VALUEOPTIONS®
LOUISIANA

August 11, 2011

Ms. Mary Fuentes
Department of Health and Hospitals
Division of Contracts and Procurement Support
628 N 4th Street, 5th Floor
Baton Rouge, LA 70802

Dear Ms. Fuentes:

On behalf of ValueOptions of Louisiana, Inc., a subsidiary of ValueOptions, Inc., I respectfully submit our proposal in response to Request for Proposals #305PUR-DHHRFP-SMO-OBH, for the Statewide Management Organization for the Louisiana Behavioral Health Partnership.

Over the past three years, it has truly been our pleasure to get to know the Louisiana's stakeholders who are so invested in improving services for those with behavioral health needs. ValueOptions has more than 30 years of experience partnering with public sector programs across the nation to establish Systems of Care for children and adults. We are fully prepared to begin program implementation and transition on day one of contract award to ensure that all program requirements are ready on March 1, 2012.

ValueOptions offers Louisiana a customized behavioral health managed care program that meets and exceeds the State's current goals and objectives. We look forward to partnering with DHH-OBH and the SCoC SGB as you transform your System of Care for children and families. Our proposal describes our utilization and care management programs, which focuses on expanding and building community based services and decreasing the reliance on emergency rooms as the primary point of access for members.

Thank you for the opportunity to participate in your procurement process. As noted in the proposal, I will serve as ValueOptions of Louisiana, Inc.'s point of contact should you have any questions or require any additional information about our proposal.

Sincerely,

Anna L Sever

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10. Provider Maps
11. Provider Letters of Intent
12. Sample Provider Profiles
13. Implementation Workflows
14. Draft All hazards Plan
15. Implementation Plan
16. Job Descriptions
17. Resumes
18. Draft Outreach Plan, Draft Cultural Competency Plan, Sample Reports, Warmline Satisfaction Survey Report, Draft All Hazards Plan
19. Kansas Draft Audit
20. New Mexico, Pennsylvania, Arkansas Reports
21. Kansas, Maryland, and Kansas IBNR Reports
22. Maryland Budget Tracking
23. Heyward Donigan Certification
24. Fraud and Abuse Experience and Fraud and Abuse Policy and Procedure
25. InvestClaim Solution

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) is the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

a. The introductory section should contain summary information about the Proposer's organization. This section should state Proposer's knowledge and understanding of the needs and objectives of the Louisiana BH services program for children and adults and the CSoC for children, as related to the scope of this RFP. It should further cite its ability to satisfy provisions of the RFP. This section should discuss how the Proposer will define success at the end of years 1 and 2 of the contract by describing milestones it expects to achieve, specifically addressing milestones for network development. The Proposer should address separately milestones for (1) the CSoC, (2) management of services for other children not eligible for the CSoC, and (3) adults with SMI and/or addictive disorders.

UNDERSTANDING THE NEEDS AND OBJECTIVES OF LOUISIANA

To better understand the needs of your region, ValueOptions met individually with agency staff, providers, advocates and other stakeholders in Louisiana over the past three years. We have a keen insight into DHH-OBH's overall vision and direction for the Louisiana Behavioral Health Partnership. Our knowledge and awareness of the vibrant and diverse Louisiana communities, plus our behavioral health expertise make us the preferred collaborative partner for DHH-OBH to achieve the desired transformation of behavioral health services. We recognize that DHH-OBH is looking for a partner who will provide a special focus on meeting the behavioral health needs of Louisianans, and develop a truly community-based system of care.

An independent review of one of our ValueOptions run statewide programs by the actuarial firm of Milliman, Inc. concluded that ValueOptions helped the State avoid between **$734 million and $883 million** in spending from 1996 to 2010, resulting in a return on investment of $2.00:1 to $2.40:1.

Our missions align: ValueOptions is a behavioral health company singularly focused on helping people live their lives to the fullest potential. We are the undisputed leader in helping people achieve a healthier life by addressing the thoughts, feelings, and behaviors that are central to good health. Our goal as your Statewide Management Organization (SMO) is to bring quality, stability, and access to Members, and creating a behavioral health system focused on enhancing and sustaining the incredible resilience of Louisianans. Our detailed management plan will result in:

- increased access to community based care
- expansion of the network and implementation and adherence to evidence-based practices
- decrease in the reliance on Emergency Room services
- decrease in recidivism in inpatient care
- mobilize the recovery and resiliency movement to support the transformation of the system of care for adults and children
- consistent and outcome-focused data measurement and system improvement
- maximization of federal funding sources for behavioral health services in Louisiana.

ORGANIZATION SUMMARY

As the largest, privately-held behavioral health care company in the nation, we offer the State of Louisiana an impressive track record of learning while doing, and a true commitment to your public

sector Members and service to our State clients. ValueOptions manages services for 24 million individuals through contracts with federal, state, and county agencies, and with health plans and employers.

We currently serve public and private sector contracts in *all* 50 states. Providing services to public sector members is—and always has been—the largest segment of our business. Today we operate public sector programs and contracts in 14 states, including Arkansas, California, Colorado, Connecticut, Florida, Illinois, Kansas, Maryland, Massachusetts, New York, North Carolina, Pennsylvania, Tennessee and Texas.

Every state and local government has unique behavioral health care priorities, delivery-system challenges and program goals, as does Louisiana. ValueOptions tailors program strategies and administrative approaches to the target populations and management vision of each client. Our experience, technological innovations, and flexible program design enable us to partner with public sector entities to deliver cost-effective behavioral health care programs that are responsive to members and families. Louisiana will receive the same.

Our Proven Approach for State Partners...

ValueOptions maximizes results while keeping costs within each client's funding parameters. Though our contracts vary from state to state, they often feature common strategies to:

- engage members and families in program oversight, design and implementation
- identify and replicate evidence-based practices (EBPs) and emerging best practices
- facilitate collaboration across multiple state agencies
- monitor improvements and document outcomes
- create incentives for provider organizations, which enhances care
- process claims electronically with average turnaround times of one week or less
- expand network capacity
- transform the system of care by focusing on recovery, resiliency and person-centered planning in the community

Meaningful Results ...

Through innovation and the use of ValueOptions' state-of-the-art technology, our government partners have integrated services more effectively across agencies and programs. Our programs have achieved:

- increased access to services in the communities
- expanded involvement and satisfaction of members and advocates
- savings that have been reinvested to transform the behavioral health care delivery system
- member self-management, recovery and resiliency

Leading Innovation ...

As more states began to braid Medicaid dollars with other funding streams, such as mental health, child welfare, substance abuse and juvenile justice, ValueOptions' Braided Funding℠ applied innovative technology to bring increased efficiency and effective monitoring. With this technology, clients are able to track dollars across agencies and programs, and they realize savings from five to 10 percent of total expenditures.

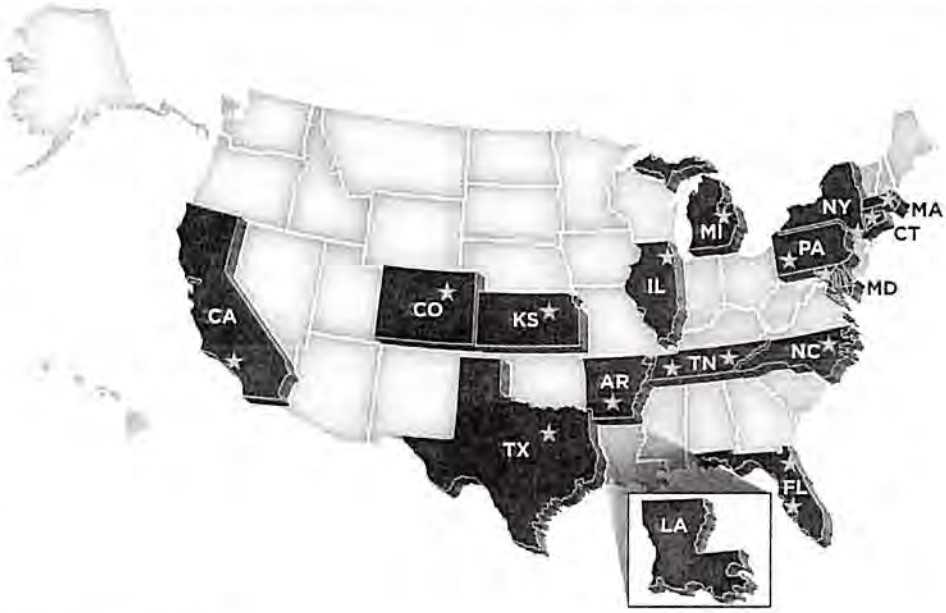
Louisiana will receive unparalleled industry knowledge regarding behavioral health issues and plan management, provided by our staff of 2,711. More than 1,000 of our staff members are devoted to public sector behavioral health and substance abuse management contracts.

Capable Structure to Fulfill Requirements of this Contract

ValueOptions of Louisiana (VO-LA) will have a service center in Baton Rouge, with full accountability for this contract. We will structure our organization to deliver results, be accountable to the State and DHH-OBH, identify priorities of the program, and design changes to improve flexibility and innovation in service delivery. Louisianans will experience the best local care, from an organization with national experience.

ValueOptions holds the State's commitment to provide a responsive public health system that is both effective and efficient in the highest regard. As locally-based company with a singular business orientation, we have the autonomy and flexibility to best respond to the different needs of the Louisiana Behavioral Health Partnership member agencies, and the Members, families, and communities they serve.

ValueOptions is built on Local and National Experience



ValueOptions Understands Louisiana

The Louisiana Medicaid program provides health care coverage for 27 percent of Louisiana's residents— more than 1.2 million people. The system is overly reliant on inpatient hospitalization for mental health services, as evidenced by the Disproportionate Share Hospital funding (DSH), historical spending, and inpatient services driving 50 percent of the behavioral health expenditures. The system does not maximize Medicaid resources for mental health and substance abuse services. Not surprisingly, Louisiana's rate of avoidable hospitalization is among the highest in the country, leading to even higher costs to taxpayers. Currently, some services that are Medicaid covered services are purchased using general funds, and safety net providers are not maximizing their ability to bill Medicaid. This will begin to change as the new State Plan Amendments are approved and substance abuse services become part of the Medicaid State Plan. Finally, as 2014 approaches and health care reform goes into effect—potentially increasing the number of Medicaid-eligible individuals by 30 to 40 percent.

Louisiana must maximize federal funding for services instead of relying on ever-dwindling state dollars and direct grants to local Human Service Districts (HSDs) and private providers.

The current national fiscal crisis has heightened the need to redirect Members to community-based recovery and resiliency services, and re-engage with private sector providers. While some Emergency Rooms (ERs) in the State have developed crisis units to address ER overcrowding, Member recidivism is still high because of the lack of community-based recovery services. Consistently, Louisiana inpatient providers have reported to us that part of the challenge in reducing recidivism rates is providing Members with "someone to call" who can assist them with redirecting or placement following discharge. The absence of community-based services is especially problematic for those Members who return to their homes in rural communities. Overreliance on the ER and subsequent hospitalization can also be attributed to the lack of utilization management and review, and the lack of community-focused discharge planning. Developing strategies to address these issues will ensure that care is delivered at the right time in the right setting. Too many resources purchase institutional care for adults and children, while too few community-based resources develop and enhance EBPs.

One of the challenges in meeting Louisiana's transformation goals is to collect data regarding the services delivered. The data that has been collected, which is often limited or inconsistent across HSDs, does not adequately represent the services purchased or delivered, nor the outcomes of those services. Measuring key quality indicators, such as HEDIS, are thwarted by the lack of Member-level data throughout the system, including hospitalization and community-based care data. Often, care is handled on a cost reimbursement basis through the DSHs. ValueOptions is ready and able to assist as the State transforms mental health delivery into a community-based model of care.

Services provided by HSDs vary widely based on local millage taxes (such as in Jefferson Parish), utilization of billing, the influx of post-Katrina grants, and personnel and operations. In New Orleans, one HSD member stated that, "the system has been enabled with general funds. Individuals do not even apply for Medicaid." Consequently, clinics and providers serve Members with general funds. Some of the HSDs have implemented EBPs, but only among the five fully-formed HSDs, now referred to as Local Governing Entities (LGE) Districts/Authorities. The five districts where the LGEs are not fully operational are challenged by their rural settings and coordinating disparate Parish needs into one collective organization. ValueOptions' staff has met with the LGEs for the past three years, and we have learned that despite state reporting requirements, a recurring concern has been the lack of comparable data. Like that collected from the LGEs, data collected from substance abuse residential providers is minimal and does not adequately describe the services purchased or the individuals served, much less the effectiveness or quality of the services.

As is evident from our Letters of Support in **Attachment 1**, we are committed to supporting Louisiana's vision for EBPs that are consistent across all providers, and the need for expanding the network of providers across the entire state, to serve all of those in need. The closing of many state-run clinics provides an opportunity to bring private providers into the Medicaid delivery system. It is essential that Louisiana leverage the resources of private providers to meet the needs of Members with behavioral health needs, and to ensure that services are outcome and data driven, person-centered, and recovery-focused. With this procurement, the State has the opportunity to expand the

provider network by enabling private CMHCs to bill Medicaid under clear utilization management standards.

Natural Disasters

Recent natural disasters have taken attention away from transforming the behavioral health delivery system, to focus instead on the "crisis at hand." Evacuating Members from psychiatric inpatient settings has been a challenge, as evidenced by some Members appearing at special needs shelters and private inpatient facilities. The issue during Hurricane Gustav was finding beds for individuals, particularly in inpatient addiction treatment. While hospitals have "at risk" registries and crisis information management software (Web Emergency Operations Center) to trace admissions related to evacuations, there is no comparable statewide system for outpatient care and services.[1] The evacuations after Hurricane Katrina, when a half million people moved to the northern part of the state, heightened the already challenging issue of rural access to services. As is often the case in rural areas, the lack of transportation became a major barrier to services. Also, rural areas in the state often have the highest illiteracy rates, so getting information to individuals became an even greater challenge. The final hurdle related to these disasters was the "repatriation" of Members who had moved out of their home community or even out of state.

VO-LA provides a single system for all inpatient and outpatient Member data that can interface with other systems and facilitate Member service coordination and tracking.

Children's System of Care

The Mercer report, *"Coordinated System of Care Report to the Commission on Streamlining Government, March 4, 2010,"* clearly delineated the need for a coordinated system of care for youth at highest risk of hospital admissions, out-of-home care, and incarceration. A successful system of care includes:

- outreach to identify low-level and early disturbances in critical areas of a child's development
- identification of needs across all ranges
- easy access to brief, effective services
- intensive care for children with more serious needs

Much has actually been accomplished towards a System of Care, such as CASSP several years ago, and LA-Y.E.S. This Coordinated System of Care (CSoC) represents a true, system-wide change in the delivery of services, and not merely a pilot project (as one provider stated, "I am sure there are file cabinets of all the CASSP material we used and then discarded.") or training effort. Still, the child mental health system must be designed to address more than just the most acute disturbances. School-based health centers in places such as Sabine and 69 other sites have become the main form of behavioral health services for children, and have expanded the use of telepsychiatry to reach out to even more rural areas. While each of the child-serving systems (i.e., child welfare, mental health,

ValueOptions' Telehealth program in Florida has demonstrated a 300% increase in services, a 200% increase in member utilization, and 100% provider satisfaction with the program.

[1] Pandya, Anand. (Spring 2011). "Preparing for disasters." NAMI Advocate, Vol. 9 No. 2., page 9.

education, juvenile justice, schools) offers important resources for children, as long as each system's resources and services are disconnected from the others they will remain duplicative, uncoordinated and ultimately, unsuccessful.

The current delivery system is also fragmented across Parishes. The system has had little accountability or a statewide measurement process to demonstrate it is delivering effective and efficient care. Louisiana has a tremendous opportunity to improve the health of its system and its Members. Currently, too many resources purchase expensive, institutionally-based care for a relatively small number of children, too few resources purchase community-based care, and most children in need of care receive few or no services.

ValueOptions' Experience – The Right Answer for Louisiana Kids

ValueOptions has the technology and clinical acumen to support a local system of care and to blend funding sources across child welfare, mental health, education and juvenile justice. We will be the DHH-OBH's collaborative partner to implement consistent:

- methods to support families and Members in accessing community based services
- clinically-based assessments and evaluations
- measures of improvement, progress and outcomes
- clinically-sound standards for all levels of care
- consistent processes for accessing services outside of the child's Parish of residence
- uniform methods of maximizing funds that are available to serve children with emotional disturbances

Children with emotional disturbances need high quality effective services early in their development. For most children in Louisiana, their parents are their best helpers, best advocates and best resources. The work now under the Coordinated System of Care under the CSoC Governance Board puts Louisiana well on its way to giving families access to multiple child-serving agencies, in an integrated manner that best meets the needs of their child. No longer will the caregivers of children with the most complex needs be alone to manage their child's care, or be forced to place their child into the justice system, or even child welfare system, to receive the level of needed behavioral health services

Recovery and Resiliency

By focusing on resilience, strength, and individual goals, VO-LA provides Members practical, concrete tools and the opportunity to use them. Empowering Members to design and direct their own recovery and resiliency increases their buy-in; greater Member participation ensues, which positively impacts individual recovery and resiliency, and inspires hope for the future. Recovery from mental illness requires many elements, including "developing hope, forging a new ability to self-manage, and pursuing meaningful life activities."[2] VO-LA will assist the State in managing behavioral health resources while also ensuring that Members are driving the treatment planning

[2] Drake, R.E., Becker, D.R., Bond, G.R. & Mueser, K.T. (2003). A process analysis of integrated and non-integrated approaches to supported employment. Journal of Vocational Rehabilitation, 18(1), 51-58.

process. Life is not about treatment for a disability; rather it is about developing strengths, recovering, and achieving the highest quality of life

Although Louisianans have experienced ongoing change—changes in services driven by natural disasters, changing leadership in the DHH-OBH, the offices of MH and SA merging—we have found that they are hopeful that the system will improve. We understand that Louisianans are deeply committed to their communities and state. To quote one Member, "it is our area—we stay." As was stated in the NAMI ADVOCATE, "Disasters may expose some vulnerability but they also are opportunities to show strength. Resilience is borne out of disasters of any size." Louisianans, more than most, have shown resilience. Raised in a culture of resilience and self-management, Louisianans have not allowed the effects of these events to deter them from their path to recovery.

Commitment to Evidenced-based Practices and Quality Management

Many opportunities exist to monitor and implement clinically proven services, and to measure the quality of the services that are delivered. Some Parishes (Capitol and Florida, for example) have taken on specific efforts related to EBPs. Louisianans have a tremendous opportunity to measure outcomes and fidelity to those practices. We will focus on person-centered planning with the Member's own words, and we will assist with emphasizing community integration as verified through clinical review processes. Our goal is to work with the DHH-OBH to continue transforming the system from a traditional, medically-based model to one that truly embraces natural supports and individualized services. The purpose is simple—to yield better outcomes for individuals with behavioral health care needs, and to develop stronger providers in the community. Our Quality Management program will be based on improving access to, and coordination of, a quality-focused, behavioral health system of care:

- ensuring prevention, early intervention, recovery and wellness -- we understand that the needs of Members are beyond "Medicaid services," and we are experts in supporting Members' complete behavioral, and social needs
- working with Primary Care Providers (PCPs) and behavioral health providers to continuously improve the quality and coordination of the services they provide
- removing any and all barriers to improved behavioral health and co-morbid outcomes for Members

VO-LA recognizes the value of EBPs across the delivery system, particularly in children's behavioral health care, where differing treatment modalities have been adopted and used by a variety of practitioners but not always resulting in the best outcomes for Louisiana children and families. We support states and providers in improving the design and delivery of their services, consistent with EBPs. ValueOptions has vast experience in improving the design and delivery of their services consistent with EBPs, as documented using fidelity measures. We will assist the DHH-OBH in designing and expanding services that increase access to community-based care. Our programs have successfully implemented telepsychiatry to improve access to care, developed comprehensive training and educational opportunities for providers that encourage the use of EBPs, and increased provider access to Achieve Solutions, ValueOptions' online educational resource for members. Achieve Solutions customized information on a host of topics that can support recovery and resiliency in the hands of Members and/or their families.

VALUEOPTIONS, THE COMPANY THAT DELIVERS

We have made it our mission to learn the unique needs and service delivery challenges in Louisiana. We have the desire, knowledge, and technology to help the State maximize resources to assist children and adults in assuming increasing control over their lives, and becoming active and contributing members of their communities. We will assist the DHH-OBH in transforming the system from a state-run clinic and institutional delivery model to a quality controlled system that brings private providers back into the Medicaid system while focusing on outcomes, recovery and resiliency.

VO-LA Design

VO-LA has designed the SMO program to be as effective and Member/child-centered as possible for each Louisiana family, and the program administration to be as cost efficient as possible. We anticipate hiring more than 130 Louisianans—in Baton Rouge alone—to serve in a variety of clinical and access capacities. Our primary Service Center will be in Baton Rouge. We will have regional teams of Provider Relations staff and clinicians assigned to cover the various regions in the State. Having service staff live and work in their assigned communities affords us the ability to take the community's "pulse" by monitoring needs. All SMO activities are coordinated and supported by our integrated IT system. CONNECTS, our comprehensive management information system, supports managed behavioral health programs from the initial Member contact through the claims adjudication and payment processes, in conjunction with the full range of management and utilization reporting requirements.

Our approach provides quick access to VO-LA representatives, which providers, advocates, and stakeholders have described as being vitally needed. VO-LA will also attend local meetings and participate on planning councils and any other organizations requested by the DHH-OBH. In addition, our local Louisiana quality committees (described in the table below) ensure that clinical practices represent the best of both worlds—Louisiana and National EBPs—are representative of providers, families and consumers, and are the primary venue for ongoing feedback and quality improvement.

Quality Committees

Committee	Membership	Responsibilities
Quality Assurance/ Performance Improvement (QA/PI) Committee	• CMO (co-chair) • QM Administrator (co-Chair)Members • families • CSoC representatives • DHH-OBH representatives NAMI • Outreach Recovery Administrator	Responsible for accountability to the state agency and to Members, family members, advocates, providers, stakeholders and the general public; focuses on both internal operations and the functioning of the entire behavioral health care delivery system; primary format for seeking and incorporating the ideas and perspectives of all those impacted by services. All hazards plan review.

Committee	Membership	Responsibilities
Member and Family Advisory Committee	• Outreach Recovery Administrator (chair) • CEO • Members/family members • Member advocates community stakeholders and representatives • WAA and FSO representatives	Advises the Program on all aspects of the BHO; quality of care, peer support services and network needs, Member communications, recovery and resiliency, system performance, and treatment guidelines; focuses on issues relevant to adult and youth Members. Create, promote, find and develop opportunities for Members in their respective communities to achieve their highest potential.
Peer Review/Clinical Advisory Committee	• CMO(chair) • Representatives from Clinical, Quality Management and Provider Relations • providers • Members	Advises on clinical and administrative issues impacting the provider network and behavioral health system; reviews utilization data to identify under- and over-utilization.
Quality of Care Committee	• CMO (chair) • State Medicaid Behavioral Health Director • representatives from Quality, Clinical and Provider relations • CMHCs private and public • appropriately licensed practitioners	Reviews quality of care concerns within the provider network to determine if care has been provided according to standard behavioral health care practices; evaluates trends and recommends performance improvement plans and system needs.
Regional QA/PI Committee	In each LGE (same membership as QA/PI Committee)	Responsible for accountability to the state agency and to Members, family members, advocates, providers, stakeholders and the general public in each LGE; focuses on both internal operations and the functioning of the regional behavioral health care delivery system; primary format for seeking and incorporating the ideas and perspectives of all those impacted by services.
Corporate Compliance Committee	• Compliance Administrator (chair) • CFO (chair)	Reviews compliance issues including contractual, audit and/or other financial issues.

Committee	Membership	Responsibilities
	• CEO • UR Administrator • QM Administrator and Network Management Administrator • stakeholder representatives	Also makes recommendations to the DHH-OBH on issues related to fraud and abuse.
Youth in Transition Subcommittee	• Regional CCMs Team • WAA • FSO • local schools • DCF • OJJ • families and children	Subcommittee to the Regional QA/PI Committee.

We will provide our proven clinical and technology solutions to ensure that financial resources are maximized when claiming federal dollars so that State general funds are used last.

Our advanced technological infrastructure minimizes the "silo effect" of separate state agencies or programs operating independently of each other.

In addition, we will continue to support family and peer-run organizations in their efforts to promote recovery and Member-directed services via Targeted Technical Assistance Training. We propose the following targeted methods for DHH-OBH consideration:

1. *Peer Specialists Engagement Program and Peer Services Micro-Grant Program*

Peer Specialists embedded within our clinical and Member services departments, and our Outreach and Recovery Administrator will provide training, technical assistance, and support to providers working to embrace a recovery-driven system of care. Peer Specialists will not be direct service providers, but instead will foster the visibility of Member/family recovery and resiliency. In addition, they will support the further development and refinement of peer-run organizations (PROs) and the Louisiana peer-led recovery movement. By hiring individuals with direct Louisiana experience to support the Louisiana Behavioral Health Partnership Membership, we are empowering both the Members we serve and the individuals we hire. Given the historical peer certification training that has been undertaken in Louisiana, we are confident in our trained peers, but we will also provide them with additional training to prepare them to respond to Member and provider inquiries as part of the SMO.

Additionally, our Peer and Family Specialists will work cross-departmentally on internal and external initiatives to improve awareness and integration of recovery within our internal framework and external provider system initiatives. We have developed a comprehensive framework in which Peer Specialists can fully support the Members we serve within CMS guidelines.

2. *Peer Services Micro-Grant*

A unique feature of our program is the flexibility to support the Peer Run Organizations and the Louisiana peer-led recovery movement through dedicated Micro-Grant funding. The Director of Recovery and Resiliency will oversee these grants and provide technical assistance and support to

the programs. The Micro-Grant funding will be awarded to Peer Run Organizations and/or providers seeking to enhance community-based, peer-directed services, and will act as seed funding for new programming.

3. Family Service Organization (FSO) Micro-Grant

We will provide grants to regional FSOs to enhance and expand family support opportunities, including the use of Family Peer Specialists in ER diversion activities.

VALUEOPTIONS MEETS CLIENTS' NEEDS

Our national experience proves our ability to perform the SMO tasks and to be responsive to the needs of the DHH-OBH and Members associated with this contract. The following are examples of our success in cost savings, and system changes to reduce discharge delays for children receiving inpatient treatment.

Reducing Discharge Delays for Youth Receiving Inpatient Behavioral Health Treatment

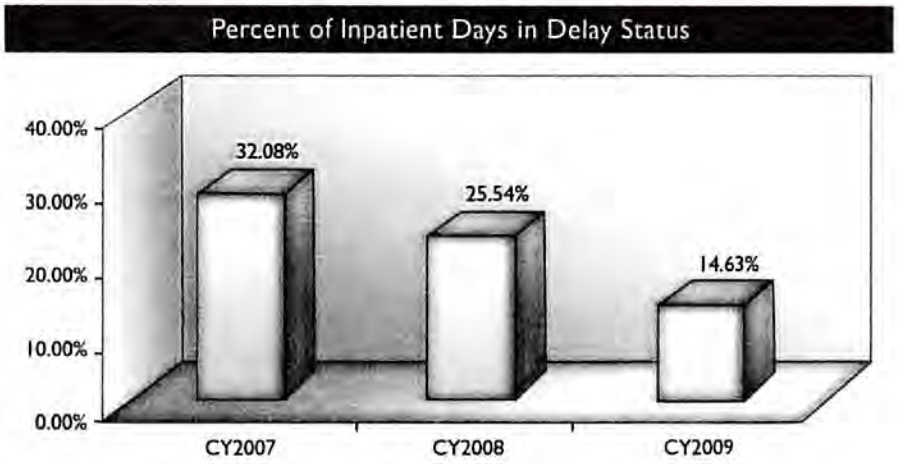
In 2008, Connecticut Behavioral Health Partnership (CT BHP) developed a quality improvement activity to reduce discharge delays (e.g. days youth remain in the hospital without medical necessity) for youth receiving inpatient behavioral health treatment.

In 2008, the discharge delays for CT BHP decreased to 5,043 for the year, which represents a 50.4 percent decrease from our initial goal established in 2008.

Although the number of discharge delay days decreased significantly from 2008 to 2009, this activity continued to be a major focus for CT BHP throughout 2009 because we realized its direct impact on cost and quality of care. In 2009 our goal was to reduce the discharge delays days to no more than 7,492 for the year (a 24.8 percent decrease from the 2008 goal), while ensuring the acute average length of stay did not increase more than three percent from the established baseline (12.92 days). CT BHP developed a number of key initiatives to assist with meeting this goal, including:

- a micro/macro focus on discharge delay at the case level and provider level
- weekly discharge delay rounds with participation from the Department of Children and Families (DCF) to review each case
- heightened intensity of utilization management approaches
- onsite review at targeted facilities
- increased area office Behavioral Health Program Director/Area Resource Group responsiveness upon contact by CT BHP clinical staff if DCF action warranted expediting a discharge delay case

The eight affiliated hospitals and our staff not only met our 2009 goal but also surpassed it. And, there was no increase in the 2009 acute average length of stay or readmission rate. The graph illustrates our success.



Inpatient days decreased from 32.08% to 14.63% in two years.

System of Care in Maryland

ValueOptions Maryland upholds the Maryland Public Mental Health System's philosophy of individual choice in treatment. We help ensure that individual services are provided at the least intensive level of care necessary for the safe and effective treatment of Members and their families. We also help ensure the continuum of care is a fluid treatment pathway, where individuals may enter treatment at any level and be moved to more- or less-intensive settings or levels of care as their changing clinical needs require.

We successfully implemented and managed the Psychiatric Residential Treatment Facility (PRTF) waiver, also known as the "RTC waiver." This program utilizes a wrap-around approach to provide mental health and medical services to youth with serious mental health needs. A Care Management Entity (CME) develops a plan of care that enables the youth to receive services and support in the community rather than in a residential treatment center. The youth can receive services for up to two years. Having enrolled the first participant in late 2009, ValueOptions has assisted with growing the program participation to more than 120 participants as of year-end 2010.

Developed Coordinated System of Care (CSoC)

We were the first MBHO to work with the State of New Jersey, and we assisted the State in developing a CSoC based on a care management model that emphasized community based care and wraparound services. The New Jersey CSoC originally contracted with ValueOptions as the Contracted Service Administrator (CSA), and we provided the following functions:

- uniform screening of children through a single point of access
- child assessments using standardized assessment tools
- child referrals to the appropriate level of care
- care coordination or child referrals for those children with complex, multi-system involvement to designated non-profit care management organizations (CMOs)
- utilization management methodologies that ensured rapid access to services and emphasized provider accountability to treatment goals and objectives
- provider network oversight and training, including CMOs, community agencies, family support organizations, and youth partnerships

Massachusetts Behavioral Health Partnership (MBHP)

ValueOptions' MBHP manages mental health and substance abuse services for a culturally and regionally diverse population of approximately 380,000 adults and children. MBHP also provides profiling, quality management and educational services to PCPs. Services for members and work with providers is carried out by regionally-based, integrated teams with the support of Boston-based clinical, network, quality, reporting, claims and customer services teams. Three levels of care management services are provided to members according to their needs. MBHP enables information to be shared between PCPs and behavioral health providers to improve coordination and integration of care. Extensive reporting and quality improvement activities are carried out with state agencies, providers and consumer groups. To assist the Commonwealth, MBHP serves as the coordinating entity for numerous statewide initiatives, including, for example, a recent redesign and re-procurement of the Commonwealth's emergency services programs. These initiatives frequently include the Departments of Mental Health, Public Health, Children and Families, Youth Services and Social Services. This contract creates a risk-sharing relationship between the Commonwealth and MBHP that incorporates performance-based incentives.

A study showed that the MBHP Intensive Clinical Management program resulted in:

- 36% reduction in ER visits
- 72% reduction in inpatient hospitalizations
- 45% reduction in average total medical cost

ValueOptions' Braided Funding

ValueOptions will work with the DHH-OBH to identify funding sources, and any current or pending funding gaps. We will develop customized processes and workflows to streamline program administration, and to ensure funds are appropriately applied. To help assess program effectiveness, we will work with you to create meaningful reports and feedback mechanisms that assess program outcomes and effectiveness. Using our Braided Funding system, Louisiana can track state, local, and federal dollars across multiple agencies and programs, and more importantly, improve access to services, enhance the quality of care, and make more efficient use of public funds.

Braided Funding Success

ValueOptions' Braided Funding system is field-tested and proven. We have worked closely with our public sector state clients to customize our Braided Funding system to meet unique challenges found in each state or region. Below we briefly describe program achievements.

- In support of the Dallas, Texas NorthSTAR Medicaid program, our Braided Funding system manages 15 federal, state, and local funding streams for indigent members. Working collectively with the various stakeholders, we have streamlined agency policies and eligibility criteria to save approximately $60 million in Medicaid funds over the past 10 years. This successful program offers enrollees a comprehensive benefit package that dramatically improves their access to care and saves them from having to switch providers when their Medicaid eligibility status changes.
- In Kansas, Braided Funding has helped the Department of Social and Rehabilitations Services save $5 million since 2007, and has enhanced enrollee access to effective substance abuse treatment services throughout the state.

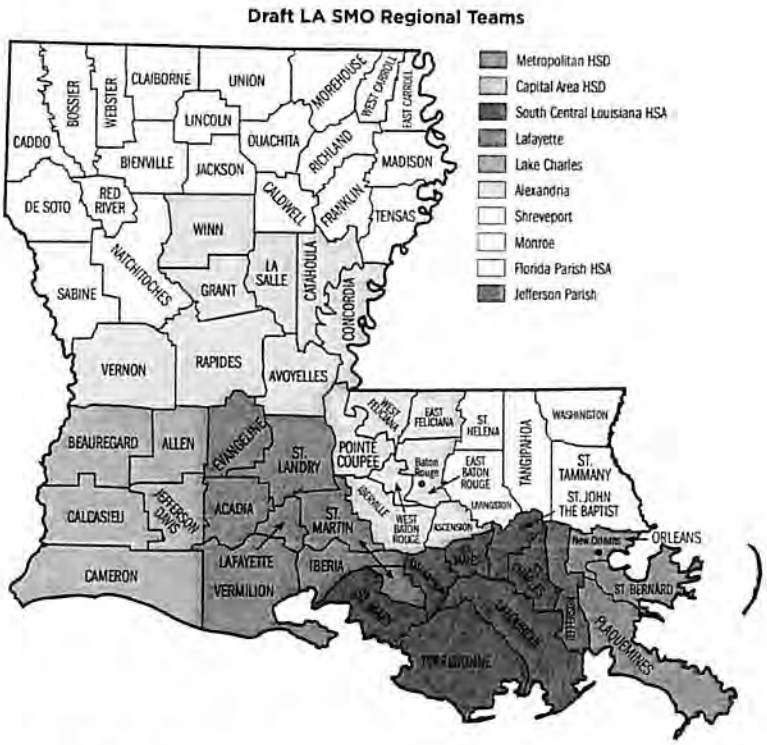
- In Connecticut, our Braided Funding system facilitates collaboration between local, state, and federal Medicaid, mental health, child welfare, substance abuse, and juvenile justice agencies to reduce cost, and improve program efficiency and enrollee outcomes.
- In Maryland, we provide behavioral health services for Medicaid and uninsured individuals through our contract with the Public Mental Health/Mental Hygiene Administration. We use our Braided Funding system to manage member services and administer claims processing for more than 800,000 enrollees.
- In New Jersey, the state contracted with us to coordinate funding streams and promote individualized service planning at the local level for Medicaid-eligible children. Our clinical staff, authorized state agency staff, and community providers accessed our secure customized systems to create an individualized electronic medical record for each child.

In FY 2008, the proportion of residential spending for children was reduced by 10 percent, while the proportion of outpatient spending increased by nine (9) percent. This data indicates an increase in community-based alternatives for children in New Mexico.

- In New Mexico, our Braided Funding filtered through 17 different behavioral health programs to find the most cost-effective program for each enrollee. This initiative saved the state $9 million over three years.
- In Arizona, we supported the Maricopa County Regional Behavioral Health Authority by integrating 18 funding streams to form a comprehensive, cost effective behavioral health system.

Our Regional Team Approach in Louisiana

ValueOptions understands that each Member's experience is unique. This experience must be understood within the context of the community where the Member lives. To that end, our SMO staff is organized into 10 Regional Teams to correspond with the 10 geographic regions of the state. Our Regional Teams establish a local presence and a level of transparency that enables us to gather feedback and information from interested stakeholders, and to ensure that the perceptions and data analysis are viewed through multiple lenses. We will include feedback from our state agency partners, regional/local staff from the LGE/Districts/Authorities, Local Wraparound Agencies, Local Family Support Organizations,



VO-LA will deploy Regional Teams in each LGE in Louisiana.

Local Education Agencies, and providers, as well as other local resources such as vocational, housing, and social support systems. And, we will collaborate with community providers to develop performance initiatives to grade their performance, review provider profile information, and offer training and education on a number of topics. In other states, this structure has enabled us to support and improve our provider relationships, establish ongoing communication and data sharing, and develop innovative programs that enhance a Member's long-term recovery.

SUCCESS IN YEARS ONE AND TWO (MILESTONES) - CSOC

Our goal is to assist Louisiana in developing systems of care for children with serious emotional disturbance (SED) and their families. We value parents and we want to ensure that services are individualized, coordinated and integrated to meet the family's cultural, linguistic and community needs. No matter the point of access, parents must be involved in the assessment planning, implementation and evaluation of the treatment necessary to support their child and family.

CSoC NETWORK DEVELOPMENT PLAN

Our approach to network development for the CSoC will:

- reduce out-of-home placements of youth with significant behavioral health challenges
- provide effective utilization of state resources and federal funding for services supporting at-risk youth
- improve school, clinical and community outcomes for at-risk youth

Following is a detailed plan with milestones to address the Coordinated System of Care network.

CHILDREN'S COORDINATED SYSTEM OF CARE (CSoC) NETWORK DEVELOPMENT PLAN Goal: Implement a Statewide Quality Management System for Children's Services			
Task	Lead	Completion Date	Description of Deliverable
Objective: Monitor Network Adherence to Clinical Standards of Care			
Monitor and review providers to ensure clinical standards of care for children with complex care needs are being met. 100% record review for all provider records for children in CSoC.	QM Administrator	Quarterly	Quarterly report of findings to Children's QM committee
Monitor and review providers to ensure clinical standards of care for children with standard needs are being met. Statistically significant random sample at 95% confidence level based on the adapted inpatient and outpatient IOC tool found in **Attachment 2.**	QM Administrator	Quarterly	Quarterly report of findings to Children's QM committee
Provide monthly provider feedback and technical assistance webinars.	Network Management Administrator	Monthly	Monthly meeting minutes and attendance rosters
Manage deliverables from monthly	Children's System	Monthly	Deliverables as

CHILDREN'S COORDINATED SYSTEM OF CARE (CSoC) NETWORK DEVELOPMENT PLAN Goal: Implement a Statewide Quality Management System for Children's Services			
Task	Lead	Completion Date	Description of Deliverable
practice reviews.	Administrator		specified in contract
Monitor sampling methodology for chart review process.	QM Administrator	Monthly	List of Sample Pulls
Ensure Practice Review Steering Committee maintains at least 25% family participation.	QM Administrator	Quarterly	Quarterly update reports
Participate in regional practice reviews to provide technical assistance to regional entities.	QM Administrator	Semi-annually	Semi-annual meeting minutes and attendance sheets
Objective: Monitor Quality Standards Using Additional Data Sources and Individual and Family Perspectives			
Evaluate provider performance on Children's System performance measures and functional outcomes.	QM Administrator	Monthly	Performance Improvement Reports
Review Children's Performance Measures in Children's QM Committee.	Children's System Administrator	Monthly	Children's QM Committee Presentation
Review Children's Utilization Measures in Children's UM Committee.	Children's System Administrator	Monthly	Children's UM Committee Presentation
Monitor Out-of-Home utilization and length of stay through the Children's QM and UM Committees.	Children's System Administrator	Monthly	Children's QM and UM Committee Presentations
Provide the ValueOptions Peer and Family Advisory Committee with Quality Management reports and other system information for review and feedback.	QM Administrator	Monthly	QM Presentation to ValueOptions Peer and Family Advisory Committee
Review and use ValueOptions Peer and Family Advisory Committee recommendations in the Children's QM Committee.	QM Administrator	Monthly	Written minutes of ValueOptions Peer and Family Advisory Committee recommendations to Children's QM Committee

CHILDREN'S COORDINATED SYSTEM OF CARE (CSoC) NETWORK DEVELOPMENT PLAN Goal: Implement a Statewide Quality Management System for Children's Services			
Task	Lead	Completion Date	Description of Deliverable
Ask peers and family members to review drafts and help develop the annual Quality Management Plan and methodology for administering Satisfaction Surveys.	QM Administrator	Year One and ongoing	Annual QM Plans
Objective: Publish Blinded Provider-Level Practice Improvement and Quality Management Data			
Post blinded, provider-level practice improvement quality management and improvement data to the ValueOptions website.	QM Administrator	Quarterly	Quarterly blinded practice improvement performance reports on the ValueOptions website
Provide a summary of performance improvement projects.	QM Administrator	Year One and annually	Performance Improvement Projects section of the Annual QM Report
Distribute blinded results of provider report cards as a comparison to providers receiving their confidential performance data to establish a baseline for performance improvement.	QM Administrator; Network Management Administrator	Year One and annually	Provider report cards
Objective: Monitor and Assure Network Adequacy			
Draft and approve annual System of Care plan.	CEO	Year One and annually	Yearly System of Care Plan and Network Development Plan
Draft and approve quarterly system performance benchmarks for network adequacy as outlined in annual System of Care (SOC) plan.	QM Administrator	Quarterly	Quarterly reports on SOC benchmarks
Monitor prescriber capacity to address network needs.	QM Administrator	Quarterly	Quarterly Prescriber Sufficiency Report
Monitor network through site visits.	QM Administrator	Monthly	Monthly Site Visit Report, follow up, and report on

CHILDREN'S COORDINATED SYSTEM OF CARE (CSoC) NETWORK DEVELOPMENT PLAN Goal: Implement a Statewide Quality Management System for Children's Services			
Task	Lead	Completion Date	Description of Deliverable
			technical assistance meetings
Through GeoMapping Reports and other information gathering, monitor changes in the network size, scope.	QM Administrator/ Network Development Administrator	Quarterly	Quarterly GeoMapping Reports
Measure network analysis data, including appointment standards complaint resolution, grievance and appeal data, eligibility data, penetration rates, Member satisfaction survey results, demographic data, and geographic access data.	QM Administrator, Network Development Administrator, Grievance and Appeals Administrator, Satisfaction Survey Contractor, and Data Management and Analysis Department	Quarterly	Quarterly Data Reports on appointment standards, complaint resolution, grievance and appeal data, eligibility, penetration rates, Member satisfaction surveys, demographics, and GeoMapping reports
Monitor network adequacy through ValueOptions Peer and Family Advisory Committee input/feedback.	QM Administrator and Outreach and Recovery Administrator	Quarterly	Meeting minutes
Develop Annual Network Analysis Report with input from stakeholders, peers, and families.	Network Development Administrator	Annually	Annual Network Analysis Report
Use Annual Network Analysis to develop measurable goals for subsequent years.	Network Development Administrator	Annually	Annual Network Goals for subsequent year
Objective: Monitor Expansion of Services for Children With Complex Care Needs			
Establish baseline data for services to children with complex care needs.	QM Administrator	Year One	Report on Service Delivery system for children with complex care needs
Establish goals for subsequent years for	QM Administrator	Year One and	Goals for

CHILDREN'S COORDINATED SYSTEM OF CARE (CSoC) NETWORK DEVELOPMENT PLAN Goal: Implement a Statewide Quality Management System for Children's Services			
Task	Lead	Completion Date	Description of Deliverable
expansion of services to children with complex care needs, including case management, rehabilitation therapy, personal attendant, and other services.		ongoing	subsequent year for expansion of specialized services for children with complex care needs
Objective: Monitor Service Capacity and Quality of Rehabilitation Services			
Establish baseline and monitor ongoing utilization trends for rehabilitation services, published quarterly.	QM Administrator	Quarterly	Quarterly Rehabilitation Care Monitoring Reports
In collaboration with DHH, identify and draft report on standards of practice for rehabilitation services.	QM Administrator	Year One	Report on Standards of Practice for Rehabilitation Services
Conduct webinar training for rehabilitation providers on EBPs and encourage their adoption through performance incentive programs.	QM Administrator and Network Development Administrator	Year One and ongoing	Webinar presentation on EBPs in rehabilitation services
Develop rehabilitation provider performance incentive program for successful adoption of EBPs.	Network Development Administrator	Year Two	Report on Rehabilitation Provider Performance Incentive Plan
Objective: Increase Capacity and Quality of Behavioral Health Services for Infants and Children Ages 0-5			
Invite a panel of experts from State and national advocacy groups such as Louisiana Pediatric Association, Federation of Families for Children's Mental Health, Picard Center, and Zero to Three to provide specialized provider training on serving and identifying behavioral health needs in infants and young children.	Network Development Administrator	Year One	Webinar presentation

CHILDREN'S COORDINATED SYSTEM OF CARE (CSoC) NETWORK DEVELOPMENT PLAN Goal: Implement a Statewide Quality Management System for Children's Services			
Task	Lead	Completion Date	Description of Deliverable
Objective: Monitor the Quality and Capacity of Substance Abuse Services for Children and Youths			
Establish baseline utilization data and report on Substance Abuse treatment services by region for children and youths.	QM Administrator and Network Management Administrator	Year One and annually	Substance Abuse Treatment Services
Provide training on EBPs for substance abuse services to youths.	QM Administrator/ Network Development Administrator	Year One and annually	Webinar presentation
Objective: Monitor the Implementation of the Child and Adolescent Needs and Strengths (CANS) Brief Screening Tool			
Provide system-wide provider training on use of the CANS Brief screening tool.	Network Development Administrator	Year One and ongoing	Monthly webinars (initial year), quarterly webinars (subsequent years)
Design report/dashboard to collect statewide data on use of the CANS Brief tool, track changes in youth outcomes.	Network Management Administrator/Data Management & Analysis Department	Year One and ongoing	Quarterly reports
Design VO-NOMS – child dashboard reports.	Network Management Administrator and Data Management & Analysis Department	Year One and ongoing	Quarterly reports
Objective: Promote Interagency Collaboration on Behalf of Children and Youths who are Involved in Multiple Systems			
Facilitate interagency meetings between representatives from the Department of Corrections, Courts, Office of Citizens with Developmental Disabilities, and Department Children and Family Services to identify behavioral health needs of children and youths served by multiple agencies.	CEO, COO	Monthly	Interagency meeting minutes

CHILDREN'S COORDINATED SYSTEM OF CARE (CSoC) NETWORK DEVELOPMENT PLAN Goal: Implement a Statewide Quality Management System for Children's Services			
Task	Lead	Completion Date	Description of Deliverable
Objective: Provide Training and Technical Assistance on the Intake, Assessment, and Service Planning Process			
Provide training to providers on intake, assessment, service planning, and EBPs.	Network Development Administrator	Quarterly	Webinar presentations
Provide training on meaningful family and youth inclusion in service planning.	Network Development Administrator	Year One	Summary Report
Establish baseline data on intake, (CANS) assessment, and service planning.	QM Administrator	Year One	Summary Baseline Report for intake, assessment, and service planning
Collect and report on data on provider adherence to intake, assessment, and service planning standards in subsequent years.	QM Administrator	Year Two and ongoing	Baseline versus yearly results for intake, assessment, and service planning
Objective: Monitor Services for Young Adults (18-21)			
Create a transition age youth plan to include outreach, vocational rehabilitation services, educational opportunities, social support, and housing resources.	Children's System Administrator and Medical Administrator	Year One	Work Plan for Transition Age Youth
Host a transition age youth summit annually for providers, families, and youth to discuss proposed training materials/topics, areas of needs in each region, and provide technical assistance to providers in best practices for assisting in smooth transitions.	Children's System Administrator and Medical Administrator	Year One and ongoing	Copies of Transition Age Youth summit materials
In collaboration with local organizations, host a series of regional round tables to discuss vocational rehabilitation development opportunities for transition age youth.	Children's System Administrator and Medical Administrator	Year One and ongoing	Meeting minutes
Provide technical assistance to youth-serving provider agencies in starting youth-driven peer support groups for transition age youth.	Outreach and Recovery Administrator	Year One and ongoing	Meeting minutes

CHILDREN'S COORDINATED SYSTEM OF CARE (CSoC) NETWORK DEVELOPMENT PLAN Goal: Implement a Statewide Quality Management System for Children's Services			
Task	Lead	Completion Date	Description of Deliverable
Create a Facebook page for transition age youth that includes resource information on outreach, vocational rehabilitation services, educational opportunities and housing in the regions.	Outreach and Recovery Administrator	Year One and ongoing	Facebook page, number of updates, number of participants, monthly print outs of resource information updates
Provide technical assistance to regional high schools, guidance counselors to promote awareness and support of transition age youth, including planning for education and work prospects.	Outreach and Recovery Administrator	Year One and ongoing	Quarterly report of number of contacts made in school systems
Objective: Expand Youth-driven Leadership and Family Involvement in the System of Care			
Invite family members and youth to participate on the ValueOptions Peer and Family Advisory Committee.	Outreach and Recovery Administrator	Year One	Membership roster of ValueOptions Peer and Family Advisory Committee
Subsidize/sponsor youth-driven groups in each region.	Outreach and Recovery Administrator	Year One	Annual statement of support for youth-driven advocacy groups
Sponsor annual youth-driven conference and resiliency fair.	Outreach and Recovery Administrator	Year One and ongoing	Event announcements and list of attendees
In collaboration with family advocacy leaders, sponsor an annual family-driven conference.	Outreach and Recovery Administrator	Year One and ongoing	Family event announcements and list of attendees
Attend local community events in each of the regions to promote behavioral health and wellness in the community.	Outreach and Recovery Administrator	Year One and ongoing	Quarterly Report of local event descriptions
Promote Family Peer Navigator Certification Program; subsidize training costs for participants.	Outreach and Recovery Administrator	Year One and annually	Description of program; number of certified Family Peer

CHILDREN'S COORDINATED SYSTEM OF CARE (CSoC) NETWORK DEVELOPMENT PLAN Goal: Implement a Statewide Quality Management System for Children's Services			
Task	Lead	Completion Date	Description of Deliverable
			Navigators annually
Develop a database of youth and family contacts in each region.	Outreach and Recovery Administrator	Year One and annually	Contacts Database

NETWORK DEVELOPMENT

ValueOptions met with many providers to determine the challenges and needs for behavioral health services in the State of Louisiana. Based on what we learned, we will develop and maintain a behavioral health network that:

- ensures access to all covered services in the most appropriate setting, regardless of geography or culture
- builds core capacity in support of local and statewide systems of care
- includes Members, families and youth engagement at all levels of system creation. Our network development process includes extensive data analysis; community and stakeholder input, planning and goal development, and identification of clear targets, metrics, and measurements that drive our strategy through to execution.

Beginning in late May 2011, ValueOptions initiated aggressive provider network assessment and development efforts by extending invitations to participate in the SMO network to more than 5,000 licensed practitioners and 750 organizations statewide. To date, we have received more than 500 Letters of Intent to participate in the VO-LA network. This is in addition to our existing network in Louisiana of more than 1,200 providers.

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We will continue to exceed minimum provider network requirements and look for innovative ways to address Louisiana service gaps. We ensure Louisianans receive the culturally-competent services they need, as close to home as possible.

Initial Network Development Plan

Our initial network development process included the following components:

Determining Network Adequacy and Capacity

Prior to the issuance of the RFP, we analyzed network adequacy and capacity, considering the size and geographic distribution of the Louisiana population, as well as cultural, language and other demographic characteristics of the population. To determine network adequacy, we reviewed current provider agency network capacity, current service mix, and other demographic data such as staff and service information obtained from current provider agencies and system partners.

To determine network capacity, we performed the following:

- identified opportunities for increased Member choice and local community availability
- established targets for service arrays in each region as compared to prevalence projected network capacity needs based upon service mix targets for increasing community based care
- projected increases in service demands based simply on reviewing the prevalence reports
- projected changes in service mix to support the implementation of the CSoC, including certified peer support and family support services, development of private providers, wraparound agencies, increased use of EBPs, community-based services, culturally competent services, systems of care implementation and therapeutic foster care

We know that a key to decreasing the over-reliance on ER and inpatient services is to builds out EBPs in the communities. Concomitantly, we must retrain providers, as currently not all providers are practicing in a manner that is person-centered, recovery and resiliency focused, and outcomes-driven.

Disruption Analysis

Our disruption analysis indicates that ValueOptions' network will exceed the current statewide network on day one of the new contract.

Transition Planning

Our transition plan includes a process to confirm that current participating providers are available and appropriate for our network. During the transition period, VO-LA will make a reasonable effort to contract with all providers who are delivering services as of July 1, 2011, during the transition period. Our Regional Provider Relations staff will be the single point of contact to provide technical assistance in completing all required information to become a contracted provider. This will eliminate any potential barriers, such as credentialing during the transition period. It will also enable us to work with providers on the more critical functions, including data collection, submission and reporting, claims processing, and payment. Additionally, our process minimizes service disruption for consumers and families.

SUCCESS IN YEARS ONE AND TWO (MILESTONES) ADULTS WITH SMI AND/OR ADDICTIVE BEHAVIORS

Success in years one and two will be based on our ability to deliver all requested services while providing Members with true options for recovery and resiliency. By expanding the provider delivery system to a community-based system of care, we offer the state an SMO that will:

- increase penetration of community-based services by 10 percent
- improve access to community based services
- decrease hospitalizations and use of ERs as the "main entry point"
- provide Members a greater means to manage their mental illness or addiction
- achieve the level of participation they desire in their communities

Current, traditional mental health models emphasize "treatment," and are typically divorced from community integration. The traditional model places treatment first in a sequential process that insists on symptom amelioration before it offers opportunities for community reintegration. The

result is that many Members leave treatment due to pressing real world needs and aspirations which cannot be addressed in the traditional, sequenced model.

VO-LA encourages and supports Members in their ability to reintegrate into their community and take control of their recovery. Our model provides Members with a powerful motivation to receive services that support their goals by offering multiple pathways, followed according to Member choice. By focusing on strengths and encouraging Members to set individual goals, we provide practical, concrete tools for recovery as well as the opportunity to use them.

An "integrated" State mental health and substance abuse department is in no way synonymous with systems integration. With the new formation of OBH, some professionals in the addictions community have expressed concern about "losing their identity" to the needs and services of mental health. Our goal is to maintain and enhance the skills of the Louisiana addictions community while also addressing the needs of co-occurring disorders

Providing and changing access points is key to a new behavioral health care system. ValueOptions has a long history of blending services and braiding funding across mental health and substance use disorder systems. Our vision is a well-coordinated, well-funded continuum of mental health and substance use disorder services that will promote healthier people and families, and achieve the maximum potential for meeting community needs. We recognize that integrated treatment of Members with co-occurring substance use and mental illness issues is the evidence-based model of treatment that has the best outcomes, and we also realize that many Members have a substance use disorder without co-occurring mental illness. According to this principle, the healthcare delivery system, and each provider within it, has a responsibility to address the range of Member needs wherever and whenever a Member presents the need for care.

With 2014 on the horizon, and the potential of more than 40 percent of the population of Louisiana being Medicaid eligible, the strategic goal is to build out the network and train the network. Above all, money should be reallocated from high cost "deep end" services that result in poor outcomes.

MANAGEMENT OF THE SYSTEM OF SERVICES FOR ADULT'S WITH SMI AND/OR ADDICTIVE AND NETWORK DEVELOPMENT PLAN

We provide a detailed plan to address the approach to network development and management of Adult's with Serious Mental Illness (SMI) and Addictive disorders in the following table:

ADULT SMI AND ADDICTIVE DISORDERS NETWORK DEVELOPMENT PLAN Goal: Develop a Statewide Recovery-oriented System of Care			
Task	Lead	Completion Date	Description of Deliverable
Objective: Assist Behavioral Health Providers in Moving From a Grants-Based to a Fee-For-Service Environment and Become Fully Credentialed Into a High Performance Managed Care Network			
Provide ongoing technical assistance to the State in moving from a grants-based to a fee-for-service system.	Network Management and Development Administrators and COO/Adult	Monthly meetings with DHH	Monthly meetings and project management

ADULT SMI AND ADDICTIVE DISORDERS NETWORK DEVELOPMENT PLAN Goal: Develop a Statewide Recovery-oriented System of Care			
	Systems Administrator		
Lend technical assistance to the State in moving from a grants-based to a fee-for-service system.	Network Management and Development Administrators and COO/Adult Systems Administrator	Quarterly	Not less than quarterly provider training schedule, presentations from monthly provider technical assistance webinars and one-on-one provider training sessions
In Year One, hire qualified clinicians within the Baton Rouge Service Center so Members can be diagnosed and the State will receive a pass-through for Medicaid funding.	UR Administrator	Quarterly	Quarterly reports
In Year Two, adopt the provider network for the program and give providers three years to create a credentialing plan and meet minimum Medicaid network requirements of the program.	Network Management and Development Administrators	Quarterly	Quarterly reports
Establish regular meetings with the provider trade association and individual providers to create strategies for meeting guidelines.	Network Development Administrator and CEO	Quarterly	Quarterly meeting minutes
Award a five percent (5%) rate increase to providers following successful credentialing	Network Management Administrator and COO/Adult Systems Administrator	Quarterly	Quarterly network report
Year Two: Implement a Provider Profiling reporting system.	Network Management Administrator	Year Two quarterly	Quarterly provider profile reports
Year Three: Provider Excellence Program. Through provider input, implement six performance measures, three chosen by ValueOptions working with DHH, and three chosen by providers, to implement a Provider	Network Management Administrator	Year Three quarterly	Quarterly reports

ADULT SMI AND ADDICTIVE DISORDERS NETWORK DEVELOPMENT PLAN Goal: Develop a Statewide Recovery-oriented System of Care			
Excellence Program, awarding high performing providers with rate increases.			
Objective: Promote Collaborative Relationships Between State, Regional, and Local Entities			
Facilitate interagency meetings between representatives from the Department of Corrections, Courts, Office of Citizens with Developmental Disabilities, and Department Children and Family Services to identify behavioral health needs of adults served by the state agencies.	CEO, COO/Adult Systems Administrator	Ongoing (Monthly or semi-annually)	Meeting agendas and minutes
Create a confidential online communication forum for information sharing and discussions between state agency liaisons and VO-LA.	Outreach and Recovery Administrator	Year One	Website documentation and quarterly utilization reports
Sponsor and promote recovery-oriented meetings and special events.	COO/Adult Systems Administrator, Outreach and Recovery Administrator	Year One and semi-annually	Annual report of scheduled recovery fairs and wellness events sponsored by VO-LA
Create a page on the VO-LA website for local events, conferences and recovery-focused activities in the state.	Outreach and Recovery Administrator	Year One and ongoing	Quarterly reports on website updates
Create a Facebook page and Twitter account for local events, conferences, and recovery-focused activities for the community at large.	Outreach and Recovery Administrator	Year One and ongoing	Number of posts to Facebook and Twitter provided in quarterly operations report
Provide one-on-one technical assistance and consulting to peer-run agencies on business continuity, grant writing, board development, program evaluation, and financial accounting.	Outreach and Recovery Administrator	Year One and ongoing	Quarterly report on technical assistance meetings to peer-run organizations
Provide grant writing assistance to behavioral health-focused prevention organizations and community peer-run organizations.	Outreach and Recovery Administrator supported by ValueOptions' Corporate Grants Management Team	Year One and Ongoing	Quarterly reports on grant writing assistance and technical meetings in the regions
Objective: Create Focus Groups to Inform a Recovery Oriented System of Care			
Create a VO-LA Peer Advisory	Outreach and	Year One	Peer Advisory

ADULT SMI AND ADDICTIVE DISORDERS NETWORK DEVELOPMENT PLAN Goal: Develop a Statewide Recovery-oriented System of Care			
Council with representation from peers, family members, and local advocacy groups.	Recovery Administrator		Council quarterly meeting minutes
Create Peer Focus Group and/or link with existing advocacy groups to provide feedback and recommendations regarding proposed managed care notifications and system development initiatives.	Outreach and Recovery Administrator	Year One	Peer Focus Group Meeting minutes (quarterly meetings)
Report on findings of Peer Focus Group to DHH leadership quarterly.	Outreach and Recovery Administrator and CEO	Year One and ongoing	Peer Focus Group Meeting summaries (quarterly)
Create Provider Focus Group to provide counsel on proposed provider notifications and new initiatives.	Network Management Administrator, COO/Adult Systems Administrator	Year One	Provider Focus Group Meeting minutes (quarterly meetings)
Report on findings of Provider Focus Group to DHH leadership quarterly.	Network Management Administrator and CEO	Year One and ongoing	Provider Focus Group Meeting summaries (quarterly)
Objective: Promote and Develop a Qualified Clinical Behavioral Health Workforce			
Create a working inventory of past and currently active workforce development projects and intern partnerships in the State.	Network Development Administrator	Year One	Report on the name and numbers of partnerships and development initiatives across the state
Identify a list of behavioral health ambassadors (Members in recovery) in each region who could provide local presentations to schools and universities within their area of the State.	Network Development Administrator	Year One and ongoing	List of possible advocates for behavioral health workforce promotion
Through university partnerships, establish a one-on-one leadership mentoring program between local behavioral health leaders/ambassadors and emerging or promising students and/or promising health care staff in their local area.	COO/Adult Systems Administrator, Network Development Administrator	Year One and ongoing	Mentors and protégés provided annually

ADULT SMI AND ADDICTIVE DISORDERS NETWORK DEVELOPMENT PLAN Goal: Develop a Statewide Recovery-oriented System of Care			
Accept nominations and sponsor annual awards ceremony for Behavioral Health Care Leaders in Recovery in the State.	CEO, COO/Adult Systems Administrator	Year One and ongoing	Award ceremony program announcement and brochure, list of annual awardees and nominees
Objective: Promote Acceptance of Individuals in Recovery in the state and Reduce Stigma associated with Mental Health Conditions			
Building upon the existing work of local advocacy groups, Regional CCMs and DHH, hire local peers and family members to create Regional Information Resource Guides to provide information about the available treatments, services and community supports in each region of the State.	Outreach and Recovery Administrator	Year One	Copies of Regional Guides
Update Guides annually.	Outreach and Recovery Administrator	Year Two and ongoing	Copies of updated Regional Guides
In partnership with local disability education and training organizations within the regions, create workforce partnership opportunities with small businesses for individuals with mental health conditions and/or disabilities who are seeking employment.	Outreach and Recovery Administrator, COO/Adult Systems Administrator	Year One and ongoing	Forge three new business relationships per year
Provide resource materials and public promotion for SAMHSA's anti-stigma campaign efforts (What A Difference A Friend Makes)in the State in regional health fairs and other public meetings and activities.	Outreach and Recovery Administrator	Year One and ongoing	Attendance at four health fairs per year
Objective: Ensure Provider Network Adequacy and Access Standards			
Analyze Quarterly GeoMapping reports on network providers in each region.	Network Management Administrator	Quarterly	Quarterly GeoMapping Reports
Issue Request for Proposal for needed community-based services.	Network Development and Management Administrator	Year One and Year Two	Contracting for needed services
Gather and report on provider data for case management services for individuals with SMI, including case	Network Management Administrator,	Year One	Quarterly data reporting on individual

ADULT SMI AND ADDICTIVE DISORDERS NETWORK DEVELOPMENT PLAN Goal: Develop a Statewide Recovery-oriented System of Care			
loads and types of practice used.	COO/Adult Systems Administrator, CMO		providers
Gather and report on data on the crisis response system in each region.	Network Management Administrator, COO/Adult Systems Administrator, CMO	Year Two and ongoing	Quarterly data reporting on individual crisis response providers
Objective: Ensure All Individuals Receiving Services are Provided With an Intake, Assessment and Service Planning.			
Create monthly intake, assessment and service planning report.	Administrator of Data Management and UR Administrator	Implementation date	Monthly report on intake, assessment, and service planning
Create Clinical Staff Training Program for intake, assessment and service planning.	UR Administrator, CMO	Implementation date	Copy of training curriculum on intake, assessment, and service planning
Provide Psychosocial Rehabilitation Training and Cultural Practices in regions.	Network Development Administrator and Training Contractor, CMO	Monthly	List of trainings provided in each region
Provide one-on-one coaching and mentoring session for each region in intake, assessment, and Person Centered Planning and WRAP.	Network Development, CMO, Outreach and Recovery Administrator	Quarterly trainings	Copy of quarterly training schedule for each region and curriculum/ materials
Deliver quarterly Web-based training on person-centered planning.	Network Development Administrator and Training Contractor	Quarterly trainings	Copy of quarterly webinars and curriculum/ materials
Create person-centered planning guides and Technical Assistance Tip Sheets for distribution in individual provider offices.	Network Development Administrator and Training Contractor	Distributed quarterly via email to all providers	Electronic copies of quarterly technical assistance materials on person-centered planning

ADULT SMI AND ADDICTIVE DISORDERS NETWORK DEVELOPMENT PLAN Goal: Develop a Statewide Recovery-oriented System of Care			
Monitor provider timeliness in submitting treatment information to medical providers through monthly tracking reports.	Network Development Administrator and staff	Monthly and ongoing	Quarterly Management Report will indicate summary data
Objective: Ensure That Individuals With Substance Use Disorders and Co-occurring Mental Health and Substance Abuse Disorders Receive Appropriate Treatment			
Provide semi-annual technical assistance calls targeted to mental health providers on substance abuse and co-occurring disorder prevention and treatment.	CM/UR Administrator and CMO	Semiannually	Minutes of technical assistance events, distribution of FAQs
Provide online trainings in conjunction with Members and advocacy groups, targeted to substance abuse providers, on early identification of mental health disorders, brief interventions, and referrals to treatment for co-occurring disorders.	Network Development Administrator, CMO, COO/ Adult Systems Administrator	Semi-annually	Training material
Objective: Ensure Clinical and Social Support for Youths Transitioning to the Adult Service System			
Create a transition age youth plan to include intended outreach, vocational rehabilitation services, educational opportunities, social support, and housing resources.	CM/UR Administrator and Medical Administrator, COO/Adult Systems Administrator, Children's Services Administrator	Year One	Work Plan for Transition Age Youth
Host a transition age youth summit annually to discuss training materials and plans, issues in each region, and provide technical assistance to providers in best practices for assisting smooth transitions.	CM/UR Administrator and Medical Administrator, COO/Adult Systems Administrator, Children's Services Administrator	Year One and ongoing	Copies of Transition Age Youth summit materials
In collaboration with local organizations, host a series of regional round tables to discuss vocational	CM/UR Administrator s and Medical	Year One and ongoing	Meeting minutes

ADULT SMI AND ADDICTIVE DISORDERS NETWORK DEVELOPMENT PLAN Goal: Develop a Statewide Recovery-oriented System of Care			
rehabilitation development opportunities for transition age youth.	Administrator, COO/Adult Systems Administrator, Children's Services Administrator		
Provide technical assistance to youth-serving provider agencies in starting youth-driven peer support groups for transition age youth.	Outreach and Recovery Administrator	Year One and ongoing	Meeting minutes
Create a Facebook page for transition age youth that includes resource information on outreach, vocational rehabilitation services, educational opportunities and housing in the regions.	Outreach and Recovery Administrator	Year One and ongoing	Facebook page, number of updates, number of participants, monthly print outs of resource information updates.
Provide technical assistance to regional high schools, guidance counselors to promote awareness and support of transition age youth including planning for education and work prospects.	Outreach and Recovery Administrator	Year One and ongoing	Quarterly report of number of contacts made in school systems.
Track youth as they transition to the adult system to ensure ongoing services.	Children's System Administrator and Adult System Administrator	Annually	Annual Report
Objective: Increase Service Capacity in the Delivery System for Sex Offenders and Promote Evidence-based Best Practices			
Research and create a specialized tag in the NetworkConnect Administrator for treatment providers who offer services for sex offenders.	Network Development Administrator	Year One	Provider Administrator with providers flagged to provide sex offender services
Analyze quarterly Geo-mapping report for each region to determine service needs.	Network Management Administrator	Year One and quarterly	Quarterly GeoMapping Reports
Create clinical training webinars for providers serving sex offenders to promote EBPs for sex offender treatment, such as Multi-systemic therapy for Youth with Problem Sexual Behaviors and other EBPs.	Network Development Administrator	Year One and semi-annually	Webinar presentation documents

ADULT SMI AND ADDICTIVE DISORDERS NETWORK DEVELOPMENT PLAN Goal: Develop a Statewide Recovery-oriented System of Care			
Objective: Clinical Supervision of Behavioral Health Services is Consistent Across the Service Delivery System and Regions			
Through monitoring and site visits, assess current clinical supervision techniques of providers	Network Management Administrator	Year One and quarterly	Report summary of site visits that focuses on survey of clinical supervision techniques in the regions
In conjunction with providers and trade associations, identify and promote best practices in clinical supervision through semi-annual webinar training.	Network Development Administrator	Year One and semiannually	Webinar presentations
Provide one-on-one technical assistance to providers on clinical supervision and EBPs.	Network Development Administrator	Year One and ongoing	Quarterly report of one-on-one training sessions completed with individual providers
Objective: Expand Education, Training, and Housing Opportunities for Individuals in Recovery			
Inventory education, and training and vocational rehabilitation programs in each region for individuals in recovery.	Outreach and Recovery Administrator	Year One	Resource Guides
Update education and training inventory annually through our website.	Outreach and Recovery Administrator	Year Two and ongoing	Annual Updated Resource Guides link on website
Create a listing of housing resources in each region and disperse electronically to network providers	COO/Adult Systems Administrator, UR Administrator	Year One	Housing Resource Guide
Update housing resources guide annually.	COO/Adult Systems Administrator, UR Administrator	Year Two and ongoing	Annual Updated Housing Resource Guide
Objective: Promote Individual and Family Participation in the Health Care Delivery System			
Invite peers and family members to participate in the VO-LA Peer Advisory Council.	Outreach and Recovery Administrator	Year One	Membership roster of Peer Advisory Council
Encourage/support peer and family advocacy organizations through subsidizing training, certification of peers, and sponsoring gatherings and	Outreach and Recovery Administrator	Year One and ongoing	Annual report of donations to regional advocacy groups

ADULT SMI AND ADDICTIVE DISORDERS NETWORK DEVELOPMENT PLAN Goal: Develop a Statewide Recovery-oriented System of Care			
annual advocacy conferences.			
Include peers and family members in the training of ValueOptions' clinical staff on cultural competency/proficiency.	Outreach and Recovery Administrator and UR Administrator	Year One and ongoing	Copy of training materials of ValueOptions' staff provided by peers and family members
Recruit a Peer and Family-run third party organization to collect satisfaction survey data on the behavioral health care delivery system.	Outreach and Recovery Administrator, COO/Adult Systems Administrator	Year One and ongoing	Survey data reports
Objective: Promote Peers and Family Members as Paraprofessionals in the Service Delivery System			
Collect data from all LGEs and Parishes on the number of peers and family members employed by providers.	Network Management Administrator	Year One	Copy of provider administrator with number of peer and family members indicated by provider
Establish baseline data to determine the number of peers and family members employed by providers.	Network Management Administrator	Year One	Report of Year One baseline data
Continue collecting data on number of peers/family members employed in subsequent years to evaluate progress.	Network Management Administrator	Year Two and ongoing	Report on baseline and data trends for employment of peers/family members
In collaboration with VO-LA Peer and Family Advisory Committee, draft a recruitment and retention strategic plan to increase numbers of employed peers/family members throughout the delivery system.	Outreach and Recovery Administrator	Year One	Copy of Recruitment and Retention plan

b. This introductory section should include a description of how the Proposer's organizational components communicate and work together in both an administrative and functional capacity from the top down. This section should contain a brief summary setting out the Proposer's management philosophy including, but not limited to, the role of Quality Control, Professional Practices, Supervision, Distribution of Work and Communication Systems. This section should include an organizational chart displaying the Proposer's overall structure including advisory and other related committees the Proposer will establish for this project. Suggested number of pages: 3 exclusive of organizational chart.

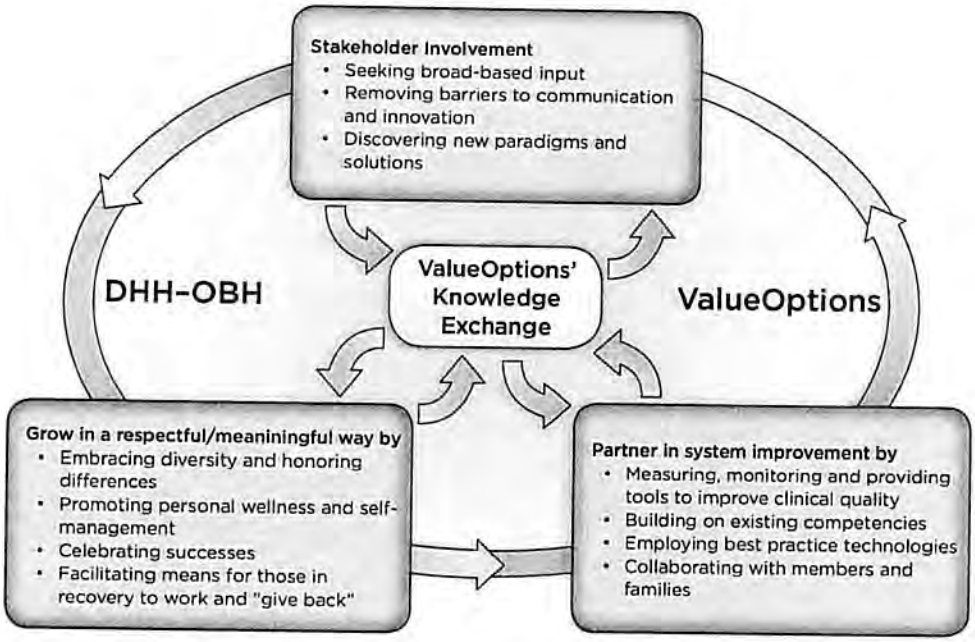
ORGANIZATION

ValueOptions' national organizational structure provides resources, expertise, and assistance to our public sector service centers while maintaining cost-effective operations. Our structure ensures that we provide our clients with the best qualified and most experienced personnel to meet and exceed expectations. Our processes are flexible enough to control contract schedule, performance, and risk, and they are designed to maintain transparency into the overall program performance.

We use a matrix management structure that groups employees both functionally and administratively, and consists of a dual-reporting relationship where staff from each of the functional areas is assigned to designated or dedicated client programs in each service center. This structure creates cross-functional teams that work in an efficient, dynamic environment that enables them to make decisions and consistently meet and exceed our clients' goals and objectives. Our organizational structure enables service center staff to interface with their peers company-wide to ensure we offer high quality, innovative products and services. The matrix management model enables staff in the clinical, service center management, IT, quality, Member Services, and Provider Services functions to collaborate, share lessons learned, and promote best practices. Under the model, service center functional leads draw upon the combined expertise of their staff to make the best decisions for each client.

MANAGEMENT PHILOSOPHY

To better serve our public sector programs, our "knowledge exchange" philosophy guides our approach to everything we do. This philosophy suggests that no one individual or organization possesses all knowledge. Rather, it asserts that everyone who has a stake in an initiative has something to offer, and that all can learn from each other. A graphical representation of this philosophy is provided below:



VO-LA's knowledge exchange creates opportunities for care coordination and feedback to better service LBHP-Members.

Building upon this philosophy, we will:

- work with the DHH-OBH to design and implement policies, procedures and protocols to guide communication and collaboration, recognizing the role of the DHH-OBH as the decision-maker, with VO-LA as an agent charged to facilitate change
- provide office space in our Louisiana Service Center for DHH-OBH staff to collaborate with our staff on the operations of the program
- actively participate in structures for communication—committees, meetings, other lines of communication—as requested by the individual agencies as well as the DHH-OBH as a whole
- provide interactive reports and dashboards that enable the DHH-OBH and DCF, OJJ and LGEs, schools, WAAs, FSOs, and providers to view data about Members, programs and CSoC services, as well as data from the overall program

We ensure that our staff follow the protocols designed by the DHH-OBH to guide communication with the individual agencies.

Quality Management (QM)

Our approach to QM promotes system change through a proven ability to use data and information to drive continuous performance improvement. Our QM process promotes transparency through information exchange, mutual education, and the active involvement of all stakeholders, including the DHH-OBH to design an integrated behavioral health recovery program for Louisiana. Internally-focused VO-LA Service Center quality assurance/quality control activities will be fully coordinated and integrated with the overarching QM efforts of the DHH-OBH.

The QM program is also a major mechanism through which Members, families, advocacy groups, provider groups, and other key stakeholders provide input on policy, oversight, activities, and evaluation of the Louisiana Program. Thus, QM is the basis for overall program monitoring, evaluation, and improvement. To encourage and reward participation, with the approval of DHH-OBH, we propose to reimburse Members and family members for their participation in QM activities, and recognizing the essential need for their participation while understanding the challenges of day care, work, and transportation.

Promotion of EBPs

We will promote, implement and monitor EBPs for children and adults, including Multi-systemic Therapy, Functional Family Therapy, Dialectical Behavior Therapy, Assertive Community Treatment, dual diagnosis assessment and treatment, illness management and recovery, medical management, and coordination with multiple community support services. Our Peer support is specifically focused on adults as they age is a best practice that is most likely to result in engagement in treatment and positive outcomes of treatment. Additionally, our approach includes support for adult children who are caregivers as they care for a Member over age 65.

Child/Adolescent Behavioral Health EBPs

1. Multi-systemic Therapy (MST): an intensive home and community-based family therapy that addresses delinquent behavior, substance abuse, and emotional disturbance. MST reduces out-of-home placement, improves job and school retention, and decreases arrests.
2. Functional Family Therapy (FFT):-an in-home intervention that directly impacts family relationships and reduces the risk of out-of-home placement, including incarcerations and hospitalizations. FFT reduces emotional and behavioral problems, decreases recidivism, and improves family functioning.
3. Dialectical Behavioral Therapy (DBT) for Youth: a cognitive behavioral treatment approach that emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance. This is a newly adopted EBP with training completed in June of 2009.
4. Motivational Enhancement Therapy/Cognitive Behavior Therapy: a model of therapy specific to youth with addictions, incorporating motivational skills to engage Members, and cognitive behavior techniques to implement change.
5. Trauma-Focused Cognitive Behavior Therapy: a model of therapy used to help youth minimize symptoms of Post-Traumatic Stress Disorder and other trauma-related events.

Adult Behavioral Health EBP

1. Matrix Model for Intensive Outpatient Treatment: used for treating adults with alcohol/drug dependence; focuses on individual counseling and group counseling for education, relapse prevention, and social support. Treatment retention and completion is significantly increased with the adoption of the model.
2. Assertive Community Treatment (ACT): intense community-based services for individuals who are most frequently hospitalized and the highest users of services, as well as those most non-compliant with traditional outpatient treatment services. ACT reduces re-hospitalization, provides housing stability, and increases contact with natural support systems. In FY 2009-2010, 95 percent of ACT members remained living in the community without re-hospitalization.

3. Supported Employment: intense support from assessment of skill sets and education, through job coaching for adults with mental illnesses. Supported Employment puts adults with SMI to work and helps keep them employed. In FY 2009-2010, 56 percent of individuals served through this program became employed. The national average is 15-25 percent.
4. Cognitive Behavior Therapy (CBT): an effective depression treatment offered in individual and group settings. For adults, CBT is a brief form of psychotherapy with focus on current issues and symptoms versus focusing on the individual's past history. Over 75 percent of CBT participants show significant improvements after treatment.
5. Mental Health First Aid (MHFA): The 12-hour MHFA trainings consist of five modules, covering the topics of depression, anxiety, psychosis, substance abuse, eating disorders, and self-harm. Every module focuses on suicide prevention and crisis intervention through a MHFA action plan which teaches the learner how to appropriately intervene. Each module contains a description of the disorders, frequent signs and symptoms, video presentations giving an inside look at individuals recovering from the disorders, and small-group, interactive activities to enhance the learning process. Program participants also learn the risk factors and early warning signs of these conditions and disorders, and they learn how to help with a problem before it progresses to a crisis situation. The program teaches a five-step approach to intervening when a mental health problem is suspected, or when an individual is in a crisis situation: Assess the risk for suicide or harm; listen non-judgmentally; give reassurance and information; encourage self-help strategies; encourage the person to get appropriate professional help.
6. Dialectical Behavioral Therapy (DBT) for Adults: a cognitive behavioral treatment approach that emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance.
7. Wellness Recovery Action Plan (WRAP): is a group intervention for adults with mental illness. WRAP guides participants through the process of identifying and understanding their personal wellness resources ("wellness tools") and then helps them develop an individualized plan to use these resources daily to manage their mental illness.

Our ongoing training programs will include clinical topics approved by the DHH-OBH, including EBPS and emerging best practices, as well as trainings related to recovery and resiliency. These will be enhanced through our relationships with NAMI-LA, NAMI-New Orleans, Mental Health America, the Federation, the FSOs, and The Extra Mile.

VO-LA Supervision

As indicated earlier, our matrix management organizational structure groups employees functionally and administratively. It consists of a dual-reporting relationship where staff from each of the functional areas (e.g., clinical, account management, IT, Member services) is assigned to designated or dedicated client programs. As a result, staff from each functional area collaborate, share lessons learned, and promote best practices across the entire spectrum of services. This approach enables our Louisiana Service Center and its staff to respond to the DHH/OBH and the requirements of the SMO for the Louisiana Members, providers, and stakeholders.

The local public sector Operations Management Team at the VO-LA Service Center will meet weekly and as needed to review performance, stage the daily interactions, collaborations, and interdependencies, and drive accomplishment of the deliverables for the DHH-OBH work. This team is wholly empowered to make decisions to fulfill the contract with the DHH-OBH. Our

approach will continue to enable our Louisiana Service Center to respond to the DHH-OBH and the requirements of SMO contract.

Distribution of Work and Communication Systems

Our Corporate Compliance Administrator will provide oversight, administration and implementation of the compliance program. The Administrator will also oversee all deliverables, fraud and abuse, and audits related to the contract.

ORGANIZATION CHART – OVERALL STRUCTURE OF VALUEOPTIONS

Chart Redacted

Overall Structure of VO-LA Org Chart

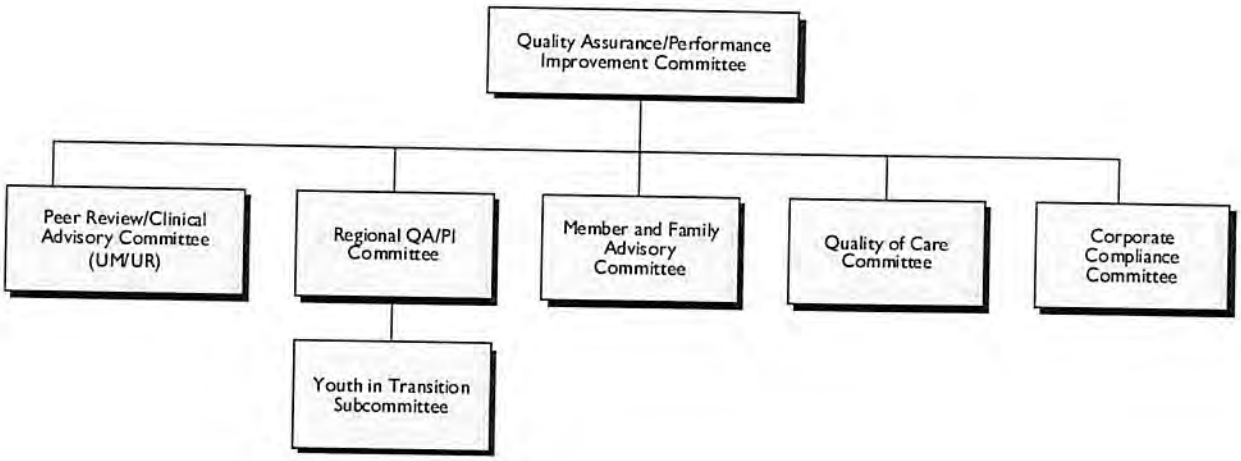
Please see the following page.

Chart Redacted

Our Quality Committees structure is illustrated below:

Quality Committees Organizational Chart

Proprietary and Confidential



c. This section should also include the following information:

i. Location of Active Office with Full-Time Personnel, including all office locations (address) with full time personnel;

We will establish an office in Baton Rouge within 10 miles of the DHH Office Building at 628 N. 4 Street. Our office location will be in Renaissance Park—a 10-minute walk of the DHH offices.

As identified on our VO-LA Organization chart, the majority of full time staff will be in Louisiana. We will have Claims/Encounters Processors and Network Analyst in Latham, New York. Credentialing and Network Operations Representatives will be located in Norfolk, Virginia.

ii. Name and address of principal officer;

[redacted]
ValueOptions, Inc.
240 Corporate Boulevard
Norfolk, Virginia 23502

Upon contract award, all local decision making will be fully vested in the VO-LA CEO.

iii. Name and address of purpose of issuing checks and/or drafts;

ValueOptions, Inc.
240 Corporate Boulevard
Norfolk, VA 23502

iv. For corporations, a statement listing name(s) and address(es) of principal owners who hold five percent interest or more in the corporation;

ValueOptions of Louisiana, Inc. is a wholly-owned subsidiary of ValueOptions, Inc.

v. If out-of-state Proposer, give name and address of local representative; if none, so state;

ValueOptions of Louisiana is incorporated in the State of Louisiana.

vi. If any of the Proposer's personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and social security number.

Not applicable

vii. If the Proposer was engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state;

Not applicable

viii. Proposed location and functions of the required Louisiana-based operations in the Baton Rouge area; and

Our location In Baton Rouge, within 10 miles of the DHH Office Building located at 628 N. 4 Street, Baton Rouge, LA 70802.

ix. Proposer's state and federal tax identification numbers.

ValueOptions of Louisiana, Inc.'s federal tax identification numbers is 45-2928750. Our state tax identification number is pending.

d. The following information must be included in the proposal:

i. Certification Statement: The Proposer must sign and submit the attached Certification Statement (See Attachment I).

We have signed and submit the Certification Statement provided behind the *Section 8. CMS Certifications* tab.

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

i. Describe how member services will be organized. Provide an organizational chart that includes position titles, numbers of positions, and reporting relationships. Describe the qualifications of member services staff and supervisors. Suggested number of pages: 2 exclusive of organizational chart.

MEMBER SERVICES DEPARTMENT

Member service call centers are integral components of our ability to meet and exceed the Department of Health and Hospitals-Office of Behavioral Health (DHH-OBH)'s expectations of exceptional member service. We understand the need and importance of these services, and we place Member satisfaction at the heart of our member services philosophy. We have designed your Member Access Center as the single point of access across the state. The Member Access Center will eliminate Members calling multiple entities such as the Human Services District (HSD), state-run clinics, and individual providers. The center will also change the pattern of individuals presenting at emergency rooms. ValueOptions employs call center technology and operations leaders who understand that managing incoming calls is an art requiring the right number of skilled people and supporting resources in place at the right times to handle an accurately forecasted workload, at the service level expected. Access Center Management is the foundation from which all centers are designed. We are proud to note our great success in achieving and maintaining excellence service levels.

In 2010, our call statistics for a public sector client similar to Louisiana indicated average speed of answer at 23 seconds, abandonment rate at 1.9 percent. This level of service exceeds the standards indicated in the RFP.

All Louisiana Member calls will be answered live by a dedicated team of Member Service Representatives (MSRs) and or Peer and Family Specialists within our Louisiana Service Center. VO-LA member services and clinical operation will work cohesively to support Members and families regardless of their reason for calling. Our telephone system will support immediate, seamless, and undetectable warm-transfers to the appropriate staff within our Louisiana Service Center. Members in crisis will have immediate access to a licensed clinician who can assist them in obtaining the necessary services. Our state-of-the-art telephony structure, which is described later in this section, can immediately direct any crisis call to a clinician within our Louisiana Service Center. All MSRs and Peer and Family Specialists are trained to identify emergency situations and immediately warm-transfer such calls while never placing members on hold. Committed to Member engagement and satisfaction, we will collaborate with DHH-OBH to customize our processes to ensure consistent operational success.

Our Avaya Call Management System (CMS) provides real-time information on call center activity. This enables us to make immediate decisions to redistribute calls to resources or redirect calls in the event it is required. Although such incidents are rare, it is vital to maintain a detailed plan. As needed, the Avaya system will redirect calls to a designated group of MSRs located in our centralized Medicaid member services call center. This designated group of MSRs will receive the same orientation and ongoing training for the Louisiana program that will be provided to member service staff located in Louisiana.

The Member Services Administrator will have overall responsibility of the Member services function and will be responsible for assuring compliance with all Member service requirements and performance standards imposed by the contract with DHH-OBH.

In addition, to foster the visibility of Member/family recovery and resiliency and to offer real employment options for the individuals who have already been trained as Peer Specialists, we are proposing to embed Peer and Family Specialists within our Member Services Department. ValueOptions has employed Peer and Family Specialists in many other public sector contracts we manage. Their expertise and experience has been instrumental in encouraging ValueOptions to continue to expand the responsibilities we assign to consumers and family members. Peer and Family staff also have helped our staff understand and appreciate the impact of recovery, resiliency, and hope in organizations and delivery systems.

Peer and Family Specialists for the Louisiana program will be located within our Louisiana Service Center and will have in-depth knowledge of both the adult and children's system of care. They will provide outreach and education to Members and families, providers, and other stakeholders. They will be available to accept calls from Members who either directly seek their assistance with community or recovery-oriented referrals or if the MSR realizes the potential need for their assistance.

Our Louisiana Peer and Family Specialists, who are embedded within our Member Services Department, will ensure that every aspect from outreach to outcomes is conducted in a manner that supports and encourages recovery and resiliency.

Within its first year, the Illinois Warm Line: Peer and Family Support by telephone, has provided support to over 3400 callers, contributed to the advance of the Illinois recovery vision and enhanced customer service within the Illinois public mental health system. It is making a positive difference in the lives of persons with mental health challenges.

Our Peer Warm Line in Illinois has been operational since 2009. We manage 200-300 calls per month (with a one call per day maximum per caller). Results from a 2011 member satisfaction survey indicate an overall satisfaction rate of 94.4 percent. Specific satisfaction results include:

- 94.4 percent of Members are satisfied with the Warm Line staff
- 96.0 percent of Members felt that the Warm Line staff listened and seemed to understand
- 97.4 percent of Members felt that the Warm Line staff was respectful of their experiences
- 94.6 percent of Members felt that the Warm Line staff encouraged them to be more involved in or take charge of the Members own mental health treatment and well being.

Member Services Organizational Chart

Our proposed organizational structure for the Member Services Department is provided below:

Chart Redacted

Qualifications of Member Services Staff and Supervisors

REDACTED	

REDACTED	

ii. Describe how the required toll-free twenty-four (24) hour, seven (7) days a week call line will be staffed. Distinguish between Baton Rouge area staff and those located outside of Louisiana within the continental United States. Also describe the system back-up plan to cover calls to the toll-free line.

24/7 ACCESS

Louisiana Members will have access to ValueOptions' staff 24 hours a day, seven days a week.

Key to meeting and exceeding the service needs of Members in Louisiana, our service level and response time objectives are having the right people in the right place at the right time, supported by the right system resources. Our staffing plans ensure outstanding Member satisfaction with flexibility to support any surge or increase in call volume. We assessed our national public sector call center operations to project the total number of staff required to maintain excellent call management performance levels and assure maximum coverage during peak demand times. We are committed to providing DHH-OBH with a staffing plan that will meet all program objectives and ensure the highest quality of service to Members and providers. Our proposed staffing plan for Member Services is provided below:

Proprietary and Confidential		
Staff	FTE	Location
Member Services Administrator	1	Louisiana Service Center Baton Rouge, Louisiana
Member Service Representatives	14	Louisiana Service Center Baton Rouge, Louisiana
Peer and Family Specialists	4	Louisiana Service Center Baton Rouge, Louisiana

In addition to the dedicated Member services staff in Louisiana, a designated pool of MSRs in our centralized Medicaid call center located in Latham, New York will be cross-trained as back-up support. Our centralized Medicaid member services structure provides flexibility to accommodate fail-over capacity. This assures there are sufficient resources to provide support in the event of unexpected fluctuations in telephone volumes during periods of illness or staff vacancies. All MSRs who work on the Louisiana program will receive the same initial training as individuals located in Louisiana.

We have the protocols in place to warm-transfer any call to the Louisiana Service Center, with no interruption to the member. This centralized structure has a proven record of performance in consistently meeting client performance requirements. **In fact, we met 100 percent of call center performance standards for our Medicaid clients in 2010.**

Ensuring Responsiveness to Louisiana Members

ValueOptions uses the industry-leading Avaya™ Call Management System (Avaya CMS) telephonic platform across our organization. The platform supports optimal call handling protocols and accommodates large volumes of telephonic activity and widely varying peak call times. A core component of this system is Enhanced Call Routing (ECR), which easily matches VO-LA personnel resources and skills to call volumes based on the caller's needs. One hundred percent of call center activity is captured, stored, and presented to call center management in real time for the purposes of historical trending and analysis.

Avaya CMS also monitors operations and collects data, offering a robust reporting package to assist call center management in directing the activities within the call center. Real time data is provided to ensure productivity and client performance measures are met. This includes average speed of answer, abandonment rate, as well as other client-specific call center performance measures. This information is provided in real time to allow for immediate decision-making regarding the redistribution of calls or resources in the event it is required.

Our Call Center Directors and Managers evaluate historical call volume data and trends to accurately project staffing needs on a daily basis. The Erlang C Calculator periodically verifies that staffing needs have not changed. It is also used as a statistical measure of the volume of telecommunications traffic. Call center management are able to calculate how many call center staff are needed based on historical program data on hourly call volume, average call talk-time and the established service level for answering a call. ValueOptions' staffing ratios are based on extensive experience providing behavioral health services to a wide variety of clients, including 14 Medicaid State clients currently, and meet changes that may occur, such as surges or increases in call volume.

Business Continuity Plan

ValueOptions understands the importance of smooth service delivery, access to information, and continuity in the event of planned or unplanned outages. We will use advanced, state-of-the-art telecommunication technology from Avaya and Verizon to facilitate call service delivery within the Louisiana Service Center. We maintain a corporate-wide formal and comprehensive Business Continuity Plan that assures minimal disruption of service in the event of a call center disaster or temporary closure. In the event that such incidents occur, we understand the importance of maintaining a detailed plan so staff can quickly and decisively respond to any planned or unplanned incidents.

Any service interruption results in immediate re-routing of calls to a pre-defined back-up call center. Back-up staff will be fully briefed and trained on the requirements of the Louisiana SMO program, and have access to all necessary program information. Because our telephony and data systems are fully integrated among all of our call centers, staff in the back-up location can quickly and easily serve Members with no degradation of quality.

iii. Describe the capabilities of the telephone system with respect to warm line transfer, live call monitoring and other relevant features. Suggested number of pages: 2.

VALUEOPTIONS' TELEPHONE SYSTEM

As mentioned, we use the industry-leading Avaya CMS. When Louisiana Members call the toll-free line, Avaya CMS easily matches VO-LA call center personnel resources and skills to call volume and customer needs, and effectively monitors critical items such as agent status, average hold time, number of calls in queue, and number of abandoned calls. By providing a comprehensive set of capabilities for call center management and reporting, the Avaya CMS helps manage VO-LA call center resources and, as a result, better serve Members and providers. Recently we implemented two new statewide programs. Even with the additional volume, we have maintained excellent Member services across our Book of Business. The system ensures that capacity is not an issue.

We use the following telephonic communication solutions by Avaya:

- **Single Image Switch Architecture**—Avaya's central telephone switch provides dynamic, seamless routing of calls to multiple service centers as dictated by either business rules, a call spike situation, or a technical issue in a particular call center. Therefore, calls can be serviced by a larger pool of staff all with equivalent skills, residing in multiple service centers as appropriate.
- **Best Service Routing (BSR)**—allows the communication server to compare specified skills, identify the skill that will provide the best service to a call, and deliver the call to that resource.
- **Call Management System** —allows us to collect and monitor facilities and personnel. We create customized reports on the status of agents, splits/skills, trunks, vectors, and vector directory numbers.
- **Expert Agent Selection (EAS)**—routes incoming calls to the agent who has the specialized skills or experience required to best meet the caller's need.
- **Queue Status Indications (QSI)**—allows us to assign queue-status indicators for calls based on the number of split/skill calls queued and time in queue.
- **Redirection on No Answer (RONA)**—redirects a ringing split/skill call or direct agent call after an administered number of rings. RONA prevents an unanswered call from ringing indefinitely.
- **Service Level Maximizer (SLM)**—ensures that a defined service level of X percent of calls will be answered in Y seconds. When SLM is active, the software verifies that inbound calls are matched with agents to ensure that the administered service level is met.
- **Business Advocate (BA)**—In addition to meeting service level targets, BA provides the VO-LA Member Services Administrators the flexibility to define the service we provide to our callers. It also provides more control in determining how agents are utilized. It does this by providing multiple rules for handling MSR or call surplus situations. These options address different business needs, such as meeting a target service level, caller segmentation, and managing multi-skilled agents.

Warm Line Transfer

VO-LA employees will use, Avaya CMS, which allows no-hold telephone conference features for crisis calls. MSRs can seamlessly connect callers with other VO-LA staff members. During the transfer process for crisis calls, the caller remains on the line and is in contact with our staff member at all times. This feature is in addition to the traditional warm transfer functionality.

The Warm Line transfer provides an unprecedented and meaningful enhancement to Member service, and it can provide much more. The VO-LA Peer and Family Specialists will take calls that are more supportive in nature. These types of calls are similar to talking with friends in a support group, and are intended to provide a sounding board and support. The conversation is relaxed, genuine, and engaging. All other calls are received or taken by Louisiana MSRs; however Warm Line transfers are available among MSRs, clinicians, and our Peer and Family Specialists.

Live Call Monitoring

Our NICE™ Perform Suite Call Record Solution (NICE Perform) provides recording capability that captures, records, and stores calls according to all requirements, both internal and DHH-OBHs. This technology allows us to store digitalized voice recording and video screen capture of the system navigation activities completed during a call from a Member or provider. All calls handled by staff through the Avaya system are recorded, allowing us to gain insight about staff interactions with Members, and our technology enables us to discontinue the recording of a call at the request of the caller.

Our quality program consists of both side-by-side mentoring and coaching, as well as silent monitoring and recording of calls. This gives us the opportunity to hear from the voice of the Member where opportunities for improvement exist.

Selective screen capture of system interactions occurs based on pre-determined business rules based on volume. NICE Perform enables customized evaluation forms, including flexible scoring and questions to support both the clinical and administrative Member interactions. The NICE Perform model focuses on interactions based on calibrated scoring to ensure consistency in the evaluation process. We will audit, by either a Quality Analyst or a member of the Member services management team, a minimum of five formal calls or inquiries and five informal calls or inquiries with at least three formal coaching sessions per MSR per month. Our analysis focuses on the complete Member experience -- from initial contact through to resolution.

iv. Describe the Proposers plan to train member services staff. Suggested number of pages: 2

MEMBER SERVICES STAFF TRAINING

Louisiana Members and providers will receive outstanding service from ValueOptions' well-trained staff. We identify qualified applicants through a stringent interviewing process. New hires undergo an intensive six- to eight-week training program that covers all aspects of the program prior to "going live" on the phones. Qualified member service trainers are responsible for the initial training of new staff members and ongoing training of experienced MSRs.

New MSRs and Peer and Family Specialists will receive training on the Louisiana program overall, the operations that support the program, and eligibility guidelines, care management activities, provider network, and claims. New staff training also includes rigorous review of detailed procedures addressing patient confidentiality requirements, the sensitivity of the information, and state and federal confidentiality requirements. Procedures clearly define what information may be released and confidentially to whom. In addition, new staff receives detailed reference materials for future use. Internal experts for each of these areas deliver customer-focused training on HIPAA, fraud and abuse, complaints, grievance and appeals, member service soft skills,

telephone/automated call distribution utilization, as well as systems and application navigation and interpretation. Crisis calls and quality assurance is emphasized by clinical and quality staff in a dedicated training setting.

All new hires participate in training as follows:

- Accreditation Standards
- Appeals, Complaints and Grievances
- Call and Inquiry Monitoring/Audits
- Role of the WAAs and FSOs
- Central Night Service (after hours coverage)
- Compliance requirements for ERISA, HIPAA, state requirements, contractual
- requirements, (CMS and Medicaid as applicable)
- Confidentiality
- Conflict of Interest
- Cultural Competency
- CSoC
- Role and Expectations of DHH-OBH
- Human Service Districts
- Member Service Workflows
- Handling Crisis Calls
- Handling difficult calls and effective listening
- Information Systems Training
- DHH-OBH Specific Guidelines
- Introduction to Care Management
- Motivational interviewing
- Signs and symptoms of mental illness
- Role of the Coroner in Louisiana
- Parish Specific Services
- Introduction to Case
- Charity Hospitals and State Clinics
- Registration/Eligibility
- Introduction to Claims Department
- Introduction to Customer Service/Customer Service Policies
- Introduction to Human Resources
- Introduction to Provider Relations/Network Management
- Introduction to Telephone System including Language Line
- Introduction to ValueOptions and Managed Care
- Medical Terminology
- Member Rights and Responsibilities
- Policies and Procedures
- Quality Management Program
- Role of Member Service Representative
- Telephone etiquette
- StaffConnect, ServiceConnect

Trainees are released to the Member Access Center in a phased-in approach. While in classroom training, they begin to handle live calls with one-on-one mentoring to ensure continued training, and quality of the member's experience. Upon successful completion of both the classroom training and achieving the quality assurance expectations, trainees are released to the unit with dedicated on-the-job mentoring support provided by member services management, quality, and training staff.

Ongoing training is provided on internal process changes, network updates, and Member services workgroups. Additional training occurs at a minimum of every other week as needs are identified through quality audits, inquiry audits, workgroups, or as a result of national, procedural, or client-specific change requests or updates.

Member service employees receive more than 300 hours of training in their first year. Our service standards are clearly defined and our employees are trained to follow through at the highest level. As we met with Members and families in Louisiana, we repeatedly heard frustration about where and how to access services. Our goal single call resolution that provides Members and families the

information they need and access to appropriate services. To ensure that all staff work to meet that goal, exceptional Member service is an objective on every annual employee performance evaluation.

v. Describe the Proposer's plan to ensure that all callers to a common single point of contact are provided accurate information that fully addresses their need, including call transfer and tracking of calls requiring follow up. Suggested number of pages: 3.

VO-LA believes that Member service is a key component of successfully serving all system stakeholders, both internal and external. The ability to quickly connect callers with the appropriate party who can answer their questions or handle their needs is vital to building trust and ensuring continuity of care. In keeping with the principles of an effective system of care and to remove barriers in accessing care, callers will be greeted with a Louisiana-customized greeting, with live answer by a MSR.

Providing Accurate Information

In 2010, 93 percent of telephone contacts achieved first-call resolution. This illustrates our focus on ensuring our employees are equipped with and have access to the necessary resources to respond to Members. We own each and every service request received.

VO-LA Member service is supported by our commitment to provide our clients, Members and their providers with the most accurate and informed benefit, eligibility, claims, and certification information in the most effective, efficient, and compassionate manner. VO-LA puts our Members' and their providers' needs and concerns first, and vigorously seeks inquiry resolution promptly using our ServiceConnect system, without the need to make re-contact. We value our Members' and providers' questions and concerns and place overall satisfaction at the heart of our member service philosophy. We also provide customized information via our award winning Achieve Solutions website. It is a valuable reinforcement refresher for the information that a Member receives from the Access Center.

Clinical MSRs perform pre-review screening activities, supported by explicit instructions and scripts, and promptly transfer any call to a Care Manager if the call cannot be completed based on the formal scripts and criteria. MSRs are trained to identify emergency situations and will transfer crisis calls to a Care Manager, using the no-hold feature which enables the MSR to remain engaged with the caller until the Care Manager is on the line.

ValueOptions' Customer Service application, ServiceConnect, provides customer service solutions via a fully integrated application. MSRs perform a wide variety of tasks in a Web-based intuitive, user-friendly environment. Through the integration with ValueOptions' CONNECTS system, MSRs access the immediate, accurate, and critical information needed to provide Louisiana Members with the information or services they are requesting, at the time they are requesting it.

Contacts can be related to a benefit, provider or referral, eligibility, claim or authorization/ certification matter. ServiceConnect, our customer relations management application, automates access to multiple IT Systems (e.g., eligibility, authorization, provider participation/reimbursement rate, claims, benefit, explanation of payment) that search, retrieve, and deliver within seconds to our staff member's desktop. Detailed, automated search features and automated data capture functionality enables our MSRs to focus on the caller.

Since ValueOptions' CONNECTS platform is a suite of fully-integrated applications, information entered in one application automatically feeds the other applications near real time. MSRs have immediate online access through ServiceConnect to ValueOptions' provider database and can assist Members with provider referrals to the most appropriate provider in any location in the country. ReferralConnect is fully integrated with the CONNECTS platform. As changes are made to the provider file, the change is reflected in ReferralConnect.

Documents such as copies of claims, explanation of payment summary, authorization letters, and checks (both issued and cancelled) are available for our staff to view via a hyper-link between ServiceConnect and the On Demand application. Through ServiceConnect and the various ValueOptions' applications interfaces, our Members' services and requests are better able to be handled at the time of the call.

In addition, our Peer and Family Specialists also serve as a point of contact for Members who require information that is educational in nature. Peer and Family Specialists support persons in recovery so that they are able to live, work, learn, and participate fully in their communities (President's New Freedom Commission 2003). It has been our experience that Member calls often fall into the following categories:

- **Emotional Support**: Peer and Family Specialists offer empathetic listening and encouragement
- **Recovery Education**: Peer and Family Specialists offer information about mental health recovery from resources such as the Member Handbook, Wellness Recovery Action Plan (WRAP), VO-LA website, and other recovery and resiliency resources. The Peer and Family Specialist self discloses vignettes that support the individual's recovery.
- **Self Advocacy Support**: Peer and Family Specialists offer tips to help the individual communicate clearly and calmly to get needs met. The Peer and Family Specialist encourages caller to "go for it" with courage, persistence and determination
- **Referral Request**: Peer and Family Specialists offer referrals to the clinical team or to resources in the community, including mental health centers and WRAP classes, as well as natural community supports such as support groups
- **Misdirected Calls**: Call is outside the scope of the purpose of the Warm Line
- **Crisis Calls**: Call is warm-transferred to clinical team to help Member manage the crisis
- **Other Information**: Member seeks information not captured above.

Our Peer and Family Specialists receive customer service training and document all their activities within our ServiceConnect system so that we can ensure continuity in service.

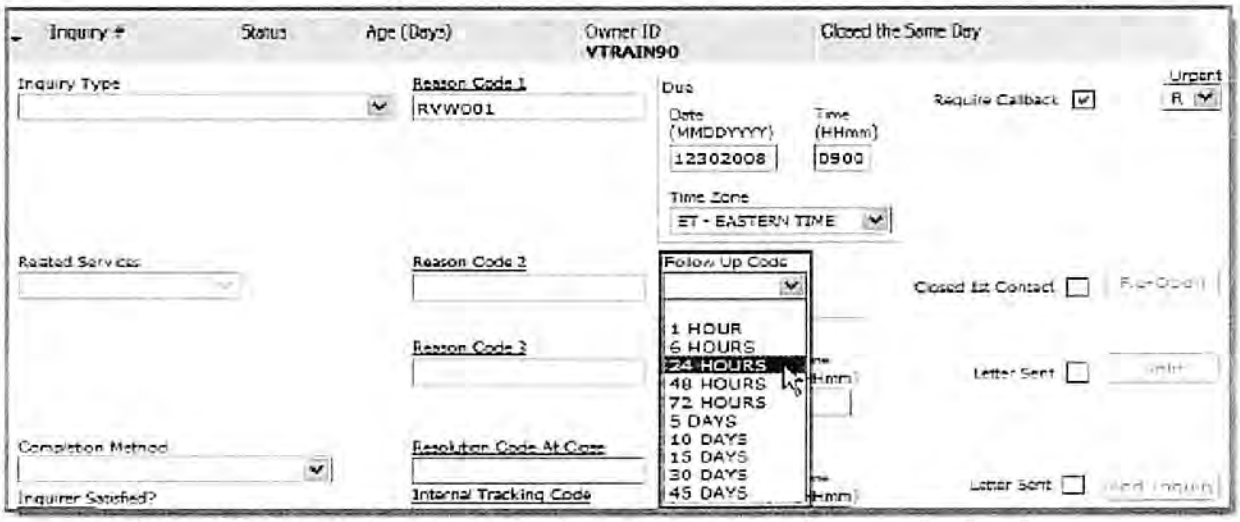
Tracking Calls for Follow-Up

ServiceConnect tracks inquiries received by MSRs and Peer and Family Specialists. ServiceConnect is a robust and easy-to-use tool for building inquiries or to conduct client and Member research. Through the integration with ValueOptions' IT system, our staff members are able to access immediate, accurate, critical information needed to provide our caller with the information or services they are requesting, at the time they are requesting it.

At the time of an inquiry or request for service, the VO-LA MSR will use ServiceConnect's automated "search and capture" features to capture and store all information pertaining to the call. If MSRs cannot respond to the service or request at the time of the call and requires the assistance

of another ValueOptions support area to resolve the inquiry, applicable data/information is captured and electronically delivered to the support area for review and resolution. Inquiries are returned to the MSR for response, review and accuracy validation, with a follow through response to the caller.

ServiceConnect maintains inquiry details and transactions, as well as who performed the actions, throughout the life of the inquiry. VO-LA MSRs will include follow-up flags for each call based on the reason. As a customer relationship management application system, ServiceConnect prioritizes the Member Service daily workload in-box, pending and resolved inquiry data to ensure timely and accurate resolution of each and every contact handled.



MSRs key the follow-up codes after each call based on the reason for the call.

vi. Describe the member experience when calling the member services line and the transition to care managers:

The service experience of Louisiana Members will be that of excellence and engagement. Louisiana Members will have a single point of contact through VO-LA's Member Access Center, the Louisiana dedicated toll-free number, where they will be greeted by a Louisiana-customized greeting. All calls will be answered live by MSRs who will take ownership to determine how best to meet the caller needs. All calls will be triaged. Established protocols will be in place for inquiry referral to other ValueOptions' areas and the transferring of calls. MSRs are trained to identify emergency situations and immediately "warm transfer" such calls to a clinician, while never placing the Member on hold.

Our MSRs will be responsible for responding to Member telephone inquiries related to benefits, eligibility, authorizations and provider referrals. Our national Claims Customer Service will answer and resolve all claim related inquiries, investigate and resolve administrative appeals, as well as manage the research and response to complaints and grievances. MSRs in your Louisiana Member Access Center will work cohesively with the clinical team, Peer and Family Specialists and National

Claims Customer Service to ensure service requests are thoroughly researched and responded to on a timely basis. Calls will be warmed transferred between areas depending on the nature of the call.

All non-emergency calls will initially be answered live by MSRs. They will not make clinical decisions, but will serve as the "front door" for all requests. All calls are triaged based on the nature of the call. Established protocols are followed for inquiry referrals to other areas within our organization, if the MSR cannot complete the Member's request during the initial conversation. Additionally, Peer and Family Specialists will accept calls from Members who either directly seek their assistance with community or recovery-oriented referrals or if the MSR realizes the need for their assistance. Our Peer and Family Specialists foster recovery and resiliency and provide support to Members as they navigate the behavioral health delivery system. For outpatient referrals, our MSRs and Peer and Family Specialists will verify the member's eligibility within our system prior to facilitating a referral.

(a) Provide a description of the process for transitioning an adult caller from member services to care management, including the process for determining and addressing a psychiatric crisis.

All crisis calls will be transferred with the no-hold feature allowing MSRs or Peer and Family Specialists to remain engaged until the Care Manager, a Licensed Behavioral Health Professional, is on the line. Once the Care Manager is on the line, the MSR or Peer and Family Specialist will release the call.

MSRs and Peer and Family Specialists perform pre-review screening activities, supported by explicit instructions and scripts, and promptly transfer any call to a Care Manager if the call cannot be completed based on the formal script and criteria. Non-clinical staff who conduct pre-review screening receive orientation and training on the scope and limits of their responsibilities. This training includes, but is not limited to: non-judgmental listening, the appropriate use of the script/criteria; the principles and procedures of collection and transfer of non-clinical data; documentation and data entry; recognizing and responding appropriately to crisis calls; and scripted clinical screening.

MSRs and Peer and Family Specialists are trained to identify emergency situations. In addition, we also provide behavioral health customer service clinical sensitivity training to our MSRs. This sensitivity training provides the groundwork to recognize and identify the different types of calls generated to a behavioral health line. The training provides the MSRs with key phrases and indicators which signal when a warm or no hold transfer to a Care Manager is required.

Our telephone technology enables for the clinician to maintain open contact with the caller at all times. Through an internal messaging system and/or three-way conference calling, the clinician is able to access identified crisis response systems, the State's suicide hotline, and 911 emergency services. This system assures that the Member has telephonic contact with a staff member at all times. **The caller is never put on hold in an emergency situation.**

Care Managers are available 24 hours a day via the toll-free number to respond to all crisis calls. When available, WRAP and crisis plans are available within our CONNECTS system to ensure Member-specific needs are identified and resolved according to their specific plans.

When a caller identifies the situation as an emergency, it will always be treated as such. If the caller and the Care Manager define the situation differently, the more urgent definition will take precedence.

(b) Provide a description of the process for transitioning a family member/parent of a child/youth from member services to care management, including the process for determining and address a psychiatric crisis. Suggested number of pages for both examples: 2.

All crisis calls will be transferred with the no-hold feature allowing MSRs or Peer and Family Specialists to remain engaged until the Care Manager is on the line. Once the Care Manager is on the line, the MSR or Peer and Family Specialist will release the call.

As indicated, the process described above in response to *Question (a)* also applies here, although the questions will be tailored to assist parents with access to their local FSO and WAA if they are identified as part of the CSoC. We also understand that parents may need reassurance, and support and assistance, with identifying what concerns they may have regarding their child. Our motivational interviewing skills will help parents identify what is needed, if they need to contact the child's PCP, or existing provider and/or to provide them with a direct linkage to services in their home community. Once it has been determined that a child is not in crisis, we will also triage to determine if the family member would benefit from discussions with the Peer and Family Specialists regarding recovery, resiliency, emotional support or advocacy on behalf of the child. In those instances where a family member is calling on behalf of a child/youth, the family member will be transferred to the appropriate Regional Care Manager who lives in that region and is available to assist the family.

vii. Describe the Proposer's plan to manage and respond to complaints, including the process for logging, tracking and trending complaints, call resolution or transfer, and staff training. Suggested number of pages: 2.

We believe in a quality-focused, culturally respectful, and recovery-oriented system of care. To this end, our sophisticated complaints process ensures we are always learning from those we serve, and we are improving the quality of the services we offer.

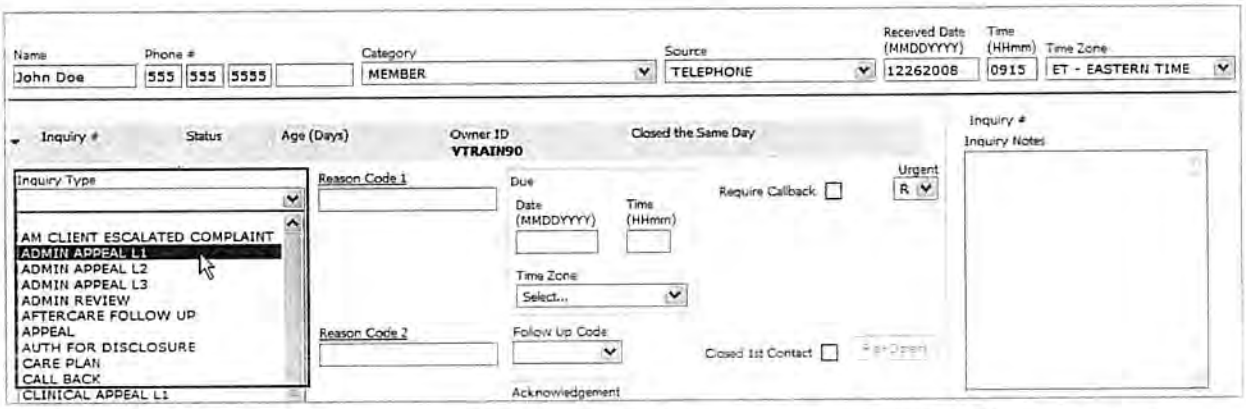
We define a "complaint" as a verbal or written communication of dissatisfaction with some aspect of a process, service or product (other than a denial of services based on medical necessity) by a Member, Member-designated representative, client, or a provider. In support of the VO-LA Grievance and Appeals Administrator, our national Complaints and Grievances Team investigates and resolves complaints, Member grievances, and Member appeals. We do not distinguish between complaints and grievances for the purpose of resolution and trending. Complaints, grievances and appeals policies and procedures for Louisiana Members will comply with all contract and regulatory requirements, including turn-around-times for responding to and resolving complaints, grievances, and appeals.

COMPLAINT PROCESS

Our complaints process is built on the following core components:

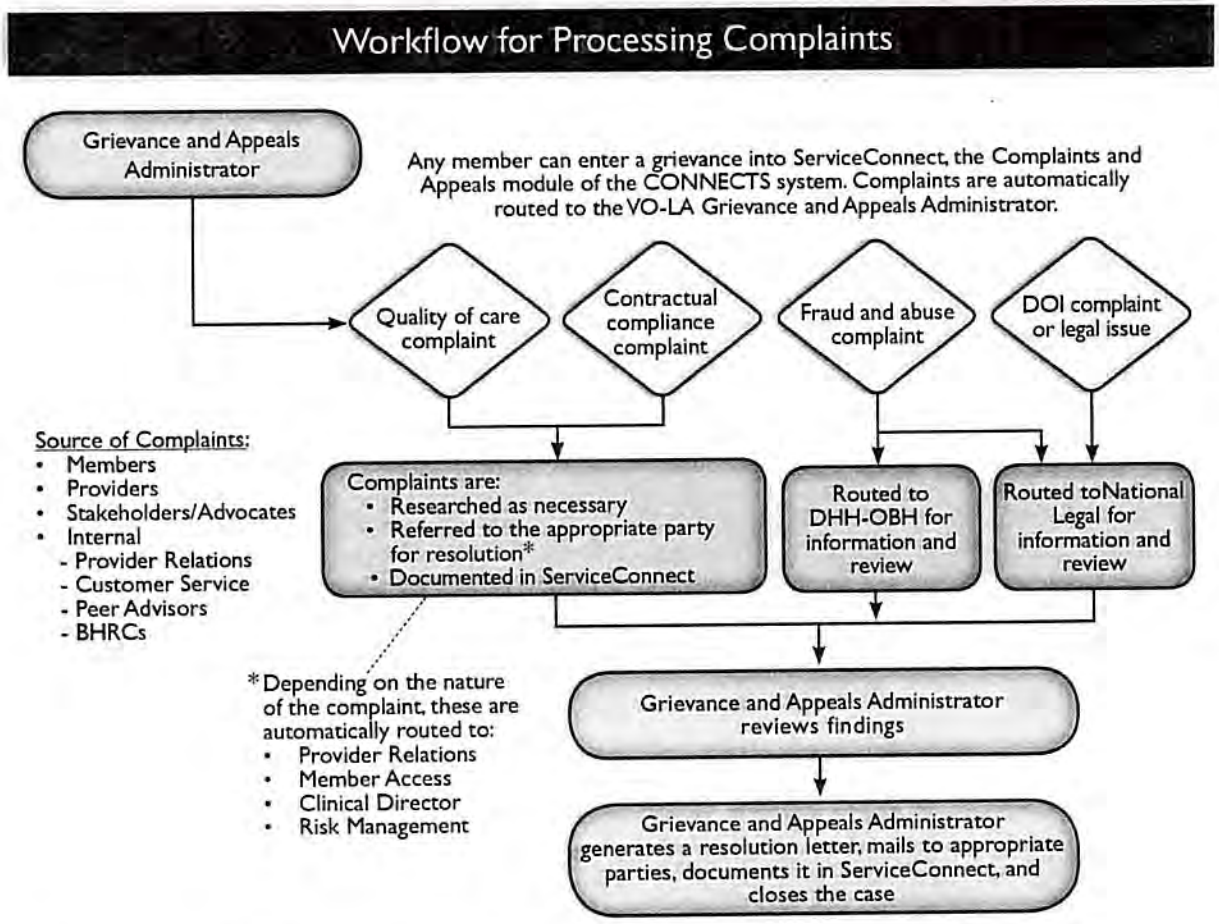
- the ability to accept any information or evidence concerning the complaint
- timely transmission of complaints to appropriate decision-making levels in the organization
- prompt, appropriate action, including a full investigation of the complaint, if necessary
- notification of investigation results to all concerned parties, consistent with State law
- procedures for tracking and maintaining records about the receipt and disposition of complaints

To file a complaint, the Member or authorized representative must call us or provide a written complaint. Complaints may come to us from any department. Our staff documents all complaints and outcomes into our ServiceConnect system (screenshot below). The information entered is then submitted to a work queue that is monitored daily by our National Complaints and Grievances Department.



Our ServiceConnect application enables our VO-LA MSRs to access all necessary information as we strive for first call resolution to all complaints.

Our complaint process assures a quick resolution for Members. It follows both National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) guidelines. A depiction of the workflow for our complaints process is provided below.



Monitoring and Reporting Complaints

Our Quality Department will monitor all complaints. This will enable us to identify and correct problems, improve the care and services we provide Members, and ensure that our complaints system is consistent with DHH-OBH policies and being used consistently.

The VO-LA Quality Department will categorize and track written complaints and grievances by type, and present our findings and recommendations to DHH-OBH leadership team to determine any necessary follow-up or corrective action. Aggregate written complaint data will be tracked and reported monthly, with trending and patterns noted on a quarterly basis. This monthly report will allow us to quickly review potential systemic problems, as both individual complaints and patterns of complaints may suggest the need for further investigation and/or corrective action by us or a provider. For instance, we will report the number, type, and resolution of written complaints by Member, provider or region. We can also analyze patterns of written complaints by population, type of complaint, and outcome. The data we collect will identify not only the timeliness of the problem-resolution process, but will also identify patterns and unique or systemic issues throughout the state system that represent opportunities for improvement.

As necessary, we will take the following steps to address the problems we identify:

- provide additional training or supervision to our staff
- provide training or technical assistance to providers
- implement individual performance improvement plans for staff with substandard performance
- implement corrective action plans (CAPs) with clear timeframes for providers who need practice changes in this area

We will use our current complaints policies and procedures as the basis for developing Louisiana-specific complaints policies and procedures. The complaint and grievances process described in this section is proposed for DHH-OBH's review and will be modified in response to your recommendations. In addition to administering the program, we will comply with all of DHH-OBH's requirements related to complaints as set forth in the RFP or as subsequently modified by DHH-OBH.

Staff Training

Properly handling a complaint is a key component of our comprehensive Member Service training program. All new hires receive training on our policies and procedures for how to respond quickly to any complaint about our services, as we consider these extremely serious. We provide Member Service staff with very detailed instruction on the listening skills necessary to identify key words or phrases, such as general expressions of anger or dissatisfaction. Key phrases include, but are not limited to, the following examples:

- "This is not the outcome I expected."
- "I want to speak to a supervisor about this."
- "I'd like to file a formal complaint."
- "I'm not happy with the service."
- "This process is/has taken too long."

viii. Describe the ongoing monitoring protocols for member services staff, including the nature and frequency of supervision, documentation of audits, call monitoring, quality review, and any other oversight activities. Suggested number of pages: 2.

We recognize the importance of providing immediate response to all callers. We also understand DHH-OBH's interest in monitoring the efficiency of our call center operations. Our sophisticated telephony technology allows for call and screen monitoring, as well as a robust reporting package that allows customized reporting based on program performance specifications.

Nature and Frequency of Supervision

MSRs and Peer and Family Specialists receive daily supervision from the VO-LA Member Services Administrator. In addition, MSRs meet monthly with their supervisor to review performance results for the previous month. During these meetings, the supervisor discusses any missed performance measures, and as appropriate, develops individual action plans for improvement. This includes one-on-one support, additional call monitoring and coaching, re-training, and other activities that will help facilitate MSRs and Peer and Family Specialists success.

Documentation of Audits and Quality Review

Each MSR and Peer and Family Specialist is audited monthly, by either a Quality Analyst or a member of the Member Service management team, to ensure professional, consistent, and appropriate Member service to the VO-LA Members. It is our objective to audit a minimum of five formal calls or inquiries and five informal calls or inquiries with at least three formal coaching sessions per MSR and Peer and Family Specialists per month. All MSRs and Peer and Family Specialists are measured on seven quality audit categories:

1. opening
2. issue definition
3. problem-solving skills
4. hold and transfer techniques
5. responding and advising
6. follow through
7. call closure and interpersonal skills, including cultural competency

Call accuracy and documentation are scored based on each of the categories listed above. Each category consists of multiple quality components, which are assigned points relative to their impact on the overall member service experience. The assigned points are then calculated as an overall percentage, as well as a percentage for call accuracy separate from documentation. VO-LA member services staff have the opportunity listen to their calls and to review call audits. The results of these audits are shared with each respective MSR and Peer and Family Specialist three times per month. They are also used in determining additional training needs or training enhancement requirements, and are applied to all performance management objectives and goals. Internal change is driven by this type of feedback, because this information is shared with other areas within our organization

Call Monitoring

NICE, our call and video recording application, ensures quality customer service to Members and providers calling the toll-free number. Our goal is to achieve total customer satisfaction by understanding what our customer's expectation is and delivering it flawlessly. Our quality program consists of both side-by-side mentoring and coaching, and also silent monitoring and recording of calls. This approach provides a key opportunity to hear from the voice of the customer where opportunities for improvement exist.

Member service reports from the NICE system are reviewed by management staff as part of the quality assurance process. These reports can be run for individual MSRs, groups of MSRs, or the entire call center for any timeframe. They can also provide detailed MSR scoring data, client-specific scoring data; drill down on specific quality categories, and data relative to MSRs below or above standards. Finally, these reports can be run on an ad hoc basis or scheduled to run periodically and e-mailed to the recipient.

All MSRs have a 98 percent call audit and 98 percent call documentation objective. A stellar 95 percent of our MSRs have exceeded this objective.

Other Oversight Activities

Audit-the-Auditor Program

Calibration is the means by which our quality program evaluates the quality assurance personnel to ensure that they apply our quality assurance scoring criteria consistently among each call center. The Quality and Member Services Administrators, Managers, and Supervisors, as well as Level II Auditors, perform the 'Audit-the-Auditor' function during random audits and bi-weekly calibration sessions. These calibration sessions review evaluated calls for consistency and promote policy and protocol changes, when needed. At this time, audits reviewed during the calibration sessions are not scored. However, random audits will be reviewed by the VO-LA Quality Management Administrator to ensure that the scoring and policy changes resulting from these sessions are being followed.

Telephone Reports

A wide variety of telephone performance management reports are available through our Avaya CMS. Avaya CMS monitors the operations of and collects data from the Avaya switch which is then organized into reports that provide the Louisiana Service Center team with information to optimally manage the call center. All call-related activity is captured, stored, and presented to the call center management for real time management as well as for historical trending and analysis. The wide variety of telephone performance management reports are available include:

- hourly, daily, weekly, and monthly telephone accessibility
- call center staff productivity and call responsiveness
- real time reporting and call center staff monitoring to ensure expectations, performance targets, call center schedule adherence, and daily productivity standards are met

Real time reports can be updated as often as every three seconds and summarized as often as every 15 minutes. Historical reports are available in intervals of 15, 30, or 60 minutes; daily, weekly, and monthly. Integrated reports include data for a specified start time in the past 24 hours up to and including the moment the report is generated. This in turn, provides our call center management with the ability to monitor and analyze virtually all telephonic activity within the call center and make real time staffing decisions to ensure a proper level of coverage is maintained at all times.

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ix. Describe how the Proposer's information management system will support member services activities. Suggested number of pages: 1.

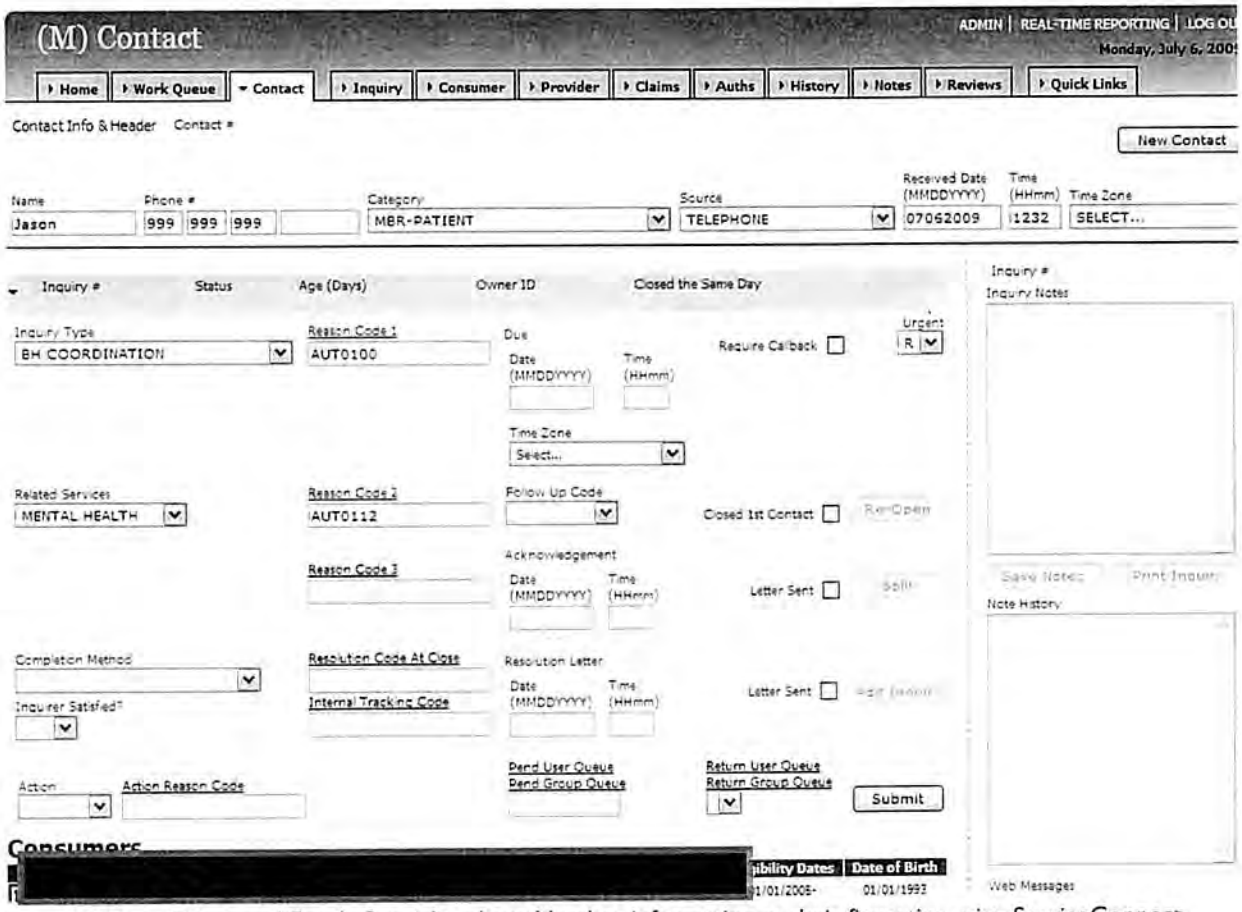
Our MSRs will have access to all information through our Member service application, ServiceConnect. MSRs and Peer and Family Specialists have the ability to perform a wide variety of tasks in this Web-based intuitive and user-friendly environment. ServiceConnect is fully integrated with each Member's specific data and is available on each Member services staff's desktop. ServiceConnect provides VO-LA MSRs with the ability to create and respond to inquiries, validate provider and Member information, research claims and authorizations, manage individual and group work queues, and access detailed Member benefit information.

At the time of an inquiry, the MSR and Peer and Family Specialist uses ServiceConnect's automated "search and capture" feature to capture and store all information pertaining to who the caller is, the individual the call is about, and the reason for the call. Although we strive to provide single call

resolution of every service request, in the event the MSR cannot respond to the service or request at the time of the call, the information is captured and delivered to the support area for review and resolution. Inquiries are then returned to the MSR for response, review, and accuracy validation, with follow through response to the caller.

Additionally, ServiceConnect serves as a customer access management system, prioritizing MSR daily workloads through electronic work queues to ensure timely and accurate resolution of each and every contact handled. ServiceConnect's powerful tracking and analytics capabilities also allow our Quality Management staff to continuously monitor MSRs performance and identify opportunities to improve processes and service delivery.

A sample screenshot of ServiceConnect is provided on the following page.



MSRs and Peer and Family Specialists have Member information at their fingertips using ServiceConnect.

x. Member Services Website

Propose a plan for implementing a website to be utilized by members and family members, providers, stakeholders and State agencies that provides a provider directory, education and advocacy information as described in the RFP. Discuss the proposed content of the website with respect to promoting holistic health and wellness. Provide an example of an active web based site that has been developed for a State agency and include information to permit access to the site. Describe the development tools that will be utilized to create the Louisiana website as well as the proposed security protocols that will be used. Suggested number of pages: 8.

LOUISIANA MEMBER SERVICES WEBSITE

VO-LA recognizes that the effective use of Web-based technology can dramatically improve access to information and the type of services we offer to the Louisiana behavioral health Members. Our guiding principles for designing the Section 508 compliant Louisiana Member Services website will ensure:

Home Internet Access has risen to 47% for individuals applying for Medicaid.
Source – 2011 APHSA Conference

- simplified access to a wide range of information, applications, people and processes
- personalized workspaces to support each Member's role, responsibilities, and preferred way of working
- a security-rich, standards-based, enterprise-wide framework
- access center telephone number
- Member services contact information, including e-mail address
- eligibility information
- hours of operations
- information on how to access behavioral health services
- crisis response information and toll –free crisis telephone numbers
- explanation of requirements and benefits of the plan
- emergency preparedness and response
- holistic health information and related links to health and wellness articles
- information regarding community forums, volunteer activities, and more
- information regarding advocacy organizations, including how children, youth, young adults and other family members/caregivers may access advocacy services
- a hyperlink to the DHH-OBH/CSoC websites
- instructions on how to file a grievance or appeal
- instructions on how to report suspected provider fraud and abuse that includes DHH's toll-free telephone number and appropriate website address
- any other documents as required by the CSoC Governance or DHH-OBH

Louisiana Members will have access to MemberConnect, our online Web portal that offers a wide range of secure flexibility for online Member service requests, 24 hours a day, seven days a week. MemberConnect allows Members to obtain information related to claims status and reconciliation; eligibility, and benefits summary verification; prior authorization status, including services authorized and services used,

We have extensive website capabilities specifically designed for our public sector clients nationwide. Our sites provide educational, clinical, and transactional information that is beneficial to both Members and providers.

identification of network providers and their locations, as well as other types of inquires. Members are presented with comprehensive and easy-to- read information within seconds. The website includes links that provide Members and family members with specific information and resources to assist with their behavioral health needs. These include links to the Member Handbook (in English, Spanish, and Vietnamese), the provider directory, Member newsletters, and articles written by Members, information regarding community resources and advocacy organizations, as well as contact information for contacting Member Services.

In addition to information mandated for Medicaid members, such as a Member Handbook that contains specific information important to understanding and using benefits, the Louisiana website (like all other ValueOptions program-specific websites) will provide access to Achieve Solutions, our online wellness and health information resource. This information is accessible to Members, families, system partners, and providers. Materials can be downloaded easily and used by individual members. We know that providers often print information to share with Members and families. They can print, e-mail, or make a PDF of any of the articles.

In 2010, ValueOptions received a merit Web Health Award, 2010 (formerly, World Wide Web Health Awards). Achieve Solutions also received the World Wide Web Health Awards in 2007 and 2002. Achieve Solutions has also received the healthcare Leadership Award in 2009, 2008, 2007, 2005, 2004, and 2002. The Healthcare Leadership Awards are presented by Healthcare Strategy & Trends, the leading Internet publication and online resource, published by Health Care Communications.

Achieve Solutions Proposed Web Content

Achieve Solutions fills the need for a confidential behavioral health and wellness website focused on recovery, resilience, and advocacy. Features include:

- **Award-winning content** – the public sector site draws from more than 2,500 articles housed under 125 health and wellness topics.
- **Find Services** – users can gain quick access to self-search tools that will help them locate a variety of services, including local VO-LA mental health providers and community resources.
- **Access Concerns** – interactive quiz-based check-up helps users identify areas of their life in distress, such as life balance, relationships, mood, stress, and substance abuse.

Achieve Solutions focuses on recovery-based navigation and client-specific internal tools and resources:

- **Explore Info** – the center titles located in the navigation bar allow the user to explore symptoms, rather than focus on a specific illness or diagnoses.
- **Spotlight** – this section will contain "cycling content" and can include customized information for Louisiana. It can include presentations, articles, audio and video clips, and/or service center news. There is also a monthly topic and poll.
- **2011 Content Plan** – New content approved by DHH-OBH will be added and written at a fifth-grade reading level. New topics may include culture matters, holistic health, transitional youth, parenting a child with serious emotion disorders, crisis planning, disasters and living on a fixed income.

Achieve Solutions' content is clinically credible, current, and consistent with our focus on quality. The majority of articles are developed in collaboration with leading experts at centers of excellence, such as the University of Florida's McKnight Brain Institute, Boston College's Center for Work and Family, and the Stepfamily Association. Our Achieve Solutions editor staff will also reach out to centers of expertise and excellence in Louisiana to partner in developing state specific information for the LBHP Members.

In addition to partnering with highly regarded experts, Achieve Solutions' editorial staff ensure the integrity of the information on the site through peer review of all clinical articles. All published clinical content is reviewed annually to ensure that the information stays current; non-clinical content is reviewed bi-annually. Source(s), author, posting date and review date are listed on each piece of content so that the Member can assess the credibility. Our Achieve Solutions in-house editorial staff is well-versed in consumer recovery, wellness, self-management, and communications, ensuring information is meaningful to visitors. These staff members strive to meet Members' interests by developing a carefully planned editorial calendar for items featured on the home page. The calendar includes feature stories and spotlight articles, video and audio with broad-based and seasonal appeal. We also continue to develop content based on internal product analysis, user and client comments, trends and significant news events.

During the past year our public sector Achieve Solutions site had 35,109 views. Joven en Transcisn (Transitional Youth) was the most visited site.

Sample screenshots of the Achieve Solutions site we have already begun customizing for Louisiana is provided on the following pages:

Members will see new articles available on the VO-LA Achieve Solutions home page.

Members can choose from 2,500 articles of interest on the VO-LA Achieve Solutions site.

Example of Active Web-Based Sites

Below, we provide the following links to other Achieve Solutions sites developed for active public sector programs ValueOptions manages:

- ValueOptions of Maryland
  https://www.achievesolutions.net/achievesolutions/en/maryland/Resources.do
- Volunteer State Health Plan (TennCare)
  https://www.achievesolutions.net/achievesolutions/en/vshptn/Home.do

We also offer the beginnings of a customized site for Louisiana, as well as customized disaster response site, which is more fully described in *Section 2h.*

Louisiana Website Development Tools

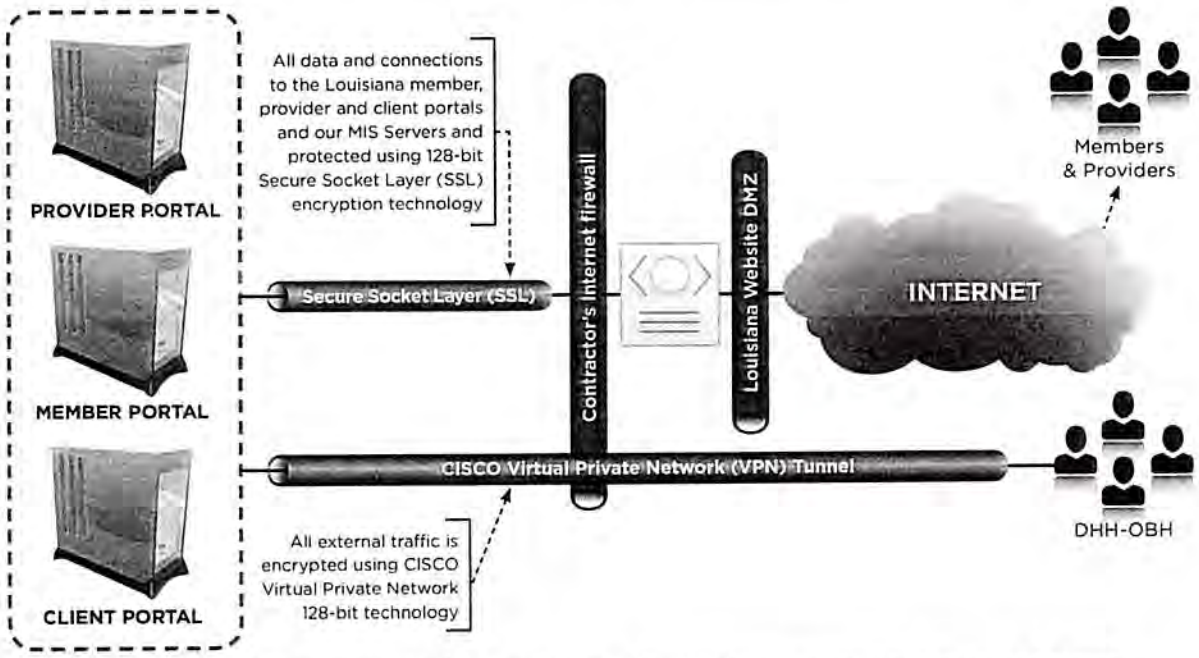
As part of the development of the Louisiana-specific website, we will work with our internal editorial staff to include recovery experts from Louisiana, including Members and family members on our Quality Committees and from the CSoC Governance Body, to ensure information is specific and relevant to your state and local communities. We will survey current wellness and recovery

literature developed for other state Medicaid program websites, and customize this information appropriately for your Louisiana-specific website. Additionally, we will also look to our Regional Teams for specific issues raised during their field work in the 10-region area throughout the State and update our information or create new topics based on this feedback. Our goal is to ensure this website is not only user-friendly, but it also contains a robust set of features and content to assist Members as they navigate the behavioral healthcare delivery system.

Security Protocols

We are committed to performing our business activities in compliance with all applicable laws, regulations, and HIPAA-related policies. We have implemented transmission security to ensure that security violations are prevented, detected, contained, and corrected in accordance with federal HIPAA Security Regulations.

We employ industry-recognized best practices and technologies to provide a stable and secure infrastructure to support the need to exchange data over the internet.



We employ industry-recognized best practices and technologies to provide a stable and secure infrastructure to support the need to exchange data over the Internet.

Our **Member Web Portals** are designed with enhanced security features including: the ability to properly identify and authenticate users; the creation of audit records when users inquire or update records; the provision for access controls that are transaction-based, role-based, or user-based; controls to ensure transmitted information has not been corrupted; message authentication to validate that a message is received unchanged; and encryption or access controls, including audit trails, entity authentication, and mechanisms for detecting and reporting unauthorized activity in the network.

In addition, Achieve Solutions leads the industry in providing the highest level of security to protect user privacy—a significant concern among Web users. Achieve Solutions includes the following security measures for users:

- The Achieve Solutions website is a VeriSign™ secure site, which enables visitors to verify the authenticity of the site and use Achieve Solutions securely via state-of-the-art Secure Socket Layer (SSL) encryption, which protects confidential information from interception and hacking.
- Most significantly, Achieve Solutions encrypts each page on the website. Should someone click on one of the page names in the computer's history after the original user has logged out, the website will automatically show the login page, rather than the page the person tried to view.

It is important for Members to be aware of our privacy policy. Achieve Solutions prominently displays a link to the privacy statement on every page. When a user first visits Achieve Solutions and verifies eligibility, the user is immediately presented with a Web page detailing ValueOptions' Privacy Statement. To proceed, the user must click on a button agreeing to the privacy statement to enter the site. A link to the Privacy Statement is included at the bottom of each page within the Achieve Solutions site to ensure ongoing accessibility. Any changes to the Privacy Statement require the visitor to review and agree to the privacy policy before proceeding to the site.

xi. Member Handbook

Describe the Proposer's experience demonstrating compliance with annual notification to members of member rights and other required information given confidentiality concerns and the transient lifestyle of some members. Suggested number of pages: 2.

