 law-enforcement/corrections officers; Implemented Forensic Peer Navigator program to assist in-reach/transition from justice system; Created a COT flag in our electronic health record to track member's status and provide timely reporting ▪ FL – Trained more than 1,100 CIT officers; In collaboration with Judge Leifman (justice system national leader), First health plan to participate in the Miami/Dade County Jail Reach-In Initiative; including embedded MCCFL CHW into the jail to coordinate re-entry activities
Addressing SDoH & Cross-System Collaboration	▪ AZ – Implemented Crisis Transition Navigator Peer Program, to assist members in transition from higher levels of care; this resulted in significant outcomes including reducing lengths of stay, and a 47% reduction in readmissions and 40% improvement in follow-up appointment and continuity of care; Partnered to deliver Transition to Independence Process (TIP) program resulting in specialized Case Managers serving as facilitators for youth transitioning to the adult system; Developed a Rapid Response Team to provide urgent, age-appropriate assessments of children immediately after removal by DCS
Opioid Crisis Solutions	▪ AZ – Chief Medical Officer participation in AZ Governor's Opioid Task Force; AZ/FL – Implemented Pharmacy Lock-in Programs; Magellan Healthcare has a National Opioid Crisis Executive Steering Committee to address opioid crisis
Member Engagement & Empowerment	▪ AZ – Created and maintained Magellan Youth Leaders Inspiring Future Empowerment (MY LIFE); still operating through the peer and family run Recovery Empowerment Network (REN)with financial support from Magellan; Created and supported large network of SUD providers, including the significant expansion of peer support services and variety of outpatient treatment modalities; Implemented culturally relevant programs resulting in 70% of adolescents completing treatment without returning to juvenile justice setting; 64% of those who completed treatment, decreased or eliminated their substance use all together
Bending Cost Curve	▪ AZ – Created alternative levels of care, to serve as a "step-down" function, including implementing large-scale access and transition point; and Crisis Respite Services ▪ FL – Developed and implemented the **Integrated Behavioral Health Program (IBHP)** to specifically meet the needs of members with high-cost/complex health needs; this value-based initiative produced significant positive outcomes, including: successfully engaged members traditionally viewed as "hard to serve"; 50% reduction in BH inpatient admits; 50% reduction in ED utilization

MCCAZ's experience delivering superior outcomes for each of the specific populations discussed above is second to none. We will work with AHCCCS and other partners to build upon and develop new innovative solutions to continue the system transformation in Arizona. We have the ability to leverage our extensive experience in other markets to identify and implement best practices. Our IHN approach recognizes certain complex populations like those listed above, and "wraps around" the member the right network and the right social supports. In addition, we have sophisticated reporting and technology platforms that allow us to identify, track, and monitor outcomes.

8. Improving outcomes, adding value and improving member experience for pregnant women and their families.

Magellan Complete Care of Arizona (MCCAZ) strives to ensure that every pregnant member has a healthy pregnancy and every baby is born healthy and into a safe and nurturing home. Our **Mother Baby Connections** program offers comprehensive ongoing education and support to all pregnant members from preconception through the first year of a newborn's life. MCCAZ's program is **evidenced-based**, incorporating the principles of our very successful Mother Baby Connections programs operating in our Florida and other state health plans. We have adapted that program to meet specific AHCCCS goals and program elements, as well as key delivery system features and underlying population characteristics and needs.

Our program empowers members with actionable health information and tools that inform, enable, influence, and incentivize member engagement in self-management promoting healthy behaviors and controlling modifiable risk factors during pregnancy. We incorporate life course concepts (i.e., U.S. Department of Health and Human Services Health Resources and Services Administration) into our design. This means our approach changes over the course of a member's life. Our programs recognize that we have a unique opportunity to intervene during certain critical periods, like pregnancy, when poor health can lead to health disparities or become the genesis of acute and chronic disease for the infant and mother over the lifespan.

Integrated Health Neighborhood: Mother Baby Connections incorporates our **Integrated Health Neighborhood℠ (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 physical health (PH), including social determinants of health (SDoH), and environmental conditions. Improving care and outcomes is best achieved within the context of where our members live – in Arizona's neighborhoods and communities. Relationships and collaborations with community partners enable us to effectively coordinate care with the community supports and services that the member knows and trusts (e.g., Arizona Healthy Families, Nurse Family Partnership, WIC, and CenteringPregnancy).

Mother Baby Connections Program

- Early identification & screening pregnancy, depression, substance use, domestic abuse, SDOH
- Rescreens at 28 weeks & postpartum
- Triage into appropriate level of care
- Connect to obstetric care/transportation
- Education & support
- Beginnings Guide
- CenteringPregnancy
- 24/7 Nurse Line & Crisis Line
- **Aunt Bertha Community Connections**, a customized community supports
- Mobile member engagement
- **Virtual Care Solution**
- Healthy weight programs
- Preparation for childbirth
- Early elective delivery prevention
- High risk pregnancy programs:
  - Preterm labor prevention
  - Substance use program
  - Perinatal depression program
  - Smoking cessation program - **Clickotine™**
- Breastfeeding support
- Home visitation programs
- Postpartum inpatient LARC/family planning
- Teen pregnancy prevention
- Preconception and inter-conception care

The IHN is MCCAZ's innovative solution that allows us to "think locally" as we customize our programs in each region to deliver locally-focused, and culturally responsive solutions to meet members where they are. The IHN informs all aspects of our health plan design including regional programs, staffing, and system transformation activities. As we strive to **eliminate disparities** in health and outcomes, the beauty of our neighborhood based program design is that it naturally bridges language and cultural barriers regardless of region. In addition to the local program design, we enhance the model with "feet on the street" staff from the communities they serve, who work within the local public health system and extend their reach. These Team members have first-hand knowledge of community strengths, resources, services and service gaps. Our IHN **Provider Support Specialists (PSS)** are clinicians who support dissemination of evidence-based practices and practice advancements through training, technical assistance and data sharing. Our IHN **Community Outreach Specialists** (COS) establish partnerships with State agencies and community organizations e.g., school nurses, school-based clinics, parish nurses, Inter Tribal Council of Arizona, home visitation programs, criminal justice system, to help increase awareness on MCCAZ programs and best practices. Our COS Team establishes community relationships and maintains a routinely-updated and convenient-to-access online community resource guide, called **Aunt Bertha Community Connections**, to provide comprehensive support to members in their local neighborhoods to address SDoH

and leverage non-traditional services. For our high risk members, our locally-based care management Team - including **Integrated OB Care Managers, Community Health Workers (CHW), promotoras, Recovery Support Navigators, doulas, and Indian Health Services (IHS) Community Health Representatives** provide additional needed support and care coordination to assist our members in navigating the healthcare and social supports system to get the care and services they need.

Unintended Pregnancy Prevention/Family Planning: A component of the Mother Baby Connections program is MCCAZ's value-add **Future Connections** program designed to improve birth outcomes and the member experience by reducing the number of unintended (unwanted, unplanned or mistimed) pregnancies. Moving beyond traditional family planning interventions, our program includes education about unintended pregnancy, the importance of spacing pregnancies at least 18 months apart, the benefits and ease of use of long acting reversible contraceptive (LARC) and the importance of optimal preconception health. Future Connections includes tools designed to empower our members - including teens, women and men - to take an active role in their own reproductive health care and education and training for providers. We incorporate "One Key Question" (http://www.onekeyquestion.org) into our adult health risk assessment (HRA): "Would you like to become pregnant in the next year?" for female members of child-bearing age. In this member-centered approach, the response can lead to further discussion about the member's reproductive life plan and/or preconception health. Based on this discussion, we connect the member to the appropriate services and offer to assist with completing the CDC's Reproductive Health Plan. We offer instructions on how to download the "Show Your Love" pre-conception health app on their Smartphone. If a member does not have a Smartphone, we will provide it to eligible members. Our Future Connections web page also encourages use of these tools and provides instructions on how to use them.

Through our **MY SUCCESS for Teens** program, MCCAZ encourages teens to take charge of their own futures and prevent teen pregnancy. On the "For Teens" section of our website and Facebook page, we provide information and links to local and nationally recognized resources like the Arizona Inter Tribal Council of Arizona (ITCA) Teen Pregnancy Prevention Program, National Campaign's Power to Decide, Bedsider, and Stay Teen free apps. We also offer education for parents/guardians/caregivers on how to talk to their teens and raise awareness of the teen's activities (e.g., use of social media) and to know where they are and what they are doing. We partner with local programs to provide education, support, and services e.g., ITCA, Arizona Family Health Partnership, school-based clinics, school nurses, and parish nurses. Our PSS provide training and technical assistance on current evidence-based guidelines and approaches incorporating the "One Key Question" approach as well as the CDC's tools. PSS provide focused education based on the American Academy of Pediatrics' Bright Futures regarding how to work with teens to prevent teen pregnancy. MCCAZ supports the use of 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 website. PSS provide training for providers on the safety and efficacy of LARC and a tiered approach to the discussion of contraception starting with LARC because an initial comparative review of all options can be overwhelming. MCCAZ provides enhanced reimbursement for insertion of LARC prior to discharge after delivery as a provider/facility incentive.

Promote/Ensure Adequate Perinatal Care: Another component of MCCAZ's Mother Baby Connections program is the promotion of best practices to ensure improvement in prenatal and postpartum HEDIS scores and birth outcomes and the member experience by promoting early and regular prenatal and postpartum care. In addition to the requirements set forth in AHCCCS policy, the value-add services to promote early prenatal care, the adequacy and frequency of prenatal care, and timeliness of postpartum care are listed below.

First 12 Weeks: MCCAZ has developed an innovative **First 12 Weeks** educational outreach program, targeting all women of childbearing age. The program raises awareness of the importance of preconception health, early prenatal care, and options for what to do if a member suspects pregnancy. Our program includes a "Signs and Symptoms of Pregnancy Guide", guide to free pregnancy testing sites, and an enhanced incentive for seeking prenatal care in the first 12 weeks.

Complete Care Counts: **Complete Care Counts** is MCCAZ's member incentive program to encourage early prenatal care and completion of all recommended prenatal visits and timely postpartum visit. Rewards are loaded onto "reloadable" debit cards that members can use to purchase health-related services and supplies.

Promoting Health Literacy, Culturally Sensitive, and Supportive Care: One of the key objectives of our Mother Baby Connections program is to **decrease the disparities** in access and care in order to improve health outcomes for racial, ethnic, and other underserved populations. MCCAZ includes CenteringPregnancy, a nationally recognized program to improve birth outcomes through group prenatal care. Participation in group care lessens the feelings of isolation and stress while building friendships, community and support systems. We will contract with all programs available in Arizona and pay an enhanced rate for these programs. Published studies show that CenteringPregnancy moms have healthier babies and nearly eliminates racial disparities in preterm birth and at the same time promotes prenatal care. MCCAZ will work with AHCCCS, Department of Health, Association of Midwives, the IHS, and similar organizations to develop and further expand programs throughout the State. In addition to CenteringPregnancy, we use peers including **Community Health Workers (CHW), promotoras, Recovery Support Navigators, doulas, and IHS Community Health Representatives** to provide additional support for our pregnant members with particular focus on high-risk members and members in rural communities. Peers help to naturally bridge cultural gaps and address health literacy and social support needs by helping the family make connections to neighborhood resources e.g., WIC and SNAP programs, farmer's markets, and other social support programs. MCCAZ also uses Beginnings Pregnancy Guides and Parent's Guides that are both teaching and learning materials for promoting health literacy, reflective function, and essential life skills for parents.

Mobile and Social Media Platforms: Our Mobile Member Engagement Program provides Smartphones, mobile applications, and texting for education and communication. With pregnancy apps like Wildflower™, we are able to send appointment reminders and tailor our health messages and education. The app helps members track symptoms, monitor key milestones, read health tips, and view benefits. Texting allows us to monitor symptoms easily and quickly resolve any barriers to care (e.g., transportation). We use social media (e.g., Facebook, Twitter, Snapchat, and YouTube) for education and to push messages and/or information including HEDIS reminders, healthy tips, community events, and appointment reminders. Facebook allows us to receive member feedback and opinions. Using our MCCAZ's **SmartScreener™** app, members can complete the depression screening. The app uses an algorithm to screen members quickly and efficiently for potential problems. Each symptom cluster has a short and longer set of questions if they score positive on the short set.

Provider Led Models of Care: PSS support providers in adopting evidence-based best practices, practice transformation and culturally sensitive integrated models. Examples include Pregnancy Integrated Health Homes (medical home), CenteringPregnancy, Care Pathways, and Team-based models. We contract with hospitals certified through the Arizona Perinatal Trust, and provide extensive access to midwives to enhance access to care and respond to member preference. Our VBP programs include incentives to promote early notification by the provider of a MCCAZ pregnant member; Screening, Brief Intervention, and Referral to Treatment (SBIRT) with the expectation that every pregnant member is screened and referred for appropriate treatment; and perinatal depression screens in the first trimester, at 28 weeks, and postpartum. Building on our BH and substance/opioid use expertise in Arizona and other states, our PSS offer training on appropriate tools and follow up and resources for members.

High Risk Pregnancy Programs: MCCAZ's **Mother Baby Connections High Risk Pregnancy Program** is unique. Built on our experience in Florida and adapted for AHCCCS, our program includes comprehensive high-touch, person-centered, integrated care management by experienced OB nurses. **Integrated OB Care Managers** provide intensive care management for the whole person including all PH and BH, and social needs. Based on risk factors identified from the OB risk assessment, depression/substance use screen, provider, claims data, and other available information, members are stratified at high risk based on existing health conditions, age, lifestyle factors, SDOH, and conditions of pregnancy. We use every means available to identify, engage, and support our pregnant members and connect them to the appropriate level of care. For more difficult to reach members, the local IHN Team, e.g., Care Manager (CM) or CHW, attempts to find her; meet her at the provider office or at home. In addition, our internal systems contain flags to alert Customer Service Associates and CMs that we are trying to find a member in case the member calls or goes to the ED or hospital. Our dedicated Team includes subject matter experts who provide consultation as needed to address unique issues or problems e.g., sickle cell disease.

Based on member needs and region, the Integrated OB CMs think creatively to best serve the member. We provide home visits by experienced OB nurses for ongoing assessment, monitoring, and education. The CM will coordinate doula services for a member without support or pay for a hotel room for a high-risk member and her family to keep her close to tertiary care. MCCAZ will also work with the High Risk Perinatal Program/Newborn Intensive Program (HRPP/NICPP) for maternal transport to a city with a Level III hospital in certain circumstances; allowing the family to stay in a hotel, if hospitalization is not required. If a newborn is admitted to the NICU, the CM provides ongoing support and education for the new mom and her family throughout the inpatient stay and transition home. Through our High Risk Pregnancy Program we offer evidence-based, value-add specialized, and **Magellan Virtual Care Solution** (listed below) to ensure improved birth outcomes and the member experience.

Preterm Labor Prevention: MCCAZ offers high-risk OB home health services including in-home obstetric nurse administration of hydroxyprogesterone caproate (17P), education about 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 member will deliver a full or near-term baby. We also work with member and providers to prevent early elective deliveries (described below).

Substance Use in Pregnancy: If a member is identified with substance use, the Integrated OB CM works to ensure the member receives the appropriate level of care and/or treatment such as residential treatment or Medication Assisted Therapy (MAT) for example. To improve access to treatment, we also offer Magellan Virtual Care Solution, including our **Digital Cognitive Behavioral Therapy (dCBT)** app for chemical dependency, and **Clickotine™** our app for smoking cessation accessible online or on mobile devices. Pregnancy often serves as motivation to adopt a healthier lifestyle. The Integrated OB CM encourages parental attachment during and after pregnancy along with breastfeeding; which can serve as a motivation for continued abstinence from substances. The CM may also link the member to one of our Recovery Support Navigators for more intensive support. The Integrated OB CM assists with coordination of care working closely with the member's OB often in consultation with a Maternal Fetal Medicine specialist, primary BH professional, RBHA if involved, local addiction medicine specialist, and will arrange for in home evaluations or the use of telehealth when other services are not viable due to transportation, psychosocial, and/or health issues. For women with opioid addiction, abrupt discontinuation can result in preterm labor or fetal demise. MAT results in a decreased likelihood of preterm birth, low birth weight, and other complications. If a woman refuses to undergo MAT, the Integrated OB CM works with her and her providers to ensure access to a medically supervised withdrawal program. Since women are at high risk for relapse and depression in the postpartum period, the Integrated OB CM provides ongoing, consistent follow up and screening, and makes referrals for ongoing post-partum MAT treatment and support.

Perinatal Depression Treatment: In addition to the screenings performed by the provider, our Integrated OB CM screens members in the initial assessment, at 28 weeks, and postpartum. If a member screens positive for depression, Integrated OB CM work with the member and provider to connect to the most appropriate community resources and treatment. We assess her ability to care for herself and her infant, and then work with her family or others to offer support. To improve access to treatment, we offer MCCAZ's dCBT application for depression; proven to be effective in reducing the need for higher levels of care and medication for post-partum depression, and used as an enhancement to telephonic/traditional face-to-face care. The programs improve member engagement, allow individuals to access care at any time day or night, and support the delivery of services in rural and underserved areas.

Early Elective Delivery Prevention: MCCAZ strategies to reduce early elective deliveries includes provider and community collaboration, member education, and provider reimbursement and incentives. We will work with the Arizona Perinatal Trust, Hospital and Healthcare Association, AHCCCS, the Department of Health Services, and our provider partners, to support and develop programs and protocols to encourage full-term births and reduce the rates of non-medically-indicated cesarean sections. 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. We plan to implement the use of modifiers for better reporting and tracking of deliveries and will consider alternate payment systems. PSS provide training and dissemination of best practices regarding the reduction of early elective and C-section deliveries and available tools. Member awareness campaigns 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 member and provider education focused on elimination of non-medically indicated (elective) deliveries before 39 weeks.

Parenting Support: Depending on the level of risk, a peer or Integrated OB CM outreaches to each new mom after delivery to complete the depression screen, assist with scheduling the postpartum appointment, baby's first well-child visit, transportation if needed, and coordinates access to social services and supports as needed e.g., diaper bank, car seat, or approved crib. MCCAZ supports the Arizona Safe Sleep Campaign and work to ensure that every baby goes home to a safe place to sleep. Prior to delivery, we assess where the baby will sleep and assist parents with obtaining an approved crib, basinet, or playpen and provide education on "never shake a baby" and Safe Sleep; including back to sleep and the use of "sleepsacks". Safe Sleep is reinforced through Text4Baby™, Beginnings Parenting Guides, and through home visits. For mothers with a short stay (<48 hours for vaginal delivery and <96 hours for a C-section), at high risk or with a high risk infant, we provide a home visit by an experienced OB or neonatal nurse. We refer families to home visitation programs as needed to support at-risk parents and or children (birth to age five). We help them access resources and develop the skills needed to raise children who are physically, socially, and emotionally healthy and ready to learn. Resources include Parents as Teachers, Health Start, Nurse Family Partnership, Resource Mothers, Early Head Start, AZ Families F.I.R.S.T., Healthy Families, and others based on the community. We also make the Text4Baby app available to all members for use in monitoring and tracking their baby's health. As an enhanced benefit, MCCAZ will pay for a member's GED if they have been unable to complete high school.

Breastfeeding: Our Mother Baby Connections program provides breastfeeding education and support; individual lactation support by a MCCAZ or community-based International Board Certified Lactation Consultant (IBCLC); and equipment rentals. Additional support includes access to our 24/7 Nurse Line; donor milk from a human milk bank for high risk infants; ongoing support from CenteringParenting where available; Text4Baby mobile app; referrals to WIC and La Leche League; and listings of baby-friendly hospitals in the Member Handbook.

Barriers identified and results from strategies previously implemented

Magellan Healthcare (Magellan) has extensive experience successfully working with special populations that pose additional challenges in improving overall outcomes for our member mothers and babies, particularly in Florida. Due to the complexities of pregnancy combined with the diagnosis of serious mental illness (SMI) and co-morbidities, all pregnant members in Florida are considered high risk. Barriers identified and results from our strategies and programs previously implemented in our Florida health plan are listed below:

Unintended Pregnancy: Many of the greatest challenges we have faced relate to supporting member goals of planned, healthy pregnancies. In 2015, we implemented programs to educate and train providers and members in the use of LARCs and enhanced reimbursement to providers. Since the inception of the program, we saw a statistically significant increase in LARC usage through Q3 of 2017.

Serious Mental Illness: Pregnancy can be destabilizing for existing conditions, and medication therapies can also contribute to pregnancy risks. The SMI itself can pose a barrier to seeking prenatal care and adhering to treatment. Our integrated high-risk pregnancy care management program includes a Team-based approach with experience Integrated OB CMs and MSWs, a triple-boarded Medical Director (OB, adolescent psychology, and addiction medicine) and Clinical Pharmacist as needed. We achieve extremely strong results as listed in **Table 8-1**.

Table 8-1. HEDIS Improvements 2015-2016

HEDIS	2015-2016 % Improvement
Frequency of prenatal care >=81% (FPC)	23.16%
Timeliness of prenatal care (PPC)	8.61%
Timely postpartum care (PPC)	20.15%

In addition, for the most recent reporting period of our Florida health plan, our preterm delivery rate is at 2.48% versus Florida's overall rate of 10.1% (National Center for Health Statistics). Also, our C-section rate of 28.45% is significantly lower than Florida's overall health plan rate of 38.78% (FL Agency for Health Care Administration). Due to our unique mother/baby expertise, depth of Arizona experience, and successful innovative solutions, MCCAZ will be a strong partner to help AHCCCS Complete Care improve outcomes and well-being of Arizona's pregnant women and newborns.

9. Addressing the developmental needs of young children including early identification of developmental delay.

Magellan Complete Care of Arizona's (MCCAZ) goal is to ensure all newborns, babies, and toddlers have a strong beginning through child and family-centered, culturally-responsive solutions to promote early physical, social, and emotional development; with a focus on the child's long term well-being and life path. We incorporate requirements of Arizona Early Intervention Programs as well as Medicaid requirements for Early Periodic Screening Diagnosis and Treatment (EPSDT) throughout. We do this by addressing the unique needs of each child and family; with child and family voice and choice being central to decision making for screening, planning, and treatment.

Our comprehensive program, is built around hands-on experience managing EPSDT and early intervention across the nation, and incorporates solid clinical programs and our dedicated national and local child and adolescent Team. We continually enhance our systems of care using nationally recognized tools, preventive services, and treatment. Our care coordination model, **MY SUCCESS**, employs a personalized approach to support needs of children with developmental delay or disability, including Team-based treatment planning and care coordination. Our strategy is consistent with AHCCCS' goals to enhance delivery system identification, screening, and treatment capabilities; and builds on our previous experience as the Maricopa RBHA, where we coordinated services for 27,000 children identified as having behavioral health (BH) and/or development delay. Our approach includes collaborative structures through cross-system agreements with other child-serving systems, and collaboration with experts to support new and advanced practices. We also incorporate successful principles employed in our Florida program as well other states for outreach and engagement of families and providers to complete necessary screenings and close gaps in care; as well as our national **Magellan Autism Connections®**, which has already shown improved outcomes and a six percent reduction in costs.

