Magellan Complete Care of Virginia
(MCC of VA)
Managed Long Term Services and Supports (MLTSS) Program
Model of Care

DRAFT

1/11/2017
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Overview and Approach

Magellan Complete Care of Virginia (MCC of VA) delivers a fully integrated model of care (MOC) specially designed for members of the MLTSS Program presenting with multiple behavioral and physical chronic conditions and long term services and supports needs. This model of care document describes our overarching MLTSS program approach. Separate and detailed Care Coordination, Utilization Management, Behavioral Health, Perinatal, Early Periodic Screening and Testing (EPSDT), Disease Management, and Nursing Facility Based Care program descriptions have been developed as an adjunct to this MOC document. Additional program descriptions and documents will continue to be developed based on program and membership need. In addition, MCC of VA has developed a library of policies, procedures, and process flows which complement our Care Coordination and Utilization Management programs.

Our model improves the health status of Virginians by developing person-centered care coordination delivered through an Integrated Health Neighborhood, which integrates community resources and non-traditional services within the local health systems. We ensure natural and peer supports, housing, and employment are in place in addition to traditional behavioral and medical treatment resources.

The key processes of our MOC in Virginia will:

- Identify the health, housing, employment status, health risk, and gaps in care of each individual through health risk screening, use of predictive modeling and health analytics
- Integrate physical, behavioral, long-term care, and waiver services with Care Coordination Teams and a single integrated individualized care plan (ICP)
- Promote member goals and aspirations by using the principles of self-determination: Freedom to plan one’s own life; Authority over one’s own resources; Support for building a life in one’s community; and Responsibility to give back to one’s community
- Incorporate the principles of recovery and resiliency including self-direction, strengths orientation and peer support, and transition navigation services
- Support practice transformation and integrated health homes within the MCC of VA provider network, focusing on meeting the needs of chronic disease and vulnerable sub-population individuals
- Improve member outcomes and quality of care by supporting providers with real-time gaps-in-care reporting, academic detailing on quality improvement, and support for practice transformation and change
- Support asset mapping and self-directed care planning which incorporates the member’s ability to organize supports and services in the community, and may include goals related to employment, transportation, life skills, and interventions for permanent housing
- Expand the existing community and health plan care coordination and partnership efforts through the creation of regional health neighborhoods throughout Virginia
- Design, expand, and manage an extensive Virginia provider network which addresses rural geographic regions through expansion of the delivery system by various methods including telehealth and telemedicine
Ensure clear and real-time awareness of the efficiency and effectiveness of Virginia managed care programs through ongoing analysis of health assessment, care planning, physical health and pharmacy claims data, and member and provider satisfaction levels and feedback.

Evaluate health risk, use of services, clinical processes, network availability and capacity, and performance outcomes.

Be responsive to the member’s needs and preferences, and take into account the health, safety, and welfare of its members.

Integrated Health Neighborhood

The Integrated Health Neighborhood (IHN) customizes MCC of VA’s MOC by region. MCC of VA’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 communities. Our Neighborhood care coordination team members live and work within the communities where our members reside. These team members have first-hand knowledge of community strengths, resources, services, and service gaps. Neighborhood team members include Care Coordinators (CC), Health Guides, Peer Specialists and Navigators, and Community Outreach Specialists supported by Housing Specialists, Employment Specialists, Clinical Pharmacists, Medical Directors, and others. We created the IHN concept where relationships and collaborations with community partners enable us to effectively coordinate care with the community supports and services the member knows and trusts and the provider delivery system can easily access. The IHN is MCC of VA’s vehicle to drive close collaboration with community partners, allowing us to customize care for our members to provide a seamless, one-stop system of services and supports. The IHN model naturally bridges language and cultural barriers and more effectively and efficiently facilitates access to services to support our members and families where they live, work and play.
This MOC is the framework for MCC of VA’s approach to serving a population who will benefit from Long-Term Services and Supports (LTSS). We comply with and have incorporated within our MOC, DMAS’s requirements, the NCQA Standards for MLTSS Care Management 2016 requirements, and applicable State and federal regulations and requirements.

Our MOC emphasizes recovery, stabilization, health maintenance, optimal safety and quality, and independence through partnering with the member, their natural supports and providers. We emphasize a whole person approach across the spectrum of care and service needs. Our provider network partnerships are built with this goal in mind, consisting of traditional healthcare providers, behavioral health specialists, LTSS, and other community agencies and resources with a shared commitment to person-centeredness, evidence-based treatment, robust communication, and teamwork.

In recognition of the complex and unique needs of our members, this MOC is continuously updated and expanded through ongoing monitoring and quality improvement initiatives. The success of MCC of VA’s dedication to quality improvement is recognized on national and state levels.

MCC of VA has the necessary values, experience and community-based provider infrastructure to assist Virginia in moving members with potential for high nursing facility utilization and those living within the community without necessary supports to a person-centered home and community-based support services setting. We believe individuals should have a choice in
where they live and receive LTSS. These same individuals are at the center of and participate in their respective service planning activities.

Based on our experience in several markets, we fully understand the current challenges LTSS programs face daily. Our innovative service coordination approach is built on a platform of historically successful performance, where we promote the use of high quality services and cost-effective approaches to assist in developing person-centered service plans. We offer access to evidence-based services, robust communication, teamwork, and a culture of “going the extra mile.”

In support of the Triple Aim\(^1\), our MOC supports improving the member experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of healthcare.

In addition, MCC of VA 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, MCC of VA’s, and DMAS’s program goals. MCC of VA is a leader in modeling the way for members needing LTSS and specialized health plan services.

MCC of VA has an experienced LTSS leadership team including physicians, directors (LTSS and UM/CM) and managers, and continues to expand our team of experts to oversee and administer the intricacies of the LTSS programs. We provide our services in collaboration with the following partners:

**Magellan Health, Inc. (Magellan):** Magellan has managed programs for large populations of Medicaid members across the country. Magellan is a leading Health Care Management Organization providing behavioral health, radiology, and pharmacy management services, serving approximately 59 million enrollees in all 50 states with annual gross revenues of $3.2 billion. Through this broad national experience, we developed numerous successful strategies for delivering clinical services, along with wellness programs that emphasize self-management and integrated, holistic health care to members.

Magellan has a strong focus on managing fully integrated healthcare benefits and programs for special populations with complex health issues and significant co-morbid conditions through care management. These programs begin with a health risk assessment and risk stratification and include utilization management of all healthcare services (medical and behavioral); integrated (medical and behavioral) care coordination and complex case management; integrated service delivery; management of transitions of care; and management of Medicare Advantage and Special Needs Plans.

**Shared Health:** MCC of VA will work in conjunction with and use Shared Health as a subcontractor for operational processing and administration services including, telephonic participant support services, enrollment activities, claims processing, information systems,

quality assurance of LTSS care plans, and overall administrative support for the IHN, primary CC and Interdisciplinary Care Team (ICT). Detailed policies, procedures, and process flows have been developed for each service that the Shared Health team provides.

Shared Health is a wholly owned subsidiary of BlueCross BlueShield of Tennessee (BCBST) and is located in Chattanooga, Tennessee. Shared Health was originally established by BCBST in July 2005 to transform healthcare by offering secure, innovative health information technology (HIT) solutions.

In 2014, Shared Health modified its mission to help managed care organizations improve their services and specializes in managed care solutions for the underserved, chronically ill, and LTSS populations.

**TMG:** Magellan recently acquired The Management Group (TMG), a provider of consumer directed, community-based LTSS and Medicaid Home and Community Based Waiver quality assurance and improvement services. With 30 years of experience partnering with the State of Wisconsin’s Department of Health Services in support of Wisconsin’s older adults and adults with physical or developmental disabilities, TMG has experienced broad success in partnering with people who self-direct their LTSS. Magellan acquired TMG because they understand that face-to-face, one-on-one relationships are integral to supporting Participants to achieve their goals.

Magellan, through TMG, is responsible for providing a broad spectrum of direct service support, nursing supervision, eligibility screening, and administrative functions for over 13,000 individuals with long-term services and supports needs in the innovative Wisconsin IRIS (Include, Respect, I Self-Direct) self-directed care program. This effort represents the largest program of its type in the nation.

**Implementation and transition in new markets:** When entering a new market or when taking on new membership in an existing market, we ensure the individuals we serve receive needed community-based supports and health care services and do not experience a disruption of services at any time. MCC of VA understands the importance of coordinating seamless transition of LTSS services during program implementation to prevent any fragmentation or duplication of care and to help ensure member safety. MCC of VA will work with DMAS to help ensure that services during periods of transition are not reduced, modified, or terminated in the absence of an updated assessment and individualized care plan.

During implementation and transition, we adhere to the following three primary focus areas:

- Ensure members have no disruption of service
- Ensure providers are paid timely and accurately
- Implement healthcare delivery and service improvements to improve clinical and quality outcomes and deliver cost savings for the state of Virginia

All aspects of our care coordination program and other MCC of VA services (such as pharmacy) are available and accessible to the LTSS members. Given our vast experience with Virginia Medicaid, paired with our current health plan best practice approaches, our LTSS program continues to focus on a “whole person,” centered approach. As a specialized health plan, we collaborate with members, providers, community partners, State agencies, and other key stakeholders to fully integrate the delivery and provision of LTSS. We actively participate
in community reinvestment by offering care and service programs to assist in promoting safe, high-quality and cost-effective care approaches.

MCC of VA proactively assists DMAS move closer to their goal to have a more balanced LTSS system. For institutionalized members, we collaborate with the member and providers in connecting both older adults and younger members with disabilities to other community-based programs, including less costly services and supports.

We assist members to connect with resources beyond LTSS programs, including faith-based programs, supporting them in building “circles of support” in their communities. AARP research shows that nationally, large percentages of consumers aged 50 and over say it is important to stay in their own homes as they age. Our person-centered MOC and care coordination program is specifically designed to assist in serving the LTSS population (all community and institutional based programs) with diverse family and natural support systems along with varying health, medical and psychosocial service and support needs.

When members reside in nursing or assisted living facilities, the facilities are primarily responsible for the care, support, and treatment of the individuals, and for addressing health and safety needs. Our MCC of VA clinical team will provide service coordination and quality oversight to members residing in these facilities. MCC of VA collaborates with the nursing facilities through CCs who are on site, visit and round regularly at the facility.

We have a unique approach which begins with building relationships with individuals. This relationship between our CC and member leads to engagement and creates the foundation for our work together. For members in all age groups and programs, either living in their own homes or other community-based residential settings, CCs serve as the primary point of contact, assess the member’s situation, and assist with the development of a person-centered service plan to address their care and service needs. The person-centered plan reinforces achieving optimal health and safety at all times. We proactively address risks inherent in a members’ desire to live as independently as possible.

For members who require individualized, enhanced staffing patterns for support in a less-restrictive setting, we do not reduce the enhanced staffing arbitrarily or without a supporting assessment, which justifies the reduction in clinical need as documented and is agreed upon by the member’s Primary Care Provider (PCP) and always include the member in any individualized care plan alteration.

We directly assist with the coordination of our members’ LTSS and in some instances, directly coordinate acute care services as well. In any event, we are always aware of the services our members are receiving, both LTSS and acute – as all care and services are integrated into the person-centered, individualized care plan. Our LTSS Director and LTSS Managers oversee and manage all aspects of the population.

Each member is assigned a CC with the support of a regionally-based team of experts, including physicians, social workers, pharmacists, and health guides to name a few. Our model focuses on improving the health status of individuals by developing person-centered care coordination, engaging members, partnering with providers, and integrating community resources and non-traditional services within the local health systems. For members presenting with chronic conditions, we focus our efforts on optimizing their health and well-being and stabilizing the condition to prevent future complications.
Our model builds an infrastructure with the health and social services system, which supports and enhances the relationship between members and their providers. We collaborate with providers and other community partners to assist our members achieve their health, wellness, and self-management goals.

We also partner with and help members achieve independent, safe, and healthy living in the least restrictive setting by integrating traditional physical and behavioral health, rehabilitation and habilitation approaches along with addressing social and supportive care needs.

Our care coordination teams focus on supporting members within the community and within institutional settings through the use of an ICT, coordination with community agencies and resources, and provision of LTSS. Our care coordination staff is regionally-based and live within the communities where our members live.

Our regional care teams are familiar with the community resources and include members when making support and service choices. Our model emphasizes treating the whole person across the spectrum of their care and service needs, promoting optimal health and well-being. Our provider network partnerships are built with the same goal in mind, consisting of traditional healthcare providers, behavioral health, intellectual disability specialists, LTSS and other community resources.

Over the years, we have learned from our members, providers, and partners most of who have lived or worked with chronic illnesses and disabilities for long periods of time. Recently, we spoke to one of our members, Mary, a 59-year-old with a disability and chronic illnesses who was receiving habilitation services. Mary shared her story and journey as she had faced many hurdles in obtaining reliable community-based caregivers who were reliable and trained in the areas of assistance she needed the most. In addition, Mary had difficulty in obtaining needed equipment for use in her daily mobility functioning. Once received, if the equipment malfunctioned, it was difficult to get a replacement or get the existing equipment repaired in a timely manner. Mary summed it up by telling us that she “wrote the book” on having to figure out how to navigate the healthcare and institutional and home and community-based waiver system. Mary is hopeful that her journey and the journey for other members will get easier.

**Focus on Service Integration and Integrated Care:** We provide an integrated and blended approach to care coordination. This approach decreases duplication of efforts and promotes a smooth and seamless member experience. Using an integrated, high touch, team-based approach, CC’s partner with each member to address the full continuum of care, services, and supports simultaneously rather than in a linear or sequential manner.

This model allows us to continually adjust our interventions based on evolving member needs, risk levels, and circumstances. We embrace a proactive population health paradigm that:

- Focuses on the individual member first along with the broader community needs
- Emphasizes sound identification of individual member health status and needs
- Delivers effective, compliant, high quality, and cost effective services
- Monitors, measures, and improves member safety and health outcomes

The CC is the primary point of contact for members, supported by a team who assists with coordinating LTSS and non-LTSS services. To meet each member’s needs and achieve desired health outcomes, we also collaborate with care managers who specialize in coordinating care for individuals with specialized or complex needs, including but not limited to: D-
SNP/Medicare Advantage care managers; brain injury care managers; disease/condition care managers; community outreach workers; behavioral health professionals; other internal supports, support center staff, and transition coordinators; community agencies; home health and hospice; community case managers; and each member’s PCP or specialist. MCC of VA fully supports provider participation on the member’s ICT, as this involvement is an integral and essential addition to the traditional Triple Aim model, and reflects our commitment to our Quadruple Aim approach.

CCs perform care coordination and care management activities, beginning with the initial assessment which guides the CC in taking the next steps to partner with the member, the interdisciplinary care team, and other resources to determine what LTSS and non-LTSS needs are present and to begin the care planning process. Ongoing monitoring and follow-up assessments are based on member need and documented within the CareAdvance system.

**Description of the MLTSS Target Population**

**Identification of Target Population:** The MOC delivered to an individual is based on his or her unique characteristics, requiring us to rapidly identify the individual’s primary medical, behavioral, substance use, functional or developmental status and applicable diagnosis as well as the Medicaid and Medicare covered services for which the individual is eligible, including waiver eligibility. MCC of VA will use a proprietary software system to identify and stratify members for care coordination and disease management (DM) and focus interventions tailored to the member’s assessed risks and needs.

Unlike traditional risk stratification programs, our analytic software categorizes members into five proprietary lifestyle “personas” based on a range of data collected from assessments, biometric screenings, historical claims data and more. MCC of VA uses this data to predict future outcomes and behavior, stratify members for enrollment into appropriate programs, and provide personalized messaging. Our software is designed to reach the member in the right way and through their preferred method (e.g., telephone, mail, or email).

Our software immediately analyzes enrollment files to identify an individual’s eligibility and assigned benefits. Next, it analyzes available medical, behavioral and pharmacy claims data to create a list of potential diagnoses, prescribed medications, and calculate predictive risk scores. As Health Risk Assessment information becomes available, it is used to further define, refine, and inform the risk scores and the individual’s needs and ensure assignment to the appropriate sub-population and MOC level as well as identify gaps in care. We calibrate the intensity of our care coordination approaches based on the individual needs of the members. These care coordination approaches can range from members receiving mail reminders or a health coach to receiving intensive community based, face to face visits between the primary CC and member.

**Overarching Description of Approach for the MLTSS Target Sub-Populations:** MCC of VA’s MOC is specifically designed with customizations for each of the target sub-populations. Our approach addresses the unique needs of children, dual eligible members, and members with co-occurring conditions.

- **Children:** Including infants, toddlers, children, and adolescents under age 21 years, this group is unified by qualifying for EPSDT benefits and the focus on correcting or ameliorating the impacts of all conditions discovered during the periodic screening activities. The group is unique because of the broad diversity of diagnoses, and age-related conditions...
characteristics. The physiology of children and adolescents changes as they age requiring changes in treatment plan, medications, and developmental and behavioral expectations.

MCC of VA customizes its MOC to children and adolescents by building within our analytic system algorithms, which classify risk relative to only other children and adolescents and ensures that risk is not under-predicted by comparing against adult populations. We assign CCs and medical directors with clinical experience and training with the pediatric population. We develop community partnerships specific to this population, including working with the Early Intervention local lead agency and school systems, families, and guardians in each region to ensure our members receive all necessary services.

MCC of VA considers all Medicaid covered youth to be at higher risk for developing mental, emotional and behavioral disorders, and with proactive care planning we address the prevention of child maltreatment, monitor academic achievement, and identify the needs of victims of violence. Each member’s ICP will prioritize the treatment of conduct problems, mood disorders, substance use, anxiety, and multiple disorders including intellectual and developmental disabilities. We have experience working with children who have been placed in foster care and address, head on, the complexities of transiency for these children. We collaborate with the foster care system to ensure that children experience a more permanent and stable foster care placement whenever possible.

- **Dual Eligible:** Dual eligible members are individuals whose health coverage benefits are divided between Medicare and Medicaid covered services. Medicare services may be administered as fee-for-service Medicare (Parts A/B) or through Medicare Advantage or a Medicare Special Needs Plans (Part C). The core covered benefits for Medicare are the same, but Medicare Advantage and Special Needs plan may offer additional benefits. This group also includes distinct sub-populations with different needs. MCC of VA customizes its MOC to dual eligible members by stratifying this group into sub-populations.

We match a CC with clinical expertise relevant to the member. For example, SMI is common among the under age 65 dual eligible population, and the CCs who work with this population have clinical expertise in SMI and SUD, DD/DI and/or SED. For dual eligible members over age 65, CCs have clinical expertise and training in geriatrics, and chronic illness management of common lung, heart, and GI disorders. The MCC CC will coordinate with the Medicare Advantage or Special Needs Plan case manager. S/he will integrate Medicare covered services such as the primary, specialized and behavioral health services with covered Medicaid and waiver services, with all of these services included in the ICP. The CC ensures authorization is in place for needed Medicare covered services as part of the implementation of the ICP.

Dual Eligible members are one of the State’s most vulnerable populations due to low income, poor health literacy, complex medical conditions, and very high health and long-term care needs and costs. People living with a serious mental illness are at higher risk of experiencing a wide range of chronic physical conditions. MCC of VA partners with a broad network of community partners to provide services and resources to these members. Upon discovery of needed services and resources (e.g., lack of food, shelter, or needed assistance with utilities and clothes, etc.), our CCs provide outreach to several community partners to help coordinate services appropriate to the enrollee’s needs. CCs maintain
current information regarding available services in the community within the Community Services Contact Grid.

- **Co-occurring Conditions:** As a health plan for individuals who are experiencing SMI, SUD, and SED, Magellan is an expert at working with providers to help identify, treat, or refer members diagnosed with SUD, which co-occur with behavioral health conditions. The incidence of co-occurring SUD is high in members with behavioral health conditions. MCC of VA CCs are trained to identify and coordinate care for members diagnosed with SUD. We also train our primary care providers to screen for common co-morbid behavioral health conditions and offer access to the same tablet enabled screening tools used by our care managers. Because of the high incidence of opioid dependence, we also help our provider network build additional capacity to support medication assisted treatment and office based opioid treatment.

**Description of Approach for Each MLTSS Target Sub-Populations:**

**Individuals Enrolled in Waivers:** Members receiving waiver services are among the most vulnerable sub-populations. Children and adolescents covered by these waivers will have EPSDT services coordinated, and the CC also works closely with the member’s Individual Educational Plan (IEP) Coordinator and service providers. All members with dual eligibility will have services coordinated with their Medicare, Medicare Advantage, or Special Needs Program. Family support services and community resources are addressed. Caregivers are offered an opportunity to complete an assessment to more thoroughly determine their needs and supports.

**Technology Assisted Waiver:** Individuals enrolled in the Technology Assisted Waiver are identified from enrollment files, which are analyzed daily. Since the majority of technology dependent children and adults have neuromuscular disease, central nervous system disease, chronic lung disease, airway problems, or have significant respiratory and nutritional support needs or require dialysis, predictive analytics are also utilized for case finding. The assigned CC is a nurse with hospital experience caring for individuals with complex medical conditions and respiratory support and ventilator operation. Nurses with neonatal or pediatric experience are matched with children receiving services under the waiver.

Rapid outreach ensures that high medical needs and services are in place, the private duty nursing services are meeting the member’s needs, the member has an engaged PCP, needed equipment is in place, and family and other community supports are identified and arranged. Specific assessments for adults and children are used, which assess the safety of the member’s physical environment, status of equipment, specific nutritional needs, quality of the private duty nursing care, emergency/disaster preparedness, and the need for respite care for family and caregivers.

**Elderly or Disabled with Consumer Direction (EDCD) Waiver:** Individuals enrolled in this waiver are identified from the State enrollment files and results generated by the HRA. The cornerstone of our person-centered approach involves genuine partnerships with each member. Unlike conventional models that surround the member with professionals and providers, our CC partners with the member, working in tandem to achieve their personal goals for a vibrant and healthy life. This model involves providing information, tools, and resources so members can make informed choices and understand consumer-directed service options, and supporting
and coaching as members bring about changes in their lives. It is a partnership built on conversations and understanding that often starts around the member’s kitchen table.

MCC of VA will partner with Centers for Independent Living (CILs), which provide an array of services that assist Virginians with all disabilities live fully integrated and self-directed lives. CILs assist with all aspects of living, learning, and earning. In addition, we use MySupport, a web-based system that assists members in locating and screening potential homecare workers. Members who do not have Internet access or are unable to use the technology necessary to access MySupport can receive assistance through our LTSS Support Center.

**Day Support for Persons with Intellectual Disabilities (DS) Waiver:** Individuals enrolled in this waiver are identified from the State enrollment files. MCC of VA assigns a CC with clinical expertise and experience working with individuals with ID/DD. Since members in this waiver are in the MLTSS Program for their medical and behavioral health, MCC of VA CCs will work closely with the case manager for the Day Support Waiver program and collaborate with applicable community resources and ARC.

**Intellectual Disabilities (ID) Waiver:** Individuals enrolled in this waiver are identified from the State enrollment files. MCC of VA assigns a CC with clinical expertise and experience working with individuals with ID/DD. Since members are in the MLTSS Program for their medical and behavioral health, CCs will work closely with the case manager for the ID Waiver. Since the waiver includes children up to age 6, care transition planning will be included if these children do not qualify for the waiver after age 6, but may need additional services to continue their growth and development.

**Individual and Family Developmental Disability (DD) Waiver:** Individuals enrolled in this waiver are identified from the State enrollment files. MCC of VA assigns a CC with clinical expertise and experience working with individuals with ID/DD. Since members in this waiver are in the MLTSS Program for their medical and behavioral health, MCC of VA CCs will work closely with the case manager for the DD Waiver.

**Individuals with Intellectual/Developmental Disabilities (I/DD):** For Individuals with I/DD, we use our analytics engine, the HRA and interviews with family, caretakers, schools and providers for identification. Medical claims and predictive models are also used to identify individuals but use of this method alone does not identify the population accurately. MCC of VA CCs assigned to this population are experienced in I/DD and designated "Qualified Developmental Disabilities Professional" or "QDDP." We ensure our CCs working with children are knowledgeable on school-based services and work with transition teams in preparing students for the transition to employment and other post-school settings. For individuals with I/DD, the CC focuses on the co-occurring conditions, communication barriers, the differences for children, youth, young adults, and adults (including older adults with I/DD), supportive services available through the community, and the family support needed.

The CC supports the member’s access to school-based and community services including ARC. For transitional youth, as they “age out” of the system of care, the CC assists with a transition care plan to support their changing needs. The CCC works with the member to transition from a pediatrician to a family practitioner. Many youth with I/DD need access to post-secondary schools, employment support, as well as community organizations (e.g., ARC, CILs, faith-based organizations and YMCAs).
Adults with I/DD need a different array of services and supports including housing, if they desire to live on their own. People who transition out of public developmental centers or private ICFs-MRs need access to services and supports in the community. Adult I/DD members need preventive healthcare services and health education, employment supports and peer support services. The CC supports access to community resources including ARC and CILs.

**Individuals with Cognitive or Memory Problems (e.g., Dementia):** Because the clinical presentation of dementia is gradual, proactive identification of individuals in this sub-population heavily relies on assessment and referrals from family and providers. As described earlier, MCC of VA additionally uses our analytics engine to identify members with cognitive or memory problems. MCC of VA assigns a CC with experience in caring for individuals with chronic neurologic and/or geriatric conditions.

Effective care coordination and referral to services and supports for participants with Alzheimer’s disease or related dementias (ADRD) and their caregivers can decrease unnecessary medical services utilization, delay institutionalization, and improve the quality of life of both members with ADRD and their caregivers. Our interventions which target both members and their caregivers are more successful in reducing caregiver stress, increasing skills and knowledge, enhancing satisfaction, and preventing or delaying institutionalization.

The CC has extensive experience in collaborating and coordinating both LTSS and acute services for individuals with ADRD and their supports. The CC uses existing programs and experts that support people with dementia including the Alzheimer’s Association, Adult and Child Protective Services agencies, local AAAs, Community Service Boards (CSBs, and the Geriatric Mental Health Partnership (GMHP), and other local entities. Recognizing the critical role of caregivers, our team works hard to ensure caregivers are connected to support groups, respite and other services.

**Individuals with Brain Injuries:** MCC of VA analyzes enrollment information and available medical and pharmacy claims data using specified algorithms to identify diagnoses and treatment protocols related to cognitive impairments and brain injuries. MCC of VA will match a CC with neurologic expertise with members in this sub-population. Our assessment and care planning tools include domains focused on addressing the specialized needs of both pediatric and adult members, inclusive of assistive technologies and accommodations for brain injury and cognitive impairment.

The assessment is customized to cognitive impairment and includes questions related to cognition, communication, health history, and medications. For individuals with brain injuries, the CC identifies service needs including residential care, day programs, family support, daily living capabilities, and co-occurring conditions. The CC coordinates with Certified Brain Injury Specialists who collaborate with a network of clinicians specially trained to provide comprehensive, enhanced care and services for members of all ages diagnosed with a brain injury.

Individuals with a brain injury diagnosis are often mistaken or diagnosed with a primary psychiatric disturbance because of prominent and commonly associated psychiatric or behavioral manifestations. MCC of VA understands that the focus of treatment in such cases is on the underlying medical condition; however, we do not overlook symptomatic treatment for the psychiatric or behavioral manifestations or even consider them secondary in nature. We address
the psychiatric disturbance in parallel to management of the medical condition. As a plan designed for individuals with behavioral challenges, MCC of VA is uniquely positioned to identify member behavioral issues proactively and work collaboratively with the member, family, and caretakers to find the right treatments, living environment, and supports. Our MOC builds in periodic screening, and our CCs are trained to ensure that changes in behavior are evaluated and addressed.

A CC with pediatric experience supports the child with a brain injury by ensuring access to necessary pediatric specialists, therapies, and behavioral health services, EPSDT, and school-based services mandated by IDEA.

**Individuals with Physical or Sensory Disabilities:** Members with physical or sensory disabilities or a combination of both represent a diverse group. They can experience health conditions including severe mental and physical disorders, plus other chronic conditions and often all of these conditions combined. Their levels of disability may vary from speech and cognitive disorders to physical and functional limitations. Magellan uses a broad array of strategies including its analytics engine to identify members with these needs.

As for all MLTSS members, self-direction, living independently in the community and transportation are also priority goals for this population. Community resources are accessed such as the CILS, and community groups, and schools for members who are blind or hearing impaired. The CC ensures that sign-language interpreters are available for individuals who are hearing impaired as well as special Braille materials for members who are blind. For individuals who are visually impaired, the CC coordinates with Virginia Industries for the Blind (VIB) and with the Virginia Rehabilitation Center for the Blind and Visually Impaired. The CC also assesses the member’s eligibility for waiver services and makes appropriate referrals.

MCC of VA receives referrals from and coordinates with the Virginia Infant Screening and Infant Tracking System (VISITS). We include in the ICP community and natural supports that the child may have school staff, community agencies, Easter Seals, Early Intervention, EPSDT, medical specialists, and in-home caregivers. We also coordinate all special equipment including wheelchairs, assistive technologies, and procedures such as cochlear implants.

**Individuals Residing in Nursing Facilities (Skilled, Custodial and Specialized Care) and Other Institutional Settings:** MCC of VA uses the enrollment file to identify members residing in nursing facility clinically eligible (NFCE) for skilled, custodial or specialized care, and have a high need for supports and services that must be delivered without service interruption. MCC of VA’s MOC for this sub-population includes an integrated care approach to maximize an individual’s self-determination and experienced CCs who work with members to: 1) understand their goals and ensure the ICP meets them; 2) support transitions from nursing facilities; 3) stabilize and control symptoms related to chronic disease; 4) provide the full spectrum of services based on need; and 5) maintain or optimize functional status and safety.

We partner with NFs through on-site comprehensive service coordination. Upon enrollment, the member/designated representative receives welcome information, including the name of the assigned CC and his/her contact information – the CC acts as liaison between member and facility staff. We review information from prior healthcare settings, the NF PASRR screening
and evaluation, and the Minimum Data Set (MDS) to obtain a comprehensive profile of the member and their current needs.

We collaborate with NFs on viable options and alternate living arrangements for members identified through the assessment process with the desire and ability to transition to community-based settings and coordinate care and services to ensure success. To determine the most appropriate services and setting, CCs and members discuss and assess the: 1) member’s desired residence and living situation and their interest and ability to direct their own care; 2) services necessary to meet their needs in the most appropriate, integrated setting; 3) potential risks associated with any service/placement decisions, including the decision to direct one’s own care; and 4) opportunities for meaningful day activities.

Children in NF Care: Children who may need NF care include children with severe illnesses that are physically and/or mentally debilitating, requiring 24-hour care. Skilled NFs are not designed to meet the unique developmental and therapeutic needs of children. When identified, these children are prioritized for evaluation and development of a transition plan to the community. Private Duty Nursing is available under the EPSDT benefit and will be utilized along with other benefits, including the Technology Assisted Waiver.

Individuals with SMI and SED: Our MOC approach to supporting individuals diagnosed with SMI and/or SED include specific customization across assessment, engagement, and care planning. Individuals diagnosed with SMI carry a disproportionate illness burden and pose significant challenges in overall management. Individuals with SMI die 25 years before their peers; frequently smoke tobacco (more than 75 percent of the time); are often overweight (including 40-60 percent of individuals with schizophrenia); have SUD (50 percent); and have diabetes (15 percent). They contribute to the 12 million emergency department (ED) visits annually by people with mental health and substance use. 70 percent of individuals with SMI have at least one chronic condition, 45 percent have two, and 30 percent have three or more. MCC of VA uses a unique, SMI/SED-tailored HRA that identifies key areas of risk and needs of individuals with SMI/SED. Based on the risk factors identified in the HRA, a member may receive specialized assessments, including assessments for substance use, depression, HIV, pregnancy, and DM conditions.

We use Health Guides and Peer Support Specialists to help locate individuals who are homeless or otherwise hard to find. The Health Guide is the member’s advocate and helps navigate through the delivery system. The Health Guide is community-based, to help the member make and keep appointments with behavioral and physical health providers, provide follow-up, and coordinate with community agencies and other resources, as needed. The Health Guide supports the CC in ensuring the member’s care coordination plan is implemented effectively.

The role of peer support in working with the SMI/SED population is particularly important. The Certified Peer Support Specialist is trained in applying resiliency and recovery principles and tools such as Wellness Recovery Action Plans (WRAP®), a wraparound process, family and person-driven care, and systems of care that use these skills to provide emotional support and inspire hope for the future. They model and assist members with lifestyle improvements and self-management of chronic conditions. Peer Support Specialists provide outreach to individuals who require assistance to obtain access to and engage in needed services.
Suicide Prevention: Suicide is the 10th leading cause of death in the U.S. and individuals with SMI have a 12 percent higher risk of suicide. We plan to implement a programmatic suicide deterrent initiative to systematically address suicide prevention. This initiative will include MCC of VA hosting an Applied Suicide Intervention Skills Training (ASIST) train-the-trainer event for willing Behavioral Health Home (BHH) providers. ASIST is an evidence-based program to identify the signs of suicidal risk and provide appropriate care. By using a train-the-trainer approach, the BHHs can expand the program over time. In addition, we will implement clinical workflows including screens, assessment and clinical decision supports, establish attempt survivor support groups, and encourage family engagement. The Magellan-led collaborative efforts with the behavioral health community in Arizona decreased the suicide rate (number of suicides per 100,000) 67 percent for the enrolled Medicaid population, and 42 percent for people with SMI.

