TECHNICAL PROPOSAL

A. Program Administration

1. Executive Summary
    a. Required Submission
        (1) Main and Branch Offices
        (2) Understanding of Requirements
        (3) Statement of Experience
        (4) Administrative and Operational Components
2. General Qualifications of the Offeror
    a. Required Submission
        (1) Experience
        (2) Account Team
        (3) Financial, Legal and Audit Oversight

B. Proposed Empire Plan MHSA Program Services

1. Account Team
    a. Duties and Responsibilities
    b. Required Submission
2. Premium Development Services
    a. Duties and Responsibilities
    b. Required Submission
3. Implementation
    a. Duties and Responsibilities
    b. Required Submission
4. Customer Service
    a. Duties and Responsibilities
    b. Required Submission
5. Enrollee Communication Support
    a. Duties and Responsibilities
    b. Required Submission
6. Enrollment Management
    a. Duties and Responsibilities

Exhibits

Attachments

6. Ad Hoc Reports
7. Proposed Provider Contract
8. Sample Communication Materials

EXECUTIVE SUMMARY

ValueOptions is pleased to have this opportunity to re-establish our relationship with the New York State Department of Civil Service for the management of mental health and substance abuse services on behalf of enrollees in the Empire Plan, Excelsior Plan, and the Student Employee Health Plan (The Empire Plan).

In many important respects, ValueOptions is the company you already know. We managed the Empire Plan Program on the Department's behalf from 1992 until 2008. Many of the key individuals and much of the Program's operational infrastructure are still in place in New York offices.

At the same time, we have undergone a number of significant changes during the past five years. In 2009, we introduced a new executive team led by CEO Heyward Donigan, who came to ValueOptions with extensive health care and health plan management experience. We re-committed ourselves to an exclusive focus on behavioral health care and its natural extensions such as employee assistance and care management for special populations and conditions. As a result, ValueOptions has deepened our clinical expertise in such areas as treating co-morbid medical and behavioral health conditions and caring for those with serious and persistent mental illness.

The company has continued to make further investments in its fully integrated, Web-based technology platform. It is the only system of its kind in the industry and will contribute to our shared ability to manage the cost and quality of the Program. In addition, our technology strategy has led to expanded access for providers and members through remote tele-health capabilities and mobile applications. As a result, our portfolio of business experience has continued to grow, adding as clients large national employers, major regional health plans, state government agencies, and the world's largest EAP program managed on behalf of the U.S. military and its families.

ValueOptions defines itself as a health improvement company that specializes in mental and emotional wellbeing and recovery. Founded in 1983 and headquartered in Norfolk, Virginia, we presently serve more than 32 million members in all 50 states and around the world, and we manage more than $3 billion in annual behavioral health care spend. ValueOptions offers the Department and Empire Plan enrollees a mature, well-managed organization in every aspect, one that enjoys exceptionally high satisfaction ratings year after year from clients, providers, and members. Our range and depth of experience, our clinical expertise, and our business and technology investments have all been directed toward one goal: making ValueOptions a trusted partner for employers, state and federal government entities, and health plans.

(1) The name and address of the Offeror's main and branch offices and the name of the senior officer who will be responsible for this account;

VALUEOPTIONS MAIN AND BRANCH OFFICES

ValueOptions' headquarters (main office) is located at 240 Corporate Boulevard, Norfolk, Virginia, 23502. The Empire Plan Program will be serviced from both our New York City Service Center (441 Ninth Avenue, 6th Floor, New York, NY 10001) and our Latham Service Center (10 British American Boulevard, Latham, New York 12110). Our Empire Plan Account Team will be based in the Latham Service Center, in close proximity to the Department, for your convenience.

The full listing of ValueOptions branch office locations is provided below:

ValueOptions' Branch Office Locations	
State	**Address**
Arkansas	Arkansas Service Center Victory Building, Suite 330 1401 West Capitol Avenue Little Rock, Arkansas 72201
California	California Service Center 10805 Holder Street, Suite 300 Cypress, California 90630
Colorado	Colorado Health Networks Service Center 7150 Campus Drive, Suite 300 Colorado Springs, Colorado 80920
Connecticut	Connecticut Service Center 500 Enterprise Drive, Suite 4D Rocky Hill, Connecticut 06067
Florida	Jacksonville Service Center 10199 Southside Boulevard, Suite 300 Jacksonville, Florida 32256 Tampa Regional Service Center 8906 Brittany Way Tampa, Florida 33619
Illinois	Chicago Clinical Service Center 200 West Adams, Suite 1625 Chicago, Illinois 60606 Springfield Operations Service Center 400 South 9th Street, Suite 201 Springfield, Illinois 62701
Kansas	Kansas Service Center 100 Southeast 9th Avenue, Suite 501 Topeka, Kansas 66612
Massachusetts	Boston Service Center and Metro-Boston Regional Office 100 High Street, 3rd Floor Boston, MA 02110 Please note: New location as of May 1, 2013;

ValueOptions' Branch Office Locations	
State	**Address**
	1000 Washington Street, 3rd Floor Boston, MA 02118 *Regional Offices located in: Bridgewater, Danvers, Holyoke, and Worcester*
Maryland	Maryland Service Center 1099 Winterson Road, Suite 200 Linthicum, Maryland 21090
Michigan	Great Lakes Service Center 48561 Alpha Drive, Suite 150 Wixom, Michigan 48393
North Carolina	North Carolina Service Center 3800 Paramount Parkway, Suite 300 Morrisville, North Carolina 27560
Pennsylvania	Pennsylvania Service Center 520 Pleasant Valley Road Trafford, Pennsylvania 15085 *Regional Offices located in: Beaver, Cambria, Crawford, Fayette, Greene County, Hermitage, and Venango*
Tennessee	TennCare East Service Center One Cameron Hill – 4.3 Chattanooga, Tennessee 37402 TennCare West Service Center 85 North Danny Thomas Boulevard Memphis, Tennessee 38103
Texas	Texas Service Center and Central Night Service 1199 South Beltline Road, Suite 100 Coppell, Texas 75019
Virginia	Chesapeake Service Center 1434 Crossways Boulevard, Suite 150 Chesapeake, Virginia 23320 National Technology Center of Excellence 12369-C Sunrise Valley Drive Reston, Virginia 20191

VALUEOPTIONS' SENIOR OFFICER RESPONSIBLE FOR EMPIRE ACCOUNT

Karen Bartlett, President of ValueOptions' New York Region, is ValueOptions' senior officer with ultimate responsibility for the Empire Plan account.

(2) A description demonstrating its understanding of the requirements presented in the RFP, and how the Offeror can assist the Department in accomplishing its objectives;

UNDERSTANDING EMPIRE PLAN REQUIREMENTS

Our understanding of what the Department requires of a successful contractor is based in part on our experience managing the Empire Plan Program from 1992 until 2008. We believe that we have an appreciation not only for the contractual and performance requirements outlined in the RFP, but also for the organizational qualities the Department is seeking in a partner to administer its mental health and substance abuse benefits. Across the functional areas described in our proposal, we regard the following attributes and capabilities as critical components of what ValueOptions offers on your behalf:

Performance Accountability: Your standards are high, and we have provided significant guarantees to ensure that we consistently achieve and exceed them. In addition, we have demonstrated our ability to manage program costs while actually improving member satisfaction and quality care.

Sophisticated, Reliable Operations and Systems: From our fully integrated IT platform to our call center environment, and from our robust reporting capabilities to our clinical operations, ValueOptions is a highly experienced organization that is entirely dedicated to managing programs similar to Empire Plan in size and complexity.

Client-Centered Partnership: We will customize reports, communications, websites, and everything we do to your specifications and approval. We will provide you with consultation and assistance on every aspect of the Program. We will take your direction with regard to network development and other program enhancements, and we will always notify you immediately of developments that may affect the Department or the Program.

Dedicated Local Management with Corporate-Level Access: We will provide you with a dedicated team located here in New York, led by highly qualified individuals who already know the Empire Plan Program. At the same time, ValueOptions assures you of access to the senior-most executives of our company at key intervals and as circumstances demand.

Broad Provider Access, Disciplined Care Management: We will meet provider access standards and continue to refine our extensive network geographically and by provider specialty. In addition, our Clinical Referral Line, our disciplined processes for all three phases of utilization management, and our intensive care management all combine to ensure that enrollees seek care in the network and in the most appropriate setting.

Flawless Implementation and Transition: As you will hear from our client references, this is one of the things we do best. We will ensure that our network, our systems, our trained staff, and our transition plans are fully operational by or before the go-live date.

In our reading of the RFP, these are the themes that are emphasized time and again, section after section. ValueOptions has confidence in its ability to implement and manage the Empire Plan Program in a manner consistent with each of these expectations.

ASSISTING THE DEPARTMENT IN ACCOMPLISHING ITS OBJECTIVES

ValueOptions is committed to providing the Department with the level of program management and support necessary to advance your objectives for the Empire Plan Program. We believe our expertise and experience will enhance the Program and streamline your oversight in several important ways:

- The quality, stability, and performance of our operations and our systems will mean that the Program will enjoy high levels of enrollee and provider satisfaction.
- Our provider contracts and the stability of our networks will mean accessible care at affordable reimbursement rates. This is true not only throughout New York, but in those out-of-state markets where the Empire Plan has a significant number of retirees and relies on access to cost-effective care.
- ValueOptions' national footprint in MHSA program management will provide the Department with insight into new clinical approaches, payment methods, and benefit options.
- Our significant investments in a 21st century technology platform will pay important dividends in care management, in reporting and data analysis, and in our ability to seamlessly integrate data from other vendors.
- One of the hallmarks of ValueOptions is our reputation for developing and maintaining strong partnerships with providers, stakeholders, and others. You will find us ready partners who are always willing to listen, to engage with you to solve problems, and to work with you in creating the next generation of the Empire Plan Program.

(3) A statement explaining previous experience managing the Mental Health and Substance Abuse Programs of other state governments or large public entities or any other organizations with over 100,000 covered lives, as well as any previous experience managing a self-funded Mental Health and Substance Abuse Program. Detail how this experience qualifies the Offeror and, if applicable, the experience of its Key Subcontractors to undertake the functions and activities required by this RFP; and

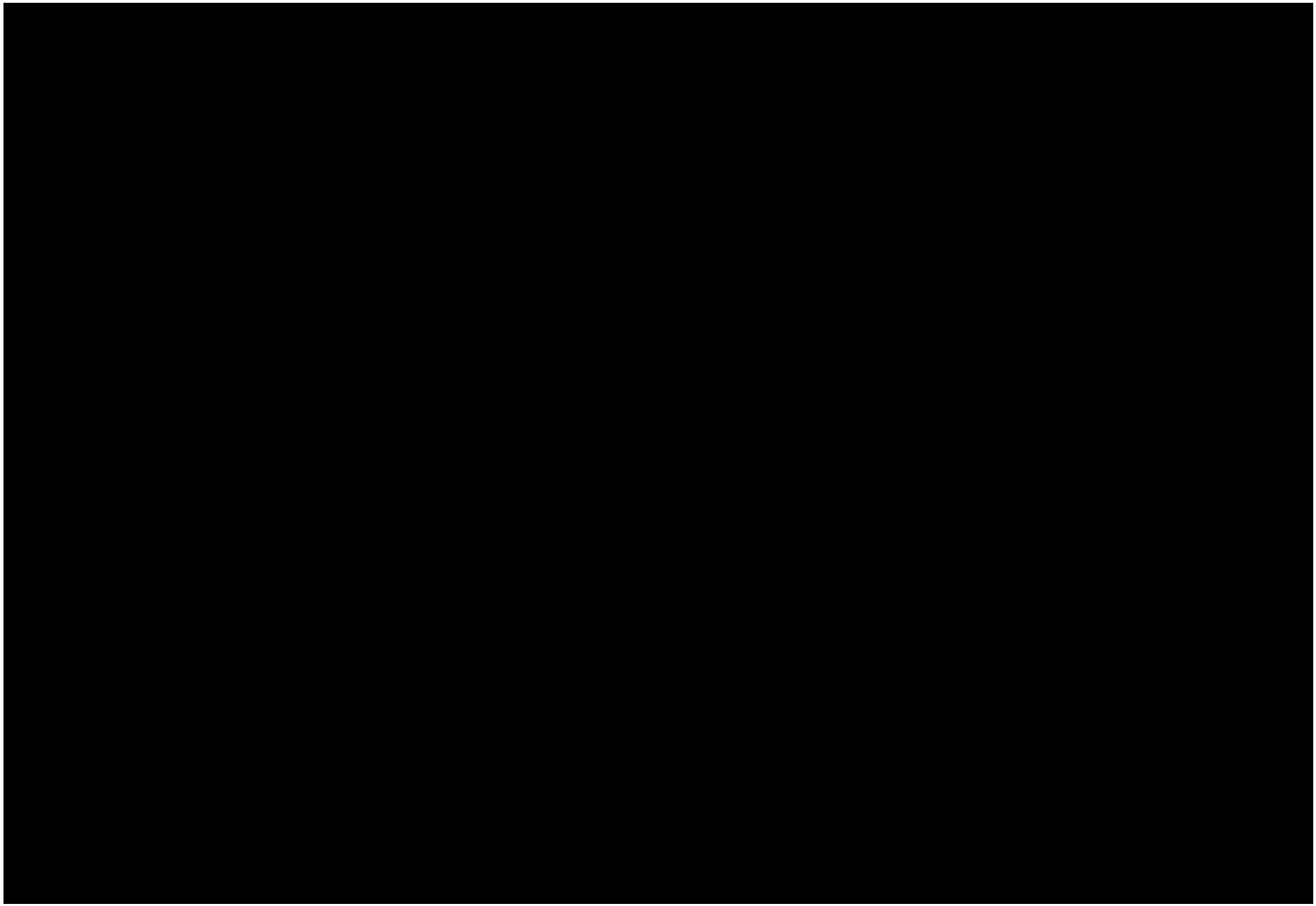
As a national leader in the fields of mental health, substance abuse, and employee assistance programming, ValueOptions has perhaps the most extensive and diverse experience of any U.S. company when it comes to managing behavioral health benefits.

[redacted]

The range and depth of our experience will enhance our management of the Empire Plan Program and our ability to help the Department meet its objectives. ValueOptions' breadth of experience and expertise keep us on the cutting edge of clinical advancements and care management best practices. From ACO pilot programs in [redacted] to embedding our team within a health plan's clinical team in [redacted] no company matches the systems infrastructure or the program experience of ValueOptions.

(4) An explanation of how the following administrative and operational components will be performed by the Offeror. Include an organizational chart explicitly detailing responsibility for the following functions;
- (a) Account Team
- (b) Premium Development Services
- (c) Implementation
- (d) Customer Service
- (e) Enrollee Communication Support
- (f) Enrollment Management
- (g) Reporting
- (h) Consulting
- (i) Transition and Termination of Contract
- (j) Network Management
- (k) Claims Processing
- (l) Clinical Management/Utilization Review

We provide an organizational chart detailing responsibility for the identified administrative and operational components on the following page. Immediately following the organizational chart, we provide brief explanations of our approach to performing functions (a)-(l).



(a) ACCOUNT TEAM

Our submission describes our extensive training and development programs and our formal compliance programs to ensure that we are operating at all times within the parameters of legislative and statutory requirements. In addition, ValueOptions stands ready to work with the Department to customize forms, letters, websites, communications, and all aspects of what we do on your behalf. Our business model is focused on advancing the brand and reputation of our client organizations, rather than our own.

(b) PREMIUM DEVELOPMENT SERVICES

We commit to providing the Department with full assistance in developing premium rates and providing justifications for financial decisions regarding the Empire Plan Program. Your Account Team includes senior-level resources from underwriting, accounting, and medical economics. In addition, we will involve our Senior Vice President of Decision Support, Eric Hamilton, as required to meet your needs.

Our submission describes our standard rate setting process involving historical claims and trend projections. However, we will adapt our methodology to meet the needs of the Department and the Empire Plan Program.

(c) IMPLEMENTATION

ValueOptions provides significant financial guarantees that if awarded the contract, all facets of the Empire Plan Program operations will be fully functional on or before the go-live date of January 1, 2014. This includes networks, call center, real-time claims processing, secure links from the Department's website to our, enrollment system verification, Clinical Referral Line activation, validation of our ability to integrate data from other vendors, and other functions.

As you will hear from our client references, this is one of the areas of program management that ValueOptions does best. We have numerous testimonies from large, complex clients–including the U.S. Government's Military OneSource program–based on our ability to not only implement flawlessly and on time, but to develop detailed implementation plans that give our clients confidence in the process.

(d) CUSTOMER SERVICE

ValueOptions's customer service centers combine highly qualified and well-trained clinical staff and Customer Service Representatives with state-of-the-art technology for telephony and system back-up. We commit to the Department not only to maintain call center access on a 24/365 basis for the Clinical Referral Line and TTY/TDD access, but from 8:00 a.m. until 8:00 p.m. Monday through Friday for inquiries from enrollees regarding benefits, eligibility, claims status, and other matters.

Furthermore, we provide substantial financial guarantees around each of the important performance measures of call center performance including system availability, blockage rates, abandonment rates, and first call resolution. Measurement of our performance will be aided by the sophisticated level of reporting and call tracking that will be available for the operation as a whole, and down to the individual clinician or Customer Service Representative level.

ValueOptions has a well-established training program of more than 300 hours, along with ongoing development and refresher training. New trainees are "staged" into member- or provider-facing roles with close monitoring by supervisors. Because our systems are entirely integrated, the ServiceConnect application for Customer Service Representatives and the CareConnect application for Clinical Referral Line managers will provide access to pertinent information regarding providers, enrollee eligibility, etc.

Our call center operations utilize robust telephony technology that allows for call tracking, internal call routing, and staffing models based on peak call times. We utilize additional technology for interactive voice response, voice pattern recognition, and other purposes. Our submission also describes our provisions for a back-up call center in the event of natural disasters. ValueOptions' entire Avaya switch is fully replicated by a hot site in Richardson, Texas for complete call center redundancy.

Our proposal also describes the availability of our secure website, operated with a dedicated link from the Department's site via single-sign on. This and all enrollee-facing materials and communications will be customized for your needs and requirements.

(e) ENROLLEE COMMUNICATION SUPPORT

Our role as your partner in managing mental health and substance abuse benefits will not be a passive one. We anticipate working collaboratively with you to ensure that everything possible is done to communicate with and engage enrollees in their health and with the Empire Plan Program. Our in-house Communications Department has writers, graphic designers, and other professionals who stand ready to assist you in this regard. We commit to not only assist in the

creation, review, and presentation of materials, but to make ourselves available in whatever venues will help to engage enrollees and enhance the Empire Plan Program's reputation.

Our submission describes in detail our willingness and ability to support the Department in the development of SPDs and Summaries of Benefit Coverage, in the staffing of Health Fairs and other events, and in our willingness to customize everything we do to your needs and specifications.

(f) ENROLLMENT MANAGEMENT

The ValueOptions business model is one that emphasizes our value as a business partner and integrator of behavioral health care services in the larger context of quality, cost effective health care. As a result, our ability to receive, integrate, and send data between and among other parties (clients, medical carriers, PBMs, others) is at the heart of what we do.

Our proposal submission assures the Department that we will load secure transactions into our system within 24 hours; that we are fully HIPAA-compliant; that we will establish a read-only connection to NYBEAS; that we will meet the requirements for National Medical Support Notices; that we are fully capable of administering Social Security numbers, entity identification numbers, or another alternative identification number; and that we will cooperate fully with the Department in new technology or process initiatives.

In addition, we describe in detail our rigorous processes for initial testing, loading, auditing, and file maintenance. As described throughout our proposal, our integrated CONNECTS technology platform has two levels of back-up and recovery, including full redundancy through IBM's Business Continuity and Recovery Services in Boulder, Colorado.

(g) REPORTING

Because our entire technology platform is written in one language and serves as an integrated whole, business and financial reporting on virtually any aspect of the Program (providers, claims, coordination of benefit recoveries and Medicare Crossover, administrative costs, clinical referrals, in-network utilization, service metrics and more are easily available. In fact, many ValueOptions clients enjoy real-time access to intuitive reports via tablet and mobile devices.

Our standard reporting packages of management reports, utilization reports, and financial reports are comprehensive and robust, and will be provided on a monthly, quarterly, and annual basis along with commentary from our Account Team regarding implications for the Empire Plan Program. These reports will be made available to the Department in a format that you specify. In addition, ad hoc reports will be available on demand.

ValueOptions also commits to providing the Department with secure access to our claims system and to our online reporting tools.

(h) CONSULTING

We understand that one of the benefits of having a specialist vendor like ValueOptions manage the Empire Plan's mental health and substance abuse benefits is that it gives the Department

additional access to a footprint of in-depth, national experience. We commit to placing our expertise and our clinical and cost management experience at your disposal, both through formal venues and in the form of ongoing advice and recommendations.

(i) TRANSITION AND TERMINATION OF CONTRACT

We place the care of your enrollees and the reputation of the Empire Plan Program foremost in our planning for a transition and termination of our contract. ValueOptions executed such a transition plan five years ago on the Department's behalf. Our processes emphasize the development of a detailed transition plan so that you have confidence that we have addressed every detail related to enrollee care, data transfer, and service maintenance.

In the event of such a transition, we pledge to cooperate fully and unequivocally with you and with the succession vendor. We will make careful provision for the continued care of enrollees, especially those who are disabled or at high risk. We will continue to maintain a level of staffing and operation that meets all contracted requirements and performance measures, and we will transfer all files and data to the Department and the succession vendor in a timely manner.

(j) NETWORK MANAGEMENT

In addition to more than 130,000 in-network provider locations nationally, ValueOptions already has a strong network in the state of New York as a result of our long history and experience here. Our existing network is comprehensive from a perspective of geographical access, and provider and facility mix. What is more, other ValueOptions contracts in New York have necessitated an emphasis on cultural competency and provider diversity. All of this is simply a baseline from which we will begin.

Our commitment to the Department and the Empire Plan Program is to ensure that our network *at least* meets the standards of access and provider mix presently available to enrollees. We will continue to monitor, recruit, and enhance our network through the term of our partnership, including monitoring for provider access within the stated network. In addition, where necessary for continuity of care or a member's cultural needs, we will execute single case agreements with non-network providers. ValueOptions provides substantial performance guarantees related to each of the dimensions of network adequacy and performance stipulated by the Department.

We are designated as a Credentialing Verification Organization, and our proposal describes in detail our primary source verification processes as well as our re-credentialing process. We describe our robust provider Web portal that receives very high satisfaction scores from our in-network providers because of its ability to simplify administrative tasks.

ValueOptions has experience with a variety of contracting and payment mechanisms, as well as with benefit designs that include tiered networks, incentive-based contracts, and Accountable Care Organizations. We stand ready to work collaboratively with the Department in any of these areas.

We audit our providers using several layers of monitoring including desk audits, outlier analysis, and on-site environmental site visits. We combine these with formal corrective action processes.

We confirm that all overpayments and recoveries will be remitted to the Department for return to the Program.

(k) CLAIMS PROCESSING

ValueOptions' claims system is entirely based in the United States and was available and on line 100 percent of 2012. The system is fully HIPAA-compliant and is capable of accepting claims in either manual or electronic formats, the latter through provider software or a secure Web environment. Our proposal thoroughly describes the lifecycle of a claim, including our processes for eligibility determination, prior authorization and concurrent review, and claims edits. Our system is entirely capable of handling coordination of benefit claims and we participate in Medicare Crossover. Claims history files will be retained for the duration of our contract.

Integrated within ValueOptions' CONNECTS technology platform, our claims adjudication system has multiple levels of data and system redundancy, including real-time back-ups of CONNECTS and the availability of IBM's hot site back-up in Boulder, Colorado.

We confirm our ability to accept daily feeds from the medical carrier/TPA for purposes of maintaining accurate deductibles and accumulators, as well as our ability provide the Department with a daily claims file and secure access to our system.

Guarantees are provided for both financial and non-financial accuracy performance standards. Our proposal also discusses our comprehensive Fraud and Abuse program and the variety of means through which we educate and improve provider performance.

(l) CLINICAL MANAGEMENT/UTILIZATION REVIEW

ValueOptions' mission and values center on our ability to achieve health care's "Triple Aim" of improving the cost, quality, and experience of care for enrollees and our clients. In that sense, everything else we do comes down to this critical function.

First, ValueOptions confirms our commitment to have the Clinical Referral Line available on a 24/365 basis, managed by a New York-based clinical team. We will perform Parity-compliant precertification, concurrent review, and retrospective review of care, and we certify our ability to manage Disabled Dependent determinations. Each level of utilization management, from precertification to concurrent review to discharge planning and retrospective review, are discussed in detail. In particular, we describe our care management of high-risk and complex cases, our approach to serving the needs of special populations, and how we make provisions for access to non-network providers when access or special needs circumstances require.

Our proposal describes in detail the qualifications for each level of our clinical staff – including our Clinical Care Managers, Peer Advisors, and Medical Director – as well as our proposed staffing levels. We describe our triage protocols, the disciplines we use to identify urgent and emergent cases, the steps we will take to encourage enrollee use of the Clinical Referral Line, and how we determine medical necessity.

ValueOptions' care management software, CareConnect, is highly integrated into our overall technology platform, meaning that clinicians have immediate access to enrollment and eligibility information, provider profile and access information, and care history.

Lastly, we describe the variety of modalities we use to promote and monitor clinical effectiveness among our network providers, focusing on our ValueSelect designation for high performing providers.

(1) What experience does the Offeror have in managing/supervising a MHSA program similar to the MHSA Program described in this RFP?

ValueOptions is a company that is singularly focused on behavioral health. As experts in mental health and substance abuse, we help our clients design and implement programs that combine both traditional and innovative methods of treatment while staying true to our mission—helping people live their lives to their fullest potential. Our programs are rooted in:

- Meeting the unique needs of our clients and the members we serve
- Maintaining the highest standards of excellence in our staff and provider network
- Promoting the value of a healthy workforce
- Coordinating with existing behavioral health vendors and community resources
- Integrating closely with physical health care providers and health plans
- Offering immediate access to exceptional care and services
- Maintaining an exemplary commitment to service
- Remaining a "people business"—enrollee and client satisfaction and retention are essential to our success

Because behavioral health is all we do, we offer multi-faceted experience and capabilities. This includes proven experience managing MHSA programs similar to those requested in this RFP in terms of size, membership, and complexity.

[redacted]

Our history and experience partnering with government agencies to administer state Medicaid programs has no equal in the managed behavioral health care industry. We currently cover more than eight million members in 14 states. We coordinate with local and regional supports, including local provider networks, community-based organizations, criminal justice systems, juvenile courts, pharmacy benefits managers, and residential treatment centers, among others. Examples of our public sector relationships, which are both risk-based and self-funded models, include the following:

[redacted]

[redacted]

[redacted]

As detailed above, we bring the Department a wealth of behavioral health care experience which we will draw on to successfully manage the Empire Plan Program. Because of the range and depth of our experience, as well as our ability to work collaboratively in a wide variety of service environments, we can assure the Department of a high quality and cost-effective behavioral health care system for Empire Plan enrollees.

(2) Explain how the Offeror's account team will be prepared to actively manage the administrative, operational and clinical aspects of the MHSA Program?

The Empire Plan will be among the most significant clients in ValueOptions' portfolio of business relationships, and its importance will be evident in how we staff the account, how we approach your unique needs and program design, and how we will make our full resources available to you during implementation and throughout the life of our partnership.

We will provide the Department an experienced Account Management Team that will maintain local accountability for ensuring the success of all administrative, operational, and clinical aspects of the Empire Plan Program. The entire Account Team, including Department personnel, will always have direct access to ValueOptions' senior executives who will be able to commit the necessary resources to ensure a successful program.

Our entire Empire Plan Account Management Team will focus on maintaining client and enrollee satisfaction, while providing in-depth consultation to the Department on a variety of issues. This includes successfully complying with all agreed-upon performance standards and operational commitments. Additional activities include:

- **Operations Management**
  - monitoring operational effectiveness, interceding where necessary
  - participating in complaint resolution process
  - participating on various committees or projects, as necessary
  - assuring appropriate training on the Empire Plan Program's benefits and procedures, such as the Clinical Referral Line
- **Relationship Building/Management**
  - developing and maintaining appropriate relationships with key decision-makers (internally and externally)
  - ensuring contractual requirements are delivered and expectations are managed
- **Customer Information/Communication**
  - continually monitoring information and communication needs both externally and internally
  - communicating and presenting information to audiences at all levels, both internally and externally
- **Financial Management**
  - performing financial oversight of the program
  - participating in financial decisions and agreements, including renewal discussions
  - discussing impact of product options and utilization on pricing
  - analyzing data and preparing all required financial reporting

(3) What internal systems or procedures will the Offeror have in place to provide financial, legal, and audit oversight of its contract with the MHSA Program?

Within many sections of our proposal (claims, customer service, clinical management, networks, reporting) we describe in detail the internal controls we have in place to provide financial, legal, and audit oversight of the MHSA program. In summary, these include:

FINANCIAL OVERSIGHT

Our comprehensive financial system, FinanceConnect, is fully integrated within our overall technology platform, CONNECTS, and enables us to manage and report on all financial aspects

of programs similar to the Empire Plan in an efficient and effective manner. FinanceConnect is based on an Oracle general ledger/accounts payable system and supported by a Hyperion reporting system. It provides a robust account structure that supports full cost accounting including appropriate capture and reporting of direct, indirect, general, and administrative costs. It also provides for the accumulation of contract-level detail as well as the overall aggregation of financial data.

LEGAL OVERSIGHT

Our National Legal and Compliance Department is ultimately responsible for providing legal oversight for our overall business operations, and ensuring full compliance with all laws and regulations of each jurisdiction. Core activities include tracking relevant federal laws and regulations, state legislative bulletins, regulatory websites, fraud alerts, and health care-related publications to ensure compliance. Legal and compliance staff issue regulatory alerts for major legislative and regulatory issues (e.g., Mental Health Parity) and distribute such communications to managers and executives at both the corporate and service center level. They also post this information to our legal page on our internal website, StaffConnect, for employees to access at their leisure.

ValueOptions has also developed an Executive Compliance Committee that is responsible for setting compliance goals for the company and overseeing compliance activities throughout the company. The Committee identifies risk areas resulting from new or revised laws and regulations, and establishes corporate policies and procedures, conduct standards, and measurement tools to monitor compliance. Our National Compliance Work Group, chaired by the National Director of Compliance and attended by Service Center and business units compliance leads, coordinates the implementation of Service Center or department-specific policies and procedures to respond to changes in the law.

Staff training concerning regulatory issues is the responsibility of all business units within ValueOptions, with assistance and support from the National Legal and Compliance Department.

AUDIT OVERSIGHT

Our Compliance Department and Special Investigations Unit will conduct ongoing monitoring and auditing activities to prevent and detect fraud, waste, abuse, and other unethical or non-compliant conduct. Monitoring and audit activities may include onsite visits, personnel interviews, review of written materials, and documentation, analysis, and trending of data including, but not limited to paid claims, clinical requests, and prior investigations/complaints.

The Department expects the Contractor to have a proactive, experienced account leader and team in place who are dedicated solely to the MHSA Program and who have the authority and expertise to coordinate the appropriate resources to implement and administer the MHSA Program.

Section 1: Account Team (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) The Contractor must maintain an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the MHSA Program during implementation and operation.	Yes
(a) The account team must be comprised of qualified and experienced individuals who are acceptable to the Department and who are responsible for ensuring that the operational, clinical, and financial resources are in place to operate the MHSA Program in an efficient manner;	Yes
(b) The Contractor must ensure that there is a process in place for the account team to gain immediate access to appropriate corporate resources and senior management necessary to meet all MHSA Program requirements and to address any issues that may arise during the performance of the Agreement.	Yes
(2) The Contractor's dedicated account team must be experienced, accessible (preferably in the New York State Capital Region district) and sufficiently staffed to: (a) provide timely responses (within 1 to 2 Business Days) to administrative and clinical concerns and inquiries posed by the Department, or other staff on behalf of the Council on Employee Health Insurance or union representatives regarding member-specific claims issues for the duration of the Agreement to the satisfaction of the Department;	Yes
(b) immediately notify the Department in writing of actual or anticipated events impacting MHSA Program costs and/or delivery of services to Enrollees such as but not limited to, legislation, class action settlements, and operational issues).	Yes
(3) The Contractor's dedicated account team must ensure that the MHSA Program is in compliance with all legislative and statutory requirements. If the Contractor is unable to comply with any legislative or statutory requirements, the Department must be notified in writing immediately. The Contractor must work with the Department to develop accurate Summary Plan Descriptions (SPDs) and/or MHSA Program material.	Yes
(4) The Contractor must work with the Department to develop appropriate customized forms and letters for the MHSA Program, including but not limited to claim forms, pre-certification forms and letters, explanation of benefits, appeal letters, etc. All such communications must be approved by the Department prior to their distribution.	Yes

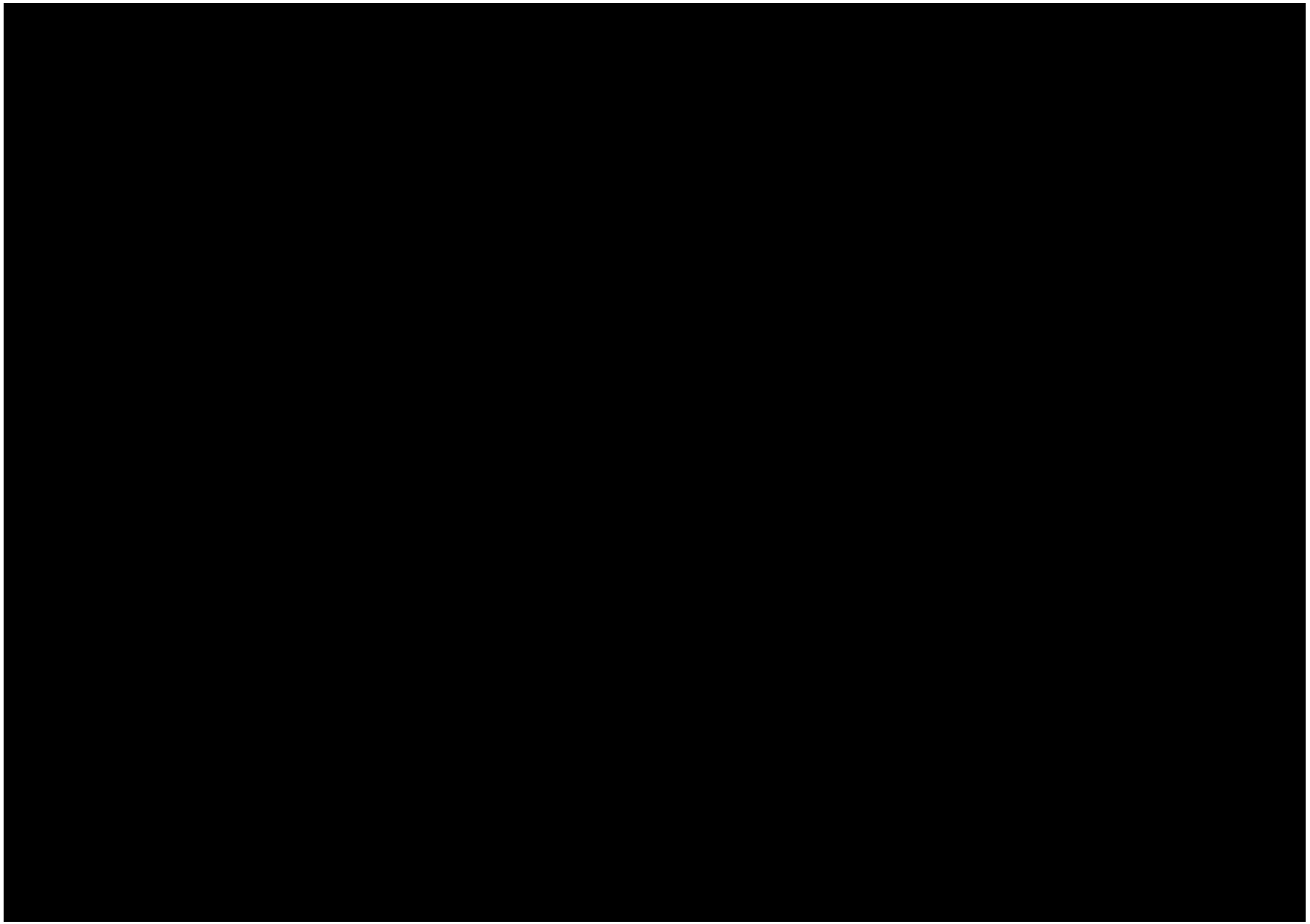
(1) Provide an organizational chart and description illustrating how you propose to administer, manage, and oversee all aspects of the MHSA Program. Include the following:
- (a) Reporting relationships and the responsibilities of each key position of the account management team; and how the team will interact with other departments such as the call center, clinical services, reporting, auditing, and network management within your organization. Describe how the account management team interfaces with senior management and ultimate decision makers within your organization;
- (b) Names, qualifications, and job descriptions of those individuals selected to comprise the operational and clinical account and management team for the Offeror. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key members of the proposed account and management team;
- (c) Where individuals are not named, include qualifications of the individuals that you would seek to fill the positions; and
- (d) Where will your account services, enrollment, claims processing, clinical management, clinical referral line and customer service staff be located and approximately how many staff members will work in each functional area?

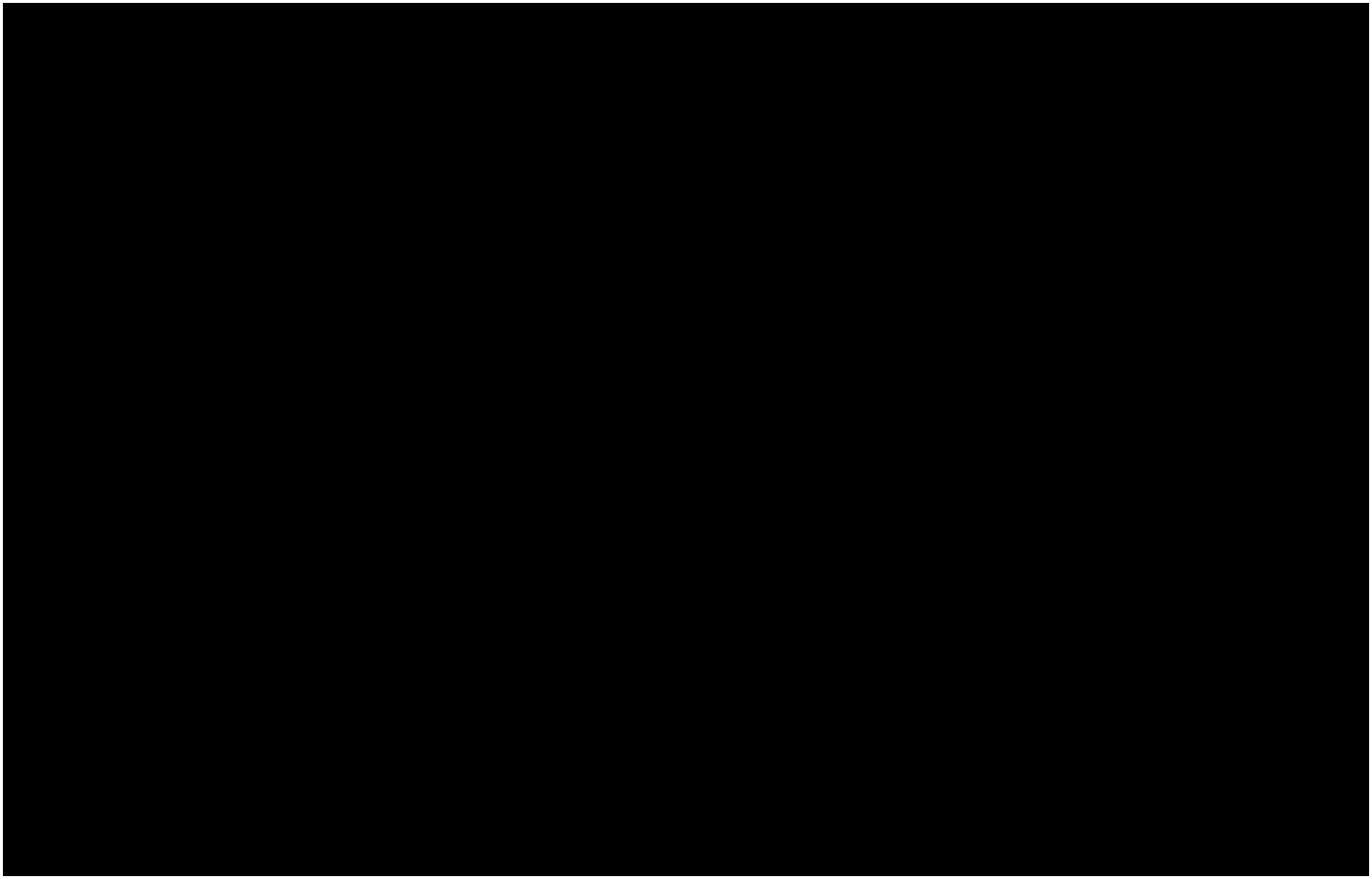
(a) REPORTING RELATIONSHIPS AND RESPONSIBILITIES

Below we provide an organizational chart that reflects our proposed New York-based ValueOptions Empire Plan Team. This multi-functional team will provide direct service on The Empire Plan account. Responsibilities for each position are included within the table provided as a response to Question 1b below.

As part of this team, ValueOptions designates a New York-based account management team to support the Empire Plan Program account. Senior Account Executive Jennifer Campione will lead this team. Vice President of the New York Region, Renée Abdou-Malta—who reports directly to Karen Bartlett, President of ValueOptions' New York Region—will work directly with Ms. Campione. Ms. Bartlett will have ultimate responsibility for ensuring the success of your program. Collectively, the Empire Plan Team will monitor each facet of the program to ensure that ValueOptions meets your expectations and requirements, and that performance standards are at optimum levels.

The second organizational chart below depicts the relationships between members of our proposed Empire Plan Team and ValueOptions' overall corporate structure. This structure provides direct access to and oversight by ValueOptions' most senior executives across all functional areas of the organization, including executive leadership, account management, clinical management, quality management, information technology, reporting and data, human resources, legal, actuarial, network development and provider relations, customer service and clinical referral line.





Empire Plan Team Reporting Relationships

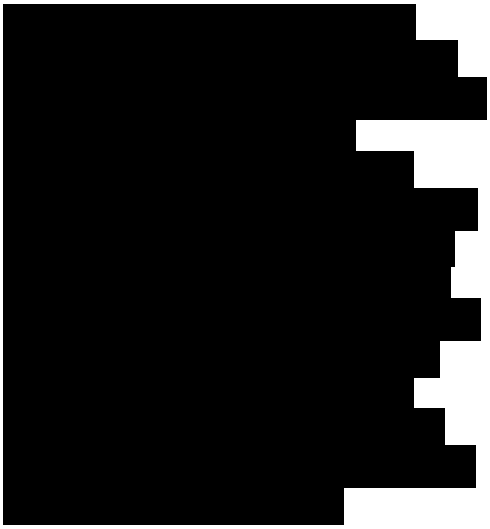
Our proposed Empire Plan Team includes seasoned individuals who not only have significant experience in their respective areas of expertise and in the New York market, but who have worked collaboratively for many years. [redacted]

[redacted] Functional areas include:

- Account management
- Claims processing
- Clinical operations
- Clinical referral line and central night service (CNS)
- Customer (enrollee) service/call center
- Data management and reporting
- Human resources and recruitment
- Information technology
- Legal advisement
- Premium development services
- Provider contracting and provider relations
- Quality management

In addition to working closely with their team members on the Empire Plan account, each of these professionals interacts with other ValueOptions professionals within their functional area. Also, cross-functional workgroups in the following areas will meet regularly. These groups will comprise the Account Management team, along with all operational leads:

- Interdepartmental Meeting
- Quality Utilization Management Committee
- Compliance (HIPAA)
- Quality Improvement Project Teams
- Enrollee/Provider Satisfaction Workgroup
- Level 1 Administrative Appeals
- Complaints Grievances and Administrative Appeals Committee



Regarding Ms. Campione and her Team:

"I wanted to let you know how pleased we are with the implementation efforts of ValueOptions. The process has been well-organized on their end, and the ValueOptions representatives have been both knowledgable and professional in their approach to all issues. Further, they've made very positive recommendations for us that will enable us to be better positioned with repsect to future NCQA accreditation efforts."

--Executive from Medicaid Start-up Client

Key Responsibilities of our Empire Plan Team

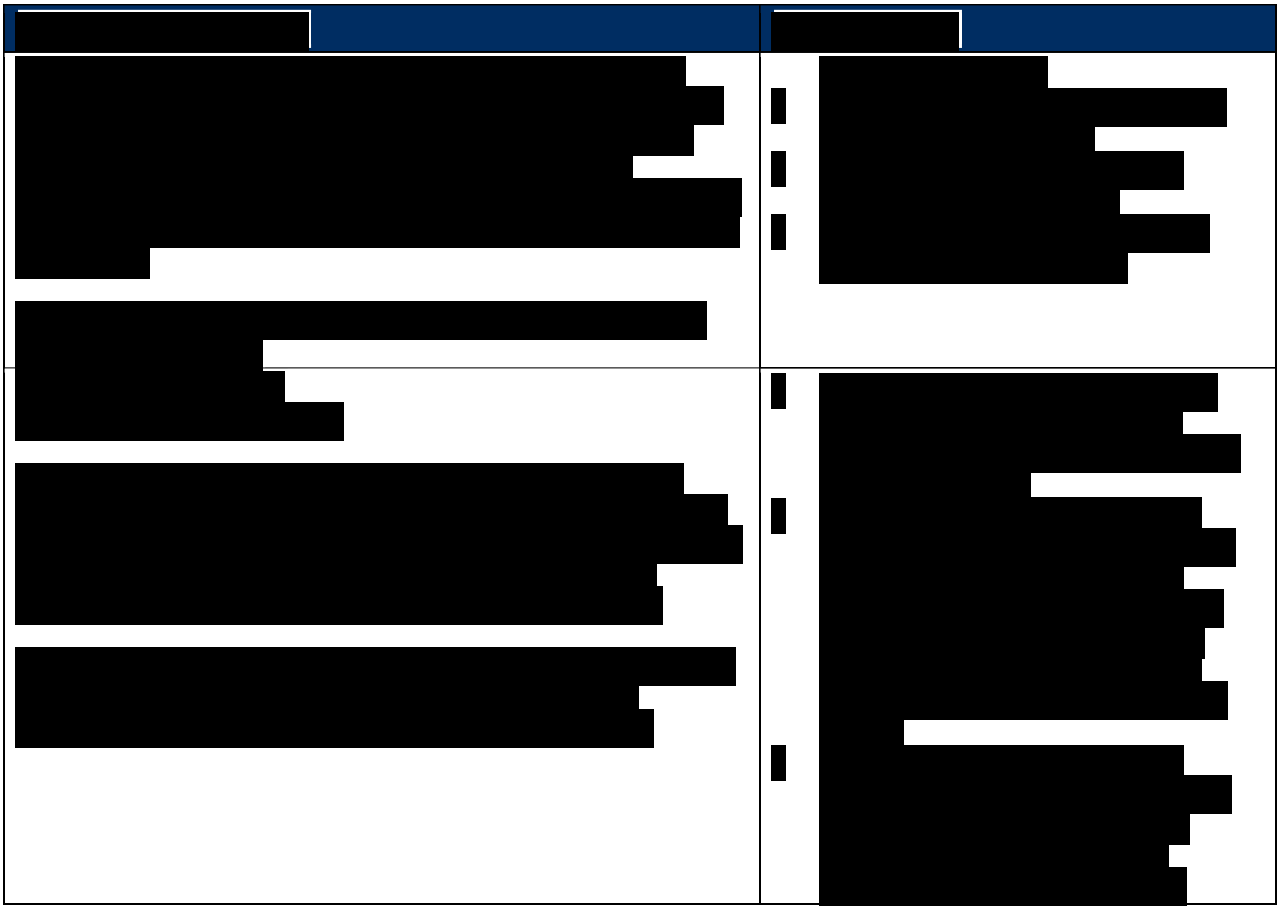
We will not only provide the Empire Plan all of the services required throughout the RFP, but will also provide you with consultation on a variety of issues that will assist you in meeting the program's goals and objectives. Toward that end, our Empire Plan Team will provide you with the following:

- On-time implementation with minimal disruption
- Experienced account leadership from a New York-based account team
- Consultation regarding industry trends and developing best practices
- Administration and oversight of all aspects of the MH/SA Program
- Enrollee access to Clinical Care Managers, 24 hours a day, seven days a week
- Oversight of a network of 13,973 providers across the state
- Timely responses to concerns raised by the Department
- Assurance that contractual obligations are being met
- Compliance with all legislative and statutory requirements
- Customized communication and education materials
- Comprehensive, accurate, on-time data reporting

Interfacing with Executive Management

ValueOptions combines a centralized structure for strategy and quality management across our organization with a de-centralized operational structure for client services and program delivery. Executives with broad functional accountability report to Heyward Donigan, Chief Executive Officer. The areas the executives represent include clinical and quality programs, networks, information technology, claims, call center and customer service operations, sales, and legal and compliance.

We operate service centers on behalf of our major client relationships. This management structure (centralized support with regional operational accountability) serves our clients exceptionally well. It enables us to be an efficient, learning organization, able to quickly transfer experience and best practices from one area to another. It enables us to be responsive to the



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SUPPORTING THE DEPARTMENT

Customer Meetings

As part of the Account Management responsibility for the Empire Plan, we will meet at least quarterly with the Department and the Governor's Office of Employee Relations (GOER) to discuss operational updates and issues. Heyward Donigan, ValueOptions Chief Executive Officer, will be available to attend these meetings upon request. The Account Management Team will also present to the Joint Committee (Department, GOER, unions) on an annual basis.

This meeting will provide an overview of the previous year's successes, and report on performance measures, utilization data, and initiatives for the future. In addition, we will discuss emerging topics of interest to the Department, from areas such as legal, clinical, actuarial, and plan design. Ms. Campione will work with you to develop the agenda for this portion of these meetings, and ValueOptions' thought leaders on each of the identified topics will be available to attend, present, and/or participate as appropriate.

Client Summits

ValueOptions also offers the Department access to our quarterly telephonic client summits. During these summits, ValueOptions' internal subject matter experts and national experts present on current challenges and trends, and address important issues in the behavioral health field that are relevant to our employer clients. The convenient Web-based format encourages open discussion among our large employer clients, during which they can share their own lessons learned. Recent summit topics and speakers have included the following:

- **From Battlefield to Workplace: Hiring and Transitioning Heroes Back into the Civilian Workforce**
  Speaker: Kia Silver Hodge, Corporate Manager of Diversity Recruitment Programs, Northrop Grumman Corporation
- **Supreme Court Upholds Most of the Affordable Care Act. What Are the Implications for Behavioral Health Care?**
  Speakers: The Association for Behavioral Health and Wellness' Pamela Greenberg and ValueOptions' Brad Lerner
- **How Will the Legalization of Marijuana Affect Your Workplace?**
  Speaker: Andrea Grubb Barthwell, M.D., F.A.S.A.M**,** former Deputy Director for Demand Reduction in the Office of National Drug Control Policy
- **Autism: Applied Behavioral Analysis and Health Plans**
  Speaker: Bryan Davey, Ph.D., BCBA-D, Licensed Behavior Analyst in Arizona, Director of Behavioral Services for the Arizona Centers for Comprehensive Education and Life-Skills

Consultative Services

Consultation services are provided on topics such as benefit design, clinical innovations and best practices, risk management strategies, behavioral health care industry trends, and technology advancements. These services —provided on an as-needed basis—are an integral part of our account management services for the Department. Ms. Campione will also present information regarding state and national legislative and regulatory issues as they arise.

ValueOptions' Account Management team will also communicate proactively with all key stakeholders associated with your benefit plan to ensure effective coordination between all vendors, as necessary. Ms. Campione will be the primary point of contact for escalated issues, and she and the Account Management team will research and respond to inquiries from the Department, providers, enrollees, and others. The Account Management staff will communicate with your other vendors, insurance carriers, and other ValueOptions staff to resolve escalated case management, claims, customer service and/or reporting issues.

In addition to Ms. Campione, other members of the Empire Account Team are available to provide input on their respective areas of expertise. From reporting, to quality, to claims, to legal, we are available to provide consultation on a variety of issues, whether directly from a member of the Empire Account Team, or from one of our hundreds of subject matter experts throughout our organization.

Reporting and Analytics

Ms. Campione will provide the Department with comprehensive quarterly and annual reports. These reports and her guidance will include:

- An executive summary and analysis with data/reports representing the Program enrollees' use of services
- Client reports, as requested
- Consultation with client with appropriate recommendations for program enhancements

ValueOptions will also provide the Department access to online reports that are updated monthly and are available via a secure Internet connection.

(3) List the national accreditations and levels (i.e. full, provisional, etc…) that your organization has achieved for the locations that will service the MHSA Program.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

Our New York City Service Center was awarded Full Accreditation – MBHO in December 2011, effective through December 2014. ValueOptions was first awarded accreditation from the National Committee for Quality Assurance (NCQA) in 1999.

URAC ACCREDITATION

In addition, ValueOptions was first awarded URAC Full Accreditation under the Health Utilization Management Standards on March 1, 1999. URAC has awarded Full Accreditation under the Health Utilization Management Standards, Version 7.0, to eight of our service centers, including our New York City Service Center.

(4) Confirm you will work with the Department to develop appropriate customized forms and letters for the MHSA Program, including but not limited to claim forms, pre-certification forms and letters, explanation of benefits, appeal letters, etc. All such communications must be approved by the Department prior to their distribution.

We confirm that we will work with the Department to develop customized forms and letters to meet your specifications. We will ensure that all communication materials receive Department approval before distribution.

The Contractor must provide underwriting assistance and support to the Department in the development of premium rates chargeable to MHSA Program participants consistent with the interests and goals of the MHSA Program and the State. The Department intends to develop premium rates to be as realistic as possible, taking into account all significant elements that can affect MHSA Program costs including, but not limited to trend factors, changes in enrollment and enacted legislation. The development of premium rates that closely match the actual costs enables the plan to provide rate stability, one of the primary goals of the State, and to meet the budgetary needs of the State and local governments that participate in NYSHIP.

The Contractor will be responsible for assisting and supporting the Department with all aspects of the premium rate development including, but not limited to:

Section 2: Premium Development Services (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) Providing a team of qualified and experienced individuals who are acceptable to the Department and who will assist and support the Department in developing premium rates consistent with the financial interests and goals of the MHSA Program and the State;	Yes
(2) Developing projected aggregate claim, trend and Administrative Fee amounts for each MHSA Program Year. Analysis of all MHSA Program components impacting the MHSA Program cost shall be performed including, but not limited to claims, trend factors, Administrative Fees and changes in enrollment; and	Yes
(3) Working with the Department and its contracted actuarial consultant through the annual premium renewal process to further document and explain any premium rate recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget and GOER.	Yes

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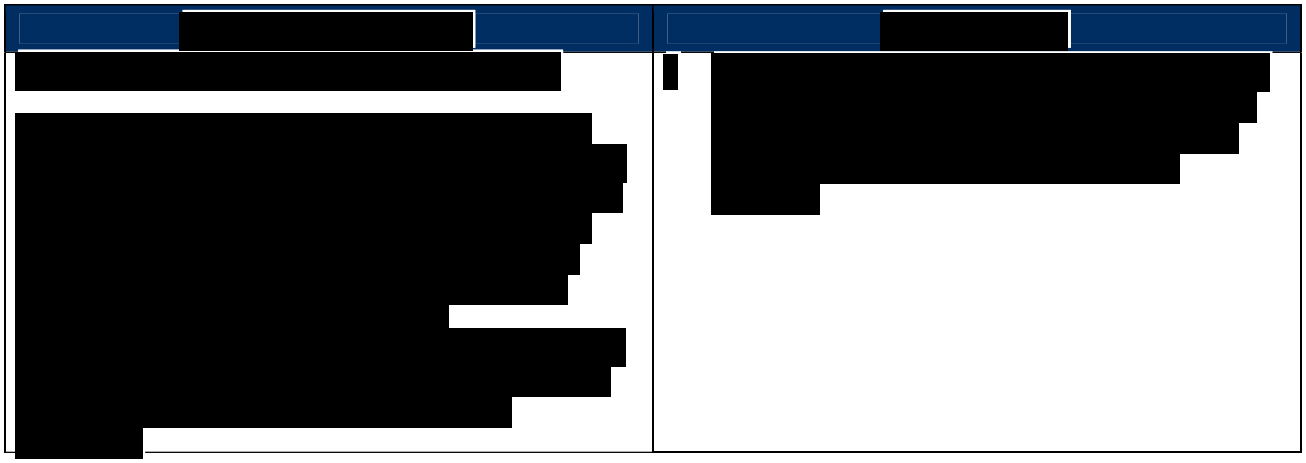

The Contractor must ensure that the MHSA Program is fully functional by January 1, 2014. The implementation plan must be detailed and comprehensive and demonstrate a firm commitment by the Contractor to complete all implementation activities by December 31, 2013.

Section 3: Implementation (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) The Contractor must commence an implementation period beginning on or around October 1, 2013 following approval of the Agreement by OSC. During the implementation period, the Contractor must undertake and complete all implementation activities, including but not limited to those specific activities set forth in Section IV.B.3.a.2a-2e. Such implementation activities must be completed no later than December 31, 2013 so that the MHSA Program is fully operational on January 1, 2014.	Yes
(2) Implementation and Start-up Guarantee: The Contractor must guarantee that all Implementation and Start-up activities will be completed no later than December 31, 2013 so that, effective January 1, 2014, the Contractor can assume full operational responsibility for the MHSA Program. For the purpose of this guarantee, the Contractor must, on January 1, 2014, have in place and operational; (a) A contracted Provider network (including Certified Behavior Analysts) that meets or exceeds the access standards set forth in Section IV.B.10 of this RFP; (b) A fully operational call center, including a Clinical Referral Line, providing all aspects of customer support and clinical services as set forth in Section IV.B.4 and Section IV.B.12 of this RFP; (c) A claims processing system that processes claims in accordance with the MHSA Program's plan design and benefits, as set forth in Section IV.B.11 of this RFP; (d) A claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by the Department to correctly pay claims for eligible Enrollees consistent with MHSA Program benefit design and contractual obligations; and (e) A fully functioning customized MHSA Program website with a secure dedicated link from the Department's website able to provide Enrollees with on-line access to the specific website requirements as set forth in Section IV. B.4 of this RFP.	Yes

(1) Provide an implementation plan (via a detailed narrative, diagram, and timeline) upon Agreement approval, on or around October 1, 2013 that results in the implementation of all MHSA Program services by the required date of December 31, 2013, including but not limited to: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. Include key activities such as member and Provider communications, training of call center and clinical staff, report generation, network development, transition benefits, customized website design, eligibility feeds and claims testing.

Upon contract award we will provide a detailed implementation plan that includes all MHSA Program services for The Empire Plan, Excelsior Plan, and the Student Employee Health Plan (The Empire Plan) program. Wes Kahle, Director of Implementations for ValueOptions, is based in New York and has managed multiple large and complex implementations for the company. He will lead the Empire Plan implementation. ValueOptions will assemble and deploy a dedicated and highly experienced team of project management professionals and subject matter experts to function as the implementation team. Mr. Kahle and other members of our team will work closely with you to identify staff to participate on functional work groups to implement the Empire Plan program. These workgroups will include, but may not be limited to:

- Administration/account management
- Benefits
- Information systems
- Clinical services
- Network management/provider relations
- Communications
- Quality management
- Eligibility
- Member and provider services
- Claims processing
- Reporting and analytics

ValueOptions does not use a “drop in” approach to implementations, in which a team with little investment in the ongoing operation of the program would work on the implementation for a limited time. Responsible for leading the implementation, our core team will be dedicated to the implementation, on the ground, and will remain in place to function as active participants throughout the pre- and post-implementation phases of this initiative. In addition to these process and technical experts, our account management team will be active participants in the process to ensure ongoing execution.

A sample implementation plan is provided as **Attachment 1**. It details the sequence of events, the responsible parties, and the timeline required for each functional area to successfully implement this program by no later than December 31, 2013. At the point of award, ValueOptions will take the attached proposed plan and, working in close cooperation with you, refine and finalize it to your satisfaction. The Department will have full rights of approval of the implementation plan. Throughout the life of the implementation process, Mr. Kahle will review and update the plan during meetings with you in order to ensure that you are completely satisfied

with our progress. Below, we also present a high-level milestone plan which provides an overview of some of the key areas of interface during the implementation.

Timeline	October 1-15	October 15-30	Oct. 30-Nov.15	November 15-30	Nov 30-Dec. 15	December 15-31
Facilitate kick-off meeting with the Department						
Begin internal implementation meetings						
Requirements review meetings with the Department and internal teams						
Submit final project plan to the Department for approval						
Post jobs internally/externally						
Initial offering of positions						
Facilitate training of call center and clinical staff						
Collaborate, develop and mail/post Enrollee and Provider communications						
Network Development (recruitment/credentialing/contracting)						
Provider training and orientation						
Claims system configured						
Toll-free line (Call Center) activated						
Call Center fully operational						
Empire Plan Benefits loaded						
Enrollment File loaded and tested						
Transition - Load Open Authorizations from Incumbent						
Identify and develop the Department's reporting package						
Develop and implement claims and accumulator exchanges						
Develop and implement fully functioning customized MHSA Program website						
Facilitate systems testing (model office)						
All systems/data exchanges tested and sign-off obtained – production go-live						

(2) The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in Section B.3.a.(2) will be in place on or before December 31, 2013. The Offeror shall propose the forfeiture of a percentage of the 2014 Administrative Fee (prorated on a daily basis) for each day that all Implementation and Start-Up requirements are not met.
The Standard Credit Amount for each day that all Implementation and Start-Up requirements for the MHSA Program are not met is a minimum of fifty percent (50%) of the 2014 Administrative Fee (prorated on a daily basis). However, Offerors may propose higher percentages.
The Offeror's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is _____ percent (%) of the 2014 Administrative Fee (prorated on a daily basis).

ValueOptions guarantees that each of the following implementation and start-up activities will be in place on or before December 31, 2013. Our implementation philosophy and team structure provides account and project management leadership beginning with pre-implementation activities through implementation and ongoing operations, as well as participation and oversight from the Department in all levels of decision-making. We know, based on our implementation experience, that communication and collaboration is critical to any new program implementation or transition. We will partner with the Department and your other vendors to establish appropriate expectations and communication protocols to ensure achievement of the implementation performance standards. This includes establishing a mutually agreed upon Statement of Work and implementation plan with clearly established milestones and dependencies for ValueOptions, other Department vendors, and the Department. The following table also identifies the penalty proposed for each of the five implementation and start-up guarantees listed in Section IV.B.3.a. (2). [redacted]

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The Contractor will be responsible for all customer support and services including, but not limited to:

Section 4: Customer Service (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) Providing Enrollees access to information on all MHSA benefits and services related to the MHSA Program through the Empire Plan consolidated toll-free number twenty-four (24) hours a Day, 365 Days a year;	Yes
(2) The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's medical carrier/third party administrator and is available to callers twenty-four (24) hours a Day, 365 Days a year. The Contractor must establish and maintain a transfer connection with AT&T (T-1 line), including a back-up system which will transfer calls to the Offeror's line at their call center service site. The Contractor must sign a shared service agreement with the Empire Plan's medical carrier/third party administrator (currently United Healthcare) and AT&T. In addition, the Contractor is also required to provide twenty-four (24) hours a Day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The TTY number must provide the same level of access to call center service as required by this Section of the RFP;	Yes
(3) Maintaining a Dedicated Call Center for the MHSA Program located in the United States that: (a) Provides direct access to trained Clinicians who direct members to appropriate Network Providers, provide clinical MHSA information and, if requested by the caller, assist in scheduling appointments on behalf of the member, twenty-four (24) hours a Day, 365 Days a year; (b) Provides access to fully trained customer service representatives and supervisors available between the hours of 8:00AM.to 5:00PM., Monday through Friday, except for legal holidays observed by the State; (c) Meets the Contractor's proposed call center telephone guarantees set forth in Section IV.B.4b (8) of this RFP.	Yes
(4) Customer service staff must use an integrated system to log and track all Enrollee calls. The system must create a record of the Enrollee contacting the call center, the call type, and all customer service actions and resolutions;	Yes
(5) Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to; MHSA Program benefits levels, status of pre-certification requests, eligibility and claim status and be able to identify calls requiring transfer to a Clinician;	Yes
(6) Maintaining a designated backup customer service staff located in the United States with MHSA Program-specific training to handle any overflow when the dedicated customer	Yes

Section 4: Customer Service (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
service center is unable to meet the Contractor's proposed customer service performance guarantees. This back-up system would also be utilized in the event the primary customer service center becomes unavailable;	
(7) Maintaining and timely updating a secure online customized website accessible by Enrollees, which is available twenty-four (24) hours a Day, 365 Days a year, except for regularly scheduled maintenance, which will provide, at a minimum access to information regarding; MHSA Program benefits, Network Provider locations, eligibility, Copayment information, pre-authorization information, claim status and clinically-based educational material. The Department shall be notified of all regularly scheduled maintenance at least one (1) Business Day prior to such maintenance being performed. The Contractor must establish a dedicated link to the customized website for the MHSA Program from the Department's website with content subject to the approval of the Department and limited to information that pertains to the MHSA Program. Links bringing a viewer back to the Department website must be provided. No other links are permitted without the written approval of the Department. Access to the online Network Provider locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the website or establishing a dedicated link for the MHSA Program shall be borne solely by the Contractor. Also, the Contractor shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal; and	Yes
(8) Call Center Telephone Guarantees: The Contractor must meet or exceed the following four (4) measures of service on the toll-free customer service telephone line; (a) Call Center Availability: The MHSA Program's service level standard requires that the Contractor's telephone line will be operational and available to Enrollees, Dependents and providers at least ninety-nine and five-tenths percent (99.5%) of the Contractor's Call Center Hours. The call center availability shall be reported monthly and calculated annually; (b) Call Center Telephone Response Time: The MHSA Program's service level standard requires that, at the least, ninety percent (90%) of the incoming calls to the Contractor's telephone line will be answered by a customer service representative within thirty (30) seconds. Response time is defined as the time it takes incoming calls to the Contractor's telephone line to be answered by a customer service representative or a Clinical Manager, if after hours. The call center telephone response time shall be reported monthly and calculated annually;	Yes

Section 4: Customer Service (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(c) Telephone Abandonment Rate: The MHSA Program's service level standard requires that the percentage of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative or Clinical Manager, if after hours will not exceed three percent (3%). The telephone abandonment rate shall be reported monthly and calculated annually. (d) Telephone Blockage Rate: The MHSA Program's service level standard requires that the Contractor guarantee that not more than zero percent (0%) of incoming calls to the customer service telephone line be blocked by a busy signal. The telephone blockage rate shall be reported monthly and calculated annually.	

(1) Confirm that you will provide Enrollees access to the Clinical Referral Line and MHSA Program information through a consolidated toll-free number 24 hours a day 365 Days a year, as described above.

We confirm that enrollees will have access to the Clinical Referral Line and MHSA Program information through a consolidated toll-free number 24 hours a day, 365 days a year. ValueOptions offers an approach to enrollee and provider services that emphasizes access and responsiveness. Our telephone system, service applications, and portals enable us to respond to enrollee and provider service requests quickly and accurately. Our Clinical Referral Line consistently meets or exceeds call center responsiveness expectations of our clients.

(2) Confirm you will enter into a shared service agreement with the Empire Plan medical carrier/ third party administrator, or other party designated by the Department, and AT&T. Confirm you will provide 24 hours a day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability.

We confirm that we will enter into a shared service agreement with the Empire Plan medical carrier/third party administrator, or other party designated by the Department, and AT&T. We further confirm that hearing and speech impaired enrollees will have access to the same level of service 24 hours a day, 365 days a year through our TTY/TDD number, which is answered by our Referral Line Clinicians. As part of our routine call center services, we offer TTY/TDD and relay services for those enrollees who are deaf or hearing impaired. We have a demonstrated commitment to overcoming the barriers to care faced by people with hearing loss or speech impairments. We will take full advantage of available technology to ensure that all Empire Plan enrollees have complete, prompt access to the behavioral health services they need.

We thoroughly train all call center staff on the use of TTY/TDD services so that callers who are deaf, hard-of-hearing, or speech impaired can talk to us without a translator. Callers can directly connect to the TTY/TDD line or be promptly transferred to speak with a Customer Service Representative. This confidential service is available to enrollees 24 hours a day.

(3) Confirm you maintain a Dedicated Call Center for the MHSA Program located in the United States, employing a staff of Clinicians and a staff of fully trained customer service representatives (CSR's) and supervisors. Confirm that customer service representatives will be available, at a minimum, for the MHSA Program between the hours of 8:00AM to 5:00PM, Monday through Friday except for legal holidays observed by the State. If additional hours are proposed, please state. Confirm that access to Clinical Managers through the Clinical Referral Line will be 24 hours a Day, 365 Days a year.

ACCESS TO CLINICAL AND CUSTOMER SERVICE STAFF

We confirm that we will maintain a Dedicated Call Center for the MHSA Program located not only in the United States but in the state of New York. This call center will employ a full trained team of Customer Service Representatives and supervisors, as well as Clinical Care Managers.

Customer Service Representatives will be available from 8:00 a.m. to 8:00 p.m. to respond to inquiries regarding enrollee benefits or claims, or to update an enrollee's contact information. While our Customer Service Representatives do not make clinical decisions, they do sometimes serve as the "front door" to the clinical process—assessing the primary and secondary reasons for an enrollee's outreach and documenting demographic and referral information in our system. They will also facilitate the enrollee's connection to the best resource based on the enrollee's reason for calling, documenting the enrollee's demographic and referral information in our system. Enrollees calling to speak with a Customer Service Representative outside of the 8:00 a.m. to 8:00 p.m. regular business hours will be advised that the office is closed and will be asked to call back the next business day. They will also be advised that they can access our online enrollee resource, MemberConnect, which is available 24 hours a day, to verify benefits and eligibility status, or check the status of a claim.

Clinical Care Managers (also referred to as Referral Line Clinicians) will be available to handle all clinical calls 24 hours a day, 365 days a year through the Clinical Referral Line or from Empire Plan's medical vendor. They will conduct a clinical assessment and coordinate the enrollee's care, including helping schedule appointments with behavioral healthcare providers, if requested. Our state-of-the-art telephone structure will immediately direct crisis calls to a Clinical Care Manager, ensuring that enrollees in crisis receive access to a clinician who can assist them in obtaining the necessary services.

FULLY TRAINED STAFF

All of our clinical, customer service and supervisory staff are fully qualified and trained to provide the services for which they are responsible. We recruit and thoroughly train our Clinical Care Managers, Customer Service Representatives and call center supervisory staff to appropriately triage all types of enrollee and provider inquiries and provide the necessary support and engagement to all call center staff. We have a rigorous interview process that identifies qualified applicants. Call center employees receive more than 300 hours of training in their first year alone. Our goal is single call resolution for enrollees.

We take a phased-in approach to releasing trainees to the call center. During the classroom phase, they begin to handle live calls with one-on-one mentoring to ensure the quality of enrollees' experiences. Trainees are only released to the call center when they successfully complete classroom training and achieve quality assurance expectations. Call center management, quality, and training staff continue dedicated on-the-job mentoring for a period of six weeks. We provide ongoing training on internal clinical policy, process changes, network updates, and customer-focused workgroups, as well as customer culture and service expectations.

(4) Describe the information, resources and system capabilities that are available for the customer service representatives to address and resolve member inquiries. Include:
- (a) Whether any Interactive Voice Response (IVR) system is proposed;
- (b) A sample of the IVR script and a description of customizable options, if any, you propose for the MHSA Program;
- (c) A description of the management reports and information available from the system including the key statistics you propose to report;
- (d) A description of the capabilities of your phone system to track call types, reasons and resolutions;

When an Empire Plan enrollee calls the dedicated toll-free number, their call will be answered by one of our staff members who have been trained to promptly and thoroughly respond to their need. To support our staff members in providing optimal service, we have made significant enhancements to our systems through automation of many elements of our customer service and data management programs. While these enhancements will provide Empire Plan enrollees with additional options for accessing information, ValueOptions remains committed to having dedicated Customer Service Representatives readily available to personally address enrollee inquiries. Below, we describe some of the resources we will use to support Empire Plan enrollees.

INTEGRATED INFORMATION SYSTEM

The Empire Plan team will have access to ValueOptions' integrated information technology platform known as CONNECTS. This state-of-the-art proprietary system serves as the backbone of our client, enrollee, and provider information data. CONNECTS supports all information necessary to address enrollee inquiries, including eligibility, benefits, authorizations, provider status, and claims. CONNECTS serves as the platform for customer service, clinical referral, care management, reporting, and outcomes data. All functions including inquiries, referrals, authorizations, clinical and provider information, claims payment, and reporting reside in the same system, and are written in the same language. CONNECTS comprises multiple fully integrated components that cover all of the functions normally required in the administration of a managed health care operation. CONNECTS uses a shared database that integrates membership and provider maintenance, inquiry tracking, clinical notes, authorizations, and claims status.

Customer Service Application

Our customer service application, ServiceConnect, is one component of the CONNECTS platform and allows our Customer Service Representatives to perform a wide variety of tasks in a Web-based, intuitive environment. The ServiceConnect application allows users to easily document and track all call center contacts including inquiries, complaints and transfers to the Clinical Referral Line. ServiceConnect allows for improved workflow efficiency, enhanced inventory management controls, and improved inquiry resolution timeframes through added system flexibility, data capture, and reporting. ServiceConnect has reduced overall call resolution time for our customer service team, increasing our first call resolution capabilities. Some of the benefits for Empire Plan enrollees include, but are not limited to, the following:

- improved inquiry/contact resolution turn-around times by having the ability to monitor an inquiry throughout its life cycle
- improved root cause analysis, allowing opportunities for process improvement because of standardized inquiry contact reasons, identification of re-contacts, enhanced tracking mechanisms, and greater standardization of workflows and reporting
- improved customer satisfaction through decreased inquiry resolution timeframes
- improvements in internal and external communications via increasingly standardized workflows, processes, and inquiry reporting

ServiceConnect also supports workflow management between departments. Since CONNECTS is an integrated platform that encompasses all managed behavioral care functions, ServiceConnect captures inquiry data and distributes it to the responsible individual or department for resolution. ServiceConnect maintains the inquiry details throughout resolution, and keeps historical data of all inquiries for all enrollees. As a user-friendly management system, ServiceConnect prioritizes the Customer Service Representative's daily workload in-box, and serves as an electronic tickler system, which reminds ValueOptions personnel when a promised response is due.

Member Referral Application

CareConnect is the corresponding care management application for the clinical team, again a component of the integrated CONNECTS platform. The referral module of the CareConnect application allows ValueOptions' Clinical Referral Line staff to locate network providers through an online searchable database. Through the referral module, ValueOptions' call center clinicians can easily address enrollee inquiries for clinical referrals by searching for network providers and facilities with specific clinical specialties, languages, disciplines, and program types located within an acceptable driving distance of enrollees. In addition, call center clinicians can sort provider search results by driving distance, list the details available on each provider (e.g., specialties and languages), and reference a map showing locations of provider offices in relation to an enrollee's location.

The referral module is designed to be easy to use and the screen layout is optimized for the Referral Line Clinician's efficient data collection and tracking capabilities. Online entry of clinical data with maintenance of clinical case history allows the clinicians to easily enter and access all clinical information, for example:

- priority (emergent, urgent, routine)
- reason for the call (referrals, verification of provider status)
- disposition of call (complete, follow up needed)
- who called (client, provider, family, etc.)
- follow-up tracking of urgent cases

Using their clinical experience and expertise, ValueOptions' clinicians will link Empire Plan enrollees to the most appropriate clinical services in convenient locations. The clinicians who will serve the Empire Plan program will have access to ValueOptions' national provider database, and can facilitate access for everything from routine to emergency care. Additionally, the clinicians are able to make referrals anywhere in the country, which can be invaluable to enrollees who may be out of the state, or to enrollees with dependents away at school.

ValueOptions' clinicians have access to all pertinent demographic information for each provider, such as name, address, phone and fax numbers, distance from the provider's location to the enrollee's location (either work or home) and can even access a map to the provider's location for the enrollee's convenience. In addition, as part of the referral process, the enrollee is asked for any unique needs or provider preferences, such as gender, race, language, clinical specialty, and location. The clinicians will then query the database to select providers that match the enrollee's preferences.

(a) INTERACTIVE VOICE RESPONSE

ValueOptions utilizes Verizon Business's enhanced call routing to provide call routing features for toll free numbers. Callers are prompted to enter a single touchtone digit in response to voice prompts which are considered part of the menu routing option. Depending upon the caller's need, the call proceeds to a licensed Clinical Care Manager, Customer Service Representative, or our Interactive Voice Response technology that is available to Enrollees and ValueOptions providers 24 hours a day, 7 days a week. Our Interactive Voice Response technology, TeleConnect, allows enrollees and providers to resolve quickly and easily to customer service issues, thus eliminating hold times and ensuring that Customer Service Representatives devote more time to calls where their interaction skills add value and impact to enrollee and provider satisfaction. In addition, the TeleConnect system:

- improves automated 24-hour service delivery for enrollees and providers for claims inquiries, requests for standard forms, and enrollee eligibility inquiries, which allows enrollees and providers to get information at times that are convenient for them, even if it is after ValueOptions' normal business hours
- permits providers to submit Requests for Service via the telephonic interface
- includes enhanced automated speech recognition to improve the service experience of our enrollees and providers
- accommodates clients who are using an alternate identifier to the Social Security Number
- interfaces with our comprehensive management information system

TeleConnect allows providers to obtain information 24 hours a day, seven days a week through either a separate toll-free number or the ValueOptions auto-attendant options. As it is currently

implemented, the service allows network providers to obtain eligibility, claims status, submit authorization requests and access standard forms 24 hours a day, seven days a week.

(b) INTERACTIVE VOICE RESPONSE SCRIPT AND CUSTOMIZATION OPTIONS

We have provided a sample of an IVR script as **Attachment 2**. All prompts and scripts from the toll-free number can be customized to meet the Department's exact specifications.

(c) MANAGEMENT REPORTS AND INFORMATION

Our enterprise-wide call management system provides call center reporting that encompasses real time statistics and historical reports from a representative or queue perspective. This tool is designed to report on inbound call activity within the representative environment. Whether it is the average wait time to answer, percent abandoned, or agent detailed call handle performance, our system provides real time information which enables us to make immediate decisions to redistribute calls to resources or redirect calls in the rare event it is required. We conduct ongoing call activity analysis to ensure that we are not just reacting to call volume, but that we are proactive in our resource allocation to respond to call demands within the customer, NCQA, and URAC service level expectations.

End-to-end reporting applications provide the ability to analyze individual calls quickly and easily, with a timeline of events for each call. This software tracks every inbound, outbound, and internal call, and uses pre-defined filters to enable even the most complex searches. We have deployed TASKE's Visualizer product to provide a 360-degree view of the entire call center for analytic purposes. Visualizer is designed to give supervisors the ability to drill down, search, and research the history of each individual call (i.e. inbound, outbound, and internal).

We will provide the following reports to the Department regarding call center activity:

- Call Center Availability
- Call Center Telephone Response Time
- Telephone Abandonment Rate
- Telephone Blockage Rate

(d) CALL TRACKING

Each contact is documented in an inquiry that includes call type and reason, actions taken and resolutions. All calls received by our call center staff (administrative and clinical) are logged into our fully integrated customer service and clinical management systems for recording, tracking, analyzing and reporting of contacts and inquiries. Through the integration with our CONNECTS platform, staff are able to access critical information to enable them to quickly respond to enrollee needs. Whether the contact is related to a benefits, provider participation or referral, eligibility or an authorization matter, our staff has automated access to the various systems within CONNECTS, thus the requested information is searched for, retrieved and delivered within seconds. In addition, our NICE Customer Feedback software with speech analytics provides an automated method of analyzing speech to gain greater insight into the caller's frame of mind. This influences our operations and helps to continuously improve the enrollee's experience with ValueOptions. This extremely valuable technology provides primary

reasons for which individuals are calling, the frequency of repeat callers and the primary drivers of dissatisfaction.

(5) Describe the training that is provided to CSR and Clinical Referral Line staff before they go "live" on the phone with Enrollees. Include:
- (a) A description of the internal reviews that are performed to ensure quality service is being provided to Enrollees;
- (b) The first call resolution rate for the proposed call center;
- (c) The turnover rate for customer service and Clinical Referral Line employees;
- (d) Ratio of management and supervisory staff to customer service representatives; and
- (e) Proposed staffing levels including the logic used to arrive at the proposed staffing levels;

ValueOptions understands that in many cases, the Customer Service Representatives or Referral Line Clinicians are the enrollee's primary point of contact. We work to ensure that our staff is well trained and provides each enrollee with high quality service. Our call center quality measures are integrated into our quality management program and will be monitored by the New York-based Quality and Utilization Management Committee on a quarterly basis.

CUSTOMER SERVICE REPRESENTATIVE TRAINING

ValueOptions' dedicated Empire Plan Customer Service Representatives will be available to answer enrollee questions regarding eligibility, benefits, provider network status, and claims issues. Customer Service personnel are identified through a rigorous interviewing process.

We recruit and thoroughly train our Clinical Care Managers, Customer Service Representatives, as well as call center supervisory staff, to appropriately triage all types of enrollee and provider inquiries and provide the necessary support and engagement to all call center staff. Call center employees receive more than 300 hours of training in their first year alone. Our goal is single call resolution for enrollees.

ValueOptions' Customer Service Representatives undergo an intensive six to eight week training program that covers all aspects of the Empire Plan program prior to "going live." The Empire Plan account-specific training will include extensive information on benefits and program design. New Customer Service Representatives will also receive training that provides them with an overall understanding of ValueOptions' operations, including care management, provider relations, and claims. New staff training includes rigorous review of detailed procedures addressing patient confidentiality requirements. Customer Service Representatives are educated on the sensitivity of the information available as well as State, Federal and HIPAA requirements related to confidentiality. Procedures clearly define what types of information may be released and to whom. In addition, staff receive training on URAC requirements and applicable State

regulations such as those governing appeals, grievances and prompt payment of claims. In addition, new staff receive detailed reference materials for future use.

A dedicated Empire Plan trainer will facilitate the training in a specially equipped room. The training environment will mirror the live call center and be equipped with desktop and automated call distribution telephones to enhance the training experience and best prepare employees to serve your enrollees.

We take a phased-in approach to releasing trainees to the call center. During the classroom phase, they begin to handle live calls with one-on-one mentoring to ensure the quality of enrollees' experiences. Trainees are only released to the call center when they successfully complete classroom training and achieve quality assurance expectations. Call center management, quality, and training staff continue dedicated on-the-job mentoring for a period of six weeks. We provide ongoing training on internal clinical policy, process changes, network updates and customer focused workgroups. Additional training is provided based on needs identified through quality or inquiry audits, workgroups, or resulting from national, procedural or client specific change requests or updates.

New Customer Service Representative training consists of the following topics:

New CSR Orientation Topics	
• Empire Plan Benefit Design, Culture, and Service Expectations	• Certificate of Insurance
• Performance Standards	• Explanation of Benefits
• Coordination of Benefits and Vendor Interface	• Confidentiality & HIPAA
• Billing Codes and Fee Schedules	• Levels of Care
• Behavioral Health Conditions	• Department Overviews
• Code of Conduct and Integrity	• Inquiry Documentation and Management
• Fraud and Abuse	• Quality Audit Process
• Policies and Procedures	• Prompt Payment Regulations
• Claims Processing Overview	• Single Case Agreement Process
• Medicare	• Complaints and Grievances
• Appeals	• Superior Service Telephone Skills
• Behavioral Health Sensitivity	• Enrollee Engagement

REFERRAL LINE CLINICIAN TRAINING

All Referral Line Clinicians are licensed behavioral health clinicians with a minimum of three years of clinical experience in a mental health or substance abuse setting. Upon hire, ValueOptions provides comprehensive, focused training and orientation programs for all Referral Line Clinicians to ensure that they are prepared to clinically and procedurally provide high quality assessments, referrals, care management and medical necessity reviews of treatment provided at all levels of care. All full and part-time clinicians are required to participate in each phase of the training and orientation process. This training is composed of supervisory and subject matter expert presentations to staff, reading and discussion of selected articles, review of all clinical policies and procedures, clinical criteria, guidelines/protocols, and phone and computer system training. Key topics include:

- The Managed Behavioral Health Care Industry
- ValueOptions' Clinical Philosophy and Values
- The Empire Plan Mental Health and Substance Abuse Program
- The Clinical Referral Process
- The Clinical Care Management Review Process for all levels of care

(a) INTERNAL REVIEWS

The Call Center Directors and Managers are responsible for developing and deploying the quality assurance processes related to internal reviews. The Call Center Supervisors and Quality Analyst play key roles in carrying out the plan.

To ensure that quality of service delivery is consistently high, the call center management team has established a number of tools to measure performance and a procedure for addressing service issues. Among the measures taken to ensure the highest level of call center performance are:

- **Performance Monitoring --** Daily, the Call Center Supervisors interact with call center staff on a range of issues associated with their daily tasks. These often include resolution of any individual service issues. In addition to these informal interactions, mechanisms that are more formal are in place to ensure that service meets our performance standards. The specific activities used for measuring performance include:
  - Daily review of conformance reports detailing individual performance
  - Monthly formal meetings to review conformance report with each staff member
- **Performance Improvement Plans --** In the event that a deficit or a trend is identified that cannot be resolved through feedback and coaching, the Call Center Manager initiates a Performance Improvement Plan (PIP) for the call center staff member. The PIP identifies the nature of the problem, documents the performance issues, and outlines a plan of action for resolution of the problem, including dates and milestones that measure improvement.

The Call Center Manager is responsible for ensuring that the PIP is followed and that the problem is resolved to ValueOptions' satisfaction. In the unlikely event that the PIP is not satisfactorily resolved, ValueOptions will move forward with the termination process.

Quality Call Monitoring and Recording

Another reflection of ValueOptions' commitment to providing Empire Plan enrollees and providers superior customer service is our use of the NICE Perform Systems' call recording solution. We use the NICE Perform Call Recording Solution system to record 100 percent of calls for staff assigned to the AVAYA system, unless the caller declines to have the call recorded. This enterprise-wide solution provides ValueOptions with the ability to achieve consistent delivery of world class customer service. The NICE system captures and stores call recordings according to ValueOptions and our client requirements. We measure call center staff on the opening, enrollee engagement and listening skills, issue definition and problem solving skills, hold and transfer techniques, response and advice, documentation of the interaction and follow through, and interpersonal skill and call closure, including cultural competency.

We also use the call recordings to monitor Clinical Care Managers' ability to:

- Elicit information thorough presenting problem during initial reviews
- Identify contributing stressors the enrollee may be experiencing, so that we can help address the stressors in collaboration with the provider
- Develop an individualized treatment plan for each enrollee
- Gauge the enrollee's progress so that we are confident treatment is beneficial
- Focus not only on the enrollee's acuity, but on active time efficient treatment planning components so recovery is possible
- Ensure that multi-disciplinary discharge planning begins at time of admission
- Help the enrollee get treatment at the least restrictive level of care
- Help shape care, in collaboration with the provider, to ensure each enrollee is receiving the treatment that will help most

The NICE system offers a host of reports for individual staff, teams, or the entire call center. The reports can cover any period, any staff grouping, and staff member or call type. The reports provide detailed staff scoring data, client-specific scoring data, drill down on specific quality categories and data relative to staff members' score relative to our standards. We also use the reports to determine any additional training enhancements.

Customer Feedback Solution

We are committed to exceptional performance and service to Empire Plan enrollees when they are calling the toll free number. Consequently, we conduct post-call surveys at the conclusion of the call to collect real-time customer feedback that provides an all-encompassing view of the customer experience.

Our telecommunications system provides flexible and intelligent survey flow capabilities that direct the caller to relevant questions within the survey, based on the caller's response. The NICE customer feedback solution provides a direct link between the post-call survey and recorded customer interaction. The architecture and design of the system provides the tools for evaluating the customer experience, gaining insight by reviewing the recording of specific interactions, and conducting root cause analyses.

Results provide insight into caller interactions, and what determines caller satisfaction and dissatisfaction. They guide us in ensuring that our business processes are compatible with enrollee expectations. We also use them to ensure continuous improvement by providing our customer service and clinical staff with the most current information about call trends.

(b) FIRST CALL RESOLUTION RATE

In 2012, the first call resolution rate for our New York-based call center was 91.86 percent.

(c) STAFF TURNOVER

The following table lists ValueOptions' staff turnover across all of our call centers/at our New York-based call center in 2012:

Position	Turnover Rate
Call Center Supervisor	2.3%
Call Center Team Lead	0%
Customer Service Representative	2.3%
Referral Line Clinician	7.6%

(d) STAFF RATIO

The ratio of management and supervisory staff to call center representatives is 1:12. The ratio of call center representatives to enrollees is 1:65,000.

(e) STAFFING LEVELS

Number of Staff

The number of personnel we propose to assign to the Empire Plan program is noted in the following table.

Functional Area	Number of Staff
Account Services	5
Enrollment	5
Claims Processing	21
Clinical Management	31
Referral Line Clinicians (Clinical Care Managers)	8
Customer Service	22

Staffing Logic

We have perfected the logic for determining the appropriate call center staffing levels needed to maintain the level and quality of service enrollees receive from our Customer Service Representatives and Referral Line Clinicians. The key to meeting and exceeding our service level and response time objectives ultimately comes down to having the right people in the right place at the right time, supported by the right system resources. To accurately project staffing levels, our call center directors and managers evaluate call volume data and trends on a daily basis. Call center managers calculate the number of call center staff that are needed based on historical program data, hourly call volume, average call talk time, and established client and call center service levels.

We are committed to providing you with a “right sized” staff that will meet all program objectives and ensure the highest quality service to you and your enrollees. We develop our staffing plans based on our sophisticated staffing models used during program design. We also use our call management system reports and other information and inputs to ensure adequate staffing to meet and exceed program requirements.

(6) Describe the back-up systems for your primary telephone system which would be used in the event the primary telephone system fails, is unavailable or at maximum capacity. If a back-up system is needed, explain how and in what order calls from Enrollees will be handled. Confirm that backup staff will have MHSA Program specific training. Indicate the number of times the back-up system has been utilized over the past two (2) years. Confirm that calls will be handled exclusively by your Dedicated Call Center and that the backup call center would only be used in case of system failure or call overflow;

We confirm that all calls from Empire Plan enrollees will be handled exclusively by our Dedicated Call Center in Latham, and only in the event of a system failure or call overflow will calls be directed to a back-up call center.

BACK-UP SYSTEM FOR PRIMARY TELEPHONE SYSTEM

Through our experience managing call centers across the country, ValueOptions appreciates the importance of smooth service delivery and continuity in the event of planned or unplanned outages. We leverage the Call Management System that is part of our telecommunications platform to manage and analyze call patterns to determine peak call times and to manage staffing to meet contract requirements. As a result, we maintain a formal and comprehensive Business Continuity Plan that promotes minimal disruption of service in the event that a call center experiences a disaster or temporary closure. Although such incidents are very rare, it is vital to maintain a detailed plan so that all staff can quickly and decisively respond to any planned or unplanned incidents.

ValueOptions' central Avaya deployment enables toll free number calls destined for one service center to be rerouted to one or more other service centers should an issue occur to prevent calls being answered in the first service center (e.g., power outage, building evacuation, etc.). In such a circumstance, all incoming calls for the affected Service Center will be rerouted to active agents within five minutes.

Our Call Center will be pre-configured to automatically re-route calls in the event of an emergency. Our telecommunications infrastructure can seamlessly and instantaneously re-route blocked call traffic. This is accomplished by invoking our Network Call Redirect service. Network Call Redirect is the automatic re-route of your toll-free traffic by our long distance vendor when our system rings busy or there is a 'ring no answer.' This process is transparent to the customer. There is no down time.

For the Empire Plan program, any interruption of service in the primary call center will result in immediate routing of call to a back-up call center locations. Because telephony and data systems are fully integrated among all call centers, staff in the back-up location can quickly and easily serve callers by accessing their information in real-time.

In support of our Business Continuity Plan, 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 and then stored off-site at a secure, vaulted location.

Telecommunications Disaster Recovery

ValueOptions has designed its central Avaya architecture to ensure a resumption of call handling in the event that the primary central Avaya telephony platform, located in Reston Virginia, is suddenly and unexpectedly out of service.

ValueOptions has deployed a mirror image of its Avaya phone system, including peripheral services such as modular messaging and NICE Call Recording, in a hosted, premier data center in Richardson, Texas. This system is kept in hot-standby mode and with all system configurations automatically synchronized to the system in Reston. In the event of a catastrophic problem in Reston, Richardson can be handling all ValueOptions' telephony requirements within 30 minutes.

Staff Training

We confirm that staff members at the back-up center will be trained on the Empire Plan program, and will have access through our CONNECTS platform to enrollee and provider information. This will ensure a seamless service experience, with no loss of data or quality degradation. Back-up procedures are completely transparent to enrollees and providers, who continue receiving service delivery whatever the emergency outage.

Back-up System Use

During the past two years, we used our back-up system three times. These were all due to a storm-related incident and occurred within a two-day time period in the summer of 2012.

(7) Describe the information and capabilities your website provides to members and describe the process you will utilize to develop it. Confirm that you will develop a customize website for the MHSA Program. Also, confirm that the following information, at a minimum, will be available on the website: MHSA Program benefits, Network Provider locations, eligibility, Copayment information and claim status. Provide the URL of your main website and provide a dummy ID and password so that the Department may view the capabilities and user-friendliness of your website; and

We will develop a fully customized website for the MHSA program that will provide Empire Plan enrollees access to all required information. Enrollees will be able to seamlessly navigate from the Department's website via single sign-on.

We will 'private-label' and customize our Achieve Solutions website for the Empire Plan Program. This site will offer enrollees a rich and accessible source of articles, tips, and information about behavioral health issues. Enrollees can learn about healthy living skills,

disease prevention, and early intervention to make positive life decisions and improve their health.

The site contains content items including interactive multimedia and streaming content, Webinars, and articles. Achieve Solutions allows enrollees to connect with a Clinical Care Manager, or use the directory to locate providers.

Clients value access to Achieve Solutions because its content is:

- **Comprehensive:** We offer breadth and depth on topics, consider the different relationships affected by a topic, and equip the individual with information *and* tools.
- **Trusted:** We partner with experts (such as the University of Florida's McKnight Brain Institute, Boston College's Center for Work and Family, and the Stepfamily Association) to develop content, send content through a peer review process, and review and refresh content on a regular basis. Clinical content is reviewed annually; all other content is reviewed twice a year.

Achieve Solutions: 2012 Facts

- 250 client sites
- 8.2 million pages viewed
- English book-of-business: 227 topics, 7,269 content items
- Spanish book-of-business: 48 topics, 679 content items
- Most accessed pieces of content:
  - Depression Screening Quiz
  - Child and Family Help Lines
  - Understanding Pathological Liars
  - What Makes Marriage L*ast?*
  - Divorce and Grief

In addition, from the Achieve Solutions page, with one click enrollees will have access to MemberConnect, ValueOptions' secure member self-service Web portal. MemberConnect will provide enrollees with access to Empire Plan benefit plan-specific information. MemberConnect will allow them to:

- View eligibility
- Check authorization
- Check claims status
- Check claims history and claim payment
- View individual or family out of pocket expenses
- Set up Health Alerts for medication and appointment reminders
- Submit an inquiry to customer service

To view the capabilities and user-friendliness of our website, please go to www.achievesolutions.net/empire. No sign-on is required.

(8) Call Center Telephone Guarantees: For each of the four (4) Call Center Telephone Guarantees above, the Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fees, for failure to meet the Offeror's proposed guarantee;

[redacted]

(a) Call Center Availability:
The Standard Credit Amount for each .01 to .50% below the standard of ninety-nine and five-tenths percent (99.5%) that the Offeror's telephone is not operational and available to Enrollees, Dependents and Providers during the Offeror's Call Center Hours, calculated on an annual basis, is $100,000 per year. However, Offerors may propose higher or lesser amounts;

The Offeror's amount to be credited against the Administrative Fee for each .01 to .50% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed guarantee) that the Offeror's telephone line is not operational and available to Enrollees, Dependents and Providers during the Offeror's Call Center Hours calculated on an annual basis is $___ per year.

CALL CENTER AVAILABILITY

[redacted]

(b) Call Center Telephone Response Time:
The Standard Credit Amount for each .01 to 1.0% below the standard of at the least ninety percent (90%) of incoming calls to the Offeror's telephone line that is not answered by a customer service or Clinical Referral Line representative within thirty (30) seconds, is $25,000 a year. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) that is not answered by a customer service or Clinical Referral Line representative within thirty (30) seconds, calculated on an annual basis, is $_____ per year;

CALL CENTER TELEPHONE RESPONSE TIME

[redacted]

(c) Telephone Abandonment Rate:
The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service or Clinical Referral Line representative in excess of the standard of three percent (3%), is $25,000 per year. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service or Clinical Referral Line representative in excess of the standard of three percent (3%) (or the Offeror's proposed guarantee), calculated on an annual basis, is $____ per year; and

TELEPHONE ABANDONMENT RATE

[redacted]

(d) Telephone Blockage Rate:
The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line that are blocked by a busy signal, in excess of the standard of zero percent (0%), is $25,000 per year. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line that is blocked by a busy signal, in excess of the standard of zero percent (0%) (or the Offeror's proposed guarantee), calculated on an annual basis, is $_____ per year.

TELEPHONE BLOCKAGE RATE

[redacted]

Section 5: Enrollee Communication Support (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) All Enrollee communications developed by the Contractor are subject to the Department's review and prior written approval, including but not limited to any regular standardized direct communication with Enrollees or their MHSA Providers in connection with covered benefits or the processing of Enrollee claims, either through mail, e-mail, fax or telephone. The Department, in its sole discretion, reserves the right to require any change it deems necessary.	Yes
(2) The Contractor will be responsible for providing Enrollee communication support and services to the Department including, but not limited to: (a) Developing language describing the MHSA Program for inclusion in the NYSHIP General Information Book and Empire Plan SPD, subject to the Department's review and approval; (b) Developing articles for inclusion in Empire Plan Reports and other publications on an "as needed" basis, detailing MHSA Program benefit features and/or highlighting trends in MHSA utilization; (c) Timely reviewing and commenting on proposed MHSA Program communication material developed by the Department; (d) Developing timely and accurate Summaries of Benefits Coverage (SBC), which will be consolidated with coverage information from other Program carriers/third party administrators for The Empire Plan, Student Employee Health Plan and Excelsior Plan. The Department will post the SBCs on NYSHIP Online. Upon Enrollee request, the Contractor must direct Enrollees to the NYSHIP Online website to view the SBC or distribute a copy of the SBC to the Enrollee within the federally required time period; and (e) Paying a portion of the Shared Communication Expenses, the cost of all production, distribution and mailing costs incurred to disseminate Program communication materials to Enrollees. The Empire Plan's medical carrier/third party administrator will bill the Contractor on a quarterly basis for a portion of the Programs' Shared Communication Expenses. The Department agrees that these costs are not included in Administrative Fees and that the Contractor will be reimbursed for these costs as set forth in Article XV of Section VII of the RFP.	Yes
(3) Upon request, subject to the approval of the Department, on an "as needed" basis, the Contractor agrees to provide staff to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. The Contractor agrees that the costs associated with these services are included in the Offeror's Administrative Fee.	Yes

Section 5: Enrollee Communication Support (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(4) The Contractor must work with the Department to develop appropriate customized forms and letters for the MHSA Programs, including but not limited to Enrollee claim forms and certification letters. All such communications must be approved by the Department, in writing, prior to distribution.	Yes

(1) Please describe the organizational resources currently dedicated to Enrollee communications including any changes that would occur if you were awarded the resultant Agreement. Please detail the process that will be utilized to develop Enrollee communications including, but not limited to the role of the Offeror's legal department. Provide several examples of the MHSA Program communications you have developed for Enrollees. Confirm your understanding that all MHSA Program communications developed by the Offeror are subject to the Department's final approval.

ORGANIZATIONAL RESOURCES DEDICATED TO ENROLLEE COMMUNICATIONS

ValueOptions has a professional communications team that includes graphic designers, writers, and project managers. Our business model is to be an agent for our client's brand rather than our own. As such, we are accustomed to customizing enrollee materials and communications to meet the requirements and specifications of each of our customers. We will work with you in a collaborative manner to develop and execute a strategic communications plan that provides for enrollment materials, program materials, customized websites, and specialized communications. This strategic communications plan will be developed during the implementation phase so that a calendar of materials can be developed for the entire year. Given the depth of our marketing and communications team, we do not anticipate the need to make any changes to our current structure in order to support the Excelsior Plan, and the Student Employee Health Plan (The Empire Plan) needs.

PROCESS FOR DEVELOPING ENROLLEE COMMUNICATIONS

Our commitment is to provide accurate and engaging communications pieces to your enrollees. As indicated above, ideally we like to create a strategic communications plan for the entire year so that projects are initiated on a regular cycle and there is adequate time for Department input, review and modification, and approval. As part of our process, we will take direction from your team regarding the messaging, audience, and tone of the communications. Our team will then develop and present a Creative Brief which describes the overall messages, the key support points, the graphic treatments, and the proposed layout. This will be presented for your approval before actual production begins.

All communication materials undergo a clear and consistent editorial development and review process to ensure that the information is accurate and up-to-date. Our editorial staff looks for the following when developing, reviewing, or editing materials to ensure the content is presented in a reader-friendly manner:

- **Scannable Text**—Text is written in a manner that recognizes that many readers scan for information. Therefore, we use tactics such as meaningful headlines and subheads, bulleted lists, and call-out boxes to visually emphasize certain information.
- **Simple and Straightforward Graphics**—Information graphics, such as charts, maps, and diagrams, are developed to be simple and easy-to-read. They are intended communicate clearly, with a sense of purpose and elegance.

- **Audience Appropriateness**—We ensure materials are informative and easily understood by the targeted audience.
- **Respectful and Culturally Competent**—All materials are developed to ensure readability for individuals with varying levels of intellectual ability and education, and acknowledge the different cultural differences within the enrollee population.

All enrollee communications, from authorization letters to enrollee tip sheets, are reviewed for compliance and approved by the ValueOptions Legal Team prior to their use. Betsy Gant, ValueOptions Senior Corporate Counsel, will be a designated member of our Empire Plan Account Team and available to answer any legal questions that may arise.

Empire Plan Enrollee Communications

ValueOptions offers you a comprehensive suite of communication materials, available in multiple formats, to support the Empire Plan program. Our materials provide enrollees easy access to education and information in order to maintain their health and identify and access services in a timely and appropriate manner. They also are intended to enhance an enrollee's ability to prevent the onset or worsening of behavioral health issues. Our strategy for enrollee communication includes, but is not limited to:

- Customized communication materials customized for the Empire Plan such as welcome letters announcing the program; targeted transition-of-care letters for enrollees currently in treatment; newsletters; articles; brochures; tip sheets; and posters
- Support in developing Summary Plan Description language as well as regulatory updates, done in conjunction with our legal team
- Coordinating with your benefits department to schedule and present orientations to familiarize enrollees with program benefits and available resources

In addition, enrollees will have access to our award-winning behavioral health information library, Achieve Solutions. Enrollees will be able to seamlessly navigate from the Department's website via single sign-on, and we will 'private-label' and customize the Achieve Solutions website for the Department.

Achieve Solutions offers enrollees a rich and accessible source of articles, tips, and information about behavioral health issues. Enrollees can learn about healthy living skills, disease prevention, and early intervention to make positive life decisions and improve their health.

Achieve Solutions: 2012 Facts

- 250 client sites
- 8.2 million pages viewed
- English book-of-business: 227 topics, 7,269 content items
- Spanish book-of-business: 48 topics, 679 content items
- Most accessed pieces of content:
  - Depression Screening Quiz
  - Child and Family Help Lines
  - Understanding Pathological Liars
  - What Makes Marriage L*ast?*
  - Divorce and Grief

The site contains content items including interactive multimedia and streaming content, Webinars, and articles. Achieve Solutions allows enrollees to connect with a Clinical Care Manager, or use the directory to locate providers.

Clients value access to Achieve Solutions because its content is:

- **Comprehensive:** We offer breadth and depth on topics, consider the different relationships affected by a topic, and equip the individual with information *and* tools.
- **Trusted:** We partner with experts (such as the University of Florida's McKnight Brain Institute, Boston College's Center for Work and Family, and the Stepfamily Association) to develop content, send content through a peer review process, and review and refresh content on a regular basis. Clinical content is reviewed annually; all other content is reviewed twice a year.

In addition, from the Achieve Solutions page, with one click enrollees will have access to MemberConnect, ValueOptions' secure enrollee self-service web portal. MemberConnect will provide Empire Plan enrollees with access to Empire Plan benefit plan-specific information. MemberConnect will allow them to:

- View eligibility
- Check authorization
- Check claims status
- Check claims history and claim payment
- View individual or family out of pocket expenses
- Set up Health Alerts for medication and appointment reminders
- Submit an inquiry to customer service

OBTAINING DEPARTMENT APPROVAL ON ALL PROGRAM COMMUNICATIONS

We will work closely with you to design and implement policies, procedures, and protocols to maximize the effectiveness of our communication efforts. We will submit all proposed enrollee materials for feedback and approval in the format specified by the Department. We will also provide a plan for material distribution, and consult the Department to determine the most effective ways to accomplish this. We will never publish any materials intended for the enrollees without prior review and approval by the Department.

SAMPLE MHSA PROGRAM COMMUNICATIONS

Please see **Attachment 3** for copies of MHSA communication materials we have developed for enrollees.

(2) Describe the resources that will be available to the Department to support the Department's development of various Enrollee communications and your ability to provide input into such communications quickly.

Our Marketing and Communications department, which includes professional writers, editors, graphic designers, and communication specialists—is available to quickly and effectively develop customized communications for your enrollees. Our team of communication experts will be available during program implementation and throughout the life of the contract to assist the Department with the development of enrollee communication materials. Specifically:

- The ValueOptions communication team works closely with your dedicated account management team to customize enrollee collateral—including letters, posters, tip sheets and brochures.
- We have in-house design and fulfillment staff responsible for collateral conceptualization and execution. This team works with the Account Manager from the idea phase to printing phase.
- We consider the clients' internal branding and employee communications campaign as well as MHSA program goals when developing collaterals.
- We offer collateral in varying media formats, to augment our clients' existing program
- Our content specialists and graphic designers develop compelling collaterals that effectively describe enrollee benefits and encourage program participation.
- The Account Manager acts as the liaison to share drafts until the client is satisfied with the customized collateral.

Our account management team will also be available to meet the ongoing needs of the Department by sharing technical expertise on a range of topics related to the Empire Plan and further informing enrollees about the program. We are committed to providing the resources and experience needed for superior decision-making.

(3) Confirm that the Offeror will pay the allocated portion of Shared Communication Expenses covering the cost of all production, distribution and mailing costs incurred to disseminate Program communication materials to Enrollees on a timely basis, and will bill the MHSA Program for reimbursement in accordance with Article XV of the Agreement.

ValueOptions confirms that we will pay the allocated portion of Shared Communication Expenses covering the cost of all production, distribution, and mailing costs incurred to disseminate Program communication materials to Enrollees in a timely basis, and will bill the MHSA Program for reimbursement in accordance with Article XV of the Agreement.

(4) Confirm that staff will be available to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. Describe the experience and qualifications of staff that will be attending these events.

ValueOptions confirms that our staff assigned to the account management team for the Empire Plan will be available to attend Health Benefit Fairs, select conferences, and benefit design information sessions in NYS and elsewhere in the United States.

EXPERIENCE AND QUALIFICATIONS OF STAFF ATTENDING EVENTS

(5) Confirm your commitment to work with the Department to develop appropriate customized forms, letters and SBCs for the MHSA Program. Provide examples of how you have worked with other large clients to produce customized communications.

ValueOptions confirms our commitment to work with the Department to develop appropriate customized forms, letters, and SBCs for the MHSA program.

EXAMPLES

Branding and Marketing Development for Communications Client

ValueOptions played an important role in the branding, look and feel of a health engagement program developed by one of our clients in the communications industry. As part of this effort, we created the logo, working with the client's branding personnel to comply with company requirements, assisted in the conceptualization and creation of customized brochure and collateral materials, helped design a roll-out campaign, met with key representatives to discuss the branding and roll-out initiatives, and oversaw printing and fulfillment to include an initial home mailing of the brochure and collaterals.

The program was integrated within the company through multiple departments, locations, and different echelons of corporate management. This partnership is a creative example of integration that provides a strong identification for the program as well as enormous value for the

client's employees. This branding initiative has extended to include presentations to top management and consultation and assistance to management in preparing presentation materials for conferences.

Customized Materials for a Retail Chain Client

For a national retail chain client with more than 300,000 employees, we provide customized materials to seamlessly brand with their internal wellness brand. Every week we provide the client customized TV slides, which are displayed on television monitors in break rooms and elevators of the corporate office. The slides include various topics important to the organization as well as national topics, such as "May is Mental Health Month" and "October is Domestic Violence Awareness Month" and "September - National Alcohol and Drug Addiction Recovery Month."

We also provide customized, monthly fliers in PDF format. The client adds these to their store communication kits, which are distributed to each retail site. Each store has a Wellness Champion who distributes the materials and helps promote the program. Fliers are meant to raise awareness on service offerings, such as depression awareness. We also provide content for their internal employee communications campaigns and ads in their internal employee magazine to promote program awareness. The magazine is delivered to the member's home.

(6) Confirm that upon Enrollee request, the Offeror will distribute SBCs to Enrollees in a timely manner.

ValueOptions confirms that upon enrollee request, we will distribute SBCs to enrollees in a timely manner.

The selected Contractor will be responsible for the maintenance of accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the Department. These enrollment files shall be used by the Contractor to process claims, provide customer service, identify individuals in the enrollment file for whom Medicare is primary, and produce management reports and data files. The Contractor must provide enrollment management services including but not limited to:

Section 6: Enrollment Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) Initial Testing: (a) Performing an initial enrollment load to commence upon receipt of the enrollment file from the Department during the MHSA Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or 834 (005010x220)), fixed length ASCII text file, or a custom file format. The determination will be made by the Department; (b) Testing to determine if the enrollment file and enrollment transactions loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The Contractor shall submit enrollment test files to the Department for auditing, provide the Department with secure, online access required to ensure accurate loading of the MHSA Program enrollment data, and promptly correct any identified issues to the satisfaction of the Department;	Yes
(2) Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions fully loaded to the claims processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Contractor shall immediately notify the Department of any delay in loading enrollment transactions. In the event the Contractor experiences a delay due to the quality of the data supplied by the Department, the Contractor shall immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will release enrollment changes to the Contractor in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a twenty-four (24) hour period. The Contractor must be capable of loading both files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 transaction set in the format specified by the Department. The latest transaction format is contained in Exhibit II.H. The Contractor must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required;	Yes

Section 6: Enrollment Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(3) Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee data contained in the enrollment file. Any transfers of enrollment data within the Contractor's system or to external parties must be completed via a secured process;	Yes
(4) Providing a back-up system or have a process in place where, if enrollment information is unavailable; Enrollees can obtain Clinical Referral Line services without interruption;	Yes
(5) Cooperating fully with any State initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement;	Yes
(6) Maintaining a read only connection to the NYBEAS enrollment system for the purpose of providing the Contractor's staff with access to current MHSA Program enrollment information. Contractor's staff must be available to access enrollment information through NYBEAS, Monday through Friday, from 8:00 am to 5:00 pm, with the exception of NYS holidays as indicated on the Department's website;	Yes
(7) Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Contractor must make payment for covered benefits or reimbursement directly to such party. The Contractor will be required to store this information in its system(s) so that any claim payments or any other plan communication distributed by the Contractor, including access to information on the Contractor's website would go to the person designated in the QMCSO; and	Yes
(8) Enrollment Management Guarantee: The Contract must guarantee that one hundred percent (100%) of all MHSA Program enrollment records that meet the quality standards for loading will be loaded into the Contractor's enrollment system within twenty-four (24) hours of release by the Department.	Yes

(1) Describe your testing plan to ensure that the initial enrollment loads for the MHSA Program are accurately updated to your system and that they interface correctly with your claims system.
   (a) What quality controls are performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system?
   (b) How does your system identify transactions that will not load into your enrollment system? What exceptions will cause enrollment transactions to fail to load into your enrollment system? What steps are taken to resolve the exceptions, and what is the turnaround time for the exception records to be added to your enrollment file?

We conduct rigorous testing during the development lifecycle and system readiness process during which we will accept and transmit test files with the Department. If an error is detected, the issue is documented in our development lifecycle library, which then triggers an alert to the programmer or business analyst that an issue needs to be resolved. Once resolved, testing continues and the fix/repair cycle is repeated until you have approved the test results. No data is released into our production environment until all the data transmissions are accepted and approved by the Department.

(a) QUALITY CONTROLS

Once the enrollment data is received by ValueOptions, it is loaded into the system, basic data integrity checks are performed to ensure that the Empire Plan-specific rules will be processed against the data. Eligibility Specialists initiate the process of loading eligibility files received from the Empire Plan to the CONNECTS platform through ValueOptions' EligibilityConnect module. If the enrollment file has an error rate greater than two percent (> 2%), the process is automatically halted for manual review. An Eligibility Specialist will investigate the records that are in error and determine if an update can be made to the translation processes that would then allow the enrollment records to load automatically. The data translation processes are defined in system crosswalk tables. Once this investigation and all applicable updates to the crosswalks are completed, the file will be re-initiated to complete processing. If the file has an error rate less than two percent (< 2%), the file will continue processing to completion and the records in error will be worked once the file has been loaded. The EligibilityConnect module also has a recycle feature for erroneous records. Once an error on a record has been resolved it can be recycled back through the EligibilityConnect module for automatic updating of the Empire Plan's information.

(b) TRANSACTIONS THAT FAIL TO LOAD

Our Enrollment Import program generates a detailed error report as a result of processing files on our CONNECTS platform prior to updating the enrollment data in the system. The errors are programmatically divided between internal errors and client-related errors, such as missing or invalid required data elements. Some examples of required data elements include name, DOB, address, member ID and other client-specific information defined during implementation. The

client errors are sent via email to your designated contact for resolution. The internal errors are reviewed and processed with an update of the file to the system. Errors are generally reviewed on a daily basis in order to be rectified prior to the next file load.

(2) Describe your system capabilities for retrieving and maintaining enrollment information within twenty-four (24) hours of its release by the Department as well as;
- (a) How your system maintains a history of enrollment transactions and how long enrollment history is kept online. Is there a limit to the quantity of history transactions that can be kept on-line?
- (b) How your system handles retroactive changes and corrections to enrollment data;
- (c) Detail how your enrollment system captures the information necessary to produce the reports entitled “Claims and Credits Paid by Agency” and “Quarterly Participating Agency Claims” required in the Reporting Section of this RFP;
- (d) Confirm your enrollment and claims processing system has the capacity to administer a social security number, Employee identification number and an alternate identification number assigned by the Department. Does your system have any special requirements to accommodate these three identification numbers? Explain how Dependents are linked to the Enrollee in the enrollment system and claims processing system;

We are able to successfully transmit and accept all files according to the schedules defined and agreed upon with our clients and their vendors. All of our data exchange procedures include development and support capabilities, such as error correction and reporting, data cleansing, and tracking and performance metrics. Where applicable, we also support HIPAA transaction formats and have the ability to develop client-customized data exchanges.

Enrollment data will be accepted daily and our commitment is to ensure enrollment within 24 hours of receipt. To initiate the Empire Plan contract, the initial eligibility data is a verify (full audit) population file. For the continued periodic eligibility updates (daily, weekly, monthly), we prefer change (update) or “transaction only” (add, change, termination, delete) files. However, we can perform verify (full audit) or total-population refresh updates as required. ValueOptions recommends weekly change (update) files with quarterly verify (full audit) files.

(a) HISTORY OF TRANSACTIONS

Enrollment history is stored for each enrollee and is used in determining eligible dates of service. All enrollment updates include: date processed, transaction type, effective date, group number, category, type of contract, and Coordination of Benefits information. These are maintained and accessible online via secure portal.

Historical enrollment segments are built at the time the file updates and are maintained in chronological order throughout the life of the contract. We will not purge or delete any data unless you specifically request us to do so. There is no limit to the quantity of historical transactions our system is able to maintain. The flexibility of our system allows us access to data and the ability to research issues at any time regarding past eligibility transactions such as changes in enrollee eligibility.

(b) RETROACTIVE CHANGES

Retroactive dates are acceptable and claims can be processed when eligibility data is available. If the claim is denied because eligibility has not been determined, the provider can re-submit the claim for payment according to the guidelines in the ValueOptions Provider Agreement. Claims history is also stored, linking all claims to the enrollee.

(c) INFORMATION CAPTURE FOR REPORTS

Our enrollment system captures all of the detail necessary to support the development of the reports entitled "Claims and Credits Paid by Agency" and "Quarterly Participating Agency Claims." Our reporting system draws upon our CONNECTS platform which maintains the level of detail requested. ValueOptions' eligibility and claims information is integrated within our CONNECTS platform, in our membership eligibility and enrollment module. This module interacts with references, benefits, contracts, groups, claims, providers, authorizations, and utilization during the adjudication process to ensure eligibility of an enrollee entering treatment.

Our CONNECTS platform unifies all functions to ensure payment is consistent with participation requirements, including benefit design, claims, eligibility, care management, financial management, provider maintenance, customer inquiries, reporting and others.

(d) ENROLLMENT AND CLAIMS PROCESSING CAPACITY

ValueOptions confirms that our eligibility system has the capacity to administer a SSN, an EIN, or an alternate identification number assigned by the Department. The eligibility module, EligibilityConnect, interacts with references, benefits, contracts, groups, claims, providers, authorizations, and utilization during the claim adjudication process to ensure eligibility of an enrollee entering treatment. Within EligibilityConnect, we are able to store a SSN, a member ID, alternate IDs, demographic data, data on primary care providers (PCPs), and coordination of benefits information. In addition, our systems can accommodate as many effective dates and termination dates as needed to indicate changes in coverage, group assignment, benefit package selection, or COB data. Our system also has the ability to link family members by assigning each family member with the same ID and a 2 digit suffix in order to distinguish each member of the family as a separate record.

During claims adjudication, the enrollee's eligibility is validated, and if the date of service on the claim is after the enrollee's termination date, the claim is denied with the reason "The enrollee is not covered for the date of service." When an eligibility discrepancy exists, or there is a question regarding the termination date for an enrollee, an electronic inquiry is pended to ValueOptions' National Eligibility unit.

(3) Describe how your enrollment system, data transfers, and procedure for handling enrollment data are HIPAA compliant.

Our secure infrastructure has built-in interfaces allowing our clients, providers, and third party trading partners to transfer data securely and accurately. The CONNECTS platform is compliant with HIPAA electronic transactions and we have fully remediated the enrollment/dis-enrollment transaction (834) and all other HIPAA-defined transactions (e.g. 837I and 837P). Our FileConnect application is designed for the interchange of electronic data files with network providers, clients, business partners or associates via secure Internet connections.

All of our data exchange procedures include development and support capabilities, such as error correction and reporting, data cleansing, tracking and performance metrics. Where applicable, we also support HIPAA transaction formats and have the ability to develop client-customized data exchanges. Only secure transmission methods are used between our CONNECTS platform and management information systems maintained by our clients and our providers. Transactions and queries submitted by providers and members through ProviderConnect and MemberConnect are via a secure Internet connection.

In addition, our system has the following HIPAA compliant capabilities:

- Access to CONNECTS is granted only after a proper electronic security access request is reviewed and approved by our IT Security official.
- CONNECTS includes role-based security, which allows employees access only to selected functions based on their job requirements. The National IT staff developed the logic required to map role-based access to specific job titles as defined by our Human Resources Department. Proper security configurations were then added to CONNECTS security screens.
- The Security Plan addresses operations security environment concerns on a wide range of topics such as virus protection, intrusion detection, incident reporting and response, disaster recovery and contingency planning and network security firewalls.
- Because our company develops and maintains its own software applications, security concerns regarding the system life cycle and configuration management are addressed.
- To control PHI distribution and meet confidentiality and security requirements, our company implemented an enterprise-wide secure e-mail capability, which we also offer to our providers and clients upon request.