VO-LA understands that Members, their families and caregivers need to understand how to access services, what their health care rights and responsibilities are, and that their conditions and information will be protected and private. The Louisiana Member Handbook will serve as an important tool not only for informing Members, but also for providing descriptions and instructions that will help them understand and use their behavioral health benefits. Our Member Handbook will include all information required by federal regulations and by DHH-OBH (as requested in *Section 3e.* Member Handbook of the RFP), including English, Spanish, and Vietnamese versions that provide information to all children, youth, adults and their families/caregivers, including the Member Bill of Rights.

VO-LA employs public sector staff that have written, translated, updated, and distributed Member Handbooks for each of ValueOptions' publicly-funded programs across 14 states. With a focus on recovery, staff members vet the documents for compliance with all Federal and State-specific Medicaid requirements, as well as tone and usability, and receive prior approval for all documents and translations before distribution to Members and families. We will do the same here. An important component of the approval process is to seek the input of peers and families in the development of Member Handbooks via our Quality Committees and the CSoC Statewide Governance Body, to ensure that the document is logical, understandable, promotes recovery and resiliency principles, and meets Members' needs. As such, we will seek input from the FSO Statewide Coordinating Council and the literacy program at Louisiana State University (LSU) Shreveport.

We will make the Member Handbook available in a number of ways, guided by federal regulations and the recommendations of DHH-OBH and the FSO Statewide Coordinating Council. For example, we expect to mail materials to Members who have Medicaid eligible through providers. We will distribute materials to those who are served through CSoC. Copies of all materials will be posted on the VO-LA website so they can be downloaded and reproduced easily. In addition, anyone will be able to request a copy of the Member Handbook by calling the VO-LA toll-free number or by submitting an e-mail request through the VO-LA website.

In addition to the Member Handbook, Members and their families will also receive information about their rights at intake. Our MSRs and Peer and Family Specialists will be trained to provide this information to Members, if requested. Also, our Regional Teams will be able to share information with Members about their rights and responsibilities.

Notification

- We will support and adhere to the Member Bill of Rights and will require that all contracted providers do so, as well.
- We will include the Member Bill of Rights in our Member Handbook, which will be provided to each customer. The Member Handbook will also contain information about the process of filing complaints, grievances, as well as services available and how to access them.
- In addition to providing the Handbook to members and families, we will make the Member Handbook widely available to families and other interested community members.
- VO-LA Care Managers will provide appropriate information to customers who contact the toll-free access line.

Our Peer and Family Specialists will provide training for customers in orientation sessions prior to the contract start date and in subsequent training sessions across the state. Peer and Family Specialists working in our Regional teams will be available to give updates and respond to questions during local stakeholder meetings.

During satisfaction surveys, meetings, focus groups and other interactions with customers, we will verify that Members have access to the Member Handbook and the information about the Member Bill of Rights.

We will work with the DHH-OBH and FOS Statewide Coordinating Council to establish a variety of ways to make sure the concerns of Members and their families are not overlooked and they understand their rights and responsibilities. A major forum for this discussion will come through the Member and Family Advisory Committee, which is part of the Quality Assurance/Performance Improvement Committee structure.

We have never been fined nor had a Corrective Action Plan related to notification of members of their rights. Our commitment to Member rights is unparalleled.

Information on Member rights also will be part of the Provider Manual. As part of orientation and ongoing training for providers, our Peer and Family Specialists will work with the provider community to ensure their responsiveness and sensitivity to the rights and responsibilities of people they serve.

We provide examples of our public sector Member Handbooks and a draft of a Louisiana Member Handbook as **Attachment 3**.

xii. Member Communications

(a) Describe how the Proposer will ensure a comprehensive communication program to provide all eligible individuals, not just those members accessing services, with appropriate information about services, their rights, network providers available, and education related to benefits and accessing BH services. Include a description of the standard materials to be included in the communications program at no additional cost to the State. Suggested number of pages: 3.

VO-LA will provide Members with timely, accurate, and easy to understand information. All Member materials will be approved by DHH-OBH and reviewed by members and other stakeholders prior to publishing. VO-LA will furnish each Member with the information required by DHH-OBH within a responsible time after we receive notice of the Member's enrollment in the program from the DHH-OBH or your contracted representative.

COMMUNICATIONS STRATEGIES

Each new Member will receive a welcome packet containing a welcome letter, a Member Handbook, including a copy of the Member's Rights and Responsibilities, and a provider directory. Member information will also be posted on our website. After the initial transition period, in addition to the Member Handbook and other material required in the RFP, VO-LA will offer an array of other communications materials important in reaching out to consumers and families in other programs that enhance and promote recovery. These include:

- **MemberConnect** provides Members with a one-stop shop for Members who wish to complete everyday service requests online 24 hours a day, seven days a week. By creating a user name and password, Members can log onto MemberConnect to locate a provider, check benefits and coverage, and view authorizations and correspondence. All information is exchanged through a secure web platform. We will inform Members about their access to MemberConnect when they become enrolled in the program in the welcome letter and in the Member Handbook.
- Our award-winning website, **Achieve Solutions**, provides more than 2,500 articles on more than 125 health topics. Topics cover health and wellness, family care, depression, anxiety, substance use disorders, recovery from mental illness and work/life balance. Achieve Solutions also provides online access to feature stories and daily news articles.
- VO-LA will maintain an array of information about mental health and wellness-related topics. This information includes **newsletters, brochures** about specific mental illnesses and their symptoms, **pamphlets**, **videotapes**, and other educational materials from advocacy groups like NAMI and the Mental Health of America.
- **Prevention Presentations and Educational Programs** will be provided based on identified need or specific request. The topics we will cover include Positive Parenting, Suicide Prevention, Preventing Teen Violence, Stress Management, and Anger Management. Special community presentations will also be provided on Advance Directives, as requested. This process will be enhanced via our regional teams who will provide local services and/or expeditiously tap services at the Baton Rouge Service Center, as needed.

- ValueOptions will also work with Member leaders (both young and old) and families to plan a **Member Conference** focused on recovery and resiliency as a means for Members to tell their stories of hope and success and inspire other Members.
- **Question and Answer sheets** that answer basic questions about how to access care, how to contact the Peer and Family Specialists, where to go for care, and what to expect from the Louisiana SMO.
- **"Tip sheets"** will offer information to enrollees on topics suggested by consumers themselves, such as self-help, parenting, child development, financial management, medication management, child discipline techniques, coping with stress, communication with children, sexually transmitted disease prevention, pregnancy prevention, AIDS prevention, how to access community resources, separation and divorce, and abuse.
- **Family Resource Guide to Mental Illness** was created to provide information for consumers and their families about mental illness, resources available, and ways to help them deal with the challenges of mental illness. This guide was created by our Colorado Health Partnership (CHP) in concert with the Western Alliance for the Mentally Ill and Colorado State Mental Health Services.
- **Rehabilitation and Recovery Handbooks for Providers.** Members served through our Colorado Service Center have helped develop a manual for service providers to help them understand recovery and empowerment from a consumer perspective. This handbook has been well received by the providers in the Colorado Health Partnership Service Area.
- **Member Newsletter.** With the assistance of Members, family members, and advocates in other programs, we have created and distributed consumer newsletters to consumers and family members. Newsletters contain information about prevention topics, forthcoming education programs, and changes in the Program. Members and family members are invited to write articles about their own experiences and act as editors and reviewers.
- **Depression and ADHD Workbooks –** were developed collaboratively with providers, consumers and family members and provide self-directed strategies for persons in treatment for depression and families who are raising a child with ADHD.
- **Recovery Toolkit** – is intended to support providers as they deliver services to children and their families. The toolkit assists providers in delivering services based upon the strengths of the child and family and including natural supports.

Alternative Formats for Written and Oral Communications

ValueOptions' public sector programs have developed a number of ways to communicate with Members and families who may have difficulty reading or understanding Member communications materials written in English, Spanish and Vietnamese. Some of these include:

- **Peer Support**—Peer and Family Specialists are often available—as they will be in Louisiana—to speak with a caller and explain policies and procedures about which they may have questions. MSRs are trained in the same skills. This feature is particularly important for people who may have limited ability to read English even though English is their primary language.
- **Recorded material**—In several programs, ValueOptions has paid consumers to make audio recordings of consumer informational material for use by people who have limited vision.
- **Translations**—In almost every program, ValueOptions contracts with certified translators to translate material written or recorded in English into other languages. Of all the languages other than English, Spanish is most prevalent. Many ValueOptions materials—including several websites—already are available in Spanish. ValueOptions will also ensure vital information (as

defined in the RFP) is presented in Vietnamese and any other prevalent language spoken in Louisiana. We will also work with DHH-OBH to review census data and determine the other languages spoken by a large percentage of its Members, and provide standard written Member materials in that language. ValueOptions has experience analyzing census data and eligibility data to determine the primary languages of its Members.

- **Signing**—It is standard practice for ValueOptions to provide translators who are competent in signing for public meetings when people who will be in attendance request the accommodation.
- **Interpreters**—ValueOptions staff will have access to a dedicated Language Line. This service can accommodate more than 170 languages, handled by highly skilled interpreters with more than 20 years of experience.

We ensure that eligible Members who are not currently accessing services know how to obtain services or more information about benefits that are available to them in several ways. We distribute the Member Handbook to all Medicaid recipients, and we forge and maintain close relationships with social services agencies and providers, advocacy groups, governmental entities, and school systems, because those entities are likely to identify and refer persons who may need to access services. These resources are kept apprised of the informational formats available to Members, how to access information or services and of changes in the program that might affect potential users. VO-LA staff members participate in local coalitions, attend local meetings of agencies that interact with our potential users of service, present the program to agencies and entities that are likely to be sources of referrals to potential users. For our public sector programs in other states, ValueOptions has developed colorful posters with access and information numbers for distribution to churches, food banks, WIC and Food Stamp offices, grocery stores, libraries, and other locations potential users frequent. Business sized cards with access information for ongoing services and mobile crisis teams are distributed to law enforcement and other first responders to make referral information easily available to persons with whom they come in contact who may need services.

(b) Illustrate an example of the Proposer's most successful member communication effort that embodies the system principles outlined in the RFP. Suggested number of pages: 2.

For our contract in Connecticut, the Connecticut Behavioral Health Partnership (ValueOptions) Peer Specialists are trained parents of children with behavioral heath needs and/or adults with personal experience of the behavioral health delivery system. The Connecticut Behavioral Health Partnership approach to care management incorporates a substantial role for the Peer Specialists because they so efficiently embrace the principles of recovery and resiliency. This framework of recovery and resiliency advocates that families and children should be directly involved in their treatment and discharge plans as they learn to live with their symptoms and thrive in the process of taking responsibility for their own lives.

These principles are outlined in the below vignette, which illustrate the recovery and resiliency model and the positive impact of this on our member outcomes through our Peer Specialists and Intensive Care Managers. The below vignette also provides evidence of the importance of communicating and practicing the principles of recovery and resiliency.

Our Peer Specialist received a referral an Intensive Care Managers to outreach to a 15 year-old member's mother. This member was stuck in an Emergency Department (ED) and the ICM and ED felt the mother could use some support as this was her daughter's first ED visit. The Peer Specialist agreed to meet the mother in the ED. Our Peer Specialist communicated the process of an ED assessment and what to expect afterwards. The member was assessed to need inpatient care for her safety. The Peer Specialist explained to her mother that once an available bed was identified, her daughter would be transported to the hospital. The Peer Specialist communicated the process of what to expect when a child is admitted including; questions about what services are in place, what brought the member to the ED and what services are needed upon discharge.

The Peer Specialist then inquired about the support currently in place. The mother stated "she has her husband and other children and nothing else." The Peer Specialist informed the mother of resources such as Care Coordination and Department of Children and Families (DCF) voluntary services. Together the Peer Specialist and mother applied for DCF voluntary services. The member was accepted. A Support Staff was put in place along with an after school program upon the member's discharge. Peer Specialist identified a support group through NAMI for the mother to meet other parents. With the help of NAMI and the Peer Specialist, the mother is now a facilitator of her own support group communicating recovery and resiliency principles to others. The member is doing well with her staff. She has finished the after school program and is now taking singing lessons.

We provide sample Member communications materials as **Attachment 4**.

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

i. Describe how the Proposer will conduct CM and UM of BH services. Describe how CM and UM will be integrated and organized for all covered populations, including workflow. Suggested number of pages: 6, exclusive of workflow.

LOUISIANA CM AND UM PROGRAM

VO-LA will conduct the Care Management and Utilization Management of behavioral health services with the focus on DHH-OBH's mission *"to promote recovery and resiliency in the community through services and supports that are preventative, accessible, comprehensive and dynamic"*. VO-LA's Care Management program focuses on access to the right services at the right time and at the right location. Our care management program will advance the Louisiana Coordinated System of Care Values and Principles within the service delivery system, promoting services that are:

- family-driven and youth-guided
- home and community based
- strength-based and individualized
- culturally and linguistically competent
- member and family centric
- integrated across systems
- connected to natural helping networks
- data-driven, with a focus on improving health and wellness outcomes

We understand that Members and their families are more likely to access appropriate services and remain engaged in treatment when they feel that their needs are understood and met. Based on the mission of DHH-OBH and driven by creating a network of providers to guarantee appropriate access, VO-LA will establish a Care Management/Utilization Management program that will meet Louisiana Behavioral Health Partnership (LBHP) needs, promote effective system management and create access to appropriate, high quality services to assist children and adults with complex behavioral health needs.

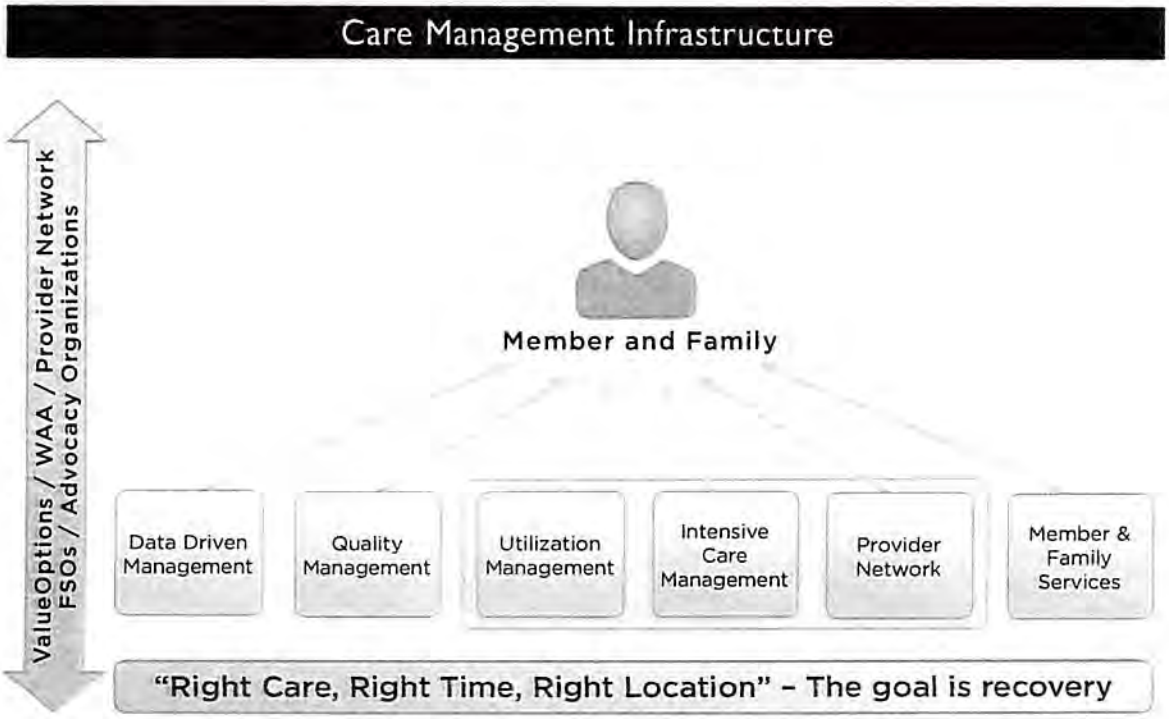
VO-LA CM/UM program embraces fundamental tenets of recovery and resiliency and begins with a person-centered, strengths-based approach to care planning that:

- promotes member learning and empowerment
- promotes a "no force first approach" to crisis planning
- promotes dignity and respect
- incorporates member's strengths, aspirations and values
- focuses on strengths of the member and family
- promotes personal responsibility and member direction for their recovery goals

Program Goals

Goals of the CM program include:

- increased time living in the community and unification with family/significant others
- increased resiliency to help overcome environmental stressors
- decreased admissions to acute inpatient psychiatric settings
- decreased admission to residential programs
- timely discharge planning and linkages into the community
- shorter length of stay in residential programs
- increased utilization of outpatient services and community supports
- reduction in duplication of services by accessing existing Systems of Care initiatives
- improved treatment planning and coordination among members, families and providers
- individualized treatment planning and education that is not limited to :
  - outreach to families and individuals
  - coordination with involved State agencies
  - community services such as WRAP
  - local support services (concrete services as needed) with emphasis on individual choice and the resiliency of the family/significant others and individual
  - development of care plans that meet the beneficiaries needs and preferences
  - coordination with a variety of behavioral and health services including medication management as indicated
  - importance of keeping regularly scheduled provider appointments
  - recognize and address psychosocial issues related to depression
  - improve functional status



The illustration above demonstrates how VO-LA conducts Care Management as an overarching process and philosophy that connects all the activities of the Clinical, Quality, Provider, and Peer recovery programs based on access to the right care at the right time, and right location.

Key to Quality Care Management

VO-LA CM processes support effective care management strategies that reduce risk to Members and families/caregivers, by monitoring Members who have high-risk needs that have not been addressed, empowering the Member to achieve self efficacy and by ensuring easy access to the right services at the right time for the right reason. To achieve improvements in care, ValueOptions' management techniques and principles support the following 'key aspects' of quality care:

Key Aspects of Customized LA Quality Care Management	
Evidence Based Practices	VO-LA will develop a provider network that uses evidence-based practices (EBPs) by establishing ongoing training opportunities such as Motivational Interviewing; Assertive Community Treatment; SBIRT; and CBT. Treatment interventions will be evidence-based and support long-term recovery.
Coordination and Continuity of Care	Care will be provided in a well-coordinated manner among multiple providers. Members and Families will have ready access to information and services through the VO-LA Member Access line a one-stop source for assistance.
Integrated Treatment Planning	To establish the coordination of care, our clinical module of our management information system, CareConnect, supports the electronic sharing of plans of care across all providers, Primary Care Physicians, Members and caregivers. Integrated Treatment Planning includes creative individual-centered and strengths-based planning that empowers the Member and builds resiliency.
Emphasis on Early Intervention	Through our provider network, Member information system, and PCP education strategies, VO-LA creates early detection points for proactive interventions and access that are essential for people with disabilities and chronic illness and children with complex behavioral and social histories.
Value-Added Services	VO-LA contracts for services that are both traditional and non-traditional and emphasize Member choice, natural supports, and holistic needs. The emphasis of value-added services is on collaboration and connectedness. We will also further develop peer-run services throughout LA.
Greater Accountability	The VO-LA service system will keep Members, families and caregivers engaged and seek the input necessary to improve its performance as measured by Member satisfaction, quality of life, connectedness to the community and positive health outcomes.
Cultural Competency/Proficiency	VO-LA will establish a provider network that understands the unique cultural diversity within the State. As the system increases its services and system scope, VO-LA will assure

Key Aspects of Customized LA Quality Care Management	
	the individual cultural needs of the Members are recognized and respected.
Family and Natural Supports	Family and natural supports build resiliency and support recovery to overcome the debilitating effects of the stigma associated with mental illness and substance use. VO-LA will develop services that support a sense of purpose and involvement in the community.
Recovery and Resiliency	VO-LA will provide training on recovery-based case management, recovery teams, Peer and Family Specialists of the Care Management team, strengths based services and self determination. The goal of these trainings is to facilitate Members in directing their treatment and developing the skills to reduce relapse.

Care Management and Utilization Management Overview

VO-LA's Care Management and Utilization Management program is supported by the entire organization, however LBHP Utilization Managers (UM) and Care Managers both perform the direct functions of utilization management and care management, which is coordinating and overseeing the behavioral, physical and special health needs services furnished to each identified Member. They also serve as the single point of contact for that Member or the Member's legal guardian or designated representative. The activities of the UMs are more fully described in our response to *Section 2.c. Utilization Management.* For Care Management activities performed by the Care Managers, the focus of care coordination and transition services ensures that Members receive needed treatment and support services without disruption. VO-LA will customize its criteria with the approval of DHH-OBH that will facilitate the identification of Members who can benefit from Care Management services. Additionally, Coordinated System of Care (CSoC) and Regional Care Managers will perform all UM functions for episodes of care, and facilitate care coordination activities for discharge planning and step-down services.

Much work as already occurred in Louisiana to develop a System of Care – from CASSP which several providers spoke of as a "great but unsustained initiative" to LA-Y.E.S. We recognize this opportunity provides a fundamental shift to truly implement a statewide, sustainable and integrated approach to meeting the mental health needs of Louisiana's most vulnerable children.

The Care Managers, will be part of our Regional Team and assigned to each of the 10 regions. The Care Managers assigned to these teams will be responsible for all aspects of a child's care management and utilization for that specific region. Care Managers on the regional teams are located in each region of the State and are knowledgeable about the System of Care principles as well as resources within the region. They will coordinate behavioral health care of individuals identified through development of comprehensive interagency treatment planning for the purposes of assisting with discharge planning for beneficiaries admitted to inpatient care, and admission diversion for those at risk of being admitted. The Regional Care Managers collaborate with the Family Services Organizations (FSOs), Wraparound Agencies (WAAs), and an array of providers and other stakeholders, including but not limited to, behavioral health providers, Primary Care Physicians, advocacy organizations and any gatekeeper organizations involved in prior authorization

of services. These Regional Care Managers serve as the "single point of contact" for an individual child and family whose needs are complex and severe. The goal is to improve the lives of the beneficiaries and families we serve and to focus on positive outcomes. This includes the identification of best practices, targeted interventions, recognition of duplication in services, and working with the family and individuals within the community and natural support setting.

The Regional Care Manager activities include but are not limited to:

- telephonic outreach and support to individuals and their families
- identification and linkages to natural supports in the community
- coordination with multiple providers and support services to maximize on the ability of the individual to remain in the least restrictive environment and avoid duplication of services
- participation in systems development to support the continuing efforts of the Systems of Care Model in the State of Louisiana
- Utilization management for CSoC Children.

These individuals will work with the FSOs and WAAs and will assist in facilitating and coordinating comprehensive inter-agency treatment planning for identified Members. If the number of children who are eligible for the CSoC becomes too great for the Care Manager to manage, we will reassign a UM from our Baton Rouge main office to serve that region solely. These individuals will be responsible for the utilization and care management functions within their assigned regions to assure management is coordinated through one Statewide Management Organization (SMO) contact person for each CSoC region. Additionally, the assigned CSoC Care Managers will also manage services for children and youth in out-of-home placement from their assigned region to assure the maximum coordination of community resources and supports.

Access to Care

VO-LA will develop and maintain a comprehensive care management function for DHH-OBH that ensures covered services are available when and where Members need them. Our care management module of our management information system, CareConnect, supports the work of our Peer and Family Specialists, UMs, and Care Managers. We will maintain staffing levels to respond 24 hours per day, 7 days per week, 365 days per year to Members, their families/caregivers, or other interested parties calling on behalf of the Member. Care coordination and referral activities will incorporate and identify appropriate methods of assessment and referral for Members requiring specialized behavioral health services and linkages to primary medical care services. These activities include scheduling assistance, monitoring, and follow-up for Members.

Key to the success of the DHH-OBH's mission, VO-LA will develop, credential, and support a comprehensive network of qualified providers that the care management team will use for referrals to services. We will also screen children and youth with the Child and Adolescent Needs and Strengths (CANS) brief screen and make referrals to the WAAs for CSoC eligible Members. As a part of every referral to a WAA, VO-LA will authorize the initial 30 days of services needed as a result of the brief screen. All referrals for services will be made according to the screening assessment for immediate, urgent, and routine needs within the appointment access standards outlined in the Request for Proposal (RFP), with the requirement that children/youth eligible for the CSoC will meet at least the urgent appointment standard.

Additionally, VO-LA and our providers will meet the management of care standards outlined in Section II, B. 4c i, ii, iii of the RFP for timely access to care and services, taking into account the urgency of need for services. We will also establish mechanisms to ensure that network providers comply with the timely access requirements, will monitor them regularly to determine compliance, and will take corrective action if there is a failure to comply. In addition, we will ensure all providers will offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

Our Care Management Workflow reflects the steps VO-LA clinical staff members take to ensure LBHP Members have optimal coordination of services.

Workflow Redacted

The workflow above illustrates the Care Management interface at the initiation of a service request through the PCP verification process.

Using Data to Support Care Management Decisions

VO-LA will measure results and performance related to standards, including clinical criteria, level of care guidelines, practice guidelines, and industry best practices, for Members, providers, and our clinical staff. We will measure and profile provider performance and use this information to help match the needs of Members with the most appropriate service provider accounting for Member choice. Clinical reports and information will support our review of care, for recovery and resiliency outcome-focused services and authorization determinations, helping to ensure consistency with medical necessity criteria and practice guidelines. Threshold indicators will help identify and track outliers for over- and under-utilization, as well as quality of care concerns, for additional or specialized management. Clinical data analytic and decision support tools will help focus more intensive monitoring and proactive interventions like care management by identifying high-risk Members and predicting those who may be at risk for negative outcomes. They also will help identify those providers more proficient at treating certain problems as well as outliers who may benefit from additional training and education.

By analyzing aggregate data for demographic, diagnostic treatment and other considerations related to Members, providers, involved departments, agencies and family support systems, we can identify best practices and areas for improvement across the system. The appropriate interventions, whether educating providers about best practices or developing system-wide improvements, can be made. These tools will also support the performance measurement of our clinical staff in managing care, and are used to continually improve our policies, processes, and procedures. They help identify areas in which training and education can improve the performance of VO-LA clinical staff, family support organizations, and providers.

Data and clinical decision support information systems will be used to support the additional care management activities identified in the RFP through data reporting and analysis, such as:

- coordination of care, including persons with serious mental illness who are incarcerated and children in out of home placement
- outreach and education to family members
- follow-up on missed appointments and treatment adherence
- poly pharmacy and co-morbid conditions
- coordination with primary care
- monitoring of plans of care and quality
- consultation with involved agencies, departments and service providers regarding fidelity to practice guidelines and to monitor unmet needs
- identification of potential quality of care issues to refer to physician advisors

Integrated Treatment Planning

The data-driven process to Care Management and Utilization Management includes the use of online integrated plans of care, treatment plans, and crisis plans available to all supports, providers, involved agencies, Primary Care Physician (PCP), Coordinated Care Networks (CCNs), and FSOs. This functionality will be important to DHH-OBH and will facilitate success in implementing the CSoC, services to high-risk Members, services to children and youths in out-of-home placement, and will advance a Member-focused system of person-centered care. When Members are receiving

Integrated Care provides better health outcomes for LBHP Members

higher levels of care such as acute care or residential services, the focus of integrated plans of care is on discharge planning and setting up effective and efficient community services to advance the Member's recovery goals.

Working with Local Education Authorities

VO-LA will ensure all children receiving school-based Medicaid behavioral services will be screened using the CANS brief screen. Louisiana has made great strides in expanding school-based health services. We will seek to collaborate and build on the work of the Picard Center to disseminate information about behavioral health services and how schools can best access these services. When clinically indicated, children and youth will be referred to appropriate services for further assessment. We will review all plans of care and coordinate services with the WAA or treatment planner. When engaging in utilization management for children with an individualized healthcare plan (IHP), we will authorize covered services based on the child's IHP. Additionally, the information from the IHP, including needs and school services provided, will be integrated into CareConnect along with all data elements described in *Section 2.s.(d)xvii of the RFP.* With appropriate releases, this information will be shared online with all treatment planners, PCPs, caregivers, and the WAA involved in the care of the child to facilitate maximum coordination of treatment needs and services and eliminate any duplication of services. We will also work with schools to identify resources and natural supports in the community, as well as addressing their behavioral health needs and achieving success in school to meet the needs of the children.

Additionally, VO-LA will monitor, through record reviews, audits, and as a part of the Care Management and Utilization Management authorization process, the delivery of school-based services and assure the services are delivered in accordance with the child's IHP, and report incidents of non-compliance to the school, the Department of Education (DOE), and Medicaid. Finally, VO-LA will provide ongoing consultation and education regarding effective treatments for eligible children with behavioral health needs. We can provide this through multiple formats including provider newsletters, online trainings, online educational materials, and community-based trainings on best practices.

Primary Care Coordination

As a part of the Care Management workflow and on every utilization management "touch" VO-LA will identify if a Member receiving behavioral health services has a PCP, and if not, we will refer the individual to a PCP in the CCN, and allow each member to choose his or her provider to the extent possible and appropriate. We will document the Member's PCP (and instances where a Member does not have an identified PCP) in their care management record within our CareConnect system. Part of our Care Management program includes follow up on referrals to PCPs and PCP referrals for services from the SMO. We have Care Management procedures that ensure Members have an ongoing source of primary care appropriate to their needs and person or entity formally designated as primarily responsible for coordinating the health care services furnished to the Member. Our CareConnect system also allows for the documentation of annual well care visits, which can then be tracked and reported for follow-up, assuring Members have scheduled and kept their appointments. We have also learned that there is still a tremendous use of older antipsychotics that carry a high risk of increasing co-morbid conditions. These issues will be identified via PharmaConnect for the PCP and also addressed through our Care Management process. Finally, our predictive modeling can flag Members by assigned PCPs so we can alert PCPs to treatment issues such as substance abuse, risk of harm to self, and recent changes in therapeutic services.

To achieve successful coordination of care with the PCP, VO-LA will obtain releases of information from the Member or the family/caregiver for children. We will coordinate if medications are prescribed by a network provider and obtain a list of medications prescribed by PCPs and other specialists for a complete and reconciled medication list that is updated every 90 days. Special emphasis will be placed on notifying the Member's PCP of the initiation of, or change in, psychotropic medication. We will also require network providers to request a standardized release of information from Members to allow them to coordinate treatment with their PCP. Having received such release, we will ensure network providers provide timely notification to the Members' PCPs regarding their behavioral health treatment recommendations.

The workflow below reflects the PCP Care Management process including the medication reconciliation and coordination with the CCNs to assure that Members' care is integrated with their medical service provider.

Workflow Redacted

ii. Provide an organizational chart for the CM/UM department(s) that includes position titles, numbers of positions, and reporting relationships. Describe the required qualifications for each position (with the exception of Psychiatrist/Psychologist Advisors that will participate in the CM/UM program, which are addressed later in this section).

VO-LA CARE MANAGEMENT/UTILIZATION MANAGEMENT STAFF

Accountability for the Louisiana CM/UM program will be delegated to the VO-LA Chief Medical Officer (CMO). The CMO will report to the Chief Executive Officer (CEO) and will have a dotted line reporting relationship to the Medical Administrator and Chief Operations Officer/Adult Systems Administrator. All clinical staff will be located within our Louisiana Service Center and will ultimately report to the CMO. These individuals will responsible for ensuring all Members receive recovery-oriented services that are the most appropriate treatment, in the least restrictive environment and include the support services required to meet their identified behavioral health needs. For children and youths eligible for the CSoC Care Managers will be assigned to each of the 10 regions, managing services to children and youths occurring within their region as well as services for children from their region who are in out-of-home placement, to assure the maximum coordination of community resources and supports. This structure is designed to match the expertise and experience of ValueOptions' staff in other state Medicaid contracts with the special needs of particular populations, such as children, while facilitating a consistent overall approach to CM/UM for Louisiana. An organizational chart depicting specific position titles and qualifications, number of positions and reporting relationships is provided below.

Chart Redacted

Qualifications for CM/UM Staff

ValueOptions has established requirements related to both the training and experience of licensed clinicians (qualifications in the table below) selected to serve in the VO-LA Care Management and Utilization Management Department as the first step in assuring quality and effectiveness of the program. All clinical staff, with the exception of the Clinical Support staff, will possess a current, valid, and unrestricted professional license issued by the applicable Louisiana Board. Between the Chief Medical Officer and Medical Administrator, we will require one to be board certified in either general psychiatry or child psychiatry. Licensure and credentials will be verified upon hire and at least every two years for all staff involved in the clinical review process. VO-LA will complete reference checks and background investigations on all applicants as required by contract and/or state law.

REDACTED		

REDACTED		

(a) Describe the ongoing monitoring protocols for CM/UM staff including the nature and frequency of supervision, documentation of audits, call monitoring, and any other oversight activities. Suggested number of pages: 4.

Our Care Management and Utilization Management program design addresses the Louisiana Member and provider's timely access to the clinical staff, the consistent use of clinical criteria for decision-making, the receipt of clinical information and the timeliness of the UM decisions, notification of authorizations and non-authorizations, and the appeals process. Our Care Management and Utilization Management process assures that appropriate care is delivered to Members according to the established level of care guidelines in the context of individualized and Member-centric treatment planning including the use of integrated plans of care (POC) and Wellness and Recovery Action Plans (WRAP). All care management and utilization audits are documented and available for review as a part of the clinical staff member's annual performance evaluation.

Clinical Training, Curricula, and Frequency

Our policy is to provide comprehensive and focused training and orientation programs for all UMs, Care Managers, and Peer Advisors to ensure that they are prepared to provide high-quality evaluations and medical necessity reviews of treatment at all levels of care. QM-UM staff participates in a comprehensive orientation and training program prior to assuming QM-UM duties. Training is broad-based and covers areas such as confidentiality, contractual standards, clinical criteria and treatment guidelines, medical necessity, information systems, human resources, customer service, conflict of interest, state and regulatory requirements, and organizational structure, as well as job specific policies and procedures. In addition, staff receive ongoing training as needed to maintain professional competency.

Qualified candidates for UM and CM positions must have a working knowledge of human development throughout the life span, psychopathology, and mental health/substance abuse treatment gained through required education and experience. UMs and Care Managers complete the Required Annual Clinical Trainings prior to initiating independent clinical reviews and each year thereafter. This assures a comprehensive knowledge base, consistent application of the Clinical Coverage Policy including CSoC, person-centered planning, cultural competency, familiarity with special populations, awareness of outliers in regard to the prescribing of Psychotropic medications, and updated understanding of best practice treatment.

The departmental training curricula is divided into the following five phases:

Phase I - The Managed Care Perspective: Phase I of ValueOptions' Utilization Management training module is a presentation on the managed care industry as a whole, and ValueOptions' role in managed behavioral health care:

- the history of the managed care industry
- ValueOptions' clinical philosophy
- ValueOptions' organizational structure
- outlines/overview of Louisiana stakeholders

Phase II - Utilization Management and Care management: Emphasis is on three areas: utilization review and care management:

- service definitions
- service class grid
- ValueOptions' review process, including:
  - review at each level of care
  - prospective and subsequent reviews
  - treatment planning, including discharge plans
  - certifications, non-certifications, peer review, and the appeals process
  - clinical supervision
  - rounds

Phase III – Policies and Procedures: Concentrates on ValueOptions' clinical policies and procedures, clinical criteria, and service definitions. Our UMs and Care Managers are expected to use these protocols to ensure that mental health and developmental disability services are medically necessary and provided at the appropriate level of care.

Phase IV – Customer Service: Focuses on ValueOptions' clinical care management training module includes service demeanor. For example, UMs and Care Managers receive training regarding customer service skills.

Phase V – Mentoring: UMs and Care Managers first observe and then are observed in the performance of their respective duties. Ongoing mentoring is provided by care management Team Leaders/Supervisors, Utilization Review Administrator, Child and/or Adult Administrator, and the CMO and/or Medical Administrator through the discussion of cases that are referred for reviews.

Frequency: All newly hired Care Management and Utilization Management staff must complete all of the first four phases prior to being placed in the mentoring phase of their training. This happens in the first two weeks of employment. During the third week, UMs and Care Managers, enter the mentoring phase. In addition, ongoing clinical trainings are provided monthly or more frequently as needed due to changes in service definition standards.

Medical/Clinical Supervision

After completion of orientation and training, new Care Management and Utilization Management staff members receive clinical supervision to ensure staff knowledge of state and local regulations and standards. Direct clinical supervision is an integral component of our care Management and Utilization Management process, especially for new staff. Clinical supervision will be provided daily in an individual and/or group setting by the supervisor. Monitoring will also be provided on a case-specific basis with respect to complex cases that require age-appropriate cultural competence assessment and extensive coordination services. Peer supervision will also be established to assist staff on effectively working with providers and managing cases through professional discussion and collegial problem solving.

Clinical Rounds

All Care Management and Utilization Management staff will receive medical supervision by rotating attendance in clinical rounds. The purpose of rounds is to provide a forum for staff to present and

review cases to ensure correct application of criteria, application of relevant practice guidelines, identification of quality of care issues, identification of people requiring more intensive monitoring, and network gaps. Decisions regarding authorization of care may also be made during clinical rounds. In addition, the Outreach Recovery Administrator will periodically attend to provide consultation on cases where there is dissonance of recovery efficacy on the part of the Member. The Outreach and Recovery Administrator reminds clinical staff that recovery is a key part of the clinical picture and decision making. Clinical rounds occur weekly at a minimum, and for some levels of care, daily.

Team Meetings

Team meetings will be used to provide clinical and administrative information to ensure that business processes are efficient, effective, and will achieve the department's established goals. Team meetings will occur at every level a minimum of two times per month. During team meetings updated criteria and/or practice guidelines will be reviewed.

Case Activity Audits

Regular audits of case activity documentation of Care Management and Utilization staff will be conducted including assessment of the review, referral and Care Management coordination process and the associated documentation in accordance with our policies and procedures. The results of these audits will be used for monitoring appropriateness of the Care Management process, individual performance evaluation, demonstration of adherence to policy, and consistency in application of criteria and or program requirements. We provide our clinical operations audits policy and procedure as **Attachment 5**.

The number of cases and frequency of audits depends on the length of employment and performance. *At a minimum*, newly hired staff will have at least four cases audited monthly for the first three months of employment and/or until all cases in an audit sample meet a criterion of 90 percent or higher. Thereafter, each staff has at least one case audited quarterly, unless divisional, service center or client-specific guidelines apply, with the expectation that all cases in the audit sample meet a criterion of 90 percent. If the 90 percent is not met, additional audits (three more within that quarter) will be completed to determine if staff is meeting performance expectations. The scores for these three additional audits are averaged to determine a single re-audit score. If criteria are met, the audit is complete for the quarter. If criteria are not met, the Utilization Review Administrator, Children's System Administrator, Adult System Administrator or designee develops an improvement plan for the individual.

Inherent in this audit process is our inter-rater reliability (IRR) audit, which audits clinical documentation, and our call recording monitoring, which audits Member service skills and identification of training needs. Both of these audits are described in more detail below:

Inter-Rater Reliability

Annually, all VO-LA Care management and Utilization Management staff will be required to participate in an inter-rater reliability (IRR) audit. These audits evaluate the appropriateness of clinical decision-making and treatment planning. All clinical and medical staff will be required to complete the audit by reading individual clinical vignettes and endorsing the appropriate authorization outcome. Audits will then be scored, tabulated, and analyzed by the Utilization Review Administrator, who will identify trends and performance issues. The Utilization Review

Administrator will then collaborate with the Chief Medical Officer to identify appropriate performance improvement strategies. Strategies will be implemented via individual supervision and/or team meetings as appropriate. The results of IRR audits will also be reported to the Louisiana Service Center Clinical and Quality Management Committees and aggregate results will be reported to ValueOptions' national Executive Medical Management Committee annually.

Call Monitoring

All member and clinical calls are recorded using the industry-leading NICE™ Perform Suite. This technology allows us to store digitalized voice recording and video screen capture of the system navigation activities completed during a call from a Member or provider. The purpose of this monitoring is to ensure consistency and reliability in managing incoming calls, as well as ensuring appropriate application of medical necessity criteria and practice guidelines. Auditing of Care management and Utilization Management staff telephone calls will be conducted by the immediate supervisor quarterly. A minimum of four calls per staff will be reviewed. Results will be reviewed with each staff member through the supervision process.

Peer and Behavioral Health Advisor Auditing

In addition to completing the annual IRR assessment, ValueOptions' Behavioral Health Advisors and Peer Advisors also undergo monthly auditing. The Medical Administrator or CMO reviews actual Peer and Behavioral Health Advisor decisions for multiple levels of care, and determines if they are consistent with training on Clinical Policy, CSoC, Best Practices and adherence to work flows. Every Peer and Behavioral Health Advisor is required to score 90 percent or higher.

(b) Describe how the Proposer's information management system will support the CM program. Suggested number of pages: 4.

VO-LA will use CareConnect, our proprietary Web-based system to support all CM activities. CareConnect was designed to reduce the administrative burden imposed on providers and UMs and Care Managers by providing a single integrated platform to gather objective clinical data and share POCs. The result is a system that allows CM/UM staff and providers to concentrate on the behavioral health needs of our Members rather than paperwork. We are the only behavioral health care company in the nation that has successfully implemented a single, integrated electronic, enterprise-wide, collaborative treatment planning and behavioral health record environment. Our shared clinical record currently includes:

- Member demographics
- treatment and service planning
- objective and standardized assessments,
- member event tracking,
- bed tracking
- CANs and NOMS collection
- clinical progress notes
- at-risk crisis plans
- high risk and special needs indicators
- Member's funding stream
- medication tracking
- centralized scheduling
- referral tracking
- admissions and triage
- authorization history
- complaint tracking,
- discharge planning
- crisis tracking
- authorized treatment plan team (PCP, WAA and other stakeholders

There are financial, clinical and technical aspects to the establishment of any braided funding program. Tracking and accountability of funds should be available at both the administrative and individual level. Care coordination is even more essential as the types and methodologies of service delivery come from disparate organizations. The eligibility and claims processes must be integrated and programmed to accommodate this utility.

Our approach to the braided funding process entails capturing data from all funding streams into a single database through the registration and assessment processes. A Web-based profile is created and made accessible to all authorized stakeholders for each Member. The registration process allows providers to manage enrollment of Members with various funding sources and ensures required information is provided to maintain consumer eligibility.

The CONNECTS platform can assign braided funds from multiple program sources to pay for an individual service package, and maintain tracking and accountability for each funding stream at the administrative level. The funds remain in separate strands but are joined or 'braided' based on the individual consumer, resulting in improved service accessibility, and claims payment processes.

Braided funding leverages all the funding streams for which an individual may be eligible and provides a comprehensive service package that maximizes the resources available for that individual. *The funds remain separate, but the services are braided together for that individual.* This approach provides seamless and comprehensive care to the individual while maintaining accountability by funding, service or agency.

Braided funding also prevents unintended duplication of services for individuals who may be eligible for more than one program's funds and can also supplement services already being provided by other programs.

ValueOptions' CONNECTS provides a single platform for DHH-OBH, Local Governing Entities, providers and the SMO. No longer will multiple disparate systems be needed to track and report on the behavioral health needs of Medicaid Members in Louisiana. Our system supports the CSoC by creating a singular yet integrated care plan for the WAA to use for CSoC children and youth. For DHH-OBH, we are proposing to integrate the POC within CareConnect to ensure that members, family, PCPs, providers, and our UMs and Care Managers are operating under the same understanding of the wishes and desires of our Members. The IHP and POC will be submitted electronically via the web by the WAA and Local Education Authority. These plans will indicate the specific stakeholders involved in the Member's plan of care. All information submitted via the web will be accessible in CareConnect and our web portals, providing all authorized stakeholders in the treatment plan to coordinate and review the Member's plan of care. The Regional Care Managers use the same CareConnect system that the utilization review clinicians use, to maintain communication with their peers and to document all utilization review decisions and care plans for the CSoC children in their regions.

CareConnect contains all information submitted through our Web portals that will direct interchanges between all stakeholders and VO-LA to produce clinical data that can demonstrate the effectiveness of various programs, therapies, and the services that we offer. CareConnect assigns a unique number to each authorization with information included in an authorization header file and an authorization detail file. The authorization number is the key to both of these files as all

authorizations are associated with a specific Member and a specific provider and are linked to a case. The system also assigns a unique number to each case. A case comprises one Member, one or more providers, and one or more treatment settings. The case may also be associated with a specific set of clinical notes. The system supports functionality to search for all authorizations and/or all cases for a specific member or for a specific provider. A member's complete history is illustrated within CareConnect and accessible by a provider with appropriate releases of information.

Our system is a fully integrated suite of tools that can be used to inform our care management program. Additional features include: tracking and monitoring services by funding streams to maximize the integration of resources from DOE, Office of Juvenile Justice, Department of Children and Family Services, and OBH, a comprehensive service tracking and referral application that is used to appropriately monitor bed/service availability in inpatient facilities and other community-based programs and match a Member's needs to a specific provider with an available bed/service; and our Web-enabled authorization and registration system for providers, which will allow our UMs and Care Managers to focus their time on outlier providers and complex cases.

Below, we provide a screenshot from our CareConnect application. This screenshot illustrates the interactive use by both providers and our UMs for Member care coordination.

Search Results

Capture	Inquiry #	Type	Inquiry Date	Rec Date	Age	Urgent	Status
	Member ID	Member Name	Parent	Reason Code 1		Due Date	Owner
	NPI ID / Provider ID	Provider Name	Category	Reason Code 2	Action Code	Action Reason	Action To
☐	02092010-7684353-010000	REFERRAL	02/09/2010	02/09/2010	0	R	CLOSED
	BOM23456701	MITCHELL BECKY	BOM	ROUTINE REFERRAL			V1DENORL
	1972611713 136825	SMITH JEAN	MBR-PATIENT		CLOSE	REFERRAL	V1DENORL
☐	02122010-7684371-010000	STANDARD INQUIRY	02/12/2010	02/12/2010	0		CLOSED
	BOM23456701	MITCHELL BECKY	BOM	VERIFY MEM ENROLL		02/12/2010	V1WSSO
	1306949912 000679	DARBY DANIEL	PROVIDER		CLOSE		V1WSSO
☐	02122010-7684372-010000	REVIEW	02/12/2010	02/12/2010	173	1	OPEN
	BOM23456701	MITCHELL BECKY	BOM	OUTLIER DIAGNOSIS F/U		02/13/2010	V1WSSO
	1306949912 000679	DARBY DANIEL	PROVIDER		PEND	PROV OUTREACH	V5CLQORH
☐	02122010-7684371-020000	REQUEST FOR SERVICES	02/12/2010	02/12/2010	0	R	CLOSED
	BOM23456701	MITCHELL BECKY	BOM	PROS OP/MED MGMT			V1WSSO
	1306949912 000679	DARBY DANIEL	PROVIDER		CLOSE		V1WSSO
☐	02122010-7684371-030000	STANDARD INQUIRY	02/12/2010	02/12/2010	0		CLOSED
	BOM23456701	MITCHELL BECKY	BOM	AUTHORIZATION STATUS		02/12/2010	V1WSSO
			PROVIDER	VERIFY MEM ENROLL	CLOSE		V1WSSO

V1WSSO signifies Submitted by Provider Via Web Portal - Inquiry routes directly to CM

Using our CONNECTS platform, providers and other stakeholders can submit inquiries to better coordinate care.

(c) Describe how the Proposer will provide an outreach program to ensure that high-risk members understand the benefits and services available to them. Include how the Proposer defines and identifies high-risk members. Provide an example of a successful outreach program. Suggested number of pages: 3.

OUTREACH TO HIGH-RISK MEMBERS

In multiple state Medicaid programs, ValueOptions has developed and implemented comprehensive programs to coordinate the treatment needs of high-risk/high-cost Members. The program typically starts the multi-level identification process for the high-risk/high-cost Member that includes data analytics, follow-up, and integration of UM as a part of our overall CM program. Our advanced data analytics are unique in the fact that they ensure that future interventions address both the Members' behavioral health and physical health conditions

VO-LA will build on our CM program to facilitate outreach to high-risk behavioral health Members, and ensure they understand the benefits and services available to them. Members who are identified as high risk will be assigned to a Care Manager. The principal role for the Care Manager will be oversight and monitoring to ensure effective communication and service delivery occurs. The Care Manager will assist the treatment team in modifying the service plan to include a Peer and Family Specialist and to incorporate actions and services specifically designed to help high-risk Members. Many high-risk Members will already have an assigned case manager. If that is not the case, the Care Manager will coordinate with a provider to evaluate the need for an assigned case manager with a provider. The case manager or service provider will communicate with Members so that they understand the benefits and services available to them. A phased plan with stratification of high-risk Members will be included in the contract implementation plan.

Defining and Identifying High-Risk Members

High-risk behavioral health Members are those at risk for, or already experiencing, poor outcomes due to symptomatology, functional limitations, or social stigma. Examples of poor outcomes include increased use of higher levels of care or crisis services, or increased risk of morbidity and mortality. The following factors help define high-risk members:

- **demographics** such as homeless behavioral health Members with serious mental illness
- **diagnosis** such as Members with co-morbid mental health, substance abuse, developmental disability, or medical problems
- **member is engaging in high risk behaviors,** such as self-destructive behaviors or anti-social behaviors, including three or more criminal charges within three months
- **treatment** such as multiple providers unknown to each other providing care to the same behavioral health Member or failure to respond to outpatient services in the past six months
- **CSoC children** by nature are high risk
- **utilization** and **cost** including over- or under-utilization of services, frequent use of crisis services over 6 in 6 months, and readmissions/recidivism (12 or more visits to the ER in 6 months)
- **placement** such as two or more failed specialized residential placements in one year and/or relapse within six months of discharge from residential services
- **limited underutilized community support resources**

High-risk behavioral health Members will be identified in several ways. We will analyze data from multiple sources, including demographic data, claims, encounters, authorizations, appeals and grievances, care management, provider performance, quality management, and member service.

VO-LA uses a behavioral health specific predictive modeling process, incorporating historical clinical data to identify high risk of future negative outcomes and case complexity. Cases identified by the predictive modeling tool become candidates for care management outreach and potential program participation. Factors used in the predictive data analysis include: age, gender, diagnosis, treatment adherence, historical utilization of higher and lower levels of care, emergency room admits, total care costs, and co-morbidity. Based on the statistical modeling, individual case factors result in cumulative clinical risk weighting. Members with higher risk weightings are prioritized for the most immediate outreach.

VO-LA also offers an enhanced outlier identification process, using a predictive model based process to search for review cases that are highly unusual in their trajectory of utilization intensity over time compared to similar cases from our large historical benchmark databases. This approach improves the timeliness of intervention as well as provides a stronger clinical justification for intervention than a fixed visit threshold approach. This method also applies a uniform episode of care definition that encompasses all outpatient services provided, regardless of provider or diagnosis.

The statistical model identifies a significant proportion of future high utilizing Members earlier than when the outlier threshold would have been triggered. Our enhanced outpatient outlier model provides additional refinement to simple numerical threshold outlier by taking in to account age, gender, periodicity, multiple providers, intensity of treatment as well as the longevity of the treatment. "Unusual" cases that are identified based on the outlier triggering process may include both too little and too extensive treatment. Additional clinical information is requested from the provider. Based on the outcome of the review process, best practice guidelines and evidence based treatment are encouraged and additional approvals are contingent on evidence of these practices.

All predictive modeling information will be consolidated into a report identifying high-risk Members that will be reviewed by the UR Administrator and the Medical Administrator. High-risk behavioral health Members will also be identified through stakeholder input, including Members and their families, our committee structure, and other community stakeholders. Our VO-LA Quality committee structure, Regional Provider Relations staff will support this process and significantly enhance our ability to for early identification and respond outreach to high-risk Members.

Additionally, VO-LA offers our outreach tool, Health Alert, an application developed to facilitate and ensure timely and effective continuity of care for Members. Health Alert is a component of our CONNECTS suite that automates appointments and medication reminders to increase aftercare compliance. Members can access Health Alert to set up and manage all of their appointments and medication reminders through MemberConnect. Providers can set up reminders for Members through ProviderConnect. Finally, as part of the inpatient discharge process or during the Care Management process, the Member will be asked if he/she agrees to be contacted with an appointment reminder for the next outpatient appointment or if they would like to work with a Peer and Family Specialist to assist in the development of a Wellness Recovery Plan. If the Member agrees, our UM or Care Manager will arrange the reminder(s) in Health Alert through CareConnect.

Successful Outreach Program Examples

ValueOptions has nearly 20 years of experience in providing a comprehensive outreach program to high-risk behavioral health Members and family members in other state Medicaid programs through our Prevention, Education, and Outreach Departments (which contracts with provider outreach and prevention programs). Contracted network prevention provider staff are trained to identify signs of substance abuse and mental illness in youth and adults, and must know relevant information and referral resources. We participate in numerous events, including health fairs and health promotion events, and provide educational in-services to medical facilities and community organizations.

New York Chronic Illness Demonstration Project (CIDP)

ValueOptions, with our community and hospital partners, have implemented two of the CIDPs in New York where members are assigned a Field Care Manager (FCM) who coordinates the services of the Primary Care Physician (PCP), behavioral health providers, hospital emergency departments, specialists, state agencies, and community agencies to ensure continuity of care within the community. The FCM works with the member, their PCP, and other providers to develop an individualized care plan that focuses on improving the member's well being and on coordinating covered services. FCMs also identify and refer members to appropriate community resources, as well as provide health education regarding the member's illnesses, monitor medical compliance, assist with transportation issues, and coordinate care between providers.

In our NorthSTAR program, ValueOptions of Texas participates with multiple community providers, the sheriff's department, court system, and peer provider and family support organizations in a monthly outreach to drug using prostitutes where members are offered treatment instead of the endless cycle of abuse, arrests, and jail time. The Bridge, a full service Homeless/Treatment and Education Facility, in Dallas Texas, consists of more than 19 health and human services organizations, providing a continuum of care, treatment and support, including integrated behavioral and physical health care services. This care management program was developed to more effectively integrate services provided at the Bridge for those high-risk/high cost individuals with a history of inappropriate use of emergency department resources. All care management interventions are provided by behavioral health providers located in a shared physical health/behavioral health clinic on the "Bridge" grounds and who are trained in motivational interviewing. This provider serves as an interim clinical home to coordinate all services required to address the member's physical as well as behavioral health care needs.

This program has been extremely successful since its inception in June 2009. We have developed unique approaches to overcome the disadvantages/challenges described above and the program has served an average of 21 percent of the daily shelter population with promising outcomes. In fact, as of July 2009, 63 percent of care management participants had successfully completed the program as evidenced by increased housing stability, adherence to and compliance with community based treatment plans, and reduced visits to hospital emergency departments.

(d) Describe how the Proposer will assist the WAA in developing POC for the 650-750 CSoC children/youth currently living in out-of-home placements to facilitate their transition to family- and community-based services. Address the following components:

ValueOptions has been a collaborative partner to multiple state Medicaid programs as we worked to address the needs of children and youth in out-of-home placements as well as facilitating their transition back to family and community-based services.

(i) Involvement of youth, families and caretakers enrolled and not enrolled in a WAA, including WF for enrolled children;

VO-LA knows DHH-OBH is committed to enhancing family engagement and caregiver support for all children and youth through the support and involvement of the family, and use of FSOs to strengthen the family and promote resiliency for the child/youth. Family engagement starts with having a family representative participation on our local quality management committee, training, and local outreach by our Regional Teams. We have extensive and successful experience in building supports and family engagement. Whether enrolled or not enrolled in the WAA, VO-LA offers a transparent process for service monitoring, service requests, shared treatment, and crisis plans through the use of MemberConnect. In addition, we have successfully used the MemberConnect system in two large Medicaid projects in two separate States (Connecticut and Maryland). In both programs, MemberConnect has been viewed as an innovative tool, allowing Members to access specific information about their care, including authorizations and treatment plans. For those instances where a child is placed in services outside of their regional, we can utilize video-conferencing as a mechanism to keep families involved in the care and service planning for their child.

As noted in the workflows, VO-LA will be reviewing all POCs for family/caregiver involvement. Parental knowledge and commitment must be utilized in service planning and implementation for each child, likewise parents must be included in decisions about resource allocations and policies, procedures and actual practices that determine what resources are available, how they are utilized, the goals they are intended to achieve and how their impact is evaluated.

Our system facilitates this process by ensuring that family and Member participation in treatment planning is documented. In fact, to reinforce this essential System of Care principle, our Care Managers must document the family and Member participation in the treatment planning process and whether or not they participated in the individualized goal setting of their treatment plan. This documentation becomes an essential part of the utilization review and care management process. In addition, by virtue of this documentation we can also target assistance to those WAAs and FSOs that consistently experience more challenges in garnering the participation of family and Members.

Annually, VO-LA will hold a Youth Summit to focus on youth wellness and resiliency. This summit will also include a "track" for families and will serve as a mechanism to disseminate information but more importantly to hear directly from Youth and Families their experience, challenges and successes in WAAs and with the SMO in those areas where the WAAs are not functioning.

(ii) Collaboration with CSoC child serving agencies on service planning;

DHH-OBH is aware that wraparound processes require a high degree of collaboration and coordination between all the agencies, supports, and caregivers who are working with a Member, even if the member is not in the CSoC caseload. To accomplish successful collaboration with CSoC child serving agencies, the VO-LA Regional Care Manager or the WAA will obtain appropriate releases of information at the POC review meetings and provide access to an integrated online treatment POC for all parties involved in the care of the CSoC Member including providers, schools, PCP, caregivers, and family support organization. Additionally, VO-LA will have regionally- assigned Care Management and Utilization Management staff who will review, approve and monitor the CSoC POCs for each Member. These regional staff will also participate in integrated treatment planning, attend regional joint rounds, and attend system of care planning meetings with a goal of:

- obtaining information related to eligibility and benefits that affect the delivery of services
- maintaining knowledge of other programs providing services to eligible's with co-morbid conditions and plans for coordination of services (e.g.; referrals to case management, community services, and others)
- consulting with providers they know, to assist with identification of resources within communities and provide assistance with regional wrap around care councils and develop a method of evaluating and improving the quality of services delivered
- coordination of services across all agencies including residential providers

From our discussions with families, stakeholders and providers, we received anecdotal evidence that underscores the fact the most of the children currently presenting with significant behavioral health needs do so in crisis and are often "forced" to use the juvenile justice system as a means to receive services. Families need a single point of contact to access in these times of crisis. The WAAs can serve as such a point of contact as well as VO-LA. Hence, collaboration between VO-LA is essential to ensure a cross-functional dialogue to re-engage a service planning team whenever a child's needs indicate.

VO-LA is aware of the need for service planning collaboration. For many of our state contracts, we also provide the function of the wraparound service planning facilitator. We applaud DHH-OBH for separating this function so that the WAAs truly function as independent community based resources to pull together all the agencies (traditional and non-traditional) who can share decision-making about the day to day needs and addressing services for a child. This strategy enables better access and coordination of services and VO-LA will seek to support and, when needed, augment resources and services designed and suggested by the WAAs. It is our role to implement (via Medicaid, Single Case Agreements) the services that the WAAs have coordinated on behalf of a specific child.

We are also offering micro-grants to regional FSOs to enhance and expand family support opportunities including use of Peer and Family Specialists in Emergency Room Diversion activities.

(iii) Needs identification and collaboration with the Proposer's network management and development staff; and

The WAAs can often serve as the "eyes and ears" of the local area regarding the needed services that are identified to keep a child successfully in their community. As the WAAs meet with families, schools, OJJ, and providers, they are able to identify what services are consistently missing or not available in a timely manner to address the needs of a specific child.

The Regional Team will serve as the "liaisons" with the WAAs to gather this information regarding gaps in care. All staff meets regularly within our Regional Team structure to share delivery system information. This integrated approach taps all parts of the operational delivery team. The meetings are conducted weekly and are co-facilitated by the Regional Provider Relations member. During the meetings, gaps and service array development will be identified and we will work with the DHH-OBH and our network development team to address those gaps. The goals of the meetings are to:

- identify gaps in services
- identify provider opportunities for development
- review regional Utilization data to understand access points and regional trends
- review regional barriers to discharge from higher levels of care including housing and transportation needs of the community
- review FSO involvement.
- create and review the regional work plan with DHH-OBH and our network development team to address the identified gaps in services and barriers to discharge

We will roll that information up into a macro level analysis to formally identify gaps in care and then to dispatch our provider relations staff assigned to those regions to either develop those resources or provide re-training opportunities for a provider to reengineer their existing service delivery. This regional approach offers a more intimate and organic understanding of Louisiana's diverse communities.

(iv) Strategies the Proposer has found useful in other programs. Suggested number of pages: 3.

Our experience offers many strategy examples, including programs in Pennsylvania, Maryland, Connecticut, and Massachusetts.

Pennsylvania

One example comes from our Pennsylvania HealthChoices contract, in which ValueOptions (VBH-PA) has worked to develop School Based Behavioral Health (SBBH that serves as a means to provide a coordinated system of care for children who are served in multiple systems. Through collaboration with the County Schools districts with the areas we serve, we have opened seven additional programs. Students, families and educators expressed satisfaction with SBBH immediately. One student remarked, on her first day in the program, that it was the "best day in school I ever had."

The programs continue to develop relationships within the schools and communities, and are growing in expertise in providing mental health services within an ecological model.

Another example from our Pennsylvania contract is the independent prescriber model which has been in place in the Northwest Behavioral Health Partnership (NWBHP) counties (Crawford, Mercer and Venango) since the summer of 2007. The purpose of the independent prescriber model is to provide comprehensive psychological/psychiatric evaluations for children and adolescents with a goal of ensuring coordination of care and cross-system communication and the development of treatment recommendations leading to effective care.

A panel of Independent Prescribers (IP) was established to provide these evaluations for children and adolescents. IPs meet established criteria and are credentialed and contracted by VBH-PA to conduct evaluations.

Maryland

In Maryland, children receiving services through the PRTF Waiver (aka the "RTC waiver") are the only kids that have the benefit of a formalized structure to view and work from the same POC. Case Management Entities (CME's- or WAAs) create the POC with the child and family team (CFT). The CME's share the POC with all the members of the CFT including the family/guardian, providers, when applicable DSS workers, juvenile justice workers, probation officers, and any other relevant agency who is part of the CFT.

In addition to the CFT members, the Core Services Agency (these are similar to the HSDs in Louisiana), ValueOptions and the Governor's Office for Children all have access to the POC.

ValueOptions uses the POC as part of the decision making process for the authorization of requested waiver services. The VO UM will ensure that all waiver authorization requests are part of a current POC, including the specific provider, the service requested and the dates of service. In addition, we will ensure that the medical necessity criteria are met for each waiver service requested.

Connecticut

In Connecticut, the Child and Adolescent Inpatient Provider Analysis Reporting (PARs) Program was conceived during 2007 and focused on the need to address exceptionally long lengths of stay of children and adolescents treated on inpatient units. All eight hospitals that treat children and adolescents in Connecticut worked with CT BHP to develop a Discharge Delay initiative. The program included the utilization of data to evaluate practice change and determine/assure fidelity to the agreed upon indicators, the use of incentives to expedite change, and also included training and consultation on Focal Treatment Planning (FTP). FTP is a well-established best-practice multi-systemic focused approach to treatment and discharge planning to support the youth's successful return to the community with the appropriate wraparound supports in place. By the end of 2008, the amount of time spent in discharge delay had decreased by 29 percent across the state.

- In conjunction with DCF Area Office staff and providers, CT BHP decreased inpatient discharge delay days by 29 percent, surpassing the goal of a 12 percent reduction in 2008.
- CT BHP decreased acute average length of stay by 2 days in 2008.
- Ambulatory follow up within 30 days achieved improvement in the rate from 64.4% in 2006 to a preliminary result of 85.8 percent in 2008.
- Children awaiting placement from ED decreased from 2.8 days (2007) to 1.8 days (2008) in part as a result of our implementing a plan for early intervention strategies, including daily direct

- Children awaiting placement from ED decreased from 2.8 days (2007) to 1.8 days (2008) in part as a result of our implementing a plan for early intervention strategies, including daily direct contact with ED staff and daily tracking of potential "stuck kids" leading to vigorous outreach in those cases.
- Hospital average length of stay (ALOS) and readmission rate: The inpatient ALOS for children 18 and younger was decreased by 15.2 percent for DCF involved children and by 12.9 percent for non-DCF involved children from 2007 to 2008. To assure that readmission rates did not increase as a result of this decrease in ALOS, we established monitors to assess readmission rates; readmission rates decreased slightly during the same time period from 4.4 percent to 4.0 percent for 7 day readmissions and from 14.3 percent to 14.1 percent for readmissions within 30 days.

Massachusetts

In our Massachusetts program, known as Massachusetts Behavioral Health Partnership (MBHP), we have an effective, statewide network management strategy and regional network management structure through which we monitor and manage services for youth. Our Regional Teams employ a data-driven, integrated approach to network management, quality management and utilization management, including network management of all youth-serving network providers and levels of care, both Children's Behavioral Health Initiative (CBHI) services, and all other services in the behavioral health continuum.

We monitor many standards and measures to ensure compliance, performance and quality. For all LOCs, performance specifications include provider requirements that ensure the delivery of quality care to meet the specific needs of youth and their families. Specific standards have been established and related measures are monitored through data- driven network management and continuous quality improvement processes. We have conducted extensive of clinical, programmatic and financial restructuring to provide for the integration of Mobile Crisis Intervention services for youth. We continue to provide statewide management to this system that provides more than 100,000 emergency behavioral health encounters annually across multiple payers.

iii. Describes strategies the Proposer has used to collaborate with wraparound facilitation staff/child and family teams and families, including family support type organizations in another client state. Discuss the Proposer's successes and challenges and provide a reference that can validate the Proposer's approach. Suggested number of pages: 3.

To achieve efficient and effective coordination and integration, ValueOptions has successful experience with geographically-based teams, called Regional Teams, as a core tool to establish a local presence and build collaborative relationships with providers and family members, and supports the objectives of the CSoC. Our Regional Teams in Louisiana will establish a local presence so that the unique needs of Zwolle, Bunkie, and Waterproof as well as the urban areas in Louisiana, and a level of transparency that allows us to gather feedback and information from interested stakeholders to assure that the perceptions and analysis of the available data are viewed through multiple lenses. We will include feedback from our state agency partners, regional/local staff from the Local Governing Entities/Districts/ Authorities, Local WAAs, Local FSOs, Local Education Agencies, DOE, DCFS, OJJ and providers, as well as other local resources such as vocational, housing, and social support

systems. Each Regional Team will include Regional Provider Relations Representatives, CSoC Care Managers and the local FSO. Our activities will include but are not limited to the following:

- education and advocacy to support parent/guardian knowledge of growth/development and options for child
- advocacy for member/family self management education (may include primary prevention, family/parent education and support, identification of concrete services, treatment planning strategies
- recognition of evidenced based practice guidelines
- collaborative practice models to include physicians/providers and support providers
- recognition of natural supports in the community
- process and outcome measurement, evaluation and management
- routine reporting/feedback loop (may include communication with member and family as well as physicians and ancillary providers
- potential for practice profiling in conjunction with the IOC (Inspections of Care)process

Additionally, as a part of our CM program and within the structure of the Regional Teams, VO-LA will have regionally-assigned CM clinicians to coordinate and authorize services for children and youth in the CSoC, PRTF, and other high-risk identified youth. CM staff will have assignments to specific facilities, providers, WAA's and LGE's. The CM clinicians will facilitate emergency room (ER) diversion and discharge planning when a member goes to the ER and is need of assistance for behavioral health issues.

ValueOptions has successfully implemented Regional Teams in other statewide public sector programs with measurable success particularly in Connecticut. Effective systems of care for children are creating formal roles for family advocates. In Connecticut, ValueOptions' Peer and Family Specialists are assigned specific regions of the state and assist members in understanding available services, locating community resources, support groups and special programs; providing information on rights and responsibilities, complaints and appeals, and answer questions.

Challenges from this experience related to the fact that families respond to issues/ concerns/ opportunities from the lens of their own experience. Often, their interpretation or analysis of what is happening within the delivery system is based on anecdotes or a single incident. While informative and valid, if we are about the work of system reform, we cannot reform on anecdotes alone. Individual's that work with the family support organizations need to approach the opportunity from a mentoring/teaching perspective. We must validate the family experience, while educating around the importance of data and it's analysis as a way to reform and measure system improvement.

Likewise, the value of the geographic team is that each individual on the team brings their own perspective based on where they "live." The challenge for the group is then to weave all the perspectives together, and to further inform the perspectives with the use of data.

A second challenge is to maintain proper perspective. At no time should system reform be enacted as a result of "outlier" network behavior. While there may need to be a provider specific intervention for a significant event, network/system reform must occur where we can move the

majority of the system in a forward motion. It is often more interesting for the geographic or regional team to focus on the outlier, but it will not result in global forward movement.

Again, both of the above forums allow for the input of many perspectives, which supports robust analysis of the system/situation or incident. However, no analysis is complete without data. Time must be invested in teaching, training and supporting families, consumers and staff to have a meaningful, activated and impactful voice in system reform.

The reference who can validate this approach is Karen Andersson, Ph.D., Director of Mental Health, Connecticut Department of Children and Families - (860) 550-6683.

Perhaps the most effective way to describe our experience is via the following vignette of a 16 year old and her mother:

Mariana is a 16 year old female with an extensive treatment history. At the time of residential admission, multiple interventions/treatment episodes had been utilized without long-term success. The identified reasons for residential care were: school refusal, verbal and physical aggression to mother and peers, lack of peer support/healthy peer relationships, PTSD symptoms related to sexual abuse, and family dysfunction thought to be related to a lack of structure, expectations, and mother's ongoing struggle to remain sober and treat her own mental health symptoms

In this case, the CM attended treatment meetings on-site monthly (at the RTC) for the purpose of reviewing treatment plans, assessing readiness for discharge, understanding collateral involvement and ensuring that communication was effective, and evaluating family readiness. The members of the RTC treatment team present for each meeting included the wraparound facilitator (WAA), clinician, director, milieu staff, teachers, psychiatrist as well as Mariana herself. With all members present the CM was able to have direct conversations with the doctor regarding medications and could hear first-hand from staff the progress and struggles in the milieu often offering feedback and contributing to behavioral interventions. In each meeting Mariana was asked, by the CM and wraparound facilitator, what she needed from her treatment team to help support her and from month to month this CM could follow up with the facility on her requests.

During the course of treatment, the wraparound facilitator and the CM determined that a ValueOptions Peer specialist referral was needed to ensure that Mariana's mother was receiving treatment and to work with the family in planning for Mariana's transition home. The VO Peer was a great support to the family as Mariana began visiting home more frequently and for longer periods of time. This service was added to the overall plan by the wraparound facilitator. In addition, Mariana's mother was connected via the ValueOptions' Peer to the local FSO for ongoing support via a local stress management group. There were some setbacks to Mariana's treatment. For example, she became increasing depressed when admitted to the RTC and went AWOL. The wraparound facilitator quickly convened the care planning team and adapt the plan (which was submitted to ValueOptions) for an evaluation of the changing needs of the member and consulted with outside treatment providers when appropriate. Mariana had outside trauma treatment during her residential stay and often the trauma clinician would be present for treatment team meetings as well as joint sessions with the residential social worker. As Mariana's trauma treatment culminated she was able to read her trauma narrative to her mother and residential social worker with her trauma clinician present.

Results

Mariana was discharged home with her mother after 6 months of residential treatment. Aftercare included Extended Day Treatment at the same agency and physical location that the residential treatment was received as well as ongoing peer specialist involvement to support her transition home. The Wraparound facilitator has reconvened the care team to begin designing a "transition plan" as Mariana begins to face aging out of the system.

Additionally, for our Massachusetts program, MBHP, maintains a lead role in driving activities with the Wraparound agencies to ensure fidelity to the Wraparound model. MBHP's experience working with the CSAs, who deliver Wraparound care planning includes:

- supporting community-level planning and implementation
- promoting professional development of wraparound staff
- ensuring accountability for fidelity and outcomes
- sustaining a community of practice

To assist with ensuring fidelity to the wraparound model, the observation of care planning team (CPT) meetings, telephone interviews, and medical record reviews. We used the following tools Massachusetts Team Observation Measure (MA-TOM), Massachusetts Wraparound Fidelity Index, Version 4 (MA WFI-4), and Massachusetts Document Review Measure (MA DRM) to monitor adherence to high-fidelity Wraparound. The WPPA displays customized results of the MA TOM, MA WFI-4 and MA DRM. It also contains a worksheet for providers to use with TA teams in identifying Wraparound principles that are strengths or weaknesses of their care planning teams in comparison to state and national averages. The fidelity index and document review measures for this program are included as **Attachment 6**.

We are also offering micro-grants to regional FSOs to enhance and expand family support opportunities including use of or training of Family Peer Specialists in Emergency Room Diversion activities.

iv. Describe how the Proposer will develop treatment planning for adults in the 1915(i) State Plan and adults eligible for treatment planning under the 1915(b) waiver, adults eligible for the 1915(i) HCBS services, IV drug users, pregnant substance abuse users, substance abusing women with dependent children or dual diagnosis, including from the point of access to the point of either case closing or reduction in CM activity to the point of care monitoring:

In multiple state programs ValueOptions has successfully partnered with providers in the development of treatment planning strategies for covered populations similar to those that will be covered in the SMO and has a differentiating level of expertise in the management of high-risk Members, including IV drug users, pregnant substance users and substance using women with dependent children or dual diagnosis.

We strongly recommend the use of an initial instrument by providers, such as the Screening, Brief Intervention and Referral to Treatment (SBIRT) to make an early assessment of the scope of need as it relates to:

1. alcohol use by quantity
2. drug use
3. prescription drug misuse
4. tobacco use

The SBIRT screen also allows physical health and behavioral health providers to conduct a brief intervention in a setting where such assistance may not have previously been offered. It allows a Member the opportunity to receive information about the nature of their substance use activity, guidance about how to address it, and a plan for future follow-up as needed. The SBIRT screening can be used anywhere LBHP Members present including in emergency rooms, PCP offices, and provider locations. VO-LA will work with DHH-OBH to facilitate the expanded use of SBIRT in the State.

The first step in the process of developing treatment planning for high needs populations starts with the early identification of the Member. VO-LA accomplishes this step through Care Management (described throughout this section), as well as outreach and data analytics, which are both described below. Our interventions are customized to meet the needs of target high-risk populations.

Outreach Identification

VO-LA's outreach program is driven by a wealth of tools driven by service, and pharmacy data and educational materials that support multi-environment screening of all Members to identify those with special needs. We have found that screening of Member's needs to occur where the member is such as shelters, schools, agencies providing welfare assistance, health fairs, family support organizations, spiritual homes and faith based assistance organizations and PCP's. Screening protocols specifically assist in identifying:

- children and youth under 22 that have significant behavioral health challenges or co-occurring disorders that are in or at imminent risk for out of home placement
- children with behavioral health needs who receive services from ODD, DOE, OJJ, DCFS or other child servicing systems
- adults eligible for 1915(i) HCBS services, IV drug users, women who are pregnant and abusing substances, and substance abusing women with dependent children, members with dual diagnosis, adults with acute stabilization needs, adults with SMI, and adults with MMD.

Additionally, we will develop ongoing relationships with the LGEs, with community and natural supports through the regional Family Support Organization, Peer Organizations, such as VOICES, MHA of Louisiana, NAMI, statewide and regional chapters, the LA Federation of Families, and other advocacy organizations.

The following is an example of how services from Care Management were reduced based on the members' improvement.

A 46-year old male with a history of suicide attempts and subsequent hospitalizations since the death of his mother.

The member engaged in outpatient services only sporadically and did not adhere to his medications. The ValueOptions Care Manager's review of the patient's history indicated the member met the criteria for Care Management. A complex case conference was scheduled, and included the provider of record, ValueOptions' doctor, the Care Management staff, ValueOptions' care Manager, and Clinical Director. The Care Manager and hospital social work began work on a recovery treatment plan. The member's self-identified goals were identified as housing, employment, reconnection to his church, and medication adherence. The treatment plan goals were to stabilize member in his community and evaluate him for Assertive Community Treatment (ACT) services. In addition, the plan addressed decreasing hospitalizations by increasing medication compliance, managing psychosocial stressors through individual counseling on his mother's death, and increasing socialization by reconnecting him to his church.

Results:

- *The member's ACT caseworker and Care Manager ensure coordination of care and provide bus passes for doctor's appointments*
- *He has rejoined his church and has joined church groups that provide counseling and social activity*
- *He remains at his boarding home and is actively seeking employment with his act caseworker and the local rehabilitation center.*
- *He is adhering to his medications*

Data Analytics

Our data analytic protocols also drive identification, treatment planning, and Care Manager assignment for high-need and high-risk Members. Our predictive modeling solution supports the Care Manager with data analytics using claims data for population health management and health risk stratification. Once the Member is identified, contact with the member will follow the treatment planning protocols based on the identified risk population and, if appropriate a Care Manager will be assigned to the Member. Care Manager assignment is driven by clinical risk and functioning factors.

(a) Involvement of individuals, certified peer specialists and families, when desired by the individual;

ValueOptions strongly supports and has implemented work with certified Peer and Family Specialists in multiple state systems. This has included an education and curriculum provided by the state to educate Peer Mentors and a process developed by ValueOptions to credential Peer Mentors. The work of Peer Mentors has proven successful with some difficult cases, including repeat criminal offenders returning to the community. Additional programs involving families have offered the continuing support needed for the substance users to maintain stability in a community-based environment. VO-LA will support the use of consumer run organizations via micro-grants to assist these organizations in becoming billable providers. These strategies and others referred to under the

category of Recovery Oriented Systems of Care (ROSC) are supported by research and best evidence in the field of substance use disorder treatment. We embrace the necessity for such efforts and we have continued to build a foundation for their success in other states and we look forward to doing so in Louisiana. We propose to employ Peer and Family Specialists to as part of our Member Services Team to assist Members navigating the system and providing experiential responses to questions they may have. In addition, we will partner with Recovery Innovations to develop peer operated "Living Rooms" as a crisis alternative where Members can stay overnight.

(b) Collaboration with community providers on assessment and treatment planning;

ValueOptions has built strong collaborative partnerships with our provider network on national, state, and local levels. These highly cooperative, quality, and service-oriented teams have led to success in addressing the needs of Medicaid members across the country. We place an emphasis on sharing information and resources with providers regarding research and best practices relative to clinical care, facility operations, and outcomes measures, as well as high-level policy developments. We will invite providers to participate on our quality committees. One additional way for sharing this information with providers is our provider Web portal, ProviderConnect. As it gains more credibility through accountability, the substance use disorder treatment field has made great advances in person-centered planning, assessment and treatment planning. We will continue to work closely with providers to ensure that assessment and treatment planning are viewed as dynamic, fluid components in the treatment of substance use disorders. This portal also allows for multiple providers to view a Member's plan of care (with appropriate role identification) and for the UM to work with all providers to ensure that treatment plans are focused on outcomes and utilizing EBPs.

Integrated treatment planning and shared treatment plans across providers are a core strategy of VO-LA for the success of working with high risk and target populations, and starts first and foremost with Member and family involvement and direction of their care. This integration starts with the ValueOptions' CareConnect platform and has controls to assure confidentiality while allowing for dynamic and shared plans of care to assist the Member in achieving individualized recovery goals.

We will also support providers through our extensive training programs described in our response to *Section 2.e. Network Management* to ensure that assessments are conducted according to clinical protocol, are timely and administered correctly. This will be an iterative process that gives providers an opportunity to gain new or grow their existing skills so that they may request, design and deliver services that are customized to meet the needs of the Member. We will collaborate and train providers on assessment, Member and family engagement in-service planning with a focus on person-centered planning and how to incorporate self-management strategies. We will also train providers to prepare additional assessments for differential diagnosis and identifying co-morbidities. Additionally, we will provide training to providers on inclusion of peer and family and natural supports for planning. We will monitor for these processes on an ongoing basis. Finally, we will provide training on recovery strategies and working with Members and families to develop relapse prevention plans.

In our New Jersey program, ValueOptions worked collaboratively with the New Jersey Department of Children and Families, Division of Child Behavioral health Services, to reduce the number of

children and youths with SED who were "stuck" in inpatient facilities or long-term out of home placements by:

- identifying Members who had a length of stay longer than the average (by provider type)
- using CANS scores to determine children and youth who may be eligible for discharge based on a low level of need
- grouping the data according to their assigned case management agency (similar to WAA in Louisiana)
- sending each agency quarterly reports on children and youths who were potentially ready to be discharged based on identification criteria
- training the agencies on the state's expectations for follow-up, discharge planning, and reporting requirements
- working with the agencies to develop performance improvement plans, and ensuring the agencies reported back on the results of performance improvement efforts

Through this process, ValueOptions initially identified 44 low-need children and a year later, 66 percent of the children had moved back home or to community-based care. Overall, 85 percent of the identified children had moved back home or to community-based care. Overall, 85 percent of the identified children returned to their communities, with many of them going back to their homes.

(c) Needs identification and collaboration with the Proposer's network management and development staff;

Network access and provider availability are crucial to serving members with substance use disorders. VO-LA understands the need for proper identification and collaboration with Louisiana's providers regarding network management and development staff. VO-LA will work closely, as it does with other states, to insure that Louisiana's network needs are comprehensively and accurately assessed and that continuing efforts are made to fill whatever gaps arise. This is an ongoing effort and will be well-supported by high-quality data collection and oversight.

We are committed to the inclusion of providers that have traditionally served the Medicaid population to be a core part of the Louisiana network. In each of our programs, VO-LA works closely with community health centers, HSDs, public hospitals such as the Charity Hospitals, private CMHCs, and psychiatric hospitals to ensure their ability to meet credentialing requirements and become a vital component of the network.

We prioritize strong relationships with these providers, often called the "safety net," which are in many areas, the HSDs because we have found that they have a keen understanding of underserved populations and have a mission that parallels our own. These safety net providers are also used to support the cyclical nature of Medicaid Members and are more accepting of the tendency of this population to move between providers. Another strength of safety net providers is that they typically have additional social services and other human service resources that are not available from many other providers. These services, including counseling and education, food and clothing banks are services that may be unavailable or inaccessible to Members without safety net providers.

VO-LA will first identify the number of specialists that are needed in terms of training, experience, and specialization. The process will identify the geographic location of each provider in relation to

the individuals who require such services. This process will assist provision of needed services, and address travel time and associated access issues that are consistent with the ultimate goal of having the necessary services in each Parish.

Our current contracted network providers will serve as the foundation to building the base of providers to participate in the program. With alliances already in place with the many of these providers, we will use our current relationships to recruit new providers. For example, we have proposed a partnership with Tulane Medical Center to contract for one adult and one child psychiatric resident who will provide 32 hours a week each of services for the LBHP membership. This service will also be leveraged out into the rural areas via our proven success with tele-psychiatry.

Our Network Development and Management staff and our clinical staff are in continual dialogue so that clinically needed services are expeditiously communicated to Provider staff for development and/or retraining and support. The regionally-based Provider Relations staff will also play an active role in network recruitment. They will monitor provider availability in each Parish and will establish positive relationships within the communities to support provider network development.

(d) Approaches to treatment planning for individuals with co-occurring disorders

There are a number of fundamental components needed to provide integrated treatment to individuals with co-occurring mental health and substance abuse disorders (COMHSA). For any such programs to be successful, the following elements must be present:

- the ability to simultaneously treat both the chemical dependency issues and the symptoms of the mental illness, including an integrated treatment plan
- the ability of the system to be Eligible-focused and friendly
- the ability of the system to follow the Eligible through the continuum of care
- Member and family involvement
- promotion of mutual support groups such as Double Trouble in Recovery or Dual Recovery Anonymous
- treating the Member and their social Systems of Care as a whole
- identification of and adherence to specific attitudes and values about co-occurring mental health and substance abuse

ValueOptions has integrated all of the above principles into its program of care for individuals with COMHSA, as well as for Members who have other diagnoses. We have actively integrated and built upon these premises in identifying, treating and ensuring continuity of care for Members with COMHSA.

Identifying Members with Co-occurring Mental Health and Substance Abuse Disorders

Identification of Members with co-occurring mental health and substance abuse disorders (COMHSA) is often a challenging and complicated process. To ensure the appropriate and timely identification of Members with COMHSA, we will use the following:

- ***Education and Training:*** We will provide extensive training and education to providers, community services, members, and UMs on COMHSA identification, assessment and treatment. We will provide technical assistance and basic resources for the establishment of mutual support programs in communities across Louisiana. On an ongoing basis, we will provide information on EBPs and ways of identifying the presence of such illnesses in Members. We will educate Members and family members on the various mechanisms through which the LBHP can be accessed. We will also continue to actively support efforts to build a community of providers with COMHSA competencies in the treatment of both mental health illnesses and chemical dependency issues. VO-LA clinical staff will receive in-depth and ongoing training on the processes of identifying and engaging individuals with COMHSA. Our training will include issues such as: myths about COMHSA, empathy for and understanding the needs of individuals with COMHSA, engaging the Member with COMHSA in the initial and ongoing treatment processes, and identifying the appropriate provider to provide treatment services.

- ***Inpatient Assessments***: Inpatient hospitalizations are often prime opportunities for a thorough and complete assessment of any Member for the presence of COMHSA. As part of the assessment process completed during member inpatient stays, facilities are expected to evaluate the member for the potential existence of COMHSA.

Treating Members with COMHSA

The clinical treatment process begins with a thorough and complete assessment of the Member. Assessments examine the Member's ability to function, the presenting problem, and the availability of treatment modalities to address identified needs. The provider assesses each of these components in more detail with the Member and family member, if appropriate, during the assessment and treatment planning process. ValueOptions' treatment process for individuals with COMHSA includes an array of components, such as:

- ***Dual Treatment:*** Providers are expected to identify mechanisms through which services can be provided in an integrated and holistic manner. Use of medications, referral to community support groups, involvement of the family in the treatment process, collaborative working relationships between mental health and chemical dependency providers, and the use of basic theories of treatment must all incorporate the interchange and integration of both the recovery and rehabilitation frameworks for treatment. The provider must ensure a culture of treatment that cultivates adherence to the essential aspects of both mental health and chemical dependency treatment processes.

- ***Relapse and Recovery Prevention Approach:*** ValueOptions uses the relapse and recovery prevention approach, designed for individuals with diagnoses of SMI, SED or co-occurring mental health and substance abuse issues, as one of its primary approaches to treatment for persons with COMHSA. The traditional approaches to such illnesses focused on the inability of the Member to recover, but the Relapse and Recovery Approach focuses primarily on providing the Member with the tools needed to maintain a healthy and functional existence. This model focuses on quality of life, the possibility of relapse, and the ability of the Member to regain stability, regroup, and find a sense of purpose in the treatment and in life, in general.

- ***Prevention Focus:*** One of the most important components of any health care program is the active education of Members about ways through which the onset of mental health and

substance abuse illnesses can either be decreased or avoided. It is imperative that prevention programs offer Members and families a clear and concise definition of COMHSA, its symptoms and complications, and treatment modalities. We will promote the use of Mental Health First Aid to provide needed skills for assessment and referral at the community level. It is also essential for any educational program to offer Members hope and a sense of empowerment in identifying and coping with such a complex behavioral health issue.

- ***Continuum of Care Follow-Through***: Providers and UMs are expected to ensure that services required for continued support and treatment are in place prior to discharge or to transition from one level of care to another. It is imperative that services be identified and established that meet the Member's mental health and chemical dependency service needs prior to the transition.

- ***Member and Family Involvement:*** One of the most important factors in understanding and developing a successful treatment program is ensuring the active participation of the Member and his or her family, if appropriate, in the treatment planning process. Involvement in assessment, treatment, establishment of goals, and discharge planning are all aspects through which families and Members can actively participate in treatment. Most Members are also more likely to maintain active participation and to follow through on assigned tasks when they, and appropriate families or support systems have had the opportunity to determine parts of the treatment process.

- ***Management of the Member and the Social Situation***: ValueOptions providers are held to a standard of addressing the Member's social needs as part of the treatment process. This includes the identification and/or development of community programs that enhance the Member's ability to manage daily life issues. Child care, transportation, mother and child residential programs for detoxification and chemical dependency management, parenting classes, collaboration with WIC and other social service agencies, in addition to the delivery of clinical treatment services, are examples of a holistic approach to the management of COMHSA.

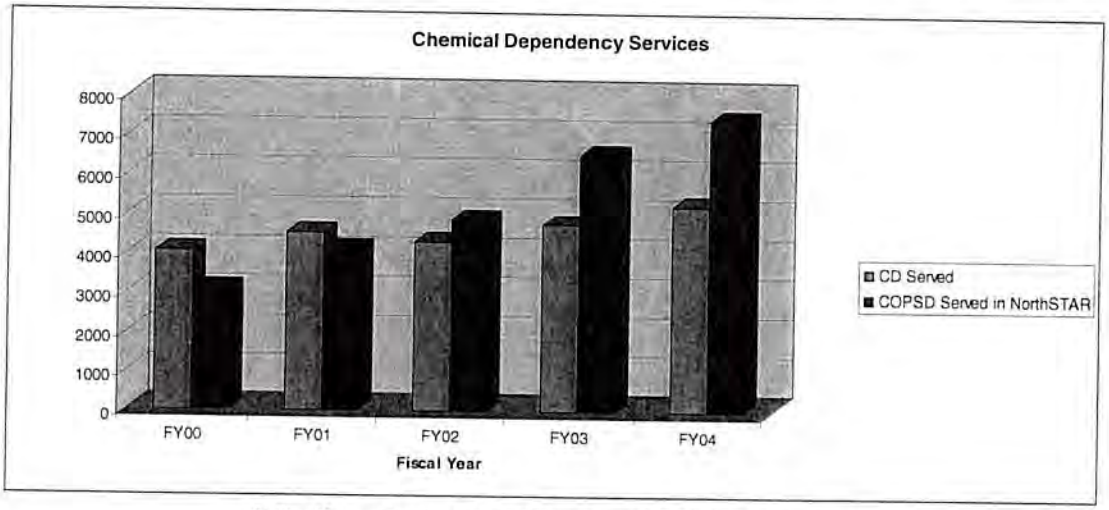
Ensuring Continuity of Care

One of the most important factors for continued remission in COMHSA is the identification and procurement of community programs of care that meet the Member's mental health and chemical dependency needs. An example of such collaboration is the expansion of the Alcoholics Anonymous support group concept to include groups that address COMHSA issues. The expanded groups that encompass issues for persons with co-occurring disorders are called Dual Recovery Anonymous. Other support groups for this group of Members are Double Trouble and APAA (Association of Persons Affected by Addictions).

By using a holistic approach to recovery and rehabilitation, providers and UMs also work closely with the Member and family to identify any wrap-around services or social supports required to assist the Member in maintaining an active and productive level of participation in the treatment program. They actively work with community programs and agencies to ensure that supportive services are available to accommodate the Member's social needs.

An Example of the Benefit of Co-Occurring Treatment

Untreated and under-treated mental health and substance abuse affect all ages and culture within the Medicaid population and are disproportionate contributors to medical costs under Medicaid, to the costs of crime and corrections, the costs of social services and child welfare, the costs of homelessness, and the costs of long-term care in nursing homes. Investment in COMHSA treatment shows significant return to the State. The following graph shows the increase in COMHSA services under ValueOptions' management of the NorthSTAR Program in Texas:



A Significant Increase in Utilization of COMHSA Services

The Return on Investment: A preliminary analysis conducted by Texas Legislative Budget Board staff in 2008 found that overall Texas Medicaid spending was lower for Medicaid adults who received integrated treatment through NorthSTAR during fiscal year 2006. As shown in below, Texas Medicaid spending in fiscal year 2006 was $5,869 less per client among SSI and SSI related Medicaid adults who received coordinated mental health and substance abuse treatment services through NorthSTAR and $4,439 less per client among TANF and TANF-related Medicaid adults.

	SSI/SSI Related	TANF/TANF Related
Untreated Group	$14,239.00	$8,366.00
NorthSTAR Treatment Group	$8,371.00	$3,928.00
Spending Reduction	$5,869.00	$4,439.00
NorthSTAR Treatment	$2,364.00	$1,443.00
Net Spending Reduction	$3,505.00	$2,996.00

(e) Experience with managing care for individuals living in permanent supportive housing; and

ValueOptions works to coordinate services to homeless individuals through a variety of programs. In some contracts, this has included staffing outreach workers to visit shelters and provide assessments, referrals, and crisis interventions. We have also encouraged the creation of provider-run community support teams for homeless individuals in several contracts. Sometimes these take the form of PACT teams, which have been shown to reduce incarceration rates, hospitalizations, and homelessness. In the paragraphs that follow, we offer several examples of our experience.

Massachusetts Behavioral Health Partnership (MBHP)

MBHP helped start the Community Support Program for People Experiencing Chronic Homelessness (CSPECH). A community-based system of care, CSPECH provides case management services and housing to more than 100 displaced adults across the Commonwealth. In operation since September 2006, MBHP's CSPECH program has touched the lives of many people in need by helping them focus on recovery and self-sufficiency. "It got me off the street – put a roof over my head. I really, really appreciate the people who helped me," said a member of the CSPECH program. Recognized by the Massachusetts Housing and Shelter Alliance (MHSA) for its commitment to helping homeless people get back on their feet, the MBHP was granted the 2007 MHSA Cornerstone Award. "I was proud to be one of the team leaders of this project and to have the privilege of working with such a great group of MBHP staff," said George Smart, Vice President of Clinical Operations. "We were all inspired by the success stories of Members who had previously spent years living on the streets, and once having a place to live, began to express how much this program helped them feel like human beings again. CSPECH truly embodies the core values of ValueOptions and MBHP of clinical excellence, compassion, and respect and innovation."

Texas - NorthSTAR

As indicated earlier in this response, our NorthSTAR program is actively involved in providing services to homeless persons, many who experience a serious and persistent mental illness. We have developed community based best practices strategies such as street outreach, shelter outreach, mobile mental health clinics, and drop in centers to reach members who otherwise would not receive services.

As part of this outreach, we are a member of the Metro Dallas Homeless Alliance (MDHA) which collaborates to provide services at "The Bridge.". The Bridge, opened in May 2008, is a multi-purpose facility based on a unique Public-Private Partnership dedicated to serving homeless men, women and children, with a primary focus on the chronically homeless. The Bridge's service model provides a dynamic entry point for homeless persons to access multiple services in one centralized site in the south downtown Dallas area.

At a cost of only $24.97 per person, per day; the Bridge aims to provide the following services every four months:

- emergency care for 700 unduplicated people experiencing homelessness
- emergency housing for 350 unduplicated people experiencing homelessness
- transitional care to 350 unduplicated people experiencing homelessness
- transitional housing to 125 unduplicated people experiencing homelessness
- outplace 125 unduplicated people experiencing homelessness into permanent or permanent supportive housing

In support of the Bridge, ValueOptions provides onsite behavioral health, pharmacy, care coordination, chemical dependency, crisis, transportation services, and innovative peer recovery support services. In addition, ValueOptions has implemented an integrated Behavioral Health and Physical Health care management care management program. The care management program was developed for the purpose of integrating services provided at the Bridge for High Risk individuals who had frequent visits to emergency rooms. Since implementation in June 2009, the care management program has served 21 percent of the average daily population served at the Bridge and

provided the critical link in managing services and enhancing outcomes for high risk individuals. The result has been reduced emergency room visits, reduced hospitalization and increased community retention for individuals with the most complex health, behavioral and psychosocial needs.

Of the 198 individuals participating in our initial 2009 pilot program (June 2009 – February, 2010), 126 (63 percent) successfully completed the program as evidenced by increased housing stability and adherence to community based treatment, with reduced visits to the hospital or emergency room. Of the individuals who had a care management service, 60 individuals had emergency room (ER) or hospitalizations in the six months prior to admission. Of those 60 individuals, there was a post-intervention reduction in psychiatric hospital and emergency room expenses of $ 72,030 based on psychiatric health care claims.

Cases with ER & Inpatient Psychiatric Service	Pre CM ER & Inpatient Psychiatric Service Cost	Post CM Intervention ER & Inpatient Psychiatric Service Cost
N=60	$ 90,486.00	$ 18,456.00

The care management provider acts as in interim clinical home for coordination of all services across physical and behavioral health care. The common physical health conditions of the population in the program include HIV, TB, diabetes, COPD, cancer, hypertension, hyperlipidemia, and other chronic health conditions. Additionally, 100 percent of the individuals served have chronic chemical dependency and mental health conditions.

(f) Strategies the Proposer has found useful in other programs. Suggested number of pages: 4.

In addition to the strategies from other programs that have been described above, VO-LA will offer our Psychiatric Consultation Line.

Physician Consult Line

The psychiatrists are available for telephonic consultation regarding all aspects of mental health and substance abuse treatment, including medications and the services are available to PCPs for no fee to consult on the treatment of LBHP Members.

These psychiatrists are available for telephonic consultation regarding all aspects of mental health and substance abuse treatment, including medications.

The consult line is a valuable tool in educating PCPs in how to recognize and refer patients who require behavioral health care services. This one-on-one communication is a value-added service because it helps Members to receive the benefit of carved-out expert behavioral health care through their PCP for the evaluation of depression, anxiety, and substance abuse.

No Wrong Door Access

Our understanding of the co-occurrence of mental health and substance use disorders, and the need for simultaneous treatment of both problems as well as related physical health conditions, has led to the type of treatment programs we have developed for other programs. Informed by this experience, VO-LA can deliver comprehensive substance use service to adults by:

- providing "no wrong door access" to substance use services in the behavioral health continuum and through PCPs
- assuring continuity of member engagement at each level of service
- assuring treatment innovation and superior clinical programs

We will contract with providers who can treat substance use conditions at the initiation of the contract.

In addition to the other inpatient and diversionary levels of substance use care, specialized substance use treatment services that we have developed for our Massachusetts program include:

- **Structured Outpatient Addiction Program Outpatient Services (SOAP)**—We operate specialty SOAP programs using motivational interviewing with those experiencing homelessness and transitioning to adulthood.
- **Opioid Replacement Therapy**—We contract with a statewide network of methadone providers who offer dosing and counseling services for approximately 7,500 individuals. We have also developed site-specific utilization data at the dispensing unit level and will utilize this data to develop facility management strategies related to utilization and outcomes.
- **Community Support for Persons Experience Chronically Homelessness (CSPECH)**—In collaboration with the Housing First Initiative, we have been a leader in providing mental health and substance use services for Members who do not have permanent housing. Under the new contract, all Members receiving 24 hour care will be assessed for their permanent housing status and be linked with our CSPECH program when that need is identified.
- **Urgent Outpatient Services (UOS)**—We have developed UOS specific to substance use in Boston and will expand this strategy to other providers under the new contract.
- **Ambulatory Detoxification Services (ADS)**—We have found a benefit to providing an extension of detoxification services in the community when prolonged tapers of medications such as benzodiazepines are required. Using our experience in Central Massachusetts and the Northeast region, we will expand ADS to all regions under the new contract.

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

Address how the Proposer will perform the following UM activities:

VO-LA' s Utilization Management program will support providers in delivering clinically necessary outcomes-focused and effective care with a minimum of administrative barriers. Utilization management points of decision are opportunities to calibrate whether treatment is on the right course and whether additional resources are appropriate or needed. Given the historical issues with the private providers and the imperative to build out a community based system of care, VO-LA will use a collaborative approach and focus on ensuring that care is clinically appropriate and supporting the individual in their recovery and self-management. We believe in clinically-driven management of care through the use of objective, standardized clinical protocols, criteria, and practice guidelines. Care Management is utilized for highly restrictive levels of care and for Members who have complex needs, are failing to be sustained in the community or who pose a significant risk to themselves or others. Our Utilization Managers (UMs), who are Licensed Mental Health Professionals (LMHPs), will base their reviews on admission and continued care criteria, recovery and resiliency principles and practice guidelines that have been developed in collaboration with, and approved by DHH-OBH.

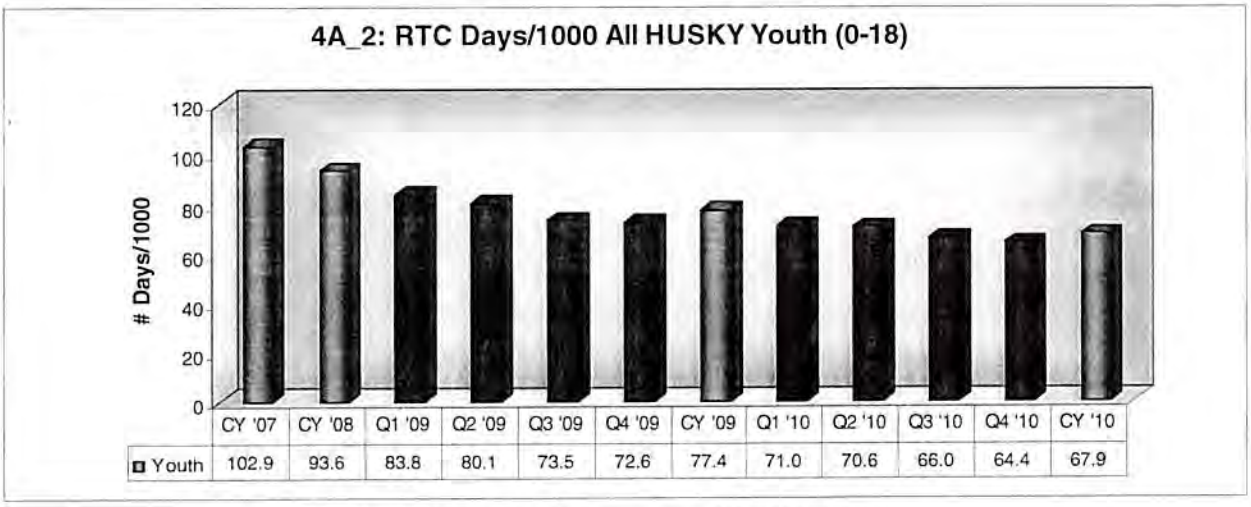
VO-LA takes great pride in the integrity of our Utilization Management program. We use data to inform our decisions and ensure there are no incentives for any staff to deny, limit or discontinue medically necessary services. This is integrated into our Code of Conduct which must be read and signed by every staff person annually.

Our Utilization Management program is built on the following principles:

- treating Members at the point of care where they are comfortable, and applying a patient-centered, strength-based approach to treatment that incorporates shared decision-making with the Member and all involved providers through the integrated interface of treatment plans, crisis plans, pharmacy history and self-management recovery plans
- assuring that individuals are treated in a holistic manner, using a single treatment plan that addresses both physical and mental health needs and taking into account unmet needs such as substance abuse treatment; and also helping individuals access their natural community supports based on their strengths and preferences
- supporting effective communication and collaboration between behavioral health and medical clinicians and natural supports
- focusing on recovery and resiliency focused services and the lowest level of care clinically appropriate and available

- supporting all involved providers to operate with a collaborative team approach and to deliver care that is outcomes focused, consistent with evidence-based practices (EBPs) and uses a standardized protocol. The team is recovery and individual driven and can include the individual, key clinicians, and other persons whom the individual may select for support in designing and accessing services, such as a neighbor, relative, friend, or case manager
- obtaining all the necessary permissions from the individual to coordinate care among different providers, and establishing the required HIPAA-approved Business Associate agreements to address protected health information (PHI).

We focus our utilization management resources on those areas that have the most impact on the quality of care provided to our Members. In addition, our utilization management is designed to promote recovery and resiliency in the community and maximize services and supports that are preventive, accessible, comprehensive, and dynamic. ValueOptions has demonstrated success in other states in achieving this mission. For example, in Connecticut, there was over-reliance on out-of-home residential care. We implemented regional systems of care and regional care teams, which has resulted in a decrease of utilization in residential placements while increasing community based services. This same experience and approach will be brought to Louisiana.



Results for Utilization Management of CSoC like services

As residential Days/1000 have decreased over the past several years there has been an identified trend of a correlating increase in the use of community based services for the same period of time.

How the authorization process will differ for acute and ambulatory levels of care for adults, CSoC and non-CSoC children;

VO-LA will manage the authorization process in accordance with the guidelines and specifications outlined in the RFP differentiating by levels of care the intensity of utilization management. We will implement the authorization process using our best-in-class authorization management system "CareConnect" that will facilitate care coordination and alleviate unnecessary administrative burden on providers.

Acute Authorization Process

VO-LA will require pre-certification and concurrent review for all inpatient psychiatric hospitalizations. VO-LA will ensure that face-to-face inpatient psychiatric hospital concurrent utilization reviews are completed by a LMHP for each Medicaid beneficiary referred for psychiatric admissions to general hospitals. Level of care criteria will be followed for adults as stated in the Request for Proposal (RFP) per R.S. 46: 153 adult admission criteria. And inpatient services for children will be based on the Child and Adolescent Needs and Strengths (CANS) screening and algorithm assessing the severity of need and intensity of service required.

VO-LA will build network capacity and crisis services programs to conduct the Emergency Inpatient Hospital Psychiatric Screenings and the required face-to-face inpatient psychiatric hospital concurrent utilization reviews within the RFP time requirements. In addition, the 24/7 availability to our Member Access Center will give emergency rooms the opportunity to reach out for assistance with diverting in appropriate inpatient utilizations. Key to this diversion is the immediate "build out" of community-based alternatives and the retraining of many existing providers to deliver recovery and resiliency oriented services and support Member empowerment and self management. Upon competition of the screening, the contracted independent provider will load the clinical screening into CareConnect. If the inpatient admission is approved, VO-LA will immediately generate a prior authorization number from the Medicaid fiscal agent, and within 48 hours, notify, in writing, the provider and individual requesting the screen of the results. If denied, VO-LA will notify the individual requesting the screen immediately, and within 48 hours provide written notification to the provider and individual requesting the screen of the results. The notification shall include whether or not an alternative community services plan is appropriate, the right of the Member to appeal and the process to do so.

VO-LA will never require an authorization for emergency services. Our Crisis Services Workflow assures timely access to needed care as illustrated on the following page.

Workflow Redacted

Psychiatric Residential Treatment Facilities (PRTF)

If psychiatric residential treatment is recommended in lieu of inpatient psychiatric hospitalization or being requested for a Member, VO-LA will perform independent initial certifications of need and recertification of need. Through the Certification of Need (CON) VO-LA will ensure that:

- ambulatory care resources available in the community meet the treatment needs of the Member
- proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician
- the services can reasonably be expected to improve the recipient's condition or prevent further regression, so that the services will no longer be needed

The CON and re-certifications will be completed by an independent team that includes a physician, and an LMHP, who have competence in the diagnosis and treatment of mental illness and when possible in child psychiatry and have knowledge of the individual's situation. The CON process will include a face-to-face assessment by an LMHP, independent of the facility, in addition to the recommendations of team that includes a physician, which determines that ambulatory resources will not meet the needs of the individual requesting PRTF services. To ensure that the team has knowledge of the ambulatory resources available to the youth and the youth's situation, VO-LA will ensure that the team is assembled by a subcontract in the youth's county of residence (if not in state custody) or the youth's county of responsibility (if in state custody). Recertification shall occur within 90 days of admission and again every 60 days thereafter. For the PRTF screens to be complete, the team shall meet and rule out other community based options. VO-LA will follow all the timelines outlined in the RFP for the completion of CON's including emergency screening procedures, and planned psychiatric screenings. One evaluation reported by the Picard Center of Louisiana's children showed that 14 percent of children over the age of four are already identified as at risk for mental health issues.

Screening and network development will be the cornerstones of VO-LA's work to stem the tide of out of home placements for children. Our residential authorization process is reflected in the following workflow.

Workflow Redacted

Other Residential Levels of Care

VO-LA will work with the DHH-OBH to develop prior authorization and concurrent utilization review of therapeutic group home and other residential levels of stays, including group homes, non-medical group homes, and therapeutic foster care. VO-LA has extensive and successful experience in several states in the management of diverse populations and a variety of levels of residential care.

Ambulatory Services Authorization Process

VO-LA outpatient authorization process will follow the guidelines outlined in the RFP and will implement procedures to efficiently collect all the required treatment plans and data elements manage the diverse programs and services with minimal administrative burden while maximizing the opportunities to coordinate care.

School Based Services

A specific focus of VO-LA ambulatory authorization process will focus on the authorization and integration of Medicaid-funded school-based behavioral services. VO-LA will customize the CareConnect and ProviderConnect functions of our integrated care management system to seamlessly manage, monitor and track children and youth service needs, outcomes and utilization. Within our integrated platform we will be able to seamlessly share information with all involved providers, including the PCP and create a central location for an individualized healthcare plan (IHP). This is where VO-LA will maintain the information and authorization from the IHP, including needs and school services provided. VO-LA will make the IHP available to treatment planners and WAA in order to facilitate understanding of the totality of the child's needs and services being received. VO-LA will authorize all services in the IHP according to the RFP guidelines. VO-LA as the SMO provides an opportunity to continue to expand the number of school-based health centers that bill Medicaid for behavioral health services, further expanding the 18 Coordinated School Health Participants the community based system of care.

VO-LA's CareConnect and Provider Connect systems will also be the repository for the CANS assessment information and treatment information for school based services. VO-LA will monitor school based services and assure the services are consistent with the IHP. As the VO-LA CONNECTS system is an integrated platform for claims payment and authorization, VO-LA can easily manage the claims payment and authorizations for school-based services as outlined in the RFP and forward authorizations for claims payment as needed to the appropriate authority or pay the claim if the service is provided by a VO-LA contracted provider who is not a school employee.

Our process for working with the Local Education Authorities ensures that children receive the appropriate coordination of care for the best service delivery to meet their needs.

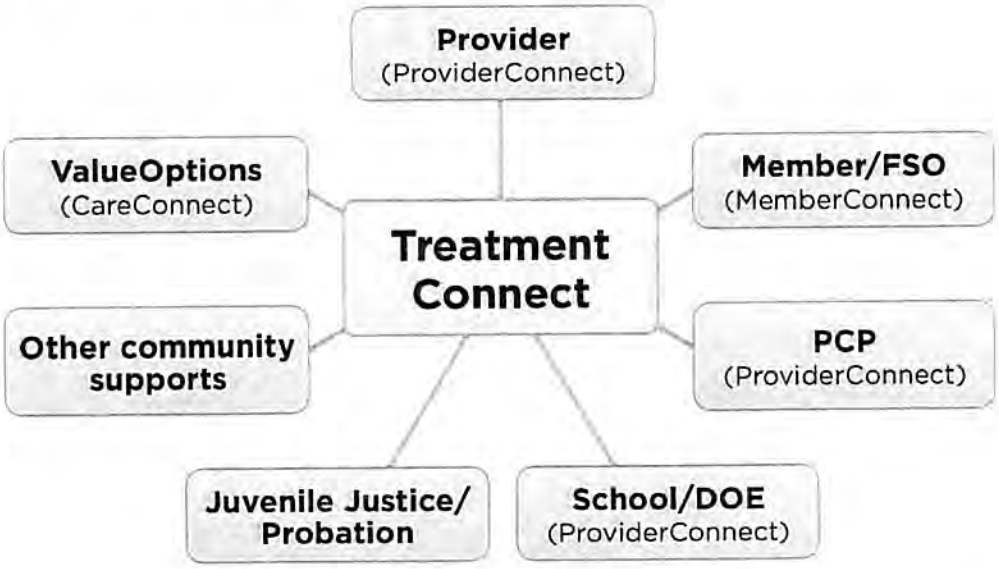
Workflow Redacted

CSoC Authorization Process

VO-LA will perform prior authorization for CSoC waiver services in accordance with the RFP, and coordinate Plan of Care review with WAAs on all CSoC services. VO-LA will have regionally placed CMs to facilitate the processing, monitoring and management of children needing services in the region. All services for children in the CSoC will be reviewed and authorized by the assigned Regional CM. This regional management includes the management of services for children who are in out of home placements. Through this regional format, ValueOptions has been successful in the implementation of CSoC like services in other States (Connecticut, Massachusetts, and Maryland) and as a result has developed an integrated treatment portal for CSoC to have a shared Plan of Care of all entities involved in the care of the child or youth. Our "TreatmentConnect" system is part of ValueOptions single platform suite of Heath Management software tools that includes care management, claims payment, network management, data management, and utilization management. TreatmentConnect is easily accessed through portals based on the rights of the person accessing the system. The following system applications are populated with the same data to assist with UM functions:

- MemberConnect is the portal for Member and caregivers or other individual defined natural supports
- ProviderConnect is the portal for VO-LA and PCP providers

- CareConnect is the portal for Utilization management and care management
- PharmaConnect is the portal for pharmacy information that feeds into TreatmentConnect
- AgencyConnect (JusticeConnect) is the portal for other involved agencies such as education teams, protective services, juvenile, probation



TreatmentConnect is easily accessed through portals based on the rights of the person accessing the system.

VO-LA will initiate the authorization process at the onset of referral for screening and will complete a brief telephone screening on referrals to the CSoC using the CANS tool to determine eligibility for the CSoC. Once the screening is complete, if the Child/Youth lives in a WAA area, the child will be authorized for community-based services, including a Family Support Organization (FSO), for up to 30 days or until the plan of care (POC) is developed and approved.

Non-CSoC Children Authorization Process

As a part of the VO-LA UM process, ValueOptions will screen all at risk children and youth for CSoC services. When a child/youth is not eligible for CSoC services VO-LA will make referrals to a LMHP for an independent assessment coordinate and authorize services based on medical necessity. This process will include the review and approval of rehabilitative service plans. Providers will utilize the ProviderConnect application to submit treatment plans, and rehabilitative service plans. Members can review treatment plans, service authorizations, and request needed services through the VO-LA MemberConnect application.

VO-LA addresses the needs of children participating in the CSoC or children who do not qualify for CSoC services to assure they receive the services at the right time and right place.

Workflow Redacted

Adult Services

Over and over, hospitals such as the University of Louisiana-Shreveport, Brentwood, Our Lady of the Lakes, and Acadia Vermilion told us that one of their biggest challenges with ER diversion was 24/7 access to "someone" who could help find an individual a bed or a different resource. Our 24/7 Louisiana access center will ensure Members are screened for crisis and referred appropriately to crisis services if they are in crisis. VO-LA will engage in telephonic screening to determine if the Member is eligible for DHH-OBH services or is a Member affected by a substance use disorder in one of the target population groups outlined in the RFP. Once the screening process is completed, the Member will be referred to appropriate service resources.

Services that require treatment planning and authorization will be managed though the system application, ProviderConnect. Providers will submit treatment plans, rehabilitation plans, ASAM Assessment, LOCUS assessment, and authorization requests seamlessly though the on-line system. VO-LA will process the service requests by reviewing the submitted clinical information and evaluate if the treatment plan is adequate and appropriate to meet the Member's aspirations and needs. If appropriate and approved, the authorization will be generated electronically and the provider will be notified. The Member can also review a provider's request and authorizations though the MemberConnect portal or submit a service authorization request.

Workflow Redacted

Our workflow for adults with substance use disorders addresses the recovery services to best address the needs for these Members.

Workflow Redacted

(a) Describe the UM workflow and processes for denial of care;

UTILIZATION MANAGEMENT WORKFLOWS

VO-LA's UM program design achieves:

- Timely access to clinical staff for Members and providers
- Consistent decision-making using our clinical criteria
- Timely UM decisions and receipt of clinical information
- Timely notification of authorizations and non-authorizations
- a structured appeals process for Members and providers

Our UM process assures that appropriate care is delivered to Members according to the Medicaid medical necessity definition, as well as the established level of care (LOC) guidelines in the context of individualized and member-centric treatment planning including the use of Wellness and Recovery Action Plans (WRAP). Our UMs conduct the review from the perspective of the whole Member and the interventions/supports, both traditional and natural supports, to achieve their goals related to recovery and resiliency. UMs work with providers to identify appropriate community alternatives and/or additional natural supports that may be needed to effectuate recovery goals related to self efficacy empowerment individual responsibility, health and wellness what may be requested as a service. Such an approach is essential for moving the Louisiana behavioral health system from a crisis/inpatient system to a community based system of care that that will supportr Members to reach ***their*** goals. We believe that life is not about treatment; rather it is about developing strengths increasing the capacity for self knowledge, love, integrity, work, learning and reintegrating into the community to have the highest quality of life.

Workflow Redacted

As seen above, for a ***First Level Initial Authorization,*** the UM process begins with the receipt of an authorization request from a provider. Below are ways in which treatment may be authorized or registered:

- *UMs are available 24 hours a day* via the toll-free number to respond to all crisis calls and to review requests for service authorizations. When available, Plans of Care, Treatment plans, Rehabilitative service plans, personal recovery plans and crisis plans are available within our MIS to ensure Member-specific needs are identified and resolved according to their specific plans. Concurrent reviews are scheduled during normal business hours.
- For routine outpatient services and other LOC approved by DHH-OBH, providers are able to *register services through fax or though our Web-based registration system.* All efforts will be made to support the providers in utilizing this to improve administrative efficiency for both providers and ValueOptions.

All our staff, including clinicians, receive orientation and ongoing training in recovery and resiliency

For each review, the UM gathers the required clinical information, including clinical symptoms, functioning impairments, diagnosis, treatment plan objectives, and the crisis and discharge plans. Additionally, they will request previous treatment information and review past treatment successes and failures to assess the likelihood of a positive treatment outcome. When needed, the UM may request additional clinical information from the individual requesting services and/or care planning team.

Upon review of the request and available clinical information, the UM determines whether the requested care meets the clinical LOC criteria. CareConnect is programmed to provide queues to the UMs in using the appropriate criteria for each review. As part of the initial authorization process, UMs review the Member's current and open authorizations to determine if the requested service is a duplicate or conflicts with an existing service authorization. The UM works with both providers and the Member to transition the Member to the most appropriate service or service locale when conflicts are found. If a transition process cannot be identified which is acceptable to the Member and both providers, the UM sends information to a Peer Advisor (PA) for review.

Each authorization period is determined by the individual Member's clinical condition and personal recovery goals. At the time of the initial authorization, the provider and the UM establish a time for the first ***Concurrent Review.*** Providers are responsible for initiating the concurrent review process; and our Clinical Support Staff use automated reports to track the need for subsequent reviews and may place a courtesy call to the provider before an authorization expires to confirm the impending review.

Concurrent reviews focus on the Member's response to treatment as well as the provider's progress in discharge planning and arranging aftercare when transitioning from a higher LOC. Just as in the initial authorization process, the UM must document all clinical information received and the basis for the services authorized. If the UM is unable to independently determine the appropriateness of the continued treatment or there are questionable or absent treatment plans, discharge plans, or questions related to the quality and appropriateness of care being delivered, the case is referred to a PA for review.

Although every effort is made to conduct reviews and to issue authorizations prior to the delivery of care, there are situations in which we will conduct a ***Retrospective Review*** on behalf of the program. These are circumstances in which the provider/facility failed to request a review for a Member in care and the review meets one of the following circumstances: the facility was unable to define that the patient was an eligible Member due to Member's mental status; the Member's eligibility was approved retrospectively following the admission; or an emergency admission for which the provider/facility was unable to request authorization within expected timeframes due to the nature of the emergency. If there are questions of medical necessity, the case is referred to a PA for review. If additional information is needed to make a decision, our UM may request the clinical record for further review/clarification.

Discharge Planning and Case Closure

For Louisiana, timely discharge planning is all too often a critical missing link for over-relied on hospitals. Over and over again, we heard from hospitals all across the State that they had "no one to call" and "no place to discharge" individuals with behavioral needs. Now is the opportunity to develop services that allow for a Member to be discharged in a timely, planned and meaningful manner to services in their home communities to develop new way of coping with life stressors . UMs initiate discussions regarding discharge planning as part of the focal treatment plan at the time of the initial authorization and continue the discussion and reassessment of the discharge plan at each subsequent review, to reduce readmission. UMs identify, document, and attempt to resolve barriers in order to affect a timely discharge. A Member's strengths/interest, and past successes may contribute to successful discharge planning and/or transition to an appropriate LOC throughout the stay and that is based on Member buy-in and ownership. All information developed as part of ongoing case planning is integrated into the WRAP and crisis plans in addition to the Discharge Plan. The UMs assist providers with implementation of the discharge plan, research and referral to appropriate services, including natural supports, non-traditional programs as well as traditional aftercare services within the Member's community. UMs engage other providers and/or family members (with permission) to educate and train to develop and implement appropriate aftercare plans that build on Member strength and nurtures resiliency . Members requiring additional clinical care management support based on high-risk status are referred to our UM) program.

If a medically necessary covered service contained in the discharge plan is not available, the UM can: 1) arrange for the service under a single case agreement, or 2) authorize an alternative service or higher LOC sufficient to meet the Member's needs. Information regarding authorization for services not available within the network will be shared with our Regional Provider Relations Representatives to identify gaps in service within various local areas. Discharge planning is an area of particular strength for ValueOptions. We offer support to providers onsite as needed; and by enlisting our regional teams and our innovative technology that supports referral to and continuity of care, this support will be easily accomplished. When a provider terminates service to a Member, whether or not the Member is being referred to another service or provider, the treating provider is responsible for notifying our Clinical Department, via telephone, fax, or Web, that services have been terminated.

DENIAL OF AUTHORIZATION - SERVICE PROCESS AND WORKFLOW

UMs refer cases that do not meet admission or continued stay criteria to a Peer Advisor, licensed in the State of Louisiana. The Peer Advisor reviews all available clinical information and may speak with the treating provider or the provider's designee to discuss the case. Included in the discussion is a consideration of medical necessity criteria, practice guidelines, and alternative levels of care. If the requestor agrees to an alternative, or if the Peer Advisor agrees with the initial request, the Peer Advisor enters any necessary authorization for services into CareConnect. If the Peer Advisor and treating provider cannot reach agreement as to disposition, the Peer Advisor will enter denial the adverse determination and rationale in CareConnect, referencing relevant authorization criteria and guidelines. The treating provider is notified in writing. **Only a Peer Advisor may deny an authorization for a service**. VO-LA will adhere to the Utilization Management Requirements in the RFP Scope of Work. We will not arbitrarily deny a required service solely because of a behavioral health Member's diagnosis, type of illness, or condition. Nor will we provide incentives to individuals or entities to deny, limit, or discontinue medically necessary services to any member according to 42 CFR 210 (e). A workflow of our peer review process is provided below:

Workflow Redacted

Upon issuing a denial for authorization of a service, a Notice of Action which includes the opportunity for appeal is sent to the person receiving services or their parent or guardian. The notification letter to the person/guardian specifies the service/level of care denied, the reason for the denial and instructions on how to file a treatment appeal. The letter is sent certified return receipt mail. We describe our appeals process in more detail in response to the following question.

(b) Describe appeals process, including the Proposer's standard and expedited appeals procedures, including the impact on the member and involved providers during the appeal process; and

ValueOptions is well-versed in the regulatory requirements regarding the issuance of appropriate and timely notifications of adverse determination which contains appeal rights, after any adverse determination. For Louisiana, our existing process for standard and expedited appeals is fully compliant with the requirements outlined in RFP Section 6. Grievance and Appeals. We will review these procedures in advance with DHH-OBH prior to the implementation of the program.

All denials and appeals will be coordinated by our Grievance and Appeals Administrator and overseen by our Quality Management Administrator within our Louisiana Service Center. Our CONNECTS system includes a denial and appeal database that is auto-populated in real time by our system and contains shell documents for all adverse determination notices. Once a decision is made to deny any service and the denial is entered into CareConnect, a Notice of Action (NOA) will be generated using this database and will be customized based on the individualized, Member-specific rational for the denial decision. Regulatory citations included in the letter vary according to the reason for denial. In addition, the letter will contain information about the Member's right to a State Fair Hearing if the Member is not satisfied with VO-LA's decision in response to an appeal.

Once the letter is generated, it is reviewed for format and content accuracy by senior management prior to mailing. Both Members and providers will receive all NOAs or denials. For providers, this information is also available through the provider Web portal, which is accessible 24 hours a day, seven days a week.

Both members and providers will receive all NOAs or denials. For providers, this information is also available through the provider Web portal, which is accessible 24 hours a day, seven days a week. We have developed a checklist system for reviewing all NOAs. This includes the following:

Denial Letter Checklist			
✓	Is the type of letter and appeal offered correct?	✓	Does the letter meet/exceed the seventh grade literacy standard?
✓	Is the date on the letter correct?		
✓	Is the member number and name included?	✓	If NOA, is the grievance and fair hearing form attached?
✓	Is this a Department-involved member?	✓	If reduction/suspension/termination, is a10-day notice provided, if needed?
✓	Has the guardian been cc'd on the letter, if applicable	✓	Are equally safe alternatives provided?
✓	Does the date of determination pre-date the denial?	✓	Are alternatives available in-network? If no, please review with the Clinical or Medical Director and state results.
✓	Is the reason for the adverse determination clear?		

Standard Appeal

If a Louisiana licensed Behavioral Health Advisor (Peer Advisor) makes a determination of no medical necessity for requested services, the member or treating provider may request a Level I appeal. Level I appeal reviews are conducted by board certified psychiatrists qualified in the area of behavioral health specialty required to render a clinical opinion about the medical condition, procedures, and/or treatment under review. Appeals regarding Psychological Testing may be reviewed by Peer Advisors who are Licensed Clinical Psychologists. That appeal reviewer must not have been involved in the initial denial decision nor can they be the subordinate of that peer

reviewer. The appeal determination is made and notification sent to the Member or representative at the earliest date possible but no later than the date of the State Fair Hearing or within thirty days from the date the appeal request is filed, whichever is earlier. In the event that the appeal is not resolved as requested by the Member, the steps necessary to request further review are provided in writing. Those steps are in line with the Member eligibility category.

Upon being assigned a case for appeal review, a Peer Advisor undertakes a full investigation of the substance of the appeal, including aspects of the clinical care involved. The Peer Advisor considers all documents, records, or other information submitted by the patient, provider, or facility rendering care, regardless of whether such information was submitted or considered in the initial consideration of the case. The Peer Advisor contacts the provider directly and conducts a telephonic review as appropriate. Based on consideration of all pertinent information, including relevant criteria and guidelines, the Peer Advisor makes a determination to reverse (i.e., overturn) the original adverse determination in whole or part, or to uphold the original adverse determination.

Standard (i.e. non-urgent) Level I Appeals are completed and a written determination is issued within 14 calendar days of the appeal request. The Peer Advisor or UM enters the results of the Level I appeal into the utilization review record the day of the determination, and the appropriate letters are generated to the Member, attending physician or other ordering provider or facility rendering service. If a determination is made to uphold the original no medical necessity decision, in whole or in part, the written notification includes:

- the principal reasons for the determination
- a statement that the clinical rationale used in making the decision will be provided in writing, on request
- instructions for initiating the next step in the appeal process
- the right of the Member/provider to submit any additional information in support of the next level of appeal

Expedited Appeals

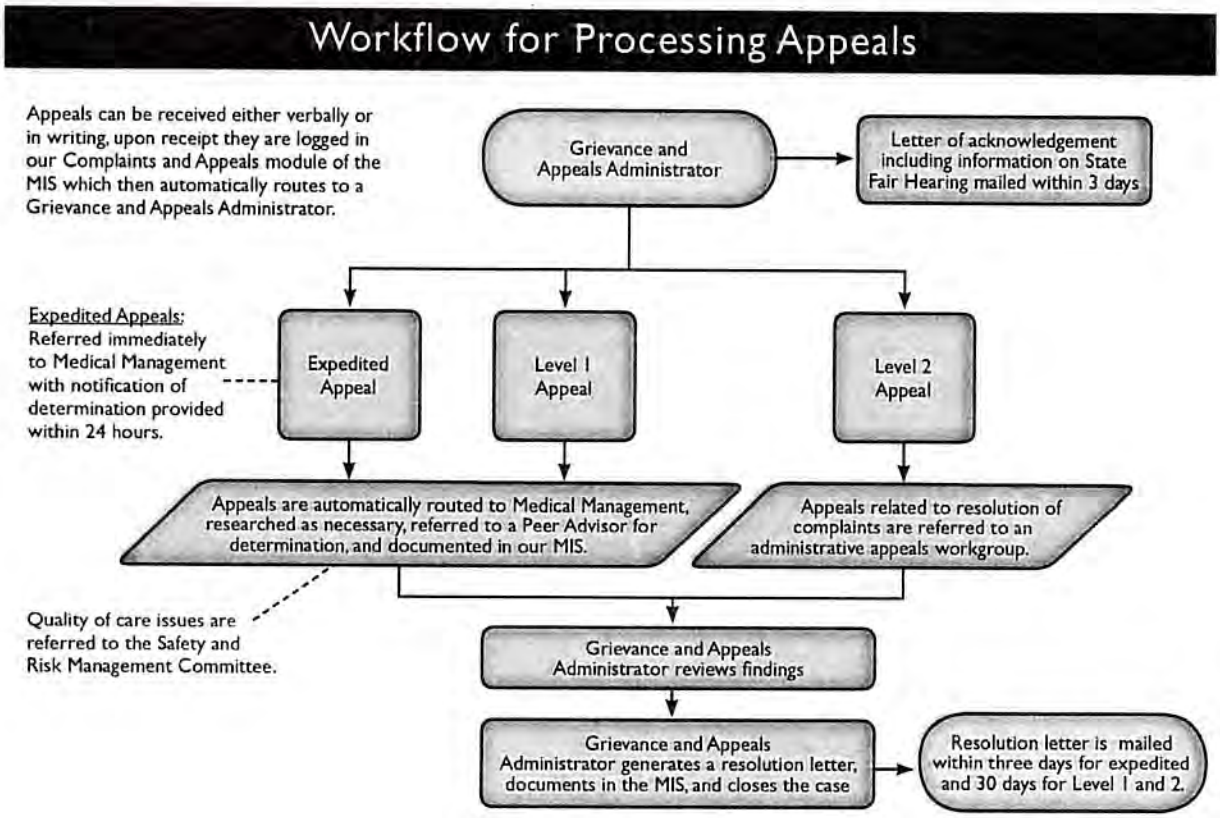
An Expedited Appeal process is initiated when a Member's life, health, or ability to gain maximum function is jeopardized by the denial of service. An expedited review is performed at the request of the attending physician, who is acting on the Member's behalf, usually at the time he or she is notified by telephone of the original non-certification decision. The expedited review is completed by a Peer Advisor who was not part of the original non-certification process. The final determination is conveyed to the member within (3) three working days. A flowchart of the appeals and expedited appeals process reflects the VO-LA process to ensure that appeals are resolved in a timely way.

Impact on the Member and Provider

ValueOptions follows industry, accreditation, and regulatory standards and processes when handling appeals, and takes extra steps to ensure that members understand their rights, responsibilities, and options. For Louisiana Medicaid recipients, these steps include the following:

- the provision of Continuation of Services in accord with provisions set forth in by DHH-OBH and CMS

- individuals, for whom English is not their primary language, may receive correspondence in their preferred language
- correspondence on appeals is written at a written level of 5th grade
- Member Service Representatives, with clinical support are available 24/7 to assist Members understand their options
- Member services staff are trained on the appeal process and are available to assist Members in filing an appeal



(c) Describe the methodology and criteria for identifying over- and under-utilization of services. Provide sample reports and how the information in those reports would be used. Suggested number of pages for all above items: 7 exclusive of report samples

To identify over- and under-utilization, we will establish upper and lower thresholds for utilization of covered services. This process includes establishing outlier management for providers who consistently have utilization of services (by type of service) that are outside the mean for that type of provider. Thresholds will be developed for covered services using a variety of information, including local and national standards of care, stakeholder input, applications like statistical process control, and strategic system importance. We will collect data and measure performance related to these thresholds. Thresholds may be revised and improved upon based on this same input and on performance data. VO-LA provides our analytics and reporting that measure clear evidence of best practice as well as practice patterns and outliers that contribute to individual hospital variance from target . In addition, we will monitor many standards and measures to ensure compliance,

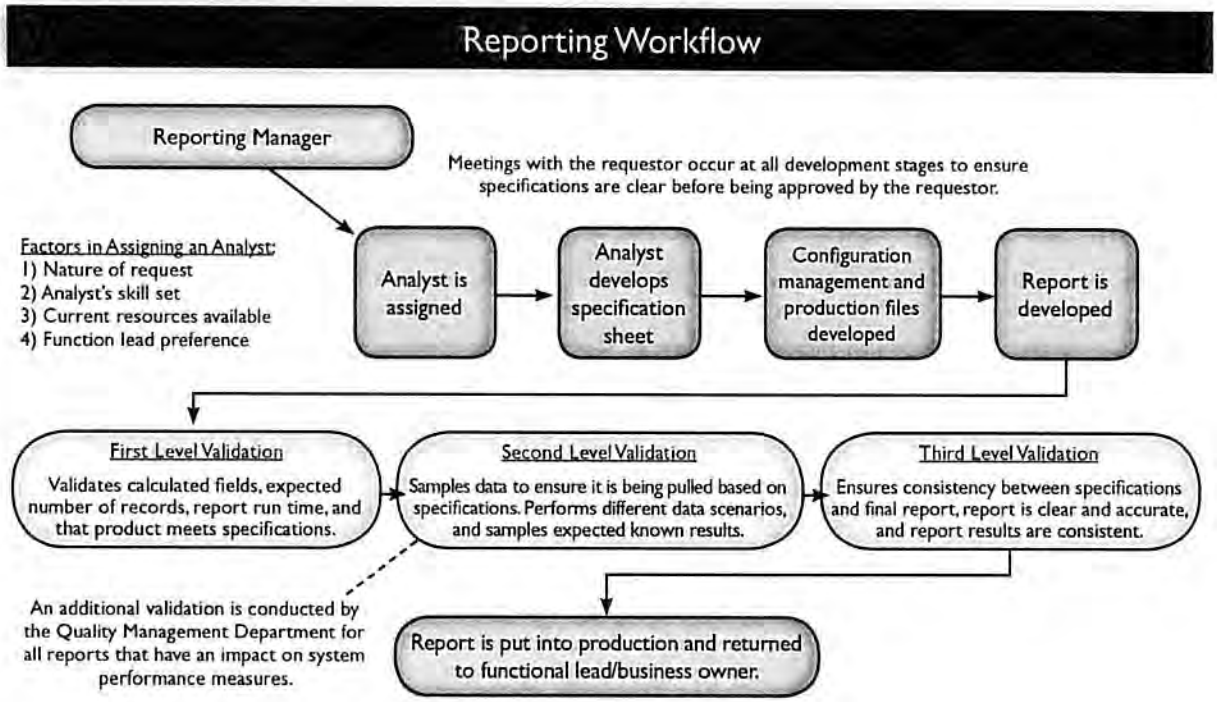
performance and quality. For all levels of care, performance specifications include provider requirements that ensure the delivery of quality care to meet the specific needs of youth and their families. Specific standards have been established and related measures are monitored through data-driven network management and continuous quality improvement processes.

The process for developing these criteria and reports includes our VO-LA team first querying the data in our warehouse to identifying providers, by type, whose practice patterns significantly deviate in some way from the norm. Next, these over- and under-utilization patterns will be further analyzed to identify specific diagnoses, specific sub-populations, or providers. Our work in other states enables ValueOptions to draw upon proven processes for improving the health beneficiaries in cases where utilization data appears to deviate from standard, acceptable practice. For example, ValueOptions has established innovative Outlier Management Programs in Massachusetts and Connecticut. These programs focus on "outliers" by diagnosis (i.e., Bipolar Disorder in Children 5 or Younger, Eating Disorders, Schizoaffective Disorder, Adjustment Disorder) or by level of care (inpatient, outpatient) or by facility/agency or by a specific population (i.e., Children 3 and Younger). This process follows a very deliberate approach to ensure the integrity of the data and that the data is analyzed for actionable results.

We take great pride in the integrity of our data and reports, and we have developed very stringent guidelines for all avenues of information delivery. There are three types of reports for which we have developed procedures to ensure timely and efficient delivery of accurate data: production reports, ad-hoc reports, and a reporting platform whereby we make data available to our clients, providers, and Members. Each delivery method has its own set-of controls, ensuring quality data is provided.

We currently have established guidelines to ensure reporting accuracies. These guidelines take on different forms depending on the collection/delivery method of the reports (i.e., CMIS, specialized databases Excel, MS Access, or manual data collection/delivery). Regardless of the collection/delivery method, they all follow a proven and established process. The report development workflow is designed to standardize the report development process, define the roles and responsibilities of the various groups involved, enable other staff members to more easily assist when necessary to help meet schedules, ensure accurate collection and delivery of the data, and ensure reports meet our client's requirements.

Our formalized guidelines for production reports incorporate the following steps:



We will analyze individual and aggregate data by Members, looking for outliers who over-utilize services (e.g., complex Members making excessive visits to emergency rooms), and incidences of under-utilization (e.g., Members with identified diagnoses who no longer use medications or support services. As an example, utilization data may show an increase in emergency room utilization. A 'fishbone' analysis will be used to identify the contributing issues and components. Considering the multiple components of a problem in this manner, and applying the data and information necessary to understand them, supports in resolution of over- or under-utilization.

Provider-specific patterns of over- and under-utilization and outliers that account, the age of Members, diagnosis, Average Length of Stay (ALOS), periodicity and other treatment variables will be evaluated during the practitioner recredentialing process. Provider profiles will be generated and evaluated. These profiles will report both quality and utilization data for each provider. The utilization data are diagnosis-specific and report the number of outpatient services delivered by the provider for each Member served. These diagnosis-specific utilization data will be compared to that of the provider's peers, and if there is significant variation from the expected, the provider's profile will be sent to a Peer Reviewer for further evaluation. Provider performance will also be monitored through our utilization management and QM Committees.

Annually, the Utilization Review Administrator will provide an analysis of performance compared to goals, including achievement of strategic initiatives established to achieve the Louisiana vision. This analysis will include discrepancies, deficiencies and barriers, what was done to resolve them, and the results achieved. This analysis will be used to determine goals for the upcoming year. The Utilization Review Administrator will ensure that key stakeholder feedback is included in the annual evaluation and plan, which is reviewed and approved the utilization management and QM committees.

Sample Utilization Reports

We provide sample utilization reports in **Attachment 18** demonstrating how VO-LA can track the following UM indicators:

- over-utilization
- under-utilization
- use of crisis services (at the Member, provider, regional analysis)
- utilization of 24 hour levels of care (at the Member, provider, regional analysis)
- out of home placement for children and youth (regional analysis)
- outcomes of CANS
- intensive services analysis (at the Member, provider, and regional level)
- pharmacy over/under utilization
- pharmacy risk analysis (adverse drug interaction, side effects, adherence, and prescription abuse)
- inter-rater reliability
- consistency of utilization management decision making
- notice of action by level of care
- length of stay analysis

In addition to these utilization reports, our enhanced outpatient outlier model provides additional refinement to simple numerical threshold outlier by taking in to account age, gender, periodicity, multiple providers, intensity of treatment as well as the longevity of the treatment. "Unusual" cases that are identified based on the outlier triggering process may include both too little and too extensive treatment. This results in additional clinical information being requested from the provider. Based on the outcome of the review process, best practice guidelines and evidence based treatment are encouraged and additional approvals are contingent on evidence of these practices

Our experienced staff can offer the DHH-OBH the skill of interpreting and transforming the CSoC data in an easy to understand format, which will enable knowledgeable decisions to be made about the program in a timely manner.

Information from these reports is used first and foremost to provide individualized technical assistance to providers. In addition, at an aggregate level, this information informs statewide provider training needs as well as needs to develop additional network services to address over utilization or to provide ease of access to services that are underutilized.

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ii. Describe how the Proposer's information management system will support UM activities. Suggested number of pages: 1.

VO-LA performs Utilization Management and Care Management using our CareConnect system, a component of CONNECTS, our proprietary and confidential management information system. ValueOptions is has successfully implemented a single, integrated electronic, enterprise-wide, ***collaborative treatment planning environment. that will create better health outcomes for LBHP Members.*** The clinical

ValueOptions has customized our best practice technical approach to align with our client's strategic objectives in every public sector program we have implemented.

module of CareConnect supports direct interchanges between providers and ValueOptions and produces clinical data demonstrating the effectiveness of various programs, therapies and the services that we offer. Our shared clinical record currently includes:

- Member demographics,
- treatment and service planning
- objective and standardized assessments,
- Member event tracking,
- clinical progress notes,
- at-risk crisis plans,
- crisis tracking,
- medication tracking,
- centralized scheduling,
- referral tracking,
- admissions and triage,
- discharge planning,
- integrated utilization management,
- complaint tracking

Clinical transactions with providers rely on various modes of data exchange, including: electronic and fax, as well as telephonic and verbal. For the majority of all 'routine' cases, there is technically less clinical case data acquired by VO-LA. However, the routine care management process is structured to capture and act on the clinical data critical to flagging potential 'outlier' cases. Once these high-cost, complex, or high-risk cases are identified and evaluated, their care is delivered and managed in a variety of specialty programs including: integrated care management, and specialized disease management.

CareConnect also serves as the base to our provider portal, ProviderConnect, which supports direct interchanges between providers and ValueOptions to produce clinical data that can demonstrate the effectiveness of various programs, therapies, and the services that we offer. CareConnect assigns a unique number to each authorization with information included in an authorization header file and an authorization detail file. The authorization number is the key to both of these files as all authorizations are associated with a specific Member and a specific provider and are linked to a case. CareConnect also assigns a unique number to each case. A case is comprised of one Member, one or more providers, and one or more treatment settings. The case may also be associated with a specific set of clinical notes. The system has functionality to search for all authorizations and/or all cases for a specific Member or for a specific provider. Denials are designated by a denial code that is associated with the reason for denial. A Member's complete history is illustrated within our system and accessible by a provider.

iii. Describe the medical necessity criteria and level of care guidelines utilized by the Proposer's organization in managing care, including the source of the criteria/guidelines in which the Proposer has experience and the Proposer's experience in utilizing guidelines provided by contracting agencies. Suggested number of pages: 3.

The clinical criteria used by VO-LA to make admission, level of care, and continuing treatment decisions values assure quality of care and measurable positive outcomes for LBHP Members. VO-LA will authorize payment only for services that are medically necessary in accordance with the rules and waivers set by DHH-OBH and provided for the identification and/or treatment of a Member's active illness. It is our policy to make medical necessity decisions promptly upon receipt of request and necessary clinical information in accordance with specific timelines corresponding to the type of request and the timing of the request. Before implementing processes for the review and authorization of services for LBHP Members, we will work with DHH-OBH to be sure we have the

same understanding and approach to two cornerstones of our utilization management system: the definition of medical necessity and the clinical criteria that guide the determination of which services are medically necessary.

Definition of Medical Necessity

VO-LA defines medical necessity as those services which are:

- intended to prevent, diagnose correct cure, alleviate or preclude deterioration of a diagnosable condition (ICD-9 or DSM-IV-TR) that threatens life, causes pain or suffering or result in illness or infirmity
- expected to improve an individuals' condition or level of function
- individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs
- essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications
- reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available
- not primarily intended for the convenience of the recipient, caretaker, or provider
- no more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency
- not a substitute for non-treatment services addressing environmental factors

Medical Necessity Criteria

Our protocols, policies, and procedures are infused with the principles of recovery and resilience, and the fact that individuals are best served in their homes and communities rather than in institutional placements. When developing our utilziatoin management process, these principles guide the development of an approach that seeks to strengthen facility and inpatient-based care so that individuals are able to move quickly from an institution to the community, recidivism is reduced, and their tenure in the community is increased. To accomplish this, we will review the State's clinical criteria and regulatory requirements and embed indicators in the audit tools that address compliance with these requirements and standards, and with evidence-based practices. In addition, we will incorporate best practice standards for quality of care, as promulgated by nationally recognized agencies such as the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), and the Centers for Medicare and Medicaid Services (CMS).