Highlights

- Early identification of at-risk children, for timely screening and intervention
- Child and family-centered planning and care coordination, reflecting the family voice, needs, culture, language, and belief system
- Best practices incorporating American Academy of Pediatrics (AAP), EPSDT and AHCCCS standard screening, referral and treatment
- Collaborative solutions to enhance delivery system capabilities and capacity
- Multi-pronged outreach and engagement to close gaps in care and improve outcomes

Through our **Integrated Health Neighborhood℠ (IHN)**, we incorporate culturally-responsive, locally-delivered, population-based and individualized approaches for engaging parents/guardians to reinforce positive parenting; identify and treat disability and developmental and BH conditions; support their child's growth and development; and support parents/caregivers in caring for their children. Our programs are aligned with AHCCCS Performance Improvement Project goals to increase the number of children screened for risks of disability, developmental, BH, and social delays using standard screening tools, and includes provider engagement focused on practice transformation to ensure the provider network supports enhanced capabilities and capacity. Our network of providers includes physical therapy (PT), occupational therapy (OT), developmental pediatricians, specialists, and community partners like Autism Connections. We fully support a system of care which includes: standardized screening and prevention programs and tools; early intervention and routine care provision; specialty consultation; treatment and coordination; and, intensive services for complex clinical problems. We also incorporate elements of our earlier, very-successful Arizona collaborative protocol, built around Arizona's Vision and 12-Principles of Children's System of Care, for coordinating with related agencies; such as Arizona Long-Term Care system (ALTCS), DES/DDD, and T/RBHAs, in the Child and Family Team (CFT) process. This program was successful in moving the system away from institutionalized care making it possible for children to stay in their homes and receive treatment in the community; resulting in a reduction of institutional care to one-third of previous levels. Our programs reflect an understanding of the importance of managing disability and developmental risks and needs from pregnancy through childhood, including the following:

Mothers Experiencing High Risk Pregnancies: MCCAZ's **Mother Baby Connections** pregnancy management program incorporates expanded biopsychosocial risk assessment, analytics, and predictive modeling to identify mothers with

previous deliveries of infants with disability or developmental delays; previous pre-term deliveries; substance use (alcohol and drugs); serious BH diagnoses; smoking; community risks; and behaviors or diagnoses that may increase risks for poor birth outcomes. Providers are incentivized to screen pregnant members for depression, substance use, domestic violence, and conditions that may affect birth outcomes and/or lead to developmental delay. Women experiencing a high-risk pregnancy are incentivized to enroll in our high-risk pregnancy care management program and are monitored by our Newborn Care Management Team, who flag infants born to high-risk mothers allowing rapid follow up after birth. Following AAP, AzEIP, and EPSDT guidelines, we provide education on the importance of newborn care; make proactive referrals to providers or community agencies as needed; and incorporate programs such as CenteringPregnancy and home visitation support for families and caregivers.

Family and Infant Support: We use **Beginnings Parent's Guides** that translate the science of early child development into easy-to-understand practical guidance for parents of 0 to 3-year-olds to support safe, healthy families and homes. Materials are culturally-responsive, multilingual, and targeted to appropriate literacy levels. Our member portal includes important parenting, child health, screening, treatment and referral, and AzEIP and EPSDT program information and parents receive regular messaging on required screenings, preventive care and treatment, gaps-in-care, and what to do if they are worried about their baby's development. We provide parents with access to mobile apps such as Text4Baby™ and WonderWeeks™**,** which supports parents in understanding and monitoring their child's developmental progress and our Mother Baby Connections program educates pregnant moms and new parents about recommended screening and treatment and their importance for their baby's health. Our Team helps parents select a pediatric provider prior to delivery, arranging the baby's first well-child visit, setting up transportation, and securing additional support through referrals to home visitation programs if needed.

Substance-exposed Infants (SEI) and Infants with Neonatal Abstinence Syndrome (NAS): For newborns with SEI or NAS, our Neonatal Nurse Case Manager (NNCM) will work with parents/caregivers and Arizona's many existing, innovative Newborn Intensive Care Units (NICU) to provide support for the parents/caregivers when their baby is admitted to the NICU to encourage parental attachment. Programs include Kangaroo Care where available, breastfeeding, the use of pacifiers, and we are exploring the use of innovative programs such as music and aromatherapy. The NNCM also assists with newborn discharge planning and care transitions; coordinating ongoing support, education, and referrals for screening and additional services.

Supporting Provider Education and Delivery Transformation: MCCAZ supports PCP/child/family relationships; emphasizing the importance of and requirements for EPSDT and AzEIP screening and treatment, and supporting prevention of complications using AAP Bright Futures evidence-based guidelines, AHCCCS, EPSDT and other federal requirements. Treatment protocols, provider training, and incentive programs incorporate AzEIP and EPSDT and use of AAP recommended screenings including: Ages and Stages (ASQ3); Parents Evaluation of Developmental Status (PEDS); Parents Evaluation of Developmental Status – Developmental Milestones (PEDS-DM); Brigance Screens; Developmental Assessment of Young Children, Communication and Symbolic Behavior Scales – Developmental Profile, Ages and Stages – Social Emotional (ASQ-SE); M-CHAT-R Childhood Autism Spectrum Test; and the Social Communication Questionnaire. We also educate providers about trauma-informed care, adverse childhood experiences (ACES), and resilience. Providers are incentivized to complete AzEIP and EPSDT timely screenings, treatment and referrals through our value-based purchasing (VBP) program, and MCCAZ **Provider Support Specialists (PSS),** who are licensed clinicians who provide training, technical assistance, and reinforce evidence-based practice guidelines for screening, referral, and treatment. Through the **Magellan Learning Alliance** we provide ongoing skills development and training of providers in both group settings and one-on-one to enhance their knowledge of child development systems and disability or developmental "red flags", multi-disciplinary approaches, development of diagnostic and clinical skills for treatment of young children, and availability of services and supports. Our provider portal provides access to our early childhood development clinical program documents and tools, developmental checklists, screening tools and usage, clinical protocols, and training tools on topics such as screening, available services, referral, and billing requirements.

For providers who may not have established BH or other specialty referral relationships, we provide access to consults telephonically, through telemedicine, or through our provider services telephone hotline. Our Care Coordination Care Management Team also supports providers and members in securing required specialty services as needed.

Our PSS provide practice transformation support to pediatricians interested in developing their screening capabilities and capacity.

We look forward to working collaboratively with the State to expand certification capacity through creation of screening hubs and Centers of Excellence. MCCAZ also believes early identification, screening and referral for disability and developmental needs is well-suited for expansion of integrated Collaborative Care models. As part of our VBP and delivery system innovation efforts, we will partner with providers, key agencies, and community organizations to build a Collaborative Care approach to act as the umbrella for required activities and services. Programs and services available in Arizona would then be linked; with MCCAZ providing education, outreach, and support to pediatricians and parents, and coordinating access to programs and services to prevent delays. We are very excited about the potential for building this model; which is successfully implemented in several other states.

Early identification of developmental delay

In addition to identifying infants by flagging high-risk pregnancies, we use our analytic model to identify newly enrolled children, who may not have previously been screened, or who require coordination and/or transfer to DES/DDD. Building on AzEIP and EPSDT screening requirements, we conduct ongoing analysis of clinical and pharmaceutical data, HIE data, state enrollment, clinical data, and scan for service intensity markers for infants and children; applying specialized predictive modeling to identify children with treatment or diagnoses indicating disability or developmental issues (including autism, mental retardation/cognitive delay, cerebral palsy, or epilepsy), but with no screening results or treatment by a developmental pediatrician, PT, OT, or similar clinician indicated. Care coordination/care management staff or the child's pediatrician, also complete our specialized pediatric biopsychosocial HRA at enrollment. We require providers to follow AAP national guidelines and approved tools for required screenings. Using our highly-developed analytics, stratification, and predictive modeling capabilities, we have developed and are continually enhancing new models to identify and target other infants and newborns with high potential for disability, developmental delay, and related diagnoses; such as lead bands, water contaminants, and mothers with late prenatal care. We are aware of the increased concern about lead and other contaminants exposure in tribal and other areas of the State. We will work closely to develop collaborative solutions to increase timely screening and treatment for those risks.

For newborns, our Care Coordinators/Care Managers (CC/CM) capture key birth outcomes in our Birth Registry and work with neonatologists, pediatricians and parents/caregivers to monitor newborn health and coordinate accelerated screening and access to services for babies who may fall into high-risk categories. We flag **ALL** children requiring EPSDT or EzEIP screenings or follow up care in our care management system for follow up by our dedicated infant and child Care Coordination/Care Management Team. Our care management system monitors timing and completion of well-child visits, completion of required screenings, referrals to AzEIP (Division for Developmental Disability (DDD), the Arizona School for the Deaf and Blind (ASDB)), members with completed assessments, and members with Individual Family Service Plans, and flags gaps-in-care or delinquent services.

Monitoring need for services and closing gaps

Quality and care coordination/care management staff conduct outreach to parents/caregivers to assist them in making required appointments and address barriers to care such as access to transportation. We also take advantage of all available member touch-points to close gaps-in-care through member profile alerts for all Team members to remind the child's parent/guardian of needed services to address gaps, and support the parent/guardian in overcoming any barriers to care. Parents who complete required screenings within designated timeframes may receive incentive gift cards. We use multiple mechanisms to remind parents/caregivers of required screenings and preventive care, including: "Welcome Calls"; member handbook; mobile messaging and reminder calls; customer service and care coordination Team alerts; social media; health fairs and clinic days; provider alerts; member portal; birthday and dental reminders. For members who are delinquent for required services and who we have been unable to reach, our IHN-based outreach staff may attempt to contact the member face-to-face.

We provide integrated care coordination and care management based on member complexity and need, providing integrated care coordination for highest-need children and those requiring coordination with other programs and payers, including children diagnosed with disability, developmental delay, intellectual disabilities, SED, SMI or other complex needs. Infants and toddlers (0-36 months) are referred for screening for Arizona Early Intervention Program

(AzEIP) when the provider or parent identifies disability, developmental delays, autism, or other covered conditions. The Care Coordination/Care Management Team ensures the child is receiving services that are best aligned with the Individualized Service Plan (ISP); that the child receives timely review and certification for state services; and, collaborates with all providers, payers and agencies to ensure there is clarity regarding coverage. This includes coordinating with specialists and other providers to support the child and family in receiving required services. Care planning then integrates AzEIP services and supports for infants and children identified with disability or developmental delay or potential for disability or developmental delay, as well as those who have previously been screened, and those who are certified and receiving services and support through AzEIP. We may also refer parents/guardians to programs such as High-Risk Perinatal Newborn Intensive Care, Safe Care, Family Support for Children with Special Needs, Family Resource Centers, Regional Partnership Council, or other community resources.

Our Care and Quality Management systems provide monitoring of ongoing AzEIP and EPSDT screening gaps, and gaps-in-care for required and recommended services and our CC/CM staff monitor gaps through Clinical Dashboards and CM system alerts. We maintain a comprehensive annual Quality Program that includes monitoring of all gaps-in-care, including all required screenings, preventive treatments, immunizations, and ISP gaps including referrals for developmental services. As part of our ongoing quality and gap closure processes, quality management staff conduct outreach and provide support to members for care-gap closure, using intervention strategies successfully deployed for our Florida plan and other states. Through that program we were able to increase HEDIS scores by more than 13% in a single year, with some scores such as immunizations for adolescents more than doubling in that same period. All providers receive gap-in-care reports which are available in both print and online.

Our provider portal flags screening and care gaps for all assigned members and our PSS conduct outreach to providers to work with them to better understand AzEIP and EPSDT screening and visit requirements, and address gaps for members in their practices. We continuously monitor program effectiveness to ensure members are receiving timely care including AzEIP and EPSDT screenings, 0-3 developmental screenings, well-child/well-adolescent visits, and childhood/adolescent immunizations. As part of our continuous quality improvement processes, we review our quality improvement and member/provider outreach programs and make required refinements to achieve targeted goals. Gap-in-care reports are provided to the child's primary care provider who are encouraged to outreach to their patients to close gaps. For high volume practices, MCCAZ may collaborate with the practice either through co-location or with other assistance. We encourage the use of electronic health records with gap in care alerts and the ability to send reminders to members. MCCAZ also provides webinars and training to improve AzEIP and EPSDT rates, including: services included in required visits; AzEIP and EPSDT guidelines; primacy of benefits; proper billing and coding of visits; and how to convert sick visits to "well visits".

Managing early intensive behavioral intervention benefit

MCCAZ's EPSDT and AzEIP review process for medical necessity will consider the EPSDT "correct, maintain or ameliorate" criteria. The determination of whether a service is medically necessary for an individual child will be made on a case-by-case basis; taking into account the particular needs of the child. MCCAZ will consider the child's long-term needs, not just what is required to address the immediate presenting problem. Services for Medicaid children that do not meet MCCAZ's general coverage criteria will receive an individualized review by a physician with experience in treating the member's condition or disease to ensure the AzEIP and EPSDT provision has been considered. MCCAZ will not use a definition of medical necessity that is more restrictive than the State's definition and will not issue a denial for children services until an individualized medical necessity review has been completed. Providers will have the ability to contact CC/CM to explore alternative services, therapies, and resources for members when necessary. No service provided to a child under AzEIP or EPSDT will be denied as "out-of-network" and/or "experimental" or non-covered," unless specifically noted as non-covered or carved out of these programs.

When a newborn or child (0-36 months) is identified by a provider or parent having a disability or developmental delay or a medical condition which puts the child at risk we work with the infant's provider and parents to coordinate referrals to the AzEIP program, as well as the Department of Economic Security (DES) Early Intervention Program and support the child and family to make sure required services are completed, including assessment by a multidisciplinary Team to determine whether the child qualifies for AzEIP services. Medically necessary early intervention (EI) services are

documented in an Individual Family Support Plan (IFSP) and signed by a physician before services can begin. CC/CM for all children identified for intensive behavioral intervention services, is overseen by our multi-disciplinary infant and child Care Coordination/Care Management Team directed by a pediatrician trained in child development. Required/approved services are incorporated into the member's ISP by the pediatric CC/CM following our developmental planning checklist and step-by-step guides for care coordination/care management decision making. These follow our clinically-defined decision tree which addresses: skill acquisition, verbal behavior, developmental benchmarks, interpersonal skills, decreases in "problem behavior", and cognitive development. EI services are provided in accordance with the child's Individualized Family Service Plan (IFSP), developed by the service provider addressing the developmental needs of the child while enhancing the capacity of families to meet the child's developmental needs through family-centered treatment. Services are performed by EI certified providers in the child's natural environment, to the maximum extent possible. Natural environments can include the child's home or a community-based setting in which children without disabilities also participate.

The CC/CM manages communication and collaboration between PH, BH, specialists, community providers, and agencies to ensure safe and positive clinical outcomes for the child in a manner which is consistent with the AzEIP Team-Based Approach. This includes **Magellan Whole Health Rx** supported monitoring of medications for contraindicated prescriptions and/or incompatible treatment approaches. Our interdisciplinary infant and child Care Coordination/Care Management Team conducts weekly rounds, to review member plans, results and to modify interventions and services as needed. The child's providers are encouraged to participate in this process. The CC/CM makes proactive referrals to providers or community agencies, and works collaboratively with organizations that can provide required support for child and family. Parent/caregivers, as well as the child's providers, are actively involved in care planning, and we apply principles of choice and control over the decisions affecting the member; working with the family to sustain and if possible, maintain health and wellness within the home and immediate community. Our goal is to support the family and member in securing needed services through the least restrictive, culturally-responsive, and most appropriate site of care. For preschool age children (3-6) who are transitioning from early intervention years to school age and need to be monitored for appropriate developmental advancements that will allow them to successfully enter schools, we coordinate the transition out of Early Intervention Services to School-Based services. We also partner with Head Start and similar programs and services to connect pre-school children and their families to services. MCCAZ assists parents of children with special needs to ensure Individual Education Plan (IEP) school-based services meet all identified needs. We welcome collaboration with other MCOs and school districts.

Care coordination/care management staff have access to links for important resources and downloadable files for caregiver or provider education and training. Parents are also provided with education and information for accessing resources to assist with applying for additional coverage, and are provided with support, education, and advocacy by the Care Coordination/Care Management Team to ensure the member has been linked to all available benefits. The CC/CM will also identify whether a family receiving EI services needs additional support and will connect them with community services. As an example, Arizona Autism United provides parent education classes and offers family peer support. We are excited about partnering with this organization as part of MCCAZ community reinvestment dollars.

We support the parent in their local community by coordinating the complex care and services needs of their children through our regionally-based IHN outreach staff. This includes Family Support Specialists with experience in caring for children with disability or developmental needs, linking members with additional community resources such as the Family Involvement Center, through support from our community outreach staff and accessing our **Aunt Bertha Community Connections**, our community resource platform. Through this approach we customize the member's ISP, quality of life goals, and health outcomes; focusing on achieving these goals within the context of where the member and family are—within a neighborhood and community of resources, support systems, and programs.

MCCAZ is committed to supporting AHCCCS goals to expand system capabilities and capacity for early screening and developmental services, including AzEIP and EPSDT, ensuring that all AHCCCS members have a healthy start. Our extensive capabilities and depth of Arizonian and national experience in this area makes MCCAZ a strong partner to achieve those goals.

10. Minimizing Emergency Department holds for behavioral health conditions; Monitoring and managing Emergency Department holds

Magellan Complete Care of Arizona's (MCCAZ) approach to monitoring and managing care, including emergency department (ED) holds, reflects our deep experience in Arizona and Florida delivering fully-integrated physical health (PH) and behavioral health (BH) services. We recognize arrival of a member in the ED is often an indication of a gap in the system of care; such as inadequate anxiety management for chronic illness, members with substance use disorder (SUD) using the ED to secure medication, or members suffering from a serious BH crisis. We also understand individuals with BH conditions disproportionately contribute to overall costs. Although approximately 14 percent of AHCCCS members will be individuals with general mental health or substance abuse conditions (GMHSA), they account for approximately 25 percent of total PH expenditures and disproportionate use of inpatient (IP), ED, and emergency transport. MCCAZ's approach to minimizing ED holds recognizes that although there is some need for IP hospitalization for these populations, significant numbers of admissions/readmissions are preventable. To address this issue, we invest in proactive member engagement and support for self-management; strong linkages between member and provider(s); monitoring to limit BH crisis risk; and, innovative outpatient (OP) and community-delivered evidence-based practices (EBP) and services built around value-based purchasing (VBP), including incentives and shared savings. We also understand effective solutions must be developed collaboratively with providers and other payers to ensure the entire system of care is strengthened to minimize gaps, increase capacity, and enhance coordination. As part of our solution we will work with AHCCCS, providers and other payers to support these goals.

MCCAZ Integrated System of Care: MCCAZ's system of care addresses each of these key drivers, with the goal of limiting the likelihood the member will present in the ED. Our integrated system of care incorporates key features, noted at right. Our innovative **Integrated Health Neighborhood℠ (IHN)** is at the heart of our solution, placing member resources in the local community where the member lives, and linking members with peer and recovery support, PH and BH providers for follow-up care and ongoing treatment, and community services to address other non-healthcare needs that may impact member recovery and resiliency. Our IHN Teams are also typically from the communities they serve; supporting culturally responsive care and support.

Key Features of an Integrated System of Care

- Meet members in their community through the IHN; delivering member-centered, local, and culturally-responsive solutions
- Proactive identification of at-risk members and management of BH health to prevent crisis
- Active crisis management to prevent or minimize ED use and manage care transitions
- Connection to medical home and/or Integrated Health Home (IHH), and tools for self-care
- Ongoing monitoring and management post-crisis to link members to providers and community to support recovery and resiliency

Beyond more clinically-focused activities, our extensive experience with BH programs shows that a key element for supporting member recovery and appropriate follow up is active engagement and support from their community. Through our IHN, we support members through the recovery process, and engagement with community resources. IHN Team members, which include Recovery Support Specialists (RSS) and peer support, work with members to identify and secure needed services or facilitate referrals to community-based programs; including addressing needs such as homelessness. Our goal is to support members in their journey through recovery and assist them in developing resiliency to manage their health for continued community tenure and productive engagement within their community.

MCCAZ's system of care focuses on addressing complex issues around ED holds, targeting underlying causes and events leading to crisis; actions once the member arrives in the ED (both good and bad) and, for transition of care to impact member recovery. **MCCAZ's solution includes identification and engagement of high risk members; integrated pharmaceutical management; enhanced access to care for all levels of BH services to prevent crisis; providing alternatives to ED for crisis services; and, engaging the innovative BH services infrastructure we helped develop through the RBHA program**. This reflects a social solution that incorporates understanding of the underlying delivery system and populations served that builds on innovations as a previous Central GSA RBHA partner with AHCCCS and providers. **In a single four-month period under that program, during the second contract term, more than 1,700 people were diverted from hospitals, ED, and other high-cost facilities to 24/7 Access Points and Transition Point**

facilities. Those programs included a joint venture to create IHH) for co-located PH-BH services, and employed telemedicine to achieve "virtual" co-location. Through that, and carefully managing pharmacy services and providing comprehensive crisis interventions, we enhanced medical capabilities to serve those challenged with serious mental illness (SMI) and accomplished significant PH and BH integration. We also implemented crisis system improvements to greatly reduce need for individuals in BH crisis to go to EDs. We will leverage this experience to stabilize safety net services critical to prevent ED encounters and holds.

Proactive Identification and Engagement of At-risk Members: MCCAZ's approach to monitoring and managing ED holds begins well before the member is in the ED; focusing on identifying and managing at-risk members using our proprietary predictive model which is customized for Arizona. Using advanced statistics, machine learning, and data which includes medical, BH, pharmacy claims, census data, other medical information, and consumer information; we begin identifying high-risk members as soon as we receive notification of enrollment. We match enrollment and claims data with data from Health Current, the State's HIE, to identify members who are frequent ED users, have specific diagnoses, or are receiving specific medications. We combine that data, with our enhanced predictive modeling that also incorporates information on social determinants of health (SDoH), to stratify and pinpoint members most in need of engagement. As an example, in our Florida SMI specialty health plan, our analysis showed members with housing instability, those with co-occurring SUD, those with certain underlying PH conditions such as diabetes, or those in specific regions of the state most likely to present in the ED, and had a higher likelihood of an IP admission. Our stratification and predictive modeling process will be applied in a similar manner for AHCCCS; allowing us to identify the specific indicators of increased risk for BH crisis and ED use. We also actively outreach to members to complete our enhanced health risk assessment (HRA) as early as possible; identifying BH risks and diagnoses, as well as SUD, allowing us to refer at-risk members for follow up and engagement by our care management Team. This outreach ensures members are informed of available programs and encouraged to participate, and are linked with a primary BH provider (PBHP) or treatment programs. We also work with key providers, including hospitals, to identify frequent utilizers and high-risk members; including those who are homeless.

Network providers receive extensive training and continuing education in integrated management of PH-BH conditions. We have developed an innovative technology solution, **Magellan Virtual Care Solution (VCS)**, which contains a number of tools such as our apps for **SmartScreener™** and **Digital Cognitive Behavioral Therapy (dCBT)** platform available for use in provider practices. Providers also have access to BH telemedicine or phone consults through MCCAZ or contracted providers. Members have access to VCS, which is available on multiple platforms and can be used in a comfortable setting. dCBT offers clinically-validated virtual care that steps members through screening for depression, anxiety/panic/phobia, insomnia and sleep problems, OCD, chronic pain management, and SUD. Based on results of screening, the member is either directed to the dCBT platform, or referred for more acute services. We also offer an online resource library, online call center/online chat, access to telehealth, and provider search. In addition to VCS, members have access to BH telemedicine services. We also maintain a 24/7 Care Line with clinical staff trained in PH and BH conditions and with ASAM certification for substance use and supported by clearly defined protocols and training for escalating members in crisis. This early, proactive management of members allows us to engage members well before crisis to prevent an ED hold from ever occurring.

MCCAZ also incorporates VBP reimbursement to incentivize providers to screen and refer members for care; supporting early, appropriate treatment in less acute settings before a crisis. Providers are reimbursed for screening and treatment for SUD; including SBIRT (screening, brief intervention, and referral for treatment). As we gain data on member needs and provider treatment patterns, we move providers to shared savings and bundled payment programs (where appropriate) to maximize provider incentives to refer members to the best, most appropriate site of care. We educate and support providers in the use of alternative sites of care and in development of integrated practice models to increase availability of these services in the community. These efforts are supported by robust, ongoing programs of provider training and practice transformation support through our **Provider Support Specialists (PSS)**, who are licensed clinicians.

Preventing Member Crisis: Once at-risk members are identified, the MCCAZ care management Team focuses on rapid outreach (telephonically or in-person), engagement, education, assessment and development of an Individualized

Service Plan (ISP) to support treatment, recovery, resiliency and community tenure. Our community-based IHN care management Team and peer and Recovery Support Specialists, outreach to members identified as being at highest risk of destabilization and/or ED or IP use, to engage with an appropriate provider, assist in addressing any barriers to care, and connect them with community services and support. Our previous work in Arizona and Florida has clearly shown that connecting members with a regular source of appropriate care for PH and BH needs demonstrates they are less likely to be seen in the ED or experience an admission; resulting in a more than 20 percent lower rate of ED utilization. Our goal is to connect at-risk members with an IHH or similar integrated provider to engage them in ongoing treatment and recovery. Members are also educated on alternatives to using ED and IP services through our Member Handbook, member website, text reminders, social media, and through engagement with the IHN Care Management Team.