(4) Describe the backup system, process or policy that will be used to ensure that Enrollees receive Clinical Referral Line services in the event that enrollment information is not available.

If an Empire Plan enrollee calls our Clinical Referral Line and we are unable to confirm his/her enrollment information during the call, our Clinical Care Manager will continue to engage the caller as he/she would an enrollee whose information was confirmed in our system. An

assessment and referral would take place for the caller with enrollment information verified after the fact via the New York Benefits Eligibility and Accounting System.

(5) Confirm you will cooperate fully with any State initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement.

ValueOptions confirms that we will cooperate fully with the Department and any State initiatives designed to improve technology and processes related to enrollment data. We will perform ongoing technology assessment reviews to uncover improvement opportunities which aid in the attainment of our strategic goals and those of the Empire Plan.

We control all data exchange development and system modifications with a formal change management (CMP) process. It facilitates partnering with clients throughout the software development lifecycle to prioritize and rapidly deliver needed system changes. This process helps control, prioritize and streamline the delivery of changes and customizations to our information technology products and services. It is also a standardized, effective and efficient process to prioritize and fulfill system enhancements and software upgrades

Prior to any data exchange changes being executed in our production environment, ValueOptions will require the Empire Plan to sign-off on all design specifications, participate in testing and render sign-off on testing cycles. This process is key to a successful implementation of the data exchanges.

(6) Confirm that you will maintain a read only connection to the NYBEAS enrollment system, and that Offeror's staff will be available to access enrollment information through NYBEAS during the required hours, Monday through Friday, from 8:00 AM. to 5:00 PM., with the exception of NYS holidays.

We confirm that we will maintain a read only connection to the NYBEAS enrollment system, and that only ValueOptions staff will have access to enrollment information through NYBEAS during the required hours.

(7) Describe your ability to meet the administrative requirements for National Medical Support Orders and dependents covered by a Qualified Medical Child Support Order (QMCSO), including storing this information in your system so that information about the Dependent is only released to the individual named in the QMCSO.

Our fully-integrated system allows us to store all demographic information from the enrollment file which is used for all correspondence, inquiry tracking, clinical notes, authorizations, and claims. Dependent records identified in the enrollment file which are covered by a Qualified Medical Child Support Order (QMCSO) can be flagged so that information about the enrollee is only released to the individual named in the QMCSO.

(8) Enrollment Management Guarantee: The MHSA Program service level standard requires that one hundred percent (100%) of all MHSA Program enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the standard.

The Standard Credit Amount for each 24 hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the MHSA Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $5,000. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each twenty-four (24) hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the MHSA Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system, is $_____ .

ENROLLMENT MANAGEMENT GUARANTEE

[redacted]

The Contractor will be responsible for accurate reporting services including, but not limited to:

Section 7: Reporting (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) Ensuring that all financial reports including claim reports are generated from amounts billed to the MHSA Program, and reconcile to amounts reported in the quarterly and annual financial experience;	Yes
(2) Developing, in conjunction with the Department, standard electronic management, financial, and utilization reports required by the Department for its use in the review, management, monitoring and analysis of the MHSA Program. These reports must tie to the amounts billed to the MHSA Program. The final format of reports is subject to the Department review and approval;	Yes
(3) Supplying reports in paper format and/or in an electronic format including but not limited to Microsoft, Access, Excel and/or Word as determined by the Department. The reports include, but are not limited to, reports and data files listed in Article XVI "Reports and Claim Files" section of this Agreement;	Yes
(4) Providing Ad Hoc Reports and other data analysis at no additional cost. The exact format, frequency, and due dates for such reports shall be specified by the Department. Information required in the Ad Hoc Reports may include but is not limited to providing: (a) Forecasting and trend analysis data (b) Utilization data (c) Utilization review savings (d) Benefit design modeling analysis (e) Reports to meet clinical program review needs (f) Reports segregating claims experience for specific populations (g) Reports to monitor Agreement compliance	Yes
(5) Providing direct, secure access to the Contractor's claims system and any online and web-based reporting tools to authorized Department representatives;	Yes
(6) Management Reports and Claim File Guarantees: The Contractor must provide accurate management reports and claim files as specified in Section IV.B.7.a.(7) of this RFP will be delivered to the Department no later than their respective due dates inclusive of the date of receipt; and	Yes
(7) Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed under Annual, Quarterly and Monthly Reports and include the time frames for submittal to the Department:	Yes
Annual Reports	
Annual Financial Experience Report: The Contractor must submit an annual experience report of the MHSA Program's charges and credits no later than seventy-five (75) Days after the end of each	Yes

Section 7: Reporting (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
Calendar Year. This statement must detail, at minimum, claims paid during the year, projected incurred claims not yet paid administration costs, performance credits, audit credits, etc. Such detail must include all charges by the Contractor to the MHSA Program;	
Annual Premium Renewal Report: The Contractor must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This report must detail all assumptions utilized to support recommended premium level necessary for the following Plan Year. The report must include, but not be limited to: paid claim amounts, projected incurred claims, trend, Administrative Fees and changes in enrollment;	Yes
Annual Summary Reporting: The Contractor must prepare and present to the Department, GOER, Division of Budget and NYS employee unions an annual report that details MHSA Program performance and industry trends. This presentation shall include, at a minimum, comparisons of the MHSA Program to book of business statistics, and other similar plan statistics. Clinical, financial and service issues are to be comprehensively addressed. The annual presentation and report is due each May after the end of each complete Calendar Year;	Yes
Annual Report of Claims and Credits Paid by Agency: The Contractor must submit a report with summary level claims and credits paid by agency. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. The report is due thirty (30) Days after the end of the Calendar Year;	Yes
Quarterly Reports	
Quarterly Financial Summary Reports: The Contractor must submit quarterly financial reports which present the MHSA Program's experience for the most recent quarter (based on a Calendar Year) and the experience from the beginning of the Calendar Year to the end of the quarter being reported. The quarterly reports must also include projections of: • annual financial performance; • assessment of MHSA Program costs; • incurred claim triangles; • audit recoveries; • settlement and litigation recoveries; • administrative expenses; • trend statistics; and • such other information as the Department deems necessary. The reports are due on a quarterly basis, fifteen (15) Days after the end of the reporting period;	Yes
Quarterly Performance Guarantee Report: The Contractor must submit quarterly the MHSA Program's Performance Guarantee report that details the Contractor's compliance with all of the	Yes

Section 7: Reporting (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
Contractor's proposed Performance Guarantees. The report should include the areas of: Implementation, customer service (telephone availability, telephone response time, abandonment rate and blockage rate); enrollment management, reporting, network composition, provider access, provider credentialing, financial and non-financial accuracy, turnaround time for processing network and non-network claims, non-network Clinical Referral Line, emergency care Clinical Referral Line, urgent care Clinical Referral Line outpatient and inpatient Utilization Review; and inpatient and outpatient appeals. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter;	
Quarterly Utilization Report: The Contractor must submit quarterly the MHSA Program's Quarterly Utilization Report that details MHSA care utilization by type of service for both network and non-network authorizations, by type of treatment (inpatient, outpatient, ALOC) Applied Behavioral Analysis, collective bargaining unit, age of the member, type of Dependent, and any other category as requested by the Department. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. The report is due forty-five (45) Days after the end of the quarter;	Yes
Quarterly Network Access: The Contractor must submit a measurement of the Network access (using Exhibit I.Y.3) based on a "snapshot" of the network taken on the last day of each quarter. The report is due thirty (30) Days after the end of the quarter;	Yes
Quarterly Coordination of Benefit Report: The Contractor must submit a report that details the amount received as a result of coordinating benefits with other health plans including Medicare. The Contractor's report should identify the COB source, the Enrollee, the original claim amounts, and the amount received from the other insurance carriers or Medicare. The final format of this report will be determined by the Department in consultation with the Contractor. The report is due thirty (30) Days after the end of the quarter;	Yes
Quarterly Participating Agency Claims: The Contractor must submit a quarterly report that presents summary level claim information by Participating Agency. The Contractor shall submit this report using the data elements specified by the Department in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the quarter;	Yes
Quarterly Website Analytics Report: The Contractor must submit a quarterly report that provides comprehensive performance information for the Contractor's customized MHSA Program website as set forth in Section IV.B.4.a.(7) of this RFP. The report must include summarized and detailed website performance information and statistics, as well as proposed modifications to the	Yes

Section 7: Reporting (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
layout and design of the website to improve communications with Enrollees. The report is due thirty (30) Days after the end of the quarter;	
Quarterly Provider Audit Report: The Contractor must submit a quarterly audit report to the Department that summarizes audits planned, initiated, in-progress and completed, as well as audit findings, recoveries and any other enforcement action by the Contractor. The report is due thirty (30) Days after the end of the quarters.	Yes
Monthly Reports	
Monthly Report of Paid Claims by Month of Incurral: The Contractor must submit a monthly report that provides summarized paid claims by month of incurral. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month;	Yes
MHSA Program Customer Service Monthly Reports: Each month the Contractor must submit a customer service report that measures the Contractor's customer service performance including call center availability, call center telephone response time, the telephone abandonment rate, the telephone blockage rate, claims processing, enrollment, and claims turnaround. The final format of these reports will be determined by the Department in consultation with the Contractor. The reports are due fifteen (15) Days after the end of the month. For the first two months of the Agreement, these reports will be due on a weekly basis. After two months, the Department will re-examine the required frequency of these reports and establish due dates with the Contractor; and	Yes
Monthly/Periodic Reports Detailed Claim File Data: The Contractor must transmit to the Department and/or its Decision Support System (DSS) Vendor a computerized file via secure transfer, containing detailed claim records using data elements acceptable to the Department to support the claims processed each reporting period and invoiced to the Department. The Department requires that all claims processed and/or adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the MHSA Program. The Contractor must securely forward the required claims data to the Department and/or its DSS vendor within fifteen (15) Days after the end of each and submit a summarized report by month utilizing a format acceptable to the Department.	Yes

(1) The Offeror must submit examples of the financial and utilization reports that have been listed without a specified format in the reporting requirements above as well as any other reports that the Offeror is proposing to produce for the Department to be able to analyze and manage the MHSA Program. Provide an overview of your reporting capabilities with the value you believe this will bring to the MHSA Program.

ValueOptions' clients benefit from our comprehensive suite of reporting options, developed through our experience working with employer, health plan, and government clients. Our reporting emphasizes timely access to data, transparency of program and performance information, and an emphasis on actionable information. We confirm that we will provide the Department all required reports outlined in the RFP, in the frequency specified, and have submitted examples of such reports as **Attachment 4**. Our reporting system also allows for easy access to ad hoc reports as may be requested by the Department to make informed decisions about the Empire Plan Program.

Our reporting suite relies on our integrated CONNECTS technology platform. It provides access to concise data to support informed decisions, program administration, and comparison across our book-of-business, as well as industry norms. In our experience, this has translated into improved service for our clients, increased capacity for clients to make data-driven decisions, and the ability to intervene early and effectively should problems arise.

Our financial system, FinanceConnect, is fully integrated within our overall technology platform and enables us to manage and report on all financial aspects of the Empire Plan in an efficient and effective manner. FinanceConnect is based on an Oracle general ledger/accounts payable system and is supported by a Hyperion reporting system. It provides a robust account structure that supports full cost accounting including appropriate capture and reporting of direct, indirect, general, and administrative costs. It also provides for the accumulation of contract-level detail as well as the overall aggregation of financial data.

In addition to the required monthly, quarterly, and annual reports, we offer additional data as part of your reporting package including utilization, claims, network access, website utilization, and customer service. Examples of the types of information captured in our system from which we can report include:

- Normalized levels of care (enables enterprise-wide reporting)
- Major diagnostic groupings (enables summarization and enterprise reporting)
- Membership information (provides accurate per 1,000 and per member per month calculations)
- Book-of-business utilization statistics
- Satisfaction survey information

As evidenced during our tenure as the MHSA provider for the Empire Plan, our comprehensive reporting capabilities will enable us to provide each of the requested reports within the timeframes required by the Department.

(2) Confirm that you will provide reports in the specified format (paper and/or electronic Microsoft Access, Excel, Word), as determined by the Department;

We confirm that we will provide reports in the specified format (paper and/or electronic Microsoft Access, Excel, Word), as determined by the Department.

(3) Confirm that you will provide direct, secure access to your claims system and any online and web-based reporting tools to the Department's offices. Include a copy of the data sharing agreement you propose for Department staff to execute in order to obtain systems access;

We confirm that we will provide direct, secure access to our claims system and our online Web-based reporting and analytics solutions, IntelligenceConnect, to the Department's offices.

Our business information capabilities are built on the premise that decision makers should have daily, direct access to the data and information that supports informed choices about their program. To that end, we offer the Department access to real-time program data 24 hours a day, seven days a week, through IntelligenceConnect. Available to you from a desktop or deployed via mobile solutions such as smartphones, iPads, and other tablets, IntelligenceConnect is a suite of interactive dashboards and Web intelligence reports that will enable you to identify trends that may not be readily apparent within a hard copy report. This trending capability creates an important level of transparency through real-time data access.

During implementation, we will customize our reporting solutions specific to your needs and the data that will be most meaningful to you. A sample dashboard is provided on the following page:

Key Metric Indicators (KMIs)

IntelligenceConnect presents each client's Key Metric Indicators (KMIs) in clear, uncomplicated graphics. By pointing and clicking on the KMIs, IntelligenceConnect allows the user to conduct a variety of analyses, including but not limited to trending by month; utilization by specific location; book of business comparisons to both ValueOptions' total client base and NAIC codes; and client-level as well as client-defined sub-groups.

Drill-Down Function

The various menus at the top allow the user to dynamically render all gauges and pie charts based on their selections in level of care, client divisions, diagnosis type and time frame. Clicking on any pie slice will also present users with a drill-down report showing more detailed data specific to their selection. Selecting the trending option will present users with a utilization trending dashboard that allows them to select the time interval of the trend and the measure, and the user can include either the ValueOptions or NAIC specific book of business data (in addition to the previously mentioned level of care, diagnosis type and client division menus).

Please see **Attachment 5** for a copy of the data sharing agreement we propose for Department staff to execute in order to obtain systems access

(4) Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that you have performed for other clients.

We confirm that we are able and willing to provide ad hoc reports and other data analysis. However, as mentioned above, our standard reporting package most often provides all of the information our clients need to evaluate program utilization and effectiveness. Please see **Attachment 6** for a sample ad hoc report we prepared for another client.

(5) Management Reports and Claim File Guarantees: The MHSA Program's service level standard requires that accurate management reports and claims files will be delivered to the Department no later than their respective due dates. For the management reports and claim files listed in Section IV.B.7.a. (7) of this RFP, the Offeror must propose a performance guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this standard.

The Standard Credit Amount for each management report or claim file that is not received by its respective due date is $1,000 per report per each Business Day. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the MHSA Program's Administrative Fee for each management report or claim file that is not received by its respective due date, is $_____ per report for each Business Day between the due date and the date the accurate management report or claims file is received by the Department inclusive of the date of receipt.

MANAGEMENT REPORTS AND CLAIM FILE GUARANTEES

[redacted]

The Contractor will be responsible for providing advice and recommendations regarding the MHSA Program. Such responsibility shall include, but not be limited to:

Section 8: Consulting (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) Informing the Department in a timely manner concerning such matters as cost containment strategies, technological improvements, Provider best practices and State/Federal legislation (e.g., Federal parity legislation, etc.) that may affect the MHSA Program. The Contractor must also make available to the Department one or more members of the clinical or account management team to discuss the implications of new trends and developments. The Department is not under any obligation to act on such advice or recommendation; and	Yes
(2) Assisting the Department with recommendations and evaluation of proposed benefit design changes and implement any changes necessary to accommodate MHSA Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed MHSA Program modifications and contemplated benefit design changes on Enrollees. In the event of a design change and should the Offeror request any change in compensation, any such change will be processed in accordance with Section V of this RFP.	Yes

(1) What resources do you utilize to ensure the MHSA Program is kept abreast of the latest developments in the MHSA field? How do you propose to communicate trends, pending legislation and industry information to the MHSA Program?

We will engage subject matter experts throughout our organization to ensure the Department is kept up-to-date on trends, pending legislation, and other information relevant to the Empire Plan MHSA Program. Our Empire Plan Team is comprised of professionals in the areas of account management, clinical operations, legal, accounting, actuarial, claims, customer service, utilization management, and provider relations.

ValueOptions maintains a dedicated group of professionals at the corporate level responsible for evaluating industry trends, technological advances, and prioritization around product development and product enhancement needs. This group evaluates emerging markets and opportunities to proactively support our customers on a variety of issues impacting behavioral health. In addition, ValueOptions' leadership is active in the behavioral health management community speaking at multiple venues and national and global conferences on behavioral health issues impacting health plans, employers, and the general public. We have identified our Senior Account Executive, Jennifer Campione, as the lead account executive if we are awarded the Empire Plan, Excelsior Plan, and the Student Employee Health Plan (The Empire Plan) account. Through Ms. Campione, we will communicate information to support the Empire health plan. Examples of issues in which we have provided guidance and support to our clients have included such topics as:

- Mental health parity
- ERISA benefit designs
- National strategy on suicide prevention
- Autism and ABA benefit management and design
- Pandemic preparedness
- New drug concerns, e.g. synthetic drugs and impact on young adults
- Generational program promotion and communication strategies

In addition, the Department will not only receive updates on industry information relevant to the Empire Plan at regularly scheduled quarterly meetings, but also periodically as time-sensitive updates are warranted; for instance, providing guidance on the final parity rules once they are in effect.

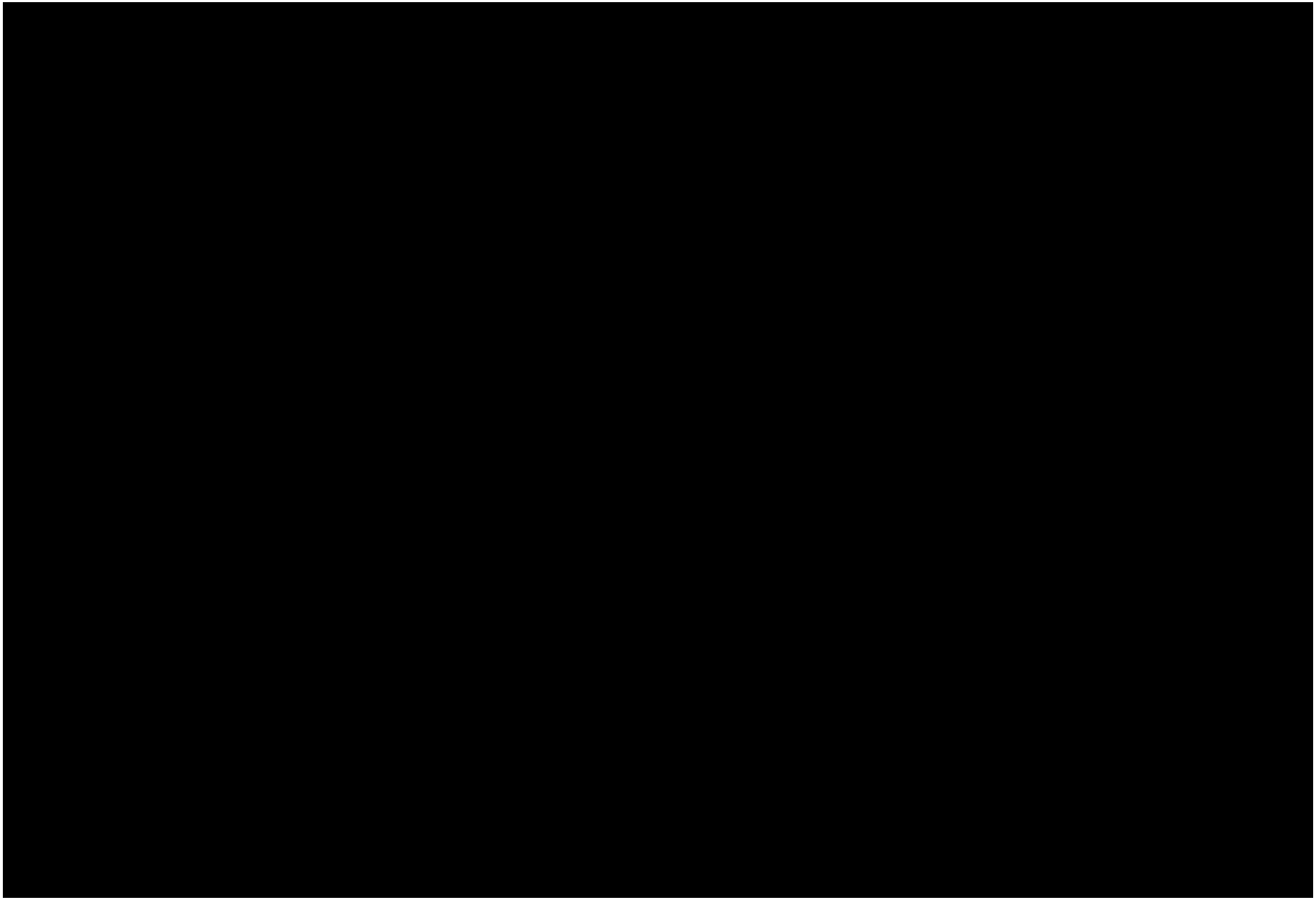
With support from ValueOptions' local and national experts, we will support the Department and communicate trends and new industry information on a variety of topics, including:

- Benefit design
- Organizational development
- Risk management strategies
- Behavioral health care industry trends

- Technological advancements
- New treatment options being offered in the field
- New medications on the market for behavioral health conditions

We also propose to conduct meetings twice a year to discuss emerging topics of interest to the Department in areas such as legal, clinical, actuarial, and plan design. Ms. Campione will work with you to develop the agenda for these meetings, and ValueOptions thought leaders and senior executives will be available to attend, present, and/or participate as requested.

The breadth of ValueOptions' Empire Plan Account Team is depicted in the organizational chart on the following page:



Throughout the life of our partnership, we will work hand-in-hand with you to ensure that we incorporate the Department's needs and requirements into the structure and management of the Empire Plan behavioral health program.

Additionally, we will invite the Department to rejoin our Corporate Customer Group (CCG). When previously a part of this group, the Department worked hand-in-hand with ValueOptions to optimize the value of the member companies' investments in employee mental health and substance abuse benefits administered by ValueOptions. The interface between the CCG and ValueOptions is advisory in nature. The goal is to promote excellence in clinical services, research, and operation. Activities of CCG include:

- Exchanging ideas and experience relating to the use of mental health/substance abuse benefits to enhance the ability of ValueOptions clients to more effectively manage their benefit and human resources
- Assisting and encouraging ValueOptions—through the cooperative efforts of CCG members—to develop, enhance and effectively deliver products and services that support the efforts of CCG members to more effectively manage their benefit and human resources
- Learning about ValueOptions' short and long-term strategic directions, new products or services, and plans for future product or service enhancements
- Ensuring that ValueOptions' efforts to develop and enhance products and services are in line with the strategic objectives of ValueOptions' clients for improving mental health/substance abuse services available to enrollees
- Ensuring that ValueOptions is taking all appropriate steps to minimize increases in the cost of services/benefits while at the same time maximizing the quality of providers and their services
- Ensuring that ValueOptions' senior management is apprised of specific client feedback through various feedback processes

Our ultimate goal will be to share information and expertise with the Department and the public employee unions resulting in improved care and service delivery, quality outcomes, cost savings and enrollee satisfaction. We would welcome the chance to work with the Department in this capacity again.

(2) Please confirm you will assist the Department with recommendations and evaluation of proposed benefit design changes and implement any changes necessary to accommodate Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State.

ValueOptions confirms that we will assist the Department with recommendations and evaluation of proposed benefit changes and implement any changes necessary to accommodate Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State.

Section 9: Transition and Termination of Agreement (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) The Contractor must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the MHSA Program;	Yes
(2) The Contractor must, within one hundred twenty (120) Days prior to the end of the Agreement, or within forty-five (45) Days of notification of termination, if the Agreement is terminated prior to the end of its term, provide the Department with a detailed written transition plan, which outlines, at a minimum, the tasks, milestones and deliverables associated with: (a) Transition of MHSA Program data, including but not limited to a minimum of one year of historical Enrollee claim data including providers' telephone numbers, names, addresses, zip codes and tax identification numbers, detailed COB data, report formats, pre-certification/prior authorization, approved - through dates, disability determination approved-through dates, any exceptions that have been entered into the adjudication system on behalf of the Enrollee, as well as other data the successor contractor may request and the Department approves during implementation of the MHSA Program in the format acceptable to the Department. The transition or pre-certification/prior authorization files should include but not be limited to the following; (i) Providing a test file to the successor contractor in advance of the implementation date to allow the successor contractor to address any potential formatting issues; (ii) Providing one or more pre-production files at least four 4 weeks prior to implementation that contains pre-certification/prior authorization approved - through dates and one year of claims history as specified by the Department working in conjunction with the successor contractor; (iii) Providing a second production file to the successor contractor by the close of business January 2nd (or 2 days after the Agreement terminates) that contains all pre-certification/prior authorization approved – through dates specified by the Department working in conjunction with the successor contractor.	Yes
(3) Within fifteen (15) Business Days from receipt of the Contractor's proposed Transition Plan, the Department shall either approve the Transition Plan or notify the Contractor, in writing, of the changes required to the Transition Plan so as to make it acceptable to the Department;	Yes
(4) Within fifteen (15) Business Days from the Contractor's receipt of the required changes, the Contractor shall incorporate said changes into the Transition Plan and submit such revised Transition Plan to the Department;	Yes
(5) The Contractor shall be responsible for transitioning the MHSA Program in accordance with the approved Transition Plan;	Yes

Section 9: Transition and Termination of Agreement (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(6) To ensure that the transition to a successor contractor provides Enrollees with uninterrupted access to MHSA benefits and associated customer services, and to enable the Department to effectively manage the Agreement, the Contractor must provide the following obligations and deliverables to the MHSA Program through the final financial settlement of the Agreement, including but not limited to: (a) Provide all Contractor-provided services associated with claims incurred on or before the scheduled termination date of the Agreement, including but not limited to paying network claims, manual submit claims including but not limited to: Medicaid, out-of-network claims, foreign claims, in-network claims, COB claims, and Medicare, reimbursing late filed claims if warranted, repaying or recovering monies on behalf of the MHSA Program for Medicare claims, retaining NYBEAS access and continuing to provide updates on pending litigation and settlements that the Contractor or the NYS Attorney General's Office has/may file on behalf of the MHSA Program. In addition, the Contractor must continue to provide the Department access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Department notifies the Contractor that access may be ended at an earlier date; (b) Complete all reports required in Section IV.B.7.a.(7) of this RFP; (c) Provide the MHSA Program with sufficient staffing in order to address State audit requests and reports in a timely manner; (d) Agree to fully cooperate with all Department and/or OSC audits consistent with the requirements of Article XXIII of the Agreement and Appendices A and B; (e) Perform timely reviews and responses to audit findings submitted by the Department and the Comptroller's audit unit in accordance with the requirements set forth in Article XXIII "Audit Authority", Section VII, Contract Provisions and Appendices A and B; and (f) Remit reimbursement due the MHSA Program within fifteen (15) days upon final audit determination consistent with the process specified in Article XXIII, "Audit Authority" and Article – "Payments/credits) to/from the Contractor" of Section VII, Contract Provisions and Appendices A and B.	Yes
(7) The Contractor must receive and apply enrollment updates, keep dedicated phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of the Agreement, adjust phone scripts, and transfer calls to the successor contractor's lines during the transition period;	Yes
(8) The Contractor must work cooperatively with the successor contractor and the Department to develop an approach to	Yes

Section 9: Transition and Termination of Agreement (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
ensure a smooth transition for members who must change Providers to maintain the network level of benefits;	
(9) The Contractor must prepare, on a case by case basis, a plan to extend and manage the care of high risk Enrollees who are nearing the end of a course of treatment beyond the transition period;	Yes
(10) The Contractor must continue to clinically manage and pay for Covered Services for Enrollees determined to be Totally Disabled on the last day of the Contract, for ninety (90) Days or until the disability ends, whichever occurs first;	Yes
(11) The Contractor must continue to manage and pay for Covered Services of Enrollees who are confined on or before December 31, 2018 until the earlier of the step down of care or midnight on the 90th day subsequent to December 31, 2018; and	Yes
(12) The Contractor must agree that, if the Contractor does not meet the Transition Plan requirements in the time frame stated above, the Contractor will permanently forfeit 100% of all Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department.	Yes

(1) Confirm that the Contractor will commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the MHSA Program.

ValueOptions confirms that we will commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the MHSA Program.

(2) Provide an outline of the key elements and tasks that would be included in your Transition Plan to ensure that all the required duties and responsibilities are completed if you were the incumbent contractor. Include a brief explanation on how you would accomplish this with the successor contractor.

TRANSITION PLAN KEY ELEMENTS

We recognize the importance of continuous care and are committed to completing all outgoing transition tasks with great sensitivity. We will implement a detailed transition plan that includes written communication to enrollees to reduce confusion and disruption in care. We will take all necessary precautions to ensure continuity of services for enrollees who are receiving treatment during the transition. We will also maintain enrollees' engagement and help motivate them to continue their care during this critical time period.

As we approach the termination of our contract we will continue to fulfill all requirements and provide all necessary and important information to the new vendor. In addition, we will conduct daily exchanges between the new vendor and our care management team to smoothly transition enrollees to the next level of care.

When we receive a notice for transition, we will immediately initiate the process. Our overall approach includes the following functional steps:

- **Administrative:** Identify our internal team leads and schedule weekly meetings with your leads.
- **Claims:** Determine where claims and their records will be sent, what information needs to be forwarded and what steps are needed to resolve finance questions. We will also ensure that all work queues are empty, and develop scripts for staff members resolving claims and calls.
- **Clinical:** Review authorizations for necessary adjustments, establish exit meetings for complex or special cases, furnish pending and open authorization data to the Department and the new vendor, and determine staffing needs for run-out period.
- **Appeals:** Develop a plan for managing appeals during transition, determine appeals workflow, and implement a process to identify pending appeals as of contract end date.
- **Communications:** Determine disposition of enrollee and provider communications materials.

- **Customer service:** Develop question-and-answer scripts for call center staff, develop client enrollee communications as directed by the Department, record auto-attendant message about account termination on the customer service line, and plan for final termination of that phone number, when appropriate.
- **Finance:** Close bank accounts, as appropriate.
- **Information services/telecommunications:** Determine your decision about transferring toll-free number and coordinate final record transfers.
- **Network:** Complete all network transfer activities and field provider inquiries about transition.
- **Quality management:** Establish workflows for complaints and grievances received after contract end date.
- **Reporting:** Establish final reporting requirements and time frames, forward appropriate data to new vendor, and forward warehouse data to you.

The goal of a comprehensive transition plan is to minimize the potential disruption in enrollee care and ensure that the appropriate information is shared with all parties involved. It is with this spirit of cooperation that ValueOptions would enter into such a process to ensure an effective and seamless closure and transition of services through a well-developed and executed exit strategy.

(3) Please detail the level of customer service and clinical management that you will provide after the termination date of the Agreement resulting from this RFP.

OUR APPROACH

We will provide the highest level of customer service and clinical management following a termination of our agreement resulting from this RFP. ValueOptions' primary goal during any transition is to ensure enrollee care is not disrupted. We have developed a standard transition project plan that we have used successfully to transition services to a new organization in those instances when a contract is awarded to a different vendor. Our plan places a great deal of emphasis on ensuring a smooth transition of services to any enrollees who are currently in our care.

For example, if an enrollee is receiving inpatient treatment on the effective date of the transition, we would recommend that we continue to handle the case until he/she moves to a different level of care. This ensures continuity of benefits for the enrollee. We would propose to meet with the new vendor and provide clinical information, in addition to the usual standard authorization reports that are provided. By providing additional clinical details the new vendor will be better able to understand the treatment plans of the enrollees and their ongoing needs. The new vendor would then commence care management of the case at the point inpatient treatment has ended.

TRANSITION SUPPORT

One of the first tasks is to review our transition plan with you and the new vendor. Together, we will review and approve a detailed project plan that will become the guiding document for achieving milestones in the process of transitioning the program.

Internally, ValueOptions conducts ongoing meetings with our subject matter experts in areas such as clinical operations, information technology, claims, and customer service. We also conduct weekly meetings with our clients to ensure that all communication channels are open. ValueOptions' customer service and clinical management services provided during a program transition period will include:

- working with the Department and its new vendor to establish a transition plan in a timely manner
- processing all run-out claims
- verifying enrollee enrollment
- providing sufficient staffing to ensure enrollees continue to receive good customer service and clinical management services after the termination date of the current contract
- developing a strategy for addressing the treatment needs of Empire Plan enrollees in treatment with providers that are not in the new vendor's network
- ensuring the Department will have access to key personnel
- maintaining access to online systems
- providing data/reports and other information regarding the program as needed after contract end
- offering the new vendor a phone system option allowing members to connect to ValueOptions prior to the transition date so that members may get their question answered prior to the change

(4) Confirm the Contractor will, if the Contractor does not meet the Transition Plan requirements in the time frame stated above, permanently forfeit 100% of all Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department.

ValueOptions confirms that if we do not meet the Transition Plan requirements in the time frame stated above, we permanently forfeit 100% of all Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department. We know, based upon experience, that communication and collaboration is critical to any new program implementation or transition. We will partner with the Department and your other vendors to establish appropriate expectations and communication protocols to ensure achievement of the transition performance standards. This includes establishing a mutually agreed upon transition plan with clearly established milestones and dependencies for ValueOptions, the incoming Contractor, and the Department.

Section 10: Network Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
Provider Network	
(1) The Contractor must maintain a credentialed and contracted MHSA Provider Network that meets or exceeds the MHSA Program's minimum access standards throughout the term of the Agreement.	Yes
(2) The MHSA Program requires that the Contractor have available to Enrollees on January 1, 2014 its proposed MHSA Provider Network in accordance with the requirements set forth in Section IV.B.3.a.(2)(a) guaranteeing effective implementation of their proposed Provider Network.	Yes
(3) The Contractor shall offer participation in its MHSA Provider Network to any Provider who meets the Contractor's credentialing criteria upon the Department's request where such inclusion is deemed necessary by the Department to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees outlined below.	Yes
(4) In developing its proposed MHSA Provider Network, the Contractor is expected to use its best efforts to substantially maintain the composition of Network Providers included in the MHSA Program's current Provider Network. The Contractor's proposed MHSA Provider Network must be composed of an appropriate mix of licensed and/or certified psychiatrists, and psychologists, licensed and registered Clinical Social Workers (CSW) (in NYS social workers must have an "R" number issued by the State Education Department), Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists and registered nurse practitioners, Certified Behavioral Analysts, Structured Outpatient Programs and Partial Hospitalization Programs including: residential treatment centers, group homes, hospitals and alternative treatment programs such as day/night centers, half-way houses and treatment programs for dually diagnosed individuals (e.g., mental health diagnosis and substance abuse diagnosis). Programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) must be included in the MHSA Provider Network. The MHSA Provider Network must include Providers throughout New York State and in areas with high concentrations of active and/or retired employees living outside of New York State such that the network access guarantees established by the terms of the Agreement are fully satisfied;	Yes
(5) Network Composition Guarantee: The Contractor must guarantee that throughout the five-year term of the Agreement, at the least, ninety percent (90%) of the Provider in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologies, Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse	Yes

Section 10: Network Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
Practitioner, Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist), listed on Exhibit I.Y.2; will be maintained. Providers who are no longer actively practicing will be excluded from the annual calculation and guarantee; and,	
(6) Network Provider Access Guarantee: The Contractor must guarantee that, throughout the term of the Agreement, the Contractor's MHSA Provider Network meets or exceeds the Department's minimum access guarantees as follows; a) Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Facility within five (5) miles; b) Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Facility within fifteen (15) miles; c) Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Facility within forty (40) miles; d) Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Practitioner within three (3) miles; e) Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Practitioner within fifteen (15) miles; and, f) Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Practitioner within forty (40) miles. Note: In calculating whether the Offeror meets the minimum access guarantees, all Enrollees must be counted; no enrollee may be excluded even if a Provider is not located within the minimum access area. Offerors should propose a guarantee for each of the three (3) areas (urban, suburban and rural) for each of the following two Provider types: Network Facility (Inpatient and ALOC) and Network Practitioner types (Psychiatrist; Psychologist; Licensed Clinical Social Worker) for a total of six separate guarantees. These guarantees are based on the distance, in miles, from a MHSA Program Enrollee's home (zip code) to the nearest MHSA Provider Network Provider location. Urban, suburban and rural are based on US Census Department classifications, as determined by GeoAccess. Offerors may guarantee better access than the minimums, but the guarantee must follow the same structure as the above minimum (i.e., access guarantees for each two Provider groups for each of the six (6) Provider type/area combinations based on the entire MHSA Program population).	Yes
Provider Credentialing	
(1) The Contractor must assure its MHSA Provider Network is	Yes

Section 10: Network Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
credentialed in accordance with all applicable federal and state laws, rules and regulations.	
(2) The Contractor must establish credentialing criteria for Network Practitioners and Facilities, including ALOC, for the purpose of ensuring quality of the MHSA Provider Network, including, but not limited to, years of experience, level of education/certification, licensure, quality of care, practice patterns, malpractice insurance coverage, hours of operation and availability of appointments.	Yes
(3) The Contractor must credential MHSA Network Providers in a timely manner and shall have an effective process by which to confirm MHSA Network Providers continuing compliance with credentialing standards.	Yes
(4) The Contractor must maintain a Provider Relations staff presence within New York State.	Yes
(5) The Contractor must maintain credentialing records and make them available for review by the Department upon request.	Yes
(6) Provider Credentialing Guarantee: The Contractor must guarantee that within sixty (60) Days of receipt of a completed MHSA Provider application to join the Program's network, the review, including credentialing, will be completed and the Provider notified of the determination.	Yes
Provider Contracting	
(1) Negotiating pricing arrangements that utilize the MHSA Program's size to optimize the Provider fee schedule;	Yes
(2) Ensuring that all MHSA Network Providers contractually agree to and comply with all of the MHSA Program's requirements and benefit design specifications;	Yes
(3) Ensuring that MHSA Network Providers accept as payment-in-full, the Contractor's contractual reimbursement for all claims for covered services, subject to the applicable MHSA Program Copayments;	Yes
(4) Notifying the Department in writing within one (1) Business Day of any substantial change to the number, composition or terms of the Provider contracts utilized by the MHSA Program;	Yes
(5) Negotiating Single Case Agreements with Non-Network Providers on a case-by-case basis when the Contractor determines that it is clinically appropriate or to address guaranteed access issues;	Yes
(6) Negotiating agreements on a case-by-case basis, with prior approval from the Department, with Licensed Marriage and Family Therapists (LMFTs) and Licensed Mental Health Counselors (LMHCs) when an LMFT or LMHC possess a particular subspecialty that is clinically appropriate or to address guaranteed access issues; and	Yes
(7) Establishing a tiered MHSA Provider Network and incentives including but not limited to financial, administrative and continuing professional education to enhance Provider	Yes

Section 10: Network Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
performance and clinical outcomes.	
Provider Audit and Quality Assurance	
(1) The Contractor must have a staffed and trained audit unit employing a comprehensive Provider audit program that includes but is not limited to: (a) Conducting routine and targeted on-site audits of Network Providers. Providers that deviate significantly from normal patterns in terms of cost, CPT coding or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. On-site audits must also be conducted upon request by the Department and/or OSC, or when information is received by the Contractor that indicates a pattern of conduct by a Provider that is not consistent with the MHSA Program's design and objectives. Any modifications to the proposed audit program must receive written prior approval by the State; (b) Providing reports to the Department detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Contractor. The Contractor must inform the Department in writing of any allegation or other indication of potential fraud and/or abuse identified within seven (7) Business Days of receipt of such allegations or identification of such potential fraud and/or abuse. The Department must be fully informed of all fraud and/or abuse investigations impacting the MHSA Program upon commencement, regardless of whether the individual fraud and/or abuse investigation has a material financial impact to the State; (c) Maintaining the capability and contractual right of the Contractor to effectively audit the MHSA Program's Provider Network, including the use of statistical sampling audit techniques and the extrapolation of errors; (d) Remitting 100% of Provider and Enrollee audit recoveries to the Department as applicable within thirty (30) Days of receipt consistent with the process specified in Section X.V, "Payments/ (credits) to/from the Contractor," of the Agreement resulting from this RFP; and (e) Utilizing the auditing tools and performance measures proposed by the Contractor to identify fraud and abuse by Network Providers and/or Enrollees.	Yes
(2) The Contractor must conduct a comprehensive quality assurance program which includes, but is not limited to: (a) Monitoring the quality of care provided by Network Providers; (b) Monitoring technical competency and customer service skills of Network Provider staff; (c) Network Provider profiling; (d) Peer review procedures;	Yes

Section 10: Network Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(e) Outcome and Quality Measurement analysis; and (f) Maintaining an ongoing training and education program that will be offered to Network Providers.	

PROVIDER NETWORK

(1) Propose access guarantees for the MHSA Program's Provider Network (excluding Certified Behavior Analysts, Licensed Mental Health Counselors and Licensed Marriage and Family Therapists) that meet or exceed the minimum set forth above. The access guarantee must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access guarantees stipulated above.

% of Enrollees with Access to Network Facilities	Enrollee Location	Access Guarantee – 1 Network Facility at least within
[redacted]		

% of Enrollees with Access to Network Practitioners	Enrollee Location	Access Guarantee – 1 Network Practitioner at least within
[redacted]		

(2) Propose access standards for Certified Behavior Analysts in the MHSA Program's Provider Network. The access standard must be provided in terms of actual distance from Enrollees' residences.

% of Enrollees with Access to Certified Behavior Analysts	Enrollee Location	1 Certified Behavior Analyst at least within
[redacted]		

(3) Complete **Exhibit I.Y.4**, entitled "Comparison of MHSA Program Providers and the Offeror's Proposed Provider Network." Identify whether each of the MHSA Program's Providers will or will not participate in the Offeror's proposed Provider Network in accordance with the instructions provided in **Exhibit I.Y.4**. The file containing the MHSA Program's Providers can be obtained by meeting the requirements specified in Section III.G of this RFP.

We provide the completed "Comparison of MHSA Program Providers and the Offeror's Proposed Provider Network" behind the Exhibit I.Y.4 tab within this proposal binder.

In order to accurately determine whether or not Empire Plan enrollees will have access to the right providers at the right time, we take a multi-dimensional view of provider access.

NETWORK SIZE AND MIX

As the previous contract holder for the Empire Plan Program from 1992 through 2008, ValueOptions consistently met access guarantees for enrollees. Since that time our network has grown. We have more than 11,100 providers throughout New York, as well as comprehensive networks in the areas out of state where claims data indicate that Empire Plan enrollees received the most care in 2012 (e.g. Miami and Philadelphia). That being said, we are committed to continuing to recruit providers to our network to ensure adequate access to all provider types for your enrollees.

DISRUPTION

We conducted a data match of the claims information provided, representing both in– and out-of-network providers to our current network. In any disruption analysis to determine network access, there are inevitable differences in the manner in which provider data is captured. What we have provided as Exhibit I.Y.4 is more accurately described as a data match than a provider match. With various non-mental health and/or substance abuse related provider types included in the data file provided, it would not be realistic for us to have an exact match. However, for those mental health providers who are currently in the Empire Plan network but with whom ValueOptions does not have a contract, we will take direction from the Department on recruitment of these individuals.

NETWORK MANAGEMENT

We believe that a provider network should be measured not just by size, but by quality. We profile providers to determine whether or not they are adhering to best practices for treatment and steer enrollees accordingly.

(4) Please confirm that if selected, you will provide an updated **Exhibits I.Y.2, I.Y.3** and **I.Y.4** on December 1, 2013 confirming that the Offeror's proposed Provider Network will be implemented as required on January 1, 2014. If necessary, the selected Offeror shall submit a second file affirmatively identifying any deviations from the proposed Provider Network along with a detailed explanation for all deviations.

ValueOptions confirms that if selected, we will provide an updated Exhibit I.Y.2, I.Y.3, and I.Y.4 on December 1, 2103 confirming that our proposed provider network will be implemented as required on January 1, 2014.

(5) Describe the types of Providers, inpatient facilities and Alternative Levels of Care (ALOC) included in your proposed Provider Network. Include a listing of programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) which are included in the Provider Network.

VALUEOPTIONS' NETWORK

ValueOptions maintains a provider network of more than 130,000 provider locations across the United States, with 11,184 within the state of New York.

ValueOptions has a distinguished record of meeting the growing needs of our clients' membership in all 50 states. One of the benefits of our comprehensive network is that Empire Plan enrollees can access care no matter where they are located geographically, as we manage a national network of 130,000 provider locations in the United States. Specifically, our provider network ensures access to Empire Plan enrollees who tend to access services outside of New York, such as in Miami and Philadelphia. ValueOptions is known as a provider-friendly organization and we support our provider network by continually developing avenues to improve their administrative processes. We strive to enable our providers to focus on what they do best—treat our clients' members. ValueOptions has an exceptionally strong provider network in the state of New York because of its long history of serving its citizens. Our comprehensive network will provide a full continuum of care that meets Empire Plan enrollees' specific cultural, socio-economic, and demographic needs. It not only encompasses all levels of care from inpatient to intensive outpatient and alternative levels of care, but also focuses on supplementing clinical care with community programs.

The following information describes the types of practitioners, facilities, and alternative level of care (ALOC) programs currently in our network.

Network Practitioners

ValueOptions' network includes a wide range of practitioners whose credentials to practice in New York state and other areas of the country are carefully evaluated and documented by our National Provider Network Operations team. We provide the credentialing requirements for practitioners included in our network below:

1. Psychiatrists

a) Must possess a Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree.
b) Board certified in psychiatry as defined by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Psychiatry and Neurology, or completed a three-year psychiatric residency training program approved by the Accreditation Council for Graduate Medical Education.
c) Licensed to practice medicine in the state where practice is to occur.
d) Certified in Suboxone Therapy in the state where practice is to occur (if applicable for Suboxone Therapy).
e) Must possess a current Drug Enforcement Administration (DEA) Certificate.
f) State Controlled Substance Registration Certificate (where applicable).
g) Foreign medical school graduates must submit an Educational Commission for Foreign Medical Graduates Certificate or certificate of completion of Fifth Pathway training before July 1, 2009.
h) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $3,000,000 aggregate. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

2. Addictionologist (non-Psychiatrist)

a) Must possess a Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree.
b) Certified by the American Society of Addiction Medicine as an Addictionologist.
c) Licensed to practice medicine in the state where practice is to occur.
d) Certified in Suboxone Therapy in the state where practice is to occur (if applicable for Suboxone Therapy).
e) Must possess a current Drug Enforcement Administration (DEA) Certificate, with additional Suboxone endorsement (if applicable for Suboxone Therapy).
f) State Controlled Substance Registration Certificate (where applicable)
g) Foreign medical school graduates must submit an Educational Commission for Foreign Medical Graduates Certificate or certificate of completion of Fifth Pathway training before July 1, 2009.
h) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $3,000,000 aggregate. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

3. Developmental Behavioral Pediatrician

a) Must possess a Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree.
b) Completed a two-year Developmental Behavioral Fellowship. Prior to availability of accreditation, documentation of an accepted application to sit for the Sub-Board of Developmental Behavioral Pediatrics or an attestation from the fellowship director that

the fellowship was completed and the developmental behavioral training provided will be sufficient.

c) Board Certified in pediatrics as defined by the American Board of Pediatrics
d) Board Certified in Developmental Behavioral Pediatrics by the Sub-Board of Developmental Behavioral Pediatrics
e) Licensed to practice medicine in the state where practice is to occur.
f) Graduates of foreign medical schools must submit an Educational Commission for Foreign Medical Graduates Certificate or certificate of completion of Fifth Pathway training before July 1, 2009.
g) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $3,000,000 aggregate. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

4. Psychologists

a) Doctoral degree (Ph.D., Ed.D., Psy.D.) in psychology
b) Licensed independently as a clinical psychologist at the highest level in the state where practice is to occur. Psychologists with prescriptive authority must be licensed in a state where prescribing certification is recognized.
c) All provider applicants must have a minimum of three year's post-licensure clinical experience in a mental health/substance abuse setting providing direct patient care. ValueOptions will consider other post licensure experience at the highest degree level.
d) Must possess a current Drug Enforcement Administration (DEA) Certificate (if applicable for prescriptive authority)
e) Must possess a current State Controlled Dangerous Substances registration (if applicable for prescriptive authority)
f) Prescription Number or Certificate issued to psychologists in order to provide prescriptive authority (if applicable for prescriptive authority). Psychologists with prescriptive authority must possess professional liability coverage at a minimum level of $1,000,000 per episode and $3,000,000 aggregate. Psychologists without prescriptive authority must possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

5. Psychoanalysts

a) Doctoral degree (Ph.D., Ed.D., Psy.D.) in psychology.
b) Licensed independently as a psychoanalyst at the highest level in the state where practice is to occur.

c) All provider applicants must have a minimum of three years' post-licensure (at the highest level) clinical experience in a mental health / substance abuse setting providing direct patient care. ValueOptions® will consider other post licensure experience at the highest degree level.
d) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

6. Masters Level Psychologists (Not licensed in New York)

a) Must possess a Master's degree.
b) Must be licensed or certified at the highest level of independent practice in the state where practice is to occur. Only acceptable in those states whose clinical experience and exam requirements equal or exceed two years or 2,000 hours of clinical experience or 1,000 hours of clinical contact (face to face) under an approved supervisor as defined by the appropriate State regulatory agency. Must have received at least 150 hours of face-to-face supervision by an approved supervisor (as defined by the state).
c) All provider applicants must have a minimum of three years' post-licensure (at the highest level) clinical experience in a mental health/substance abuse setting providing direct patient care.
d) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

7. Social Worker

a) Master's degree or higher from a graduate school of social work.
b) State licensed or certified to practice at the highest level of independent practice in the state where practice is to occur.
c) All provider applicants must have a minimum of three years' post-licensure (at the highest level) clinical experience in a mental health/substance abuse setting providing direct patient care.
d) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

8. Advanced Practice Nurse, APN (Clinical Nurse Specialist or Nurse Practitioner)

a) Master's degree or higher in nursing.
b) Licensed at the highest level of independent practice in the state where practice is to occur.
c) Must possess a current Drug Enforcement Administration (DEA) Certificate (if applicable for prescriptive authority)
d) Must possess a current State Controlled Dangerous Substances registration (if applicable for prescriptive authority)
e) Prescription Number or Certificate issued to the applicant in order to provide prescriptive authority (if applicable for prescriptive authority)
f) Board Certified by the American Nurses Credentialing Center in **one** of the following areas:
   (1) Clinical Specialist in Adult Psychiatric and Mental Health Nursing, or
   (2) Clinical Specialist in Child and Adolescent Psychiatric & Mental Health Nursing, or
   (3) Family Psychiatric and Mental Health Nurse Practitioner, or
   (4) Adult Psychiatric and Mental Health Nurse Practitioner; or
   (5) Psychiatric and Mental Health Nurse Certification.
g) All provider applicants must have a minimum of three years' post-licensure (at the highest level) clinical experience in a mental health/substance abuse setting providing direct patient care
h) Required to maintain compliance with collaboration/supervision licensing requirements issued by the state(s) where practice is to occur. Where required, the APN must be supervised by a psychiatrist (MD or DO) and submit a copy of the agreement.
i) APN **with** prescriptive authority must possess professional liability coverage at a minimum level of $1,000,000 per episode and $3,000,000 aggregate. APN **without** prescriptive authority must possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

9. Physician Assistants

a) Licensed as a Physician Assistant in the state where practice is to occur
b) Certified by the National Commission on Certification of Physician Assistants
c) Must possess a current Drug Enforcement Administration (DEA) Certificate
d) Must possess a current State Controlled Dangerous Substances registration
e) All provider applicants must have a minimum of three years' post-licensure (at the highest level) clinical experience in a mental health/substance abuse setting providing direct patient care
f) The Physician Assistant may only provide patient care services under the direction and supervision of a physician and only such services that are within the scope of practice of the supervising physician. The Physician Assistant must be supervised by a psychiatrist (MD or DO) and submit a copy of the agreement.

g) Must practice in the same service location as the supervising psychiatrist.
h) Required to maintain compliance with supervision licensing requirements issued by the State(s) where practice is to occur.
i) Must possess professional liability coverage at a minimum level of $1,000,000 per episode and $3,000,000 aggregate except where state requirements are more stringent. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

10. Professional Counselors / Mental Health Counselors

a) Master's degree or higher.
b) State licensed or certified at the highest level of independent practice in the state where practice is to occur.
c) All provider applicants must have a minimum of three years' post-licensure (at the highest level) clinical experience in a mental health/substance abuse setting providing direct patient care.
d) In states without licensure or certification, provider applicant must be a Certified Clinical Mental Health Counselor as determined by the Clinical Academy of the National Board of Certified Counselors [proof of certification required] **OR** meet all requirements to become a Certified Clinical Mental Health Counselor [documentation of eligibility required].
e) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

11. Marriage & Family Therapist

a) Master's degree or higher.
b) State licensed or certified at the highest level of independent practice in the state where practice is to occur, **OR** certified as a full clinical member of the American Association for Marriage and Family Therapy, **OR** proof of eligibility for full clinical membership in the Association (documentation required).
c) All provider applicants must have a minimum of three years' post licensure or post certification (at the highest level) clinical experience in a mental health/substance abuse setting providing direct patient care.
d) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage

amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

12. Pastoral Counselors

a) Master's degree or higher in mental health discipline.
b) Must be licensed in one of the disciplines recognized by ValueOptions (Medical Doctor/Doctor of Osteopathy, Psychologist, Social Worker, Registered Nurse Clinical Specialist, Advanced Nurse Practitioner, Marriage and Family Therapist, or Licensed Pastoral Counselor) at the highest level of independent practice in the state where the practice is to occur and meet ValueOptions credentialing criteria. **OR** must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
c) All provider applicants must have a minimum of three years' post-licensure (at the highest level) clinical experience in mental health/substance abuse setting providing direct patient care.
d) Must be a fellow or diplomat member of the American Association of Pastoral Counselors **OR** meet all requirements to become a fellow or diplomat member of the American Association of Pastoral Counselors [documentation of eligibility required].
e) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

13 Certified Behavior Analyst

a) Master's degree or higher from a graduate school with a specialty of behavior analysis, psychology, special education or related field **and**
b) A minimum of 12 credit hours of graduate level course work in behavioral analysis. Courses must have focus on application of behavior analysis, rather than more generic topics in the discipline for which the graduate degree was awarded. The courses should address the following issues in applied behavior analysis: family dynamics; ethical considerations; definition and characteristics; principles, processes and concepts; behavioral assessment and the selection of intervention strategies and outcomes; experimental evaluation of interventions; measurement of behavior and displaying/interpreting behavioral data; behavioral change procedures and systems support (Adapted from the Behavior Analyst Certification Board) **and**
c) A minimum of six months full-time supervised employment (or internship/Practicum in behavior analysis under the supervision of a behavior analysis)
d) Certified as a Behavioral Analyst by the Behavior Analyst Certification Board.
e) State Licensed to practice at the highest level of independent practice in the state where practice is to occur (if applicable).
f) All provider applicants must have a minimum of one (1) year post certification experience providing direct patient care g) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state

or client requirements are more stringent. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

15. Certified Behavior Analyst-Doctoral

a) Doctoral degree, conferred at least ten (10) years prior to applying with a specialty of behavior analysis, psychology, education or another related field **and**
b) A minimum of 10 years post-doctoral experience in behavior analysis **and**
c) Certified as a Board Certified Behavior Analyst – Doctoral by the Behavior Analyst Certification Board.
d) State Licensed to practice at the highest level of independent practice in the state where practice is to occur (if applicable).
e) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

16. Certified Assistant/Associate Behavior Analyst

a) Bachelor's degree or higher with course work in behavior analysis, including ethical considerations; definition and characteristics; principles, processes and concepts; behavioral assessment and the selection of intervention strategies and outcomes; experimental evaluation of interventions; measurement of behavior and displaying/interpreting behavioral data; and behavioral change procedures and systems support. (Adapted from the Behavioral Analyst Certification Board)
b) A minimum of 1,000 hours of supervised independent fieldwork in behavior analysis conducting assessment activities related to the need for behavioral interventions; designing, implementing, and monitoring behavior analysis programs for clients; and overseeing he implementation of behavior analysis programs by others. (Adapted from the Behavioral Analyst Certification Board)
c) Certified as an Assistant Behavior Analyst by the Behavior Analyst Certification Board.
d) May only provide patient care services under the direction and supervision of a Master's level Certified Behavior Analyst. Must report the name of their supervisor(s) and provide documentation of that supervision as requested.
e) All provider applicants must have a minimum of one year post certification experience providing direct patient care.
f) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent. *The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.* Copy of current face sheet must be included (must indicate applicant as the insured, policy period and coverage

amounts and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable).

Provider Mix

As part of our comprehensive network, the specialties recognized by ValueOptions include, but are not limited to, the following:

- Addictions, Non-Chemical
- Adoption
- Affective Disorders
- Anger Management/Impulse Disorders
- Anxiety Disorders
- Alcohol/Chemical Dependency
- Autistic Spectrum Disorder
- Childhood Behavioral Disturbances
- Attention Deficit Hyperactivity Disorder (ADHD)/School-related problems
- Chronic Pain
- Co-Occurring Disorders
- Death and Dying/Terminal Illness
- Depression
- Disability Assessment/Treatment
- Dissociative Identity Disorders
- Domestic Violence
- Fitness for Duty Assessment
- Eating Disorders
- Forensics
- Gangs/Cults
- Lesbian/Bisexual Issues,
- Geropsychiatry/Alzheimer's Syndrome
- Grief/Bereavement
- Hearing Impaired
- Marital/Separation/Divorce
- Men's Issues
- Military Lifestyle Issues
- Neuropsychology
- Obsessive Compulsive Disorder
- Panic/Phobias
- Personality Disorders
- Physical Abuse Perpetrators
- Physical Abuse Victims
- Post-Traumatic Stress Disorder
- Reactive Attachment Disorder
- Schizophrenia
- Severe and Persistent Mental Illness
- Sex Abuse Perpetrators
- Sex Abuse Victims
- Sexual Dysfunction
- Trichotillomania
- Women's Issues
- Worker's Comp Evaluations

Facilities and Alternative Levels of Care

In addition to our extensive network of practitioners, ValueOptions' comprehensive network includes carefully evaluated and credentialed treatment programs that lead to cost-effective services and promote recovery from mental illness and addictive disorders. In order to effectively meet enrollee needs, we offer:

- Availability of alternative levels of care
- Cultural preferences for treatment modalities
- Specialty providers
- Access to community resources
- Familial influences
- Benefit coverage for the available alternatives
- Ability of the local providers to provide all recommended services within the estimated length of stay

The following criteria apply to all facilities and programs included in our network:

1. Possess all valid and applicable state licenses
2. Possess professional liability coverage at a minimum level of $1,000,000 per episode and $3,000,000 aggregate. The National Credentialing Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions. Applicants must submit a copy of the current face sheet indicating the applicant as the insured, policy period, coverage amounts, and participation in the state's catastrophic loss fund or Federal Tort Claims Act, if applicable.
3. Must meet acceptable criteria for malpractice claims history for the past five years – if applicable. When a judgment or settlement includes a confidentiality agreement or is pending, the applicant must provide a brief statement detailing the facts of the claim, the allegation, and the response of the applicant. The applicant must submit a corrective action plan that details areas of deficiency, action steps implemented, and relevant prevention initiatives.
4. Accreditation from one of the following accrediting bodies: The Joint Commission; The Rehabilitation Accreditation Commission; Council on Accreditation; American Osteopathic Association; Healthcare Facilities Accreditation Program; Accreditation Association for Ambulatory Health Care; Det Norske Veritas; or Community Health Accreditation Program. When **not** accredited, a site visit review must be completed prior to the credentialing decision being made.
5. Certification from Medicare, Medicaid, TRICARE, or State agencies, if applicable.
6. Drug Enforcement Administration certification, if applicable.

Our specific criteria are provided below:

1. Inpatient Psychiatric

a) Must provide 24 hours a day, seven days per week skilled nursing staff.
b) Must accept admissions 24 hours a day, seven days per week.
c) Must have written admission and discharge criteria.
d) Must provide medical diagnostic services on-site or by contract.
e) Must provide a full range of treatment programming seven days per week.
f) Must provide individualized treatment plans.
g) Must provide emergency psychiatric/medical services on-site or by contract.
h) Must receive oversight from a Medical Director.
i) Must have an initial visit with an attending physician within 24 hours of admission for evaluation and treatment planning and a documented daily visit with an attending licensed prescribing provider.

2. Inpatient Detoxification

a) Must provide 24 hours a day, seven days per week skilled nursing staff.
b) Must accept admissions 24 hours a day, seven days per week.
c) Must have written admission and discharge criteria.
d) Must provide medical diagnostic services on-site or by contract.
e) Must provide a full range of treatment programming seven days per week.

f) Must provide individualized treatment plans.
g) Must provide emergency psychiatric/medical services on-site or by contract.
h) Must require and/or encourage family involvement in treatment.
i) Must provide structured recovery support groups.
j) Must have an Addictionologist either on staff or contracted or Medical Director must have three years' experience treating substance abuse patients as evidenced in resume.
k) Must receive oversight from a Medical Director.

3. Inpatient Substance Abuse Rehabilitation

a) Must provide 24 hours a day, seven days per week coverage by licensed staff.
b) Must accept admissions 24 hours a day, seven days per week.
c) Must have written admission and discharge criteria.
d) Must provide medical diagnostic services on-site or by contract.
e) Must provide a full range of treatment programming seven days per week.
f) Must provide individualized treatment plans.
g) Must provide emergency psychiatric/medical services on-site or by contract.
h) Must require and/or encourage family involvement in treatment.
i) Must provide structured recovery support groups and aftercare.
j) Must have an Addictionologist either on staff or contracted or Medical Director must have three years' experience treating substance abuse patients as evidenced in resume.
k) Must receive oversight from a Medical Director.

4. Residential (Psychiatric or Substance Abuse)

a) Must provide 24 hours a day, seven days per week supervision of all residents by licensed staff.
b) Must provide a multi-disciplinary licensed staff (i.e. social worker, counselors, nurses etc.)
c) Must have written admission and discharge criteria.
d) Must provide a full range of social and recreational therapies.
e) Must provide individualized treatment plans.
f) Must provide a full range of treatment programming seven days per week, with structured programming provided a minimum of six hours per day.
g) Must require and/or encourage family involvement in treatment.
h) Must provide emergency psychiatric/medical services on-site or by contract.
i) Must receive oversight from a Medical or Clinical Program Director.
j) Must conduct criminal background check on all staff.
k) Must have a documented patient visit with a Psychiatrist at least one time per week.

5. Partial Hospitalization (Psychiatric or Substance Abuse)

a) Must be under the supervision of a physician.
b) Must have written admission and discharge criteria.
c) Must provide physician medication management.
d) Staffing must include psychiatry, nursing, psychology, and social work.
e) Must provide chemical dependency education and treatment. (CD only)
f) Must provide individualized treatment plans.

g) Must provide a full program schedule to include individual and group therapy.
h) Must operate at least three to five days per week and at least a minimum of four to six hours per day.
i) Must receive oversight from a Medical or licensed Program Director.
j) Must have a documented patient visit with a Psychiatrist at least one time per week. (Psychiatric only)

6. 23-Hour Observation/Holding Bed

a) Must have a physician available 24 hours a day, seven days per week.
b) A physician must conduct medical histories and physicals on all admissions.
c) Must accept admissions 24 hours a day, seven days per week.
d) Must provide 24 hours a day, seven days per week skilled nursing staff.
e) Must have a 24 hour emergency on-call staff.
f) Must have written admission and discharge criteria.
g) Must receive oversight from a Medical Director.

7. Ambulatory Detoxification

a) Must have written admission and discharge criteria.
b) Must provide individualized treatment plans.
c) Must provide drug and/or blood alcohol level screens on-site or by a State-licensed or certified lab.
d) Must have the ability to refer to a Medical Doctor for any health problem that may interfere with this service.
e) Must have emergency services available, if needed.
f) Must provide and/or encourage education and counseling for family members/significant others.
g) Must provide or make available any structured recovery support groups.
h) Must receive oversight from a Medical Director.

8. Intensive Outpatient (Psychiatric or Substance Abuse)

a) Must have a written program narrative.
b) Must provide individualized treatment plans.
c) Must have written procedures for handling medical/psychiatric emergencies.
d) Must provide or make available any structured recovery support groups.
e) Must have the supervision of a licensed clinician.
f) Must have written admission and discharge criteria.
g) Must have a written schedule of program activities.
h) Must provide services at least three hours per day, two to four days per week.

9. Day Treatment (Psychiatric or Substance Abuse)

a) Must have written admission and discharge criteria.
b) Must have the supervision of a licensed clinician.
c) Must provide individualized treatment plans.
d) Must have a full program schedule to provide psychotherapy every day.
e) Must provide chemical dependency education and treatment (substance abuse only)

f) Staffing must include nursing, psychology, and social work.
g) Must provide services at least four hours per day, five days per week.

10. Halfway House

a) Must provide 24 hours a day, seven days per week supervision of residents.
b) Must be compliant with after-care/continuing care.
c) Must provide or have access to a full range of educational, social and recreational therapies.
d) Must conduct criminal background checks on all staff.
e) Must provide assistance with activities of daily living.
f) Must monitor for potential/suspected substance abuse via random urine drug screens.
g) Must require and/or encourage family involvement in treatment.
h) Must have emergency psychiatric/medical services available either on site or by agreement.
i) Must have oversight by a director who is a licensed clinician.

11. Methadone Maintenance Program

a) Must have oversight by a licensed physician
b) Staff must include clinicians with diagnostic skill to identify co-existing psychiatric disorders and implement appropriate treatment plans.
c) Must have access to psychologist, social workers and nurses when needed.
d) Staff must have at least one year of experience working with opioid abusing population.
e) Must have on-site medical services or the availability of immediate referrals.
f) program must include the following components:
    1) medical history and physical exams
    2) psychosocial assessment
    3) counseling and education programs
    4) relapse prevention element
    5) random urine toxicology testing
g) Must provide individualized treatment and discharge plans that are developed with the involvement of the consumer and his/her family.
h) Must provide treatment at least one time per week based on consumer need.

12. Treatment Group Home

a) Must provide 24 hours a day, seven days per week supervision of residents.
b) A licensed mental health practitioner must supervise all staff.
c) Must provide or have access to a full range of educational, social, and recreational therapies.
d) Must conduct criminal background check on all staff.
e) Must provide or have access to a full range of treatment programming seven days per week.
f) Must provide individualized treatment plans.
g) Must require and/or encourage family involvement in treatment.
h) Must have emergency psychiatric/medical services on-site or by contract.
i) Must receive oversight from a Medical Director or licensed Program Director.

13. Home Health

a) Must provide individualized treatment plans.
b) Must have crisis intervention available 24 hours a day, seven days per week.
c) Must have specially trained home health workers providing care.
d) Must conduct criminal background checks on all in-home staff.
e) Must have a written narrative of services.
f) Must have medical/nursing supervision.
g) Must receive oversight from a Medical Director or licensed Program Director.

14. Respite Care

a) Must have written policies explaining the procedures and criteria for respite provider training and selection.
b) Must have specially trained staff to implement treatment plans.
c) Must provide medical consultation 24 hours a day, seven days per week.
d) Must provide 24 hours a day, seven days per week supervision of residents.
e) Must have written procedures for handling psychiatric/medical emergencies.
f) Must require and/or encourage family involvement in treatment.
g) Must receive oversight from a licensed clinician.

15. Outpatient Mental Health and/or Substance Abuse Clinic

a) Must have a governing body and an organized professional staff.
b) Must have, or have a formal contract with, a multi-disciplinary staff that includes at least one licensed psychiatrist, one licensed psychologist (psychologist must also be licensed to perform psychological testing), and at least one-licensed masters or doctoral level mental health clinician.
c) Must have written credentialing criteria for all clinical staff.
d) Must have criteria for admissions, screening, and referral.
e) Must provide comprehensive individualized treatment plans.
f) Must provide 24 hours a day, seven days per week coverage for crisis assessment/intervention.
g) All non-licensed staff must have direct clinical supervision by licensed staff; non-licensed staff may not provide the predominant portion of any major intervention modality, other than educational services.
h) Must have written quality improvement program.
i) Must receive oversight from a licensed behavioral health professional.
j) All billing must be under the clinic's name and tax identification number.
k) Must have centralized intake and billing.
l) Must provide or have access to individual, group and family therapy.

16. Eating Disorders

NOTE: Services can be provided at different levels of intensity, including inpatient, structured outpatient, or partial hospital depending on the clinical needs of the patient.

a) Must provide the following program components:
    1) Initial medical evaluation and follow-up
    2) Initial psychiatric evaluation and follow-up, when indicated

3) Psycho education program and self-growth activities
4) Family educational program
5) Nutritionist consultation
6) Individual, group, family therapy for eating disorders
7) Self-help programs, if appropriate
8) Psychological testing, if indicated
9) Aftercare program
10) Individualized treatment programs.

b) Must offer separate treatment programs for adult and adolescent patients.
c) Program must be sufficient length with graded levels of intensity to address relevant medical/psychiatric issues.
d) Must have, or have a formal contract with, a multi-disciplinary staff which includes, but is not limited to, psychiatrist, nurses, psychologist, social workers, and licensed mental health professionals.
e) A licensed professional, who has training and expertise in the treatment of eating disorders, including three years of experience in the field, must supervise program.
f) Program must have a non-psychiatric physician on staff, or by formal contract, who provides adequate medical coverage to meet patient care requirements.
g) Must have emergency medical services available, either on site or by contract with a The Joint Commission facility.
h) Must have oversight by a Medical Director or licensed Program Director.

17. Dual Diagnosis

NOTE: Services can be provided at different levels of intensity, including inpatient, structured outpatient, partial hospital, Residential, Day Treatment, or outpatient, depending on the clinical needs of the patient.

a) Must have oversight by a Medical Director or licensed Program Director.
b) Must provide the following program components:
1) Access to individual, group and family therapy
2) Access to full education program for children and adolescents (if applicable)
3) History and physical within 24 hours of admission (inpatient only)
4) Focus on individualized treatment vs. fixed programs
5) Discharge planning
6) Disease model based CD education and self-growth activities
7) Medication Management
8) Access to full range of social and recreational therapies
9) Regular plan for blood and/or urine screens, as clinically indicated
10) Access to family program (education & therapy)
11) Aftercare program including monthly random urine drug screens

c) Program staff must include or have a formal contract with psychologists, social workers, counselors, marriage & family therapist, and Board certified psychiatrists
d) Must have 24 hour on-site nursing coverage (In-patient only).
e) The following requirement applies to inpatient services only: If the facility provides disposition services (i.e., a dispositional bed contracted to allow for a patient with decreased symptom acuity to remain at the facility for continued, brief observation until

they are transitioned to another level of care), then there must be 24-hour on-site nursing coverage. "Dispositional beds" are required to meet all of the above criteria.

18. Pathological Gambling

NOTE: Services can be provided at different levels of intensity, including inpatient, structured outpatient, partial hospital, or outpatient, depending on the clinical needs of the patient.

a) Must be under Medical Director supervision.
b) Must provide the following program components:
   1) Focus on individualized treatment vs. fixed programs
   2) Active family involvement
   3) Discharge Planning
   4) Education program (Disease Model) and self-growth activities
   5) Family Program (educational and therapy)
   6) Individual, group, and family therapy
   7) Continuing care (aftercare) program
   8) Relapse program
   9) Structured recovery support groups.
   10) Restitution program
   11) Financial planning
c) Must have a designated Program Director who has completed one year of full time equivalent work experience in the treatment of pathological gambling.
d) Staff must include psychologist, counselors, social workers, and nurses.
e) Program must meet at least three times per week in the intensive phase, for a minimum of nine hours per week.

19. Applied Behavior Analysis (ABA)

NOTE: Services will be provided at an Outpatient Mental Health Clinic level of intensity.

a) Must receive oversight from a licensed behavioral health or Behavior Analyst Certification Board (BACB) certified professional.
b) All non-licensed / non-BACB certified staff must have direct clinical supervision by qualified licensed staff with an Autism Spectrum Disorder specialty or BACB certification in accordance with recommended clinically appropriate supervision (i.e., a minimum of 1.5 hours for every 10 hours of direct service).
c) Assistant Behavior Analyst staff must be supervised by Board Certified Behavior Analyst or Board Certified Behavior Analyst–Doctoral supervisors in accordance with BACB requirements.
d) All non-licensed staff (paraprofessionals/tutors/therapists) must have completed criminal background checks, drug screening (including random testing), and confirmation of required ABA specific training
e) Must follow pre-certification and utilization review requirements for ABA services.
f) All billing must be under the clinic's name and tax identification number, including use of modifiers to designate provider of specific units of service.

20. Crisis Intervention

a) Program is part of a facility accredited by the Joint Commission as a hospital or as a health care organization that provides psychiatric services to adults or children/adolescents, or Program is part of a facility accredited by American Osteopathic Association, TRICARE, or program itself is accredited by Commission on Accreditation of Rehabilitation Facilities or Council on Accreditation as a crisis intervention program that provides psychiatric services, **or** Program is licensed or holds a certificate of compliance from the state in which it operates, and meets all applicable federal, state, and local laws and regulations.
b) Must provide 24-hour accessibility/availability, 7 days a week, 365 days a year.
c) Services may be provided through emergency inpatient admission, emergency shelters, hot lines, walk-in intervention, crisis residential services, and mobile crisis teams.
d) Must attest to a formal written agreement with a provider of inpatient services, 23 or 24-hour observation/residential services for emergency medical and psychiatric care.
e) Service operates without restrictions to sex, race, religion, creed, or national origin.
f) Service is part of a program that has an organized quality monitoring/improvement program.
g) Program must provide the following:
    1) Crisis evaluation
    2) Crisis intervention and management
    3) Coordination of care with other known providers of care to individual enrollees
    4) Disposition and referral to appropriate treatment-setting including "bed finding."
    5) Emergency medication management or referral
h) 24-hour psychiatrist or licensed physician coverage when psychiatrist is not available (on call or on site).
i) Licensed nursing staff and other licensed mental health professionals (minimum of one in a supervisory role).
j) Combination of mental health workers and other appropriately trained staff (e.g., paraprofessional, psychiatric technicians).

21. Crisis Stabilization Unit

a) Program must be part of a The Joint Commission accredited hospital or health care organization that provides psychiatric services or
b) Program is part of a facility accredited by the American Osteopathic Association, TRICARE, or the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation accredits the program itself, as an observation/holding bed program that provides psychiatric services.
c) Program must meet state licensure/certification and Medicaid requirements (as applicable).
d) Program must meet all applicable federal, state, and local laws and regulations.
e) Program must attest to a formal written agreement with The Joint Commission accredited provider for emergency psychiatric, substance abuse, and/or medical care if such care is not available on site.
f) Program has a written quality monitoring/improvement program.
g) Program operates without restrictions to sex, race, religion, creed, or national origin.

h) Program must provide the following:
   1) Safe, secure environmental setting
   2) Crisis intervention and management with both the individual and his/her family or significant other.
   3) Ability to recognize need for psychiatric or substance abuse screening or evaluation as needed.
   4) Emergency medication management
   5) Access to a psychiatrist 24-hour per day, seven days per week.
   6) Initial assessment and treatment plan focused on stabilizing and resolving the crisis situation.
   7) Discharge/disposition planning including the development of a crisis relapse plan.

i) Combination of licensed mental health professional, mental health workers, and other appropriate paraprofessional staff.

Programs Certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS)

All New York substance abuse clinics in ValueOptions' network are licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS). A clinic is an outpatient level of service which provides less than ten hours of service per individual per week in the area of substance abuse or mental health counseling. ValueOptions' network clinics adhere to OASAS criteria which include two classes of licensure: Clinic Module and Intensive Module. ValueOptions has utilized OASAS-licensed clinics since 1992 and currently refers to 218 substance abuse clinics within the state of New York. Mental health clinics that participate in the ValueOptions network must have an operating certificate issued by the New York State Office of Mental Health. There are currently 2,183 certified mental health clinics in our national network and 370 in the state of New York, as listed below:

FACILITY NAME	CITY
820 RIVER STREET INC	ALBANY
820 RIVER STREET INC	JAMAICA
820 RIVER STREET INC	QUEENSBURY
820 RIVER STREET INC	ALTAMONT
AHRC HEALTH CARE INC	NEW YORK
ALBANY COUNTY, NY USA	ALBANY
ALCOHOL AND DRUG DEP ENDENCY SVCS	BUFFALO
ALCOHOL AND DRUG DEP ENDENCY SVCS	WEST SENECA
ALCOHOL SERVICES INC	EAST SYRACUSE
ALLEGANY REHABILITATION ASSOCIATES	WARSAW
ALTERNATIVES COUNSELING SERVICES IN	SOUTHAMPTON
ALTERNATIVES COUNSELING SERVICES IN	RIVERHEAD
AREBA CASRIEL INC	NEW YORK
AREBA CASRIEL INC	NEW YORK
ARMS ACRES INC	CARMEL

FACILITY NAME	CITY
ARMS ACRES INC	CHESTER
ARMS ACRES INC	BRONX
ARMS ACRES INC	HASTINGS ON HUDS
ARMS ACRES INC	KEW GARDENS
ASACSC INC	SCHENECTADY
ASI OF CORTLAND LLC	CORTLAND
BASSETT MEDICAL CENTER	COOPERSTOWN
BELVEDERE HEALTH SERVICES	ALBANY
BENEDICTINE HOSPITAL	KINGSTON
BETH ISRAEL MEDICALCENTER	BROOKLYN
BETH ISRAEL MEDICALCENTER	NEW YORK
BETH ISRAEL MEDICALCENTER	NEW YORK
BETH ISRAEL MEDICALCENTER	NEW YORK
BETH ISRAEL MEDICALCENTER	NEW YORK
BETH ISRAEL MEDICALCENTER	NEW YORK
BETH ISRAEL MEDICALCENTER	NEW YORK
BETH ISRAEL MEDICALCENTER	BROOKLYN
BGR SERVICES INC	BROOKLYN
BON SECOURS COMMUNIT Y HOSPITAL	PORT JERVIS
BRIDGE BACK TO LIFE	BROOKLYN
BRIDGE BACK TO LIFE	BETHPAGE
BRIDGE BACK TO LIFE	NEW YORK
BRIDGE BACK TO LIFE	BROOKLYN
BRIDGE BACK TO LIFE	STATEN ISLAND
BRIDGING ACCESS TO CARE INC	BROOKLYN
BRIGHT PATH COUNSELING CENTER	NORTH SYRACUSE
BRONX ADDICTION SERVICES INTEGRATED	BRONX
BRONX LEBANON HOSPIT AL CENTER	BRONX
BRONX LEBANON HOSPITAL CENTER	BRONX
BROOKDALE UNIV HOSPITAL AND MED CTR	BROOKLYN
BROOKHAVEN MEMORIAL HOSPT MED CNTR	PATCHOGUE
BROWNSVILLE COMMUNITY DEVELOPMENT C	BROOKLYN
BROWNSVILLE COMMUNITY DEVELOPMENT C	BROOKLYN
BROWNSVILLE COMMUNITY DEVELOPMENT C	BROOKLYN
BROWNSVILLE COMMUNITY DEVELOPMENT C	BROOKLYN
BRYLIN HOSPITALS INC	WILLIAMSVILLE
BRYLIN HOSPITALS INC	BUFFALO
BUFFALO BEACON CORPO RATION	BUFFALO
BUFFALO BEACON CORPO RATION	AMHERST

FACILITY NAME	CITY
BUFFALO BEACON CORPO RATION	LOCKPORT
BUFFALO BEACON CORPO RATION	NIAGARA FALLS
BUFFALO BEACON CORPORATION	UTICA
BUFFALO BEACON CORPORATION	HERKIMER
C.A.R.E. LLC	RONKONKOMA
CAMELOT OF STATEN ISLAND	STATEN ISLAND
CAN/AM YOUTH SERVICE S INC	MASSENA
CANARSIE AWARE INC	BROOKLYN
CANTON POTSDAM HOSPI TAL	POTSDAM
CATHOLIC CHARITIES DIOCESE ROCKVILL	COMMACK
CATHOLIC CHARITIES DIOCESE ROCKVILL	HAMPTON BAYS
CATHOLIC CHARITIESNEIGHBORHOOD SV	BROOKLYN
CATHOLIC FAMILY CENTER	ROCHESTER
CATHOLIC FAMILY CENTER	ROCHESTER
CATSKILL REGIONAL ME DICAL CENTER	HARRIS
CHAMPLAIN VALLEY FAMILY CENTER FOR	PLATTSBURGH
CITIZEN ADVOCATES INC	MALONE
CITIZEN ADVOCATES INC	SPECULATOR
CITIZEN ADVOCATES INC	SARANAC LAKE
CITIZEN ADVOCATES INC	TUPPER LAKE
CLINTON COUNTY	PLATTSBURGH
COMMUNITY COUNSELING AND MEDIATION	BROOKLYN
COMMUNITY COUNSELING SVC OF W NASSA	FRANKLIN SQUARE
CONEY ISLAND HOSPITAL	BROOKLYN
CONFIDENTIAL HELP FOR ALCOHOL & DRU	AUBURN
CONFIDENTIAL HELP FOR ALCOHOL & DRU	AUBURN
CONIFER PARK INC	GLENS FALLS
CONIFER PARK INC	ROCHESTER
CONIFER PARK INC	SCHENECTADY
CONIFER PARK INC	SCHENECTADY
CORNERSTONE TREATMENT FACILITIES	RHINEBECK
CORNERSTONE TREATMENT FACILITIES	NEW YORK
CORNERSTONE TREATMENT FACILITIES	FRESH MEADOWS
CORNERSTONE TREATMENT FACILITIES	NEW YORK
COUNCIL ON ALCOHOL AND SUBSTANCE AB	GENESEO
COUNCIL ON ALCOHOL AND SUBSTANCE AB	DANSVILLE
COUNCIL ON ALCOHOLISM & DRUG	MONTICELLO
COUNSELING MEDIATION AND FORENSIC	BOHEMIA
COUNSELING SERVICEOF EDNY INC	BROOKLYN

FACILITY NAME	CITY
COUNSELING SERVICEOF EDNY INC	BROOKLYN
COUNSELING SERVICEOF EDNY INC	JAMAICA
COUNSELING SERVICEOF EDNY INC	HEMPSTEAD
COUNTY OF CHENANGO	NORWICH
COUNTY OF DELAWARE	DELHI
COUNTY OF DELAWARE	MARGARETVILLE
COUNTY OF DELAWARE	HAMDEN
COUNTY OF DELAWARE	SIDNEY
COUNTY OF OTSEGO	ONEONTA
COUNTY OF OTSEGO	COOPERSTOWN
COUNTY OF STEUBEN TREASURER'S OFFICE	HORNELL
COUNTY OF STEUBEN TREASURER'S OFFICE	BATH
COUNTY OF STEUBEN TREASURER'S OFFICE	CORNING
COUNTY OF SULLIVAN	MONTICELLO
COUNTY OF SULLIVAN	LIBERTY
CREATE INC	NEW YORK
CREDO COMMUNITY CENTER FOR THE TREA	WATERTOWN
DAYTOP VILLAGE INC	STATEN ISLAND
DAYTOP VILLAGE INC	JAMAICA
DAYTOP VILLAGE INC	BROOKLYN
DAYTOP VILLAGE INC	RHINEBECK
DAYTOP VILLAGE INC	HUNTINGTON STATION
DAYTOP VILLAGE INC	NEW YORK
DAYTOP VILLAGE INC	HARTSDALE
DAYTOP VILLAGE INC	RHINEBECK
DAYTOP VILLAGE INC	BLAUVELT
DAYTOP VILLAGE INC	RHINEBECK
DAYTOP VILLAGE INC	BRONX
DELAWARE VALLEY HOSP ITAL INC	WALTON
DISCIPLESHIP OUTREACH MINISTRIES	BROOKLYN
DUTCHESS COUNTY DEPTOF MENTAL HYGNE	POUGHKEEPSIE
EASTERN LONG ISLAND HOSPITAL ASSOCI	GREENPORT
EASTERN LONG ISLANDHOSPITAL ASSOCI	RIVERHEAD
ELLIS HOSPITAL	SCHENECTADY
ELMHURST HOSPITAL CENTER	ELMHURST
EMPLOYEE ASSISTANCERESOURCE SERVIC	SMITHTOWN
EXODUS CLINIC LLC	MONROE
FAMILY AND CHILDRENSASSOCIATION	HICKSVILLE
FAMILY AND CHILDRENSASSOCIATION	WEST HEMPSTEAD

FACILITY NAME	CITY
FAMILY AND CHILDRENSASSOCIATION	HEMPSTEAD
FAMILY COUNSELING SERVICES	SHIRLEY
FINGER LAKES ADDICTI ONS COUNSELING	CLIFTON SPRINGS
FIRST STEPS TO RECOVERY INC	NEW YORK
FLUSHING HOSPITAL MEDICAL CENTER	FLUSHING
FOUR WINDS OF SARATOGA INC	SARATOGA SPRINGS
GENESEE COUNCIL ON ALCOHOLISM	ALBION
GLENS FALLS HOSPITAL	GLENS FALLS
GLENS FALLS HOSPITAL	HUDSON FALLS
GOOD SAMARITAN HOSPI TAL	SUFFERN
HAMILTON MADISON HOUSE	NEW YORK
HANAC INC	ASTORIA
HARLEM HOSPITAL CENTER	NEW YORK
HARLEM HOSPITAL CENTER	NEW YORK
HARLEM HOSPITAL CENTER	NEW YORK
HAZELDEN	NEW YORK
HAZELDEN	NEW YORK
HAZELDEN	NEW YORK
HOPE FOR YOUTH INC	AMITYVILLE
HOPE HOUSE INC	ALBANY
HOPE HOUSE INC	ALBANY
HOPE HOUSE INC	ALBANY
HOPE HOUSE INC	ALBANY
HOPE HOUSE INC	ALBANY
HOPE HOUSE INC	ALBANY
HORIZON HEALTH SERVICES INC	ORCHARD PARK
HUDSON MOHAWK RECOVERY CENTER, INC	HOOSICK FALLS
HUDSON MOHAWK RECOVERY CENTER, INC	TROY
HUNTINGTON YOUTH BUREAU YOUTH DEVEL	HUNTINGTON
HUTHER DOYLE MEMORIAL INSTITUTE INC	ROCHESTER
HUTHER DOYLE MEMORIAL INSTITUTE INC	ROCHESTER
HUTHER DOYLE MEMORIAL INSTITUTE INC	ROCHESTER
HUTHER DOYLE MEMORIAL INSTITUTE INC	ROCHESTER
IMPACT COUNSELING SERVICES I INC	LAKE GROVE
INNOVATIVE HEALTH SYSTEMS INC	WHITE PLAINS
INSIGHT HOUSE CHEMICAL DEPENDENCY S	UTICA
INSIGHT HOUSE CHEMICAL DEPENDENCY S	UTICA
INTER CARE LTD	NEW YORK
INTERFAITH MEDICAL CENTER	BROOKLYN

FACILITY NAME	CITY
INWOOD COMMUNITY SERVICES INC	NEW YORK
ITHACA ALPHA HOUSE C ENTER, INC	TRUMANSBURG
ITHACA ALPHA HOUSE CENTER, INC	ITHACA
JACOBI MEDICAL CENTER	BRONX
JAMAICA HOSPITAL MEDICAL CENTER	JAMAICA
JNS COUNSELING SERVICES, INC	BROOKLYN
JOHN T MATHER MEMORIAL HOSPITAL	PORT JEFFERSON
KENNETH PETERS CENTER FOR RECOVERY	SYOSSET
KENNETH PETERS CENTER FOR RECOVERY	HAUPPAUGE
KINGS COUNTY HOSPITAL CENTER	BROOKLYN
KINGS COUNTY HOSPITAL CENTER	BROOKLYN
KINGS COUNTY HOSPITAL CENTER	BROOKLYN
LAKE SHORE BEHAVIORAL HEALTH INC	BUFFALO
LAKE SHORE BEHAVIORAL HEALTH INC	ORCHARD PARK
LENOX HILL HOSPITAL	NEW YORK
LENOX HILL HOSPITAL	NEW YORK
LESBIAN AND GAY COMMSVCS CTR INC	NEW YORK
LEXINGTON CENTER FOR RECOVERY INC	POUGHKEEPSIE
LEXINGTON CENTER FOR RECOVERY INC	NEW ROCHELLE
LEXINGTON CENTER FOR RECOVERY INC	MOUNT KISCO
LEXINGTON CENTER FOR RECOVERY INC	WEST HAVERSTRAW
LEXINGTON CENTER FOR RECOVERY INC	DOVER PLAINS
LEXINGTON CENTER FOR RECOVERY INC	RHINEBECK
LEXINGTON CENTER FOR RECOVERY INC	POUGHKEEPSIE
LEXINGTON CENTER FOR RECOVERY INC	SUFFERN
LEXINGTON CENTER FOR RECOVERY INC	MILLBROOK
LEXINGTON CENTER FOR RECOVERY INC	POUGHKEEPSIE
LEXINGTON CENTER FOR RECOVERY INC	BEACON
LINCOLN MEDICAL ANDMENTAL HLTH CTR	BRONX
LONG BEACH MEDICAL CENTER	LONG BEACH
LONG BEACH REACH INC	LONG BEACH
LONG ISLAND CENTER FOR RECOVERY INC	HAMPTON BAYS
LONG ISLAND JEWISH MEDICAL CENTER	WEST HEMPSTEAD
LONG ISLAND JEWISH MEDICAL CENTER	GLEN OAKS
LONG ISLAND JEWISH MEDICAL CENTER	NEW HYDE PARK
LONG ISLAND JEWISH MEDICAL CENTER	ELMONT
LONG ISLAND JEWISH MEDICAL CENTER	FAR ROCKAWAY
LONG ISLAND JEWISH MEDICAL CENTER	MINEOLA
LOWER EASTSIDE SERVICE CENTER INC	NEW YORK

FACILITY NAME	CITY
LOWER EASTSIDE SERVICE CENTER INC	NEW YORK
LUTHERAN MEDICALCENTER	BROOKLYN
MARYHAVEN CENTER OFHOPE INC	RIVERHEAD
MENTAL HEALTH ASSOCIATION OF ROCKLA	VALLEY COTTAGE
MENTAL HEALTH PROVIDERS OF W QUEEN	WOODSIDE
MENTAL HEALTH SERVICES ERIE COUNTY	KENMORE
MENTAL HEALTH SERVICES ERIE COUNTY	BUFFALO
MERCY MEDICAL CENTER	GARDEN CITY
MERCY MEDICAL CENTER	ROCKVILLE CENTRE
MERCY MEDICAL CENTER	GARDEN CITY
METROPOLITAN CENTER FOR MNTL HLTH	NEW YORK
METROPOLITAN HOSPITAL CENTER	NEW YORK
MID-ERIE MENTAL HEALTH SERVICES, IN	CHEEKTOWAGA
MID-ERIE MENTAL HEALTH SERVICES, IN	BUFFALO
MOUNT VERNON HOSPITAL	MOUNT VERNON
NARCO FREEDOM INCORPORATED	LONG ISLAND CITY
NASSAU ALTERNATIVE ADVOCACY PROGRAM	NEW HYDE PARK
NASSAU HEALTH CARE CORPORATION	EAST MEADOW
NEVER ALONE INC	HURLEY
NEW DIRECTIONS	BROOKLYN
NEW YORK SERVICE NETWORK INC	BROOKLYN
NORTH SHORE UNIVERSITY HOSPITAL	MANHASSET
NORTHPOINTE COUNCIL INC	LOCKPORT
NYACK HOSPITAL	NYACK
OCEANSIDE COUNSELING CENTER INC	OCEANSIDE
ONTARIO COUNTY MENTAL HEALTH	CANANDAIGUA
ORANGE REGIONAL MEDICAL CENTER	MIDDLETOWN
OUTREACH DEVELOPMENTCORPORATION	RICHMOND HILL
OUTREACH DEVELOPMENTCORPORATION	BELLPORT
OUTREACH DEVELOPMENTCORPORATION	BRENTWOOD
PARALLAX CENTER INC	NEW YORK
PEDERSON-KRAG CENTER INC	HUNTINGTON
PEDERSON-KRAG CENTER INC	WYANDANCH
PEDERSON-KRAG CENTER INC	SMITHTOWN
PHELPS MEMORIAL HOSPITAL CENTER	OSSINING
PHELPS MEMORIAL HOSPITAL CENTER	SLEEPY HOLLOW
PHOENIX HOUSES OF NE W YORK INC	BROOKLYN
PHOENIX HOUSES OF NEW YORK INC	EAST HAMPTON
PHOENIX HOUSES OF NEW YORK INC	LONG ISLAND CITY

FACILITY NAME	CITY
PHOENIX HOUSES OF NEW YORK INC	NEW YORK
PHOENIX HOUSES OFLONG ISLAND	BRENTWOOD
PHOENIX HOUSES OFLONG ISLAND	EAST HAMPTON
PORT COUNSELING CENTER INC	PORT WASHINGTON
PROJECT RENEWAL INC	NEW YORK
PROMESA	BRONX
PUTNAM FAMILY AND COMMUNITY SVS INC	CARMEL
QSA SERVICES INC	ELMHURST
QUEENS HOSPITAL CENTER	JAMAICA
REALITY HOUSE INC	LONG ISLAND CITY
REALIZATION CENTER INC	BROOKLYN
REALIZATION CENTER INC	NEW YORK
RESTORATIVE MANAGEMENT CORP	PORT JERVIS
RESTORATIVE MANAGEMENT CORP	MIDDLETOWN
RESTORATIVE MANAGEMENT CORP	NEWBURGH
RICHARD C WARD ADDIC TION TREATMENT	MIDDLETOWN
RICHMOND UNIVERSITY MEDICAL CENTER	STATEN ISLAND
RICHMOND UNIVERSITY MEDICAL CENTER	STATEN ISLAND
RIVERDALE MENTAL HEALTH ASSOCIATION	BRONX
ROCHESTER GENERAL HOSPITAL	ROCHESTER
ROME MEMORIAL HOSPITAL	ROME
ROME MEMORIAL HOSPITAL	ROME
ROOSEVELT EDU ALCOHCNSL TRMT CTR	ROOSEVELT
SAFE FOUNDATION, INC	BROOKLYN
SAINT FRANCIS HOSPITAL	POUGHKEEPSIE
SAINT JOHNS RIVERSIDE HOSPITAL	YONKERS
SAINT JOHNS RIVERSIDE HOSPITAL	WHITE PLAINS
SAINT JOHNS RIVERSIDE HOSPITAL	MOUNT VERNON
SAINT JOHNS RIVERSIDE HOSPITAL	HAWTHORNE
SAMARITAN MEDICALCENTER	WATERTOWN
SANCTUARY EAST LTD	EAST ISLIP
SCHOHARIE COUNTY CHEMICAL DEPENDENC	SCHOHARIE
SEAFIELD SERVICES INC	MEDFORD
SEAFIELD SERVICES INC	PATCHOGUE
SEAFIELD SERVICES INC	AMITYVILLE
SEAFIELD SERVICES INC	RIVERHEAD
SEAFIELD SERVICES INC	MINEOLA
SEAFIELD SERVICES INC	PATCHOGUE
SENECA COUNTY TREASURER	SENECA FALLS

FACILITY NAME	CITY
SES OPERATING CORP	NEW YORK
SETON HEALTH SYSTEM INC	TROY
SOUTHEAST NASSAU GUIDNCE CENTER INC	WANTAGH
SOUTHEAST NASSAU GUIDNCE CENTER INC	SEAFORD
SOUTHEAST NASSAU GUIDNCE CENTER INC	LEVITTOWN
SPECTRUM HUMAN SERVICES	BUFFALO
SPECTRUM HUMAN SERVICES	WARSAW
SPECTRUM PSYCHOLOGYAND SOCIAL WORK	KINGSTON
SPECTRUM PSYCHOLOGYAND SOCIAL WORK	POUGHKEEPSIE
SPECTRUM PSYCHOLOGYAND SOCIAL WORK	POUGHKEEPSIE
SPECTRUM PSYCHOLOGYAND SOCIAL WORK	FISHKILL
ST BARNABAS HOSPITAL	BRONX
ST CHARLES HOSPITAL AND REHAB CTR	PORT JEFFERSON
ST CHRISTOPHERS INN INC	GARRISON
ST JOSEPHS ADDICTION TREATMENT	LAKE PLACID
ST JOSEPHS ADDICTION TREATMENT	ELIZABETHTOWN
ST JOSEPHS ADDICTION TREATMENT	TICONDEROGA
ST JOSEPHS ADDICTION TREATMENT	MALONE
ST JOSEPHS ADDICTION TREATMENT	SARANAC LAKE
ST JOSEPH'S HOSPITAL	ELMIRA
ST JOSEPHS MEDICAL CENTER	TUCKAHOE
ST JOSEPHS MEDICAL CENTER	HARRISON
ST JOSEPHS MEDICAL CENTER	YONKERS
ST JOSEPHS MEDICAL CENTER	YONKERS
ST JOSEPHS VILLA OF ROCHESTER	ROCHESTER
ST LUKES ROOSEVELT HOSPITAL CENTER	NEW YORK
ST LUKES ROOSEVELT HOSPITAL CENTER	NEW YORK
ST LUKES ROOSEVELT HOSPITAL CENTER	NEW YORK
ST MARK'S PLACE INSTITUTE FOR MENTA	NEW YORK
ST REGIS MOHAWK TRIB E	AKWESASNE
ST. MARY'S HEALTHCARE	AMSTERDAM
ST. MARY'S HEALTHCARE	GLOVERSVILLE
ST. VINCENT'S SERVICES	STATEN ISLAND
STATEN ISLAND MENTALHLTH SOC INC	STATEN ISLAND
STATEN ISLAND UNIVERSITY HOSPITAL	STATEN ISLAND
STATEN ISLAND UNIVERSITY HOSPITAL	STATEN ISLAND
STATEN ISLAND UNIVERSITY HOSPITAL	STATEN ISLAND
STEP ONE	ELLENVILLE
STEP ONE	HIGHLAND

FACILITY NAME	CITY
SUFFOLK CO DEPT OFHEALTH SRVCS	HAUPPAUGE
SUFFOLK CO DEPT OFHEALTH SRVCS	HUNTINGTON STATION
SUFFOLK CO DEPT OFHEALTH SRVCS	HAUPPAUGE
SUFFOLK CO DEPT OFHEALTH SRVCS	RIVERHEAD
SUMMIT PARK HOSPITALDEPT OF MH	POMONA
SUMMIT PARK HOSPITALDEPT OF MH	POMONA
SUPPORT CENTER INC	PORT JERVIS
SYRACUSE BRICK HOUSEINC	SYRACUSE
SYRACUSE BRICK HOUSEINC	SYRACUSE
SYRACUSE BRICK HOUSEINC	SYRACUSE
TEMPO GROUP INC	WOODMERE
TEMPO GROUP INC	N MERRICK
THE ADDICTIONS CARECTR OF ALBANY	ALBANY
THE BRIDGE INC	NEW YORK
THE CHILD CENTER OFNEW YORK INC	ELMHURST
THE CHILD CENTER OFNEW YORK INC	JAMAICA
THE FORTUNE SOCIETYINC	NEW YORK
THE FORTUNE SOCIETYINC	LONG ISLAND CITY
THE KINGSTON HOSPITAL	KINGSTON
THE KINGSTON HOSPITAL	KINGSTON
THE LONG ISLAND HOME	AMITYVILLE
THE NEW YORK FOUNDLING HOSPITAL	NEW YORK
THE PAC PROGRAM OFTHE BRONX INC	BRONX
THE RESOURCE TRAINING CENTER	BROOKLYN
TIOGA COUNTY	OWEGO
TIOGA COUNTY	WAVERLY
TOWN OF ISLIP	BRENTWOOD
TOWN OF ISLIP	ISLIP
TOWN OF SMITHTOWN	SMITHTOWN
TRI CENTER INC	BRONX
TRI CENTER INC	NEW YORK
TRI CENTER INC	BROOKLYN
TULLY HILL CORPORATION	TULLY
UNITED HEALTH SERVICES HOSPITALS	BINGHAMTON
UNIVERSITY HOSPITAL	SYRACUSE
VILLA VERITAS FOUND ATION INC	KERHONKSON
WHITNEY M YOUNG JR HEALTH CENTER IN	ALBANY
WHITNEY M YOUNG JR HEALTH CENTER IN	ALBANY
WHITNEY M YOUNG JR HEALTH CENTER IN	ALBANY

FACILITY NAME	CITY
WOODHULL MEMORIAL MNTL HLTH CNTR	BROOKLYN
YMCA OF GREATER NEWYORK	BROOKLYN
YMCA OF GREATER NEWYORK	STATEN ISLAND
YMCA OF GREATER NEWYORK	STATEN ISLAND

(6) Describe the approaches you would use to solicit additional Providers to enhance your proposed Provider Network for Facilities, OASAS Programs and Practitioners or to fulfill a request to add a specific Provider.

NETWORK ENHANCEMENTS

Our network development efforts are ongoing. Once a stable network is in place, we will continuously monitor and evaluate the network to ensure appropriate access for Empire Plan enrollees.

We currently maintain an extensive, stable, and NCQA-credentialed network of more than 130,000 behavioral health provider locations across the country, including 11,184 in the state of New York. Nevertheless, our approach in New York will be to immediately begin the recruitment and contracting process for providers of specific interest to the Department. As we conduct ongoing network recruitment, we will work with you to evaluate the comprehensiveness of our network by provider type, and by reviewing provider access.

Our network currently meets the Department's access standards. Our geographic review details the number of contracted providers, the disciplines of the contracted providers, and covered enrollees for a specific geographic area. Using the GeoAccess and the disruption analyses, our New York-based staff will identify and establish targeted recruitment needs for providers and facilities, and each will receive application materials to become credentialed in our network. Throughout this process, we will provide the Department with progress reports detailing the contracting status of each provider under recruitment. We will also use the following sources for potential provider recruitment:

- Potential providers identified during ongoing ValueOptions recruitment efforts
- Network providers already under contract with ValueOptions. Network referrals ensure the recruitment of providers who will bring not only their individual talents, but will work cooperatively with their peers to provide clinically sound, cost-effective behavioral health care services.
- Recommendations from facility providers that meet ValueOptions' credentialing criteria
- Recommendations from Empire Plan enrollees and stakeholders
- New York-based Value Options medical director and other clinical staff
- National associations representing the desired disciplines or specialties, such as the New York State Applied Behavior Analysis Association, New York State Psychological Association, New York State Alzheimer's Association, New York State Nurses Association, and New York State Health Plan Association.

(7) Members may have successful therapy plans with current Network Providers that are not in the Offeror's Network. For key Providers (i.e., those who provide services for a significant number of Members or who are in an underserved area), what criteria would be used to determine which to recruit?

Each Empire Plan enrollee case in progress at the time of transition will receive careful consideration focused on the enrollee's needs. Treating providers eligible to join our network will be a top priority for recruitment. Our primary concern is to sustain each enrollee's continuous, uninterrupted care. We will also work with the Department to identify specific providers with whom you would like us to reach out to for contracting.

At the time of transition, if the recruitment and contracting is not yet completed, we will ensure continuity of services to enrollees in treatment through individual, case rate provider contracts (single case agreements). Our single case agreements enable enrollees to continue their care through the change in vendors, even if their provider is not part of our current network.

If an Empire Plan enrollee needs treatment and there is no specialized provider already contracted in our network in a particular service location, or if the network contracting process is incomplete at the program's start date, we will establish a single case agreement with a local, out-of-network provider. We have specially trained administrative staff to issue single case agreements, and cases are reviewed by clinical staff on an ongoing basis to ensure that they meet medical necessity criteria. A record will be established within our system, and the provider's credentials will be verified to allow payment for enrollees in care for a provisional period of up to 180 days following the transition. Additional criteria used to determine recruitment of a non-network provider are as follows:

- Inadequate network resources for the required covered service
- Network facility is at capacity and cannot accommodate new enrollees
- Clinical service needs (clinical specialty, language, cultural sensitivity, gender) are not met by the current network
- Enrollee preferences cannot be met by the available network and are relevant to treatment outcome
- Enrollee is in need of emergency treatment

(8) Describe your strategy for maintaining the MHSA Program's Network throughout the term of the Agreement resulting from the RFP.

We will support the Department throughout the life of our partnership to recruit, credential, and contract a comprehensive behavioral health network that ensures enrollee choice and access. We have identified providers who are currently in your MHSA network but are not included in ours. (Conversely, there are also providers in our network that are not in the incumbent contractor's

network) Our first step will be to begin to recruit these providers to ensure minimal disruption in care to your enrollees.

Our network management and development efforts will be supported by a team of expert staff who have the necessary knowledge and expertise to develop diverse provider networks. ValueOptions is well-positioned to retain the provider network over the long term because we have a seasoned New York-based provider relations and contracting staff that is community-based and has built credibility with the provider network.

Our New York team is involved in such local organizations as the New York State Applied Behavior Analysis Association, New York State Psychological Association, New York State Alzheimer's Association, New York State Nurses Association, and New York State Health Plan Association. This team will be led by Amanda Pyskadlo, a ValueOptions' Provider Relations Director located in New York, who will be dedicated full-time to this program. Ms. Pyskadlo will have responsibility for managing the adequacy and availability of the provider network and recruiting providers to meet enrollee geographic and clinical specialty needs.

We will regularly monitor the access and availability of all facilities and provider disciplines in the network to ensure access and ample diversity to meet the needs of Empire Plan enrollees. Our provider network composition will be analyzed each quarter, and providers will be actively recruited to maintain network integrity and fill any identified gaps. We will use geographical analysis, ease of scheduling, scheduling audits, and enrollee feedback as the means of monitoring overall appropriateness of the network.

We also listen carefully to our providers' concerns, complaints, and compliments so that we can always maintain and improve our relationship with them. Our provider satisfaction survey is one ongoing instrument that we use for this purpose. These surveys, performed by a third party, measure providers' opinions regarding our clinical and administrative practices, and assess our training needs.

The resulting data is aggregated and trended by our Provider Relations Department to identify improvement opportunities—including areas in which our administrative and clinical practices need revision—and to create specific performance improvement plans. Provider survey data is shared with divisional staff and each Service Center so that corrective action plans can be developed and monitored locally. The survey results are also used for provider training purposes or to improve our own operations.

Moreover, we actively solicit enrollee feedback through member satisfaction surveys to help us. ValueOptions' member satisfaction survey results consistently score in the 90th percentile across all categories. Some specific results from our enrollee surveys pertaining to New York providers include the following:

- Therapist Protects Confidential information – 99.2 percent
- Therapist is just right for needs – 90percent
- First Appointment as soon as desired – 91 percent

(9) How do you monitor whether Network Providers are accepting new patients into their practices? Do your proposed access standards take into account Provider availability? If yes, how?

ValueOptions does not allow providers to limit the cases they accept; however, we do allow a provider to "close" his/her practice to new referrals for a limited time period if he/she believes the practice is at capacity. This limitation is made when the request is received by written notice and the practice is then monitored to assure duration is limited and the practice reopened to new referrals as soon as possible. ValueOptions' percentage of open provider practices in New York state is more than 99 percent.

We also carefully evaluate and document the capacity of network providers to ensure enrollees receive the benefits to which they are entitled according to established, reasonable access performance standards. The methods used to conduct the evaluation are described below:

- **Credentialing Process**—ValueOptions' extensive credentialing process includes an assessment of a provider's capacity to accept additional enrollees. Because our network is driven primarily by enrollee referral, providers are not accepted into the network unless they are able to accept additional enrollees and provide a minimum of 20 hours per week in clinical practice. We do not contract with providers who have full practices or waiting lists. Our credentialing and recredentialing processes provide information about caseload and availability, which provide the opportunity to assess capacity both at the point of entry to the network and at the point of recredentialing. Our provider contract, as well as the Provider Handbook, require provider applicants who have been invited to join our network to inform us if their availability falls below the minimum standard.
- **Network Monitoring**—In addition to evaluating provider capacity during initial credentialing, we also monitor the network continuously to ensure enrollees receive the services and treatment they need promptly and according to established performance standards. This is accomplished via two methods:
  1. ***Enrollee Feedback:*** First, we listen carefully to enrollees regarding any difficulties they may encounter with providers regarding appointment times or waiting periods for treatment. This type of enrollee feedback is typically generated from letters, through our clinical referral or customer service line, or through response to our enrollee satisfaction survey. Information indicating that a provider is unable to provide enrollees with treatment according to established protocols is included in the provider's file. Providers who are non-compliant are then contacted by our Provider Relations team and educated regarding our protocols for availability.
  2. ***Access Analysis—***We further monitor capacity through the completion of access studies such as out-of-plan requests for cultural and ethnic needs, referrals for emergency or urgent services to ensure enrollees access to care within established standards, and provider surveys regarding a provider's ability to accept new enrollees.
- **Provider Demographic Validation**—Between a provider's recredentialing cycle, we outreach to providers to confirm critical information (e.g., demographic, billing, other

information to support referral and claims payment). This pre-populated form enables the provider to quickly review all information and make necessary changes. Updates can also be made via our provider Web portal, ProviderConnect.

- **GeoAccess and Density Measures**—Regular reports through GeoAccess software enable us to ensure that the provider network meets client-prescribed standards for access. These reports are produced regularly to ensure ongoing enrollee access. If providers are suspended from enrollee referrals, they are not included in this measure until a decision regarding their status is rendered.

(10) Network Composition Guarantee: The MHSA Program's service level standard requires that at the least ninety-percent (90%) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologist, Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse Practitioner, Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist), listed on Exhibit I.Y.2; will be maintained throughout the five-year term of the Agreement. Providers who are no longer actively practicing will be excluded from the annual calculation and guarantee.

The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the guarantee.

The Standard Credit Amount for each .01 to 1.0% below the MHSA Program's service level standard requiring that at least ninety-percent (90%) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologist, Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse Practitioner, Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist), listed on Exhibit I.Y.2 will be maintained is $25,000 per year. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologist, Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse Practitioner, Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist), listed on Exhibit I.Y.2 as calculated on an annual basis is $_____. Providers who are no longer actively practicing will be excluded from the annual calculation and guarantee.

NETWORK COMPOSITION GUARANTEE

[redacted]

[redacted]

(11) Network Provider Access Guarantees: You must guarantee that throughout the term of the Agreement resulting from this RFP, Enrollees living in urban, suburban and rural areas will have access, as proposed by the Offeror, to a Network Provider. The Offeror must propose an access guarantee that meets or exceeds the minimum access guarantees set forth in the "Provider Network" Section of this RFP. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the guarantee.

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee, for any quarter, in which the Network Facility Access for Urban Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Facility Access-for Urban Areas Guarantee, is not met by the Offeror.

NETWORK FACILITY ACCESS FOR URBAN AREAS GUARANTEE

[redacted]

[redacted]

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the Network Facility Access for Suburban Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Facility Access-for Suburban Areas Guarantee, is not met by the Offeror.

NETWORK FACILITY ACCESS FOR SUBURBAN AREAS GUARANTEE

[redacted]

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the Network Facility Access for Rural Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Facility Access-for Rural Areas Guarantee, is not met by the Offeror.

NETWORK FACILITY ACCESS FOR RURAL AREAS GUARANTEE

[redacted]

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee, for any quarter, in which the Network Practitioner Access for Urban Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Practitioner Access-for Urban Areas Guarantee, is not met by the Offeror.

NETWORK PRACTITIONER ACCESS FOR URBAN AREAS GUARANTEE

[redacted]

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the Network Practitioner Access for Suburban Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Practitioner Access-for Suburban Areas Guarantee is not met by the Offeror.

NETWORK PRACTITIONER ACCESS FOR SUBURBAN AREAS GUARANTEE

[redacted]

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the Network Practitioner Access for Rural Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $___ for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Practitioner Access-for Rural Areas Guarantee, is not met by the Offeror.

NETWORK PRACTITIONER ACCESS FOR RURAL AREAS GUARANTEE

[redacted]

[redacted]

Measurement of compliance with each access guarantee will be based on a "snapshot" of the Provider Network taken on the last day of each quarter within the current plan year. The results must be provided in the format contained in **Exhibit I.Y.3**. The report is due thirty (30) Days after the end of the quarter.

[redacted]

PROVIDER CREDENTIALING

(1) Confirm that you will utilize a credentialing verification organization or establish credentialing criteria for Practitioners and Facilities, including ALOC, for the purpose of ensuring quality of the Network, including, but not limited to, years of experience, level of education/certification, licensure, quality of care, practice patterns, malpractice insurance coverage, hours of operation and availability of appointments.

ValueOptions is certified by NCQA as a Credentialing Verification Organization (CVO) for 10 out of 10 verification services for our commercial provider network. This certification is effective through December, 2014 and specifically includes the following ten areas:

1. License to practice
2. Malpractice claims history
3. DEA registration
4. Medicaid/Medicare sanctions
5. Medical Board sanctions
6. Work history
7. Education and training
8. Practitioner application processing
9. Ongoing monitoring
10. CVO application and attestation content

Obtaining this certification demonstrates that we have the systems, processes, and personnel in place to thoroughly and accurately verify providers' credentials.

(2) Describe the Offeror's process to ensure that Network Providers meet the applicable state licensing requirements and are in compliance with all other federal and state laws, rules and regulations. What is the resource, data base, or other information used by your organization to verify this information?

ValueOptions will ensure that the Empire Plan provider network meets and maintains licensure and insurance through primary source verification. This includes verifying the provider's education and training, board certifications, malpractice history, and ensuring that the provider maintains an active, unencumbered license at the highest level available across the service area. Additionally, we require all practitioners to have a minimum of three years post-licensure clinical experience in direct behavioral health care. If during the course of primary source verification we identify an issue, we will engage in further research to reconcile the identified concerns and/or seek additional information from the provider.

We also determine whether there have been sanctions that might compromise the provider's ability to provide safe, appropriate care to enrollees. At initial credentialing, and monthly thereafter, we query the following to verify that providers have not been excluded from participation in Medicare, Medicaid, or any other federal health care program:

- Office of the Inspector General's List of Excluded Individuals/Entities
- General Service Administration's Excluded Parties List System
- Office of Foreign Assets Control, a U.S. Department of Treasury agency that enforces mandatory screening of all employees, vendors, and providers against a database of individuals and entities involved with terrorists or terrorist activities

We will also query other applicable licensing boards and agencies to identify providers not listed in good standing. We do not execute agreements with providers who have active sanctions from any of the above-named agencies.

(3) Describe your approach for credentialing Network Providers.
  (a) Specify if you utilize an external credentialing verification organization. When was this process last completed? What is your process for confirming continuing compliance with credentialing standards? How often do you conduct a complete review?
  (b) What steps do you take between credentialing periods to ensure that Network Providers that are officially sanctioned, disciplined, or had their licenses revoked are removed from the Provider Network as soon as possible? What steps, if any, do you take to advise members when a Provider has been removed from the Provider network? Under what circumstance would you notify the Department of the removal of a Network Provider?

(a) CREDENTIALING NETWORK PROVIDERS

Credentialing Verification Organization

ValueOptions does not use an external credentialing verification organization because our organization was accredited by NCQA as a CVO (credentialing verification organization) in December, 2012 and our current certification is effective through December, 2014. ValueOptions is fully accredited in all ten areas of expertise, and as such credentials and re-credentials providers, facilities, and programs according to policies and procedures set forth by our National Networks Development and Management Department, which are based on National Committee for Quality Assurance (NCQA) requirements. The credentialing program will specify the procedures for application to the Empire Plan network, URAC/NCQA-compliant credentialing verification, and submission of applications for review and approval by our National Credentialing Committee. The ValueOptions National Credentialing Committee will also provide oversight of the recredentialing of applicants for continued network participation. The re-credentialing process, which occurs every three years for practitioners, is described below.

Credentialing Process Completion Date

Once a network provider is nominated for inclusion into our network and the application is sent to the provider, the provider is required to complete the application, sign it, and send it back for the credentialing process to begin. Our policies and procedures state the credentialing process must be completed within one year of the date the provider signs the application's attestation form, unless otherwise regulated by state or federal laws. However, we are routinely able to credential and notify the provider of the credentialing decision within 30-60 days of receipt of a completed application.

Confirming Continuing Compliance with Credentialing Standards

ValueOptions establishes criteria for credentialing network practitioners, facilities, and programs through a process involving client input and internal departmental knowledge of industry standards, including any related quality issues. All credentialing criteria are reviewed by the ValueOptions National Credentialing Committee at least annually. In addition, in accordance with URAC/NCQA requirements, ValueOptions monitors provider compliance with credentialing standards through the following mechanisms:

- recredentialing process, incorporating a full review including primary source verification every three years
- ongoing evaluation of enrollee-reported issues (i.e., complaint and grievances) at the time of their occurrence and trended every six months per URAC/NCQA requirements
- annual review of enrollee-reported issues including complaints or quality of care issues
- trends of enrollee-reported issues every six months
- ongoing monitoring of provider-reported issues (i.e., adverse incident reporting)
- continuous monitoring of expired documents (i.e., malpractice and licensure)
- analysis of provider practice patterns, utilization management activities, enrollee complaints and clinical outcomes to identify best practice for targeted populations

Frequency of Complete Review

The following are critical review points that supplement the full review:

- **Monthly**—Ongoing sanctions (Office of Inspector General, DARS, State sanctions/licensure reports, expired documents including malpractice and license, and Medicare/Medicaid opt-outs)
- **Semi-Annually**—Complaint and incident patterns and trends
- **Annually**—Provider Demographic Validation, consisting of a complete review of all demographic elements contained in the provider information system, including all relevant addresses and phone numbers (practice, mailing and billing), specialties, availability
- **Every Three Years**—Complete review of all elements, including primary source verification, consistent with URAC/NCQA requirements

We use our Web-based credentialing software program that includes imaging, automated forms processing, on-line faxing, and ad hoc query capabilities. The system automatically feeds into ValueOptions' other administrative and clinical systems to help manage claims payment, referrals to specific providers, provider service inquiries, provider demographic changes, as well

as application submission and/or recredentialing submission and review activities. Our integrated electronic credentialing program serves as the single source of all data entry related to providers, and can be customized to accommodate the Empire Plan's specific guidelines.

Credentialing Process

Our document support team mails the provider an application packet—consisting of an application, two copies of the provider agreement(s), and fee schedules—and updates our system to indicate the mailing date. Provider data entered into our network management and credentialing platform during the credentialing process automatically downloads into ValueOptions' other applications. For example, the provider's tax identification number downloads into the claims system to enable claims payments, and the provider's office address, practice specialties, and business hours download to the referral system.

Upon receiving the provider's application packet, a document support team member date stamps the documents, enters that date in the credentialing portal, scans the application and forwards the information to the data entry team for processing. A data entry specialist indexes the electronic documents and enters the application data into the system, and then forwards the application to a Credentialing Specialist.

The Credentialing Specialist reviews the application for completeness and determines if the provider meets ValueOptions' license-specific credentialing criteria. If any of these conditions are not met, the provider is denied network status. These denials are presented to our National Credentialing Committee for possible exceptions to this process. If the exception is granted, the reason and documentation of the authorized exception request are included in the provider file.

Any information missing from the packet is noted in the system, as well as attempts made by the Credentialing Specialist to collect the missing information. The Credentialing Specialist will contact the provider three times to collect missing information. If the information is not received, the credentialing process is terminated and the termination status noted. Once missing information is received, the Credentialing Specialist begins the primary source verification process.

Re-Credentialing Process

The re-credentialing process, which occurs every three years for practitioners, is typically initiated six months prior to the re-credentialing due date. The practitioner is sent a re-credentialing application, or has the option of completing the re-credentialing packet online through our provider portal. Once the packet is completed and received by ValueOptions, the re-credentialing process follows the same course as credentialing except that once the practitioner's application is verified through primary sources, the Credentialing Specialist gathers performance data which further demonstrates the practitioner's continuing eligibility for inclusion in our network. This information is gathered from enrollee complaints, quality improvement activities, and utilization management data and is part of our Provider Quality Performance tool.