ValueOptions refers to nationally recognized bodies of literature to ensure that the criteria and treatment methods reflect the latest developments in serving individuals with psychiatric and substance abuse disorders. Other types of information are current educational material from professional, Member, and family member organizations such as the following:

- American Psychiatric Association
- American Psychological Association
- American Academy of Psychiatrists in Alcoholism and Addictions
- American Academy of Child and Adolescent Psychiatry
- American Society of Addiction Medicine

- Member and family empowerment organizations (e.g., state-based Member Councils; National Mental Health Members' Self-Help Clearinghouse; National Alliance on Mental Illness; Federation of Families for Children's Mental Health US Psychiatric Rehabilitation Association)
- International Association of Psychosocial Rehabilitation Services
- InterQual
- Substance Abuse Mental Health Service Administration
- The National Institutes of Health
- The National Institute on Alcohol Abuse and Alcoholism
- The National Institute of Drug Abuse
- The DATTA Program of the American Medical Association
- Department of Health and Human Services' Center for Substance Abuse Treatment
- standard psychiatric texts
- current publications in professional journals and books

ValueOptions uses the ASAM PPC-2R criteria for considering requests when a substance use/abuse issue is identified. Member's presentation is considered in regard to their assessed level of severity on six "dimensions" or primary problem areas. The six dimensions considered with substance abuse are listed below:

- Dimension 1 – Acute Intoxication and/or Withdrawal Potential
- Dimension 2 – Bio-Medical Conditions and Complications
- Dimension 3 – Emotional/Behavioral Conditions and Complications
- Dimension 4 – Treatment Acceptance and Resistance
- Dimension 5 – Relapse and Continued Use Potential
- Dimension 6 – Recovery Environment

Experience Using Guidelines by Other Contracting Agencies

ValueOptions has extensive experience utilizing guidelines provided by other contracting agencies in several public sector contracts including Texas, Florida, Pennsylvania, and New Mexico as well as several commercial contracts. We have also worked with these same states to customize criteria for particular levels of care as needed. We anticipate that such experience will be valuable as Louisiana builds out a richer community-based service array.

iv. Describe the specialties/expertise areas of the Psychiatrist/Psychologist Advisors that will be assigned to this contract. Suggested number of pages: 2.

Psychiatrist/Psychologist Advisors' Specialties/Expertise

ValueOptions uses several criteria to aid in the selection of Psychiatrist/Psychologist Advisors (Peer Advisors) including their years of experience in practicing psychiatry and performing utilization review/medical management, conducting peer reviews and participating in hearing appeals. We also require Peer Advisors to be a board-eligible psychiatrist or licensed clinical psychologist (Ph.D.) and a license to practice independently.

Peer Advisors are employed and assigned based on their credentials, cultural competence as appropriate, and expertise in clinical areas and in utilization management and managed care principles.

ValueOptions has found that credentialing and/or significant experience in one or more of the following areas adds strength and depth to our program, including:

- substance abuse
- forensics
- serious mental illness
- assertive treatment
- child/adolescent psychiatry
- general adult psychiatry
- psychopharmacology

Additionally, exposure to recovery environments and philosophy and co-morbid physical health conditions is helpful to the Peer Advisor. VO-LA is strongly committed to ensuring that the Peer Advisors for the children's system are board certified in child psychiatry or hold board certification in general psychiatry with significant experience and expertise in child and adolescent psychiatry. VO-LA will have 4.5 peer advisors, of which 2.5 will be child and adolescent advisors and the remaining 2.0 will be adult advisors.

The VO-LA CMO, or a designee, will be responsible for ensuring that Peer Advisors who make medical necessity determinations, perform utilization review, conduct peer review, and hear appeals have the necessary training and experience to make proper determinations. All Peer Advisors will receive orientation and initial training on the Louisiana program requirements. At a minimum, the initial orientation will consist of an overview of the VO-LA provider handbook, medical necessity criteria, clinical practice guidelines, procedures for peer review and appeals, state and federal regulatory standards, documentation standards, and our CONNECTS system. Ongoing training topics will include:

- long-term treatment strategies in the context of recovery and resiliency
- changes/updates to the provider handbook
- updates on behavioral health and psychiatric issues, e.g., assessments, differential diagnosis, new medications, , new treatments and therapies
- updates on pertinent topics in physical health, e.g., identifying physical problems in Members with behavioral health diagnoses, medication interactions, management of Members with multiple behavioral and physical health problems, updates on illnesses such as diabetes

In addition, we will also enlist Peer Advisor specialists for children's addiction, dual diagnosis [(Developmentally Disabled/Mental Retardation) and mental health and substance abuse)] forensics – children, forensics – adults, trauma informed care and post traumatic stress disorder.

v. Practice Guidelines. Describe the Practice Guidelines for utilization of care proposed for the program. Suggested number of pages: 2.

An important aspect of VO-LA's strategy is partnering with members, network providers and with other stakeholders to promote innovative and evidence-based behavioral health practices. Clinical practice guidelines promote the development of effective behavioral health practices focused on the

assessment and treatment of psychiatric and substance abuse disorders. ValueOptions has developed a set of diagnosis-based and treatment-based guidelines that are used in addition to the medical necessity criteria during clinical reviews. These guidelines represent standards and best practice for treatment complex conditions and help guide appropriate and clinically effective care. VO-LA will seek input from participating Louisiana providers, consultants from Picard Center and has already begun dialogue with LGEs clinical directors and psychiatrists to identify areas of customization for Louisiana, and other expert clinicians to develop some of the guidelines; however in most instances we adopt established and/or published guidelines such as those developed by the American Psychiatric Association (e.g., Bipolar, Major Depression, Schizophrenia, Eating Disorder and Electro-convulsive Therapy).

The following is a list of guidelines that have been formally adopted by ValueOptions:

- Acute Stress Disorder and Posttraumatic Stress Disorder (PTSD Assessing and Treating Suicidal Behaviors (Adopted from APA)
- Attention-deficit/Hyperactivity Disorder for Children & Adolescents (Adopted from AACAP)
- Attention-Deficit/Hyperactivity Disorder for Adults
- Autism Spectrum Disorder (ASD)
- Bipolar Disorder (Adopted from APA)
- Co-Occurring Disorders Eating Disorder (Adopted from the APA
- Electroconvulsive Therapy
- Generalized Anxiety Disorder (Adopted from Canadian Psychiatric Association Anxiety Guidelines with Annotation Page)
- Major Depression (Adopted from the APA)
- Opiod-Related Disorders (Adopted SAMHSA Guideline)
- SAMSHA Guideline Tip 43
- Schizophrenia (Adopted from APA with Annotation Page)
- Schizophrenia Guideline Watch
- Suboxone Treatment Guideline (SAMHSA/CSAT TIP 40)
- Tele-psychiatry
- Treating Panic Disorder (Adopted from APA)
- Treating Substance Use Disorders (Adopted from APA)

We continually update our practice guidelines to keep abreast of current approved EBPs and guidelines.

vi. Describe how the Proposer will address the high utilization of inpatient services in Louisiana through the CM and UM process. Discuss strategies the Proposer has used successfully in other programs to divert children and adults from inpatient and residential care, decrease their length of stay in inpatient and residential settings, and prevent readmissions. Suggested number of pages: 2.

Addressing High Utilization of Inpatient Services in Louisiana

ValueOptions has extensive experience in facilitating a state's goals to reduce reliance on inpatient services through building community based intensive services. This result is initiated through the acute services management process of ValueOptions. Embedded in our utilization management program is a clinical and quality review of a Member's prior outpatient treatment plan for each

admission or readmission to an inpatient facility. VO-LA recognizes acute behavioral health inpatient admissions as evidence of a lack of availability or a failure of the outpatient treatment, appropriateness of the outpatient program or an issue of internal Member engagement. Therefore our utilization management workflow includes a quality review of the following components:

- the Member's internal barriers to engagement in the out-patient treatment plan
- access to needed services including housing options
- appropriateness of services in discharge plan
- use of evidence based discharge planning including motivational interviewing
- under utilization of out-patient services
- recovery and resiliency focused and person centered planning including the development of the Member's recovery plan prior to discharge.

Essential to addressing high utilizers is developing clinically appropriate community based services. This may include increasing the use of selected Rehab Option services to support Members' sustainability in the community. Our experience in Louisiana tells us that we will need to recruit and procure additional community-based alternatives to address the over-utilization of inpatient services as the initial point of access to behavioral health services. The criterion for a quality review is any admission to a higher level of care. VO-LA engages in this review on 100 percent of all admissions to higher levels of care in order to assist the facility and facilitate an improved recovery oriented discharge plan for the member. If the Member's discharge plan includes intensive outpatient services such as, case management, ACT, or other community-based services, VO-LA will coordinate and pre-authorize the services as a part of the discharge plan development. Additionally, when indicated as critical to the success of the discharge plan, VO-LA will engage the provider to meet the Member at the facility on the day of discharge to initiate out-patient services.

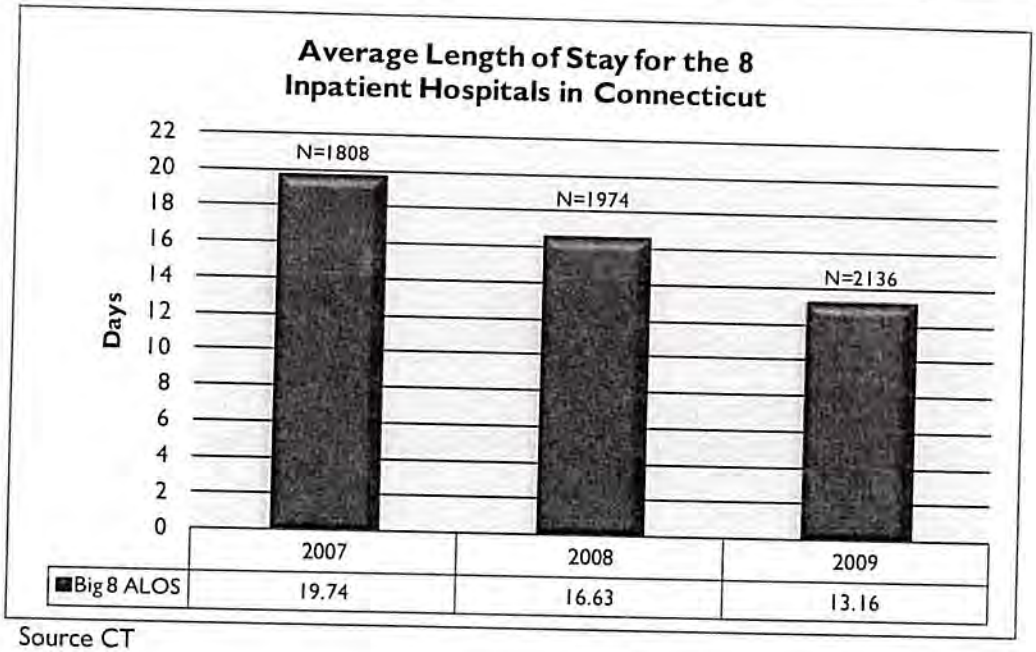
Examples of Success

We are committed to ensure that Members in need of inpatient and residential services have convenient access to services that support our concept of recovery and resiliency, and integrating Members back into their community. Below, we provide some examples of successful management initiatives we have developed for inpatient and residential services.

Connecticut

To advance the Connecticut system of care and encourage and support the use and development of best practice standards, our Connecticut Behavioral Health Partnership (CT BHP) developed two Provider Analysis and Reporting (PARs) initiatives focused on effectively managing inpatient and residential services.

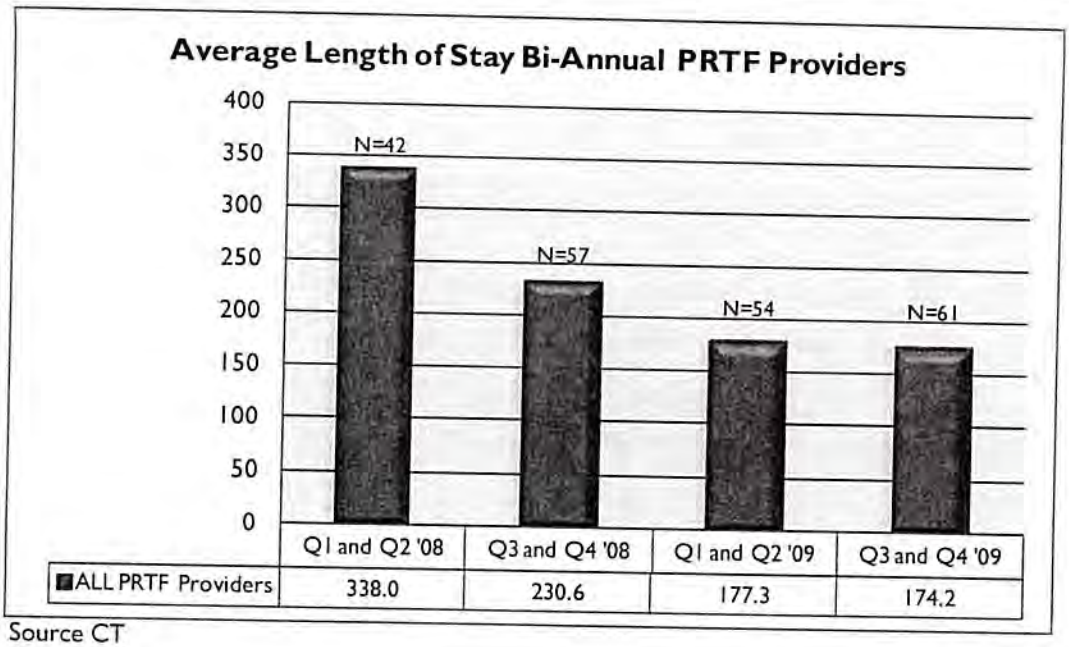
- Our ***Inpatient Child and Adolescent PARs*** program focuses on decreasing pediatric psychiatric hospital lengths of stay and improving family engagement during those stays. As part of this program, participating inpatient facilities are awarded a share of a performance fund based on their demonstrated ability to further reduce lengths of stay (or maintain already efficient lengths of stay) as well as to implement programs that will improve family engagement. Since the 2007 inception, the average length of stay for the eight hospitals participating in this program has declined substantially as evidenced in the chart below:



Source CT

- Our ***Psychiatric Residential Treatment Facilities (PRTF) PARs*** program was developed to focus on decreasing youth discharge delays and increasing hospital access to PRTF services. PRTFs had originally been designed to serve as step down "sub-acute" programs for children 12 or under who no longer needed hospitalization but who were not yet ready to return to the community for services. Over time, delays in discharging youth from these programs grew as community services required by children being discharged became harder to access. This program focused on two key goals: to improve process and quality while decreasing the average length of stay to anticipated performance levels. Additionally, as a result of improved performance, the four PRTF providers participating in this program had the potential to be awarded a full or partial share of a performance fund by achieving the target adjusted average length of stay or by making significant movement towards the targeted length of stay. Our most recent evaluation of this program shows that while the volume of Members that experienced a PRTF stay in 2009 increased from 57 during to 61, the average length of stay days decreased by 24.4 percent (230.6 to 174.2). This compares to 42 Members and an average length of stay days of 338.0, just prior to implementation of this program, reflecting a 48.4 percent decrease in the average length of stay days and an improvement in access to PRTF programs.

  The graph below captures this dramatic improvement.



Source CT

Tennessee

In Tennessee, where we serve as a subcontractor to Volunteer State Health Plan for the TennCare program, we have focused our efforts in helping the State Hospitals in Tennessee, known as the Regional Mental Health Institution (RMHI), reduce the number of Members in extended hospital stays. This is a goal of the TennCare program, the Tennessee Department of Mental Health and Mental Retardation as Members with severe and persistent mental illness have often been admitted and remain in the hospital for months, even years. As part of our efforts, we have sent our Utilization Management Care Managers to the hospitals regularly to participate in discharge planning meetings. Also, our Provider Relations Department has worked with providers to develop options for Members being discharged and re-integrated into the community. This includes the development of the programs of supported housing and enhanced supported housing.

As a result of our efforts, in the first year, we discharged 31 long term care Members from inpatient care at the RMHI's. Those 31 Members spent a total of 4,138 days in the hospital from the start of our contract in both the East and West regions of Tennessee. Since discharge from the RMHI, seven Members have been readmitted to inpatient level of care for a total of nine admissions and a total of 54 inpatient days. These same Members, who lived 4,138 days in the hospital before discharge, have lived 3,819 days in the community since that time. This result reinforces our belief that with the right support and available community resources, recovery is real.

Additionally, as a result of our build out of community based services, over all acute service (higher levels of care: Inpatient, State Hospital, Residential, and partial hospitalization) use has decreased from a starting PMPM of 8.93 with 9,699 units of service in January 2009 to a average PMPM of 5.05 in 2010 and an average of 5,688 units a month for 2010.

vii. Assuming that pharmacy data for members will be provided to the Proposer by DHH, describe how the Proposer will review, monitor and analyze pharmacy data for medication side effects, adverse drug interactions, and member adherence. Describe strategies to detect under- and over-utilization and potential inappropriate utilization of medications by members and by providers. Suggested number of pages: 2.

MEDICATION MONITORING

VO-LA is committed to ensuring appropriate behavioral health prescribing patterns via strategies that are specifically tailored to public delivery systems. Regardless of the payor, the percentage of overall health care dollars spent on pharmacy, as well as the high cost of medications, mandates the development of medication strategies that promote clinical effectiveness and cost efficiency. The strategies must be consistent with best practices and promote positive clinical outcomes. VO-LA will collaborate with stakeholders to establish multi-tiered strategies ranging from education and outreach based on academic detailing, specific Member and provider communication resulting from care gap analytics, to assistance in establishing 340B and incentive programs where warranted.

PharmaConnect has provided services for hundreds of clients including small, medium and large employers, Medicaid, Medicare and commercial managed care plans. Over one million alerts have been delivered to providers with an average change rate that exceeds 60 percent.

The most critical application of our pharmacy management strategies will be related to children as data show that they are prescribed very powerful antipsychotic and other mental health medications at what some consider an alarming rate. VO-LA will collaborate with DHH-OBH and the prescribing network in continuing the progressive programs that have already been established to address best practice prescribing for children and provide additional assistance through the use of analytical and engagement tools. Through the administration of pharmacy management programs involving children in multiple markets, we have found that securing "buy in" from prescribers via data sharing is the key to coordinated and effective children's pharmacy management programs.

VO-LA will review, monitor, and analyze pharmacy data provided by DHH-OBH and the PBM – University of Louisiana-Monroe using our unique PharmaConnect and ValuePrescribe applications. PharmaConnect and ValuePrescribe integrate medical and pharmacy data then use alert engines to identify care gaps, establish prescriber profiles, and monitor side effects and adverse drug interactions. By unifying advanced analytics with public oriented engagement strategies VO-LA will enhance provider collaboration, increase our ability to help Members, and establish more coordinated care for the Member.

The key benefits of our strategies include:

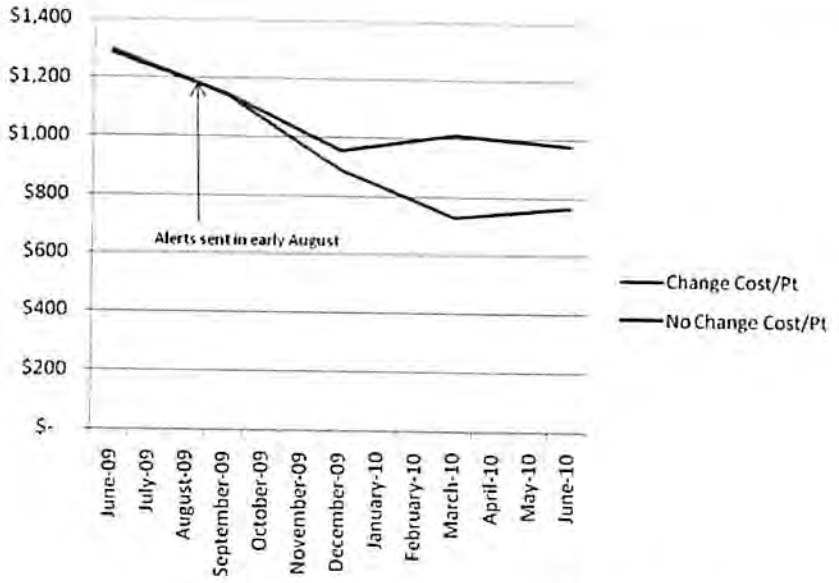
- reduced hospitalizations, often exceeding 10 percent, primarily due to medication compliance and persistency for all maintenance drugs
- positive provider reaction with a change rate that often exceeds 60 percent
- early intervention to reduce the change of Members becoming high-risk and/or high-cost
- alerts sent to VO-LA clinical staff for inclusion in the treatment plan
- customization of cover letter content and alert selection

Under- and over-utilization and inappropriate use of medications by both Members and providers are both identified as a care gap and alerts are sent to both the Utilization Manager and prescribing provider. Additional examples of alerts provided from PharmaConnect are provided in the following table:

Alert	Example
Poor Compliance	Monitors *all* chronic physical and behavioral health drugs for under use or inconsistent refill patterns; along with Early Discontinuation, this type has the greatest impact on reducing preventable hospitalizations.
Early Discontinuation	Monitors *all* chronic physical and behavioral health drugs for discontinuation of therapy for all drugs within that category
Overuse/Substance Abuse	Primarily used to identify overuse of controlled substances when received from multiple prescribers and pharmacies; combines percentage of daily usage for related drugs (e.g., a member receiving 50 percent of the maximum recommended daily amount of four narcotics generates a total daily narcotic use of 200 percent)
Duplicate Therapy	Concurrent therapy with more than one drug within all chronic medication categories (i.e., lipid-lowering, diabetes, antipsychotics, antidepressants, etc.) prescribed by more than one physician and dispensed by more than one pharmacy
Polypharmacy	Concurrent therapy with more than a set number of chronic drugs (e.g., >5) and prescribed by more than one physician and dispensed by more than one pharmacy, indicating a need to confirm care coordination.
Drug-Drug Interactions	Identifies moderate to severe alerts for ALL maintenance drugs when prescribed an dispensed by multiple physicians and pharmacies
Age-Inappropriate Therapy	Drugs to be avoided in the elderly or pediatric Members
Monitoring	Missing labs (e.g., HbA1c, therapeutic drug levels)
Missing Procedures	Missed screenings (e.g., colonoscopy, mammography), flu vaccines
Sup-Optimal Therapy	No beta-blockers after heart attacks, no ACEI/ARBs in CHF, etc.

PharmaConnect lowers costs by approximately $200 per quarter by getting schizophrenia patients back in therapy. Results from a study of our NorthSTAR members shows

- Pharmacy costs go up but behavioral health claims costs go down.
- Total cost at list price for the service: ~$10,000
- Two quarters of savings for just one alert type in a single condition: >$40,000



NorthSTAR data shows reduction in costs per quarter

When an alert is produced, we will notify the prescribing provider of the care gap and we will provide associated guidelines to assist them with improving the quality of care for their patients. Prescribing providers (specifically PCPs) will also have access to our clinical staff for consultation via a Physician Consult Line.

In addition to care gap reductions and prescriber profiling, ValueOptions has unique experience in establishing and managing 340B programs. For our Texas NorthSTAR contract we integrated behavioral and primary care via telemedicine through a partnership with the University of Texas Medical Branch resulting in a 20 percent increase in access and a 15 percent decrease in cost.

VO-LA is uniquely positioned to assist DHH-OBH in managing pharmacy utilization based on the deployment of state of the art analytical engines and delivery structures in conjunction with proven Member and prescriber engagement strategies.

Physician Consult Line

Because more Members are seeing their PCPs for behavioral health issues, we have developed psychiatric consultation lines across the county to ensure these Members receive the most clinically effective treatment. In our Massachusetts program (Massachusetts Behavioral Health Partnership), we have been instrumental in the development of the Massachusetts Child Psychiatry Access Project (MCPAP). The service provides telephonic consultation to over 95 percent of the PCPs in Massachusetts seeing children. Forty percent of the calls are for Medicaid youth, while the other 60 percent are for youth with commercial insurance. Annually, MCPAP is averaging about 19,000 encounters and serving about 6,000 youth. For youth with symptoms too complex for PCP care, MCPAP also provides face-to-face consultations and assistance with accessing mental health services. With MCPAP, 50 percent of the consultations result in the medical management remaining with the PCP, and not requiring child psychiatry. By survey, the

MCPAP has become a national model for programs in 12 states. MCPAP was featured as an emerging best practice in peer reviewed article in the December, 2010 issue of Pediatrics® (Pediatrics 2010;126;1191-1200).

ability of PCPs to obtain a child psychiatry consultation in a timely manner increased from eight percent before the MCPAP to 80 percent with the program.

viii. Assuming that DHH will provide utilization data for individuals who are not enrolled as members of the SMO, but receive their BH services from other sources (e.g., Federal Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs), Louisiana's Community Care Network), describe how the Proposer will review and monitor this data for utilization, trends and other QM purposes. Suggested number of pages: 1.

Our highly sophisticated, scalable Web-based system, CONNECTS, will provide us with the platform for review and monitoring utilization data, trends for individuals who are not enrolled as Members. This system accomplishes Member enrollment, provider network management, care coordination, provider communication, Member service, claims payment, electronic data exchanges and integrated data warehouse and reporting functions. As all data is one platform, our clinical, quality, provider relations, and reporting staff members all have access to the same data.

ValueOptions continuously enhances the CONNECTS platform to specifically meet the current and future needs of the innovative public sector behavioral health programs that we manage. These enhancements serve as the over-arching umbrella of the CONNECT platform, the ValueOptions Braided Funding System. The ValueOptions Braided Funding System is unlike any other system in the industry. This unprecedented system automatically identifies Medicaid eligibility and applies the State's funding source hierarchy and managed care principles. This allows appropriate maximization of federal matching funds while reducing administrative burden for providers during the Member registration and claims submission processes. In addition, advanced capabilities have been designed throughout the system over the past two years to further improve coordination of care services. In summary, the new ValueOptions Braided Funding System is unparalleled and can be customized specifically for the State of Louisiana contract.

The ValueOptions' CONNECTS systems allows for the seamless integration of Member registration, authorization, and reporting. Current and historical DHH-OBH data will be electronically imported into the CONNECTS system and data warehouse. ValueOptions' Data Warehouse, KnowledgeConnect, is a database that receives imports from the CONNECTS platform and other systems for reporting purposes. This data is formatted and stored as standard data into our Oracle relational database system. An advantage of this data warehousing technique is the easy insertion of data from external sources. Data from outside sources can be integrated into the data models to enhance reporting capabilities. These standard data models are used as the foundation for report generation, statistical analysis, decision support, and outcomes management. Our dashboards allow for tracking and trending and comparing with other public sector program results.

In addition, VO-LA will review, monitor, and analyze pharmacy data provided by DHH-OBH and the PBM – University of Louisiana-Monroe using our unique PharmaConnect application. PharmaConnect integrates medical and pharmacy data then uses an alert engine to identify care gaps. More specifically, PharmaConnect automatically screens medical and pharmacy claims to identify patient-specific care gaps. It enhances provider collaboration and increases our ability to help Members by notifying all providers related to the specific issue in writing so they can work together to coordinate care for the Member.

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

Describe how QM functions will be organized, including staff that will be Louisiana-based and staff available from the Proposer's corporation operations. Provide an organizational chart for QM that includes position titles, number of positions, qualifications and reporting relationships. Suggested number of pages: 2, exclusive of organizational chart.

Quality Management (QM) is the framework by which ValueOptions assures our accountability to state agencies we serve as well as Members, families, advocates, providers, state and local officials, and the general public. QM focuses on both our internal operations and the functioning of the entire behavioral health care delivery system. QM is our major strategy for seeking and incorporating the ideas and perspectives of all program stakeholders. We recognize the considerable data needs of DHH-OBH, as well as the valuable contribution that Members, families, providers, state decision makers, and advocates can bring to the Statewide Management organization (SMO) QM process. Our goal is to make QM inclusive and representative of all stakeholders across the diverse Louisiana Local Governing Entities (LGEs).

We will leverage our experience in all 14 of our public sector state contracts to ensure that Members and families direct and guide all of our activities.

The QM program offers a unique, transparent management approach that allows functions to be integrated across all departments. The integration of the QM philosophy, goals, principles, and priorities into all departmental activities will allow for focused problem solving and rapid plan development. We use a multifaceted approach to problem solving that involves all relevant departments. We promote a culture of continuous improvement, infusing QM into all areas of our organization and facilitating staff participation representing all departments. We use utilization management and data from both macro and micro levels to inform quality initiatives and provide reporting at the provider level to ensure targeted outcomes. We also use provider data to manage quality, utilization and outcomes to ensure that Members have access to quality behavioral health services that increases Member satisfaction, provider accountability, and cost containment. Our QM committee structure provides the foundation to carry out goals and objectives developed from strong data-driven assessments. Our QM approach will, in addition, assist DHH-OBH in: planning for changes to Medicaid enrollment and eligibility, measuring the impact of closings of facilities, and responding to CMS waiver reporting requirements and preparing DHH-OBH to respond to new federal regulations.

As the SMO for the Louisiana Behavioral Health Partnership (LBHP), staffing patterns will be designed to support all aspects of the contract and expansion of our use of Six Sigma expertise and the application of Six Sigma approaches.

QM activities are performed not only by QM Department staff but across all departments and all staff; quality is the responsibility of everyone. The QM program for VO-LA will focus on:

- data collection, management and outcomes reporting
- clinical and process improvements based on data that are measureable and focused on increasing access to community based care that is consistent with evidence-based practices (EBP), recovery and resiliency and person-centered planning
- stakeholder inclusion in the operations of the SMO to drive system improvements
- accountability of the SMO to the contractual requirements

We have organized our onsite VO-LA QM Department to be supported by our National QM infrastructure and oversight to provide accountability from our own operations and from the provider network. Our Louisiana QM team will be supported by our National QM department, including the National Vice President of QM and the National Committee structure. Physician leadership will include oversight of the QM program by the VO-LA Chief Medical Officer. The National Vice President of QM develops, coordinates, implements, and provides oversight of the National QM Program. The Vice President of QM works collaboratively with the Chief Medical Officers of each business unit to obtain consultation on any program activities that involve or affect clinical care and patient safety. Following, we have provided the proposed QM Department Organizational Chart and Louisiana QM staff:

Chart Redacted

Staff Qualifications

VO-LA will provide highly experienced and qualified QM staff to create a quality structure and data analysis and reporting to ensure an effective and accountable program.

	REDACTED

	REDACTED

	REDACTED

i. Describe the essential elements of the Quality Assurance/Quality Improvement Plan the Proposer would develop for the program and how the Proposer will assure it is a dynamic document that focuses on continuous QI activities; include:

(a) Covered BH services and administrative and clinical processes and functions to be addressed;

ValueOptions' approach to QM promotes system change through a proven ability to use data and information to drive continuous performance improvement. Our QM process promotes transparency through information exchange, mutual education, and the active involvement of all stakeholders, including DHH-OBH, to design an integrated behavioral health recovery program for the LBHP. One of the primary goals of our QM program is to improve access to and engagement with recovery-oriented services. We will fully coordinate and integrate our VO-LA Service Center quality assurance/process improvement activities with the goals of DHH-OBH.

QM is the basis for overall program monitoring, evaluation, and improvement as well as a major mechanism through which Members, families, advocacy groups, provider groups, and other key stakeholders provide input on policy, oversight, activities, and evaluation of the program. To encourage and reward participation, with DHH-OBH approval, we will reimburse Members and families for their travel expenses, and to facilitate child care, during their participation in QM committee meetings and activities.

The QM Program monitors and evaluates quality across the entire range of services provided by ValueOptions and ensures all regulatory and contractual requirements. The annual Quality Improvement Plan is revised as needed based on processes within the quality improvement cycle. Work plans are reviewed at least quarterly through the committee structure, opportunities for improvement are identified and implemented and ongoing monitoring is continuous. The QM Program includes within its scope, the following:

- care management and utilization management
- quality improvement activities/projects
- identification and dissemination of best practices
- quality indicators and outcomes management
- provider profiling analysis
- Member and provider satisfaction

- Member rights
- inter-rater reliability
- person-centered planning
- credentialing and recredentialing program
- behavioral health provider site and record evaluation
- recovery and resiliency services
- Member and provider call center service (including Member education and website enhancement)
- adverse incidents/quality of care program
- complaints, grievances and appeals
- staff, Member and provider education
- compliance and risk management
- cultural, linguistic and recovery-oriented services
- agency and stakeholder collaboration

(b) Committee structure, responsibility and membership;

VO-LA's quality committee structure is designed not only for efficiency but to enhance Member and family input. The committee structure proposed for our QM Program was designed to assure the input of the DHH-OBH and all Louisiana stakeholders into the development of each annual QA/PI Plan. The following table describes our proposed committees, including their scope of work and the membership for each:

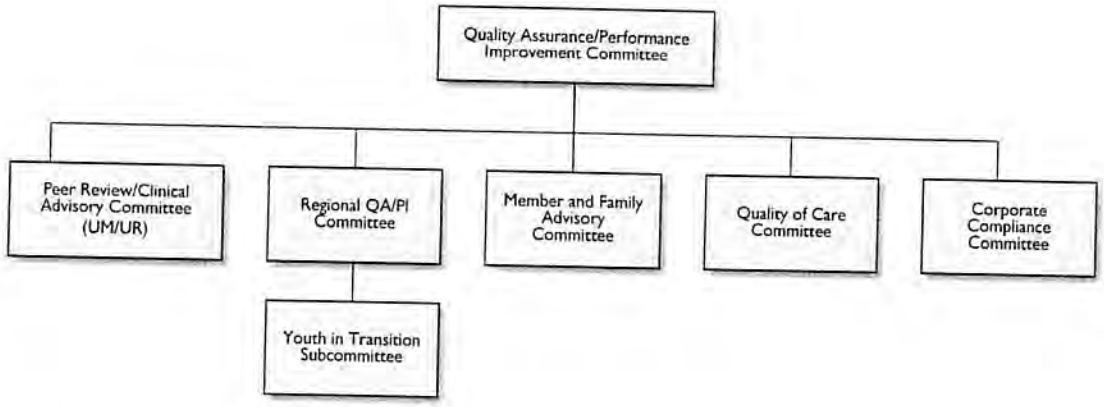
VO-LA has designed specific Louisiana based Quality committees that address the State's desire for inclusive Member and family inclusion, provider inclusion, and other stakeholders, as indicated in the following chart.

Local Committee	Membership	Responsibilities
Quality Assurance/ Performance Improvement (QA/PI) Committee	CMO (co-chair), QM Administrator (co-Chair), members, families, Children's System of Care (CSoC) representatives, DHH-OBH representatives, and National Alliance for Mental Illness (NAMI) representatives	Responsible for accountability to DHH-OBH and to Members, family members, advocates, providers, stakeholders and the general public; focuses on both internal operations and the functioning of the entire behavioral health care delivery system; primary format for seeking and incorporating the ideas and perspectives of all those impacted by services. All hazards plan review
Member and Family Advisory Committee	Outreach Recovery Administrator (chair); Chief Executive Officer, Members/family members, member advocates, community stakeholders and representatives, Wraparound Agency (WAA) and Family Support Organization (FSO) NAMI, Federation of Families, representatives	Advises the Program on all aspects of the SMO, Member communications, recovery and resiliency, system performance, and treatment guidelines; focuses on issues relevant to adult and youth Members. Create, promote, find and develop opportunities for Members in their respective communities to achieve their highest potential
Peer Review/Clinical	Chief Medical Officer and Utilization Review	Provides a mechanism for participating network provider input into the UM and QM

Local Committee	Membership	Responsibilities
Advisory Committee	Administrator (co-chair) representatives from Clinical and Provider Relations; participating network providers and academic training institutions in Louisiana	program. This committee annually reviews and makes recommendations for changes in the clinical level of care criteria and clinical guidelines. Advises on clinical and administrative issues impacting the provider network and behavioral health system; reviews clinical quality improvement projects and utilization patterns for provider input into barrier analysis and interventions
Quality of Care Committee	Chief Medical Officer (chair), representatives from Quality, Clinical and Provider Relations	Reviews quality of care concerns/allegations within the provider network to determine if care has been provided according to standard behavioral health care practices; evaluates trends and recommends performance improvement plans and system needs
Regional QA/PI Committees	In each LGE (same membership as QA/PI Committee)	Responsible for accountability to DHH-OBH and to members, family members, advocates, providers, stakeholders and the general public in each LGE; focuses on both internal operations and the functioning of the regional behavioral health care delivery system; primary format for seeking and incorporating the ideas and perspectives of all those impacted by services
Corporate Compliance Committee	Compliance Administrator (chair) Chief Financial Officer (chair), CEO, UR Administrator, QM Administrator and Network Management Administrator, and stakeholder representatives	Reviews compliance issues including contractual, audit and/or other financial issues. Also makes recommendations to the DHH-OBH on issues related to fraud and abuse.
Youth in Transition Sub-committee	Regional Team, WAA, FSO, local schools, DCF, OJJ, families and children	Subcommittee to the Regional QA/PI Committee

We depict our Quality Committee Structure in the following organizational chart.

Quality Committees Organizational Chart
Proprietary and Confidential



In addition, our QM program is supported by our National QM Committee structure.

NATIONAL COMMITTEES

- **Executive Quality Council (EQC).** The EQC is the governing body of the Quality Management and Utilization Management Program and maintains ultimate authority for overseeing its management and direction. The EQC meets quarterly and is chaired by the Chief Executive Officer of ValueOptions and is co-chaired by the National Vice President of Quality Management. The EQC reviews and approves, at least annually, the National Quality Management Program, articulates ValueOptions' company mission, philosophy and values, and establishes, prioritizes and allocates the appropriate resources necessary to accomplish the goals of the Quality Management and Utilization Management Programs. Committee members are selected to ensure the appropriate representation of executive management.
- **Company Quality Council (CQC).** The CQC is chaired by the Vice President of Quality Management of ValueOptions. The CQC meets at least every other month and is comprised of representatives from key functional area leadership and QM sub-committee chairs. Participating network providers and Member representatives sit on the Stakeholders Committee, a subcommittee of the CQC that provides input to the CQC. The CQC's purpose is to oversee the entire National QM Program by establishing priorities and reviewing and approving all Service Center QM and UM Program Descriptions, Cultural Competence Plans, Work plans and Evaluations, and recommending to the EQC allocation of appropriate resources necessary to accomplish the goals of the National QM Program and to review National Quality Indicator reports from all functional areas and service centers in order to identify potential company-wide opportunities for improvement.

(c) Necessary data sources;

ValueOptions' approach to QM allows the data from our integrated CONNECTS information platforms to drive the "barrier" or "root cause" analysis that leads to solutions for system problems. Using this process, ValueOptions has played a leadership role in developing services and programs to address systemic problems. VO-LA is capable of capturing and incorporating data from the State's SACWIS system, OJJ, DOE and others related to: children system performance reviews,

behavioral health Member and provider satisfaction surveys, assessments, demographics, service utilization, claims, and encounter data. We will also capture service denials, complaints, grievance and appeals, request for hearings, quality of care allegations, morbidity and mortality, performance on appointment standards/appointment availability, eligibility/enrollment data, concerns reported by eligible or enrolled persons, unmet needs data, prevalent diagnoses and special audit activities. We will collect data from LBHP Members regarding their perception of success in achieving the goals included on their individual service plans. We continuously solicit feedback via advisory and decision-making committees, satisfaction surveys, community forums, advocacy organizations and steering committees. As we go forward, this data will help us to assess progress towards recovery and resiliency based outcome measures.

(d) Proposed outcomes measures and instruments;

VO-LA's goal is to work with DHH-OBH to create a system of care that enhances Member clinical and functional outcomes. We will therefore create a system that not only measures outcomes, but puts trended Member-specific results back into the hands of the providers. VO-LA will use CONNECTS as the single statewide data management system for the collection of Substance Abuse and Mental Health Services Administration (SAMHSA) National Outcomes Measures (NOMs) and Treatment Episode Data Set (TEDs) and other data requirements for all Members. For adults and children, we have a customized NOMS dashboard that we will make available. CONNECTS is ValueOptions' single platform information system that provides Web-based applications. Through a simple-to-use Web-based Member registration process (ProviderConnect), VO-LA will collect all demographic, clinical, and functional criteria required to meet SAMHSA and DHH-OBH reporting requirements.

BEHAVIORAL HEALTH SCREENING INSTRUMENTS

ValueOptions integrates several behavioral health assessment and educational tools into our CareConnect system. These assessment tools will be used to conduct more in-depth evaluations, based on the information gathered from initial risk assessments.

These tools are used to confirm clinical conditions and establish baseline and subsequent improvement status related to the treatment and care management process:

- Patient Health Questionnaire (PHQ-9), which assesses depression
- SF-12™ Health Survey, which assesses health status (physical and mental health)
- Generalized Anxiety Disorder Scale (GAD-7)
- Alcohol Use Disorder Identification Test (AUDIT)
- CAGE (Cut, Annoyed, Guilty, Eye-Opener), an online, self-scoring, self-screening alcohol use questionnaire
- Evaluation of Psychosocial Barriers, which is based on the Diagnostic and Statistical Manual of Mental Disorders – DSM-IV

CHILD & ADOLESCENT NEEDS (CANS) ASSESSMENT

We will use the CANS assessment to guide service delivery for children with mental health needs, developmental disabilities, and issues of sexual development, juvenile justice involvement and child

welfare involvement. We will administer the assessment via telephone for CSoC eligible children. The following items will be assessed using the CANS tool:

- Problem presentation
- Risk Behaviors
- Functioning
- Care Intensity and organization
- Caregiver capacity
- Strengths

Reducing Discharge Delays for Youth Receiving Inpatient Behavioral Health Treatment

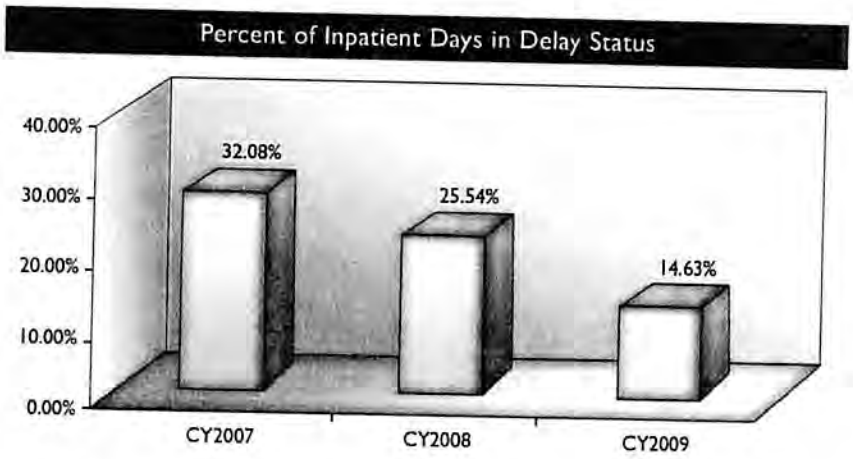
Positive outcomes measures are also calculated through initiatives that are processed through the quality improvement cycle. VO-LA's mission, for example, is to ensure that Members receive the right level of care and that transitions across the care continuum are smooth and timely. Delays in discharge may occur due to lack of access to step-down or outpatient services, transportation issues, lack of familial support, or delayed facility care management coordination. Experience has shown that these issues can be addressed with positive outcomes and developing levels of care such as therapeutic foster care services.

In 2008, ValueOptions' Connecticut Behavioral Health Partnership (CT BHP) developed a quality improvement activity focused on reducing discharge delays for youth receiving inpatient behavioral health treatment. While the number of discharge delay days decreased significantly from 2008 to 2009, this activity continued to be a major focus for CT BHP throughout 2009, as we realize the direct impact it has on cost and recipients' quality of care. In 2009 our goal was to reduce the discharge delays days to no more than 7,492 for the year (a 24.8 percent decrease from the 2008 goal), while ensuring the acute average length of stay did not increase more than three percent from the baseline established (12.92 days). CT BHP developed a number of key initiatives to assist with meeting this goal, including:

- a greater systems and detailed operational level focus on discharge delay at the case level and provider level
- weekly discharge delay rounds with participation from the Department of Children and Families to review each case
- heightened intensity of utilization management approaches
- onsite review at targeted facilities
- increased area office Behavioral Health Program Director/Area Resource Group responsiveness upon contact by CT BHP clinical staff if DCF action warranted to expedite a discharge delay case

Concurrently, CT BHP initiated a Child/Adolescent Pay for Performance Initiative (P4P) and Provider Analysis and Reporting (PARs) program, in collaboration with the eight area hospitals that treat children and adolescents. These initiatives focus on improving lengths of stay and decreasing discharge delay for all children receiving inpatient behavioral health treatment. The program includes the utilization of data to evaluate practice change and determine/assure fidelity to the agreed upon indicators, the use of incentives to expedite change, and also included training and consultation on Focal Treatment Planning (FTP). FTP is a well-established best-practice multi-systemic focused approach to treatment and discharge planning to support the youth's successful return to the community with the appropriate wraparound supports in place.

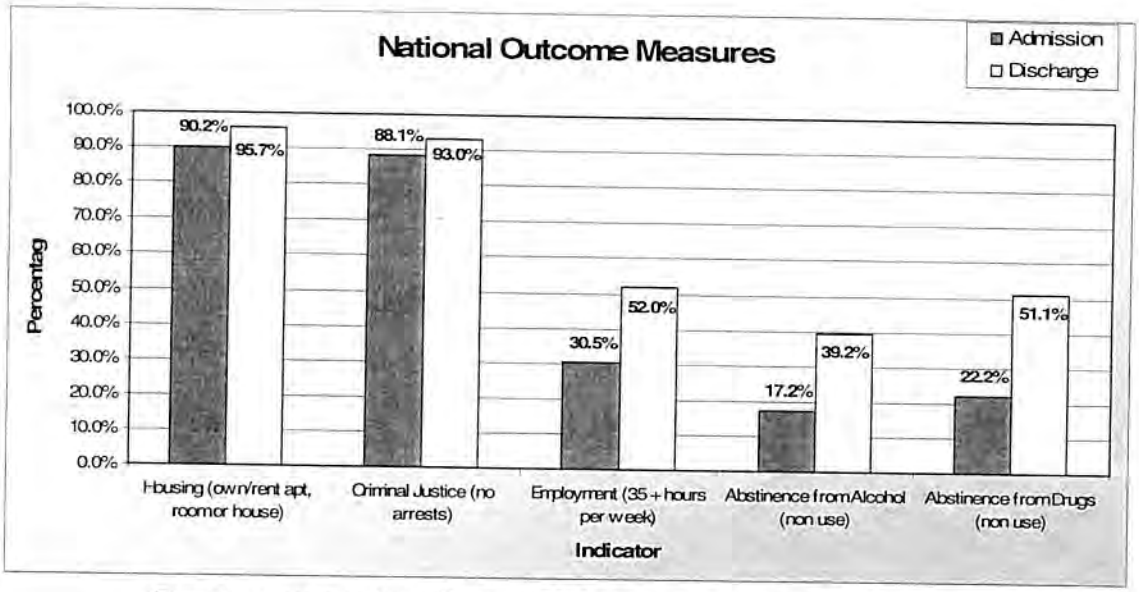
The graph below illustrates our success:



Inpatient days decreased from 32.08% to 14.63% in two years.

As a result of the initiatives described above and the continued focus of DCF, the eight hospitals, and our staff not only met our 2009 goal but surpassed it. Additionally, there was no increase in the 2009 acute average length of stay or readmission rate. This is an example of a program we could initiate in LA to better assure appropriate follow-up care.

Improved Substance Abuse Quality – Consumer-Reported Outcome Measures.
During implementation of the Kansas contract, one of the largest barriers facing the vulnerable citizens of Kansas was access to substance abuse services. These results were confirmed in an annual member satisfaction survey (95 percent confidence level +/- 5 percent). When asked, "For this urgent problem, were you seen as soon as you wanted?" only 60 percent of members gave a positive response. When asked, "Were you seen within 24 hours, 24 to 48 hours, or did you wait longer than 48 hours?" 61 percent of members responded that the wait was over 48 hour for an urgent appointment. Over the first two years of the contract, ValueOptions of Kansas (VO-KS) stressed access to care. Since national outcome measures (NOMs) data shows that treatment positively affects member recovery, improving access was the top priority for VO-KS. This emphasis on access to care was reviewed using the outcomes of treatment based upon NOMS data for Medicaid and Block Grant members. As seen below, the data showed that treatment improved the lives of members in the five key functional areas measured. Since NOMs data show that treatment positively affects member recovery, this emphasis on increased access and the subsequent increase in NOMs measures as reported by VO-KS members validated this approach and led to additional efforts to make substance abuse services widely available and accessible across the state.



Data compares member self-report 30 days prior to admission and discharge.

(e) Monitoring activities (e.g., surveys, audits, studies, profiling, etc.); and

One of the primary goals of the VO-LA QM Program is to continuously improve Member care and services. We provide state agencies with multiple means of monitoring the quality of our programs including satisfaction surveys, data collection and reporting, CSoC chart audits, measurement and analysis, and reporting aspects of care and service that demonstrate opportunities for improvement and targeted as possible quality improvement programs. Data collected for quality improvement projects and activities are frequently related to key industry measures of quality that tend to focus on high-volume diagnoses or services and high-risk diagnoses, services, or special populations. Data collected are valid, reliable and comparable over time. Our quality standards incorporate both NCQA and URAC standards and we hold each service center accountable for those exacting standards. Our service center quality management teams are responsible for monitoring service and care quality and ensuring compliance with our standards. The service center staff is charged with identifying and resolving any non-compliance issues. Below are a few key ways in which our clients monitor our services.

Satisfaction Surveys

ValueOptions is a customer-driven organization and therefore focuses on satisfaction of both internal and external customers as a key quality indicator. We perform Member, provider, employee, and client satisfaction surveys to improve our service delivery.

Provider Profiling

The content of provider profiles must be responsive to the needs of Louisiana Members, families, advocates, state decision-makers and providers. The process of designing a provider profiling program and selecting data elements is often almost as valuable as the findings: by working together to determine the most important elements to include, the behavioral health community can come to a consensus on what represents excellent provider performance. This process also improves

communication and relationships with providers. Working together with stakeholders in an honest and transparent manner is one way that ValueOptions will help DHH-OBH to successfully launch the Louisiana Behavioral Health Partnership.

Upon approval by DHH-OBH, VO-LA will provide opportunity for public input into the provider profiling process and selected data elements by convening a Provider Profiling Workgroup, holding public information meetings, provider forums, and requesting public comment on the draft provisions our web site. Subject to review by DHH-OBH, the general public, and the provider community, we have suggested several data elements below that we have found to be supportive of provider accountability and performance in other publicly-funded state programs in which we have collaborated. VO-LA's information systems and data collection methods will enable us to identify sub-par performance and specific outlier providers, to recognize opportunities for improvement, and to implement changes and corrective actions to increase the effectiveness of the delivery system.

Outcome Measurement

To maintain our role as a leader in the managed behavioral healthcare industry, ValueOptions has increasingly enhanced our abilities to measure not only the quality of our processes, but also the impact of those processes and the clinical care it provides on Members receiving services, as noted in the previous section. We have therefore increased the resources and attention given to outcomes measurement. ValueOptions has begun to establish outcome measures that are meaningful to individual clients, and more importantly, to the Members of those populations.

VO-LA will implement a standardized Member and family self-report survey demonstrating improved functioning, reduced symptoms, and improved quality of life. We will utilize the NOMS and Mental Health Statistics Improvement Program surveys and begin by administering this through our SMO staffing structure with a goal of moving to a Member-directed survey tool.

Our experience in Maryland will translate to the Louisiana program. The Outcomes Measurement System (OMS), based on NOMS, is a system for tracking how well a Member is doing over time for Outpatient treatment in the Maryland Public Mental Health System (PMHS). Clinicians use the information in clinical assessment and treatment planning. A provider conducts an interview and administers a questionnaire to the member upon entry into the program in which the member answers a series of questions to determine how well they are doing

There are two different questionnaires – one for Adult (18-64 years) and one for Child/Adolescent (6-17 years). The specific life domains included in the OMS questionnaires are:

- Living Situation
- Psychiatric Symptoms (Child/Adolescent)
- Functioning and Symptoms (Adult)
- Functioning and Social Connectedness (Child/Adolescent)
- Alcohol and Substance Use
- Legal System Involvement
- Somatic Health
- Employment
- School Performance (Child/Adolescent)

The type of analysis for the interviews is PIT – Point in Time or COT – Change Over Time. PIT is for a single interview for the member. COT is a comparison of an initial interview and the most recent interview for the Member. The analysis creates counts of members based on the specific life

domain. The analysis can also be done based on length of time in treatment, most recent interview for calendar year (CY), fiscal year (FY) or a rolling 12-months, age, gender, race and counts only. The analysis is presented in a Dashboard system with Webi software reports behind the scene. Data is fed from Webi software into the dashboards. There are currently four Dashboard templates – for Adult PIT, Adult COT, Child/Adolescent PIT and Child/Adolescent COT. A sample guide to how the NOMS is being administered by ValueOptions in Maryland is located in **Attachment 7**. We will also develop a customized dashboard for reporting on NOMS known as ValueOptions Outcomes Measurement System (VOMS) for Louisiana.

Additionally, for our Maryland program, ValueOptions' data system that supports the work of the Care Management Entities has facilitated the tracking and measurement of outcomes and CANS. A recent report on the first full year of operations of the program indicated that 84 percent of youth and 79 percent of caregivers were positive about the services they received from the Maryland equivalent of the Louisiana WAAs.

Complaints and Grievances

One method of identifying opportunities for improvement in our processes is to collect and analyze the content of Member, provider, and client complaints. The VO-LA complaints and grievance process has been developed to:

- enable the company to address Member, provider, and client complaints, grievances, and quality of care issues in a timely manner
- provide a structure for individual service centers to track and trend complaint and grievance data by providing categories into which complaints and grievances can be sorted (service center data is reported at least quarterly to the CQC and is also incorporated into the credentialing process)

Quality of Care and Service Issues and Trends

ValueOptions has a defined procedure for the identification, investigation, resolution and monitoring of quality of care and service issues and trends that utilizes a severity risk rating to determine the credentials of the investigator and the timeframe for investigation. Quality of care and service issues and trends are those that decrease the likelihood of desired health outcomes and that are inconsistent with current professional knowledge. Quality of care and service issues are primarily identified via complaints from Members and are resolved and monitored at both the service center and network-wide level in order to identify providers who are providing poor quality care. The VO-LA service center will have a designated committee, in which the Medical Director participates to oversee the investigation and resolution of these issues.

CSoC Chart Audits

Our Regional Team will review provider chart audits for Members who are in the CSoC. We have developed customized assessment and treatment plan forms which (a) providers complete and submit to the plan for review and authorization, and (b) generate clinical outcomes and provide performance data to assist in the monitoring of the system of care. A sample of audit tool that we have used in Connecticut is located in **Attachment 8**. We have also developed a variety of non-clinical forms to support the administrative functions necessary for the provision of services. Systems partners can submit information electronically via ProviderConnect, or an innovative fax system that enables the information to go directly into the child or adolescent's record.

(f) Feedback loops Suggested number of pages: 5.

First and foremost, our feedback loop is based on our continuous efforts to receive data, anecdotal, qualitative and quantitative from every possible venue, including but not limited to:

- **Committee Structure Development.** We will support DHH-OBH in implementing the required committee structure of the LBHP QM Program. Our staff will support all the committees' activities by:
  - working collaboratively with each of the committees to determine the indicators that will be monitored by that committee, the reports necessary to accomplish that task, and the frequency with which those reports are needed
  - providing information concerning those indicators in a transparent manner and format that allows the Members of the committee to understand the data as well as to identify movement in the indicator
  - acting as the integrating agent so that information that impacts more than one committee is shared across committees
  - making recommendations to the committees regarding new or more detailed indicators or measures that would allow them to make more informed decisions

- **Clinical Studies and Quality Initiatives.** We will help identify, define, implement, and evaluate clinical studies, quality initiatives, and other interventions to address identified opportunities or problem areas. Initiatives will be identified based on information from the regular review of data (including pharmacy data) as well as on information from stakeholders regarding high-risk populations. At least one initiative will address improving the care for Members with co-morbid medical and behavioral health diagnoses. Our staff will support the identification of these studies and initiatives by conducting literature reviews to identify the most effective interventions to address clinical problems and by keeping abreast of and participating in initiatives of agencies that focus on improving the care of Medicaid populations. We have already begun discussions with Tulane University to assist us with the external validation, analysis, and design of these studies.

- **Satisfaction Surveys of Members and Providers.** We use Member/provider satisfaction surveys to measure program success and inform improvement opportunities within the system of care including access and quality care. We will engage third party survey entities to facilitate completion of general/complex Member and provider surveys on an annual basis. We will use proven research methods to ensure an adequate sample size and a general satisfaction survey instrument approved by the DHH-OBH that include the required areas of assessment. We will also ensure Members and providers will be involved in the interpretation of findings and resulting recommendations.

- **Provider Satisfaction.** We recognize the concern that currently exists among Louisiana providers about the impact of the transition to a behavioral health management approach. While some providers were already concerned with the integration of Mental Health and Addictions, other providers, such as Psychiatric Nurse Practitioners, are trying to find a way to become Medicaid providers, particularly for the underserved parishes. VO-LA has had many different provider types express concern regarding what will happen to their practices and businesses in the midst of all these changes. While we ultimately anticipate the provider

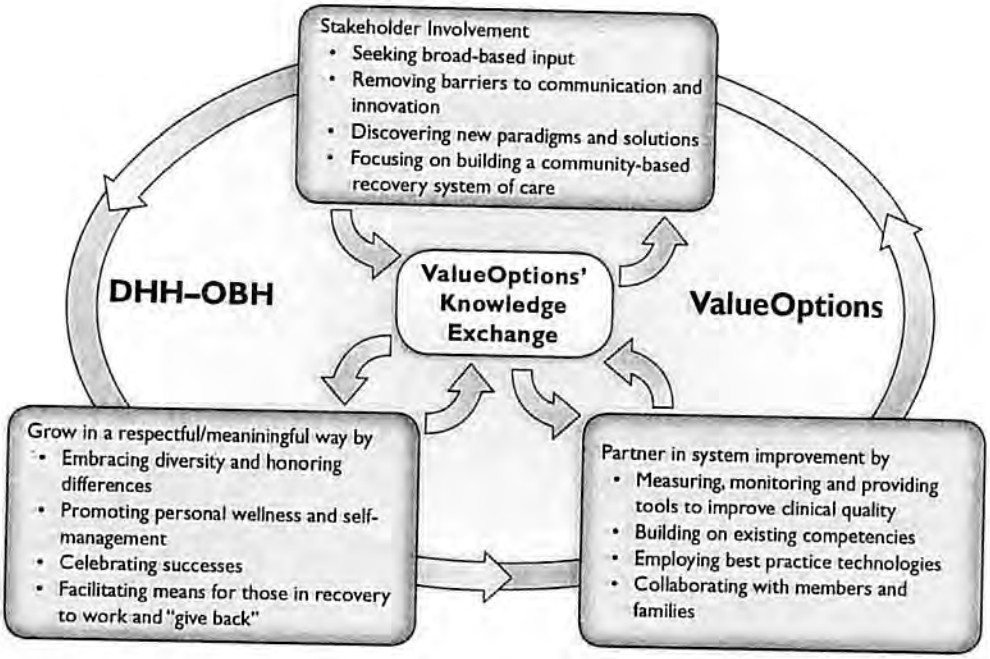
satisfaction with the new Systems of Care will increase, we also understand that any new system change brings about concerns (as we have heard numerous times from providers and Members alike). Providers are concerned about now being required to meet credentialing standards, new licensing regulations (such as PRTFs) and how to adjust their service array to meet EBPs. Hence, we will use year one as the baseline from which to measure ongoing improvement.

- **Focus on Recovery-Oriented Services.** As SMO, ValueOptions will work with DHH-OBH to identify opportunities to improve access to and engagement of recovery-oriented services. These efforts will include working closely with DHH-OBH and stakeholders to build capacity for recovery-oriented services throughout the system of care in Louisiana. We will support these efforts by using technology that allows the measurement of timeliness of access at point of intake and then for follow-up care. We have already partnered with organizations such as NAMI-Louisiana, The Extra Mile, Mental Health America, and others to enhance our recovery-oriented training and support program.

- **Provider Profiling.** We will develop a provider profiling process to improve the quality, efficiency and coordination of care of the provider network under this contract. In collaboration with the DHH-OBH, provider representatives, and Members, we will identify: 1) LOC profiles that allow providers to compare themselves against their peers on measures developed collaboratively with them and the departments, 2) key indicators that provide meaningful measures of provider performance and accurate means of measuring those indicators and 3) goals for performance on those indicators.

- **Collaboration with Outside Organizations.** We will create a QM program that provides opportunities for collaboration with other agencies such as the school systems, housing agencies, justice system, Coordinated Care Networks (CCNs), Members and families, and law enforcement.

All of these communication venues provide ways for feedback to be delivered to the SMO, DHH-OBH as well as for feedback to be delivered to and from providers and Members, as depicted in the knowledge exchange illustration below. This knowledge exchange process ensures that all stakeholders have a voice in the LBHP.



VO-LA creates feedback loops for all LBHP stakeholders.

The quality improvement cycle is an essential element of what makes our company successful. Each year, the QM Program will formulate a work plan that includes goals and the actions that are necessary to achieve those goals. Monitors of almost every aspect of our operation are developed and maintained. The collection of data for each measure is only begun after a consistent data collection methodology has been established. This approach allows tracking and trending of progress towards QM goals. The QM QA Plan includes formal and informal feedback loops to assess the effectiveness of the QM program. Issues identified by DHH-OBH, local agencies and community stakeholders testify to the efficacy of our performance improvement initiatives. Performance data, QA/PI Committee review and recommendations and collateral sources of information can validate that deficiencies exist for an identified aspect of care, administrative process or clinical function.

The following thirteen steps are enacted within our quality committee structures to ensure a systematic approach to the development and implementation of the quality management work plan and improvement activities. The QM Work Plan is a dynamic document that specifies actions and time frames for each individual quality improvement project.

1. A problem is identified through a variety of sources (e.g., Member complaints, providers, over or under utilization, clinical quality or safety, or administrative quality indicators).
2. Baseline data are collected and reviewed, trended, and analyzed by multi-disciplinary, multi-functional teams for performance, root cause, and/or outcomes.
3. Barriers to improving the process or outcome are identified and problem-solving conducted to determine the best ways to overcome the barriers.

4. Thoughtful identification of interventions that are robust enough to impact the enrolled population are identified based on data analysis, research, best practices, root cause analysis, barrier analysis, demographics, utilization, cost of care, and staff resources.
5. Quality indicators are then selected (i.e., it is determined what will be measured and how it will be measured). Through this step, it is determined what data is appropriate for measurement.
6. Performance goals or desired levels of improvement over current performance are established.
7. A specific work plan is developed that will lead to improvement in performance and/or outcomes.
8. The plan is approved or modified as necessary and implemented.
9. After an appropriate time period, new data will be gathered to determine the impact of the intervention. Data may also be gathered at regular intervals on an ongoing basis for continuous assessment of performance.
10. Through analysis of the data, barriers to improvement are identified.
11. Based on the analysis, a decision is made regarding the next step:
    a. Continue the process as is with the same indicators/data monitoring
    b. Continue the process with modifications (i.e., implement additional interventions to remove identified barriers)
    c. Add new monitors/quality indicators
    d. Stop monitoring
12. New thresholds are developed or current targets are maintained.
13. A new work plan is developed.

THE QM PROGRAM EVALUATION AND FEEDBACK PROCESS

A QM evaluation will be conducted that consists of an annual comprehensive summary of the accomplishments of objectives, subcommittee activity, quality improvement activities and indicators. It may lead to the identification of education and training needs, the establishment and revision of policies and procedures or altering operations to minimize risk in the delivery of care and service.

As a result of this analysis of the previous year's findings, activities that need to be carried over into the next year will be identified as well as new areas of measurement or improvement focus. The annual evaluation may also lead to identification of educational/training needs, the establishment and/or revision of policies and procedures, or the alteration of operations to minimize risks in the delivery of care and service. It is the responsibility of the QM Administrator to review all documents and present findings and recommendations through the committee structure. Results of the evaluation are also shared with relevant clients and relevant medical or behavioral health delivery systems via client reports, advisory councils, quality forums, and/or the website.

DEVELOPING GOALS AND OBJECTIVES FOR THE QM PROGRAM DESCRIPTION AND WORK PLAN

Once the annual QM Program Evaluation is complete, the findings and recommendations resulting from the evaluation are incorporated into the next year's QM Program Description and Work Plan. Input into the development of goals and objectives for the coming year is obtained from stakeholders, including, but not limited to, Members of the quality committees including participating clinical representation. The annual QM Work Plan includes the goals for the coming year and activities that will allow achievement of what is proposed. The work plan describes the means of measuring whether goals have been met as well as the persons responsible and the time frames for achieving the goals. The resulting work plan thus represents the strategies and major activities

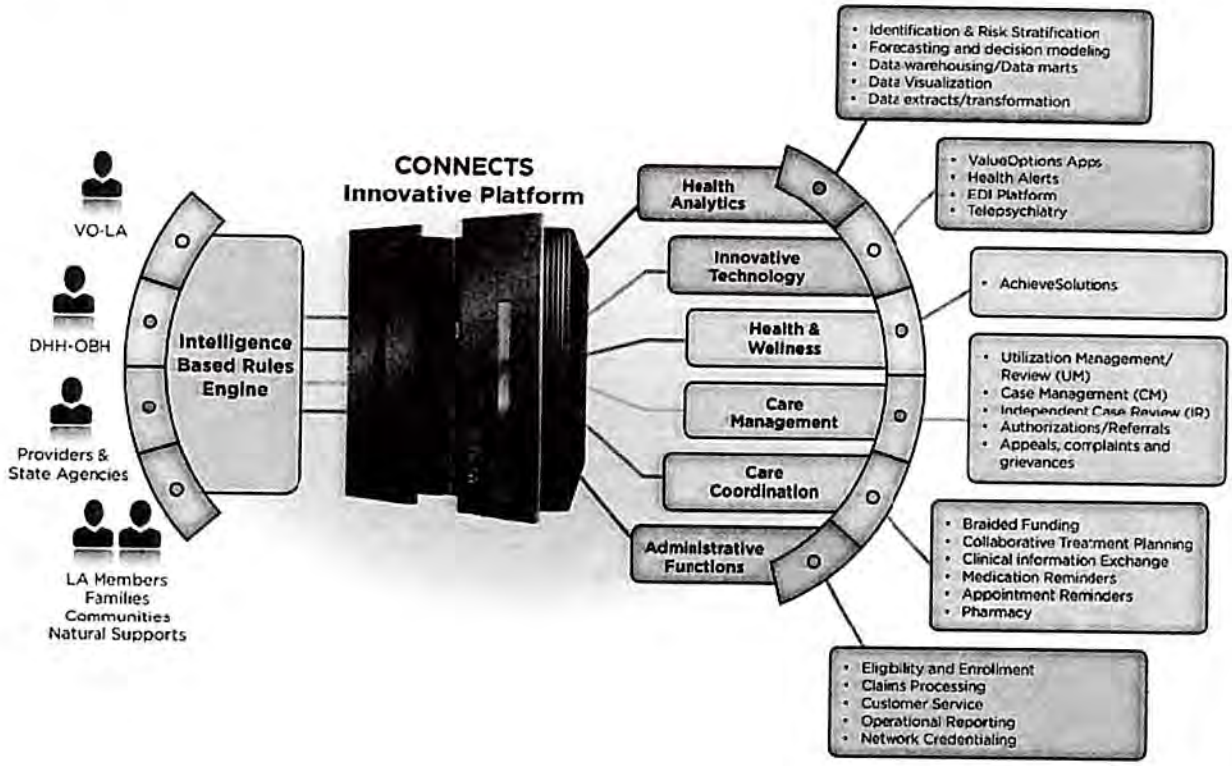
required to ensure the quality improvement of the delivery of services, both clinical and administrative, to all of our customers, both internally and externally. The complete QM Program is described as the QM Program Evaluation, the QM Program Description, the QM Work Plan and the QM policies and procedures.

This judicious and structured approach is based on URAC and NCQA quality management program requirements and ensures our State customers that VO-LA will provide consistent and measured feedback on all aspects of our program.

ii. Describe how the Proposer's information management system will support continuous QI. Suggested number of pages: 1.

ValueOptions' comprehensive information systems are capable of supporting complete managed behavioral health programs from the initial Member contact through the claims adjudication and payment processes, in conjunction with the full range of management and utilization reporting requirements. Our premier system, CONNECTS serves as the platform for care management, reporting, research, financial, and claims payment in one repository. Providers will not have to enter authorizations or clinical information or even claims in separate systems. All functions including authorizations, clinical and provider information, claims payment, quality management, tracking, and reporting reside in the same system, and are written in the same language.

CONNECTS is comprised of multiple fully integrated components that cover all of the functions normally required in the administration of a managed health care operation, including a shared database that integrates membership and provider maintenance, inquiring tracking, clinical notes, authorization, and claims processing.



Our comprehensive CONNECTS system enhances the quality of care management and quality reporting for DHH-OBH and LBHP Members.

We recognize the critical importance of sound data to be used in evaluating performance, including quality, cost, utilization and other clinical information. ValueOptions continuously enhances and strengthens the links between our clinical, claims, customer service, inquiry, provider and credentialing data systems to ensure we are able to collect a wide array of information, that the information is accurate, and that it is useful to ValueOptions and our customers.

In addition, we use a secure, Web-based adverse incident tracking system for reporting, tracking and investigation of all adverse incidents company-wide. Our QualityConnect system facilitates the investigation of adverse incidents by assigning a Severity Index (SI) to each incident that occurs. The four SI categories from most serious to least serious are: sentinel, major, moderate, and minimal. Recommended investigation guidelines, standard response expectations and variables are established for each severity index category to ensure patient safety. This system has the capability of sending e-mails to notify select users that an event has occurred. In QualityConnect, users are assigned a role/level that determines what information they can access. The application is located on the ValueOptions network.

iii. Describe how the Proposer will resolve quality of care concerns and how information related to the concerns will be used to improve the quality of care provided to members at the individual and BH system level. Suggested number of pages: 2.

ValueOptions has a defined process for the identification, reporting, investigation and analysis of occurrences which represent actual or potential serious harm to the well-being of Members or to others by a Member while the Member is in treatment. A specialized Web-based application and database for the tracking of all adverse incidents has been developed and implemented company-wide. Quality of care and service issues and trends are those that decrease the likelihood of desired health outcomes and that are inconsistent with current professional knowledge. Quality of care and service issues are identified in multiple ways including complaints from Members, adverse incidents, the credentialing process, network monitoring, utilization management, clinical treatment record review, survey data and provider profiling. Issues are resolved and monitored at both the service center and network-wide level in order to identify practitioners and providers who are providing poor quality care. Service centers have a designated committee, in which the Medical Director participates, that oversees the investigation and resolution of these issues.

Peer review is the mechanism used to conduct review of suspected inappropriate care or inappropriate behavior by a practitioner or provider while providing care to a Member managed by VO-LA. If the findings of the independent investigation indicate that a practitioner or provider who is subject to investigation has provided substandard or inappropriate care, or has exhibited inappropriate professional conduct, VO-LA will exercise its discretion and take appropriate action against such practitioner. The process and scope of the actions that may be taken are identified in the VO-LA policies and procedures defining the quality of care process. The actions that may be taken if a quality issue is identified may include, but are not limited to: development of a corrective action plan with timeframes for improvement, education, counseling, monitoring and trending of data, sanctions on the practitioner's practice, notification to appropriate state and federal bodies, and limitation or termination from participation in VO-LA's network.

Quality of care is improved as investigations include requiring corrective action plans from providers and ongoing monitoring as needed. In addition, quality of care cases are incorporated into the credentialing process to ensure that any grievances or adverse incidents are reviewed as part of the decision-making process at the Credentialing Committee. Tracking and trending is done at both the aggregate and provider level, opportunities for improvement are identified and initiatives are implemented and monitored as part of the ongoing quality improvement cycle.

QUALITYCONNECT

As indicated above, QualityConnect serves as ValueOptions' secure, Web-based Adverse Incident and Quality of Care Complaint (QOC) Tracking Application. The access controlled application is used for reporting, tracking, and investigation of all adverse incidents and quality of care complaints company-wide. Users are assigned a role level that determines what information can be accessed on a "need-to-know" basis. Using QualityConnect, we document adverse incidents and quality of care incidents for identifying patterns of quality of care or quality of service issues, utilizing the following definitions and categorizations:

Quality of Care (QOC) Issues

Any action or failure to take action on the part of a provider that has the potential to decrease the likelihood of a positive health outcome and/or is inconsistent with current professional knowledge and/or puts the safety of the Member at risk.

QOC issues are categorized into one of the five following categories

1. Clinical Practice-related issues
2. Access to Care-related issues
3. Provider Inappropriate Behavior issues
4. Provider Attitude and Service issues
5. Other Monitored Events

Quality of Service

Action related to the timely delivery and availability of care. Such issues would not be under the preview of QOC unless a determination has been made by clinical that there is a potential for a quality of care issue.

The adverse incident module has recommended investigation guidelines, standard response expectations, and established variables for each Severity Index category to ensure patient safety is contained with the system. The quality of care module has built in features which assign a risk rating of classifying quality of care complaints according to their risk in relation to the severity of risk of harm to the Member.

iv. Describe the methods the Proposer will use to ensure its own and its provider's compliance with QM initiatives and requirements. Suggested number of pages: 2.

The quality work plan and annual evaluation processes ensure compliance with QM initiatives and requirements, as previously noted in *Section ii.f.* Reporting throughout the committee structure creates a standardized process for ongoing tracking, trending and monitoring of compliance with the QM goals and objectives across VO-LA and the provider network.

Providers are engaged in the QM process during the contracting process, when they are educated about policies and procedures, the Provider Manual and requirements in their contract. Ongoing communication and meetings with providers by network staff educates them about quality management, participation in committees and stakeholder meetings, medical necessity criteria, continuum of care, care management programs, performance specifications for the services for which they are contracting, and the many ways they can obtain assistance through VO-LA.

Provider compliance with initiatives and requirements occurs across many venues including the previously stated quality of care monitoring and the credentialing process. Additional ways that QM is reviewed and monitored across providers includes areas such as:

PROVIDER PROFILING

We will develop a provider profiling process to improve the quality, efficiency and coordination of care of the provider network under this contract as well as to provide NOMS and other outcome

measures. In collaboration with the DHH-OBH, provider representatives, and Members, we will identify: 1) LOC profiles that allow providers to compare themselves against their peers on measures developed collaboratively with them and the departments; 2) key indicators that provide meaningful measures of provider performance; accurate means of measuring those indicators; and 3) goals for performance on those indicators. ValueOptions has a long history of providing profile reports across all levels of care.

PROVIDER SATISFACTION

As previously stated, we understand the concerns Louisiana providers have with the impending move to a behavioral health management approach. While some providers were already concerned with the integration of Mental Health and Addictions, other providers, such as Psychiatric Nurse Practitioners are trying to find a way to become Medicaid providers, particularly for the underserved parishes. VO-LA has had many different provider types express concern regarding what will happen to their practices and businesses in the midst of all these changes.

SATISFACTION SURVEYS OF MEMBERS AND PROVIDERS

One way to measure any change in a system of care is Member and family satisfaction with the access and care Members receive. We will engage third party survey organizations to facilitate completion of general/complex Member and provider surveys on an annual basis. We will use proven research methods to ensure an adequate sample size and a general satisfaction survey instrument approved by the DHH-OBH that include the required areas of assessment. We will also ensure Members and providers will be involved in the interpretation of findings and resulting recommendations.

CLINICAL STUDIES AND QUALITY INITIATIVES

Providers will be involved in helping us identify, define, implement, and evaluate clinical studies, quality initiatives, and other interventions to address identified opportunities or problem areas. Initiatives will be identified based on information from the regular review of data (including pharmacy data) as well as on information from stakeholders regarding high-risk populations. At least one initiative will address improving the care for Members with co-morbid medical and behavioral health diagnoses. Our staff will support the identification of these studies and initiatives by: conducting literature reviews that identify the most effective interventions to address clinical problems; and keeping abreast of and participating in initiatives of agencies that focus on improving the care of Medicaid populations. We will also gather stakeholder input into the planning of QI initiatives through all of our advisory councils. Providers will be notified of statewide quality initiatives through the Quality Program summary posted on our website, *Provider Alerts*, newsletters, and word of mouth through training events and various meetings with our staff. We have already begun discussions with Tulane University to assist us with the external validation, analysis, and design of these studies.

CLINICAL TREATMENT RECORD REVIEW

VO-LA conducts treatment record reviews to determine quality of care delivered by providers, in the absence of specific QoC allegations, provider understanding of and adherence to clinical practice guidelines and assessment of medical necessity. Standardized core record keeping standards broadly modeled after the Joint Commission for the Accreditation of Healthcare Organizations and audit tools are in place and are shared with providers. Periodic random auditing of treatment records of network providers by our Medical Director or Quality department ensures that the treatments

adhere to national standards of practice and reflect appropriate behavioral health care management, as well as unique needs of Louisiana, such as:

- appropriate treatment plans, including comprehensive clinical assessments
- Member buy-in and participation in setting treatment goals
- involvement , as appropriate, of significant others in the treatment goals, and in ensuring that the records appropriately document interventions and treatment plan outcomes
- the records appropriately document interventions and treatment plan outcomes

TRAINING AND EDUCATION PROGRAMS

Provider training and education represent principle components of building, maintaining and enhancing a community based Behavioral Health network in Louisiana. LBHP is an opportunity to work with providers; to enhance those who are not utilizing EBPs; to assist traditional clinic providers in embracing fidelity adherence rehabilitation services and to build a system of care that allows individuals to live and contribute in their Parishes. ValueOptions believes in not only issuing expectations of providers but also enabling them to meet those expectations by providing information, support, technical assistance and capacity building. Under the new contract, we plan to continue to conduct provider training through a variety of venues, including:

- **Individual provider-based meetings and trainings**- In various provider meetings, such as substance use profile meetings, network staff will use data to show providers how their performance compares to other providers and provide consultation and technical assistance including sharing best practices that we have observed across other provider agencies and service centers. We can also provide more formal, structured trainings at the provider level, such as a program on medical necessity criteria and health record documentation.

- **Forums and statewide learning collaborative**- We can provide consultation, training and technical assistance in these venues that reach a larger number of providers and engage them in sharing information and modeling best practices with each other, but they also involve small enough groups for providers to receive individualized assistance. We utilize our web-based resources to conduct webinars as well as provide access to self-directed learning via Essential Learning. Essential Learning is the largest provider of e-learning services for the human service industry, serving more than 500 agencies. It is a completely Web-based application, no application software is installed on the provider side and all application activity occurs on a Web browsers. The service offers an extensive online course library on mental health, addiction, and many other materials. Through this portal, ValueOptions can upload training materials including PowerPoint, audio and video presentations for provider staff to view and complete from any location with Internet access. The users who complete the training can be tracked and reported on for each facility. In addition, we provide a sample list of Provider Trainings developed by ValueOptions in **Attachment 9.**.

- **Statewide conferences**- These events reach the largest and broader range of providers for the primary purpose of information sharing and training.

Ongoing training is essential to broaden and sustain the provider network.

v. Describe how members, families/caretakers, providers, advocates and stakeholders will be involved in the design and implementation, and evaluation of QM information. Suggested number of pages: 1.

During the transition of Medicaid services and the creation of the LBHP, stakeholder involvement will not end with implementation of the SMO contract on March 1, 2012. In fact, many key stakeholders in Louisiana, with whom we have met over the past three years, have clear expectations that the SMO will provide an open and collaborative system for involvement of all stakeholders.

Stakeholders bring tremendous value to a QM program by helping to design it to properly address their vision, priorities and concerns. We will provide a committee structure for the QM program to ensure involvement in the QM process across all stakeholders. This involvement reflects our belief that Members, family/caretakers, providers, advocates, state decision makers, and stakeholders should be viewed as resources and active participants in the treatment and recovery process. They will provide input into policy and procedure development, help create and evaluate Member collateral materials, and assist in the collection and interpretation of health status data.

ValueOptions has extensive experience and expertise in this area. For example, in the Massachusetts service center, providers are on all quality committees with mature and robust Member and family advisory committees. The Member and family committees have been extremely successful in areas such as:

- soliciting and involving consumer-run organizations to participate in activities and perform paid services such as satisfaction surveys
- implementing consumer-run self-help groups in the community
- developing trainings for behavioral health providers and staff to gain an understanding of the recovery process from the Member perspective
- reviewing new services and offering feedback on all performance incentive and quality initiatives
- providing feedback related to crisis planning, informed consent, and quality of care and proposed the development of a hospital report card with quality indicators related to these issues
- suggesting topics, speakers, and locations forums and trainings
- serving as mentors for Peer and Family Specialists
- proposing and writing articles and stories for the Member and provider newsletters
- website review with recommendations for content and navigation enhancements
- reviewing activities of the Parent Support Subcommittee, Youth in Transition, of the State Mental Health Planning Council and offering suggestions
- co-leading provider training on the impact of person-centered planning and recovery and resiliency-focused services

We will leverage our experience in all 14 of our public sector state contracts to ensure that Members and families direct and guide all of our activities.

vi. Describe how the Proposer will involve members, family members, the Proposer's personnel, subcontracted providers and other stakeholders in the development and ongoing work of the QM system and share results of QI initiatives. Suggested number of pages: 1.

ValueOptions was an early advocate of a vision for behavioral health that embraces recovery and resilience as an overarching goal, fostering inclusion and active involvement of Members in treatment, and supporting development of community-based initiatives. We recognize that the unique experiences and perspectives of individuals who have been impacted most directly by public sector behavioral health are invaluable within our operations, and serve as a positive influence on the way in which we do business. Members and their families are the reason for ValueOptions' existence and their input during all stages of planning, development and implementation, and in the performance improvement process is crucial. We propose involving Members and family members in our overall program through the following strategies:

QM COMMITTEES

VO-LA has developed a thoughtful structure for overall SMO management, as well as quality, clinical, and committees that are locally-based but also supported by the national activities of ValueOptions. VO-LA will be a champion of Member and family voice in all aspects of the behavioral health services delivery system.. The success and effectiveness of treatment cannot be fully or meaningfully measured without the involvement of those who are receiving treatment—Members and their families.

VO-LA will involve Members and families in the QM program by actively soliciting their advice through membership on advisory and quality management committees, as well as by aggressively recruiting them as employees within the organization. In addition, quality monitoring and performance measurement reports, satisfaction survey results, and plans for performance improvement projects and studies will be presented at VO-LA Member and Family Committee meetings. The VO-LA Member and Family Committee also reviews practice guidelines for the presence of recovery and resiliency concepts and language, and recommends revisions, as needed.

PEER AND FAMILY SPECIALISTS

Recruiting Members and their family members to serve as Peer and Family Specialists to support our recovery outreach efforts is a high-priority. Peers interact with Members in ways fundamental to self-determination and empowerment in a unique and meaningful way; peers are able to empathize and to provide concrete proof that people can and do achieve success beyond the behavioral health system. Therefore, we believe these individuals will make a significant impact on the direction of the entire program.

TRAINING AND TECHNICAL ASSISTANCE

Leveraging our Strategic Relationships with NAMI-LA, and our innovative Micro Grant program, training, education, and outreach will build capacity within the Member community to become empowered to engage in a decision-making capacity.

NATIONAL SUPPORT

Our National Recovery and Resiliency team, which includes recovery leaders from each of our public sector programs across the nation, meets monthly to share resources, create solutions for local barriers, and advise leadership on recovery and resiliency issues. These experts will be available to consult and provide onsite training and technical support as we implement and expand an effective behavioral health system of care for Louisiana residents.

Reimbursement for Members and Family Members

All VO-LA QM Committees will include Members and family member representatives. To encourage their participation, those participants will be reimbursed for their travel expenses. In addition, with the approval of the DHH-OBH, Members and family members will be compensated for their participation in QM activities.

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vii. Provide the following information regarding the two most recent member satisfaction surveys with members of government/public sector managed BH care programs:

a) Time Period
b) Overall response rate
c) Percent of respondents satisfied overall
d) Lowest Rated Item and percent satisfied. Suggested number of pages 1

We provide data from two of our public sector member satisfaction surveys for 2009 and 2010. The results are from our Pennsylvania and Colorado programs.

Colorado

Overall Response Rate	Overall Satisfaction	Lowest Rated/% satisfied
2009: 400 members in total were surveyed; all members did not answer all questions. Response rate to individual questions ranged from 94% to 100%.	2009: Members responded as follows to the overall satisfaction question: Overall, how satisfied are you with the mental health services of ValueOptions Completely satisfied: 26.6% (n=105) Very satisfied: 39.5% (n=156) Somewhat satisfied: 25.6% (n=101) Total respondents to question = 395	2009: Thinking back to your first appointment, did you get an appointment as soon as you wanted? 80.4% got an appointment as soon as desired. (Overall respondents to this question=387).
2010: 400 members in total were surveyed; all members did not answer all questions. Response rate to individual questions ranged from 95% to 100%	2010: Members responded as follows to the overall satisfaction question: Completely satisfied: 30.8% (n=123) Very satisfied: 42.9% (n=171) Somewhat satisfied: 17.8% (n=71) Total respondents to question = 399	2010: Thinking back to your first appointment, did you get an appointment as soon as you wanted? 83.7% got an appointment as soon as desired. (overall respondents to this question=381)

Pennsylvania

Overall Response Rate	Overall Satisfaction	Lowest Rated/% satisfied
2009: The total number of members interviewed was 1,200, which included fourteen counties. The overall refusal rate of members selected to be in the 2009 survey was 10.8%.	2009: Overall quality of service of services received from the provider – 92% Overall satisfaction with Mental Health/D&A Services of VBH-PA – 94%	2009: Know how to contact or have already contacted VBH-PA with a grievance – 47%
2010: The total number of members interviewed was 1,200, which included fourteen counties. The overall refusal rate of members selected to be in the 2010 survey was 4.7%.	2010: Overall quality of service of services received from the provider – 92% Overall satisfaction with Mental Health/D&A Services of VBH-PA – 95%	2010: Know how to contact or have already contacted VBH-PA with a grievance – 52%

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

i. Describe how Network management (NM) and development functions will be organized, including staff that will be located in Louisiana and staff support available at the Proposer's Corporate or other operations. Suggested number of pages: 2, exclusive of organizational chart.

LOUISIANA-BASED NETWORK MANAGEMENT AND DEVELOPMENT TEAM

VO-LA understands the importance of a full complement of network management and development staff for the Statewide Management Organization (SMO) contract. Our Louisiana Network Management and Development team includes provider relations, network development, and operations professionals as detailed below.

Network Development Administrator assures network adequacy and appointment access, development of network resources in response to unmet needs, and adequacy of the provider network to provide Member choice of providers. This position is also accountable for contracting qualified service providers in compliance with federal and State laws and the requirements in this Contract, including all documents incorporated by reference. The Network Development Administrator will be responsible for network development, contracting, credentialing, and provider communications.

Network Management Administrator assures timely inter-provider referrals and associated appointment access. This position is also accountable for assisting to resolve provider grievances, disputes between providers and investigating Member grievances regarding providers, coordinating corrective action plans as needed, and assuring the accuracy of provider service delivery reports (e.g., encounter information verification).

Provider Relations Representatives support the recruitment, credentialing, and contracting process for potential and current providers. Our Regional Provider Relations Team will also serve as resources for regional network providers, offering training and assistance as needed or warranted.

Provider Trainers train Provider Relations staff and providers in the use of various provider systems, policies and procedures and the credentialing process, including system setup, provider fee schedules, evidence-based practices (EBPs), recovery and resiliency, service planning, assessment and the development of policies and procedures related to system setup.

Credentialing Specialists process and conduct timely and accurate verification of credentialing and re-credentialing applications of behavioral healthcare practitioners.

Contracting Specialists manage the development of provider contracts, contract amendments, and rate negotiations.

Provider Relations Administrative Assistants supports the Provider Relations Representatives.

Network Operations Representatives provide a full array of provider file related services to internal and external customers of the organization.

CORPORATE NETWORK SUPPORT STAFF

Our VO-LA Network team will be supported by our expert national network staff members, including:

1. **Vice President, National Provider Contracting** has executive oversight of provider contracting and negotiation functions for our national provider network.
2. **Contract Development Directors** coordinate the development and management of ValueOptions provider networks, including the initial and (re)contracting, rate negotiation and provider network management.
3. **Vice President, National Provider Relations** has executive oversight of all staff and activities related to the recruitment of new practitioners and facilities.
4. **National Directors, Provider Relations** oversee provider relations and related functions in our service centers, including provider network management for state deliverables.
5. **Provider Relations Representatives** are responsible for various levels of activities supporting the recruitment, credentialing, and contracting process for potential and current ValueOptions providers.
6. **Provider Training Coordinator** trains Provider Relations staff and providers in the use of various provider systems, policies and procedures and the credentialing process, including system setup, provider fee schedules, and the development of policies and procedures related to system setup.
7. **Provider Network Specialists** train and guide Member and Provider Service Representatives in resolving problems for providers to ensure and improve customer/provider service.
8. **Provider File Maintenance Specialists** are responsible for timely and accurate data entry of provider information into data system.

ii. Provide an organizational chart for NM that includes position titles, numbers of positions, qualifications and reporting relationships. Discuss how provider relations, network development and network monitoring will be addressed. Suggested number of pages: 2 exclusive of organizational chart.

Chart Redacted

VO-LA's Network Management professionals assure that Louisiana Behavioral Health Partnership (LBHP) Members have access to qualified providers. Staff qualifications are detailed in the following table.

Louisiana Staff	Qualifications

Louisiana Staff	Qualifications

PROVIDER RELATIONS, NETWORK DEVELOPMENT AND NETWORK MONITORING

Provider Relations

The VO-LA Provider Relations team will assist the DHH-OBH with training and technical assistance to provider agencies and practitioners who need assistance in adapting their clinical services and programs. To assure the viability of Louisiana's behavioral health delivery system, it will be important to work through the DHH-OBH and your committees to monitor the progress of every provider in implementing any changes necessary.

Network Development

ValueOptions' goal is to develop and maintain a behavioral health network that:

- ensures access to all covered services in the most appropriate setting, regardless of geography or culture
- builds core capacity in support of local and statewide systems of care
- includes Member, families and youth engagement at all levels of system creation

Our network development process includes extensive data analysis, community and stakeholder input, planning and goal development, and identification of clear targets, metrics, and measurements that drive our strategy through to execution. Our network development in Louisiana is detailed throughout our response to this section. We have received letters of intent (LOI) from more than 496 private providers, Family Support Organizations, Wraparound Agencies, therapeutic foster care and more inpatient as well as community-based providers.

Also, we include a very detailed plan for Coordinated System of Care (CSoC) and Adult system network development in our response to *1. Introduction/Administrative Data.*

Defining, Establishing and Monitoring Network Sufficiency

As soon as we receive updated information about current utilization and customers, we will analyze the distribution of customers for each funding stream by ZIP codes and regions, as well as statewide. Next, we will overlay the providers that have traditionally rendered care to Members by program to determine the existing levels of care to which Members have had access. In the next step, we will review the aggregate data and estimate both geographic and level-of-care needs. This data will be compared to utilization data from the other programs we run in other public sector programs. We also will make comparisons to national norms. All these factors are included in the process of estimating the sufficiency of the provider network required and the availability of service providers. All of the data will be used to develop a network development model for the whole system of care.

VO-LA understands the importance to expand and refocus the array of providers to ensure recovery and resiliency-focused services.

Most importantly, VO-LA will expand and refocus the array of providers to ensure recovery and resiliency focused services in the communities across the State. This expansion includes, but is not limited to, the use of Member-run programs, crisis teams, and Assertive Community Treatment (ACT) teams. For example, we will recruit medical clinics and FQHCs, as well as private practitioners, into the network during Phase Two to enable them to assume responsibility for the

"traditional" users of mental health and substance abuse services, who require only incidental outpatient services. This will free staff of specialty behavioral health care providers to focus on serving those with more serious and complex issues.

Assistance in Network Planning

During implementation, VO-LA will ask the DHH-OBH to assign a Work Group to assist in finalizing the network development plan. Representatives of local peer organizations will be part of that Work Group, and will be crucial in providing input to the plan for their region. We anticipate that the Work Group will continue to advise the VO-LA Network Management Department on an ongoing basis, especially in evaluating proposed changes in network strategies or expanding the array of covered services.

We propose enlisting peer organizations to provide input into network planning in their respective regions.

Network Assessment and Design

Regularly during the contract period, our Network staff will perform Geo-Mapping studies and density reports to highlight gaps in the array of services to maintain and preserve optimum delivery of behavioral healthcare services. Results of these studies will be shared and discussed with the DHH-OBH as well as with those committees and work groups designated to support operations. As part of our ongoing network assessment process, we will identify additional providers and evaluate the need for specialty services, review rates of service utilization where data are available, and determine capacity requirements to serve LBHP Members.

We provide Geo-maps as **Attachment 10**. This report shows the provider network that will serve Louisiana Members.

iii. Describe how the Proposer's information management system will support NM and development. Suggested number of pages: 1.

VO-LA will use the ValueOptions' single platform information management system for all administrative functions of the SMO contract. To support network management and development, we use the NetworkConnect, ProviderConnect, and ServiceConnect applications. To analyze network needs, we use a Geo-Mapping application.

NetworkConnect is ValueOptions' Web-based provider credentialing program. It serves as a single repository of documents and activities related to each provider. Operating much like an electronic file cabinet, this system allows for the electronic storage and retrieval of all documents relating to provider credentialing and participation. Because our management information system, CONNECTS, is fully-integrated, information entered into NetworkConnect automatically feeds into the CONNECTS application suite to help manage claims payments, referrals to specific providers, provider service inquiries, and provider demographic changes, as well as application submission and/or recredentialing submission and review activities. NetworkConnect has the following features and benefits:

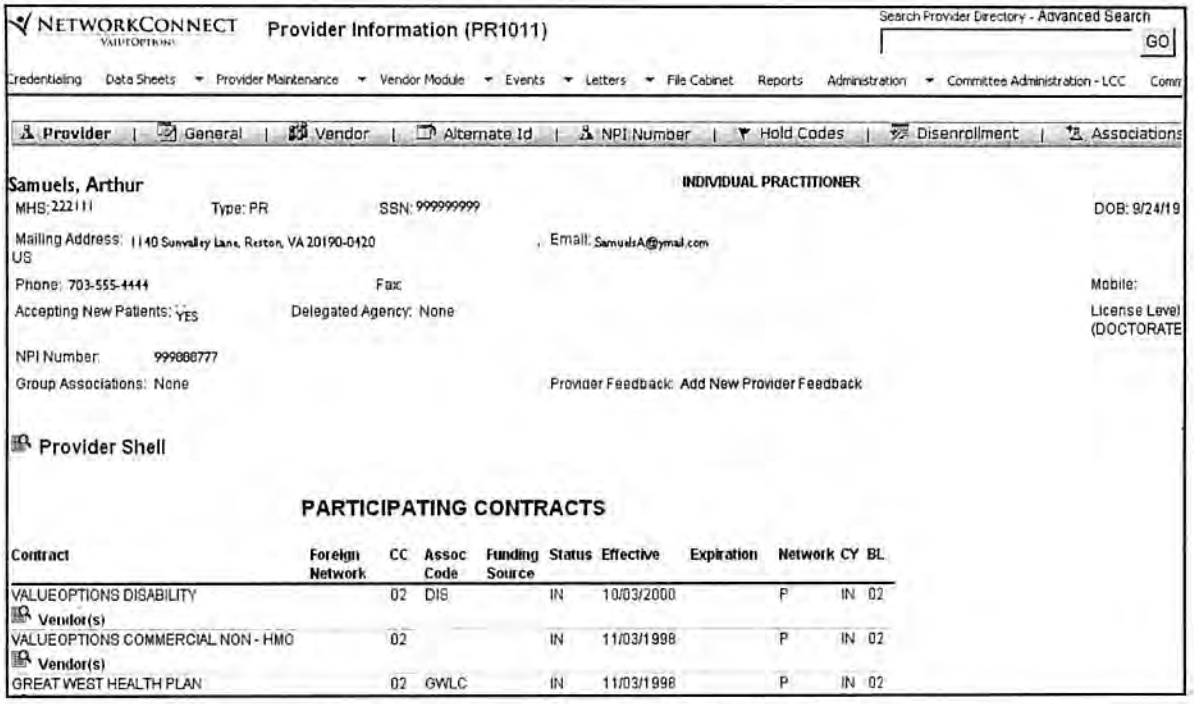
- automated tracking of expired documents (i.e., malpractice and licensure) via a report from IntelligenceConnect, and key timeframes (i.e., recredentialing cycles) to ensure accurate, up-to-date provider information for referral and claims payment
- secure multi-user, multi-location access to provider data to ensure accurate and timely information is available to all ValueOptions locations
- workload management capabilities that support electronic shifting of work among staff as necessary to meet deadlines and expedite provider credentialing
- in-bound and out-bound communication technology via multiple methods (e.g., e-mail and fax) to help maintain provider data accuracy without disrupting the provider's practice
- an audit module, which allows remote access to identified provider files and key elements allowing network audits to occur efficiently (i.e., without travel or movement of hard-copy files)
- "Electronic File Cabinet" providing immediate access to review all provider demographic, credentialing and contracting documentation specific to each provider and facility

NetworkConnect assigns each provider a unique identification number. It also can store multiple alternative provider identification numbers, such as the Medicaid ID or any other customer-assigned provider identification number. Each practice location or vendor is also assigned a unique NetworkConnect number for each different location. The combination of provider and vendor numbers identifies a specific provider at a specific location, and a separate file lists all the valid combinations of provider and vendor numbers. This automated provider numbering system eliminates duplicate provider records, thus ensuring accurate referrals and claims payment. It also mitigates the common customer concern regarding managed care companies offering "phantom networks" often comprised of repeated or duplicate provider names.

In addition to credentialing, NetworkConnect supports other critical processes involving provider network management. Fee arrangements, service pricing and controls, provider reports, and more can be managed to support the requirements our organization is expected to meet to maintain our accreditations and quality standards. In addition, the system includes built-in and customizable tools that allow:

- primary source verification, including automated access to key verification sources such as licensure boards and the National Practitioner Data Bank (NPDB)
- system-generated letters, guided by provider's method of choice (i.e., fax or email)
- automated medical director "approval" process based on system triggers and embedded credentialing criteria
- auto-population of critical claims payment data, resulting in quick and error-free loading of customer-specific fee codes
- field-level security and ongoing tracking of every system transaction (i.e., date, time, user,) to support quality control monitoring
- easy access to pre-populated provider performance reports

Please see the screen shot of the NetworkConnect Provider Information Screen on the following page.


NETWORKCONNECT Provider Information (PR1011)

Search Provider Directory - Advanced Search GO

Credentialing | Data Sheets | Provider Maintenance | Vendor Module | Events | Letters | File Cabinet | Reports | Administration | Committee Administration - LCC | Comm

Provider | General | Vendor | Alternate Id | NPI Number | Hold Codes | Disenrollment | Associations

Samuels, Arthur — INDIVIDUAL PRACTITIONER

MHS: 222111 Type: PR SSN: 999999999 DOB: 9/24/19

Mailing Address: 1140 Sunvalley Lane, Reston, VA 20190-0420 US Email: SamuelsA@ymail.com

Phone: 703-555-4444 Fax: Mobile:

Accepting New Patients: YES Delegated Agency: None License Level (DOCTORATE

NPI Number: 999888777

Group Associations: None Provider Feedback: Add New Provider Feedback

Provider Shell

PARTICIPATING CONTRACTS

Contract	Foreign Network	CC	Assoc Code	Funding Source	Status	Effective	Expiration	Network	CY	BL
VALUEOPTIONS DISABILITY		02	DIS		IN	10/03/2000		P	IN	02
Vendor(s)										
VALUEOPTIONS COMMERCIAL NON - HMO		02			IN	11/03/1998		P	IN	02
Vendor(s)										
GREAT WEST HEALTH PLAN		02	GWLC		IN	11/03/1998		P	IN	02

We can use NetworkConnect to update provider data

ProviderConnect is a Web-based application developed and maintained by ValueOptions' internal information technology staff that enables our contracted providers to conduct administrative transactions via a secure Internet portal accessible from their office computer. Designed to lighten the provider's administrative burden and capitalize on technological efficiencies, ProviderConnect enables providers to perform many routine customer service transactions via a secure website including:

- eligibility inquiries
- authorization requests
- submitting questions and requesting help
- educational tools
- Provider Handbook
- registering for provider forums and reviewing materials from previous forums
- outpatient care and registration
- inpatient registration/authorization

User Logon and Password

DHH-OBH can access a demonstration website at the following address: http://www.valueoptions.com/.

- Select the Provider tab, click on "Try the Demo" in the right hand column

Supporting Care Management and Administrative Efficiency

Providers can submit a request for service (electronic request for authorization) using a secure electronic method. When providers submit their request, the system generates an electronic notification to the provider. For outpatient requests, ValueOptions applies the client-specific clinical rules to define the number of sessions that can be authorized without clinical review. Once

providers submit the request for outpatient services, they are provided with an electronic message that notifies them that the services were approved, the number of units approved, and an authorization number that is systematically assigned to the case.

For higher levels of care, such as Inpatient Mental Health, Inpatient Detoxification, Partial Hospitalization Programs, Intensive Outpatient Programs, Child and Family Intensive Treatment, and Adult Intensive Treatment, the system ensures we meet our commitment to our clients to review these specific cases for medical necessity. Providers still have the ability to submit their requests via the request for service function. Instead of receiving an automated message of approval, the message will explain that our care management staff is reviewing their request and that they will contact the provider once a determination is made or if additional information is required.

The Utilization Manager (UM) then reviews the request for medical necessity and authorizes the services based upon the predetermined number of days as outlined in the benefit plan (i.e., five days for inpatient, three days for detoxification, and seven days for partial hospitalization). This process provides the UM with the appropriate clinical information to assess for case management and the discharge planning information when needed. Once the UM has made a final determination, based on plan requirements, VO-LA will update the system with the final decision and contact the provider verbally with the authorization parameters. An automatically generated letter is sent to the provider and the ProviderConnect site is systematically updated to reflect the status and number of units authorized.

Resources

ProviderConnect enables providers to focus on care delivery for Louisiana Members and CSoC Members. The website includes a Users Guide that outlines the various functions of ProviderConnect. It also includes a forms section, HIPAA resources, and tools to support our online services. Providers can access our comprehensive Provider Handbook that provides information about our administrative and clinical polices from this website.

Education Center provides access to our Achieve Solutions website, training resources and information on workshops and other tools. Providers can also access our online training tool CEQuick through the Education Center. CEQuick is a convenient way to earn continuing education credit through engaging courses that provide concise, comprehensive information that will help you acquire new skills and learn about current research. In addition to CEQuick we will provide customized training for Louisiana providers via EssentialLearning which is discussed later in response to Question 2.e.ix later in this section.

Compliance Section includes information related to current legislative initiatives and laws governing behavioral health care service delivery. The site also includes access to a variety of relevant tools, trainings and forms that help providers reduce their administrative burden, and the cost of doing business.

ServiceConnect

ValueOptions' staff documents all complaints, grievances, appeals and related activities and outcomes into the ValueOptions' ServiceConnect system. Member Service Representatives and other VO-LA provider staff, as appropriate, will record and document all grievances they receive, and any they are able to resolve, in ServiceConnect. The information entered is then submitted to a work queue that is monitored daily by the Grievance and Appeals Administrator.

Geo-Mapping

VO-LA will use Geo-Mapping software to analyze the adequacy of the provider network, including Geo-mapping and density reports and all of the data gathered and analyzed. We have attached samples of our Louisiana provider geo-mapping based on our current network and the providers who have committed to be part of the SMO network through the LOIs as **Attachment 11**.

iv. Address the Proposer's experience with contracting for services typically provided by child welfare and juvenile justice agencies that are funded through State general funds or Grants (i.e., not Medicaid-reimbursable services). Suggested number of pages: 2.

ValueOptions has nearly 20 years of experience contracting with state agencies that provide child welfare and juvenile justice services through both our Texas NorthSTAR and New Mexico public sector contracts. We have operational experience and capacity to handle funding such state agencies through general state funds and public grants. We can and have developed contracts to include state agency services into our network utilizing state provided guidelines and requirements. We have contracted with agencies that provide the following child welfare services:

- Family Preservation
- Family Support
- Parent Education and Training
- Family Reunifcation
- Post-placement Adoption Services
- Therapeutic Foster Care
- Independent Living

We have also contracted with agencies that provide the following juvenile justice services:

- Intensive Supervision
- Parent Education and Training
- Independent Living
- Restorative Justice
- Diversion
- Gender Specific Programming for Juveniles
- Alternative Schools

Many of our public sector clients seek coordinated services between behavioral health, social services child welfare and juvenile justice programs to assure limited financial resources are used appropriately and efficiently. ValueOptions' Braided Funding℠ system helps our clients reduce costs and improve Member care by eliminating service gaps and duplicative processes. Braided Funding allows contracting and fund management with a variety of provider who typically are not funded by Medicaid but may be funded by: ATR, MH and SAPT Block Grants, IV-E, IV-B, OJJDP Block Grants and Discretionary Grants. Braided Funding takes advantage of our robust IT systems to reduce costs and improves Member care by identifying and eliminating service gaps and duplicative processes.

ValueOptions' Braided Funding applies new and innovative technology to increase efficiency and effective monitoring to enable client's to assess funding availability and program success. Using our Braided Funding program, our clients can deliver cost effective, coordinated services by blending multiple funding streams and program operations. Our programs feature sophisticated financial management systems that track and report on expenditures and services for individuals across multiple funding streams. Our staff facilitates inter-agency planning and coordination, both at the system level and for individual treatment planning, to increase efficiency, effectiveness, and improve clinical outcomes.

Braided Funding Successes -- Kansas Department of Social and Rehabilitation Services

ValueOptions began administering the Substance Abuse Prepaid Inpatient Health Plan (SA-PIHP) for the Kansas Department of Social and Rehabilitation Services in July of 2007. Much like Louisiana, on behalf of the Department, ValueOptions of Kansas (VO-KS) manages substance abuse services provided through Medicaid as well as through Substance Abuse Prevention and Treatment block grant funds. The Division of Addiction and Prevention Services supervises the contract, which covers some 320,000 Medicaid beneficiaries as well as persons eligible for block grant services. Braided Funding has helped the Kansas Department of Social and Rehabilitations Services save $5 million since 2007.

Since 2007, ValueOptions Braided Funding has helped KDSRS save $5 million

Texas Department of State Health Services

In 1999, ValueOptions became the managed behavioral health organization for NorthSTAR, a behavioral health managed care project that fundamentally reformed the structure of public behavioral health services in a seven-county area around Dallas. The NorthSTAR program provides an integrated system of care with mental health care and chemical dependency services supported by multiple programs and funding sources, including the Texas Commission on Alcohol and Drug Abuse, Health and Human Services and Department of Mental Health and Mental Retardation. NorthSTAR created a single, coordinated system of care, offering beneficiaries a comprehensive benefit package. Six new community mental health providers emerged to offer crucial specialty services to Members in both rural and urban areas. ValueOptions of Texas has a strong prevention, education and outreach department that employs beneficiaries and family advocates who act as internal change agents and bring beneficiary and advocate perspectives to our organization. NorthSTAR was one of the first Medicaid waiver programs in Texas to integrate Medicaid, TANF, general revenue and Substance Abuse Block Grant funds. In four years, the program saved $20 million in Medicaid funds.

Illinois Department of Human Services

ValueOptions began serving as the Administrative Services (ASO) for the Illinois Department of Human Services' Division of Mental Health (the Division) in December 2007. This initiative, called the Illinois Mental Health Collaborative for Access and Choice, has improved the Division's capacity to serve mental health Members and their family Members. ValueOptions provides key administrative functions as the Division transitions from a grant-based to a fee-for-service financing system. Additionally, ValueOptions reviews requests for services and treatment and assures the appropriateness of the community and hospital-based mental health services for which the Division is responsible. Services requiring review are being added incrementally and include those funded

through Medicaid, block grant and state dollars. The contract covers the 166,000 Illinois residents who use Division-funded services and the approximately 200 providers who serve them. On September 1, 2008, using the ValueOptions Braided Funding system, we began to administer claims transactions incorporating 20 different funding streams. Claims payment administration is no longer provided for this contract as of July 1, 2011.

v. Provide an example of how the Proposer has developed, organized, or implemented another public sector mental health and substance abuse provider network to successfully achieve system goals similar to those outlined in the RFP. Provide a contract from a contracting agency that can verify the Proposer's experience. Suggested number of pages: 2.

ValueOptions has implemented public sector networks serving adults and children in various forms and structures, and has developed partnerships with provider organizations in urban, suburban and rural areas. The same staff that supported many of these implementations in other states will support our work in Louisiana. Many of these programs required large and multi-faceted networks similar to the one in Louisiana, such as our ValueOptions' networks in Arizona, Colorado, Florida, Pennsylvania, New Mexico, and Texas.

Some of our major strengths and advantages include:

- the longest term public sector behavioral health experience
- more experience with diverse populations
- experience building community-based care and moving services to a Recovery and Resiliency focus

EXAMPLE OF SUCCESSFUL NETWORK DEVELOPMENT

The following narrative demonstrates how ValueOptions of Texas (VO-TX), VO-LA's sister company, implemented a MHSA network to successfully achieve system goals. ValueOptions of Texas has managed the NorthSTAR contract under a full risk public sector contract since 1999.

In the Beginning: Transitioning to Managed Care

The LBJ School's Independent Assessment provides the historical context:

State administrators and local planners of NorthSTAR encountered much opposition, visibly from the Community Mental Health and Mental Retardation Centers (CMHMRs), and their representative body the Texas Council of Community MHMR Centers. Less visibly, there were also advocates and other providers who were skeptical about the potential adverse effect of such a system change. The CMHMRCs were the primary providers of public behavioral health services in their respective areas Before NorthSTAR, the centers were paid prospectively for services for both Medicaid members and the medically indigent. The centers resisted the transition to NorthSTAR because they lost their status as the local mental health authority. They also lost their lump sum payments and some of their clientele.[1]

[1]. Lyndon Baines Johnson School of Public Affairs, The University of Texas. *NorthSTAR: A Successful Blended-Funding, Integrated Behavioral Health Carve-Out Model.* September 2003. p. 2

The transition from a provider payment system based on program funding to one that requires providers to bill for services provided was the first major opportunity for VO-TX to work cooperatively with Texas state agencies in effecting system change. The transition process for members and families was an equally important emphasis for both the state agencies and our staff.

The transition process offered VO-TX an opportunity to develop a strong working relationship with our provider network—one that continues to exist today. With the support of the Texas Department of Mental Health Mental Retardation (TDMHMR-now incorporated into the Texas Department of Health Services) as well as the Texas Commission on Alcohol and Drug Abuse (TCADA), our staff provided written materials, in-service training and one-on-one, on-site training to support the agencies and individual practitioners. VO-TX also was the only Behavioral Health Organization (BHO) to establish separate, regular meetings with the Special Provider Networks (SPNs), which further supported their transition to a managed care environment. The most significant change for the providers was the necessity of tracking, billing and reconciling claims. Almost all of the original providers in the NorthSTAR catchment area remain as network providers, and 95 percent of all claims are electronically filed today.

Transition for Members

When the original plan to begin NorthSTAR with Medicaid and indigent members was not possible, ValueOptions and the State collaborated to develop processes that allowed NorthSTAR to begin as scheduled. On July 1, 1999, the medically indigent population was transitioned into the NorthSTAR model. On December 1, 1999 the Medicaid population was transitioned. Both transitions were smooth and seamless to the member population.

Working Cooperatively to Improve Services and Accountability

Cooperation with state and federal agencies certainly did not end after the initial start-up period. Almost every facet of our work as the BHO for the NorthSTAR program requires ongoing cooperation with state and federal agencies as well as local stakeholders.

Combining BHO Membership and Responsibilities

On July 27, 2000, TDHMR announced the transition of 130,000 new members to ValueOptions' care from the network of another managed behavioral health care company. VO-TX worked cooperatively with TDHMR, TCADA, providers, and members to honor all outstanding services and authorizations. VO-TX also expanded its provider network to encompass all NorthSTAR providers who were not previously ValueOptions providers. The transition process resulted in no serious disruptions for members, families or providers.

On a smaller scale, but equally important, VO-TX worked with state agencies and providers to assist in two subsequent transitions when the Hunt County MHMR and Johnson/Ellis/Navarro MHMR agencies both were required to transfer their responsibilities for NorthSTAR enrollees to other agencies. In both instances, VO-TX assisted county and regional officials in facilitating changes in authorizations to the new agencies, identifying high need members for the receiving agencies,

notifying members of the transition, and in explaining its impact. Similar to the larger transition process, the changeovers were accomplished without disruption to members, providers or the overall delivery system.

Dr. Matthew Ferrar, Office of NorthSTAR and Special Initiatives, Department of State Health Services. (512) 206-5470 can verify this achievement.

vi. Describe the Proposer's approach to contracting with the current provider delivery system in a new client state to assure continuity of care during the program start-up and implementation period. Describe how the Proposer will transition providers that do not meet credentialing requirements or do not offer services covered by Medicaid or other funding sources identified by DCFS, DHH-OBH, DHH-OCDD, DOE, and OJJ. Suggested number of pages: 4.

We are committed to including providers who have traditionally served the Medicaid population to be a core part of the Louisiana network. In each of our programs, ValueOptions works closely with Human Service Districts (HSDs), community mental health providers, public hospitals, and psychiatric hospitals to ensure their ability to meet credentialing requirements and become a vital component of the network.

We prioritize strong relationships with these providers, often called the "safety net" (and in Louisiana that often is the HSDs or the State Clinics) or community-based providers, because they have a keen understanding of underserved populations and have a mission that parallels our own. These providers also support the cyclical nature of Medicaid Members and are more accepting of the tendency of this population to move between providers. Another strength is that they typically have additional social services and other human service resources that are not available from many other providers. These services, including counseling and education, food and clothing banks are services that may be unavailable or inaccessible to Members without safety net providers.

In our time Louisiana meeting and recruiting private practitioners, Psychiatric Residential Treat Facilities (PRTFs), Group Homes, HSDs, and Peer Organizations, we learned of their concerns regarding credentialing. We know that the PRTFs are most concerned about the staffing ratios and continue to express concern over being able to maintain these ratios under their current financial obligations. However, with the transition of the block grant funding over the course of the SMO, these providers will also have some time to meet the credentialing needs before relying as heavily on Medicaid dollars.

VO-LA will first identify the number of providers needed in terms of training, experience, and specialization. The process will identify the geographic location of each provider in relation to the individuals who require such services. This process will assist provision of needed services, and address travel time and associated access issues that are consistent with the ultimate goal of having the recovery and resiliency oriented community based services in each Parish or Local Governing Entity (LGE) at a minimum.

Our current network in Louisiana contains over 1,200 providers with an additional 496 committed to joining our network under this contract. The benefit of this network will be to serve as the foundation to building the base of providers to participate in the program. With alliances already in

place with the many of these providers, we will use our current relationships to recruit new providers. We will maintain a provider database to assure that Members who are seeking care will be able to access the appropriate resource. We will hire 10 Provider Relations staff, who will be located in strategic locations across the state. The Provider Relations staff will explain the responsibilities of being a provider. We will provide the DHH-OBH with the name of the providers who are interested in providing services to the Members and also notify the DHH-OBH when a specialist elects not to participate and the reasons for non-participation.

Regionally-based Provider Relations staff will also play an active role in network recruitment and supportive training to ensure recovery and resiliency oriented services. They will monitor provider availability in each Parish and will establish positive relationships within the communities to support provider network development.

Our process for constructing and refining our network development plan will be an incremental one that minimizes disruption of care and maximizes participation by the current providers in the system. Stability and viability of the current provider network is our initial goal. In subsequent years, as the system matures, we will propose redesign and other network development initiatives to enhance the State's vision of a unified system of care that embraces the concepts of resiliency, recovery, and empowerment.

In addition, VO-LA's parent organization, ValueOptions, is currently contracting providers in Louisiana to serve the State's employees for the Office of Group Benefits contract. We have contracted 1,200 providers and continue the development and contracting processes. Also as part of this contracting effort, we are requesting the providers to sign LOIs for the SMO program. As of August 5, 2011, we have obtained LOIs from an additional 496 providers. Details regarding these providers can be found in our response to *Question 2.e.vii* later in this section of this proposal. We provide the LOIs as **Attachment 11**.

The lack of specialists in many of the rural Parishes creates a challenge to providing adequate access to care. While most of these rural areas may have providers, they may not have all the necessary specialties. Many Members face social, economic and health maintenance challenges that cause the need for specialty services. Therefore, there will be constant requirement and associated due diligence in promoting both availability and access for services required.

ValueOptions' Telehealth in Florida demonstrated a 300% increasing of services and doubling of clients served prior to the service being available in one program and provider satisfaction with the program has been 100%.

A powerful strategy increasingly used in other states is telemedicine. It links rural areas with specialty care providers in other locations and builds on the work of the Louisiana Rural Health Information Exchange. We have already successfully implemented telemedicine programs in support of our public sector clients in several states. For example, we currently operate a telemedicine program in support of several rural Pennsylvania counties. The telemedicine program provides child psychiatric services to Member's in rural locations that otherwise would not have access these specialists. We also operate telemedicine programs in two other states. Based on this experience, we will develop a telemedicine program suited for underserved areas of Louisiana.

Transitioning Providers who do not meet Credentialing Requirements

VO-LA will follow our corporate policy that allows exceptions to the credentialing criteria when there is a need for a practitioner or provider to meet access standards, specialty, cultural competency or other requirements mandated by state or federal law. Our National Credentialing Committee (NCC) must review and approve all exception requests. The NCC may consider granting exceptions to established credentialing criteria/policies under the following circumstances:

- access and availability needs (underserved geographic locations or inability to obtain appointments in appropriate timeframes)
- specialty (training and/or expertise)
- cultural competency (experience / expertise with cultural / ethnic groups)
- mandated legal requirements
- unique circumstances requiring flexibility in credentialing criteria or policies

The DHH-OBH can be assured of our experience in recruiting and transitioning providers. In Tennessee, ValueOptions built an ABA network, expanded Supported Housing for the medically fragile population, and implemented recovery and resiliency initiatives to support members in community-based settings. Our inpatient utilization has decreased dramatically since the beginning of the contract even though we manage the most adversely selected population with TennCare.

vii. Describe how the Proposer will secure sufficient numbers of providers to assure service access on Contract Start Date. What barriers are anticipated with having sufficient access by Contract Start Date? What strategies would the Proposer employ to address these barriers? Identify any staff or subcontractors who will facilitate the transition and discuss their qualifications. Suggested number of pages: 3.

For the past several months, ValueOptions has been actively recruiting providers to participate in the VO-LA network. The first step in the recruitment process was to develop a network assessment identifying essential and available providers throughout the State. Resources used to identify key providers included the list of Medicaid provider available on the Louisiana DHH website, required provider types identified in the RFP, lists of BUP and addiction treatment centers, the SAMSHA website, the NAMI website, direct contacts with the HSDs, the our current commercial network and individual provider websites.

Once the initial network assessment was completed, a strategy was developed to target facilities, groups, and individual practitioners in the most populated cities/Parishes of Louisiana.

City	Parish
New Orleans	Orleans
Baton Rouge	East Baton Rouge
Shreveport	Caddo
Metairie	Jefferson
Lafayette	Lafayette
Lake Charles	Calcasieu
Monroe	Ouachita

Providers were contacted via email, phone, fax or regular mail with an introductory letter, a FAQ document, an LOI, and a Provider Information Form. Interested providers were asked to sign the LOI and return it to ValueOptions with a completed Provider Information Form.

Once providers in the initial phase were contacted, efforts were expanded to include providers located in all other areas of the State. By mid-July, we had attempted to reach 100 percent of the providers on the master network assessment list through one of the methods listed above. We researched for updated information and mailed or faxed an invitation to participate in the network for providers that we were unable to reach due to incorrect mailing address or phone numbers

To increase the outreach to independent practitioners, we also approached the State chapters of various professional organizations to assist in communicating the network participation opportunity to applicable behavioral health and addiction treatment professionals. The table below provides the detail on which organizations were contacted and the activity that has taken place to date:

Organization	Contact	Licensed Professionals	Communication
American Psychiatric Nurses Association – Louisiana Chapter (APNA)	Tari Dilks, President	APRNs	On 7/11, the organization sent an email message to all members with an invitation to participate in the LA-VO SMO network.
Louisiana Counseling Assoc (LCA)	Diane Austin, President	Licensed Professional Counselors (LPCs)	The organization sent an email out to all LPCs in the state on 6/13 with the LOI documents attached. LCA also provided us with a mailing list of all LPCs that had no email addresses. We mailed documents to these LPCs the week of 6/21.
Louisiana Behavioral Health (LBH)	Becky Thibodaux	CMHCs	The organization invited ValueOptions senior management to attend a member meeting on July 13th where recruitment materials were disseminated to interested providers
Louisiana Chapter--National Association of Social Workers (NASWLA)	Carmen Weisner, ED	Licensed Clinical Social Workers (LCSWs)	The organization posted the ValueOptions invitation for network participation on the member link on their website.

Organization	Contact	Licensed Professionals	Communication
Louisiana Association of Substance Abuse Counselors and Trainers, Inc. (LASACT)	Marolon Mangham	LACs, RACs, CACs	The organization sent an email out to all licensed, certified, registered and in-training addiction professionals and prevention specialists on 6/27 with the recruitment documents attached

ValueOptions also purchased mailing lists of all Licensed Clinical Social Workers (LCSWS) from the Louisiana State Board of Social Work Examiners and all Psychologists from the Louisiana State Board of Examiners for Psychologists. A mailing was completed to professionals on these lists (approximately 3,300) the first week of July 2011. Although the network continues to grow as we receive LOIs on a daily basis from interested practitioners, the table below provides the detail on practitioner network development efforts as of August 5, 2011.

Provider Type*	ValueOptions current Louisiana Providers	Additional Providers with signed LOIs
Psychiatrists	118	2
Psychologists	98	20
LCSWs	270	105
Licensed Professional Counselors (LPC)	150	75
Licensed Addiction Counselors	0	16
Other licensed professionals	23	2

*Many of the independent practitioners hold more than one type of licensure (i.e. LPC/LMFT, LCSW/LAC).

ValueOptions has also been aggressively pursuing LOIs with facility providers throughout the state. Below is a table indicating our progress as of August 8, 2011.

Provider Type*	VO LOIs	% of the available network*
Human Service Districts	5	100%
OBH Regions	3	80%
OBH MH Clinics	HSDs and Regions (6)	92%
MH Rehabilitation	20	23%
MST	9	36%
Therapeutic Foster Care	1 (Louisiana Mentor)	100%
Wraparound Agency	1 (NHS Human Services	100%

Provider Type*	VO LOIs	% of the available network*
Family Support Organization	2	100%
Residential Treatment	6	19%

*As listed in the document "Potential CSoC Louisiana Provider Information" located in the DHH procurement library and other resources available on the DHH website.

Other LOIs for both public and private providers have been obtained for the following services:

Provider Type	Number of Sites
Inpatient Mental Health	27
Inpatient SA	8
IOP	10
PHP	11
Outpatient BH/SA*	119

*Excludes private practitioners

ValueOptions has also established LOIs with the following:

- The two Family Service Organizations (FSOs) selected by the state, Families Helping Families of Greater Baton Rouge and Families Helping Families of Jefferson
- The Wrap Around Agency (WAA) selected by the state for the Capital Area HSD (CAHSD) and the Jefferson Parish HSA (JPHSA), NHS Human Services, and;
- The state's contracted provider for Therapeutic Foster Care, Louisiana Mentor

Eliminating Barriers

The three primary barriers to contracting providers were:

1. An unwillingness to engage in the LOI process but a stated intent to participate with the organization eventually awarded the SMO contract. ValueOptions has been documenting all contacts with providers regarding the LOI process and noted those providers that have expressed an interest in becoming part of the network once the vendor has been selected for the SMO. For all of these providers, most of whom are the acute hospitals, upon notification of award, VO-LA implementation staff will reach out to the designated contact to facilitate the contracting process.
2. A historic focus on traditional clinical-based services and a need to re-tool services to be recovery and resiliency focused has been a source of trepidation for some private providers during our due diligence discussions.
3. A lack of understanding about the proposed changes and the impact of those changes. While DHH-OBH has been working diligently to provide information regarding the changes and opportunities that the SMO brings about for providers, we continue to receive questions about reimbursement, credentialing, staffing ratios, training, and licensure, to name just a few. We have already had significant dialogue with all of the HSDs regarding technical issues (such as batch load of files from their Anasazi systems) into our CONNECTS as well as clinical issues regarding expanding their use of EBPs. In addition, we have met with individual providers who have expressed concerns ranging from obtaining a Medicaid number, meeting credentialing standards, reimbursement rates, CEUs, staffing ratios, and the movement towards more

community-based care. The key to addressing these issues will be ongoing provider forums across the State, as well as Webinars dedicated to a series of "How To" sessions:

- How to be a Medicaid provider
- Licensure and Credentialing\Certification Issues
- Implementation of EBPS
- How to submit an authorization
- How to submit a claim
- How to provide services under the rubric of the SMO
- Family Inclusion in Service Planning
- Recovery and Resiliency Focused Services
- Relapse prevention planning with Members and Families
- Communicating Advance Directives

This is a start-up list that will be constantly updated and addressed via trainings, Webinars, FAQs and technical assistance.

ONGOING STRATEGIES - SINGLE CASE AGREEMENTS

Should a specialized network provider not be available within a specific service location, VO-LA will work with a local provider to establish a Single Case Agreement (SCA). ValueOptions has a specially trained administrative staff to perform SCAs, and agreements are reviewed on an ongoing basis to ensure that they meet medical necessity criteria. We will perform a SCA in any circumstance where Members' and CSoC Members' needs cannot be met with our existing provider network. Specifically, SCA requests are performed when:

- there are no network resources for medically necessary care within 30 miles/30 minutes of an individual's residence (Note: these distances may be altered to DHH-OBH specifications)
- our network facilities are full
- our network practitioners are not accepting new patients
- clinical needs (e.g., clinical specialty, language, cultural sensitivity, gender) cannot be met by available network resources
- Member preferences cannot be met by available network resources and are deemed relevant to treatment outcome
- a single case agreement supports necessary continuity of care for a Member with a history of treatment with an out-of-network provider
- transportation available to a Member enables the Member to access only an out-of-network resource
- the available network resources believe they cannot meet the Member's treatment needs
- a network facility is not participating for a specific required modality
- a network facility assigned a non-network practitioner to the Member
- participating practitioner utilized a non-participating practitioner for coverage
- a participant requires emergency treatment and/or admission
- the facility/practitioner terminated network status during the Member's course of treatment
- medically necessary psychiatric consultations are required on a medical unit and a participating psychiatrist is not available

- during new client transition as part of client implementation plan
- an administrative decision has been made by the client or ValueOptions to approve a single case agreement

OUT-OF-NETWORK CARE

Should a provider be unwilling to establish a SCA, the Medicaid and CSoC Members will have the option of seeing an out-of-network provider.

viii. Describe the Proposer's plan for expanding the network to include family-based and community services for the 650-750 children/youth currently in out-of-home placements. Discuss the approach to developing alternative services including:

a. Input from the Proposers' CM and UM staff
b. Input from individuals, families and system stakeholders
c. Establishment of priorities for network development
d. Assessment of current provider capabilities, and
e. Collaboration with DHH-OBH in plan development

Suggested number of pages: 4

NETWORK EXPANSION PLAN

The first step in expanding the network to include family-based and community services and identifying the alternative specialized services needed in our network is gathering data and input. Methods used to collect this information include both internal and external sources—Members, their families, stakeholders and advocates (via community forums, Regional Teams, Member and Family Advisory Committee, member service data, satisfaction surveys, regional QA/PI committees), and DHH-OBH. For example, for our former Arizona contract, development of Clarendon House, a community residential placement for youth age 18 to 25, was the direct result of a concerned mother's participation in a Child and Family Team.

Additionally, VO-LA staff will:

- review and analyze quality and network data (including pharmacy, crisis, customer complaints, Geo-Mapping) and monitor access to appointment availability, SCAs, Process Improvement Reviews, or on-site clinical record reviews
- conduct ongoing Network Sufficiency Analysis, including network inventories
- coordinate with State, LGE, Court or other stakeholder agencies
- use new technologies to identify unmet needs data, aggregated through CareConnect and ProviderConnect systems
- support initiatives and priorities of DHH-OBH

Recruitment of Specialized Providers

Recruitment of behavioral health providers qualified to provide specialized services, such as ACT and crisis teams, is somewhat different than those methods required for providers who offer basic covered services. As the transition process moves forward, VO-LA will work closely with local providers to augment specialized services. Additional considerations, such as credentialing, licensure, specialized training, and local government requirements and restrictions on community placements present unique challenges.

To recruit these specialty providers, VO-LA uses a competitive procurement process. This process includes an evaluation of proposals based on clinical expertise, experience working with the identified issue, and financial considerations. In situations where the need is more urgent, we by-pass the competitive procurement process and secure the service as quickly as possible through known providers. If we use an out-of-network provider, a programmatic review is completed expediently to ensure appropriateness of services.

We also maintain a prospective provider process. We review services of non-contracted providers who are interested in contracting with VO-LA. Our program development staff complete a programmatic review with all prospective providers and submit a summary report to the Executive Management Committee. If the services offered do not meet a current need or an annual network development plan goal, the provider's information (including services offered) is entered into a prospective provider database that can be accessed for single case agreements or future system initiatives. Additional strategies include:

- ***Local Development Activities***—education, training and conferences in the community to generate knowledge of and interest in evidence-based or emerging practices in behavioral health. For example, we increased the number of trained DBT therapists through our extensive DBT training program in another state
- ***Conversion of Traditional Service Programs***—by providing technical assistance, program specifications and support, and developing partnerships with providers, traditional service programs can be transformed into specialized services
- ***Incentives and Contract Requirements***—designed to facilitate provision and expansion of specialized services by providers, and to maintain fidelity to evidence-based models of treatment
- ***"Preferred Provider" Status***—ensuring specialized providers who meet more stringent credentialing and privileging criteria receive competitive rates

ix. Describe the resources for providers to obtain information about covered services, billing requirements, payments, and training, or other resources. Suggested number of pages: 1.

VO-LA's Provider Relations staff are available to assist providers with any questions they may have. The role of Provider Relations is to provide education, outreach, and support for the provider network in all interactions with VO-LA from covered services, credentialing, contracting, authorization, claims payment, training and other resources.

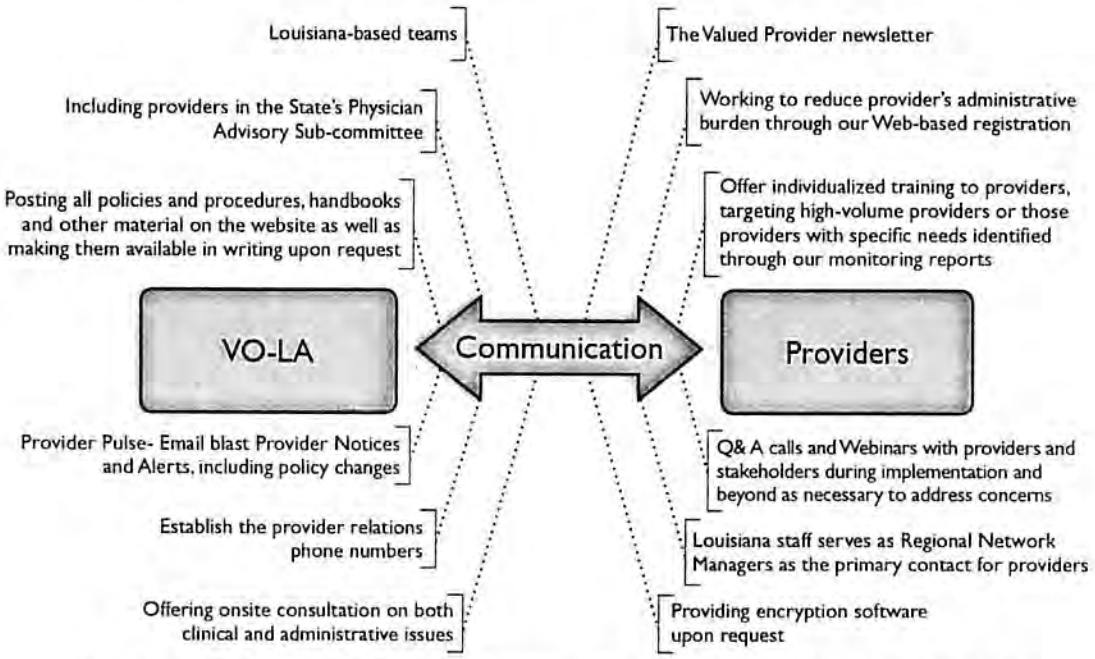
PROVIDER RESOURCES

VO-LA will offer providers a comprehensive information infrastructure that assures providers are both continuously informed of our programs and services as well as offered an opportunity to provide us with meaningful feedback. Recognizing that communication vehicles must be varied and frequent, we have developed a myriad of approaches including:

- ProviderConnect website information
- Web-based Message Centers
- ValueOptions' Provider Handbook
- Essential Learning

- "The Valued Provider" Provider Newsletter
- Provider Pulse – automated voice messaging software
- face-to-face provider forums
- Webcast forums
- individualized face-to-face meetings or provider site visits

Practitioners can provide input for our Clinical Criteria, proposed practice guidelines, clinical quality monitors and indicators, new technology and other vital issues concerning our policies and procedures. We also solicit their assessment and evaluation of the credentialing and recredentialing process and input regarding sanctions that result from provider performance issues.



VO-LA provider education and outreach services result in better care for LBHP Members.

All network providers are required to maintain their license(s) for their specific field(s) of practice. State and federal licensing boards have established specific guidelines for completion of Continuing Education Units (CEUs), and the timeframe for their completion. In order to meet license renewal requirements, all ValueOptions' providers are responsible for completing the requisite number of CEUs for their license(s). To aid in this process, VO-LA will use Essential Learning, an online behavioral health training provider, as a primary part of our training platform for providers in Louisiana. Essential Learning is the largest provider of e-learning services for the behavioral health, mental health, child welfare and human service industry. This is a completely Web-based application. No application software is installed on the provider side and all application activity occurs on a Web browsers. The service offers an extensive online course library on mental health, addiction, and many other materials. Through this portal, VO-LA can upload training materials including PowerPoint, audio and video presentations for provider staff to view and complete from any location with Internet access. The users who complete the training can be tracked and reported on for each facility. We will integrate the outcomes and measures from Essential Learning into our overall reporting structure.

x. Describe how the Proposer will develop service alternatives to unnecessary inpatient utilization for children and adults, including those with addictive disorders. Discuss strategies the Proposer has used to develop services that divert individuals from non-medically necessary inpatient care, decrease length of stay, and prevent readmissions. Discuss the approach for developing services alternatives, including:

VO-LA's Quality Management Specialists and Regional Provider Relations staff will perform random audits to ensure that services are tailored to the customer and are individualized according to the individual's assessed needs. Records will also be reviewed when they are submitted as part of the utilization management process or in appeal and grievance hearings. Information collected through these reviews of records will contribute to the overall assessment of provider performance. Should a provider be found deficient, VO-LA will work with the provider on a plan of correction. Should deficiencies continue, the concerns would become part of the overall re-credentialing process.

(a) Input from the Proposer's CM and UM staff;

In particular, our Regional Care Managers will be living and working in the regions that they serve. This is an invaluable resource for determining what the service needs are for each of the communities as well as for identifying providers that may be able to expand their capabilities.

(b) Input of individuals, families and system stakeholders;

Family input at all levels of the system is crucial to identifying services needed to divert from unnecessary inpatient hospitalization. Perhaps one of the best approaches to such a diversion is ensuring that those instances when a child is hospitalized, truly engage the family in returning, and maintain, that child in the community. ValueOptions has successfully implemented such a program in our Connecticut contract.

Example of Strategic Importance - Connecticut Family Involvement

In 2009, our Connecticut Behavioral Health Partnership (CT BHP) initiated a goal to address the improvement of family engagement in the inpatient treatment of youth, a crucial aspect of care, and created a performance initiative for this purpose. Family members of youth who had recently experienced inpatient treatment in Connecticut were invited to participate in the workgroup and assisted in the development of this goal. Ultimately, the eight inpatient hospitals agreed to an initiative that included both the creation of an ongoing Family Support Group at each of the facilities, as well as the development of an Individualized Plan for each Member admitted to the hospital. The performance period for this goal was the first quarter of 2010.

Measures used for this goal included the rate of the hospital offering the family support group as well as the rate of participation in the Family Support Group. While only the rate of offering the group was used to assess performance on this indicator, the rate of participation in the group was used to establish a baseline measurement. To earn the entire 0.5 points for this indicator, the facility was required to provide documentation that they implemented and sustained the Family Support Group for the entire performance period (January 1, 2010 through March 31, 2010) and that they had documentation that demonstrated that 90 percent of the eligible families were offered participation in the group.

Each hospital agreed to create a mutually agreed upon individualized communication plan (ICP) with the family within 24 hours of admission of each youth admitted. To earn the entire 0.5 points for this indicator, the hospital was required to provide documentation that they established or had documentation of an attempt to establish an ICP within 24 hours of admission with 90 percent of the families. They were eligible to earn 0.25 points if they had documentation that they established or documented an attempt to establish an ICP within 24 hours of admission with <90 percent but > 75 percent of the families.

While each of the participating hospitals submitted proposals regarding the format and method for documenting their Family Support Groups, at the time of audit many of the hospitals lacked the specific documentation required to earn points. With respect to the implementation of the ICPs the majority of the hospitals also lacked sufficient documentation to earn points for this indicator. The outcome for this goal is reported below.

Outcome Goal II:

- ***Indicator 1, Creation of a Family Support Group***: Results for this indicator reveal that three out of the eight inpatient facilities earned maximum points (0.5) for this indicator.
- ***Indicator 2, Creation of an Individualized Communication Plan***: Results for this indicator showed that six out of the eight hospitals earned zero points, one hospital earned 0.25 points and one hospital earned the maximum points of 0.5. The chart below reveals the performance results.

Pediatric Psychiatric Hospital Performance Initiative SFY 2010					
	Goal 2				
Hospital	Goal 2 Indicator 1 Family Engagement	Goal 2 Indicator 1 *Points Earned* (out of 0.5)	Goal 2 Indicator 2 ICP	Goal 2 Indicator 2 *Points Earned* (out of 0.5)	Total *Points Earned Goal 2* (out of 1)
	0/30 = 0%	0	0/30 = 0%	0	**0**
	29/30 = 97%	0.5	0/30 = 0%	0	**0.5**
	15/18 = 83%	0	6/18 = 33%	0	**0**
	4/30 = 13%	0	0/30 = 0%	0	**0**
	30/30 = 100%	0.5	18/30 = 60%	0	**0.5**
	30/30 = 100%	0.5	28/30 = 93%	0.5	**1**
	6/17 = 35%	0	13/17 = 76%	0.25	**0.25**
	23/30 = 77%	0	16/30 = 53%	0	**0**

Throughout 2010, the Pediatric Inpatient provider workgroups continued to meet on a regular basis. Workgroup discussions focused on methods for maintaining efficient lengths of stay, stabilizing re-admission rates, enhancing discharge planning practices, and continuing to improve family engagement strategies.

In addition to the workgroup meetings, the quarterly pediatric inpatient Provider Analysis and Reporting (PAR) meetings continued to occur. These meetings are conducted by the Regional Network Management (RNM) team and attended by the CT BHP Medical Director and/or additional CT BHP staff as necessary. In prior years, the provider's utilization data was reviewed and analyzed with providers using paper data profiles to guide the discussions. In August of 2010, CT BHP rolled out a Pediatric Inpatient Web-based Dashboard. This Web-based report not only enables the RNM team to review pediatric inpatient hospital provider data during the quarterly meetings, but also enables providers to monitor their own facilities' utilization for HUSKY youth. They can also view other in-state pediatric inpatient facility data. A wide variety of data points including graphs on length of stay, discharge delay, aggregate demographic information regarding members treated, DCF area offices associated with members treated, case mix, and re-admission rates are able to be viewed. The Dashboard data refreshes each business day, enabling providers to view their utilization in real time. Data can be viewed in monthly and quarterly and yearly increments.

(c) Establishment of priorities for network development;

Upon contract award, VO-LA will begin holding provider education Webinars and onsite education sessions to address what the change to the SMO will mean for them. As we have engaged in the process of developing LOIs for this RFP, numerous providers have asked questions regarding how to become Medicaid providers, how to bill successfully, and what type of services are most needed. First and foremost, the goal for Louisiana must be to redirect access to services and decrease reliance on inpatient services. In response, we will rely on our experience in successfully implementing performance improvement projects in other states that specifically work with inpatient hospitals to decrease lengths of stay. VO-LA will build out more crisis response teams in each of the LGEs/HSDs. Metropolitan HSD has contracted widely to have fidelity based crisis services, such as ACT, available and we will leverage their experience to broaden the availability statewide.

A second key priority is bringing the private CMHCs back into the network under clear guidelines for billing and use of EBPs. Much attention will be given to this group, given the historical challenges with overuse of key services, to ensure that service are provided in accordance with clinical guidelines and to work to implement Fidelity based EBPs models such as MST (Multi-Systemic Therapy), FFT (Functional Family Therapy), DBT (Dialectic Behavioral Therapy) for children and adults, Trauma Informed Care, and CBT (Cognitive Behavioral Therapy). This activity will also need to be balanced with how best to use the State run clinics, and how to leverage their capabilities in underserved areas.

A third priority will be working with the essential and implemented HSDs to ensure that they have successfully moved to a "billing model" (versus a "grant in aid" model) to ensure that these essential safety net providers continue to deliver services in the LGEs where they have formed. We know from our due diligence that Capitol and Jefferson are much further along with the billing process than other HSDs. Even these two HSDs are still quite reliant on "grant in aid" funding and will require support to maintain their services, particularly since they both deliver quite a few of the EBP practices mentioned previously.

Finally, a fourth priority is access to psychiatry care. To that end, VO-LA will contract with Tulane Medical Center for a dedicated child psychiatric resident and adult psychiatric resident for 32 hours per week, 48 weeks per year. These residents will be focused on serving the Membership in the SMO to broaden the access to psychiatrists in Louisiana as well as serving as a workforce development and recruitment approach to keep Louisiana-trained psychiatrists in the State.

These initial priorities will be weighed against the information and feedback we receive via the regional discussions, and that of the State to continually refine and adjust these initial priorities.

(d) Assessment of current provider capabilities; and

VO-LA will use our PAR program to assist in shaping and adapting the outcomes of the behavioral health delivery system in Louisiana as it supplies services to the Medicaid population. Under this program, providers are evaluated against generally accepted industry utilization and quality measures, using the providers own data and contextualizing it within the performance of the industry/state as well as against the performance of like providers. This performance improvement program was launched in Connecticut in 2007 and has grown to be a fundamental strategy used to assist network providers to improve the quality of care.

ValueOptions has more than four years of experience in administering the PAR program. We found the more successful programs typically entail two phases of development. Specifically:

1. The initial phase of the PAR program involves the establishment of a workgroup that includes provider representatives from level of care specific programs (i.e., child and adolescent inpatient provider representatives for a Youth Inpatient PARs, Residential Treatment Center (RTC) clinical and administrative staff for an RTC PARs, and more. The workgroup then collaborates with VO-LA to agree upon measures of key aspects of performance in relationship to other providers supplying the same or similar services and to develop a template "profile."

   The providers will meet with VO-LA at least quarterly. Some meetings are with individual providers and some include multiple providers. During these meetings, providers are given their own profile data regarding their performance, and a collaborative review/analysis of the findings is conducted. Variation between programs and the identification of variables that may account for those differences occurs during these meetings. This is the time when providers learn from each other with regard to best practices. Most importantly, goals for improving performance are agreed upon by all participants and there is buy-in to the PARs program.

2. The second phase of the PAR program entails the attachment of financial incentives to the accomplishment of goals in an effort to motivate progress and expedite change. The first performance initiative was implemented in Connecticut in 2008 and these types of initiatives continue to productively supplement the PAR program.

The PAR programs and the subsequent Performance Initiative programs in Connecticut were begun at different times, so the programs are in different phases of maturity with consequent variation evident in the types of measures used and the goals targeted.

(e) Collaboration with DHH-OBH in plan development. Suggested number of pages: 4.

We will collaborate with DHH-OBH continuously during plan development. As stated earlier, several of the priorities are dependent upon DHH-OBH activities (such as HSDs moving to a billable service protocol, and State-run clinics focusing on underserved areas). VO-LA will need to coordinate changes to priorities with the State's efforts to decease reliance on State fun clinics in areas where there are private providers who can deliver these services. Clearly DHH-OBH has already established priorities of provider development via releasing RFAs for the WAAs, FSOs and directing the HSDs that they will need to move to a billable services approach. We will first attempt to prioritize the network development activities that DHH-OBH has already formalized and to work on those. Providers will have a formal "voice" in identifying and addressing the needs of the network via the Quality Assurance/Performance Improvement Committee and the Clinical Advisory Committee outlined in our response to *Section 2d Quality Management.*

In addition, as the CSoC becomes fully functional, we anticipate that additional service capacities will be identified by families, providers, and the CSoC Statewide Governing Body at large. We will provide a dynamic network development plan to the State and welcome ongoing feedback and comment on this plan.

xi. Describe how the Proposer will develop and maintain sufficient qualified service providers to ensure culturally-appropriate services, including outreach, engagement, and re-engagement of the Latino, African American, Vietnamese, Native American and other minority populations and delivery of a service array and mix comparable to the majority population within each region. Suggested number of pages: 3.