Individuals with SUD: Identification of patients with SUD and co-occurring SUD involves approaches specifically designed to follow the laws and regulations which protect member privacy. MCC of VA’s predictive model and claims analyses look directly and indirectly for substance use by looking for specific diagnoses, as well as for signs of SUD, such as medical claims associated with frequent ED visits for pain management or opiate seeking, and previous trials of medication assisted treatment of a SUD. We identify members using our HRA, which includes a substance use screening tool. We also train PCPs to use tools which screen for common behavioral health issues, including SUD. MCC of VA staff obtains appropriate member consent to share member information related to SUD diagnoses with their providers. CCs assigned to members with SUD have clinical experience in behavioral health and SUD. We will coordinate the provision of community-based therapies to help recovering members work through co-occurring psychological disorders. Outpatient treatment programs may include approaches such as nutritional counseling, recreational therapy, and supportive services on life skills to regain independence, such as job skills, resume building, and interviewing skills. The CC ensures access to peer supports for successful recovery and transition from inpatient and residential treatment.

For members who use substances and are under the age of 18, the CC engages both the child and family as well as appropriate community supports such as schools. CCs ensure that EPSDT screening is provided to children with SUD and coordinate with the BHSA to ensure the member receives substance use residential treatment services and behavioral therapy as needed. For children in acute or residential facilities, the CC works with the facility staff and care transition planners. Family members are assisted to access community-based mental health or substance services and support groups.

Individuals with End Stage Renal Disease: MCC of VA identifies members with ESRD from the HRA and analytics to identify dialysis utilization. For ESRD members, the CC ensures access to services including specialized care, dialysis, and support for self-care for renal disease including nutrition. The CC also ensures the specific issues facing mid-to-late stage kidney disease are addressed including preventing unnecessary hospitalizations and addressing co-morbid conditions. Members needing dialysis follow a complex regimen of diet and fluid restrictions, medication, and dialysis therapy, and members and caregivers are educated on all aspects of care needed. Peer supports also provide reinforcement and support. The CC educates members on the transplant process, early referral for evaluation, and assistance in maintaining
transplant readiness. The CC for children with renal disease is experienced in pediatric ESRD and assists with the necessary services to support the child’s physical and behavioral healthcare needs as well as supports for dialysis treatments.

**Individuals Receiving Hospice Benefits:** The MCC of VA Care Coordination approach ensures that members with a limited life expectancy and diagnosed with a terminal, life threatening illness, receive comprehensive and appropriate hospice and palliative care services. If the member is not ready to receive and accept hospice care, MCC of VA will ensure they are offered and receive palliative care services provided by the hospice program or a home health agency that specializes in the provision of palliative home health services. In addition to receiving coverage for hospice benefits and related services, MCC of VA collaborates with the Hospice Team to ensure that non-hospice related services are covered and provided based on individual member need and preference.

Palliative care for children represents a special, closely related field to adult palliative care. The MCC of VA Team works closely with local palliative and hospice professionals to meet the complex member needs at the end of life. MCC of VA considers all individuals in this category as vulnerable, due to their complex symptom control needs, the need to improve and maintain comfort and quality of life, pain management, psychosocial needs throughout the end of life timeframe, age, other chronic conditions, or disability.

The MCC of VA CC supports each member and their family with all aspects of end of life planning and advance directive development. We ensure that we fully understand and honor their needs and desires at the end of life. The ICT and CC focuses on educating the member and caregiver on available options regarding palliative and or end-of-life care. The education includes providing the member and family with appropriate resources and coordinating necessary care conferences and care coordination meetings. At the end of life, MCC of VA strongly supports that our role is to support the member while promoting the member and provider relationship. The CC works closely with local external palliative and hospice professionals to meet the member’s complex needs at the end of life. We collaborate with the Virginia Hospice and Palliative Care Organization to ensure that our staff have obtained education on up to date palliative and end-of-life care approaches and understand the menu of available resources.

In addition, MCC of VA utilizes the “Five Wishes” program as an advance directive tool for use with members, their families, and natural supports. “Five Wishes” is an easy-to-use legal document written in everyday language that lets adults of all ages plan how they want to be cared for in case they become seriously ill.

**Children in Foster Care or Adoption Assistance:** MCC identifies children in foster care or adoption assistance from the State enrollment files. We assign a CC knowledgeable in the Child Welfare System. The CC plays a critical role in this population to keep all parties, including the State dependency case worker, involved in the child’s care and placement, informed and involved. Family engagement is especially important since 48 percent of Virginia’s foster children are reunited with their families. When reunification is the goal, families are essential to helping by-pass step-down placement from an inpatient setting and return home. We provide care coordination for both in and out of state residential providers that treat Virginia youth.
We engage all parties in a highly collaborative approach with emphasis on respect for the child and consideration of their needs and goals, as well as safety. Comprehensive care planning includes goals related to medical and behavioral health conditions, substance use treatment, educational or developmental goals, and participation in extracurricular activities. In community settings, we coordinate with the school to ensure the child or adolescent is placed in the appropriate classroom and explore natural support in the home community based on his or her strengths and interests. The care manager also assists family members with developing community-based supports such as behavioral health or SUD services and support groups. Adopted children may receive post adoption services to ensure ongoing support.

**High-Risk Pregnant Women:** Due to the complexities of pregnancy combined with the realities of some of the profound social determinants of health experienced by individuals in the MLTSS program including homelessness, substance use, food insecurity, teenage pregnancy, a diagnosis of SMI/SED/SUD and related treatments, we consider all pregnant members as high risk or ultra-high-risk. We employ OB CC subject matter experts in the area of high risk Obstetrics (OB) and a SMI/SED/SUD and LTSS. We improve prenatal and behavioral healthcare by promoting healthy behaviors and controlling risk factors including opioid use, binge drinking, perinatal depression, HIV, and smoking during pregnancy. Since pregnancy often provides an impetus toward recovery, we have designed an approach that….. We refer to Centering Pregnancy programs, as available and appropriate.

**Individuals with Other Complex or Multiple Chronic Conditions:** We use our proprietary analytics engine to identify and stratify these members. We assign CCs with broad internal medicine and/or pediatrics experience. The CC works with the member to identify and address the complex or multiple chronic conditions. The CC supports access to providers, community and peer supports. The CC also identifies and addresses co-occurring conditions such as behavioral health and SUD. The CC supports the member’s self-management of their overall health and wellness. This approach applies to all categories, including children, adults, dual eligibles, and individuals of all ages with co-occurring conditions, with resources tailored to be most responsive to age/development and particular chronic conditions.

**Individuals who are referred to as Emerging High Risk/Community Well:** We use our proprietary analytics engine MCMD to identify and stratify these members. We assign CCs with experience in health and wellness coaching. These individuals typically present with a lower overall risk level (a stable and controlled health and living situation) and will be assigned to a Primary CC with support of the Care Coordination Team. Our care coordination approach is focused on prevention, health and wellness, education, and promotion of safety, self-determination, and healthy member outcomes. Our CCs and support staff conduct assessments and care plans based on DMAS guidelines and more frequently when a significant change occurs in the individual’s situation. Our team monitors the Community Well population’s health status at set intervals.

For these members, the CC supports improvement of current health status, maintenance of community connections, and promotion of self-determination and self-advocacy. The CC monitors members’ health status, screens for behavioral health conditions and completes a health risk screening annually to determine if their needs or condition have changed. Our approach applies to all categories, including children, adults, dual eligibles, and individuals of all ages with co-occurring conditions. Member medication use is also monitored to ensure
compliance with medication utilization guidelines are used in order to prevent the progression of chronic conditions.

Member interventions are driven by the member’s level of healthcare risk. This group receives interventions, which are applied to all sub-populations including preventive care reminders. Automated telephone, email, and postcard reminder campaigns target members in the appropriate age bands (HEDIS technical specifications), who have not had a preventive screening or a gap in care in the past 12 months. Reminder campaigns include: Wellness, Smoking Cessation, Asthma, Attention-deficit/hyperactive disorder (ADHD), Diabetes Care, Coronary Artery Disease, Women’s Health, Mammograms, Controlling High Blood Pressure, Depression, Flu, Pneumococcal immunizations, and Appropriate Antibiotic use.

Department’s Developmental Disability (DD) waivers (the Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers):

Individuals enrolled in one of the Department’s Developmental Disability (DD) waivers (the Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers) will be enrolled in the CCC Plus program for their non-waiver services (e.g., acute and primary, behavioral health, pharmacy, and non-LTSS waiver transportation services). Their waiver services (including when covered under EPSDT) and transportation to the waiver services, will be paid through Medicaid fee-for-service as “carved-out” services. MCC of VA will provide care coordination services for these members to ensure they receive appropriate care and services.

Covered Services

Magellan’s Collective Understanding and Similar Experience with Virginia’s MLTSS Covered Services: MCC of VA possesses both an understanding of, and experience with, the covered services as required in Virginia’s MLTSS Program. MCC of VA will be responsible for the delivery of all covered and medically necessary services to the population eligible within RFP requirements.

We understand and confirm that in addition to operating a fully integrated health plan, MCC of VA will meet and exceed all program requirements as a person-centered, community-focused, evidence-driven MLTSS Plan by proposing a MOC that achieves the goals of the MLTSS Program. We will focus on activities designed to improve quality of life and health outcomes by targeting and influencing behavioral, social, economic, and clinical determinants of those outcomes at both the group and individual level.

We propose a consistently person-centered approach that will drive the services to effectively interact with the provider delivery system and to successfully engage individuals with disabilities and chronic conditions to ensure choice, control, and access to a full array of quality services. This approach ensures optimal outcomes such as independence, health and wellness, and quality of life.
We will support members as they face challenges and: 1) cover the services listed as non-covered by Medicaid, when medically necessary for children under age 21 in accordance with federal EPSDT requirements, PDN services for children under age 21, and services for children in foster care and adoption assistance; and 2) address gaps in covered services through enhanced benefits.

The critical components of MCC of VA’s MOC include:

- Active participation by the member (or his/her designee) in the ICP delivery and planning process that starts with the member’s goals and meaningful choices of service alternatives
- Holistic ICPs based on a comprehensive needs assessment
- Opportunities to self-direct community-based services.

Our MOC builds an infrastructure within the health system that supports and enhances the relationship between members and their providers. Based on the member’s goals, choice, and medical and psychosocial necessity criteria, we offer holistic support and demonstrated cost savings through the delivery of medical and pharmacy services at the most appropriate, least restrictive level of care. Our understanding of each service category of the covered services begins by creating benefit coverage policies based on the DMAS criteria and its policy requirements. We will create an infrastructure where these requirements are documented in policies, and will include detail at the CPT, ICD-10, and HCPCS levels.

The business requirements for our claims payment system are built off of these policies. The policies are updated whenever DMAS issues new web communications and updates to provider manuals, contract, Technical Manual, and Medicaid memos. The claims system is set up with indicators of whether a service is covered or not and, if covered, whether prior authorization or other review is required. The claim system will approve a service as covered, deny as non-covered, pend it for coverage review, or pay for the service, as appropriate. Services are reviewed for coverage in the following circumstances: medical necessity; EPSDT coverage; prior authorization list, cosmetic, experimental and other coverage exclusions; out of network; and emergency services.

MCC of VA will use the DMAS medical necessity definition, which follows CMS, State, DMAS, and NCQA guidelines and has the goal of ensuring that health concerns are diagnosed as early as possible. We promote the provision of proactive screening and treatment before problems become complex. We authorize medically justified services to treat or correct identified problems as early as possible. We utilize the EPSDT definition of medical necessity for individuals under the age of 21 years, and the DMAS medical necessity definition for those over age 21 years.

Many services on the DMAS list are only covered if they are medically necessary; hence medical necessity can be a condition for benefit coverage and service payment. We will follow DMAS criteria for medical necessity when they exist, and when absent will follow medical policy and clinical guidelines approved by the Health Service Committee. We will not deny reimbursement of covered services based on the presence of a pre-existing condition or avoid costs by referring to publicly supported health resources. For example, we will coordinate with community-based resources to reduce potential duplication of child and adolescent immunizations by coordinating with the Vaccines for Children Program.
Care Coordination staff will understand and be familiar with all carved out services including ID, DD, and DS Waiver services (and the new DD Waivers when they have been approved and implemented) to support members and the development of their associated ICPs. Our staff’s knowledge of MLTSS benefits will facilitate effective coordination of services for our members. MCC of VA will assume responsibility for all covered medical conditions of each member as of the effective date of coverage under the MLTSS Program, regardless of the date on which the condition arose.

We will cover all pre-existing conditions. MLTSS members will be exempt from cost sharing other than for any patient pay established by DSS covered services. We comply with federal, State, DMAS and NCQA authorization guidelines ensuring that appropriate authorizations are secured for both acute and LTSS services. We have dedicated, experienced, Care Coordination and Utilization Management staff who understand the unique and complex needs of members accessing both acute and LTSS.

Our CCs will be trained in the wide array of covered services and benefits as defined by DMAS to effectively identify potential support needs, current risks of institutionalization, and program eligibility. CCs authorize LTSS in accordance with 42 CFR §431.151, considering a member’s desire to select any willing and qualified provider to furnish care. Our Care Coordination Team has a wide variety of experience in partnering with and serving individuals with community and nursing facility based LTSS needs as well as vulnerable sub-populations as defined within the MOC, including those living with SMI and disability.

This team makes determinations that requested services are medically necessary and necessary to live safely within the community or nursing facility (NF) setting. Only physicians may make determinations that requested services are not medically necessary.

For members in home and community-based settings, we authorize the full spectrum of LTSS and acute medical and pharmacy services and items. Services are determined “necessary” if the service and/or item assists members in living safe and healthy lives and achieving or maintaining maximum capacity in performing daily activities.

For individuals of all ages with complex behavioral and physical health conditions, brain injuries, and cognitive or language impairments, we use experienced professionals with related expertise to review and authorize the ICP services. We conduct in-person meetings that include the member, CC, and providers when a change in service is recommended to ensure that we communicate the information clearly to the member and provide additional supports as needed. Face-to-face meetings take place prior to any reduction or denial of service, when possible.

**Experience and Approach to Providing Covered Services:** Magellan Healthcare, Inc. (parent of MCC of VA), brings the experience of coordinating covered benefit services for millions of Medicaid members in 26 states and the District of Columbia. We have extensive experience providing similar services to individuals with complex and co-occurring behavioral health conditions including adults with SMI, children with serious emotional disturbance (SED), and
participants with substance use disorders (SUD). Our experience enables us to bring national lessons learned as well as best and promising practices to inform our implementation and service delivery. Throughout the country, Magellan Healthcare, Inc. is focused on today’s most complex and costly vulnerable populations. The depth of our experience in managing supports and services for individuals with special needs of all ages enables us to deliver invaluable insights and innovative solutions that positively impact both the quality and the cost of some of the nation's fastest growing areas of healthcare. We have experience coordinating the full spectrum of covered services to ensure all members have access to high-quality, timely, and accessible healthcare and services.

Our MOC is customized to address the specific needs and challenges of individuals requiring specialized care and services. To support integration across all covered services, MCC of VA has developed comprehensive HRA tools and triggers within the CareAdvance clinical system to increase easy and timely notification and access to services, further supporting the importance of the Quadruple Aim approach. Our CareAdvance tools and applications are quick and easy to use for members, providers, and CCs. CareAdvance has built-in portal access and capabilities that help to uncover areas of physical, behavioral, social, functional, psychosocial, environmental, caregiver, and LTSS needs so that CCs easily explore enrollment in Care Coordination and/or health and wellness programs with our members. When conducting face-to-face assessments, the CC discusses the member’s preferences, goals, and environment, such as housing, and informal/paid supports, which may impact ability to access covered services.

**Virginia-Specific Experience:** MCC of VA’s affiliate, Magellan Rx Management (MRx) has worked with DMAS since 1972 when, as the Commonwealth’s Fiscal Agent, it implemented Magellan’s first Medicaid pharmacy engagement. MRx worked continuously with DMAS on multiple Medicaid PBM and PDL initiatives through its engagement. MCC of VA’s affiliate Magellan of Virginia (Magellan) was selected by DMAS to serve as the Behavioral Health Services Administrator (BHSA). Magellan began administering behavioral health services for members enrolled in Virginia’s Medallion and FAMIS programs on December 1, 2013. Magellan is responsible for managing all behavioral health services for members enrolled in these programs as well as services not covered through DMAS’ Medallion managed care programs.

As the Commonwealth’s partner, Magellan has a statewide understanding of local communities and the unique population of members and has worked collaboratively with DMAS on service expansions while containing cost. Magellan also supports more than 2,000 Governor’s Access Plan (GAP) members across Virginia. The BHSA contract covers psychiatric community-based rehabilitation services for all members as we manage inpatient and routine outpatient services for individuals not enrolled in managed care. Our members’ access to high-quality services resulted in higher program effectiveness and improved outcomes, including a reduction in: 1) inpatient bed days per 1000; 2) ED presentation; 3) inpatient readmissions; and 4) an increase in ambulatory follow-up rates after psychiatric hospitalization. MCC of VA will leverage this knowledge and infrastructure to serve the MLTSS program.

**Integration Experience:** Magellan Complete Care of Florida (MCC of FL) is a Florida Medicaid specialty health plan that focuses on Medicaid beneficiaries with SMI. As a specialty plan, MCC of FL has longstanding relationships in the State. We developed our MOC by incorporating unique knowledge that we have gained clinically and operationally to reach a difficult to reach population and listen to the needs of the communities we serve. MCC of FL
combined its experience and resources with traditional health plan services to coordinate covered benefit services similar to this contract that integrate the management of behavioral and physical health services. Through our experience of working with high-risk members, we collaborate differently now with hospitals to reduce inpatient days and authorize medications. Our programs improved partnerships with law enforcement, justice system, emergency departments, and other community groups where our members live. This model, already used at other Magellan locations, provides a transparent system that creates trust and constructive collaboration, which we will use to be successful.

**Consumer Direction and LTSS Experience:** Our ability to manage covered MLTSS services for Virginia is enhanced by the acquisition of The Management Group (TMG), now a Magellan subsidiary. TMG has more than 30 years of quality assurance and improvement consulting regarding LTSS and eight years of operating the nation’s largest self-direction program with full budget authority in Wisconsin. TMG manages consumer directed, community-based long-term care services and Medicaid home and community-based waiver quality assurance and improvement services. TMG has organizational expertise and capacity in the areas of integrated managed care program development, regulatory compliance, and behavioral health service delivery system design. This real world, lived experience demonstrates our understanding from a provider and member perspective that informs how we configure and manage services. TMG is currently under contract to provide a broad spectrum of administrative functions and direct service plan support, nursing supervision, and eligibility screening to over 13,000 enrollees in the innovative Wisconsin Include, Respect, I Self-Direct (IRIS) Program. IRIS helps older adults and adults with disabilities manage a personal budget and self-direct the supports and services that are essential to achieving a meaningful life and valued social roles in their communities.

**LTSS Experience in New York:** Magellan operates a Managed Long-Term Care (MLTTC) plan, AlphaCare, in New York, as well as a Medicare Advantage Plan (MAPD), and a Dual Special Needs Plan (D-SNP). Our New York affiliate was selected as a Medicare-Medicaid Plan to participate in New York’s duals demonstration, the Fully Integrated Duals Advantage (FIDA) program, which began January 1, 2015. For 2015, AlphaCare was awarded Tier 3 status in the state of New York, placing it in the highest tier of Quality for MLTSS plans. AlphaCare’s improvement in Quality tiering from 2014 to 2015 was second to only one peer plan in the state.

**LTSS Experience in Tennessee:** Magellan’s best-in-class business operations partner, Shared Health, has operated a Managed Long-Term Services and Supports (MLTSS) program since 2010, as well as a Dual Special Needs Plan (D-SNP) since 2014. The MLTSS program covers over 12,000 members in both NF and home- and community-based settings across Tennessee, with 4,500 members in their companion D-SNP. Our experience in these three states provides a background to provide a broad spectrum of services to the residents of Virginia, focusing on the unique needs of consumer-directed, MLTSS, and D-SNP members.

**Acute and Primary Care Services**

We understand that acute care includes preventive care, primary care, and other inpatient and outpatient medical and behavioral health care provided under the direction of a physician for a condition having a relatively short duration. Many members with disabilities face challenges in obtaining acute and primary care services. Most primary medical providers refer their patients
with behavioral health challenges to specialists. We provide open access to services for in-network providers from our broad network of providers with ongoing/constant capacity building as we recruit physicians with behavioral health expertise.

**Experience Providing Acute and Primary Care Services:** We have extensive experience coordinating acute and primary care services for members, including ensuring claims payment of covered benefits and administering different coverages for members who are dually eligible for Medicare and Medicaid. MCC of VA ensures seamless continuity of care using approaches that have been tested by our health plans in New York and Florida.

- Our health plan in New York provides services to the Medicaid and Medicare populations, including Managed Long-term Care (MLTC), Fully Integrated Duals Advantage (FIDA), and Duals Special Needs Plan (D-SNP). Individuals in the New York programs have complex long-term supportive health and service needs, as well as both chronic and acute physical and behavioral conditions.

- Our health plan in Florida provides the full array of acute, primary, behavioral, and pharmacy Medicaid services to members with SMI and chronic and acute medical conditions.

**Ensuring Primary Care Services are Provided:** During initial enrollment, we expect to find members who need both a physical and behavioral health primary care provider (PCP) but are lacking one or both. While in some cases those members are identified by analysis of claims or other data, we also find these members during the development of the ICP. We connect these members to primary care by speaking directly with providers’ offices and members of the Interdisciplinary Care Team (ICT).

After initial enrollment, we expect that members will require assistance and encouragement to develop and maintain strong relationships with their PCPs. Members who are deemed high-risk will receive this assistance as part of their ongoing Care Coordination, while an analysis of claims will be performed monthly to identify lower risk members who are not seeing primary care providers regularly.

**Acute Emergency Services and Diversion Experience:** Magellan Healthcare has extensive expertise providing emergency services when and where warranted for individuals on Medicaid and Medicare, including those members with behavioral and physical health needs. We prevent and reduce non-emergent and inappropriate ED use through multiple strategies, such as ensuring that primary care is delivered through medical homes and our Integrated Health Homes (IHHs), using appropriate urgent care settings, employing community-based Health Guides (non-licensed, field-based support staff to assist in navigating the care delivery system), and using CCs for coordinating interventions. We educate members and providers regarding appropriate utilization of ED services, including behavioral health emergencies, and monitor emergency services utilization by provider and member. We also partner with community stakeholders such as first responders to assist with appropriate use of emergency services for behavioral health situations.

Members are informed and engaged about alternatives to emergency care, including the role and availability of urgent care providers, through a variety of tools and interactions, such as:

- Our new member Welcome Packet, Welcome Call, Provider Directory, Member Handbook, and the MCC of VA website
CC working with members to complete assessments and ICPs, as part of the appropriate access member education process

Member Services Call Center and 24/7 CareLine (nurse line) with urgent care questions or needs.

MCC of VA will continue to leverage its existing relationships with hospitals to create an environment of efficient information exchange to minimize utilization of emergency services. Based on our history and relationships with a variety of behavioral and physical health providers, we will partner with them to align incentives to improve access for our members, resulting in reduced utilization of emergency services. Our ED diversion activities include community based treatment alternatives for crisis intervention and management. MCC of VA will implement a prudent layperson review process to ensure reimbursement is aligned with medically necessary services. Emergency services will be available 24/7 to all members throughout the state.

In accordance with 42 CFR 438.114, MCC of VA will cover emergency services without the need for prior authorization and will not limit reimbursement to in-network providers. We will cover the medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA), provided to a member who presents to an ED with an emergency medical condition.

Through our MOC, our CC, RNs, and Licensed Social Workers who have prior work experience with both members who live in the community as well as members residing in institutions and facilities coordinate the full spectrum of covered services as needed by members through a robust network of primary, behavioral health, and LTSS providers. The ICT, in partnership with the member, develops an ICP based on the network provider’s treatment plans and the care team assessments. The MOC summarizes the covered services which are medically necessary. Our fully-integrated MOC includes physical, behavioral, home and community-based services (HCBS), LTSS, pharmacy benefits. We rely on our experience developing provider networks and our ability to identify providers who understand and serve our members’ needs, including acute and PCPs.

In Florida, for example, we developed a network of providers, specialists, and behavioral health providers who understand the special needs and challenges of our members diagnosed with SMI, in addition to being able to address acute and primary care for co-occurring and co-morbid chronic conditions. We will ensure that MCC of VA members receive all medically necessary covered services and obtain high touch, individualized, timely, and effective assistance to access the care and resources they need to live healthier lives. From this experience, our MOC will facilitate improving the health status of Virginians by engaging members, partnering with providers, and integrating community resources, and non-traditional services into local health systems.

Already established and available in Virginia as well all of our national markets, Magellan Healthcare’s 24/7 CareLine is a resource for helping members reduce unnecessary ED use by providing education and support to address member questions and help members access appropriate medical and behavioral services. CareLine nurses help members choose appropriate medical care, find a physician or hospital in their community, understand treatment options, achieve a healthy lifestyle or answer medication questions. The CareLine nurses reinforce education about appropriate ED use and help members understand the resources and services
available and how to access the services. We build upon local expertise in the hiring process and expect that our staff become experts on each of Virginia’s service regions, languages, service use patterns, transportation challenges, and other issues that impact the member’s ability to access services.

Magellan Healthcare CareLine receives calls which are successfully referred to non-emergency services (PCP office, after hour clinics, specialists, or health education). When appropriate, callers were referred to the ED or to contact 911 due to the nature of their health issue. Callers receive the appropriate community-based level of care instead of utilizing higher cost services. MCC of VA will expand its current call center capabilities to create a new Warmline in Virginia called MCC of VA Warmline, providing access to telephonic peer support through trained Peer Specialists. The Warmline will help members by providing information for appropriate access to health benefit services.

By supporting a peer-operated Warmline, complimented by MCC of VA Peer Recovery Navigators and Family Support Specialists, the Warmline will fill a gap in the current crisis system. The Warmline telephonic peer support capabilities are an integral part of our approach to avoiding unnecessary ED utilization. As an example, for individuals with SMI and SED, this confidential support line service will not only help with situations of crisis, but all urgent care needs. We have experience in developing, implementing, and measuring outcomes for peer-oriented warmlines.

**Institutional and Community-based LTSS**

Our planned approach to ensuring access to LTSS covered services is focused on maximizing community support for our members to help them remain in their homes and out of institutional care through effective Care Coordination assessment and ICP service management. The Medicaid program allows for the coverage of long-term care services through several vehicles and over a continuum of settings, which includes institutional care and home- and community-based LTSS. When a member first enters our system, the CC reviews the person-centered ICP to determine if the resources and services adequately meet the member’s needs. For example, if there is an authorization for 10 hours of in-home services a week, but the member is only receiving five hours of services, our community-based CC will reach out to the service providers to confirm that the plan of care is being met. Upon implementation of a member’s person-centered ICP, and the start of services identified, our community-based CC will monitor the delivery of services to confirm that services have begun and they are being provided on an ongoing basis, as authorized in the ICP.

Our integrated clinical system and care coordination platform, CareAdvance prompts the CC to contact all members receiving services within five business days of the scheduled initiation of services to confirm that services are provided and that the member’s needs are met. CareAdvance also generates reports for supervisors who monitor the promptness of these initial contacts. When the CC identifies a service gap, s/he addresses the gap, confirms that back-up plans have been implemented and are functioning effectively to ensure services are covered while the gap is being addressed, and reports the issue and resolution to the supervisor. The supervisor then documents this process in the member’s record in accordance with our policies and procedures for identifying, responding to, and resolving service gaps. We developed policies and procedures for ongoing identification of members who may be eligible for MLTSS.
based on our long-standing experience working with members in Florida, Wisconsin and New York.

To determine the most appropriate services and setting, CCs and members discuss and assess: 1) the member’s desired residence and living situation and their interest and ability to direct their own care; 2) services necessary to meet their needs in the most appropriate, integrated setting; 3) potential risks associated with any service/placement decisions, including the decision to direct one’s own care; 4) strategies for mitigating risk and development of back-up plans and 5) opportunities for meaningful day activities and community integration.

**Experience Providing Institutional and Community-based Services:** We have extensive experience providing community-based behavioral health services to at-risk populations, and we believe each member should receive services in the least restrictive, most appropriate setting.

**Wisconsin Experience:** In Wisconsin, we have supported the largest self-directed, community-based LTSS option of its kind in the country. We collaborated with the State to develop the IRIS (Include, Respect, I Self-Direct) program, which began in 2008 and operates under 1915(c) waiver authority. We support more than 13,000 older adults and individuals with physical and intellectual/developmental disabilities enrolled in IRIS. With the support of a community-based IRIS consultant (e.g., service facilitator) that the member selects, they have full employer and budget authority to self-direct up to approximately 30 covered home- and community-based services, including supportive home care, transportation, supportive employment, respite, and adaptive aids. In addition, we provide oversight and support for the largest personal care program in Wisconsin, serving approximately 5,600 members who have chosen IRIS Self-Directed Personal Care (SDPC) operating under a 1915(j) state plan amendment. Our community-based service facilitators and SDPC nurses partner with members to provide flexible and specialized support responsive to individuals’ needs and preferences. Approximately, 90 percent of individuals in IRIS live in a home that they own, rent, or share with family or friends. Other covered services experience includes 1915(c) waiver and 1915(b)(3) waiver contracts in Louisiana and Iowa as illustrated below.

**Louisiana Experience:** In Louisiana, Magellan Healthcare (Magellan) managed both the home- and community-based service benefits for Medicaid recipients for both adults and children. For children, Magellan implemented a Coordinated System of Care (CSoC) for youth in imminent danger of out-of-home placement. The CSoC was governed by an HCBS SED 1915(c) waiver, as well as a 1915(b)(3) waiver. Through these waivers, eligible youth had access to five services in addition to their EPSDT benefits. These services were Parent Support and Training, Youth Support and Training, Crisis Stabilization, Short-term Respite, and Independent Living/Skills Building. In addition, youth in the program had access to wraparound services and an on-the-ground coordinator who develops a plan of care informed by the family and child that guides all accessible services and supports.

After two years of managing youth, we experienced very positive outcomes, including a 50 percent decline in in-patient readmission rates for youth engaged in CSoC, a reduction in inpatient admissions once enrolled in CSoC by an average of 82 percent, and in number of total days spent in an inpatient hospital once enrolled by an average of 79 percent. We also reduced all restrictive placements by about 40 percent after enrollment; a reduction in percentage of CSoC youth suspended from school by 20 percentage points after engaging in CSoC; an
increase in waiver services received by CSoC youth of 275 percent over the past 18 months; and an increase in EPSDT outpatient or in-home services by CSoC youth of 29 percent. For the adult population, Magellan managed the 1915(i) waiver to provide for home and community-based services for individuals with serious mental illness. The 1915(i) State Plan Amendment requires an intense coordination of care for eligible individuals. Through a capitated management contract with the State of Louisiana, Magellan was responsible for managing and coordinating care for this population.

**Iowa Experience:** We used this approach to maximize community support for our members to help them remain in their homes and out of the hospital for service delivery in Iowa from 1995 to 2016 and evolved our provider network to increase home- and community-based service access. We took responsibility for habilitation services in July 2013. We trained all staff on the necessity to use this approach prior to the start of this contract and provided annual refresher training each year. This training also covered our requirements under the 1999 Supreme Court decision for the *Americans with Disabilities Act*.

**Planned Approach to Ensuring Access:** Our Care Coordination Teams live in the same communities as our members and establish close partnerships and relationships with community-based LTSS providers, institutional providers, and community supports to ensure member access to needed services, especially in rural and underserved areas of Virginia. We will comply with and provide coverage for both institutional and community-based LTSS services based on at minimum, the core DMAS covered services requirements. In addition, our CC will have the ability to authorize beyond the enhanced benefits we propose, based on member need and with approval of the ICP and DMAS when necessary. We will incorporate referrals from a member’s provider(s), self-referrals, hospital admission notifications, and ongoing review of claims data. We use a conflict-free, compliant, objective assessment process. We will contract with a vendor acceptable to the Commonwealth to provide conflict-free annual and ongoing assessments for waiver members. MCC of VA ensures network adequacy at all times, including transportation services focused on getting members to and from appointments. We also ensure that providers and the ICT are able to successfully communicate with members by offering comprehensive interpreter and communication services. We are cognizant and address our member’s cultural, health literacy and linguistic needs when planning our network and provider approaches.