(b) MONITORING PROVIDERS BETWEEN CREDENTIALING CYCLES

All credentialed providers are monitored between re-credentialing cycles for possible sanctions from the Office of the Inspector General (OIG); Medicare/Medicaid; a State agency, State licensure, or certification board; and the Medicare Opt-Out listings for exclusions from Medicare programs. Our National Networks and Compliance departments review reports, document review findings, and maintain logs of all sanctioned or disciplined providers identified by the licensing boards from each state and the reports from the OIG Medicare/Medicaid on a monthly basis. In addition, ValueOptions' provider contracts, the Provider Handbook, and the Empire Plan Provider Guide require each provider to notify ValueOptions of any changes to their licensure or malpractice status.

Notification of the Department

When a network provider is removed from our network for any reason we will promptly notify the Department in writing. We will also document how care will be transitioned for any patients seeking to retain a network provider.

(4) How does Provider Relations staff keep abreast of Provider practices, attitudes, and concerns in New York State and other areas? Do you have Provider Relations staff that is located in NYS? How do you support a strong information infrastructure for your Network Providers?

ValueOptions is committed to retaining a local, New York-based team of Provider Relations and Credentialing professionals. We have eleven New York state-based staff who will support the Empire Plan account. These staff members will provide training, contracting, and provider relations services. This team is further supported by our Provider Relations staff located throughout the country. If needed, ValueOptions will add additional dedicated Provider Relations and Contracting staff to our New York-based team to support the Empire Plan network. This professional group maintains rapport with our providers through active participation in various community and professional organizations such as the New York State Applied Behavior Analysis Association, New York State Psychological Association, New York State Alzheimer's Association, New York State Nurses Association, and New York State Health Plan Association.

We believe this staffing model and approach to Provider Relations and Contracting will enable our local subject matter experts to promote the needs of the Empire Plan and its enrollees, and fairly represent our network of providers both in New York and nationally.

We will monitor and address provider attitudes and concerns via the following:

- Annual provider survey, conducted through an independent research firm
- Ongoing complaint monitoring
- Quarterly stakeholder meetings, comprised of a panel of providers who will provide feedback and input into ValueOptions' policies, procedures and practices

- Regular review of provider inquiries collected through our provider services line and electronic inquiries from our Web portal
- Participation of professional groups (i.e., National Association of Social Workers, New York State Psychological Association, etc.) at both the national and local level
- Participation in trade associations and provider conferences (sponsored by ValueOptions and other organizations)

Provider treatment practices will be evaluated through:

- Clinical treatment record reviews
- Site visits
- Enrollee satisfaction surveys
- Access and availability analyses
- Provider quality monitoring
- Adverse incident review monitoring
- Administrative process reviews (i.e., fraud and abuse reviews)
- Outcomes and quality measurement analysis

Supporting a Strong Information Infrastructure

ValueOptions has developed a comprehensive information infrastructure that assures providers are both continuously informed of our programs and services and 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:

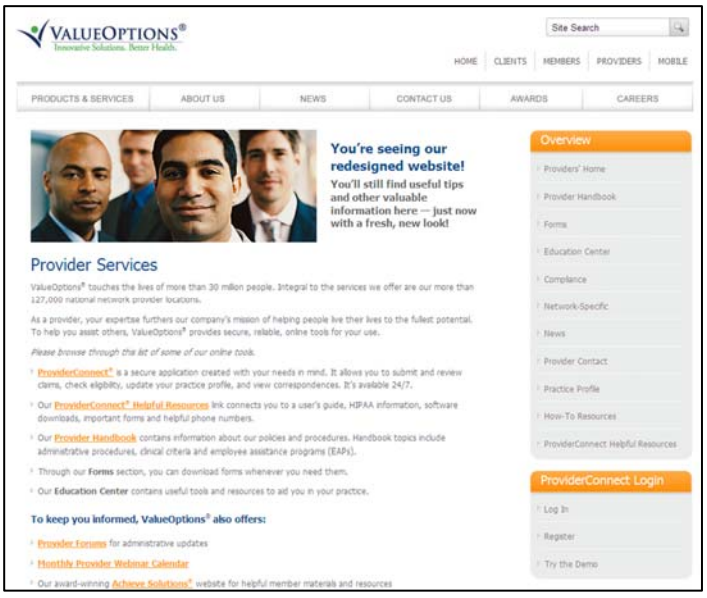
- **Web-based education forums:** Each quarter, our Provider Relations team presents orientation and training Webinars that include topical information on current issues. All Webinar training sessions are offered live, but are also recorded and posted on our website for providers to review at their convenience. ValueOptions' national Provider Relations team offered 187 training forums in 2011, reaching a total of 7,000 providers.
- **Face-to-face educational forums:** We have developed focused, training programs based on quality and network management data analysis. Hands-on technical assistance facilitates provider usage of our technology and improves transactional efficiency. It also enables us to forge relationships to promote best practices in clinical care.

- **Telephone support:** We offer telephone support for providers who need technical assistance or who have questions about our programs or services. A Provider Relations representative is always available to handle calls promptly and efficiently.
- **Provider Alerts:** Our Provider Alerts are delivered either via e-mail blast or fax blast to promptly communicate any policy changes. They are continuously available online, and can easily be sorted by content or date.
- **Onsite, individualized support:** Our Provider Relations staff makes onsite support available on request.
- **Newsletters:** Our monthly e-newsletter, *The Valued Provider*, covers pertinent clinical and administrative topics.
- **E-mail taglines:** Our Provider Relations staff uses e-mail taglines to promote initiatives and share important information. These taglines offer providers direct links to a variety of resources.
- **Free and discounted CEUs/CMEs:** We offer providers access to free or discounted continuing education units and continuing medical education credits through our learning management system. It is an online library comprising hundreds of accredited courses on mental health topics—more than 900 hours of interactive courses.

We routinely conduct customized provider trainings to accommodate our clients' needs. Our ongoing training programs typically include clinical topics, such as evidence-based and emerging best practices, as well as training related to regulatory and industry-specific topics. For example, with the advent of Mental Health Parity, we provided a series of newsletter articles and Webinars to ensure providers were fully aware of and understood the impact to their practice. We also compiled a list of frequently asked questions which we made available to providers, including describing any differences in how they conduct business with us, and how to contact us for additional questions. Additionally, we have created specific training around fraud and abuse and duty-to-warn, to name just a few topics. Our national Provider Relations team will coordinate with the Department to develop Empire Plan-specific curricula based on geographic considerations, enrollee issues, and clinical specifications.

Provider Web Portal

We offer providers 24 hours a day, seven days a week access a dedicated provider portal that allows them to conduct administrative transactions such as submitting claims or requesting authorizations via a customized, user-friendly website. Our secure provider Web portal enables them to view, submit, and execute care management transactions online. This easy-to-use website gives providers real-time access to the tools they need to answer a majority of their administrative and care questions, to request services for enrollees, and to set up



reminders for enrollees. Processes for filing claims, service authorizations and UM functions are an integrated part of our management information system, all accessible through the provider portal. The automated authorization edits built into our claims processing system and the online care management functions of our care management system reduce providers' administrative burden so that they can focus more time on providing care.

Key features our provider portal include the following:

- Verifying enrollee eligibility and benefits
- Accessing personalized messages and submitting secure communications
- Requesting and viewing authorizations and status
- Submitting HIPAA-compliant claims via single claim or batch process
- Entering enrollee reminders for appointments and medications
- Obtaining detailed claims status information
- Submitting updates to provider demographic information
- Submitting recredentialing applications

Our provider Web portal is easy to use and has a high rate of adoption in other behavioral health programs we manage. For example, in Maryland, Illinois, and Arkansas, provider adoption of our system ranges from 96% to above 98%.

(5) How do you help your Network Providers achieve patient-centered care? How do you help Network Providers improve their diagnosis and assessment abilities to ensure that the care they provide is based upon the best available scientific knowledge? How do you ensure that your Network Providers collaborate with other clinicians to ensure an appropriate exchange of Enrollee information and coordination of care?

ACHIEVING PATIENT-CENTERED CARE

ValueOptions' Empire Plan Provider Relations and Contracting Team will be the cornerstone of our provider training and relationship development, providing information and resources to our provider network in support of patient-centered care. The Provider Relations Team, along with our Clinical Operations and Quality Management Team, will offer providers access to the data and information they need to advise and make appropriate behavioral health care decisions for Empire Plan enrollees. In addition to the information infrastructure described above in response to Question 4, ValueOptions has developed various processes and tools to help providers achieve patient-centered care and to ensure that the care they provide is based on the best available scientific knowledge. These include:

- clinical protocols supporting evidence-based best practices
- clinical criteria and practice guidelines
- telephonic Peer Advisor consultation
- telephonic clinical reviews with Care Managers

- quality initiatives supporting the involvement of enrollees in treatment planning and goal setting
- clinical forums
- Web-based technology
- Outpatient Review Form questions specifically aimed at ensuring patient-centered care and coordination of care, including:
  - "I am treating this patient according to ValueOptions' treatment guidelines"
  - "I am coordinating this patient's case with other behavioral/medical providers as appropriate"
  - "The treatment plan was developed with the patient and has measurable, time-limited goals"

An additional tool used to achieve patient-centered care includes our Achieve Solutions website. This online resource contains thousands of articles, quizzes and other tools on hundreds of topics including depression, stress, relationships, health, parenting, workplace issues, addictions and more. Available to enrollees as well as providers, this application can be used to engage enrollees as active participants in their own treatment.

COLLABORATING WITH OTHER CLINICIANS

The importance to ValueOptions of coordination of care is evidenced by the fact that we include a requirement in our provider contracts to adhere to coordination of care standards. Further, adherence is verified via provider audits.

ValueOptions also participates in team rounds to support primary care physicians and to ensure integrated care for enrollees. In weekly meetings, the medical and behavioral health care teams typically present an average of 12-15 cases to coordinate care plans. The Medical Directors from physical and behavioral health attend with the case managers. With the staff co-location model that we employ on behalf of some clients, many of the cases are dealt with as a routine part of the care management work day. The most complex cases are typically dealt with through ad hoc meetings involving the health plan.

ValueOptions has established a toll-free Physician Consult Line staffed by ValueOptions board certified psychiatrists. These psychiatrists are available for telephonic consultation regarding all aspects of mental health and substance abuse treatment, including medications. This one-on-one communication helps enrollees receive the benefit of expert behavioral health care through their primary care physician for the evaluation of depression, anxiety, and substance abuse.

In addition, we provide opportunities for network providers to collaborate with other clinicians in the community as well as ValueOptions through the following venues:

- treatment record review audits
- site visits to program facilities with an emphasis on coordination of care
- provider forums and focus groups
- National Stakeholder's Committee
- New York State Professional Groups

(6) Confirm that you will maintain credentialing records and make them available for review by the Department upon request.

ValueOptions confirms that we will maintain credentialing records and make them available for review by the Department upon request.

(7) Provider Credentialing Guarantee: The MHSA Program's service level standard requires that at least within sixty (60) Days of receipt of a completed Provider application to join the MHSA Program's Network, the review, including credentialing, will be completed and the Practitioner, ALOC Program or Facility notified of the determination. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The Standard Credit Amount for each Provider application to join the MHSA Program's Network where the review, including credentialing, and notification of the determination to the provider is not completed within sixty (60) Days is $1,500. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $_____for each Provider application to join the MHSA Program's Network where the review, including credentialing, and notification of the determination to the Provider is not completed within sixty (60) Days (or the Offeror's proposed guarantee).

PROVIDER CREDENTIALING GUARANTEE

[redacted]

Provider Contracting

(1) Explain your approach to Network Provider fee schedules, including a description of the type(s) of financial arrangements you have with each type of Provider (e.g., per diems, case rates, hourly rates, all inclusive per diems covering Facility and Practitioner fees, etc.). Specify if Providers are reimbursed at varying levels of the Provider fee schedule for the same covered service.

ValueOptions' current reimbursement models include fee-for-service, case rates, and capitated arrangements. Our contracted network providers are reimbursed on a fee-for-service basis while hospitals and facilities are typically reimbursed based on negotiated per diem rates for the various levels of care that are offered. The per diem rate may or may not be inclusive of the attending practitioner fees.

Several of our high quality, high volume inpatient and outpatient providers have opted for case rate arrangements to maximize the focus on efficient and effective care rather than length of stay. For example, a fee-for-service model does not fully support outpatient providers who have unique programs that focus on outcomes rather than actual mix of services, nor does it support inpatient providers who have a very intense assessment and disposition approach that enables them to stabilize and transition enrollees to lower levels of care effectively.

Moving forward, ValueOptions continues to explore innovative payment models more focused on quality and cost components, while also ensuring compliance with our clients' specific program requirements. In addition, we are also implementing pay-for-performance models and provider incentives to drive performance, improve the quality of care provided to enrollees, and achieve better outcomes.

Our providers are reimbursed at various levels of the provider fee schedule for the same service based upon discipline and licensure level.

(2) Confirm that your agreements with Network Providers require their compliance with all the MHSA Program's requirements and benefit design specifications. Provide a copy of the Offeror's proposed Provider contract for both Facilities and Practitioners.

ValueOptions confirms that our provider agreements require their compliance with all of the MHSA Program's requirements and benefit design specifications. We provide a copy of our standard contracts for facilities and practitioners as **Attachment 7**.

(3) Confirm that Network Providers accept as payment-in-full, the Contractor's contractual reimbursement for all claims for covered services, subject to the applicable MHSA Program copayments.

ValueOptions confirms that network providers accept as payment in-full our contractual reimbursement for all claims for covered services, subject to the applicable MHSA Program copayments.

(4) Confirm that you will, without delay, notify the Department in writing of any substantial changes to the number, composition or terms of Provider contracts utilized by the MHSA Program.

ValueOptions confirms that we will, without delay, notify the Department in writing any substantial changes to the number, composition, or terms of provider contracts utilized by the MSHA program.

(5) Complete the following chart listing reasons for voluntary Provider Network terminations:

Facilities/ALOCs/Practitioners	2012	2011	2010
Voluntary Terminations:			
Dissatisfaction with fees	23	43	81
Disagreement with clinical decision	0	0	2
Dissatisfaction with administrative process or paperwork	0	0	0
Dissatisfaction with contractual terms	40	31	41
Other (describe)	920	729	737
Total Voluntary terminations	983	803	861
Number of Network Providers on December 31st	60,343	55,101	53,109
Percent of Network	1.6%	1.5%	1.6%

(6) Describe the circumstances under which the Offeror will negotiate a single case agreement with a Non-Network Provider. Estimate the frequency with which you would expect to authorize network level benefits for non-network inpatient and outpatient services received under the MHSA Program.

SINGLE CASE AGREEMENTS

While ValueOptions' network is comprehensive both clinically and geographically, there are instances where a single case agreement is utilized. A single case agreement occurs when ValueOptions authorizes a referral to a non-network provider with reimbursement at the network

level of benefits, or when it is in the best interest of a member to continue treatment with a non-network provider during a transition period. When a single case agreement is approved, it would typically be due to the enrollee presenting with a unique clinical need, such as a provider fluent in sign language. In these cases, we will negotiate a case rate with the non-network provider and would begin recruiting efforts to enlist the provider into our network.

Based on our previous experience and the strength of our network in New York, we expect the rate of non-network utilization and single case agreements to be low.

(7) Describe the tiering criteria and incentives you propose for the MHSA Program.

Below we describe our incentives programs for providers and facilities. We would be pleased to work with the Department, leveraging our experience with innovative payment models, to develop a customized tiered provider network for your enrollees.

PROVIDER REWARD PROGRAM

Our provider reward program, ValueSelect[SM], is designed to identify and reward providers who are high performers. The ValueSelect designation recognizes network outpatient providers for engaging in activities that promote clinical effectiveness, enrollee access to services, enrollee satisfaction, and administrative efficiency. Currently we have 6,200 ValueSelect designated providers throughout the country, with 811 of those in the state of New York. ValueSelect providers are eligible for a number of valuable benefits, including distinction in our provider search engine.

ValueSelect Eligibility Criteria

Providers are eligible for ValueSelect based on the following criteria:

- Accessibility: Seeing five or more ValueOptions members in the past 12 months (or at least 10 commercial members for clinics)
- Administrative efficiency: conducting transactions using ValueOptions' ProviderConnect portal within the past 12 months
- ValueSelect Activities: Engaging in one or more of the following activities:
  - Participation in the "On Track" outcomes program
  - Submitting at least 50 percent of claims electronically
  - Having clients complete the ValueOptions Patient Treatment Survey

Eligibility for ValueSelect is reviewed semi-annually. ValueOptions also distributes a semi-annual ValueSelect Provider Performance Report with provider-specific results on the ValueSelect and other practice pattern metrics.

Benefits of the ValueSelect Designation

Outpatient providers who qualify for ValueSelect enjoy a number of benefits:

- Opportunity for increased referrals – ValueSelect providers are identified in the ValueOptions provider search engine, ReferralConnect.
- Free CEU/CMEs – ValueOptions has partnered with Essential Learning to provide online CEU courses at NO CHARGE to ValueSelect providers. Providers are able to access this Web portal and sign up for self-paced online courses through ProviderConnect. In addition, ValueSelect providers receive invitations to participate in live CME, CEU or professional development hour seminars offered at no charge.
- Training Discounts – ValueOptions has partnered with Behavioral Tech, LLC a nationally renowned evidenced-based practice training firm. Behavioral Tech offers a 10 percent discount on training for ValueSelect providers.
- Access to Achieve Solutions – ValueSelect providers have access to Achieve Solutions, ValueOptions' award-winning website that offers valuable mental health resources, assessment tools and articles that may be shared with clients.

FACILITY AND OUTPATIENT CLINIC REWARD PROGRAM

Our Facility ValueSelect Program supports the identification of high quality inpatient programs and steerage of enrollees. Currently we have 304 ValueSelect facilities in our nationwide network with 94 in the state of New York. The Facility ValueSelect Program identifies inpatient facilities that have exhibited track records of consistency with regard to specific metrics. Included in these metrics are patient length of stay, length of certification, step-downs to alternate levels of care, appropriate and timely discharge plans, and key quality indicators such as applicable HEDIS measures (i.e., 7-day and 30-day ambulatory follow-up rates) and readmission rates.

Facilities that have partnered with us in this program generally receive an initial block certification for the inpatient level of care if the patient meets medical necessity at time of pre-certification. The numbers of days for the block certification are based on historical data which indicate how the facility has been able to manage the stays within certain lengths of stay. Concurrent reviews are not necessary during the "block certification" time frames.

We then have telephonic monthly meetings with the facility to monitor and discuss the data and/or any other issues which may impact the indicators. We work toward assisting the facility to succeed, and offer whatever resources we might bring to bear in order to optimize the continued success of the partnership. If facilities have difficulties maintaining the standards, we make every attempt to work with the facility to return to baseline so that the partnership can continue. Our experience with this type of program has been quite successful, and has proven to be a true "win-win" situation for ValueOptions and our key inpatient facility partners.

The following criteria are monitored for inclusion in the ValueOptions' ValueSelect Program:

- demonstrated history of collaboration with ValueOptions on treatment planning and coordination of care
- facility favorably compares to the average community length of certification for care
- facility meets HEDIS standards for discharges and has acceptable ambulatory follow-up rates
- facility maintains readmission rates lower than the community standard

- complaints from members meet acceptable standards
- adverse incidents meet acceptable standards
- claims are correctly submitted with all appropriate information
- compliance with Quality Improvement audits

In some areas, ValueOptions has Clinical Care Managers on site for UM reviews. This is usually reserved for high-volume facilities. ValueOptions will also conduct on-site reviews for quality as needed. On-site reviews of quality are done when a pattern of quality of care or quality of service is identified. ValueOptions is in compliance with the URAC standards for on-site reviews.

Similar to the Facility ValueSelect program, ValueOptions initiated a ValueSelect program for select outpatient mental health/substance abuse providers who demonstrate excellent service. This program has been in place for 12 years, and currently includes 15 large outpatient groups. Performance metrics include average number of sessions, average number of sessions by diagnostic category (i.e., Mood Disorders or Substance Abuse Disorders), average number of sessions by age category (i.e., Child 0 to 12 or Geriatric 65+), and other categories such as cases referred to Integrated Care Management Program, Primary Care Physician integration, and quality indicators such as complaints/grievances.

ValueOptions works to establish relationships with our providers and facilities to ensure excellent quality of care for all enrollees.

Diagnostic Specialty Units

ValueOptions believes that stratification of the provider network system is essential to cost effective care. One facet of our strategy has been the creation of a sub-network of Diagnostic Specialty Units to serve as tertiary referral centers for complex, high-cost cases requiring a specialized level of clinical expertise with an eye toward insuring higher quality care that will reduce not only long term mental health care costs, but also medical/surgical and workplace costs. We began this process by identifying those conditions for which routine care is often insufficient to bring about satisfactory outcomes. We arrived at the following list of conditions:

- Chemical Dependency and Dual Diagnosis (combined Psychiatric and CD)
- Complex Adolescent Behavioral Disorders
- Disorders with significant cultural modifiers
- Developmentally Disabled/Psychiatric Disorders
- Eating Disorders
- Gambling Addiction
- Co-Morbid Medical and Psychiatric Disorders
- Mood/Affective Disorders
- Anxiety Disorders
- Psychotic Disorders
- Self Mutilation
- Sexual Disorders

Researching various sources, we identified facilities with acknowledged reputations in the treatment of these disorders. Subsequently, we cross-referenced identified facilities against our own multi-year, 20+ million lives database that includes information on utilization, readmission rates, outcomes, complaints, grievances, administrative compliance, credentialing information, and contract status to arrive at a draft list of facilities to utilize as centers of excellence.

PROVIDER AUDIT AND QUALITY ASSURANCE

(1) Describe the Provider audit program you would conduct for the MHSA Program including a description of the criteria you use to select Providers for audit and a description of the policy that you follow when a Provider audit detects possible fraudulent activity by the Provider or an Enrollee. Include all types of audits performed and offered by your organization.

PROVIDER AUDIT PROGRAM

ValueOptions audits providers for clinical quality of care, compliance with outpatient and inpatient policies, clinical criteria, clinical practice guidelines, and other standards of care, as well as financially for potential cases of fraudulent activity.

Clinical Provider Audits

ValueOptions adheres to the clinical treatment record evaluation and guidelines as defined by NCQA. Periodic, random auditing of network providers' treatment records by our Medical Director or Clinical Director ensures that the records adhere to national standards of practice and reflect appropriate behavioral health care management, including following evidenced-based care practices.

These audits also check for compliance with elements of our Quality Management Program, which monitors and evaluates quality across our entire range of our services, focusing on:

- Strengthening the consistency and effectiveness of member and provider services
- Ensuring that our policies and procedures comply with the stringent accreditation standards of NCQA and URAC, as well as federal requirements of CMS

Specifically in the provider audits, we look to ensure that providers are including coordination of care with primary care physicians and other behavioral healthcare providers as appropriate, and compliance with clinical practice guidelines. In addition to standard random audits, other conditions under which a treatment record audit could be triggered include:

- quality of care issues
- follow-up to an adverse incident
- instances of possible over- or under-utilization
- suspected or alleged fraud

Aggregate results of the treatment record reviews are reported to the Service Center and ValueOptions Corporate Quality and Utilization Management Committees to identify opportunities for improvement. The review process includes an assessment of:

- coordination of care
- customized treatment plans
- risk assessment
- legibility

Facilities and programs may be chosen for an audit when the following circumstances demonstrate the need for a visit:

- average length of stay (ALOS) utilization patterns do not reflect local norms
- facility treatment protocols require further investigation
- complaints are received from enrollees and dependents
- Care Managers report general misunderstanding of ValueOptions' protocols and procedures by facility staff
- adverse incidents have occurred
- Quality Improvement Projects (e.g., project to decrease inpatient readmissions within seven and 30 days of discharge)
- quality of care issues exist

ValueOptions has both legal and fiduciary obligations to ensure that the funds it receives from clients is properly paid for services rendered by providers. All suspected fraud and abuse cases are sent to our Special Investigation Unit for further investigation and resolution.

Environmental Site Visit

All high-volume practitioners and facilities require site visits prior to the initial credentialing decision, when a quality of care issue warrants a site visit, when a high-volume provider relocates or opens an additional office, or when contractually obligated. The structured site visit must include the following elements:

- parking
- wheelchair accessibility
- cleanliness
- telephone access
- appointment access for routine, urgent, and emergent referrals
- after hours coverage
- assessment of storage of patient records (e.g., locked cabinet)

Once a site visit is required, ValueOptions must perform the site visit within 45 days. Once completed, a ValueOptions Credentialing Administrator reviews the site visit report and scores the visit form. If the site visit meets all criteria at 80 percent, the site will pass. If the score is less than 80 percent, the Provider Relations Team is notified and a corrective action plan is put into place with the provider. The provider will then have 120 days to take the necessary steps to correct the issues. The corrective action plan is then forwarded to ValueOptions' National Credentialing Committee for any additional recommendations. ValueOptions will report the total number of environmental site visits to the Department on a quarterly basis.

Financial/Fraud and Abuse Audits

ValueOptions has policies in place to address provider fraud and abuse. We conduct regular claims sampling and data validation audits of network providers to ensure compliance with Federal and State documentation and billing requirements, as well as monitor for fraud and

abuse. Internal control procedures are analyzed for inconsistencies and risk. We conduct three types of audits:

1. **Desk Reviews**—Desk review audits include random or focused claims samples and medical records that providers fax, scan, or mail to the auditors.
2. **Focused Field Audits**—Similar in scope to the desk reviews, focused field audits may warrant onsite visits due to issues or questions identified during the review or deemed appropriate by the Department.
3. **Comprehensive Audits**—These audits are detailed investigations that may include all areas relevant to proper claims payment and incorporate other departments such as Clinical, Quality, and Credentialing, for example.

If a provider is suspected of fraudulent activity, the case is referred to our Special Investigations Unit for further research and resolution. We describe this unit and the specific investigation and resolution procedures in response to the following question.

(2) Describe the corrective action and the monitoring that takes place when you find that a Provider is billing incorrectly or otherwise acting against the interests of your clients. Please indicate whether you have a fraud and abuse unit within your organization and its role in the Provider audit program. In the extreme case of potentially illegal activity, what procedures do you have in place to address illegal or criminal activities by the Provider?

PROVIDER MONITORING AND CORRECTIVE ACTION

We fully investigate all potential cases of provider fraud and abuse and develop appropriate corrective action, as necessary. We rely on several resources to gather information on fraud and abuse allegations, including coordination with our clients, reports made to our Ethics & Privacy Hotline, telephone referrals, and provider and enrollee communications.

When a provider is referred for alleged fraud and abuse, we target the specific issues identified and use an array of tools to evaluate provider compliance. This may include, but is not limited to:

- Onsite reviews
- Interviews with management, operations, finance, or other personnel
- Questionnaires soliciting impressions from a broad cross-section of employees
- Internal control assessment surveys
- Reviews of financial and compliance documents
- Financial, claim, or record auditing
- Trend analyses that uncover errors over a period of time

We will review provider accounting records, as necessary, to ensure services were provided to eligible enrollees, billed services were actually those of the provider, provider billing is in

compliance with program rules, and accurate records are kept for all services rendered. We investigate any unexplained differences in the following:

- enrollee name
- number of enrollees
- visit/session number
- length of session or length of stay
- treatment modality
- diagnostic code

Results of our investigation will dictate the type of resolution required. This may include, but not be limited to:

- **Education**—Working with our Provider Relations team, we may develop an educational program to review deficiencies identified, and provide tools to assist the provider in correcting such deficiencies
- **Corrective Action Plan**—We may require that the provider implement and/or submit a corrective action plan that clearly identifies the steps the provider will take to meet our standards and correct all identified deficiencies. Corrective action plans include, at a minimum, confirmation of the providers' understanding of the findings and affirmation of the providers' agreement to carry out and/or implement all recommendations in the findings, and the specific timeframe for completion of the corrective action plan and correction of identified deficiencies.
- **Repayment of Claims**—We will specify any requirements for repayment of amounts previously paid in either a written report of findings and/or any corrective action plans required. The repayment amount will be based on the actual deficiency determined. The provider will be responsible for paying the actual amount owed within 10 business days unless an installment payment plan is approved.
- **Monitoring**—We may require additional monitoring of a provider's claims submissions and treatment records for additional time periods of six to 12 months.

Special Investigations Unit

Our Special Investigations Unit is part of larger Legal and Compliance Team. This unit reviews and monitors all provider claims and billing practices in response to questions raised, complaints filed, and or issues identified. They conduct a thorough investigation and provide a written report of all findings.

Addressing Illegal or Criminal Activities by a Provider

In accordance with all applicable state and federal laws, rules, and regulations and government-sponsored requirements, ValueOptions will report any suspicion or knowledge of fraud, waste, and abuse to the appropriate authorities and/or regulatory agency. We expect all participating providers to cooperate fully with external investigations and requests for access to administrative, financial, and/or treatment records requested by authorities or regulatory agencies, or their respective authorized designees.

(3) Provide a copy of the audit language and fraud and abuse language that is contained in your standard contract(s) for Network Providers.

We provide excerpts of the audit and fraud and abuse language contained in our standard provider contracts below:

Section 5.2 Confidentiality and Patient Records.
Practitioner agrees to maintain the medical and claims-related data concerning services provided to Members that Practitioner would maintain in the normal course of business. Upon reasonable notice and during Practitioner's regular business hours, ValueOptions, its authorized representatives, and duly authorized third parties (such as governments and Payors) shall have the right to inspect and/or be given copies of medical records directly related to services rendered to Members by Practitioner. Copies of medical records requested shall be provided at no cost to ValueOptions or any Payor.

Section 5.3 Regulatory Access.
Practitioner records and information shall be open to inspection upon request, during normal business hours by state and federal regulators with jurisdiction over Payors, ValueOptions and/or the Practitioner, including the U.S. Department of Health and Human Services, the Comptroller General of the United States, other authorized state or federal regulatory agencies or entities, or their duly authorized representatives to the extent required by law. This provision shall survive expiration or termination of the Agreement, regardless of the cause.

Additional language contained in our Provider Handbook, which is considered an extension of our standard provider contract, is provided below:

Access to Treatment Records & Treatment Record Reviews/Audits
ValueOptions may request access to and/or copies of member treatment records and/or conduct member treatment record reviews and/or audits: (a) on a random basis as part of continuous quality improvement and/or monitoring activities; (b) as part of routine quality and/or billing audits; (c) as may be required by clients of ValueOptions; (d) in the course of performance under a given client contract; (e) as may be required by a given government or regulatory agency; (f) as part of periodic reviews conducted pursuant to accreditation requirements to which ValueOptions is or may be subject; (g) in response to an identified or alleged specific quality of care, professional competency or professional conduct issue or concern; (h) as may be required by state and/or federal laws, rules and/or regulations; (h) in the course of claims reviews and/or audits; and/or (j) as may be necessary to verify compliance with the provider agreement. ValueOptions treatment record standards and guidelines for member treatment record reviews conducted as part of quality management activities are set out in the quality management section of this handbook. Unless otherwise specifically provided for the in provider agreement, access to and any copies of member treatment records requested by ValueOptions or designees of ValueOptions shall be at no cost. Participating providers will grant access for members to the member's treatment records upon written request and with appropriate

identification. Participating providers should review member treatment records prior to granting access to members to ensure that confidential information about other family members and/or significant others that may be referenced and/or included therein is redacted.

Fraud, Waste and Abuse

ValueOptions interacts with employees, clients, vendors, providers/participating providers and members using standard clinical and business ethics seeking to establish a culture that promotes the prevention, detection and resolution of possible violations of laws and unethical conduct. In support of this, ValueOptions' compliance and anti-fraud plan was established to prevent and detect fraud, waste or abuse in the behavioral health system through effective communication, training, review and investigation. The plan, which includes ValueOptions' code of conduct, is intended to be a systematic process aimed at monitoring of operations, subcontractors and providers/participating providers compliance with applicable laws, regulations, and contractual obligations. Participating providers are required to comply with provisions of ValueOptions' code of conduct where applicable, including without limitation cooperation with claims billing audits, post-payment reviews, benefit plan oversight and monitoring activities, government agency audits and reviews, and participation in training and education. ValueOptions' code of conduct is accessible on the website.

Claims Billing Audits

The ValueOptions Special Investigations Unit (SIU) reviews and monitors claims and billing practices of providers/participating providers in response to questions raised, complaints filed and/or issues identified and submitted to the SIU. Questions regarding claims, billing practices or issues identified as a result of internal reviews and audits may be referred to the SIU for review and investigation from a variety of sources, including without limitation: (a) member inquiry or complaint; (b) external referral from state, federal and other regulatory agencies; (c) internal staff inquiry, (d) data analysis of certain statistical anomalies; and/or (e) whistleblowers.

The SIU conducts the majority of audits through record review audits, but in some instances on-site audits are performed as well. Record review audits entail requesting an initial sample[1] of records from the provider/participating provider to compare against claims submission records. If a conclusion cannot be determined based on the initial sample of records, ValueOptions may request additional records up to and including records of all members for the date span of the audit

[1] *Unless otherwise required by a specific ValueOptions client or a government agency, the initial sample size is based on the greater of five (5) records or the number of records equivalent to five percent (5%) of the total number of members for whom the provider/participating provider rendered services in the relevant audit sample date span.*

(4) Confirm that the Offeror will remit 100% of Provider and Enrollee audit recoveries to the Department within thirty (30) Days of receipt consistent with the process specified in Section V, "Payments/ (credits) to/from the Contractor" and Appendix B of Section VII.

ValueOptions confirms that we will remit 100 percent of provider and enrollee audit recoveries to the Department within 30 days of receipt consistent with the process specified in Section V, "Payments/ (Credits) to/from the Contractor" and Appendix B of Section VII.

(5) Describe the Offeror's proposed auditing tools and performance measures for identifying fraud and abuse by Network Providers and/or Enrollees.

Cases involving fraud and abuse may be identified through the following means:

- Review of Claims submitted for payment
- Requests for clinical review and certification
- Inquiries submitted by customer service, claims, provider relations, or other departments
- Reports from enrollees, providers, clients, or other sources
- Suspicious billing patterns identified via Special Investigation Unit data mining techniques
- Reports to our Ethics & Privacy Hotline

As mentioned above, when a provider is referred for alleged fraud and abuse, we target the specific issues identified and use an array of tools to evaluate provider compliance. This may include, but is not limited to:

- Onsite reviews
- Interviews with management, operations, finance, or other personnel
- Questionnaires soliciting impressions from a broad cross-section of employees
- Internal control assessment surveys
- Reviews of financial and compliance documents
- Financial, claim, or record auditing
- Trend analyses that uncover errors over a period of time

It should be noted that the vast majority of enrollees seek treatment within the ValueOptions network and are not responsible for claims submission; therefore, fraudulent billing by an enrollee is extremely rare.

Section 11: Claims Processing (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) The Contractor must provide all aspects of claims processing. Such responsibility shall include but not be limited to: (a) Maintaining a claims processing center located in the United States staffed by fully trained claims processors and supervisors; (b) Verifying that the MHSA Program's benefit design has been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly; (c) Accurate and timely processing of all claims submitted under the MHSA Program in accordance with all applicable laws as well as the benefit design applicable to the Enrollee including Copayment, Deductible, Coinsurance, annual maximums and coinsurance maximums, at the time the claim was incurred as specified to the Contractor by the Department; (d) Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed by the Contractor and approved by the Department. The Contractor's system must ensure that payments are made only for authorized services; (e) Maintaining claims histories for twenty-four (24) months online and archiving older claim histories for the balance of the calendar year in which they were made and for six (6) additional years thereafter, per Appendix A, with procedures to easily retrieve and load claim records; (f) Maintaining the security of the claim files and ensuring HIPAA compliance; (g) Adjusting all attributes of claim records processed in error crediting the MHSA Program for the amount of the claim processed in error; (h) Agreeing that all claims data is the property of the State. Upon the request of the Department, the Contractor shall share claims data with other MHSA Program carriers and consultants for various programs (e.g. Disease Management, Centers of Excellence) and the Department's Decision Support System vendor. The Contractor cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Department; (i) Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible; (j) Maintaining a claims processing system capable of integrating and enforcing the various clinical management and utilization review components of the MHSA Program; including pre-certification, prior authorization, concurrent review and benefit maximums; (k) Developing and securely routing a MHSA daily claims file that reports claims incurred to date which have been	Yes

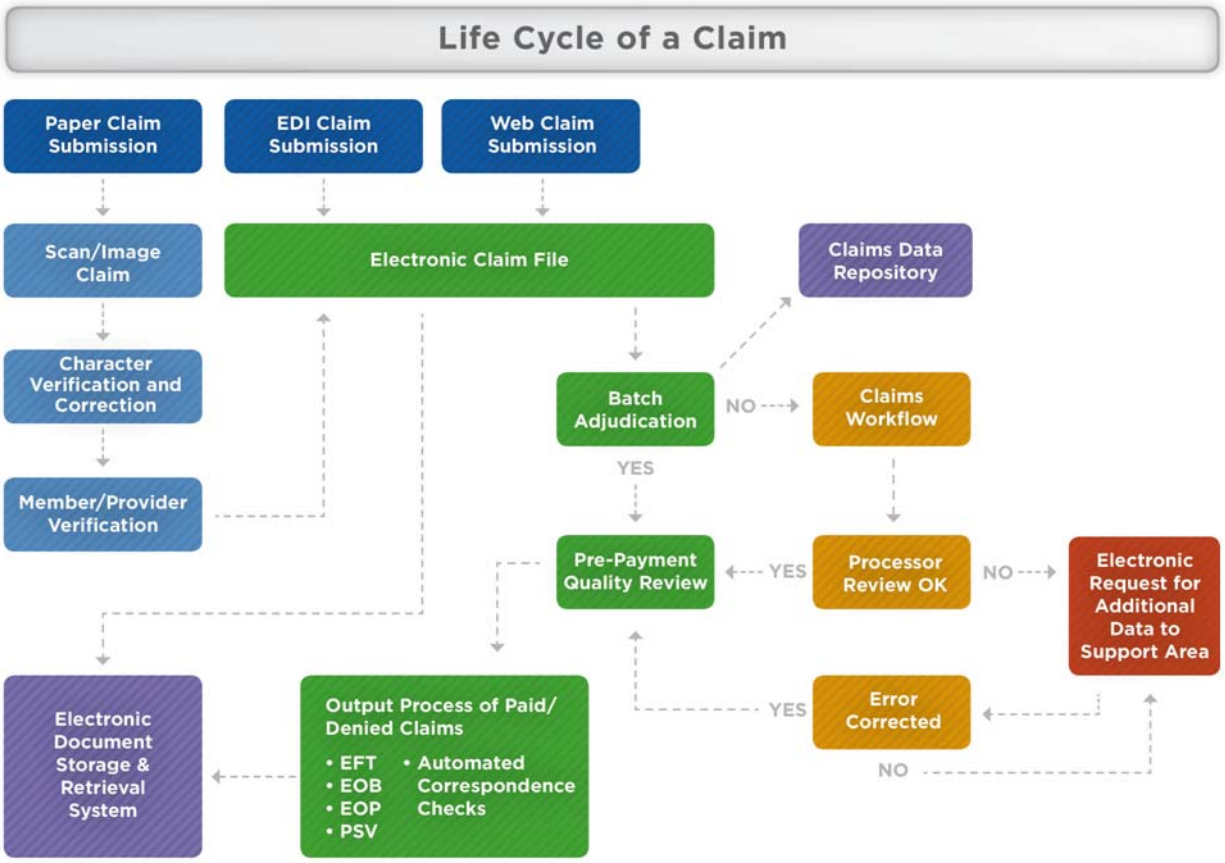
Section 11: Claims Processing (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
applied to the shared Deductible and Coinsurance Maximums between the Empire Plan Hospital Program, Medical Program and MHSA Program; (l) Loading a daily claims file from the Empire Plan medical carrier/third party administrator and hospital carrier that reports shared Deductible and Coinsurance Maximums; (m) Participating in Medicare Crossover by entering into an agreement with the Empire Plan medical carrier /third party administrator to accept electronic claims data record files from the medical carrier/third party administrator for Empire Plan Enrollees that have Medicare as their primary coverage. Claims data will only be sent to the Contractor for possible Empire Plan mental health and substance abuse outpatient claims which also involve Medicare coverage. The claims information sent from the medical carrier/third party administrator will include claims filed with the Center for Medicare and Medicaid Services (CMS) that should be considered by the Contractor for secondary coverage. The Empire Plan medical carrier/third party administrator will sort out any claims for benefits that are for mental health or substance abuse services and electronically forward the claim to the Contractor for consideration; (n) Pursuing collection of up-to-date coordination of benefit information that is integrated into the claims processing edits and pursuing collection of any money due the MHSA Program from other payers or Enrollees who have primary MHSA coverage through another carrier; (o) Analyzing and monitoring claim submissions to promptly identify errors, fraud and/or abuse and reporting to the State such information in a timely fashion in accordance with a State approved process. The Contractor will credit the MHSA Program the amount of any overpayment regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Contractor error, without additional administrative charge to the MHSA Program. The Contractor shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, or due to fraud and abuse the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the MHSA Programs upon receipt; however, the Contractor is not responsible to credit amounts that are not recovered; (p) Establishing a process through which Providers can verify eligibility of Enrollees and Dependents during Call Center Hours; (q) Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. The Department agrees to reimburse the Contractor for claims processed under the	

Section 11: Claims Processing (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
Disabled Lives Benefit in accordance with Section V.C of this RFP; and (r) Updating the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year.	
(2) Financial Accuracy Guarantee: The Offeror must meet or exceed the following performance guarantee. The Program's service level standard requires that the MHSA Program's financial accuracy be maintained for a minimum of ninety-nine percent (99%) of all claims processed and paid each Plan year. Financial accuracy shall be measured by dividing the number of claims paid correctly by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%);	Yes
(3) Non-Financial Accuracy Guarantee: The Offeror must meet or exceed the following performance guarantee. The Program's service level standard requires that the Program's non-financial accuracy be maintained for a minimum of at least ninety-five percent (95%) of all claims processed and paid during the first contract year. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-seven percent (97%) of all claims processed and paid during years two through five of the Agreement. Non-financial accuracy shall be measured by dividing the number of claims with no errors by the total number of claims reviewed. Non-financial errors include, but are not limited to, entry of incorrect: patient name, date of service, Provider name, Provider Identification Number, and remark code, as well as incorrect application of Deductibles and/or Coinsurance amounts to the shared accumulators. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%);	Yes
(5) Turnaround Time for Non-Network Claims Adjudication Guarantee: The Offeror must meet or exceed the following performance guarantee. The MHSA Program's service level standard requires that, at the least, ninety-nine and five-tenths percent (99.5%) of enrollee-submitted claims that are received in the Offeror's designated post office box, and require no additional information in order to be properly adjudicated, will be turned around within eighteen (18) Business Days or twenty-four (24) Days of receipt. Turnaround time is measured from the date the Enrollee-submitted claim is received in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent.	Yes

(1) Provide a flow chart and step-by-step description of your proposed claims processing methodology for adjudicating Non-Network and Network claims. Provide a description of the comprehensive edits you propose to ensure proper claim adjudication.

CLAIMS PROCESSING WORKFLOW AND METHODOLOGY

We process in-network and out-of-network claims using the same adjudication logic in our claims processing system. Below is a workflow of our claims process:



Our system is fully integrated with all provider information, including provider fee schedules, participation status, and licensure. Using the provider capacity (in-network or out-of-network), the benefit and fee schedule setup drives the appropriate reimbursement.

Claims Submission

Claims can be submitted in both paper and electronic formats. Our no-cost electronic solutions for claims submission include HIPAA standard 837 formatted files from any provider's software application or third-party vendor. Alternatively, providers without electronic claims software can submit via our Web-based direct claims submission application.

This application is easy to use and provides immediate validation results. Providers who wish to create batch files may also use our free software that can be downloaded to their desktops directly from our website.

In response to our 2012 provider satisfaction survey, approximately 94 percent of providers surveyed were satisfied with the quality of our claims service; 96 percent were satisfied with our claims payment timeliness.

We scan all paper claims to create a digital version. Claims that are submitted electronically and paper claims that are manually keyed or converted into an electronic format during our scanning process are loaded into our system and then processed automatically applying all systematic edits, including any client-specific benefit requirements.

Electronic claims are subject to various audits ensuring that all electronic submission requirements are satisfied. These include verification and validation of data fields such as enrollee identification number, date of birth, service from and through date, service code, number of units, place of service, amount charged, and diagnosis code. Additional editing and validation requirements occur once the claim is uploaded into our claims processing system.

Claims Entry/Upload

We process all claims, regardless of the submission method, against the same business rules. Claims that are uploaded into our system are processed automatically, subjecting them to industry standard systematic edits, as well as customized, client-specific benefits or business requirements. Our proprietary system also enables us to apply client-specific settings for our edits.

While we can automatically deny a claim when it fails an edit, and do so in certain situations, many claims are resolved with additional claims processor review. In these instances, the claims processor will review all relevant current and historical data pertinent to the claim (e.g., enrollee eligibility and claims payment history, authorization data, and provider file update history), and take the necessary steps to complete the claim validation for appropriate reimbursement.

ENSURING PROPER CLAIMS ADJUDICATION

Once entered or uploaded, claim and encounter batches are reiteratively run through the adjudication cycle. This cycle performs the following edits and audits by procedure line item:

- Verifies enrollee eligibility
- Locates the servicing provider that matches the claim servicing provider and the claim service date
- Considers transitional authorizations based on the claim service date and number of visits accumulated
- Checks to see if an authorization is required
- Determines if the claim is a duplicate submission
- Applies benefit plan parameters, such as maximums and excluded charges
- Establishes compatibility of third party liability (TPL), or coordination of benefits (COB)
- Identifies potential fraud and abuse

- Applies the approved amount from the appropriate fee schedule
- Determines if a valid authorization is on file

If adjudication edits and audits cannot be satisfied directly by information in our system, the claim is denied and a summary voucher is sent to the provider indicating the information needed to complete adjudication for payment. If the adjudication edits and audits are ultimately satisfied, the claim is approved for the payment cycle and checks or electronic fund transfers, with associated correspondence, are produced. Our information platform 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
- Duplicate claims submissions are identified
- Authorization requirements are not met
- Eligibility discrepancies are identified
- Issues exist regarding coordination of benefits or specific diagnosis codes that are excluded entirely as eligible for reimbursement

The edits can be soft or hard edits, depending on the action to be taken.

Hard and Soft Edits

Hard and soft claim edits are accessed internally and online by ValueOptions' claims processors to ensure the proper handling of claims. Hard edits in our system allow claims to automatically adjudicate based on pre-determined system set-up of specific claim edits. For example, when a claim is entered into our claims system, the diagnosis code is validated against the diagnosis codes in the system reference file, as well as against the diagnosis codes covered by the Empire Plan in the benefit set up.

If the diagnosis code on the claim is not covered by the Empire Plan, the claim is automatically denied during batch adjudication with an explanatory code and message. If the diagnosis code is not a valid code in the system reference file, a default value of 'unknown' is entered in the diagnosis field and the claim is automatically denied with a request to resubmit it with a valid diagnosis code.

With soft edits, the claims processor receives an edit indicating there is a condition that needs to be manually reviewed before adjudication of the claim can be completed. An example of a soft-edit review may include an eligibility problem in the enrollee's benefit plan. In this case, the claims processor will determine if the correct identification or member number is on the claim for eligibility purposes. If it is determined the claim should be paid, the edit is validated and the claim is adjudicated. If the claim should be denied, the claims processor applies the appropriate denial code to the claim before completing adjudication.

(2) Describe your claims processing system platform including any backup system utilized. Describe your disaster recovery plan and how Enrollee disruption will be kept to a minimum during a system failure.

We offer the industry's only fully integrated information platform, called CONNECTS, for assimilating all claims, payment, clinical, and related data from disparate formats and sources. It is a proven suite of flexible applications, customizable to meet your program needs. This highly adaptable system manages complex behavioral health programs from initial enrollment and eligibility through claims adjudication and payment. It maintains benefit structures, provider reimbursement methodologies, and adjudication rules for each of our programs. Fee schedules can be set up based on provider licensure and participation status.

CLAIMS PROCESSING SYSTEM

Our claims processing 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 also performed for those claims that require further examination. These include duplicate claim submission, coordination of benefits, eligibility discrepancies, and authorization edits. Authorizations are used for limiting and/or controlling provider access. Utilization review capabilities are also included in the claims subsystem to enable the connection between the claim being processed and authorizations in the system. The decision as to whether a claim requires an authorization for payment is part of the benefit set-up logic.

Additional features found in the claims processing subsystem include the following:

- Online authorization/adjudication capabilities
- Efficient CMS 1500 and UB04 forms screen entry formats for high volume processing
- Specific/generic service authorization capabilities
- Automatic matching of claim activity to available authorizations
- User defined processing edits
- Online/batch claims adjudication capabilities
- Split payment and enrollee reimbursement capability

Backup System Utilized

We perform the traditional daily back-ups to tape and storage off-site methodology as a precautionary measure, as well as daily system back-ups on all servers to ensure that the content of all ValueOptions' production systems can be recovered in the event of a disaster. These back-ups are performed on both host and local area network systems. Software and production data files are copied to tape. 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.

DISASTER RECOVERY PLAN

ValueOptions maintains multi-level system and data redundancy to minimize interruptions to operations in case of system outages or disaster. Our fully developed disaster recovery and business continuity plan includes requirements, strategies and actions necessary to rapidly recover business operations including real-time data replication of core applications, hot-site recovery, and redundant failover of systems and power. We leverage a two-scenario recovery plan:

1. Clustered WebSphere Application servers and real-time core data replication are at the heart of our primary recovery approach. All transactions of proprietary CONNECTS data are replicated in real time to a fully redundant IBM iSeries. This fully addresses the more likely event of single server failure.
2. We have engaged IBM® Business Continuity and Recovery Services (BCRS) for hosting and recovery subscription services from their premier BCRS hot site in Boulder, Colorado. This contingency addresses unlikely catastrophic disasters comprising total National Data Center outages. Additional redundancy to facilitate re-routing of data traffic is built into our wide area network (WAN) connections.

Our disaster recovery and continuity plans are monitored continuously and are updated as needed for configuration and compliance needs. We also review our plans and conduct a test of the plan annually. The latest test was in December 2012 and all data and voice systems were successfully restored.

Minimizing Enrollee Disruption

For 2012, our actual systems up-time for our claims processing system was 100 percent. Our Service Level Standard allows for a 0.01 percent downtime for scheduled maintenance. To mitigate risk to users and reduce system downtime, we schedule maintenance during off-peak, non-business hours.

(3) Confirm that all aspects of claims processing are located only in the United States staffed by fully trained claims processors and supervisors.

ValueOptions confirms that all aspects of claims processing are located only in the United States staffed by fully trained claims processors and supervisors.

(4) Describe the capabilities of your claims processing system to integrate each of the following required MHSA Program components:
- (a) Prior authorization for inpatient services, psychological testing and electro-convulsive treatment and concurrent review of outpatient services;
- (b) Eligibility verification;
- (c) Customized edits for variations in benefits required various employee groups;
- (d) Historic look up capability for claims and clinical information; and
- (e) Multi-level cost sharing (Deductibles, Co-insurance, Co-payments).

ValueOptions maintains a fully integrated information platform that accurately administers behavioral health care services from initial eligibility through claims adjudication and payment. Our platform delivers on its promises because we have already made the investment in 21st century integrated technology. All integration occurs within our one platform. Simply stated, everything communicates with everything else, and updates are immediately available to all service and functional areas. And we own the source code, so a special request or urgent need can be accommodated with ease.

(a) PRIOR AUTHORIZATION AND CONCURRENT REVIEW

Authorization of services is based on the medical and clinical information obtained at the time of the review. We have separate medical necessity criteria for inpatient, psychological testing, electro-convulsive treatment, and outpatient services. Our Clinical Care Managers will certify care based on these criteria as well as the benefit plans prescribed by the Department for the Empire Plan. If medical necessity for a requested level of care is met, a Clinical Care Manager will certify the care and document the outcome of the review and certification information into our care management application, CareConnect.

The utilization review capabilities in our claims processing system and the benefit set-up logic will determine whether a claim requires or has the appropriate authorization in order to be paid. The authorization entered by the Clinical Care Manager determines if and how a claim is paid.

(b) ELIGIBILITY VERIFICATION

Eligibility verification is a key component in the adjudication process and occurs prior to service delivery during the authorization process. When a claim is submitted, eligibility validation is performed during the scanning and adjudication process. Our claims system is fully integrated and takes into account all required elements, including eligibility. When a discrepancy occurs, the claim will be suspended for a Claims Processor to review. If the Claims Processor determines the eligibility differs, an electronic inquiry is sent to an Eligibility Specialist for further review. The claim is then finalized once the inquiry is complete.

(c) CUSTOMIZED EDITS FOR VARIATIONS IN BENEFITS

We have extensive experience serving clients with varying and multiple benefit structures similar to the Empire Plan. 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. Claims are then processed automatically applying all systematic edits, including the client-specific benefit requirements.

(d) HISTORIC LOOK UP CAPABILITY FOR CLAIMS AND CLINICAL INFORMATION

Our system maintains online claims history indefinitely, unless a client requests us not to do so.

(e) MULTI-LEVEL COST SHARING

Our claims system accepts accumulations of maximums, deductibles, coinsurance and/or out-of-pocket limit amounts from medical benefit plan payments and calculates them as one limit for many of our clients. Our management information system stores accumulator data received from the exchange file separately from the accumulators derived during claims processing, but uses the combined amount to calculate benefits. This includes accumulation of cost sharing information from multiple sources, such as the medical vendor and any associated third-party vendors. Accumulation from each unique source is stored separately.

(5) Confirm that you will develop and securely route a daily claims file of shared accumulator amounts to the Empire Plan medical carrier/third party administrator and hospital carrier.

ValueOptions confirms that we will develop and securely route a daily claims filed of shared accumulator amounts to the Empire Plan medical carrier/third party administrator and hospital carrier.

ValueOptions interfaces with a majority of our clients via batch data exchanges to cover all lines of business. Our data exchange experience not only includes the typical data exchanges in our industry (i.e., eligibility, membership, authorization, claims, and financial data) but also includes client-specific or customized data exchanges based on our CONNECTS data collection capabilities and our clients' requirements. When required, we also establish the required connectivity to accommodate online access to a client's system for our staff.

For our major medical partners such as Aetna, United, Medco, and BCBS, we created "multi-client exchanges" which allows combined file sharing and seamless process exchanges. Our single platform technology infrastructure has enabled us to develop a specific exchange solution with each medical system which "bends and flexes" file formats to accommodate the medical carrier's systems (which typically do not have this flexibility).

(6) Confirm that you will timely load the daily claims files of shared accumulator amounts received from the Empire Plan medical carrier/third party administrator and hospital carrier.

ValueOptions confirms that we will timely load the daily claims files of shared accumulator amounts received from the Empire Plan medical carrier/third party administrator and hospital carrier.

(7) Describe how any changes to the benefit design would be monitored, verified and tested for the MHSA Program, and the quality assurance program to guarantee that changes to other client benefit programs do not impact the MHSA Program.

All features of the Empire Plan benefit design, including all changes, will be documented in our electronic benefit application, BenefitConnect. BenefitConnect provides immediate access to all client contractual and benefit information. All staff dedicated to the Empire Plan program will refer to this information when looking for information on Empire Plan-specific benefits and claims payment guidelines.

Our Systems Configuration and Claims Department will engage with Department staff to participate in testing the benefit structure prior to implementation and via a post-implementation audit. This same methodology is followed when there are any changes to the Program benefits throughout the contract. Testing of benefits is a unit testing approach to assure quality. Our testing protocols for benefits consist of a staged 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 results to ensure that the results meet expectations.

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, deductibles, etc.)
- State or Federal regulations (Parity law requirements)
- 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 3 month post-implementation random audit is conducted and continuous on-going communication between ValueOptions and the client to remedy discrepancies.

We will encourage the Department to participate in the testing of benefits pre-implementation by presenting specific claims scenarios to be tested and reviewing the output. Our systems configuration team would discuss the results with you and remedy any discrepancies. Upon your approval of the review and signoff on all benefit structures, we will configure the benefits in a production environment. Our claims team will refer to established procedures that govern the claims adjudication process to ensure appropriate and consistent decision making.

(8) Confirm that you participate in Medicare Crossover and provide details of your experience with Medicare Crossover.

Yes, we participate in Medicare Crossover. For example, we currently work with BCBS of Illinois to provide Medicare Crossover support for one of our clients. For this contract, BCBS of Illinois is responsible for the Medicare portion of the claim and the crossover is submitted to us daily via an 837 transaction. We adjudicate and pay the remainder of the claim based on the client's benefit structure.

(9) Describe your procedures for the collection, storage and investigation of COB information other than Medicare.

ValueOptions' experience has demonstrated the financial value of our coordination of benefits (COB) program. Our system has the technical flexibility to adjust our coordination of benefits workflows to meet the needs of the Empire Plan program. Our COB process is compliant with CMS, state, and federal regulatory requirements.

In general, ValueOptions uses a "pay and pursue" approach. We will use COB data to validate other insurance coverage. We can accept COB information electronically from any approved source and automatically update the COB record associated with an enrollee. COB information is integrated with our claims adjudication system requiring the application of the primary payer's benefit. Claims submitted with COB indicators for enrollees without a COB record are automatically pended for review. If COB is subsequently confirmed, a COB record is built that will be used in future claims processing. A claim for an enrollee over age 64 without a COB record is automatically pended to determine Medicare eligibility.

(10) Explain how your claims processing system collects overpayments from your Provider network.

When payment discrepancies are identified, either through our comprehensive audit process, by member services, or during claims processing, we require the use of our automated adjustment processing system. Underpaid or overpaid claims are reversed and a new claim is created with the correct payment amount. For underpaid claims, our system will automatically calculate and issue additional payment with any interest that may be due. If the adjustment results in an overpayment, a financial transaction is created to automatically recover the overpaid amount from future claims. Our system is capable of immediate recovery, or allowing a grace period before recouping the amount from future claims based on the regulations applicable to the Empire Plan and provider's state. If an overpayment occurs for a provider with infrequent claims, a collection will be initiated after an agreed-upon period of time.

(11) Describe how your adjudication system feeds the reporting systems including how claims backlogs are captured and reported.

Our CONNECTS platform unifies all functions to ensure payment is consistent with participation requirements including benefit design, claims, eligibility, care management, financial management, provider maintenance, customer inquiries, among others. Because all functions are performed within CONNECTS, updates are immediately available to all service and functional areas including reporting.

ValueOptions' CONNECTS system has extensive tracking and reporting capabilities that provide comprehensive information for the purposes of monitoring claims turnaround time. Claim activity is measured daily and includes claim volume at all stages in the adjudication process, including pended claims, denied claims, adjustments, and processing time. Detailed pended claims reports are monitored daily by claims managers to ensure that client performance and regulatory standards are being met, and to efficiently deploy processing resources. Daily client summary reports are closely reviewed by multiple levels of management to monitor claims turn-around time and other performance measurements. Individual client performance reports are reviewed monthly to identify trends and any barriers.

(12) Confirm the Offeror will adjust all attributes of claim records processed in error and credit the MHSA Program for all costs associated with the claim processed in error.

ValueOptions confirms that we will adjust all attributes of claim records processed in error and credit the MHSA Program for all costs associated with the claim processed in error.

(13) Describe how the Offeror will analyze and monitor claim submissions to promptly identify errors, fraud and abuse and report such information in a timely fashion to the State in accordance with a State approved process. Confirm the MHSA Program shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses and will be charged an Administrative Fee only for Final Paid Claims. Confirm the Offeror will credit the MHSA Program the amount of any overpayment regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Offeror error. In cases of overpayments resulting from errors only found to be the responsibility of the Department and for fraud and abuse, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Program upon receipt; however the Offeror, is not responsible to credit amounts that are not recovered.

ANALYZING AND MONITORING CLAIMS SUBMISSION

Our claim processing quality review is an integral part of the claims adjudication process, so 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.

We perform internal audits daily, using a process that mirrors external audits. We evaluate claims processors' ability to consistently meet individual and departmental goals. The following is an overview of the internal claims audit process:

- A prepayment audit is conducted for all claims exceeding specific dollar thresholds. Dollar thresholds can be managed according to need; for example, a new group or one with a significant change in benefits is typically set at a lower threshold until our claims management is satisfied that all processes are functioning as expected.
- All trainee claims are audited before payment. As new processors meet their goals and objectives, this percentage is gradually decreased until it reaches the standard three percent.
- A continuous three percent pre-payment sample is taken of all paid and denied claims.
- A statistical, stratified random sample of three to five percent of adjudicated claims is generated weekly. This sample is audited post-payment and used for client reporting purposes.

FRAUD AND ABUSE

We offer the Department and the Empire Plan Program a proactive fraud, waste, and abuse program that meets all state and federal regulations. Our compliance program comprises four major functions: prevention, audit and detection, investigation, and resolution. Our effective prevention efforts are built on provider education, training, communication, and industry partnerships.

In addition, our claims system allows us to establish edits to provide a more proactive approach to fraud and abuse. If the system identifies any anomalies that may indicate potential fraud or

abuse, the system will pend the claim and not allow it to adjudicate further. Automatic claim suspension routines are performed for those claims that require further examination. These include duplicate claim submission, Coordination of Benefits (COB), 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 enable the connection between the claim being processed and authorizations in the system. The decision as to whether a claim requires an authorization for payment is part of the benefit set-up logic.

Prevention

Our primary concern is awareness and communication of the program. This component includes technology tools, training, awareness, and communication. Specific examples of prevention mechanisms include:

- **Provider communication**: Providers can find information relating to their roles and responsibilities in ensuring compliant practices in their Provider Handbook. Additionally, information in the handbook informs the provider of the reason and nature of audits done by the Special Investigations Unit and the ways that an audit can be triggered. During site visits, we discuss prevention and reporting policies, including data validation audits, to ensure ongoing communication and awareness. There is also a monthly webinar for providers that includes education on the Fraud, Waste and Abuse program for ValueOptions.
- **Training and education**: We conduct comprehensive anti-fraud training to deter fraudulent, abusive, or wasteful practices and continue to expand our training and education resources available to enrollees and providers. Our training programs detail current federal and state regulations concerning ValueOptions' obligation to actively work to identify and stop fraudulent activity and educate stakeholders. Our training program also includes examples of simple claims billing errors that may trigger a fraud investigation and provides an overview of the False Claims Act and other applicable laws, fraud reporting and referral processes, and whistleblower protection. Our Special Investigations Unit staff ensures content consistency and accuracy on topics such as company policy, pertinent laws and regulations, and reporting processes. Additionally, all ValueOptions' employees receive comprehensive anti-fraud training when first hired and annually thereafter, while enrollees receive written materials communicating methods for identifying suspicious activities.
- **Provider profiling and credentialing**: We require all providers to register with appropriate types and categories of service, and to be credentialed prior to contracting. As part of our credentialing process, we screen providers through databases, such as the Federal List of Excluded Individuals and Entities, to ensure that they are not sanctioned or excluded from participation in federal programs.
- **Ethics & Privacy Hotline:** We disseminate our toll-free ethics and privacy hotline number through enrollee materials and Provider Handbooks to give enrollees and others a confidential means for reporting fraud and other issues.
- **Website**: Through our online provider portal, we maintain a specific compliance Web page with current events, updates, policy changes, and fraud, waste, and abuse reporting guidelines.
- **Claim edits**: Our system has edits in place that automatically deny claims for duplicates, unknown service, unknown or ineligible enrollee, and ineligible providers. Knowledge

revealed (e.g., emerging patterns) by data validation audits and trend analyses are used to design new rules/edits to prevent improper payments.

Audit and Detection

We have numerous avenues that supply information about suspicious provider activity. These avenues include:

- Monthly checks by our network operations department for sanctions by licensing boards and the Office of Inspector General on our contracted providers
- Daily reports from the Federal Bureau of Investigation and Department of Justice on providers accused of health care fraud
- Weekly updates from the National Health Care Anti-Fraud Association
- Internal referrals by clinical staff to Special Investigations Unit from clinical chart audits, clinical outlier reports, and utilization reviews on providers
- Identification of suspicious provider practices that enrollees may reveal to customer service staff when asking questions (e.g., why claims are paid for sessions they did not attend, or for providers they did not see)
- Notification through Provider Relations from provider's staff or other providers who feel that there is fraudulent activity in their practice group

Our Special Investigations Unit reviews and monitors claims and billing practices of providers in response to questions raised, complaints filed, or issues identified and submitted to the unit. Through data mining and trend analysis, the Special Investigation Unit conducts audits on random providers looking for any patterns that may suggest improper billing practices that may be part of fraud, waste or abuse. This includes examining factors such as:

- high volume of sessions
- family groupings of sessions
- high volumes of unduplicated enrollees (high quantity of patients)
- high volume of dollars paid
- duplicate claim submission
- matching surnames (providers and members with matching surnames)

We re-audit providers who have had past errors to ensure that education and corrective action plan have corrected past inaccuracies. If the same errors are present after education, this may indicate a clear intention of fraudulent behavior.

Investigation

ValueOptions audits providers referred for alleged fraud and abuses, targeting the specific issues identified. We rely on an array of tools to evaluate provider compliance programs. These may include onsite reviews; interviews of management, operations, finance or other personnel; questionnaires soliciting impressions from a broad cross-section of employees; internal control assessment surveys; reviews of financial and compliance documents; financial, claim or record auditing; and trend analyses that uncover deviations over a period of time. We track all referrals submitted with a unique case number to include allegation specifics, referral source, and actions taken and will report these findings to you based on your desired frequency.

Resolution

Each provider is required to demonstrate his or her understanding of the errors identified in the Special Investigations Unit audit by creating a corrective action plan to address the steps they will take to ensure the errors are not repeated in the future. Every audit is followed up with a contact from Provider Relations staff to reinforce the education given and to offer any support or further education the provider may need.

The Findings letter sent to the provider once an audit is complete gives a very detailed explanation of the errors found and the expectation for future practices by the provider if they remain in the network. To ensure future compliance, action plans taken by the Special Investigations Unit may include any or all of the following:

- Recovery of overpayments
- Provider submitted corrective action plan
- National Credentialing Committee review for credentialing issues
- State and/or federal agency notification
- Monitoring program (six or 12 months)
- Provider education

We consistently take data, audit results, and investigative findings resulting from program activities to enhance training and education materials and develop new claims edits in an effort to avoid repeat occurrences of inappropriate billing, fraudulent and wasteful practices.

(14) Confirm that the Offeror will update the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year.

ValueOptions confirms that we will update the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year.

(15) Financial Accuracy Guarantee: The MHSA Program's service level standard requires that the MHSA Program's financial accuracy be achieved for a minimum of ninety-nine percent (99%) of all claims processed and paid each year. Financial accuracy shall be measured by dividing the number of claims paid correctly by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%). The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-nine percent (99%) the Offeror's financial accuracy rate of all claims processed and paid each year is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine percent (99%) (or the Offeror's proposed guarantee) that the MHSA Program's financial accuracy isn't achieved as calculated on an annual basis is $_____.

FINANCIAL ACCURACY GUARANTEE

[redacted]

(16) Non-Financial Accuracy Guarantee: The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-five percent (95 %) of all claims processed and paid during the first year of the Agreement. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-seven percent (97%) of all claims processed and paid during years two through five of the Agreement. Non-financial accuracy shall be measured by dividing the number of claims with no errors by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%). The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95 %) of the Offeror's non-financial accuracy rate of all claims processed and paid during the first contract year is $10,000 per year and for each .01 to 1.0% below ninety-seven percent (97 %) of the Offeror's non-financial accuracy rate of all claims processed and paid during years two through five of the Agreement is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (of the Offeror's proposed guarantee) of all claims processed and paid during the first contract year (ninety-seven percent (97%) (or the Offeror's proposed guarantee) in years two through five of the Agreement) that the MHSA Program's non-financial accuracy isn't achieved, as calculated on an annual basis is $_____.

NON-FINANCIAL ACCURACY GUARANTEE

[redacted]

(17) Turnaround Time for Non-Network Claims Adjudication Guarantee: The MHSA Program's service level standard requires that a minimum of ninety-nine and five -tenths percent (99.5%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror be turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-nine and five-tenths percent (99.5%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received electronically or in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent is $6,000 per each quarter. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed guarantee) of enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent, as calculated on a quarterly basis, is $_____.

TURNAROUND TIME FOR NON-NETWORK CLAIMS ADJUDICATION GUARANTEE

[redacted]

[redacted]

Section 12: Clinical Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
Pre-Certification of Care	
To ensure that the resources available to the MHSA Program are utilized for appropriate, medically necessary care, the Contractor is required to perform pre-certification of care which includes, at a minimum: (1) Use of a voluntary Clinical Referral Line (CRL) located in the United States to evaluate Enrollees MHSA care needs and direct Enrollees to the most appropriate, cost-effective Providers and levels of care. The CRL must be structured to facilitate Clinicians' assessment of the caller's MHSA treatment needs and to provide suitable, timely referrals especially in emergency or urgent situations or for care that requires inpatient admission;	Yes
(2) Use of alternate procedures to precertify care when the Enrollee fails to call the CRL, as follows: (a) When an Enrollee contacts a Network Provider directly for treatment without calling the CRL, the Contractor is ultimately responsible for ensuring that Enrollees receive the Network level of benefits and obtaining all necessary authorizations for treatments for Network outpatient services for "Recurrent Therapy Visits" and Network inpatient care, when an Enrollee contacts a Network Provider directly for treatment without calling the CRL; (b) When an Enrollee contacts a Network Provider directly and the Network Provider is not the appropriate Provider to treat that Enrollee, the Contractor is responsible for ensuring that its Network Providers take responsibility for assisting the member in obtaining an appropriate referral; and (c) When an Enrollee contacts a Non-Network Facility for treatment and the Contractor is notified in advance of the admission, the Contractor must provide the Enrollee or other HIPAA authorized representative of the Enrollee, with a written determination of medical necessity of care in advance of the inpatient admission, where feasible.	Yes
(3) Timely written notification to the Enrollee, or other HIPAA authorized representative of the Enrollee, of the potential financial consequence of remaining in a Non-Network Facility when the initial determination of medical necessity occurs;	Yes
(4) Preparing and sending communications to notify Enrollees and/or their Providers of the outcome of their pre-certification or prior authorization request and notifying them in writing of the date through which MHSA Program services are approved;	Yes
(5) Promptly loading into the clinical management and/or claims processing system approved authorizations determined by the Contractor;	Yes
(6) Pre-certifying inpatient hospital admissions for alcohol detox, advising the facility to send the claim to the Hospital Program	Yes

Section 12: Clinical Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
carrier/third party administrator and managing the Enrollee's care if transferred to rehab;	
(7) Loading into the Contractor's clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once acceptable files are received; and	Yes
(8) Clinical Referral Line Guarantees: The Contractor must meet or exceed the following three (3) performance guarantees as follows: (a) Non-Network CRL Guarantee: The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non-emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate MHSA Non-Network Provider or program within two (2) Business Days of the call in, a minimum of at least ninety percent (90%) of the cases. (b) Emergency Care CRL Guarantee: The Program's service level standard requires one hundred percent (100%) of Enrollees who call the CRL in need of life-threatening emergency care be referred to the nearest emergency room and be contacted within (thirty) minutes to assure their safety. Additionally, one hundred percent (100%) of Enrollees in need of non life-threatening emergency care shall be contacted by a Network Provider or recontacted by the CRL clinician within thirty (30) minutes of the Enrollee's call to the CRL. (c) Urgent Care CRL Guarantee: The Program's service level standard requires that, at the least, ninety-nine percent (99%) of Enrollees in need of urgent care be contacted by the Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the Enrollee's call to the CRL.	Yes
Concurrent Review	
(1) To safeguard Enrollee health and ensure adherence with the MHSA Program's benefit design and requirements on mental health parity, the Contractor must administer a concurrent utilization review program in the United States which: (a) Enforces the MHSA Program's benefit design features and ensures that Network Providers use the latest MHSA care protocols for Enrollees; (b) Uses Clinicians to review Provider treatment plans which must detail, at a minimum: past clinical and treatment history; current symptoms, functional impairment; and DSM-IV diagnosis. The Contractor must require that the Network Provider's proposed treatment plan and goals be in writing for outpatient services. The Contractor must review the treatment plan for a member when the	Yes

Section 12: Clinical Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
member's visits to the Network Provider exceed the expected duration of services for the Enrollee's clinical diagnosis; (c) is conducted in a manner which is parity compliant as required by the Mental Health Parity and Addiction Equity Act; We need to talk to legal (d) The Contractor must perform concurrent review of outpatient and inpatient care rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider; legal (e) For inpatient admissions, the Contractor must recognize when to utilize more appropriate and less restrictive levels of care when medically appropriate. The Contractor must have procedures for identifying when transfer to an alternate inpatient or outpatient setting is appropriate and for arranging such transfers; (f) Establishes maximum time frames for inpatient review based upon the level of care provided, and a time frame that allows for discharge planning where the continued stay is not certified; (g) Employs appropriately skilled clinicians to review treatment plans in a manner that does not disrupt or delay treatment; and (h) Renders certification decisions on a timely basis and requires that Peer Advisors render non-certification decisions.	
(2) For Enrollees admitted to non-network facilities, the Contractor must have procedures to either arrange to transfer the Enrollee to a Network Facility as soon as medically appropriate, or manage the care as if the facility was in the network, including negotiating discounts with the facility;	Yes
(3) The Contractor must perform appropriate discharge planning by identifying when discharge from an inpatient network setting is appropriate and by directing the Enrollee to appropriate outpatient network care following discharge, including scheduling the initial appointment. Discharge planning must include continual review of the progress of aftercare treatment with the Provider by a care manager, as follows: (a) Care managers must obtain and review, as part of the discharge plan, specifics that include, at a minimum: the name of the follow-up Provider; date and time of initial follow-up appointment; and the names of responsible family members; and (b) Care managers must assist Providers in locating aftercare services. The Contractor must maintain a database of local community resources to assist Providers in locating aftercare services or alternative care in their areas.	Yes
(4) The Contractor must provide case management on a voluntary basis for complex cases or cases requiring long-term	Yes

Section 12: Clinical Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
treatment. The Contractor must cooperate with the Empire Plan hospital carrier and other Empire Plan carriers in cases of medical/mental health multiple diagnoses in accordance with guidelines established by the Department. Under those guidelines, in cases where there is both a medical and a psychiatric diagnosis, responsibility for case management is determined by the unit (medical or psychiatric) to which the admission is made and the specialty of the attending physician. When those guidelines are insufficient to determine case management responsibility, the Empire Plan hospital carrier and the Contractor must come to an agreement using other factors such as the condition causing the person to remain hospitalized and the proposed treatment plan;	
(5) The Contractor must use care managers or Peer Advisors to manage the care of members;	Yes
(6) The Contractor must measure and assess the effects of clinical management and utilization review processes and procedures on the quality of MHSA care and MHSA Program costs;	Yes
(7) Outpatient Treatment UR Guarantee: The Offeror must guarantee that, at the least, ninety percent (90%) of outpatient treatment plans be reviewed and the Provider notified within twelve (12) Business Days of receipt of the report as calculated on an annual basis; and	Yes
(8) Inpatient Treatment UR Guarantee: The Offeror must guarantee that, at least, ninety percent (90%) of requests for authorization of inpatient care be reviewed within twenty-four (24) hours from the receipt of the request and the Enrollee or Provider be notified within one (1) Business Day of the determination calculated on an annual basis.	Yes
Disabled Dependent Determinations	
(1) The Contractor must establish a process to perform reviews of the PS-451 form and all additional medical information for mental health and substance abuse-related dependent disabilities. The review must be completed in the United States and clinical determination must be completed within 10 Business Days of receipt of a complete form.	Yes
(2) The Contractor must send a determination letter, approved in advance by the Program, to the Enrollee and to the Department advising of the determination within 3 Business Days of the determination.	Yes
Appeal Process	
The Contractor must: (1) Perform administrative (non-clinical) appeals in a timely manner by an employee of the Contractor with problem-solving authority above that of the original reviewer;	Yes
(2) Administer an expeditious, HIPAA and PPACA compliant internal clinical appeal process which allows Providers and/or Enrollees to appeal denied coverage on the basis of medical	Yes

Section 12: Clinical Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
necessity or an experimental or investigational treatment, including: (a) Developing a clinical appeal form and criteria for establishing medical necessity and experimental or investigational treatment; (b) Reviewing clinical appeals for medical necessity and experimental or investigational treatment and preparing communications to notify Enrollees of the outcome of appeals; and (c) Integrating the appeal decisions into the clinical management and claims processing systems.	
(3) Establish two levels of internal clinical appeals as follows: (a) A level 1 clinical appeal must be performed by an independent Peer Advisor; and (b) A level 2 clinical appeal must be conducted by a panel of two board-certified psychiatrists and a Clinical Manager who work for the Contractor. Panel members must not have been involved in the previous determinations of the case. (c) Clinical Appeals must be completed in a timely manner consistent with NYS and federal laws: (i) For a second level clinical appeal of a post-service claim, within 30 days of the member's request; (ii) For a second level clinical appeal of a pre-service request for benefits, within 15 days of the member's request; and (iii) For clinical appeals involving urgent situations, in no more than seventy-two hours following receipt of the appeal.	Yes
(4) Oversee and enforce the MHSA Program's appeal processes including reporting the results of the administrative, clinical and external appeal processes for the MHSA Program to the Department in the format and frequency required in the "Reporting" section of this RFP;	Yes
(5) Interface with the New York State Department of Financial Services' External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal where denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service;	Yes
(6) Inpatient Appeal Guarantee: The Contractor must guarantee that at least ninety-five percent (95%) of level one appeals for inpatient care shall be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required	Yes

Section 12: Clinical Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
timeframe, will be included as having met the standard. This standard will be calculated on an annual basis; and	
(7) Outpatient and Alternate Level of Care Appeal Guarantee: The Contractor must guarantee that at least ninety-five percent (95%) Outpatient Care and Alternative Levels of Care level one appeals shall be reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis.	Yes

PRE-CERTIFICATION OF CARE

(1) Describe in detail how you propose to precertify services including;
(a) An overview of your Clinical Referral Line (CRL) and proposed precertification process as well as the criteria you use to identify the services that the Program should consider for pre-certification or prior authorization.

Our foremost goal is to ensure that Empire Plan enrollees receive the services they need, when they need them, and in the clinically appropriate, least restrictive setting. We will ensure our clinical review and care authorization processes mirror the current Empire Plan requirements. In general, under the Interim Final Rules, a blanket precertification process for certain levels of mental health/substance abuse (MHSA) care may violate Mental Health Parity and Addiction Equity Act (MHPAEA). Therefore, we will review the Empire Plan medical/surgical utilization management requirements and rigorously examine the clinical appropriateness of the proposed precertification process to ensure full Parity compliance. All precertification processes will be reviewed again once the final rules are issued, which is expected to occur in the fall of 2013.

OVERVIEW OF CLINICAL REFERRAL LINE PROCESS

Empire Plan enrollees will have access to our Clinical Referral Line 24 hours a day, seven days a week. Our referral line is staffed by licensed Clinical Care Managers, each of whom has a minimum of three years of post-graduate clinical experience. During the assessment and referral process, one of our Clinical Care Managers will speak with the enrollee to identify the treatment/resources needed and refer them to the appropriate, qualified resource (i.e., ValueOptions' network practitioner, community resource, medical plan, and/or other sponsored programs). All clinical information, including the timing, rationale for the level of care decision, and key persons involved with the disposition, will be documented in our care management system, CareConnect.

Triage Criteria and Protocols

ValueOptions' triage protocols are based on the following risk rating scale that is employed during the assessment process to help determine the most appropriate level of treatment and the urgency of clinical intervention:

Risk Rating 4—Emergency/Life Threatening Risk

ValueOptions defines it as an emergency/life threatening risk when an enrollee demonstrates one or more of the following:

- Failure to obtain immediate care would place the enrollee's life, another's life, or property in jeopardy, or cause serious impairment of bodily functions.
- Enrollee indicates that failure to obtain immediate care would place his or her life, another's life, or property in jeopardy, or cause serious impairment of bodily functions.

Required Action (Emergency/Life Threatening Risk)

- The Clinical Care Manager must ensure immediate emergency intervention.
- The Clinical Care Manager must maintain telephonic contact with the enrollee or otherwise ensure safety up until the emergency intervention begins. If the Clinical Care Manager cannot maintain telephonic contact, he/she must confirm provision of emergency intervention as soon as clinically indicated, usually within one hour.
- The Clinical Care Manager must clearly document all actions taken, times at which they occurred and the rationale supporting them.

Risk Rating 3—Emergency/Non-Life Threatening Risk

ValueOptions defines a situation as an emergency/non-life threatening risk when an enrollee demonstrates one or more of the following:

- A potential danger to self or others as indicated by behavior, plan, or ideation.
- Labile and unstable behavior and significant impairment in judgment, impulse control, and/or functioning.
- An immediate and severe medical complication concurrent with, or as a consequence of, psychiatric or substance abuse illness and its treatment.
- An indication that emergency treatment is needed.

Required Action (Emergency/Non-Life Threatening Risk)

- The Clinical Care Manager must arrange for the completion of a psychiatric or substance abuse assessment within specific time frames specified by contractual requirements. Generally, network staff members must complete high-risk emergency assessments within six hours. If the network staff members are unavailable to complete an assessment, the Clinical Care Manager may refer the enrollee to the closest emergency room. At all times, the Clinical Care Manager's primary concern shall be the safety of the enrollee.
- If the enrollee suffers from medical complications, the Clinical Care Manager must arrange for a psychiatric assessment in a setting (e.g., emergency room, multi-specialty clinic) with immediate access to other medical specialists who can adequately address a medical emergency.
- The Clinical Care Manager must clearly document all steps that took place, the times at which they occurred and the rationale supporting them.
- In all cases, the Clinical Care Manager must ensure that the enrollee has accessed emergency care in order to safeguard the enrollee or others.
- Depending on the nature and imminence of the risk, ValueOptions may require the following to take place: emergency hospitalization, or police and/or social service intervention to safeguard the enrollee and others, and to ensure that staff members conduct a psychiatric assessment.
- Disposition of the enrollee and notification to the Clinical Care Manager within specific timeframes, as specified by contractual requirements.

Risk Rating 2—Serious Risk (Urgent)

The enrollee demonstrates one or more of the following:

- He or she is upset and distressed but not in immediate danger of harm to self or others and, while the Clinical Care Manager does see evidence of adequate pre-morbid functioning, social/family supports have significantly changed or diminished, and the Clinical Care Manager expects the patient will further decompensate within the next 24 hours.
- He or she shows moderate impairment in judgment, impulse control and/or functioning, which the Clinical Care Manager expects to further diminish with time.
- Indications of intoxication or risk of withdrawal.
- Enrollee indicates an urgent need to receive treatment.

Required Action—Serious Risk (Urgent)

- The Clinical Care Manager must arrange for a face-to-face assessment by a licensed mental health professional within 24 hours of the call.
- If no provider is available to assess the patient, the Clinical Care Manager must treat the situation as an emergency.
- The Clinical Care Manager must document the timing, rationale, outcomes, and key persons involved with the disposition.

Risk Rating 1—Moderate/Mild Risk (Routine)

The enrollee demonstrates one or more of the following:

- He or she experiences some distress, but the Clinical Care Manager can easily identify the precipitants of the distress and associated stressors.
- He or she shows some impairment in judgment, and the Care Manager can find evidence of functioning and/or impulse control.

PRECERTIFICATION OF SERVICES

There are three ways in which the certification process can begin: (1) the enrollee contacts the Clinical Referral Line and is referred to a network provider; (2) the enrollee is directly connected with a network provider or facility for treatment; or, (3) the enrollee seeks treatment from a non-network provider and contacts ValueOptions in advance of the admission.

Once an enrollee contacts the Clinical Referral Line and is referred to the appropriate level of treatment, the ValueOptions network provider is responsible for contacting ValueOptions to begin the pre-certification process. Network providers are also responsible for obtaining all necessary authorizations for outpatient services beyond ten pass-through visits.

If an enrollee elects to obtain care from a non-network provider, the enrollee must inform his or her provider that they need to contact our Clinical Referral Line to obtain certification prior to admission. The enrollee may also call the Clinical Referral Line and we will contact the provider to conduct a certification review. We will also advise the enrollee of the difference between an in- and out-of-network benefit and encourage him or her to use the in-network benefit. ValueOptions will assist with scheduling an appointment if necessary. If the admission

to treatment is an emergency, a 48-hour grace period is allowed for notification. For enrollees who are admitted to out-of- network facilities, ValueOptions will assist in arranging for transfer to a network provider as soon as the situation stabilizes. On the day of the pre-certification determination, a letter advising enrollees of the potential financial consequences of remaining in a non-network facility is faxed to the enrollee, in care of the facility.

Clinicians are available for pre-certification and referrals 24 hours a day, every day of the year. During the pre-certification process, clinicians apply ValueOptions' medical necessity criteria. We have developed our own set of criteria for all levels of mental health services and substance abuse services. The mental health criteria are based on nationally recognized standards of psychiatric care including the American Psychiatric Association and the substance abuse criteria are based on the American Society of Addiction Medicine's Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R) for all levels of substance abuse services. Our clinicians also use other tools, such as the DSM-IV-TR and ValueOptions' Clinical Practice Guidelines, to identify particular diagnoses and support the development of appropriate treatment plans.

Once contacted by a provider seeking certification for inpatient treatment or an alternative level of care, a Clinical Care Manager will discuss and document the proposed treatment plan with the appropriate staff at the facility. Contacts may include the attending provider, primary therapist, or an internal utilization review nurse. The Clinical Care Manager will determine medical necessity by reviewing the symptoms, diagnosis, history, treatment goals, and planned interventions against ValueOptions' medical necessity criteria.

New York-Based Clinicians Providing Pre-Certification

All pre-certifications are conducted by ValueOptions employed, New York-based licensed behavioral health clinicians who have at least three years of active psychiatric clinical experience, as well as care management and telephone assessment skills. ValueOptions has been successfully managing inpatient utilization for multiple clients for more than 30 years and our approach continues to ensure that enrollees receive an optimal level of care in the least restrictive setting. In an effort to provide an enhanced service delivery system, under our previous contract with the Empire Plan, ValueOptions provided 24-hour telephonic pre-certification through our New York-based Clinical Care Managers who know the market. We will do the same under a new contract. Providers and facilities are able to access a Clinical Care Manager 24 hours per day, through the toll-free number, to pre-certify inpatient level of care.

(b) Your proposed Clinical Referral Line staffing and qualifications of each level of clinician rendering authorizations and denials of care. Will clinical management staff be dedicated to the Program or will they service other customers as well?

CLINICAL REFERRAL LINE STAFFING

The staffing complement for our New York-based Clinical Referral Line team will include eight Clinical Referral Line staff (Clinical Care Managers) who will perform pre-certifications and three physicians who will handle all denials. ValueOptions will have 36 clinical management staff dedicated to the Empire Plan with an additional team who will be available to provide back-up as needed.

CLINICAL STAFF QUALIFICATIONS

Following are qualification descriptions for each of the clinical staff positions responsible for making decisions regarding authorizations and denials of care. All staff are thoroughly trained on effective enrollee engagement strategies, which are designed to help enrollees become active participants in their health care decisions.

Medical Director Qualifications

ValueOptions' medical directors are psychiatrists with significant experience in the field prior to their employment with ValueOptions. Dr. Hal Levine will serve as the Medical Director for the Empire Plan Program. Dr. Levine is a licensed, board-certified psychiatrist who will provide leadership and direction for all services rendered under the Empire Plan contract, as well as having ultimate oversight of the utilization management process.

Dr. Levine has significant knowledge and expertise directly related to the Empire Plan Program, having served as the Medical Director when ValueOptions held the account from 1992 to 2008. Dr. Levine will be supported by Dr. Christopher Dennis, the Chief Medical Officer for ValueOptions' commercial division. Dr. Dennis currently sits on the National Committee for Quality Assurance (NCQA) Standards Committee, which currently supports the development of new and revised accreditation standards for Managed Behavioral Healthcare Organizations, health plans, and other entities. Both of these physicians are licensed to practice in the state of New York, with Dr. Dennis residing in the state. Both also exceed ValueOptions' requirements for our Medical Directors, including having the following:

- Doctor of Medicine (MD) or Doctor of Osteopathy (DO) from an accredited medical school
- Board certification in psychiatry by the Board of Psychiatry and Neurology. Board certification by the American Board of Quality Assurance and Utilization Review Physicians is preferred. Current, valid and unrestricted clinical license is required.
- At least five years of post-graduate clinical practice
- At least two years of inpatient or hospital-based treatment experience
- At least three years of managed care/utilization management experience

Additionally, ValueOptions Medical Directors must have in-depth knowledge in the areas of:

- Medical care delivery systems
- Utilization management
- Quality improvement
- Peer review
- Contracting benefits interpretation
- Provider relations
- Enrollee services

ValueOptions also expects its Medical Directors to have extensive knowledge, experience, and proven success in the operation of a behavioral health delivery system, a proven ability to manage for results, and the flexibility to meet enrollee, company, and customer objectives.

Peer Advisor Qualifications

Peer Advisor qualifications include the following:

- Licensed to practice independently in New York state
- Board-certified psychiatrist (M.D. or D.O.) or licensed clinical psychologist (Ph.D.)
- Minimum of five years of post-graduate clinical experience
- Minimum of 20 hours per week in active practice

Peer Advisors must also demonstrate strong communication and negotiation skills, the ability to work effectively as facilitators and teachers in a multi-disciplinary team environment, and a genuine concern for the welfare of individual enrollees, coupled with a willingness to assume a clinical advocacy role on the enrollee's behalf, when indicated.

Clinical Care Manager Qualifications

ValueOptions' Clinical Care Managers must have a current license and meet one of the following criteria:

- Master's level mental health clinician, social worker, or psychologist with minimum three years' post-graduate clinical experience in a psychiatric/substance abuse treatment program with an emphasis on crisis intervention
- Master's level psychiatric nurse or registered nurse with three years' minimum post-graduate clinical experience in a psychiatric/substance abuse treatment program with an emphasis on crisis intervention
- Doctorate-level clinical psychologist with three years' minimum post-graduate clinical experience in a psychiatric/substance abuse treatment program with an emphasis on crisis intervention

All Clinical Care Managers are required to have had a minimum of three years of previous experience working in mental health and substance abuse treatment programs and must follow a treatment team approach to achieve the common goal of high quality behavioral health care for

enrollees. Many of our Clinical Care Managers are also certified in alcohol and drug abuse counseling.

Clinical Care Managers can render approvals but not denials. In the event a Clinical Care Manager is unable to determine that medical necessity is met, a Peer Advisor is immediately involved. The Peer Advisor is the first level of clinical staff with the authority to issue a denial.

(c) For the calendar year 2012, the percentage of Enrollees who called the CRL and who received a referral at a different level of care from the one initially requested.

In 2012, approximately 10 percent of enrollees who called a ValueOptions Clinical Referral Line received a referral at a different level of care from the one requested. Our goal is to direct each enrollee to the most appropriate level of care for their specific situation. In order to accomplish this, our Clinical Referral Line staff members are all licensed professionals who have experience in mental health or substance abuse programs and have the ability to identify enrollee needs and direct them to the most appropriate level of care. Many of our Clinical Care Managers have worked in emergency rooms, inpatient psychiatric hospitals, or clinics and have significant experience conducting comprehensive evaluations and assessments. In addition to their professional training, these clinicians receive additional training on assessment of emergencies over the phone and how to deal with individuals in distress.

Our Clinical Care Managers will have comprehensive knowledge of the benefits available to Empire Plan enrollees and will use this information to help inform their referral decisions. For enrollees who call requesting routine referrals, the Clinical Care Manager will complete an assessment to determine the level of risk. If their assessment reveals that an appointment needs to be arranged more quickly, the clinician will refer the enrollee appropriately.

For enrollees looking for referrals for higher levels of care—including inpatient and residential—the Clinical Care Manager will always refer him or her to one of our network providers who can complete a face-to-face assessment to determine if this level of care is appropriate. Emergency situations are the exception to this rule. The level of urgency or emergency is always caller-defined. However, if the Clinical Care Managers assesses the situation to be more serious than presented by the enrollee, the clinician will override the caller-defined urgency of the situation and increase the level of urgency for the referral provided.

Enrollees are also likely to call the Clinical Referral Line with a provider already identified. If the provider is not in the ValueOptions network, the clinician will review with the enrollee the benefits of using a network provider and offer to arrange the appointment as necessary. In situations in which referral to an out-of-network provider is needed based upon the specific circumstances, we will engage the provider in a single case agreement.

(d) A description of your proposed precertification program including the type of services subject to precertification, staffing levels, the timeline for completion, clinical information requested, and the number of cases reviewed, approved and declined for a client similar to the Program (for the most recent calendar year). Provide a sample of any pre-certification forms used by the Offeror.

PROPOSED PRECERTIFICATION PROGRAM

ValueOptions will offer providers needing to precertify services either a telephonic or an automated precertification process. The precertification line will be staffed 24 hours a day, seven days a week, with licensed clinical staff who will immediately be able to complete the request for services. Similarly, any request for care can be submitted via our online provider portal, ProviderConnect. ProviderConnect enables our clinical staff to review all clinical information submitted by the provider – in addition to past treatment records – prior to completing an outreach call to the provider to finalize the request. All providers are notified both verbally and in writing of the authorization decision.

TYPES OF SERVICE SUBJECT TO PRECERTIFICATION

Per Empire Plan requirements, ensuring full compliance with Parity regulations, inpatient and higher levels of care (with the exception of crisis/emergency admissions), as well as non-routine outpatient services (e.g., ECT, psychological testing, Applied Behavioral Analysis) will require a precertification. While emergency inpatient services do not require precertification, the telephonic review process will be available to providers for both psychiatric inpatient and detoxification services. We will educate our network providers to contact us as soon as eligibility and benefits are known for the initial review.

The precertification of the above services has been approved as "clinically appropriate" by our behavioral health experts and, as such, MHPAEA compliant. For example, precertification of psychological testing is clinically appropriate given the wide variability of practice and the lack of consensus on which the testing is appropriate to use in a particular situation. Similarly, it is clinically appropriate to institute a preauthorization of Applied Behavioral Analysis given this is a treatment comprised of many evidence-based techniques and procedures for changing behavior. Treatment is highly individualized and adjusted continuously based on data. Treatment delivery models range from focused interventions addressing a small number of target behaviors to comprehensive treatment programs addressing multiple targets. Additionally, ranges of treatment settings are possible (e.g., home-based, hospital, clinic, school, workplace, community). At this time, the field of Applied Behavioral Analysis has not produced treatment standards, and the frequency of treatment, the intensity, and duration required for positive outcomes is not yet established. Therefore, precertification, as well as regular monitoring and/or utilization reviews, is needed to ensure ongoing effectiveness and quality. In addition, precertification for inpatient care is allowable under MHPAEA because, according to federal regulators, diagnosis-related, group-based fees have not been established for psychiatric hospitalizations.

Because guidelines under MHPAEA as to how the "clinically appropriate exception" should be utilized have not been issued by federal regulators as of yet, we will review our policies and Empire Plan requirements once the final rules are issued.

STAFFING LEVELS

ValueOptions will staff the precertification line with eight Clinical Referral Line clinicians (Clinical Care Managers) to ensure adequate coverage and so that providers do not have to wait.

TIMELINE FOR COMPLETION

All timelines begin with the request for review and end with the issuance of the determination. Our requirements for completion are detailed in the following chart:

Type of Request	Timeframe For Decision and Written Notice Issued
Pre-Certification for Inpatient Care	24 hours from request with written notification within one business day
Pre-Certification for Alternative Levels of Care	Three business days from receipt of necessary information with written notification within the decision timeframe

If there is insufficient information to make a medical necessity determination, the Peer Advisor may elect to make the decision based on the information that has been received, or may invoke the Lack of Information provision. If the decision is made based on available information, written notification is issued within the determination timeframe for the type of care request (e.g. urgent, non-urgent). If the Peer Advisor invokes the Lack of Information provision, the provider and/or enrollee must be notified of the information needed within prescribed timeframes based on the type of care requested. A minimum period of time is given for the provider or enrollee to furnish the necessary information. Once information is received, or the time period for furnishing the information has expired, the decision and notice will be issued.

CLINICAL INFORMATION REQUESTED

ValueOptions' clinical staff (i.e., Clinical Care Managers, Peer Advisors) gather information from several sources to support the precertification process. For programmatic treatment settings (e.g., acute inpatient programs, residential treatment centers), clinical information can be provided by any of a number of individuals including:

- the physician or provider with responsibility for management of the case, including the decision to admit and discharge
- a licensed professional who is a key member of the treatment team
- a substance abuse counselor
- a facility-designated utilization review professional who has access to the treatment team meetings and to the treating provider

Clinical Care Managers collect only the clinical information necessary to certify the medical necessity of the admission, procedure, or treatment under consideration. ValueOptions' clinical staff do not routinely request complete copies of medical or treatment records. For prospective and concurrent determinations, the clinical staff base their review decisions solely on the clinical information obtained at the time of the review.

Clinical Care Managers obtain information relevant to the enrollee's clinical condition and the request for services during the review process. Clinical data that relates to the need for a requested level of care and treatment, and that is relevant and sufficient to make a medical necessity determination, is documented in the electronic clinical record. This clinical data is maintained as confidential in accordance with ValueOptions' policies and HIPAA regulations, and is used solely for the purposes of utilization management, case management, quality management, disease management, and discharge planning. It is shared only with those entities that have authority to receive such information and with those individuals who need access to such information in order to conduct utilization management and related processes.

Clinical Documentation

Clinical information relevant to the review process is documented in the enrollee's case in the CareConnect module. The clinical data supporting the review request, the medical necessity criteria applied and met, as well as the source and time of receipt of the clinical data are all documented. If additional information is needed and requested, that request and the agreed-upon timeframe to provide the information are also documented. If a Peer Review or other consultation is conducted, the Clinical Care Manager documents with whom the review was done, what additional care was confirmed as medically necessary, and the date of the next review. Goals for subsequent reviews based on treatment plan discussions are also documented. Finally, the Clinical Care Manager documents the date, time, and his/her name and credentials in the review.

Documentation in the case is required for reconsideration and appeal requests, including the date and time of the request, the person making the request, and relationship to the patient who is the subject of the appeal. For certain appeal requests, information regarding the enrollee's involvement in the request is also documented. Reconsideration and appeal decision notifications, both verbal and written, are documented in the case as well. Documentation includes date, time, and method(s) of notification.

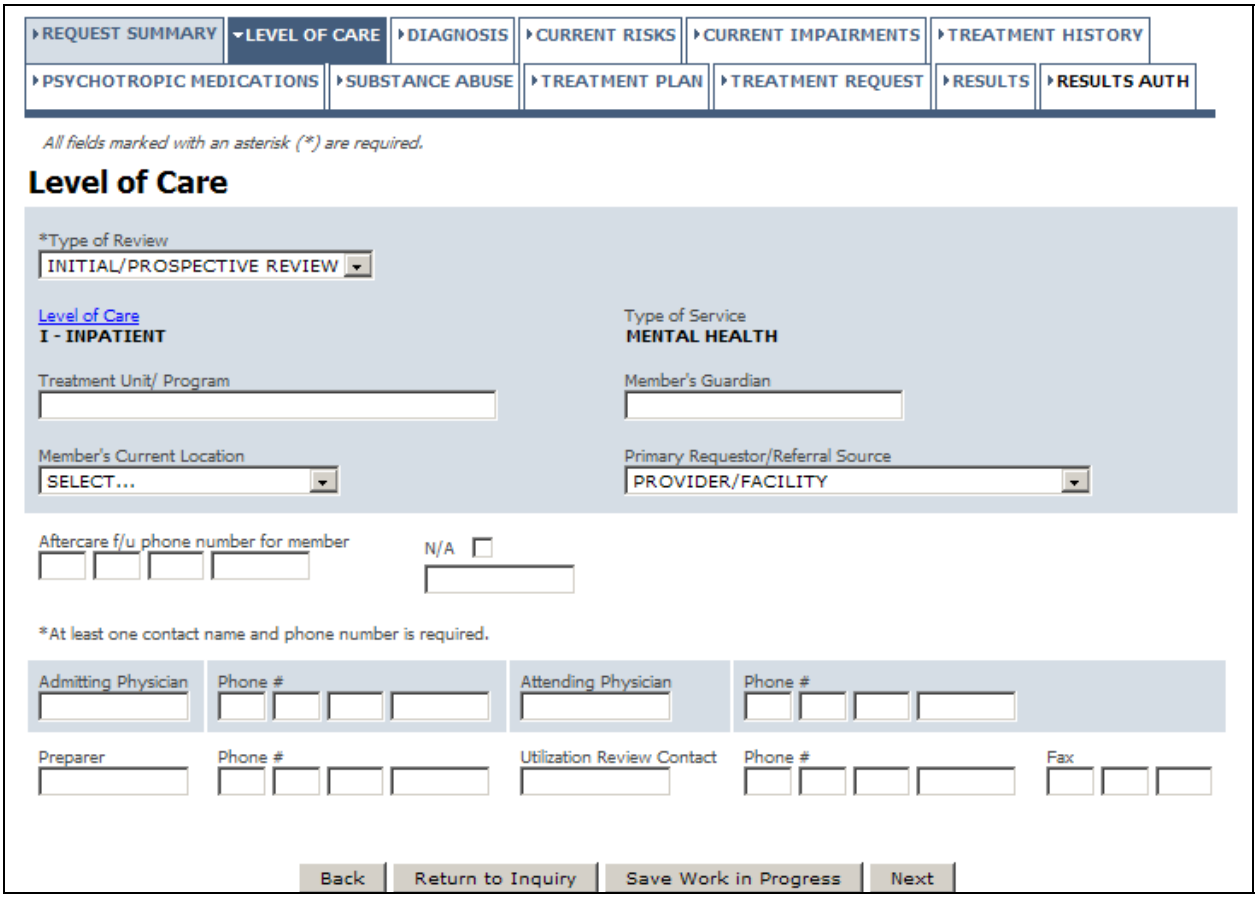
All notifications of appeal decisions are fully documented in the clinical record. Copies of written appeal determinations are maintained, either in hard copy or electronic format, for use in any audit of decision and notification timeliness.

EXAMPLE OF CASES REVIEWED, APPROVED AND DECLINED

For a similar State employee client (for the most recent calendar year), ValueOptions reviewed 10,367 cases, with 9,936 being approved and 971 being "declined." It is important to note that when ValueOptions "declines" a requested level of care, we refer the enrollee to an alternate level of care that is more appropriate for their particular needs. For example, if an enrollee calls our Clinical Referral Line and requests a referral for an office visit with one of our providers, but during that call they express that they are considering committing suicide, our Clinical Case Managers would ensure that the caller was provided with immediate emergency intervention. Requests for a higher level of care that are denied (declined) either at precertification or concurrent review are always referred to another level of care and followed to ensure that the enrollee obtains necessary services.

SAMPLE PRECERTIFICATION FORM

Below, we provide a screenshot of our clinical system showing a request for precertification.



(e) A description of the steps that will be taken to meet the needs of Enrollees who require a Provider with subspecialties, especially those who require pediatric, adolescent or geriatric mental health services. How will you meet the ongoing therapy needs of those Enrollees whose first language is not English; who are hearing impaired; or who request a Provider with a particular ethnic background?

OUR ROBUST PROVIDER NETWORK

ValueOptions utilizes a sophisticated software system to store all provider information and ensure that our clinical staff has continuous access to that information. The system allows a Clinical Care Manager to request a very specific provider search within a circumscribed geographic area. The Clinical Care Manager may initiate a search based upon provider discipline, clinical specialty, spoken language, and/or age group. Within seconds, a list of ValueOptions' practitioners matching the specified parameters appears online to the Clinical

Care Manager, who is then able to view all demographic and clinical practice information available regarding that provider.

ValueOptions' network includes a wide range of practitioner disciplines and facility programs. In addition, providers who especially serve minority and other groups, reflective of the diverse nature of the enrollee populations we serve, are recruited into our network. ValueOptions' practitioner application includes questions related to the disabled accessibility of the provider's office and to the ethnic and cultural groups the provider feels qualified to treat. The ValueOptions provider practitioner application – available online to clinicians to assist them in providing appropriate referrals – includes more than 60 fields that request the following information:

- Language competency
- Special populations they treat (e.g., age groups, hearing impaired)
- Clinical areas of expertise (e.g., depression, anxiety, chemical dependency)
- Treatment modalities (e.g., cognitive behavioral therapy, dialectical behavior therapy, group therapy)

ValueOptions' application includes questions asking if providers wish to identify themselves as a member of a particular ethnic group, gender, or religious affiliation. Due to the sensitive nature of this information, the provider is reminded that this information is optional, and only for the purpose of accommodating a stated enrollee preference. Providers with skills treating particular workforce populations, such as safety sensitive positions or law enforcement officers, are identified. This information is maintained online in the provider's file. Referral Line Clinicians have access to this information to ensure that enrollee's needs are met at the time of referral.

SERVING CHILDREN AND ADOLESCENTS

Children and adolescents require treatment by individuals who are specially trained to meet their unique developmental treatment needs and coordinate care across systems. ValueOptions actively recruits and contracts with Board Certified Child Psychiatrists and individuals who have subspecialties in the areas of Adolescent Psychiatry and Family Treatment. Additionally, community-based programs and facility-based units that deal with the specific needs of children are always evaluated for inclusion into the network.

SERVING THE RETIREE/GERIATRIC POPULATION

ValueOptions recognizes that the retiree/elderly population has special needs and may require assistance with daily living, including medication management and securing appropriate transportation. We accommodate these needs by soliciting providers who have expertise in treating this population and by promoting effective linkages with family and support systems, community based services, and primary care physicians through the care management process. We bring special programs into the network that may be required to meet the needs demonstrated by enrollees. In-home-based psychiatric services and telephone counseling sessions are additional ValueOptions programs available for this specialized population.

SERVING ENROLLEES WHOSE FIRST LANGUAGE IS NOT ENGLISH

We recognize a large segment of the population in New York is Spanish-speaking; therefore, a number of our Clinical Care Managers are bilingual. When necessary, staff members will warm-transfer a caller to the appropriate bilingual Clinical Care Manager. If the bilingual staff member is not available, the Clinical Care Manager assisting the enrollee can access our language line, Voiance, for assistance from a professional interpreter who speaks the enrollee's language fluently. These on-demand, three-way calls enable our Clinical Care Managers to provide the same enrollee-centric, high-quality service in the enrollee's native tongue.

We use Voiance because of their highly-trained, certified interpreters who can accommodate more than 200 languages, 24 hours per day, 7 days per week. Voiance has 18 years of experience in interpretation services, with thorough dedication to serving clients in health care as well as state and federal government.

SERVING THE HEARING IMPAIRED

As part of our routine call center services, we offer TTY/TDD and relay services for those enrollees who are deaf or hearing impaired. We have a demonstrated commitment to overcoming the barriers to care faced by people with hearing loss or speech impairments. We take full advantage of available technology to ensure that all enrollees have complete, prompt access to behavioral health services they need. We thoroughly train all call center staff on the use of TTY/TDD services so that enrollees who are deaf, hard-of-hearing or speech-impaired can talk to us without a translator. Callers can directly connect to the TDD line or be promptly transferred to speak with a customer service representative. This confidential service is available to enrollees 24 hours a day, seven days a week.

PROVIDER ETHNICITY

ValueOptions' Provider Relations and Clinical Operations teams work together on an ongoing basis to identify and recruit new providers to meet any specific ethnic and cultural needs identified by enrollees. In those rare instances where we are unable to locate a provider who meets the enrollee's identified needs within our comprehensive network, a single case agreement is negotiated with a clinically appropriate non-network provider to provide services.

SEVERELY MENTALLY ILL POPULATION

ValueOptions has significant experience serving enrollees who are identified as severely mentally ill. In fact, we hold public sector contracts that specifically draw upon our expertise and capabilities to manage care for these difficult populations. We have developed an expanded, coordinated care process for children and adult enrollees with serious and persistent mental illness and diagnoses of serious emotional disturbance, especially when accompanied by hospitalizations, complex needs, and at-risk or out-of-home placement.

Components of our expanded, intensive care coordination process include development of a personalized WRAP plan (wellness and recovery action plan), interventions targeted at the individual level, ongoing monitoring of enrollee needs, coordination with human and social service agencies, re-evaluating enrollees' risk levels, addressing care gaps, and conducting pre-admission screenings. In addition, we manage coordination with primary health care services,

share information between and among providers and the health plan team, and develop a behavioral health care "home." We collaborate to ensure that all expanded care coordination services are delivered efficiently and effectively. To ensure the highest quality of care, we continuously monitor performance measures, including community tenure, readmissions, overall service utilization, individual enrollee goal attainment, and quality chart audits.

(f) An explanation of how urgent and emergency cases will be identified. Who on the Clinical Management team will be responsible for making such determinations? Describe the procedures that will be followed for ensuring that Enrollees receive appropriate care in urgent and emergency situations.

IDENTIFICATION OF URGENT AND EMERGENCY CASES

The Clinical Referral Line assessment process is a standardized format designed to elicit relevant clinical information and necessary demographics in an effective but supportive manner. Our licensed and trained clinicians answer all calls and conduct assessments. Detailed clinical protocols and procedures are in place to assure the appropriate handling of any urgent or emergency cases. The protocols emphasize swift identification of emergencies, rapid facilitation of access to appropriate services, and prescribed follow-up by the ValueOptions clinician to monitor the provision of emergency services. ValueOptions uses the following Risk Rating Scale (which is detailed further in response to *Question 1a* earlier in this section) to help determine the most appropriate level of treatment and the urgency of clinical intervention:

- Risk Rating 1: Moderate/Mild Risk (Routine)
- Risk Rating 2: Serious Risk (Urgent)
- Risk Rating 3: Non-Life Threatening Emergency
- Risk Rating 4: Life Threatening Emergency

This scale enables clinicians to quickly identify callers who require emergency psychiatric treatment. The clinician asks the enrollee to describe the current presenting problem and to verbalize his/her perceived level of urgency. The enrollee is assessed for any prior treatment history, medication history, and/or relevant medical conditions. He or she is also assessed for risk of harm to himself or herself or others. Enrollees unable to articulate a level of urgency are asked questions such as, "How quickly would you like to be seen?" or "Would you like to see a therapist within the next 48 hours?" Such questions assist the caller in characterizing the situation.

As part of the assessment, the clinician applies ValueOptions' criteria to assist in determining the urgency of the call. Cases are identified as urgent when the enrollee presents with one or more of the following:

- Enrollee is upset and distressed, but not in immediate danger of harm to self or others, and while there is evidence of adequate pre-morbid functioning, social/family supports have significantly changed or diminished

- Moderate impairment in judgment, impulse control, and/or functioning
- Indications of active substance abuse or threat of relapse
- A substance abuse-related situation exists
- Enrollee indicates an urgent need to be seen

The level of urgency/emergency is always caller-defined. However, if the clinician assesses the situation to be more serious than presented by the caller, the clinician will override the caller-defined urgency of the situation and increase the level of urgency for the referral provided.

PROCESSES FOR ENSURING ENROLLEES RECEIVE APPROPRIATE CARE

ValueOptions' protocol for managing an urgent case requires that the enrollee receive a face-to-face assessment with a licensed mental health or substance abuse practitioner within 48 hours of the original call. The clinician schedules the appointment for the enrollee unless he or she indicates a preference to do so him/herself.

The clinician will conduct a follow-up call with the enrollee within 48 hours to ensure that his/her clinical needs have been met. The clinician will make three attempts to reach the enrollee and, if unable to speak with him or her, will follow up with the provider to determine the final disposition. It should be noted that clinicians always request enrollee permission to conduct the 48-hour follow-up call and to disclose minimally necessary information to the provider to whom the caller is referred. Our protocols for emergent, urgent, and routine care are described in more detail below.

Emergencies

If the enrollee is assessed as requiring an immediate evaluation and is not incapacitated by a life-threatening emergency, the clinician directs the enrollee to the nearest facility or the closest emergency room. It is important to note that emergencies are caller-defined. If the caller says that it is an emergency, it is always treated as such. Additionally, ValueOptions' clinicians assist by making arrangements for emergency transportation, ambulance services, and, if necessary, intervention by the police or emergency services while the caller is on the phone. In addition, once these arrangements have been made, the following crisis referral procedures occur:

- The clinician follows up by contacting the nearest emergency room or facility where the face-to-face psychiatric evaluation will be completed. He or she notifies the emergency room or other facility that, as a licensed clinician, he or she directed an "at risk" caller to the facility. Then, the Clinical Care Manager makes a follow-up call in 30 minutes to determine if the enrollee has arrived and to inform the emergency room admissions staff of the pre-certification process if admission is requested.
- The clinician continues to monitor for disposition. If the enrollee is not admitted after evaluation, the clinician contacts the enrollee again in approximately one hour. He or she offers the enrollee referrals to ValueOptions' network providers and offers to facilitate the scheduling of an appointment. The case is kept "open" until 24-hour follow-up is completed.
- If the enrollee has not arrived for emergency evaluation at that facility, the clinician contacts the caller to assess for appropriate follow-up action. If the attempt to reach a caller is

unsuccessful, he or she continues to follow up with the caller and emergency room until disposition is clarified.

If admission to a non-network facility is requested, ValueOptions assists in making arrangements for transfer to a network facility or, if transfer is not possible, a ValueOptions staff member contacts and negotiates payment arrangements with the non-network facility and authorizes payment of benefits at the network level of benefit until the enrollee is clinically stable for transfer to a network facility.

In addition, to ensure care coordination and provision of care in the most appropriate and least restrictive setting, we engage in the following practices:

- Rapid notification process with high volume facilities for enrollees presenting at the emergency department for care transition or real-time follow-up coordination.
- The use of alternative resources (community-based programs) for safe transitioning of acute care presentations that may be appropriately stabilized in non-inpatient programs or settings.
- Based on data-driven identification of enrollees with frequent behavioral health admissions, assignment of an Intensive Case Manager is initiated to develop a care plan to address alternative means of accessing care.
- Conjoint identification, management, and integrated care plan protocols with our client's medical health plan for enrollees with frequent admissions and co-morbid conditions such as chronic pain/substance abuse.
- Critical Time Intervention, a specialized transition case management for enrollees with patterns of high utilization of emergency room and inpatient services and unstable psychosocial issues to address living circumstances that contribute to high utilization.

Urgent

For enrollees who request or are assessed as requiring urgent care, the ValueOptions clinician will ensure the enrollee receives a face-to-face assessment with a licensed mental health professional utilizing the following protocols:

- The clinician locates an appropriate provider who meets the enrollee's specific needs.
- With the enrollee's permission, the clinician contacts the desired provider's office and obtains an appointment time for the enrollee within 48 hours.
- The clinician requests that the provider call back if the enrollee does not present for the appointment at the prescribed time.
- The clinician calls the enrollee back and gives them the appointment information.
- The clinician contacts the enrollee within 48 hours of the initial call to follow up.
- If the provider contacts the clinician to report the enrollee did not show for his/her appointment, the clinician makes three attempts to contact the enrollee to ensure his/her safety.

As safety is ValueOptions' number one concern for those in crisis, the Department can be assured that the above protocols, along with our clinicians' extensive experience, will enable us

to respond swiftly to emergent and urgent situations, provide linkage to the most appropriate resource and follow-up in a timely manner.

ValueOptions uses a multi-faceted approach to monitoring the timeframes enrollees are seen within by network providers, including:

- performing proactive follow-up to assure enrollees are linked with treatment providers
- reviewing care management records to obtain information on network provider performance
- tracking and documenting enrollee inquiries and complaints
- instituting quality improvement and management programs that include measures for monitoring timeliness of services being rendered

ValueOptions ensures waiting time standards are met by network providers primarily through proactive care management. Our licensed clinicians conduct an individualized assessment of each enrollee's clinical needs, referring the enrollee to the appropriate resource, and following up through each step of the process. In addition, a Clinical Supervisor and consulting physician are always available for consultation.

(g) An explanation of the procedures followed in cases where a Network Provider is contacted directly by an Enrollees seeking treatment.

We understand that there are instances when an enrollee directly contacts a network provider for treatment instead of going through ValueOptions' Clinical Referral Line. For example, an enrollee experiencing a mental health crisis may seek help at an emergency room. ValueOptions will require network providers contacted directly by an Empire Plan enrollee to inform and educate enrollees about the various benefits available to them under the Plan. They are also responsible for contacting ValueOptions directly to assist in referring the enrollee to the appropriate level of care, should they not be able to provide the needed course of treatment. Providers will receive a ValueOptions Provider Handbook and Empire Plan Provider Guide during their initial contracting process, detailing processes and information necessary to assist enrollees in receiving appropriate services.

Enrollees also access network benefits by contacting providers directly because of a recommendation from a friend, physician, or another provider. Consistent with other providers, ValueOptions requires group practice providers to educate enrollees about the benefits available to them under the Empire Plan and to assist them in accessing benefits accordingly.

(h) A description of the steps you will take to encourage the use of the toll-free number for the Clinical Referral Line to minimize self-referrals to Providers, as well as steps you will take to encourage the use of Network Providers; (i) Specify the location where Clinical Referral Line and other clinical management services for the Program will be provided. How will you ensure that CRL and clinical management staff are aware of MHSA community resources?

ENCOURAGEMENT THROUGH ENROLLEE COMMUNICATIONS AND EDUCATION

The first proactive initiative that ValueOptions will utilize to educate Empire Plan enrollees on the advantages of using the Clinical Referral Line involves the use of communication materials and education. These materials, including brochures, displays on the Empire Plan website, and similar initiatives, will emphasize the following:

- The Clinical Referral Line is available 24 hours a day, every day of the year.
- Accessing the Clinical Referral Line ensures that the practitioner or program selected participates in ValueOptions' network, allowing enrollees to receive the highest level of benefits.
- All calls are answered by clinicians who are licensed professionals trained in handling emergency and crisis situations.
- Clinicians are available to refer enrollees to the most appropriate provider to meet their needs and facilitate appointment scheduling.
- Clinicians are able to locate providers convenient to the enrollee's residence or place of work.
- Clinicians have access to information regarding a provider's area(s) of clinical expertise.
- All calls are treated as confidential.

ENCOURAGEMENT THROUGH ONLINE PROVIDER DIRECTORY

Enrollees who locate a provider using the online provider directory will be reminded to contact ValueOptions prior to beginning care and will be provided with the Empire Plan consolidated toll-free phone number. The first screen of the online provider directory states, *"You have selected the provider search program. Please note that prior to beginning any care or program with a provider; you need to contact ValueOptions to receive authorization. Using the provider search capabilities of the ReferralConnect does not replace any pre-certification requirements of your plan. For more information, please call ValueOptions at [insert number]."*

ENCOURAGEMENT THROUGH DIRECT TRANSFERS

Additionally, when enrollees contact a Customer Service Representative to inquire about benefits or verify a particular provider's status in the network, the Customer Service Representative offers to directly transfer the caller to a Clinical Referral Line clinician. Clinicians are then available to assist the enrollee in identifying the best course of action using in-network providers, given the enrollee's clinical presentation.

ENCOURAGEMENT THROUGH PROVIDER EDUCATION

ValueOptions also includes education regarding the use of the toll-free referral line in all training sessions with the network provider community. Clinical Care Managers, Peer Advisors, and Provider Relations staff members conduct informal sessions during telephonic interactions with providers. Formal training, which includes this information, is conducted in provider forums and seminars, and as a part of the scheduled on-site review process. Provider newsletters are another vehicle for encouraging the use of the toll-free number.

In addition, ValueOptions participates in the annual Health Benefits Administrators conferences throughout the state. These conferences are also used as an opportunity to educate enrollees and administrators regarding the use of the Clinical Referral Line.

Training practitioners, EAPs, enrollees, and benefit administrators is an ongoing process that occurs formally and informally on an almost daily basis. ValueOptions is committed to continuing these activities, as well as the other activities described.

(i) CLINICAL REFERRAL LINE AND CLINICAL MANAGEMENT LOCATION

All Clinical Referral Line and other clinical management services for the Empire Plan program will be provided in New York by New York-licensed behavioral health clinicians.