Preserving the cultural integrity of the people we serve is a priority at ValueOptions. Our contracts nationwide have provided opportunities to become part of many different communities. From Native American communities in New Mexico and Colorado, to Hispanic-Latino neighborhoods in Florida, California, and the Commonwealth of Puerto Rico, to African-American families in New Jersey, to the rural Appalachian Mountain culture of Western Pennsylvania, and Vietnamese in Massachusetts, we have developed expertise in serving behavioral health recipients and their families of diverse cultures and backgrounds effectively. We utilize culturally competent program design as a means to ensure optimal behavioral care services for all populations, and provide leadership for our local networks throughout the country.

VO-LA is aware that linguistic barriers can prevent Members from accessing behavioral health care. Because communication is fundamental to an effective therapeutic relationship, we make every effort to meet the language needs of our customers' Members.

Examples of our approach to meeting the needs of Members who are not fluent in English include:

- bilingual UMs who are fluent in languages other than English
- interpreters services on our toll-free line through the Language Line services
- bilingual and multi-lingual providers throughout our network

- communication materials (e.g., brochures, tipsheets, articles) translated into other languages
- Achieve Solutions Español—the Spanish language version of our award winning Web resource

CULTURAL DIVERSITY AND LANGUAGES

ValueOptions has a strong record of incorporating cultural awareness issues into our network development programs. After determining the cultural and ethnic mix within each geographic area, we identify specific areas which may be deficient, then we provide staff and provider training and other actions to ensure a culturally sensitive service delivery system. Our network providers are expected to provide linguistically and culturally appropriate services to all ethnic groups regardless of ethnocentric differences. ValueOptions' provider training program includes interactive sessions with providers focusing on issues of cultural competence and diversity in planning and delivering all health care services. When possible, representatives from different cultural and ethnic groups are enlisted to conduct or augment this training. The provider training program emphasizes the dynamics and challenges arising from cultural differences in planning and delivering these services to culturally, ethnically, racially, and linguistically diverse populations. We realize the importance of developing and maintaining a culturally competent system of care, and commit to acknowledging and incorporating, at all levels, the following principles:

- importance of cultural awareness
- sensitivity to cultural diversity brought about by a variety of factors including ethnicity language, lifestyle, age, sexual preference socioeconomic status
- bridging linguistic differences in appropriate ways
- assessment of cross-cultural relations
- expansion of cultural knowledge
- adaptation of services to meet the specific cultural needs of the Members
- how to access non-traditional services

Additional provider training needs will be monitored by our clinical staff, network management personnel, and the Louisiana Service Center provider relations staff, as well as the Quality Management Department, who will be collectively responsible for working with providers to provide training and follow-up on additional issues.

Recruiting and Retaining Sufficient Providers

Our strategies ensure an adequate number of qualified, culturally competent providers are available to serve economically and culturally diverse populations. They include:

Support through Financial Structures—to support recruitment and program development. Through our contracting processes, we will ensure that our providers meet geographic accessibility requirements for culturally appropriate services throughout the State. Funding strategies may include incentives for increasing penetration rates within zip codes identified as having high concentrations of minority recipients, or meeting targets for bilingual staff.

Consolidate Recruitment Efforts—Our Network Development team will support recruitment efforts for the network, providing technical assistance, identifying leads, and publicizing employment opportunities.

Develop Recruitment Partnerships—We will assertively reach out to select psychiatric residency programs throughout the continental US and Puerto Rico, particularly in markets where there is a higher prevalence of bilingual/bicultural students in these programs. In addition, we will collaborate with local community colleges, universities and training programs.

Developing and Maintaining Qualified Service Providers

Provide Expertise and Develop Relationships: Our relationship with WICHE will provide for the development of evaluation standards for program design, and provide technical assistance and consultation for our provider network on cultural competency and multicultural issues.

Develop Competencies: We have developed an extensive cultural competency training program (that is available to all recipients, family members, providers and staff), including competency testing. We have long-standing relationships with many national experts in cultural competency, who have supported us in developing our training programs for other contracts. Further, we require all providers to participate in training regarding policies.

Establish Peer Supports: Building on the work of local groups such as VOICES or Extra Mile, MH America, NAMI, and the Federation of Families, we will continue to expand peer support training program that is specific to the values and traditions of Louisiana that include an incredible focus on resiliency and a commitment to Louisiana and a stable population.

Support Education and Outreach: Our Outreach and Recovery program supports providers in developing creative strategies to educate and engage diverse populations in services. The Strengthening Families Program offered by Ebony House includes outreach efforts targeting African-American males between the ages of 12-17. The goals and objectives of the program are focused on reducing risk factors related to family management problems and favorable attitudes toward drugs. The program works to increase resiliency and youth social skills.

Creatively Fill Gaps: Through standard provider contracts and SCAs, we will recruit specialty providers who utilize services indigenous to their community, population and culture. For example, for our Arizona contract, with our technical assistance and financial support, a group of minority providers were organized into a single network—the People of Color Network (PCN). This network served not only Latino but also Native American and African-American recipients.

Set Priorities: Our corporate Cultural Competence Committee comprises a diverse group of staff, providers and stakeholder and establishes system priorities, which are articulated in our Cultural Competency (CC) Plan. Workforce development within the network will be a priority identified within the CC Plan, which is based on nationally recognized standards (Cultural and Linguistic Appropriate Services Standards – CLAS).

Expect Results: Adult and children's providers will be required to regularly submit internal monitoring findings. Providers who fall below established thresholds for Cultural Competence or Outreach, Engagement, and Re-engagement standards will be required to submit a Corrective Action Plan (CAP) with performance improvement strategies. VO-LA will conduct targeted audits or other activities to validate provider's related data. We will exercise remedies available in provider contracts if performance is not improved.

xii. Describe the Proposer's plan for implementing a statewide network of crisis response providers to service people of all ages. Provide an example of the Proposer's success in developing, implementing and managing crisis response network providers. Suggested number of pages: 3.

We currently have LOIs in place with the following Louisiana Behavioral Health Regional Offices offering the following crisis response services. They are the basis for our approach to building out the crisis response network:

BH Regional Office	24 hr telephone crisis assistance	Mobile Crisis Team	23 hour crisis stabilization program	1-5 day Residential Program
Capital Area HSD	X	Child Adolescent Response Team (CART) and Adult Outreach Team (AOT)		
Florida Parishes HSD	X			
Jefferson Parish HSD	X	X		
Metropolitan HSD	X	X	Developing with local hospital	X
Region 5 BHS	X	CART		
Region 6 BHS	X			
S. Central Louisiana HSA	X			

We have identified these services as essential to a regional capability to delivering a statewide network of crisis responders. We will leverage the successful implementation of these services in existing regions to support and train new programs in other regions.

Mobile Crisis Teams

VO-LA will work with DHH-OBH, local providers, emergency responders, and other stakeholders to develop and implement mobile crisis response teams throughout the State. A mobile crisis team is an interdisciplinary team of mental health professionals (e.g., nurses, social workers, psychiatrists, psychologists, mental health technicians, addiction specialists, peer counselors) in addition to designated first responders. Teams operate under the auspices of designated providers agencies, municipals hospitals, or city or county first responders. They respond to persons in the community, usually visiting them at home or at other designated locations to ensure safety of all parties.

VO-LA will consider using the crisis response system developed by the Metropolitan Human Services District (MHSD) as a model for other regions of the State. This program consists of the following services:

- 24 hour telephonic crisis triage is operated by MHSD during business hours
- emergent/urgent walk-in crisis intervention. All clients with urgent/emergent issues can walk into the MHSD Access Center located centrally in the Greater New Orleans area which is easily accessed via public transportation (MHSD and the New Orleans Police Department also provide transportation). Clients may receive a full screening and assessment at the MHSD Access Center. Additionally there are dedicated crisis workers, nurses and psychiatrists in the Access Center. A pharmacy, owned and operated by MHSD, is also located at the Access Center so clients may receive psychiatric medications within minutes
- Mobile Crisis Team, known as the Metro Crisis Response Team (MCRT), may be dispatched to evaluate a client in the field face to face. The team consists of 2 mental health professionals and a psychiatrist. The MCRT team/services are delivered through a contracted provider funded by MHSD
- MHSD funds five Crisis Residential beds. The beds are centrally located and staffed with clinicians, nurses and psychiatrists. The Crisis Residential Beds are a 1-5 day intensive program. Services are delivered via a contracted provider funded by MHSD
- MCRT is the gatekeeper for the five crisis beds
- MCRT provides daily follow up with the client after the acute issues are resolved
- MCRT refers clients to an array of services and treatments
- All crisis services operate 24 hours a day/7 days a week, afterhours, weekends and holidays
- Through the MHSD Access Center and MCRT after hours, clients with urgent/emergent needs are diverted from the ER and "plugged" into an array of services and resources- transitional housing, detoxification, Intensive Outpatient Programs, Clinics, Residential, and more
- All levels of crisis services are determined using standardized acuity scales
- MHSD is presently in discussions with a free standing psychiatric hospital for a 23 hour bed program, mental health partial hospitalization program and intensive outpatient program

We have successfully implemented Mobile Crisis Services in both urban and the rural areas for the NorthSTAR service area. Part of the successful implementation in rural areas has included the use of telemedicine interviews at the Hunt County Sheriff's Department. The Sheriff's Department has told us how pleased they have been with the way that these interviews have helped them move toward jail diversion and successful interventions for people in a behavioral health crisis. Before the implementation of telemedicine interviews, limited availability of local resources to screen persons prior to and at incarceration for behavioral health issues resulted in many persons being jailed for offenses who would have been more appropriately treated in inpatient settings.

23-Hour Crisis Stabilization Services (Peer-Run)

VO-LA will work with the Member and Family Advisory Committee to identify or develop 23-hour crisis stabilizations in each region. We have engaged Recovery Innovations to develop peer-operated "Living Rooms" as an innovative crisis alternative. This service allows Members in crisis to stay overnight in a safe and comfortable setting and with a peer who focuses on the hope of recovery. We anticipate providing this resource at some point during the first year of the contract.

Other strategies under consideration include:

- Regional/virtual regional team - have a crisis component.
- Telephonic family-to-family and peer-to-peer crisis/warm line
- Transfer from crisis to family/peer warm line
- Staff mobile crisis teams or urgent care centers with family/peers
- Family/peer role in personal crisis plans
- Crisis stabilization training

Member Access Line

The Member Access Line clinicians are available 24 hours a day, seven days a week to respond to Member needs for emergency, urgent or routine services. As part of our initial recruitment process and ongoing training process, we will recruit UMs and CMs from the rural areas of the State and provide extensive information on the unique aspects of each of the rural counties in the area. We also build on the Member's natural support systems -- families, churches, community and civic organizations, and cultural centers to help Members access the service delivery sites.

Members in rural areas have access similar to that of urban Members to emergency and crisis services in a variety of ways: through the Mobile Crisis toll-free number, the Member Access Line clinicians, general medical providers, CMs, providers, community programs, emergency rooms, and primary care providers.

These clinicians will follow the protocols and procedures developed by ValueOptions for the provision of emergency services. They assure that services are provided in a timely manner and that the Enrollee obtains appropriate treatment and follow-up. In addition, we use the services of area ACT teams and the Mobile Crisis Team in providing initial triage and assessment services. ACT teams, and the Mobile Crisis Teams will continue to be contracted to provide ongoing services for those Medicaid and CSoC Members who require a more comprehensive array of services and coordination of services with other community resources and programs.

VO-LA will use Peer and Family Specialists to maintain direct contact with Members who are stepping down from inpatient care on the warm-line in the Member Access Center

1. ***Smoothing transitions for Members:*** When a person with a serious mental illness and/or suicidal ideation is discharged from an inpatient or emergency service, the wait for an outpatient appointment can be prolonged in certain areas of the state. During this delay, many people will be lost to the service system or, tragically, will take their own life. By reaching out to them by phone and/or text message within 24 hours of discharge and at least every 72 hours thereafter, VO-LA's Peer and Family Specialists will reduce suicide attempts,[2] ensure that they remain engaged, make an outpatient visit appointment, keep their appointment and receive the support

[2] Suicide Prevention Resource Center and SPAN USA. David Litts, ed. *Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead.* 2010. Newton, MA: Educations Development Center, Inc.

they need to successfully step down into care by an outpatient provider. Our Peer and Family Specialists will also contact Members after their initial appointment to ensure that they are satisfactorily engaged with the outpatient provider, and if not, make a new referral.

2. ***Around the clock crisis support:*** The VO-LA Peer and Family Specialists will make crisis services available by telephone or text message 24 hours a day, seven (7) days a week, 365 days a year. This support by our trained professionals has been shown to reduce a Member's crisis state, psychological pain, hopelessness and anxiety for an extended period.[3] Our effective suicide risk assessments and crisis counseling services provide an important triage function, ensuring Members at imminent risk of suicide receive appropriate emergency interventions from EMS, mobile crisis teams, or 911 dispatch. Members not in imminent risk are helped to make an action plan and diverted away from unnecessary emergency/inpatient services. Evidence has shown that a large majority of these Members take all or most action plan steps.[4]

24 Hour Crisis Stabilization Services – Hospital Diversion Homes

Hospital Diversion Homes will provide peer-operated services based on the philosophy that recovery is not only possible, but is the expectation. The project shall promote full recovery, active engagement, hope, stabilization and development of an extensive personal support system, and the pursuit of productive meaningful lives. Program values center on human resiliency, hope and respect. This compassion-based approach has been proven to be successful in helping those at risk to accept and respond to engagement that they find open and productive.

The Hospital Diversion Model will provide innovative and unique crisis diversion services where individuals seeking temporary residential care/respite care can stay for one to five nights. Each Hospital Diversion House will be designed to help "at risk" individuals break the cycle of learned helplessness and recidivism through twenty-four hour peer support, self-advocacy education and self-help training. The program will use an integrated services team approach that includes crisis diversion as an integral part of treatment and recovery. We have used this approach in rural areas of Colorado, where an employed Peer Specialists is located in a hostel setting to serve as an observation bed and crisis intervention setting.

ValueOptions has a LOI in place with the Metropolitan Human Services District which is currently working with a hospital to develop such a diversion program.

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[3] Kalafat J., Gould, M. S., Munfakh Harris, J. L., and Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 1: Nonsuicidal crisis callers. *Suicide and Life-Threatening Behavior, 37*(3) 322-337.

[4] Gould, M. S., Kalafat, J., Munfakh Harris, J. L., and Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal crisis callers. *Suicide and Life-Threatening Behavior, 37*(3) 338-352.

xiii. Describe the Proposer's provider profiling system proposed for this Contract. List the elements the Proposer will use to profile providers:

PROVIDER PROFILING: BEGINNING A QUALITY IMPROVEMENT DIALOG

ValueOptions has learned the importance of customizing our program offerings for each state agency and delivery system we serve. The content of provider profiles, for example, must be responsive to the needs of Louisiana Members, families, advocates, state decision-makers and providers. The process of designing a provider profiling program and selecting data elements is oftentimes almost as valuable as the findings: by working together to determine the most important elements to include, the behavioral health community can come to a consensus on what represents excellent provider performance. This process also improves communication and relationships with providers. Working together with stakeholders in an honest and transparent manner is one way that VO-LA will help DHH-OBH to successfully launch the LBHP.

Upon approval by DHH-OBH, VO-LA will provide opportunity for public input into the provider profiling process and selected data elements by convening a Provider Profiling Workgroup, holding public information meetings, provider forums, and requesting public comment on the draft provisions our web site. Subject to review by DHH-OBH, the general public, and the provider community, we have suggested several data elements below that we have found to be supportive of provider accountability and performance in other publicly-funded state programs in which we have collaborated. VO-LA's information systems and data collection methods will enable us to identify sub-par performance and specific outlier providers, to recognize opportunities for improvement, and to implement changes and corrective actions to increase the effectiveness of the delivery system. The initial performance data that will be reported to DHH-OBH for the system as a whole will include:

- service utilization patterns and trends, including hospital admissions per thousand and bed days by adult, youth and eligibility category, and average length of stay
- readmission rates
- over- and under- utilization of services based on utilization trends in historical Louisiana data; the norms and trends will be revised as more current information is accumulated in the VO-LA data warehouse
- ambulatory follow-up after discharge from 24-hour care
- timeliness of service access, including emergent, urgent, routine access to care
- network adequacy, including access and availability of providers, Geo-mapping reports
- penetration rates by geographical area
- adverse incident data and findings
- chart audit results
- top five diagnoses for adults and children and treatment patterns (type and units of service) for the top five diagnoses
- outlier practice patterns for outpatient care
- coordination of care
- complaint trends and resolution times
- consumer satisfaction findings
- compliance with diagnosis-based treatment guidelines and evidence-based practices

Elements for Provider Profiles

The performance of contracted providers is systematically monitored and evaluated using the performance data listed above. Results of chart audits, access data, complaints, adverse incident investigations, satisfaction surveys, utilization data and quality activities are primary sources of provider performance information. They are utilized as part of network management strategies, quality improvement activities and recredentialing of providers. Using a subset of the information listed above, VO-LA will create a PAR that uses the information to assess provider performance and the appropriateness and effectiveness of services provided to Members. In general, performance is monitored by individual provider category, and individual performance is compared against the average performance of the all providers in that provider category. Summary reports also will be provided which show all provider profiles blinded except for the provider being given the summary. In this format, the data allow providers an even more detailed comparison of the performance of their agency and that of all peer agencies.

PARs not only identify areas needing improvement, but they also identify areas of excellence. Providers or services identified as outstanding will be asked to give presentations at provider forums or write articles for the provider newsletter explaining their best practices that have been effective in their agency. Often, excellent providers are selected to participate in quality improvement initiatives and pilot programs because of their proven capabilities.

Building on our experience managing behavioral health networks and producing both behavioral health and primary care profile reports, we have created several behavioral health profile reports which contain core measurements of inpatient, outpatient, diversionary, and emergency services provider performance. Providers depend on these data to manage their practices and we have enhanced the reports repeatedly to produce data requested by providers.

Examples of profile elements that have been extremely successfully include the following:

Inpatient Hospital Provider Profile Reports. Since 2002, ValueOptions in Massachusetts has had a structured inpatient macro-utilization management strategy that is implemented by regional network management (RNM) staff and our Medical Affairs Department. RNMs provide inpatient mental health providers with standard, authorization- based data reports on a monthly basis and conduct in- person site visits, often in collaboration with Medical Affairs, to review this data. The site visits occur monthly, bimonthly or quarterly, depending on provider performance. The profile reports are based on a risk adjustment methodology and provide facility specific data and statewide comparative data. Some core measurements use to monitor inpatient provider performance through these reports are length of stay and both 7- and 30-day readmission rates. We also monitor other measures for this level of care, including compliance with reporting daily bed availability on a Web-based system and timely submission of discharge forms.

Outpatient Provider Practice Analysis Report. The Outpatient Provider Practice Analysis (OPPA) reports have been distributed to outpatient clinics and facilities twice yearly since 2004 in Massachusetts. These reports present data on the Members assigned to each provider as their "primary" outpatient provider, using an algorithm ValueOptions of Massachusetts developed. This practice of assigning responsibility for a Member's care to a specific behavioral health provider mirrors the logic used in the primary care arena and serves to promote continuity of care. This "assignment" method has been very well received by behavioral health providers who have

embraced the responsibility for coordinating care not only with other behavioral health providers but also with primary care and other providers. Based on the number of Members assigned to their practices, providers are divided into small (50-199), medium (200-499), and large (500+) provider groups. Practice data is benchmarked against similar-sized providers. Some of the core measurements use to monitor outpatient provider performance through these reports, and enable to manage their practices, include:

- number and list of Members receiving diagnostic evaluations with no billed follow up
- percentile related to utilization of various treatment modalities
- number and list of Members who required behavioral health emergency services or inpatient care (i.e., "step ups")
- number of Members receiving "medication only"
- percent and list of youth without the required number of Well Child Care visits
- number and list of Members with diabetes

Substance Abuse Provider Practice Analysis Report. Since 2008, Substance Abuse Provider Practice Analysis (SAPPA) reports have been distributed to providers by Regional Network Managers on a semi-annual basis through on- site provider visits. Like the OPPAs, the SAPPAs include provider level and statewide level data, including the following addiction treatment levels of care: Acute Treatment Services (ATS), including Enhanced Acute Treatment Services (EATS) for adults and adolescents and Inpatient Level IV and Structured Outpatient Addiction Program (SOAP). The core measurement used to monitor substance use provider performance through these reports is data about the next billed service following discharge from the given level of care. This data indicated readmissions, step ups and step downs, and those with no billed services post discharge. The goal is to work with providers around engaging Members with substance use conditions in continuous treatment.

VO-LA Provider Relations staff will use this provider profiling data to monitor provider performance, identify and manage providers who fall below established benchmarks and performance standards. PARs will be issued quarterly, and VO-LA Provider Relations staff will review the report with providers to assure they understand how to interpret the data and incorporate it, as appropriate, into their own internal quality management programs.

Providers whose performance is consistently below expectations will receive technical assistance in developing and implementing a corrective action plan. If poor performance continues, the provider may no longer be allowed to accept new Members and could be terminated from the provider network, depending on the degree to which performance remained unsatisfactory. VO-LA will take no action to terminate any provider from the network without providing all information supporting that recommendation to the DHH-OBH. To demonstrate the variety between profiling strategies, we include several from other programs as **Attachment 12**.

Through our many public sector contracts, ValueOptions has learned that a "one size fits all" approach is sure to fail. This is true in provider profiling because the content of provider profiles must be responsive to each program in which they are used. In fact, in our experience, the process of designing a provider profiling program and selecting provider profiling elements is almost as valuable as the findings. By working together to determine the most important elements to include, the behavioral health community—beneficiaries and their families, advocates, providers, the state

agencies and ValueOptions—came to a consensus on what represents excellent performance. An additional result of this process has been improved communication and relationships with providers. Working together in an honest and transparent process has been invaluable in impacting many network/provider initiatives.

(a) Indicate if the profiling elements will differ by provider;
(b) Describe the process for collecting accurate baseline data that engenders provider confidence and the time table for development of accurate baseline data; and

Creating Customized Provider Profiling Elements Differentiated by Provider Type

As the SMO, VO-LA will bring value to DHH-OBH's LBHP by strengthening provider performance and accountability through a customized PAR program with input from providers, Members, families, and other stakeholders. Because each provider has different strengths and serves diverse populations in the delivery system, we have found it helpful in other public programs for profiling elements to differ by provider type (e.g., group home, hospital, psychiatric residential treatment facilities, etc.). We will collaborate with each type of provider to ensure Members receive high quality services and improved outcomes. As part of the PAR program, providers will be evaluated against generally accepted industry utilization and quality measures and feedback will be provided at specific intervals to keep providers informed of their performance. Additionally, we will establish a PAR Workgroup that will oversee the development and implementation of this program. This workgroup, which will meet weekly and consist of staff from our quality, provider relations, and reporting departments, will develop measures, indicators, and reporting specifications; establish quality indicators and strategies for delivering performance; and review the methodology for assessing individual provider success. Profiles will be shared with our Regional Teams, Members, families, and other stakeholders to assure a local "lens" is used in evaluating the outcomes and preparing for site visits at provider locations.

The Louisiana PAR program will consist of the following two elements:

1. We will collaborate with our providers to develop specific monitoring tools to assess their performance compared to other providers who provide the same or similar services. Profiles will be reviewed by DHH-OBH and designated QM committees to ensure a broad range of input, including Members and families, and will be distributed quarterly to participating providers. We will offer providers the opportunity to discuss the profiling results and focus on areas of system improvement and potential training needs when performance does not meet established goals. In other state contracts, ValueOptions has tailored profiling activities for specific provider types, including child, adolescent, and adult inpatient psychiatric hospitals, enhanced care clinics, PRTF, and hospital EDs. At VO-LA, each provider type will be in a singular phase of development with variation evident in the targeted outcomes and established goals.

2. In conjunction with DHH-OBH, VO-LA, once the program matures, may incent providers as part of a Performance Initiative Program. In ValueOptions' Connecticut program, for example, based on the provider's individual performance toward established goals, we have started providing monetary incentives to expedite improvement practice standards. To date, Performance Initiative Programs have been developed with hospital emergency departments, emergency mobile psychiatric services, PRTFs, and pediatric psychiatric hospitals.

Collecting a Baseline for Provider Performance Improvement

VO-LA understands the importance of making sure the LBHP has an accurate baseline for data on provider performance for quality improvement to be measured over time. ValueOptions has a well-established, multi-pronged, data-driven system for monitoring the performance of our provider network across all levels of care. To that end, VO-LA will work collaboratively with providers to obtain their input into the data elements and the collection process used for the Louisiana PAR system. Data elements will be broken down into documented data specifications consistent with industry standards and customized to the specific report. Draft reporting will be done with consistent quality assurance checks done across data and reporting areas, as well as the business owners of the reports. Final quarterly reports will be produced in compliance with all contractual requirements with ongoing quality assurance checks performed at each report cycle. We will ensure that the data collection process does not add to the administrative burden of providers and, with DHH-OBH approval, we will publish aggregate results on system quality improvement on our website via dashboard quarterly.

Provider Quality Profiling

ValueOptions also maintains an automated database that tracks claims-based performance data on all contracted network practitioners with Members in outpatient treatment. As a recredentialing tool, the standard performance report covers a three-year period and is designed to capture relevant events between recredentialing cycles. As a quality improvement tool, key performance indicators identify patterns of care and are designed to support national and regional comparative analyses. Analysis can be performed on an individual practitioner basis or on an aggregate across provider and/or Member groups. This system of analysis provides ValueOptions with monitored data that ensures quality services with positive clinical outcomes. The data is used to evaluate the successes and weaknesses of service delivery, determine the need for training, and examine the need for new clinical protocols. It also satisfies national accreditation and quality assurance reporting requirements for practitioner credentialing, utilization management, and quality of care activities.

As part of the Continuous Quality Improvement process, this measurement system enables ValueOptions to assess objectively the outcomes of care and to identify best practices for targeted populations. The database includes a wealth of information, and measures currently reported track both utilization and quality of care activities. Each performance indicator reported has a specific measure, a performance standard, and a performance improvement strategy.

Other information routinely reported addresses:

- general utilization statistics including total number of Members seen and average number of sessions over a two-year period
- diagnostic information
- case mix and volume data including average number of sessions and Member episodes of care for 13 different diagnostic categories
- quality of care measures based on ValueOptions' clinical guidelines and the American Managed Behavioral Healthcare Associations' (AMBHA) Performance Measures for the Managed Behavioral Healthcare Programs (PERMS)
- analyzing provider practice patterns, both at an individual and aggregate level, to evaluate the successes and weaknesses of service delivery as it relates to our Members' outcomes in treatment

- quality of care measures based on clinical guidelines and NCQA and URAC performance measures
- determining whether or not treatment plans providers submit contain recovery and resiliency goals, objectives, and outcomes that are related to the assessment; are individualized and specific; and measurable with achievement time frames
- determining if all presenting problems/functional impairments were addressed or justification was given for not addressing them
- determining Member satisfaction
- identifying and guiding provider training opportunities, and examining the need for new clinical protocols

(c) Include a description of the parties who will have access to the provider profile and how the information will be utilized. Describe how the Proposer has used provider profiles for other public sector BH managed care contracts. Suggested number of pages: 3.

Access to Provider Profiles

Provider profiles will be shared with Quality, Provider Relations, and Clinical staff members. We will also share provider profiles with our Regional Provider Relations staff. VO-LA Regional Provider Relations Representatives will review reports with providers to assure that they understand how to interpret the report and incorporate it, as appropriate, into their internal quality management program.

Using the Profile Information

The performance of contracted providers is systematically monitored and evaluated using the performance data listed above. Results of chart audits, access data, complaints, adverse incident investigations, satisfaction surveys, utilization data and quality activities also are primary sources of provider performance information.

We use the profile information to assess provider performance and the appropriateness and effectiveness of services provided to Members. In general, performance is monitored by individual provider category, and individual performance is compared against the average performance of the all providers in that provider category. Summary reports also will be provided which show all provider profiles blinded except for the provider being given the summary. In this format, the data allow a provider an even more detailed comparison of the performance of his/her agency and that of all peer agencies.

Provider Performance Reports not only identify areas needing improvement, but they also identify areas of excellence. Outstanding providers or services will be asked to give presentations at provider forums or write articles for the provider newsletter explaining the treatment approach that has been effective in their agency. Often, excellent providers are selected to participate in quality improvement initiatives and pilot programs because of their proven capabilities.

Providers whose performance is consistently below expectations will receive technical assistance in developing and implementing a corrective action plan. If poor performance continues, the provider may no longer be allowed to accept new customers, and could be terminated from the provider network, depending on the degree to which performance remained unsatisfactory.

Experience with Another Public Sector Contract

For our contract in Pennsylvania, Value Behavioral Health of Pennsylvania (VBH-PA) uses profiling to compare provider practice patterns. Profiling elements include: average cost per Member by diagnosis, age, gender; and type of service; number of Member Level I complaints listed by provider, percent of complaints per Member; number of cases sent to peer review; and Member/family satisfaction data. Superior performers are interviewed to identify best practices. For example, outpatient providers are compared based on number of visits per Member. A higher rate of visits per Member indicates a provider has a lower no-show or cancellation rate and low staff turnover. Best practices identified include: centralized intake/triage process to decrease no-show rate and increase staff direct service hours; use of an advanced training programs at a local university to improve the education and reduce staff turnover; attendance at a psycho-educational group for behavioral health recipients with two consecutive no shows/cancellations; and engagement of the Member in decisions regarding treatment sessions.

We provide sample provider profiles from other contracts as **Attachment 12**.

xiv. Describe at least one (1) goal, measurable outcome and strategy from another client state where improvements in the availability of and member engagement in culturally appropriate services occurred. Also, describe one (1) strategy that did not result in positive change and the Proposer's understanding of why this strategy was not successful. Suggested number of pages: 3.

At ValueOptions, we are deeply sensitive to cultural issues, especially because of the variety of nationalities, ethnic backgrounds, and languages represented in the public sector programs we serve. For these programs, we have made major strides in developing a multi-cultural staff and provider network and we design and implement services that are tailored or matched to the unique needs of the individuals, children, families, organizations, and communities we serve. Our practice is driven by Member-preferred and family friendly choices, not by culturally blind or culture-free interventions. Furthermore, we recognize behavioral health as an integral and inseparable aspect of primary health care, and we have integrated policies and procedures that incorporate the standards for Culturally and Linguistically Appropriate Services (CLAS standards) established by the Office of Minority Health..

Below is an example of a goal, measureable outcome and strategy from our Connecticut contract.

Successful Strategy

We have implemented a number of initiatives and projects that reflect the cultural needs of Connecticut residents and solidify our commitment to delivering culturally competent services. We provide some examples below:

We collaborated with F.A.V.O.R. and NAMI-CT, as well as members from our Member and Family Advisory Committee, to review our distribution documents (i.e. Member Handbook and the pamphlet developed in English and Spanish) that educate families of members newly admitted to the hospital regarding the importance of ongoing care after discharge. Specifically, in 2008, our Member and Family Advisory Committee, which includes representation from F.A.V.O.R, and biological and foster parents, assisted in the enhancement of our Foster Family Resource Manual by

providing recommendations for revisions to the manual. A total of 17 Member and Family Advisory Committee members participated in this process.

One of our clinical staff worked closely with NAMI over the past two years to raise awareness of mental illness in the African American faith community. She has presented to numerous churches in the area, educating clergy and congregations about the nature of mental illness and the role that spirituality can play in recovery. Based on this work, NAMI FaithNet, an outreach program for faith communities, has created a national program to recruit members and faith-based leaders to participate in a presentation to African American churches throughout Connecticut on how to seek guidance, support, and understanding from their faith community.

We publish our Connecticut documents (i.e., satisfaction surveys, post-partum brochure, and ambulatory follow-up letters) in Spanish to assist different ethnic groups.

Our staff training includes cross-cultural and linguistic training that is respectful of the needs of members, as well as colleagues, peers, and customers in the field and the importance of communicating effectively with colleagues and customers from different backgrounds (verbal and non-verbal communication styles). Such training addresses cross-cultural conflict resolution and culturally-specific mediation strategies.

Our Peer/Family Specialist team provides culturally competent services within the "family culture." This team has also conducted a number of cultural competency workshops for providers and trainings for Department of Children and Families.

Cultural awareness is incorporated into all of our daily practices at the Service Center. Clinicians conducting level of care authorizations will ask the provider "Do Language and Cultural Needs Impact Treatment?" and "If Yes, List Language Cultural Issues." This information is discussed with the provider, documented in our system, and is reviewed upon concurrent reviews to ensure that the member is receiving culturally competent services.

Member satisfaction with their counselor's provision of culturally sensitive treatment is assessed annually. Our most recent results indicate a **97.2 percent satisfaction in this area. In addition, 99 percent of members think the counsel respects culture, religion and values.** (2009 Fact Finders Connecticut Member Satisfaction Survey).

Unsuccessful Strategy—*Translation of Materials*

For our Arizona contract, we made available many different types of materials in various languages. We used this information to educate and inform potential recipients about behavioral health services that are available, and to engage individuals in treatment that is culturally and linguistically appropriate. Our materials were translated into Spanish by a licensed and bonded firm specializing in Spanish translations. In 2006, the Child and Family Team Practice pilot review tool and reviewer's guide was translated into Spanish. However, once we began to use the tool with Spanish-speaking families, we discovered that the firm responsible for translations had incorrectly translated the materials into European Spanish. The translator did not take into account differences in Spanish dialects and idioms of Mexican, Central, or South American recipients or their families.

While identified early on in the implementation of this process, this error could have negatively impacted our credibility and ability to effectively engage Spanish-speaking families in the child and family team process. The translation agency was released from their contract; a new agency with a local reputation for exceptional translation services was hired. After this discovery, all translated materials met the needs of our Spanish speaking communities. In addition, all translated materials were critically reviewed at multiple levels internally and externally to ensure they were linguistically appropriate for Spanish speakers in Maricopa County and were of appropriate reading level prior to public release/dissemination.

xv. Describe the strategies the Proposer will use to facilitate BH provider, PCP, DCFS, OJJ, DOE and OBH collaboration other than at the individual case level. Describe the Proposer's experience in at least one (1) example of collaboration including the actions and strategies taken and results. Suggested number of pages: 3.

One of the strategies that VO-LA will use to facilitate collaboration other than at the individual case level is through the use of ValueOptions Braided Funding.

Like Louisiana, many of our public sector clients seek to coordinate services between programs to assure limited financial resources are used in the most appropriate manner. ValueOptions' Braided Funding system helps our clients reduce costs while improving Member care by eliminating service gaps and duplicative processes to assure the most efficient and effective service delivery system. Usually, Medicaid funding provides the foundation for braided or blended funding approaches, with other federal and state funds supplementing the Medicaid funding.

Our Braided Funding programs enable clients to track dollars across agencies and programs, and to realize savings from five percent to ten percent of total expenditures.

ValueOptions' Braided Funding system will help DHH-OBH reduce costs and improve the efficiency and effectiveness of the service delivery system. Braided Funding takes advantage of our robust IT systems to reduce costs and improves Member care in by identifying and eliminating service gaps and duplicative processes.

As more states began to braid Medicaid dollars with other funding streams (i.e. mental health, child welfare, substance abuse and juvenile justice), ValueOptions' Braided Funding applies new and innovative technology to increase efficiency and effective monitoring to enable client's to assess funding availability and program success.

Using Braided Funding, DHH-OBH will be able to deliver cost-effective, coordinated services by blending multiple funding streams and program operations. Our programs feature sophisticated financial management systems that track and report on expenditures and services for individuals across multiple funding streams. Our staff facilitates inter-agency planning and coordination, both at the system level and for individual treatment planning, to increase efficiency, effectiveness, and improve clinical outcomes. ValueOptions' information systems integrate data

Our staff and our advanced technological infrastructure minimize the "silo effect" of separate state agencies or programs operating independently of each other.

gathered through Member registration and assessment processes into a single database for all funding streams. Our staff uses this information to record and track Member treatment, and outcomes. We also provide funding information to our clients through secure, real time Internet-based dashboard reports.

Features and benefits of our Braided Funding system include:

- One-stop shopping – For enrollees and their families, the confusing maze of separate programs and services is replaced with a single toll-free number
- Data and reporting – ValueOptions generates meaningful reports and analysis across multiple delivery systems to help clients and other stakeholders plan and make improvements
- Reduced administrative costs – We minimize administrative costs through the centralization of services, while direct services, case management, clinical monitoring, and provider support staff can be located across a geographical region and have better access to enrollees and providers
- Cost savings – Through risk-based arrangements, ValueOptions has generated cost savings that we reinvest back into the service delivery system or help to offset state budget deficits affecting programs

Our Braided Funding system is sophisticated, but the concept is simple. If the Braided Funding program identifies a federal program to fund the care, the state does not use any of its funds and saves money. As long as the Braided Funding system is used to enter authorizations and service requests we can support multiple funding or financing models.

ValueOptions will work with DHH-OBH to identify funding sources, and any current or pending funding gaps. We will develop customized processes and workflows to streamline program administration, and to ensure funds are appropriately applied. To help assess program effectiveness, we will work with you to create meaningful reports and feedback mechanisms that assess program outcomes and effectiveness.

Braided Funding Success

ValueOptions' Braided Funding system is field-tested and proven. We have worked closely with our public sector clients to customize our Braided Funding system to meet unique challenges found in each state or region. Below we briefly describe how our program has been instrumental in transforming the System of Care and improving programs and operations for several of our current and past clients.

- In support of the Dallas NorthSTAR Medicaid program, our Braided Funding system manages 15 federal, state, and local funding streams for indigent members. Working collectively with the various stakeholders, we have streamlined agency policies and eligibility criteria to saved approximately $60 million in Medicaid funds over the past 10 years. This successful program offers enrollees a comprehensive benefit package that dramatically improves their access to care and saves them from having to switch providers when their Medicaid eligibility status changes
- In Kansas, Braided Funding has helped the Department of Social and Rehabilitation Services save $5 million since 2007, and has enhanced enrollee access to effective substance abuse treatment services throughout the state

- In Connecticut, ValueOptions, through the Behavioral Health Partnership, manages services statewide for children and their families, and adults. Our Braided Funding system facilitates collaboration between local, state, and federal Medicaid, mental health, child welfare, substance abuse, and juvenile justice agencies to reduce cost, and improve program efficiency and enrollee outcomes
- In Maryland, we provide behavioral health services for Medicaid and uninsured individuals through our contract with the Public Mental Health/Mental Hygiene Administration. Our Braided Funding system manages member services and administers claims processing for more than 800,000 enrollees
- In New Jersey, the state contracted with ValueOptions to coordinate the funding streams and promote individualized service planning at the local level for Medicaid eligible children. Our clinical staff and authorized state agency staff and community providers accessed our secure customized systems to create an individualized electronic medical record for each child
- In New Mexico, ValueOptions' Braided Funding sifted through 17 different behavioral health programs to find the most cost-effective one for each enrollee. It saved the state $9 million over three years
- In Arizona, we supported the Maricopa County Regional Behavioral Health Authority by integrating 18 funding streams to form a comprehensive, cost effective behavioral health system

Using our Braided Funding system, clients track state, local, and federal dollars across multiple agencies and programs, and ultimately, improve access to services, enhance the quality of care, and make better use of public funds.

Our Experience and Example

Improving the Quality of Care Provided to Behavioral Health Recipients

For our Arizona Contract, VO-AZ took aggressive action to prevent adverse incidents and quality of care concerns from ever occurring. However, when quality of care concerns were identified, VO-AZ utilized the experience to improve services and used the information to adjust clinical practices to prevent future events from recurring. VO-AZ improved the quality of care provided to behavioral health recipients at the individual and systemic level through the following practices.

Individual Level

VO-AZ validated that the behavioral health recipient's immediate health care needs were met, and ensured that interventions in response to identified quality of care concerns have proven effectiveness.

VO-AZ avoided the provision of training as the primary and sole response to quality of care issues and substantiated that peer reviews, clinical supervision and role playing are more effective in positively impacting clinical practice and improving the quality of care provided to behavioral health recipients. In individual cases for which corrective action is required, VO-AZ ensured validation that the action has been fully implemented and effective at resolving the identified quality of care issue.

Systemic Level

VO-AZ instituted a variety of methods to improve quality of care at the systemic level. These methods included tracking and trending of quality of care concern data including:

- number and type of incidents for a particular provider or provider system
- tracking the most recurring quality of care concerns identified during the investigative process
- reporting relevant indicators through the QM/PI Committee and subcommittees and ensuring appropriate follow-up actions in response to trended data
- evaluating and aligning multi-disciplinary clinical practices with practice guidelines that improve safe practices

VO-AZ used this information to inform changes in policy, develop training and technical assistance, and focus future performance measurement activities.

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

Describe how the Proposer will assure Members understand and know how to exercise their rights. Include a description of how the Proposer will assure members' rights are recognized and supported by employees and providers. Suggested number of pages: 2.

ValueOptions ensures that Members are treated in a manner that respects their rights and dignity. ValueOptions' staff members receive an orientation at the time of hiring that includes training on the rights and responsibilities policy, as well as the expectation that all employees adhere to this policy.

ValueOptions places great primacy on protecting Member rights, enabling Members to assume responsibility for their own recovery, and keeping Member health information private. We provide written and verbal communication regarding Member's rights and responsibilities in full compliance with 42 CFR § 438.100. VO-LA will distribute a Member Rights and Responsibility Statement that incorporates all elements required in *Section 8* of the RFP as part of the Member Handbook and upon request by a Member or his or her family/caregiver. We encourage and empower Members and families to know and exercise their rights and provide input into the service delivery system.

Staff Education and Monitoring

Communication, education and monitoring are the primary ways VO-LA will ensure that Member rights are protected by providers and VO-LA. We will meet this requirement by:

- clearly communicating relevant policy expectations through the VO-LA Provider Manual
- providing a comprehensive provider education program to reinforce program requirements/expectations
- providing mandatory, targeted provider training sessions specific to Member Rights
- providing information and education to Members on their rights using whatever method of communication and/or language is preferred by the Member, including Achieve Solutions and MemberConnect, ValueOptions' Web portal for members, the Member Handbook, pamphlets, posters, health fairs and regional events, and during each clinical, peer, and Member service contact with a member or family
- conducting specialized training sessions and follow up training as needed with individual providers
- conducting comprehensive monitoring of all providers' adherence to the requirements
- identifying deficiencies in provider performance and requiring corrective action plans

VO-LA's education curriculum for Members focuses on Member rights within the context of both federal and state Medicaid rules. Education will be ongoing through face-to-face opportunities in small group trainings, using the web and also using our Peer and Family Specialists on the warmline, as well as through the Louisiana website. Education will be monitored annually. We have met extensively with NAMI, MHA of Louisiana as well as VOICES and Extra Mile to begin the outreach and dialogue process with as many Member and family groups as possible. Such outreach will serve as the basis for ongoing discussion and dialogue to ensure Member access and complete

understanding of Member and families rights, responsibilities and opportunities to participate in and shape the activities of the SMO.

In addition to educating Members, advocates and Peer and Family Specialists, it will also be important to educate VO-LA staff and providers about Member rights. Advocates will conduct new staff training and continuing education about Member rights at provider and staff offices.

Helping Members and Families Know and Understand their Rights

As part of our Member education and empowerment process, VO-LA will provide information on Member Rights to Members through every available channel. We will provide rights and responsibilities education to Members through the Member newsletter and the Louisiana website to remind them about their rights and remedies available if they believe their rights have been violated, including filing a grievance and being helped to file it. Additionally, contact information for the Outreach and Recovery Administrator will be posted in prominent areas at all provider sites.

Written Materials on Member Rights and Responsibilities

Written lists of Member rights and responsibilities will be posted at all provider sites, including the Human Service Districts, Wraparound Agencies, and Family Support Organizations, and will also be distributed to member and family associations including, but not limited to NAMI (state level and local chapters), Mental Health America – Louisiana Chapter, Louisiana Volunteers of America and the Louisiana Federation of Families. The lists will also be provided in the Member Handbook, which will be mailed to all Medicaid Members and distributed at intake appointments. In addition, Member rights will be listed in the Provider Manual, the provider-credentialing packet, the Louisiana website, and Web-education for providers. We encourage providers to post the Member Rights in their offices or waiting rooms or distribute the statement to Members at their initial visit. This information will be available to Members in English, Spanish, and Vietnamese and will be written at a reading comprehension no higher than a 5th grade level, or as determined appropriate by DHH-OBH.

Monitoring Member Rights

VO-LA's Outreach and Recovery Administrator will collaborate with our Quality Management Department to effectively monitor Member rights. The monitoring mechanisms will include: analyzing grievance and appeals reports; reviewing quality of care reports; conducting chart audits; and reviewing grievance information in a variety of forums (i.e., staff meetings, quality committees, and clinical review committees).

In addition, we will conduct annual Member satisfaction surveys, which will include questions on whether Members believe their rights were upheld and if the information has been communicated effectively and is easily understood. We will review results annually. Any rights violations or trends will be reported to the appropriate entity; for example, trends will be reported to the Quality Assurance/Performance Improvement Committee and the executive management team. Individual violations will be reported to other appropriate entities, such as a staff member's supervisor.

In other public sector programs, ValueOptions has worked with consumer-run advocacy organizations to act as researchers and trainers to promote Member rights and collect valuable information about the health of the larger delivery system. Here are some ideas of ways that we can

work with DHH-OBH to promote consumer-run organizations as well as Member rights and responsibilities.

- In Massachusetts, ValueOptions' subsidiary Massachusetts Behavioral Health Partnership contracted with several advocacy organizations to develop customer satisfaction teams composed of individuals and family members. The customer satisfaction teams conduct surveys of mental health and substance abuse treatment programs and collect system data on Member access, satisfaction and whether they feel they were treated fairly by providers. VO-LA can work with DHH-OBH on the possibility of issuing an RFP for contracting with a local advocacy organization to collect this data in each Parish.
- We have also used Consumer Report Cards administered to Members by Members. In Louisiana, we could develop an instrument that collects data on the overall satisfaction of the Member and family with the services received as well as measures of how hopeful the individual is about their life and how empowered they feel regarding making treatment decisions for themselves. This information could be aggregated and developed into a dashboard on the VO-LA website.
- In our Colorado program, family members provide ongoing training to peers, professionals and other human service employees about family-centered practices. Family groups have provided training that is specially geared to the faith community, with the recognition that the faith community can provide much needed support to families of a child with SED, who often feel isolated. VO-LA could subsidize the costs of training family members in each Region to become Parent Support Providers using the newly developed Parent Support Providers certification available through the National Federation of Families for Children's Mental Health.

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i. Describe the Proposer's telephone system capabilities, call center software and operating systems. Suggested number of pages: 1.

Our state-of-the-art, industry-leading telecommunication technology from Avaya, delivers services supporting the Louisiana dedicated call center operations. Our call center technology has been successfully implemented by ValueOptions with government clients and private sector industry clients in support of the more than 24 million members we serve throughout the US. It will significantly enhance the service experience for the State of Louisiana members and providers. The chart below describes the unique features and benefits of our advanced technical infrastructures.

Feature	Benefit
Optimal Call flow	Improves the average speed of answer by directing calls to the appropriate queue -- ensures outstanding responsiveness and overall quality of service.
Robust Reporting Tools	Ability to monitor metrics and manage and plan for call volume and meet surge requirements.
Virtual Routing Capability	Allows seamless instant routing of calls to available call center clinicians, regardless of location, and features automated call overflow handling with no human intervention.

Call Center Technology Advanced Features and Benefits

Avaya Telephone System

ValueOptions uses the industry-leading Avaya™ Call Management System (Avaya CMS). When members call the toll-free line, Avaya CMS easily matches call center personnel resources and skills to call volume and customer needs, and effectively monitors critical items such as agent status, average hold time, number of calls in queue, and number of abandoned calls. By providing a comprehensive set of capabilities for call center management and reporting, the Avaya CMS helps us effectively manage call center resources and, as a result, better serve members and providers.

When a Client or provider calls the 800 line, the Avaya system easily matches the call center personnel resources and skills to call volumes and caller needs. The Avaya system provides our staff and Clients with optimal call flow.

The Avaya architecture used by VO-LA is designed for high reliability through the deployment of separate servers. Each Avaya component in our architecture is duplicated for maximum redundancy including servers, UPS, modems, switches, and Internet Protocol Server Interface (IPSI). Our mirrored infrastructure allows the systems to provide automatic load balancing and redundancy for voice and data to eliminate any service interruptions. Leveraging this industry-leading platform supports optimal call handling protocols. We can easily accommodate large increases in phone call volume and widely varying peak call times. Our central Avaya infrastructure handles all call routing,

management, and reporting requirements. This central telephone switch provides dynamic, seamless routing of calls to multiple call centers as dictated by business rules, a call spike, or in the event of a technical issue in any call center.

Incoming calls will be delivered directly to the VO-LA Member Access Center via dedicated voice circuits. These circuits will be sized to accommodate the projected number of simultaneous calls, transfers, multi-party conferencing, and call-backs. The sizing criteria will take into account the need for all incoming calls to be answered within the requested time by a live agent. All calls will be delivered to the service center over the DHH/OBH dedicated and secure (Multprotocol Label Switching) MPLS. The combination of the Avaya technology platform, coupled with a MPLS network architecture, will ensure the availability of the call center and the successful delivery of all calls.

Nice Call Recording Software

ValueOptions uses the NICE™ Perform Suite Call Record Solution (NICE Perform) as a measure of our commitment to providing Members ever-improving member service. NICE provides recording capability that allows calls to be captured, recorded, and stored according to all requirements, both internal as well as those applicable to DHH-OBH. This technology allows us to store digitalized voice recording and video screen capture of the system navigation activities completed during a call from a member or provider. All calls handled by staff through Avaya CMS are recorded, allowing us to gain insight about staff interactions with members calling the toll-free line. However, our technology allows us to discontinue the recording of a call at the request of the caller.

Selective screen capture of system interactions occurs based on pre-determined business rules based on volume. NICE Perform allows for the use of customized evaluation forms, including flexible scoring and questions to support both the clinical and administrative member interactions. The NICE Perform model focuses on interactions calibrated scoring to ensure consistency in the evaluation process. It is our objective to audit, by either a Quality Analyst or a member of the member services management team, a minimum of five formal calls or inquiries and five informal calls or inquiries with at least three formal coaching sessions per MSR per month. This analysis focuses on the member's experience from initial contact through resolution.

ii. Describe how Information Technology (IT) and claims management functions will be organized, including staff that will be Louisiana based and staff available from the Proposer's corporate operations. Provide an organizational chart for IT and claims management that includes position titles, numbers of positions, and reporting relationships. Describe the qualification of staff. Suggested number of pages: 4, exclusive of organizational chart.

VO-LA INFORMATION TECHNOLOGY DEPARTMENT STAFFING

VO-LA's IS Administrator will have overall responsibility for IT functions within the Louisiana Service Center and oversee all IT and business support personnel dedicated to this program. The IS Administrator will be responsible for the management of the local IT program, daily operations of the IT program, data interfaces with DHH-OBH and supporting all reporting requirements of this contract. IT staff within the service center will also have access to ValueOptions' National IT Department, which consists of over 200 professionals, including WAN Engineers, PC Specialists, Network Engineers, and LAN Administrators, PC and LAN Technicians, Client/Server Developers,

Web Producers, and Programmer/Analysts. These professionals, who have also received various industry certifications, are experienced in providing systems support to over 24 million members throughout the United States. This provides DHH-OBH with not only the capacity to effectively monitor the services provided to Louisiana members, but it also allows you to leverage the flexibility, integration, and reporting capacity of a proven information system designed to support a Medicaid program.

An organizational chart, depicting the position titles, number of positions, and reporting relationships for our proposed IT staff, is provided below:

Chart Redacted

IT Staff Qualifications

	Redacted

	Redacted

VO-LA CLAIMS DEPARTMENT STAFFING

All claims processing functions for Louisiana will be handled by a designated team of skilled professionals, located in our National Claims Service Center in Latham, New York. The National Claims team will have a matrix reporting relationship to the Louisiana Service Center and will work closely with the Claims/Encounters Administrator. The Claims/Encounter Administrator, along with the Claims Management team will ensure that the appropriate policies and protocols are in place to meet all claims requirements and performance standards imposed by the contract with DHH-OBH. ValueOptions' National Claims Department is structured into two distinct units; one serving commercial clients and one serving public sector.

The structure and staffing of our centralized National Claims Service Center provides an employee base large and flexible enough to accommodate failover capacity. This ensures that there is sufficient backup support in the event of fluctuations in claims volume and to absorb periods of staff coverage variations due to illness, vacations and turnover. Our National Claims Service Center has a strong and well-seasoned management team. This team consistently exceeds industry standards through continual improvement and oversight by skilled professionals. Our Claims Management organization chart is illustrated on the following page.

Chart Redacted

Claims Staff Qualifications

REDACTED	

REDACTED	

REDACTED	

iii. Describe training for IT and claims staff, including any subcontractors. Suggested number of pages: 5.

INFORMATION TECHNOLOGY STAFF TRAINING

ValueOptions' National IT Systems Training Team provides system orientation training to both new and existing employees, as well as business associates. This training covers our key business applications and processes. The courses offered by the National IT Systems Training Team have been designed to accommodate operational workflows at a high-level and individual job specific training. The IT Systems Training Team strives to provide a comfortable and efficient learning environment, while offering training that enhances job performance and productivity. This is accomplished by initial new hire training as well as ongoing courses and refreshers. Newly hired IT employees and other associates receive a required initial training consisting of an overview of the behavioral health industry and a systems and applications overview within two weeks of being hired. More job specific training is offered through a standard course curriculum which is maintained on our internal StaffConnect Intranet. Courses are offered on a monthly and as-needed basis. Training can be provided in a group or individual setting. In addition, our trainers provide training documentation, reviews and instruction whenever systems or applications are enhanced with features or changes that impact end users. We offer training in many forms, including group seminars, workshops, one-on-one tutorials, and college courses. Each year, employees are given a stipend for professional development at colleges and universities. We currently have staff studying to obtain degrees, ranging from an associates to a Ph.D.

Cross-Training

Cross-training of IT staff members starts the day an employee is hired. It begins with a series of standardized training courses to orient the employee to the company and to the behavioral health system. This training includes everything from details on the specific client information systems for the contract or project they will initially support, to HIPAA standards and cultural competency. Then, each new IT employee is assessed by their immediate manager to determine the individual training needed to perform their core job duties. For a programmer, this could include technical classes and clinical system classes to understand the scope of work performed. Through operational training, the IT department staff members become aware of issues that affect the system as a whole, while technical training gives them a multitude of tools and skills to address these issues and develop solutions to help the system run smoothly. In addition, what makes our cross-training unique is the fact that it capitalizes on the skills of each IT employee to help train others and make the group stronger as a whole. Each employee is encouraged to share their knowledge and to train others in areas of special expertise. This part of cross training ensures business continuity, providing assurance that even if one person on our team is unable to perform their job, the IT department would still be able to perform.

Operations Training

On the operational side of our cross-training system, IT business analysts work with other departments within the organization, and with our affiliates and other state agencies, to understand

and document each group's operational processes. Our business analysts then create operational process flow charts, and train other IT employees to help our team understand how each part of the behavioral health system works. Through this training, the team can see and identify areas of the system that are in need of streamlining, and can apply their expertise to make the system more efficient. As IT employees are trained on internal operations, they develop a deeper understanding of how their own job duties fit into the whole process, and are often able to find ways to make the overall system more efficient. For example, after one of our programmers received claims processing training, he had a better understanding of how his programming could help streamline the claims processing operation. As a result of the training, a software application was designed that allows thousands of claims to be processed in just a few hours, instead of the days or weeks it used to take to process the claims manually. By automating this system, claims are processed more accurately, saving time, energy, and money.

Technical Skills Training

On the technical side, our cross-training system provides access to advanced training resources such as workshops, seminars, college courses, and other continuing education. External technical training enhances the staff's current technical skills, and brings new skills into the IT department. These courses give IT employees the knowledge to improve the performance, reliability, and integrity of data. With the extensive technical skills our IT Department employees have developed though this training, we have been able to offer technical support and training for the subcontracted providers in our network. This includes one-on-one training and technical assistance, as well as group trainings. These collaborative relationships will continue in the future as the IT department continues to look for ways to strengthen communications and data transmission with providers.

Security Training

Managing and addressing security, confidentiality and privacy issues are at the heart of the ValueOptions' National Compliance and IT Security Department's responsibilities. We take federal and state HIPAA legislation, privacy and protection requirements very seriously. National IT has developed a computer-based training session that is required for all workforce members, including all employees, consultants, and volunteers. In order to remain compliant with current HIPAA security legislation, all ValueOptions employees are required by law to complete our online HIPAA Awareness and Security training during new hire orientation and on an annual basis. This training provides each employee with:

- A clear understanding of HIPAA and HIPAA Security Rules.
- An understanding of the differences between electronic PHI and PHI.
- An understanding of how security impacts daily work activities.
- At the end of each training module, staff must complete and pass a test of the information covered in the training. Staff must submit a copy of the training certificates to their supervisor, who must sign and submit the certifications to Human Resources for the employee's file.

Security training completion is tracked and audited for compliance reporting purposes.

Also, as a result of offering certified information systems security professional (CISSP) training, which is part of our advanced technical training, our IT Department now has three internationally certified security professionals. With this training, we have developed and implemented an

application development methodology that ensures the security of confidential recipient information.

CLAIMS STAFF TRAINING

Our claims processing excellence begins with the quality of our claims processing staff. ValueOptions' Claims training program consists of four to six weeks of formal classroom training combined with on-the-floor practical experience. The program incorporates an eight-week step down program for quality initiatives. The training program consists of orientation to ValueOptions' general business policies and procedures, as well as technical training. Technical training is designed for the trainees to become familiar with the claims payment system, understand the behavioral health care business, and begin to become familiar with client specific procedures and claim payment rules. During the classroom training, the new claims processor will begin to process claims in order for management to accurately assess their knowledge and accuracy. All trainee claims are audited at 100 percent. Each trainee is given several worksheets and examinations at various intervals throughout the classroom training to evaluate his or her progress in understanding and applying the material being taught. Once the processors have passed the appropriate skill assessment examination, they are released from training into the claims team. Initially, their claims are audited and reviewed at 100 percent, decreasing as pivotal points are achieved.

Trainers oversee progress for at least two weeks after trainees have been released from the classroom. Each trainer works closely with his or her trainees as they process claims, responding to their questions, helping them with difficult claims, and reviewing their quality monitoring results.

Claims /Encounters Quality

Louisiana members and providers will benefit from the claims audit program that ValueOptions has in place to ensure timely and accurate adjudication of claims. Our claims units are constantly measured using a variety of quality monitoring processes. We have both internal and external audit processes in place to ensure we are meeting and exceeding the expectations of our customers and providers. There are various levels of audits conducted that focus on the financial outcome of the claim, and on policies and workflows used in the adjudication process. Claims are audited both pre- and post-payment to evaluate the abilities of Claims Processors to consistently meet individual and departmental goals.

Each claim audit reviews 41 elements to check mechanical and financial accuracy, such as:

- the correct authorization was used,
- the correct provider record is selected for adjudication,
- the benefits have been applied correctly,
- the correct procedure codes have been entered,
- the dates of service match the bill lines on the claim image,
- the appropriate fee schedule or rate was applied,
- the claim received date meets timeliness provisions,
- claim notes have been entered appropriately,
- the diagnosis is valid and payable based on clients benefit structure,
- the place and type of service is accurate,
- checking claims history to ensure that the claim in not a duplicate,

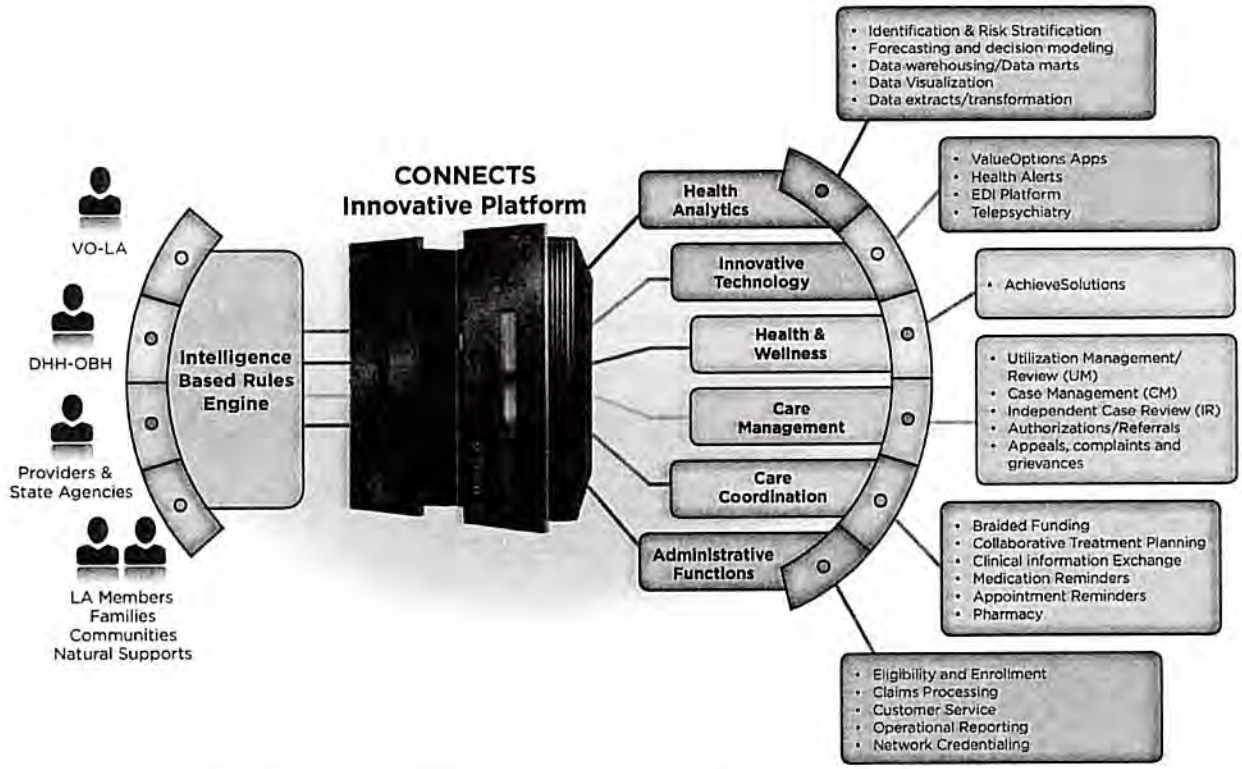
- confirming eligibility against the dates of service on the claim,
- determining if coordination of benefits applies, and
- confirming the number of units against the claim image.

iv. Describe the Proposer's software systems and hardware for managed care and claims payment functions. Include any ancillary modules or systems in use for other related functions (e.g., provider, eligibility, authorizations, data store) and how the systems are interfaced. Please provide a workflow diagram of the process as indicated in the Implementation Planning section of the RFP. Suggested number of pages: 6.

ValueOptions' comprehensive management information system, the CONNECTS platform, is capable of supporting complete managed behavioral health programs from the initial member contact through the claims adjudication and payment processes, in conjunction with the full range of management and utilization reporting requirements. Unveiled in 2005, CONNECTS is a suite of fully-integrated applications designed to support our innovative behavioral healthcare programs. In particular, the CONNECTS platform represents over 20 years of behavioral health experience and associated best practices in supporting public sector behavioral healthcare programs. Working off of a shared database, the platform consists of highly sophisticated, scalable Web-based components designed for:

- member enrollment
- care coordination
- authorizations
- research
- inquiry tracking
- customer service
- electronic data exchanges
- financial operations
- appointment and medication reminders
- provider network management
- care management
- clinical notes
- provider communication
- appeals, complaints and grievances
- claims processing and payment
- reporting functions
- braided funding
- bed tracking

This integrated computing environment has significantly enhanced ValueOptions' ability to improve the coordination of care and service delivery for the nearly 24 million behavioral health recipients we serve throughout the country. It also has allowed us to customize our system to support the varying requirements of our public/private partnerships across the nation. Since 2005, ValueOptions has continued to enhance the CONNECTS platform to specifically meet the current and future needs of the public sector behavioral health programs that we manage. Advanced capabilities have been designed throughout the system to further improve coordination of care services, and can be customized specifically for the DHH-OBH contract.



We provide a comprehensive IT solution that meets the need of DHH-OBH

This behavioral healthcare management information technology is highly functional. By developing a collaborative working relationship with the DHH-OBH, CONNECTS, in conjunction with the systems used by the providers and other State Agencies, will provide a comprehensive IT solution to meet the requirements of DHH-OBH.

SYSTEM SOFTWARE

The following descriptions of the CONNECTS Web-based software systems and technologies provide specific information regarding the processes and tools used to gather the required data to perform the functions for the Louisiana program.

Software Applications
BenefitConnect is our online comprehensive repository which contains all client account information in one accessible program accessible to ValueOptions' staff, which offers a reduction of processing times for customer service calls, and allowing more efficient service to members.
CareConnect is our online care management system that allows ValueOptions' Care Managers to devise, monitor, follow-up, and report on individualized treatment plans for the members they serve. Authorized DHH-OBH staff will have read-only access to CareConnect for auditing needs.
ClaimsConnect is one of the most robust overall claims systems in the industry. ValueOptions provider claims may be received via paper or electronically.
ClientConnect provides DHH-OBH with web based access to search and view Authorization, Member data, submit files and view reports.

Software Applications
EligibilityConnect, is our fully integrated membership eligibility and enrollment module which interacts with references, benefits, contracts, groups, claims, providers, authorizations, and utilization during the adjudication process to ensure eligibility of a member entering treatment.
FileConnect is ValueOptions' infrastructure to support electronic data interfaces that allows clients, providers and ValueOptions to transfer accurate data.
FinanceConnect is our fully-integrated Accounts Payable, Accounts Receivable and General Ledger module.
IntelligenceConnect a secure portal offering clients with a collective suite of on line Business Objects solutions. Presents clients with useful data on-demand by offering interactive dashboard reports and parameter driven report templates.
KnowledgeConnect is ValueOptions' National Data Warehouse, this robust repository receives imports from the CONNECTS platform and other external data sources for reporting purposes.
MemberConnect, a secure web-based application provides behavioral health recipients with the ability to verify eligibility check benefits and check authorizations.
NetworkConnect supports internal users responsible for all contracting, credentialing, provider relations, and network operations administrative processes.
PharmaConnect integrates medical and pharmacy data then uses an alert engine to identify care gaps in a client's total population. The system also generates alert notifications to be sent to physicians, ValueOptions' Care Managers and others.
ProviderConnect, a secure Web-based application allows providers to perform eligibility inquiry, claim status inquiry, claims submission, benefit inquiry, and outpatient care registration.
QualityConnect is our secure, Web-based Adverse Incident and Quality of Care/Service (QOC/QOS) Tracking Application
ReferralConnect is an innovative Web-based provider referral system that offers members access to the wealth of ValueOptions' network resources, online, in real time.
ServiceConnect is our online Customer Service Management System which delivers quicker, better and more efficient customer service to behavioral health recipients and providers that we serve by providing powerful tracking and analytics capabilities.
TeleConnect, functionality allows behavioral health recipients and providers to verify eligibility, check the status of a claim, submit claim through the IVR and request any needed forms.

SYSTEM HARDWARE

Our JAVA-based CONNECTS applications are developed and deployed to the J2EE standard in a two tier configuration utilizing IBM's WebSphere Application Server on pSeries in a clustered configuration. Backend DB2 and Oracle application databases reside on an iSeries i5 595 and two pSeries p5 570's respectively. The ValueOptions i5 and p5's each consist of multiple logical partitions including dedicated production, development, staging, training, and load test environments.

The platform resides on an IBM iSeries (AS/400) i5 595 application server running IBM's V6R1 i5/OS operating system. The ValueOptions i5 595 consists of multiple logical partitions including production and development environments. It is configured with a 17-way POWER5 64bit CPU with 384GB of memory, 58500 CPW Enterprise Edition and over 40 Terabytes of mirrored disk storage. An IBM 3584 Automated Tape Library (ATL) containing 28 3592-E06 high-speed tape drives are attached for fully automated backups. Additional tape device support includes IBM 3590

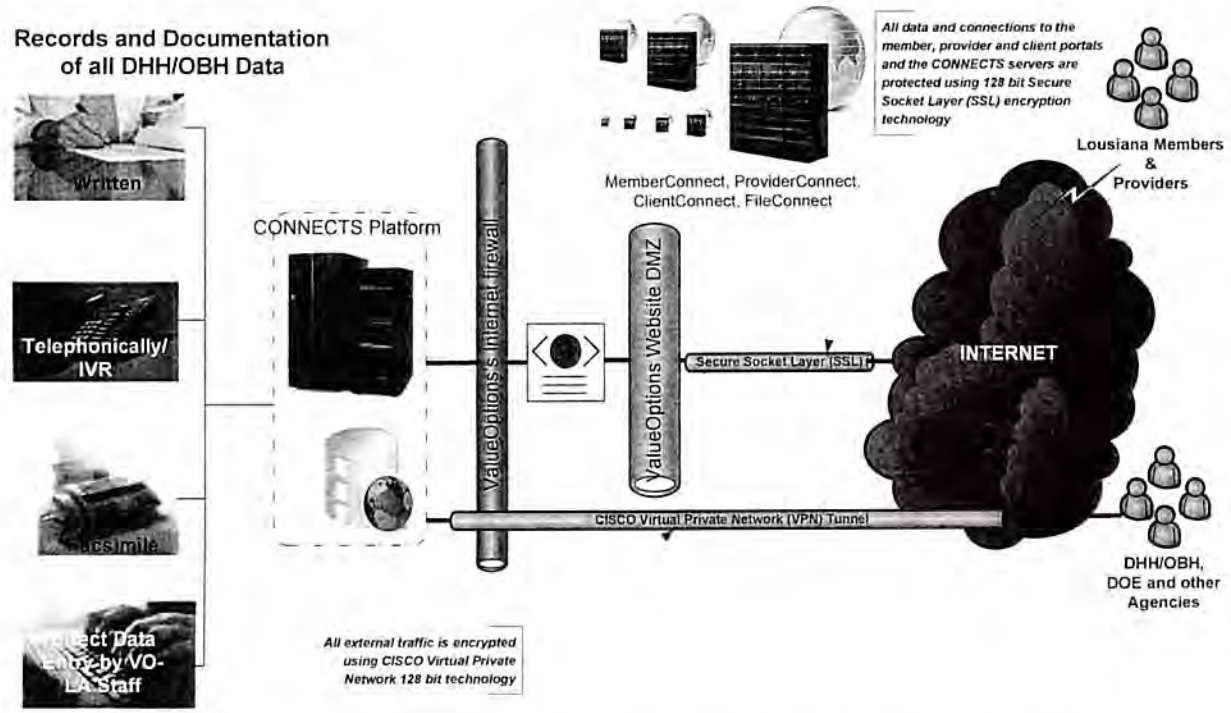
and 3490E tape cartridge for client file compatibility. Host network communications includes four 1Gbps and seven 100Mbps Ethernet adapters.

Our National Data Processing Center will link CONNECTS and our local Louisiana Service Center-based personnel into a seamless and integrated information system solution. Centrally administered through our Reston, Virginia National Data Center, the i595 is accessed by both local and remote users via Local Area Networks (LAN) in a Wide Area Network (WAN) in a Verizon Business, fully-meshed MPLS network configuration.

Providing behavioral health services and service integration is our only lines of business and sole focus. As the largest, privately-held behavioral health and wellness innovator, we specialize in delivering customized services. Since we are not owned by a medical carrier, integration and partnership is what we do. We have a strong commitment to Information Technology. CONNECTS uses a shared database that integrates membership, provider data, clinical information, program information, and encounter/claims processing. CONNECTS, our proprietary and confidential IT Management Information system, comprises multiple, fully-integrated components that cover all of the functions required to administer the State of Louisiana's DHH/OBH Program.

Workflow Diagrams as Indicated in the Implementation Planning Section

The CONNECTS data flow overview provided below illustrates the client flow, data flow, authorization and provider payment process. We have provided workflows throughout our technical response. Additional workflows indicated in the Implementation Section including intake, member service, claims, network development, contracting, credentialing, have been provided as **Attachment 13**.



Our data flow shows client and data flows and the authorization and provider payment process.

Our integrated system will contain all pertinent data related to the DHH/OBH members. The IHP and POC submitted electronically via the web will be accessible to our care managers in our CareConnect application. All eligibility, pharmacy and medical claims data provided by DHH/OBH and encounter data supplied by the DOE will also be available to our staff.

v. Describe how the BH MIS will electronically and securely interface with the DHH Medicaid Medical Information System (MMIS), the WAAs, the DHH-OBH data warehouse, including the capability of interagency electronic transfer to and from the participating state agencies (DHH, DHH-OBH, DCFS, DOE & OJJ) as needed to support operations. Suggested number of pages: 3.

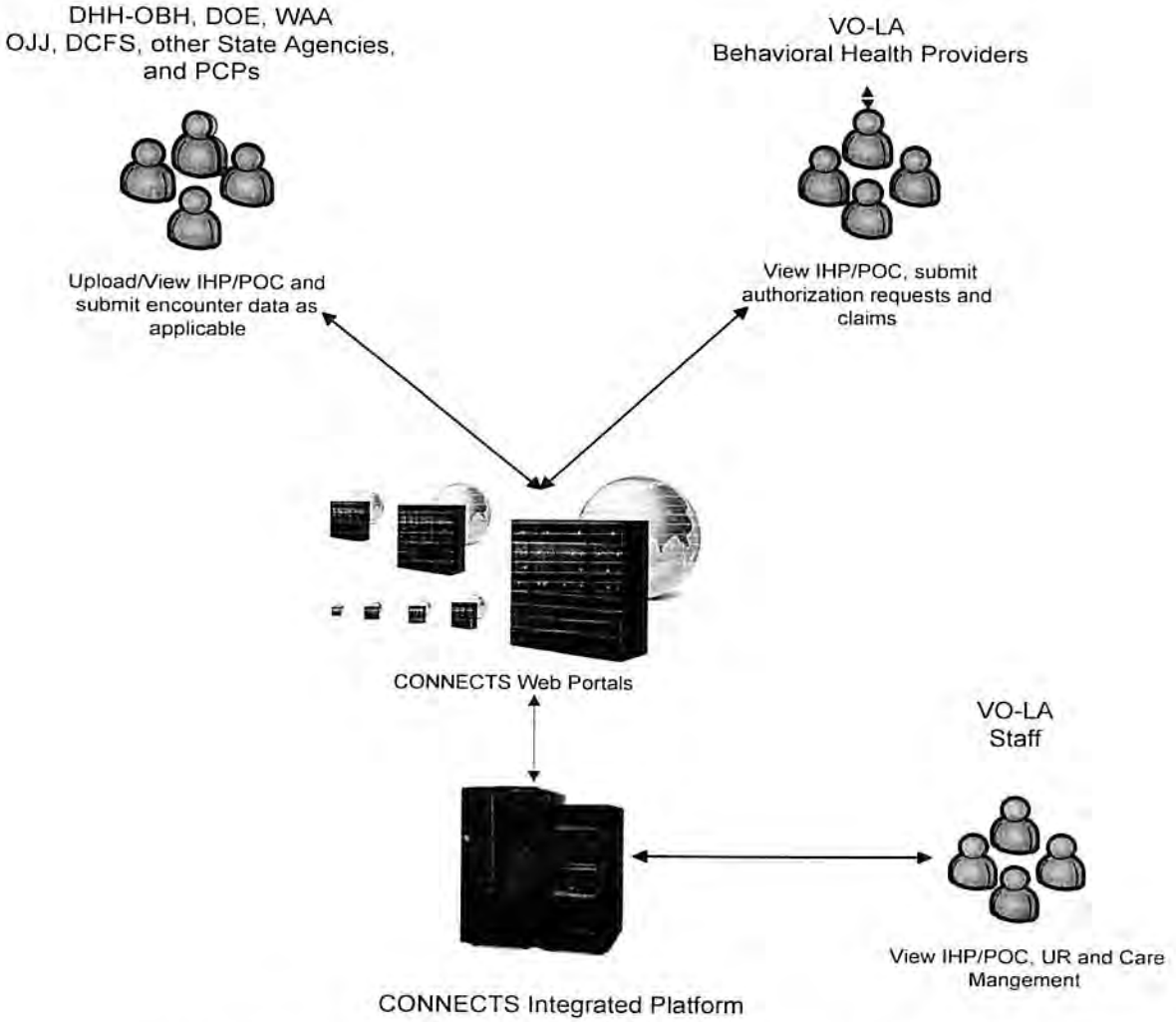
Interfacing with our CONNECTS platform and the DHH Medicaid Medical Information System (MMIS), the WAAs, the DHH-OBH data warehouse and other state agencies' information systems is a must in order to provide the DHH/OBH program with an effective "program-wide" information system. ValueOptions has experience with this type of coordination from working with our over 900 accounts, including large public sector programs and large health plans.

Our integrated behavioral health management information system, the CONNECTS platform optimizes the delivery of healthcare at the point-of-care by focusing on:

- Increasing care quality and ensuring meaningful use for all stakeholders
- Enhancing member satisfaction by eliminating technical barriers to care
- Streamlining communications amongst all stakeholders involved in the member's plan of care

Our platform serves as the mental health point of care and supports opportunities for direct patient interaction. By connecting all stakeholders in the plan of care equation we deliver person-centered, supportive services that optimize and improve health. Our mission is to recognize the whole person and promote consumer and family driven care.

Our CONNECTS web portals offer a complete, integrated behavioral healthcare solution suite that grants all stakeholders access to the plan of care. The web portals allow users to access information 24 hours per day/seven days per week. Additionally, the portals offer several other functionalities to help users automate routine administrative and clinical activities. Our web portals are used by behavioral health providers, government clients and other stakeholders whose goals are to improve the quality of patient care, improve clinical outcomes, reporting and streamline administrative tasks to drive increased efficiency.



CONNECTS enables all State Agencies and Providers to view the IHP and POCs.

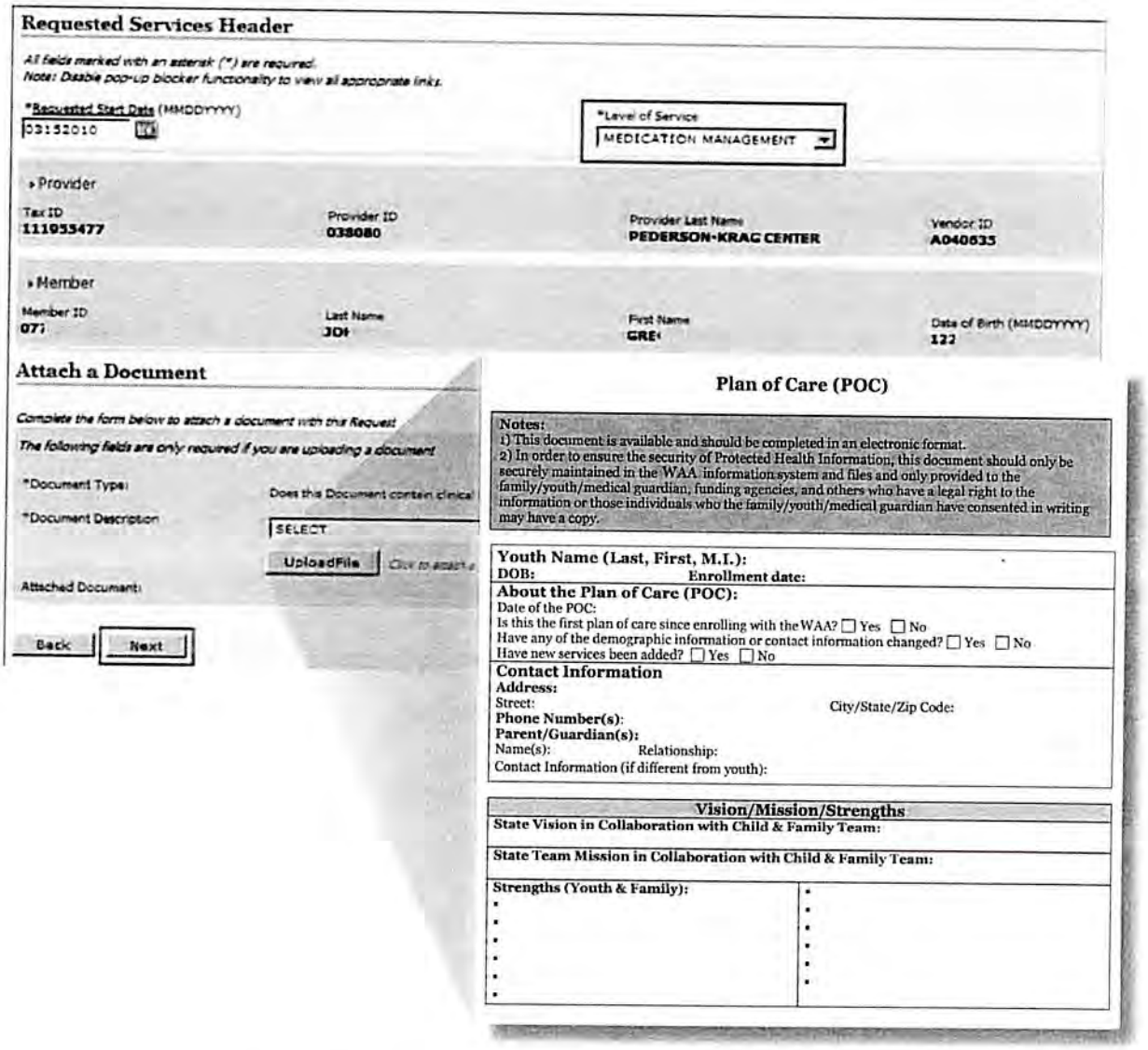
The CONNECTS web portals will allow:

- WAA and LEA's to upload the members IHP and POC;
- Behavioral health providers to submit a request for authorization, view the IHP, POC and a list of prescribed medications for a specific member, submission of claims, view authorization history and other administrative tasks;
- DOE to view the IHP and POC as well as submit encounters on line;
- DHH-OBH to search and view authorization data and access to on line reports; and
- PCPs and other authorized stakeholders will have limited access to view IHP and POC

The extensive functionality of our CONNECTS web portals also enables and empowers users to make informed, knowledge-driven decisions by leveraging shared data in a manner that's useful and meaningful to all stakeholders. Our effective behavioral health platform ensures appropriate, high-quality care; integration of medical and behavioral health needs; ease of administrative burdens; facilitates reporting and offers opportunities for the early detection and proactive implementation of

intervention strategies and protocols. We are dedicated and focused on working with providers, state agencies, and community resources to support individuals in improving their quality of life.

Below is an example of how the WAA would submit the POC via the portal.



WAAs can submit Plans of Care using our Web portal.

DATA EXCHANGES

We interface with a majority of our clients via batch data exchanges. Our data exchange experience not only includes the data exchanges typical to our industry (i.e., eligibility, membership, authorization, claims, and financial data) but also includes client-specific or customized data exchanges based on our CONNECTS application's data collection capabilities and our clients' requirements. When required, we also can establish the required connectivity to accommodate the capability of interagency electronic transfer via a T1 or site to site virtual private network connection with 128b SSL for security compliance. ValueOptions will support the required connectivity by

working with DHH/OBH, other state agencies and providers to ensure all the necessary data circuits and communications lines are installed to support the expected data exchanges.

We transmit data via our robust and secure electronic file transfer infrastructure, File Connect to support electronic data interfaces that allows clients, providers, and third party trading partners to transfer accurate data via secure internet connections. FileConnect, is fully operational and has been successfully in processing inbound and outbound files on a daily basis. FileConnect employs JBoss messaging for '*guaranteed delivery*' of information exchanged with our clients and business partners. FileConnect also has the capability to send and retrieve (push/pull) files in a secure manner from our client and business partners' servers remotely. FileConnect offers different pathways to accommodate clients with diverse infrastructural needs, including:

- File Transfer Protocol (FTP) over Virtual Private Network (VPN)
- FTP with Pretty Good Protections (PGP) encryption/FTPS
- Secure Shell (SSH) over FTP
- Web Service call over Hyper text Transfer Protocol (HTTPS)
- Secure Web site submission over HHTPS

FileConnect is programmed to receive and process electronic records automatically and seamlessly with our CONNECTS Platform. FileConnect also includes provisions for file and format verification, allows for prompt addition of new file types, and provides notification of file validation results (whether the file was successfully processed or not) via the internet. FileConnect allows for desktop retrieval of processing results via an intranet server using any Web browser and Internet Service Provider (ISP).

The specific advantages and features of FileConnect include:

- facilitates electronic file transfers for providers, clients, and other computer systems using secure Internet connections
- accepts inbound transactions from multiple sources
- compliance-checks all inbound/outbound HIPAA-regulated EDI transactions
- supports customer-specific file formats
- allows submitters to track all file submissions
- allows for the prompt addition of new file types, and provides notification of file validation results (whether the file was successfully processed or not) via the internet
- support industry standard security protocols; supports multiple file transfer protocols including FTP, FTPS, SFTP, Web interface, Web services
- sends and retrieves (Push/Pull) files in a secure manner from our client and business partners' servers remotely

This interface provides a reliable, efficient, and uniform process for transferring data. We also maintain a backup system for the EDI, so that even if one line goes down we can handle the same job multiple ways. FileConnect, complies with HIPAA standards for all EDI transactions. The solution is highly scalable, and receives, routes, stores and sends transactions consistent with ANSI X12 standards. It supports all HIPAA-regulated EDI transactions as well as client specific custom files that ValueOptions exchanges with DHH Medicaid Medical Information System (MMIS), the WAAs, the DHH-OBH data warehouse, other state agencies and the provider network.

Interfaces/Transaction Types	Compatible Solution(s)
Authorization data	FileConnect
837 Professional 837 Professional Health Care Claim - ASC X12N 837	FileConnect
837 Institutional Health Care Claim - ASC X12N 837	FileConnect
835 Health Care Claim Payment Advice - ASC X12N 835	FileConnect
276 Health Care Claim Status Request – ASC X12N 276	FileConnect
277 Health Care Claim Status Response – ASC X12N 277	FileConnect
278 Healthcare services review – ACS X12N 278	FileConnect
834 Benefit Enrollment and Maintenance – ACS X12N 834	FileConnect

As noted previously, CONNECTS uses a shared database that integrates membership, provider data, clinical information, program information, and encounter/claims processing; as well as external data collected from the multiple state agencies. As the data is submitted by the agencies, the file is compared to validate it meets the expected format, then integrity checks are executed for data inside the file and from data supplied from the submitter (number of records), lastly required critical data elements are checked. If the file fails any one of these validation routines, an automated message will be sent to the submitter. Once the system validates the data it is integrated within CONNECTS thus making the DHH/OBH and other data collected to support the contract accessible to all stakeholders.

vi. Describe Proposer's web-based capabilities to receive and respond to providers and State agencies for referrals and prior authorizations for services. Suggested number of pages 2

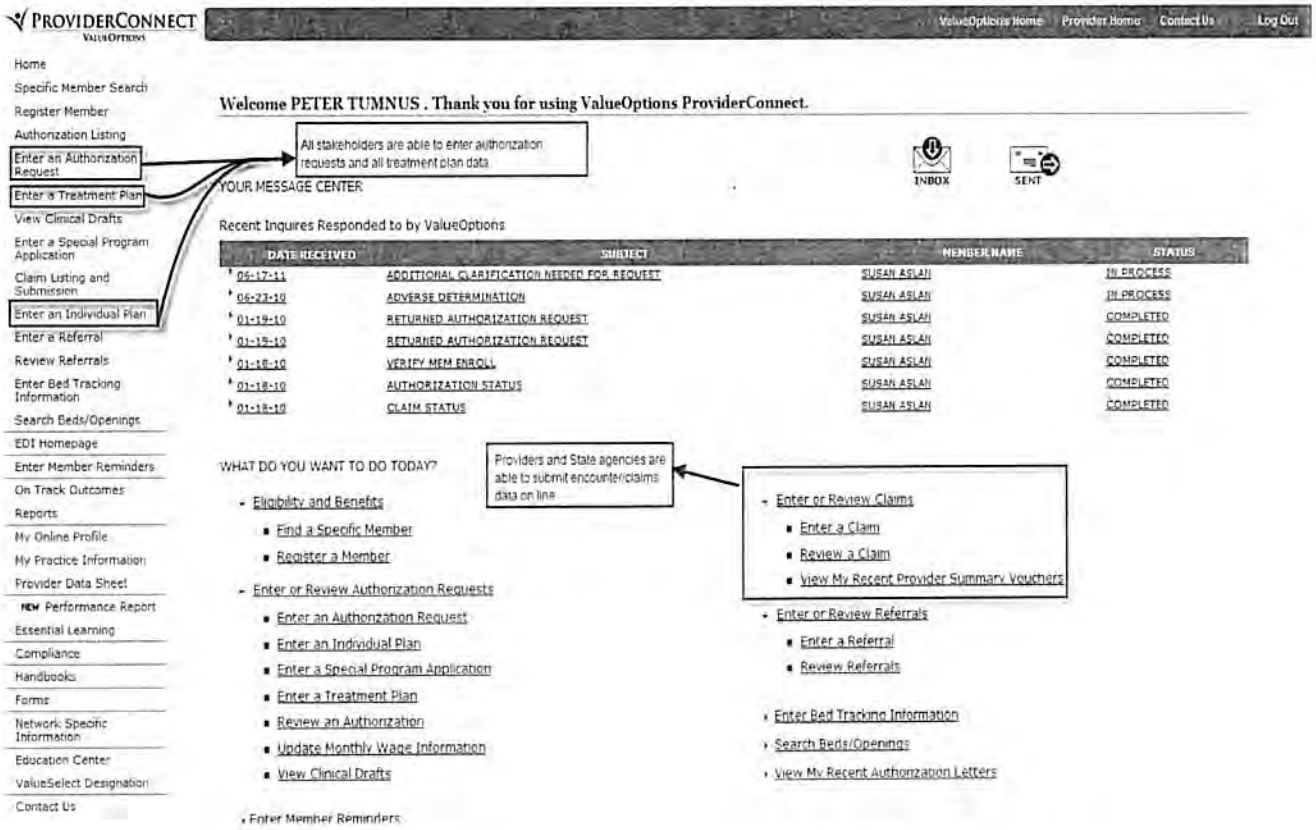
ValueOptions' secure, 24-hour-a-day, seven-day-a-week accessible provider web portal empowers providers, the WAAs, and the State agencies and enables them to view, submit, and execute care management transactions online, via our secure, scalable and trusted web portal. Through a robust, yet highly intuitive web portal, providers have real-time access to the tools necessary to answer a majority of their administrative and care questions, as well as request services for members, and set up reminders for members. ProviderConnect accelerates data interfacing with providers and State agencies by delivering an interactive web-based system for collaborative business processes. Key features of the ProviderConnect website include the ability to:

- check status of a member's enrollment;
- register a member for services,
- review and submit requests for prior authorization of care, as well as, the ability to print or save requests into their management information system (MIS) or electronic medical record,
- review and submit individual health plans (IHP) and treatment plans (POC),
- view and submit discharge plans,
- enter member reminders for appointment and medication,
- submit/attach documents to all submissions;
- view and print online correspondence, such as authorization letters/provider summary vouchers; exchange electronic data between providers, WAAs and State agencies through our electronic transport system , FileConnect;
- create and view other types of inquiries via a message center;
- view authorization and letter history;

- manage bed tracking (bed matching and referral) and search for beds/openings,
- view and submit updates to demographic data for providers;
- directly enter and submit a claim/encounter or upload HIPAA compliant claim/encounter files online
- view provider handbooks, obtain information on trainings, current clinical articles, and workshops;
- access DHH-OBH network information;
- download and print standard forms;
- submit NOMS and CANS data
- run robust, parameter driven claims and authorization reports as approved

ProviderConnect will allow all stakeholders involved in the member's care treatment plan to coordinate, review and submit all pertinent information related to the member's care.

Below is a screenshot of the ProviderConnect home page; which illustrates the many administrative functions accessible to the providers. All WAAs are able to submit their POC and via the Web portal. All providers and State agencies will be able to view the POC and submit encounter files online as well.



Providers can accomplish many administrative functions using ProviderConnect.

vii. Describe how the Proposer's BH MMIS will meet the requirements for regular (e.g., bi-weekly) electronically transfer client/episode-level recipient, assessment, service, and provider data to the DHH-OBH data warehouse/business intelligence system operated by the State for purposes of state and federal reporting (e.g., SAMHSA National Outcome Measures (NOMS), Treatment Episode Data Sets (TEDS), Government Performance Reporting Act (GPRA), and for ad hoc reporting as needed by the state for service quality monitoring and performance accountability as outlined in the Quality Management Strategy). Suggested number of pages: 4.

Leveraging our advanced technology and open- source information systems architecture, we have highly adaptive interface mechanisms available for electronically transferring the required data to the DHH-OBH data warehouse/business intelligence system. In every public sector program ValueOptions has implemented, we have modified our system to accommodate the unique requirements of that state. As a result, we have continued to assemble technologies that allow us to improve our approach to data collection, analysis, and management in new and more efficient ways. The CONNECTS platform is capable of collecting all federal reporting elements required by the Center for Mental Health Services, including the National Outcome Measures (NOMS), Treatment Episode Data Sets (TEDS) and other data set required for quality monitoring and reporting needs.

All data exchanges are facilitated through our FileConnect application, which has been described in detail throughout this section. We have successfully experience with both industry-standard data exchanges including eligibility, enrollment, membership, authorization, claims and financial data, as well as client-specific proprietary data systems exchanges. These exchanges are based on our CONNECT data collection capabilities and, as required, can be further customized to meet specific requirements for the Louisiana program.

More specifically, we have experience transferring data to our other State clients for the purposes of meeting federal reporting requirements such as NOMS and TEDS. During implementation, we will work with DHH-OBH to outline the specific data interfaces that will occur to support such reporting requirements.

ValueOptions has direct experience in developing the data sets required to support TEDS. We recognize the significance of meeting this federal deliverable and are dedicated to ensuring the timely and accurate submission of TEDS data on behalf of DHH/OBH. In order to ensure that DHH-OBH continuously meets the federal requirements, we will support all current and future modifications to the TEDS data set, including any updates to enrollment forms, claims, and other necessary data elements.

Our goal for the TEDS project is to provide DHH/OBH the flexibility to run data for any time frame, thus improving the frequency of the reporting. The first part of this initiative is to create a data set that would meet the federal requirements. We will work closely with DHH/OBH staff in the development of this first data set. Since ValueOptions has developed and owns the TEDS code set, we are able to easily adjust it in house as a result of input from DHH/OBH. This data set encompasses many different types of data including encounters, member, provider, enrollment, diagnosis information and data collected from the other state agencies (i.e. DOE, WAA, DCFS, and OJJ).

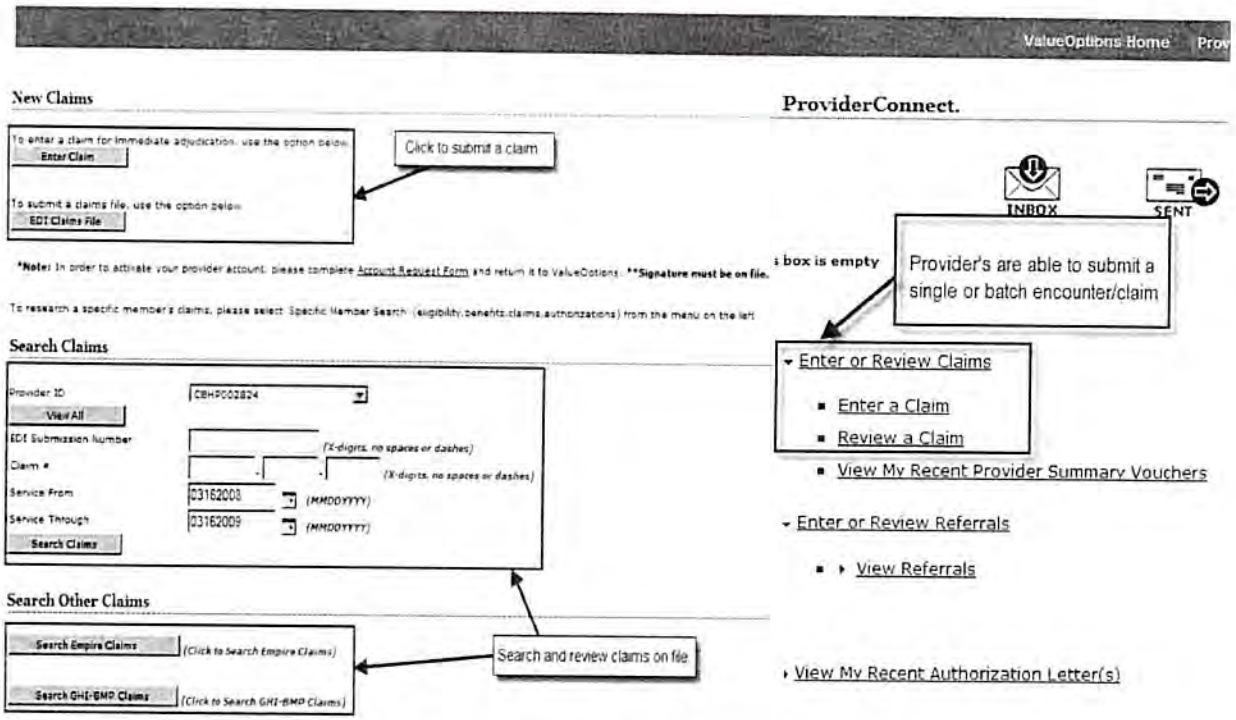
viii. Describe the Proposer's use of Internet website for providers, including any interface with the claims system, eligibility and provider data. Include provider capabilities to use the website to submit authorization requests, claims or inquiries. Suggested number of pages: 4.

ValueOptions' secure provider Web portal, ProviderConnect, empowers our providers and enables them to view, submit, and execute care management transactions online, via our secure, scalable and trusted Web portal. Through this robust, yet highly intuitive web portal, providers have real-time access to the tools necessary to answer a majority of their administrative and care questions, as well as request services for members, and set up reminders for members. ProviderConnect accelerates provider's workflows by delivering an interactive web-based system for collaborative business processes. Key features of the ProviderConnect website include the ability to:

- check status of a member's enrollment
- register a member for service
- check a member's benefit information
- review and submit requests for authorization of care, as well as, the ability to print or save requests into their MIS or electronic medical record (some requests will receive immediate authorization based on benefit)
- review a detailed payment status of submitted claims
- view and submit updates to demographic data for providers
- submit/attach documents to all authorization requests and other submissions
- directly enter and submit a claim or upload HIPAA compliant claim files online (as a registered user and claims submitter on ProviderConnect, providers can elect to register for Electronic Funds Transfer)
- view and print online correspondence, such as authorization letters and provider summary vouchers
- create and view other types of inquiries via a personalized message center
- view authorization history and letter history
- enter member reminders for appointments and medications
- view provider handbooks, obtain information on trainings, current clinical articles and workshops
- access client specific network information
- download and print standard forms
- review and submit individual plans and treatment plans
- enter special program applications
- submit NOMS and CANS data

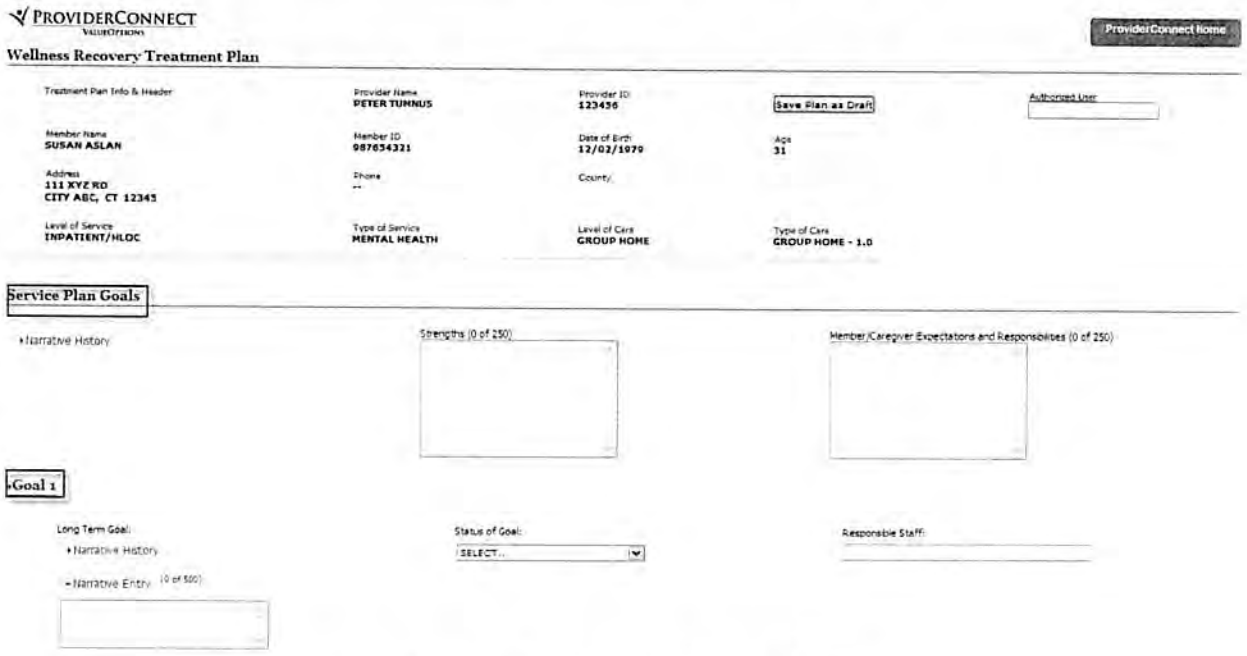
CONNECTS, our proprietary and confidential IT system, comprises multiple, fully-integrated components that cover all of the functions required to administer the Louisiana program. CONNECTS uses a shared database that integrates membership, provider data, clinical information, program information, and claims processing. Thus all data submitted via each of our Web portals, including ProviderConnect, appears in 'real-time' within our care management system, CareConnect, allowing our staff to provide immediate service to providers, members, and our clients.

A screenshot of the claims submission options from the ProviderConnect home page is provided below:



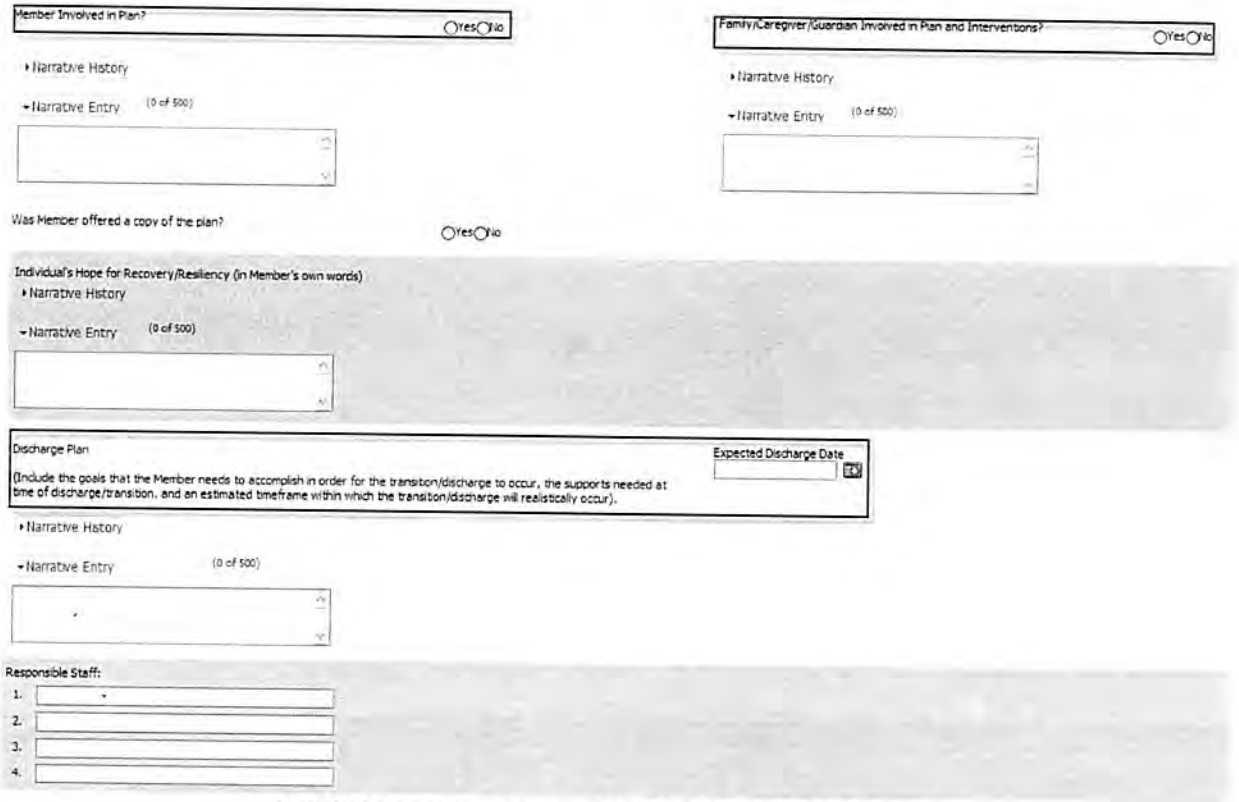
ProviderConnect provides claims submission options.

Below are some screenshots of the online Treatment Plan. Providers are able to submit 10 long term goals and three short term goals within each of the 10 long term goals.



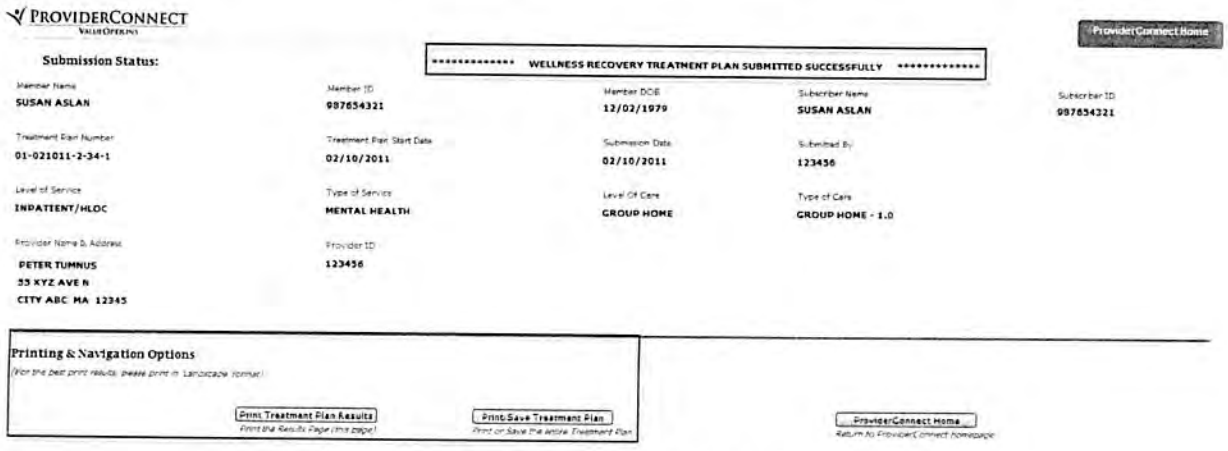
Providers can submit goals using ProviderConnect.

Providers can indicate whether the member or other stakeholders were involved in developing the treatment plan. ProviderConnect allows for the submission of a discharge plan as well.



Stakeholder participation can be included on ProviderConnect.

The system automatically displays a confirmation that the treatment plan was successfully submitted. Providers have the ability to print a copy of the treatment plan they submitted or save it to their personal device.



The system provides a confirmation.

ix. Describe the Proposer's system's ability to provide an electronic data interface to allow transfer of Health and Insurance Portability and Accountability Act- (HIPAA) compliant information from and to WAA, DOE or other agencies. Include the transfer of eligibility and encounter data in the Proposer's response. Suggested number of pages: 2.

We are committed to performing business activities in compliance with all applicable laws, regulations, and HIPAA-related policies. We have implemented transmission security to ensure that security violations are prevented, detected, contained, and corrected in accordance with federal HIPAA Security Regulations.

As noted previously, our CONNECTS Web portals offer a complete, integrated behavioral healthcare solution suite that grants all stakeholders access to the plan of care. The Web portals allow users to access information 24 hours per day/seven days per week. Additionally, the portals offer several other functionalities to help users automate routine administrative and clinical activities. Our web portals are used by behavioral health providers, government clients and other stakeholders whose goals are to improve the quality of patient care, improve clinical outcomes, reporting and streamline administrative tasks to drive increased efficiency.

The CONNECTS web portals will allow:

- WAA and LEA's to upload the members IHP and POC;
- Behavioral health providers to submit a request for authorization, view the IHP, POC and a list of prescribed medications for a specific member, submission of claims, view authorization history and other administrative tasks;
- DOE to view the IHP and POC as well as submit encounters on line;
- DHH-OBH to search and view authorization data and access to on line reports; and
- PCPs and other authorized stakeholders will have limited access to view IHP and POC

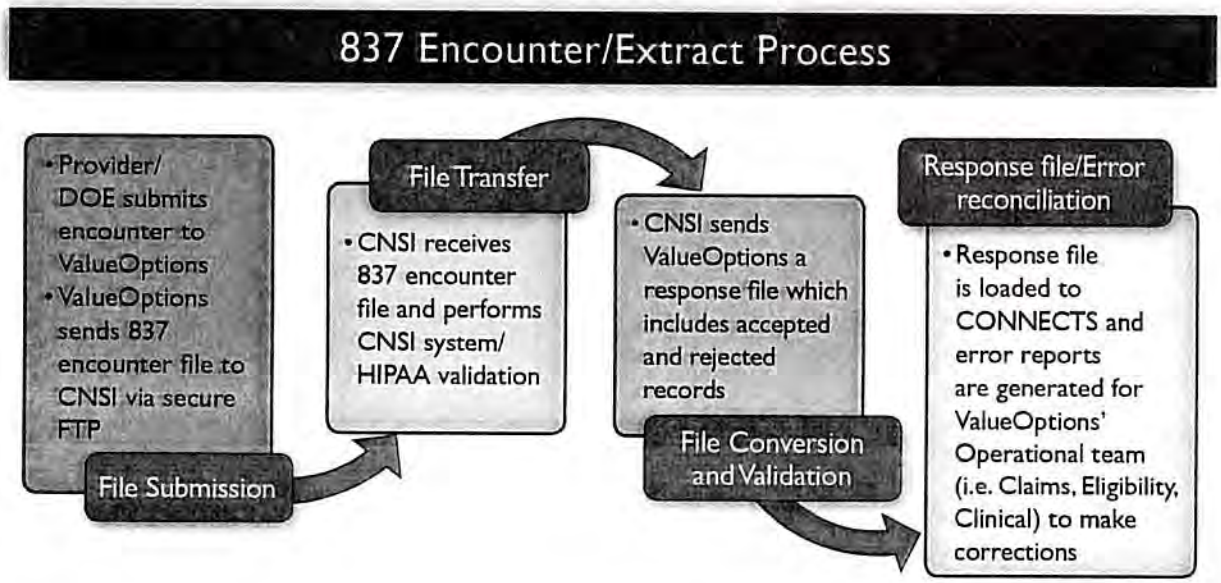
In addition, the portals offers DHH-OBH, providers and the state agencies to exchange files with VO-LA via FileConnect, our automated FTP system. VO-LA will also use FileConnect to transfer test files with CNSI, the Louisiana MMIS vendor, WAA, DOE, or other agencies for the purposes of exchanging data, including but not limited to eligibility and encounter data. This interface allows us to provide a reliable, efficient, and uniform process for transferring data. We also maintain a backup system for the EDI, so that even if one line goes down we can handle the same job multiple ways. FileConnect complies with HIPAA standards for all EDI transactions. The solution is highly scalable, and receives, routes, stores and sends transactions consistent with ANSI X12 standards. It supports all HIPAA-regulated EDI transactions as well as client specific custom files that ValueOptions exchanges with providers and state agencies.

In support of 11 of our Medicaid and Health Choice contracts, ValueOptions interfaces with the specific state or it's fiscal agent to exchange over 50 different data exchanges.

ValueOptions has demonstrated experience in the development of outbound 837 encounter and pre-priced claims extracts as well as corresponding response files (997,277 and client-specific formats). We currently provides extracts for several public sector and health care trading partners and has transmitted approximately 2.5 million claims in outbound 837 files since 2005. Our experience includes interfacing with several different fiscal agents in our other state contracts.

We have developed a core set of standard programs to select and format the outbound data and import response files. Data is tracked throughout the transmission process, including submission and response status. We have the ability to check compliance of file formatting and data content using nationally accredited compliance checking tools. The DHH-OBH extract will be tailored to meet the requirements of CNSI's companion guidelines in addition to the national HIPAA standards.

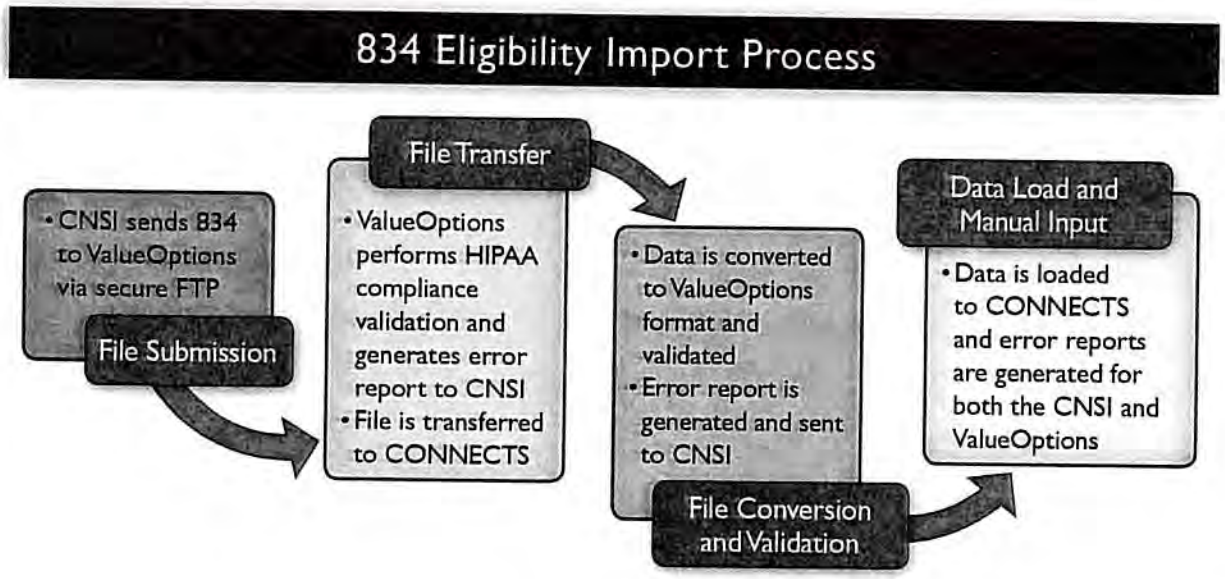
Below we offer an example of the data flow for the 837 encounter file. The actual data flow may vary based upon review of CNSI's companion guide and further discussion to define the specific business and technical requirements.



ValueOptions currently receives and processes enrollment data for more than 24 million commercial, federal, and public assistance consumers. Our system has an automated front-end eligibility load module, EligibilityConnect, which can either process enrollment and disenrollment information in ValueOptions' standard format, or develop a customized load. Client preferences control identification codes that control processing requirements, such as including a link from a family unit to an individually enrolled member.

Our fully integrated membership eligibility and enrollment module interacts with references, benefits, contracts, groups, claims, providers, authorizations, and utilization during the adjudication process to ensure eligibility of a member entering treatment. Eligibility Specialists coordinate eligibility data transfer, in concert with ValueOptions' National IT Department, to ensure that all information is loaded properly and interpreted quickly so that the system remains up-to-date.

Below is an example of a data flow for the 834 – Eligibility file transfer. As noted above, we will work with the CNSI to obtain their companion guide, confirm file formats, frequency of exchange, and coordinate testing of file transfer before implementing in our production environment.



x. Describe the Proposer's experience and capabilities in using, creating, and sharing data and maintaining electronic health records. Suggested number of pages: 2.

For decades, ValueOptions has pioneered collecting, integrating, managing, and applying the key data used to comprise comprehensive Electronic Behavioral Health Records (e-BHR). Our e-BHR includes but is not limited to the ability to capture the following data:

- consumer demographics
- treatment and service planning (joint care review)
- objective and standardized assessments
- consumer event tracking
- clinical progress notes
- at-risk crisis plans
- crisis tracking
- medication tracking
- referral tracking
- admissions and triage
- discharge planning
- integrated utilization management
- complaint tracking
- bed tracking (bed matching and referral)

We develop and support integrated e-Health platforms consisting of behavioral, pharmaceutical, disease management and medical information to drive improved clinical outcomes for the members we serve. Examples of this work include the following:

- We assisted state agencies in Arizona, Connecticut, Colorado, Florida, Illinois, Massachusetts, New Jersey and Pennsylvania define their technical requirements for a comprehensive Electronic Behavioral Health Record (e-BHR), key data elements, and data sharing strategies
- We developed HIPAA-compliant data exchange processes and systems, such as our universal file exchange gateway, FileConnect.
- We developed and deployed advanced data collection tools and data management strategies to meet their requirements for ensuring the safety and security of personal health data. This resulted in driving down health care cost and improving clinical outcomes by making critical health information readily available at the point of care.

In support of our continuous quality improvement process, we assign dedicated technical personnel to review, assess, and determine the most effective methods for ensuring interoperability with Health Information Exchange (HIE) platforms being used or designed by our state-level clients. Our knowledge and expertise also extend to the use and integration of new care coordination technologies such as HIE. We have strategic alliances with several vendors and core technical insight which enables us to securely exchange and share member health data across multiple EMRs, Laboratory Management Systems (LMS), and Practice Management Systems (PMS) used by behavioral health providers and the PCPs to save providers time and money, while improving clinical outcomes and the quality of care provided to the members we serve.

xi. Describe the Proposer's system's ability to send and receive data from other agencies consistent with the collaboration requirement in the Scope of Work. Suggested number of pages: 3.

As previously mentioned, our web portals are designed to allow providers and state agencies to submit and view data online. As noted earlier, we will also leverage our internally built secure FTP platform, FileConnect to exchange data. When required, we also establish the required connectivity to client's systems.

Our integrated platform is flexible and scalable to support the required data exchanges including but not limited to eligibility, IHPs, encounters and pharmacy data from DHH-OBH, DOE, OJJ, providers as well as any other agencies that we'd need to interface with in order to support the DHH-OBH contract. During implementation, we will work closely with DHH-OBH, CNSI and all agencies to gather detailed requirements, write functional specifications, conduct testing, and coordinate the delivery of the application and data integration necessary to support the implementation. We will mitigate any unforeseen difficulties with interfacing with the other agencies' information systems by working closely and collaboratively with DHH-OBH and the other agencies' IT representatives during this time period.

The CONNECTS system is designed to support the need to share treatment plan information with all stakeholders involved in the member's treatment. The system allows users to upload supporting documents; which will also be visible to all stakeholders involved in the members treatment. Also, our web portal is designed with the functionality to allow the submission of encounter data via a batch file load process or single claim submission.

ValueOptions' CONNECTS platform can assign funds from multiple program sources to pay for an individual service package, and maintain tracking and accountability for each funding stream at the administrative level. The funds remain in separate strands but are joined or 'braided' based on the individual consumer, resulting in improved service accessibility, and claims payment processes.

The revolutionary design of the eligibility logic embedded in ValueOptions' Braided Funding℠ System was developed to overcome the challenges experienced through the development of the model. ValueOptions forms collaborative partnerships with government agencies to provide fully integrated clinical services with the capacity to support administrative functions and reporting through an integrated (MIS) infrastructure. The graphic below describes the eight-step process ValueOptions uses to accommodate a braided funding client.

xii. Describe the Proposer's reporting capabilities. Include the reporting functionality, where the reporting is performed (e.g., online or separate database) with how current data is for reporting. Describe ad hoc reporting capabilities and who can perform them. Provide a listing of system reports and their frequency. Suggested number of pages: 5.

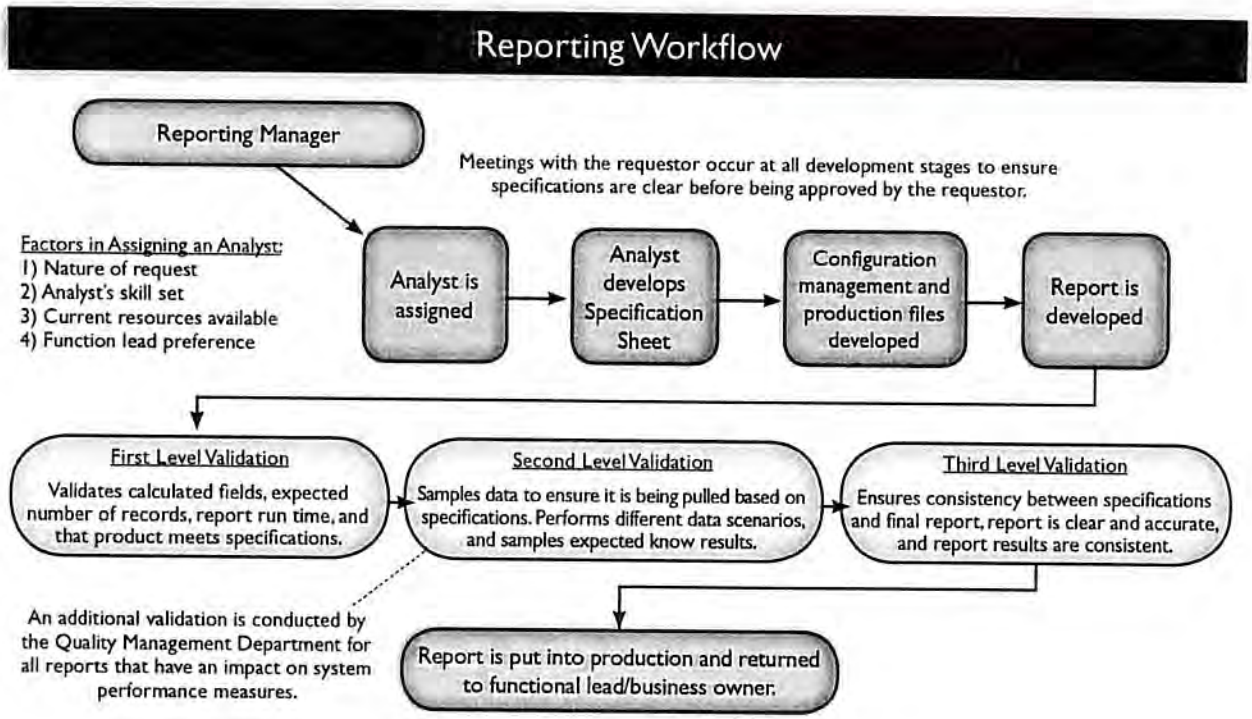
REPORTING CAPABILITIES

VO-LA knows that DHH-OBH requires accurate and timely information to drive program development and management. Our reporting processes will increase transparency and accountability by making data available for oversight of our performance, and to continuously enhance provider quality.

To ensure the development of accurate reports, we employ a stringent development, review, and validation process. This process is one that has been adopted from the ValueOptions Data Management & Analysis (DM&A) Department and is employed in other state Medicaid contracts. The basic tenets of this process include:

- **Technical Specifications**—The DM&A Department follows an internal policy and procedure for the development of technical specifications for all report requests. This includes the Technical Specification Request (TSR) application, which tracks key information about a report, including the report name, description, and formulas.
- **Report Development**—All system-generated production reports are developed by special programmers using Crystal Reports Professional and adhere to the specifications noted in the TSR and accompanying mock-up.
- **Validation**—This is the most important step in the process for the DM&A Department. Every report is developed using the same validation process to ensure the accuracy of the report. The validation process is as follows:
  - The Programmer of the report will conduct three tests on the report. Each test is documented and included in the TSR application.
  - The assigned Analyst will conduct independent validation tests on the report. One of the tests will use the same report parameters and criteria utilized in the Programmer's test scenario while the other two will be independent.
  - The Department Manager reviews the TSR, the report, and test data output before signing off on the report.

Because our DM&A Department follows these time-tested report development processes, we are confident in our ability to meet the reporting goals of DHH-OBH. On the following page is a depiction of our reporting workflow.



Reporting Product Process

VO-LA recognizes that timely and accurate delivery of production reports is key to meeting DHH-OBH's needs for relevant information concerning program operations and results. We have delivered a tremendous volume of monthly, quarterly, and annual reports as required by our state Medicaid clients to continuously monitor program performance. As a result of this experience, we continuously work to improve our processes associated with the timely provision of reports for other clients. Our plan to ensure timely report delivery for DHH-OBH will include the following:

- **Management Oversight by Chief Executive Officer (CEO)**—The VO-LA CEO and our Compliance Administrator will have ultimate oversight of the process for the development and provision of all contract deliverables. The VO-LA CEO will work closely with quality management, data management, and each report owner to ensure data is validated, reports are quality-checked, submissions are timely, and all reporting requirements are met. The CEO will certify all data and documents prior to submission to DHH-OBH
- **Monthly Production Process**—Effective workflows and processes will be developed to ensure accurate and timely production reports are delivered to DHH-OBH. The workflows and process will include:
  - Monthly system-generated reports produced and delivered to report owners by the 8th calendar day following the end of the reporting cycle
  - Report owners completes review and analysis, if required, by the 14th calendar day following the end of the cycle

Management and Financial Reports

VO-LA will submit regular monthly reports, including but not limited to: statement of account, itemized invoices, and all reports necessary to determine satisfactory contract performance within 10

calendar days of the following month. We will furnish special reports within the timeframes designated by DHH-OBH at the time of the report request. Under the direction of ValueOptions' Public Sector Division Chief Financial Officer, the Finance Department is responsible for assuring all funding is properly tracked and documented in accordance with generally accepted auditing principles and federal and state requirements.

IntelligenceConnect Online Reporting

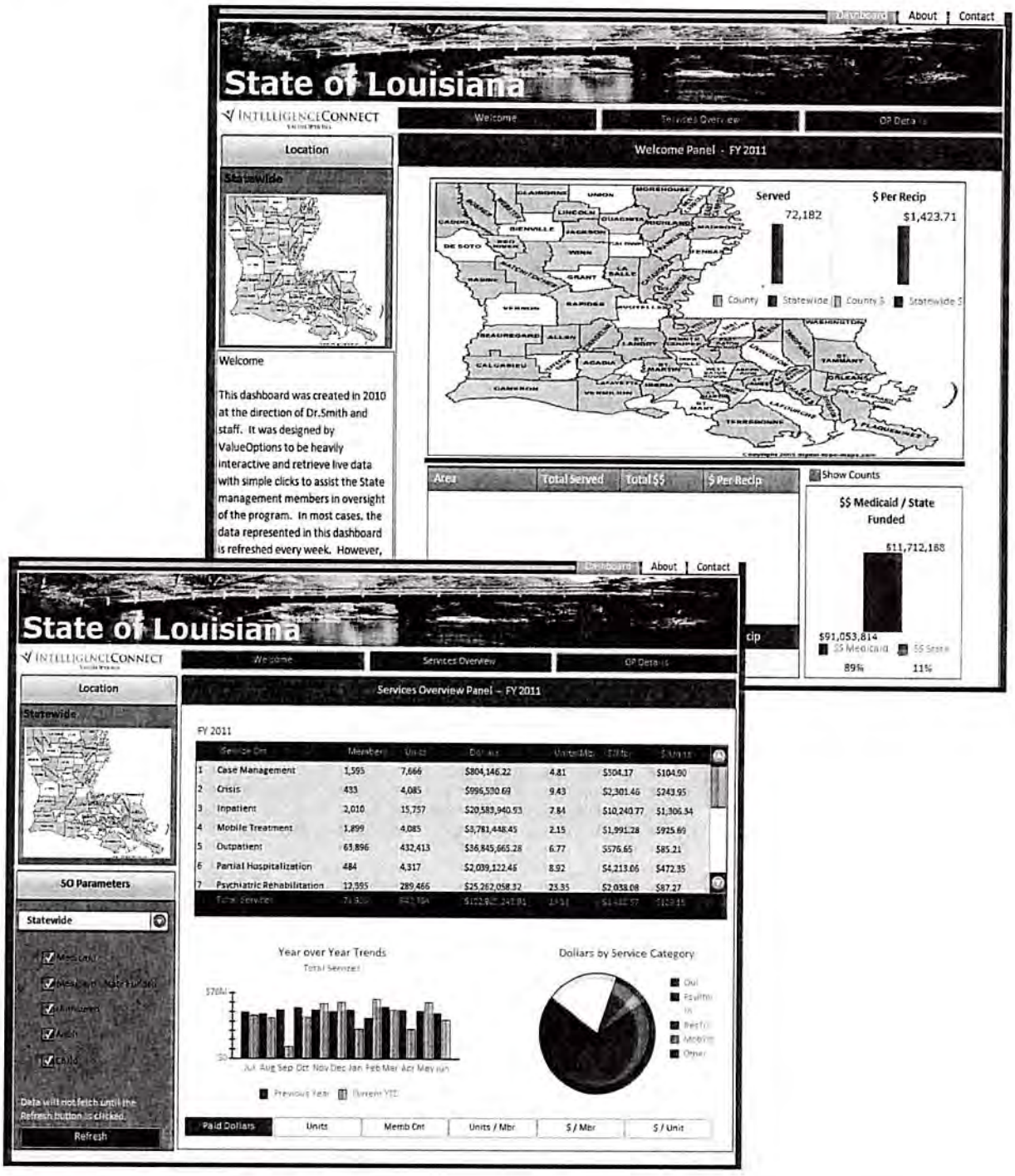
VO-LA recognizes that there are many different consumers of data and information within the State of Louisiana – from DHH-OBH to providers, Members and constituents. We are committed to working with DHH-OBH to design information delivery solutions to ensure access to data for all levels of users within the State. We will delivery access to data through our online reporting platform, IntelligenceConnect.

We have adopted a fully integrated Business Intelligence (BI) philosophy using the products and services of SAP™, the recognized leader in BI. We will develop a customized dashboard solution for DHH-OBH which leverages our vast experience in developing these solutions for our other public sector contracts. We have been successful in applying their products and solutions for both internal and external customers for more than 10 years. The foundation of our BI philosophy is that on a day-to-day basis, every decision maker should have direct access to the data and information that allows him or her to make informed decisions. Our BI philosophy further recognizes that the technical skills of our community vary, and that their data needs are constantly changing. To address the dynamic nature of users and requirements, we offer products that span the full spectrum of technical abilities. This philosophy will guide our reporting solution for DHH-OBH.

ValueOptions' dashboard reports, including NOMS data provides data and performance statistics that are fully customizable to meet our client's needs, and are available online to DHH-OBH key stakeholders. Our secure, user friendly and easily understood formats provide dashboard, report statistics, and ongoing trending and identification of services used by members. The online reports also document any gaps in care for program-related services. In addition, the online dashboard can serve as a compliance benchmark for DHH-OBH contract monitoring staff to ensure ongoing and 'live' data regarding the activities of VO-LA.

Our data structures are flexible and can accommodate DHH-OBH's reporting requirements. Our system can also be modified to accommodate any future needs. This flexibility stems from the fact that ValueOptions owns the source code to our management information system, CONNECTS. All the data structures contained within the CONNECTS DB2 database and reporting database were designed and are maintained by our IT staff.

Provided on the following page are sample screenshots of an existing dashboard being utilized in another state. We have taken the liberty of inserting a Louisiana County map to showcase its capabilities.



List of System Reports and Frequency

On the following page, we include a list of sample reports available to DHH-OBH and their frequency. We will work with DHH-OBH to ensure this list is all-encompassing and includes all required reports to allow the State to conduct its own analysis and reporting.

Report	Description of Report	Report Frequency
Number of Calls	Total number of calls received by clinical, member service, and crisis queues	Quarterly
Average Speed of Answer (ASA)	Average number of seconds to answer all calls with a live person, including after hours calls and authorization lines, measured by the selection of a menu option	Quarterly
Call Abandonment Rate (CAR)	Total number and percentage of calls abandoned, including after hours calls; measured by each hour of the day and average for the month	Quarterly
Calls Answered within 30 sec.	Total number and percentage of calls answered within 30 seconds	Quarterly
Busy No Answer	Total number of telephone calls and percentage of calls that reached a busy signal	Quarterly
Hold Time	Total number and percentage of calls placed on hold and average length of time on hold for clinical and member services	Quarterly
Average length of time of call.	Average length of time of call.	Quarterly
Higher Levels of Care Timeliness Summary for Initial Authorizations (with and without peer review)	Number and percentage of cases that met the required timeframe broken out by approved, denied, partially denied, suspended, or terminated. For those cases which did not meet the goal, report will include average time frame for completion	Monthly
Lower Levels of care Timeliness Summary for Initial Authorizations (with and without peer review)	Number and percentage of cases that met the required timeframe broken out by approved, denied, partially denied, suspended, or terminated. For those cases which did not meet the goal, the report shall include average time frame for completion	Monthly
Higher levels of Care Timeliness Report for Concurrent Reviews (with and without peer review)	Number and percentage of cases that met the required timeframe broken out by approved, denied, partially denied, suspended or terminated. For those cases which did not meet the goal, the report shall include average time frame for completion	Monthly
Lower levels of Care Timeliness Report for Concurrent Reviews	Number and percentage of cases that met the required timeframe broken out by approved, denied, partially denied, suspended or terminated. For those cases which did not meet the goal, the report shall include average time frame for completion.	Monthly
Authorization-based Utilization	Authorization-based utilization statistics by LOC, comparing children to adults, with summary. Includes admissions, admissions/1000 member months, days/1000 member months, and average and Median LOS	Monthly
High Utilizer/Rapid Recidivist Summary	Authorization report by member name for a six-month period of time with four or more admits to the same or different levels of care	Monthly
Inpatient and Residential Current Daily Census Report	A listing of all members in 24-hour care, indicating status and reason for delay. The electronic report will be sortable by: name, ID, facility, facility type, local area, CCN, date of admission, length of stay, DX, DCF identifier, gender, race/ethnicity, and provider	Daily

Report	Description of Report	Report Frequency
Quarterly Report	Quarterly report showing statistics (e.g., number of individuals in delay status, total days in delay status, average days in delay status, range of days in delay status) about occurrences of discharge delays by service class and provider. Includes only those members who received service for IPD, IPF, IPM, residential detoxification, PRTF or Group Home, or RTC at any time during the quarter, and were discharged during the quarter, and were discharged during the quarter or still in care at the end of the quarter.	Quarterly
Quarterly Report	Quarterly report showing counts of occurrences of discharge delay reasons, by local area. Includes children members who received service and were discharged during the quarter or were still in care at the end of the quarter.	Quarterly
Discharge Delay	Report showing statistics about discharge delays which occurred during the quarter, by service class. Includes only those members who received service for IPF, IPM, PRTF, or RTC, and were discharged during the quarter or were still in care at the end of the quarter. IPF and IPM data are combined. For members age 0-18.	Quarterly
Total Number of NOAs and Denials issued	This report reflects the number of NOAs and Denials issued for lack of Medical Necessity or coverage within the designated reporting period. The report is broken by Adult/Child cases, and Levels of care based on the type of NOA/Denial issued. This version does not contain administrative denials. Quarterly totals and YTD totals also include a count of NOAs/Denials per 1000.	Quarterly
Total Number of Administrative Denials issued	This report reflects the number of administrative denials issued within the designated reporting period, broken out by adult/child cases, and LOC based on the type of denial issued. This version contains only administrative denials. Quarterly totals and YTD totals also include a count of Denials per 1000.	Quarterly
Routine Outpatient Registration Dashboard	Quarterly metrics on specific question selection on the Service Registration Form for only routine outpatient services (OTP). Selections are counted based on the beginning date of requested services.	Quarterly
Methadone Maintenance Outpatient Registration Dashboard	Quarterly metrics on specific question selection on the Service Registration Form for only methadone maintenance outpatient services (MET). Selections are counted based on the beginning date of requested services.	Quarterly
Ambulatory Detox Outpatient Registration Dashboard	Quarterly metrics on specific question selection on the Service Registration Form for only ambulatory detox outpatient services (AMD). Selections are counted based on the beginning date of requested services.	Quarterly
Outpatient Registration (OTP) Timely Receipt of Evaluations Dashboard	Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.	Quarterly

Report	Description of Report	Report Frequency
Outpatient Registration (OTP) Timely Receipt of Evaluations Dashboard - ECC	Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining ECC compliance with Emergent/Urgent/Routine Access measures.	Quarterly
Complaint Tracking Report by Status and Month and Total Number of Complaints Received by Quarter	Summarizes complaints received.	Quarterly
Complaints broken out by reason code.	Complaints received YTD by complaint reason and received month. Broken down by provider vs. member.	Monthly
Provider Appeals and Determination Timeliness	Level 1: Total number of first level provider clinical appeals resolved by reason for appeal, during the reporting time period. Number and percentage resolved timely. Number and percentage overturned. Level 2: Total number of second level provider clinical appeals resolved by reason for appeal, during the reporting time period. Number and percentage resolved timely. Number and percentage overturned.	Annual
Member Appeals and Determination Timeliness	Total number of member clinical appeals resolved by reason for appeal, during the reporting time period. Number and percentage of member appeal determinations that met the 30 calendar day timeframe for routine appeals and the 3 day (5 day with a member meeting) timeframe for expedited appeals. Number and percentage overturned. Report all of above separately for routine and expedited appeals and combined.	Annual
Appeals - Administrative	Total number of administrative appeals resolved, by type of appeal for original denial, during the reporting time period. Number and percentage resolved timely (7 day timeframe). Number and percentage overturned.	Annual
Referrals	Master list of children referred for residential placement	Monthly
Residential Vacancies	Report of existing and anticipated (within 30 days) residential service vacancies	Monthly
Over- and Under-Utilization Report (e.g. length of stay, admissions and readmissions)	Utilization report including Intensive Outpatient, Outpatient and Other services reported together. The report details include the diagnosis description to include 'abuse' or 'dependency' along with the total # of units and percent of total unit. The report will include a pie graph showing a visual representation of the diagnosis distribution. This report will be provided as an aggregate, as well as by SRS region. Diagnoses will be broken out to the 5th digit of detail.	Quarterly/Annual

Report	Description of Report	Report Frequency
Appointment Access (Emergent, Urgent and Routine; time between assessment and first treatment contact)	Utilization report to manage access to care performance guarantees. The report details include the level of service (Emergent, Urgent, Routine), Standard (Assessment/Referral, Treatment), # of Contacts, Total # Meeting Standard, Total # Not Meeting Standard, and Total % Meeting Standard (Total # of Contacts/Total # Meeting Standard). There will be two versions of this report, one provided quarterly to show a monthly snapshot within the quarter, and one provided annually to show a full 12 month rolled up.	Quarterly
Over- and Under-Utilization	Utilization report to determine over and under utilization. Report is broken out by all providers and reported separately by modality. The report will contain a rolling 12 months of data of all programs split by adult/adolescent including higher levels of care (hospital detox, social detox, reintegration, intermediate) and lower levels of care (intensive outpatient, outpatient and other).	Quarterly/Annual
Grievance Summary	By category, by region, by type, timeliness of resolution Grievance Summary by Region, Grievance Summary by Funding, Grievance Client Detail, and Fair Hearing detail	Annual
Appeals Summary	Standard and expedited appeals. Appeals Summary by Region, Appeals Summary by Funding, Appeals Detail; appeals are categorized as Clinical and Administrative.	Annual
Adults Discharged from 24 Hour Residential Settings (homelessness or none)	The report shall include why the discharge was chosen. The report will capture data for adults discharged to homeless shelters or with no discharge location listed.	Monthly
Adolescents Discharged from 24 Hour Residential Settings (homelessness or none)	The report shall include why the discharge was chosen and the names of those who gave consent to the discharge. The report will capture data for youth discharged to homeless shelters or with no discharge location listed.	Monthly
Quarterly Outreach Reports	Report showing outreach activities such as meetings, presentations, coalition involvement, recovery-focused events and tip sheets. Outreach will also be shown for priority populations. Annual report will show the activities for the previous year and a new work plan will be developed.	Quarterly
Adverse Incident Report	Summary information that represents occurrences of actual or potential serious harm to the well being of a member or to others by the actions of a member, who is receiving services managed by VO-LA or has recently been discharged from services managed by VO-LA.	Semi-Annual/Annual

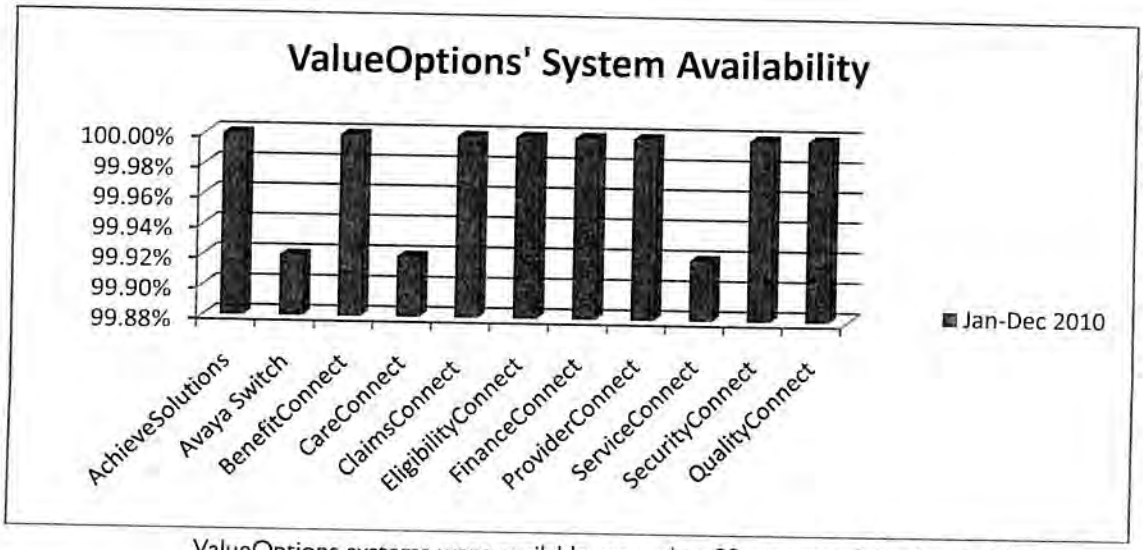
xiii. Provide a detailed description of scheduled and unscheduled system downtime for the past 12 months for all government contracts. Suggested number of pages: 2.

ValueOptions understands the importance of smooth service delivery and continuity in the event of planned or unplanned outages. ValueOptions Information Technology Department uses industry recognized best practices for managing our robust design of our Enterprise Computing infrastructure which collects, aggregates and analyze system availability and performance data against pre-defined service levels. Service levels exist for each CONNECTS application and each operational service area including WAN, Telecommunications, and desktop software services. We established Service Level Standards which target 99.9 percent systems availability, with a 0.01 percent allotment for scheduled maintenance. To achieve these performance targets, mitigate risk to users, and reduce system downtime, ValueOptions schedules maintenance downtime during off-peak, non-business hours and will comply with the specific requirements outlined in the DHH-OBH RFP.

System availability statistics are monitored and maintained by the IT call center (Help Desk) manager who has no internal responsibility in uptime results. Our uptime for the past 12 months has exceeded 99 percent. We encountered no system downtime as related to Katrina, Ike, Rita or other natural disasters. We have had to implement our business recovery plans to reroute our call centers due to inclement weather, but this is implemented in a manner that results in no degradation in services provided. Our back-up call centers have access to the client information and are able to continue servicing the contract seamlessly.

ValueOptions experienced no system downtown during Hurricanes Katrina and Ike.

All servers and associated applications are scheduled to be available for use from 7:00 am to 9:30 pm EST, Monday through Friday. As noted above, our scheduled maintenance window is scheduled during off-peak, non-business hours.