Our MCC of VA providers, or one of our Care Coordination staff, conduct initial assessments for members who have been identified as potentially meeting an institutional level of care or needing institutional placement, a DMAS waiver, or habilitation enrollment. From the results of the assessments, we determine benefit and service coverage and the LTSS member needs. We also refer individuals whom we identify as potentially eligible for MLTSS to DMAS with a level of care recommendation, as needed. We will comply with the DMAS assessment and ICP completion requirements. When we become aware of a change in the member’s circumstances, which may necessitate a new level of care assessment, either an MCC of VA provider or one of our community-based CCs will perform the assessment within the required DMAS timeline or sooner, once we are aware of the member’s change in circumstances. We will ensure that home and community-based services are always delivered in the least restrictive setting possible. We will submit our MLTSS policies and procedures to DMAS for review prior to identifying members who may be eligible for MLTSS.
Behavioral Health Services (Please also refer to the detailed Behavioral Health program description)

Experience with Behavioral Health Services: For more than 40 years, Magellan Health has provided comprehensive, evidence-based behavioral healthcare management to improve healthcare outcomes. For more than 20 of those years, we have been a national leader partnering with state Medicaid agencies to improve access to high quality behavioral health services with a focus on promoting recovery, resiliency, and self empowerment. Setting us apart from others in the market has been our focus on the improvement and evolution of our capabilities to address the needs of those individuals with the greatest challenges to living independent, healthy lives in the community. Leveraging our understanding that adults with mental illness and children with SED face challenges with their overall health, we developed successful integrated behavioral health homes for adults and youth in Arizona and Iowa.

Magellan has been proudly serving DMAS as the Commonwealth’s Behavioral Health Services Administrator (BHSA) since the program’s inception in December of 2013. During that time we have managed all of Virginia’s covered behavioral health services included in the LMLTSS Program. This effort includes both “traditional” and “non-traditional” benefits for more than 300,000 Virginians, and an additional 600,000 for “non-traditional” services.

Magellan, as a national company, currently manages the behavioral health benefits for 29 million Americans directly on behalf of states or through our work for other Health Plans.

Planned Approach to Ensure Access: MCC of VA will leverage this vast national expertise and the Virginia-specific knowledge of the covered behavioral health services and existing relationships with the behavioral health provider community and advocates to implement a health plan for persons with both behavioral and physical health conditions. We will subcontract with our affiliate Magellan to manage the specialized behavioral health services, ensuring that gains in the transformation of Virginia’s System of Care are retained. We will also expand and continue to transform the system through the creation and expansion of behavioral health homes and building the capacity of providers to address the whole health of members. We bring our specialized health plan’s concept of the IHN, where our CCs, Health Guides, Peer Specialists, and Community Outreach Specialists engage members where they live – in local Virginia Communities.

Behavioral Health Values Incorporated into Policies and Practices

MCC of VA’s behavioral health philosophy and values focus on the promotion of hope, self-determination, empowering relationships, meaningful/productive roles, and eliminating stigma and discrimination. These are more than just words; they inspire us to walk the walk in every aspect of how we put these values and principles into practice for the individuals and families we serve. Our approach to addressing each value is presented in the table below.

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| (1) Hope based in the knowledge that personally-valued recovery is possible. MCC of VA actively fosters hope. We know that hope is essential to recovery. Hope and recovery are intertwined, each influencing the other. In 2001, President Bush announced the formation of the New Mental Health Initiative (NMHI). As part of MCC of VA’s QM/QI programs, the behavioral health providers utilize customized assessment tools to help inform treatment planning discussions as well as to identify early interventions that can drive positive changes for their client population. One question assesses the member’s view of treatment. We believe this question represents a strong
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| Freedom Commission on Mental Health, Commission President Mike Hogan, Ph.D., recognized hope as the core and engine of recovery. The hope of recovery was identified as the single most important goal of the people served by the mental health system. | indicator of the work our providers do every day to increase the hope of members in their recovery journey, as well as members’ confidence of the positive impact of treatment/therapy. Providers use the results to talk with the member and if this question is scored negatively, it’s discussed during the session. MCC of VA also assesses our own staff. We administer the Recovery Knowledge Inventory (RKI) developed by Yale University. The RKI is a validated tool used to measure staff knowledge of and attitudes toward recovery-oriented practices in four dimensions and to identify training needs for our staff. The four dimensions have direct relevance to each of the five values described in the Scope of Work, including:  
  - Roles and responsibilities in recovery  
  - Non-linearity of the recovery process (includes an item specifically about hope)  
  - Roles of self-definition and peers in recovery  
  - Expectations regarding recovery (includes an item specifically about hope)  
  Assessing our team’s knowledge and attitudes about recovery is essential to learning where we are at and where we need to go in this regard. We update training and education materials for staff to enhance shared learning across these domains. |
| (2) Member self-determination. Self-determination is the process by which a person controls his or her own life. In order for a person to drive their recovery and wellness, they must have decision-making power, access to information and resources, a range of options from which to make choices, an understanding of their rights, and the capacity for assertive self-advocacy. | We work to ensure the decision-making power of our members by providing access to information and resources, and maximizing member choice about choosing their preferred provider. Members are central participants in the personalized care planning process. We actively support assertive self-advocacy of members and if a member lacks the skills of assertive self-advocacy, we support their education and empowerment. MCC of VA honors the principle of “nothing about us, without us.” We use a case management/care coordination model that employs a strengths-based approach to assist members in identifying and achieving self-determined goals and dreams. We provide members with health and wellness information and tools such as mobile phone applications that allow them to succeed in not only managing the behavioral health challenges they face, but actually realizing improved, meaningful individual health outcomes. |
| (3) Empowering relationships. Empowerment is the capacity for strong self-direction. Yet people who have experienced trauma, tragedy or other stresses may not always have the sense of self-efficacy, or the skills, to confidently direct their recovery. Healthcare crises are defined by a loss of control. Empowered healthcare consumers are educated; they seek to understand the challenges they face and the choices available to them. Finally, empowered healthcare consumers have self-efficacy; | Through our relationship and support of members, we provide health-related education and enhance member self-efficacy by measuring, monitoring and improving, by celebrating and sharing success, and by promoting self-confidence. We assist the timely resolution of serious health concerns and a return to a focus on wellness and prevention. MCC of VA has implemented multiple resources to support self-management and relapse prevention skills. The WRAP® is an evidence based tool that helps individuals identify the steps needed to take more control over their health. |

WRAP®
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<td>they believe the decisions they make and the actions they take can make a positive difference in their lives.</td>
<td>recovery and prevent relapse. MCC of VA has access to a Magellan developed library of tools, including tip sheets and self-management tools including links to other reference and information sites. Members can print out tip sheets and review them during behavioral health appointments before taking them home. One example is “Substance Use: Staying Alcohol –or Drug Free After Treatment.” Going forward, Magellan will offer additional content designed to promote self-management and relapse prevention.</td>
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<td>(4) Members having a meaningful, productive role in society. While healthcare services and supports are important to improve personal health outcomes, it is connectedness to and participation in communities that contribute to an individual’s improved sense of social well-being.</td>
<td>Our core Recovery and Resiliency Principles are the foundation of our beliefs and organizational cultural values. Our programs are coordinated to provide members with a greater sense of self-confidence, self-determination, and hope. We build on this foundation to help members identify goals, measurable steps, and actionable objectives to achieve full, meaningful participation in communities of their choice in self-determined roles.</td>
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<td>(5) Eliminating stigma and discrimination. Widespread misunderstanding of mental illness and substance use disorders exists in the community. This lack of understanding leads to stigma and discrimination.</td>
<td>We will implement numerous strategies to increase the understanding of behavioral health in the community. Our Peer Specialist staff will provide in-service trainings, workshops, and presentations to providers, community groups, university, college, and high school classes to increase understanding and eliminate stigma and discrimination. We support stigma reducing activities through state and local organization such as NAMI and through Virginia Mental Health advocacy groups.</td>
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**Behavioral Health Principles**

In addition to our behavioral health program values, MCC of VA adheres to the following principles related to the delivery of behavioral health services.

**Freedom of Choice**

Due to our extensive knowledge, we are able to align providers and members to ensure the best fit or providers for members. The choice of a specific professional is made by the member and those people closest to him/her during the first or second meeting with the member that allows time to identify the ICT members. Members may choose to change their preferred behavioral health professional at any time. In these instances MCC of VA’s care coordination team will assist the member in finding another provider. We request the member’s permission to share information with all of their identified treating providers.

**Policies to Support Member Involvement**

MCC of VA’s policies and procedures involve the member, and those significant in his/her life, in the process of selecting a provider and in decisions about services to meet the member’s behavioral health needs. The member and significant others are critical to the planning process and making health/service decisions. For minors, the lead role is often assumed by a family member, a significant other, or a support person. We encourage members to include natural supports in their healthcare and service need planning process. If the member or his/her representative is not able to be present during a planning meeting, our policy requires that we cancel the meeting and reschedule it at a time the member or representative is available.
Engagement of Members

As described earlier, our MOC includes screening members to determine their level of risk. Members with a history of inconsistent involvement in treatment are assigned to a higher level of care coordination involvement, including a Health Guide (non-licensed, field-based support staff who assists the member in navigating the care delivery system), a Peer Support Specialist (individual with recovery lived experience) and/or a Family Support Specialist (trained parent with lived experience of raising a child with mental health challenges) and the primary CC. Our health guides, peer recovery specialists/family support specialists, and CCs perform both telephonic and in-person outreach to ensure the member is safe, has a place to live and has access to basic necessities and medications. Members with histories of inconsistent involvement in treatment, due to missed appointments or not taking medications as prescribed, often end up in the ED or inpatient hospitals and possibly in homeless shelters. Many of these members have co-occurring mental health and substance use disorders and need integrated treatment. Engaging with members who are ambivalent about treatment is vital. We utilize a listening first and “start where the member is” approach and leverage peer recovery specialists who are better able to make connections with the member. We will send peer recovery specialists or a health guide to meet with these members in their home, shelter or other preferred community location to identify any barriers in accessing treatment and to assist them in accessing the needed service or medication. The health guides and peer recovery specialists use motivational interviewing (tool to engage the member and assist them to identify the member’s strengths, goals and needs) to identify the member’s goals and preferences, and explain the rationale for recommendations in ways that take into account the member’s health literacy, culture, and goals.

Rehabilitation Recovery and Strengths-Based Approach to Services

MCC of VA uses a personalized approach to treatment with recovery-based services for our members. When designing our services and supports, listening to and honoring the strengths, needs, and preferences of members and their families is a central theme throughout our work with members. We continue to develop and support peer and family-operated recovery centers and mutual self-help networks for persons of all ages and behavioral health conditions. Our work emphasizes the use of these programs and self-help networks, in addition to promoting meaningful participation in self-determined roles within communities of one’s choice. Through this work, we actively support the development of “recovery communities”. Recovery communities are a resource for education, information, support and socialization for those in recovery and their family and friends. The non-clinical services available through the recovery communities focus on removing barriers and providing invaluable resources to those who are seeking to achieve and maintain long-term recovery. Peer driven and peer delivered support services are fueled by the energy of volunteers who seek to share their experience and knowledge with others.

We continue to promote the development of healthy social support networks, skills that improve wellness, and community participation through employment, volunteer opportunities, school performance, and lifelong learning, recreational and retirement activities. Adult and Family Peer Support Specialists are catalysts for meaningful community involvement and connection and have provided comfort to parents and families by letting them know they are not alone in ensuring the well-being of their children.

MCC of VA will embody rehabilitation, recovery and strengths-based approach to services, as described below:

- Our approach is a personalized approach to treatment and recovery. We value each person who presents to us with their unique needs and strengths. This approach is evident throughout our philosophy, our passion for successful outcomes, and the way we engage with members.
We have provided numerous trainings with our staff and providers on the importance of rehabilitation, recovery, and using strengths-based approach to services (e.g., Larry Fricks, Appalachian Consulting Group on PSWH). Trainings around the state have included topics such as PMIC, WRAP®, parent-centered trainings, and outreach to community colleges on mental health issues.

Key rehabilitation, recovery and strengths based initiatives have been implemented in partnership with members, DHS and providers. For example, we developed a consumer-operated crisis walk-in program; and facilitated numerous peer and family support services trainings.

Magellan has demonstrated knowledge of the state of Iowa’s behavioral health system and worked with DHS through its mental health redesign efforts, addressing adult and family peer support and recovery coaching.

We are known and relied upon for leveraging our staff’s knowledge of adjunct social support organizations, community organizations, and partners connecting members to their community resources. We firmly believe that “people get better within their communities” because stigma is decreased in these settings. Adult and family peer support services assist in breaking down these stigmas.

**Special Medicaid Services**

Our success in other states shows our commitment to improving the quality of life for the children, youth, and families within the communities we serve, examples include:

Magellan Healthcare’s Arizona program established strong partnerships with the state agencies responsible for child protective services (CPS) and foster care. Behavioral health personnel were co-located in CPS offices to participate in team decision-making and coordinate care for children in CPS custody. Magellan also participated in frequent planning meetings with child welfare system partners, keeping abreast of data trends and system barriers to ensure collaborative solutions are quickly developed and implemented. One hundred percent of children removed from their home received a comprehensive assessment and 96 percent of the children assessed received behavioral health treatment services within 30 days.

Magellan Healthcare’s Prepaid Mental Health Program for Child Welfare in Florida increased adoptions and reunifications of children with their families through integrating psychiatric and medical care; expanding specialized therapeutic foster care; unifying our concurrent review and child welfare teams; and ensuring that a child’s mental health services are integrated
Magellan Healthcare’s programs in Louisiana and Pennsylvania used community-based services (e.g., Wraparound) to assist with improving outcomes for foster care and other youth within the system of care. Outcomes were tracked using the CANS (Children and Adolescent Needs and Strengths) and findings showed functional improvement in all areas, including improvement in life domains, child and caregiver strengths and needs, child behavioral/emotional needs, child risk behaviors, and school behavior.

**Early Intervention – Ensuring Access:** Early identification (EI) of infants and children with developmental disabilities is critical to the future health of the child and the well-being of the family. For eligible infants and toddler, EI services provide critical supports to family members and caregivers to enhance their child’s development. These services are incorporated into the ICP for members under age three. Infants and toddlers birth through age two years are referred to Early Intervention when there are risk factors for developmental delay, premature birth or suspicion of developmental delays.

Referrals to early intervention can be completed by the parent, CC, medical or services provider, and parents are consulted prior to referral by a CC. Our CCs encourage parents to fully participate in the referral, assessment, and service planning process to ensure the infant or toddler receives all needed services. When the infant or toddler is in foster care, the CC facilitates the transfer of clinical information, including diagnoses, medications, provider names, and other clinical assessments and available medical records. The CC also ensures the member’s PCP signs the Individualized Family Service Plan (IFSP) and Physical Therapy referral quickly to ensure timely commencement of services.

Infants and toddlers are eligible for EI services after a thorough assessment and evaluation by a Multidisciplinary Team. EI services which are medically necessarily are documented in an IFSP which must be signed by a physician for services to be considered medically necessary and to begin. EI services are delivered at home by qualified providers including physical, occupational, speech therapists and others. CC access to the IFSP requires a signed parental consent which is obtained by MCC as part of the MLTSS ICP process. CCs also work with the EI Service Coordinators to arrange coverage of Assistive Technology devices prescribed by the IFSP.

MCC of VA will cover EI services, in accordance with EI coverage criteria and guidelines in 12 VAC 30-50-131 and the Early Intervention Program Manual (billing codes and coverage criteria). We will work with the Local Lead Agencies to ensure that EI service providers understand how to bill MCC. MCC PCPs follow the EPSDT screening exam periodicity schedule and screen for developmental milestones at Well Child exams starting at age nine months and using standard developmental screening tools or approaches.

We will ensure that EI services are available to qualified individuals who are identified through EPSDT, as outlined in the EPSDT program description, focusing on services for children under Age 21, and our services for foster care or adoption assistance. MCC monitors the delivery of EI services in three ways: 1) CCs ensure the appropriate delivery of services to eligible members as part of monitoring the member’s ISP; 2) Care planning tools assist CCs and ensure that all infants and toddlers in the MLTSS plan are referred for EI assessment; and 3) at a global level, MCC measures the percentage of members under age three referred to EI.
percentage of members who complete the assessment, and the percentage of members with IFSP.

**EPSDT – Ensuring Access**: MCC of VA understands DMAS’ obligation of assuring the federal government that EPSDT services are being provided as required. MCC of VA will support the EPSDT screenings according to the American Academy of Pediatrics periodicity schedule, diagnostic services, as well as any and all services identified as necessary to correct, maintain, or ameliorate any identified defects or conditions for members who are under age 21. In partnership with our network providers, MCC of VA offers comprehensive healthcare services through primary prevention, early intervention, diagnosis, and medically necessary treatment to correct or ameliorate defects and physical or mental illness discovered by the screening of members under age 21. MCC of VA will screen, assess, and monitor all children; cover immunizations; educate providers and schools regarding reimbursement of immunizations; and work with the Department to achieve its goal related to increased immunization rates.

We will monitor the conditions which are discovered during screening to ensure they are diagnosed, evaluated, and then treated. We will use our Member Centric Decision Support Predictive Model and Care Gap Analytics Engine to monitor diagnoses for which individuals under age 21 are treated. All diagnoses will be in the ICP. We know and value the importance of tracking, recording, measuring, and improving PCP coordination and adherence to EPSDT standards to improve outcomes for our child members. Our workflows use both automation and clinical documentation effectively to track and intervene in meeting the EPSDT requirements. Experience has shown us that aligning member and provider incentives, combined with outreach and education, can significantly improve utilization of preventive services.

Through our Maternal and Child Health Program in Virginia, member incentive programs promote self-care and personal responsibility by rewarding members for participation in healthy behaviors like completing a preventative visit or Health Risk Screening and Assessment. Eligible members or their parents can earn rewards for healthy behaviors, for example, completing annual preventive health visits, participating in DM programs and completing a health risk screening tool. The reward is loaded onto a Complete Care Counts “reloadable” debit card. Members can use the funds they earn to purchase health-related services and supplies. Through a collaborative, multi-departmental effort, MCC of VA has developed numerous education, promotion, and outreach strategies, and continuously monitors the effectiveness of these strategies to ensure all members eligible for EPSDT are receiving appropriate screenings, diagnosis, and most importantly, treatment.

Multiple modes of communication are used proactively to reach out to members regarding EPSDT screenings and services. Members needing each service are identified by MCC of VA’s analytics systems. These systems consolidate information on appointment compliance, utilization, and venue in which members received services. When specific members are known to lack needed services such as immunizations or dental services, MCC of VA reaches out to influence participation among those members.

We employ evidence-based practices that have been researched and proven to be effective year after year: targeted post card mailers, reminder calls, and direct person-to-person calls and education. MCC of VA attempts to improve participation by reminding, educating, assisting
and encouraging our members to obtain the recommended screenings and services. The following interventions are employed to achieve the desired participation:

- Member education and information
- Mailed cards or written correspondence
- Automated telephone outreach
- Outreach to community organizations and systems, (e.g., schools)
- Dental reminders
- Direct person-to-person telephonic outreach calls
- OB Care Coordination Team
- Member health alerts
- Assistance with transportation arrangements
- Assistance with medication obtainment, education and adherence.

The real-time quality incentive program will provide additional reimbursement through claims payment to providers for completing essential components of the preventive care visits. MCC of VA follows and promotes established guidelines and tools including:

- Centers for Disease Control and Prevention Advisory Committee on Immunization Practices Immunization Schedules [www.cdc.gov/vaccines/acip/index.html](http://www.cdc.gov/vaccines/acip/index.html)
- American Academy of Pediatrics (AAP) Bright Futures [www.brightfutures.aap.org](http://www.brightfutures.aap.org)
- American Academy of Family Physicians [www.aafp.org](http://www.aafp.org)

**Private Duty Nursing (PDN) – Ensuring Access:** MCC of VA will cover medically necessary PDN services for children under age 21 consistent with the Department’s criteria described in the DMAS Manual and in accordance with EPSDT regulations. We understand that individuals who require continuous nursing that cannot be met through home health may qualify for PDN. We currently have experience in New York contracting with PDN agencies that specialize in pediatric home health services and PDN services for children under the age of 21. In Wisconsin, our nurses and service facilitators work with adults who qualify for LTSS services, including PDN. Our staff partner with individuals to develop ICPs that provide appropriate levels of PDN and coordinate services across the Medicaid benefit (e.g., PDN waiver services versus state plan services) and coordinate PDN with available personal care services.

MCC of VA will provide health benefits and services for children with special healthcare needs and contract with private duty nursing agencies for those children requiring private duty nursing care. The pediatric population presenting with special healthcare needs often present with complex conditions, including those which are both physical and behavioral in nature. MCCs existing risk stratification and enrollment criteria will be applied to this pediatric population. MCC realizes that children present with different conditions, which may result in the authorization and provision of enhanced services at any time. These enhanced services will require medical necessity review. Any services requested and not approved can only be denied by a Medical Director to ensure that safety and optimal health outcomes are achieved.

**Foster Care and Adoption Assistance Children – Experience and Ensuring Access:** MCC of VA will cover services for children in foster care and those that receive adoption assistance if they meet the MLTSS eligibility criteria outlined in the MLTSS contract. We will extend
coverage to all medically necessary EPSDT or required evaluation and treatment services of the foster care program, including services accessed out of our service area. We will reference the MOC Assessment and Individualized Care Plan Expectations table from the RFP for further guidance on assessment, reassessment, and ICP development timelines.

We are prepared to work collaboratively with DMAS and Departments of Social Services in meeting the federal requirements related to the Virginia Health Care Oversight and Coordination Plan for children in foster care. Our experience providing children’s services is enhanced from our Magellan Healthcare Medicaid contracts. As the BHSA in Virginia, we currently provide behavioral health services to all ages statewide. As the Care Management Entity in Wyoming, we currently serve 235 children/youth with complex behavioral health needs. In Louisiana, we provided behavioral health home and community-based services; special waiver-supported services 1915(c), including youth peer support, parent support, independent living skills, crisis respite, crisis stabilization, case management, care coordination with primary and acute medical care providers to more than 2,400 children/youth.

For the Florida AHCA Child Welfare Prepaid Mental Health Plan, we provided behavioral health management services to more than 20,000 children with SED. In addition, for the HealthChoices Behavioral Health Managed Care Organization in Pennsylvania, Magellan has provided case management and self-directed care for children with autism and their families along with other services. Our collective experience providing services for children and youth prepares us to work with foster care and adoption assistance. Our coverage extends to all medically necessary EPSDT or foster care program required evaluations and treatment services, including services that are accessed out of our service area for children under 21 years.

We will collaborate with DMAS and the Department of Social Services to address the high rates of initial and second pregnancies before age 18 in this population. Our understanding of how to address the challenges in serving this group of children, (e.g., changing foster care placements, moving across service regions), is that we need to work across and within systems, including child welfare (and other non-medical systems) to ensure access to services is achieved.

**Care Coordination**

**Care Coordination for All Members:** Consistent with our Integrated Health Neighborhood approach, MCC of VA’s Care Coordination Program is person-centered, community-focused/where the member lives, and evidence-based. Our program is built upon our experience coordinating care for complex members with multiple chronic physical and behavioral health conditions. We specialize in supporting individuals with SMI, SED, and SUD who have complex needs and require intense care coordination by a specialized team of professionals. Magellan covers 29 million members with behavioral health benefits, many of whom have physical, functional, and psychosocial needs. These members require intensive care coordination to address multiple chronic conditions and collaboration with multiple providers, specialists, family supports, across and within multiple systems of care, and community resources. As a result, MCC of VA has extensive experience and success partnering with members to improve health outcomes through a comprehensive and evidence-based Care Coordination Program. MCC of VA has developed a separate, Care Coordination Program description document which provides the detail and framework of the MCC of VA care
Coordination approach. In addition, MCC of VA has developed a library of policies, procedures, and process flows which compliment the care coordination approach.

As we leverage our experience serving members who have complex and multiple chronic conditions, we have the knowledge and resources to support all MLTSS populations and services. Our CCs have the background, credentials and experience to assist LTSS members with their waiver services as well as their physical, behavioral, and social healthcare needs. We often hire CCs from local communities who have experience providing care coordination for the waiver programs.

The core of our Care Coordination Program is the person-centered planning process. A key component is member choice and control, starting with members choosing their own CC as well as providers and services. We employ and assign experienced CCs to work with the LTSS population. These CCs are educated and trained in caring for individuals in specialized populations along with person-centered assessment and planning principles, processes, and requirements. The CCs are skilled in establishing trusting relationships, where the member is the center of the process along with the support of the member’s family, caregivers, and providers. The CC collaborates with all of these stakeholders to complete an ICP that ensures the greatest degree of success to meet the member’s goals.

The CCs recruited and hired by MCC of VA will demonstrate passionate and dedicated care to the MLTSS vulnerable sub-populations. They will live in the communities where members live and have relationships with local providers and community resources. At this time, MCC of VA has partnerships with the local community resources in all areas of Virginia including the CILs, AAAs, ARCs, CSBs, places of worship, and numerous associations and organizations for specialized needs such as housing, transportation, and wellness programs.

MCC of VA operates a call center which has a single, 24/7 toll-free number for assistance and includes a warm transfer to the CareLine (Nurse Line). As part of business continuity, call center staff have the ability to work remotely in case of unplanned events like natural disasters. The call center has trained staff operating the telephone lines during regular business hours to assist members for changing providers, obtaining transportation, scheduling interpreters in 200 languages, accessing a CC, and obtaining needed services.

If requested by the member, the LTSS Support Center staff assists in scheduling timely appointments for referrals from physicians, the CC, or other providers. The Support Center staff contacts the provider, sets up the appointment, and ensures the provider receives the documentation from the referring provider. In addition, the Support Center staff ensures the member’s appointment is timely with transportation for the appointment. For members having problems getting a timely appointment, the Support Center will contact other providers in the network on behalf of the member.

MCC of VA provides communications and education on available services and community resources to the member from numerous sources including the CC, the ICP, the LTSS Support Center, the Member Handbook, and the document packet sent following a home visit. The CC makes sure the member understands the information provided in the ICP, including available services and community resources. MCC of VA also develops the communication and education materials based on input from focus groups and the Enrollee Advisory Committee. Member materials are reviewed to ensure consideration of a member’s physical and cognitive
skills, and level of literacy with a culturally sensitivity for culturally appropriateness for all populations.

The CC supports the member with self-management skills to access care by arranging for peer support and education. The CC also assists in accessing community support agencies who offer education and training on self-management skills such as CILs, ARC, and AAA. We work with members to gain access to Magellan Community Connections.

**Member Notification**

MCC of VA provides a CC who meets with the member either face-to-face or telephonically to review the care coordination program, contact information, including name and information for reaching the CC. This same information is included in the Member Welcome Kit received upon enrollment. The CC places the contact information in an easily accessible place for the member, family, and caregivers. MCC of VA works closely with the member to ensure that the member agrees with the CC assignment.

The CC explains to the member and/or their family that the LTSS Support Center staff is able to assist when the CC is not available. The Support Center staff is able to handle the majority of requests from a member when the CC is not immediately available. For example, Support Center staff will assist members with changing service providers, scheduling appointments and referrals, and making transportation arrangements. The Support Center staff also sends a message to the CC summarizing when the member called, the actions taken, and a request to follow up. In addition, the Support Center staff has direct access to the CareLine Clinical Team available 24/7 to assist the with both non-LTSS and LTSS care and service coordination activities.

For health plan-initiated changes, the current CC notifies the member with the new CC contact information. When the member requests a CC change, MCC of VA assigns another CC who contacts the member and provides contact information. To follow up, the Support Center staff sends the member a written notification of the change with contact information. When appropriate, the new and previous CCs make a joint visit to ensure a smooth transition.

**Provider Notification**

During program implementation, MCC of VA identifies providers through historical claims data or by the member informing the CC during the initial visit. The name of the CC, how to contact them, and when they are available is then given to the provider by the LTSS Support Center. This communication is completed through the provider portal, secure email, or telephone. Whenever there is a new or modified service, the Support Center uses the same communication methods. Staff also provide information on the alternative resources if the CC is unavailable, as noted above, and when there is a change in CC assignment. Providers also receive a secure follow-up email with the service authorization details, CC’s name and phone number, Support Center contact information, available hours, and information on how to access the 24/7 CareLine after normal business hours.

**Additional Communication Strategies**

Magellan currently works with complex Medicaid populations in Virginia and other states and is very familiar with the difficulties of contacting and locating members. When attempting to locate members, we initially use the member’s enrollment file information for address and phone numbers. If this effort does not work, we contact providers and community agencies
serving the member including the PCP, LTSS providers, and behavioral health providers who may have current contact information. We also try contacting family members and friends when the information is available.

MCC of VA employs community-based staff who resides in and near the same communities as members. The staff have existing relationships and contacts in the community, which often helps in successfully locating members. We also leave notes and cards at their home address emphasizing the importance of contacting us to continue receiving services. We monitor utilization management and claims data for information on the member if they are accessing EDs, filling prescriptions at pharmacies, or admitted to hospitals. In other markets, Magellan (or we) has utilized a company, Integra, a company that specializes in locating hard-to-find individuals. The Integra Team has a solid track record of collaborating with the our Care Coordination teams in successfully locating members.

The CC uses a person-centered approach engaging members about available services and supports to assist in achieving optimal health, wellness, and self-management goals. The CC also explains the support provided to the member for self-direction and self-management. However, we understand from previous experience there will be members who decline Care Coordination services. The CC will explain our role is to support the member in accessing services and supports to meet their goals. The CC also advises that an assessment must be completed to validate the need for services and to certify eligibility for the waiver program. The CC provides the member with contact information with each interaction.

**Enhanced Care Coordination for Vulnerable Sub-populations:** The MCC of VA health plan will serve the most complex populations presenting with a primary diagnosis of SMI, SED, and SUD, and who also have co-occurring illnesses and chronic physical conditions. Members who have multiple chronic conditions are designated as high-risk members and receive complex and enhanced care coordination and case management services. Based on years of providing an enhanced Care Coordination Program and lessons learned, we have refined and improved the enhanced Care Coordination Model to a highly effective person-centered, community focused, and evidence-based MOC.

For example, Magellan’s health plan in Florida, MCC of Florida, is a Specialty Plan that specializes in working with individuals with SMI, SED, and SUD who also have co-occurring illnesses and chronic physical conditions. As the first Specialty Plan in the nation for individuals with SMI, we have experience and lessons learned to bring to Virginia. The State of Florida has acknowledged on numerous occasions the extensive experience and proven success we provide in high quality and enhanced Care Coordination services for this complex population.

A essential element to enhanced care coordination is using a planning process with the member at the center. Our staff are culturally competent and prepared to collaborate with all members regardless of their levels of health literacy or any communication, language and cognitive barriers. Despite these barriers, the CC ensures the member is able to actively participate in the assessment and care planning process with the necessary supports. The CC assists the member in defining short-term as well as life goals, and services needed to reach these goals. The member chooses the CC, services needed, and providers. The CC ensures the member, family, and caregivers all participate in developing an ICP, which is designed to meet the member’s
goals. The CC also supports members, with very complex and multiple chronic conditions, understand the multiple services and providers that will be included in the individual’s care.

We build highly-specialized teams of subject matter experts dedicated solely to the engagement of vulnerable sub-populations. The CC for each vulnerable sub-population will have experience and expertise in supporting needs for unique areas, such as pediatric care, long-term services and supports for members in the EDCD Waiver, and seniors and individuals living with physical disabilities. The CCs will also have extensive knowledge and experience with the available community resources to support these specific populations. The CCs leverage their knowledge of providers, community supports (such as existing community agencies, advocates, faith-based organizations, and child services agencies), as part of the solution. We invest in making an positive impact, one member at a time, by taking a highly individualized, high touch, community-based approach to enhanced care coordination.

MCC of VA’s Care Coordination Program uses an integrated, high touch, team-based approach. We address the full continuum of care and services simultaneously rather than in a linear or sequential manner. This approach enables us to continually adjust the ICP based on evolving member needs and circumstances. The elements of our care coordination approach include:

- identifying health risks
- using person-centered planning to work with the member in identifying goals and services needed
- partnering with the member to develop an ICP
- engaging the Interdisciplinary Care Team (ICT)
- focusing on effective and comprehensive transitional care from inpatient to other settings and between levels of care

MCC of VA will implement its Care Coordination Program using our experience and lessons learned operating fully integrated behavioral and physical healthcare coordination programs in all of Magellan’s markets. MCC of Florida has successfully managed very complex member populations across the life span. Our experience establishing successful integrated behavioral and physical healthcare coordination programs has uniquely positioned us to develop enhanced Care Coordination Programs and expertise in caring for various and specific vulnerable and complex populations, including MLTSS, which we would establish in Virginia. The diagram and example below shows a member’s success in achieving increased self-determination through our enhanced Care Coordination Program approach:
Member Success Story — Lucy

Vulnerable Sub-population: We believe most of the eligible MLTSS members will be high risk and very complex, who are also living with multiple chronic conditions that will need enhanced care coordination, including:

- **Individuals with SMI or SED:** The CC, with experience in SMI or SED, assesses physical, behavioral, functional, and social needs and develops a care plan to address the identified needs. The CC coordinates services to address all of the behavioral health issues and needs, the PCP and specialists’ activities, pharmacists for medication coordination, family education and support needs, and provides access to community supports including the CSBs.

- **Individuals with SUD:** Through our comprehensive ARTS program structure and offerings, the CC assists members experiencing SUD with access to wellness and recovery services. The CC ensures access to specialized services, the member’s physicians and specialists in SUD, community resources and peer supports.