MHSA COMMUNITY RESOURCES

ValueOptions has been in business in New York since 1992. In addition to developing a robust network of providers throughout the state, since that time we have also developed a rich database of various community resources. This database is continuously reviewed and updated, and the resources are sorted by region in the state so they are easily sortable to assist enrollees. In addition to community resources, staff will have Empire Plan benefits information available to them. This would include medical carrier information, disease management programs, and any health and wellness programs. Below is a specific, recent example of a situation in which a ValueOptions Intensive Case Manager provided referrals to community resources to help an enrollee.

The Situation: A 52-year-old woman with a 10 year history of schizophrenia was referred to ValueOptions' Intensive Case Management program after having been hospitalized for psychiatric treatment three times in less than a year. The hospitalizations were the result of the return of schizophrenic symptoms following medication non-compliance. During evaluation, the woman revealed that her boyfriend had recently died of a drug overdose for which she felt guilty and responsible due to an argument they had shortly before his death.

The Plan: In addition to receiving psychiatric treatment and other appropriate behavioral health services, the ValueOptions Intensive Case Manager suggested that the enrollee consider participating in a bereavement support group. The Intensive Case Manager conducted a search of the bereavement groups in the woman's area and contacted each program to inquire about cost and availability. Based on this research, the Intensive Case Manager provided the woman with a referral to a no-cost drop-in bereavement support group offered by Good Samaritan Hospital. While the woman initially indicated that she was apprehensive about attending the group—as she

was fearful it would increase her depression—the Intensive Case Manager normalized the woman's feelings and encouraged her to attend when she was ready. The woman agreed to attend the program the week the referral was provided.

The Outcome: The Intensive Case Manager followed up with the woman after she attended the group. The woman reported that she no longer felt alone and that she was better able to cope with the guilt of her boyfriend's death. She further indicated that she will continue to attend the group as it was helpful to her treatment. In addition, the Intensive Case Manager worked with her to help her find an in-network therapist and offered support services as she applied for Social Security Disability. The woman has been able to stabilize her symptoms by complying with treatment and medication, and she was awarded Social Security Disability and continues to attend the bereavement group. She further reports feeling a decrease in her depression and guilt since engaging with her treatment providers, and expressed gratitude for the Intensive Case Management program and the Intensive Case Manager's kindness.

(i) The methods you use to measure the effectiveness of the Clinical Referral Line and pre-certification services (Do not include any reference to specific monetary savings).

We measure the effectiveness of our Clinical Referral Line and precertification services in the following ways:

1. We evaluate and ensure the effectiveness of the precertification process in several ways. All Clinical Referral Line calls are tracked by type of call. These include emergency, urgent, and routine referrals. All emergency and urgent calls are audited to ensure the service standards are met, and results are reported into the quality management and utilization management committee.
2. Our Quality Management team conducts random audits on a monthly basis of precertification reviews conducted by our Clinical Care Managers and Peer Advisors. The audit tool evaluates whether medical necessity criteria were met for admission and whether the level of care approved was the most appropriate, least restrictive level of care based on the enrollee's clinical needs.
3. ValueOptions assesses clinical effectiveness of precertification through our facility on-site treatment record review process. Periodic random auditing of treatment records of network facilities by our clinical and quality management staff will ensure that the records adhere to national standards of practice and reflect the clinical appropriateness of the behavioral health admission.
4. ValueOptions measures the effectiveness of precertification by tracking and investigating any quality of service or quality of care complaints initiated by enrollees or providers regarding the precertification and/or admission process.
5. ValueOptions tracks provider requests to ensure they are provided in a timely manner. If they are not, outreach and education is provided to encourage them to comply with guidelines. We also track—by provider—the number of requests approved, denied, or

modified. Providers who receive a significant number of denials or modifications are contacted by a member of our Provider Relations department to receive education on alternate levels of care and appropriate referral guidelines.

(j) How you will transition Enrollees with existing precertifications with a Network Provider into your system. Confirm you will load one or more files of pre-certifications and Prior Authorizations approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once acceptable files are received.

ValueOptions will work directly with the Department and the current Empire Plan behavioral health administrator to obtain and load all precertification and prior authorization data prior to January 1, 2014. Our recommendation is to have the data loaded at least 10 days prior to our system readiness testing period, which begins 30 days prior to go-live.

Our dedicated IT technical analysts and clinical subject matter experts will work side-by-side to determine detailed requirements, write functional specifications, conduct testing, and coordinate the delivery of the application and data integration necessary to support the implementation. ValueOptions will develop a detailed transition plan that will include suggestions for:

- notifications and trainings for network providers
- notification to enrollees
- opening phone lines at least one month prior to go live to allow enrollees and providers to ask questions about benefit transition
- performing outreach to high volume providers to ensure they are knowledgeable regarding the transition benefits
- receipt of updated case records regarding enrollees engaged in treatment to facilitate transition of care as needed and appropriate
- contacted providers at the time authorizations are due to expire to ensure enrollees have discharge plans in place
- a 90-day transition benefit for outpatient for any providers who have opted not to join our network

(2) Confirm that you will prepare and send approved communications to notify Enrollees and/or their Providers of the outcome of their pre-certification and/or prior authorization request.

Yes, ValueOptions will notify providers and enrollees both verbally and in writing of all authorization decisions.

(3) Confirm that you will promptly load into the clinical management and/or claims processing system approved pre-certification and prior authorizations determined by the Offeror.

We confirm that we will promptly load clinical management and/or claims processing system approved precertification and prior authorizations determined by ValueOptions.

(4) Describe the steps the Contractor will take to pre-certify inpatient hospital admissions for alcohol detox and manage the patient's care if transferred to rehab.

PRE-CERTIFYING INPATIENT DETOX

ValueOptions' staff will work with all inpatient detox programs, including those programs located on a medical unit or within free-standing facilities. Our clinical staff will assess the need for and pre-certify an inpatient hospital admission for alcohol detox using the following criteria:

1. Individual has been evaluated by a licensed clinician and meets diagnostic criteria using our internally developed medical necessity criteria and criteria under DSM-IV-TR (or most current DSM) for Substance Dependence which requires and can reasonably be expected to respond to detoxification treatment.
2. Facility demonstrates ability to safely treat patients with quality care by being in ValueOptions network or being accredited by appropriate agencies.
3. The enrollee's use of alcohol and/or other drugs is significant and persistent, and discontinuation is associated with any of the following:
   a. Current symptoms of severe, potentially life threatening withdrawal requiring 24-hour medical supervision and management. This does not include the patient having mere physical or mental discomfort.
   b. The enrollee's history of use, history of severe withdrawal (such as seizures or actual delirium tremens), or presenting condition indicates that severe withdrawal is imminent and requires 24-hour medical supervision and management.
   c. Presence of a serious, unstable medical or mental health condition that is likely to complicate detoxification to the extent that 24 hour observation and intervention is necessary.
   d. Potential risk of serious harm to self or others complicating the detoxification to the extent that a 24 hour acute setting is required for the enrollee's safety (assessment to include risk, intent, plans, mitigating factors).
4. There are significant medical complications from drug and/or alcohol use that require 24-hour monitoring and nursing care and can be safely managed in an inpatient detoxification program.
5. Blood and/or urine drug screen was (will be) ordered upon admission.
6. Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) score at least 10 (or an equivalent severity score on a similar standardized scoring system).

DISCHARGE AND NEXT LEVEL OF CARE

Our Clinical Care Managers will work with the facility to ensure an appropriate discharge plan is developed. The multi-disciplinary discharge planning process starts from the assessment and includes the enrollee and family/significant other as appropriate, unless contraindicated secondary to risk of harm to the enrollee or family/support. Once the enrollee meets the criteria for discharge from inpatient detox, follow-up aftercare is arranged for a timeframe consistent with the enrollee's condition and applicable standards. Discharge is considered appropriate under various circumstances, including:

- the enrollee no longer meets admission criteria or meets criteria for a less intensive level of care
- co-morbid conditions have been controlled to the point that a lower level of care is indicated
- the enrollee, family, legal guardian and/or custodian are non-participatory in treatment or in following program rules and regulations, rendering treatment at this level of care ineffective or unsafe, despite multiple, documented attempts to address non-participation issues
- support systems that allow the enrollee to be maintained in a less restrictive treatment environment have been thoroughly explored and/or secured
- the enrollee's physical condition necessitates transfer to a medical facility

Treatment is not considered complete until a suitable aftercare plan has been designed and implemented. In substance abuse cases, where recidivism rates are generally higher than in psychiatric cases, consistent and thorough follow-up is key. We will work to transition enrollees from inpatient detox to the next level of care that is appropriate for each specific case. We verify and monitor the provision of aftercare follow-up not only during inpatient and residential stays, but also through discharge to outpatient treatment and community programs. Enrollees who have had high-risk medical conditions, multiple detoxes, or multiple rehabilitations will be referred into our Intensive Case Management program for more intensive follow-up.

(5) Confirm the Contractor will load into the clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once acceptable files are received.

ValueOptions will work directly with the Empire Plan and its incumbent to obtain and load all pre-certification and prior authorization data prior to January 1, 2014. Our preference would be to have the data loaded prior to our system readiness period, which occurs 30 days prior to our go-live date. Our dedicated IT technical analysts and clinical subject matter experts will work side by side to determine detailed requirements, write functional specifications, conduct testing, and coordinate the delivery of the application and data integration necessary to support the implementation.

(6) Non-Network CRL Guarantee: The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non-emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate Non-Network Provider within two (2) Business Days of the call in at least ninety percent (90%) of cases. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of cases where Enrollees are referred to Non-Network Providers within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) of cases (or the Offeror's proposed guarantee) when an Enrollee is referred to a Non-Network Provider within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available, is $_____.

NON-NETWORK CRL GUARANTEE

[redacted]

(7) Emergency CRL Guarantee: The MHSA Program's service level standard requires that when one hundred percent (100%) of Enrollees who call the CRL in need of life- threatening emergency care be referred to the nearest emergency room and be contacted within thirty (30) minutes to assure their safety. Additionally, one hundred percent (100%) of Enrollees in need of non-life threatening emergency care shall be contacted within thirty (30) minutes by a Network Provider or the CRL. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below one hundred percent (100%) of Enrollees who call the CRL in need of emergency care will be contacted by either the Network Provider or the clinicians within 30 minutes of the Enrollee's call to the Clinical Referral Line, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of one hundred percent (100%) when an Enrollee requires emergency care , contact will be made by either the Network Provider or the Contractor's Clinicians within thirty (30) minutes of the Enrollee's call to the Clinical Referral Line is $_____.

EMERGENCY CRL GUARANTEE

[redacted]

[redacted]

(8) Urgent Care CRL Guarantee: The MHSA Program's service level standard requires that at least ninety-nine percent (99%) of Enrollees who call the CRL in need of urgent care will be contacted by a the Contractor to ensure that the Network Provider contacted the Enrollee within 48 hours of the call to the CRL. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-nine percent (99%) of cases when an Enrollee calls the CRL and requires urgent care, contact will be made by the Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the call to the CRL, is $10,000per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine percent (99%) (or the Offeror's proposed guarantee) when an Enrollee requires urgent care, contact will be made by the Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the call to the CRL, is $_____.

URGENT CARE CRL GUARANTEE

[redacted]

[redacted]

CONCURRENT REVIEW

(1) Please detail the full scope of the concurrent UR program that you are proposing to utilize for the Program, including:
- (a) The qualifications of the staff responsible for oversight of your concurrent UR program;
- (b) Review of outpatient care;
- (c) Review of inpatient care;
- (d) Discharge planning and follow-care; and
- (e) Case management of high risk cases.

(a) STAFF QUALIFICATIONS

Below, we provide the qualifications of staff responsible for the oversight of our concurrent UR program:

Medical Director

ValueOptions' Medical Director for the Empire Plan Team, Dr. Hal Levine, is a licensed, board-certified psychiatrist who will provide leadership and direction for all services rendered under the contract, as well as ultimate oversight of the utilization management process. Dr. Levine has significant knowledge and expertise directly related to the Empire Plan program, having served as the Medical Director for the Program when ValueOptions held the account from 1992 to 2008. Dr. Levine will be supported by Dr. Christopher Dennis, the Chief Medical Officer for ValueOptions' Commercial Division. Both of these physicians are licensed to practice in the state of New York—with Dr. Dennis residing in the state—and also exceed ValueOptions' minimum requirements for our Medical Directors. All of our Medical Directors, including Dr. Levine and Dr. Dennis, are required to have the following skills, education, and experience:

- Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) from an accredited medical school
- Board certification in psychiatry by the Board of Psychiatry and Neurology. Board certification by the American Board of Quality Assurance and Utilization Review Physicians is preferred.
- current, valid and unrestricted clinical license
- at least five years of post-graduate clinical practice
- at least two years of inpatient or hospital based treatment experience
- at least three years of managed care/utilization management experience

Additionally, ValueOptions' Medical Directors must have in-depth knowledge in the following areas:

- medical care delivery systems
- utilization management
- quality improvement
- peer review

- contracting benefits interpretation
- provider relations
- enrollee services

Clinical Director

ValueOptions' Clinical Directors must have a current, valid, and unrestricted clinical license (RN, LCSW/ACSW, Ph.D., LLP, LMFT, and LPC) and meet the following criteria:

- Master's-level or higher degree in a mental health related field (RN, LCSW/ACSW, LMFT, Ph.D.)
- minimum of eight years of post-Master's clinical practice experience
- minimum of two years inpatient or hospital based treatment experience and two years of outpatient treatment experience
- minimum of three years managed care experience
- minimum of five years administrative and management experience

Clinical Care Managers

ValueOptions' Clinical Care Managers are responsible for the continued review of all enrollee care (i.e., for both inpatient and outpatient services). Clinical Care Managers may certify care, but cannot render non-certification decisions. Clinical Care Managers must have a current license and meet one of the following criteria:

- Master's level mental health clinician, social worker, or psychologist with minimum three years' post-graduate clinical experience in a psychiatric/substance abuse treatment program with an emphasis on crisis intervention
- Master's level psychiatric nurse or registered nurse with three years' minimum post-graduate clinical experience in a psychiatric/substance abuse treatment program with an emphasis on crisis intervention
- Doctorate-level clinical psychologist with three years' minimum post-graduate clinical experience in a psychiatric/substance abuse treatment program with an emphasis on crisis intervention

Peer Advisors

Peer Advisors are responsible for reviewing care requested by the provider that a Clinical Care Manager is unable to certify. Only Peer Advisors may render a non-certification decision. Peer Advisors must have the following qualifications:

- licensed to practice independently in New York state
- board-certified psychiatrist (M.D. or D.O.) or licensed clinical psychologist (Ph.D.)
- minimum of five years of post-graduate clinical experience
- minimum of 20 hours per week in active practice

Peer Advisors must also demonstrate strong communication and negotiation skills, the ability to work effectively as facilitators and teachers in a multi-disciplinary team environment, a genuine

concern for the welfare of individual enrollees, and a willingness to assume a clinical advocacy role on the enrollee's behalf, when indicated.

(b) REVIEW OF OUTPATIENT CARE

Authorizing Continued Treatment

ValueOptions has developed an outpatient treatment review form for concurrent review that allows the provider to use the information that he/she is completing to ascertain if the treatment being providing meets best practice standards. The form is available for on-line completion or can be faxed in for review. Once the form is received, it is reviewed by one of our Clinical Care Managers for diagnosis, risk, impairments, past treatment, and treatment planning. The provider is required to attest to the use of best practices to ensure the enrollee is receiving the most appropriate level of care, including:

- that co-occurring medical conditions have been assessed and addressed, if applicable, in the treatment plan
- that co-occurring psychiatric conditions have been assessed and addressed for those presenting with primary substance abuse disorders, and if applicable, included in the treatment plan
- that risk issues have been assessed and addressed in the treatment plan and are continually monitored during treatment.

If the treatment meets medical necessity and the provider attests to evidenced based practices, an authorization to continue treatment is given. All reviews are completed within New York state-specific turn-around times, with written notification sent to both the provider and the enrollee.

If the treatment plan is incomplete, the Clinical Care Manager will call the provider to conduct a telephonic review to facilitate the medical necessity determination. If the information given supports medical necessity, the Clinical Care Manager will authorize services. She/he will advise the provider of the authorization with written notification sent to both the provider and the enrollee.

If the provider is unable to supply enough information for medical necessity, the provider is advised that a telephonic review is required with a Peer Advisor. The provider is transferred to a scheduler who sets up an appointment with the provider. Outpatient treatment requests that are modified or denied contain a recommendation for alternative community supports. All requests are completed in the appropriate time frame with visits allowed for transition of enrollees.

More Frequent Reviews for High Need Enrollees

Specific enrollee situations often require more frequent outpatient review. These include:

- Enrollees in long-term outpatient treatment
- Enrollees in treatment multiple times per week
- Enrollees in treatment with multiple providers
- Enrollees who seek services from multiple providers being unable to engage in treatment
- Children in treatment without family involvement

These enrollees may be referred to Intensive Case Management services in an attempt to determine other community resources that may be of benefit to them. Outpatient providers are notified that an enrollee is involved in Intensive Case Management services when a release of information authorization is provided.

Measuring Outcomes and Treatment Success

This program is designed to ensure that outpatient behavioral health recipients are on track in achieving their goals. This process is based on the enrollee-completed Client Feedback Form. This form is designed to assess global mental health status, self-harm risk, substance abuse risk, absenteeism, presenteeism, and therapeutic alliance (which has been shown to be a critical factor in the effectiveness of psychotherapy).

The Clinical Feedback Form is designed to assess clinical risk and monitor changes in health status as individuals receive services. Participating ValueOptions providers are asked to administer the Client Feedback Form prior to the first session, at the third session, and then every third session thereafter. The completed form is then faxed to a toll-free number for analysis and secure online reporting back to the practitioner. On Track directly promotes the delivery of cost-effective behavioral health services by using predictive modeling to identify risks early and continually monitoring progress during the treatment process.

Although program participation currently remains voluntary, the number of providers registered for On Track has steadily increased since the program's launch in August 2008. To date, more than 1,100 ValueOptions network providers have registered to participate in this program.

(c) REVIEW OF INPATIENT CARE

Care management staff will conduct telephonic concurrent review of inpatient and alternative level of care cases. The telephonic clinical review process allows the Clinical Care Managers to engage in a dialogue with the treating providers to ensure enrollees are receiving the highest quality behavioral health treatment at the most appropriate and least restrictive level of care. Clinical Care Managers closely monitor the patient's status, medications, and the treatment planning process at each review.

ValueOptions initiates a concurrent review prior to the end of every certified period. This allows time for discharge planning and transfers to an appropriate alternative inpatient or outpatient setting, should the ultimate review decision result in non-certification of the current level of care. If ValueOptions renders a non-certification decision, and the enrollee is in a network facility, ValueOptions will offer network referrals to an appropriate alternative level of care or outpatient provider and facilitate an appointment.

If the individual is receiving treatment in a non-network facility, ValueOptions will inform the enrollee how to obtain care from an appropriate network provider, offer to make a referral, and arrange for transfer if needed. ValueOptions recognizes that the transition of care process from one level of care to another is important for the enrollee. We work with the network provider and the enrollee to ensure that the enrollee receives the appropriate level of care during this transition with follow up calls to ensure the enrollee is connected to services at the right level of care.

Inpatient and Alternative Level of Care Review Frequency

The frequency of concurrent reviews is dictated by clinical issues in each case and occurs more or less often depending on the severity and complexity of the patient's condition. However, maximum time frames for standard inpatient care management and Alternative Level of Care (ALOC) reviews for medical necessity have been established as follows:

Inpatient and ALOC Care Management	
Level of Care	**Maximum Review Frequency**
Inpatient Psychiatric	Pre-certification and every 2-4 days
Inpatient Detoxification	Pre-certification and every 2-3 days
Inpatient Rehabilitation (Substance Abuse)	Pre-certification and every 3-5 days
Partial Hospitalization Program (Psychiatric/Substance Abuse)	Pre-certification and every 3-5 days
Intensive Outpatient Program (Psychiatric/Substance Abuse)	Pre-certification and every 7-14 days
Residential Treatment Center (Psychiatric/Substance Abuse)	Pre-certification, 14 days (initial), and every 2-3 weeks (concurrent)

Concurrent Review Required Documentation

During the concurrent review process, Clinical Care Managers document the following information in the enrollee's case via the clinical review screens in the CareConnect application:

- Date of review/contact/title
- Enrollee name
- Number of days/visits certified to date
- Diagnosis (if changed, justify)
- Current risks and impairments
- Significant new history obtained (document any work, home/school-related issues, including any work updates, not completed in previous review. Are there situational workplace factors that are contributing to the patient's condition? Is the EAP involved?)
- Medications (document changes, lab/test results, levels)
- Treatment plan updates (document family participation, progress towards goals or obstacles to achievement, and changes in treatment plan)
- Reasons for continued stay and estimated length of stay
- Medical necessity criteria met for level of care
- Discharge plan (including planned discharge residence, planned discharge level of care, and aftercare appointment dates)
- Barriers to discharge
- Issues for next review

(d) DISCHARGE PLANNING AND FOLLOW-UP CARE

Discharge Planning

ValueOptions' clinical philosophy maintains that inpatient treatment services should be designed to return the enrollee to his/her pre-morbid level of functioning and to the community as quickly as possible. Therefore, services in an acute care setting should be designed to re-stabilize the enrollee and address risk-related symptomatology. Once achieved, the next goal is to safely transition the enrollee back to the community and to the least-restrictive treatment setting

possible. At times, the enrollee may need to transition through multiple levels of care. Accomplishing this requires that ValueOptions maintain a superior network of programs covering all levels of treatment. ValueOptions not only encourages providers to offer a variety of programs, but also collaborates with the provider community to locate and/or develop such programs.

The role of the Clinical Care Manager in the discharge process is to assure that alternative levels of care are considered and utilized whenever appropriate. This often involves educating facilities and providers as to what resources (e.g., self-help and support groups) are available in their community and coordinating follow-up care appointments. The Clinical Care Manager is involved in the discharge planning process from the time of admission. This enables ValueOptions to more effectively manage the case and to serve as a resource to the provider throughout the treatment and discharge phases. ValueOptions will work closely with enrollees and their families during this transition process ensuring all barriers to discharge are addressed.

Discharge plans and transition to less restrictive levels of care are also discussed on an ongoing basis in clinical rounds. Clinical rounds occur daily and are composed of the Medical Director or a ValueOptions staff psychiatrist, the Inpatient Clinical Manager or Supervisor, and a group of Clinical Care Managers. This meeting serves as a valuable resource for sharing case information and seeking guidance from a psychiatrist or from other Clinical Care Managers to resolve complex case issues. Case consultations are also held one-on-one between a ValueOptions psychiatrist and a Care Manager on a daily basis as needed. This assists the Clinical Care Manager in resolving any open issues that require immediate attention.

Discharge Planning Procedures

ValueOptions' Clinical Care Managers proactively discuss discharge planning as part of every review. It begins in the initial care management review to assure that a realistic plan is formulated and implemented. The discharge plan specifies involvement of family members, if therapeutically indicated, and relevant follow-up and aftercare by medical providers.

Prior to the projected discharge date, the Clinical Care Manager confirms the enrollee's status and speaks with the provider. Clinical Care Managers assure that components of a concrete discharge plan have been properly coordinated and necessary resources are in place. Our intent is to confirm that an appropriate discharge plan is in place to maintain the clinical gains achieved in inpatient treatment. Specifics, such as the name, address and phone number of follow-up providers, the date and time of the initial follow-up appointment, and the names of any responsible family members are obtained from the provider.

Follow-up Care

ValueOptions has a comprehensive follow-up program to confirm enrollee compliance with aftercare. The clinical reviews conducted by our Clinical Care Managers during the treatment period following an acute care admission are central to our program. We measure HEDIS follow-up after hospitalization across all programs and we have adopted clinical quality indicators that measure whether an enrollee is seen for a follow-up appointment within seven and 30 calendar days of discharge from an acute level of care.

We continuously implement programs and activities to improve the quality of care and service we provide to enrollees. These improvements often result in improved behavioral health HEDIS score reporting. For example, a program focusing on increasing ambulatory follow up after discharge has been in place since 2008. The focus of this activity is to increase the rate of ambulatory follow-up for all enrollees discharged from inpatient care.

We know that managing early post-acute hospitalization is an effective intervention in preventing early re-hospitalization. In addition, non-compliance with follow up is also a major predictor of re-hospitalization. We have identified several factors contributing to these phenomena including the failure to aggressively link enrollees leaving inpatient settings to the appropriate aftercare. We deliver improved outcomes through successfully linking the following components:

- Accurate assessment of discharge needs prior to discharge and development of services to meet those needs
- Enrollee participation in identifying appropriate services
- Enrollee buy-in and consent to discharge plan
- Immediate access to planned follow-up services
- Comprehensive case management of those enrollees at risk for non-compliance
- Systematic monitoring of aftercare appointments

(e) CASE MANAGEMENT OF HIGH-RISK CASES

ValueOptions maintains a proactive Intensive Case Management Program that is designed to more effectively manage the care of those enrollees who are determined to be "high-risk." Intensive Case Management is a specific approach to managing the care of enrollees who have not been able to stabilize with standard care management strategies. Intensive Case Management is a collaborative process involving Clinical Care Managers, physical and behavioral health care providers, patients, family members, and other community supports. Intensive Case Managers assess, plan, implement, coordinate, monitor, and evaluate options and services to ensure that an enrollee's health needs are met. Moreover, Intensive Case Management promotes quality, cost-effective outcomes. Intensive Case Management is reserved for clinically complex cases that involve a high level of clinical risk and/or require high-cost, highly restrictive levels of care. The program is offered to enrollees on a voluntary basis.

Criteria for Intensive Case Management

ValueOptions has established a list of factors or clinical indicators related to the enrollee's condition that may identify him or her as a candidate for Intensive Case Management. All Clinical Care Managers and providers are aware of these clinical indicators so that when appropriate, patients can be referred for Intensive Case Management. These factors include:

- Three or more inpatient episodes within one year
- Inpatient lengths of stay greater than 21 days
- All residential treatment center cases
- Multi-diagnosis cases (including medical conditions)
- Complex depression management cases

- Hospitalized children, ten years or under
- Adolescents with multiple or extended treatment episodes without improvement and/or with inadequate family involvement during treatment
- Safety sensitive employment status
- Conditions that, by virtue of their complexity, would benefit from intensive care management services (e.g., concomitant medical disorder)

Intensive Case Management Program for High Risk Cases

ValueOptions' program is designed to identify and manage those enrollees who require more intensive services that go beyond routine care management. The Intensive Case Management program is essentially used to provide more "hands-on" care management for complex cases to ensure consistency, coordination of care, and compliance, given clinical and/or behavioral indicators of clinical instability. High-risk patients often require greater attention and coordination to facilitate smooth transition from one level of care to another, including follow-up. It is common for these enrollees to seek services from multiple providers, resulting in the potential for problems to arise around coordination of care. The Intensive Case Management Program prevents these patients from receiving services in a fragmented manner, improves continuity of care, and promotes appropriate utilization of services.

Intensive Case Management Components

The major components of the Intensive Case Management process are described below:

- **Goals of intensive case management.** To minimize the reliance on facility-based care; decrease the need for repeated crisis management; focus on maintenance and stabilization in outpatient care; and establish a customized comprehensive plan that over the longer term will increase functioning in areas such as self-care, work/school, family/interpersonal, and will decrease symptomatology and risk factors
- **Intensive case management program components.** The key components of the Intensive Case Management program include:
  - More educational and informative phone contacts with patients/providers/parents on the care management and treatment processes, including the discharge plan and need for compliance with aftercare
  - Comprehensive discharge planning including relapse planning and crisis intervention
  - Assuring linkage with discharge location and community resources
  - Evaluating provider's efficacy with this particular patient and referring for a second opinion as appropriate
  - Assuring that the facility has performed drug screens and substance abuse evaluations
  - More frequent reviews by Clinical Care Managers and Peer Advisors
  - Utilizing internal staffing meetings and clinical rounds to discuss the patients' needs
  - Coordinating with the workplace; conferencing with the various providers, PCPs, workplace representatives, parents, or the patient, all as appropriate and with necessary releases of information
  - Enabling high risk patients to use available resources (including services available through schools and community agencies) in a more efficient, effective manner

- **Criteria for moving a patient from intensive case management when stability has been achieved and maintained over an extended period of time.** A patient is considered appropriate for "discharge" from the Intensive Case Management program once he/she has met his/her care plan goals for the program and is able to function in traditional outpatient therapy with no hospitalizations for a period of at least six months, and/or has demonstrated a level of progress and engagement in self-care and treatment which no longer requires Intensive Case Management level services. If discharged, patients can be re-referred for Intensive Case Management at any point in the future when they are determined to be at high risk.

Intensive Case Managers

ValueOptions' Intensive Case Management program requires that a senior Clinical Care Manager be assigned to coordinate these cases and monitor the Empire Plan enrollee's progress through all levels of care. A dedicated Intensive Case Manager will follow each case and provides comprehensive care throughout the treatment process for the Empire Plan enrollee and family members in treatment.

This includes review of any future requests for precertification of care. The assigned Intensive Case Manager ensures integrated services through ongoing communication with the Empire Plan enrollees and provider(s) involved in the case, establishing linkages to family service agencies, community services organizations, the court system, schools, the Employee Assistance Program, external care management providers, and any other appropriate resources. The Intensive Case Managers will also interface and cooperate with the Empire Plan hospital carrier and other Empire Plan carriers in cases where there are co-morbid medical conditions impacting care.

Follow-Up for High-Risk Cases

The Clinical Care Manager calls the outpatient provider and informs them of the Intensive Case Management process. The Clinical Care Manager then confirms the appointment date and time and instructs the provider to contact the Clinical Care Manager directly to conduct all subsequent clinical reviews. The Clinical Care Manager contacts the provider on the day following the enrollee's scheduled appointment. If the enrollee does not keep the appointment, the Clinical Care Manager requests that the provider contact the enrollee. The Clinical Care Manager also sends a letter to the enrollee encouraging discharge follow-up and offering assistance.

(2) Describe the software you will utilize to administer the concurrent UR program and any other technologies that will be used to apply UR.

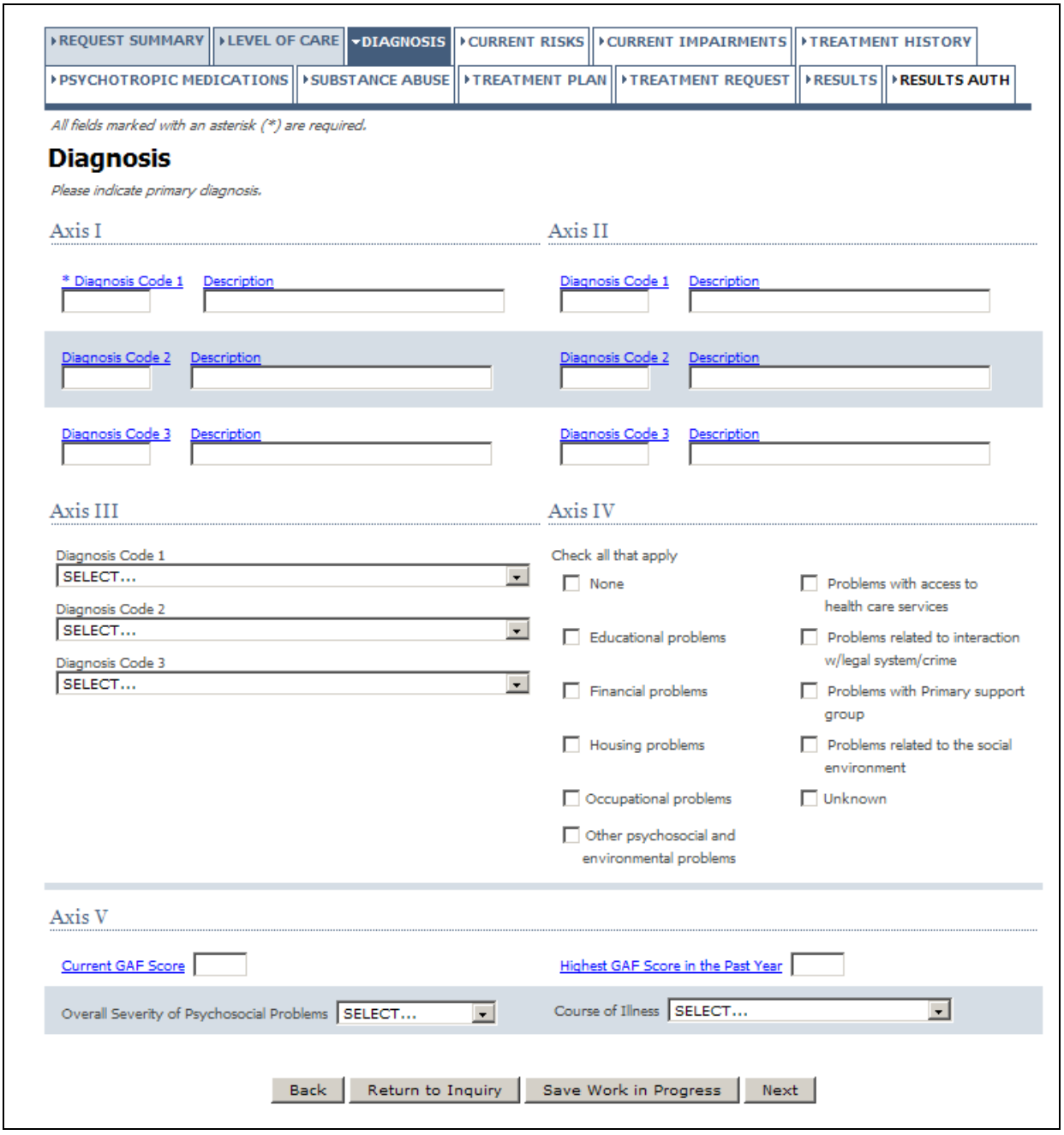
ValueOptions utilizes the clinical care module, CareConnect, which is part of our integrated CONNECTS platform to support all clinical care management functions and document all case activity from the point of referral through all levels of care. CareConnect supports direct interchanges between providers and ValueOptions and produces clinical data demonstrating the effectiveness of various programs, therapies and the services that we offer. CareConnect also:

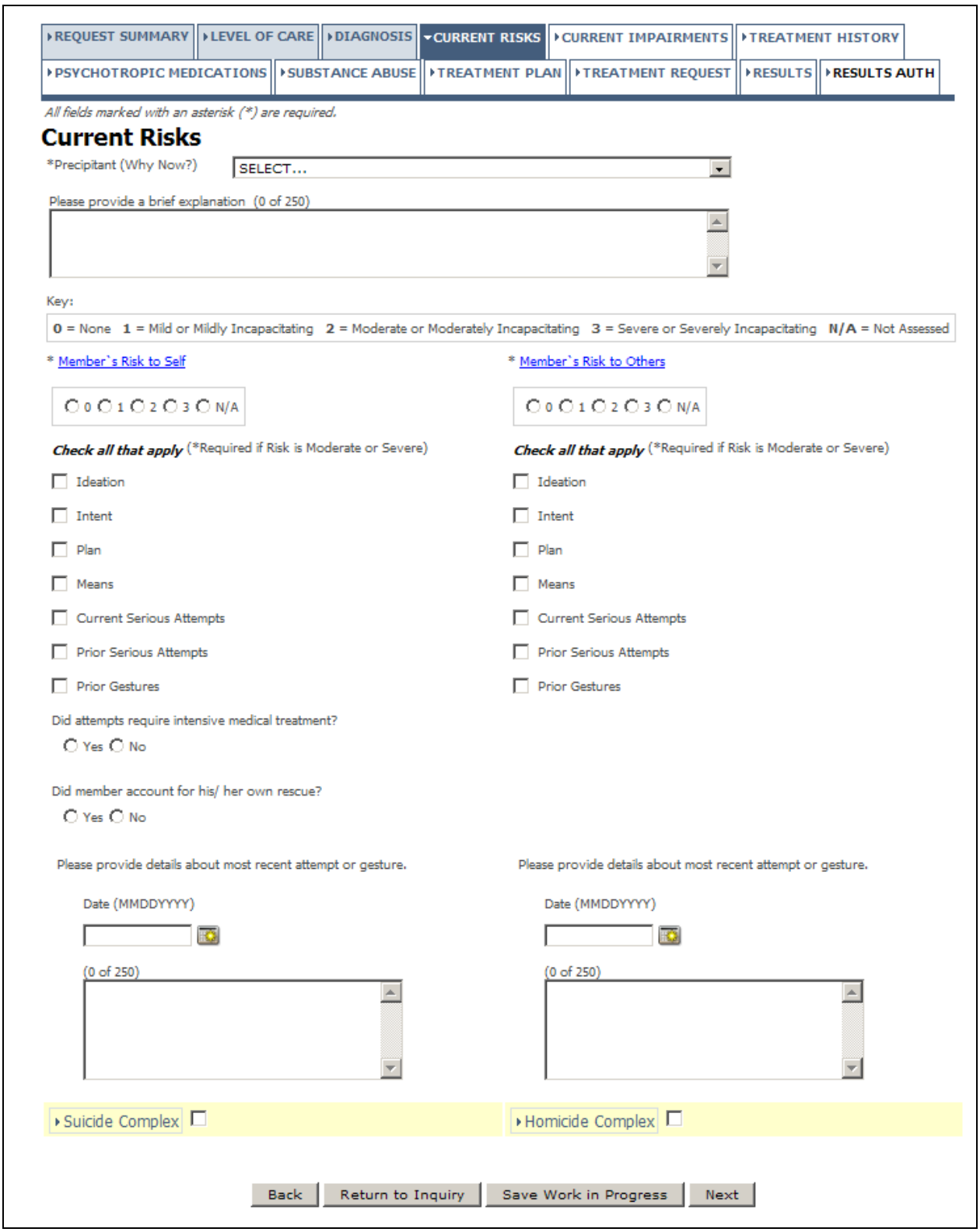
- Uses data fields that capture reportable outcomes and other clinical data to track and exhibit the effectiveness of services
- Delivers an effective work management system that integrates across other ValueOptions applications to allow for seamless continuity
- Minimizes administrative requirements for both the clinical staff and providers
- Allows for multiple, longitudinal data exchanges with providers for complex outlier cases
- Interfaces with our ProviderConnect application, which allows providers to request outpatient care online via a secure Web site and unique provider submitter ID

The CareConnect system maintains an enrollee's complete treatment history and supports functionality to search for all cases for a specific enrollee or for a specific provider. CareConnect addresses the specific needs of the Clinical Care Managers and allows them to quickly focus on the most pertinent clinical data for each enrollee, easily locate and view historical data summaries to efficiently formulate cases, and access advanced tools to devise, monitor, follow-up and report on individualized treatment plans.

Additionally, CareConnect serves as a management tool. Much of the clinical review information is documented in reportable fields, so managers receive weekly and monthly reports allowing them to closely monitor and ensure compliance with all regulatory decision-making timeframes.

We provide sample screenshots of the CareConnect diagnosis and risk assessment screens below:


REQUEST SUMMARY
LEVEL OF CARE
DIAGNOSIS
CURRENT RISKS
CURRENT IMPAIRMENTS
TREATMENT HISTORY
PSYCHOTROPIC MEDICATIONS
SUBSTANCE ABUSE
TREATMENT PLAN
TREATMENT REQUEST
RESULTS
RESULTS AUTH
All fields marked with an asterisk (*) are required.
Diagnosis
Please indicate primary diagnosis.
Axis I
* Diagnosis Code 1
Description
Diagnosis Code 2
Description
Diagnosis Code 3
Description
Axis II
Diagnosis Code 1
Description
Diagnosis Code 2
Description
Diagnosis Code 3
Description
Axis III
Diagnosis Code 1
SELECT...
Diagnosis Code 2
SELECT...
Diagnosis Code 3
SELECT...
Axis IV
Check all that apply
None
Educational problems
Financial problems
Housing problems
Occupational problems
Other psychosocial and environmental problems
Problems with access to health care services
Problems related to interaction w/legal system/crime
Problems with Primary support group
Problems related to the social environment
Unknown
Axis V
Current GAF Score
Highest GAF Score in the Past Year
Overall Severity of Psychosocial Problems
SELECT...
Course of Illness
SELECT...
Back
Return to Inquiry
Save Work in Progress
Next


REQUEST SUMMARY
LEVEL OF CARE
DIAGNOSIS
CURRENT RISKS
CURRENT IMPAIRMENTS
TREATMENT HISTORY
PSYCHOTROPIC MEDICATIONS
SUBSTANCE ABUSE
TREATMENT PLAN
TREATMENT REQUEST
RESULTS
RESULTS AUTH
All fields marked with an asterisk (*) are required.
Current Risks
*Precipitant (Why Now?)
SELECT...
Please provide a brief explanation (0 of 250)
Key:
0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed
* Member`s Risk to Self
0 1 2 3 N/A
Check all that apply (*Required if Risk is Moderate or Severe)
Ideation
Intent
Plan
Means
Current Serious Attempts
Prior Serious Attempts
Prior Gestures
Did attempts require intensive medical treatment?
Yes No
Did member account for his/ her own rescue?
Yes No
Please provide details about most recent attempt or gesture.
Date (MMDDYYYY)
(0 of 250)
* Member`s Risk to Others
0 1 2 3 N/A
Check all that apply (*Required if Risk is Moderate or Severe)
Ideation
Intent
Plan
Means
Current Serious Attempts
Prior Serious Attempts
Prior Gestures
Please provide details about most recent attempt or gesture.
Date (MMDDYYYY)
(0 of 250)
Suicide Complex
Homicide Complex
Back
Return to Inquiry
Save Work in Progress
Next

(3) Completely describe the criteria used to establish medical necessity as defined by the Program and how medical necessity is determined.

MEDICAL NECESSITY CRITERIA

ValueOptions' medical necessity guidelines reflect our philosophy and clinical values. They are used to guide our admission, level of care, and continued treatment authorizations and decisions. These criteria are behavioral health-specific and are founded on and supported by nationally recognized standards and industry-leading clinical best practice standards (reviewed and revised annually by internal clinical leadership, external behavioral health experts, and providers, with final approval and adoption by our Executive Medical Management Committee). Among the sources we consult are:

- The American Psychiatric Association
- The American Psychological Association
- The American Academy of Psychiatrists in Alcoholism and Addictions
- The American Academy of Child and Adolescent Psychiatry
- The American Society of Addiction Medicine
- The Alliance for the Mentally Ill
- The International Association of Psychosocial Rehabilitation Services
- The National Institutes of Health
- Substance Abuse & Mental Health Services Administration
- The National Institute on Alcohol Abuse and Alcoholism
- The National Institute of Drug Abuse
- The Department of Health and Human Services' Center for Substance Abuse Treatment
- Professional journals and publications

Criteria Review and Approval

All medical necessity criteria are approved by committee. While our quality management and clinical staff follow a well-defined process to develop and approve our medical necessity criteria, we have also complied with requests from select clients who elect to direct the medical necessity criteria for their self-funded programs. Below we describe the process we use to develop and approve criteria.

1. The Executive Medical Management Committee determines which guidelines to establish or adopt based on analyses of characteristics of the covered population (cultural, demographic, risk). The Executive Medical Management Committee is co-chaired by ValueOptions' Chief Medical Officer and its Vice President of Clinical Development.
2. The Executive Medical Management Committee assigns a workgroup to study diagnostic and treatment information of the targeted disorder or treatment modality through:
   a. a review of the scientific, professional, and clinical literature
   b. input from National and Service Center Clinical Advisory Committees, UM, and Quality Management Committees and subcommittees
   c. input from providers, community agencies, and enrollees at the service center level
   d. input from provider at a national level

e. a review of published guidelines

3. The Executive Medical Management Committee workgroup prepares a draft of the proposed guideline or selects an existing published guideline for review by Medical Directors, Clinical Advisory Committees, and others as determined by the Executive Medical Management Committee. The workgroup considers the diagnostic and treatment information and, in order to ensure consistency, reviews relevant utilization management criteria, enrollee education materials, benefit interpretations, and practitioner communications in preparing the draft guideline or guideline selection.
4. The Executive Medical Management Committee considers all comments received, and recommends a final draft of the guideline or the adoption of an existing guideline to the Company Quality Committee.
5. All Treatment Guidelines receive final approval from the Company Quality Committee.
6. Service centers may use other guidelines in addition to, or instead of, the national treatment guidelines for management of their individual contracts. These guidelines may serve as templates for new national guidelines. Annually, ValueOptions' service centers submit all non-national treatment guidelines currently in use to the appropriate workgroup of the Executive Medical Management Committee.

HOW MEDICAL NECESSITY IS DETERMINED

Our medical necessity criteria are applied with consideration of the enrollee's needs, age, cultural factors, co-morbidities and complications, benefit coverage, access to natural supports, progress of treatment, desired outcomes, psychosocial needs, and home/work environment.

ValueOptions ensures that treatment is provided at the most appropriate level of care to meet a specific clinical need through the use of level of care criteria. Criteria for a given level of care represent signs, symptoms, and functional impairments of such a nature and severity that require treatment at a specified level, at a given point in time. Level of care criteria should match the enrollee's dysfunction and treatment needs. These criteria represent treatment modalities that, by virtue of the complexity and/or attendant risks, require a specified level of care for their safe, appropriate, and effective application. Therefore, Clinical Care Managers and Peer Advisors use the level-of-care criteria as the framework for determining the level of care required by an enrollee. If the clinical data meet the criteria for the proposed level of care, the Clinical Care Manager or Peer Advisor will evaluate the remaining elements of medical necessity.

Our criteria are based on three primary variables:

1. **Severity of Condition** – Signs, symptoms, and functional impairments requiring treatment
2. **Intensity of Service** – Developmental strengths and limitations (e.g., physical, psychological, social, cognitive, intellectual, and academic skills), plus psychosocial and related needs.
3. **Occupational, Cultural, and Linguistic Factors** – These factors either aggravate an enrollee's clinical condition or need to be addressed for effective treatment. Enrollees should have the opportunity to be assessed and treated in their preferred language. The care plan is enhanced when their cultural customs and communication norms guide the process.

To ease the burden on providers, we maintain a highly sophisticated, Web-based care program that offers providers immediate access to our medical necessity criteria, evidence-based guidelines and authorization capabilities. Through a robust, yet highly intuitive Web interface, providers have real-time access to the tools necessary to answer a majority of the care and administrative questions they might have as well as request services for enrollees.

(4) Describe your utilization review process and confirm that it is parity compliant as required by MHPAEA.

We provide a description of our utilization review process for outpatient and inpatient services in the following detail. Our current processes mirror those of our clients' medical management practices, ensuring full compliance with MHPAEA. We will do the same for the Empire Plan Program to ensure MHPAEA compliance. In general, we believe that if a medical/surgical plan utilizes a variety of techniques depending on the specifications of the procedure, diagnosis, and service process that are best suited for that particular procedure, diagnosis, and service process (e.g., no use of concurrent review for pre-natal outpatient visits, but the use of precertification for MRI or low back pain), the MHSA plan can utilize the technique(s) that best suit the procedure, diagnosis, and/or service process and within the scope of those utilized on the medical surgical side. Therefore, our outlier model described below, for example, is a viable management technique for outpatient services such as psychotherapy. However, because MHPAEA has not issued the final rules, we will review our utilization review policies and Empire Plan requirements once they are released.

UTILIZATION REVIEW PROCESS—OUTPATIENT CARE

Upon review of the Empire Plan's medical/surgical utilization process, ValueOptions will likely be able to administer a registration process, a pass through model, or an outpatient outlier model that we currently have in place for several accounts. If a registration model is preferred, ValueOptions has recommended to other clients a ten-visit pass-through which a provider can obtain by contacting ValueOptions for an initial authorization. This authorization can be obtained via Web, IVR, or telephonically. A ten-session model typically enables 70 percent of enrollees to complete treatment without requiring a treatment plan. Once these ten sessions are completed, the treating provider would need to submit an outpatient treatment request form, which requires the provider to identify diagnosis, risk, and symptoms. The provider is required to attest to the use of best practices to ensure the enrollee is receiving the most appropriate level of care, including:

- that co-occurring medical conditions have been assessed and addressed, if applicable, in the treatment plan
- that co-occurring psychiatric conditions have been assessed and addressed for those presenting with primary substance abuse disorders, and if applicable, included in the treatment plan
- that risk issues have been assessed and addressed in the treatment plan and are continually monitored during treatment

If treatment meets medical necessity with the provider attesting to evidenced-based practices, an authorization to continue treatment is given. All reviews are completed within New York state-specific turn-around times, with written notification sent to both the provider and the enrollee.

If the treatment plan is incomplete, the Clinical Care Manager will call the provider to conduct a telephonic review to facilitate the medical necessity determination. If the information supports medical necessity the Clinical Care Manager will authorize services and advises the provider of the authorization with written notification sent to both the provider and the Enrollee.

If the provider is unable to supply enough information for medical necessity the provider is advised that a telephonic review is required with one of our Peer Advisors or Medical Directors. The provider is transferred to a scheduler to set up an appointment with the provider. Outpatient treatment requests that are modified or denied contain a recommendation for alternative community supports. All requests are completed in the appropriate timeframe with visits allowed for transition of enrollees.

If a pass though model is preferred, ValueOptions will set up a claims payment system to allow ten sessions prior to a treatment plan being requested. Under this scenario, ValueOptions would educate all of our network providers on the specific requirements of this model to ensure that treatment plans were received prior to the tenth session for each enrollee engaged in treatment.

Management of Outliers

This is a two-pronged approach that includes complex care management and outlier provider management. Under this model, we will conduct reviews in the outpatient setting based on a claims outlier model which will include a review for medical necessity and quality. Benchmarks of utilization have been established by diagnosis and provider.

Complex Care Management

Complex care management is used for eating disorders, cognitive disorders, psychotic disorders, alcohol disorders, pervasive development disorders and autism. Both enrollee and provider interventions take place at the time the first claim is received. All enrollees with these diagnoses will be assessed for intensive (complex) care management services. Follow-up is continued based on additional sessions utilized, new inpatient claims, or an emergency room claim. Cases are also identified based on high utilization compared to the population norm (e.g., 95th percentile) across all diagnoses. Providers are contacted to ensure that their treatment meets best practice guidelines and that continued medical necessity is met.

Outlier Provider Management

Outlier provider management will monitor general information about provider services such as number of patients, number of episodes, numbers of sessions, and average sessions per episode. Our Clinical Care Managers also review the number of complaints and/or compliments, if any. Providers will be compared to other practicing providers in their region, and based on the information, outreach and potential chart audits will be completed.

UTILIZATION REVIEW PROCESS—INPATIENT CARE

Precertification

Inpatient treatment is precertified by the Clinical Care Manager when an attending provider or facility calls to register care prior to admission, except in emergencies. When the medical necessity criteria for inpatient treatment are met, the Clinical Care Manager renders an initial certification. The certification decision and clinical documentation are entered into our online care management information system, CareConnect, and letters are generated to the practitioner, facility, and enrollee. Emergency care does not require precertification.

Initial Review

An initial admission review is conducted after the actual admission has occurred. Clinical information is obtained on admission—practitioner's name, evaluation of symptoms, proposed treatment plan, expected length of stay, and others— to determine if the admission is medically necessary. When the medical necessity criteria for inpatient treatment or alternative level of care are met, the Clinical Care Manager certifies the care. Again, the certification decision and clinical documentation are entered into CareConnect and letters are generated to the practitioner and facility. ValueOptions' Clinical Care Managers have online access to our medical necessity criteria for all utilization review and care management activities to determine the medical necessity of treatment at all levels of care.

Concurrent Review

A concurrent review is conducted after the initial review has been completed and days have been certified based on medical necessity. Concurrent review is an ongoing process that evaluates the enrollee's progress in treatment, the necessity for continued stay at the current level of care, and discharge planning. The Clinical Care Manager contacts the attending practitioner, provider utilization review department, or enrollee's therapist to obtain clinical information by the last day certified. If criteria for medical necessity are met, the Clinical Care Manager certifies additional days and clinical documentation is entered into CareConnect.

Retrospective Review

Retrospective reviews are done based on the design of customer-specific benefit plans. A request from a facility or practitioner for a retrospective review of an inpatient case may be received via letter, facsimile, or telephone and must include an explanation of the circumstances of the request. Once a certification decision is rendered, the enrollee, practitioner, and facility are notified of the decision in writing.

Non-Certification Process

When the Clinical Care Manager questions the medical necessity or appropriateness of the recommended treatment or when quality-of-care issues are present, the case is referred to a Peer Advisor (either an M.D. or a Ph.D., depending on the level of care under review) for Peer Review. The Peer Advisor reviews the available information (e.g., documentation by the Clinical Care Manager, the medical record, and others) and then speaks directly with the attending clinician to discuss the case.

Peer Reviews are intended to be a collegial exchange between Peer Advisors and the treating provider to reach agreement on an alternative course of treatment, or to give the treating provider an opportunity to present information that might result in approval of the requested level of care. Non-certifications are rendered only in those situations where the Peer Advisor and the attending provider are unable to reach a consensus. In cases of non-certification, there are two levels of appeal available to providers in which another Peer Advisor or an Appeals Panel reviews the case. However, in the vast majority of cases (98 percent nationally), the Peer Advisor and attending provider reach agreement regarding the enrollee's care.

(5) Describe the methods you utilize to measure Program effectiveness (Do not include any reference to specific monetary savings).

We use various tools to measure program effectiveness, both from the perspective of the enrollee and from the perspective of our adherence to the clinical guidelines and ultimate outcomes for your enrollees.

CLINICAL EFFECTIVENESS AND PERFORMANCE

Utilization Management Dashboards – Performance Against Account-Specific and Industry-Based Standards

Dashboards that track utilization trends are published with daily, weekly, and monthly reports. Trends provide the management team with information on the performance of the program. We compare these to our book-of-business as well as to regional and national benchmarks.

Periodic Clinical Treatment Record Review

ValueOptions also assesses clinical effectiveness and performance through our treatment record review process. ValueOptions adheres to the clinical treatment record evaluation and guidelines as defined by NCQA. Periodic random auditing of treatment records of network providers by our Medical Director or Clinical Director ensures that the records adhere to national standards of practice and reflect appropriate behavioral health care management.

Additionally, the Director of Clinical Services reviews cases weekly with clinical supervisors. Aside from the routine clinical treatment record reviews, conditions under which a treatment record audit could be triggered include: quality of care issues, appeals, review of a case requiring intensive care management, instances of possible over- or under-utilization, questionable emergency admissions, instances of poly-pharmaceuticals, and suspected or alleged fraud.

ValueSelect Program

ValueSelect, our provider reward program, is designed to identify and reward providers who are high performers. The ValueSelect designation recognizes network outpatient providers for engaging in activities that promote clinical effectiveness, enrollee access to services, enrollee satisfaction, and administrative efficiency. ValueSelect providers are eligible for a number of valuable benefits, including distinction in our provider search engine.

Monitoring Over- and Under-Utilization of Services

Analysis of over- and under-utilization is a fundamental component of every utilization management program. It allows organizations to review utilization for appropriate use of resources and evaluate the impact of utilization management on quality outcomes. Outliers and trends may indicate, among other things, problems with access to care and inefficient use of resources.

Provider Analytic Reports

Provider-specific patterns of over- and under-utilization are also evaluated via ValueOptions' Provider Quality Profiling (PQP) process during the practitioner recredentialing process. Provider profiles are generated and evaluated. These profiles report both quality and utilization data for each practitioner. The utilization data are diagnosis-specific and report the number of outpatient services delivered by the provider for each enrollee served. These diagnosis-specific utilization data are compared to that of the provider's peers, and if there is significant variation from the expected, the practitioner's profile is forwarded to our Clinical Review Committee for further evaluation and any necessary follow-up actions.

Outcomes and Productivity Study

Our Outcomes and Productivity Study is another method used to measure program effectiveness. This study assesses the impact of behavioral health problems within the workplace using absenteeism and lost productivity as indicators. The study has shown that utilization of behavioral health services can improve productivity in the workplace. Participating enrollees are questioned at the time of referral and with their permission a follow-up call is made to ask the same questions 3-4 months after the initial referral. Over the course of the study, enrollees have reported a decrease in absenteeism of 52.3 percent. Additionally, presenteeism (lost productivity while present on the job) decreased by 69.2 percent. Further, 79.6 percent of enrollees also reported that their mental health status improved, based upon on a 10-point rating scale.

Treatment Record Audits

Aside from the routine clinical treatment record reviews, conditions under which a treatment record audit could be triggered include:

- average length of stay (ALOS) utilization patterns do not reflect local norms
- facility treatment protocols require further investigation
- complaints are received from enrollees and dependents
- Clinical Care Managers report general misunderstanding of ValueOptions' protocols and procedures by facility staff
- adverse incidents have occurred
- as part of a specific quality improvement project (for example, a quality improvement initiative to decrease re-admissions after discharge from an inpatient stay)
- quality of care issues exist

Inter-Rater Reliability Audits

These audits evaluate the appropriateness of clinical decision-making and treatment planning. Staff members read case vignettes and endorse the appropriate authorization outcome. Audits are scored, tabulated, and analyzed to highlight variances and make improvements.

Internal Care Management Documentation Audits

Another method used to measure and ensure program effectiveness is documentation audits conducted by our dedicated quality management team. Random audits of concurrent reviews conducted by our Clinical Care Managers and Peer Advisors are completed on a monthly basis. The audit tool evaluates all aspects of the concurrent review process.

Clinical Rounds

These meetings include medical directors, clinical managers, and care management staff. Outlier cases and higher levels of care cases are reviewed, including clinical data integrity and adherence to medical necessity criteria and treatment guidelines.

Documentation Audits

Another method used to measure and ensure program effectiveness is documentation audits conducted by our dedicated quality management team. Random audits of concurrent reviews conducted by our Clinical Care Managers and Peer Advisors are completed on a monthly basis. The audit tool evaluates all aspects of the concurrent review process.

ENROLLEE SATISFACTION SURVEYS

One method used to measure Program effectiveness is through our enrollee satisfaction surveys. ValueOptions contracts with Fact Finders, an NCQA-certified independent opinion research company, to conduct our enrollee satisfaction surveys. Enrollee surveys are conducted semi-annually in the areas of satisfaction with outcomes, access, availability, service delivery, and provider quality of care.

In the last three years, we have maintained an overall enrollee satisfaction level of more than 90 percent.

Fact Finders complies with all HIPAA requirements, thereby maintaining the security and confidentiality of all enrollee information. All findings are reported in aggregate, and are used to improve the quality of care and service that we provide. Enrollees may elect to opt out of the survey at any time. The survey provides ValueOptions and our clients with a reliable measurement of enrollees' experience with, and attitude toward, ValueOptions.

(6) Outpatient Treatment UR Guarantee: The MHSA Program's service level standard requires that, at least, ninety percent (90%) of outpatient treatment plans be reviewed and the Provider and Enrollee notified within twelve (12) Business Day of receipt of the report, calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of outpatient treatment plans that the Offeror reviews and does not notify the Provider within twelve (12) Business Day of receipt of the report is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) of outpatient treatment plans not reviewed and the Provider notified within twelve (12) Business Day of receipt of the report, is $_____.

OUTPATIENT TREATMENT UR GUARANTEE

[redacted]

(7) Inpatient Treatment UR Guarantee: The MHSA Program's service level standard requires that at least ninety percent (90%) of requests for authorization of inpatient care be reviewed and completed within twenty-four (24) hours from the receipt of the request and the Enrollee or Provider be notified within one (1) Business Day of the determination calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of requests for authorization of inpatient care that are not reviewed within twenty-four (24) hours from the receipt of the request the Enrollee or Provider notified within one (1) Business Day of the determination, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee of requests for authorization of inpatient care that are not reviewed within twenty-four (24) hours from the receipt of the request the Enrollee or Provider notified within one (1) Business Day of the determination, is $_____.

INPATIENT TREATMENT UR GUARANTEE

[redacted]

[redacted]

DISABLED DEPENDENT DETERMINATIONS

(1) Provide a description of your process when determining disabled dependent status. Confirm that the Offeror will review the PS-451 form and all additional medical information required to make a clinical determination within 10 Business Days.

PROCESS FOR DETERMINING DISABLED DEPENDENT STATUS

We confirm that we will review the PS-451 form and all additional medical information required to make a clinical determination within ten business days regarding disabled dependent status for Mental Health and Substance Abuse cases, while the medical contractor will determine disability status for those with physical disabilities.

Disabled dependents of Empire Plan enrollees are entitled to be covered under the enrollee's family coverage beyond the normal age-out limits if those dependents are incapable of self-support. An "Application for Coverage for your Disabled Dependent Child for Medical, Dental and/or Vision Coverage" (form PS-451) is completed by the enrollee, the dependent's physician, and the enrollee's employer and then we will determine if the dependent is disabled. All determinations are subject to review by the contractors on a periodic basis. The following guidelines are used for all disabled dependent reviews.

If improvement of the dependent's condition is:

- "Expected," the case will be normally reviewed within six to eight months, unless the contractor determines a need for a more frequent review.
- Possible," the case will be normally reviewed no sooner than three years, unless the contractor determines a need for a more frequent review.
- "Not expected," the case will normally be reviewed no sooner than seven years, unless the contractor determines a need for a more frequent review.

ValueOptions is willing to make disabled determination coverage decisions for enrollees diagnosed with mental health or substance abuse disorders. We currently have criteria for disabled dependents and can easily incorporate this review process into our care management program for the Empire Plan.

We will develop a process with the Department of Civil Service and the Empire Plan's medical carrier to ensure requests are received in a timely fashion. One of our licensed Clinical Care Managers will review all requests to determine disabled status, and if additional information is required to make the determination, every attempt will be made to contact the enrollee by letter or phone. All determination requests will be made within ten days of receipt.

If a Clinical Care Manager has any questions regarding the medical necessity of a determination, the case will be submitted for review by one of our consulting psychiatrists. If the request is approved, we will forward the PS451 to the Department using a mutually agreed upon process.

If medical necessity to support disabled status is not found, letters will be sent to all parties informing them of the decision. The enrollee has the option to appeal the decision, in which case another consulting psychiatrist will review the information and any additional information that was submitted. The enrollee will then be informed of the final decision in writing. Lastly, all determinations are entered into an inquiry system so that reports can be tracked including outcomes.

(2) Confirm that the Offeror will send a letter to the Enrollee and to the Department advising of the determination within 3 Business Days of the determination.

We confirm that a letter will be sent to the enrollee and to the Department advising of the determination within three business days of the determination.

APPEAL PROCESS

(1) Confirm the Contractor will perform administrative (non-clinical) appeals in a timely manner by an employee of the Contractor with problem-solving authority above that of the original reviewer.

We confirm that we will perform administrative (non-clinical) appeals in a timely manner by an employee of ValueOptions with problem-solving authority above that of the original reviewer.

(2) Confirm the Contractor will administer an expeditious, HIPAA and PPACA compliant internal clinical appeal process which allows Providers and/or Enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment.

We confirm that we will administer an expeditious HIPAA and PPACA compliant internal clinical appeal process which allows providers and/or enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment.

(3) Describe in detail how you would administer the required appeal processes for the Program, including:
- (a) Turnaround time;
- (b) Qualifications of the staff that would conduct the reviews for administrative and level 1 and level 2 clinical appeals;
- (c) Description of the criteria that would be used to determine whether the care is medically necessary or experimental and/or investigational;
- (d) Do you currently administer an appeals process as described above for MHSA? If yes, provide the number of appeals you review annually and the approval and denial rates for a client similar to the Program (for the most recent calendar year); and
- (e) How is the Enrollee's care handled during the appeal process?

When ValueOptions receives an appeal request, the appropriate staff person verifies timeliness and the appropriate appeal type (administrative, clinical, expedited, standard, retrospective) by referencing the Utilization Management record. The determination of administrative versus clinical appeals is based on the nature of the adverse determination. When an appeal is filed in reference to an adverse medical necessity determination, the appeal is processed as a "clinical" appeal, as outlined below. When the appeal is filed in reference to an adverse determination based on reasons other than medical necessity (e.g. lack of information, benefit exhaustion, lack of eligibility, failure to follow plan requirements, not a covered benefit), the appeal is processed as an "administrative" appeal.

(a) TURNAROUND TIME

Standard (i.e. non-urgent) Level I appeals are completed and a written determination is issued within 15 calendar days of the appeal request. The Peer Advisor or Clinical Care Manager enters the results of the Level I appeal into the utilization management record the day of the determination, and the appropriate letters are generated to the enrollee, attending physician or other ordering provider or facility rendering service.

Expedited appeals are conducted by a Peer Advisor not involved in previous adverse determinations. Decisions are communicated by telephone on the same day as the determination, with written notification sent within the 72-hour timeframe. Written notices conform to the same requirements as outlined above under "Standard (non-urgent) Level I Appeals."

All retrospective appeals are decided and notification issued within 30 calendar days of the appeal request, or as specified in the client contract.

All standard Level II appeals are completed, including issuance of the written notification to enrollee, provider and facility, within 15 calendar days of receiving the appeal request.

Appeal Type	Level I Standard	Level I Expedited	Level II Standard	Retrospective
Urgent	N/A	72 hours	15 calendar days	N/A
Standard	15 calendar days	N/A	15 calendar days	N/A
Retrospective	N/A	N/A	N/A	30 calendar days

(b) STAFF QUALIFICATIONS

Administrative Appeals

ValueOptions' administrative appeals system offers two levels of appeal. Appeal reviews are conducted by the appropriate Service Center Vice President, or by staff or a committee designated by the Service Center Vice President for this purpose. Appeal reviewers are neither the individual who made the original non-certification, nor the subordinate of such an individual.

Clinical Appeals

Clinical appeals are handled by a Peer Advisor, who is either an M.D. or PhD. Clinician whose qualifications have been described earlier in this section.

(c) DETERMINING MEDICAL NECESSITY

When an appeal is filed in reference to an adverse medical necessity determination, the appeal is processed as a "clinical" appeal.

Standard (Non-Urgent) Level I Clinical Appeals

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.

When the appeal review is completed telephonically, the Peer Advisor verbally informs the provider of the decision. If a determination confirming medical necessity is made, the Peer Advisor informs the provider of the length of stay and level of care that has been determined to be medically necessary. If the determination of no medical necessity is upheld, in whole or in part, the Peer Advisor informs the provider of any recommendations for treatment for which medical necessity could be confirmed and the procedure for following the next step in the appeals process, if any.

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 enrollee or provider to submit any additional information in support of the next level of appeal
- when required, the appropriate ERISA language related to the enrollee's right to file suit and to pursue other voluntary dispute options

Expedited Clinical Appeals

An expedited appeal is a request to review a decision concerning admission, continued stay, or other behavioral health care services for an enrollee who has received urgent services but has not been discharged from a facility, or when a delay in decision-making might seriously jeopardize the life or health of the enrollee. Only a Level I Appeal can be processed as an expedited appeal. ValueOptions follows the same determination procedures outlined above for standard appeals, but issues the decision and notification for all expedited appeals within 72 hours of the appeal request.

Level I - Retrospective Clinical Appeals

A Retrospective Appeal is one requested after the enrollee has been discharged from the level of care or treatment service under consideration. Typically, Retrospective Appeals require that the provider send in specific sections of the treatment record for review. Decision notices are issued within the decision timeframe and contain the required information outlined above under "Standard (non-urgent) Level I Appeals."

Level II - Clinical Appeals

If a Level I appeal upholds the determination of no medical necessity, in whole or in part, the enrollee, enrollee representative, or treating provider may request a Level II appeal, unless otherwise restricted by contract or regulatory requirement. In accordance with the Department's requirements, this level of appeal will be handled by a ValueOptions' Level II Appeal Committee, comprised of two board certified psychiatrists or Peer Advisors, and a Clinical Care

Manager, none of whom have been previously involved with the adverse determination. The Committee will review of all pertinent clinical information. When the appeal is conducted by a Level II Appeal Committee, in some circumstances the enrollee has the right to appear before the Committee.

The treating provider has the opportunity to forward to ValueOptions all pertinent treatment information which may include the relevant portions of the medical record, and any other supporting material deemed necessary.

When the appeal decision is to uphold the original adverse determination, in whole or in part, the written notification includes the principal reasons for the determination of no medical necessity, a statement that the clinical rationale used in making the decision will be provided in writing, on request, and instructions for any additional level of appeal, if applicable. For contracts subject to ERISA claims rules, the required ERISA language is included as well.

When an outside reviewer is stipulated in the contract, this may include a third party medical reviewer or a medical review unit established within a state department. This review may occur while the enrollee is receiving the disputed level of care or after the enrollee has been discharged. All external appeals will be completed within guidelines established contractually for such outside reviews.

If the determination of no medical necessity is upheld, in whole or in part, the case might then be referred to any additional entity if so stipulated in the contract.

(d) APPEALS EXPERIENCE

Yes, ValueOptions does currently administer an appeals process as described above for MHSA. Below, we provide 2012 data for a State client of similar size to the Empire Plan:

- Number of appeals reviewed in 2012: 95
- Number of approvals: 9
- Number of denials: 65
- Number of modified decisions (appeal was partially approved and partially denied): 21

(e) ENROLLEE CARE DURING APPEALS PROCESS

As of the date of the denial a network provider cannot balance bill an enrollee until all levels of appeal are exhausted. We will stay in touch with the facility or provider to ensure the enrollee is receiving needed care.

(4) Confirm that you will interface with the New York State Department of Financial Services' External Appeals Process to provide an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service.

We confirm that we will interface with the New York State Department of Financial Services' External Appeals Process to provide an opportunity for enrollees and dependents to appeal denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service.

(5) Inpatient Appeal Guarantee: The MHSA Program's service level standard requires that, at the least, ninety-five percent (95%) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Offeror having made and documented three (3) aggressive attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95%) of level one appeals for inpatient care that are not be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Offeror's proposed guarantee) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal, is $_____.

INPATIENT APPEAL GUARANTEE

[redacted]

(6) Outpatient and ALOC Appeal Guarantee: The MHSA Program's service level standard requires that, at the least, ninety-five percent (95%) of Outpatient Care and Alternative Levels of Care level one appeals must be reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Offeror having made and documented three (3) aggressive attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95%) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Offeror's proposed guarantee) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal, is $_____.

OUTPATIENT AND ALOC APPEAL GUARANTEE

[redacted]

[redacted]

Section 13: Other Clinical Management Programs (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) The Contractor must provide voluntary opt-in programs for Depression Management, Eating Disorders and Attention Deficit Hyperactivity Disorder (ADHD). The cost of the Depression Management, Eating Disorder and ADHD Programs shall be included in the Administrative Fee. The programs must include: (a) a method to identify members with depression, eating disorders and ADHD using screening tools, both on-line and by mail; (b) methods to educate members about the symptoms, effects and treatment of depression, eating disorders and ADHD; (c) accepting referrals to Network Providers; (d) telephonic support, coordination with treating providers and referrals to community services; and (e) a method to establish contact with Empire Plan primary care physicians, and other medical specialists likely to have patients that present with symptoms of depression, eating disorders and ADHD in order to educate medical Providers about the availability of the depression, eating disorder and ADHD programs.	Yes
(2) The Offeror may propose other voluntary opt-in programs which are available at no additional cost. The Department reserves the right to not participate in any program offered and the right to opt out of any program at any time.	Yes

OUR CLINICAL PHILOSOPHY

We maintain a focus on recovery, based on treating the whole person. As experts in coordinating care to address each enrollee's full spectrum of mental health needs, we craft unique disease management programs and protocols to target care concerns for each of our clients. Our experience includes program development, policy consultation, specialized coordination of referrals, and incorporating innovative health and wellness solutions to aid the recovery process.

For each of the programs we administer for The Empire Plan, Excelsior Plan, and the Student Employee Health Plan (The Empire Plan) Program, we will actively work with you to review the effectiveness of the service entry and assessment process. Our goal is to provide a highly effective design that provides a no-wrong-door approach to coordinating mental health and substance abuse services. We have proven methodologies for coordinating disease management efforts that have been demonstrated to achieve measureable results. Below, we provide examples of the specific customized programs of particular interest to you.

(1) Describe the depression management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.

DEPRESSION MANAGEMENT PROGRAM OVERVIEW

Our Depression Management Program begins with an emphasis on early identification. It supports the treatment process for enrollees with depression by increasing the number of enrollees identified with depressive symptoms, using a variety of screening resources and program entry points. The program ensures that depressed enrollees understand the range of treatment options and are connected to resources, and it provides case management support and monitoring to enhance treatment outcomes.

Enrollees who will benefit from care support are stratified into three tiers of service intensity based on the referral source and the perceived level of need: Tier one – general education and automated support; Tier two – behavioral health care manager outreach; and Tier three – intensive case management. The assigned tier establishes the type of intervention provided to the enrollee and the frequency of follow-ups.

HOW THE PROGRAM OPERATES

Screening for Depression, Depression Care Coordination

ValueOptions encourages the use of screening tools for depression; especially for high-risk populations such as those with diabetes, congestive heart failure, chronic obstructive pulmonary disease, asthma, post-partum depression, and/or coronary artery disease. We would coordinate with Empire Plan's health benefits management companies to screen and refer enrollees. Once an enrollee is identified he/she would be referred to our program for additional screening, triage of clinical need, coordination of service access, and monitoring care connections. These screening tools are also available on our website for providers, and will be made available to

Empire Plan enrollees on the single-sign on customized website. They are also distributed to primary care physicians.

Examples of standardized instruments that have been used to screen enrollees and determine eligibility for depression management programs include the Whooley two-item depression screening instrument (similar to the PHQ-2) and the Patient Health Questionnaire (PHQ). A positive response of possible depression on one of these scales leads to further assessment using the PHQ-9. The PHQ-9 is a brief, 9-item, nationally recognized patient self-report depression assessment tool that was derived from the interview-based PRIME-MD, and specifically targets the nine DSM-IV signs and symptoms of major depression.

As described above, we will work directly with the Empire Plan's medical health plan staff who manage complex or disease management programs. In those situations, we will collaborate on the screening process to ensure that it is suited to the needs of your enrollees and sensitive to a variety of indicators of possible depression. Once enrollees are screened positive for depression, they are eligible for various components of our disease management program for depression.

Provider Training and Support

Primary Care Physicians will benefit from our training services that are designed to increase their comfort in working with enrollees suffering from depression, and in understanding depression guidelines and effective interventions. Part of this training enables Primary Care Physicians to recognize when a consult with a psychiatrist is indicated, or when a referral to another behavioral health provider might improve the enrollee's symptoms and outcomes. Examples of our recent education and training initiatives with Primary Care Physicians include:

- Face-to-face training on the HEDIS anti-depressant medication management measures
- Sessions led by our Medical Directors for PCPs, pediatricians, cardiologists, and other specialties to address diagnoses such as eating disorders, co-morbid complications, and contra-indications associated with certain medications and populations
- An "early warning" program that alerts providers when members fail to pick up prescriptions as scheduled for psychotropic medications
- Primary Care Physician/Prescriber Treatment Support:
  - Provision of Practice Guidelines/ Treatment Tools
  - Provision of articles to be included in health plan newsletters
  - Education on the appropriate use of generics
  - Consultation line giving physicians direct telephonic access to a psychiatrist

Identification

Enrollees receive access to the depression care management support through a number of entry points:

- Health plan screening of high risk enrollees and referral for additional care coordination including screening, identification of need, service coordination, and monitoring treatment connections and clinical progress

- Service access with depression diagnosis triggering outbound support materials as appropriate
- Data mining and analytics including routine care outlier status identification benefitting from clinical guidance and identification of complex cases for ICM participation and outreach
- PCP referral based on program awareness and desire for additional care coordination
- Enrollee self-referral based on program materials or online self-service with depression screening tools

Interventions

Once identified for program participation, enrollees will receive services appropriate to their level of need. For enrollees just getting started with depression care, a lower level of intensity intervention is applied – providing information and resources on best practice care and self-management. For enrollees whose conditions and service needs are less clearly identified or need additional guidance on treatment options, a clinician provides short-term coordination and guidance. For enrollees with more acute and complex health conditions requiring additional assistance, our most intensive intervention involves our Intensive Care Management program with in depth assessments, care plans and monitoring. The following are various interventions that are included in our depression management program:

- 24-hour, seven day a week toll-free line for assessment and clinical triage of general behavioral health conditions, including depression
- Enrollee-focused medication treatment support via ValueOptions' Health Alert. These are daily calls reminding enrollees to take their medications and refill prescriptions
- Teen Screen – Screening and referral support for adolescents during routine office visits

Clinical Treatment and Care Management Resources

Outpatient Care

- Standard mailings of best practice treatment for depression to selected enrollees as identified via utilization and case management for outpatient services
- Outlier Management: psychotherapy effectiveness analysis/telephonic outreach to "non-improvers" who have depression conditions
- On-Track: Enrollee treatment outcomes self-report and/ provider guidance tool
- Tele-health solutions for geographic access and personal connectivity. Online treatment and consultation
- Screening and Support for 'Depression Related Conditions' – differential screening and treatment coordination (bipolar, anxiety, alcohol)

Inpatient and Alternative Levels of Care

- Utilization and case management for intensive services provides opportunities for clinical reviews on behalf of enrollees with depression. These reviews include application of evidence-based guidelines to ensure appropriate treatment is being provided for depression or recommendation for a different course of action is being offered.
- Post-hospital follow-up coordination for all enrollees including depression conditions
- Intensive Care Management is our standard program for the top one percent of most complex cases including depression, via referral criteria (treatment resistant and refractory cases) and

predictive modeling identification. Enrollees with depression comprise approximately 47 percent of Intensive Care Management program participants.

BENEFITS TO THE EMPIRE PLAN AND ENROLLEES

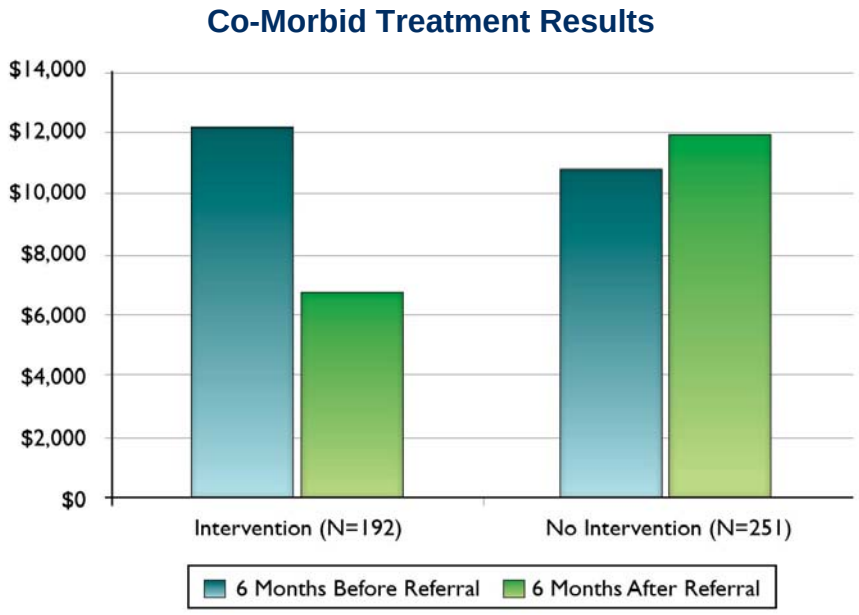
The overall benefit of our Depression Management Program is cost savings for our clients and coordinated, timely care for enrollees with a reduced risk for higher levels of care. The specific benefits of the program include:

- An increase in enrollee adherence to the treatment plan through education about:
  - Basic pathophysiology of depression
  - Current treatment modalities with emphasis on acute and continuation phases of treatment
  - Self-management techniques
  - Appropriate use of medications and services
  - Importance of keeping regularly scheduled provider appointments
  - Acute treatment phase
  - Continuation treatment phase
  - Recognize and address psychosocial issues related to depression
- improve functional status
- decrease inpatient admissions and emergency room visits

One ValueOptions client has achieved an observed ROI of nearly three dollars for each dollar expended on this program, while another experienced a $1 million savings in claims costs over a three and a half year period. Still another saw a 32 percent reduction in symptoms for engaged enrollees at 90-day follow up. Our Great Lakes Service Center received a Michigan Association of Health Plans (MAHP) Pinnacle Award, in recognition of our Depression Management program.

Our Depression Coordination program for another State employer accomplished the following results:

- Reduction in depression symptoms in the 90 days following initial contact for engaged members – 32%
- Reduction in total claims costs - $1.27 million (medical only)
- Return on Investment - $2.38:$1



SAMPLE COMMUNICATION MATERIALS

Please see **Attachment 8** for copies of communication materials that we would propose to use or modify for the Empire Plan Program.

(2) Describe the eating disorder management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.

HOW THE PROGRAM OPERATES

ValueOptions has a multi-pronged approach for the treatment of eating disorders:

1. All outpatient providers treating enrollees with eating disorders are provided an outreach letter at the time of first claim submission with a reminder and recommendation to follow APA treatment practice guidelines. Outpatient providers submitting outpatient treatment plans for eating disorder cases based on identification as potential outlier status are required to attest to:

   - Tracking and monitoring of weight and progress toward this goal
   - Enrollees involvement with a nutritionist

   For those providers not responding positively to the best practices, ValueOptions care management staff outreach to the provider to review the treatment plan and arrange for a peer review as necessary.

2. ValueOptions currently has as part of our network three Centers of Excellence in New York for treatment of eating disorders. These are Albany Medical Center, Strong, and Long Island Jewish Hospital.
3. All enrollees with eating disorders are referred for Intensive Care Management services with assignment to clinical staff having eating disorder specialty training. ValueOptions educates network providers, physical health providers and the enrollee's health plan regarding the availability of ICM services for members with eating disorders. ICM services for enrollees with eating disorders includes:

    - Comprehensive assessment of all health needs and psychosocial issues
    - Enrollee-centered treatment planning
    - Coordination of services including provider conferences to ensure best practice care
    - Ongoing care monitoring and evaluation of progress toward treatment goals

ValueOptions recognizes that eating disorders require long-term treatment and resources, and we have developed programs that support this.

BENEFITS TO THE EMPIRE PLAN AND ENROLLEES

The overall benefit of our program is enhanced coordination of care and resources for enrollees with eating disorders; ultimately resulting in cost savings for the Department and better outcomes for the enrollee. This is supported by ValueOptions' proactive engagement of three Centers of Excellence in New York for treatment of eating disorders—Albany Medical Center, Strong, and Long Island Jewish Hospital.

SAMPLE COMMUNICATION MATERIALS

Please see **Attachment 8** for copies of communication materials that we would propose to use or modify for the Empire Plan program.

(3) Describe the ADHD management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.

ADHD MANAGEMENT PROGRAM OVERVIEW

This program provides parents with easy access to screening questionnaires, educational materials, and a referral for behavioral health assessment and treatment. The program targets children up to 18 years of age who may have undiagnosed ADHD or who have been diagnosed but may benefit from additional support.

HOW THE PROGRAM OPERATES

ValueOptions will offer Empire Plan enrollees access to an ADHD program that promotes education, early detection, and treatment. This program relies on claims data, with an invitation

being mailed to the parents at the time of first claim submission. They are advised of the care management services available to them and the ability to contact ValueOptions 24 hours a day, seven days a week for referrals or assistance in finding necessary resources. The program will include outreach and educational activities for parents who have children who have recently been diagnosed with ADHD and who are treated by behavioral health practitioners. We will provide parental education materials and resources for these parents, along with treatment practice guidelines to practitioners. In addition to educational materials, we will provide outreach materials to these parents to help them manage stress related to ADHD.

In addition, we would also recommend that a secondary prevention program be considered if medical claims data can be made available.

The program screens children who may have ADHD by targeting high-risk enrollees who have just turned six years old. This secondary program focus is based on the diagnostic requirement that ADHD symptoms must be present before the age of seven in order to fulfill the age of onset criterion. Early intervention and treatment is critical in preventing or minimizing the development of other co-morbid conditions.

This early detection program consists of:

- Claims-based data screen to identify high risk six-year old children
- The Vanderbilt Parent Rating Scale—the short version of the rating scale is mailed to the parents of children identified as high-risk.
- Distribution of psycho-educational preventive health material about ADHD
- Mailing authorized disclosure of results to primary care physicians or pediatricians.

In order to identify this population for screening, ValueOptions will stratify the children who turn age six in order to target high risk children. High-risk children are defined as those children who are high users of pediatric services (six or more visits in a year or experiencing accidental injury/poisoning or having a mental health diagnosis). Once identified, parents will be mailed the screening tool along with educational materials to read. They are encouraged to mail the screening tool back to ValueOptions for scoring. A Release Of Information is enclosed so that ValueOptions can send the positive screening results to the pediatrician. ValueOptions will contact parents to follow up on the results of these screening and to offer any other additional support and encourage follow-up. Providing educational and resource information to the parent at this stage is critical to ensure appropriate follow-up, evaluation, and if, indicated, engagement in treatment. Educational materials sent to the parents include:

- A letter explaining the importance of following-up with the pediatrician
- A list of "Questions to Ask the Doctor"
- Safety Tips for children with ADHD
- Tips for parents of children with ADHD
- ADHD resource list
- National Institute of Mental Health booklet: "Attention Deficit Hyperactivity Disorder"

Through the ValueOptions ADHD program we can perform outreach to high volume pediatricians, if data is available from the Program's health plan or medical benefits administrator. This includes mailing packets of information are to pediatricians that includes a Vanderbilt screen. When a pediatrician identifies a child less than 12 years of age that he/she suspect has ADHD, the pediatrician can give this packet of information to the parent. The parent can then complete the information and return it to ValueOptions for screening. Results of the screening then go to the pediatrician. Information about our primary care Physicians' Line—staffed by ValueOptions board certified psychiatrists—is also included in this mailing. This is made available to assist physicians regarding the management of behavioral health disorders commonly seen in primary care such as depression.

BENEFITS TO THE EMPIRE PLAN AND ENROLLEES

This program has had positive results and is seen as a benefit to the parents of children with ADHD, reducing the intensity and duration of the symptomatic period and minimizes the disruption to school and family life.

SAMPLE COMMUNICATION MATERIALS

Please see **Attachment 8** for copies of communication materials that we have used for other clients that we would propose to use or modify for the Empire Plan program.

(4) Please describe any other voluntary clinical management or utilization review programs that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees.

Below we provide descriptions of the additional clinical management programs that we would offer as part of our program for the Empire Plan. Unless otherwise noted, the cost for these programs is included in our proposed fees.

AUTISM CARE MANAGEMENT PROGRAM

Screening, evaluation, and treatment (including Applied Behavioral Analysis or ABA) for individuals diagnosed with autism and other developmental disabilities is now a covered benefit in various areas throughout the country. ValueOptions' Autism Care Management Program includes basic management of autism and includes ABA services that utilize dedicated and licensed clinicians who specialize in management of these cases. We use comprehensive Autism Spectrum Disorder (ASD) treatment guidelines specified by the American Academy of Child and Adolescent Psychiatry, the American Academy of Neurology and Child Neurology Society, the American Academy of Pediatrics, and the Agency for Healthcare Research and Quality.

ValueOptions also provides established medical necessity criteria to guide our review process for ASD cases. Following an initial assessment and care plan, the frequency of clinical reviews may range from one month to three-to-six months. In addition, we provide intensive case management for families considered at the highest risk for related health issues and adverse

events that are directly or indirectly related to the enrollee's ASD condition. We offer three levels of ASD care management to support the needs of your enrollees and their families:

1. Our **standard** ASD care management program includes an initial evaluation with a qualified provider; provision of standard services such as outpatient therapies and medication management; intensive care management for the highest risk and most complex enrollees; transition care management to assist with level of care changes; and coordination of medically necessary occupational therapy, physical therapy, or speech therapy.
2. Our **enhanced** ASD care management program incorporates ABA intensive behavioral health treatment and all standard activities outlined above as well as review of ABA utilization and network recruitment of qualified providers to address geographic ABA needs.
3. For an additional cots, our **comprehensive** ASD care management program includes all program activities outlined above as well as care navigation assistance, enhanced coaching, and work/life support; as well as intensive case management for all individuals with ASD and their families

Non-clinical support services are also critical to ASD care management. We leverage our experience and expertise in the delivery of EAP and work/life services to also address the practical needs of families, such as respite care and community support services. Our Achieve Solutions website also offers caregiver supports and resources, such as articles, resource materials, and information on ASD; links to community and national service organizations established to assist families; and audio presentations on the early signs of ASD.

In Pennsylvania, ValueOptions manages behavioral health rehabilitation services for children on the autism spectrum. We adopted the Bureau of Autism Services' protocol, which incorporates an evaluation algorithm based on symptom complexity. Recent data show that the number of enrollees with ASD in Pennsylvania increased 20 percent from 2007-2009, but the average cost per enrollee had decreased due to our medical management as well as our provider education on the use of the new protocol.

In addition to those programs described above, ValueOptions can craft similar initiatives in partnership with the Empire Plan for addressing any of a range of special needs, from co-occurring mental health and substance abuse issues to other issues related to complex care. Further examples include:

OUTPATIENT DETOXIFICATION (SUBOXONE)

ValueOptions' Outpatient Suboxone Maintenance Program is designed to help individuals suffering from prescription medications and other opioids abuse. We have developed guidelines for Suboxone treatment, which incorporates a detoxification and induction phase of treatment, a stabilization phase, and a maintenance phase. In addition to medication therapy, counseling and self-help groups are frequently recommended during any or all three phases.

Depending on enrollee history and usage patterns, we recommend approximately one week of intensive outpatient services for detoxification and induction, followed by approximately six months of outpatient stabilization and maintenance sessions. Under ideal conditions,

discontinuation of medication should occur when an enrollee has achieved the maximum benefit from treatment and no longer requires continued treatment to maintain a drug-free lifestyle. In some situations, a provider may feel that an enrollee is not progressing satisfactorily and may discontinue Suboxone and offer an alternative treatment modality.

TEEN SCREEN PROGRAM

In partnership with Columbia University, ValueOptions developed the "Teen Screen Program" aimed at assisting PCPs with appropriate screenings for early identification of mental illness, suicide prevention in youth, and linking those in need with appropriate services. The program provides all parents the opportunity for their teens to receive a voluntary mental health check-up at the doctor's office, online, or over the phone. Using standardized screening tools, youth aged 11 to 18 can be assessed for behavioral and psychosocial problems in just 10 minutes. Parents of youth scoring positive on the screening questionnaires are provided with referral recommendations to ValueOptions' providers for further evaluation or treatment as indicated. Results of a recent provider satisfaction survey about the Teen Screen program, materials, referral, and reimbursement, indicate that 100 percent of providers felt comfortable using the materials to screen their patients and 95 percent agreed that screening helped them to identify a patient they otherwise might not have.

POST-PARTUM DEPRESSION SCREENING PROGRAMS

Our post-partum depression screening programs have screened more than 10,000 enrollees. Post-partum mothers experience depression at a higher rate than is found in the general population. ValueOptions collaborated with one of our health plan clients in the design of a preventive health program. The health plan mails an invitation to each post-partum mother along with a depression screening test and a postage paid return envelope. Post-partum mothers who wish to be screened return the test to ValueOptions and receive an outreach.

Exhibit I.B: Biographical Sketch Forms

This Exhibit is redacted.

Exhibit I.Y.4: Comparison of Current Program Providers to Offeror's MHSA Network

This Exhibit is redacted.

THE DEPARTMENT
Sample MHSA Implementation Project Plan
Total Duration: 90 Days
Start Date: October 1, 2013

TASK NAME	DURATION	RESOURCE NAMES
Administration/Account Management	**90 days**	**ValueOptions and The Department**
Contract Award	1 day	ValueOptions and The Department
Identify members of the Implementation Team	3 days	ValueOptions
Establish interface with The Department	4 days	ValueOptions
Begin contract negotiations and finalization process with The Department	20 days	ValueOptions and The Department
Conduct initial implementation meeting with The Department	5 days	ValueOptions
Develop deliverables approval process	5 days	ValueOptions and The Department
Determine frequency of The Department update meetings/reports	5 days	ValueOptions and The Department
Conduct update meetings/deliverables reports per developed schedule	90 days	ValueOptions
Conduct internal implementation meetings with Implementation Team	90 days	ValueOptions
Clinical Operations/Care Management	**75 days**	**ValueOptions**
Authorization and registration processes	30 days	ValueOptions
Level of Care Clinical Criteria	45 days	ValueOptions
Clinical policies and procedures	45 days	ValueOptions
UM/UR Plan and guidelines	30 days	ValueOptions
Medical necessity criteria	30 days	ValueOptions
Peer Advisor Protocols	30 days	ValueOptions
Access timeframes	15 days	ValueOptions
Clinical/Administrative Appeals Process	30 days	ValueOptions
Crisis intervention/critical incident process	30 days	ValueOptions
Tailor clinical workflows as necessary	45 days	ValueOptions
Develop internal interfaces	60 days	ValueOptions
Submit authorization letters to The Department for review	10 days	ValueOptions and The Department

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THE DEPARTMENT
Sample MHSA Implementation Project Plan
Total Duration: 90 Days
Start Date: October 1, 2013

Coordination	**30 days**	**ValueOptions and The Department**
Establish interface with other suppliers of The Department benefits as needed	30 days	ValueOptions
Refine coordination processes with PCPs (e.g. if medical consultation is needed)	30 days	ValueOptions
Transition Benefit	**60 days**	**ValueOptions and The Department**
Identify The Department benefit contact for benefit related questions	5 days	ValueOptions
Discuss The Department benefit issues relating to Active, Retirees, COBRA, etc.	5 days	ValueOptions and The Department
Confirm transition process with The Department	5 days	ValueOptions
Confirm utilization review and customer service workflows currently being utilized	2 days	ValueOptions
Establish transition plan	30 days	ValueOptions and The Department
Develop interface protocols with incumbent	10 days	ValueOptions, The Department and incumbent
Request and load active case data from incumbent for transition process	30 days	ValueOptions, The Department and incumbent
Coordinate discharge process with former vendors	10 days	ValueOptions

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THE DEPARTMENT
Sample MHSA Implementation Project Plan
Total Duration: 90 Days
Start Date: October 1, 2013

Communication	**60 days**	**ValueOptions and The Department**
Member Communication	**30 days**	**ValueOptions and The Department**
Review required member materials and establish schedule for material distribution with The Department	10 days	ValueOptions
Refine materials as needed	20 days	ValueOptions
Material distribution	5 days	ValueOptions
Provider Communication	**30 days**	**ValueOptions**
Determine appropriate materials	15 days	ValueOptions
Establish notification and timeframe	15 days	ValueOptions
Distribute Provider Handbook to newly credentialed providers	15 days	ValueOptions
Provider Network Development and Management*(a)*	**75 days**	**ValueOptions**
Confirm current in-network providers in The Department areas	10 days	ValueOptions
Confirm current providers of service not in-network with The Department	20 days	ValueOptions
Develop strategic plan for recruiting The Department providers	30 days	ValueOptions
Develop and complete provider mailing for needed providers	60 days	ValueOptions
Phones live for provider mailing inquiries	30 days	ValueOptions
Review applications and contracts	30 days	ValueOptions
Review credentialing criteria and P&Ps	30 days	ValueOptions
Finalize provider complaint and grievance process/P&Ps	30 days	ValueOptions
Finalize P&Ps regarding out-of-network services	30 days	ValueOptions
Review provider performance monitoring program/P&Ps	30 days	ValueOptions
Identify targeted practitioners and facilities for site visits	60 days	ValueOptions
Verify any required license or certification for facilities	60 days	ValueOptions
Primary source practitioners/facilities with returned packages	60 days	ValueOptions
Perform site visits on identified providers	60 days	ValueOptions
Begin new provider file data entry	60 days	ValueOptions
Network fully Credentialed and Contracted	75 days	ValueOptions

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THE DEPARTMENT
Sample MHSA Implementation Project Plan
Total Duration: 90 Days
Start Date: October 1, 2013

Customer Service*(b)	**60 days**	**ValueOptions**
Review following Policies and Procedures for new program	60 days	ValueOptions
Review and Confirm Correspondence Protocols	60 days	ValueOptions
Telephonic Translator Service	60 days	ValueOptions
Utilizing TDD for hearing-impaired callers	60 days	ValueOptions
Handling complaints and grievances	60 days	ValueOptions
Member rights and responsibilities	60 days	ValueOptions
Prepare scripted response for commonly-asked questions	60 days	ValueOptions
Develop training materials to include benefit design and company culture	60 days	ValueOptions
Call Center Activated for general information and transition cases pre-go live	60 days	ValueOptions
Call Center fully activated	90 days	ValueOptions
Facilities	**40 days**	**ValueOptions**
Confirm impact of new business on existing service location(s)	10 days	ValueOptions
Identify, order and install any additional furniture/equipment, if necessary	40 days	ValueOptions
Financial	**60 days**	**ValueOptions and The Department**
Determine primary billing contact for The Department	3 days	ValueOptions and The Department
Establish banking arrangements, as needed	10 days	ValueOptions
Complete Contract Action Form and submit to Finance	4 days	ValueOptions
Coordinate The Department billing and membership reconciliation processes	30 days	ValueOptions
Establish Claims Funding Account	15 days	ValueOptions
Determine check signing/mailing process (claims funds)	15 days	ValueOptions
Order check stock, if applicable	15 days	ValueOptions
Establish check run dates	15 days	ValueOptions
Establish process for issuance of provider and or member payments	15 days	ValueOptions
Finance system configuration	30 days	ValueOptions
Support for revenue and payment	15 days	ValueOptions
Determine 1099 reporting requirements	15 days	ValueOptions

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THE DEPARTMENT
Sample MHSA Implementation Project Plan
Total Duration: 90 Days
Start Date: October 1, 2013

Finalize EOB-RA processing requirements	30 days	ValueOptions
Benefit Configuration*(c)*	**75 days**	**ValueOptions**
Determine list of covered services	60 days	ValueOptions
Determine listing of covered diagnosis codes	60 days	ValueOptions
Receive decision regarding pre-cert penalties	60 days	ValueOptions
Receive the transition benefit information and consistent across agencies	60 days	ValueOptions
Receive transition plan for exiting providers	60 days	ValueOptions
Receive decision regarding the applicability of parity	60 days	ValueOptions
Receive the authorization requirements	60 days	ValueOptions
Receive information regarding approach for non-covered services	60 days	ValueOptions
Receive information regarding covering codes outside the covered service list	60 days	ValueOptions
Receive information related to EOP messaging	60 days	ValueOptions
Receive any special processing guidelines	60 days	ValueOptions
Receive information on funding arrangements	60 days	ValueOptions
Receive information regarding reimbursement on OON providers - part of transition	60 days	ValueOptions
Receive information on the plan pay out of area providers (versus OON provider)	60 days	ValueOptions
Receive information regarding the Mixed Service Protocol	60 days	ValueOptions
Draft of Service Class Grid	60 days	ValueOptions
Forward and Receive Clinical Sign-off	60 days	ValueOptions
Load Service Class Grid into MHS	60 days	ValueOptions
Benefit Set Up	**90 days**	**ValueOptions**
Assign Parent Code	60 days	ValueOptions
Develop Benefit Shells	60 days	ValueOptions
Assign GL Codes	60 days	ValueOptions
The Department to submit all plan docs to ValueOptions	60 days	The Department
Review benefit flexing protocols	60 days	ValueOptions
Assign Benefit Codes	60 days	ValueOptions
Map sets developed	90 days	ValueOptions

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THE DEPARTMENT
Sample MHSA Implementation Project Plan
Total Duration: 90 Days
Start Date: October 1, 2013

Reference File Set Up	**60 days**	**ValueOptions**
Enter The Department required code configurations (modifiers)	90 days	ValueOptions
Enter The Department specific EOP	90 days	ValueOptions
Enter Hold Codes for Claims	90 days	ValueOptions
Enter Benefit Hold Codes	90 days	ValueOptions
Service class exceptions	90 days	ValueOptions
Diagnosis Codes defined	90 days	ValueOptions
POS cross walk	60 days	ValueOptions
Set up Eligibility parameters	60 days	ValueOptions
Financial Components	**60 days**	**ValueOptions**
Defining GL Codes	60 days	ValueOptions
Define Medical Posting Tables	60 days	ValueOptions
Load GL Codes	60 days	ValueOptions
Load Medical Posting Tables	60 days	ValueOptions
The Department Benefits Configured in System	90 days	ValueOptions
Claims*(d)*	**75 days**	**ValueOptions and The Department**
Determine claims contact and interface protocols with The Department	5 days	ValueOptions and The Department
Confirm requirements for tracking/maintaining applicable deductibles	30 days	ValueOptions
Review/refine workflow for tracking applicable co-payments and/or maximums	30 days	ValueOptions
Review/refine process to administer exclusions, exceptions, and/or limitations	30 days	ValueOptions
Refine guidelines for split claims payment	30 days	ValueOptions
Refine out-of-state and out-of-network claim procedures	30 days	ValueOptions
Clarify responsibility for TPL	30 days	ValueOptions
Revise process and policies and procedures	30 days	ValueOptions
Review TPL data supplied by The Department	30 days	ValueOptions
Revise letter formats as needed	60 days	ValueOptions
Adapt applicable P&Ps/materials to meet program/mixed services, transition requirements	60 days	ValueOptions

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THE DEPARTMENT
Sample MHSA Implementation Project Plan
Total Duration: 90 Days
Start Date: October 1, 2013

Adapt mixed services and transition protocols to comply with requirements	60 days	ValueOptions
Review EOBs	30 days	ValueOptions
Establish interface process regarding claims run out	30 days	ValueOptions, The Department and Incumbent
Establish workflow for misdirected claims	30 days	ValueOptions
Establish requirements for historical data	30 days	ValueOptions
Complete claims payment rules	90 days	ValueOptions
Information Systems	**90 days**	**ValueOptions and The Department**
CONNECTS (System) set-up	**15 days**	**ValueOptions**
Update security and audit files	15 days	ValueOptions
Account Set-up	15 days	ValueOptions
Set-up User admin roles	15 days	ValueOptions
Set up company/master file	15 days	ValueOptions
Determine group setup	15 days	ValueOptions
Review for new program	15 days	ValueOptions
Security needs	15 days	ValueOptions
Procedure codes	15 days	ValueOptions
Screens	15 days	ValueOptions
Provider codes/types	15 days	ValueOptions
Inquiry tracking coding	15 days	ValueOptions
System modifications	**90 days**	**ValueOptions**
Gather requirements	30 days	ValueOptions and The Department
Develop specifications	30 days	ValueOptions
Conduct mid-Level review	10 days	ValueOptions
Obtain business Sign-Off	10 days	ValueOptions
Develop program modifications	30 days	ValueOptions
Conduct development testing	30 days	ValueOptions

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THE DEPARTMENT
Sample MHSA Implementation Project Plan
Total Duration: 90 Days
Start Date: October 1, 2013

Conduct integrations testing	15 days	ValueOptions
Conduct user acceptance testing	15 days	ValueOptions
Move to Production	1 day	ValueOptions
Enrollment/Eligibility Import*(d)	**60 days**	
Gather requirements (including but not limited to transmissions method and frequency)	30 days	ValueOptions and The Department
Develop specifications	30 days	ValueOptions
Conduct mid-Level review	10 days	ValueOptions
Obtain business Sign-Off	10 days	ValueOptions
Develop program modifications	30 days	ValueOptions
Conduct development testing	30 days	ValueOptions
Conduct integrations testing	15 days	ValueOptions
Conduct user acceptance testing	15 days	ValueOptions
Move to Production (Receive and process initial live file)	1 day	ValueOptions
Other Data Exchanges (e.g. claims, accumulators)	**90 days**	**ValueOptions**
Gather requirements (including but not limited to transmissions method and frequency)	30 days	ValueOptions and The Department
Develop specifications	30 days	ValueOptions
Conduct mid-Level review	10 days	ValueOptions
Obtain business Sign-Off	10 days	ValueOptions
Develop program modifications	30 days	ValueOptions
Conduct development testing	30 days	ValueOptions
Conduct integrations testing	15 days	ValueOptions
Conduct user acceptance testing	15 days	ValueOptions
Move to Production	1 day	ValueOptions
Custom Website (Achieve Solutions) *(e)	90 days	ValueOptions
Gather customization requirements (including but not limited to SSO from The Department site and return link)	30 days	ValueOptions and The Department
Develop specifications	30 days	ValueOptions

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THE DEPARTMENT
Sample MHSA Implementation Project Plan
Total Duration: 90 Days
Start Date: October 1, 2013

Conduct mid-Level review	10 days	ValueOptions and The Department
Obtain The Department Sign-Off	10 days	ValueOptions
Develop program modifications	30 days	ValueOptions
Conduct development testing	30 days	ValueOptions
Conduct integrations testing	15 days	ValueOptions
Conduct user acceptance testing	15 days	ValueOptions
Move to Production	1 day	ValueOptions
Correspondence	90 days	ValueOptions
Gather requirements	30 days	ValueOptions and The Department
Make necessary modifications to authorization letters (ALA)	30 days	ValueOptions
Load and test authorization letter	5 days	ValueOptions
Make necessary modifications to Provider Summary Vouchers (PSV) and Explanation of Benefits (EOB)	30 days	ValueOptions
Load and test PSV and EOB	5 days	ValueOptions
Obtain The Department approval of all correspondence (ALA, PSV and EOB)	5 days	ValueOptions and The Department
Telecommunications and LAN/WAN Services	90 days	ValueOptions
Confirm need for additional lines and equipment if necessary	1 day	ValueOptions
Order necessary telecommunications equipment and additional lines	15 days	ValueOptions
Establish transfer connection with AT&T	60 days	ValueOptions, The Department and AT&T
Develop and record auto attendant script and decision tree	15 days	ValueOptions and The Department
Setup language line interpreter services and TDD equipment, if needed	5 days	ValueOptions
Install and test telecommunications equipment	5 days	ValueOptions
Order toll-free number	30 days	
Activate applicable lines, toll-free number and auto attendant	1 day	ValueOptions
Review business continuity and after-hours plan	10 days	ValueOptions and The

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THE DEPARTMENT
Sample MHSA Implementation Project Plan
Total Duration: 90 Days
Start Date: October 1, 2013

		Department
Provide report on most recent business continuity/disaster recovery test results	2 days	ValueOptions
Review and agree on duplicate data processing record protocol	5 days	ValueOptions and The Department
Legal/Regulatory	**45 days**	**ValueOptions**
Ensure compliance with State and Federal requirements	45 days	ValueOptions
Review licenses/bonds to determine additional needs	45 days	ValueOptions
Ensure professional/liability policy includes The Department requirements	45 days	ValueOptions
Review contract	45 days	ValueOptions
Quality Management	**60 days**	**ValueOptions and The Department**
Review and obtain The Departments approval of performance standards/indicators	60 days	ValueOptions and The Department
Review outcomes management requirements	60 days	ValueOptions
Submit ValueOptions QM work plan to The Department	1 day	ValueOptions
Submit Fraud and Abuse Policy to The Department	5 days	ValueOptions
Present Satisfaction Surveys to The Department	10 days	ValueOptions
Reporting	**45 days**	**ValueOptions and The Department**
Identify Reporting contact person at The Department	1 day	ValueOptions
Identify external reporting requirements	45 days	ValueOptions
Determine internal management requirements	45 days	ValueOptions
Submit reporting plan to The Department for approval	45 days	ValueOptions
Receive The Department approval for reporting	45 days	ValueOptions
Put records on standard production schedule	45 days	ValueOptions
Internal Training	**60 days**	**ValueOptions and The Department**
Identify internal training needs	10 days	ValueOptions
Establish internal training plan and schedule	10 days	ValueOptions

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THE DEPARTMENT
Sample MHSA Implementation Project Plan
Total Duration: 90 Days
Start Date: October 1, 2013

Confirm internal training location/set up	10 days	ValueOptions
Prepare internal project specific training materials	30 days	ValueOptions
Conduct internal training	20 days	ValueOptions
The Department Training	**30 days**	**ValueOptions and The Department**
Identify The Department training needs	10 days	ValueOptions and The Department
Establish The Department training plan and schedule	2 days	ValueOptions and The Department
Prepare The Department training materials	30 days	ValueOptions
Conduct The Department training	20 days	ValueOptions
Provider Training	**30 days**	**ValueOptions and The Department**
Determine need for additional provider training/orientation	10 days	ValueOptions
Confirm sites and dates with The Department	10 days	ValueOptions and The Department
Prepare provider materials	30 days	ValueOptions
Conduct provider training/orientation	20 days	ValueOptions

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SAMPLE IVR SCRIPT

Yes, ValueOptions' phone system allows members to speak to a live person at any point during a call. Our telephone system allows callers to select from the menu by simply pressing the corresponding digit on their touch-tone telephone, and from there they will be immediately be routed to the appropriate staff to assist them with their needs. Members in crisis can choose the emergency option and be directed to a Care Manager immediately. The emergency option is the first option on the main menu.

Although we offer an automated telephone solution, members will always have the option of connecting to a live person at any time. The following is the menu script:

- "To confirm that you are authorized to access, receive and use the protected health information provided by this system", please press one. [Routes to TeleConnect]. At this point the member again is given the option to speak to a live representative, by simply stating 'representative'.
- "To speak to a customer representative, please press two."
- "To hear the entire content of this disclaimer, please press three." [Hear entire content of the Disclaimer].
- "To repeat this information, please press star."
- "To return to the main menu, please press nine."

VALUEOPTIONS®
Innovative Solutions. Better Health.

KEY BENEFITS OF USING VALUEOPTIONS' NETWORK PROVIDERS

Understanding your health care benefits – and using them appropriately – helps save you time and money.

ValueOptions negotiates the best possible rates with its network providers and passes along that cost savings to you. The best way you can save out-of-pocket expenses is to use the plan's network providers for your health and wellness needs. These in-network providers have undergone a stringent credentialing process to ensure their licensure, education and qualifications meet ValueOptions' standards.

There are significant benefits to using ValueOptions' in-network health care providers:

	In Network Provider	Out of Network
Cost	• You are only responsible for your co-payments or co-insurance • There are typically lower thresholds for deductible and out-of-pocket maximums • You have protection from ValueOptions' provider contracts so that you cannot be billed additional fees after ValueOptions has paid your healthcare claim.	• You might have to pay all out-of-pocket costs at admission • You may be potentially liable for days/costs your facility does not get approved • Attending doctor charges are likely to be separate and also considered out-of-network • Deductible and out-of-pocket maximums are typically higher • A facility can bill you directly for additional charges even after ValueOptions has made payment
Convenience	• There is no need for you to file claims	• You may need to file your own claims
Quality of Care	• All facilities/providers are screened on admission to the network and on a regular basis thereafter regarding accreditation, staffing levels, licensure, qualifications and programming, to ensure high quality, appropriate care • In-network providers are subject to review by our Quality of Care and Credentialing Committees • ValueOptions can assist with any concerns or complaints you have about quality of care, accessibility, billing, etc.	• You conduct your own research to evaluate potential providers to determine the best choice for your needs • Advertising claims and marketing may not truly reflect the patient experience • There is a potential risk if the provider does not have the correct license or accreditation for coverage under your plan

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[Union Bug]

WHO IS ELIGIBLE?

All non-medicare active employees, retirees, surviving spouses and their eligible dependents enrolled in the ABC Company Health Plan. ABC Company HMO Enrollees should contact their health plan directly.

Mental Health and Substance Abuse (MHSA) benefits are administered by ValueOptions®, a company that specializes in managing treatment for mental health and substance abuse conditions.

The ValueOptions®' confidential Help-Line is staffed 24 hours a day, seven days a week to help you with most mental health and substance abuse conditions such as:

- Feelings of depression, stress and anxiety
- Alcohol or drug use
- Referrals for therapy
- Immediate mental health crisis assistance

The Help-Line network consists of psychiatrists, substance abuse and psychiatric clinics, and other contracted behavioral health professionals. They specialize in mental health issues. Services are offered at convenient times and locations. Help is just a phone call away! Call today to inquire about coverage.

HOW DO I GET HELP?

To access your benefits, simply call the toll-free number on the wallet card attached to this brochure. You will be connected with a behavioral health care professional who will obtain information about your concerns and refer you to appropriate care.

You also have access to ValueOptions® web site, Achieve Solutions®, an online resource that offers valuable information.

Log on to Achieve Solutions® 24 hours a day to:

- Access a comprehensive library of educational materials
- Use self-assessment tools and interactive training tools
- Read news briefs and feature stories, which are updated weekly

Instructions to the web site can be found on the back of this brochure.

WHAT SERVICES ARE COVERED?

Help-Line covers mental health and substance abuse services that are deemed clinically appropriate. Services include:

- Inpatient admission
- Partial hospitalization programs
- Outpatient visits
- Psychological testing

HOW DO I CONFIRM THE NETWORK STATUS OF A PROVIDER?

- Check your local ABC Company Health Plan website Provider Directory selecting ABC Company Health Plan
- Call (800) XXX-XXXX for voluntary referral assistance

WHAT IF I CHOOSE TO SEE AN OUT-OF-NETWORK PROVIDER?

Use of a network provider ensures a higher benefit level. In most cases, you can still receive benefits if you use a non-network provider, but you may have increased copayments or deductibles. Some benefits and providers types (such as psychologists) may not be covered

MENTAL HEALTH AND SUBSTANCE ABUSE CARE — CALL ANY TIME FOR REFERRALS AND COUNSELING SERVICES.

1-800-XXX-XXXX

www.achievesolutions.net/xxx

VALUEOPTIONS®

MENTAL HEALTH AND SUBSTANCE ABUSE CARE — CALL ANY TIME FOR REFERRALS AND COUNSELING SERVICES.

1-800-XXX-XXXX

www.achievesolutions.net/xxx

VALUEOPTIONS®

ARE MY PHONE CALL AND TREATMENT CONFIDENTIAL?

All services through ValueOptions® are voluntary and confidential in accordance with state and federal laws. ValueOpitons® will not disclose information to anyone without your explicit written authorization, except within federal and state guidelines for release of confidential information.

If an employee or their eligible dependent is unable to call to request help any interested party acting as an advocate for the member can call to request help on behalf of the member.

Mental Health and Substance Abuse Care

Referral and counseling services:

- Assistance for depression, stress and anxiety
- Referrals for therapy
- Immediate mental health crisis assistance
- Alcohol or drug abuse

VALUEOPTIONS®

Mental Health and Substance Abuse Care

Referral and counseling services:

- Assistance for depression, stress and anxiety
- Referrals for therapy
- Immediate mental health crisis assistance
- Alcohol or drug abuse

VALUEOPTIONS®

ABC Company

(800) XXX-XXXX

To access Achieve Solutions® go to:

www.achievesolutions.net/xxx

ValueOptions® along with ABC Company Health Plan manages your mental health and substance abuse benefits at the request of ABC Company.

VALUEOPTIONS®

MHSA

The MHSA program upholds strict confidentiality standards. No one will know you have accessed the program services unless you specifically grant permission or express a concern that presents the MHSA with a legal obligation to release information.

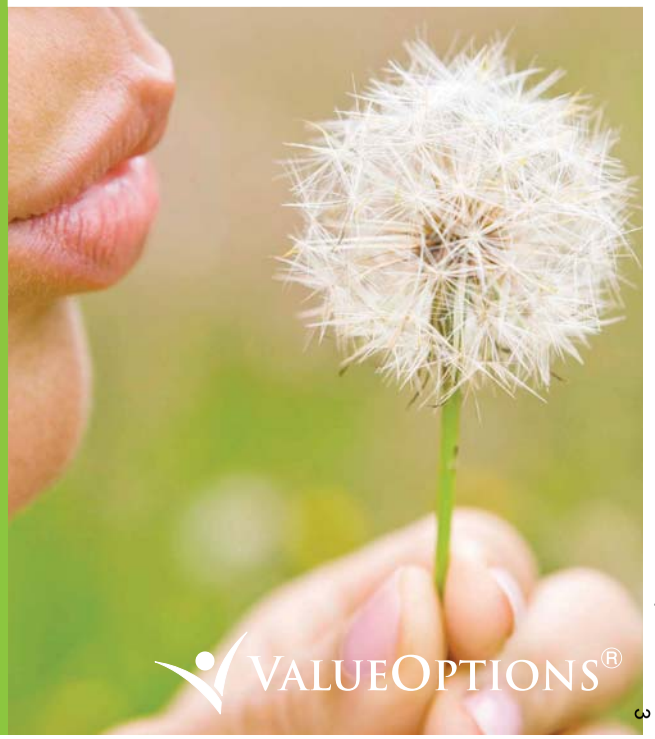
This brochure is for informational purposes only and does not guarantee eligibility for program services. ValueOptions® services do not replace regular medical care. In an emergency, seek help immediately.

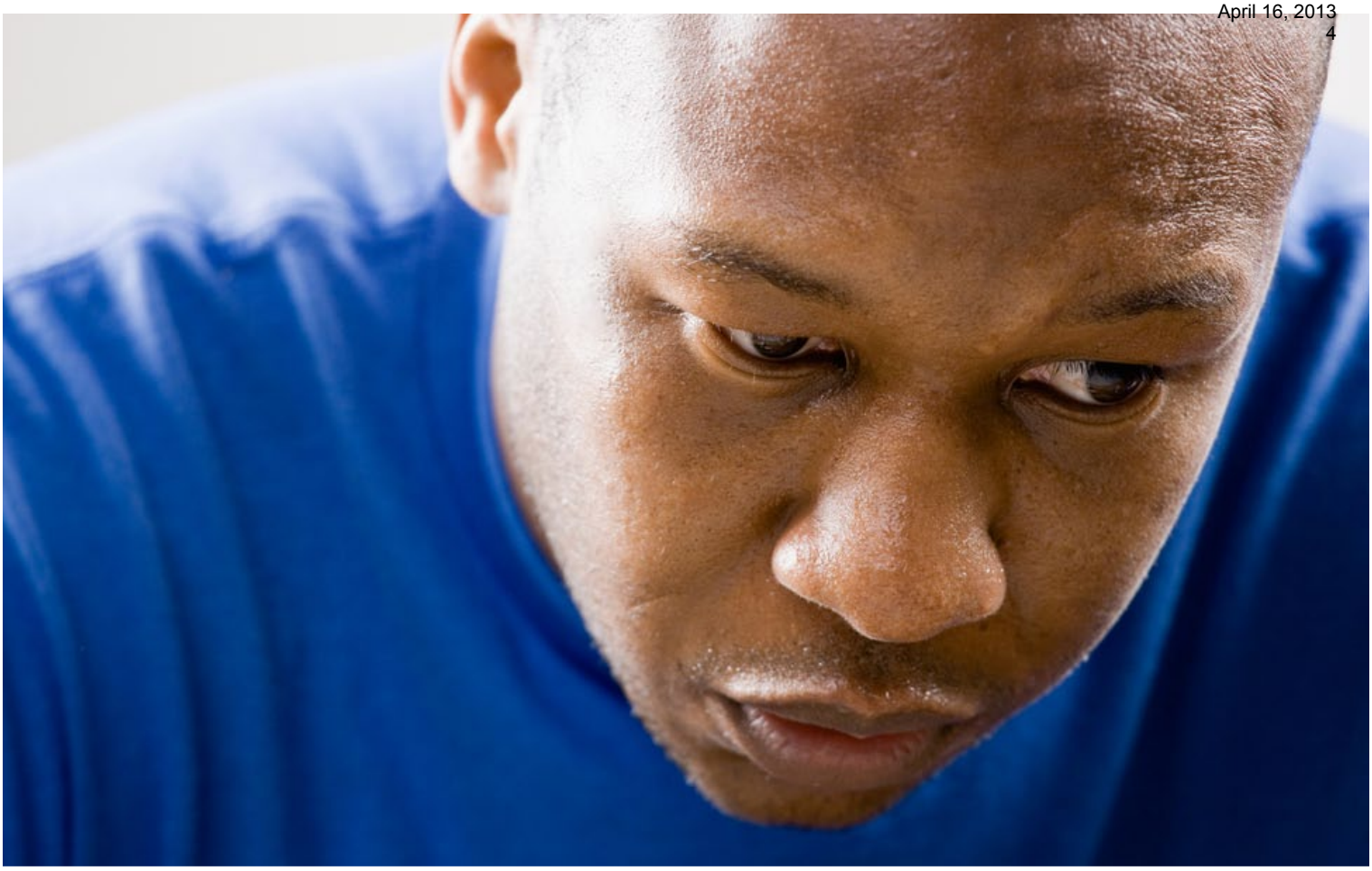
[Union Bug]

MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM

OFFERING CONFIDENTIAL COUNSELING, EDUCATION AND REFERRAL

Accessing Your Mental Health and Substance Abuse (Help-Line) Program Benefits.