ValueOptions systems were available more than 99 percent of the time in 2010.

xiv. Describe the Proposer's system's data archive and retrieval system including disaster recovery procedures, including loss of the Proposer's main site or computer systems. Indicate when the disaster recovery was last used and tested and describe the outcome. Suggested number of pages: 4.

DISASTER RECOVERY PROCEDURES

ValueOptions understands that in the event of a crisis or disaster, business must continue and members must still be able to access and receive the care they need. As such, we have developed a comprehensive disaster recovery process, which includes data archive and retrieval, to ensure information is safeguarded in such instances.

ValueOptions leverages a two scenario recovery contingency plan:

1. Clustered WebSphere Application servers and real time data replication of core application data is at the heart of our primary recovery approach. In this recovery approach, all transactions of our CONNECTS application data is replicated in real time to a fully redundant IBM iSeries application servers utilizing third party data replication software. The more likely event of a single server failure is addressed in this primary recovery design.
2. Our secondary recovery contingency provides support for an unlikely catastrophic disaster involving a total site outage of the National Data Center. ValueOptions has engaged IBM Business Continuity and Recovery Services (BCRS) for hosting and recovery subscription services at their premier BCRS hot site in Sterling Forest, New York. Additional redundancy is built into our WAN connections, which facilitate rerouting of data traffic.

Data Back-Up

ValueOptions maintains a scrupulous data back-up process. The IT teams conduct traditional incremental data back-ups of all applications on a daily basis and full data back-ups on a weekly basis. All back-up tapes are audited and verified for completeness. Saved media is duplicated daily with the primary copy stored off-site at a secure, vaulted location and the duplicate copy remaining within an IBM 3584 Automated Tape Library (ATL) at the National Data Center.

ValueOptions utilizes two IBM back-up and recovery software products in conjunction with the 3584 ATL to provide an enterprise recovery solution:

1. IBM Tivoli Storage Manager (TSM) Server software is used for back-up and recovery of all UNIX and Windows-based application servers
2. IBM Backup, Recovery and Media Services (BRMS) are used exclusively at ValueOptions as the iSeries enterprise backup and recovery solution.

The National Data Center is supported by skilled ValueOptions technology professionals. Additionally, to further strengthen the integrity of ValueOptions' data center solutions, we have established long-standing partnerships with leading technology vendors, such as: IBM, Caterpillar, Liebert, Power Ware, Vision Solutions, Oracle, Cisco, and Nokia.

While Reston, Virginia resides on one of the nation's more stable power grids, auxiliary power to the ValueOptions National Data Center is provided by a Caterpillar 625 kVA generator. A 325 kVA Uninterrupted Power Supply (UPS) supported by Power Ware provides seamless power transition between utility and generator power. Five 20-ton Liebert HVAC units provide cooling and

humidification control to our 5,500sq ft data center. Overhead pre-action dry fire suppression and moisture detection systems provide preventive fire and flood protection.

ValueOptions' core application servers residing in the National Data Center are built utilizing IBM's enterprise class pSeries and iSeries platforms. These systems are designed by IBM and configured in partnership with IBM by ValueOptions' systems engineering staff to provide maximum redundancy and resiliency in both internal power and computing capability. By virtue of their design, the iSeries and pSeries platforms each enjoy industry leading availability ratings. Our newer i5 and p5 models provide 64bit POWER5+ computing power and non-disruptive autonomic CPU and memory failure capabilities. Each platform remains highly scalable with processor and memory CUoD (Capacity Upgrade on Demand) feature capability. CUoD allows additional memory and processing resources to be added without interruption to application availability.

The ValueOptions JAVA-based CONNECTS applications are developed and deployed to the J2EE standard in a two tier configuration utilizing IBM's WebSphere Application Server on pSeries in a clustered configuration. Backend DB2 and Oracle application databases reside on an iSeries i5 570 and two pSeries p5 570's respectively. The ValueOptions i5 and p5's each consist of multiple logical partitions including dedicated production, development, staging, training and load test environments.

Documenting Disaster Recovery Procedures

ValueOptions utilizes Living Disaster Recovery Planning System (LDRPS) Enterprise Edition by Sungard to document disaster recovery procedures and to mitigate the risk of data loss or systems inaccessibility due to an emergency or disaster (such as fire, vandalism, terrorism, system failure, or natural disaster). Managed by our IT Systems Technology, this comprehensive disaster recovery plan provides for the timely and well-coordinated restoration and recovery of any lost electronic protected health information (ePHI). The disaster recovery plan includes procedures to restore ePHI from data back-ups in the case of data loss, procedures to document and track system outages, failures, and data loss to critical systems and workforce employee training on disaster recovery plan implementation.

Hot-Site Recovery

In the event of a man-made or natural disaster affecting the Reston National Data Center, ValueOptions has contracted with IBM to restore recovery within 48 hours at IBM's BCRS site in Sterling Forest, New York, which is included as a node on ValueOptions' WAN. In the event of a disaster, ValueOptions will send the latest tapes to the IBM New York site, where the data will be restored to a back-up iSeries and pSeries server. Since the IBM site is a node on ValueOptions' WAN, local IT staff in all service centers will have access and the ability to operate the system without traveling to the hot site. In addition, traffic from all service centers will be automatically rerouted to the IBM hot-site. In addition to systems that ValueOptions has contracted for with IBM, ValueOptions maintains our own pSeries based WebSphere application servers, DNS and firewall services at the IBM BCRS New York site, thus providing users immediate access to the CONNECTS applications once associated databases are fully restored. Maintaining a mix of hosted and subscribed services with IBM allows ValueOptions to provide one of the industry's most rapid recovery solutions.

IT Business Continuity Plan

ValueOptions' National IT Department is responsible for maintaining and executing the Disaster Recovery, or IT Business Continuity plan. ValueOptions performs the traditional daily back-ups to tape and storage off-site methodology as a precautionary measure. All servers are backed-up daily to ensure that the content of all our production systems can be recovered in the event of a disaster. These back-ups are performed on both host and LAN systems. Software and production data files are copied to tape. TSM and BRMS verification and audit programs are then used to confirm that the system back-ups are complete and accurate. Copies of the tapes are then created and stored off-site. In the event of a physical disaster, the back-up tapes that are stored off-site can be used to recover and reload our production systems. System back-up tapes are rotated regularly to ensure physical integrity of the tapes and to minimize tape parity error problems. This traditional back-up approach provides a fail-safe for all of ValueOptions' data and programs to ensure IT business continuity.

Our Business Continuity Plan covers all systems, including telephony, LAN/WANs, data servers, application servers; help desk processes, and facility power. It also includes specific support activities for each department within ValueOptions (e.g., Finance, Human Resources). The plan incorporates detailed instructions that cover all phases of the disaster recovery process, including:

Phase	Function
Phase I - Plan Activation	Protocols for first alert procedures, identification of emergency team members, assessment of the severity of an incident, impending regional disaster procedures (e.g., snow storm or hurricane), contingency contact procedures to alert appropriate internal staff and client representatives
Phase II – Incident Response	Activate alternate data processing locations, data center vendor notifications, internal and external notification process, team communication requirements
Phase III – Recovery	Procedures for recovery operations, monitoring alternate processing operations
Phase IV – Site Restoration	Initial assessment procedures, transitioning services back to the call center
Phase V - Documentation	Monitoring, reporting and recordkeeping of incident to support lessons learned and contribute to IT knowledgebase

ValueOptions' Business Continuity Plans also encompasses telephone service recovery for all call centers. A telephony Business Recovery Plan (BRP) can be invoked in the event that a call center is not able to continue to provide call handling service as normal.

Every service center has its own unique BRP plan. These BRP plans are managed 24 hours a day, 7 days a week, by the ValueOptions National Telecommunications Group. Our geographically dispersed call centers provide back-up call management services for each other. This ensures the level of service our participants will receive, even when a site may be operating under BRP conditions, is meeting ValueOptions standards and client service level expectations. BRP's are activated by service centers when needed. To activate or de-activate a BRP plan, a service center simply calls or e-mails the Technology Call Center and requests that their center be put into or taken

out of Business Recovery. This process can be accommodated within minutes of notification, 24 hours, seven days a week, 365 days a year.

LATEST DISASTER RECOVERY TEST RESULTS

ValueOptions' IT systems and network engineers conduct a test of the disaster recovery plan twice annually with IBM Recovery Services experts. At the time of this writing, the latest tests conducted with IBM occurred in April 2011 and June of 2010. The tests resulted in full restoration of systems and data, with no degradation in response time. Upon contract award, our Operational and IT leads we will meet with DHH-OBH to ensure that our disaster recovery and business continuity plans are in alignment with your expectations.

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xv. Describe the Proposer's technical support or "help desk" services available to front-end users of your information systems. Suggested number of pages: 2.

ValueOptions' Technology Call Center (TCC) is the first point of contact for all users experiencing system, application, network, PC, or telecommunication problems. TCC personnel initially identify the problem and determine a possible resolution, or they contact second-level support to assist in the problem resolution. In support of their documented service level commitment, the TCC:

- provides first-level telephone assistance between the hours of 6:00 am through 9:00 pm EST and personnel are available after hours for critical issues; prior to 6:00 am and after 9:00 pm, users report problems to the National Operations team, who passes the information on to the TCC Coordinator who is on-call to triage the issue
- determines problem priority, coordinates the appropriate resources to effectively resolve the problem, and performs the proper escalation of problems
- provides timely and accurate alerts to users regarding current and potential impacts to application, system, network, and telecommunication availability
- follows up with users to ensure problems are resolved in a timely and efficient manner
- processes all requests for access to applications, and user-access deactivations for employees who are no longer with the company

ValueOptions is committed to helping our providers manage administrative functions more efficiently and encourages them to take advantage of our provider portal, ProviderConnect. This self-service, easy-to-use tool is available for completing routine service requests. To utilize these easy to use, secure online services, providers must obtain a User ID before registering for ProviderConnect. ValueOptions' EDI Help Desk is available to assist during the registration process and for ongoing support. This includes training and other resources for new users or providers experiencing issues navigating through the system. The ProviderConnect application allows providers to submit claims and encounters, request authorization, obtain claims and eligibility information, etc. The most common types of questions are surrounding system navigation, electronic claim submission and the registration process. During implementation, providers have the opportunity to participate in interactive face to face and administrative webinars which includes a demonstration and discussion of the ProviderConnect system.

xvi. Describe the Proposer's ability to access the system for end users not working in the office. Suggested number of pages: 2.

ValueOptions provides remote staff with company-owned equipment to access the CONNECTS platform via our virtual private network (VPN). Access to systems and applications are provided through a secure client connection via the firewall to limit access only to authorized personnel. A Cisco concentrator provides 3DES encryption algorithms, and Domain user authentication is used for access control. All passwords are required to adhere to our strong password management policy.

ValueOptions' IT systems infrastructure complies with the security requirements outlined in this RFP. Our information system and application access is granted only after a proper request is made and approved by our IT Security Official.

Our National Information Technology Security program has the following HIPAA-compliant features:

- In the CONNECTS platform, each employee's access is designed to accommodate his or her personal job functions (role-based security). ValueOptions limits access to different functional areas of the system, depending upon job classification. A finite list of security levels is defined for each function and is authorized by department managers. Furthermore, specific departments have a third level of internal security to limit the extent to which certain functions, such as claims adjudication, may be restricted.
- Access to information in the CONNECTS platform is divided into "inquiry only" or "update," which allows certain employees to view pieces of information, without the capability to change data. User changes are date stamped and identified with their user profile.
- Any unauthorized attempts to access the CONNECTS platform are recorded and are reviewed immediately. The system administrator is alerted by CONNECTS platform of the location of an unsuccessful logon, such as an attempt to logon using a legitimate logon ID or an illegitimate ID. User IDs are disabled after three unsuccessful attempts, and users are required to submit a written request to our Technology Call Center to have their profile reactivated.

Authorized DHH, WAA and other agency users will access our system via our web portals to conduct transactions. Our Client, Member and Provider portals were designed with enhanced security features including:

- the ability to properly identify and authenticate users
- the creation of audit records whenever users inquire or update records
- the provision for access controls that are transaction-based, role-based, or user-based
- controls to ensure that transmitted information has not been corrupted
- message authentication to validate that a message is received unchanged
- encryption or access controls, including audit trails, entity authentication, and mechanisms for detecting and reporting unauthorized activity in the network

xvii. Describe the Proposer's experience with the 270/271 Eligibility Request/Response transactions as well as submitting and receiving 834 Enrollment/Disenrollment transaction sets. Suggested number of pages: 3.

ELIGIBILITY PROCESS AND EXPERIENCE

ValueOptions understands that the eligibility process is critical to the overall success in managing each member's care. We have extensive experience in developing comprehensive eligibility databases and protocols. We partner with our clients, and will do so with DHH-OBH, so that we can clearly understand all contract requirements related to the eligibility and data exchange process.

We have developed a robust and secure infrastructure to support electronic data interfaces that enable our clients and third party trading partners to transfer accurate data. Our data exchange application, FileConnect, is designed for the interchange of electronic data files via secure internet connections. It also has the capability to send and retrieve (push/pull) files in a secure manner from our client and business partners' servers remotely, and we can pick up the eligibility file from the designated mailbox that DHH-OBH assigns. Our data exchange process successfully processes inbound and outbound files. It is programmed to receive and process electronic records automatically and seamlessly with our integrated CONNECTS system.

EligibilityConnect

ValueOptions maintains and systematically updates a master file of all enrollment information using the eligibility module in the CONNECTS platform, our eligibility module, EligibilityConnect, has an automated front-end eligibility load module that can process enrollment and disenrollment information in the standard HIPAA 834 format, in ValueOptions' standard format, or via the development of a customized data load. Client preferences control identification codes, which control processing requirements, such as allowing the capability to link a family unit to an individually enrolled member. ValueOptions can accept eligibility data as frequently as daily, although our preferred frequency is weekly. To initiate a customer's contract, the initial eligibility data is a full population file. For the continued periodic eligibility updates (daily, weekly, monthly), we prefer updates or "transaction only" (add, change, deleted) eligibility updates. However, we can perform total-population refresh updates, as required and defined during implementation,

After the eligibility data is received, it is logged and basic data integrity checks are performed. If the data is not received in our preferred eligibility format, the data is reformatted to meet our standard. Client specific rules are then processed against the data. An initial audit posting of the data to our membership system is then performed. This process generates an audit report that is reviewed by the assigned Eligibility Specialist for the specific client.

Unless the client dictates a specific error threshold rate, any eligibility audit report that is less than two percent error rate is loaded into EligibilityConnect. The client is informed of any eligibility records that error out due to missing or inconsistent data. When the errors have been corrected, the data is then posted to the eligibility system. An update report is generated which includes the number of records that have been read and the percentage of records loaded.

Our fully integrated eligibility module interacts with all processing systems, web-based applications, references, benefits, providers, authorizations, utilization and claims to ensure eligibility of a member entering treatment. CONNECTS displays eligibility history as well as current status on each

member to ensure services are approved or denied appropriately. Manual validation of a member's eligibility, and the subsequent updating of that member's data in our system, is used to accommodate changes and additions that arise in between receipt of electronic data to accommodate urgent situations. These updates are handled real-time, and are immediately available online to all operational areas.

During the implementation process, we will work with DHH-OBH to ensure that a seamless data exchange process is in place. This will begin with a comprehensive review of eligibility procedures with DHH-OBH staff within 30 days after award of the contract. The purpose of this meeting is to discuss the proposed eligibility file layout and transfer capability. A workgroup will be established that will continue until the final requirements are finalized. Within 45 days of the final requirements, ValueOptions will prepare a design document that:

- confirms the agreed upon file layout
- provides a data dictionary for the file layout
- outlines any assumptions and processing rules

Once the documents and final requirements are approved by DHH-OBH, our IT and Eligibility staff will begin creating the necessary import routines for the eligibility database. To meet your implementation timeline, the eligibility import will be tested and ready to receive the full eligibility file 15 days prior to start up.

All of the features of our eligibility process bring a technology infrastructure to Louisiana that will increase accountability and transparency by improving the administrative efficiency of your program.

In 2010, ValueOptions processed 6,255 eligibility files for our public sector clients and all files were loaded within 0.06 days.

270/271 Eligibility Request/Response Transactions

The CONNECTS system is compliant with all HIPAA electronic transactions and has obtained certification for its HIPAA standard transactions from Claredi, the same certification organization selected by the Centers for Medicare and Medicaid Services. We have fully remediated the enrollment/disenrollment transaction (834), eligibility inquiry and response (270/271). However, we do not currently interface with any client's or third-party vendors that require the Health Care Eligibility Benefit Inquiry and Response file transactions (270/271).. These types of requests are generated by our providers, who are able to inquire about the status of a member's eligibility, including benefits and details regarding the types of services covered via ProviderConnect. ProviderConnect is a secure, HIPAA compliant web-portal that offers the provider with immediate response to their request.

834 Enrollment/Disenrollment Transaction Sets

ValueOptions' system is fully compliant with submitting and receiving the 834 enrollment/ disenrollment transaction sets. As noted above, we have extensive experience in coordinating large membership databases for a variety of contract partners, from large populations of public assistance members, to state and corporate employees with diverse benefit arrangements. For example, ValueOptions accepts 834 transaction sets in most of our public sector programs, specifically Kansas, Pennsylvania and Connecticut. Additionally, we have extensive experience coordinating

large membership databases for a variety of contract partners, from state and commercial employers with diverse benefit arrangements, to large populations of public assistance recipients.

ValueOptions Braided Funding℠

ValueOptions shares DHH-OBHs vision of providing a fully integrated system of services for consumers and families that includes services from various funding streams. Such a system allows for and supports the healthy development of consumers while maintaining the integrity of service delivery through a seamless system of benefit provisions. The core requirements of an integrated system include:

- immediate funding stream category and identification per member
- comprehensive assessment tools
- the organization and reporting of outcome data
- claim identification and payment per benefit/funding/agency
- reporting per funding stream
- accounting per funding / service/ agency
- a system for organizing and reporting outcome data

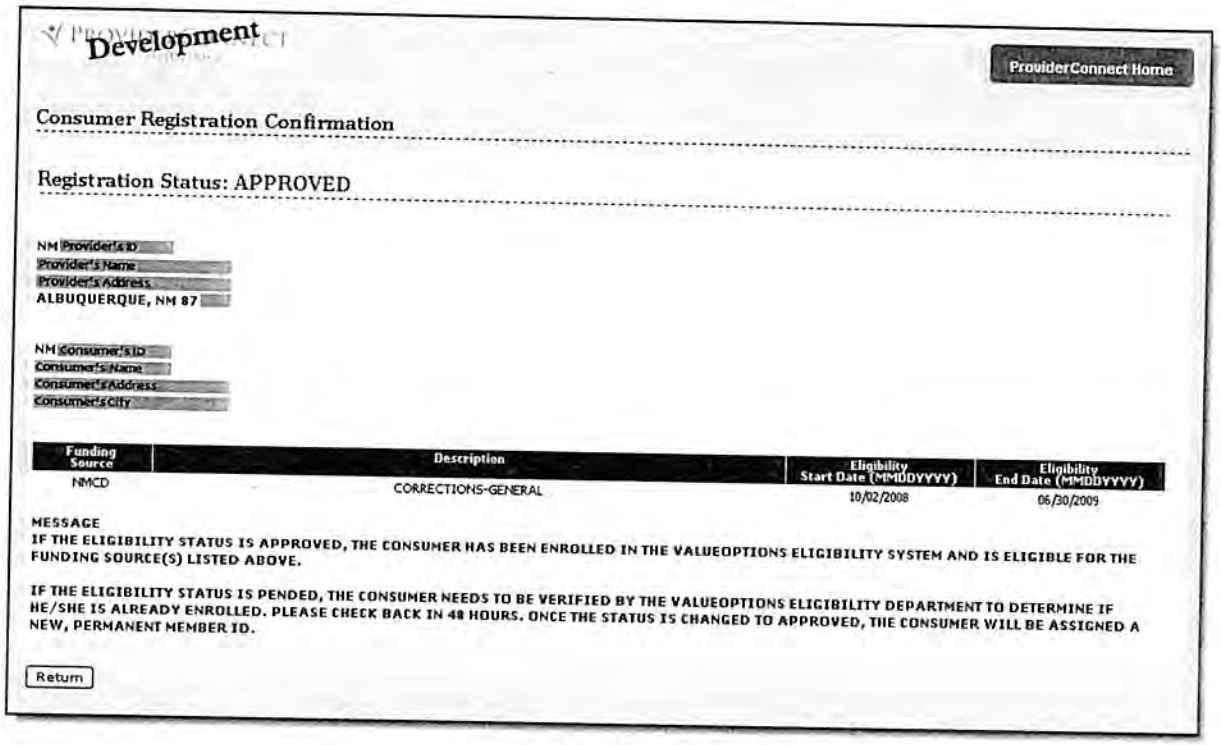
The ValueOptions Braided Funding System design within the CONNECTS platform enables ValueOptions to flag consumers as 'braided funding' by associating each consumer with a single, unique ID number. Each consumer is then linked with multiple, active eligibility records. Each eligibility record represents a different funding stream, including Medicaid and non-Medicaid eligibility data. Updates to the consumer's record for non-Medicaid funding streams are added when requested by a provider registering the consumer.

ProviderConnect, ValueOptions' online Web tool designed specifically for use by providers, is fully-integrated with additional modules of ValueOptions' CONNECTS application platform. The online ValueOptions Braided Funding System, Consumer Registration module within ProviderConnect loads or updates the eligibility files in real time. As the Medicaid files are loaded and/or updated in CONNECTS, the Medicaid information is immediately accessible, in real time, by the treating provider(s) via ProviderConnect.

ValueOptions' Braided Funding System, Consumer Registration Module features flexible configurations that make it easy for authorized providers to register consumers for non-Medicaid funding streams. Once the provider enters the consumer's specific demographic and clinical information, the online Consumer Registration Module will generate a list of appropriate funding streams for which the consumer may be registered. The online Consumer Registration Module includes a provider authentication process that filters the list of available funding streams down to only those for which the provider is contracted. The provider can then select the funding stream(s) in which he or she wants to register the consumer. The online Consumer Registration Module will then prompt the provider to complete specific forms within the module in order to complete the registration process. The forms to be completed will vary based on the funding stream(s) selected for each consumer.

When all required forms are completed, the confirmation page will be displayed to the provider, as illustrated on the following page. The confirmation page includes the status of the registration, lists the funding stream(s) and their effective and termination dates for which the consumer is registered.

The confirmation results in the Member being added/updated in ValueOptions' CONNECTS application platform. The CONNECTS platform houses the eligibility data for Medicaid and non-Medicaid Members.


Development

ProviderConnect Home

Consumer Registration Confirmation

Registration Status: APPROVED

NM Provider's ID
Provider's Name
Provider's Address
ALBUQUERQUE, NM 87

NM Consumer's ID
Consumer's Name
Consumer's Address
Consumer's City

Funding Source	Description	Eligibility Start Date (MMDDYYYY)	Eligibility End Date (MMDDYYYY)
NMCD	CORRECTIONS-GENERAL	10/02/2008	06/30/2009

MESSAGE
IF THE ELIGIBILITY STATUS IS APPROVED, THE CONSUMER HAS BEEN ENROLLED IN THE VALUEOPTIONS ELIGIBILITY SYSTEM AND IS ELIGIBLE FOR THE FUNDING SOURCE(S) LISTED ABOVE.

IF THE ELIGIBILITY STATUS IS PENDED, THE CONSUMER NEEDS TO BE VERIFIED BY THE VALUEOPTIONS ELIGIBILITY DEPARTMENT TO DETERMINE IF HE/SHE IS ALREADY ENROLLED. PLEASE CHECK BACK IN 48 HOURS. ONCE THE STATUS IS CHANGED TO APPROVED, THE CONSUMER WILL BE ASSIGNED A NEW, PERMANENT MEMBER ID.

Return

Consumer Registration Confirmation Screen

Eliminating Duplicate Entries

ValueOptions' Braided Funding System includes consumer 'Best Match' logic, which identifies potential duplicate entries by comparing demographic information such as last name, first name or nickname, date of birth, Social Security Number and gender. When a potential duplicate entry is identified, the online Consumer Registration Module assigns the entry a 'Pending' status and a temporary identification number (ID). The registration confirmation page will display a status of 'Pending' for that registration. This process automatically generates an inquiry to the ValueOptions National Eligibility Department, who will research the consumer's information, determine if this is a new consumer or a consumer already on file, and assign the appropriate permanent ID. The provider will receive notification through ProviderConnect that the consumer's registration status was changed from 'Pending' to 'Approved,' along with the consumer's permanent ID.

Funding Stream Hierarchy

In the ValueOptions Braided Funding System, all funding streams are part of a hierarchy, and each funding stream is assigned a priority. The hierarchy determines the order of payment primacy among the various funding streams for which each consumer is registered. This hierarchy is applied to both the authorization and claim payment process, so providers will no longer be required to provide funding stream information on their claim submissions. As a result, the DHH-OBH providers' administrative processes associated with ValueOptions Braided Funding System are significantly simplified. However, to enhance communication with providers, ValueOptions will retain the funding stream information submitted on a claim if and when a provider gives us this

information. The Provider Summary Voucher communicated to the provider will list the funding stream submitted by the provider, as well as the funding stream which was applied to the claim, based on the funding stream hierarchy within the ValueOptions Braided Funding System.

Registration Parameters

Through ProviderConnect, providers will have access to any prior registrations they have submitted for a given consumer. Any department or agency re-registration requirements will be triggered by a new module, Registration Parameters, which allows us to control the frequency of re-registration by funding stream. The registration parameters set for each fund define the applicable registration period. Providers will be required to re-register the consumer according to the parameters set for each non-Medicaid funding stream. Termination dates applicable to non-Medicaid funding streams are controlled by the Registration Parameters module. The termination dates for Medicaid are dependent upon the eligibility feed ValueOptions receives from DHH-OBH and other agencies.

All registration updates processed through the online Consumer Registration Module are automatically updated to the CONNECTS platform, our claims adjudication system, and are immediately available to all staff for authorization and claims processing. Within our Braided Funding System, each consumer is assigned a unique ID, which is associated with the Medicaid funding stream and benefit plan (for consumers eligible through DHH-OBH and other agencies, and any non-Medicaid funding streams and benefit plans for which the consumer has been registered. The effective date and termination date(s) for each funding stream (including Eligibility source vendor eligibility data) are displayed. A single consumer can be associated with multiple, active eligibility records. Each eligibility record represents a different funding stream. Each funding stream is linked to a unique benefit plan, which is then linked to each associated identification number. If a consumer is first registered for a non-Medicaid funding stream, the consumer will be assigned a Collaborative consumer ID. If the same consumer later becomes eligible for Medicaid, he or she will then receive a Medicaid ID. Both IDs will be linked to the single consumer record in our system.

xviii. **Describe the Proposer's experience with the HIPAA 835 and electronic funds transfer. Suggested number of pages: 2.**

ValueOptions offers Electronic Funds Transfer (EFT) and HIPAA 835 electronic remittances as an alternative to traditional check and paper voucher. Payments can be sent electronically direct to a provider's financial institution. The EFT and reconciliation system is free for all providers and is designed to ease the administrative burden and enable provider's straightforward reconciliation of payments. EFT can mean faster payments, leading to improvements in cash flow through automated payments. Providers have secured online access to remittance records and reporting tools.

HIPAA 835 electronic remittance files are available with EFT and can be downloaded directly to a HIPAA-compliant Practice Management or Patient Account System, eliminating the need for manual re-keying.

xix. Describe the Proposer's system's ability to send and receive data from other agencies such as eligibility (HIPAA 834) and member's plan of care data consistent with the collaboration requirement in the Scope of Work. Suggested number of pages: 3.

As previously mentioned, our web portals are designed to allow providers and state agencies to submit and view data on line.

The CONNECTS web portals will allow:

- WAA and LEA's to upload the members IHP and POC;
- Behavioral health providers to submit a request for authorization, view the IHP, POC and a list of prescribed medications for a specific member, submission of claims, view authorization history and other administrative tasks;
- DOE to view the IHP and POC as well as submit encounters on line;
- DHH-OBH to search and view authorization data and access to on line reports; and
- PCPs and other authorized stakeholders will have limited access to view IHP and POC

Also, ValueOptions has developed a robust and secure infrastructure known as FileConnect to support electronic data interfaces that allow clients, providers, and third-party trading partners to transfer accurate data. FileConnect offers DHH-OBH, providers and the state agencies to exchange files with VO-LA. VO-LA will also use FileConnect to transfer test files with CNSI, the Louisiana MMIS vendor, WAA, DOE, or other agencies for the purposes of exchanging data, including but not limited to eligibility and encounter data. FileConnect supports secure FTP file transfers via secure Internet connections, and site-to-site VPN. This system has been fully operational and successfully processes inbound and outbound files daily.

FileConnect has several unique features and capabilities. FileConnect is programmed to receive and process electronic records automatically and seamlessly with our CONNECTS application. FileConnect also includes provisions for file and format verification, allows for prompt addition of new file types, and provides notification of file validation results (whether the file was successfully processed or not) via the Internet. FileConnect allows for desktop retrieval of processing results via an intranet server using any Web browser and Internet Service Provider (ISP).

FileConnect complies with HIPAA standards for all electronic data interface (EDI) transactions. The solution is highly scalable, and receives, routes, stores, and sends transactions consistent with ANSI X12 standards. It supports all HIPAA-regulated EDI transactions as well as client- specific custom files that ValueOptions exchanges with providers and state agencies. The specific advantages and features of FileConnect include the following functions:

- accepts inbound transactions from multiple sources,
- compliance-checks all inbound/outbound HIPAA-regulated EDI transactions,
- supports customer-specific file formats,
- allows submitters to track all file submissions,
- supports industry-standard security protocols, and
- supports multiple file transfer protocols including FTP, FTPS, SFTP, Web interface, and Web services

xx. Describe the Proposer's current status of implementing the HIPAA ANSI 5010 formats and preparation for the ICD-10 implementation. Suggested number of pages: 3

HIPAA 5010/ICD-10 Preparations

The HIPAA 5010 requirements are updates to the formatting of standard transactions (e.g. the formatting of electronic transactions related to such things as claims, eligibility, etc.). The changes to the formatting in the 5010 version account for the transition to ICD-10. In addition to the formatting changes for file transactions, some changes with 5010 standards include:

- A physical street address must be reported for the billing provider's service address. A PO Box address will not be accepted
- Only a provider Pay-to address can be a PO Box address
- Require 9 digit zip code
- Enhanced NPI Reporting rules
- Expansion of the number of Diagnosis Codes
- Strong emphasis on COB information

Our National IT has completed the discovery phase of the project and conducted a comparative analysis of the existing requirements and the newly defined ones. IT will execute the required changes following our change management protocol and a project manager will be assigned to the project to monitor the progress of each system required change. A team of dedicated Business Systems Analysts and Programming resources will be assigned to each task to meet the required timeline. In addition, appropriate resources will be assigned from each business area to conduct user acceptance testing of the changes prior to making any changes to our production environment.

ValueOptions has initiated its internal testing period (Level I) in which covered entities perform all internal readiness activities to prepare for testing the new standards with our trading partners. Later this fall the testing period (Level II) with our Trading Partner will occur, in which covered entities perform end-to-end testing with each of its trading partners. ValueOptions will be fully compliant with HIPAA5010 by January 1, 2012.

Below is an outline of the test plan ValueOptions has put into effect in order to implement its 5010 system and services. A similar test plan will be used with DHH/OBH, DHH MMIS, DOE, other state agencies and providers during implementation to validate each stakeholders ability to meeting the 5010 changes.

- Contact trading partners to coordinate and schedule test file exchanges.
- Send the ValueOptions test file submission requirements to the trading partners.
- Determine if the trading partners will verify test files for HIPAA Levels 1-6 compliance prior to sending.
- Determine the process for requesting test files to be sent.
- Determine the trading partners approach for creating test files.
- Determine the trading partners schedule for sending test files.
- Confirm contact information for requesting test files and reporting errors.
- Communicate with the trading partners on how the test files will be acknowledged.
- Communicate with the trading partners on how file rejects will be handled.
- Communicate with the trading partners on how errors will be reported back to them.

- Request the trading partners to send test files.
- Check transaction file compliance.
- Load and process the file.
- Identify testing issues.
- Assign testing issues to the trading partners or to the internal ValueOptions development team.
- Remediate issues.
- Retest as needed until expected results are achieved.
- Obtain testing sign-off.

Beginning in October of 2013, CMS will require ICD code sets be applied to all HIPAA transaction. In order to meet this requirement, our IT team is planning a gap assessment of our system and data exchanges that are currently in place. This imitative is scheduled to begin in third quarter calendar year of 2011. We will be fully compliant with the ICD-10 code set changes to meet the mandated timelines.

xxi. Provide claim submission statistics as directed below for the most recently completed month overall for your current clients, for electronic and paper submission. All formats, including proprietary formats, should be included.

Below are the claim submission statistics for ValueOptions' book of business for the most recently completed month.

Claim Type	Number Received
CMS UB 04 (paper)	16,171
CMS 1500 (paper)	176,533
HIPAA 837I (Institutional)	40,065
HIPAA 837P (Professional)	1,366,545
NCPDP	950,645
Other (web portal)	126,882

xxii. Describe the Proposer's process for receipt, storage, and data entry of provider paper format billings. Suggested number of pages: 2.

ValueOptions receives paper claims and encounters through a client-specific post office box. We require providers to submit paper claims or encounters using standard CMS 1500 and UB04 forms and include industry standard CPT codes, HCPCS codes, revenue codes, and ICD-9 diagnosis codes. We request them to use red ink forms to facilitate the scanning process. Paper claims are scanned, allowing ValueOptions to create a digital version which is uploaded into the CONNECTS system. The scanning process assigns a unique Internal Control Number (ICN) to each claim, which includes the Julian date of receipt. Claims that cannot be scanned are manually keyed. Approximately 90 percent of paper claims are scannable. ValueOptions utilizes technology called FormWorks, which is a front-end vehicle to the CONNECTS platform. The application was developed by Recognition Research, Inc. (RRI). The process incorporates OCR repair and data validation, as well as providing a mechanism by which staff members with specialized training are able to make

member and provider selections. The data is uploaded into the CONNECTS system and batch adjudication occurs. The ability to have claims "repaired" through FormWorks allows daily averages of approximately 63 percent of claims to auto adjudicate.

Claims that are loaded into CONNECTS are processed automatically, subjecting them to industry standard systematic edits, as well as customized, client-specific benefits or business requirements. Claims and encounters received via paper forms are adjudicated through the same process.

The CONNECTS system supports all claims processes involving claims entry, adjudication, payment, and reporting. All provider fee schedules, hospital per diem rates (contracted rates), and individual client benefit plans are maintained online. Automatic claim suspension routines are performed for those claims that require further examination; for example, duplicate claim submission, COB notification, eligibility discrepancies, and authorization edits.

Authorizations are used for limiting and/or controlling provider access. Utilization Review (UR) capabilities are also included in the claims subsystem to allow for the connection between the claim being processed and authorizations that have been loaded in the system. The decision whether a claim requires an authorization in order to be paid is part of the benefit configuration logic. On-line edits ensure data integrity and appropriate benefit application requiring that critical data is present and valid, but our system also permits us to define which claims the Claims Processor is required to evaluate. If all adjudication elements are satisfied, the claim will auto-adjudicate.

If any of the data validation fails, the processor will receive a specific warning message as to the specific reason for the claim pending. The processors receive warning edits when limits are met, or when specific combination of codes are billed together, and for specific diagnosis codes that are excluded entirely as eligible for reimbursement. Claim edits are designed to ensure data integrity and appropriate benefit application. Every claim is subject to extensive systematic validation. While we can automatically deny a claim when it fails and edit and do so for a certain set of situations, many claims can be resolved with additional review. These edits can be soft edits or hard edits, depending on the action to be taken. A soft edit allows the processor to make the decision as whether to pay, deny, or limit the number of services. The hard edits automatically deny the claim based on the benefit set up. The CONNECTS system provides the flexibility to process claims according to client specific processing rules. Customization of claim edits ensures that only qualified claims are adjudicated.

On a daily basis, claims that have been fully adjudicated are submitted for posting. The claims payment cycle creates a report that produces a batch to the Finance system for payment. Providers have the option of registering for Electronic Fund Transfer (EFT) or paper check. If they register for EFT, they will receive an 835 Electronic Remittance and have the option of also printing a paper voucher.

The volume of paper forms (CMS 1500/UB04 appears in response to *Question xxi*. All paper forms are imaged and available for historical viewing by claims and customer service staff.

SYSTEM CAPACITY

From a software and database architectural view, CONNECTS is configured to support over 999 million members, 99 million claims per day, 99 million authorizations per day, 450,000 clients, three million groups, and over 450,000 benefit plans.

The IT infrastructure is scalable to include ample disk storage, memory, and processing power to accommodate the anticipated membership. Our online screens utilize JAVA, COBOL and DB2 to provide a solution that dynamically scales to simultaneously support more than 5,000 internal users and 50,000 interactive providers. The response time is second or sub-second as a result of the above mentioned architecture. The VO-LA Service Center staff access the CONNECTS system through our WANs fully meshed MPLS network. Other online access is available through our toll-free number and access is available via a secure Internet connection.

Our platform resides on an IBM® iSeries (AS/400) i6 595® application server running IBM's V6R1 i6/OS® operating system. The ValueOptions i6 595® consists of multiple logical partitions including production and development environments. It is configured with a 24-way POWER5 64bit CPU with 512GB of memory, 108,096 CPW Enterprise Edition® and over 40 Terabytes of mirrored disk storage. An IBM 3584 Automated Tape Library® (ATL) containing 33 3592-E06 high-speed tape drives are attached for fully automated backups. Additional tape device support includes IBM 3590 and 3490E tape cartridge for client file compatibility. Host network communications includes four (4) 1Gbps and seven 100Mbps Ethernet adapters.

xxiii. Describe the Proposer's internal claims audit including percent of claims audited. Provide a sample of the reports used in the process. Suggested number of pages: 5.

CLAIMS AUDITING

ValueOptions' claims units are constantly measured using a variety of quality monitoring processes. Internal audits of our claims are performed on a daily basis. Our audit process has been created to mirror that of an external audit. This program is an effective tool in evaluating the abilities of the Claims Processor to consistently meeting individual and departmental goals.

The following is an overview of the internal claims audit process:

- A continuous three percent prepayment sample is taken of all paid and denied claims.
- A statistical, stratified random two percent sample is generated on a daily basis for all claims posted the previous day. These claims are all audited post payment and used for client reporting purposes.
- A prepayment audit is done of all claims that exceed a specific dollar threshold. This threshold varies depending on the situation occurring for a particular client, or for the person responsible for processing the claims. A new client or existing client with a significant benefit change is typically set at a lower dollar threshold until ValueOptions' claims management is certain that all processes are functioning properly.
- All trainee claims are audited on a prepayment basis beginning at 100 percent of all claims adjudicated and as an individual processor meets their goals and objectives they are gradually decreased until they are audited at the standard three percent.

The prepayment claims are typically audited the day after they are completed and the processor normally receives feedback the day after the audit occurs. This means that processors have their errors reviewed within 48 hours of having made them, and then the processor is responsible for correcting the error(s). The claims management team meets with the individual processor on a monthly basis to review the audit results for the previous month.

As claims are quality reviewed, the results documented in a quality database specifically designed to allow flexible reporting. The reporting information available through the quality database is used to identify retraining needs and for performance evaluation purposes. Monthly trending of audit errors is also completed to identify problem areas and implement continuous improvement.

In addition to our internal claims audit, ValueOptions conducts on-going internal monitoring and auditing activities to prevent and detect fraud and abuse. These activities include, monitoring of claims submitted for compliance, adherence to treatment record standards, provider credentialing and re-credentialing criteria, clinical requests and reviews, analysis and trending of data collected through various reporting tools, and investigation of complaints and allegations of potential fraud, waste and abuse and coordinating with the Program Integrity Section of DHH.

There are a series of reporting tools used to identify billing trends and issues. These "data mining" tools include biweekly, monthly, and yearly reports examining such elements as:

- high volume of sessions
- family groupings of sessions
- high volumes of unduplicated enrollees report (high quantity of patients)
- high volume of dollars paid
- duplicate claim submission
- matching surnames (providers and members with matching surnames)

Sample Audit Reports

We provide sample audit reports on the following pages.

Report Title **Client Audit Report** **Summary**

Client: ABC Company

For Audits Processed From: 04/01/2011 **Through** 04/30/2011

Audit Type: Random

Report Description/Data Source

Client Audit Report

Table(s): AuditStandard,AuditStandard_ErrorCode, ref_ErrorCode_Standard

Client Totals:

Total # of Audits processed for the Period:	563	**Total # of Audits with Statistical Errors:**	8
Total $ of Audits processed for the Period:	$295,469.05	**Procedural Accuracy:**	99.97%
Avg of Total Dollars:	$524.81	**Payment Accuracy Rate:**	100.00%
Overall Accuracy:	99.82%	**Financial Accuracy:**	100.00%
Total Paid:	$104,378.35	**Total # of Audits with Medicare Errors:**	0

	Count	$ in error	$ Correct
Overpaid:	0	$0.00	
Underpaid:	0	$0.00	
Total:	0	$0.00	$104,378.35

Error Code	Description	Count
11	Incorrect Provider/Vendor	1
12	Incorrect/Missed CL1035-CU1012	1
37	Incorrect patient #	5
47	Missing notes	1
	Total	8

Report #

Report Run Date: 05/16/11

Page 1 of 2

Report Title **Client Audit Report** **Summary**

Client: ABC Company

For Audits Processed From: 04/01/2011 **Through** 04/30/2011

Audit Type: Random

Report Description/Data Source

Client Audit Report

Table(s): AuditStandard AuditStandard_ErrorCode, ref_ErrorCode_Standard

All Client Totals:

Total # of Audits processed for the Period:	563	**Total # of Audits with Statistical Errors:**	8
Total $ of Audits processed for the Period:	$295,469.05	**Procedural Accuracy:**	99.97%
Avg of Total Dollars:	$524.81	**Payment Accuracy Rate:**	100.00%
Overall Accuracy:	99.82%	**Financial Accuracy:**	100.00%
Total Paid:	$104,378.35	**Total # of Audits with Medicare Errors:**	0

	Count	$ in error	$ Correct
Overpaid:	0	$0.00	
Underpaid:	0	$0.00	
Total:	0	$0.00	$104,378.35

Report #

Report Run Date: 05/16/11

Page 2 of 2

xxiv. Explain the Proposer's high-level testing process to fulfill the claims testing process requirements.

VO-LA has a formal process that governs new client implementations as well as ongoing changes. Our Systems Configuration team will work closely with DHH-OBH to assure comprehension of terminology and benefit rules. Our program is customized to meet your needs and we are capable of managing even the widest variety of benefit plan designs and structures. We have the ability to administer by line of business or product type, different or varied authorization rules, diagnosis rules, covered service codes, benefit rules, age based benefits rules and place of service rules.

ValueOptions' CONNECTS system has the technical flexibility to manage claims processing requirements across and within multiple funding sources. ValueOptions' Braided Funding logic uses client-defined hierarchy rules to determine the funding sources applicable for authorization and claims processing. Therefore, the highest priority funding stream, as defined by the client, is used to process the claim where the service is covered, the member is eligible or registered, and the provider of service is contracted. To facilitate robust reporting of claims data, the correct funding source is associated to all claim lines and is available for all reporting, customer support, and processing functions within the system.

During the implementation process, VO-LA will work closely with DHH-OBH to conduct a review and analysis of the benefit information and related requirements. This process is designed to clarify and assure comprehension of terminology and benefit rules that are applied. Discussions will include application of authorization rules, adjudication edits, explanation of payment messages, out of network rules, and the review of state and federal regulations that would impact benefits.

Successful implementations of benefits include, but are not limited to:

- analysis of benefit information to clarify and assure comprehension of terminology and benefit rules
- review of relevant state and/or federal regulations that would impact benefits
- definitions of covered services, diagnoses codes, service codes, (i.e., medical versus behavioral health)
- establishing mixed services protocols
- authorization requirements
- systems set up, mapping of any accumulator data, timely filing requirements, coordination of benefits/third-party liability requirements

Testing of benefits is a multi-faceted approach to assure quality. Our testing protocols for benefits consists of a three step process:

1. Preparation of a known testing base (also called testing cases or testing scenarios). Preparation of regression testing scenarios against baseline cases. These are developed to ensure that the implementation of changes does not adversely affect other functions.
2. Application of a known set of transactions against the base. These test cases are designed to specify every requirement.
3. Inspection of the test scenarios to ensure that the outcome meets the expected results.

The test scenarios are designed to validate a single function or multiple functions within a claim scenario to authenticate the benefit infrastructures. They confirm how a claim will perform based on a set of criterion set forth from the client. All results are compared to the benefit information provided by the client as well as System Configuration including but not limited to:

- accurate accumulation
- benefit limitations (visits, out-of-pockets, and deductibles)
- state or federal regulations
- system setup and data entry integrity

One-hundred percent quality assurance is conducted on all plans at the time of implementation and on any benefit amendments. Additionally, a three-month post-implementation random audit is conducted and continuous ongoing communication between ValueOptions and the client to remedy discrepancies.

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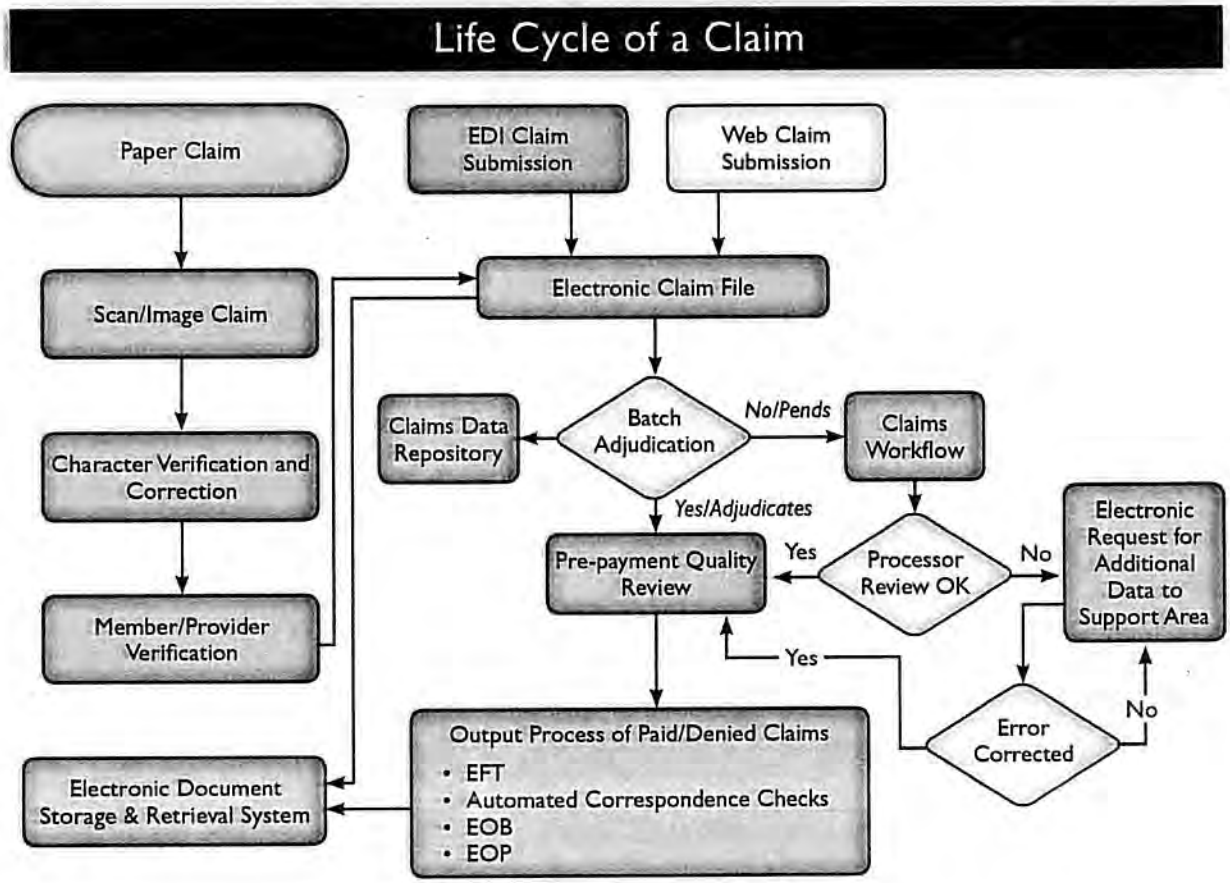
xxv. Describe the Proposer's process of paying claims and ensuring prior authorization has been obtained. Include the process or system functions that ensure only the number of services authorized are paid. Suggested number of pages: 3.

VO-LA has the technological infrastructure in place to ensure correct benefit accumulation. Our CONNECTS system has been specifically configured to support clients with varying and multiple benefit structures, benefit limits and practices such as requiring prior authorization and utilization review. The utilization review capabilities in the CONNECTS system allows for the connection between the claim being processed and authorizations that have been loaded in the system. The CONNECTS system provides automatic matching of claim activity to outstanding authorizations. The decision as to whether a claim requires an authorization in order to be paid is part of the benefit set up logic. The utilization review component is fully integrated with the CONNECTS system and will determine whether a claim requires or has the appropriate authorization and available visits in order to be paid.



SYSTEM EDITS THAT PREVENTION OF OVERPAYMENTS

Payment is made to providers based on service code fee schedules and benefit setup stored in our system. Allowed amounts, deductibles and OOP amounts cannot be overridden

CONNECTS contains edits to detect possible duplicates and exact duplicates during adjudication. The system assigns a "suspect duplicate" hold code which will require an examiner review or to automatically deny the claim. The system has logic to detect situations is DHH-OBH is not the primary payer and automatically puts specific hold codes on the claim to prevent payment.

CONNECTS can be configured at the client level to prevent payments of claims that exceed a pre-defined dollar amount and allowed services. The system applies a hold code to any claims whereby the automatic claims adjudication is overridden. The hold code tracks the reason as well as the claims examiner.

In addition to the edits described above, the system can automatically limit the number of services allowed based upon the number of units available in an authorization, preventing claims processing from allowing more units than the clinician intended.

Our Claims/Encounters Processors will have real time access to all Louisiana-specific benefit plan information through BenefitConnect, and other online resources. BenefitConnect serves as a comprehensive warehouse for all general client account information, demographics, benefits and

eligibility requirements, appeals information, as well as claims and referral guidelines. Current client benefit information grids are available within seconds, and are updated on a regular basis. Embedded within BenefitConnect will be the specific claims processing guidelines for Louisiana which will provide detailed client specific information as well as any special processes.

The information housed in BenefitConnect is maintained by ValueOptions' Systems Configuration area, which is the department responsible for the set up and maintenance of benefit information in our CONNECTS system. This assures consistency between the way claims adjudicate and the language that defines the benefit information that is used in response to service inquiries.

xxvi. Describe the fields utilized in the exact duplicate match. Suggested number of pages: 1.

The CONNECTS system is fully integrated taking all elements of the benefit plan and reference codes into account as the claim is adjudicated. Claims receive edits when limits are met, or when specific combinations of codes are billed together, as well as for duplicate claims submission. The edits can be soft or hard edits, depending on the action that is to be taken. Hard edits are automatically denied based on pre-determined system set-up of specific claim edit rules. With soft edits, the Claims Processor will review the specific edit condition and take the appropriate action.

ClaimsConnect, our claims application within our CONNECTS platform, identifies a duplicate claim by comparing the information submitted on a claim to information in the member's claim history. A claim is denied as a duplicate when there is an identical match. The system detects the duplicate condition when it exists on the current claim or on a previous claim. In situations where the adjudication logic detects a possible duplicate, an edit is applied to the claim and pended for Processor review. This would include claims with different but related service codes.

ValueOptions uses the following criteria to identify duplicate claims submission:

- member ID
- provider of service
- date of service
- service code.

When a duplicate claim edit is received, the Claims Processor reviews the claim history to validate that the service was previously paid to the provider. The Claims Processor also verifies the number of services allowed to be paid per day, and either validates the edit and pays the claim or applies a denial code and denies the claim.

xxvii. Describe the process for determining covered service payments that may not require an authorization. Suggested number of pages: 2.

ValueOptions' CONNECTS system is fully integrated, taking all elements of the benefit plan and reference codes into account as the claim is adjudicated. The flexibility of the system allows for client specific requirements, such as varied authorization rules. Within the benefit set up, variations in authorization rules, covered services, place of service can be managed. As claims are uploaded, the information captured through the data entry process is compared to data loaded in the claim

payment rules built through the benefit configuration set up. The decision as to whether a claim requires an authorization to be paid is part of the benefit set up logic. Emergency Room is an example of a service that does not require authorization and would have varied rules within the benefit set up. The utilization review component is fully integrated with the CONNECTS platform and will determine whether a claim requires or has the appropriate authorization and available visits in order to be paid.

As noted previously, the CONNECTS system can be configured at the client level to prevent payments of claims that exceed a pre-defined dollar amount and allowed services.

Claims and encounters are adjudicated through the same process, but have different preparatory and identification guidelines depending upon whether they are submitted electronically or via paper forms. Our CONNECTS system uses client-defined hierarchy rules to determine the funding source applicable to each claim or encounter. ValueOptions can accommodate encounter-based services, including applying the appropriate funding stream, adjudication rules, provider accumulation (application of encounter value and payment maximums either at the service level or for a specific time period) and payment methodologies.

All encounter reporting is fully integrated with our CONNECTS system and will be provided to the State of Louisiana in accordance with the specifications agreed upon during implementation.

xxviii. Describe the process of ensuring that paid claims are for providers that are credentialed to perform the specific service rendered. Suggested number of pages: 2.

ValueOptions' CONNECTS system is capable of supporting complete managed behavioral health programs from the eligibility through claims adjudication and payment. CONNECTS can maintain benefit structures, provider reimbursement methodologies and adjudication rules for each program. It is fully integrated with all provider information, including provider fee schedules, with the capability of setting up fee schedules based on provider licensure, participation status, licensure, etc. Our NetworkConnect application is the single repository of provider data and collects and stores all required data elements. Information about network providers' services addresses, billing addresses, clinical specialties and licensure or certification status is maintained in this system. Our National Network Services department carefully evaluates the credentials of each provider seeking network participation based on uniform established criteria. Providers are credentialed and re-credentialed for designated services and/or level(s) of services.

Because CONNECTS is a suite of fully-integrated applications, information entered into NetworkConnect automatically feeds into our other applications.

NetworkConnect collects provider data elements that include but are not limited to provider name, practice location, NPI, Tax ID, Medicaid ID, contracted services, clinical specialties, languages spoken, licensure levels, etc. The integration of the provider data allows us to manage claims payment and referrals to specific providers. Most of the required fields are listed in the following paragraph including member and provider information, procedure codes, diagnosis, billing codes, Coordination of Benefit information.

ValueOptions' claim processing module, ClaimsConnect, is fully integrated to ensure payment is consistent with participation requirements including benefit design, eligibility, care management, provider maintenance, and others. Claims that are uploaded into CONNECTS are processed automatically, subjecting them to industry standard systematic edits, as well as customized, client-specific benefits or business requirements. Upon claims entry/upload, the CONNECTS system performs online automated edits that validate:

- procedure codes, diagnosis codes, and billing codes (CPT codes, HCPC's codes, ICD-9 and revenue codes)
- eligibility and enrollment of the subscriber and /or dependents
- excessive charges
- benefit maximums such as visit limitations, out-of pocket expenses, and lifetime maximums
- unauthorized services
- matches related to authorization
- provider name, licensure, address, fee schedule, W-9 information, and network status
- duplicate submissions, services, and providers
- compatibility of Third Party Liability (TPL), Other Health Insurance (OHI), and/or Coordination of Benefits (COB)
- potential fraud and/or abuse

Not only do ValueOptions' online edits ensure data integrity and appropriate benefit application requiring that critical data is present and valid, but our system also permits us to define which claims the Processor is required to evaluate. The information captured through the data entry process is compared to the data loaded in the claim payment rules built through the benefit configuration set-up (provider, fee schedule information, licensure, etc). Automatic claim suspension routines are performed for those claims that require further examination (for example, provider file discrepancy). CONNECTS has the capability to assign hard and soft edits based on individual client requirements.

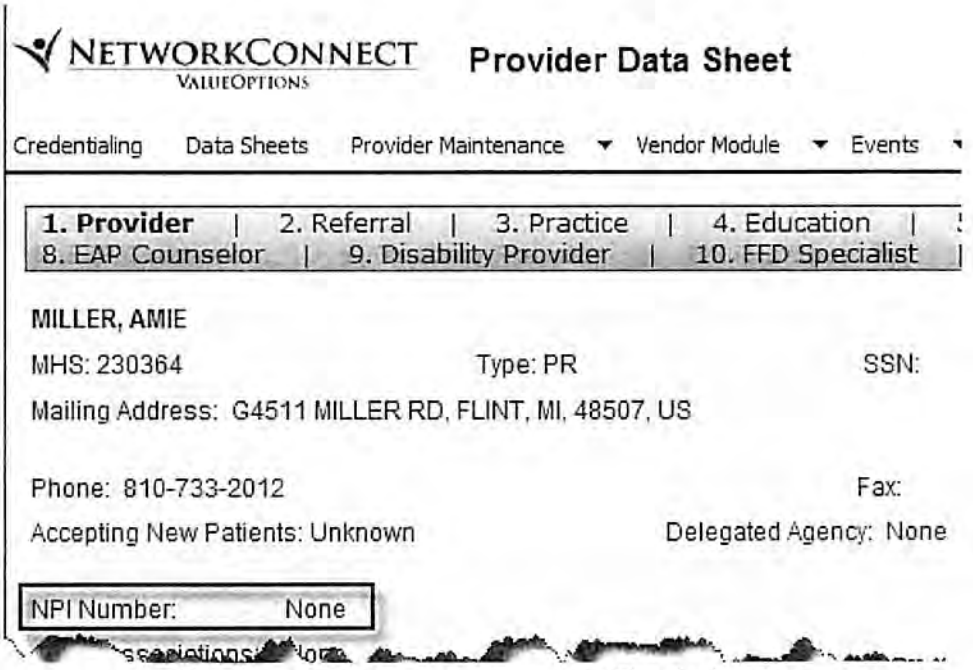
Hard edits allow claims to automatically adjudicate based on pre-determined system set-up of specific claim edits. Soft edits indicate that there is a condition on the claim that needs to be manually reviewed before adjudication of the claim can be completed. For example, when a claim is entered into our claims system, the provider information is validated against the information in our NetworkConnect system, as well as against the client benefit set up. If a discrepancy exists, the claim is pended for Process review. The Claims Processor will review the claim against the provider file, as well as the client specific claim payment rules to determine if the claim should be paid or denied. Claim edits are designed to ensure data integrity and appropriate benefit application. Every claim is subject to extensive systematic validation. Customization of claim edits ensures that only qualified claims are paid.

xxix. Describe the Proposer's storage of and use of national provider identification NPI) numbers. Suggested number of pages: 2.

Since 2007, CONNECTS has been able to capture, store, and report provider data via the National Provider Identification (NPI). The NPI is used in CONNECTS for administrative, claims payment, and reporting needs.

The NPI and other alternative provide identification numbers, such as Medicaid ID are collected and stored in NetworkConnect. This applications serves as the single source of all data entry related to providers. Because CONNECTS is fully-integrated, information entered into NetworkConnect automatically feeds into the CONNECTS suite to help manage claims payments, referrals to specific providers, provider service inquiries, provider demographic changes, as well as application submission and/or recredentialing submission/review activities.

The screenshot below illustrates our ability to collect the provider NPI and other demographic data elements.



Using NetworkConnect, we can record NPI and other data

xxx. Describe the process for capturing DOE data as encounters. Suggested number of pages: 2.

We will work with DOE to develop a data exchange which will allow DOE to transmit data to VO-LA, which will include but not be limited to member demographics, dates of service, services provided, type of service, frequency, provider name, and service goals. This data will be loaded into our CONNECTS system and identified as an encounter. The DOE data will then be reported as encounter records and will be included in the encounter data exchange that VO-LA will transmit to DHH-OBH.

xxxi. Provide a list of the system edits and their description to be used when processing the medical claims. Suggested number of pages: 8.

We provide a representative sample of our hold codes (claims system edits) used in processing behavioral health claims in the table below. This listing contains our standard codes; however, we are able to customize our system edits with client-specific hold codes upon request. This customization can include information and direction to members concerning special processes unique to Louisiana. We will work with DHH-OBH during the implementation process to identify your specific requirements.

Claim Hold Codes	Hold Code Description
DFN	RESUBMIT W/FULL CONSUMER NAME
AT	REFER SERVICE TO MEDICAL PAYOR
GF	DUPLICATE CLAIM
NAF	NO OPEN AUTHORIZATION ON FILE
JQ	SUBMIT PRIMARY EOB
GI	CLM FILED OUTSIDE TIME LIMIT
HG1	NOT A COV'D SERVICE AND/OR DX
E9	NOT A COVERED BENEFIT
JR	SUBMIT MEDICARE EOMB
JR1	SUBMIT MEDICARE PART B EOMB
JR2	SUBMIT MEDICARE PART A EOMB
XN	NOT A COVERED SERVICE
DID	PLEASE RESUBMIT W/CONSUMER ID
GK	CONSUMER NOT ELIGIBLE AT TIME OF SERVICE
GE	PROVIDER NOT LICENSED TO PERFORM SERVICE
KR	RESUBMIT WITH VALID PLACE OF SERVICE
G4	AUTHORIZED UNITS ARE EXHAUSTED
EY	SERVICE CODE NOT VALID WITH PLACE OF SERVICE
XT	NON-COVERED WITH SUBSTANCE ABUSE DIAGNOSIS
G6	DAILY THERAPY LIMITS EXCEEDED
JW	ITEMIZE EACH DATE OF SERVICE
G7	BILLING PROVIDER NOT AUTHORIZED
G8	LEVEL OF CARE BILLED NOT AUTHORIZED
GD	NO AUTHORIZATION FOR DATE OF SERVICE AND PROVIDER
IS	BENEFIT NOT COVERED
RNPT	RESUBMIT WITH CORRECT NPI OR TAX IDENTIFICATION NUMBER

Claim Hold Codes	Hold Code Description
G5	DATES OF SERVICE OUTSIDE DATES AUTHORIZED
JPS	POSSIBLE DUPLICATE
JRM	ADDITIONAL EOMB REQUIRED
JK	SERVICING PROVIDER UNKNOWN
GH	INVALID DIAGNOSIS CODE
B4	NON COVERED CHARGES
MU	MEDICARE PRIME
JQC	ADDITIONAL EOB REQUIRED
JT	RESUBMIT WITH VALID ICD-9 CODE
JX	EOB DOES NOT MATCH SERVICES
F9	CLAIM SUBMITTED IN ERROR
ZD	NOT A COVERED SERVICE WHEN OON
JP	RESUBMIT WITH VALID SERVICE CODE
RBT	RESUBMIT WITH CORRECT BILL TYPE
M9	CONSUMER NOT ELIGIBLE
KH	SUBMIT VALID DATES OF SERVICE
IH	RESUBMIT CLAIM WITH CORRECT TAX IDENTIFICATION NUMBER
MOD2	RESUBMIT WITH MODIFIER
DOB	RESUBMIT WITH CORRECT DATE OF BIRTH FOR PATIENT
HB	MAXIMUM NUMBER OF VISITS/DAYS EXCEEDED
DFN	RESUBMIT W/ FULL CONSUMER NAME
CNC	NON COVERED CHARGE
GX	AUTHORIZED UNITS EXCEEDED
TA	PROVIDER LICENSE REQUIRED

xxxii. Provide the policy and procedure for fraud detection in claims submissions.

We provide a copy of ValueOptions' policies and procedures related to fraud detection in claims submission as **Attachment 24**.

xxxiii. Describe the Proposer's coordination of benefits (COB) experience for determining payment. Suggested number of pages: 5.

ValueOptions has been processing and coordinating benefits on behavioral health claims since 1983. We have well-defined protocols and policies governing the Coordination of Benefits (COB) process to ensure appropriate and consistent decision making. Our policies ensure that the appropriate investigation is initiated when it is identified that another insurer has responsibility to pay for

services incurred by a Medicaid member. Claims are cost avoided and the provider is instructed to submit the other insurer/third parity's proof of payment or denial prior to payment under the Medicaid program. This assures that benefits are coordinated appropriately and that Medicaid is the payer of last resort.

ValueOptions complies with state and federal regulatory requirements surrounding COB and other carrier liability. ValueOptions collects and stores other health insurance coverage in the member's eligibility record, allowing systematic COB editing during claims adjudication. We work closely with the state Medicaid agency to capture existing primary payer information on file. As additional information is obtained, we establish workflows with Medicaid to communication our respective information. The coordination of benefits with other potential payers, is critical in the claims process to ensure that the provider is reimbursed at an appropriate level and by the proper carrier as determined by industry standards.

ValueOptions is able to identify members and adjudicate claims accurately for members eligible for Medicare. The process for identifying and adjudicating these claims depends on the information received from the state Medicaid agency. For example:

- ValueOptions can set up different processing rules for those who are over age 65 and ineligible for Medicare if these members are identified by the state through the enrollment process.
- ValueOptions can handle various types of "ineligible" members typically encountered, including members who are not eligible for services due to insufficient Social Security contributions, as well as those who have failed to elect Part B coverage. In the case of those who have not elected Medicare Part B, ValueOptions will adjudicate these members' claims in accordance with the Summary Plan Description.

We assume, until we have evidence to the contrary, that all over 65 members have both Part A and B Medicare coverage. The first time ValueOptions receives a claim for one of these members, it will be investigated unless an Explanation of Medicare Benefits (EOMB) is attached.

During the implementation process, coordination protocols will be established for informing the state when there is a discrepancy in the eligibility information provided compared to our current research efforts. ValueOptions' National Claims Department is staffed with high level Processors experienced in Coordination of Benefits, Third Party Liability, Medicaid and Medicare requirements. COB information is typically updated with each eligibility file received from the state, and from information gathered during the claims adjudication process. Benefits are coordinated based on the COB methodology designated by the client. ValueOptions offer several different industry standard methodologies such as traditional, carve-out and maintenance of benefits.

xxxiv. Describe the Proposer's third party liability and COB process for identifying other health insurance. Include the capture and storing of other health insurance information. Include any system edits invoked during claims processing. Suggested number of pages: 3.

VALUEOPTIONS' TPL AND COB PROCESS

ValueOptions actively researches and identifies Coordination of Benefits (COB) and other third party liability (TPL). We collect and store other health insurance coverage in the member's eligibility

record, allowing systematic COB editing during claims adjudication. Claims Processors are trained on situations that fall within subrogation provisions. Should a situation arise that is perceived to be a potential subrogation claim, VO-LA will research and follow-up as appropriate. When we are aware of other third party resources, the claim is cost avoided and the provider is redirected to bill the other third party resource as the primary payer. This process was used for the BP Gulf Oil Spill.

Capturing and Storing Other Health Insurance

Information regarding other insurance coverage is entered into the claims adjudication system in the eligibility record for each member. This data is considered as claims are entered in the system (whether the claim is submitted electronically or in paper format) and the processor receives edits that will direct them as to next steps.

System Edits

ValueOptions' CONNECTS system is fully integrated with eligibility information, including data collected regarding COB/TPL. Upon claims entry/upload, the CONNECTS system performs online automated edits that include compatibility of COB, Third Party Liability (TPL), and/or Other Health Insurance (OHI). Automatic claim suspension routines are performed for those claims that require further evaluation. Our integrated CONNECTS platform plays a critical role in our ability to maintain an effective COB process. CONNECTS perform systematic edits that helps to identify members with other health coverage and automatically pends claims to alert the Claims Processor that an investigation is required. Throughout our COB process, each step contributes to assuring files are updated and benefits are coordinated appropriately with other payers

ValueOptions has a systematic process in place to collect overpayment from the provider if a claim has been paid as primary and it is later determined that ValueOptions paid in error due to other insurance liability. We understand the importance of immediate restitution to prevent subsequent erroneous payments. ValueOptions' comprehensive management information system, the CONNECTS platform, stores the overpayment amount and automatically attempts to recover the portion that remains uncollected each time the provider or member, who received the overpayment, is eligible for an additional payment as a result of a new claim submission. The CONNECTS system continues this automated deduction process until the full amount of the overpayment is recovered. If regulatory or contractual requirements do not permit an automated recovery process, a letter is sent to the provider requesting a refund on the overpayment

We have well defined protocols established with the state Medicaid agencies which enables us to resolve coordination of benefits discrepancies and ensure enrollment fields are updated to accurately reflect primacy. This process minimizes the number of recoveries that are initiated for claims paid as primary in error.

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xxxv. Describe the Proposer's hardware and platform on which the software runs. Describe the environment in which the processor is or will be located. Suggested number of pages: 3.

VO-LA believes that improving the quality of care for recipients of behavioral health care in Louisiana is not only dependent upon transforming the current clinical and structural aspects of the Louisiana behavioral health system, but also ensuring that the technical infrastructure used to collect,

analyze, and share information is robust, reliable and scalable to meet the clinical information needs of the behavioral health system. Throughout the years, ValueOptions has continued to evolve our technical infrastructure and clinical management systems to adjust to the changing requirements and increased need for improved information systems that permit us to:

- produce better clinical outcomes
- provide useful, qualified data to make the right decisions at the right level
- develop the clinical and case management workforce by promoting a continuous learning environment by leveraging the Web and other related technologies

Our carefully designed and constructed technical infrastructure is based upon leading-edge hardware platforms that enable us to function effectively while leading the transition to the new Louisiana behavioral health system model, and coordinate service delivery DHH-OBH and all other state agencies in the future. Below are the details regarding ValueOptions' hardware and the platform on which it runs, the electronic medical record, as well as environmental and physical security safeguards for our national computing center in Reston, Virginia.

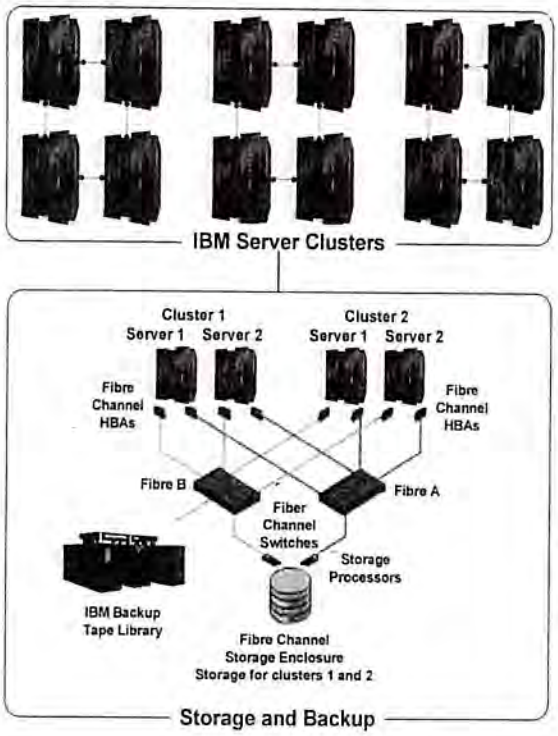
The National Data Processing Center links the CONNECTS platform, the VO-LA service center and national personnel into a seamless and integrated information system. Centrally administered through ValueOptions' Reston National Data Center, the i595® is accessed by both local and remote users via Local Area Networks (LAN) in a Wide Area Network (WAN) in an Verizon Business fully meshed MPLS network configuration

DATA CENTER HARDWARE PLATFORM – RESTON, VA

ValueOptions' primary data center, residing in Reston, Virginia, leads the industry with state-of-the-art systems and a supporting infrastructure. Operating on a 24-hour-a-day, seven-day-a-week support schedule, the data center was designed based on data center best practices and leading class technologies in the areas of power, cooling, fire suppression, moisture detection, backup and recovery, and physical security.

ValueOptions' core application servers residing in the primary data center are built utilizing IBM's enterprise class pSeries and iSeries platforms. These systems are designed by IBM and configured in partnership with IBM by ValueOptions systems engineering staff to provide maximum redundancy and resiliency in both internal power and computing capability.

By virtue of their design, the iSeries and pSeries platforms each receive industry recognized leading availability ratings. Our i5 and p5 models provide 64bit POWER5+ computing power and non-disruptive autonomic CPU and memory failure capabilities. Each platform remains highly scalable with processor and memory CUoD (Capacity Upgrade on Demand) feature capability. CUoD allows additional memory and processing resources to be added without interruption to application availability.



Servers Platform

- IBM® iSeries (AS/400) i5 595® application servers running IBM's V6R1 i5/OS® operating system.
- IBM i5 595® configured with multiple logical partitions including production and development environments.
- 17-way POWER5 64bit CPU with 384GB of memory, 58500 CPW Enterprise Edition®

Storage Platform

- Over 40 Terabytes of mirrored disk storage
- IBM 3584 Automated Tape Library® (ATL) containing 28 3592-E06 high-speed tape drives for fully automated backups.
- IBM 3590 and 3490E tape cartridge for client file compatibility.
- Host network communications includes four (4) 1Gbps and seven 100Mbps Ethernet adapters.

Capacity

- Over 999 million members
- 99 million claims per day
- 99 million authorizations per day
- 450,000 clients, 3 million groups, and over 450,000 benefit plans
- 1000 simultaneous, interactive users (dynamically scalable to 2000) and,
- Sub-second response time

The backend DB2 and Oracle application databases reside on an iSeries i5 595 and pSeries p5 570 respectively. ValueOptions' i5 595 and p5 570 each consist of multiple logical partitions including dedicated production, development, staging, training and load test environments.

DATA CENTER ENVIRONMENTAL AND SECURITY SAFEGUARDS

Mission-critical systems and valuable building resources are monitored 24 hours a day, seven days a week by internal onsite operations staff and a contracted third party environmental monitoring firm, for life-threatening situations, like fires and panic alarms, unauthorized personnel intrusion and business continuity.

Fire suppression for the National Data Center in Virginia is provided by a 'pre-action' (dry-pipe) sprinkler-head system. The first floor Data Center is above grade. There are multiple moisture detection sensors positioned throughout the Data Center flooring that alert operations staff to possible flood or moisture exposure. Four redundant 20-ton Liebert glycol high-capacity Computer Room Air Conditioning (CRAC) units handle the Data Center temperature and humidity control. Power to the Data Center equipment is provided through fully redundant internal power supplies, with additional redundancy supplied by separate power feeds from two external Power Distribution Units. Both a PowerWare 325kVA UPS and a Caterpillar 625kVA diesel generator with over 72 hours of fuel supply provides uninterrupted power to the Data Center during events of utility power loss.

The data center is secured by Kastle Systems physical access controls and this key card controlled access system secures the office building and workspaces. Video surveillance of the building's exterior and interior, including the data center, is also provided. Access to the National Data Center in Virginia is restricted to a limited number of employees, and picture identification badges with proximity readers are used to control physical access. Access to the Data Center is restricted to

those persons required to operate, supervise, or provide maintenance to the facility and equipment. Authorized employee access is controlled through the use of electronic key cards and Electronic Security Access Requests (eSAR's). Electronic key card access to the data center is controlled by the Manager of IT Security with approval for use granted by the Chief Information Officer, the Director of IT Core Operations, or the Manager of Data Center Operations.

ValueOptions utilizes the Nokia Firewall/VPN appliance, which includes market-leading VPN-1 Pro software from Check Point Software Technologies, allowing ValueOptions to deploy a single, integrated solution for secure Internet communications and access control. Two firewalls are configured in High Availability mode to ensure that network access is always available and protected. The integrity of our firewall design is further strengthened by the incorporation of Tipping Points IPS (Intrusion Prevention System) solution; this added layer of security ensures integrity of all Internet traffic before it reaches our Firewall. ValueOptions providers and clients access systems and applications through a secure client connection via the firewall to limit access to authorized personnel.

Security administrators review firewall and IPS logs on a daily basis. Both firewall and IPS logs are maintained on the ValueOptions internal network. Utilizing eEye's 'Retina Vulnerability Scanner,' the IT Security team proactively performs internal network scans to identify potential network and client/server node vulnerabilities. Working closely with appropriate network and systems teams, the IT Security team enforces corrective actions where needed.

Procedurally, the IT Security department executes a bi-annual internal network vulnerability and remediation project.

xxxvi. Describe the Proposer's operating system/network infrastructure on which the software runs. Describe the programming language utilized and the software used to develop it. Describe how the source code can be purchased and if the Proposer can customize the software. Describe the Proposer's policy and procedure on software upgrades. Suggested number of pages: 5.

VO-LA recognizes that the DHH/OBH has unique behavioral health care priorities, delivery system challenges, and program goals. Our extensive experience, technological innovations, and flexible program design capability will enable us to work well with DHH/OBH to develop and implement an adaptive operating system and network infrastructure environment that responds quickly to the needs of Louisiana members' behavioral health care needs. The following section provides details on ValueOptions' operating system, database management system, programming language and customized software applications.

Operating System/Network Infrastructure

ValueOptions' JAVA-based CONNECTS applications are developed and deployed to the J2EE standard in a two tier configuration utilizing IBM's WebSphere Application Server on pSeries in a clustered configuration. Backend DB2 and Oracle application databases reside on an iSeries i5 570 and two pSeries p5 570's respectively. The ValueOptions i5 and p5's each consist of multiple logical partitions including dedicated production, development, staging, training and load test environments.

Programming Languages and Software Development

We utilize a variety of programming and development tools to create an efficient and technically advanced software development system. These tools have been carefully chosen to match the level of complexity and flexibility needed by all those who depend on it. The following table lists the tools we have incorporated into our system.

Development Tool	Vendor	Application Area
COBOL	IBM	CONNECTS management information system
Transact SQL	Microsoft	Data Warehouse
JAVA/COBOL/DB2	IBM	ClaimsConnect EligibilityConnect FinanceConnect ProviderConnect CareConnect
Java, DB2	IBM	CareConnect Clinical Management system
Java, DB2	IBM	ServiceConnect
CMOD V8	IBM	Content Manager OnDemand
Java Serviet 2.2 Javascript JSP 1.0 Oracle 11i WebSphere 5.2	IBM/ORACLE	BenefitConnect
Oracle 11i	ORACLE	QualityConnect
AJAX Javascript Java Serviet 2.2 JSP 1.0 Oracle 11i Struts WebSphere 5.2 Sybase XML	ORACLE/IBM	SecurityConnect
Vignette 6.07 Tomcat Oracle 11i	Oracle/IBM/Vignette	Achieve Solutions
MS SQL Server	Microsoft	KnowledgeConnect

These applications provide flexible and easily customizable ways to manage, develop, and constantly improve our information system services. Together these tools will ensure a faster, more efficient service for the Louisiana behavioral health system.

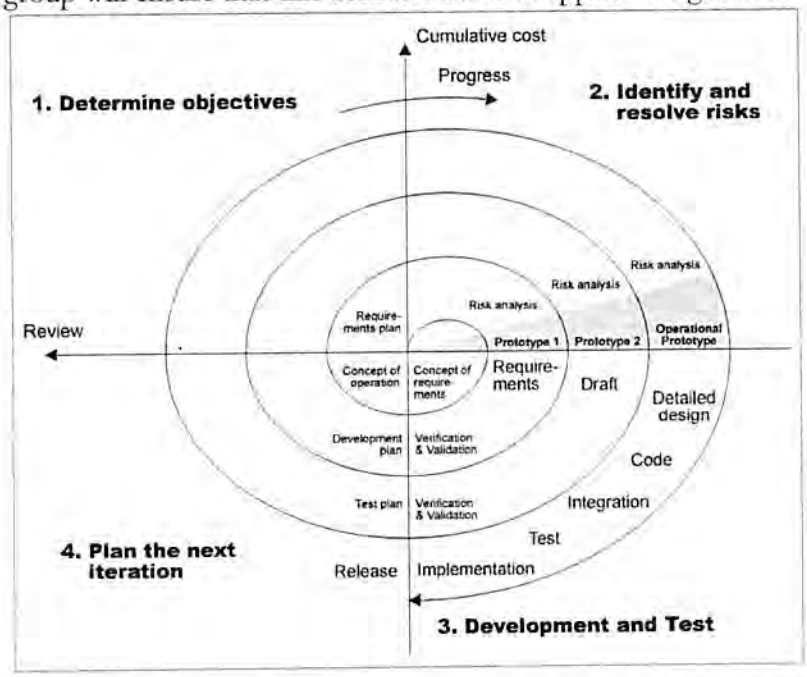
Source Code Ownership and Customization

ValueOptions has over 20 years of extensive experience in designing, developing and customizing high end systems to support state Medicaid programs. Our National Information Technology (IT) Division employs the latest methodology, design strategies and leading-edge tools to deliver optimized solutions to best support innovative Medicaid programs such as the DHH-OBH contract.

The extensive expertise we have acquired over the years has allowed us to implement an effective information systems software development and implementation methodology that is comprehensive and flexible. The methodology we apply for implementing information systems is derived from the industry-recognized Spiral Model (illustrated to the right), which combines elements of Rapid Applications Development (RAD) and the Waterfall Model. Since over 95 percent of our applications are internally developed, this software development methodology allows us to quickly and effectively deliver current and future system requirements to support the customized components of the DHH/OBH contract.

Information Systems Software Implementation Methodology

We recognize the importance of having an Information Technology Department that is supportive and responsive. Our internal IT Governance Board was established to identify, coordinate, and prioritize local IT initiatives. This group will ensure that this contract has the support and guidance required to meet all contractual requirements and establishes priorities that align with DHH/OBH goals.



The National IT Development Department provides change management, project management, and deployment oversight at the National level. Each application is assigned an Executive Sponsor and Business Owner who have the responsibility of any product-specific development, enhancement, quality assurance, and configuration management. Source code level configuration management is the responsibility of the business owner assigned to the application development team. Only authorized users are granted direct access to the source code library. Changes are deployed into the production environment only after rigorous test procedures are completed successfully. ValueOptions uses the development partition of the AS400 server as the software engineering environment for development and testing.

ValueOptions' Systems Development and Programming group has included a methodology and defined processes that are used for management and control of the application source code. The process includes all steps in the project life cycle, from initial program checkout, to the ultimate final production implementation. The application development source control manager is responsible for ensuring adherence to these policies and procedures. All decisions relative to source code management are the sole responsibility of the source code control manager. The policy is enforced to ensure that all production source code is maintained in accordance with industry standards and adequate security protection. This program enables ValueOptions to respond to internal and external audits, relative to source control.

If and whenever there are any upgrades, changes, or enhancements required to meet DHH/OBH needs, ValueOptions will use our formal Change Management Process to ensure a quality product is delivered within the required time frames. Our formal Change Management Process (CMP) was designed on the basis of partnering with clients throughout the software development lifecycle to ensure change orders are prioritized and rapidly delivered. This process helps control, prioritize, and streamline the delivery of changes to our information technology products and services. The process also provides a standardized, effective, and efficient process to prioritize and fulfill changes for system enhancements and software upgrades.

If it is anticipated that any of our application or system modifications may affect any of the data interfaces with DHH/OBH, we will provide DHH/OBH with the details of the planned changes the estimated impact upon the interface process, and unit and parallel test files. We will not implement the proposed change until DHH/OBH evaluates and approves the test data.

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

Describe the Proposer's business continuity, disaster recovery and emergency preparedness plans. Address how the Proposer will participate in disaster recovery when a disaster occurs and a state of emergency is declared by the Governor or designee. Suggested number of pages: 2.

BUSINESS CONTINUITY/DISASTER RECOVERY

VO-LA understands that in the event of a crisis or disaster, business must continue and members must still be able to access the care they need. We have developed a comprehensive disaster recovery process, which includes data archive and retrieval, to ensure information is safeguarded in such instances. ValueOptions leverages a two scenario recovery contingency plan:

1. Clustered WebSphere Application servers and real time data replication of core application data lies at the heart of our primary recovery approach. In this recovery approach, all transactions of our CONNECTS application data are replicated in real time to a fully redundant IBM iSeries application servers utilizing third party data replication software. The event of a single server failure is addressed in this primary recovery design.
2. Our secondary recovery contingency provides support for an unlikely catastrophic disaster involving a total site outage of the National Data Center. ValueOptions has engaged IBM Business Continuity and Recovery Services (BCRS) for hosting and recovery subscription services at their premier BCRS hot site in Sterling Forest, New York. Additional redundancy is built into our WAN connections, which facilitate rerouting of data traffic.

IT Business Continuity Plan

ValueOptions' National IT Department is responsible for maintaining and executing the Disaster Recovery or IT Business Continuity plan. We perform the traditional daily back-ups to tape and storage off-site methodology as a precautionary measure. All servers are backed-up daily to ensure that the content of all production systems can be recovered in the event of a disaster. These back-ups are performed on both host and LAN systems. Software and production data files are copied to tape. Tivoli Storage Manager (TSM) and Backup Recovery and media Services (BRMS) verification and audit programs are used to confirm that the system back-ups are complete and accurate. Copies of the tapes are then created and stored off-site. In the event of a physical disaster, the back-up tapes stored off-site can be used to recover and reload our production systems. System back-up tapes are rotated regularly to ensure physical integrity of the tapes and to minimize tape parity error problems. This traditional back-up approach provides a fail-safe for all of ValueOptions' data and programs to ensure IT business continuity.

The VO-LA service center will have a customized Business Continuity Plan that will be managed 24 hours a day, seven days a week by the ValueOptions National Telecommunications Group. Our geographically dispersed call centers provide back-up call management services for each other. This ensures the level of service our participants will receive, even when a site may be operating under Back-up Recovery Plan (BRP) conditions, is meeting ValueOptions standards and DHH-OBH service level expectations. BRP's are activated by service centers when needed. To activate or de-activate a BRP plan, a service center simply calls or e-mails the Technology Call Center and requests

that their center be put into or taken out of Business Recovery. This process can be accommodated within minutes of notification, 24 hours, seven days a week, 365 days a year.

EMERGENCY PREPAREDNESS PLAN

VO-LA will work with the DHH Office of Public Health Center for Community Preparedness in the event of a disaster. Our plan will follow the National Response framework created by the Federal Emergency Management Agency, as well as the Centers for Disease Control for public health emergencies. We provide a draft All Hazards plan as **Attachment 14**.

VO-LA will work to engage and develop collaborative relationships with all Designated Regional Coordinators (DRCs), including attending the trainings and webinars conducted by the DRCs. We understand that the DRCs are the point of contact for information on how each Region will work together in the event of emergency and, that VO-LA must be part of that planning in each region to understand the logistical needs for the ESF 6 (Mass Care, Emergency Assistance and Housing) for the sheltering of dependent children and families. Once an emergency is projected (within 96 to 120 hours) we will begin implementing our BRP plan as well as working with providers to ensure that they are aware of the locations of all their members and assist in organizing resources for any members who must be evacuated.

Part of our work with providers will include email blasts to remind them to ensure that all member-based information is current, to encourage them to direct members to our Emergency activated website (https://www.achievesolutions.net/achievesolutions/en/emergency/Home.do) and to assist with member and family emergency planning. In addition, we can assist other professionals, as noted in recent experience with The Weather Channel (TWC). ValueOptions provided TWC with critical incident debriefing services onsite in Atlanta following the tragic Joplin tornado events. During a live TWC broadcast, ValueOptions' Chicago-based Todd Kasdan, M.D. answered viewers' questions on tornadoes and their psychological effects on children. The broadcast aired Sunday, June 5, 2011, in three segments, at 8:40 a.m., 9:40 a.m. and 10:40 a.m. ET.

VO-LA website provides information for Members in the event of a disaster.

From our discussions with providers and stakeholders in Louisiana, we know the importance of providing a seamless continuum of care for members during an emergency. ValueOptions has extensive experience in various private and state public sector programs with providing services to persons in times of catastrophic events, either man made, such as 9-11 and the tragic shootings at Virginia Tech, or natural disasters, such as Katrina and other hurricanes. ValueOptions mobilizes resources quickly to provide onsite evaluation, clinical, and pharmacological services to persons affected by disasters. Grief counseling and stress management resources are available to those affected both directly and peripherally by such events. In addition, we have experience working with the Red Cross, numerous government entities, and providers in establishing shelter-based behavioral health services following a disaster for individuals with special needs. The ValueOptions process begins with maintaining a comprehensive clinical system that has the most recent clinical activity data on all enrolled members. Through our secure Web-based portal, ValueOptions can access the

current clinical histories including medications, treatment needs, emergency contacts, and personal treatment plans for enrolled members who are active in treatment while onsite at emergency shelters

We use the clinical and pharmacy histories within CareConnect to establish access to medications individuals need while in a shelter. Additionally, VO-LA will enlist our specialty providers to provide behavioral health clinical interventions beyond mental health first aid, as needed, at the shelters.

For example, ValueOptions organized the following shelter-based services in Texas following Katrina, Gustav, and Rita:

- medication management
- mental health first aid
- methadone maintenance
- AA and NA groups
- case management

In addition, we worked with FEMA and the Red Cross to transition affected individuals from shelters, such as Medical Special Needs Shelters, to temporary housing. ValueOptions created special enrollment tracking for all special needs individuals who received services at shelters. Our enrollment process facilitated follow-up with members and to ensure ongoing services were provided to individuals in need and to facilitate repatriation with a designated provider. This process will greatly benefit repatriation as it will allow ValueOptions and VO-LA to provide a continual follow-up that is member based (vs. geography-based) and follows the member throughout the cycle of an emergency.

We also contract with providers to respond to emergencies and disasters including onsite shelter-based services. We dispatch our staff to support Family Assistance Centers, provide stress management and grief counseling. In coordination with the Red Cross, the State Incident Officer and the Coordinators for Environmental Health, Community Preparedness and Community Health, we will engage in direct onsite support to the clinical provider teams. We will establish a behavioral health clinic administrative infrastructure, allowing the providers to focus on the clinical interventions while the ValueOptions' clinical team focuses on coordination of care, providing clinical histories to the crisis providers, and establishing enrollment and tracking protocols so individuals do not get lost in the system.

Finally, we can also assist with helping to reconnect families (assuming appropriate releases for HIPPA compliance) via our integrated clinical system. Our systems have served as a key means for families to reconnect with families because we were able to identify and maintain information about the location of members before, during and after an emergency.

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Provide an Implementation Plan that addresses the requirements of this RFP, including but not limited to establishing a Louisiana site, recruitment, hiring and training personnel, network development, and IT. The Implementation Plan should include tasks, milestones, due dates, and parties responsible. Provide a narrative that describes the Proposer's approach to implementation, highlighting tasks identified in the Implementation Plan.

IMPLEMENTATION PLAN AND TIMELINE

Building upon the conversations we have had with stakeholders to understand the needs of DHH-OBH, Department of Children and Family Services, Louisiana providers, Human Services Districts (HSD)/Local Governing Entities (LGEs), members and their families, ValueOptions will ensure that the Louisiana Behavioral Health Partnership (LBHP) has a strong and secure foundation. We know that this transition period brings with it an enormous amount of anxiety, so it is our job to provide clear communication to *all* stakeholders, and to support Members and providers as they navigate this change to how they have previously accessed or delivered services.

ValueOptions has never missed a go-live date and has never paid a penalty for implementation performance.

A successful program implementation begins with a shared commitment to the health and recovery of LBHP Members, and with an organizational understanding and commitment of the National and local resources required to implement a statewide program that will serve the needs of Louisiana's diverse communities. With our extensive discussions with stakeholders across the State, we learned of Members' concerns regarding access, and providers' concerns regarding licensure, payment, and systems changes. We have already started to demonstrate our commitment to the LBHP model, as well as our willingness to ensure this program is successful.

Along with a clear understanding of the State's vision and the needs of a true System of Care for children and adults, we recognize that a third key to success is a clear, direct and ongoing communication plan. This plan will be led by the VO-LA Chief Executive Officer (CEO), and will be supported by our experienced National Implementation Team, all of whom will be actively involved in all aspects of program implementation. ValueOptions' implementation philosophy and team structure provides:

- continuity of leadership from pre-implementation activities, through implementation, to ongoing operations
- project management leadership available to, and working directly with, DHH-OBH through all stages of the implementation
- participation from, and oversight by DHH-OBH, as available, in all levels of decision making
- continuity of care for Members
- respect for Louisiana's diverse communities and the providers serving them
- seamless program transition with minimal disruption

Implementation Team Leadership

In support of our VO-LA-based CEO, COO, CMO and various departmental Administrators, ValueOptions' Core Implementation Team will be led by [redacted] ValueOptions has assembled and will deploy a dedicated team of more than 100 Subject Matter Experts, staff, and project management professionals to function as the implementation team for the Louisiana Statewide Management Organization (SMO) program. The Core Implementation Team responsible for leading the implementation will be on the ground and remain in place throughout the pre- and post-contract execution phases of this initiative. These individuals will participate in an implementation planning exercise with DHH-OBH and will coordinate and oversee the transition activities in their functional area or department. The graphic below depicts ValueOptions' implementation structure.

CHART REDACTED

ValueOptions' Implementation Team ensures a seamless program transition and no disruption of services to Louisiana Members, or providers.

Based on our experience with large public sector implementations, ValueOptions understands that a successful implementation of this contract will be predicated on a strong partnership and continuous dialogue with DHH-OBH. We will plan to meet with DHH-OBH within the first five days of the contract award to define the project management team, the communication paths and reporting standards between DHH-OBH, the LBHP and CSoC Statewide Governance Body (SGB). Key to beginning this partnership will be the dissemination of contact information for the VO-LA CEO, COO, CMO, CFO and the implementation project lead. We know how difficult these large scale implementations can be, and we want to ensure access to our key staff. We recommend that members of the DHH-OBH staff be asked to participate as integral technical assistance experts in several of the work groups that will be formed to implement services in DHH-OBH. We also suggest that during the implementation phase we establish no less than weekly formal meetings between the VO-LA leadership and project implementation team and DHH-OBH. This will ensure a clear communication of deliverables, issues, and opportunities to make any mid-course corrections.

We understand the incredible demands on DHH-OBH staff time, but we have found this approach to be the most effective way of ensuring that clients are satisfied with the activities and progression of an implementation. Our three years of experience talking with stakeholders, and our recent successful implementation of the Office of Group Benefits contract, will ensure a smooth and successful implementation. ValueOptions does not use a "drop-in" approach to implementations, where a team of project managers with a limited interest in the ongoing operation of the program would work on the implementation only for a short period of time. Our Implementation Team of national experts and members of the local Louisiana Operations Team will be part of the core team responsible for implementing services for the SMO.

VO-LA APPROACH TO PROJECT MANAGEMENT AND PROJECT CONTROL

VO-LA employs a suite of standardized and tested methodologies and best practices to effectively and rapidly integrate people, technology and business processes to execute an orderly, seamless and error-free implementation.

Strategy and Method to Develop and Implement an Implementation Plan

Our approach to developing and implementing the plan follows a well-defined methodology and is based upon relevant industry best practices adopted from Six Sigma and Project Management Institute processes. Our processes and knowledge are integrated in the implementation plan to meet due dates and milestones, and to identify and mitigate risk. The process for developing and implementing the plan will be managed as a project with seven distinctive phases:

- Phase I – Pre-Implementation Activities
  - identification of critical tasks and stakeholders
- Phase II – Discovery and Transition Process
  - planning critical path and key milestone dates
  - verification and validation of key assumptions with DHH-OBH
  - finalize communication plan
- Phase III – Implementation Plan Finalization
  - implementation of plan
  - execution of communication plan and risk mitigation strategy regarding implementation activities

- Phase IV - Implementation Activity
  - technical implementation
  - contractual implementation
  - operational implementation
- Phase V – Readiness Testing and DHH-OBH Review and Acceptance
- Phase VI – Implementation Transition
  - knowledge transfer
- Phase VII – Operations Validation/Lessons Learned

Pre-Implementation Activity

The pre-implementation activity process identifies the activities that will begin immediately upon contract award. The purpose of the pre-implementation activity is to facilitate key foundational activity that will enable VO-LA to move forward quickly once the award is announced. Pre-implementation activities run the gamut of initiating staff recruitment, identifying potential office space, utilization management strategy formulation, and other activities, as necessary. Also, VO-LA will work with DHH-OBH to ensure that the scheduling of tasks and use of resources does not conflict with other DHH-OBH activities. More specifically, within in the first five days of contract award, VO-LA will meet with DHH-OBH to:

- introduce the project management team, the communication paths, and reporting standards between the DHH-OBH and VO-LA
- establish the implementation plan, including the schedule for key activities and milestones
- define expectations for content and format of contract deliverables.

Discovery and Transition Process

During the Discovery and Transition Process phase, we will work with DHH-OBH to identify the most effective method of gathering the specific and detailed information necessary to support the implementation effort. We will work closely with you prior to any information requests to ensure that our information requests are initiated with the appropriate individuals and do not pose an unnecessary burden on DHH-OBH. It has been our experience that this activity fosters both positive relationship development from the onset of the implementation, and streamlines the information transfer. Information gathered during this process informs the development of deliverable lists and drives the finalization of the implementation plan.

Implementation Plan Finalization and Task Activity

The initial goal of the Implementation Plan Finalization and Activity phase is to gather consensus on, and approval of the detailed implementation plan, and it begins once the Discovery Process is complete. The approved implementation plan will contain the step-by-step detail on how VO-LA will seamlessly implement the Louisiana SMO program. We will take the draft implementation plan (weekly timeline) and combine it with the information received from DHH-OBH during the Discovery Process to develop a fully functional implementation plan. We will work with you to facilitate understanding and acceptance of the plan to ensure all parties are fully engaged and committed to the identified tasks and timelines. The comprehensive implementation plan and timeline is included as **Attachment 15**.

This plan includes requirements as outlined in the RFP on pages 130 and 131, including:

- schedules and timetables for implementation
- communication plan that includes a plan to communicate with Members, providers and stakeholders, including Member service and provider service call centers, and Member and provider handbook
- website development plan
- network development plan, including analysis and plans to effect a smooth transition, including a transition plan for state-operated providers
- clinical transition and service continuation plan
- a staffing plan identifying hiring expectations and staff associated with each task
- training plan for VO-LA staff, state agency staff, Members, Wraparound Agencies, Family Support Organizations, LGEs, other providers and stakeholders
- facilities, fiscal requirements and cost avoidance plans
- quality management plan
- utilization management plan, including outlier management and care coordination plans
- grievances and appeals plan
- overall information system project plan, including reports and interface plans, claims processing and information management integration, hardware and equipment acquisition and installation, operating system and software installation, systems testing, and more
- business continuity, disaster recovery, all hazards, and risk management plan
- contract compliance/fraud and abuse plan
- operational readiness plan

Managing the Transition

Successful management of the transition to the SMO will require careful planning, hard work, and the coordinated efforts of all affected parties—the DHH-OBH, the CSoC SGB, providers, Members, families, HSDs and State Clinics, and the VO-LA Implementation Team. Upon award of a contract, ValueOptions will bring a team of skilled administrators to Louisiana who will develop and implement detailed transition plans for each component of the system. Although we include a preliminary draft of the transition plan as **Attachment 15**, this plan will be revised to meet the specific transition needs and issues that are identified in our early discussions with the DHH-OBH.

At a high level, the transition activities that will be required to ensure continuity of services to DHH-OBH agency constituents are as follows:

1. We will meet with the DHH-OBH to identify key staff from each department who will assist VO-LA in designing and implementing transition activities.

2. We will form work groups comprising ValueOptions Implementation Team members, newly hired VO-LA staff, DHH-OBH staff and representative Members, providers, and other stakeholders who will take responsibility for the various tasks that are part of the implementation process, including:

    - reviewing, adapting and recommending clinical policies and procedures, such as Utilization Management Guidelines and Diagnosis-related Treatment Guidelines

- updating the Network Inventory and Plans, and reviewing, approving and implementing network development activities, including provider contracting
- developing a clinical transition plan to ensure the continuation of services for each affected Member, including the:
  - continued authorization of necessary services after March 1, 2012
  - monitoring of individual cases to ensure that care is not disrupted
  - problem-resolution processes and key contacts to ensure that problems, complaints, grievances, and appeals are promptly addressed
- public information activities to ensure that all Members, families, providers, DHH-OBH agencies and other stakeholders are aware of transition plans and activities, and that they know how to initiate the resolution of any problems that may occur

Example of a Successful ValueOptions Transition in Connecticut

Like Louisiana, the Connecticut system experienced a major transition earlier this year. The Connecticut Behavioral Health Partnership (CT BHP) began January 1, 2006, to take on the task of creating an integrated behavioral health care service system. The original partners included the Connecticut Departments of Social Services, Children and Families (the Departments), and a legislature-mandated Oversight Council. The Departments contracted with ValueOptions to be the administrative services organization (ASO). Under this contract, ValueOptions' CT BHP managed services for portions of the Medicaid membership, while Advanced Behavioral Health (ABH) retained utilization management responsibility for the Medicaid Low Income Adult population (MLIA). Services for the MLIA population most often fell under the auspices of the Department of Mental Health and Addiction Serves.

CT BHP was expanded in April 2011 to include the Connecticut Department of Mental Health and Addiction Services, and ValueOptions was awarded the contract for managing and creating an integrated behavioral health service system for all members receiving Medicaid. A ValueOptions transition team put special priority on ensuring that MLIA members and their providers would not experience service disruptions. ValueOptions lead the transition effort, working with ABH staff and each of the State partner agencies during and after the transition period.

A ValueOptions senior clinical leader was designated to be the ABH liaison, and to review utilization management service practices, identify open and current authorizations for behavioral health services for Members, and negotiate a "run off" period so that authorizations specifically related to Connect to Care services could be moved seamlessly from ABH to ValueOptions. Additionally, since ABH would continue to be a service provider for a segment of the Medicaid population, the transition team collaborated to create policies, procedures and work flows to ensure referrals to ABH occur flawlessly.

Another example of this collaboration includes CT BHP regularly assigning Intensive Care Managers (ICM) to this vulnerable population. ABH clinicians and the ICMs have collaborated on treatment planning, inpatient rehabilitation referrals, and status updates regarding our mutually identified members. Cases are addressed daily with ABH staff regarding newly assigned members to Intensive Care Management at ValueOptions, and similarly, ABH staff will contact the staff at ValueOptions on members they feel would benefit from Intensive Care Management services.

In one particular case, during an inpatient admission, a ValueOptions Care Manager identified the members as a rapid recidivist, because on multiple occasions the member had been admitted to several inpatient psychiatric and detoxification facilities.

As a result, the member met the criteria for assignment to Intensive Care Management. The ValueOptions ICM Director contacted ABH to determine if the member was assigned to their program. On the same day as being discharged from a brief inpatient psychiatric stabilization, the member walked to an Emergency Room to seek readmission. Upon learning of this, our ICM contacted the staff at ABH to discuss the member, and arrange an emergency treatment meeting with the member later that same day. The ICM and ABH staff quickly assembled a treatment plan that included a referral to a substance abuse rehabilitation program. The member was then discharged from the Emergency Room directly to the rehabilitation facility. The member's treatment plan focused on additional care coordination activities, including an Intensive Outpatient program, and community services to address housing needs. Since this intervention nearly three months ago, the member has not presented to an Emergency Room.

We continue to retain scheduled contact with our partners and ABH to ensure an ongoing dialog in which opportunities for improvement are identified and pursued. This is in keeping with our company values as well as our mission to provide access to a more complete, coordinated, and effective continuum of community-based behavioral health services and supports.

Implementation Activity

Once we have jointly approved the implementation plan, we will move immediately into the Implementation Activity phase, and actively manage the outlined tasks and timelines towards full program implementation.

Examples of some of the specific steps we will take during the Implementation Activity phase include:

- detailed work product development by the Functional Area work groups
- designing, developing and deploying benefit configuration, eligibility and Information Technology (IT) interfaces
- refining workflows, policies and procedures
- deploying all approved plans, including communication, network development and training plans

The detailed draft implementation plan provided as an attachment outlines all the tasks required to operationalize each requirement of the RFP and program design, broken down by functional area. A brief overview of some of the key tasks in a number of the functional areas is provided below.

Human Resources

The Talent Acquisition team is responsible for building the required infrastructure and processes required for recruiting and hiring all of the staff positions that will support the contract. We have already identified key recruits for our leadership team, and we are confident that our pre-RFP recruitment efforts across the State have set us well on the way to hiring the most qualified people to be part of the Statewide Management Organization (SMO).

We will continue our recruitment and training efforts by:

- using multiple, external recruitment methods including traditional newspaper and Internet advertisements, professional networking websites, as well as informal, non-traditional methods such as social media, job fairs, radio ads, and outreach to trade and professional associations
- posting positions internally, which will offer career opportunities for existing ValueOptions staff, and enable the program to benefit from experienced personnel

Commitment to Maintenance of Effort

Although any major system transition is fraught with frustration and "glitches" as new infrastructures are put into place, we absolutely do not want our arrival in Louisiana to be followed with unhappy Members, angry providers, or collateral agencies who do not believe that they are getting the quality or quantity of services that their constituents received under the "old" system. We will only implement planned changes in consultation with the DHH-OBH, after an acceptable level of post-transition stability has been achieved. We will work with and through the DHH-OBH, HSDs, state clinics, charity hospitals, private hospitals, providers, and other stakeholders to maintain open communication at all levels of the system, so that problems that are identified by providers, Members, families, or DHH-OBH can be resolved quickly and expeditiously.

In addition to the CEO, CMO and COO we hire, we will identify specific members of the VO-LA Implementation Team who can be contacted by providers and help them resolve problems that occur during the transition period. This identification will be one component of the "transition safety net" that we put in place for all stakeholders.

Changes to Quality Oversight Processes

To tap the experience and enthusiasm of those who have been involved in creating the vision for an integrated behavioral health care delivery system for Louisiana, VO-LA recommends that the functions of the Quality Management (QM) Committees be integrated into existing work groups, task forces, and sub-committees that already have been working on concepts closely aligned with the traditional focus of each QM Committee. Alternatively, we recommend that members from those existing groups be named to appropriate QM Committees. Initial QM Committees will be the QA/PI, Member and Family Advisory Committee, and Peer Review/Clinical Advisory Committee.

Inherent in the design is leveraging the CSoC, the DHH-OBH and Local HSDs as part of the process of reviewing performance data, establishing priorities, making recommendations on new projects and initiatives, and monitoring the overall functioning of the delivery system, as well as VO-LA's performance as the SMO.

Informing and Communicating with Stakeholders

As one part of our overall Transition Plan, we will work with the DHH-OBH to implement a comprehensive Communications Plan and Outreach Plan (that we have provided in Attachment 18) to inform Members, families, providers, and all other stakeholders about how to initiate or continue to receive services after March 1, 2012, without disruption. We realize that one or more work groups have already begun planning how to communicate effectively with all of the involved stakeholders, so we will blend our ideas with the plans already made to ensure an effective process with groups such as NAMI, MHA and the Federation. We will also work with the newly contracted

Family Services Organizations (FSOs) to facilitate their ability to reach out to families in their regions and inform them of the changes.

Community Information Sessions

One of the most important steps in disseminating information will be a series of community education forums. The goal of these forums will be to ensure that all interested individuals have the opportunity to hear about the transition and to ask questions about issues that affect them. Of particular importance are local agencies and other referral sources, local family and advocacy groups, current Members, and providers in all communities. In addition to sharing information about the transition process, and assuring attendees of the continuation of services, we will emphasize ways in which problems and complaints should be registered so they can be promptly resolved.

We will host orientation sessions for Members, family members, providers, and other stakeholders in each region of the State. In planning for these meetings, we will ask that representatives from the DHH-OBH, CSoC SGB (if possible), HSDs, the FSO, and Wraparound Agency (WAA), if applicable, assist us in establishing the agenda, picking meeting sites, encouraging attendance, preparing lists of people, agencies, and groups to notify, hosting the meeting, and reviewing written explanatory material in preparation for planning these orientation sessions. We also would encourage representatives from appropriate DHH-OBH departments to participate at orientation and training sessions because we have found that having State staff attend such meetings encourages Members to attend. Additionally, many times in these forums, questions are raised that require the expertise of State staff to answer.

In addition to community forums and individual meetings with local DHH-OBH representatives, providers, and Member/family groups, we will:

- develop a variety of written educational materials, as described in other sections of this proposal
- finalize the Member Handbook that includes information needed to access services, contact VO-LA and understand the Member Bill of Rights
- publish newsletters with information needed by Members, families, and other community stakeholders;
- continue to meet with and provide updates on the activities of the SMO at association meetings such as Louisiana Council on Alcoholism, Louisiana Substance Abuse Counselors and Trainers, Louisiana Rehabilitation Providers Association, Louisiana Association of Behavioral Health Providers, Louisiana Social Work Association, Louisiana LPC Association, Louisiana Hospital Association
- publish a Provider Manual that contains detailed information needed by providers regarding VO-LA policies and procedures
- develop a VO-LA website that contains a wealth of useful information for Members, families, providers, and other stakeholders as well as our customized Achieve Solutions website for Member information and self-care information
- provide information on the Warmline staffed by Peer and Family Specialists and develop processes to coordinate with any other warmlines operating (such as those with Extra Mile) to eliminate duplication
- provide updates at every regular meeting of the DHH-OBH, the SCoC and other bodies as requested by DHH-OBH

VO-LA will ask the DHH-OBH to post meeting notices on your website site. . We will also post meeting notices on our website, and will also utilize the mailing lists of any advocacy groups that are available for notification.

Communicating with Members and Families

VO-LA will communicate with Members and families to assure them that they can continue to receive services from their current provider(s), and about how to contact VO-LA. Our goal is to provide information in a manner that reassures Members and does not increase their anxiety about their continued ability to access the services they need and with which they are familiar.

To the greatest extent possible, we will use Members and family members in our efforts to reach out to Members and families. Although VO-LA's Outreach and Recovery Department may not be fully staffed prior to March 1, 2012, we will work with Louisiana's advocacy groups—such as NAMI, MHA, and the Federation— to share information with their members.

The following are the outreach strategies that VO-LA will use to inform Members and families of the transition process:

- We will notify Members and families of all community education sessions, and invite them to attend sessions in their communities.
- We will mail a letter to all current Members and/or parents/guardians who have mailing addresses on record. The letter will introduce VO-LA as the SMO, and will assure them that they can continue to receive services from their current provider(s). Alternatively, if the DHH-OBH prefers that the notification come from their Departments, VO-LA will provide whatever technical assistance may be required.
- We will require that contracted providers give a copy of the letter to each Member during regularly scheduled, routine visits or crisis visits during January and February 2012.
- We will request that providers attempt telephone or other regularly-planned outreach activities for Members without mailing addresses or whose mailed letters are returned as "undeliverable."
- We will provide copies of the introductory letter and other transition education materials to HSDs, state clinics, DCFS, OJJ, FQHCs, community centers, coordinated care networks, homeless shelters, and other places that provide support to individuals who are receiving behavioral health services.
- VO-LA will reach out to advocacy groups to request assistance with sharing information with families, and to volunteer to talk with their Members.

Outreach, Education, and Recovery and Resiliency Organizational Resources

Outreach and education activities often include three foci known as Prevention, Education, and Outreach activities. These are activities educate Members, families, community stakeholders, relevant agency personnel, and providers about a behavioral health program. We will begin reaching out to train Members on self-management, and providers and families on recovery resiliency, and relapse prevention planning prior to March 1, 2012. Recovery and resiliency typically occurs at three levels: individual, program, and system. Therefore, our Outreach and Recovery Administrator will begin providing training to identify roles for Members within the SMO, Quality Committees, as staff, or in other volunteer roles. Training will start no later than January 2012, and will be offered via MHA, NAMI, Extra Mile, the Federation, and other regional meetings. For many Members, this

training will also be the initial introduction to how they will be able to access services when the SMO goes live on March 1, 2012.

Maintaining Current Provider Network

Prior to March 1, 2012, we will execute contracts with all current network providers and those who signed the letters of intent. As of March 1, 2012, VO-LA will assume full responsibility for the provision of a comprehensive provider network, including all providers identified as "essential" by the DHH-OBH. When clinically appropriate, we will permit Members to conclude their current treatment episodes with a provider who does not choose to remain in the network. Additionally, if a Member requires specialty care not available within the network, we will negotiate single case agreements with non-network providers.

Beginning during implementation, we will focus our outreach and training on strengthening current providers, reconfiguring providers within the network, and recruiting new providers. These changes will be undertaken with the continuous involvement and input from HSDs, as well as stakeholders and the CSoC.

Communicating with Providers

When providers have current, up-to-date information, they can be very effective in sharing that information with Members and families, and allaying any concerns about an upcoming change. Therefore, VO-LA will make every effort to ensure that providers understand how the new system will operate, and how they can work with us in resolving problems that surface during the initial year of the transition. In addition, we will implement specific communication and teaching/training strategies to ensure that providers know how to interact with the VO-LA system for all critical functions and operations, such as the following:

- Early in the implementation period, we will work with the DHH-OBH to sponsor orientation sessions for all providers, much like the meetings OBH held for the LBHP and CSoC, to give an overview of the transition process and to ask providers' help in identifying issues and challenges that will need to be addressed in the transition. At a minimum, an initial, statewide provider orientation initiative and at least two subsequent rounds of provider orientation sessions will be held in all ten regions of the State during the first year. We will alert providers to the various meetings through direct mailings, coordination with professional organizations, notices posted on our website, and personal invitations issued by our staff.

- We will also ask providers to help us evaluate each orientation session so that we can make any necessary changes.

Training and Technical Assistance for Providers

VO-LA will begin offering training and technical assistance to providers during the pre-March 1, 2012 implementation period to ensure their ability to participate successfully in VO-LA network operations, including administrative and clinical functions. Technical assistance to assist and encourage providers to bill electronically will be provided during implementation. We will provide substantial training on all aspects of the new system, including new forms, eligibility and benefits structures, service definitions and billing codes, enrollment and authorization procedures, credentialing, and billing/service reporting requirements and processes. We are committed to reducing the overall burden placed on providers, and believe that the movement to electronic data

exchange, medical records, and practice management solutions will achieve this, while also achieving increased accuracy in authorization requests and claims. While we strongly encourage providers to use our easy, Web-based tools, we also offer them the ability to fax, and our imaging process enables us to store the faxed documents for integration and action within our platforms. We will work closely with the DHH-OBH and providers to ensure that our training agenda includes all topics that are required for providers to be able to interact effectively with the system on March 1, 2012.

The VO-LA Implementation Team will prepare specific orientation and teaching materials for each VO-LA function with which providers must be able to interact. These include provider registration, Member/service registration, service authorization, claims submission, and others. As described more fully in the Technology section of this proposal, we will provide onsite provider training as well as Web-based training in these functions, including the use of new forms and electronic processes. We will provide "in vivo" practice sessions to familiarize providers with Web-based or other electronic means of submitting data.

Although we will initiate provider training and technical assistance in the pre-March 1, 2012 implementation period, these core activities will continue throughout the duration of our SMO contract. Through our Provider Relations Representatives and Service Center staff, we will provide both orientation sessions and onsite provider training, and technical assistance in all areas related to data and claims submission. Our goal is to become familiar with providers' existing information management systems and to help them build on these systems to manage their interactions with VO-LA in ways that are as efficient as possible. so that the majority of their efforts and energy can be devoted to providing and improving the quality of services to Members.

Throughout the implementation and transition periods, we will actively seek and use suggestions from the DHH-OBH about how to make the transition "seamless" and successful for Members, families, providers, and other stakeholders.

As part of the overall implementation process, ValueOptions will be establishing a test environment for the electronic submission of claims and encounters. The test environment will enable providers who are not accustomed to submitting claims/encounter data electronically to have an opportunity to train their staff prior to March 1, 2012. The test environment also will support the testing of several of the forms that will be developed.

Utilization Review Processes

Involving the Community in the Development of Utilization Management Guidelines

During implementation, we will introduce and implement, as appropriate, a common set of utilization management guidelines and diagnosis-related treatment guidelines. Utilization Management Practice Guidelines (also sometimes referred to as Clinical Care Criteria or Level of Care Criteria) include admission, exclusion, continued stay, and discharge criteria for each specified level of care. They are used to guide service authorizations for services requiring authorization, and can be similarly used as an informal tool to consider service-planning decisions, even when formal authorization is not needed.

The Clinical Work Group, which will become the QM Peer Review/Clinical Advisory Committee, will review proposed criteria and practice guidelines, and recommend changes to ensure that they

match all current Louisiana levels of behavioral health care, including clinical, rehabilitative, and supportive services. As VO-LA Utilization Managers, providers, and the VO-LA Chart Audit Team use the guidelines across all funding streams, clinical services and clinical decisions will become more consistent throughout the system.

Our practice guidelines are used to identify best practice protocols for the treatment of common behavioral health conditions. They are used as clinical teaching tools and can be invaluable in helping to move the system toward best practice models. The practice guidelines also will be reviewed and adapted for Louisiana by the Clinical Work Group prior to March 1, 2012. These guidelines will be used in clinical record audits and clinical record review.

Implementation of Uniform Protocols for Managing Complaints/Grievances/Appeals

Upon award of a contract, VO-LA will work with the DHH-OBH, providers, and Members to identify current practices regarding handling complaints from Members served by multiple agencies. As a starting point, VO-LA will work with the DHH-OBH and convene a Work Group to create uniform protocols for managing complaints and resolving problems. We will identify agency-specific rights and requirements, and will include these in all Member education materials. We will train providers to ensure that all parts of the system understand their obligations when serving multi-agency Members. Finally, we will continue to work with all stakeholders to create uniform statements of rights and uniform protocols for complaint resolution, as described above. The Work Group also will identify the steps and changes required to implement an integrated and uniform appeals process.

Gradual Introduction of Provider Profiling as a Quality Management Tool

Over the first contract year, the VO-LA QM Committees will identify five to seven elements for provider profiles. To ensure that provider profiles are both accurate and accepted, it is important to start with a few elements and expand and/or change the monitoring parameters over time. Ensuring that provider profiles are accurate and representative requires a substantial quantity of data for each provider, and for each level of care being profiled. As a first priority, VO-LA will implement quality improvement initiatives that use provider profiling to improve prescribing patterns, and the utilization of 24-hour levels of care.

Developing Communication Protocols with Primary Care Physicians and the CCNs

We will begin development of referral protocols and policies outlining coordination of care by VO-LA, the CCNs, FQHCs and Primary Care Physicians (PCPs). These protocols will continue to be developed over the contract period, as will committee structures in which to coordinate services, pharmacy benefits, quality management initiatives, prevention and outreach initiatives. We will provide PCPs the information on accessing and viewing Member's service plans to coordinate care at all levels. We will implement policies describing behavioral health providers' responsibilities for communicating with PCPs. We will also require documentation of such coordination, which will be audited as part of clinical record reviews.

Member Access Center Implementation

VO-LA will install a Member Service toll free access line which will be the single point of entry for all individuals that seek information about the SMO services. The Member Services team will focus on the development of call flow, process excellence, and prompt inquiry resolution. Operational specifics of the call center include, but are not limited to:

- Members will be able to access to the call center 24 hours a day, seven days per week, 365 days per year
- VO-LA will ensure that the toll-free number is publicized throughout Louisiana, and is listed in all local telephone books
- the Member Access Center will be able to respond to individuals with limited English proficiency through bilingual staff or language assistance services

Facility Implementation for our Baton Rouge Office

We have already located space within a short walk of the DHH Office Building at 628 N. 4 Street, Baton Rouge. The location was picked because of proximity, efficiency and cost. For the preparation of the spaces, the facility team will work with the landlords, architect, designers, general contractor and others to build the spaces to conform to the requirements needed to operate the facility. Given that this space was previously occupied by FEMA, build out will be rapid, and we are experienced at using "temporary space" while awaiting the readiness of our final space.

Actively Minimizing Confusion and Maintaining Access to Care

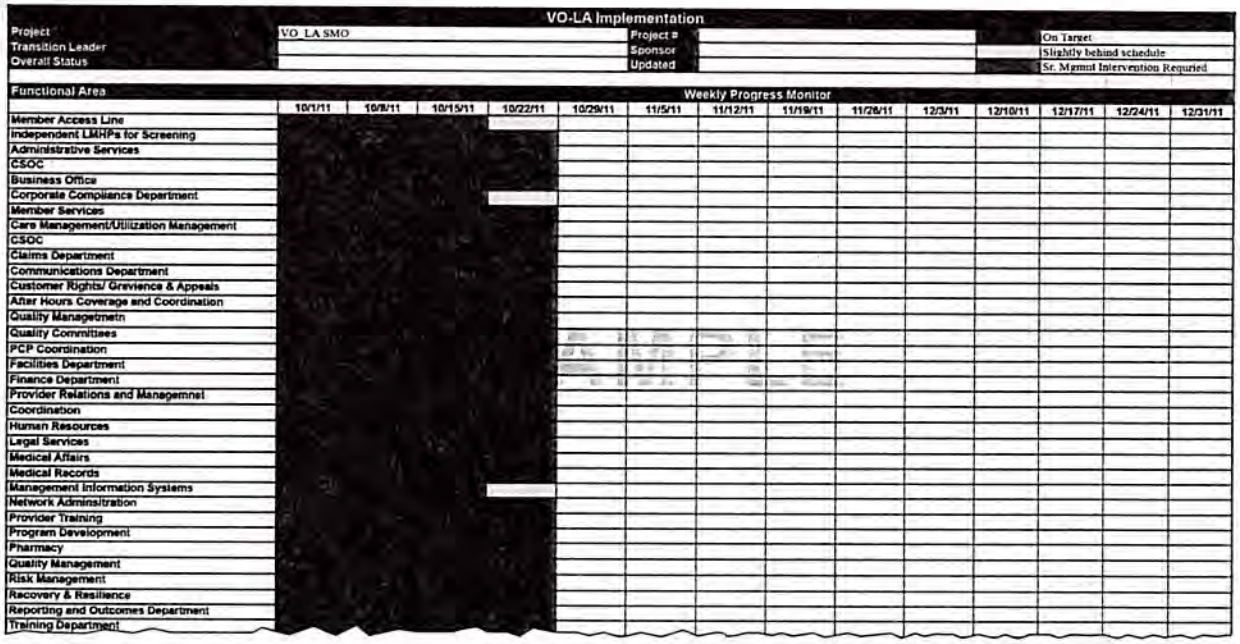
We are aware that one possible cause for a decrease in enrollment or utilization during a major system transition can be increased confusion among providers and referral agencies. Another cause is logistical difficulties related to new processes for submitting enrollment/registration data. To minimize the impact of these problems on enrollment and utilization of service statistics, we will:

- work with the DHH-OBH, the CSoC SGB and their committees to finalize a "public awareness" plan to inform stakeholders and the general public about the March, 1, 2012 change in the behavioral health care delivery system
- explain all continuity of care and maintenance-of-effort requirements to all providers, Members, and stakeholders
- require that providers notify VO-LA of significant planned or unplanned changes in the number of Members served, including changes in the number of Members requesting services compared to historical referral rates
- ensure that current Members are informed about the transition and have information about how to contact VO-LA for any issues related to access to, or continuity of services
- use the implementation phase to identify and minimize possible logistical problems that could affect the smooth referral of Members after March 1, 2012
- continuously identify problems individual providers experience in enrolling new Members, and provide immediate training and technical assistance to providers experiencing difficulty

ENSURING A SMOOTH IMPLEMENTATION FOR LOUISIANA

To manage the implementation plan and ensure that all tasks outlined on the plan are moving forward appropriately, the ValueOptions Implementation Project Manager and relevant implementation team members will meet and provide weekly project status updates to the State Contract Monitor and other State staff. We will use these status meetings to communicate actual progress, identify problems, recommend courses of action, and obtain approval for making modifications to the implementation plan. The Implementation Project Manager will also provide written status reports to the Contract Monitor at least every two weeks. To enhance the utility of that status report, VO-LA will provide a spotlight report by functional area. The Stoplight report

contains a snapshot of progress by functional area, and will keep DHH-OBH informed of any issues. A sample of a detailed Stoplight report is shown below.



VO-LA Implementation															
Project	VO_LA SMO				Project #								On Target		
Transition Leader					Sponsor								Slightly behind schedule		
Overall Status					Updated								Sr. Mgmnt Intervention Required		
Functional Area	Weekly Progress Monitor														
	10/1/11	10/8/11	10/15/11	10/22/11	10/29/11	11/5/11	11/12/11	11/19/11	11/26/11	12/3/11	12/10/11	12/17/11	12/24/11	12/31/11	
Member Access Line															
Independent LMHPs for Screening															
Administrative Services															
CSOC															
Business Office															
Corporate Compliance Department															
Member Services															
Care Management/Utilization Management															
CSOC															
Claims Department															
Communications Department															
Customer Rights/ Grevience & Appeals															
After Hours Coverage and Coordination															
Quality Managetmetn															
Quality Committees															
PCP Coordination															
Facilities Department															
Finance Department															
Provider Relations and Managemnet															
Coordination															
Human Resources															
Legal Services															
Medical Affairs															
Medical Records															
Management Information Systems															
Network Administration															
Provider Training															
Program Development															
Pharmacy															
Quality Management															
Risk Management															
Recovery & Resilience															
Reporting and Outcomes Department															
Training Department															

The VO-LA stoplight report will keep DHH-OBH informed about project progress.

Problem Escalation

A key component of any implementation is an escalation process. VO-LA will work diligently with DHH-OBH as part of the Discovery Process to ensure that we have a mutually agreed upon implementation plan and deliverables list. However, we understand that there may be times when questions or differences may arise as tasks are being managed within the workgroups. In those instances, we recommend that if the work group is unable to resolve the issue, the DHH-OBH and VO-LA co-leads jointly complete an Escalation Form and submit it to the Oversight Committee for review and decision.

Change Management

Any time there are upgrades, changes or enhancements required to meet DHH-OBH needs, but that were not originally agreed upon as part of either the implementation plan or deliverable list, we will use our formal change management process. We approach change management from two perspectives—business and operational change management, and IT change management. The change management process helps control, prioritize, and streamline the delivery of changes to our products and services. A key component of this process is to review and re-establish priorities so that the resources from both DHH-OBH and ValueOptions are able to effectively focus on the work required to meet the remaining deliverable, and respond to any changes.

Risk Identification and Mitigation

The VO-LA Team acknowledges that risk is an inherent factor in any contract or program transition and needs to be managed effectively. Through our experience from transitioning in and out of contracts, we have learned that a fine line separates an acceptable risk level from an unacceptable one, and assessments have to be made on a project-by-project basis, considering the project and processes complexity, stability and transition approach. A critical element of our ability to provide

error-free transitions is the use of our structured project management approach, which enables us to recognize potential risks and manage those risks to neutralize their negative effects.

MINIMIZING TRANSITION RISKS

The remainder of this section describes the process we will employ to minimize transition risks.

Assessing and Classifying Risk

The Functional Area Leads will list all potential risks and rank them as high, medium, or low, depending on the effect they have on the technical, contractual, financial, clinical and operational aspects of the transition, and will assess their potential impact on the success of the project. This enables the Implementation Project Manager, Ms. DeVault, to consolidate and review all risks at one time. The combination of risks may alter the approach and set of countermeasures that we implement to control the effects and reduce or eliminate the risks.

Developing Risk Mitigation Countermeasures

After identifying and classifying the list of risks associated with the operational areas, the Functional Area Leads will indentify the specific countermeasures that will be used to control the effects that these risks might have on the quality, cost, or schedule of events for the implementation. The process of classifying risks and identifying countermeasures facilitates the development of more reliable and effective mitigation strategies by providing a complete view of all transition risks.

Implementing Countermeasures

Once we have developed targeted countermeasures associated with a particular transition risk item, the Functional Area Leads will institute the mitigation countermeasure to minimize the impact of the risk item on the implementation effort. When the risk has been eliminated or an acceptable level of reduction in the impact level or service disruption is achieved, the Functional Area Leads will present the plan to the Implementation Lead for independent review, verification, and approval.

Readiness Testing and DHH-OBH Review and Acceptance

The purpose of the Readiness Testing phase is to ensure that VO-LA is on track for a seamless transition, and to ensure we have enough time to troubleshoot potential problematic areas before the go-live date. Central to this phase will be an audit of the contract requirements to ensure each requirement is satisfied. The audit will be performed by the Implementation Lead, who will note any requirements in need of remediation. We will engage in a joint, end-to-end testing process to ensure that all process throughputs designed for the program operate in the expected manner and meet the requirements of the program. Prior to moving out of the Readiness Testing Phase, we will work with DHH-OBH to ensure the acceptance of test results and approval to move forward.

Implementation Transition

The purpose of the Implementation Transition phase is to facilitate a thoughtful transition of the Implementation Team to the permanent VO-LA Service Center personnel who will be responsible for the ongoing operations of the SMO program. A hand-off document will be formulated for each department, and will identify specific activities and timeframes that are necessary prior to the transition of services to the operational staff.

Operations Validation/Lessons Learned

Post implementation, VO-LA will monitor all aspects of the new operation to ensure success. The following are several examples of our monitoring and audit structures:

- a minimum of two weeks of floor support post go-live staffed by ValueOptions' National subject matter experts
- establishment of daily reports required from each operational area that measure key management indicators and progress against performance standards
- daily team meetings with representation from each operational area, to include reviewing staff effectiveness, operational response timeliness, and monitoring any post go-live activities
- implementation team remains attached to the new program for 30-60 days post go-live, and continues to run/monitor the project in conjunction with the operational leads
- implementation team conducts a thorough audit of all the knowledge transition activities and hand-offs to the operational teams, and measures the staff's level of competency in handling the operational responsibilities

Implementation will only be considered complete with formal approval from DHH-OBH. Once the implementation is complete, VO-LA will offer DHH-OBH the opportunity to participate in a formal "lessons learned" process to gather input and feedback for improvement—both positive and negative—as part of our commitment to continuous improvement.

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

Describe the Proposer's plan to mandate subcontractor's acceptance of all contract requirements and monitoring protocol to ensure that subcontractors' accounting and financial controls are adequate to permit the effective administration of the contract. Suggested number of pages: 2.

VO-LA will be subcontracting cultural competency training services to Western Interstate Commission for Higher Education (WICHE). WICHE, in partnership with Substance abuse and Mental Health Services Agency (SAMHSA), developed cultural competence standards in mental health across different ethnicities/races, ultimately producing the SAMHSA/CMHS National Standards for Cultural Competence. WICHE will also provide training for Mental Health First Aid (MHFA). MHFA participants learn a 5-step procedure for recognizing and assisting people who are experiencing mental health problems or crises, while being introduced to the risk factors and warning signs of specific illnesses such as anxiety, depression, psychosis and addiction. Like CPR training, MHFA trains members of the public to provide support services until professional mental health care is available.

WICHE Mental Health Program staff members routinely conduct trainings across a breadth of topic areas in behavioral health. Staff expertise includes, but is not limited to, rural behavioral health, public mental health system transformation, Mental Health First Aid, Suicide Prevention in Rural Primary Care, behavioral health workforce development, research and program evaluation, Children's System of Care, competency development for behavioral health providers, and integrated care models (primary care and behavioral health).

Additionally, VO-LA is subcontracting with McKesson Technology Solutions (McKesson) for an automated Fraud and Abuse program. McKesson is a leader in software, automation, services and consulting to hospitals, physician offices, imaging centers, home healthcare agencies, and payers. McKesson also provides interactive connectivity services that streamline clinical, financial and administrative communication between patients, providers, payers, pharmacies, and financial institutions. McKesson's solutions are designed to improve patient safety, reduce the cost and variability of care, improve healthcare efficiency and better manage revenue streams and resources.

Peer Advisor review will be completed primarily by the ValueOptions medical directors dedicated to the Louisiana contract and independently contracted external board certified psychiatrist reviewers. These reviewers will be contracted directly to perform peer advisor review including physician to physician review. ValueOptions has approximately 20 contracted psychiatrists, many of whom are not only board certified in general psychiatry, but also have secondary boards in child and adolescent psychiatry, geriatric psychiatry, and addictions. A very small percentage of peer review that cannot be accomplished by the medical directors or contracted psychiatrists, will be completed by PREST and Associates (PREST). ValueOptions has a longstanding relationship with PREST and has worked closely with them on other lines of business. PREST is a leader in the industry as an Independent Review Organization (IRO) dedicated to specializing in Mental Health and Substance Abuse reviews. They are accredited by URAC as an IRO and provide a nationwide network of

psychiatrist reviewers to perform peer review. These psychiatrists have subspecialties in many areas such as addiction, child and adolescent psychiatry, forensic psychiatry and geriatrics.

We will also subcontract services to Payformance Corporation (Payformance), the nation's leading provider of healthcare payment simplification solutions, to pay providers nationally who have registered for electronic funds payment. Payformance developed PaySpan® Health to help healthcare payers and providers seamlessly transition to electronic payment processing.

We will include as part of the contract with each subcontractor an acceptance to all Statewide Management Organization (SMO) contract requirements. ValueOptions will establish clear lines of authority with each subcontractor. We will ensure that the subcontractor clearly understands the requirements of the subcontract and the SMO program objectives. In order to facilitate communications and program status reporting, each subcontractor will provide a principal Point of Contact (POC) who will work with our Corporate Compliance Administrator and other members of the management team to satisfy the requirements of the contract.

Throughout the contract period of performance, VO-LA will use multiple methods to assess program status. Managing the subcontract relationship entails monitoring and evaluating subcontractor performance, processes, and deliverables as specified in the contract. Successful subcontract management includes continuous open and clear communication, tracking of costs, schedule, risks, changes and technical performance, as well as conducting informal and formal reviews of both deliverables and status.

Subcontractor performance metrics will be established and monitored by the VO-LA Quality Management Administrator in coordination with the managers representing each subcontractor. Some of the key performance standards we will monitor under this program will include:

- compliance with all contract requirements
- submission of timely, accurate reporting
- overall satisfaction with services
- quality of training materials

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i. Describe the Proposer's corporate policy regarding risk and liability insurance coverage. Provide declaration page for each policy that illustrates compliance with the risk and liability insurance requirements of the RFP (not included in suggested number of pages). Suggested number of pages: 2.

VO-LA, through our parent company, ValueOptions, Inc. parent, FHC Health Systems, meets all risk and liability insurance requirements outlined in the RFP.

Homeland Insurance Company of New York provides a claims-made policy for managed care errors and omissions coverage in the amount of $15,000,000 per claim and $15,000,000 in the aggregate over a self-insured retention of $2,500,000 per occurrence.

An extended reporting period endorsement (tail coverage) is available if the policy is not renewed to cover claims incurred but not reported during that policy period. We anticipate that the renewal coverage will be available at the expiration of the current policy.

A copy of our current insurance certificate is provided on the following pages:

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 01/07/2011

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA, INC. THREE JAMES CENTER 1051 EAST CARY STREET, SUITE 900 RICHMOND, VA 23219 Attn: 804-244-8600	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:** **PRODUCER CUSTOMER ID #:**
INSURED FHC HEALTH SYSTEMS, INC. 240 CORPORATE BLVD. NORFOLK, VA 23502	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** Homeland Insurance Company Of New York — 34452 **INSURER B :** N/A — N/A **INSURER C :** National Union Fire Ins Co Pittsburgh PA — 19445 **INSURER D :** N/A — N/A **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CLE-002710211-18 **REVISION NUMBER:** 10

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	**GENERAL LIABILITY** COMMERCIAL GENERAL LIABILITY [X] CLAIMS-MADE [ ] OCCUR X MANAGED CARE E&O GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [ ] LOC			MCB460510	12/15/2010	12/15/2011	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $ $ $ $ SEE NEXT PAGE $
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
	UMBRELLA LIAB [ ] OCCUR **EXCESS LIAB** [ ] CLAIMS-MADE DEDUCTIBLE RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N [N] N/A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						WC STATU-TORY LIMITS [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $
C	Crime incl Fidelity Coverage			011818872	09/30/2010	09/30/2011	Limit	5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
ValueOptions, Inc. is recognized as a Named Insured

CERTIFICATE HOLDER

"Evidence of Coverage"

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Susan B. Vignone — Susan B. Vignone

ACORD 25 (2009/09) The ACORD name and logo are registered marks of ACORD

VALUEOPTIONS® LOUISIANA

ADDITIONAL INFORMATION

CLE-002710211-18

DATE (MM/DD/YY): 01/07/2011

PRODUCER
MARSH USA, INC.
THREE JAMES CENTER
1051 EAST CARY STREET, SUITE 900
RICHMOND, VA 23219
Attn: 804-244-8600

INSURED
FHC HEALTH SYSTEMS, INC.
240 CORPORATE BLVD.
NORFOLK, VA 23502

INSURERS AFFORDING COVERAGE	NAIC #
INSURER G:	
INSURER H:	
INSURER I:	
INSURER J:	

TEXT

MANAGED CARE ERRORS & OMISSIONS LIABILITY COVERAGE PROVIDED ON A CLAIMS MADE BASIS.
$15,000,000 EACH CLAIM
$15,000,000 AGGREGATE SUBJECT TO A RETENTION OF $2,500,000 EACH CLAIM

CERTIFICATE HOLDER

"Evidence of Coverage"

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Susan B. Vignone

Susan B. Vignone

Page 2

ii. If there is no current coverage or coverage does not cover all RFP requirements, provide an explanation on how the Proposer will meet the risk and liability insurance requirements of this RFP. Suggested number of pages: 2.

VO-LA's insurance covers all RFP requirements.

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

Describe a Contract that either the Proposer or a government client cancelled or terminated and the Proposer's approach to transition planning particularly in relation to assuring that member's services were not interrupted. Provide a client reference to verify this experience. Suggested number of pages: 2.

In 2008, ValueOptions lost the contract for the New York State Empire Plan and Student Employee Health Plan Managed Mental Health and Substance Abuse Program (Empire Plan) via a competitive bid process. ValueOptions served as the administrator of the plan for 17 years, including the last 11 years in partnership with Group Health Insurance (GHI). The New York State Empire Plan covered 1.2 million members located throughout the state. Our record was one of high-quality care, exceptional customer and client services, as well as cost containment. As the Empire Plan administrator, ValueOptions was committed to excellence in every facet of our performance, as evidenced by our 92.6 percent satisfaction rating the last year of the contract. We began the transition of the contract to the new vendor in January of 2009.

Our Approach

ValueOptions' goal during the outgoing transition was to ensure that members have consistent care and that our client experienced no interruption in service. We recognize the importance of continuous care and are committed to transitioning cases that are in process during the outgoing transition phase with great sensitivity by implementing a detailed member-specific transition plan. We also provided a written transition member communication to reduce confusion and disruption of care. ValueOptions took the necessary precautions to ensure continuity of service for members who were in the program during the outgoing transition. We recognized the importance of maintaining member engagement and motivation during this critical time period.

We also took every action to ensure that, at the end of a contract, we continued to fulfill all requirements and pass along vital information to the State's new vendor. In addition, there were daily exchanges between the new vendor and our care management team to carefully transition members in higher levels of care to the next level of care. Our de-implementation tasks included:

- **Administrative**—identified ValueOptions and GHI Team Leads and scheduled weekly meetings with Empire Plan leads
- **Claims**—determined where claims and claims records would be sent, what information from claims records needed to be forwarded and the steps needed to resolve finance questions, made sure work queues were empty, and developed scripts for staff members resolving claims calls
- **Clinical**—reviewed authorizations for necessary adjustments, sent notification letter to Advisory Committee members and other stakeholders in the community, furnished pending authorization data and treatment crisis plans for high needs consumers, and furnished census data
- **Appeals**—developed a plan for managing appeals during transition, determined workflow for appeals, and implemented process to identify pending appeals as of contract end date
- **Communications**—determined disposition of member and provider communications materials
- **Customer Service**—developed a Question and Answer (Q&A) script for representatives on phones, obtained client communication to members, recorded auto-attendant message on

Member Line regarding account termination, and planned for final termination of Member Line phone number, when appropriate

- **Finance**—closed bank accounts, as appropriate
- **Human Resources**—included transitioning and offering of severance packages and employee placements
- **Information Services/Telecommunications**—determined client's decision to transfer toll-free number and coordinated final record transfers
- **Network**—completed all network transfer activities and fielded provider inquiries about transition
- **Quality Management**—established workflows for complaints/grievances received after contract end date
- **Reporting**—established final reporting requirements to New York State Empire Plan and timeframes, forwarded reporting data to new vendor, as required, and forwarded data warehouse data to the Plan

The client who can verify this information is Priscilla Feinberg, NYS Governor's Office of Employee Relations, (518) 473-6215.

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

a. The Proposer should describe how its corporate experience will assist DHH-OBH with implementation and management of the BH services program and the CSoC. Suggested number of pages: 2.

We offer DHH-OBH the assurance that by choosing VO-LA as the Statewide Management Organization (SMO) you will receive services from the most experienced managed behavioral health organization in the country. We have succeeded as an innovator and pioneer in behavioral health and wellness for more than 30 years. Serving more than 24 million members, we offer unparalleled experience in behavioral health, wellness, and care management for public sector clients around the country. We hold more public sector behavioral health contracts than any other vendor, and we have been serving the State of Louisiana's citizens through our commercial and federal contracts since 1989.

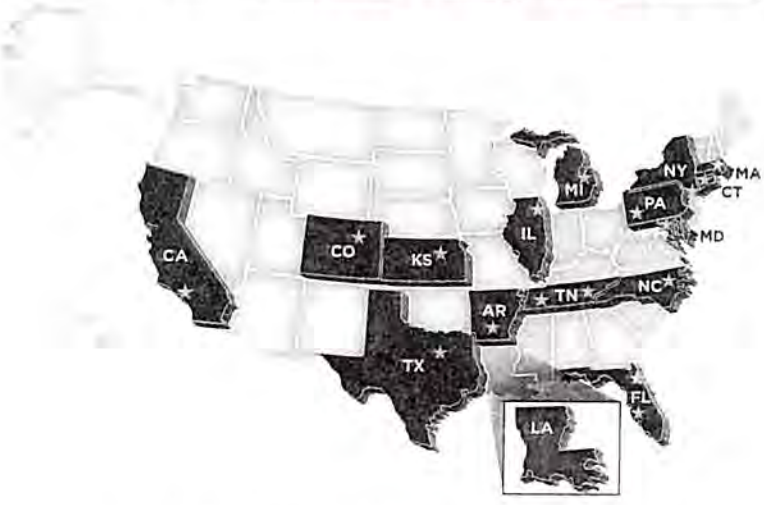
Our approach is founded on the core belief that individuals experiencing mental illnesses can recover to live, work, learn and participate fully in their communities. Our programs value the strengths that people possess, and we build on these individual strengths to enable people to live lives with a sense of mastery, and focus on competence and hope. We believe that a truly effective approach to care management requires strategies in which participants and all stakeholders partner to decide how services are chosen and delivered.

ValueOptions began providing managed care services to large Medicaid populations in 1995 and currently manages Medicaid mental health and substance abuse programs in 14 states.

Publicly-Funded Program Experience

We are pleased that we have never had a public sector contract terminated. We have chosen not to rebid on contracts that were assessed to be inconsistent with our core values. We have never been asked to cease services prematurely. We cover more than 6.2 million public sector members in the 14 states where we currently have contracts to provide behavioral health services to public sector behavioral health beneficiaries. Our public sector client contracts range from ASO arrangements to full-risk contracting. Our lengthy tenure with public sector clients is a testament to their satisfaction. In

ValueOptions is built on Local and National Experience



addition, ValueOptions also collaborates with HMOs to provide behavioral health care services for Medicaid, Medicare, and State Child Health Insurance Programs (CHIP).

Experience with Systems of Care

Mercer's Coordinated System of Care Report to the Commission on Streamlining Government dated March 4, 2010, delineated the need for a coordinated system of care for those youths at highest risk of hospital admissions, out-of-home care and incarceration. Two of the three programs cited in the Mercer report, New Jersey and Maryland, were developed with ValueOptions assistance.

Our approach provides effective utilization management and the measurement of quality and outcomes focused services that aid youths' resilience and ability to remain in their communities. The Administrative Services Organization (ASO) realigns resources from expensive out-of-home care to community-based care. The ASO in New Jersey helped support and work with local FSOs and WAAs to develop a single view integrated care plan to ensure interagency collaboration and planning for children. In addition, Maryland found that the ASO can assist with leveraging funding by augmenting the ASO processes of utilization review and management, including braided funding. This prioritizes the funding available for services and uses funds that draw down the most advantageous match rate first and general State funds or local funds last.

Also in Maryland, we successfully implemented and managed the Psychiatric Residential Treatment Facility (PRTF) waiver, also known as "RTC waiver." This program utilizes a wrap-around approach to provide mental health and medical services to youth with serious mental health needs. A Care Management Entity (CME) develops a plan of care that enables the youth to receive services and support in the community rather than in a residential treatment center. The youth can receive services for up to two years. Having enrolled and authorized integrated services plans for the first participant in late 2009, ValueOptions has assisted with growing the program participation to more than 120 participants as of calendar year end 2010. We are proud of these results.