- **Technology assisted waiver:** The CC for the children in this waiver will have pediatric nursing experience. The CC ensures the assessment focuses on the private duty nursing service needs, access to a PCP and specialist services and the special equipment needed. The CC ensures the member receives the relevant services and that family and caregiver supports are provided.

- **Elderly or disabled with consumer direction (EDCD) waiver:** The CC is specially trained with experience in LTSS, consumer direction, and assessing members’ functional and ADL needs. The CC assesses the member’s long-term services and supports as well as physical and behavioral health needs. The CC supports the member with consumer

### Case Example of Enhanced Care Coordination:

*Lucy*

**Quote from Lucy’s mother:** “No one ever took the time to help Lucy, no one cared. But Magellan cares.”

1. **Diagnoses:**
   - SMI – Schizophrenia
   - SUD – Substance use
   - Diabetes – uncontrolled

2. **Service use:**
   - 20 inpatient hospitalizations in 12 months

3. **Enhanced care coordination:**
   - Discharge planning on day of admission
   - Care transition plan back to community
   - Coordinated with pharmacist and psychiatrist — obtained order for long-acting injectable antipsychotic
   - Coordinated with Housing Director to find housing
   - Made follow-up appointments with psychiatrist and primary care
   - Accompanied member to follow-up appointments
   - Arranged ICT meeting all providers and family
   - Continued to assist making appointments and arranging transportation
   - Connected with peer support specialist

4. **Outcomes:**
   - Improved adherence with medications
   - Keeping appointments
   - Staying out of hospital
   - More proactive in self-management of care
   - Has family involved in her life again
direction and assists in selecting the best option(s) for consumer direction, budgeting, and arranging a back-up plan.

- **Day support program for persons with intellectual disabilities:** The CC coordinates with a case manager for the Day Support Waiver services and integrates these services into the member’s overall ICP. Since this waiver is changing to the Building Independence Waiver, the CCs will be trained on the changes. The CC ensures access to physical and behavioral health services for these members.

- **Intellectual disabilities waiver:** The CC works with these members to ensure they have access to physical and behavioral health services, including access to primary care, community supports and family support services. As this waiver will change to the Community Living Waiver, MCC of VA will educate and train staff on the changes.

- **Individual and family developmental disabilities support waiver:** The CC assesses these members for their physical and behavior healthcare needs and ensures the ICP is integrated with the waiver services. The CC ensures access to the specialized providers for these members who often have co-occurring conditions including a behavioral healthcare need.

- **I/DD:** The CC assesses the member’s physical and behavioral health needs and identifies any co-occurring conditions that are typical with this population including behavioral health issues and chronic physical health issues. The CC ensures access to behavioral health specialists and PCPs.

- **Individuals with cognitive or memory problems:** The CC assists members with cognitive or memory problems to identify and assess their physical and behavior health care needs. The CC ensures access to specialized providers, community resources, and support services for family members. The CC supports eliminating communication barriers and offers assistance in understanding the care plan.

- **Individuals with physical or sensory disabilities:** The CC assesses the functional capabilities and needs for members, special equipment, plus the physical and behavioral health care needs. The CC ensures access to community supports and special organizations for individuals with sensory disabilities.

- **Individuals residing in nursing facilities (NFs) and other institutional settings:** The CC collaborates with members residing in NFs or members in other institutional settings. The CC conducts an assessment onsite at the facility and coordinates the care plan with the facility clinical care team, the Medicare and MDS coordinator, facility physicians, and pharmacists. The assessment may also involve examining alternative living possibilities in the community and will include a care transition plan.

- **Individuals with end-stage renal disease:** The CC assists members with access to kidney disease specialists and the dialysis services. In addition, the CC determines if any services are needed to educate and support the member and family about the different stages of this disease. The CC identifies co-occurring conditions such as diabetes and ensures access to services to prevent diabetic risks such as loss of vision.

- **Individuals receiving hospice benefits:** The CC assists the member and family with the hospice care plan and services and supports. The CC frequently monitors and follows up with the member to assess their condition and the status of documented advance directives.
- **Children in foster care or adoption assistance:** The CC supports the child, foster family, member’s natural family, if appropriate, and the child’s permanency plan. The behavioral and physical health care needs of these children are more complex. Care transition planning is ongoing and changing depending on the child’s situation, and the CC ensures a smooth transition back to home or other settings.

- **Women with high-risk pregnancy:** The CC for these members has obstetrics (OB) and maternal fetal medicine (MFM) nursing experience and knowledge. The CC ensures the member has access to the OB/MFM specialists, and is living in a safe environment with capabilities to self-manage her high-risk pregnancy.

- **Individuals with chronic or multiple chronic conditions:** The CC addresses all conditions and ensures access to multiple providers and supports. The CC ensures that all providers and services are integrated and that the member and family are educated on the conditions and plan of care.

**Care Coordination Staffing:** The roles and responsibilities of the care coordination function include responsibility for the overall coordination of the member’s acute and chronic behavioral and physical health care, LTSS, and related service needs to support the member’s overall health and wellness. Each member is assigned to a CC who has support staff and subject matter expert assistance as part of the ICT.

The CC functions as the member’s contact within the health plan, the facilitator of the member’s ICT, and the liaison between the providers and the health plan. The CC and support staff acts as the liaison for the family, caregiver, provider, and any targeted CCs involved with the member’s care and service coordination. The CC is responsible for having strong working relationships with all of the community resources involved with the member’s care and service provision.

The CC complies with the MOC element requirements to ensure care assessments, care plans, service arrangements, care transition efforts, follow-up contacts and visits, and quality monitoring are undertaken fully and effectively. The CC ensures the process is person-centered and uses all of the required components of person-centered planning.

All members have access to some level of care coordination services and ICT engagement. Through the use of our validated stratification algorithms, the frequency of meetings and type of participants on the team vary in accordance with the member’s specific needs.

Care is coordinated through all levels of care including primary care, specialists, and LTSS. The CC and Health Guide are the member’s advocates and help navigate the member through the delivery system.

The CCs and Health Guides are community-based, and help the member make and keep appointments with behavioral and physical health providers, provide follow up and coordinate with community agencies and other resources, as needed.

The primary behavioral health provider is responsible for overseeing the delivery and quality of the services the member receives. The primary medical or physical health provider oversees the medical services that the member receives to ensure they are medically appropriate and coordinated. Magellan’s Care Coordination Team coordinates with service providers and community organizations to meet the person-centered needs of the member. The goal is to link
members with the appropriate service providers to ensure providers address the member’s ongoing needs.

**Additional Care Coordination Resources**

MCC of VA designates the core, regionally-based care team carry out care coordination, case management, and other related programs processes and procedures. MCC of VA ensures that upon enrollment, the member is educated and fully understands that the regional Care Coordination Team works together and offers back-up to the member at all times. The primary CC is available as needed; however, the CC has access to office-based LTSS Support Center staff and field-based support staff. Any member of the regional or office-based care team is able to assist the member at any time.

Depending on the member’s needs, the regional Care Coordination Team members may include:

- **Peer Support Specialist**: A certified specialist trained to assist members by applying whole health resiliency and recovery principles and tools such as wellness recovery action plans (WRAP®), a wraparound process, family and person-driven care, and systems of care that use these skills to provide emotional support to inspire hope for the future. They model and assist members in making lifestyle improvements and the self-management of chronic conditions. Peer Support Specialists provide additional outreach to individuals who require assistance to obtain access to and engage in needed services.

- **Clinical Pharmacist**: Participates as needed to review the medications the member receives and in collaboration with the prescribing physicians on the team; responsible for identifying potential over- or under-utilization, potential drug disease interactions, and optimal therapeutic regimens. The Pharmacist consults on complex cases where there is risk to the member due to potential drug interactions between drugs for chronic medical conditions and psychotropic medications. The Pharmacist will also take advantage of the sophisticated analysis of claims data to identify care gaps or potential concerns.

- **Care Coordinator**: Either a licensed Registered Nurse or a licensed social work professional is utilized for all levels of member engagement. The CC carries out the Care Coordination process, including the initial HRA and subsequent reassessments, and develops the ICP consistent with the member’s health care needs, LTSS, and non-medical needs and goals such as transportation, chores and light housekeeping, companionship, grocery shopping, feeding the pets at home, home-delivered and congregate day program meals. The CC monitors and intervenes for members with complex situations and ensures implementation of the ICP. The CC is actively involved during any care transition, including planned and unplanned admissions, and works in conjunction with the member’s Health Guide to ensure ICP communication between all providers and members.

- **Health Guide**: A non-clinical staff member responsible for supporting the CC and contributes to the case management process. The Health Guide assists the Care Coordination Teams with a variety of member engagement activities, including care transitions and discharge planning activities. Other Health Guide activities may include assisting the member in coordinating medical and non-medical needs. Administrative activities include mailing letters/educational materials, obtaining authorizations for disclosure of protective health information, assisting with referrals, scheduling appointments, scheduling case conference meetings, and assisting with other basic care coordination activities.
**Care Coordination Caseload Ratio:** We recognize that caseload distribution is critically important to ensure the responsibilities that our CCs have to our members are achievable. We base our caseload standards on current nationally recognized case management model examples recommended by the Case Management Society of America (CMSA) and the National Association of Social Work - Case Management Standards.

We established a flexible approach and standard for the number of members who could be responsibly taken care of by one CC, depending on the members’ needs, care setting, or living situation. Our approach, to caseload assignment, allows the CC to be flexible in adjusting activities based on the specific needs of each member. We believe having manageable caseloads allows CCs to be successful supporting members in achieving their goals.

When assigning members to CCs, we consider the services needed by the member as well as a member’s acuity and complexity of needs. We also consider geography, including travel time and where members are living (e.g., NF, assisted living facility, home). Each CC has access to Support Center staff members who assist with various service coordination and case management activities.

We will comply with the staffing ratios as outlined and required in the DMAS CCC Plus contract.

MCC of VA will aggressively recruit, hire, and train staff in advance of go-live and hire more staff than projected for implementation. We monitor staffing and make necessary adjustments to ensure that caseloads are manageable for CCs to be the primary contact. MCC of VA ensures that we have an adequate number of CCs by continually tracking membership, staffing, and caseloads, and if necessary, hiring additional staff to meet caseload requirements.

Please refer to the table below. **Care Coordination Job Descriptions** for all staff members involved in Care Coordination activities, including:

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<th>Care Coordination Job Descriptions</th>
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<td>Senior Medical Director</td>
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<td>Behavioral Health Lead</td>
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<td>Pharmacy Director</td>
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<tr>
<td>LTSS Support Lead</td>
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<tr>
<td>MLTSS Care Coordination Manager</td>
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<td>Care Coordination Hub Manager</td>
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Care Transitions

**Goals, Processes, and Systems Ensuring Smooth Transitions:** A care transition occurs when a member moves from one care or residential setting to another due to a planned choice, change in health status, circle of support, or living circumstance, or as a result of moving in and out of the judicial system. We incorporate nationally recognized best practice approaches and measures, and those outlined by DMAS. These approaches are based on key components of the National Transitions of Care Coalition and Eric Coleman’s Care Transitions Program®, and the Camden Coalition’s work with super-utilizers to reduce preventable hospital readmissions.

Planned and unplanned care transitions require diligent planning and follow-up to avoid ED utilization, potential readmissions to acute care settings, hasty placements into potentially inappropriate institutions.

Our care transitions approach aims to:

- Ensure continuity between settings while including the member’s choice, preference and goals
- Assist members/caregivers learn self-management skills to ensure their safety, behavioral, and physical health needs are met
- Provide adequate support for the member to return to the setting of their choice
- Reduce preventable readmissions, institutionalizations, and adverse outcomes

To prevent unplanned care transitions, we provide proactive service coordination and care management interventions, including:

- Setting member-specific, prioritized goals that promote coordinated care
- Addressing social, medical, and behavioral risk factors affecting the member
- Providing members and families one point of contact/accountability
- Making and keeping specific tasks/appointments/calls/follow-up with members
- Creating a communication process for involved providers
- Facilitating member self-management capabilities and closing gaps in care
- Working with existing community transition programs to support a safe transition plan
- Educating the member on use of the 24/7 Nurse Hotline and Support Center
- Establishing a physical and behavioral health home if one does not exist
- Building a circle of support with the member within their community or neighborhood

To further support the member, we assign a CC with SMI, SED, or SUD experience to partner with the ICT, to support the member’s choices and manage the ICP, to identify potential care/service gaps, enhance communication among providers, and ensure safer outcomes. The CC communicates with all relevant parties involved in the transition and the ICP and supports the member in the least restrictive and safest environment.

Transition Coordinators, who do not carry case caseloads, work with the CC during complex care transition is complicated. We embed a Transition Coordinator at high volume inpatient sites, to support hospital discharge planners and initiate ED admission avoidance protocols. The Support Center LTSS Member Associate assists the CC and members to schedule services,
follow-up appointments, transportation, home health and personal care attendants, order DME supplies and arrange back-up plans.

**Transitions in Care Planning:** We develop protocols with medical and behavioral hospitals, EDs, AAAs, CILs, home health agencies, and residential facilities/skilled nursing facilities (SNFs) to address early notification, avoid care interruption, and support community transitions. We have met and will continue to work with VA-based community agencies with expertise in care transition management, including Leading Age, AAAs, CILs, CSBs, Alere, and federally qualified health centers (FQHCs). A Letter of Intent with Bay Aging D/B/A the Eastern Virginia Care Transitions Partnership (EVCTP) has been signed, which will allow us to exchange member data to reduce unnecessary readmissions, coordinate referrals, and streamline billing.

**Transition-in-care Tools:** The Transition Checklist guides the process, and key elements are imbedded in our NF HRA, HCBS HRA, and ICP to assist the CC and ICT. Condition-specific tools, such as medication reconciliation, Welcome Home scripts, Discharge Checklists, Life Skills Strengths and Needs Assessment, and symptom and crisis response plans further guide transition interventions and augment the member’s ICP.

**Partnering with Caregivers:** We are committed to supporting caregivers, who play a critical role in successful transitions. Using a specially designed assessment tool, the CC and/or Transition Coordinator meet face-to-face to discuss how to manage the demands of caregiving and other stressors or concerns, and identify training, knowledge, and/or skill needs and additional service and/or support needs.

**Formal ICT/Care Conference/Case Review:** Part of the integrated model for members with complex needs include daily, formal ICT case review. We focus these case reviews on members with SMI/SED/SUD and physical health conditions who are transitioning between levels of care or experiencing a significant event, safety risk, potential quality of care variance, or have an identified complex physical and/or behavioral health situation requiring intensive review and follow-up. Additionally, the ICT members, including behavioral and physical health physicians, CCs, clinical pharmacist, and utilization management professionals, offer input to assist the member and CC.

Goals of the ICT case review include:

- Managing the integrated behavioral and physical care by sharing information with the team responsible for the direct care and service coordination of the member
- Ensuring the member’s movement through the care continuum and across living situations results in positive outcomes
- Obtaining advice, guidance, and insight of subject matter experts to improve the planning process, ensuring optimal care, safety, and avoidance of unnecessary care transitions
- Creating an understanding of the unique and complex needs of the integrated population which may or may not respond to traditional case management approaches
- Enhancing and develop approaches and tools that can be used systematically
- Sharing problems or poor outcomes to support quality management initiatives
- Discussing best practice care transition approaches – review look-back periods to assess precipitating events to a transition or support contingency plan development
- Sharing information to improve program operations with other key stakeholders, including other health plans, partners, regulators, or other clients
- Identifying opportunities for LTSS members to remain in or move to the least restrictive, safest living environment, per his/her wishes
- Promoting opportunities for members who are willing and capable of self-directing their care

**Post Transition in Care Follow-Up:** The CC or Transition Coordinator meets the member on-site immediately after the transition to a new setting to ensure continuity of care. The CC, assisted by the LTSS Member Associate, makes follow-up contacts, tapering their visit frequency based on member need. Formal review of complex cases or ICT conference sessions occur daily, as needed. For urgent/emergent hospital transfers, the CC, with support of the ICT, conducts a seven-day look-back to evaluate precipitating events for the unplanned transition. The ICT uses the findings of this review to adjust the ICP, identify educational or other member needs, and create contingency plans to further mitigate the risk of future unplanned transitions. The look-back results are formally reviewed in the ICT and case review meetings.

**Information Systems that Support Transitions:** The CareAdvance care management system integrates data and is used to share information among providers, members, and CCs in near real-time. This system ensures coordination of care, tracks services used by members through episodes of care, and streamlines care transitions to ensure positive health outcomes. Care transition information is available through the provider portal or by contacting the Support Center. CCs use CareAdvance to complete assessments, update the ICP, and document care transitions. During face-to-face visits, our Mobile App contains all available relevant documents. We use our JumpStart tool, a rules-based algorithm system, to systematically process due dates for assessments, tasks related to transitions in care, and any member contact.

CareAdvance interfaces to receive real-time transition notifications from Cureatr by providing a communication infrastructure between care settings including acute care, NFs, and the criminal justice system. Cureatr automates notification of admissions, discharge, and transfer for acute and sub-acute admissions, ED visits, and other transactions nearly real-time to the CC, PCP and ICT. When a member accesses a different point of service, providers who are responsible for that member’s transition ICP are immediately notified by text or computer message. The CC and PCP are also notified of any planned or unplanned moves. This early notification step permits prompt intervention, avoidance of hospitalizations, and exception tracking and immediate investigation when a transition move did not occur as planned. Cureatr’s reports and data help us to improve our processes and identify providers who may need additional education and support during member care transitions.

**Identification of Members Approaching or Requiring Transitions in Care:** Members must be assessed for the need or opportunity to transition to a different level of care or residence. For members in long-term care (LTC) and NFs, minimum data set (MDS) data is available to support repatriation to the community. If MDS data or the NF HRA indicates the member may return to the community, the CC works with the member, their circle of supports, and the facility to determine if transition is safe and feasible. The CC may contact ICT members, such as Housing and Employment Specialists, to contribute to the transition process. The goal for members, who are living in the community, is to maintain their current status while being able to receive safe delivery of care, supports and services in the least restrictive environment. Periodic assessments conducted by CCs along with interactions with caregivers, providers, and
the ICT are used to identify the services needed to support the member. These efforts are also used to identify when a particular service option may be harmful to the member. When data and CC observations indicate that continued community care, even with supports, may no longer be safe, the CC will explore care alternatives with the member. The CC solicits input from the ICT and ICP and adjustments are made with members and caregivers.

**Transitions for Members Requiring DMAS Authorization:** The service description, criteria, service units and limitations, and provider requirements, per 12VAC30-120-2000, are supported by Transition Coordinators for members in EDCD, Tech and other eligibility categories from transition from institutions to the community. Transition Coordinators support members to obtain DMAS authorization for one-time transition authorization.

**Transitions from One MLTSS MCO to MCC of VA:** When notified of a member transferring from another MCO to MCC of VA, we request member information, specifically the most current assessment and ICP.

**Transitions from MCC of VA to Another MLTSS MCO:** When MCC of VA is notified of a member transitioning from our plan to another MCO, we release the member’s records and ICP to the new MCO/delivery system within five business days of receipt of notification. We identify the treating providers to ensure the new MCO can request records. Finally, we ensure the CC responds to any questions from the new MCO or delivery system.

**Transitions Between Care Settings:** Our approach to transitions between specific care settings is shown in the table below: Types of Care Transitions

<table>
<thead>
<tr>
<th>Types of Care Coordination Transitions</th>
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<tr>
<td>The Care Coordinator coordinates transitions from hospitals (acute/psychiatric discharge) to:</td>
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<table>
<thead>
<tr>
<th>Community</th>
<th>Nursing Facility (skilled or custodial)</th>
<th>Residential Treatment Facility (RTF)</th>
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<tr>
<td>1. Before discharge, arranges inpatient on-site case conferences for transition/community discharge planning, conducts assessments, and generates a transition plan/ICP which contains member goals, preferences, clinical and living status. The ICP reflects logistical arrangements, coordination among care/service providers, identifies and documents member/caregiver education and additional community resources collaborating with CILS, AAAs</td>
<td>1. Coordinates with the NF Admissions Coordinator and member’s support system</td>
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<tr>
<td>2. As needed, arranges additional services (including behavioral and telehealth) and peer support</td>
<td>2. Prior to discharge, arranges an on-site care conference, explores community transitions/next steps, collects member goals, preferences, assesses status, agrees to an ICP, arranges services, and coordinates supports among entities to ensure a successful transition</td>
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<tr>
<td>3. Ensures ICP is shared and monitors at the earliest opportunity for community repatriation</td>
<td>3. As needed, arranges additional services (including behavioral and telehealth), peer support, intensive community treatment or possible transitional housing between care settings to ensure adequate treatment and support</td>
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<tr>
<td>4. Develops LTSS services list and schedules for Support Center LTSS Member Specialist, who contacts the member and providers daily until transition is complete</td>
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<td>1. Coordinates with RTF Admissions Coordinator and member’s support system</td>
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<tr>
<td>5. As feasible, is on-site during move</td>
<td>2. Prior to discharge, arranges an on-site care conference, explores community transitions/next steps, collects member goals, preferences, assesses status, agrees to an ICP, arranges for additional services, and coordinates supports among other involved entities to ensure a successful transition</td>
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The Care Coordinator coordinates transitions from communities (w/HCBS waiver) to:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Nursing Facility</th>
<th>Residential Treatment Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ensures continuity of care by notifying providers, assisting with medication reconciliations, sharing the current ICP.</td>
<td>1. Coordinates with the NF Admissions Coordinator and member’s support system.</td>
<td>1. Coordinates with RTF Admissions Coordinator and member’s support system.</td>
</tr>
<tr>
<td>2. Before discharge, arranges inpatient on-site case conferences for transition/community discharge planning, conducts assessments, produces a transition plan/ICP which contains member goals, preferences, clinical and living status or assesses feasibility of continuation of current ICP. The ICP reflects logistical arrangements, coordination among care/service providers, identifies and documents member/caregiver education and community supportive resources.</td>
<td>2. Ensures continuity of care by participating in on-site care conferences and sharing the member’s current ICP.</td>
<td>2. Prior to discharge, arranges an on-site care conference to explore community transitions/next steps, collects member goals, preferences, assesses status, agrees to an ICP, and arranges for additional services and coordinates supports among other involved entities to assure a successful transition.</td>
</tr>
<tr>
<td>3. Ensures information is shared among involved parties, including current ICP, member preferences, and current service providers.</td>
<td>3. Regularly visits the member and participates in case conferences.</td>
<td>3. As needed, arranges additional services (including behavioral and telehealth), peer support or transitional housing to ensure adequate treatment and support. The ICP/transition plan reflects logistical arrangements, coordination among care/service providers, identifies and documents member/caregiver education and community supportive resources.</td>
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The Care Coordinator coordinates transitions from communities (w/o HCBS waiver) to:

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Nursing Facility</th>
<th>HCBS Waiver</th>
<th>Residential Treatment Facility</th>
</tr>
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<tbody>
<tr>
<td>1. Coordinates with the NF Admissions Coordinator and member’s support system.</td>
<td>2. Ensures continuity of care by participating in on-site care conferences and sharing the member’s current ICP.</td>
<td>3. Plans and assesses feasibility to return to the community by conducting assessments, working with the member to develop a transition plan/ICP with member goals, preferences, clinical and living status.</td>
<td>4. Ensures information is shared including current ICP, member preferences, and monitors the earliest opportunity for repatriation to community.</td>
</tr>
<tr>
<td>2. Prior to discharge, arranges an on-site care conference to explore community transitions/next steps, collects member goals, preferences, assesses status, agrees to an ICP, and arranges for additional services and coordinates supports among other involved entities to assure a successful transition.</td>
<td>3. As needed, arranges additional services (including behavioral and telehealth), peer support or transitional housing to ensure adequate treatment and support. The ICP/transition plan reflects logistical arrangements, coordination among care/service providers, identifies and documents member/caregiver education and community supportive resources.</td>
<td>4. Ensures information is shared including current ICP, member preferences, and monitors the earliest opportunity for repatriation to community.</td>
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The Care Coordinator coordinates transitions from long-term institutions to:

<table>
<thead>
<tr>
<th>HCBS Waiver</th>
<th>Hospital and Back to Nursing Facility</th>
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</table>
| 1. Monitors MDS data and participates in on-site case conference for transition/community discharge planning, conducts assessments, produces a transition plan/ICP containing member goals, preferences, clinical and living status and reflects logistical arrangements, coordination among care/service providers, identifies and documents member/caregiver education and additional community resources.  
2. Develops an LTSS services list and schedule for the LTSS Support Center Staff, who contacts the member and service providers daily until the transition is complete.  
3. As feasible, is on-site during move. | 1. Coordinates with NF Admissions Coordinator and member’s support system.  
2. Arranges on-site care conference prior to inpatient discharge. During that meeting, the reasons for admissions (especially if unplanned), root causes for the readmissions, and prevention strategies are identified.  
3. Develops ICP/Transition plan including the member’s preferences and goals, supports, and community resources to avoid re-admissions.  
4. Arranges for additional services (such as behavioral and telehealth), monitors MDS data for opportunities to repatriate to community. |
Our CC participates in the other plan’s transition team and works with them to ensure expeditious decision-making and communication of Medicare authorizations.

- **Inpatient acute/psychiatric-Medicare Coordination of Benefits (COB):** We communicate with a member’s health plan while they are hospitalized to coordinate their discharge plan and ensure a warm hand-off to our CCs at discharge. This coordination effort facilitates the resumption of the ICP upon the member’s return to the Community/NFs, or transfer to a residential treatment center.

- **NFs/institutional care:** NF coordination of benefits is related to the Medicare coverage of skilled days, their associated copayments, and other LTC Coverage. We coordinate with the other health plan’s case management process. If the member is not covered under skilled benefits or Medicare Managed Care/other insurance, we lead the assessment, coordination, authorization of supports and services for benefits under MLTSS.

- **Community with and without HCBS:** We coordinate with the other plans to ensure there are no duplicative services and that ICPs are collaboratively developed to meet the member’s goals to remain in the community. We assess, coordinate, arrange, and authorize services for HCBS benefits for those eligible. For members who are not eligible, we offer similar supports but arrange for their provision through community resources.

- **Medicare fee-for-service (FFS):** These members lack coordination support for Medicare services, so the CC coordinates care related to transitions in all settings in close collaboration with other identified transition teams.

**Assessments**

*Health Risk Assessment (HRA) Tools:* Magellan Health is a recognized leader in supporting people with complex physical and behavioral health conditions. Our Florida Medicaid health plan supports many populations, but in particular, those individuals with complex presentations of SMI, SED, and/or SUD, and chronic co-morbid physical health conditions.

These members require specialized, targeted tools and strategies to support their diverse support and service needs. Our assessment process is person centered and strength based. We collaborated with Shared Health, a health plan business process partner with 10 years of experience with LTSS populations, to develop comprehensive Nursing Facility (NF) and Home and Community Based Services (HCBS) Health Risk Assessments (HRAs), incorporating the nationally recognized, evidence-based Universal Assessment Instrument (UAI), Minimum Data Set 3.0 (MDS 3.0), and SF12 Quality of Life assessment components. Our tools capture the elements of the Virginia UAI tool. We will modify the attached HRA tools based on DMAS review, guidance, and approval.

HRAs will be carried out in compliance with DMAS requirements and timeframes and will address each member’s psychosocial, cognitive, functional, medical, behavioral, LTSS, wellness and preventive status based on member need. Each member is assigned a case management risk level segment which also guides the CC and Interdisciplinary Care Team (ICT) in the HRA completion process, as illustrated below:
Case Management Risk Level Segments:

Care Coordination Program

- **Ultra High Risk (UHR) Complex/Intensive Level Membership**
  - Populations Include:
    1. Members referred to the complex program or scoring at an UHR level

- **High Risk (HR)**
  - Populations Include:
    1. Members Experiencing any Type of Planned or Unplanned Care Transition
    2. HCBS waiver participants
    3. Individuals residing in nursing facilities
    4. Other Vulnerable Subpopulations, as defined in the Model of Care (MOC)

- **Monitor Risk Ultra High and High Risk**
  - Populations Include:
    1. "Unable to Reach, Locate, or Engage Membership"

- **Moderate Risk**
  - Populations Include:
    1. Non UHR or HR Members
    2. Members with High Prevalence Disease Management or Chronic Condition Management needs
    3. Members with Short Term Case Management Needs

- **Low Risk/Community Wells**
  - Populations Include:
    1. Members with stable Health and Wellness Status

The information collected within these segments assists the member and CC in determining the LTSS and clinical care needs. Our NF and HCBS HRAs include assessments of the member’s physical, behavioral, and psychosocial needs, including capturing information related to housing and employment. The demographic data collection process associated with the HRA tools gathers information related to the member, his/her preferences, goals, community connections, circle of support, PCP, preferred medical and service providers, and current services (including Targeted Case Management (TCM), community resources, and supportive services).

The NF and HCBS HRAs are augmented by additional branching assessment tools, which encompass a broader scope of acute, chronic LTSS, behavioral, and physical health conditions. This approach and branching logic provides holistic, integrated data that allows CCs and members to paint a comprehensive picture of members’ needs, capabilities, goals, and preferences. This information is the basis on which the member and the CC begin to develop the ICP.

CCs are equipped with mobile devices, which support touch-screen functionality. The devices have encryption, signature capability, and integrated cameras for scanning documents for upload into members’ records. The Mobile App allows the CC to select and build the library of documents to conduct the face-to-face visit. This library consists of approximately 70 required and optional forms, available and utilized, as each member’s circumstance requires. Prior to the visit, the CC completes as much documentation as possible from information available from the enrollment files and claims data. During the assessment, and as other requirements are identified during the visit, additional branching assessments and forms are accessed by the CC. Network connectivity is not required during the visit because information is retained in the mobile device until it can be connected and uploaded to CareAdvance (care management system).
information system). Once connected to our network, the CC securely uploads the member-specific information. The data gleaned from this process stratifies, integrates, and populates the information within the member’s ICP.

MCC of VA developed a reporting and operational management tool called JumpStart. The name references prompt to get a “jump start” on contractual timeframes that are designed to ensure members get the attention they need and require. JumpStart is a rules-based algorithm system that systematically processes the due dates for assessments, touch points, and other contacts with the member. This tool has been used successfully in Tennessee to track timeframes for initial and subsequent assessments, prompt service initiation, and tickler annual documentation requirements. The JumpStart reports track all newly enrolled and current members, including any required documents, for contractual compliance.

**Identification of Initial HRA and Annual Level of Care (LOC) Reassessments:** We will comply with DMAS requirements to complete initial and periodic LOC assessments, and attempt to schedule all members for the indicated HRA as soon as convenient for the member.

Upon receipt of the enrollment file, the JumpStart system notes the member’s eligibility category, due date for the initial assessment, and other information, including if the member transferred from another Plan/has other coverage. That information populates the files and appears on the CC’s reports to schedule the visit or contact the sending/coordinating Plan to obtain current assessment and ICP information.

Members are prioritized for face-to-face HRAs based on due dates for the assessment, change in condition triggers prompted from a pending situation, such as a hospital discharge, identified from claims data, and notified priorities from agencies or provider referrals. Members, caregivers, providers, and other members of the ICT can request an assessment, regardless of due dates.

Application of our risk stratification and predictive models, using available enrollment and current assessment and claims information, also stratifies members for outreach and scheduling priority. If a member’s enrollment data reveals a concern that should be addressed more promptly, every effort will be made to expedite the face-to-face visit. For example, if a member’s only support is suddenly unavailable, the visit will be prioritized for immediate assessment of safety and adequate supports.

Using the JumpStart tracking logic, we can customize the HRA due date notification process. The CC is alerted 30 days prior to the assessment due date.

**Identifying Members who may be Appropriate for Transition to Community Settings:** The NF HRA outlines the specific questions addressing the care a member receives while residing in an NF. Within this document, the Transition Screening and Assessment asks about the member’s desire to transition to a community setting. In addition, we have incorporated the MDS 3.0 assessment elements into our NF HRA, ensuring that the integration of key institutional nursing facility information is captured and utilized to further meet the individual member needs. We review the member’s previous and current MDS information as an adjunct to the MCC NF HRA tool. We will also use the information to continuously identify potential service gaps that can be addressed.

The CC will not duplicate the NF’s ICP development, documentation, and assessment process. When on site at the facility, the CCs will attend the regularly scheduled morning stand-up
meetings and monthly or quarterly care conference and care planning meetings. They also gather data from the medical record, medication administration record (MAR), and 24-hour reports to identify who may be appropriate for transition to community settings.

**Personnel who Review, analyze, and Stratify Healthcare Needs**: The CC is responsible for assessing, reviewing, analyzing, and prioritizing member healthcare needs, in collaboration with the member, his/her representative, family members, and other individuals whom the member designates as part of the care team. Additionally, the CC and member invite others to participate in the ICT, including the PCP, behavioral health specialists, and providers with a role in supporting the member. On an aggregate level, MCC of VA uses its analytics application to analyze and stratify risk category based on the expressed needs of the information in the HRA.

The HRA information is invaluable, as it guides the complexities of supporting members who typically present with many disparate needs. HRAs are essential tools to assist the ICT, but do not replace sound clinical judgment that the CCs and ICT apply when carrying out the case management and ICP development process. For that reason, assessments are conducted by CCs who are Registered Nurses or Licensed Social Workers, and experienced and trained to work with the populations we serve. The member chooses ICT participants qualified to support him/her with the expertise to interpret the information gleaned through the HRAs – including physicians, pharmacists, and case managers.

