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
   b. Required Submission
7. Reporting
   a. Duties and Responsibilities
   b. Required Submission

8. Consulting
    a. Duties and Responsibilities
    b. Required Submission
9. Transition and Termination of Agreement
    a. Duties and Responsibilities
    b. Required Submission
10. Network Management
    a. Duties and Responsibilities
    b. Required Submission
11. Claims Processing
    a. Duties and Responsibilities
    b. Required Submission
12. Clinical Management
    a. Duties and Responsibilities
    b. Required Submission
13. Other Clinical Management Programs
    a. Duties and Responsibilities
    b. Required Submission

Exhibits

Exhibit I.B. Biographical Sketch Form

Exhibit I.Y.4. Comparison of Current MHSA Program Providers and the Offeror's Proposed Provider Network

Attachments

Attachment 1 – Empire Plan Implementation Plan

Attachment 2 – Empire Plan Call Routing Script

Attachment 3 – Empire Plan MHSA Program Communication Material

Attachment 4 – Empire Plan Communication Material

Attachment 5 – Annual Financial Experience Report

Attachment 6 – Data Sharing Agreement

Attachment 7 – Ad Hoc Reports

Attachment 8 – State Licensure Chart

Attachment 9 – Proposed Provider Contracts

Attachment 10 – Standard Non-Disclosure Agreement

EXECUTIVE SUMMARY

The Empire Plan, Excelsior Plan, and the Student Employee Health Plan (The Empire Plan) play vital roles in the lives of the populations they serve. Within the scope of the responsibilities of these Plans, no part is more important than the behavioral health needs of its enrollees. ValueOptions is committed to continuing to work with the New York State Department of Civil Service and the stakeholders of each of these Plans to advance behavioral health quality and value in the years ahead.

In 2013 you re-affirmed that ValueOptions was the company you had come to know from 1992-2008 for our commitment to health and service and to keeping jobs in New York State and the Capital District. You also learned of a number of significant improvements we have made. ValueOptions is your best option to manage the complexities of a rapidly evolving care delivery marketplace, address ongoing regulatory change, and support you by enabling effective and affordable care.

In addition to our employment commitment and proximity to support the Empire Plan, ValueOptions is also actively involved in the community. We support a wide range of efforts aimed at improving behavioral health in New York and the quality of life in the community we share. ValueOptions employees join with State and employees and community members to support workplace and public health.

ValueOptions' staff participated in the 2013 CDPHP Workforce Team Challenge.

We maintain an exclusive focus on effective behavioral health care 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, supporting Autism services and caring for those with serious and persistent mental illness.

We empower our care support with the only fully integrated, Web-based technology platform of its kind in the industry. This makes ValueOptions the most reliable/soundest contributor to our shared goal to optimize quality and value for 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, we have been selected as the partner of choice for sophisticated groups with complex program designs like the Empire Plan. Our portfolio of business experience has grown, 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 is a health improvement company that specializes in mental and emotional wellbeing and recovery. ValueOptions offers the Empire Plan a focused, mature, well-managed organization in every aspect, one that enjoys exceptionally high satisfaction ratings year after year from clients, providers, and members. Our vision, 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 the Empire Plan.

(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 is serviced from our Latham Engagement Center (10 British American Boulevard, Latham, New York 12110) with support from our New York City Engagement Center (441 Ninth Avenue, 6th Floor, New York, NY 10001) and. Our Empire Plan Account Team is based in the Latham Engagement 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 Engagement Center Victory Building, Suite 330 1401 West Capitol Avenue Little Rock, Arkansas 72201
California	California Engagement Center 10805 Holder Street, Suite 300 Cypress, California 90630
Colorado	Colorado Health Networks Engagement Center 7150 Campus Drive, Suite 300 Colorado Springs, Colorado 80920
Connecticut	Connecticut Engagement Center 500 Enterprise Drive, Suite 4D

ValueOptions' Branch Office Locations	
State	**Address**
	Rocky Hill, Connecticut 06067
Florida	Jacksonville Engagement Center 10199 Southside Boulevard, Suite 300 Jacksonville, Florida 32256 Tampa Regional Engagement Center 8906 Brittany Way Tampa, Florida 33619
Illinois	Chicago Clinical Engagement Center 200 West Adams, Suite 1625 Chicago, Illinois 60606 Springfield Operations Engagement Center 400 South 9th Street, Suite 201 Springfield, Illinois 62701
Kansas	Kansas Engagement Center 100 Southeast 9th Avenue, Suite 501 Topeka, Kansas 66612
Massachusetts	Boston Engagement Center and Metro-Boston Regional Office 1000 Washington Street, 3rd Floor Boston, MA 02118 *Regional Offices located in: Bridgewater, Danvers, Holyoke, and Worcester*
Maryland	Maryland Engagement Center 1099 Winterson Road, Suite 200 Linthicum, Maryland 21090
Michigan	Great Lakes Engagement Center 48561 Alpha Drive, Suite 150 Wixom, Michigan 48393
North Carolina	North Carolina Engagement Center 3800 Paramount Parkway, Suite 300 Morrisville, North Carolina 27560
Pennsylvania	Pennsylvania Engagement Center 520 Pleasant Valley Road Trafford, Pennsylvania 15085 *Regional Offices located in: Beaver, Cambria, Crawford, Fayette, Greene County, Hermitage, and Venango*
Tennessee	TennCare East Engagement Center One Cameron Hill – 4.3 Chattanooga, Tennessee 37402 TennCare West Engagement Center 85 North Danny Thomas Boulevard Memphis, Tennessee 38103
Texas	Texas Engagement Center and Central Night Service 1199 South Beltline Road, Suite 100 Coppell, Texas 75019
Virginia	Chesapeake Engagement Center 1434 Crossways Boulevard, Suite 150

ValueOptions' Branch Office Locations	
State	**Address**
	Chesapeake, Virginia 23320 National Technology Center of Excellence 12369-C Sunrise Valley Drive Reston, Virginia 20191
Washington	Bellevue Engagement Center 15395 SE 30th Place Suite 120 Bellevue, Washington 98007

VALUEOPTIONS' SENIOR OFFICER RESPONSIBLE FOR EMPIRE ACCOUNT

David Busch, President of ValueOptions' Commercial Division, 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 from 1992 until 2008 and from our experience as the emergency contract holder in 2014. 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 continue to customize reports, communications, websites, and everything we do to your specifications and approval. We will continue to provide you with consultation and assistance on every aspect of the Program. We will continue to 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 provide you with a dedicated team located in the Capital District in Latham, New York, led by highly qualified individuals who know the Empire Plan. 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 continue to 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 have experienced, this is one of the things we do best. We will continue to 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 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. 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 continue to 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, positive relationships 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 continuously improving value.

(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

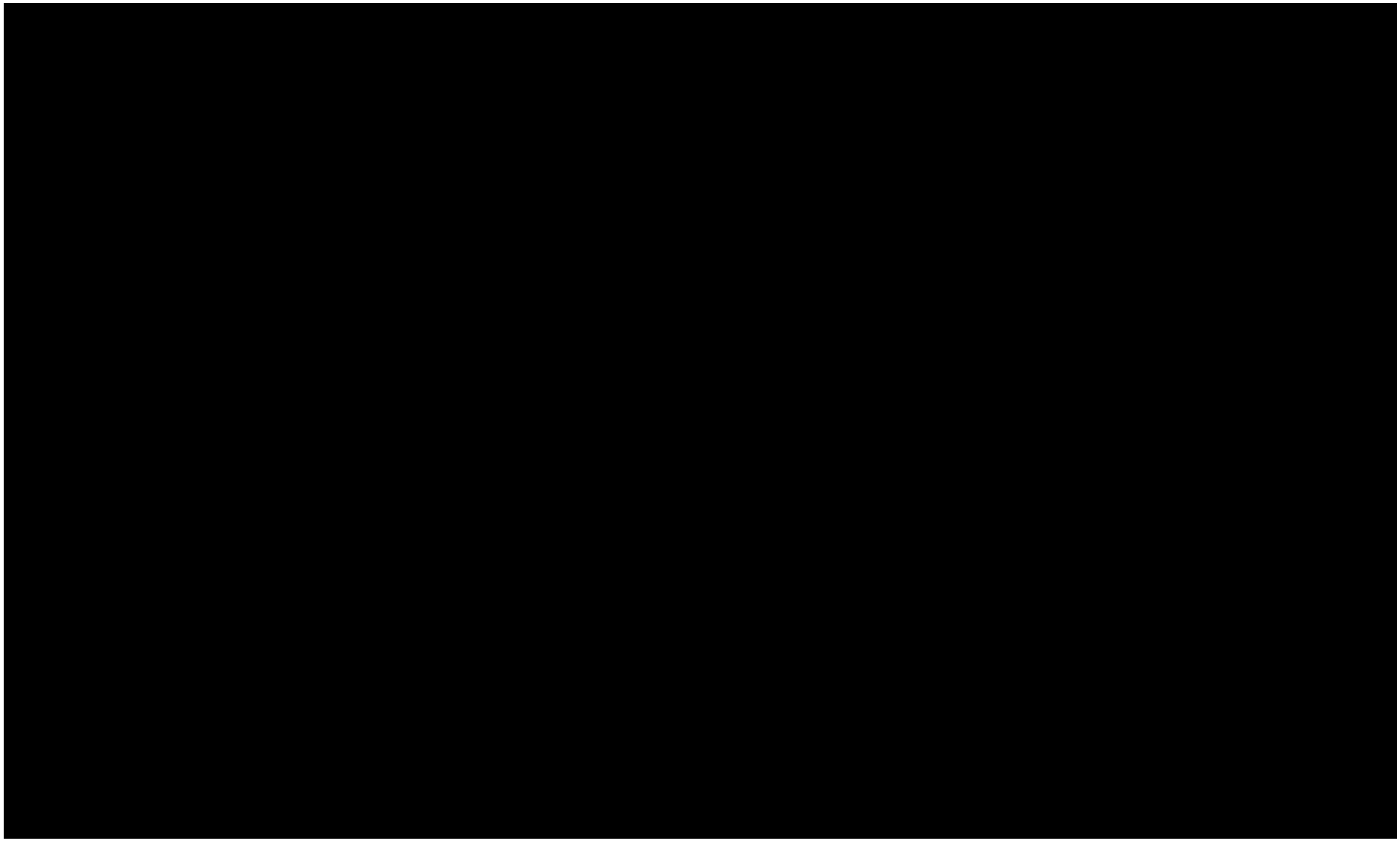
As a national leader in the fields of mental health, substance abuse, and employee assistance programming, ValueOptions has perhaps the most extensive and diverse experience of any U.S. company when it comes to managing behavioral health benefits.

In the commercial sector, ValueOptions counts some of America's best-known companies as clients. Comparable to the Empire Plan in size, these include [redacted], [redacted]. In addition, we manage the mental health and substance abuse benefits for major health plans such as [redacted], and [redacted], and we are presently in the implementation stage for [redacted].
In the government sector, we manage mental health and substance abuse services for more than eight million lives in 14 states. Ten of these contracts cover more than 100,000 lives, and are a combination of risk-based contracts and self-funded arrangements. This includes large-scale Medicaid programs in Massachusetts, Tennessee, New York, Connecticut, North Carolina, Florida, Illinois, and Texas, among others. These programs are highly relevant to the experience we bring to the Empire Plan because each is highly customized to the needs of our client, and each has involved the creation of innovative programs to meet the needs of special populations relating to eating disorders, depression management, serious and complex mental illness, adolescent treatment, improving access through tele-psychiatry, and more.

The range and depth of our experience enhances our management of the Empire Plan 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 Colorado to embedding our team within a health plan's clinical team in Tennessee, 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

[redacted]

(b) PREMIUM DEVELOPMENT SERVICES

[redacted]

(c) IMPLEMENTATION

ValueOptions provides significant financial guarantees that if awarded the contract, all facets of the Empire Plan operations will be fully functional on or before the go-live date of 90 days after award announcement. 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' Engagement Center in Latham combines 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 hours a day, 365 days a year 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 enrollee- 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 provide access to pertinent information regarding providers, enrollee eligibility, and similar items.

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. This and all enrollee-facing materials and communications are customized for your needs and requirements.

(e) ENROLLEE COMMUNICATION SUPPORT

We work proactively and collaboratively with you to ensure that everything possible is done to communicate with and engage enrollees in their health and with the Empire Plan. 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'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

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 Empire Plan that we load secure transactions into our system within 24 hours; that we are fully HIPAA-compliant; that we establish a read-only connection to NYBEAS; that we 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 cooperate fully with the Empire Plan 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

Our standard reporting packages of management reports, utilization reports, and financial reports are comprehensive and robust, and are be provided on a monthly, quarterly, and annual basis along with commentary from our Account Team regarding implications for the Empire Plan. These reports are made available to the Empire Plan in a format that you specify. In addition, ad hoc reports are available on demand. We will continue to develop, prepare and deliver any customized reports the Empire Plan needs as we do today.

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

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.

(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 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 Empire Plan 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 an enrollee'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 Empire Plan.

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 Empire Plan 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 Empire Plan.

(k) CLAIMS PROCESSING

ValueOptions' claims system is entirely based in the United States and was available and on line 100 percent of 2013. 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 Empire Plan 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 hours a day, 365 days a year basis, managed by a dedicated Latham, 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 has extensive experience in managing MHSA programs similar to the Empire Plan. We have built our reputation on more than 30 years of working with clients and a depth of sophisticated client relationships like the Empire Plan. Our commercial book-of-business includes more than 250 clients, ranging from large State employers to clients in almost every business sector. We currently serve nearly 60 of America's Fortune 500 companies, including five of the top 10. Our success comes from a deep understanding of the challenges and pressures large employers face in design benefits plans and care management programs to serve the diverse behavioral health needs of employees and their dependents. As a result, we develop comprehensive, yet affordable behavioral health programs that utilize a broad range of provider and facility types and community resources.

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.

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]

[redacted]

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

[redacted]

Our entire Empire Plan Account Management Team focuses 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. Most recently the Empire Plan Account Management Team provided consultation to discuss Mental Health Parity and Addiction Equity Act Compliance for 2015. This consultation included discussions regarding inpatient treatment, alternate levels of care, outpatient treatment, out-of-network reimbursement, and provider types.

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 dedicated 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 Engagement 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 Engagement Center and business units compliance leads, coordinates the implementation of Engagement 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, operation and transition.	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, litigation, 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

(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 dedicated account 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 dedicated account 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 dedicated operational and clinical account team for the Offeror. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key members of the proposed dedicated account 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 Latham, New York-based ValueOptions Empire Plan Team. This multi-functional team provides direct service on The Empire Plan account. Responsibilities for each position are included within the table provided as a response to Question 1b.

As part of this team, ValueOptions has designated a Latham, New York-based account management team to support the Empire Plan MHSA Program. Director of Account Services for the Latham Engagement Center, [redacted], leads this team. [redacted]. Under [redacted], a dedicated Latham-based team supports all aspects of the MHSA Program. Vice President of the New York Region, [redacted]—who reports directly to [redacted], Senior Vice President and President of the Employer and Health Plan Divisions—works directly with [redacted]. [redacted] has ultimate responsibility for ensuring the success of your program. Collectively, the Empire Plan Team monitors each facet of the program to ensure that ValueOptions continues to meet your expectations and requirements, and that performance standards are at optimum levels.

The second organizational chart below depicts the relationships between members of our 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, and customer service.

<<Remainder of page intentionally left blank.>>

ValueOptions' Empire Plan Team

ValueOptions' Corporate Oversight Team for the Empire Plan Program

Empire Plan Team Reporting Relationships

[redacted]

[redacted]

[redacted]

Name and Qualifications	Responsibilities
[redacted]	[redacted]

Name and Qualifications	Responsibilities
[redacted]	[redacted]

Name and Qualifications	Responsibilities
[redacted]	• [redacted]
[redacted]	[redacted]
[redacted]	• [redacted]
[redacted]	• [redacted]

Name and Qualifications	Responsibilities
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Name and Qualifications	Responsibilities
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Name and Qualifications	Responsibilities
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Name and Qualifications	Responsibilities
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	

Name and Qualifications	Responsibilities
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Name and Qualifications	Responsibilities
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Name and Qualifications	Responsibilities
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

(c) VACANT POSITIONS

There are four key positions for which we are actively recruiting. We would welcome the input of the Empire Plan during the hiring process. A description of the roles and responsibilities are provided below.

Dedicated Medical Director

The dedicated Medical Director will be responsible for:

- Developing and executing medical/clinical strategy in conjunction with Dr. Levine.
- Providing consultation to the Empire Plan regarding trends and industry best practices.
- Providing oversight of the Empire Plan clinical team.

[redacted]

(d) SERVICE LOCATION

Account services, enrollment, claims processing, clinical management, the dedicated Clinical Referral Line, the customer service call center, clinical services, reporting and provider relations are all located in Latham, New York.

We will continue providing you with comprehensive staff resources that will meet all program objectives and ensure the highest quality service to you and your enrollees. During program design, we developed our staffing plans based on sophisticated staffing models. We also used

call management system reports and other information and inputs to ensure adequate staffing to meet and exceed program requirements. The following staffing meets the needs of the Empire Plan account. These staffing levels have proven to be commensurate with the needs of the account:

Position	Actual Number of Staff
Account Services	5
Enrollment	5
Claims Processing	25
Clinical Management	31
Clinical Referral Line	8
Customer Service	27

(2) Describe how the dedicated account team will have access to larger corporate resources as well as upper level management. What tools and resources are available to the account team to manage the MHSA Program? What tools will be available to the Department to work with the dedicated account team to manage the MHSA Program?

CORPORATE ACCESS AND SUPPORT

Our organizational structure is designed to allow dedicated Empire Plan staff and the client to interact with their peers company-wide to ensure we offer our clients high quality, innovative products and services.

Having all of our operational areas located in Latham, New York, facilitates collaboration between staff in each functional area, and fosters sharing their lessons learned and promoting best practices across the entire spectrum of services. The various Empire Plan Team functional leads draw upon the aggregate expertise of their staff to make the best decisions for the Empire Plan. This ensures quick resolution of any issues identified.

Our dedicated Latham, New York team, via Ms. Abdou-Malta, has direct access to Mr. Busch—who reports weekly to our CEO—so issues raised are reported directly to our CEO team. Ms. Abdou-Malta meets with Mr. Busch and the Empire Plan Account Team on a weekly basis. ValueOptions' executive leadership is briefed on a monthly basis regarding the Empire Plan's ongoing performance.

ACCOUNT TEAM TOOLS AND RESOURCES

National Support

The Empire Plan Account Management Team has regular access to the various ValueOptions National teams for support including but not limited to Legal, Compliance and Communications staff.

Staff Training and Development

Another resource for our Empire Plan Team is ongoing training provided by ValueOptions' Health and Performance Solutions team. These trainings help keep our employees up-to-speed on trends in the industry that may affect our clients. Recent training titles include:

- Financial Resilience
- Self-care for Crisis Workers
- Achieving Goals
- Post-Traumatic Stress Disorder

In addition, ValueOptions' Account Management team receives continuous training from our National Account Management Department—led by Marla Lamontagna, ValueOptions' Vice President of Account Services—to enhance our professional development and level of competency. Examples of recent trainings topics include:

- Parity Training
- Legal Financial Program support for customers
- Strategies for Productive Meetings
- Medicaid 101
- Finance Training
- Communication Skills
- Depression in the Workplace
- Private Health Care Exchanges
- Effective Business Presentation Skills
- DSM V Training
- Underwriting
- Healthcare Reform
- Health Plans
- Bi-Weekly National Compliance Trainings

SUPPORTING THE DEPARTMENT

Customer Meetings

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

This meeting provides an overview of the previous year's successes, and reports on performance measures, utilization data, and initiatives for the future. In addition, we discuss emerging topics of interest to the Department, from areas such as legal, clinical, actuarial, and plan design. Ms. Campione will work with the Department to develop the agenda for this portion of these meetings.

The Account Management Team also attends Health Benefit Fairs, Union Conferences and Delegate meeting as requested. The team has also provided trainings and attended meetings for the EAP coordinators. This allows ValueOptions to provide an overview of the MHSA Program and answer any questions on how we can collaborate with the EAP coordinators to ensure enrollees get the help they need.

Client Summits

ValueOptions also offers the Empire Plan 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:
"How Will the Legalization of Marijuana Affect Your Workplace?"

- Speaker was Andrea Grubb Barthwell, M.D., F.A.S.A.M., who is the founder and Medical Director of Encounter Medical Group, PC and Director at Two Dreams Outer Banks Treatment Center with programs in Chicago, IL and Outer Banks, NC.
- Description: Colorado state and Washington state recently passed ballot initiatives to legalize marijuana for recreational use while other states, such as Massachusetts, have passed a measure to legalize marijuana for medicinal use. However, under federal law, marijuana is still an illegal drug. There are several measures employers can take to ensure that the legalization of marijuana does not impact their organization.
- Recording and materials: http://healthandperformancesolutions.net/summit%20info/Legalization_workplace/legalization_workplace.html

"Stamp Out Stigma in Your Workplace: Inspiration, Practical Advice and Tools."

- Speakers were Clarence Jordan, M.B.A, who is the Vice President of Wellness and Recovery for ValueOptions, and Lisa Teems, L.C.S.W., C.E.A.P., C.A.S., who is the Employee Assistance Program Manager for the U.S. Coast Guard.
- Description: One in 4 U.S. adults will have a mental illness this year—25 percent of our population—making mental illness more common than most physical diseases we talk about. The good news is that there are many effective treatments for those who seek care. Sadly, not everyone does seek help. Some of this hesitation is due to stigma. Communities, such as the workplace, have a significant opportunity to effect change in how people think about, and talk about, mental illness.
- Recording and materials: http://healthandperformancesolutions.net/summit%20info/SOS/sos.html

"Best Practices in Workforce Reductions: Restructuring With Care and Dignity."

- Speaker was Greg Simpson. Greg is Senior Vice President and Career Transition Practice Leader for Lee Hecht Harrison, which is the world's largest outplacement firm.
- Description: Unfortunately, downsizing and layoffs are a reality in our current economic climate. While downsizing can be an emotional and stressful process for employers and

employees if it is poorly executed, there are steps organizations can take to minimize the harmful effect of layoffs.
- Recording and materials: http://healthandperformancesolutions.com/summit%20info/Workforce_Reductions/workforce_reductions.html

Consultative Services

Consultation services are provided on topics such as benefit design, regulatory developments, 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 Empire Plan. Ms. Campione also presents information regarding state and national legislative and regulatory issues as they arise such as Federal Mental Health Parity, the Affordable Care Act and Health Care Reform.

ValueOptions' Account Management team communicates proactively with all key stakeholders associated with your benefit plan to ensure effective coordination between all vendors, as necessary. Ms. Campione is the primary point of contact for escalated issues, and she and the Account Management team research and respond to inquiries from the Empire Plan, providers, enrollees, and others. The Account Management staff communicates 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 an enrollee of the Empire Account Team, or from one of our hundreds of subject matter experts throughout our organization.

Reporting and Analytics

Ms. Campione provides the Empire Plan with comprehensive quarterly and annual reports. These reports and her guidance currently 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 can also provide the Empire Plan 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

The Latham Engagement Center was awarded Full Accreditation – MBHO for its Commercial and Medicare products effective October 24, 2013 through October 25, 2015. The Latham Engagement Center is one of five ValueOptions Engagement Centers currently accredited by the National Committee for Quality Assurance (NCQA). ValueOptions was first awarded accreditation from NCQA in 1999.

URAC ACCREDITATION

In addition, ValueOptions was first awarded URAC Full Accreditation under the Health Utilization Management Standards on March 1, 1999 and is currently accredited through March 1, 2016. URAC has awarded Full Accreditation under the Health Utilization Management Standards, Version 7.0, to eight of our engagement centers. The Latham Engagement Center will seek URAC accreditation as part of ValueOptions' next reaccreditation process, which will begin in September 2015. While not currently accredited by URAC, the Latham Engagement Center has adopted ValueOptions' URAC compliant Utilization Management, Quality Improvement and IT Security policies and procedures, and has incorporated these policies into all of its operations to ensure compliance with all URAC standards.

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

(1) Provide the names, qualifications and job descriptions of those key individuals who will provide premium rate development services for the MHSA Program. Describe their experience in providing financial assistance and support to other large health plans. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key staff involved in the premium rate development.

ValueOptions will engage the services of its financial professionals in the areas of underwriting, accounting, and medical economics in support of the development of premium rates for the MHSA program. Within our underwriting division, both our Vice President, Kara Moore, and our Executive Director, Dave Bassett, have extensive experience underwriting a variety of financial arrangements from administrative services only (ASO), to ASO with claims targets, to fully insured (risk) programs, including those with multiple health plans. ValueOptions' Director of Medical Cost and Analysis, Sean Monaghan, is an actuary with considerable experience in claims analysis.

ValueOptions' Vice President of Medical Economics, Stephanie Walling, is another key contributor to the team, pulling from her broad knowledge of data analytics techniques and her professional and health plan experience with Amerigroup, Universal American, and Sentara Health System. ValueOptions' Senior Vice President of Data Analytics and Reporting Services, Dan Santmyer, will provide executive level oversight and support of this team and brings a wealth of actuarial experience to the team. In the event the services of an outside actuarial firm are deemed appropriate to provide an unbiased, external evaluation or analysis of claims projections and/or developed premiums, ValueOptions can engage an outside actuary on an as needed basis to support this process.

The following table presents the names, qualifications and responsibilities of the individuals who will provide premium rate development services for the Empire Program. We provide completed Biographic Sketch Forms for each of the individuals listed below behind the **Exhibit I.B** tab in this proposal binder.

Name and Qualifications	Responsibilities
[redacted]	[redacted]

Name and Qualifications	Responsibilities
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Name and Qualifications	Responsibilities
[redacted]	[redacted]
[redacted]	[redacted]

(2) Describe the general steps that you will follow to develop the annual premium renewal recommendation for submission to the Department. Include any different steps that will be employed to develop the first year premium vs. the premium for subsequent years of the Agreement. Include a description and source of the data you will utilize, assumptions you will use and how these assumptions will be developed, as well as any resources you will utilize.

The premium rate development process employed by ValueOptions, and the one we would propose to use to develop our annual premium renewal recommendation for the Department, includes an assessment of historical claims and utilization data by level of care and by line of business. Specifically we will review claims expenses on an incurred and paid basis employing paid claims information and triangle or claims lag reports and calculating client specific completion factors. We will analyze claims trends both on a dollar basis and on a per capital basis to forecast claims expense for future periods. We will also calculate the effect of enrollment demographic variations, benefit design changes and legislative influences.

We will investigate details of utilization history – eligibility, access patterns, proper care modality application (inpatient, alternative or outpatient care) appropriateness of facility and/or provider and average length of stay. We will also calculate volume trends and search for underlying operational deficiencies affecting adverse utilization patterns.

Using the combination of claims and utilization data we will calculate performance ratios such as average unit costs, costs per employee and the relationships between types and quality of care and in and out-of-network expense. We then will forecast these measures for future periods, and combined with historical analysis subsequently will compile related information such as

gain/loss reports, reserve movements and requirements, potential outstanding claims liabilities and surcharges and taxes.

Finally, we will evaluate our administrative fee to ensure the appropriate funding is available to provide the resources necessary to service the contract. We will re-evaluate the administrative budget based upon an assessment of resource requirements necessary to fulfill programmatic commitments. We will review staffing positions and salary levels, fringe benefits, operational expenses and capital requirements. Staffing modifications will be evaluated in terms of meeting operational deficiencies or the need for re-alignment among positions/departments. During subsequent years of the Agreement, we propose to conduct a full experience rating, encompassing the steps and information above supplemented by incorporating data gathered during our management of the program, such as triangle/lag data and internally developed utilization and operations reports.

(3) Confirm your commitment to work with the Department and its contracted actuarial consultant on the annual premium renewal recommendation and your availability to present such recommendation to the Department, Division of the Budget and GOER.

ValueOptions confirms its commitment to work with the Department and its contracted actuarial consultant on the annual premium renewal recommendation and our availability to present such recommendation to the Department, Division of the Budget, and GOER.

The Contractor must ensure that the MHSA Program is fully functional by the first day of the month following a minimum 90-day implementation period after the Office of the State Comptroller approves the Agreement. The implementation plan must be detailed and comprehensive and demonstrate a firm commitment by the Contractor to complete all implementation activities within the 90-day implementation period.

Section 3: Implementation (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) During the 90-day 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.(2)(a)—(e). Such implementation activities must be completed no later than the first day of the month following a minimum 90-day implementation period after the Office of the State Comptroller approves the Agreement.	Yes
(2) Implementation and Start-up Guarantee: The Contractor must guarantee that all Implementation and Start-up activities will be completed the first day of the month following a 90-day implementation period after the Office of the State Comptroller approves the Agreement (Implementation Date) so that Contractor can assume full operational responsibility for the MHSA Program on the designated date. For the purpose of this guarantee, the Contractor must, on the designated date, have in place and operational; (a) A contracted Provider network that meets or exceeds the access standards set forth in Section IV.B.10 of this RFP; (b) A fully operational dedicated 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. The Dedicated Call Center must be open and operational a minimum of thirty (30) days prior to Program Implementation Date to assist Enrollees with questions concerning Program transition; (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 available a minimum of thirty (30) days prior to the Program Implementation Date, 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) that results in the implementation of the Dedicated Call Center and customized website a minimum of thirty (30) days prior to the Program Implementation Date and implementation of all other MHSA Program services by the Implementation Date, including but not limited to: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. For all tasks that require Department review and approval, a minimum review period of five (5) Business Days must be built into the implementation plan. Include key activities such as member and Provider communications, training of a dedicated call center and clinical referral line staff, report generation, network development, transition benefits, customized website design, eligibility feeds and claims testing.

Our Empire Team implemented the current Empire Plan contract in five days.

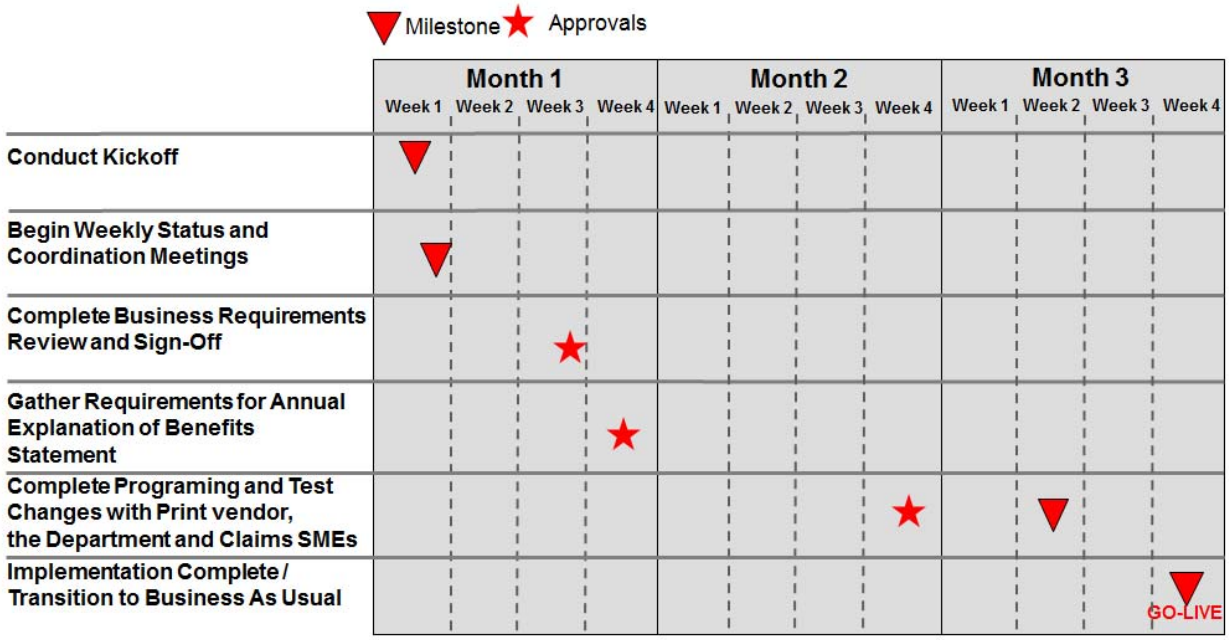
Fundamentally, as the incumbent, the implementation is a much less complicated affair; many of the key deliverables/milestones that a new vendor would be required to complete have already been completed, tested and level two corrections made. Completed implementation tasks include, and are not limited to configuring our system with all Empire Plan benefit plans and claims payment rules, establishing the dedicated Empire Plan Call Center, developing required data exchanges, customizing the Empire Plan website and other initial implementation tasks. Upon contract re-award, we will assemble and deploy a dedicated and highly experienced team of project management professionals and subject matter experts to function as the implementation team. Our Director of Implementations, [redacted] is based in Binghamton, New York and will be the designated implementation lead for the new contract implementation. [redacted] and many other members of our team who worked closely with the Empire Plan earlier this year will continue to work 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
- Reporting and analytics

IMPLEMENTATION PLAN OVERVIEW

Provided as **Attachment 1**, we have included a detailed and customized implementation plan that was used for the Empire Plan emergency contract. This plan includes identification of all key tasks, roles and responsibilities, timelines and testing dates to ensure our dedicated call center and customized website are in place 30 days prior to program implementation date and

that all other services are available on implementation date. Additionally, this plan includes key activities such as enrollee and Provider communications, training of a dedicated call center and dedicated clinical referral line staff, report generation, network development, transition benefits, customized website design, eligibility feeds, and claims testing. Below, we have identified the high-level milestones which will be the focus of this implementation.



EMPIRE PLAN TEAM RESPONSIBILITIES

Our approach to implementing Empire Plan's program stresses close communication with you throughout the process. This focus on communication is essential to ensuring the mutual understanding of the plan and goals for the implementation. We provide a high-level resource allocation grid as an attachment to this question. In addition, we provide specific areas of support, the required time dedicated to each, and a description of the participants below:

Area of Involvement	Reason	Empire Plan Time Requirement	Empire Plan Participants
Implementation Kick-off Meeting	This meeting kicks off the implementation process.	1-3 hours depending on agenda. Usually scheduled immediately following award.	Project Owners, Project Management Support (EPMO), Subject Matter Experts (SMEs)
Requirements	This is the process we use to engage with Empire Plan to allow ValueOptions to ask any open questions regarding programmatic requirements, confirm any assumptions, to develop the operational requirements	Equivalent of 1-2 day face to face meeting. Usually scheduled immediately following the kickoff. Depending on the progress achieved during the face-to-face meeting – there may also be telephonic follow-up	Project Owners, Project Management Support (EPMO), Subject Matter Experts (SMEs)

Area of Involvement	Reason	Empire Plan Time Requirement	Empire Plan Participants
	document and to refine/finalize the project plan.	meetings (potential of 3-5 additional hours).	
Review Project Plan	This meeting is to review the finalized project plan.	Approximately 1-3 hours for the initial review and then subsequent reviews determined by Empire Plan requirements.	Project Owners, Project Management Support (EPMO)
Empire Plan and ValueOptions Implementation Oversight Meetings	This meeting is a focused on expedited review and resolution of any risks, issues or barriers that come up during the implementation process.	Meetings are one hour and generally occur monthly for the course of the implementation, with ad-hoc meetings scheduled to address any immediate need.	Project Owners
Empire Plan and ValueOptions Implementation Progress Meetings	This meeting is focused on providing Empire Plan with progress reports on the overall implementation.	Meetings are one hour, usually once a week or twice a month during implementation, depending on client preference. Frequency may increase as go-live date nears.	Project Owners, Project Management Support (EPMO)
Empire Plan and ValueOptions Functional Workgroup Meetings	These meetings are focused on the detailed level work product development.	Meeting length and frequency is decided by the joint functional workgroup. Not all functional areas will need to meet weekly, but key areas – eligibility, system/benefit configuration, IT, and shared accumulators will require focused attention to ensure that the foundation of the programmatic requirements are built correctly.	Project Management Support (EPMO), Subject Matter Experts (SMEs)

Our implementation methodology provides for the following artifacts to ensure no expectation, risk or requirement drops through the cracks:

1. Minutes for every meeting that is held; whether the meeting is with the client, vendor, a third party or just among internal representatives, a record of the substance of the meeting is created.
2. Ongoing tracking of all action items, risks, issues and requirements that are captured in any program instrument (status, minutes, approval correspondence, and similar items).

3. Date stamping of all activities on each item to ensure the state of each item is fixed and that momentum is maintained.

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.

ESTIMATED TIMEFRAME FOR TASK COMPLETION

The plan used to implement the Empire Plan emergency contract is provided as **Attachment 1**. It details the sequence of events, the responsible parties, and the timeline required for each functional area for a successful continuation of this program within 60-days of award and no later than December 31, 2014. At the point of award, ValueOptions reviews the proposed plan and works in close cooperation with the Department to refine and finalize it to your satisfaction. The Department has full rights of approval of the implementation plan. Throughout the life of the implementation process we conduct weekly status review meetings with the Department. During the weekly status review meetings, Mr. Kahle communicates the status of the project and discusses any concerns with the Department in order to ensure that all parties are satisfied with the progress and state of the implementation.

As mentioned above, as your incumbent much of the typical 'start-up' milestones and tasks have already been completed. As such, all the steps required to implement the emergency contract will be updated to reflect the new "on-going" agreement. Based upon our review of the revised RFP, the requirement to generate an annual explanation of benefit (EOB) statement is a task that will require implementation support. Once we meet with the Department to review and finalize the business requirements for the new contract, we should have a more comprehensive understanding related to the timing of this particular deliverable. We will work with you to finalize the implementation timeline in order to account for the review/approval period required by the Department and to complete the operational and development tasks necessary to implement the annual EOB statements.

AREAS WHERE COMPLICATIONS MAY BE EXPECTED

We do not anticipate any areas where complications may be expected. As a result of our extensive experience with implementations, we have identified lessons learned and developed a robust, well designed and tested IT system key to the success of any program. The IT component of program implementation covers a broad range of requirements and includes everything from determining system and platform integration to new application development. Because of the complexity of these tasks and the impact any set back or disruption to the schedule can have on our overall success, we have incorporated strategic steps into the plan that ensure a successful implementation. Important lessons learned include:

- Without clear communication of IT requirements that include a well-defined scope of work, key implementation dates may be missed and unresolved issues may have a negative impact on our ability to provide service.
- Need for initial program-specific training for both the customer and ValueOptions' staff.
- Adherence to project timeline

Defining IT Requirements

One of the challenges we have encountered is defining key IT requirements. IT plans are sometimes vague and require considerable discussion between ValueOptions and the customer. Ambiguous requirements can jeopardize the success of the entire project. All parties must clearly understand the functional expectations and requirements of the program and develop clearly defined plans to meet the expectations. A lack of understanding of the requirements can result in project delays and missed deadlines. To resolve the vague requirement dynamic, we have found success in partnering with the customer's Subject Matter Expert (SME) for each particular IT project deliverable. Partnering the customer's SME with the ValueOptions SME from the onset of the project and throughout the entire lifecycle will ensure that expectations are defined. We also invite and recommend that the customer's SME participate in the Level III testing or beta periods to ensure the final product is satisfactory.

User Training

The lack of user training as another lesson learned regarding IT project implementation. An IT project's development and testing quality can be superior, but without a robust training program with a well-documented curriculum, the IT project may fail to meet expectations. To ensure proper training on new programs or processes, all IT project teams include a training lead who participates in the project's workgroup from the onset. The training lead develops the system's technical documentation (i.e., step diagrams, work flows), and partners with the customer's Human Resources and technical staff to develop a comprehensive training program for new users. The training programs use many training methods including instructor led training, Computer Based Training (CBT), readiness evaluations, and remedial training sessions.

Project Timeline

We have learned that when the project timeline defined at the inception of the program is not followed and deadlines are missed, the success of the implementation is put at risk. The most commonly seen departures from the timeline include:

- Requirement and testing commitments from vendors/clients not being met fully or within defined project timelines
- Trading partners are not available or attend meetings but do not include the correct subject matter experts
- External data loads required to complete the process are not received as expected

We diligently work with our clients and vendors to adhere to the project timeline and obtain required data and information as scheduled, in an effort to achieve successful outcomes.

EMPIRE PLAN EMERGENCY CONTRACT IMPLEMENTATION

Below, we provide a table detailing the implementation items, and their status, of the emergency contract.

We have recruited and hired for 81 positions and provided more than 15,000 hours of training.

Task Name	Status
2014 Empire Implementation	**Open**
Project Setup	Open
Develop Project Schedule	Open
Review and Analyze Performance Guarantees	Complete
Conduct Detailed Business Requirements Gathering	Complete
Execute Facility Planning and Build-out	Complete
Finance	Complete
Establish charge codes and account setup	Complete
Complete GRF process	Complete
Determine Reporting Needs and Develop Reporting	Complete
Establish Invoicing Process	Complete
Legal	Open
Perform contract review	Open
Obtain Signatures/Approvals	Open
Human Resources /Staffing	Complete
Determine staffing needs	Complete
Conduct Recruitment	Complete
Performance Guarantee Achievement	Complete
Develop Day 1 Reports	Complete
Develop Monthly and Quarterly Performance Reports	Complete
Clinical Program	Complete
Develop P&P for Case Management Planning	Complete
Transition Plan: Develop and Obtain Approvals	Complete
Transition Plan: Execute	Complete
Mail Transition of Care Letters to Providers and Members (Multiple Mailings)	Complete
Build >6000 Transition Authorizations	Complete
Conduct IP/ICM Patient Transition	Complete
Transition Plan: Close-Out Planning and Execution	Open
Develop Utilization Management program	Complete
Define and Obtain Approval of Mixed Services Protocol (MSP)	Complete
Clinical Staffing: identify and recruit	Complete
Clinical Staff Training	Complete
Clinical QM	Complete
Develop Depression Management, Eating Disorders and ADHD Programs	Complete
Develop Provider QA Audit Program	Complete
Network Management	Complete
Conduct Disruption Analysis	Complete

Provider Recruitment: Identify needs and recruit	Complete
Provide Notifications to Network Providers	Complete
Value-Based Initiatives: Develop and Deploy	Open
Customer Service	Complete
Determine the Administrative Complaints and Appeals Process	Complete
Determine Clinical Appeal and Denial Process	Complete
Phone Scripts: Develop, Obtain Approval and Record	Complete
Call Center Staffing: identify and recruit	Complete
Call Center Training (8 weeks classroom)	Complete
Claims Operations	Open
Process Automation Development to Improve OFPR	Complete
Claims Staffing: identify and recruit	Complete
Claims Staff Training	Complete
Eligibility: Test and Conduct Initial Eligibility Load	Complete
Eligibility: Test and Execute Daily Change Files Process	Complete
Configure Benefits	Complete
Configure Claims	Complete
Process Change: Daily Manual File Review	Open
Correspondence Delivery	Complete
EOB - Explanation of Benefits Definition and Approval	Complete
Voucher Definition and Approval: Provider (PSV, and Member (MSV)	Complete
Voucher Definition and Approval: ISV Approval	Complete
ALA Letter Definition and Approval: 41 letters	Complete
Develop Annual EOB Statement	Open
System Set Up	Complete
References and Tables	Complete
SecurityConnect Set Up	Complete
ServiceConnect/CareConnect Set Up	Complete
NetworkConnect (Provider System) set-up	Complete
ReferralConnect Set Up	Complete
ClientConnect Set Up	Complete
ProviderConnect Setup	Complete
MemberConnect Setup	Complete
Achieve Solutions Modifications	Open
FileConnect Set Up	Complete
IT Operations	Complete
Estimate and Order LAN/WAN Equipment	Complete
Install all LAN/WAN Equipment	Complete
Order, Install and Configure all PCs	Complete
Telecom	Complete
Define Equipment Requirements, process POs, Receive and Install	Complete
Program Switch and ACD	Complete
Program Phones	Complete
Program Voicemail	Complete
Establish Business Recovery and Disaster Recovery Failover Process	Complete

Conduct Model Office Testing of all Processes	Complete
Go Live	Open

(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 the Implementation Date, with the exception of opening the Dedicated Call Center and completing work on the customized website each of which must be completed a minimum of thirty (30) days prior to the Implementation Date. The Offeror shall propose the forfeiture of a percentage of the 2015 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 2015 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 2015 Administrative Fee (prorated on a daily basis).

[redacted]

Implementation and Start-Up Guarantee	Proposed Penalty
[redacted]	[redacted]
[redacted]	[redacted]

Implementation and Start-Up Guarantee	Proposed Penalty
[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

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 Dedicated 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. Programing and scripting changes to The Empire Plan's consolidated phone line takes 4-6 weeks. 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 a minimum of thirty (30) days prior to the Implementation Date through and including four (4) months after termination of the Agreement between the hours of 8:00AM.to 5:00PM., Monday through Friday, except for Business holidays; (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; Transition of Care; MHSA Program benefits levels, status of pre-certification requests, eligibility and claim status and be able to identify calls requiring	Yes

Section 4: Customer Service (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
transfer to a Clinician;	
(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 call 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 dedicated call center becomes unavailable;	Yes
(7) Maintaining and timely updating a secure online Empire Plan specific customized website accessible by Enrollees a minimum of thirty (30) days prior to the Implementation Date, 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 website may not contain any links to the Contractor's standard website used for other customers. The website Provider search may only contain Provider types that are covered under The Empire Plan. 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	Yes

Section 4: Customer Service (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
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 weekly for the first month of the Agreement and then monthly for the remainder of the Agreement and calculated annually; (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 weekly for the first month of the Agreement and then monthly for the remainder of the Agreement 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 Contractor's telephone line be blocked by a busy signal. The telephone blockage rate shall be reported weekly for the first month of the Agreement and then monthly for the remainder of the Agreement 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 Empire Plan enrollees will continue to have access to the dedicated Clinical Referral Line and MHSA Program information through a consolidated toll-free number 24 hours a day, 365 days a year, under the direction of [redacted]—the current Latham-based Director of Clinical Referral Line. **These calls are answered by dedicated Empire Plan master's level clinicians and are not triaged through customer service representatives.** 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. Since our assumption of the Empire Plan contract on January 1, 2014, our dedicated Clinical Referral Line has consistently met or exceeded Empire Plan call center responsiveness expectations.

In Latham, New York, 91% of calls are answered within 30 seconds by a licensed clinician.

The primary purpose of the dedicated Clinical Referral Line is to refer enrollees expeditiously to a practitioner who is skilled in the assessment and treatment of mental health and substance abuse problems. The Referral Line clinician's primary role is to determine the urgency of the call based on ValueOptions' Referral Guidelines and identify and direct the beneficiary to the appropriate referral source. It is to this end that the Referral Line Clinician will collect information.

A secondary and very important purpose of the dedicated Clinical Referral Line is to provide a positive **introduction** to accessing mental health or substance abuse help; to reassure beneficiaries that making this call is actually the first step in alleviating stress. The goal is to help beneficiaries approach the first treatment visit in a positive and hopeful fashion.

In a supportive and professional fashion, the Referral Line Clinician will ascertain if the situation is an emergency or non-emergency by helping the enrollee identify his/her problem and assisting him/her in selecting the appropriate source of care. This structured exchange will calm most anxious callers and allow them to focus on their current situation and referral needs.

If the situation might be an emergency, or the beneficiary identifies the problem as an emergency, the call will be handled as an emergency referral.

The referral call is concluded with a supportive acknowledgment that the caller has taken the important first step and the caller is assured that the dedicated Clinical Referral Line staff will remain available for additional referral assistance, if needed.

(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.

Effective January 1, 2014, we entered into a shared service agreement with the Empire Plan medical carrier/third party administrator, United Health Care, and AT&T. We further confirm that hearing and speech impaired enrollees 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 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 Engagement 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. Enrollees 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, for the MHSA Program a minimum of thirty (30) days prior to the Implementation Date and through and including four (4) months after termination of the Agreement between the hours of 8:00AM to 5:00PM, Monday through Friday except for Business holidays. 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.

DEDICATED CALL CENTER IN PLACE

We confirm that we will maintain a Dedicated Call Center for the MHSA Program located in Latham, New York. This call center is led by our current Latham-based Director of Customer Service Operations—[redacted]—and employs a fully trained team of Customer Service Representatives, Technical Advisors and Supervisors, and collaborates with our dedicated licensed Clinical Care Managers focusing on urgent and emergent clinical follow through.

STAFF AVAILABILITY

Dedicated Empire Plan Clinical Care Managers (also referred to as Referral Line Clinicians) are available to handle all clinical calls 24 hours a day, 365 days a year through the dedicated

Clinical Referral Line or from Empire Plan's medical vendor. They 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 immediately directs crisis calls to a dedicated Empire Plan Clinical Care Manager, ensuring that enrollees in crisis receive access to a clinician who can assist them in obtaining the necessary services.

Dedicated Empire Plan Customer Service Representatives are available from 8:00 a.m. to 8:00 p.m. to respond to inquiries regarding enrollee eligibility, benefits, claims, and for gathering and documenting enrollee's demographic information.

(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 via the dedicated NYSHIP toll-free number, their call is answered by one of our dedicated Customer Service Representatives who are trained to promptly and thoroughly respond to their need. To assist our Customer Service Representatives in providing optimal service, system enhancements have been made automating many elements of our customer service and data management programs. These enhancements provide Empire Plan enrollees various options for accessing information. Below are descriptions of resources currently in place to support Empire Plan enrollees.

INTEGRATED INFORMATION SYSTEM

Today, the Empire Plan team accesses all information necessary to address enrollee inquiries, including eligibility, benefits, authorizations, provider status, and claims via our CONNECTS platform. Customer service, clinical referral, care management, reporting, and outcomes data are managed within this system.

Customer Service Application

Our customer service application, ServiceConnect, is used today by Customer Service to document and track all call center contacts including inquiries, complaints and transfers to the dedicated Clinical Referral Line when assisting Empire Plan Enrollees. ServiceConnect provides improved workflow efficiency, enhanced inventory management controls, and improved inquiry resolution timeframes to the Empire Plan.

ServiceConnect also supports workflow management between departments. As part of the CONNECTS integrated platform, ServiceConnect captures inquiry data and distributes it to the responsible individual or department for resolution. Inquiry details are maintained through resolution, and historical data of all inquiries for all enrollees is retained. The system also 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—a component of the integrated CONNECTS platform—is used by our dedicated Clinical Referral Line staff to locate network providers through an online searchable database. Through the referral module, clinicians 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. Search results contain all pertinent demographic information for each provider, such as name, address, phone and fax numbers. Clinicians can sort provider search results by unique enrollee needs or provider preferences, such as gender, race, language, clinical specialty, driving distance, and can reference a map showing locations of provider offices in relation to an enrollee's location.