Finally, the statewide Maryland and New Jersey models successfully balanced the utilization of local resources and the implementation of clinically consistent practices such as:

ValueOptions' services to New Jersey created a responsive, family-friendly and community-based approach to the provision of behavioral health services for children, generally, and particularly to those high-risk children and youth served by the State's child welfare and juvenile justice systems.

- clinically based assessments and evaluations
- measures of improvement, progress and outcomes
- clinically sound standards for all levels of care
- consistent processes for accessing services outside of the child's Parish of residence
- uniform methods of maximizing funds that are available to serve children with emotional disturbances

Like New Jersey or Maryland, the Louisiana SMO will help meet the needs of consumers and their families as they seek services throughout the state.

b. Provide the number of government/public sector customers for which the Proposer has managed BH care services of persons eligible for Medicaid in the most recent five (5) calendar years (i.e., 2006, 2007, 2008, 2009, 2010), including the following information:

i. Customer Name;
ii. Number of eligibles;
iii. Approximate revenue in most recent year of the contract;
iv. Payment type (e.g., administrative services only fee, full capitation, etc.)
v. Direct contract with Agency or via health plan;
vi. Populations served (e.g., Title XIX, XXI, State only, CHIP, SAPT, CMHS block grants);
vii. Number of years Proposer has held contract; and
viii. Contract active or terminated

Because past performance is the best way to demonstrate an organization's capacity, we list those government/public sector customers for whom ValueOptions has managed the most Medicaid behavioral health services in the last five years.

3. Relevant Corporate Experience

Customer Name/Direct Contract of via Health Plan	Eligibles and populations served	Time Period	Revenue and payment type	Active/ Terminated
Arkansas Department of Human Services, Division of Medical Services Direct	152,000 Arkansas Medicaid beneficiaries under the age of 21	7/1/2010 to present	$1,600,000	Active
Arkansas Department of Human Services, Division of Medical Services Direct	400,000 covered lives Medicaid beneficiaries and Substance Abuse to eligible pregnant women and youth	7/1/2010 to present	$3,500,000	Active
California - individual contracts with 28 counties ValueOptions of California 10805 Holder Street Suite 300 Cypress, CA 90630 (5 additional counties have brought the services in house from 2007-2009) Direct	2,200 Medi-Cal children placed in out of county	1999 to present, contract terms vary by county and are renewable indefinitely	$500,000	Active
Colorado Health Partnership (VO partnership with CMHCs for 60 counties) Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203 Direct	170,000 recipients Medicaid	9/1/1995 to present	$78,900,000	

3. Relevant Corporate Experience

Customer Name/Direct Contract of via Health Plan	Eligibles and populations served	Time Period	Revenue and payment type	Active/ Terminated
Foothills Behavioral Health Partners Colorado Medicaid Community Mental Health Services for the Metro West Region 1570 Grant Street Denver, CO 80203 Direct	Approximately 55,371 Medicaid recipients, including adults and children	7/1/2009 to present	Approx. $33,500,000	Active
Northeast Behavioral Health Partnership Colorado Medicaid Community Mental Health Services for the Northeast Region 1570 Grant Street Denver, CO 80203 Direct	Approximately 60,872 Medicaid recipients, including adults and children	7/1/2009 to present	Approx. $23,332,000	
Connecticut Behavioral Health Partnership Connecticut Department of Social Services and Connecticut Department of Children and Families 25 Sigourney Street Hartford, CT 06106-5033 Direct	Approximately 585,000 TANF Families	1/1/2006 renewed and expanded in 2011	$500,000,000 ASO	Active

3. Relevant Corporate Experience

Customer Name/Direct Contract of via Health Plan	Eligibles and populations served	Time Period	Revenue and payment type	Active/ Terminated
Florida Agency for Health Care Administration 2295 Victoria Avenue Room 309 Ft. Myers, FL 33906 Direct	95,000(Medicaid, TANF and SSI, includes SMI/SED)	4/1/2007 to present	$12,100,000	Active
Florida Agency for Health Care Administration 6800 N Dale Mabry Highway Suite 220 Tampa, FL 33614 Direct	Area 5 – 26,000 TANF and SSI Area 7 – 53,000 TANF and SSI	8/1/2005 to present	Area 5 - $10,600,000 Area 7 - $19,900,000	Active
Florida Agency for Health Care Administration Bureau of Medicaid Services 2441 W Silver Springs Blvd. Ocala, FL 34475 Direct	Approximately 97,000 TANF and SSI recipients	10/1/2006 to present	$25,700,000	Active
Florida Agency for Health Care Administration 6800 N Dale Mabry Highway Suite 220 Tampa, FL 33614 Direct	63,000 TANF and SSI recipients	3/1/1996 to present	$16,500,000	Active

3. Relevant Corporate Experience

Customer Name/Direct Contract of via Health Plan	Eligibles and populations served	Time Period	Revenue and payment type	Active/ Terminated
Illinois Department of Human Services Division of Mental Health 222 S. College 2nd floor Springfield, IL 62701 Direct	63,000 TANF and SSI recipients	12/1/2007 to present	$8,900,000 ASO	Active
Kansas Department of Social and Rehabilitation Services Docking State Office Building 915 SW Harrison Street 9th Floor Topeka, KS 66612 Direct	260,000 beneficiaries Medicaid and SAPT	7/1/2007 to present	$22,000,000	Active
Maryland Administrative Services Organization (ASO) for Maryland's Public Mental Health System 55 Wade Avenue Catonsville, Maryland 21228 Direct	Approximately 708,000 Medicaid enrollees and 100,000 uninsured individuals	9/1/2009 to present	$9,900,000	Active
Executive Office of Health and Human Services, Office of Behavioral Health 100 Hancock Street Quincy, MA 02114 Direct	Approximately 380,000 Medicaid adults and children.	7/1/1996 to present	$37,000,000	Active

3. Relevant Corporate Experience

Customer Name/Direct Contract of via Health Plan	Eligibles and populations served	Time Period	Revenue and payment type	Active/ Terminated
New York City Chronic Illness Demonstration Project (CDIP) Pathways to Wellness NYS Department of Health, Office of Health Insurance Programs, Division of Managed Care, Bureau of Disease & Care Management 99 Washington Ave. Suite 720 Ref: Pathways to Wellness CIDP Albany, New York 12210 Direct	500 Medicaid Adults	8/1/2009 to present	$1,800,000	Active
New York Chronic Illness Demonstration Project (CIDP) Nassau Wellness Partners NYS Department of Health Office of Health Insurance Programs, Division of Managed Care Bureau of Disease & Care Management Ref: F-E-G-S CIDP 99 Washington Avenue, Suite 720 Albany, New York 12210 Direct	250 Medicaid Adults	8/1/2009 to present	$900,000	Active

3. Relevant Corporate Experience

Customer Name/Direct Contract of via Health Plan	Eligibles and populations served	Time Period	Revenue and payment type	Active/ Terminated
North Carolina Division of Medical Assistance 1985 Umstead Drive Raleigh, NC 27603 Direct	1,300,000 Medicaid recipients	1/1/2002 to present	Approximately $23,000,000	Active
Pennsylvania Behavioral Health of Cambria County 411 Main Street Johnstown, PA 15901 Direct	21,000 Medicaid Adults and Children	9/1/2007 to present	$26,800,000	Active
Pennsylvania Office of Mental Health & Substance Abuse Services 2520 New Butler Road New Castle, PA 16101 Direct	118,000 Medicaid Adults and Children	1/1/1999 to 12/31/2011	$129,000,000	Active
Pennsylvania Beaver County MH/MR Program 1040 Eighth Avenue Beaver Falls, PA 15010 Direct	24,000 Medicaid Adults and Children	1/1/1999 to 12/31/2011	$1,200,000	Active

3. Relevant Corporate Experience

Customer Name/Direct Contract of via Health Plan	Eligibles and populations served	Time Period	Revenue and payment type	Active/ Terminated
Pennsylvania Fayette County MH/MR Program 215 Jacob Murphy Lane Uniontown, PA 15401 Direct	30,000 Medicaid Adults and Children	1/1999 to present	$1,300,000	Active
Pennsylvania Northwest Behavioral Health Partnership 8406 Sharon-Mercer Road Mercer, PA 16137 Direct	43,000 Medicaid Adults and Children	7/1/2007 to present	$64,600,000	Active
Pennsylvania Office of Mental Health & Substance Abuse Services Department of Public Welfare 300 Liberty Avenue Room 413 Pittsburgh, PA 15222 Direct	7,600 Medicaid Adults and Children.	1/1/1999 to 12/31/2011	$7,825,000	Active
Tennessee TennCare East Region Volunteer State Health Plan One Cameron Hill Circle-4.3 C35 Chattanooga, TN 37402 Subcontract to Volunteer State Health Plan	Approximately 240,000 Medicaid Adults and Children	1/1/2009 to present	$5,200,000	Active

3. Relevant Corporate Experience

Customer Name/Direct Contract of via Health Plan	Eligibles and populations served	Time Period	Revenue and payment type	Active/ Terminated
Tennessee TennCare West Region Volunteer State Health Plan One Cameron Hill Circle-4.3 C35 Chattanooga, TN 37402 Subcontract to Volunteer State Health Plan	Approximately 190,000 Medicaid Adults and Children	1/1/2009 to present	$5,000,000	Active
Texas Department of State Health Services P.O. Box 12668 Austin, TX 78711-2668 Direct	330,022 Medicaid recipients, adults and children with SPMI, SED Also 610,140 non-Medicaid eligible and indigent beneficiaries	7/1/1999 to present	$146,100,000	Active
New Jersey Division of Child Behavioral Health Services 50 West Street P.O. Box 700 Trenton, NJ 08625 Direct	38,000 children with emotional, behavioral, and mental health needs	9/11/2001 to 9/7/09	$10,000,000 ASO	Terminated
New Mexico Interagency Behavioral Health Purchasing Collaborative P. O. Box 2348 Santa Fe, NM 87504-2348 Direct	280,000 managed; 112,000 FFS -total 392,000 Medicaid, Federal Block Grants, TANF, DOH, IV-E and child welfare/juvenile justice funds, community corrections, housing and other grants and state appropriations	7/1/2005 to 6/30/09	$375,010,000	Terminated

3. Relevant Corporate Experience

Customer Name/Direct Contract of via Health Plan	Eligibles and populations served	Time Period	Revenue and payment type	Active/ Terminated
Arizona Department of Health Services Davison of Behavioral Health Services Maricopa County Direct	440,000 Maricopa County Medicaid, Non-Medicaid, and KidsCare beneficiaries	9/1/1998 to 8/2007	$548,000,000	Terminated
Maryland Helix Family Choice Subcontract to Helix Family Choice Health Plan Subcontract	15,000 Medicaid other public behavioral health Adults, SPMI only	Contract end 7/2006	$5,200,000	Terminated
Pennsylvania Erie County Department of Human Services 154 West 9th Street Erie, PA 16501-1303 Direct	48,800 Medicaid Adults and Children	7/1/2007 to 6/30/2011	$53,200,000	Terminated

c. Provide the percentage of the Proposer's managed BH care revenue attributed to government public sector customers in fiscal years 2006, 2007, 2008, 2009, and the third quarter of 2010.

As noted in our Audited Financial Statement, ValueOptions, Inc. and Affiliated Companies, which is the parent company of ValueOptions of Louisiana, had the following percentage of the Proposer's managed Behavioral Health (BH) care revenue attributed to government public sector customers in fiscal years 2006, 2007, 2008, 2009, and 2010:

- 2006 – 80.0%
- 2007 – 80.2%
- 2008 – 77.9%
- 2009 – 77.7%
- 2010 – 74.0%

d. For all government/public sector customers for whom the Proposer currently manages Medicaid BH care services, provide the following information for a state contract:
   i. Name;
   ii. Address;
   iii. City, State, Zip;
   iv. Telephone Number; and
   v. Email address

Name/Email address	Address, City, State, Zip	Telephone Number
Anita Castleberry Medical Assistance Manager Arkansas Department of Human Services, Division of Medical Services Anita.castleberry@arkansas.gov	Division of Medical Services Mail Slot #413 P.O. Box 1437 Little Rock, AR 72203-1437	(501) 682-8292
Alycin Bellamy ValueOptions Account Representative ValueOptions of California Alycin.bellamy@valueoptions.com	10805 Holder Street Suite 300 Cypress, CA 90630	(800) 228-1286 Ext. 262406
Marceil Case Behavioral Health Contracts Manager Colorado Health Partnership Colorado Department of Healthcare Policy and Financing Marceil.cse@state.co.us	1570 Grant Street Denver, CO 80203	(303) 866-2992

3. Relevant Corporate Experience

Name/Email address	Address, City, State, Zip	Telephone Number
Karen Andersson, Ph.D. Director of Mental Health Connecticut Department of Children and Families Connecticut Behavioral Health Partnership Connecticut Department of Social Services and Connecticut Department of Children and Families Karen.andersson@ct.gov	25 Sigourney Street Hartford, CT 06106-5033	(860) 550-6683
Karen Brooks Contract Manager PMHP Area 8 Florida Agency for Health Care Administration brooksk@ahca.myflorida.com	2295 Victoria Avenue Room 309 Ft. Myers, FL 33906	(239) 338-2638
Amanda Eagle Contract Manager PMHP Areas 5 & 7 Florida Agency for Health Care Administration eaglea@acha.myflorida.com	6800 N. Dale Mabry Highway Suite 220 Tampa, FL 33614	(813) 871-7600 Ext. 133
Kellyanne Rush-Staley PMHP Contract Manager Area 3 Florida Agency for Health Care Administration rushtak@ahca.myflorida.com	2441 W. Silver Springs Boulevard Ocala, FL 34475	(904) 732-1349 Ext. 104
Jorja Daniels PMHP Area 6 Contract Manager Florida Agency for Health Care Administration Danielsj@ahca.myflorida.com	6800 N. Dale Mabry Highway Suite 220 Tampa, FL 33614	(813) 871- 7600 Ext. 132
Jacqueline J. Manker Associate Director for Community Services Illinois Department of Human Services Division of Mental Health Jackie.manker@illinois.gov	222 S. College 2nd floor Springfield, IL 62701	(217) 782-5700
Deborah Stidham, M.S. Director Addiction and Prevention Services Kansas Social and Rehabilitation Services Deborah.Stidham@srs.ks.gov	915 SW Harrison, 9th Floor South Topeka, KS 66612	(785) 296.6807

3. Relevant Corporate Experience

Name/Email address	Address, City, State, Zip	Telephone Number
Brian Hepburn, MD Executive Director Maryland Department of Mental Health and Hygiene Maryland Administrative Services Organization (ASO) for Maryland's Public Mental Health System bhepburn@dhmh.state.md.us	55 Wade Avenue Catonsville, Maryland 21228	(410) 402-8452
Christopher Counihan Director of Behavioral Health Office of MassHealth Executive Office of Health and Human Services, Office of Behavioral Health Christopher.Counihan@state.ma.us	100 Hancock Street Quincy, MA 02114	(617) 348-5101
Danika Mills, MPS, ATR-BC, LCAT Project Director Institute for Community Living, Inc. Pathways to Wellness New York Chronic Illness Demonstration Project (CIDP) NYS Department of Health, Office of Health Insurance Programs, Division of Managed Care, Bureau of Disease & Care Management dmills@iclinc.net	99 Washington Avenue Suite 720 Ref: Pathways to Wellness CIDP Albany, New York 12210	(718) 855-4035 Ext. 1390
Sue McKenna, LCSW-C Project Director Nassau Wellness Partners F-E-G-S Pathways to Wellness New York Chronic Illness Demonstration Project (CIDP) NYS Department of Health, Office of Health Insurance Programs, Division of Managed Care Bureau of Disease & Care Management SMcKenna@FEGS.ORG	Ref: F-E-G-S CIDP 99 Washington Avenue, Suite 720 Albany, New York 12210	(516) 505-2003 Ext. 285
Tara Larson Chief Clinical Operation Officer North Carolina Division of Medical Assistance Tara.larson@ncmail.net	1985 Umstead Drive Raleigh, NC 27603	(919) 855-4103

3. Relevant Corporate Experience

Name/Email address	Address, City, State, Zip	Telephone Number
Cindy McLaughlin Chief Executive Officer Pennsylvania Behavioral Health of Cambria County Cmclaughlin15@verizon.net	411 Main Street Johnstown, PA 15901	(814) 534-4436
Dave McAdoo Executive Director Southwest Behavioral Health Management, Inc. (can discuss our contract for the Southwest 6 counties) Pennsylvania Office of Mental Health & Substance Abuse Services dmcdoo@swsix.com	2520 New Butler Road New Castle, PA 16101	(724) 657-3470
Mike Gerard Administrator Pennsylvania Beaver County MH/MR Program gmike@bcbh.org	1040 Eighth Avenue Beaver Falls, PA 15010	(724) 847-6225
Lisa Ferris-Kusniar Administrator/ CEO Pennsylvania Fayette County MH/MR Program lfk@faymhmr.org	215 Jacob Murphy Lane Uniontown, PA 15401	(724) 430-1370
George Cavanaugh Chief Executive Officer and Chairman of the Board Pennsylvania Northwest Behavioral Health Partnership (Crawford, Mercer, and Venango Counties) george.cavanaugh@mercercountybhc.org	8406 Sharon-Mercer Road Mercer, PA 16137	(724) 662-1550 Ext. 216
Valerie Vicari Area Director Western Service Area, Pennsylvania Office of Mental Health & Substance Abuse Services, Department of Public Welfare (state contact, also can discuss our contract for Greene County) vavicari@state.pa.us	300 Liberty Avenue Room 413 Pittsburgh, PA 15222	(412) 565-5226

3. Relevant Corporate Experience

Name/Email address	Address, City, State, Zip	Telephone Number
Ronald Wigley, Ph.D. Manager, Behavioral Health Program Tennessee TennCare East and West Regions Volunteer State Health Plan Ron_Wigley@vshptn.com	One Cameron Hill Circle-4.3 C35 Chattanooga, TN 37402	(423) 535-7105
Matthew Ferrara Office of NorthSTAR and Special Initiatives Texas Department of State Health Services Matthew.ferrara@dshs.state.tx.us	P.O. Box 12668 Austin, TX 78711-2668	(512) 206-5470

e. For current customers listed in letter d above, provide the number of complaints per 1,000 members received during the past two (2) calendar years. Also provide the most common types of complaints ranked by order of frequency.

Complaints Per 1,000 Members	
2009	2010
0.22 per 1,000	0.06 per 1,000

The most common types of complaints ranked by order of frequency are:

- quality of a member's clinical care by a provider
- member's service or significant administrative problems with a provider
- ability to access appropriate care within a reasonable geographic vicinity and timeframe.

f. Provide three (3) references from governmental/public sector clients, at least of which two (2) are from government/public sector clients with whom the Proposer currently holds contracts for management of behavioral health services. Include the following information:

i. Name;
ii. Address;
iii. City, State, Zip;
iv. Telephone Number; and
v. Email address

ValueOptions' References *Proprietary and Confidential*		
Client Name/Address	Contact Name/Email Address	Phone Number
Maryland Department of Mental Health and Hygiene 55 Wade Avenue Catonsville, Maryland 21228	Brian Hepburn, MD Executive Director bhepburn@dhmh.state.md.us	(410) 402-8452
Texas Health and Human Services Commission; Department of State Health Services P.O. Box 12668 Austin, TX 78711-2668	Matthew Ferrera, Office of NorthSTAR and Special Initiatives Matthew.ferrara@dshs.state.tx.us	(512) 206-5444
Kansas Department of Social and Rehabilitation Services, Division of Addiction and Prevention Services 915 SW Harrison, 9th Floor South Topeka, KS 66612	Deborah Stidham, M.S., Director Deborah.Stidham@srs.ks.gov	(785) 296.6807

4. Personnel Qualifications

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

a. Job descriptions including the percentage of time allocated to the project and the number of personnel should be included and should indicate minimum education, training, experience, special skills and other qualifications for each staff position as well as specific job duties identified in the proposal. Job descriptions should indicate if the position will be filled by a subcontractor.

VO-LA job descriptions are provided in **Attachment 16**.

b. Key personnel and the percentage of time directly assigned to the project should be identified.

Key Personnel	Percentage of Time Assigned
Chief Executive Officer (CEO)	REDACTED
Chief Medical Officer (CMO)	
Chief Operating Officer (COO)/Adult Systems Administrator	
Chief Finanical Officer (CFO)	
Corporate Compliance Administrator	
Quality Administrator	
Medical Administrator	
Children's System Administrator	
IS Administrator	
Network Development Administrator	
Member Services Administrator	
Outreach Recovery Administrator	
Human Resources Director	
Claims/Encounters Administrator	
Director of Provider Analysis and Reporting	
Network Management Administrator	
Grievances and Appeals Administrator	
Utilization Review Administrator	

c. Resumes of all known personnel should be included. Resumes of proposed personnel should include, but not be limited to:
   i. Experience with Proposer;
   ii. Previous experience in projects of similar scope and size; and
   iii. Educational background, certifications, licenses, special skills, etc.

VO-LA is in the process of recruiting key personnel. We have selected Louisiana professionals to serve as the CEO, CMO, CFO, Children's System Administrator, and Outreach and Recovery Administrator.

We are continuing to recruit for the other leadership positions. Some of the individuals to whom we have made verbal offers have asked not to be named at this juncture but have committed to employment with VO-LA upon successful procurement. Of course, all of these key leadership positions will be vetted with DHH-OBH prior to tendering formal offers and official hiring. In addition, we will fill other key positions with seasoned ValueOptions professionals during implementation on an interim basis until our key personnel recruiting has been completed. We provide biographies for the key staff below. Resumes including ValueOptions' or similar experience and educational background, certifications, licenses and more are provided as **Attachment 17.**

PROPRIETARY AND CONFIDENTIAL

Chief Executive Officer

Redacted

Chief Medical Officer

Redacted

Chief Operations Officer/Adult Systems Administrator

Redacted

Chief Financial Officer

Redacted

Corporate Compliance Administrator

Redacted

Quality Administrator
Redacted

Medical Administrator
Redacted

Children's System Administrator
Redacted

IS Administrator
Redacted

Network Development Administrator
Redacted

Member Services Administrator

Redacted

Outreach Recovery Administrator

Redacrted.

Claims/Encounters Administrator

Redacted

Network Management Administrator
Redacted

d. If subcontractor personnel will be used, the Proposer should clearly identify these persons, if known, and provide the same information requested for the Proposer's personnel.

As discussed in our response to *Section 2.j. Subcontracting*, VO-LA will be subcontracting cultural competency training services to Western Interstate Commission for Higher Education (WICHE). We provide the resumes for WICHE personnel as **Attachment 17**.

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

As an appendix to its proposal, if available, a Proposer may provide samples of specific policies and procedures that would highlight its expertise in serving the populations identified in the RFP, inclusive of organizational standards, employee expectations, member rights, UM guidelines and ethical standards. Full copies of manuals are not desired. This appendix should also include a copy of the Proposer's All Hazards Response Plan, if available.

VO-LA provides samples of work we have completed for other contracts that reflect the experience that we will provide to the Louisiana Behavioral Health Partnership, as attachments referenced in various sections of our response. Examples that are not included in other attachments as indicated are included in **Attachment 18**. In addition, we have also provided draft plans for the LBHP as in this attachment. To streamline your review process, we provide a list of the sample documents we are providing below:

- Louisiana Draft All Hazards Response Plan (also in Attachment 14)
- Louisiana Draft Outreach Plan
- Draft Cultural Competency Plan
- Provider Training Experience (Attachment 9)
- Sample Public Sector Reports
- Sample Provider Profiles (Attachment 12)
- Sample Audit Tools (Attachments 2 and 8)
- Draft Louisiana Member Handbook (Attachment 3)
- Warmline Satisfaction Survey Results

Throughout this proposal, ValueOptions of Louisiana, Inc. (VO-LA) means the legal entity proposing services as the Statewide Management Organization. ValueOptions® (ValueOptions) is VO-LA's parent company, and the use of ValueOptions represents experience in other public programs.

a. Maintaining Records for Governmental Contracts. Describe the Proposer's experience in maintaining records for governmental contracts and submitting financial statements to governmental agencies and compliance with the requirements of subsection 6 b. below – Federal Financial Participation. Suggested number of pages: 2.

ValueOptions and its affiliates have many years of experience with reporting and record keeping in all of our public sector contracts, and we are currently in good standing under all such contracts.

The following responses and example reports will demonstrate ValueOptions' long standing ability to maintain and submit financial statements to governmental agencies.

b. Federal Financial Participation and Access to Records, Books, and Documents.

i. Describe the Proposer's general ledger and accounting system and how the system tracks and records revenue and expenses from separate funding streams, including location of system and records. Suggested number of pages: 3.

FinanceConnect is the name applied to ValueOptions General Ledger and overall financial system. FinanceConnect consists of Oracle software for Accounts Payable, Accounts Receivable and General Ledger functions and Hyperion software for budgeting and forecasting software. The General Ledger and related suite applications provide the ability to manage large contracts in an efficient and effective manner.

In choosing Oracle as a component of our finance system ValueOptions selected one of the world's leading financial application systems. The Oracle General Ledger system is a comprehensive financial management solution that provides advanced financial controls and data collection for the entire ValueOptions enterprise. The General Ledger system provides a robust account structure that supports full cost accounting including appropriate capture and reporting of direct, indirect and General and Administrative (G&A) costs. The system is able to support cost-plus, firm fixed price and time and material type contracts. The system provides for the detail accumulation of contract-level detail as well as the overall aggregation of financial data. The detailed configuration flexibility will enable VO-LA to report not only at the department level, but also to further break down the reporting at an individual appropriation level, such as reporting for Access to Recovery grants.

The Oracle Accounts Receivable Subsystem module provides the necessary functions to support the related processes involving invoicing, adjustments, and payments for supplied services and/or products.

The Oracle Accounts Payable Subsystem supports the related processes involving invoices, adjustments, and payments for supplied services and products. The basic components of the

accounts payable system are the entry, inquiry, and reporting aspects typically found in an accounts payable system, along with the ability to receive the generated invoices from other system components. The Accounts Payable vendor setup supports small, disadvantaged business reporting.

Tools and Technologies

Our ability to effectively track and report funding and expenditures is enhanced by our technologies. ValueOptions' information system, and in particular our financial system, afford flexibility to track operations by funding stream. Our system has the flexibility to meet the standards required by the State of Louisiana.

Braided Funding℠ System

We created the industry-unique ValueOptions Braided Funding system which eliminates administrative inconvenience for providers and streamlines consumer registration and tracking of a consumer's record regardless of the multiple funding sources and benefit structures. Unlike any other claims payment system, braided funding automatically identifies Medicaid eligibility and other funding streams, allowing for maximization of Federal matching funds.

ValueOptions' Braided Funding is designed to assign the correct braided funds from any program source to pay for an individual service package, thus braiding funds in a primary order and maintaining tracking and accountability for each funding stream at the administrative level. The funds remain in separate strands but are joined or "braided" for the individual, resulting in improved service accessibility and savings for the State. The objective of the braided funding model is to integrate service delivery to the individual while documenting, tracking, accounting, and reporting for funds back to each federal and state program.

The following sections provide several examples of how our system can record revenue and assign expenses by funding streams:

Assignment of Members to Funding Streams

Members are assigned to various funding streams using the registration process. The ValueOptions Braided Funding System creates a unique member identification number and one member record, which can be associated with multiple funding sources and benefit structures. The system is structured so that providers can only enroll consumers into funding sources for which the provider is contracted to provide services. The effective and expiration dates for each funding source are also maintained for each consumer record.

As stated, a provider can only register consumers for services the provider is authorized to provide. However, the ValueOptions Braided Funding system will also show a list of all possible funding sources based on the consumer's eligibility profile. If there are multiple funding sources, the system will auto-select the highest priority funding using a pre-loaded algorithm. Historically, providers sometimes enrolled consumers in the non-Medicaid programs that were most accessible, or that had the simplest registration and reporting requirements. The ValueOptions Braided Funding system directs providers to the correct program enrollment based on algorithms agreed upon by VO-LA and the State. This ensures that funding is used appropriately for the priority population selected by the funding agency. The Web-based authorization process has also been streamlined.

Assignment of Providers to Funding Streams

The Provider Record is set up with multiple funding sources, fee schedules, contracts, and alternate IDs. Each of these elements can be easily changed when contracts and programs change. Claims adjudication is simplified and claims processing and payment is accelerated. Financial reports are easily generated for individual providers for each funding source.

Assignment of Expenses to Funding Streams

Expenses are assigned to specific funding sources based upon use of service codes and modifiers. For example, we have used this system capability for several of our contracts to identify and segregate housing services from core Medicaid services. VO-LA can support separate rules for each funding stream. Our claims adjudication program uses client-defined hierarchy rules to determine the funding source applicable to each claim. VO-LA can accommodate encounter-based services, including non-standard CPT or HCPCS service codes, while maintaining HIPAA compliancy and applying appropriate funding stream, adjudication rules, provider accumulations (e.g., one/twelfth drawdown, application of encounter value maximums, and payment maximums either at the service level or for a specific time period), and payment methodologies.

Eligibility Classification by Rate Cohort

Eligibility classification by rate cohort is used to segregate revenue and expenses by fund source. For example, in Pennsylvania, eligibility information is used to facilitate the identification of revenues and related medical expense at Medicaid rate cohort funding level. ValueOptions reports financial results to the Department of Public Welfare for seven distinct rate cohorts monthly.

The Financial System is housed in ValueOptions' Corporate Offices with specific back-up/redundancy locations across the country. VO-LA staff will have 24 hour accessibility to the Financial System. Records are stored electronically for all transactions and are accessible to both VO-LA and ValueOptions staff on a 24 hour basis.

ii. Describe the Proposer's experience with audits from governmental agencies. Provide two examples of actual audit reports and the resulting corrective action plan. Suggested number of pages: 2.

ValueOptions has significant experience in both the development and execution of audits from various Governmental Agencies. ValueOptions is also experienced in other types of specialty audits which our various government clients may require. Examples of recent audits include:

1) Compliance Audits
2) Internal Revenue Service Audits
3) Sales and Use Tax Audits
4) Agreed Upon Procedures Audits
5) SAS 70 Claims Compliance Audits
6) Pennsylvania Department of Public Welfare HealthChoices Behavioral Health Program

The Company is proud to state that none of these various types of audits has ever produced any significant adverse findings or resulting corrective action plans. Additionally, it is important to note that the financial systems are designed to support most audits in an extremely efficient manner which should assist most auditing entities in controlling their audit costs.

Annually, an independent financial statement audit is completed not only for ValueOptions, but also for our Colorado, Florida, Kansas, Massachusetts, Pennsylvania, and Texas NorthSTAR contracts.

A number of states require a separate audit to be completed periodically by the State's Department of Insurance (DOI) staff. Recent audits have been completed for Florida, Kansas, Pennsylvania, and Texas NorthSTAR. A draft copy of a recent audit performed by the Kansas Insurance Department is included as an example in **Attachment 19**.

Also included as an example is an Independent Accountants' Audit Report for one of the Pennsylvania County contracts operated by Value Behavioral Health of Pennsylvania, Inc. (VBH-PA), which is a wholly-owned subsidiary of ValueOptions.

c. Financial Reporting. Submit the Proposer's audited financial statements that cover the two (2) most recent years and the most recent unaudited quarterly financial statements (year-to-date). If the Proposer is a newly formed corporation and does not have any audited financial statements submit the most recent annual audited (to cover the most recent two (2) years) and quarterly unaudited financial statements of the corporation that intends to provide funding or support to the newly-formed corporation. Disclose the relationships of the corporation funding to the Proposer. Suggested number of pages: 1, excluding the audited financial statements.

As VO-LA is a newly formed corporation and does not have any audited financial statements, the financial statements of VO- LA's parent company, ValueOptions, are being submitted as **Attachment 1 in the Cost Proposal**. These include the most recent two years audited financial statements and quarterly unaudited financial statements as of March 31, 2011.

i. Describe the Proposer's experience in developing and submitting financial statements to governmental agencies and tracking revenue and expenditures by funding source. Suggested number of pages: 2, and include three examples of actual reports submitted to governmental agencies. Identify customer(s) who can verify the experience.

ValueOptions has significant experience in developing and submitting financial statements to governmental agencies and tracking revenue and expenditures by funding source:

Texas NorthSTAR – For a multiple county region located in the Dallas area, ValueOptions manages and reports on several different funding streams including:

- Title XIX Medicaid
- State Indigent Program Appropriation
- State Hospital Trust Fund
- Texas Correctional Office on Offenders with Medical or Mental Impairments

The appropriate contact person who can verify this is:

Matthew Ferrara
Manager
Medicaid Services Unit
Department of State Health Services-MC 2012
P.O. Box 149347
Austin TX 78714-9347
Phone: (512) 206-5470
Fax: (512) 206-5383
Matthew.Ferrara@dshs.state.tx.us

Arizona and New Mexico - In the now terminated contracts of Arizona and New Mexico, it was ValueOptions responsibility to successfully report on several different funding streams and appropriations including:

- Title XIX Medicaid
- Title XX Medicaid
- Indian Health Services
- Tobacco Tax Settlement Funding
- Children Youth and Families Department Funding (Child Welfare)
- Department of Corrections
- Department of Aging
- Department of Health
- Department of Housing and Urban Development
- Access to Recovery Grants
- SBIRT Grants

An example of one of the New Mexico reports is included in **Attachment 20**. The lead schedule allocates revenue and expenses among the indicated funding streams and the supporting schedules further allocate costs within each separate funding stream. The appropriate contact person who can verify this is:

Julie Weinberg
Director at Medical Assistance Division New Mexico
Human Services Department
New Mexico Human Services Department's Medical Assistance Division
P. O. Box 2348
Santa Fe, NM 87504
Phone: (505) 827-3100
Julie.weinberg@state.nm.us

Pennsylvania - In Pennsylvania, for 13 separate county programs, ValueOptions has been required to and has successfully reported on the following Medicaid Funding Streams:

- Temporary Assistance to Needy Families (TANF) Child
- TANF Adult

- Healthy Beginnings
- SSI and Healthy Horizons With Medicare
- SSI and Healthy Horizons Without Medicare
- Federal GA
- Categorically Needy State Only GA (CNO)
- Medically Needy State Only GA (MNO)

In addition, for two of the 13 counties, ValueOptions also manages and reports expenditures for a separate specific county appropriation called Base Services Unit.

An example of one of the Pennsylvania county reports which allocates revenue and expenses among the indicated funding streams is included in **Attachment 20**. The appropriate contact person who can verify this is:

Patty Piatt, CFO
Southwest Behavioral Health Management, Inc
2520 New Butler Road
New Castle, PA 16101
Phone: (724) 657-3470
Fax: (724) 657-3461
PattyP@swsix.com

Kansas - For Kansas, ValueOptions manages several different funding streams for which revenues and expenditures are separately tracked including:

- Title XIX Medicaid
- State and Federal Substance Abuse Block Grants
- Problem Gambling Appropriations
- Driving Under the Influence (DUI) Appropriation

Arkansas – For Arkansas, ValueOptions currently manages and separately reports on two distinct funding streams/programs. These are Medicaid Outpatient Review Services and Medicaid Inpatient Review Services.

An example of the Arkansas monthly billing reports split between the Outpatient and Inpatient portion with a further breakdown of the types of reviews is included in **Attachment 20**. The appropriate contact person who can verify this is:

Sheryl Baker, Medical Assistance Manager
Arkansas Department of Human Services,
Division of Medical Services Financial Activities
Donaghey Plaza South
P.O. Box 1437, Slot S416
Little Rock, AR 72203
Phone: (501) 683-6504
Fax: (501) 682-8873
Sheryl.Baker@arkansas.gov

ii. Describe the Proposer's experience in working with governmental agencies in developing and submitting financial and utilization data to assist in the monitoring of contractual performance and operations. Suggested number of pages: 2 and include three examples of actual reports submitted to governmental agencies. Identify customer(s) who can verify the experience.

ValueOptions has significant experience in working with various government agencies and clients to develop, maintain, and submit various financial and utilization reports to assist in the monitoring of contractual performance and operations.

In Kansas, a report is prepared on a monthly basis that indicates the claims that have been submitted in order to draw down the substance abuse block grants for which ValueOptions has been contracted to manage. Reports are prepared at an aggregate level and for individual providers. This data is used to both measure the overall performance of the grant allocation, and to reallocate block grant funding among providers based on performance. A copy of a recent report is included as **Attachment 21**. The contact within the state who can verify the experience is:

Melissa Warfield, MSA II
Director of Fiscal Services
State of Kansas Social and Rehabilitative Services
915 SW Harrison, 9th Floor West
Topeka, KS 66612
Phone:(785) 296-1482
Melissa.Warfield@srs.ks.gov

For ValueOptions' Maryland contract, we provide on a monthly basis several different types of paid claims reports to our client including:

- Claims paid by coverage type/age
- Claims paid by funding type
- Claims paid by level of care, by funding stream, by eligibility category

In turn, the state is able to utilize these reports to monitor consistent payment patterns as well as target utilization fluctuations in a detailed manner in order to determine if program adjustments are in order. A copy of a recent report is included as **Attachment 21**. The contact within the state who can verify the experience is:

Mr. Randolph Price
Director of Fiscal Services
Mental Hygiene Administration
55 Wade Avenue, Dix Building
Catonsville, MD 21228

In both of ValueOptions' Kansas and Pennsylvania contracts, we submit a Claims Payment Lag / Incurred but not Reported (IBNR) analysis.

Our clients have been able to utilize this report for several different types of monitoring including:

- adequacy of IBNR reserves
- estimate of prior periods claims yet to be processed
- consistent claims payment patterns by month

A copy of a recent Kansas report is included as **Attachment 21**. The contact within the state who can verify the experience is:

Melissa Warfield, MSA II
Director of Fiscal Services
State of Kansas Social and Rehabilitative Services
915 SW Harrison, 9th Floor West
Topeka, KS 66612
Phone: (785) 296-1482
Melissa.Warfield@srs.ks.gov

The production of actionable monitoring reports is critical to the success of our programs. Our system is designed to be extremely flexible in order to facilitate the production of a wide variety of reports. We have been called upon to produce reports in a variety of scenarios, including:

1. Payments/Utilization by Provider
2. Payments/Utilization by Consumer
3. Payments/Utilization by Zip Code
4. Utilization by Type of Level Care
5. Utilization by Eligibility Category
6. Utilization by Age Cohort

Additionally, we are able to produce traditional financial statement reports such as income statements and balance sheets on both Generally Accepted Accounting Principles (GAAP), or statutory accounting basis in order to assist our clients, or the state Department of Insurance monitoring of the program's financial soundness.

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d. Budget Tracking System (Early Warning System). Describe the Proposer's experience in working with governmental agencies in developing and submitting budget tracking systems (early warning systems) to track expenditures, utilization, cost per service and recipients in service by funding source. Suggested number of pages: 2 and include one example of actual reports submitted to governmental agencies. Identify customer(s) who can verify the experience.

ValueOptions has substantial experience in working with our various clients in developing, maintaining and submitting reports that are used for early warning systems to track expenditures, utilization, cost per service, and more.

Perhaps the best example of a current monthly reporting suite that illustrates this capability occurs in the state of Maryland. This reporting suite includes:

1. Payments by Level of Care by Rate Cohort are indicated
2. Payments by Funding Source by Level of Care by Age are provided by fiscal year
3. Number of units by Funding Source by Age by Level of Care are provided by fiscal year

A copy of the Maryland report is provided as **Attachment 22**.

Additionally, on a monthly basis, a specialized report has been developed for Maryland that indicates:

1. Number of active cases
2. Number of new cases
3. Concurrent requests
4. Denials/Appeals
5. Average Length of Stay/Average units per member per fiscal year
6. Number of consumers with paid claims

A copy of this Maryland report is also provided as **Attachment 22**. The state contact who can verify this experience is:

Mr. Randolph Price
Director of Fiscal Services
Mental Hygiene Administration
55 Wade Avenue, Dix Building
Catonsville, MD 21228

e. Protection Against Liability and Insolvency. Describe how the Proposer will ensure that members are not held liable for services from providers and maintain compliance with 42 CFR §438.106 and Section 1932(b)(6), Social Security Act (as enacted by section 4704 of the Balanced Budget Act of 1997). In addition, provide the Proposer's experience with the regulations contained within this requirement. Suggested number of pages: 2.

VO-LA will satisfy this requirement by including such prohibitions in our provider contracts. VO-LA's parent, ValueOptions, Inc. has been providing and administering public sector behavioral health services since our inception in 1987, and we have historically included language in our provider contracts that prohibits members from being held liable for services from providers.

f. Solvency and Corporate Financial Condition

i. The Proposer agrees to have in place within thirty (30) days of the Contract award date, capitalization requirements as will be established for this contract in the amount of funds equal to sixty (60) days of estimated payments to the Contractor, which is met with no encumbrances, such as loans subject to repayment. Describe in detail how this requirement will be met. If the Proposer is relying on another organization to meet the capitalization requirement, submit the most recent audited financial statements of the other organization. In addition, in this case, submit a written certification, signed and dated by the President/Chief Executive Officer of the parent organization, indicating the parent organization's plan to provide the initial minimum capitalization to the Proposer, without restrictions, within the time frame contained in the RFP. Suggested number of pages: 3.

In addition to ValueOptions plan to fund any potential losses (as described in the response to *6.f.ii.* below), we agree to have in place within thirty days of the contract award date capitalization requirements in the amount of funds equal to sixty days of estimated payments to VO-LA. These funds will be met with no encumbrances such as loans subject to repayment.

We also submit a written verification as **Attachment 23** signed and dated by the President of the parent organization (ValueOptions, Inc.) which indicates our plan to provide the initial minimum capitalization to ValueOptions of Louisiana, without restrictions, and within the time frame contained in the RFP.

The most recent audited financial statements of ValueOptions are provided as **Attachment 1 in the Cost Proposal**.

ii. Describe the Proposer's business plan to fund any potential losses to ensure continued compliance with the capitalization requirements. Suggested number of pages: 1.

As one of the nation's largest behavioral health care managers, ValueOptions/First Hospital Corporation (FHC) is a successful and financially solvent company. In the unlikely event that the Louisiana program was to incur a loss, it could be funded in a number of ways to insure continued compliance with capitalization requirements, including:

- The company has successfully operated and accumulated cash/earnings from its large number of contracts. As of 12/31/10, FHC, the ultimate parent had $209 million in current assets as evidenced in the audited financial statements herein enclosed.
- FHC credit facilities provide revolving lines of credit in the total amount of $30 million that could be accessed if necessary.
- The shareholders would be prepared to make an additional equity investment if required.

In summary, the company is well positioned and has a number of tools available to fund any potential losses to insure continued compliance.

g. Non-Allowable Costs. Describe the Proposer's experience with following the guidelines of OMB Circular A-87 and maintaining compliance with those requirements. Suggested number of pages: 2 and include one example of A-87 Audit Report. Identify customer(s) who can verify the experience.

Historically, ValueOptions has not participated with any contracts or grants that require accounting or reporting under OMB Circular A-87 requirements. However, ValueOptions has had the responsibility for reporting on a wide variety of grants, trust fund allocations, and special appropriations.

This reporting is accomplished through our Oracle financial accounting system and FinanceConnect platform which allows us to specifically segregate revenues and expenses associated with a particular funding stream. Importantly, expenses can further be segregated into allowable and non-allowable categories as determined by the contract, a specific grant, trust fund allocation, or special appropriation.

For the State of Louisiana proposal, if a particular funding stream or streams require accounting pursuant to OMB Circular A-87, ValueOptions technical accounting team will configure the General Ledger, Accounts Payable, Payroll, and Revenue tracking systems to meet the requirements. The corporate financial accounting team for this configuration represents a group of persons with over 100 years of financial accounting experience, the majority of which has accrued in the health care arena. The majority of the leaders of this unit has more than 10 years of experience with ValueOptions and has passed the Virginia Certified Public Accountant examination.

h. Performance Bond/Retainage. Describe how the Proposer will meet the performance bonding requirement outlined in the RFP. For purposes of this response, assume that the initial performance bonding/retainage requirement is approximately ten percent of the total annual contract. Suggested number of pages: 2.

ValueOptions maintains an agreement with a national broker, AON Surety, to secure various performance bonds as required. Presently ValueOptions has approximately $18 million in bonds issued using this relationship.

AON Surety maintains relationships with several insurance/bonding companies. The companies have met AON's financial due diligence requirements. For the bonds required in Louisiana, AON will review the Request for Proposal issued by the State and meet with key ValueOptions leadership in order to review the opportunity. AON will then solicit bids from its approved list of insurance/bonding companies and recommend the appropriate bonding company to ValueOptions. Importantly, during ValueOptions entire existence, there has never been an instance when a performance bond was cashed or drawn upon for any reason.

i. Liquidated Damages. Describe the Proposer's experience in performing contracts with liquidated damages provisions and acknowledge the Proposer's acceptance of the liquidated damages provisions of this RFP. Suggested number of pages: 2.

ValueOptions, Inc. and its affiliates have entered into and performed contracts with liquidated damages provisions in the past and have not paid any amounts under such provisions. Furthermore, ValueOptions and its affiliates have also entered into and performed contracts with performance guarantees in the past.

VO-LA accepts the liquidated damages provisions under this RFP.

j. Fraud and Abuse. The Proposer shall describe its approach for meeting program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss Proposer's approach for meeting the requirements for coordination with DHH and other State funding agencies. Include a description of the internal controls and policies and procedures the Proposer will implement to detect fraud and abuse within its own organization, and for providers and members. Describe the Proposer's experience with implementing a comprehensive fraud and abuse monitoring program. Include key personnel and departmental structure involved in Proposer's fraud and abuse program. Provide three (3) examples of fraud or abuse the Proposer has detected and what Proposer did upon detection. Identify a customer that can verify the experience. Suggested number of pages: 4.

It is the policy of ValueOptions to comply with all laws governing our operations and to conduct business in keeping with legal and ethical standards. It is also our policy to deal with employees and behavioral health recipients using the highest clinical and business ethics as well as to maintain a culture which promotes the prevention, detection and resolution of possible violations of laws and unethical conduct. Compliance is a priority built into all levels of operations. As a service center within the ValueOptions, Inc. Public Sector Division, VO-LA will operate its anti-fraud program under the direction of the National Legal and Compliance Department. VO-LA will have access to an array of national resources to support its compliance efforts and to implement an anti-fraud plan. In partnership with McKesson Health Solutions, VO-LA will implement a fraud, waste and abuse detection and management solution, InvestiClaim, which detects billing aberrances that can result from abusive provider billing. VO-LA will also have a Compliance Department and Compliance Committee and have vested with them the appropriate authority to administer the fraud and abuse program.

Compliance Plan and Oversight

ValueOptions has established and will continue to maintain a compliance program that, to the extent applicable, conforms to the Compliance Program Guidance issued by the Office of the Inspector General of the U.S. Department of Health and Human Services and other relevant state compliance program guidelines that will directly affect the operations of VO-LA.

As part of the compliance program, VO-LA will follow ValueOptions' Compliance and Anti-Fraud Plan, but utilize VO-LA specific procedures as necessary to comply with Louisiana requirements. The purpose of the plan is to develop a mechanism to prevent and detect fraud, waste, or abuse in the behavioral health system under the scope of the contract with the State of Louisiana. The plan

is intended to be a systematic process aimed at ensuring that VO-LA and our subcontractors comply with applicable laws, regulations, standards, and contractual obligations. The Compliance and Anti-Fraud Plan will serve as a guiding document in the development and implementation of fraud and abuse operations and procedures, and to establish a process for identifying and reducing risk and improving internal controls.

The day-to-day operations of the compliance program and anti-fraud plan will be administered by the VO-LA Compliance Department, led by the Compliance Administrator, who will report directly to the National Director of Compliance, Program Integrity and the Louisiana Service Center Chief Executive Officer. VO-LA staff will have appropriate qualifications and experience.

VO-LA will also establish a Compliance Committee to provide oversight for the compliance program. The Compliance Committee will consist of representatives from primary departments including Quality Management, Claims, Information Technology, Clinical, Network Operations and Finance. It will be chaired by the Compliance Administrator or designee. Committee member responsibilities will include:

- reviewing new regulations affecting compliance issues and revising strategies accordingly
- reviewing new and ongoing compliance issues
- identifying potential fraud and abuse issues that may put VO-LA, the State, and the program at risk and developing strategies to avoid such problems
- developing training programs that support the prevention and detecting of fraud and abuse
- developing and monitoring data validation processes and outlier reporting processes

VO-LA Compliance Program

Our compliance program will be comprised of three major areas: Prevention, Audit and Detection, and Investigation and Resolution.

Prevention

The Prevention component of the compliance program will include technological tools, training, awareness and communication. Awareness and communication of the fraud and abuse program will be of paramount importance. Specific examples of prevention mechanisms include:

- *Industry/Peer Partnership* – VO-LA will regularly communicate with the Louisiana Department of Health and Hospitals, Office of Behavioral Health (DHH-OBH) – Program Integrity, the Attorney General's Medicaid Fraud Control Unit (MFCU), EQRO and other State funding agencies to ensure consistency and coordination of anti-fraud program activities. ValueOptions staff regularly reviews federal and industry reports to identify vulnerabilities for review as potential risks to VO-LA's anti-fraud program. In addition, ValueOptions staff maintains membership with industry agencies, including the Health Care Compliance Agency (HCCA) and the Association of Certified Fraud Examiners (ACFE), to attend training conferences and maintain knowledge of current fraud, waste and abuse issues.
- *Provider Communication* – VO-LA will hold provider forums/meetings specific to fraud, waste and abuse activities. Prevention and reporting policies will be discussed during site visits, including data validation audits, to ensure ongoing communication and awareness.
- *Provider Profiling and Credentialing* – All providers must be registered with the appropriate provider type and categories of service and be credentialed by ValueOptions prior to contracting.

- *Sanction Screening* – Providers will also be screened to ensure they have not been sanctioned or excluded from participation in federal programs through the Federal List of Excluded Individuals and Entities.
- *Training and Education* – VO-LA will conduct comprehensive anti-fraud training and education as a means to deter and identify fraudulent, abusive or wasteful practices that will include information on the False Claims Act and other fraud laws, fraud reporting and referral processes, and whistleblower protection, for example. It will coordinate with national staff overseeing operations to ensure consistency and accuracy of content such as company policy, pertinent laws and regulations, and reporting processes. All new employees will receive comprehensive anti-fraud training as part of their new hire orientation and annually thereafter, and to providers, vendors, and consumers through written materials, billing and documentation standards, audit processes; and regular compliance-specific meetings.
- *DHH Fraud Hotline* – VO-LA will ensure that the DHH-OBH toll-free Fraud Hotline Number (800-488-2917) is distributed to members and providers through our Member and Provider Handbooks. In addition, ValueOptions maintains an Ethics Hotline (888-293-3027) to provide all employees and others an open atmosphere to report issues surrounding fraud and abuse.
- *VO-LA Website* – Within our provider portal, ProviderConnect, we have a specific Compliance Web page to provide current events, updates and policy change information and fraud, waste and abuse reporting guidelines to providers and members.
- *McKesson/InvestiClaim* – Through the use of neural analytics and clinical alerts, the InvestiClaim module finds claims that fall within both known patterns of abuse as well as new and emerging, previously unidentified practices of billing aberrances, changing fraud patterns and practices. The application has the capability to continuously 'learn' new patterns from claims data. Rules-based reporting solutions can only find known aberrances; therefore, rules can only be written to detect what you already know or suspect. InvestiClaim's data-driven analytics, the known and unknown are detected and scores are calculated suggesting the likelihood of fraud or abuse based on the data provided. The analytic models take into consideration thousands of variables and relationships within the data while calculating the score. Because the scores represent a relative level of aberrance, it will allow VO-LA to focus in on the most highly aberrant claims and providers. In this way, Louisiana can determine the levels at which resources and capacities are optimized to existing resources. The claims and providers are scored based on 15 models, including:
  - *Procedure Repetition* identifies procedures that are repeated unusually quickly.
  - *High Dollars in a Day* looks at the total dollars paid for all procedures performed for a single date of service.
  - *High Paid Procedures* finds claims with unusually high paid amounts given the procedure and the number of units billed on the claim.
  - *Procedure Rate* identifies situations where the rate at which a code is billed is unusually high.
  - *Facility - Global Model* combines all separate focused models together in a manner that captures the correlations and interactions across all these models.
- *Claim Edits* – Our claims system has edits in place that automatically deny claims for items such as duplicate claim, unknown service, unknown or ineligible individuals and provider not eligible to provide service. The knowledge gathered (emerging patterns) through data validation audits, trend analysis and InvestiClaim will be used to design new rules/edits and close the gap on improper payments.

Audit and Detection

The Detection component of VO-LA's compliance program will include:

- *Data Mining & Trend Analysis* – InvestiClaim utilizes unsupervised neural network technology to evaluate claims, providers, and members based on simultaneous analysis of hundreds of claim, provider, and member variables. It clusters this data along a myriad of dimensions and then identifies outliers from those clusters of normal behavior. These neural models produce a risk score with explanation codes indicating how aberrant or unusual the behavior is, allowing the auditors to drill down to actionable detail and trend the data over time.
- *Data Validation Audits* – VO-LA will conduct regular claims sampling and data validation audits of contracted providers to ensure compliance with Federal and State documentation and billing requirements, as well as to monitor the providers for fraud and abuse. Internal control policies and procedures will be monitored and analyzed for inconsistencies, risk, etc. In addition, InvestiClaim will focus on the claims and providers that are most likely costing money, allowing us to respond to savings opportunities. InvestiClaim's combination of clinically-based content with deep, data-driven analytics review each claim line for both clinical appropriateness as well as thousands of data combinations. This provides a more detailed and factually based result, removing much of the guesswork and manual analysis that takes place in a rules-only system.
- *Member Surveys* – Upon request, VO-LA will contact members and conduct reviews to ensure they have received the services billed by their provider agencies.

Investigation and Resolution

The Resolution component of VO-LA's compliance program will include:

- *Internal/External Referral Process* – VO-LA will utilize several resources for gathering information related to fraud and abuse allegations including, DHH-OBH coordination, DHH and ValueOptions Ethics Hotlines, telephone referrals and direct provider and member communication.
- *Targeted Audits/Investigations* – VO-LA will conduct audits of providers identified in referrals alleging fraud and abuse, targeting the specific issues identified in the referrals, and coordinate with DHH-OBH, as required.
- *Reporting Requirements* – As required, VO-LA's compliance program will report all complaints of fraud and abuse made to the state that warrant preliminary investigation and any suspicion or knowledge of fraud and abuse to DHH-OBH. Any suspicion or knowledge of fraud and abuse including, but not limited to, the false or fraudulent filings of claims and the acceptance of or failure to return monies allowed to be paid on claims known to be fraudulent will be immediately reported to DHH-OBH. The VO-LA Compliance Administrator will submit to DHH-OBH quarterly statistical reports to detail fraud and abuse detection and sanctioning activities regarding providers. In addition, provider contracts will require providers to report any incidents of potential fraud or abuse to the Louisiana service center.
- *Investigation and Disciplinary Processes* – VO-LA will utilize tools to evaluate compliance, including, but not limited to, on-site reviews; interviews of personnel involved in management, operations, finance, and other related activities; questionnaires developed to solicit impressions of a broad cross-section of employees; internal control assessment surveys; review of financial and compliance related documents; financial, claim or record auditing; and trend analyses that seek deviations in specific areas over a period of time. Investigations will be reported to the Compliance Committee and, if applicable, to DHH-OBH as required. Any corrective action, if

applicable, will be developed for areas of non-compliance according to a corrective action protocol, to include claims reversals and Medicaid recoupment; sanctions; penalties; corrective action plans; monitoring; or other actions in coordination with DHH-OBH and other appropriate agencies.

Please see **Attachment 24** for examples related to ValueOptions' experience with implementing fraud, waste and abuse programs, audit/investigation examples, and applicable fraud, waste and abuse-specific policies and procedures. Please also see **Attachment 25** for additional information regarding the InvestiClaim solution.

a. The Proposer shall specify costs for performance of tasks. The Proposal shall include all anticipated costs of successful implementation of all deliverables outlined. An item by item breakdown of costs shall be included in the proposal, including per member per month costs associated with the covered populations.

Redacted

b. Proposers shall submit the breakdown described in Attachment IV.

The narrative above coincides with the breakdown described in Attachment IV.

The Proposer shall complete the CMS required certifications listed in the Attachments section of this RFP.

Completed certifications immediately follow this page.

CERTIFICATION STATEMENT ATTACHMENT I

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

OFFICIAL CONTACT. The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below: (Print Clearly)

Date	August 10, 2011
Official Contact Name	Anna K. Sever
Email Address	Anna.Sever@valueoptions.com
Fax Number with Area Code	(724) 864-6042
Telephone Number	(724) 864-6042
Street Address	1070 Aerie Drive
City, State, and Zip	North Huntington, PA 15642

Proposer certifies that the above information is true and grants permission to DHH-OBH to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, proposer certifies that:

1. The information contained in its response to this RFP is accurate;
2. Proposer accepts the procedures, evaluation criteria, contract terms and conditions, and all other administrative requirements set forth in this RFP.
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer's technical proposal and cost proposal are valid for at least 120 days from the date of proposer's signature below;
5. Proposer understands that if selected as the successful Proposer, he/she will have 10 business days from the date of delivery of final contract in which to complete contract negotiations, if any, and execute the final contract document
6. Proposer certifies, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the Internet at www.epls.gov).

Authorized Signature: _____
(Must be an original signature signed in ink)

Typed or Printed Name: Paul Rosenberg

Title: Secretary

Company Name: ValueOptions of Louisiana, Inc.

To be Completed Upon
Contract Award

Attachment II
DHH - CF - 1

AGREEMENT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

AND

FOR

☐ Personal Services ☐ Professional Services ☐ Consulting Services ☐ Social Services

1) **Contractor (Legal Name if Corporation)**	5) **Federal Employer Tax ID# or Social Security #** (11 digits)
2) **Street Address**	6) **Parish(es) Served**
City and State **Zip Code**	7) **License or Certification #**
3) **Telephone Number**	8) **Contractor Status**
4) **Mailing Address (if different)**	Subrecipient: ☐ Yes ☐ No Corporation: ☐ Yes ☐ No For Profit: ☐ Yes ☐ No Publicly Traded: ☐ Yes ☐ No
City and State **Zip Code**	8a) **CFDA#**(Federal Grant #)

9) **Brief Description Of Services To Be Provided:**
Include description of work to be performed and objectives to be met; description of reports or other deliverables and dates to be received (when applicable). In a consulting service, a resume of key contract personnel performing duties under the terms of the contract and amount of effort each will provide under terms of contract should be attached.

10) **Effective Date**	11) **Termination Date**

12) This contract may be terminated by either party upon giving thirty (30) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.

13) **Maximum Contract Amount**

14) **Terms of Payment**
If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility,

payments are to be made as follows: (stipulate rate or standard of payment, billing intervals, invoicing provisions, etc.). Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	**Name**	
	Title	**Phone Number**

15) **Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):**

During the performance of this agreement, the Contractor hereby agrees to the following terms and conditions:

1. Contractor hereby agrees to adhere as applicable to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services. All contracts shall contain provisions requiring Equal Employment Opportunity Provisions. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.

2. Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of DHH-OBH, confidentiality rules and facility access procedures.)

3. The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by DHH-OBH shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by DHH-OBH. Records will be made available during normal working hours.

   Contractor shall comply with federal and state laws and/or DHH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (4) copies of the audit report shall be sent to DHH-OBH of Health and Hospitals,

Attention: **Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797** and one (1) copy of the audit shall be sent to the **originating DHH Office.**

4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to DHH-OBH such records within thirty (30) days of DHH-OBH's written request and shall deliver such records to DHH-OBH's central office in Baton Rouge, Louisiana, all without expense to DHH-OBH. Contractor shall allow DHH-OBH to inspect, audit or copy records at the contractor's site, without expense to DHH-OBH.

5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or notation), without written consent of DHH-OBH thereto, provided, however, that claims for money due or to become due to Contractor from DHH-OBH under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to DHH-OBH and the Division of Administration, Office of Contractual Review.

6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds, and shall maintain, at Contractor's expense, all necessary insurance for its employees, including but not limited to automobile insurance, workers' compensation and general liability insurance.

7. In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.

8. No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.

9. Should contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.

10. All records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall, upon request, be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.

11. Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of DHH-OBH. Any subcontracts approved by DHH-OBH shall be subject to conditions and provisions as DHH-OBH may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required under this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein.

12. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by DHH-OBH. In the event DHH-OBH determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, DHH-OBH shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.

13. This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of DHH-OBH; and, if contract exceeds $20,000, the Director of the Office of Contractual Review, Division of Administration in accordance with La. R.S. 39:1502.

14. The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

15. Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of DHH-OBH; and; if contract exceeds $20,000, approved by the Director of the Office of Contractual Review, Division of Administration. Budget revisions in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

16. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals or district courts as appropriate.

17. Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, DHH-OBH shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH's name, but at Contractor's expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.

18. Any equipment purchased under this contract remains the property of the Contractor for the period of this contract and future continuing contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of $1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of DHH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an update, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to DHH-OBH. Contractor agrees to deliver any such equipment to DHH-OBH within 30 days of termination of services.

19. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor's agents, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides malpractice coverage to the contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further it does not apply to premises liability when the services are being performed on premises owned and operated by DHH.

20. Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.

21. Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

THIS AGREEMENT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS AGREEMENT IS SIGNED AND ENTERED INTO ON THE DATE INDICATED BELOW.

1 - CT BHP Call Management - Section 1, Timeliness of Telephone Access - Q1 Q2 2010 Results

Report	Q1 2010	Q2 2010	2010 YTD
1. A. Total Number of Calls	**18,626**	**16,914**	**35,540**
Provider/Auth Queues	10326	9,356	19,682
Member Queues	8224	7,487	15,711
Crisis Queues	76	71	147
1. B. Average Speed of Answer (ASA)			
Provider/Auth Queues (Standard within 30 Seconds)	0:09	0:07	0:08
Member Queues (Standard within 30 Seconds)	0:07	0:05	0:06
Crisis Queues (Standard within 15 Seconds)	0:06	0:04	0:05
1. C. Call Abandonment Rate Average (Standard 5% or less)			
Total # of Abandoned Calls	26	12	38
Total Percentage of Abandoned Calls	**0.14%**	**0.07%**	**0.11%**
1. D. Percentage of Total Calls to Call Center Answered within 30 Seconds			
Total # of Calls Answered within 30 Seconds	17159	15616	32775
Total % of Calls Answered within 30 Seconds (Standard 90%)	**93.63%**	93.67%	**93.65%**
1. E. Busy No Answer (Monitoring Indicator)			
Total Number of Busy Signals to (877) 55CTBHP	0	0	0
% Busy Signal Calls	0.00%	0.00%	0.00%
1. F. Number and Percentage of Calls placed on hold and average length of hold time			
Total Number of Clinical Services Calls placed on hold	2699	3207	5906
% of Clinical Services Calls placed on hold	26.14%	34.28%	30.01%
Average Length of Time Clinical Services Calls placed on hold (Standard 5 Minutes	0:34	0:40	0:37
1. G. Number and Percentage of calls placed on hold and average length of hold time			
Total Number of Customer Services Calls placed on hold	3552	3,639	7,191
% of Customer Services Calls placed on hold	43.19%	48.60%	45.77%
Average Length of Time Customer Services Calls placed on hold (Standard 3	0:49	0:47	0:48
Number and Percentage of calls placed on hold and average length of hold time			
Total Number of Crisis Calls placed on hold	5	9	14
% of Crisis Calls placed on hold	6.58%	12.68%	9.52%
Average Length of Time Crisis Calls placed on hold (Standard 1 Minute or Less)	0:27	0:24	0:25
1. H. Average length of time of call.			
Average Call Length Time	4:48	4:08	4:28
1. I. Network Call Rerouting (NCR) Report			
Number of Rerouting Incidents (reported separately)	0	0	0

Report Title: 999999 - 5.A Acute Inpatient High Volume Provider
Report by Region

Report Period: 2010
Run Date: 01/15/2011

List the top 10 facilities for each reporting period by total number of admissions (cases), by approved number of days authorized, average length of stay (ALOS) per case and units denied. Report is broken out by Region then Provider.

	JAN	FEB	MAR	Q1	APR	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	YTD
STATEWIDE																	
Cases	50	45	10	105	43	34	21	98	54	33	21	108	21	35	43	99	410
Days	200	150	100	450	180	130	50	360	250	100	78	428	300	120	75	495	1733
ALOS	4.0	3.3	10.0	4.3	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.2
Units Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
REGION 1																	
PROVIDER 1																	
Cases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
Days	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
ALOS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
Units Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
PROVIDER 2																	
Cases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
Days	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
ALOS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
Units Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
PROVIDER 3																	
Cases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
Days	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
ALOS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
Units Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
PROVIDER 4																	
Cases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
Days	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
ALOS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
Units Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
PROVIDER 5																	
Cases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
Days	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
ALOS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
Units Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317

eport Title: **999999 - 5.A Acute Inpatient High Volume Provider**
Report by Region

List the top 10 facilities for each reporting pe..od by total number of admissions (cases), by approved number of days authorized, average length of stay (ALOS) per case and units denied. Report is broken out by Region then Provider.

port Period: 2010
in Date: 01/15/2011

	JAN	FEB	MAR	Q1	APR	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	YTD
TATEWIDE																	
ases	50	45	10	105	43	34	21	98	54	33	21	108	21	35	43	99	410
ays	200	150	100	450	180	130	50	360	250	100	78	428	300	120	75	495	1733
.OS	4.0	3.3	10.0	4.3	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.2
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
EGION 1																	
ROVIDER 1																	
ases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ays	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
.OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 2																	
ases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ays	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
.OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 3																	
ases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ays	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
.OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 4																	
ases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ays	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
.OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 5																	
ases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ays	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
.OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317

port Title: 999999 - 5.A Acute Inpatient High Volume Provider
Report by Region

List the top 10 facilities for each reporting period by total number of admissions (cases), by approved number of days authorized, average length of stay (ALOS) per case and units denied. Report is broken out by Region then Provider.

ort Period: 2010
Date: 01/15/2011

	JAN	FEB	MAR	Q1	APR	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	YTD
OVIDER 6																	
ses	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ys	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
ts Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
OVIDER 7																	
ses	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ys	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
ts Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
OVIDER 8																	
ses	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ys	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
ts Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
OVIDER 9																	
es	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
s	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
s Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
OVIDER 10																	
es	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
s	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
S	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
s Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317

eport Title: **999999 - 5.A Acute Inpatient High Volume Provider Report by Region**

List the top 10 facilities for each reporting pe..od by total number of admissions (cases), by approved number of days authorized, average length of stay (ALOS) per case and units denied. Report is broken out by Region then Provider.

port Period: 2010
in Date: 01/15/2011

	JAN	FEB	MAR	Q1	APR	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	YTD
EGION 2																	
TATEWIDE																	
ases	50	45	10	105	43	34	21	98	54	33	21	108	21	35	43	99	410
ays	200	150	100	450	180	130	50	360	250	100	78	428	300	120	75	495	1733
.OS	4.0	3.3	10.0	4.3	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.2
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 1																	
ases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ays	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
.OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 2																	
ases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ays	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
.OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 3																	
ases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ays	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
.OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 4																	
ses	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ys	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
its Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
'OVIDER 5																	
ses	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ys	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
ts Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317

port Title: 999999 - 5.A Acute Inpatient High Volume Provider
Report by Region

ort Period: 2010
Date: 01/15/2011

List the top 10 facilities for each reporting period by total number of admissions (cases), by approved number of days authorized, average length of stay (ALOS) per case and units denied. Report is broken out by Region then Provider.

	JAN	FEB	MAR	Q1	APR	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	YTD
OVIDER 6																	
ies	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
's	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
)S	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
s Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
OVIDER 7																	
es	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
s	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
)S	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
s Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
OVIDER 8																	
es	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
s	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
)S	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
s Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
OVIDER 9																	
es	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
s	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
'S	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
s Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
OVIDER 10																	
es	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
s	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
S	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
s Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317

eport Title: **999999 - 5.A Acute Inpatient High Volume Provider Report by Region**

List the top 10 facilities for each reporting pe..od by total number of admissions (cases), by approved number of days authorized, average length of stay (ALOS) per case and units denied. Report is broken out by Region then Provider.

port Period: 2010
in Date: 01/15/2011

	JAN	FEB	MAR	Q1	APR	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	YTD
EGION 3																	
TATEWIDE																	
ases	50	45	10	105	43	34	21	98	54	33	21	108	21	35	43	99	410
ays	200	150	100	450	180	130	50	360	250	100	78	428	300	120	75	495	1733
.OS	4.0	3.3	10.0	4.3	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.2
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 1																	
ases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ays	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
.OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 2																	
ases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ays	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
.OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 3																	
ases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ays	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
.OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 4																	
ases	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ays	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
.OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
iits Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
ROVIDER 5																	
ses	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
ys	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
OS	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
its Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317

port Title: 999999 - 5.A Acute Inpatient High Volume Provider
Report by Region

List the top 10 facilities for each reporting period by total number of admissions (cases), by approved number of days authorized, average length of stay (ALOS) per case and units denied. Report is broken out by Region then Provider.

ort Period: 2010
Date: 01/15/2011

	JAN	FEB	MAR	Q1	APR	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	YTD
OVIDER 6																	
es	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
s	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
)S	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
s Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
OVIDER 7																	
es	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
s	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
)S	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
s Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
OVIDER 8																	
es	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
s	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
)S	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
s Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
OVIDER 9																	
es	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
s	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
S	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
s Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317
OVIDER 10																	
es	5	45	10	60	43	34	21	98	54	33	21	108	21	35	43	99	365
s	20	150	100	270	180	130	50	360	250	100	78	428	300	120	75	495	1553
S	4.0	3.3	10.0	4.5	4.2	3.8	2.4	3.7	4.6	3.0	3.7	4.0	14.3	3.4	1.7	5.0	4.3
s Denied	34	55	65	154	21	12	0	33	30	23	43	96	21	13	0	34	317

Report Title: 6. Consistency of UM Decision Making (Survey Scores - Individual Summary)

Service Center: Connecticut **Survey Name:** Corporate Inter-Rater Reliability Assessment **Survey**

Schedule: From 12/1/2009 **to** 1/7/2010

Report Description/Data Source

A report informing the Clinical Director at a service center the scores for individuals on a survey.

Table(s): IRR, IRR Answers, IRR Code

Name	License	Service Center	Department	Unit	Date of Assessment	Correct Answers	Percent Correct
Connecticut							
Staff 1	Counselor	Connecticut	Clinical	ICM	12/12/2009	19	95.00%
Staff 2	Counselor	Connecticut	Clinical	ICM	12/17/2009	20	100.00%
Staff 3	Social Worker	Connecticut	Clinical	Other	12/11/2009	18	90.00%
Staff 4	Other	Connecticut	Clinical	ICM	12/17/2009	18	90.00%
Staff 5	Psychologist	Connecticut	Clinical	IP/ALOC	12/5/2009	19	95.00%
Staff 6	Counselor	Connecticut	Clinical	Other	12/16/2009	19	95.00%
Staff 7	MD	Connecticut	Clinical	MD	12/17/2009	19	95.00%
Staff 8	Counselor	Connecticut	Clinical	Other	12/5/2009	19	95.00%
Staff 9	Counselor	Connecticut	Clinical	ICM	12/16/2009	19	95.00%
Staff 10	Counselor	Connecticut	Clinical	Other	12/4/2009	16	80.00%
Staff 11	MD	Connecticut	Clinical	MD	12/22/2009	20	100.00%
Staff 12	Social Worker	Connecticut	Clinical	Other	12/15/2009	17	85.00%
Staff 13	Social Worker	Connecticut	Clinical	ICM	12/12/2009	19	95.00%
Staff 14	Social Worker	Connecticut	Clinical	Other	12/3/2009	16	80.00%
Staff 15	Social Worker	Connecticut	Clinical	ICM	12/16/2009	18	90.00%
Staff 16	Social Worker	Connecticut	Clinical	IP/ALOC	12/4/2009	20	100.00%
Staff 17	Social Worker	Connecticut	Clinical	ICM	12/10/2009	17	85.00%
Staff 18	Other	Connecticut	Clinical	Other	12/15/2009	16	80.00%
Staff 19	Counselor	Connecticut	Clinical	Other	12/12/2009	18	90.00%
Staff 20	Counselor	Connecticut	Clinical	ICM	12/11/2009	20	100.00%

16A-Total Medical Necessity Denials by LOC Q2 '10

Total NOA/Denial by LOC	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Total
23 Hour Observation	2	0	1	0	0	0	0	0	0	0	0	0	3
HBS (II CAPS)	0	0	0	0	0	1	0	0	0	0	0	0	1
Inpatient Detox	1	0	1	1	0	3	0	0	0	0	0	0	6
Inpatient Psychiatric	4	1	6	7	7	7	0	0	0	0	0	0	32
Intensive Outpatient	1	1	1	2	1	3	0	0	0	0	0	0	9
Residential Rehab	1	0	1	2	0	0	0	0	0	0	0	0	4
Residential Treatment Center	0	0	0	0	0	2	0	0	0	0	0	0	2
Totals	**9**	**2**	**10**	**12**	**8**	**16**	**0**	**0**	**0**	**0**	**0**	**0**	**57**

Quarterly Totals			21			36			0			0	

CONNECTICUT
Behavioral Health Partnership

16A-Total Medical Necessity Denials by Adult Q2 '10

Adult Medical Necessity Denials	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Total
23 Hour Observation	1	0	0	0	0	0	0	0	0	0	0	0	1
Inpatient Detox	1	0	1	1	0	3	0	0	0	0	0	0	6
Inpatient Psychiatric	1	0	1	0	0	1	0	0	0	0	0	0	3
Intensive Outpatient	0	1	1	2	1	2	0	0	0	0	0	0	7
Residential Rehab	1	0	1	2	0	0	0	0	0	0	0	0	4
Totals	**4**	**1**	**4**	**5**	**1**	**6**	**0**	**0**	**0**	**0**	**0**	**0**	**21**

Quarterly Totals

9	12	0	0

CONNECTICUT
Behavioral Health Partnership

16A-Total Youth Administrative Denials by LOC Q2 '10

Child Administrative Denials	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Total
23 Hour Observation	0	0	1	0	1	0	0	0	0	0	0	0	2
Case Management	0	0	1	0	1	0	0	0	0	0	0	0	2
Extended Day Treatment	2	2	3	4	2	1	0	0	0	0	0	0	14
Family Support Teams	0	0	0	1	1	0	0	0	0	0	0	0	2
Functional Family Therapy	4	0	0	1	0	0	0	0	0	0	0	0	5
Group Home 1.0	0	0	0	0	1	0	0	0	0	0	0	0	1
Group Home 1.5	1	0	0	0	2	0	0	0	0	0	0	0	3
HBS (II CAPS)	8	8	4	5	1	4	0	0	0	0	0	0	30
Inpatient Detox	0	0	0	0	1	0	0	0	0	0	0	0	1
Inpatient Medical	1	0	0	0	2	4	0	0	0	0	0	0	7
Inpatient Psychiatric	21	5	17	18	10	5	0	0	0	0	0	0	76
Intensive Outpatient	5	11	8	6	4	3	0	0	0	0	0	0	37
Multi-Dimensional Family Therapy	2	3	2	3	0	0	0	0	0	0	0	0	10
Multi-Systemic Therapy	1	0	0	3	0	0	0	0	0	0	0	0	4
Outpatient	26	31	49	49	63	46	0	0	0	0	0	0	264
Partial Hospitalization	1	4	1	3	2	1	0	0	0	0	0	0	12
Psychiatric Residential Treatment Facility	0	6	0	0	1	1	0	0	0	0	0	0	8
Residential Treatment Center	1	0	0	2	2	4	0	0	0	0	0	0	9
Totals	73	70	86	95	94	69	0	0	0	0	0	0	487

Quarterly Totals	229	258	0	0

CONNECTICUT
Behavioral Health Partnership

16B-Total Medical Necessity Denials by Adult Q2 '10

Adult Medical Necessity Denials	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Total
23 Hour Observation	1	0	0	0	0	0	0	0	0	0	0	0	1
Inpatient Detox	1	0	1	1	0	3	0	0	0	0	0	0	6
Inpatient Psychiatric	1	0	1	0	0	1	0	0	0	0	0	0	3
Intensive Outpatient	0	1	1	2	1	2	0	0	0	0	0	0	7
Residential Rehab	1	0	1	2	0	0	0	0	0	0	0	0	4
Totals	**4**	**1**	**4**	**5**	**1**	**6**	**0**	**0**	**0**	**0**	**0**	**0**	**21**

Quarterly Totals				
	9	12	0	0

16C-Total Youth Administrative Denials by LOC Q2 '10

Child Administrative Denials	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Total
23 Hour Observation	0	0	1	0	1	0	0	0	0	0	0	0	2
Case Management	0	0	1	0	1	0	0	0	0	0	0	0	2
Extended Day Treatment	2	2	3	4	2	1	0	0	0	0	0	0	14
Family Support Teams	0	0	0	1	1	0	0	0	0	0	0	0	2
Functional Family Therapy	4	0	0	1	0	0	0	0	0	0	0	0	5
Group Home 1.0	0	0	0	0	1	0	0	0	0	0	0	0	1
Group Home 1.5	1	0	0	0	2	0	0	0	0	0	0	0	3
HBS (II CAPS)	8	8	4	5	1	4	0	0	0	0	0	0	30
Inpatient Detox	0	0	0	0	1	0	0	0	0	0	0	0	1
Inpatient Medical	1	0	0	0	2	4	0	0	0	0	0	0	7
Inpatient Psychiatric	21	5	17	18	10	5	0	0	0	0	0	0	76
Intensive Outpatient	5	11	8	6	4	3	0	0	0	0	0	0	37
Multi-Dimensional Family Therapy	2	3	2	3	0	0	0	0	0	0	0	0	10
Multi-Systemic Therapy	1	0	0	3	0	0	0	0	0	0	0	0	4
Outpatient	26	31	49	49	63	46	0	0	0	0	0	0	264
Partial Hospitalization	1	4	1	3	2	1	0	0	0	0	0	0	12
Psychiatric Residential Treatment Facility	0	6	0	0	1	1	0	0	0	0	0	0	8
Residential Treatment Center	1	0	0	2	2	4	0	0	0	0	0	0	9
Totals	73	70	86	95	94	69	0	0	0	0	0	0	487

Quarterly Totals			229			258			0			0	

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH07034 - Routine Outpatient (OTP) Registration Dashboard (18-A)

Report Date: QTR 2 2010

Report Description

Quarterly metrics on specific question selection on the Service Registration Form for only routine outpatient services (OTP). Selections are counted based on the beginning date of requested services.

Data source(s): RPT_CTBH08000, SP_CTBH07034A

	FREE STANDING CLINICS						HOSPITALS						INDEPENDENT PRACTITIONERS						TOTALS					
	Child		Adult		Total		Child		Adult		Total		Child		Adult		Total		Child		Adult		Total	
Question/Selection	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.
	3819	61.3	2412	38.7	6231	56.8	212	29.9	497	70.1	709	6.5	1877	46.5	2162	53.5	4039	36.8	5908	53.8	5071	46.2	10979	100.0
Referral Source																								
Self/Family Member	1895	49.6	1156	47.9	3051	49.0	126	59.4	318	64.0	444	62.6	1337	71.2	1618	74.8	2955	73.2	3358	56.8	3092	61.0	6450	58.7
PCP/Medical Provider	331	8.7	277	11.5	608	9.8	41	19.3	68	13.7	109	15.4	201	10.7	194	9.0	395	9.8	573	9.7	539	10.6	1112	10.1
Stp Dwn Intermed LOC	47	1.2	27	1.1	74	1.2	11	5.2	26	5.2	37	5.2	5	0.3	15	0.7	20	0.5	63	1.1	68	1.3	131	1.2
Step Down Inpt LOC	18	0.5	19	0.8	37	0.6	5	2.4	17	3.4	22	3.1	4	0.2	10	0.5	14	0.3	27	0.5	46	0.9	73	0.7
Other BH Provider	186	4.9	80	3.3	266	4.3	15	7.1	19	3.8	34	4.8	115	6.1	165	7.6	280	6.9	316	5.3	264	5.2	580	5.3
School	410	10.7	4	0.2	414	6.6	3	1.4	0	0.0	3	0.4	42	2.2	5	0.2	47	1.2	455	7.7	9	0.2	464	4.2
Comm. Collaborative	21	0.5	1	0.0	22	0.4	1	0.5	0	0.0	1	0.1	2	0.1	4	0.2	6	0.1	24	0.4	5	0.1	29	0.3
CT BHP ASO	4	0.1	0	0.0	4	0.1	0	0.0	0	0.0	0	0.0	11	0.6	35	1.6	46	1.1	15	0.3	35	0.7	50	0.5
DCF	396	10.4	366	15.2	762	12.2	5	2.4	9	1.8	14	2.0	90	4.8	45	2.1	135	3.3	491	8.3	420	8.3	911	8.3
DMHAS	5	0.1	5	0.2	10	0.2	0	0.0	4	0.8	4	0.6	0	0.0	0	0.0	0	0.0	5	0.1	9	0.2	14	0.1
Hospital Emergency Dept.	26	0.7	11	0.5	37	0.6	2	0.9	5	1.0	7	1.0	1	0.1	4	0.2	5	0.1	29	0.5	20	0.4	49	0.4
Managed Service System	1	0.0	4	0.2	5	0.1	0	0.0	0	0.0	0	0.0	4	0.2	9	0.4	13	0.3	5	0.1	13	0.3	18	0.2
Court-Ordered	126	3.3	210	8.7	336	5.4	1	0.5	15	3.0	16	2.3	11	0.6	17	0.8	28	0.7	138	2.3	242	4.8	380	3.5
Other Legal	114	3.0	176	7.3	290	4.7	0	0.0	5	1.0	5	0.7	27	1.4	3	0.1	30	0.7	141	2.4	184	3.6	325	3.0
Other	239	6.3	76	3.2	315	5.1	2	0.9	11	2.2	13	1.8	27	1.4	38	1.8	65	1.6	268	4.5	125	2.5	393	3.6
Screening Type																								
Walk-in	644	16.9	876	36.3	1520	24.4	33	15.6	83	16.7	116	16.4	511	27.2	579	26.8	1090	27.0	1188	20.1	1538	30.3	2726	24.8
Telephone	3174	83.1	1536	63.7	4710	75.6	179	84.4	414	83.3	593	83.6	1366	72.8	1583	73.2	2949	73.0	4719	79.9	3533	69.7	8252	75.2
No Selection	1	0.0	0	0.0	1	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.0	0	0.0	1	0.0
Referral Type																								
Routine	3562	93.3	2352	97.5	5914	94.9	207	97.6	486	97.8	693	97.7	1788	95.3	2101	97.2	3889	96.3	5557	94.1	4939	97.4	10496	95.6
Urgent	190	5.0	50	2.1	240	3.9	4	1.9	11	2.2	15	2.1	83	4.4	57	2.6	140	3.5	277	4.7	118	2.3	395	3.6
Emergent	67	1.8	10	0.4	77	1.2	1	0.5	0	0.0	1	0.1	6	0.3	4	0.2	10	0.2	74	1.3	14	0.3	88	0.8
BH Treatment Past 6 Months																								
Mental Health	1042	27.3	611	25.3	1653	26.5	85	40.1	212	42.7	297	41.9	746	39.7	825	38.2	1571	38.9	1873	31.7	1648	32.5	3521	32.1
Substance Abuse	74	1.9	346	14.3	420	6.7	2	0.9	50	10.1	52	7.3	8	0.4	116	5.4	124	3.1	84	1.4	512	10.1	596	5.4
NA	2741	71.8	1617	67.0	4358	69.9	129	60.8	263	52.9	392	55.3	1134	60.4	1297	60.0	2431	60.2	4004	67.8	3177	62.7	7181	65.4
Family/Significant Other Involved in Member Tx Plan																								
Yes	2661	69.7	321	13.3	2982	47.9	137	64.6	59	11.9	196	27.6	1471	78.4	711	32.9	2182	54.0	4269	72.3	1091	21.5	5360	48.8
No	825	21.6	1708	70.8	2533	40.7	26	12.3	259	52.1	285	40.2	262	14.0	1058	48.9	1320	32.7	1113	18.8	3025	59.7	4138	37.7
NA	333	8.7	383	15.9	716	11.5	49	23.1	179	36.0	228	32.2	144	7.7	393	18.2	537	13.3	526	8.9	955	18.8	1481	13.5

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH07034 - Routine Outpatient (OTP) Registration Dashboard (18-A)

Report Date: QTR 2 2010

Report Description

Quarterly metrics on specific question selection on the Service Registration Form for only routine outpatient services (OTP). Selections are counted based on the beginning date of requested services.

Data source(s): RPT_CTBH08000, SP_CTBH07034A

Question/Selection	FREE STANDING CLINICS						HOSPITALS						INDEPENDENT PRACTITIONERS						TOTALS					
	Child		Adult		Total		Child		Adult		Total		Child		Adult		Total		Child		Adult		Total	
	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.
	3819	61.3	2412	38.7	6231	56.8	212	29.9	497	70.1	709	6.5	1877	46.5	2162	53.5	4039	36.8	5908	53.8	5071	46.2	10979	100.0
Family/Significant Other Receiving Own MH/SA Tx																								
Yes	733	19.2	139	5.8	872	14.0	28	13.2	30	6.0	58	8.2	550	29.3	335	15.5	885	21.9	1311	22.2	504	9.9	1815	16.5
No	2366	62.0	1070	44.4	3436	55.1	139	65.6	283	56.9	422	59.5	1126	60.0	1115	51.6	2241	55.5	3631	61.5	2468	48.7	6099	55.6
No Selection	720	18.9	1203	49.9	1923	30.9	45	21.2	184	37.0	229	32.3	201	10.7	712	32.9	913	22.6	966	16.4	2099	41.4	3065	27.9
Obtained Consent to Contact School																								
Yes	2666	69.8	33	1.4	2699	43.3	125	59.0	3	0.6	128	18.1	1100	58.6	89	4.1	1189	29.4	3891	65.9	125	2.5	4016	36.6
No	1059	27.7	2336	96.8	3395	54.5	78	36.8	417	83.9	495	69.8	745	39.7	2034	94.1	2779	68.8	1882	31.9	4787	94.4	6669	60.7
Denied	94	2.5	43	1.8	137	2.2	9	4.2	77	15.5	86	12.1	32	1.7	39	1.8	71	1.8	135	2.3	159	3.1	294	2.7
Obtained Consent to Contact Medical Provider																								
Yes	2490	65.2	617	25.6	3107	49.9	181	85.4	202	40.6	383	54.0	1158	61.7	976	45.1	2134	52.8	3829	64.8	1795	35.4	5624	51.2
No	1296	33.9	1749	72.5	3045	48.9	28	13.2	218	43.9	246	34.7	691	36.8	1147	53.1	1838	45.5	2015	34.1	3114	61.4	5129	46.7
Denied	33	0.9	46	1.9	79	1.3	3	1.4	77	15.5	80	11.3	28	1.5	39	1.8	67	1.7	64	1.1	162	3.2	226	2.1
Obtained Consent to Contact Prev BH Tx Prov																								
Yes	888	23.3	488	20.2	1376	22.1	73	34.4	107	21.5	180	25.4	593	31.6	533	24.7	1126	27.9	1554	26.3	1128	22.2	2682	24.4
No	974	25.5	1031	42.7	2005	32.2	8	3.8	79	15.9	87	12.3	335	17.8	512	23.7	847	21.0	1317	22.3	1622	32.0	2939	26.8
Denied	45	1.2	29	1.2	74	1.2	0	0.0	2	0.4	2	0.3	19	1.0	26	1.2	45	1.1	64	1.1	57	1.1	121	1.1
NA	1912	50.1	864	35.8	2776	44.6	131	61.8	309	62.2	440	62.1	930	49.5	1089	50.4	2019	50.0	2973	50.3	2262	44.6	5235	47.7
No Selection	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	0.1	2	0.0	0	0.0	2	0.0	2	0.0
Obtained Consent to Contact BH Tx Prov for Family/Significant Other																								
Yes	234	6.1	88	3.6	322	5.2	28	13.2	17	3.4	45	6.3	366	19.5	234	10.8	600	14.9	628	10.6	339	6.7	967	8.8
No	1215	31.8	1138	47.2	2353	37.8	24	11.3	111	22.3	135	19.0	399	21.3	497	23.0	896	22.2	1638	27.7	1746	34.4	3384	30.8
Denied	60	1.6	22	0.9	82	1.3	1	0.5	4	0.8	5	0.7	23	1.2	17	0.8	40	1.0	84	1.4	43	0.8	127	1.2
NA	2310	60.5	1164	48.3	3474	55.8	159	75.0	365	73.4	524	73.9	1089	58.0	1414	65.4	2503	62.0	3558	60.2	2943	58.0	6501	59.2
Who is Lead Case Management Prov																								
DCF Case Worker	655	17.2	323	13.4	978	15.7	17	8.0	15	3.0	32	4.5	149	7.9	84	3.9	233	5.8	821	13.9	422	8.3	1243	11.3
DCF Enhanced Care Coord	22	0.6	29	1.2	51	0.8	1	0.5	0	0.0	1	0.1	0	0.0	2	0.1	2	0.0	23	0.4	31	0.6	54	0.5
DMHAS (Sys. of Care/Collab	33	0.9	53	2.2	86	1.4	1	0.5	3	0.6	4	0.6	11	0.6	7	0.3	18	0.4	45	0.8	63	1.2	108	1.0
DMHAS Case Manager	9	0.2	4	0.2	13	0.2	2	0.9	9	1.8	11	1.6	0	0.0	4	0.2	4	0.1	11	0.2	17	0.3	28	0.3
DMHAS CM Provider	3099	81.1	2003	83.0	5102	81.9	191	90.1	470	94.6	661	93.2	1717	91.5	2065	95.5	3782	93.6	5007	84.7	4538	89.5	9545	86.9
No Selection	1	0.0	0	0.0	1	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.0	0	0.0	16 1	0.0

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH07034 - Routine Outpatient (OTP) Registration Dashboard (18-A)

Report Date: QTR 2 2010

Report Description

Quarterly metrics on specific question selection on the Service Registration Form for only routine outpatient services (OTP). Selections are counted based on the beginning date of requested services.

Data source(s): RPT_CTBH08000, SP_CTBH07034A

	FREE STANDING CLINICS						HOSPITALS						INDEPENDENT PRACTITIONERS						TOTALS					
	Child		Adult		Total		Child		Adult		Total		Child		Adult		Total		Child		Adult		Total	
Question/Selection	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.
	3819	61.3	2412	38.7	6231	56.8	212	29.9	497	70.1	709	6.5	1877	46.5	2162	53.5	4039	36.8	5908	53.8	5071	46.2	10979	100.0
Member Currently Taking Psych. Meds																								
Yes	805	21.1	763	31.6	1568	25.2	82	38.7	265	53.3	347	48.9	591	31.5	986	45.6	1577	39.0	1478	25.0	2014	39.7	3492	31.8
No	3014	78.9	1649	68.4	4663	74.8	130	61.3	232	46.7	362	51.1	1286	68.5	1176	54.4	2462	61.0	4430	75.0	3057	60.3	7487	68.2
Is Psych. Med Eval or Visit Indicated																								
Yes	1497	39.2	1328	55.1	2825	45.3	157	74.1	343	69.0	500	70.5	798	42.5	1163	53.8	1961	48.6	2452	41.5	2834	55.9	5286	48.1
No	2322	60.8	1084	44.9	3406	54.7	55	25.9	154	31.0	209	29.5	1079	57.5	999	46.2	2078	51.4	3456	58.5	2237	44.1	5693	51.9
Co-ocurring MH and SA Condition																								
Yes	213	5.6	696	28.9	909	14.6	10	4.7	89	17.9	99	14.0	67	3.6	315	14.6	382	9.5	290	4.9	1100	21.7	1390	12.7
No	3327	87.1	1472	61.0	4799	77.0	163	76.9	329	66.2	492	69.4	1681	89.6	1675	77.5	3356	83.1	5171	87.5	3476	68.5	8647	78.8
Not Assessed	279	7.3	244	10.1	523	8.4	39	18.4	79	15.9	118	16.6	129	6.9	172	8.0	301	7.5	447	7.6	495	9.8	942	8.6
Member Involved in Legal System																								
Juvenile Justice	165	4.3	7	0.3	172	2.8	2	0.9	1	0.2	3	0.4	62	3.3	12	0.6	74	1.8	229	3.9	20	0.4	249	2.3
Probation	215	5.6	369	15.3	584	9.4	6	2.8	14	2.8	20	2.8	28	1.5	41	1.9	69	1.7	249	4.2	424	8.4	673	6.1
Parole	12	0.3	17	0.7	29	0.5	0	0.0	1	0.2	1	0.1	0	0.0	4	0.2	4	0.1	12	0.2	22	0.4	34	0.3
Other Court	169	4.4	441	18.3	610	9.8	4	1.9	48	9.7	52	7.3	63	3.4	175	8.1	238	5.9	236	4.0	664	13.1	900	8.2
None Identified	3292	86.2	1593	66.0	4885	78.4	200	94.3	435	87.5	635	89.6	1736	92.5	1940	89.7	3676	91.0	5228	88.5	3968	78.2	9196	83.8
Information Regarding Peer Support or Self-Help																								
Yes	1970	51.6	1707	70.8	3677	59.0	134	63.2	386	77.7	520	73.3	1073	57.2	1336	61.8	2409	59.6	3177	53.8	3429	67.6	6606	60.2
No	1849	48.4	705	29.2	2554	41.0	78	36.8	111	22.3	189	26.7	804	42.8	826	38.2	1630	40.4	2731	46.2	1642	32.4	4373	39.8

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH07034 - Outpatient (MET) Registration Dashboard (18-B)

Report Date: QTR 2 2010

Report Description

Quarterly metrics on specific question selection on the Service Registration Form for methadone maintenance outpatient services (MET). Selections are counted based on the beginning date of requested services.

Data source(s): RPT_CTBH05000, SP_CTBH07034B

Question/Selection	METHADONE MAINTENANCE CLINICS					
	Child		Adult		Total	
	Count	Pct.	Count	Pct.	Count	Pct.
	3	1.3	234	98.7	237	100.0
Member Currently Maintained on Met						
Yes	3	100.0	205	87.6	208	87.8
No	0	0.0	29	12.4	29	12.2
How Long Recv. Met. Services						
6 months or less	3	100.0	108	46.2	111	46.8
7 months - 1 year	0	0.0	26	11.1	26	11.0
1-3 years	0	0.0	52	22.2	52	21.9
3-5 years	0	0.0	18	7.7	18	7.6
5 years or longer	0	0.0	11	4.7	11	4.6
No Selection	0	0.0	19	8.1	19	8.0
Duration of Opioid Use						
Less than one year	0	0.0	12	5.1	12	5.1
1-3 years	1	33.3	32	13.7	33	13.9
3-5 years	0	0.0	17	7.3	17	7.2
5 years or longer	0	0.0	14	6.0	14	5.9
No Selection	2	66.7	159	67.9	161	67.9
Other Services in TX Plan						
OP Therapy	1	33.3	118	50.4	119	50.2
Comm. Supp (NA/AA)	2	66.7	189	80.8	191	80.6
IOP/PHP	0	0.0	18	7.7	18	7.6
PCP/MD Follow-up	1	33.3	73	31.2	74	31.2
Other Behav Hlth Svcs	0	0.0	50	21.4	50	21.1
Ultimate Treatment Goal						
Methadone Maintenance	3	100.0	208	88.9	211	89.0
Abstinence	0	0.0	26	11.1	26	11.0
Referral Source						
Self/Family Member	2	66.7	220	94.0	222	93.7
PCP/Medical Provider	1	33.3	1	0.4	2	0.8
Other BH Provider	0	0.0	10	4.3	10	4.2
Court-Ordered	0	0.0	1	0.4	1	0.4
Other	0	0.0	2	0.9	2	0.8
Screening Type						
Walk-in	2	66.7	191	81.6	193	81.4
Telephone	1	33.3	43	18.4	44	18.6
Referral Type						
Routine	2	66.7	218	93.2	220	92.8
Urgent	1	33.3	15	6.4	16	6.8
Emergent	0	0.0	1	0.4	1	0.4
BH Treatment Past 6 Months						
Mental Health	0	0.0	30	12.8	30	12.7
Substance Abuse	0	0.0	145	62.0	145	61.2
NA	3	100.0	83	35.5	86	36.3
Family/Significant Other Involved in Member Tx Plan						
Yes	2	66.7	78	33.3	80	33.8
No	1	33.3	126	53.8	127	53.6
NA	0	0.0	30	12.8	30	12.7

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH07034 - Outpatient (MET) Registration Dashboard (18-B)

Report Date: QTR 2 2010

Report Description
Quarterly metrics on specific question selection on the Service Registration Form for methadone maintenance outpatient services (MET). Selections are counted based on the beginning date of requested services.
Data source(s): RPT_CTBH08000, SP_CTBH07034B

	METHADONE MAINTENANCE CLINICS					
	Child		Adult		Total	
Question/Selection	Count	Pct.	Count	Pct.	Count	Pct.
	3	1.3	234	98.7	237	100.0
Family/Significant Other Receiving Own MH/SA Tx						
Yes	1	33.3	40	17.1	41	17.3
No	1	33.3	130	55.6	131	55.3
No Selection	1	33.3	64	27.4	65	27.4
Obtained Consent to Contact School						
Yes	0	0.0	3	1.3	3	1.3
No	3	100.0	224	95.7	227	95.8
Denied	0	0.0	7	3.0	7	3.0
Obtained Consent to Contact Medical Provider						
Yes	0	0.0	108	46.2	108	45.6
No	3	100.0	124	53.0	127	53.6
Denied	0	0.0	2	0.9	2	0.8
Obtained Consent to Contact Prev BH Tx Prov						
Yes	1	33.3	96	41.0	97	40.9
No	1	33.3	77	32.9	78	32.9
Denied	0	0.0	2	0.9	2	0.8
N/A	1	33.3	59	25.2	60	25.3
Obtained Consent to Contact BH Tx Prov for Family/Significant Other						
Yes	1	33.3	31	13.2	32	13.5
No	0	0.0	90	38.5	90	38.0
Denied	0	0.0	2	0.9	2	0.8
N/A	2	66.7	111	47.4	113	47.7
Who is Lead Case Management Prov						
DCF Case Worker	1	33.3	3	1.3	4	1.7
No CM Provider	2	66.7	231	98.7	233	98.3
Member Currently Taking Psych. Meds						
Yes	0	0.0	40	17.1	40	16.9
No	3	100.0	194	82.9	197	83.1
Is Psych. Med Eval or Visit Indicated						
Yes	1	33.3	39	16.7	40	16.9
No	2	66.7	195	83.3	197	83.1
Co-ocurring MH and SA Condition						
Yes	0	0.0	62	26.5	62	26.2
No	0	0.0	132	56.4	132	55.7
Not Assessed	3	100.0	40	17.1	43	18.1
Member Involved in Legal System						
Probation	0	0.0	23	9.8	23	9.7
Parole	0	0.0	1	0.4	1	0.4
Other Court	1	33.3	12	5.1	13	5.5
None Identified	2	66.7	198	84.6	200	84.4

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH07034 - Outpatient (MET) Registration Dashboard (18-B)

Report Date: QTR 2 2010

Report Description

Quarterly metrics on specific question selection on the Service Registration Form for methadone maintenance outpatient services (MET). Selections are counted based on the beginning date of requested services.

Data source(s): RPT_CTBH08000, SP_CTBH07034B

	METHADONE MAINTENANCE CLINICS					
	Child		Adult		Total	
Question/Selection	Count	Pct.	Count	Pct.	Count	Pct.
	3	1.3	234	98.7	237	100.0
Information Regarding Peer Support or Self-Help						
Yes	3	100.0	226	96.6	229	96.6
No	0	0.0	8	3.4	8	3.4

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH07034 - Outpatient (AMD) Registration Dashboard (18-C)

Report Date: QTR 2 2010

Report Description

Quarterly metrics on specific question selection on the Service Registration Form for ambulatory detox outpatient services (AMD). Selections are counted based on the beginning date of requested services.

Data source(s): RPT_CTBH08000, SP_CTBH07034C

	FREE STANDING CLINICS						HOSPITALS						TOTALS					
	Child		Adult		Total		Child		Adult		Total		Child		Adult		Total	
Question/Selection	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.
	3	7.0	40	93.0	43	100.0	0	0.0	0	0.0	0	0.0	3	7.0	40	93.0	43	100.0
Substance Need of Detoxification																		
Opiates	3	100.0	40	100.0	43	100.0	0	0.0	0	0.0	0	0.0	3	100.0	40	100.0	43	100.0
Cocaine	0	0.0	2	5.0	2	4.7	0	0.0	0	0.0	0	0.0	0	0.0	2	5.0	2	4.7
Previous Detox in Past Year																		
Yes	0	0.0	15	37.5	15	34.9	0	0.0	0	0.0	0	0.0	0	0.0	15	37.5	15	34.9
No	3	100.0	25	62.5	28	65.1	0	0.0	0	0.0	0	0.0	3	100.0	25	62.5	28	65.1
Number of Detoxes Past Year																		
1	0	0.0	16	40.0	16	37.2	0	0.0	0	0.0	0	0.0	0	0.0	16	40.0	16	37.2
No Selection	3	100.0	24	60.0	27	62.8	0	0.0	0	0.0	0	0.0	3	100.0	24	60.0	27	62.8
Discharge Plan																		
OP Therapy	2	66.7	17	42.5	19	44.2	0	0.0	0	0.0	0	0.0	2	66.7	17	42.5	19	44.2
Comm. Supp. (AA/NA)	2	66.7	35	87.5	37	86.0	0	0.0	0	0.0	0	0.0	2	66.7	35	87.5	37	86.0
IOP/PHP	0	0.0	8	20.0	8	18.6	0	0.0	0	0.0	0	0.0	0	0.0	8	20.0	8	18.6
PCP/MD Follow-Up	2	66.7	22	55.0	24	55.8	0	0.0	0	0.0	0	0.0	2	66.7	22	55.0	24	55.8
Methadone Services	2	66.7	15	37.5	17	39.5	0	0.0	0	0.0	0	0.0	2	66.7	15	37.5	17	39.5
Other Behav Hth Svc	1	33.3	16	40.0	17	39.5	0	0.0	0	0.0	0	0.0	1	33.3	16	40.0	17	39.5
Referral Source																		
Self/Family Member	3	100.0	36	90.0	39	90.7	0	0.0	0	0.0	0	0.0	3	100.0	36	90.0	39	90.7
PCP/Medical Provider	0	0.0	1	2.5	1	2.3	0	0.0	0	0.0	0	0.0	0	0.0	1	2.5	1	2.3
DCF	0	0.0	1	2.5	1	2.3	0	0.0	0	0.0	0	0.0	0	0.0	1	2.5	1	2.3
Hospital Emergency Dept.	0	0.0	1	2.5	1	2.3	0	0.0	0	0.0	0	0.0	0	0.0	1	2.5	1	2.3
Other	0	0.0	1	2.5	1	2.3	0	0.0	0	0.0	0	0.0	0	0.0	1	2.5	1	2.3
Screening Type																		
Walk-in	3	100.0	39	97.5	42	97.7	0	0.0	0	0.0	0	0.0	3	100.0	39	97.5	42	97.7
Telephone	0	0.0	1	2.5	1	2.3	0	0.0	0	0.0	0	0.0	0	0.0	1	2.5	1	2.3
Referral Type																		
Routine	3	100.0	39	97.5	42	97.7	0	0.0	0	0.0	0	0.0	3	100.0	39	97.5	42	97.7
Urgent	0	0.0	1	2.5	1	2.3	0	0.0	0	0.0	0	0.0	0	0.0	1	2.5	1	2.3
BH Treatment Past 6 Months																		
Mental Health	0	0.0	4	10.0	4	9.3	0	0.0	0	0.0	0	0.0	0	0.0	4	10.0	4	9.3
Substance Abuse	1	33.3	13	32.5	14	32.6	0	0.0	0	0.0	0	0.0	1	33.3	13	32.5	14	32.6
NA	2	66.7	25	62.5	27	62.8	0	0.0	0	0.0	0	0.0	2	66.7	25	62.5	27	62.8

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH07034 - Outpatient (AMD) Registration Dashboard (18-C)

Report Date: QTR 2 2010

Report Description

Quarterly metrics on specific question selection on the Service Registration Form for ambulatory detox outpatient services (AMD). Selections are counted based on the beginning date of requested services.

Data source(s): RPT_CTBH08000, SP_CTBH07034C

Question/Selection	FREE STANDING CLINICS						HOSPITALS						TOTALS					
	Child		Adult		Total		Child		Adult		Total		Child		Adult		Total	
	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.
	3	7.0	40	93.0	43	100.0	0	0.0	0	0.0	0	0.0	3	7.0	40	93.0	43	100.0
Family/Significant Other Involved in Member Tx Plan																		
Yes	1	33.3	17	42.5	18	41.9	0	0.0	0	0.0	0	0.0	1	33.3	17	42.5	18	41.9
No	2	66.7	19	47.5	21	48.8	0	0.0	0	0.0	0	0.0	2	66.7	19	47.5	21	48.8
NA	0	0.0	4	10.0	4	9.3	0	0.0	0	0.0	0	0.0	0	0.0	4	10.0	4	9.3
Family/Significant Other Receiving Own MH/SA Tx																		
Yes	1	33.3	3	7.5	4	9.3	0	0.0	0	0.0	0	0.0	1	33.3	3	7.5	4	9.3
No	1	33.3	30	75.0	31	72.1	0	0.0	0	0.0	0	0.0	1	33.3	30	75.0	31	72.1
No Selection	1	33.3	7	17.5	8	18.6	0	0.0	0	0.0	0	0.0	1	33.3	7	17.5	8	18.6
Obtained Consent to Contact School																		
No	3	100.0	40	100.0	43	100.0	0	0.0	0	0.0	0	0.0	3	100.0	40	100.0	43	100.0
Obtained Consent to Contact Medical Provider																		
Yes	0	0.0	16	40.0	16	37.2	0	0.0	0	0.0	0	0.0	0	0.0	16	40.0	16	37.2
No	3	100.0	24	60.0	27	62.8	0	0.0	0	0.0	0	0.0	3	100.0	24	60.0	27	62.8
Obtained Consent to Contact Prev BH Tx Prov																		
Yes	0	0.0	10	25.0	10	23.3	0	0.0	0	0.0	0	0.0	0	0.0	10	25.0	10	23.3
No	2	66.7	16	40.0	18	41.9	0	0.0	0	0.0	0	0.0	2	66.7	16	40.0	18	41.9
N/A	1	33.3	14	35.0	15	34.9	0	0.0	0	0.0	0	0.0	1	33.3	14	35.0	15	34.9
Obtained Consent to Contact BH Tx Prov for Family/Significant Other																		
Yes	1	33.3	2	5.0	3	7.0	0	0.0	0	0.0	0	0.0	1	33.3	2	5.0	3	7.0
No	2	66.7	18	45.0	20	46.5	0	0.0	0	0.0	0	0.0	2	66.7	18	45.0	20	46.5
N/A	0	0.0	20	50.0	20	46.5	0	0.0	0	0.0	0	0.0	0	0.0	20	50.0	20	46.5
Who is Lead Case Management Prov																		
DCF Case Worker	0	0.0	3	7.5	3	7.0	0	0.0	0	0.0	0	0.0	0	0.0	3	7.5	3	7.0
No CM Provider	3	100.0	37	92.5	40	93.0	0	0.0	0	0.0	0	0.0	3	100.0	37	92.5	40	93.0
Member Currently Taking Psych. Meds																		
Yes	0	0.0	6	15.0	6	14.0	0	0.0	0	0.0	0	0.0	0	0.0	6	15.0	6	14.0
No	3	100.0	34	85.0	37	86.0	0	0.0	0	0.0	0	0.0	3	100.0	34	85.0	37	86.0

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH07034 - Outpatient (AMD) Registration Dashboard (18-C)

Report Date: QTR 2 2010

Report Description

Quarterly metrics on specific question selection on the Service Registration Form for ambulatory detox outpatient services (AMD). Selections are counted based on the beginning date of requested services.

Data source(s): RPT_CTBH08000, SP_CTBH07034C

	FREE STANDING CLINICS						HOSPITALS						TOTALS					
	Child		Adult		Total		Child		Adult		Total		Child		Adult		Total	
Question/Selection	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.	Count	Pct.
	3	7.0	40	93.0	43	100.0	0	0.0	0	0.0	0	0.0	3	7.0	40	93.0	43	100.0
Is Psych. Med Eval or Visit Indicated																		
Yes	0	0.0	8	20.0	8	18.6	0	0.0	0	0.0	0	0.0	0	0.0	8	20.0	8	18.6
No	3	100.0	32	80.0	35	81.4	0	0.0	0	0.0	0	0.0	3	100.0	32	80.0	35	81.4
Co-ocurring MH and SA Condition																		
Yes	0	0.0	7	17.5	7	16.3	0	0.0	0	0.0	0	0.0	0	0.0	7	17.5	7	16.3
No	2	66.7	25	62.5	27	62.8	0	0.0	0	0.0	0	0.0	2	66.7	25	62.5	27	62.8
Not Assessed	1	33.3	8	20.0	9	20.9	0	0.0	0	0.0	0	0.0	1	33.3	8	20.0	9	20.9
Member Involved in Legal System																		
Probation	0	0.0	7	17.5	7	16.3	0	0.0	0	0.0	0	0.0	0	0.0	7	17.5	7	16.3
Other Court	0	0.0	1	2.5	1	2.3	0	0.0	0	0.0	0	0.0	0	0.0	1	2.5	1	2.3
None Identified	3	100.0	32	80.0	35	81.4	0	0.0	0	0.0	0	0.0	3	100.0	32	80.0	35	81.4
Information Regarding Peer Support or Self-Help																		
Yes	3	100.0	38	95.0	41	95.3	0	0.0	0	0.0	0	0.0	3	100.0	38	95.0	41	95.3
No	0	0.0	2	5.0	2	4.7	0	0.0	0	0.0	0	0.0	0	0.0	2	5.0	2	4.7

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH07082 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18D)

Report Date: 01/01/2010 to 06/30/2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures. ECC Providers are excluded.

Data Source(s): RPT_CTBH08000, SP_CTBH07082

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
All Providers					
# Total Emergent Evaluations	25	9	0	0	34
# Total Urgent Evaluations	196	170	0	0	366
# Total Routine Evaluations	5075	4728	0	0	9803
# Total Evaluations	5296	4907	0	0	10203
# Total Evaluations (Total Volume)	*7262*	*6813*	*0*	*0*	*0*
% Total Emergent Evaluations/Total Evaluations	0.47	0.18	0.00	0.00	0.33
% Total Urgent Evaluations/Total Evaluations	3.70	3.46	0.00	0.00	3.59
% Total Routine Evaluations/Total Evaluations	95.83	96.35	0.00	0.00	96.08
Emergent - All Providers					
Avg. Time Until Receipt of Emergent Evaluations (min.)	11.44	0.00	0.00	0.00	8.41
# Receipt Time of Emergent Evaluations within 2hrs.	25	9	0	0	34
% Emergent Evaluations Received within 2hrs.	100.00	100.00	0.00	0.00	100.00
Emergent - Free Standing Clinics (FSC)					
# FSC Emergent Evaluations	5	2	0	0	7
% FSC Emergent Evaluations/Total Emergent Evaluations	20.00	22.22	0.00	0.00	20.59
Avg. Time Until Receipt of FSC Emergent Evaluations (min.)	36.00	0.00	0.00	0.00	25.71
# Receipt Time of FSC Emergent Evaluations within 2hrs.	5	2	0	0	7
% FSC Emergent Evaluations Received within 2hrs.	100.00	100.00	0.00	0.00	100.00
Emergent - Individual Practitioners (INP)					
# INP Emergent Evaluations	19	7	0	0	26
% INP Emergent Evaluations/Total Emergent Evaluations	76.00	77.78	0.00	0.00	76.47
Avg. Time Until Receipt of INP Emergent Evaluations (min.)	2.89	0.00	0.00	0.00	2.12
# Receipt Time of INP Emergent Evaluations within 2hrs.	19	7	0	0	26
% INP Emergent Evaluations Received within 2hrs.	100.00	100.00	0.00	0.00	100.00
Emergent - Hospitals (HOS)					
# HOS Emergent Evaluations	1	0	0	0	1
% HOS Emergent Evaluations/Total Emergent Evaluations	4.00	0.00	0.00	0.00	2.94
Avg. Time Until Receipt of HOS Emergent Evaluations (min.)	51.00	0.00	0.00	0.00	51.00
# Receipt Time of HOS Emergent Evaluations within 2hrs.	1	0	0	0	1
% HOS Emergent Evaluations Received within 2hrs.	100.00	0.00	0.00	0.00	100.00
Urgent - All Providers					
Avg. Time Until Urgent Appointment Offered (days)	4.11	3.01	0.00	0.00	3.60
# Urgent Appointments Offered within 2 days	156	128	0	0	284
% Urgent Appointments Offered within 2 days	79.59	75.29	0.00	0.00	77.60
Avg. Time Until Receipt of Urgent Evaluations (days)	5.16	3.76	0.00	0.00	4.51
# Receipt Time of Urgent Evaluations within 2 days	137	121	0	0	258
% Urgent Evaluations Received within 2 days	69.90	71.18	0.00	0.00	70.49
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	16	5	0	0	21
# No-shows/Cancellations Prior to First Urgent Evaluation Received	10	5	0	0	15

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH07082 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18D)

Report Date: 01/01/2010 to 06/30/2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures. ECC Providers are excluded

Data Source(s): RPT_CTBH08000, SP_CTBH07082

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
Urgent - Free Standing Clinics (FSC)					
# FSC Urgent Evaluations	82	59	0	0	141
% FSC Urgent Evaluations/Total Urgent Evaluations	41.84	34.71	0.00	0.00	38.52
Avg. Time Until FSC Urgent Appointment Offered (days)	6.22	4.31	0.00	0.00	5.42
# FSC Urgent Appointments Offered within 2 days	63	39	0	0	102
% FSC Urgent Appointments Offered within 2 days	76.83	66.10	0.00	0.00	72.34
Avg. Time Until Receipt of FSC Urgent Evaluations (days)	7.07	5.42	0.00	0.00	6.38
# Receipt Time of FSC Urgent Evaluations within 2 days	57	36	0	0	93
% FSC Urgent Evaluations Received within 2 days	69.51	61.02	0.00	0.00	65.96
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	5	3	0	0	8
# No-shows/Cancellations Prior to First Urgent Evaluation Received	6	1	0	0	7
Urgent - Individual Practitioners (INP)					
# INP Urgent Evaluations	111	106	0	0	217
% INP Urgent Evaluations/Total Urgent Evaluations	56.63	62.35	0.00	0.00	59.29
Avg. Time Until INP Urgent Appointment Offered (days)	2.66	2.41	0.00	0.00	2.53
# INP Urgent Appointments Offered within 2 days	90	85	0	0	175
% INP Urgent Appointments Offered within 2 days	81.08	80.19	0.00	0.00	80.65
Avg. Time Until Receipt of INP Urgent Evaluations (days)	3.50	2.92	0.00	0.00	3.22
# Receipt Time of INP Urgent Evaluations within 2 days	78	82	0	0	160
% INP Urgent Evaluations Received within 2 days	70.27	77.36	0.00	0.00	73.73
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	11	1	0	0	12
# No-shows/Cancellations Prior to First Urgent Evaluation Received	3	4	0	0	7
Urgent - Hospitals (HOS)					
# HOS Urgent Evaluations	3	5	0	0	8
% HOS Urgent Evaluations/Total Urgent Evaluations	1.53	2.94	0.00	0.00	2.19
Avg. Time Until HOS Urgent Appointment Offered (days)	0.33	0.60	0.00	0.00	0.50
# HOS Urgent Appointments Offered within 2 days	3	4	0	0	7
% HOS Urgent Appointments Offered within 2 days	100.00	80.00	0.00	0.00	87.50
Avg. Time Until Receipt of HOS Urgent Evaluations (days)	14.00	2.00	0.00	0.00	6.50
# Receipt Time of HOS Urgent Evaluations within 2 days	2	3	0	0	5
% HOS Urgent Evaluations Received within 2 days	66.67	60.00	0.00	0.00	62.50
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	1	0	0	1
# No-shows/Cancellations Prior to First Urgent Evaluation Received	1	0	0	0	1
Routine - All Providers					
Avg. Time Until Routine Appointment Offered (days)	4.41	4.48	0.00	0.00	4.44
# Routine Appointments Offered within 14 days	4867	4426	0	0	9293
% Routine Appointments Offered within 14 days	95.90	93.61	0.00	0.00	94.80
Avg. Time Until Receipt of Routine Evaluations (days)	5.97	6.30	0.00	0.00	6.13
# Receipt Time of Routine Evaluations within 14 days	4632	4266	0	0	8898
% Routine Evaluations Received within 14 days	91.27	90.23	0.00	0.00	90.77
# Routine Appt Offered within 14 days yet Member Requested Later Appt	263	223	0	0	486
# No-shows/Cancellations Prior to First Routine Evaluation Received	453	383	0	0	836

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH07082 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18D)

Report Date: 01/01/2010 to 06/30/2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures. ECC Providers are excluded.

Data Source(s): RPT_CTBH08000, SP_CTBH07082

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
Routine - Free Standing Clinics (FSC)					
# FSC Routine Evaluations	1923	1877	0	0	3800
% FSC Routine Evaluations/Total Routine Evaluations	37.89	39.70	0.00	0.00	38.76
Avg. Time Until FSC Routine Appointment Offered (days)	4.21	4.40	0.00	0.00	4.30
# FSC Routine Appointments Offered within 14 days	1818	1730	0	0	3548
% FSC Routine Appointments Offered within 14 days	94.54	92.17	0.00	0.00	93.37
Avg. Time Until Receipt of FSC Routine Evaluations (days)	6.70	5.80	0.00	0.00	6.26
# Receipt Time of FSC Routine Evaluations within 14 days	1674	1627	0	0	3301
% FSC Routine Evaluations Received within 14 days	87.05	86.68	0.00	0.00	86.87
# Routine Appt Offered within 14 days yet Member Requested Later Appt	126	95	0	0	221
# No-shows/Cancellations Prior to First Routine Evaluation Received	228	186	0	0	414
Routine - Individual Practitioners (INP)					
# INP Routine Evaluations	2851	2604	0	0	5455
% INP Routine Evaluations/Total Routine Evaluations	56.18	55.08	0.00	0.00	55.65
Avg. Time Until INP Routine Appointment Offered (days)	4.51	4.38	0.00	0.00	4.45
# INP Routine Appointments Offered within 14 days	2758	2487	0	0	5245
% INP Routine Appointments Offered within 14 days	96.74	95.51	0.00	0.00	96.15
Avg. Time Until Receipt of INP Routine Evaluations (days)	5.34	6.37	0.00	0.00	5.83
# Receipt Time of INP Routine Evaluations within 14 days	2702	2446	0	0	5148
% INP Routine Evaluations Received within 14 days	94.77	93.93	0.00	0.00	94.37
# Routine Appt Offered within 14 days yet Member Requested Later Appt	112	112	0	0	224
# No-shows/Cancellations Prior to First Routine Evaluation Received	203	175	0	0	378
Routine - Hospitals (HOS)					
# HOS Routine Evaluations	301	247	0	0	548
% HOS Routine Evaluations/Total Routine Evaluations	5.93	5.22	0.00	0.00	5.59
Avg. Time Until HOS Routine Appointment Offered (days)	4.82	6.08	0.00	0.00	5.39
# HOS Routine Appointments Offered within 14 days	291	209	0	0	500
% HOS Routine Appointments Offered within 14 days	96.68	84.62	0.00	0.00	91.24
Avg. Time Until Receipt of HOS Routine Evaluations (days)	7.31	9.32	0.00	0.00	8.22
# Receipt Time of HOS Routine Evaluations within 14 days	256	193	0	0	449
% HOS Routine Evaluations Received within 14 days	85.05	78.14	0.00	0.00	81.93
# Routine Appt Offered within 14 days yet Member Requested Later Appt	25	16	0	0	41
# No-shows/Cancellations Prior to First Routine Evaluation Received	22	22	0	0	44

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: ECC TOTAL
Report Year: 2010

Report Description
Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	70	69	0	0	139
# Total Urgent Evaluations	176	133	0	0	309
# Total Routine Evaluations	2698	2513	0	0	5211
# Total Evaluations	2944	2715	0	0	5659
# Total Evaluations (Total Volume)	3657	3421	0	0	7078
% Total Emergent Evaluations/Total Evaluations	2.38	2.54	0.00	0.00	2.46
% Total Urgent Evaluations/Total Evaluations	5.98	4.90	0.00	0.00	5.46
% Total Routine Evaluations/Total Evaluations	91.64	92.56	0.00	0.00	92.08
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	39.25	55.44	0.00	0.00	47.10
# Receipt Time of Emergent Evaluations within 2hrs.	67	58	0	0	125
% Emergent Evaluations Received within 2hrs.	95.71	84.06	0.00	0.00	89.93
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.60	0.51	0.00	0.00	0.56
# Urgent Appointments Offered within 2 days	172	130	0	0	302
% Urgent Appointments Offered within 2 days	97.73	97.74	0.00	0.00	97.73
Avg. Time Until Receipt of Urgent Evaluations (days)	1.31	1.71	0.00	0.00	1.48
# Receipt Time of Urgent Evaluations within 2 days	150	117	0	0	267
% Urgent Evaluations Received within 2 days	85.23	87.97	0.00	0.00	86.41
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	26	12	0	0	38
# No-shows/Cancellations Prior to First Urgent Evaluation Received	9	9	0	0	18
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	7.45	7.63	0.00	0.00	7.54
# Routine Appointments Offered within 14 days	2655	2462	0	0	5117
% Routine Appointments Offered within 14 days	98.41	97.97	0.00	0.00	98.20
Avg. Time Until Receipt of Routine Evaluations (days)	11.85	10.60	0.00	0.00	11.25
# Receipt Time of Routine Evaluations within 14 days	2252	2075	0	0	4327
% Routine Evaluations Received within 14 days	83.47	82.57	0.00	0.00	83.04
# Routine Appt Offered within 14 days yet Member Requested Later Appt	473	451	0	0	924
# No-shows/Cancellations Prior to First Routine Evaluation Received	428	326	0	0	754

Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 1 (PROVNO 1)

Report Year: 2010

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent, Urgent, Routine Access measures
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	0	0	0	0	0
# Total Routine Evaluations	7	5	0	0	12
# Total Evaluations	7	5	0	0	12
# Total Evaluations (Total Volume)	9	6	0	0	15
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Routine Evaluations/Total Evaluations	100.00	100.00	0.00	0.00	100.00
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0	0	0	0	0
# Urgent Appointments Offered within 2 days	0	0	0	0	0
% Urgent Appointments Offered within 2 days	0	0	0	0	0
Avg. Time Until Receipt of Urgent Evaluations (days)	0	0	0	0	0
# Receipt Time of Urgent Evaluations within 2 days	0	0	0	0	0
% Urgent Evaluations Received within 2 days	0	0	0	0	0
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	8.71	0.00	0.00	0.00	5.08
# Routine Appointments Offered within 14 days	7	5	0	0	12
% Routine Appointments Offered within 14 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Routine Evaluations (days)	8.71	0.00	0.00	0.00	5.08
# Receipt Time of Routine Evaluations within 14 days	7	5	0	0	12
% Routine Evaluations Received within 14 days	100.00	100.00	0.00	0.00	100.00
# Routine Appt Offered within 14 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Routine Evaluation Received	0	0	0	0	0

SITE DATA

Primary					Start Date	End Date	Emerg. Exempt
SITE 1					04/13/2007		N
	Emergent	0	0	0	0	0	0
	Routine	7	5	0	0	12	
	Urgent	0	0	0	0	0	

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 10 (PROVNO 10)
Report Year: 2010

Report Description
Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	*0*	*0*	*0*	*0*	*0*
# Total Urgent Evaluations	*1*	*1*	*0*	*0*	*2*
# Total Routine Evaluations	*81*	*64*	*0*	*0*	*145*
# Total Evaluations	82	65	0	0	147
# Total Evaluations (Total Volume)	*85*	*65*	*0*	*0*	*150*
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	1.22	1.54	0.00	0.00	1.36
% Total Routine Evaluations/Total Evaluations	98.78	98.46	0.00	0.00	98.64
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	*0*	*0*	*0*	*0*	*0*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	2.00	2.00	0.00	0.00	2.00
# Urgent Appointments Offered within 2 days	1	1	0	0	2
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	2.00	3.00	0.00	0.00	2.50
# Receipt Time of Urgent Evaluations within 2 days	1	0	0	0	1
% Urgent Evaluations Received within 2 days	100.00	0.00	0.00	0.00	50.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	1	0	0	1
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	9.22	9.86	0.00	0.00	9.50
# Routine Appointments Offered within 14 days	81	63	0	0	144
% Routine Appointments Offered within 14 days	*100.00*	*98.44*	*0.00*	*0.00*	*99.31*
Avg. Time Until Receipt of Routine Evaluations (days)	13.22	16.94	0.00	0.00	14.86
# Receipt Time of Routine Evaluations within 14 days	61	42	0	0	103
% Routine Evaluations Received within 14 days	75.31	65.62	0.00	0.00	71.03
# Routine Appt Offered within 14 days yet Member Requested Later Appt	11	9	0	0	20
# No-shows/Cancellations Prior to First Routine Evaluation Received	24	23	0	0	47

SITE DATA

Primary				Start Date	End Date	Emerg. Exempt
SITE 1				04/13/2007	-	N
	Emergent	0	0	0	0	0
	Routine	81	64	0	0	145
	Urgent	1	1	0	0	2

Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 11 (PROVNO 11)

Report Year: 2010

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	2	1	0	0	3
# Total Routine Evaluations	65	55	0	0	120
# Total Evaluations	67	56	0	0	123
# Total Evaluations (Total Volume)	68	57	0	0	125
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	2.99	1.79	0.00	0.00	2.44
% Total Routine Evaluations/Total Evaluations	97.01	98.21	0.00	0.00	97.56
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	1.00	1.00	0.00	0.00	1.00
# Urgent Appointments Offered within 2 days	2	1	0	0	3
% Urgent Appointments Offered within 2 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Urgent Evaluations (days)	3.00	1.00	0.00	0.00	2.33
# Receipt Time of Urgent Evaluations within 2 days	0	1	0	0	1
% Urgent Evaluations Received within 2 days	0.00	100.00	0.00	0.00	33.33
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	2	0	0	0	2
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	7.82	8.31	0.00	0.00	8.04
# Routine Appointments Offered within 14 days	65	55	0	0	120
% Routine Appointments Offered within 14 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Routine Evaluations (days)	11.98	13.84	0.00	0.00	12.83
# Receipt Time of Routine Evaluations within 14 days	51	40	0	0	91
% Routine Evaluations Received within 14 days	78.46	72.73	0.00	0.00	75.83
# Routine Appt Offered within 14 days yet Member Requested Later Appt	17	14	0	0	31
# No-shows/Cancellations Prior to First Routine Evaluation Received	12	13	0	0	25

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary						
SITE 1				04/13/2007		N
	Emergent	0	0	0	0	0
	Routine	65	55	0	0	120
	Urgent	2	1	0	0	3

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 12 (PROVNO 12)
Report Year: 2010

Report Description
Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	3	1	0	0	4
# Total Routine Evaluations	39	36	0	0	75
# Total Evaluations	42	37	0	0	79
# Total Evaluations (Total Volume)	59	51	0	0	110
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	7.14	2.70	0.00	0.00	5.06
% Total Routine Evaluations/Total Evaluations	92.86	97.30	0.00	0.00	94.94
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	3.33	3.00	0.00	0.00	3.25
# Urgent Appointments Offered within 2 days	2	0	0	0	2
% Urgent Appointments Offered within 2 days	66.67	0.00	0.00	0.00	50.00
Avg. Time Until Receipt of Urgent Evaluations (days)	10.00	42.00	0.00	0.00	18.00
# Receipt Time of Urgent Evaluations within 2 days	0	0	0	0	0
% Urgent Evaluations Received within 2 days	0.00	0.00	0.00	0.00	0.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	2	1	0	0	3
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	8.87	9.47	0.00	0.00	9.16
# Routine Appointments Offered within 14 days	37	30	0	0	67
% Routine Appointments Offered within 14 days	94.87	83.33	0.00	0.00	89.33
Avg. Time Until Receipt of Routine Evaluations (days)	12.23	14.44	0.00	0.00	13.29
# Receipt Time of Routine Evaluations within 14 days	30	24	0	0	54
% Routine Evaluations Received within 14 days	76.92	66.67	0.00	0.00	72.00
# Routine Appt Offered within 14 days yet Member Requested Later Appt	3	6	0	0	9
# No-shows/Cancellations Prior to First Routine Evaluation Received	6	5	0	0	11

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary SITE 1				04/13/2007	-	N
	Emergent	0	0	0	0	0
	Urgent	3	1	0	0	4
	Routine	39	36	0	0	75
Secondary SITE 2				04/13/2007	-	Y
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	0	0	0	0	0

Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Providers: PROVIDER 13 (PROVNO 13)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	1	2	0	0	3
# Total Routine Evaluations	25	14	0	0	39
# Total Evaluations	26	16	0	0	42
# Total Evaluations (Total Volume)	29	23	0	0	52
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	3.85	12.50	0.00	0.00	7.14
% Total Routine Evaluations/Total Evaluations	96.15	87.50	0.00	0.00	92.86
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	1.00	1.50	0.00	0.00	1.33
# Urgent Appointments Offered within 2 days	1	2	0	0	3
% Urgent Appointments Offered within 2 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Urgent Evaluations (days)	1.00	1.50	0.00	0.00	1.33
# Receipt Time of Urgent Evaluations within 2 days	1	2	0	0	3
% Urgent Evaluations Received within 2 days	100.00	100.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	9.16	11.07	0.00	0.00	9.85
# Routine Appointments Offered within 14 days	25	14	0	0	39
% Routine Appointments Offered within 14 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Routine Evaluations (days)	10.16	13.00	0.00	0.00	11.18
# Receipt Time of Routine Evaluations within 14 days	22	12	0	0	34
% Routine Evaluations Received within 14 days	88.00	85.71	0.00	0.00	87.18
# Routine Appt Offered within 14 days yet Member Requested Later Appt	1	1	0	0	2
# No-shows/Cancellations Prior to First Routine Evaluation Received	4	1	0	0	5

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary						
SITE 1				03/04/2008	-	N
	Emergent	0	0	0	0	0
	Routine	25	14	0	0	39
	Urgent	1	2	0	0	3

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 14 (PROVNO 14)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	1	1	0	0	2
# Total Urgent Evaluations	1	0	0	0	1
# Total Routine Evaluations	43	42	0	0	85
# Total Evaluations	45	43	0	0	88
# Total Evaluations (Total Volume)	55	51	0	0	106
% Total Emergent Evaluations/Total Evaluations	2.22	2.33	0.00	0.00	2.27
% Total Urgent Evaluations/Total Evaluations	2.22	0.00	0.00	0.00	1.14
% Total Routine Evaluations/Total Evaluations	95.56	97.67	0.00	0.00	96.59
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0.00	60.00	0.00	0.00	30.00
# Receipt Time of Emergent Evaluations within 2hrs.	1	1	0	0	2
% Emergent Evaluations Received within 2hrs.	100.00	100.00	0.00	0.00	100.00
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.00	0.00	0.00	0.00	0.00
# Urgent Appointments Offered within 2 days	1	0	0	0	1
% Urgent Appointments Offered within 2 days	100.00	0.00	0.00	0.00	100.00
Avg. Time Until Receipt of Urgent Evaluations (days)	0.00	0.00	0.00	0.00	0.00
# Receipt Time of Urgent Evaluations within 2 days	1	0	0	0	1
% Urgent Evaluations Received within 2 days	100.00	0.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	8.84	10.69	0.00	0.00	9.75
# Routine Appointments Offered within 14 days	43	42	0	0	85
% Routine Appointments Offered within 14 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Routine Evaluations (days)	13.65	13.48	0.00	0.00	13.56
# Receipt Time of Routine Evaluations within 14 days	33	34	0	0	67
% Routine Evaluations Received within 14 days	76.74	80.95	0.00	0.00	78.82
# Routine Appt Offered within 14 days yet Member Requested Later Appt	8	8	0	0	16
# No-shows/Cancellations Prior to First Routine Evaluation Received	22	16	0	0	38

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary SITE 1				03/04/2008	-	N
	Emergent	1	1	0	0	2
	Urgent	1	0	0	0	1
	Routine	43	42	0	0	85
Secondary SITE 2				03/04/2008	-	N
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	0	0	0	0	0

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 15 (PROVNO 15)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	1	1	0	0	2
# Total Routine Evaluations	141	119	0	0	260
# Total Evaluations	142	120	0	0	262
# Total Evaluations (Total Volume)	149	127	0	0	276
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	0.70	0.83	0.00	0.00	0.76
% Total Routine Evaluations/Total Evaluations	99.30	99.17	0.00	0.00	99.24
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	1.00	0.00	0.00	0.00	0.50
# Urgent Appointments Offered within 2 days	1	1	0	0	2
% Urgent Appointments Offered within 2 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Urgent Evaluations (days)	1.00	0.00	0.00	0.00	0.50
# Receipt Time of Urgent Evaluations within 2 days	1	1	0	0	2
% Urgent Evaluations Received within 2 days	100.00	100.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	8.88	6.77	0.00	0.00	7.92
# Routine Appointments Offered within 14 days	132	119	0	0	251
% Routine Appointments Offered within 14 days	93.62	100.00	0.00	0.00	96.54
Avg. Time Until Receipt of Routine Evaluations (days)	12.31	10.86	0.00	0.00	11.65
# Receipt Time of Routine Evaluations within 14 days	102	97	0	0	199
% Routine Evaluations Received within 14 days	72.34	81.51	0.00	0.00	76.54
# Routine Appt Offered within 14 days yet Member Requested Later Appt	28	28	0	0	56
# No-shows/Cancellations Prior to First Routine Evaluation Received	23	16	0	0	39

SITE DATA

					Start Date	End Date	Emerg. Exempt
Primary							
SITE 1					04/13/2007	-	N
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	133	111	0	0		244
Secondary							
SITE 2					04/13/2007	-	Y
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	0	0	0	0		0
SITE 3					04/13/2007	-	N
	Emergent	0	0	0	0		0
	Urgent	1	1	0	0		2
	Routine	8	8	0	0		16
SITE 4					04/13/2007	-	Y
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	0	0	0	0		0
SITE 5					04/13/2007	-	Y
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	0	0	0	0		0
SITE 6					04/13/2007	-	Y
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	0	0	0	0		0
SITE 7					04/13/2007	-	Y
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	0	0	0	0		0

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 16 (PROVNO 16)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	3	2	0	0	5
# Total Routine Evaluations	77	70	0	0	147
# Total Evaluations	80	72	0	0	152
# Total Evaluations (Total Volume)	102	94	0	0	196
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	3.75	2.78	0.00	0.00	3.29
% Total Routine Evaluations/Total Evaluations	96.25	97.22	0.00	0.00	96.71
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.67	1.00	0.00	0.00	0.80
# Urgent Appointments Offered within 2 days	3	2	0	0	5
% Urgent Appointments Offered within 2 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Urgent Evaluations (days)	3.67	1.00	0.00	0.00	2.60
# Receipt Time of Urgent Evaluations within 2 days	2	2	0	0	4
% Urgent Evaluations Received within 2 days	66.67	100.00	0.00	0.00	80.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	1	0	0	0	1
# No-shows/Cancellations Prior to First Urgent Evaluation Received	1	0	0	0	1
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	5.32	7.27	0.00	0.00	6.25
# Routine Appointments Offered within 14 days	77	68	0	0	145
% Routine Appointments Offered within 14 days	100.00	97.14	0.00	0.00	98.64
Avg. Time Until Receipt of Routine Evaluations (days)	9.68	11.79	0.00	0.00	10.68
# Receipt Time of Routine Evaluations within 14 days	68	55	0	0	123
% Routine Evaluations Received within 14 days	88.31	78.57	0.00	0.00	83.67
# Routine Appt Offered within 14 days yet Member Requested Later Appt	33	31	0	0	64
# No-shows/Cancellations Prior to First Routine Evaluation Received	10	13	0	0	23

SITE DATA

Primary				Start Date	End Date	Emerg. Exempt
SITE 1				04/13/2007		N
	Emergent	0	0	0	0	0
	Routine	77	70	0	0	147
	Urgent	3	2	0	0	5

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 17 (PROVNO 17)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	0	0	0	0	0
# Total Routine Evaluations	138	146	0	0	284
# Total Evaluations	138	146	0	0	284
# Total Evaluations (Total Volume)	166	174	0	0	340
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Routine Evaluations/Total Evaluations	100.00	100.00	0.00	0.00	100.00
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0	0	0	0	0
# Urgent Appointments Offered within 2 days	0	0	0	0	0
% Urgent Appointments Offered within 2 days	0	0	0	0	0
Avg. Time Until Receipt of Urgent Evaluations (days)	0	0	0	0	0
# Receipt Time of Urgent Evaluations within 2 days	0	0	0	0	0
% Urgent Evaluations Received within 2 days	0	0	0	0	0
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	6.93	6.34	0.00	0.00	6.63
# Routine Appointments Offered within 14 days	137	141	0	0	278
% Routine Appointments Offered within 14 days	99.28	96.58	0.00	0.00	97.89
Avg. Time Until Receipt of Routine Evaluations (days)	7.78	7.92	0.00	0.00	7.85
# Receipt Time of Routine Evaluations within 14 days	126	126	0	0	252
% Routine Evaluations Received within 14 days	91.30	86.30	0.00	0.00	88.73
# Routine Appt Offered within 14 days yet Member Requested Later Appt	16	22	0	0	38
# No-shows/Cancellations Prior to First Routine Evaluation Received	13	9	0	0	22

SITE DATA

				Start Date	End Date	Emerg Exempt
Primary						
SITE 1				04/13/2007		N
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	67	91	0	0	158
Secondary						
SITE 2				04/13/2007		Y
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	71	55	0	0	126

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 18 (PROVNO 18)
Report Year: 2010

Report Description
Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	*0*	*0*	*0*	*0*	*0*
# Total Urgent Evaluations	*1*	*0*	*0*	*0*	*1*
# Total Routine Evaluations	*64*	*70*	*0*	*0*	*134*
# Total Evaluations	65	70	0	0	135
# Total Evaluations (Total Volume)	*91*	*95*	*0*	*0*	*186*
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	1.54	0.00	0.00	0.00	0.74
% Total Routine Evaluations/Total Evaluations	98.46	100.00	0.00	0.00	99.26
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	*0*	*0*	*0*	*0*	*0*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	2.00	0.00	0.00	0.00	2.00
# Urgent Appointments Offered within 2 days	1	0	0	0	1
% Urgent Appointments Offered within 2 days	*100.00*	*0.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	2.00	0.00	0.00	0.00	2.00
# Receipt Time of Urgent Evaluations within 2 days	1	0	0	0	1
% Urgent Evaluations Received within 2 days	100.00	0.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	8.59	10.57	0.00	0.00	9.63
# Routine Appointments Offered within 14 days	63	55	0	0	118
% Routine Appointments Offered within 14 days	*98.44*	*78.57*	*0.00*	*0.00*	*88.06*
Avg. Time Until Receipt of Routine Evaluations (days)	9.56	11.79	0.00	0.00	10.72
# Receipt Time of Routine Evaluations within 14 days	57	51	0	0	108
% Routine Evaluations Received within 14 days	89.06	72.86	0.00	0.00	80.60
# Routine Appt Offered within 14 days yet Member Requested Later Appt	7	5	0	0	12
# No-shows/Cancellations Prior to First Routine Evaluation Received	10	5	0	0	15

SITE DATA

Primary					Start Date	End Date	Emerg. Exempt
SITE 1					04/13/2007	-	N
	Emergent	0	0	0	0	0	0
	Routine	64	70	0	0	0	134
	Urgent	1	0	0	0	0	1

Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 19 (PROVNO 19)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	2	0	0	0	2
# Total Urgent Evaluations	8	1	0	0	9
# Total Routine Evaluations	52	73	0	0	125
# Total Evaluations	62	74	0	0	136
# Total Evaluations (Total Volume)	93	110	0	0	203
% Total Emergent Evaluations/Total Evaluations	3.23	0.00	0.00	0.00	1.47
% Total Urgent Evaluations/Total Evaluations	12.90	1.35	0.00	0.00	6.62
% Total Routine Evaluations/Total Evaluations	83.87	98.65	0.00	0.00	91.91
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0.00	0.00	0.00	0.00	0.00
# Receipt Time of Emergent Evaluations within 2hrs.	2	0	0	0	2
% Emergent Evaluations Received within 2hrs.	*100.00*	*0.00*	*0.00*	*0.00*	*100.00*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.00	0.00	0.00	0.00	0.00
# Urgent Appointments Offered within 2 days	8	1	0	0	9
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	0.00	0.00	0.00	0.00	0.00
# Receipt Time of Urgent Evaluations within 2 days	8	1	0	0	9
% Urgent Evaluations Received within 2 days	100.00	100.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	3.85	3.95	0.00	0.00	3.92
# Routine Appointments Offered within 14 days	48	71	0	0	119
% Routine Appointments Offered within 14 days	*92.31*	*97.26*	*0.00*	*0.00*	*95.20*
Avg. Time Until Receipt of Routine Evaluations (days)	5.37	5.29	0.00	0.00	5.32
# Receipt Time of Routine Evaluations within 14 days	46	69	0	0	115
% Routine Evaluations Received within 14 days	88.46	94.52	0.00	0.00	92.00
# Routine Appt Offered within 14 days yet Member Requested Later Appt	2	6	0	0	8
# No-shows/Cancellations Prior to First Routine Evaluation Received	5	5	0	0	10

SITE DATA

					Start Date	End Date	Emerg. Exempt
Primary							
SITE 1					03/04/2008		N
	Emergent	2	0	0	0		2
	Urgent	8	1	0	0		9
	Routine	52	73	0	0		125
Secondary							
SITE 2					03/04/2008		Y
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	0	0	0	0		0

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 2 (PROVNO 2)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	*0*	*0*	*0*	*0*	*0*
# Total Urgent Evaluations	*0*	*0*	*0*	*0*	*0*
# Total Routine Evaluations	*46*	*32*	*0*	*0*	*78*
# Total Evaluations	46	32	0	0	78
# Total Evaluations (Total Volume)	*50*	*35*	*0*	*0*	*85*
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Routine Evaluations/Total Evaluations	100.00	100.00	0.00	0.00	100.00
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	*0*	*0*	*0*	*0*	*0*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0	0	0	0	0
# Urgent Appointments Offered within 2 days	0	0	0	0	0
% Urgent Appointments Offered within 2 days	*0*	*0*	*0*	*0*	*0*
Avg. Time Until Receipt of Urgent Evaluations (days)	0	0	0	0	0
# Receipt Time of Urgent Evaluations within 2 days	0	0	0	0	0
% Urgent Evaluations Received within 2 days	0	0	0	0	0
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	10.15	8.78	0.00	0.00	9.59
# Routine Appointments Offered within 14 days	43	32	0	0	75
% Routine Appointments Offered within 14 days	*93.48*	*100.00*	*0.00*	*0.00*	*96.15*
Avg. Time Until Receipt of Routine Evaluations (days)	12.26	10.12	0.00	0.00	11.38
# Receipt Time of Routine Evaluations within 14 days	34	29	0	0	63
% Routine Evaluations Received within 14 days	73.91	90.62	0.00	0.00	80.77
# Routine Appt Offered within 14 days yet Member Requested Later Appt	10	6	0	0	16
# No-shows/Cancellations Prior to First Routine Evaluation Received	13	6	0	0	19

SITE DATA

Primary					Start Date	End Date	Emerg. Exempt
SITE 1					04/13/2007	-	N
	Emergent	0	0	0	0	0	
	Routine	46	32	0	0	78	
	Urgent	0	0	0	0	0	

Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 20 (PROVNO 20)