On an aggregate and population level, the Clinical Leadership Team uses the HRA data to evaluate the appropriateness of its clinical programs, to measure member health and wellness outcomes, and assist with determining and adjusting staffing and caseload ratios. We continuously build the database of information to refine predictive models that are evolving for the MLTSS population. The graphic below provides an overview of our population assessment process map.
The Quality Management staff uses the data at a systems level to support the overall improvement in the Health Plan’s delivery of services, programs, and other supportive interventions for its members, caregivers, and providers.

Member education occurs during the face-to-face visit and is documented on the Population Health Integration form for LTSS Designated members. Non-LTSS members, including Community Wells, are educated by a telephone call with the CC. All member education activities are documented in the CareAdvance care management system.

**Metrics for Identification of High-utilizer Trend Analysis:** We define high utilization and high and emerging high-risk individuals using metrics and other criteria such as multiple chronic conditions, multiple ED visits or hospitalizations, readmission with the same/similar diagnosis, transitions from one healthcare provider or setting to another, polypharmacy, functional needs, and lack of caregiver/social supports. Conditions used as risk/emerging risk indicators include: complex BH conditions (such as schizophrenia, major depression, bipolar disorder with co-morbid chronic medical conditions); spinal injury; brain injury; dementia; organ transplants; cancer; trauma; HIV/AIDS; renal failure; homelessness and high-risk pregnancy. We also consider the degree and
complexity of illness or condition, level of management necessary, and the amount of resources required to regain optimal health or improved functionality.

**Evaluating Effectiveness of Strategies Implemented**: We evaluate the effectiveness of our strategies in several ways. Our strategy uses the methodology and measures for evaluating case management program effectiveness recommended by NCQA’s *Care Management for Individuals Receiving Long Term Services and Supports* as its foundation. Our strategy includes a review of HEDIS for chronic physical health conditions, percentage of members making progress on goals, member health status scores (such as SF-12 or SF-36 results), member satisfaction with care coordination, percentage of unmet needs addressed, and improved quality of life measures. Evaluations involve the assessment of reductions in potentially preventable events (PPEs) for high utilizers including inpatient admissions, ED visits, readmissions, and complications.

Our evaluation occurs at the individual and overall program levels. At the individual level, CCs evaluate the effectiveness of ICP strategies through regular monitoring of member progress toward ICP goals. CCs evaluate effectiveness through assessment of such indicators as prevention/reduction of ED use, hospital, and NF utilization; prevention/reduction of events and exacerbations (such as falls and behavioral health crisis events); medication adherence; improvement in access to preventive/primary care, follow-up care, and medications; and member satisfaction with their providers and services.

At the program level, the CC Director reviews measures quarterly to identify outliers and evaluate care coordination strategy effectiveness. This activity includes reviewing our High Utilizer Dashboard to determine how well our strategies are reducing high utilization over time and to identify trends that inform program modifications and innovations. The CC Director works with Care Coordination and Quality Improvement (QI) staff to develop and implement necessary changes in process, programs, and/or training to ensure desired member outcomes. The CC Director and QI staff monitors progress on these changes and make corrections as needed based on preliminary results to ensure continuous improvement.

In addition, the CC Director and CMO are responsible for the annual evaluation and revision of our Care Coordination Program. This activity includes all aspects of program operations including policies and procedures and service delivery effectiveness. Our Quality Improvement Committee provides oversight by reviewing the evaluation. The Committee’s feedback informs and is incorporated into any necessary Quality Improvement Work Plans.

**Initial Brief Screening Tool Usage**: Within five calendar days of notification of enrollment, members in the Technology Assisted (Tech Assist) and Elderly or Disabled with Consumer Direction (EDCD) waiver groups are contacted telephonically by the CC to schedule a face-to-face HRA. The HRA and ICP are completed in person within 14 calendar days of enrollment in the Tech Assist Waiver, and 30 calendar days of enrollment in the EDCD Waiver. Because these visits are conducted quickly after enrollment, we will not utilize a brief screening tool. If aware that an EDCD member requires an HRA more quickly, the CC will visit the member as soon as possible, but not to exceed 14 calendar days from notification of urgent or escalated needs.

Members included in the NF vulnerable subpopulation will not be screened individually prior to the in-person HRA, but the CC will contact the NF within 10 calendar days of enrollment. During this call, the CC and the NF will discuss members who reside in the facility to
determine if there are any urgent or escalated needs. If members are identified who require an HRA more quickly, the CC will visit the member as quickly as possible, but not to exceed 14 calendar days from notification of urgent or escalated needs. The CC will complete the HRAs for all other NF members and accept the NF’s ICP or complete one within 60 calendar days of enrollment. We will not utilize a brief screening tool for these members.

For members who are in vulnerable subpopulations other than Tech Assist, EDCD, or NF groups, including Community Well, we will use a brief screening tool during the member Welcome Call. In an effort to ensure that every member is contacted and stratified as quickly as possible, our Member Outreach Team will contact every member to complete a brief screening tool, also referred to as a mini-HRA. If, during that telephone call, the member has an escalated need (indicating the need for a more comprehensive assessment), the member is immediately triaged to the Care Coordination Supervisor overseeing the geographic region and will be assigned a CC. The CC will schedule a face-to-face visit to conduct an HRA and ICP as quickly as possible, but not to exceed 14 calendar days from notification of urgent or escalated needs.

**Ensuring that Initial HRAs are Conducted in Accordance with Model of Care Assessment and ICP Expectations:** MCC of VA’s CC will conduct individual member assessments to gather information to support the development of the ICP and determine an appropriate level of supports and services for the member. The goal is to maintain the member in the least restrictive setting, while providing support to achieve his/her goals.

As described above, upon receipt of the eligibility information and claims/encounter data, members will be prioritized in the JumpStart report. JumpStart is rules-based, and tracks all initial, periodic, and annually required member touches, and documents them within the CareAdvance system. The table below depicts the various JumpStart reports and functionality to support assessment management and staff deployment.

<table>
<thead>
<tr>
<th>Type of Tracking</th>
<th>Description of Tracking</th>
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<tbody>
<tr>
<td>JumpStart Process</td>
<td>A systematic process where critical timelines and care coordination contacts are tracked and monitored by dedicated Operational Oversight staff, who conduct daily calls for staff with upcoming deadlines. This focus ensures our awareness and actions needed to prevent non-compliance.</td>
</tr>
<tr>
<td>Operational JumpStart Report</td>
<td>An internal operational report to identify members who are due, compliant, or out of compliance for a visit. The report is based on contractual timelines and touch-points with each member and provided to all care coordination staff, including management and can be filtered to show a dashboard for each specific CC, regional Care Coordination Team, or entire Care Coordination Team.</td>
</tr>
<tr>
<td>JumpStart Report Specifications</td>
<td>The JumpStart report goes together with JumpStart calls to provide operational oversight for the Care Coordination Team. All report elements can be customized based on business and contractual requirements.</td>
</tr>
</tbody>
</table>

We established internal best-practice deadlines to assure that we meet or exceed contractual requirements for assessment completion, and the JumpStart parameters are programmed to support that goal. Using our innovative Mobile App, CCs conduct reassessments effectively and efficiently for all members. We leverage our innovative approach and experience to support accurate, complete, thorough, and timely reassessments for our Virginia members.
We anticipate locating some members may be challenging. We use a “no stone unturned” approach to engage them. To aid our efforts, we apply sophisticated database matching capabilities, utilizing public information proven successful in other states.

In addition, we locate members through providers by utilizing any enrollment and ongoing claims data files. We attempt to find members through claims we receive, such as pharmacy, PCP, specialists, and any other possible means. Pharmacy data is “point of service” and very timely to locate members, as opposed to other claims data which may be less relevant as it reflects dates of service months in the past.

MCC of VA’s CCs and Health Guides may visit members who are difficult to locate or engage in the ICT process. As a last resort, an unscheduled visit may be attempted by our field staff with the chance they may find the member. As Magellan does in other markets, MCC of VA will subcontract with Integra, a company which specializes in locating hard to find individuals. The Integra team has a solid track record of collaborating with the Magellan Care Coordination Teams in successfully locating members.

Any members who are unable to be reached will be mailed a letter requesting a return call to schedule their in-person HRA. If that is unsuccessful, we will notify the Department. All notification attempts will be documented and tracked for contractual compliance within CareAdvance.

Members who can be located but decline to be assessed or engaged will also be placed within the “Monitor Risk” Care Coordination Program segment and receive ongoing health status monitoring. The MCC Health Guide or Peer Support Specialist will attempt to engage the member in a peer relationship. If the MCC of VA staff is unsuccessful in finding or engaging members, we utilize a specialized vendor who is specifically trained in the area of locating and finding individuals. We will refer the member to our delegated vendor, Integra, which has had success in engaging reticent members/caregivers in our other markets by making unannounced visits, or conducting phone assessments.

Members transferring to our plan from another MCO will not be required to complete another HRA if the information is current, the member’s needs are stable and addressed, and the most recent HRA is consistent with timeframes associated with eligibility requirements. Members who transfer to our plan from another MCO will be contacted by our CC to conduct an in-person visit whenever possible. The CC will utilize all data the other MCO sends to fill out as much documentation within the Mobile App as possible. Merging the member’s prior assessments with our own allows for a streamlined process, while also ensuring that we capture the necessary information to best address the member’s needs.

**Involving Members and Family Members/Caregivers in the HRA Process:** Members drive the assessment and care planning process, as they are included in the processes each step of the way. The CC and member collaborate when completing the NF or HCBS HRA by the member and CC, followed by joint development of the ICP. The member can designate others to participate and assist with developing both the assessment and the ICP. The member’s agreement to the ICP is captured by electronic signature on the Mobile App. Forms that capture either the member’s consent, or choice to opt out of a program or process, require a signature and are all automated on the Mobile App. This process is routinely followed, regardless of the member’s living situation or care setting.
As part of both our welcome call and letter, we encourage new members to include people closest to them in the HRA process and/or in the initial visit with their CC. Those individuals who represent the person’s circle of support are an important part of the planning process, and can provide helpful insights to the HRA. This group may include family members, caregivers, friends or others who support the member in decision-making or by providing natural or unpaid supports. The group will include parents or guardians and school representatives for children and youth. We believe it is important to have a full understanding of all the key people in the member’s life and the various ways they support the member. If members have an individual in their life that supports them in a particular area, such as healthcare decision-making, and they are not available for the HRA meeting, we ask the member for permission to contact the individual to seek additional input. We involve the member’s circle of support in the HRA process by making their involvement easy and convenient, and seek their input whenever a reassessment occurs.

To accommodate members with limited English proficiency, the CC has access to a real-time language line for interpreter services. Also, we hire CCs with a background in diverse cultures and populations, including those who may have physical disabilities themselves. Members who are unable to communicate due to other limitations, such as blindness, illiteracy, or developmental disability, are engaged by reading materials to them, providing large print documents or communicating, employing simple language or utilizing assisted communication devices. All staff that interface directly with members are trained to communicate in a culturally and developmentally appropriate manner.

The member’s desires, goals and priorities are solicited and integrated when conducting the assessment, as well as in accommodating any barriers to his/her participation in the process.

By using the Mobile App, the process of obtaining signatures from the member and/or their representative is simplified. Once the CC uploads the documents to CareAdvance, a printed copy of the assessment and ICP is mailed to the member from our print house. All outgoing mail is bar-coded, permitting MCC to easily track its disposition.

The mobile devices used by the field staff are also equipped with cameras, which permit scanning of any required documents during any face-to-face visits. The documents are automatically attached to the member’s files, encrypted and protected, and uploaded.

Using a specially designed assessment tool, we meet face-to-face with caregivers to discuss how they are managing the demands of caregiving: the stressors they may have such as children, work, or household demands, and identify any training, knowledge, and/or skill needs, and additional service and/or support needs.

Our person-centered ICP process supports family caregivers by:

- Identifying caregivers in ICPs and inviting participation in ICT (with member approval)
- Incorporating caregiver questions into the comprehensive needs assessment and reassessment, including questions about caregiver well-being
- Making self-assessments available for caregivers to identify areas of concern
- Providing virtual health solutions programs
- Identifying any training needs caregivers may have (e.g., administering medications, conducting transfers, operating equipment, managing chronic conditions)
Providing caregivers with contact information for CCs, including instructions on contacting during non-business hours

- Linking caregivers with community-based resources and support groups, where appropriate
- Explaining MCC of VA Program Respite Benefits and how to access
- Including respite on the ICP for any member with unpaid caregivers

Caregivers, who are often described as the backbone of the LTSS system, play an important role and we are committed to continuing our support for them.

**Ensuring that HRA Reassessments Identify any Changes in the Specialized Needs of Members:** JumpStart tracks initial and ongoing HRA due dates and ICP development timeframes. It also tracks Level of Care Review/Reassessments and their due dates. Trigger events are identified through CareAdvance, which is the care management documentation system tied to a care management event.

The CC has the historic information from previous assessments, claims and encounter data, authorization and utilization history available when s/he conducts a re-assessment HRA through CareAdvance and the Mobile App. This system is intuitive and assists the CC with updated information over time. The same processes to risk stratify, outreach, find, schedule the appointment, and assess the member’s needs to update his/her ICP are followed.

**Annual Level of Care (LOC) Reassessments:** JumpStart is used to track the completion of all LOC reassessments and can be programmed to prompt the scheduling within the 365-day timeframe or more frequently as required by DMAS and based on population need. JumpStart tracks the completion of all HRAs and ICPs.

We generate reports daily through JumpStart that are easily customized to include all reassessment due dates in 14-, 30-, 60-, 90-, 120- or 180-day increments. In addition, JumpStart can reset the clock, and recalculate due dates for an annual assessment, based upon a Change in Condition Assessment that triggered an adjustment to the due date. The report can be programmed to capture members at any time prior to the due date to ensure the visit occurs on time. For example, if a program permits an assessment to occur no sooner than 30 days (a month ahead), the report may reflect members due a month in advance to assure the visit is made during the permitted window.

The CCs download regularly updated reports from JumpStart regarding all upcoming reassessments, as required to meet the ongoing needs of our members. These reports are provided to the regional Clinical Managers who are responsible for managing the day to day clinical operations of the health plan. These Clinical Managers assist the CCs in planning the member reassessments in advance of the due date, prioritizing member needs, and providing regional leaders the ability to deploy additional supports to schedule visits, and assure the timeliness of reassessments.

In the deployment of the required NF and HCBS HRA tools, the CC may uncover changes in the member’s needs and can access additional sub-assessment branching tools to further explore those.

The annual reassessments prompt a review and, if indicated, revision to the ICP. A member experiencing significant changes to his/her ICP may require a prompt, focused ICT review, inclusive of member participation whenever possible, to address any pressing arrangements to
be implemented. Members with routine updates to ICPs will be reviewed at routine, scheduled ICT meetings, and addressed in order of placement on the ICT agenda. ICT meetings are scheduled to accommodate, as feasible, participation by the member’s PCP, caregiver, and others the member requests.

**TechWaiver Assessment:** The CC will use all other assessment information available from other sources, and avoid duplication of assessment efforts as much as possible. For example, for TechWaiver members, a recent OASIS performed by a Medicare Certified Home Care Agency will contain the bulk of the information needed to populate a HRA. Similarly, MDS data in NFs will be used to complete the bulk of the NF HRA. The CC will deploy collateral tools to supplement the information already gathered.

**Elderly and Disabled Consumer Direction Waiver:** The CC’s assessment encompasses physical, behavioral, and functional needs and identifies the waiver and physical and behavioral services needed, including a 360-degree view of the member’s environment to identify necessary home modifications, transportation, or equipment needs. The CC, with the member, will assess the member’s ability to perform activities of daily living and to self-direct their services. This effort also includes supporting the member to ensure all the consumer-directed services are arranged and provided with a back-up plan in place.

- **Child:** The CC ensures the child on the EDCD waiver is assessed for and receives all necessary services including supporting the child’s family with consumer direction. The CC assesses and coordinates with school-based services and integrates the child’s physical and behavioral health needs with the waiver services.

- **Adult:** Adults on the EDCD waiver are supported by the CC for self-direction of the waiver services. The CC assesses and ensures the member’s physical and behavioral health needs are addressed since adults can have both medical and behavioral conditions in conjunction with a physical disability.

- **Dual Eligible:** For the dual members, the CC coordinates with the Medicare Health Plan CC to assess and fully integrate the Medicare services such as the primary care services with the waiver services. The CC ensures that needed specialized and ancillary services are covered by Medicare.

- **Co-occurring Conditions:** Since behavioral health needs are often identified with EDCD members, the CC assesses the member for behavioral health needs and ensures access to behavioral health services and community supports.

**Change in Condition Assessments:** When a change in condition or circumstances occurs, whether related to the member’s physical or mental health, living situation, or caregiver support, it will prompt a member “touch.” The assessment may or may not culminate in a change to the ICP, a transition to an alternate level of service/care, and/or ICT review. A Change in Condition assessment will reset the clock for the annual reassessment in JumpStart. The timeframe and type of that interaction is outlined in the table below:
Virginia MLTSS Trigger Events

<table>
<thead>
<tr>
<th>Group and Trigger Events</th>
<th>Timeframe for Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1: Nursing Facility Members - At a minimum, the following are considered a significant change in needs or circumstances: Pattern of recurring falls Incident, injury or complaint Frequent hospitalizations Prolonged or significant change in health and/or functional status</td>
<td>Contact Nursing Facility within 5 business days of becoming aware the member has a potential significant change in needs or circumstances.</td>
</tr>
<tr>
<td>Group 2 and 3: Home and Community-Based members - At a minimum, the following are considered a significant change in needs or circumstances: Change of residence, primary caregiver, or loss of essential social supports Significant change in health and/or functional status, including any change that results in the member’s level of care and transition between eligibility groups Loss of mobility An event that significantly impacts the health and safety of a member Member has been referred to APS because of abuse, neglect or exploitation</td>
<td>Visit the member face-to-face within 5 business days of becoming aware that the member has a significant change in needs or circumstances</td>
</tr>
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</table>

The Interdisciplinary Care Team

The Interdisciplinary Care Team (ICT) ensures a collaborative approach to care coordination. The ICT is comprised of the member and individuals engaged in the member’s circle of support, who represent the continuum of physical and behavioral health, social, and long-term services and support delivery systems based on their relationship and knowledge of the member. The member ultimately determines who represents him/her and who participates on their ICT. The composition of a member’s ICT varies according to his/her choice, place of residence (community or nursing facility), and individual needs. At a minimum, we recommend each ICT include:

- The member and/or his/her designated representative, and other individuals selected by the member
- Primary Care Provider (PCP)
- Behavioral Health Providers
- Care Coordinator (field based)
- Health Guide (field based)
- LTSS Member Associate (office based)
- Magellan Medical Director(s)
- Clinical Pharmacist

Based on member requirements or requests, the ICT could include (not in order of significance):

- LTSS Providers
  - Provider Agency RN Supervisor (TechWaiver)

- Physical/Occupational/Speech Therapists
- DME and Prosthetics Experts
DD Waiver Case Manager  
Adult Day Health Care (ADHC) Staff  
Nursing Facility Staff  
Targeted Case Management Service Providers  
Services Facilitator  
Peer Support Specialist  
Community Outreach Specialist (field based)  
Housing Specialist  
Employment Specialist  
Member Advocate  
Home Modification Contractors  
Physician Specialists  
Community Partner/Agency Subject Matter Experts  
Early Intervention Coordinator  
IEP Case Manager  
Area Agency on Aging Representative  
Center for Independent Living Representative  
Community Service Board Representative  
Others, as requested by member

The CC assures the Interdisciplinary Care Team involved in the member’s ICP is working together, informed of the member’s goals, preferences, and aspirations, and responsive to the member’s care and service needs, safety, and care gaps. The CC also ensures cooperation and Coordination-of-Benefits with other payers.

The ICT Members are Supported by a “Deep Bench” of Expertise

ICT Process Empowers and Supports the Care Team in Recognizing Signs of Emerging Issues and the Mechanism to Follow-up on Identified Risks: The ICT and ICP process provides members, their caregivers, and service/clinical providers with a “deep bench” of expertise inclusive of clinical and non-clinical assessment data. The ICT supports the Care Team during development of an ICP, which documents care gaps, safety risks, member preferences, and sets goals and strategies to overcome obstacles. Through the ICP development process, a holistic picture of the member is established, which supports early identification of
potential issues, alerts the Care Team to real or potential challenges, and is used to lay out a plan to address these challenges.

As part of the ICT, we offer care coordination programs to further assist the Care Team to meet the member’s specific needs and goals, including: complex case management, DM, peer support, behavioral health, integrated pharmacy management, care transitions, preventive health and wellness, pediatric/adolescent care, HIV/AIDS, transplant, Sickle Cell disease, and high-risk maternity management.

The ICT supports the Care Team in many powerful ways, because it:

- Engages many disciplines to support the member and caregivers
- Has a composition that adapts to a member’s dynamic needs, offering proactive support to the Care Team by providing additional resources
- Addresses care gaps within appropriate timeframes and based on the member’s wishes
- Supplements and enhances the Care Team’s expertise because of its interdisciplinary nature
- Serves as one mechanism to engage all key stakeholders
- Coordinates communication and information in a consolidated, format including:
  - HRA data – care gaps, member goals, and preferences
  - ICP information, including strategies to meet goals
  - Progress toward goals in the ICP
  - Data monitoring for care gaps through:
    - Claims data and exceptions logic
    - Member Service calls
    - 24/7 CareLine
    - Calls to and from the Support Center/LTSS Member Associate interactions

**ICT Process Supports the Development of a Comprehensive ICP:** At the member’s direction, the CC facilitates the ICT to develop and maintain a person-centered ICP that addresses their needs and reflects their goals, strengths, and preferences in a holistic, fully integrated way. The CC gathers information through a multi-faceted HRA process inclusive of the ICT that:

- Identifies service gaps by reviewing the HRA data, member-stated preferences, goals not captured by the HRA, and any existing plan for care or services
- Assesses need for and develops back-up plans to ensure member safety and continuity of care and services in case of emergency or gap in formal or informal supports
- Obtains member approval and signature on the ICP by the Mobile App during a face-to-face visit and ICT meeting. Any changes to the ICP must include the member’s signature, though scheduled changes may be approved/requested verbally by the member;
- Assures the CC communicates and implements the ICP
- Assures the CC monitors the ICP, communicates progress to the ICT as needed, and repeats the process when the next review is due.
Following the ICT, the care plan system is updated with areas for monitoring using automatic tasks and reminders alerting the CC that updates may be warranted.

**Strategies to Engage and Solicit Input from All ICT Participants:** Efficient ICT meetings start with preparation. The member or designee, as the ICT leader, is supported by the CC as co-leader who prepares the materials and ensures the meeting is conducted efficiently. The member is prepared and guided through the development of the draft ICP for discussion, so the meeting addresses what is most important to him/her. Materials are prepared at the appropriate literacy level and distributed prior to the meeting. We send a confirmation letter prior to the ICT meeting to both members and providers. Reimbursing providers for ICT participation also supports their broad engagement in the process.

**Supporting Active Participation in the ICT Process:** Successful engagement of all ICT participants requires the meeting date and time be convenient and accessible for all ICT members. The meeting approach, whether in-person or by teleconference and using technology to facilitate written ICP review, also promotes active ICT participant engagement.

CCs may accompany members to a PCP visit or provide transportation to the caregiver who accompanies the member. The CC or Health Guide may arrange to be at the member’s home with a mobile device to enable participation by video. Reminders and confirmations are sent prior to the ICT meeting. We also authorize reimbursement for provider meeting attendance, per the CMS-approved Medical Team Conference coding criteria.

Off cycle/ad hoc ICT meetings are convened at multiple times throughout the day and are typically focused on situational case reviews and utilization management activities. Due to limitations of on-the-spot availability, these prove more difficult to engage the full complement of the ICT, but are necessary to address the member’s immediate needs in a timely fashion.

Our ICT process aims to avoid duplication of other ICT/care planning efforts. In other care sites, the CC will attend the care conference and accept and/or wraparound ICPs from other entities that support the member with an ICT. If a care site wishes to access subject matter experts on MCC’s ICT, we encourage them to do so.

Providers are oriented to the expectations to participate in ICT meetings. Through written materials and targeted e-mail blasts with links to these materials on our website, our Provider Support Specialists (PSS) engage and offer training opportunities on the importance of ICT participation and claims submission for participation in meetings.

**Enabling Member and Member Designated Representatives Participation:** The member and member-designated representative, as appropriate, set goals with the option to invite and select participants on the ICT, with final approval of the ICP. The CC engages and enables active participation in ICT activities by scheduling them at convenient times, providing access to Video Conference or teleconference, provide access to member portal information, and other accommodations, as feasible and per the consent of the member/member’s designee. The CC contacts the member’s designated representative to support their participation in the ICT process.

The Health Guide or PSS visits members who are difficult to engage in the ICT process and may facilitate a video/audio conference or participate in the ICT in the member’s home, as appropriate.
Participation is further enabled by presenting materials and conducting meetings in a culturally competent and accessible manner, including the provision of interpreter services and assistive communication technology. We have been successful in “taking the meeting to the member” during scheduled PCP or CC visits.

**Coordinating the ICT with other ICTs:** The CC will attend and participate in the other care planning meetings to support both the member and other staff. The CC is further responsible for ensuring the ICP is communicated with the MCC ICT and accessible to those supporting the member.

In addition to reviewing and supporting ICPs developed by other ICTs, we also offer and encourage other ICTs to collaborate and/or participate with the MCC of VA’s ICT. Our ICT will look for care gaps and areas where we can partner with the other site to address them.

**ICT Operations, Communication Strategies, and Team Member Accommodation:**

**ICT Operations:** The composition of the ICT is unique to each member, set by the member, and configured to support the member’s individual needs. After the HRA is completed and the goals are documented, the ICT meets to collaborate and review/devise the ICP. The member, involved parties, the PCP, and participants of the ICT assist the member in identifying goals that are measurable, important to the member and achievable. The plan documents the steps to meet the identified and perceived needs, address care gaps, solve for access and delivery system issues, and define success measures. The LTSS Member Associate coordinates the tasks in the ICP and follows up to ensure they are carried out. The same process occurs for members residing in the community and in nursing facilities (NFs).

**Communication:** The CC distributes the ICP to the member and the ICT participants by secured email, mail, fax, or a link to the member/provider portal and assures the latest information is available on the member portal. The CC drafts the ICT agenda and minutes. The member/caregivers have a “leave-behind” with his/her CC and ICT participant contact information. The information is also available on the portal.

The CC notifies members of updates to the ICP, ICT meetings and ICT summaries and reports. The communication strategies, service processes and procedures, and assessments are continuously reviewed as part of our commitment to continuous quality improvement and ensure our communication strategies are most supportive of robust, inclusive and participant-engaged ICT processes. Sample metrics include: 1) number of members who completed HRA within the contractually required timeframe; 2) number of ICPs completed; 3) number of ICTs completed with member/caregiver participation; 4) number of interactions with member by the ICT; 5) number of providers participating in the ICT and 5) Provider portal use.

The data is compiled and analyzed regularly to identify process improvement opportunities. The ICT and senior leadership monitor the data on an ongoing basis to ensure we reach members and coordinate their care safely and appropriately. Performance reports are regularly shared with ICT participants. When improvement opportunities are identified, changes are made to ensure the program effectiveness. Annually, the Chief Medical Officer or his/her designee, and the Quality Improvement staff, formally reviews items such as the MOC communications strategies, frequency of communication, service standards for each ICT member, assessments, and administrative data. Results and improvement recommendations are shared with all ICT stakeholders.
**Accommodation:** ICT meetings are scheduled at convenient, accessible locations and times, are accessible by Video Conference or teleconference, and access to portal information is enabled to accommodate participants. Meetings are scheduled with a purpose and agendas are prepared in advance to focus the team, enable sufficient preparation, and efficient use of time. Translators are provided as needed.

**Individualized Care Plan**

**Individualized Care Plan (ICP):** We employ a person-centered approach to develop meaningful and appropriate strategies to maximize member independence, control, and autonomy. Throughout the individualized care planning process, we ensure members and their caregivers are actively involved. The CCs and Interdisciplinary Care Teams ensure every ICP reflects the member’s goals, preferences, values, strengths and challenges, family situation, social circumstances, and lifestyle.

**Methods of Stratification:** The results of the Health Risk Assessment and claims data are used to identify members’ needs and stratify them into risk categories. Identification of risk is critical to success in assisting members with the management of their chronic physical and behavioral health conditions and in addressing the unique needs of the MLTSS population. Risk stratification cannot be reliably done solely through claims analysis or member self-reporting; critical components of risk assessment can often only be provided by observation. Indicators such as health habits, living situations and social connectedness, are all predictors of outcomes and are used to develop the ICP and target education and interventions. Because of our unique behavioral health, pharmacy expertise, and experience integrating with physical health in special populations, our risk stratification approach combines self-reported assessments, observation, and claims data with analytical software-based approaches.

**Stratification of Aggregated HRA Findings:** The purpose of the HRA stratification is to identify opportunities to support the member in achieving their best possible health and life in the community. Stratification and predictive modeling are driven by internal systems, leveraging proprietary and external methods. Predictive models are currently in use, which include emerging and existing risk elements (e.g., serious mental illness, pre-diabetes, pre-CAD, high risk OB). Methods include:

- Every member is stratified (receives a numeric value and a level: ultra high, high, monitor risk, moderate and low).
- Several data sources are used and seamlessly integrated, including but not limited to: medical and behavioral health claims, pharmacy claims, psychographic data sets, biometric data sets using Clinical Data Exchange (CDE), and lifestyle data sets, solving for quality of care based on consistency with evidence based guidelines.
- Predictive modeling allows us to predict and anticipate the future risks, utilization, and costs of the population, and identify gaps in care. We significantly customized our tools to address the unique clinical issues that pertain to the population with Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Substance Use Disorders (SUD), chronic illnesses, and long-term care needs.
- We have specific pharmacy analytics expertise, which is particularly important given its timeliness and completeness; we have access to real time pharmacy information, including
polypharmacy, unnecessary medications, sub optimal dosing, and contraindicated medications

- Third party data is incorporated (e.g., Experian or Lexus Nexus data), which helps to microsegment the population into “personas” that consider lifestyle characteristics and to tailor the way the intervention is presented and delivered.
- Data outputs are aggregated onto the dashboards and displayed through our application called Agent Workspace allowing access to the member-specific information.
- The predicted risk, gaps in care, and other relevant information, are part of the “360 degree view” that is shared with treating providers, and is useful to quickly focus the attention of providers on key information about the member.

**Individualized Care Plan Development Process:** At enrollment, the CC calls the member or designated representative to welcome and educate them about the importance of the ICP process and begins the ICP conversation. The foundation of the ICP is the HRA, which is conducted in person and encompasses: medical and physical needs, psychosocial, behavioral, developmental, cultural influences, and functional abilities. Information provided by the member through assessments and conversation along with data from claims, providers, and other resources are gathered, in the care planning process.

As directed by the member, the CC organizes an ICT meeting, including the PCP, NF/LTSS providers, and other persons identified by the member. The ICT is in-person whenever possible or by phone or Webcast if an in-person meeting is not possible. The member directs the ICT activities, communicates his/her needs freely at any time, and chooses the ICT composition. Based on the assessments, member preference, and other information, the member and other ICT members develop a goal-oriented and person-centered ICP. The ICP supports all services regardless of payment source; plan adherence and care coordination among providers; and promotes preventive care and healthy lifestyles. ICP elements are tailored to the specific needs and risk level of the member. Our Mobile App has a tool which calculates the proposed ICP recommendations in the area of frequency and intensity of services, as well as estimates costs of services.

The CC reviews the ICP with the member using the Mobile App. The ICP is then modified as needed and then the member’s consent is obtained. The ICP is uploaded into the CareAdvance system. The CC assures all involved parties have access to the ICP on the secure member and provider portals with member consent, and that alternate format copies are distributed as needed. The LTSS Member Associate uses the ICP to enter LTSS authorizations into CareAdvance, arrange services with providers, and monitor the implementation and maintenance of the ICP. New or changed ICPs prompt the LTSS Member Associate to make verification calls to the member and service provider(s) to ensure compliance and satisfaction with the LTSS changes.

The CC continues to address SMI/SED/SUD, MLTSS, and non-MLTSS needs and makes in-person visits to further partner with and support the member in achieving goals. The CC assesses and educates the member and care giver on an ongoing and as needed basis. The Support Center serves as back up, is available 24/7 to assist with any schedule adjustments, and to troubleshoot when a service provider issue arises. The member may contact the CC at any time to request changes to the ICP or with questions/concerns. Adjustments to schedules that don’t require a change to the ICP can be made simply through the LTSS Member Associate.
Coordinating with Targeted Case Management: Members who are receiving TCM support through a service entity will not be asked to duplicate the process. The TCM’s assessments, and ICP, will be accepted and incorporated into the MCC assessment and ICP process. MCC will offer access to additional data that the TCM organization may not have, including but not limited to: claims, member services calls, etc.