Identifying and Supporting Members in Crisis: MCCAZ's 24/7 Care Line identifies members in crisis allowing us to immediately connect the member to the appropriate level of care or emergency services. However, we recognize that not all members will call the MCCAZ Care Line. To increase the likelihood that we identify and divert members to a non-ED setting when appropriate, we have established relationships with providers and agencies throughout the state; building on our prior experience, understanding, and relationships in Arizona. These include contracted relationships with regionally-based Crisis Lines; allowing us to be notified when our members contact them. We will contract with Crisis Mobile Teams; working with local providers to establish Teams where they are not currently available. We will also work with BH-certified Community Paramedicine providers and selected police and sheriff's departments throughout the State. All are supported with hotline access to our Care Line as well as tele-consults to BH clinicians. We have established relationships with shelters and community organizations with regular contact with our members for education on how to access our services. Our goal is timely identification of members in crisis to support rapid assessment to direct member care to the most appropriate setting. Members are triaged and transferred to 23-hour Crisis Observation Centers or an IP facility if appropriate given their acuity. Members not transferred to a crisis or IP facility are flagged for next-day follow up by our Care Management Team to assist in securing treatment and to connect members with IHN outreach and a Recovery Support Specialist to address barriers to care; while establishing relationships with the member to support recovery. We also pull admission/discharge/transfer (ADT) information from the HIE on a daily basis to identify members not identified through other mechanisms, flag them for immediate follow up by care management staff, and conduct virtual daily rounds with primary hospitals, service providers, T/RBHAs, step-down facilities, crisis centers, and IP psychiatric facilities to identify open beds, manage open cases, and address ADT concerns.

Active Support of Members Referred for Care: MCCAZ has contracted relationships with Crisis Observation Centers throughout the State, and is working with providers such as Community Bridges, Inc., and ConnectionsAZ, Inc., in locations without those resources, to establish services. For members transferred to those facilities where they are available, the Crisis Observation Center is responsible for stabilizing the member, assessing need for additional treatment, referring the member, or transferring them to the step down level of care for a period up to seven days, until the member is stable enough to be discharged to home or OP treatment. Members brought to the ED receive triaging and screening by contracted Rapid Response Teams and secure transport service (CBI) or MCCAZ contracted BH-hospitalists. Our goal is to stabilize and transfer members out of the ED as quickly as possible to minimize excessive lengths of stay and quickly connect members with appropriate care. For individuals who originally entered the ED through an involuntary process and who are medically stable, we contract with credentialed Centers of Excellence (COE) providers to conduct in-hospital evaluations and recommend discharge or transfer. Rural and remote facilities have access to these same services through the use of telemedicine. If volumes warrant, we may also place care management staff on-site in high-volume EDs to identify and immediately begin transition of care, identify and link members with follow-up services, and assign to an IHH. Where available, MCCAZ will contract with Post-Crisis Navigators to support members through the discharge and transition process. All contracted hospitals have standing orders from MCCAZ, to notify Post-Crisis Navigators when our members presents in the ED. Where they are not available, MCCAZ transition of care staff coordinate the member's transition, scheduling of required follow-up care; connecting the member with a MCCAZ Recovery Support Specialist and peer support. Members may also be referred to a contracted Comprehensive Community Health Program (CCHP), referred to by SAMHSA as ACT or Assertive Community Treatment. CCHP offers services to members who are identified in the 1-3 percent of highest risk and complexity and would benefit from a suite

of services, including PH, BH, MAT, social and peer support, wraparound, transportation, counseling, housing assistance, SMI evaluation/referral, and SSI application. CCHP offers a bridge focused on coordinated entry/reentry, smooth transitions, optimal continuity of care, and access to OP services.

Reducing psychiatric hospital admissions (including out-of-state)

MCCAZ follows a "right service-right time" model for BH treatment, with a goal of ensuring availability of broad treatment options for members, and directing them to the most appropriate site of care to meet their needs. Whenever possible, our goal is for treatment in the community; however, we recognize that not all treatment options are readily available or appropriate for members in all regions of the state. We work with members, families, and providers to secure the most appropriate form of treatment or secure transport given their needs and circumstances. MCCAZ uses a number of approaches to reduce the use of out-of-state or non-contracted providers, including utilization management (UM) policies that require notification for all admissions, allowing us to stabilize and transfer members if appropriate. As part of our network development strategy we also review utilization patterns and attempt to contract with providers in border regions, and work with providers to expand evening and weekend access. Members are also educated about in-state options, as well as alternatives to IP treatment at all member touchpoints and in regular communications.

MCCAZ has established an expansive network, which includes alternatives to IP admissions including BH observation, OP, day treatment, partial-day treatment, substance use treatment, tele-psychiatry, CCHP, and dCBT, to encourage the use of the least intensive site of care and to reduce risks of member destabilization. Our Transition of Care Team works with members and providers to find IP alternatives to transition members back into the community. Where alternate sources of care are not available, we work with providers to establish treatment options. As a non-provider-based integrated health plan, MCCAZ has greater flexibility over where member's care is directed; placing member and family needs at the center of decisions about the site of care. We contract with IHH and other integrated care solutions, all at-risk members have access to integrated care management and we continually monitor both engaged and non-engaged members to identify rising risks which may indicate the need for additional care or CM intervention. Members with significant ongoing issues with high utilization may also be enrolled in our innovative **Integrated Behavioral Health Program (IBHP)**, established in our Florida plan. The IBHP, which is a collaborative member support program, pays providers an enhanced case rate/bundled payment to engage the member and address SDoH. The IBHP has resulted in a nearly 50 percent reduction in IP use and 40 percent reduction in ED use. Through **Magellan Whole Health Rx** we also monitor pharmaceutical usage, including poly-pharmacy, drug-drug interactions, and late-to-refill; all of which may increase the likelihood of destabilization. MCCAZ also encourages the use of long-acting-injectable psychotropic medications as well as Medication Assisted Therapy (MAT). Each of these interventions and supports are designed to limit the chance that a member's BH condition destabilizes to a point where an IP admission is required.

Increasing alternative community-based services

MCCAZ is committed to supporting continued transformation of the delivery system to provide increased community-based services. Through our previous experience with the T/RBHA, and our continuing delivery of BH services in Arizona we have gained a deep understanding of available services and key gaps that need to be addressed. Our Community Outreach Team assists with community assessments, determining gaps, and developing alternative community-based services that are needed. We are an active participant in the Arizona Council and continue to work closely with community organizations, agencies, and providers to support development of community-based services and alternate care sites. As an example, we will be working collaboratively with the T/RBHAs, other managed care organizations (MCOs), and providers to establish additional crisis centers to support unserved and underserved communities.

We will also work collaboratively and proactively with AHCCCS and Treat and Refer Community Paramedicine Providers; as well as EMS, fire departments, and local law enforcement to expand the availability of certified providers, including those with BH certification. We currently contract with those providers and will continue to expand that contracting as services become available. We are also very excited about the potential for collaboration with the State Department of Health Services, Phoenix Fire, and local providers in their pilot of a new approach for opioid services. The approach for this pilot parallels and supports MCCAZ's approach for early identification and targeting of at-risk members. By combining early identification with hot-spotting of communities at higher-risk and aligning providers and support services with those communities, we take a proactive, population-based approach to combatting the opioid epidemic

together. Through the IHN approach, MCCAZ targets these communities through increased education, outreach, and community engagement. We recognize it "takes a community" to address SUD, and intentionally collaborate with community partners and stakeholders. This requires significant expertise and an array of service choices and evidence-based practices delivered in an integrated, member-centric approach. We have built networks and support services to meet these needs. Our 360-degree approach brings together our comprehensive PH/BH experience, integrated pharmacy benefits management, expanded models of member self-direction, and expertise in specialty healthcare to deliver solutions that positively impact quality, access, availability, and cost.

MCCAZ works collaboratively with our provider partners to develop integrated PH-BH solutions that support broader availability of community-based treatment options. We provide practice development and transformation support for providers interested and capable of developing integrated solutions, including IHH and similar collaborative care solutions. As we gain more experience with our members and knowledge of their needs, we also look to establish a facility-based solution (IBHP) that integrates all member care, including substance use treatment, in a single site of care that includes intensive, integrated care management. These programs may be located at a number of types of facilities and greatly expand the potential for participation by different types of providers. Both the IHH and IBHP models are built around VBP reimbursement models that include incentives (including shared savings) to reduce preventable events and increase utilization of lower acuity services.

Monitoring and managing follow-up care

MCCAZ's transition of care programs are an integral element in our overall system of care, supporting member transitions from one site of care to another, or their return to the community. Through our use of the existing network of Post-Crisis Navigators and our own IHN and Care Management Teams, we actively engage members and providers in planning and managing the member's post-discharge care. This also includes use of MCCAZ Recovery Support Specialists, a model we developed for our Florida plan, which has demonstrated a more than 50 percent decrease in total costs of care for engaged members. If the member has an active relationship with an IHH or other PCP, we support the member in arranging required follow-up care and for attending required appointments. For members who may be in the continuity of care period of transitioning into the health plan, we will work with the member and their provider(s) to ensure seamless transitions; including entering into contracting arrangements with a member's non-par provider if needed to support continuity of care. If a member does not have a relationship with an existing BH provider, we work with the member to arrange that care or connect them with an IHH. For members distant from available services, or who may feel more comfortable and secure in their own home, we offer telemedicine services for appropriate levels of follow-up care. MCCAZ also offers providers use of an innovative technology-based solution called **PsychTrac™** to monitor and manage treatment post-discharge. PsychTrac technology provides treatment professionals with tools to interact proactively with members through a patient-facing mobile platform; allowing them to gather key behavioral and diagnostic information about members in a readily available and cost-effective way. As issues are identified, the provider can intervene directly with a client via any mobile phone to provide clinical tasks, reminders, and track follow up. Much in the same way a diet program tracks food and exercise, PsychTrac monitors the patient's activity, allowing providers to monitor behavioral interventions or course of therapy.

Through our VBP program, providers are incentivized to complete timely follow-up care. We monitor performance as part of our quality management programs. Through ongoing care analytics and predictive modeling, we continue to monitor members for indicators that may suggest potential for destabilization; such as lack of timely follow up and unfilled or late refill of medications. These events trigger alerts for our Care Management Team to follow up with the member; including through our Certified Peer Support Specialists or **Community Outreach Specialists**. If the member is registered on our member portal, they also receive reminder messages. Our goal is to limit the chance for an ED hold to ever occur by increasing member resiliency, recovery and community tenure, and delivering care at the right time in the right setting. We believe our fully-integrated system of care focused on total member health and innovative services, will accomplish that goal – allowing us to significantly reduce the incidence of ED holds and ED utilization.

11. Ensuring development of a comprehensive specialty and behavioral health provider network

Magellan Complete Care of Arizona's (MCCAZ) goal to ensure development of a comprehensive specialty and behavioral health (BH) provider network is to work with providers to ensure every member receives the very best in health care services. We deeply value our provider partnerships and have developed meaningful relationships to support them in the care of our members. Our network strategy begins with a firm commitment to collaborating with providers to create programs and policies that are fair and simple; so that providers can stay focused on what they do best – caring for their patients, our members.

For more than 20 years, Magellan Healthcare (Magellan) has worked collaboratively with Arizona healthcare providers to deliver services to a variety of Arizona Medicaid populations and health plan members; including many vulnerable children and adults with complex physical health (PH) and BH needs. Magellan of Arizona established an all-inclusive integrated care network of BH providers for children and adults beginning in 2007 as the Regional Behavioral Health Authority (RBHA) for Maricopa County. Magellan's comprehensive network of organizations, facilities, and individual service providers established the foundation of a one-of-kind system for ensuring simple access to care, collaboration with provider partners, and continual improvement for individualized and well-coordinated health services.

> Similar to the focus for reducing fragmentation of behavioral health and acute services in the AHCCCS Complete Care Program, the State of Florida selected Magellan Complete Care of Florida to develop a comprehensive network of specialists and behavioral health providers as part of the nation's first Medicaid health plan, specifically designed to fully integrate services for individuals with serious mental illness.

Given the complex needs of our members, our network extends beyond traditional facilities, clinics, and practitioners to include community advocates, peer and professional support organizations, specialty pharmacies, and families/caregivers. **Our considerable network of contracted hospitals, specialists, ancillary, and BH providers will serve as the basis for MCCAZ's network of providers for exceeding adequacy and accessibility requirements in advance of our go-live for the AHCCCS Complete Care Program.**

Nationally, for more than 20 years, Magellan has been a leader in partnering with state Medicaid agencies to improve access to high quality specialty and BH services. We have built and continue to manage fully-integrated health plans and provider networks for our Medicaid and Medicare Advantage D-SNP health plans throughout the country. Across Magellan, we manage pharmacy, physical, specialty and BH networks that serve more than 57.9M members. For many years, health plans in other markets have contracted Magellan to manage specialty and BH services based on our ability to successfully build accessible and effective provider networks. **Given our existing Arizona network, our deep knowledge of the needs/challenges facing AHCCCS populations, and our proven local and national experience building networks for children and adults requiring complex PH and BH services, we are uniquely positioned to deliver a comprehensive and effective provider network solution to accelerate the transformation of the healthcare delivery system in Arizona.**

Ensuring development of a comprehensive provider network of specialty and behavioral health providers

Delivery of quality healthcare to AHCCCS members is dependent on a diverse, comprehensive, and competent network of acute care hospitals, children's hospitals, BH providers, social support providers, and specialists (including but not limited to endocrinology, dermatology, orthopedic surgeons, nephrology, gastroenterology, cardiology, oncology, OB/GYN, allergy, specialized healthcare providers for medically fragile and chronically ill infants, children, young adults, and an array of pediatric specialists and sub-specialists).

Our locally-based Network Teams work collaboratively with providers to ensure that covered services are accessible, person-centered, and evidence-based and spans the full spectrum of services. Our Network Development Team is responsible for establishing our provider network; contracting negotiations; ensuring network adequacy at all times for each GSA; monitoring provider gaps; ensuring provider disruptions do not effect member access to care; and creating innovative contracting strategies such as value-based contracting and successful onboarding.

We are currently expanding our existing network to establish and maintain a provider network of specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution, to meet the unique needs of AHCCCS Complete Care members without excessive travel requirements.

Our network solutions and approaches to a comprehensive delivery system are built on the belief that:

- Member choice must be maximized when selecting providers for their healthcare; including location, gender, and cultural, as well as more subtle aspects of rapport, trust, mutual respect, and shared values
- Healthcare is delivered locally; therefore we account for the unique patterns in which members in urban and rural communities seek care; and how providers manage their patients
- Accountability and transparency, by both payer and provider, drive improved outcomes throughout all parts of the delivery system
- High touch provider relations supports the development of strong, lasting relationships with providers that affect positive outcomes for members
- Local Teams dedicated and focused on network development and provider engagement are agile and effective, and provide more than transactional support.

Network Strategies: Ensuring member choice and access to high-quality healthcare across the full continuum of services is at the core of our network development strategy. In developing our overall network strategy, we take a holistic approach that includes our medical, clinical, quality, and operations staff, and leverages community-specific knowledge gathered from our **Integrated Health Neighborhood℠ (IHN)** to develop a comprehensive Network Development and Management Plan**.** Central to the Plan, is an understanding of what we are truly working towards; a comprehensive system of care that is centered on the member and the member's needs. As we continue to build out and enhance our specialty and BH network, we employ the following key elements as shown in **Table 11-1**.

Table 11-1. Key Elements to Optimize and Maintain our Provider Network

Component	Key Elements of Optimize and Maintain our Provider Network
Assess	▪ Assess estimated number of members served in each GSA, county, and community ▪ Evaluate expected utilization of services taking into account the unique characteristics and health care needs of specific sub-populations among potential members ▪ Analyze demographics, cultural, language, race, and ethnicity ▪ Analyze geoaccess coverage of additional specialties needed for AHCCCS Complete Care Program covered services and identify any network gaps
Identify	▪ Identify all additional providers currently delivering Medicaid services across all of the GSAs
Engage	▪ Recruit qualified providers for all specialties through proven recruitment and contracting strategies ▪ Encourage current providers to expand office hours and service offerings to increase access, and introduce innovative engagement and accessibility processes ▪ Leverage and expand existing relationships with providers, facilities, and statewide associations for specialty access
Monitor	▪ Monitor current network against targets based on business analytic tools to monitor and ensure coverage and choice based on membership characteristics ▪ Review metrics, including distance/time access standards, timely scheduling of appointments, hours of operation, panel capacity, and wait times ▪ Incorporate IHN learnings to refine and inform network composition ▪ Evaluate cultural, language, race and ethnicity characteristics of the population served relative to the network ▪ Review member and provider satisfaction surveys to analyze satisfaction related to access

The MCCAZ network development strategy delivers a system of providers that extends beyond routine network accessibility. Our network design considers the unique needs of our members, understands where and how members seek care, and leverages the unique service and provider options of Arizona. We will implement specific strategies to include the following in **Table 11-2**.

Table 11-2. Strategies to Deliver Adequate System of Providers

Strategies	Example
Incorporating the Arizona State Hospital (ASH) in the network	MCCAZ has leveraged its experience with ASH to enhance admission protocols and discharge/transition planning, including psychiatric and forensic members.
Developing a robust network of providers focused on serving: ▪ Members with PH, BH, social and emotional health care needs ▪ Members of all age groups with developmental of cognitive disabilities ▪ Specialized providers of excellence to offer a continuum of care for members with complex care needs ▪ Transition aged youth, and members experiencing substance or sexual abuse ▪ Individuals needing dialectical behavioral therapy (DBT) services ▪ Children under the age of 5	MCCAZ's high value network emphasizes these specialty providers critical to ensuring continuity and holistic care for members with complex developmental and BH issues: ▪ Primary Care ▪ Obstetrics & Gynecology ▪ Ear, Nose & Throat ▪ Allergy & Immunology ▪ Cardiology ▪ Dermatology ▪ Endocrinology ▪ Psychiatry ▪ Infectious Disease ▪ Behavioral Counseling
Targeting engagement and partnership with Multi-Specialty Interdisciplinary Clinics (MSICs)	MCCAZ recognizes the unique role the MSICs play in serving CRS kids and has multi-state experience working with this population, including AZ.
Working with housing organizations and homeless clinics	MCCAZ has administered, partnered, and collaborated with housing organization/clinics in multiple states, including AZ.
Facilitating programs and services within the American Indian Health Program and engagement and partnership with Native American providers	MCCAZ will leverage existing relationships to partner and develop collaborative protocols with the AIHP and NA providers. We have already been outreaching and discussing our unique model of care with these entities.
Contracting and expanding our partnerships with peer run and family run organizations that support BH needs and community wellness	MCCAZ assists with the development and stabilization of the peer and family run organization in Arizona and has expanded this best practice in other markets.

We will also engage in focused workforce development activities within the local BH community and medical providers, including:

- Develop strategies for Community Health Workers will be broadened and locally driven in Arizona
- Implement the **Magellan Apprenticeship Program (MAP)** in Arizona; recently launched in our MCC of Florida program, focused on developing additional skill sets for peers and readying them for the workforce
- Develop strategies and relationships with specialty providers focused on addressing the Social Determinants of Health (SDoH) in communities within the GSA's
- Investigate opportunities for resident participation in our medical management and committee activities, leveraging the existing Graduate Medical Education (GME) Residency Training Programs currently operating in Arizona.

Advancing the Delivery System: MCCAZ believes that ongoing provider support fosters healthcare integration at the system and service level by ensuring collaboration and communication with all providers and caregivers across the member's entire care continuum. We offer an integrated, high touch provider relations and network management model that offers a hybrid of onsite, personalized support within each Arizona GSA, as well as virtual and technology-based support capabilities. Our staffing model includes dedicated local Provider Relations Managers (PRM) and **Provider Support Specialists (PSS)** organized for each AHCCCS Complete Care GSA to ensure real-time, personalized support access. The PRM serves as the primary contact to providers and manages the overall support needs of their region. This includes the management of provider issues and concerns to ensure they are addressed in a timely manner.

We track provider issues and concerns through Sales*F*orce and use this information to inform training opportunities and internal process improvements. To further support providers, MCCAZ has designed a unique provider support model using PSS. Our knowledgeable PSS are licensed clinicians, live and work in communities throughout the state; with their primary responsibility to provide onsite support in provider offices. Using the principles of practice facilitation, the PSS leverage their clinical and public health knowledge, along with their deep understanding of the neighborhoods they serve to provide consultation, training, and technical assistance to help providers improve the quality of care and develop integrated care solutions.

Using a broad set of tools and reports, the PSS role includes the following:

- Assesses the provider's practice to determine their level of integration and build plans to facilitate practice transformation as providers move towards a fully-integrated healthcare practice
- Works with provider groups to improve quality, outcomes and efficiency, and to adopt evidence-based practices for individuals with co-occurring disorder
- Assists with facilitating the relationship between PH and BH providers
- Works with providers to transform data into actionable information at the practice and member level (e.g., over- and under-utilization, pharmacy reports, gaps in care, and quality)
- Trains providers and their staff on the special needs of the Medicaid population, best practices, screening tools, etc.
- Establishes a Learning Collaborative to engage all network providers in important topics for the Arizona Medicaid population, including techniques for the delivery of integrated care.

Areas of concern and MCCAZ solutions to overcome these challenges and ensure accessibility

In Arizona for more than 20 years and having implemented and currently operating integrated health plans in other States, Magellan has a keen understanding of the network contracting issues and the associated accessibility challenges that exist. In our planning and evaluation of the Arizona delivery system today, we identified specific areas of concern and preliminary strategies and solutions to ensure accessibility for all members. When developing our network in rural areas there may be a lack of providers. To address this, MCCAZ will use a variety of providers to fill any gaps; including temporary providers, nurse practitioners, physician assistants, and urgent care centers with rotating PCPs. These providers are critical when community health clinics experience high caseloads and long patient wait times when trying to make up for this critical practitioner shortage.

Also, Magellan has developed an innovative technology driven suite of tools that supports system transformation to bridge this shortage, augmenting our telehealth platform by contracting locally with rural providers who utilize mobile services to access hard to reach members to promptly address gaps in accessibility. **Magellan Virtual Care Solution (VCS)** provides individualized treatment in a virtual care environment. Magellan's VCS platform (in its third generation and designed by clinician/researchers for clinicians and patients), improves access to care and drives consumer engagement through a virtually-organized, multilingual ecosystem of digital health tools, integrating tested and proven online clinical programs, such as:

- **SmartScreener™** app to screen for common BH conditions, substance abuse, and insomnia
- **Digital Cognitive Based Therapy (dCBT)**, providing online and app-based cognitive therapy for depression, anxiety disorders, substance abuse, chronic pain, and insomnia
- **Clickotine™**, an app-based smoking cessation tool
- **ClickHeart™**, an app-based program for persons with heart disease
- Mobile member portal, which contains messaging, Rx information and reminders and member education capabilities
- Live Chat with a clinician to address urgent issues and receive coaching.

These digital health tools are packaged in a seamless user experience. The solution is designed to provide proactive early interventions to reduce escalation to higher levels of care. VCS integrates with our care coordination/care management programs to provide highly effective, evidence-based care. These innovative technology driven tools allow providers to "prescribe" digital therapies to members to be leveraged through applications that are accessible through cell phones, tablets, and other personal computing devices.

The VCS tools assist members with access to treatments on their schedule and in a setting of their choice, and also assists with provider access issues. This solution results in network providers being equipped with an additional innovative treatment option to add to their cadre of treatment approaches. **Table 11-3** shows other areas of accessibility concern with accompanying mitigation strategies.