The design of the referral module is optimized for the efficient data collection and tracking capabilities Clinicians can easily enter clinical data with maintenance of clinical case history online and access all clinical information including:

- 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, our clinicians will link Empire Plan enrollees to the most appropriate clinical services in convenient locations

(a) INTERACTIVE VOICE RESPONSE

ValueOptions utilizes Verizon Business's enhanced call routing to provide call routing features for toll-free numbers. Enrollees 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 Enrollee's need, the call proceeds to a licensed dedicated Clinical Care Manager or a Customer Service Representative.

(b) INTERACTIVE VOICE RESPONSE SCRIPT AND CUSTOMIZATION OPTIONS

We have provided a sample of the Empire Plan's call routing script as **Attachment 2**. All prompts and scripts from the toll-free number have been customized to meet the Empire Plan's exact specifications.

(c) MANAGEMENT REPORTS AND INFORMATION

Our enterprise-wide call management system provides the Empire Plan call center reporting that encompasses real time statistics and historical reports from a representative or queue perspective. This tool reports on inbound call activity within the representative environment. Using real time information on average wait time to answer, percent abandoned, or agent detailed call handle performance, allows us to make immediate decisions to redistribute calls to resources or redirect calls in the rare event it is required. We continuously analyze call activity to be proactive and not just reactive in our resource allocation to meet 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 currently 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

All Empire Plan calls and inquires received by our Latham-based call center staff are documented in ServiceConnect, our fully integrated customer service and clinical management information system for recording, tracking, analyzing, and reporting of contacts and inquiries. One-hundred percent of calls are recorded. The call type, reason, actions taken and resolutions are all captured. If the caller (enrollee or provider) already exist in our system, staff can easily search and retrieve the electronic enrollee or provider record prior to document the call. If the caller does not exist in our system, the Customer Service Representative creates a contact record for that call and enters the following reportable data elements:

- Enrollee's name
- Phone number
- Type of caller (Category)
- Source (e.g. telephonic, web inquiry)
- Date and time of call
- E-mail address
- Subject (Inquiry Type/Reason Code)
- Resolution of call
- Follow up required
- Urgency of call (e.g. Routine, Urgent, Emergent)
- Correspondence Sent

(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 dedicated 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 are monitored by the Latham-based Quality and Utilization Management Committee on a monthly basis.

CUSTOMER SERVICE REPRESENTATIVE TRAINING

We are committed to providing the training, tools and infrastructure our employees need to provide accurate and efficient service which meets Empire Plan enrollee expectations. ValueOptions' customer service philosophy lies in our commitment to provider enrollees and provider with the most accurate and informed benefit, eligibility, claims and authorization information in the most effective, efficient and compassionate manner.

ValueOptions' dedicated Empire Plan Customer Service Representatives are 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 dedicated 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 needing information and access to services.

All customer service staff are required to go through consumer engagement training, which includes a consumer engagement video. This effective training tool has three distinct chapters and contains real life testimonials of people in recovery and the important role that customer service plays in the recovery process. We provide an overview of the training below.

1. **Chapter One: Every Call Is Different; Every Call is a Person** – From Curtis and Clarence's experience with substance abuse, to Emily's personal battles with depression, to Andrea, Joan and Brenda's perspective on how to cope with a family member going through trying times, each of our interviewees is a very different archetype from the next as to the

type of person likely to be on the other end of a call center employee's line. Highlighting this variance, and allowing each subject to paint their stories will show the trainee watching just how large the gamut of callers and problems can be, and too that behind each call is a real person in need of real attention.

2. **Chapter Two: Knowing How To Handle It –** This section will be full of insights from the interviewees largely on how to apply the five original pillars identified for this video, listening with a smile, recognizing need; responding with clarity, being non-judgmental & exhibiting patience, being in the caller's shoes and making a positive impact, to their everyday interactions with enrollees. While these themes will of course be present across all 3 "chapters", it's here that we can truly drive them home for the viewer.
3. **Chapter Three: Your Responsibility; Your Opportunity** – Here, we bring the film to a close by both revealing these folks as actual ValueOptions employees with lived experience, and by letting them lay out their calls to action for all watching. The viewer will hopefully walk away understanding both his responsibility to those on the other side of the line, but also his unique privilege and opportunity to make a real difference in someone's life.

All customer service staff attend behavioral health sensitivity training which provides the groundwork for recognizing and identifying the different types of calls generated to a behavioral health customer service line. This training provides our staff with key phrases and indicators which signal when a warm or no hold transfer to a dedicated Clinical Care Manager is required.

Specialized ValueOptions staff delivers customer service focused training on program integrity, compliance and regulatory requirements. This focused training reinforces to staff that all inquiries are to be handled ethically, and consistent with all applicable contractual obligations and regulatory requirements.

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 includes 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 facilitates the training in a specially equipped room. The training environment mirrors the live call center and is 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—also located at our Latham Engagement Center—are responsible for developing and deploying the quality assurance processes related to internal reviews. Continuous feedback and coaching is provided to staff to make certain that enrollees receive services that meet their unique needs. This approach ensures program effectiveness, enrollee engagement, a successful enrollee experience, and enhances job satisfaction for our employees. The Call Center Supervisors and Quality Analyst are fully engaged in the quality process and 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 Latham-based 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 dedicated 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. **As of April 2014, more than five percent of Empire Plan enrollees have participated in post-call surveys, and we have received an average score of more than 99 percent.**

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.

Empire Plan Enrollee Feedback

"Good afternoon this is Mary Ellen S. I just spoke with a case manager Trent. He was very professional and very caring; highly recommend him and thank you for employing someone like him."

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 2013, the first call resolution rate for our Latham-based call center was 93.01 percent.

(c) STAFF TURNOVER

The following table lists ValueOptions' staff turnover at our Latham-based call center in 2013:

Position	Turnover Rate
Call Center Supervisor	0%
Call Center Team Lead	0%
Customer Service Representative	9%
Referral Line Clinician	8.2%

(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 1:57,000.

(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	25
Clinical Management	31
Referral Line Clinicians (Clinical Care Managers)	8
Customer Service	27

Staffing Logic

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.

The Avaya Business Advocate technology ensures that appropriate staff is available to respond to calls quickly and efficiently. The technology automates many call routing functions based on

pre-determined staffing requirements, and we can automatically adjust call routing thresholds to meet and maintain our targeted service levels. The system monitors critical items such as customer service and dedicated Clinical Care Manager staff status, average hold time, number of calls in queue, and number of abandoned calls and provides real time information that enables us to make immediate decisions to redistribute calls.

(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 are handled exclusively by our Dedicated Call Center in Latham, New York and only in the event of a system failure or call overflow are calls directed to our back-up call center in Wixom, Michigan. Our Wixom, Michigan Engagement Center is not treated as a triage location, it is a full-service call center.

We have not had any calls routed to our Wixom, Michigan Engagement Center due to system failure or call overflow.

BACK-UP SYSTEM FOR PRIMARY TELEPHONE SYSTEM

ValueOptions understands the importance of smooth service delivery and business continuity in the event of planned or unplanned outages. Although such incidents are very rare, maintaining a detailed plan is essential so that our staff can quickly and decisively respond to any planned or unplanned incident. Our formal and comprehensive Business Continuity Plan was developed to minimize service disruptions in the event that a call center experiences a disaster or temporary closure. This plan was developed and is maintained with the use of the Call Management System that is part of our telecommunications platform to manage and analyze call patterns and determine peak call times to manage staffing.

For the Empire Plan program, any interruption of service in the Latham Engagement Center will result in immediate routing of calls to our Wixom location. Our central Avaya deployment enables toll free number calls destined for Latham to be rerouted to Wixom and other engagement centers should an issue occur preventing calls from being answered due to power outage, building evacuation, and similar issues. In such situations, all incoming calls are rerouted to active agents within five minutes. Since telephony and data systems are fully integrated among all call centers, staff in Wixom can quickly and easily serve callers by accessing their information in real-time.

In addition, our Latham, New York Engagement Center is 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 which automatically re-routes Empire Plan's toll-free traffic through our long distance vendor when our system rings busy or there is a 'ring no answer.' This process is transparent to the caller and there is no down time.

In support of our Business Continuity Plan, we maintain 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

Our central Avaya architecture is designed to ensure 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.

We have deployed a mirror image of our 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 telephony requirements within 30 minutes.

Staff Training

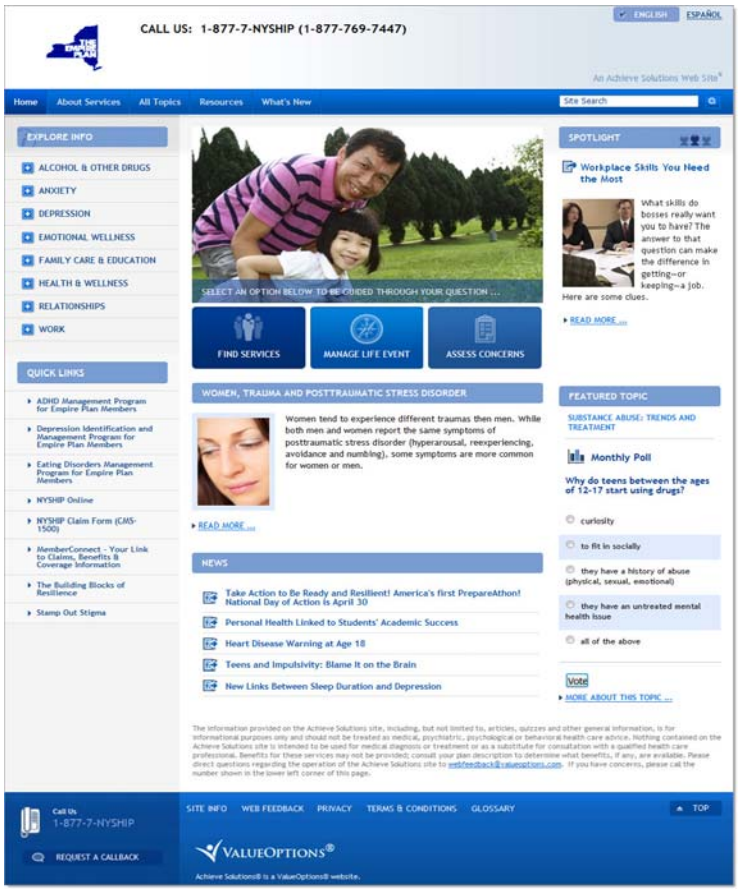
We confirm that staff members at the Wixom, Michigan location are trained on the Empire Plan program, and have access through our CONNECTS platform to enrollee and provider information. This provides a seamless service experience, with no loss of data or quality degradation. Back-up procedures are completely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

(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 an Empire Plan specific customized website for the MHSA Program that will be complete a minimum of thirty (30) days prior to the Implementation Date. Also, confirm that the following information, at a minimum, will be available on the website: MHSA Program benefits, Network Provider locations, eligibility, Copayment information Pre-authorization information; claim status and clinically-based educational material. 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

ACHIEVE SOLUTIONS

Empire Plan enrollees currently use our fully customized website for the MHSA program to access to all required information. Enrollees can seamlessly navigate from the Department's website.

We have 'private-labeled' and customized our Achieve Solutions website for the Empire Plan Program. This site offers enrollees a rich and accessible source of articles, tips, and information about behavioral health issues. Enrollees learn about healthy living skills, disease prevention, and early intervention to make positive life decisions and improve their health. A screenshot of the Empire Plan's customized Achieve Solutions website is provided for review.



The site contains content items including interactive multimedia and streaming content, Webinars, and articles. Achieve Solutions allows enrollees to connect with a dedicated Clinical Care Manager, or use the directory to locate providers. In addition, the dedicated Empire Plan Account Services team reviews all material to ensure that it is appropriate for the Empire Plan Enrollees.

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: 2013 Facts

- More than 250 client sites
- More than 5 million page views in 2013
- English: More than 200 topics, 6,000 content items
- Spanish: More than 40 topics, 600 content items
- The most accessed pieces of content across the MHSA book of business were: When an Adult Child Won't Grow Up, Understanding Pathological Liars, Teen Depression Quiz, Male and Female Communication: Differences Worth and Bullying: When Adults Are the Victims.
- The most accessed topics across the MHSA book of business were: Depression in Children and Teens, Parenting, Obsessive-compulsive Disorder, Communication and Conflict Management.

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 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

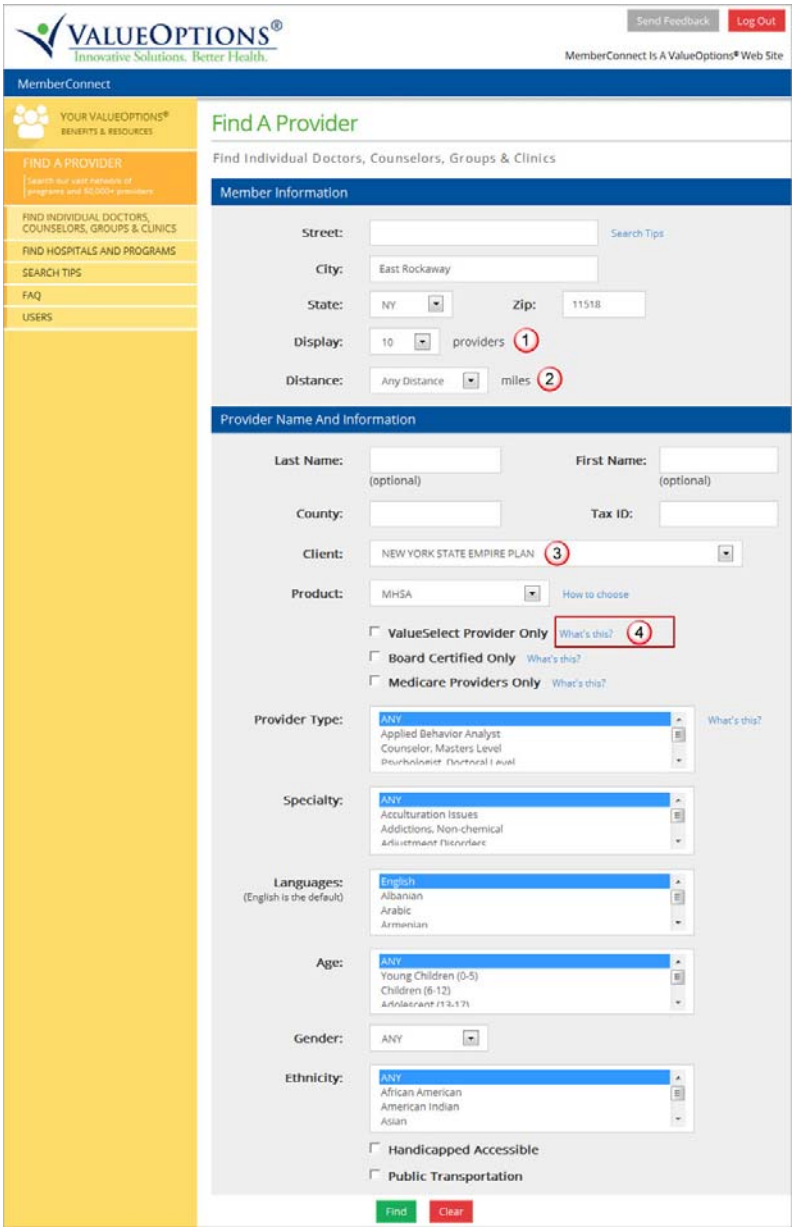
To view the capabilities and user-friendliness of our website, please go to www.achievesolutions.net/empire. No sign-on is required.

MEMBERCONNECT

Our MemberConnect portal is a one-stop e-shop where enrollees can complete everyday service requests online 24 hours a day. Enrollees can access MemberConnect via a "quick link" form the Empire Plan Achieve Solutions website. Via this password-protected site, enrollees can check benefits, authorization and claims status, claims history, claims payments, and view correspondence online. Enrollees are presented with comprehensive and easy to read information within seconds.

The toolbar options allow enrollees to download Empire claim forms, review enrollee Rights and Responsibilities, and make informed decisions about mental health care and wellness. The

"ABCs of Mental Health Care" page enables enrollees to comfortably browse articles about how to select a mental health specialist, what to expect during treatment, and how to evaluate the effectiveness of the treatment. The "About Care Providers" menu provides descriptions of the various types of providers available under the plan, while the "Treatment Types" menu describes the array of counseling, therapies, and testing methodologies available.



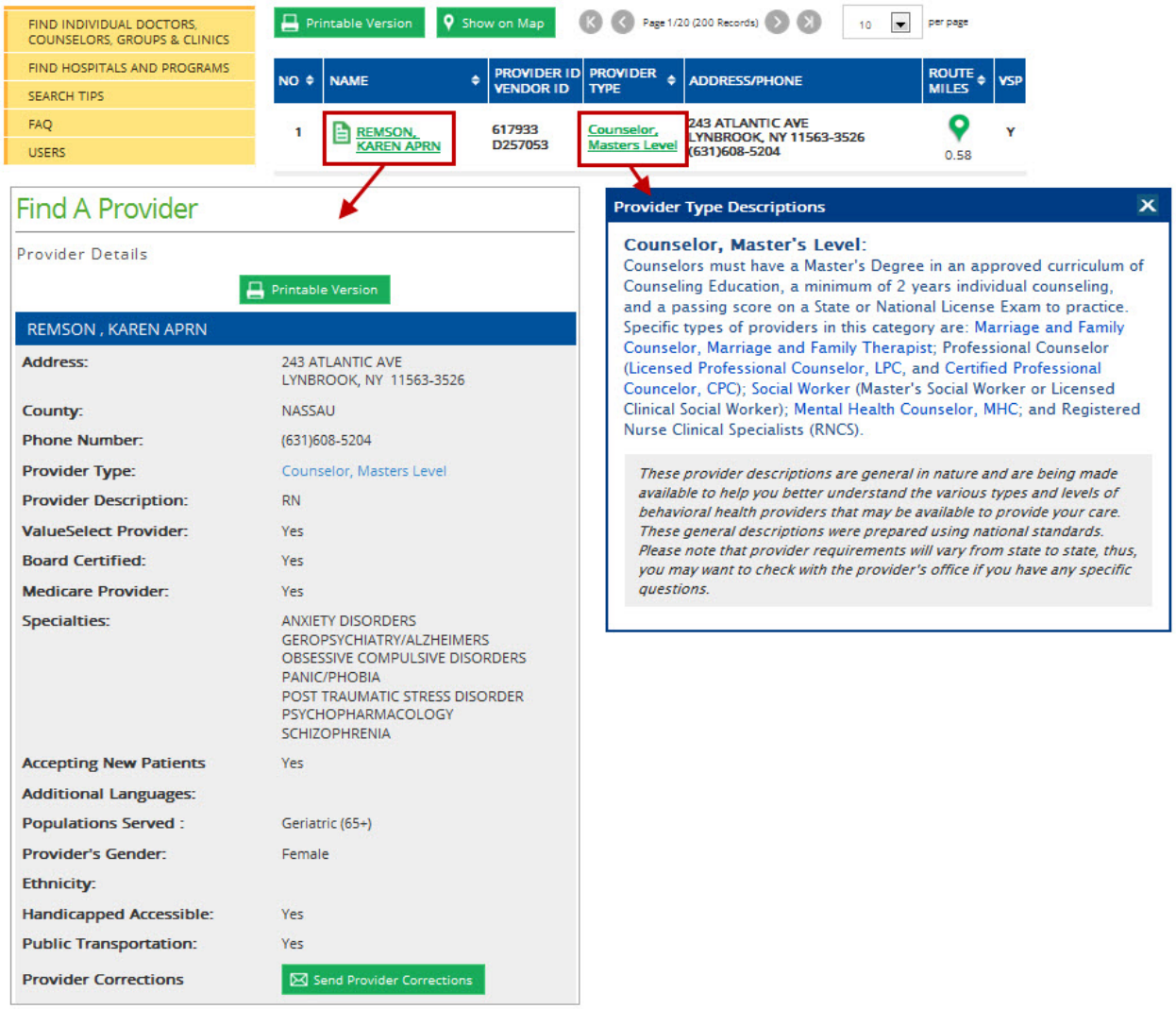
Benefits

Our enrollee portal was designed with the following features:

- encryption or access controls, including audit trails, entity authentication mechanisms for detecting and reporting unauthorized activity in the network
- eligibility verification
- ability to view and print authorization letters, explanation of benefits and other correspondence
- ability to submit questions to the ValueOptions customer service team or request assistance

REFERRALCONNECT

ValueOptions has developed an innovative Web-based Provider Referral System, ReferralConnect, that offers enrollees access to the wealth of ValueOptions' network resources, online, and in near real time. ReferralConnect can be accessed by enrollees, providers, or dedicated Clinical Care Managers.



The directory is linked to our information system, which houses the provider file. As changes are made to the provider file, each change is reflected near real time in ReferralConnect. Our application also offers a "feedback" button that allows the user to provide immediate feedback about demographic changes needed (i.e., address, phone number). ReferralConnect can be accessed from the Empire Achieve Solutions website and also directly from the NYSHIP Online website. Regardless of the route used to access the site, enrollees are able to search ValueOptions' network database to locate a provider online from their own computer.

Easy to Use Provider Search

To conduct a provider search, enrollees enter their location, the distance they are willing to travel, and the type of provider they would like to locate. Based on the enrollee's search criteria, ReferralConnect supplies appropriate provider information and a map to help the enrollee locate the provider. ReferralConnect is user-friendly, and is equipped with a "help" function that provides assistance for users. ReferralConnect provider data is refreshed daily.

ValueOptions dedicated Clinical Care Managers and Intake Specialists also have immediate online access to ValueOptions' provider database electronically. Any staff member can provide a referral to the most appropriate provider for the given enrollee from any location in the country.

ReferralConnect offers the following key features:

- online provider directory that can be accessed by enrollees, providers, or dedicated Clinical Care Managers
- the directory is directly linked to our information system, which houses the provider file
- updates occur daily in near real time
- "feedback" button that allows the user to provide immediate feedback about changes needed (i.e., address, phone number)
- "help" button for user assistance

(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]

[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 XIII 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
(4) The Contractor must work with the Department to develop appropriate customized forms and letters for the MHSA	Yes

Section 5: Enrollee Communication Support (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
Programs, 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, in writing, prior to distribution.	

(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

Our dedicated account team is the Empire Plan's primary resource for enrollee communications, but we rely on the resources and experience of our internal Marketing and Communications experts that include graphic designers, writers, and project managers. We consult with our legal team as a support to ensure the content we provide is accurate. Our business model is to be an agent for our client's message rather than our own. As such, we are equipped to customize The Empire Plan's enrollee materials and communications to meet your requirements and specifications. We will work with you in a collaborative manner to develop and execute customized enrollment communications, materials, customized websites, and specialized communications. Given the experience of our marketing and communications team, we do not anticipate the need to make any changes to our current structure to support the Empire Plan, Excelsior Plan, or the Student Employee Health Plan's needs. We understand that all MHSA Program communications developed would be subject to the Department's final approval.

PROCESS FOR DEVELOPING ENROLLEE COMMUNICATIONS

As part of our process, we will take direction from the Department regarding the messaging, audience, and tone of the communications. When asked to develop any enrollee communication, 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 subheadings, 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 the designated member of our Empire Plan Account Team available to answer any legal questions that may arise.

Empire Plan Enrollee Communications

ValueOptions offers a comprehensive suite of communication materials, available in multiple formats, to support the Empire Plan MHSA Program. Our strategy for enrollee communication includes, but is not limited to:

- Customized communication materials tailored for the Empire Plan, such as welcome letters announcing the program, targeted transition-of-care letters for enrollees currently in treatment, articles, brochures, and tip sheets
- Support in developing Summary Plan Description language and regulatory updates, done in conjunction with our legal team
- Coordinating with the Department to attend and present at any orientations for enrollees regarding 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 NYSHIP Online website to the customized Achieve Solutions website for the Empire Plan. As we have demonstrated, we will continue to maintain the customized Achieve Solutions website in a manner that will protect enrollees from accessing material that does not align with the Empire Plan program benefits.

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.

The site contains content items including interactive multimedia and streaming content, Webinars, and articles. Achieve Solutions allows enrollees to connect with a dedicated Clinical Care Manager, access the Disease Management Program materials and the resilience program, 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. The Empire Account Services team will also review new content to ensure that it is appropriate for inclusion on the Empire Plan's custom website.

Achieve Solutions: 2013 Facts

- More than 250 client sites
- More than 5 million page views in 2013
- English: More than 200 topics, 6,000 content items
- Spanish: More than 40 topics, 600 content items
- The most accessed pieces of content across the MHSA book of business were: When an Adult Child Won't Grow Up, Understanding Pathological Liars, Teen Depression Quiz, Male and Female Communication: Differences, and Work and Bullying: When Adults Are the Victims.
- The most accessed topics across the MHSA book of business were: Depression in Children and Teens, Parenting, Obsessive-compulsive Disorder, Communication and Conflict Management.

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

- View eligibility
- Check authorizations
- Check claims status
- Check claims history and claim payments
- 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 the Department 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 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 customized Empire Plan MHSA communication materials we have developed for enrollees. These materials include invitation letters, brochures, and

educational information regarding our Attention Deficit/Hyperactivity Disorder (ADHD), Depression, and Eating Disorder programs.

(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 Account Management team—serving as the main point of contact for the Department—will 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.

Our Marketing and Communications department, which includes professional writers, editors, graphic designers, and communication specialists—is also 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, tip sheets and brochures.
- We have in-house design and fulfillment staff responsible for collateral conceptualization and execution. This team works with the Account Executive from the idea phase to printing phase.
- We consider the clients' internal employee communications 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 Executive acts as the liaison to share drafts until the client is satisfied with the customized collateral.

SOCIAL MEDIA CAMPAIGN

In addition to our standard resources referenced above, we would like to discuss a formal social media campaign for the Empire Plan enrollees. Enrollees will know that it is our priority that they are well-informed regarding their behavioral health benefits—this is clearly communicated with our expansion into top-ranking social media networking websites. Our social media presence is focused on helping people live their lives to the fullest potential. We provide a wide array of health and wellness information from national news sources, quizzes and polls to find out what our audience thinks and what we can do to better help them.

(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, and will bill the MHSA Program for reimbursement in accordance with Article XIII 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 XIII of the Agreement.

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

ValueOptions confirms that our Account Management staff 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

[redacted]

(5) Confirm your commitment to 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 and appeal letters. Provide samples of customized communications you have produced for other large clients.

ValueOptions confirms our commitment to work with the Department to develop appropriate customized forms, and letters for the MHSA program. We provide communication material used for Empire Plan enrollees as **Attachment 4**.

(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. As the incumbent contractor, we have not distributed SBCs to date, but we will distribute SBCs upon enrollee request and as directed by DCS.

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
(a) Initial Testing: (i) 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; (ii) Testing to determine if the initial enrollment file and daily enrollment transactions files 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
(b) 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, on a daily basis, manually review and load any transactions which did not process correctly from the daily ANSI x.12 834 standard 005010x220 file by reviewing the correct enrollment date maintained in the NYBEAS. 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	Yes

Section 6: Enrollment Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
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;	
(c) 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
(d) 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
(e) 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
(f) 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; and	Yes
(g) 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	Yes

(1) Describe your testing plan to ensure that the initial enrollment load and daily enrollment transition files 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?

The Empire Plan enrollee data is fully integrated within the CONNECTS platform to support all operational functions, including but not limited to claims payment, customer services, and clinical transactions.

During the Empire Plan implementation, we worked closely with the Empire Plan's Information Technology Specialists at the Department of Civil Services (DCS) to gather detailed requirements, write the functional specifications, conduct testing, and coordinated the delivery of the enrollment data integration necessary to ensure a successful, error-free implementation of the enrollment files.

Throughout the development lifecycle of the initial and daily transactional enrollment files, we conducted rigorous testing along with the Empire Plan's technical team. The level of testing conducted further validated that the enrollment data was accurately loaded and updated in our system. No Empire Plan data was released into our production environment until all the data transmissions were accepted and approved by the Empire Plan's technical team.

The Empire Plan enrollment load procedure includes agreed-upon quality controls, reporting and correction of errors, tracking, and performance metrics. Our commitment to service excellence is proven by our ability to successfully transmit and accept all files according to the defined schedule in place for the Empire Plan contract.

(a) QUALITY CONTROLS

Once the Empire Plan enrollment data is received by ValueOptions, it is loaded into the system and basic data integrity checks are performed to ensure that the Empire Plan-specific rules are processed against the data. The processing rules identify possible:

- duplicate records
- missing demographic/data from required fields
- surviving family situations
- Medicare Part B and other Empire Plan enrollment-specific data integrity checks

Our Empire Plan-designated Eligibility Specialists initiate the process of loading eligibility files received from the Empire Plan to the CONNECTS platform. If the enrollment file has an error rate greater than two percent (> 2%), the process is automatically halted for manual review. An Eligibility Specialist investigates the records that are in error and determines 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. The process generates an error report that is reconciled by validating the enrollment data with the data in the New York Benefits Eligibility and Accounting System (NYBEAS). Once an error on a record has been resolved, it is recycled back through the system for automatic updating of the Empire Plan's information.

(b) TRANSACTIONS THAT FAIL TO LOAD

As noted above, the Empire Plan 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 into internal errors and Empire Plan-specific errors, such as missing or invalid required data elements. Some examples of required data elements include name, date of birth, address, enrollee ID and other Empire Plan-specific validation rules. The errors are sent via email to our Empire Plan designated contact for resolution. The internal errors are reviewed and processed with an update of the file to the system. Errors are reviewed daily 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;
- (e) Confirm you will, on a daily basis, manually review and load any transactions which did not process correctly from the daily 834 file.

We successfully transmit and accept all Empire Plan files according to the schedules defined and agreed upon. All of our data exchange procedures include development and support capabilities, such as error correction and reporting, data cleansing, and tracking and performance metrics.

The Empire Plan enrollment data is accepted daily and our commitment is to ensure enrollment within 24 hours of receipt. To initiate the Empire Plan contract, we loaded an initial eligibility population file. Subsequent to the initial enrollment file, we have continued to accept and process the daily incremental (transactional) files to maintain our system with the most up-to-date Empire Plan enrollment data.

(a) HISTORY OF TRANSACTIONS

All Empire Plan 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 a 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 do not purge or delete eligibility segments. 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

Our system accepts retroactive dates for the Empire Plan enrollee, and processes claims according to the most current eligibility segment in our system. The daily transactional Empire Plan enrollment file is used to update the Empire Plan enrollment data in our system. If an enrollee's effective date has been changed from the previous eligibility segment supplied, the import program is designed to automatically replace/over-write the existing record on file. Essentially, the new enrollee data supersedes the previous record provided by the Department. All enrollment records are retained in our system for research and claims payment purposes.

(c) INFORMATION CAPTURE FOR REPORTS

Our system captures all of the detail and data necessary to support the generation of the "Claims and Credits Paid by Agency" and "Quarterly Participating Agency Claims" reports. Our reporting system draws upon the Empire Plan data collected in the CONNECTS platform, including but not limited to enrollment, claims, authorizations, and provider data.

The data collected in CONNECTS by our staff and submitted by the Empire Plan providers is all stored and maintained in our system, which is imported directly into our data warehouse for reporting purposes. The Empire Plan data is formatted and stored as standard data in our data warehouse, an Oracle relational database system. In addition, data from outside sources (e.g., physical health, pharmacy) can be integrated into the data models to enhance reporting capabilities. These standard data models are used as the foundation for the required claims-based reports, statistical analysis, decision support, and outcomes management.

(d) ENROLLMENT AND CLAIMS PROCESSING CAPACITY

We currently store the individual social security number (SSN) and the unique ID assigned by the Department for each of the Empire Plan enrollees and their dependents. There were no special requirements necessary for us to accept and store the Empire Plan subscriber SSN and Department issued ID. Our import system is designed based upon the agreed-upon specifications and file layout defined with Empire Plan's Information Technology Specialists at the DCS.

As the Empire Plan enrollment file loads into our system, the SSN is the primary identifier for each unique enrollee and dependent's record. In addition, we store the unique employee ID assigned by the department as an alternate ID in the system. The enrollee's SSN and Department issued employee ID are used to link each enrollee's dependents in our system. The Empire Plan enrollment load program assigns the primary subscriber's SSN and employee ID with a numeric suffix (e.g., xxx-xx-xxxx-01 or 89xxxxxxx-01) to identify and link each dependent associated with the Empire Plan employee enrollment record.

Because the system is fully integrated, all enrollment data is accessible and used during the claims adjudication process. The claims adjudication logic validates the enrollee's eligibility and the date of service on the claim. If the date of service 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, our current Empire Plan eligibility staff in Latham, New York, accesses the NYBEAS to verify the correct information and manually update the system.

(e) REVIEWING AND LOADING TRANSACTIONS

ValueOptions will, on a daily basis, manually review and load any transactions which did not process correctly from the daily 834 file.

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

All information and data exchanged manually or electronically is housed in our CONNECTS system and is compliant with all State and Federal confidentiality and transaction security requirements and regulations, including all HIPAA and HITECH compliance requirements.

As a major contractor with the federal government and multiple state agencies, ValueOptions has extensive knowledge and experience in complying with government regulations. We constantly monitor all applicable government legislative activity (on federal, state, and local levels) where we are geographically performing services. Our diligence on compliance applies not only to the security and management of our data and data systems, but also to continuous training within our organization. ValueOptions places the highest priority on compliance with government regulations, and adherence to our HIPAA, HITECH, privacy, and Code of Conduct policies. We will continue to commit all necessary resources to ensure we maintain the Empire Plan's data in a compliant and secure manner, and that we conduct business within appropriate moral, ethical and legal standards.

ValueOptions' system is fully compliant with submitting and receiving the Empire Plan 834 enrollment/disenrollment transaction sets. The system maintains and systematically updates the Empire Plan enrollment data daily, always ensuring the most accurate information is available to our staff, providers and enrollees.

(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.

When an Empire Plan enrollee calls our dedicated Clinical Referral Line and we are unable to confirm his or her enrollment information during the call, our dedicated Clinical Care Managers continue to engage the caller as they 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 NYBEAS.

(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 Empire Plan and any State initiatives designed to improve technology and processes related to enrollment data. We continue to leverage new technologies and enhance applications to improve administrative efficiencies, accommodate the Empire Plan's requirements, and remain in compliance with all New York State and Federal regulations. Because the suite of technology applications is on a single platform and is owned by ValueOptions, we are able to work with you collaboratively to make updates quickly without having to wait for a third-party technology vendor's next "release."

As noted previously, we control all data exchange development and system modifications with a formal change management (CMP) process.

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, as well as any future changes required to the existing enrollment file.

(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 continue to maintain a read-only connection to the NYBEAS enrollment system, and that 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.

ValueOptions is currently meeting these administrative requirements today and can meet a turnaround time of 24 hours. 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.

We demonstrate our current process with the Empire Plan below:

A. Account Services receives a National Medical Child Support Notice from the DCS.
B. Empire Account Services scans in the correspondence and saves the document in the Account Services Share Drive (k): Commercial Accounts- Empire – NMCSN
C. Account Service builds an inquiry and attaches the NMCSN notice identifying the custodial parent of a dependent covered under the Empire Plan, along with the alternate address. The inquiry is pended to Corporate Eligibility in ServiceConnect (V4elqpd2). Corporate Eligibility will FLAG the account with the hold code BM (See P&P for member alt address), once the inquiry is sent back to Account Services, the updates are verified in ServiceConnect and the inquiry is closed.
D. All inquiries must be completed within twenty-four hours of receipt of the NMCSN from the DCS.

(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 XV "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 Shared Communication Expenses, 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 with the exception of the May following termination of the Agreement for which on the report is due;	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	Yes

Section 7: Reporting (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
submit quarterly the MHSA Program's Performance Guarantee report that details the Contractor's compliance with all of the 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 health plans 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	Yes

Section 7: Reporting (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
must include summarized and detailed website performance information and statistics, as well as proposed modifications to the 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 thirty (30) Days after the end of the month. For the first month of the Agreement, these reports will be due on a weekly basis; and	Yes
Detailed Claim File Data: The Contractor must transmit to the Department and/or its Decision Support System (DSS) Vendor, currently Truven Health Analytics, 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 month and submit a summarized report by month utilizing a format acceptable to the Department. The Contractor must continue to send the Detailed Claim File each month after termination of the Agreement until such time as the Department and Contractor mutually agree that the claims run-out is complete.	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.

Today, the Empire Plan benefits from our comprehensive suite of reporting options, developed through our experience working with large employer groups. Our reporting emphasizes timely access to data, transparency of program and performance information, and an emphasis on actionable information. We confirm that we currently provide the Empire Plan with all required reports outlined in the RFP, in the frequency specified, and have submitted examples of such reports as **Attachment 5**. Our reporting system also allows easy access to ad hoc reports which 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, identify opportunities for improvement, and significant changes in utilization; 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 enables the accumulation of contract-level detail and 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 enrollee 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 provide reports in the specified format (paper and/or electronic Microsoft Access, Excel, Word) or any format requested, 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 currently provide the Department's offices direct, secure access to our claims system and our Web-based reporting and analytics solutions, IntelligenceConnect, and will continue to do so for the duration of the proposed contract.

Please see **Attachment 6** for a copy of the data sharing agreement we propose for Department staff to execute to obtain systems access.

CLAIMS PROCESSING SYSTEM

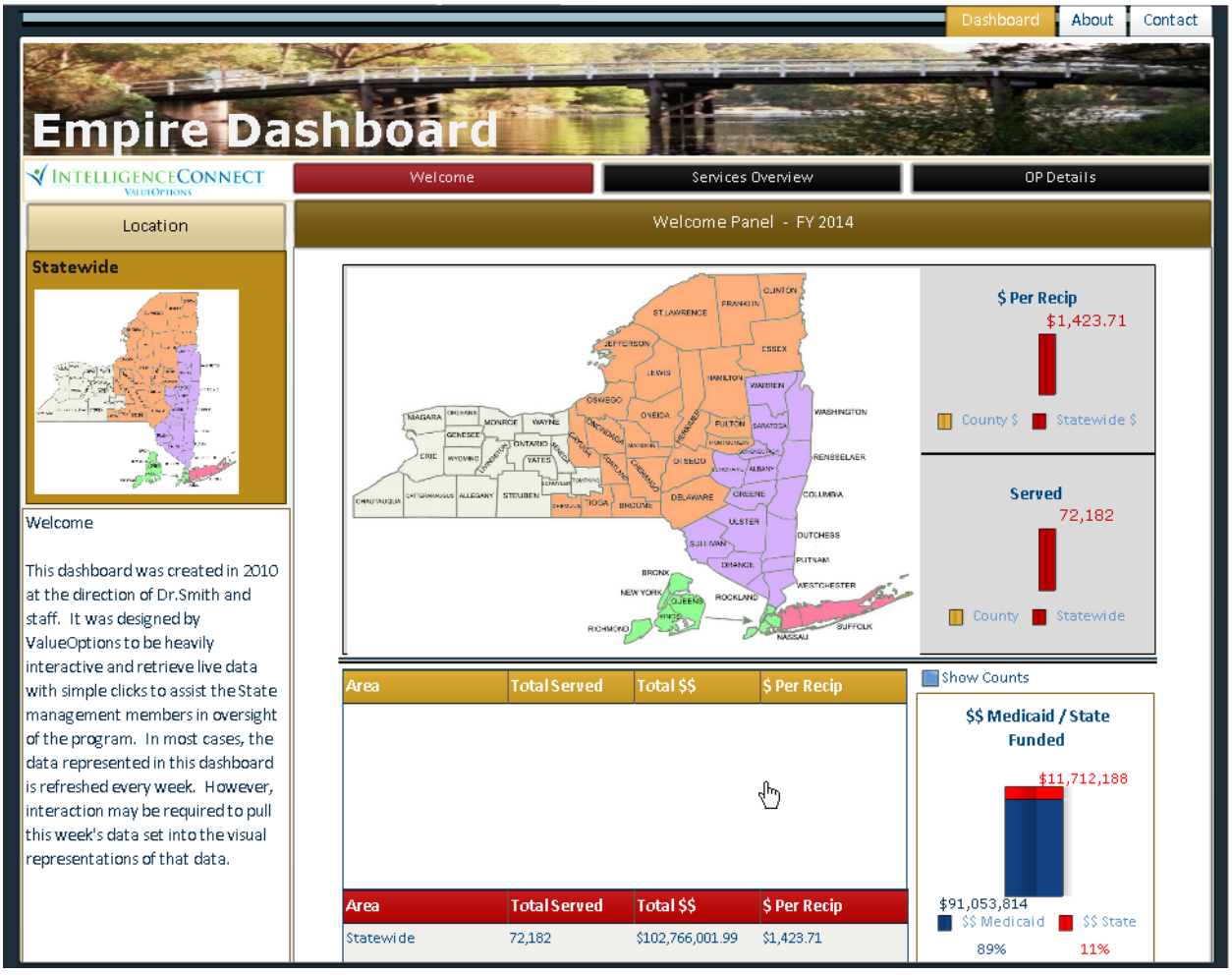
Our claims processing system, called "ClaimsConnect," is part of our fully integrated network of systems, CONNECTS, that unifies all care management, benefit design, eligibility, reporting, research, finance, and claims payment data and capabilities. ClaimsConnect supports all claims processes involving claims entry, adjudication, payment, and reporting. Authorizations are used for limiting and/or controlling provider access. Utilization Review (UR) capabilities are also included in the claims subsystem to allow the connection between the claim being processed and authorizations that have been loaded in the system. The decision as to whether a claim requires an authorization to be paid is part of the benefit set-up logic. Additional features found in the claims processing subsystem are the following:

- online authorization/adjudication capabilities
- efficient HCFA-1500 and UB92 screen entry formats for high volume processing
- unlimited claims services per claim
- specific/generic service authorization capabilities
- automatic matching of claim activity to outstanding authorizations
- user defined processing edits
- online/batch claims adjudication capabilities
- all conditions listed per service item for history of adjudication

- follow-up capabilities for claims and authorizations
- split payment and member reimbursement capability

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. Also, when special needs arise, we have the ability to produce on-demand reports requested by the Empire Plan. 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 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.

We have customized our reporting solutions specific to your needs and the data that will be most meaningful to you. A sample dashboard is provided below:



Key Metric Indicators (KMIs)

IntelligenceConnect presents the Empire Plan'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 along the dashboard's 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 presents the Empire Plan with a utilization trending dashboard that allows you to select the time interval of the trend and the measure, and you 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).

(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 provide ad hoc reports and other data analysis. However, as mentioned above, our standard reporting package routinely meets expectations that will meet the vast majority of your reporting requirements. Please see **Attachment 7** for a sample ad hoc reports we prepared for the Empire Plan.

(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 and Decision Support Vendor, as applicable, 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 engage subject matter experts throughout our organization to ensure the Empire Plan is kept up-to-date on trends, pending legislation, and other information relevant to the Empire Plan MHSA Program. In addition, our Empire Plan Team is comprised of professionals in the areas of:

- Account management
- Clinical operations
- Legal
- Accounting
- Actuarial
- Claims (dedicated quality analyst)
- Customer service
- Utilization management
- 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.

Jennifer Campione—Director of Account Management for the Latham Engagement Center—will continue to lead the team for the Empire Plan, Excelsior Plan, and the Student Employee Health Plan. Through Ms. Campione, we continue to communicate information to support the Empire Plan. Examples of issues in which we have recently provided guidance and support to the Empire Plan have included such topics as:

- Federal Mental Health Parity and Timothy's Law
- ACA
- 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

A demonstration of our commitment to consultation for the Empire Plan is evidenced with our recent formulary recommendations to various medications. We provided recommendations for 22 different medications while noting potential issues from patient abuse to availability. This consultation was provided by Dr. Hal Levine, our Corporate Chief Medical Officer, and Dr. Christopher Dennis, our Chief Medical Officer of the Commercial Division. Also, we recently held a meeting with the Empire Plan to discuss Mental Health Parity and Addiction Equity Act Compliance for 2015.

In addition, the Empire Plan not only receives 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 support the Empire Plan 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 conduct quarterly meetings to discuss utilization trends, book of business comparisons, general operational updates and emerging topics of interest to the Empire Plan in areas such as legal, clinical, actuarial, and plan design. Ms. Campione currently works with you to develop the agenda for these meetings, and ValueOptions operational leaders and senior executives are 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:

ValueOptions' Empire Plan Team

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

Additionally, we will invite the Empire Plan to rejoin our Corporate Customer Group (CCG). When previously a part of this group, the Empire Plan worked collaboratively 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 Empire Plan 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 Empire Plan 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 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 and will continue do so for the duration of the proposed agreement.

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, receipt of all information necessary to transfer administration of 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, submit to the Department for approval 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 Coordination of Benefits 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 such as a Single Case Agreement, 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 data files should include but not be limited to the following; (i) Providing a test file to the successor contractor at least seventy-five (75) days 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 eight (8) weeks prior to implementation that contains the above MHSA Program data as specified by the Department and working in conjunction with the successor contractor; (iii) Providing a second production file four (4) weeks prior to implementation; and (iv) Providing a third production file to the successor contractor by the close of business three (3) days after Agreement terminates;	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, Coordination of Benefit 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 XXI 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 XXI "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 XXI, "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 call center 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	Yes

Section 9: Transition and Termination of Agreement (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
contractor and the Department to develop an approach to ensure a smooth transition for members who must change Providers to maintain the network level of benefits;	
(9) The Contractor must prepare and communicate with the successor Contractor, 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 as inpatient and in Residential Treatment Centers on or before the Agreement termination date until the earlier of the step down of care or midnight on the 90th day subsequent to the Agreement termination date;	Yes
(12) The Contractor must forward to the successor contractor on a weekly basis all misdirected authorization requests received by the contractor after the Agreement termination date for a period of ninety (90) days.	Yes
(13) 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, receipt of all information necessary to transfer administration of 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. We have a project schedule that is very comprehensive and will supply the necessary information to provide a seamless process as to not disrupt the enrollee's treatment process.

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.

Our highest priority is to ensure that the transition process safeguards the continuity and quality of care that your enrollees receive, avoids client disruption and minimizes as well as mitigates transition risks on behalf of the Empire Plan. To this degree, we will commit in not only providing the required data to the successful contractor, but we will provide them with the necessary knowledge transfer and support that will offer them a more thorough understanding of the data we supply (e.g. enrollees in care, Intensive Case Management cases, coordination of benefit data, paid claims history).

(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 transferring duties to a successor contractor. Include a brief explanation on how you would accomplish this with the successor contractor.

TRANSITION PLAN KEY ELEMENTS

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 in treatment to the next level of care necessary.

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 the Empire Plan.
- **Claims:** Determine what claims data needs to be sent and to whom, what information needs to be forwarded and what steps are needed to resolve financial questions. We will also ensure

that all work queues are worked to completion and develop scripts for staff members resolving claims.

- **Clinical:** Review authorizations for ongoing care beyond the termination date, establish care coordination meetings for complex or special needs cases, furnish pending and open authorization data to the Empire Plan 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 for handling appeals through the run out period.
- **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 Empire Plan, record auto-attendant message about account transition on the customer service line, and plan for final termination of that phone number, when appropriate.
- **Finance:** Determine run out period. Close bank accounts, as appropriate.
- **Network:** Field provider inquiries about transition.
- **Quality management:** Establish workflows for complaints and grievances received after contract end date, coordinate the transfer of enrollees information for those in the Disease Management Programs.
- **Reporting:** Establish final reporting requirements and time frames, forward appropriate data to new vendor, and the Empire Plan as required.

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 dedicated customer service and clinical management for a minimum of four months after the termination of the Agreement. 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 the Empire Plan 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, claims, and customer service. We also conduct weekly meetings with our client to ensure that all communication channels are open. ValueOptions' customer service, claims and clinical management services provided during a program transition period will include:

- Working with the Empire Plan 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 Empire Plan 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

Below we have outlined the specific milestones that would be included in our transition plan.

Task Name
Execute Transition Plan
Submit Transition Plan for review and approval
Telecom Setup
Conduct Coordination Meeting
Exchange POCs and Contact Information with Successor
Submit cut-over scripts for review and approval
Record cut-over scripts
Complete configuration of ACD changes
Conduct Clinical Transition Coordination Meeting
Begin data file format discussions
Determine coordination of ICM, IP and ALOC cases with Successor
File Generation

Task Name
Agree on formats and date-specific delivery for all files
Open authorization files
Open ICM case files
Coordination of benefit records
Transition Complete

(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 standard. 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 (or the Contractor's proposed access standards, if greater) throughout the term of the Agreement.	Yes
(2) The MHSA Program requires that the Contractor have available to Enrollees on the Implementation Date 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 if the Provider is a high volume provider or 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.	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 Masters Level Clinician (MLC) (in NYS, MLCs must qualify for the "R" designation issued by the State Education Department; elsewhere, they must have the highest licensure offered in the state for a MLC) 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 and optional eleven (11) month extension period, if exercised at the sole discretion of the Department, that at least ninety percent (90%) of the Providers in each of the Facility or	Yes

Section 10: Network Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician who qualifies for the "R" designation in NYS or in other states as Masters Level Clinician with highest licensure, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner-Other Prescriber), listed on Exhibit I.Y.2; will be maintained. Providers who are retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee. This standard shall be measured annually.	
(6) Network Provider Access Guarantee: The Contractor must guarantee that effective the first day of the month following 90 day implementation period after OSC approves the Contract, and throughout the term of the Agreement: 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, ALOC and Outpatient Clinic Group for Mental Health and Substance Abuse combined) and Network Practitioner types (Psychiatrist; Psychologist; Masters Level Clinician combines) for a total of six (6) separate guarantees. These guarantees are based on the distance, in miles, from a MHSA Program Enrollee's home address to the nearest MHSA Provider Network Provider location.	Yes

Section 10: Network Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
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).	
(7) Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Guarantee: The Contractor must propose a guarantee for access to Network Certified Behavioral Analysts and Applied Behavioral Analysis Facilities that will be effective the first day of the month following 90 day implementation period after OSC approves the Contract, and throughout the term of the Agreement	Yes
Provider Credentialing	
(1) The Contractor must assure its MHSA Provider Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.	Yes
(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

Section 10: Network Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(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
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 XIV, "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	Yes

Section 10: Network Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
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; (e) Outcome and Quality Measurement analysis; and (f) Maintaining an ongoing training and education program that will be offered to Network Providers.	
Value Based Initiatives	
(1) The Contractor must establish a tiered MHSA Provider Network and/or incentives including but not limited to financial, administrative and continuing professional education to promote value-based MHSA Services and enhance Provider performance and clinical outcomes.	Yes

PROVIDER NETWORK

(1) Propose access guarantees for the MHSA Program's Provider Network (excluding Certified Behavior Analysts, Applied Behavior Analysis Agencies, Mental Health & Substance Abuse Practitioners – Other Prescribers) 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
%		

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

(2) Understanding that Applied Behavioral Analysis is often provided in a home setting and it is most applicable to young children, confirm which of the sixty-two (62) counties within the State of New York are served by Network Certified Behavioral Analysts and Applied Behavioral Analysis Agencies.