Report Year: 2010

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	30	33	0	0	63
# Total Urgent Evaluations	46	53	0	0	99
# Total Routine Evaluations	143	110	0	0	253
# Total Evaluations	219	196	0	0	415
# Total Evaluations (Total Volume)	240	229	0	0	469
% Total Emergent Evaluations/Total Evaluations	13.70	16.84	0.00	0.00	15.18
% Total Urgent Evaluations/Total Evaluations	21.00	27.04	0.00	0.00	23.86
% Total Routine Evaluations/Total Evaluations	65.30	56.12	0.00	0.00	60.96
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	38.17	75.93	0.00	0.00	57.05
# Receipt Time of Emergent Evaluations within 2hrs	28	23	0	0	51
% Emergent Evaluations Received within 2hrs.	93.33	69.70	0.00	0.00	80.95
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.57	0.19	0.00	0.00	0.36
# Urgent Appointments Offered within 2 days	45	52	0	0	97
% Urgent Appointments Offered within 2 days	97.83	98.11	0.00	0.00	97.98
Avg. Time Until Receipt of Urgent Evaluations (days)	0.70	0.58	0.00	0.00	0.64
# Receipt Time of Urgent Evaluations within 2 days	44	50	0	0	94
% Urgent Evaluations Received within 2 days	95.65	94.34	0.00	0.00	94.95
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	1	0	0	1
# No-shows/Cancellations Prior to First Urgent Evaluation Received	1	1	0	0	2
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	5.13	7.95	0.00	0.00	6.36
# Routine Appointments Offered within 14 days	143	107	0	0	250
% Routine Appointments Offered within 14 days	100.00	97.27	0.00	0.00	98.81
Avg. Time Until Receipt of Routine Evaluations (days)	10.25	12.24	0.00	0.00	11.11
# Receipt Time of Routine Evaluations within 14 days	113	82	0	0	195
% Routine Evaluations Received within 14 days	79.02	74.55	0.00	0.00	77.08
# Routine Appt Offered within 14 days yet Member Requested Later Appt	44	29	0	0	73
# No-shows/Cancellations Prior to First Routine Evaluation Received	32	15	0	0	47

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary						
SITE 1				04/13/2007	-	N
	Emergent	30	33	0	0	63
	Urgent	46	52	0	0	98
	Routine	139	108	0	0	247
Secondary						
SITE 2				04/13/2007	-	N
	Emergent	0	0	0	0	0
	Urgent	0	1	0	0	1
	Routine	1	2	0	0	3
SITE 3				04/13/2007	-	N
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	3	0	0	0	3

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 21 (PROVNO 21)
Report Year: 2010

Report Description
Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	1	0	0	0	1
# Total Urgent Evaluations	1	1	0	0	2
# Total Routine Evaluations	18	15	0	0	33
# Total Evaluations	20	16	0	0	36
# Total Evaluations (Total Volume)	27	16	0	0	43
% Total Emergent Evaluations/Total Evaluations	5.00	0.00	0.00	0.00	2.78
% Total Urgent Evaluations/Total Evaluations	5.00	6.25	0.00	0.00	5.56
% Total Routine Evaluations/Total Evaluations	90.00	93.75	0.00	0.00	91.67
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0.00	0.00	0.00	0.00	0.00
# Receipt Time of Emergent Evaluations within 2hrs.	1	0	0	0	1
% Emergent Evaluations Received within 2hrs.	*100.00*	*0.00*	*0.00*	*0.00*	*100.00*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.00	1.00	0.00	0.00	0.50
# Urgent Appointments Offered within 2 days	1	1	0	0	2
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	0.00	1.00	0.00	0.00	0.50
# Receipt Time of Urgent Evaluations within 2 days	1	1	0	0	2
% Urgent Evaluations Received within 2 days	100.00	100.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	5.11	6.73	0.00	0.00	5.85
# Routine Appointments Offered within 14 days	18	15	0	0	33
% Routine Appointments Offered within 14 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Routine Evaluations (days)	10.22	9.14	0.00	0.00	9.75
# Receipt Time of Routine Evaluations within 14 days	15	12	0	0	27
% Routine Evaluations Received within 14 days	83.33	80.00	0.00	0.00	81.82
# Routine Appt Offered within 14 days yet Member Requested Later Appt	7	4	0	0	11
# No-shows/Cancellations Prior to First Routine Evaluation Received	9	6	0	0	15

SITE DATA

Primary				Start Date	End Date	Emerg. Exempt
SITE 1				04/13/2007	-	N
	Emergent	1	0	0	0	1
	Routine	18	15	0	0	33
	Urgent	1	1	0	0	2

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 22 (PROVNO 22)

Report Year: 2010

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP) Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	1	0	0	0	1
# Total Routine Evaluations	16	17	0	0	33
# Total Evaluations	17	17	0	0	34
# Total Evaluations (Total Volume)	30	25	0	0	55
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	5.88	0.00	0.00	0.00	2.94
% Total Routine Evaluations/Total Evaluations	94.12	100.00	0.00	0.00	97.06
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (mn.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	2.00	0.00	0.00	0.00	2.00
# Urgent Appointments Offered within 2 days	1	0	0	0	1
% Urgent Appointments Offered within 2 days	100.00	0.00	0.00	0.00	100.00
Avg. Time Until Receipt of Urgent Evaluations (days)	4.00	0.00	0.00	0.00	4.00
# Receipt Time of Urgent Evaluations within 2 days	0	0	0	0	0
% Urgent Evaluations Received within 2 days	0.00	0.00	0.00	0.00	0.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	1	0	0	0	1
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	9.31	7.94	0.00	0.00	8.61
# Routine Appointments Offered within 14 days	15	17	0	0	32
% Routine Appointments Offered within 14 days	93.75	100.00	0.00	0.00	96.97
Avg. Time Until Receipt of Routine Evaluations (days)	13.69	12.76	0.00	0.00	13.21
# Receipt Time of Routine Evaluations within 14 days	12	14	0	0	26
% Routine Evaluations Received within 14 days	75.00	82.35	0.00	0.00	78.79
# Routine Appt Offered within 14 days yet Member Requested Later Appt	1	2	0	0	3
# No-shows/Cancellations Prior to First Routine Evaluation Received	5	5	0	0	10

SITE DATA

Primary					Start Date	End Date	Emerg. Exempt
SITE 1					03/04/2008	-	N
	Emergent	0	0	0	0		0
	Routine	16	17	0	0		33
	Urgent	1	0	0	0		1

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 23 (PROVNO 23)
Report Year: 2010

Report Description
Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	*0*	*0*	*0*	*0*	*0*
# Total Urgent Evaluations	*3*	*1*	*0*	*0*	*4*
# Total Routine Evaluations	*85*	*83*	*0*	*0*	*168*
# Total Evaluations	88	84	0	0	172
# Total Evaluations (Total Volume)	*90*	*84*	*0*	*0*	*174*
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	3.41	1.19	0.00	0.00	2.33
% Total Routine Evaluations/Total Evaluations	96.59	98.81	0.00	0.00	97.67
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	*0*	*0*	*0*	*0*	*0*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.00	0.00	0.00	0.00	0.00
# Urgent Appointments Offered within 2 days	3	1	0	0	4
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	0.00	0.00	0.00	0.00	0.00
# Receipt Time of Urgent Evaluations within 2 days	3	1	0	0	4
% Urgent Evaluations Received within 2 days	100.00	100.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	5.29	5.94	0.00	0.00	5.61
# Routine Appointments Offered within 14 days	85	83	0	0	168
% Routine Appointments Offered within 14 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Routine Evaluations (days)	11.11	12.28	0.00	0.00	11.68
# Receipt Time of Routine Evaluations within 14 days	65	61	0	0	126
% Routine Evaluations Received within 14 days	76.47	73.49	0.00	0.00	75.00
# Routine Appt Offered within 14 days yet Member Requested Later Appt	20	11	0	0	31
# No-shows/Cancellations Prior to First Routine Evaluation Received	26	24	0	0	50

SITE DATA

Primary				Start Date	End Date	Emerg. Exempt
SITE 1				04/13/2007	-	N
	Emergent	0	0	0	0	0
	Routine	85	83	0	0	168
	Urgent	3	1	0	0	4

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 24 (PROVNO 24)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	1	0	0	0	1
# Total Routine Evaluations	60	59	0	0	119
# Total Evaluations	61	59	0	0	120
# Total Evaluations (Total Volume)	61	59	0	0	120
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	1.64	0.00	0.00	0.00	0.83
% Total Routine Evaluations/Total Evaluations	98.36	100.00	0.00	0.00	99.17
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	2.00	0.00	0.00	0.00	2.00
# Urgent Appointments Offered within 2 days	1	0	0	0	1
% Urgent Appointments Offered within 2 days	100.00	0.00	0.00	0.00	100.00
Avg. Time Until Receipt of Urgent Evaluations (days)	2.00	0.00	0.00	0.00	2.00
# Receipt Time of Urgent Evaluations within 2 days	1	0	0	0	1
% Urgent Evaluations Received within 2 days	100.00	0.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	5.77	6.37	0.00	0.00	6.07
# Routine Appointments Offered within 14 days	60	59	0	0	119
% Routine Appointments Offered within 14 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Routine Evaluations (days)	9.08	7.86	0.00	0.00	8.48
# Receipt Time of Routine Evaluations within 14 days	52	55	0	0	107
% Routine Evaluations Received within 14 days	86.67	93.22	0.00	0.00	89.92
# Routine Appt Offered within 14 days yet Member Requested Later Appt	5	3	0	0	8
# No-shows/Cancellations Prior to First Routine Evaluation Received	26	9	0	0	35

SITE DATA

					Start Date	End Date	Emerg. Exempt
Primary							
SITE 1					04/13/2007	-	N
	Emergent	0	0	0	0		0
	Urgent	1	0	0	0		1
	Routine	51	51	0	0		102
Secondary							
SITE 2					04/13/2007	-	Y
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	9	8	0	0		17

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 25 (PROVNO 25)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	2	0	0	0	2
# Total Routine Evaluations	14	15	0	0	29
# Total Evaluations	16	15	0	0	31
# Total Evaluations (Total Volume)	26	25	0	0	51
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	12.50	0.00	0.00	0.00	6.45
% Total Routine Evaluations/Total Evaluations	87.50	100.00	0.00	0.00	93.55
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.00	0.00	0.00	0.00	0.00
# Urgent Appointments Offered within 2 days	1	0	0	0	1
% Urgent Appointments Offered within 2 days	50.00	0.00	0.00	0.00	50.00
Avg. Time Until Receipt of Urgent Evaluations (days)	1.00	0.00	0.00	0.00	1.00
# Receipt Time of Urgent Evaluations within 2 days	2	0	0	0	2
% Urgent Evaluations Received within 2 days	100.00	0.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	1	0	0	0	1
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	2.71	0.79	0.00	0.00	1.75
# Routine Appointments Offered within 14 days	14	14	0	0	28
% Routine Appointments Offered within 14 days	100.00	93.33	0.00	0.00	96.55
Avg. Time Until Receipt of Routine Evaluations (days)	3.21	1.07	0.00	0.00	2.10
# Receipt Time of Routine Evaluations within 14 days	14	15	0	0	29
% Routine Evaluations Received within 14 days	100.00	100.00	0.00	0.00	100.00
# Routine Appt Offered within 14 days yet Member Requested Later Appt	0	1	0	0	1
# No-shows/Cancellations Prior to First Routine Evaluation Received	0	1	0	0	1

SITE DATA

Primary					Start Date	End Date	Emerg. Exempt
SITE 1					04/13/2007	-	N
	Emergent	0	0	0	0		0
	Routine	14	15	0	0		29
	Urgent	2	0	0	0		2

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 26 (PROVNO 26)

Report Year: 2010

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP) Determining Emergent/Urgent/Routine Access measures
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	4	0	0	4
# Total Urgent Evaluations	2	2	0	0	4
# Total Routine Evaluations	32	16	0	0	48
# Total Evaluations	34	22	0	0	56
# Total Evaluations (Total Volume)	40	31	0	0	71
% Total Emergent Evaluations/Total Evaluations	0.00	18.18	0.00	0.00	7.14
% Total Urgent Evaluations/Total Evaluations	5.88	9.09	0.00	0.00	7.14
% Total Routine Evaluations/Total Evaluations	94.12	72.73	0.00	0.00	85.71
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0.00	31.25	0.00	0.00	31.25
# Receipt Time of Emergent Evaluations within 2hrs.	0	4	0	0	4
% Emergent Evaluations Received within 2hrs.	*0.00*	*100.00*	*0.00*	*0.00*	*100.00*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	1.00	0.50	0.00	0.00	0.75
# Urgent Appointments Offered within 2 days	2	2	0	0	4
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	1.00	0.50	0.00	0.00	0.75
# Receipt Time of Urgent Evaluations within 2 days	2	2	0	0	4
% Urgent Evaluations Received within 2 days	100.00	100.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	8.03	8.00	0.00	0.00	8.02
# Routine Appointments Offered within 14 days	30	13	0	0	43
% Routine Appointments Offered within 14 days	*93.75*	*81.25*	*0.00*	*0.00*	*89.58*
Avg. Time Until Receipt of Routine Evaluations (days)	11.28	9.25	0.00	0.00	10.60
# Receipt Time of Routine Evaluations within 14 days	26	12	0	0	38
% Routine Evaluations Received within 14 days	81.25	75.00	0.00	0.00	79.17
# Routine Appt Offered within 14 days yet Member Requested Later Appt	7	3	0	0	10
# No-shows/Cancellations Prior to First Routine Evaluation Received	4	2	0	0	6

SITE DATA

Primary				Start Date	End Date	Emerg. Exempt
SITE 1				03/04/2008		N
	Emergent	0	4	0	0	4
	Routine	32	16	0	0	48
	Urgent	2	2	0	0	4

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 27 (PROVNO 27)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	4	4	0	0	8
# Total Routine Evaluations	31	20	0	0	51
# Total Evaluations	35	24	0	0	59
# Total Evaluations (Total Volume)	69	68	0	0	137
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	11.43	16.67	0.00	0.00	13.56
% Total Routine Evaluations/Total Evaluations	88.57	83.33	0.00	0.00	86.44
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.50	0.25	0.00	0.00	0.37
# Urgent Appointments Offered within 2 days	4	4	0	0	8
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	2.00	0.25	0.00	0.00	1.12
# Receipt Time of Urgent Evaluations within 2 days	3	4	0	0	7
% Urgent Evaluations Received within 2 days	75.00	100.00	0.00	0.00	87.50
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	1	0	0	0	1
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	6.10	6.75	0.00	0.00	6.35
# Routine Appointments Offered within 14 days	31	20	0	0	51
% Routine Appointments Offered within 14 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Routine Evaluations (days)	11.68	7.10	0.00	0.00	9.88
# Receipt Time of Routine Evaluations within 14 days	26	20	0	0	46
% Routine Evaluations Received within 14 days	83.87	100.00	0.00	0.00	90.20
# Routine Appt Offered within 14 days yet Member Requested Later Appt	7	1	0	0	8
# No-shows/Cancellations Prior to First Routine Evaluation Received	2	0	0	0	2

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary						
SITE 1				04/13/2007	-	N
	Urgent	0	0	0	0	0
	Emergent	0	0	0	0	0
	Routine	0	0	0	0	0
Secondary						
SITE 2				04/13/2007	-	N
	Urgent	0	0	0	0	0
	Emergent	0	0	0	0	0
	Routine	1	0	0	0	1
SITE 3				04/13/2007	-	N
	Emergent	0	0	0	0	0
	Urgent	4	4	0	0	8
	Routine	27	18	0	0	45
SITE 4				04/13/2007	-	Y
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	3	2	0	0	5

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 28 (PROVNO 28)

Report Year: 2010

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP) Determining Emergent/Urgent/Routine Access measures
ECC
Data Source(s): RPT_CTBH08006, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	0	0	0	0	0
# Total Routine Evaluations	45	59	0	0	104
# Total Evaluations	45	59	0	0	104
# Total Evaluations (Total Volume)	80	92	0	0	172
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Routine Evaluations/Total Evaluations	100.00	100.00	0.00	0.00	100.00
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0	0	0	0	0
# Urgent Appointments Offered within 2 days	0	0	0	0	0
% Urgent Appointments Offered within 2 days	0	0	0	0	0
Avg. Time Until Receipt of Urgent Evaluations (days)	0	0	0	0	0
# Receipt Time of Urgent Evaluations within 2 days	0	0	0	0	0
% Urgent Evaluations Received within 2 days	0	0	0	0	0
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	3.82	4.12	0.00	0.00	3.99
# Routine Appointments Offered within 14 days	45	59	0	0	104
% Routine Appointments Offered within 14 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Routine Evaluations (days)	4.82	7.08	0.00	0.00	6.11
# Receipt Time of Routine Evaluations within 14 days	42	51	0	0	93
% Routine Evaluations Received within 14 days	93.33	86.44	0.00	0.00	89.42
# Routine Appt Offered within 14 days yet Member Requested Later Appt	3	8	0	0	11
# No-shows/Cancellations Prior to First Routine Evaluation Received	3	7	0	0	10

SITE DATA

					Start Date	End Date	Emerg. Exempt
Primary							
SITE 1					04/13/2007		N
	Emergent	0	0	0	0	0	0
	Urgent	0	0	0	0	0	0
	Routine	38	49	0	0	87	
Secondary							
SITE 2					04/13/2007		N
	Emergent	0	0	0	0	0	0
	Urgent	0	0	0	0	0	0
	Routine	7	10	0	0	17	

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 29 (PROVNO 29)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP) Determining Emergent/Urgent/Routine Access measures
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	9	9	0	0	18
# Total Urgent Evaluations	4	5	0	0	9
# Total Routine Evaluations	59	46	0	0	105
# Total Evaluations	72	60	0	0	132
# Total Evaluations (Total Volume)	92	75	0	0	167
% Total Emergent Evaluations/Total Evaluations	12.50	15.00	0.00	0.00	13.64
% Total Urgent Evaluations/Total Evaluations	5.56	8.33	0.00	0.00	6.82
% Total Routine Evaluations/Total Evaluations	81.94	76.67	0.00	0.00	79.55
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	68.37	68.25	0.00	0.00	68.31
# Receipt Time of Emergent Evaluations within 2hrs.	8	8	0	0	16
% Emergent Evaluations Received within 2hrs.	88.89	88.89	0.00	0.00	88.89
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.25	1.00	0.00	0.00	0.67
# Urgent Appointments Offered within 2 days	4	5	0	0	9
% Urgent Appointments Offered within 2 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Urgent Evaluations (days)	3.25	1.20	0.00	0.00	2.11
# Receipt Time of Urgent Evaluations within 2 days	2	4	0	0	6
% Urgent Evaluations Received within 2 days	50.00	80.00	0.00	0.00	66.67
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	3	1	0	0	4
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	6.53	6.76	0.00	0.00	6.63
# Routine Appointments Offered within 14 days	59	46	0	0	105
% Routine Appointments Offered within 14 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Routine Evaluations (days)	10.61	9.24	0.00	0.00	10.01
# Receipt Time of Routine Evaluations within 14 days	44	40	0	0	84
% Routine Evaluations Received within 14 days	74.58	86.96	0.00	0.00	80.00
# Routine Appt Offered within 14 days yet Member Requested Later Appt	28	13	0	0	41
# No-shows/Cancellations Prior to First Routine Evaluation Received	0	0	0	0	0

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary						
SITE 1				04/13/2007	-	N
	Emergent	1	3	0	0	4
	Urgent	2	1	0	0	3
	Routine	47	32	0	0	79
Secondary						
SITE 2				04/13/2007	-	Y
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	1	0	0	0	1
SITE 3				04/13/2007	-	Y
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	4	2	0	0	6
SITE 4				04/13/2007	-	Y
	Emergent	8	6	0	0	14
	Urgent	2	4	0	0	6
	Routine	7	12	0	0	19
SITE 5				04/13/2007	-	Y
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	0	0	0	0	0

Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 3 (PROVNO 3)

Report Year: 2010

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08006, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	13	8	0	0	21
# Total Urgent Evaluations	12	8	0	0	20
# Total Routine Evaluations	55	38	0	0	93
# Total Evaluations	80	54	0	0	134
# Total Evaluations (Total Volume)	84	62	0	0	146
% Total Emergent Evaluations/Total Evaluations	16.25	14.81	0.00	0.00	15.67
% Total Urgent Evaluations/Total Evaluations	15.00	14.81	0.00	0.00	14.93
% Total Routine Evaluations/Total Evaluations	68.75	70.37	0.00	0.00	69.40
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	34.00	24.75	0.00	0.00	30.48
# Receipt Time of Emergent Evaluations within 2hrs.	13	8	0	0	21
% Emergent Evaluations Received within 2hrs.	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.17	0.12	0.00	0.00	0.15
# Urgent Appointments Offered within 2 days	12	8	0	0	20
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	0.75	0.62	0.00	0.00	0.70
# Receipt Time of Urgent Evaluations within 2 days	11	7	0	0	18
% Urgent Evaluations Received within 2 days	91.67	87.50	0.00	0.00	90.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	3	2	0	0	5
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	6.98	7.24	0.00	0.00	7.09
# Routine Appointments Offered within 14 days	54	38	0	0	92
% Routine Appointments Offered within 14 days	*98.18*	*100.00*	*0.00*	*0.00*	*98.92*
Avg. Time Until Receipt of Routine Evaluations (days)	10.96	10.24	0.00	0.00	10.67
# Receipt Time of Routine Evaluations within 14 days	43	31	0	0	74
% Routine Evaluations Received within 14 days	78.18	81.58	0.00	0.00	79.57
# Routine Appt Offered within 14 days yet Member Requested Later Appt	7	1	0	0	8
# No-shows/Cancellations Prior to First Routine Evaluation Received	16	9	0	0	25

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary						
SITE 1				04/13/2007		N
	Emergent	13	8	0	0	21
	Routine	55	38	0	0	93
	Urgent	12	8	0	0	20

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 30 (PROVNO 30)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	*0*	*2*	*0*	*0*	*2*
# Total Urgent Evaluations	*9*	*5*	*0*	*0*	*14*
# Total Routine Evaluations	*115*	*123*	*0*	*0*	*238*
# Total Evaluations	124	130	0	0	254
# Total Evaluations (Total Volume)	*161*	*150*	*0*	*0*	*311*
% Total Emergent Evaluations/Total Evaluations	0.00	1.54	0.00	0.00	0.79
% Total Urgent Evaluations/Total Evaluations	7.26	3.85	0.00	0.00	5.51
% Total Routine Evaluations/Total Evaluations	92.74	94.62	0.00	0.00	93.70
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0.00	45.00	0.00	0.00	45.00
# Receipt Time of Emergent Evaluations within 2hrs.	0	2	0	0	2
% Emergent Evaluations Received within 2hrs.	*0.00*	*100.00*	*0.00*	*0.00*	*100.00*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.78	0.80	0.00	0.00	0.79
# Urgent Appointments Offered within 2 days	9	5	0	0	14
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	3.44	5.40	0.00	0.00	4.14
# Receipt Time of Urgent Evaluations within 2 days	5	2	0	0	7
% Urgent Evaluations Received within 2 days	55.56	40.00	0.00	0.00	50.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	5	2	0	0	7
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	3	0	0	3
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	8.22	9.34	0.00	0.00	8.80
# Routine Appointments Offered within 14 days	115	122	0	0	237
% Routine Appointments Offered within 14 days	*100.00*	*99.19*	*0.00*	*0.00*	*99.58*
Avg. Time Until Receipt of Routine Evaluations (days)	14.57	15.56	0.00	0.00	15.08
# Receipt Time of Routine Evaluations within 14 days	76	70	0	0	146
% Routine Evaluations Received within 14 days	66.09	56.91	0.00	0.00	61.34
# Routine Appt Offered within 14 days yet Member Requested Later Appt	38	41	0	0	79
# No-shows/Cancellations Prior to First Routine Evaluation Received	26	32	0	0	58

SITE DATA

Primary					Start Date	End Date	Emerg. Exempt
SITE 1					03/04/2008	-	N
	Emergent	0	2	0	0		2
	Routine	115	123	0	0		238
	Urgent	9	5	0	0		14

Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 31 (PROVNO 31)

Report Year: 2010

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP) Determining Emergent/Urgent/Routine Access measures
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08000, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	6	6	0	0	12
# Total Urgent Evaluations	20	5	0	0	25
# Total Routine Evaluations	112	97	0	0	209
# Total Evaluations	138	108	0	0	246
# Total Evaluations (Total Volume)	233	191	0	0	424
% Total Emergent Evaluations/Total Evaluations	4.35	5.56	0.00	0.00	4.88
% Total Urgent Evaluations/Total Evaluations	14.49	4.63	0.00	0.00	10.16
% Total Routine Evaluations/Total Evaluations	81.16	89.81	0.00	0.00	84.96
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	33.17	35.00	0.00	0.00	34.08
# Receipt Time of Emergent Evaluations within 2hrs.	6	6	0	0	12
% Emergent Evaluations Received within 2hrs.	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.70	1.40	0.00	0.00	0.84
# Urgent Appointments Offered within 2 days	20	5	0	0	25
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	1.85	1.40	0.00	0.00	1.76
# Receipt Time of Urgent Evaluations within 2 days	15	5	0	0	20
% Urgent Evaluations Received within 2 days	75.00	100.00	0.00	0.00	80.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	6	0	0	0	6
# No-shows/Cancellations Prior to First Urgent Evaluation Received	1	0	0	0	1
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	8.23	7.51	0.00	0.00	7.89
# Routine Appointments Offered within 14 days	112	97	0	0	209
% Routine Appointments Offered within 14 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Routine Evaluations (days)	10.62	8.94	0.00	0.00	9.84
# Receipt Time of Routine Evaluations within 14 days	90	86	0	0	176
% Routine Evaluations Received within 14 days	80.36	88.66	0.00	0.00	84.21
# Routine Appt Offered within 14 days yet Member Requested Later Appt	27	19	0	0	46
# No-shows/Cancellations Prior to First Routine Evaluation Received	8	4	0	0	12

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary						
SITE 1				04/13/2007	-	N
	Urgent	11	1	0	0	12
	Emergent	2	3	0	0	5
	Routine	63	48	0	0	111
Secondary						
SITE 2				04/13/2007	-	N
	Urgent	1	1	0	0	2
	Emergent	1	0	0	0	1
	Routine	37	31	0	0	68
SITE 3				04/13/2007	-	N
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	5	1	0	0	6
SITE 4				04/13/2007	-	N
	Emergent	3	3	0	0	6
	Urgent	8	3	0	0	11
	Routine	7	17	0	0	24

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 32 (PROVNO 32)
Report Year: 2010

Report Description
Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	*1*	*3*	*0*	*0*	*4*
# Total Urgent Evaluations	*4*	*2*	*0*	*0*	*6*
# Total Routine Evaluations	*212*	*186*	*0*	*0*	*398*
# Total Evaluations	217	191	0	0	408
# Total Evaluations (Total Volume)	*276*	*265*	*0*	*0*	*541*
% Total Emergent Evaluations/Total Evaluations	0.48	1.57	0.00	0.00	0.98
% Total Urgent Evaluations/Total Evaluations	1.84	1.05	0.00	0.00	1.47
% Total Routine Evaluations/Total Evaluations	97.70	97.38	0.00	0.00	97.55
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	14.00	9.00	0.00	0.00	10.25
# Receipt Time of Emergent Evaluations within 2hrs.	1	3	0	0	4
% Emergent Evaluations Received within 2hrs.	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.00	1.50	0.00	0.00	0.50
# Urgent Appointments Offered within 2 days	4	2	0	0	6
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	0.25	1.50	0.00	0.00	0.67
# Receipt Time of Urgent Evaluations within 2 days	4	2	0	0	6
% Urgent Evaluations Received within 2 days	100.00	100.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	1	0	0	0	1
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	9.03	9.62	0.00	0.00	9.31
# Routine Appointments Offered within 14 days	212	186	0	0	398
% Routine Appointments Offered within 14 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Routine Evaluations (days)	9.11	9.70	0.00	0.00	9.38
# Receipt Time of Routine Evaluations within 14 days	212	186	0	0	398
% Routine Evaluations Received within 14 days	100.00	100.00	0.00	0.00	100.00
# Routine Appt Offered within 14 days yet Member Requested Later Appt	4	2	0	0	6
# No-shows/Cancellations Prior to First Routine Evaluation Received	0	0	0	0	0

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary						
SITE 1				04/13/2007	-	N
	Emergent	0	3	0	0	3
	Urgent	2	2	0	0	4
	Routine	135	121	0	0	256
Secondary						
SITE 2				04/13/2007	-	N
	Emergent	1	0	0	0	1
	Urgent	2	0	0	0	2
	Routine	77	65	0	0	142

Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 33 (PROVNO 33)

Report Year: 2010

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	1	0	0	0	1
# Total Urgent Evaluations	27	27	0	0	54
# Total Routine Evaluations	225	216	0	0	441
# Total Evaluations	253	243	0	0	496
# Total Evaluations (Total Volume)	267	253	0	0	520
% Total Emergent Evaluations/Total Evaluations	0.40	0.00	0.00	0.00	0.20
% Total Urgent Evaluations/Total Evaluations	10.67	11.11	0.00	0.00	10.89
% Total Routine Evaluations/Total Evaluations	88.93	88.88	0.00	0.00	88.91
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0.00	0.00	0.00	0.00	0.00
# Receipt Time of Emergent Evaluations within 2hrs.	1	0	0	0	1
% Emergent Evaluations Received within 2hrs.	*100.00*	*0.00*	*0.00*	*0.00*	*100.00*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.07	0.00	0.00	0.00	0.04
# Urgent Appointments Offered within 2 days	27	27	0	0	54
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	0.07	0.00	0.00	0.00	0.04
# Receipt Time of Urgent Evaluations within 2 days	27	27	0	0	54
% Urgent Evaluations Received within 2 days	100.00	100.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	8.80	9.51	0.00	0.00	9.15
# Routine Appointments Offered within 14 days	225	216	0	0	441
% Routine Appointments Offered within 14 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Routine Evaluations (days)	8.92	9.53	0.00	0.00	9.22
# Receipt Time of Routine Evaluations within 14 days	223	216	0	0	439
% Routine Evaluations Received within 14 days	99.11	100.00	0.00	0.00	99.55
# Routine Appt Offered within 14 days yet Member Requested Later Appt	9	3	0	0	12
# No-shows/Cancellations Prior to First Routine Evaluation Received	3	0	0	0	3

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary						
SITE 1				04/13/2007		N
	Emergent	1	0	0	0	1
	Urgent	27	27	0	0	54
	Routine	225	216	0	0	441
Secondary						
SITE 2				04/13/2007		Y
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	0	0	0	0	0

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 34 (PROVNO 34)
Report Year: 2010

Report Description
Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	0	1	0	0	1
# Total Routine Evaluations	217	262	0	0	479
# Total Evaluations	217	263	0	0	480
# Total Evaluations (Total Volume)	344	393	0	0	737
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	0.00	0.38	0.00	0.00	0.21
% Total Routine Evaluations/Total Evaluations	100.00	99.62	0.00	0.00	99.79
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (mn.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.00	13.00	0.00	0.00	13.00
# Urgent Appointments Offered within 2 days	0	0	0	0	0
% Urgent Appointments Offered within 2 days	0.00	0.00	0.00	0.00	0.00
Avg. Time Until Receipt of Urgent Evaluations (days)	0.00	20.00	0.00	0.00	20.00
# Receipt Time of Urgent Evaluations within 2 days	0	0	0	0	0
% Urgent Evaluations Received within 2 days	0.00	0.00	0.00	0.00	0.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	8.66	8.02	0.00	0.00	8.31
# Routine Appointments Offered within 14 days	202	259	0	0	461
% Routine Appointments Offered within 14 days	93.09	98.85	0.00	0.00	96.24
Avg. Time Until Receipt of Routine Evaluations (days)	12.59	12.18	0.00	0.00	12.37
# Receipt Time of Routine Evaluations within 14 days	160	188	0	0	348
% Routine Evaluations Received within 14 days	73.73	71.76	0.00	0.00	72.65
# Routine Appt Offered within 14 days yet Member Requested Later Appt	47	81	0	0	128
# No-shows/Cancellations Prior to First Routine Evaluation Received	5	11	0	0	16

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary						
SITE 1				04/13/2007	-	N
	Urgent	0	0	0	0	0
	Emergent	0	0	0	0	0
	Routine	154	143	0	0	297
Secondary						
SITE 2				04/13/2007	-	Y
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	0	0	0	0	0
SITE 3				04/13/2007	-	N
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	0	0	0	0	0
SITE 4				04/13/2007	-	Y
	Urgent	0	0	0	0	0
	Emergent	0	0	0	0	0
	Routine	0	0	0	0	0
SITE 5				04/13/2007	-	N
	Urgent	0	1	0	0	1
	Emergent	0	0	0	0	0
	Routine	49	104	0	0	153
SITE 6				04/13/2007	-	Y
	Urgent	0	0	0	0	0
	Emergent	0	0	0	0	0
	Routine	1	0	0	0	1
SITE 7				04/13/2007	-	Y
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	13	15	0	0	28
SITE 8				04/13/2007	-	N
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	0	0	0	0	0

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 35 (PROVNO 35)

Report Year: 2010

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	1	0	0	0	1
# Total Routine Evaluations	84	76	0	0	160
# Total Evaluations	85	76	0	0	161
# Total Evaluations (Total Volume)	106	96	0	0	202
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	1.18	0.00	0.00	0.00	0.62
% Total Routine Evaluations/Total Evaluations	98.82	100.00	0.00	0.00	99.38
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.00	0.00	0.00	0.00	0.00
# Urgent Appointments Offered within 2 days	1	0	0	0	1
% Urgent Appointments Offered within 2 days	100.00	0.00	0.00	0.00	100.00
Avg. Time Until Receipt of Urgent Evaluations (days)	0.00	0.00	0.00	0.00	0.00
# Receipt Time of Urgent Evaluations within 2 days	1	0	0	0	1
% Urgent Evaluations Received within 2 days	100.00	0.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	7.54	7.91	0.00	0.00	7.71
# Routine Appointments Offered within 14 days	82	73	0	0	155
% Routine Appointments Offered within 14 days	97.62	96.05	0.00	0.00	96.87
Avg. Time Until Receipt of Routine Evaluations (days)	14.23	14.24	0.00	0.00	14.23
# Receipt Time of Routine Evaluations within 14 days	66	46	0	0	112
% Routine Evaluations Received within 14 days	78.57	60.53	0.00	0.00	70.00
# Routine Appt Offered within 14 days yet Member Requested Later Appt	42	46	0	0	88
# No-shows/Cancellations Prior to First Routine Evaluation Received	27	14	0	0	41

SITE DATA

					Start Date	End Date	Emerg. Exempt
Primary							
SITE 1					04/13/2007	-	N
	Emergent	0	0	0	0	0	0
	Routine	84	76	0	0	160	
	Urgent	1	0	0	0	1	

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 4 (PROVNO 4)
Report Year: 2010

Report Description
Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	0	0	0	0	0
# Total Routine Evaluations	21	42	0	0	63
# Total Evaluations	21	42	0	0	63
# Total Evaluations (Total Volume)	26	51	0	0	77
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Routine Evaluations/Total Evaluations	100.00	100.00	0.00	0.00	100.00
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0	0	0	0	0
# Urgent Appointments Offered within 2 days	0	0	0	0	0
% Urgent Appointments Offered within 2 days	0	0	0	0	0
Avg. Time Until Receipt of Urgent Evaluations (days)	0	0	0	0	0
# Receipt Time of Urgent Evaluations within 2 days	0	0	0	0	0
% Urgent Evaluations Received within 2 days	0	0	0	0	0
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	5.90	4.81	0.00	0.00	5.17
# Routine Appointments Offered within 14 days	21	42	0	0	63
% Routine Appointments Offered within 14 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Routine Evaluations (days)	8.33	6.45	0.00	0.00	7.08
# Receipt Time of Routine Evaluations within 14 days	20	39	0	0	59
% Routine Evaluations Received within 14 days	95.24	92.86	0.00	0.00	93.65
# Routine Appt Offered within 14 days yet Member Requested Later Appt	5	6	0	0	11
# No-shows/Cancellations Prior to First Routine Evaluation Received	1	7	0	0	8

SITE DATA

Primary				Start Date	End Date	Emerg. Exempt
SITE 1				04/13/2007	-	N
	Emergent	0	0	0	0	0
	Routine	21	42	0	0	63
	Urgent	0	0	0	0	0

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 5 (PROVNO 5)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	2	1	0	0	3
# Total Urgent Evaluations	5	3	0	0	8
# Total Routine Evaluations	130	111	0	0	241
# Total Evaluations	137	115	0	0	252
# Total Evaluations (Total Volume)	160	147	0	0	307
% Total Emergent Evaluations/Total Evaluations	1.46	0.87	0.00	0.00	1.19
% Total Urgent Evaluations/Total Evaluations	3.65	2.61	0.00	0.00	3.17
% Total Routine Evaluations/Total Evaluations	94.89	96.52	0.00	0.00	95.63
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	90.00	60.00	0.00	0.00	80.00
# Receipt Time of Emergent Evaluations within 2hrs.	2	1	0	0	3
% Emergent Evaluations Received within 2hrs.	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	1.60	1.00	0.00	0.00	1.37
# Urgent Appointments Offered within 2 days	5	3	0	0	8
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	2.80	5.67	0.00	0.00	3.87
# Receipt Time of Urgent Evaluations within 2 days	3	0	0	0	3
% Urgent Evaluations Received within 2 days	60.00	0.00	0.00	0.00	37.50
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	1	3	0	0	4
# No-shows/Cancellations Prior to First Urgent Evaluation Received	2	1	0	0	3
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	6.47	6.23	0.00	0.00	6.36
# Routine Appointments Offered within 14 days	130	111	0	0	241
% Routine Appointments Offered within 14 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Routine Evaluations (days)	37.19	7.79	0.00	0.00	23.65
# Receipt Time of Routine Evaluations within 14 days	112	100	0	0	212
% Routine Evaluations Received within 14 days	86.15	90.09	0.00	0.00	87.97
# Routine Appt Offered within 14 days yet Member Requested Later Appt	2	6	0	0	8
# No-shows/Cancellations Prior to First Routine Evaluation Received	35	20	0	0	55

SITE DATA

					Start Date	End Date	Emerg. Exempt
Primary							
SITE 1					04/13/2007	-	N
	Urgent	5	3	0	0		8
	Emergent	2	1	0	0		3
	Routine	110	102	0	0		212
Secondary							
SITE 2					04/13/2007	-	Y
	Urgent	0	0	0	0		0
	Emergent	0	0	0	0		0
	Routine	0	0	0	0		0
SITE 3					04/13/2007	-	Y
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	3	1	0	0		4
SITE 4					04/13/2007	-	Y
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	17	8	0	0		25

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 6 (PROVNO 6)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	5	1	0	0	6
# Total Routine Evaluations	104	67	0	0	171
# Total Evaluations	109	68	0	0	177
# Total Evaluations (Total Volume)	121	77	0	0	198
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	4.59	1.47	0.00	0.00	3.39
% Total Routine Evaluations/Total Evaluations	95.41	98.53	0.00	0.00	96.61
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	2.20	0.00	0.00	0.00	1.83
# Urgent Appointments Offered within 2 days	4	1	0	0	5
% Urgent Appointments Offered within 2 days	80.00	100.00	0.00	0.00	83.33
Avg. Time Until Receipt of Urgent Evaluations (days)	2.80	0.00	0.00	0.00	2.33
# Receipt Time of Urgent Evaluations within 2 days	3	1	0	0	4
% Urgent Evaluations Received within 2 days	60.00	100.00	0.00	0.00	66.67
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	1	0	0	0	1
# No-shows/Cancellations Prior to First Urgent Evaluation Received	1	0	0	0	1
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	7.38	5.56	0.00	0.00	6.68
# Routine Appointments Offered within 14 days	104	65	0	0	169
% Routine Appointments Offered within 14 days	100.00	97.01	0.00	0.00	98.83
Avg. Time Until Receipt of Routine Evaluations (days)	11.68	9.49	0.00	0.00	10.82
# Receipt Time of Routine Evaluations within 14 days	79	54	0	0	133
% Routine Evaluations Received within 14 days	75.96	80.60	0.00	0.00	77.78
# Routine Appt Offered within 14 days yet Member Requested Later Appt	16	16	0	0	32
# No-shows/Cancellations Prior to First Routine Evaluation Received	33	22	0	0	55

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary						
SITE 1				04/13/2007	-	N
	Emergent	0	0	0	0	0
	Urgent	0	1	0	0	1
	Routine	61	44	0	0	105
Secondary						
SITE 2				04/13/2007	-	Y
	Emergent	0	0	0	0	0
	Urgent	1	0	0	0	1
	Routine	8	4	0	0	12
SITE 3				04/13/2007	-	Y
	Emergent	0	0	0	0	0
	Urgent	4	0	0	0	4
	Routine	35	19	0	0	54

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 7 (PROVNO 7)
Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	1	1	0	0	2
# Total Urgent Evaluations	1	1	0	0	2
# Total Routine Evaluations	60	49	0	0	109
# Total Evaluations	62	51	0	0	113
# Total Evaluations (Total Volume)	64	51	0	0	115
% Total Emergent Evaluations/Total Evaluations	1.61	1.96	0.00	0.00	1.77
% Total Urgent Evaluations/Total Evaluations	1.61	1.96	0.00	0.00	1.77
% Total Routine Evaluations/Total Evaluations	96.77	96.08	0.00	0.00	96.46
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0.00	0.00	0.00	0.00	0.00
# Receipt Time of Emergent Evaluations within 2hrs.	1	1	0	0	2
% Emergent Evaluations Received within 2hrs.	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	1.00	1.00	0.00	0.00	1.00
# Urgent Appointments Offered within 2 days	1	1	0	0	2
% Urgent Appointments Offered within 2 days	*100.00*	*100.00*	*0.00*	*0.00*	*100.00*
Avg. Time Until Receipt of Urgent Evaluations (days)	1.00	1.00	0.00	0.00	1.00
# Receipt Time of Urgent Evaluations within 2 days	1	1	0	0	2
% Urgent Evaluations Received within 2 days	100.00	100.00	0.00	0.00	100.00
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	5.12	6.31	0.00	0.00	5.65
# Routine Appointments Offered within 14 days	60	48	0	0	108
% Routine Appointments Offered within 14 days	*100.00*	*97.96*	*0.00*	*0.00*	*99.08*
Avg. Time Until Receipt of Routine Evaluations (days)	5.25	8.27	0.00	0.00	6.59
# Receipt Time of Routine Evaluations within 14 days	60	45	0	0	105
% Routine Evaluations Received within 14 days	100.00	91.84	0.00	0.00	96.33
# Routine Appt Offered within 14 days yet Member Requested Later Appt	1	3	0	0	4
# No-shows/Cancellations Prior to First Routine Evaluation Received	4	3	0	0	7

SITE DATA

Primary					Start Date	End Date	Emerg. Exempt
SITE 1					04/13/2007	-	N
	Emergent	1	1	0	0		2
	Routine	60	49	0	0		109
	Urgent	1	1	0	0		2

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 8 (PROVNO 8)

Report Year: 2010

Report Description

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures.
ECC
Data Source(s): RPT_CTBH08000, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	3	1	0	0	4
# Total Urgent Evaluations	7	5	0	0	12
# Total Routine Evaluations	33	27	0	0	60
# Total Evaluations	43	33	0	0	76
# Total Evaluations (Total Volume)	48	38	0	0	86
% Total Emergent Evaluations/Total Evaluations	6.98	3.03	0.00	0.00	5.26
% Total Urgent Evaluations/Total Evaluations	16.28	15.15	0.00	0.00	15.79
% Total Routine Evaluations/Total Evaluations	76.74	81.82	0.00	0.00	78.95
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	60.00	30.00	0.00	0.00	52.50
# Receipt Time of Emergent Evaluations within 2hrs.	3	1	0	0	4
% Emergent Evaluations Received within 2hrs.	100.00	100.00	0.00	0.00	100.00
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0.71	1.40	0.00	0.00	1.00
# Urgent Appointments Offered within 2 days	7	5	0	0	12
% Urgent Appointments Offered within 2 days	100.00	100.00	0.00	0.00	100.00
Avg. Time Until Receipt of Urgent Evaluations (days)	0.71	11.20	0.00	0.00	5.08
# Receipt Time of Urgent Evaluations within 2 days	7	3	0	0	10
% Urgent Evaluations Received within 2 days	100.00	60.00	0.00	0.00	83.33
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	1	2	0	0	3
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	3	0	0	3
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	5.19	8.63	0.00	0.00	6.76
# Routine Appointments Offered within 14 days	31	25	0	0	56
% Routine Appointments Offered within 14 days	93.94	92.59	0.00	0.00	93.33
Avg. Time Until Receipt of Routine Evaluations (days)	8.31	18.30	0.00	0.00	12.88
# Receipt Time of Routine Evaluations within 14 days	26	22	0	0	48
% Routine Evaluations Received within 14 days	78.79	81.48	0.00	0.00	80.00
# Routine Appt Offered within 14 days yet Member Requested Later Appt	7	9	0	0	16
# No-shows/Cancellations Prior to First Routine Evaluation Received	11	15	0	0	26

SITE DATA

				Start Date	End Date	Emerg. Exempt
Primary						
SITE 1				03/04/2008	-	N
	Emergent	3	1	0	0	4
	Urgent	7	5	0	0	12
	Routine	33	27	0	0	60
Secondary						
SITE 2				03/04/2008	-	Y
	Emergent	0	0	0	0	0
	Urgent	0	0	0	0	0
	Routine	0	0	0	0	0

CONNECTICUT
Behavioral Health Partnership

Report Title: CTBH08006 – Outpatient Registration (OTP) Timely Receipt of Evaluations (18E)

ECC Provider: PROVIDER 9 (PROVNO 9)

Report Year: 2010

Quarterly metrics on the Service Registration Form for routine outpatient services (OTP). Determining Emergent/Urgent/Routine Access measures
ECC
Data Source(s): RPT_CTBH08006, SP_CTBH08006, Ref_ECC_Providers

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	0	0	0	0	0
# Total Urgent Evaluations	0	0	0	0	0
# Total Routine Evaluations	49	53	0	0	102
# Total Evaluations	49	53	0	0	102
# Total Evaluations (Total Volume)	54	55	0	0	109
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Routine Evaluations/Total Evaluations	100.00	100.00	0.00	0.00	100.00
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	0	0	0	0	0
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	0	0	0	0	0
# Urgent Appointments Offered within 2 days	0	0	0	0	0
% Urgent Appointments Offered within 2 days	0	0	0	0	0
Avg. Time Until Receipt of Urgent Evaluations (days)	0	0	0	0	0
# Receipt Time of Urgent Evaluations within 2 days	0	0	0	0	0
% Urgent Evaluations Received within 2 days	0	0	0	0	0
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	0	0	0	0	0
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	6.10	5.02	0.00	0.00	5.54
# Routine Appointments Offered within 14 days	49	52	0	0	101
% Routine Appointments Offered within 14 days	100.00	98.11	0.00	0.00	99.02
Avg. Time Until Receipt of Routine Evaluations (days)	12.59	7.68	0.00	0.00	10.04
# Receipt Time of Routine Evaluations within 14 days	39	46	0	0	85
% Routine Evaluations Received within 14 days	79.59	86.79	0.00	0.00	83.33
# Routine Appt Offered within 14 days yet Member Requested Later Appt	10	7	0	0	17
# No-shows/Cancellations Prior to First Routine Evaluation Received	10	8	0	0	18

SITE DATA

					Start Date	End Date	Emerg. Exempt
Primary							
SITE 1					03/04/2008	-	N
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	39	45	0	0		84
Secondary							
SITE 2					03/04/2008	-	Y
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	2	3	0	0		5
SITE 3					03/20/2009	-	Y
	Emergent	0	0	0	0		0
	Urgent	0	0	0	0		0
	Routine	8	5	0	0		13

CT BHP ECC Routine Access Standard Compliance Tracking (18F)

Print date 7/22/10/Filtered

2nd Qtr 2010

	RNM	Adult/ Child	C	ECC Start Date	Letter Type	Must Meet Access Std by	Provider	Q2 10 Routine Evals	Q2 10 % w/i 14 dys	Q2 10 Total Volume	Q2 10 % Diff	Q1 10 Routine Evals	Q1 10 % w/i 14 dys	Q1 10 Total Volume	Q1 10 % Diff	Q4 09 Routine Evals	Q4 09 % w/i 14 dys	Q3 09 Routine Evals	Q3 09 % w/i 14 dys	Q2 09 Routine Evals	Q2 09 % w/i 14 dys
1	HP	A		04/13/07	na	OK	A	5	100.00%	6	-57.1%	7	100.00%	9	28.6%	17	100.00%	11	100%	13	92% V
2	HP	A		04/13/07	A	OK	B	32	100.00%	34	13.3%	45	93.33%	47	30.6% V	31	83.87% V	34	94% V	27	100%
3	HP		C	04/13/07	na	OK	C	37	100.00%	59	-30.6%	53	98.11%	82	3.8%	42	100.00%	45	100%	46	98%
4	AN	A		04/13/07	na	OK	D	42	100.00%	51	-12.1%	21	100.00%	26	-36.6%	55	100.00%	36	100%	57	100%
26	HP	A	C	04/13/07	na	OK	E	47	97.87%	49	-46.7%	60	100.00%	64	-17.9%	48	100.00%	54	98%	87	93% V
31	AN	A	C	03/04/08	A	OK	F	23	95.65%	34	-17.1%	33	93.94%	48	-2.0% G	34	97.06%	37	84% V	30	97%
25	SF	A	C	03/04/08	na	OK	G	52	98.08%	54	3.8%	48	100.00%	53	15.2%	43	100.00%	38	95%	48	94%
24	HP		C	04/13/07	na	OK	H	60	98.33%	61	-4.7%	78	100.00%	82	-8.9%	37	100.00%	43	98%	55	93%
5	AN		C	04/13/07	na	OK	I	54	100.00%	56	-5.1%	61	100.00%	54	28.6%	41	90.24% V	40	95%	33	100%
33	AN	A		04/13/07	C	OK	J	34	88.24%	47	0.0%	39	94.87%	64	-28.1%	52	100.00%	64	100%	46	100%
6	SF		C	03/04/08	na	OK	K	14	100.00%	23	-11.5%	25	100.00%	29	7.4%	28	100.00%	24	92%	25	88%
7	SF		C	03/04/08	na	OK	L	42	100.00%	51	-8.9%	43	100.00%	55	-5.2%	37	100.00%	47	98%	53	98%
8	HP		C	04/13/07	AO	OK	M	117	100.00%	123	108.5%	141	93.62%	149	-7.5%	150	92.67% G	119	100%	55	89%
9	AN		C	04/13/07	na	OK	N	109	100.00%	143	-27.0%	125	100.00%	154	-4.9%	120	100.00%	103	99%	158	99%
29	AN	A	C	04/13/07	na	OK	O	60	96.67%	70	-25.5%	99	100.00%	115	-0.9%	81	98.77%	64	97%	82	95%
23	HP		C	04/13/07	na	OK	Q	63	98.41%	86	-1.1%	77	100.00%	102	6.3%	67	98.51%	81	99%	78	97%
30	HP	A	C	04/13/07	na	OK	R	141	96.45%	169	33.1%	138	99.28%	166	28.7%	156	100.00%	139	99%	123	100%
35	HP	A	C	04/13/07	V	OK	S	69	78.26%	94	88.0% V	65	98.46%	92	16.5%	70	100.00%	79	100%	50	96%
28	JS		C	03/04/08	A	OK	T	72	97.22%	109	22.5%	52	92.31%	93	45.3% V	98	98.98%	94	97%	58	93%
21	JS		C	04/13/07	na	OK	U	105	99.05%	218	9.0%	140	100.00%	229	15.7%	117	100.00%	108	98%	124	96%
10	HP	A		04/13/07	na	OK	V	15	100.00%	16	-36.0%	18	100.00%	27	-10.0%	16	100.00%	18	83%	23	91% V
11	HP		C	03/04/08	A	OK	W	17	100.00%	25	-41.9%	16	93.75%	30	0.0% G	38	100.00%	28	96%	40	93% V
12	HP	A		04/13/07	na	OK	X	78	100.00%	79	-6.0%	83	100.00%	88	0.0%	51	100.00%	83	96%	84	96%
13	AN		C	04/13/07	na	OK	Y	59	100.00%	59	-15.7%	57	100.00%	60	-15.5%	48	100.00%	59	100%	67	99%
32	AN	A		04/13/07	G	OK	Z	15	93.33%	25	19.0% G	14	100.00%	25	-30.6%	19	100.00%	28	100%	21	100%
14	SF	A	C	04/13/07	na	OK	AA	20	100.00%	63	14.5%	31	100.00%	68	-6.8%	81	100.00%	56	100%	49	90%
34	JS		C	03/04/08	C	OK	BB	14	85.71%	27	-41.3%	30	96.67%	37	-5.1%	44	86.36% V	31	97%	29	86% V
15	HP	A	C	04/13/07	na	OK	CC	59	100.00%	90	20.0%	45	100.00%	79	8.2%	81	100.00%	50	100%	73	95%
16	JS		C	04/13/07	na	OK	DD	45	100.00%	72	-12.2%	56	100.00%	88	6.0%	89	97.75%	57	89%	66	97%
20	SF	A	C	03/04/08	na	OK	FF	117	99.15%	143	-19.7%	113	100.00%	157	-30.5%	107	100.00%	102	97%	153	73%
17	SF	A	C	04/13/07	na	OK	GG	92	100.00%	183	-28.2%	109	100.00%	227	-16.5%	181	100.00%	170	100%	201	100%
18	HP		C	04/13/07	na	OK	HH	185	100.00%	264	-7.0%	211	100.00%	275	8.7%	196	100.00%	184	100%	263	98%
19	AN		C	04/13/07	na	OK	II	208	100.00%	243	29.9%	222	100.00%	264	37.5%	188	100.00%	167	98%	171	92%
22	AN	A	C	04/13/07	A	OK	JJ	250	98.80%	369	18.3%	210	94.29%	331	-7.5% G	308	98.70%	262	96%	301	97%
27	HP		C	04/13/07	na	OK	KK	75	97.33%	95	79.2%	83	98.80%	105	105.9%	105	95.24%	75	96%	34	53%
							35	2,427		3,290	-0.2%	2,648		3574		2,876		2,630		2,823	

Note: The "Routine Evals" column value for Q1'10 forward is generated by enhanced report that "filters out" the evals that are not held to access standard. The "Total Volume" and "% Diff" column values reflect the total volume of the ECC.

Ltrs	Ltr Type	Letter Description
25	na	No Letter (met access std at least 2 consecutive Q's)
5	A	No Letter: (met access std post-grace or volume exemption)
1	AO	Off CAP (for access)
1	V	Volume Exempt. w/ warning of CAP if access std not met in next Q
1	G	Grace w/ warning on CAP if access std not met in next Q (90-94.49 range)
2	C	New CAP (1st Q access std not met)

ECC- MYSTERY SHOPPER CALL LOG (18G) - CYCLE II
1 = Yes, 2= No, 3=N/A

ECC Name	Call#	Caller	RNM	Appropriate Phone Access? *(Phone answered promptly and if VM left, it was returned)*	Use of Triage Process? *(Upon live response, triage questions asked)*	Referral Completed in a timely fashion? *(Referral and triage completed on the day of initial contact?)*	Compliant with Access Standard? *(Appt offered within 14 days)*	Comments	QM Contact Notes *(RNM contact w/ QC for ECC)*	ON CAP? Y / N
CC A			HP							
	1	A		1	1	1	1	Shopper called and was asked all the appropriate info, was told she would receive a call back and this was done within minutes of the 1st one. Appt rec'd	N/A	N
	2	A		1	1	1	1	Shopper called and was asked all the appropriate info, was told she would receive a call back and this was done within minutes of the 1st one. Appt rec'd	N/A	N
	3	A		1	1	1	1	Shopper called and was asked all the appropriate info. Appt rec'd	N/A	N
CC B			AN							
	1	B		1	1	1	2	Shopper reports that info was taken and was told she'd receive a call back - no call back rec'd	RNM called Mitch Mines as Cynthia Neareo-Pearson is out on leave. RNM explained Mystery Shopper process and that the agency had not passed on their recent mystery shopper call. Mr. Mines followed up w/ staff at the agency and placed a follow-up call to	N
	2	A		1	1	1	1	Shopper called and was asked all the appropriate info, was told she would receive a call back and this was done within minutes of the 1st one. Appt rec'd	N/A	
	3	B		1	1	1	1	Shopper was redirected to call the XXXX office due to her reported XXXXX address.	N/A	
CC			AN							

ECC- MYSTERY SHOPPER CALL LOG - CYCLE II
1 = Yes, 2= No, 3=N/A

ECC Name	Call#	Caller	RNM	Appropriate Phone Access? *(Phone answered promptly and if VM left, it was returned)*	Use of Triage Process? *(Upon live response, triage questions asked)*	Referral Completed in a timely fashion? *(Referral and triage completed on the day of initial contact?)*	Compliant with Access Standard? *(Appt offered within 14 days)*	Comments	QM Contact Notes *(RNM contact w/ QC for ECC)*	ON CAP? Y / N
	1	B		1	1	2	2	Shopper indicated that some sx information was obtained but felt the provider cut her off and summed up the issue. Shopper was told she would receive a call back and was told "if no one calls you in a couple of days, please call me back"	RNM called XXXXXXXXX . RNM explained Mystery Shopper process and that the agency had not passed on their recent mystery shopper call. XXXXXX was informed of the details of the mystery shopper call.	Y
	2	A		2	2	2	2	Phone menu indicated that to make a 1st time appt "press 0" which then led to a VM. Shopper initially did not LM and tried an hour later and got the same thing. Left VM and never rec'd call back	RNM spoke w/ XXXXXXXX and informed her of the details and outcome of the mystery shopper call placed on 3/26/09. XXXXXXX is looking into the issue at the XXXXX site and will share update w/ RNM immediately.	
	3	B		2	2	2	2	Shopper called on 4/8/09 and left a message. No CB rec'd		
EGC D			SF							See Cap LOG
	1	B		2	2	2	2	Shopper reports that she did not get to speak to a live person, was sent into the intake persons VM. Shopper left a message and did not receive a call back.	3/12/09 Had left VM with XXXXXXX (QC) who had XXXXXXX call me back. Informed XXXXX of no call back and she reported that they had been having unexpected yet temporary staffing issues but that they still should have managed to return calls.	Y
	2	A		2	2	2	2	Shopper Left VM and no call was returned	3-30-09 LVM for XXXXXXX services stating that another call had been made and not returned. Asked her to call me back with updates on staffing or interventions to deal with this issue.	
	3	B		1	1	1	1	Shopper left VM on 4/8/09, call was returned 4/9/09, a little more than 24 hrs later. Shopper called back and was triaged and offered an appt within the 14 days	N/A	

ECC- MYSTERY SHOPPER CALL LOG - CYCLE II
1 = Yes, 2= No, 3=N/A

ECC Name	Call#	Caller	RNM	Appropriate Phone Access? *(Phone answered promptly and if VM left, it was returned)*	Use of Triage Process? *(Upon live response, triage questions asked)*	Referral Completed in a timely fashion? *(Referral and triage completed on the day of initial contact?)*	Compliant with Access Standard? *(Appt offered within 14 days)*	Comments	QM Contact Notes *(RNM contact w/ QC for ECC)*	ON CAP? Y / N
ECC I										
	1	A		2	2	2	2	Shopper reports that the person who answered the phone told her that the intake worker was not there today and to call back tomorrow. Shopper did not get that persons name and so when she called back to get it, she got a different person who was able to t	RNM called XXXXXX 3/9/09 about the 1st call. XXXX stated that she did not know who the person might have been that would have answered this way. She stated she will check with her staff. Also told XXXXX about the next call below	Y
	2	A		1	1	1	1	Shopper called back to get the name of the previous call handler and got a different person and went ahead with the Mystery Call. There was no issue with this	N/A	
2nd round of calls)	3	A		1	2	2	2	Shopper made initial call 3/25/09 at 10am, was told by Kim she had to call her back b/c she was on the other line. No CB rec'd until 3/26/09 at 11:16am. Had Shopper call the ECC back and this time Kim told shopper she needed to call back in 2 weeks b/c th	3/26/09 - Spoke with XXXXXX and informed her of the staff member not triaging the call and her instructions to the shopper to call back in 2 weeks d/t lack of availability. XXXXX indicated that this should never happen b/c XXXX has a spot in her sc	
	4	A		1	1	1	1	Shopper made the final call and spoke again toXXXX. No triage done and XXXX would not proceed with the call or offer an appt b/c the shopper did not have her own insurance information (not that of her child, which she did have). XXXX asked for the Shoppers	4/7/09 - Called and left a detailed VM for XXXXX who on her message stated she is not in today. LM indicating that the 3rd and final call was placed and that no triage took place and that the shopper was given a hard time over not having her own i	

CT BHP VALUEOPTIONS
FOSTER CARE PILOT PROJECT
QUALITY IMPROVEMENT ACTIVITY (QIA) (22)

Date: March 12, 2010

The **Foster Care Pilot Project** is a quality improvement activity designed to address the higher disruption rate of children in a first time foster care placement who have a history of behavioral health treatment prior to placement. The goal of this activity is to prevent disruption by intervening with foster parents to ensure continuity of behavioral healthcare treatment in the new placement and to immediately assess for the need for additional treatment for the child or support services for the foster parent(s).

Background of the Quality Improvement Activity

During 2007, ValueOptions, in collaboration with the Connecticut Department of Children and Families (CT DCF) and Department of Social Service (DSS), conducted a retrospective analysis of data on children and adolescents placed in DCF Foster care to identify any relationship between use of behavioral health services and disruption from a first or second foster home placement. This project grew out of clinical discussions with the Departments regarding children who experienced delayed discharges from emergency departments (ED). An unknown number of children were brought to the ED by foster families who felt they were no longer able to care for these children as a result of their behavioral health problems. This led to questions regarding whether a foster child appearing in the ED should trigger an urgent behavioral health intervention to prevent a possible disruption from the foster care placement. Early in 2007, a decision was made to include a Performance Target in the Year Two contract between ValueOptions and the Departments that would determine if there is a correlation, hereafter described as a relationship, between disruption of a first or second foster home placement and prior use of behavioral health services.

In June 2007, DCF provided CT BHP with a file extract containing data regarding the children who had been removed from their homes and placed in foster care between July 1, 2006 and December 31, 2006. This allowed CT BHP to attach any authorization data that might have been entered into the information system during the six (6) months before removal and the six (6) months after removal, as well as ED data routinely received from the Department of Social Services (DSS), in order to then analyze the data for possible relationships between use of services and disruption.

An analysis of the findings of the study was submitted to the Departments in November 2007. The analysis revealed that children aged 4 to 18 who had received behavioral healthcare services in the 18 months prior to first time placement in foster care were significantly more likely to disrupt from placement than children who had not received behavioral healthcare services. Youth in foster care who were authorized for inpatient or intermediate level of care before placement were more likely to subsequently disrupt from placement than those authorized for outpatient services.

The recommendation that resulted from these findings was to develop an intervention with youth in a first foster care placement who had been authorized for behavioral health treatment during the 18 month period prior to their placement. During the latter half of 2008, CT BHP worked with several DCF Area Offices across the state to develop a protocol for the intervention. Initially, two DCF Area Offices agreed to pilot the program (Waterbury and Norwich). The pilot began in January 2009. Three more DCF Area Offices agreed to participate since that time (Hartford, New Britain, and Manchester).

Qualifications for Inclusion in the Quality Improvement Activity

In order to qualify for the study, the member must :

- Be between the ages of 4 to 18, who are
- Placed in foster care for the first time (as opposed to a safe home), or who are placed in foster care after having been reunited with their birth parents for more than 3 years,
- Have been authorized for behavioral health treatment within the past 18 months, and
- Be a CT BHP member covered by HUSKY A or B (Medicaid)

Protocol for the Quality Improvement Activity:

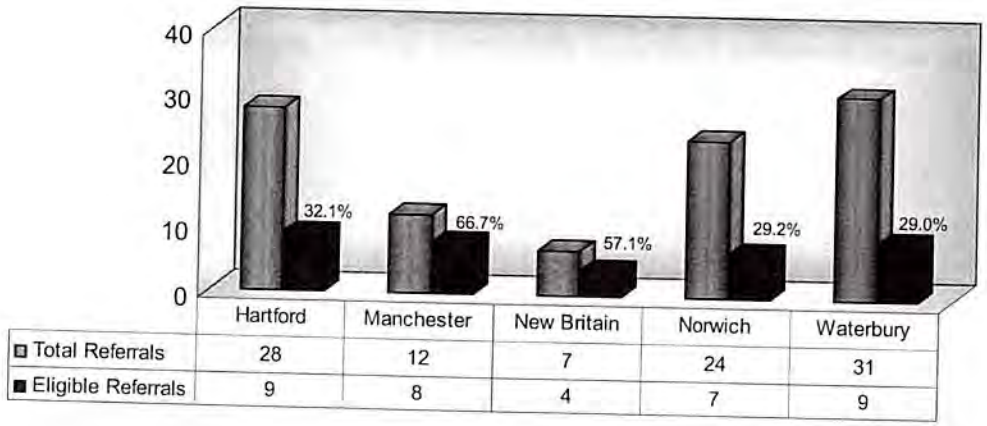
- Each participating DCF Area Office Foster Care "Matcher" notifies the Central Office DCF liaison of any foster care placements within 24 hours of the removal from the home.
- The DCF Liaison identifies active HUSKY members and notifies the CT BHP/QM department liaison.
- QM liaison determines whether the identified member meets the activity's criteria and, as appropriate, assigns member to an Intensive Case Manager (ICM) and Peer Specialist (PS). The ICM and PS are assigned based on DCF Area Office location.
- A case is considered "urgent" if the child has been authorized for an intensive level of care within the past 6 months
  - Telephonic outreach to the DCF worker by the ICM and to the foster family by the PS is initiated within1 business day for cases considered "urgent" and 3 business days for all other cases
  - For urgent referrals, member information is sent over to the ICM and PS in the same business day and outreach was expected to take place within that day.
- Non-urgent referrals were made for members with authorizations for lower levels of behavioral health care within the past 18 months.
  - The turn-around time for these referrals is attempted contact within three business days. In all cases attempts at contact were made far earlier than 3 business days.
- Upon receipt of the case, the **ICM**
  - Researches the child's behavioral health history in AIS and assesses current clinical needs via communication with the DCF Worker and PS after they have spoken with the foster parents.
  - Reaches out to the DCF worker assigned to the member and provides assistance with coordinating appropriate care to assist with the transition into foster care.
  - Outreaches to the members current behavioral health provider in order to provide additional support.
  - Summarizes the history and forwards the information to QM and DCF
  - Completes the Treatment and Crisis Plans
- Upon receipt of the case, the **Peer Specialist**
  - Contacts the foster family to assist in identifying immediate needs and to offer support in the form of phone contact, referrals for traditional and non-traditional services, (community supports, mentors, after school programs, etc) and anything the foster parent might need assistance with during the fragile transition period
  - Works in coordination with the ICMs and DCF to identify the needs of the family and child
  - Works with the foster family to assist them in gaining access to behavioral health services as well as necessary supports and resources in their community.
  - Encourages each family to obtain services
  - Works to address the identified needs as quickly as possible.

Referrals for the QIA

The table below displays the total referrals from each of the participating area offices and the percentage of those eligible for the activity.

Area Office/ Pilot Start Date	Total	Total Percent	Total Eligible	Total Eligible Percent
Hartford (7/09)	28	27.5%	9	32.1%
Manchester (9/09)	12	11.8%	8	66.7%
New Britain (8/09)	7	6.9%	4	57.1%
Norwich (1/09)	24	23.5%	7	29.2%
Waterbury (1/09)	31	30.4%	9	29.0%
Total	**102**	**100.0%**	**37**	**36.3%**

- Norwich and Waterbury began participating in the study in January 2009. Hartford (July 2009), New Britain (August 2009) and Manchester (September 2009) joined the study later in the year.
- The highest volume of referrals, 31 (30.4%) came from the Waterbury Area Office; out of those 9 (29%) were eligible.
- Hartford had the next highest volume of referrals (28, (27.5%) despite the fact that they participated in the QIA for the shortest period of time. Of those referrals, 9 (32.1%) were eligible for activity.
- New Britain submitted the least number of referrals (7; 6.9%) and of those, 4 (57.1%) were eligible for the activity.



Demographic Information-

The table below displays demographic information regarding the age and gender of the referrals from the participating area offices.

Age Category	Total Male Referrals	Total Female Referrals	Total Referrals
Age 4-7	17 (43.6%)	22 (56.4%)	**39**
Age 8-11	7 (38.9%)	11 (61.1%)	**18**
Age 12-15	10 (47.6%)	11 (52.4%)	**21**
Age 16-18	4 (16.7%)	20 (83.3%)	**24**
Total	**38 (37.3%)**	**64 (62.7%)**	**102**

The demographic information above indicates that a higher percentage of HUSKY eligible females (67.6%) were placed into foster care than males (32.4%) across all participating DCF area offices. More females were placed than males in every age category. The largest discrepancy between male and female placement occurred in the 16 to 18 year old age category when 20 of the 24 referrals/placements (83.3%) were females.

The table below displays a comparison of the age demographics of members referred by the participating area offices to those of members eligible for the QIA.

Age Category	Total Referrals	# Eligible	% Eligible
Age 4-7	39	10	25.6%
Age 8-11	18	7	38.9%
Age 12-15	21	7	33.3%
Age 16-18	24	13	54.2%
Total	**102**	**37**	**36.3%**

The highest number of referrals to the activity from the Area Offices were of children in the 4 to 7 age bracket. This age bracket also had the lowest percentage of children eligible for the activity. Children aged 16 to 18 had the highest percentage of eligible referrals.

The table below displays demographic information regarding the effect of gender and age category on eligibility for the activity.

Age Category	Eligible Males	Eligible Females	Total Eligible
Age 4-7	5 (50%)	5 (50%)	10
Age 8-11	3 (42.9%)	4 (57.1%)	7
Age 12-15	4 (57.1%)	3 (42.9%)	7
Age 16-18	0	13 (100%)	13
Total	**12 (32.4%)**	**25 (67.6%)**	**37**

More than twice as many females as males were eligible for the activity. This aligns with the earlier finding that twice as many females were placed in foster care. However, this difference is almost solely accounted for by the differences in gender eligibility in the 16 to 18 year old age category when of the 13 eligible members, no males were included. Below the age of 16, there were essentially no gender differences in eligibility for the activity.

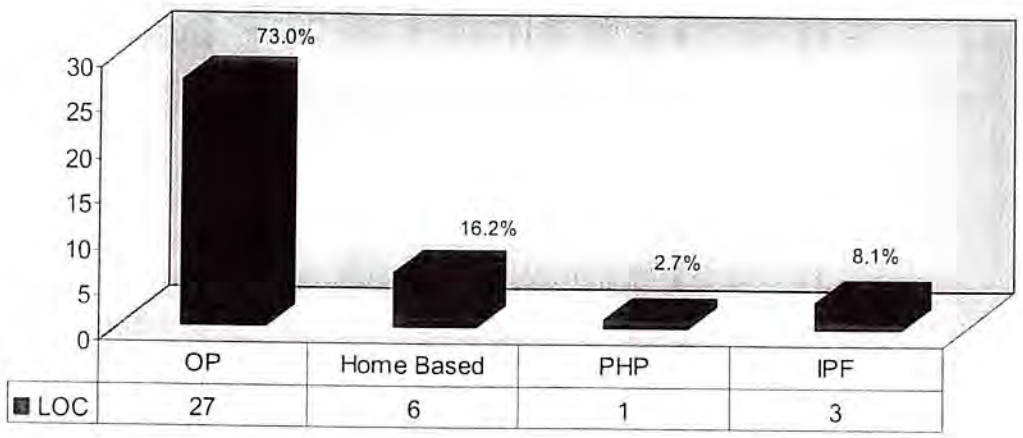
The table below displays demographic information broken out by DCF Area Office. It shows the total numbers of eligible members referred and their percentages by gender.

Area Office	Total Eligible	% of Total Eligible	Eligible Males	% of Total Eligible Males	Eligible Females	% of Total Eligible Females
Hartford	9	24.3%	4	44.4%	5	55.6%
Manchester	8	21.6%	2	25.0%	6	75.0%
New Britain	4	10.8%	2	50.0%	2	50.0%
Norwich	7	18.9%	2	28.6%	5	71.4%
Waterbury	9	24.3%	2	22.2%	7	77.8%
Total	**37**	**100.0%**	**12**	**32.4%**	**25**	**67.6%**

The largest percentage of members eligible for the activity came from the Hartford and Waterbury area offices. As noted above, while overall more females than males are placed in foster care and more females than males were eligible for the activity, exceptions to this finding came from the Hartford and New Britain area offices where equal or nearly equal numbers of females and males were eligible for the study.

Previously Authorized Level of Behavioral Healthcare.

In order to qualify for the foster care project, members needed to have had behavioral healthcare services within the 18 months prior to being removed from their home. The graph below shows the types of behavioral healthcare services that were authorized prior to removal. In those instances when the member was authorized for more than one level of care, the member is included in the highest level of care authorized.



Members eligible for the activity had most frequently used (73%) outpatient services prior to being removed. Home based services (IICAPS, MDFT, and FFT) were the second most frequently authorized at 16.2%, followed by inpatient (8.1%) and partial hospitalization (2.7%).
There were three members with IPF authorizations prior to removal and they were treated as urgent cases due to the intensive level of care and potentially high level of support that would be needed to maintain the youth in placement.

Acceptance of Services

The following charts provide information regarding the number of families who received new authorizations and/or Peer Support (PS) services within 45 days of placement. The PS services include support by CT BHP staff members who are not clinicians but who have lived experience of the behavioral health system either through their own service use of use by their children. The PS services are in the form of phone contact, referrals for traditional and non-traditional services (community supports, mentors, after school programs, etc) and help with anything else the foster parent might need assistance with during the transition period.

The following charts are broken out by Area Office, Gender, and Age. Some families are duplicated if they received both a new authorization for treatment and also accepted PS services. Please view these analyses with caution; the sample sizes are small.

Acceptance of Services by Area Office

Area Office	Total Eligible Number	# Members with New Auth	Percent of Members with New Auth	# Members with PS Accepted	Percent of Members with Acceptance of PS Services
Hartford (7/09)	9	0	0.0%	6	66.7%
Manchester (9/09)	8	3	37.5%	1	12.5%
New Britain (8/09)	4	2	50.0%	2	50.0%
Norwich (1/09)	7	6	85.7%	3	42.9%
Waterbury (1/09)	9	5	55.6%	5	55.6%
Total	**37**	**16**	**43.2%**	**17**	**45.9%**

- Of the 37 members eligible for the study, less than half accepted a new authorization for additional behavioral healthcare services or peer support services. Please keep in mind that these children were already receiving services prior to placement and that these new authorizations only reflect the addition of new services.
    - 16 (43.2%) of them received at least one new authorization for behavioral healthcare within 45 days of placement.
    - 17 (45.9%) accepted PS services.

With regard to specific Area Office findings:

- There are no consistent trends across the area offices.
- 85.7% (6) of Norwich families accepted a new authorization for behavioral healthcare services within 45 days of placement while 42.9% (3) accepted PS services.
- Hartford families had no new authorizations within 45 days of placement but 66.7% accepted PS services.
- Waterbury and Norwich had the same percentage of families (55.6% and 50% respectively) with new authorizations and PS services.
- Manchester had the fewest families who accepted authorizations (37.5%) or PS services (12.5%).

Acceptance of Services by Age Category

Total Eligible Age	Total Eligible Number	New Auth	Percent of New Auth	Peer Support Accepted	Percent of PS Accepted
Age 4-7	10	4	40.0%	4	40.0%
Age 8-11	7	4	57.1%	3	42.9%
Age 12-15	7	3	42.9%	3	42.9%
Age 16-18	13	5	38.5%	7	53.8%
Total	**37**	**16**	**43.2%**	**17**	**45.9%**

- There are no clear trends in acceptance of services by age category. Again, sample sizes are small and any trends must be viewed with caution.
- The highest percent of families who accepted new authorizations was 57.1% for children in the 8 to 11 year old category.
- With regard to acceptance of PS services, the highest rate of acceptance of services (53.8%) was for families fostering 16-18 year olds.

Acceptance of Services by Gender and Age Category

Male Age	Total Eligible Number	New Auth	Percent of New Auth	PS Accepted	Percent of PS Accepted
Age 4-7	5	1	20.0%	2	40.0%
Age 8-11	3	2	66.7%	1	33.3%
Age 12-15	4	2	50.0%	2	50.0%
Age 16-18	0	0	0.0%	0	0.0%
Total	**12**	**5**	**41.7%**	**5**	**41.7%**

Female Age	Total Eligible Number	New Auth	Percent of New Auth	PS Accepted	Percent of PS Accepted
Age 4-7	5	3	60.00%	2	40.0%
Age 8-11	4	2	50.00%	2	50.0%
Age 12-15	3	1	33.30%	1	33.3%
Age 16-18	13	5	38.50%	7	53.8%
Total	**25**	**11**	**44.00%**	**12**	**48.0%**

- Overall, there were no major differences by gender of the foster child with regard to foster families accepting services.
- The "Ns" within the age categories broken out by gender are small; trends can not be safely identified.

Disruptions and Reunifications

For the purposes of the following analysis, disruption is defined as any movement of the youth following the initial foster care placement unless the move was for reunification.

Disruption and Reunification Across Participating Area Offices and by Area Office

The table below displays the number and percentage of disruptions and reunifications by Area Office.

Area Office	Total Eligible	Disruptions	Percent	Reunifications	Percent of Reunifications
Hartford	9	3	33.3%	0	0.0%
Manchester	8	4	50.0%	1	12.5%
New Britain	4	1	25.0%	0	0.0%
Norwich	7	2	25.0%	2	28.6%
Waterbury	9	0	0.0%	3	33.3%
Total	**37**	**10**	**27.0%**	**6**	**16.2%**

- Of the 37 youth who met the criteria for involvement in the improvement activity, 10 (27%) disrupted from their placement within 45 days. This is lower than the disruption rate found for children with a history of previous behavioral health care during the analysis of disruption rates conducted in 2008 (52%).
- The Manchester Area Office had the highest rate of disruption (4 of 8 youth or 50%) and Waterbury had the lowest rate of disruption 0 of 9 youth or 0%)
- Waterbury also had the highest rate of reunification (3 of 9 youth or 33.3%).
- New Britain had the lowest rate of reunification (0 of 4 youth or 0%); however, they also had a low number of youth eligible for the activity so that this variation should be viewed with caution.

Disruptions and Reunifications by Gender

Gender	Total Eligible	Disruptions	Percent Disruptions	Reunifications	Percent Reunification
Male	**12**	**1**	**8.3%**	**3**	**25.0%**
Female	**25**	**9**	**36.0%**	**3**	**12.0%**

- Males were less likely to disrupt than were females.
- Males were also more likely to be reunified with their biologic family than were females.

Disruptions and Reunifications by Age Groupings

Age Groupings	Total Eligible	Disruptions	Percent Disruptions	Reunifications	Percent Reunifications
Age 4-7	10	0	0%	1	10%
Age 8-11	7	2	28.6%	3	42.9%
Age 12-15	7	2	28.6%	0	0%
Age 16-18	13	6	46.2%	2	33.3%
Total	**37**			**6**	

- Youth in the Age 16-18 category were most likely to disrupt from their placement (46.2%).
- Youth in the Age 8-11 category were most likely to be reunified with their biologic family (42.9%).

Disruptions and Reunifications by Age Groupings and Gender

Male	Total Eligible	Disruptions	Percent Disruptions excluding reunifications	Reunifications	Percent of Reunifications
Age 4-7	5	0	0.0%	1	20.0%
Age 8-11	3	0	0.0%	2	66.7%
Age 12-15	4	1	25.0%	0	0.0%
Age 16-18	0	0	0.0%	0	0.0%
Total	**12**	**1**	**8.3%**	**3**	**25.0%**

Female	Total Eligible	(Excluding Reunifications) Disruptions	Percent Disruptions excluding reunifications	Reunifications	Percent of Reunifications
Age 4-7	5	0	0.0%	0	0.0%
Age 8-11	4	2	50.0%	1	25.0%
Age 12-15	3	1	33.3%	0	0.0%
Age 16-18	13	6	46.2%	2	15.4%
Total	**25**	**9**	**36.0%**	**3**	**12.0%**

- While youth in the Age 16-18 age category were most likely to disrupt, this category is made up completely of females. There were no males in the Age 16 to

18 age category.
- The remainder of the cells are too small to comment on trends.

Relationship between Services Received and Disruption

There does not appear to be any clear relationship between the receipt of additional behavioral health services or PS services and disruption.
- Of the 27 youth who either did not disrupt from their placement or who were reunified with their biologic family
  - 8 had only additional behavioral health services authorized
  - 15 had either additional behavioral health services or PS services, and
  - 4 had no additional behavioral health services or PS services.
- Of the 10 who disrupted,
  - 6 had only additional behavioral health services authorized
  - 3 had either additional behavioral health services or PS services, and
  - 1 received no additional behavioral health services

Summary

Although it can not be said with certainty that the intervention prevented disruption, the activity of offering and providing early behavioral health and support services to youth with a first placement in foster care and a recent history of having received behavioral health services may have had a positive impact on disruption rates. While the number of participants in the activity was small (37), the disruption rate of 27% within 45 days was lower than the disruption rate found during the retrospective data analysis of youth with a first placement and a history of previous behavioral health treatment conducted in 2007 (52%). It may be that foster families simply knowing that there were services and/or support available should they need it had a positive effect on their willingness to stick with troubled youth.

Interestingly, less than half of the foster parents were willing to accept an authorization for behavioral health services or for peer support services. Of the 37 members eligible for the study, 16 (43.2%) of them received at least one new authorization for behavioral healthcare within 45 days of placement and 17 (45.9%) accepted PS services. This finding is at least partially explained by the difficulty in reaching foster parents by telephone. In some cases, there was never any direct contact between CT BHP staff and the foster parent. Telephone messages were left for foster parents and follow-up letters were mailed whenever foster parents could not be reached directly.

At the same time, this finding is in line with the feedback received during focus groups with foster parents conducted during 2007. Those foster parents reported that they did not feel that behavioral health services were always necessary or helpful. Instead, they requested more community support services as well as quicker access to behavioral health services when they were necessary. The intervention of contacting foster parents within days of placement and of offering both behavioral health services and/or peer support was designed to address those stated needs.

The low number of eligible participants was the most significant barrier to this project. A total of 102 referrals for this quality improvement activity were received. Of those, only 37 were found to be eligible for the activity.
Other barriers included:
- The difficulty in reaching the foster parents by telephone.
- The difficulty of ICMs reaching DCF workers by telephone
- DCF staff having concerns about sharing information with CT BHP staff as a result of their lack of knowledge about the activity and/or concerns about sharing PHI.

The last two barriers were addressed several months into the activity by sending an e-mail to the DCF worker involved with each case that included a brief description of the activity, the name of the ICM that would be contacting them, and a DCF point person from their Area Office who could answer their questions about the activity.

Recommendations:

1. Discontinue the project as a quality improvement activity given the small number of eligible participants.
2. Consider the continuation of service to this high risk population by including them in the CT BHP ICM program as "youth at risk" youth.
3. Consider expanding the population receiving the intervention to include:
    a. Children placed initially in Star homes and then moved to foster care
    b. Children with multiple disruptions from placement

Improving Access to Behavioral Healthcare Services for Children Newly Placed in Foster Care

Report 22

Value Options and the CT Department of Children and Families

Needs Assessment

- **Scope of the problem**
  - High rate of identification of need for BH services for newly placed foster children
  - Access to care was poor: long waiting lists for outpatient services
  - No reports available to area offices regarding rate of connection to services
- **Priorities**
  - Failure to provide behavioral healthcare services can result in disruption of placement
- **Opportunities**
  - Improve area office knowledge of current performance
  - Improve area office knowledge re local services available
- **Strategic plan**
  - Gain attention of DCF leadership regarding MDE process

Overall Aim Statements

- To increase by 25% the rate at which foster children from two DCF area offices in CT, removed from their home for the first time and identified as having behavioral health needs via the Multi-Disciplinary Exam (MDE), receive the recommended behavioral health treatment within 60 days by informing the area offices of their rates and improving access to care.

- To decrease by 10% the amount of time between the MDE and first behavioral health visit by improving access to care.

Target Population

Identification

- Foster children between the ages of 4 and 17 from across CT removed for the first time
  - Subset of those children from two DCF area offices participating (7 to 14%)
    - Subset of those children identified by the MDE as needing BH treatment within 60 days (55% to 100%)
      - Subset of those children who received BH treatment within 60 days (44.7% to 94.4%)

Stratification

Waterbury

- Percentage of children identified as having BH needs and who received treatment within 60 days ranged from 35.7%-100.0%; Q2 '09 rate = 75.0%
- Average number of days from MDE to date of first BH treatment ranged from 5.0 days-46.0 days; Q2 '09 rate = 6.0 days

Bridgeport

Percentage of children identified as having BH needs and who received treatment within 60 days ranged from 53.8%-100.0%; Q2 '09 rate = 100.0%

Average number of days from MDE to date of first BH treatment ranged from 6.5 days-36.8 days; Q2 '09 rate = 6.5 days

Project Summary

The project was designed to improve the rate of the connection of children from two CT DCF Area Offices, newly placed in foster care and identified during the administration of a Multidisciplinary Exam (MDE) as needing behavioral health (BH) treatment, to those services in a shorter length of time.

Baseline measures:

- 44.7% of newly placed foster children with identified BH treatment needs received it within 60 days.
- The average number of days until the treatment was received was 22.5.

Interventions:

- Providing feedback to the Area Office staff regarding performance
- Implementation of "Enhanced Care Clinics" across the state that required access to BH care within 14 days and sooner for urgent needs

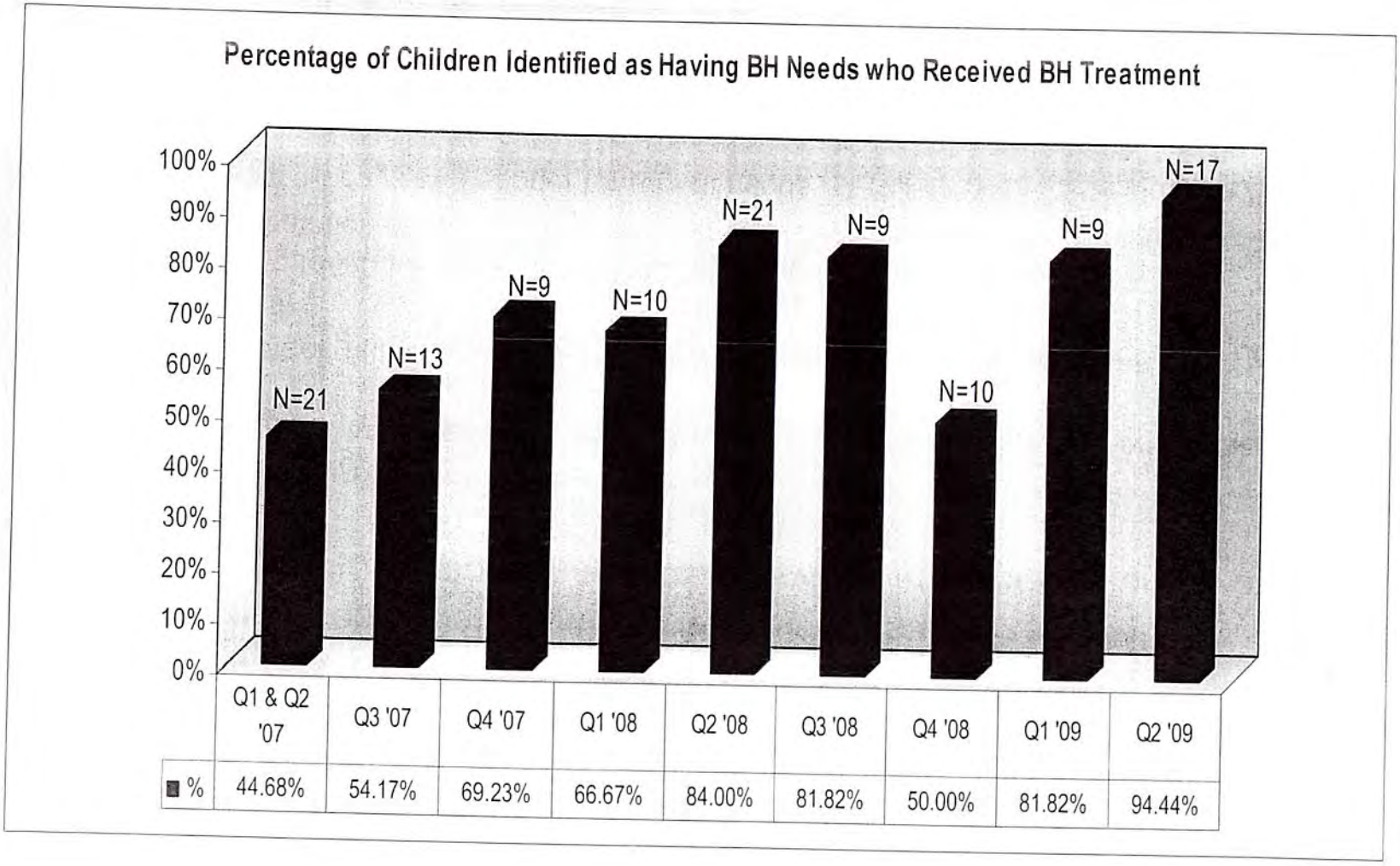
Important Finding:

- Drill down on children with lack of claims-based evidence of follow-up revealed that 38.1% of children categorized as having received no follow-up had received treatment paid from a different funding stream.

Results:

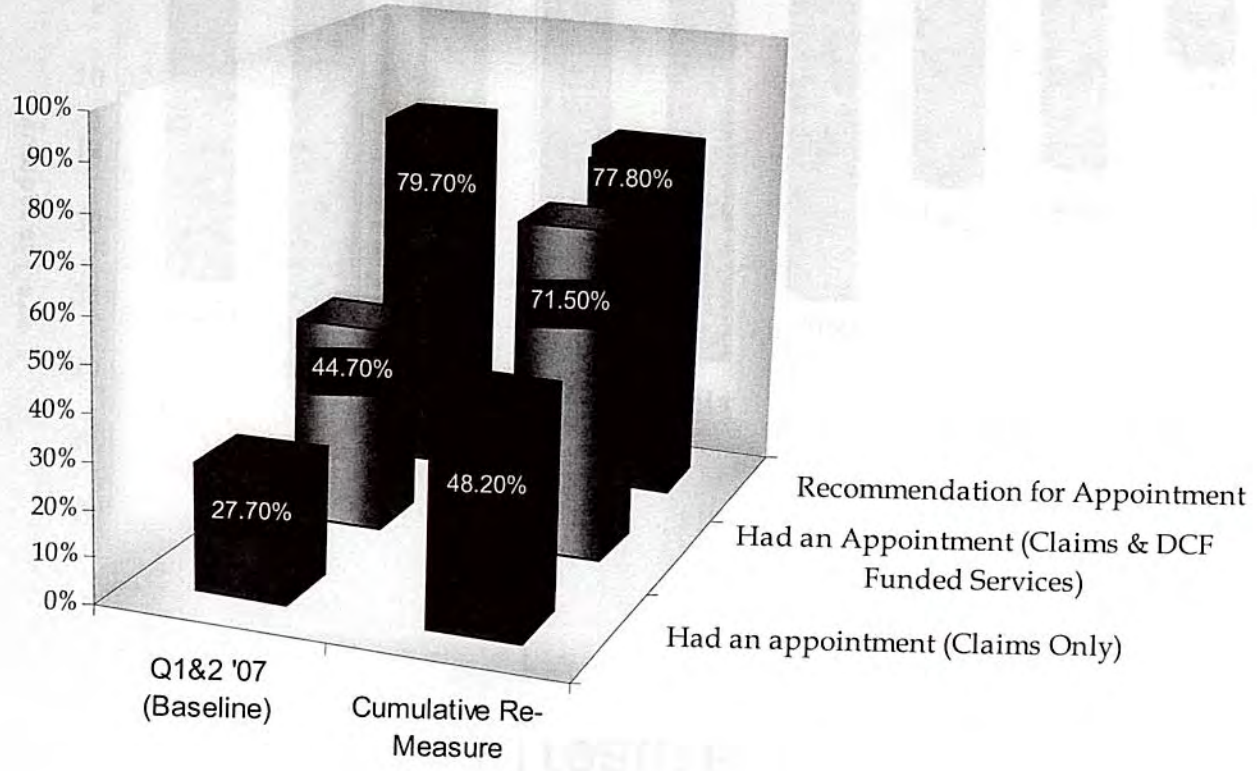
- By Q2 '09, and based on all funding streams, 94.4% of identified children received BH treatment within an average of 6.4 days.

Results:

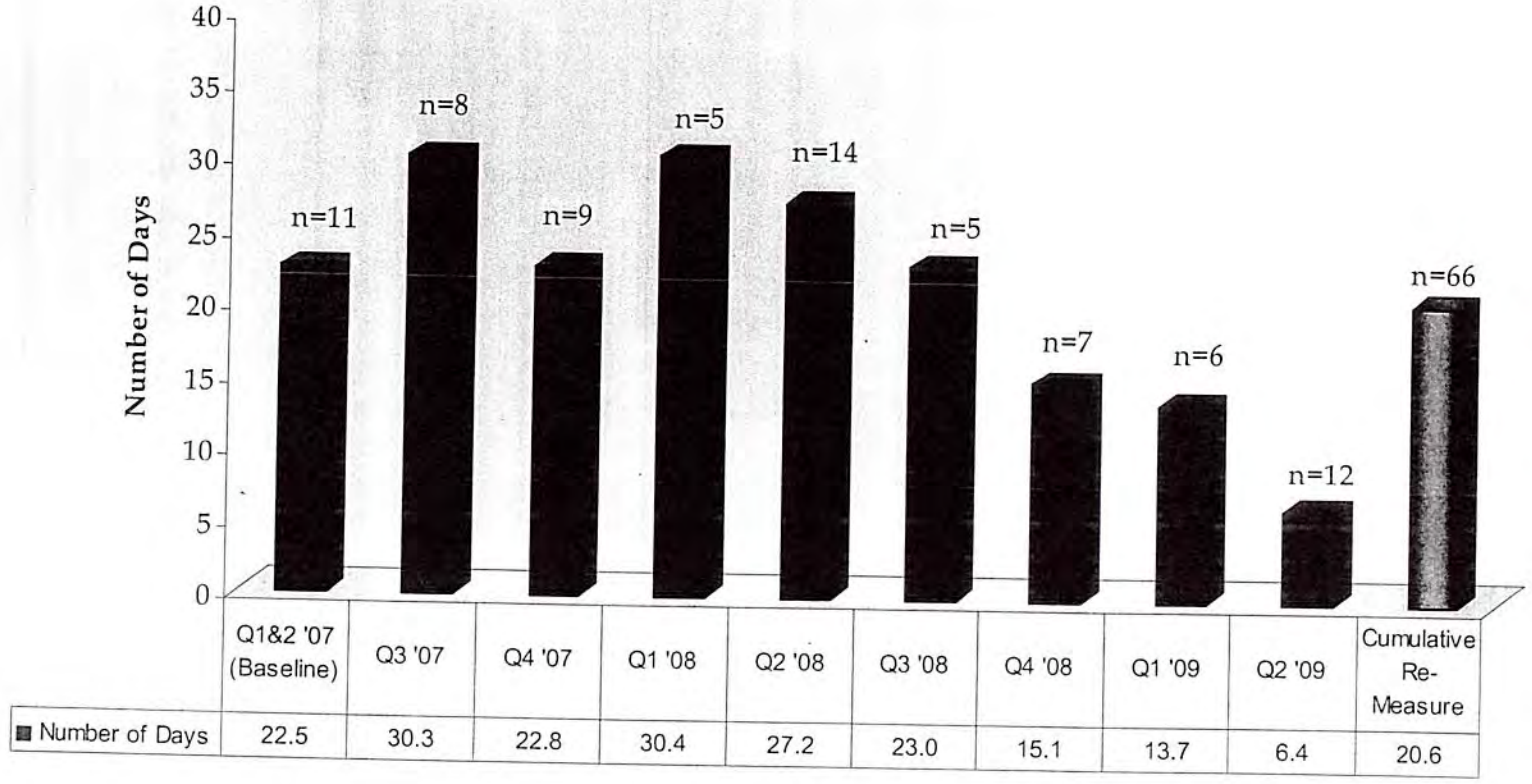

Percentage of Children Identified as Having BH Needs who Received BH Treatment
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
N=21
N=13
N=9
N=10
N=21
N=9
N=10
N=9
N=17
Q1 & Q2 '07
Q3 '07
Q4 '07
Q1 '08
Q2 '08
Q3 '08
Q4 '08
Q1 '09
Q2 '09
% 44.68% 54.17% 69.23% 66.67% 84.00% 81.82% 50.00% 81.82% 94.44%

Percentage of Children with BH Treatment within 60 Days

Claims only vs. Claims & DCF Funded Services



Average Number of Days from MDE to Date of First Treatment



	Q1&2 '07 (Baseline)	Q3 '07	Q4 '07	Q1 '08	Q2 '08	Q3 '08	Q4 '08	Q1 '09	Q2 '09	Cumulative Re-Measure
Number of Days	22.5	30.3	22.8	30.4	27.2	23.0	15.1	13.7	6.4	20.6

**Average number of days represents CTBHP claims data only

Quality Improvement Activity

Outreach

- Educating the Area Offices re their performance led to:
  - Increased attention paid to assuring follow-up
  - The discovery that additional services were being paid via another funding stream, and
  - Area Office understanding that the local clinics that had become Enhanced Care Clinics should be given another chance to provide services

Implications

- Need to build quality improvement oversight into processes like the administration of the MDE
  - No ongoing oversight of MDE vendors
  - Inconsistent administration of the MDE across area offices
  - Inconsistent skill sets of administrators of MDE

- State is now implementing short term improvements of the MDE process and planning longer term system reform
  - Short term improvements include review of vendor contracts and payment arrangements
  - Longer term system reform to include:
    - Re-procurement of MDE contracts,
    - Improved standardization of MDE process and
    - Increased expectations regarding the credentials of the administers of the MDE (i.e. use of developmental psychologists)

Quality Improvement Project

Strengths

- **Increased by 49.7%** the percentage of children who were identified as needing behavioral health services who received behavioral health services within 60 days (from 44.7% to 94.4%)
- **Decreased by 71.6%** the amount of time between the MDE and the first behavioral health visit (from 22.5 days to 6.4 days)
- Project brought attention to MDE process weaknesses

Limitations

- Included only two DCF area offices
- Reorganization of DCF during the study period resulted in lost momentum mid-way thru the project
- High degree of coordination between DCF, DSS, and CT BHP was necessary; information needed for measures was in three different systems
- No assessment of the quality of the care being provided
- DCF funded services not captured within claims data

Next Steps

Sustainability:

Determination regarding whether to expand the project beyond the two area offices to be decided by DCF leadership

Barriers:

- Data collection currently requires highly manual process

Dissemination:

Data and findings will be presented to Foster Care Department Leadership in May 2010

Findings will also be shared with DCF Clinical Leadership in June 2010

CONNECTICUT
Behavioral Health Partnership

Report Title: 26 - CTBH10004 - Adult IPF Length of Stay Analysis

Population: Adult Ages 19 +, Statewide

Reporting Period: 01/01/2010 To 07/31/2010

Report Description

Report Description: Monthly authorization based utilization statistics for In-State Adult (19+) Inpatient Psychiatric Facilities. All data is based on effective discharge dates that occurred in the report period and represents all service days which occurred during the episode of care. Report includes total days, number of discharges, ALOS and standard deviation both by provider and statewide with quarterly and YTD roll-ups. Discharges, ALOS and Standard deviation calculations exclude cases with a LOS greater than 100 days.

CT Valley Hospital, Cedarcrest, State of CT SW CT and State of CT MH are excluded from the report.

PROVIDERS

	JAN	FEB	MAR	QTR 1	APR	MAY	JUN	QTR 2	JUL	AUG	SEP	QTR 3	OCT	NOV	DEC	QTR 4	YTD
Provider Name 1 (ProvNo)																	
NO. DISCHARGES	4	3	1	8	2	8	6	16	4	0	0	4	0	0	0	0	28
TOTAL DAYS	22	17	1	40	13	39	47	99	29	0	0	29	0	0	0	0	168
ALOS	5.50	5.67	1.00	5.00	6.50	4.88	7.83	6.19	7.25	0.00	0.00	7.25	0.00	0.00	0.00	0.00	6.00
STDDEV	1.73	1.53	0.00	2.14	.71	2.59	6.24	4.26	4.19	0.00	0.00	4.19	0.00	0.00	0.00	0.00	3.71
Provider Name 2 (ProvNo)																	
NO. DISCHARGES	5	2	8	15	6	5	5	16	9	0	0	9	0	0	0	0	40
TOTAL DAYS	15	8	32	55	13	18	23	54	38	0	0	38	0	0	0	0	147
ALOS	3.00	4.00	4.00	3.67	2.17	3.60	4.60	3.38	4.22	0.00	0.00	4.22	0.00	0.00	0.00	0.00	3.68
STDDEV	2.00	2.83	1.77	1.88	.75	.89	.55	1.26	2.17	0.00	0.00	2.17	0.00	0.00	0.00	0.00	1.72
Provider Name 3 (ProvNo)																	
NO. DISCHARGES	3	3	5	11	3	2	5	10	5	0	0	5	0	0	0	0	26
TOTAL DAYS	28	18	48	94	20	14	25	59	29	0	0	29	0	0	0	0	182
ALOS	9.33	6.00	9.60	8.55	6.67	7.00	5.00	5.90	5.80	0.00	0.00	5.80	0.00	0.00	0.00	0.00	7.00
STDDEV	2.89	1.73	3.36	3.08	.58	1.41	1.87	1.66	1.79	0.00	0.00	1.79	0.00	0.00	0.00	0.00	2.67
Provider Name 4 (ProvNo)																	
NO. DISCHARGES	2	3	3	8	2	2	5	9	2	0	0	2	0	0	0	0	19
TOTAL DAYS	24	9	7	40	5	5	36	46	17	0	0	17	0	0	0	0	103
ALOS	12.00	3.00	2.33	5.00	2.50	2.50	7.20	5.11	8.50	0.00	0.00	8.50	0.00	0.00	0.00	0.00	5.42
STDDEV	8.49	2.00	.58	5.50	2.12	2.12	3.90	3.86	3.54	0.00	0.00	3.54	0.00	0.00	0.00	0.00	4.50
Provider Name 5 (ProvNo)																	
NO. DISCHARGES	8	3	8	19	8	4	6	18	5	0	0	5	0	0	0	0	42
TOTAL DAYS	34	23	40	97	37	15	23	75	46	0	0	46	0	0	0	0	218
ALOS	4.25	7.67	5.00	5.11	4.63	3.75	3.83	4.17	9.20	0.00	0.00	9.20	0.00	0.00	0.00	0.00	5.19
STDDEV	1.98	3.79	2.00	2.47	2.92	2.87	1.33	2.38	12.21	0.00	0.00	12.21	0.00	0.00	0.00	0.00	4.69
Provider Name 6 (ProvNo)																	
NO. DISCHARGES	2	1	4	7	2	3	2	7	2	0	0	2	0	0	0	0	16
TOTAL DAYS	16	12	30	58	16	33	15	64	11	0	0	11	0	0	0	0	133
ALOS	8.00	12.00	7.50	8.29	8.00	11.00	7.50	9.14	5.50	0.00	0.00	5.50	0.00	0.00	0.00	0.00	8.31
STDDEV	4.24	0.00	3.11	3.25	5.66	3.61	2.12	3.67	.71	0.00	0.00	.71	0.00	0.00	0.00	0.00	3.32

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PROVIDERS

	JAN	FEB	MAR	QTR 1	APR	MAY	JUN	QTR 2	JUL	AUG	SEP	QTR 3	OCT	NOV	DEC	QTR 4	YTD
Provider Name 7 (ProvNo)																	
NO. DISCHARGES	17	21	20	58	21	26	28	75	20	0	0	20	0	0	0	0	153
TOTAL DAYS	112	142	117	371	110	178	150	438	117	0	0	117	0	0	0	0	926
ALOS	6.59	6.76	5.85	6.40	5.24	6.85	5.36	5.84	5.85	0.00	0.00	5.85	0.00	0.00	0.00	0.00	6.05
STDDEV	1.91	7.01	5.47	5.33	3.35	6.02	3.55	4.52	3.31	0.00	0.00	3.31	0.00	0.00	0.00	0.00	4.69
Provider Name 8 (ProvNo)																	
NO. DISCHARGES	12	5	17	34	10	10	8	28	5	0	0	5	0	0	0	0	67
TOTAL DAYS	65	30	83	178	75	59	41	175	17	0	0	17	0	0	0	0	370
ALOS	5.42	6.00	4.88	5.24	7.50	5.90	5.13	6.25	3.40	0.00	0.00	3.40	0.00	0.00	0.00	0.00	5.52
STDDEV	3.80	2.92	3.31	3.37	11.19	3.31	3.40	7.03	1.67	0.00	0.00	1.67	0.00	0.00	0.00	0.00	5.16
Provider Name 9 (ProvNo)																	
NO. DISCHARGES	2	2	2	6	2	4	1	7	4	0	0	4	0	0	0	0	17
TOTAL DAYS	10	12	52	74	25	26	7	58	48	0	0	48	0	0	0	0	180
ALOS	5.00	6.00	26.00	12.33	12.50	6.50	7.00	8.29	12.00	0.00	0.00	12.00	0.00	0.00	0.00	0.00	10.59
STDDEV	2.83	1.41	12.73	12.11	14.85	3.87	0.00	7.25	10.23	0.00	0.00	10.23	0.00	0.00	0.00	0.00	9.44
Provider Name 10 (ProvNo)																	
NO. DISCHARGES	1	3	5	9	2	4	1	7	2	0	0	2	0	0	0	0	18
TOTAL DAYS	6	16	35	57	15	33	6	54	15	0	0	15	0	0	0	0	126
ALOS	6.00	5.33	7.00	6.33	7.50	8.25	6.00	7.71	7.50	0.00	0.00	7.50	0.00	0.00	0.00	0.00	7.00
STDDEV	0.00	1.15	2.00	1.73	.71	2.22	0.00	1.80	2.12	0.00	0.00	2.12	0.00	0.00	0.00	0.00	1.81
Provider Name 11 (ProvNo)																	
NO. DISCHARGES	2	4	5	11	6	2	2	10	5	0	0	5	0	0	0	0	26
TOTAL DAYS	26	33	37	96	25	41	18	84	23	0	0	23	0	0	0	0	203
ALOS	13.00	8.25	7.40	8.73	4.17	20.50	9.00	8.40	4.60	0.00	0.00	4.60	0.00	0.00	0.00	0.00	7.81
STDDEV	15.56	3.40	6.88	7.16	2.32	23.33	4.24	10.49	2.30	0.00	0.00	2.30	0.00	0.00	0.00	0.00	7.97
Provider Name 12 (ProvNo)																	
NO. DISCHARGES	5	9	4	18	11	10	11	32	9	0	0	9	0	0	0	0	59
TOTAL DAYS	54	46	21	121	91	93	52	236	74	0	0	74	0	0	0	0	431
ALOS	10.80	5.11	5.25	6.72	8.27	9.30	4.73	7.38	8.22	0.00	0.00	8.22	0.00	0.00	0.00	0.00	7.31
STDDEV	7.69	2.26	1.71	4.86	5.57	6.65	2.53	5.37	7.51	0.00	0.00	7.51	0.00	0.00	0.00	0.00	5.51

CONNECTICUT
Behavioral Health Partnership

Report Title: 26 - CTBH10004 - Adult IPF Length of Stay Analysis

Population: Adult Ages 19 +, Statewide

Reporting Period: 01/01/2010 To 07/31/2010

Report Description

Report Description: Monthly authorization based utilization statistics for In-State Adult (19+) Inpatient Psychiatric Facilities. All data is based on effective discharge dates that occurred in the report period and represents all service days which occurred during the episode of care. Report includes total days, number of discharges, ALOS and standard deviation both by provider and statewide with quarterly and YTD roll-ups. Discharges, ALOS and Standard deviation calculations exclude cases with a LOS greater than 100 days.

CT Valley Hospital, Cedarcrest, State of CT SW CT and State of CT MH are excluded from the report.

PROVIDERS

	JAN	FEB	MAR	QTR 1	APR	MAY	JUN	QTR 2	JUL	AUG	SEP	QTR 3	OCT	NOV	DEC	QTR 4	YTD
Provider Name 13 (ProvNo)																	
NO. DISCHARGES	3	4	2	9	1	0	7	8	4	0	0	4	0	0	0	0	21
TOTAL DAYS	17	27	11	55	6	0	35	41	18	0	0	18	0	0	0	0	114
ALOS	5.67	6.75	5.50	6.11	6.00	0.00	5.00	5.13	4.50	0.00	0.00	4.50	0.00	0.00	0.00	0.00	5.43
STDDEV	2.52	.96	3.54	1.96	0.00	0.00	1.41	1.36	1.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	1.66
Provider Name 14 (ProvNo)																	
NO. DISCHARGES	2	1	2	5	0	2	3	5	1	0	0	1	0	0	0	0	11
TOTAL DAYS	15	3	8	26	0	12	11	23	3	0	0	3	0	0	0	0	52
ALOS	7.50	3.00	4.00	5.20	0.00	6.00	3.67	4.60	3.00	0.00	0.00	3.00	0.00	0.00	0.00	0.00	4.73
STDDEV	4.95	0.00	2.83	3.56	0.00	0.00	2.08	1.95	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.65
Provider Name 15 (ProvNo)																	
NO. DISCHARGES	1	1	2	4	0	1	1	2	1	0	0	1	0	0	0	0	7
TOTAL DAYS	6	6	5	17	0	6	6	12	3	0	0	3	0	0	0	0	32
ALOS	6.00	6.00	2.50	4.25	0.00	6.00	6.00	6.00	3.00	0.00	0.00	3.00	0.00	0.00	0.00	0.00	4.57
STDDEV	0.00	0.00	.71	2.06	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.81
Provider Name 16 (ProvNo)																	
NO. DISCHARGES	1	5	2	8	1	0	0	1	3	0	0	3	0	0	0	0	12
TOTAL DAYS	2	24	18	44	6	0	0	6	20	0	0	20	0	0	0	0	70
ALOS	2.00	4.80	9.00	5.50	6.00	0.00	0.00	6.00	6.67	0.00	0.00	6.67	0.00	0.00	0.00	0.00	5.83
STDDEV	0.00	2.05	5.66	3.55	0.00	0.00	0.00	0.00	5.69	0.00	0.00	5.69	0.00	0.00	0.00	0.00	3.76
Provider Name 17 (ProvNo)																	
NO. DISCHARGES	19	14	11	44	6	10	7	23	6	0	0	6	0	0	0	0	73
TOTAL DAYS	120	84	57	261	62	71	54	187	60	0	0	60	0	0	0	0	508
ALOS	6.32	6.00	5.18	5.93	10.33	7.10	7.71	8.13	10.00	0.00	0.00	10.00	0.00	0.00	0.00	0.00	6.96
STDDEV	2.93	1.96	1.72	2.38	8.82	4.43	1.38	5.30	12.33	0.00	0.00	12.33	0.00	0.00	0.00	0.00	4.94
Provider Name 18 (ProvNo)																	
NO. DISCHARGES	8	13	14	35	9	7	6	22	9	0	0	9	0	0	0	0	66
TOTAL DAYS	53	188	101	342	58	51	66	175	64	0	0	64	0	0	0	0	581
ALOS	6.63	14.46	7.21	9.77	6.44	7.29	11.00	7.95	7.11	0.00	0.00	7.11	0.00	0.00	0.00	0.00	8.80
STDDEV	4.47	19.95	3.95	12.81	3.47	2.56	7.48	4.85	2.93	0.00	0.00	2.93	0.00	0.00	0.00	0.00	9.78

CONNECTICUT
Behavioral Health Partnership

Report Title: 26 - CTBH10004 - Adult IPF Length of Stay Analysis

Population: Adult Ages 19 +, Statewide

Reporting Period: 01/01/2010 To 07/31/2010

Report Description

Report Description: Monthly authorization based utilization statistics for In-State Adult (19+) Inpatient Psychiatric Facilities. All data is based on effective discharge dates that occurred in the report period and represents all service days which occurred during the episode of care. Report includes total days, number of discharges, ALOS and standard deviation both by provider and statewide with quarterly and YTD roll-ups. Discharges, ALOS and Standard deviation calculations exclude cases with a LOS greater than 100 days.

CT Valley Hospital, Cedarcrest, State of CT SW CT and State of CT MH are excluded from the report.

PROVIDERS

	JAN	FEB	MAR	QTR 1	APR	MAY	JUN	QTR 2	JUL	AUG	SEP	QTR 3	OCT	NOV	DEC	QTR 4	YTD
Provider Name 19 (ProvNo)																	
NO. DISCHARGES	6	5	5	16	5	2	4	11	9	0	0	9	0	0	0	0	36
TOTAL DAYS	29	31	26	86	50	12	20	82	52	0	0	52	0	0	0	0	220
ALOS	4.83	6.20	5.20	5.38	10.00	6.00	5.00	7.45	5.78	0.00	0.00	5.78	0.00	0.00	0.00	0.00	6.11
STDDEV	1.60	3.56	1.30	2.25	6.40	1.41	3.56	5.15	1.20	0.00	0.00	1.20	0.00	0.00	0.00	0.00	3.30
Provider Name 20 (ProvNo)																	
NO. DISCHARGES	4	6	2	12	1	0	3	4	1	0	0	1	0	0	0	0	17
TOTAL DAYS	38	32	21	91	7	0	10	17	9	0	0	9	0	0	0	0	117
ALOS	9.50	5.33	10.50	7.58	7.00	0.00	3.33	4.25	9.00	0.00	0.00	9.00	0.00	0.00	0.00	0.00	6.88
STDDEV	2.65	3.78	3.54	3.90	0.00	0.00	2.08	2.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.74
Provider Name 21 (ProvNo)																	
NO. DISCHARGES	4	5	8	17	4	3	2	9	4	0	0	4	0	0	0	0	30
TOTAL DAYS	34	16	34	84	16	12	7	35	24	0	0	24	0	0	0	0	143
ALOS	8.50	3.20	4.25	4.94	4.00	4.00	3.50	3.89	6.00	0.00	0.00	6.00	0.00	0.00	0.00	0.00	4.77
STDDEV	3.79	1.30	3.20	3.45	1.83	2.00	2.12	1.69	6.06	0.00	0.00	6.06	0.00	0.00	0.00	0.00	3.41
Provider Name 23 (ProvNo)																	
NO. DISCHARGES	0	1	0	1	1	0	2	3	1	0	0	1	0	0	0	0	5
TOTAL DAYS	0	7	0	7	4	0	14	18	3	0	0	3	0	0	0	0	28
ALOS	0.00	7.00	0.00	7.00	4.00	0.00	7.00	6.00	3.00	0.00	0.00	3.00	0.00	0.00	0.00	0.00	5.60
STDDEV	0.00	0.00	0.00	0.00	0.00	0.00	1.41	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.07
Provider Name 24 (ProvNo)																	
NO. DISCHARGES	4	2	7	13	6	7	4	17	2	0	0	2	0	0	0	0	32
TOTAL DAYS	34	10	54	98	32	33	22	87	15	0	0	15	0	0	0	0	200
ALOS	8.50	5.00	7.71	7.54	5.33	4.71	5.50	5.12	7.50	0.00	0.00	7.50	0.00	0.00	0.00	0.00	6.25
STDDEV	2.38	1.41	5.65	4.35	1.21	2.06	1.29	1.58	.71	0.00	0.00	.71	0.00	0.00	0.00	0.00	3.18
Provider Name 25 (ProvNo)																	
NO. DISCHARGES	3	6	3	12	3	4	10	17	4	0	0	4	0	0	0	0	33
TOTAL DAYS	33	23	45	101	12	20	58	90	23	0	0	23	0	0	0	0	214
ALOS	11.00	3.83	15.00	8.42	4.00	5.00	5.80	5.29	5.75	0.00	0.00	5.75	0.00	0.00	0.00	0.00	6.48
STDDEV	7.21	1.94	10.00	7.38	1.73	1.41	1.62	1.65	1.26	0.00	0.00	1.26	0.00	0.00	0.00	0.00	4.74

CONNECTICUT
Behavioral Health Partnership

Report Title: 26 - CTBH10004 - Adult IPF Length of Stay Analysis

Population: Adult Ages 19 +, Statewide

Reporting Period: 01/01/2010 To 07/31/2010

Report Description

Report Description: Monthly authorization based utilization statistics for In-State Adult (19+) Inpatient Psychiatric Facilities. All data is based on effective discharge dates that occurred in the report period and represents all service days which occurred during the episode of care. Report includes total days, number of discharges, ALOS and standard deviation both by provider and statewide with quarterly and YTD roll-ups. Discharges, ALOS and Standard deviation calculations exclude cases with a LOS greater than 100 days.

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PROVIDERS

Provider Name 26 (ProvNo)	JAN	FEB	MAR	QTR 1	APR	MAY	JUN	QTR 2	JUL	AUG	SEP	QTR 3	OCT	NOV	DEC	QTR 4	YTD
NO. DISCHARGES	14	11	14	39	8	8	9	25	13	0	0	13	0	0	0	0	77
TOTAL DAYS	114	71	111	296	57	88	70	215	102	0	0	102	0	0	0	0	613
ALOS	8.14	6.45	7.93	7.59	7.13	11.00	7.78	8.60	7.85	0.00	0.00	7.85	0.00	0.00	0.00	0.00	7.96
STDDEV	2.60	2.38	3.65	2.98	4.55	9.59	3.11	6.24	3.53	0.00	0.00	3.53	0.00	0.00	0.00	0.00	4.35

CONNECTICUT
Behavioral Health Partnership

Report Title: 26 - CTBH10004 - Adult IPF Length of Stay Analysis

Population: Adult Ages 19 +, Statewide

Reporting Period: 01/01/2010 To 07/31/2010

Report Description

Report Description: Monthly authorization based utilization statistics for In-State Adult (19+) Inpatient Psychiatric Facilities. All data is based on effective discharge dates that occurred in the report period and represents all service days which occurred during the episode of care. Report includes total days, number of discharges, ALOS and standard deviation both by provider and statewide with quarterly and YTD roll-ups. Discharges, ALOS and Standard deviation calculations exclude cases with a LOS greater than 100 days.

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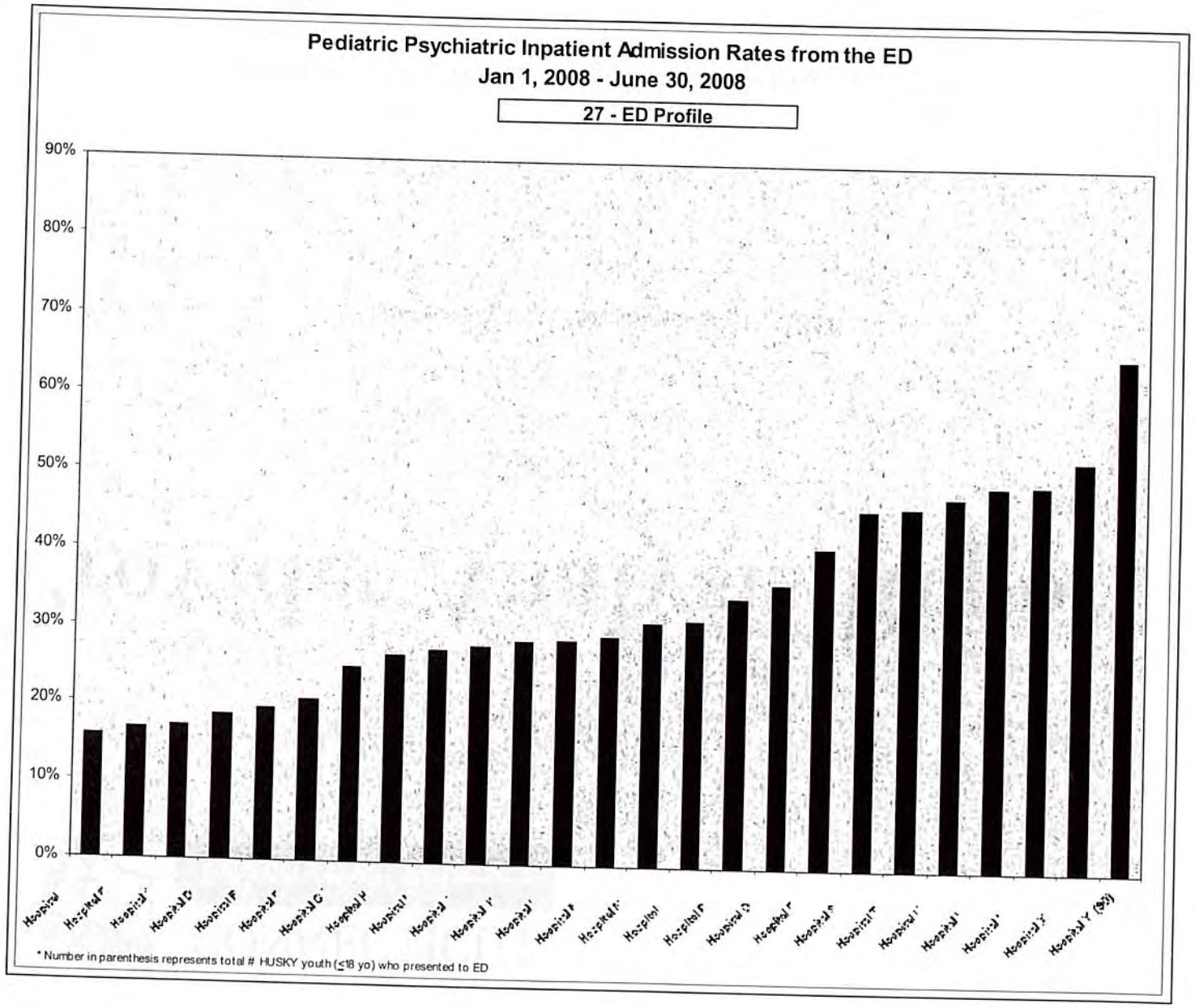
STATEWIDE

STATEWIDE	JAN	FEB	MAR	QTR 1	APR	MAY	JUN	QTR 2	JUL	AUG	SEP	QTR 3	OCT	NOV	DEC	QTR 4	YTD
NO. DISCHARGES	132	133	154	419	120	124	138	382	130	0	0	130	0	0	0	0	931
TOTAL DAYS	907	888	994	2789	755	859	816	2430	860	0	0	860	0	0	0	0	6079
ALOS	6.87	6.68	6.45	6.66	6.29	6.93	5.91	6.36	6.62	0.00	0.00	6.62	0.00	0.00	0.00	0.00	6.53
STDDEV	3.97	7.43	4.87	5.58	5.34	5.63	3.47	4.86	5.12	0.00	0.00	5.12	0.00	0.00	0.00	0.00	5.23


Pediatric Psychiatric Inpatient Admission Rates from the ED
Jan 1, 2008 - June 30, 2008
27 - ED Profile
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
* Number in parenthesis represents total # HUSKY youth (≤18 yo) who presented to ED

Provider Analysis Report

Report 27

Date of Visit: September 10, 2010

Quarterly Date Range: April 1, 2010-June 30, 2010

Provider Analysis Report

Table of Contents:

▪Big 8:

▪Unless otherwise specified, Average Length of Stay (ALOS)= Total number of days associated with discharged cases ***divided by*** the total number of discharged cases.

▪Unless otherwise specified, in graphs representing ALOS: The vertical axis reflects the ALOS in days. The horizontal axis represents the quarter being reported. (N) represents the number of discharged cases.

▪Unless otherwise specified, all data within this report is based on discharges in the quarter; therefore days included in the stay may have occured in previous quarters.

▪Data run date throughout this report reflects run date of Q2 2010 data only.