Table 11-3. Areas of Concern and Mitigation Strategies

Areas of concern	Mitigation Strategies
System fragmentation	▪ Deploy full integration of care to avoid duplication of services ▪ Expand Integrated Health Home, co-location, "reverse" co-location, and virtual co-location ▪ Offer technology solutions to enhance/expedite coordination and increase access to therapies; utilize VCS ▪ Develop financial models to incent/encourage integration
Behavioral health access across all populations	▪ Offer an expansive network of BH and community BH providers ▪ Leverage our IHN approach ▪ Promote screening tools within primary medical care to identify and access BH needs ▪ Leverage technology solutions, PCP Referral line, PCP Tool Kit, and utilize VCS
Physical health specialists accessibility, especially in rural areas	▪ Deploy robust network recruitment and development ▪ Utilize VCS where providers are able to "prescribe" digital therapies to members through cell phone and tablet applications ▪ Leverage mobile and web-based specialists ▪ Analyze population health-based provider data and detailing ▪ Create Centers of Excellence for complex conditions (sickle cell, diabetes, etc.) ▪ Expand hours of current participating provider ▪ Encourage participating providers with closed panels to re-open their panel
Treatment of children with complex needs (BH, autism, child welfare involvement)	▪ Develop Centers of Excellence ▪ Engage family support partners ▪ Utilize VCS ▪ Partner and expand school-based programs ▪ Collaborate with other systems (Arizona's DCS specifically)
Providers unwilling to serve Medicaid members	▪ Offer flexible network design to allow for specialists/needed services on ad-hoc basis ▪ Align incentives and value-based reimbursement ▪ Monitor continuous network development and refinement for specialized providers ▪ Enact simple and fair administrative processes for providers and their staff
Providers unfamiliar with managed care and integrated care environment	▪ Offer orientation training to address start up and/or transition issues ▪ Train and educate; online and in-person ▪ Engage and partner with our PSS ▪ Encourage use of provider services hotline ▪ Offer informative website with provider-friendly tools

MCCAZ has successfully demonstrated an ability to build and manage comprehensive specialist and BH networks when implementing fully-integrated Medicaid and Medicare Advantage health plans and provider networks across the country. Magellan of Arizona established an all-inclusive integrated care network of BH providers for children and adults beginning in 2007 as the RBHA. Given our existing Arizona network, our deep knowledge of the needs/challenges facing AHCCCS populations, and our proven national experience building networks for children and adults, **we are poised and ready to expand our existing statewide provider network to create a single system of care to deliver efficient, coordinated, and high quality healthcare that promotes accountability in healthcare coordination and member choice**.

12. Effectively managing provider relations and communications.

Magellan Complete Care of Arizona (MCCAZ) has in place **well-established and proven processes and systems to effectively manage provider relations and communications**. Our goal is to work with providers to ensure every member receives the very best care. We deeply value our provider partnerships and have developed meaningful relationships to support them in the care of our members. MCCAZ firmly commits to our continued efforts to improve the provider experience through a high-touch provider engagement model that is designed to streamline provider management processes. We maintain an executive commitment and an effective staffing model to support this commitment to our network providers.

Our integrated provider engagement model offers a hybrid of onsite, personalized support within each Arizona GSA; as well as virtual, self-service, and technology-based support capabilities. Our practice is that a provider engagement model fosters healthcare innovation, integration, community inclusion, and collaboration with all providers and caregivers across the member's entire care continuum. MCCAZ embraces system transformation. We believe that healthcare providers are essential partners in the delivery of integrated healthcare services**.** Our providers are in fact the foundation of our **Integrated Health Neighborhood℠ (IHN)**; consisting of our locally-based Care Management Teams designed to meet the PH and BH needs of the whole person and the overall delivery of quality care services to our members.

Under our 2007 Maricopa County RBHA contract, we collaborated with providers, AHCCCS health plans, community partners, and all key stakeholders to establish protocols and processes to effectively manage provider relations and communications; which we continue to maintain today. Our broad experience in provider relations extends through various healthcare programs and includes physical health (PH), behavioral health (BH), and integrated health networks. As we have built complex integrated networks across the country, we have identified tried-and-tried approaches to effectively management provider relations and communications – our network infrastructure design is one of them. We value our providers and understand the challenges they experience during this time of transformation of the delivery system.

Provider Support Specialist (PSS) Team: Our dedicated PSS Teams proactively engage and respond timely to provider inquiries, concerns, and issues. We recognize that each GSA and community presents unique provider compositions and variations for how members seek health care services. Our locally-based PSS Teams deliver a comprehensive support system for engaging key providers and associations; including the Arizona Alliance for Community Health Center, Arizona Hospital Association, Primary Care Association, and Arizona Council for Human Service Providers. The Teams are comprised of individuals with extensive experience in contracting, value-based transitioning, claims and billing, and importantly the expertise to successfully foster relationships with providers and their staff.

Testimonial from Sally Leonard, Federally Qualified Health Center

"The Provider Support Specialist's (PSS) role has helped us…educated us…and responded timely to internal issues. The PSS truly makes for a better working relationship with the health plan, than a plan without it."

Network Development Team: This Team is committed to building strong collaborative relationships with providers and their staff. Our Network Manager serves as the primary contact to providers and manages the overall support needs of their GSA; including the management of provider issues and concerns that are addressed in a timely manner. We rely on our Team approach to effectively communicate and operate in a manner that increases provider satisfaction. The Network Development Team includes the position of a Sr. Network Director, responsible for the Contracting Specialist, Network Management Specialist, Reporting Analyst, Credentialing Director, and Credentialing Specialist. The Team is responsible for establishing our provider network; contracting negotiations; ensuring network adequacy at all times for each GSA; monitoring provider gaps; ensuring provider disruptions do not effect member's access to care; and creating innovative contracting strategies, such as value-based contracting, and onboarding.

Provider Relations Team: This Team includes the positions of Provider Relations Sr. Manager (PRM), Provider Relations Liaison, and PSS, Provider Claims Educator, and Tribal Coordinator. This Team is responsible for proactively engaging providers and internal staff (e.g., PSS such as our Tribal Coordinator and Provider Claims Educator), conducting provider

meetings, going on regular field visits, educating providers, conducting outreach, and maintaining practice profile information.

Our field-based PSS role has been a unique differentiator among our provider partners. The PSS are clinicians who work side-by-side with our provider practices to assist with the implementation of integrated care models and capacity building to improve the quality of care for our members. Using the principles of practice facilitation, PSS leverage their clinical and public health knowledge; along with their deep understanding of the neighborhoods they serve to provide consultation, training, and technical assistance to help providers improve the quality of care and develop integrated care solutions.

Testimonial from Vivian Roberts, Rural Health Network

"As I have said, the biggest issue for us has been trying to understand which services we offer require prior authorization and which do not; as well as how to access drug formulary information…for our members. Having you [the PSS] come down and meet with us, showing us how to access this information on the portal, made it so much easier for us…thank you so much!"

Testimonial from Jennifer Grow, Community Mental Health Center

"I am working to collect payment on all our claims being denied from all Medicaid HMOs. Magellan is the most helpful when I have a question about our claims. Thanks to Corey, Malerie, and to your PSS Team for prompt attention to this issue. Hope for your continued support and assistance; we really appreciate it."

Our PSS work to improve outcomes and adopt evidence-based practices, facilitate relationships between PH and BH providers, transform data into actionable information, and support value-based purchasing (VBP) initiatives. They conduct initial assessments of readiness for adoption of integrated models and develop detailed plans with the providers to move forward toward integration. Our PSS offer a clinical background that fosters a Team approach to member care to assist with any care coordination or navigation issues that may arise. Additionally, PSS play a key role in assisting providers with any referral and authorizations that may be required during or after the continuity periods to ensure seamless coordination and approval for appropriate service. **The unique role of the PSS is evidence of our commitment to further the transformation of the delivery system in Arizona**.

Provider Trainings: The **Magellan Learning Alliance (MLA)** is a central hub for all provider training related activities—a training ecosystem to ensure provider success and increase provider engagement. This multi-module training hub creates a central point of access for all training and is designed to ensure all federal and state requirements are met. Training modules include provider orientation, model of care, claims processing, quality improvement, care coordination, stakeholder engagement, care management, cultural competency, and member services.

Training is delivered in a variety of formats including instructor led training, online courses, customized technical assistance, coaching and modeling, community-based education, printed resources, and self-study alternatives. The MLA offers a full range of integrated health, PH, BH, and MCCAZ health plan process trainings to our provider network. We have additionally earmarked technical training, support and guidance for the Targeted (TI) Investment Providers to further their success in their areas of concentration. MCCAZ offers onboarding training for our providers at or before the start of their contract.

In addition, we offer regional onboarding where multiple providers can attend our sessions that are also available via webinar. The Team meets with providers and staff onsite to ensure proper onboarding and successful navigation within the program. This process includes a review of key system configuration for appropriate claims adjudication and prior authorization process. Providers and their staff are encouraged to use our online tools and resources to decrease errors in their claims and prior authorization submissions. Additionally, we consider changes to program requirements and incorporate provider, member, and community stakeholder feedback.

Listening and Communicating*:* The ability to communicate and connect with providers and health care professionals builds strong trusting relationships; encourages transparency and accountability; prevents mistakes and errors, which disrupt providers and their practices. We value and encourage opportunities to listen and understand the perspectives and experiences of our providers. We strategically employ multi-channels of communication with our community of providers and all stakeholders in the delivery system, this enables providers to utilize the tools and support to deliver a high level of care for our members. During implementation of the AHCCCS Complete Care Program, we will intensify our

communication and outreach by field-based Teams to ensure providers are equipped and prepared to administer the program, including the following.

- **Our Employees:** We believe that listening and communicating is the responsibility of every employee from member services to our senior leadership. We strive to build a culture of learning and continuous improvement that encourages sharing of information within our Teams. We recognize the opportunities to be proactive about an issue before they escalate and often times these moments are in the daily communication between our Customer Service staff and a provider's office. For example, our Call Center Managers round on the floor with our Call Center staff to review our call dispositions and engage employees real-time in solutions to improve provider relations.
- **Our Tools*:*** We share and disseminate information to providers and delivery system stakeholders through provider portals, newsletters, our website, webinars, Twitter, Facebook, and Fax blasts. Our provider website offers online/ongoing support and includes the provider manuals, newsletters, forms, clinical guidelines, and other support resources. Our secure portal offers self-service tools to ease the administrative burden for providers. Providers have access to our Provider Services Call Center where they can receive immediate support and response. We also administer provider surveys to measure satisfaction and areas of improvement.
- **Our Connections:** We design communication to foster two-way interaction in order to improve engagement, build strong partnerships and receive feedback on our performance. In Arizona, as we have in the past and in our current states, we will keep communication open; connecting with the provider community through the use of provider forums, advisory boards, in-person trainings, face-to-face meetings and Town Hall events. We connect providers with other providers and community resources; this builds stronger relationships and networks while fostering a culture of collaboration.

Monitoring Resolution, Transparency and Accountability, and Monitoring Best Practices: MCCAZ utilizes advanced technological systems that store, quantify, and categorize network provider information, communication, and data. Our network staff document their interactions with providers, which includes issues, notes, and status in a HIPAA compliant Customer Relationship Management (CRM) called Sales*F*orce. Our Provider Relation's Team utilizes Sales*F*orce to assign and track daily tasks including preparation, planning, research, outreach, and follow up. Sales*F*orce includes data about our network providers, including groups, contacts, practice profile, meeting agendas, and minutes. Additionally, our call center receives and dispositions all provider calls within our care management system. Our process makes it possible for any of the Team to provide the same quality of service to our providers by having access to the same provider data; which lowers the risk of miscommunication. If our providers experience a problem that needs resolution, we can quickly retrieve all available activity concerning past communications that might assist the Team in finding an expeditious solution.

We strive to build processes that provide transparency and accountability with our provider network. Our CRM and care management platforms, added to our robust analytical tools, provides reporting, scorecards, and metrics for operations and clinical outcomes. All data is aggregated for reporting to analyze trends and patterns. Outliers and emerging issues related to a particular provider or a particular set of circumstances is identified. Our PSS Team proactively visits with providers and shares data and reporting during their visit; allowing for meaningful dialogue about performance and outcomes.

We also establish Joint Operating Committees (JOCs) in collaboration with high volume providers as a preventive measure and opportunity to collaboratively hold accountability. Our JOCs also include Physical Health Operating Committees, Integrated Operating Committees, and Behavioral Health Operating Committees. We focus on opportunities to address and resolve contractual concerns, operational challenges, and areas to support the transformation of the delivery system. JOCs are further designed to increase provider relations, eliminate unnecessary delays in member care and associated costs, and maintain member outcomes and satisfaction.

The provider relation meetings are cross-functional, by design, and incorporate representation from our member services, appeals and grievances, Medical Directors, care coordination, utilization management, claims, quality improvement, compliance, and legal departments. We conduct monthly and quarterly JOC meetings with our network hospital systems, delegated subcontractors, vendors, and multi-specialty provider groups as well as clinics, facilities, and high-volume practitioners, which include members of our Senior Leadership Team. The agenda for our JOC meetings

may include immediate and relevant issues at hand, discussions with the provider community, concerns, and functional considerations in order to increase communication, offer transparency and accountability to providers, and to establish rapport in future partnership initiatives.

Our monitoring approach also includes the identification of "what is working well". As the PSS Team meet regularly, they share challenges and identify interventions to improve our provider's satisfaction. The Team monitors their interventions and systematically looks for what is working well to leverage across the system. When a "Best Practice" is identified, we formalize the process by designing protocols, communicating the new process, implementing approaches with continuous monitoring. One strategy that we instituted as a best practice was our effort to align PH and BH providers and foster collaborate relationships. We directly facilitated engagement and provider-to-provider communication to link providers to close fragmentation and improve care with specialists; such as psychiatrist and primary care providers.

Minimizing provider complaints, contracting issues, prior authorization and claims concerns.

We leverage our many years of experience to proactively build relationships and systems to minimize provider issues. We are committed to listening to providers, timely resolution of issues, and process improvement to ensure a better experience for the provider and ultimately our members. **Table 12-1** outlines our solutions to effectively manage provider relations to reduce provider complains, contracting issues, prior authorization and claims concerns.

Table 12-1. Solutions for Effectively Managing Provider Issues

Issues/Concerns	Solutions
Provider complaints	▪ Collaborate and proactively resolve issues by the PSS Team ▪ Track and trend areas of concern and improvement ▪ Use an onboarding and checklist process to provide accurate information to minimize errors ▪ Train and educate providers on service integration and care coordination ▪ Share information through our technology tools to prevent miscommunication ▪ Institute best practices to reduce complaints ▪ Use the Quality Improvement Committee to resolve complex or multi-faced issues ▪ Review results of provider satisfaction surveys and incorporate feedback ▪ Employ self-monitoring and self-correcting to improve relations ▪ Promote health information exchange for improved communication
Contracting issues	▪ Consider PH and BH care needs of members during contracting practices ▪ Demonstrate flexible provider contracting and ease-in-use credentialing tools ▪ Work toward resolving and finding solutions that meet the needs of all parties by the Network Contracting Team ▪ Bring concerns (proactively) to the Network Contracting Team by PRM and PSS ▪ Use Contract Specialist role to include initial set up of contracts in the system to avoid future issues ▪ Assess complaints through tools and data to avoid contracting issues ▪ Monitor network adequacy to support provider referrals and promote continuity between PH/BH ▪ Anticipate and solution around contracting barriers and challenges through weekly meetings ▪ Address and resolve administrative, procedural, and contract issues at JOC
Prior authorization (PA) concerns	▪ Encourage electronic submission to the provider portal ▪ Review PA list and refine as needed ▪ Leverage PSS to work with internal Utilization Management (UM) Team to resolve PA concerns ▪ Employ UM Team to use evidence-based clinical best practice guidelines and policies to ensure timeliness ▪ Use dashboards by PA staff to manage workload and accountability ▪ Use internal monitoring processes ▪ Leverage functionality of integrated care management systems to ensure timeliness ▪ Use concurrent review processes

Issues/Concerns	Solutions
	▪ Deploy QM audits ▪ Streamline UM workflows
Claims concerns	▪ Offer an enterprise-wide, integrated MIS suite that updates claims information real time ▪ Use nationally recognized claims editing software that identifies concerns at the code level and makes the appropriate denials and/or carve out upon claims adjudication ▪ Use Claims Educator for 1:1 support onsite and/or live web support to troubleshoot claims issues directly ▪ Dedicate Claims Support Team to ensure regular monitoring ▪ Provide direct claims submission option through our provider portal ▪ Encourage use of electronic funds transfer ▪ Host monthly JOC meetings for issue identification ▪ Offer initial and ongoing provider orientation and training programs with dedicated curriculum to support timely and appropriate billing by providers ▪ Provide live training, webinars, and virtual training through the provider portal on our website

Helping Providers through the Transition: Transitioning to a managed care program can be difficult for providers, particularly for specialists and BH providers. For some practices, the AHCCCS Complete Care Program may create administrative and operational challenges that can seem daunting and overwhelming. Magellan of Arizona has a proven track record of working successfully with providers to implement integrated programs. In Arizona, we have experience working with AHCCCS and providers to implement new programs such as Integrated Health Homes. In New York, Magellan assisted providers during the launch of the Duals Demonstration; a capitated model to integrate care while aligning Medicaid and Medicare financing for dual eligible beneficiaries. In Florida, we led providers through a paradigm shift of integration as we launched the nation's first Medicaid health plan for serious mental illness.

From our experience, we understand the business challenges facing providers and their staff. We understand the hesitation and concern related to significant change. We have developed simple, streamlined processes and educational programs to help providers understand the key elements of managed care. A critical component of helping providers through the transition is a series of orientation forums addressing start up issues including continuity of care procedures. We provide targeted training for specialists and BH providers that address various facets of managed care and their practice. For example, accurate and timely payments are always critical to providers, but even more important when first working with a health plan. We conduct regular claims training sessions for the first 12 months following implementation and provide ongoing claims training as dictated by the needs of the provider network throughout the life of the Contract.

In addition to these training sessions and resources, we have expertly trained staff who interact with providers frequently. We have developed a "Frequently Asked Questions" guide to help answer provider questions and clearly explain the benefits of managed care. Also, providers can call our Provider Hotline or find helpful information on our provider website.

Transforming the health care delivery system requires closer alignment and strong relationships with our providers. With our experience, we understand the challenges providers face during these transformative and evolving times. We are committed to operate in a manner that is efficient and effective for the provider community and AHCCCS.

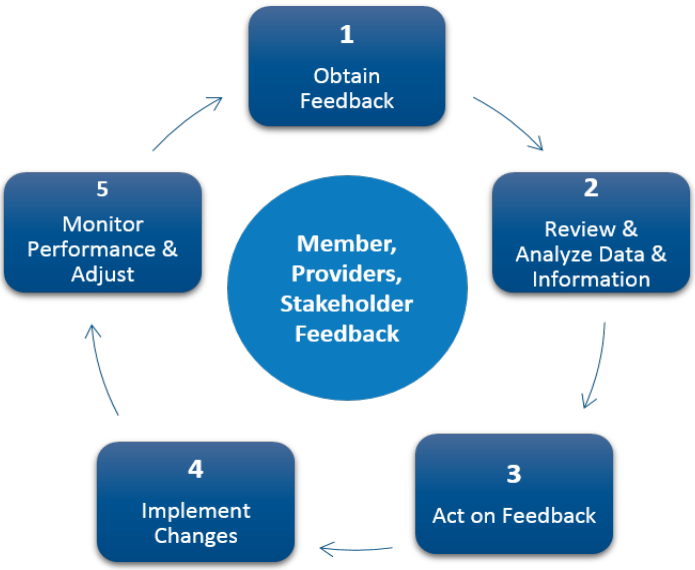
13. Effectively obtaining and utilizing member and provider feedback.

Magellan Complete Care of Arizona, Inc., (MCCAZ) understands the importance and value of member and provider feedback and has integrated mechanisms to evaluate our performance, improve our processes, and enhance member and provider experience. Our Teams are passionate about delivering care under the guiding principle of engaging members and providers at all system levels. We welcome and encourage member and provider feedback as part of our continuous quality improvement approach.

Offering opportunities for voice and participation is how we do business; in fact in 2007, **we created the first Governance Board** as the Maricopa RBHA. This board was comprised of (1) 50 percent community stakeholders, plan members, family members, and providers, and (2) 50 percent Magellan of Arizona staff. The primary goal of the board was to move beyond advisory and invite members and providers to have a seat at the table to impact change; which resulted in several impactful changes based on their feedback. MCCAZ continues that tradition and approach as we strategically seek feedback on new initiatives, proactively seek opportunities for improvement, and apply lessons learned from areas in need of improvement. MCCAZ will institute a Governance Board structure, as well as strategically seek feedback for improvement through multiple channels.

We have a formal structure and approach for obtaining and utilizing member and provider feedback. Our approach is based on the "no wrong door" philosophy as everyone plays a role in obtaining feedback; starting with our Teams from Member Services call center, peer support, network, appeals and grievance, care coordination, and any other Team who may receive member and provider feedback, and specific staff including **Provider Support Specialists (PSS)** and Community Health Workers (CHW). All staff are trained and well prepared to receive feedback and resolve concerns immediately. Our systems capture feedback; which is then tracked and aggregated for trends. We also incorporate feedback from State agencies and/or community-based organization partners. Our open and transparent process for obtaining feedback drive improved outcomes for our members and providers; while supporting system transformation. **Figure 13-1** shows a process flow to demonstrate this process.

Figure 13-1. Process Flow to Obtain and Utilize Member and Provider Feedback



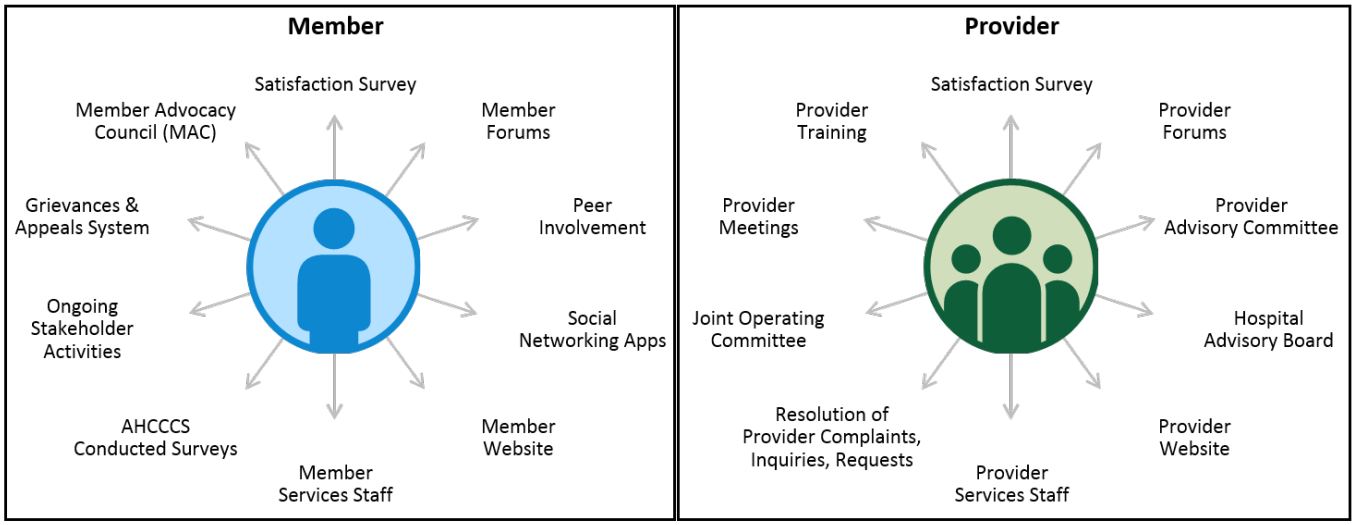
Our Quality Management/Quality Improvement (QM/QI) Committee ensures we have the right structure in place to monitor feedback and is ultimately responsible to the Governance Board for ensuring that feedback from members and providers is documented, tracked, trended, and acted upon. **The QM/QI Committee invites members and providers to participate on quality committees**. Our quality improvement goal is to use the invaluable information gathered through these processes to continually, improve member and provider satisfaction, improve outcomes for AHCCCS, and improve member health outcomes.

Process for obtaining member and provider feedback.

MCCAZ recognizes that obtaining feedback is an ongoing process that requires a formal structure and monitoring process to evaluate performance, progress, positive outcomes, and areas for improvement. Our multi-channel feedback processes are a result of the seamless integration of both formal and informal mechanisms to improve program effectiveness and experience for both members and providers.

Through our robust electronic processes and information management systems, we are able to capture, monitor, resolve, and provide reports on the feedback received on an ongoing basis. **Figure 13-2** details our feedback mechanisms.

Figure 13-2. Member and Provider Feedback Mechanisms



We understand that Arizona is in the midst of further transformation to its health care delivery system, and that **obtaining feedback from those receiving the services, providing the services and/or those who are involved in the system, is essential to the success of the transformation.** This includes supporting a continual learning environment, being an agent of change, and continually working together across the system. MCCAZ will work with AHCCCS, agencies, community-based organizations, other Contractors, providers, and members to obtain feedback to assist with this system transformation and the ongoing improvement of healthcare service delivery.