Below is a listing of the 62 counties within the State of New York. In the right hand column, we list whether or not ValueOptions currently has a Certified Behavioral Analysts or Applied Behavioral Analysis Agencies in our network who covers this county. For those in which we do not currently have a provider, we are either recruiting or there is not a Certified Behavioral Analysts or Applied Behavioral Analysis Agency in the area. This is noted in the chart as well.

We are committed to continuously recruit Certified Behavioral Analysts and Applied Behavioral Analysis Agencies throughout the life of our Empire Plan contract. ValueOptions maintains a high level working group to stay abreast of emerging trends and to identify and recruit new providers in New York. We have collaborated with the New York State Association for Behavior Analysis on opportunities to recruit their members as well as provide education on managed care. **Access to Certified Behavioral Analysts and Applied Behavioral Analysis Agencies by County Across the State of New York**

County	Served by ValueOptions' Network Certified Behavioral Analysts and Applied Behavioral Analysis Agencies?
Albany	No (recruitment in progress)
Allegany	No (recruitment in progress)
Broome	No (recruitment in progress)
Bronx	Yes
Cattaraugus	No (recruitment in progress)
Cayuga	No, there are no providers available to recruit
Chautauqua	No (recruitment in progress)
Chemung	No, there are no providers available to recruit
Chenango	No, there are no providers available to recruit
Clinton	No, there are no providers available to recruit
Columbia	Yes
Cortland	No, there are no providers available to recruit
Delaware	No, there are no providers available to recruit
Dutchess	Yes
Erie	Yes
Esses	No, there are no providers available to recruit
Franklin	No, there are no providers available to recruit
Fulton	No (recruitment in progress)
Genesee	No (recruitment in progress)
Greene	Yes
Hamilton	No, there are no providers available to recruit
Herkimer	No, there are no providers available to recruit
Jefferson	No, there are no providers available to recruit
Kings	Yes
Lewis	No, there are no providers available to recruit
Livingston	No, there are no providers available to recruit
Madison	No, there are no providers available to recruit
Monroe	No (recruitment in progress)
Montgomery	No (recruitment in progress)
Nassau	Yes
New York	Yes
Niagara	No (recruitment in progress)
Oneida	No
Onondaga	No
Ontario	Yes
Orange	No (recruitment in progress)
Orleans	No (recruitment in progress)
Oswego	No
Otsego	No, there are no providers available to recruit
Putnam	Yes

We are committed to continuously recruit Certified Behavioral Analysts and Applied Behavioral Analysis Agencies throughout the life of our Empire Plan contract. ValueOptions maintains a high level working group to stay abreast of emerging trends and to identify and recruit new providers in New York. We have collaborated with the New York State Association for Behavior Analysis on opportunities to recruit their members as well as provide education on managed care. **Access to Certified Behavioral Analysts and Applied Behavioral Analysis Agencies by County Across the State of New York**

County	Served by ValueOptions' Network Certified Behavioral Analysts and Applied Behavioral Analysis Agencies?
Queens	Yes
Rensselaer	No (recruitment in progress)
Richmond	Yes
Rockland	Yes
Saratoga	No (recruitment in progress)
Schenectady	No (recruitment in progress
Schoharie	No, there are no providers available to recruit
Schuyler	No, there are no providers available to recruit
Seneca	No, there are no providers available to recruit
St. Lawrence	No, there are no providers available to recruit
Steuben	No, there are no providers available to recruit
Suffolk	Yes
Sullivan	No, there are no providers available to recruit
Tiago	No, there are no providers available to recruit
Tompkins	No, there are no providers available to recruit
Ulster	Yes
Warren	No, there are no providers available to recruit
Washington	No, there are no providers available to recruit
Wayne	No, there are no providers available to recruit
Westchester	Yes
Wyoming	No (recruitment in progress)
Yates	No, there are no providers available to recruit

(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 current contract holder, ValueOptions consistently meets access guarantees for enrollees. While we already have a robust network of 12,789 providers throughout New York, we are committed to continuing to recruit providers to our network to ensure adequate access to all provider types for your enrollees. Sources for provider recruitment include but are not limited to:

- Referrals from providers who are already under contract with ValueOptions. Network referrals ensure the recruitment of providers who will bring not only their individual talents, but who will work cooperatively with their peers to provide clinically sound, cost-effective behavioral health care services.
- Recommendations from network institutional providers that meet ValueOptions' credentialing criteria.
- Recommendations from Plan enrollees and stakeholders.
- New York-based ValueOptions 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.

DISRUPTION

ValueOptions conducted a data match of the claims information provided, representing both in– and out-of-network providers, to our current network. We developed our match to the best of our ability given the scope of the provider identifiers included in the data set. 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. In any disruption analysis to determine network access, there are inevitable differences in the manner in which network provider profile data is maintained. These differences can make it difficult to ensure a complete and accurate match has been accomplished. Given this, it is possible that our true match may be higher than that reflected in our submission.

In the period in which we have been engaged under the emergency contract we have initiated outreach to providers identified as non-network to minimize the disruption to Empire Plan members. We have prioritized this effort by historical service volume. Our results in response to this RFP reflect the network access improvements we have achieved to date. We are committed to continuing these efforts to ensure the highest level of access possible. In addition to historically high volume providers, we are also focusing on areas identified to be underserved. We will continue to take direction from the Empire Plan on recruitment of providers deemed to be important to the overall value of the program.

(4) Please confirm that if selected, you will provide an updated **Exhibits I.Y.2, I.Y.3** and **I.Y.4** thirty (30) days prior to the Implementation Date confirming that the Offeror's proposed Provider Network will be implemented as required on the first day of the month following a 90 day implementation period after OSC approves the Contract. 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** 30 days prior to the Implementation Date confirming that our proposed provider network will be implemented as required on the first day of the month following a 90 day implementation period after OSC approves the contract.

(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. Provide a listing of Comprehensive Care Centers for Eating Disorders and continuum of care providers (as established by Article 27-j of the NYS Public Health law) that 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 12,789 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. 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' enrollees.

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. **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).

3. 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).

4. 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).

5. 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).

6. 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).

7. 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).

8. 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).

9. 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).

10. 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
- Dialectical Behavior Therapy
- 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' 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.

Additional criteria used for facilities that are not accredited, or facilities located in a State that does not license the program being credentialed, are listed 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.

OASIS 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

OASIS FACILITY NAME	CITY
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
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

OASIS FACILITY NAME	CITY
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
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

OASIS FACILITY NAME	CITY
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
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

OASIS FACILITY NAME	CITY
ELLIS HOSPITAL	SCHENECTADY
ELMHURST HOSPITAL CENTER	ELMHURST
EMPLOYEE ASSISTANCERESOURCE SERVIC	SMITHTOWN
EXODUS CLINIC LLC	MONROE
FAMILY AND CHILDRENSASSOCIATION	HICKSVILLE
FAMILY AND CHILDRENSASSOCIATION	WEST HEMPSTEAD
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

OASIS FACILITY NAME	CITY
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
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

OASIS FACILITY NAME	CITY
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
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

OASIS FACILITY NAME	CITY
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
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

OASIS FACILITY NAME	CITY
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
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

OASIS FACILITY NAME	CITY
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
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

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

Comprehensive Care Centers for Eating Disorders and Continuum of Care Providers

Primary care physicians, pediatricians and mental health care providers are among the treatment resources available for patients and their families. In addition, the New York State Department of Health has identified seven Comprehensive Care Centers for Eating Disorders which specialize in providing comprehensive and integrated treatment specifically for patients with eating disorders. The Comprehensive Care Centers for Eating Disorders provide inpatient and outpatient services and ensures the patient's care is integrated across care settings through clinical collaboration among the providers. Of these seven facilities, listed below, three are part of ValueOptions contracted network and two are pending.

Northeast Comprehensive Care Center for Eating Disorders (NECCCED):

- Albany Medical Center, Albany New York **(Contracted ValueOptions provider)**
- Four Winds Hospital - Saratoga, Saratoga Springs, New York **(Contracted ValueOptions provider)**

Metropolitan Comprehensive Care Center (Metro):

- Columbia University Medical Center, New York State Psychiatric Institute, New York City
- Schneider Children's Hospital, Long Island Jewish Hospital, Lake Success, New York **(Contracted ValueOptions provider)**
- New York Presbyterian Hospital, Westchester Division/Weill Cornell Medical Center, White Plains NY

Western New York Comprehensive Care Center for Eating Disorders
The Eating Disorders Recovery Center of Western New York:

- Golisano Children's Hospital at Strong Memorial Hospital, Rochester New York (Contracted ValueOptions provider **(Pending)**
- Unity Health Care System, Rochester New York **(Pending)**

(6) For the Master Level Clinician category, provide a chart listing the licensure types that you include in your network in each State and indicate which of those licensure types the Offeror considers to be the highest licensure type in each State.

We provide a chart listing the licensure types that we include in our network in each State and indicate which of those licensure types we consider to be the highest licensure type in each state as **Attachment 8**.

(7) Explain how you determine the highest licensure type in each State.

ValueOptions works with the licensing body appropriate within each state to identify the highest licensure level for a given profession within that state. The highest level as determined by the state is taken from each states' licensing board website and we populate an internal grid that becomes the basis for our credentialing process. ValueOptions sets its credentialing requirement at the highest level of licensure for each state within which we operate.

(8) 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

ValueOptions currently provides the most extensive and comprehensive network for the Empire Plan that the state would be able to attain. We 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 12,789 in the state of New York.

Our network currently meets the Empire Plan’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 Latham, 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. We provide the Empire Plan with progress reports detailing the contracting status of each provider under recruitment. As we conduct ongoing network recruitment, we will continue to work with you to evaluate the comprehensiveness of our network by provider type, and by reviewing provider access.

We also use the following sources for potential provider recruitment:

- Potential providers identified during ongoing ValueOptions recruitment efforts.
- Referrals from network providers who are already under contract with ValueOptions. Network referrals ensure the recruitment of providers who bring not only their individual talents, but 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.
- Latham, 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.

(9) Describe the criteria the Offeror will use to determine Providers to recruit into the Network to allow Enrollees to continue successful therapy plans with current Network Providers that are not in the Offeror's Network or who are in an underserved area.

PROVIDER RECRUITMENT

ValueOptions continuously monitors for any gaps via network analysis, the review of claims data to identify high-volume out of network providers and via any single case agreements with providers. Based upon this monitoring, we develop a list of key behavioral health care providers for recruitment.

Our Provider Relations staff contacts identified providers to recruit. All providers are subject to meeting our credentialing criteria defined for the respective licensure levels.

In addition, if a deficiency is identified, we use our current network providers to solicit peer recommendations of qualified providers in the deficient area. We also draw upon the following sources for potential provider recruitment:

- potential provider identified during ongoing ValueOptions recruitment efforts (ValueOptions maintains an extensive nationwide database of potential providers)
- recommendations from facility providers in the area(s) that meet ValueOptions' credentialing criteria
- national associations in the disciplines desired (e.g., APA, NASW)

Through network referrals, we 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.

In situations of new enrollees to the Empire Plan who may be in treatment with a provider not in the ValueOptions network, our team will work with the provider to ensure a smooth transition of care. Continuity of care and the enrollee's well-being will always be ValueOptions' primary concern. The goal is to assist the Empire Plan enrollees in receiving care without disrupting their present course of treatment, and without compromising the positive therapeutic results they may be experiencing. We work together to determine the length of the transition period, and to determine what qualifications treating providers need to meet for reimbursement eligibility during the transition period as we attempt to recruit the provider.

In areas that may be underserved by in-network providers, ValueOptions would enter into a Single Case Agreement with a provider to ensure enrollees had access to care while we attempted to recruit any qualified, available providers in that geographic area.

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

We will continue to support the Empire Plan throughout the life of our partnership to recruit, credential, and contract a comprehensive behavioral health network that ensures enrollee choice and access. Our network management and development efforts are supported by a team of expert staff who has 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 Latham, New York-based provider relations and contracting staff that is community-based and has built credibility with the provider network.

Our dedicated Latham 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 is led by our Provider Relations Director located in Latham, New York, who is dedicated and full-time to this program. The Provider Relations Director has responsibility for managing the adequacy and availability of the provider network and recruiting providers to meet enrollee geographic and clinical specialty needs.

We 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 is analyzed each quarter, and providers are actively recruited to maintain network integrity and fill any identified gaps. We use geographical analysis, ease of scheduling, scheduling audits, and enrollee feedback as the means of monitoring overall appropriateness of the network.

(11) 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.

(12) 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 and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters level Clinicial (MLC) who qualifies for the "R" designation in NYS or a MLC with highest licensure in other states, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner – Other Prescriber), listed on Exhibit I.Y.2; will be maintained throughout the five-year term of the Agreement and optional eleven (11) month extension. Providers who are retired, deceased or 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 and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician (MLC) who qualifies for the "R" designation in NYS or a MLC with highest licensure in other states, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner – Other Prescriber), 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 and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters level Clinicial (MLC) who qualifies for the "R" designation in NYS or a MLC with highest licensure in other states, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner – Other Prescriber), listed on Exhibit I.Y.2 as calculated on an annual basis is $_____. Providers who retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee.

NETWORK COMPOSITION GUARANTEE

[redacted]

(13) 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 Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) 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 Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) 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 Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) 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 Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) 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 Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) 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 Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) 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 (Psychiatrist, Psychologist and Master's Level Clinician, combined) 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 (Psychiatrist, Psychologist and Master's Level Clinician, combined) 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 (Psychiatrist, Psychologist and Master's Level Clinician, combined) 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 (Psychiatrist, Psychologist and Master's Level Clinician, combined) Access-for Suburban Areas Guarantee is not met by the Offeror.

NETWORK PRACTITIONER ACCESS FOR SUBURBAN 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 Practitioner (Psychiatrist, Psychologist and Master's Level Clinician, combined) 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 (Psychiatrist, Psychologist and Master's Level Clinician, combined) 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]

(14) Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee: (The Offeror must quote a performance standard and amount to be credited against the Administrative Fee for access that is below the Offeror's proposed guarantee for any quarter in which the Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee is not met by the Offeror.)

Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee

[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 ensures 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 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 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 was accredited by NCQA as a CVO (credentialing verification organization) in December, 2012. 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. We will not use external credentialing organization. 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 re-credentialing 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:

- re-credentialing 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 re-credentialing 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.

ValueOptions also participants with The Council for Affordable Quality Healthcare, a nonprofit alliance of health plans and trade associations designed to simplify healthcare administration. CAQH UPD is an online provider data-collection service. It streamlines provider data collection by using a standard electronic form that meets the needs of nearly every health plan, hospital and other healthcare organization. UPD enables physicians and other healthcare professionals in all 50 states and the District of Columbia to enter information free-of-charge into a secure central database, then authorize healthcare organizations to access that information. UPD eliminates redundant paperwork and reduces administrative burden.

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 Enrollee

When a provider has been removed from our provider network, we send written notification at least 30 calendar days prior to the effective date of provider disenrollment to those enrollees with open authorizations or a claim with a date of service within the past six months of the effective date of disenrollment. This notification to enrollees includes any rights they may have to continue services with the provider, and information on assistance in the selection of a new provider.

Notification of the Department

For any provider termination that would have an effect on an Empire Plan enrollee, notification will come from Jennifer Campione and the Account Services department. 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?

Keeping Abreast of Provider Practices, Attitudes, and Concerns

We 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 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 are 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

Provider Relations Staff in New York State

ValueOptions is committed to retaining a local, New York-based team of Provider Relations professionals. We have nine New York state-based staff who support the Empire Plan account. These staff members 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 Latham, New York-based team to support the Empire Plan network. This professional group maintains rapport with our providers through regular meetings with 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 enables 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.

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 has offered 47 training forums year-to-date in 2014, reaching a total of 1,300 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.


May 2014

VALUED PROVIDER eNEWSLETTER

SPOTLIGHT:

SCHIZOPHRENIA IN TEENS

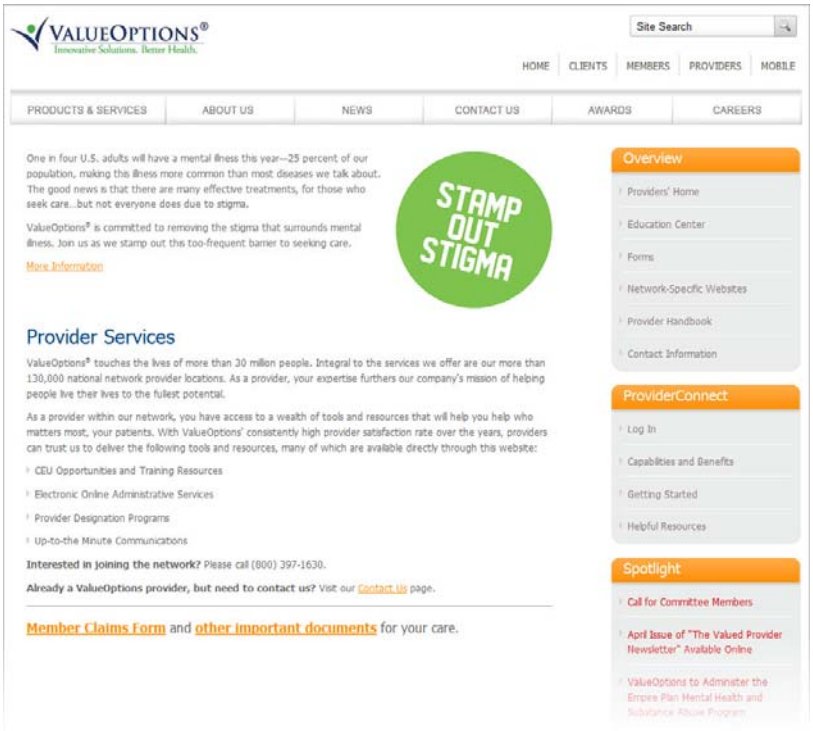
VALUEOPTIONS® GOES ELECTRONIC:
PREPARE NOW FOR VALUEOPTIONS' F-COMMERCE JANUARY 2015 DEADLINES

UTILIZE CAQH TO CREDENTIAL OR RECREDENTIAL WITH VALUEOPTIONS®

- **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 Empire Plan 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 to 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

"I am very pleased with the ProviderConnect software. It facilitates claims submission and expedites payment, both of which are very important to me in my practice."

Lawrence Bauman, New York Provider

(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 is 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 offers 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 dedicated Clinical 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.

IMPROVING DIAGNOSIS AND ASSESSMENT ABILITIES

The ValueOptions' On Track Outcomes Program is designed to help clinicians incorporate patient-reported feedback into their counseling and psychotherapy practices. A growing body of research demonstrates the power of this type of routine feedback to improve patient outcomes. The On Track program gives clinicians valuable tools to track patient progress relative to benchmarks, to identify clients at risk for poor outcomes, and to demonstrate the impact of their services. On Track is based on a brief patient-completed assessment and online reports.

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 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.

We coordinate with Primary Care Physicians for enrollees with certain behavioral health diagnoses, such as Eating Disorders, Substance Abuse (especially for prescription drug abuse and Chronic Pain). These diagnoses are typically associated with high levels of medical comorbidity and/or utilization of medical services. Proper management of these cases usually needs coordination between the Medical and Behavioral Health providers and vendors.

In these cases, ValueOptions dedicated Clinical Care Managers facilitate the appropriate coordination between the Primary Care Physicians and the behavioral health providers. These interventions may range from something such as ensuring that a Release of Information that allows the appropriate exchange of information between providers to holding conference calls with providers, our dedicated Clinical Care Managers, the Medical Care Manager and one of our three onsite, full-time psychiatrists.

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 continue to 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.).

ValueOptions takes a two-fold approach in performing a competitive analysis of network provider reimbursement: evaluation is internal through our National Network Services Leadership team and external through outreach to our network providers during our annual provider survey. On at least a bi-annual basis, all of ValueOptions' fee schedule rates are reviewed against available state Medicaid and Medicare reimbursement rates, and other trends and data obtained to determine ValueOptions' competitiveness in the marketplace.

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.

ValueOptions is actively engaging in the introduction of innovative payment models and 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.

(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 9**.

(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	2013	2012	2011
Voluntary Terminations:			
Dissatisfaction with fees	74	43	81
Disagreement with clinical decision	0	0	2
Dissatisfaction with administrative process or paperwork	0	0	0
Dissatisfaction with contractual terms	33	31	41
Other (describe)	792	729	737
Total Voluntary terminations	899	803	861
Number of Network Providers on December 31st	53,957	55,101	53,109
Voluntary terminations as a 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 an enrollee 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 negotiate a case rate with the non-network provider and begin recruiting efforts to enlist the provider into our network.

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

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 enrollee 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
- dedicated Clinical 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 the Empire Plan 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 performs 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 Empire Plan on a quarterly basis.

Financial/Fraud and Abuse Audits

As evidence of our support, we provide financial/fraud abuse reports on a quarterly basis.

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 two types of audits:

1. **Discovery Audits**—Audits including smaller samples of claims to identify potential patterns or errors and an estimated error rate. These audits may be used to determine if a Full Audit is warranted.
   i. Desk Audits include a random or focused claims sample and medical records that providers scan or mail to the auditors. Entrance and exit meeting are conducted via telephone/conference calls.
   ii. On-Site Audits are conducted at the provider's facility. Entrance and exit meetings are conducted on-site, directly with provider staff.
2. **Full Audits**—Comprehensive audits that include larger volumes of claims or services where fraud, waste or abuse is suspected and potential recoveries or reimbursements are likely. These audits are detailed investigations, often targeting specific issues that may include all areas relevant to the proper payment of funds and incorporate other departments such as clinical, quality management, or credentialing. Full Audits can also be conducted as a Desk Audit or On-Site Audit.

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?

CORRECTIVE ACTION AND PROVIDER MONITORING

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 the Empire Plan, data mining, trending and analysis of reports, media reports, 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 use an array of tools to evaluate provider compliance. This may include, but is not limited to:

- Evaluation of the reasons for the referral
- Evaluation of any supporting documentation
- Review of historical data for previous referrals for similar reasons
- Evaluation of the potential magnitude of the problem
- Review with other appropriate internal resources
- Member/beneficiary verification of services
- Review of additional evidence related to the allegation, such as:
  - Research – Google maps search of physical address to ensure legitimate clinic, practice and/or provider location;
  - NPI Verification – Confirmation of billing and rendering provider, via the National Plan & Provider Enumeration System (NPPE) website. Verification that the provider has an individual, group or facility NPI and comparison of the provider's status in ValueOptions' systems.
  - Licensure – Verification that the provider's license is current and that there aren't any actions on their record.
  - Exclusions – Screening the provider against any applicable state exclusion databases and the OIG's LEIE website to ensure the provider is not an excluded provider.

We 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 may investigate any unexplained differences in the following:

- enrollee name
- dates of service
- place of service
- 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 develop an educational program to review deficiencies identified, and provide tools to assist the provider in correcting such deficiencies
- **Corrective Action Plan**—We 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 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 is 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 require additional monitoring of a provider's claims submissions and treatment records for additional time periods of six to 12 months.
- **Network Termination**—If, after the audit, there is a suspicion that the provider has engaged in fraudulent activity, our Special Investigations Unit staff will recommend that the provider be terminated from the network.
- **Reporting to State and Federal Agencies**—Depending upon state contractual requirements, the auditor will report suspicion or knowledge of fraud, waste or abuse to the appropriate state, legal or law enforcement agencies prior to initiating any action or recoupment efforts.

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 reports 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. SIU also conducts random audits.

The SIU conducts a majority of audits by reviewing records, but in some instances on-site audits are performed as well. Record review audits entail requesting an initial sample5 of records from the provider/participating provider to compare against claims submission records. Following the review of the initial sample, ValueOptions may request additional records. Records reviewed may include, but are not limited to, financial, administrative, current and past staff rosters, and treatment records. For the purpose of SIU audits, the "treatment record" includes, but is not limited to progress notes, medication prescriptions and monitoring, documentation of counseling sessions, the modalities and frequency of treatment furnished, and results of clinical tests. It may also include summaries of the: diagnosis; functional status; treatment plan; symptoms, prognosis; and progress to date.

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.

(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 XIV, "Payments/ (credits) to/from the Contractor" and Appendix B of Section VII.

ValueOptions confirms that we will continue to remit 100 percent of provider and enrollee audit recoveries to the Department within 30 days of receipt consistent with the process specified in Section XIV, "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.

ValueOptions utilizes a variety of methods to prevent the payment of potentially fraudulent claims. 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

[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.*

- 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.

(6) Describe the Offeror's ongoing quality assurance procedures for Network Practitioners. With respect to Network Practitioners, do you;
(a) Share practice pattern with the respective Network Practitioners?
(b) Validate patient satisfaction?

ValueOptions maintains an automated database that tracks claims-based performance data on all contracted network practitioners who have members in outpatient treatment. As a re-credentialing tool, the standard performance report covers a three-year period and is designed to capture relevant events between re-credentialing cycles. As a quality improvement tool, key performance indicators identify patterns of care and are designed to support national and regional comparative analyses. Analysis can be performed on an individual practitioner basis or in aggregate across provider and/or member groups. This system of analysis provides ValueOptions with monitored data that ensures quality services with positive clinical outcomes. The data is used to evaluate the successes and weaknesses of service delivery, determine the need for training, and examine the need for new clinical protocols. It also satisfies national accreditation and quality assurance reporting requirements for practitioner credentialing, utilization management, and quality of care activities.

As part of the Continuous Quality Improvement process, this measurement system allows ValueOptions to objectively assess the outcomes of care and to identify best practices for targeted populations. The database includes a wealth of information, and measures currently reported track both utilization and quality of care activities. Each performance indicator reported has a specific measure, a performance standard, and a performance improvement strategy.

Other information routinely reported addresses:

- general utilization statistics, including total number of members seen and average number of sessions over a two-year period
- case mix and volume data, including average number of sessions and enrollee episodes of care for 13 different diagnostic categories
- quality of care measures based on ValueOptions' clinical guidelines and the American Managed Behavioral Healthcare Associations' (AMBHA) Performance Measures for the Managed Behavioral Healthcare Programs (PERMS)

ValueOptions' quality management, provider relations and clinical departments monitor network therapists and other providers through:

- credentialing
- re-credentialing
- ValueOptions' Provider Quality Performance Tool
- case activity audits
- clinical treatment record reviews
- outlier reporting
- reports that measure their capacity to meet ValueOptions' access standards
- recidivism and relapse rates
- complaints and grievances
- responsiveness to Clinical Care Manager and Peer Advisor recommendations
- enrollee satisfaction

(a) Share Practice Pattern with the Respective Network Practitioners

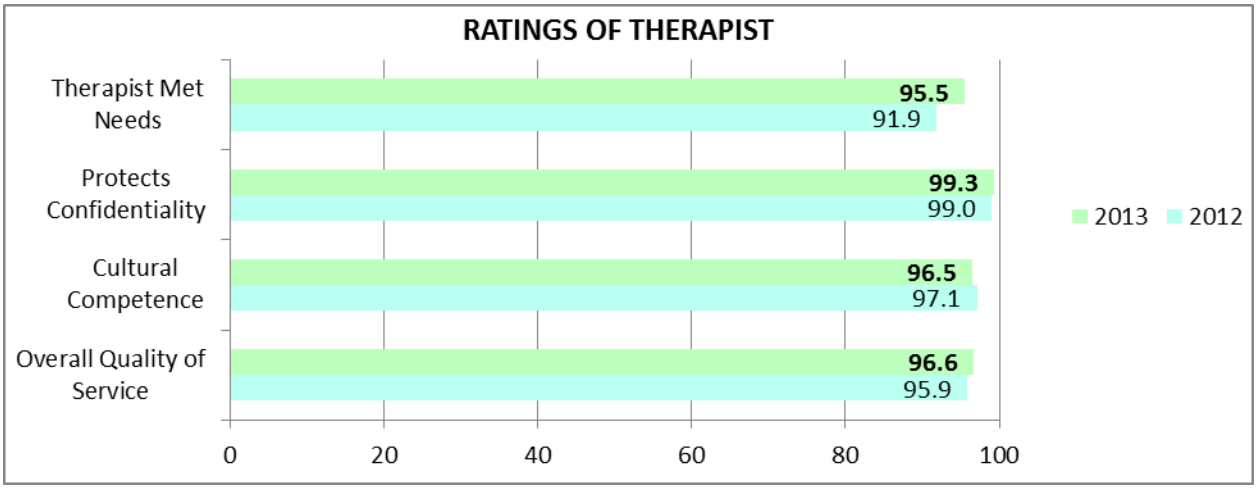
Yes, we share practice pattern with the respective network practitioners—twice a year—via provider report cards. ValueOptions has developed provider report cards for inpatient and outpatient providers to determine if the provider has engaged the enrollee regarding their medical care. For example, one of the areas addressed as part of this report card is "How many well-child care visits have been attended?" Based upon the findings of the report card, ValueOptions will recommend the provider encourage the enrollee to seek treatment from their PCP. In addition, our OnTrack Outcomes Program provides valuable information about treatment progress compared to benchmark norms, providing an indication of how the enrollee's change on the Global Distress Scale (GDS) compares to expected change based on data from comparable cases in the database.

(b) Validate Patient Satisfaction

ValueOptions validates patient satisfaction with network practitioners on an ongoing basis. Our annual enrollee satisfaction survey process has been developed to measure key indicators of quality care and services. The questionnaire used to survey ValueOptions enrollees includes questions that specifically assess quality of services received from ValueOptions practitioners. Enrollees are asked to rate their provider on the following dimensions:

- Do you feel your therapist is just right for your needs?
- Do you feel your therapist protects confidential information?
- Do you feel your therapist is able to meet your cultural, religious and language needs?
- Overall, would you rate the quality of service you receive form your therapist as excellent, very good, good, fair or poor? *(Positive result =% excellent + very good + good)*

The below table reflects the Latham Engagement Center enrollee satisfaction results for 2012 and 2013. In 2013, overall quality of service received was rated 96.6 percent.



ValueOptions also validates patient satisfaction by conducting a full investigation of any enrollee quality of care concerns. ValueOptions defines a quality of care issue as any action or failure to take action on the part of a provider that has the potential to decrease the likelihood of a positive health outcome and/or is inconsistent with current professional knowledge and/or puts the safety of the enrollee at risk. Quality of care issues are categorized as follows:

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

Potential quality of care (QOC) issues may be reported or identified by members or their authorized representatives, any ValueOptions staff during their interactions with members or providers, client representatives, and other external sources. On receipt of a potential QOC issue, it is the responsibility of the ValueOptions staff member receiving or identifying the issue to document the information and forward it to the Latham Quality Management (QM) department for investigation and review by the Latham Engagement Center's Quality of Care Committee. In urgent situations, the QOC issue is immediately relayed to the Medical Director and/or Clinical Director.

The QM Department investigation activities include but are not limited to: Requesting sections of medical records that are pertinent to the issue, contacting the enrollee or their representative for further information if needed, and contacting the provider to obtain additional information or to discuss the issue. The investigation findings are then shared with the Quality of Care Committee (QOCC), which is co-chaired by the Medical Director and Quality Management Director. The QOCC's responsibilities include:

1. Review and evaluation of individual cases and supporting documentation involving potential quality of care issues
2. Oversight of the investigation of potential quality of care issues

3. Determining risk ratings and disposition of quality of care issues
4. Implementing appropriate corrective action plans and overseeing progress through completion
5. Review and evaluation of aggregate data concerning quality of care issues to identify trends or patterns of possible substandard quality of care
6. Reporting any recommendations regarding a practitioner's participation status to the ValueOptions' National Credentialing Committee.

(7) Describe the Offeror's ongoing quality assurance procedures for Network Facilities including inpatient, ALOC and other healthcare Facilities. With respect to Network Facilities do you:
(a) Require that treatment protocols be used?
(b) Investigate whether changes to quality controls are made after adverse outcomes?
(c) Monitor readmission rates after inpatient discharge?

ValueOptions executes comprehensive quality assurance procedures for Network Facilities to ensure quality care.

(a) Require that Treatment Protocols be Used

Yes, ValueOptions requires that providers follow evidenced-based treatment protocols. Our Service Authorization and Utilization Management (UM) program promotes the delivery of superior clinical quality and services that are consumer-focused, clinically appropriate, cost-effective, data-driven, and culturally competent. Interaction between our dedicated Clinical Care Managers and the provider community is critical in shaping the way services are delivered. The ValueOptions Diagnosis-Based Treatment Guidelines support the use of evidence-based and best practices that are consistent with national standards. These guidelines are peer reviewed, consistent with, and based upon independent professional medical societies' treatment guidelines (American Psychiatric Association, American Academy of Child and Adolescent Psychiatry), national health related organizations recommendations (SAMHSA, AHRQ, NIMH), clinical thought leaders' expert consensus, and peer reviewed behavioral health literature. Our Executive Medical Management Committee is dedicated to the review of evidence based guidelines for inclusion in our provider handbook and makes these guidelines available on our provider website. The Executive Medical Management Committee assigns a workgroup to study diagnostic and treatment information of a targeted disorder or treatment modality through:

1. a review of the scientific, professional, and clinical literature
2. input from National and Engagement Center Clinical Advisory Committees, UM, and Quality Management Committees and subcommittees
3. input from providers, community agencies, and enrollees at the engagement center level
4. input from provider at a national level
5. a review of published guidelines

In our current prior authorization model, dedicated Clinical Care Managers review the authorization request forms and additional materials submitted to verify that the service levels, intensity, and frequency are consistent with medical necessity criteria and evidence-based practices. Our Clinical Care Managers have been trained to look for documentation notating provider use of evidence-based and best practices as part of the review process. The Medical Necessity Criteria utilized by our Clinical Care Managers in the utilization review process are reflective of adherence to clinical best-practice standards. Our Clinical Department Managers and Clinical Director are responsible for ongoing staff training to ensure that the clinical staff remain current in their knowledge of evidence-based treatment protocols. This is achieved through 1:1 clinical staff orientation, group training seminars, monthly staff in-services, and daily clinical rounds with the dedicated Medical Director to ensure that each Clinical Care Manager is competent in assessing for evidence-based best practices. When a Clinical Care Manager identifies as part of the review process that a quality of care concern is evident, these concerns are discussed with the Director of Clinical Services and the Medical Director and referred to our Quality Department, which then tracks and trends these concerns and requests facility/provider records as appropriate.

(b) Investigate Whether Changes to Quality Controls are made after Adverse Outcomes

The Latham Engagement Center Quality of Care Committee (QOCC) investigates the need for and ensures that any necessary changes to quality controls are made after adverse outcomes for enrollees. ValueOptions defines an adverse incident as an occurrence that represents actual or potential serious harm to the wellbeing of an enrollee or to others by an enrollee while the enrollee is in treatment or recently discharged. All clinical staff receives training from the Quality Management Director on the identification and reporting of adverse incidents. Adverse incidents include, but are not limited to, the following categories of alleged occurrences:

1. Self-inflicted harm requiring urgent or emergent treatment (e.g., self-mutilation or attempted suicide)
2. Unanticipated death occurring in any setting (e.g., suicide, homicide, death by medical cause)
3. Violent/Assaultive behavior with physical harm to self or others (e.g., attempted murder, physical assault) and requiring urgent or emergent medical intervention
4. Serious adverse reaction to treatment requiring urgent or emergent medical treatment in response (e.g. neuroleptic malignant syndrome, tardive dyskinesia, other serious drug reaction)
5. Sexual behavior with other patients or staff, whether consensual or not, while in behavioral health treatment setting.
6. Elopements from a behavioral health treatment setting when the patient is considered or alleged to be a danger to self or others.
7. Injuries (e.g. accidents) in a behavioral health treatment setting that require urgent or emergent treatment
8. Property damage due to the intentional actions of an enrollee while in a behavioral health treatment setting
9. Medication errors resulting in the need for urgent or emergent intervention.
10. Human Rights Violations (e.g. neglect, exploitation)

Adverse incident investigations are undertaken to determine if there is reason to believe that an incident resulted, in whole or in part, because of deviations from a reasonable standard of care that existed or occurred at the time of the incident, and to ensure that suspected or identified deficiencies are corrected. The investigation process ensures that any potential urgent patient safety issues are evaluated and addressed and that an evaluation of the potential need for urgent provider sanction to ensure patient safety occurs. The Medical Director, or designee, is notified within 24 hours if a major adverse incident has been discovered.

When an adverse incident investigation determines that deficiencies in reasonably expected standards of care appear to exist, or appear to have existed at the time of the incident, the Medical Director or designee notifies the provider of any expected corrective action, the timeframe for completion and any period of monitoring. Any failure or refusal of a ValueOptions network provider or facility to cooperate in an adverse incident investigation is reported immediately to the National Quality Management, Provider Relations, and Legal Departments for follow-up.

The role of the QOCC is to review both individual cases and aggregate data regarding adverse incidents, identify any trends, and make recommendations regarding best practices, necessary actions and performance and safety improvements. Trend analysis also occurs at the National Quality Management (NQM) level. Suspected trends identified by NQM are reported to the appropriate Engagement Centers. Additionally suspected trends identified by the Latham Engagement Center are reported to NQM for possible further analysis and reporting. If a suspected trend is confirmed, the Latham Engagement Center evaluates necessary corrective action and ensures any necessary changes to quality controls are made.

(c) Monitor Readmission Rates after Inpatient Discharge

Yes, ValueOptions does monthly analysis of readmission rates to monitor quality of both providers and ValueOptions' utilization management and Intensive Case Management practices. Lower readmission rates demonstrate quality practices are in place around discharges and transition of care. ValueOptions—through our utilization management and Intensive Case Management processes—works to ensure timely discharge and transitions of care.

ValueOptions monitors readmission rates with the following indicators:

- by overall client
- by mental health and substance use disorders
- at, 30, 60 and 365 days frequency
- by facility
- by enrollees admitted into our Intensive Case Management program

ValueOptions uses a benchmark of an overall 10 percent readmission rate for thirty days. This percentage is calculated by readmissions to the same facility or alternate facility during the 30 day span of time. ValueOptions

Current first quarter Empire data shows readmission rates for January 2014 and February 2014 are 7.27 percent and 9.29 percent respectively.

maintains a schedule of monthly meetings with high-volume providers to review re-admission rates and does ad-hoc meetings with identified providers with consistent trending of higher than 10 percent readmission rates.

As part of our Intensive Case Management program all enrollees with three readmissions to an inpatient level of care are referred into our ICM program. More complex cases are not required to meet the criteria of three readmissions if an ICM referral is warranted beforehand.

In completing an analysis of readmission rates ValueOptions is able to identify what interventions are necessary to improve overall quality of our clinical program. Examples of program improvements that have been made due to readmission monitoring:

- Identification of facilities that do not consistently schedule follow up appointments within seven days for enrollees being discharged
- Identification of enrollees who do not follow up on their medications refills and need the additional support of daily phone call reminders to take their medications.

VALUE BASED INITIATIVES

(1) Describe the tiering criteria and/or incentives you propose for the MHSA Program to promote value-based MHSA services.

At the core of any tiering program is the establishment of clear quality standards upon which tiers can be established. At a time when resources to support behavioral health are limited, it is challenging to get providers to behavioral health providers to engage in new care delivery models. As a result, behavioral health practitioners are careful about committing to tiered network models. Hence, we developed Value Preferred Network which is a select network of quality providers and has a pay for performance component based on the clinical, quality and financial performance of their community. Care must be taken to work collaboratively with practitioners and facilities to develop standards. As noted below, ValueOptions is in the process of transforming care delivery and reimbursement with key New York providers to establish care quality and overall value as basis for network participation. Over the course of the contract period we will work closely with the Empire Plan to introduce value-based initiatives that build on ValueOptions market relationships and are customized to Empire Plan financial and benefit design requirements.

ValueOptions is in the process of introducing value-based reimbursement models (provider-at-risk and incentive driven) with New York providers that can serve as the basis for a tiered benefit program.

By incentivizing provider best practices, the performance network also offers significant value to enrollees and the Empire Plan, to include:

- Increased transparency and ease of identifying top providers
- Providers are more engaged and proactive
- Increased support during transitions of care
- Less confusion and frustration when coordinating between multiple providers
- Increased reporting and transparency
- Enrollees are more likely to see a high-quality provider and receive effective care
- Increased clinical effectiveness leading to greater administrative efficiency and decreased costs over time
- Engagement of physicians on the outpatient side, hospital /health systems and primary care physicians to participate on our Physician Advisory Committee. At this committee we discuss clinical outcomes, predictive modeling, quality and needs for our network.

(2) Describe any experience you currently have with emerging alternative care delivery models (e.g. Accountable Care Organizations – ACOs).
(a) Are you currently working with any Medicare or other ACOs? What are your goals and objectives for working with these groups?
(b) Provide an overview of the general ACO structure, including the breadth of the networks.
(c) What requirements do you have for working with these groups, such as size requirements, for credentialing; for monitoring their care and services; for measuring their quality; and for measuring and managing their cost and utilization?
(d) What are the lengths, start dates, and end dates of your existing ACO contracts?
(e) Do you use different reimbursement models with these groups? Do not include any cost information in the technical proposal.
(f) List all methods of payment utilized for your various ACO relationships.
(g) Describe steps you have taken to further integrate care, such as behavioral health, reducing readmissions and preventing unnecessary emergency room visits.
(h) How do you monitor and measure the ongoing care, quality results, cost results, and outcomes provided by these organizations?
(i) What performance guarantees are offered?
(j) What are your plans for adding ACO delivery in the future?
(k) Describe important outcomes you have achieved as a result of ACOs with which you have been involved. This might include improved health, reduced utilization of expensive services, improved member experience, and reduced costs.
(l) What have you learned from initiatives that have already been implemented, and how has this program evolved from these learnings?

ValueOptions is experienced with ACO development around the country including programs in New Jersey, Colorado, Washington, Massachusetts, Florida, and New York. We have worked

with health plan partners and providers in the New York market to support ACOs for the Medicaid population.

The foundation of our new provider outreach is our Value Preferred Network. Currently this is under development with providers in Nassau and Suffolk counties. This is currently a pilot program, but providers have expressed interest in expanding the basis of the program to include a broader set of members and payers.

(A) ACO EXPERIENCE

As we note above, the Value Preferred Network program acts as an integrated ACO for behavioral health. The objectives of the Value Preferred Network program are to:

- Improve access to care
- Improve overall population health outcomes
- Slow the growth of health care cost
- Improve care coordination/ health integration
- Improve enrollee's experience receiving care

Value Preferred Network

ValueOptions proposes our Value Preferred Network, a high-performing, select network developed to maximize the health improvement, mental and emotional wellbeing, and recovery for enrollees. This concept develops a comprehensive select network to improve access to care, improve the health of Empire Plan enrollees, and drive down health care costs. In order for us to change and make improvements in our behavioral health capability, the development of the Value Preferred Network needs to be a strategic and tactical priority. Our collaborative contracting approach, along with our Intensive Care Management program, sets the basis for addressing both physical and behavioral health needs of enrollees. Our Value Preferred Network strategy focuses on the community and providers are incentivized to work collaboratively to make an impactful difference on the enrollees.

We have developed a Physician Advisory Committee for each County whereby, medical directors from Value Preferred Network facilities, key large outpatient providers and key PCP groups discuss quality, clinical outcomes, best practices, issues in the community, performance data, use of our Predictive Modeling tools and overview of their Pay for Performance program. Our Value Preferred Network reduces the frustrations of hospitals and providers as it eliminates most denials, appeals and grievances and focuses the time and attention on the enrollee to ensure they are set up for success not just at that moment but for the rest of their life. This happens by having those Value Preferred Network facilities accept a case rate and we overlay their reimbursement with a Pay for Performance program based on the results of the state and meeting seven key metrics. Our denials will only focus on the initial admission to ensure it meets medical necessity. We then work on a care management plan with the facility to ensure an effective care plan for the enrollee. By integrating primary care with behavioral health we have been able to address the fragmentation with an integrated financial and pay for performance solution focused on community based interventions and peer support services and all parties are now all equally incentivized to focus on the health and wellness of the enrollee. Our Value Preferred Network moves a step closer with our Intensive Case Management program to focus

not only on behavioral health but collaborating on key chronic conditions that impact physical and mental/cognitive conditions.

(B) ACO STRUCTURE

The Value Preferred Network is currently under development for specific applications. As we learn more about the Empire Plan's interests and priorities we will provide specific details on where the Value Preferred Network could be applied to the empire Plan.

(C) PARTICIPATION REQUIREMENTS

There are a number of requirements that serve as the basis for identifying potential Value Preferred Network participants including:

Health Systems – Facilities:

- Specialized treatment units or programs
- Full continuum of care
- Ability to address diverse needs of multi-cultural population
- Full compliance with NCQA
- Acceptable HEDIS statistics
- Active QM program and outcomes
- Committed partner
- Adequate volume to accommodate risk and gain sharing methodology

Health System - Facility Process Requirements:

- ICM/UM care collaboration
- Retro quality and UM audits – PRN on-site reviews
- Practice consistent with Medical Necessity Criteria
- Practice consistent with evidenced-based treatment, including review of EBPs utilized (or endorsement of ValueOptions)
- Inclusion of family/ significant other in care*
- Multi-disciplinary discharge planning process

The care management protocols are developed across the spectrum of providers including primary care physicians. This requires buy-in from practice physician and behavioral health provider leadership.

(D) CONTRACT DURATION

Value Preferred Network contracts are currently being finalized for specific payer relationships. Providers have expressed a willingness to engage in this model with other payers (e.g. Empire Plan).

(E) REIMBURSEMENT MODELS

There are two critical reimbursement elements present in the Value Preferred Network model:

1. Case-based payment
2. Gain-sharing for improved outcomes

Gain-sharing is a payment methodology that involves creation of annual performance targets. If provider specific performance falls below the pre-determined target (while continuing to maintain quality standards) the amount under the target (gains) will be shared between the provider and payer (e.g. Empire Plan). For the Empire Plan to directly participate in programs like this it would have to be willing to share a portion of the care improvement savings with the designated providers. Regardless of whether the Empire Plan elects to directly participate in the gain-sharing programs ValueOptions introduces in the market, it will benefit from the care delivery improvements that the program introduces into the delivery system.

(F) PAYMENT METHODS

Today, reimbursement is based on fee-for-service and per-diem payment arrangements. The Value Preferred Network introduces case-based payment and gain-sharing as the next generation of reimbursement methodology. With the introduction of gain-sharing, payers (e.g. Empire Plan) would need to agree to a structure in which it would agree to share saving identified under this program with participating providers.

(G) INTEGRATION STRATEGIES

Under the Value Preferred Network model we extend the core care integration components of our care management model including:

- Best practice care transition protocols
- ICM/UM care collaboration
- Retro quality and UM audits – PRN on-site reviews
- Direct outreach to collaborating physicians
- Inclusion of family/ significant other in care
- Multi-disciplinary discharge planning process

By structuring the reimbursement model to include case rates and care improvement incentives we ensure that providers not only acknowledge the availability of integration opportunities, but have the financial incentive to actively participate in them.

(H) MEASURING RESULTS

ValueOptions has developed a comprehensive suite of management reports that are exchanged on a regular basis with Value Preferred Network providers. These reports serve as the basis for ongoing monitoring and control. We also monitor and measure the ongoing care, quality results, cost results, and outcomes provided by these organizations by:

- Routine screening for depression / alcohol
- ED admission/1000; ER diversion rate
- IP admissions /1000
- Readmission rates
- CAHPS survey: getting needed care; how well doctors communicate; rating of personal doctor
- Follow-up within 7 days after mental health admission
- Routine outpatient appointment availability within 5 days

- Depression improvement scores
- Initiation / Engagement of alcohol and drug dependence treatment
- Reduction of polypharm
- Monitoring metabolic syndrome
- Anti-depressant medication management (adherence)

(I) PERFORMANCE GUARANTEES

ValueOptions continuously monitors the performance of Value Preferred Network providers. A provider's continuing participation is predicated on maintenance of the quality standards required for inclusion in the network. Given the provider-at-risk structure in place with Value Preferred Network reimbursement the Empire Plan would be protected from any care inefficiency or adverse outcomes by the fixed level of payment under the model. Re-admission thresholds and fixed payment would serve to provide a guarantee that Empire Plan enrollee and overall Plan interests are protected.

(J) PLANS FOR ACO GROWTH

ValueOptions is aggressively promoting the Value Preferred Network. There is increasing provider interest in participation. We are planning to engage self-funded clients like the Empire Plan on how it can achieve the advantages of the Value Preferred Network model while maintaining its self-funded plan status. We anticipate that over the course of the proposed contact period significant numbers of New York providers will migrate to the Value Preferred Network model. As statewide access becomes available the Value Preferred Network model will provide a significant opportunity for the Empire Plan to influence the quality and cost of care throughout the State and gain in the financial benefits that will accrue as a result.

(K) OUTCOMES

At the present time, the Value Preferred Network is in the early launch phase. Hard results have yet to be documented. However, the principals upon which this model is based have been validated in physical medicine by health plans across the country. The design integrity and operating principals present in the Value Preferred Network model ensure that similar levels of care improvement and cost reduction will be present as the model matures.

(L) KEY LEARNINGS

ValueOptions staff has extensive experience in introducing and operating value-based models. We have learned that clear communication, well documented expectations and transparency are critical to gaining and sustaining provider participation.

(3) Do you ever incorporate pay-for-performance, shared savings, risk pools, risk sharing, and/or withholds into the payment methodologies for Network Providers? If yes, describe. Describe any potential future plans to develop any of these care delivery models, including a timeline for implementation.

Yes. The foundation of our Value Preferred Network is a reimbursement model incorporating case-based payment and ultimately gain-sharing to ensure providers are fully engaged in quality and health improvement efforts. We are introducing case-based payment in 2014 and intend to expand this throughout the State as re-contracting allows. The timing of inclusion under the Empire Plan will be determined by mutual agreement of the Empire Plan and ValueOptions.

(4) How do or will your alternative provider contract payment methodologies reflect quality performance (i.e., measured against standard)?

Our new payment methodologies are built through collaboration with providers on jointly developed care and cost improvement targets. We incorporate industry best practices into the design and performance thresholds at the core of our approach.