Essential Elements of the ICP: The HRA is completed by the member, his/her representative, CC, and any other members of the ICT he member chooses to include. The results of the HRA serve as a guideline for the services listed on the ICP including all services the member is currently receiving, as well as, services that need to be put into place, regardless of payer source. The ICP is documented in the Mobile App and then maintained in CareAdvance, ensuring that all members of the ICT can access the ICP.

The ICP elements are listed below.

Services, referrals, or follow up that the member currently receives or needs to receive, based on completion of the HRA, including:

- Transportation for initial and follow-up appointments and community-based activities
- Referral to a DM Wellness Specialist
- Assistance with establishing, meeting, and monitoring progress personal health and life goals
- Reinforce effective coping skills when dealing with stressful situations
- Assistance with medication adherence; arrange in-home support for medication management
- Self-direction and skill development to independently obtain and administer personal care benefits
- Support transitions in care with referral to the Transitions Coordinator to evaluate return to the community
- Schedule appointments for follow-up care and monitor adherence with scheduled appointments
- Monitor abnormal or missing lab results
- Conduct shared treatment planning sessions
- Health education to individuals members and family about managing ongoing conditions
- Work with member to identify personal health targets and steps to meet them
- Close gaps in care
- Provide integrated health services
- Self-management support and development of self-management plans and/or relapse prevention plans
- Engage member in condition education

Schedule related to the service listed:

- Frequency (how many days a week or month)
- Hours or amount of services (e.g., four hours per day, one meal per day)
Provider type:
Medicaid service, LTSS, consumer directed, health plan, Medicare service, BHSA, DSNP, and other community agencies and partners.

**Documenting and Maintaining the ICP:** ICPs are updated at least annually, as often as required, or when significant changes occur in the member’s condition. The CC Supervisors review a sample of the files to assure the ICPs meet the standards, and those findings are discussed in individual supervision meetings. The CC monitors the member’s success in following the plan and attaining the defined goals, and identifies barriers or clinical issues that may impact the member’s progress. S/he communicates with the member and providers at least monthly, ensuring communication between providers and the member is occurring as needed. CCs and LTSS Member Associates select “task dates” in CareAdvance to re-evaluate ICP goals from a drop-down menu. Standard interventions are pre-populated in the system, but the ICT may customize them to meet the unique needs of the member.

**ICP Development to Meet Member Needs and Preferences:** Our MOC and person-centered approach is a process structured around supporting members in achieving their health and life goals, focusing on the following:

- Providing members with choice in as many ways as possible and decision-making authority, such as choice of providers and ICT members
- Members (or parents of children) have control over who is involved in the planning process
- Informing members and their representatives on the choices regarding service options and providers

ICT meetings are held in a place and at a time convenient for the member and their representative, or other arrangements to participate are made. The CC prepares the member for the ICT, and involves him/her and the designated representatives. When possible, direct quotes from the member are captured to ensure that his/her desires are considered in the ICP and that s/he is informed of his/her choices. The ICP is entered into the ICT Meeting note template using person-first language. We apply the principles of “plain language” that meets CMS and reading comprehension standards. Goals are documented in the member’s own words.

**Approach for MLTSS Sub-population:** MCC of VA employs dedicated CCs and other members of the ICT who possess specialized knowledge to address the needs of the vulnerable sub-populations. These staff live alongside our members and are experts at connecting members to community supports and resources. Members included in the vulnerable sub-populations are considered complex, and high risk, with access to all of the Care Coordination Program services. The ICP follows a similar development process for each vulnerable sub-population, and also includes behavioral and physical health components.

Our ICP includes information related to the member’s priority risk level in the event of an emergency or natural disaster. At any time, our Care Coordination Team is able to view the priority risk designation within the CareAdvance system.
We have expert experience in managing complex members with co-occurring behavioral health and physical health conditions:

- **Individuals with Serious Mental Illness or Serious Emotional Disturbance:** The CC with experience and expertise in SMI or SED collaborates with the ICT to assess and develop an ICP to address physical, behavioral, functional, and social needs. The CC coordinates all of the behavioral health issues and needs, with the PCP, specialists, CSBs, and other behavioral health providers, pharmacists for medication reconciliation, family education and support needs, and coordinates access to community supports (including CSBs).

- **Individuals with Substance Use Disorders** – Through our ARTS program framework, the CC assists members with substance use disorders with wellness and recovery services. The CC and ICT develop the ICP ensuring access to specialized services, the member’s physicians and SUD specialists, and with the community resources and peer supports that will benefit these members.

**Additional ICP approaches for each of the vulnerable sub-populations are outlined below:**

- **Technology Assisted Waiver:** The pediatric-experienced CC includes the following entities as part of the ICT and ICP process: the private duty nursing agency, the member’s family, PCP, specialist, and the DME vendor that supplies specialized equipment. The CC and ICT develop the ICP with the member and ensure the member receives the services needed and that family and caregiver supports are also provided. The CC, member/member designee, and the ICT review and update the ICP based on member need. The ICP includes the tailored information and interventions specific to necessary home evaluation, including appropriate electrical, generator back-up, and alerts to the care and transportation providers specific to member high tech needs.

- **Elderly or Disabled with Consumer Direction Waiver:** The specially trained CC with experience in LTSS, consumer direction, and assessing the functional and ADL needs of member’s partners with the member, ICT, AAAs, CILs, FEA involvement and IEP inclusion, along with other key community groups to develop the waiver LTSS ICP. The CC supports the member in selecting the best option for consumer direction, and arranging a back-up plan.

- **Day Support Program for Persons with Intellectual Disabilities:** The CC coordinates with the case manager for the Day Support Waiver services and integrates these services into the member’s overall ICP. Since this waiver is changing to the Building Independence Waiver, MCC of VA will educate and train staff on the changes to the waiver services. We will adapt our Care Coordination activities based on changing requirements. Our CC carries out the non-waiver service coordination activities.

- **Intellectual Disabilities Waiver:** The ID knowledgeable CC works with ID members and the ICT to develop the ICP and ensure the member has access to physical and behavioral health services, including primary care, community and family support services. As this waiver will change to the Community Living Waiver, MCC of VA will educate and train staff on the changes to the waiver services. Our CC carries out the non-waiver service coordination activities.
**Individual and Family Developmental Disabilities Support waiver:** The CC and ICT assess physical and behavior healthcare needs and ensure the ICP is integrated with the waiver services. The CC ensures access to the specialized providers for these members who often have co-occurring conditions.

**I/DD:** The CC and ICT develop the ICP based on the member’s physical and behavioral healthcare needs and identify any co-occurring conditions that are typical with this population. The CC ensures access to behavioral health specialists and PCPs along with the school systems and IEP information.

**Individuals with cognitive or memory problems:** The CC and ICT assist members with cognitive or memory problems with ICP development. Our CCs are trained specifically in all areas of cognitive and memory specialties. The CC ensures access to specialized providers, community resources, and support services for family members and includes specific ICP interventions based on this collaboration. The CC eliminates communication barriers and offers assistance to understand the ICP.

**Individuals with physical or sensory disabilities:** The CC and ICT develop the ICP with an emphasis on addressing the functional capabilities for member’s special equipment needs. The CC ensures access and input of community supports, community agencies, DME, transportation, and medical supply companies, in addition to accessing support from specialized organizations for individuals with sensory disabilities.

**Individuals residing in nursing facilities and other institutional settings:** The CC collaborates with members residing in NFs or in other institutional settings. The CC, ICT, and NF team collaborate and develop the ICP, which includes assessment for alternative living possibilities in the community and a care transition plan.

**Individuals with end-stage renal disease:** The CC and ICT develop the ICP and assist members with access to kidney disease specialists and the dialysis services, and they educate and support the member and family about the different stages of this disease. The CC identifies co-occurring conditions, such as diabetes, and ensures access to services to prevent diabetic risks such as loss of vision. We collaborate with dialysis providers and continue to monitor coordination of benefits with other payers, including Medicare and provide dialysis center information in the ICP. We coordinate with centers of excellence for transplant services and incorporate the specialized transplant information within the ICP.

**Individuals receiving hospice benefits:** The CC and ICT develop the ICP with the Hospice Team. The CC frequently monitors and follows-up to assess the member’s condition and ensure advance directives are current. We collaborate with local hospice and palliative care providers, including Capital Caring, to assist with the management of developing appropriate goals of care and assistance with pain and symptom control.

**Children in foster care or adoption assistance:** The CC and ICT support the child, foster family, member’s natural family, if appropriate, and the plan of care for the permanent living situation of the child. The child’s behavioral health and physical care needs are typically more complex. Care transition planning is ongoing and changing depending on the child’s situation. We collaborate and incorporate ICP interventions based on school, DSS, CPS, and other non-medical systems and support inputs. We adopt a trauma informed care approach and include it in the ICP process.
Women with high risk pregnancy: The CC for these members has OB and Maternal Fetal Medicine nursing experience and knowledge. The CC ensures the member has access to the OB/MFM, MAT, and SMI, SED, and SUD specialists, and that she is living in a safe environment and able to self-manage her high-risk pregnancy. We incorporate the information received in the ICP and utilize Alere to assist with home-based high-risk OB situations.

Individuals with chronic or multiple chronic conditions: The CC and ICT tailor the approach individually to address all the conditions and ensure access to multiple providers and supports. The CC integrates the management of all providers and services, and educated the member and family.

Incorporating External Existing Plans of Care: We collaborate with a TCM service teams, NFs, and other provider programs and either participate in the existing ICT process (e.g., for individuals who are dual eligible but not in our D-SNP) or invite representatives to participate in our ICT meetings. Our CCs attend the provider’s periodic Care Planning meetings, and gather data from the medical record, MARs, etc., and incorporate it into the ICP. We will honor the existing HRA and ICPs during the continuity period, and will not require members to complete a new HRA and ICP, provided that the information is current, the member’s needs are stable and addressed and the most recent ones are consistent with timeframes associated with his/her eligibility requirements. The CC uses HRAs and ICPs from other sources, and will avoid duplication of efforts. This information includes ICPs developed by Targeted Case Managers, NFs, and other qualified entities. MCC of VA accepts the electronic health records/files of other providers and agencies. Similarly, MDS data in NFs will provide a large portion of the information needed to complete the HRA and ICP, and the CC deploys collateral tools to supplement the information already gathered.

Personnel Developing the ICP: Core to our model is the close relationship between the CC, member, and the member’s supports. The CC is the member’s primary point of accountability and s/he relies on other members of the team to develop and implement all aspects of the ICP. CCs are Registered Nurses and licensed Social Workers, recruited based on specific experience with the vulnerable sub-populations included in the MLTSS program. Members of the ICT are similarly professionally licensed within their specialties, as required. CCs are specially trained in all areas of behavioral and physical health specialized services, inclusive of having a full understanding of the case management process, clinical overview of the ICP and ICP process. Each CC is teamed up with an LTSS Member Associate, based in the LTSS Support Center, who decides and follows up to assure the member’s ICP is carried out. The CC also has access to community-based Health Guides and Peer Support Specialists to assist in the ICP process.

We seek to hire culturally diverse staff who reside in the communities where our members live, because they have detailed knowledge about local services and resources. We match the expertise of the CC to individual member’s health conditions, service needs and personal preferences, when possible. All staff are engaged in ongoing Cultural Competency learning to help ensure that members’ preferences are expressed and reflected in the ICP. In addition, we offer intensive training for all staff regarding the clinical and special needs of each sub-population. Each module offers training unique to the populations served, an appreciation of the nuances of managing co-occurring conditions, and recognizing challenges. Best practices and availability of community resources are addressed.
We partner with local groups, including CILS, AAAs, ARCs, CSBs, and other organizations to access their training, ensuring we stay current on best practices.

**Ensuring Member and Family/Preferred Support System Engagement in the Ongoing Development of the ICP:** We encourage member/family participation at all times and attempt to remove obstacles to their participation in the ICP planning process. We assist the member and their preferred support system representatives with transportation, as needed, and attempt to schedule the ICT at a convenient time. Health Guides will attempt to visit members who are difficult to locate or engage, and we will reach out to locate these members through any possible lead. Our internal team utilizes a *no stone unturned* approach to locating members. The Health Guide also may be asked to facilitate a video/audio conference to participate in the ICT in the home or the caregiver’s workplace (if feasible). We have been successful in “taking the meeting to the member” during a scheduled PCP visit.

Caregivers play a critical role in ensuring successful transitions in care, and we are committed to supporting them. Using a specially designed assessment tool, the CC and/or Transition Coordinator meet face-to-face with caregivers to discuss how they are managing the demands of caregiving; other stressors they may have such as children, work, or household demands; and to identify any training, knowledge, and/or skill needs, and any additional service and support needs.

**Communication regarding the Initial ICP and Revisions:** To ensure the member and his/her caregiver understand and agree with the plan, the initial ICP is completed and reviewed with the member and designated representatives using the *Mobile App* on the CC’s mobile device. The ICP is then reviewed with the member during each scheduled follow up, including check-in calls by the LTSS Member Associate, and at any time the member requests a review. The hard copy of the plan is mailed to the member as soon as the CC uploads it into CareAdvance, where it is viewable and shared on the secure portal for all ICT members. Whenever the ICP is updated and upon request, a printed copy is mailed to the member, which is bar-coded and tracked.

Communication of the initial ICP and revisions may occur by telephone or TTY; through secure email; face-to-face in the member’s home or at a provider’s office, or another location; and through the mail. Staff may communicate with members directly, or with a designated representative.

The initial ICP is shared with the ICT and updates are shared at a minimum during the following events:

- Hospitalization or other transition
- Member refusal or self-disenrollment from a Care Coordination program
- Any/all established ICP goals have been met
- New medical diagnosis or medications started and impacted the ICP
- Referral for/requests of new services or a significant expansion of services
- Annually when the reassessment HRA is performed
- Level of care review (LOCR) completed could trigger a need for alerts/review by ICT

MCC communicates updates to the ICP with the ICT through a variety of secure channels, including: in-person meetings (ICT meetings, in provider office, member’s home); by telephone (web or teleconferencing); through secure email; by regular mail; other electronic...
dissemination including fax; and through the Provider Portal. Use of the portal supports seamless reminders and updates to the ICP. If a provider uses the portal, the ICT can assign tasks to users.

**Accommodations for Communication Impairments and Limited English Proficiency:** Members with Limited English Proficiency (LEP) are offered interpreter services. Other communication obstacles will be accommodated per individual need to assure the member fully understands the ICP. Examples include reading materials to the member, providing large type or having a sign language interpreter present.

**Member Acknowledgement of the ICP:** After the initial or updated ICP is completed and reviewed with the member and designated representatives, the member is asked to sign using the Mobile App. If the member is unwilling or unable to sign the ICP, the Care Management system continues to record the ICP process and notations from the ICT meeting. A mailed copy of the ICP (bar coded) serves as documentation of the member’s notification. If the member is unwilling to agree to the ICP, and there are perceived safety issues, it is reviewed with a MCC Medical Director.

**Identifying Trigger Events for ICP Revision:** When a change in circumstances related to the member’s physical health, mental health, living situation, and caregiver support occurs; it prompts a member “touch.” The assessment may or may not culminate in a change to the ICP, a transition to an alternate level of service/care, and/or ICT review. A Change of Condition assessment will reset the clock for the annual reassessment in JumpStart. The timeframe and type of that interaction is outlined in the table below.

Also, the CC monitors utilization reports against the ICP and communicates with the member to identify gaps in care and overall compliance with the plan. Significant deviation may prompt an immediate assessment. The annual reassessments prompt a review and, if indicated, revision to the ICP. A member experiencing significant changes to his/her ICP may require a prompt, focused ICT review to address any pressing changes or arrangements to be put into place.

**Utilization Management**

Providing effective Utilization Management (UM) requires a special understanding of the needs of the population being served and the network of providers serving the population. Leveraging MCC of VA’s leadership experience, we have developed effective UM processes, policies, procedures and clinical decision tools to meet the population needs, community standards, contractual obligations, and state and federal requirements. MCC of VA has developed a separate, UM program description document which provides the detail and framework of the MCC of VA UM approach. In addition, MCC of VA has developed a library of policies, procedures, and process flows which complement the UM approach.

In support of the Quadruple Aim, our goal is to ensure that our members receive the right care in the right setting at the right time by the right provider. MCC of VA’s U M program is centered on integrating and delivering the care and services that support our members in achieving optimal quality health while ensuring timely, appropriate, person-centered, coordinated, and cost-effective healthcare delivery.

Our UM program is based on the principles of person-centered approaches, medical necessity, psychosocial necessity for mental health services, evidence-based medicine, and continuous
quality improvement to facilitate member access to care and services. Our UM program, processes, and staffing models are designed to assist each member and provider in appropriately utilizing healthcare resources and to identify opportunities to improve health outcomes and quality of care.

Our CCs are trained in all aspects of UM practice applicable to both LTSS and acute care services. These CCs assume primary responsibility of the UM process and have full access to the UM experts and medical staff whenever necessary. Our CCs offer seamless coordination and communication options for all types of providers, LTSS or acute. All authorizations, LTSS and/or acute are reflected in the ICP.

Through a comprehensive, systematic and ongoing process, our UM program defines, identifies and implements improvement activities to enhance clinical and program efficiency and quality. The UM program incorporates a variety of components, including: utilization data analysis and data management; prior authorization; concurrent review of acute levels of care; discharge planning; adoption and dissemination of evidence-based practice guidelines; evaluation of new technologies and new uses/applications of existing technologies; care coordination; disease/condition/chronic illness management; and drug utilization review.

Our UM program is designed to:

Perform data analysis:
- Developing data-driven population health management strategies to target super-utilizers
- Detecting patterns of over- and under-utilization of services
- Identifying and addressing gaps in physical, behavioral and long-term care support and services, including social and environmental barriers to optimal health outcomes
- Identifying aberrant provider practice patterns
- Evaluating efficiency and appropriateness of service delivery

Conduct utilization management activities:
- Promoting the management of healthcare services and facilitating access to care
- Addressing rising healthcare costs by eliminating waste and ensuring medical appropriateness
- Proactively identifying and referring individuals with chronic or complex physical or behavioral conditions into tailored programs as Integrated Health Homes/Behavioral Health Homes provide early interventions and alternative care options
- Reducing variation in care by ensuring treatment plans are consistent with evidence-based medicine
- Coordinating and implementing clinical interventions to improve member care
- Appropriately identifying and resolving potential member quality of care concerns
- Monitoring clinical coverage decisions

Provide care coordination:
- Preventing avoidable hospital readmissions by carefully managing care transitions
Coordinating program activities with quality improvement initiatives through collaborative programs across all components of care during an acute episode of illness

Providing an interdisciplinary team approach to address the member's needs

Deliver member and provider supports:

- Providing resources to members to improve health status, including the use of community health workers to assist members with access to care issues
- Educating members and providers on preventive care
- Improving member and provider satisfaction

To facilitate achieving its purpose, our UM program is based upon an approach intended to assist each member with attaining the highest degree of value by providing:

- Consideration of the member’s level of well-being, cultural characteristics, safety and preferences
- An available and accessible healthcare delivery system
- Proactive assessment and development of guidelines and predictors
- A holistic approach allowing the member to: (1) participate fully in their lives within a community setting through reduction or complete remission of symptoms; (2) enable positive internal qualities (e.g., optimism and problem-solving) and social skills that foster positive support from social circles (e.g., family, friends and community); and (3) receive quality care and support when required for physical and behavioral health conditions

MCC of VA’s leadership team has developed the UM program to ensure the provision of timely, appropriate, coordinated, and cost-effective healthcare services to our members, driven by the desire to assure optimum health outcomes across the full continuum of care while achieving clinical quality and excellence. The UM program is a system-wide, integrated process in which activities are designed to identify and develop interventions to address over- and under-utilization and to ensure services are coordinated across the spectrum of physical, behavioral and psychosocial needs.

Our detailed UM program description summarizes our philosophy, structure and standards that govern UM and review responsibilities and functions. The UM program goal is to manage the services to our members by effectively utilizing existing and appropriate resources while assuring that quality care is delivered. MCC of VA works collaboratively with our members, practitioners, providers and community resources to promote a seamless delivery of healthcare services. Our UM program is based on the principles of medical necessity, evidence-based medicine, continuous quality improvement, and is member-centric to facilitate member access to care and services.

**LTSS Service Authorization:** We follow a straightforward process that ensures appropriate authorization while avoiding delays for members. We have dedicated, experienced LTSS staff who understand the unique needs of members accessing LTSS. Our CCs will be trained in the
wide array of Medicare and Medicaid covered services and the waivers under which LTSS services are authorized in Virginia. The LTSS Service Guide and care planning tools will also provide guidance on when service authorizations are required.

Our approach includes verbal confirmation of authorized services and documentation of services in the ICP which automatically feeds into the CareAdvance clinical information system. For individuals who self-direct, CCs ensure that all supports and service placed on the ICP and purchased within the member’s self-direction budget are compliant with DMAS requirements. In addition, managers conduct ongoing monitoring and inter-rater reliability of ICPs, corresponding authorizations, and denials to ensure consistency of practice and application of the authorization process.

**Consumer-Directed Services**

**Experience with Consumer-Directed Services:** Consumer-direction is both a philosophy and a service delivery approach. The four principles of self-determination: Freedom, Authority, Support, and Responsibility are the foundation for consumer-directed services. MCC of VA will work collaboratively with members, who choose consumer-directed services (CDS), to focus on their individual goals, strengths, needs, and preferences. Our commitment to promoting self-determination through CDS comes from our deep understanding of the benefits it offers, including improved LTSS quality and cost performance and the increased ability to help solve the issue of shortages of direct care workers through self-directed employer and budget authority.

For example, in both rural and urban communities of Wisconsin, Magellan delivers, the largest self-directed LTSS option of its kind. We collaborated with the State to develop the IRIS (Include, Respect, I Self-Direct) program in 2008. As the original IRIS Consultant Agency, we support 96 percent of the more than 13,300 older adults and individuals with physical and intellectual/developmental disabilities currently enrolled in IRIS. With the support of a local IRIS consultant (i.e., service facilitator) the member selects, a person can self-direct up to approximately 30 covered LTSS, including supportive home care, transportation, supportive employment, respite, and adaptive aids.

In addition, we provide oversight and support for Wisconsin’s largest personal care program serving approximately 5,600 members who have chosen IRIS Self-Directed Personal Care (SDPC). Our community-based service facilitators and SDPC nurses partner with members to ensure that not only health and safety, but personal outcomes are achieved. Data indicates that 95 percent of outcomes identified having high importance to members were either achieved or
in progress. Some of these outcomes are shared by individuals in the Voices of Self-Direction video [https://youtu.be/rRa-iiDQDKY](https://youtu.be/rRa-iiDQDKY).

Our experience with self-direction also includes pioneering the innovative Consumer Recovery Investment Funds Self-Directed Care program in Delaware County, Pennsylvania. With the help of recovery coaches, individuals develop recovery-focused ICPs including traditional and non-traditional (out-of-plan) goods and services. In the Lehigh Valley area, we designed and implemented a self-directed program to enhance the array of services for children with autism spectrum disorders. Participating families collaborated with coaches to purchase goods and services not covered by insurance and access existing community resources. Results showed that individuals were highly satisfied, with 100 percent reporting they would recommend the program.

**Proposed Approach:** The cornerstone of our person-centered approach involves genuine partnerships with each member. Unlike conventional models that surround the member with professionals and providers, our CC partners with the member, working in tandem to achieve their personal goals for a vibrant and healthy life. This approach involves providing information, tools, and resources so members can make informed choices, and supporting and coaching to bring about changes in their lives. It is a partnership built on conversations and understanding that often starts around the member’s kitchen table.

At the time of enrollment, all new members eligible for CDS receive information regarding the consumer-directed service options and the choices within those options. This information is provided in culturally and linguistically accessible formats including written, audio, and video, and translated into the languages members use. The CC will explore the member’s interest in self-directing their services as part of the planning process and at least annually thereafter or any time the member has questions or experiences a significant life event. We recognize the important role of CILs in promoting consumer-direction and facilitating connections between individuals in consumer-direction and potential personal care attendants, and we work collaboratively with local CILs to support member success in consumer-directed services. In addition, we use MySupport, a web-based system to assist members in locating and screening potential home care workers.

**Proposed Approach to Service Facilitation:** Our proposed approach to service facilitation is based on our extensive experience in self-directed LTSS.

**Design:** For effective coordination, training, and quality assurance, it is important for service facilitators to be employed by organizations versus operating independently. Some county and state systems have tried to use independent service facilitators or similar positions and struggled with ongoing development of these positions and quality of the services they provide. MCC of VA will have a network of service facilitator organizations with the capacity to support members who choose CDS. We will collaborate with these organizations to provide online access for members to choose a service facilitator in their area with the specialized/expertise desired. One of the most important aspects of design will be the delineation of roles between the member’s CC and service facilitator, so that services are coordinated and tasks are not duplicated.

**Implementation:** MCC of VA will contract with existing organizations providing service facilitation now and in the future, to ensure access to dedicated organizations with qualified service facilitators in all areas of the state and within the specialties needed. We will provide
continuity for members utilizing independent service facilitators, and encourage these service facilitators to migrate to an organization where they can continue their support. This approach may require developing new service facilitation organizations, and supporting existing organizations through recruiting efforts and/or additional training to ensure consistent, quality service facilitation is provided. We will collaborate with the Commonwealth’s contracted Fiscal Employer Agent (FEA) to provide initial training on MLTSS program operations and meet at least quarterly in the first year with all service facilitation providers to establish effective communications and ensure a smooth transition for members and their service facilitators.

Best Practices: Based on our experience as a recognized thought leader working with national, state and local stakeholders on the design and delivery of consumer-directed services, we offer several best practices and innovations for your consideration. MCC of VA is ready to collaborate with DMAS and its contracted FEA to explore these options.

Expansion of Consumer-Direction to Include a Broader Array of LTSS Services and/or Budget Authority: The more flexibility and control individuals have over the services they can self-direct, and a budget to purchase what they need, the better able they are to develop cost-effective plans tailored to meet their comprehensive LTSS needs and goals, mitigating the risk of nursing home placement. For example, Magellan’s approach and experience in Wisconsin resulted in:

- Average savings of 17 percent on every dollar budgeted for members’ service expenditures
- Less than one percent disenrollment due to placement in a licensed facility including nursing home placements.

Expansion of Consumer-Direction to Behavioral Health Services: The philosophy and values of self-direction are very closely aligned with the recovery principles underlying behavioral healthcare. In self-directed behavioral healthcare, individuals are empowered to fully and more effectively participate in their own recovery, experiencing improved choice and greater satisfaction with their services and supports. In addition, self-directed behavioral healthcare can support the Commonwealth’s system rebalancing efforts from emergency or inpatient services to more community-based services.

Development of the Consumer-Directed Marketplace: Unlike traditional service delivery approaches, consumer-directed programs operate in a different environment with the member “buying direct”. For consumer direction to be successful, a vibrant marketplace must evolve where members have ready access to qualified home care workers and providers that are responsive to their needs. We successfully connect members and service providers at networking and learning events focused on educational topics and socializing, so they can share and learn together.

Promotion of Initiatives to Support Community Living: In Wisconsin, we partnered with members and families to promote innovative, family-led initiatives that support community living, such as microboards and family-governed groups. A microboard is a small group of family members and friends who come together with a person with a disability to create a non-profit community board that typically purchases goods and services on behalf of the person and employs support workers and others to assist on a day-to-day basis. A family-governed group is organized by like-minded families as a legal business entity with by-laws to ensure the ongoing stability of supports to their loved ones for a quality life in the community. MCC of VA will
work with DMAS, the Virginia Microboard Association and other stakeholders to build on best practices with these models, and to expand opportunities to enjoy community living through approaches that are sustainable over the long term.

Community Partnerships

*Magellan Complete Care’s (MCC) experience forming partnerships with community-based organizations:* MCC of VA’s focus and expertise fully integrating physical and behavioral healthcare and services sets us apart as a leader in coordinating care for individuals with complex needs, including those with a co-occurring disability and behavioral health condition. We invest our resources in making an impact, one member at a time, by taking a community-focused approach to care coordination. Our overall MOC and care coordination approach relies on strong, collaborative community-based partnerships – from inclusion in members’ ICTs to support for the delivery of services identified within the ICP – to ensure members’ access to high-quality services. These partnerships include organizations that provide innovative solutions supporting not only care coordination but also access to critical social services and supports that address social determinants of health critical to:

- Eliminating disruption to members’ existing support systems
- Locating hard-to-reach members, and engaging in care coordination by building trusted relationships
- Understanding members’ unique services needs
- Linking members with community-level services, supports, and solutions
- Integrating care and services across the continuum and eliminating fragmentation
- Ensuring members’ access to home- and community-based services that promote independence

*Coordinating Care and Services with Our Community-based Partners:* Magellan’s Wisconsin service facilitators coordinate with community-based partners, including local behavior specialists and support brokers (who provide more intense, ongoing, and complex support of self-direction beyond traditional service facilitation) to ensure services and supports are coordinated under the nation’s most comprehensive model of self-direction. This partnership reinforces our members’ ability to continue living in the community. The key to these collaborations has been the clear delineation of roles between our staff and the community partners. From our experience, this approach works best when we formalize the relationship with an agreement that is signed by all participants and partners, including the member.

*Regional IHNs Promote Community Partnership:* Improved member health, wellness, and independence can be achieved only within the context of where the members live—within their neighborhoods and communities. Our regional IHNs include local team members with first-hand knowledge of community strengths, resources, services, and service gaps. They facilitate relationships and collaborations with urban and rural community partners to coordinate care with those entities members know and trust. This partnership allows us to naturally bridge language and cultural barriers and more effectively facilitate access to support our members where they live, work, and play.
Coordinating Behavioral Health Services with Community-based Health Home Partners: Magellan’s community-based partnerships include our Integrated Behavioral Health Home (IBHH) program in Iowa. Partnering with the State, community mental health centers, Federally Qualified Health Centers, and other stakeholders, we implemented 40 IBHHs to coordinate care for adults with SMI and children with SED. These IBHHs adopt a whole-person philosophy, inclusive of all primary, acute, mental health, substance use, and long-term services and supports. With these community-based partners, we collaborated on select care coordination functions, including: facilitation of joint treatment plans among providers; shared efforts to close gaps in care and address social determinants of health that discourage members from seeking healthcare and services; robust use of community services and supports; fully supported transitions; and, use of health information and data analytics. Through this partnership, our IBHH program decreased ED visits by 19 percent and inpatient admissions by 16 percent.

Promoting Access to Behavioral Health Services through Our Community Partners: Magellan Healthcare of Pennsylvania has collaborated with community-based providers and provider groups for more than 15 years. Our service facilitators link and refer members to behavioral health programs; initiate and complete bed searches for members who are assessed and recommended for inpatient mental health or drug-and-alcohol detoxification and rehabilitation programs; connect members to integrated physical-behavioral health programs; and, referrals to natural supports in the community (including Alcoholics Anonymous, Narcotics Anonymous, and permanent supportive housing resources). This partnership resulted in the launch of the Partners in Care Program, a collaborative effort with mental health adult inpatient facilities using on-site chart review and provider-specific data to streamline members’ access to high-quality services and decrease administrative burden.

Addressing Social Determinants of Health through Care Coordination and Community Partnership: Stable housing is a prerequisite for member health, wellness, and independence. Supporting programs in two states, we formed community-based partnerships to ensure member access to permanent supportive housing.

MLTSS Innovative and Community Partnerships: Magellan will implement several innovative community-based partnerships based on our experience to improve care coordination and service delivery across the Commonwealth with Area Agencies on Aging (AAAs), CILs, and CSBs.

AAAs and CILs: Magellan staff met with the Virginia Association of CILs, the Virginia Association of AAAs, Bay Aging (representing AAAs across the Commonwealth), and representatives from various individual AAAs and CILs across the past year, reflecting a great opportunity to collaborate closely on many functions of care coordination and service delivery. Our proposed partnership with AAAs and CILs will spur broader innovations related to:

- Assessment completion
- Care transitions planning
- Employment services and supports
- Peer mentoring programs
- Identification of community resources
- Meal planning and delivery
- Environmental modifications
- Educational services and supports
- Youth transitions
- Independent living and self-advocacy skills training
- Access to assistive technology
- Affordable and access to permanent supportive housing in the community
Transportation services

Specific examples of our proposed collaboration with AAAs and CILs include:

- **Community Reintegration and Personal Care Attendant Services:** MCC of VA and Bay Aging d/b/a Eastern Virginia Care Transitions Partnership (EVCTP) have a signed letter of intent to partner on many aspects of care coordination, including community reintegration, avoidable readmissions, personal care attendant services, and transportation. EVCTP represents a unique mix of AAAs supporting members in rural and urban communities – due to their impact on reducing unnecessary Medicare readmissions – has been recognized by CMS as one of their top performing pilot programs in the United States.

- **Supplemental Access to Transportation Services:** We will partner with AAAs, CILs and other community groups that offer transportation services to augment existing gaps. For example, the Rappahannock AAA has its own fleet of accessible vehicles, as does the Junction Center for Independent Living used in conjunction with the local AAA.

- **Conducting Assessments, including Environmental Modifications:** We will partner with CILs to conduct assessments for environmental modifications, prepare appropriate recommendations, and identify local contractors to perform as authorized by DMAS.