Please see **Table 13-1** for processes we utilize to obtain member and provider feedback.

Table 13-1. Processes for Obtaining Member and Provider Feedback

Obtaining Member and Provider Feedback	
Member Processes	**Provider Processes**
Member Satisfaction Survey: ▪ Annual Member Satisfaction Survey including CAHPS ▪ Clinical Program Member Satisfaction Survey ▪ AHCCCS surveys (future)	**Provider Satisfaction Survey:** ▪ Annual Provider Satisfaction Survey ▪ AHCCCS surveys (future)
Member Forums: ▪ Periodic member forums throughout the regions to gather real-time feedback, organized by our Member and Family Advocate	**Provider Forums:** ▪ Semi-annually and as needed for collaboration with all providers, including: ❖ Integrated and Targeted Investment providers ❖ Non-traditional community organizations
Member Advocacy Council (MAC): ▪ Member/family involvement with an executive sponsor	**Provider Advisory Committee:** ▪ Host quarterly meetings in each GSA
Member Complaints, Grievances, and Appeals Process: ▪ Complaint Acknowledgement and Resolution processes ▪ Systems supported process flows and reporting on key metrics	**Provider Complaints and Appeals Process:** ▪ Claims dispute resolution process ▪ Tracking and trending to identify potential changes needed to payment policies and procedures
Member Services and Field Staff: ▪ Dedicated 1-800 # available 24/7 for members, stakeholders ▪ Community Health Workers meeting face-to-face in community	**Provider Services and Field Staff:** ▪ Dedicated 1-800 # available 24/7 for providers ▪ PSS and Provider Relations Managers (PRMs) meeting face-to-face in community

Obtaining Member and Provider Feedback	
MCCAZ Website and Technology: ▪ Member portal (24/7) ▪ Question/feedback link ▪ Member Service chat feature ▪ Social Networking (i.e., Facebook, Twitter)	**MCCAZ Website and Technology:** ▪ Provider portal (24/7) ▪ Question/feedback link
Member Outreach: ▪ Community outreach events approved by AHCCCS to connect members to all resources available to them through the plan ▪ Health fair events outside business hours to increase access to preventive services	**Provider Meetings/Committees**: ▪ PH, BH, and integrated provider meetings (Q, yr. 1) ▪ Arizona State Medicaid Health Information Technology Initiative and Committee ▪ Joint Operating Committees (JOCs)
Peer and Family Support Team: ▪ Work specifically with members experiencing complex health and social needs	**Provider Training and Learning Collaboratives:** ▪ Utilize evaluation forms for gather feedback
Multi-agency Collaboration: ▪ Member concerns and barriers identified and assessed for systematic improvement ▪ Identification and resolution of cultural barriers	**Community-based Organizations:** ▪ Feedback from non-traditional providers/community resource agencies

Examples of Improvements to the member and provider experience

By utilizing a "no wrong door approach" to gathering feedback from members, providers, and stakeholders, we are able to improve their experience in a timely manner; while also improving both MCCAZ's processes/procedures and overall system of care. In **Table 13-2**, we provide contract examples, as outlined in **Question 1. Contracts***,* from our Arizona experience, our Florida Medicaid Health Plan, and our New York Integrated Health Plan showing our continued commitment to utilizing feedback to make real-time program enhancements with the goal of improving quality, satisfaction, and outcomes.

Table 13-2. Examples of Utilizing Feedback to Enhance Programs

Contract Example	Type (Member, provider, both)	Issue/Concern Identified from Feedback	Steps to Resolution	Outcomes
1 - AZ	Both	Gap between routine care, inpatient, and crisis services (including hospital hold)	▪ **Governance Board** authorized a series of focus groups with members, stakeholders, and providers ▪ **Created the Crisis Transition Navigator (CTN) program using Certified Peer Support Specialists** to act as a recovery coach/guide and assist members in navigating short-term crisis/post-crisis services	▪ 40% increase in kept follow-up appointments after referral ▪ 26% reduction in inpatient admissions and 47% decrease in inpatient readmissions ▪ 72% member engagement rate ▪ This model was emulated across the state and delivered by a variety of provider agencies
2 - AZ	Member	Identified need to promote a culture of recovery in Maricopa SMI clinics	▪ **Created clinic advisory councils (CACs) as a forum to listen and learn from members** about suggestions, ideas, and opportunities for broader inclusion in decision making	▪ Improved member voice and shared decision making ▪ Improved facility ADA accessibility for members and emergency preparedness

Contract Example	Type (Member, provider, both)	Issue/Concern Identified from Feedback	Steps to Resolution	Outcomes
			▪ **Co-created the Recovery Culture Roadmap in partnership with members who served as CAC leaders**	▪ Increased education and participation by members in creating member-focused emergency preparedness plans
3 - AZ	Provider	Concerns regarding State budget crisis (2010)	▪ **Developed a member and provider task force to help prioritize key services** in the midst of a non-title 19 budget cut ▪ **Program data was reviewed and priority services were outlined** to create and enhance safety net services	▪ Redirected critical funding to crisis safety net services including funding peer navigators, front door services such as the Level III drop-off centers such as Access Point ▪ Even though providers received a reduction in funding, having a seat at the table and a voice in the process went a long way to minimize disruption and increased provider satisfaction minimized and improved
4 - FL	Both	Assistance with integrating care between PCPs and BH	▪ **PSS Team identified high volume providers to engage in practice improvement activities** related to integration of care ▪ Using principles of Practice Facilitation, **the PSS Team gathered provider feedback and assessed their readiness for integration of care using SAMHSA's 6-stages of collaboration:** ❖ This process supported a reciprocal feedback loop between the provider and health plan	▪ PSS Team developed referral form for provider use, worked individually with providers (specifically those with large membership) to hold collaborative regional meetings between PCPs and BH providers ▪ Developed and implemented the **Integrated Behavioral Health Program (IBHP)** with providers to meet members with high-cost/complex health needs. This value-based initiative has produced significant positive outcomes, such as: ❖ Ability to successfully engage members traditionally viewed as "hard to serve" ❖ 50% reduction in BH inpatient admits ❖ 50% reduction in ED utilization
5 - FL	Both	Issues with access to peer support services, getting peers certified, and need for improving workforce development use of peers in provider settings	▪ **Conducted a series of "Listening to Our Community" forums around the state** to hear from families, individuals with lived experience, providers, advocates, and other stakeholders to understand what they see as areas of improvement ▪ **Focused discussions with providers** interested in improving peer support services ▪ Offered **enhanced rate** for participating PEP providers	▪ Developed the **Peer Excellence Program (PEP)** to increase access to evidence-based peer support, expert technical assistance and ongoing collaboration ▪ Developed the **Magellan Apprenticeship Program (MAP)**, an internal peer workforce expansion program designed to train and educate peer apprentice, assist with certification and increase the number of paid peer specialists; Established MAP advisory Group with Vocational Rehabilitation and FL Certification Board ▪ Created and provided tailored **technical assistance and toolkits** (e-course catalog of 40 on-demand learning opportunities for peer specialists to improve knowledge, skills, and abilities)
6 - NY	Member	Members in our NY health plan asked for	▪ **Engaged transportation vendor and modified processes** to allow	▪ Held member or participant feedback sessions quarterly; reported less transportation issues

Contract Example	Type (Member, provider, both)	Issue/Concern Identified from Feedback	Steps to Resolution	Outcomes
		improvements in scheduling transportation on short notice	members to schedule rides on less notice	▪ Vendor participates in member feedback sessions and they now survey members after rides to gain additional feedback ▪ Improved satisfaction results
7 - NY	Provider	Enhanced care management system	▪ **MCO reached out to key providers (large membership base) to obtain feedback on Case Management system improvements** to assist with provider admin efficiency	▪ Recommendations improved provider functionality within the provider portal, by allowing providers to access member lists and information within the system ▪ Increased provider satisfaction for the system

Ongoing feedback process through oversight and innovation: Our Member Services Call Center staff, CHW, peer support staff, and PSS staff accept feedback and attempt to resolve concerns immediately as they work with members and providers in the field. We are able to report on member or provider inquiries through our Member Services Call Center that may not be characterized as a complaint, yet gives valuable feedback for plan performance and leveraged for process improvement.

MCCAZ will utilize our formal QM Program, QI/QM Committee structure to ensure data are collected, reviewed on a regular basis, and that QI activities are tracked to completion. MCCAZ will develop and monitor an ongoing QM/QI Plan, with specific measurable objectives and activities. The QM/QI Plan will align with AHCCCS requirements, and NCQA Health Plan Accreditation standards, and is dedicated to continuously improving the efficiency and effectiveness of our Medicaid program while supporting member choice in the delivery of the highest quality care. Our QM/QI Committees will include members and providers; and are structured to systemically monitor member and provider feedback to ensure opportunities are addressed and improvements are made to enhance the member and provider experience.

We set benchmark goals for each metric and assign a quality committee for ongoing monitoring, consistent with the AHCCCS mission and vision. As we implement the new AHCCCS Complete Care Program, obtaining timely and ongoing feedback will be instrumental to our success. MCCAZ is committed to working within the entire system of care to develop culturally competent, innovative ideas that capture feedback and allow for the implementation of process improvements. We will specifically work with members, providers, AHCCCS, other MCOs, T/RBHAs, community organizations and stakeholders as part of this process with the goal of ensuring smooth transitions between plans, improved member and provider experience, improved health outcomes and bending the cost curve.

14. Value-based strategies aligning incentives between providers and the Offeror in order to reduce fragmentation and improve member outcomes.

Magellan Complete Care of Arizona (MCCAZ) applauds the work already done by AHCCCS and Arizona providers to transform the delivery system and encourage development of integrated models for the delivery of physical health (PH) and behavioral health (BH) care and services in a coordinated and collaborative manner. We have shared and aligned goals, with value-based-purchasing (VBP) and alternative-payment-models (APM) as important elements of achieving that goal. We are committed to exceeding AHCCCS threshold goals of 25 percent VBP reimbursement by 2020, and in fact, already have several large providers contracted under VBP.

MCCAZ's approach incorporates a multi-tiered and appropriately paced implementation of VBP; built on provider collaboration, assessment of provider readiness, and support to minimize disruption and risks. It is also tightly linked to our system of care and the quality and cost outcomes targeted for those programs, with incentives and shared savings linked to those outcomes and payment tied to savings generated through improved delivery of care. Our approach builds on important experience from similar transformation efforts in our Florida fully-integrated Medicaid (MCCFL) plan where approximately 70 percent of our providers are currently under some form of VBP (primarily capitation with incentives); in New York where our Senior Whole Health (SWH) plan also have nearly 70 percent of providers in VBP (including nearly all home care providers); and, in our previous work in Arizona as the RBHA for Maricopa (Magellan of AZ) where we worked with existing block funding. We believe VBP has been an important element in Florida where we have achieved a 15 percent reduction in per-member-per-month (PMPM) costs since program launch three years ago; quality outcomes improvements in more than 90 percent of state-targeted HEDIS measures and, have far exceeded year-to-year improvements by our top three competitors.

Highlights

- Multi-tiered approach to support flexible reimbursement options
- Solutions clearly tied to improvements in member outcomes, experience and costs
- Carefully paced implementation to limit risks of disruption
- Transformation support to assist provider practice enhancement

Our experience has also shown us that movement toward VBP must be done through partnership with providers and should strengthen their capabilities without jeopardizing core services. This is particularly true for providers, who have been partners with us in past work with AHCCCS, and currently receive block funding. Our VBP solutions for those providers are aimed at enhancing capabilities and ensuring their continued viability as important partners for delivery of integrated care. We have designed an approach that reflects these important lessons.

Transformation Focus: MCCAZ's VBP strategy reflects our point of view on the importance of providers in delivering on the promise of the integrated model of care. It includes provider transformation support while incentivizing improved member outcomes, access to services, reductions in total cost of care, and improved member satisfaction. It supports our overall provider strategy which sees providers as partners and collaborators in management of member outcomes and experience. In addition, it is focused on supporting providers operationally and financially as they transition from one form of payment to another. We meet each of the providers "where they are" and support their transformation with assistance from our **Provider Support Specialists (PSS)** who are trained and experienced in assessing provider readiness; training providers in requirements for fully-integrated care; developing required capabilities through practice transformation; and, supporting providers in adopting VBP models and strategies. We invest deeply in people, processes and knowledge to support varied payment models including: capitated and fee-for-service (FFS) reimbursement with pay-for-performance (P4P) outcomes incentives and/or shared savings; bundled payments; Centers of Excellence (COE); risk-adjusted capitation; and, two-sided risk-sharing.

Key Elements of Our Approach

- Engage providers early and work collaboratively to design solutions
- Dig deep to understand the market, and provider readiness for APM by structured readiness assessment
- Provide superior data and analytics that are transparent to all engaged in development of solutions and execution
- Develop and employ solutions that will be supported by the provider community and support progress toward AHCCCS goals

We are actively engaged in converting existing and new providers to VBP models throughout our organization, and are in the process of converting vendors (including vision, dental, and transportation) to capitated payment models.

VBP Strategy for AHCCCS: Our approach aligns with AHCCCS goals in recognizing the need to integrate Medicaid delivery by aligning provider payments and incentives to better integrate PH and BH services, reduce fragmentation and improve outcomes. As of the date of this response, we already have VBP contracts for Jewish Child & Family Services, Community Bridges, and Equality Health. We will implement a structure inclusive of Arizona subject matter experts (SMEs), and our efforts will be directed by a dedicated senior executive with expertise and focus on payment alignment. Experience shows us success requires a methodological approach that includes the elements highlighted at right. We work closely with our Provider Advisory Council(s), and use our **Magellan Learning Alliance (MLA)** and PSS staff in a collaborative model to engage providers in developing mutually beneficial solutions following these principles.

Assessing Provider VBP Readiness

- Does the provider serve sufficient numbers of members to support VBP efficiency and affect outcomes?
- Is there sufficient, accurate baseline data to support effective outcomes reporting and monitoring?
- Does the provider have sufficient capabilities and resources to accept VBP risks?
- Is the VBP solution financially and operationally sound for both the provider and MCCAZ?
- Will agreed outcome improvements result in better member and AHCCCS care, access, satisfaction, and costs?
- Can both parties support required monitoring and reporting to drive improved performance?

MCCAZ APM/VPB Reimbursement Progression: Providers are in different phases of readiness and will need a graduated model to move from the most basic APMs (e.g., pay for performance) to the most complex alternate payment arrangements (e.g., including upside and downside risk); as shown in **Table 14-1**.

Table 14-1. VBP Reimbursement Continuum

Level	Type of APM	Provider Activity
1	Pay-for-Performance (P4P)	We use activity-based pay for P4P to engage providers in earliest state of readiness or who will not participate in care management
2	Outcomes-Based Tiered Payment	Providers can achieve higher tiered payments based on activity and outcomes improvements. Base portion of provider compensation will be lower as we increase the bonus or "value" portion of total compensation. After the second year, providers could see lower reimbursement if performance benchmarks are not achieved
3	Gain-Sharing/Shared Savings	Providers assessed as ready to accept risk and/or ongoing success at Level 2; early gain sharing participation may move to both upside/downside risk based on readiness
4	Bundled Payments	Providers with scope of services/capabilities for effective management of bundles, as we develop a greater based on data to inform contracting; likely would include COEs

Based on assessment of provider readiness, we work collaboratively with providers to agree to reimbursement models; metrics; data sources, reporting and timing; ongoing collaboration and transformation support. Data sources for PCP/physician groups/BH providers include: historical monthly utilization (PH, BH, and Rx), enrollment and encounter data, financial data, medical record review, and other supporting data and documentation. For utilization metrics, we provide performance data no less than quarterly. For quality metrics such as HEDIS (including screening and referral measures), and potentially preventable events for avoidable admissions, readmissions, and ED visits (PPEs); metrics are shared annually. Progress toward full implementation of VBP/APM reimbursement models typically follow the timeline in **Table 14-2**.

Table 14-2. VBP/APM Reimbursement Progression Timeline

Timeline	Type	Progress
	P4P	Provide performance results against baseline measures, with early focus on administrative measures; collaborate to define Year 2 goals, metrics and benchmarks for payments

Timeline	Type	Progress
After First Full Year	P4P with Tiered Payments	Payment rates are at baseline and define higher payments achievable in Year 2; in addition to the opportunity for higher payments, rate reductions are built in if performance declines
	Gainsharing	Provide Year 1 results on quality and cost metrics and cost savings based on reductions in PPEs; we set gainsharing elements for Year 2 based on Advisory Council input
	Condition-specific Bundles	We develop this model collaboratively with providers who have established capabilities to support; target AHCCCS and MCCAZ condition-specific performance and improvement goals
After Second Full Year	P4P	Payments per contract for providers at goal; those not meeting given additional support. Assess whether high-performing providers readiness for additional incentives
	P4P with Tiered Payments	Payments for those reaching tiers aligned with financial increases; additional increases for achieving/maintaining tiers and high performing providers assessed for additional incentives
	Gainsharing	Year 1 payments based on contract percentage of shared savings; for successful providers, gainsharing is developed to increase upside potential and to include downside risk
	Condition-specific Bundles	Refine bundles, outcome measurement and reimbursement, and begin roll-out to additional bundle-ready providers
Year Three Forward	P4P with Tiered Payments	Goal by Year 3 is to have moved off pure P4P to P4P with tiers; follows Year 2 model, with increased tiers to accommodate differing provider readiness
	Gainsharing	Follows Year 2 model
	Bundles with Gainsharing	Payments based on bundled reimbursement; we work with providers to incorporate gainsharing focused on improved total cost of care
	Risk Sharing	Payments based on prior year results and sharing percentages; sharing percent evaluated for impact and adjusted if needed to support provider viability

Reducing fragmentation and improving member outcomes

MCCAZ's system of care is built to support fully-integrated care delivery and management for our members, and our provider partners are important for achieving that goal. However, our experience tells us this takes time. Our VBP/APM strategy includes immediate emphasis on screening, ED reduction and preventable events, and gap-in-care closure for both PH and BH conditions for key providers, including primary care (PH and BH), medical homes (PCMH and Native American Medical Homes), and Integrated Health Homes (IHH). We support these models by assigning members to each type based on member need for integrated PH-BH services and/or care management. This approach encourages a shared focus on both PH and BH conditions and key drivers of higher utilization and poor health outcomes. Our strategy also includes progressive movement toward shared savings programs, eventually including inpatient and outpatient providers, and specialists. Initial phases specifically include IHHs, which are one solution for integrated PH-BH care delivery and management along the continuum of integrated solutions based on concepts of the SAMHSA Four-Quadrant model for integration.

As we work collaboratively with our provider partners to identify other attractive solutions for PH-BH integration, we look to develop other models including the creation of provider-provider shared savings arrangements and collaboratives; which allow providers to self-affiliate and jointly participate in shared savings programs within a given geographic area. This model, which has been used by some integrated delivery systems and Accountable Care Organizations (ACOs) is an effective way to break down barriers and integrate provider activities. We have already identified several ACOs that we believe may be candidates for this approach. MCCAZ also believes free-standing crisis (24-hour transition points) and step-down centers may be strong candidates for development of shared savings and bundled payment. We have long-established relationships with these providers through our BH programs in the state and will work with these, and similar providers to develop solutions along the VBP/APM continuum; including incentivizing solutions such as e-prescribing or DSNP participation, highlighted by AHCCCS. We also believe that COE focused on combined PH-BH care for high-complexity conditions such as sickle-cell, CHF, or serious mental illness with

substance abuse, are very good candidates for VBP/APM models that emphasize integrated care through bundled payments. Recognizing this we have included these programs in our strategy and will be working with select providers to implement these solutions. Our experience has shown us breaking down barriers between providers, and supporting operations and practices for this transition requires collaboration, education, and information sharing about the benefits. Progress toward VBP/APM is determined by provider readiness. We assess and promote readiness through the activities outlined in **Table 14.3**.

Table 14-3. Provider Readiness Activities

Activity	Example
Provider Education	MCCAZ has developed a proprietary education program, the Magellan Learning Alliance, a program to support provider education through a facilitated educational curriculum, and will continue to grow the program in conjunction with network growth through the AHCCCS program.
Readiness Assessment	We assess current and future provider readiness. To accomplish setting a baseline and developing the pace and rate of change for APMs, 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. Outcomes data for the assessment is shared with the advisory committee(s) and our APM development to inform design and implementation.
Provider Advisory Council	The power of provider ownership is key to success in value-based care delivery models and providers are central to cost control and quality improvement efforts and should be closely involved in planning groups and executing initiatives targeted in these areas. We develop and actively facilitate Provider Advisory Councils to represent and influence BH, PCP, and specialty providers.
Operational Support	Our PSS 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 interpreting and using the data to support VBP.
Monitoring and Reporting Support	We recognize that successful VBP/APM models require timely, reliable, and accurate reporting of results to support providers in achieving expected outcomes. Good data is also essential for the health plan to support monitoring, identification of problems, and refinement of programs as needed. We work with providers to design appropriate reporting, and support programs with detailed analytical and statistical support to evaluate program effectiveness and continuous improvement.

Provider-specific value-based strategies for integrated providers, PH-only providers, and BH-only providers

Our strategy for implementation of VBP/APM solutions with integrated providers, PH-only providers, and BH-only providers is linked to timing for contract execution and provider contracting readiness. Our goal initially is to allow and encourage primary care provider (including PH, BH providers, pediatricians, and OB/GYN) participation in P4P. For key targeted providers who have moved to some form of integrated delivery care, such as Integrated Health Homes (IHH), or management of member care, such as medical homes, including primary care medical homes (PCMH) or Native American Medical Homes; this will include focus on clinical outcomes as well as administrative measures. For providers who have not moved toward integration or who are not interested in moving toward integration, we will initially, tie outcomes more heavily to such metrics as access to encourage use of primary care. We would then target other primary care providers (PH and BH) for participation.

Programs are developed collaboratively with our provider partners, and would include both process measures, gap-in-care, and clinical outcome measures. The types of process measures used typically depends on the underlying base reimbursement for that of provider. As an example, providers who are capitated might be incentivized to consistently submit zero-dollar claims, or provide integrated access to their electronic medical record (EMR) systems. Quality and outcomes incentives would expand over time as we gain experience with provider performance and have a better understanding of the types of activities and outcomes we want to incentivize. However, based on our experience in Florida and elsewhere, we know that there are specific types of incentives for specific types of providers that we want to incentivize from the outset. As shown in our continuum of VBP/APM solutions, our goal over time will be to move many of these providers to shared savings solutions in addition to, or as a replacement for P4P incentive programs.

Those programs will be tied to total care costs and would include focus on preventable events and total care outcomes such as those tied to births and pregnancies. Initially, P4P incentives would include those listed in **Table 14-4**.

Table 14-4. P4P Incentives

Provider Type	Incentive
Primary care providers (adult and pediatric) and OB/GYN	Completion of HEDIS depression, alcohol and opiate use screenings appropriate for member age, medication management, and post-discharge follow-up; performance on EPSDT and HEDIS birth outcome measures; performance on AHCCCS-specific program metrics. Additional incentives for same-day access to services and member satisfaction
Behavioral health providers	HEDIS diabetes and cardiovascular measures for BH conditions; HEDIS alcohol and opiate use screenings and treatment; HEDIS follow-up (FUH) after member I/P or ED discharge; screening for smoking and obesity and referral to treatment; performance on EPSDT and AHCCCS-specific program metrics. Additional incentives tied to member satisfaction
Integrated providers	Both groups of metrics noted above

In addition, all providers are incentivized to implement and use telemedicine solutions and MCCAZ reimburses for those services based on AHCCCS guidelines. Providers with developed care management capabilities, such as PCMH and IHH, may also receive additional reimbursement for care management activities. All providers will also have access to MCCAZ's **SmartScreener™** app, which supports automated BH and SUD screening of members using a tablet in the provider's office. **Centers of Excellence (COE)** are expected to provide comprehensive care for members with specific conditions. Since this delivery model supports care management and delivery of a bundle of services around specific diagnoses, we will work with qualified Centers of Excellence to develop payment bundles for comprehensive care. Movement to bundled payment methodologies will require experience data for development of appropriate reimbursement. We know that some providers are already capable of supporting bundles and will move quickly to implement for those providers.