NO, YOU CAN'T "JUST GET OVER IT"

Everyone feels "blue" sometimes, but when low feelings last for weeks at a time and interfere with daily life, it could be depression.

Depression is real, common and treatable. Your employee assistance program (EAP) provides confidential, free counseling and referral services that can help you overcome depression, anxiety and stress.

Let us help. Call today.

XXX-XXX-XXXX
WWW.ACHIEVESOLUTIONS.NET/XXX

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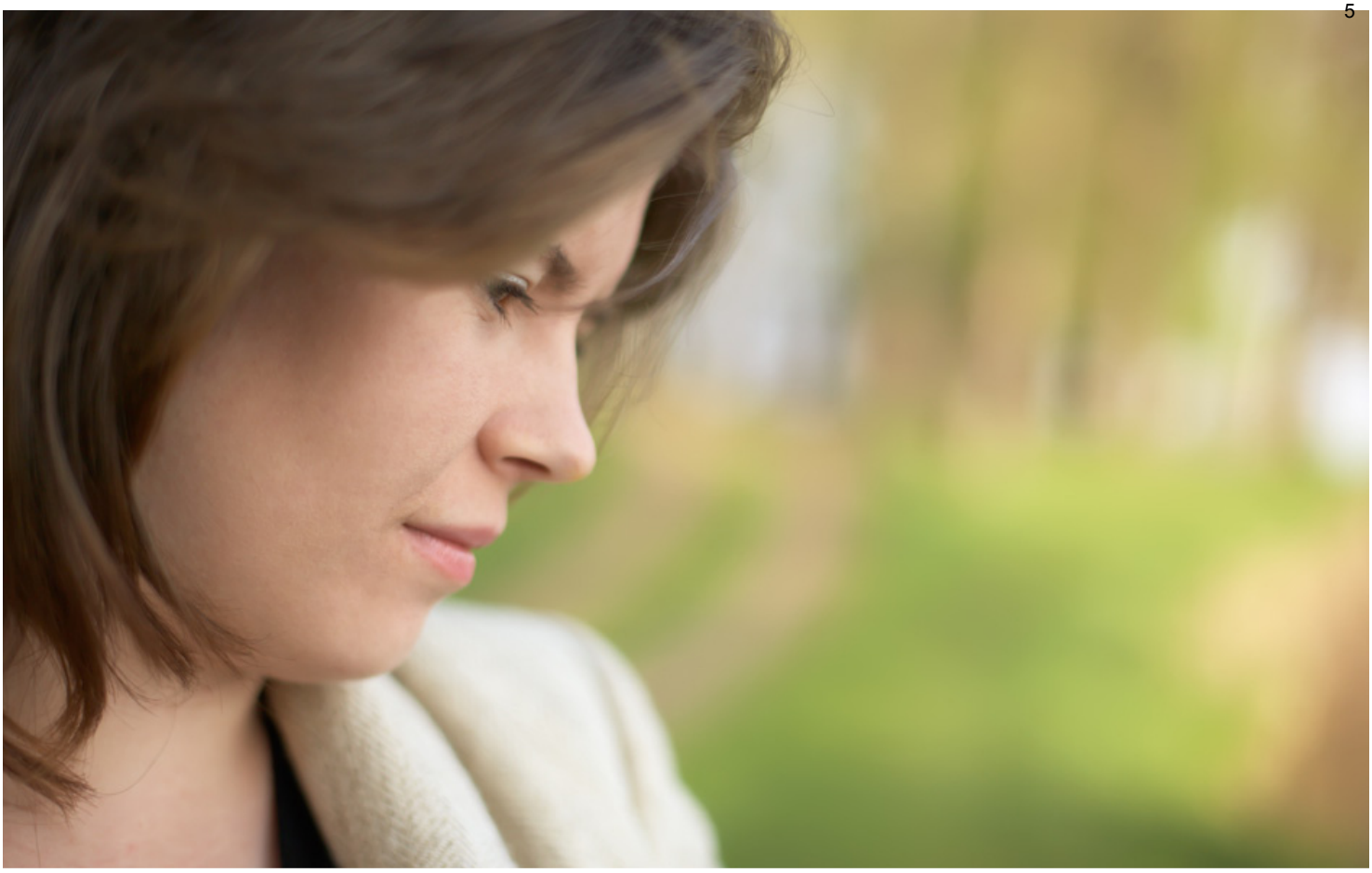
ValueOptions®
Innovative Solutions. Better Health.



NO, YOU CAN'T "JUST GET OVER IT"

Everyone feels "blue" sometimes, but when low feelings last for weeks at a time and interfere with daily life, it could be depression.

Depression is real, common and treatable. Your employee assistance program (EAP) provides confidential, free counseling and referral services that can help you overcome depression, anxiety and stress.

Let us help. Call today.

XXX-XXX-XXXX
WWW.ACHIEVESOLUTIONS.NET/XXX

8/24/12

[union bug]

ValueOptions®
Innovative Solutions. Better Health.

EVERYONE

DESERVES TO BE TREATED WITH

RESPECT

Does someone in your life insult, criticize or try to control you? Does your relationship have you feeling frightened, isolated, exhausted or bad about yourself? Have you been hit, kicked, shoved, threatened or sexually assaulted? It doesn't have to be that way. Help is available.

Call ABC Company for confidential counseling and support. Counselors are available 24 hours a day, seven days a week to help you create a plan for safety or to put you in touch with local resources that can help you find protection from the abuse.

Asistencia telefónica y sitio web disponibles en español

A SUPPORTIVE HAND WHEN YOU NEED IT MOST...

A life event or situation can cause intense pain. Every year in the U.S., 750,000 people attempt to take their lives, and about 35,000 die from suicide. Friends, co-workers and loved ones often are left shocked and guilt-ridden for not noticing the danger signs for suicide before it was too late.

If you, or someone you care about, is feeling depressed, overwhelmed, or having thoughts about self-harm, call **ABC Company Program Name** for immediate, ***confidential*** help.

Some Warning Signs of Suicide

- Appearing depressed, hopeless
- Threatening to hurt or kill oneself
- Talking or writing about suicide or death
- Seeking access to firearms, pills, or other lethal means of death
- Preparing for departure (giving away prized possessions, tying up "loose ends")

Take all threats seriously and get immediate expert help. Contact:

- ABC Company Program Name: 800-XXX-XXXX
- Your local emergency services, often available by calling 911
- National Suicide Prevention Lifeline: (800) 273-TALK (1-800-273-8255)
- Kristin Brooks Hope Center: (800) SUICIDE (800-784-2433)

1-800-XXX-XXXX / 1-800-XXX-XXXX TTY
www.achievesolutions.net/xxx

April is Alcohol Awareness Month

Heavy alcohol use can impact your health, your behavior and your performance. Concerned about your drinking or someone else's? Call ABC program name.

1-800-XXX-XXXX / 1-800-XXX-XXXX TTY
www.achievesolutions.net/XXX

What are the types of mental health professionals?

There are many types of mental health professionals and finding the right one for you may require some research.

- **A clinical social worker** is a counselor with a master's degree in social work and six or more years of supervised work experience. They are trained to provide individual, group and family therapy. Their qualifications include state licensure.

- **A psychologist** is a counselor with a doctoral degree in psychology and three or more years of supervised work experience. They are trained to conduct psychological testing and provide individual and group therapy. Their qualifications include state licensure.

- **A psychiatrist** is a medical doctor with special training in the diagnosis and treatment of mental and emotional illnesses. Like other doctors, psychiatrists are qualified to prescribe medication. Their qualifications include state licensure as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). Additionally, they are either certified by the American Board of Psychiatry and Neurology or eligible for board certification.

- **An advanced practice registered nurse** is an RN with specialized training and is able to prescribe medications under the supervision of a psychiatrist. They are trained to provide individual, group and family therapy.

For more information...

Please contact any of the following:

- ValueOptions®: Please call the number on the back of your identification card, and a ValueOptions® staff member will be happy to assist you.

- Your local mental health association.

- National Mental Health Association at www.nmha.org or call toll-free: 800-969-NMHA (800-969-6642).

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Innovative Solutions. Better Health.

VALUEOPTIONS®

What to Expect from Mental Health Treatment

ValueOptions®' Referral Line is available 24 hours a day to assist you.

Which type of professional is right for me and how do I find one?

ValueOptions®' Referral Line is available 24 hours a day to assist you in finding a ValueOptions® network practitioner. The toll-free line is answered by trained staff who can assist you in choosing the right professional. Describe your symptoms to the ValueOptions® staff member and he or she can provide referrals to appropriate mental health professionals.

What should I expect at my first appointment?

A well-trained mental health professional will treat you in a respectful and courteous manner. The first few sessions will be used to get to know you and your history and the problems you are facing. You may be asked to fill out, review and sign forms that describe the problems you are dealing with. Be sure to identify what you see as the main reason for seeking treatment and what you hope to gain. Write down all of your questions, so you can ask them during your appointment. Your doctor and/or counselor should be someone with whom you are comfortable. Different people are comfortable with different styles. It is important to choose a provider with a style that is in line with your own.

What can I expect after the first visit?

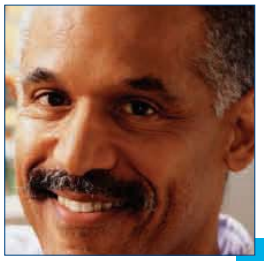
If you decide to pursue the treatment recommended, your provider will work with you to set goals for treatment. Be sure to be involved in the goal setting process. Your provider may ask for your permission to call or write to your primary care physician or another mental health professional. When you or your family member needs to see more than one provider, your treatment needs may be more complex. It is particularly important for your providers to communicate, especially at these times:

- When you start therapy
- Have a change in your health status,
- Start or change medications or
- Have laboratory tests

Your provider(s) may request that family and loved ones join you for some appointments, but only with your consent. Involving others may provide support and help to work on issues. Keep in mind that treatment is not always comfortable. You may improve and/or feel worse at different times in your treatment. Communicate these feelings clearly and honestly with your provider(s), particularly if there is a sudden change in symptoms or a severe worsening. Sometimes you and your provider may not make a "connection." You can always discuss this with your provider and/or seek a referral to a different provider.

What is a treatment plan?

A treatment plan is like a road map that you build with your treatment team. It will help you to help yourself feel better. Ask for services that you think you need. The treatment team may include a doctor, case manager, therapist, and/or counselors. It may involve family members and other community supports. Your treatment plan will include learning about your illness and how to cope with your illness.



It may talk about having your family or friends help you. Your treatment plan has specific goals for you to regain and maintain your emotional health and well-being.

Help Anytime, Anywhere

Primary care physicians can assist ABC Company members with accessing mental health and substance abuse services (MHSA) benefits through ValueOptions®, a company that specializes in managing treatment for mental health and substance abuse conditions.

HOW THE MHSA WORKS

To access these benefits and have the member talk to someone about their feelings, call the toll-free number on this brochure. You will speak to a master's-level behavioral health care professional who will listen, help sort things out and collaborate with you to come up with a workable plan of action. Your MHSA counselor may continue to work with you directly, or may refer you to another professional in your community for counseling or specialized treatment. If you choose, your counselor will research the most appropriate options and whether extended services are covered under your health plan.

The ValueOptions®' confidential help line is staffed 24 hours a day, 7 days a week to help you with:

- feelings of depression, stress and anxiety
- referrals for therapy
- immediate mental health crisis assistance

The ValueOptions®' network of health care providers includes psychiatrists, psychologists, psychiatric nurses and master's-level counselors. They specialize in mental health issues such as depression, stress, substance abuse and anxiety, and offer services at convenient times and locations.

Achieve Solutions®

You also have access to Achieve Solutions®, an award-winning online resource that offers valuable information.

Visit Achieve Solutions® (www.achievesolutions.net) to:

- Access a library of educational materials in 200 different topic areas, including stress, depression, anxiety and substance abuse treatment and recovery.
- Learn how to manage a life event such as a divorce or death of a loved one.
- Complete self-assessment tools and interactive quizzes.
- Find a mental health provider in your area.

WHAT SERVICES ARE COVERED?

ValueOptions® help line covers mental health and substance abuse services that are deemed clinically appropriate and medically necessary. Services include:

- inpatient admission
- partial hospitalization programs
- outpatient visits
- psychological testing

To access the help line, call (800) XXX-XXXX.

PREVENTION PROGRAMS

ValueOptions® maintains preventative health programs for ABC Company members that are aimed at prevention and treatment. The programs provide education, self-help strategies, referral and assessment. All of the programs utilize as a primary component clinically validated screening tools to identify potential behavioral health issues. The current programs are:

- **ADHD (attention-deficit/hyperactivity disorder)**—focused on education and screening.
- **Depression (major depressive disorder [MDD])**—focused on increasing member knowledge of depression and its various types, treatment, and medication. Offers referral and self-help strategies.
- **Postpartum depression (PPD)**—focused on early detection and referral of new mothers who may potentially be suffering from postpartum depression.
- **Medical Behavioral Healthcare Coordination for Mixed Services Protocol**—Please contact ValueOptions at (800) XXX-XXXX to make a behavioral health referral for those patients experiencing a behavioral health condition as a result of a medical condition (such as depression for a diabetic). Please obtain informed consent in making the referral in order to ensure ongoing communication between Medical and Behavioral Health components of a patient's treatment.
- **TeenScreen & Adult Behavioral Health Screening Pilot Program**—designed to provide early identification of behavioral health issues in adolescent and adults. To participate in these two pilots, call the ABC Company Quality Assurance Department at (XXX) XXX-XXXX.

For information on any of these prevention programs, call ValueOptions® at (800) XXX-XXXX or visit www.ValueOptions.com and follow the link to tips and resources.

MENTAL HEALTH AND SUBSTANCE ABUSE CARE — CALL ANY TIME FOR REFERRALS AND COUNSELING SERVICES.

1-800-XXX-XXXX

www.achievesolutions.net

VALUEOPTIONS®

Annual Financial Experience Report

Mental Health and Substance Abuse Program

Financial Experience

	CORE		NY ENHANCEMENT		PA ENHANCEMENT		TOTAL	
1. Earned Premium (2 tier)		**$X**		**$X**		**$X**		**$X**
2a. Paid Claims	$X		$X		$X		$X	
2b. Paid Bad Debt & Charity	$X		$X		$X		$X	
2c. Liability of Outstanding Claims at End of Reporting Period	$X		$X		$X		$X	
2d. Liability of Outstanding Claims at Beginning of Reporting Period	$X		$X		$X		$X	
2e. Total Incurred Claim Cost (2a+2b+2c-2d)		**$X**		**$X**		**$X**		**$X**
2f. Unit Cost Guarantee Credit		**($X)**		**($X)**		**($X)**		**($X)**
2g. Net Incurred Claim Cost (2e+2f)		**$X**		**$X**		**$X**		**$X**
3a. Administrative Expenses	$X		$X		$X		$X	
3b. Other Retention								
Risk Charges	$X		$X		$X		$X	
Taxes	$X		$X		$X		$X	
Contribution to Statutory Reserves	$X		$X		$X		$X	
NYSID Assessment	$X		$X		$X		$X	
Community Contribution	$X		$X		$X		$X	
Total Other Retention	$X		$X		$X		$X	
3c. Interest Charge/(Credit)	($X)		($X)		($X)		($X)	
3d. Total Retention (3a+3b+3c)		**$X**		**$X**		**$X**		**$X**
3e. Performance Penalty		**$X**		**$X**		**$X**		**$X**
3f. Net Retention (3d - 3e)		**$X**		**$X**		**$X**		**$X**
4. Experience Gain/(Loss) (1-2g-3f)		**$X**		**$X**		**$X**		**$X**
5a. 5-Tier Premium	($X)		($X)		($X)		($X)	
5b. 2-Tier Premium	($X)		($X)		($X)		($X)	
5c. Adjustment of Experience Gain/(Loss) (5a-5b)		$X		$X		$X		$X
6. Net Receivable/(Payable)		**$X**		**$X**		**$X**		**$X**

Reserves

A. Reserve and Paid Claims Reconciliation

Total Projected Incurred Claims	Claims Paid Through	Claims Paid Through	Claims Paid Through	Outstanding Reserve at
$X	$X	$X	$X	$X
$X	$X	$X	$X	$X
$X	$X	$X	$X	$X
$X (a)	$X	$X	$X (a)&(c)	$X

(a) Ties to paid claims on IA before application of credits.

Gross Claims/Payments	$X
Less: Claims Credits	$X
Net Paid Claims	$X

(b) Ties to open and unreported reserve calculation.
(c) Incurred claims and paid claims are reported before credits.

Total Projected Incurred BD&C	BD&C Paid Through	BD&C Paid Through	BD&C Paid Through	Outstanding Reserve at
$X	$X	$X	$X	$X
$X	$X	$X	$X	$X
$X	$X	$X	$X	$X
$X	$X	$X	$X	$X

B. Projection of Open & Unreported Reserve

I.	Incurred But Unpaid Claims @	$X
	Incurred But Unpaid Debt & Charity	X
	Total Incurred But Unpaid Claim Cost	X
II.	Administrative Component (4.4%)	X
	Disabled Lives Reserve	X
III.	Margin (3.09%)	X
IV.	Total Open & Unreported Reserve	$X

ADMINISTRATIVE EXPENSE

	Direct Charge		Indirect Charge		Total Charge	Basis of Calculation
ValueOptions Administrative Expenses						
Claim Administration	$X		$X		$X	
Executive Administration	$X		$X		$X	
Office Services	$X		$X		$X	
Account Services	$X		$X		$X	
Customer and Provider Relations	$X		$X		$X	
Toll Free Telephone Expenses	$X		$X		$X	
Medicare Affairs	$X		$X		$X	
Case Management	$X		$X		$X	
General/Occupancy	$X		$X		$X	
Other (Corporate Overhead)	$X		$X		$X	
Profit	$X		$X		$X	
Subtotal	**$X**	[3]	**$X**	[4]	**$X**	
Total Administrative Expenses	**$X**		**$X**		**$X**	[5]

[1] Indirect Charge: $X.XX Per Claim; X Claims Processed
[2] Indirect Charge: X% of Net Premium
[3] Actual direct charges incurred by ValueOptions
[4] Indirect Charge: X% of Revenue Received $X
[5] Allocation of Total to Core, NY Enhancement and PA Enhancement is based on percentage of premium.

TRIANGLE REPORT (Incurred Claim Projection)

Triangle Report by Year of Incurral - In-Network

EXCLUDING SURCHARGE

MONTH PAID	MONTH INCURRED											
	Jan-	Feb-	Mar-	Apr-	May	Jun-	Jul	Aug-	Sep	Oct-	Nov	Dec
Jan-	0	0	0	0	0	0	0	0	0	0	0	0
Feb-	0	0	0	0	0	0	0	0	0	0	0	0
Mar-	0	0	0	0	0	0	0	0	0	0	0	0
Apr-	0	0	0	0	0	0	0	0	0	0	0	0
May-	0	0	0	0	0	0	0	0	0	0	0	0
Jun-	0	0	0	0	0	0	0	0	0	0	0	0
Jul-	0	0	0	0	0	0	0	0	0	0	0	0
Aug-	0	0	0	0	0	0	0	0	0	0	0	0
Sep-	0	0	0	0	0	0	0	0	0	0	0	0
Oct-	0	0	0	0	0	0	0	0	0	0	0	0
Nov-	0	0	0	0	0	0	0	0	0	0	0	0
Dec-	0	0	0	0	0	0	0	0	0	0	0	0
Jan-	0	0	0	0	0	0	0	0	0	0	0	0
Total	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Completion Factor	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
In-Network Incurred	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

In-Network Incurred thru 12/03	$0
Completion Factor	1.0000
In-Network Incurred	$0

INTEREST SUMMARY

	Interest Charge/(Credit)
Jan	($X)
Feb	($X)
Mar	($X)
Apr	($X)
May	($X)
Jun	($X)
Jul	($X)
Aug	($X)
Sep	($X)
Oct	($X)
Nov	($X)
Dec	($X)
TOTAL:	**($X)**

STATEMENT OF EXPERIENCE

Retrospective

Line items in left-hand column below correspond to the information required by the Employee Retirement Income Security Act of 1974 (ERISA), Schedule A, Form 5500, Part I and Part III.

PART I

1. (a)	Plan: Mental Health & Substance Abuse	
2. (b)	Group Name: NEW YORK STATE MENTAL HEALTH & SUBSTANCE ABUSE PROGRAM	Group No.
(d) (e)	Contract Period: 12 Months, from	
	Type of Coverage CORE BENEFITS Supplementary Coverage to Medicare:	Category No.

(c) Enrollment as of	Type and Number of Contracts				Totals	
	Individual X	Parent & Child	Husband & Wife	Family X	Total X	Persons

PART III Experience Rated Contracts

9. (a)	Premiums:			
	(i) Amount received	$0.00		
	(ii) Increase(decrease) in amount due but unpaid	$0.00		
	(iii) Increase(decrease) in unearned premium reserve	$0.00		
	(iv) Premiums earned, (i) plus (ii), minus (iii)		$0.00	[1]
(b)	Benefit Charges:			
	(i) Claims paid	$0.00	[2]	
	(ii) Increase(decrease) in claim reserves	$0.00		
	(iii) Incurred claims (i) plus (ii)		$0.00	
	(iv) Claims charged		$0.00	[3]
(c)	Remainder of premium:			
	(i) Retention charges (on an accrual basis)			
	(A) Commissions			
	(B) Administrative service or other fees	$0.00		
	(C) Other specific acquisition costs			
	(D) Other expenses			
	(E) Taxes			
	(F) Charges for risks or contingencies			
	(G) Other retention charges			
	(H) Total retention		$0.00	[4]
	(ii) Retroactive Premium Adjustment (Such amounts were paid in cash.)		$0.00	[5]
(d)	Status of policyholder reserves at end of year.			
	(i) Amount held to provide benefits after retirement		$0.00	
	(ii) Claim reserves		$0.00	
	(iii) Other reserves		$0.00	
(e)	Retroactive Premium Adjustments Due..(do not include amount entered in (c) (ii)		$0.00	

PREMIUM RATES Monthly

	FROM	TO	Individual	Parent & Child	Husband & Wife	Family	Composite
CURRENT			$0.00 $0.00			$0.00 $0.00	

COMMENTS:

[1] 2 Tier Premium

[2] Paid Claims $0.00
Paid Bad Debt and Charity $0.00
Total Paid Claims $0.00

[3] Incurred Claims $0.00
2002 Unit Cost Guarantee Credit ($0.00)
Net Incurred Claims $0.00

[4] Retention $0.00
2003 Performance Penalty $0.00
Net Retention $0.00

[5] Retroactive Premium Adjustment $0.00
(a) 5 Tier Premium $0.00
(b) 2 Tier Premium $0.00
(c) Adjustment of Experience Gain/(Loss) [(a) - (b)] $0.00
(d) Net Retroactive Premium Adjustment $0.00

Annual Premium Renewal Report

DEVELOPMENT OF 2003 EXPERIENCE AND RATES

A. EXPERIENCE PROJECTION

	2002 Claims Inc*	2002 Trend**	2003 Claims Inc	Margin	HCRA	Expenses	(Gain)/ Loss Adj.	2003 Required Premium	2002 Annual Premium	2003 Renewal Action (%)
ee	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
dep	X	1.0000	X	X	X	X	X	X	X	0.00%
total	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
ee	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
dep	X	1.0000	X	X	X	X	X	X	X	0.00%
total	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
ee	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
dep	X	1.0000	X	X	X	X	X	X	X	0.00%
total	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
ee	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
dep	X	1.0000	X	X	X	X	X	X	X	0.00%
total	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
ee	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
dep	X	1.0000	X	X	X	X	X	X	X	0.00%
total	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%

B. RATE RECOMMENDATION

	CORE			NY ENHANCEMENT			PA ENHANCEMENT			GRADUATE STUDENT EMPLOYEE UNION		
	EE	DEP	FAM	EE	DEP	FAM	EE	DEP	FAM	EE	DEP	FAM
Rates:	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Renewal Rates:	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

* Employee and Dependent Claim Allocation Split Ratios from Exhibit II

** Based on 2002 Current Trend Factor

Mental Health & Substance Abuse Program
Renewal Rate Rationale

	Core	NY Enhancement	PA Enhancement	GSEU	Total
1. Annualized Premium	$X	$X	$X	$X	$X
2. Estimated Incurred Claims	$X	$X	$X	$X	$X
3. Trend Per Annum	0.00%	0.00%	0.00%	0.00%	
Midpoint to Midpoint Trend Factor (12 Months)	1.0000	1.0000	1.0000	1.0000	
Trended Incurred Claims 1/1/03 - 12/31/03	$X	$X	$X	$X	$X
4. HCRA	$X	$X	$X	$X	$X
5. Margin [(3.+4.) x 0.00%]	$X	$X	$X	$X	$X
6. Retention					
Administrative Fees	$X	$X	$X	$X	$X
Other (includes Risk Charge 0.00%)	$X	$X	$X	$X	$X
Interest Charge/(Credit)	$X	$X	$X	$X	$X
Total Retention	$X	$X	$X	$X	$X
7. Required Premium (3.+4.+5.+6.)	$X	$X	$X	$X	$X
8. Year 2002 (Gain) / Loss Adjustment	$X	$X	$X	$X	$X
9. Adjusted Required Premium (7.+8.)	$X	$X	$X	$X	$X
10. Renewal Rate Action (9. / 1.)	0.00%	0.00%	0.00%	0.00%	0.00%

NEW YORK STATE MHSA PROGRAM

Projected Premium Jan-02 through Dec-02

Date		Core (Excl GSEU) Premium	NY Enhanced Premium	PA Enhanced Premium	Total Premium
Jan-02		$X	$X	$X	$X
Feb-02		$X	$X	$X	$X
Mar-02		$X	$X	$X	$X
Apr-02		$X	$X	$X	$X
May-02		$X	$X	$X	$X
Jun-02		$X	$X	$X	$X
Jul-02		$X	$X	$X	$X
Aug-02	[1]	$X	$X	$X	$X
Sep-02	[1]	$X	$X	$X	$X
Oct-02	[1]	$X	$X	$X	$X
Nov-02	[1]	$X	$X	$X	$X
Dec-02	[1]	$X	$X	$X	$X
Total		$X	$X	$X	$X

[1] Estimated based on premium from Xxx-02 through Xxx-02

GRADUATE STUDENT EMPLOYEE UNION
Projected Premium Jan-02 through Dec-02

Date		GSEU Premium	Total Premium
Jan-02		$X	$X
Feb-02		$X	$X
Mar-02		$X	$X
Apr-02		$X	$X
May-02		$X	$X
Jun-02		$X	$X
Jul-02		$X	$X
Aug-02	[1]	$X	$X
Sep-02	[1]	$X	$X
Oct-02	[1]	$X	$X
Nov-02	[1]	$X	$X
Dec-02	[1]	$X	$X
Total		$X	$X

[1] Estimated based on premium from Xxx-02 through Xxx-02

NEW YORK STATE MHSA PROGRAM

Total Projected Premium Jan-02 through Dec-02

Date		Core Premium	NY Enhanced Premium	PA Enhanced Premium	Total Premium
Jan-02		$X	$X	$X	$X
Feb-02		$X	$X	$X	$X
Mar-02		$X	$X	$X	$X
Apr-02		$X	$X	$X	$X
May-02		$X	$X	$X	$X
Jun-02		$X	$X	$X	$X
Jul-02		$X	$X	$X	$X
Aug-02	[1]	$X	$X	$X	$X
Sep-02	[1]	$X	$X	$X	$X
Oct-02	[1]	$X	$X	$X	$X
Nov-02	[1]	$X	$X	$X	$X
Dec-02	[1]	$X	$X	$X	$X
Total		$X	$X	$X	$X

[1] Estimated based on premium from Xxx-02 through Xxx-02

NEW YORK STATE MHSA PROGRAM

Incurred Claims Development
(Excluding Surcharge)
Excluding Graduate Student Employee Union (GSEU)

Incurred Month	(A) Incurred & Paid Claims [1]	(B) Completion Factor	(C) Incurred Claims	(D) Total Contracts	(E) Adjusted Total Contracts	(F: E/D) Contracts Adjustment	(G: C x F) Contract Adjusted Incurred Claims	(H) Benefit Adjustment	(I: G x H) Adjusted Incurred Claims	(J: I / E) Estimated Cost Per Contract
1/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
2/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
3/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
4/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
5/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
6/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
7/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
8/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
9/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
10/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
11/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
12/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
1/01 - 12/01	$X		$X	X	X		X		$X	$0.00
1/01 - 6/01	$X		$X	X	X		X		$X	$0.00
1/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
2/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
3/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
4/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
5/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
6/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
1/02 - 6/02	$X		$X	X	X		X		$X	$0.00
Trend Factor 1st 6 Months										**0.00%**
7/02 [2]	n/a	n/a	$X	X	X	1.0000	X	n/a	$X	$0.00
8/02 [2] [3]	n/a	n/a	$X	X	X	1.0000	X	n/a	$X	$0.00
9/02 [2] [3]	n/a	n/a	$X	X	X	1.0000	X	n/a	$X	$0.00
10/02 [2] [3]	n/a	n/a	$X	X	X	1.0000	X	n/a	$X	$0.00
11/02 [2] [3]	n/a	n/a	$X	X	X	1.0000	X	n/a	$X	$0.00
12/02 [2] [3]	n/a	n/a	$X	X	X	1.0000	X	n/a	$X	$0.00
1/02 - 12/02			$X	X	X		X		$X	**$0.00**

I. Employee and Dependent Claim Allocation

Split [4]	Incurred & Paid Claims	Ratio	Core Incurred & Paid Claims	Ratio	NY Enhanced Incurred & Paid Claims	Ratio	PA Enhanced Incurred & Paid Claims	Ratio
Ee	$X	0.0000	$X	0.0000	$X	0.0000	$X	0.0000
Dep	$X	0.0000	$X	0.0000	$X	0.0000	$X	0.0000
Total	$X	0.0000	$X	0.0000	$X	0.0000	$X	0.0000
Core/NY Enh/ PA Enh Ratio	0.0000		0.0000		0.0000		0.0000	

II. Core, NY Enhanced, PA Enhanced Incurred Claims Allocation

Split	2002 Adjusted Incurred Claims	Core Incurred Claims	NY Enhanced Incurred Claims	PA Enhanced Incurred Claims
Ee	$X	$X	$X	$X
Dep	$X	$X	$X	$X
Total	$X	$X	$X	$X

[1] Exhibit IV
[2] Estimated based on prior year's cost per contract plus current trend factor
[3] Estimated based on contracts from 0/02 - 0/02
[4] Actual employee and dependent claims split incurred 1/1/01-12/31/01 and paid through 7/31/02

NEW YORK STATE MHSA PROGRAM

Incurred Claims Development
(Excluding Surcharge)
Graduate Student Employee Union (GSEU)

Incurred Month	(A) Incurred & Paid Claims [1]	(B) Completion Factor	(C) Incurred Claims	(D) Total Contracts	(E) Adjusted Total Contracts	(F: E/D) Contracts Adjustment	(G: C x F) Contract Adjusted Incurred Claims	(H) Benefit Adjustment	(I: G x H) Adjusted Incurred Claims	(J: I / E) Estimated Cost Per Contract
1/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
2/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
3/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
4/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
5/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
6/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
7/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
8/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
9/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
10/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
11/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
12/01	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
1/01 - 12/01	$X		$X	X	X		X		$X	$0.00
1/01 - 6/01	$X		$X	X	X		X		$X	$0.00
1/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
2/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
3/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
4/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
5/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
6/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
1/02 - 6/02	$X		$X	X	X		X		$X	$0.00
Trend Factor 1st 6 Months										0.00%
7/02 [2]	n/a	n/a	$X	X	X	1.0000	X	n/a	$X	$0.00
8/02 [2] [3]	n/a	n/a	$X	X	X	1.0000	X	n/a	$X	$0.00
9/02 [2] [3]	n/a	n/a	$X	X	X	1.0000	X	n/a	$X	$0.00
10/02 [2] [3]	n/a	n/a	$X	X	X	1.0000	X	n/a	$X	$0.00
11/02 [2] [3]	n/a	n/a	$X	X	X	1.0000	X	n/a	$X	$0.00
12/02 [2] [3]	n/a	n/a	$X	X	X	1.0000	X	n/a	$X	$0.00
1/02 - 12/02			$X	X	X		X		$X	$0.00

I. Employee and Dependent Claim Allocation

Split [4]	Incurred & Paid Claims	Ratio
Ee	$X	0.0000
Dep	$X	0.0000
Total	$X	0.0000

Split	2002 Adjusted Incurred Claims
Ee	$X
Dep	$X
Total	$X

[1] Exhibit IV
[2] Estimated based on prior year's cost per contract plus current trend factor
[3] Estimated based on contracts from 0/02 - 0/02
[4] Actual employee and dependent claims split incurred 1/1/01-12/31/01 and paid through 7/31/02

NYS MHSA Program

Analysis of HCRA Estimate

A. Incurred & Paid Claims 1/1/02-6/30/02, with claims paid thru 7/31/02	$X
B. Total Paid HCRA	$X
C. HCRA % of Incurred & Paid Claims (B./A.)	**0.00%**

COMPONENTS OF DIVIDEND/(LOSS) FOR THE 2002 CONTRACT YEAR

	2002 Contract Year	
Projected 2002 Renewal Dividend (Margin)	$X	
Change in 2002 Premium Base	$X	(1) See page 14
Change in 2001 Claim Base	$X	(2) See page 14
2001 Unit Cost Guarantee Credit	$X	(3) See page 14
Change in 2002 Expected Trend	$X	(4) See page 14
Change in Retention	$X	(5) See page 14
2002 Performance Penalty	$X	(6) See page 14
Total Projected Dividend/(Loss):	**$X**	

COMPONENTS OF DIVIDEND/(LOSS) FOR THE 2002 CONTRACT YEAR

(1) Due to increase in enrollment of 0.0%

(2) Due to changes in 2001 Incurred Claims projections:

	2002 Renewal	Current Projection	$ Change	% Change
Estimated Incurred Claims 1/1/01 - 12/31/01	$X	$X	$X	0.0%

(3) Based on claims incurred 1/1/01-7/31/01 paid through 7/31/01 for Network Services Only (all surcharges excluded)

	2002 Renewal	Current Projection	$ Change
Mental Health Inpatient	$X	$X	$X
Substance Abuse Inpatient	$X	$X	$X
Total	$X	$X	$X

(4) Due to change in 2002 Expected Trend:

	2002 Renewal	Current Projection	$ Change
Financial Experience for Year Ended 12/31/02	$X	$X	$X
Less Estimated Incurred Claims 1/1/01 - 12/31/01	$X	$X	$X
Change in 2002 Expected Trend	$X	$X	$X

(5) Due to changes in Total Retention projections:

	2002 Renewal	Current Projection	$ Change	% Change
Administrative Expenses	$X	$X	$X	0.0%
Risk Charges	$X	$X	$X	0.0%
Taxes	$X	$X	$X	0.0%
Contribution to Statutory Reserves	$X	$X	$X	0.0%
NYSID Assessment	$X	$X	$X	0.0%
Community Contribution	$X	$X	$X	0.0%
Interest Charge/(Credit)	$X	$X	$X	0.0%
Total	$X	$X	$X	0.0%

(6)

Standard	Reported Perfomance	Penalty
Total Penalty		$0

Mental Health and Substance Abuse Program

Financial Experience
For Year Ended 12/31/03

		CORE		NY ENHANCEMENT		PA ENHANCEMENT		TOTAL	
1.	**Earned Premium (2 tier)**		**$X**		**$X**		**$X**		**$X**
2a.	Paid Claims	$X		$X		$X		$X	
2b.	Paid Bad Debt & Charity	$X		$X		$X		$X	
2c.	Liability of Outstanding Claims at End of Reporting Period	$X		$X		$X		$X	
2d.	Liability of Outstanding Claims at Beginning of Reporting Period	$X		$X		$X		$X	
2e.	**Total Incurred Claim Cost (2a+2b+2c+2d)**		**$X**		**$X**		**$X**		**$X**
	2002 Unit Cost Guarantee Credit		**$X**		**$X**		**$X**		**$X**
	Net Incurred Claim Cost		**$X**		**$X**		**$X**		**$X**
3a.	Administrative Expenses	$X		$X		$X		$X	
3b.	Other Retention								
	Risk Charges	$X		$X		$X		$X	
	Taxes	$X		$X		$X		$X	
	Contribution to Statutory Reserves	$X		$X		$X		$X	
	NYSID Assessment	$X		$X		$X		$X	
	Community Contribution	$X		$X		$X		$X	
	Total Other Retention	$X		$X		$X		$X	
3c.	Interest Charge/(Credit)	$X		$X		$X		$X	
3d.	**Total Retention (3a+3b+3c)**		**$X**		**$X**		**$X**		**$X**
4.	**Experience Gain/(Loss) (1-2e-3d)**		**$X**		**$X**		**$X**		**$X**
5a.	5-Tier Premium	$X		$X		$X		$X	
5b.	2-Tier Premium	$X		$X		$X		$X	
5c.	Adjustment of Experience Gain/(Loss) (5a-5b)		$X		$X		$X		$X
6.	**Net Receivable/(Payable)**		**$X**		**$X**		**$X**		**$X**

Support of Projected 2002 Administrative Expenses & Retention

	Direct Charge	Indirect Charge	Total Charge	Basis of Charge
Value Options Administrative Expenses *				
Claim Administration	$X	$X	$X	
Executive Administration	$X	$X	$X	
Office Services	$X	$X	$X	
Account Services	$X	$X	$X	
Customer and Provider Relations	$X	$X	$X	
Toll Free Telephone Expenses	$X	$X	$X	
Medicare Affairs	$X	$X	$X	
Case Management	$X	$X	$X	
General/Occupancy	$X	$X	$X	
Other (Corporate Overhead)	$X	$X	$X	(3)
Profit	$X	$X	$X	
Subtotal	**$X**	**$X**	**$X**	
Total Administrative Expenses	**$X**	**$X**	**$X**	
Risk Charges	$X	$X	$X	
Taxes	$X	$X	$X	(2)
NYS Statutory: Bad Debt & Charity Assessments	$X	$X	$X	
Cash Flow Charge/(Credit)	$X	$X	$X	
Other Retention Items not Listed Above				
Contribution to Statutory Reserves	$X	$X	$X	(2)
NYSID Assessment	$X	$X	$X	(2)
Community Contribution	$X	$X	$X	(2)
Total Other Retention	**$X**	**$X**	**$X**	
Total Retention	**$X**	**$X**	**$X**	

* See Executive Summary

(1) Allocated on a per claim basis; see Section VII for explanation.
(2) Allocated as a percentage of net premium; see Section VII for explanation.
(3) Allocated as a percentage of revenue; see Section VII for explanation.

Support of Projected 2003 Administrative Expenses & Retention

	Direct Charge	Indirect Charge	Total Charge	Basis of Charge
Value Options Administrative Expenses *				
Claim Administration	$X	$X	$X	
Executive Administration	$X	$X	$X	
Office Services	$X	$X	$X	
Account Services	$X	$X	$X	
Customer and Provider Relations	$X	$X	$X	
Toll Free Telephone Expenses	$X	$X	$X	
Medicare Affairs	$X	$X	$X	
Case Management	$X	$X	$X	
General/Occupancy	$X	$X	$X	
Other (Corporate Overhead)	$X	$X	$X	(3)
Profit	$X	$X	$X	
Subtotal	**$X**	**$X**	**$X**	
Total Administrative Expenses	**$X**	**$X**	**$X**	
Risk Charges	$X	$X	$X	
Taxes	$X	$X	$X	(2)
NYS Statutory: Bad Debt & Charity Assessments	$X	$X	$X	
Cash Flow Charge/(Credit)	$X	$X	$X	
Other Retention Items not Listed Above				
Contribution to Statutory Reserves	$X	$X	$X	(2)
NYSID Assessment	$X	$X	$X	(2)
Community Contribution	$X	$X	$X	(2)
Total Other Retention	**$X**	**$X**	**$X**	
Total Retention	**$X**	**$X**	**$X**	

* See Executive Summary

(1) Allocated on a per claim basis; see Section VII for explanation.
(2) Allocated as a percentage of net premium; see Section VII for explanation.
(3) Allocated as a percentage of revenue; see Section VII for explanation.

Basis of 2002 and 2003 Retention Charges

	2002		2003	
I. Indirect Charges	**Indirect Charge Factor**	**Indirect Charge Base**	**Indirect Charge Factor**	**Indirect Charge Base**
Insurance Company Administrative Fees				
Claims Administration	$0.000 per claim	X claims	$0.000 per claim	X claims
Other Insurance Company Administrative Cost	0.000% of net premium (1)	$X	0.000% of net premium (1)	$X
Benefit Management Administrative Fees				
Other (Corporate Overhead)	0.000% of revenue (2)	$X	0.000% of revenue (2)	$X
Other				
Taxes	0.000% of net premium (1)	$X	0.000% of net premium (1)	$X
Contribution to Statutory Reserves	0.000% of net premium (1)	$X	0.000% of net premium (1)	$X
NYSID Assessment	0.000% of net premium (1)	$X	0.000% of net premium (1)	$X
Community Contribution	0.000% of net premium (1)	$X	0.000% of net premium (1)	$X

II. Direct Charges	**Direct Charge Factor**	**Direct Charge Base**	**Direct Charge Factor**	**Direct Charge Base**
Risk Charges	0.000% of net premium (1)	$X	0.000% of net premium (1)	$X

(1) Gross premium less margin / dividend and Performance Penalty
(2) Subtotal of Benefit Management Administrative Fees

Annual Summary Reporting

Client XXX Executive Summary

2011

Client XXX Managed Mental Health and Substance Abuse Care
January 1, 2011 – December 31, 2011

"We help people live their lives to the fullest potential."
ValueOptions Mission

ValueOptions is honored to have partnered with and provided best-in-class mental health and substance abuse (MHSA) services to Client XXX members during the 2011 calendar year. We are always available for consultation and support to those who reach out to us whether at an organizational or individual level. We also reach out on key issues that might affect the overall health of Client XXX employees and their families. The following information highlights the mental health and substance abuse activity during the 2011 calendar year along with comparisons to ValueOptions 2011 Book of business.

Executive Summary

Mental Health and Substance Abuse Utilization

Membership
The total number of covered lives under the Client XXX Managed Mental Health and Substance Abuse Program at the end of 2011 was 81,483 contract holders and 192,449 dependents. The 2011 employee count was lower than 2010 (82,736) by 1.6 percent and the dependent count increased 3.6 percent (from 185,667) in 2010.

Paid Claims
2011 paid claims totaled $15,058,430 an 8.7 percent increase over 2010 wherein claims paid totaled $13,115,075.

Program Cost Drivers
The predominant reason for the increase in 2011 paid claims is utilization of the inpatient benefits. In particular, admissions to inpatient substance abuse facilities increased to 1,186 from 851 in 2010. The days utilized for substance abuse increased 35.3 percent to 8,015 from 5,924 in 2010.

Unique Members & Inpatient Admissions - 2011

Members	SA IPD – With Outpt. History	SA IPD – No Prior Outpt. History	MH IPD – With Outpt. History	MH IPD - No Prior Outpt. History
Employee	164	13	165	24
Spouse	60	9	200	27
Dependent	105	11	289	16
Totals	329	33	654	67

Client XXX Executive Summary

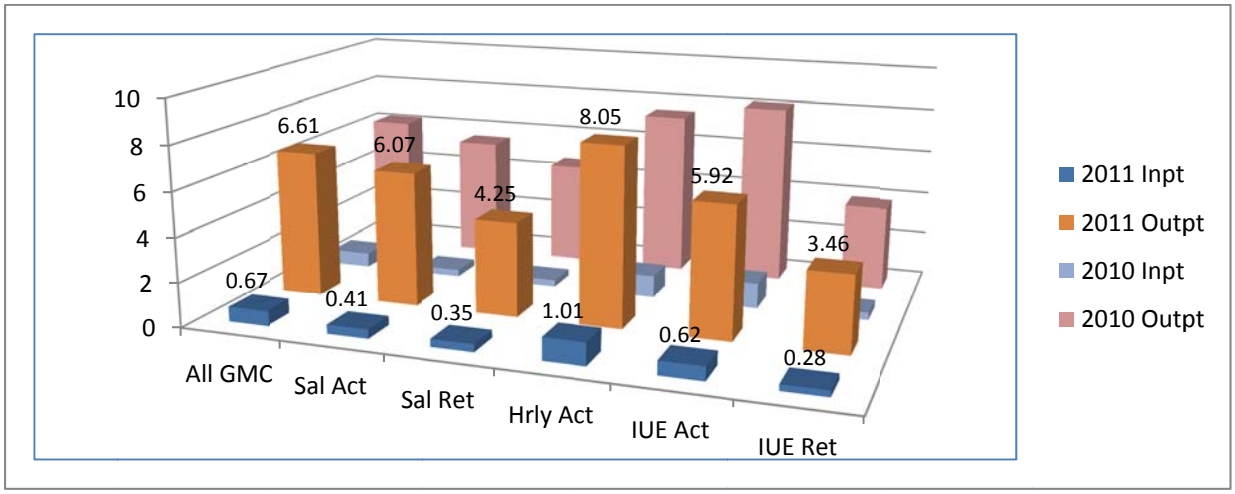
2011

Unique Members & Inpatient Admissions - 2010

Members	SA IPD – With Outpt. History	SA IPD – No Prior Outpt. History	MH IPD – With Outpt. History	MH IPD - No Prior Outpt. History
Employee	168	60	262	56
Spouse	43	1	156	11
Dependent	55	5	239	18
Totals	266	66	657	85

Penetration Rate

The penetration rate measures the number of unique members who access the managed mental health and substance abuse benefit. National trends show that approximately 20 percent of the population will present such disorders during the calendar year and about a third of the population will present such a disorder at least once in their lifetime. Only about a 6 ½ percent of the overall population is likely to seek treatment for behavioral illness regardless of the type of medical professional providing the service. Data indicates an additional 6 ½ percent of the total population will seek treatment with a general medical professional such as a primary care physician (PCP)[1]. Still, an additional 6 percent will cope with their disorders without seeking any professional care.



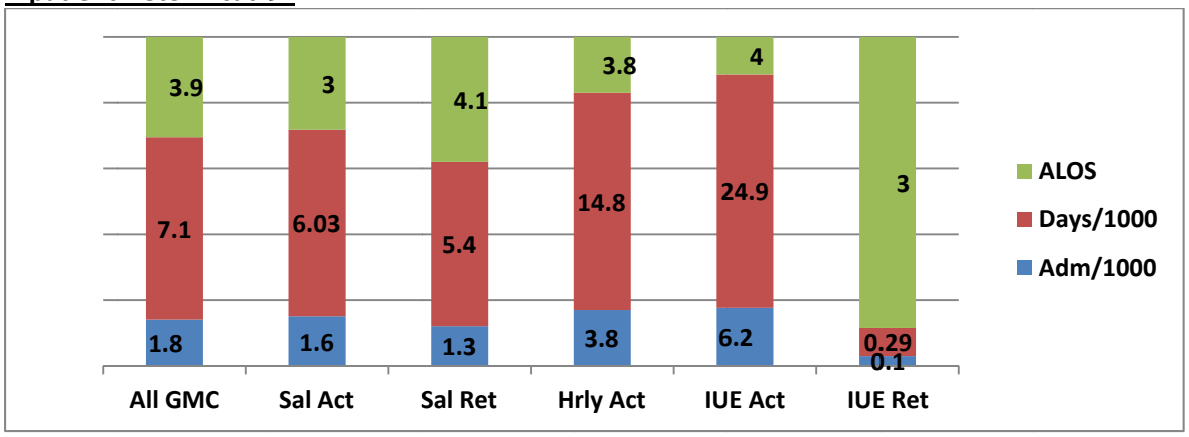
Client XXX overall penetration rate for 2011 was 7.28 percent representing 13,992 unique members seeking professional care. This is an increase from 6.34 (11,645 unique members) in 2010. When compared to ValueOptions 2011 auto Book of Business, the mean rate for outpatient treatment was 3.52 percent. The ValueOptions commercial Book of Business showed a penetration rate of 5.2 percent for similar manufacturing companies; however, the Client XXX data represents a 28.6 percent higher penetration rate when compared to ValueOptions' overall Book of Business.

[1] Primary Care Physician Pilot Program

Client XXX Executive Summary

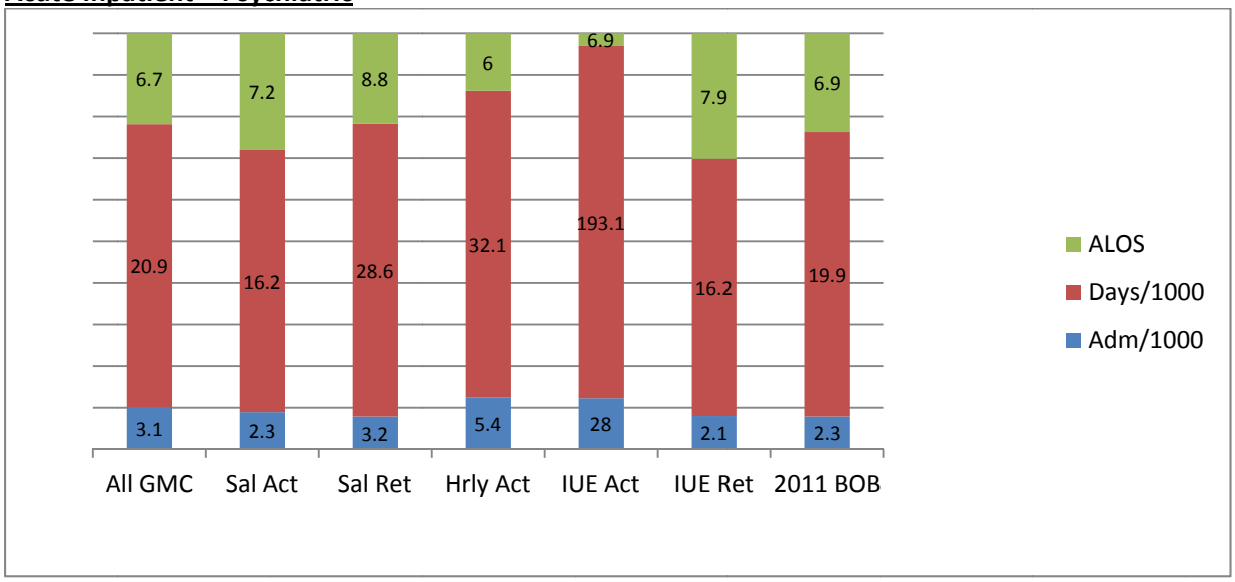
2011

Inpatient Detoxification



For the Client XXX Active Hourly population, the first three (3) days of detoxification are covered by registration. Confinement longer than three days must be approved by the Central Diagnostic Review agency (CDR) or Central Review Organization (CRO). While the Client XXX Active & Other Retiree group reflects a much higher use of the Days/1000, it had only 2 admissions. Compared to the Hourly Active group which had 343 Admissions, its' Days/1000 resulted in 14.8.

Acute Inpatient – Psychiatric

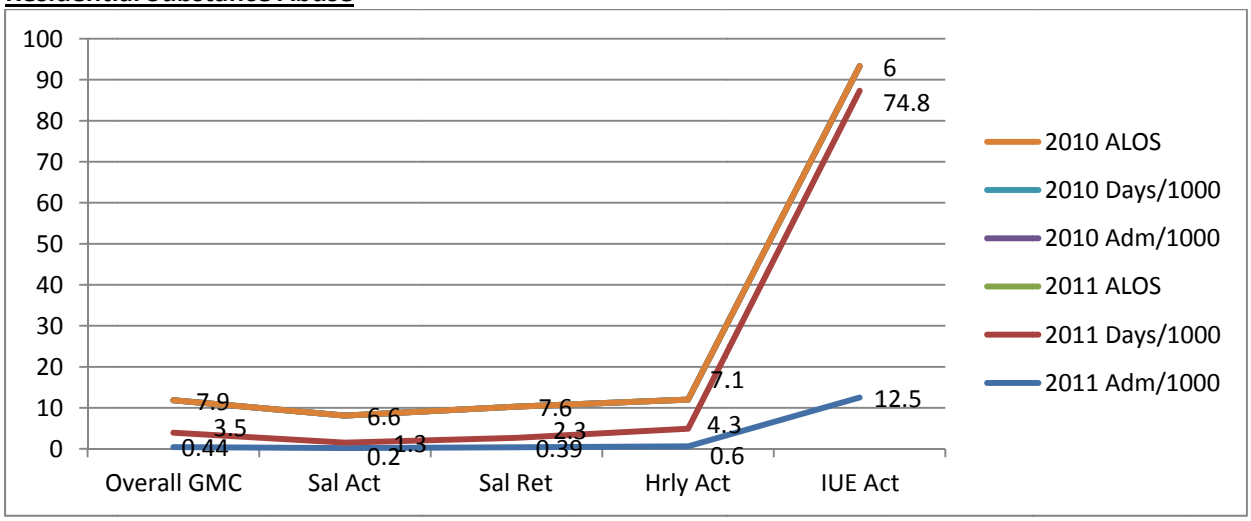


Active Hourly & Client XXX Active members admitted into an acute inpatient facility with a primary mental health diagnosis resulted in a higher than average use of Days/1000. However, the average length of stay for both of these groups was the lowest among all Client XXX groups.

Client XXX Executive Summary

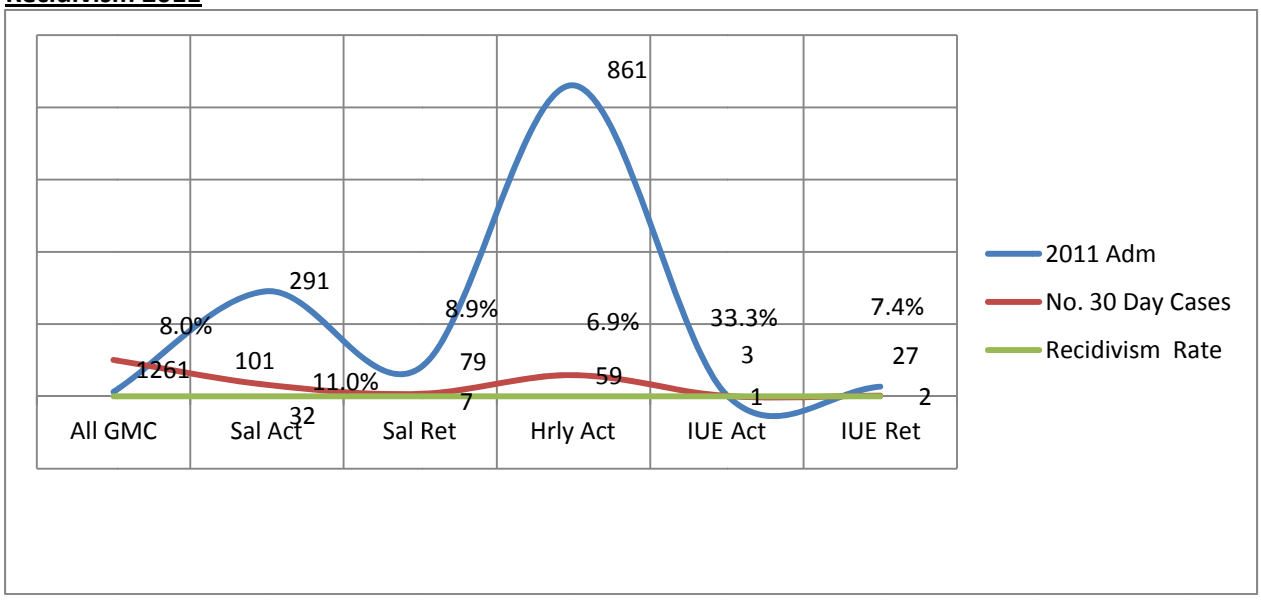
2011

Residential Substance Abuse



The Client XXX Active & Other Hourly employees show the Days/1000 at more than 10 times higher than all populations in total although that rate is actually skewed because the number of admissions was four (4) out of a cumulative total of 162 admissions for all groups.

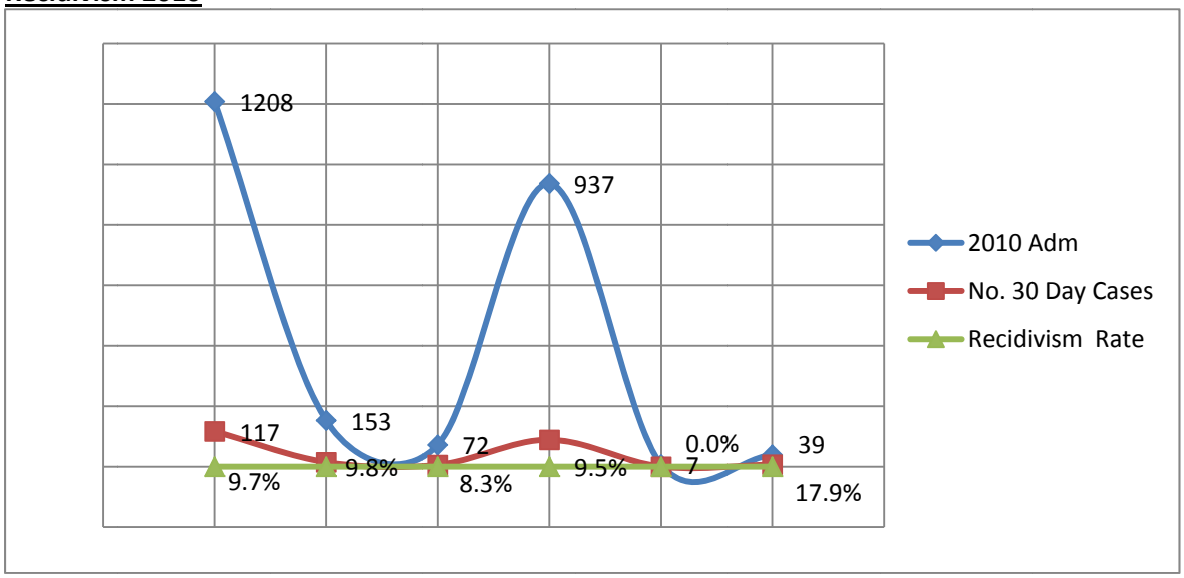
Recidivism 2011



Client XXX Executive Summary

2011

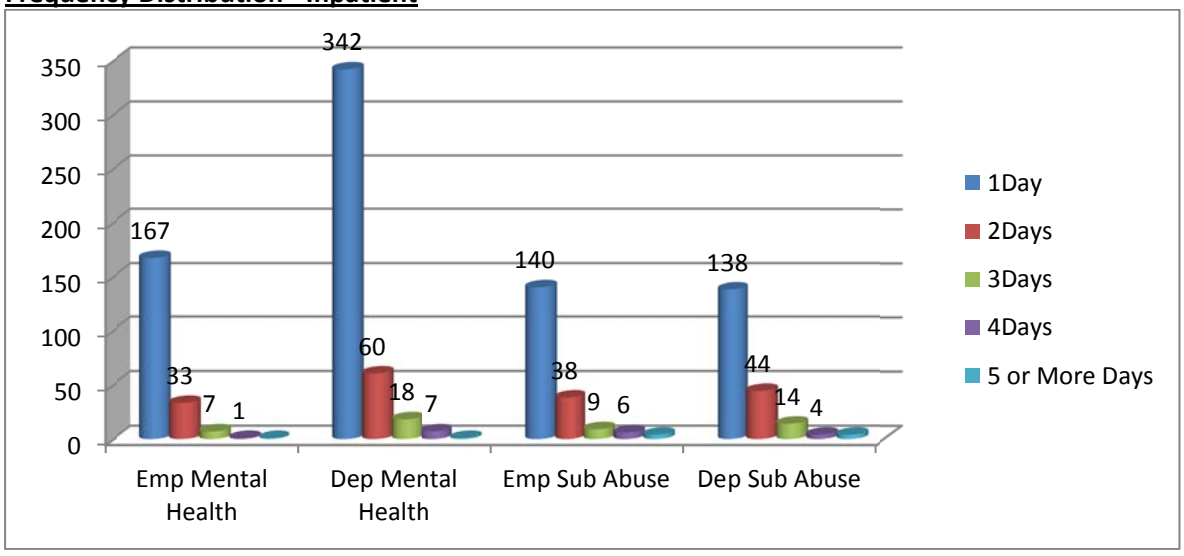
Recidivism 2010



The overall 2011 recidivism rate was 8.0 percent down from 9.7 percent in 2010. The Active Hourly members had 861 admissions for inpatient mental health and substance abuse care with 59 re-admissions or 7 percent within a 30 day period after discharge. Active & Retired Salaried members had a total of 370 admissions for inpatient mental health and substance abuse care with 39 re-admissions within a 30 day period.

Through ValueOptions' Intensive Care Management (ICM) program, those Client XXX members that present with a re-admission into an in-patient level of care within a 30-day period will continue to be closely monitored through monthly rounds which include ValueOptions and BCBSM clinical care managers and ValueOptions and BCBSM psychiatrists.

Frequency Distribution - Inpatient



Client XXX Executive Summary

2011

This information displays the number of distinct admissions by employee and dependent, mental health and substance abuse and shows the number of employees who were confined one or more days.

Outpatient Treatment - Mental Health & Substance Abuse

There were 104,840 outpatient visits for mental health and substance abuse in the 2011 calendar year. When compared to 2010 in which there were 92,971 outpatient visits, 2011 represents an increase of 11.4% increase in the number of outpatient visits.

Outpatient Visits – 4 or More Visits Per Unique Member

	Number of Unique Members	Penetration Rate	2011 Members w/4 or More Visits	2010 Members w/4 or More Visits
Employee	4,813	6.26%	4,076	365
Spouse	3,380	6.5%	3,171	278
Dependent	4,513	7.19%	3,157	278
Totals	12,706	6.61%	10,404	921

Outpatient Utilization - Psychiatric

	Overall Client XXX	Sal Act	Sal Ret	Hrly. Act	IUE Act	IUE Ret
Unique Members Seen	12,218	4,089	977	6,802	19	346
Avg. # of Visits	8.12	9.76	7.31	7.40	6.53	4.95

- *12,218 unique Client XXX members accessed outpatient mental health services*
- *The Client XXX Hourly Active segment comprised 55.8 percent of the overall outpatient utilization.*

Outpatient Utilization – Substance Abuse

	Overall Client XXX	Sal Act	Sal Ret	Hrly. Act	IUE Act	IUE Ret
Unique Members Seen	732	136	35	552	1	8
Avg. # of Visits	7.72	9.28	8.54	7.17	1	15.75

- 732 unique Client XXX members accessed outpatient substance abuse services.
- The Client XXX Hourly Active accounted for 75.4 percent of the utilization for outpatient substance abuse care.
- With a substance abuse diagnosis, members will seek resources within their communities such as Alcoholics Anonymous, Al-Anon &/or religious groups.

Client XXX Executive Summary

2011

Out of the 12,950 unique Client XXX members that accessed treatment at the outpatient level, the overwhelming majority presented with a mental health diagnosis (94) percent vs. a substance abuse diagnosis (6) percent. It is probable that an increasingly larger number of members are seeking care through their primary care physician[2]

Paid Claims Experience - Total paid claims: $15,409,854

	Overall Client XXX	Sal Act	Sal Ret	Hrly Act.	IUE Act	IUE Ret
In-Network	$14,139,304	$3,102,684	$674,426	$9,699,246	$9,670	$653,279
Out-of-Network	$919,126	$668,035	$146,039	$92,919	$2,038	$10,093

Total Paid Distribution by Major Diagnosis Category – Top 3 Diagnostic Categories

Overall Client XXX

Diagnostic Categories	2011 Client XXX % Paid	VO BOB % Paid	Difference Client XXX vs. VO BOB	2010 Client XXX % Paid
Mood Disorders	44.42%	47.48%	-6.5%	48.38%
SA Related Disorders	27.75%	19.53%	29.6%	24.97%
Adjustment Disorders	7.83%	10.35%	24.6%	7.77%

Salaried Active

Diagnostic Category	2011 Client XXX %	VO BOB % Paid	Difference Client XXX vs. VO BOB	2010 Client XXX % Paid
Mood Disorders	51.11%	47.48%	7.2%	51.08%
SA Related Disorders	14.46%	19.53%	-26.0%	9.90%
Anxiety & Stress Disorders	7.83%	8.75%	-19.2%	14.45%

Salaried Retiree

Diagnosis Category	2011 Client XXX %	VO BOB % Paid	Difference Client XXX vs. VO	2010 Client XXX % Paid
Mood Disorders	51.56%	47.48%	8.0%	56.07%
SA Related Disorders	22.70%	19.53%	14.0%	16.77%
Schiz & Other Psych	10.76%	4.36%	246.78%	10.36%

UAW Active Hourly

Diagnostic Category	2011 Client XXX %	VO BOB % Paid	Difference Client XXX vs. VO	2010 Client XXX % Paid
Mood Disorders	43.38%	47.48%	9.1%	46.55%
SA Related Disorders	34.96%	19.53%	55.8%	29.59%
Adjustment Disorders	8.20%	10.35%	-20.8%	8.0%

[2] *Primary Care Physician Pilot Program*

Client XXX Executive Summary

2011

IUE & Other Hourly Active

Diagnostic Category	2011 Client XXX %	VO BOB % Paid	Difference Client XXX vs. VO	2010 Client XXX % Paid
Mood Disorders	56.79%	47.48%	16.4%	69.86%
Disorders Diag. in Infancy	14.44%	4.49%	321.0%	14.7%
Adjustment Disorders	9.53%	10.35%	8.0%	3.5%

IUE & Other Hourly Retired

Diagnosis Category	2011 Client XXX %	VO BOB % Paid	Difference Client XXX vs. VO	2010 Client XXX % Paid
Eating Disorders*	78.78%	3.31%	420.1%	66.48%
Mood Disorders	12.79%	47.48%	-371.2%	21.11%
Schiz. & Other Psych	3.60%	4.36%	-17.54%	4.11%

- The highest percentage of claims paid for all 5 populations continues to be for those members presenting with a primary diagnosis of Mood Disorder.

* There were 38 IUE Hourly Retiree claims paid for "eating disorders" totaling $522,599 in 2011. In 2010 there were no claims for "eating disorders."

A mood disorder is the term given for a group of diagnoses in the Diagnostic and Statistical Manual of Mental Disorder (DSM IV TR) classification system where a disturbance in the person's mood is hypothesized to be the main underlying feature. Two groups of mood disorders are broadly recognized: 1) Major Depressive Disorder and 2): Bi-polar Disorder. Both diagnoses classified in ICD-9 as 296.0 -296.9.

High Cost Member Case Analysis – Cases with Claims > $20,000

- Across all 5 populations, there was a total of 86 cases with catastrophic claims
- The following populations had 86 catastrophic cases with claims greater than $20,000:

Client XXX Hourly Active: 62 Claims
Salaried Active: 19 Claims
Salaried Retired: 4 Claims
IUE Retire: 1 Claims

Total catastrophic claims paid during 2011 amounted to $3,098,876 & represented 20.58 percent of the total claims paid. Of the 86 high dollar claims, 12 members incurred $476,857 in high dollar claims in 2010. Of the 12, Active Hourly members had 7 claims, Active Salary had 4 claims, Retired Salary had 1 claim & IUE Active members had no claims and. $3,098,876

Client XXX Active members presented with more catastrophic illnesses that generated claims greater than $20,000 than the Salaried Active & Retired populations combined.

Client XXX Executive Summary

Of interest to note, there were 465 claims paid for "eating disorders"

Central Diagnostic and Referral (CDR) Agency Activity

- CDR activity reported 1,546 cases opened by the CDR during 2011
- 2011 CDR costs totaled $128,181

Telephone Performance

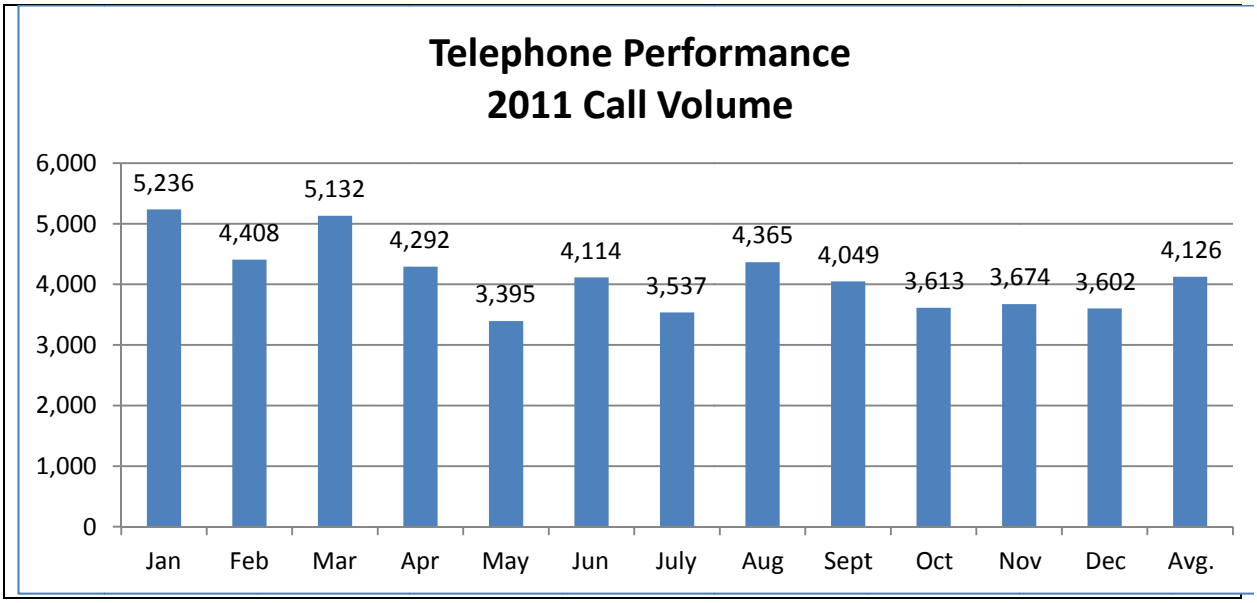
For the 2011 reporting calendar year, ValueOptions received a total of 49,507 calls regarding Client XXX contract holders and their beneficiaries.

The average speed of answer: 19 seconds

- ValueOptions servicing standard is 30 seconds or less

The average percentage of calls abandoned: 1.0%

- ValueOptions servicing standard is 5% or less.



Managed Mental Health and Substance Abuse Activity Report

2011 Fourth Quarter Report
January 1, 2011 – December 31, 2011

Innovative Solutions. Better Health.

Managed Mental Health and Substance Abuse Activity Report
Fourth Quarter 2011
January 1, 2011 - December 31, 2011

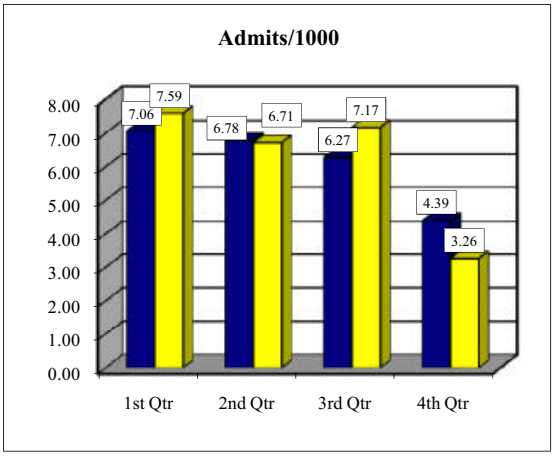
Table of Contents

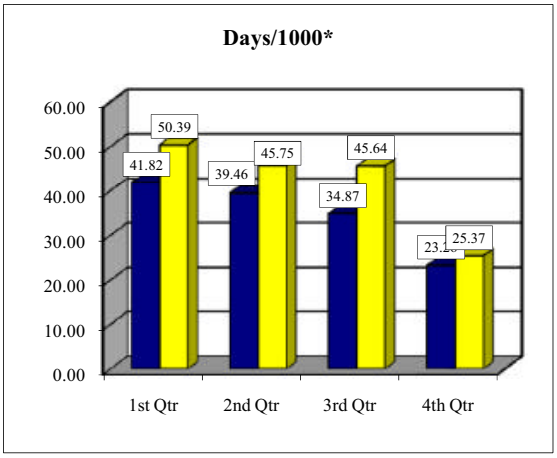
Utilization Highlights

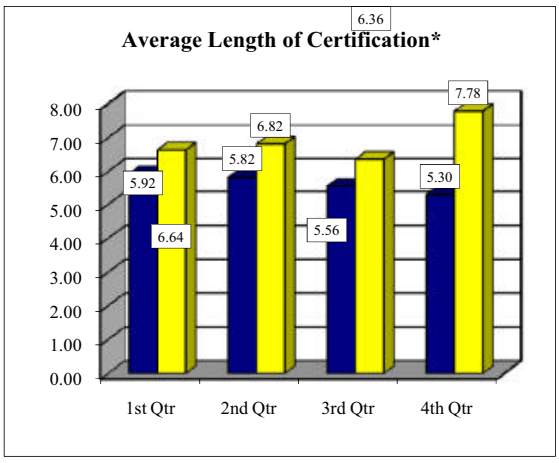
Managed Mental Health and Substance Abuse Activity Report
January 1, 2011 - December 31, 2011

Acute Inpatient & Alternative Levels of Care Utilization
Psychiatric vs Substance Abuse

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Year to Date	
Avg Covered Lives	188,149		190,689		195,812		193,956		192,152	
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	332	357	323	320	307	351	213	158	1,175	1,186
Days*	1,967	2,370	1,881	2,181	1,707	2,234	1,128	1,230	6,683	8,015
Admissions/1000 Lives	7.06	7.59	6.78	6.71	6.27	7.17	4.39	3.26	6.11	6.17
Days/1000 Lives*	41.82	50.39	39.46	45.75	34.87	45.64	23.26	25.37	34.78	41.71
Avg Length of Certification*	5.92	6.64	5.82	6.82	5.56	6.36	5.30	7.78	5.69	6.76







Alternative Modality Ratios have been applied.

**All data has been annualized.*

Report # 2001.1.01

Managed Mental Health and Substance Abuse Activity Report
January 1, 2011 - December 31, 2011

Total Acute Inpatient and Alternative Levels of Care Detail

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Year to Date	
AVG COVERED LIVES	**188,149**		**190,689**		**195,812**		**193,956**		**192,152**	
	1st Quarter		**2nd Quarter**		**3rd Quarter**		**4th Quarter**		**Year to Date**	
	Psych	**Sub**	**Psych**	**Sub**	**Psych**	**Sub**	**Psych**	**Sub**	**Psych**	**Sub**
ACUTE INPATIENT										
Admissions	208	90	190	82	200	85	207	134	598	256
Days	1,475	1,005	1,294	986	1,257	944	1,342	1,383	4,026	2,844
Admissions/1,000 Lives	4.42	1.91	3.99	1.72	4.09	1.74	4.27	2.76	3.11	1.33
Days/1,000 Lives	31.36	21.37	27.14	20.68	25.68	19.28	27.68	28.52	20.95	14.80
Avg Length of Certification	7.09	11.17	6.81	12.02	6.29	11.11	6.48	10.32	6.73	11.11
DETOX										
Admissions	0	135	0	107	0	109	0	185	0	351
Days*	0	505	0	409	0	378	0	711	0	1,361
Admissions/1,000 Lives	0.00	2.87	0.00	2.24	0.00	2.23	0.00	3.82	0.00	1.83
Days/1,000 Lives*	0.00	10.74	0.00	8.58	0.00	7.72	0.00	14.66	0.00	7.08
Avg Length of Certification	0.00	3.74	0.00	3.82	0.00	3.47	0.00	3.84	0.00	3.88
RESIDENTIAL TREATMENT PROGRAM										
Admissions	3	18	4	24	3	23	5	19	15	84
Days*	27	123	82	187	27	163	35	193	136	666
Admissions/1,000 Lives	0.06	0.38	0.08	0.50	0.06	0.47	0.10	0.39	0.08	0.44
Days/1,000 Lives*	0.57	2.61	1.72	3.92	0.55	3.33	0.72	3.98	0.71	3.47
Avg Length of Certification	9.00	6.83	20.50	7.79	9.00	7.09	7.00	10.16	9.07	7.93
PARTIAL HOSPITAL PROGRAM										
Admissions	69	46	79	39	61	45	77	34	286	164
Days*	349	282	371	220	305	278	361	211	1,024	991
Admissions/1,000 Lives	1.47	0.98	1.66	0.82	1.25	0.92	1.59	0.70	1.49	0.85
Days/1,000 Lives*	7.42	6.00	7.78	4.61	6.23	5.68	7.44	4.35	5.33	5.16
Avg Length of Certification	5.06	6.13	4.70	5.64	5.00	6.18	4.69	6.21	3.58	6.04
IOP										
Admissions	51	58	49	59	41	76	29	40	170	233
Days	115	205	131	177	106	265	81	112	352	647
Admissions/1,000 Lives	1.08	1.23	1.03	1.24	0.84	1.55	0.60	0.82	0.88	1.21
Days/1,000 Lives*	2.44	4.36	2.75	3.71	2.17	5.41	1.67	2.31	1.83	3.37
Avg Length of Certification	2.25	3.53	2.67	3.00	2.59	3.49	2.79	2.80	2.07	2.78
HALFWAY HOUSE										
Admissions	0	10	0	8	0	13	0	5	0	36
Days	0	249	0	199	0	227	0	114	0	674
Admissions/1,000 Lives	0.00	0.21	0.00	0.17	0.00	0.27	0.00	0.10	0.00	0.19
Days/1,000 Lives*	0.00	5.29	0.00	4.17	0.00	4.64	0.00	2.35	0.00	3.51
Avg Length of Certification	0.00	24.90	0.00	24.88	0.00	17.46	0.00	22.80	0.00	18.72

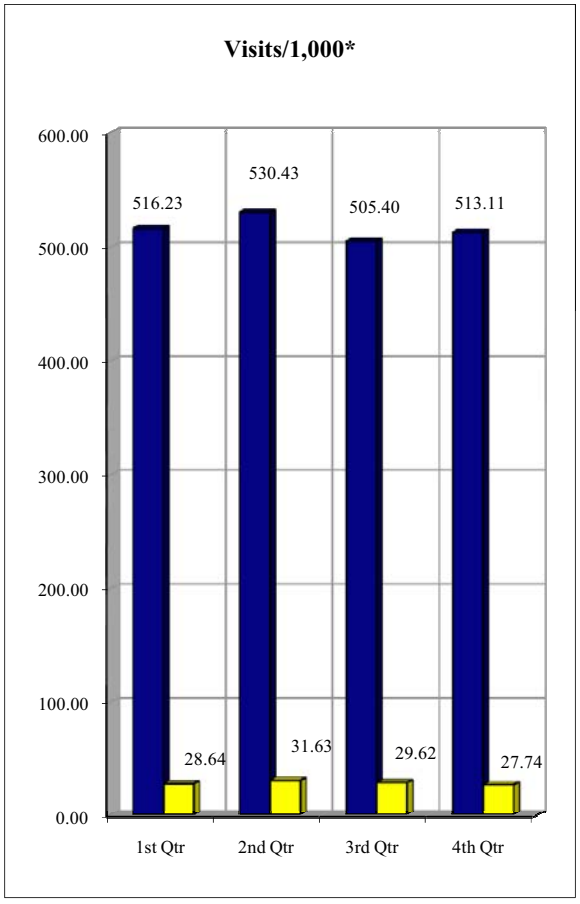
**Alternative Modality Ratios applied*

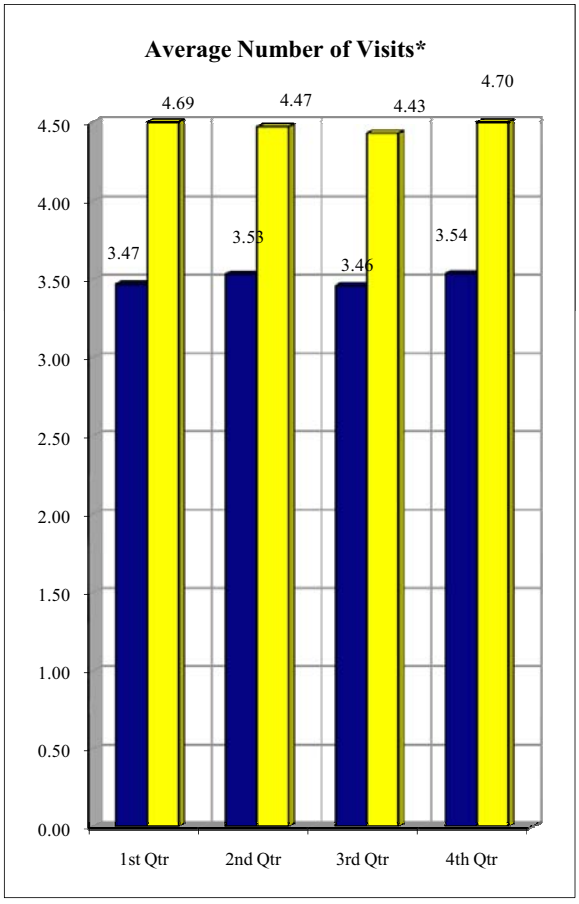
48561 Alpha Drive, Suite 150
Wixom, MI 48393

Managed Mental Health and Substance Abuse Activity Report
Service Dates: January 1, 2011 -December 31, 2011
Paid Through s: March 31, 2012

Total Outpatient Utilization by Psychiatric/Substance Abuse (Claims)

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Year to Date	
Avg Covered Lives	188,149		190,689		195,812		193,956		192,152	
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Visits*	24,282	1,347	25,287	1,508	24,741	1,450	24,880	1,345	99,190	5,650
Unique Members Seen	7,003	287	7,155	337	7,151	327	7,035	286	12,218	732
Visits/1,000 Lives*	516.23	28.64	530.43	31.63	505.40	29.62	513.11	27.74	516.21	29.40
Avg Number of Visits*	3.47	4.69	3.53	4.47	3.46	4.43	3.54	4.70	8.12	7.72





Alternative Modality Ratios have been applied.

Report # 2016.2.1

Managed Mental Health and Substance Abuse Activity R
Service Dates: January 1, 2011 -December 31,
Paid Through s: March 31,

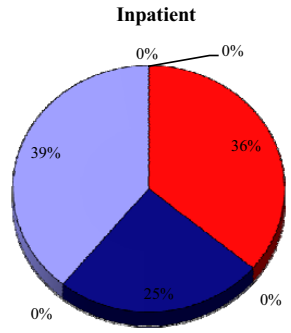
Penetration Rate by Beneficiary Type (Claims)
Inpatient vs Outpatient

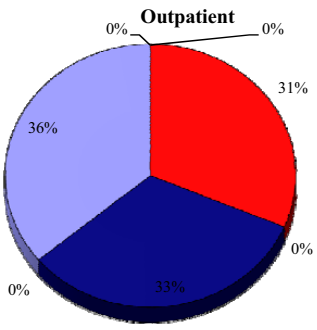
Inpatient

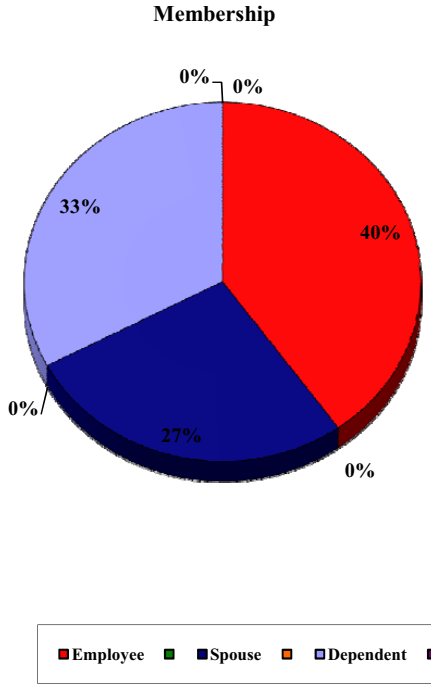
	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	548	254	484	1,286
Membership	76,910	52,035	62,761	192,152
Penetration Rate	0.71%	0.49%	0.77%	0.67%

Outpatient

	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	4,813	3,380	4,513	12,706
Membership	76,910	52,035	62,761	192,152
Penetration Rate	6.26%	6.50%	7.19%	6.61%







Report # 20.

Penetration Rate by Age Category (Claims)
Inpatient vs Outpatient

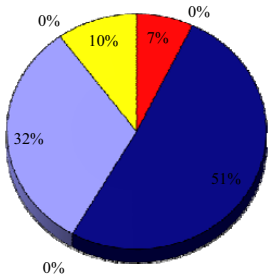
Inpatient

	0-12	13-17	18 - 64	65+	Total
Unduplicated Members Accessing Care	38	184	1,064	5	1,286
Membership	23,962	16,042	149,479	2,223	192,152
Penetration Rate	0.16%	1.15%	0.71%	0.22%	0.67%

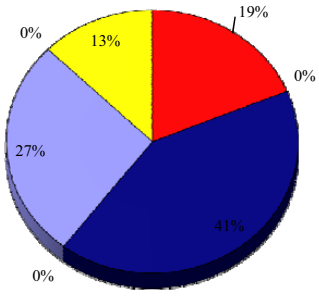
Outpatient

	0-12	13-17	18 - 64	65+	Total
Unduplicated Members Accessing Care	1,102	1,638	9,897	69	12,706
Membership	23,962	16,042	149,479	2,223	192,152
Penetration Rate	4.60%	10.21%	6.62%	3.10%	6.61%

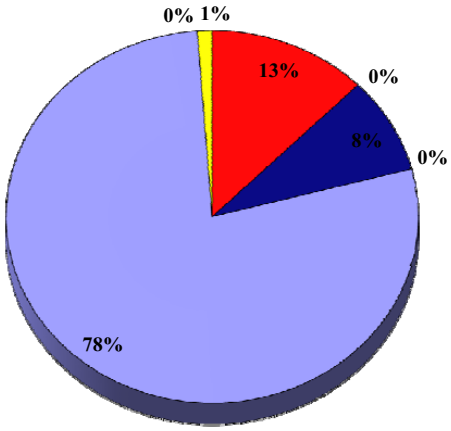
Inpatient



Outpatient



Membership



Managed Mental Health and Substance Abuse Activity Report
Service Dates: January 1, 2011 -December 31, 2011
Paid Through s: March 31, 2012

Paid Claims Analysis -In-Network versus Out-of-Network

In-Network

Level of Care	Psych Units	Psych Paid $'s	Substance Abuse Units	Substance Abuse Paid $'s	Total Units	Total Paid $'s	Average Cost per Unit	PEPM	PMPM
Inpatient	4,836	$4,043,083	4,653	$2,485,759	9,489	$6,528,842	$688.04	$7.07	$2.83
Residential	36	$15,519	1,666	$350,757	1,702	$366,276	$215.20	$0.40	$0.16
Partial Hospitalization	2,200	$782,057	1,725	$499,797	3,925	$1,281,854	$326.59	$1.39	$0.56
Intensive Outpatient	2,293	$457,699	2,930	$453,725	5,223	$911,424	$174.50	$0.99	$0.40
Outpatient	85,328	$4,769,218	5,196	$281,690	90,524	$5,050,908	$55.80	$5.47	$2.19
Sub Total	94,693	$10,067,576	16,170	$4,071,728	110,863	$14,139,304		$15.32	$6.13

Out-of-Network

Level of Care	Psych Units	Psych Paid $'s	Substance Abuse Units	Substance Abuse Paid $'s	Total Units	Total Paid $'s	Average Cost per Unit	PEPM	PMPM
Inpatient	282	$187,063	53	$41,182	335	$228,245	$681.33	$0.25	$0.10
Residential	0	$0	38	$16,230	38	$16,230	$0.00	$0.02	$0.01
Partial Hospitalization	38	$9,869	16	$5,325	54	$15,194	$281.37	$0.02	$0.01
Intensive Outpatient	0	$0	165	$24,638	165	$24,638	$0.00	$0.03	$0.01
Outpatient	13,847	$614,725	452	$20,094	14,299	$634,819	$44.40	$0.69	$0.28
Sub Total	14,167	$811,657	724	$107,469	14,891	$919,126		$1.00	$0.40

Total

Level of Care	Psych Units	Psych Paid $'s	Substance Abuse Units	Substance Abuse Paid $'s	Total Units	Total Paid $'s	Average Cost per Unit	PEPM	PMPM
Inpatient	5,118	$4,230,146	4,706	$2,526,941	9,824	$6,757,087	$687.81	$7.32	$2.93
Residential	36	$15,519	1,704	$366,987	1,740	$382,506	$219.83	$0.41	$0.17
Partial Hospitalization	2,238	$791,926	1,741	$505,122	3,979	$1,297,048	$325.97	$1.41	$0.56
Intensive Outpatient	2,293	$457,699	3,095	$478,363	5,388	$936,062	$173.73	$1.01	$0.41
Outpatient	99,175	$5,383,943	5,648	$301,784	104,823	$5,685,727	$54.24	$6.16	$2.47
Grand Total	108,860	$10,879,233	16,894	$4,179,197	125,754	$15,058,430		$16.32	$6.53

**In-Network Claims include OOPA*

Report # 2017.2.01

Managed Mental Health and Substance Abuse Activity Report

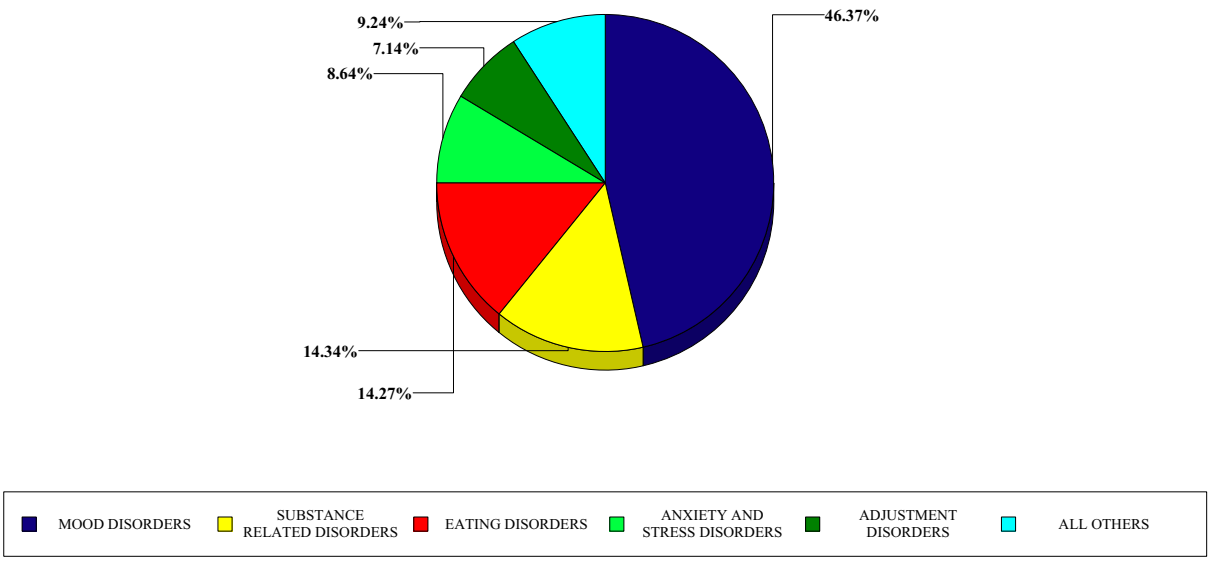
Service Dates: **January 1, 2011 - December 31, 2011**

Paid Through: **March 31, 2012**

Total Paid Distribution by Major Diagnosis Category

Rank	Diagnosis Category	Total Paid	% of Total Paid	Book of Business
1	MOOD DISORDERS	$6,689,296.64	44.42%	47.48%
2	SUBSTANCE RELATED DISORDERS	$4,178,776.27	27.75%	19.53%
3	ADJUSTMENT DISORDERS	$1,178,443.25	7.83%	10.35%
4	ANXIETY AND STRESS DISORDERS	$1,003,695.04	6.67%	8.74%
5	EATING DISORDERS	$891,991.28	5.92%	3.31%
6	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	$549,062.97	3.65%	4.36%
7	DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE	$442,603.59	2.94%	4.49%
8	OTHER MENTAL DISORDERS	$40,133.00	0.27%	0.75%
9	MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED	$28,519.04	0.19%	0.30%
10	DISSOCIATIVE, SOMATOFORM AND FACTITIOUS DISORDERS	$25,517.11	0.17%	0.19%
11	DELIRIUM, DEMENTIA, AMNESTIC AND OTHER COGNITIVE DISORDERS	$16,190.59	0.11%	0.28%
12	PERSONALITY DISORDERS	$13,780.76	0.09%	0.10%
13	OTHER CONDITIONS THAT MAY BE THE FOCUS OF CLINICAL ATTENTION	$421.00	0.00%	0.11%
	Total for All Diagnosis Categories	**$15,058,430.54**	**100.00%**	**100.00%**

Top Five Diagnosis Categories



Managed Mental Health and Substance Abuse Activity Report

Service Dates: January 1, 2011 - December 31, 2011
Paid Through: March 31, 2012

Paid Claim Analysis - Gender/Dependency

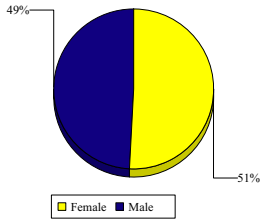
Males

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$368,889	$368,889
13 - 17	$0	$0	$891,904	$891,904
18 - 64	$4,158,368	$362,927	$1,602,479	$6,123,775
65+	$30,249	$2,931	$0	$33,180
Total	**$4,188,617**	**$365,858**	**$2,863,272**	**$7,417,747**

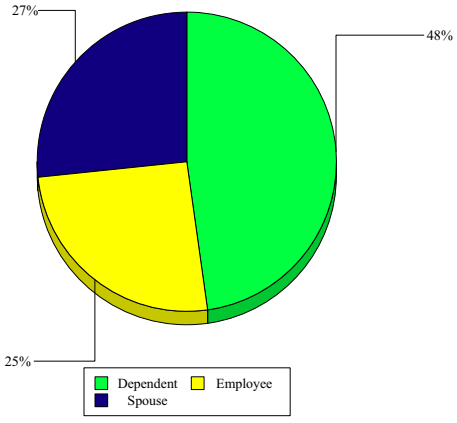
Females

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$290,389	$290,389
13 - 17	$0	$0	$1,071,005	$1,071,005
18 - 64	$1,633,523	$2,793,886	$1,837,626	$6,265,034
65+	$1,739	$11,915	$600	$14,255
Total	**$1,635,263**	**$2,805,801**	**$3,199,620**	**$7,640,683**

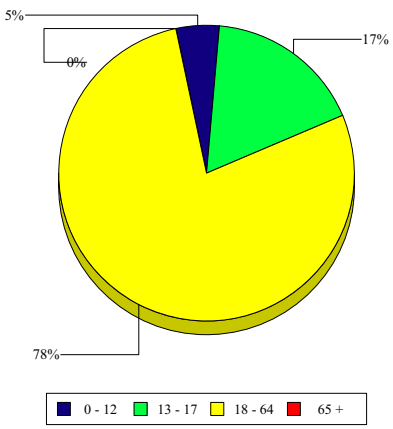
Total Paid % by Gender



Total Paid % by Dependency



Total Paid % by Age Band



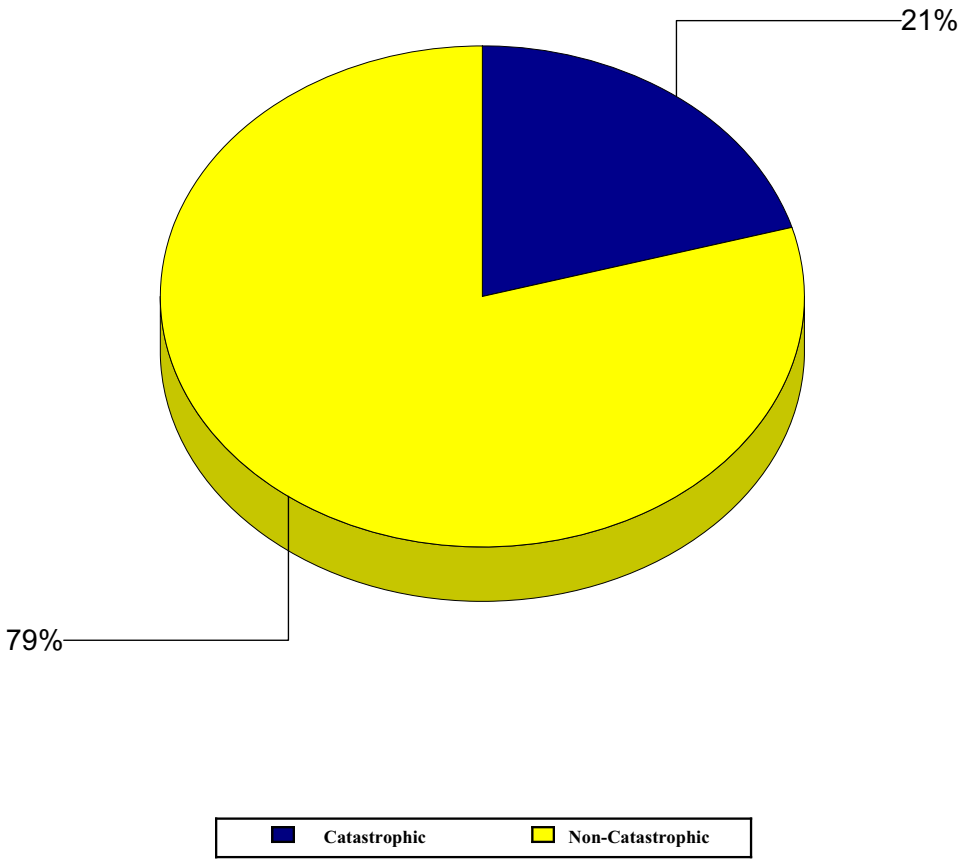
Managed Mental Health and Substance Abuse Activity Report

Service Dates: **January 1, 2011 - December 31, 2011**
Paid Through: **March 31, 2012**

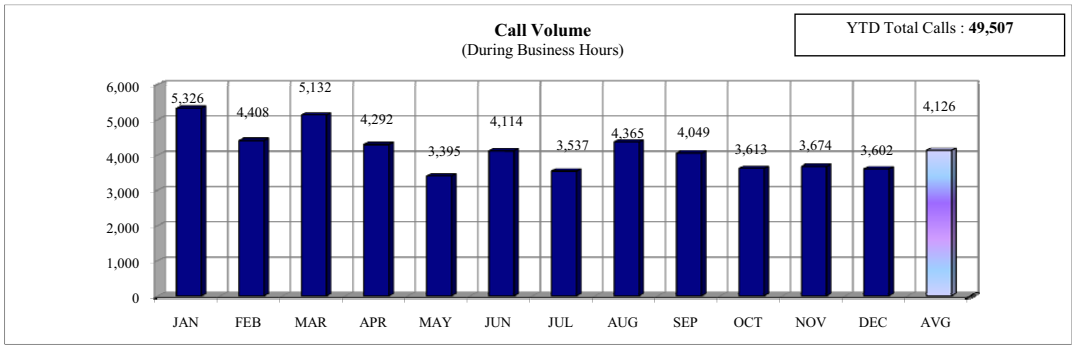
Catastrophic Cases Greater than $20,000

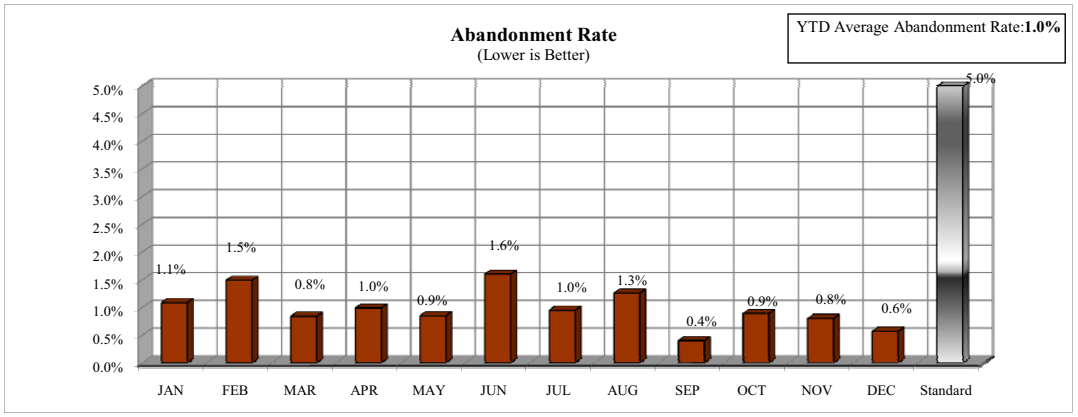
	# of Unduplicated Members	Total Claim Amount	Total Allowed Amount	Total Paid Amount	% of Total
Catastrophic Cases	86	$5,577,753	$3,284,182	$3,098,876	20.58%
Non-Catastrophic Cases	12,828	$27,215,659	$13,766,692	$11,959,554	79.42%
Total	**12,914**	**$32,793,412**	**$17,050,873**	**$15,058,431**	**100.00%**

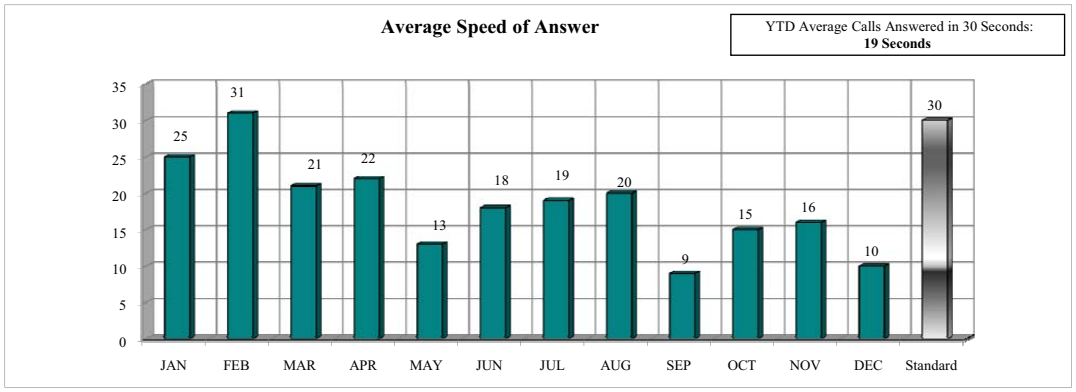
Catastrophic Cases



Telephone Performance







Annual Report of Claims and Credits Paid by Agency

NYS MENTAL HEALTH/SUBSTANCE ABUSE ANNUAL REPORT IVG
CLAIMS PAID BY AGENCY

YEARPD	YEARINC	NETWORK	AGNCYCD	EEDEP	EE Type	CLAIMS	AMTPD	CARRIER
0000	0000	I	00000	E	A	0	$0.00	C-MHSA
0000	0000	O	00000	E	R	0	$0.00	C-MHSA
0000	0000	I	00000	E	O	0	$0.00	C-MHSA

Quarterly Financial Summary Reports

EXPERIENCE OF CURRENT QUARTER AND YEAR TO DATE

Quarterly Report
Projection Based on Claims Paid through _____

IN (000'S)

	CORE			NY ENHANCEMENT			PA ENHANCEMENT			COMBINED		
	Estimated YTD Prior Qtrly Rpt	Estimated Experience Current Qtr	Estimated YTD Experience	Estimated YTD Prior Qtrly Rpt	Estimated Experience Current Qtr	Estimated YTD Experience	Estimated YTD Prior Qtrly Rpt	Estimated Experience Current Qtr	Estimated YTD Experience	Estimated YTD Prior Qtrly Rpt	Estimated Experience Current Qtr	Estimated YTD Experience
1. Earned Premium (2 tier) *	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**
2a. Paid Claims	X	X	X	X	X	X	X	X	X	X	X	X
2b. Paid Bad Debt & Charity **	X	X	X	X	X	X	X	X	X	X	X	X
2c. Liability of Outstanding Claims at End of Reporting Period	X	X	X	X	X	X	X	X	X	X	X	X
2d. Liability of Outstanding Claims at Beginning of Reporting Period	X	X	X	X	X	X	X	X	X	X	X	X
2e. Total Incurred Claim Cost (2a+2b+2c-2d)	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Estimated 2002 Unit Cost Guarantee Credit	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**
Net Incurred Claim Cost	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
3a. Administrative Expense	X	X	X	X	X	X	X	X	X	X	X	X
3b. Other Retention	X	X	X	X	X	X	X	X	X	X	X	X
3c. Interest Charge/(credit)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
3d. Total Retention (3a+3b+3c)	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
3e. 2003 Performance Penalty	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
3f. Net Retention (3d-3e)	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
4. Experience Gain/(Loss) (1-2e-3F)	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
5a. 5-Tier Premium	X	X	X	X	X	X	X	X	X	X	X	X
5b. 2-Tier Premium	X	X	X	X	X	X	X	X	X	X	X	X
5c. Adjustment to Experience Gain/(Loss) (5a-5b)	X	X	X	X	X	X	X	X	X	X	X	X
6. Net Receivable/(Payable)	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**

* Includes Graduate Student Employee Union (GSEU): Current Quarter $X; YTD $X

RECONCILIATION OF EXPERIENCE PROJECTIONS FOR PRIOR YEAR
IN (000'S)

	CORE		NY ENHANCEMENT		PA ENHANCEMENT		COMBINED	
	Renewal	Financial	Renewal	Financial	Renewal	Financial	Renewal	Financial
1. Earned Premium	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**
2a. Paid Claims	X	X	X	X	X	X	X	X
2b. Paid Bad Debt & Charity	X	X	X	X	X	X	X	X
2c. Liability of Outstanding Claims at End of Reporting Period	X	X	X	X	X	X	X	X
2d. Liability of Outstanding Claims at Beginning of Reporting Period	X	X	X	X	X	X	X	X
2e. Total Incurred Claim Cost (2a+2b+2c-2d)	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
2f. 2001 Unit Cost Guarantee Credit	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**
2g. Net Incurred Claim Cost (2e+2f)	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
3a. Administrative Expense	X	X	X	X	X	X	X	X
3b. Other Retention	X	X	X	X	X	X	X	X
3c. Interest Charge/(credit)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
3d. Total Retention (3a+3b+3c)	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
3e. 2002 Performance Penalty	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
3f. Net Retention (3d - 3e)	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
4. Experience Gain/(Loss) (1-2e-3f)	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**	**$X**
2c. 1st Quarter Ending Outstanding Claims	N/A	X	N/A	X	N/A	X	N/A	X
4. Experience Gain/(Loss)		X		X		X		X
2c. 2nd Quarter Ending Outstanding Claims	N/A	X	N/A	X	N/A	X	N/A	X
4. Experience Gain/(Loss)		X		X		X		X
2c. 3rd Quarter Ending Outstanding Claims	N/A	X	N/A	X	N/A	X	N/A	X
4. Experience Gain/(Loss)		X		X		X		X
2c. 4th Quarter Ending Outstanding Claims	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4. Experience Gain/(Loss)		N/A		N/A		N/A		N/A

CURRENT YEAR PROJECTED EXPERIENCE

Quarterly Report
Projection Based on Claims Paid through _____

IN (000'S)

COMBINED

	Projected at Renewal	1st Q Report	2nd Q Report	3rd Q Report	4th Q Report
1. Earned Premium (2 tier) *	**$X**	**$X**	**$X**	**$X**	**$X**
2a. Paid Claims	X	X	X	X	X
2b. Paid Bad Debt & Charity	X	X	X	X	X
2c. Liability of Outstanding Claims at End of Reporting Period	X	X	X	X	X
2d. Liability of Outstanding Claims at Beginning of Reporting Period	X	X	X	X	X
2e. Total Incurred Claim Cost (2a+2b+2c-2d)	**X**	**X**	**X**	**X**	**X**
Estimated 2002 Unit Cost Guarantee Credit	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**
Net Incurred Claim Cost	**X**	**X**	**X**	**X**	**X**
3a. Administrative Expense	X	X	X	X	X
3b. Other Retention	X	X	X	X	X
3c. Interest Charge/(credit)	(X)	(X)	(X)	(X)	(X)
3d. Total Retention (3a+3b+3c)	**X**	**X**	**X**	**X**	**X**
3e. 2003 Performance Penalty					
3f. Net Retention (3d-3e)					
4a. Experience Gain/(Loss) (1-2e-3f)	**X**	**X**	**X**	**X**	**X**
4b. Prior Period Experience Gain/(Loss)	**X**	**X**	**X**	**X**	**X**
4c. Net Experience Gain/(Loss) (4a-4b)	**X**	**X**	**X**	**X**	**X**
5a. 5-Tier Premium	X	X	X	X	X
5b. 2-Tier Premium	X	X	X	X	X
5c. Adjustment to Experience Gain/(Loss) (5a-5b)	X	X	X	X	X
6. Net Receivable/(Payable)	**$X**	**$X**	**$X**	**$X**	**$X**

CORE

	Projected at Renewal	1st Q Report	2nd Q Report	3rd Q Report	4th Q Report
1. Earned Premium (2 tier)	**$X**	**$X**	**$X**	**$X**	**$X**
2a. Paid Claims	X	X	X	X	X
2b. Paid Bad Debt & Charity	X	X	X	X	X
2c. Liability of Outstanding Claims at End of Reporting Period	X	X	X	X	X
2d. Liability of Outstanding Claims at Beginning of Reporting Period	X	X	X	X	X
2e. Total Incurred Claim Cost (2a+2b+2c-2d)	**X**	**X**	**X**	**X**	**X**
Estimated 2002 Unit Cost Guarantee Credit	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**
Net Incurred Claim Cost	**X**	**X**	**X**	**X**	**X**
3a. Administrative Expense	X	X	X	X	X
3b. Other Retention	X	X	X	X	X
3c. Interest Charge/(credit)	(X)	(X)	(X)	(X)	(X)
3d. Total Retention (3a+3b+3c)	**X**	**X**	**X**	**X**	**X**
3e. 2003 Performance Penalty					
3f. Net Retention (3d-3e)					
4a. Experience Gain/(Loss) (1-2e-3f)	**X**	**X**	**X**	**X**	**X**
4b. Prior Period Experience Gain/(Loss)	**X**	**X**	**X**	**X**	**X**
4c. Net Experience Gain/(Loss) (4a-4b)	**X**	**X**	**X**	**X**	**X**
5a. 5-Tier Premium	X	X	X	X	X
5b. 2-Tier Premium	X	X	X	X	X
5c. Adjustment to Experience Gain/(Loss) (5a-5b)	X	X	X	X	X
6. Net Receivable/(Payable)	**$X**	**$X**	**$X**	**$X**	**$X**

*** Based on annual average contracts of X; includes Graduate Student Employee Union Earned Premium $X**

CURRENT YEAR PROJECTED EXPERIENCE

Quarterly Report
Projection Based on Claims Paid through _____

IN (000'S)

NY ENHANCEMENT

	Projected at Renewal	1st Q Report	2nd Q Report	3rd Q Report	4th Q Report
1. Earned Premium (2 tier)	**$X**	**$X**	**$X**	**$X**	**$X**
2a. Paid Claims	X	X	X	X	X
2b. Paid Bad Debt & Charity	X	X	X	X	X
2c. Liability of Outstanding Claims at End of Reporting Period	X	X	X	X	X
2d. Liability of Outstanding Claims at Beginning of Reporting Period	X	X	X	X	X
2e. Total Incurred Claim Cost (2a+2b+2c-2d)	**X**	**X**	**X**	**X**	**X**
Estimated 2002 Unit Cost Guarantee Credit	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**
Net Incurred Claim Cost	**X**	**X**	**X**	**X**	**X**
3a. Administrative Expense	X	X	X	X	X
3b. Other Retention	X	X	X	X	X
3c. Interest Charge/(credit)	(X)	(X)	(X)	(X)	(X)
3d. Total Retention (3a+3b+3c)	**X**	**X**	**X**	**X**	**X**
3e. 2003 Performance Penalty					
3f. Net Retention (3d-3e)					
4a. Experience Gain/(Loss) (1-2e-3f)	**X**	**X**	**X**	**X**	**X**
4b. Prior Period Experience Gain/(Loss)	**X**	**X**	**X**	**X**	**X**
4c. Net Experience Gain/(Loss) (4a-4b)	**X**	**X**	**X**	**X**	**X**
5a. 5-Tier Premium	X	X	X	X	X
5b. 2-Tier Premium	X	X	X	X	X
5c. Adjustment to Experience Gain/(Loss) (5a-5b)	X	X	X	X	X
6. Net Receivable/(Payable)	**$X**	**$X**	**$X**	**$X**	**$X**

PA ENHANCEMENT

	Projected at Renewal	1st Q Report	2nd Q Report	3rd Q Report	4th Q Report
1. Earned Premium (2 tier)	**$X**	**$X**	**$X**	**$X**	**$X**
2a. Paid Claims	X	X	X	X	X
2b. Paid Bad Debt & Charity	X	X	X	X	X
2c. Liability of Outstanding Claims at End of Reporting Period	X	X	X	X	X
2d. Liability of Outstanding Claims at Beginning of Reporting Period	X	X	X	X	X
2e. Total Incurred Claim Cost (2a+2b+2c-2d)	**X**	**X**	**X**	**X**	**X**
Estimated 2002 Unit Cost Guarantee Credit	**(X)**	**(X)**	**(X)**	**(X)**	**(X)**
Net Incurred Claim Cost	**X**	**X**	**X**	**X**	**X**
3a. Administrative Expense	X	X	X	X	X
3b. Other Retention	X	X	X	X	X
3c. Interest Charge/(credit)	(X)	(X)	(X)	(X)	(X)
3d. Total Retention (3a+3b+3c)	**X**	**X**	**X**	**X**	**X**
3e. 2003 Performance Penalty					
3f. Net Retention (3d-3e)					
4a. Experience Gain/(Loss) (1-2e-3f)	**X**	**X**	**X**	**X**	**X**
4b. Prior Period Experience Gain/(Loss)	**X**	**X**	**X**	**X**	**X**
4c. Net Experience Gain/(Loss) (4a-4b)	**X**	**X**	**X**	**X**	**X**
5a. 5-Tier Premium	X	X	X	X	X
5b. 2-Tier Premium	X	X	X	X	X
5c. Adjustment to Experience Gain/(Loss) (5a-5b)	X	X	X	X	X
6. Net Receivable/(Payable)	**$X**	**$X**	**$X**	**$X**	**$X**

PROJECTED COMPONENTS OF DIVIDEND/(LOSS) FOR THE 2003 CONTRACT YEAR IN (000'S)

	1st Quarter Report	2nd Quarter Report	3rd Quarter Report	4th Quarter Report
Projected 2003 Renewal Dividend (Margin)	$X	$X	$X	$X
Change in 2003 Premium Base	X	X	X	X
Change in 2002 Claim Base	(X)	(X)	(X)	(X)
2002 Unit Cost Guarantee Credit	(X)	(X)	(X)	(X)
Change in 2003 Expected Trend	(X)	(X)	(X)	(X)
Retention	(X)	(X)	(X)	(X)
Performance Penalty	X	X	X	X
Total Projected Dividend/(Loss):	X	X	X	X

CLAIM RESERVE
IN (000'S)

A. Reserve and Paid Claims Reconciliation

	Total Projected Incurred Claims	Claims Paid Through 12/31/01	Claims Paid Through 12/31/02	Claims Paid Through 12/31/03	Outstanding Reserve at 12/31/03 (b)
2001	$X	$X	$X	$X	$X
2002	$X	$X	$X	$X	$X
2003	$X	$X	$X	$X	$X
TOTAL	$X (a)	$X	$X (a) & (c)	$X	$X

(a) Ties to paid claims on IA before application of credits.

Gross Claims/Payments	$X
Less: Claims Credits	$X
Net Paid Claims	$X

(b) Ties to open and unreported reserve calculation.
(c) Incurred claims and paid claims are reported before credits.