(5) To what extent, if any, would your MHSA Network Practitioners and Facilities be paid under an alternative (non-fee-for-service) provider payment structure.
(a) For each year of the proposed contract effective period (2015 through 2019), what proportion of Network Providers will be or is expected to be paid exclusively on an alternative basis, and therefore, not paid according to the schedule shown on Exhibit V.A.2, and Exhibit V.A.3?
(b) For each year of the proposed contract effective period (2015 through 2019), what proportion of Network Providers will or is expected to optionally be paid on an alternative basis, and therefore, the State can choose to pay these providers according to the schedule shown on Exhibit V.A.2 and Exhibit V.A.3?

(A) PORTION OF PROVIDERS UNDER ALTERNATE PAYMENT CONTRACTS

We anticipate that 20 percent of total plan payment could be transitioned to alternative payment models in 2015 depending on the incentive dollars allocated and if an agreement is reached between the Empire Plan, ValueOptions and providers. This number will grow based on the Empire Plan's interest and support throughout the remainder of our agreement.

(B) PORTION OF PROVIDERS OFFERED ALTERNATE PAYMENT CONTRACTS

We anticipate that 20 percent of total plan payment could be transitioned to alternative payment models in 2015 if agreement is reached between the Empire Plan, ValueOptions and providers.

This number will grow based on the Empire Plan's interest and support throughout the remainder of our agreement.

(6) How do your Network Provider contract payments encourage adherence to clinical guidelines?

Part of the inclusion criteria as a Value Preferred Network provider requires attestation of following clinical practice guidelines and providing internal quality monitoring and their Pay for Performance is tied to adherence. Our case-based payment rates are based on the actuarial value of payment assuming a normal level of case intensity and adherence to best practice protocols. As a result, providers are incented to maintain high levels of quality in order to optimize reimbursement. Further, gain-sharing ensures that as quality improves all stakeholders are rewarded.

(7) How will the Network Provider payment structures result in savings to the State and its members, and ensure high quality of care is provided? Do not include cost information in the technical proposal.

Our Value Preferred Network reimbursement strategy is designed to protect the Empire Plan from provider inattention to quality and remove any incentives that may exist for providers to attempt to maximize revenue through increasing the volume of services without attention to quality and outcomes. While we carefully monitor provider behavior under the present system, we feel that both cost and outcomes are improved when provider self-interest is tied to improved outcomes rather than directed through concurrent or retrospective oversight. Our model drives towards long term solution to the enrollees' health and wellness.

(8) Does the Offeror utilize a predictive modeling tool to identify individuals at risk for mental health or substance abuse admissions or re-admissions? Explain how the tool is used, including the type of data utilized.

ValueOptions offers comprehensive predictive modeling tools as an optional component that can be used to identify at-risk members. In collaboration with your other vendors, we will identify members who might benefit from outreach. This could include, for example, members with a chronic physical health disease or those members who have positively answered any behavioral health screening instruments. Our predictive modeling algorithm uses advanced statistical software to deliver quantified and concise enrollee data and measurable cost savings. We go through this data with our Physician Advisory Committee to enhance our success in our pay for performance program.

(9) Describe any emerging provider payment or delivery system pilot initiatives in which the State's population would be eligible to participate.

VALUEOPTIONS ONTRACK OUTCOMES PROGRAM

The ValueOptions' On Track Outcomes Program is designed to help clinicians incorporate patient-reported feedback into their counseling and psychotherapy practices. A growing body of research demonstrates the power of this type of routine feedback to improve patient outcomes. The On Track program gives clinicians valuable tools to track patient progress relative to benchmarks, to identify clients at risk for poor outcomes, and to demonstrate the impact of their services. On Track is based on a brief patient-completed assessment and online reports.

On Track Participation

The number of providers who have activated their online On Track toolkit has steadily increased since the program's launch in August 2008. After initial rollout to targeted EAP providers in 2008, the program was progressively expanded to include all EAP and commercial outpatient MHSA providers, with promotional activities focusing on high volume clinicians. Through December 2013, a total of 4,033 providers had activated their accounts. Approximately one in five registered providers (799, or 19.8%) has submitted at least one Client Feedback Form (CFF). In all, 316 providers submitted 15,950 forms in 2013, of which 163 (49.8%) submitted at least 10 forms.

Between the program's inception in late 2008 and the end of 2013, participating providers submitted 57,822 On Track Client Feedback Forms, representing 24,097 cases. At least one reassessment was completed on 40.5 percent of cases.

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 at no additional cost. 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 applied to the shared Accumulators between the Empire Plan Hospital Program, Medical Program and MHSA Program; (l) Loading a daily claims file from the Empire Plan medical	Yes

Section 11: Claims Processing (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
carrier/third party administrator and hospital carrier that reports shared Accumulators; (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 system through a pursue and pay methodology 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 Disabled Lives Benefit in accordance with Section V of this RFP. (r) Updating the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year. (s) Mailing Explanation of Benefits to Enrollees for all Non-Network Claims and any other claims for which the Enrollee cost share is	

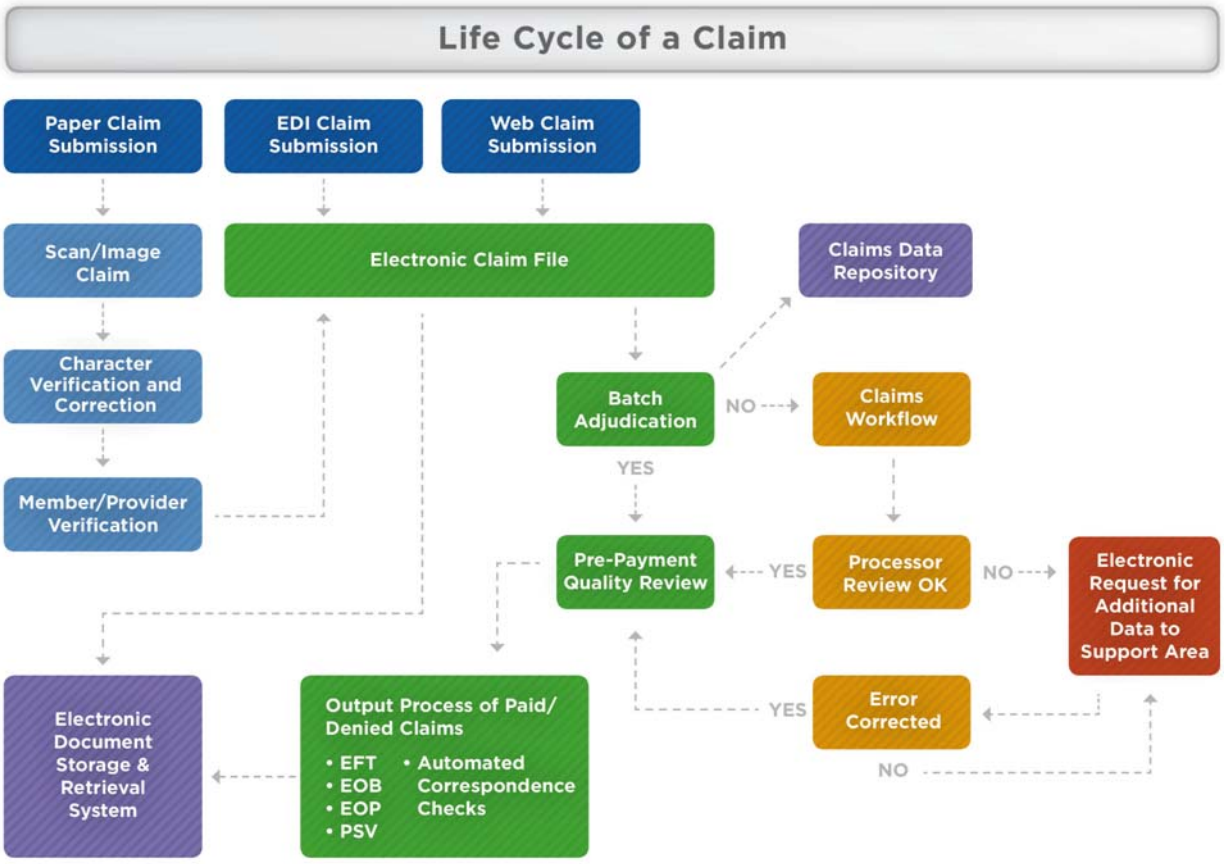
Section 11: Claims Processing (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
in excess of the applicable Copayment for the MHSA service. Explanation of Benefits for all MHSA services must be mailed to the Enrollee upon request from the Contractor's Dedicated Call Center and available for download by register users of the Contractor's customized website. An annual Explanation of Benefits statement must be mailed to all Enrollees who have submitted claims within thirty (30) days of the end of each Plan Year; and (t) Following the guidelines for escheatment as outlined on the NYS Office of the State Comptroller's website at: www.osc.state.ny.us/agencies/guide/MyWebHelp/Content/XIV/1.htm	
(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
(4) Turnaround Time for 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 Provider-submitted claims that are received electronically, or 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 Provider-submitted claim is received electronically or received in the Offeror's designated post office box to the date the Provider payment is	Yes

Section 11: Claims Processing (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
received by the U.S. Post Office or Contractor's mailing agent; and	
(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 currently process the Empire Plan 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 set up drives the appropriate reimbursement.

Step 1: 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.

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 Empire Plan specific benefit requirements.

Empire Plan First Quarter Claims Statistics:

- ***Financial Accuracy – 98.21%***
- ***Non-Financial Accuracy – 95.47%***
- ***Non-Network Claim Turnaround Time – 98%***

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, enrollee date of birth, service from and through dates, 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.

Step 2: Claims Entry/Upload

We currently process all Empire Plan 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 the Empire Plan-specific benefits or business requirements. Our proprietary system also enables us to apply Empire Plan-specific settings to the adjudication logic and 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.

Step 3: 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
- Matches the claim to a valid authorization
- 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

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. The table below outlines the specific edits we have in place for the Empire Plan claims process.

Edit Category	DESCRIPTION OF SYSTEM USE
Authorization	Single Case Agreement on file, Confirm rate
Authorization	Date of Service on Claim is close to authorized dates of service, is it a match?
Authorization	The service requires an authorization, however a matching authorization is not found
Authorization	The authorized units have been exceeded.
Benefit	Service billed is not covered
Benefit	Date of service on claim is before or after the benefit effective date
Benefit	Diagnosis is not a covered MHSA dx
Benefit	Service has been performed more frequency than allowed. Pend for review
Coordination of Benefit	Coordination of Benefit (COB) data is outdated on COB file for member; send questionnaire
Coordination of Benefit	We have record of COB information for enrollee, no primary carrier payment information was included on claim
Coordination of Benefit	COB QUESTIONNAIRE sent but not returned
Coordination of Benefit	Enrollee is over age 64 - check for Medicare coverage
Coordination of Benefit	Medicare is primary on COB file
Coding	Charge totals do not match line item charges
Coding	Date of service is before or after when the diagnosis code is valid
Coding	Dates of service on claim are not in chronological order
Coding	FUTURE DATE of service is not valid
Coding	INVALID SERVICE DATE

Edit Category	DESCRIPTION OF SYSTEM USE
Coding	Missing specific data on a UB form
Compliance	Timely Filing limit exceeded
Duplicate	Duplicate of claim currently in process
Duplicate	Possible duplicate claim - related procedure same date of service
Duplicate	These services performed on the same day are allowed
Duplicate	Claim is an exact duplicate of another in history
Eligibility	Date of service on claim is outside of the enrollee's effective date
Eligibility	Enrollee data does not match file
Pricing	This service does not have a rate on file
Pricing	Out of network provider pricing not applied to claim
Provider	NPI submitted does not match NPI on file
Provider	The provider license level does not support service on claim

Hard and Soft Edits

The hard and soft claim edits outlined above 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 a 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.

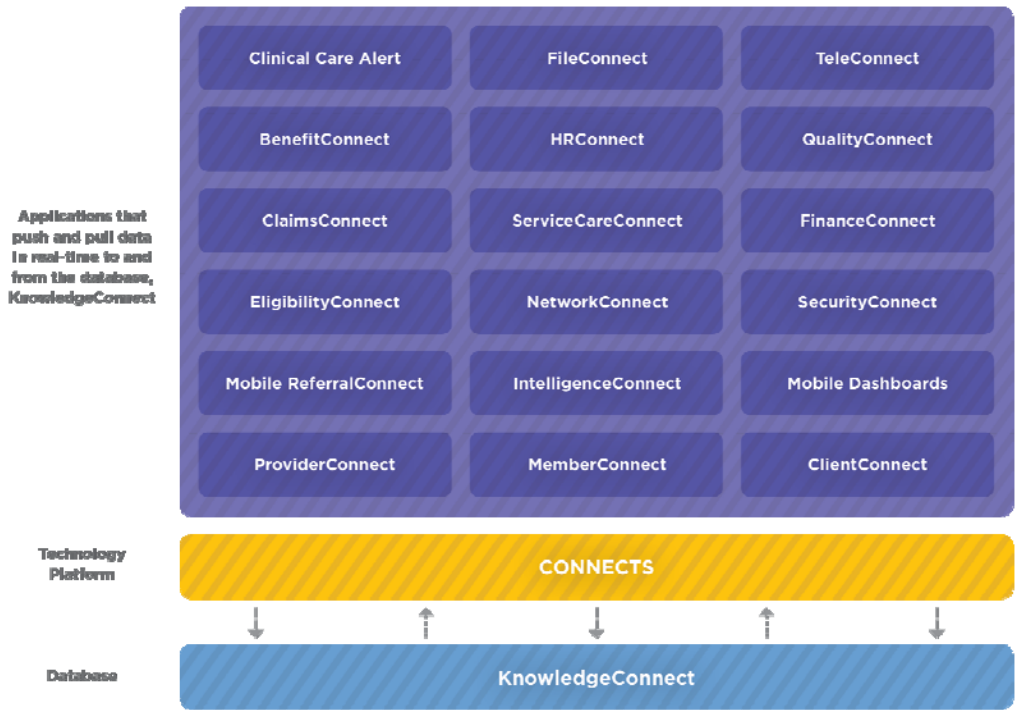
If the diagnosis code on the claim is not covered by the Empire Plan, the claim is automatically denied during batch adjudication with an explanatory code and message. If the diagnosis code is not a valid code in the system reference file, a default value of 'unknown' is entered in the diagnosis field 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 enrollee 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 the Empire Plan's program needs. This highly adaptable system manages the Empire Plan's behavioral health programs from initial enrollment and eligibility through claims adjudication and payment.

Our system maintains all Empire Plan benefit structures, provider reimbursement methodologies, and adjudication rules to accommodate the Empire Plan's program. Fee schedules are set up based on provider licensure and participation status. We demonstrate how all applications relate to each other in the diagram below.



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 Empire Plan 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.

ValueOptions' latest test of our disaster recovery and continuity plan was in October 2013. All data and voice systems were successfully restored.

Minimizing Enrollee Disruption

For 2013, our actual systems up-time for our claims processing system was nearly 100 percent

(99.99 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 our dedicated claims processing unit which is located in Latham, New York. The dedicated claims processing staff, consisting of 26 EDI coordinators, processors, and auditors, are fully trained on the unique Empire Plan claims processing requirements.

(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, Applied Behavioral Analysis, 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).

As noted above, our fully integrated information platform is currently configured and programed specifically to support the Empire Plan's benefit structures and claims payment requirements. Our BenefitConnect application stores all pertinent information relative to the Empire Plan's administration of benefit rules and your relationship to the plans, products, and various lines of business. The data housed in the BenefitConnect application was created during the Empire Plan's implementation and is updated with ongoing changes to the Empire Plan's benefits during the tenure of a contract. Detailed discussions were held with the Empire Plan to identify and include the application of benefit rules, authorization rules, adjudication edits, plan year versus calendar year products, out-of-network rules, and the review of state and federal regulations that would impact benefits, such as parity rules and any other pertinent information. Our platform delivers on its promises because we have already made the investment in twenty-first 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

Our system is configured to support the Empire Plan's benefits, group structures and clinical parameters. We worked closely with the Empire Plan to define the benefit design document, mixed service protocols, and service class grid during initial implementation. All of the information and data collected in these tools were loaded into our system to support the Empire Plan-specific clinical and claims payment rules which included a customized transition plan.

CONNECTS is fully configured with over forty unique Empire Plan benefit packages, covering union, management and Student Empire Plan enrollees and dependents.

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, Applied Behavioral Analysis, and outpatient services. Our dedicated Clinical Care Managers will certify care based on these criteria as well as the benefit plans prescribed by the Empire Plan. If medical necessity for a requested level of care is met, a dedicated 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 dedicated 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

During the five-day Empire Plan Emergency Contract implementation, we worked closely with the Empire Plan to collect the pertinent benefit and cost share information for the various Empire Plan benefit structures from the Department via our benefit design documents (BDD). All benefit packages for the grandfathered, non-grandfathered, SEHP and Excelsior Empire Plan populations are programmed into our system to reflect in-network and out-of-network benefits for each of the unique Empire Plan benefit structures.

ValueOptions successfully completed the five-day emergency contract implementation over the Christmas and New Year's holiday.

Custom edits based upon each of the benefit packages are applied during the authorization and claims adjudication process. These edits include but are not limited to psychiatric and substance abuse services, outpatient and inpatient services, whether precertification is required, visits maximums.

We have extensive experience serving clients with varying and multiple benefit structures similar to the Empire Plan. We have the ability to administer the slightest differences in benefit design such as those for the Student Employee Health Plan or the Excelsior Plan. 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 sophisticated and fully integrated system maintains all claims history and is available to our staff, providers and enrollees indefinitely unless otherwise instructed by the Empire Plan. There is no limit to how many claims or authorizations can be viewed by our Latham, New York staff for calls or online for enrollees through our MemberConnect application.

(e) MULTI-LEVEL COST SHARING

Each of the Empire Plan grandfathered, non-grandfathered, SEHP and Excelsior benefit packages have been programmed into our system along with the appropriate maximum deductibles, co-insurance, and/or out-of-pocket limits.

Our claims system accepts accumulations of maximums, deductibles, coinsurance and/or out-of-pocket limit amounts from United Health Care's (United) plan payments and calculates them as one limit for the Empire Plan. Our management information system stores the Empire Plan accumulator data received from the United file separately from the accumulators derived during claims processing, but uses the combined amount to calculate benefits. Our system also allows for various cost sharing within a plan by group.

(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.

Annually, we exchange approximately 650,000 total files including accumulator extracts and imports, and claim extracts to Truven.

ValueOptions confirms that we can support an electronic exchange of a daily claims file of shared accumulator amounts with United and other trading partners, as demonstrated by our past three months of Empire Plan operations. We have demonstrated experience with other major medical partners such as Aetna, Blue Cross Blue Shield (BCBS), and Medco and developed "multi-client exchanges" which allow combined file sharing and seamless process exchanges.

Our infrastructure enables us to develop custom exchange solutions with each medical system when required in order to accommodate a medical carrier systems limitations; which typically do not have the same level of flexibility as ours. For example, we currently support the need to manually share accumulators in order to support the in-network out of pocket maximums related to Affordable Care Act (ACA).

Below is a list of the current data exchanges we have in place to support the Empire Plan program.

Data Exchange	Type (Import/Extract)	Format (HIPAA or Custom)	Trading Partner	Frequency
Accumulator Extract	Extract	Custom/VO Standard	United Health Care	Daily M-F
Accumulator Import	Import	Custom/VO Standard	United Health Care	Daily M-S
Claim Extract to Truven	Extract	Custom/VO Standard	Truven Health Care	Monthly

(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 continue to 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.

To support any changes to the benefit design throughout the contract, ValueOptions' Systems Configuration and Claims departments engage with the Empire Plan's staff to participate in testing the benefit structure prior to making any changes in the production environment of our system. 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 cases or testing scenarios of the benefit change. We have noted a few examples below.
    a. Functionality validation of the benefits using multiple claim scenarios
    b. System queries to document and validate the benefits
    c. Validation and audit of accumulators
    d. Partnership with claims for robust, end-to-end benefit testing against claims adjudication rules

2) Preparation of regression testing scenarios against baseline cases. These are developed to ensure that the implementation of changes does not adversely affect other functions.
3) Application of a known set of transactions against the base. These test cases are designed to specify every requirement.
4) Inspection of the results to ensure that the results meet expectations.

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

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 Empire Plan. All results are compared to the benefit information provided by the Empire Plan, as well as system configuration including but not limited to:

- Accurate accumulation
- Benefit structure (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 three-month post-implementation random audit is conducted and continuous on-going communication between ValueOptions and the Empire Plan to identify and remedy any unexpected discrepancies.

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

ValueOptions will continue to support the manual work around to share the Medicare Crossover data that we have established today for the Empire Plan. As the medical carrier supplies the information, the dedicated Empire Plan claims team adjudicates and pays the remainder of the claim based on the Empire Plan benefit structure.

Additionally, we currently participate in electronic sharing of Medicare Crossover data via an 837 transaction for other contracts that we support. We are prepared to support an electronic interface for the Empire Plan. We will pursue this at such a time as the Empire Plan's medical carrier indicates it is prepared to support this effort.

(9) Describe your pursue and pay procedures for the collection, storage and investigation of coordination of benefit (COB) information other than Medicare. Explain how frequently COB information is updated.

COLLECTION, STORAGE AND INVESTIGATION OF COORDINATION OF BENEFIT

A coordination of benefit (COB) questionnaire is automatically sent to the enrollee, triggered by a claim for dates of service a year or more after the last update. The last updated record is automatically read during adjudication, and claims are denied until we receive the completed questionnaire, or through Customer Service contact. Once the update is received, we systematically identify impacted claims, and reprocess them if the enrollee's COB information is negative (i.e., no other coverage is reported). If the COB information is positive, denied claims must be resubmitted with the primary carrier's payment information to allow for coordination of benefits. The COB information is stored on our proprietary CONNECTS platform.

Our COB process is compliant with CMS, state, and federal regulatory requirements.

We 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 or with a negative 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.

ValueOptions' experience has demonstrated the financial value of our COB program. Our system has the technical flexibility to adjust our COB workflows to meet the needs of the Empire Plan program.

COORDINATION OF BENEFITS UPDATES

Using a pursue and pay approach, ValueOptions' updates COB information annually.

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

We will indemnify the state for any planned and enrollee costs resulting from any ValueOptions error. When payment discrepancies are identified, either through our comprehensive audit process, by enrollee services, or during claims processing, we use our automated adjustment processing system. Overpaid or underpaid claims are reversed, and a new claim is created with the correct payment amount. If the adjustment results in an overpayment, we notify the provider via letter of the overpayment amount with an explanation. The provider is allotted 30 days to refund that amount, or the provider can chose to have the overpayment deducted from future payments. We create a financial transaction 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 the provider's state. If an overpayment occurs for a provider with infrequent claims, a collection will be initiated.

For underpaid claims, our system will automatically calculate and issue additional payment with any interest that may be due.

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

All data collected for the Empire Plan are captured and stored 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 the Empire Plan's claims turnaround times. 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 the Empire Plan's performance and regulatory standards are being met, and to efficiently deploy processing resources. Daily Empire Plan summary reports are closely reviewed by multiple levels of management to monitor claims turn-around times and other performance measurements. Empire Plan-specific performance reports are reviewed monthly to identify trends and any barriers to exceeding payment standards.

(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 continue to 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. 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. 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 Empire Plan and provider expectations.

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:

- All trainee claims are audited before payment. As new processors meet their goals and objectives, this percentage is gradually decreased.
- A statistical, stratified random sample of three to five percent of adjudicated claims is generated weekly. This sample is audited both pre- and post-payment and used for Empire Plan reporting purposes.
  - A continuous pre-payment sample is taken of all paid and denied claims.
  - 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.

FRAUD AND ABUSE

We provide 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
- Resolution

Our effective prevention efforts are built on provider education, training, communication, and industry partnerships.

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, 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 the 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 enrollees with matching surnames)

We re-audit providers who have had past errors to ensure that education and corrective action plans 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

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. 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 continue to update and maintain the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year.

(15) Confirm that the Offeror will:
(a) mail Explanation of Benefits to Enrollees for all Non-Network claims and any other claims for which the Enrollee cost share is in excess of the applicable Copayment for the MHSA service;
(b) mail Explanation of Benefits for all MHSA services to the Enrollee upon request from the Contractor's Dedicated Call Center;
(c) make available Explanation of Benefits for all MHSA services for download by register users of the Contractor's customized website; and
(d) mail an annual Explanation of Benefits statement to all Enrollees who have submitted claims within thirty (30) days of the end of each Plan Year.

ValueOptions confirms that we will continue to generate and mail all Explanation of Benefits (EOBs) to enrollees for all claims (e.g., network, non-network, other) for which the enrollee cost share is in excess of applicable copayment for the MHSA service and upon requests received in the ValueOptions dedicated call center.

In addition, enrollees are able to access and download EOBs and other correspondence from the Empire Plan website.

Additionally, we confirm that we will provide all enrollees with an annual EOB statement meeting the format and requirements set by the Empire Plan.

The Empire Plan EOBs are formatted in an easy to read format which clearly outlines for the Enrollee how their benefits were applied to each claim. Currently the Empire Plan EOBs include the following data elements:

- Enrollee Name/ID
- Provider Name/ID/NPI
- Dates of Service
- Procedure Codes
- Modifier Codes
- Charged Amount
- Allowed Amount
- Paid Amount
- Deductible Amount
- Co-Pay Amount
- Co-Insurance Amount
- Other Insurance Amount
- Maximum Co-Pay/Co-Insurance
- Explanation of Payment Codes and descriptions

(16) Confirm the Offeror will follow the guidelines for escheatment as outlined on the NYS Office of the State Comptroller's website at: www.osc.state.ny.us/agencies/guide/MyWebHelp/Content/XIV1.htm.

ValueOptions confirms that we currently and will continue to follow the escheatment guidelines defined by NYS Office of the State Comptroller. Our unclaimed property process flow, which was developed with the Empire Plan, requires us to generate due diligence (outreach) letters to owners of checks that remain outstanding. When we get a response, the appropriate action is taken. For instance, we may void and reissue the check, or void the check and adjust the claim, depending on the response we receive. If we receive no response from the owner, we escheat the funds to the state when they become dormant; using the dormancy guidelines of NYS.

(17) 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]

(18) 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]

(19) Turnaround Time for 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 Provider-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 electronically or in the Offeror's designated post office box to the date the Provider payment 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 Provider-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 Provider payment 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 Provider-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 Provider payment is received by the mailing agent, as calculated on a quarterly basis, is $_____.

TURNAROUND TIME FOR NETWORK CLAIMS ADJUDICATION GUARANTEE

[redacted]

[redacted]

(20) 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 carrier/third party administrator and managing the Enrollee's	Yes

Section 12: Clinical Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
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 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 as calculated annually. (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 re-contacted 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
Transition of Care	
(1) The Contractor must identify members who are receiving MHSA services from the incumbent contractor's network from a Provider who is not in the Contractor's network. The Contractor must send these members a letter notifying them of a Transition of Care benefit 3-4 weeks prior to the Implementation Date.	Yes
(2) The Contractor must notify the corresponding Providers of the Transition of Care benefit, including how to submit claims so that the member is responsible only for the applicable Copayment.	Yes
Concurrent Review	
(1) To safeguard Enrollee health and ensure adherence with the MHSA Program's benefit design and requirements on mental	Yes

Section 12: Clinical Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
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 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; (d) Is performed by the Contractor for outpatient and inpatient care rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider; (e) For inpatient admissions, recognizes when to utilize more appropriate and less restrictive levels of care, when medically appropriate. The Contractor must have procedures to identify when transfer to an alternate inpatient or outpatient setting is appropriate and arrange 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 it was a Network Facility, 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 clinical manager, as follows:	Yes

Section 12: Clinical Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(a) Clinical 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) Clinical 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.	
(4) The Contractor must provide intensive case management on a voluntary basis for complex cases or cases requiring long-term 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 Mixed Services Protocol (MSP) guidelines established by the Department. Under those MSP 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 MSP 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; the current MSP is presented in Exhibit II.M.	Yes
(5) The Contractor must use Clinical 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 Contractor must guarantee that at least ninety percent (90%) of outpatient treatment plans be reviewed and the Provider and Enrollee 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 Contractor 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 and 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	Yes

Section 12: Clinical Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
States (preferably in New York State) and clinical determination must be completed within 10 Business Days of receipt of a complete form.	
(2) The Contractor must send a determination letter, approved in advance by the MHSA Program, to the Enrollee and to the Department advising of the determination within three (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 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.	Yes
(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 thirty (30) days of the member's request; (ii) For a second level clinical appeal of a pre-service request for benefits, within fifteen (15) days of the member's request; and (iii) For clinical appeals involving urgent situations, in no more than seventy-two (72) 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

Section 12: Clinical Management (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(5) Respond to all External Appeals on behalf of the Department as requested by the New York State Department of Financial Services through a 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 timeframe, will be included as having met the standard. This standard will be calculated on an annual basis; and	Yes
(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.

ValueOptions offers enrollees, providers and facilities access to precertification of all care requests 24 hours per day, 365 days per year, via the consolidated NYSHIP telephone line. Skilled, dedicated Clinical Care Managers assess the presenting issue, offer problem solving techniques, assess clinical treatment needs and conduct thorough safety assessments via telephonic enrollee assessment or via data offered by the provider/referent.

Monday through Friday, 8 a.m. to 5 p.m., via the consolidated NYSHIP telephone line, ValueOptions' dedicated Latham-based, Empire-dedicated precertification team is directly available to providers who are seeking authorization for services. A utilization management staff of eight dedicated Clinical Care Managers is readily available to check eligibility, verify benefits, and obtain the necessary clinical information from providers to make a level-of-care determination. After 5 pm, this same line is staffed by dedicated after-hours clinical staff who offer the same level of service.

LATHAM, NEW YORK-BASED CLINICIANS PROVIDING PRE-CERTIFICATION

Our Latham-based licensed behavioral health clinicians have at least three years of clinical psychiatric 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 the optimal level of care in the least restrictive setting. ValueOptions currently provides 24-hour telephonic pre-certification through our Latham-based, dedicated Clinical Care Managers, who know the market. Providers and facilities are able to access a dedicated Clinical Care Manager 24 hours per day through the NYSHIP toll-free number, to pre-certify all levels of care.

(A) OVERVIEW OF CLINICAL REFERRAL LINE PROCESS

Empire Plan enrollees currently have access to our dedicated Clinical Referral Line 24 hours a day, 365 days of the year, via the NYSHIP consolidated line. Our dedicated Clinical Referral Line is staffed by dedicated 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 dedicated Clinical Care Managers speaks with the enrollee to identify the treatment/resources needed, and will refer the enrollee to the appropriate, qualified resource (i.e., ValueOptions' network practitioner, facility, 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. As a part of the hiring process, we interview staff to ensure that they possess assessment and engagement skills. The dedicated Clinical Care Managers are

trained to assess all enrollees for safety, and to complete a more comprehensive assessment whenever there is an identified safety issue. This includes assessing the enrollee's risk and protective factors, determining if there is risk of harm to the enrollee or others, if domestic violence is an issue, or if the enrollee is at risk for substance withdrawal. This information then guides the Clinical Care Manager in identifying urgent and emergent cases.

Triage Criteria and Protocols

ValueOptions' triage protocols are based on the following risk rating scale. Clinical Care Managers use the risk rating scale during the assessment process to help determine the most appropriate level of treatment and the urgency of clinical intervention required:

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 seriously impair bodily functions.
- The enrollee indicates that failure to obtain immediate care would place his or her life, another's life, or property in jeopardy, or seriously impair bodily functions.

Required Action (Emergency/Life Threatening Risk)

1. The Clinical Care Manager must ensure immediate emergency intervention.
2. 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 or she must confirm provision of emergency intervention as soon as clinically indicated, usually within one hour. The Program's service level standard requires 100 percent of enrollees who call the dedicated Clinical Referral Line in need of life-threatening emergency care be contacted within 30 minutes to ensure their safety.
3. The Clinical Care Manager must clearly document all actions taken, times at which they occurred, and the rationale supporting them.

We currently meet or exceed all Empire Plan CRL standards.

For the first quarter of 2014, 100 percent of enrollees that identified an Emergency were re-contacted by the dedicated Clinical Care Manager within 30 minutes of the enrollee's call to the dedicated Clinical Referral Line.

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.
- The enrollee indicates a need to be seen on an emergency basis.

Required Action (Emergency/Non-Life Threatening Risk)

1. 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 providers 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 is the safety of the enrollee and any others at risk.
2. 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.
3. The Clinical Care Manager must clearly document all steps that took place, the times at which they occurred, and the rationale supporting them.
4. In all cases, the Clinical Care Manager must ensure that the enrollee has accessed emergency care in order to safeguard the enrollee or others.
5. Depending on the nature and imminence of the risk, ValueOptions may require the following to take place:
   a. emergency hospitalization
   b. psychiatric assessment
   c. police and/or social service intervention to safeguard the enrollee and others
   d. ensure that staff members conduct a psychiatric assessment
6. In accordance with the current Empire Plan Emergency Care Clinical Referral Line Guarantee: 100 percent of enrollees in need of non-life-threatening emergency care shall be contacted by a Network Provider or re-contacted by the Clinical Care Manager within 30 minutes of the enrollee's call to the dedicated Clinical Referral Line.

For the first quarter of 2014, 100 percent of enrollees that identified an Emergency were re-contacted by the dedicated Clinical Care Manager within 30 minutes of the enrollee's call to the dedicated Clinical Referral Line.

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
- He or she shows moderate impairment in judgment, impulse control and/or functioning, which the Clinical Care Manager expects to further diminish
- Indications of intoxication or risk of withdrawal
- Enrollee indicates an urgent need to receive treatment

Required Action—Serious Risk (Urgent)

1. In accordance with current standard, at the least, 99 percent of enrollees in need of urgent care will be contacted by the Clinical Care Manager to ensure that a Network Provider contacted the enrollee within 48 hours of the enrollee's call to the dedicated Clinical Referral Line. For the first quarter of 2014, this standard was met 100 percent of the time
2. The Clinical Care Manager will arrange for a face-to-face assessment by a licensed mental health professional within 48 hours of the call.
3. If no provider is available to assess the patient, the Clinical Care Manager must treat the situation as an emergency.
4. 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 Clinical Care Manager can find evidence of functioning and/or impulse control

PRECERTIFICATION OF SERVICES

Providers and enrollees have access to our Empire-dedicated Latham based precertification team 24 hours per day, 365 days per year via the NYSHIP consolidated telephone line. There are multiple ways in which the precertification process can begin:

1. The enrollee contacts the dedicated Clinical Referral Line and is referred to a network provider.
2. The enrollee is directly connected with a network provider or facility for treatment.
3. The enrollee seeks treatment from a non-network provider and contacts ValueOptions in advance of the admission.
4. The provider—either in or out-of-network—contacts us for a request for authorization for any higher level of care.

Once an enrollee contacts the dedicated Clinical Referral Line and is referred to the appropriate level of treatment, the ValueOptions network provider is responsible for contacting ValueOptions to review for medical necessity and obtaining all necessary authorizations for services.

If an enrollee elects to obtain care from a non-network provider, the enrollee must inform his or her provider that the provider needs to contact our dedicated Clinical Referral Line to review for medical necessity prior to admission. The enrollee may also call the dedicated Clinical Referral Line and we will contact the provider to conduct a certification review. We 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 assists 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 assists in arranging for transfer to a network provider as soon as the situation stabilizes. On the day of the determination, a letter advising the enrollee 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 to review care for medical necessity and provide referrals 24 hours a day, every day of the year. During the review 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-V 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 dedicated Clinical Care Manager discusses and documents 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 dedicated Clinical Care Manager determines medical necessity by reviewing the symptoms, diagnosis, history, treatment goals, and planned interventions against ValueOptions' medical necessity criteria.

Medical necessity is applied in conjunction with consideration of the enrollee's unique needs, characteristics such as age, cultural factors, co-morbidities, complications, readiness for change, access to natural supports, progress of treatment, desired outcomes, psychosocial needs, and the home and/or work environment.

ValueOptions' approach to clinical care management/coordination, assessment/triage, and utilization review is based on the premise that individuals are more likely to access appropriate services and remain engaged in treatment when they feel empowered, and that their needs are understood and met.

Through consistent application of these criteria, ValueOptions' Clinical Staff/Peer Advisors and Providers can deliver appropriate services for the Empire Plan's enrollees. Included in care management is the assessment and referral to clinical practitioners and programs; coordinating a continuum of services with behavioral health and medical disciplines; implementing health and wellness strategies; identifying natural supports in the community, such as self-help groups; identifying resources to meet basic needs; and, making educational materials concerning MH/SA disorders available.

ValueOptions' clinical staff and Peer Advisors must determine that proposed services are medically necessary according to the following definition. Medically necessary services are those that are:

1. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (using the most current versions of the ICD and DSM) that threatens life, causes pain or suffering, or results in illness or infirmity
2. Expected to improve an enrollee's condition or level of functioning
3. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of the enrollee's needs
4. Essential and consistent with nationally accepted standard clinical practices generally recognized by mental health or substance use care professionals or publications
5. Reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available
6. Not primarily intended for the convenience of the recipient, caretaker, or provider
7. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency
8. Not a substitute for non-treatment services addressing environmental factors

(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?

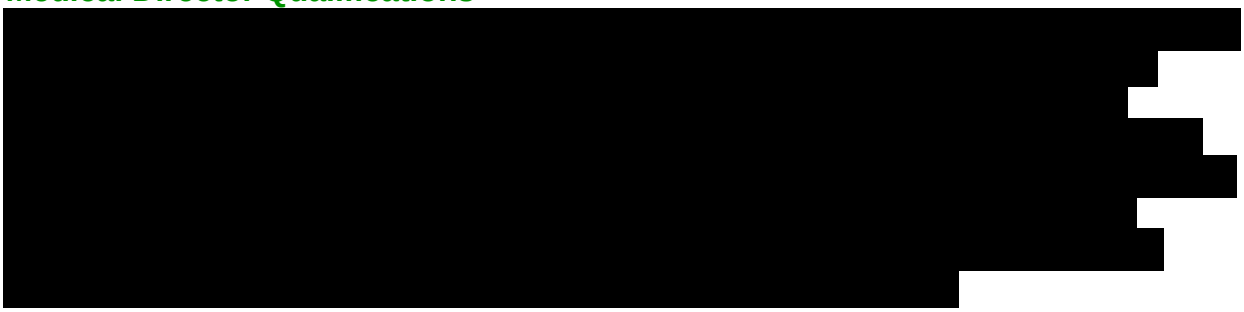
CLINICAL REFERRAL LINE STAFFING

The dedicated staffing complement for our Latham, NY-based dedicated Clinical Referral Line team will include eight dedicated Clinical Referral Line staff (Clinical Care Managers) who will perform pre-certifications, and three physicians who will handle all second-level reviews. ValueOptions will have 31 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

The following are descriptions of the qualification we require 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



[redacted]

Dedicated Clinical Director

[redacted]

[redacted]

Peer Advisor Qualifications

[redacted]

Dedicated Departmental Clinical Managers

[redacted]

Clinical Care Manager Qualifications

[redacted]

(c) For the calendar year 2013, the percentage of Enrollees who called the CRL and who received a referral at a different level of care from the one initially requested.

The number of enrollees who call the dedicated Clinical Referral Line and are directed to another level of care is 10 percent. Examples of this include:

- enrollees requesting to see a psychiatrist, but after an assessment are referred to a master's-level therapist or Ph.D. for talk therapy instead of medication management
- enrollees who call seeking a referral but based on an assessment are then referred for emergency or urgent appointments instead of routine services
- enrollees who call for mental health appointments but based on assessment are referred for a substance use evaluation

Our goal is to direct each enrollee to the most appropriate level of care for his or her specific situation. To accomplish this, our dedicated Latham-based 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 dedicated 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 dedicated Clinical Care Managers have comprehensive knowledge of the benefits available to Empire Plan enrollees through our proprietary CONNECTS platform, and use this information to help inform their referral decisions. For enrollees who call requesting routine referrals, the dedicated Clinical Care Manager completes an assessment to determine the level of risk. If the assessment reveals that an appointment needs to be arranged more quickly, the clinician refers the enrollee appropriately.

When enrollees request referrals for higher levels of care—including inpatient and residential—the dedicated Clinical Care Manager always refers him or her to one of ValueOptions' 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 dedicated Clinical Care Manager assesses the situation to be more serious than presented by the enrollee, the clinician overrides the caller-defined urgency of the situation and increases the level of urgency for the referral provided.

Enrollees are also likely to call the dedicated Clinical Referral Line with a provider already in mind. If the provider is not in the ValueOptions network, the clinician reviews with the enrollee the benefits of using a network provider and offers 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 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 offers providers who need to pre-certify services a telephonic precertification process that is Mental Health Parity compliant. The precertification line is staffed 24 hours a day, 365 days per year with licensed, Latham-based clinical staff that will immediately be able to complete the request for services. Similarly, any request for outpatient 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 and to ensure full compliance with Parity regulations, inpatient and higher levels of care (with the exception of crisis/emergency admissions), and non-routine outpatient services (e.g., electroconvulsive therapy (ECT), Transcranial Magnetic Stimulation (TMS), psychological testing, Applied Behavior 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 to establish medical necessity of services. We will educate our network providers to contact us for the initial review as soon as eligibility and benefits are known.

The precertification of the above services is compliant with the non-quantitative treatment limit (NQTL) rules set forth in MHPAEA as it was developed using comparable processes, strategies and evidentiary standards to authorization programs used to manage non-routine outpatient services. Similar authorization mechanisms are used for non-routine outpatient medical services. Precertification is also applied in a manner that is no more stringent than similar precertification applied to medical benefits. Precertification for these services is intended to ensure that the patient is receiving quality treatment, as opposed to denying medically necessary treatment or reducing an enrollee's access to care. The goal is to help enrollees access the most appropriate type of provider, in the most appropriate environment for non-routine services. 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.

Furthermore, although the MHPAEA final rules no longer provide for a "clinically appropriate exception," precertification of psychological testing is clinically appropriate given the wide variability of practice and the lack of consensus on when the testing is appropriate to use in a particular situation. Similarly, it is clinically appropriate to institute a preauthorization of Applied Behavior Analysis given this is a treatment composed 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 Behavior 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.

STAFFING LEVELS

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

TIMELINES FOR COMPLETION

All timelines begin with the request for review and end with the issuance of the determination. We are in compliance with New York state law in addition to the Empire Plan's performance guarantees. 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
ECT, ABA, TMS, Psychological Testing	Three business days from receipt of necessary information, with written notification within the decision timeframe.

If a clinical care management staff is unable to make a determination based on the information they have received, they will refer for peer review.

CLINICAL INFORMATION REQUESTED

ValueOptions' Latham-based clinical staff (i.e., Clinical Care Managers, Peer Advisors) gathers clinical 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

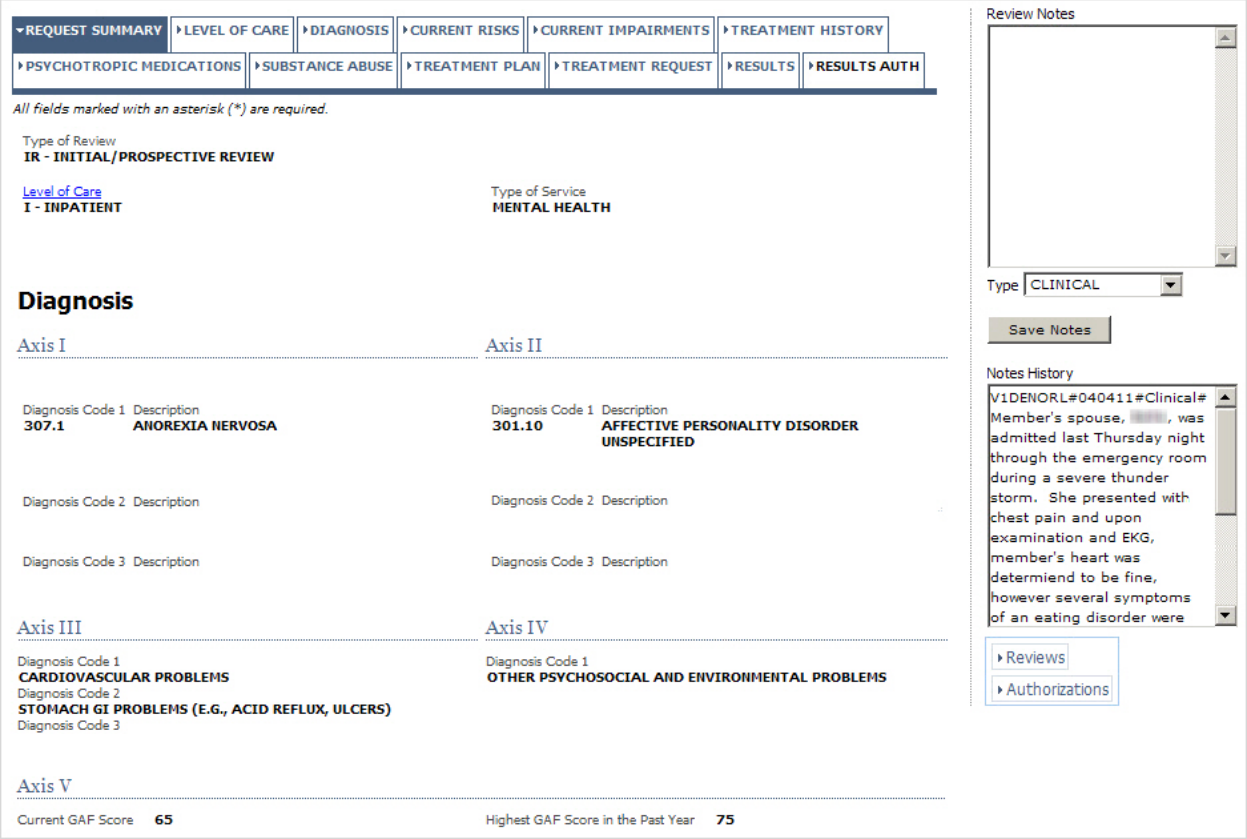
Dedicated Clinical Care Managers collect only the clinical information necessary to certify the medical necessity of the admission, procedure, or treatment under consideration. ValueOptions' clinical staff do not routinely request complete copies of medical or treatment records. For prospective and concurrent determinations, the clinical staff base their review decisions solely on the clinical information obtained at the time of the review.

Dedicated 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 i to conduct utilization management and related processes.

Clinical Documentation

ValueOptions utilizes the clinical care module, CareConnect, for all clinical documentation. This is part of our integrated, proprietary, behavioral health-specific CONNECTS platform which supports all clinical care management functions and documents all case activity, from the point of referral through all levels of care.

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 dedicated 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.



The sophistication of the CareConnect system allows the dedicated Clinical Care Manager to review the data necessary, promptly enter information to avoid delays in treatment, and to provide rapid response to our providers seeking precertification of services.

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, and 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 dedicated 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 dedicated Clinical Care Manager documents the date, time, and his or her name and credentials in the review. Once medical necessity is established, the dedicated Clinical Care Manager promptly enters the authorization into CareConnect at the time the review is documented.

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.

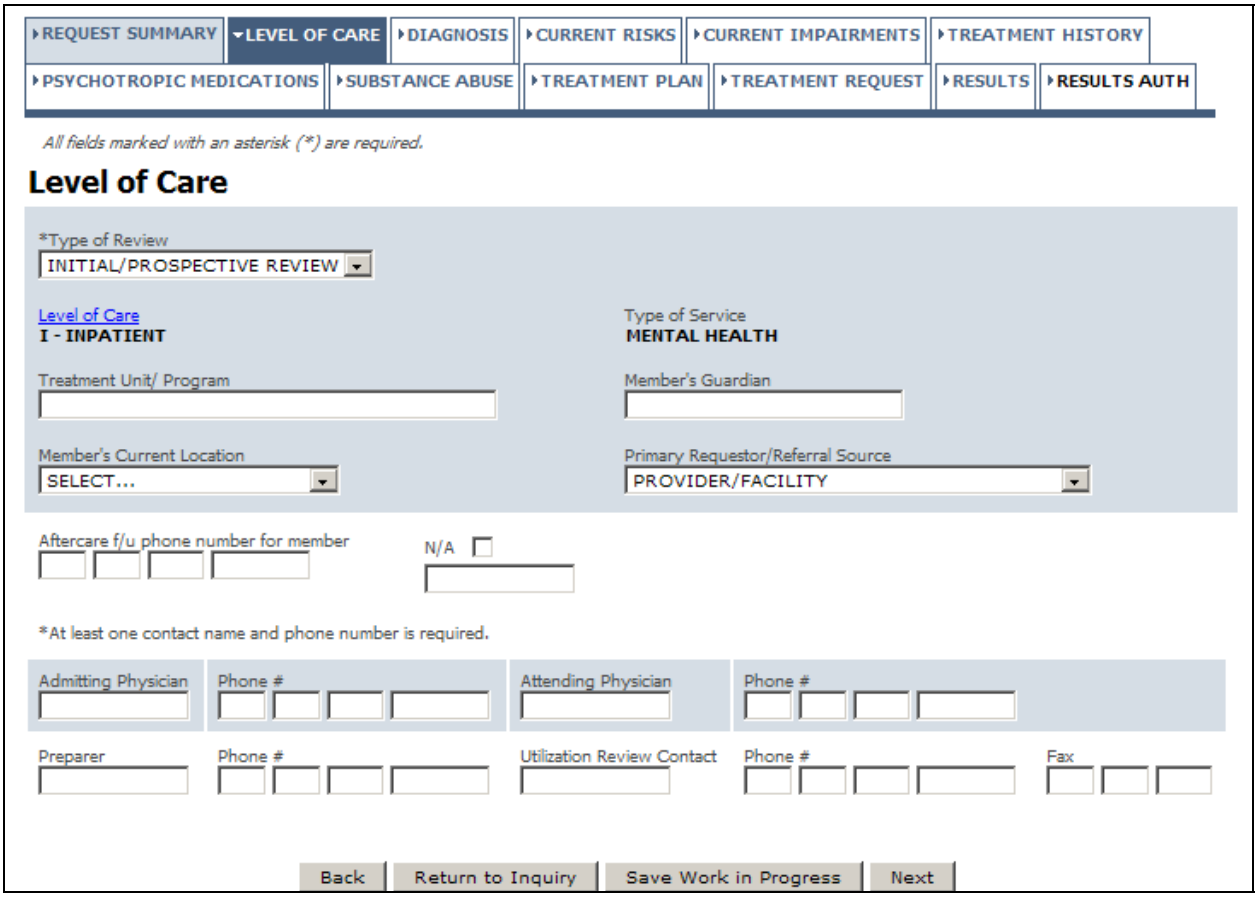
CASES REVIEWED, APPROVED AND DECLINED FOR THE EMPIRE PLAN

For the Empire Plan's first quarter of 2014, ValueOptions reviewed 21,830 unique reviews, with 21,365 being approved and 465 being "declined."