Payment of behavioral health providers transitioning off block purchasing

We are committed to working closely with all BH providers who are currently receiving block funding, to develop solutions that ensure their continued viability while moving toward VBP and further development of integrated care capabilities. In fact, building on our deep relationships with these organizations through our prior work with AHCCCS, we have already initiated discussions on proposed solutions for progressively moving these providers off block funding. Current proposed reimbursement is for payment incorporating the follow elements:

- **Year 1:**
  - Shadow capitation at amounts equal to current PMPM funding for AHCCCS members served
  - Participation in P4P incentives as noted above, allowing for upside payment of incentives
- **Year 2:**
  - Shadow capitation at amounts equal to 95% of current PMPM funding for AHCCCS members served
  - Participation in P4P incentives, allowing for upside payment of incentives, with particular focus on incentives tied to integration
  - Participation in gain-sharing, up to 101% of prior PMPM funding on reductions in total costs of care
- **Year 3 – Forward:**
  - Negotiated capitation
  - Participation in P4P incentives, allowing for upside payment of incentives
  - Participation in gainsharing up to 101% of prior PMPM funding on reductions in total costs of care
  - Risk sharing up to 10% risk corridor for all members assigned for IHH integrated care.

To support block-funded providers MCCAZ proposes setting aside a pool of investment dollars to assist providers in making required transformation investments. The investment pool would follow priorities set by AHCCCS for its Targeted Investments. As we have done with similar providers in Florida, we will also provide grant-writing assistance to support these providers in securing funds from other sources. As with all our other providers, we will of course provide readiness assessment and practice transformation support, with specific staff designated to support block-funded providers. Our goal will be to ease their transition from block funding to VBP while ensuring their long-term viability and, enhancing their future as important participants in the integrated model.

15. Monitoring and controlling health care cost trends. Approach for monitoring health care costs

Magellan Complete Care of Arizona's (MCCAZ) system of care and our approach to health care cost management, are well aligned with AHCCCS goals for bending the cost curve through system transformation and best practice approaches to cost management; including active engagement of providers through value-based purchasing (VBP). We know one of the best ways to manage costs is to keep our members healthy and that goal is achieved through a system of care that is integrated from end-to-end, allowing us to target key drivers of cost and outcomes, including social determinants of health (SDoH) such as homelessness, food insecurity, and criminal justice system involvement through our **Integrated Health Neighborhood℠ (IHN)**. Our IHN allows us to deliver member-centered, community and culturally-responsive services and supports in the local community, where our experience has shown we can positively affect health outcomes and costs. Results speak for themselves. In Florida, where we established this model, we have **reduced total costs by 15 percent, emergency department (ED) costs by 27 percent, and pharmacy costs by 7 percent, in the three years since we began accepting members.**

Key Features

- Integrated system of care targeted at key drivers of cost and utilization
- Continuous improvement methods throughout all operations
- Comprehensive monitoring and reporting for key operations and clinical programs
- Well-designed claims processing, fraud, waste and abuse programs for all key areas
- Targeted programs to improve member health and limit costly complications

MCCAZ does not rely solely on strategies such as narrow networks, overly-restrictive utilization management (UM), or aggressive provider reimbursement rates to control costs. Instead, we focus on deep, and analytically-driven understanding of populations we serve, their needs, and delivery system and community services, to drive results. We overlay that with benefit design, program features, delivery system and reimbursement design, and targeted interventions and supports for both members and providers, to address key gaps and drive innovation to achieve improved outcomes and costs. That model is backed up by well-designed and well-executed medical economics and medical cost management programs, continuous quality improvement (CQI) which is integrated across all functions and cost categories, efficient claims management and billing operations, and effective fraud, waste and abuse management.

We manage costs through a holistic approach to care and outcomes management. Our goal is to connect each member to a health home appropriate for their risks to ensure their medical (PH), behavioral health (BH) and social needs are met, and provide them with tools needed for self-care. We deploy an integrated and comprehensive system of care coordination/care management, UM, and quality improvement/quality management (QI/QM). UM includes automated claims edits, prior authorization, concurrent review, and retrospective review, driven by evidence-based clinical best practice guidelines and policies. Our programs integrate QI/QM and CQI activities to support continuous evaluation of trends and/or patterns of care across regions, providers, programs and member categories, identifying opportunities to refine our system and improve interventions, make changes to contracting and/or reimbursement strategies, or work with providers to improve practices. We compare our data to regional and nationally recognized thresholds to alert us to over- and under-utilization and key trends. As an example, in our early analysis of Arizona cost data we have already identified somewhat higher hospital, specialty and ancillaries costs in certain regions of the state. We have also identified opportunities in what we believe to be higher-than-expected pharmaceutical costs. One of our first tasks would be to assess opportunities to reduce that spend in those categories.

Our care coordination/care management system integrates population health management in its approach to identify member needs within diverse populations; provide services and programs that promote healthier lifestyles; ensure adherence to treatment protocols; and coordinate care across the care continuum, provider types, and benefit categories (PH, BH, social, and intellectual). We leverage technology to identify, target and engage members at all risk levels, providers, and internal Teams to improve care delivery and outcomes (quality and costs) while managing resources efficiently. We also incorporate Magellan-owned programs such as pharmaceutical management through **Magellan Whole Health Rx,** and ancillary management through **Magellan Specialty**, which is specifically focused on contracting, clinical, and cost outcomes for those two increasingly high-cost categories. Both of these important participants in our solution will be instrumental in helping us identify and target savings opportunities in both pharmaceutical spend and high-cost specialty services.

Continuous Improvement Methods: MCCAZ continuously evaluates interventions, programs, member treatment and utilization patterns, and operations to assess effectiveness in improving outcomes and controlling costs. Our cost of care management processes are built on a discipline of monitoring absolute costs and cost trends, which are material to the plan's overall financial picture, then implementing interventions that can impact those results. We continuously monitor costs, and when a trend is identified we drill into it for specific purposes of designing initiatives to address those trends. Interventions are designed around the well-established, plan-do-study-act (PDSA) model and are backed by robust, statistically valid analytics to drive continuous improvement. As an example, for our fully-integrated Medicaid health plan in Florida, we completed a detailed statistical analysis of our members to determine what characteristics (diagnoses, location, providers, and social determinants) were linked to high inpatient (IP) and ED utilization, as well as total costs of care. We used results of that analysis to reconfigure our care coordination/care management programs, network contracting and reimbursement strategies, and the members being targeted, driving improved clinical and cost outcomes. We have also recently initiated a comprehensive analysis of all key member engagement and care coordination/care management activities to determine consistency of use and effectiveness in achieving targeted outcomes, including total cost of care, admissions, readmissions, ED utilization, and other key metrics. This effort will drive even more efficient design of care coordination/care management and member support to optimize results for members, and program sponsors like AHCCCS. This approach to continuous improvement is integrated into every aspect of our operations and is supported from the very top to the lowest levels of our organization. It provides for continuous measuring and management of clinical and operational outcomes, and ongoing operational improvement.

Comprehensive Monitoring and Reporting: MCCAZ programs and practices incorporate robust, comprehensive and continuous monitoring, reporting and management of quality and cost outcomes and overall performance. In addition to standard financial reporting on weekly, monthly, and quarterly claims trends, each operational area is provided with operational dashboards through our **Business Analytics Reporting Tool (BART)** reporting and tracking system. They report key metrics for each functional area, performance trends, comparison to prior periods, and other key indicators. They are regular elements of operations management and oversight, are used for daily management of each area, and for executive-level monitoring and oversight. We also use clinical dashboards for key programs that present performance on clinical outcomes and metrics. As an example, our pregnancy management program dashboards present current and trend data on cesarean-section rates, pre-term delivery rates, delivery method, birth outcomes and lengths of stay. Both the clinical program and BART dashboards are used daily to monitor organization performance, and quickly correct or implement improvements if we are not achieving goals. Clinical outcomes, costs and gap-in-care data are also shared with providers through our Provider Portal and printed reports. As part of our provider support activities, we have **Provider Support Specialists (PSS)**, who are licensed clinicians that work with providers to review results and assist with practice transformation or other improvements to address unfavorable trends or results. As part of MCCAZ's UM, QI/QM and compliance programs we also regularly review trends related to provider utilization, access to care, vendor performance against contracting standards, and other key metrics. These analyses allow us to detect and address issues such as problems with member access that may be resulting in increased use of higher acuity services such as the ED.

Magellan Rx Management (MRx) provides invaluable support for appropriate utilization of pharmaceuticals and associated expense, conducting ongoing analysis of pharmaceutical utilization, flagging inappropriate use, poly-pharmacy, drug-drug interactions, and patterns suggesting abuse. Clinical pharmacists work with providers to address issues and modify prescribing behavior. In instances in which analyses suggest potential for abuse, the issue is flagged to be addressed by our care coordination/care management staff if it relates to member behavior, or directed to our fraud, waste, and abuse department if warranted. We also use pharmacy lock-in programs for members showing evidence of abuse. **Benefits of our pharmacy programs are clear, evidenced by results in our Florida program where we achieved an 11 percent reduction in polypharmacy use in just one year.** Similarly, we use Magellan Specialty comprehensive system to support management of imaging services through their radiology benefit management programs. The program uses a clinically-intensive approach for managing advanced imaging for more than 27M members nationwide and has been shown to reduce utilization by 25 percent or more.

Claims Processing and Fraud, Waste and Abuse (FWA): We consider claims processing, benefits configuration, administration, and education to be fundamental capabilities. Our integrated systems provide a full 360-degree view of

all claims, member and provider activity. Appropriate care is delivered and paid through our robust information systems including enrollment, claims processing, member services, and clinical systems. These systems are all configured according to the unique benefit packages established by AHCCCS in accordance with the member's eligibility category based on age, gender, and region; and match those codes to the applicable benefit package with all benefits mapped and loaded into our claims adjudication system.

We configure our payment system based on medical benefits policies, our experience, and criteria of AHCCCS and its policy requirements, with detail at the CPT, ICD-10, and HCPCS levels to ensure appropriate benefit configuration. These policies reside in our Compliance 360™ system, and are updated any time AHCCCS issues new communications, triggering updates to provider manuals, contracts, Technical Manual, and Medicaid memos. Compliance 360 has automated reminders that trigger benefit policy review at regular intervals. Our claims system is configured on these policies with indicators for whether a service is covered, and/or if review is required. Services are approved as covered, denied as non-covered, pended for coverage review, or paid, as appropriate. We work with members to find appropriate alternatives in instances when coverage is denied. Claims management also includes programs for regular analysis and auditing of claims trends and results to detect coding inaccuracies and up-coding by providers or potential FWA.

MCCAZ has robust programs to manage coordination of benefits (COB)/third party liability (TPL) and coordinate care with other carriers; including Medicare, Veterans Administration, Indian Health Services (IHS), TriCare/military, worker's compensation, and commercial payers – ensuring that needed care is coordinated and provided for members, regardless of payer. Benefit and services coordination includes early identification of dual eligible members, assessment of individual needs and preferences, and coordination and planning of services and supports. Systems and processes are invisible to members and families. Our cost containment department is dedicated to COB and detecting TPL. Our highly configurable systems and processes minimize AHCCCS' costs by maximizing other coverage parameters in the claims system and includes checks and balances to adjudicate claims with other insurance coverage and ensure Medicaid is payer of last resort; with the exception of IHS. To minimize involvement of the member, we work directly with the other payers and providers to coordinate other coverage and resolve any issues.

Our culture of compliance and business integrity, and our focus on ensuring members get appropriate high quality services, includes robust and proactive compliance programs that provide direct, practical, day-to-day support for operations. Our formalized and well-documented compliance program meets all federal and State requirements, as well as industry best practices. The dedicated MCCAZ Compliance Officer (CO) and Team provide federal and State regulatory guidance to senior leaders and the rest of the organization and the CO is a key staff member who reports compliance program and anti-fraud activities to our Board of Directors. A central feature of our compliance program is ensuring program integrity, which includes detecting, preventing, and effectively following up on FWA. Our compliance officer works closely with our Special Investigations Unit (SIU), which is responsible for investigation of potential and actual fraud, as well as abuse or overpayment. MCCAZ's Compliance and Anti-Fraud Plan describes, among other things, how the Compliance and SIU Teams work together to ensure the highest possible level of program integrity through proactive, comprehensive approaches, processes, policies and protocols. The SIU has procedures to ensure compliance with all FWA reporting provisions for AHCCCS within required timeframes, including regular FWA reporting to Medicaid Program Integrity (MPI). MCCAZ conducts frequent and regular monitoring and auditing activities based on occurrence of identified issues. Compliance auditing is done by the Compliance Department as issues are identified, and corporate auditing of internal controls is done by the Internal Audit Department. Annual and mid-year compliance risk assessment and compliance and auditing work plan are completed, and define areas of highest risk and review for the plan.

Approach for controlling health care costs

In addition to the elements described above, MCCAZ programs and practices include features specifically directed at managing and controlling costs within the context of the AHCCCS integrated model. Many are informed by our experience with similar populations in both Florida and New York. However, they also reflect unique Arizona elements and build on benefits of system transformation that has already occurred under the RBHA program.

Delivery System and Reimbursement Design: MCCAZ has developed a network and reimbursement strategy, and overall system of care to support AHCCCS goals described in its DSRIP, and which include critical elements of the RBHA-influenced delivery system and VBP. MCCAZ programs incorporate data exchange, and analytics to maximize use of the

State's HIE and other technology solutions to minimize duplication and increase efficiency; integration of PH and BH services in multiple settings to limit fragmentation, improve outcomes and reduce costs through thoughtful coordinated delivery and management of both; and, VBP contracting strategies to incentivize improved quality outcomes and share savings for reductions in costs of care to support cost stability. Our programs are funded through improved quality outcomes and utilization, decreasing preventable events, and encouraging use of the most appropriate, least-intensive site of care. As an example, we incorporate free-standing Crisis Clinics and step-down units allowing care to be directed to the safest, lowest acuity site of care for members in need of BH services. Consistent with this practice, we have incorporated other elements such as Treat and Refer Community Paramedicine and Post-Crisis Navigators. Each of these elements also support our programs to minimize unnecessary use of the ED for BH issues, and minimize ED holds. This approach is also applied to other parts of our system of care. We have placed significant emphasis on contracting for free-standing outpatient and ancillary services and expanded use of enhanced access sites for routine care. We also routinely monitor and review member access to care to identify issues that may lead to increased use of the ED for routine services. Our VBP strategy includes incentives to encourage routine primary care services, and reduction in preventable events, including those tied to ambulatory-care sensitive conditions, as well as opportunities to participate in shared savings programs.

MCCAZ's network design includes significant emphasis on use of telemedicine and technology-assisted care; which are particularly important for members located in remote, outlying areas. Enhanced access to these services allows members to seek care before problems become acute or reach crisis levels, triggering a visit to an ED or IP admission. Technology-assisted care, through our innovative **Magellan Virtual Care Solution (VCS)**, such as our **Digital Cognitive Behavioral Therapy (dCBT)** platform, or our **Clickotine™** smoking-cessation tool also enhance member access and reduce overall costs of care. These tools are extremely effective sources of care for members and enhance member self-management, and have been validated in multiple clinical studies and, while Clickotine, has been FDA-certified. All members also have access to our 24/7 Care Line which can be called for information on health issues, services, or other information. Care Line staff, who are licensed clinicians, are trained on protocols for identifying emergencies and crises and elevating when necessary.

Benefit Administration and Care Program Design: Our UM and care coordination/care management programs emphasize use of lower acuity services where medically appropriate. We proactively identify high-risk members and AHCCCS priority populations to manage their health and minimize use of high-acuity, high-cost services and have robust programs for discharge planning and transitions of care to manage lengths of stay, and ensure safe and healthy transitions of members. Our programs include unique features that reflect our extensive experience in managing the health of similar populations in Arizona and Florida. As an example, our experience has shown that certain social determinants of health (SDoH), such as housing or food insecurity, significantly increase the likelihood that members will have difficulty managing chronic conditions, with higher likelihood of IP admissions and ED use. We address those risk factors through programs like our **Homeless Housing** initiative and **Healthy Neighborhood Toolbox** food security program, and other member supports provided through our locally-based care and member engagement Teams that are part of our innovative IHN. We also know members with substance use disorder (SUD) typically experience higher ED utilization regardless of other co-morbidities, and are more likely to be admitted if they have other chronic illnesses. Recognizing that, we incentivize providers to screen for these risks and refer promptly, and include screening for SUD, as well as BH conditions in ALL care coordination/care management programs. MCCAZ pays for, and encourages use of long-acting medications, including long-acting-injectable (LAI) psychotropic medications, which increase medication adherence and reduce risks of BH destabilization, and long-acting-reversible-contraceptives (LARC), which have been proven to reduce rates of unintended pregnancies.

Targeted Member Interventions: MCCAZ makes extensive use of member data available through the State's HIE for early identification of member diagnoses and ongoing treatment at the point of member enrollment. Early capture of that information, combined with active outreach, allows us to quickly identify and monitor member risks, and provide appropriate care coordination/care management support and access to required providers, medications, and other services. Access to the HIE also allows us to target programs such as use of hospitalists, and active engagement with facilities for discharge planning, and to identify members who have received care in the ED and may require outreach from care coordination/care management staff and/or IHN-based Community Health Workers (CHW), promotoras, or

IHS community health representatives. If members are having difficulty accessing services through their designated PCP, or the member has transportation or other issues that may need to be addressed, we work with the member to support them in seeking and receiving care in the most appropriate setting. We continually assess member interventions and clinical programs for effectiveness to support member health, outcomes, and costs of care. As we identify groups of members, in particular geographies, among particular communities, or with specific conditions, we develop new care coordination/care management programs directed at assisting those members in achieving targeted results. MCCAZ has well-designed, comprehensive programs for population health and wellness; incorporating NCQA population health standards and guidelines. These programs, which are integrated with our Quality Management programs and initiatives, support members for routine and preventive care, as well as management of chronic illness, and are integrated with programs such as pharmacy management, incorporating late-to-refill and poly-pharmacy monitoring for members on medication therapies. Our goal is to keep members as healthy as possible, minimizing the chances of developing chronic or acute illness, including BH conditions.

We maintain extensive programs for member education, outreach, and support through automated tools such as our wellness library, member messaging and reminders, active use of social media, and member self-management tools for specific populations, such as Text4Baby™ for pregnant members. Our IHN actively engages members through regular member outreach, coordination with community resources, peer support, and other features. We also actively monitor members who are coming up for Medicaid redetermination, and work through AHCCCS' programs and supports to minimize member loss of coverage and lapses in treatment which can destabilize or degrade member health adding to poor outcomes and higher costs.

Identifying unfavorable cost trends; strategies and specific actions taken

Our integrated Medicaid health plan in Florida has been very successful in improving outcomes and controlling costs with specific programs that have yielded significant reductions in costs, for example:

- ***Members Enrolled in Integrated Diabetes, Hypertension, and Asthma Disease and Care Coordination/Care Management Programs:*** Our entire system of care is built around a model of integrated PH-BH management of health, including management of common chronic illnesses for Medicaid beneficiaries, and for which individuals with BH conditions are at increased risk. Our diabetes, hypertension, and asthma management programs have shown particularly significant results. As an example, **members enrolled for asthma management showed a 36% decrease in total costs, while ED use declined by 35%.** Our hypertension management program showed a 30% reduction in total costs, and a 27% decrease in ED use. **In our diabetes program, costs held steady during a period of increasing pharmaceutical unit costs, while members who were not enrolled saw a 26% increase in costs. Enrolled diabetic members also saw a 21% decrease in ED utilization.**
- ***Members Enrolled in Sickle Cell Integrated Specialty Management Program:*** Our integrated sickle-cell management program includes member education on managing illness and focused care coordination/care management for pain management and substance use. **The results for this program have been significant, with a 41% reduction in total costs for members enrolled in that program, and a 58% decrease in IP utilization, and 29% decrease in ED utilization for members who completed the program.** Benefits of these programs continue even after members graduate from the program, with those members showing a continuing 31% decrease in IP utilization and 20% decrease in ED utilization.
- ***Members Assisted Through Homeless Housing Program:*** Our Florida plan also operates a Homeless Housing Program that supports homeless members in securing housing and needed supports to manage their illnesses. For members placed in assisted living or supportive housing, we have experienced **a 41% decrease in total costs**.
- ***High Risk Pregnancy Management Program:*** Our Florida pregnancy management program has also yielded significant outcomes that drive lower costs. Through that program **we achieve pre-term delivery rates of 2.48%, versus 10.4% as reported by the Center for Medicaid and CHIP Services and 9.63% for all populations in 2015, as reported by the CDC. We achieve C-section rates of 28.45% versus the 32% rate in 2015 for all populations as reported by the CDC. These outcomes reduce costs both directly and through improved birth outcomes and lessened newborn complications.**

16 A. Unique aspects of service delivery to members in the North GSA

MCCAZ unique experience and approach translates well to meet the needs of members across Arizona. As an Arizona-based company, we know first-hand the strengths, needs and resilience of Arizonians. We have had hundreds of meetings with providers and stakeholders who are ready to partner with us to further advance the delivery system. We already have relationships in place that have been active in the Arizona market for more than a decade. Based on our past experience serving AHCCCS populations and recent conversations with stakeholders, we understand that social determinants of health (SDoH), resources, and conditions within a member's immediate environment may impede their ability to achieve health and wellness goals. We recognize that the availability of health care services and the needs of the population will vary across GSAs. Improvement of member care and health outcomes can only be achieved within the context of where the members live – neighborhoods and communities. To this end, we created the **Integrated Health Neighborhood℠ (IHN)**, where relationships and collaborations with community partners enable us to effectively coordinate care with the community supports and services that the member knows and trusts.

MCCAZ will have an office in Flagstaff with key staff as well as IHN staff who will be regional across the North GSA. We have over 900 Magellan Healthcare (Magellan) associates in Arizona, including senior executive leadership that will be a key part of this program. Our process for identifying and implementing health improvement initiatives begins with local-focused evaluation and analysis of need at the county and ZIP code level. Our knowledge of the communities we serve allows us to excel in the development of innovative strategies to combat vulnerabilities linked to SDoH that further compromise the health status of members. As we customize care and services, AHCCCS can have confidence that local dynamics and challenges will be considered and proactively addressed as we meet the needs of our most vulnerable members. We will bring innovative tools and technology to deliver best practice in care for members across the state.

To better understand the unique aspects of service delivery to members in the North GSA, MCCAZ has invested countless hours meeting with service providers, members, and community stakeholders, understanding Medicaid expenditures and trends and researching specific county health initiatives. We understand the North GSA has a diverse population including communities that are largely represented by the American Indians, bringing a diverse array of cultures, with a significant proportion of individuals under the age of 18 and over 65 residing in these communities. We understand that the American Indian population is disproportionately affected by health conditions like obesity, diabetes, cardiovascular disease, and mental health issues. Based on our experience in this market, MCCAZ has outlined strategies that address the specific physical health (PH) and behavioral health (BH) needs for children, adults, and aging adults. We have a comprehensive provider network already in place to improve access to care and quality of service delivery for members. We have also reviewed the data in the data room specific to the North GSA. We see a greater percentage of childless adults receiving services than the South GSA, with the expansion adults accounting for a very high membership trend and a greater reliance on emergency facilities. There is a consistent trend of spend at the FQHC's in the North GSA with almost twice as much utilized as compared to CYE15, as shown in **Table 16-1**.