	Total Projected Incurred BD&C	BD&C Paid Through 12/31/00	BD&C Paid Through 12/31/01	BD&C Paid Through 12/31/02	Outstanding Reserve at 12/31/02 (b)
2001	$X	$X	$X	$X	$X
2002	$X	$X	$X	$X	$X
2003	$X	$X	$X	$X	$X
TOTAL	$X	$X	$X	$X	$X

B. Projection of 12/31/03 Open & Unreported Reserve

I.	Incurred But Unpaid Claims @ 12/31/03	$X
	Incurred But Unpaid Bad Debt & Charity	X
	Total Incurred But Unpaid Claim Cost	$X
II.	Administrative Component (4.4%)	X
	Disabled Lives Reserve	X
III.	Margin (3.09%)	X
IV.	Total Open & Unreported Reserve	$X

TRIANGLE REPORT (Incurred Claim Projection)

Triangle Report by Year of Incurral - In-Network
Excluding Graduate Student Employee Union (GSEU)
Claims Paid to Date as of _____

EXCLUDING SURCHARGE

MONTH PAID	MONTH INCURRED											
	Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03	Oct-03	Nov-03	Dec-03
Jan-03	0	0	0	0	0	0	0	0	0	0	0	0
Feb-03	0	0	0	0	0	0	0	0	0	0	0	0
Mar-03	0	0	0	0	0	0	0	0	0	0	0	0
Apr-03	0	0	0	0	0	0	0	0	0	0	0	0
May-03	0	0	0	0	0	0	0	0	0	0	0	0
Jun-03	0	0	0	0	0	0	0	0	0	0	0	0
Jul-03	0	0	0	0	0	0	0	0	0	0	0	0
Aug-03	0	0	0	0	0	0	0	0	0	0	0	0
Sep-03	0	0	0	0	0	0	0	0	0	0	0	0
Oct-03	0	0	0	0	0	0	0	0	0	0	0	0
Nov-03	0	0	0	0	0	0	0	0	0	0	0	0
Dec-03	0	0	0	0	0	0	0	0	0	0	0	0
Total	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Completion Factor	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000			
In-Network Incurred	$0	$0	$0	$0	$0	$0	$0	$0	$0			
In-Network Incurred thru __/__	$0											
Completion Factor	0.0000											
In-Network Incurred	$0											

DEVELOPMENT OF 2004 EXPERIENCE AND RATES
IN (000's)

A. EXPERIENCE PROJECTION

		2003 Claims Inc *	2003 Trend**	2004 Claims Inc	Margin	HCRA	Expenses	Gain/ (Loss) Adj.	2004 Required Premium	2003 Annual Premium	2004 Renewal Action (%)
CORE	ee	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
	dep	X	1.0000	X	X	X	X	X	X	X	0.00%
	total	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
NY ENH	ee	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
	dep	X	1.0000	X	X	X	X	X	X	X	0.00%
	total	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
PA ENH	ee	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
	dep	X	1.0000	X	X	X	X	X	X	X	0.00%
	total	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
GSEU	ee	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
	dep	X	1.0000	X	X	X	X	X	X	X	0.00%
	total	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
C & E & GSEU	ee	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%
	dep	X	1.0000	X	X	X	X	X	X	X	0.00%
	total	$X	1.0000	$X	$X	$X	$X	$X	$X	$X	0.00%

B. RATE RECOMMENDATION

	CORE			NY ENHANCEMENT			PA ENHANCEMENT			GRADUATE STUDENT EMPLOYEE UNION		
	EE	DEP	FAM	EE	DEP	FAM	EE	DEP	FAM	EE	DEP	FAM
2003 Rates:	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Projected 2004 Rates:												
Optimistic (-5%)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Realistic	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Pessimistic (+5%)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

* Employee and Dependent Claim Allocation Split Ratios from Section V-2

** Based on Current Trend Factor

Incurred Claims Development
(Excluding Surcharge)
Excluding Graduate Student Employee Union (GSEU)

Incurred Month	(A) Incurred & Paid Claims [1]	(B) Completion Factor	(C) Incurred Claims	(D) Total Contracts	(E) Adjusted Total Contracts	(F: E/D) Contracts Adjustment	(G: C x F) Contract Adjusted Incurred Claims	(H) Benefit Adjustment	(I: G x H) Adjusted Incurred Claims	(J: I / E) Estimated Cost Per Contract
1/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
2/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
3/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
4/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
5/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
6/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
7/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
8/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
9/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
10/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
11/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
12/02	$X	0.0000	$X	X	X	1.0000	X	1.0000	$X	$0.00
1/02 - 12/02	$X		$X	X	X		X		$X	$0.00
1/03	$X	0.0000	$X	X	X	1.0000	$X	1.0000	$X	$0.00
2/03	$X	0.0000	$X	X	X	1.0000	$X	1.0000	$X	$0.00
3/03	$X	0.0000	$X	X	X	1.0000	$X	1.0000	$X	$0.00
4/03	$X	0.0000	$X	X	X	1.0000	$X	1.0000	$X	$0.00
5/03	$X	0.0000	$X	X	X	1.0000	$X	1.0000	$X	$0.00
6/03	$X	0.0000	$X	X	X	1.0000	$X	1.0000	$X	$0.00
7/03	$X	0.0000	$X	X	X	1.0000	$X	1.0000	$X	$0.00
8/03	$X	0.0000	$X	X	X	1.0000	$X	1.0000	$X	$0.00
9/03	$X	0.0000	$X	X	X	1.0000	$X	1.0000	$X	$0.00
10/03	$X	0.0000	$X	X	X	1.0000	$X	1.0000	$X	$0.00
11/03	$X	0.0000	$X	X	X	1.0000	$X	1.0000	$X	$0.00
12/03	$X	0.0000	$X	X	X	1.0000	$X	1.0000	$X	$0.00
1/03 - 12/03	X		X	X	X		X		X	$0.00

I. Employee and Dependent Claim Allocation

Split [2]	Incurred & Paid Claims	Ratio	Core Incurred & Paid Claims	Ratio	NY Enhanced Incurred & Paid Claims	Ratio	PA Enhanced Incurred & Paid Claims	Ratio
Ee	$X	0.0000	$X	0.0000	$X	0.0000	$X	0.0000
Dep	$X	0.0000	$X	0.0000	$X	0.0000	$X	0.0000
Total	$X	0.0000	$X	0.0000	$X	0.0000	$X	0.0000
Core/NY Enh/ PA Enh Ratio	0.0000		0.0000		0.0000		0.0000	

II. Core, NY Enhanced, PA Enhanced Incurred Claims Allocation

Split	2003 Adjusted Incurred Claims	Core Incurred Claims	NY Enhanced Incurred Claims	PA Enhanced Incurred Claims
Ee	$X	$X	$X	$X
Dep	$X	$X	$X	$X
Total	$X	$X	$X	$X

[1] Exhibit IV
[2] Actual employee and dependent claims split incurred 1/1/02-12/31/02 and paid through 12/31/03

TREND STATISTICS
(PROJECTED FOR THE YEAR END)
IN (000'S)

	In & Out of Network				In Network				Out of Network			
	Core	NY Enh	PA Enh	Total	Core	NY Enh	PA Enh	Total	Core	NY Enh	PA Enh	Total
2003												
# of Charges	N/A	N/A	N/A	X	N/A	N/A	N/A	X	N/A	N/A	N/A	X
$ Claims Incurred	N/A	N/A	N/A	$X	N/A	N/A	N/A	$X	N/A	N/A	N/A	$X
# of Contracts	N/A	N/A	N/A	X	N/A	N/A	N/A	X	N/A	N/A	N/A	X
Cost/Charge	N/A	N/A	N/A	$0.00	N/A	N/A	N/A	$0.00	N/A	N/A	N/A	$0.00
# Charges/1000 Contracts	N/A	N/A	N/A	X	N/A	N/A	N/A	X	N/A	N/A	N/A	X
Cost/Contract	N/A	N/A	N/A	$0.00	N/A	N/A	N/A	$0.00	N/A	N/A	N/A	$0.00
2002												
# of Charges	N/A	N/A	N/A	X	N/A	N/A	N/A	X	N/A	N/A	N/A	X
$ Claims Incurred	N/A	N/A	N/A	$X	N/A	N/A	N/A	$X	N/A	N/A	N/A	$X
# of Contracts	N/A	N/A	N/A	X	N/A	N/A	N/A	X	N/A	N/A	N/A	X
Cost/Charge	N/A	N/A	N/A	$0.00	N/A	N/A	N/A	$0.00	N/A	N/A	N/A	$0.00
# Charges/1000 Contracts	N/A	N/A	N/A	X	N/A	N/A	N/A	X	N/A	N/A	N/A	X
Cost/Contract	N/A	N/A	N/A	$0.00	N/A	N/A	N/A	$0.00	N/A	N/A	N/A	$0.00
2001												
# of Charges	N/A	N/A	N/A	X	N/A	N/A	N/A	X	N/A	N/A	N/A	X
$ Claims Incurred	N/A	N/A	N/A	$X	N/A	N/A	N/A	$X	N/A	N/A	N/A	$X
# of Contracts	N/A	N/A	N/A	X	N/A	N/A	N/A	X	N/A	N/A	N/A	X
Cost/Charge	N/A	N/A	N/A	$0.00	N/A	N/A	N/A	$0.00	N/A	N/A	N/A	$0.00
# Charges/1000 Contracts	N/A	N/A	N/A	X	N/A	N/A	N/A	X	N/A	N/A	N/A	X
Cost/Contract	N/A	N/A	N/A	$0.00	N/A	N/A	N/A	$0.00	N/A	N/A	N/A	$0.00
% Change 2003 over 2002												
Cost/Charge	N/A	N/A	N/A	0.00%	N/A	N/A	N/A	0.00%	N/A	N/A	N/A	0.00%
# Charges/1000 Contracts	N/A	N/A	N/A	0.00%	N/A	N/A	N/A	0.00%	N/A	N/A	N/A	0.00%
Cost/Contract	N/A	N/A	N/A	0.00%	N/A	N/A	N/A	0.00%	N/A	N/A	N/A	0.00%
% Change 2002 over 2001												
Cost/Charge	N/A	N/A	N/A	0.00%	N/A	N/A	N/A	0.00%	N/A	N/A	N/A	0.00%
# Charges/1000 Contracts	N/A	N/A	N/A	0.00%	N/A	N/A	N/A	0.00%	N/A	N/A	N/A	0.00%
Cost/Contract	N/A	N/A	N/A	0.00%	N/A	N/A	N/A	0.00%	N/A	N/A	N/A	0.00%

PROJECTED 2003 RETENTION
IN (000'S)

		Projected Charge	Method of Allocation (1)
Value Options Administrative Expenses		$X	Prorated by Premium
Other Retention			
Risk Charges	$X		Prorated by Premium
Taxes	$X		Prorated by Premium
Contribution to Statutory Reserves	$X		Prorated by Premium
NYSID Assessment	$X		Prorated by Premium
Community Contribution	$X		Prorated by Premium
Total Other Retention		$X	
Interest Charge/(Credit)		($X)	Prorated by Premium
Total Retention		$X	

Quarterly Performance Guarantee Report

EMPIRE PLAN
Managed Mental Health and Substance Abuse Activity Report
January 1, 2007 - September 30, 2007

	ValueOptions Performance Standards	Standard	QTR 3	YTD
	Provider Access			
1.a.	Urban - For enrollees residing in New York State, 95% must have an Inpatient/ALOC network facility within 5 miles.	95.00%	99.10%	99.20%
1.b.	Suburban - For enrollees residing in New York State, 95% must have an Inpatient/ALOC network facility within 15 miles.	95.00%	100.00%	100.00%
1.c.	Rural - For enrollees residing in New York State, 95% must have an Inpatient/ALOC network facility within 40 miles.	95.00%	100.00%	100.00%
2.a.	Urban - For enrollees residing in New York State, 95% must have a network individual or group practitioner within 3 miles.	95.00%	100.00%	100.00%
2.b.	Suburban - For enrollees residing in New York State, 95% must have a network individual or group practitioner within 15 miles.	95.00%	100.00%	100.00%
2.c.	Rural - For enrollees residing in New York State, 95% must have a network individual or group practitioner within 40 miles.	95.00%	100.00%	100.00%
3.a.	Urban - For enrollees residing outside of New York State, 95% must have an Inpatient/ALOC facility within 10 miles.	95.00%	99.70%	99.70%
3.b.	Suburban - For enrollees residing outside of New York State, 95% must have an Inpatient/ALOC within 20 miles.	95.00%	98.40%	98.60%
3.c.	Rural - For enrollees residing outside of New York State, 95% must have an Inpatient/ALOC facility within 40 miles.	95.00%	100.00%	100.00%
4.a.	Urban - For enrollees residing outside of New York State, 95% must have an individual or group practitioner within 10 miles.	95.00%	100.00%	100.00%
4.b.	Suburban - For enrollees residing outside of New York State, 95% must have an individual or group practitioner within 20 miles.	95.00%	100.00%	100.00%
4.c.	Rural - For enrollees residing outside of New York State, 95% must have an individual or group practitioner within 40 miles.	95.00%	100.00%	100.00%

EMPIRE PLAN
Managed Mental Health and Substance Abuse Activity Report
January 1, 2007 - September 30, 2007

	ValueOptions Performance Standards	Standard	QTR 3	YTD
	Network Operations			
1.	In 90% of non-emergency/non-urgent cases where a network provider is not available, a referral will be made to a non-network provider within 2 business days.	90.00%	100.00%	100.00%
2.	Within 60 days of receipt of completed provider application, provider will be notified of determination.*	100.00%	100.00%	100.00%
3.	In 100% of emergency cases, either a network provider or ValueOptions will contact the patient within 30 minutes.	100.00%	100.00%	100.00%
4.	In 99% of urgent cases, the patient will be contacted within 48 hours.	99.00%	100.00%	100.00%
5.	98% of all enrollee, dependent, and provider correspondence will be responded to within 5 business days.	98.00%	100.00%	100.00%
6.	98% of all non-emergency calls to CRL and Customer Service will be returned within 2 business days.	98.00%	100.00%	100.00%
7.	95% of Inpatient Level 1 appeals will be reviewed by a Peer Advisor and a decision made within 1 business day.	95.00%	100.00%	100.00%
8.	95% of Outpatient or ALOC Level 1 appeals will be reviewed by a Peer Advisor and a decision made within 2 business days.	95.00%	100.00%	100.00%
10.a.	90% of requests for inpatient authorization will be reviewed and completed within 24 hours of receipt and enrollee/provider notified within 1 business day 100% of cases.	90.00%	99.95%	99.99%
10.b.	90% of completed OTR's will be reviewed and provider notified of decision within 12 business days of receipt of OTR.	90.00%	100.00%	99.98%
11.a.	100% of Network claims without need for additional information will be paid within 18 business days.	100.0%	100.0%	100.0%
11.b.	100% of Non-Network claims without need of additional information will be paid within 18 calendar days.	100.0%	100.0%	100.0%
12.a.	Network composition guarantee for Psychiatrists will be maintained.**	90.00%		
12.b.	Network composition guarantee for Psychologists will be maintained.**	90.00%		
12.c.	Network composition guarantee for Other Providers will be maintained.**	90.00%		

** Data may be reported as a percentage; however, penalty is assessed on an occurrence basis. Should the standard fall below the guaranteed percentage, ValueOptions must also provide the number of occurrences.*

***These performance standards are measured on an average annual basis.*

Report # 2047.1.E1

EMPIRE PLAN
Managed Mental Health and Substance Abuse Activity Report
January 1, 2007 - September 30, 2007

	ValueOptions Performance Standards	Standard	QTR 3	YTD
	Customer Service & CRL			
1.	The toll-free telephone system shall be operational and available to callers 99.5% of the scheduled time.	99.50%	100.00%	100.00%
2.	90% of calls to the toll-free line will be answered within 30 seconds.	90.00%	92.22%	92.30%
3.	The telephone abandonment rate on the toll-free line to CRL and Customer Service will not exceed 3%.	<3%	0.31%	0.29%
4.	The telephone blockage rate will not exceed 0%.	0.00%	0.00%	0.00%

EMPIRE PLAN
Managed Mental Health and Substance Abuse Activity Report
January 1, 2007 - September 30, 2007

Performance Standards	Standard	QTR 3	YTD
100% of all possible enrollment data transmissions shall be processed within 24 hours of receipt.	100.00%	100.00%	100.00%
100% of management reports shall be mailed no later than the "mail date" or delivered by the agreed-upon date.	100.00%	100.00%	100.00%
99% financial accuracy rate for all clean claims processed and paid.*	99.00%		
97% non-financial coding accuracy rate for all clean claims processed and paid.*	97.00%		

* These performance standards are measured through an annual audit by Civil Service.

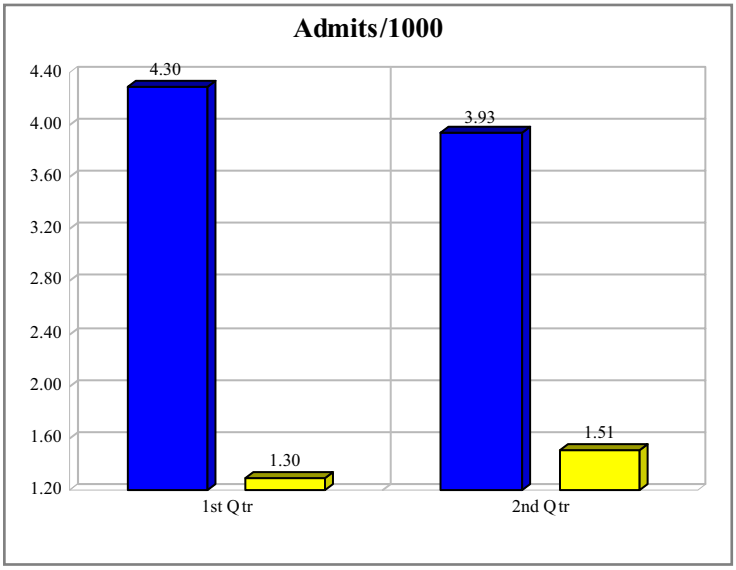
Quarterly Utilization Report

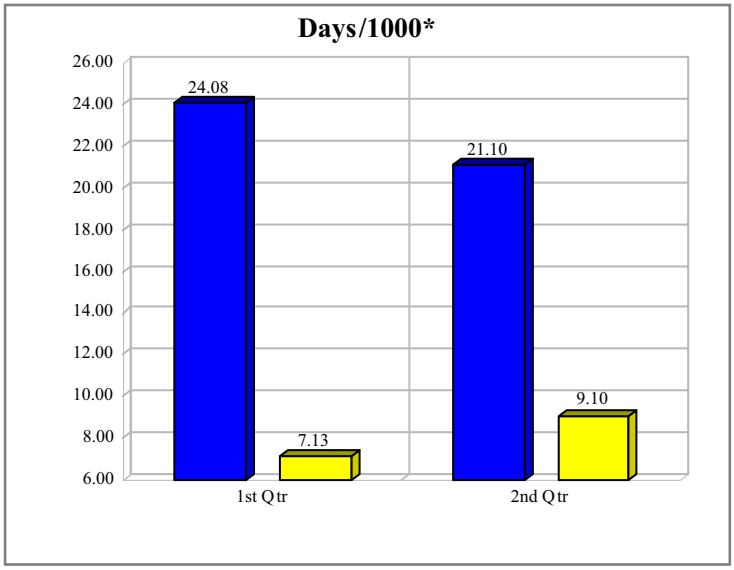
Managed Mental Health and Substance Abuse Activity Report

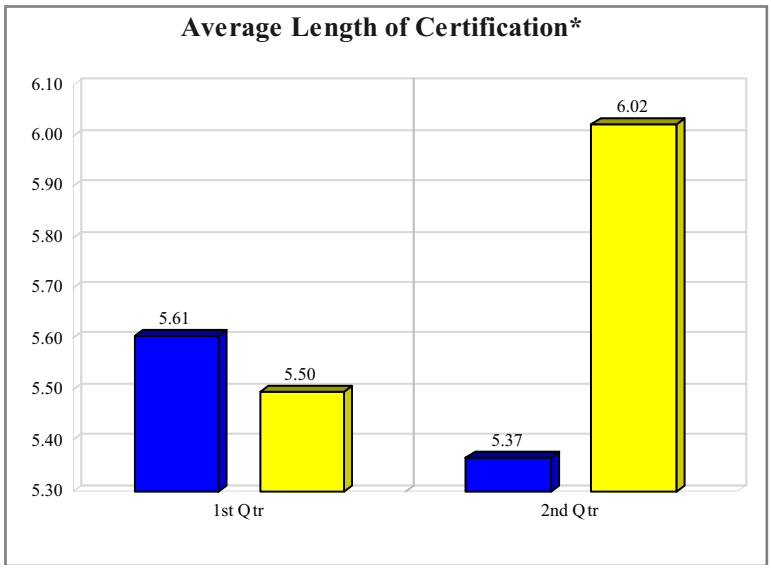
July 1, 2012 - December 31, 2012

Acute Inpatient & Alternative Levels of Care Utilization
Psychiatric vs Substance Abuse by Division

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Year to Date	
Avg Covered Lives	178,803		180,022		0		0		179,413	
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	192	58	177	68	0	0	0	0	369	126
Days*	1,076	319	950	410	0	0	0	0	2,026	728
Admissions/1000 Lives	4.30	1.30	3.93	1.51	0.00	0.00	0.00	0.00	4.11	1.40
Days/1000 Lives*	24.08	7.13	21.10	9.10	0.00	0.00	0.00	0.00	22.58	8.12
Avg Length of Certification*	5.61	5.50	5.37	6.02	0.00	0.00	0.00	0.00	5.49	5.78







Alternative Modality Ratios have been applied.

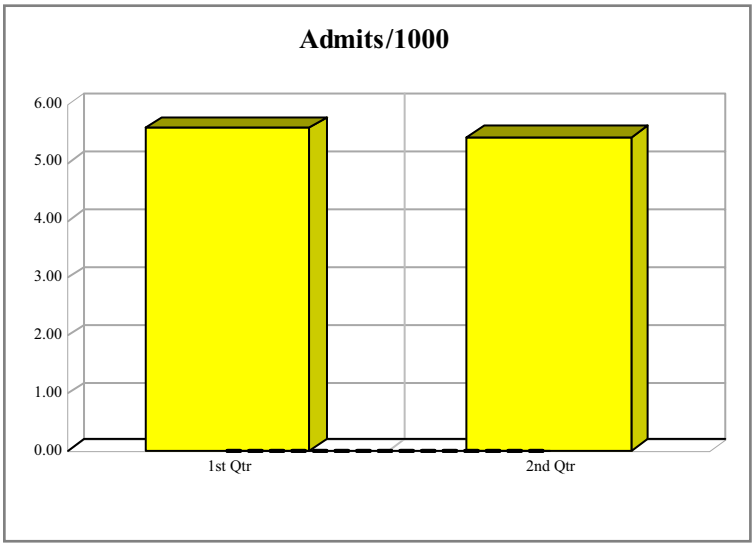
** All data has been annualized.*

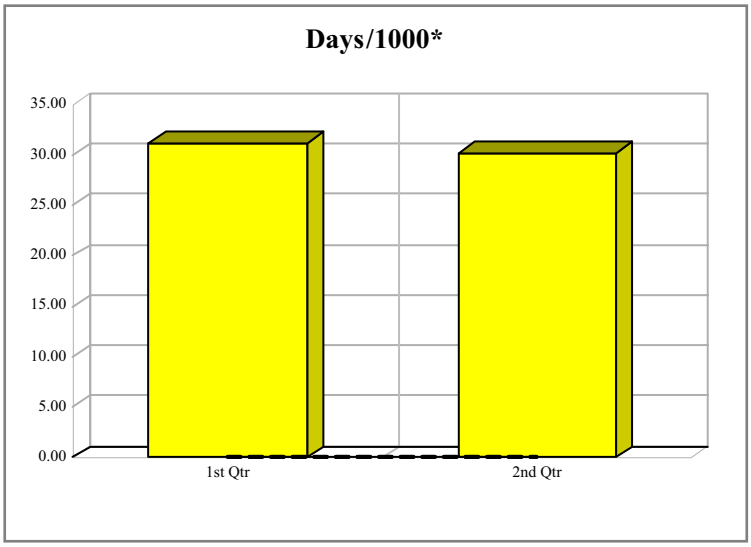
Managed Mental Health and Substance Abuse Activity Report

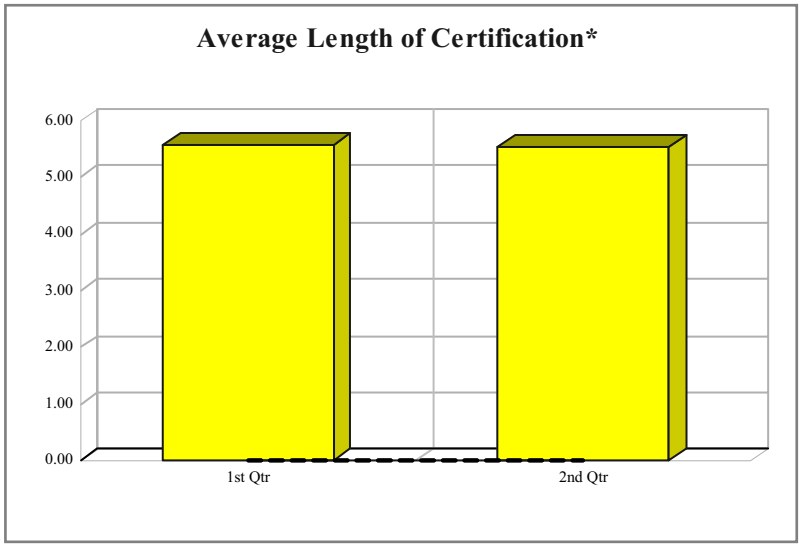
July 1, 2012 - December 31, 2012

Acute Inpatient & Alternative Levels of Care Utilization by Division

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	178,803	180,022	0	0	179,413
Admissions	250	245	0	0	495
Days*	1,395	1,359	0	0	2,754
Admissions/1000 Lives	5.59	5.44	0.00	0.00	5.52
Days/1000 Lives*	31.21	30.20	0.00	0.00	30.70
Avg Length of Certification*	5.58	5.55	0.00	0.00	5.56







*Alternative Modality Ratios have been applied.

** All data has been annualized.

Managed Mental Health and Substance Abuse Activity Report

July 1, 2012 - December 31, 2012

Total Acute Inpatient & Alternative Levels of Care Detail by Division

Psychiatric vs Substance Abuse

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Year to Date	
Avg Covered Lives	178,803		180,022		0		0		179,413	
ACUTE INPATIENT										
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	170	23	145	18	0	0	0	0	315	41
Days*	963	117	802	88	0	0	0	0	1,765	205
Admissions/1000 Lives	3.80	0.51	3.22	0.40	0.00	0.00	0.00	0.00	3.51	0.46
Days/1000 Lives*	21.54	2.62	17.82	1.96	0.00	0.00	0.00	0.00	19.68	2.29
Avg Length of Certification*	5.66	5.09	5.53	4.89	0.00	0.00	0.00	0.00	5.60	5.00
PARTIAL HOSPITALIZATION PROGRAM										
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	18	19	27	26	0	0	0	0	45	45
Days*	99	128	134	220	0	0	0	0	232	347
Admissions/1000 Lives	0.40	0.43	0.60	0.58	0.00	0.00	0.00	0.00	0.50	0.50
Days/1000 Lives*	2.20	2.85	2.97	4.88	0.00	0.00	0.00	0.00	2.59	3.87
Avg Length of Certification*	5.47	6.71	4.94	8.44	0.00	0.00	0.00	0.00	5.16	7.71
IOP/GROUP HOME/HALFWAY HOUSE										
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	4	16	5	24	0	0	0	0	9	40
Days*	15	74	14	102	0	0	0	0	29	176
Admissions/1000 Lives	0.09	0.36	0.11	0.53	0.00	0.00	0.00	0.00	0.10	0.45
Days/1000 Lives*	0.33	1.66	0.32	2.27	0.00	0.00	0.00	0.00	0.32	1.96
Avg Length of Certification*	3.69	4.64	2.85	4.25	0.00	0.00	0.00	0.00	3.22	4.41
TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE										
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	192	58	177	68	0	0	0	0	369	126
Days*	1,076	319	950	410	0	0	0	0	2,026	728
Admissions/1000 Lives	4.30	1.30	3.93	1.51	0.00	0.00	0.00	0.00	4.11	1.40
Days/1000 Lives*	24.08	7.13	21.10	9.10	0.00	0.00	0.00	0.00	22.58	8.12
Avg Length of Certification*	5.61	5.50	5.37	6.02	0.00	0.00	0.00	0.00	5.49	5.78

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

Managed Mental Health and Substance Abuse Activity Report

July 1, 2012 - December 31, 2012

Total Acute Inpatient & Alternative Levels of Care Detail by Division

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	178,803	180,022	0	0	179,413
ACUTE INPATIENT					
Admissions	193	163	0	0	356
Days*	1,080	890	0	0	1,970
Admissions/1000 Lives	4.32	3.62	0.00	0.00	3.97
Days/1000 Lives*	24.16	19.78	0.00	0.00	21.96
Avg Length of Certification*	5.60	5.46	0.00	0.00	5.53
PARTIAL HOSPITALIZATION PROGRAM					
Admissions	37	53	0	0	90
Days*	226	353	0	0	579
Admissions/1000 Lives	0.83	1.18	0.00	0.00	1.00
Days/1000 Lives*	5.06	7.84	0.00	0.00	6.45
Avg Length of Certification*	6.11	6.66	0.00	0.00	6.43
IOP/GROUP HOME/HALFWAY HOUSE					
Admissions	20	29	0	0	49
Days*	89	116	0	0	205
Admissions/1000 Lives	0.45	0.64	0.00	0.00	0.55
Days/1000 Lives*	1.99	2.58	0.00	0.00	2.29
Avg Length of Certification*	4.45	4.01	0.00	0.00	4.19
TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE					
Admissions	250	245	0	0	495
Days*	1,395	1,359	0	0	2,754
Admissions/1000 Lives	5.59	5.44	0.00	0.00	5.52
Days/1000 Lives*	31.21	30.20	0.00	0.00	30.70
Avg Length of Certification*	5.58	5.55	0.00	0.00	5.56

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

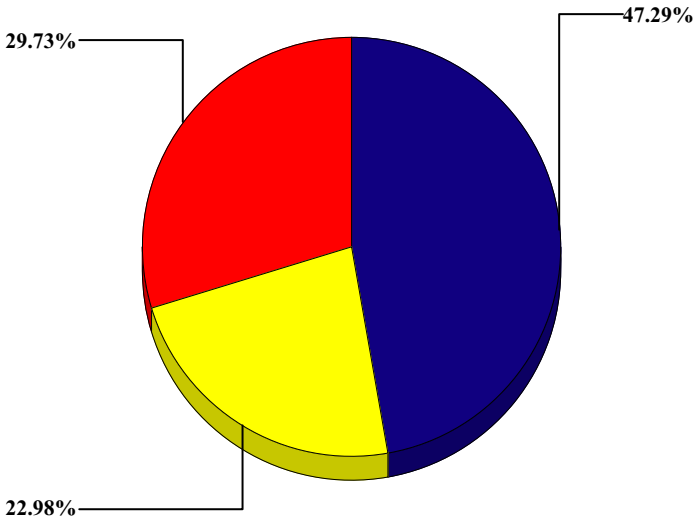
Managed Mental Health and Substance Abuse Activity Report

July 1, 2012 - December 31, 2012

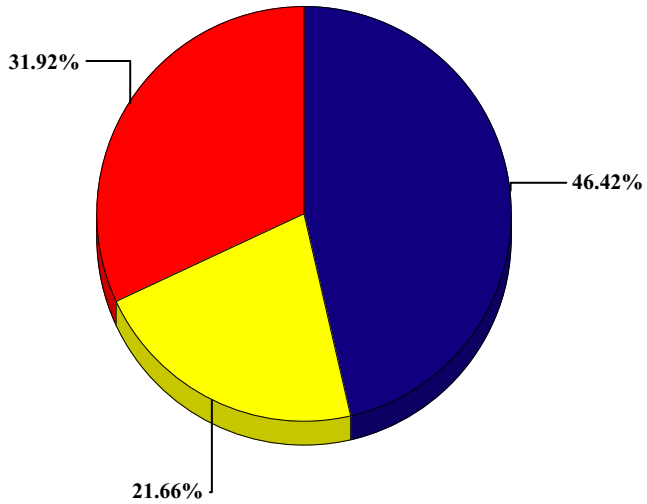
Penetration Rate by Beneficiary Type - Claims Based

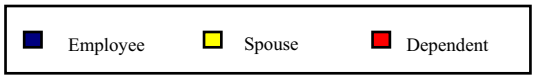
	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	4,494	2,184	2,826	9,504
Membership	83,283	38,862	57,268	179,413
Penetration Rate	5.40%	5.62%	4.93%	5.30%

Unduplicated Members Accessing Care



Membership





Penetration Rate by Beneficiary Type (Claims)

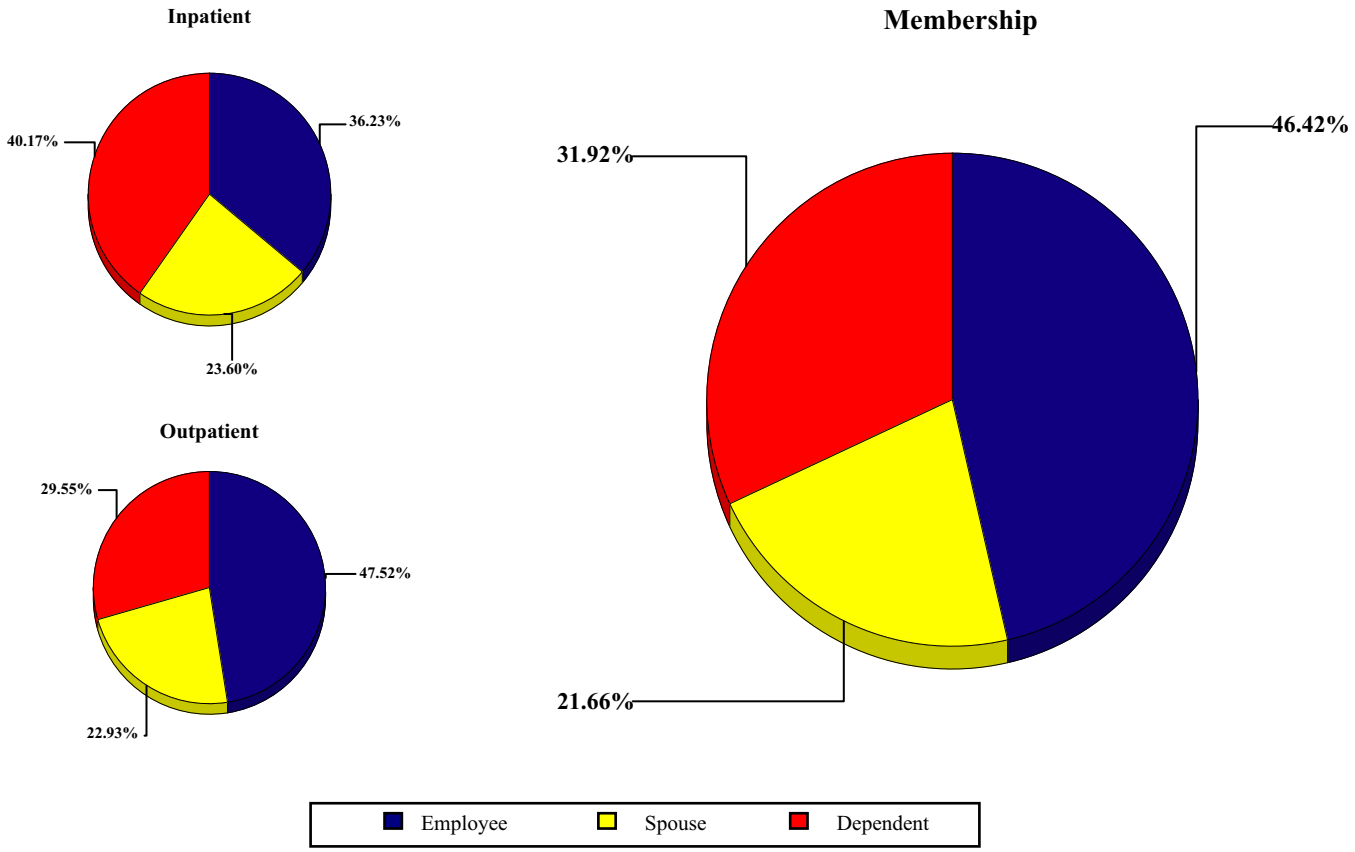
Inpatient and Higher Level of Care vs Outpatient

Inpatient

	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	175	114	194	483
Average Membership	83,283	38,862	57,268	179,413
Penetration Rate	0.21%	0.29%	0.34%	0.27%

Outpatient

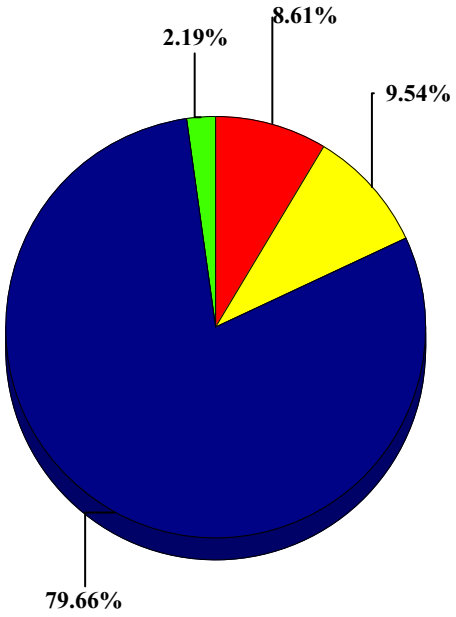
	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	4,446	2,146	2,765	9,357
Average Membership	83,283	38,862	57,268	179,413
Penetration Rate	5.34%	5.52%	4.83%	5.22%



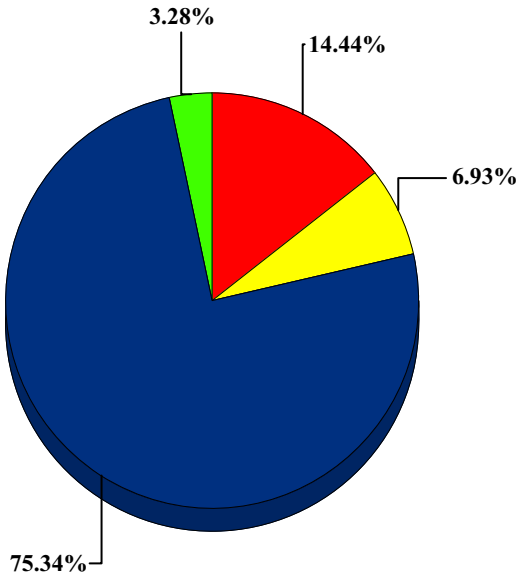
Division Penetration Rate by Age Category (Claims)

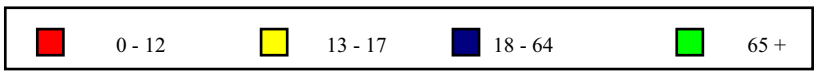
	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	827	916	7650	210	9504
Average Membership	25,911	12,434	135,174	5,894	179,413
Penetration Rate	3.19%	7.37%	5.66%	3.56%	5.30%

Unduplicated Members Accessing Care



Membership





Division Penetration Rate by Age Category (Claims)
Inpatient and Higher Level of Care vs Outpatient

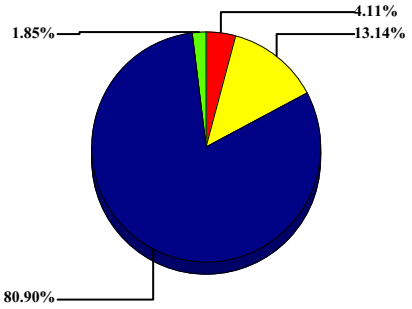
Inpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	20	64	394	9	483
Average Membership	25,911	12,434	135,174	5,894	179,413
Penetration Rate	0.08%	0.51%	0.29%	0.15%	0.27%

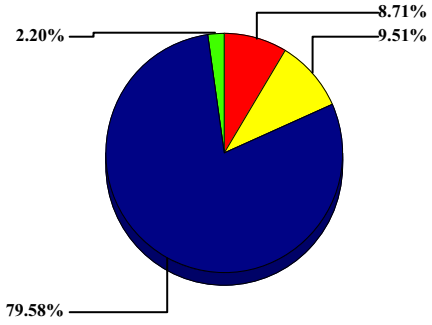
Oupatient

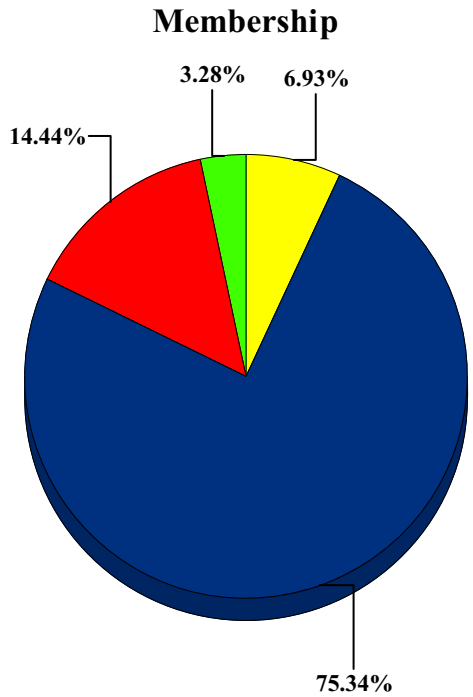
	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	823	899	7,522	208	9,357
Average Membership	25,911	12,434	135,174	5,894	179,413
Penetration Rate	3.18%	7.23%	5.56%	3.53%	5.22%

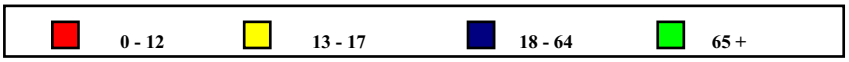
Inpatient



Outpatient





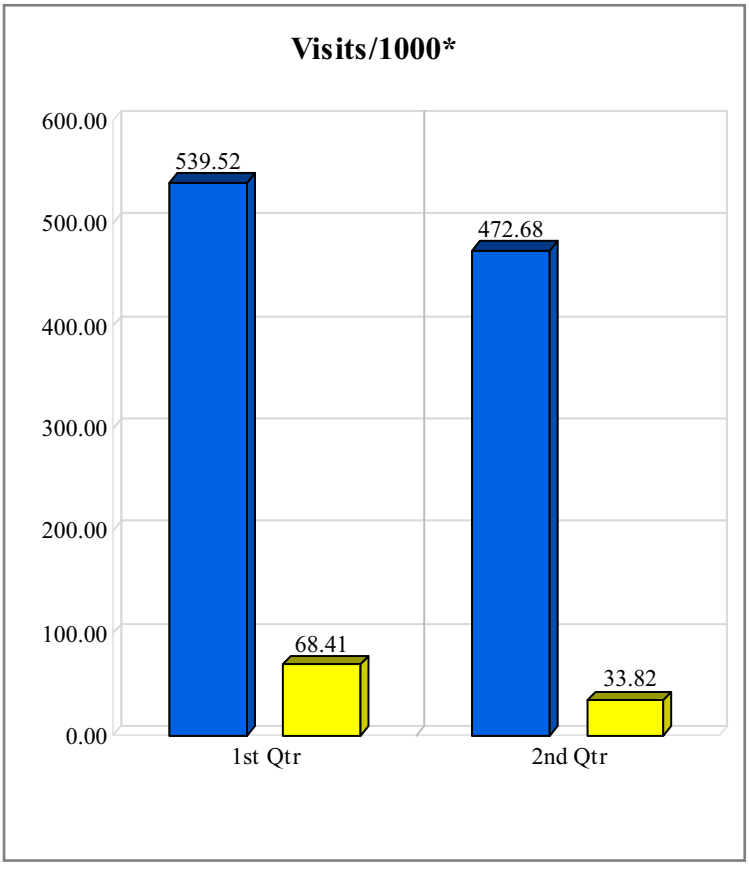


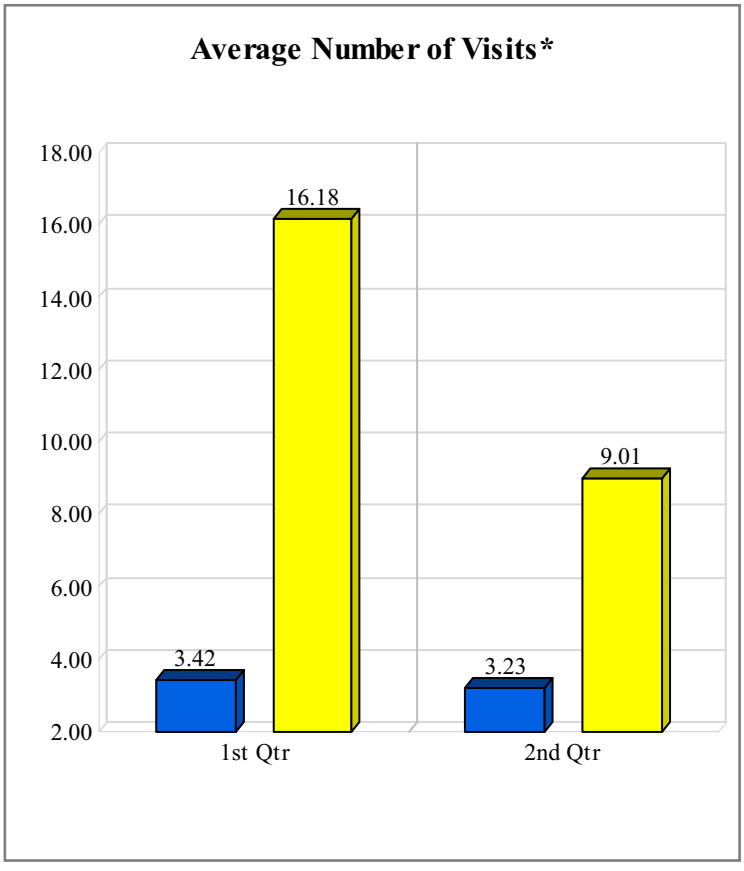
Managed Mental Health and Substance Abuse Activity Report
July 1, 2012 - December 31, 2012

Total Outpatient Utilization by Psychiatric/Substance Abuse (Paid Claims) by Division

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	178,803	180,022	0	0	179,413

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Visits *	24,117	3,058	21,273	1,522	0	0	0	0	45,390	4,580
Members Seen	7,053	189	6,594	169	0	0	0	0	9,172	278
Visits/1000 Lives*	539.52	68.41	472.68	33.82	0.00	0.00	0.00	0.00	505.98	51.06
Avg Number of Visits*	3.42	16.18	3.23	9.01	0.00	0.00	0.00	0.00	4.95	16.47





Psych

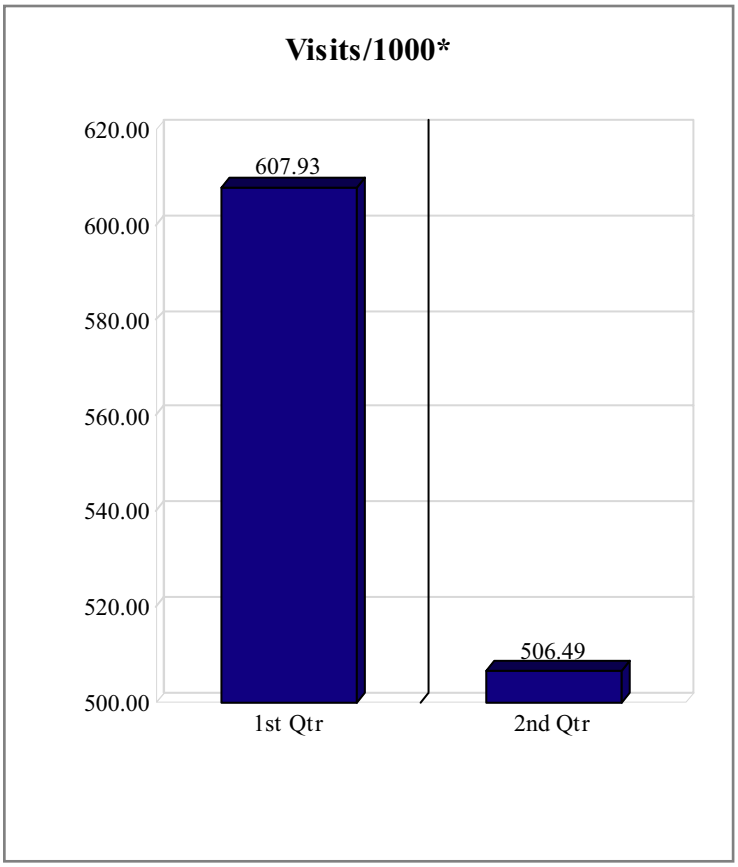
Substance Abuse

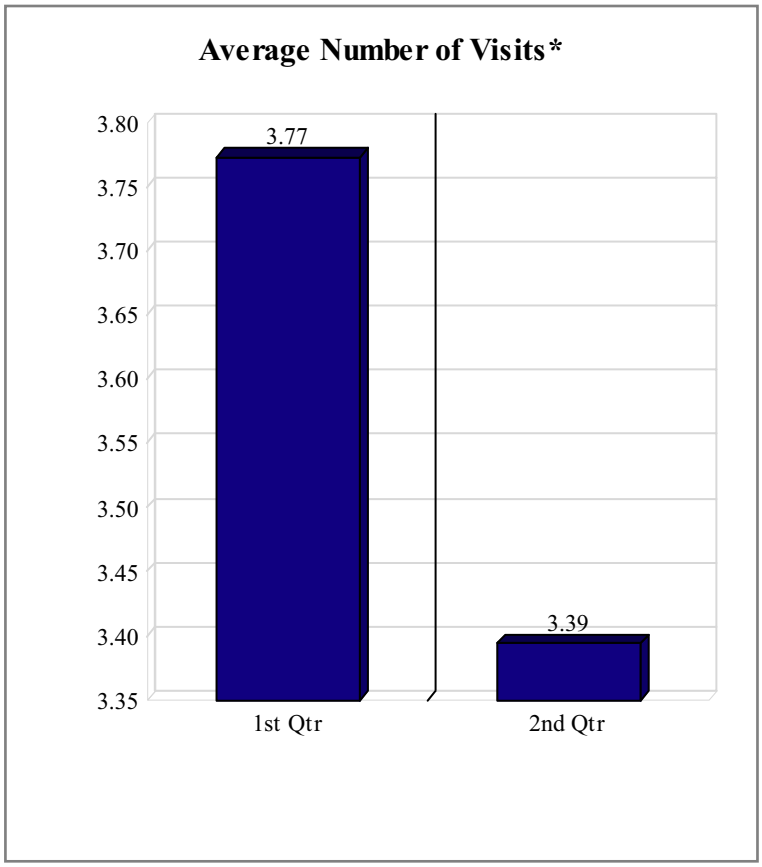
** Data is based on paid claims and has been annualized.*

Managed Mental Health and Substance Abuse Activity Report
July 1, 2012 - December 31, 2012

Total Outpatient Utilization (Paid Claims) by Division

Avg Covered Lives	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
	178,803	180,022	0	0	179,413
Visits *	27,175	22,795	0	0	49,970
Members Seen	7,202	6,716	0	0	9,357
Visits/1000 Lives*	607.93	506.49	0.00	0.00	557.04
Avg Number of Visits*	3.77	3.39	0.00	0.00	5.34





** Data is based on paid claims and has been annualized.*

Division Paid Claim Analysis - In-Network versus Out-of-Network

In-Network

Level of Care	Psych Units	Psych Paid $'s	Substance Abuse Units	Substance Abuse Paid $'s	Total Units	Total Paid $'s	Average Cost per Unit	PEPM	PMPM
Inpatient	1,456	$1,505,148	227	$170,290	1,683	$1,675,438	$995.51	$3.35	$1.56
Residential	0	$0	0	$0	0	$0	$0.00	$0.00	$0.00
Partial Hospitalization	306	$135,179	526	$168,482	832	$303,661	$364.98	$0.61	$0.28
Intensive Outpatient	96	$20,188	441	$64,280	537	$84,469	$157.30	$0.17	$0.08
Outpatient	41,093	$2,186,946	4,181	$98,586	45,274	$2,285,533	$50.48	$4.57	$2.12
Sub Total	**42,951**	**$3,847,461**	**5,375**	**$501,639**	**48,326**	**$4,349,100**		**$8.70**	**$4.04**

Out-of-Network

Level of Care	Psych Units	Psych Paid $'s	Substance Abuse Units	Substance Abuse Paid $'s	Total Units	Total Paid $'s	Average Cost per Unit	PEPM	PMPM
Inpatient	46	$40,903	3	$1,390	49	$42,293	$863.12	$0.08	$0.04
Residential	0	$0	0	$0	0	$0	$0.00	$0.00	$0.00
Partial Hospitalization	15	$4,508	69	$17,145	84	$21,653	$257.77	$0.04	$0.02
Intensive Outpatient	0	$0	49	$5,974	49	$5,974	$121.91	$0.01	$0.01
Outpatient	4,297	$306,753	399	$74,802	4,696	$381,555	$81.25	$0.76	$0.35
Sub Total	**4,358**	**$352,164**	**520**	**$99,310**	**4,878**	**$451,474**		**$0.90**	**$0.42**

Total

Level of Care	Psych Units	Psych Paid $'s	Substance Abuse Units	Substance Abuse Paid $'s	Total Units	Total Paid $'s	Average Cost per Unit	PEPM	PMPM
Inpatient	1,502	$1,546,051	230	$171,680	1,732	$1,717,730	$991.76	$3.44	$1.60
Residential	0	$0	0	$0	0	$0	$0.00	$0.00	$0.00
Partial Hospitalization	321	$139,687	595	$185,627	916	$325,313	$355.15	$0.65	$0.30
Intensive Outpatient	96	$20,188	490	$70,254	586	$90,442	$154.34	$0.18	$0.08
Outpatient	45,390	$2,493,699	4,580	$173,388	49,970	$2,667,088	$53.37	$5.34	$2.48
Grand Total	**47,309**	**$4,199,625**	**5,895**	**$600,949**	**53,204**	**$4,800,574**		**$9.61**	**$4.46**

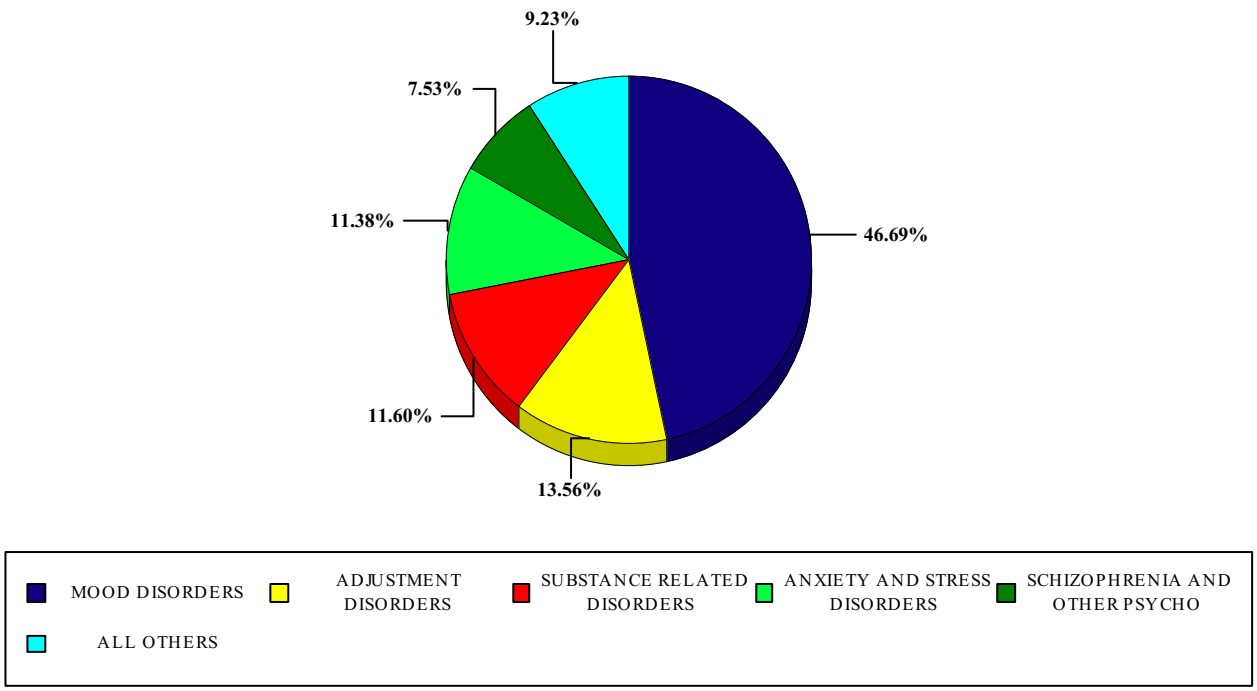
** In-Network Claims include SCA.*

Managed Mental Health and Substance Abuse Activity Report
July 1, 2012 - December 31, 2012

Total Paid Distribution by Major Diagnosis Category by Division

Rank	Diagnosis Category	Total Paid	% of Total Paid	Book of Business
1	MOOD DISORDERS	$2,241,621.72	46.69%	41.67%
2	ADJUSTMENT DISORDERS	$650,905.78	13.56%	9.47%
3	SUBSTANCE RELATED DISORDERS	$556,886.51	11.60%	26.06%
4	ANXIETY AND STRESS DISORDERS	$546,286.20	11.38%	9.41%
5	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	$361,643.30	7.53%	3.79%
6	DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE	$188,683.63	3.93%	4.54%
7	EATING DISORDERS	$136,814.27	2.85%	3.48%
8	OTHER CONDITIONS THAT MAY BE THE FOCUS OF CLINICAL ATTENTION	$46,147.09	0.96%	0.16%
9	OTHER MENTAL DISORDERS	$39,162.50	0.82%	0.66%
10	DISSOCIATIVE, SOMATOFORM AND FACTITIOUS DISORDERS	$9,656.70	0.20%	0.19%
11	PERSONALITY DISORDERS	$8,636.25	0.18%	0.13%
12	MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED	$7,576.50	0.16%	0.24%
13	DELIRIUM, DEMENTIA, AMNESTIC AND OTHER COGNITIVE DISORDERS	$6,553.21	0.14%	0.20%
	Total for All Diagnosis Categories	**$4,800,573.66**	**100.00%**	**100.00%**

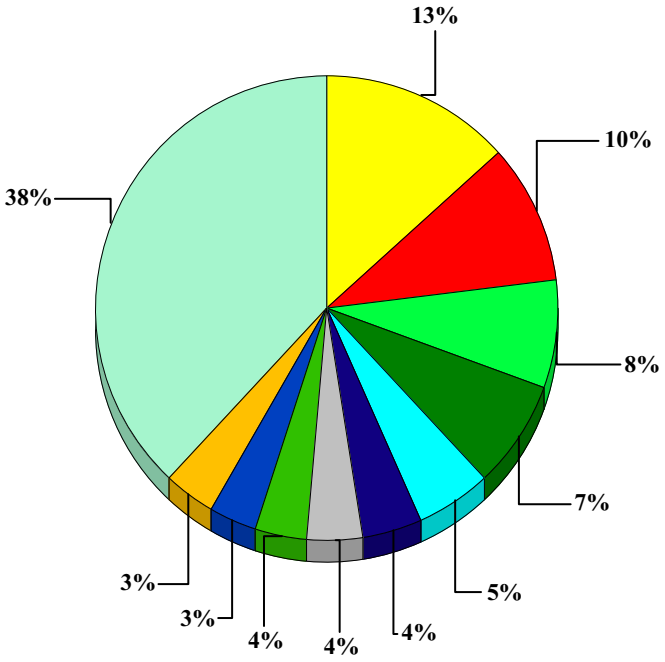
Top Five Diagnosis Categories



Managed Mental Health and Substance Abuse Activity Report
July 1, 2012 - December 31, 2012

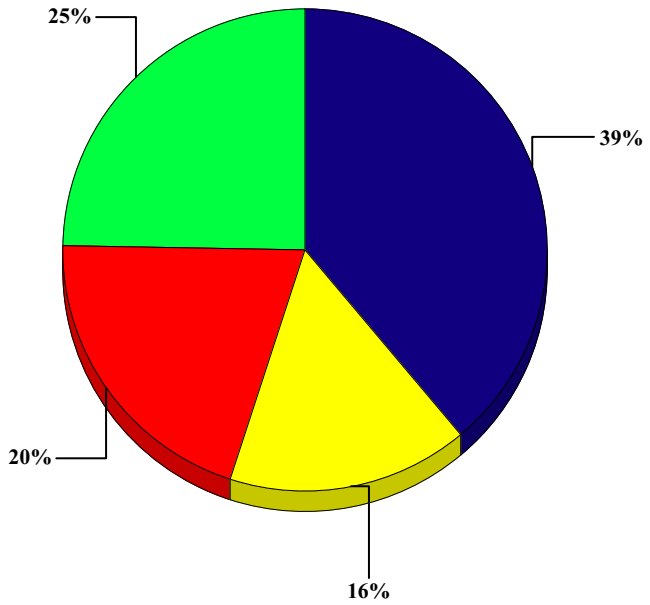
Top Ten High Volume Facilities - Inpatient and Alternative Levels of Care (Division)

Facility	Total Paid	% of Total Paid
CHIPPENHAM & JOHNSTO-WILLIS HOSPITA	$268,143	13%
LEWIS GALE MEDICALCENTER LLC	$192,309	10%
VIRGINIA COMMONWEALTH UNIV HLTH SYS	$151,727	8%
BON SECOUR ST MARY'S HOSPITAL INC	$149,001	7%
GALAX TREATMENT CENTER INC	$105,808	5%
CENTRO HEALTH INC	$83,869	4%
CARILION NEW RIVER VALLEY MEDICAL CE	$77,100	4%
POPLAR SPRINGS HOSPITAL	$74,503	4%
CHILDREN'S HOSPITALCOLORADO	$69,730	3%
MOUNT REGIS CENTER	$69,222	3%
ALL OTHER FACILITIES	$763,604	38%
Total	**$2,005,016**	**100.00%**



Outpatient Distribution by Provider Discipline

Provider Discipline	Total Paid	% of Total Paid
MD	$541,327	20%
PHD	$656,324	25%
LCSW	$434,576	16%
ALL OTHER DISCIPLINES	$1,034,860	39%
Total	**$2,667,088**	**100.00%**



Managed Mental Health and Substance Abuse Activity Report

July 1, 2012 - December 31, 2012

Paid Claim Analysis - Gender/Dependency-By Division

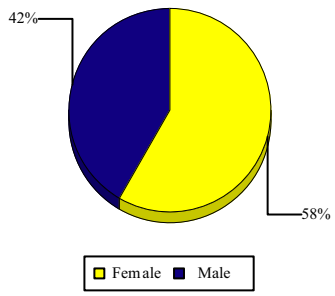
Males

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$154,530	$154,530
13 - 17	$44	$0	$205,237	$205,281
18 - 64	$708,505	$358,361	$518,168	$1,585,033
65+	$12,822	$48,086	$0	$60,907
Total	**$721,370**	**$406,447**	**$877,935**	**$2,005,752**

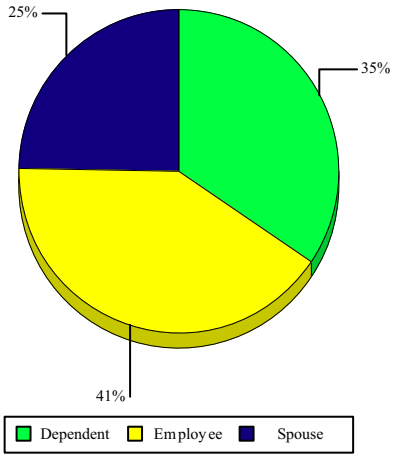
Females

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$8,692	$0	$85,902	$94,594
13 - 17	$23	$0	$319,584	$319,607
18 - 64	$1,209,179	$749,436	$376,634	$2,335,250
65+	$14,510	$30,861	$0	$45,371
Total	**$1,232,405**	**$780,297**	**$782,120**	**$2,794,822**

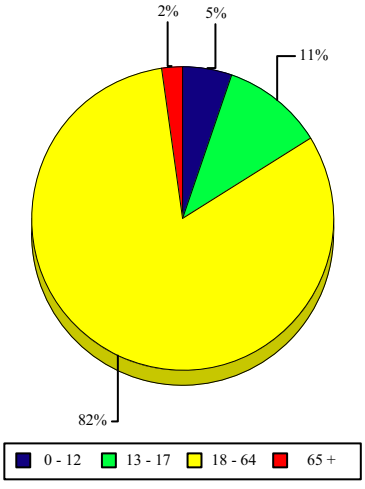
Total Paid % by Gender



Total Paid % by Dependency



Total Paid % by Age Band



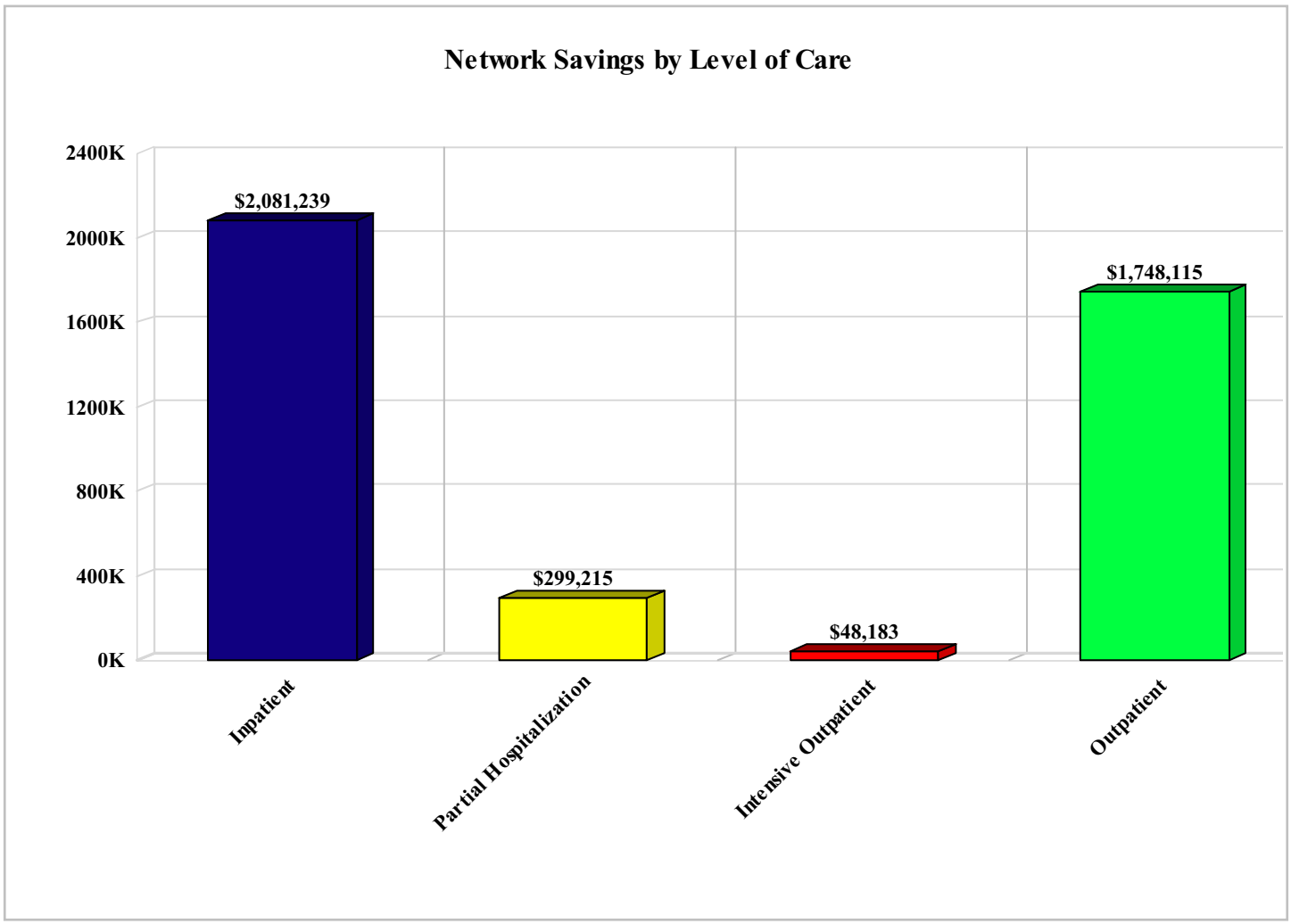
**In-Network Claims Only*

Managed Mental Health and Substance Abuse Activity Report

July 1, 2012 - December 31, 2012

Network Savings by Division

Level of Care	Billed Amount	Allowed Amount	*Network Savings
Inpatient	$3,834,334	$1,753,095	$2,081,239
Residential	$0	$0	$0
Partial Hospitalization	$612,773	$313,559	$299,215
Intensive Outpatient	$137,584	$89,401	$48,183
Outpatient	$5,049,605	$3,301,489	$1,748,115
Total	**$9,634,296**	**$5,457,544**	**$4,176,752**



*In-Network Claims Only

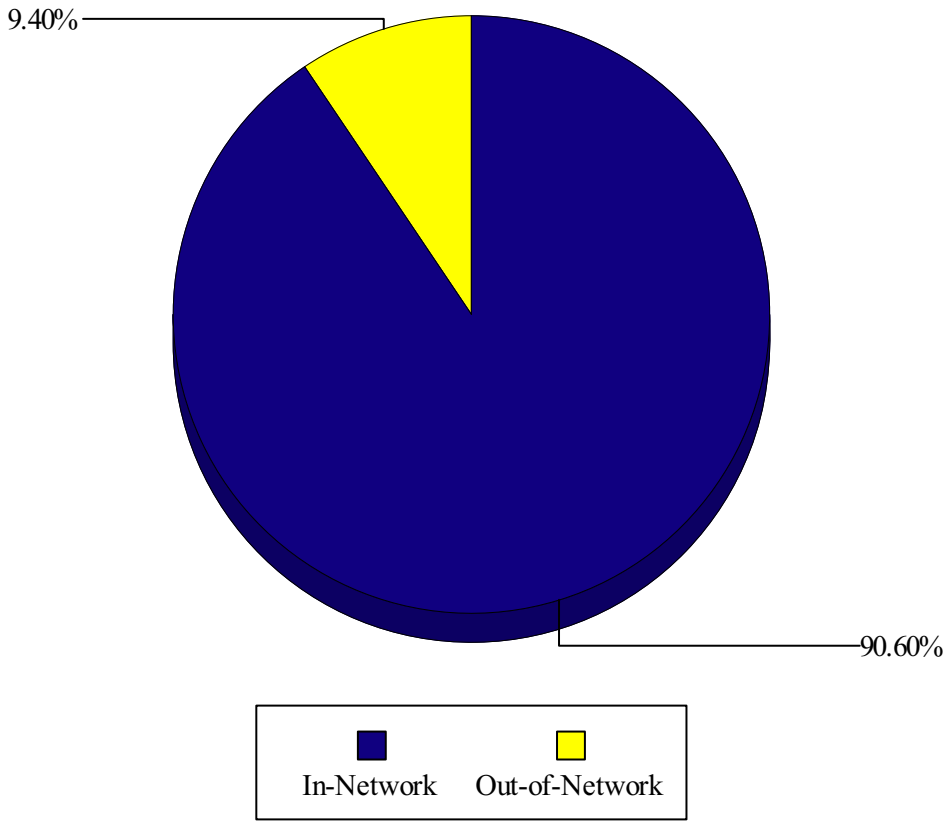
** Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

July 1, 2012 - December 31, 2012

Division Total Paid Distribution by Provider Status

Network Status	Total Paid	% of Total Paid
In-Network*	$4,349,099.65	90.60%
Out-of-Network	$451,474.01	9.40%
Unknown Network Status	$0.00	0.00%
Total	**$4,800,573.66**	**100.00%**



*In-Network Claims Only

* In-Network claims include SCA.

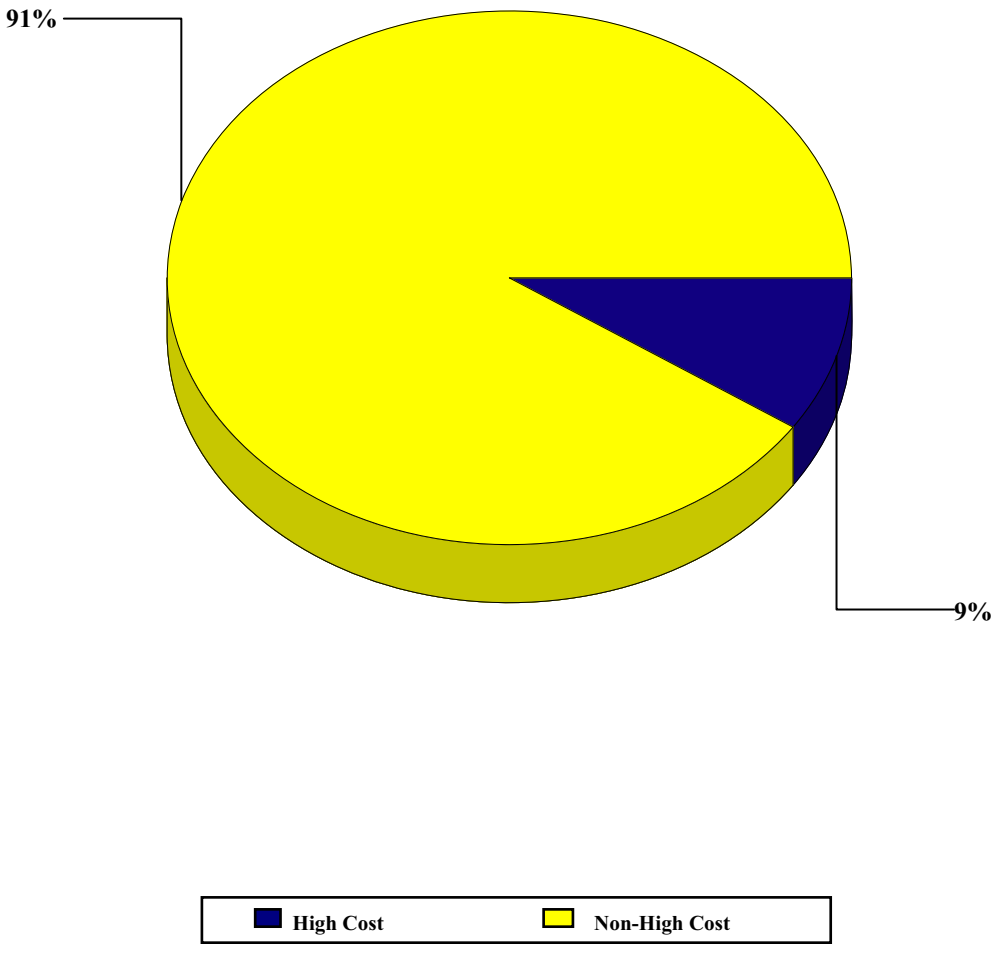
Managed Mental Health and Substance Abuse Activity Report

July 1, 2012 - December 31, 2012

High Cost Member Cases Greater than $20,000

	# of Unduplicated Members	Total Claim Amount	Total Allowed Amount	Total Paid Amount	% of Total
High Cost Cases	14	$901,451	$454,611	$448,846	9.35%
Non-High Cost Cases	9,490	$9,682,712	$5,618,689	$4,351,727	90.65%
Total	**9,504**	**$10,584,163**	**$6,073,300**	**$4,800,574**	**100.00%**

High Cost Member Cases



**In-Network Claims Only*

Managed Mental Health and Substance Abuse Activity Report

As of December 31, 2012

Recidivism Rates - Psychiatric vs Substance Abuse

Psychiatric

Age Band	Hospitalized in Previous Year	Readmitted within 365 Days Admits	%
0 - 12	21	0	0.00%
13 - 17	85	7	8.24%
18 - 64	380	52	13.68%
65 +	3	1	33.33%
Total	486	60	12.35%

Substance Abuse

Age Band	Hospitalized in Previous Year	Readmitted within 365 Days Admits	%
0 - 12	0	0	0.00%
13 - 17	0	0	0.00%
18 - 64	73	13	17.81%
65 +	0	0	0.00%
Total	73	13	17.81%

Total

Age Band	Hospitalized in Previous Year	Readmitted within 365 Days Admits	%
0 - 12	21	0	0.00%
13 - 17	85	7	8.24%
18 - 64	453	65	14.35%
65 +	3	1	33.33%
Total	559	73	13.06%

Quarterly Network Access

Offeror's Proposed MHSA Provider Network File

Managed Care Accessibility Analysis

March 11, 2013

A report on the accessibility of the

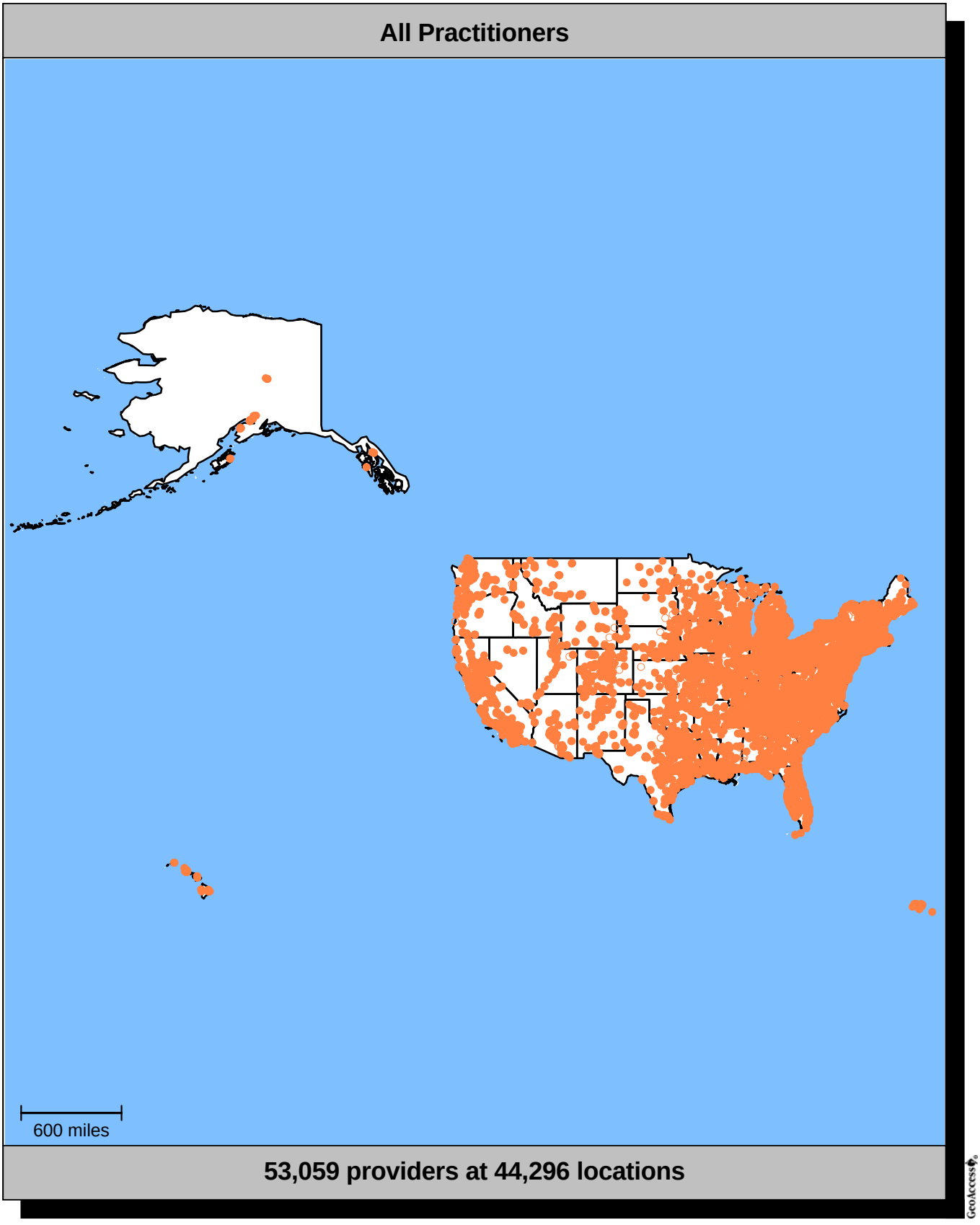
ValueOptions MHSA Provider Network

for the covered lives of

Offeror's Proposed MHSA Provider Network File

ValueOptions MHSA Provider Network - Offeror's Proposed MHSA Provider Network File

Provider locations



Offeror's Proposed MHSA Provider Network File

Managed Care Accessibility Analysis

A report on the accessibility of the

ValueOptions MHSA Provider Network

for the covered lives of

Offeror's Proposed MHSA Provider Network File

Urban Covered Lives
With Access to
Various Provider Groups

Accessibility summary

Accessibility analysis specifications	
Provider group:	**Inpatient Facilities** 1,298 providers at 1,981 locations (based on 8,157 records)
Covered life group:	**Urban Covered Lives** 454,235 covered lives
Access standard:	**1 provider within 5 miles**
Covered lives with desired access:	412,045 (90.7%)

Average distance to a choice of providers for covered lives with desired access

Number of providers	1	2	3	4	5
Miles	2.3	2.5	3.0	3.3	3.9

Key geographic areas

City	Total number of covered lives	Covered lives with desired access		
		Number	Percent	Average distance to 1 provider
BROOKLYN, NY	33,082	33,082	100.0	1.4
BRONX, NY	16,611	16,611	100.0	1.4
NEW YORK, NY	15,241	15,241	100.0	0.8
YONKERS, NY	11,901	11,901	100.0	2.2
STATEN ISLAND, NY	11,854	11,585	97.7	2.2
MASSAPEQUA, NY	8,544	8,544	100.0	2.6
ALBANY, NY	7,938	7,938	100.0	0.9
LEVITTOWN, NY	6,578	6,578	100.0	2.8
SYRACUSE, NY	6,149	5,700	92.7	2.1
MERRICK, NY	5,971	5,683	95.2	3.4

ZIP Codes meeting the access standard

Urban Covered Lives

County/City	ZIP Code	Total number of covered lives	Total number of providers	Covered lives with desired access		
				Number	Pct	Average distance to a choice of 1 provider
JEFFERSON - AL						
BIRMINGHAM	35205	2	0	2	100.0	2.5
	35209	2	12	2	100.0	2.3
MOBILE - AL						
MOBILE	36604	3	0	3	100.0	4.1
	36607	2	2	2	100.0	0.8
MARICOPA - AZ						
AVONDALE	85392	2	0	2	100.0	4.2
CHANDLER	85224	15	0	15	100.0	2.6
	85225	14	3	14	100.0	1.6
	85246	2	0	2	100.0	1.9
GILBERT	85233	10	0	10	100.0	2.4
	85234	16	0	11	68.8	3.5
	85295	6	0	2	33.3	2.2
GLENDALE	85301	2	0	2	100.0	3.3
	85302	6	12	6	100.0	1.6
	85304	4	0	4	100.0	2.7
	85306	9	0	4	44.4	4.2
	85312	2	0	2	100.0	4.6
	85318	1	0	1	100.0	3.4
MESA	85201	9	0	9	100.0	3.1
	85202	4	0	4	100.0	3.5
	85203	6	0	5	83.3	2.7
	85204	8	6	8	100.0	1.0
	85205	21	0	9	42.9	4.0
	85206	14	0	13	92.9	3.3
	85210	4	3	4	100.0	3.0
	85213	13	0	13	100.0	2.9
	85274	1	0	1	100.0	4.1
PEORIA	85345	12	0	12	100.0	2.9
	85381	11	0	4	36.4	4.1
PHOENIX	85003	1	0	1	100.0	1.5
	85004	1	0	1	100.0	2.6
	85008	2	3	2	100.0	1.2
	85012	1	0	1	100.0	0.4
	85013	5	0	5	100.0	2.2
	85014	6	4	6	100.0	1.5
	85015	4	0	4	100.0	2.6
	85016	1	0	1	100.0	2.2

GeoAccess®

Access standard: 1 provider within 5 miles
Provider group: Inpatient Facilities

ZIP Codes meeting the access standard

Urban Covered Lives

County/City	ZIP Code	Total number of covered lives	Total number of providers	Covered lives with desired access		
				Number	Pct	Average distance to a choice of 1 provider
MARICOPA - AZ						
PHOENIX	85017	3	0	3	100.0	3.8
	85018	2	12	2	100.0	0.9
	85020	6	0	3	50.0	4.3
	85021	4	0	3	75.0	4.5
	85029	2	0	1	50.0	4.4
	85032	6	0	5	83.3	4.1
	85037	4	0	1	25.0	4.8
	85042	3	0	1	33.3	1.3
	85044	18	0	11	61.1	2.5
	85046	1	0	1	100.0	3.8
	85051	2	0	1	50.0	4.9
	85067	1	0	1	100.0	2.0
SCOTTSDALE	85250	12	0	9	75.0	3.9
	85251	8	1	8	100.0	1.6
	85254	25	2	25	100.0	1.8
	85257	15	0	14	93.3	2.5
	85261	2	0	2	100.0	1.6
TEMPE	85281	2	0	2	100.0	3.4
	85282	9	0	9	100.0	2.9
	85283	8	12	8	100.0	2.4
PIMA - AZ						
TUCSON	85701	1	0	1	100.0	2.1
	85703	2	0	2	100.0	3.7
	85705	1	0	1	100.0	4.0
	85710	35	0	5	14.3	4.4
	85711	10	0	8	80.0	3.4
	85712	11	0	10	90.9	3.8
	85716	10	0	10	100.0	1.8
	85719	1	2	1	100.0	1.2
	85730	13	2	6	46.2	2.2
	85741	4	0	2	50.0	3.9
ALAMEDA - CA						
ALBANY	94706	4	0	4	100.0	3.1
BERKELEY	94702	10	0	10	100.0	1.7
	94703	5	0	5	100.0	1.2
	94704	2	0	2	100.0	1.0
	94705	1	0	1	100.0	1.2
	94707	6	0	6	100.0	2.5

GeoAccess®

Access standard: 1 provider within 5 miles
Provider group: Inpatient Facilities

ZIP Codes meeting the access standard

Urban Covered Lives

County/City	ZIP Code	Total number of covered lives	Total number of providers	Covered lives with desired access		
				Number	Pct	Average distance to a choice of 1 provider
ALAMEDA - CA						
BERKELEY	94709	2	1	2	100.0	0.6
EMERYVILLE	94608	2	0	2	100.0	1.1
FREMONT	94536	5	0	2	40.0	3.8
	94538	1	4	1	100.0	1.9
OAKLAND	94602	4	0	1	25.0	4.7
	94606	2	0	2	100.0	3.4
	94609	2	25	2	100.0	0.6
	94610	3	0	3	100.0	2.6
	94611	11	0	11	100.0	3.0
	94612	4	0	4	100.0	1.9
	94618	4	0	4	100.0	1.5
CONTRA COSTA - CA						
BERKELEY	94708	3	0	3	100.0	1.1
CONCORD	94518	1	0	1	100.0	0.9
EL CERRITO	94530	3	0	1	33.3	5.0
PLEASANT HILL	94523	2	0	2	100.0	3.2
WALNUT CREEK	94597	1	0	1	100.0	4.8
LOS ANGELES - CA						
ALHAMBRA	91801	1	0	1	100.0	3.3
ALTADENA	91001	4	0	4	100.0	2.2
ARCADIA	91006	2	0	1	50.0	4.6
	91007	1	0	1	100.0	4.1
AZUSA	91702	2	2	2	100.0	1.8
BEVERLY HILLS	90210	5	0	2	40.0	3.6
	90211	2	0	2	100.0	3.3
	90212	5	0	5	100.0	3.0
BURBANK	91501	1	0	1	100.0	4.6
	91505	2	0	2	100.0	1.4
	91506	2	0	2	100.0	2.2
CARSON	90746	2	0	1	50.0	4.7
CLAREMONT	91711	7	0	7	100.0	2.4
COVINA	91722	1	0	1	100.0	1.4
	91723	1	0	1	100.0	2.2
	91724	1	13	1	100.0	2.0
CULVER CITY	90230	6	0	6	100.0	2.4
	90232	1	6	1	100.0	0.7
ENCINO	91316	4	0	4	100.0	2.4
GLENDALE	91202	1	0	1	100.0	2.7

GeoAccess®

Access standard: 1 provider within 5 miles
Provider group: Inpatient Facilities

ZIP Codes meeting the access standard

Urban Covered Lives

County/City	ZIP Code	Total number of covered lives	Total number of providers	Covered lives with desired access		
				Number	Pct	Average distance to a choice of 1 provider
LOS ANGELES - CA						
GLENDALE	91203	1	0	1	100.0	1.6
	91206	1	8	1	100.0	1.7
GRANADA HILLS	91344	2	0	2	100.0	2.9
HACIENDA HEIGHTS	91745	3	0	2	66.7	4.1
HARBOR CITY	90710	1	0	1	100.0	2.2
LA CRESCENTA	91214	1	0	1	100.0	2.5
LOMITA	90717	2	0	2	100.0	2.0
LONG BEACH	90801	1	0	1	100.0	2.0
	90802	5	0	5	100.0	2.0
	90803	2	0	1	50.0	1.4
	90804	1	2	1	100.0	0.6
	90807	1	5	1	100.0	1.7
	90808	3	0	3	100.0	3.2
	90814	1	0	1	100.0	2.0
	90815	2	0	2	100.0	3.7
LOS ANGELES	90004	1	0	1	100.0	1.8
	90005	1	0	1	100.0	0.8
	90007	2	0	2	100.0	3.3
	90008	2	0	1	50.0	3.5
	90015	2	0	2	100.0	3.4
	90016	1	0	1	100.0	3.6
	90018	2	0	2	100.0	2.8
	90020	1	4	1	100.0	0.1
	90024	9	0	2	22.2	4.7
	90027	1	0	1	100.0	3.2
	90033	2	3	2	100.0	0.9
	90034	4	0	4	100.0	1.1
	90035	2	0	2	100.0	3.0
	90036	6	0	6	100.0	3.6
	90039	1	0	1	100.0	3.4
	90042	2	0	2	100.0	3.7
	90045	2	0	2	100.0	4.3
	90046	4	0	4	100.0	4.5
	90048	8	0	8	100.0	3.9
	90056	2	0	2	100.0	3.8
	90064	2	0	2	100.0	3.6
	90065	1	0	1	100.0	2.4
	90067	3	0	3	100.0	3.7

Access standard: 1 provider within 5 miles
Provider group: Inpatient Facilities

ZIP Codes meeting the access standard

Urban Covered Lives

County/City	ZIP Code	Total number of covered lives	Total number of providers	Covered lives with desired access		
				Number	Pct	Average distance to a choice of 1 provider
LOS ANGELES - CA						
LOS ANGELES	90068	1	0	1	100.0	4.0
	90078	1	0	1	100.0	3.9
MISSION HILLS	91345	1	0	1	100.0	2.7
MONTEBELLO	90640	1	0	1	100.0	2.5
MONTEREY PARK	91754	2	0	2	100.0	2.9
NORTH HILLS	91343	1	0	1	100.0	2.2
NORTH HOLLYWOOD	91602	3	0	3	100.0	1.7
	91605	1	0	1	100.0	4.4
NORTHRIDGE	91325	2	8	2	100.0	2.3
PALOS VERDES PENINSULA	90274	8	0	8	100.0	1.6
PANORAMA CITY	91402	2	0	2	100.0	4.4
PASADENA	91103	1	4	1	100.0	1.3
	91106	5	0	5	100.0	0.8
	91107	5	3	5	100.0	1.1
	91116	1	0	1	100.0	0.7
	91121	1	0	1	100.0	0.4
RANCHO PALOS VERDES	90275	4	1	4	100.0	1.9
REDONDO BEACH	90277	3	0	2	66.7	4.5
RESEDA	91335	3	0	3	100.0	1.8
SAN PEDRO	90731	1	12	1	100.0	1.0
SANTA MONICA	90404	3	0	1	33.3	4.3
	90405	6	0	2	33.3	4.4
SHERMAN OAKS	91423	2	0	2	100.0	1.4
SIERRA MADRE	91024	1	0	1	100.0	3.2
SOUTH PASADENA	91030	3	0	3	100.0	2.5
STUDIO CITY	91604	9	0	9	100.0	2.8
TARZANA	91356	1	21	1	100.0	0.8
TORRANCE	90503	6	0	6	100.0	3.8
	90505	5	9	5	100.0	2.1
VALENCIA	91354	3	0	3	100.0	2.4
VALLEY VILLAGE	91607	3	0	3	100.0	2.1
VAN NUYS	91406	2	0	2	100.0	4.5
WOODLAND HILLS	91364	6	0	5	83.3	3.4
	91367	13	0	7	53.8	4.1
MONTEREY - CA						
PACIFIC GROVE	93950	8	4	8	100.0	1.0
ORANGE - CA						
ALISO VIEJO	92656	2	0	2	100.0	4.2

Access standard: 1 provider within 5 miles
Provider group: Inpatient Facilities

ZIP Codes meeting the access standard

Urban Covered Lives

County/City	ZIP Code	Total number of covered lives	Total number of providers	Covered lives with desired access		
				Number	Pct	Average distance to a choice of 1 provider
ORANGE - CA						
ANAHEIM	92801	1	4	1	100.0	2.6
BUENA PARK	90620	2	0	2	100.0	3.3
CAPISTRANO BEACH	92624	2	4	2	100.0	0.4
CORONA DEL MAR	92625	1	0	1	100.0	3.1
COSTA MESA	92627	2	9	2	100.0	0.9
CYPRESS	90630	1	0	1	100.0	4.3
DANA POINT	92629	8	0	8	100.0	2.8
FOUNTAIN VALLEY	92708	3	0	2	66.7	4.8
FULLERTON	92833	1	0	1	100.0	3.3
	92835	2	0	1	50.0	4.8
HUNTINGTON BEACH	92615	2	0	2	100.0	2.5
	92646	6	0	6	100.0	3.2
	92648	8	0	1	12.5	4.2
IRVINE	92602	4	0	4	100.0	2.8
	92604	3	0	1	33.3	4.4
	92606	2	0	2	100.0	3.8
	92612	6	0	6	100.0	2.6
	92614	7	0	5	71.4	4.3
	92620	2	0	1	50.0	4.6
LAGUNA HILLS	92653	9	0	9	100.0	2.9
LAGUNA NIGUEL	92677	15	0	11	73.3	3.8
LAGUNA WOODS	92637	76	0	76	100.0	2.4
LAKE FOREST	92630	1	2	1	100.0	0.6
MISSION VIEJO	92691	11	0	9	81.8	3.5
	92692	12	0	8	66.7	4.7
NEWPORT BEACH	92658	2	4	2	100.0	0.0
	92660	2	0	2	100.0	1.0
	92663	4	0	4	100.0	1.3
ORANGE	92869	2	11	2	100.0	2.9
SANTA ANA	92705	3	1	3	100.0	1.3
SEAL BEACH	90740	8	0	1	12.5	4.9
TUSTIN	92780	2	20	2	100.0	1.2
PLACER - CA						
ROSEVILLE	95661	4	0	4	100.0	3.2
RIVERSIDE - CA						
RIVERSIDE	92501	2	40	2	100.0	0.6
SACRAMENTO - CA						
CARMICHAEL	95608	4	0	4	100.0	3.0

GeoAccess®

Access standard: 1 provider within 5 miles
Provider group: Inpatient Facilities

Quarterly Coordination of Benefit Report

Report Title **Quarterly Coordination of Benefits**

Client Name Place parent/group name field in the formula here

Report Period **From** **to**

Report Description/Data Source

Quarterly report showing COB savings by member. The report is grouped by name of other insurer with subtotals for each insurer and grand totals for the report.

Member ID	Member Name	BILLED	ALLOWED	COBAMT	RCVAMT	PAID
AETNA						
123456789	Member's name here	$485.00	120.00	$11.14	$0.00	$80.00
123456789	Member's name here	$150.00	150.00	$50.00	$0.00	$0.00
123456789	Member's name here	$390.00	0.00	$360.00	$0.00	$0.00
123456789	Member's name here	$130.00	80.00	$0.00	$0.00	$40.00
AETNA	Totals:	**$1,155.00**	**$350.00**	**$421.14**	**$0.00**	**$120.00**
ANTHEM BLUE CROSS AND BLUE SHIELD						
123456789	Member's name here	$90.00	0.00	$46.22	$0.00	$0.00
ANTHEM BLUE CROSS AND BLUE SHIELD	Totals:	**$90.00**	**$0.00**	**$46.22**	**$0.00**	**$0.00**
ANTHEM HEALTH						
123456789	Member's name here	$960.00	578.76	$409.74	$458.76	$120.00
ANTHEM HEALTH	Totals:	**$960.00**	**$578.76**	**$409.74**	**$458.76**	**$120.00**
BC OF THE ROCHESTER AREA						
123456789	Member's name here	$200.00	110.00	$82.34	$0.00	$60.00
123456789	Member's name here	$380.00	281.53	$110.83	$105.83	$40.70
123456789	Member's name here	$301.64	207.42	$177.53	$53.70	$50.00
BC OF THE ROCHESTER AREA	Totals:	**$881.64**	**$598.95**	**$370.70**	**$159.53**	**$150.70**
BC/BS (GENERIIC)						
123456789	Member's name here	$3,594.00	870.00	$1,272.00	$370.00	$500.00
123456789	Member's name here	$225.00	90.00	$0.00	$0.00	$80.00
123456789	Member's name here	$250.00	141.20	$84.18	$10.60	$50.60
123456789	Member's name here	$400.00	196.43	$289.08	$106.43	$40.00
123456789	Member's name here	$115.00	55.00	$0.00	$0.00	$5.00
123456789	Member's name here	$1,224.06	0.00	$633.41	$0.00	$0.00
123456789	Member's name here	$440.70	300.85	$239.79	$0.00	$0.00
123456789	Member's name here	$855.00	0.00	$417.05	$0.00	$0.00
BC/BS (GENERIIC)	Totals:	**$7,103.76**	**$1,653.48**	**$2,935.51**	**$487.03**	**$675.60**
BLUE CHOICE						
123456789	Member's name here	$165.03	0.00	$155.03	$0.00	$0.00
123456789	Member's name here	$90.00	69.36	$75.42	$9.36	$10.00
123456789	Member's name here	$0.00	0.00	$0.00	$0.00	$0.00

Report Title **Quarterly Coordination of Benefits**

Client Name Place parent/group name field in the formula here

Report Period **From** **to**

Report Description/Data Source

Quarterly report showing COB savings by member. The report is grouped by name of other insurer with subtotals for each insurer and grand totals for the report.

Member ID	Member Name		BILLED	ALLOWED	COBAMT	RCVAMT	PAID
BLUE CHOICE		Totals:	**$255.03**	**$69.36**	**$230.45**	**$9.36**	**$10.00**
BLUE CROSS AND BLUE SHIELD							
123456789	Member's name here		$565.65	565.65	$390.65	$390.65	$61.87
BLUE CROSS AND BLUE SHIELD		Totals:	**$565.65**	**$565.65**	**$390.65**	**$390.65**	**$61.87**
BLUE CROSS ONLY							
123456789	Member's name here		$26,699.76	0.00	$7,685.36	$0.00	$0.00
BLUE CROSS ONLY		Totals:	**$26,699.76**	**$0.00**	**$7,685.36**	**$0.00**	**$0.00**
BLUE CROSS/BLUE SHIELD OF NY							
123456789	Member's name here		$825.00	451.89	$422.00	$346.89	$45.00
123456789	Member's name here		$150.00	60.00	$45.75	$50.00	$0.00
BLUE CROSS/BLUE SHIELD OF NY		Totals:	**$975.00**	**$511.89**	**$467.75**	**$396.89**	**$45.00**
BLUESHIELD OF NORTHEASTERN NY							
123456789	Member's name here		$120.00	79.89	$94.19	$39.89	$15.00
BLUESHIELD OF NORTHEASTERN NY		Totals:	**$120.00**	**$79.89**	**$94.19**	**$39.89**	**$15.00**
CIGNA HEALTHCARE							
123456789	Member's name here		$674.72	0.00	$315.57	$0.00	$0.00
123456789	Member's name here		$490.62	271.49	$0.00	$0.00	$0.00
123456789	Member's name here		$1,440.00	1,260.00	$398.44	$178.08	$694.86
CIGNA HEALTHCARE		Totals:	**$2,605.34**	**$1,531.49**	**$714.01**	**$178.08**	**$694.86**
EMPIRE							
123456789	Member's name here		$215.28	0.00	$31.25	$0.00	$0.00
123456789	Member's name here		$3,700.00	600.00	$1,280.00	$40.00	$160.00
123456789	Member's name here		$175.00	138.38	$0.00	$113.38	$0.00
123456789	Member's name here		$100.00	78.03	$21.50	$35.00	$13.03
123456789	Member's name here		$558.00	239.50	$327.50	$174.50	$20.00
123456789	Member's name here		$320.00	192.00	$0.00	$20.60	$151.40
123456789	Member's name here		$150.00	48.00	$23.00	$0.00	$0.00
EMPIRE		Totals:	**$5,218.28**	**$1,295.91**	**$1,683.25**	**$383.48**	**$344.43**
EMPIRE BC/BS OF NY							
123456789	Member's name here		$340.06	65.00	$146.00	$53.00	$12.00

Report Title **Quarterly Coordination of Benefits**

Client Name Place parent/group name field in the formula here

Report Period **From** **to**

Report Description/Data Source

Quarterly report showing COB savings by member. The report is grouped by name of other insurer with subtotals for each insurer and grand totals for the report.

Member ID	Member Name		BILLED	ALLOWED	COBAMT	RCVAMT	PAID
EMPIRE BC/BS OF NY		Totals:	**$340.06**	**$65.00**	**$146.00**	**$53.00**	**$12.00**
ESRD - MCB PRIMARY							
123456789	Member's name here		$252.22	164.79	$174.60	$107.08	$57.71
123456789	Member's name here		$250.00	0.00	$70.76	$0.00	$0.00
ESRD - MCB PRIMARY		Totals:	**$502.22**	**$164.79**	**$245.36**	**$107.08**	**$57.71**
EXCELLUS BC BS OF ROCHEST							
123456789	Member's name here		$190.00	0.00	$111.02	$0.00	$0.00
EXCELLUS BC BS OF ROCHEST		Totals:	**$190.00**	**$0.00**	**$111.02**	**$0.00**	**$0.00**
EXCELLUS BLUE CROSS BLUE SHIELD							
123456789	Member's name here		$3,467.52	1,506.00	$1,649.19	$856.00	$150.00
123456789	Member's name here		$315.00	201.00	$147.12	$121.95	$49.05
123456789	Member's name here		$160.00	48.00	$0.00	$0.00	$18.00
123456789	Member's name here		$200.00	130.00	$100.00	$5.00	$75.00
123456789	Member's name here		$1,808.00	1,376.63	$1,463.35	$707.03	$344.60
EXCELLUS BLUE CROSS BLUE SHIELD		Totals:	**$5,950.52**	**$3,261.63**	**$3,359.66**	**$1,689.98**	**$636.65**
GROUP HEALTH INC.							
123456789	Member's name here		$660.00	450.00	$330.00	$330.00	$0.00
GROUP HEALTH INC.		Totals:	**$660.00**	**$450.00**	**$330.00**	**$330.00**	**$0.00**
INPATIENT (MEDICARE PART A) ONLY							
123456789	Member's name here		$0.00	0.00	$0.00	$0.00	$0.00
123456789	Member's name here		$123,541.28	7,128.00	$53,589.77	$6,628.00	$0.00
123456789	Member's name here		$1,634.94	0.00	$1,190.88	$0.00	$0.00
INPATIENT (MEDICARE PART A) ONLY		Totals:	**$125,176.22**	**$7,128.00**	**$54,780.65**	**$6,628.00**	**$0.00**
MEDICARE							
123456789	Member's name here		$265.00	0.00	$59.78	$0.00	$0.00
123456789	Member's name here		$94.68	0.00	$72.82	$0.00	$0.00
123456789	Member's name here		$240.00	215.22	$0.00	$30.89	$134.33
123456789	Member's name here		$206.05	0.00	$41.25	$0.00	$0.00
123456789	Member's name here		$1,005.00	565.00	$353.89	$332.93	$142.07
123456789	Member's name here		$-700.00	-565.00	$-171.95	$-312.90	-$152.10
123456789	Member's name here		$242.00	0.00	$80.80	$0.00	$0.00

Report Title **Quarterly Coordination of Benefits**

Client Name Place parent/group name field in the formula here

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Report Description/Data Source

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Member ID	Member Name	BILLED	ALLOWED	COBAMT	RCVAMT	PAID
123456789	Member's name here	$143.56	0.00	$2.85	$0.00	$0.00
123456789	Member's name here	$12,754.61	0.00	$8,406.10	$0.00	$0.00
123456789	Member's name here	$504.00	126.00	$105.60	$99.60	$0.00
123456789	Member's name here	$229.00	0.00	$182.05	$0.00	$0.00
MEDICARE	Totals:	**$14,983.90**	**$341.22**	**$9,133.19**	**$150.52**	**$124.30**
MEDICARE CARVE OUTS						
123456789	Member's name here	$0.00	0.00	$0.00	$0.00	$0.00
MEDICARE CARVE OUTS	Totals:	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
MEDICARE DISABILITY						
123456789	Member's name here	$344,953.24	19,000.00	$125,723.66	$16,977.00	$2,023.00
123456789	Member's name here	$150.00	133.51	$60.70	$93.05	$30.46
123456789	Member's name here	$90.00	51.00	$0.00	$0.00	$0.00
123456789	Member's name here	$175.00	0.00	$0.00	$0.00	$0.00
123456789	Member's name here	$1,008.00	178.00	$308.82	$126.52	$21.48
123456789	Member's name here	$150.00	60.00	$40.19	$38.36	$0.00
123456789	Member's name here	$450.00	308.67	$154.37	$173.71	$59.96
123456789	Member's name here	$1,470.00	390.01	$604.34	$86.41	$104.38
123456789	Member's name here	$94.00	0.00	$75.20	$0.00	$0.00
123456789	Member's name here	$278.73	0.00	$88.55	$0.00	$0.00
123456789	Member's name here	$910.00	444.69	$268.81	$339.69	$0.00
123456789	Member's name here	$450.00	300.00	$188.95	$174.00	$51.00
123456789	Member's name here	$788.00	0.00	$459.94	$0.00	$0.00
123456789	Member's name here	$90.00	60.00	$35.32	$36.46	$23.54
123456789	Member's name here	$0.00	798.90	$0.00	$534.24	$0.00
123456789	Member's name here	$762.09	87.43	$115.72	$76.42	$0.00
123456789	Member's name here	$198.03	198.03	$128.70	$128.70	$9.33
123456789	Member's name here	$272.26	215.83	$134.08	$145.26	$0.00
123456789	Member's name here	$15,406.20	3,562.44	$4,096.15	$1,827.26	$1,735.18
123456789	Member's name here	$960.00	680.22	$420.94	$290.52	$0.00
123456789	Member's name here	$225.00	118.94	$102.83	$90.39	$0.00
123456789	Member's name here	$375.00	160.00	$75.58	$109.60	$50.40
123456789	Member's name here	$320.00	48.00	$79.02	$23.68	$14.32
123456789	Member's name here	$537.00	0.00	$128.04	$0.00	$0.00
123456789	Member's name here	$203.22	0.00	$121.95	$0.00	$0.00
123456789	Member's name here	$210.00	134.00	$35.99	$50.94	$63.06
123456789	Member's name here	$950.00	191.86	$470.34	$136.72	$35.14

Report Title **Quarterly Coordination of Benefits**

Client Name Place parent/group name field in the formula here

Report Period **From** **to**

Report Description/Data Source

Quarterly report showing COB savings by member. The report is grouped by name of other insurer with subtotals for each insurer and grand totals for the report.

Member ID	Member Name	BILLED	ALLOWED	COBAMT	RCVAMT	PAID
123456789	Member's name here	$370.00	156.00	$51.08	$48.50	$59.93
123456789	Member's name here	$450.00	191.86	$124.11	$136.72	$5.14
123456789	Member's name here	$1,217.56	476.00	$383.05	$253.93	$222.07
123456789	Member's name here	$2,775.00	2,775.00	$860.77	$2,192.15	$291.43
123456789	Member's name here	$1,295.00	1,295.00	$376.53	$1,043.98	$125.51
123456789	Member's name here	$1,570.00	1,550.79	$466.34	$1,239.91	$167.44
123456789	Member's name here	$300.00	0.00	$65.91	$0.00	$0.00
123456789	Member's name here	$810.00	0.00	$207.76	$0.00	$0.00
123456789	Member's name here	$160.00	111.00	$118.07	$81.48	$29.52
123456789	Member's name here	$475.00	0.00	$227.95	$0.00	$0.00
123456789	Member's name here	$105.00	0.00	$13.42	$0.00	$0.00
123456789	Member's name here	$160.00	60.00	$32.86	$37.43	$12.57
123456789	Member's name here	$280.00	90.00	$57.90	$51.41	$38.59
123456789	Member's name here	$232.50	103.85	$78.07	$61.81	$2.04
123456789	Member's name here	$725.00	183.34	$319.29	$128.20	$0.00
123456789	Member's name here	$222.69	91.00	$133.78	$57.56	$0.00
123456789	Member's name here	$337.57	216.00	$117.08	$84.91	$76.81
123456789	Member's name here	$5,250.00	840.00	$0.00	$168.00	$672.00
123456789	Member's name here	$160.00	60.00	$33.86	$37.43	$12.57
123456789	Member's name here	$120.00	14.60	$0.00	$63.91	-$45.29
MEDICARE DISABILITY	Totals:	**$388,491.09**	**$35,335.97**	**$137,586.02**	**$27,146.26**	**$5,891.58**
MEDICARE DISABILITY A,B & D						
123456789	Member's name here	$1,000.00	0.00	$244.15	$0.00	$0.00
123456789	Member's name here	$298.32	226.80	$136.10	$52.48	$0.00
MEDICARE DISABILITY A,B & D	Totals:	**$1,298.32**	**$226.80**	**$380.25**	**$52.48**	**$0.00**
MEDICARE PART B						
123456789	Member's name here	$370.00	196.00	$140.91	$107.45	$8.55
123456789	Member's name here	$730.00	449.16	$379.83	$328.57	$80.59
123456789	Member's name here	$275.23	0.00	$146.84	$0.00	$0.00
123456789	Member's name here	$630.00	330.00	$287.94	$120.00	$0.00
123456789	Member's name here	$180.00	141.58	$36.02	$71.58	$0.00
123456789	Member's name here	$250.00	133.01	$135.00	$18.01	$90.00
123456789	Member's name here	$200.00	175.00	$118.36	$145.41	$9.59
123456789	Member's name here	$0.00	155.41	$0.00	$128.00	$27.41
123456789	Member's name here	$140.00	89.00	$47.99	$57.00	$0.00
123456789	Member's name here	$185.00	82.45	$0.00	$65.96	$6.89

Report Title **Quarterly Coordination of Benefits**

Client Name Place parent/group name field in the formula here

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Member ID	Member Name	BILLED	ALLOWED	COBAMT	RCVAMT	PAID
123456789	Member's name here	$533.68	300.00	$171.88	$125.00	$0.00
123456789	Member's name here	$17,373.67	6,234.00	$6,461.65	$5,043.00	$1,156.00
123456789	Member's name here	$120.00	0.00	$78.98	$0.00	$0.00
123456789	Member's name here	$120.00	95.22	$0.00	$60.22	$0.00
123456789	Member's name here	$300.00	150.00	$43.83	$53.63	$71.37
123456789	Member's name here	$475.30	0.00	$245.84	$0.00	$0.00
123456789	Member's name here	$1,263.00	256.00	$376.32	$116.00	$0.00
123456789	Member's name here	$520.00	220.00	$143.96	$124.00	$36.00
123456789	Member's name here	$150.00	133.51	$60.70	$93.05	$20.46
123456789	Member's name here	$580.00	240.00	$108.96	$167.36	$32.64
123456789	Member's name here	$177.22	0.00	$125.85	$0.00	$0.00
123456789	Member's name here	$90.00	70.79	$36.02	$46.79	$4.00
123456789	Member's name here	$7,984.20	0.00	$1,081.91	$0.00	$0.00
123456789	Member's name here	$255.00	156.76	$134.10	$134.42	$0.00
123456789	Member's name here	$177.22	94.00	$125.85	$59.00	$0.00
123456789	Member's name here	$890.00	413.17	$138.46	$150.67	$262.50
123456789	Member's name here	$157.31	80.00	$125.85	$45.00	$0.00
123456789	Member's name here	$275.00	244.97	$105.71	$174.50	$20.47
123456789	Member's name here	$135.00	0.00	$88.55	$0.00	$0.00
123456789	Member's name here	$341.92	0.00	$179.84	$0.00	$0.00
123456789	Member's name here	$875.00	240.00	$282.38	$132.40	$107.60
123456789	Member's name here	$145.00	31.00	$22.92	$15.72	$15.28
123456789	Member's name here	$171.00	0.00	$40.53	$0.00	$0.00
123456789	Member's name here	$260.00	0.00	$161.41	$0.00	$0.00
123456789	Member's name here	$150.00	0.00	$0.00	$0.00	$0.00
123456789	Member's name here	$528.00	108.00	$180.51	$62.86	$45.14
123456789	Member's name here	$329.00	0.00	$95.80	$0.00	$0.00
123456789	Member's name here	$175.00	80.00	$124.34	$0.00	$0.00
123456789	Member's name here	$220.00	0.00	$76.22	$0.00	$0.00
123456789	Member's name here	$200.00	0.00	$118.07	$0.00	$0.00
123456789	Member's name here	$0.00	0.00	$0.00	$0.00	$0.00
123456789	Member's name here	$375.00	266.77	$161.38	$213.60	$13.17
123456789	Member's name here	$339.00	0.00	$109.65	$0.00	$0.00
123456789	Member's name here	$193.00	0.00	$0.00	$0.00	$0.00
123456789	Member's name here	$959.84	839.86	$400.67	$406.25	$293.61
123456789	Member's name here	$105.00	67.00	$0.00	$7.94	$49.06
123456789	Member's name here	$1,485.00	737.00	$556.42	$473.00	$0.00
123456789	Member's name here	$180.00	141.58	$84.55	$91.45	$26.13
123456789	Member's name here	$320.00	130.00	$114.12	$57.73	$26.33

Report Title **Quarterly Coordination of Benefits**

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123456789	Member's name here	$1,125.00	540.00	$396.70	$314.80	$90.20
123456789	Member's name here	$11,977.06	1,606.00	$1,847.66	$0.00	$0.00
123456789	Member's name here	$884.00	425.00	$146.24	$241.29	$29.36
123456789	Member's name here	$343.00	0.00	$109.65	$0.00	$0.00
123456789	Member's name here	$386.25	0.00	$92.21	$0.00	$0.00
123456789	Member's name here	$0.00	175.00	$0.00	$150.50	$24.50
123456789	Member's name here	$785.34	0.00	$227.52	$0.00	$0.00
123456789	Member's name here	$420.00	360.00	$226.74	$208.80	$0.00
123456789	Member's name here	$155.00	60.00	$40.19	$0.00	$0.00
123456789	Member's name here	$485.00	156.00	$306.38	$35.40	$0.00
123456789	Member's name here	$580.00	380.00	$335.35	$145.35	$114.65
123456789	Member's name here	$349.07	161.00	$107.52	$66.14	$94.86
123456789	Member's name here	$243.91	131.00	$157.76	$78.26	$6.46
123456789	Member's name here	$300.00	196.17	$0.00	$52.43	$123.74
123456789	Member's name here	$393.28	0.00	$98.01	$0.00	$0.00
123456789	Member's name here	$280.00	110.00	$141.21	$52.76	$37.24
123456789	Member's name here	$200.00	135.06	$57.32	$96.85	$18.21
123456789	Member's name here	$160.00	96.00	$0.00	$26.52	$49.48
123456789	Member's name here	$200.00	135.06	$57.32	$96.85	$13.21
123456789	Member's name here	$1,005.00	649.00	$503.12	$355.28	$158.72
123456789	Member's name here	$200.00	156.76	$67.04	$112.06	$0.00
123456789	Member's name here	$174.62	0.00	$60.92	$0.00	$0.00
123456789	Member's name here	$200.00	188.34	$0.00	$0.00	$150.67
123456789	Member's name here	$345.00	266.77	$151.59	$214.90	$31.87
123456789	Member's name here	$180.00	141.20	$65.03	$80.32	$40.88
123456789	Member's name here	$510.00	55.00	$61.79	$35.38	$9.62
123456789	Member's name here	$292.00	135.06	$57.32	$96.85	$28.21
123456789	Member's name here	$-79.21	-124.00	$-49.18	$-99.50	-$24.50
123456789	Member's name here	$0.00	0.00	$0.00	$0.00	$0.00
123456789	Member's name here	$96.03	0.00	$53.90	$0.00	$0.00
123456789	Member's name here	$66.01	66.01	$42.90	$42.90	$0.00
123456789	Member's name here	$881.62	0.00	$361.74	$0.00	$0.00
123456789	Member's name here	$1,849.62	0.00	$642.65	$0.00	$0.00
123456789	Member's name here	$360.00	187.00	$61.24	$61.20	$0.00
123456789	Member's name here	$200.00	186.86	$0.00	$49.98	$116.88
123456789	Member's name here	$411.00	209.00	$138.88	$174.28	$0.13
123456789	Member's name here	$231.00	107.90	$77.17	$40.75	$13.20
MEDICARE PART B	Totals:	**$68,078.19**	**$19,972.43**	**$20,300.01**	**$11,625.92**	**$3,530.38**

Report Title **Quarterly Coordination of Benefits**

Client Name Place parent/group name field in the formula here

Report Period **From** **to**

Report Description/Data Source

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MEDICARE-RETIRED						
123456789	Member's name here	$105.00	67.00	$38.39	$46.33	$0.00
123456789	Member's name here	$128.00	60.00	$36.38	$35.75	$0.00
123456789	Member's name here	$90.00	51.00	$0.00	$0.14	$30.86
123456789	Member's name here	$1,175.00	720.00	$343.54	$360.17	$259.83
123456789	Member's name here	$960.00	960.00	$0.00	$768.00	$0.00
123456789	Member's name here	$300.00	164.00	$116.17	$93.79	$50.21
123456789	Member's name here	$2,100.00	736.00	$568.97	$392.44	$123.56
123456789	Member's name here	$330.00	132.00	$57.01	$5.32	$20.68
123456789	Member's name here	$450.00	210.00	$143.97	$114.00	$54.00
123456789	Member's name here	$543.08	179.93	$167.45	$78.20	$101.73
123456789	Member's name here	$288.00	95.00	$122.91	$63.85	$0.00
123456789	Member's name here	$150.00	65.00	$41.78	$37.14	$2.86
123456789	Member's name here	$146.00	31.00	$57.56	$11.81	$0.00
123456789	Member's name here	$657.00	359.89	$123.96	$194.57	$165.32
123456789	Member's name here	$850.00	0.00	$116.76	$0.00	$0.00
123456789	Member's name here	$500.00	227.40	$0.00	$181.92	$45.48
123456789	Member's name here	$282.39	210.00	$161.37	$102.42	$107.58
123456789	Member's name here	$1,240.00	360.00	$226.74	$208.80	$151.20
123456789	Member's name here	$150.00	50.00	$29.54	$30.31	$19.69
123456789	Member's name here	$275.00	50.00	$146.96	$30.31	$19.69
123456789	Member's name here	$150.00	94.29	$56.58	$0.00	$0.00
MEDICARE-RETIRED	Totals:	**$10,869.47**	**$4,822.51**	**$2,556.04**	**$2,755.27**	**$1,152.69**
MI EDUCATION SPECIAL SERVICES ASSOC						
123456789	Member's name here	$1,408.00	571.00	$374.92	$427.28	$93.72
123456789	Member's name here	$113.24	69.36	$33.86	$36.79	$22.57
123456789	Member's name here	$53.61	53.61	$32.17	$22.17	$21.44
123456789	Member's name here	$720.00	479.34	$0.00	$383.46	$0.00
123456789	Member's name here	$3,763.78	2,594.29	$1,114.96	$1,928.08	$406.21
123456789	Member's name here	$2,515.00	1,357.34	$531.98	$480.25	$212.09
123456789	Member's name here	$104.00	45.00	$36.18	$10.88	$24.12
MI EDUCATION SPECIAL SERVICES ASSOC	Totals:	**$8,677.63**	**$5,169.94**	**$2,124.07**	**$3,288.91**	**$780.15**
MVP DUAL-SECONDARY POLICY						
123456789	Member's name here	$14,765.16	7,000.00	$6,500.00	$5,134.99	$500.00
123456789	Member's name here	$1,050.00	420.00	$315.00	$175.00	$105.00
123456789	Member's name here	$75.00	60.00	$35.00	$30.00	$0.00

Report Title **Quarterly Coordination of Benefits**

Client Name Place parent/group name field in the formula here

Report Period **From** **to**

Report Description/Data Source

Quarterly report showing COB savings by member. The report is grouped by name of other insurer with subtotals for each insurer and grand totals for the report.

Member ID	Member Name	BILLED	ALLOWED	COBAMT	RCVAMT	PAID
123456789	Member's name here	$875.00	560.00	$320.00	$40.00	$345.00
123456789	Member's name here	$110.00	55.00	$15.00	$0.00	$5.00
123456789	Member's name here	$200.00	110.00	$10.00	$0.00	$30.00
123456789	Member's name here	$390.00	200.87	$177.77	$125.87	$25.00
123456789	Member's name here	$1,255.00	635.09	$604.09	$425.09	$70.00
123456789	Member's name here	$375.00	270.00	$120.00	$0.00	$50.00
123456789	Member's name here	$3,250.00	1,092.00	$567.00	$0.00	$0.00
123456789	Member's name here	$150.00	80.00	$60.00	$60.00	$0.00
123456789	Member's name here	$150.00	80.00	$60.00	$60.00	$0.00
123456789	Member's name here	$160.00	70.00	$50.00	$0.00	$50.00
123456789	Member's name here	$317.00	197.02	$130.62	$64.23	$66.40
123456789	Member's name here	$469.00	289.81	$177.01	$58.50	$112.80
123456789	Member's name here	$100.00	77.92	$77.92	$57.92	$0.00
123456789	Member's name here	$1,114.22	933.15	$933.15	$933.15	$0.00
MVP DUAL-SECONDARY POLICY	Totals:	**$24,805.38**	**$12,130.86**	**$10,152.56**	**$7,164.75**	**$1,359.20**
NATIONAL BENEFIT FUND						
123456789	Member's name here	$180.00	141.58	$150.00	$91.58	$0.00
NATIONAL BENEFIT FUND	Totals:	**$180.00**	**$141.58**	**$150.00**	**$91.58**	**$0.00**
OTHER INSURANCE						
123456789	Member's name here	$435.00	0.00	$0.00	$0.00	$0.00
OTHER INSURANCE	Totals:	**$435.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
OTHER UNKNOWN HEALTH INSURANCE						
123456789	Member's name here	$-300.00	-130.00	$-82.95	$0.00	$0.00
123456789	Member's name here	$420.00	300.00	$210.00	$260.00	$40.00
123456789	Member's name here	$100.00	77.64	$43.79	$57.64	$20.00
123456789	Member's name here	$118.00	0.00	$0.00	$0.00	$0.00
OTHER UNKNOWN HEALTH INSURANCE	Totals:	**$338.00**	**$247.64**	**$170.84**	**$317.64**	**$60.00**
POMCO						
123456789	Member's name here	$356.00	89.00	$0.00	$0.00	$71.20
123456789	Member's name here	$280.00	178.00	$0.00	$0.00	$158.00
POMCO	Totals:	**$636.00**	**$267.00**	**$0.00**	**$0.00**	**$229.20**
PRAIRIE STATES						

Report Title **Quarterly Coordination of Benefits**

Client Name Place parent/group name field in the formula here

Report Period **From** **to**

Report Description/Data Source

Quarterly report showing COB savings by member. The report is grouped by name of other insurer with subtotals for each insurer and grand totals for the report.