- **Coordinating Access and Repair of Durable Medical Equipment (DME):** We will work to identify locally qualified DME re-use and repair programs and vendors. We have found limited access to DME repair facilities in select communities, which frequently results in loss or limitation of members’ independence and access to care.

- **Member Engagement, Self-management and Self-advocacy, and Health Promotion:**
  - MCC of VA supports the evidence-based Healthy Ideas Program, which supports depression awareness and management for older adults.
  - We will partner with AAAs and CILs to implement a Chronic Disease Self-Management model to promote members’ self-management of chronic disease and maintain and/or increase individual skills, strengths, and ability to manage life’s daily activities. This model supports the appropriate use of medications; teaches effective communication with family, friends and health professionals; promotes health literacy; and reinforces nutrition and healthy decision-making skills.
  - To measure and support member engagement, we will partner with the AAAs to administer and interpret the Patient Activation Measure (PAM) survey to further support members in selecting and maintaining healthy behaviors by promoting member self-advocacy of their health, wellness, and independence.

*CSBs:* MCC of VA will partner with CSBs on select functions of care coordination, including:

- Coordinating clinical services, including behavioral and physical health services
- Assisting in identifying available providers and making appointments for members
- Following up with members, when appropriate, to ensure appointment adherence
- Assisting with care transitions
Leveraging our informational technology infrastructure to improve care coordination through data analytics, monitoring wellness and recovery progress, and communicating with providers

**Coordination with Medicare**

*Coordination for Dual Eligible Members:* We take a person-centered approach that promotes integration across all services regardless of payer source and all network and non-network providers; this approach includes aligned and non-aligned D-SNP and other Medicare Advantage (MA) plan or fee-for-service (FFS) arrangements. We coordinate Medicaid and Medicare services by creating comprehensive care plans that address individual needs and preferences and include the actions necessary to coordinate with Medicare coverage regardless of payer. We make this process a seamless integration for members by using the tools, technology, and provider relationships to meet members’ overall health and wellness goals.

*Trained staff:* We train all Care Coordination and support staff on Medicare services and processes, including Part D, and integrate both sets of benefits. Our dedicated Enrollment Specialists are Medicare subject matter experts supporting CCs, members, and families offering coordination of benefit guidance (including verification of MA Plan enrollment and benefits) and assisting with applying for other benefits (such as Medicare Part D or veteran’s coverage).

*Member and family/caregiver education:* Members are educated on covered services, provider prohibitions on balance billing, and their right to access Medicare providers for covered services regardless of payer network and without prior approval.

*Provider education and support:* We provide provider training on coordinating care and benefits for dual eligible members (discussed below) and include guidance in the provider manual. We also provide the name of the members’ Medicare plan, if available.

*Systems:* Our claims system is configured to ensure that Medicaid is the payer of last resort. Our CareAdvance and Customer Service systems allow for easy viewing of eligibility status.

*Experience:* MCC of VA and our associate organizations have extensive experience coordinating Medicaid and Medicare benefits and cost sharing, in our aligned D-SNP or other product, for over 125,000 members as of May 2016. Our approach is built on experience, best practices, and lessons learned from serving individuals in Medicaid Managed Care plans, Managed Long-Term Care (MLTC), Fully Integrated Duals Advantage (FIDA), and D-SNP programs. We will build on this foundation to ensure seamless and comprehensive access to services, regardless of member’s Medicare plan.

Complex coordination of care and benefits for individuals with serious mental illness, social emotional disorder and substance use disorders requires our unique expertise and knowledge of Virginia’s system of care and covered services including all payer and funding sources. As a health plan serving individuals with complex needs, MCC of VA provides the added value of targeted coordination processes and customized systems that promote Medicaid and Medicare integration; and staff with Medicare expertise to support members, CCs, and providers.

**Successes and Challenges:** The table below shows examples of our successes and challenges in coordinating with Medicare.
Selected Successes and Challenges in Coordinating With Medicare

**Successes**

When an individual is a member of our aligned D-SNP, we use a single platform to collect and analyze all available Medicaid and Medicare data, as well as document and share information among staff, allowing a comprehensive view of each member’s needs and care.

Assigning a single Care Coordinator responsible for coordinating both sets of benefits

Developing a single ICP incorporating Medicare services regardless of payer

Our LTSS Support Center staff (rather than Care Coordinators) review LTSS requests from other MA plans, allowing quick action on non-clinical and routine requests maximizing the time Care Coordinators spend with members.

Working with the Cureatr Health Information Exchange Event Notification System (ENS), we receive real-time notifications of all dual eligible admissions to the ER, hospital, urgent care, rehab or SNF.

Configuring our claims system to automatically pay certain services (e.g., Targeted Case Management) not covered by Medicare without requiring an attached Evidence of Payment (EOP) from Medicare.

**Common Challenges**

| Unwillingness of Medicare providers to participate in ICT meetings | We increased participation in ICT meetings by allowing Medicare providers (both in and out of network) to bill for their time. |
| Lack of coordination protocols between our Medicaid plan and unaligned D-SNPs | We established specific protocols and training for Care Coordinators to notify the unaligned D-SNP of events such as new non-LTSS needs, inpatient and NF admissions, and other changes in status and added this information to our regular reports to other D-SNPs (Request For Care Coordination and Inpatient Census Report). |
| Difficulty identifying the member’s Medicare delivery system | We developed codes for CareAdvance to reflect the member’s Medicare status (aligned D-SNP, unaligned MA plan, FFS) to alert all staff working with the member of the appropriate coordination pathway. |

Magellan’s CareAdvance system integrates all Medicaid and Medicare data to provide a comprehensive view of the member’s physical and mental health status, and LTSS needs to assist in identifying and addressing risks and changing needs as early as possible. We also work closely with all the member’s providers to ensure all aspects of Medicaid and Medicare are coordinated. In addition, we meet the needs of Community Well members, providing preventative activities to prevent or delay functional declines that may require LTSS. All members will have access to our MCC of VA Enhanced Benefit packages included in our Medicaid and D-SNP plans; (e.g., reloadable debit cards to access preventative services for chronic health conditions such as diabetes).

**Approaches for Individuals Enrolled in Medicaid but Not Medicare:** We will encourage members to enroll in our D-SNP and work with DMAS to align member enrollment with the same contractor for Medicare and Medicaid abiding by Medicare marketing guidelines. We will continue coordinating care and payment as required for members not in our D-SNP. We will pay cross-over claims per DMAS policies. We pay Medicare deductibles and coinsurance up to Medicaid rates except for Part D prescriptions. If no contracted rate exists or the provider is out-of-network, we pay up to the Medicaid fee schedule rate. For Medicare, we pay cost sharing to the extent the payment made under Medicare and by us does not exceed 80 percent of the Medicare-approved amount.
Our approach for **duals in Medicare FFS** includes recognizing that these members lack coordinated support for Medicare services. In our current Florida program, the CC ensures the member receives needed Medicare services and coordinates both benefit packages. CCs invite Medicare providers to participate in the care team, and educate them about covered Medicaid services and CC functions. CCs participate in discharge planning and assist members with access to follow up appointments, and provide monitoring information to the Medicare provider.

Our approach for duals in another MA plan includes establishing coordination processes for shared members with other MA plans. We educate MA plans on Medicaid services and the availability of CC assistance. CCs outreach to the plan’s coordination staff to alert them of the shared member, request and share information about member needs and care, and discuss how Medicaid and Medicare services will be coordinated. Our CC will participate as requested with the MA plan care team. For new members transitioning from the Commonwealth Coordinate Care (CCC) program, we will request recent service plans and provider information and invite CCC staff to participate in care planning. Magellan will honor CCC plan authorizations for their duration or 90 days, whichever comes first.

**Coordination with Medicare Providers:** MCC will have procedures and processes in place to coordinate care with Medicare providers, per our current experience and the MIPPA contract. Our tools assist in coordination of care with all Medicare providers (in/out of network and across payer type) with the following: (1) our secure provider portal.; (2) 24/7 LTSS Support Center Concierge Service; and (3) behavioral health coordination using a Physician Assistance Line to establish direct communication between PCPs and Magellan psychiatrists.

**Identification of providers:** We identify the member’s current providers during our initial contact and use claims information. To coordinate care for members not enrolled in our aligned D-SNP, we ask for consent to receive and share health information with their providers and MA plan.

**Coordination of care for individuals enrolled in both Medicare and Medicaid services:** Our contracts with MLTSS and D-SNP providers require coordination processes consistent with the MIPPA contract, including coordinating with our CCs and all the member’s providers regardless of network status, and participation on other MA plans’ care teams as requested. We maintain a single ICT, ICP and CC. Our Provider Support Specialists and Learning AllianceSM provide initial and ongoing education about all aspects regarding dual eligible coordination.

**Coordination of care with providers when members are enrolled in Medicaid not Medicare:** Our CCs participate in all needs assessments and person-centered planning of unaligned D-SNP and encourage providers to contact us if they need support in caring for members such as during anticipated or actual transitions in care. For members in FFS Medicare, our CCs actively outreach to both in and out of network providers to coordinate care. Provider Support Specialists meet face-to-face with the providers to work together to overcome barriers to coordination.

**High Utilizers**

**Quantitative Methods to Identify and Monitor Members with High Utilization or Emerging High-Risk Factors:** Our quantitative identification methods to identify and monitor members
with high utilization or emerging high-risk factors include predictive modeling and risk stratification using claims and utilization analytics.

**Predictive Modeling and Risk Stratification:** MCC of VA uses customized and sophisticated analytic software to conduct predictive modeling and risk stratification to identify and monitor members with high utilization patterns as well as those that are at risk of becoming high utilizers. Our enhanced tools predict future utilization, and assign each member a score that reflects the probability of a hospital or nursing facility (NF) admission. The process not only includes utilization data but also member-reported information. Our customizations improve upon standard analytic software modules, which often inadequately address the unique and increasingly complex needs of high-risk Medicaid and dual-eligible populations. We use enhanced analytics to appropriately identify high utilization and risk among those with SMI/SED/SUD and co-morbid/co-occurring conditions and LTSS needs.

Examples of our tailored software include: complex pharmacy algorithms to evaluate cumulative anticholinergic or morphine dose burden; algorithms that analyze pharmacy and medical utilization in context to identify metabolic disorder risk; and analysis of prescribed psychiatric medications to identify risk for serious medical conditions such as diabetes. Other customization includes incorporating home and community-based LTSS and NF assessment data and social support status. In addition, MCC of VA has created customized alerts that quickly identify critical needs and gaps in care for priority interventions and detect trends that may indicate emerging risk and a need for intervention. Claims data alone is not sufficient to risk-stratify LTSS members. Claims history is not always available or may be inadequate. More importantly, some critical factors important to identify risk can only be provided by member-reported information (health habits, living situation, and social connectedness) that are important predictors of risk for this population. For this reason, we use our screening and assessment data to construct enhanced, customized risk profiles that incorporate member-reported physical, BH, functional, and environmental risks, such as living situation; access to social support; smoking; or substance use.

**Claims and Utilization Analysis:** Our Medical Informatics department reviews and analyzes claims and utilization information to identify and monitor members with high utilization or emerging high-risk factors and provides data and reports to the CC and the ICT. Service providers have access to the information through the provider portal and discussions with Provider Support Specialists. At least monthly, and when significant changes occur, CCs review member care coordination information. Our quarterly Utilization Management Report identifies members, alerting CCs to re-assess and identify needed modification to their ICP, or to outreach and assess members who do not yet have an ICP to determine how to address their needs.

**Using Information to Improve Care Coordination:** We incorporate data within our predictive analytic process to inform CCs daily, and inform clinical leadership as they design the clinical model and approaches. We incorporate our claims and utilization data within the CareAdvance
system which offers real time alerts on a wide variety of key metrics, including: gaps in care, ED use, hospital admission, hospital readmission utilization, and polypharmacy information.

Our CCs use this information to improve care coordination by addressing identified risk factors and ensuring appropriate utilization. We also use this information in ongoing evaluation and improvement of our care coordination strategies, with special attention to vulnerable subpopulations.

**Care Coordination Process:** Our care coordination process is founded on the NCQA Complex Case Management Standards, which we use in evidence-based care coordination for high utilizer/high-risk members. We tailor our approach to include evidence-driven methods that reflect the unique needs of the various vulnerable subpopulations and the multiple health care, psychosocial, behavioral, physical, and LTSS needs of each member.

We will replicate our successful practice of building highly specialized care coordination teams. In Virginia, we will build teams of CCs with specialized knowledge and expertise for each complex, vulnerable subpopulation and develop approaches for other high-risk and high volume populations discovered through data analysis and reporting.

For members identified as high utilizers and emerging high-risk, we complete the initial contact and assessment in-person within seven business days of identification. The CC performs outreach and works with the ICT to complete the Health Risk Assessment (HRA) providing a comprehensive view of the member’s health status including: condition-specific issues and history, medications, ability to perform daily living activities, cognition and mental health status, life planning activities, cultural and linguistic needs or preferences, and caregiver resources and involvement.

Based on identified risk factors, a member receives specialized assessments such as brain injury, dementia, substance use, depression, HIV, pregnancy, and chronic medical conditions. The CC and ICT develop a goal-oriented and person-centered ICP with individualized and prioritized short- and long-term goals and interventions. Interventions are tailored to the member’s specific needs and risks, and reflect preferences such as language and cultural needs, providers, and options for service delivery (such as self-directed LTSS). The CC finalizes and authorizes the ICP based on member need and DMAS requirements. Monitoring complex, high-risk members occurs in person and as back up by phone, at least once a month and more often as consistent with member needs and preferences.

**Personnel Involved:** Our CCs are registered nurses, masters level social workers or other mental health professionals (with assignment based on the primary need of the member, such as an RN assigned to a member with complex medical needs, and a social worker assigned to members primarily needing assistance coordinating LTSS). Staff receives assistance as needed from our Medical Directors, pharmacy staff, Peer Support Specialists, and non-clinical support that assist with administrative tasks.

**Staff and Provider Training**

MCC of VA provides comprehensive training for staff and providers. The foundation of our training is built on person-centered best practices, evidenced-based clinical practice guidelines, and the Virginia-specific MOC. For the MLTSS population, MCC of VA established the *Magellan Learning Alliance*, our training ecosystem.
The Learning Alliance uses customized training for MCC of VA employees to ensure all MLTSS program, federal, and state requirements are met. The training offers a variety of mechanisms including instructor-led training, online courses, customized technical assistance, coaching and modeling, community-based education, printed-resources, and self-study alternatives. Learning Alliance trainings are organized by regionally-based training topics and include but not limited to:

- Provider orientation
- MOC
- Claims processing
- Quality improvement
- Care management
- Stakeholder engagement
- Care coordination
- Member services
- MLTSS
- Community health/community partners
- Self-direction
- Wellness and recovery

The regionally-based training team combines subject matter experts, learning and development best practices, and lessons learned in other states to develop curriculum and classroom instruction. MCC of VA engages local community-based partners to assist in developing training material on the specific needs of the MLTSS populations. Training is enhanced by input from the Enrollee Advisory Committee. The Learning Alliance includes a guest faculty program, featuring individuals representing local and national advocacy, academic, and service-oriented professionals to participate in the Aging and Disability in Focus and Vibrant Communities Speaker Series on topics covering SMI, SED, SUD, aging, disability, and community resources.

**Staff Training:**

Care Coordination training is facilitated by regionally-based trainers and covers person-centered MLTSS, Compliance Program training, the MOC, specialized populations, and specific Care Coordination responsibilities. We include topics such as: understanding vulnerable populations, person-centered care planning, health screening and risk stratification, assessment, ICT, care coordination, self-direction, care transitions, connecting individuals to community and social supports, ICP, cultural competency, monitoring health outcomes, NCQA/HEDIS, clinical practice guidelines, and safety. For on-the-job learning, our CCs partner with an experienced mentor who guides them as they develop competency-based skills and knowledge. This phase of learning involves observation, practice, feedback, coaching, and role-specific training demonstrating daily role responsibilities and tasks. After initial training, CCs receive ongoing professional development and supervision that includes: best practices, just-in-time training topics, quality improvement, refresher training, and training on policy changes.
The table below summarizes the types of MLTSS CC training, including the frequency and method:

<table>
<thead>
<tr>
<th>Types of MLTSS Care Coordinator Training</th>
<th>MLTSS Care Coordination</th>
<th>Frequency</th>
<th>Method</th>
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<tbody>
<tr>
<td>Employee Orientation</td>
<td>MLTSS Program Components and Role-Specific Training Systems Training</td>
<td>Upon hire and as needed</td>
<td>ILT, online, individual and group exercises</td>
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<td></td>
<td>MOC Elements</td>
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<td></td>
<td>Compliance Program Training</td>
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<td></td>
<td>State and federal requirements</td>
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<td></td>
<td>Safety Training</td>
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<td>Preceptor Program</td>
<td>Paired with experienced preceptor/mentor</td>
<td>Matched with mentor during first week for 90-day program; additional training provided as needed</td>
<td>Hands-on, field-based shadowing, coaching and modeling; additional training provided as needed</td>
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<tr>
<td>Ongoing Development</td>
<td>Learning Connections</td>
<td>Bi-weekly and as needed</td>
<td>ILT, web-based</td>
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<td></td>
<td>❖ Best Practices</td>
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<td></td>
<td>❖ Just-In-Time Topics</td>
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<td></td>
<td>❖ Quality Improvement</td>
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<td>❖ Refresher</td>
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<td></td>
<td>❖ Policy Changes</td>
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<tr>
<td>Supervision</td>
<td></td>
<td>As identified by supervisor or as needed</td>
<td>1:1 in-person or telephonic</td>
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MCC of VA ensures that training content is kept current with state and federal policy changes, and is regularly updated to reflect learnings from quality improvement efforts, member satisfaction surveys, staff performance evaluations, and training evaluation surveys. Under no circumstances are trainings reviewed less than annually.

The Training Team has many different sources available to help identify personnel training needs, including: partnering with our quality team on quality improvement efforts, grievance and appeal data, policy changes, audits, training evaluation surveys, preceptor evaluation forms, employee performance trends, Enrollee Advisory Committee input, and emerging practices.

MCC of VA provides cultural competency and health disparities training as part of new employee orientation to explore cultural concepts and awareness and offer guidance on providing culturally and linguistically appropriate care for all individuals. All training includes culturally competent components that address cultural differences, the impact of poverty, geography, and disabilities on access to healthcare, service utilization, prevention, diagnosis, and treatment.
MCC of VA uses a learning management system (LMS) to assign role-specific training plans and document completion for employees and contracted personnel. Training plans assign employees to specialized sets of content and/or development actions.

MCC of VA assigns oversight of the MOC training to the MLTSS Medical Directors and MLTSS Project Director in coordination with the Compliance Department.

**Provider Training**

MCC of VA has experience working with DMAS and providers to implement a train-the-trainer approach and we will continue this practice. The Learning Alliance and subject matter experts will participate in DMAS delivered training as requested. We will update training materials, policies, procedures, and workflows to ensure they align with DMAS best practices.

MCC of VA network providers are accountable for ensuring personnel are trained on the MLTSS program, including initial and annual MOC and compliance program trainings to meet state and federal requirements. During the implementation and transition process, we offer regionally-based provider training sessions that can supplement or be coordinated with their own trainings.

Our provider training begins with an orientation to our network requirements, the MLTSS program and covered services, our MOC and member population, and billing and claims payment. The Learning Alliance provides a full range of MLTSS, physical and behavioral health trainings with the integration among those services to our provider network through multimodal techniques. Our training approach contributes to successful ICTs who understand the goals of MLTSS, the role of each member, and how to apply care planning strategies to achieve positive health outcomes. MCC of VA also partners with CILs, ARCs, AAAs, and other community-based organizations to assist in training on sub-populations.

We offer customized onsite technical assistance for LTSS providers who require additional support to transition to a managed care environment. Our regionally based Provider Support Specialists attend to provider inquiries and address measures of accountability. We stay connected through frequent communications with our provider network through newsletters and educational mailings. These efforts engage providers and build collaborative partnerships.

MCC of VA’s Learning Alliance program uses instructor-led training, web-based instruction, and online training to conduct initial, annual, and ongoing Virginia-specific MOC training. Employee and provider orientation includes MOC training. In addition, MOC training resources are accessible on the provider website. The MOC training describes all elements including: care coordination for the vulnerable sub-populations including health risk screening, risk stratification, assessments, care plan, service arrangements, and follow-up and monitoring. Staff and providers must complete MOC training upon hire/contracting and annually thereafter. MCC of VA updates its MOC training to address enhancements and changes to the model.

We conduct audits and credentialing to ensure providers meet MOC training requirements. MCC of VA uses our automated LMS to track completion of initial and annual MOC staff training. Employees who do not complete training receive supervision and a plan of action to complete the training. Failure to complete assigned training results in intervention by human resources and consequences up to and including termination.
Integrated Health Home Systems of Care: Behavioral Health Home

MCC of VA brings to DMAS and DBHDS unique knowledge and expertise to assist in the development and implementation of behavioral health homes (BHH) for individuals with serious mental illness (SMI) using CSBs and other community systems and providers. This expertise is demonstrated through our successful work in multiple states, including Florida, Arizona and Iowa. MCC of Florida, the nation’s first Specialty Plan for persons with SMI, implemented the Provider Partnership Project where we worked with nine PCP and FQHC providers to transform their practices to assist in integrated medical and behavioral care for more than 300 high and ultra-high-risk members. We assisted these providers in co-location, information sharing arrangements, and building internal capacity to include behavioral health services.

In our Iowa program, Pediatric Health Home members, saw improvements for both members and caregivers across multiple domains including medical, school, familial, economic, psychological and legal issues. Highlights included: children/youth reporting to have shown self-harm behaviors between intake and three months of IHH dropped from 17 percent to 10 percent and of those currently employed, the number of caregivers who reported missing at least one day of work per month due to a child’s emotional or behavioral problem dropped 13 percent from 31 percent at intake to 18 percent at three months.

Magellan, as the Commonwealth’s BHSA, has done preliminary work in this area, providing consultation, technical assistance and information to DMAS as the Department designed and implemented the BHH pilot within the Medallion 3.0 programs. MCC of VA will work with DMAS, DBHDS, and community providers to expand and enhance BHHs to all six regions and will work to develop health homes for children and youth with SED. The table below shows MCC of VA’s suite of tools and approaches to BHH.

### MCC of VA’s Suite of Tools and Approaches to Behavioral Health Homes

<table>
<thead>
<tr>
<th>Suite of Tools and Approaches</th>
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<tbody>
<tr>
<td>We identify, assess, educate, and support BHH providers in their delivery of integrated care to vulnerable Virginians</td>
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<tr>
<td>We provide oversight and technical support for the BHH providers, as well as infrastructure and tools</td>
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<tr>
<td>We provide Practice Transformation Coaching to provide ongoing consultation during and post BHH implementation.</td>
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<tr>
<td>We provide clinical and care coordination support to BHH providers in development of person-centered care plans, including access to MCC of VA’s Clinical Pharmacist as part of the ICT</td>
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<tr>
<td>We jointly identify case management interventions for BHH members</td>
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<tr>
<td>We directly deliver care coordination, holding face-to-face meetings as necessary to ensure implementation of person-centered care plans and appropriate receipt of services for BHH members</td>
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<tr>
<td>We gather and share member-level information regarding health care utilization, gaps in care, and medications, allowing us to support measurement capabilities and outcomes data</td>
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<tr>
<td>We monitor and intervene for BHH members with high needs by developing and implementing complex treatment regimens</td>
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We support providers through a Learning Collaborative and the Magellan Learning Alliance

We facilitate shared treatment planning meetings for members with complex situations

**MCC of VA’s Plan for Assisting BHH Development in Virginia:**

CCBHC Support and Contracting in All Six Regions: As the BHSA, Magellan has existing relationships with the eight CSBs currently working through the SAMHSA planning grant to adopt the CCBHC model for their BHHs and we serve on the Department’s advisory board for the CCBHC project. MCC of VA proposes to add additional consulting resources to the advisory board, and will contract and support the CBHCs through our suite of tools and expertise as described above.

**Establish and Expand a BHH Pilot Program for Adults in the Central Region:** MCC of VA has a letter of intent with Henrico CSB to expand and support an existing co-location arrangement between the CSB and the Daily Planet FQHC. We will provide funding for additional time for a Nurse Practitioner at the CSB to serve MCC of VA’s members with SMI and provide linkage to our CC and suite of tools. This funding would begin at contract go-live.

**Continue Discussions for a Year 1 BHH Program in the Tidewater Region:** We will engage in continued discussions upon contract award with another CSB in the CCBH Planning Grant effort in a similar fashion, supplementing the funding for a co-located Nurse Practitioner serving MCC of VA’s members with SMI.

**Enhance and Expand BHH Models of Integrated Care in the Additional Four Regions - Employing whatever integration model works locally to ensure member health:**

- **Model 1: “Reverse” Co-location:** In this model, primary care services are delivered on-site through arrangements with PCPs, and the BHH manages all the member’s medical and behavioral care coordination needs. This model is already in place in Richmond Behavioral Health and Hampton Roads, and is in progress with Colonial CSB. This model can also be done in collaboration with a FQHC establishing a satellite site.

- **Model 2: Traditional Integrated Health Homes:** In this model, behavioral services are integrated into the FQHCs. Behavioral health providers are on-site and help the FQHC identify and treat members. We will provide FQHCs with smart screening tools that assess prevalent BH conditions such as depression, anxiety, and SUD with assessments scored in real-time. Decision logic then directs the FQHC to the appropriate types of BH service based on each individual’s results. Possibilities include referrals to CCBT modules, therapist on-site at the FQHC, psychiatric care, and/or case management.

- **Model 3: Virtual Co-location:** MCC of VA recognizes that it will not be possible to develop traditional BHHs for all members. We will facilitate linkages between PCP offices and behavioral health clinics to promote access to collaboration and communication between physical and behavioral health providers. These linkages include formal collaboration agreements between the two entities that highlight mutual expectations regarding timeliness of routine and urgent appointments, frequency and type of communication, and availability for member consultations. We assign a primary behavioral health provider and share rosters of members and assigned member and associated data.
**Initiate Expanded Discussions for a BHH for Children and Youth with SED for Possible Year 2 Implementation:** We have an agreement in place with John Dougherty and Innovations, LLC to discuss a demonstration pilot for a health home for children and youth with SED in at least one region. This pilot would leverage existing relationships with CSA administrators, the BHSA, private behavioral health, CSBs, and pediatric providers.

**Develop and Implement Expanded BHH Care Coordination Teams within Community Providers:** Following successful completion of Magellan’s Health Home Readiness Tool and using a combination of MCC of VA administrative funds and Medicaid eligible procedures such as TCM, we will fund providers including CSBs to create local Care Coordination Teams to serve our members. The teams would include RNs, Peer or Family Specialists, and a behavioral health professional to serve the members and be connected to our Care Manager, provider network, and suite of tools. These Provider Teams would receive value-based incentive payments linked to selected measures from the VA MLTSS Core Quality Measures, such as Ambulatory Care - ED Visits or Follow-up after hospitalization for Mental Illness (7-Day Rate Only). We would implement this payment model in each of the six regions and leverage the BHHs established in the Central and Tidewater Regions.

**Partnering with CSBs and Community Providers:** Magellan collectively has well developed relationships with all CSBs, and we will work with them and their association on MLTSS program changes and enhancements. We value CSB input and make adjustments based on their feedback. For example, VACSB has a dedicated seat on the BHSA Governance Board. MCC of VA has existing as well as evolving relationships with other community providers including the private behavioral health provider community and many FQHCs. MCC of VA will leverage these relationships to partner for the development and implementation of BHHs in the following ways:

- Contract with every CSB for Medicaid, and ultimately Medicare, covered services
- Provide consultation and technical assistance to developing CCBHs
- Provide consultation, facilitation, and funding to support to the three BHH co-location models described above – Reverse, Traditional, and Virtual Co-location
- Convene Regional, Local and Commonwealth-wide entities to facilitate development of Health Homes for children and youth with SED
- Perform Readiness reviews for BHHs to serve our members using the SAMHSA-HRSA Standard Framework for Integrated Levels of Healthcare as a guide
- Create provider-led Care Coordination Teams
- Provide ongoing technical assistance and address any areas identified for improvement utilizing our regional field-based Provider Support Specialists.

**Serving as a Behavioral Health Management Program:** As a health plan that serves multiple regions, the BHHs will have the benefit of working with an entity with a singular focus on the needs of persons with SMI, SED and co-occurring SUD needs and a common set of readiness capabilities, tools, resources and approaches. While the BHH models may evolve differently within or across regions, collectively, they will serve as the primary entity for local delivery and collaborative care coordination for high-risk members. We will convene the BHHs within and across regions to share lessons learned, best practices, and performance improvement by sharing performance metrics from the DMAS Core Quality Measures.
MCC of VA will provide quality oversight and monitor BHH program effectiveness on a system and member level using a technology-enabled approach through our Health Home Portal, which allows us to drill down on a member level to measure engagement, completion of plans, and individual outcomes. The portal also allows us to monitor key outcome measures, such as hospital readmissions, on a system level. We will outline our outcome metrics with those of the CCBHs and other BHH models.

**Using a Team-Based Treatment Approach:** Within MCC of VA, our BHHs are responsible for coordinating the total care of the member in consultation with our CC. Each BHH has an Interdisciplinary Care Team (ICT) that includes Nurse Care Managers, CCs, and Peer Support Specialists with defined roles. The team is the hub for MCC of VA’s BHH approach. In our person-centered approach, members not only identify key members of the ICT, they are supported and encouraged to facilitate care planning meetings, and are an active participant as the driver of his/her care plan. The ICT works with the member to develop a person-centered care plan through a strength-based, goal-oriented approach that ensures members have choice but do not have to navigate the healthcare service system on their own. The ICT focuses attention on physical and behavioral health needs, and addresses social determinants such as housing and employment assistance. We earned from our Florida experience among others that housing and employment are critical to advances in overall member health.

Person-centered planning meetings, held by the ICT at a frequency appropriate for the member based on their risk stratification, include the member, family/caregivers, internal staff, and treating providers for members with complex situations. Natural supports and other non-traditional team members who support the wellness plan also participate. We will leverage our existing relationships using the Quality Caregiver Survey analysis of flagged domains, reflected with the CSBs, FQHCs, and other community-based organizations to identify potential ICT members.

**Staff and Resources to Improve Health Care Delivery:** MCC of VA will employ a variety of methods to support the BHH in having the sufficient staff to address member needs. We will offer a case rate for CSBs and FQHCs to hire staff that focus on BHH, integrated care coordination, and value-based payments for meeting certain VA MLTSS Core Quality Measures. We will as appropriate, fund a NP or embed CC within CSBs and/or FQHCs. MCC of VA will use a variety of tools and technology to achieve seamless integration, communication, and bi-directional behavioral health and primary care services. Our Provider Portal has a wide range of resources available to all providers. All member interactions are captured in the same system, ensuring each member of the ICT, including primary care and behavioral health providers, has access to up-to-date information about the member’s care. Our PCP Toolkit, available on our Provider Portal, contains resources such as tip sheets related to substance use disorders, ADHD, anxiety, coordination of care, depression, HEDIS measures related to behavioral health and substance use, and screening tools for high volume diagnoses.

**Responding and Preventing Acute Episodes:** As a health plan with extensive experience serving persons with serious behavioral health conditions, we will utilize the following quality driven and evidenced based strategies, capabilities, supports, tools and partnerships:

- Staff our Member Services 800 line and 24/7 Nurse Line with skilled individuals equipped to triage and assist members who call in crisis
Work with providers to expand the continuum of community-based services to increase accessibility and reduce wait times

Implement incentives to transition current ICT providers to become Program of Assertive Community Treatment (PACT) fidelity models, an evidenced-based practice to assist high-risk members to stay in the community

Add Program for Assertive Community Treatment (PACT) as an enhanced Benefit

Solicit feedback from members on barriers and stressful aspects of their healthcare experience, such as care transitions, and put measures in place to achieve and monitor system improvements

Include in our MOC the use of Recovery Navigators to assist members with SMI in navigating care transitions, including transition from a hospital, jail or ED, which could otherwise result in a crisis. Recovery Navigators are trained and highly skilled peers who provide short-term community-based services and act as a bridge to coordinate, arrange, and monitor services and supports. They assist with connections to natural supports, pre-crisis planning, wellness plans, and access to post-crisis services to navigate individuals through a crisis and reduce the likelihood of future crises. Our Recovery Navigator program in Florida achieved over $900,000 in inpatient savings (translated to 1,381 days living successfully in the community instead of in a hospital) in just three months of implementation.

Partner with Cureatr Inc., to provide real-time clinical alerts for members presenting at ERs. Cureatr receives live feeds from hospitals and health information exchanges and provides real-time registration, admission, and discharge event notifications that becomes part of the single member clinical record and alerts our CCs and the member’s ICT receives for follow up with the BHH team.

**Establishing Health Homes:** Health homes can lead to higher quality, lower costs, and improved member and provider experiences. We will support and promote the utilization of Behavioral Health Homes. For members who select our plan who do not have a behavioral health condition, we recognize and support more traditional health homes.

We draw on our experience supporting chronic condition health homes and patient-centered medical homes (PCMH) to apply best practices in managing co-occurring conditions, particularly for older adults and persons with a disability. We fully support health homes to optimize primary care and emphasize care coordination and communication to deliver "what members want." We encourage the NCQA PCMH designation, but also support other recognition programs.