Table 16-1. Utilization Trends in the North GSA

Spend by Population Cohort (CYE16)	Spend by Level of Care (CYE16)	Top Trend by Service (CYE16)
▪ Prop 204 Childless Adults 34.0% ▪ TANF Age 21+ 18.0% ▪ TANF Age 1-20 14.4% ▪ SSI W/O 13.2% ▪ Expansion Adults 7.2%	▪ Pharmacy 20% ▪ Hospital Inpatient 18% ▪ Physician 17% ▪ Outpatient Facility 12% ▪ Emergency Facility 10%	▪ FQHC 101% trend ▪ Pharmacy 13% trend ▪ Physician Surgery 5% trend ▪ DME 8% trend

Strategies employed to ensure effective delivery of services

As part of our approach to understanding the unique aspects of service delivery to members in the North GSA, MCCAZ has also reviewed the County Health data to identify key service gaps, local based priorities, and strategies to address these gaps in care. Our approach is to meet the community where they are and leverage best practices currently in place. We will build and enhance the service delivery system to assist AHCCCS in their bold vision of transformation. MCCAZ recognizes the significant impact the Targeted Investment (TI) program will have towards transforming the

delivery systems by improving integration at the provider level. We are committed to working with the TI provider in each core component and supporting their success in the north; building strong collaborative partnerships with TI providers, American Indian members, and special populations. We will be inclusive in our approach and establish a governance structure unique to northern Arizona. Magellan has developed an innovative technology driven suite of tools that supports system transformation called **Magellan Virtual Care Solution (VCS)**, providing individualized treatment in a virtual care environment including: **SmartScreener™** to screen for common BH conditions, substance abuse, and insomnia; **Digital Cognitive Based Therapy (dCBT)**, providing online and app-based cognitive therapy for depression, anxiety disorders, substance abuse, chronic pain, and insomnia; **Clickotine™** and **ClickHeart™**, app-based tools; **online resource library** for PH and BH conditions; and **Live Chat** with a clinician to address urgent issues and receive coaching. These tools are packaged in a seamless user experience. The solution is designed to provide proactive early interventions to reduce escalation to higher levels of care. These innovative technology driven tools allow providers to "prescribe" digital therapies to members to be leveraged through applications that are accessible through cell phones, tablets, and other personal computing devices. The VCS tools assist members with access to treatments on their schedule and in a setting of their choice, and also assists with provider access issues. In addition, providers in Magellan's network are now equipped with an additional innovative treatment option to add to their cadre of treatment approaches.

We will hire local and culturally competent community-based **Provider Support Specialists (PSS)**, **Community Outreach Specialists (COS)**, Community Health Workers (CHW) and other local personnel. Through the use of data, provider and member forums, and surveys, we will continue to analyze the delivery system and proactively address gaps. We already are talking with providers about ways to expand services in the North GSA and will use quality bonuses and other value based strategies to align the incentives across the delivery system. **Table 16-2** summarizes the unique elements in the North GSA with specific strategies/solutions that MCCAZ will look to employ.

Table 16-2. Strategies to Ensure Effective Delivery of Services in the North GSA

Unique Aspects of Care	Strategies/Solutions
Access to Care	
Difficult to navigate delivery system	▪ Offer **Patient Centered Medical Home, IHN approach**, and virtual integration strategies; Offer **bundled payment** to offer unique service delivery model and address SDoH
SDoH factors impacting health and wellness	▪ Launch **IHN** to develop partnership with local social service organization to address SDoH; Employ **"feet on the street" staffing model** while **expanding access to peer services** as well as CHWs**; Partner with agencies** like Buena Vista Children's Services and Catholic Charities to assist veterans and their families, sex-trafficked survivors, victims of domestic abuse, refugees, and the homeless
Lack of consistent source of PCP and specialty providers in Mohave and Navaho County	▪ Use **Telehealth**, expand PCPs through outreach campaign, PCP incentives, and other support; Develop **paramedicine** and other mobile health care delivery; **Incentivize for PCP after hours and 24-hour nurse line access**, leverage Centers of Excellence; Hire American Indian care coordination / care management staff to support providers in service navigation; Hire a **Tribal Coordinator**
Lack of mental health (MH) and substance abuse (SA) specialists and/or confidentiality concerns in rural areas	▪ Leverage **peer support**, CHWs; **Educate/support PCPs related to MH/SA issues** – e.g., PCP Support Line, PCP Tool Kit; Use **VCS**; Tele psychiatry; Contract culturally informed BH providers
Access to healthcare includes long distances and transportation barriers	▪ **Expand beyond basic transportation** including working with first responders, mobile crisis outreach, and non-emergent transportation approaches; Leverage **tele medicine;** use **VCS**
Health Promotion and Education	
Lack of health literacy for healthy lifestyles, including preventive care, importance of	▪ Launch **IHN approach** including community-based staff – e.g., PSS, COS, and CHW; **Educate and train** through health fairs, partnerships with FQHC/CMHC, work with county health officials to target strategies and initiatives, and sponsorships to provide education; Partner with **Su Corazon Su Vida** to

Unique Aspects of Care	Strategies/Solutions
physical activity, healthy eating, and chronic DM	address diabetes in the Hispanic community; Use **innovative programs**– mobile enabled evidence-base practice to help members stop smoking, and expand Disease Management focusing on specific populations with chronic conditions; Offer **decision support tools** and use of **Healthwise™** (or other educational tools /library for DM)
Lack of mental health and behavioral health awareness	▪ Leverage **peers, CHWs** and **partner with existing organizations** like W. Yavapai Guidance Clinic to support free community education**;** Participate and lead **community events**, health fairs and promotion of key campaigns such as mental health month, suicide prevention month, etc.; Provide **online learning, webinars,** use **VCS**
Low health literacy and health education not seen as a priority in many counties	▪ Involve **county agencies in community outreach** and health initiatives; Partner with **counties to provide resources and best practices** around health literacy such as patient-centered communication, materials that reflect age, social/cultural diversity, considerations of communication capacity of members and enhancement of messaging with pictures, videos and interactive features
Culturally Competent Care	
Lack of bilingual providers make it difficult to explain health concerns, symptoms	▪ Focus on PCP education/support – e.g., **PCP Support Line, PCP Tool Kit, PSS;** Leverage **Language Line** and incentivize hiring of bi-lingual staff; Use **Global Interpreters** for face-to-face interpretation
Large concentration of American Indians in rural parts of the North GSA	▪ Provide **cultural training**; bilingual staff and/or Language Line; **Support initiatives for serving American Indian members**: CMC formation, HIE and data linkage, PCMHs; Develop **collaborative protocols with tribal nations** and leadership, hire a **Tribal Coordinator**
Decrease health disparities	▪ Launch IHN approach, targeted DM; Support AZ's Zero Suicide Initiative
Service Delivery System	
Heart disease, obesity, and mgmt of other diseases especially in Apache County	▪ Use **VCS**; Use **Chronic Disease Self-Management Program (CDSMP)** and expand relationships with Su Corazon Su Vida to address diabetes in the Hispanic community; Offer **decision support tools and use of Healthwise** (other educational tools/library for DM)
Over-utilization of ED services in rural counties	▪ Expand use of **paramedicine**, crisis support navigators, access point levels of care / mobile crisis; Pilot **co-location of EMT/secure transport at Flagstaff Shelter Services for SA ambulance dispatches**
High prevalence of SUD, including opioid, alcohol, and smoking; especially Mohave having high opioid prescriber rates	▪ Provide **education to the community/providers** regarding SBIRT, SUD, treatment and community options; information on our website; Work with Mohave Substance Abuse Team to address SUD & alcohol abuse intervention; Implement **Medical Assisted Treatment (MAT)** for SUD, tele medicine & peer support, use **VCS**; Use **TMS Center of Excellence** for high cost service UM and work with MATForce to reduce SA
Lack of dental/oral health care	▪ Expand **tele dentistry; Leverage mobile dental services** – e.g., Arizona Sealant Program with portable dental equipment brought into schools for children; outreach to community campaigns; Offer expanded benefit for adults
Challenges of birth issues	▪ Use **data to identify members who are pregnant**, enroll in care management pregnancy programs to ensure expectant moms are getting the right prenatal care; Partner with Health Start program designed to utilize health educators to provide support and advocacy services to pregnant/postpartum women and their families – e.g., Apache county's Baby Sprouts and North Country; Use Magellan's **Mother Baby Connections Program; Work with providers to expand best practices** – e.g., CenteringPregnancy, decrease elective C-sections, SUD, promote family planning, treatment of STDs, work with home visitation programs

The strategies outlined above are not hypothetical. We will execute a customized approach in Arizona, leveraging our experience and success in other diverse states. The Medicaid agency in Florida undertook a similar transformative RFP in which they integrated and aligned PH, BH, and pharmacy services. MCCAZ will leverage that experience and other local and national implementation to meet the needs of the North GSA.

16 B. Unique aspects of service delivery to members in the South GSA

MCCAZ's unique experience and approach translates well to meet the needs of members across Arizona. As an Arizona-based company, we know first-hand the strengths, needs and resilience of Arizonians. We have had hundreds of meetings with providers and stakeholders who are ready to partner with us to further advance the delivery system. We already have relationships in place that have been active in the Arizona market for more than a decade. Based on our past experience serving AHCCCS populations and recent conversations with stakeholders, we understand that social determinants of health (SDoH), resources, and conditions within a member's immediate environment may impede their ability to achieve health and wellness goals. We recognize that the availability of health care services and the needs of the population will vary across GSAs.

Improvement of member care and health outcomes can only be achieved within the context of where the members live – neighborhoods and communities. To this end, we created the **Integrated Health Neighborhood℠ (IHN)**, where relationships and collaborations with community partners enable us to effectively coordinate care with the community supports and services that the member knows and trusts. MCCAZ will have an office in Tucson with key staff as well as IHN staff who will be regional across the South GSA. We have over 900 Magellan Healthcare (Magellan) associates in the State of Arizona, including senior leadership that will be a part of this program. Our process for identifying and implementing health improvement initiatives begins with local-focused evaluation and analysis of need at the county and ZIP code level. Our knowledge of the communities we serve allows us to excel in the development of innovative strategies to combat vulnerabilities linked to SDoH that further compromise the health status of members. As we customize care and services for our members, AHCCCS can have confidence that local dynamics and challenges will be considered and proactively addressed as we meet the needs of our most vulnerable members. We will also bring in innovative tools and technology to delivery best practice in care for members.

To better understand the unique aspects of service delivery to members in the South GSA, MCCAZ has invested countless hours meeting with service providers, members, and community stakeholders, understanding Medicaid expenditures and trends and researching specific county health initiatives. We understand the South GSA has a diverse population including border communities that are largely Hispanic, bringing a diverse array of cultures. We will hire local and culturally competent community-based staff. MCCAZ has outlined strategies that address the specific PH and BH needs for children, adults and aging adults. We are prepared to design and maximize a comprehensive provider network continuum and to improve access to care and quality of service delivery for all member populations in southern Arizona. In addition to meeting with provider, members, and stakeholders, MCCAZ has also reviewed the data in the data room specific to the South GSA. In the South GSA, we see an increase trend of expansion adults receiving services. We see a greater reliance on emergency facilities than the Central GSA. Finally, there is a consistent trend of spend at the FQHC's in the South GSA with almost twice as much utilized as compared to CYE15, as shown in **Table 16-3.**

Table 16-3. Utilization Trends in the South GSA

Spend by Population Cohort (CYE16)	Spend by Level of Care (CYE16)	Top Trend by Service (CYE16)
▪ Prop 204 Childless Adults 28.5% ▪ TANF Age 21+ 20.4% ▪ TANF Age 1-20 16.5% ▪ SSI W/O 13.0% ▪ Expansion Adults 6.7%	▪ Pharmacy 19% ▪ Hospital Inpatient 18% ▪ Physician 17% ▪ Outpatient Facility 12% ▪ FQHC 9% ▪ Emergency Facility 8%	▪ FQHC 96% trend ▪ Pharmacy 16% trend ▪ Physician Surgery 12% trend ▪ OP Facility 6% trend ▪ DME 16% trend

Strategies employed to ensure effective delivery of services

As part of our approach to understanding the unique aspects of service delivery to members in the South GSA, MCCAZ has also reviewed the County Health data to identify key service gaps, local based priorities, and strategies to address these gaps in care. Our approach is to meet the community where they are and leverage best practices currently in place. We will build and enhance the service delivery system to assist AHCCCS in their bold vision of transformation.

We understand that the South GSA communities are largely represented by Latino, White, and American Indian populations, bringing a diverse array of cultural and linguistic considerations. Although this GSA has a large urban hub within a rural part of the state, there is a shared theme of high rates of poverty, chronic conditions, unemployment and teen birth rates compared to the state as a whole. MCCAZ recognizes the significant impact the Targeted Investment (TI) program will have towards transforming the delivery systems by improving integration at the provider level. We are committed to working with the TI provider in each core component and supporting their success in the south. Building strong collaborative partnerships with TI provider, American Indian members and special populations. We will be inclusive in our approach and establish a governance structure unique to southern Arizona.

Magellan has developed an innovative technology driven suite of tools that supports system transformation called **Magellan Virtual Care Solution (VCS)**, providing individualized treatment in a virtual care environment including: **SmartScreener** app to screen for common BH conditions, substance abuse, and insomnia; **Digital Cognitive Based Therapy (dCBT)**, providing online and app-based cognitive therapy for depression, anxiety disorders, substance abuse, chronic pain, and insomnia; **Clickotine™** and **ClickHeart™**, app-based tools; **online resource library** for PH and BH conditions; and **Live Chat** with a clinician to address urgent issues and receive coaching. These innovative technology driven tools allow providers to "prescribe" digital therapies to members to be leveraged through applications that are accessible through cell phones, tablets, and other personal computing devices. The VCS tools assist members with access to treatments on their schedule and in a setting of their choice, and also assists with provider access issues. Providers are now equipped with an additional innovative treatment options.

We will hire local and culturally competent community-based **Provider Support Specialists (PSS)**, **Community Outreach Specialists (COS)**, Community Health Workers (CHW) and other local personnel. Our data-driven strategies are member directed, provider informed, and geographically specific; leveraging value based incentives across the delivery system, as highlighted in **Table 16-4.**

Table 16-4. Strategies to Ensure Effective Delivery of Services in the South GSA

Unique Aspects of Care	Strategies/Solutions
Access to Care	
Difficult to navigate delivery system	▪ Offer **Patient Centered Medical Home, IHN approach**, and virtual integration strategies; B**undled payment** to offer unique service delivery model, address **SDoH** and collaborate with the **Patient Center Primary Care Collaborative**
SDoH factors impacting health and wellness	▪ Launch **IHN** to develop partnership with local social service organizations to address SDoH; **Employ "feet on the street" staffing model** to meet members in their communities; Expand **access to peer services** and CHWs; engage with AZ Community Action Association in **the Poverty and Justice Project**
Lack of consistent source of PCP and specialty providers	▪ Use **Telehealth**, expand PCP through outreach campaign, PCP incentives and other support; **Develop paramedicine** and other mobile health care delivery methods; **Incentivize for PCP after hours and 24-hour nurse line access;** leverage Centers of Excellence; and Partner through community reinvestment with the **Southern Arizona Children's Health Project**
Shortage of MH/SA specialists; confidentiality concerns	▪ Leverage **peer support**, Community Member Health Workers, COS; **Educate/support to PCPs related to MH/SA issues** – e.g., PCP Support Line, PCP Tool Kit; Use **VCS**
Low utilization of dental care	▪ Expand **tele dentistry; Leverage mobile dental services** – e.g., **Arizona Sealant Program** (portable dental equipment in schools); outreach to community campaigns for dental; Expanded benefit for adults
Access to healthcare includes long distances and transportation barriers	▪ Expand **beyond basic transportation** including working with first responders, mobile crisis outreach and non-emergent transportation approaches; Align with the **University of Arizona Mobile Health Program;** and **Leverage tele medicine;** use **VCS**
Health Promotion and Education	

Unique Aspects of Care	Strategies/Solutions
Lack of or low health literacy for healthy lifestyles (e.g., preventive care, importance of physical activity, healthy eating, and chronic DM)	▪ Launch **IHN approach** including community-based staff – e.g., **PSS, COS, and CHWs** partnering with the Arizona CHW's Association; **Educate and train** at health fairs, partnerships with FQHC/CMHC, work with **county health officials** to target initiatives, and sponsorships to provide education; **Expand DM** programs focusing on specific populations; Offer **decision support tools** and use of **Healthwise™** (or other educational tools /library for DM); and Collaborate with **Activate Tucson, Grow2B Fit and Let's Move! Outside** programs; partner with **YMCA Diabetes Prevention Program; VCS**
Lack of mental health and behavioral health awareness	▪ Leverage **peers, CHWs; Participate and lead community events**, health fairs and promotion of key campaigns such as mental health month, suicide prevention month, etc.; **Provide online learning**, webinars, use **VCS**; Contract culturally informed BH providers
Culturally Competent Care	
Lack of bilingual providers	▪ Focus on PCP education and support - **PCP Support Line, PCP Tool Kit, PSS**; Leverage **Language Line** and incentivize hiring bilingual staff; **Global Interpreters for face-to-face interpretation; Leverage promotoras and CHWs** where possible
Diverse population base especially in border and rural parts of the South GSA	▪ Launch **IHN**, Targeted DM; Provide **cultural training**; Bilingual staff and/or Language Line; Support **initiatives for American Indian members** – e.g., CMCs formation, HIE, and data linkage, PCMHs; Develop **collaborative protocols with tribal nations** and leadership, including hiring a Tribal Coordinator; Work with **promotoras and CHWs** in their communities to understand cultural differences, behaviors, and attitudes towards DM and healthcare; Support **AZ's Zero Suicide Initiative**
Domestic violence is the leading cause of injury in Yuma	▪ Education and outreach using promotoras, CHWs, and peers; **Expand school-based programs**; and **Collaborate with organization** such as **Emerge! Center against Domestic Abuse**, **Southern Arizona Against Sexual Assault,** and **Arizona Coalition to End Sexual and Domestic Violence**
Lack of affordable housing across the South GSA	▪ Work with **housing authorities and T/RBHA's** to leverage dollars and provide supportive housing - e.g., National Community Health Partners, La Frontera, CPLC and Old Pueblo Community Services
Service Delivery System	
Heart disease, obesity, and management of other diseases poses health risks	▪ Use **VCS**; Use **CDSMP**; Collaborate with the **Arizona Asthma Coalition**; Align with **Living Well Institute**, and the **American Academy of Pediatrics Childhood Obesity Committee**; Support the Tohono O'odham Community Action initiatives; Offer **Healthwise** (educational tools/library for DM)
Over-utilization of ED services	▪ Expand **paramedicine**, Crisis Support Navigators, access point level of care and mobile crisis; **Plan re-entry** programs, EMT for mobile services; **Manage high-risk populations** with 24/7 coverage and home visits
High prevalence of SUD, including opioid, alcohol, and smoking	▪ Provide **education to the community/providers** regarding SBIRT, treatment and community options; provide info on our website; work with Amistades –focus on underage alcohol abuse; **Implement Medical Assisted Treatment (MAT),** tele medicine & peer support; Chronic Pain Mgmt Intensive Case Mgmt Program; Use TMS Center of Excellence for high cost service UM; Promote **AZ ASH line; VCS**
55% of Pima in medically underserved areas	▪ Create a **Network Development and Management Plan**; tele medicine and use of CHWs as part of service delivery; **Develop partnerships with first responders** to explore paramedicine approach
Challenges of birth issues (preterm births, low birth rates, lack of prenatal care)	▪ **Mother Baby Connections** program to ensure appropriate prenatal care and care management; **Education and outreach; Incent prenatal care** and after-care; **Offer high risk OB care coordination**; **Collaborate with agencies and community programs** for teens; Partner with p**romatoras, doulas, Health Start**; Work with **providers to expand best practices** – e.g., CenteringPregnancy, SUD, promote family planning, treatment of STDs; work with home visitation programs

The strategies outlined above are not hypothetical. We will execute a customized approach in Arizona, leveraging our experience and success in other diverse states. The Medicaid agency in Florida undertook a similar transformative RFP in which they integrated and aligned PH, BH, and pharmacy services. MCCAZ will leverage that experience and other local and national implementation to meet the needs of the South GSA.

17. Engaging and collaborating with tribes for the delivery of services to American Indian members.

Magellan Complete Care of Arizona (MCCAZ) steps to engage and collaborate with tribes for the delivery of services are founded in an understanding of the complexity of each tribe and the diversity of American Indian members. We recognize the differences in resources, governance structures, geographic remoteness of tribal communities, and access-to-care barriers related to language and culture. We also recognize the sovereign nation status of the 22 tribes in Arizona and place a strong emphasis on developing relationships with tribal nations based on mutual trust through tribal consultation and community involvement. We are aware that over 60 percent of American Indian AHCCCS members reside on reservation lands and that nearly one half (48%) of Arizona's American Indian population are enrolled in AHCCCS. Therefore, it is imperative that tribal nations be consulted on policies to engage and collaborate with tribes for the delivery of services that have significant impact on their American Indian members.

> Magellan Healthcare's tribal initiatives, in markets like Arizona, include improving quality and culturally appropriate integrated physical and behavioral health services that are easily accessible by American Indian members.

We understand that the American Indian population is disproportionately affected by physical health (PH) conditions such as obesity, diabetes, cardiovascular disease, behavioral health (BH) and substance use issues; and has a significantly high rate of suicide and unintentional injuries. These individuals also experience significant barriers to accessing healthcare services. Therefore, we plan to **utilize a systematic process to track barriers once identified, escalate them, and then work collaboratively to find solutions** in an effort to improve member choice, provide effective care coordination, improve health outcomes, and ultimately to assist with successful integrated system transformation.

MCCAZ's model of care includes fully-integrated systems, policies, procedures, and tools, supporting members to ensure provision of individualized primary PH and BH services, coordinated care, access to preventive health services, substance treatment services, and specialty care services. Our model includes locally-defined, culturally diverse, integrated engagement and delivery through our **Integrated Health Neighborhood℠ (IHN)**; targeted interventions/support based on member bio-psycho-social risk, complexity and needs; enhanced member risk assessment, segmentation and stratification; fully-integrated PH-BH clinical protocols; Integrated CM Teams; and, programs specifically designed for high-risk populations and members with special needs. We work across settings, bringing together community resources and nontraditional services to support individualized member needs. Our approach is flexible and we are able to collaborate with providers such as the Indian Health Service (IHS) to ensure that we capture data and information, including HEDIS, gaps in care, and overall claims information in both traditional and nontraditional ways.

Our Magellan of AZ experience as **the RBHA from 2007-2014,** provides the necessary understanding to work with American Indian members and tribal nations; including managing transitions between medical homes. We partnered with ADHS to build processes and procedures that helped inform initial practices; some of which are still in practice today. Our experience working with all tribal nations in Arizona resulted in Memorandums of Agreement (MOA) with the Fort McDowell Yavapai Nation for the delivery of BH, prevention, and crisis services on tribal land; and a Letter of Permission to provide mental health and crisis services to the Tohono O'Odham Nations tribal members. Magellan of AZ was the only managed care organization to forge a MOA with the Phoenix Indian Medical Center (PIMC) to develop and implement an onsite integrated co-located health clinic on their campus.

Magellan of AZ and PIMC integrated health model, **first of its kind in Arizona**, established connectivity for patients with high risk PH and BH needs. The positive outcomes from the co-location of such services improved cross-discipline integrated health coordination in a familiar clinical and community-based setting for American Indian members and their families. We successfully bridged PH and BH systems with a model of care locally to improve access to BH services within tribal communities. Magellan of AZ shaped member choice and participation to American Indian members and in particular, created crisis services and promoted self-directed management of health issues; with shared decision-making with tribal communities, healthcare providers, and peer supports. The following collaborative process example with IHS captures the increase in service capacity and delivery to American Indian members that Magellan of AZ accomplished:

American Indian Medical Home: In 2011, Magellan of AZ established a partnership with IHS and the PIMC through a Collaborative Agreement to co-locate managed care services on the campus of PIMC in order to increase capacity and

accessibility of services for American Indian members. PIMC is one of the largest IHS service units that provides a range of PH and BH services; including emergency, inpatient, ambulatory care, community health services, disease prevention, and health promotion; and encounters the largest number of American Indian AHCCCS members in the state of Arizona. Magellan of AZ, IHS, and PIMC understood the importance of aligning the co-located project alongside the IHS Improvements in Patient Care (IPC) driven medical home model established across the state of Arizona's I/T/U. The collaboration provided opportunities for the enhancement of additional BH services; addressing the unique barriers to service delivery; access to care, program development on and off tribal land, and integrating health services by sharing resources and data exchange. We contracted a provider, Crisis Preparation and Recovery (CPR), Inc., for services that included onsite mental health evaluations for serious mental illness determination, an onsite liaison that streamlined AHCCCS screening and eligibility; provided home-based service outreach, and coordinated care from care management to crisis services. CPR triaged integrated health services for American Indian members accessing services at PIMC and maximized the identification of members enrolled in an acute care health plan or the FFS American Indian Health Plan. Through a coordinated health record with PIMC, CPR was able to identify and manage members at high risk including those with chronic health conditions such as diabetes, alcoholism, depression, and those at greater risk for suicide; ultimately reducing the number of crisis services accessed at PIMC. Using a care Team approach, CPR and PIMC partnered with tribal communities, community health representatives, families, and patients that enhanced health services and provided interventions for patients at the highest risk of utilization.