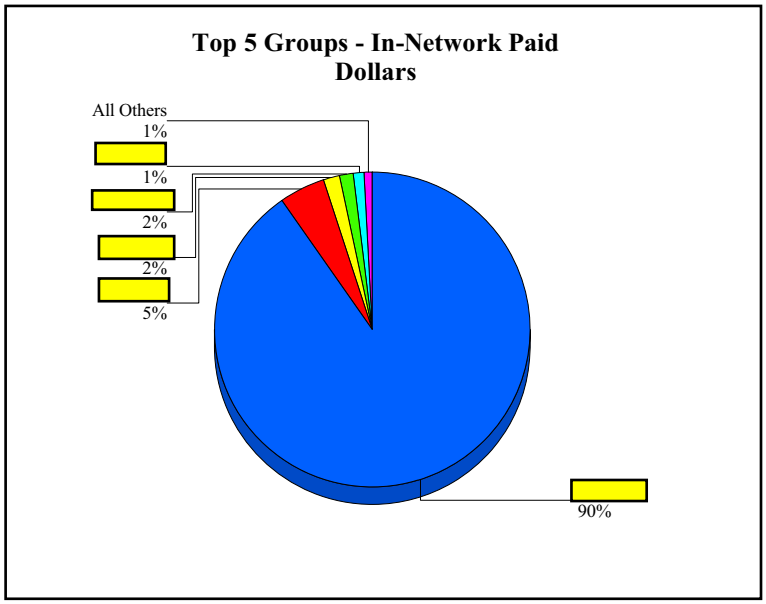
Member ID	Member Name		BILLED	ALLOWED	COBAMT	RCVAMT	PAID
123456789	Member's name here		$-6,033.00	-1,938.00	$-2,752.56	$0.00	$0.00
PRAIRIE STATES		Totals:	**$-6,033.00**	**$-1,938.00**	**$-2,752.56**	**$0.00**	**$0.00**
RISK MANAGEMENT SERVICE C							
123456789	Member's name here		$344.98	266.66	$195.99	$37.33	$79.33
RISK MANAGEMENT SERVICE C		Totals:	**$344.98**	**$266.66**	**$195.99**	**$37.33**	**$79.33**
UNITED HEALTHCARE							
123456789	Member's name here		$120.00	34.00	$29.25	$0.00	$0.00
UNITED HEALTHCARE		Totals:	**$120.00**	**$34.00**	**$29.25**	**$0.00**	**$0.00**
Quarterly Coordination of Benefits		Totals:	**$692,673.44**	**$95,323.41**	**$254,447.32**	**$63,942.39**	**$16,150.65**

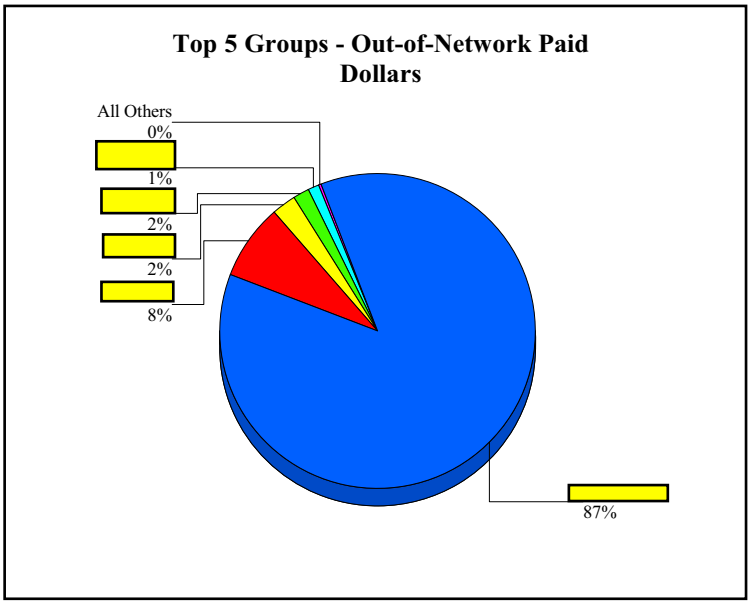
Quarterly Participating Agency Claims

Report Name:	Group/Division Paid Claims by Network Status Summary
Report Number:	2026.2.02
Description:	A claims-based analysis report listing the group/division in/out-of-network dollars paid and percent of total.
Data Source:	Claims
Features:	1. variable reporting periods, by date range 2. summary line for each group/division 3. in-network claims dollars paid and percent of total for each group/division 4. out-of-network dollars paid and percent of total for each group/division 5. graph of top 5 in-network groups by paid dollars (percentage) 6. graph of top 5 out-of-network groups by paid dollars (percentage) 7. available in group and division formats
Ties to Report(s):	N/A

Managed Mental Health and Substance Abuse Activity Report

Group Paid Claims by Network Status Summary Report





Group Name	Group Number	In-Network Dollars Paid	In-Network % of Total [1]	Out-of-Network Dollars Paid	Out-of-Network % of Total [1]	Total Paid
		$19,559.89	94.56%	$1,125.44	5.44%	$20,685.33
		$155.18	100.00%	$0.00	0.00%	$155.18
		$38.00	100.00%	$0.00	0.00%	$38.00
		$2,412,154.18	86.89%	$363,922.30	13.11%	$2,776,076.48
		$43,328.10	56.89%	$32,837.54	43.11%	$76,165.64
		$27,432.34	85.14%	$4,787.30	14.86%	$32,219.64
		$128,234.02	92.68%	$10,131.55	7.32%	$138,365.57
		$42,996.00	85.44%	$7,326.90	14.56%	$50,322.90
		$1,201.00	100.00%	$0.00	0.00%	$1,201.00
Total		**$2,675,098.71**	**86.43%**	**$420,131.03**	**13.57%**	**$3,095,229.74**

[1] *% of Total shows network status distribution for Group.*

Quarterly Website Analytics Report

XYZ CLIENT
Employee Assistance Program Activity Report
January 1, 2012 - December 31, 2012

Achieve Solutions Utilization Data

SUMMARY

	Views	Views - YTD
Total Page Views	7,039	7,039
Total Unique Sessions	3,275	3,275

	Reporting Period		YTD	
MOST FREQUENTLY VISITED TOPICS	**Views**	**% of Page Views**	**Views**	**% of Page Views**
Informational Articles	1,605	34.61%	1,605	34.61%
General Parenting	646	13.93%	646	13.93%
Alcohol	459	9.90%	459	9.90%
Depression	192	4.14%	192	4.14%
Communication	166	3.58%	166	3.58%
Child Care	131	2.82%	131	2.82%
Bipolar Disorder	122	2.63%	122	2.63%
Codependence	116	2.50%	116	2.50%
Stress	109	2.35%	109	2.35%
Heart Health	89	1.92%	89	1.92%
Health	75	1.62%	75	1.62%
Generalized Anxiety Disorder	69	1.49%	69	1.49%
Cancer	62	1.34%	62	1.34%
Elder Care	57	1.23%	57	1.23%
Financial Planning	54	1.16%	54	1.16%
All Others	686	14.79%	686	14.79%
Total	**4,638**	**100.00%**	**4,638**	**100.00%**

XYZ CLIENT
Employee Assistance Program Activity Report
January 1, 2012 - December 31, 2012

Achieve Solutions Utilization Data

MOST FREQUENTLY VIEWED CENTERS	Reporting Period Views	Reporting Period % of Page Views	YTD Views	YTD % of Page Views
Family Care & Education	955	20.94%	955	20.94%
Alcohol and Other Drugs	755	16.55%	755	16.55%
Health & Wellness	644	14.12%	644	14.12%
Relationships	577	12.65%	577	12.65%
Depression	515	11.29%	515	11.29%
Money & Legal	449	9.84%	449	9.84%
Anxiety	333	7.30%	333	7.30%
Work	185	4.06%	185	4.06%
Managers' Tools	88	1.93%	88	1.93%
Emotional Wellness	60	1.32%	60	1.32%
Total	**4,561**	**100.00%**	**4,561**	**100.00%**

CONTENT TYPE	Reporting Period Views	Reporting Period % of Page Views	YTD Views	YTD % of Page Views
Articles	3,493	94.46%	3,493	94.46%
Audio / Video	2	0.05%	2	0.05%
Child Care Services	7	0.19%	7	0.19%
Community Services	27	0.73%	27	0.73%
Mental Health Providers	5	0.14%	5	0.14%
News	88	2.38%	88	2.38%
Quizzes	21	0.57%	21	0.57%
Resources	10	0.27%	10	0.27%
Schools And Camps	5	0.14%	5	0.14%
Others	40	1.08%	40	1.08%
Total	**3,698**	**100.00%**	**3,698**	**100.00%**

Quarterly Provider Audit Report

(CLIENT) WASTE, ABUSE AND FRAUD (WAF) REPORT
Date thru Date
Calander Year xxxx

SIU Case #	Complaint Filed	Date Complaint Filed	Date Case Opened	Provider Name	Provider #	Parent	# of Records Requested	Date Records Received	Date of Findings	Amount of Refund Due	MVP Refund Due	Date Refund Received or Claims Retracted	Case Closed (Y or N)	Comments

* indicates that allegation was not submitted by an (client) member, but there were claims associated with (client) members that were captured

Confidential:
Note: Open cases from prior Calendar year are included until closed.

Monthly Report of Paid Claims by Month of Incurral

Report Title: **Claim Lag Triangulation Report**

Exhibit A

Client Name: **Sample Group**

Paid From: 01/01/2012

Paid Thru: 03/31/2013

Inpatient

Paid Date	Total	Service Date ==> 201201	201202	201203	201204	201205	201206	201207	201208	201209	201210	201211	201212	201301	201302	201302
201201	0.00	0.00														
201202	0.00	0.00	0.00													
201203	9,956.30	3,884.40	6,071.90													
201204	28,322.00	0.00	16,812.14	11,509.86												
201205	14,411.62	312.00	0.00	6,647.82	7,372.80	79.00										
201206	39,612.81	0.00	230.00	14,709.60	7,841.35	15,517.86	1,314.00									
201207	25,724.17	0.00	0.00	13,232.00	4,732.50	2,074.20	5,685.47	0.00								
201208	34,670.39	0.00	0.00	0.00	0.00	5,416.77	13,006.08	16,197.54	50.00							
201209	15,175.20	0.00	0.00	100.00	180.00	45.00	6,229.70	7,870.50	750.00	0.00						
201210	40,375.21	0.00	0.00	0.00	2,475.00	0.00	0.00	3,684.00	3,271.64	13,161.31	17,783.26					
201211	77,779.92	0.00	0.00	0.00	8,154.10	0.00	0.00	29,784.00	10,623.28	144.00	29,027.54	47.00				
201212	20,302.30	0.00	0.00	0.00	0.00	0.00	744.30	0.00	0.00	0.00	0.00	19,558.00	0.00			
201301	59,882.90	86.00	0.00	9,056.00	0.00	1,389.30	2,681.80	3,648.00	1,857.00	0.00	20,088.20	21,032.60	44.00	0.00		
201302	10,421.64	0.00	0.00	0.00	0.00	0.00	2,241.00	1,275.00	1,700.00	0.00	0.00	194.00	4,024.64	987.00	0.00	
201303	36,706.33	0.00	0.00	900.00	0.00	0.00	1,267.92	-1,267.92	0.00	1,967.11	0.00	0.00	21,305.22	0.00	12,534.00	0.00
+Total	$ 413,340.79	4,282.40	23,114.04	56,155.28	30,755.75	24,522.13	33,170.27	61,191.12	18,251.92	15,272.42	66,899.00	40,831.60	25,373.86	987.00	12,534.00	0.00

Outpatient

Paid Date	Total	Service Date ==> 201201	201202	201203	201204	201205	201206	201207	201208	201209	201210	201211	201212	201301	201302	201303
201201	1,405.00	1,405.00														
201202	10,020.00	7,187.00	2,833.00													
201203	36,805.41	11,940.70	17,425.96	7,438.75												
201204	31,296.98	3,072.19	7,079.29	14,715.50	6,430.00											
201205	34,485.57	1,195.13	2,788.88	8,275.41	14,107.20	8,118.95										
201206	43,621.65	2,428.80	3,013.27	3,821.97	9,589.36	15,834.75	8,933.50									
201207	27,665.33	441.87	-69.00	644.00	3,498.15	5,843.28	11,615.28	5,691.75								
201208	35,422.17	0.00	129.00	727.70	995.40	2,374.32	5,477.00	17,416.50	8,302.25							
201209	34,326.70	1,278.00	732.00	1,721.00	3,638.00	2,361.00	1,871.00	3,066.70	12,818.25	6,840.75						
201210	33,916.58	64.00	48.00	255.58	192.00	892.00	1,735.00	1,963.00	5,232.00	14,999.00	8,536.00					
201211	23,463.53	0.00	501.00	501.00	160.00	569.00	791.00	379.00	1,222.00	2,974.00	10,770.53	5,596.00				
201212	23,259.36	15.00	74.00	0.00	88.00	79.00	0.00	0.00	478.00	1,158.34	4,763.00	11,700.02	4,904.00			
201301	27,825.32	699.80	681.83	309.70	153.00	168.00	139.00	107.00	330.00	714.00	2,465.82	4,751.50	13,310.01	3,995.66		
201302	19,707.38	0.00	0.00	0.00	0.00	0.00	0.00	-175.00	0.00	0.00	766.00	1,752.00	2,911.00	10,892.65	3,560.73	
201303	26,979.51	0.00	0.00	0.00	3,250.00	975.00	1,175.00	45.00	28.00	261.00	378.00	1,079.70	922.53	4,582.13	9,464.03	4,819.12
+Total	$ 410,200.49	29,727.49	35,237.23	38,410.61	42,101.11	37,215.30	31,736.78	28,493.95	28,410.50	26,947.09	27,679.35	24,879.22	22,047.54	19,470.44	13,024.76	4,819.12

VALUEOPTIONS - IBNR ANALYSIS -- Claims Paid thru 3/31/2013 -- Sample Group

Exhibit B

Inpatient

Month of Service ==>

	Paid Month	1/2012	2/2012	3/2012	4/2012	5/2012	6/2012	7/2012	8/2012	9/2012	10/2012	11/2012	12/2012	1/2013	2/2013	3/2013	Total
1a.	1/2012																-
1b.	2/2012																-
1c.	3/2012	3,884	6,072														9,956
1d.	4/2012		16,812	11,510													28,322
1e.	5/2012	312		6,648	7,373	79											14,412
1f.	6/2012		230	14,710	7,841	15,518	1,314										39,613
1g.	7/2012			13,232	4,733	2,074	5,685										25,724
1h.	8/2012					5,417	13,006	16,198	50								34,670
1i.	9/2012			100	180	45	6,230	7,871	750								15,175
1j.	10/2012				2,475			3,684	3,272	13,161	17,783						40,375
1k.	11/2012				8,154			29,784	10,623	144	29,028	47					77,780
1l.	12/2012						744					19,558					20,302
1m.	1/2013	86		9,056		1,389	2,682	3,648	1,857		20,088	21,033	44				59,883
1n.	2/2013						2,241	1,275	1,700			194	4,025	987			10,422
1o.	3/2013			900			1,268	(1,268)		1,967			21,305		12,534		36,706
2a.	Incurred & Paid	4,282	23,114	56,155	30,756	24,522	33,170	61,191	18,252	15,272	66,899	40,832	25,374	987	12,534	-	413,341
2b.	Completion Factor	0.99500	0.98500	0.97500	0.97000	0.96500	0.95600	0.93400	0.91700	0.91200	0.87700	0.83200	0.74600	0.58000	0.26200	0.01400	
2c.	Lagged Estimate	4,304	23,466	57,595	31,707	25,412	34,697	65,515	19,904	16,746	76,282	49,076	34,013	1,702	47,840	-	488,258
2d.	Members	25,508	26,258	22,855	25,058	26,093	24,504	25,253	25,776	25,017	24,359	25,732	24,537	23,344	17,858	20,035	362,187
2e.	Paid PMPM	$ 0.17	$ 0.88	$ 2.46	$ 1.23	$ 0.94	$ 1.35	$ 2.42	$ 0.71	$ 0.61	$ 2.75	$ 1.59	$ 1.03	$ 0.04	$ 0.70	$ -	$ 1.14
2f.	Lagged PMPM	$ 0.17	$ 0.89	$ 2.52	$ 1.27	$ 0.97	$ 1.42	$ 2.59	$ 0.77	$ 0.67	$ 3.13	$ 1.91	$ 1.39	$ 0.07	$ 2.68	$ -	$ 1.35
2g.	**Seasonality: DY**	1.02	***0.9534***	1.02	0.99	1.02	0.99	1.02	1.02	0.99	1.02	0.99	1.02	1.02	0.92	1.02	
2h.	Seas.Adj. PMPM	$ 0.17	$ 0.94	$ 2.47	$ 1.28	$ 0.96	$ 1.44	$ 2.55	$ 0.76	$ 0.68	$ 3.07	$ 1.93	$ 1.36	$ 0.07	$ 2.91	$ -	
2i.	Averaged PMPM	$ 0.17	$ 0.53	$ 1.21	$ 1.54	$ 1.60	$ 1.52	$ 1.58	*$ 1.57*	*$ 1.36*	***$ 1.61***	*$ 1.55*	*$ 1.61*	*$ 1.61*	*$ 1.45*	*$ 1.61*	
2j.	Weight Factor	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	70%	60%	40%	5%	0%	
2k.	Final Est PMPM	$ 0.17	$ 0.89	$ 2.52	$ 1.27	$ 0.97	$ 1.42	$ 2.59	$ 0.77	$ 0.67	$ 2.98	$ 1.80	$ 1.47	$ 0.99	$ 1.51	**$ 1.610**	$ 1.43
2l.	Final Est (Sum)	$ 4,304	$ 23,466	$ 57,595	$ 31,707	$ 25,412	$ 34,697	$ 65,515	$ 19,904	$ 16,746	$ 72,564	$ 46,345	$ 36,163	$ 23,164	$ 26,989	$ 32,256	$ 516,826
2m.	IBNR for Month	$ 22	$ 352	$ 1,440	$ 951	$ 889	$ 1,527	$ 4,324	$ 1,652	$ 1,474	$ 5,665	$ 5,514	$ 10,789	$ 22,177	$ 14,455	$ 32,256	$ 103,485
2n.	Recast IBNR	4,304	27,770	85,365	78,794	89,794	84,878	124,669	109,902	111,473	143,662	112,227	128,087	91,368	107,935	103,485	

Outpatient

Month of Service ==>

	Paid Month	1/2012	2/2012	3/2012	4/2012	5/2012	6/2012	7/2012	8/2012	9/2012	10/2012	11/2012	12/2012	1/2013	2/2013	3/2013	Total
3a.	1/2012	1,405															1,405
3b.	2/2012	7,187	2,833														10,020
3c.	3/2012	11,941	17,426	7,439													36,805
3d.	4/2012	3,072	7,079	14,716	6,430												31,297
3e.	5/2012	1,195	2,789	8,275	14,107	8,119											34,486
3f.	6/2012	2,429	3,013	3,822	9,589	15,835	8,934										43,622
3g.	7/2012	442	(69)	644	3,498	5,843	11,615	5,692									27,665
3h.	8/2012		129	728	995	2,374	5,477	17,417	8,302								35,422
3i.	9/2012	1,278	732	1,721	3,638	2,361	1,871	3,067	12,818	6,841							34,327
3j.	10/2012	64	48	256	192	892	1,735	1,963	5,232	14,999	8,536						33,917
3k.	11/2012		501	501	160	569	791	379	1,222	2,974	10,771	5,596					23,464
3l.	12/2012	15	74		88	79			478	1,158	4,763	11,700	4,904				23,259
3m.	1/2013	700	682	310	153	168	139	107	330	714	2,466	4,752	13,310	3,996			27,825
3n.	2/2013							(175)			766	1,752	2,911	10,893	3,561		19,707
3o.	3/2013				3,250	975	1,175	45	28	261	378	1,080	923	4,582	9,464	4,819	26,980
4a.	Incurred & Paid	29,727	35,237	38,411	42,101	37,215	31,737	28,494	28,411	26,947	27,679	24,879	22,048	19,470	13,025	4,819	410,200
4b.	Completion Factor	0.99700	0.99500	0.99300	0.99100	0.98600	0.98300	0.98000	0.97600	0.97200	0.96700	0.95700	0.93000	0.86200	0.70300	0.22900	
4c.	Lagged Estimate	29,817	35,414	38,681	42,483	37,744	32,286	29,075	29,109	27,723	28,624	25,997	23,707	22,588	18,527	21,044	442,821
4d.	Members	25,508	26,258	22,855	25,058	26,093	24,504	25,253	25,776	25,017	24,359	25,732	24,537	23,344	17,858	20,035	362,187
4e.	Paid PMPM	$ 1.17	$ 1.34	$ 1.68	$ 1.68	$ 1.43	$ 1.30	$ 1.13	$ 1.10	$ 1.08	$ 1.14	$ 0.97	$ 0.90	$ 0.83	$ 0.73	$ 0.24	$ 1.13
4f.	Lagged PMPM	$ 1.17	$ 1.35	$ 1.69	$ 1.70	$ 1.45	$ 1.32	$ 1.15	$ 1.13	$ 1.11	$ 1.18	$ 1.01	$ 0.97	$ 0.97	$ 1.04	$ 1.05	$ 1.22
4g.	**Seasonality: DY**	1.02	***0.9534***	1.02	0.99	1.02	0.99	1.02	1.02	0.99	1.02	0.99	1.02	1.02	0.92	1.02	
4h.	Seas.Adj. PMPM	$ 1.15	$ 1.41	$ 1.66	$ 1.72	$ 1.42	$ 1.34	$ 1.13	$ 1.11	$ 1.12	$ 1.15	$ 1.02	$ 0.95	$ 0.95	$ 1.13	$ 1.03	
4i.	Averaged PMPM	$ 1.17	$ 1.22	$ 1.43	$ 1.58	$ 1.63	$ 1.51	$ 1.48	$ 1.42	*$ 1.32*	*$ 1.33*	*$ 1.19*	*$ 1.17*	***$ 1.10***	*$ 1.00*	*$ 1.10*	
4j.	Weight Factor	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	80%	60%	5%	
4k.	Final Est PMPM	$ 1.17	$ 1.35	$ 1.69	$ 1.70	$ 1.45	$ 1.32	$ 1.15	$ 1.13	$ 1.11	$ 1.18	$ 1.01	$ 0.97	$ 0.99	$ 1.02	**$ 1.100**	$ 1.23
4l.	Final Est (Sum)	$ 29,817	$ 35,414	$ 38,681	$ 42,483	$ 37,744	$ 32,286	$ 29,075	$ 29,109	$ 27,723	$ 28,624	$ 25,997	$ 23,707	$ 23,215	$ 18,227	$ 22,039	$ 444,142
4m.	IBNR for Month	$ 89	$ 177	$ 271	$ 382	$ 528	$ 549	$ 582	$ 699	$ 776	$ 945	$ 1,118	$ 1,659	$ 3,745	$ 5,202	$ 17,219	$ 33,942
4n.	Recast IBNR	29,817	63,826	92,488	66,869	70,127	58,791	60,201	53,888	47,285	41,992	44,525	44,973	40,363	38,883	33,942	

Samp Lags 2013-03: ExB SAMPLE Lag Calc: 4/11/2013: 10:29 AM

Monthly Program Customer Service Monthly Reports

Sample Avaya Reports

Split/Skill Comparison

Report Data Start Time: **12:00 AM**

Split/Skill	Skill State	Agents Staffed	Calls Waiting	Oldest Call Waiting	ACD Calls	Avg ACD Time	Aban Calls	Avg Aban Time	Avg Speed Ans
Client A	NORMAL	17	0	:00	37	3:13	3	2:29	:18
Client B	NORMAL	31	0	:00	0		0		
Client C	NORMAL	41	0	:00	230	3:23	5	1:29	:21
Client D	NORMAL	28	0	:00	28	3:54	0		:10
Client E	NORMAL	23	0	:00	0		0		
Client F	NORMAL	5	0	:00	19	2:55	2	1:12	1:28
	NORMAL	20	0	:00	5	7:50	0		:00

Sample Avaya Reports

Split/Skill Summary Interval - Financial CS

Date:

Split/Skill: **Financial CS**

Time	Avg Speed Ans	Avg Aban Time	ACD Calls	Avg ACD Time	Avg ACW Time	Aban Calls	Max Delay	Flow In	Flow Out	Extn Out Calls	Avg Extn Out Time	Dequeued Calls	Avg Time to Dequeue	% ACD Time	% Ans Calls	Avg Pos Staff	Calls Per Pos
Totals	**:05**	**:23**	**2015**	**3:20**	**1:30**	**10**	**2:10**	**0**	**0**	**1010**	**:49**	**0**		**35.12**	**99.51**	**35.7**	**56**
6:30 - 7:00AM			0			0	:00	0	0	0		0		.00		.0	0
7:00 - 7:30AM	:00		3	:58	1:45	0	:00	0	0	0		0		5.64	100.00	7.5	0
7:30 - 8:00AM	:00		11	2:41	1:25	0	:00	0	0	4	:26	0		12.59	100.00	12.8	1
8:00 - 8:30AM	:00		59	2:44	1:20	0	:00	0	0	28	:39	0		42.10	100.00	23.3	3
8:30 - 9:00AM	:00		83	3:12	1:55	0	:00	0	0	38	:52	0		41.70	100.00	32.5	3
9:00 - 9:30AM	:00		80	2:59	1:19	0	:00	0	0	42	:55	0		31.89	100.00	40.8	2
9:30 - 10:00AM	:04		93	3:42	1:34	0	:59	0	0	42	:59	0		37.32	100.00	42.3	2
10:00 - 10:30AM	:02	:08	99	3:43	1:38	1	:38	0	0	44	:34	0		37.65	99.00	48.4	2
10:30 - 11:00AM	:00		130	3:13	1:28	0	:39	0	0	73	:45	0		38.60	100.00	54.0	2
11:00 - 11:30AM	:02		129	2:56	1:35	0	:29	0	0	75	:48	0		38.43	100.00	53.6	2
11:30 - 12:00PM	:10	:05	118	3:03	1:20	1	2:10	0	0	58	1:13	0		30.40	99.16	53.0	2
12:00 - 12:30PM	:02		99	3:09	1:48	0	1:52	0	0	47	:32	0		29.60	100.00	53.0	2
12:30 - 1:00PM	:01		109	3:50	1:35	0	:43	0	0	32	:43	0		37.65	100.00	53.0	2
1:00 - 1:30PM	:01		122	2:45	1:40	0	:41	0	0	73	:45	0		36.69	100.00	52.1	2
1:30 - 2:00PM	:03		132	3:23	1:14	0	:41	0	0	64	:45	0		39.62	100.00	52.0	3
2:00 - 2:30PM	:12	:36	115	3:40	1:17	3	1:49	0	0	51	:43	0		34.60	97.46	53.0	2
2:30 - 3:00PM	:25	:30	122	3:29	1:28	3	2:06	0	0	76	1:11	0		41.54	97.60	53.0	2
3:00 - 3:30PM	:08	:09	139	3:30	1:21	2	1:34	0	0	69	:43	0		41.92	98.58	53.0	3
3:30 - 4:00PM	:06		127	3:14	1:38	0	:48	0	0	68	:38	0		35.08	100.00	49.6	3
4:00 - 4:30PM	:08		92	3:22	1:35	0	1:17	0	0	56	:47	0		32.52	100.00	48.0	2
4:30 - 5:00PM	:10		70	3:56	1:37	0	1:19	0	0	38	1:02	0		35.73	100.00	34.6	2
5:00 - 5:30PM	:00		38	3:59	1:38	0	:00	0	0	12	:34	0		32.27	100.00	17.8	2
5:30 - 6:00PM	:00		15	2:48	1:01	0	:00	0	0	4	1:06	0		16.24	100.00	15.3	1
6:00 - 6:30PM	:00		14	4:51	1:39	0	:00	0	0	9	1:03	0		16.58	100.00	13.2	1
6:30 - 7:00PM	:00		12	2:36	1:16	0	:00	0	0	6	:30	0		14.41	100.00	11.0	1
7:00 - 7:30PM	:50		4	5:23	:05	0	1:42	0	0	1	1:24	0		49.75	100.00	1.1	4

Sample Avaya Reports

Split/Skill Summary Interval - Financial CS

Date

Split/Skill: **Financial CS**

Time	Avg Speed Ans	Avg Aban Time	ACD Calls	Avg ACD Time	Avg ACW Time	Aban Calls	Max Delay	Flow In	Flow Out	Extn Out Calls	Avg Extn Out Time	Dequeued Calls	Avg Time to Dequeue	% ACD Time	% Ans Calls	Avg Pos Staff	Calls Per Pos
Totals	**:05**	**:23**	**2015**	**3:20**	**1:30**	**10**	**2:10**	**0**	**0**	**1010**	**:49**	**0**		**35.12**	**99.51**	**35.7**	**56**
6:30 - 7:00AM			0			0	:00	0	0	0		0		.00		.0	0
7:00 - 7:30AM	:00		3	:58	1:45	0	:00	0	0	0		0		5.64	100.00	7.5	0
7:30 - 8:00AM	:00		11	2:41	1:25	0	:00	0	0	4	:26	0		12.59	100.00	12.8	1
8:00 - 8:30AM	:00		59	2:44	1:20	0	:00	0	0	28	:39	0		42.10	100.00	23.3	3
8:30 - 9:00AM	:00		83	3:12	1:55	0	:00	0	0	38	:52	0		41.70	100.00	32.5	3
9:00 - 9:30AM	:00		80	2:59	1:19	0	:00	0	0	42	:55	0		31.89	100.00	40.8	2
9:30 - 10:00AM	:04		93	3:42	1:34	0	:59	0	0	42	:59	0		37.32	100.00	42.3	2
10:00 - 10:30AM	:02	:08	99	3:43	1:38	1	:38	0	0	44	:34	0		37.65	99.00	48.4	2
10:30 - 11:00AM	:00		130	3:13	1:28	0	:39	0	0	73	:45	0		38.60	100.00	54.0	2
11:00 - 11:30AM	:02		129	2:56	1:35	0	:29	0	0	75	:48	0		38.43	100.00	53.6	2
11:30 - 12:00PM	:10	:05	118	3:03	1:20	1	2:10	0	0	58	1:13	0		30.40	99.16	53.0	2
12:00 - 12:30PM	:02		99	3:09	1:48	0	1:52	0	0	47	:32	0		29.60	100.00	53.0	2
12:30 - 1:00PM	:01		109	3:50	1:35	0	:43	0	0	32	:43	0		37.65	100.00	53.0	2
1:00 - 1:30PM	:01		122	2:45	1:40	0	:41	0	0	73	:45	0		36.69	100.00	52.1	2
1:30 - 2:00PM	:03		132	3:23	1:14	0	:41	0	0	64	:45	0		39.62	100.00	52.0	3
2:00 - 2:30PM	:12	:36	115	3:40	1:17	3	1:49	0	0	51	:43	0		34.60	97.46	53.0	2
2:30 - 3:00PM	:25	:30	122	3:29	1:28	3	2:06	0	0	76	1:11	0		41.54	97.60	53.0	2
3:00 - 3:30PM	:08	:09	139	3:30	1:21	2	1:34	0	0	69	:43	0		41.92	98.58	53.0	3
3:30 - 4:00PM	:06		127	3:14	1:38	0	:48	0	0	68	:38	0		35.08	100.00	49.6	3
4:00 - 4:30PM	:08		92	3:22	1:35	0	1:17	0	0	56	:47	0		32.52	100.00	48.0	2
4:30 - 5:00PM	:10		70	3:56	1:37	0	1:19	0	0	38	1:02	0		35.73	100.00	34.6	2
5:00 - 5:30PM	:00		38	3:59	1:38	0	:00	0	0	12	:34	0		32.27	100.00	17.8	2
5:30 - 6:00PM	:00		15	2:48	1:01	0	:00	0	0	4	1:06	0		16.24	100.00	15.3	1
6:00 - 6:30PM	:00		14	4:51	1:39	0	:00	0	0	9	1:03	0		16.58	100.00	13.2	1
6:30 - 7:00PM	:00		12	2:36	1:16	0	:00	0	0	6	:30	0		14.41	100.00	11.0	1
7:00 - 7:30PM	:50		4	5:23	:05	0	1:42	0	0	1	1:24	0		49.75	100.00	1.1	4

Monthly/Periodic Reports Detailed Claim File Data

Due to the nature of data transmitted "containing detailed claim records", we are unable to provide a sample of the requested report (a claims extract). Below, we provide a sample file layout for a standard claims extract. In the event our client is a covered entity as defined by the HIPAA regulation, we defer to the client's companion guide to develop the HIPAA-compliant claims file.

Standard Claims Extract

The following is the file layout for the Standard Claims Extract:

A = Alphanumeric

Field Name	Field Description	Type	Length	Start Pos.	End Pos.
PARENT	PARENT CODE	A	4	1	4
CREDAT	CREATION DATE	Cyymmdd	7	5	11
CRESEQ	CREATION SEQUENCE NUMBER	A	7	12	18
BRANCD	BRANCH CODE	A	4	19	22
BATDAT	BATCH DATE	Cyymmdd	7	23	29
BATSEQ	BATCH SEQUENCE NUMBER	A	5	30	34
SEQNUM	SEQENCE NUMBER	A	5	35	39
LINENO	LINE NUMBER	A	3	40	42
CLMREV	CLAIM REVERSAL	A	1	43	43
ORGBRN	BRANCH CODE-ORIGINAL LINE	A	4	44	47
ORGDAT	BATCH DATE ORIGINAL LINE	Cyymmdd	7	48	54
ORGSEQ	BATCH SEQUENCE ORIGINAL LINE	A	5	55	59
ORGNUM	SEQUENCE- ORIGINAL LINE	A	5	60	64
ORGLIN	LINE NUMBER – ORIGINAL LINE	A	3	65	67
MEMBNO	MEMBER NUMBER	A	15	68	82
RELCOD	RELATIONSHIP CODE	A	1	83	83
MEMLST	MEMBER LAST NAME	A	20	84	103
MEMFST	MEMBER FIRST NAME	A	15	104	118
MEMMID	MEMBER MIDDLE INITIAL	A	1	119	119
MEMAD1	MEMBER STREET ADDRESS1	A	26	120	145
MEMAD2	MEMBER STREET ADDRESS2	A	26	146	171
MEMCTY	MEMBER CITY	A	20	172	191
MEMSTA	MEMBER STATE	A	2	192	193
MEMZIP	MEMBER ZIP CODE	A	10	194	203
MEMEFF	MEMBER EFFECTIVE DATE	Cyymmdd	7	204	210
MEMALT	MEMBER ALT ID	A	15	211	225
SUBSNO	SUBSCRIBER NUMBER	A	15	226	240
SUBLST	SUBSCRIBER LAST NAME	A	20	241	260
SUBFST	SUBSCRIBER FIRST NAME	A	15	261	275
SUBMID	SUBSCRIBER MIDDLE INITIAL	A	1	276	276
SUBAD1	SUBSCRIBER STREET ADDRESS 1	A	26	277	302
SUBAD2	SUBSCRIBER STREET ADDRESS 2	A	26	303	328
SUBCTY	SUBSCRIBER CITY	A	20	329	348
SUBSTA	SUBSCRIBER STATE	A	2	349	350
SUBZIP	SUBSCRIBER ZIP CODE	A	10	351	360
SUBSOC	SUBSCRIBER SOCIAL SECURITY NUMBER	A	12	361	372
SUBBTH	SUBSCRIBER BIRTH DATE	Cyymmdd	7	373	379

Field Name	Field Description	Type	Length	Start Pos.	End Pos.
SUBSEX	SUBSCRIBER GENDER	A	1	380	380
SUBALT	SUBSCRIBER ALT ID	A	15	381	395
FORMCD	CLAIM FORM	A	1	396	396
CLATYP	CLAIM TYPE	A	2	397	398
PRVCPY	PROVIDER CAPACITY CODE	A	2	399	400
PROVNO	PROVIDER NUMBER	A	15	401	415
PRVORG	PROVIDER ORGANIZATION	A	4	416	419
PRVTYP	PROVIDER TYPE	A	2	420	421
LICENO	LICENSE NUMBER	A	15	422	436
PPARCD	PARTICIPATING PROVIDER CODE	A	2	437	438
PRVLST	PROVIDER LAST NAME	A	20	439	458
PRVFST	PROVIDER FIRST NAME	A	15	459	473
PRVMID	PROVIDER MIDDLE INITIAL	A	1	474	474
PRVTTL	PROVIDER TITLE	A	4	475	478
PRVAD1	PROVIDER STREET ADDRESS 1	A	26	479	504
PRVAD2	PROVIDER STREET ADDRESS 2	A	26	505	530
PRVCTY	PROVIDER CITY	A	18	531	548
PRVSTA	PROVIDER STATE	A	2	549	550
PRVZIP	PROVIDER ZIP CODE	A	10	551	560
FEDNUM	FEDERAL TAX ID NUMBER	A	15	561	575
PCPNUM	PRIMARY CARE PROVIDER NUMBER	A	15	576	590
PCPLST	PRIMARY CARE PROVIDER LAST NAME	A	20	591	610
PCPFST	PRIMARY CARE PROVIDER FIRST NAME	A	15	611	625
PCPMID	PRIMARY CARE PROVIDER MIDDLE INITIAL	A	1	626	626
PCPTTL	PRIMARY CARE PROVIDER TITLE	A	4	627	630
PCPAD1	PRIMARY CARE PROVIDER STREET ADDRESS 1	A	26	631	656
PCPAD2	PRIMARY CARE PROVIDER STREET ADDRESS 2	A	26	657	682
PCPCTY	PRIMARY CARE PROVIDER CITY	A	18	683	700
PCPSTA	PRIMARY CARE PROVIDER STATE	A	2	701	702
PCPZIP	PRIMARY CARE PROVIDER ZIP CODE	A	10	703	712
ALWUCN	ALLOWED UNITS	A	3	713	715
CLAAMT	CLAIMED AMOUNT	A	9	716	724
ALWAMT	ALLOWED AMOUNT	A	9	725	733
DEDAMT	DEDUCTIBLE AMOUNT	A	7	734	740
COIAMT	CO-INSURANCE AMOUNT	A	7	741	747
COPAMT	CO-PAYMENT AMOUNT	A	7	748	754
WHDAMT	WITHHOLD AMOUNT	A	7	755	761
NONAMT	NON-COVERED AMOUNT	A	7	762	768
COBAMT	COORDINATE OF BENEFITS AMOUNT	A	7	769	775
PREAMT	PREPAID AMOUNT	A	7	776	782
DSCAMT	DISCOUNT AMOUNT	A	7	783	789
PENAMT	PRE-CERT PENALTY AMOUNT	A	7	790	796
CPAICN	INTERNAL CONTROL NUMBER	A	16	797	812
ELGDNY	MEMBER INELIGIBLE	A	1	813	813
INSCOD	COORDINATION OF BENEFITS INSURANCE CODE	A	3	814	816
PATAMT	AMOUNT PATIENT HAS PAID	A	7	817	823
USERID	USERID	A	8	824	831
PATSTA	PATIENT STATUS UPON DISCHARGE	A	2	832	833

Field Name	Field Description	Type	Length	Start Pos.	End Pos.
PATNUM	PATIENT NUMBER	A	15	834	848
SEXCOD	SEX CODE	A	1	849	849
BTHDAT	PATIENT BIRTH DATE	Cyymmdd	7	850	856
BILCOD	BILLING CODE	A	3	857	859
GRPNUM	GROUP NUMBER	A	6	860	865
POSCOD	PLACE OF SERVICE CODE	A	2	866	867
TOSCOD	TYPE OF SERVICE CODE	A	2	868	869
SVCDAT	DATE OF SERVICE	Cyymmdd	7	870	876
ENDDAT	ENDING DATE	Cyymmdd	7	877	883
SVCCOD	SERVICE CODE	A	6	884	889
MODCOD	MODIFIER CODE 1	A	2	890	891
MODCD2	MODIFIER CODE 2	A	2	892	893
MODCD3	MODIFIER CODE 3	A	2	894	895
MODCD4	MODIFIER CODE 4	A	2	896	897
FEECOD	FEE CODE	A	6	898	903
TYPCOD	TYPE CODE	A	2	904	905
UNICNV	UNIT LIMIT	A	3	906	908
PADAMT	PAID AMOUNT	A	15	909	923
SYSDAT	SYSTEM DATE	Cyymmdd	7	924	930
DIAGN1	DIAGNOSIS CODE	A	8	931	938
DIAGN2	DIAGNOSIS CODE	A	8	939	946
DIAGN3	DIAGNOSIS CODE	A	8	947	954
DIAGN4	DIAGNOSIS CODE	A	8	955	962
DIAGX1	DIAGNOSIS CODE	A	8	963	970
DIAGX2	DIAGNOSIS CODE	A	8	971	978
DIAGX3	DIAGNOSIS CODE	A	8	979	986
DIAGX4	DIAGNOSIS CODE	A	8	987	994
PIDATE	PAID DATE	Cyymmdd	7	995	1001
BENCOD	BENEFIT CODE	A	3	1002	1004
BENPKG	BENEFIT PACKAGE	A	4	1005	1008
HLDCD1	HOLD CODE 1	A	4	1009	1012
HLDCD2	HOLD CODE 2	A	4	1013	1016
HLDCD3	HOLD CODE 3	A	4	1017	1020
HLDCD4	HOLD CODE 4	A	4	1021	1024
HLDCD5	HOLD CODE 5	A	4	1025	1028
EOPCD1	EOP CODE 1	A	3	1029	1031
EOPCD2	EOP CODE 2	A	3	1032	1034
EOPCD3	EOP CODE 3	A	3	1035	1037
EOPCD4	EOP CODE 4	A	3	1038	1040
EOPCD5	EOP CODE 5	A	3	1041	1043
HOSBEG	HOSPITAL BEGIN DATE	Cyymmdd	7	1044	1050
HOSEND	HOSPITAL END DATE	Cyymmdd	7	1051	1057
ACCTIM	ACCIDENT TIME	A	2	1058	1059
DISTIM	DISCHARGE TIME	A	2	1060	1061
ALTPRV	ALTERNATE PROVIDER NUMBER	A	15	1062	1076
MXBDAT	BEGIN DATE	Cyymmdd	7	1077	1083
MXEDAT	END DATE	Cyymmdd	7	1084	1090
MXSDAT	SYSTEM DATE	Cyymmdd	7	1091	1097
ADMTYP	ADMISSION TYPE	A	1	1098	1098
RCVDAT	RECEIVED DATE	Cyymmdd	7	1099	1105

Field Name	Field Description	Type	Length	Start Pos.	End Pos.
ATHBCH	AUTHORIZATION BRANCH CODE	A	4	1106	1109
ATHDAT	AUTHORIZATION BATCH DATE	Cyymmdd	7	1110	1116
ATHBAT	AUTHORIZATION BATCH SEQUENCE	A	5	1117	1121
ATHSEQ	AUTHORIZATION SEQUENCE NUMBER	A	5	1122	1126
ATHTYP	AUTHORIZATION TYPE	A	1	1127	1127
DISTAT	DISCHARGE STATUS	A	2	1128	1129
PROVFR	AUTHORIZATION REFERRING PROVIDER	A	15	1130	1144
CHKNUM	CHECK NUMBER FOR THE PAYMENT ISSUED	A	10	1145	1154
NCVDAY	NOT COVERED DAYS	A	3	1155	1157
SUBTID	SUBMITTER ID	A	16	1158	1173
USRNUM	USER DEFINED FIELD FOR ACCOUNT	A	18	1174	1191
SVCVND	SERVICING VENDOR NUMBER	A	15	1192	1206
SVVLST	SERVICING VENDOR LAST NAME	A	20	1207	1226
SVVFST	SERVICING VENDOR FIRST NAME	A	15	1227	1241
SVVMID	SERVICING VENDOR MIDDLE INITIAL	A	1	1242	1242
SVVTTL	SERVICING VENDOR TITLE	A	4	1243	1246
SVVAD1	SERVICING VENDOR STREET ADDRESS 1	A	26	1247	1272
SVVAD2	SERVICING VENDOR STREET ADDRESS 2	A	26	1273	1298
SVVCTY	SERVICING VENDOR CITY	A	18	1299	1316
SVVSTA	SERVICING VENDOR STATE	A	2	1317	1318
SVVZIP	SERVICING VENDOR ZIP CODE	A	10	1319	1328
PAYVEN	PAID VENDOR	A	15	1329	1343
PDVFED	PAID VENDOR FEDERAL TAX ID	A	16	1344	1359
PDVLST	PAID VENDOR LAST NAME	A	20	1360	1379
PDVFST	PAID VENDOR FIRST NAME	A	15	1380	1394
PDVMID	PAID VENDOR MIDDLE INITIAL	A	1	1395	1395
PDVTTL	PAID VENDOR TITLE	A	4	1396	1399
PDVAD1	PAID VENDOR STREET ADDRESS 1	A	26	1400	1425
PDVAD2	PAID VENDOR STREET ADDRESS 2	A	26	1426	1451
PDVCTY	PAID VENDOR CITY	A	18	1452	1469
PDVSTA	PAID VENDOR STATE	A	2	1470	1471
PDVZIP	PAID VENDOR ZIP CODE	A	10	1472	1481
RCVAMT	COORDINATION OF BENEFITS RECOVERY AMOUNT	A	7	1482	1488
TIERCD	COVERAGE SELECTED BY THE SUBSCRIBER	A	4	1489	1492
PAYCOD	PAYMENT CODE	A	1	1493	1493
ORIGPD	ORIGINAL PAID DATE	Cyymmdd	7	1494	1500
ORIGCK	ORIGINAL CHECK NUMBER	A	10	1501	1510
PSTDAT	POSTING DATE	Cyymmdd	7	1511	1517
PROCOD	A/P PROFILE CODE	A	3	1518	1520
MEMEXP	MEMBER EXPIRATION DATE	Cyymmdd	7	1521	1527
PRVSOC	PROVIDER SOCIAL SECURITY NUMBER	A	12	1528	1539
SPECD1	SPECIALTY CODE 1	A	5	1540	1544
PRVMED	PROVIDER MEDICAID NUMBER	A	15	1545	1559
TOTCLA	TOTAL CLAIM AMOUNT	A	11	1560	1570
ADMSRC	ADMISSION SOURCE	A	1	1571	1571
SVCCD1	PRINCIPAL PROCEDURE CODE 1	A	6	1572	1577
SVCDT1	PRINCIPAL PROCEDURE DATE 1	Cyymmdd	7	1578	1584
SVCCD2	PROCEDURE CODE 2	A	6	1585	1590
SVCDT2	PROCEDURE DATE 2	Cyymmdd	7	1591	1597

Field Name	Field Description	Type	Length	Start Pos.	End Pos.
SVCCD3	PROCEDURE CODE 3	A	6	1598	1603
SVCDT3	PROCEDURE DATE 3	Cyymmdd	7	1604	1610
SVCCD4	PROCEDURE CODE 4	A	6	1611	1616
SVCDT4	PROCEDURE DATE 4	Cyymmdd	7	1617	1623
SVCCD5	PROCEDURE CODE 5	A	6	1624	1629
SVCDT5	PROCEDURE DATE 5	Cyymmdd	7	1630	1636
SVCCD6	PROCEDURE CODE 6	A	6	1637	1642
SVCDT6	PROCEDURE DATE 6	Cyymmdd	7	1643	1649
SPNCOD	SPAN CODE	A	2	1650	1651
SPNBEG	SPAN BEGIN DATE	Cyymmdd	7	1652	1658
SPNEND	SPAN END DATE	Cyymmdd	7	1659	1665
SPNCOD 2	SPAN CODE 2	A	2	1666	1667
SPNBEG 2	SPAN BEGIN DATE 2	Cyymmdd	7	1668	1674
SPNEND 2	SPAN END DATE 2	Cyymmdd	7	1675	1681
PMTCD1	OCCURENCE CODE 1	A	2	1682	1683
PMTDT1	OCCURENCE DATE 1	Cyymmdd	7	1684	1690
PMTCD2	OCCURENCE CODE 2	A	2	1691	1692
PMTDT2	OCCURENCE DATE 2	Cyymmdd	7	1693	1699
PMTCD3	OCCURENCE CODE 3	A	2	1700	1701
PMTDT3	OCCURENCE DATE 3	Cyymmdd	7	1702	1708
PMTCD4	OCCURENCE CODE 4	A	2	1709	1710
PMTDT4	OCCURENCE DATE 4	Cyymmdd	7	1711	1717
PMTCD5	OCCURENCE CODE 5	A	2	1718	1719
PMTDT5	OCCURENCE DATE 5	Cyymmdd	7	1720	1726
PMTCD6	OCCURENCE CODE 6	A	2	1727	1728
PMTDT6	OCCURENCE DATE 6	Cyymmdd	7	1729	1735
VALCD1	UB VALUE CODE 1	A	2	1736	1737
VALAM1	UB VALUE AMOUNT 1	A	9	1738	1746
VALCD2	UB VALUE CODE 2	A	2	1747	1748
VALAM2	UB VALUE AMOUNT 2	A	9	1749	1757
VALCD3	UB VALUE CODE 3	A	2	1758	1759
VALAM3	UB VALUE AMOUNT 3	A	9	1760	1768
INSCD2	OTHER INSURANCE TYPE CODE	A	3	1769	1771
GRPPOL	OTHER INSURANCE GROUP NAME	A	30	1772	1801
MEMNUM	OTHER INSURANCE MEMBER NUMBER	A	30	1802	1831
TOTPAD	TOTAL PAID AMOUNT	A	11	1832	1842
EMGCOD	EMERGENCY INDICATOR	A	1	1843	1843
HRAIND	HRA INDICATOR	A	1	1844	1844
ADMTIM	ADDMISSION TIME	A	2	1845	1846
NPINUM	PROVIDER NPI	A	10	1847	1856
SUBTXMYB	Submitted Taxonomy Code Billing	A	10	1857	1866
SUBTXMYR	Submitted Taxonomy Code Rendering	A	10	1867	1876
SUBTXMYA	Submitted Taxonomy Code Attending	A	10	1877	1886
SUBNPIB	Submitted NPI Billing	A	10	1887	1896
SUBNPIR	Submitted NPI Rendering	A	10	1897	1906

VALUEOPTIONS®	**Section: IV**	**Number: LC427**
	Keywords: BAA	**Category: A**
Review Date: 8/13/07, 12/06/07, 11/10/09, 11/01/10, 12/01/10, 12/22/11, 9/27/12	**Page 1 of 4**	**Original Date of Issue: 8/12/05**
Functional Area: Compliance Department	**Date(s) Revised: 8/21/06, 11/13/08**	
Service Center/Operating Unit: All	**Subject: Business Associate Agreements**	
Approval Signatures: [redacted]		

I. Purpose:

To set forth the requirements necessary to document ValueOptions® efforts to assure that Business Associates comply with HIPAA privacy standards.

II. Committee(s) and Department(s) Affected:

A. National Compliance Committee

B. National Departments and all Service Centers

C. All Staff

III. Policy:

A. ValueOptions®, as a covered entity under HIPAA, is required to assure that any vendor contracted as a Business Associate and with whom it shares protected health information (PHI) handles that information in accordance with federal and state privacy regulations.

B. In situations where ValueOptions® is the contracted Business Associate of another covered entity, ValueOptions® is required to comply with the terms set forth in the Business Associate Agreement with that covered entity.

IV. Definitions:

A. BUSINESS ASSOCIATE (BA): An individual or entity which has an agreement to perform a function or activity involving the use or disclosure of PHI, including claims processing or administration, data analysis, utilization review, quality assurance, billing, benefit management, practice management and repricing. Business Associates are not part of ValueOptions® workforce.

B. BUSINESS ASSOCIATE AGREEMENT (BAA): A written contract between a BA and a covered entity that specifies the permitted uses and disclosures and the safeguards for protected health information (PHI) by a BA in order to perform a

function or activity, or to provide a service on behalf of the covered entity. Providers are generally not Business Associates of ValueOptions®, unless they are performing services on behalf of ValueOptions other than the provision of Treatment.

C. COVERED ENTITY (CE): A health plan, healthcare clearinghouse or healthcare provider who transmits any health information in electronic form with a HIPAA transaction.

D. DISCLOSURE: The release, transfer, provision of, access to, or divulging of an individual's PHI in any manner, electronic, verbal or written to an individual, agency or organization within or outside of ValueOptions®.

E. HIPAA: Health Insurance Portability and Accountability Act of 1996, Public Law 104-191:

1. Allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships;
2. Mandates the use of standards for electronic exchange of health care data, specifies what code sets should be used; and requires the use of national identification systems for health care patients, providers, payers and employers; and
3. Specifies the types and measures required to protect the security and privacy of PHI.

F. PROTECTED HEALTH INFORMATION (PHI): Individually identifiable *health information* that is: **(**1) Transmitted by electronic media; (2) Maintained in any medium; and (3) Transmitted or maintained in any other form or medium.

HEALTH INFORMATION is defined under HIPAA as any information, whether oral or recorded in any form or medium that:

1. Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

G. TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO): The use and disclosure of PHI for purposes of TPO is allowed without specific Authorization from the patient. Treatment means the provision, coordination and management of health care and related services by one or more health care providers. Payment includes activities undertaken to obtain reimbursement for health care services, determine eligibility for coverage and/or to provide benefits. Health care operations encompass a variety of activities of a covered entity including, but not limited to, quality assessment and improvement, outcome evaluation and development of clinical guidelines, reviewing competence, qualifications and performance of health care professionals, conducting health

care practitioner training programs, accreditation, certification, licensing and credentialing.

H. USE: With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

V. Procedures:

A. A BA must sign a Business Associate Agreement with ValueOptions® in order to access, use or disclose PHI. The BAA must be in writing, contain HIPAA-compliant language, and include authorized signatures.

B. PHI may be disclosed and/or used by Business Associates as necessary to allow the BA to carry out a health care-related function or activity on behalf of, or to provide services to, ValueOptions®.

C. If ValueOptions® determines that a BA has violated a material term or obligation of the BAA, the service center or national department that is party to the agreement, with assistance from the service center or national department's designated privacy official, shall be notified and shall seek to remedy the breach or, if that is not possible, to terminate the agreement.

D. Responsibilities:

1. Service Center/National Department Responsibility:

a. It is the responsibility of each business unit of ValueOptions® contracting for the services to assure that a valid BAA is in place before any PHI is released to the BA. The Legal Department may provide a BAA template for use or review a pending contract for HIPAA compliant language.

b. A signed copy of the BAA shall be sent to the Legal Department for retention. BAA are retained in the manner and for the duration identified in the ValueOptions® document retention policy.

c. ValueOptions® has no obligation to monitor the activities or practices of the BA, but may request additional information or assurances from the BA including:

i. requesting a copy of the BA's current security and privacy policies;

ii. confirmation with the BA that all subcontractors have executed agreements to protect the integrity and confidentiality of PHI received from the BA;

iii. confirmation that the BA's employees and subcontractors have been trained to protect the confidentiality of any PHI accessed pursuant to the contract;

iv. confirmation that the BA has a contingency plan in place that provides for a one (1) year data back-up plan; disaster recovery plan; and an emergency mode of operation plan; and/or

Policy: Business Associate Agreements	Page 4 of 4	Number: LC427

v. confirmation that the BA has written policies and procedures establishing rules for granting access to PHI.

2. The responsibilities of the BA is specified, in accordance with federal and state privacy regulations, in the BAA.
3. A BAA is not required in the following circumstances:
   a. With a healthcare provider unless the provider is performing a service other than treatment, and
   b. Where the service provided does not require the exchange of protected health information.

E. All known or suspected violations of this policy shall be reported to the service center or national department's designated privacy official.

VI. Attachments: None

VII. References:

A. 45 CFR §164.103: Definitions
B. 45 CFR §164.502(e): Use and disclosures of protected health information to business associates
C. 45 CFR §164.504(e): Uses and disclosures of protected health information in business associate contracts

Sample Monthly Appeals Report (Blinded)

PATIENT NAME	CERT #	CATEGORY #	CASE TYPE P = Prospective CC = Concurrent R = Retro	REVIEW TYPE S = Standard E =Expedited	REF #	APPEAL TYPE A = Admin M = Medical Necessity	APPEAL REC'D	DATE OF DETERM	DETERMINATION UPH = Upheld MOD = Modified OVR = Overturned
PATIENT NAME	CERT #	254	R	S	REF #	M	06/07/2010	06/21/2010	UPH
PATIENT NAME	CERT #	64D	R	S	REF #	M	06/10/2010	06/22/2010	UPH
PATIENT NAME	CERT #	737	R	S	REF #	M	05/10/2010	06/01/2010	UPH
PATIENT NAME	CERT #	272	R	S	REF #	M	05/25/2010	06/08/2010	UPH
PATIENT NAME	CERT #	250	R	S	REF #	M	06/07/2010	06/15/2010	UPH
PATIENT NAME	CERT #	259	R	S	REF #	M	05/25/2010	06/08/2010	UPH
PATIENT NAME	CERT #	250	R	S	REF #	M	05/25/2010	06/08/2010	UPH
PATIENT NAME	CERT #	286	CR	S	REF #	M	06/08/2010	06/08/2010	OVR
PATIENT NAME	CERT #	263	R	S	REF #	M	06/14/2010	06/22/2010	UPH
PATIENT NAME	CERT #	251	R	S	REF #	M	05/12/2010	06/08/2010	UPH
PATIENT NAME	CERT #	273	CR	S	REF #	M	06/09/2010	06/17/2010	UPH
PATIENT NAME	CERT #	674	R	S	REF #	M	05/21/2010	06/08/2010	UPH
PATIENT NAME	CERT #	251	CR	S	REF #	M	06/08/2010	06/08/2010	MOD
PATIENT NAME	CERT #	286	R	S	REF #	M	05/25/2010	06/08/2010	UPH
PATIENT NAME	CERT #	267	CR	S	REF #	M	06/17/2010	06/22/2010	MOD
PATIENT NAME	CERT #	4E5	R	S	REF #	M	05/19/2010	06/08/2010	UPH
PATIENT NAME	CERT #	250	R	S	REF #	M	06/01/2010	06/15/2010	UPH
PATIENT NAME	CERT #	250	R	S	REF #	M	05/24/2010	06/01/2010	UPH
PATIENT NAME	CERT #	GAI	R	S	REF #	M	06/01/2010	06/07/2010	UPH
PATIENT NAME	CERT #	282	R	S	REF #	M	05/21/2010	06/15/2010	UPH
PATIENT NAME	CERT #	251	R	S	REF #	M	05/10/2010	06/08/2010	UPH
PATIENT NAME	CERT #	263	R	S	REF #	M	06/16/2010	06/22/2010	UPH
PATIENT NAME	CERT #	289	R	S	REF #	M	06/17/2010	06/29/2010	UPH
PATIENT NAME	CERT #	254	R	S	REF #	M	05/17/2010	06/01/2010	UPH
PATIENT NAME	CERT #	254	R	S	REF #	M	06/08/2010	06/17/2010	UPH
PATIENT NAME	CERT #	263	R	S	REF #	M	05/26/2010	06/08/2010	UPH
PATIENT NAME	CERT #	263	R	S	REF #	M	06/07/2010	06/15/2010	UPH
PATIENT NAME	CERT #	GDM	R	S	REF #	M	05/26/2010	06/22/2010	UPH
PATIENT NAME	CERT #	G8Z	R	S	REF #	M	05/26/2010	06/08/2010	UPH
PATIENT NAME	CERT #	G1M	R	S	REF #	M	05/26/2010	06/15/2010	UPH
PATIENT NAME	CERT #	4E1	CR	E	REF #	M	06/03/2010	06/03/2010	UPH
PATIENT NAME	CERT #	250	CR	E	REF #	M	06/07/2010	06/07/2010	OVR
PATIENT NAME	CERT #	6EC	R	S	REF #	M	06/18/2010	06/24/2010	UPH
PATIENT NAME	CERT #	263	CR	E	REF #	M	06/17/2010	06/17/2010	OVR
PATIENT NAME	CERT #	250	R	S	REF #	M	06/18/2010	06/29/2010	UPH
PATIENT NAME	CERT #	293	CR	E	REF #	M	06/14/2010	06/16/2010	OVR
PATIENT NAME	CERT #	286	CR	E	REF #	M	06/14/2010	06/14/2010	UPH
PATIENT NAME	CERT #	GDT	CR	E	REF #	M	06/23/2010	06/23/2010	OVR
PATIENT NAME	CERT #	260	CR	E	REF #	M	06/08/2010	06/08/2010	UPH

Title:
Plan:
Dates: 09/04/2010 to 09/10/2010

Alt ID#	Member #	Member Name	Svc Date	CPT Code	Provider	Claim Amt	Paid Amt	Paid Date	SCA Flag Indicator
Alt ID#	**Member #**	**Member Name**							
			08/20/2010	90807	**Provider**	$170.00	$84.00	09/10/2010	
					Total for Member:	**$170.00**	**$84.00**		
Alt ID#	**Member #**	**Member Name**							
			07/27/2010	90807	**Provider**	$150.00	$48.31	09/10/2010	
			06/03/2010	90806	**Provider**	$140.00	$43.28	09/10/2010	
			06/15/2010	90806	**Provider**	$140.00	$43.28	09/10/2010	
			06/18/2010	90806	**Provider**	$140.00	$43.28	09/10/2010	
			06/08/2010	90806	**Provider**	$140.00	$43.28	09/10/2010	
			06/12/2010	90806	**Provider**	$140.00	$43.28	09/10/2010	
					Total for Member:	**$850.00**	**$264.71**		
Alt ID#	**Member #**	**Member Name**							
			07/31/2010	90818	**Provider**	$125.00	$55.00	09/10/2010	
			08/07/2010	90818	**Provider**	$125.00	$55.00	09/10/2010	
					Total for Member:	**$250.00**	**$110.00**		
Alt ID#	**Member #**	**Member Name**							
			05/25/2010	90807	**Provider**	$170.00	$84.00	09/10/2010	
			06/30/2010	90807	**Provider**	$170.00	$84.00	09/10/2010	
			06/11/2010	90807	**Provider**	$170.00	$84.00	09/10/2010	
			07/21/2010	90807	**Provider**	$170.00	$84.00	09/10/2010	
			08/06/2010	90807	**Provider**	$170.00	$84.00	09/10/2010	
					Total for Member:	**$850.00**	**$420.00**		
Alt ID#	**Member #**	**Member Name**							
			07/28/2010	90818	**Provider**	$120.00	$76.89	09/10/2010	
			07/21/2010	90801	**Provider**	$175.00	$144.32	09/10/2010	
					Total for Member:	**$295.00**	**$221.21**		
Alt ID#	**Member #**	**Member Name**							
			08/10/2010	90807	**Provider**	$200.00	$84.00	09/10/2010	
			08/17/2010	90807	**Provider**	$200.00	$84.00	09/10/2010	
					Total for Member:	**$400.00**	**$168.00**		
Alt ID#	**Member #**	**Member Name**							
			06/28/2010	90806	**Provider**	$55.00	$35.00	09/10/2010	
					Total for Member:	**$55.00**	**$35.00**		
Alt ID#	**Member #**	**Member Name**							
			08/17/2010	90806	**Provider**	$100.00	$35.00	09/10/2010	
			08/05/2010	90806	**Provider**	$100.00	$35.00	09/10/2010	
					Total for Member:	**$200.00**	**$70.00**		
Provider	**Provider**	**Provider**							
			07/13/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	
			07/10/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	
			08/21/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	
			08/07/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	
			07/27/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	
			07/20/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	
			07/24/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	
			08/10/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	
			07/06/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	
			08/17/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	
			07/17/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	
			07/31/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	
			08/14/2010	90806	**Provider**	$125.00	$35.00	09/10/2010	

OVERSIGHT KEY INDICATOR REPORT

		Q1				Q2				Q3			
	Standard	Jan	Feb	Mar	1st Qtr Sum. Total/Avg	Apr	May	June	2nd Qtr Sum. Total/Avg	Jul	Aug	Sep	3rd Qtr Sum. Total/Avg
CUSTOMER SERVICE INDICATORS													
Total Calls Received		8213	6124	8076	22413	6956	6771	7761	21488	7635	8265		
Average calls per day		411	306	385	367	316	339	353	336	364	376		
Abandonment Rate	≤5%	0.7%	0.6%	0.4%	0.6%	0.4%	0.8%	0.5%	0.6%	0.7%	0.5%		
Average Speed of Answer (to reach a person)	≤30 sec.	8	8	5	7	7	7	9	8	8	7		
%Calls Answered w/in 30 secs.	≥ *90%*	91%	91%	94%	92%	92%	91%	91%	91%	91%	91%		
CLAIMS PROCESSING INDICATORS		N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
Total Claims Received (By Receive Date)		N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
Total Claims Processed		N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
Payment Cycle Time	≤10 days	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
Denied Claim Processing TAT % - 30 days	100%	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
Paid Claim Paid TAT % - 45 days	100%	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
Claim FiN/A 1ncial Accuracy (If available)		N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
Claim Payment Accuracy (If available)		N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
# of Claims Denied Past 30 days		N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
# of Claims Paid Past 45 days		N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
# of Claims Paid with Interest		N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
Total # of Adjustments		N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
% Adjustments denied w/in 15 days	100%	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
% Adjustments Paid w/in 30 days	≥95%	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
% Adjustments Paid w/in 45 days	100%	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
# of Adjusted Claims Paid with Interest		N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]	N/A [1]
QUALITY INDICATORS													
MEMBER COMPLAINTS: Regarding non-plan determinations (ie quality of care)													
# of Complaints		NR [2]	1	2	3	4	1	3	8	NR [2]	6		
Acknowledgement TAT	100%≤15c days	NR [2]	100%	100%	100%	100%	100%	100%	100%	NR [2]	100%		
Expedited Review Resolution Determination and Verbal/Written Notification TAT	100%<48hrs. recpt. all info	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NA		
All Others Resolution Determination and Written Notification TAT	100%<45c days recpt. all info	NR [2]	100%	100%	100%	100%	100%	100%	100%	NR [2]	100%		
Member Complaint Ratio/1000 members										NR [2]	0.006		
MEMBER GRIEVANCES: (Non-UR plan Determinations)													
# of Grievances		NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	1		
Acknowledgement TAT	100%≤15c days	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	100%		
Expedited Review Resolution Determination and Notification TAT	100%≤48hrs. recpt. all info, not	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NA		
Grievance - Pre-service Request for Benefit Coverage Resolution Determination and Notification TAT	HMO - 100%≤15c days; PPO - 100%≤30c days	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NR [2]	NA		

TAT= Turn Around Time

OVERSIGHT KEY INDICATOR REPORT

		Q1				Q2				Q3			
	Standard	Jan	Feb	Mar	1st Qtr Sum. Total/Avg	Apr	May	June	2nd Qtr Sum. Total/Avg	Jul	Aug	Sep	3rd Qtr Sum. Total/Avg
Post Service Resolution Determination and Notification TAT	HMO- 100%<30c days PPO- 100%≤60c days	NR[2]	NR[2]	NR[2]	NR[2]	NR[2]	NR[2]	NR[2]	NR[2]	NR[2]	100%		
Member Grievance Ratio/1000 members		NR[2]	NR[2]	NR[2]	NR[2]	NR[2]	NR[2]	NR[2]	NR[2]	NR[2]	0.001		
Member Appeals of a Grievance or Complaint Decision: (GHI HMO and HMO vendors only)		N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]
# of Grievance Appeals		N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]
# of Complaint Appeals		N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]
Acknowledgement TAT	100%≤15c days	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]
Grievance/Complaint -Expedited Review Resolution Determination and Notification TAT	100%≤48hrs. recpt. all info, not to exceed 72 hrs receipt. Req.	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]
Grievance - Pre-service Request for Benefit Coverage Resolution Determination and Notification TAT	100%≤15c days	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]
Grievance -Post Service Resolution Determination and Notification TAT	100%<30c days	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]
Complaint Resolution Determination and Notification TAT	100%<30b days recpt. all info	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]
Member Grievance Appeals Ratio/1000 members		N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]
PROVIDER COMPLAINTS/GRIEVANCES (contractual)													
# of Complaints/Grievances		5	9	4	18	10	14	24	48	26	24		
Benefit Resolution Determination and Notification TAT	100%<30b days recpt. all info	100%	100%	100%	100%	100%	NA	100%	100%	100%	N/A		
All Others Resolution Determination and Notification TAT	100%<45c days recpt. all info	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
CREDENTIALING INDICATORS (commercial)													
Total Providers Added		34	29	19	82	11	25	27	63	31	35		
Total Providers Terminated		48	34	125	207	100	105	24	229	53	51		
Unique Commercial Providers		8338	8337	8333	8336	8337	8335	8337	8336	8338	8338		
Net Network Growth		Reported Annually											
Annual Turnover Rate		Reported Annually											
Board Certification Rate		72%	72%	72%	72%	72%	72%	72%	72%	72%	72%		
UM Call Service Indicators													
Calls Received		1535	1347	1932	4814	1658	1559	1794	5011	1260	1456		
Average Calls Per Day		77	67	92	79	75	78	82	78	60	66		
Abandonment Rate	≤5%	1.6%	1.4%	1.9%	1.6%	5.7%	2.9%	2%	3.6%	3.2%	1.5%		
Average Speed of Answer (to reach a person)	95%≤30 sec.	9	10	8	9	21	12	8	14	10	11		
%Calls Answered w/in 30 sec.	≥90%	98%	99%	91%	96%	81%	88%	90%	86%	90%	92%		
Authorization Requests													

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OVERSIGHT KEY INDICATOR REPORT

		Q1				Q2				Q3			
	Standard	Jan	Feb	Mar	1st Qtr Sum. Total/Avg	Apr	May	June	2nd Qtr Sum. Total/Avg	Jul	Aug	Sep	3rd Qtr Sum. Total/Avg
Total Authorizations Requests Received		3799	3165	6654	13618	5910	6332	6447	18689	3205	2458		
# of Clinical Denials Due to Lack of Info.		0	0	0	0	0	0	0	0	0	0		
Total Prior-Authorization Reviews:		3066	2534	5408	11008	4161	3394	3043	10598	1561	1172		
Total Prior Auths Approvals (Administrative)		3	2	3	8	9	2	6	17	2	0		
Total Prior Auths Approvals (Medical Necessity)		3030	2503	5340	10873	4105	3348	3005	10458	1535	1148		
Total Prior Auths Denied (Medical Necessity)		23	25	47	95	32	33	24	89	19	20		
Total Prior Auths Denied-Modified (Medical Necessity)		2	1	11	14	6	6	4	16	3	4		
Total Prior Auths Denied (Administrative)		8	3	7	18	9	5	4	18	2	0		
Total Concurrent Reviews:		690	584	1202	2476	1694	2840	3296	7830	1547	1205		
Concurrent Review Approvals (Administrative)		4	0	0	38114	3	3	2	8	3	1		
Concurrent Review Approvals (Medical Necessity)		666	557	1161	2384	1627	2791	3252	7670	1506	1166		
Concurrent Review Denied (Medical Necessity)		18	21	31	70	45	34	27	106	28	29		
Concurrent Review Denied - Modified (Medical Necessity)		1	5	8	14	12	8	11	31	7	5		
Concurrent Review Denied (Administrative)		1	1	2	4	3	4	4	11	3	4		
Retrospective Review Requests:		43	47	44	134	55	96	104	255	97	81		
Retrospective Review Approvals (Administrative)		0	0	0	0	2	0	0	2	0	1		
Retrospective Review Approvals (Medical Necessity)		9	12	16	37	12	40	18	70	16	18		
Retrospective Review Denials (Medical Necessity)		26	30	19	75	28	41	63	132	70	57		
Retrospective Review Denials - Modified (Medical Necessity)		5	3	5	13	4	11	10	25	3	2		
Retrospective Review Denials (Administrative)		3	2	4	9	9	4	13	26	8	3		
Total Withdrawals		0	0	0	0	0	2	4	6	0	0		
UR Determinations and Notification Response Rates:													
Prior Authorization Requests:		2766	2273	5032	10071	3823	3110	2730	9663	1356	965		
Determination Response Rate	100%≤3b	99%	100%	100%	100%	100%	100%	100%	100%	100%	99%		
Verbal Notification Response Rate	Within the Determination Timeframe	99%	100%	100%	100%	100%	100%	100%	100%	100%	99%		
Written Notification Response Rate	Within the Determination Timeframe	99%	100%	100%	100%	100%	100%	100%	100%	100%	99%		
Expedited/Urgent Prior-Authorization Requests: (where applicable)		300	261	376	937	338	284	313	935	205	207		
Determination Response Rate	100%≤72 Hrs	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Verbal Notification Response Rate	Within the Determination Timeframe	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Written Notification Response Rate	Within the Determination Timeframe	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Expedited/Urgent Concurrent Review Requests >24 hours:		156	192	284	632	244	242	238	724	273	324		

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OVERSIGHT KEY INDICATOR REPORT

		Q1				Q2				Q3			
	Standard	Jan	Feb	Mar	1st Qtr Sum. Total/Avg	Apr	May	June	2nd Qtr Sum. Total/Avg	Jul	Aug	Sep	3rd Qtr Sum. Total/Avg
Determination Response Rate	100%≤24 hours	100%	100%	100%	100%	98%	99%	100%	99%	99%	99%		
Verbal Notification Response Rate	Within the Determination Timeframe	100%	100%	100%	100%	98%	99%	100%	99%	99%	99%		
Written Notification Response Rate	Within the Determination Timeframe	100%	100%	99%	100%	98%	99%	100%	99%	99%	99%		
Expedited/Urgent Concurrent Review Requests <24 hours: (Do Not Track (DNT))		DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT
Determination Response Rate	100%≤72 hours	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT
Verbal Notification Response Rate	Within the Determination Timeframe	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT
Written Notification Response Rate	Within the Determination Timeframe	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT	DNT
Concurrent Review Requests:		534	392	918	1844	1450	2598	3058	7106	1274	881		
Determination Response Rate	100%≤1b	100%	100%	100%	100%	100%	100%	100%	100%	96%	98%		
Verbal Notification Response Rate	Within the Determination Timeframe	100%	100%	100%	100%	100%	100%	100%	100%	96%	98%		
Written Notification Response Rate	Within the Determination Timeframe	100%	100%	100%	100%	100%	100%	100%	100%	96%	98%		
Retrospective Review Requests:		43	47	74	164	68	96	104	268	97	81		
Determination Response Rate	100%≤30c days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Written Notification Response Rate	within the Determination timeframe	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Utilization Indicators (applicable to VO; authorization based)													
Inpatient Admits/1000 MH/SA		2.94/1.69	2.12/1.03	2.74/1.60	2.6/1.44	2.32/1.44	2.17/1.09	2.28/1.52	2.14/1.29	1.92/1.28	2.15/1.39		
Inpatient Days/1000 MH/SA		26.47/18.13	20.70/10.25	29.18/15.29	25.45/14.56	21.32/13.23	23.31/10.29	22.83/13.90	22.02/11.46	20.36/12.67	24.38/15.11		
Inpatient ALOS MH/SA		8.92/9.21	8.00/8.71	9.28/9.14	8.73/9.02	7.85/8.29	8.88/8.67	8.56/8.79	8.48/8.23	8.87/8/84	9.34/9.98		
Partial Hospital Admits/1000 MH/SA		0.63/0.06	0.32/0.03	0.57/0.06	0.51/0.05	0.46/0.10	0.43/0.06	0.45/0.05	0.41/0.023	0.35/0.07	0.58/0.12		
Partial Hospital Days/1000 MH/SA		6.21/0.53	4.34/0.34	6.12/0.72	5.55/0.53	6.18/1.51	4.71/0.63	5.95/1.19	4.60/0.46	5.54/1.26	6.46/1.49		
Partial Hospital ALOS MH/SA		9.81/9.60	8.89/8.00	9.17/11.33	9.29/9.64	10.20/13.64	8.51/10.50	9.76/12.78	8.63/11.87	11.35/12.40	9.22/11.31		
Outpatient Visits/1000 [3] MH/SA		300.49/153.39	134.14/37.66	411.15/53.08	281.93/81.34	101.41/49.79	452.75/40.91	471.88/44.95	360.22/47.51	124.64/11.44	89.49/13.63		
Outpatient PMPMM													
# of members hospitalized (acute care) for mental illness (excludes Detox and SA) - Magellan and VO ONLY.[4]					620 [4]				621 [4]				
# who followed up within 7 days post dc.					316 [4]				338 [4]				
# who followed up within 30 days post dc.					65 [4]				57 [4]				
Reconsideration Requests:		3	1	6	10	6	8	6	20	5	7		
Determination Response Rate	100%≤1b day	100%	100%	83%	94%	83%	100%	83%	89%	100%	100%		
Written/Verbal Notification Response Rate	within the Determination timeframe	100%	100%	83%	94%	83%	100%	83%	89%	100%	100%		

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OVERSIGHT KEY INDICATOR REPORT

		Q1				Q2				Q3			
	Standard	Jan	Feb	Mar	1st Qtr Sum. Total/Avg	Apr	May	June	2nd Qtr Sum. Total/Avg	Jul	Aug	Sep	3rd Qtr Sum. Total/Avg
UR Appeals Acknowledgement, Determination and Notification Rates:													
Written Acknowledgment Rate	100%≤15c days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Internal													
Expedited/Urgent Appeals:		NR[2]	NR[2]	NR[2]	NR[2]	5	NR[2]	NR[2]	5	NR[2]	NR[2]		
Determination Response Rate	100%≤2 BD recpt. all info, not to exceed 72 hours recpt. Req.	NR[2]	NR[2]	NR[2]	NR[2]	100%	NR[2]	NR[2]	100%	NR[2]	NR[2]		
Written Notification Response Rate	Within the Determination Timeframe	NR[2]	NR[2]	NR[2]	NR[2]	100%	NR[2]	NR[2]	100%	NR[2]	NR[2]		
Non-Urgent Pre Auth Standard Appeals:		11	10	20	41	NR[2]	19	13	32	16	16		
Determination Response Rate	100%≤30c days	100%	100%	100%	100%	NR[2]	100%	100%	100%	100%	100%		
Written Notification Response Rate	Within the Determination Timeframe	100%	100%	100%	100%	NR[2]	100%	100%	100%	100%	100%		
Non-Urgent Concurrent Appeals		4	1	5	10	26	11	3	40	4	1		
Determination Response Rate	100%≤2 BD recpt. all info, not to exceed 30c days recpt. Req.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Written Notification Response Rate	Within the Determination Timeframe		100%	100%	100%	100%	100%	100%	100%	100%	100%		
Retrospective Appeals		14	15	30	59	21	20	30	71	36	28		
Determination Response Rate	100%≤30c recpt. all info, not to exceed 60c days recpt. Req.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Written Notification Response Rate	Within the Determination Timeframe	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Total Volume:		29	26	55	110	52	50	46	148	56	45		
Resolution TAT (business day)		1	1	1	1	1	1	1	1	1	1		
Upheld %		93%	85%	82%	87%	88%	78%	80%	82%	86%	76%		
Overturned %		0%	4%	11%	5%	10%	18%	13%	14%	14%	18%		
Modified %		7%	11%	7%	8%	2%	4%	7%	4%	0%	6%		
# Pended from Prior Month		0	0	0	0	0	0	0	0	0	0		
# of New Appeals Received		29	26	55	110	52	49	46	147	56	45		
# Closed in Current Month:		29	26	55	110	52	49	46	147	56	45		
Upheld		27	22	45	94	46	39	37	122	48	34		
Modified		2	3	4	9	1	2	3	6	0	3		
Overturned		0	1	6	7	5	9	6	20	8	8		
# Pended End of Month		0	0	0	0	0	0	0	0	0	0		
# of Appeals for Cases that were Denied for LOI		0	0	0	0	0	0	0	0	0	0		

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OVERSIGHT KEY INDICATOR REPORT

		Q1				Q2				Q3			
	Standard	Jan	Feb	Mar	1st Qtr Sum. Total/Avg	Apr	May	June	2nd Qtr Sum. Total/Avg	Jul	Aug	Sep	3rd Qtr Sum. Total/Avg
External:													
Total Volume:		2	1	2	5	1	3	3	7	1	1		
Upheld %		50%	0%	50%	33%	100%	75%	100%	92%	0%	100%		
Overturned %		50%	100%	50%	67%	0%	25%	0%	8%	100%	0%		
Modified %		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
Withdrawn %		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
Notes:													
* Review glossary carefully to accurately calculate time frames													
C= Calendar Days													
B= Business Days													
[1] **NA indicates that the measure does not apply to this BOB.**													
[2] **NR indicates no data reported for the specified measure.**													
[3] **Please note that due to the outpatient pass through visits calculating monthly outpatient utilization indicators is not truly reflective of utilization.**													
[4] **Ambulatory Follow Up indicator only counts applicable HEDIS measure data and will be reported quarterly based on verbal confirmation.**													

TAT= Turn Around Time

Sample Suboxone Report

Member_No	Script_FillDate	FillDate_Plus30Days	Member_Lstname	Member_Fstname	Drug_Code	Drug_Name	Claim_No	Proc_Code	Svc_Date
Member_No	1/7/2010	2/6/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0004	1/21/2010
Member_No	1/21/2010	2/20/2010	Member_Lstname	Member_Fstname	124960128302	SUBOXONE		0906	2/4/2010
Member_No	1/21/2010	2/20/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		0906	2/4/2010
Member_No	1/21/2010	2/20/2010	Member_Lstname	Member_Fstname	124960128302	SUBOXONE		0906	2/16/2010
Member_No	1/21/2010	2/20/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		0906	2/16/2010
Member_No	1/21/2010	2/20/2010	Member_Lstname	Member_Fstname	124960128302	SUBOXONE		0906	2/18/2010
Member_No	1/21/2010	2/20/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		0906	2/18/2010
Member_No	1/21/2010	2/20/2010	Member_Lstname	Member_Fstname	124960128302	SUBOXONE		0906	2/19/2010
Member_No	1/21/2010	2/20/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		0906	2/19/2010
Member_No	1/7/2010	2/6/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/21/2010
Member_No	1/7/2010	2/6/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/22/2010
Member_No	1/7/2010	2/6/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/26/2010
Member_No	1/7/2010	2/6/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/28/2010
Member_No	1/7/2010	2/6/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/29/2010
Member_No	1/7/2010	2/6/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/2/2010
Member_No	1/7/2010	2/6/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/4/2010
Member_No	1/15/2010	2/14/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/21/2010
Member_No	1/15/2010	2/14/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/22/2010
Member_No	1/15/2010	2/14/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/26/2010
Member_No	1/15/2010	2/14/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/28/2010
Member_No	1/15/2010	2/14/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/29/2010
Member_No	1/15/2010	2/14/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/2/2010
Member_No	1/15/2010	2/14/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/4/2010
Member_No	1/22/2010	2/21/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/22/2010
Member_No	1/22/2010	2/21/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/26/2010
Member_No	1/22/2010	2/21/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/28/2010
Member_No	1/22/2010	2/21/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/29/2010
Member_No	1/22/2010	2/21/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/2/2010
Member_No	1/22/2010	2/21/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/4/2010
Member_No	1/22/2010	2/21/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/18/2010
Member_No	1/23/2010	2/22/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/26/2010
Member_No	1/23/2010	2/22/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/28/2010
Member_No	1/23/2010	2/22/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/29/2010
Member_No	1/23/2010	2/22/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/2/2010
Member_No	1/23/2010	2/22/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/4/2010
Member_No	1/23/2010	2/22/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/18/2010
Member_No	1/29/2010	2/28/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	1/29/2010
Member_No	1/29/2010	2/28/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/2/2010
Member_No	1/29/2010	2/28/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/4/2010
Member_No	1/29/2010	2/28/2010	Member_Lstname	Member_Fstname	124960130602	SUBOXONE		H0015	2/18/2010

ValueOptions® Facility Participation Agreement

_____

Print Name of Facility

_____

Print Type of Facility (i.e., Hospital, Rehab Facility, Outpatient Clinic, Community Mental Health Center, etc.)

_____

Print Address of Facility

_____

Print Contact Person's Name, Telephone Number and E-Mail Address

_____ _____

Federal Tax Identification Number (TIN) *NPI Number(s)*

_____ _____

Medicaid Provider Number *Medicare Provider Number*

If Facility has more than one location or facility, please provide a complete listing of all locations and/or facilities with all of the above information in Exhibit A.

EFFECTIVE DATE:

_____

(To be Inserted by ValueOptions Following Satisfactory Completion of Credentialing)

This ValueOptions Facility Participation Agreement ("Agreement") is made and entered into, by and between _____, an _____ for itself and on behalf of those certain facilities which Facility represents and warrants it wholly owns and operates (severally and collectively, as the context may require, "Facility") and ValueOptions, Inc. and its Affiliates (severally and collectively, as the context may require, "ValueOptions®[1]"), to be effective on the date set forth as the Effective Date on the Signature Page of this Agreement.

In consideration of the mutual promises and consideration herein, the sufficiencies of which are hereby acknowledged, the parties agree as follows:

Article I: Definitions

Capitalized terms used in this Agreement and/or in the introductory paragraphs above, all of which are hereby incorporated by reference, shall, unless otherwise defined in a Payor or Plan specific exhibit to this Agreement, have the following meanings:

1.1 "*AAA*" means the American Arbitration Association.

1.2 "*Affiliate*" means those entities and companies that are: (a) wholly owned subsidiaries of and/or share a common parent company with ValueOptions; and/or (b) at least thirty-three percent (33%) owned or controlled by ValueOptions.

1.3 "*Case Management*" means the case management and/or utilization management programs and processes implemented and directed by ValueOptions with respect to the provision of Covered Services.

1.4 "*Certification*" or "*Certifies or* "*Certified*" means the decision of ValueOptions or its designee resulting from the Case Management process to determine whether proposed or rendered treatment is Medically Necessary.

1.5 "*Clean Claim*" means a complete and accurate UB-04 or CMS 1500 claim form, their HIPAA compliant electronic equivalents, or their respective successor forms, along with any required substantiating documentation, submitted for mental health, alcohol and/or substance abuse services rendered to a Member which contains at a minimum the following information including, but not limited to: patient name, patient's date of birth, Member's identification number, Facility's name, address and tax identification number and NPI number, date(s) and place of service or purchase, ICD-9 code(s)/CPT-4 code(s)/revenue code(s), or their respective HIPAA compliant successor code sets, services and supplies provided, and charges.

1.6 "*Confidential Information*" means a party's non-public information confidential and proprietary information, data, content, utilization management procedures, credentialing criteria, patient treatment and/or finances, such party's earnings, volume of business, methods, systems, practices, plans, technical and non-technical data, and other proprietary information. Confidential Information also includes information that has been disclosed to ValueOptions, Affiliates or their parent company by a third party and which they, individually or collectively are obligated to treat as confidential.

1.7 "*Covered Services*" means those Medically Necessary mental health, alcohol and/or substance abuse services for which Members are covered pursuant to a Plan and for which a Member covered thereunder is entitled.

1.8 "*Emergency*", unless otherwise defined in a Member's Plan, means the sudden onset of acute symptoms from a mental health or substance abuse disorder and one or more of the following circumstances are present: (a) the patient is in imminent or potential danger of harming himself or others; (b) the patient shows symptoms (e.g., hallucinations, agitation, delusions, etc.) resulting in impairment in judgment, functioning and/or impulse control severe enough to endanger his or her own welfare or that of another person; or (c) there is an immediate need for hospitalization as a result of or in conjunction with a very serious situation such as an overdose, detoxification or potential suicide.

[1] 'ValueOptions' is a registered service mark of ValueOptions, Inc. Any use of or reference to 'ValueOptions' in any communication, publication, notice, disclosure, mailing or other document, whether written or electronic, requires the prior written authorization of ValueOptions, Inc.

1.9 "*HIPAA*" means the federal Health Insurance Portability and Accountability Act of 1996, including without limitation its privacy, security and administrative simplification provisions, and the rules and regulations promulgated there under, each as may be amended from time to time.

1.10 "*Level of Care*" means the duration, frequency, location, intensity and/or magnitude of a treatment setting, treatment plan, or treatment modality, including, but not limited to: (a) acute care facilities; (b) less intensive inpatient or outpatient alternatives to acute care facilities such as residential treatment centers, group homes or structured outpatient programs; (c) outpatient visits; or (d) medication management.

1.11 "*Medically Necessary*", unless otherwise defined in the Member's Plan, means those services which are: (a) 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 results in illness or infirmity; (b) expected to improve an individual's condition or level of functioning; (c) individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs; (d) essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals and publications; (e) reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available; (f) not primarily intended for the convenience of the recipient, caretaker, or provider; (g) not more intensive or restrictive than necessary to balance safety, effectiveness and efficiency; and (h) not a substitute for non-treatment services addressing environmental factors.

1.12 "*Member*" means an individual who is enrolled in a Payor Plan and eligible to receive Covered Services under such Plan.

1.13 "*Member Expenses*" means those copayments, coinsurance, deductible and/or other cost-share amounts due from Members for Covered Services pursuant to their respective Plan.

1.14 "*Non-Covered Services*" means, for purposes of this Agreement, those services, items, supplies or levels of care that are excluded from coverage under a Member's Plan or for which the Member has exhausted benefits under their Plan.

1.15 "*Participating Provider*" means: (a) an appropriately trained and licensed or certified individual practitioner or group of practitioners (psychiatrist, physician, psychologist, psychiatric social worker or other licensed mental health provider), hospital, institution, facility, clinic, program, or agency that has entered into a written contractual arrangement with ValueOptions to provide Covered Services to Members at agreed upon payment rates; and/or (b) an appropriately trained and licensed or certified individual practitioner (psychiatrist, physician, psychologist, psychiatric social worker or other licensed mental health provider) who has entered into a written contractual arrangement with a facility, group, agency, and/or clinic contracted with ValueOptions to provide Covered Services to Members at agreed upon payment rates.

1.16 "*Payor*" means the entity financially responsible for claims payments for Covered Services. Payors may include insurance companies, health maintenance organizations, preferred provider organizations, provider sponsored networks/organizations, third party administrators, provider network administrators, self-funded employer group health plans, multiple employer trusts, union trusts and government agencies.

1.17 "*Payor Contract*" means the written agreement between ValueOptions and a Payor identifying those Plans and associated administrative services related to mental health alcohol and/or substance abuse Covered Services for which ValueOptions is responsible and obligating Payors to pay or make funds available for payment of Clean Claims for Covered Services for their respective Plan Members.

1.18 "*Plan*" means any benefit plan or benefit arrangement offered and/or administered by a Payor for whom ValueOptions has agreed to provide services under a Payor Contract and that identifies at a minimum Covered Services for Members, any limitations and/or exclusions, and processes for appealing coverage determinations.

1.19 "*Practitioner*" means an appropriately trained and licensed or certified psychiatrist, psychologist, psychiatric social worker or other licensed mental health provider: (a) employed by Facility; (b) who is identified in Exhibit A and who will be providing Covered Services to Members under this Agreement; and (c) for whom Facility will submit claims for Covered Services hereunder.

1.20 "*Protected Health Information*" or "*PHI*" means a Member's '*individually identifiable health information'* as defined in 45 C.F.R. §160.103 and/or applicable state law, and/or '*patient identifying information*' as defined in 42 C.F.R. Part 2.

1.21 "*Provider Handbook*" or "*Provider Manual*" means the ValueOptions proprietary document(s) which contains ValueOptions' Participating Provider policies and procedures and which ValueOptions, in its sole discretion, may amend from time to time. The Provider Handbook, available and accessible through the 'provider' section of ValueOptions' website at www.valueoptions.com, is incorporated in its entirety by reference.

1.22 "*Rate Schedule*" means the rates payable to Facility by a Payor, as payment in full, for Covered Services rendered to Members. Payment to Facility shall be as specified in Exhibit A and shall be subject to any limitations or exclusions of the Member's Plan. Unless otherwise expressly provided for in a Rate Schedule, reimbursements for facilities, hospitals, institutions or programs made on a per diem, per case or other global payment are all inclusive of facility fees, technical fees, and professional fees of individual and/or group Practitioners. The Rate Schedule(s) set out in Exhibit A will identify the Members and/or Plans for which they apply.

Article II: Relationship

2.1 Independent Contractors. None of the provisions of this Agreement is intended to create, nor shall be deemed or construed to create, any relationship between ValueOptions and Facility other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Except as specifically provided for in this Agreement, the parties agree that neither ValueOptions nor Facility will be liable for the activities of the other nor their representative agents or employees, including without limitation, any liabilities, losses, damages, injunctions, lawsuits, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or government agency arising out of or related to this Agreement; however, any rights to indemnification that may be available to either party at law or in equity are not affected by execution of this Agreement.

2.2 Facility/Patient Relationship. Nothing in this Agreement shall change or alter any clinical relationship which exists or may come to exist between Facility and any Member(s). Facility: (a) shall have the same duties, liabilities and responsibilities to Members as exist generally between Facility and patients; (b) shall always exercise its best medical judgment in the treatment of Members; and (c) is not an agent of ValueOptions, and shall not hold itself out as an agent of ValueOptions.

2.3 Referrals. Facility understands that ValueOptions does not, by this Agreement or future patterns of practice promise or guarantee any minimum volume of referrals of Members to Facility by ValueOptions or any Payor.

2.4 No Third Party Beneficiary. This Agreement does not create any third party beneficiary rights in any person or entity, including without limitation Members or Payors.

2.5 Cooperation. The parties agree to cooperate and take such further actions and execute such other documents or instruments as necessary or appropriate to implement this Agreement.

Article III: Facility Information

3.1 Authority. Facility represents and warrants that Facility is authorized to negotiate and execute participation agreements, including this Agreement, and to bind itself and all Practitioners to the terms and conditions of this Agreement. Whenever in this Agreement the term "Facility" is used to describe an obligation or duty, such duty or obligation shall also be the responsibility of each individual Practitioner, and where applicable each individual Facility location and/or facility, as the context may require.

3.2 Licensure. Facility represents that during the term of this Agreement and any required continuation period following its expiration or termination, Facility: (a) and each Practitioner shall maintain licensure, certification and/or registration in good standing under applicable laws and regulations in the state and/or states in which services are rendered; and (b) if applicable to its status, is accredited by The Joint Commission (JC), Commission on Accreditation of Rehabilitation Facilities (CARF), or the American Osteopathic Association (AOA); and (c) maintains all requisite certifications,

accreditations, approvals and authorizations required under applicable laws and regulations to operate each of its facilities and/or locations. Evidence of such licensure, certifications, registrations, and accreditations shall be submitted to ValueOptions in a timely manner upon ValueOptions' reasonable request. Facility (on behalf of itself and its Practitioners) shall promptly notify ValueOptions in writing of any: (i) action against state licenses, certifications and/or registrations; (ii) action taken regarding Medicare or Medicaid program participation status, or by a review organization; (iii) any change in licensure, certification, registration, or accreditation status; (iv) changes in ownership or business address; (v) legal or government action initiated that could materially affect the rendering of services under this Agreement; (vi) legal action commenced by or on behalf of a Member against Facility or a Practitioner; (vii) any compromise, settlement or judgment of a malpractice claim against Facility; (viii) initiation of bankruptcy or insolvency proceedings with regard to Facility whether voluntary or involuntary; or (ix) other occurrence known to Facility that could materially affect the rendering of services under this Agreement.

3.3 Insurance. Facility agrees to procure and maintain such policies of comprehensive general liability insurance, as are reasonably necessary to insure Facility, its employees, Practitioners, and agents against any claim or claims for damages arising out of personal injuries or death occasioned directly or indirectly in connection with the provision of any service provided hereunder, the use of any property and facilities provided by it, or its employees or agents, and activities performed by Facility, or its employees, Practitioners, or agents, in connection with this Agreement. Facility shall maintain professional liability insurance coverage or self-insurance covering Facility, its employees, Practitioners and agents in an amount of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate individually for Facility and each Practitioner. In the event Facility maintains professional liability insurance coverage on a 'claims made' basis, Facility also agrees to maintain such policy in effect, or maintain appropriate 'tail coverage' following any expiration or termination of this Agreement for the time period(s) identified under the applicable state and/or federal statute of limitations law or regulation. Facility shall also: (a) supply upon reasonable request a copy of the face sheet reflecting any changes in insurance coverage prior to their effective date; (b) supply upon reasonable request a copy of the face sheet for each annual renewal of professional liability coverage; (c) ensure that ValueOptions receives such face sheet within ten (10) days of each annual renewal; and (d) ensure that ValueOptions is notified at least thirty (30) days prior to the expiration, termination or material change to such professional liability coverage.

3.4 Locations. All locations identified by Facility in Exhibit A that meet ValueOptions credentialing/re-credentialing criteria and standards and for which Facility has provided written information required to ValueOptions under this Agreement and where care is rendered by Practitioners, all of which facility and/or office locations and Practitioners bill under the same federal tax identification number as Facility, and will be considered a part of the ValueOptions provider network(s) and payment for Covered Services rendered to Members at such identified locations will be according to the Rate Schedule(s) in this Agreement.

3.5 Practitioners. Facility shall ensure that each of Facility's Practitioners provide Covered Services to Members in compliance with the terms hereof.

(a) Practitioners admitting Members to, and rendering care to Members in Facility, will be members in good standing of Facility's medical staff and subject to all Facility medical staff rules and regulations including, without limitation, Facility's quality assurance review program. It is expressly understood by the parties hereto that Facility has the sole and exclusive responsibility for all medical staff membership determinations and that ValueOptions shall in no way participate in and/or control the medical staff membership decision-making process.

(b) Facility represents and warrants that as part of its standard privileging and credentialing bylaws, policies and procedures, Facility requires all Practitioners employed by and/or contracted with Facility to be appropriately licensed and/or certified under the laws of the state and/or states in which services are rendered. Facility shall require all Practitioners rendering Covered Services to Members under this Agreement to comply with the terms and conditions of this Agreement, and (i) bill and submit claims for Covered Services rendered to Members using the Facility's single tax identification; and (ii) look to Facility for payment/reimbursement for Covered Services rendered to Members under this Agreement.

(c) Facility: (i) represents that Facility maintains written agreements directly with contracted Practitioners; (ii) shall provide ValueOptions with a complete list of all Practitioners prior to execution of this Agreement and updates

(additions/deletions) quarterly thereafter during the term of this Agreement; and (iii) taking into account the importance of an accurate listing of Facility locations and that payment for Covered Services is contingent upon submission of up-to-date and accurate tax identification/NPI/government program numbers, Facility shall provide ValueOptions with at least: (1) thirty (30) days advance written notice of a change in the tax identification number/NPI/government program number of Facility as it relates to Facility and its locations and Practitioners; and/or (2) as much advance written notice as is commercially reasonable, but in any event at least ten (10) business days in advance of: (A) any addition or deletion of Practitioners; and/or (B) the closing of or change in location of a Facility location and/or any office or clinic location where Practitioners render services to patients.

(d) In the event of any conflict between Facility agreements with Practitioners rendering services under this Agreement and the terms of this Agreement, this Agreement shall control with respect to Covered Services rendered to Members. Upon reasonable request and where necessary to meet regulatory and/or government contract requirements and/or where necessary to confirm payment for services rendered to Members, Facility agrees to provide ValueOptions, and/or an authorized government agency, with access to copies of Facility's written agreements with contracted Practitioners.

Article IV: ValueOptions Information

4.1 Licensure. ValueOptions represents that ValueOptions maintains in good standing appropriate licensure or certification as required by applicable state laws. ValueOptions will notify Participating Providers, including without limitation Facility, through public notice or otherwise, of: (a) final revocation of its license or authorization to do business in the state; or (b) initiation of bankruptcy or insolvency proceedings with regard to ValueOptions whether voluntary or involuntary.

4.2 Insurance. ValueOptions shall procure and maintain such policies of comprehensive and general liability insurance coverage or self-insured coverage as are reasonably necessary to ensure ValueOptions, its employees, officers and directors against any claim or claims for damages arising out of performance under this Agreement. Such policies shall be in amounts of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.

4.3 Affiliates. The joinder of ValueOptions' entities under the designation 'ValueOptions' shall not be construed as imposing joint responsibility or cross-guarantee between or among such entities. All rights and responsibilities arising in respect to individual Members and/or Covered Services rendered to individual Members shall be applicable only to ValueOptions or the applicable Affiliate that administers the Plan covering the Member.

4.4 Relationship with Payors. Unless ValueOptions' contractual relationship with a Payor includes the transfer of financial risk for claims, the Payor and not ValueOptions is ultimately responsible for making sufficient amounts available for claims payments for Covered Services.

Article V: Participation, Policies & Procedures

5.1 Network Participation. Facility agrees to participate in provider networks of ValueOptions made available to Payors for Members covered under benefit plans offered or administered by such Payors, including without limitation commercial plans, State Medicaid/government programs, and Medicare Advantage plans, in accordance with the terms and conditions of this Agreement, and for which there is a Rate Schedule (Exhibit A) attached to this Agreement.

(a) Regulatory agencies periodically conduct telephonic audits by contacting Participating Providers. Facility shall and shall require Practitioners to provide information and respond to questions from regulatory agencies and/or individuals or entities conducting surveys or inquiries on their behalf as to those provider networks and products/lines of business (e.g. commercial or Medicare Advantage PPOs, commercial EPOs, commercial provider network supporting self-funded ERISA group health plans, etc.) in which Facility and Practitioners participate under this Agreement.

5.2 Credentialing & Re-credentialing. Facility understands that participation in ValueOptions' provider networks is subject to the successful completion of ValueOptions' credentialing and re-credentialing procedures and conformance with applicable standards. Facility agrees to: (a) comply with the requirements of ValueOptions' credentialing program; (b) notify ValueOptions in writing immediately of any material change in information included in credentialing and/or re-credentialing applications submitted to ValueOptions or its designee. Facility represents and warrants that all information included in credentialing and re-credentialing applications or otherwise upon request as part of the credentialing or re-credentialing process is true and complete. Facility acknowledges that this Agreement may be terminated, or its participation in ValueOptions' provider networks may be suspended for any failure of Facility to remain in continuous compliance with ValueOptions' credentialing and/or re-credentialing standards.

(i) For those Practitioners: (1) who render services only at Facility: (2) who do not maintain a separate office; (3) who will in no event submit independently a claim or bill for their respective services rendered to Members at a Facility location; and (4) for whose services Facility will in all cases submit claims for services to Members on their behalf: (A) Facility represents that all such Practitioners are privileged/credentialed initially and re-evaluated for privileges/re-credentialed at least every three (3) years and in accordance with Facility's bylaws, policies and procedures; (B) upon request Facility to provide documentation of such privileging and credentialing/re-credentialing; and (C) ValueOptions is relying upon such Facility privileging and credentialing/re-credentialing of such Practitioners. Other Practitioners will need to be individually credentialed in accordance with ValueOptions' credentialing/re-credentialing policies and procedures.

(ii) Facility agrees that: (1) Payors may periodically conduct reasonable investigations of the licenses and background of Facility and Practitioners; and (2) subject to any legal or contractual restrictions, that ValueOptions may provide Payors with information reasonably requested by Payors regarding the credentialing and/or re-credentialing of Facility and/or Practitioners.

(iii) Facility holds harmless ValueOptions, its officers and directors, and members of the credentialing committee and all Payors from any liability resulting from their respective good faith use of any information about Facility (including members of the Facility's medical staff and/or Practitioners) in the performance of credentialing and/or re-credentialing activities.

5.3 Payor Contracts & Payor Specific Provisions. Payor and/or government program specific provisions applicable only to such Payor's Members, Plans, and/or the specific government program in addition to the provisions of this Agreement, if any, are set out in Exhibits B.

5.4 ValueOptions' Policies and Procedures. Facility agrees to comply with and upon request participate in ValueOptions' policies and procedures and such other administrative policies and procedures as are identified in the Provider Handbook (as may be amended from time to time), and any Payor specific policies and procedures made available to Participating Providers and related to participation in such Payor's provider network(s) for their Members and any Covered Services rendered to their respective Members, including without limitation credentialing, re-credentialing, utilization management, utilization review, referral, quality assurance, quality improvement, and appeals and grievances. Except to the extent specifically provided for by applicable state and/or federal law, rule or regulation, accreditation requirement, or applicable Payor specific requirement, in the event of any conflict between the terms of this Agreement and the terms of the Provider Handbook, the provisions of this Agreement shall control. Otherwise, the terms of the Provider Handbook are in addition to the terms of this Agreement.

(a) Facility, in the course of Facility's participation in the ValueOptions provider network(s), supports the statement of Members' rights and responsibilities contained in the Provider Handbook.

(b) ValueOptions will give Facility prior notice in the same time period as made for all other ValueOptions' Participating Providers (thirty (30) days or such lesser period of time as required by applicable law prior to the effective date of the change) through the ValueOptions' Provider Newsletter, formal notice or through the ValueOptions' website of material additions, deletions, and modifications to the Provider Handbook. Notice to Facility is notice to all Practitioners hereunder.

5.5 Quality Initiatives. In particular, Facility agrees to comply and cooperate with any quality initiatives that are required of ValueOptions by quality assurance committees, accrediting bodies (e.g. NCQA, URAC), Payors, and/or government agencies.

5.6 Notice of Proceeding. In the event Facility is in possession of documents concerning a claim, suit, criminal or administrative proceeding that has been brought against Facility relating to: (a) services provided to Members; or (b) the quality of services provided by Facility; or (c) Facility's compliance with community standards and/or applicable laws and regulations, then Facility shall notify ValueOptions of such claims, suit or proceeding within ten (10) business days.

5.7 Actions. ValueOptions may take certain actions as described in the Provider Handbook with regard to a Participating Provider who fails to carry out such Participating Provider's agreement to comply with ValueOptions' policies and procedures, Provider Handbook and the terms of this Agreement. Any disputes concerning actions undertaken pursuant to this Section shall be resolved pursuant to the dispute resolution procedures of this Agreement, however, implementation of any second or subsequent notification(s), suspension or termination shall not be delayed due to a grievance being filed by Facility.

5.8 Audits. Upon reasonable written request, Facility agrees that ValueOptions, or ValueOptions' designee, shall have the right to audit and reasonable access and an opportunity to examine during normal business hours, on at least forty-eight (48) hours' advance notice, or such shorter period of time as maybe imposed on ValueOptions by a Payor, federal or state regulatory agency or accreditation organization, the facilities, billing and financial books, records and operations of Facility, Practitioners, any individual or entity performing services for or on behalf of Facility, or any related organization or entity, as they apply to the obligations of Facility under this Agreement. The purpose of this requirement is to permit ValueOptions to assure compliance by Facility with all obligations, financial, operational, quality assurance, as well as other obligations of Facility under this Agreement and Facility's continuing ability to meet such obligations.

Article VI: Services

6.1 Eligibility Verification & Certification. ValueOptions maintains processes or makes available access to processes for Participating Providers to: (a) verify Member eligibility; (b) where required to do so, to obtain Certification for proposed services and/or transition between Levels of Care; or (c) where not required to obtain Certification to provide notice of all inpatient admissions, which notice must be done within twenty-four (24) hours of any such inpatient admission. Facility agrees to use these processes and to verify Member eligibility and obtain Certification (where required) prior to the provision of non-emergency services. Facility: (i) understands that failure to obtain Certification where required for proposed non-emergency services, or where not required to obtain Certification failure to provide notice of all inpatient admissions, which notice must be done within twenty-four (24) hours of any such inpatient admission may result in an administrative denial of any Claim submitted thereafter for lack of Certification or required notice; and (ii) in the event of an administrative denial of any Claim submitted thereafter for lack of Certification or required notice as identified above, Facility may not bill, charge or otherwise seek payment or reimbursement from the Member or the Member's authorized representative.

(a) Once ValueOptions has Certified a proposed Covered Service as Medically Necessary and unless the information initially provided by Facility was erroneous or incomplete or initially proposed services are later modified: ValueOptions shall not (i) later reverse this Medically Necessary determination for services previously Certified, or (ii) deny payment for those same services based solely on Medical Necessity, unless the information provided at the time of Certification or information in the Member's medical records or authorized plan of treatment materially differs from the services provided and documented in the Member's medical records or the plan of treatment.

(b) Where Facility is uncertain as to whether a service is covered, the Facility shall make reasonable efforts to contact ValueOptions and obtain a coverage determination prior to advising a Member as to coverage and liability for payment and prior to providing the service.

6.2 Services. Facility agrees to provide to Members Covered Services: (a) in accordance with generally accepted medical standards and all applicable laws and regulations; (b) pursuant to the same standards as services rendered to Facility's other patients; (c) in a non-discriminatory manner and without regard for race, color, gender, sexual orientation, age,

religion, national origin, marital status, place of residence, mental or physical disability, genetic information, health status, health plan membership or source of payment, including without limitation Medicare and Medicaid; (d) that are within the scope of Facility's and/or Practitioner's respective licensure; (e) that are within the scope of services for which Facility is credentialed and/or re-credentialed; and (f) that are Medically Necessary. Emergency services should be provided in clinically appropriate locations. In Emergency situations, Facility shall contact ValueOptions within twenty-four (24) hours or the next business day after a Member presents for treatment. Per-Certification is not required for Emergency services; however, where required by the Member's Plan Facility agrees to obtain Certification or pre-authorization for post-stabilization and other services thereafter.

(i) Facility agrees, except in case of an Emergency, that Facility shall coordinate all referrals with ValueOptions. Documentation of referrals must be noted in the patient record. If Facility is required to refer a Member for services that Facility is unable to provide or for services which are not within the scope of Facility's licensure or certification, whether in an Emergency or otherwise, Facility shall use its best efforts to refer the Member to another Participating Provider but, subject to the Member's written agreement and understanding that their respective Plan may not cover out-of-network referrals and the Member may be held financially responsible for such non-emergency out-of-network services, and subject to the Member's clinical needs, may make the referral to another appropriate provider.

(ii) Notice of adverse determinations or denial of Certification or determination that a service is not Medically Necessary will be in accordance with applicable Plan and state and/or federal laws, rules or regulations to which the applicable Plan is subject. Facility agrees to notify Members of adverse determinations for inpatient services/continued inpatient admission/continued outpatient services for which Facility has received verbal notice.

6.3 Records. Facility shall maintain and retain all patient care, financial and administrative records and information related to services provided pursuant to this Agreement for the greater of: (a) the time required by applicable federal or state law, or where applicable the government sponsored program; or (b) ten (10) years from the date of service.

6.4 Access. Facility agrees to maintain the medical, patient care, financial and claims-related records and data concerning services provided to Members that Facility would maintain in the normal course of business and in accordance with state and/or federal laws, rules and/or regulations applicable to medical and patient records. Upon reasonable notice and during Facility's regular business hours, ValueOptions, its authorized representatives, and duly authorized third parties (such as government agencies, quality improvement organizations (QIOs and QIO-like entities), accreditation organizations, and Payors) shall have the right to inspect and/or be given copies of medical and claims related records directly related to services rendered to Members by Facility. Copies of medical records requested shall be provided at no cost to ValueOptions or any Payor.

6.5 Non-Certified Services. Notwithstanding anything to the contrary herein, Facility understands and agrees: (a) in the event that Facility fails to secure Certification from ValueOptions where required by the Member's Plan for services that are included in the Member's Plan, the Member shall not be held liable for the cost of such services; and (b) for those services that are not Certified as Medically Necessary by ValueOptions, or where applicable the Payor, following submission or request by Facility, Facility may bill Members for such non Certified services included the Member's Plan only if Facility has followed the procedures set forth in this Section.

(a) Subject to assignment by the Member, Facility may initiate an appeal on behalf of the Member following ValueOptions' appeals policies and procedures set out in the Provider Handbook and as provided for in the Member's Plan: (i) in the event that: (1) Facility fails to secure Certification from ValueOptions where required by the Member's Plan for services that are included in the Member's Plan; or (2) ValueOptions notifies Facility that: (A) a proposed treatment or services for a Member will not be Certified; or (B) treatment or services for a Member which had previously been Certified will no longer continue to be Certified.

(b) Prior to seeking payment from a Member for any services not Certified (whether due to Facility's failure to secure Certification where required or as determined by ValueOptions, or where applicable Payor or Payor's designee), Facility shall first exhaust all appeals of any Certification or authorization denial; and thereafter Facility shall: (i) advise the Member that the service or services are not Certified and will not be covered or paid for by ValueOptions

or the Payor; and (ii) obtain written acknowledgment from the Member that the Member is and will be financially responsible for all costs of such services not Certified.

6.6 Outpatient Treatment Reports & Payment for Outpatient Covered Services. Where Certification or prior-authorization is required for outpatient services by a Member's Plan, or when requested by ValueOptions, Facility shall complete and sign the ValueOptions outpatient treatment report and supply other requested substantiating documentation related to continued treatment authorization requests and/or Claims submitted for outpatient Covered Services. Regardless of any provision to the contrary, failure to complete the outpatient treatment report where required by the Member's Plan and/or failure to respond to a request from ValueOptions for completion of an outpatient treatment report and/or other substantiating documentation may result in denial of Claims submitted for such outpatient services.

6.7 Appeal Process. Facility agrees to: (a) cooperate with ValueOptions' complaints, grievances and appeal processes (as stated in the Provider Handbook) maintained to: (i) fairly and expeditiously resolve Members' or Participating Providers' concerns; (ii) resolve any complaints by Members regarding Facility or Practitioner's services; and (b) exhaust all ValueOptions and/or Payor complaint, grievance and/or appeal processes available prior to: (i) pursuit of any available legal or equitable remedies, including without limitation pursuit of any alternative dispute resolution pursuant to the provisions of Article X below; and/or (ii) seeking payment from a Member for any services not Certified as provided for in Section 6.5(b) above and/or for any Non-Covered Services as provided in Section 7.4(2) below. Regardless of any provision to the contrary, the parties understand and agree that the determination of Member eligibility, what is a Covered Service, and appeal rights for Members shall be pursuant to and in accordance with the applicable Member Plan.

6.8 Treatment Options. The parties acknowledge and agree that: (a) nothing contained in this Agreement is intended to interfere with or hinder communications between Facility/Practitioner and Members regarding a Member's health condition or available treatment options; and (b) regardless of any payment or coverage determination made by ValueOptions or Payors, the treating provider is responsible for determining clinically appropriate treatment and services.

Article VII: Claims & Payment

7.1 Claims Submission. Facility agrees to prepare and submit Clean Claims for Covered Services in the form and manner required by ValueOptions as specified in the Provider Handbook such that they are received within: (a) ninety (90) days of the date of service; or (b) sixty (60) days of the date of claim determination by the primary payer in instances of other health benefits coverage. Facility: (i) understands that failure to submit Claims within the above noted time period(s) will be denied for lack of timely filing; and (ii) in the event of such a denial of any Claim submitted thereafter for lack of timely filing as identified above, Facility may not bill, charge or otherwise seek payment or reimbursement from the Member or the Member's authorized representative. Facility agrees to cooperate with ValueOptions in providing any information reasonably requested in connection with claims processing and in obtaining necessary information relating to coordination of benefits, subrogation, verification of coverage, and health status.

(i) When submitting claims, Facility: (1) shall use the most current coding methodologies on all forms; (2) shall abide by all applicable coding rules and associated guidelines, including without limitation inclusive code sets; and (3) agrees that regardless of any provision or term in this Agreement, in the event a code is formally retired or replaced, Facility agrees to discontinue use of such code and begin use of the new or replacement code following the issue date by the appropriate coding entity or government agency. Should Facility submit claims using retired or replaced codes, Facility understands and agrees that ValueOptions, or Payors, may deny such claims until appropriately coded and re-submitted.

(ii) Facility further agrees Facility will not knowingly and shall contractually require Practitioners not to bill ValueOptions, Payor or Member separately for Practitioner's services when they are included as a comprehensive payment in the Rate Schedule. If certain Practitioner services are excluded from amounts paid to the Facility directly, payments made directly to the Practitioner should be considered a comprehensive payment pursuant to ValueOptions professional fee schedule(s).

(iii) All Claim submissions by Facility will be considered final, unless Facility requests reconsideration of the Claim or submits a corrected Claim within sixty (60) days of receipt of a request to submit a corrected Claim, payment or denial from the Payor. Any corrected claims submitted must be identified as a corrected Claim.

7.2 Payment.

(a) Subject to the terms of this Agreement and of the Member's Plan, payment for Covered Services rendered to Members will be made to Facility: (i) by Payor within ninety (90) days of receipt of a Clean Claim submitted by Facility; or (ii) by ValueOptions, where ValueOptions is functioning as a Payor, within sixty (60) days of receipt of a Clean Claim submitted by Facility.

(b) Payment: (i) for Covered Services shall be the lesser of the rates specified in the applicable Rate Schedule (Exhibit A) or Facility's billed charges; (ii) for Covered Services is funded by Payors and not by ValueOptions, except where ValueOptions has specifically contracted with a client to function as a Payor for Covered Services; (iii) is based upon: (1) compliance with the terms of this Agreement; (2) the determination that the service is a Covered Service under the Member's Plan; and (3) Member's eligibility at the time of service. Payment from the Payor plus any Member Expenses collected from the Member is payment in full for Covered Services rendered. Payment or coverage determinations by ValueOptions or Payors shall not be construed as a directive that medically appropriate treatment be withheld.

(c) As more fully set forth in Section 7.4 below, Facility agrees that under no circumstances shall Facility seek payment from Members or their authorized representatives for Covered Services other than for applicable Member Expenses as authorized by Member's Plan.

(d) Should ValueOptions or a Payor overpay Facility: (i) Facility shall cooperate in the efforts to recover overpayments made; and (ii) Facility agrees that ValueOptions may offset any outstanding claims payment with amounts owed to ValueOptions and/or the Payor as a result of overpayments.

7.3 Coordination of Benefits. The coordination of benefit rules of the applicable Payor's Plan will determine payment to Facility. In no event, shall a Payor be obligated to pay Facility any portion of a secondary payment whereby the sum of the primary payment, plus the secondary payment, exceeds the compensation specified in the Rate Schedule. Facility agrees to cooperate with ValueOptions in providing any information reasonably requested in connection with claims and in obtaining necessary information relating to coordination of benefits, subrogation, verification of coverage, and health status. Facility agrees to: (a) make reasonable efforts to determine if Members have insurance or other health care coverage other than through Payor and promptly report any duplicate coverage to ValueOptions; and (b) notify ValueOptions promptly in the event it provides services in connection with work-related injuries, motor vehicle accidents, or other occurrences that may involve third-party liability. Nothing contained herein, however, shall restrict or otherwise affect Facility's rights or obligations with respect to third-party payors other than Payor.

7.4 No Balance Billing. Facility agrees that in no event, including, but not limited to nonpayment by ValueOptions or Payor, insolvency of ValueOptions or Payor, or breach of this Agreement, shall Facility bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Member, subscriber, enrollee person to whom health care services have been provided, or person acting on behalf of the Member, for whom health care services were provided pursuant to this Agreement. This does not prohibit Facility from collecting Member Expenses or: (a) fees for Non-Covered Services delivered on a fee-for-service basis to persons referenced above (provided that Facility complies with Section 7.4(2) below); (b) fees for services that are not Certified provided that Facility complies with Section 6.5(b) above; or (c) from recourse against ValueOptions or Payors. Facility: (i) agrees this provision supersedes any oral or written contrary agreement previously entered into between Facility and Member or anyone acting on their behalf; and (ii) Facility shall abide by the terms of this provision in the event of non-payment by ValueOptions or Payor for any reason, including, but not limited to voluntary or involuntary bankruptcy proceedings involving ValueOptions or Payor.

(1) Facility agrees that: (a) Facility shall not bill Members for services which have been denied for payment because they were not submitted to ValueOptions in a timely fashion as required by Section 7.1 above.

(2) Notwithstanding the above and prior to rendering any Non-Covered Services, Facility: (A) shall advise the Member that the service or services are not covered; and (B) will obtain written acknowledgment from the Member that the service or services will not be covered or paid for by ValueOptions or the Payor and further that the Member is financially responsible for all costs of such Non-Covered Services.

(3) This Section 7.4 and its subparts: (A) shall survive the expiration or termination of this Agreement regardless of the cause; (B) shall be construed to be for the benefit of Members; and (C) supersedes any oral or written contrary agreement now existing or hereafter entered into between Facility and a Member or any person acting on such Member's behalf.

7.5 Claims Disputes. In accordance with and subject to ValueOptions' policies and procedures and subject to the terms of the applicable Member Plan, Facility may appeal administrative Claim denials based upon lack of timely submission or lack of Certification or authorization or failure to provide required notice of inpatient admissions. All such Claims payments administrative appeals must be made in writing to ValueOptions within sixty (60) days of the date of payment.