For the Empire Plan's first quarter of 2014, ValueOptions reviewed 21,830 unique reviews, with 21,365 being approved and 465 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 his or her particular needs. For example, if an enrollee calls our dedicated Clinical Referral Line and requests a referral for an office visit with one of our providers, but during that call the enrollee express that he or she is 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 offered a medically necessary alternative level of care, and are followed by a dedicated Clinical Care Manager to ensure that the enrollee obtains necessary services.

SAMPLE PRECERTIFICATION FORM

Below, we provide a sample screenshot of our CareConnect system showing a request for precertification. This form is completed by our dedicated Clinical Care Managers telephonically, while speaking with providers. CareConnect is a subset of our fully-integrated information technology platform. Our comprehensive information systems are capable of supporting complete managed behavioral health programs from the initial enrollee contact, through the claims adjudication and payment processes, in conjunction with the full range of management and utilization reporting requirements.



(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?

ACCESS TO PROVIDERS WITH SUBSPECIALITIES

ValueOptions' network includes a wide range of practitioner disciplines and facility programs. We recruit providers who reflect the diverse enrollee populations we serve, especially providers who are bilingual (including providers who speak American Sign Language or can read Braille), or who specialize in treating specific populations. Our practitioner application includes more than 70 fields pertaining to clinical expertise, therapeutic modalities, and personal demographics that enable providers to identify:

- Languages they speak fluently other than English
- Their ethnicity (e.g., African-American/Black, Asian, Biracial)
- Their religion

Due to the sensitive nature of this information, the provider applications states that this information is optional, and is used only for the purpose of accommodating a stated enrollee preference.

Other provider-specific practice information the application captures includes:

- Special populations they treat (e.g., children ages 6-12, hearing impaired, geriatric)
- Clinical areas of expertise (e.g., anxiety disorders, chemical dependency, childhood behavioral disturbances)
- Treatment modalities (e.g., cognitive behavioral therapy, dialectical behavior therapy, group therapy)
- If the practice is handicapped accessible
- If the practice is accessible by public transportation

Providers with skills treating particular workforce populations, such as safety-sensitive positions or law enforcement officers, are also recruited.

Referral Line Clinicians have access to all of this information to ensure that enrollee's needs are met at the time of referral. ValueOptions uses our CONNECTS system's sophisticated software to identify subspecialties, store all provider information, and ensure that our Latham-based clinical staff has continuous online access to that information. The system allows a dedicated Clinical Care Manager to request a very specific provider search within a circumscribed geographic area. The dedicated 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 dedicated Clinical Care Manager, who is then able to view all available demographic and clinical practice information regarding that provider.

SERVING CHILDREN AND ADOLESCENTS

Children and adolescents require age-appropriate treatment from providers 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 providers 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 in 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 programs ValueOptions makes 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. Voiance has 18 years of experience in interpretation services, with thorough dedication to serving clients in health care as well as federal and state governments.

SERVING THE DEAF AND HARD-OF-HEARING

As part of our routine call center services, we offer TTY/TDD and relay services for those enrollees who are deaf, hard-of-hearing, or have a speech disorder. We have a demonstrated commitment to overcoming the barriers to care faced by people with hearing loss or speech disorders. 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 have a speech disorder can talk to us without an interpreter. 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 to continuously identify and recruit new providers to meet any specific ethnic and cultural needs identified by enrollees. In those rare instances when 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 adult enrollees who are identified as severely mentally ill (SMI), and child/adolescent enrollees who are diagnosed with a serious emotional disturbance (SED). In fact, we hold public sector contracts that specifically draw upon our expertise and capabilities to manage care for these difficult-to-treat populations. We have developed an expanded, coordinated care process for children and adult enrollees with serious and persistent mental illness, especially those whose clinical histories include hospitalizations, complex needs, and at-risk or out-of-home placement.

Components of our expanded, intensive case coordination process include development of a personalized wellness and recovery action plan (WRAP)), 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 enrollees' 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

ValueOptions has detailed clinical protocols and procedures in place to ensure the appropriate handling of any urgent or emergency cases. The dedicated 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. They are responsible for making determinations of the severity of the presenting case. 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 or 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

Urgent

For enrollees who request or are assessed as requiring urgent care, the ValueOptions clinician uses the following protocols to ensure the enrollee receives a face-to-face assessment with a licensed mental health professional:

- 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 him or her 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 or her appointment, the clinician makes three attempts to contact the enrollee to ensure his or her safety.

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 dedicated 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 a 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 the caller is unsuccessful, the clinician 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 the Empire Plan'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.

As safety is ValueOptions' number one concern for those in crisis, the Empire Plan can be assured that the above protocols, along with our clinicians' extensive experience, enables 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 within which enrollees are seen by network providers, including:

- ***performing proactive follow-up to ensure 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.

ValueOptions requires network providers contacted directly by an Empire Plan enrollee to inform and educate enrollees about the various benefits available to them under the Plan. Providers 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. During their initial contracting process, providers receive a ValueOptions Provider Handbook and Empire Plan Provider Guide detailing processes and information necessary to assist enrollees in receiving appropriate services.

(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

As the current Contractor, our call volume evidence indicates that the consolidated NYSHIP line is widely utilized in the provider and enrollee community. As of April 2014, we have had a total of 9,169 calls to the dedicated Clinical Referral Line. We will continue proactive initiatives to educate Empire Plan enrollees on the advantages of using the dedicated Clinical Referral Line with the distribution of communication materials. These materials, including explanations of benefits, brochures, the Empire Plan-specific Achieve Solutions website, displays on the Empire Plan website, and similar initiatives, will emphasize the following:

- The dedicated Clinical Referral Line is available 24 hours a day, every day of the year via the NYSHIP toll-free number.
- Accessing the dedicated 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.
- Clinicians are able to provide support and brief solutions and strategies for enrollees to utilize prior to their appointments

ENCOURAGEMENT THROUGH ONLINE PROVIDER DIRECTORY

Enrollees who locate a provider using the online, enrollee-facing provider directory within Achieve Solutions are reminded to contact ValueOptions prior to beginning care, and are provided with the Empire Plan consolidated NYSHIP 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 ReferralConnect does not replace any pre-certification requirements of your plan. For more information, please call ValueOptions at the NYSHIP toll-free number."*

ENCOURAGEMENT THROUGH DIRECT TRANSFERS

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 dedicated 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 NYSHIP consolidated line in all training sessions with the network provider community. Dedicated 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 NYSHIP toll-free number.

Additionally, ValueOptions participates in the annual Health Benefits Administrators conferences throughout the state. These conferences are used as another opportunity to educate enrollees and administrators regarding the use of the NYSHIP toll-free consolidated dedicated 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) DEDICATED CLINICAL REFERRAL LINE AND CLINICAL MANAGEMENT LOCATION

All dedicated Clinical Referral Line and other clinical management services for the Empire Plan program are provided in Latham, New York, by New York-licensed behavioral health clinicians.

MHSA COMMUNITY RESOURCES

ValueOptions has been in business in New York since 1992. Besides 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 has Empire Plan benefits information available to them. This would include medical carrier information, disease management programs, and any health and wellness programs. Clinical Care Management staff are provided monthly Lunch and Learn training sessions on available community resources. Our staff of dedicated Clinical Care Managers are consistently exploring newly available and ever-changing community resources, namely in underserved areas. Our database is subject to regular updates and modifications to maintain the most accurate and available information to assist the Empire enrollees in obtaining the most rounded wellness and recovery plans utilizing the community supports in their home area. Our Intensive Case Managers utilize their well-developed relationships with community agencies, such as Offices on Aging, the National Alliance on Mental Illness, and the various New York County agencies to remain abreast of changes to the local resources.

(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 dedicated Latham-based Clinical Referral Line and precertification services in the following ways:

Methods to Measure the Effectiveness of the Clinical Referral Line and Pre-Certification Services	
Call Tracking	All dedicated 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.
Quality Management Audits	Our Quality Management team conducts monthly random audits of precertification reviews conducted by our dedicated Clinical Care Managers and Peer Advisors. The audit tool evaluates whether medical necessity criteria were met for admission; whether the level of care approved was the most appropriate, least restrictive level of care based on the enrollee's clinical needs; and, care protocols are evidence-based. Dedicated Clinical Care Managers are evaluated at least monthly, and more frequently for new employees. The audits are used as a tool in: the orientation and training of new clinicians; quality

Methods to Measure the Effectiveness of the Clinical Referral Line and Pre-Certification Services	
	assurance in maintaining performance standards with regards to professionalism, collection of critical clinical information and appropriate application of criteria; a routine part of performance evaluations; and, as a follow-up on complaints received. During the telephone audit, the quality auditor listens to calls and evaluates the interaction in six areas – opening, triage, assessment, treatment planning, hold and transfer techniques, closure, comprehensive service and resolution.
Facility On-site Treatment Record Review	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 ensures that the records adhere to national standards of practice and reflect the clinical appropriateness of the behavioral health admission.
Tracking and Investigating Complaints	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.
Tracking Provider Requests	ValueOptions tracks provider requests to ensure they are provided in a timely manner. If they are not, outreach and education is provided to practitioners 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.
Inter-rater Reliability Tool	ValueOptions utilizes an Annual Inter-rater Reliability tool, administered to all Clinical Care Management staff to test for consistent application and adherence to medical necessity criteria. Competency on this tool is a passing score of 80% or above. This tool assists in determining that our precertification services are effective and reliable across clinicians and consistent from the provider standpoint.
Facility Readmission Tracking	ValueOptions utilizes facility readmission tracking to assess for effectiveness of appropriate precertification assessment, and sound discharge planning (from time of admission) to prevent recidivism due to ineffective transition of care planning.

(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 implementation date, once acceptable files are received.

As the Contractor providing behavioral health services for the Empire Plan, we will not have to transition enrollees as part of this new contract. However, there are times when enrollees are new to the Empire Plan and a transition of benefits is necessary.

When ValueOptions receives calls from enrollees new to the plan, the dedicated Clinical Care Managers advise them of their transition benefit. If the provider is not in the Empire Plan network, a single case agreement is completed for a 90-day period to allow the enrollee time to terminate treatment or begin the transition to a network provider if they chose. An assessment and evaluation is also completed to determine if that enrollee may have unique needs that cannot be met by a network provider. In those situations, ValueOptions works with the provider to become in-network, or a long term single case agreement would be completed.

As a part of transition of benefits for enrollees new to the Empire plan retroactive reviews may be required.

(k) The guidelines you use to determine length of stay. Have these guidelines been peer reviewed?

ValueOptions has policies and medical necessity criteria that guide the length of stay determination . All criteria are reviewed yearly by ValueOptions' medical and clinical staff, and a provider advisory committee. ValueOptions uses the clinical expertise of the contributors and evidence-based data from a variety of resources to develop our criteria. These criteria are objective, evidence-based and take individual circumstances and the local delivery system into account when determining the medical appropriateness of the health care requested. In our development of clinical criteria, we rely upon the following organizations for review:

- 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 and 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

Reviews and length of stay are conducted at a frequency dictated by clinical issues in each case, the severity and complexity of the enrollee's condition, or on medically necessary treatment and discharge planning activity. The frequency of the review may occur more or less often depending on the severity and complexity of the enrollee's condition. Our reviews are structured based on Symptom Complexes, with each Symptom Complex having a unique set of questions related to that type of presentation. Symptom Complexes are a set of tools to help conceptualize cases based on categories of similar symptoms or conditions. We developed our Symptom

Complexes based on the most common presentations we tend to see. These include suicide, homicide, psychosis, eating disorders, Child/Adolescent Behavioral Disorders, Comorbid Organic Brain Syndrome/Psychiatric Disorders, Chemical Dependency, and Mood Disorders.

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)

We consider many factors when applying criteria to determine a length of stay for a given enrollee, such as:

- age
- comorbidities
- complications
- progress of treatment
- psychosocial situations
- home environment
- characteristics of the local delivery system
- availability of alternative levels of care
- the service area's ability to support the patient after hospital discharge—this can include family community and natural support systems

During the concurrent review process, early identification of issues provides opportunity to shape the treatment plan and encourage timely intervention to reduce the risk of adverse outcomes or delayed progress for the enrollees. All decisions are made in a timely manner and in accordance with the risk and potential harm to an individual if there is a delay.

(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.

ValueOptions confirms that it 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.

ValueOptions confirms 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 DETOXIFICATION

ValueOptions' staff works with all inpatient detoxification programs, including those programs located on a medical unit or within free-standing facilities. For hospital detoxification admissions, the facility is advised to send claims to the Hospital Program Carrier. As the Contractor providing services to the Empire Plan, ValueOptions supplies a daily report to the Hospital Program Carrier that tracks detoxification admissions that will be applied to the hospital benefit. Our clinical staff assesses the need for and pre-certifies an inpatient hospital admission for alcohol detoxification using the following criteria:

1. Enrollee 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 enrollee 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 dedicated Clinical Care Managers work with the facility to ensure an appropriate discharge plan is developed. All review cycles are completed with a discharge review to ensure appropriate transition of care to the identified aftercare provider. 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 detoxification, 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 work to transition enrollees from inpatient detoxification 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 detoxifications, or multiple rehabilitations are 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 implementation date, once acceptable files are received.

ValueOptions will have all existing authorizations in our clinical management and claims processing system as the existing Contractor. ValueOptions will be able to accept any other files that are necessary to ensure continuity and quality of care for new enrollees.

(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 reported quarterly and calculated on an annual basis, 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 reported quarterly and calculated on an annual basis is $_____.

EMERGENCY CRL GUARANTEE

[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 reported quarterly and calculated on an annual basis, is $_____.

URGENT CARE CRL GUARANTEE

[redacted]

TRANSITION OF CARE

(1) Confirm that the Offeror will identify appropriate members and mail Transition of Care letters to members and Providers in a timely manner.

ValueOptions confirms that we will identify appropriate enrollees and mail Transition of Care letters to enrollees and Providers in a timely manner.

(2) Confirm that the Offeror will process Transition of care benefits so that the member is responsible only for the applicable Copayment.

ValueOptions confirms that we will process Transition of care benefits so that the enrollee is responsible only for the applicable Copayment.

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) Intensive Case management of high risk cases.

ValueOptions employs a Mental Health Parity Compliant concurrent review UR program staffed by licensed clinicians that ensure Network providers adhere to Empire Plan program benefits and evidence-based care protocols.

(a) STAFF QUALIFICATIONS

Below, we provide the qualifications of staff responsible for the oversight of our concurrent UR program:

Medical Director

ValueOptions' medical directors are psychiatrists with significant experience in the field prior to their employment with ValueOptions. We are actively recruiting a dedicated Empire Plan Medical Director who will report through to [redacted]. [redacted] will still serve in an oversight capacity for the Empire Plan Program. [redacted] is a licensed, board-certified psychiatrist who provides leadership and direction for services rendered under the Empire Plan contract, as well as having ultimate oversight of the utilization management process. [redacted] 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.

The dedicated Empire Plan Medical Director will meet ValueOptions' requirements for Medical Directors, including having the following:

- Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) degree 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

Clinical Director

[redacted] currently serves as the dedicated Clinical Director for the Empire Plan. She is a New York State-licensed clinical social worker with 16 years of post-graduate clinical experience, and has worked in inpatient and outpatient mental health settings. [redacted] has four years of experience as a Clinical Care Manager with ValueOptions from 2010 to 2014, and [redacted].

[redacted] responsibilities for the current Empire Plan includes:

- Ensuring all utilization management and intensive care management programs meet accreditation and regulatory standards
- Understanding all national medical and clinical best practices and implementing them in the Latham Engagement Center
- Collaborating with the Medical Director to identify and resolve clinical issues
- Interfacing with the Empire Plan, internal, and external customers in a prompt and professional manner to ensure optimal quality of service
- Collaborating with the QM department to identify and implement quality improvement activities

ValueOptions' Clinical Directors must have a current, valid, and unrestricted clinical license (R.N., L.C.S.W./A.C.S.W., Ph.D., L.L.P., L.M.F.T., and L.P.C.) and meet the following criteria:

- Master's-level or higher degree in a mental health related field (R.N., L.C.S.W./A.C.S.W., L.M.F.T., Ph.D.)
- minimum of eight years of post-master's clinical practice experience
- minimum of two years of inpatient or hospital-based treatment experience and two years of outpatient treatment experience
- minimum of three years of managed care experience
- minimum of five years of administrative and management experience

Clinical Department Managers

The Empire Plan dedicated staffing includes two Clinical Department managers; one to oversee Utilization Management daily staff operations, and one to oversee daily Intensive Case Management operations.

Clinical Department Managers must have a have a current, valid, and unrestricted New York State clinical license (R.N., L.C.S.W./A.C.S.W., Ph.D., L.L.P., L.M.F.T., and L.P.C.) and meet the following criteria:

- Master's-level or higher degree in a mental health related field (R.N., L.C.S.W./A.C.S.W., L.M.F.T., Ph.D.)
- A minimum of five years of post-graduate clinical/administrative experience, some of which has been in a supervisory capacity
- solid knowledge base and working knowledge of mental health systems, with clear understanding of psychiatric clinical case management

Clinical Care Managers

ValueOptions' dedicated Clinical Care Managers are responsible for the continued review of all enrollee care (i.e., for both inpatient and outpatient services). Dedicated Clinical Care Managers may certify care, but cannot render non-certification decisions. Dedicated 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 a minimum of 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 dedicated Clinical Care Manager is unable to certify. Only Peer Advisors may render a non-certification decision. Peer Advisors must have the following qualifications:

- license 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 or she is completing to ascertain if the treatment being providing meets best practice standards. The form is available for online completion or can be faxed in for review. Once the form is received, it is reviewed by one of our dedicated 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 continuously 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 dedicated Clinical Care Manager calls the provider to conduct a telephonic review to facilitate the medical necessity determination. If the information given supports medical necessity, the dedicated Clinical Care Manager authorizes services. She or 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 a dedicated Clinical Care Manager to establish 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 due to 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 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

The ValueOptions' On Track Outcomes Program helps clinicians incorporate patient-reported feedback into their counseling and psychotherapy practices. A growing body of research demonstrates the power of this type of routine feedback to improve patient outcomes. We designed the program to ensure that outpatient behavioral health recipients are on track in achieving their goals. On Track gives clinicians valuable tools to track patient progress relative to benchmarks, to identify patients at risk for poor outcomes, and to demonstrate the impact of their services. The process is based on the enrollee-completed Client Feedback Form, which monitors changes in health status as individuals receive services. This Client Feedback Form assesses 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).

Participating ValueOptions providers are asked to administer the Client Feedback Form prior to the enrollee's 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 continuously 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 4,033 ValueOptions network providers have registered to participate in this program.

(c) REVIEW OF INPATIENT CARE

Intensive Case Management

ValueOptions' Intensive Case Management (ICM) program identifies and manages those enrollees who require services that go beyond routine care management. We have ICM-specific protocols and procedures, and make all ICM determinations according to prescribed admission criteria and track them accordingly. For referrals to our ICM program, dedicated Clinical Care Managers monitor enrollees who undergo outpatient treatment and are at risk for admission to an inpatient facility. Our criteria for the ICM program includes the following:

- adults with three or more inpatient admissions within the past 365 days
- adults with one inpatient admission and co-morbid cardiovascular disease
- adults with one inpatient admission and co-morbid diabetes
- adults with one inpatient admission and co-morbid asthma
- pregnant women with co-morbid substance abuse

The Medical Director also reviews cases that may benefit from case management services and makes referrals to the ICM program, considering the following types of cases:

- inpatient stay greater than 21 days
- children/adolescents with two or more admissions
- non-adherence to medication/treatment regimens
- medical complications
- psychiatric disability
- pain management cases with emergency room visits
- enrollees with two or more admissions to the emergency room
- enrollees diagnosed with schizophrenia
- enrollees with eating disorders
- enrollees admitted to an Intensive Care Unit for self-injurious behaviors who were not admitted to inpatient behavioral health care

Concurrent Review of Inpatient and Alternative Level of Care

Dedicated Clinical Care Managers conduct telephonic concurrent review of inpatient and alternative level of care cases. The telephonic clinical review process allows the dedicated 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. Dedicated Clinical Care Managers closely monitor the patient's status, medications, and the treatment planning process at each review. Additionally, dedicated Clinical Care Managers delve into the contextual reasons for admission. This includes a comprehensive evaluation of stressors, strengths and supports, and availability of the same to mobilize in support of recovery.

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 informs the enrollee how to obtain care from an appropriate network provider, offers to make a referral, and arranges 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 enrollee's condition; with

maximum time frames for standard inpatient care management and Alternative Level of Care (ALOC) reviews for medical necessity established for each (please see chart below).

Our reviews are structured based on Symptom Complexes, with each Symptom Complex having a unique set of questions related to that type of presentation. We developed our Symptom Complexes based on the most common presentations we tend to see.

Symptom Complexes are a set of tools to help conceptualize cases based on categories of similar symptoms or conditions. It is not based on diagnoses due to the large volume of diagnoses currently in the DSM-IV-TR. A symptom complex provides a manageable way to understand the needs of an individual patient. This is vital in order to ensure the member receives the most appropriate treatment for his/her unique circumstances.

Each symptom complex contains treatment planning questions specific to that complex. The Symptom Complexes are:

- Suicide
- Homicide
- Psychosis
- Eating Disorder
- Child/Adolescent Behavioral Disorders
- Comorbid Organic Brain Syndrome/Psychiatric Disorder
- Chemical Dependency
- Mood Disorder

We continue to receive and record diagnosis information from providers in our CareConnect system as well.

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, dedicated 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, symptoms and functional 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

Discharge planning begins with the first concurrent review. ValueOptions' clinical philosophy maintains that inpatient treatment services should be designed to return the enrollee to his or 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 dedicated Clinical Care Manager in the discharge process is to ensure 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 dedicated 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 works closely with enrollees and their families during this transition process to ensure that all barriers to discharge are addressed. When it is determined that care can be provided in a less restrictive setting, the dedicated Clinical Care Managers will assist with locating the aftercare provider, will ensure authorization for the next medically necessary level of care, and will assist in facilitating a safe transition of care to the next treatment level.

Discharge plans and transition to less restrictive levels of care are also discussed in clinical rounds on an ongoing basis. Clinical rounds occur daily and are composed of the dedicated Medical Director or a ValueOptions staff psychiatrist, the Clinical Director, Utilization Review

Clinical Manager or Supervisor, and a group of dedicated Clinical Care Managers. This meeting serves as a valuable resource for sharing case information and seeking guidance from a psychiatrist or from other dedicated Clinical Care Managers to resolve complex case issues. Case consultations are also held one-on-one between a ValueOptions psychiatrist and a dedicated Clinical Care Manager on a daily basis, as needed. This assists the dedicated Clinical Care Manager in resolving any open issues that require immediate attention.

Discharge Planning Procedures

Dedicated Clinical Care Managers proactively discuss discharge planning as part of every review. It begins in the initial care management review to ensure 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 dedicated Clinical Care Manager confirms the enrollee's status and speaks with the provider. Dedicated Clinical Care Managers ensure 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 dedicated Clinical Care Managers during the treatment period following an acute care admission are central to our program. We measure HEDIS®[1] 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. ValueOptions has dedicated follow-up care staff that provides enrollee outreach to identify obstacles to a successful link with the aftercare services identified at time of discharge.

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

[1] "HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)."

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) INTENSIVE CASE MANAGEMENT OF HIGH-RISK CASES

Goals of Intensive Case Management

The goals of our Intensive Case Management program are 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.

There are two basic functions of our ICM program, oversight of integration among providers, and active engagement for enrollees to support the coaching process and adherence to the plan. ValueOptions maintains a proactive ICM Program that is designed to more effectively manage the care of those enrollees who are determined to be "high-risk." ICM is a specific approach to managing the care of enrollees who have not been able to stabilize with standard care management strategies. ICM is a collaborative process involving dedicated 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, ICM promotes quality, cost-effective outcomes. ICM 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 ICM. All dedicated Clinical Care Managers and providers are aware of these clinical indicators so that when appropriate, patients can be referred for ICM. 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, 10 years old 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 ICM 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 ICM 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 ICM process are described below:

- **Intensive Case Management program components.** The key components of the ICM program include:
  - More educational and informative phone contacts with enrollees/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
  - Ensuring linkage with discharge location and community resources
  - Evaluating provider's efficacy with this particular enrollee and referring for a second opinion as appropriate
  - Ensuring that the facility has performed drug screens and substance abuse evaluations
  - More frequent reviews by dedicated Clinical Care Managers and Peer Advisors
  - Utilizing internal staffing meetings and clinical rounds to discuss the enrollees' needs
  - Coordinating with the workplace; conferencing with the various providers, PCPs, workplace representatives, parents, or the enrollee, all as appropriate and with necessary releases of information
  - Enabling high-risk enrollees to use available resources (including services available through schools and community agencies) in a more efficient, effective manner
- **Criteria for moving an enrollee from ICM when stability has been achieved and maintained over an extended period of time.** An enrollee is considered appropriate for "discharge" from the ICM program once he or she has met his or 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 ICM-level services. If discharged, enrollees

can be re-referred for ICM at any point in the future when they are determined to be at high risk.

Intensive Case Managers

ValueOptions' ICM program requires that a senior dedicated 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 follows 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.

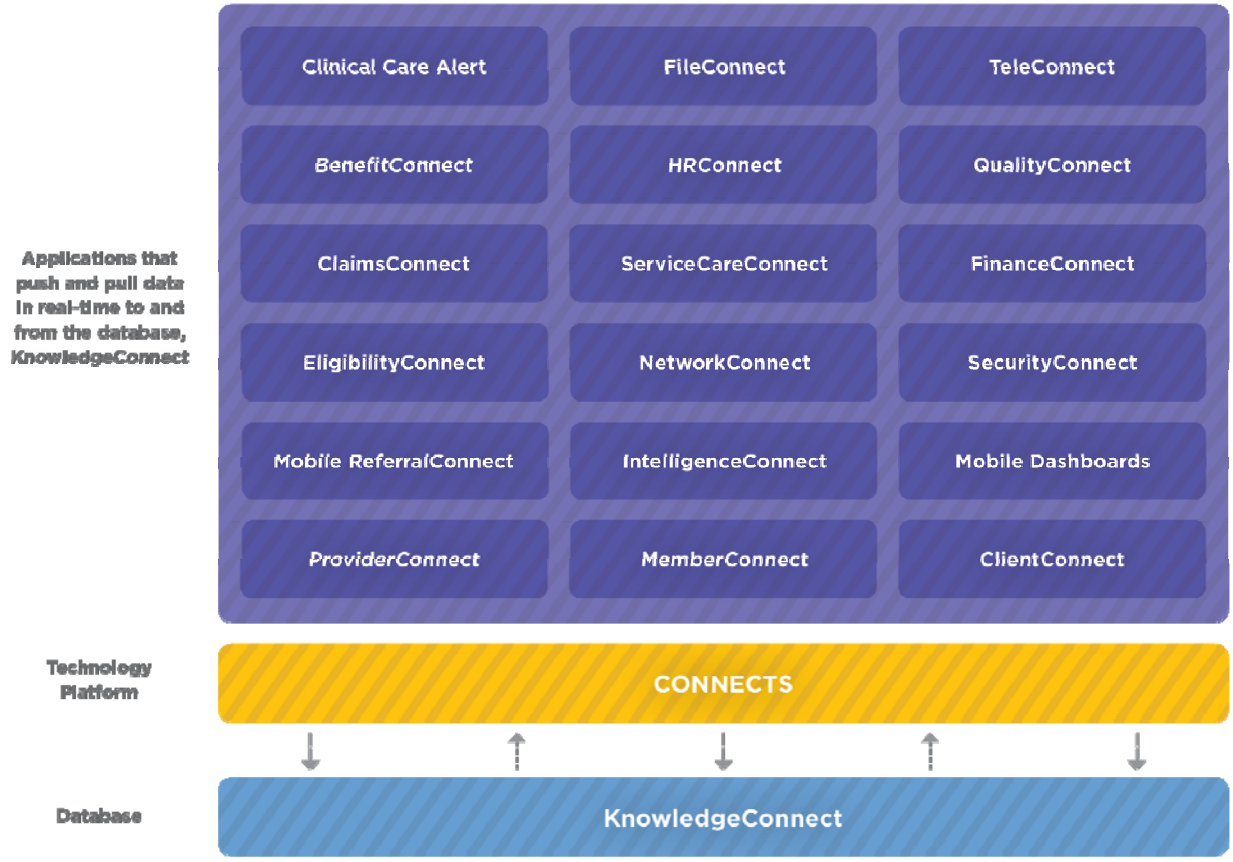
The assigned Intensive Case Manager ensures integrated services through ongoing communication with the Empire Plan enrollees and provider(s) involved in the case, establishing linkages to family service agencies, community services organizations, the court system, schools, the Employee Assistance Program, external care management providers, and any other appropriate resources. The Intensive Case Managers 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 dedicated Clinical Care Manager calls the outpatient provider and informs them of the ICM process. The dedicated Clinical Care Manager then confirms the appointment date and time and instructs the provider to contact the dedicated Clinical Care Manager directly to conduct all subsequent clinical reviews. The dedicated Clinical Care Manager contacts the provider on the day following the enrollee's scheduled appointment. If the enrollee does not keep the appointment, the dedicated Clinical Care Manager requests that the provider contact the enrollee. The dedicated 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, proprietary, behavioral health-specific 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. We demonstrate how all applications relate to each other in the diagram below.



CareConnect also:

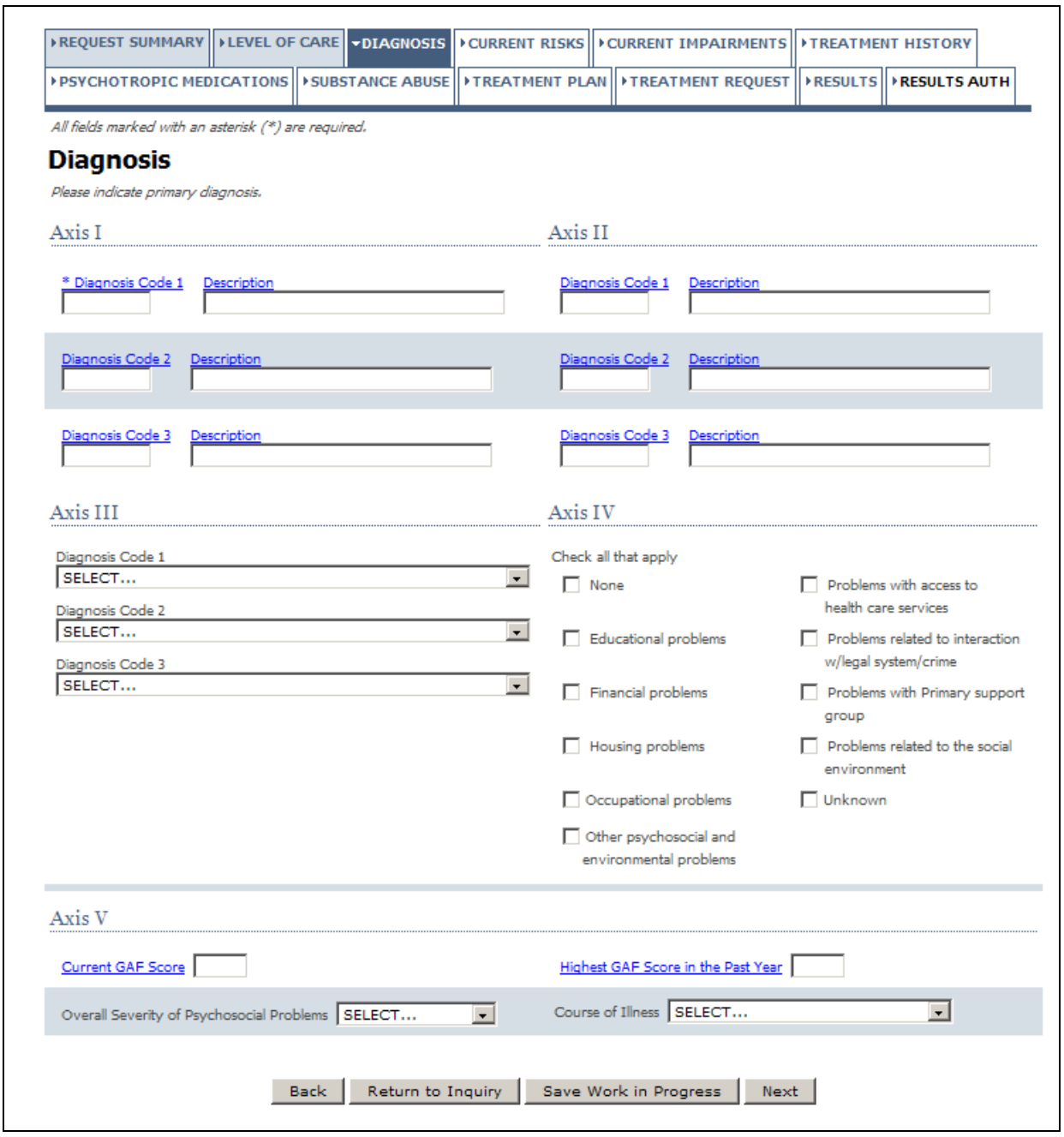
- Uses data fields that capture reportable outcomes and other clinical data to track and exhibit the effectiveness of services
- Delivers an effective work management system that integrates across other ValueOptions applications to allow for seamless continuity
- Minimizes administrative requirements 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 website and unique provider submitter ID

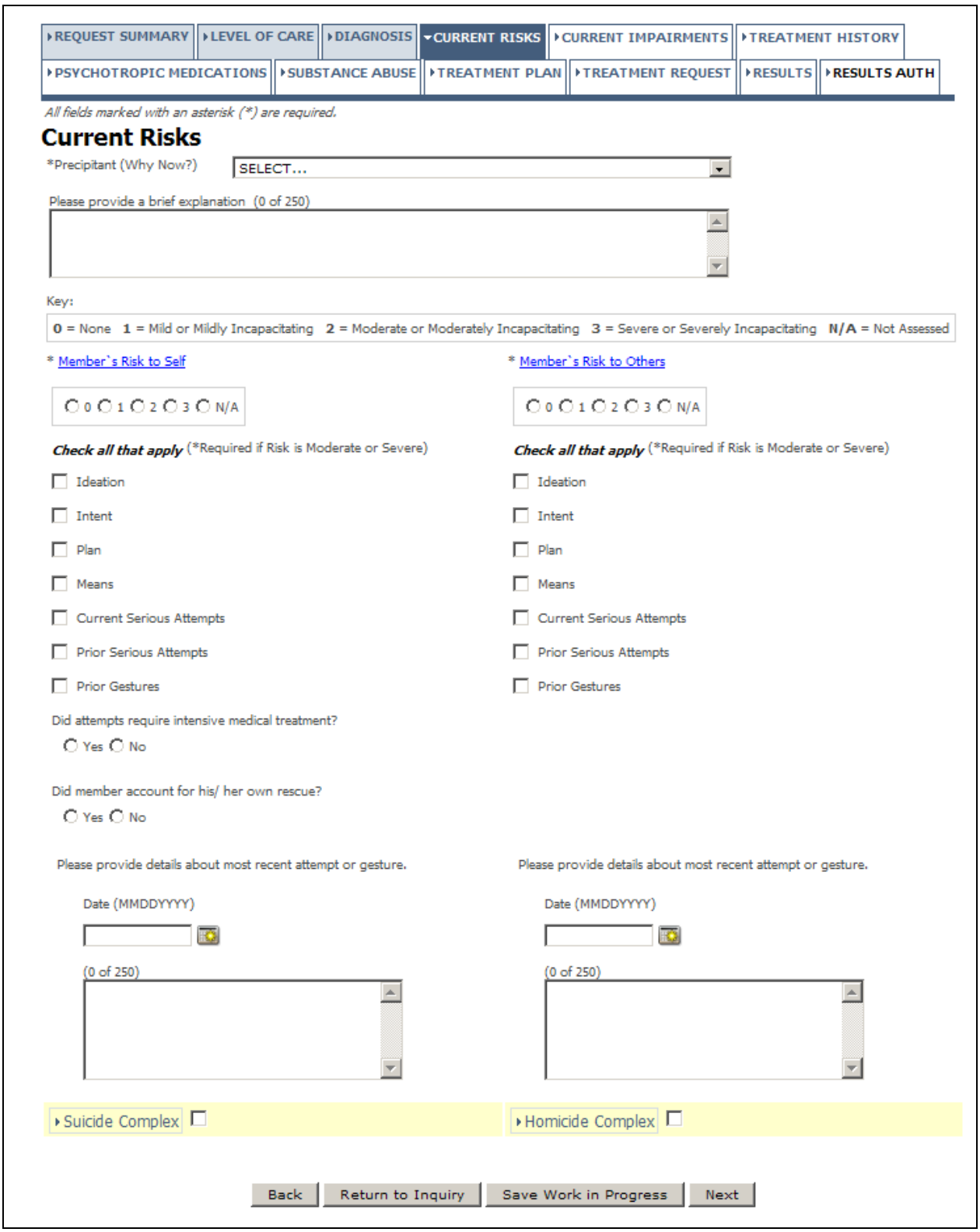
The CareConnect system maintains an enrollee's complete treatment history and supports functionality to search for all cases for a specific enrollee or for a specific provider. CareConnect addresses the specific needs of the dedicated Clinical Care Managers and allows them to quickly focus on the most 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.
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 MHSA 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). In our development of clinical criteria, we rely upon the following organizations for review, which include:

- 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 and 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 (e.g., 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 Engagement Center Clinical Advisory Committees, UM, and Quality Management Committees and subcommittees
   c. input from providers, community agencies, and enrollees at the engagement center level

   d. input from providers 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. Engagement 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' engagement 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, dedicated 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 dedicated 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) Explain which of the Offeror's staff (and their clinical licensure level) has the authority to deny payment for services.

Denials based on medical necessity criteria are only rendered by a member of our peer advisor team with clinical licensure of Ph.D., Psy.D., M.D. or D.O. ValueOptions peer advisor doctors are available to the Latham-based clinical staff 24 hours per day to assist in medical necessity determinations.

(5) Describe your utilization review process and confirm that it is parity compliant as required by MHPAEA.

ValueOptions has an established utilization review process that is parity compliant for inpatient and outpatient services and such processes mirror current medical management practices, ensuring full compliance with MHPAEA. ValueOptions has obtained documents from the state that describe the current utilization management on the medical and hospital side of the plan. These documents have been reviewed from both a legal and clinical perspective. Findings have been reviewed with the state and at this time medical, hospital, and behavioral health processes are aligned.

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.

UTILIZATION REVIEW PROCESS—OUTPATIENT CARE

Our clinical management program is designed to support the Triple Aim of healthcare by: 1) promoting effective clinical outcomes and the quality of care for outpatient, non-emergent treatment, 2) improving the member's experience of healthcare delivery, and 3) promoting efficient use of healthcare resources. The Enhanced Outpatient Care Management program monitors the delivery of outpatient care to meet these objectives using concurrent care review for select cases. Our program utilizes clinical algorithms and informed decision making based on

national practice guidelines to identify individual cases with unusual treatment patterns compared to the health population. This analysis takes into account the following factors to help determine whether an individual's ongoing outpatient treatment is consistent with nationally recognized best practice:

- Diagnostic condition
- Severity of condition
- Individual demographics including age and gender
- Co-morbid heath issues
- Length of time in treatment
- Coordination of care with other treating providers
- Number of practitioners associated with treatment and types of services
- Medication management treatment
- Frequency of service delivery
- Number of services rendered compared to cases with similar characteristics
- Treatment progress as measured by standardized outcomes tools
- Adherence to best practice treatment

ValueOptions notifies the treating provider regarding this analysis and requests high level clinical information submitted on a two page review form[2] which includes treatment elements such as illness severity, contact with physicians involved in the patient's treatment, family member involvement, medications involved and the patient's adherence to the treatment plan and an endorsement of evidence based care for the specific condition. These factors are consistently referenced as evidenced based practice interventions within multiple published clinical practice guidelines[3]. The provider submits the screening information online and receives either an immediate authorization or a request for clarifying information.

The purpose of requesting this clinical information is to help identify plan of care enhancement opportunities and additional treatment recommendations to the provider. The exchange between the treating provider and ValueOptions Clinical Care Managers related to complex cases typically includes discussions about additional care resources that may not be currently utilized such as adding medications, intensive care management, and community resources.[4] While denial of care is an option in the review for medical necessity, the intent is not to deny treatment or reduce access[5].

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

[2] See: ValueOptions Outpatient Review Form

[3] See: Clinical Practice Guideline Sources Including Specific Guidelines Utilized by ValueOptions

[4] See: Clinical Practice Guideline Sources, IBID

[5] See: Outpatient Medical Necessity Criteria

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. 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 continuously 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 dedicated 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 dedicated 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.

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 dedicated 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 dedicated 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 dedicated 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 dedicated 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. Dedicated 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 dedicated 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 dedicated Clinical Care Manager certifies additional days and clinical documentation is entered into CareConnect.

Retrospective Review

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 medical necessity determination is rendered, the enrollee, practitioner, and facility are notified of the decision in writing.

Non-Certification Process

When the dedicated 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 dedicated 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.

(6) Describe the methods you utilize to measure MHSA 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 currently assesses clinical effectiveness and performance through our treatment record review process for the Empire Plan. 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.

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 three to four months after the initial referral. Over the course of the study, enrollees have reported a decrease in absenteeism of 50.1 percent. Additionally, presenteeism (lost productivity while present on the job) decreased by 67.7 percent. Further, 76.4 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
- dedicated 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. Staff are required to take and achieve passing scores on an annual inter-rater reliability test based on ValueOptions' medical necessity criteria.

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 dedicated Clinical Care Managers and Peer Advisors are completed on a monthly basis. The audit tool evaluates all aspects of the concurrent review process. All dedicated Clinical Care Managers are subject to monthly call and documentation audits by the UM department Clinical Manager and/or Clinical Director.

Clinical Rounds

These daily meetings include the Empire Plan medical director, 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 dedicated Clinical Care Managers and Peer Advisors are completed on a monthly basis. The audit tool evaluates all aspects of the concurrent review process.

ValueSelect Program

ValueSelect, our provider recognition program, is designed to identify and acknowledge providers who are high performers. The ValueSelect designation recognizes network inpatient and 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.

ValueOptions' Signature Network

The ValueOptions Signature Network is composed of programs and treatment centers that specialize in intensive treatment options and inpatient care for behavioral health and substance use disorders and that have a demonstrated track record of performance excellence. This special network is unique in the behavioral health industry and is designed to acknowledge providers that adhere to evidence-based practices, high quality member/family services, a safe environment of care, individualization of treatment plans, and a multidisciplinary approach to discharge planning that supports continuity of care and transition back into the community.

Typically enrollees identified as appropriate for Value Signature Network facility admission will have tried treatment in their home area but found that services were not specialized enough for the complexity of their condition. Our ValueOptions Signature Network treatment centers are skilled in treating some of the most difficult behavioral health conditions with good outcomes. Enrollees can access a referral through ValueOptions' dedicated Clinical Care Managers and Intensive Case Managers who collaborate with ValueOptions Medical Directors when referring enrollees into the Signature Network. If a treatment center identifies an enrollee as potentially qualified for a Signature Network admission, a dedicated Clinical Care Manager or Intensive Case Manager, in collaboration with a ValueOptions Medical Director, will assist in determining

if criteria are met. If an enrollee is interested, a dedicated Clinical Care Manager or Intensive Case Manager can provide assistance.

An important part of the Signature Network program is coordination between the Signature Network treatment center, the enrollee's supports, ValueOptions staff, and outpatient services in an enrollee's home area. The ValueOptions ICM team will ensure that active, timely, open communication is taking place between all involved supports and providers. Additionally, the ValueOptions ICM staff would welcome calls from any supports and providers.

Today's Value Signature Network program focuses on eating disorders and substance use disorders, including:

- Arms Acres in New York, which treats substance use disorders
- BHC Alhambra Hospital in California, which treats eating disorders
- CRC Health Group's Sierra Tucson Treatment Center in Arizona, which treats eating disorders and substance use disorders
- Eating Disorder Center of Denver in Colorado, which treats eating disorders
- Pinnacle Treatment Centers/Endeavor House in New Jersey, which treats substance use disorders
- Memorial Hermann Prevention & Recovery Center (PARC) in Texas, which treats substance use disorders
- Hazelden Foundation's facilities in Minnesota, Oregon and Florida, which treat substance use disorders
- Rogers Memorial Hospital in Wisconsin, which treats eating disorders and substance use disorders
- The Renfrew Center in Florida and Pennsylvania, which treats eating disorders
- Timberline Knolls in Illinois, which treats eating disorders
- Valley General Hospital in Washington, which treats substance use disorders

The Signature Network will expand in additional phases addressing the most complex behavioral health conditions.

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 2013, overall enrollee satisfaction in our Latham Engagement Center was 93.3 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.

(7) Confirm that you will adhere to the Empire Plan Mixed Services Protocol.

ValueOptions confirms that as the current Contractor, we are adhering to the Empire Plan Mixed Services Protocol and have worked with the medical carrier on mixed services requests. We remain committed to this process and will continue to adhere to this for the duration of the new agreement.

(8) Will you be providing the Empire Plan with a dedicated Clinical team including the Medical Director and Clinician Referral Line staff? Please provide an organizational chart that indicates the titles and number of people associated with the Clinical team.

As the current Contractor, ValueOptions will continue to provide the Empire Plan with a dedicated Clinical team including the Medical Director and Clinician Referral Line staff.

ValueOptions' Empire Plan Team

(9) 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 Enrollee and 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 Enrollee and Provider notified within twelve (12) Business Day of receipt of the report as reported quarterly and calculated on an annual basis, is $_____.

OUTPATIENT TREATMENT UR GUARANTEE

[redacted]

(10) 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 as reported quarterly and calculated on an annual basis, is $_____.

INPATIENT TREATMENT UR GUARANTEE

[redacted]

[redacted]

DISABLED DEPENDENT DETERMINATIONS

(1) Provide a description of your process when evaluating 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 ten (10) Business Days of receipt of a complete form.

PROCESS FOR DETERMINING DISABLED DEPENDENT STATUS

We confirm that we will continue to 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 determines disability status for those with physical disabilities.

Disabled dependents of Empire Plan enrollees are 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 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 is normally reviewed within six to eight months, unless the contractor determines a need for a more frequent review.
- "Possible," the case is normally reviewed no sooner than three years, unless the contractor determines a need for a more frequent review.
- "Not expected," the case is normally reviewed no sooner than seven years, unless the contractor determines a need for a more frequent review.

ValueOptions is making disabled determination coverage decisions for enrollees diagnosed with mental health or substance abuse disorders. We utilize our medical necessity criteria for disabled dependents. A mental impairment must be established by objective medical/psychological evidence consisting of demonstrable and measurable signs, symptoms, laboratory and psychological test findings. Subjective reporting alone is not adequate as a source of measurement. Sources of medical/psychological evidence generally include examination by licensed physicians, by licensed or certified psychologists, or by other health care practitioners. In addition, information from other sources may also help show the extent to which a person's impairment(s) affect his or her ability to function or to perform activities of daily living. Other sources include public and private social welfare agencies and non- medical sources such as teachers, day care providers, social workers and employers. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in our provider manual/credentialing information.

As the current Contractor, we have improved the process with the Department of Civil Service and the Empire Plan's medical carrier to ensure requests are received in a timely fashion via fax, minimizing time between receipt at UHC and delivery to ValueOptions. One of our licensed dedicated Clinical Care Managers reviews 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 10 days of receipt of necessary and complete information.

If a dedicated 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. Finally, all determinations are entered into an inquiry system so that reports can be tracked, including outcomes. ValueOptions currently maintains a report tracking all disabled dependent requests from 1/1/2014 forward.

(2) Confirm that the Offeror will send a letter to the Enrollee and to the Department advising of the determination within three (3) Business Days of the determination.

Letters are currently sent to the enrollee and to the Department advising of the determination within three (3) 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 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 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 Programs? If yes, provide the number of appeals you review annually and the approval and denial rates for a client similar to the MHSA 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 (i.e., 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

Inpatient (expedited/urgent) and Outpatient/Alternate Level of Care (standard) Level 1 appeals are conducted by an independent Peer Advisor not involved in previous adverse determinations within the timeframes detailed in the table below. ValueOptions applies the most stringent requirement to determine the applicable standard. Decisions are communicated by telephone on the same day as the determination, with written notification sent within the required timeframe. The Peer Advisor or dedicated Clinical Care Manager enters the results of the 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, and facility rendering service.

Level 2 clinical appeals (pre-service and post-service) are conducted by a panel of two board-certified psychiatrists and a ValueOptions Clinical Manager not involved in previous adverse determinations. All standard Level 2 appeals are completed, including issuance of the written notification to enrollee, provider and facility, within 15 calendar days of receiving the appeal request. All post-service appeals are decided and notification is issued within 30 calendar days of the appeal request.

Appeal Type	NCQA/ValueOptions	NYS Article 49	Empire Plan Contract
Level 1 Inpatient (Expedited/Urgent) Clinical Appeal	72 hours from request	2 business days from receipt of necessary information	1 business day from receipt of appeal request*
Level 1 Outpatient/ ALOC (Standard) Clinical Appeal	15 days from request	60 days from receipt of necessary information	2 business days from receipt of appeal request*
Level 2 Clinical Appeal (Pre-service)	15 days from request	N/A	15 days from request
Level 2 Clinical Appeal (Post-service)	30 days from request	N/A	30 days from request

*Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three 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.

(b) STAFF QUALIFICATIONS

Administrative Appeals

ValueOptions' administrative appeals system offers two levels of appeal. Appeal reviews are conducted by the Latham Engagement Center Vice President, or by staff or a committee designated by the Latham Engagement 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—pre- and post-service—are handled by a Peer Advisor, who is either an M.D. or Ph.D. clinician whose qualifications have been described earlier, and who was not involved in the initial adverse determination review.