Demographic research and data has shown that AHCCCS services are increasingly important to American Indians in Arizona who meet AHCCCS Medicaid categorical and financial eligibility, whether they live on or off a reservation and whether or not they are eligible for IHS, tribal nations, Urban Indian Health Facilities (I/T/U) services. MCCAZ understands that these programs support the delivery of health services to individuals residing on or near reservations; as well as those living in urban areas. We also recognize that American Indian members encounter ongoing challenges related to availability of providers and continuity of care. Therefore, MCCAZ is leveraging and building upon our previous experience, MOAs and collaborative protocols with I/T/U and providers to increase access and improve care coordination, integrated care and member outcomes while ensuring that all AHCCCS requirements are met.

Our steps to engage and collaborate with tribes for the delivery of services to American Indian members begins with utilizing our highly trained Tribal Coordinators who work within each awarded Geographic Service Area(s) (GSA). The Tribal Coordinators engage and collaborate with each specific tribe within their assigned regions, ensuring the availability of appropriate and accessible services to include all covered physical health (PH) and BH services that are available to American Indian members; whether they live on or off reservation. Our Tribal Coordinators will work proactively with the tribes, providers, and most importantly members and their families to identify, track, and resolve barriers. As a member of the MCCAZ IHN Team, our Tribal Coordinators interface as the single point of contact with tribal nations and providers to bridge systems of care and to improve the development, accessibility, and delivery of integrated health services for American Indian members.

Our Tribal Coordinators provide the leadership and vision on tribal relations initiatives and will be the cornerstone in leading the Tribal Relations Steering Committees. The Tribal Coordinator is the tribal relations liaison and lead representative to build relationships and collaborations with I/T/U; as well as invested community stakeholders. The Tribal Coordinators will build gap analyses collaboratively with tribal nations and collaborate with providers within the communities to ensure access to care and lead initiative that help resolve identified gaps. We will coordinate service delivery for American Indian members receiving services at IHS or tribally operated 638 facilities, and I/T/U. Our ongoing tribal consultation activities will include monthly meetings with tribes and tribal providers and quarterly meetings with the I/T/Us. We will also collaborate with AHCCCS Contractors in our GSA(s) to facilitate, at least semi-annually, meetings/forums with the I/T/Us that collectively serve American Indian members.

In addition to our experienced Tribal Coordinators for each GSA we are awarded, another step includes hiring staff with experience working with American Indians, including Care Managers, as well as Community Health Workers (CHWs), and Recovery Support Navigators. These roles will be integral in assisting members as they navigate the system, develop culturally competent Individualized Service Plans (ISP), and provide necessary support to our members both in the field and telephonically. Any of these staff may contact and coordinate with the Tribal Coordinator for any concerns or

barriers to be tracked, escalated, and assisted for resolution. An additional step is to develop an Integrated Care Tribal Relations Plan upon Contract award for each tribe to identify gaps and barriers. An overview of all of the steps we will take to engage and collaborate with tribes for the delivery of services to American Indian members by GSA Contract award, include the following:

- Employ and train Tribal Coordinator to be located per GSA awarded that acts as the liaison with tribal nations and tribal providers, attends all AHCCCS tribal consultation meetings, and consults with the internal MCCAZ Team
- Employ staff on our IHN Team with experience working with American Indians (Care Managers, CHW, Recovery Support (Peer) Navigators)
- Develop an Integrated Care Tribal Relations Plan for each tribe to identify gaps and barriers
- Host Stakeholder Forums to explain structure and function of the health plan, member engagement; to gain feedback on historical gaps and barriers; invitations to all tribes and I/T/U
- Initiate and host the Tribal Relations Steering Committee
- Host monthly tribal community meetings
- Host quarterly I/T/U meetings; engage Navajo, Phoenix, and Tucson area IHS
- Host semi-annual forums with AHCCCS Contractors providing services for tribal nations
- Conduct a yearly forum to gain member, provider, and tribal feedback across adult and children's systems.
- Work with Tribal Nations, I/T/Us to improve HIE.

Identifying, escalating, and resolving unique barriers to service delivery on and off tribal lands.

As we noted above, MCCAZ will leverage the previous experience gained as Magellan of AZ partnered with the Arizona Indian Tribes utilizing collaborative protocols that contributed to improving the delivery of services to American Indian members.

Figure 17-1. Feedback Loop for Identification, Escalation, and Resolution of Unique Barriers

Our longstanding partnerships with tribal nations created opportunities to integrate service delivery strategies with the Indian Health Network that focused on identifying unique barriers to service delivery on and off tribal lands that included: equal access to health care services; program development on or near tribal communities; and integrating health services with shared resources. The primary challenge to the delivery of integrated health services to American Indian members is that services are frequently divided between multiple providers, which fragments the continuum of care and disrupts the flow of important health information. It is for these reasons that it is necessary to have a clearly developed process for identifying, escalating, and resolving unique barriers to service delivery both on and off tribal lands. The process begins with tribal consultation and a Tribal Coordinator with lived experience of American Indian culture, geography, and a thorough understanding of tribal governance and its tightly woven partnerships with the I/T/U. Please see **Figure 17-1** for a high level process flow for a feedback loop for identification, escalation, and resolution of unique barriers.

Examples of how our process for identification, escalation and resolution of unique barriers to service delivery on and off tribal lands: Our previous collaborative processes and tribal initiatives as Magellan of AZ addressed partnerships with the Maricopa Country Indian Tribes and created opportunities to integrate service strategies with the Indian Health

Network; comprised of the Indian Health Service (IHS), tribes and tribal programs, and Urban Indian Health Organizations. We were able to resolve multiple barriers that included improving access to timely service delivery to remote reservation lands, program development on tribal lands, program development for BH services on or near tribal communities, and integrating PH and BH, enhanced care coordination, member tracking, accessible transportation, and transitions to healthcare facilities. Magellan of AZ's leadership and clinical initiatives were the mechanisms that directed each task, including the examples below.

Native Health-Tohono O'odham Co-located Project: Magellan of AZ partnered with the Tohono O'odham Nation San Lucy District Health staff and Native Health, Inc., to make available additional community-based adult and children's outpatient services to adult tribal members living on or near the reservation. Native Health, an urban Indian health provider, was the contracted service delivery provider. Native Health acquired an AHCCCS Tribal Provider ID specific to service delivery on the reservation in the Tohono O'odham San Lucy District. Native Health's scope of service included school-based children's service delivery and expanding on-reservation and tribal school-based services to the community's youth and families. Native Health was co-located at the tribal school and at the San Lucy Health Building. The Tohono O'odham Nation led this effort in terms of integrating native health into the Nation's community-based resources.

Native Health launched the Assertive Adolescent and Family Treatment program in the San Lucy District aligning program services with the tribe's need to expand services to members. Native Health provided services to the community specific to two days per week; adding 20 hours of additional service delivery for the community. Onsite community-based services reduced the number of transportation hours for members that previously drove from a remote area of the reservation to an urban-based clinic, and increased the number of service appointments met by community members; including family therapy, individual and group counseling, alcohol, and substance abuse counseling. School-based children's counseling services expanded as Native Health was able to increase care management services and streamline coordinated treatment plans for members. Native Health is a Federally Qualified Health Center (FQHC) and also coordinated referrals and transportation to members that required family practice medical care services at their urban clinics.

Community Reinvestment Southwestern Institute for the Education of Native Americans (SIENA): Magellan of AZ sponsored a community reinvestment initiative in partnership with the Southwestern Institute for the Education of Native Americans (SIENA) to support the Native American Fitness, Lifestyle, Health and Wellness Project; supporting SIENA's initiative to create college scholarship funds for Native American students. Scholarship funds have supported students from various tribes across the southwest region. Magellan of AZ and SIENA focused on work with transition age Native American students to develop the necessary skills to manage, reduce, and eliminate health disparities that affect Native Americans; through life style changes, education, and fitness; and provided shared resources necessary for Native American youth to get the best education they can in a culturally rich environment. Magellan of AZ had the opportunity to work with an organization that focused on the development of education, health, and welfare of Native American communities in Arizona; one of the most underserved populations in the state. This project demonstrates MCCAZ's commitment to support organizations that serve ethnically diverse populations. Magellan of AZ partnered with SIENA and their vision "Native American Leadership Today" which in turn supported the development of programs and resources for Native American students in the areas of apprenticeship, counseling, entrepreneurship, and student mentoring programs. Community reinvestment efforts resulted in Native American obtaining tools to become ambassadors for change in their homes and communities; peer mentors to effectuate personal growth in others, and to take charge of their health and educational success.

Innovation to lead toward a system transformation for American Indian member's healthcare needs: MCCAZ has leveraged our existing relationships to strengthen our partnerships with each of the tribes to create innovative system transformation that includes member voice and choice, service accessibility, and personalized and culturally relevant care. We recognize that it is imperative for us to partner with existing tribal programs and each tribe's strategic plan of initiatives for their communities. We understand that working with tribal communities on program development and enhancement is unique from tribe to tribe.

We also understand that tribes operate from a government-government relationship with the State of Arizona; therefore the expectation for statewide entities to encompass an understanding of the federal trust responsibility regarding health care in Indian Country is key to building sustainable relationships with tribes, as well as sustainable programs in American Indian communities. To strengthen our relationship with the tribes for delivering services to American Indian members, we will develop collaborative relationships with I/T/U serving tribes in our assigned GSA(s) for the purposes encouraging person/family-centered, personalized and culturally relevant healthcare services that result in positive outcomes for American Indian members. Our primary goal is to integrate care to meet specific care needs and to make sure that resources are available to American Indian members, their families, and stakeholders. As indicated above, we will work with different organizations to identify, escalate, and resolve barriers. To ensure the care and services provided to our members is individualized, coordinated, fully-integrated, and cost effective, we use a person- and family-centered approach to reflect the holistic evaluation of each member's circumstances.

The foundation of MCCAZ's approach to implementing person-centered, high quality integrated service delivery is our IHN built on our deep understanding that each member's ability to achieve and maintain a healthy and vibrant life is tied to multiple factors beyond healthcare – namely social determinants of health; such as housing, poverty, education, and access to transportation and healthy food. Through our experience, we know improved overall health and wellness can only be achieved where members live – in Arizona's neighborhoods, communities, and tribal nations. The IHN model allows us to "think locally" as we use our deep understanding of the members, communities and neighborhoods we serve and all available data to design our programs to holistically serve members in each GSA. The IHN is also closely linked with other community services and supports that are critical for the stability, health, and resiliency of our members; including peer and family supports, and engagement.

We recognize the need to address ways to improve health outcomes for American Indians members by creating more robust care coordination and care management for AIHP members. Through our collaborations, we will seek to improve infrastructure, communication, use of data, consistent outcome measures, and application of operational and clinical protocols to assist providers to be successful. We intend to work closely with our providers to build collaborative protocols/partnerships within the community, enhance care coordination and move toward building Patient Centered Medical Homes (PCMH) within their current practices. As part of this process, we will work closely with our tribal, provider, and community partners to design ways to utilize Health Information Technology (HIT) to improve connectivity that will allow the exchange of information needed to coordinate care and improve a member's health outcomes. We understand that there is room for improvement to transform the system of care to effectively work with American Indian members and that collaboration will be imperative to its success. We are engaged and committed to designing innovations that involve the following:

- AZ's An End to Suicide Initiative and Opioid Taskforce
- Intervention and postvention
- Partnering for the use and expansion of telemedicine to include psychiatry mobile units to the reservations
- Increasing coordination with the Veteran's Administration
- Collaborating with tribal police for pilot "iPad-hospital" interface model
- Ensuring smooth transition procedures when members change enrollment between AIHP, MCCAZ, and/or other Contractors
- Develop creative opportunities to ensure access to specialty providers
- Provider and community training for unique culturally related components specific to Americans Indian members
- Building unique transportation options
- Consideration for short-term post-crisis navigation by local providers
- Developing a specific tribal relations webpage on our MCCAZ website
- Improved access to substance abuse treatment options, specifically for opioid and alcohol abuse

To strengthen our relationship with the tribes for delivering services to American Indian members, we will develop collaborative relationships with I/T/U serving tribes in our assigned GSA(s) for the purposes encouraging person/family-centered, personalized and culturally relevant healthcare services that result in positive outcomes for American Indian members. Our primary goal is to integrate care to meet specific care needs and to make sure that resources are available to American Indian members, their families, and stakeholders.

18. Magellan Complete Care of Arizona, Inc. identifies as Category 2: Not a current AHCCCS Contractor, nor affiliate.

Magellan Complete Care of Arizona (MCCAZ) is not a current AHCCCS Contractor nor an Affiliated Organization of a current AHCCCS Contractor; therefore we identify the category for our organization as **"Category 2"**. MCCAZ recognizes that our response is limited to the identified contracts in **Question 1. Contracts** that represent our experience in managing similar healthcare delivery systems to the AHCCCS Complete Care Program. We are pleased to submit our New York health plan, SWH Holdings, Inc.'s, (Senior Whole Health), most recent review in compliance with 42 CFR 438.66 for a business line with physical or integrated physical and behavioral health services. Please see **Attachment 18-1: Report of Examination of Senior Whole Health of New York, Inc**., from July 20, 2017.

Senior Whole Health of New York, Inc., (SWH) received a Certificate of Authority (Certificate) to be a HMO, effective August 17, 2006, from the New York State Department of Health (DOH) to operate as a HMO pursuant to Article 44 of the New York State Public Health Law. In addition, the Certificate also empowered the HMO to enroll members covered under the Medicare program. DOH granted SWH amended Certificate, effective September 15, 2007, which permitted the HMO to participate in New York State's Medicaid Advantage Program. The services delivered by Magellan Healthcare's (Magellan) New York health plan are comparable to the Scope of Services for this AHCCCS Complete Care RFP. These services include serving complex, high-risk populations and providing Medicaid, Medicare, and Medicaid dual-eligible benefits for members.

SWH operates in six counties in the New York City area, and offers three products: (1) Medicaid Managed Long Term Care (MLTC), which covers all Managed Long Term Care Services (MLTSS) for individuals 21 years of age and older who require these services for more than 120 days. Enrollment in an MLTC Plan is mandatory in order to receive services in the areas where SWH operates; (2) Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) where the plan, operating under a Dual Eligible SNP contract with CMS and a Medicaid Advantage Plus contract with the State of New York, is responsible for all benefits including physical health, MLTSS, behavioral health, long-term care, dental, vision, and transportation. Enrollment is voluntary and individuals receive a single ID card and a single health plan that integrates all Medicare and Medicaid services; and (3) FIDA in New York, which stands for Fully Integrated Dual Advantage and is part of the CMS Financial Alignment Demonstration. In FIDA, SWH has a single three-way contract with CMS and the State of New York to cover Medicare and Medicaid benefits for individuals 21 years of age and older, including long-term care, behavioral health, transportation, dental, and vision. The FIDE SNP and the FIDA products both provide advanced forms of integration and serve the dual population; yet they operate under slightly different payment methods and administrative structures with the goal of the FIDA product as a demonstration to simplify the operations and improve efficiencies and/or care outcomes.

The required elements for CFR 42 438.66 reviewed by the State of New York are similar in scope to the AHCCCS Complete Care Program including the areas of: Enrollment and Disenrollment; Beneficiary Notification; Payment; Providers and Provider Network; Coverage; Quality and Utilization Management; Grievances and Appeals; Program Integrity; and Health Information Systems and Enrollee Data. In addition to state audits, our Compliance Department oversees the seven fundamental elements (Standards of Conduct; Compliance Officer; Education and Training; Reporting Problems and Incidents; Responding to Problems and Enforcement; Audits and Monitoring Compliance; and Response Plan and Corrective Actions), of an effective compliance program and is committed to conducting health plan management administrative services in a manner that is consistent with recognized compliance standards. We have strong compliance oversight with internal monitoring including a Policy and Procedure Committee; focused on ensuring policies and procedures are well documented and implemented to meet all regulatory requirements.

Our Compliance Department performs regular internal mock audits that include sampling data to ensure Magellan is meeting all regulatory requirements. As noted in the SWH findings, **the majority of items had been remedied by the time the report was generated.** In addition, **any remaining deficiencies noted in the audit have been remedied to the satisfaction of the State of New York.**

Magellan Complete Care of Florida, Inc., our other referenced Medicaid plan, is also a comparable health plan; however, it has not yet had a CFR 42 438.66 audit with the Agency for Health Care Administration (AHCA).

ORAL PRESENTATIONS

A list of the names and titles of individuals participating in the oral presentation, as well as accompanying resumes, can be found in the Oral Presentations folder, per RFP instructions, as follows:

- Names and Titles of Participating Individuals – **Page 116**
- Resumes of Participating Individuals – **Pages 117-136**

EXHIBIT D: A.R.S. §35-393.01 ATTESTATION

Recognizing legislation has been enacted to prohibit the State from contracting with companies currently engaged in a boycott of Israel, to ensure compliance with A.R.S. §35-393.01, this form must be completed and returned with the response to the solicitation and any supporting information to assist the State in making its determination of compliance.

As defined by A.R.S. §35-393.01:

1."Boycott" means engaging in a refusal to deal, terminating business activities or performing other actions that are intended to limit commercial relations with Israel or with persons or entities doing business in Israel or in territories controlled by Israel, if those actions are taken either:
(a) In compliance with or adherence to calls for a boycott of Israel other than those boycotts to which 50 United States Code section 4607(c) applies.
(b) In a manner that discriminates on the basis of nationality, national origin or religion and that is not based on a valid business reason.
2. "Company" means a sole proprietorship, organization, association, corporation, partnership, joint venture, limited partnership, limited liability partnership, limited liability company or other entity or business association, and includes a wholly owned subsidiary, majority-owned subsidiary, parent company or affiliate.
3. "Direct holdings" means all publicly traded securities of a company that are held directly by the state treasurer or a retirement system in an actively managed account or fund in which the retirement system owns all shares or interests.
4."Indirect holdings" means all securities of a company that are held in an account or fund, including a mutual fund, that is managed by one or more persons who are not employed by the state treasurer or a retirement system, if the state treasurer or retirement system owns shares or interests either:
(a) together with other investors that are not subject to this section.
(b) that are held in an index fund.
5."Public entity" means this State, a political subdivision of this STATE or an agency, board, commission or department of this state or a political subdivision of this state.
6. "Public fund" means the state treasurer or a retirement system.
7. "Restricted companies" means companies that boycott Israel.
8. "Retirement system" means a retirement plan or system that is established by or pursuant to title 38.

All Offerors must select one of the following:

X My company **does not** participate in, and agrees not to participate in during the term of the contract a boycott of Israel in accordance with A.R.S. §35-393.01.

_____ My company **does** participate in a boycott of Israel as defined by A.R.S. §35-393.01. :

By submitting this response, proposer agrees to indemnify and hold the State, its agents and employees, harmless from any claims or causes of action relating to the State's action based upon reliance on the above representations, including the payment of all costs and attorney fees incurred by the State in defending such an action.

Magellan Complete Care of Arizona, Inc.	
Company Name	Signature of Person Authorized to Sign
4800 N. Scottsdale Rd. Suite 4400	James R. Stringham
Address	Printed Name
Scottsdale AZ 85251	CEO
City State Zip	Title

Exhibit E: Affiliated Organization Attestation

Affiliated Organization means a party that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with an entity.

Offeror Name: **Magellan Complete Care of Arizona, Inc.**

Affiliated Organization Name: **NA**

All Offerors must select one of the following:

____ The Offeror is bidding as an Affiliated Organization and attests to the following:

The Offeror shall come into compliance with the Affiliated Organization requirements of the RFP YH19-0001 no later than October 1, 2018.

- If the Offeror awarded an AHCCCS Complete Care Contract (the AHCCCS Complete Care Contractor) has an Affiliated Organization that holds an AHCCCS RBHA contract serving one or more counties in the same Geographic Service Area (the RBHA affiliate), the Offeror shall make arrangements for a single legal entity to hold both the RBHA and AHCCCS Complete Care Contract effective on or before October 1, 2018. This requirement does not apply to Gila or Pinal County.

- The Offeror shall establish a single brand and market the services provided under both the AHCCCS Complete Care Contract and the RBHA contract as a single product.

X The Offeror is not bidding as an Affiliated Organization.

Magellan Complete Care of Arizona, Inc.	
Company Name	Signature of Person Authorized to Sign
4800 N. Scottsdale Rd. Suite 4400	**James R. Stringham**
Address	Printed Name
Scottsdale AZ 85251	**CEO**
City State Zip	Title

Exhibit F: State Only Pregnancy Termination Agreement

THIS AGREEMENT is entered into by and between the Arizona Health Care Cost Containment System (AHCCCS), located at 701 E. Jefferson, Phoenix, Arizona 85034, and **Magellan Complete Care of Arizona, Inc.** (Offeror).

WHEREAS, it is the intention of AHCCCS to use the services of the Contractor for medically necessary pregnancy terminations.

WHEREAS, the Contractor represents itself to be qualified for such services in accordance with all applicable laws and regulations governing this profession.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants and agreements hereinafter set forth, the parties hereto, and legally intending to be bound thereby, do covenant and agree for themselves and their respective successors and assigns as follows:

1. The Contractor agrees to provide those services described below:

   1.1 Pregnancy terminations which are medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:

      1.1.1 Creating a serious physical or mental health problem for the pregnant member,

      1.1.2 Seriously impairing a bodily function of the pregnant member,

      1.1.3 Causing dysfunction of a bodily organ or part of the pregnant member,

      1.1.4 Exacerbating a health problem of the pregnant member, or

      1.1.5 Preventing the pregnant member from obtaining treatment for a health problem.

   1.2 Conditions, Limitations and Exclusions:

      1.2.1 The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the *Certificate of Necessity for Pregnancy Termination* and clinical information that supports the medical necessity for the procedure, as referenced in the AHCCCS Medical Policy Manual (AMPM), Chapter 400, Policy 410, *Maternity Care Services*. This form must be submitted to the appropriate assigned Contractor Medical Director or designee for enrolled pregnant members, or the AHCCCS Chief Medical Officer or designee for Fee-For-Service (FFS) members. The Certificate must certify that, in the physician's professional judgment, one or more of the above criteria have been met.

1.2.2 Pregnancy terminations must be provided in compliance with AMPM Policy 410, *Maternity Care Services*.

2. All outpatient medically necessary covered services related to the pregnancy termination, for dates of service only on the day the pregnancy was terminated, will be considered for reimbursement at 100% of the lesser of the contractors paid amount or the AHCCCS Fee Schedule amount. Adjudicated encounters for these covered services provided to enrolled members will be used to determine reimbursement.

3. Any changes, modifications or revisions to this Agreement shall only be executed through a written amendment, issued and signed by the authorized AHCCCS procurement officer.

4. Either party to this Agreement may terminate this Agreement without penalty by giving the other party written notice of such termination at least thirty (30) days prior to termination.

5. This agreement shall be governed by the laws of the State of Arizona.

6. The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its service hereunder.

7. The Contractor shall not assign any interest in this Agreement, and shall not transfer any interest, whatsoever, in the same (whether by assignment or novation), without the prior written consent of AHCCCS.

8. The initial term of this Agreement shall be for the term **October 1, 2018** through **September 30, 2024.**

9. Termination – Availability of Funds: If, funds are not presently available to support the continuation of performance under this Contract beyond the current fiscal year, this Contract may be terminated at the end of the period for which funds are available. No legal liability on the part of AHCCCS for any payment may arise under this Contract until funds are made available for performance of this Contract.

   Notwithstanding any other provision in the Agreement, this Agreement may be terminated by Contractor, if, for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining this Agreement. In the event of such termination, the Contractor shall have no further obligation to AHCCCS.

   IN WITNESS WHEREOF, the parties have executed this agreement the day and year first written above.

10. Termination For Conflict of Interest: AHCCCS may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of AHCCCS is, or becomes at any time while the Contract or any extension of the Contract is in effect, an employee of, or a consultant to, any other party to this Contract with respect to the subject matter of the Contract. The

cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.

If the Contractor is a political subdivision of the State, it may also cancel this Contract as provided by A.R.S. §38-511.

Magellan Complete Care of Arizona, Inc.	
Offeror Name	Signature of Person Authorized to Sign
4800 N. Scottsdale Rd. Suite 4400	**James R. Stringham**
Address	Printed Name
Scottsdale **AZ** **85252**	**CEO**
City State Zip	Title