Article VIII: Term & Termination

8.1 Term. The term of this Agreement shall be for a period of one (1) year commencing on the Effective Date specified on the Execution Page of this Agreement and will renew automatically for additional one (1) year terms unless and until: (a) either party notifies the other party sixty (60) days prior to the renewal date that the Agreement will not be renewed; or (b) this Agreement is terminated by either party in accordance with the termination provisions specified in this Agreement.

8.2 Termination Without Cause. This Agreement may be terminated by either party for any reason upon sixty (60) days written notice to the other; provided however, that ValueOptions shall not terminate Facility on the grounds that Facility: (a) advocated on behalf of a Member, (b) filed a complaint against ValueOptions, (c) appealed a decision of ValueOptions or (d) requested a review or challenged a termination decision of ValueOptions. ValueOptions and Facility agree that there will be no requirement or obligation to provide a reason for exercising its right to terminate the Agreement pursuant to this provision unless same is otherwise specifically required by applicable law or regulation.

8.3 Termination With Cause. This Agreement may be terminated by either party effective by giving sixty (60) days written notice to the other of a breach by such other party of its obligations hereunder. Any such termination shall be effective if the other party has failed to cure the breach within the first thirty (30) days following receipt of such written notice to the reasonable satisfaction of the non-breaching party.

8.4 Suspension or Termination. Notwithstanding the foregoing, this Agreement and/or an individual Practitioner's participation under this Agreement, as applicable, may be terminated or suspended immediately by ValueOptions upon the occurrence of: (a) suspension, revocation, condition, expiration or other restriction of license, credentials or certification; (b) criminal charges related to the rendering of health care services being filed; (c) the termination or lapse of the insurance requirements specified in Section 3.3 above; (d) failure to remain in compliance with ValueOptions' licensure and credentialing/re-credentialing standards; (e) debarment, suspension or exclusion from participation in any federal or state government sponsored health program, including without limitation Medicare or Medicaid; (f) a determination of fraud; (g) a threat to the health or well-being of a Member; or (h) if ValueOptions becomes aware of prior license/certification sanctions against or unsatisfactory malpractice history of Facility or an individual Practitioner. ValueOptions may suspend referrals to and/or reassign Members from Facility and/or a particular Practitioner pending investigation of the alleged occurrences of the events listed in this Section and ValueOptions shall notify Facility or the Practitioner, as applicable, in writing of same. Further, ValueOptions may terminate this Agreement immediately upon written notice to Facility in the event that: (i) there is a change in control in Facility or new owner or ownership is not acceptable to ValueOptions; and (ii) Facility engages in or acquiesces to any act of bankruptcy, receivership or reorganization.

8.5 Practitioner/Facility/Location Exclusion from Participation. Facility agrees that if ValueOptions requests in writing and with explanation that a Practitioner no longer render services to Members pursuant to this Agreement, Facility shall immediately comply with such request and agrees to remove such Practitioner from participation under this Agreement. Facility agrees that should ValueOptions determine that it no longer desires to have one of Facilities facilities or locations

identified in Exhibit A participate under this Agreement, Facility will immediately remove such facility or location from participation under this Agreement.

8.6 Payor Termination. The parties agree that a Payor may terminate Facility's participation in such Payor's provider network(s) and their status as a participating provider with Payor upon at least sixty (60) days prior written notice to ValueOptions and Facility containing the reason for the proposed termination in the event of the following: (a) the occurrence of an event that renders Facility unable to provide services as required under this Agreement; (b) Payor determines Facility does not satisfy criteria for participation as a Payor participating provider, including without limitation criteria related to quality of care, utilization management, billing practices or failure to cooperate with re-credentialing processes; or (c) Payor determines that Facility fails to comply with the terms of this Agreement as they apply to Facility's services to Payor's Members, and Facility fails to cure such non-compliance during the above noted sixty (60) day notice period.

8.7 Application. Regardless of any provision to the contrary, Facility understands and agrees that termination of this Agreement for any reason shall simultaneously terminate Facility's participation, through ValueOptions, in the Plans of all Payors. Facility agrees that ValueOptions will notify each Payor of the termination of Facility from the ValueOptions provider network(s).

8.8 Continuation of Service. Unless ValueOptions advises to the contrary, Facility shall continue to provide Covered Services, at the rates and pursuant to the requirements specified in this Agreement, to Members in an inpatient status or receiving active treatment at the time of expiration or termination until discharge for inpatient Covered Services and until the course of treatment is completed or until ValueOptions makes reasonable and medically appropriate arrangements to have another Participating Provider render such services for the greater of the time period required by applicable state and/or federal, law or regulation or ninety (90) days. In the case of Members receiving inpatient service, on-going treatments shall include Medically Necessary post-discharge ambulatory services. Payment for Covered Services hereunder shall be in accordance with the applicable Rate Schedule in Exhibit A.

8.9 Transition. Upon notice of non-renewal or termination of this Agreement for any reason, Facility agrees to reasonably cooperate with ValueOptions and Payors to enable and support the transition and/or transfer of Members under the care of Facility to other Participating Providers.

8.10 Audits & Investigations. To the extent ValueOptions and/or a Payor commenced an audit or investigation prior to the effective date of expiration or termination of this Agreement, Facility agrees to continue to cooperate with such audit or investigation and to provide access to documents and records reasonably requested in the course of such audit or investigation.

Article IX: Governing Law and Compliance

9.1 Governing Law. This Agreement shall be interpreted and construed in accordance with the laws of the Commonwealth of Virginia, without regard to its conflicts of law provisions and except to extent preempted by applicable federal laws or regulations.

9.2 Legal Compliance. The parties agree to comply with all applicable state and/or federal laws, rules and/or regulations. The alleged failure by either party to comply with applicable state and/or federal laws, rules or regulations shall not be construed as allowing either party a private right of action against the other in any legal or administrative proceeding in matters in which such right is not recognized by such law, rule or regulation.

9.3 State Government Sponsored Plans and Programs. In addition to the terms and conditions of this Agreement, provisions applicable to Covered Services rendered to Members covered under Medicaid Plans and such other state government sponsored plans and/or health benefit programs are set out in Exhibits B.

9.4 Medicare Advantage Plans. In addition to the terms and conditions of this Agreement, provisions applicable to Covered Services rendered to Members covered under Medicare Advantage Plans are set out in Exhibits B.

9.5 Excluded Individuals/Entities. Facility and ValueOptions respectively represent that neither is nor knowingly employs or contracts with individuals or entities excluded from or ineligible for participation in any government sponsored health care program.

9.6 Confidentiality of Member Records. The parties agree to: (a) have and implement procedures designed to preserve the privacy and confidentiality of Member records; and (b) maintain, retain, use and/or disclose such Member records and any Protected Health Information in accordance with HIPAA, 42 C.F.R. Part 2 as related to alcohol and/or substance abuse services and/or records, and all applicable other federal and state laws, rules and regulations regarding the confidentiality, privacy and/or security of Protected Health Information and/or medical/behavioral health/alcohol-substance abuse records and any patient consent required there under. Facility shall cooperate with ValueOptions and Payors to ensure that all consents to the release of Members records are in conformity with applicable state and federal laws and regulations governing the release of records maintained in connection with mental health and/or substance abuse treatment. Facility shall also ensure that any records maintained electronically meet all applicable federal and state laws and regulations related to the storage, transmission and maintenance of such records.

9.7 Regulatory Access. Facility medical records, encounter data, and financial information shall be open to inspection upon request, during normal business hours by state and federal regulators with jurisdiction over Payors, ValueOptions and/or the Facility, including the U.S. Department of Health and Human Services, the Comptroller General of the United States, the State Superintendent of Insurance, and/or other authorized state or federal regulatory agencies or entities, or their duly authorized representatives to the extent required by law. This provision shall survive expiration or termination of the Agreement, regardless of the cause.

9.8 Physician Incentive Plans. Any incentive plans between ValueOptions and Facility and/or between ValueOptions and physicians, practitioners, providers and/or facilities employed or owned by and/or contracted with Facility to render services to Members under the Agreement shall be in compliance with applicable state and federal laws, rules and regulations, including without limitation 42 C.F.R. §§417.479 and 434.70. Upon request, Facility agrees to disclose to ValueOptions and Payors the terms and conditions of any 'physician incentive plan' as defined by applicable state or federal law or regulation. Each party represents that no specific payment will be made directly or indirectly to a physician or physician group as an incentive or inducement to limit Medically Necessary Covered Services furnished to a Member. This requirement shall be contained in any subcontract of this Agreement between Facility and Practitioners.

9.9 Reporting. Upon reasonable request, Facility agrees to provide ValueOptions and Payors with timely access to records, reports, clinical information and/or encounter data in the format required to meet obligations under contracts with any government agency sponsoring or overseeing Plans covered under this Agreement.

Article X: Dispute Resolution

10.1 Unresolved Disputes. ValueOptions and Facility agree to attempt to resolve any disputes arising with respect to the performance or interpretation of this Agreement promptly by negotiation between the parties. Prior to submission of any unresolved disputes to binding arbitration and/or pursuit of any termination of the Agreement pursuant to the provisions herein, Facility agrees to use available ValueOptions' administrative review and/or grievance and appeal procedures as specified in the Provider Handbook.

(a) In the case of a dispute concerning ValueOptions credentialing or re-credentialing of Facility, or a dispute arising out of ValueOptions' implementation of any requirements imposed upon ValueOptions or Facility by a Payor, the decision of the respective ValueOptions internal grievance system shall be final and binding on Facility. Facility shall not maintain any action against ValueOptions, or its shareholders, officers, directors, agents or committee members, to seek financial or other compensation for any damages arising out of the ValueOptions' ministerial implementation of a Payor's credentialing determination.

(i) The parties agree that the exclusive remedy for unresolved disputes between the parties under this Agreement, including without limitation a dispute involving interpretation of any provision of this Agreement, questions regarding application and/or interpretation of applicable state and/or federal laws, rules or regulations, the parties' respective obligations under this Agreement, or otherwise arising out of the parties' business

relationship, shall be resolved by binding arbitration as provided for below.

(ii) The party initiating binding arbitration shall provide prior written notice to the other party identifying the nature of the dispute, the resolution sought, the amount, if any, involved in the dispute, and the names and background of at least two (2) potential arbitrators. The submission of any dispute to arbitration shall not adversely affect any party's right to seek available preliminary injunctive relief.

(iii) Any arbitration proceedings shall be held in Norfolk, Virginia in accordance with and subject to the Commercial Arbitration Rules of the AAA then in effect, or under such other mutually agreed upon guidelines and before a single arbitrator selected by the parties. Discovery shall be permitted in the same manner, types and times periods provided for by the Federal Rules of Civil Procedure. To the extent the parties are unable to agree upon an arbitrator, the parties agree to use an arbitrator selected by the AAA from a list of arbitrators chosen by the parties as individuals with knowledge and expertise in the area or issue in dispute.

(iv) The arbitrator: (1) may construe or interpret but shall not vary or ignore the terms of this Agreement; (2) shall be bound by applicable state and/or federal controlling laws, rules and/or regulations; and (3) shall not be empowered to certify any class or conduct any class based arbitration or award punitive or consequential damages. The decision of the arbitrator shall be final, conclusive and binding. Judgment upon the award rendered in any such arbitration may be entered in any court of competent jurisdiction, or application may be made to such court for judicial application and enforcement of the award, as applicable law may require or allow.

(v) Each party shall assume its own costs (including without limitation its own attorneys' fees and such other costs and expenses incurred related to the proceedings), but the compensation and expenses of the arbitrator and any administrative fees or costs of any arbitration proceeding(s) hereunder shall be borne equally by ValueOptions and Facility.

Article XI: Miscellaneous

11.1 Notice. Any notice required to be given pursuant to the terms of this Agreement shall be in writing and shall be sent by certified or registered mail, return receipt requested, postage prepaid, or by hand delivery, to the receiving party at the address set forth on the signature page, or at any other address of which a party has given notice in accordance with this Section. Notice shall be deemed given on the date of delivery or refusal as shown on the return receipt if delivered by mail or the date upon which such notice is personally delivered in writing to the designated liaison person. Notice to "Facility" and "ValueOptions" is notice to all individuals and entities under this Agreement, respectively.

11.2 Amendments. Except as provided for below, any amendment to this Agreement must be made in writing and executed by both parties. Notwithstanding the above: (a) this Agreement shall be automatically amended to comply with applicable state and/or federal laws, rules or regulations, and/or accreditation requirements to which ValueOptions is or may be subject; and/or (b) ValueOptions may amend this Agreement by giving Facility prior written notice setting forth the terms of the proposed amendment. Notice to Facility is notice to Facility and all of its Practitioners. Facility shall then have thirty (30) days from the receipt of ValueOptions' notice to reject the proposed amendment by written notice of rejection to ValueOptions. If ValueOptions does not receive such written notice of rejection within that thirty (30) day period, the proposed amendment shall be deemed accepted by and shall be binding upon Facility, effective as of the end of such thirty (30) day period. If Facility rejects a proposed amendment, either party may, in its discretion, elect to terminate this Agreement upon thirty (30) days written notice to the other party.

11.3 Newly Acquired Persons/Entities. In the event: (a) Facility acquires, through purchase, asset acquisition, merger, consolidation, or other means, or enters into a management agreements to manage other acute care hospitals, medical facilities or other Practitioners, and such other acute care hospitals, medical facilities or other Practitioners have in effect an agreement with ValueOptions to provide mental health and/or substance abuse services to Members; and/or (b) ValueOptions acquires through purchase, asset acquisition, merger, consolidation, or other means other licensed or authorized third party administrators, utilization review agents, or health plans in the state, and such other licensed third party administrators, utilization review agents or health plans have in effect an agreement with Facility to provide mental health and/or substance abuse services: (i) Facility or ValueOptions, respectively, will notify the other within thirty (30)

days of the effective date of such acquisition, purchase, merger, management contract or other transaction referenced herein; and (ii) the parties agree that the payment rates for Covered Services contained in such other agreements shall continue to apply for such newly acquired persons and/or entities of a party for the six (6) month period following the effective date of completion of transaction and thereafter the payment rates for Covered Services rendered by such newly acquired persons and/or entities will be those payment rates included in Exhibit A of this Agreement unless the parties otherwise mutually agree in writing during the above noted transition period.

11.4 Assignment. This Agreement, being intended to secure the services of Facility hereunder, may not be assigned, delegated or transferred by Facility without the prior written consent of ValueOptions; provided, however, ValueOptions may assign this Agreement to any entity that controls, is controlled by, or is under common control with ValueOptions.

11.5 Use of Name. During the term of this Agreement, Facility consents to the use of its name and other identifying and descriptive material in provider directories and marketing materials. Use of the Facility name, logos, trademarks or service marks in public advertising shall require prior written consent of the Facility. Facility may use ValueOptions name, logos, trademarks and service marks in marketing material or otherwise, with ValueOptions prior written consent except that Facility may without ValueOptions' consent, list ValueOptions in its standard list of contracted managed care organizations that is routinely provided to patients.

11.6 Confidentiality. Each party or their respective employees or agents may, in the course of the relationship established by this Agreement, disclose in confidence to the other party certain Confidential Information. Each party acknowledges that the disclosing party shall at all times be and remain the owner of all Confidential Information disclosed by such party, and that the party to which Confidential Information is disclosed shall in a manner consistent with the manner in which it protects its own Confidential Information, preserve the confidentiality of any such Confidential Information which such party knows or reasonably should know that the other party deems to be Confidential Information. Neither party shall use for its own benefit or disclose to third parties any Confidential Information of the other party without such other party's written consent.

(a) Facility agrees that at no time during or after the term of this Agreement, except as may be required to carry out or its duties and obligations hereunder, shall Facility, Practitioners, or officers, directors, agents, contractors or employees of Facility, without the prior written consent of ValueOptions, whether directly or indirectly, or for competitive or other purposes, disclose or cause to be disclosed to a third party, or make or cause any unauthorized use of: (i) any ValueOptions' policy manuals or other proprietary information of ValueOptions; or (ii) any term or condition of this Agreement, its exhibits, attachments or schedules. Nothing herein shall be construed as prohibiting or penalizing communication between Facility and/or Practitioners and Members regarding available treatment options, including appropriate or Medically Necessary care for the Member.

(b) Facility shall protect the confidentiality of any Payor specific confidential or proprietary information received by Facility.

11.7 Force Majeure. Except for payment of sums due, neither party shall be liable to the other nor deemed in default under this Agreement if and to the extent that such party's performance of this Agreement is prevented by reason of force majeure.

(a) Force majeure means an occurrence that is beyond the reasonable control of the party affected and occurs without its fault or negligence. Without limiting the foregoing, force majeure includes acts of God; acts of the public enemy; war; riots; strikes; terrorism; mobilization; labor disputes; civil disorders; fire; flood; lockouts; or failure or refusals to act by government authority; and other similar occurrences beyond the control of the party declaring force majeure which such party is unable to prevent by exercising reasonable diligence. Force majeure shall not include the inability of either party to acquire or maintain any required insurance, bond, licenses or permits.

(b) Force majeure shall be deemed to commence when the party declaring force majeure notifies the other party of the existence of the force majeure and shall be deemed to continue as long as the results or effects of the force majeure prevent the party from resuming performance in accordance with this Agreement.

(c) Any delay or failure in performance by either party hereto shall not constitute default hereunder or give rise to any claim for damages or loss of anticipated profits if, and to the extent that, such delay or failure is caused by force majeure.

11.8 Waiver. Waiver, whether express or implied, of any breach of any provision of this Agreement shall not be deemed to be a waiver of any other provision or a waiver of any subsequent or continuing breach of the same provision. In addition, waiver of one of the remedies available to either party in the event of a default or breach of this Agreement by the other party shall not at any time be deemed a waiver of a party's right to elect such remedy(ies) at any subsequent time if a condition of default continues or recurs.

11.9 Severability. If any portion(s) of this Agreement shall, for any reason, be invalid or unenforceable, such portions shall be ineffective only to the extent of any such invalidity or unenforceability, and the remaining portion or portions shall nevertheless be valid, enforceable and of full force and effect; provided however, that if the invalid provision is material to the overall purpose and operation of this Agreement, then this Agreement shall terminate upon the severance of such provision.

11.10 Entire Agreement. This Agreement and Amendments thereto constitute the entire understanding and agreement of the parties and supersedes any prior written or oral agreement pertaining to the subject matter hereof.

11.11 Survival of Provisions. The provisions set forth in Sections 2.1, 2.2, 2.4, 3.2, 3.3, 3.4, 3.5, 4.3, 4.4, 5.3, 5.8, Article VI, 7.1, 7.2, 7.4, 7.5, 8.7, 8.8, 8.9, Article IX, Article X, 11.6, 11.8, 11.10, 11.11, and those provisions identified in a Payor Specific Provisions Exhibit shall survive any expiration or termination of this Agreement.

11.12 Counterparts/Captions. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which constitute one and the same Agreement. The captions in this Agreement are for reference purposes only and shall not affect the meaning of terms and provisions herein.

---Signatures Follow---

Intending to be legally bound, the parties have caused their authorized representatives to execute this Agreement effective as of the date set forth by ValueOptions below.

Facility:

_____ _____
Signature *Date*

_____
Print Name & Title

_____
Federal Tax Identification Number

Address for Notice:

ValueOptions:

_____ _____
Signature *Date*

_____
Print Name & Title

Address for Notice:

ValueOptions, Inc.
P.O. Box 41055
Norfolk, VA 23541-1055
Attn: National Provider Network Operations

Please do NOT write below this line. For ValueOptions office use ONLY.

_____
EFFECTIVE DATE

Negotiated By: _____
Print Name

_____
Title

_____
Date Received By ValueOptions

Please check if included: ☐ _____ ☐ _____

Exhibit A
Facility Location(s) & Practitioners, Services & Payment

I: Facility Locations & Practitioners.

(1) The list of those Facility locations and Practitioners who are or will be rendering available Covered Services to Members under this Agreement is set out below.

---To Be Provided by Facility Prior to Execution---

II: Facility Services.

(1) All Behavioral Health Services: (a) available from Facility and/or Practitioners pursuant to their respective licensure or certification; (b) for which Facility and/or Practitioners have been credentialed pursuant to ValueOptions' credentialing/re-credentialing policies and procedures; and (c) for which there is a corresponding payment rate herein.

III: Rate Schedules & Payment.

(1) The parties agree that:

(a) Payment amounts for Covered Services shall be in accordance with the Rate Schedule(s) attached hereto and incorporated herein by reference;

(b) The date of receipt of a claim is the date ValueOptions, or Payor, receives the claim, as indicated by its date stamp on the claim;

(c) The date of payment is the date of the check or other form of payment;

(d) The inpatient payment rates listed in attached Rate Schedules are inclusive, including without limitation, facility, supplies, materials, drugs, equipment, x-ray, laboratory (technical, facility, and where identified in a Rate Schedule - professional) and other diagnostic fees, semi-private room and board (where applicable), operating room (where applicable), nurses and other Facility employees and permitted contracted entities and individuals; and

(e) Inpatient days commence at 12:00 midnight, however no payment is due for the date of discharge.

(2) No payment in addition to the applicable inpatient rate for Covered Services above will be made for: (a) any outpatient services rendered in the emergency room of Facility prior to an inpatient admission; or (b) any outpatient observation services rendered prior to an inpatient admission.

Exhibit B
Payor/Government Program/State Specific Provisions

I: Facility acknowledges and agrees that the provisions set out in the attached Exhibits B-1, B-2 and on, each of which are incorporated herein by reference, apply solely with respect to Members of the identified Payor and/or government sponsored health benefit program, and/or solely with respect to Plans subject to identified State laws and regulations.

Exhibit B-1
Medicare Advantage Provisions

This Exhibit contains additional provisions applicable to Covered Services rendered to MA Members (as defined below) covered under Medicare Advantage ("MA") Plans (as defined below) offered and/or administered by Payor(s). In the event of any conflict between the provisions of the Agreement and this Exhibit, the provisions of this Exhibit control as related to services rendered to MA Members.

I: General Provisions.

(1) Whenever in this Exhibit the term "Facility" is used to describe an obligation or duty, such obligation or duty shall also be the responsibility of each individual licensed health care practitioner, facility and provider employed or owned by or under contract with Facility, as the context may require.

(2) Facility agrees:

(a) To participate in Payors' MA Plans in accordance with the terms of this Agreement and this Exhibit; and
(b) Payors, in their sole discretion, may elect to develop and/or implement MA Plans with limited or alternative provider networks in which Facility does not participate.

II: Definitions.

(1) All capitalized terms not otherwise defined in this Exhibit shall have the meanings ascribed to them in the Agreement.

(2) For purposes of this Exhibit, the following additional terms shall have the meaning set out below:

(a) "CMS" means the Centers for Medicare and Medicaid Services.
(b) "MA Member(s)" means those designated individuals eligible for traditional Medicare under Title XVIII of the Social Security Act and the CMS rules and regulations and enrolled in a Payor MA Plan.
(c) "MA Plan" means one or more plans in the Medicare Advantage program offered or administered by a Payor and covered under Payor's contract with ValueOptions and/or one of ValueOptions' affiliates.
(d) "Medicare Advantage Program or MA Program" means the federal Medicare managed care program for Medicare Advantage products run and administered by the CMS, or the CMS' successor.
(e) "Medicare Contract" means a Payor's contract(s) with the CMS, to arrange for the provision of health care services to certain persons enrolled in an MA Plan and eligible for Medicare under Title XVIII of the Social Security Act.

III: Accountability & Oversight.

Regardless of any provision to the contrary, Payors, or their respective designees, oversee and monitor the provision of services to their respective MA Members on an on-going basis and Payors remain accountable and responsible to the CMS for compliance with the terms and conditions of their respective Medicare Contracts, regardless of the provisions of the Agreement or any delegation of administrative activities or functions to ValueOptions.

IV: Facility Status.

(1) Facility represents that Facility:

(a) Maintains full participation status in the federal Medicare program (This includes Facility, all Facility employed, owned and contracted health care practitioners, health care providers, and health care facilities, and those other employees, contracted individuals and entities who will provide services to MA Members under the Agreement, including without limitation, mental health and/or substance abuse, utilization review, medical social work and/or other administrative services.);

(b) Does not have any agents, management staff, or persons with ownership or control interests whom have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social service programs under Title XX of the Social Security Act;
(c) Has not been excluded from participation in any federal health care program, including without limitation the Medicare program; and
(d) Shall notify ValueOptions immediately in the event that Facility is excluded from Medicare participation.

(2) Prior to rendering services to MA Members and subject to any credentialing or re-credentialing processes, Facility understands and agrees that Facility must submit to Facility's Medicare provider number, State Medicaid provider number, and Facility's NPI number(s).

V: Compliance.

(1) Facility agrees to:

(a) Comply with all applicable state and federal laws, rules and regulations governing the MA Program, CMS operating procedures, CMS instructions, and applicable requirements of the Medicare Contract, including without limitation:

(i) Laws and regulations designed to prevent or ameliorate fraud, waste, and abuse;
(ii) Laws and regulations applicable to recipients of federal funds;
(iii) State and federal laws, rules and regulations regarding the privacy, security, confidentiality, accuracy and/or disclosure of records, protected health information and/or personally identifiable information, including without limitation, the federal Health Insurance Portability and Accountability Act of 1996 and the rules and regulations promulgated thereunder (each as may be amended);
(iv) 42 C.F.R. §422.516 and 42 C.F.R. §422.310 regarding reporting obligations to the CMS; and
(v) Laws, regulations and CMS instructions and guidelines regarding medical policies, billing requirements, and marketing.

(b) Comply and cooperate with training and education given as part of a Payor's compliance plan to detect, correct and prevent fraud, waste and abuse.

(c) Provide ValueOptions and/or Payors with timely access to records, information and data necessary for: (i) Payors to meet their respective obligations under their Medicare Contracts; and/or (ii) the CMS to administer and evaluate the MA program.

(d) Submit all reports and clinical information required by ValueOptions and/or Payors that may be required by Medicare Contract(s) and/or MA regulations, including without limitation all claims and/or encounter data required by the CMS and/or pursuant to 42 C.F.R. §422.516 and 42 C.F.R. §422.257. Facility shall certify the accuracy, completeness and truthfulness of all such claims and/or encounter data provided to Payors and/or ValueOptions.

VI: Services.

(1) Facility agrees to:
(a) Make available to MA Members those Covered Services provided by Facility within the scope of its professional license, registration and/or certification twenty-four (24) hours a day, seven (7) days a week;
(b) Provide ValueOptions with all requisite information regarding his/her/its twenty-four (24) hour coverage, including notifying ValueOptions immediately when needing to arrange alternate coverage;
(c) Participate in and cooperate with any and all of ValueOptions and Payor specific policies and procedures, including but not limited to, those for quality assurance (including independent quality review and improvement organization activities), utilization review, and resolution of MA Member appeals and grievances, as well as the procedures set forth in 42 C.F.R. §422.562(a);

(d) Comply with ValueOptions and any Payor specific credentialing and re-credentialing processes and requirements;
(e) Maintain Facility's credentialing, verification and/or privileging procedures and practices for physicians, practitioners and other health care providers employed by or under contract with Facility and rendering services under the Agreement, which procedures and practices are relied upon by ValueOptions and Payors as to Practitioners participating under this Agreement;
(f) Comply with Payor specific programs, policies and procedures, including without limitation those regarding: (1) confidentiality of patient records, and (ii) advance health care directives;
(g) Upon request, participate in any internal or external quality assurance reviews, utilization reviews, quality improvement initiatives, peer review and/or grievance procedures established by ValueOptions and/or a Payor, or the CMS, or their respective designees;
(h) Comply with and implement corrective action where necessary for that level of care within the professional practices and standards in the community and/or as established or required by ValueOptions, a Payor or the CMS; and

VII: Payment.

(1) Subject to the terms and provisions set forth in the Agreement and this Exhibit, ValueOptions or Payor shall pay Facility for Covered Services rendered to MA Members in accordance with the payment terms and Rate Schedule(s) applicable to Covered Services rendered to MA Members set out in the Agreement. Facility agrees that payments of amounts specified in the Agreement (including any applicable MA Member Expenses) shall constitute payment in full for the Facility's provision of Covered Services to MA Members.

(2) Regardless of any provision to the contrary, to the extent a MA Member receives Covered Services from Facility on an out-of-network basis and/or there is no specific Rate Schedule (Exhibit A) for that MA Member's MA Plan attached to this Agreement, maximum payment for any Covered Services rendered to such MA Member is limited to the lesser of one hundred percent (100%) of Medicare allowable or the amount provided for under applicable MA laws, rules and/or regulations applicable to such MA Member's Plan and is subject to the terms of the MA Member's Plan.

(3) Facility acknowledges and agrees that in no event, including without limitation the insolvency of a Payor or ValueOptions, breach of the Agreement by ValueOptions, and/or non-payment for Covered Services by ValueOptions or where applicable a Payor, shall Facility bill, charge or seek compensation, remuneration or reimbursement from, or assert any legal action against MA Members for payment of any fees or amounts that are the legal obligation of ValueOptions and/or the Payor.

(4) With respect to the MA Member who are designated as a 'dual eligible' (as defined under Medicare regulations) for whom the State Medicaid Agency is otherwise required by law, and/or voluntarily has assumed responsibility, to cover those Member Expenses identified and at the amounts provided for in the State Medicaid Plan, Facility agrees: (a) to accept payment from the Payor, or where applicable ValueOptions when acting as the Payor, as payment in full for Covered Services rendered to such dual eligible MA Members; and (b) not to collect or seek to collect any Member Expenses for Covered Services from such dual eligible MA Members.

VIII: Records.

(1) Facility agrees to maintain records, including separate financial, administrative and medical records, related to services rendered by Facility to MA Members for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of this Agreement occurs or from completion of any audit or investigation, whichever is greater, unless an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (a) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; or (b) completion of any review or audit should that date be later than the time frame(s) indicated above; or (c) such greater period of time as provided for by law.

(2) Subject to any legal restrictions, Facility agrees to provide the Department of Health and Human Services (DHHS), the Office of Inspector General (OIG), the General Accounting Office (GAO), the Comptroller General, the CMS and/or other applicable regulatory agencies, Payors' accrediting bodies, or their respective designees with timely access to any contracts, books, financial records, medical records, documents, papers and other records and information, including without limitation financial or otherwise, and their respective facilities, as they apply to Facility's obligations under the Agreement and/or as related to services rendered to MA Members and/or as required by the Medicare Program Contract necessary for: (a) Payors to meet obligations under their Medicare Contracts; and/or (b) the CMS to administer and evaluate the MA program. Facility agrees to cooperate in investigations conducted by the above noted authorized regulatory agencies and any resulting legal actions. This provision shall survive the termination of this Exhibit and the Agreement.

IX: Delegation.

(1) Should ValueOptions, in its sole discretion, elect to sub-delegate any administrative activities or functions to Facility, any such sub-delegation: (a) is subject to the prior approval of Payor; (b) shall be in writing and accordance with applicable delegation requirements set forth in MA regulations; (c) shall specify the delegated activities and reporting responsibilities; (d) shall include provisions for monitoring and oversight by ValueOptions and Payors; and (e) shall provide for corrective action measures, up to and including termination without limitation termination or revocation of the delegated activities or functions or other correction or remedy if the CMS or a Payor determines that such activities were not performed satisfactorily.

(i) If credentialing is delegated, Facility shall meet all ValueOptions and Payor credentialing requirements, and Payors, respectively, will review the credentials of medical professionals or will review, approve and audit the credentialing process on an ongoing basis.
(ii) If ValueOptions sub-delegates the selection of providers for participation in a Payor's provider network, Payors, respectively, retain the right to approve, suspend or terminate any such arrangement.

X: Term & Termination.

(1) In addition to the provisions set forth in the Agreement, this Exhibit may be suspended or terminated by ValueOptions as to any one or more Payor's MA Plans immediately upon written notice if:

(a) A Payor's Medicare Contract is suspended or terminated for any reason;
(b) Facility is disqualified, terminated, suspended, debarred, or otherwise excluded from or ineligible for participation under the MA program or any other state or federal government-sponsored health program; or
(c) The Agreement is terminated or not renewed.

(2) Following expiration or termination (whether due to insolvency or cessation of operations of ValueOptions or a given Payor, or otherwise) of the Agreement, Facility will continue to provide Covered Services to MA Members: (a) for those MA Members confined in an inpatient facility on the date of expiration or termination until their discharge; (b) for all MA Member through the period for which payments have been made by the CMS to the applicable Payor MA Plan under its Medicare Contract; and (c) for those MA Members in active treatment of chronic or acute behavioral health or substance abuse conditions as of the date of expiration or termination of the Agreement through their current course of active treatment not to exceed ninety (90) days unless otherwise require by subsection (b) above. The terms and conditions of the Agreement apply to such post-expiration or post-termination Covered Services. Payment for Covered Services rendered to MA Members post expiration or post-termination of this Agreement will be the fee-for-service rates set out in the applicable Rate Schedule, less any MA Member Copayments.

Exhibit B-2
Medicaid & Other Government Sponsored Health Benefit Program Provisions

This Exhibit contains additional provisions applicable to Covered Services rendered to MCD Members (as defined below) covered under MCD Plans (as defined below) offered and/or administered by Payor(s). In the event of any conflict between the provisions of the Agreement and this Exhibit and subject to the provisions set out in Exhibit, the provisions of this Exhibit control as related to services rendered to MCD Members.

I: General Provisions.

(1) Whenever in this Exhibit the term "Facility" is used to describe an obligation or duty, such obligation or duty shall also be the responsibility of each individual licensed health care practitioner, facility and provider employed or owned by or under contract with Facility, as the context may require.

(2) Facility agrees:

(a) To participate in Payors' MCD Plans in accordance with the terms of this Agreement and more specifically this Exhibit.
(b) Payors, in their sole discretion, may elect to develop and/or implement MCD Plans with limited or alternative provider networks in which Facility does not participate.

II: Definitions. All capitalized terms not otherwise defined in this Exhibit shall have the meanings ascribed to them in the Agreement.

(1) For purposes of this Exhibit, the following additional terms shall have the meaning set out below:

(a) "MCD Member(s)" means those designated individuals eligible for traditional Medicaid under Title XIX of the Social Security Act and applicable New York State rules and regulations and enrolled in a Payor MCD Plan.
(b) "MCD Plan" means one or more plans in the New York State Medicaid program and/or other New York State government agency sponsored health benefit program(s) offered or administered by a Payor and covered under Payor's contract with ValueOptions.
(c) "Medicaid Contract" means a Payor's contract(s) with applicable New York State government agencies, to arrange for the provision of health care services to certain persons enrolled in a MCD Plan.

III: Accountability & Oversight. Regardless of any provision to the contrary, Payors, or their respective designees, oversee and monitor the provision of services to their respective MCD Members on an on-going basis and Payors remain accountable and responsible for compliance with the terms and conditions of their respective Medicaid Contract, regardless of the provisions of the Agreement or any delegation of administrative activities or functions to ValueOptions.

IV: Compliance. Facility agrees to:

(1) Comply with all applicable state and federal laws, rules and regulations related to services rendered to MCD Members, and applicable requirements of the Medicaid Contract, including without limitation:
(2) Comply and cooperate with training and education given as part of a Payor's compliance plan to detect, correct and prevent fraud, waste and abuse;
(3) Provide ValueOptions and/or Payors with timely access to records, information and data necessary for Payors to meet their respective obligations under their Medicaid Contracts; and
(4) Submit all reports and clinical information required by ValueOptions and/or Payors that may be required by Medicaid Contract(s) and/or applicable laws and regulations.

V: Services. Facility agrees to:

(1) Make available to MCD Members those Covered Services provided by Facility within the scope of Facility's license, registration and/or certification as provided for in the Agreement;

(2) Participate in and cooperate with any and all of ValueOptions and Payor specific policies and procedures, including but not limited to, those for quality assurance (including independent quality review and improvement organization activities), utilization review, credentialing and resolution of MCD Member appeals and grievances;
(3) Cooperate with Payors' cultural competency plans as made available by Payors to their respective participating providers;
(4) Comply with Payor specific programs, policies and procedures; and
(5) Comply with and implement corrective action where necessary for that level of care within the professional practices and standards in the community and/or as established or required by ValueOptions or a Payor.

VI: Payment.

(1) Subject to the terms and provisions set forth in the Agreement and this Exhibit, ValueOptions, Payor or Payor's designee shall pay Facility for Covered Services rendered to MCD Members in accordance with the payment terms and Rate Schedule (Exhibit A) applicable to Covered Services rendered to MCD Members as set out in the Agreement. Facility agrees that payments of amounts specified in the Agreement (including any applicable MCD Member Expenses) shall constitute payment in full for the provision of Medically Necessary Covered Services to MCD Members. Notwithstanding the foregoing, in the event that the amount payable to a Payor under their Medicaid Contract is decreased and a Payor's payment to ValueOptions is decreased, Facility agrees that ValueOptions may amend the MCD Plan payment rates to decrease the amount payable in accordance with the terms of the Agreement.

(2) Regardless of any provision to the contrary, to the extent a MCD Member receives Covered Services from Facility under this Agreement on an out-of-network basis and/or there is no specific Rate Schedule (Exhibit A) for that MCD Member's MCD Plan attached to this Agreement, maximum payment for any Covered Services rendered to such MCD Member is limited to the lesser of one hundred percent (100%) of the applicable MCD fee schedule for the MCD Member's Plan or the amount provided for under applicable state or federal laws, rules and/or regulations applicable to such MCD Member's Plan and is subject to the terms of the MCD Member's Plan.

VII: Term & Termination.

(1) In addition to and notwithstanding the provisions set forth in the Agreement, this Exhibit may be suspended or terminated by ValueOptions as to any one or more Payor's MCD Plans immediately upon written notice if:

(a) A Payor's Medicaid Contract is suspended or terminated for any reason;
(b) Facility is disqualified, terminated, suspended, debarred, or otherwise excluded from or ineligible for participation under the MCD program or any other state or federal government-sponsored health program; or
(c) The Agreement is terminated or not renewed.

ValueOptions® Practitioner Participation Agreement

_____

Print Name of Practitioner

_____

Print Type of Practitioner (i.e., Psychiatrist, Psychologist, Masters Level Licensed Social Worker, Licensed Mental Health Provider, etc.)

_____

Print Address of Practitioner

_____

Print Contact Person's Name, Telephone Number and E-Mail Address

_____ _____

Federal Tax Identification Number (TIN) *NPI Number(s)*

_____ _____

Medicaid Provider Number *Medicare Provider Number*

If Practitioner has more than one office location, please provide a complete listing of all office locations with all of the above information in Exhibit A.

EFFECTIVE DATE:

_____

(To be Inserted by ValueOptions Following Satisfactory Completion of Credentialing)

This ValueOptions Practitioner Participation Agreement ("Agreement") is made and entered into, by and between the appropriately trained and licensed or certified psychiatrist, psychologist, psychiatric social worker or other licensed mental health provider identified on the Signature Page of this Agreement ("Practitioner"), and ValueOptions, Inc. and its Affiliates (severally and collectively, as the context may require, "ValueOptions®[1]"), to be effective on the date set forth as the Effective Date on the Signature Page of this Agreement.

In consideration of the mutual promises and consideration herein, the sufficiencies of which are hereby acknowledged, the parties agree as follows:

Article I: Definitions

Capitalized terms used in this Agreement and/or in the introductory paragraphs above, all of which are hereby incorporated by reference, shall, unless otherwise defined in a Payor or Plan specific exhibit to this Agreement, have the following meanings:

1.1 "*AAA*" means the American Arbitration Association.

1.2 "*Affiliate*" means those entities and companies that are: (a) wholly owned subsidiaries of and/or share a common parent company with ValueOptions; and/or (b) at least thirty-three percent (33%) owned or controlled by ValueOptions.

1.3 "*Case Management*" means the case management and/or utilization management programs and processes implemented and directed by ValueOptions with respect to the provision of Covered Services.

1.4 "*Certification*" or "*Certifies or* "*Certified*" means the decision of ValueOptions or its designee resulting from the Case Management process to determine whether proposed or rendered treatment is Medically Necessary.

1.5 "*Clean Claim*" means a complete and accurate UB-04 or CMS 1500 claim form, their HIPAA compliant electronic equivalents, or their respective successor forms, along with any required substantiating documentation, submitted for mental health, alcohol and/or substance abuse services rendered to a Member which contains at a minimum the following information including, but not limited to: patient name, patient's date of birth, Member's identification number, Practitioner's name, address and tax identification number and NPI number, date(s) and place of service or purchase, ICD-9 code(s)/CPT-4 code(s)/revenue code(s), or their respective HIPAA compliant successor code sets, services and supplies provided, and charges.

1.6 "*Confidential Information*" means a party's non-public information confidential and proprietary information, data, content, utilization management procedures, credentialing criteria, patient treatment and/or finances, such party's earnings, volume of business, methods, systems, practices, plans, technical and non-technical data, and other proprietary information. Confidential Information also includes information that has been disclosed to ValueOptions, Affiliates or their parent company by a third party and which they, individually or collectively are obligated to treat as confidential.

1.7 "*Covered Services*" means those Medically Necessary mental health, alcohol and/or substance abuse services for which Members are covered pursuant to a Plan and for which a Member covered thereunder is entitled.

1.8 "*Emergency*", unless otherwise defined in a Member's Plan, means the sudden onset of acute symptoms from a mental health or substance abuse disorder and one or more of the following circumstances are present: (a) the patient is in imminent or potential danger of harming himself or others; (b) the patient shows symptoms (e.g., hallucinations, agitation, delusions, etc.) resulting in impairment in judgment, functioning and/or impulse control severe enough to endanger his or her own welfare or that of another person; or (c) there is an immediate need for hospitalization as a result of or in conjunction with a very serious situation such as an overdose, detoxification or potential suicide.

[1] 'ValueOptions' is a registered service mark of ValueOptions, Inc. Any use of or reference to 'ValueOptions' in any communication, publication, notice, disclosure, mailing or other document, whether written or electronic, requires the prior written authorization of ValueOptions, Inc.

1.9 "*HIPAA*" means the federal Health Insurance Portability and Accountability Act of 1996, including without limitation its privacy, security and administrative simplification provisions, and the rules and regulations promulgated there under, each as may be amended from time to time.

1.10 "*Level of Care*" means the duration, frequency, location, intensity and/or magnitude of a treatment setting, treatment plan, or treatment modality, including, but not limited to: (a) acute care facilities; (b) less intensive inpatient or outpatient alternatives to acute care facilities such as residential treatment centers, group homes or structured outpatient programs; (c) outpatient visits; or (d) medication management.

1.11 "*Medically Necessary*", unless otherwise defined in the Member's Plan, means those services which are: (a) 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 results in illness or infirmity; (b) expected to improve an individual's condition or level of functioning; (c) individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs; (d) essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals and publications; (e) reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available; (f) not primarily intended for the convenience of the recipient, caretaker, or provider; (g) not more intensive or restrictive than necessary to balance safety, effectiveness and efficiency; and (h) not a substitute for non-treatment services addressing environmental factors.

1.12 "*Member*" means an individual who is enrolled in a Payor Plan and eligible to receive Covered Services under such Plan.

1.13 "*Member Expenses*" means those copayments, coinsurance, deductible and/or other cost-share amounts due from Members for Covered Services pursuant to their respective Plan.

1.14 "Non-Covered Services" means, for purposes of this Agreement, those services, items, supplies or levels of care that are excluded from coverage under a Member's Plan or for which the Member has exhausted benefits under their Plan.

1.15 "*Participating Provider*" means: (a) an appropriately trained and licensed or certified individual practitioner or group of practitioners (psychiatrist, physician, psychologist, psychiatric social worker or other licensed mental health provider), hospital, institution, facility, clinic, program, or agency that has entered into a written contractual arrangement with ValueOptions to provide Covered Services to Members at agreed upon payment rates; and/or (b) an appropriately trained and licensed or certified individual practitioner (psychiatrist, physician, psychologist, psychiatric social worker or other licensed mental health provider) who has entered into a written contractual arrangement with a facility, group, agency, and/or clinic contracted with ValueOptions to provide Covered Services to Members at agreed upon payment rates.

1.16 "*Payor*" means the entity financially responsible for claims payments for Covered Services. Payors may include insurance companies, health maintenance organizations, preferred provider organizations, provider sponsored networks/organizations, third party administrators, provider network administrators, self-funded employer group health plans, multiple employer trusts, union trusts and government agencies.

1.17 "*Payor Contract*" means the written agreement between ValueOptions and a Payor identifying those Plans and associated administrative services related to mental health alcohol and/or substance abuse Covered Services for which ValueOptions is responsible and obligating Payors to pay or make funds available for payment of Clean Claims for Covered Services for their respective Plan Members.

1.18 "*Plan*" means any benefit plan or benefit arrangement offered and/or administered by a Payor for whom ValueOptions has agreed to provide services under a Payor Contract and that identifies at a minimum Covered Services for Members, any limitations and/or exclusions, and processes for appealing coverage determinations.

1.19 "*Protected Health Information*" or "*PHI*" means a Member's '*individually identifiable health information'* as defined in 45 C.F.R. §160.103 and/or applicable state law, and/or '*patient identifying information*' as defined in 42 C.F.R. Part 2.

1.20 "*Provider Handbook*" or "*Provider Manual*" means the ValueOptions proprietary document(s) which contains ValueOptions' Participating Provider policies and procedures and which ValueOptions, in its sole discretion, may amend

from time to time. The Provider Handbook, available and accessible through the 'provider' section of ValueOptions' website at www.valueoptions.com, is incorporated in its entirety by reference.

1.21 "*Rate Schedule*" means the rates payable to Practitioner by a Payor, as payment in full, for Covered Services rendered to Members. Payment to Practitioner shall be as specified in Exhibit A and shall be subject to any limitations or exclusions of the Member's Plan. Unless otherwise expressly provided for in a Rate Schedule, reimbursements for facilities, hospitals, institutions or programs made on a per diem, per case or other global payment are all inclusive of facility fees, technical fees, and professional fees of individual and/or group Practitioners. The Rate Schedule(s) set out in Exhibit A will identify the Members and/or Plans for which they apply.

Article II: Relationship

2.1 Independent Contractors. None of the provisions of this Agreement is intended to create, nor shall be deemed or construed to create, any relationship between ValueOptions and Practitioner other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Except as specifically provided for in this Agreement, the parties agree that neither ValueOptions nor Practitioner will be liable for the activities of the other nor their representative agents or employees, including without limitation, any liabilities, losses, damages, injunctions, lawsuits, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or government agency arising out of or related to this Agreement; however, any rights to indemnification that may be available to either party at law or in equity are not affected by execution of this Agreement.

2.2 Practitioner/Patient Relationship. Nothing in this Agreement shall change or alter any clinical relationship which exists or may come to exist between Practitioner and any Member(s). Practitioner: (a) shall have the same duties, liabilities and responsibilities to Members as exist generally between Practitioner and patients; (b) shall always exercise his/her best medical judgment in the treatment of Members; and (c) is not an agent of ValueOptions, and shall not hold themselves out as an agent of ValueOptions.

2.3 Referrals. Practitioner understands that ValueOptions does not, by this Agreement or future patterns of practice promise or guarantee any minimum volume of referrals of Members to Practitioner by ValueOptions or any Payor.

2.4 No Third Party Beneficiary. This Agreement does not create any third party beneficiary rights in any person or entity, including without limitation Members or Payors.

2.5 Cooperation. The parties agree to cooperate and take such further actions and execute such other documents or instruments as necessary or appropriate to implement this Agreement.

Article III: Practitioner Information

3.1 Authority. Practitioner represents and warrants that Practitioner is authorized to negotiate and execute participation agreements, including this Agreement, and to bind Practitioner and all employees and/or contractors of Practitioner to the terms and conditions of this Agreement. Whenever in this Agreement the term "Practitioner" is used to describe an obligation or duty, such duty or obligation shall also be the responsibility of each individual or entity employed by and/or contracted with Practitioner, and where applicable each individual Practitioner office location, as the context may require. Notwithstanding any provisions or statement to the contrary, Practitioner understands and agrees that any licensed or certified health care practitioner or professional employed by or under contract with Practitioner (including without limitation any physician, psychologist, psychiatric social worker, therapist, advanced registered nurse practitioner, physician's assistant, or other licensed mental health provider) must be separately contracted and credentialed in accordance with ValueOptions' policies and procedures.

3.2 Licensure. Practitioner represents that during the term of this Agreement and any required continuation period following its expiration or termination, Practitioner: (a) shall maintain licensure, certification and/or registration in good standing under applicable laws and regulations in the state and/or states in which services are performed; (b) to the extent such licensure and/or certification permits the prescribing of drugs, shall maintain certification by the United States Drug Enforcement Agency (DEA); and (c) maintains all requisite certifications, accreditations, approvals and authorizations

required under applicable laws and regulations to operate each of Practitioner's office locations. Evidence of such licensure, certifications, registrations, and accreditations shall be submitted to ValueOptions in a timely manner upon ValueOptions' reasonable request. Practitioner shall promptly notify ValueOptions in writing of any: (i) action against state licenses, certifications and/or registrations; (ii) action taken regarding Medicare or Medicaid program participation status, or by a review organization; (iii) any change in licensure, certification or registration status; (iv) changes in ownership or business address; (v) legal or government action initiated and final action taken by a government agency, board or professional association that could materially affect the rendering of services under this Agreement; (vi) legal action commenced by or on behalf of a Member against Practitioner relating to services rendered pursuant to this Agreement; (vii) any compromise, settlement or judgment of a malpractice claim against Practitioner; (viii) initiation of bankruptcy or insolvency proceedings with regard to Practitioner whether voluntary or involuntary; or (ix) other occurrence known to Practitioner that could materially affect the rendering of services under this Agreement.

3.3 Insurance. Practitioner agrees to procure and maintain such policies of comprehensive general liability insurance, as are reasonably necessary to insure Practitioner, its employees, contractors, and agents against any claim or claims for damages arising out of personal injuries or death occasioned directly or indirectly in connection with the provision of any service provided hereunder, the use of any property and facilities provided by Practitioner, or its employees, contractors or agents, and activities performed by Practitioner, or its employees, contractors/subcontractors, or agents, in connection with this Agreement. Practitioner shall maintain professional liability insurance coverage or self-insurance covering Practitioner, its employees, contractors, and agents in an amount of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate. In the event such professional liability insurance coverage is on a 'claims made' basis, Practitioner also agrees to maintain such policy in effect, or maintain appropriate 'tail coverage' following any expiration or termination of this Agreement for the time period(s) identified under the applicable state and/or federal statute of limitations law or regulation. Practitioner shall also: (a) supply upon reasonable request a copy of the face sheet reflecting any changes in insurance coverage prior to their effective date; (b) supply upon reasonable request a copy of the face sheet for each annual renewal of professional liability coverage; (c) ensure that ValueOptions receives such face sheet within ten (10) days of each annual renewal; and (d) ensure that ValueOptions is notified at least thirty (30) days prior to the expiration, termination or material change to such professional liability coverage.

3.4 Locations. All office locations identified by Practitioner in Practitioner's credentialing and/or re-credentialing application and/or change of address form submitted to ValueOptions and which office locations meet ValueOptions credentialing/re-credentialing criteria and standards will be considered a part of the ValueOptions provider network(s) and payment for Covered Services rendered by Practitioner to Members at such identified office locations will be according to the Rate Schedule(s) in this Agreement.

3.5 Employees & Contractors. Practitioner shall: (a) ensure that Practitioner's employees and contractors comply with the terms and conditions of this Agreement; and (b) bill and submit claims for Covered Services rendered by Practitioner to Members using the Practitioner's single tax identification.

Article IV: ValueOptions Information

4.1 Licensure. ValueOptions represents that ValueOptions maintains in good standing appropriate licensure or certification as required by applicable state laws. ValueOptions will notify Participating Providers, including without limitation Practitioner, through public notice or otherwise, of: (a) final revocation of its license or authorization to do business in the state; or (b) initiation of bankruptcy or insolvency proceedings with regard to ValueOptions whether voluntary or involuntary.

4.2 Insurance. ValueOptions shall procure and maintain such policies of comprehensive and general liability insurance coverage or self-insured coverage as are reasonably necessary to ensure ValueOptions, its employees, officers and directors against any claim or claims for damages arising out of performance under this Agreement. Such policies shall be in amounts of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.

4.3 Affiliates. The joinder of ValueOptions' entities under the designation 'ValueOptions' shall not be construed as imposing joint responsibility or cross-guarantee between or among such entities. All rights and responsibilities arising in respect to individual Members and/or Covered Services rendered to individual Members shall be applicable only to ValueOptions or the applicable Affiliate that administers the Plan covering the Member.

4.4 Relationship with Payors. Unless ValueOptions' contractual relationship with a Payor includes the transfer of financial risk for claims, the Payor and not ValueOptions is ultimately responsible for making sufficient amounts available for claims payments for Covered Services.

Article V: Participation, Policies & Procedures

5.1 Network Participation. Practitioner agrees to participate in provider networks of ValueOptions made available to Payors for Members covered under benefit plans offered or administered by such Payors, including without limitation commercial plans, State Medicaid/government programs, and Medicare Advantage plans, in accordance with the terms and conditions of this Agreement, and for which there is a Rate Schedule (Exhibit A) attached to this Agreement.

(a) Regulatory agencies periodically conduct telephonic audits by contacting Participating Providers. Practitioner shall provide information and respond to questions from regulatory agencies and/or individuals or entities conducting surveys or inquiries on their behalf as to those provider networks and products/lines of business (e.g. commercial or Medicare Advantage PPOs, commercial EPOs, commercial provider network supporting self-funded ERISA group health plans, etc.) in which Practitioner participates under this Agreement.

5.2 Credentialing & Re-credentialing. Practitioner understands that participation in ValueOptions' provider networks is subject to the successful completion of ValueOptions' credentialing and re-credentialing procedures and conformance with applicable standards. Practitioner agrees to: (a) comply with the requirements of ValueOptions' credentialing program; (b) notify ValueOptions in writing immediately of any material change in information included in credentialing and/or re-credentialing applications submitted to ValueOptions or its designee. Practitioner represents and warrants that all information included in credentialing and re-credentialing applications or otherwise upon request as part of the credentialing or re-credentialing process is true and complete. Practitioner acknowledges that this Agreement may be terminated for any failure of Practitioner to remain in continuous compliance with ValueOptions' credentialing and/or re-credentialing standards.

(i) Practitioner agrees that: (1) Payors may periodically conduct reasonable investigations of the licenses and background of Practitioner; and (2) subject to any legal or contractual restrictions, that ValueOptions may provide Payors with information reasonably requested by Payors regarding the credentialing and/or re-credentialing of Practitioner.

(ii) Practitioner holds harmless ValueOptions, its officers and directors, and members of the credentialing committee and all Payors from any liability resulting from their respective good faith use of any information about Practitioner in the performance of credentialing and/or re-credentialing activities.

5.3 Payor Contracts & Payor Specific Provisions. Payor and/or government program specific provisions applicable only to such Payor's Members, Plans, and/or the specific government program in addition to the provisions of this Agreement, if any, are set out in Exhibits B.

5.4 ValueOptions' Policies and Procedures. Practitioner agrees to comply with and upon request participate in ValueOptions' policies and procedures and such other administrative policies and procedures as are identified in the Provider Handbook (as may be amended from time to time), and any Payor specific policies and procedures made available to Participating Providers and related to participation in such Payor's provider network(s) for their Members and any Covered Services rendered to their respective Members, including without limitation credentialing, re-credentialing, utilization management, utilization review, referral, quality assurance, quality improvement, and appeals and grievances. Except to the extent specifically provided for by applicable state and/or federal law, rule or regulation, accreditation requirement, or applicable Payor specific requirement, in the event of any conflict between the terms of this Agreement

and the terms of the Provider Handbook, the provisions of this Agreement shall control. Otherwise, the terms of the Provider Handbook are in addition to the terms of this Agreement.

(a) Practitioner, in the course of Practitioner's participation in the ValueOptions provider network(s), supports the statement of Members' rights and responsibilities contained in the Provider Handbook.

(b) ValueOptions will give Practitioner prior notice in the same time period as made for all other ValueOptions' Participating Providers (thirty (30) days or such lesser period of time as required by applicable law prior to the effective date of the change) through the ValueOptions' Provider Newsletter, formal notice or through the ValueOptions' website of material additions, deletions, and modifications to the Provider Handbook.

5.5 Quality Initiatives. In particular, Practitioner agrees to comply and cooperate with any quality initiatives that are required of ValueOptions by quality assurance committees, accrediting bodies (e.g. NCQA, URAC), Payors, and/or government agencies.

5.6 Notice of Proceeding. In the event Practitioner is in possession of documents concerning a claim, suit, criminal or administrative proceeding that has been brought against Practitioner relating to: (a) services provided to Members; or (b) the quality of services provided by Practitioner; or (c) Practitioner's compliance with community standards and/or applicable laws and regulations, then Practitioner shall notify ValueOptions of such claims, suit or proceeding within ten (10) business days.

5.7 Actions. ValueOptions may take certain actions as described in the Provider Handbook with regard to a Participating Provider who fails to carry out such Participating Provider's agreement to comply with ValueOptions' policies and procedures, Provider Handbook and the terms of this Agreement. Any disputes concerning actions undertaken pursuant to this Section shall be resolved pursuant to the dispute resolution procedures of this Agreement, however, implementation of any second or subsequent notification(s), suspension or termination shall not be delayed due to a grievance being filed by Practitioner.

5.8 Audits. Upon reasonable written request, Practitioner agrees that ValueOptions, or ValueOptions' designee, shall have the right to audit and reasonable access and an opportunity to examine during normal business hours, on at least forty-eight (48) hours' advance notice, or such shorter period of time as maybe imposed on ValueOptions by a Payor, federal or state regulatory agency or accreditation organization, the facilities, billing and financial books, records and operations of Practitioner, any individual or entity performing services for or on behalf of Practitioner, or any related organization or entity, as they apply to the obligations of Practitioner under this Agreement. The purpose of this requirement is to permit ValueOptions to assure compliance by Practitioner with all obligations, financial, operational, quality assurance, as well as other obligations of Practitioner under this Agreement and Practitioner's continuing ability to meet such obligations.

Article VI: Services

6.1 Eligibility Verification & Certification. ValueOptions maintains processes or makes available access to processes for Participating Providers to: (a) verify Member eligibility; and (b) where required to do so, to obtain Certification for proposed non-Emergency services and/or transition between Levels of Care. Practitioner agrees to use these processes and to verify Member eligibility and obtain Certification (where required) prior to the provision of non-emergency services. Practitioner: (i) understands that failure to obtain Certification where required for proposed non-emergency services may result in an administrative denial of any Claim submitted thereafter for lack of Certification or required notice; and (ii) in the event of an administrative denial of any Claim submitted thereafter for lack of Certification as identified above, Practitioner may not bill, charge or otherwise seek payment or reimbursement from the Member or the Member's authorized representative.

(a) Once ValueOptions has Certified a proposed Covered Service as Medically Necessary and unless the information initially provided by Practitioner was erroneous or incomplete or initially proposed services are later modified: ValueOptions shall not (i) later reverse this Medically Necessary determination for services previously Certified, or (ii) deny payment for those same services based solely on Medical Necessity, unless the information provided at the

time of Certification or information in the Member's medical records or authorized plan of treatment materially differs from the services provided and documented in the Member's medical records or the plan of treatment.

(b) Where Practitioner is uncertain as to whether a service is covered, Practitioner shall make reasonable efforts to contact ValueOptions and obtain a coverage determination prior to advising a Member as to coverage and liability for payment and prior to providing the service.

6.2 Services. Practitioner agrees to provide to Members Covered Services: (a) in accordance with generally accepted medical standards and all applicable laws and regulations; (b) pursuant to the same standards as services rendered to Practitioner's other patients; (c) in a non-discriminatory manner and without regard for race, color, gender, sexual orientation, age, religion, national origin, marital status, place of residence, mental or physical disability, genetic information, health status, health plan membership or source of payment, including without limitation Medicare and Medicaid; (d) that are within the scope of Practitioner's licensure; (e) that are within the scope of services for which Practitioner is credentialed and/or re-credentialed; and (f) that are Medically Necessary. Emergency services should be provided in clinically appropriate locations. In Emergency situations, Practitioner shall contact ValueOptions within twenty-four (24) hours or the next business day after a Member presents for treatment. Per-Certification is not required for Emergency services; however, where required by the Member's Plan Practitioner agrees to obtain Certification or pre-authorization for post-stabilization and other services thereafter.

(i) Practitioner agrees, except in case of an Emergency, that Practitioner shall coordinate all referrals with ValueOptions. Documentation of referrals must be noted in the patient record. If Practitioner is required to refer a Member for services that Practitioner is unable to provide or for services which are not within the scope of Practitioner's licensure or certification, whether in an Emergency or otherwise, Practitioner shall refer the Member to another Participating Provider but, subject to the Member's written agreement and understanding that their respective Plan may not cover out-of-network referrals and the Member may be held financially responsible for such non-emergency out-of-network services, and subject to the Member's clinical needs, may make the referral to another appropriate provider.

(ii) Notice of adverse determinations or denial of Certification or determination that a service is not Medically Necessary will be in accordance with applicable Plan and state and/or federal laws, rules or regulations to which the applicable Plan is subject. Practitioner agrees to notify Members of adverse determinations for continued outpatient services for which Practitioner has received verbal notice.

6.3 Records. Practitioner shall maintain and retain all patient care, financial and administrative records and information related to services provided pursuant to this Agreement for the greater of: (a) the time required by applicable federal or state law, or where applicable the government sponsored program; or (b) ten (10) years from the date of service.

6.4 Access. Practitioner agrees to maintain the medical, patient care, financial and claims-related records and data concerning services provided to Members that Practitioner would maintain in the normal course of business and in accordance with state and/or federal laws, rules and/or regulations applicable to medical and patient records. Upon reasonable notice and during Practitioner's regular business hours, ValueOptions, its authorized representatives, and duly authorized third parties (such as government agencies, quality improvement organizations (QIOs and QIO-like entities), accreditation organizations, and Payors) shall have the right to inspect and/or be given copies of medical and claims related records directly related to services rendered to Members by Practitioner. Copies of medical records requested shall be provided at no cost to ValueOptions or any Payor.

6.5 Non-Certified Services. Notwithstanding anything to the contrary herein, Practitioner understands and agrees: (a) in the event that Practitioner fails to secure Certification from ValueOptions where required by the Member's Plan for services that are included in the Member's Plan, the Member shall not be held liable for the cost of such services; (b) for those services that are not Certified as Medically Necessary by ValueOptions, or where applicable the Payor, following submission or request by Practitioner, Practitioner may bill Members for such non Certified services included in the Member's Plan only if Practitioner follows the procedures set forth in this Section.

(a) Subject to assignment by the Member, Practitioner may initiate an appeal on behalf of the Member following ValueOptions' appeals policies and procedures set out in the Provider Handbook and as provided for in the

Member's Plan: (i) in the event that: (1) Practitioner fails to secure Certification from ValueOptions where required by the Member's Plan for services that are included in the Member's Plan; or (2) ValueOptions notifies Practitioner that: (A) a proposed treatment or services for a Member will not be Certified; or (B) treatment or services for a Member which had previously been Certified will no longer continue to be Certified.

(b) Prior to seeking payment from a Member for any services not Certified (whether due to Practitioner's failure to secure Certification where required or as determined by ValueOptions, or where applicable Payor or Payor's designee), Practitioner shall first exhaust all appeals of any Certification or authorization denial; and thereafter Practitioner shall: (i) advise the Member that the service or services are not Certified and will not be covered or paid for by ValueOptions or the Payor; and (ii) obtain written acknowledgment from the Member that the Member is and will be financially responsible for all costs of such services not Certified.

6.6 Outpatient Treatment Reports & Payment for Outpatient Covered Services. Where Certification or prior-authorization is required for outpatient services by a Member's Plan, or when requested by ValueOptions, Practitioner shall complete and sign the ValueOptions outpatient treatment report and supply other requested substantiating documentation related to continued treatment authorization requests and/or Claims submitted for outpatient Covered Services. Regardless of any provision to the contrary, failure to complete the outpatient treatment report where required by the Member's Plan and/or failure to respond to a request from ValueOptions for completion of an outpatient treatment report and/or other substantiating documentation may result in denial of Claims submitted for such outpatient services.

6.7 Appeal Process. Practitioner agrees to: (a) cooperate with ValueOptions' complaints, grievances and appeal processes (as stated in the Provider Handbook) maintained to: (i) fairly and expeditiously resolve Members' or Participating Providers' concerns; (ii) resolve any complaints by Members regarding Practitioner or Practitioner's services; and (b) exhaust all ValueOptions and/or Payor complaint, grievance and/or appeal processes available prior to: (i) pursuit of any available legal or equitable remedies, including without limitation pursuit of any alternative dispute resolution pursuant to the provisions of Article X below; and/or (ii) seeking payment from a Member for any services not Certified as provided for in Section 6.5(b) above and/or for any Non-Covered Services as provided in Section 7.4(2) below. Regardless of any provision to the contrary, the parties understand and agree that the determination of Member eligibility, what is a Covered Service, and appeal rights for Members shall be pursuant to and in accordance with the applicable Member Plan.

6.8 Treatment Options. The parties acknowledge and agree that: (a) nothing contained in this Agreement is intended to interfere with or hinder communications between Practitioner and Members regarding a Member's health condition or available treatment options; and (b) regardless of any payment or coverage determination made by ValueOptions or Payors, the treating provider is responsible for determining clinically appropriate treatment and services.

Article VII: Claims & Payment

7.1 Claims Submission. Practitioner agrees to prepare and submit Clean Claims for Covered Services in the form and manner required by ValueOptions as specified in the Provider Handbook such that they are received within: (a) ninety (90) days of the date of service; or (b) sixty (60) days of the date of claim determination the primary payer in instances of other health benefits coverage. Practitioner: (i) understands that failure to submit Claims within the above noted time period(s) will be denied for lack of timely filing; and (ii) in the event of such a denial of any Claim submitted thereafter for lack of timely filing as identified above, Practitioner may not bill, charge or otherwise seek payment or reimbursement from the Member or the Member's authorized representative. Practitioner agrees to cooperate with ValueOptions in providing any information reasonably requested in connection with claims processing and in obtaining necessary information relating to coordination of benefits, subrogation, verification of coverage, and health status.

(i) When submitting claims, Practitioner: (1) shall use the most current coding methodologies on all forms; (2) shall abide by all applicable coding rules and associated guidelines, including without limitation inclusive code sets; and (3) agrees that regardless of any provision or term in this Agreement, in the event a code is formally retired or replaced, Practitioner agrees to discontinue use of such code and begin use of the new or replacement code following the issue date by the appropriate coding entity or government agency. Should Practitioner submit claims using retired or replaced codes, Practitioner understands and agrees that ValueOptions, or Payors, may deny such claims until appropriately coded and re-submitted.

(ii) Practitioner further agrees Practitioner will not knowingly bill ValueOptions, Payor or Member separately for Practitioner's services when they are included as a comprehensive payment in the Rate Schedule. If certain Practitioner services are excluded from amounts paid to the Practitioner directly, payments made directly to the Practitioner should be considered a comprehensive payment pursuant to ValueOptions professional fee schedule(s).

(iii) All Claim submissions by Practitioner will be considered final, unless Practitioner requests reconsideration of the Claim or submits a corrected Claim within sixty (60) days of receipt of a request to submit a corrected Claim, payment or denial from the Payor. Any corrected claims submitted must be identified as a corrected Claim.

7.2 Payment.

(a) Subject to the terms of this Agreement and of the Member's Plan, payment for Covered Services rendered to Members will be made to Practitioner: (i) by Payor within ninety (90) days of receipt of a Clean Claim submitted by Practitioner; or (ii) by ValueOptions, where ValueOptions is functioning as a Payor, within sixty (60) days of receipt of a Clean Claim submitted by Practitioner.

(b) Payment: (i) for Covered Services shall be the lesser of the rates specified in the applicable Rate Schedule (Exhibit A) or Practitioner's billed charges; (ii) for Covered Services is funded by Payors and not by ValueOptions, except where ValueOptions has specifically contracted with a client to function as a Payor for Covered Services; (iii) is based upon: (1) compliance with the terms of this Agreement; (2) the determination that the service is a Covered Service under the Member's Plan; and (3) Member's eligibility at the time of service. Payment from the Payor plus any Member Expenses collected from the Member is payment in full for Covered Services rendered. Payment or coverage determinations by ValueOptions or Payors shall not be construed as a directive that medically appropriate treatment be withheld.

(c) As more fully set forth in Section 7.4 below, Practitioner agrees that under no circumstances shall Practitioner seek payment from Members or their authorized representatives for Covered Services other than for applicable Member Expenses as authorized by Member's Plan.

(d) Should ValueOptions or a Payor overpay Practitioner: (i) Practitioner shall cooperate in the efforts to recover overpayments made; and (ii) Practitioner agrees that ValueOptions may offset any outstanding claims payment with amounts owed to ValueOptions and/or the Payor as a result of overpayments.

7.3 Coordination of Benefits. The coordination of benefit rules of the applicable Payor's Plan will determine payment to Practitioner. In no event, shall a Payor be obligated to pay Practitioner any portion of a secondary payment whereby the sum of the primary payment, plus the secondary payment, exceeds the compensation specified in the Rate Schedule. Practitioner agrees to cooperate with ValueOptions in providing any information reasonably requested in connection with claims and in obtaining necessary information relating to coordination of benefits, subrogation, verification of coverage, and health status. Practitioner agrees to: (a) make reasonable efforts to determine if Members have insurance or other health care coverage other than through Payor and promptly report any duplicate coverage to ValueOptions; and (b) notify ValueOptions promptly in the event it provides services in connection with work-related injuries, motor vehicle accidents, or other occurrences that may involve third-party liability. Nothing contained herein, however, shall restrict or otherwise affect Practitioner's rights or obligations with respect to third-party payors other than Payor.

7.4 No Balance Billing. Practitioner agrees that in no event, including, but not limited to nonpayment by ValueOptions or Payor, insolvency of ValueOptions or Payor, or breach of this Agreement, shall Practitioner bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Member, subscriber, enrollee person to whom health care services have been provided, or person acting on behalf of the Member, for whom health care services were provided pursuant to this Agreement. This does not prohibit Practitioner from collecting Member Expenses or: (a) fees for Non-Covered Services delivered on a fee-for-service basis to persons referenced above (provided that Practitioner complies with Section 7.4(2) below); (b) fees for services that are not Certified provided that Practitioner complies with Section 6.5 above; or (c) from recourse against ValueOptions or Payors. Practitioner: (i) agrees that this provision supersedes any oral or written contrary agreement previously entered into between Practitioner and Member or

anyone acting on their behalf; and (ii) shall abide by the terms of this provision in the event of non-payment by ValueOptions or Payor for any reason, including, but not limited to voluntary or involuntary bankruptcy proceedings involving ValueOptions or Payor.

(1) Practitioner agrees that Practitioner shall not bill Members for services which have been denied for payment because they were not submitted to ValueOptions in a timely fashion as required by Section 7.1 above

(2) Notwithstanding the above and prior to rendering any Non-Covered Services, Practitioner: (A) shall advise the Member in writing that the service or services are not covered; and (B) will obtain written acknowledgment from the Member that the service or services will not be covered or paid for by ValueOptions or the Payor and further that the Member is financially responsible for all costs of such Non-Covered Services.

(3) This Section 7.4 and its subparts: (A) shall survive the expiration or termination of this Agreement regardless of the cause; (B) shall be construed to be for the benefit of Members; and (C) supersedes any oral or written contrary agreement now existing or hereafter entered into between Practitioner and a Member or any person acting on such Member's behalf.

7.5 Multiple Agreements. In the event Practitioner is a party to more than one agreement with ValueOptions for the provision of Covered Services to Members, Practitioner will be paid by ValueOptions, or where applicable the Payor, for Covered Services under the agreement selected by ValueOptions.

7.6 Claims Disputes. In accordance with and subject to ValueOptions' policies and procedures and subject to the terms of the applicable Member Plan, Practitioner may appeal administrative Claim denials based upon lack of timely submission or lack of Certification or authorization or failure to provide required notice of inpatient admissions. All such Claims payments administrative appeals must be made in writing to ValueOptions within sixty (60) days of the date of payment.

Article VIII: Term & Termination

8.1 Term. The term of this Agreement shall be for a period of one (1) year commencing on the Effective Date specified on the Execution Page of this Agreement and will renew automatically for additional one (1) year terms unless and until: (a) either party notifies the other party sixty (60) days prior to the renewal date that the Agreement will not be renewed; or (b) this Agreement is terminated by either party in accordance with the termination provisions specified in this Agreement.

8.2 Termination Without Cause. This Agreement may be terminated by either party for any reason upon sixty (60) days written notice to the other; provided however, that ValueOptions shall not terminate Practitioner on the grounds that Practitioner: (a) advocated on behalf of a Member, (b) filed a complaint against ValueOptions, (c) appealed a decision of ValueOptions or (d) requested a review or challenged a termination decision of ValueOptions. ValueOptions and Practitioner agree that there will be no requirement or obligation to provide a reason for exercising its right to terminate the Agreement pursuant to this provision unless same is otherwise specifically required by applicable law or regulation.

8.3 Termination With Cause. This Agreement may be terminated by either party effective by giving sixty (60) days written notice to the other of a breach by such other party of its obligations hereunder. Any such termination shall be effective if the other party has failed to cure the breach within the first thirty (30) days following receipt of such written notice to the reasonable satisfaction of the non-breaching party.

8.4 Suspension or Termination. Notwithstanding the foregoing, this Agreement may be terminated or suspended immediately by ValueOptions upon the occurrence of: (a) suspension, revocation, condition, expiration or other restriction of license, credentials or certification; (b) criminal charges related to the rendering of health care services being filed; (c) the termination or lapse of the insurance requirements specified in Section 3.3 above; (d) failure to remain in compliance with ValueOptions' licensure and credentialing/re-credentialing standards; (e) debarment, suspension or exclusion from participation in any federal or state government sponsored health program, including without limitation Medicare or Medicaid; (f) a determination of fraud; (g) a threat to the health or well-being of a Member; or (h) if ValueOptions becomes aware of prior license/certification sanctions against or unsatisfactory malpractice history of Practitioner. ValueOptions may suspend referrals to and/or reassign Members from Practitioner pending investigation of

the alleged occurrences of the events listed in this Section and ValueOptions shall notify Practitioner in writing of same. Further, ValueOptions may terminate this Agreement immediately upon written notice to Practitioner in the event that: (i) there is a change in control in Practitioner or new owner or ownership is not acceptable to ValueOptions; and (ii) Practitioner engages in or acquiesces to any act of bankruptcy, receivership or reorganization.

8.5 Payor Termination. The parties agree that a Payor may terminate Practitioner's participation in such Payor's provider network(s) and their status as a participating provider with Payor upon at least sixty (60) days prior written notice to ValueOptions and Practitioner containing the reason for the proposed termination in the event of the following: (a) the occurrence of an event that renders Practitioner unable to provide services as required under this Agreement; (b) Payor determines Practitioner does not satisfy criteria for participation as a Payor participating provider, including without limitation criteria related to quality of care, utilization management, billing practices or failure to cooperate with re-credentialing processes; or (c) Payor determines that Practitioner fails to comply with the terms of this Agreement as they apply to Practitioner's services to Payor's Members, and Practitioner fails to cure such non-compliance during the above noted sixty (60) day notice period.

8.6 Application. Regardless of any provision to the contrary, Practitioner understands and agrees that termination of this Agreement for any reason shall simultaneously terminate Practitioner's participation, through ValueOptions, in the Plans of all Payors. Practitioner agrees that ValueOptions will notify each Payor of the termination of Practitioner from the ValueOptions provider network(s).

8.7 Continuation of Service. Unless ValueOptions advises to the contrary, Practitioner shall continue to provide Covered Services, at the rates and pursuant to the requirements specified in this Agreement, to Members in an inpatient status or receiving active treatment at the time of expiration or termination until discharge for inpatient Covered Services and until the course of treatment is completed or until ValueOptions makes reasonable and medically appropriate arrangements to have another Participating Provider render such services for the greater of the time period required by applicable state and/or federal, law or regulation or ninety (90) days. In the case of Members receiving inpatient service, on-going treatments shall include Medically Necessary post-discharge ambulatory services. Payment for Covered Services hereunder shall be in accordance with the applicable Rate Schedule in Exhibit A.

8.8 Transition. Upon notice of non-renewal or termination of this Agreement for any reason, Practitioner agrees to reasonably cooperate with ValueOptions and Payors to enable and support the transition and/or transfer of Members under the care of Practitioner to other Participating Providers.

8.9 Audits & Investigations. To the extent ValueOptions and/or a Payor commenced an audit or investigation prior to the effective date of expiration or termination of this Agreement, Practitioner agrees to continue to cooperate with such audit or investigation and to provide access to documents and records reasonably requested in the course of such audit or investigation.

Article IX: Governing Law and Compliance

9.1 Governing Law. This Agreement shall be interpreted and construed in accordance with the laws of the Commonwealth of Virginia, without regard to its conflicts of law provisions and except to extent preempted by applicable federal laws or regulations.

9.2 Legal Compliance. The parties agree to comply with all applicable state and/or federal laws, rules and/or regulations. The alleged failure by either party to comply with applicable state and/or federal laws, rules or regulations shall not be construed as allowing either party a private right of action against the other in any legal or administrative proceeding in matters in which such right is not recognized by such law, rule or regulation.

9.3 State Government Sponsored Plans and Programs. In addition to the terms and conditions of this Agreement, provisions applicable to Covered Services rendered to Members covered under Medicaid Plans and such other state government sponsored plans and/or health benefit programs as are set out in Exhibits B.

9.4 Medicare Advantage Plans. In addition to the terms and conditions of this Agreement, provisions applicable to Covered Services rendered to Members covered under Medicare Advantage Plans are set out in Exhibits B.

9.5 Excluded Individuals/Entities. Practitioner and ValueOptions respectively represent that neither is nor knowingly employs or contracts with individuals or entities excluded from or ineligible for participation in any government sponsored health care program.

9.6 Confidentiality of Member Records. The parties agree to: (a) have and implement procedures designed to preserve the privacy and confidentiality of Member records; and (b) maintain, retain, use and/or disclose such Member records and any Protected Health Information in accordance with HIPAA, 42 C.F.R. Part 2 as related to alcohol and/or substance abuse services and/or records, and all applicable other federal and state laws, rules and regulations regarding the confidentiality, privacy and/or security of Protected Health Information and/or medical/behavioral health/alcohol-substance abuse records and any patient consent required there under. Practitioner shall cooperate with ValueOptions and Payors to ensure that all consents to the release of Members records are in conformity with applicable state and federal laws and regulations governing the release of records maintained in connection with mental health and/or substance abuse treatment. Practitioner shall also ensure that any records maintained electronically meet all applicable federal and state laws and regulations related to the storage, transmission and maintenance of such records.

9.7 Regulatory Access. Practitioner medical records, encounter data and financial information shall be open to inspection upon request, during normal business hours by state and federal regulators with jurisdiction over Payors, ValueOptions and/or the Practitioner, including the U.S. Department of Health and Human Services, the Comptroller General of the United States, the State Superintendent of Insurance, and/or other authorized state or federal regulatory agencies or entities, or their duly authorized representatives to the extent required by law. This provision shall survive expiration or termination of the Agreement, regardless of the cause.

9.8 Physician Incentive Plans. Any incentive plans between ValueOptions and Practitioner shall be in compliance with applicable state and federal laws, rules and regulations, including without limitation 42 C.F.R. §§417.479 and §434.70, 42 C.F.R. §438.6(h), 42 C.F.R. §422.208, and 42 C.F.R. §422.210. Upon request, Practitioner agrees to disclose to ValueOptions and Payors the terms and conditions of any 'physician incentive plan' as defined by applicable state or federal law or regulation. Each party represents that no specific payment will be made directly or indirectly to a physician or physician group as an incentive or inducement to limit Medically Necessary Covered Services furnished to a Member. This requirement shall be contained in any subcontract of this Agreement between Practitioner and any other physician.

9.9 Reporting. Upon reasonable request, Practitioner agrees to provide ValueOptions and Payors with timely access to records, reports, clinical information and/or encounter data in the format required to meet obligations under contracts with any government agency sponsoring or overseeing Plans covered under this Agreement.

Article X: Dispute Resolution

10.1 Unresolved Disputes. ValueOptions and Practitioner agree to attempt to resolve any disputes arising with respect to the performance or interpretation of this Agreement promptly by negotiation between the parties. Prior to submission of any unresolved disputes to binding arbitration and/or pursuit of any termination of the Agreement pursuant to the provisions herein, Practitioner agrees to use available ValueOptions' administrative review and/or grievance and appeal procedures as specified in the Provider Handbook.

(a) In the case of a dispute concerning ValueOptions' credentialing or re-credentialing of Practitioner, or a dispute arising out of ValueOptions' implementation of any requirements imposed upon ValueOptions or Practitioner by a Payor, the decision of the respective ValueOptions internal grievance system shall be final and binding on Practitioner. Practitioner shall not maintain any action against ValueOptions, or its shareholders, officers, directors, agents or committee members, to seek financial or other compensation for any damages arising out of the ValueOptions' ministerial implementation of a Payor's credentialing determination.

(i) The parties agree that the exclusive remedy for unresolved disputes between the parties under this Agreement, including without limitation a dispute involving interpretation of any provision of this Agreement, questions

regarding application and/or interpretation of applicable state and/or federal laws, rules or regulations, the parties' respective obligations under this Agreement, or otherwise arising out of the parties' business relationship, shall be resolved by binding arbitration as provided for below.

(ii) The party initiating binding arbitration shall provide prior written notice to the other party identifying the nature of the dispute, the resolution sought, the amount, if any, involved in the dispute, and the names and background of at least two (2) potential arbitrators. The submission of any dispute to arbitration shall not adversely affect any party's right to seek available preliminary injunctive relief.

(iii) Any arbitration proceedings shall be held in Norfolk, Virginia in accordance with and subject to the Commercial Arbitration Rules of the AAA then in effect, or under such other mutually agreed upon guidelines and before a single arbitrator selected by the parties. Discovery shall be permitted in the same manner, types and times periods provided for by the Federal Rules of Civil Procedure. To the extent the parties are unable to agree upon an arbitrator, the parties agree to use an arbitrator selected by the AAA from a list of arbitrators chosen by the parties as individuals with knowledge and expertise in the area or issue in dispute.

(iv) The arbitrator: (1) may construe or interpret but shall not vary or ignore the terms of this Agreement; (2) shall be bound by applicable state and/or federal controlling laws, rules and/or regulations; and (3) shall not be empowered to certify any class or conduct any class based arbitration or award punitive or consequential damages. The decision of the arbitrator shall be final, conclusive and binding. Judgment upon the award rendered in any such arbitration may be entered in any court of competent jurisdiction, or application may be made to such court for judicial application and enforcement of the award, as applicable law may require or allow.

(v) Each party shall assume its own costs (including without limitation its own attorneys' fees and such other costs and expenses incurred related to the proceedings), but the compensation and expenses of the arbitrator and any administrative fees or costs of any arbitration proceeding(s) hereunder shall be borne equally by ValueOptions and Practitioner.

Article XI: Miscellaneous

11.1 Notice. Any notice required to be given pursuant to the terms of this Agreement shall be in writing and shall be sent by certified or registered mail, return receipt requested, postage prepaid, or by hand delivery, to the receiving party at the address set forth on the signature page, or at any other address of which a party has given notice in accordance with this Section. Notice shall be deemed given on the date of delivery or refusal as shown on the return receipt if delivered by mail or the date upon which such notice is personally delivered in writing to the designated liaison person. Notice to "Practitioner" and "ValueOptions" is notice to all individuals and entities under this Agreement, respectively.

11.2 Amendments. Except as provided for below, any amendment to this Agreement must be made in writing and executed by both parties. Notwithstanding the above: (a) this Agreement shall be automatically amended to comply with applicable state and/or federal laws, rules or regulations, and/or accreditation requirements to which ValueOptions is or may be subject; and/or (b) ValueOptions may amend this Agreement by giving Practitioner prior written notice setting forth the terms of the proposed amendment. Practitioner shall then have thirty (30) days from the receipt of ValueOptions' notice to reject the proposed amendment by written notice of rejection to ValueOptions. If ValueOptions does not receive such written notice of rejection within that thirty (30) day period, the proposed amendment shall be deemed accepted by and shall be binding upon Practitioner, effective as of the end of such thirty (30) day period. If Practitioner rejects a proposed amendment, either party may, in its discretion, elect to terminate this Agreement upon thirty (30) days written notice to the other party.

11.3 Newly Acquired Persons/Entities. In the event Practitioner acquires, through purchase, asset acquisition, merger, consolidation, or other means, or enters into a management agreements to manage other individual and/or group physician or other health care professional practices, and such other physician or other health care professional practices have in effect an agreement with ValueOptions to provide mental health and/or substance abuse services to Members: (a) Practitioner will notify ValueOptions in advance of the effective date of such acquisition, purchase, merger, management contract or other transaction referenced herein; and (b) the parties agree: (i) to modify or replace this

Agreement with a group practice agreement to include the payments for Covered Services as set out in Exhibit A of this Agreement; and (ii) that such modification or replacement of this Agreement identified in subsection (i) above and application of same to any such other individual or group practice is subject to credentialing and re-credentialing of each individual health care professional and practitioner.

11.4 Assignment. This Agreement, being intended to secure the services of Practitioner hereunder, may not be assigned, delegated or transferred by Practitioner without the prior written consent of ValueOptions; provided, however, ValueOptions may assign this Agreement to any entity that controls, is controlled by, or is under common control with ValueOptions.

11.5 Use of Name. During the term of this Agreement, Practitioner consents to the use of its name and other identifying and descriptive material in provider directories and marketing materials. Use of the Practitioner name, logos, trademarks or service marks in public advertising shall require prior written consent of the Practitioner. Practitioner may use ValueOptions name, logos, trademarks and service marks in marketing material or otherwise, only with ValueOptions prior written consent except that Practitioner may without ValueOptions' consent, list ValueOptions in Practitioner's standard list of contracted managed care organizations that is routinely provided to patients.

11.6 Confidentiality. Each party or their respective employees or agents may, in the course of the relationship established by this Agreement, disclose in confidence to the other party certain Confidential Information. Each party acknowledges that the disclosing party shall at all times be and remain the owner of all Confidential Information disclosed by such party, and that the party to which Confidential Information is disclosed shall in a manner consistent with the manner in which it protects its own Confidential Information, preserve the confidentiality of any such Confidential Information which such party knows or reasonably should know that the other party deems to be Confidential Information. Neither party shall use for their own benefit or disclose to third parties any Confidential Information of the other party without such other party's written consent.

(a) Practitioner agrees that at no time during or after the term of this Agreement, except as may be required to carry out or its duties and obligations hereunder, shall Practitioner, or officers, directors, agents, contractors or employees of Practitioner, without the prior written consent of ValueOptions, whether directly or indirectly, or for competitive or other purposes, disclose or cause to be disclosed to a third party, or make or cause any unauthorized use of: (i) any ValueOptions policy manuals or other proprietary information of ValueOptions; or (ii) any term or condition of this Agreement, its exhibits, attachments or schedules. Nothing herein shall be construed as prohibiting or penalizing communication between Practitioner and Members regarding available treatment options, including appropriate or Medically Necessary care for the Member.

(b) Practitioner shall protect the confidentiality of any Payor specific confidential or proprietary information received by Practitioner.

11.7 Force Majeure. Except for payment of sums due, neither party shall be liable to the other nor deemed in default under this Agreement if and to the extent that such party's performance of this Agreement is prevented by reason of force majeure.

(a) Force majeure means an occurrence that is beyond the reasonable control of the party affected and occurs without its fault or negligence. Without limiting the foregoing, force majeure includes acts of God; acts of the public enemy; war; riots; strikes; terrorism; mobilization; labor disputes; civil disorders; fire; flood; lockouts; or failure or refusals to act by government authority; and other similar occurrences beyond the control of the party declaring force majeure which such party is unable to prevent by exercising reasonable diligence. Force majeure shall not include the inability of either party to acquire or maintain any required insurance, bond, licenses or permits.

(b) Force majeure shall be deemed to commence when the party declaring force majeure notifies the other party of the existence of the force majeure and shall be deemed to continue as long as the results or effects of the force majeure prevent the party from resuming performance in accordance with this Agreement.

(c) Any delay or failure in performance by either party hereto shall not constitute default hereunder or give rise to any claim for damages or loss of anticipated profits if, and to the extent that, such delay or failure is caused by force majeure.

11.8 Waiver. Waiver, whether express or implied, of any breach of any provision of this Agreement shall not be deemed to be a waiver of any other provision or a waiver of any subsequent or continuing breach of the same provision. In addition, waiver of one of the remedies available to either party in the event of a default or breach of this Agreement by the other party shall not at any time be deemed a waiver of a party's right to elect such remedy(ies) at any subsequent time if a condition of default continues or recurs.

11.9 Severability. If any portion(s) of this Agreement shall, for any reason, be invalid or unenforceable, such portions shall be ineffective only to the extent of any such invalidity or unenforceability, and the remaining portion or portions shall nevertheless be valid, enforceable and of full force and effect; provided however, that if the invalid provision is material to the overall purpose and operation of this Agreement, then this Agreement shall terminate upon the severance of such provision.

11.10 Entire Agreement. This Agreement and Amendments thereto constitute the entire understanding and agreement of the parties and supersedes any prior written or oral agreement pertaining to the subject matter hereof.

11.11 Survival of Provisions. The provisions set forth in Sections 2.1, 2.2, 2.4, 3.2, 3.3, 3.4, 3.5, 4.3, 4.4, 5.3, 5.8, Article VI, 7.1, 7.2, 7.4, 7.5, 7.6, 8.7, 8.8, 8.9, Article IX, Article X, 11.6, 11.8, 11.10, 11.11, and those provisions identified in a Payor Specific Provisions Exhibit shall survive any expiration or termination of this Agreement.

11.12 Counterparts/Captions. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which constitute one and the same Agreement. The captions in this Agreement are for reference purposes only and shall not affect the meaning of terms and provisions herein.

---Signatures Follow---

Intending to be legally bound, the parties have caused their authorized representatives to execute this Agreement effective as of the date set forth by ValueOptions below.

Practitioner:

_____ _____
Signature *Date*

_____
Print Name & Title

_____
Federal Tax Identification Number

Address for Notice:

ValueOptions:

_____ _____
Signature *Date*

_____
Print Name & Title

Address for Notice:

ValueOptions, Inc.
P.O. Box 41055
Norfolk, VA 23541-1055
Attn: National Provider Network Operations

Please do NOT write below this line. For ValueOptions office use ONLY.

_____
EFFECTIVE DATE

Negotiated By: _____
Print Name

_____
Title

_____
Date Received By ValueOptions

Please check if included: ☐ _____ ☐ _____

Exhibit A
Practitioner Location(s), Services & Payment

I: Practitioner Locations.

(1) Only those Practitioner office locations identified in Practitioner's credentialing or re-credentialing applications or a change of address form and submitted to ValueOptions will be covered under this Agreement.

II: Practitioner Services.

(1) All Behavioral Health Services: (a) available from Practitioner pursuant to Practitioner's respective licensure or certification; (b) for which Practitioner has been credentialed pursuant to ValueOptions' credentialing/re-credentialing policies and procedures; and (c) for which there is a corresponding payment rate herein.

III: Rate Schedules & Payment.

(1) The parties agree that:

(a) Payment amounts for Covered Services shall be in accordance with the Rate Schedule(s) attached hereto and incorporated herein by reference;

(b) The date of receipt of a claim is the date ValueOptions, or Payor, receives the claim, as indicated by its date stamp on the claim; and

(c) The date of payment is the date of the check or other form of payment.

Exhibit B
Payor/Government Program/State Specific Provisions

I: Practitioner acknowledges and agrees that the provisions set out in the attached Exhibits B-1, B-2 and on, each of which are incorporated herein by reference, apply solely with respect to Members of the identified Payor and/or government sponsored health benefit program, and/or solely with respect to Plans subject to identified State laws and regulations.

Exhibit B-1
Medicare Advantage Provisions

This Exhibit contains additional provisions applicable to Covered Services rendered to MA Members (as defined below) covered under Medicare Advantage ("MA") Plans (as defined below) offered and/or administered by Payor(s). In the event of any conflict between the provisions of the Agreement and this Exhibit, the provisions of this Exhibit control as related to services rendered to MA Members.

I: General Provisions.

(1) Whenever in this Exhibit the term "Practitioner" is used to describe an obligation or duty, such obligation or duty shall also be the responsibility of each individual employed or owned by or under contract with Practitioner, as the context may require.

(2) Practitioner agrees:

(a) To participate in Payors' MA Plans in accordance with the terms of this Agreement and this Exhibit; and
(b) Payors, in their sole discretion, may elect to develop and/or implement MA Plans with limited or alternative provider networks in which Practitioner does not participate.

II: Definitions.

(1) All capitalized terms not otherwise defined in this Exhibit shall have the meanings ascribed to them in the Agreement.

(2) For purposes of this Exhibit, the following additional terms shall have the meaning set out below:

(a) "CMS" means the Centers for Medicare and Medicaid Services.
(b) "MA Member(s)" means those designated individuals eligible for traditional Medicare under Title XVIII of the Social Security Act and the CMS rules and regulations and enrolled in a Payor MA Plan.
(c) "MA Plan" means one or more plans in the Medicare Advantage program offered or administered by a Payor and covered under Payor's contract with ValueOptions and/or one of ValueOptions' affiliates.
(d) "Medicare Advantage Program or MA Program" means the federal Medicare managed care program for Medicare Advantage products run and administered by the CMS, or the CMS' successor.
(e) "Medicare Contract" means a Payor's contract(s) with the CMS, to arrange for the provision of health care services to certain persons enrolled in an MA Plan and eligible for Medicare under Title XVIII of the Social Security Act.

III: Accountability & Oversight.

Regardless of any provision to the contrary, Payors, or their respective designees, oversee and monitor the provision of services to their respective MA Members on an on-going basis and Payors remain accountable and responsible to the CMS for compliance with the terms and conditions of their respective Medicare Contracts, regardless of the provisions of the Agreement or any delegation of administrative activities or functions to ValueOptions.

IV: Practitioner Status.

(1) Practitioner represents that Practitioner:

(a) Maintains full participation status in the federal Medicare program (This includes Practitioner, all Practitioner employed, owned and contracted health care practitioners, health care providers, and health care facilities, and those other employees, contracted individuals and entities who will provide services to MA Members under the Agreement, including without limitation, mental health and/or substance abuse, utilization review, medical social work and/or other administrative services.);

(b) Does not have any agents, management staff, or persons with ownership or control interests whom have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social service programs under Title XX of the Social Security Act;
(c) Has not been excluded from participation in any federal health care program, including without limitation the Medicare program; and
(d) Shall notify ValueOptions immediately in the event that Practitioner is excluded from Medicare participation.

(2) Prior to rendering services to MA Members and subject to any credentialing or re-credentialing processes, Practitioner understands and agrees that Practitioner must submit to Practitioner's Medicare provider number, State Medicaid provider number, and Practitioner's NPI number(s).

V: Compliance.

(1) Practitioner agrees to:

(a) Comply with all applicable state and federal laws, rules and regulations governing the MA Program, CMS operating procedures, CMS instructions, and applicable requirements of the Medicare Contract, including without limitation:

(i) Laws and regulations designed to prevent or ameliorate fraud, waste, and abuse;
(ii) Laws and regulations applicable to recipients of federal funds;
(iii) State and federal laws, rules and regulations regarding the privacy, security, confidentiality, accuracy and/or disclosure of records, protected health information and/or personally identifiable information, including without limitation, the federal Health Insurance Portability and Accountability Act of 1996 and the rules and regulations promulgated thereunder (each as may be amended);
(iv) 42 C.F.R. §422.516 and 42 C.F.R. §422.310 regarding reporting obligations to the CMS; and
(v) Laws, regulations and CMS instructions and guidelines regarding medical policies, billing requirements, and marketing.

(b) Comply and cooperate with training and education given as part of a Payor's compliance plan to detect, correct and prevent fraud, waste and abuse.

(c) Provide ValueOptions and/or Payors with timely access to records, information and data necessary for: (i) Payors to meet their respective obligations under their Medicare Contracts; and/or (ii) the CMS to administer and evaluate the MA program.

(d) Submit all reports and clinical information required by ValueOptions and/or Payors that may be required by Medicare Contract(s) and/or MA regulations, including without limitation all claims and/or encounter data required by the CMS and/or pursuant to 42 C.F.R. §422.516 and 42 C.F.R. §422.257. Practitioner shall certify the accuracy, completeness and truthfulness of all such claims and/or encounter data provided to Payors and/or ValueOptions.

VI: Services.

(1) Practitioner agrees to:
(a) Make available to MA Members those Covered Services provided by Practitioner within the scope of its professional license, registration and/or certification twenty-four (24) hours a day, seven (7) days a week;
(b) Provide ValueOptions with all requisite information regarding his/her/its twenty-four (24) hour coverage, including notifying ValueOptions immediately when needing to arrange alternate coverage;
(c) Participate in and cooperate with any and all of ValueOptions and Payor specific policies and procedures, including but not limited to, those for quality assurance (including independent quality review and improvement organization activities), utilization review, and resolution of MA Member appeals and grievances, as well as the procedures set forth in 42 C.F.R. §422.562(a);

(d) Comply with ValueOptions and any Payor specific credentialing and re-credentialing processes and requirements;
(e) Maintain Practitioner's credentialing, verification and/or privileging procedures and practices for physicians, practitioners and other health care providers employed by or under contract with Practitioner and rendering services under the Agreement, which procedures and practices are relied upon by ValueOptions and Payors as to Practitioners participating under this Agreement;
(f) Comply with Payor specific programs, policies and procedures, including without limitation those regarding: (1) confidentiality of patient records, and (ii) advance health care directives;
(g) Upon request, participate in any internal or external quality assurance reviews, utilization reviews, quality improvement initiatives, peer review and/or grievance procedures established by ValueOptions and/or a Payor, or the CMS, or their respective designees;
(h) Comply with and implement corrective action where necessary for that level of care within the professional practices and standards in the community and/or as established or required by ValueOptions, a Payor or the CMS; and

VII: Payment.

(1) Subject to the terms and provisions set forth in the Agreement and this Exhibit, ValueOptions or Payor shall pay Practitioner for Covered Services rendered to MA Members in accordance with the payment terms and Rate Schedule(s) applicable to Covered Services rendered to MA Members set out in the Agreement. Practitioner agrees that payments of amounts specified in the Agreement (including any applicable MA Member Expenses) shall constitute payment in full for the Practitioner's provision of Covered Services to MA Members.

(2) Regardless of any provision to the contrary, to the extent a MA Member receives Covered Services from Practitioner on an out-of-network basis and/or there is no specific Rate Schedule (Exhibit A) for that MA Member's MA Plan attached to this Agreement, maximum payment for any Covered Services rendered to such MA Member is limited to the lesser of one hundred percent (100%) of Medicare allowable or the amount provided for under applicable MA laws, rules and/or regulations applicable to such MA Member's Plan and is subject to the terms of the MA Member's Plan.

(3) Practitioner acknowledges and agrees that in no event, including without limitation the insolvency of a Payor or ValueOptions, breach of the Agreement by ValueOptions, and/or non-payment for Covered Services by ValueOptions or where applicable a Payor, shall Practitioner bill, charge or seek compensation, remuneration or reimbursement from, or assert any legal action against MA Members for payment of any fees or amounts that are the legal obligation of ValueOptions and/or the Payor.

(4) With respect to the MA Member who are designated as a 'dual eligible' (as defined under Medicare regulations) for whom the State Medicaid Agency is otherwise required by law, and/or voluntarily has assumed responsibility, to cover those Member Expenses identified and at the amounts provided for in the State Medicaid Plan, Practitioner agrees: (a) to accept payment from the Payor, or where applicable ValueOptions when acting as the Payor, as payment in full for Covered Services rendered to such dual eligible MA Members; and (b) not to collect or seek to collect any Member Expenses for Covered Services from such dual eligible MA Members.

VIII: Records.

(1) Practitioner agrees to maintain records, including separate financial, administrative and medical records, related to services rendered by Practitioner to MA Members for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of this Agreement occurs or from completion of any audit or investigation, whichever is greater, unless an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (a) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; or (b) completion of any review or audit should that date be later than the time frame(s) indicated above; or (c) such greater period of time as provided for by law.

(2) Subject to any legal restrictions, Practitioner agrees to provide the Department of Health and Human Services (DHHS), the Office of Inspector General (OIG), the General Accounting Office (GAO), the Comptroller General, the CMS and/or other applicable regulatory agencies, Payors' accrediting bodies, or their respective designees with timely access to any contracts, books, financial records, medical records, documents, papers and other records and information, including without limitation financial or otherwise, and their respective facilities, as they apply to Practitioner's obligations under the Agreement and/or as related to services rendered to MA Members and/or as required by the Medicare Program Contract necessary for: (a) Payors to meet obligations under their Medicare Contracts; and/or (b) the CMS to administer and evaluate the MA program. Practitioner agrees to cooperate in investigations conducted by the above noted authorized regulatory agencies and any resulting legal actions. This provision shall survive the termination of this Exhibit and the Agreement.

IX: Delegation.

(1) Should ValueOptions, in its sole discretion, elect to sub-delegate any administrative activities or functions to Practitioner, any such sub-delegation: (a) is subject to the prior approval of Payor; (b) shall be in writing and accordance with applicable delegation requirements set forth in MA regulations; (c) shall specify the delegated activities and reporting responsibilities; (d) shall include provisions for monitoring and oversight by ValueOptions and Payors; and (e) shall provide for corrective action measures, up to and including termination without limitation termination or revocation of the delegated activities or functions or other correction or remedy if the CMS or a Payor determines that such activities were not performed satisfactorily.

(i) If credentialing is delegated, Practitioner shall meet all ValueOptions and Payor credentialing requirements, and Payors, respectively, will review the credentials of medical professionals or will review, approve and audit the credentialing process on an ongoing basis.
(ii) If ValueOptions sub-delegates the selection of providers for participation in a Payor's provider network, Payors, respectively, retain the right to approve, suspend or terminate any such arrangement.

X: Term & Termination.

(1) In addition to the provisions set forth in the Agreement, this Exhibit may be suspended or terminated by ValueOptions as to any one or more Payor's MA Plans immediately upon written notice if:

(a) A Payor's Medicare Contract is suspended or terminated for any reason;
(b) Practitioner is disqualified, terminated, suspended, debarred, or otherwise excluded from or ineligible for participation under the MA program or any other state or federal government-sponsored health program; or
(c) The Agreement is terminated or not renewed.

(2) Following expiration or termination (whether due to insolvency or cessation of operations of ValueOptions or a given Payor, or otherwise) of the Agreement, Practitioner will continue to provide Covered Services to MA Members: (a) for those MA Members confined in an inpatient facility on the date of expiration or termination until their discharge; (b) for all MA Member through the period for which payments have been made by the CMS to the applicable Payor MA Plan under its Medicare Contract; and (c) for those MA Members in active treatment of chronic or acute behavioral health or substance abuse conditions as of the date of expiration or termination of the Agreement through their current course of active treatment not to exceed ninety (90) days unless otherwise require by subsection (b) above. The terms and conditions of the Agreement apply to such post-expiration or post-termination Covered Services. Payment for Covered Services rendered to MA Members post expiration or post-termination of this Agreement will be the fee-for-service rates set out in the applicable Rate Schedule, less any MA Member Copayments.

Exhibit B-2
Medicaid & Other Government Sponsored Health Benefit Program Provisions

This Exhibit contains additional provisions applicable to Covered Services rendered to MCD Members (as defined below) covered under MCD Plans (as defined below) offered and/or administered by Payor(s). In the event of any conflict between the provisions of the Agreement and this Exhibit and subject to the provisions set out in Exhibit, the provisions of this Exhibit control as related to services rendered to MCD Members.

I: General Provisions.

(1) Whenever in this Exhibit the term "Practitioner" is used to describe an obligation or duty, such obligation or duty shall also be the responsibility of each individual licensed health care practitioner, facility and provider employed or owned by or under contract with Practitioner, as the context may require.

(2) Practitioner agrees:

(a) To participate in Payors' MCD Plans in accordance with the terms of this Agreement and more specifically this Exhibit.
(b) Payors, in their sole discretion, may elect to develop and/or implement MCD Plans with limited or alternative provider networks in which Practitioner does not participate.

II: Definitions. All capitalized terms not otherwise defined in this Exhibit shall have the meanings ascribed to them in the Agreement.

(1) For purposes of this Exhibit, the following additional terms shall have the meaning set out below:

(a) "MCD Member(s)" means those designated individuals eligible for traditional Medicaid under Title XIX of the Social Security Act and applicable New York State rules and regulations and enrolled in a Payor MCD Plan.
(b) "MCD Plan" means one or more plans in the New York State Medicaid program and/or other New York State government agency sponsored health benefit program(s) offered or administered by a Payor and covered under Payor's contract with ValueOptions.
(c) "Medicaid Contract" means a Payor's contract(s) with applicable New York State government agencies, to arrange for the provision of health care services to certain persons enrolled in a MCD Plan.

III: Accountability & Oversight. Regardless of any provision to the contrary, Payors, or their respective designees, oversee and monitor the provision of services to their respective MCD Members on an on-going basis and Payors remain accountable and responsible for compliance with the terms and conditions of their respective Medicaid Contract, regardless of the provisions of the Agreement or any delegation of administrative activities or functions to ValueOptions.

IV: Compliance. Practitioner agrees to:

(1) Comply with all applicable state and federal laws, rules and regulations related to services rendered to MCD Members, and applicable requirements of the Medicaid Contract, including without limitation:
(2) Comply and cooperate with training and education given as part of a Payor's compliance plan to detect, correct and prevent fraud, waste and abuse;
(3) Provide ValueOptions and/or Payors with timely access to records, information and data necessary for Payors to meet their respective obligations under their Medicaid Contracts; and
(4) Submit all reports and clinical information required by ValueOptions and/or Payors that may be required by Medicaid Contract(s) and/or applicable laws and regulations.

V: Services. Practitioner agrees to:

(1) Make available to MCD Members those Covered Services provided by Practitioner within the scope of his/her/its professional license, registration and/or certification as provided for in the Agreement;

(2) Participate in and cooperate with any and all of ValueOptions and Payor specific policies and procedures, including but not limited to, those for quality assurance (including independent quality review and improvement organization activities), utilization review, credentialing and resolution of MCD Member appeals and grievances;
(3) Cooperate with Payors' cultural competency plans as made available by Payors to their respective participating providers;
(4) Comply with Payor specific programs, policies and procedures; and
(5) Comply with and implement corrective action where necessary for that level of care within the professional practices and standards in the community and/or as established or required by ValueOptions or a Payor.

VI: Payment.

(1) Subject to the terms and provisions set forth in the Agreement and this Exhibit, ValueOptions, Payor or Payor's designee shall pay Practitioner for Covered Services rendered to MCD Members in accordance with the payment terms and Rate Schedule (Exhibit A) applicable to Covered Services rendered to MCD Members as set out in the Agreement. Practitioner agrees that payments of amounts specified in the Agreement (including any applicable MCD Member Expenses) shall constitute payment in full for the provision of Medically Necessary Covered Services to MCD Members. Notwithstanding the foregoing, in the event that the amount payable to a Payor under their Medicaid Contract is decreased and a Payor's payment to ValueOptions is decreased, Practitioner agrees that ValueOptions may amend the MCD Plan payment rates to decrease the amount payable in accordance with the terms of the Agreement.

(2) Regardless of any provision to the contrary, to the extent a MCD Member receives Covered Services from Practitioner under this Agreement on an out-of-network basis and/or there is no specific Rate Schedule (Exhibit A) for that MCD Member's MCD Plan attached to this Agreement, maximum payment for any Covered Services rendered to such MCD Member is limited to the lesser of one hundred percent (100%) of the applicable MCD fee schedule for the MCD Member's Plan or the amount provided for under applicable state or federal laws, rules and/or regulations applicable to such MCD Member's Plan and is subject to the terms of the MCD Member's Plan.

VII: Term & Termination.

(1) In addition to and notwithstanding the provisions set forth in the Agreement, this Exhibit may be suspended or terminated by ValueOptions as to any one or more Payor's MCD Plans immediately upon written notice if:

(a) A Payor's Medicaid Contract is suspended or terminated for any reason;
(b) Practitioner is disqualified, terminated, suspended, debarred, or otherwise excluded from or ineligible for participation under the MCD program or any other state or federal government-sponsored health program; or
(c) The Agreement is terminated or not renewed.

ADHD

Take Care of Yourself

Attention Deficit Hyperactivity Disorder (ADHD) is a common childhood problem that may continue into adult years. Having ADHD makes it hard for your child to sit still, think things through before acting, or pay attention. These problems can interfere with normal activities. Dealing with your child's behavior can be frustrating. There are many things that you can do to help your child control his behavior. Taking care of you is also important.

Take Care of Yourself

- Ask for help. Tell your doctor, family or friends what you need. Do not wait for them to ask.
- Take time to relax. Do fun things with and without your child.
- Join a support group. Talking with other caregivers can help.
- Talk to your doctor if you are feeling frustrated or overwhelmed.
- Organize your home and your schedule. Your children can do some chores for you.

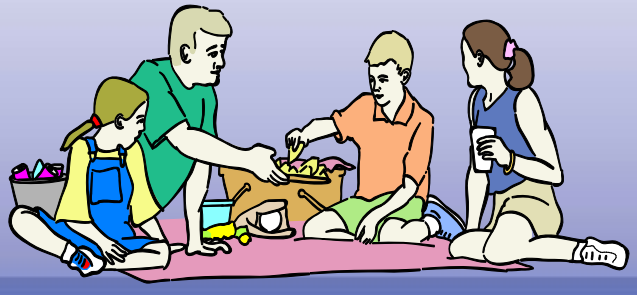
Get Support

For more information, contact:

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
Telephone: (800) 233-4050
Web site: http://www.chadd.org/

Take Care of Your Child

- Learn all you can about the symptoms and treatment of ADHD.
- Set up a routine for your child.
- Help your child take his medicine the way his doctor tells you to.
- Help your child take care of his body with healthy foods, exercise and sleep.
- Teach your child new tasks by breaking them down in to small steps and giving him time to practice.
- Talk to your older child about not taking risks with smoking, alcohol, drugs and sexual activity.
- Plan for change. Young children need a 2 to 5 minute warning before changing activities. Talk to your older child about new plans and what you expect from him.
- Help your child solve problems and make decisions.



ADHD

What Is Attention Deficit Hyperactivity Disorder?

Attention Deficit Hyperactivity Disorder (ADHD) is a common childhood problem that may continue into adult years. It makes it hard for your child to sit still, think things through before acting, or pay attention.

It is normal for kids to run in circles, daydream or fidget sometimes. However, ADHD causes your child to behave differently from other children. His behavior can get in the way of doing normal things. As your child gets older, not paying attention or being overactive can cause problems with school, a job or with other people.

Symptoms

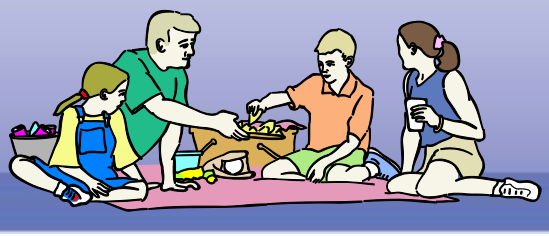
Symptoms of ADHD usually start before age 7. If your child has ADHD, he may have some of these symptoms:

Pre-school age

- Cannot sit still to eat, play a game or read a book
- Doesn't pay attention to what is being said
- Grabs toys away from other kids
- Is very active, running through the house, jumping and climbing on furniture

Pre-teen and teenagers

- Makes careless mistakes
- Doesn't finish chores or homework
- Gets distracted or forgets what he's supposed to do
- Talks a lot and invites self into other kids' games or conversations
- Starts activities without getting instructions
- Always "on the go"



Treatment

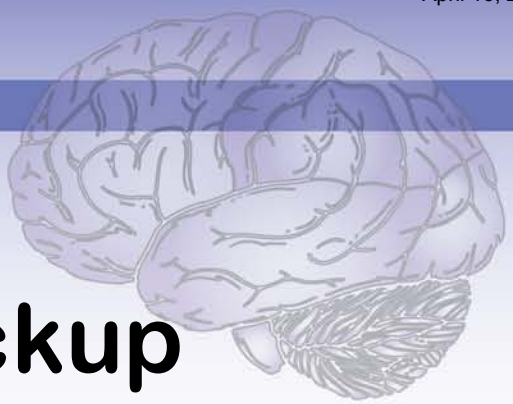
There is no cure for ADHD. Without treatment, your child may have trouble with teachers, family and other children. You may feel frustrated dealing with the way your child acts. Therapy can help your child control his behavior.

Behavior Therapy is a training program that teaches you how to manage your child's behavior. This is the best treatment for children under age 6. You will learn how to:

- Identify ADHD symptoms
- Organize your home and your child's activities
- Keep your child on a regular schedule
- Set clear rules
- Teach your child new tasks
- Plan for changes
- Respond to your child's symptoms, including when to praise, ignore or punish
- Limit the things that distract your child

ADHD Medicines along with Behavior Therapy helps children age 6 and older. Children who take ADHD medicine may behave better, do better in school and have fewer problems with family, teachers and other kids. Talk to your child's doctor about which medicine is best for your child.

Depression



Get a Checkup

You need to see your doctor to make sure your treatment is working. At first, you may need to visit or call your doctor every week. As you get better, you may not need to go as often. Ask your doctor how often you need to have a checkup.

At Your Checkup

At your checkup, your doctor will ask how you are feeling and if you are able to take care of yourself and family. Tell your doctor about any problems you are having. Your doctor may need to change your treatment. It can take time to find what works best for you.

If you are not feeling better, tell your doctor right away.

Things to Tell Your Doctor

At your checkup tell your doctor:

- If you are feeling worse.
- If you are not able to do things you should do or want to do.
- If you think about hurting yourself.
- If you are having trouble taking your medicine.
- If you are not able to follow your treatment plan.
- If after 6 to 8 weeks, you do not feel like the medicine is helping.

Even after you feel better, it is important to have regular checkups.

Depression

Take Your Medicine

Be Safe

- Ask your doctor to write down the name of your medicine and how to take it.
- Ask if you can take it with food.
- Tell your doctor if you are taking anything else, even vitamins.
- Take your medicine just like your doctor told you to. Don't skip a day.
- Bring a list of all your medicines to your checkups.
- Tell your doctor if you think a medicine is making you feel bad.
- Do not stop taking your medicine without asking your doctor first.
- Throw away any medicine your doctor has told you to stop taking.

Medicine can help you feel better and enjoy life again. It helps most people who have depression. It usually takes 6 to 8 weeks before you can tell if a new depression medicine is working. If you start to feel better, keep taking your medicine. That means it is working!

Don't Forget

Remember to take your medicine.

- Keep pills in a pillbox, someplace where you will see it every day.
- Use a reminder like a calendar, an alarm on your phone, or an "app" if you have a smart phone or tablet computer.
- Have a friend or family member remind you when to take your medicine.
- Don't run out of medicine. Mark on your calendar when you will run out. Order refills 5 to 7 days before you will run out. If you have prescription insurance, ask if they have automatic home delivery.

Depression

Take Care of Yourself

There are things you can do every day to take care of your depression.

Get Help

- Take your medicine.
- Go to counseling.
- See your doctor for checkups.
- Do activities you like, even if you don't feel like it.
- Join a support group.
- Spend time with friends and family.
- Talk to your family and friends about how you feel.
- Ask for help when you need it.

Stay Healthy

- Eat healthy foods and drink less coffee and soda.
- Stay away from alcohol and drugs.
- Try to get 2 ½ hours of exercise each week. 10-minute sets several times a day are just as good as an hour at a time.
- Get 8 hours of sleep per night.
- Find time to relax every day.
- When you have stress, try to breathe deeply.
- Think about the good things in your life.
- Learn new and better ways to take care of problems.

Depression

Follow Your Treatment Plan

It takes time to get well after depression. If you follow your treatment plan, you should start to feel better in a few weeks. You may take medicines, talk to a counselor, or do both. If you don't follow your treatment plan, the depression may keep coming back and get worse.

Medicine

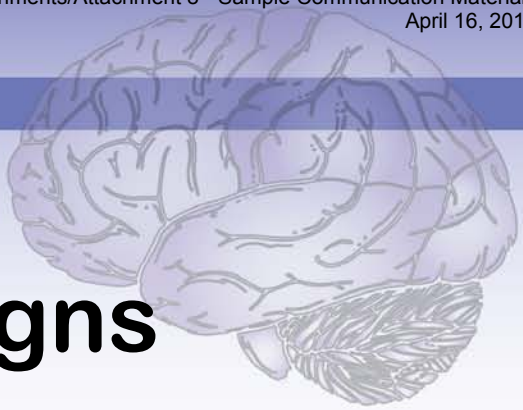
Take your medicine. Do not stop taking your medicine until your doctor tells you to. It is not a good idea to stop all of a sudden.

The medicine may take 6 to 8 weeks to start working. You may need to keep taking the medicine for a long time, even after you feel better.

Talk Therapy

Talking with a counselor can help. You can learn to change the way you think and feel. Keep going until your counselor thinks you can stop. It may take many weeks before talk therapy makes you feel better.

Depression



Warning Signs

Take time every day to stop and "check your mood." Look for signs that your depression is coming back or getting worse. Your family and friends can help you. They may see changes before you do.

You may be getting depressed if you feel sad and uninterested in things you usually like. If you feel like this every day for more than 2 weeks, you should call your doctor right away. Do not try to fix it yourself.

Signs of Trouble

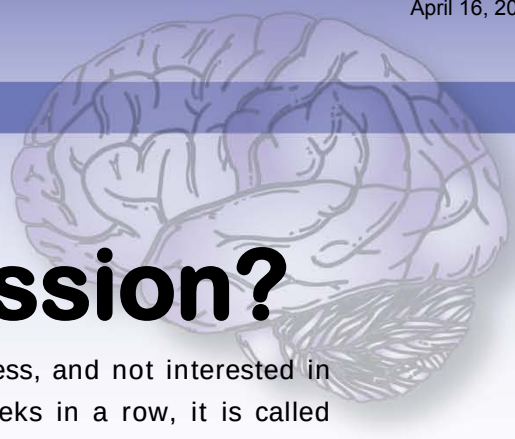
Your depression may be getting worse if you are feeling sad and you also:

- Are tense or upset.
- Are eating less and have lost weight.
- Are eating more and have gained weight.
- Have trouble sleeping or sleep more.
- Feel tired and have no energy.
- Feel nervous and restless.
- Lose interest in activities you enjoy.
- Feel bad about yourself and guilty.
- Have trouble thinking clearly.
- Find it hard to remember things.
- Feel hopeless or just don't care about anything.
- Have pain for no reason or get headaches.
- Think about death or hurting yourself.

Danger Signs

Get emergency care if you have plans or serious thoughts of suicide or hurting others.

Depression



What Is Depression?

Depression is a condition in which you feel sad, hopeless, and not interested in daily life. When you feel this way for more than 2 weeks in a row, it is called depression. It takes time to treat. You won't just "snap out of it." Depression can last a few weeks and never come again. It can also last months or years. You may notice it come and go throughout your life.

Symptoms

Besides feeling sad, you may also:

- Be irritable.
- Have trouble sleeping or sleep too much.
- Not feel like eating or eat too much.
- Have less energy, or sometimes feel restless.
- Lose interest in activities you enjoy.
- Feel worthless and guilty.
- Have trouble thinking.
- Feel hopeless or just not care.
- Think about death or suicide.

Depression doesn't only cause sad feelings. It can also cause you to have stomachaches, backaches and other pains.

Treatment

You should not try to deal with depression by yourself. It can be treated.

- **Medicine**: Talking to your doctor about what medicines can help. It may take a few weeks for the medicine to start working.
- **Talk Therapy:** Talking to someone about how you feel can help. Your therapist can help you understand your depression and learn ways to feel better. You may need to work with a therapist for several months.
- **Coping Skills**: Doing activities and being with other people can help your mood. Try to get some exercise every day. Do something fun with friends or family.

For More Information

National Alliance for the Mentally Ill (NAMI)
1-800-950-NAMI -- www.nami.org

Mental Health America
1-800-969-NMHA -- www.nmha.org