(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 enrollee, 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
- the identified alternative level of care that is determined to be medically necessary for the enrollee at the time of review
- 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, or the enrollee representative may request a Level II appeal, unless otherwise restricted by contract or regulatory requirement. In accordance with the Empire Plan's requirements, this level of appeal will be handled by a ValueOptions' Level II Appeal Committee, composed of two board certified psychiatrists or Peer Advisors, and a dedicated 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 2013 data for a State client of similar size to the Empire Plan:

2013	Level 1	Level 2
Number of appeals reviewed	92	15
Number of approvals	25	1
Number of denials	137	52 modified denial
Number of modified decisions (appeal was partially approved and partially denied)	7	2

(e) ENROLLEE CARE DURING APPEALS PROCESS

ValueOptions aims to protect the financial and clinical needs of members. A Clinical Care Manager remains assigned to all higher level of care cases for the duration of admission through discharge and is available to assist with transition of care needs to lower levels of care when appropriate. As of the date of the denial a network provider cannot balance bill an enrollee until all levels of appeal are exhausted, if the enrollee chooses to continue to receive the care and waives held harmless rights. 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 continue to 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 as reported quarterly and calculated on an annual basis, is $_____.

INPATIENT APPEAL GUARANTEE

[redacted]

[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, as reported quarterly and calculated on an annual basis 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

(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 — currently in place for the Empire Plan — 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.

The official launch of the Depression Management Program was March 10, 2014, and there are 11enrollees currently enrolled.

Enrollees who currently 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. There is an ongoing assessment of the enrollees' needs, and as their needs change the level of intervention is adjusted accordingly.

HOW THE PROGRAM OPERATES

Screening for Depression, and 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 coordinate with the Empire Plan's health benefits management companies to screen and refer enrollees. Once an enrollee is identified, he/she is referred to our program for screening, triage of clinical need, coordination of service access, and monitoring care connections. The screening tool, educational materials and other resources are available to the Empire Plan's enrollees on the customized Achieve Solutions website, www.achievesolutions.net/empireplan. The program materials are also available on our website for providers and shared with primary care physicians.

The screening tool used is the Patient Health Questionnaire (PHQ-9). This a brief, nine-item, nationally recognized patient self-report depression assessment tool was derived from the interview-based PRIME-MD, and specifically targets the signs and symptoms of major depression. When clinically indicated, and with enrollee consent, screening results are shared with the enrollee's primary care physician.

As described above, we work directly with the Empire Plan's medical health plan staff who manage complex or disease management programs. In those situations, we 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 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:

- Training on the HEDIS anti-depressant medication management measures
- Sessions led by our Medical Directors for primary care physicians, pediatricians, and other medical specialties to address diagnoses such as depression, co-morbid complications, and contra-indications associated with certain medications and populations
- An "early warning" program, Clinical Care Alerts, that alerts providers when enrollees fail to pick up prescriptions as scheduled for medications
- Primary care physician/prescriber treatment support:
  - Access to Clinical Practice Guidelines/treatment tools
  - Topic-related articles available online and included in health plan newsletters
  - Education on the appropriate use of generic medications
  - Consultation line giving physicians direct telephonic access to a psychiatrist

Identification

Enrollees have access to the depression management program through a number of entry points:

- Enrollee self-referral via the NYSHIP program information line with 24-hour access to a clinician
- Enrollee self-referral based on program materials or online depression screening tool available on the dedicated Achieve Solutions website
- Health plan referral of high-risk enrollees for additional care coordination including screening, identification of need, service coordination, and monitoring treatment connections and clinical progress
- Invitation letter and program materials mailed to enrollees with a depression diagnosis who have accessed services
- Data mining and analytics including routine care outlier status identification benefitting from clinical guidance and identification of complex cases for ICM participation and outreach
- Primary care physicians referral based on program awareness and desire for additional care coordination

Interventions

Once identified for program participation, enrollees 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 NYSHIP toll-free line for assessment and clinical triage of behavioral health conditions with referral to network providers specializing in the treatment of depression
- Education about the symptoms, effects and treatment options available for depression
- Telephonic support and wellness coaching
- Coordination with treating providers and referrals to community services and resources
- Enrollee-focused medication treatment support via ValueOptions' Health Alerts, which offers automated calls reminding enrollees to take their medications and refill prescriptions

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
- Enhanced Outpatient Care Management: psychotherapy effectiveness analysis/telephonic outreach to "non-improvers" who have depression conditions
- OnTrack: 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 those with depression conditions.
- Intensive Care Management is our standard program for the top one percent of the most complex cases, including depression, via referral criteria (e.g., 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 coordinated, timely care for enrollees with a reduced risk for higher levels of care and a resultant cost savings for the Empire Plan. The specific benefits of the program include:

- Early identification, education and access to services for enrollees
- Access to online tools, educational materials and resources on the customized Achieve Solutions website
- Access to a clinician 24 hours a day, 7 days a week
- An increase in enrollee adherence to the treatment plan through education about:
  - Basic pathophysiology of depression
  - Current treatment modalities with an 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
  - How to recognize and address psychosocial issues related to depression
- Improved functional status
- Decreased inpatient admissions and emergency room visits

SAMPLE COMMUNICATION MATERIALS

Please see **Attachment 3** for copies of the Depression Management Program communication materials that we currently offer Empire Plan enrollees.

(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.

EATING DISORDER MANAGEMENT PROGRAM OVERVIEW

Similar to our Depression Management Program, our Eating Disorder Management Program begins with an emphasis on early identification. It supports the treatment process for enrollees by increasing the number of enrollees identified with eating disorder symptoms, using a variety of screening resources and program entry points. The program ensures that enrollees understand the range of treatment options and are connected to resources, and it provides case management support and monitoring to enhance treatment outcomes. The intensity of services provided are based on the level of need

The official launch of the Eating Disorder Management Program was March 10, 2014, and there are two enrollees currently enrolled.

and include general education, telephonic support, network referrals, coordination with primary care physicians, and intensive case management.

HOW THE PROGRAM OPERATES

Identification

Enrollees are identified for the eating disorder management program through several access points:

- Enrollee self-referral via the NYSHIP program information line with 24-hour access to a clinician
- Enrollee self-referral based on program materials or an online eating disorder screening tool available on the dedicated Achieve Solutions website
- Health plan referral of high-risk enrollees for additional care coordination including screening, identification of need, service coordination, and monitoring treatment connections and clinical progress
- Targeted outreach and education about the Eating Disorder Management Program and referral process to primary care physicians and other medical providers likely to treat Empire Plan enrollees with eating disorder symptoms
- Behavioral Health Care Manager internal referrals based on triggering utilization events such as inpatient or alternative levels of care admissions

Interventions

Once identified for program participation, enrollees receive education about the symptoms, effects and treatment of eating disorders, including referrals to network providers and available community resources. For enrollees who need additional guidance on treatment options, a clinician is available to provide telephonic support and coordination with treating providers. Enrollees with more acute and complex health conditions are referred to our Intensive Care Management program.

Clinical Treatment and Care Management Resources

ValueOptions uses a multi-pronged approach for the treatment of eating disorders for the Empire Plan:

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 — participating in our Signature Network — 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 providers 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. These facilities have demonstrated consistently positive outcomes for enrollees with eating disorders. Our clinical care management staff directs enrollees requiring 24-hour care to these high-quality and efficient specialty units whenever clinically appropriate.
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 Intensive Care Management services for enrollees with eating disorders. Intensive Care Management 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 a program that supports this.

BENEFITS TO THE EMPIRE PLAN AND ENROLLEES

The overall benefit of our program is early identification, enhanced coordination of care and resources for enrollees with eating disorders; ultimately resulting in better outcomes for the enrollee and cost savings for the Empire Plan.

SAMPLE COMMUNICATION MATERIALS

Please see **Attachment 3** for copies of the Eating Disorder Management Program communication materials available online and by mail for Empire Plan enrollees.

(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

ValueOptions offers Empire Plan enrollees access to an ADHD management program that promotes early detection, education, and treatment. This program provides parents with easy access to the ADHD Rating Scale - IV: Home Version screening tool,

The official launch of the ADHD Management Program was March 10, 2014, and there are eight enrollees currently enrolled.

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

Identification

Enrollees are identified for the ADHD management program through several access points:

- Parent referral via the NYSHIP program information line with 24-hour access to a clinician
- Parent referral based on program materials or online ADHD screening tool available on the dedicated Achieve Solutions website
- Health plan referral of high-risk enrollees for additional screening, assessment of needs, service coordination, and monitoring treatment connections and clinical progress
- Targeted outreach and education about the ADHD Management Program and referral process to pediatricians and primary care physicians likely to treat Empire Plan enrollees with ADHD symptoms

Interventions

Once identified for program participation, parents receive education about the symptoms, effects and treatment of ADHD, including referrals to network providers and available community supports. The parents 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. In addition to educational materials, the program provides telephonic support to the parents to help them manage stress related to their child's ADHD.

In addition to targeted outreach to Empire Plan pediatricians and primary care physicians educating them on the availability of the ADHD program, ValueOptions also provides the following support to physicians and prescribers:

- Access to Clinical Practice Guidelines/Treatment Tools
- Topic-related articles available online and available for inclusion in health plan newsletters
- Education on the appropriate use of generic medications
- Consultation line giving physicians direct telephonic access to a psychiatrist

If medical claims data can be made available, we would also propose expanding the screening and early detection components of the program to screen children who may have ADHD by targeting high-risk enrollees who have just turned six years old. This recommendation 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 would consist of:

- Medical claims-based data screenings to identify high-risk six-year old children
- Mailing the ADHD Rating Scale - IV: Home Version to the parents of children identified as high-risk

- Distributing 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 would 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 would 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 form is enclosed so that ValueOptions can send the positive screening results to the pediatrician. ValueOptions contacts parents regarding the results of the 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"

BENEFITS TO THE EMPIRE PLAN AND ENROLLEES

This program benefits children with ADHD as well as their parents. It reduces the intensity and duration of the symptomatic period and minimizes the disruption to school, work and family life.

SAMPLE COMMUNICATION MATERIALS

Please see **Attachment 3** for copies of the ADHD Management Program communication materials available online and by mail for Empire Plan enrollees.

(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 the 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 cost, our **comprehensive** ASD care management program includes all program activities outlined above as well as care navigation assistance, enhanced coaching, and work/life support, and 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. Our outcomes data indicated 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 (BUPRENORPHINE)

ValueOptions' Outpatient Buprenorphine Maintenance Program is designed to help individuals suffering from opioid and other prescription medications abuse. We have developed guidelines for Buprenorphine 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 Buprenorphine and offer an alternative treatment modality.

ADOLESCENT SCREENING PROGRAM

In partnership with Columbia University, ValueOptions developed an adolescent screening program aimed at assisting primary care providers 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. Using standardized screening tools, youth aged 11 to 18 can be assessed for behavioral and psychosocial problems in just 10 minutes. Parents of youths 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 adolescent screening program, materials, referral, and reimbursement, indicate that:

- 100 percent of providers felt comfortable using the materials to screen their patients
- 95 percent of providers agreed that screening helped them to uncover a patient with a mental health concern that might not have otherwise been identified
- 80 percent of the providers find the materials helpful and easy to use

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.

RESILIENCE INITIATIVE

Resilient individuals and organizations have a competitive advantage. When enrollees learn to better deal with stressors in their personal lives, they are more content and productive at work. Resilient organizations have leaders positioned at all levels who communicate and model ways to cope with both company-wide and personal worries. Because resiliency is critical to optimal performance, a sustained commitment of resources is necessary to achieve results. ValueOptions can guide the Empire Plan's leadership in creating a culture of resiliency.

This graphic illustrates the variety of proactive solutions we offer to encourage core resilience, address eight additional challenges, and focus on the potential for enrollees to grow after they experience a challenge. We emphasize the importance of environmental support. Our years of experience in working with employer organizations means that we understand that the workplace is a community, and we can help teams and leadership shape that community and that culture to be supportive of its enrollees.

Our program offers a single gateway for the Empire Plan enrollees to access the services, programs, and information that they need to become more resilient. Visit our website at http://valueoptions.com/resilience/ to learn more about the solutions we offer to help your organization not just survive, but *thrive*.

STAMP OUT STIGMA CAMPAIGN

Our experience as managers of behavioral health benefits is that many individuals could benefit from accessing their behavioral health benefit but fail to do so. In fact, although one in four Americans will experience a mental illness in a given year, less than one-third will seek help. ValueOptions has long worked to bring the dialogue about mental illness and substance use from a whisper to an open conversation. To that end, in 2013, we spearheaded our Stamp Out Stigma (S.O.S.) campaign to ensure we remove stigma as a barrier to people seeking the care they need to recover. This initiative commits us all to recognize the high prevalence of mental illness and to reeducate ourselves, friends and family about the truths of mental illness. When we do this, we reduce the stigma. We will make this program available for NYSHP enrollees at cost.

Since its introduction in May 2013, S.O.S. has been one of ValueOptions' most important initiatives. We implemented the initiative in every ValueOptions

location across the country, created a Facebook app exclusively for the campaign, and developed a client toolkit embraced by several large employer organizations. The toolkit includes resources and information to help organizations launch their own S.O.S. campaign. It features talking points, messaging templates, posters, pledge cards and wrist bands. Last year, we circulated over 25,000 green wristbands that display S.O.S. brand and message, encouraging people to talk about mental illness awareness.

We are now taking this message nationwide. Our partner, the Association for Behavioral Health and Wellness (ABHW), has fully adopted the S.O.S. campaign. This not-for-profit organization lobbies for behavioral health and substance use policy and legislation change in our nation's capital. ABHW is launching the campaign in partnership with ValueOptions and several other industry leaders including Cigna and Aetna, who are rolling out the campaign to their employees and eventually their clients and providers. This exciting development gives S.O.S. an exponential platform to change even more lives – we expect messaging to reach more than 1 million people in 2014.

Visit www.stampoutstigma.com for more ways to starting talking about mental health. The site offers online tools, such as personal stories shared on social media, as well as campaign pledge cards and wristbands to help ignite the conversation about mental illness and substance use disorders.

(5) If you are proposing to receive a data feed from the Empire Plan's Prescription Drug Program to be used as a method to identify members with depression, eating disorders and ADHD, please include a copy of your Non-Disclosure Agreement you have executed with CaremarkPCS Health, LLC.

We will explore the utility of receiving a data feed from Caremark PCS Health, LLC to identify enrollees with depression, eating disorders and ADHD. If we proceed, we have attached our standard Non-Disclosure Agreement—as **Attachment 10**—that we will execute with Caremark PCS Health, LLC.

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Vice President, New York Region

Relationship to Project: [redacted] will be responsible for the overall operations and administrative management of the engagement center that will serve Empire. She will work closely with Empire and key stakeholders to ensure optimal operational performance and maintain satisfaction.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2011 – present	ValueOptions	Service Center Vice President
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

[redacted]

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Executive Vice President and Chief Medical Officer

Relationship to Project: [redacted] is the Chief Medical Officer for the New York Engagement Center and will maintain this role for Empire.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2003-present	ValueOptions, Inc.	EVP and CMO
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Director of Account Services

Relationship to Project: [redacted] will be the Director of Account Services for the Empire Plan.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2003 - present	ValueOptions, Inc.	Director, Account Service
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Senior Director of National Customer Service

Relationship to Project: [redacted] will be responsible for the oversight of key call center operations.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2012 – present	ValueOptions, Inc.	Senior Director, Customer Service
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Director, Quality Management

Relationship to Project: This individual will be responsible oversight of the engagement center that will serve Empire, including commercial quality activities, the operations of the quality management department and the quality management program, and the coordination of the engagement center's participation in National and the engagement center Quality Management (QM) activities.

Essential Duties and Responsibilities

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Clinical Referral Line & Central Night Service Director
Relationship to Project: [redacted] will be responsible for oversight and leadership of virtual call center operations.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
1993-present	ValueOptions, Inc.	Director of Centralized Call Center

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Human Resources Director

Relationship to Project: [redacted] will be responsible for providing human resources support to all ValueOptions employees associated with the contract.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2005 - present	ValueOptions, Inc.	Senior HR Business Partner
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Director of Network Operations

Relationship to Project: [redacted] will provide management of the technical resources with regards to servers, networking, telecommunications and PC computing.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
1998- present	ValueOptions, Inc.	Director of Network Operations

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Director, Data Analytics

Relationship to Project: [redacted] will oversee all reporting for Empire, both internal and external.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2004 – present	ValueOptions	Director, Data Analytics
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: National Claims Director

Relationship to Project: [redacted] will oversee all claims operations.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2002 - present	ValueOptions, Inc.	Senior Director, National Claims
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Director, Implementations

Relationship to Project: [redacted] will be responsible for the management of the overall implementation effort.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2012 - present	ValueOptions, Inc.	Director, Implementations
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Vice President Medical Economics

Relationship to Project: [redacted] will provide premium Services Support.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]		

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Vice President, Underwriting and Pricing

Relationship to Project: [redacted] will provide underwriting analytic support.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Old [redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
1996 - Present	ValueOptions, Inc.	Underwriter, Underwriting Director, Vice President, Underwriting and Pricing
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Executive Director, Underwriting and Pricing

Relationship to Project: [redacted] will serve as a participating underwriter for the Empire Plan. He will contribute to the operational analysis and prepare pricing and budgeting for the RFP response, as well as calculate staffing, expenses and claims forecasts related to the renewal process.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
1986 - Present	ValueOptions	Mgr. Financial Analysis, Dir., Financial Analysis, Dir. Of Pricing, Exec. Dir. Pricing and Underwriting
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Senior Vice President, Data Analytics

Relationship to Project: [redacted] will oversee reporting and data analysis services.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2014 - present	ValueOptions, Inc.	SVP Data Analytics
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Director, Medical Cost & Analysis

Relationship to Project: [redacted] will provide actuarial support, as needed.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2011 - present	ValueOptions, Inc.	Director, Medical Cost/Analysis
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Jo**b Title:** Senior Corporate Counsel

Relationship to Project: [redacted] will serve as Empire's legal advisor.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2012 - present	ValueOptions, Inc.	Senior Corporate Counsel
[redacted]		

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Senior Provider Relations Director

Relationship to Project: [redacted] will be the Director of Provider Relations for Empire.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2006 - present	ValueOptions, Inc.	Senior Provider Relations Director
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Senior Vice President, Employer and Health Plan Divisions

Relationship to Project: [redacted] has overall responsibility for the Employer Division, which includes the Empire relationship.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2011 - present	ValueOptions, Inc.	SVP Commercial Sales
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Director of Clinical Services

Relationship to Project: [redacted] will serve as the clinical administrator for Empire's MHSA benefit.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2010 – present	ValueOptions, Inc.	Clinical Care Manager
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

[redacted]

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: Director of Communications

Relationship to Project: [redacted] will provide consultation on the development and execution of Empire's communications and materials.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2012 – present	ValueOptions	Director of Communications
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

DCS Provider Identifier	Provider Tax ID	Provider Name
[redacted]		

"The rest of this Exhibit has been redacted."

Task No.	Task Name	Start*	Finish*	Resource Names
1	**2014 Empire Implementation**	**9/1/2014**	**12/31/2014**	Header
2	**Project Setup**			**W. Kahle**
3	Notification of Award/CIG Received			K. Greco/J. Campione
4	Identify Account Mgmt Team			R. Abdou-Malta
5	Identify Implementation Leads (Functional Areas)			Functional Area Leads
6	Obtain Contract			K. Greco
7	Obtain and review budget			W. Kahle
8	Obtain Finance Code			W. Kahle
9	Review Staffing			Functional Area Leads
10	**Setup SharePoint**			W. Kahle
11	Obtain reference files from Proposals			W. Kahle
12	Create SP site and Load			W. Kahle
13	Obtain and distribute CIG			J. Campione
14	**Review Underwriting**			Functional Area Leads
15	Obtain Final UW			W. Kahle
16	Review with Functional Area Leads			W. Kahle
17	Identify Impacts / Issues / Constraints			Functional Area Leads
18	Meet to Finalize			W. Kahle
19	Resolve Issues			Functional Area Leads
20	Lessons Learned Scrub			W. Kahle
21	**Develop Project Schedule**			W. Kahle
22	Draft Schedule			W. Kahle
24	Distribute to Functional Area Leads			W. Kahle
25	Review Schedule: compare to CRTG			Functional Area Leads
26	Receive Updates			W. Kahle
27	Distribute v.2 to Team and Client			W. Kahle
28	Client Review: Milestones and Project Schedule			Empire:
29	Approval: Client: Milestones and Schedule			Empire:
30	**Performance Guarantees**			**W. Kahle**
31	Assemble and Format			W. Kahle
32	Distribute to Functional Area Leads			W. Kahle
33	Review & Q/A PGs			Functional Area Leads

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
34	Latham Planning Meeting			W. Kahle
35	Obtain understanding sign-off from FA Leads			W. Kahle
36	**Complete CRTG - 1st Attestation**			W. Kahle
37	Update CRTG from RFP, Proposal and Other docs			W. Kahle
38	Distribute to Functional Area Leads			W. Kahle
39	Review and Identify Issues if any			Functional Area Leads
40	Provide 1st Attestation			Functional Area Leads
44	**KickOff Meetings**			**W. Kahle**
45	**Internal KO**			**W. Kahle**
46	Draft Presentation			W. Kahle
47	Review and Approve			K. Greco
48	Conduct Internal KO			W. Kahle
49	Determine Status Meeting Schedule			W. Kahle
50	**External KO**			**W. Kahle**
51	Draft Agenda/Presentation			J. Campione
52	Review and Approve Agenda			J. Campione
53	Prep for Pre-Brief			W. Kahle
54	Conduct Pre-Brief			J. Campione
55	Conduct External KO			J. Campione
56	Determine Client/VO IT Weekly Status Meeting schedule			W. Kahle
57	Provide POC list to Empire			W. Kahle
58	**Establish Governance**			**W. Kahle**
59	Decision Making Process: Sign-offs, Change Control, Escalations			W. Kahle
60	Communications Flows			W. Kahle
61	**Detailed Business Requirements Gathering (Disc)**			**Client / VO**
62	Distribute Detailed Bus Rqmts Track Grid			W. Kahle
63	Populate Grid with Questions			Functional Area Leads
64	Submit to Client			W. Kahle
65	Client Review: DBRs			Empire:
66	Client Initial Response: DBRs			Empire:
67	Resolve Gaps			W. Kahle

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
68	DBR Gathering Complete			W. Kahle
69	Client: Final DBR Review			Empire:
70	Client: Final DBR Sign-off			Empire:
71	**Facility Planning**			**M. Hester**
72	Determine Gaps and Develop Build-Out/Occupation Plan			M. Hester
73	Facility Plan Complete			M. Hester
74	Begin Occupation of Space (Initial Stake in Ground)			Functional Area Leads
75	Complete lease negotiations for additional space			M. Hester
76	**Finance**			**P. Webb**
77	Set up/communicate implementation charge code			P. Webb
78	Determine if Performance Bonds are needed and establish			P. Webb
79	Ensure VO meets all insurance requirements			P. Webb
80	Set up invoicing			P. Webb
81	Payment and Reconciliation Process Approved			P. Webb
82	Set up ACH/EFT if applicable			P. Webb
83	Determine tax reporting requirements			P. Webb
84	Payroll setup			P. Webb
85	Establish Claims funding account			P. Webb
86	Finance system configuration			P. Webb
87	**Reporting**			**P. Webb**
88	Determine reporting requirements and Approvals			P. Webb
89	Develop Reports			M. Irvine
90	Reports Approved			P. Webb
91	**Legal**			**B. Gant**
92	**Perform contract review**			**B. Gant**
93	Perform contract review			B. Gant
94	Ensure compliance with applicable State and Federal requirements			B. Gant
95	Receive input from internal stakeholders			B. Gant
96	Present questions to Empire			B. Gant

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
97	Negotiate new language in contract			K. Greco
98	Incorporate all edits			B. Gant
99	Finalize contract			K. Greco
100	Contract fully executed			K. Greco
101	Send executed contract to Legal for filing			K. Greco
102	**Award Letter Considerations**			K. Greco
103	**Deliverables**			**K. Greco**
104	NYS Sales Tax Certification			K. Greco
105	Worker's Comp & Disability Benefit Coverage Certification			K. Greco
106	MWBE Utilization Plan			K. Greco
107	Listing of all sub-contracts that are >%100k over 5 yr life of contract			K. Greco
108	**Approvals**			**K. Greco**
109	NY AG Approval			K. Greco
110	Comptroller Approval			K. Greco
111	90-day post approval window			K. Greco
112	**Human Resources /Staffing**			**M. Mankabady**
113	**Preparation for Recruitment**			**M. Mankabady**
114	Distribute final staffing grid to VO functional area leads			M. Mankabady
115	Develop qualifications and criteria for certain positions which include vendor staff locations			M. Mankabady
116	Prepare Ads			M. Mankabady
117	**Recruitment (first round)**			**M. Mankabady**
118	Post jobs internally/Externally			M. Mankabady
119	Interview candidates (and complete background checks)			M. Mankabady
120	Confirm staff licensure			M. Mankabady
121	Offer Positions			M. Mankabady
122	**Training/Employee setup (first round)**			**M. Mankabady**
123	Coordinate new hire training with operational departments			M. Mankabady

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
124	**Performance Guarantee Achievement**			**W. Kahle**
125	Latham Planning Meeting			W. Kahle
126	Plan Formalized			W. Kahle
127	**Reporting: PG Deliverables**			**J. Campione**
128	Determine count of reports that satisfy requirement			J. Campione
129	Internal Review (TBD)			J. Campione
130	Submit to Empire for approval			J. Campione
134	Develop mockup			K. Bradley
135	Develop Report			K. Bradley
136	Internal Review			Multiple
137	Approved: Internal			J. Campione
138	Submit to Empire			J. Campione
155	**Clinical Program**			**J. Maurizio**
156	**Case Management Planning**			**J. Maurizio**
157	Identify Empire expectations/requirements			J. Maurizio
158	Develop policy and procedures for CM and other programs			J. Maurizio
159	Establish reports to monitor program			J. Maurizio
160	**Develop Transition Plan**			**J. Maurizio**
161	Identify populations to service			J. Maurizio
162	Develop overall approach			J. Maurizio
163	Develop available information for member identification for programs			J. Maurizio
164	Create Transition Plan			J. Maurizio
165	Transition Plan Complete			J. Maurizio
166	Develop reports to support transition plan			J. Maurizio
167	Submit to Empire: Transition Plan			J. Campione
168	Empire review: Transition Plan			Empire:
169	Approval: Client: Transition Plan			Empire:
170	**Develop utilization management programs**			**J. Maurizio**
172	Develop process for input and HLOC			J. Maurizio
173	**Mixed Services Protocol**			J. Maurizio
174	Review Internal			J. Maurizio

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
175	Approve Internal			R. Abdou-Malta
176	Submit to Empire: MSP			J. Campione
177	Empire review: MSP			Empire:
178	Approval: Client: MSP			Empire:
179	Develop process for output review (10-passthrough)			J. Maurizio
180	Develop process for light box			J. Maurizio
181	Develop process for Detox			J. Maurizio
182	Develop disability management program			J. Maurizio
183	Submit to Empire: CM material and clinical letters			J. Maurizio
184	Empire review: CM and Clinical Letters			Empire:
185	Approval: Client: CM and Clinical Letters			Empire:
186	**Clinical QM**			**D. Hakala**
187	**Develop Depression Management, Eating Disorders and ADHD Programs**			**D. Hakala**
188	Develop program description to include methods for identifying and educating members			D. Hakala
189	Develop written program materials (correspondence and educational materials)			D. Hakala
190	Legal Review			B. Gant
191	Submit to Empire for approval			W. Kahle
192	Review Empire			Empire:
193	Approval: Client			Empire:
194	Develop program workflows, including method for contacting/educating PCPs			D. Hakala
195	**Develop Provider QA Audit Program**			**D. Hakala**
196	Develop program description for Provider Quality Assurance Audits			D. Hakala
197	Develop workflows for identification of providers that deviate significantly from normal utilization patterns			D. Hakala
198	**QM Accreditation**			**D. Hakala**
199	QM committee setup			D. Hakala
200	Identify committee requirements			D. Hakala

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
201	Identify committee members			D. Hakala
202	Develop committee charters			D. Hakala
203	**Network Management**	**9/2/2014**		**N. Martin**
204	**Disruption Analysis**			**C. Gilbert**
205	Provide disruption info to Nat Networks			W. Kahle
206	Complete initial Disruption Analysis to determine gaps			A. Pyskadlo
207	Empire sends updated GeoAccess date from Empire (Claims Dump)			Empire:
208	Update Disruption Analysis (v.2)			A. Pyskadlo
209	**Provider Recruitment**			**A. Pyskadlo**
210	Recruitment identified: Practitioner			A. Pyskadlo
211	Recruitment identified: Facility			A. Pyskadlo
212	Priority recruitment identified: Practitioner			A. Pyskadlo
213	Priority recruitment identified: Facility			A. Pyskadlo
214	**Develop recruitment strategy**			A. Pyskadlo
215	Develop provider engagement and recruitment timeline			A. Pyskadlo
216	Develop interim workflow for recruitment			A. Pyskadlo
217	Strategy Complete			A. Pyskadlo
218	**Outreach to providers**			**A.Sachs**
219	Recruitment mailing			A.Sachs
225	Newsletter article			A.Sachs
226	Post information to website			A.Sachs
227	**Develop Policies and Procedures for Network Pricing**			**G. Lipson**
228	Review and assess current state process			G. Lipson
229	Based on CRTG and Perf Guarantees, develop process for determination/negotiation of provider rates (as appropriate, incorporate into the fee schedules (FH and Burgess)			G. Polansky
230	**Identify any special contracting arrangements (sub-cap, Delegation, Exclusive TPNs)**			**G. Lipson**
231	Determine fee schedules needed (Agreement to use VO commercial non-HMO state specific schedules for practitioners)			G. Lipson

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
232	Identify need for 'specific' provider contracts			G. Lipson
233	Develop response plan			G. Lipson
234	**Develop Policies and Procedures for Credentialing**			**J. Holte**
235	Determine Credentialing effort			J. Holte
236	Review and assess current state process			J. Holte
238	**Customer Service**			**J. Hargis**
239	**Telephony**			**J. Hargis**
240	**Phone scripting - coordinate with Telecom**			**J. Hargis**
241	Develop phone scripting			J. Hargis
242	Complete Design Document			J. Hargis
243	Program phone scripting			J. Hargis
244	Conduct testing			J. Hargis
245	Complete setup			J. Hargis
246	Complete setup to support Call Center general information and transition cases pre-go live.			J. Hargis
247	Request and obtain TASKE licenses for CS/CRL			J. Hargis
248	Request and obtain NICE licenses for CS/CRL			J. Hargis
249	**ACD_Customer Service Reporting**			**J. Hargis**
250	Identify reporting requirements - internal/external			J. Hargis
251	Coordinate report development/approval with Reporting			J. Hargis
252	Implement reports into production			M. Irvine
253	**Call Center Policies and procedures, including call transfer protocols**			**J. Hargis**
254	Transfer protocols			J. Hargis
255	Crisis calls			J. Hargis
256	Routine/urgent calls			J. Hargis
257	Greetings			J. Hargis
258	Conferencing			J. Hargis
259	Voicemail protocols			J. Hargis

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
260	Set up language line protocols			J. Hargis
261	TDD/TTY protocols			J. Hargis
262	After hours calls			J. Hargis
263	Call Center Policies and procedure approval			J. Hargis
264	**Administrative Complaints and Appeals Protocols**			**S. Healey**
265	Understand and document the turn around time for all administrative appeals and complaints			S. Healey
266	Understand all documentation requirements for all administrative appeals and complaints			S. Healey
267	Understand what levels of appeals and complaints are delegated for all lines of business			S. Healey
268	Understand NY provider appeals rights			S. Healey
269	Understand NY member appeals rights			S. Healey
270	Obtain all Service Plan Description (SPD) Documentation.			S. Healey
271	Obtain, analyze and understand the NY regulations impact on appeals and complaints			S. Healey
272	Develop policies and procedures			S. Healey
273	Develop workflow for case summary preparation for non-delegated appeals and complaints			S. Healey
274	Develop letter templates			S. Healey
275	Establish process/protocols for level II appeal committees			S. Healey
276	Approval-Admin Appeal Ltrs			**S. Healey**
277	VO Approval: AM, Clinical, CS			S. Healey
278	Submit to Empire for approval			S. Healey
279	Review Empire: Admin Appeal Letters			Empire:
280	Approval: Client: Admin Appeal Letters and Policies			Empire:
281	**Administrative Appeals auditing process**			S. Healey
282	Understand the State's plan for auditing of appeals			S. Healey
283	Develop internal and external reports for performance monitoring, accreditation and open inventory			S. Healey
284	Develop change management process			S. Healey

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
285	**Clinical Appeal and Denial Protocols**			**P. Regan**
286	Understand and document the turn around time for all administrative appeals and complaints			P. Regan
287	Understand what levels of appeals and complaints are delegated for all lines of business			P. Regan
288	Understand all documentation requirements for all administrative appeals and complaints			P. Regan
289	Understand NY provider appeals rights			P. Regan
290	Understand NY member appeals rights			P. Regan
291	Obtain copies of all appeal and complaint letters for all lines of business			P. Regan
292	Obtain, analyze and understand the NY regulations impact on appeals and complaints			P. Regan
293	Obtain all Service Plan Description (SPD) Documentation.			P. Regan
294	Develop policies and procedures			P. Regan
295	Develop workflow for case summary preparation for non-delegated appeals and complaints			P. Regan
296	Develop letter templates			P. Regan
297	Establish process/protocols for level II appeal committees			P. Regan
298	**NYS will approve all appeal and complaint process policies, procedures and letter templates**			**P. Regan**
299	Submit policies, procedures and templates to VO team			P. Regan
300	Internal Review			P. Regan
301	Approval VO: AM, CS			Functional Area Leads
302	Submit to Client			J. Campione
303	Client Review: Appeal and Complaint policies, letters, etc.			Empire:
304	Approval: Client: Appeal and Complaint policies, letters, etc.			Empire:
305	**Member Inquiry process**			**S. Healey**
306	Review current inquiry processes			S. Healey

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
307	Establish processes and systems to document and monitor the status and outcome of all member inquiries and develop appropriate reporting mechanisms to track progress and evaluate trends			S. Healey
308	**Provider Inquiries**			**S. Healey**
309	Review current inquiry processes			S. Healey
310	Establish processes and systems to document and monitor the status and outcome of all provider inquiries and develop appropriate reporting mechanisms to track progress and evaluate trends			S. Healey
311	Call Center Design Document Approved			J. Hargis
312	**Call Center Staffing**			**J. Hargis**
313	Assess staffing needs			J. Hargis
314	Recruit and hire Claims Customer Service			J. Hargis
315	Recruit and hire Clinical Customer Service			J. Hargis
316	Assess floor space requirement			J. Hargis
317	Request workstation configurations			J. Hargis
318	**Call Center Training**			**N. Wagner**
319	Assess Training needs and timelines			N. Wagner
320	Identify Training Resource			N. Wagner
321	Develop Clinical/Claims Customer Service Training material			N. Wagner
322	Schedule weekly training workgroup sessions			N. Wagner
323	Establish Train the Trainer sessions			N. Wagner
324	Conduct Clinical/ Claims Customer Service Training			N. Wagner
325	Identify go live floor support for Latham and Service Center			N. Wagner
326	**Scanning/Mailroom**			**J. Trupiano**
327	Secure New PO Box			J. Trupiano

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
328	Notify AE of New PO Box			J. Trupiano
329	**Claims Operations**			**C. Troxler**
330	Determine if new PO Box required			L. LaPlante
331	Review, revision and documentation of appropriate Behavioral Health claims edit rules			L. LaPlante
332	Develop claims processing workflows			L. LaPlante
333	Refine pend resolution / electronic error correction ("EEC") workflows			L. LaPlante
334	Refine claims adjustment / revision workflows			L. LaPlante
335	Confirm Transition benefit and provider configuration			L. LaPlante
336	Confirm recovery protocols			L. LaPlante
337	Establish recovery correspondence			L. LaPlante
342	Identify Claims reporting requests and associated required data			L. LaPlante
343	Performance Guarantee reporting established			L. LaPlante
344	Determine claims extract process			L. LaPlante
345	Review extract error reports			L. LaPlante
346	**Process Automation Development to Improve OFPR**			**L. LaPlante**
347	Operational workflows evaluated by process automation team			L. LaPlante
348	Process requirements determined and approved			L. LaPlante
349	Automation solution options developed			L. LaPlante
350	Solutions evaluated by business SMEs and refined			L. LaPlante
351	Final solution option defined and approved			L. LaPlante
352	**Claims Audit**			**L. LaPlante**
353	Develop claims audit processes			L. LaPlante
354	**Claims Staffing**			**L. LaPlante**
355	Develop claims operations staff training plan			L. LaPlante
356	Staff Hired and Trained			L. LaPlante
357	**System/Benefits Configuration**			**A. Daversa**

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
358	**Requirements**			**G. Rainsberg**
359	Gather requirements for benefit information/benefit rules			G. Rainsberg
360	Obtain list of covered services			G. Rainsberg
361	Obtain BRD (Benefit Requirements Details) - AM			J. Campione
362	Obtain listing of covered diagnosis codes by state			G. Rainsberg
363	Create draft of Service Class Grid{s}			G. Rainsberg
364	Review Service Class Grid			G. Rainsberg
365	Service Class Grid Approved			G. Rainsberg
366	Mixed Services Protocol - Completed & Approved			G. Rainsberg
367	Draft BRD			J. Campione
368	Internal Review of BRD			G. Rainsberg
369	Internal Approval of BRD			G. Rainsberg
370	Submit to Empire for approval - BRD			J. Campione
371	Review Empire - BRD			Empire:
372	Approval: Client - BRD			Empire:
373	Obtain authorization requirements/auth types			G. Rainsberg
374	**VO Internal Workflow**			**G. Rainsberg**
375	Track GL Code Workflow to completion			G. Rainsberg
376	Complete benefit related tasks for BSG workflow			G. Rainsberg
377	**CAS Claims Configuration/Reference File Setup/CC & Service Connect**			**G. Rainsberg**
378	Assign Parent Code{s}			G. Rainsberg
379	Develop Benefit Shells			G. Rainsberg
380	Load Service Mapset{s} into CAS			G. Rainsberg
381	Load general reference files as needed			G. Rainsberg
382	Load CareConnect/Service Connect reference files as needed			G. Rainsberg
383	**Configure MemberConnect SSO Admin**			**G. Rainsberg**
384	Load Parent code			G. Rainsberg
385	Obtain ReferralConnect information {username, Pswd, URL}			G. Rainsberg
386	Obtain Achieve Solutions information {client user ID, URL}			G. Rainsberg
387	Obtain Medicaid Website {URL specific website}			G. Rainsberg

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
388	**Benefit Configuration (CAS)**			**G. Rainsberg**
389	Configure Benefits			G. Rainsberg
390	Peer-to-peer audit			G. Rainsberg
391	Test Benefits			G. Rainsberg
392	**BenefitConnect**			**G. Rainsberg**
393	Load Client {s}			G. Rainsberg
394	Load Benefit Packages			G. Rainsberg
395	Load Benefit Information			G. Rainsberg
396	Peer-to-peer audit			G. Rainsberg
397	Activate Client			G. Rainsberg
398	**Data Analytics**			**D. Santmyer**
399	**External reporting requirements**			**M. Irvine**
400	Identify required reports			M. Irvine
401	Identify performance guarantees			M. Irvine
402	Identify/prioritize Day 1 reports			M. Irvine
403	Identify/prioritize non-Day 1 reports (Monthly, Quarterly, etc.)			M. Irvine
404	**Develop Day-1 and Monthly Reports**			M. Irvine
405	Create mock-ups for Day 1 and monthly reports			M. Irvine
406	Submit to Empire for approval: Day 1 and monthly reports			M. Irvine
407	Empire reviews: Day 1 and monthly reports			Empire:
408	Approval: Empire - Day 1 and monthly reports			Empire:
409	Create technical specifications for reports			M. Irvine
410	Determine data mart requirements			M. Irvine
411	Program Day 1 reports			M. Irvine
412	Validate Day 1 Reports			M. Irvine
413	Program, Validate, and implement non-day 1 Monthly Reports			M. Irvine
414	**Review/Approve Day 1 and Monthly Reports**			M. Irvine
415	Submit reports for review and sign-off by the VO Functional Areas			M. Irvine
416	VO FA review			Functional Area Leads

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
417	Approval VO: AM, CS			Functional Area Leads
418	Submit to Empire for approval			W. Kahle
419	Empire Review: Day-1 and Monthly Reports			Empire:
420	Approval: Empire: Day-1 and Monthly Reports			Empire:
421	Set up Day 1 reports on IntelligenceConnect to begin running			M. Irvine
422	Set up process for ad hoc reporting requests from Empire			M. Irvine
423	**Quarterly and Annual Reports**			M. Irvine
424	Program, Validate, and implement Quarterly Reports in 2014			M. Irvine
425	Quarterly Report Due: 30 days past quarter end			M. Irvine
426	Quarterly Report Due: 45 days past quarter end			M. Irvine
427	**Internal reporting requirements**			**M. Irvine**
428	Identify required reports			M. Irvine
429	Identify performance guarantees			M. Irvine
430	Identify/prioritize day 1 reports			M. Irvine
431	Identify/prioritize non-day 1 reports			M. Irvine
432	Meet with teams to define report specifications/mock-ups			M. Irvine
433	Create technical specifications for reports			M. Irvine
434	Determine data mart requirements			M. Irvine
435	Program Day 1 reports			M. Irvine
436	Program, Validate, and implement non-day 1 Monthly Reports			M. Irvine
437	Program, Validate, and implement Quarterly Reports in 2014			M. Irvine
438	Validate Day 1 Reports			M. Irvine
439	Implement new reports for day 1			M. Irvine
440	**System Set Up**			**Header**
441	**CAS Set Up**			S. Costello

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
442	Determine which CAS environment Empire will be implemented in			S. Costello
443	**References and Tables**			**K. Vendetti**
444	Establish ELGPAR			K. Vendetti
445	Define Groups			K. Vendetti
446	Set Up Unknown Member			K. Vendetti
447	Set Up Groups			K. Vendetti
448	~~Parent/Reason Code Cross Reference (RF1321)~~	-	-	~~A. Daversa~~
449	**CONNECTIONS Set Up**			Header
450	**SecurityConnect Set Up**			**Header**
451	**Internal Users**			Header
452	Submit request to create/update service center information			Multiple
453	Determine Security Access Needs for Service Center Staff			Multiple
454	Submit eSars for Service Center Staff			Multiple
455	Receive Group Ranges from Eligibility for Set up			T. Miller
456	Set Up Security Levels, Profiles & Roles (New FTEs Hired)			T. Miller
462	Set Up Security Levels, Profiles & Roles			T. Miller
463	Distribute VALUEOPTIONS System Access P&Ps (Password management, Access Controls, User Acct Terminations…)			C. Bennett
465	Define/communicate technical support services protocol (e.g. local service center or TCC)			C. Bennett
466	**ServiceConnect/CareConnect Set Up**			**J. Maurizio**
467	Determine Client Auto Routing Set Up for Clinical services			J. Gaspard
468	Complete WARMAS/SECFLA set up			J. Maurizio
469	Determine Client Auth Parameter Set Up			J. Gaspard
471	Set Up Service Center & Market Segments Codes on Group Record (ME1031) to support auth auto-routing			K. Vendetti
472	Confirm Service/CareConnect Set Up			J. Gaspard
473	**NetworkConnect (Provider System) set-up**			**M. Mills,D. Ellis**
474	Identify Provider File Configuration needs			D. Ellis
475	Create Client Contract Code (cc)			D. Ellis
476	Create Network Association Code			D. Ellis

Task No.	Task Name	Start*	Finish*	Resource Names
477	Data Entry of Files (If Applicable)			M. Mills
478	Create fee codes			D. Ellis
479	Create any additional REFMAS elements			M. Mills
480	Load rates into HIAAMAS (Manual = D. Ellis, Automated = M. Mills)			M. Mills
481	Map Parent Code to assigned Network (RF1015)			D. Ellis
482	Notify NetOps, Eligibility and Implementation Team of Provider Configuration			D. Ellis
483	**ReferralConnect Set Up**			**M. Mills**
484	Gather Requirements			D. Ellis
485	Communicate Network Configuration Information To IT			M. Mills,D. Ellis
486	Set Up Access			M. Mills
487	Test Access			M. Mills
488	Sign Off			M. Mills
489	**ClientConnect Set Up**			J. Campione
491	Define format of Utilization Reports			
492	Set Up Access			J. Campione
493	Test Access			J. Campione
494	Sign Off			J. Campione
495	**ProviderConnect Setup**			**J. Gaspard**
496	Determine Inquiry routing needs			J. Gaspard
497	Submit THC ticket to initiate inquiry routing set-up			J. Gaspard
498	Set up inquiry routing			J. Gaspard
506	**MemberConnect Setup**			**S. Healey**
507	Determine Inquiry routing needs			S. Healey
508	Submit THC ticket to initiate inquiry routing set-up			S. Healey
509	Set up inquiry routing			S. Healey
510	Provide ReferralConnect set up to Systems Configuration			M. Mills
511	**Achieve Solutions Setup**			J. Campione
512	Submit AS Implementation FormObtain set up form			J. Campione
513	Retrieve and Review Implementation Form			L.Dashield,A. Rizzo
514	Provide link to AchieveSolutions to Systems Configuration			L.Dashield,A. Rizzo

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
515	Enter Client Configuration into MemberConnect Admin			G. Rainsberg
516	**FileConnect Set Up**			**K. Roberts**
517	Assign Grid Owner			K. Roberts
518	Determine File Transfer Method and Resources Assigned			K. Roberts
519	Request encryption keys or SFTP credentials from Empire			A. DeSieno
520	Empire sends encryption keys or SFTP credentials to VO			Empire:
521	Request server path info from Empire			A. DeSieno
522	Empire sends server path info to VO			Empire:
523	Complete Grid			A. DeSieno
524	Assign User ID's and Passwords			A. DeSieno
525	FileConnect account setup			A. DeSieno
526	Test connectivity			A. DeSieno
527	**EOB - Explanation of Benefits Set Up (Annual Statement)**	**9/2/2014**	**12/31/2014**	**H. Thompson**
528	Business Requirements			H. Thompson
529	Distribute group rules form to Business Owners for review			H. Thompson
530	Obtain Business Requirements Signoff			J. Campione
531	Send Group Rules to Emdeon			H. Thompson
532	Confirm Emdeon Set Up			H. Thompson
533	Confirm CAS Set Up			H. Thompson
534	Create test temp member records			H. Thompson
535	Create test authorizations			H. Thompson
536	Create test claims			H. Thompson
537	Send Test File to Emdeon			H. Thompson
538	Validate Results			H. Thompson
539	Submit to Empire for approval: EOB			W. Kahle
540	Empire Review: EOB			Empire:
541	Approval: Empire: EOB			Empire:
542	Sign Off			H. Thompson
543	Implement into production			H. Thompson
544	**Summary Vouchers - Provider (PSV) & Member (MSV)**			**H. Thompson**
545	Business Requirements			H. Thompson
546	Distribute group rules form to Business Owners for review			H. Thompson

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
547	Obtain Business Requirements Signoff			J. Campione
548	Send Group Rules to Payformance			H. Thompson
549	Confirm Payformance Set Up			H. Thompson
550	Confirm CAS Set Up			H. Thompson
551	Receive mockups back from Payformance			H. Thompson
552	Submit to Empire for approval (MSV, not PSV)			W. Kahle
553	Empire Review: MSV (not PSV)			Empire:
554	Approval: Empire: MSV (not PSV)			Empire:
555	Create test temp member records			H. Thompson
556	Create test authorizations			H. Thompson
557	Create test claims			H. Thompson
558	Send Test File to Payformance			H. Thompson
559	Validate Payformance Results			H. Thompson
560	Sign Off			H. Thompson
561	Implement into production			H. Thompson
562	**ISV Approval**			
563	Business Requirements			H. Thompson
564	Confirm PaySpan Set Up			H. Thompson
565	Confirm CAS Set Up			H. Thompson
566	Submit to Empire for approval (MSV, not PSV)			W. Kahle
567	Empire Review: MSV (not PSV)			Empire:
568	Approval: Empire: MSV (not PSV)			Empire:
569	Implement into production			H. Thompson
570	**KnowledgeConnect (Data Warehouse) Set Up and Internal Loads**			**J. Park**
571	**Production Internal Loads**			J. Park
572	Define requirements			J. Park
573	Create and test new AS/400 extract processes			J. Park
574	Create new DWH tables			J. Park
575	Create new DWH control files			J. Park
576	Create and test new DWH load processes			J. Park
577	Perform Initial extract			J. Park

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
578	Perform Initial Load			J. Park
588	**ALA-Authorization Letter Set Up/Printing**			**H. Thompson**
589	**Develop Business Requirements**			**J. Campione**
590	Develop Letter Tracking Grid			H. Thompson
591	Distribute group rules and letter matrix forms to AE for review			H. Thompson
592	Obtain Business Requirements Signoff			H. Thompson
593	Create tasks request and submit to DA			H. Thompson
594	Creation of Letter Templates by DA			M. Irvine
595	Update Client Information (RF1820)			H. Thompson
596	Confirm/Create CAS Letter Codes (CO1031)			H. Thompson
597	Confirm/Create CAS Letter Group (RF1321)			H. Thompson
598	Confirm/Create CAS Letter Matrix (RF1322)			H. Thompson
599	Create Test Temp Members			H. Thompson
600	Create Test Authorizations			H. Thompson
601	Confirm Approval and Completion of Letter Templates from DA			H. Thompson
602	Run Test Letter Process			H. Thompson
603	**Printing Suppression Process**			H. Thompson
604	Review Printing Requirement			H. Thompson
605	Receive Reason Codes for Suppression from Clinical			H. Thompson
606	Set Up Suppress printing			H. Thompson
607	Verify OnDemand setup			H. Thompson
608	Level II Testing for ALA Letters			H. Thompson
609	Coordinate Error Resolution			H. Thompson
610	DA Create PDFs			M. Irvine
611	Request ALA Letters to be loaded to OnDemand (if applicable)			H. Thompson
612	Service Center Signoff of PDFs			R. Abdou-Malta
613	Add Client to Letter Group			H. Thompson
614	Configure ALA PC (New Service Center Only)			H. Thompson
615	Provide ALA Training (PC Side)			H. Thompson
616	Provide ALA Training (CAS Side)			H. Thompson
617	Implement ALA Letters into production			H. Thompson
618	**IT Operations**			Header