**Partnerships with Community Partners/Providers:** Utilizing our network development efforts and data, we identify medical practices with NCQA PCMH certification and develop others by using data to identify those with a high concentration of Medicaid members. NCQA-recognition requires practice transformations, including: training certified content experts (CCE) who must complete two NCQA educational seminars, pass an exam, commit to
continuous NCQA PCMH learning about standards and updates, and achieve periodic recertification to maintain PCMH credentials.

We assist providers and practices, including those in rural areas without the resources to obtain health homes or PCMH recognition, by supporting their adoption of processes that improve care coordination and communication. At an enterprise level, we provide access to an NCQA PCMH CCE.

As in other states, our coaching and incentive programs will be aligned to focus providers on key clinical issues and to engage them. In partnership with providers well-positioned to integrate technologically, we offer Value Based Payments, and other risk sharing arrangements. For those unable to integrate, but who still collaborate to achieve a member-centered approach to integrated care delivery with great outcomes, we offer other arrangements.

**Health Home Comprehensive Health Management Program:** Magellan realized great successes partnering with health homes supporting chronic conditions including: hypertension, obesity, heart disease, diabetes, asthma, SUD, and other behavioral health conditions. Through our CCs, we will publicize the availability of health homes and encourage member’s access.

**Team-based Treatment:** Health homes inherently focus on a team-based approach. In our partnerships, health homes are accountable for coordinating total member care. Similar to our Interdisciplinary Care Teams (ICT), each health home’s ICT includes CCs, PCPs, and other providers collaborating in a member-centric model.

The health home ICT supports the member, contributing their individual experiences and areas of expertise to maximize assistance to address each individual’s unique needs. The ICT works at the member’s direction, driving the development of a person-centered ICP. The ICP is developed through a strengths-based, goal-oriented approach allowing the member to drive the development but ensuring they do not have to navigate the healthcare and LTSS/HCBS service systems on their own. We communicate and coordinate between teams and collaborate in all aspects of ICP development.

We offer our tools, access to our ICT resources, and invitations to our periodic learning opportunities to promote best practice to our Health Home partners.

**Health Home Staff and Resources to Improve Overall Healthcare Delivery:** Health homes must do the following:

- Advocate in the community on behalf of their members
- Engage organizational leadership through the transformation process and sustain transformed practice processes
- Agree to participate in learning activities
- Offer enhanced access 24/7
- Document the member’s housing, legal, employment status, education, custody, etc.
- Participate in CMS and State-required evaluation, outcomes, and quality activities
- Submit reports required by the Commonwealth or other oversight entities
- Commit to using an interoperable patient registry or electronic health record (EHR).
We link health home compensation to staffing and competency. To achieve incentives, providers must meet or exceed goals. We structure contracts and payments to support integration, improved outcomes, and increased enrollment in member-centric initiatives.

**Health Home’s Rapid Response Processes to Prevent Acute Episodes:** We will provide TeleHealth video capabilities and access to Tele-Urgent Care for medical conditions to both CSBs and health homes to prevent acute episodes and avoid escalation in the event of an acute episode.

MCC of VA partners with Cureatr to make real-time clinical notification alerts available at no cost to providers willing to provide data feeds. Cureatr helps prevent repeat acute episodes by tracking members as they move through Care Transitions, and providing a communication infrastructure between acute care and intermediate/skilled nursing facilities.

Cureatr links care sites by automating the notification of moves, such as admissions, discharges, and transfers for acute and sub-acute admissions, ED admissions, etc. Promptly notifying PCPs or CCs of an ED visit can prevent a hospitalization, if notification is early enough to allow intervention and establish an alternative care plan.

**Working with Nursing Facilities**

Our collaborative approach with NFs optimizes the promotion of high quality, cost effective care and services, member choice and safety, which results in a higher quality of life and better health outcomes for residents. We promote the use of best practices, and evidence-based interventions by the NFs in our daily and weekly contacts. We offer training for providers and members, member and caregiver information and encouragement and peer support are key aspects of our approach.

Systematic monitoring, tracking, trending and feedback loops create the foundation for our quality oversight. The Quality Department and Quality Committee provide oversight of data and outcomes as well as constant review by operational staff for opportunities for improvement. We incorporate value based payment arrangements to target evidence-based practices specific to MLTSS services within an institutional setting.

In our discussions with NF Associations to determine the best ways to partner under the new program, they indicated a lack of communication and responsiveness from assigned CCs and poor coordination of transitions of care/discharge planning in the Dual Eligible Pilot. Our solution will assign one dedicated CC to a small number of facilities to ensure communication and care coordination in a timely fashion. They also described a challenging transition to update Resource Utilization Group categories for Medicare and Medicaid. We provide training and testing of systems prior to, concurrent with, and after go-live.

Members of Leading Age expressed several requests to improve care in their facilities. To address these points, we will deploy dedicated behavioral health specialists and other high-need behavioral health personnel to accompany NF staff on regular rounds to identify and help coordinate care for our members. We will also train NF staff to identify members exhibiting signs of serious mental illness (SMI) to ensure they can immediately address issues when possible. Our staff will be available to NFs for training, seminars, and online support.

We will assign onsite CCs to NFs to assist the team and members with coordination of necessary care and services. The CC assigned to the NF will work with the member to ensure
they are offered a choice when selecting members of the ICT. Our CCs extend the ICT process to include the NF staff daily.

A specialized Provider Optimization Delivery Services (PODS) Team member will provide targeted support to NFs responsible for contracting, providing technical assistance, conducting site visits, and educating network providers. Each NF will be assigned a Provider Support Specialist as the point of contact, promoting the adoption of evidence-based interventions and providing support from a clinical and quality perspective. They interact directly with providers and their office staff, utilize other information to conduct in-depth needs analyses, and review workflows to identify opportunities for improvement. We hold Quarterly Joint Operations Committee meetings which bring together our staff and NF staff to review performance metrics and related information.

**Reducing Avoidable Hospitalizations:** An estimated 40 to 50 percent of long-term care hospitalizations are preventable according to evidence-based reports from the Centers for Disease Control and the American Medical Directors Association (AMDA). Hospitalizations of older adults or persons with complex needs and disabilities are often followed by an irreversible decline in functional status and a change in the quality and style of life. Our institutional clinical model promotes a significant increase in the volume of key interdisciplinary clinical services brought to the member’s bedside, especially PCPs, psychiatric consultation, extenders, and CCs. The member’s chronic physical and behavioral condition(s) are closely observed and changes are more easily identified and acted upon. NF medical and behavioral health providers work with our CCs and Utilization Management (UM) Team to ensure that optimal care and services are determined, authorized, and provided.

Our CCs are trained and knowledgeable of the AMDA Clinical Practice Guideline: “*Acute Change of Condition*”. They are adept at assisting NF staff in identifying subtle changes and acting quickly to avoid further complications. When members are experiencing a change in condition, CCs and the ICT participate in the NF’s daily morning case review meetings either on-site or by telephone. Members with significant changes in condition are discussed and ICTs and care plans are adjusted.

We collaborate with the member’s PCP and NF team to ensure the appropriate tests and clinical work up are carried out, ensuring the member can be treated safely within the NF. We waive the three-day hospital inpatient requirement to ensure the NF can keep and treat the member in the facility.

**Physician Support:** Our experience shows that availability of physicians, especially during after-hours, is critical to avoiding unnecessary hospitalizations. We incentivize providers to offer extended coverage as needed at the NF and promote the use of telehealth and telemedicine to increase physician access. In addition, we leverage our current behavioral health network to provide additional psychiatric consultations either in person or by telehealth with NFs. In our conversations with the state nursing facility association, this service was noted as an area of need. Often residents in NFs have behavioral health issues that could benefit from psychiatric oversight to avert unnecessary hospitalization and ED visits.

**Management of Chronic Conditions:** We utilize the member’s Minimum Data Set (MDS) assessment information augmented by our own condition-specific assessments to ensure accurate identification of chronic conditions. We incorporated the nationally recognized and evidence-based MDS assessment elopements and the SF-12 Quality of Life assessment
elements into our NF HRA tool. We incorporate both behavioral and physical health chronic condition care needs and goals into the ICP. We share the assessment and ICP contents with the NF providers as needed and as often as daily based on member need. We deliver the same information to providers using our provider portal in between face-to-face meetings. We leverage technology, including telecare and telehealth, and incorporate innovative approaches such as the “group visits” model into our strategy. For example, we have CCs who specialize in diabetic education, incontinence management, behavioral health, skin care/integrity, and dementia. These experts bring their knowledge to the NF and can offer education on the spot or a group setting; especially with members diagnosed with diabetes, group training sessions are very effective.

Our Wellness Specialists offer additional support to NF providers and members with chronic condition education and self-management in partnership with the CC.

Our strategy for controlling chronic conditions assists providers and members in reaching goals for treatment, gaps in care, health and wellness screening, and immunization for such conditions as COPD, osteoarthritis, CVA, high cholesterol, high blood pressure, diabetes, depression, anxiety, pain management, and other high volume, prevalent chronic conditions. We use Member 360 analytics and assessments to build a comprehensive view of preventive care, chronic conditions, screening and immunization, and gaps in care needs and goals. Providers and NF staff can look up a member’s information and care gaps at any time, and they also get a view of their performance across the entire population and are accountable for closing care gaps across all members.

We know from experience that a high percentage of members with a chronic condition also experience depression and anxiety, the prevalence can be even higher for individuals living in facilities. We have extensive experience in supporting members with depression and anxiety and can offer our behavioral health expertise to our contracted NFs. Psychiatrists and psychologists are available to assist with medication optimization and consultation. NFs also have access to our provider line, and we utilize telehealth for rural areas.

We leverage telehealth to extend access to care for members in and out of NFs. Connecting members with behavioral health specialists, from counselors to psychiatrists and nurse practitioners, complement the care the member is receiving in the NF. Non-behavioral health specialists can be utilized as appropriate including pain management experts, dermatologists, geriatricians, etc. Our CCs assist members with the simple steps of logging into the cloud-based, secure platform or Mobile App to “see” a specialist. This capability broadens access to care by eliminating provider geographic and travel constraints.

**Medication Optimization:** Our Care Coordination Team will collaborate with the NF pharmacy provider and our own Magellan Rx Team to ensure the member is always receiving safe and effective medication therapy management. Our Magellan Rx Team proactively reviews each member’s medication profile to ensure optimal safety, efficacy, and cost effectiveness and communicates with the NF pharmacy team on a regular basis.

This collaboration results in individualized medication therapy management (MTM) programs specific to the unique needs of the NF population. Special attention is paid to members receiving any black box warning medications to verify the lack of alternative treatment options and to ensure member safety.
**Fall Prevention:** We ensure that all contracted facilities have a fall prevention program in place and can assist with the development of a program when needed. Components of these programs include: adhering to CMS guidelines for fall risk and prevention; educating MCC staff, NF staff, members, and family about fall risk factors and prevention strategies; identifying, assessing, monitoring, and planning for members who are determined to be a fall risk - utilizing falls risk assessment tools which are easy to administer and incorporate into the NF staff’s daily routines; and reviewing prescribed medicines to assess their potential risks and benefits and minimize use.

**Pressure Ulcer Prevention:** We comply with the CMS guidelines and F tags F314 42 CFR 483.25(c) related to pressure sore prevention. We adhere to a prevention program that promotes prevention of pressure ulcer development, promotes healing, and prevents development of new pressure ulcers. We collaborate with the NF clinical team to ensure that a pressure ulcer prevention program is in place and meets the CMS requirements and is fully compliant with current best practice and evidence-based guidelines.

**Coordination of Services Beyond the Scope of the NF Benefit:** We evaluate and establish the offering of add-on benefits on geographic NF population utilization patterns, feedback from members and NF staff regarding gaps in covered services/benefits, and overall needs of the population. Add-on services embrace the unique needs of the population.

We use trusted relationships among vendors, partner agencies, NF staff, behavioral health providers, PCPS, and the member to support improvements in whole health and self-care, and monitor measurable health outcomes. Our framework encourages our members, their families/caregivers, and NF staff to participate in the treatment team and offers opportunities for community resources; to the degree possible, supports self-management of health conditions and/or lifestyle risk factor reduction; and stimulates and facilitates communication among providers and NF staff so that a whole-person treatment approach is applied.

**Evaluating NF Quality:** We carry out population specific quality measurement and performance improvement activities with targeted and comprehensive measurement of health outcomes. We leverage and enhance our current Quality Improvement processes and monitor improvement initiatives to continue to achieve outstanding results. We ensure NFs follow evidence-based clinical practice guidelines and protocols. During initial contracting meetings, facility on-site review meetings, and ongoing joint operating meetings, we review and evaluate the NF’s application and presence of evidence-based clinical practice guidelines. We also review the NF’s clinical and quality programs and participate in the NF’s clinical and quality committee meetings as appropriate.

Required DMAS quality metrics will serve as the foundation for system capture of data and ongoing monitoring. High emphasis will be placed on quality of care concerns, fall prevention, adverse and critical incidents and member/caregiver quality of life measures reported through grievances and feedback on service and care surveys. Quality Measures include the percent of residents who experience one or more falls with major injury; self-report moderate to severe pain; have pressure ulcers; have been given influenza and pneumococcal vaccines; have a urinary tract infection; lose control of their bowels or bladder; were physically restrained; lose too much weight; have depressive symptoms; or received an antipsychotic medication. We will also incorporate the six quality measures CMS recently added to its Nursing Home Compare website.
**Additional Measures:** In addition to the metrics required by DMAS, we intend to develop additional NF metrics. We will evaluate the unique characteristics of the population and implement internally developed metrics that measure NF quality of care. For example, these metrics might include measures such as inpatient measures for physical and behavioral health including admissions/1,000, average length of stay, days/1,000, readmissions/1,000; ED measures including percent members without an ED visit in the last 90 days.

**Innovative Payment Strategy Results:** Through our subcontractor, Shared Health, we implemented two innovative quality payment strategies - Pay for Gap Closures incentive bonus and Pay Groups using PMPM bonus/fee schedule escalators based on group quality scores (1-5 STARs). The Pay for Gap strategy plays a role as a first step to collaborate with providers in the process of population management. Group scores play a role in a more mature program that introduces providers to more risk sharing for a purer population management approach. Results show an estimated 12 percent increase in quality scores for several HEDIS measures. We will also explore with Cureatr, a subcontracted company of MCC of VA, that partners with regional NFs, to launch a technology-enabled IPA/regional network of NFs. They provide the clinical and technology infrastructure, while facilitating the financial incentive model, to enable nursing homes to successfully participate in value-based payment initiatives.

**Quality Outcomes:** Patient and system outcomes are core to shaping payment, patient placement, referral and case management interventions and work with members and caregivers. Data capture systems support evidence-based decision-making as shown in the table below.

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<th>Impact of Outcomes</th>
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<tbody>
<tr>
<td><strong>Element</strong></td>
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<tr>
<td>Payment</td>
</tr>
<tr>
<td>Patient Placement</td>
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<tr>
<td>Referral</td>
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<td>Case Management Interventions</td>
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**Returning Home/Community Living:** Our NF to community transition approach involves a partnership with members, providers, and caregivers empowering members to make informed decisions about their life and healthcare. CCs assist in identifying accessible, affordable housing, as well as needed supports, and solutions that reinforce community living options for members transitioning from NFs. We understand local housing options and available wraparound services, including supportive housing, both for members transitioning and experiencing homelessness. CCs offer information about options to sustain community living...
arrangements while temporarily in an institution, promote a return to community living on discharge, and prioritize return-to-community as an expectation. We work with CILs, AAAs, community resources and partner with local housing and resource authorities, supportive housing providers, and wraparound service providers to ensure member access to community living options, including shared living. We have experience coordinating innovative community-based alternative housing and services, including individuals in recovery from substance use.

Close collaboration and partnership with NFs is critical to the success of our approach. CCs serve as the primary advocate in ensuring the member’s well-being across multiple care settings. They are responsible to engage members to ensure the ICP reflects their individual goals, outcomes, and interest in living in a community-based setting. At the time of enrollment, members are maintained within their existing NF and only in rare circumstances will be considered for a move to a different NF. We will comply with DMAS’ guidelines and will consult DMAS if a member may need to be moved to a different NF based on extenuating circumstances. The transition plan addresses all needs and services necessary to safely transition to the community.

**Care Management Technology System**

Our strength in electronic data management is the ability to deliver a dependable resource of updated, actionable information to all participants in the member’s ICT. Integration among our data intake facilities, claims processing system, and data warehouse ensure that data essential to providing services is streamed to the user.

*Care Management Technology System:* We will use an enterprise-wide, integrated suite of Management Information Systems (MIS) that includes informatics, data analytics, care coordination, and utilization management, integrating information from a multitude of sources. This system will comply with all DMAS requirements, policies, and standards as outlined in the RFP, MLTSS contract, and all future enhancements or modifications.

MCC of VA uses a combination of the TriZetto platform and custom built systems:

- **Facets** is used for claims processing, member management, and customer service inquiries
- **CareAdvance** is used to document and coordinate care for Medicaid and LTSS members
- **Care Communications Management System** supports and tracks member outreach
- **Agent Workspace** call center application supports information from Facets and CareAdvance, facilitating first call resolution by showing our Member Services staff any previous interactions.

Systems data is updated in real-time through manual entry by our staff when they enter notes, upload documents, and complete member assessments. Batch program transactions of data feeds from customers and agencies upload on predetermined data cycles. Facets feeds member demographics, eligibility, and provider demographics and network information into CareAdvance. Authorization information, claims data, and care coordination information feeds bi-directionally, ensuring that both systems are updated. Our robust MIS systems are easily adaptable and expandable, allowing us to interface with many types of customer systems. MCC of VA will gladly participate in any DMAS Systems Workgroup to strengthen the systematic relationship between the two entities.
Care Management System Facilitates Communication: Magellan has existing member and provider portals for our behavioral health program and we can expand this access to the MLTSS population. Our toll-free number is staffed 24 hours a day, 7 days a week for both members and providers. Due to the existing relationship between Magellan and DMAS, we can update our current website, www.MCCofvirginia.com, to meet the program requirements. The current site includes an external resource site that directs visitors back to DMAS, ensuring that members and providers use our website as a one-stop resource.

Providers: Clinicians have access to their data and have authority to approve attestations entered into the portal by support staff. Non-clinician roles have access to see all data and enter attestations to close gaps in care. Both access data through the online provider portal and to communicate contractual program progress as well as the ability to enter attestation with the goal to close gaps in care in EMR systems but not in administrative claims data.

MCC of VA Helpline: Following on-site visits, members receive copies of certain documents, ensuring they have access to their own information. Members can contact their CC, the member call center, or the LTSS Support Center during business hours if they have questions about benefits, services, claims, or general questions. After hours calls are directed to the 24/7 Nurse Hotline.

Members: Our website includes a member portal to establish a password-protected user account. Members can access personalized plan details, keep records, track claims information, benefits and coverage information, find an in-network doctor, order a new ID card and/or print a temporary card, change PCPs, and choose from a wealth of health and wellness tools and resources.

Care Coordinators: CCs have access to all the systems necessary to complete their member contact in the office and community. In the office, CCs use CareAdvance to review member eligibility, open cases related to specific medical conditions, view notes from other staff contact with the member or ICT, and requests for medical, behavioral health, or LTSS benefits. In the community, our Mobile Application (App) can be used with or without an Internet connection. The App contains all available relevant member documents. CCs and members work together to complete the ICP and all supporting documents. Once the CC connects to the Internet, the member’s data is uploaded into CareAdvance.

Types of Data Stored: Data stored within CareAdvance shows a complete picture of the member’s past, present, and future needs. The data includes member eligibility for Medicaid, DSNP, LTSS, and other available insurance, and episodes of care for all aspects of physical, behavioral, and LTSS needs. The Address Book contains up-to-date information about how to contact the member, their representatives, and providers. Individual areas of CareAdvance outline specific medical information, such as conditions, medications, allergies, vaccinations and procedures, and all notes and actions are captured in the Member Chart, where all staff documents contacts or updates to the member’s status, ensuring that different areas of the organization have the most recent information available. Notes are visible once saved in the system, allowing for real-time updates. LTSS benefits are stored and authorized within a central area of CareAdvance to stream data to providers, CCs, case managers, member services, and the member/representative.
**How Information is Fed into the System:** Systematic updates feed into Facets when the 834 is received from DMAS on a weekly basis. Manual entries occur thousands of times a day, updating both Facets and CareAdvance when staff enters notes into the systems.

**Quality Management and Improvement**

*Quality Management / Improvement Structure and Approach – MCC of VA’s Integrated Solution:* MCC of VA’s integrated Quality Management (QM) structure is poised to build on established and strong quality program foundations to support DMAS’ program goals and MOC. Our comprehensive QM program reflects the *Institute of Medicine’s Crossing the Quality Chasm: A New Health System for the 21st Century* aim for national healthcare quality including a focus on “safe care.” The Quality Management/Improvement (QM/QI) Program is organized around processes that align with the Department’s MLTSS program goals and model of care, and is compliant with the NCQA and Centers for Medicare and Medicaid Services (CMS). Our quality infrastructure is integrated throughout our operations and clinical delivery system. The table below summarizes the key components and the quality structure we use to support the MLTSS MOC.

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<th>QM Component</th>
<th>QM/Improvement Infrastructure Summary</th>
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| **Comprehensive Program Structure** | Dedicated and experienced quality resources  
Strong governance and committee structure under the leadership of a Medical Director and supported by a Director of Quality Management  
Program policies, procedures, and processes covering all operational aspects that meet contractual, DMAS, and federal guidelines  
Use of continuous quality improvement (CQI) processes; detailed quality program description, quality work plan with metrics, comprehensive care components including medical, LTSS, mental illness and substance use disorders and vendor quality oversight |
| **Person-centered** | Person-centered service planning ensuring members and caregivers “voice and choice”  
Provision of culturally-, linguistically-, and disability-competent services with interventions to address healthcare disparities and mitigate inequities  
Regular face-to-face monitoring of member satisfaction, along with access to care and ongoing monitoring of complaints and grievances and targeted satisfaction surveys to assess service quality  
Use of quality of life measures and standard survey –CAHPS  
Active and engaged Enrollee Advisory Committee |
| **Provider Engagement and Partnerships** | Comprehensive network and simplified processes make it easy for members to access services with a meaningful choice of providers  
Leveraged data and advanced analytics equip providers with the data to close gaps in care and support the best possible member health outcomes  
Targeted support for LTSS and physical health providers through each step of the member transition process  
Provider pay for performance program implemented based on selected measures of quality, member satisfaction, outcomes, HEDIS and utilization measures such as ED and |

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Continuous Quality Improvement (philosophy / methodology): MCC of VA’s integrated QM Program promotes continuous quality improvement, uses systematic processes to assess, plan, implement and evaluate QM, and implements performance improvement activities to enhance service delivery and member outcomes. Our plan builds on the foundation of the DMAS approved BHSA QI Plan. We use an enhanced PDSA (Plan Do Study Act) quality improvement model, with an added “Re-measure” task, to promote continuous quality improvement while supporting and enhancing the integration of operational quality and accountability. This approach leads to systems’ evolution and the development of a culture of quality. We use this model in all QM activities to resolve complex or multifaceted issues in a logical and systemic manner and to engage stakeholders in planning efforts. These activities include capturing, trending, and analyzing data for root causes of below-goal performance, then developing and implementing measurable interventions to improve performance and finally monitoring over time to ensure sustained improvement. Executive leadership proactively reviews the results generated by these activities and then integrates into other MCC of VA functional units.

Leadership / Organizational Structure: Our MLTSS Project Director and Senior Medical Director are jointly responsible for meeting all quality program aspects and goals. These individuals model a commitment to quality and the promotion of a culture of quality. Additionally, our strong clinical, operational and network leaders address day-to-day monitoring of member care and services. Our dedicated and well-resourced Quality Department supports the Quality Program with experienced professionals, including Quality and Accreditation Specialists, Data Analysts, Grievance and Appeals Coordinators and Clinical Reviewers.

Quality Committees and Committee Structure: MCC of VA’s QM/QI Committee is responsible for QM/QI program oversight. This interdisciplinary Committee’s membership listed in the table below is drawn from internal operations and external stakeholder representation, and is based on the roles and functions needed to support the Committee’s goals and objectives. At least one QM/QI Committee seat will be reserved for a representative from the Enrollee Advisory Committee. Providers representing physical health, pharmacy, behavioral health, and long-term care services are included.

The QM/QI committee is chaired by the MCC of VA’s Senior Medical Director, and supported administratively by our QM Department. Key responsibilities include: the development and

<table>
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<th>Continuous Measurement of Effectiveness and Outcomes</th>
<th>Advanced clinical analytics with ongoing measurement, evaluation and actions based on clinical and service indicators, such as LTSS-specific quality measures HEDIS, accurate reporting of encounter data, quality studies, and CAHPS performance measures. Established workflows, IT systems and processes to capture, report, analyze and act on DMAS prescribed measures with the goal to improve individual and population health and wellness outcomes.</th>
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<tr>
<td>Transparency and Accountability</td>
<td>QM program components and MOC outcomes are transparent and accountable to the State, members, providers, and other stakeholders; data are posted on websites and distributed using multiple modalities. Positive outcomes are validated by external quality reviews. Enhanced connections to members, through external Member/Family/Advocate Satisfaction Teams (MFAST), supplement member satisfaction and quality of life measures to inform quality improvement activities.</td>
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implementation of quality management and improvement initiatives to support the MOC, accreditation, credentialing, outcomes, appeals and grievances and vendor oversight. The QM/QI Committee provides oversight, direction, and coordination of activities within and between its functional sub-committees and reports its results to the Magellan Health Enterprise Quality Committee.

**MCC of VA’s QM/QI Committee Composition**

<table>
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<tr>
<th>Committee Composition</th>
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<tr>
<td>Senior Medical Director – Physical Health (Chair)</td>
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<tr>
<td>MLTSS Project Director</td>
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<td>Director of Quality Management</td>
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<td>Case Management Manager</td>
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<td>Chief Compliance Officer</td>
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<td>Director of Network Management</td>
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<td>Appeals Coordinator</td>
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<tr>
<td>Network Provider Representatives – Physical, Behavioral, and LTSS</td>
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<tr>
<td>Enrollee Advisory Committee Representative</td>
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**Performance Improvement Framework:** MCC of VA operates a comprehensive performance improvement program with performance measures and performance improvement projects (PIPs). These efforts are an integral part of our overall continuous quality improvement and collaboration efforts with providers. Our performance improvement approach and resulting success align with the DMAS program goals and model of care, and uniquely positions us to partner with DMAS to achieve the program’s goals.

**Quality Management Integrated Data Platform:** Our Integrated Data Platform represents the foundation of our Quality Management Program, and is a centralized system for collecting, integrating, and managing data. This system integrates information across all enterprise subsystems, and delivers comprehensive, meaningful and actionable information across all functional departments and analytical systems.

**Methodology to Analyze Results**

MCC of VA’s processes are built on the use of continuous quality improvement principles and methodologies. Utilization of the Plan, Do, Study, Act (PDSA) model is built into analytical and evaluative processes. As data are collected and analyzed, it is done within the context of continuous identification of possible deficiencies and opportunities for improvements. Staff is trained on PDSA processes and support is available for providers within the network to employ these processes so that all elements of the MOC and the goals for MOC outcomes are continuously evaluated and prioritized interventions are implemented and monitored for sustainability of results. Please see the Model for Improvement diagram below.
Ownership of quality and evaluation of results is the responsibility of all within the MCC of VA organization. Management teams utilize the data, reports and analyses to assess barriers to improvement and to identify interventions in a timely manner. A mature and comprehensive Quality Committee structure, under the direction of the Chief Executive Officer and Chief Medical Director, provides oversight of the evaluation and “acting on results” processes for MOC performance and outcome measurement.

**Oversight Responsibility for Monitoring and Evaluation of MOC Effectiveness:**

While MCC of VA staff, providers and vendors share responsibility for, and contribute to the effectiveness of the MOC, the Administrator and Medical Director have ultimate responsibility for oversight. MCC of VA will comply with DMAS, NCQA, HEDIS, STARS, other Medicaid and Medicare required and agreed upon performance metrics. These metrics will be used to measure the overall effectiveness of the MCC of VA MOC, care coordination program, and UM program. These detailed measures will be outlined within the UM, CC and QI work plans and within the QI program description.

**Processes involved in monitoring and evaluating performance and the delivery of services to Participants:**

The QI Department uses a strategic plan that promotes prioritized goals, including member voice, family involvement, outcomes, and results, race and equity and collaboration and partnerships with the provider community. In addition, QI staff support all committees and provide expertise in continuous quality improvement processes in committee discussions. The QI Department prepares the annual quality documents, which consist of the QI Program Description, the QI/Health Services Work Plan and the QI/Health Services Program Evaluation which include the MOC goals and an evaluation of effectiveness. Recognizing that QI
programs benefit from a breadth of knowledge, resources and expertise, the QI Program has additional corporate support to expand its depth and ability to rapidly respond to issues and be in the forefront with technology.

MCC of VA will communicate to Participants, at a minimum annually, improvements to the MOC. MCC of VA uses its existing communication vehicles to convey MOC improvements and changes.

**Types of Participant Communications:**

- The member handbook is one of the primary vehicles for member orientation to the program. It includes comprehensive, detailed descriptions regarding the MOC programs and services that members and family members are entitled to access. The member handbook is updated at a minimum annually.
- The MCC of VA newsletter is a quarterly newsletter for members and the community that focuses on various health related topics, events and services. The newsletter is used to communicate MOC updates and improvements to members, at least quarterly.
- MCC of VA outreaches to members in the community with a focus on minority and traditionally underserved populations, identifying their needs and informing them about MOC improvements and available health services, educating about improving and maintaining a healthy lifestyle (both mentally and physically), providing information and connecting them to additional community resources.
- Community sales and marketing representatives engage these populations within their respective communities in a culturally sensitive and appropriate manner.
- Community based member outreach meetings are held four times per year. These meetings enable MCC of VA to communicate in person with members, their families, providers and other stakeholders to obtain feedback from them about the system of care and how the system and services can be improved. MCC of VA uses these forums to communicate MOC enhancements and outcomes.

In addition to the diverse array of listed member communication options, MCC of VA offers our website as a vehicle for communicating program improvements.

**Communication with Providers:**

In addition, MCC of VA evaluates the impact of the MOC annually and will share its aggregate findings with the provider community through its newsletter. MCC of VA communicates other improvements and changes more frequently depending upon the nature of the findings and the impact to the members and or the provider network.

**Communications among MCC of VA Staff, the ICT, and Providers:**

When working with the ICT, providers and MCC of VA staff may use the telephone, secure email or mail to communicate. They also meet face to face with some providers in members’ homes, at providers’ offices, and for ICT meetings.

**Communication with MCC of VA Staff:**

MCC of VA adopts a variety of methods to communicate internally to staff about improvements to the MOC. These include but are not limited to the following strategies:

- **MCC of VA meetings:** MCC of VA departmental staff meetings occur at least monthly.
These meetings are facilitated by the senior leader of each department and are used to provide updates on MOC successes and changes, performance improvement projects and other operational topics

- **ICT weekly meetings:** ICT members meet weekly to discuss clinical issues, identify other issues, and develop action plans

- **“All Employee” meetings:** MCC of VA hosts “All Employee” meetings at least twice per year. These meetings are attended by line staff through senior leadership and provide the opportunity to showcase progress and success stories across the entire organization

- **Annual Program Evaluation:** The Annual Program Evaluation analyzes the effectiveness and efficacy of MCC of VA’s MOC by continuously utilizing evidenced-based monitoring and measurement of clinical and service performance indicators, quality of care and quality of service issues, member complaints, and timeliness of services delivered to members. The annual evaluation identifies problems and/or concerns that may limit a member’s equitable access to health care and provides recommendations for improvement

- **Other:** MCC of VA uses emails, training alerts, employee newsletters and its internal intranet communication site to communicate MOC changes and improvements

**Communication with State and Federal Agencies:**

MCC of VA staff members are also in regular contact with the DMAS through individual telephone and group conference calls, email (including secure email when discussing member information), face-to-face meetings and trainings, and through electronic submission of reports. MCC of VA uses this same approach with the Centers for Medicare and Medicaid Services (CMS) to communicate improvements to the MOC.

**Communication with Family, Members and the Community:**

Each quarter, MCC of VA hosts community based member outreach meetings to get input from members, family members, providers, advocates, and others in the community. These venues are also used to communicate vital information to key stakeholders which include the community at large. MCC of VA uses these meetings as an opportunity to communicate MOC improvements to the community at large. Senior staff from MCC of VA are in attendance to share information, hear input, recommendations, learn about any barriers to service and brainstorm solutions for overcoming those barriers.

**Distributing Quality Information:**

MCC of VA organizes and conducts regular feedback sessions, forums, and round-table events in the community for members and their families.

These events serve as another primary conduit for the dissemination of MOC enhancements, quality information, including the annual quality work plan, performance improvement projects, and satisfaction surveys. Other topics of importance and interest to the community at large are also addressed. MCC of VA allots time for feedback on specific programs and the overall QI program.