Provider Analysis Report

Date Range: April 1, 2010-June 30, 2010

Demographics- Provider 1

DCF

	# Male	# Female	Total #
Bridgeport	2	2	4
Danbury	0	0	0
Milford	5	2	7
Hartford	3	0	3
Manchester	0	0	0
Meriden	1	0	1
Middletown	0	1	1
New Britain	1	1	2
New Haven	8	6	14
Norwalk	0	0	0
Norwich	0	1	1
Other	0	0	0
Stamford	0	0	0
Torrington	1	0	1
Waterbury	0	0	0
Willimantic	0	1	1
DCF Total	**21**	**14**	**35**
Provider 1 Total			**132**
Percent DCF			**26.5%**

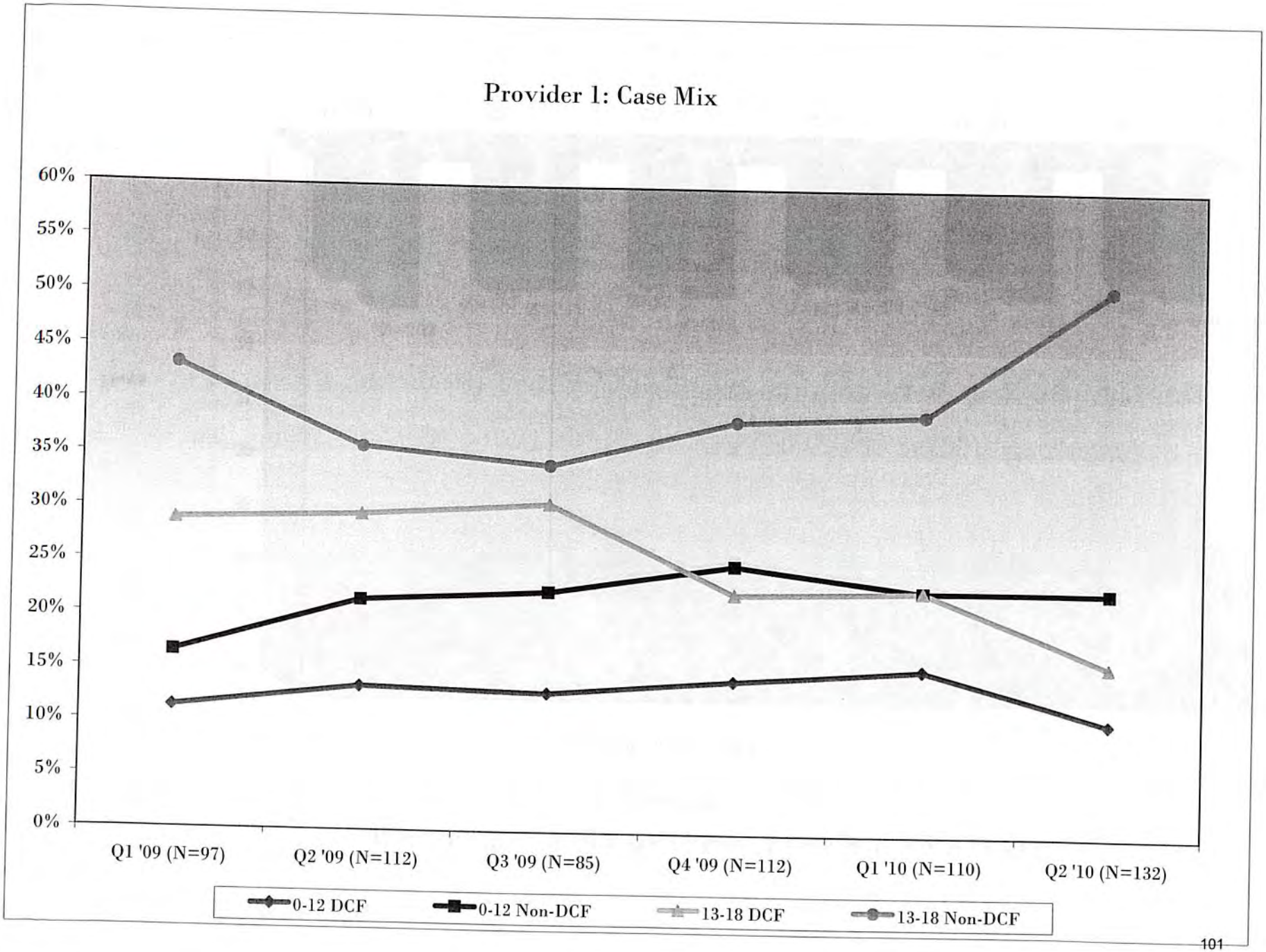
Non- DCF

	# Male	# Female	Total #
Bridgeport	3	0	3
Danbury	0	1	1
Milford	22	17	39
Hartford	0	0	0
Manchester	1	2	3
Meriden	3	2	5
Middletown	3	0	3
New Britain	1	1	2
New Haven	19	13	32
Norwalk	2	0	2
Norwich	0	0	0
Other	0	0	0
Stamford	1	0	1
Torrington	0	2	2
Waterbury	3	1	4
Willimantic	0	0	0
Non-DCF Total	**58**	**39**	**97**
Provider 1 Total			**132**
Percent Non-DCF			**73.5%**

TOTAL

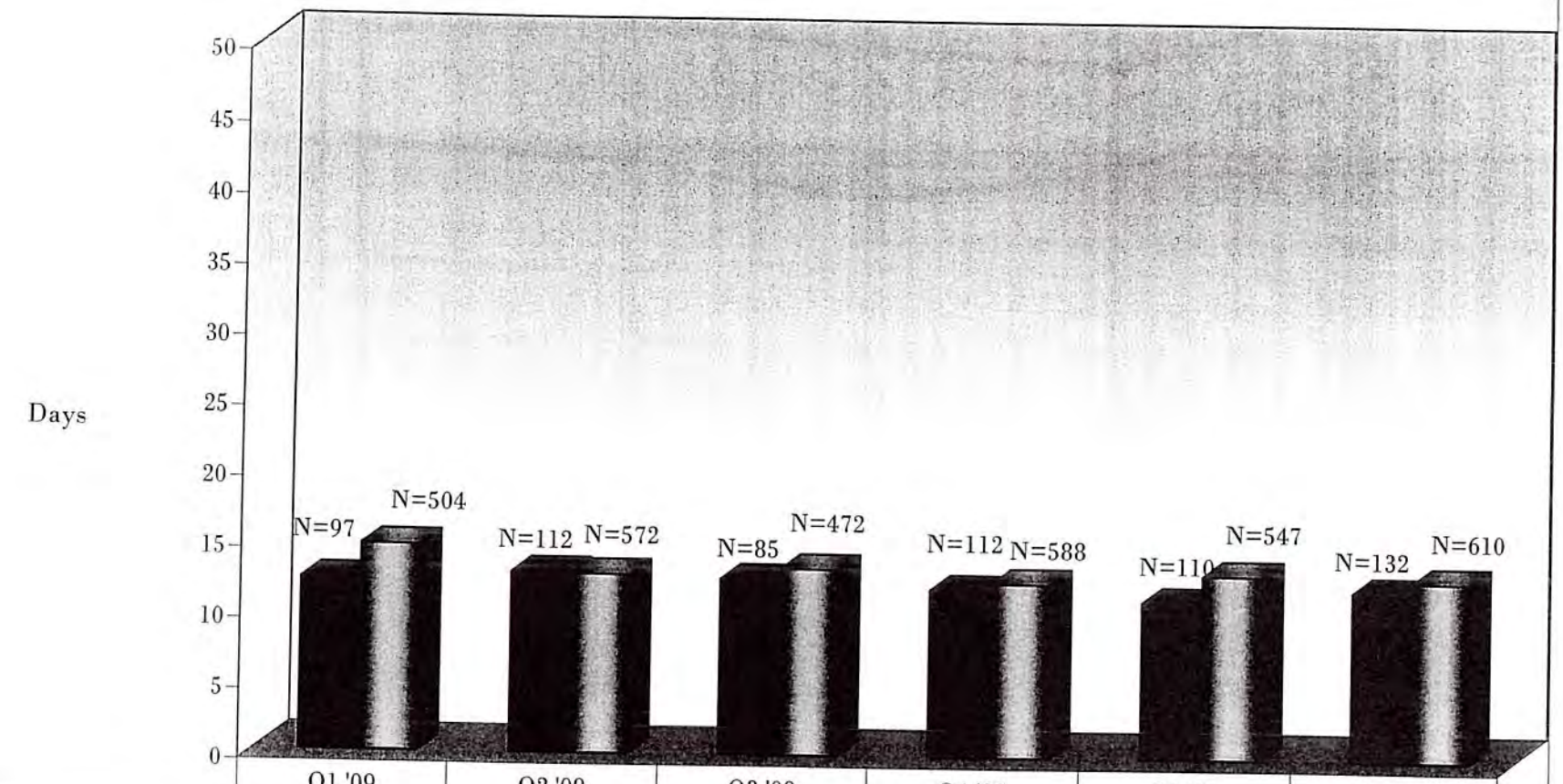
% by Area
5.3%
0.8%
34.8%
2.3%
2.3%
4.5%
3.0%
3.0%
34.8%
1.5%
0.8%
0.0%
0.8%
2.3%
3.0%
0.8%
100.0%

Provider 1:
Percent of all Children discharged from inpatient for the reporting period:
132 of 610 or 21.6%


Provider 1: Case Mix
60%
55%
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Q1 '09 (N=97)
Q2 '09 (N=112)
Q3 '09 (N=85)
Q4 '09 (N=112)
Q1 '10 (N=110)
Q2 '10 (N=132)
0-12 DCF
0-12 Non-DCF
13-18 DCF
13-18 Non-DCF

Provider 1 vs. Big 8 Providers: Average Length of Stay by Quarter

All Children: Age 0-18



	Q1 '09	Q2 '09	Q3 '09	Q4 '09	Q1 '10	Q2 '10
Provider 1	12.18	12.76	12.44	11.85	11.11	11.98
Big 8 Providers	14.61	12.68	13.21	12.34	13.04	12.73

ValueOptions of Louisiana
Implementation Plan

ID	Task Name	Duration	Start	Finish	Resource Names
1	**ValueOptions of Louisiana Implementation**	**210 days**	**Tue 9/6/11**	**Mon 6/25/12**	
2	**Project Administration**	**200 days**	**Tue 9/6/11**	**Mon 6/11/12**	**Chief Executive Officer,Chief Operations Officer**
3	Contract award	1 day	Tue 9/6/11	Tue 9/6/11	Chief Executive Officer,Chief Operations Officer
4	**Project workplan**	**54 days**	**Wed 9/7/11**	**Mon 11/21/11**	**Chief Executive Officer,Chief Operations Officer**
5	Update VO-LA implementation plan	43 days	Wed 9/7/11	Fri 11/4/11	Chief Executive Officer,Chief Operations Officer
6	Submit plan to DHH-OBH for approval	1 day	Mon 11/7/11	Mon 11/7/11	Chief Executive Officer,Chief Operations Officer
7	DHH-OBH approval	10 days	Tue 11/8/11	Mon 11/21/11	Chief Executive Officer,Chief Operations Officer
8	Plan for ongoing workplan submissions	15 days	Thu 9/15/11	Wed 10/5/11	Chief Executive Officer,Chief Operations Officer
9	**Project setup**	**74 days**	**Wed 9/7/11**	**Mon 12/19/11**	**Chief Executive Officer,Chief Operations Officer**
10	Submit Implementation Manager name to DHH-OBH	1 day	Thu 9/8/11	Thu 9/8/11	Chief Executive Officer,Chief Operations Officer
11	Review RFP, proposal, contract language, sample docs submitted	15 days	Wed 9/7/11	Tue 9/27/11	Chief Executive Officer,Chief Operations Officer
12	Initiate project workgroup teams with LA Staff named in RFP	15 days	Wed 9/7/11	Tue 9/27/11	Chief Executive Officer,Chief Operations Officer
13	Initiate task deliverable discovery process	25 days	Wed 9/7/11	Tue 10/11/11	Chief Executive Officer,Chief Operations Officer
14	Develop change management process with DHH-OBH	45 days	Wed 9/7/11	Tue 11/8/11	Chief Executive Officer,Chief Operations Officer
15	Develop project deliverables list	45 days	Wed 9/7/11	Tue 11/8/11	Chief Executive Officer,Chief Operations Officer
16	Develop deliverable approval process and approval timelines with DHH-OBH	45 days	Wed 9/7/11	Tue 11/8/11	Chief Executive Officer,Chief Operations Officer
17	Implement Provider and Member Communication Plan	45 days	Wed 9/7/11	Tue 11/8/11	Chief Executive Officer,Chief Operations Officer
18	Develop Beginning-of-Contract Transition Plan	45 days	Wed 9/7/11	Tue 11/8/11	Chief Executive Officer,Chief Operations Officer
19	Finalize project plan	45 days	Wed 9/7/11	Tue 11/8/11	Chief Executive Officer,Chief Operations Officer
20	Internal planning sessions	15 days	Wed 9/7/11	Tue 9/27/11	Chief Executive Officer,Chief Operations Officer
21	Begin weekly implementation meetings with DHH-OBH	15 days	Wed 9/7/11	Tue 9/27/11	Chief Executive Officer,Chief Operations Officer
22	Begin weekly implementation meetings with functional teams	15 days	Wed 9/7/11	Tue 9/27/11	Chief Executive Officer,Chief Operations Officer

ID	Task Name	Duration	Start	Finish	Resource Names
23	Identify readiness review requirements and develop plan with DHH-OBH	25 days	Tue 11/15/11	Mon 12/19/11	Chief Executive Officer,Chief Operations Officer
24	**Kickoff meeting**	**5 days**	**Wed 9/7/11**	**Tue 9/13/11**	**Chief Executive Officer,Chief Operations Officer**
25	Identify DHH-OBH Contract Manager and contacts	4 days	Wed 9/7/11	Mon 9/12/11	Chief Executive Officer,Chief Operations Officer
26	Develop agenda and meeting materials	4 days	Wed 9/7/11	Mon 9/12/11	Chief Executive Officer,Chief Operations Officer
27	Kickoff meeting with DHH-OBH	1 day	Tue 9/13/11	Tue 9/13/11	Chief Executive Officer,Chief Operations Officer
28	Kickoff meeting with CSoC	1 day	Mon 9/12/11	Mon 9/12/11	Chief Executive Officer,Chief Operations Officer
29	**Project close out**	**51 days**	**Mon 4/2/12**	**Mon 6/11/12**	**Chief Executive Officer,Chief Operations Officer**
30	Lessons learned	30 days	Mon 4/2/12	Fri 5/11/12	Chief Executive Officer,Chief Operations Officer
31	Transition to Operational teams	30 days	Tue 5/1/12	Mon 6/11/12	Chief Executive Officer,Chief Operations Officer
32	**Legal**	**65 days**	**Wed 9/7/11**	**Tue 12/6/11**	**Chief Executive Officer,Chief Operations Officer**
33	Contract negotiations	60 days	Wed 9/7/11	Tue 11/29/11	Chief Executive Officer,Chief Operations Officer
34	Execute contract	5 days	Wed 11/30/11	Tue 12/6/11	Chief Executive Officer,Chief Operations Officer
35	**Finance**	**74 days**	**Wed 9/7/11**	**Mon 12/19/11**	**Chief Financial Officer**
36	Set up/communicate implementation charge code	20 days	Wed 9/7/11	Tue 10/4/11	Chief Financial Officer
37	Performance bonds	30 days	Wed 9/7/11	Tue 10/18/11	Chief Financial Officer
38	Set up invoicing/recovery process with DHH-OBH	30 days	Wed 9/7/11	Tue 10/18/11	Chief Financial Officer
39	Determine state revenue/funding setup	30 days	Wed 9/7/11	Tue 10/18/11	Chief Financial Officer
40	Set up ACH/EFT if applicable	58 days	Wed 9/7/11	Fri 11/25/11	Chief Financial Officer
41	Set up process for tax reporting requirements	30 days	Wed 9/7/11	Tue 10/18/11	Chief Financial Officer
42	Identify and set up state financial reporting requirements	30 days	Wed 9/7/11	Tue 10/18/11	Chief Financial Officer
43	Payroll setup	35 days	Tue 11/1/11	Mon 12/19/11	Chief Financial Officer
44	Notify staff of travel policies and travel budget	5 days	Wed 9/7/11	Tue 9/13/11	Chief Financial Officer

ValueOptions of Louisiana
Implementation Plan

ID	Task Name	Duration	Start	Finish	Resource Names
45	**Human Resources**	**113 days**	**Wed 9/7/11**	**Fri 2/10/12**	**Chief Executive Officer**
46	**Recruitment**	**90 days**	**Wed 9/7/11**	**Tue 1/10/12**	**Chief Executive Officer**
47	Formally hire named individuals for key leadership positions	15 days	Wed 9/7/11	Tue 9/27/11	Chief Executive Officer
48	Review and confirm staffing plan	20 days	Wed 9/7/11	Tue 10/4/11	Chief Executive Officer
49	Submit staffing plan to DHH-OBH	5 days	Wed 10/5/11	Tue 10/11/11	Chief Executive Officer
50	Review proposal staffing and job descriptions	20 days	Wed 9/7/11	Tue 10/4/11	Chief Executive Officer
51	Prepare ads	15 days	Wed 10/5/11	Tue 10/25/11	Chief Executive Officer
52	Post jobs internally/externally	10 days	Wed 10/5/11	Tue 10/18/11	Chief Executive Officer
53	Interview candidates	35 days	Wed 10/19/11	Tue 12/6/11	Chief Executive Officer
54	Background checks	35 days	Wed 10/19/11	Tue 12/6/11	Chief Executive Officer
55	Offer positions	25 days	Wed 12/7/11	Tue 1/10/12	Chief Executive Officer
56	**Training/Employee setup**	**30 days**	**Mon 1/2/12**	**Fri 2/10/12**	**Chief Executive Officer**
57	Coordinate new hire training with operational departments	30 days	Mon 1/2/12	Fri 2/10/12	Chief Executive Officer
58	Ensure employees update StaffConnect	15 days	Mon 1/2/12	Fri 1/20/12	Chief Executive Officer
59	Staff licensure	15 days	Mon 1/2/12	Fri 1/20/12	Chief Executive Officer
60	**Key Personnel**	**38 days**	**Wed 12/7/11**	**Fri 1/27/12**	**Chief Executive Officer**
61	Add additional individuals and submit finalized Key Personnel to DHH-OBH	20 days	Wed 12/7/11	Tue 1/3/12	Chief Executive Officer
62	Key personnel change notification plan	20 days	Mon 1/2/12	Fri 1/27/12	Chief Executive Officer
63	**Local VO LA HR setup**	**15 days**	**Thu 12/1/11**	**Wed 12/21/11**	**Chief Executive Officer**
64	Train staff on HR tasks	15 days	Thu 12/1/11	Wed 12/21/11	Chief Executive Officer
65	Display state, federal, contractual posters	15 days	Thu 12/1/11	Wed 12/21/11	Chief Executive Officer
66	**Facilities**	**118 days**	**Wed 9/7/11**	**Fri 2/17/12**	**Chief Operations Officer**

ID	Task Name	Duration	Start	Finish	Resource Names
67	Finalize and sign lease for space located at Renaissance Park West	25 days	Wed 9/7/11	Tue 10/11/11	Chief Operations Officer
68	Finalize building layout	25 days	Wed 10/12/11	Tue 11/15/11	Chief Operations Officer
69	**Build-out**	**68 days**	**Wed 11/16/11**	**Fri 2/17/12**	**Chief Operations Officer**
70	Hire contractors for remodeling (if required)	15 days	Wed 11/16/11	Tue 12/6/11	Chief Operations Officer
71	Build-out	45 days	Wed 12/7/11	Tue 2/7/12	Chief Operations Officer
72	Move in new cubicle and furniture	5 days	Wed 2/8/12	Tue 2/14/12	Chief Operations Officer
73	Sign off on build-out completion	3 days	Wed 2/15/12	Fri 2/17/12	Chief Operations Officer
74	Set up shipping/mail accounts	10 days	Wed 2/1/12	Tue 2/14/12	Chief Operations Officer
75	Establish supply orders	10 days	Wed 2/1/12	Tue 2/14/12	Chief Operations Officer
76	**Member Access Center**	**108 days**	**Mon 10/3/11**	**Wed 2/29/12**	**Member Services Administrator**
77	Review performance guarantee requirements	15 days	Mon 10/3/11	Fri 10/21/11	Member Services Administrator
78	Set up/transfer TFN, coordinate with Telecom	45 days	Mon 10/3/11	Fri 12/2/11	Member Services Administrator
79	**Phone scripting - coordinate with Telecom**	**85 days**	**Mon 10/3/11**	**Fri 1/27/12**	**Member Services Administrator**
80	Develop phone scripting for Access Center and transfer to Warmline	55 days	Mon 10/3/11	Fri 12/16/11	Member Services Administrator
81	Approval	15 days	Mon 12/19/11	Fri 1/6/12	Member Services Administrator
82	Program and test phone scripting	15 days	Mon 1/9/12	Fri 1/27/12	Member Services Administrator
83	**Member Services Reporting**	**55 days**	**Thu 12/15/11**	**Wed 2/29/12**	**Member Services Administrator**
84	Identify reporting requirements - internal/external	15 days	Thu 12/15/11	Wed 1/4/12	Member Services Administrator
85	Coordinate report development/approval with Reporting	30 days	Thu 1/5/12	Wed 2/15/12	Member Services Administrator
86	Implement reports into production	10 days	Thu 2/16/12	Wed 2/29/12	Member Services Administrator
87	**Policies and procedures, including transfer protocols**	**30 days**	**Mon 1/2/12**	**Fri 2/10/12**	**Member Services Administrator**
88	Transfer protocols	30 days	Mon 1/2/12	Fri 2/10/12	Member Services Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
89	Crisis calls	30 days	Mon 1/2/12	Fri 2/10/12	Member Services Administrator
90	Warmline	30 days	Mon 1/2/12	Fri 2/10/12	Member Services Administrator
91	After hours calls	30 days	Mon 1/2/12	Fri 2/10/12	Member Services Administrator
92	Routine/urgent calls	30 days	Mon 1/2/12	Fri 2/10/12	Member Services Administrator
93	Greetings	30 days	Mon 1/2/12	Fri 2/10/12	Member Services Administrator
94	Conferencing	30 days	Mon 1/2/12	Fri 2/10/12	Member Services Administrator
95	Voicemail protocols	30 days	Mon 1/2/12	Fri 2/10/12	Member Services Administrator
96	Set up language line protocols	30 days	Mon 1/2/12	Fri 2/10/12	Member Services Administrator
97	TDD/TTY protocols	30 days	Mon 1/2/12	Fri 2/10/12	Member Services Administrator
98	Additional P&Ps/workflows	30 days	Mon 1/2/12	Fri 2/10/12	Member Services Administrator
99	**Member Communications**	**95 days**	**Mon 10/17/11**	**Fri 2/24/12**	**Member Services Administrator**
100	**Member Handbook**	**70 days**	**Tue 11/15/11**	**Mon 2/20/12**	**Member Services Administrator**
101	Finalize member handbook content	40 days	Tue 11/15/11	Mon 1/9/12	Member Services Administrator
102	Obtain CSoC information from FSOs	25 days	Fri 11/25/11	Thu 12/29/11	Member Services Administrator
103	Submit to Family and Member Committee for review	15 days	Tue 1/10/12	Mon 1/30/12	Member Services Administrator
104	Submit to DHH-OBH for review	15 days	Tue 1/31/12	Mon 2/20/12	Member Services Administrator
105	Distribution plan	15 days	Tue 1/10/12	Mon 1/30/12	Member Services Administrator
106	**Finalize Member website and Louisiana AchieveSolutions website**	**65 days**	**Tue 11/1/11**	**Mon 1/30/12**	**Member Services Administrator**
107	Develop website materials with Communications/IT	65 days	Tue 11/1/11	Mon 1/30/12	Member Services Administrator
108	**Cultural Competency Plan**	**95 days**	**Mon 10/17/11**	**Fri 2/24/12**	**Member Services Administrator**
109	Review requirements	15 days	Mon 10/17/11	Fri 11/4/11	Member Services Administrator
110	Finalize cultural competency plan	45 days	Mon 11/7/11	Fri 1/6/12	Member Services Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
111	Quality Committee review	10 days	Mon 1/9/12	Fri 1/20/12	Member Services Administrator
112	DHH-OBH coordination	10 days	Mon 1/23/12	Fri 2/3/12	Member Services Administrator
113	Update plan	10 days	Mon 2/6/12	Fri 2/17/12	Member Services Administrator
114	Post/distribute	5 days	Mon 2/20/12	Fri 2/24/12	Member Services Administrator
115	Begin training	5 days	Mon 2/20/12	Fri 2/24/12	Member Services Administrator
116	Plan for additional member materials	35 days	Mon 1/2/12	Fri 2/17/12	Member Services Administrator
117	**Member and Family Advisory Committee setup**	**60 days**	**Thu 12/1/11**	**Wed 2/22/12**	**Member Services Administrator**
118	Finalize charters	45 days	Thu 12/1/11	Wed 2/1/12	Member Services Administrator
119	Request nominations from DHH-OBH, CSoC, Provider Organizations and Advocacy Organizations	15 days	Thu 12/1/11	Wed 12/21/11	Member Services Administrator
120	Send formal invitations	15 days	Thu 12/22/11	Wed 1/11/12	Member Services Administrator
121	Finalize membership	15 days	Thu 1/12/12	Wed 2/1/12	Member Services Administrator
122	Initiate first meeting	15 days	Thu 2/2/12	Wed 2/22/12	Member Services Administrator
123	**Youth in Transition Committee setup**	**60 days**	**Thu 12/1/11**	**Wed 2/22/12**	**Member Services Administrator**
124	Finalize charters	45 days	Thu 12/1/11	Wed 2/1/12	Member Services Administrator
125	Request nominations from DHH-OBH, CSoC, Provider Organizations and Advocacy Organizations	15 days	Thu 12/1/11	Wed 12/21/11	Member Services Administrator
126	Send formal invitations	15 days	Thu 12/22/11	Wed 1/11/12	Member Services Administrator
127	Finalize membership	15 days	Thu 1/12/12	Wed 2/1/12	Member Services Administrator
128	Initiate first meeting	15 days	Thu 2/2/12	Wed 2/22/12	Member Services Administrator
129	**Provider Networks**	**130 days**	**Wed 9/7/11**	**Tue 3/6/12**	**Network Development Administrator**
130	**Network Operations**	**118 days**	**Wed 9/7/11**	**Fri 2/17/12**	**Network Development Administrator**
131	**Provider file**	**53 days**	**Wed 9/7/11**	**Fri 11/18/11**	**Network Development Administrator**
132	Review provider data requirements	25 days	Mon 10/17/11	Fri 11/18/11	Network Development Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
133	Coordinate provider file with IT	45 days	Wed 9/7/11	Tue 11/8/11	Network Development Administrator
134	**Provider Directory**	**45 days**	**Mon 11/21/11**	**Fri 1/20/12**	**Network Development Administrator**
135	Develop directory	30 days	Mon 11/21/11	Fri 12/30/11	Network Development Administrator
136	Post/distribution plan	15 days	Mon 1/2/12	Fri 1/20/12	Network Development Administrator
137	**Network assessment**	**100 days**	**Mon 10/3/11**	**Fri 2/17/12**	**Network Development Administrator**
138	Complete final network assessment	20 days	Mon 10/3/11	Fri 10/28/11	Network Development Administrator
139	Identify gaps for recruitment efforts	10 days	Mon 10/31/11	Fri 11/11/11	Network Development Administrator
140	Develop plan for network assessment	65 days	Mon 10/3/11	Fri 12/30/11	Network Development Administrator
141	Submit plan to DHH-OBH	15 days	Mon 1/2/12	Fri 1/20/12	Network Development Administrator
142	Ongoing network development plan	35 days	Mon 1/2/12	Fri 2/17/12	Network Development Administrator
143	**Credentialing**	**50 days**	**Thu 9/15/11**	**Wed 11/23/11**	**Network Development Administrator**
144	Identify credentialing requirements	20 days	Thu 9/15/11	Wed 10/12/11	Network Development Administrator
145	Gap analysis vs. VO policies and procedures	15 days	Thu 10/13/11	Wed 11/2/11	Network Development Administrator
146	Update program P&Ps and requirements	15 days	Thu 11/3/11	Wed 11/23/11	Network Development Administrator
147	**Contracting**	**55 days**	**Wed 9/7/11**	**Tue 11/22/11**	**Network Development Administrator**
148	**Contracting for providers who submitted LOIs**	**25 days**	**Wed 9/7/11**	**Tue 10/11/11**	**Network Development Administrator**
149	Send provider agreements	15 days	Wed 9/7/11	Tue 9/27/11	Network Development Administrator
150	Execute agreements and negotiate rates	25 days	Wed 9/7/11	Tue 10/11/11	Network Development Administrator
151	**Additional contracting**	**55 days**	**Wed 9/7/11**	**Tue 11/22/11**	**Network Development Administrator**
152	Identify additional contracting requirements	15 days	Wed 9/7/11	Tue 9/27/11	Network Development Administrator
153	Update contracts with Legal	25 days	Wed 9/28/11	Tue 11/1/11	Network Development Administrator
154	Coordinate with DHH-OBH	25 days	Wed 9/28/11	Tue 11/1/11	Network Development Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
155	Ensure compliance with state and federal requirements	25 days	Wed 9/28/11	Tue 11/1/11	Network Development Administrator
156	Confirm targeted providers	25 days	Wed 9/28/11	Tue 11/1/11	Network Development Administrator
157	Distribution/outreach plan with Provider Relations	25 days	Wed 9/28/11	Tue 11/1/11	Network Development Administrator
158	Develop tracking document/plan	25 days	Wed 9/28/11	Tue 11/1/11	Network Development Administrator
159	Implement provider contracting activities	15 days	Wed 11/2/11	Tue 11/22/11	Network Development Administrator
160	**Provider Relations**	**102 days**	**Mon 10/17/11**	**Tue 3/6/12**	**Network Development Administrator**
161	**Provider Training**	**93 days**	**Mon 10/17/11**	**Wed 2/22/12**	**Network Development Administrator**
162	Develop provider training plan	20 days	Mon 10/17/11	Fri 11/11/11	Network Development Administrator
163	**Program orientation - FHH Regional town halls**	**50 days**	**Thu 12/15/11**	**Wed 2/22/12**	**Network Development Administrator**
164	Curriculum and materials	20 days	Thu 12/15/11	Wed 1/11/12	Network Development Administrator
165	Committee review	5 days	Thu 1/12/12	Wed 1/18/12	Network Development Administrator
166	DHH-OBH approval	10 days	Thu 1/19/12	Wed 2/1/12	Network Development Administrator
167	Implement provider trainings via regional Provider Relations Staff and via Webcasts	15 days	Thu 2/2/12	Wed 2/22/12	Network Development Administrator
168	**Provider Handbook**	**55 days**	**Tue 11/15/11**	**Mon 1/30/12**	**Network Development Administrator**
169	Develop provider handbook content	40 days	Tue 11/15/11	Mon 1/9/12	Network Development Administrator
170	Submit to DHH-OBH for review	15 days	Tue 1/10/12	Mon 1/30/12	Network Development Administrator
171	Distribution plan, capitalizing on LA Provider Associations	15 days	Tue 1/10/12	Mon 1/30/12	Network Development Administrator
172	**Provider Communications**	**102 days**	**Mon 10/17/11**	**Tue 3/6/12**	**Network Development Administrator**
173	Develop provider communication plan	25 days	Mon 10/17/11	Fri 11/18/11	Network Development Administrator
174	**Newsletter**	**47 days**	**Mon 1/2/12**	**Tue 3/6/12**	**Network Development Administrator**
175	Develop draft provider newsletter	15 days	Mon 1/2/12	Fri 1/20/12	Network Development Administrator
176	Committee review	5 days	Mon 1/23/12	Fri 1/27/12	Network Development Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
177	Submit to DHH-OBH	5 days	Mon 1/30/12	Fri 2/3/12	Network Development Administrator
178	Post newsletter	5 days	Mon 2/6/12	Fri 2/10/12	Network Development Administrator
179	Develop plan and schedule for future newsletters	15 days	Wed 2/15/12	Tue 3/6/12	Network Development Administrator
180	Plan for provider alerts	30 days	Mon 1/16/12	Fri 2/24/12	Network Development Administrator
181	**Provider website**	**65 days**	**Tue 11/1/11**	**Mon 1/30/12**	**Network Development Administrator**
182	Develop website materials with Communications/IT	65 days	Tue 11/1/11	Mon 1/30/12	Network Development Administrator
183	**Provider Network Reporting**	**95 days**	**Mon 10/17/11**	**Fri 2/24/12**	**Network Development Administrator**
184	Identify reporting requirements - internal/external	25 days	Mon 10/17/11	Fri 11/18/11	Network Development Administrator
185	Coordinate report development/approval with Reporting	65 days	Mon 11/21/11	Fri 2/17/12	Network Development Administrator
186	Implement reports into production	5 days	Mon 2/20/12	Fri 2/24/12	Network Development Administrator
187	**Communications**	**85 days**	**Tue 11/1/11**	**Mon 2/27/12**	**Network Development Administrator,Member Services**
188	**Provider handbook**	**20 days**	**Tue 1/10/12**	**Mon 2/6/12**	**Network Development Administrator**
189	Coordinate formatting and printing with Provider Relations	20 days	Tue 1/10/12	Mon 2/6/12	Network Development Administrator
190	**Member handbook**	**20 days**	**Tue 1/10/12**	**Mon 2/6/12**	**Member Services Administrator**
191	Coordinate formatting and printing with Member Services	20 days	Tue 1/10/12	Mon 2/6/12	Member Services Administrator
192	**Website**	**85 days**	**Tue 11/1/11**	**Mon 2/27/12**	**Network Development Administrator,Member Services**
193	Coordinate website formatting and editing with Member Services	65 days	Tue 11/1/11	Mon 1/30/12	Member Services Administrator
194	Coordinate website formatting and editing with Provider Relations	65 days	Tue 11/1/11	Mon 1/30/12	Network Development Administrator
195	AchieveSolutions content	65 days	Tue 11/1/11	Mon 1/30/12	Member Services Administrator
196	Post provider handbook	5 days	Tue 2/21/12	Mon 2/27/12	Network Development Administrator
197	Post member handbook	5 days	Tue 2/21/12	Mon 2/27/12	Member Services Administrator
198	**Clinical and Medical Management**	**123 days**	**Wed 9/7/11**	**Fri 2/24/12**	**Care Management/Utilization Review Administrator**

ID	Task Name	Duration	Start	Finish	Resource Names
199	**Clinical Operations**	**30 days**	**Wed 9/7/11**	**Tue 10/18/11**	**Care Management/Utilization Review Administrator**
200	Review resource requirements	15 days	Wed 9/7/11	Tue 9/27/11	Care Management/Utilization Review Administrator
201	Review current health care services/resources	10 days	Wed 9/7/11	Tue 9/20/11	Care Management/Utilization Review Administrator
202	Review culturally appropriate service requirements	10 days	Wed 9/7/11	Tue 9/20/11	Care Management/Utilization Review Administrator
203	Customize for target population of CSoC	30 days	Wed 9/7/11	Tue 10/18/11	Care Management/Utilization Review Administrator
204	Gap analysis	30 days	Wed 9/7/11	Tue 10/18/11	Care Management/Utilization Review Administrator
205	Action plan	30 days	Wed 9/7/11	Tue 10/18/11	Care Management/Utilization Review Administrator
206	Clinical Management Committee setup	10 days	Wed 9/7/11	Tue 9/20/11	Care Management/Utilization Review Administrator
207	**Policies, Procedures & workflows**	**105 days**	**Mon 10/3/11**	**Fri 2/24/12**	**Care Management/Utilization Review Administrator**
208	Review program requirements	20 days	Mon 10/3/11	Fri 10/28/11	Care Management/Utilization Review Administrator
209	**Finalize Clinical P&Ps**	**65 days**	**Mon 10/31/11**	**Fri 1/27/12**	**Care Management/Utilization Review Administrator**
210	Registration	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
211	Prior authorization	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
212	CSoC coordination	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
213	Continued care review	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
214	Expedited authorizations	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
215	Concurrent review	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
216	Retrospective review	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
217	Prospective review	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
218	LOC criteria - adult/child	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
219	Inpatient Psych	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
220	Substance abuse	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
221	Co-occurring disorders	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
222	Annual reviews	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
223	Medical necessity	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
224	Evidence-based practices	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
225	Wrap-around services	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
226	Intensive Care Management	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
227	Crisis Management	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
228	Discharge review, planning, and follow up	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
229	Treatment planning	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
230	Retroactive eligibility review	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
231	Retroactive medical necessity review	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
232	Provider bypass	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
233	Court-ordered services	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
234	Member transition to/from other programs	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
235	Duplicate authorizations	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
236	NOA/Denials/Partial denials	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
237	Care coordination	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
238	Coordination with other agencies	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
239	WAA training and outreach	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
240	Coordination with PCPs	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
241	Coordination with CCNs	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
242	Coordination with SGB	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
243	Referrals	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
244	Assertive Community Treatment	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
245	PRTF	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
246	Inpatient behavioral health	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
247	Inpatient substance abuse	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
248	Notification	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
249	Peer review (including QC check of letters and notification)	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
250	Out of state services	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
251	Auth extract error process	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
252	ED diversion and disposition	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
253	Outlier management	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
254	Advance Directives	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
255	CSoC	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
256	Coordination with WAAs	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
257	Single case agreements	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
258	Fax server protocols	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
259	Termination/suspension/reduction of services	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
260	Other policies and procedures as needed	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
261	Coordinate P&P with DHH-OBH	20 days	Mon 1/30/12	Fri 2/24/12	Care Management/Utilization Review Administrator
262	**UM Plan**	**82 days**	**Mon 10/31/11**	**Tue 2/21/12**	**Care Management/Utilization Review Administrator**
263	Develop UM Plan	65 days	Mon 10/31/11	Fri 1/27/12	Care Management/Utilization Review Administrator
264	Collaboration with departments in DHH and the CSoC	20 days	Thu 12/1/11	Wed 12/28/11	Care Management/Utilization Review Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
265	Submit to DHH-OBH for review	15 days	Mon 1/30/12	Fri 2/17/12	Care Management/Utilization Review Administrator
266	Develop ongoing review process and schedule	15 days	Wed 2/1/12	Tue 2/21/12	Care Management/Utilization Review Administrator
267	**Practice Guidelines**	**92 days**	**Mon 10/17/11**	**Tue 2/21/12**	**Care Management/Utilization Review Administrator**
268	Customize Practice Guidelines for VO-LA	50 days	Mon 10/17/11	Fri 12/23/11	Care Management/Utilization Review Administrator
269	Collaboration with state agencies and other programs	20 days	Thu 12/1/11	Wed 12/28/11	Care Management/Utilization Review Administrator
270	Clinical Advisory Group review and sign off	15 days	Mon 12/26/11	Fri 1/13/12	Care Management/Utilization Review Administrator
271	Submit to DHH-OBH for review	15 days	Mon 12/26/11	Fri 1/13/12	Care Management/Utilization Review Administrator
272	Develop ongoing review process and schedule	15 days	Wed 2/1/12	Tue 2/21/12	Care Management/Utilization Review Administrator
273	**Utilization Management Reporting**	**115 days**	**Wed 9/7/11**	**Tue 2/14/12**	**Care Management/Utilization Review Administrator**
274	Identify reporting requirements - internal/external	45 days	Wed 9/7/11	Tue 11/8/11	Care Management/Utilization Review Administrator
275	Coordinate report development/approval with Reporting	65 days	Wed 11/9/11	Tue 2/7/12	Care Management/Utilization Review Administrator
276	Implement reports into production	5 days	Wed 2/8/12	Tue 2/14/12	Care Management/Utilization Review Administrator
277	**Denial letters**	**75 days**	**Mon 10/17/11**	**Fri 1/27/12**	**Care Management/Utilization Review Administrator**
278	Review letter requirements	15 days	Mon 10/17/11	Fri 11/4/11	Care Management/Utilization Review Administrator
279	Obtain letter templates from DHH-OBH	15 days	Mon 11/7/11	Fri 11/25/11	Care Management/Utilization Review Administrator
280	Develop letters	45 days	Mon 11/28/11	Fri 1/27/12	Care Management/Utilization Review Administrator
281	Letter workflow process	45 days	Mon 11/28/11	Fri 1/27/12	Care Management/Utilization Review Administrator
282	**Authorization letters**	**75 days**	**Mon 10/17/11**	**Fri 1/27/12**	**Care'Management/Utilization Review Administrator**
283	Review letter requirements	15 days	Mon 10/17/11	Fri 11/4/11	Care Management/Utilization Review Administrator
284	Develop letter templates	15 days	Mon 11/7/11	Fri 11/25/11	Care Management/Utilization Review Administrator
285	Develop letters in coordination with Reporting	45 days	Mon 11/28/11	Fri 1/27/12	Care Management/Utilization Review Administrator
286	Coordinate ALA letter process with IT	45 days	Mon 11/28/11	Fri 1/27/12	Care Management/Utilization Review Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
287	**Clinical/UM Reporting**	**85 days**	**Mon 10/17/11**	**Fri 2/10/12**	**Care Management/Utilization Review Administrator**
288	Identify reporting requirements - internal/external	25 days	Mon 10/17/11	Fri 11/18/11	Care Management/Utilization Review Administrator
289	Coordinate report development/approval with Reporting	55 days	Mon 11/21/11	Fri 2/3/12	Care Management/Utilization Review Administrator
290	Implement reports into production	5 days	Mon 2/6/12	Fri 2/10/12	Care Management/Utilization Review Administrator
291	**Clinical Team Review**	**15 days**	**Wed 2/1/12**	**Tue 2/21/12**	**Care Management/Utilization Review Administrator**
292	Develop quarterly review process for Clinical team	15 days	Wed 2/1/12	Tue 2/21/12	Care Management/Utilization Review Administrator
293	**Peer Review/Clinical Advisory committee setup**	**60 days**	**Thu 12/1/11**	**Wed 2/22/12**	**Care Management/Utilization Review Administrator**
294	Finalize charters	45 days	Thu 12/1/11	Wed 2/1/12	Care Management/Utilization Review Administrator
295	Request nominations from DHH-OBH, CSoC, Provider Organizations and Advocacy Organizations	15 days	Thu 12/1/11	Wed 12/21/11	Care Management/Utilization Review Administrator
296	Send formal invitations	15 days	Thu 12/22/11	Wed 1/11/12	Care Management/Utilization Review Administrator
297	Finalize membership	15 days	Thu 1/12/12	Wed 2/1/12	Care Management/Utilization Review Administrator
298	Initiate first meeting	15 days	Thu 2/2/12	Wed 2/22/12	Care Management/Utilization Review Administrator
299	**Quality Management**	**209 days**	**Wed 9/7/11**	**Mon 6/25/12**	**Quality Management Administrator**
300	**Quality Management policies and procedures**	**94 days**	**Mon 10/17/11**	**Thu 2/23/12**	**Quality Management Administrator**
301	Review requirements	20 days	Mon 10/17/11	Fri 11/11/11	Quality Management Administrator
302	Review performance guarantee requirements	15 days	Mon 10/17/11	Fri 11/4/11	Quality Management Administrator
303	**Develop policies and procedures**	**74 days**	**Mon 11/14/11**	**Thu 2/23/12**	**Quality Management Administrator**
304	Quality of Care/Quality of Service	65 days	Mon 11/14/11	Fri 2/10/12	Quality Management Administrator
305	Fraud/abuse	65 days	Mon 11/14/11	Fri 2/10/12	Quality Management Administrator
306	QIO-like status verification/reporting	65 days	Mon 11/14/11	Fri 2/10/12	Quality Management Administrator
307	Program evaluation	65 days	Mon 11/14/11	Fri 2/10/12	Quality Management Administrator
308	Critical incident reporting	65 days	Mon 11/14/11	Fri 2/10/12	Quality Management Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
309	Quality improvement initiatives	65 days	Mon 11/14/11	Fri 2/10/12	Quality Management Administrator
310	**Complaint, grievance, appeals**	**74 days**	**Mon 11/14/11**	**Thu 2/23/12**	**Grievances and Appeals Administrator**
311	Documentation requirements	65 days	Mon 11/14/11	Fri 2/10/12	Grievances and Appeals Administrator
312	Expedited reviews	65 days	Mon 11/14/11	Fri 2/10/12	Grievances and Appeals Administrator
313	Administrative hearings	65 days	Mon 11/14/11	Fri 2/10/12	Grievances and Appeals Administrator
314	Coordination with DHH-OBH	65 days	Mon 11/14/11	Fri 2/10/12	Grievances and Appeals Administrator
315	Record retention	65 days	Mon 11/14/11	Fri 2/10/12	Grievances and Appeals Administrator
316	Response/resolution	65 days	Mon 11/14/11	Fri 2/10/12	Grievances and Appeals Administrator
317	Reporting requirements - DHH-OBH	65 days	Mon 11/14/11	Fri 2/10/12	Grievances and Appeals Administrator
318	Train all VO-LA Access Center staff	10 days	Fri 2/10/12	Thu 2/23/12	Grievances and Appeals Administrator
319	**Contract performance**	**60 days**	**Mon 10/17/11**	**Fri 1/6/12**	**Quality Management Administrator**
320	Identify performance indicators	15 days	Mon 10/17/11	Fri 11/4/11	Quality Management Administrator
321	Develop analysis plan and reports	45 days	Mon 11/7/11	Fri 1/6/12	Quality Management Administrator
322	Develop plan to monitor contract performance	45 days	Mon 11/7/11	Fri 1/6/12	Quality Management Administrator
323	Identify annual performance targets	45 days	Mon 11/7/11	Fri 1/6/12	Quality Management Administrator
324	**Compliance plan**	**70 days**	**Tue 11/1/11**	**Mon 2/6/12**	**Corporate Compliance Administrator**
325	Identify compliance plan requirements	20 days	Tue 11/1/11	Mon 11/28/11	Corporate Compliance Administrator
326	Clarify national/local roles in compliance monitoring	15 days	Tue 11/1/11	Mon 11/21/11	Corporate Compliance Administrator
327	Develop compliance plan	45 days	Tue 11/29/11	Mon 1/30/12	Corporate Compliance Administrator
328	Implement into production	5 days	Tue 1/31/12	Mon 2/6/12	Corporate Compliance Administrator
329	Hire Fraud and Abuse Auditors	65 days	Tue 11/1/11	Mon 1/30/12	Corporate Compliance Administrator
330	**Provider audits**	**100 days**	**Tue 11/1/11**	**Mon 3/19/12**	**Quality Management Administrator**

ID	Task Name	Duration	Start	Finish	Resource Names
331	Review requirements	20 days	Tue 11/1/11	Mon 11/28/11	Quality Management Administrator
332	Identify/develop audit tools	65 days	Tue 11/29/11	Mon 2/27/12	Quality Management Administrator
333	Process (coordinate with DHH-OBH)	65 days	Tue 11/29/11	Mon 2/27/12	Quality Management Administrator
334	Statistical sampling methodologies	65 days	Tue 11/29/11	Mon 2/27/12	Quality Management Administrator
335	Scheduling	15 days	Tue 2/28/12	Mon 3/19/12	Quality Management Administrator
336	Documentation requirements	65 days	Tue 11/29/11	Mon 2/27/12	Quality Management Administrator
337	**QM Plan**	**103 days**	**Mon 10/17/11**	**Wed 3/7/12**	**Quality Management Administrator**
338	Develop QM plan	50 days	Mon 10/17/11	Fri 12/23/11	Quality Management Administrator
339	Committee review	15 days	Mon 12/26/11	Fri 1/13/12	Quality Management Administrator
340	Coordinate with DHH-OBH	15 days	Mon 1/16/12	Fri 2/3/12	Quality Management Administrator
341	Implement plan	5 days	Thu 3/1/12	Wed 3/7/12	Quality Management Administrator
342	Develop plan/schedule for future submissions and review	25 days	Mon 1/16/12	Fri 2/17/12	Quality Management Administrator
343	**Quality Assurance/Performance Improvement Program**	**79 days**	**Tue 11/1/11**	**Fri 2/17/12**	**Quality Management Administrator**
344	Develop QA/PI program	65 days	Tue 11/1/11	Mon 1/30/12	Quality Management Administrator
345	Identify reporting requirements	25 days	Thu 12/15/11	Wed 1/18/12	Quality Management Administrator
346	Coordinate with DHH-OBH	15 days	Thu 1/19/12	Wed 2/8/12	Quality Management Administrator
347	Develop plan/schedule for future submissions and review	25 days	Mon 1/16/12	Fri 2/17/12	Quality Management Administrator
348	**Outcomes Management and Quality Improvement Plan**	**79 days**	**Tue 11/1/11**	**Fri 2/17/12**	**Quality Management Administrator**
349	Develop OM/QI plan	65 days	Tue 11/1/11	Mon 1/30/12	Quality Management Administrator
350	Identify reporting requirements	25 days	Thu 12/15/11	Wed 1/18/12	Quality Management Administrator
351	EQRO for LA	25 days	Thu 12/15/11	Wed 1/18/12	Quality Management Administrator
352	Coordinate with DHH-OBH	15 days	Thu 1/19/12	Wed 2/8/12	Quality Management Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
353	Develop plan/schedule for future submissions and review	25 days	Mon 1/16/12	Fri 2/17/12	Quality Management Administrator
354	**QA/PI committee setup**	**60 days**	**Thu 12/1/11**	**Wed 2/22/12**	**Quality Management Administrator**
355	Finalize charters	45 days	Thu 12/1/11	Wed 2/1/12	Quality Management Administrator
356	Request nominations from DHH-OBH, CSoC, Provider Organizations and Advocacy Organizations	15 days	Thu 12/1/11	Wed 12/21/11	Quality Management Administrator
357	Send formal invitations	15 days	Thu 12/22/11	Wed 1/11/12	Quality Management Administrator
358	Finalize membership	15 days	Thu 1/12/12	Wed 2/1/12	Quality Management Administrator
359	Initiate first meeting	15 days	Thu 2/2/12	Wed 2/22/12	Quality Management Administrator
360	**Regional QA/PI committee setup**	**60 days**	**Thu 12/1/11**	**Wed 2/22/12**	**Quality Management Administrator**
361	Finalize charters	45 days	Thu 12/1/11	Wed 2/1/12	Quality Management Administrator
362	Request nominations from DHH-OBH, CSoC, Provider Organizations and Advocacy Organizations	15 days	Thu 12/1/11	Wed 12/21/11	Quality Management Administrator
363	Send formal invitations	15 days	Thu 12/22/11	Wed 1/11/12	Quality Management Administrator
364	Finalize membership	15 days	Thu 1/12/12	Wed 2/1/12	Quality Management Administrator
365	Initiate first meeting	15 days	Thu 2/2/12	Wed 2/22/12	Quality Management Administrator
366	**Quality of Care Committee setup**	**60 days**	**Thu 12/1/11**	**Wed 2/22/12**	**Quality Management Administrator**
367	Finalize charters	45 days	Thu 12/1/11	Wed 2/1/12	Quality Management Administrator
368	Request nominations from DHH-OBH, CSoC, Provider Organizations and Advocacy Organizations	15 days	Thu 12/1/11	Wed 12/21/11	Quality Management Administrator
369	Send formal invitations	15 days	Thu 12/22/11	Wed 1/11/12	Quality Management Administrator
370	Finalize membership	15 days	Thu 1/12/12	Wed 2/1/12	Quality Management Administrator
371	Initiate first meeting	15 days	Thu 2/2/12	Wed 2/22/12	Quality Management Administrator
372	**Corporate Compliance Committee setup**	**60 days**	**Thu 12/1/11**	**Wed 2/22/12**	**Corporate Compliance Administrator**
373	Finalize charters	45 days	Thu 12/1/11	Wed 2/1/12	Corporate Compliance Administrator
374	Request nominations from DHH-OBH, CSoC, Provider Organizations and Advocacy Organizations	15 days	Thu 12/1/11	Wed 12/21/11	Corporate Compliance Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
375	Send formal invitations	15 days	Thu 12/22/11	Wed 1/11/12	Corporate Compliance Administrator
376	Finalize membership	15 days	Thu 1/12/12	Wed 2/1/12	Corporate Compliance Administrator
377	Initiate first meeting	15 days	Thu 2/2/12	Wed 2/22/12	Corporate Compliance Administrator
378	**Provider satisfaction surveys**	**170 days**	**Tue 11/1/11**	**Mon 6/25/12**	**Quality Management Administrator**
379	Develop survey plan	66 days	Tue 11/1/11	Tue 1/31/12	Quality Management Administrator
380	Identify sampling methodology	65 days	Tue 11/1/11	Mon 1/30/12	Quality Management Administrator
381	Identify/develop survey tools	65 days	Tue 11/1/11	Mon 1/30/12	Quality Management Administrator
382	Data collection	55 days	Tue 1/31/12	Mon 4/16/12	Quality Management Administrator
383	Analysis and reporting	45 days	Tue 4/17/12	Mon 6/18/12	Quality Management Administrator
384	Report submission	5 days	Tue 6/19/12	Mon 6/25/12	Quality Management Administrator
385	Ongoing schedule and plan for surveys	15 days	Mon 4/2/12	Fri 4/20/12	Quality Management Administrator
386	**Member satisfaction surveys**	**170 days**	**Tue 11/1/11**	**Mon 6/25/12**	**Quality Management Administrator**
387	Develop survey plan	65 days	Tue 11/1/11	Mon 1/30/12	Quality Management Administrator
388	Identify sampling methodology	65 days	Tue 11/1/11	Mon 1/30/12	Quality Management Administrator
389	Identify/develop survey tools	65 days	Tue 11/1/11	Mon 1/30/12	Quality Management Administrator
390	Data collection	55 days	Tue 1/31/12	Mon 4/16/12	Quality Management Administrator
391	Analysis and reporting	45 days	Tue 4/17/12	Mon 6/18/12	Quality Management Administrator
392	Report submission	5 days	Tue 6/19/12	Mon 6/25/12	Quality Management Administrator
393	**Provider profiling**	**70 days**	**Thu 12/15/11**	**Wed 3/21/12**	**Quality Management Administrator**
394	Develop profiling plan - reporting, schedule, tracking elements, tools	45 days	Thu 12/15/11	Wed 2/15/12	Quality Management Administrator
395	Submit to DHH-OBH for review	10 days	Thu 2/16/12	Wed 2/29/12	Quality Management Administrator
396	Implement provider profiling plan	10 days	Thu 3/1/12	Wed 3/14/12	Quality Management Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
397	Develop plan for annual review and submission	15 days	Thu 3/1/12	Wed 3/21/12	Quality Management Administrator
398	**Performance indicator reporting**	**92 days**	**Tue 11/1/11**	**Wed 3/7/12**	**Quality Management Administrator**
399	Identify key performance indicators	15 days	Tue 11/1/11	Mon 11/21/11	Quality Management Administrator
400	Develop specifications for reporting	65 days	Tue 11/22/11	Mon 2/20/12	Quality Management Administrator
401	Coordinate reporting needs with Reporting	65 days	Tue 11/22/11	Mon 2/20/12	Quality Management Administrator
402	Implement performance indicator reporting	5 days	Thu 3/1/12	Wed 3/7/12	Quality Management Administrator
403	**Quality Management Reporting**	**115 days**	**Wed 9/7/11**	**Tue 2/14/12**	**Quality Management Administrator**
404	Clarify QM role in state reporting	15 days	Tue 11/1/11	Mon 11/21/11	Quality Management Administrator
405	Identify reporting requirements - internal/external	45 days	Wed 9/7/11	Tue 11/8/11	Quality Management Administrator
406	Coordinate report development/approval with Reporting	65 days	Wed 11/9/11	Tue 2/7/12	Quality Management Administrator
407	Implement reports into production	5 days	Wed 2/8/12	Tue 2/14/12	Quality Management Administrator
408	**Member appeals**	**75 days**	**Tue 11/15/11**	**Mon 2/27/12**	**Quality Management Administrator**
409	Develop member appeal policies and procedures	45 days	Tue 11/15/11	Mon 1/16/12	Quality Management Administrator
410	DHH-OBH Review	15 days	Tue 1/17/12	Mon 2/6/12	Quality Management Administrator
411	Update policies and procedures	15 days	Tue 2/7/12	Mon 2/27/12	Quality Management Administrator
412	**Provider appeals**	**124 days**	**Wed 9/7/11**	**Mon 2/27/12**	**Quality Management Administrator**
413	**Develop provider appeal policies and procedures**	**94 days**	**Wed 9/7/11**	**Mon 1/16/12**	**Quality Management Administrator**
414	Medical necessity and administrative	45 days	Tue 11/15/11	Mon 1/16/12	Quality Management Administrator
415	Level 1 process and notification	45 days	Wed 9/7/11	Tue 11/8/11	Quality Management Administrator
416	Level 2 process and notification	45 days	Wed 9/7/11	Tue 11/8/11	Quality Management Administrator
417	DHH-OBH Review	15 days	Tue 1/17/12	Mon 2/6/12	Quality Management Administrator
418	Update policies and procedures	15 days	Tue 2/7/12	Mon 2/27/12	Quality Management Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
419	**Data Management and Analysis (DM&A)**	**110 days**	**Mon 10/3/11**	**Fri 3/2/12**	**Information System Administrator**
420	**External reporting requirements**	**110 days**	**Mon 10/3/11**	**Fri 3/2/12**	**Information System Administrator**
421	Finalize required reports including any additional reports from those listed in the RFP	20 days	Mon 10/3/11	Fri 10/28/11	Information System Administrator
422	Identify performance guarantees	20 days	Mon 10/3/11	Fri 10/28/11	Information System Administrator
423	Create report mock-ups	20 days	Mon 10/31/11	Fri 11/25/11	Information System Administrator
424	Meetings with DHH-OBH and CSoC to review reporting requirements/formats/mock-ups	15 days	Mon 11/28/11	Fri 12/16/11	Information System Administrator
425	Identify/prioritize day 1 reports	15 days	Mon 11/28/11	Fri 12/16/11	Information System Administrator
426	Identify/prioritize non-day 1 reports	15 days	Mon 11/28/11	Fri 12/16/11	Information System Administrator
427	Create technical specifications for reports	15 days	Mon 12/19/11	Fri 1/6/12	Information System Administrator
428	Determine data mart requirements	15 days	Mon 12/19/11	Fri 1/6/12	Information System Administrator
429	Program reports	20 days	Mon 1/9/12	Fri 2/3/12	Information System Administrator
430	Validate Reports	5 days	Mon 2/6/12	Fri 2/10/12	Information System Administrator
431	Submit reports for review and sign-off by the State	5 days	Mon 2/13/12	Fri 2/17/12	Information System Administrator
432	Update reports	5 days	Mon 2/20/12	Fri 2/24/12	Information System Administrator
433	Set up reports on IntelligenceConnect	5 days	Mon 2/27/12	Fri 3/2/12	Information System Administrator
434	Set up process for ad hoc reporting requests from State	15 days	Wed 2/1/12	Tue 2/21/12	Information System Administrator
435	**Internal reporting requirements**	**105 days**	**Mon 10/3/11**	**Fri 2/24/12**	**Information System Administrator**
436	Identify required reports	20 days	Mon 10/3/11	Fri 10/28/11	Information System Administrator
437	Identify performance guarantees	20 days	Mon 10/3/11	Fri 10/28/11	Information System Administrator
438	Meet with teams to define report specifications/mock-ups	30 days	Mon 10/31/11	Fri 12/9/11	Information System Administrator
439	Create technical specifications for reports	20 days	Mon 12/12/11	Fri 1/6/12	Information System Administrator
440	Identify/prioritize day 1 reports	15 days	Mon 12/12/11	Fri 12/30/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
441	Identify/prioritize non-day 1 reports	15 days	Mon 12/12/11	Fri 12/30/11	Information System Administrator
442	Determine data mart requirements	15 days	Mon 12/12/11	Fri 12/30/11	Information System Administrator
443	Program reports	25 days	Mon 1/9/12	Fri 2/10/12	Information System Administrator
444	Validate Reports	5 days	Mon 2/13/12	Fri 2/17/12	Information System Administrator
445	Implement new reports	5 days	Mon 2/20/12	Fri 2/24/12	Information System Administrator
446	**BI Dashboard Development**	**85 days**	**Tue 11/1/11**	**Mon 2/27/12**	**Information System Administrator**
447	**Initiate Phase**	**30 days**	**Tue 11/1/11**	**Mon 12/12/11**	**Information System Administrator**
448	Introductory GoTo Meeting with State with Storyboard	15 days	Tue 11/1/11	Mon 11/21/11	Information System Administrator
449	Complete Dashboard Storyboard / Receive Sign-Off from State	15 days	Tue 11/22/11	Mon 12/12/11	Information System Administrator
450	Complete Project Charter / Receive Sign-Off from State	15 days	Tue 11/22/11	Mon 12/12/11	Information System Administrator
451	**Analyze Phase**	**20 days**	**Tue 12/13/11**	**Mon 1/9/12**	**Information System Administrator**
452	Complete requirements gathering and analysis	20 days	Tue 12/13/11	Mon 1/9/12	Information System Administrator
453	Define data source for all metrics and categories of information to be used	15 days	Tue 12/13/11	Mon 1/2/12	Information System Administrator
454	Receive sign-off from State on all calculations on dashboard	15 days	Tue 12/13/11	Mon 1/2/12	Information System Administrator
455	**Design Phase**	**15 days**	**Tue 1/10/12**	**Mon 1/30/12**	**Information System Administrator**
456	Data Model / ETL Design	15 days	Tue 1/10/12	Mon 1/30/12	Information System Administrator
457	Semantic Layer Design	15 days	Tue 1/10/12	Mon 1/30/12	Information System Administrator
458	**Development Phase**	**15 days**	**Tue 1/31/12**	**Mon 2/20/12**	**Information System Administrator**
459	ETL / Semantic Layer Build	15 days	Tue 1/31/12	Mon 2/20/12	Information System Administrator
460	Dashboard Development / Testing	15 days	Tue 1/31/12	Mon 2/20/12	Information System Administrator
461	**Implement Phase**	**5 days**	**Tue 2/21/12**	**Mon 2/27/12**	**Information System Administrator**
462	Promote to Production / Testing	5 days	Tue 2/21/12	Mon 2/27/12	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
463	Face to Face with State for roll-out of Dashboard	5 days	Tue 2/21/12	Mon 2/27/12	Information System Administrator
464	**Eligibility**	**45 days**	**Thu 12/15/11**	**Wed 2/15/12**	**Claims/Encounters Administrator**
465	Setup employee access on AEVS and PES	15 days	Mon 1/16/12	Fri 2/3/12	Claims/Encounters Administrator
466	Develop temporary member process	45 days	Thu 12/15/11	Wed 2/15/12	Claims/Encounters Administrator
467	Develop eligibility file reconciliation process	45 days	Thu 12/15/11	Wed 2/15/12	Claims/Encounters Administrator
468	**Claims**	**90 days**	**Tue 11/1/11**	**Mon 3/5/12**	**Claims/Encounters Administrator**
469	Identify client-specific requirements	45 days	Tue 11/1/11	Mon 1/2/12	Claims/Encounters Administrator
470	Coordinate VO set up and requirements for CNSI transition	45 days	Tue 11/1/11	Mon 1/2/12	Claims/Encounters Administrator
471	Review performance guarantee requirements	15 days	Tue 11/1/11	Mon 11/21/11	Claims/Encounters Administrator
472	Coordinate system setup with IT	45 days	Tue 1/3/12	Mon 3/5/12	Claims/Encounters Administrator
473	Develop client-specific P&Ps	25 days	Tue 1/3/12	Mon 2/6/12	Claims/Encounters Administrator
474	Train claims staff	10 days	Tue 2/7/12	Mon 2/20/12	Claims/Encounters Administrator
475	**Information Technology**	**117 days**	**Tue 9/6/11**	**Wed 2/15/12**	**Information System Administrator**
476	**Implementation Process**	**17 days**	**Tue 9/6/11**	**Wed 9/28/11**	**Information System Administrator**
477	Notification of Award/CIG Received	1 day	Tue 9/6/11	Tue 9/6/11	Information System Administrator
478	Identify Implementation Leads (Functional Areas)	3 days	Wed 9/7/11	Fri 9/9/11	Information System Administrator
479	Obtain and review contract	10 days	Wed 9/7/11	Tue 9/20/11	Information System Administrator
480	Obtain and review budget	5 days	Wed 9/21/11	Tue 9/27/11	Information System Administrator
481	Review Staffing	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
482	Request Approval to Incur IT Labor Charges	1 day	Wed 9/7/11	Wed 9/7/11	Information System Administrator
483	Receive Approval to Incur IT Labor Charges	1 day	Wed 9/7/11	Wed 9/7/11	Information System Administrator
484	Obtain and distribute CIG	2 days	Wed 9/7/11	Thu 9/8/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
485	Obtain Finance Code	1 day	Wed 9/7/11	Wed 9/7/11	Information System Administrator
486	Submit request to create project in CPTS	1 day	Thu 9/8/11	Thu 9/8/11	Information System Administrator
487	Submit request for P1 to be created in DevTrack	1 day	Thu 9/8/11	Thu 9/8/11	Information System Administrator
488	Create Draft Project Plan	5 days	Wed 9/7/11	Tue 9/13/11	Information System Administrator
489	Hold Internal IT Kick Off Meeting	1 day	Wed 9/14/11	Wed 9/14/11	Information System Administrator
490	Determine IT Meeting Schedule	3 days	Thu 9/15/11	Mon 9/19/11	Information System Administrator
491	Assign IT Resources	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
492	Schedule Internal IT Weekly Meeting	3 days	Thu 9/15/11	Mon 9/19/11	Information System Administrator
493	**Hold Initial Meeting with Client**	**5 days**	**Thu 9/15/11**	**Wed 9/21/11**	**Information System Administrator**
494	Review IT Processes and Communication Protocols	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
495	Review IT Requirements/Deliverables List	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
496	Review Change Management	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
497	Review Change Order Process	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
498	Determine Joint (Client/VO) IT Weekly Status Meeting schedule	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
499	**Discovery Phase**	**15 days**	**Thu 9/15/11**	**Wed 10/5/11**	**Information System Administrator**
500	Hold discovery meetings (internal & external) and resolve all questions/issues	15 days	Thu 9/15/11	Wed 10/5/11	Information System Administrator
501	Discovery Phase Complete	0 days	Wed 10/5/11	Wed 10/5/11	Information System Administrator
502	**IT Operations**	**90 days**	**Wed 9/7/11**	**Tue 1/10/12**	**Information System Administrator**
503	**Facility Management Tasks**	**90 days**	**Wed 9/7/11**	**Tue 1/10/12**	**Information System Administrator**
504	**New Contract Award Notification**	**5 days**	**Wed 9/7/11**	**Tue 9/13/11**	**Information System Administrator**
505	Obtain copy UW budget; determine go live date; verify staffing requirements; determine facility location if one	5 days	Wed 9/7/11	Tue 9/13/11	Information System Administrator
506	Work with underwriting & implementation leader to obtain information	5 days	Wed 9/7/11	Tue 9/13/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
507	**Perform Search for Required Property**	**5 days**	**Wed 9/14/11**	**Tue 9/20/11**	**Information System Administrator**
508	Tenant broker perform search based upon information provided from above requirements	5 days	Wed 9/14/11	Tue 9/20/11	Information System Administrator
509	**Daily IT/Facility Mtgs**	**90 days**	**Wed 9/7/11**	**Tue 1/10/12**	**Information System Administrator**
510	Participate in preparation of facility / IT project plan and provide progress updates	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
511	**Data Voice Circuits**	**1 day**	**Thu 9/15/11**	**Thu 9/15/11**	**Information System Administrator**
512	IT order required circuits	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
513	**Select Preferred Properties**	**16 days**	**Wed 9/21/11**	**Wed 10/12/11**	**Information System Administrator**
514	Request proposals	1 day	Wed 9/21/11	Wed 9/21/11	Information System Administrator
515	Complete Nat'l Facility Site Survey	5 days	Thu 9/22/11	Wed 9/28/11	Information System Administrator
516	Forward to IT	1 day	Thu 9/29/11	Thu 9/29/11	Information System Administrator
517	Receive/evaluate proposals	3 days	Thu 9/22/11	Mon 9/26/11	Information System Administrator
518	Schedule IT site visits	3 days	Tue 9/27/11	Thu 9/29/11	Information System Administrator
519	Solicit IT property preference	1 day	Fri 9/30/11	Fri 9/30/11	Information System Administrator
520	Obtain IT drawing/ environmental requirements for computer room - Data Center Requirements	5 days	Mon 10/3/11	Fri 10/7/11	Information System Administrator
521	Submit counter-proposal	3 days	Mon 10/10/11	Wed 10/12/11	Information System Administrator
522	**Receive/evaluate LL counter proposal response**	**5 days**	**Thu 10/13/11**	**Wed 10/19/11**	**Information System Administrator**
523	Compare LL responses	1 day	Thu 10/13/11	Thu 10/13/11	Information System Administrator
524	Execute recommendation	3 days	Fri 10/14/11	Tue 10/18/11	Information System Administrator
525	Request real estate lease	1 day	Wed 10/19/11	Wed 10/19/11	Information System Administrator
526	**Facility Floor Plan**	**9 days**	**Thu 10/20/11**	**Tue 11/1/11**	**Information System Administrator**
527	Obtain CAD File	3 days	Thu 10/20/11	Mon 10/24/11	Information System Administrator
528	Complete space/furniture design	5 days	Tue 10/25/11	Mon 10/31/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
529	Submit plans for approval	1 day	Tue 11/1/11	Tue 11/1/11	Information System Administrator
530	**Plans Approved**	**13 days**	**Wed 11/2/11**	**Fri 11/18/11**	**Information System Administrator**
531	LL request permits	1 day	Wed 11/2/11	Wed 11/2/11	Information System Administrator
532	Submits plans for bids	5 days	Wed 11/2/11	Tue 11/8/11	Information System Administrator
533	IT forwards to cable vendor	5 days	Wed 11/9/11	Tue 11/15/11	Information System Administrator
534	Facility orders furniture	3 days	Wed 11/16/11	Fri 11/18/11	Information System Administrator
535	**Real Estate Lease**	**5 days**	**Mon 11/21/11**	**Fri 11/25/11**	**Information System Administrator**
536	Review/compare lease w/approved LL proposal	3 days	Mon 11/21/11	Wed 11/23/11	Information System Administrator
537	Negotiate any issues	1 day	Thu 11/24/11	Thu 11/24/11	Information System Administrator
538	Finalize lease	1 day	Fri 11/25/11	Fri 11/25/11	Information System Administrator
539	**Construction build-out schedule**	**6 days**	**Wed 11/9/11**	**Wed 11/16/11**	**Information System Administrator**
540	Obtain construction build out schedule	5 days	Wed 11/9/11	Tue 11/15/11	Information System Administrator
541	Communicate to IT, cable, furniture and security vendors	1 day	Wed 11/16/11	Wed 11/16/11	Information System Administrator
542	**Office Equipment**	**16 days**	**Wed 9/14/11**	**Wed 10/5/11**	**Information System Administrator**
543	Order copiers	1 day	Wed 9/14/11	Wed 9/14/11	Information System Administrator
544	Order fax	5 days	Wed 9/14/11	Tue 9/20/11	Information System Administrator
545	Order postage machines	5 days	Wed 9/21/11	Tue 9/27/11	Information System Administrator
546	Set up UPS & eWay accounts	5 days	Wed 9/28/11	Tue 10/4/11	Information System Administrator
547	Establish local PO Box/courier required	1 day	Wed 10/5/11	Wed 10/5/11	Information System Administrator
548	**Office Signage & Business Licenses**	**45 days**	**Wed 9/14/11**	**Tue 11/15/11**	**Information System Administrator**
549	Submit & obtain office signage	30 days	Wed 9/14/11	Tue 10/25/11	Information System Administrator
550	Local business licenses	15 days	Wed 10/26/11	Tue 11/15/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
551	**Schedule Construction Mtgs**	**30 days**	**Wed 11/16/11**	**Tue 12/27/11**	**Information System Administrator**
552	Weekly mtgs w/construction project mgr	30 days	Wed 11/16/11	Tue 12/27/11	Information System Administrator
553	Mtgs w/trade vendors, as necessary	30 days	Wed 11/16/11	Tue 12/27/11	Information System Administrator
554	**Cubicle/Furniture Install**	**5 days**	**Thu 11/17/11**	**Wed 11/23/11**	**Information System Administrator**
555	Schedule cubicle/furniture installations w/cable vendor & GC	5 days	Thu 11/17/11	Wed 11/23/11	Information System Administrator
556	**Build out Completion**	**3 days**	**Thu 11/17/11**	**Mon 11/21/11**	**Information System Administrator**
557	Perform final walk thru w.construction project mgr/GC	1 day	Thu 11/17/11	Thu 11/17/11	Information System Administrator
558	Identify/document all issues	1 day	Fri 11/18/11	Fri 11/18/11	Information System Administrator
559	Receive timeline for correction	1 day	Mon 11/21/11	Mon 11/21/11	Information System Administrator
560	**Final Build out cost reconciliation**	**2 days**	**Tue 11/22/11**	**Wed 11/23/11**	**Information System Administrator**
561	Work w/GC & construction project mgr for completion of build out reconciliation	1 day	Tue 11/22/11	Tue 11/22/11	Information System Administrator
562	Obtain approval and submit to finance	1 day	Wed 11/23/11	Wed 11/23/11	Information System Administrator
563	**IT Information Gathering for Data Center**	**38 days**	**Thu 11/17/11**	**Mon 1/9/12**	**Information System Administrator**
564	**Building Security**	**38 days**	**Thu 11/17/11**	**Mon 1/9/12**	**Information System Administrator**
565	**Select Vendor**	**18 days**	**Thu 11/17/11**	**Mon 12/12/11**	**Information System Administrator**
566	Identify locations for building security card readers	3 days	Thu 11/17/11	Mon 11/21/11	Information System Administrator
567	Provide AutoCAD of card reader locations	7 days	Tue 11/22/11	Wed 11/30/11	Information System Administrator
568	Contact Security Vendor with target move in date	2 days	Thu 12/1/11	Fri 12/2/11	Information System Administrator
569	Provide Security Vendor soft copy of electrical drawings	2 days	Thu 12/1/11	Fri 12/2/11	Information System Administrator
570	Provide pricing for purchase order for cabling new location	3 days	Mon 12/5/11	Wed 12/7/11	Information System Administrator
571	Create Purchase Order for security cabling	2 days	Thu 12/8/11	Fri 12/9/11	Information System Administrator
572	Cabling new location	1 day	Mon 12/12/11	Mon 12/12/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
573	**Data Center Leases, Contracts & Accounts**	**38 days**	**Thu 11/17/11**	**Mon 1/9/12**	**Information System Administrator**
574	Establish Vendor Contract for HVAC	20 days	Thu 11/17/11	Wed 12/14/11	Information System Administrator
575	Establish Vendor Contract for Security	20 days	Tue 12/13/11	Mon 1/9/12	Information System Administrator
576	**Network Services LAN/WAN IT Implementation Template**	**77 days**	**Wed 9/7/11**	**Thu 12/22/11**	**Information System Administrator**
577	**Identify LAN/WAN equipment for data center**	**77 days**	**Wed 9/7/11**	**Thu 12/22/11**	**Information System Administrator**
578	**Power/UPS/Generator**	**1 day**	**Wed 11/2/11**	**Wed 11/2/11**	**Information System Administrator**
579	Calculate power requirements for data center equipment - LAN	1 day	Wed 11/2/11	Wed 11/2/11	Information System Administrator
580	Calculate power requirements for data center equipment - WAN	1 day	Wed 11/2/11	Wed 11/2/11	Information System Administrator
581	Prepare Server Room Diagram	1 day	Wed 11/2/11	Wed 11/2/11	Information System Administrator
582	**LAN Tasks**	**16 days**	**Wed 9/7/11**	**Wed 9/28/11**	**Information System Administrator**
583	**Determine Needed LAN Hardware/Software**	**3 days**	**Wed 9/7/11**	**Fri 9/9/11**	**Information System Administrator**
584	**Obtain Staffing Information**	**1 day**	**Wed 9/7/11**	**Wed 9/7/11**	**Information System Administrator**
585	On-Site	1 day	Wed 9/7/11	Wed 9/7/11	Information System Administrator
586	Off-Site	1 day	Wed 9/7/11	Wed 9/7/11	Information System Administrator
587	Determine the number of servers	1 day	Thu 9/8/11	Thu 9/8/11	Information System Administrator
588	Determine Set Up Date	1 day	Thu 9/8/11	Thu 9/8/11	Information System Administrator
589	Determine shipping plan	1 day	Fri 9/9/11	Fri 9/9/11	Information System Administrator
590	**Order LAN Equipment**	**1 day**	**Mon 9/12/11**	**Mon 9/12/11**	**Information System Administrator**
591	Create and submit Purchase Requests (PR) for all LAN equipment	1 day	Mon 9/12/11	Mon 9/12/11	Information System Administrator
592	Obtain VP management approval for PR and Purchase Order (PO)	1 day	Mon 9/12/11	Mon 9/12/11	Information System Administrator
593	Document Equipment Ordered into LAN Services Inventory	1 day	Mon 9/12/11	Mon 9/12/11	Information System Administrator
594	Order hardware (Server, Rack, Cable, Video, Mouse)	1 day	Mon 9/12/11	Mon 9/12/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
595	**Receive LAN Equipment**	**10 days**	**Tue 9/13/11**	**Mon 9/26/11**	**Information System Administrator**
596	Servers	10 days	Tue 9/13/11	Mon 9/26/11	Information System Administrator
597	Software	10 days	Tue 9/13/11	Mon 9/26/11	Information System Administrator
598	Racks to include: Cable, Video, Mouse	10 days	Tue 9/13/11	Mon 9/26/11	Information System Administrator
599	**Install/Setup LAN Equipment**	**1 day**	**Tue 9/27/11**	**Tue 9/27/11**	**Information System Administrator**
600	Configure Servers	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
601	Install Software	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
602	Setup Racks to include: Cable, Video, Mouse	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
603	Test Servers	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
604	**WAN Tasks**	**77 days**	**Wed 9/7/11**	**Thu 12/22/11**	**Information System Administrator**
605	**Determine Method of connectivity**	**1 day**	**Wed 9/7/11**	**Wed 9/7/11**	**Information System Administrator**
606	Determine WAN Equipment Needed for connectivity	1 day	Wed 9/7/11	Wed 9/7/11	Information System Administrator
607	Determine File Transfer Needs/ Method and Resources Assigned	1 day	Wed 9/7/11	Wed 9/7/11	Information System Administrator
608	**Determine Circuit Size**	**5 days**	**Thu 9/8/11**	**Wed 9/14/11**	**Information System Administrator**
609	Data	5 days	Thu 9/8/11	Wed 9/14/11	Information System Administrator
610	Voice	5 days	Thu 9/8/11	Wed 9/14/11	Information System Administrator
611	**Obtain Location Information**	**60 days**	**Wed 9/7/11**	**Tue 11/29/11**	**Information System Administrator**
612	**Obtain Location Description**	**2 days**	**Mon 11/28/11**	**Tue 11/29/11**	**Information System Administrator**
613	Obtain Site Address	1 day	Mon 11/28/11	Mon 11/28/11	Information System Administrator
614	Obtain Site Layout	1 day	Tue 11/29/11	Tue 11/29/11	Information System Administrator
615	Obtain Local Contact Information (e.g. Building/Property Management)	1 day	Tue 11/29/11	Tue 11/29/11	Information System Administrator
616	Obtain IT Contact Information	1 day	Tue 11/29/11	Tue 11/29/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
617	**Obtain Staffing Information**	**5 days**	**Wed 9/7/11**	**Tue 9/13/11**	**Information System Administrator**
618	On-Site	1 day	Wed 9/7/11	Wed 9/7/11	Information System Administrator
619	Off-Site	5 days	Wed 9/7/11	Tue 9/13/11	Information System Administrator
620	**Order WAN Equipment**	**15 days**	**Wed 11/30/11**	**Tue 12/20/11**	**Information System Administrator**
621	**Hardware**	**15 days**	**Wed 11/30/11**	**Tue 12/20/11**	**Information System Administrator**
622	Determine hardware needs	3 days	Wed 11/30/11	Fri 12/2/11	Information System Administrator
623	Generate PR	1 day	Mon 12/5/11	Mon 12/5/11	Information System Administrator
624	Obtain VP management approval for PR	1 day	Tue 12/6/11	Tue 12/6/11	Information System Administrator
625	Order hardware	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
626	Receive Hardware	5 days	Thu 12/8/11	Wed 12/14/11	Information System Administrator
627	Configure Hardware	1 day	Thu 12/15/11	Thu 12/15/11	Information System Administrator
628	Install Hardware	2 days	Fri 12/16/11	Mon 12/19/11	Information System Administrator
629	Test Hardware	1 day	Tue 12/20/11	Tue 12/20/11	Information System Administrator
630	**Cabling**	**10 days**	**Wed 9/14/11**	**Tue 9/27/11**	**Information System Administrator**
631	Determine cabling needs	3 days	Wed 9/14/11	Fri 9/16/11	Information System Administrator
632	Identify vendor	1 day	Mon 9/19/11	Mon 9/19/11	Information System Administrator
633	Design cable	2 days	Mon 9/19/11	Tue 9/20/11	Information System Administrator
634	Confirm Construction Completion Before Cable Installation	1 day	Wed 9/21/11	Wed 9/21/11	Information System Administrator
635	Lay Cable(s)	3 days	Thu 9/22/11	Mon 9/26/11	Information System Administrator
636	Test Cable(s)	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
637	**Data Circuits & CPE**	**11 days**	**Wed 9/14/11**	**Wed 9/28/11**	**Information System Administrator**
638	Determine Data Circuit & CPE needs	2 days	Wed 9/14/11	Thu 9/15/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
639	Determine size	2 days	Wed 9/14/11	Thu 9/15/11	Information System Administrator
640	Place Data Circuit & CPE order	1 day	Fri 9/16/11	Fri 9/16/11	Information System Administrator
641	Obtain Data Circuits & CPE	5 days	Mon 9/19/11	Fri 9/23/11	Information System Administrator
642	Install Data Circuit & CPE	2 days	Mon 9/26/11	Tue 9/27/11	Information System Administrator
643	Network Planning and Engineering (NPE) Testing	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
644	**Client Site**	**17 days**	**Wed 11/30/11**	**Thu 12/22/11**	**Information System Administrator**
645	**Method of connectivity**	**17 days**	**Wed 11/30/11**	**Thu 12/22/11**	**Information System Administrator**
646	**Router(s)**	**10 days**	**Wed 12/7/11**	**Tue 12/20/11**	**Information System Administrator**
647	Order Router(s) for Client Site	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
648	Receive Router(s) for Client Site	5 days	Thu 12/8/11	Wed 12/14/11	Information System Administrator
649	Configure Router(s) for Client Site	3 days	Thu 12/15/11	Mon 12/19/11	Information System Administrator
650	Ship Router(s) to Client Site	1 day	Tue 12/20/11	Tue 12/20/11	Information System Administrator
651	**Switch(es)**	**14 days**	**Wed 11/30/11**	**Mon 12/19/11**	**Information System Administrator**
652	Determine Switch/Hub Requirements	4 days	Wed 11/30/11	Mon 12/5/11	Information System Administrator
653	Order Switch(es) for Client Site	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
654	Receive Switch(es) for Client Site	5 days	Thu 12/8/11	Wed 12/14/11	Information System Administrator
655	Configure Switch(es) for Client Site	2 days	Thu 12/15/11	Fri 12/16/11	Information System Administrator
656	Ship Switch(es) to Client Site	1 day	Mon 12/19/11	Mon 12/19/11	Information System Administrator
657	**Site to Site VPN**	**17 days**	**Wed 11/30/11**	**Thu 12/22/11**	**Information System Administrator**
658	Determine need for Site to Site VPN	10 days	Wed 11/30/11	Tue 12/13/11	Information System Administrator
659	Distribute VPN form to Client	1 day	Wed 12/14/11	Wed 12/14/11	Information System Administrator
660	Obtain completed form and sign off from Client (VPN form)	3 days	Thu 12/15/11	Mon 12/19/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
661	Configure Site to Site VPN	2 days	Tue 12/20/11	Wed 12/21/11	Information System Administrator
662	Test Site to Site connectivity	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
663	**Desktop Services Tasks**	**43 days**	**Thu 9/15/11**	**Mon 11/14/11**	**Information System Administrator**
664	Determine the number of Desktops / Laptops	15 days	Thu 9/15/11	Wed 10/5/11	Information System Administrator
665	Determine number of desktops/laptops for the MD/PA staff	14 days	Thu 9/15/11	Tue 10/4/11	Information System Administrator
666	Determine the number of Printers, Copiers, and Fax Machines	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
667	Determine Fax Purposes to be setup on the Fax server	15 days	Thu 9/15/11	Wed 10/5/11	Information System Administrator
668	Order equipment	24 days	Thu 10/6/11	Tue 11/8/11	Information System Administrator
669	Setup Desktops and Monitors for staff functional 5/1	2 days	Wed 11/9/11	Thu 11/10/11	Information System Administrator
670	Setup Printers	2 days	Wed 11/9/11	Thu 11/10/11	Information System Administrator
671	Test Setup	2 days	Fri 11/11/11	Mon 11/14/11	Information System Administrator
672	Determine equipment count for expansion space	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
673	Place Equipment Order	30 days	Thu 9/22/11	Wed 11/2/11	Information System Administrator
674	Complete Desktop/Monitors setup as additional staff join	2 days	Fri 11/11/11	Mon 11/14/11	Information System Administrator
675	Test Setup	1 day	Fri 11/11/11	Fri 11/11/11	Information System Administrator
676	**Telecom Tasks**	**76 days**	**Thu 9/15/11**	**Thu 12/29/11**	**Information System Administrator**
677	**Determine Telecom Requirements**	**15 days**	**Thu 9/15/11**	**Wed 10/5/11**	**Information System Administrator**
678	Obtain Staffing Numbers	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
679	Determine the type/number of Phones and Headsets Needed	8 days	Thu 9/15/11	Mon 9/26/11	Information System Administrator
680	Determine # of fax lines needed	8 days	Thu 9/15/11	Mon 9/26/11	Information System Administrator
681	Review PBX Requirements & Determine Additional Equipment Required	15 days	Thu 9/15/11	Wed 10/5/11	Information System Administrator
682	Determine Circuit Size - Voice	2 days	Thu 9/15/11	Fri 9/16/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
683	Submit Request to Vendor for Quote	3 days	Mon 9/19/11	Wed 9/21/11	Information System Administrator
684	Review Costs & Quotes with the Telecom Implementation Team	2 days	Thu 9/22/11	Fri 9/23/11	Information System Administrator
685	Submit Telecom PO	1 day	Mon 9/26/11	Mon 9/26/11	Information System Administrator
686	Obtain PO Approval of Capital Purchase Request	2 days	Tue 9/27/11	Wed 9/28/11	Information System Administrator
687	**PRE-IMPLEMENTATION**	**22 days**	**Thu 9/15/11**	**Fri 10/14/11**	**Information System Administrator**
688	**Order Telco Lines**	**8 days**	**Thu 9/29/11**	**Mon 10/10/11**	**Information System Administrator**
689	Local Lines/SIP and DIDs	1 day	Thu 9/29/11	Thu 9/29/11	Information System Administrator
690	Order POTS lines	8 days	Thu 9/29/11	Mon 10/10/11	Information System Administrator
691	**Order Equipment**	**18 days**	**Thu 9/15/11**	**Mon 10/10/11**	**Information System Administrator**
692	Design meeting with SPS on the equipment being installed	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
693	Ship Site Equipment to SPS warehouse	4 days	Fri 9/16/11	Wed 9/21/11	Information System Administrator
694	Order Phones, Headsets, Polycoms, TDD Phone as applicable	10 days	Tue 9/27/11	Mon 10/10/11	Information System Administrator
695	Conduct Site Survey by Technician to examine Switch room lighting, electrical requirements, grounding, cabling,	1 day	Thu 10/6/11	Thu 10/6/11	Information System Administrator
696	Complete Network Design/Numbering Plan	5 days	Thu 10/6/11	Wed 10/12/11	Information System Administrator
697	Complete Network Assessment	2 days	Thu 10/13/11	Fri 10/14/11	Information System Administrator
698	**EQUIPMENT DELIVERY/ INVENTORY/STAGING**	**29 days**	**Thu 9/15/11**	**Tue 10/25/11**	**Information System Administrator**
699	Ship IP phones from Reston to Site	1 day	Tue 10/11/11	Tue 10/11/11	Information System Administrator
700	SPS to Stage the servers	15 days	Thu 9/22/11	Wed 10/12/11	Information System Administrator
701	Receive IP Address from the WAN team	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
702	Load any necessary Avaya software patches	4 days	Thu 10/13/11	Tue 10/18/11	Information System Administrator
703	Prep Equipment for shipping to service center	1 day	Wed 10/19/11	Wed 10/19/11	Information System Administrator
704	Verify loading Dock / Elevator	1 day	Tue 10/11/11	Tue 10/11/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
705	Deliver Equipment and Telephones to AR	4 days	Thu 10/20/11	Tue 10/25/11	Information System Administrator
706	**IMPLEMENTATION**	**64 days**	**Thu 9/15/11**	**Tue 12/13/11**	**Information System Administrator**
707	**Define System Programming**	**10 days**	**Thu 9/15/11**	**Wed 9/28/11**	**Information System Administrator**
708	Define System Feature Codes (activate malicious call trace)	3 days	Thu 9/15/11	Mon 9/19/11	Information System Administrator
709	Define System Dial Plan (number of digits dialed, etc)	3 days	Thu 9/15/11	Mon 9/19/11	Information System Administrator
710	Define System Trunking (qty, interface type, line frame & format)	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
711	Determine TFTP Server Setup	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
712	Determine DHCP Server Setup	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
713	**Define Station Programming**	**15 days**	**Thu 9/15/11**	**Wed 10/5/11**	**Information System Administrator**
714	**Standard Telephones (non-ACD)**	**15 days**	**Thu 9/15/11**	**Wed 10/5/11**	**Information System Administrator**
715	Determine Features Required	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
716	Determine Button Locations - per set type(s)	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
717	Determine Bridged Appearances	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
718	Determine Busy Stations (if needed)	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
719	Determine Intercom Groups (if needed)	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
720	Determine Call Pickup Groups (if needed)	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
721	Determine COR/COS	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
722	Determine Cover Paths	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
723	Determine Quantity by Type	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
724	Complete Station Design	3 days	Thu 9/29/11	Mon 10/3/11	Information System Administrator
725	Document the NON ACD Phone Layout	2 days	Tue 10/4/11	Wed 10/5/11	Information System Administrator
726	**ACD Telephones**	**5 days**	**Thu 9/15/11**	**Wed 9/21/11**	**Information System Administrator**

ID	Task Name	Duration	Start	Finish	Resource Names
727	Determine the Layout Will Work	3 days	Thu 9/15/11	Mon 9/19/11	Information System Administrator
728	Document the ACD Phone Layout (agents/supervisor)	2 days	Tue 9/20/11	Wed 9/21/11	Information System Administrator
729	**Define TFN and ACD Programming**	**53 days**	**Thu 9/15/11**	**Mon 11/28/11**	**Information System Administrator**
730	Provide toll-free numbers (TFNs) for publications to Business	1 day	Thu 10/6/11	Thu 10/6/11	Information System Administrator
731	**Gather Requirements**	**45 days**	**Thu 9/15/11**	**Wed 11/16/11**	**Information System Administrator**
732	Business to provide scripts for the TFN	35 days	Thu 9/15/11	Wed 11/2/11	Information System Administrator
733	Define BRP site	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
734	Define Agent Groups	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
735	Define Service Levels on VDN's	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
736	Define Service Levels on Skills	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
737	Define VDN Names	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
738	Define Announcements	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
739	Define AUX Reason Codes	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
740	Provide Holiday Schedule	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
741	Confirm Zip Tone	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
742	Provide Vector's for the VDN's	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
743	Provide Aux Reason Code Description	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
744	Provide Skill Level for Agents	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
745	Provide Vu Stat Formats	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
746	**Complete Design**	**8 days**	**Thu 11/17/11**	**Mon 11/28/11**	**Information System Administrator**
747	Prepare Call Center Design Documents	5 days	Thu 11/17/11	Wed 11/23/11	Information System Administrator
748	Review Design with business team	1 day	Thu 11/24/11	Thu 11/24/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
749	Update design document if needed	2 days	Fri 11/25/11	Mon 11/28/11	Information System Administrator
750	**Setup Other Applications**	**54 days**	**Thu 9/29/11**	**Tue 12/13/11**	**Information System Administrator**
751	Order Language Line Services	26 days	Thu 9/29/11	Thu 11/3/11	Information System Administrator
752	Setup service center on E911	54 days	Thu 9/29/11	Tue 12/13/11	Information System Administrator
753	**Test Plan**	**10 days**	**Tue 11/29/11**	**Mon 12/12/11**	**Information System Administrator**
754	Prepare Test Plan, Execution, Executive Summary and Analysis Package	10 days	Tue 11/29/11	Mon 12/12/11	Information System Administrator
755	**Define CMS Programming**	**5 days**	**Tue 11/29/11**	**Mon 12/5/11**	**Information System Administrator**
756	CMS Dictionary (agent names, trunk group names)	5 days	Tue 11/29/11	Mon 12/5/11	Information System Administrator
757	The Service Levels on VDN's for the Call Profile Reports	5 days	Tue 11/29/11	Mon 12/5/11	Information System Administrator
758	The Service Levels on Skills for the Call Profile Reports	5 days	Tue 11/29/11	Mon 12/5/11	Information System Administrator
759	Agent Groups	5 days	Tue 11/29/11	Mon 12/5/11	Information System Administrator
760	**Define Voicemail Programming**	**10 days**	**Thu 9/15/11**	**Wed 9/28/11**	**Information System Administrator**
761	Mailbox Password Length	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
762	System Features	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
763	Out calling	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
764	Mailbox Storage Sizes	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
765	Mailbox Classes of Service	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
766	Define Zero Out Path	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
767	**TELCO FACILITIES READY**	**48 days**	**Thu 9/15/11**	**Mon 11/21/11**	**Information System Administrator**
768	Program Trunks Translations	2 days	Thu 9/15/11	Fri 9/16/11	Information System Administrator
769	Program 6 digit translations	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
770	Install Pots Lines for 911 and INADS	5 days	Tue 11/15/11	Mon 11/21/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
771	Install and Extend Local Circuits (smart jacks) to the Switch Room	4 days	Fri 11/4/11	Wed 11/9/11	Information System Administrator
772	**ON-SITE INSTALLATION**	**58 days**	**Thu 10/6/11**	**Mon 12/26/11**	**Information System Administrator**
773	**Complete Initial Installation**	**1 day**	**Thu 11/10/11**	**Thu 11/10/11**	**Information System Administrator**
774	Install S8300, G700 in AK	1 day	Thu 11/10/11	Thu 11/10/11	Information System Administrator
775	Set Time per Time Source	1 day	Thu 11/10/11	Thu 11/10/11	Information System Administrator
776	Register System	1 day	Thu 11/10/11	Thu 11/10/11	Information System Administrator
777	**ENTER DATA INTO SYSTEMS**	**53 days**	**Thu 10/6/11**	**Mon 12/19/11**	**Information System Administrator**
778	Program Stations and Voice Mails for Staff functional from 5/1	5 days	Thu 10/6/11	Wed 10/12/11	Information System Administrator
779	Provide Completed Cut-sheet and ACD Documents	10 days	Tue 11/29/11	Mon 12/12/11	Information System Administrator
780	Program Stations in PBX	5 days	Tue 12/13/11	Mon 12/19/11	Information System Administrator
781	Program ACD (vectors, translate announcements, skills, VDN's) in PBX	10 days	Tue 11/29/11	Mon 12/12/11	Information System Administrator
782	Complete Voice Mail Programming	5 days	Tue 12/13/11	Mon 12/19/11	Information System Administrator
783	Complete CMS Programming	5 days	Tue 12/13/11	Mon 12/19/11	Information System Administrator
784	Complete ECR Programming	5 days	Tue 12/13/11	Mon 12/19/11	Information System Administrator
785	**Complete Remaining Installation**	**2 days**	**Fri 11/11/11**	**Mon 11/14/11**	**Information System Administrator**
786	Install 110 Blocks, Run & Connect Switch Tails (new frame)	2 days	Fri 11/11/11	Mon 11/14/11	Information System Administrator
787	Activate T-1 Circuits	1 day	Fri 11/11/11	Fri 11/11/11	Information System Administrator
788	Tag, ID & Install Cross-connects for Analog Lines	2 days	Fri 11/11/11	Mon 11/14/11	Information System Administrator
789	Place and Test Avaya Telephones (during day or after hours)	2 days	Fri 11/11/11	Mon 11/14/11	Information System Administrator
790	Install Training Room Sets in Conference rooms	2 days	Fri 11/11/11	Mon 11/14/11	Information System Administrator
791	**COMPLETE TESTING**	**31 days**	**Mon 11/14/11**	**Mon 12/26/11**	**Information System Administrator**
792	Test T-1 Circuits	1 day	Mon 11/14/11	Mon 11/14/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
793	Perform Failover Testing	1 day	Tue 11/15/11	Tue 11/15/11	Information System Administrator
794	Test Call Routing	5 days	Tue 12/13/11	Mon 12/19/11	Information System Administrator
795	Record Announcements	1 day	Tue 12/13/11	Tue 12/13/11	Information System Administrator
796	Test ACD Call Flows (variable remote activation)	5 days	Tue 12/13/11	Mon 12/19/11	Information System Administrator
797	Test CMS Services	5 days	Tue 12/20/11	Mon 12/26/11	Information System Administrator
798	Test TFN Routing	5 days	Tue 12/20/11	Mon 12/26/11	Information System Administrator
799	**Expansion**	**20 days**	**Thu 9/15/11**	**Wed 10/12/11**	**Information System Administrator**
800	Determine Equipment Count (Phone Types / Headsets / Analog)	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
801	Send Equipment to Baton Rouge from Reston Inventory	5 days	Thu 9/29/11	Wed 10/5/11	Information System Administrator
802	Order equipment if needed	10 days	Thu 9/29/11	Wed 10/12/11	Information System Administrator
803	Install Phones in the expansion space	3 days	Thu 10/6/11	Mon 10/10/11	Information System Administrator
804	**CONDUCT END USER TRAINING**	**44 days**	**Thu 9/15/11**	**Tue 11/15/11**	**Information System Administrator**
805	Confirm End User Training Schedule	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
806	**TELEPHONE TRAINING**	**1 day**	**Tue 11/15/11**	**Tue 11/15/11**	**Information System Administrator**
807	4610 Non-ACD Training	1 day	Tue 11/15/11	Tue 11/15/11	Information System Administrator
808	Vmail Training	1 day	Tue 11/15/11	Tue 11/15/11	Information System Administrator
809	ACD Training (cover aux code usage)	1 day	Tue 11/15/11	Tue 11/15/11	Information System Administrator
810	**SYSTEM TRAINING**	**1 day**	**Tue 11/15/11**	**Tue 11/15/11**	**Information System Administrator**
811	Load Centre-Vu Supervisor Software on local Supervisor PC's	1 day	Tue 11/15/11	Tue 11/15/11	Information System Administrator
812	Centre-Vu Supervisor / CMS Training	1 day	Tue 11/15/11	Tue 11/15/11	Information System Administrator
813	Value Options Custom CMS Reporting	1 day	Tue 11/15/11	Tue 11/15/11	Information System Administrator
814	**POST CUTOVER SUPPORT**	**3 days**	**Tue 12/27/11**	**Thu 12/29/11**	**Information System Administrator**

ID	Task Name	Duration	Start	Finish	Resource Names
815	1st & 2nd Day of Business Support on 3/2012 for Baton Rouge	3 days	Tue 12/27/11	Thu 12/29/11	Information System Administrator
816	1st & 2nd Day of Business Support (Baton Rouge)	3 days	Tue 12/27/11	Thu 12/29/11	Information System Administrator
817	Technicians, Trainer, Software Support & Call Center Consultant On Site	1 day	Tue 12/27/11	Tue 12/27/11	Information System Administrator
818	**System Set Up**	**117 days**	**Tue 9/6/11**	**Wed 2/15/12**	**Information System Administrator**
819	**CAS Set Up**	**104 days**	**Tue 9/6/11**	**Fri 1/27/12**	**Information System Administrator**
820	**System/Benefits Configuration**	**90 days**	**Wed 9/7/11**	**Tue 1/10/12**	**Information System Administrator**
821	**Requirements**	**90 days**	**Wed 9/7/11**	**Tue 1/10/12**	**Information System Administrator**
822	Gather requirements for benefit information/benefit rules	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
823	Obtain list of covered services	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
824	Obtain listing of covered diagnosis codes by state	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
825	Obtain authorization requirements/auth types	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
826	Create draft of Service Class Grid{s}	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
827	**CAS Claims Configuration/Reference File Setup/CC & Service Connect**	**90 days**	**Wed 9/7/11**	**Tue 1/10/12**	**Information System Administrator**
828	Assign Parent Code{s}	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
829	Develop Benefit Shells	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
830	Load Service Class Grid{s} into CAS	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
831	Configure CareConnect/Service Connect	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
832	**Configure MemberConnect SSO Admin**	**10 days**	**Wed 9/7/11**	**Tue 9/20/11**	**Information System Administrator**
833	Load Parent code	10 days	Wed 9/7/11	Tue 9/20/11	Information System Administrator
834	Obtain ReferralConnect information {username, Pswd, URL} from Matt Christian	10 days	Wed 9/7/11	Tue 9/20/11	Information System Administrator
835	Obtain Achieve Solutions information {client user ID, URL} from Matt Christian	10 days	Wed 9/7/11	Tue 9/20/11	Information System Administrator
836	Obtain Medicaid Website {URL specific website} from Matt Christian	10 days	Wed 9/7/11	Tue 9/20/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
837	**Benefit Configuration**	**90 days**	**Wed 9/7/11**	**Tue 1/10/12**	**Information System Administrator**
838	Configure Benefits	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
839	Peer-to-peer audit	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
840	Test Benefits	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
841	**BenefitConnect**	**90 days**	**Wed 9/7/11**	**Tue 1/10/12**	**Information System Administrator**
842	Load Client {s}	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
843	Load Benefit Packages	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
844	Load Benefit Information	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
845	Activate Client	90 days	Wed 9/7/11	Tue 1/10/12	Information System Administrator
846	**References and Tables**	**60 days**	**Wed 9/7/11**	**Tue 11/29/11**	**Information System Administrator**
847	Establish ELGPAR	3 days	Wed 9/7/11	Fri 9/9/11	Information System Administrator
848	Define Groups	5 days	Wed 9/7/11	Tue 9/13/11	Information System Administrator
849	Set Up Unknown Member	1 day	Wed 9/21/11	Wed 9/21/11	Information System Administrator
850	Set Up Groups	5 days	Wed 9/14/11	Tue 9/20/11	Information System Administrator
851	Parent/Reason Code Cross Reference (RF1321)	60 days	Wed 9/7/11	Tue 11/29/11	Information System Administrator
852	**Braided Funding Configuration**	**104 days**	**Tue 9/6/11**	**Fri 1/27/12**	**Information System Administrator**
853	Gather requirements for funding streams	90 days	Tue 9/6/11	Mon 1/9/12	Information System Administrator
854	Document requirements	90 days	Tue 9/6/11	Mon 1/9/12	Information System Administrator
855	Obtain Client Signoff	2 days	Tue 1/10/12	Wed 1/11/12	Information System Administrator
856	Complete system configuration	10 days	Thu 1/12/12	Wed 1/25/12	Information System Administrator
857	Validate system configuration	10 days	Thu 1/12/12	Wed 1/25/12	Information System Administrator
858	Obtain functional area(s) Signoff	2 days	Thu 1/26/12	Fri 1/27/12	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
859	**CONNECTIONS Set Up**	**117 days**	**Tue 9/6/11**	**Wed 2/15/12**	**Information System Administrator**
860	**StaffConnect Set Up**	**8 days**	**Thu 9/15/11**	**Mon 9/26/11**	**Information System Administrator**
861	Determine Service Center location(s)	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
862	Submit request to create/update service center information	5 days	Fri 9/16/11	Thu 9/22/11	Information System Administrator
863	Load Service Center information	2 days	Fri 9/23/11	Mon 9/26/11	Information System Administrator
864	**TechHelpConnect Set Up**	**8 days**	**Thu 9/15/11**	**Mon 9/26/11**	**Information System Administrator**
865	Determine Service Center location(s)	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
866	Submit request to create/update service center information	5 days	Fri 9/16/11	Thu 9/22/11	Information System Administrator
867	Load Service Center information	2 days	Fri 9/23/11	Mon 9/26/11	Information System Administrator
868	**DevTrack Set Up**	**10 days**	**Thu 9/15/11**	**Wed 9/28/11**	**Information System Administrator**
869	Add Service Center Information to DevTrack	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
870	Create P2 for each IT Deliverable	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
871	**SecurityConnect Set Up**	**110 days**	**Thu 9/15/11**	**Wed 2/15/12**	**Information System Administrator**
872	**Internal Users**	**110 days**	**Thu 9/15/11**	**Wed 2/15/12**	**Information System Administrator**
873	Determine Service Center locations	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
874	Submit request to create/update service center information	1 day	Fri 9/16/11	Fri 9/16/11	Information System Administrator
875	Load Service Center information	2 days	Mon 9/19/11	Tue 9/20/11	Information System Administrator
876	Determine Security Access Needs for Service Center Staff	60 days	Thu 9/15/11	Wed 12/7/11	Information System Administrator
877	Submit eSars for Service Center Staff	60 days	Wed 9/21/11	Tue 12/13/11	Information System Administrator
878	Receive Group Ranges from Eligibility for Set up	1 day	Wed 12/14/11	Wed 12/14/11	Information System Administrator
879	Set Up Security Levels, Profiles & Roles (New FTEs Hired)	45 days	Thu 12/15/11	Wed 2/15/12	Information System Administrator
880	**External Users (DHH-OBH Read Only Access)**	**71 days**	**Thu 9/15/11**	**Thu 12/22/11**	**Information System Administrator**

ID	Task Name	Duration	Start	Finish	Resource Names
881	Obtain list of users, roles and locations	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
882	Distribute Guest Account access form to external users	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
883	Obtain signed guest account agreements	10 days	Thu 9/22/11	Wed 10/5/11	Information System Administrator
884	Submit eSars/THC ticket for external users	10 days	Thu 10/6/11	Wed 10/19/11	Information System Administrator
885	Set Up Security Levels, Profiles & Roles	45 days	Thu 10/20/11	Wed 12/21/11	Information System Administrator
886	Distribute VALUEOPTIONS System Access P&Ps (Password management, Access Controls, User Acct	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
887	Distribute user IDs and Passwords to External Users	45 days	Thu 10/6/11	Wed 12/7/11	Information System Administrator
888	Define/communicate technical support services protocol (e.g. local service center or TCC)	2 days	Thu 9/22/11	Fri 9/23/11	Information System Administrator
889	**ServiceConnect/CareConnect Set Up**	**20 days**	**Thu 9/15/11**	**Wed 10/12/11**	**Information System Administrator**
890	Determine Client Auto Routing Set Up for Clinical services	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
891	Complete WARMAS/SECFLA set up	5 days	Thu 9/29/11	Wed 10/5/11	Information System Administrator
892	Determine Client Auth Parameter Set Up	10 days	Thu 9/29/11	Wed 10/12/11	Information System Administrator
893	Submit THC ticket to update WARMAS	1 day	Thu 10/6/11	Thu 10/6/11	Information System Administrator
894	Set Up Service Center & Market Segments Codes on Group Record (ME1031) to support auth auto-routing	5 days	Wed 9/21/11	Tue 9/27/11	Information System Administrator
895	Confirm Service/CareConnect Set Up	5 days	Wed 9/28/11	Tue 10/4/11	Information System Administrator
896	**NetworkConnect (Provider System) set-up**	**47 days**	**Thu 9/15/11**	**Fri 11/18/11**	**Information System Administrator**
897	Review CIG	2 days	Thu 9/15/11	Fri 9/16/11	Information System Administrator
898	Determine if Network is Import of Recruitment	7 days	Mon 9/19/11	Tue 9/27/11	Information System Administrator
899	Identify Provider File Configuration needs	7 days	Wed 9/28/11	Thu 10/6/11	Information System Administrator
900	Create Client Contract Code (cc)	1 day	Fri 10/7/11	Fri 10/7/11	Information System Administrator
901	Create Network Association Code	1 day	Fri 10/7/11	Fri 10/7/11	Information System Administrator
902	Create Parent Organization Code (PORG)	1 day	Fri 10/7/11	Fri 10/7/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
903	Data Entry of Files (If Applicable)	30 days	Mon 10/10/11	Fri 11/18/11	Information System Administrator
904	Work with IT to develop Provider File Import (If applicable)	30 days	Fri 10/7/11	Thu 11/17/11	Information System Administrator
905	Create fee codes	1 day	Mon 10/10/11	Mon 10/10/11	Information System Administrator
906	Create any additional REFMAS elements	10 days	Mon 10/10/11	Fri 10/21/11	Information System Administrator
907	Load rates into FEEMAS	10 days	Tue 10/11/11	Mon 10/24/11	Information System Administrator
908	Map Parent Code to assigned Network (RF1015)	1 day	Mon 10/10/11	Mon 10/10/11	Information System Administrator
909	Notify NetOps, Eligibility and Implementation Team of Provider Configuration	1 day	Tue 10/11/11	Tue 10/11/11	Information System Administrator
910	**ReferralConnect Set Up**	**9 days**	**Fri 10/7/11**	**Wed 10/19/11**	**Information System Administrator**
911	Gather Requirements	5 days	Fri 10/7/11	Thu 10/13/11	Information System Administrator
912	Communicate Network Configuration Information To IT	1 day	Fri 10/14/11	Fri 10/14/11	Information System Administrator
913	Set Up Access	1 day	Mon 10/17/11	Mon 10/17/11	Information System Administrator
914	Test Access	1 day	Tue 10/18/11	Tue 10/18/11	Information System Administrator
915	Sign Off	1 day	Wed 10/19/11	Wed 10/19/11	Information System Administrator
916	**ClientConnect Set Up**	**4 days**	**Thu 9/15/11**	**Tue 9/20/11**	**Information System Administrator**
917	Gather Requirements	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
918	Set Up Access	1 day	Fri 9/16/11	Fri 9/16/11	Information System Administrator
919	Test Access	1 day	Mon 9/19/11	Mon 9/19/11	Information System Administrator
920	Sign Off	1 day	Tue 9/20/11	Tue 9/20/11	Information System Administrator
921	**ProviderConnect Setup**	**11 days**	**Thu 9/15/11**	**Thu 9/29/11**	**Information System Administrator**
922	Determine Inquiry routing needs	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
923	Submit THC ticket to initiate inquiry routing set-up	1 day	Thu 9/22/11	Thu 9/22/11	Information System Administrator
924	Set up inquiry routing	5 days	Fri 9/23/11	Thu 9/29/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
925	**TeleConnect Set Up**	**31 days**	**Thu 9/15/11**	**Thu 10/27/11**	**Information System Administrator**
926	Gather Requirements	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
927	Verify ECR set up	20 days	Thu 9/22/11	Wed 10/19/11	Information System Administrator
928	Provider Opt out numbers for Claims and Customer Service	2 days	Thu 10/20/11	Fri 10/21/11	Information System Administrator
929	Enter opt out data and Parent codes in TeleConnect	2 days	Mon 10/24/11	Tue 10/25/11	Information System Administrator
930	Set Up Access	1 day	Wed 10/26/11	Wed 10/26/11	Information System Administrator
931	Test Access	1 day	Thu 10/27/11	Thu 10/27/11	Information System Administrator
932	**MemberConnect Setup**	**26 days**	**Thu 9/15/11**	**Thu 10/20/11**	**Information System Administrator**
933	Determine Inquiry routing needs	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
934	Submit THC ticket to initiate inquiry routing set-up	1 day	Thu 9/22/11	Thu 9/22/11	Information System Administrator
935	Set up inquiry routing	1 day	Fri 9/23/11	Fri 9/23/11	Information System Administrator
936	Provide ReferralConnect set up to Systems Configuration	1 day	Thu 10/20/11	Thu 10/20/11	Information System Administrator
937	**Achieve Solutions Setup**	**32 days**	**Thu 9/15/11**	**Fri 10/28/11**	**Information System Administrator**
938	Submit AS Implementation FormObtain set up form	15 days	Thu 9/15/11	Wed 10/5/11	Information System Administrator
939	Retrieve and Review Implementation Form	1 day	Thu 10/6/11	Thu 10/6/11	Information System Administrator
940	Provide link to AchieveSolutions to Systems Configuration	15 days	Fri 10/7/11	Thu 10/27/11	Information System Administrator
941	Enter Client Configuration into MemberConnect Admin	1 day	Fri 10/28/11	Fri 10/28/11	Information System Administrator
942	**FileConnect Set Up**	**69 days**	**Thu 9/15/11**	**Tue 12/20/11**	**Information System Administrator**
943	Assign Grid Owner	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
944	Determine File Transfer Method and Resources Assigned	10 days	Fri 9/16/11	Thu 9/29/11	Information System Administrator
945	Complete Grid	50 days	Fri 9/30/11	Thu 12/8/11	Information System Administrator
946	Assign User ID's and Passwords	5 days	Fri 12/9/11	Thu 12/15/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
947	Test connectivity	3 days	Fri 12/16/11	Tue 12/20/11	Information System Administrator
948	**835/EFT Set Up**	**18 days**	**Tue 9/6/11**	**Thu 9/29/11**	**Information System Administrator**
949	Gather Requirements	2 days	Tue 9/6/11	Wed 9/7/11	Information System Administrator
950	Complete configuration	10 days	Thu 9/8/11	Wed 9/21/11	Information System Administrator
951	Test Configuration	5 days	Thu 9/22/11	Wed 9/28/11	Information System Administrator
952	Sign Off	1 day	Thu 9/29/11	Thu 9/29/11	Information System Administrator
953	**820 Remittance Set Up**	**18 days**	**Tue 9/6/11**	**Thu 9/29/11**	**Information System Administrator**
954	Gather Requirements	2 days	Tue 9/6/11	Wed 9/7/11	Information System Administrator
955	Complete configuration	10 days	Thu 9/8/11	Wed 9/21/11	Information System Administrator
956	Test Configuration	5 days	Thu 9/22/11	Wed 9/28/11	Information System Administrator
957	Sign Off	1 day	Thu 9/29/11	Thu 9/29/11	Information System Administrator
958	**EOB - Explanation of Benefits Set Up**	**80 days**	**Thu 9/15/11**	**Wed 1/4/12**	**Information System Administrator**
959	Business Requirements	21 days	Thu 9/15/11	Thu 10/13/11	Information System Administrator
960	Send Group Rules to ABF	22 days	Fri 10/14/11	Mon 11/14/11	Information System Administrator
961	Confirm ABF Set Up	10 days	Tue 11/15/11	Mon 11/28/11	Information System Administrator
962	Confirm CAS Set Up	28 days	Tue 11/15/11	Thu 12/22/11	Information System Administrator
963	Send Test File to ABF	9 days	Fri 12/23/11	Wed 1/4/12	Information System Administrator
964	Validate ABF Results	20 days	Fri 12/2/11	Thu 12/29/11	Information System Administrator
965	Sign Off	1 day	Fri 12/30/11	Fri 12/30/11	Information System Administrator
966	Implement into production	1 day	Mon 1/2/12	Mon 1/2/12	Information System Administrator
967	**PSV - Provider Summary Vouchers**	**74 days**	**Thu 9/15/11**	**Tue 12/27/11**	**Information System Administrator**
968	Notify vendor of the new client PSV (include go live date)	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
969	Distribute group rules form to AE for completion	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
970	Business Requirements	20 days	Fri 9/16/11	Thu 10/13/11	Information System Administrator
971	Obtain Business Requirements Signoff	1 day	Fri 10/14/11	Fri 10/14/11	Information System Administrator
972	Send Group Rules to Payformance	1 day	Mon 10/17/11	Mon 10/17/11	Information System Administrator
973	Confirm Payformance Set Up	51 days	Tue 10/18/11	Tue 12/27/11	Information System Administrator
974	Confirm CAS Set Up	20 days	Tue 10/18/11	Mon 11/14/11	Information System Administrator
975	Create test temp member records	2 days	Tue 11/15/11	Wed 11/16/11	Information System Administrator
976	Create test authorizations	2 days	Tue 11/15/11	Wed 11/16/11	Information System Administrator
977	Create test claims	2 days	Thu 11/17/11	Fri 11/18/11	Information System Administrator
978	Send Test File to Payformance	1 day	Mon 11/21/11	Mon 11/21/11	Information System Administrator
979	Validate Payformance Results	5 days	Tue 11/22/11	Mon 11/28/11	Information System Administrator
980	Sign Off	1 day	Tue 11/29/11	Tue 11/29/11	Information System Administrator
981	Implement into production	1 day	Wed 11/30/11	Wed 11/30/11	Information System Administrator
982	**Fax Server Set Up**	**40 days**	**Thu 9/15/11**	**Wed 11/9/11**	**Information System Administrator**
983	**Coversheet**	**11 days**	**Thu 9/15/11**	**Thu 9/29/11**	**Information System Administrator**
984	Supply language for the document coversheet	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
985	Supply example coversheets for providers to use	5 days	Thu 9/22/11	Wed 9/28/11	Information System Administrator
986	Approve sample coversheets	1 day	Thu 9/29/11	Thu 9/29/11	Information System Administrator
987	**Fax/Server Configuration**	**40 days**	**Thu 9/15/11**	**Wed 11/9/11**	**Information System Administrator**
988	Identify & Create Network Shares	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
989	Fax number allocated and fax server configured for routing	5 days	Thu 9/22/11	Wed 9/28/11	Information System Administrator
990	CLEXT domain user provided read-write access to all directories	5 days	Thu 9/29/11	Wed 10/5/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
991	Complete setup of new purposes on central FOIP server	25 days	Thu 10/6/11	Wed 11/9/11	Information System Administrator
992	**Development/Testing**	**19 days**	**Fri 9/30/11**	**Wed 10/26/11**	**Information System Administrator**
993	Programming & Level 1 Testing	5 days	Fri 9/30/11	Thu 10/6/11	Information System Administrator
994	Level 2 Testing	5 days	Fri 10/7/11	Thu 10/13/11	Information System Administrator
995	Level 3 Testing/Sign-off	7 days	Fri 10/14/11	Mon 10/24/11	Information System Administrator
996	Production deployment	2 days	Tue 10/25/11	Wed 10/26/11	Information System Administrator
997	**KnowledgeConnect (Data Warehouse) Set Up and Internal Loads**	**91 days**	**Wed 9/7/11**	**Wed 1/11/12**	**Information System Administrator**
998	**Model Office Internal Load**	**71 days**	**Wed 9/7/11**	**Wed 12/14/11**	**Information System Administrator**
999	Define Requirements	5 days	Wed 9/7/11	Tue 9/13/11	Information System Administrator
1000	Create MO Schema in DWH CORP database	1 day	Wed 9/14/11	Wed 9/14/11	Information System Administrator
1001	Create and test new extracts for standard MO tables	5 days	Thu 9/15/11	Wed 9/21/11	Information System Administrator
1002	Create and test new extracts for client specific MO tables	15 days	Thu 9/22/11	Wed 10/12/11	Information System Administrator
1003	Create new DWH tables	5 days	Wed 9/14/11	Tue 9/20/11	Information System Administrator
1004	Create new DWH control files	5 days	Wed 9/14/11	Tue 9/20/11	Information System Administrator
1005	Create and test new DWH load processes for standard tables	5 days	Thu 9/22/11	Wed 9/28/11	Information System Administrator
1006	Create and test new DWH load processes for client specific tables	15 days	Thu 10/13/11	Wed 11/2/11	Information System Administrator
1007	Load test data to DWH for standard tables	5 days	Thu 9/29/11	Wed 10/5/11	Information System Administrator
1008	Load test data to DWH for client specific tables	15 days	Thu 10/13/11	Wed 11/2/11	Information System Administrator
1009	Validate DWH load	30 days	Thu 11/3/11	Wed 12/14/11	Information System Administrator
1010	Generate test/sample client reports	30 days	Thu 11/3/11	Wed 12/14/11	Information System Administrator
1011	Validate test reports	30 days	Thu 11/3/11	Wed 12/14/11	Information System Administrator
1012	**Production Internal Loads**	**20 days**	**Thu 12/15/11**	**Wed 1/11/12**	**Information System Administrator**

ID	Task Name	Duration	Start	Finish	Resource Names
1013	Define requirements	5 days	Thu 12/15/11	Wed 12/21/11	Information System Administrator
1014	Create and test new AS/400 extract processes	5 days	Thu 12/22/11	Wed 12/28/11	Information System Administrator
1015	Create new DWH tables	5 days	Thu 12/22/11	Wed 12/28/11	Information System Administrator
1016	Create new DWH control files	5 days	Thu 12/22/11	Wed 12/28/11	Information System Administrator
1017	Create and test new DWH load processes	10 days	Thu 12/22/11	Wed 1/4/12	Information System Administrator
1018	Perform Initial extract	5 days	Thu 1/5/12	Wed 1/11/12	Information System Administrator
1019	Perform Initial Load	5 days	Thu 1/5/12	Wed 1/11/12	Information System Administrator
1020	**KnowledgeConnect (Data Warehouse) Set Up and External Loads**	**17 days**	**Tue 9/6/11**	**Wed 9/28/11**	**Information System Administrator**
1021	**Pharmacy Data Load (Historical)**	**10 days**	**Thu 9/15/11**	**Wed 9/28/11**	**Information System Administrator**
1022	Define Requirements	2 days	Thu 9/15/11	Fri 9/16/11	Information System Administrator
1023	Create new DWH tables	3 days	Mon 9/19/11	Wed 9/21/11	Information System Administrator
1024	Create new DWH control files	3 days	Mon 9/19/11	Wed 9/21/11	Information System Administrator
1025	Create and test new DWH load processes	3 days	Mon 9/19/11	Wed 9/21/11	Information System Administrator
1026	Request and validate ETS setup	5 days	Mon 9/19/11	Fri 9/23/11	Information System Administrator
1027	Create scheduled job	5 days	Thu 9/22/11	Wed 9/28/11	Information System Administrator
1028	Perform Initial load	5 days	Thu 9/22/11	Wed 9/28/11	Information System Administrator
1029	**Medical Claims Data Load (Historical)**	**10 days**	**Tue 9/6/11**	**Mon 9/19/11**	**Information System Administrator**
1030	Define Requirements	2 days	Tue 9/6/11	Wed 9/7/11	Information System Administrator
1031	Create new DWH tables	3 days	Thu 9/8/11	Mon 9/12/11	Information System Administrator
1032	Create new DWH control files	3 days	Thu 9/8/11	Mon 9/12/11	Information System Administrator
1033	Create and test new DWH load processes	3 days	Thu 9/8/11	Mon 9/12/11	Information System Administrator
1034	Request and validate ETS setup	5 days	Thu 9/8/11	Wed 9/14/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1035	Create scheduled job	5 days	Tue 9/13/11	Mon 9/19/11	Information System Administrator
1036	Perform Initial load	5 days	Tue 9/13/11	Mon 9/19/11	Information System Administrator
1037	**Claims & Encounters Data Load (Weekly)**	**10 days**	**Tue 9/6/11**	**Mon 9/19/11**	**Information System Administrator**
1038	Define Requirements	2 days	Tue 9/6/11	Wed 9/7/11	Information System Administrator
1039	Create new DWH tables	3 days	Thu 9/8/11	Mon 9/12/11	Information System Administrator
1040	Create new DWH control files	3 days	Thu 9/8/11	Mon 9/12/11	Information System Administrator
1041	Create and test new DWH load processes	3 days	Thu 9/8/11	Mon 9/12/11	Information System Administrator
1042	Request and validate ETS setup	5 days	Thu 9/8/11	Wed 9/14/11	Information System Administrator
1043	Create scheduled job	5 days	Tue 9/13/11	Mon 9/19/11	Information System Administrator
1044	Perform Initial load	5 days	Tue 9/13/11	Mon 9/19/11	Information System Administrator
1045	**ALA-Authorization Letter Set Up/Printing**	**63 days**	**Thu 9/15/11**	**Mon 12/12/11**	**Information System Administrator**
1046	Notify vendor of the new client (include go live date)	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
1047	Distribute group rules and letter matrix forms to AE for completion	2 days	Thu 9/15/11	Fri 9/16/11	Information System Administrator
1048	Obtain Business Requirements	17 days	Mon 9/19/11	Tue 10/11/11	Information System Administrator
1049	Create tasks request and submit to DM&A	2 days	Wed 10/12/11	Thu 10/13/11	Information System Administrator
1050	Request Letter Templates from DM&A	9 days	Fri 10/14/11	Wed 10/26/11	Information System Administrator
1051	Update Client Information (RF1820)	8 days	Wed 10/12/11	Fri 10/21/11	Information System Administrator
1052	Confirm/Create CAS Letter Codes (CO1031)	8 days	Wed 10/12/11	Fri 10/21/11	Information System Administrator
1053	Confirm/Create CAS Letter Group (RF1321)	8 days	Wed 10/12/11	Fri 10/21/11	Information System Administrator
1054	Confirm/Create CAS Letter Matrix (RF1322)	8 days	Wed 10/12/11	Fri 10/21/11	Information System Administrator
1055	Create Test Temp Members	5 days	Wed 10/12/11	Tue 10/18/11	Information System Administrator
1056	Create Test Authorizations	3 days	Mon 10/24/11	Wed 10/26/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1057	Confirm Approval and Completion of Letter Templates from DM&A	7 days	Thu 10/27/11	Fri 11/4/11	Information System Administrator
1058	Run Test Letter Process	5 days	Mon 11/7/11	Fri 11/11/11	Information System Administrator
1059	**Printing Suppression Process**	**4 days**	**Mon 11/14/11**	**Thu 11/17/11**	**Information System Administrator**
1060	Review Printing Requirement	1 day	Mon 11/14/11	Mon 11/14/11	Information System Administrator
1061	Receive Reason Codes for Suppression from Clinical	1 day	Tue 11/15/11	Tue 11/15/11	Information System Administrator
1062	Set Up Suppress printing	1 day	Wed 11/16/11	Wed 11/16/11	Information System Administrator
1063	Verify OnDemand setup	1 day	Thu 11/17/11	Thu 11/17/11	Information System Administrator
1064	Send Test File to ABF	1 day	Mon 11/14/11	Mon 11/14/11	Information System Administrator
1065	Level II Testing for ALA Letters	5 days	Fri 11/18/11	Thu 11/24/11	Information System Administrator
1066	Coordinate Error Resolution	5 days	Fri 11/25/11	Thu 12/1/11	Information System Administrator
1067	DM&A Create PDFs	3 days	Fri 12/2/11	Tue 12/6/11	Information System Administrator
1068	Request ALA Letters to be loaded to OnDemand (if applicable)	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1069	Service Center Signoff of PDFs	3 days	Wed 12/7/11	Fri 12/9/11	Information System Administrator
1070	Add Client to Letter Group	1 day	Mon 12/12/11	Mon 12/12/11	Information System Administrator
1071	Configure ALA PC (New Service Center Only)	15 days	Mon 9/19/11	Fri 10/7/11	Information System Administrator
1072	Provide ALA Training (PC Side)	5 days	Mon 10/10/11	Fri 10/14/11	Information System Administrator
1073	Provide ALA Training (CAS Side)	5 days	Mon 10/10/11	Fri 10/14/11	Information System Administrator
1074	Implement ALA Letters into production	1 day	Mon 12/12/11	Mon 12/12/11	Information System Administrator
1075	**CONNECTIONS - Web Application Development**	**75 days**	**Tue 9/6/11**	**Mon 12/19/11**	**Information System Administrator**
1076	**Client Specific Website**	**63 days**	**Thu 9/15/11**	**Mon 12/12/11**	**Information System Administrator**
1077	Gather Requirements	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
1078	Functional Specs	5 days	Thu 9/29/11	Wed 10/5/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1079	Sign Off	1 day	Thu 10/6/11	Thu 10/6/11	Information System Administrator
1080	Identification of marketing contract	1 day	Fri 10/7/11	Fri 10/7/11	Information System Administrator
1081	Approve content submitted to marketing	5 days	Thu 10/6/11	Wed 10/12/11	Information System Administrator
1082	Approve content submitted to IT	5 days	Thu 10/13/11	Wed 10/19/11	Information System Administrator
1083	Publishing	15 days	Thu 10/20/11	Wed 11/9/11	Information System Administrator
1084	Level 1 Testing	5 days	Thu 11/10/11	Wed 11/16/11	Information System Administrator
1085	Level 2 Testing	5 days	Thu 11/17/11	Wed 11/23/11	Information System Administrator
1086	Level 3 Testing	10 days	Thu 11/24/11	Wed 12/7/11	Information System Administrator
1087	Sign Off	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1088	Operationalize	2 days	Fri 12/9/11	Mon 12/12/11	Information System Administrator
1089	**Service/CareConnect Enhancements**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1090	**Custom Plan of Care Form**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1091	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1092	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1093	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1094	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1095	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1096	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1097	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1098	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1099	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1100	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1101	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1102	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1103	**Permanent Supportive Housing Review Screens**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1104	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1105	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1106	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1107	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1108	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1109	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1110	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1111	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1112	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1113	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1114	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1115	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1116	**Well Care Visit Tracking**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1117	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1118	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1119	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1120	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1121	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1122	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1123	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1124	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1125	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1126	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1127	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1128	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1129	**Display List of Prescribed Meds**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1130	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1131	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1132	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1133	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1134	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1135	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1136	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1137	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1138	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1139	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1140	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1141	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1142	**Display Member Specific PCP Information**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1143	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1144	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1145	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1146	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1147	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1148	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1149	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1150	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1151	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1152	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1153	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1154	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1155	**Enhancement to capture/search PSH by district**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1156	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1157	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1158	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1159	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1160	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1161	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1162	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1163	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1164	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1165	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1166	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1167	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1168	**ProviderConnect Enhancements**	**75 days**	**Tue 9/6/11**	**Mon 12/19/11**	**Information System Administrator**
1169	**Member Registration**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1170	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1171	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1172	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1173	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1174	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1175	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1176	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1177	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1178	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1179	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1180	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1181	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1182	**Custom Plan of Care Form**	**68 days**	**Thu 9/15/11**	**Mon 12/19/11**	**Information System Administrator**
1183	Business Requirements Defined	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
1184	Design Specifications	5 days	Thu 9/29/11	Wed 10/5/11	Information System Administrator
1185	Internal Sign Off	1 day	Thu 10/6/11	Thu 10/6/11	Information System Administrator
1186	Specifications Review Meeting with Client	1 day	Fri 10/7/11	Fri 10/7/11	Information System Administrator
1187	Client Offline Review	2 days	Mon 10/10/11	Tue 10/11/11	Information System Administrator
1188	Specification Review Follow Up/Modifications	1 day	Wed 10/12/11	Wed 10/12/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1189	Client Sign Off	1 day	Thu 10/13/11	Thu 10/13/11	Information System Administrator
1190	Programming/Level 1 Testing	25 days	Fri 10/14/11	Thu 11/17/11	Information System Administrator
1191	Level 2 Testing	10 days	Fri 11/18/11	Thu 12/1/11	Information System Administrator
1192	UAT sign-off	10 days	Fri 12/2/11	Thu 12/15/11	Information System Administrator
1193	Production Release	1 day	Fri 12/16/11	Fri 12/16/11	Information System Administrator
1194	Post-production testing	1 day	Mon 12/19/11	Mon 12/19/11	Information System Administrator
1195	**Display List of Prescribed Meds**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1196	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1197	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1198	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1199	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1200	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1201	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1202	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1203	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1204	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1205	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1206	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1207	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1208	**Submission of Individual Health Plans (non-behavorial health providers)**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1209	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1210	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1211	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1212	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1213	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1214	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1215	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1216	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1217	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1218	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1219	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1220	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1221	**Access via web to view member's plan of care (non-behavorial health providers)**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1222	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1223	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1224	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1225	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1226	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1227	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1228	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1229	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1230	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1231	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1232	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1233	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1234	**ReferralConnect**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1235	**Add new field to search capability**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1236	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1237	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1238	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1239	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1240	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1241	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1242	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1243	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1244	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1245	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1246	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1247	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1248	**Customize display element by user**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1249	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1250	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1251	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1252	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1253	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1254	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1255	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1256	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1257	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1258	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1259	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1260	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1261	**Enhancement to capture/search PSH by district**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1262	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1263	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1264	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1265	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1266	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1267	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1268	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1269	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1270	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1271	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1272	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1273	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1274	**ClientConnect**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1275	**Access via web to view member's plan of care (State Agencies)**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1276	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1277	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1278	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1279	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1280	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1281	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1282	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1283	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1284	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1285	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1286	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1287	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1288	**NetworkConnect**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1289	**Provider Import**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1290	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1291	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator
1292	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1293	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1294	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1295	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1296	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1297	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1298	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1299	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1300	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1301	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1302	**PharmaConnect**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1303	Identify State of LA-DHH-OBH Rx PBM	42 days	Wed 9/7/11	Thu 11/3/11	Information System Administrator
1304	Obtain State of LA-DHH-OBH PBMs Pharmacy Data and File Layout	10 days	Thu 9/15/11	Wed 9/28/11	Information System Administrator
1305	Build Data Import for Rx data (to data warehouse)	5 days	Thu 9/29/11	Wed 10/5/11	Information System Administrator
1306	Load Rx Data to PharmaConnect DB (From Data Warehouse). Connect to existing Eligibility data	10 days	Thu 10/6/11	Wed 10/19/11	Information System Administrator
1307	Link date into PharmaConnect. Make data conversions as needed.	5 days	Thu 10/20/11	Wed 10/26/11	Information System Administrator
1308	Add client name into PharmaConnect, modify data rules.	5 days	Thu 10/27/11	Wed 11/2/11	Information System Administrator
1309	Run Care Alerts	1 day	Thu 11/3/11	Thu 11/3/11	Information System Administrator
1310	Clinical Review	3 days	Thu 11/3/11	Mon 11/7/11	Information System Administrator
1311	Level 1 Testing	1 day	Tue 11/8/11	Tue 11/8/11	Information System Administrator
1312	Level 2 Testing	1 day	Wed 11/9/11	Wed 11/9/11	Information System Administrator
1313	UAT	2 days	Thu 11/10/11	Fri 11/11/11	Information System Administrator
1314	Submit data to letter vendor	2 days	Mon 11/14/11	Tue 11/15/11	Information System Administrator
1315	Letters in production	3 days	Wed 11/16/11	Fri 11/18/11	Information System Administrator
1316	Sign Off on PharmaConnect implementation	1 day	Mon 11/21/11	Mon 11/21/11	Information System Administrator
1317	**Systems Enhancement**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1318	**Send Letters/Notifications to PCPs**	**68 days**	**Tue 9/6/11**	**Thu 12/8/11**	**Information System Administrator**
1319	Business Requirements Defined	10 days	Tue 9/6/11	Mon 9/19/11	Information System Administrator
1320	Design Specifications	5 days	Tue 9/20/11	Mon 9/26/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1321	Internal Sign Off	1 day	Tue 9/27/11	Tue 9/27/11	Information System Administrator
1322	Specifications Review Meeting with Client	1 day	Wed 9/28/11	Wed 9/28/11	Information System Administrator
1323	Client Offline Review	2 days	Thu 9/29/11	Fri 9/30/11	Information System Administrator
1324	Specification Review Follow Up/Modifications	1 day	Mon 10/3/11	Mon 10/3/11	Information System Administrator
1325	Client Sign Off	1 day	Tue 10/4/11	Tue 10/4/11	Information System Administrator
1326	Programming/Level 1 Testing	25 days	Wed 10/5/11	Tue 11/8/11	Information System Administrator
1327	Level 2 Testing	10 days	Wed 11/9/11	Tue 11/22/11	Information System Administrator
1328	UAT sign-off	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1329	Production Release	1 day	Wed 12/7/11	Wed 12/7/11	Information System Administrator
1330	Post-production testing	1 day	Thu 12/8/11	Thu 12/8/11	Information System Administrator
1331	**CONNECTIONS - CAS Systems Development**	**91 days**	**Tue 9/6/11**	**Tue 1/10/12**	**Information System Administrator**
1332	**Data Exchanges**	**91 days**	**Tue 9/6/11**	**Tue 1/10/12**	**Information System Administrator**
1333	**Data Imports**	**91 days**	**Tue 9/6/11**	**Tue 1/10/12**	**Information System Administrator**
1334	**834 HIPAA Enrollement File Import**	**90 days**	**Tue 9/6/11**	**Mon 1/9/12**	**Information System Administrator**
1335	Gather Requirements	35 days	Tue 9/6/11	Mon 10/24/11	Information System Administrator
1336	Functional Specs	15 days	Tue 10/25/11	Mon 11/14/11	Information System Administrator
1337	Sign Off	1 day	Tue 11/15/11	Tue 11/15/11	Information System Administrator
1338	Programming	10 days	Wed 11/16/11	Tue 11/29/11	Information System Administrator
1339	Level 1 Testing	10 days	Wed 11/30/11	Tue 12/13/11	Information System Administrator
1340	Level 2 Testing	17 days	Wed 12/14/11	Thu 1/5/12	Information System Administrator
1341	Sign Off	1 day	Fri 1/6/12	Fri 1/6/12	Information System Administrator
1342	Operationalize	1 day	Mon 1/9/12	Mon 1/9/12	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1343	**Eligibility Import - Custom File Layout-DCFS**	**90 days**	**Wed 9/7/11**	**Tue 1/10/12**	**Information System Administrator**
1344	Gather Requirements	35 days	Wed 9/7/11	Tue 10/25/11	Information System Administrator
1345	Functional Specs	15 days	Wed 10/26/11	Tue 11/15/11	Information System Administrator
1346	Sign Off	1 day	Wed 11/16/11	Wed 11/16/11	Information System Administrator
1347	Programming	10 days	Thu 11/17/11	Wed 11/30/11	Information System Administrator
1348	Level 1 Testing	10 days	Thu 12/1/11	Wed 12/14/11	Information System Administrator
1349	Level 2 Testing	17 days	Thu 12/15/11	Fri 1/6/12	Information System Administrator
1350	Sign Off	1 day	Mon 1/9/12	Mon 1/9/12	Information System Administrator
1351	Operationalize	1 day	Tue 1/10/12	Tue 1/10/12	Information System Administrator
1352	**Eligibility Import - Custom File Layout-OJJ**	**90 days**	**Tue 9/6/11**	**Mon 1/9/12**	**Information System Administrator**
1353	Gather Requirements	35 days	Tue 9/6/11	Mon 10/24/11	Information System Administrator
1354	Functional Specs	15 days	Tue 10/25/11	Mon 11/14/11	Information System Administrator
1355	Sign Off	1 day	Tue 11/15/11	Tue 11/15/11	Information System Administrator
1356	Programming	10 days	Wed 11/16/11	Tue 11/29/11	Information System Administrator
1357	Level 1 Testing	10 days	Wed 11/30/11	Tue 12/13/11	Information System Administrator
1358	Level 2 Testing	17 days	Wed 12/14/11	Thu 1/5/12	Information System Administrator
1359	Sign Off	1 day	Fri 1/6/12	Fri 1/6/12	Information System Administrator
1360	Operationalize	1 day	Mon 1/9/12	Mon 1/9/12	Information System Administrator
1361	**Eligibility Import - Custom File Layout-DOE**	**90 days**	**Tue 9/6/11**	**Mon 1/9/12**	**Information System Administrator**
1362	Gather Requirements	35 days	Tue 9/6/11	Mon 10/24/11	Information System Administrator
1363	Functional Specs	15 days	Tue 10/25/11	Mon 11/14/11	Information System Administrator
1364	Sign Off	1 day	Tue 11/15/11	Tue 11/15/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1365	Programming	10 days	Wed 11/16/11	Tue 11/29/11	Information System Administrator
1366	Level 1 Testing	10 days	Wed 11/30/11	Tue 12/13/11	Information System Administrator
1367	Level 2 Testing	17 days	Wed 12/14/11	Thu 1/5/12	Information System Administrator
1368	Sign Off	1 day	Fri 1/6/12	Fri 1/6/12	Information System Administrator
1369	Operationalize	1 day	Mon 1/9/12	Mon 1/9/12	Information System Administrator
1370	**PCP Demographic Import**	**78 days**	**Wed 9/7/11**	**Fri 12/23/11**	**Information System Administrator**
1371	Gather Requirements	30 days	Wed 9/7/11	Tue 10/18/11	Information System Administrator
1372	Functional Specs	10 days	Wed 10/19/11	Tue 11/1/11	Information System Administrator
1373	Sign Off	1 day	Wed 11/2/11	Wed 11/2/11	Information System Administrator
1374	Programming	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
1375	Level 1 Testing	15 days	Thu 11/17/11	Wed 12/7/11	Information System Administrator
1376	Level 2 Testing	10 days	Thu 12/8/11	Wed 12/21/11	Information System Administrator
1377	Sign Off	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
1378	Operationalize	1 day	Fri 12/23/11	Fri 12/23/11	Information System Administrator
1379	**Custom Authorization Import (from DOE)**	**78 days**	**Tue 9/6/11**	**Thu 12/22/11**	**Information System Administrator**
1380	Gather Requirements	30 days	Tue 9/6/11	Mon 10/17/11	Information System Administrator
1381	Functional Specs	10 days	Tue 10/18/11	Mon 10/31/11	Information System Administrator
1382	Sign Off	1 day	Tue 11/1/11	Tue 11/1/11	Information System Administrator
1383	Programming	10 days	Wed 11/2/11	Tue 11/15/11	Information System Administrator
1384	Level 1 Testing	5 days	Wed 11/16/11	Tue 11/22/11	Information System Administrator
1385	Level 2 Testing	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1386	Level 3 Testing	10 days	Wed 12/7/11	Tue 12/20/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1387	Sign Off	1 day	Wed 12/21/11	Wed 12/21/11	Information System Administrator
1388	Operationalize	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
1389	**CANS Import**	**90 days**	**Tue 9/6/11**	**Mon 1/9/12**	**Information System Administrator**
1390	Gather Requirements	35 days	Tue 9/6/11	Mon 10/24/11	Information System Administrator
1391	Functional Specs	15 days	Tue 10/25/11	Mon 11/14/11	Information System Administrator
1392	Sign Off	1 day	Tue 11/15/11	Tue 11/15/11	Information System Administrator
1393	Programming	10 days	Wed 11/16/11	Tue 11/29/11	Information System Administrator
1394	Level 1 Testing	10 days	Wed 11/30/11	Tue 12/13/11	Information System Administrator
1395	Level 2 Testing	17 days	Wed 12/14/11	Thu 1/5/12	Information System Administrator
1396	Sign Off	1 day	Fri 1/6/12	Fri 1/6/12	Information System Administrator
1397	Operationalize	1 day	Mon 1/9/12	Mon 1/9/12	Information System Administrator
1398	**Custom Claims 837 Response File Import**	**78 days**	**Wed 9/7/11**	**Fri 12/23/11**	**Information System Administrator**
1399	Gather Requirements	30 days	Wed 9/7/11	Tue 10/18/11	Information System Administrator
1400	Functional Specs	10 days	Wed 10/19/11	Tue 11/1/11	Information System Administrator
1401	Sign Off	1 day	Wed 11/2/11	Wed 11/2/11	Information System Administrator
1402	Programming	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
1403	Level 1 Testing	5 days	Thu 11/17/11	Wed 11/23/11	Information System Administrator
1404	Level 2 Testing	10 days	Thu 11/24/11	Wed 12/7/11	Information System Administrator
1405	Level 3 Testing	10 days	Thu 12/8/11	Wed 12/21/11	Information System Administrator
1406	Sign Off	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
1407	Operationalize	1 day	Fri 12/23/11	Fri 12/23/11	Information System Administrator
1408	**Custom Claims 837 Response File Import (LEA)**	**78 days**	**Wed 9/7/11**	**Fri 12/23/11**	**Information System Administrator**

ID	Task Name	Duration	Start	Finish	Resource Names
1409	Gather Requirements	30 days	Wed 9/7/11	Tue 10/18/11	Information System Administrator
1410	Functional Specs	10 days	Wed 10/19/11	Tue 11/1/11	Information System Administrator
1411	Sign Off	1 day	Wed 11/2/11	Wed 11/2/11	Information System Administrator
1412	Programming	10 days	Thu 11/3/11	Wed 11/16/11	Information System Administrator
1413	Level 1 Testing	5 days	Thu 11/17/11	Wed 11/23/11	Information System Administrator
1414	Level 2 Testing	10 days	Thu 11/24/11	Wed 12/7/11	Information System Administrator
1415	Level 3 Testing	10 days	Thu 12/8/11	Wed 12/21/11	Information System Administrator
1416	Sign Off	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
1417	Operationalize	1 day	Fri 12/23/11	Fri 12/23/11	Information System Administrator
1418	**Provider Import**	**78 days**	**Tue 9/6/11**	**Thu 12/22/11**	**Information System Administrator**
1419	Gather Requirements	30 days	Tue 9/6/11	Mon 10/17/11	Information System Administrator
1420	Functional Specs	10 days	Tue 10/18/11	Mon 10/31/11	Information System Administrator
1421	Sign Off	1 day	Tue 11/1/11	Tue 11/1/11	Information System Administrator
1422	Programming	10 days	Wed 11/2/11	Tue 11/15/11	Information System Administrator
1423	Level 1 Testing	5 days	Wed 11/16/11	Tue 11/22/11	Information System Administrator
1424	Level 2 Testing	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1425	Level 3 Testing	10 days	Wed 12/7/11	Tue 12/20/11	Information System Administrator
1426	Sign Off	1 day	Wed 12/21/11	Wed 12/21/11	Information System Administrator
1427	Operationalize	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
1428	**Provider Import Response File**	**78 days**	**Tue 9/6/11**	**Thu 12/22/11**	**Information System Administrator**
1429	Gather Requirements	30 days	Tue 9/6/11	Mon 10/17/11	Information System Administrator
1430	Functional Specs	10 days	Tue 10/18/11	Mon 10/31/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1431	Sign Off	1 day	Tue 11/1/11	Tue 11/1/11	Information System Administrator
1432	Programming	10 days	Wed 11/2/11	Tue 11/15/11	Information System Administrator
1433	Level 1 Testing	5 days	Wed 11/16/11	Tue 11/22/11	Information System Administrator
1434	Level 2 Testing	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1435	Level 3 Testing	10 days	Wed 12/7/11	Tue 12/20/11	Information System Administrator
1436	Sign Off	1 day	Wed 12/21/11	Wed 12/21/11	Information System Administrator
1437	Operationalize	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
1438	**Data Extracts**	**85 days**	**Tue 9/6/11**	**Mon 1/2/12**	**Information System Administrator**
1439	**Custom Member Registration Extract**	**78 days**	**Thu 9/15/11**	**Mon 1/2/12**	**Information System Administrator**
1440	Gather Requirements	30 days	Thu 9/15/11	Wed 10/26/11	Information System Administrator
1441	Functional Specs	10 days	Thu 10/27/11	Wed 11/9/11	Information System Administrator
1442	Sign Off	1 day	Thu 11/10/11	Thu 11/10/11	Information System Administrator
1443	Programming	10 days	Fri 11/11/11	Thu 11/24/11	Information System Administrator
1444	Level 1 Testing	5 days	Fri 11/25/11	Thu 12/1/11	Information System Administrator
1445	Level 2 Testing	10 days	Fri 12/2/11	Thu 12/15/11	Information System Administrator
1446	Level 3 Testing	10 days	Fri 12/16/11	Thu 12/29/11	Information System Administrator
1447	Sign Off	1 day	Fri 12/30/11	Fri 12/30/11	Information System Administrator
1448	Operationalize	1 day	Mon 1/2/12	Mon 1/2/12	Information System Administrator
1449	**837 P/I Outbound Claims Extract**	**78 days**	**Thu 9/15/11**	**Mon 1/2/12**	**Information System Administrator**
1450	Gather Requirements	30 days	Thu 9/15/11	Wed 10/26/11	Information System Administrator
1451	Functional Specs	10 days	Thu 10/27/11	Wed 11/9/11	Information System Administrator
1452	Sign Off	1 day	Thu 11/10/11	Thu 11/10/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1453	Programming	10 days	Fri 11/11/11	Thu 11/24/11	Information System Administrator
1454	Level 1 Testing	5 days	Fri 11/25/11	Thu 12/1/11	Information System Administrator
1455	Level 2 Testing	10 days	Fri 12/2/11	Thu 12/15/11	Information System Administrator
1456	Level 3 Testing	10 days	Fri 12/16/11	Thu 12/29/11	Information System Administrator
1457	Sign Off	1 day	Fri 12/30/11	Fri 12/30/11	Information System Administrator
1458	Operationalize	1 day	Mon 1/2/12	Mon 1/2/12	Information System Administrator
1459	**837 P/I Outbound Claims Extract (LEA)**	**78 days**	**Tue 9/6/11**	**Thu 12/22/11**	**Information System Administrator**
1460	Gather Requirements	30 days	Tue 9/6/11	Mon 10/17/11	Information System Administrator
1461	Functional Specs	10 days	Tue 10/18/11	Mon 10/31/11	Information System Administrator
1462	Sign Off	1 day	Tue 11/1/11	Tue 11/1/11	Information System Administrator
1463	Programming	10 days	Wed 11/2/11	Tue 11/15/11	Information System Administrator
1464	Level 1 Testing	5 days	Wed 11/16/11	Tue 11/22/11	Information System Administrator
1465	Level 2 Testing	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1466	Level 3 Testing	10 days	Wed 12/7/11	Tue 12/20/11	Information System Administrator
1467	Sign Off	1 day	Wed 12/21/11	Wed 12/21/11	Information System Administrator
1468	Operationalize	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
1469	**Claims Extract - Invoice for Child Services**	**78 days**	**Tue 9/6/11**	**Thu 12/22/11**	**Information System Administrator**
1470	Gather Requirements	30 days	Tue 9/6/11	Mon 10/17/11	Information System Administrator
1471	Functional Specs	10 days	Tue 10/18/11	Mon 10/31/11	Information System Administrator
1472	Sign Off	1 day	Tue 11/1/11	Tue 11/1/11	Information System Administrator
1473	Programming	10 days	Wed 11/2/11	Tue 11/15/11	Information System Administrator
1474	Level 1 Testing	5 days	Wed 11/16/11	Tue 11/22/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1475	Level 2 Testing	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1476	Level 3 Testing	10 days	Wed 12/7/11	Tue 12/20/11	Information System Administrator
1477	Sign Off	1 day	Wed 12/21/11	Wed 12/21/11	Information System Administrator
1478	Operationalize	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
1479	**Claims Extract - Supporting Claims for Invoicing**	**78 days**	**Tue 9/6/11**	**Thu 12/22/11**	**Information System Administrator**
1480	Gather Requirements	30 days	Tue 9/6/11	Mon 10/17/11	Information System Administrator
1481	Functional Specs	10 days	Tue 10/18/11	Mon 10/31/11	Information System Administrator
1482	Sign Off	1 day	Tue 11/1/11	Tue 11/1/11	Information System Administrator
1483	Programming	10 days	Wed 11/2/11	Tue 11/15/11	Information System Administrator
1484	Level 1 Testing	5 days	Wed 11/16/11	Tue 11/22/11	Information System Administrator
1485	Level 2 Testing	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1486	Level 3 Testing	10 days	Wed 12/7/11	Tue 12/20/11	Information System Administrator
1487	Sign Off	1 day	Wed 12/21/11	Wed 12/21/11	Information System Administrator
1488	Operationalize	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
1489	**Provider Extract**	**78 days**	**Thu 9/15/11**	**Mon 1/2/12**	**Information System Administrator**
1490	Gather Requirements	30 days	Thu 9/15/11	Wed 10/26/11	Information System Administrator
1491	Functional Specs	10 days	Thu 10/27/11	Wed 11/9/11	Information System Administrator
1492	Sign Off	1 day	Thu 11/10/11	Thu 11/10/11	Information System Administrator
1493	Programming	10 days	Fri 11/11/11	Thu 11/24/11	Information System Administrator
1494	Level 1 Testing	5 days	Fri 11/25/11	Thu 12/1/11	Information System Administrator
1495	Level 2 Testing	10 days	Fri 12/2/11	Thu 12/15/11	Information System Administrator
1496	Level 3 Testing	10 days	Fri 12/16/11	Thu 12/29/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1497	Sign Off	1 day	Fri 12/30/11	Fri 12/30/11	Information System Administrator
1498	Operationalize	1 day	Mon 1/2/12	Mon 1/2/12	Information System Administrator
1499	**McKesson Extracts**	**78 days**	**Tue 9/6/11**	**Thu 12/22/11**	**Information System Administrator**
1500	**Eligibility Extract**	**78 days**	**Tue 9/6/11**	**Thu 12/22/11**	**Information System Administrator**
1501	Gather Requirements	30 days	Tue 9/6/11	Mon 10/17/11	Information System Administrator
1502	Functional Specs	10 days	Tue 10/18/11	Mon 10/31/11	Information System Administrator
1503	Sign Off	1 day	Tue 11/1/11	Tue 11/1/11	Information System Administrator
1504	Programming	10 days	Wed 11/2/11	Tue 11/15/11	Information System Administrator
1505	Level 1 Testing	5 days	Wed 11/16/11	Tue 11/22/11	Information System Administrator
1506	Level 2 Testing	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1507	Level 3 Testing	10 days	Wed 12/7/11	Tue 12/20/11	Information System Administrator
1508	Sign Off	1 day	Wed 12/21/11	Wed 12/21/11	Information System Administrator
1509	Operationalize	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
1510	**Provider Extract**	**78 days**	**Tue 9/6/11**	**Thu 12/22/11**	**Information System Administrator**
1511	Gather Requirements	30 days	Tue 9/6/11	Mon 10/17/11	Information System Administrator
1512	Functional Specs	10 days	Tue 10/18/11	Mon 10/31/11	Information System Administrator
1513	Sign Off	1 day	Tue 11/1/11	Tue 11/1/11	Information System Administrator
1514	Programming	10 days	Wed 11/2/11	Tue 11/15/11	Information System Administrator
1515	Level 1 Testing	5 days	Wed 11/16/11	Tue 11/22/11	Information System Administrator
1516	Level 2 Testing	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1517	Level 3 Testing	10 days	Wed 12/7/11	Tue 12/20/11	Information System Administrator
1518	Sign Off	1 day	Wed 12/21/11	Wed 12/21/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1519	Operationalize	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
1520	**Paid Claims Extract**	**78 days**	**Tue 9/6/11**	**Thu 12/22/11**	**Information System Administrator**
1521	Gather Requirements	30 days	Tue 9/6/11	Mon 10/17/11	Information System Administrator
1522	Functional Specs	10 days	Tue 10/18/11	Mon 10/31/11	Information System Administrator
1523	Sign Off	1 day	Tue 11/1/11	Tue 11/1/11	Information System Administrator
1524	Programming	10 days	Wed 11/2/11	Tue 11/15/11	Information System Administrator
1525	Level 1 Testing	5 days	Wed 11/16/11	Tue 11/22/11	Information System Administrator
1526	Level 2 Testing	10 days	Wed 11/23/11	Tue 12/6/11	Information System Administrator
1527	Level 3 Testing	10 days	Wed 12/7/11	Tue 12/20/11	Information System Administrator
1528	Sign Off	1 day	Wed 12/21/11	Wed 12/21/11	Information System Administrator
1529	Operationalize	1 day	Thu 12/22/11	Thu 12/22/11	Information System Administrator
1530	**Training**	**37 days**	**Thu 9/15/11**	**Fri 11/4/11**	**Information System Administrator**
1531	**Preparation**	**17 days**	**Thu 9/15/11**	**Fri 10/7/11**	**Information System Administrator**
1532	Determine CAS security group access profiles	1 day	Thu 9/15/11	Thu 9/15/11	Information System Administrator
1533	Obtain CSG from Benefit Configuration team	1 day	Fri 9/16/11	Fri 9/16/11	Information System Administrator
1534	Obtain workflows from functional work groups	5 days	Mon 9/19/11	Fri 9/23/11	Information System Administrator
1535	Modify training curriculum for client specific enhancements	10 days	Mon 9/26/11	Fri 10/7/11	Information System Administrator
1536	**Clinical**	**36 days**	**Fri 9/16/11**	**Fri 11/4/11**	**Information System Administrator**
1537	Determine training schedule	3 days	Mon 9/26/11	Wed 9/28/11	Information System Administrator
1538	Coordinate creation of CAS log-ons	3 days	Fri 9/16/11	Tue 9/20/11	Information System Administrator
1539	Assign students to individual classes	5 days	Thu 9/29/11	Wed 10/5/11	Information System Administrator
1540	Conduct Clinical Training Class	20 days	Thu 10/6/11	Wed 11/2/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1541	Confirm Go Live Support	2 days	Thu 11/3/11	Fri 11/4/11	Information System Administrator
1542	**Model Office**	**102 days**	**Tue 9/6/11**	**Wed 1/25/12**	**Information System Administrator**
1543	**Model Office Planning**	**18 days**	**Wed 11/23/11**	**Fri 12/16/11**	**Information System Administrator**
1544	Complete Model Office Checklist/System Validation	3 days	Wed 11/23/11	Fri 11/25/11	Information System Administrator
1545	Schedule Model Office Meetings	1 day	Mon 11/28/11	Mon 11/28/11	Information System Administrator
1546	Confirmed Development Environment is Refreshed	2 days	Tue 11/29/11	Wed 11/30/11	Information System Administrator
1547	Confirm Data Required in MO	1 day	Thu 12/1/11	Thu 12/1/11	Information System Administrator
1548	Confirm Model Office Testing Environment	1 day	Fri 12/2/11	Fri 12/2/11	Information System Administrator
1549	Confirm Model Office Data Warehouse Environment	1 day	Mon 12/5/11	Mon 12/5/11	Information System Administrator
1550	**Operations**	**5 days**	**Mon 11/28/11**	**Fri 12/2/11**	**Information System Administrator**
1551	Confirm Location/Office Space	5 days	Mon 11/28/11	Fri 12/2/11	Information System Administrator
1552	Confirm Connectivity	5 days	Mon 11/28/11	Fri 12/2/11	Information System Administrator
1553	Confirm phone availability	5 days	Mon 11/28/11	Fri 12/2/11	Information System Administrator
1554	Confirm PC availability	5 days	Mon 11/28/11	Fri 12/2/11	Information System Administrator
1555	**Coordination of Test Scripts**	**15 days**	**Mon 11/28/11**	**Fri 12/16/11**	**Information System Administrator**
1556	Document Members and Scenarios	10 days	Mon 11/28/11	Fri 12/9/11	Information System Administrator
1557	Document Dates of Service	10 days	Mon 11/28/11	Fri 12/9/11	Information System Administrator
1558	Document Providers, Service Codes, and Diagnosis	10 days	Mon 11/28/11	Fri 12/9/11	Information System Administrator
1559	Circulate Completed Test Scripts	5 days	Mon 12/12/11	Fri 12/16/11	Information System Administrator
1560	Review Test Scripts	5 days	Mon 12/12/11	Fri 12/16/11	Information System Administrator
1561	**Eligibility**	**20 days**	**Thu 12/15/11**	**Wed 1/11/12**	**Information System Administrator**
1562	Generate Initial Eligibility Import(s)	10 days	Thu 12/15/11	Wed 12/28/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1563	Validate Initial Eligibility Import(s)	10 days	Thu 12/29/11	Wed 1/11/12	Information System Administrator
1564	**Claims/Finance**	**20 days**	**Thu 12/15/11**	**Wed 1/11/12**	**Information System Administrator**
1565	Enter test claims	5 days	Thu 12/15/11	Wed 12/21/11	Information System Administrator
1566	Adjudicate Claims	15 days	Thu 12/22/11	Wed 1/11/12	Information System Administrator
1567	Generate Check Run	15 days	Thu 12/22/11	Wed 1/11/12	Information System Administrator
1568	Produce/validate PSVs/EOBs	15 days	Thu 12/22/11	Wed 1/11/12	Information System Administrator
1569	**Provider**	**20 days**	**Thu 12/15/11**	**Wed 1/11/12**	**Information System Administrator**
1570	Validate Provider File Configuration / Set-up	5 days	Thu 12/15/11	Wed 12/21/11	Information System Administrator
1571	Test Provider File Scenarios /SCC	15 days	Thu 12/22/11	Wed 1/11/12	Information System Administrator
1572	Validate / Test CareConnect Workflows	15 days	Thu 12/22/11	Wed 1/11/12	Information System Administrator
1573	**Customer Service**	**19 days**	**Thu 12/15/11**	**Tue 1/10/12**	**Information System Administrator**
1574	Create test inquiries (PC, MC and SC)	19 days	Thu 12/15/11	Tue 1/10/12	Information System Administrator
1575	Test Provider File Scenarios / Customer Service	15 days	Thu 12/15/11	Wed 1/4/12	Information System Administrator
1576	Validate / Test ServiceConnect Workflows	19 days	Thu 12/15/11	Tue 1/10/12	Information System Administrator
1577	**Clinical**	**19 days**	**Thu 12/15/11**	**Tue 1/10/12**	**Information System Administrator**
1578	Create clinical scenarios/workflows	19 days	Thu 12/15/11	Tue 1/10/12	Information System Administrator
1579	Create Test Authorizations	19 days	Thu 12/15/11	Tue 1/10/12	Information System Administrator
1580	Generate Auth Letters	19 days	Thu 12/15/11	Tue 1/10/12	Information System Administrator
1581	Validate Authorization Letters	19 days	Thu 12/15/11	Tue 1/10/12	Information System Administrator
1582	**Data Exchanges**	**102 days**	**Tue 9/6/11**	**Wed 1/25/12**	**Information System Administrator**
1583	Run Provider File Import (NetworkConnect)	30 days	Thu 12/15/11	Wed 1/25/12	Information System Administrator
1584	Run Provider File Import (CAS)	30 days	Tue 9/6/11	Mon 10/17/11	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1585	Run Provider Response File Import (CAS)	30 days	Tue 9/6/11	Mon 10/17/11	Information System Administrator
1586	Run Authorization Import for DOE	30 days	Thu 12/15/11	Wed 1/25/12	Information System Administrator
1587	Run CANS Import	30 days	Thu 12/15/11	Wed 1/25/12	Information System Administrator
1588	Run 837 Extracts	30 days	Thu 12/15/11	Wed 1/25/12	Information System Administrator
1589	Run Claims Custom Response Imports	30 days	Thu 12/15/11	Wed 1/25/12	Information System Administrator
1590	Run Member Registration File Extract	30 days	Thu 12/15/11	Wed 1/25/12	Information System Administrator
1591	Run Provider File Extract	30 days	Thu 12/15/11	Wed 1/25/12	Information System Administrator
1592	Run McKesson File Extracts	30 days	Thu 12/15/11	Wed 1/25/12	Information System Administrator
1593	**DWH/Data Management**	**20 days**	**Thu 12/15/11**	**Wed 1/11/12**	**Information System Administrator**
1594	Load test data to DWH (internal data)	20 days	Thu 12/15/11	Wed 1/11/12	Information System Administrator
1595	Validate DWH load	20 days	Thu 12/15/11	Wed 1/11/12	Information System Administrator
1596	Generate test/sample client reports	20 days	Thu 12/15/11	Wed 1/11/12	Information System Administrator
1597	Validate test reports	20 days	Thu 12/15/11	Wed 1/11/12	Information System Administrator
1598	Load external data to DWH	20 days	Thu 12/15/11	Wed 1/11/12	Information System Administrator
1599	Validate external data	20 days	Thu 12/15/11	Wed 1/11/12	Information System Administrator
1600	**Model Office Sign-off**	**2 days**	**Mon 1/9/12**	**Tue 1/10/12**	**Information System Administrator**
1601	IT Leads (System Development, DWH...)	1 day	Tue 1/10/12	Tue 1/10/12	Information System Administrator
1602	Eligibility	1 day	Tue 1/10/12	Tue 1/10/12	Information System Administrator
1603	Network Operations	1 day	Tue 1/10/12	Tue 1/10/12	Information System Administrator
1604	Customer Service	1 day	Mon 1/9/12	Mon 1/9/12	Information System Administrator
1605	Clinical	1 day	Mon 1/9/12	Mon 1/9/12	Information System Administrator
1606	DM&A	1 day	Tue 1/10/12	Tue 1/10/12	Information System Administrator

ID	Task Name	Duration	Start	Finish	Resource Names
1607	Operations Implementation Team Sign-off	0 days	Tue 1/10/12	Tue 1/10/12	Information System Administrator
1608	**Go Live**	**1 day**	**Wed 1/11/12**	**Wed 1/11/12**	**Information System Administrator**
1609	Go Live	1 day	Wed 1/11/12	Wed 1/11/12	Information System Administrator