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
619	Submit request to create project in CPTS			S. Costello
620	**Network Services LAN/WAN IT Implementation Template**			**C. Rajpal**
621	**Identify LAN/WAN equipment for data center**			**C. Rajpal**
622	**LAN Tasks**			**C. Rajpal**
623	**Determine Needed LAN Hardware/Software**			C. Rajpal
624	**Obtain Staffing Information**			C. Rajpal
625	On-Site			C. Rajpal
626	Off-Site			C. Rajpal
627	Determine the number of servers			C. Rajpal
628	Determine Set Up Date			C. Rajpal
629	Determine shipping plan			C. Rajpal
642	**WAN Tasks**			**C. Rajpal**
643	**Determine Method of connectivity**			C. Rajpal
644	Determine WAN Equipment Needed for connectivity			C. Rajpal
645	Determine File Transfer Needs/ Method and Resources Assigned			C. Rajpal
646	**Obtain Location Information**			C. Rajpal
647	**Obtain Location Description**			**C. Rajpal**
648	Obtain Site Address			C. Rajpal
649	Obtain Site Layout			C. Rajpal
650	Obtain Local Contact Information (e.g. Building/Property Management)			C. Rajpal
651	Obtain IT Contact Information			C. Rajpal
652	**Order WAN Equipment**			C. Rajpal
653	**Hardware**			C. Rajpal
654	Determine hardware needs			C. Rajpal
655	Generate PR			C. Rajpal
656	Obtain VP management approval for PR			C. Rajpal
657	Order hardware			C. Rajpal
658	Receive Hardware			C. Rajpal
659	Configure Hardware			C. Rajpal
660	Install Hardware			C. Rajpal

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
661	Test Hardware			C. Rajpal
662	**Cabling**			C. Rajpal
663	Determine cabling needs			C. Rajpal
664	Identify vendor			C. Rajpal
665	Design cable			C. Rajpal
666	Confirm Construction Completion Before Cable Installation			C. Rajpal
667	Lay Cable(s)			C. Rajpal
668	Test Cable(s)			C. Rajpal
669	**Desktop Services Tasks**			**R. Alesio**
670	Determine the number of Desktops / Laptops			R. Alesio
671	Determine the number of Multi-function Printers			M. Hester
672	Determine Fax Purposes to be setup on the Fax server			R. Alesio
673	Order equipment			R. Alesio
674	Receive desktops, laptops			R. Alesio
675	Configure equipment			R. Alesio
676	Install Multi-function Printers			M. Hester
677	Test Setup			R. Alesio
678	**Telecom Tasks**			**R. Corduck**
679	**Determine Telecom Requirements**			R. Corduck
680	Obtain Staffing Numbers			R. Corduck
681	Determine the type/number of Phones and Headsets Needed			R. Corduck
682	Determine # of fax lines needed			R. Corduck
683	Review PBX Requirements & Determine Additional Equipment Required			R. Corduck
685	Submit Request to Vendor for Quote			R. Corduck
686	Review Costs & Quotes with the Telecom Implementation Team			R. Corduck
687	Submit Telecom PO			R. Corduck
688	Determine Option to Connect to Empire			R. Corduck
689	Program Connection to Empire			R. Corduck

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
690	**Obtain PO Approval of Capital Purchase Request**			**R. Corduck**
691	**Order Equipment**			**R. Corduck**
692	Design meeting with SPS on the equipment being installed			R. Corduck
693	Ship Site Equipment to SPS warehouse			R. Corduck
694	Order: Phones, Headsets, Polycoms, TDD Phone as applicable			R. Corduck
695	Conduct Site Survey by Technician to examine Switch room lighting, electrical requirements, grounding, cabling, wall field, jacks, paging, music on hold.			R. Corduck
696	Complete Network Design/Numbering Plan			R. Corduck
697	Complete Network Assessment			R. Corduck
698	**EQUIPMENT DELIVERY/ INVENTORY/STAGING**			**R. Corduck**
699	Receive: Phones - Ship phones to Site			R. Corduck
700	SPS to Stage the servers			R. Corduck
701	Receive IP Address from the WAN team			R. Corduck
702	Load any necessary Avaya software patches			R. Corduck
703	Prep Equipment for shipping to service center			R. Corduck
704	Verify loading Dock / Elevator			R. Corduck
705	Deliver Equipment and Telephones to Site			R. Corduck
706	**Implementation**			**R. Corduck**
707	**Define System Programming**			**R. Corduck**
708	Define System Feature Codes (activate malicious call trace)			R. Corduck
709	Define System Dial Plan (number of digits dialed, etc.)			R. Corduck
710	Define System Trunking (qty, interface type, line frame & format)			R. Corduck
711	Determine TFTP Server Setup			R. Corduck
712	Determine DHCP Server Setup			R. Corduck
713	**Define Station Programming**			**R. Corduck**

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
714	**Standard Telephones (non-ACD)**			**R. Corduck**
715	Determine Features Required			R. Corduck
716	Determine Button Locations - per set type(s)			R. Corduck
717	Determine Bridged Appearances			R. Corduck
718	Determine Busy Stations (if needed)			R. Corduck
719	Determine Intercom Groups (if needed)			R. Corduck
720	Determine Call Pickup Groups (if needed)			R. Corduck
721	Determine COR/COS			R. Corduck
722	Determine Cover Paths			R. Corduck
723	Determine Quantity by Type			R. Corduck
724	Complete Station Design			R. Corduck
725	Document the NON ACD Phone Layout			R. Corduck
726	**ACD Telephones**			**R. Corduck**
727	Determine the Layout Will Work			R. Corduck
728	Document the ACD Phone Layout (agents/supervisor)			R. Corduck
729	**Define ACD Programming**			**R. Corduck**
730	**Gather Requirements**			**R. Corduck**
731	Receive Business signoff on scripting			R. Corduck
732	Define BRP site			R. Corduck
733	Define Agent Groups			R. Corduck
734	Define Service Levels on VDN's			R. Corduck
735	Define Service Levels on Skills			R. Corduck
736	Define VDN Names			R. Corduck
737	Define Announcements			R. Corduck
738	Define AUX Reason Codes			R. Corduck
739	Provide Holiday Schedule			R. Corduck
740	Confirm Zip Tone			R. Corduck

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
741	Provide Vector's for the VDN's			R. Corduck
742	Provide Aux Reason Code Description			R. Corduck
743	Provide Skill Level for Agents			R. Corduck
744	Provide Vu Stat Formats			R. Corduck
745	**Complete Design**			**R. Corduck**
746	Prepare Call Center Design Documents			R. Corduck
747	Review Design with business team			R. Corduck
748	Update design document if needed			R. Corduck
749	Submit to Empire for approval			R. Corduck
750	Empire Review: ACD Design Document			Empire:
751	Empire sign off on Call Center Design Document: ACD Design Document			Empire:
752	**Setup Other Applications**			**R. Corduck**
754	Setup service center on E911			R. Corduck
755	**Test Plan**			**R. Corduck**
756	Prepare Test Plan, Execution, Executive Summary and Analysis Package			R. Corduck
757	**Define CMS Programming**			**R. Corduck**
758	CMS Dictionary (agent names, trunk group names)			R. Corduck
759	The Service Levels on VDN's for the Call Profile Reports			R. Corduck
760	The Service Levels on Skills for the Call Profile Reports			R. Corduck
761	Agent Groups			R. Corduck
762	**Define Voicemail Programming**			**R. Corduck**
763	Mailbox Password Length			R. Corduck
764	System Features			R. Corduck
765	Out calling			R. Corduck
766	Mailbox Storage Sizes			R. Corduck
767	Mailbox Classes of Service			R. Corduck

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
768	Define Zero Out Path			R. Corduck
769	**COMPLETE TESTING**			**R. Corduck**
771	Perform Failover Testing			R. Corduck
772	Test Call Routing			R. Corduck
773	Record Announcements			R. Corduck
774	Test ACD Call Flows (variable remote activation)			R. Corduck
775	Test CMS Services			R. Corduck
776	Test TFN Routing			R. Corduck
777	**CONDUCT END USER TRAINING**			**N. Wagner**
778	Confirm End User Training Schedule			N. Wagner
779	**TELEPHONE TRAINING**			**R. Corduck**
780	4610 Non-ACD Training			R. Corduck
781	Vmail and ACD Training (cover aux code usage)			R. Corduck
782	Service Center Infrastructure Finalized			R. Corduck
783	System Training			N. Wagner
784	**CONNECTIONS - CAS Systems Development**			**Header**
785	**Data Exchanges**			**Header**
786	**Data Imports**			**Header**
787	**Eligibility Import - Custom File Layout**			**K. Vendetti**
788	Gather Requirements			J. Obernesser
789	Functional Specs			J. Obernesser
790	Sign Off			J. Campione
791	Programming			J. Obernesser
792	Receive NDA file so DCS can send Eligibility Test File			Empire:
793	Send Eligibility Test File			Empire:
794	Level 1 Testing			J. Obernesser
795	Level 2A Testing			J. Obernesser
796	Level 2B Testing			J. Obernesser
797	Sign Off			J. Obernesser
798	Operationalize			J. Obernesser

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
799	**Data Extracts**			Header
800	**Claims/Accumulator Exchanges (Inbound/Outbound)**			**B. Wolford**
801	Gather Requirements			B. Wolford
802	Functional Specs			B. Wolford
803	Sign Off			B. Wolford
804	Programming			B. Wolford
805	Level 1 Testing			B. Wolford
806	Level 2 Testing			B. Wolford
807	Level 3 Testing			B. Wolford
808	Sign Off			Empire
809	Operationalize			B. Wolford
929	**Go Live**	**12/15/2014**	**12/31/2014**	**Header**
930	Establish Daily Checkpoint Calls			W. Kahle
931	Go Live			VO
932	**Post Go-Live Operations**	**1/1/2014**	**2/28/2015**	**Header**
933	**CRTG Sign-Off: 2nd Attestation**			**W. Kahle**
934	Review the CRTG for change control impacts			W. Kahle
935	Distribute for 2nd Attestation			W. Kahle
936	Provide Sign-Offs			Functional Area Leads
937	Load to SharePoint			W. Kahle
938	**Post Project Assessment**			**W. Kahle**
939	Review policy			W. Kahle
940	Distribute template			W. Kahle
941	Provide feedback			Functional Area Leads
942	Organize feedback			W. Kahle
943	Conduct PPA Meeting			W. Kahle
944	Update PPA Inventory			W. Kahle
945	Resolve with PPA manager disposition if issues			W. Kahle
946	**Transition to BAU**	**1/1/2014**	**1/31/2015**	**W. Kahle**
947	Rationalize DTL			W. Kahle
948	Determine if ready to transition to Account Team			W. Kahle
949	Establish Handover date			W. Kahle

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

Task No.	Task Name	Start*	Finish*	Resource Names
950	Update all records to SharePoint			W. Kahle
951	Hand-over to AM (Project Complete)			W. Kahle

*Plan assumes an award date of September 2, 2014
*Start and end dates of all milestones are subject to change based upon date of award and final review/approval by the Department

---

Empire Plan **877.769.7447 [Not owned by VO]**
VO Transfer# **855-254-9336 [Option 3 off of Empire's above TFN]**

Empire Direct to CS# **855-254-9393**
CS Hours: **Monday – Friday 8:00 am – 8:00 pm ET**
[8:00 am – 6:00 pm] [Latham Clinical *CS*]
[6:00 pm – 8:00 pm] [Claims CS]
Clinical: **Monday – Friday 8:00 am – 5:00 pm ET**

DNIS INDEX

ECR Destination	DNIS	Skill	BRP VDN	Service Center	BC VDN
EMG Queue	296470	282	507071	VCC	208679
Extension Lookup	296299	N/A	n/a	VCC	N/A
CS Member Queue	223924 (208635)	586	Closed	L4BA	N/A
CS Provider Queue	223925 (208636)	588	Closed	L4BA	N/A
Referral CCM Queue	296471	283	507651	VCC	208680
InpatientCCM Queue	296479	611	507651	L4BA	208681
Claims CS Member	246001	539	507651	L10BA	N/A
Claims CS Provider	246065	546	507651	L10BA	N/A
Emg CNS	224236	210	507071	VCC	208682
CNS Member	224237	285	507651	VCC	208683
CNS Provider	224238	286	507651	VCC	208684

Introduction

Thank you for calling The Empire Plan Mental Health and Substance Abuse Program administered by ValueOptions.

Please be advised for quality assurance purposes, your call may be monitored or recorded. If you do not want this call monitored or recorded, please inform the representative who answers the call.

If this is a clinical life threatening emergency, press one (1) immediately.
Working Hours [*EMG Queue*]
After Hours [EMG *CNS*]

[*In Spanish*] To hear this menu in Spanish, please press nine (9). [*Main Menu Span*]

Time out to [*Main Menu*]

Main Menu

If you know the extension you're trying to reach, please press two (2) [*Extension Lookup*]

If you are a enrollee, please press three (3). [*Member Menu*]

If you are a provider, please press four (4). [*Provider Menu*]

To repeat this menu, please press star (*).[*Main Menu*]

For all other inquiries, please stay on the line for the next available representative.
Time Out

Working Hours	[8:00 am – 6:00 pm] [*CS Queue Member*]
	[6:00 pm – 8:00 pm [Claims CS Member]
After Hours	[*CS Closed Message Span*]

Main Menu Span

If you know the extension you're trying to reach, please press two (2) [*Extension Lookup*]

If you are an enrollee, please press three (3). [*Member Menu Span*]

If you are a provider, please press four (4). [*Provider Menu Span*]

To repeat this menu, please press star (*). [*Main Menu Span*]

For all other inquiries, please stay on the line for the next available representative.
Time Out

Working Hours	[8:00 am – 6:00 pm] [*CS Queue Member*]
	[6:00 pm – 8:00 pm [Claims CS Member]
After Hours	[*CS Closed Message Span*]

Member Menu

If you are calling regarding your outpatient transion benefit, please press one (1)

Working Hours	[8:00 am – 6:00 pm] [*CS Queue Member*]
	[6:00 pm – 8:00 pm [Claims CS Member]
After Hours	[*CS Closed Message*]

If you are calling for a referral, please press two (2).

Working Hours	[8:00 am -5:00 pm] [Referral *CCM Queue*]
After Hours	[*CNS Member*]

If you are calling for eligibility, benefits verification, or to discuss a claim related matter please press three (3).

Working Hours	[8:00 am – 6:00 pm] [*CS Queue Member*]
	[6:00 pm – 8:00 pm [Claims CS Member]
After Hours	[*CS Closed Message*]

For information on the claims mailing address, please press four (4). [*Address One*]

To repeat this menu, please press star (*). [*Member Menu*]

To return to the main menu, please press nine (9). [*Main Menu*]

For all other inquiries, please stay on the line for the next available representative.
Time Out

Working Hours	[8:00 am – 6:00 pm] [*CS Queue Member*]
	[6:00 pm – 8:00 pm [Claims CS Member]
After Hours	[*CS Closed Message*]

Member Menu Span

If you are calling regarding your outpatient transion benefit, please press one (1)

Working Hours	[8:00 am – 6:00 pm] [*CS Queue Member*]
	[6:00 pm – 8:00 pm [Claims CS Member]
After Hours	[*CS Closed Message*]

If you are calling for a referral, please press two (2).

Working Hours	[8:00 am -5:00 pm] [Referral *CCM Queue*]
After Hours	[*CNS Member*]

If you are calling for eligibility, benefits verification, or to discuss a claim related matter please press three (3).

Working Hours [8:00 am – 6:00 pm] [*CS Queue Member*]
[6:00 pm – 8:00 pm [Claims CS Member]
After Hours [*CS Closed Message*]

For information on the claims mailing address, please press four (4). [*Address One*]

To repeat this menu, please press star (*). [*Member Menu Span*]

To return to the main menu, please press nine (9). [*Main Menu Span*]

For all other inquiries, please stay on the line for the next available representative.
Time Out

Working Hours [8:00 am – 6:00 pm] [*CS Queue Member*]
[6:00 pm – 8:00 pm [Claims CS Member]
After Hours [*CS Closed Message Span*]

Provider Menu

To review for in-patient or an alternative level of care, please press one (1).

Working Hours [8:00 am -5:00 pm] [Inpatient *CCM Queue*]
After Hours [CNS Provider]

If you are a provider calling for authorization of outpatient services or psychological testing, please press two (2). [*Address Menu*]

If you are calling for eligibility, benefits verification, or to discuss a claims related matter, please press three (3).

Working Hours [8:00 am – 6:00 pm] [*CS Queue Provider*]
[6:00 pm – 8:00 pm [Claims CS Provider]
After Hours [*CS Closed Message*

For information on our provider portal and how to submit claims and clinical forms, please press four (4). [*Address Menu*]

To repeat this menu, please press star (*) [*Provider Menu*]

To return to the main menu, please press nine (9). [
Main Menu]

For all other inquiries, please stay on the line for the next available representative.

Time Out Working Hours [8:00 am – 6:00 pm] [*CS Queue Provider*]
[6:00 pm – 8:00 pm [Claims CS Provider]

After Hours [*CS Closed Message*]

Provider Menu Span

[*In Spanish*] To review for in-patient or an alternative level of care, please press one (1).

Working Hours [8:00 am – 5:00 pm] [Inpatient *CCM Queue*]
After Hours [CNS Provider]

If you are a provider calling for authorization of outpatient services or psychological testing, please press two (2). [*Address Menu Span*]

If you are calling for eligibility, benefits verification, or to discuss a claims related matter, please press three (3).

Working Hours [8:00 am – 6:00 pm] [*CS Queue Provider*]
[6:00 pm – 8:00 pm [Claims CS Provider]
After Hours [*CS Closed Message Span*]

For information on our provider portal and how to submit claims and clinical forms, please press four (4). [*Address Menu Span*]

To repeat this menu, please press star (*) [*Provider Menu Span*]

To return to the main menu, please press nine (9). [*Main Menu Span*]

For all other inquiries, please stay on the line for the next available representative.
Time Out

Working Hours [8:00 am – 6:00 pm] [*CS Queue Provider*]
[6:00 pm – 8:00 pm [Claims CS Provider]
After Hours [*CS Closed Message Span*]

Address Menu

If you are an in-network provider requesting authorization of outpatient services, please press one (1). [*Address Two*]

If you an out-of-network provider, please press two (2) [*Address One*]

For the information on how to submit claims and clinical forms, please press three (3) [*Address Four*]

To repeat this menu, please press star (*) [*Address Menu*]

To return to the main menu, please press nine (9). [*Main Menu*]

Time Out
Working Hours [8:00 am – 6:00 pm] [*CS Queue Provider*]
[6:00 pm – 8:00 pm [Claims CS Provider]
After Hours [*CS Closed Message*]

Address Menu Span

If you are an in-network provider requesting authorization of outpatient services, please press one (1). [*Address Two Span*]

If you are an out-of-network provider, please press two (2) [*Address One*]

For the information on how to submit claims and clinical forms, please press three (3) [*Address Four Span*]

To repeat this menu, please press star (*) [*Address Menu Span*]

To return to the main menu, please press nine (9). [*Main Menu Span*]

Time Out
Working Hours 8:00 am – 6:00 pm] [*CS Queue Provider*]
[6:00 pm – 8:00 pm [Claims CS Provider]
After Hours [*CS Closed Message Span*]

Address One

The mailing address for claims is:

ValueOptions Empire Plan
PO Box 1800
Latham, New York 12110-8847

If you would like to speak with a representative, please press one (1).
Working Hours 8:00 am – 6:00 pm] [*CS Queue Member*]
[6:00 pm – 8:00 pm [Claims CS Member]
After Hours [*CS Closed Message*]

To repeat this information, please press star (*) [*Address One*]

To return to the main menu, please press nine (9). [*Main Menu*]

Address Two

For fastest service, in-network providers should submit outpatient authorization requests online through ProviderConnect. Please submit your request online at www.ValueOptions.com. and follow the links to ProviderConnect or log in directly at https://www.valueoptions.com/pc/eProvider/providerLogin.do

If you would like to speak with a representative, please press one (1).

Working Hours	8:00 am – 6:00 pm] [*CS Queue Provider*]
	[6:00 pm – 8:00 pm [Claims CS Provider]
After Hours	[*CS Closed Message*]

To repeat this information, please press star (*) [*Address Two*]

To return to the main menu, please press nine (9). [*Main Menu*]

Address Three

Out-of-network providers can download and print copies of the Outpatient review forms at www.ValueOptions.com. Completed forms can be faxed to 855-732-1197.

If you would like to speak with a representative, please press one (1).

Working Hours	8:00 am – 6:00 pm] [*CS Queue Provider*]
	[6:00 pm – 8:00 pm [Claims CS Provider]
After Hours	[*CS Closed Message*]

To repeat this information, please press star (*) [*Address Three*]

To return to the main menu, please press nine (9). [*Main Menu*]

Address Four

ValueOptions' website www.ValueOptions.com contains valuable information for providers, along with links to clinical forms.

Participating providers can submit single and multiple electronic claims submission via ProviderConnect.

The mailing address for claims is:

ValueOptions' Empire Plan
PO Box 1800
Latham, New York 12110-8847

If you would like to speak with a representative, please press one (1).
Working Hours 8:00 am – 6:00 pm] [*CS Queue Provider*]
[6:00 pm – 8:00 pm [Claims CS Provider]
After Hours [*CS Closed Message*]

To repeat this information, please press star (*) [*Address Four*]

To return to the main menu, please press nine (9). [*Main Menu*]

Address One Span

The mailing address for claims is:

ValueOptions' Empire Plan
PO Box 1800
Latham, New York 12110-8847

If you would like to speak with a representative, please press one (1).
Working Hours 8:00 am – 6:00 pm] [*CS Queue Member*]
[6:00 pm – 8:00 pm [Claims CS Member]
After Hours [*CS Closed Message*]

To repeat this information, please press star (*) [*Address One*]

To return to the main menu, please press nine (9). [*Main Menu Span*]

Address Two Span

[In Spanish] For fastest service, in-network providers should submit outpatient authorization requests online through ProviderConnect. Please submit your request online at www.ValueOptions.com. and follow the links to ProviderConnect or log in directly at https://www.valueoptions.com/pc/eProvider/providerLogin.do

If you would like to speak with a representative, please press one (1).
Working Hours [8:00 am – 6:00 pm] [*CS Queue Provider*]
[6:00 pm – 8:00 pm [Claims CS Provider]
After Hours [*CS Closed Message Span*]

To repeat this information, please press star (*) [*Address One Span*]

To return to the main menu, please press nine (9). [*Main Menu Span*]

Address Three Span

[In Spanish] Out-of-network providers can download and print copies of the Outpatient review forms at www.ValueOptions.com. Completed forms can be faxed to 855-732-1197.

If you would like to speak with a representative, please press one (1).

Working Hours	8:00 am – 6:00 pm] [*CS Queue Provider*]
	[6:00 pm – 8:00 pm [Claims CS Provider]
After Hours	[*CS Closed Message*]

To repeat this information, please press star (*) [*Address Three*]

To return to the main menu, please press nine (9). [*Main Menu Span*]

Address Four Span

[*In Spanish*] ValueOptions' website www.ValueOptions.com contains valuable information for providers, along with links to clinical forms.

Participating providers can submit single and multiple electronic claims submission via ProviderConnect.

The mailing address for claims is:

ValueOptions' Empire Plan
PO Box 1800
Latham, New York 12110-8847

If you would like to speak with a representative, please press one (1).

Working Hours	8:00 am – 6:00 pm] [*CS Queue Provider*]
	[6:00 pm – 8:00 pm [Claims CS Provider]
After Hours	[*CS Closed Message*]

To repeat this information, please press star (*) [*Address 4 Span*]

To return to the main menu, please press nine (9). [*Main Menu Span*]

CS Closed Message

If this is a life threatening emergency, press one (1) immediately. [EMG *CNS*]

Our office is now closed. Since this is not an emergency, please call back during normal business hours, Monday through Friday, 8:00 am to 8:00 pm Eastern Standard

Time. Please visit our website at www.ValueOptions.com where you can find valuable information. You can check eligibility, benefits, authorization and claim status.

To return to the main menu, please press nine (9). [*Main Menu*]

CS Closed Message Span

[*In Spanish*] If this is a life threatening emergency, press one (1) immediately. [EMG *CNS*]

Our office is now closed. Since this is not an emergency, please call back during normal business hours, Monday through Friday, 8:00 am to 8:00 pm Eastern Standard Time. Please visit our website at www.ValueOptions.com where you can find valuable information. You can check eligibility, benefits, authorization and claim status.

To return to the main menu, please press nine (9). [*Main Menu Span*]

Date

Member Name
Member Address
City, State, Zip

Dear [Member F Name],

ValueOptions® is the administrator of the mental health and substance abuse program for the Empire Plan.

We are offering a program to help Empire Plan members who think their child might be exhibiting symptoms of Attention Deficit Hyperactivity Disorder (ADHD). ValueOptions' ADHD Management Program provides educational resources, a screening tool and assistance obtaining a behavioral health assessment and treatment.

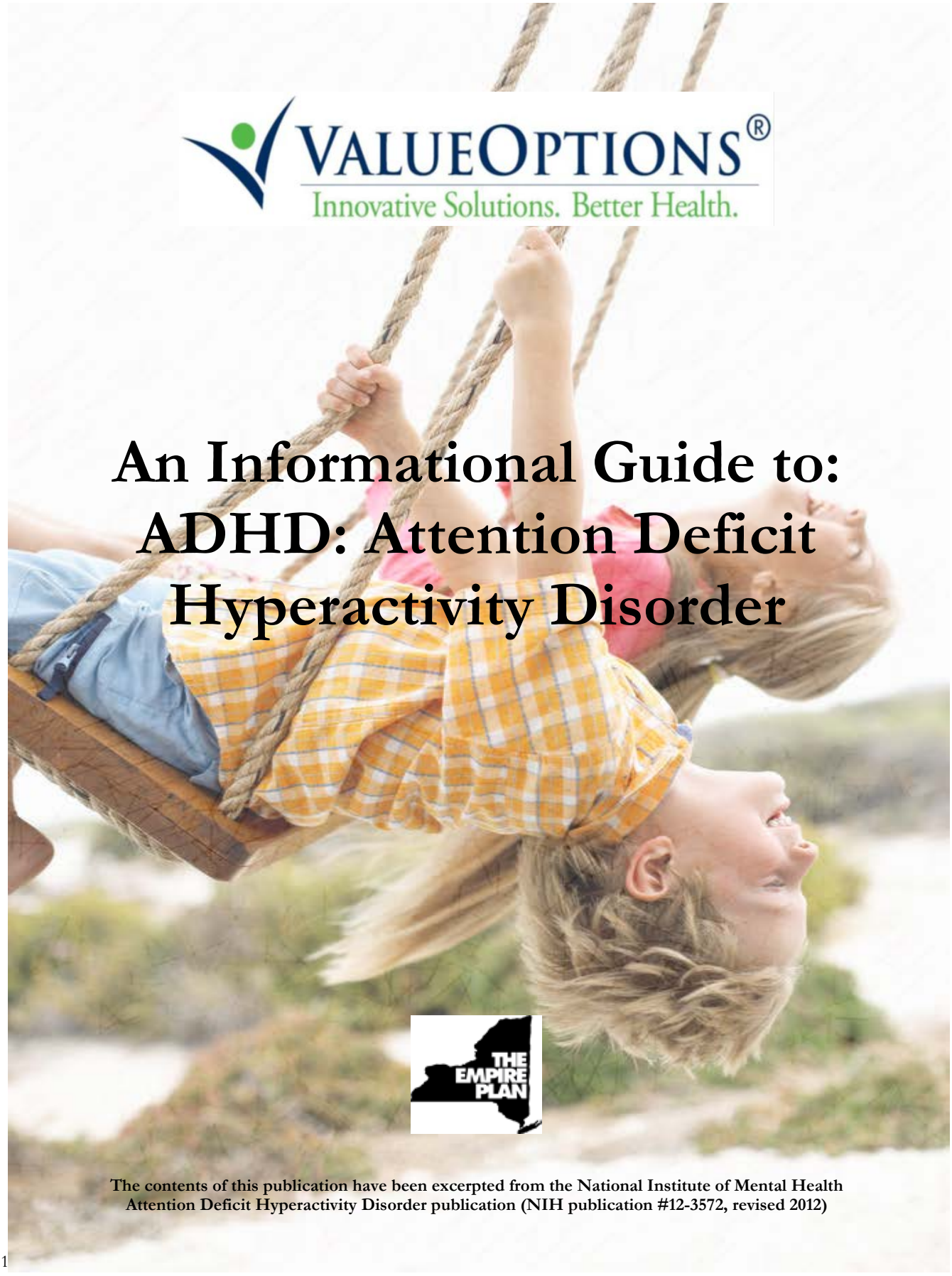
Our goal is to provide you with information on ADHD and identify resources that will help you, your child and family learn skills that will help reduce the behaviors and increase success in all aspects of your child's life.

Throughout the course of treatment, we offer additional support and resources to ensure you, your child and family are receiving the proper care and that your questions or concerns are being addressed.

If you would like to participate in the ADHD Management Program, please go on-line at www.achievesolutions.net/empireplan or contact ValueOptions at (877) 7-NYSHIP [(877) 769-7447], Option 3. A clinician is available to speak with you 24 hours a day, 7 days a week.

Sincerely,

Quality Management Team
ValueOptions, Inc.



An Informational Guide to: ADHD: Attention Deficit Hyperactivity Disorder

The contents of this publication have been excerpted from the National Institute of Mental Health Attention Deficit Hyperactivity Disorder publication (NIH publication #12-3572, revised 2012)

Table of Contents:

What is attention deficit hyperactivity disorder? Page 3

What are the symptoms of ADHD in children? Page 3

What causes ADHD? Page 4

How is ADHD diagnosed? Page 5

How is ADHD treated? Page 6
- Medications
- Psychotherapy

What conditions can coexist with ADHD? Page 7

How can I work with my child's school? Page 8

Do teens with ADHD have special needs? Page 9

Can adults have ADHD? Page 9

Citations Page 11

Additional Information Page 13

What is attention deficit hyperactivity disorder?

Attention deficit hyperactivity disorder (ADHD) is one of the most common childhood brain disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity). These symptoms can make it difficult for a child with ADHD to succeed in school, get along with other children or adults, or finish tasks at home.

Brain imaging studies have revealed that, in youth with ADHD, the brain matures in a normal pattern but is delayed, on average, by about 3 years.[1] The delay is most pronounced in brain regions involved in thinking, paying attention, and planning. More recent studies have found that the outermost layer of the brain, the cortex, shows delayed maturation overall,[2] and a brain structure important for proper communications between the two halves of the brain shows an abnormal growth pattern.[3] These delays and abnormalities may underlie the hallmark symptoms of ADHD and help to explain how the disorder may develop.

Treatments can relieve many symptoms of ADHD, but there is currently no cure for the disorder. With treatment, most people with ADHD can be successful in school and lead productive lives. Researchers are developing more effective treatments and interventions, and using new tools such as brain imaging, to better understand ADHD and to find more effective ways to treat and prevent it.

What are the symptoms of ADHD in children?

Inattention, hyperactivity, and impulsivity are the key behaviors of ADHD. It is normal for all children to be inattentive, hyperactive, or impulsive sometimes, but for children with ADHD, these behaviors are more severe and occur more often.

To be diagnosed with the disorder, a child must have symptoms for 6 or more months and to a degree that is greater than other children of the same age.

Children who have symptoms of inattention may:

- Be easily distracted, miss details, forget things, and frequently switch from one activity to another
- Have difficulty focusing on one thing
- Become bored with a task after only a few minutes, unless they are doing something enjoyable
- Have difficulty focusing attention on organizing and completing a task or learning something new
- Have trouble completing or turning in homework assignments, often losing things (e.g., pencils, toys, assignments) needed to complete tasks or activities
- Not seem to listen when spoken to
- Daydream, become easily confused, and move slowly
- Have difficulty processing information as quickly and accurately as others
- Struggle to follow instructions.

Children who have symptoms of hyperactivity may:

- Fidget and squirm in their seats
- Talk nonstop
- Dash around, touching or playing with anything and everything in sight
- Have trouble sitting still during dinner, school, and story time
- Be constantly in motion
- Have difficulty doing quiet tasks or activities.

Children who have symptoms of impulsivity may:

- Be very impatient
- Blurt out inappropriate comments, show their emotions without restraint, and act without regard for consequences
- Have difficulty waiting for things they want or waiting their turns in games often interrupt conversations or others' activities.

ADHD Can Be Mistaken for Other Problems

Parents and teachers can miss the fact that children with symptoms of inattention have ADHD because they are often quiet and less likely to act out. They may sit quietly, seeming to work, but they are often not paying attention to what they are doing. They may get along well with other children, whereas children who have more symptoms of hyperactivity or impulsivity tend to have social problems. But children with the inattentive kind of ADHD are not the only ones whose disorders can be missed. For example, adults may think that children with the hyperactive and impulsive symptoms just have disciplinary problems.

What Causes ADHD?

Scientists are not sure what causes ADHD, although many studies suggest that genes play a large role. Like many other illnesses, ADHD probably results from a combination of factors. In addition to genetics, researchers are looking at possible environmental factors, and are studying how brain injuries, nutrition, and the social environment might contribute to ADHD.

Genes: Inherited from our parents, genes are the "blueprints" for who we are. Results from several international studies of twins show that ADHD often runs in families. Researchers are looking at several genes that may make people more likely to develop the disorder.[4,5] Knowing the genes involved may one day help researchers prevent the disorder before symptoms develop. Learning about specific genes could also lead to better treatments.

Environmental factors: Studies suggest a potential link between cigarette smoking and alcohol use during pregnancy and ADHD in children.[6,7] In addition, preschoolers who are exposed to high levels of lead, which can sometimes be found in plumbing fixtures or paint in old buildings, have a higher risk of developing ADHD.[8]

Brain injuries: Children who have suffered a brain injury may show some behaviors similar to those of ADHD. However, only a small percentage of children with ADHD have suffered a traumatic brain injury.

Sugar: The idea that refined sugar causes ADHD or makes symptoms worse is popular, but more research discounts this theory than supports it.[9] In one study, researchers gave children foods containing either sugar or a sugar substitute every other day. The children who received sugar showed no different behavior or learning capabilities than those who received the sugar substitute.[10] Another study in which children were given higher than average amounts of sugar or sugar substitutes showed similar results.[11]

In another study, children who were considered sugar-sensitive by their mothers were given the sugar substitute aspartame, also known as NutraSweet. Although *all* the children got aspartame, half their mothers were told their children were given sugar, and the other half were told their children were given aspartame. The mothers who thought their children had gotten sugar rated them as more hyperactive than the other children and were more critical of their behavior, compared to mothers who *thought* their children received aspartame.[12]

Food additives: There is currently no research showing that artificial food coloring causes ADHD. However, a small number of children with ADHD may be sensitive to food dyes, artificial flavors, preservatives, or other food additives. They may experience fewer ADHD symptoms on a diet without additives, but such diets are often difficult to maintain.[9,13]

How is ADHD diagnosed?

Children mature at different rates and have different personalities, temperaments, and energy levels. Most children get distracted, act impulsively, and struggle to concentrate at one time or another. Sometimes, these normal factors may be mistaken for ADHD. ADHD symptoms usually appear early in life, often between the ages of 3 and 6, and because symptoms vary from person to person, the disorder can be hard to diagnose. Parents may first notice that their child loses interest in things sooner than other children, or seems constantly "unfocused" or "out of control." Often, teachers notice the symptoms first, when a child has trouble following rules, or frequently "spaces out" in the classroom or on the playground.

No single test can diagnose a child as having ADHD. Instead, a licensed health professional needs to gather information about the child, and his or her behavior and environment. A family may want to first talk with the child's pediatrician. Some pediatricians can assess the child themselves, but many will refer the family to a mental health specialist with experience in childhood brain disorders such as ADHD. The pediatrician or mental health specialist will first try to rule out other possibilities for the symptoms. For example, certain situations, events, or health conditions may cause temporary behaviors in a child that seem like ADHD.

A specialist will also check school and medical records for clues, to see if the child's home or school settings appear unusually stressful or disrupted, and gather information from the child's parents and teachers. Coaches, babysitters, and other adults who know the child well also may be consulted.

The specialist also will ask:

- Are the behaviors excessive, and do they affect all aspects of the child's life?
- Do they happen more often in this child compared with the child's peers?
- Are the behaviors a continuous problem or a response to a temporary situation?
- Do the behaviors occur in several settings or only in one place, such as the playground, classroom, or home?

The specialist pays close attention to the child's behavior during different situations. Some situations are highly structured, some have less structure. Others would require the child to keep paying attention. Most children with ADHD are better able to control their behaviors in situations where they are getting individual attention and when they are free to focus on enjoyable activities. These types of situations are less important in the assessment. A child also may be evaluated to see how he or she acts in social situations, and may be given tests of intellectual ability and academic achievement to see if he or she has a learning disability.

Finally, after gathering all this information, if the child meets the criteria for ADHD, he or she will be diagnosed with the disorder.

How is ADHD treated?

Currently available treatments aim at reducing the symptoms of ADHD and improving functioning. Treatments include medication, various types of psychotherapy, education and training, or a combination of treatments.

Medications*

Stimulants such as methylphenidate and amphetamines are the most common type of medication used for treating ADHD. Although it may seem counterintuitive to treat hyperactivity with a stimulant, these medications actually activate brain circuits that support attention and focused behavior, thus reducing hyperactivity. In addition, a few non-stimulant medications, such as atomoxetine, guanfacine, and clonidine, are also available. For many children, ADHD medications reduce hyperactivity and impulsivity and improve their ability to focus, work, and learn. Medications also may improve physical coordination.

However, a one-size-fits-all approach does not apply for all children with ADHD. What works for one child might not work for another. One child might have side effects with a certain medication, while another child may not. Sometimes several different medications or dosages must be tried before finding one that works for a particular child. Any child taking medications must be monitored closely and carefully by caregivers and doctors.

What are the side effects of stimulant medications?

The most commonly reported side effects are decreased appetite, sleep problems, anxiety, and irritability. Some children also report mild stomachaches or head-aches. Most side effects are minor and disappear over time or if the dosage level is lowered. Talk to your child's prescribing physician if you see any side effects.

Are stimulant medications safe?

Under medical supervision, stimulant medications are considered safe. Stimulants do not make children with ADHD feel high, although some kids report feeling slightly different or "funny." Preschoolers are more sensitive to the side effects of methylphenidate, and some may experience slower than average growth rates. Very young children should be closely monitored while taking ADHD medications.[14,15,16]

Do medications cure ADHD?

Current medications do not cure ADHD. Rather, they control the symptoms for as long as they are taken. Medications can help a child pay attention and complete schoolwork. It is not clear, however, whether medications can help children learn better. Adding behavioral therapy, counseling, and practical support can help children with ADHD and their families to better cope with everyday problems. NIMH-funded research has shown that medication works best when treatment is regularly monitored by the prescribing doctor and the dose is adjusted based on the child's needs.[17]

*NOTE: Be sure to check your pharmacy plan to determine which medications are covered.

Psychotherapy

Different types of psychotherapy are used for ADHD. Behavioral therapy aims to help a child change his or her behavior. It might involve practical assistance, such as help organizing tasks or completing schoolwork, or working through emotionally difficult events. Behavioral therapy also teaches a child how to monitor his or her own behavior. Learning to give oneself praise or rewards for acting in a desired way, such as controlling anger or thinking before acting, is another goal of behavioral therapy. Parents and teachers also can give positive or negative feedback for certain behaviors. In addition, clear rules, chore lists, and other structured routines can help a child control his or her behavior.

Therapists may teach children social skills, such as how to wait their turn, share toys, ask for help, or respond to teasing. Learning to read facial expressions and the tone of voice in others, and how to respond appropriately can also be part of social skills training.

How can parents help?

Children with ADHD need guidance and understanding from their parents and teachers to reach their full potential and to succeed in school. Before a child is diagnosed, frustration, blame, and anger may have built up within a family. Parents and children may need special help to overcome bad feelings. Mental health professionals can educate parents about ADHD and how it impacts a family. They also will help the child and his or her parents develop new skills, attitudes, and ways of relating to each other.

Parenting skills training helps parents learn how to use a system of rewards and consequences to change a child's behavior. Parents are taught to give immediate and positive feedback for behaviors they want to encourage, and ignore or redirect behaviors they want to discourage. In some cases, the use of "time-outs" may be used when the child's behavior gets out of control. In a time-out, the child is removed from the upsetting situation and sits alone for a short time to calm down.

Parents are also encouraged to share a pleasant or relaxing activity with the child, to notice and point out what the child does well, and to praise the child's strengths and abilities. They may also learn to structure situations in more positive ways. For example, they may restrict the number of playmates to one or two, so that their child does not become overstimulated. Or, if the child has trouble completing tasks, parents can help their child divide large tasks into smaller, more manageable steps. Also, parents may benefit from learning stress-management techniques to increase their own ability to deal with frustration, so that they can respond calmly to their child's behavior.

Sometimes, the whole family may need therapy. Therapists can help family members find better ways to handle disruptive behaviors and to encourage behavior changes. Finally, support groups help parents and families connect with others who have similar problems and concerns. Groups typically meet regularly to share frustrations and successes, to exchange information about recommended specialists and strategies, and to talk with experts.

Tips to Help Kids Stay Organized and Follow Directions

Schedule. Keep the same routine every day, from wake-up time to bedtime. Include time for homework, outdoor play, and indoor activities. Keep the schedule on the refrigerator or on a bulletin board in the kitchen. Write changes on the schedule as far in advance as possible.

Organize everyday items. Have a place for everything, and keep everything in its place. This includes clothing, backpacks, and toys.

Use homework and notebook organizers. Use organizers for school material and supplies. Stress to your child the importance of writing down assignments and bringing home the necessary books.

Be clear and consistent. Children with ADHD need consistent rules they can understand and follow.

Give praise or rewards when rules are followed. Children with ADHD often receive and expect criticism. Look for good behavior, and praise it.

What conditions can coexist with ADHD?

Some children with ADHD also have other illnesses or conditions. For example, they may have one or more of the following:

- **A learning disability:** A child in preschool with a learning disability may have difficulty understanding certain sounds or words or have problems expressing him or herself in words. A school-aged child may struggle with reading, spelling, writing, and math.

- **Oppositional defiant disorder:** Kids with this condition, in which a child is overly stubborn or rebellious, often argue with adults and refuse to obey rules.

- **Conduct disorder:** This condition includes behaviors in which the child may lie, steal, fight, or bully others. He or she may destroy property, break into homes, or carry or use weapons. These children or teens are also at a higher risk of using illegal substances. Kids with conduct disorder are at risk of getting into trouble at school or with the police.

- **Anxiety and depression:** Treating ADHD may help to decrease anxiety or some forms of depression.

- **Bipolar disorder:** Some children with ADHD may also have this condition in which extreme mood swings go from mania (an extremely high elevated mood) to depression in short periods of time.

- **Tourette syndrome:** Very few children have this brain disorder, but, among those who do, many also have ADHD. People with Tourette syndrome have nervous tics, which can be evident as repetitive, involuntary movements, such as eye blinks, facial twitches, or grimacing, and/or as vocalizations, such as throat-clearing, snorting, sniffing, or barking out words inappropriately. These behaviors can be controlled with medication, behavioral interventions, or both.

ADHD also may coexist with a sleep disorder, bed-wetting, substance abuse, or other disorders or illnesses. For more information on these disorders, visit the NIMH website. Recognizing ADHD symptoms and seeking help early will lead to better outcomes for both affected children and their families.

How can I work with my child's school?

If you think your child has ADHD, or a teacher raises concerns, you may be able to request that the school conduct an evaluation to determine whether he or she qualifies for special education services.

Start by speaking with your child's teacher, school counselor, or the school's student support team, to begin an evaluation. Also, each state has a parent training and information center and a protection and advocacy agency that can help you get an evaluation. A team of professionals conducts the evaluation using a variety of tools and measures. It will look at all areas related to the child's disability.

Once your child has been evaluated, he or she has several options, depending on the specific needs. If special education services are needed and your child is eligible under the individuals with Disabilities education act, the school district must develop an "individualized education pro-gram" specifically for your child within 30 days.

If your child is considered not eligible for special education services—and not all children with ADHD are eligible—he or she still can get "free appropriate public education," available to all public-school children with disabilities under Section 504 of the rehabilitation act of 1973, regardless of the nature or severity of the disability.

For more information on Section 504, consult the U.S. Department of education's office for civil rights, which enforces Section 504 in programs and activities that receive federal education funds.

Visit the Department of education website (www.ed.gov) for more information about programs for children with disabilities.

Transitions can be difficult. Each school year brings a new teacher and new schoolwork, a change that can be especially hard for a child with ADHD who needs routine and structure. Consider telling the teachers that your child has ADHD when he or she starts school or moves to a new class. Additional support will help your child deal with the transition.

Do teens with ADHD have special needs?

Most children with ADHD continue to have symptoms as they enter adolescence. Some children are not diagnosed with ADHD until they reach adolescence. This is more common among children with predominantly inattentive symptoms because they are not necessarily disruptive at home or in school. In these children, the disorder becomes more apparent as academic demands increase and responsibilities mount. For all teens, these years are challenging. But for teens with ADHD, these years may be especially difficult.

Although hyperactivity tends to decrease as a child ages, teens who continue to be hyperactive may feel restless and try to do too many things at once. They may choose tasks or activities that have a quick payoff, rather than those that take more effort, but provide bigger, delayed rewards. Teens with primarily attention deficits struggle with school and other activities in which they are expected to be more self-reliant.

Teens also become more responsible for their own health decisions. When a child with ADHD is young, parents are more likely to be responsible for ensuring that their child maintains treatment. But when the child reaches adolescence, parents have less control, and those with ADHD may have difficulty sticking with treatment.

To help them stay healthy and provide needed structure, teens with ADHD should be given rules that are clear and easy to understand. Helping them stay focused and organized—such as posting a chart listing household chores and responsibilities with spaces to check off completed items—also may help.

Can adults have ADHD?

Some children with ADHD continue to have it as adults. And many adults who have the disorder don't know it. They may feel that it is impossible to get organized, stick to a job, or remember and keep appointments. Daily tasks such as get-ting up in the morning, preparing to leave the house for work, arriving at work on time, and being productive on the job can be especially challenging for adults with ADHD.

These adults may have a history of failure at school, problems at work, or difficult or failed relationships. Many have had multiple traffic accidents. Like teens, adults with ADHD may seem restless and may try to do several things at once, most of them unsuccessfully. They also tend to prefer "quick fixes," rather than taking the steps needed to achieve greater rewards.

How is ADHD diagnosed in adults?

Like children, adults who suspect they have ADHD should be evaluated by a licensed mental health professional. But the professional may need to consider a wider range of symptoms when assessing adults for ADHD because their symptoms tend to be more varied and possibly not as clear cut as symptoms seen in children.

To be diagnosed with the condition, an adult must have ADHD symptoms that began in childhood and continued throughout adulthood.[18] Health professionals use certain rating scales to determine if an adult meets the diagnostic criteria for ADHD. The mental health professional also will look at the person's history of childhood behavior and school experiences, and will interview spouses or partners, parents, close friends, and other associates. The person will also undergo a physical exam and various psychological tests.

For some adults, a diagnosis of ADHD can bring a sense of relief. Adults who have had the disorder since childhood, but who have not been diagnosed, may have developed negative feelings about themselves over the

years. Receiving a diagnosis allows them to understand the reasons for their problems, and treatment will allow them to deal with their problems more effectively.

How is ADHD treated in adults?

Much like children with the disorder, adults with ADHD are treated with medication, psychotherapy, or a combination of treatments.

Medications: ADHD medications, including extended-release forms, often are prescribed for adults with ADHD.[19]
Although not FDA-approved specifically for the treatment of ADHD, antidepressants are sometimes used to treat adults with ADHD. The antidepressant bupropion (Wellbutrin), which affects the brain chemical dopamine, showed benefits for adults with ADHD.[20] Older antidepressants, called tricyclics, sometimes are used because they, like stimulants or atomoxetine, affect the brain chemical norepinephrine.

Adult prescriptions for stimulants and other medications require special considerations. For example, adults often require other medications for physical problems, such as diabetes or high blood pressure, or for anxiety and depression. Some of these medications may interact badly with stimulants. An adult with ADHD should discuss potential medication options with his or her doctor. These and other issues must be taken into account when a medication is prescribed.

Education and psychotherapy: A professional counselor or therapist can help an adult with ADHD learn how to organize his or her life with tools such as a large calendar or date book, lists, reminder notes, and by assigning a special place for keys, bills, and paperwork. Large tasks can be broken down into smaller, more manageable steps so that completing each part of the task provides a sense of accomplishment.

Psychotherapy, including cognitive behavioral therapy, also can help change one's poor self-image by examining the experiences that produced it. The therapist encourages the adult with ADHD to adjust to the life changes that come with treatment, such as thinking before acting, or resisting the urge to take unnecessary risks.

Citations

1. Shaw P, Eckstrand K, Sharp W, Blumenthal J, Lerch JP, et al. Attention-deficit/hyperactivity disorder is characterized by a delay in cortical maturation. *Proc Natl Acad Sci U S A.* 2007 Dec 4;104(49):19649–54. Epub 2007 Nov 16. PubMed PMID: 18024590; PubMed Central PMCID: PMC2148343.

2. Shaw P, Malek M, Watson B, Sharp W, Evans A, Greenstein D. Development of cortical surface area and gyrification in attention-deficit/hyperactivity disorder. *Biol Psychiatry.* 2012 Aug 1;72(3):191–7. Epub 2012 Mar 13. PMID: 22418014.

3. Gilliam M, Stockman M, Malek M, Sharp W, Greenstein D, et al. Developmental trajectories of the corpus callosum in attention-deficit/hyperactivity disorder. *Biol Psychiatry.* 2011 May 1;69(9):839– 46. Epub 2011 Jan 17. PMID: 21247556.

4. Faraone SV, Mick E. Molecular genetics of attention deficit hyperactivity disorder. *Psychiatr Clin North Am.* 2010 Mar;33(1):159–80. Review. PubMed PMID: 20159345; PubMed Central PMCID: PMC2847260.

5. Gizer IR, Ficks C, Waldman ID. Candidate gene studies of ADHD: a meta-analytic review. *Hum Genet.* 2009 Jul;126(1):51–90. Epub 2009 Jun 9. Review. PubMed PMID: 19506906.

6. Nomura Y, Marks DJ, Halperin JM. Prenatal exposure to maternal and paternal smoking on attention deficit hyperactivity disorders symptoms and diagnosis in offspring. *J Nerv Ment Dis.* 2010 Sep;198(9):672–8. PubMed PMID: 20823730; PubMed Central PMCID: PMC3124822.

7. Millichap JG.Etiologic classification of attention-deficit/hyperactivity disorder. *Pediatrics.* 2008 Feb; 121 (2): e358-65. Review. PubMed PMID: 18245408.

8. Froehlich TE, Lanphear BP, Auinger P, Hornung R, Epstein JN, Braun J, Kahn RS. Association of tobacco and lead exposures with attention-deficit/hyperactivity disorder. *Pediatrics.* 2009 Dec;124(6):e1054–63. Epub 2009 Nov 23. PubMed PMID: 19933729; PubMed Central PMCID: PMC2853804.

9. Millichap JG, Yee MM. The diet factor in attention-deficit/hyperactivity disorder. *Pediatrics.* 2012 Feb;129(2):330–7. Epub 2012 Jan 9. Review. PubMed PMID: 22232312.

10. Wolraich M, Milich R, Stumbo P, Schultz F. Effects of sucrose ingestion on the behavior of hyperactive boys. *J Pediatr.* 1985 Apr;106(4):675–82. PMID: 3981325.

11. Wolraich ML, Lindgren SD, Stumbo PJ, Stegink LD, Appelbaum MI, Kiritsy MC. Effects of diets high in sucrose or aspartame on the behavior and cognitive performance of children. *N Engl J Med.* 1994 Feb 3;330(5):301–7. PMID: 8277950.

12. Hoover DW, Milich R. Effects of sugar ingestion expectancies on mother-child interactions. *J Abnorm Child Psychol.* 1994 Aug;22(4):501–15. PMID: 7963081.

13. Nigg JT, Lewis K, Edinger T, Falk M. Meta-analysis of attention-deficit/hyperactivity disorder or attention-deficit/hyperactivity disorder symptoms, restriction diet, and synthetic food color additives. *J Am Acad Child Adolesc Psychiatry.* 2012 Jan;51(1):86–97.e8. PMID: 22176942.

14. Wigal T, Greenhill L, Chuang S, McGough J, Vitiello B, et al. Safety and tolerability of methylphenidate in preschool children with ADHD. *J Am Acad Child Adolesc Psychiatry.* 2006 Nov;45(11):1294–303. PubMed PMID: 17028508.

15. Swanson J, Greenhill L, Wigal T, Kollins S, Stehli A, et al. Stimulant-related reductions of growth rates in the PATS. *J Am Acad Child Adolesc Psychiatry.* 2006 Nov;45(11):1304–13. PubMed PMID: 17023868.

16. Greenhill L, Kollins S, Abikoff H, McCracken J, Riddle M, et al. Efficacy and safety of immediate-release methylphenidate treatment for preschoolers with ADHD. *J Am Acad Child Adolesc Psychiatry.* 2006 Nov;45(11):1284–93. Erratum in: *J Am Acad Child Adolesc Psychiatry.* 2007 Jan;46(1):141. PubMed PMID: 17023867.

17. The MTA Cooperative Group. A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Arch Gen Psychiatry.* 1999 Dec;56(12):1073–86. PMID: 10591283.

18. Post RE, Kurlansik SL. Diagnosis and management of adult attention-deficit/hyperactivity disorder. *Am Fam Physician.* 2012 May 1;85(9):890–6. PMID: 22612184.

19. Ramos-Quiroga JA, Corominas M, Castells X, Bosch R, Casas M. OROS methylphenidate for the treatment of adults with attention-deficit/hyperactivity disorder. *Expert Rev Neurother.* 2009 Aug;9(8):1121–31. Review. PubMed PMID: 19673602.

20. Wilens TE, Haight BR, Horrigan JP, Hudziak JJ, Rosenthal NE, Connor DF, Hampton KD, Richard NE, Modell JG. Bupropion XL in adults with attention-deficit/hyperactivity disorder: a randomized, placebo-controlled study. *Biol Psychiatry.* 2005 Apr 1;57(7):793–801. PubMed PMID: 15820237.

For more information on Attention Deficit Activity Disorder:

Visit the National Library of Medicine's

- MedlinePlus
  - http://medlineplus.gov
- En Espanol
  - http://medlineplus.gov/spanish
- For information on clinical trials
  - http://www.nimh.nih.gov/health/trials/index.shtml
- National Library of Medicine clinical trials database
  - http://www.clinicaltrials.gov

Information from NIMH is available in multiple formats. You can browse online, download documents in PDF, and order materials through mail. Check the NIMH website at http://www.nimh.nih.gov for the latest information on this topic and to order publications. If you do not have Internet access, please contact the NIMH Information Resource Center at the numbers listed below.

National Institute of Mental Health
Office of Science Policy, Planning and Communications
Science Writing, Press and Dissemination Branch
6001 Executive Boulevard
Room 6200, MSC 9663
Bethesda, MD 20892-9663
Phone: (301) 443-4513 OR Toll free: (866) 615-NIMH (6464)
TTY: (301) 443-8431 OR Toll free: (866) 415-8051
Fax: (301) 443-4279
E-mail: nimhinfo@nih.gov
Website: http://www.nimh.nih.gov

Signs of ADHD in children

- Have a hard time paying attention
- Are easily distracted
- Have trouble controlling their actions (even when they want to)
- Are unusually active or "agitated" (overexcited)
- Have difficulty sitting still
- Act without thinking first
- Start things but do not finish them
- Get bored after just a short while
- Daydream or seem to be in another world
- Get frustrated with school or homework
- Are always moving—fingers, hands, arms, feet or legs

VALUEOPTIONS®
Innovative Solutions. Better Health.

If you suspect your child may have ADHD, discuss his or her symptoms with the child's pediatrician and contact ValueOptions®.

You can learn more about the ValueOptions ADHD Program on-line at **www.achievesolutions.net/empireplan** or by calling toll free at **(877) 7-NYSHIP [(877) 769-7447], Option 3**

ValueOptions®
P.O. Box 547
Latham, NY 12110

Could your child have ADHD?

THE EMPIRE PLAN

ADHD Management Program

ADHD Disorders

- Are a chronic condition for school age children and can last throughout adulthood.
- Affect up to 7% of the population.
- Have the highest prevalence of co-occurrence with depression, anxiety, learning disabilities, Oppositional Defiant Disorder, Conduct Disorder and Substance Use Disorders.
- Can impact the child's schoolwork, self-esteem and relationships with peers and family.
- Are treatable.

ValueOptions®, the administrator of the mental health and substance abuse program for the New York State Empire Plan, offers something that can help you.

The Program includes

- A free confidential screening tool that you can take on-line, by telephone or by mail.
- Information about ADHD symptoms and treatment.
- Assistance in assessing your child's treatment options and in coordinating care among treatment providers.

When you sign up you will receive:

- An ADHD screening tool
- A tip sheet on understanding ADHD
- Information on treatment options and conditions associated with ADHD
- Information on coordination of care

Participation is:

Confidential - We do not share information without your permission.

Voluntary - Participation is strictly voluntary.

Free - ValueOptions® offers this program as part of your behavioral health benefit.

Easy - Just call or log-on to join.

Date

Member Name
Member Address
City, State, Zip

Dear Mr. /Ms. [Last Name],

ValueOptions® is the administrator of the Mental Health and Substance Abuse program for the Empire Plan.

We are offering a program to help members who are, or think they may be, experiencing depression. The program, entitled "Depression Identification and Management," provides educational resources including educational mailings, information about treatment options and help with getting treatment. The program also offers free depression screening, which can be completed online or by mail.

Depression is a common and treatable health condition that can affect how you feel, think and act. Our goal is to provide you with the information and support necessary to help you understand depression and obtain the treatment you need to relieve the symptoms and feel better.

Throughout the course of your treatment, we offer additional support and resources to ensure you are receiving the proper care and that your questions or concerns have been addressed.

If you would like to learn more about the Depression Identification and Management Program, please go on-line at www.achievesolutions.net/empireplan or contact ValueOptions at (877) 7-NYSHIP [(877) 769-7447], Option 3. A clinician is available to speak with you 24 hours a day, 7 days a week.

Sincerely,

Quality Management Team
ValueOptions, Inc.

Understanding Depression and How to Get Help

Brought to you by ValueOptions®

ValueOptions® Depression Series

1

What is depression?

Depression is an illness of the brain — more than a case of "the blues."

Medical studies show that our brains have millions of cells that allow us to function physically and emotionally. None of these cells directly communicate with each other. Chemicals, which send messages between our brain cells, are necessary for our brain to function. Some forms of depression are caused by a reduction in these chemicals and benefit from medication treatment.

Anyone may have depression: old or young, rich or poor, male or female. Sometimes people feel depressed even when their life is going well. Many things may contribute to depression. Life changes and/or traumas such as losing a loved one or job, serious people conflicts, physical health problems, or moving. Depression may be brief or it may happen again and again. If you or someone you know has depression, you are not alone. Recovery is possible, and with treatment, there is hope.

What does depression feel like?

Many people think that depression means you feel sad, but this is not always the case. Depression may change many things in your life including:

It can change:

- How you look at things
- How you think
- Your sleep habits
- Your attitude

You may:

- Lose interest in sex or life in general
- Not be able to concentrate
- Gain or lose weight
- Become confused or forget things easily
- Lose track of what you are talking about
- Misuse drugs and alcohol
- Feel tired or anxious all the time
- Become more impulsive or get angry more quickly
- Not be able to leave your home or room
- Not be able to leave safe places
- Not be doing well at work, school, or home
- See and hear things that other people do not
- Experience body aches and pains
- Become very quiet and withdrawn
- Neglect personal hygiene
- Avoid people
- Have racing thoughts
- Withdraw from relationships or friendships
- Push people away or impair relationships

It may seem as if there's no tomorrow or no hope. Nothing makes you happy anymore. If you have serious depression, you may think about suicide, or hurting yourself or someone else. If this is the case you should seek help immediately.

When should I seek help?

If you are thinking about hurting yourself or someone else, or attempting suicide, seek emergency help immediately.

ValueOptions® Depression Series

1

If you are suffering from depression, there are steps to control your symptoms and begin living a positive life. If you answer "yes" to any of the following, consider seeking professional help:

- Is your mood interfering with your personal relationships or how you do your job?
- Have these feelings lasted longer than two weeks?
- Is your stress from a single, identified stress (for example, the serious illness of a child) that does not have a clear end in sight?
- Are you beginning to feel worthless or guilty about the situation?
- Is the stress not allowing you to find happiness in other parts of your life?

Where do I go for help?

If you think you have depression, the first step is to get a proper diagnosis. Your family doctor may be the best place to start. He or she will rule out other health conditions or medications as the cause of your symptoms. However, you may not be comfortable in contacting your family doctor. If not, you may contact anyone you feel will support you such as your church, hospital, community mental health center or state agency.

Your family doctor or behavioral health expert may start treating your depression. He or she will consider how your body and environment work together to cause depression. From there, a treatment plan is made from any previous treatment you may have had, the seriousness of your depression, and your choice of treatment options. Professionals who treat depression include psychiatrists, psychologists, or Master's level mental health professionals.

Which type of health care professional will be right for me?

More often than not, you will be treated by a combination of these professionals who team up to provide your care.

Psychiatrist

A psychiatrist is a medical doctor. They can prescribe medication and provide talk therapy. This may be the best choice when your problem is particularly severe, or if you have medical problems.

Psychologist

A psychologist has a doctoral degree (PhD or PsyD) in psychology. They have special skills for evaluation of problems and do talk therapy as well.

Social Worker or Master's level therapist

Licensed social workers or professional counselors in behavioral health have Master's degrees (MSW, LPC). They are helpful when your problems are complicated by family issues and problems with your daily environment. They provide talk therapy as well.

There are several treatment options. Your doctor may recommend "talk therapy" or "counseling," medication with antidepressants, lifestyle and self-care activities, or a combination of all of these options.

These treatments have been shown to successfully treat depression. A combination of medications and therapy is used to treat many people, and your doctor can help decide what may work best.

On rare occasions, medication has been known to increase energy levels before improving mood, a person with suicidal thoughts and increased energy levels could make a plan of self- harm. With this odd combination of good and bad feelings, as well as improved energy, some may carry out suicide attempts. This is not the time to stop taking prescribed medication!

Any suicidal thoughts must be reported immediately to your doctor, therapist or 911! ValueOptions is also available 24 hours a day, 7 days a week at (877) 7-NYSHIP [(877) 769-7447], Option 3.

What You Should Know About Your Treatment

Brought to you by ValueOptions®

ValueOptions® Depression Series

2

Luckily, there is much known on how to relieve depression. The sections below explain several treatment options and tips to make them work.

Methods that work together to relieve depression:

- Education on helpful health practices
- Therapy to help you learn to:
  - accomplish daily tasks
  - correct negative thinking
  - reduce stress of daily living
  - keep track of your response to prescribed medications
- Antidepressant medication for correction of biological causes and/or physical symptoms of depression

Seek professional treatment

Often, people need professional help to overcome depression even after trying the methods above. Your doctor or health plan may refer you to a mental health provider. Treatment with a psychiatrist, psychologist or social worker can help reduce the severity and length of your depression.

Some facts to help you understand therapy:

- Therapy consists of scheduled appointments to identify and resolve stressors that trigger depression.
- It is very common for special medications called "anti-depressants" to be recommended.
- The most effective treatment of depression often includes both medication and therapy.
- You may have a psychiatrist prescribe and monitor medication, and a psychologist or social worker to conduct therapy and coordinate your treatment.

Get the most out of therapy

- **Attend all appointments**, even if you are feeling better.
- **Learn tools to manage stress**. There may be classes available in your community to help you learn in a group setting.
- **Report any problem** or concern that may complicate your situation. This is especially important if you use drugs or alcohol. Treatment of substance abuse is necessary for recovery from depression.
- **Ask your therapist about bringing family members to sessions**. When family members understand depression they are able to help you. This is as important for your loved ones as it is for you — they often feel confused and helpless about what they can do.

Medication for depression: The following are reasons to consider medication:

- Depressed people have too few of some chemicals that send messages between nerve cells within the part of the brain that controls moods and feelings.
- Antidepressant medications help increase the level of key brain chemicals in the body.
- Stressful life events and changes in how your brain works seem to go together, although no one knows exactly why.

VALUEOPTIONS®

ValueOptions® Depression Series

2

- You may not be able to get rid of life stressors well or soon enough to get relief from depression.
- Medication will reduce brain chemistry changes while you work on your stress.
- Medication may speed up your recovery.

Benefits of antidepressant treatment: When used safely and properly, antidepressant medications help:

- Improve mood
- Increase energy
- Increase interest in usual activities and sex
- Decrease restlessness
- Reduce thoughts of guilt or unworthiness
- Increase hope and happiness
- Eliminate thoughts of self- harm or suicide
- Improve sleep
- Improve appetite

Choice of antidepressant medications: There are more than 24 antidepressant medications from which your doctors will choose.* The following criteria will assist with the decision:

- Your symptoms
- Your other health issues and any current medications
- Medications that have helped you in the past
- Medications that have helped relatives in the past
- Impact of possible medication side effects on your lifestyle

*You will want to check your prescription coverage to ensure medication coverage.

How to use antidepressant medications: You may find this information useful:

- Once your doctor starts antidepressant medication with you, he or she will watch your reaction carefully.
- Specific medications or dosages can be changed according to your reports.
- Most side effects from medication disappear as your body adjusts within the first six weeks of treatment.
- Until you adjust, you may be able to relieve symptoms through change in sleep habits or simple remedies.
- Be sure to ask your doctor what side effects to expect. Some common side effects may include: dry mouth, increase/decrease in weight, constipation, or change in your sexual responsiveness.

Your role in treatment: Your doctor will need your help in making treatment with antidepressant medication successful. You need to pay attention to your reactions and report the following situations immediately:

- Side effects that are particularly bad or do not disappear after about six weeks
- Side effects that seem dangerous to your health
- Medical conditions that occur after start of antidepressant treatment
- New medications prescribed by other doctors
- Any suicidal or self -harming thoughts, or thoughts of harming anyone else
- Any use of alcohol or street drugs

On rare occasions, medication sometimes increases energy levels before improving mood, and a person with suicidal thoughts and increased energy levels could make a plan of self- harm. With a combination of good and bad feelings, as well as improved energy, some may carry out suicide attempts. This is not the time to stop taking prescribed medication!

Any suicidal thoughts must be reported immediately to your doctor, therapist or 911! ValueOptions is also available 24 hours a day, 7 days a week at (877) 7-NYSHIP [(877) 769-7447], Option 3.

Managing Depression

Brought to you by ValueOptions®

ValueOptions® Depression Series

3

According to the World Health Organization, 121 million people currently suffer from depression. An estimated 5.8% of men and 9.5% of women will experience a depressive episode in any given year. The good news is that depression is easy to treat and many people are being helped.

Signs of depression include:

- Loss of interest in enjoyable activities
- Feeling worthless
- Sleeping too much, too little or waking up very early
- Loss of appetite and weight loss or increased appetite and weight gain
- Having less energy or feeling slowed down
- Feeling grumpy and restless
- Problems focusing and remembering
- Physical problems that don't go away (i.e. headaches or stomach pain)
- Thoughts of death or suicide

If you are suffering from depression, there are steps you can take to control your symptoms and begin living a positive life.

Tips for managing depression

Get medical care: Some depressions are caused by medical problems. The first step in treating depression is to treat any physical illness. Some medications that you may be taking to treat high blood pressure or other common problems can cause depression.

Educate yourself: Learn about the illness. Knowing about the illness and what to expect gives you a sense of control. Your mental health center, doctor and self-help groups are all good sources of information.

Avoid negative people and situations: Do your best to avoid people who put you down and make you feel bad. Try to be around people who care about you, although depression can cause feelings that loved ones no longer care. This may be a direct result of depression changing your perception of how your loved ones interact.

Think positive thoughts: Keep in mind that when people are depressed they think negatively, especially about themselves.

- Catch yourself when you think negative thoughts, and instead focus on the positive.
- Make a list of nice things people say about you to remind yourself.

Evaluate your lifestyle: Sometimes, your lifestyle can contribute to depression. Evaluate the way you live, things you need to change in your life and do them. Try to avoid stress, loneliness or being around angry people.

Be social: Depression can make you want to avoid other people, which is not helpful. Your family and/or close friends are important helpers. Below are some tips for using social relationships to help:

- **Don't shut people out.** Make time for family and close friends.
- **Share your thoughts and concerns** with people who are close, as talking helps.

VALUEOPTIONS®

ValueOptions® Depression Series

3

Set small goals: Depression has a negative impact on self- esteem, and it often makes you feel worthless. Setting and accomplishing small goals will give a sense of self worth and achievement.

For example:

- Have a daily routine and do one thing at a time
- Set reachable goals
- Notice your success
- Reward yourself

Caring for your health: It is important to take care of your health. You may become depressed because you are physically ill.

Some health tips include:

- Get enough sleep: Almost everyone with depression has a problem with sleep; either they get too little or too much.
  - Sleep about 8 hours a day.
  - Wake up and go to sleep at the same time daily.
- Eat a well-balanced diet: People with depression often eat too little, which can cause poor nutrition and weight loss. Some people are nervous and may eat too much.
  - Eat at least three meals per day.
  - Talk with your doctor or dietician about foods that can help you feel better.
- Exercise: Exercise can do wonderful things, and it may help your brain to release chemicals that improve mood and self-control.
  - Pick an activity you enjoy and can stick with, such as walking or biking.
  - Plan on doing it at least three days per week for half an hour.
- Learn to relax and manage stress: Stress can make you feel out of control and add to depression. Find something relaxing to do:
  - Learn to meditate.
  - Try yoga or tai chi for gentle, focused exercise.
- Take your medicine: Most people with depression or who are recovering will do better with medication.* If your doctor has given you medication and it works, keep taking it. Often one medication will not remove your symptoms, and a change in medications or addition of a second one is helpful. Remember, antidepressant medications are not "uppers" or "downers," but work by leveling the chemicals in your brain so that your brain cells can communicate normally. It may take several months for medication to correct the problem, so even if you start to feel better continue the medication(s) until your physician says to reduce or stop. If you stop too soon the depression will re-occur.

*You will want to check your prescription coverage to ensure medication coverage.

On rare occasions, medication sometimes increases energy levels before improving mood, and a person with suicidal thoughts and increased energy levels could make a plan of self- harm. With a combination of good and bad feelings, as well as improved energy, some may carry out suicide attempts. This is not the time to stop taking prescribed medication!

Any suicidal thoughts must be reported immediately to your doctor, therapist or 911! ValueOptions is also available 24 hours a day, 7 days a week at (877) 7-NYSHIP [(877) 769-7447], Option 3.

Risk for Relapse

Brought to you by ValueOptions®

ValueOptions® Depression Series

4

The risk for relapse: return of depressive symptoms

Depressed people remain vulnerable to relapse even after successful treatment, and it can be worse than the initial episode. It is very upsetting because the symptoms you worked so hard to get rid of may come back, and treatment usually starts all over again.

It is important that you and your therapist or doctor plan the completion of your treatment together. You may have identified factors that trigger depressed feelings, and can continue to cause stress. Many of these problems developed over many years and will not get resolved in a matter of months. It is very useful to make notes on upsetting situations and what to do when they repeat. Therapy can help you learn ways to cope with your problems, find what triggers them, and teach strategies for keeping them under control. When you feel better, you can think about and solve problems for the long term. For extra support, you should feel free to contact your therapist at any time during your recovery.

Stages of therapy

It is often useful to think of your recovery in stages:

Initial phase

During the first stage of treatment your doctor may put you on an antidepressant medication.*

- Antidepressants are not "uppers" or stimulants, but rather remove or lessen symptoms of depression by bringing the chemicals in your brain that affect mood back to normal. They help depressed people feel the way they did before they became depressed.
- Your doctor may ask you some questions and possibly add a second medication in a few weeks.
- You may begin to feel better in a couple of weeks or it could take longer. Continue to take the medication even if you don't feel better right away.
- Talk to your doctor about any side effects.
- It is possible to have symptoms gradually go away.
- Do not stop taking the medication without talking to your doctor first.

*You will want to check your prescription coverage to ensure medication coverage.

Continuation phase

- The period when your depressive symptoms have mostly gone away.
- You have returned to normal (how it was at work, with friends, family, etc.).
- Discuss with your doctor before you stop taking any medications, especially if this is your first period of depression. He/she may want you to keep taking them even if you are feeling better.
- Stopping medications should be done gradually over a period of weeks. Just quitting medications can result in a variety of flu-like symptoms. When stopping medications, tell your doctor if you feel the symptoms of depression again. He/she will decide if medication should be started or changed early, before you develop a full relapse.

ValueOptions® Depression Series

4

Maintenance phase

Major depression happens only once for about half the people who get it. For the other half, it is an illness that will return one or more times.

- For most people with repeated bouts of depression, symptoms go away completely between episodes, but for some there are continuing symptoms.
- Maintenance treatment refers to ongoing use of medications, which is often recommended for people with more than one period of depression. The more times you have been seriously depressed, the more likely you are to have it come back. The more episodes of untreated depression you experience, the more difficult it may be to eliminate the illness.
- Your doctor may talk to you about using medications on a long-term basis (over several years). He/she may even urge lifetime use of medications that have been helpful in treating your symptoms.
- Use self-help books and support groups to help your recovery progress.

On rare occasions, medication sometimes increases energy levels before improving mood, and a person with suicidal thoughts and increased energy levels could make a plan of self- harm. With a combination of good and bad feelings, as well as improved energy, some may carry out suicide attempts. This is not the time to stop taking prescribed medication!

Any suicidal thoughts must be reported immediately to your doctor, therapist or 911! ValueOptions is also available 24 hours a day, 7 days a week at (877) 7-NYSHIP [(877) 769-7447], Option 3.

Signs of Depression:

- Have you **lost interest** in activities you usually enjoy?
- Are you **sleeping too much**, too little or waking up early?
- Are you having **trouble focusing** or remembering?
- Do you have unexplained **physical symptoms** that don't go away?

If you answered "Yes" to any of these questions, you may be suffering from depression.

If you would like to learn more about this free program and see if you qualify, call *ValueOptions at (877) 7-NYSHIP [(877) 769-7447], Option 3* or go online at www.achievesolutions.net/empireplan.

Brought to you by:

VALUEOPTIONS®
Innovative Solutions. Better Health.

VALUEOPTIONS®
Innovative Solutions. Better Health.

We can help with depression.

THE EMPIRE PLAN

Depression Identification and Management Program

Depression

- Is a common and serious medical condition.
- Affects nearly 10% of adults in the US.
- Is a leading cause of disability.
- Can impact your family, friends, health and job.
- **Is treatable.**

If you suspect you may be depressed, discuss your symptoms with your doctor and contact ValueOptions® at (877) 7-NYSHIP [(877) 769-7447], Option 3.

The program includes:

- Free, confidential screening that you can take online, by telephone or by mail;
- Information about depression, its symptoms and treatment; and
- Assistance in assessing your treatment options.
- An Intensive Care Management component. ValueOptions will invite those members with more severe symptoms to participate.

Participation is:

- **Confidential –** We don't share information without your permission.
- **Voluntary –** Participation is strictly voluntary.
- **Free –** ValueOptions offers this program as part of your benefit.

When You Participate:

You can call to receive a copy of our depression fact sheets or access the information online . These materials contain important information about depression, its treatment and suggestions for managing symptoms.

With your permission we will share your confidential screening with your doctor or other health care professional.

Date

Member Name
Member Address
City, State, Zip

Dear [Member F Name],

ValueOptions® is the administrator of the mental health and substance abuse program for the Empire Plan.

We are offering a program to help New York State Empire Plan members who think they or their child might be exhibiting symptoms of an Eating Disorder. ValueOptions' Eating Disorder Management Program provides educational resources, a screening tool and assistance obtaining a behavioral health assessment and treatment.

Our goal is to provide you with information on Eating Disorders and identify resources that will help you, your child and family obtain the skills that will help reduce the symptoms and increase success in managing your or your child's health.

Throughout the course of treatment, we offer additional support and resources to ensure you, your child and family are receiving the proper care and that your questions or concerns are being addressed.

If you would like to participate in the Eating Disorder Management Program please go on-line at www.achievesolutions.net/empireplan or contact ValueOptions at (877) 7-NYSHIP [(877) 769-7447], Option 3. A clinician is available to speak with you 24 hours a day, 7 days a week.

Sincerely,

Quality Management Team
ValueOptions, Inc.

VALUEOPTIONS®
Innovative Solutions. Better Health.

An Informational Guide to:

Eating Disorders

THE EMPIRE PLAN

Table of Contents

Tip 1: What is an Eating Disorder? Page 3

Tip 2: A fact sheet for Parents & Families Page 5

Tip 3: Eating Disorder Treatment & Support Page 7

Eating Attitude Survey: What's your attitude about Eating? Page 9

Tip 1: What is an Eating Disorder?

What is an Eating Disorder?

Eating disorders are characterized by severe disturbances in eating behavior, such as limiting food, extreme overeating or binging, vomiting after overeating or feelings of extreme distress or concern about body weight or shape. They involve extreme emotions, attitudes, and behaviors around weight and food issues. An eating disorder includes both emotional and physical problems and it can have life-threatening consequences.

Types of Eating Disorders:

Binge Eating Disorder: Binge eating disorder is defined as recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, episodes marked by feelings of lack of control. Someone with binge eating disorder may eat too quickly, even when he or she is not hungry. The person may have feelings of guilt, embarrassment or disgust and may binge eat alone to hide the behavior. This disorder is associated with marked distress and occurs, on average, at least once a week over three months.

Anorexia Nervosa: Anorexia nervosa, which primarily affects adolescent girls and young women, is characterized by distorted body image and excessive dieting that leads to severe weight loss with a pathological fear of becoming fat.

Bulimia Nervosa: Bulimia nervosa is characterized by frequent episodes of binge eating followed by inappropriate behaviors such as self-induced vomiting to avoid weight gain.

(site: American Psychiatric Association)

Who develops eating disorders?

Eating disorders occur in both men and women and do not discriminate between cultural backgrounds or age. Because of the secretiveness and shame associated with eating disorders, many more cases are probably not even reported. In addition, many individuals struggle with body dissatisfaction and unhealthy eating attitudes and behaviors that are not necessarily diagnosed as an eating disorder.

(site: NIMH www.nih.gov; NEDA www.nationaleatingdisorders.org)

Why do people develop eating disorders?

There continues to be ongoing research to learn more about the underlying causes of eating disorders but what they do know is that eating disorders can arise from a combination of factors most commonly involving:

- Psychological
- Interpersonal
- Social

While eating disorders may begin with a preoccupation with food and weight, they are often about much more than food. People with eating disorders often use food and the control of food in an attempt to compensate for feelings and emotions that may otherwise seem overwhelming. For some, dieting, binging, and purging may begin as a way to cope with painful emotions and to feel in control of one's life, but ultimately, these behaviors will damage a person's physical and emotional health, self-esteem, and sense of competence and control.

Psychological Factors that can contribute to Eating Disorders:

- Low self-esteem
- Feelings of inadequacy or lack of control in life
- Depression, anxiety, anger, or loneliness

Interpersonal Factors that can contribute to Eating Disorders:

- Troubled family and personal relationships
- Difficulty expressing emotions and feelings
- History of being teased or ridiculed based on size or weight
- History of physical or sexual abuse
- Struggle with developmental issues surrounding puberty

Social Factors that can contribute to Eating Disorders:

- Cultural pressures that glorify "thinness" and place value on obtaining the "perfect body"
- Narrow definitions of beauty that include only women and men of specific body weights and shapes
- Cultural norms that value people on the basis of physical appearance and not inner qualities and strengths

(site: NIMH www.nih.gov; NEDA www.nationaleatingdisorders.org)

What are the signs & symptoms of eating disorders?

The signs and symptoms of a person suffering from an eating disorder vary for one person to another. Below is a list of the most common physical and behavioral signs:

Physical:	**Behavioral:**
* marked weight gain or loss/fluctuations in weight of up to 10 pounds or more.	*preoccupation with food and calories
*chronic fatigue	*compulsive, excessive exercise habits
*dehydration	*depression and/or anxiety
*growth of lanugo or baby like hair	*purging behaviors (vomiting, laxatives/diuretics)
*chronic sore throats or stomach aches	*fear of eating food that contain fat
*decay of tooth enamel	*frequent weighing of self
*hair loss	*intense fear of weight gain or becoming fat
*amenorrhea; menstrual cycle irregularities	*denial of eating problems or weight loss
(no longer considered a criteria for diagnosis but doctor may ask)	*withdrawal from friends and family

It wasn't until recently that eating disorders were recognized as a treatable medical illness. Early diagnosis and intervention leads to very good outcomes. While the signs and symptoms of eating disorders can present in various ways, it's the complex underlying psychological causes that are the greatest cause for concern. Until the emotional and mental problems are addressed the eating disorder will not go away.

(site: NIMH www.nih.gov; NEDA www.nationaleatingdisorders.org)

Tip 2: A fact sheet for Parents & Families

Things parents/families can do to help prevent eating disorders:

- Consider your thoughts, attitudes, and behaviors toward your own body. Children learn from the things you say and do! If you openly talk about your weight (either in a negative or positive way), your children will pick up on that and possibly copy your thoughts, actions and comments.
- Learn and discuss with your children the dangers of trying to alter one's body shape through dieting, and excessive exercising. Instead focus on the value of moderate exercise for health, and the importance of eating a variety of foods in well-balanced meals consumed at least three times a day. Teach about moderation and not denying a craving. For example, if your child wants something sweet, don't deny them the treat but instead talk about how they can indulge with moderation.
- Make a commitment to exercise for the joy of feeling your body move and grow stronger, not to purge fat from your body or to compensate for calories eaten.
- Help children appreciate and resist the ways in which television, magazines, and other media distort the true diversity of human body types, and explain that bodies come in different shapes and sizes. When you start to notice your child focusing on the media's view, take them somewhere public and show them the different body types and how beauty and confidence comes in different shapes and sizes.
- Do whatever you can to promote the self-esteem and self-respect of all of your children in intellectual, athletic, and social endeavors. Give boys and girls the same opportunities and encouragement. A well-rounded sense of self and solid self-esteem is perhaps the best antidotes to dieting and disordered eating.
- Monitor changes in diet and their attempts to control body during puberty and do not try to reinforce your concern about normal variations in weight. Remember your child's body is different than your body and what works for you might not work for them.

What should I say if I think my child or teen has an eating disorder?

- **Set a time to talk.** Set aside a time for a private, respectful meeting with your child to discuss your concerns openly and honestly in a caring, supportive way. Make sure you will be some place away from other distractions.
- **Communicate your concerns.** Share specific times when you felt concerned about your child's eating or exercise behaviors (i.e., going to the bathroom right after eating, always saying they are not hungry, exercising on a daily basis for extended periods of time) . Explain how you are concerned about the specific behaviors.
- **Ask your child to explore these concerns** with a counselor, doctor, nutritionist, or other health professional who is knowledgeable about eating issues. If you feel comfortable doing so, offer to help your child make an appointment or accompany them on their first visit.
- **Avoid conflicts or a battle of the wills** with your child. If your child refuses to acknowledge that there is a problem or any reason for you to be concerned, restate your feelings and the reasons for them and leave yourself open and available as a supportive listener. Try not to get into fights for control over what you think your child should eat or how they should look.
- **Avoid placing shame, blame, or guilt** on your child regarding their actions or attitudes. Do not use accusatory "you" statements like, "You just need to eat" or, "You are acting irresponsibly." Instead use "I" statements. For example, "I'm concerned about you because you refuse to eat breakfast or lunch" or, "It makes me afraid to hear you vomiting."
- **Avoid giving simple solutions.** For example, "If you'd just stop, then everything would be fine!"
- **Express your continued support.** Remind your child that you care and you want them to be healthy and happy.
- **Explore concerns about body changes during puberty and what that means to the adolescent.**

After speaking with your child if you still have concerns, consult with a physician or contact the ValueOptions Clinical Referral Line at (877) 7-NYSHIP, Option 3, for any questions you may have as to what the next step should be.

(site: NIMH www.nih.gov; NEDA www.nationaleatingdisorders.org)

Resources for Parents & Families:

Eating Disorders Coalition
720 7th Street NW
Suite 300
Washington, DC 20001
(202) 543-9570
www.eatingdisorderscoalition.org

The Eating Disorders Coalition is the go-to organization for eating disorders and federal advocacy. If you are impacted by eating disorders, be it as a sufferer, family member, friend, treatment provider, or in other ways, we invite you to become part of the solution to the problem by joining forces with the EDC.

National Eating Disorder Association (NEDA)
165 West 46th Street
New York, NY 10036
(212) 575-6200 OR Toll Free information & Referral Helpline: (800) 931-2237
www.nationaleatingdisorders.org

NEDA mission: NEDA supports individuals and families affected by eating disorders, and serves as a catalyst for prevention, cures and access to quality care.

National Institute of Mental Health (NIMH)
Science Writing, Press, and Dissemination Branch
6001 Executive Boulevard
Rockville, MD 20852
(866) 615-6464
www.nimh.nih.gov

NIMH mission: The mission of NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery and cure.

Tip 3: Eating Disorder Treatment & Support

Program Types:

The first step to addressing and/or treating an eating disorder is to schedule an appointment with a primary care physician who will assess any medical concerns. You will also want to identify an individual counselor to assess any mental/emotional needs. A release of information should be signed so that the primary care physician and counselor can have open communication in order to determine the best possible care. The counselor and physician will assess and discuss the treatment options that will best fit your needs.

**Unless there is a medical urgency or life threatening situation, most treatment programs begin with an outpatient clinic in order to complete an initial assessment. It is during this initial assessment that the provider will assess if a different level of care is needed depending on the severity of the symptoms.*

There are four different levels of care:

Outpatient: (weekly or bi-weekly):

- Individual counseling
- Family counseling
- Group counseling
- Structured outpatient program (this can occur during the day, after school or during the evening)

**Outpatient is considered the lowest level of care. Meaning the client does not need any medical treatment outside of the routine checkups established by the physician nor do they have any active suicidal/homicidal ideation. The client is able to maintain their safety at home.*

Partial Hospitalization Program: provides a full range of specialized treatments in both a group setting and private sessions. This type of program usually operates Monday through Friday about 7 hours a day. Most participants live at home while attending treatment sessions. However, some programs may offer a live in component where participants reside at the facility.

Residential: provides a more intense level of treatment intervention. Residential facilities are intended to offer individuals a highly structured and supervised 24 hour a day environment where intensive support is provided to promote recovery from an eating disorder.

Inpatient: treatment is used when an individual requires medical intervention resulting in a hospital stay. The need for this level of treatment is determined by one's physician.

Inpatient treatment is considered the highest level of care. An individual will be referred for inpatient only if they need 24 hour monitoring for medical or psychiatric reasons that cannot be safely monitored at home, in a residential program or in a day program. Inpatient treatment is* ***NOT* *long term and its only purpose is to medically stabilize the patient and ensure they are safe enough to transition to a lower level of care (i.e., residential treatment, partial hospitalization OR outpatient).*

During the treatment process it is important to maintain regularly scheduled appointments with both the physician and the counselor. The physician will monitor you and/or your child's health including heart, weight, blood pressure, and other important areas of physical wellbeing that can be affected by an eating disorder. While the counselor will help you and/or your child understand the thought process about food, weight and body image. Together both providers will assist you and/or your child in changing eating behaviors, thoughts about food, body image and self-esteem. Proper coordination will ensure that you and/or your child receive the ***right care at the right time.***

Please note: Contact the ValueOptions Clinical Referral Line at (877) 7-NYSHIP, Option 3, prior to initiating treatment to help identify providers that are in network and covered by your insurance plan.

For additional information on providers in your area:

1. Western New York State:
    a. Website: www.nyeatingdisorders.org
    b. Phone: (800) 700-4573
2. Northeastern New York State:
    a. Website: www.amc.edu/Patient/services/NECCCED/index.html
    b. Phone: (888) 747-4727
3. Metropolitan New York
    a. Website: www.eatingdisordercenterofexcellence.org
    b. Phone: (877) 669-2332

What's Your Attitude about Eating?

Are you at risk for an eating disorder? Answer the following questions truthfully then consult the score at the bottom of the page to learn how to interpret your score.

1. I am obsessed or preoccupied with what I am eating and with dieting	True	False
2. I use laxatives or diuretics as a means of weight control	True	False
3. If I don't get to exercise every day I get upset	True	False
4. I think I'm fat in spite of what family/friends tell me	True	False
5. I think my body is ugly	True	False
6. I am afraid of losing control in my life	True	False
7. I have urges to eat large amounts of food in a short time	True	False
8. I make myself vomit to get rid of food after eating	True	False
9. I constantly compare my appearance and weight to others thinking they are better looking or thinner than I am	True	False
10. I avoid eating in public or around others.	True	False
11. I have an overwhelming fear of gaining weight	True	False
12. No matter what I do, it's never good enough	True	False

Scoring:

0-4 True responses:	Low Risk
5-8 True responses:	Moderate Risk
9-12 True responses:	High Risk

**If you answer True to either the use of laxatives/diuretics or vomiting question – please seek help by either contacting your primary care physician or the ValueOptions Clinical Referral Line at (877) 7-NYSHIP, Option 3.

If you score at moderate or higher risk, you should seek help to avoid serious health problems.

Please Note: if your answers fall within the Low Risk range and you feel as if you are having continued thoughts of food and/or weight concerns PLEASE always consult your primary care physician. Your medical provider can answer any questions you might have. You can also call the ValueOptions Clinical Referral Line to obtain names of counselors in your area that can address any concerns you might have.

This survey is not meant to be used as a substitute for medical or psychological evaluation or treatment. We strongly encourage discussing the results of this survey with your physician or mental health provider.

Signs of an Eating Disorder

Anorexia and Bulimia -

- Restricting food intake or eating excessive amounts of food followed by purging
- Obsession with calories, fat grams and food
- Use of any medicines and/or exercise to keep from gaining weight
- Distorted body image - thinking you are fat even when at a normal or below normal weight
- A feeling that you can't stop eating or control how much you eat

Binge Eating Disorder

- Eating excessive amounts of food in a short amount of time
- No purging, excessive exercise or fasting

VALUEOPTIONS®

Innovative Solutions. Better Health.

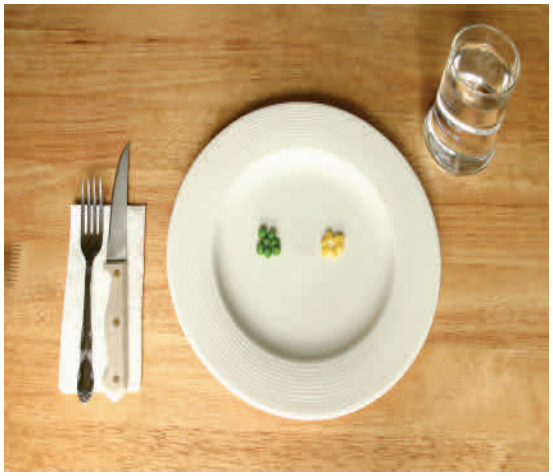
If you suspect you or your child may have an eating disorder, discuss your symptoms with your physician and contact ValueOptions

You can learn more about the ValueOptions Eating Disorder Program on-line at **www.achievesolutions.net/empireplan**

or by calling toll free at
(877) 7-NYSHIP
[(877) 769-7447], Option 3

ValueOptions®
P.O. Box 547
Latham, NY 12110

VALUEOPTIONS®



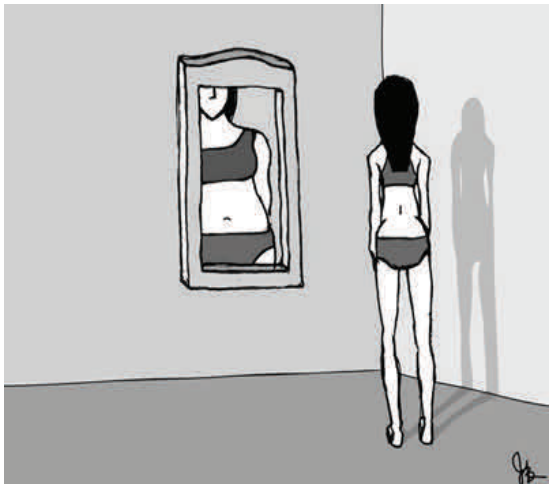
Why suffer with an Eating Disorder? We can help.

THE EMPIRE PLAN

Eating Disorders Management Program

Eating Disorders

- Are a complex and serious medical condition.
- Have the highest premature mortality rate of any psychiatric disorder.
- Can impact your health, family, friends, and job.
- Are treatable.



ValueOptions®, the administrator of the mental health and substance abuse program for the Empire Plan, offers a program that can help you.

The Program includes:

- Free healthy eating quiz that you can take on-line or by mail.
- Information about eating disorder symptoms and treatment.
- Assistance in assessing your treatment options and in coordinating care among treatment providers.
- An Intensive Care Management component. ValueOptions will invite those members with more severe symptoms to participate.

When you sign up you'll receive:

- Tip sheets on eating disorders
- An Eating Behavior Quiz
- Educational Information
- Tip sheet for parents of children and teens with an eating disorder
- Treatment options and support
- Information on coordination of care to ensure the right care at the right time

Participation is:

Confidential - We do not share information without your permission.

Voluntary - Participation is strictly voluntary.

Free - ValueOptions offers this program as part of your behavioral health benefit.

Easy - Just call or log-on to join.

P604802802A

ValueOptions, Inc.
P O Box 1800
Latham, NY 12110
1-877-7-NYSHIP

Forwarding Service Requested

WHITE STOCK
201405013339
TEST

THE EMPIRE PLAN

1 OF 4

ENV 1

SINGLE PIECE

1 0.8502 SP 0.480

ANDRES TANZMAN
3422 FENIMORE AVENUE
MOHEGAN LAKE, NY 10547-1309

1

Enrollee Name: MAURA GREGORY
Patient ID: 890785740
Patient Name: ANDRES TANZMAN
Provider Name: SILVIU BURCESCU
Parent Code: NYS
Group Number: NYS015
Claim #: 010128140983700001
Check Date: 03/03/14
Check #: 0000008385

Explanation of Benefits -- This is NOT a Bill

Date of Service	Proc Code	Procedure Description	No. of Service	Charged Amount	Allowed Amount	Co-Pay Amount	Co-Ins Amount	Deduct. Amount	Other Ins. Amount	Paid Amount	Remark Code
0123-012314	99214	OFFICE/OUTPATIENT VISIT, EST	1	232.50	0.00	0.00	0.00	0.00	0.00	0.00	1,2
0123-012314	90836	45 MINUTE PSYCHOTHERAPY ADD ON CODE	1	262.50	0.00	0.00	0.00	0.00	0.00	0.00	
Claim Totals				495.00	0.00	0.00	0.00	0.00	0.00	0.00	

Code **Message Description**

PROV ADDR:7 CROTON AVE CORTLANDT MANOR NY 10567-5203 US

1 Provider notice: the member's coordination of benefits information needs to be updated. Important member information about this denial. Please complete and return the coordination of benefits questionnaire sent to you so that we can update your file.

2 PLEASE RETURN COMPLETED COB QUESTIONNAIRE.

*** You, or your authorized representative, have the right to appeal if you disagree with any portion of the claim decision indicated in the Explanation of Benefits. Along with the claim determination, the Explanation of Benefits also lists the address, telephone number and fax number for contacting us. You may send your written appeal to the address shown on this notice. By calling the Customer Service number listed on the Explanation of Benefits, you can also: (1) Request additional information that supports our decision on this claim. If you feel a coding error may have caused this claim to be denied, you have the right to have the billing and diagnosis codes sent to you as well. (2) Find out more about the appeal rights for your benefit plan. If you request an appeal, you or your representative may submit any additional information you would like ValueOptions to consider in our decision. ValueOptions will notify you, or your representative, of the information we need to decide the appeal. Please note that a request for appeal is not considered complete until all necessary information has been received, at a minimum, the name of the patient for whom a denial is being appealed or a valid member number for the patient, and the dates for which a denial is being appealed. ValueOptions must receive your appeal request within 180 days from the date of this Explanation of Benefits notice, unless your benefit plan or State regulation allows a longer period to file an appeal. Appeal decisions are made within thirty (30) calendar days.

If you appeal, we will review our decision and provide you with a written determination. If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician; you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal and, if applicable, simultaneous external review. If you believe your situation is urgent, please fax your claim to (855) 378-8309 and request an expedited appeal.

VOID

If your claim is denied, in whole or in part, on internal review and you disagree with that decision, or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Contact us at (877) 7-NYSHIP (877-769-7447), Option 3, with any questions on your internal and external appeal rights.

P604802802A

20140501333 9

ValueOptions, Inc.
P O Box 1800
Latham, NY 12110
1-877-7-NYSHIP

WHITE STOCK

TEST

[redacted]

2 OF 4

ENV 1

Enrollee Name: MAURA GREGORY
Patient ID: 890785740
Patient Name: ANDRES TANZMAN
Provider Name: SILVIU BURCESCU
Parent Code: NYS
Group Number: NYS015
Claim #: 010128140983700001
Check Date: 03/03/14
Check #: 0000008385

Explanation of Benefits -- This is NOT a Bill

*** You can find a copy of ValueOptions Privacy Rules on our website at www.achievesolutions.net/empireplan

VOID

P6048028062

20140501333 9

WHITE STOCK

VALUEOPTIONS

TEST

3 OF 4

ENV 1

03/03/14

ANDRES TANZMAN
3422 FENIMORE AVENUE
MOHEGAN LAKE, NY 10547

Dear Enrollee:

ValueOptions is the Mental Health and Substance Abuse Program administrator for the Empire Plan. Our goal is to ensure quality services for our membership.

Your contract for behavioral health care coverage through *ValueOptions* contains a Coordination of Benefits (COB) provision that requires *ValueOptions* to investigate any duplicate coverage or benefits to which you may be entitled. Please complete the questionnaire and return to *ValueOptions*, Attn COB Department. If you have any questions pertaining to this questionnaire please contact Customer Service at 1-877-7-NYSHIP, option 3.

If you are unsatisfied with our decision to request completion of the questionnaire to process your claim(s) you have the right to request a grievance. A grievance must be requested within 90 calendar days of your receipt of this notice. Please identify the issue and provide any comments or supporting documentation that you wish to be considered in the resolution of your grievance. To contact *ValueOptions* to file a grievance, call the Customer Service line 8am to 8pm Monday through Friday at 1-877-7-NYSHIP (1-877-769-7447) Option 3 or mail to:

ValueOptions, Inc
Attn Complaints and Grievance Coordinator
PO Box 370
Latham NY 12110

Thank you for providing the requested information so that we may continue to process your claim(s) properly.

Sincerely,

ValueOptions
COB Processing Unit
PO Box 1800
Latham, NY 12110

VOID

P6048028063

20140501339

ValueOptions, Inc. COB Questionnaire

Enrollee Number: 5740 **Parent Code: NYS** **Claim #: 010128140983700001**

SUBSCRIBER INFORMATION (Please Print Clearly or Type)

Subscriber Name: _____ Subscriber ID#: _____

Employment Information (Please check the appropriate boxes)

Actively at Work: ☐ Yes ☐ No

Retired: ☐ Yes ☐ No Date of Retirement: _____/_____/_____

Spouse's Name: _____ Spouse's Date of Birth: _____/_____/_____

COVERAGE INFORMATION

- Please Note: If you, your spouse or dependent(s) have other mental health/substance abuse coverage currently or within the last 24 months, please complete the appropriate section(s) below. **If this does not apply, please sign and date the form below and return to ValueOptions.**

PART A

1. Current other mental health/substance abuse coverage
   Carrier Name: _____
   Subscriber's Name: _____ Subscriber's ID#: _____
   Policy Effective Dates: Start _____/_____/_____ End _____/_____/_____
   Covered Dependents: _____

PART B: Complete if divorced, legally separated, or a single parent and you have dependent children covered under this plan.

1. Does the other biological parent of your dependent child(ren) provide mental health/substance abuse coverage? ☐ Yes ☐ No

   If yes, please provide the following information:

   Name of other mental health/substance abuse plan:_____
   Subscriber's ID#: _____

2. Are you divorced or legally separated? ☐ Yes ☐ No
   Date of divorce/separation: _____/_____/_____
   Are you a single parent? ☐ Yes ☐ No
   Please provide a copy of the section of the court decree pertaining to health coverage.

PART C: Complete this section if you, your spouse and/or your dependents are eligible for Medicare.

Please enclose a copy of the Medicare ID card for each member of your family.

1. Name of Member eligible for Medicare: _____
   Effective Dates of Medicare: Part A: _____/_____/_____ Part B:_____/_____/_____
2. Reason for Medicare coverage, please check one:
   ☐ Age 65 or older ☐ Retirement ☐ Disability
   ☐ End Stage Renal Disease (ESRD) Date Dialysis Treatment Began:_____/_____/_____

Signature:_____ Daytime Telephone #:_____ Date:____/____/____

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

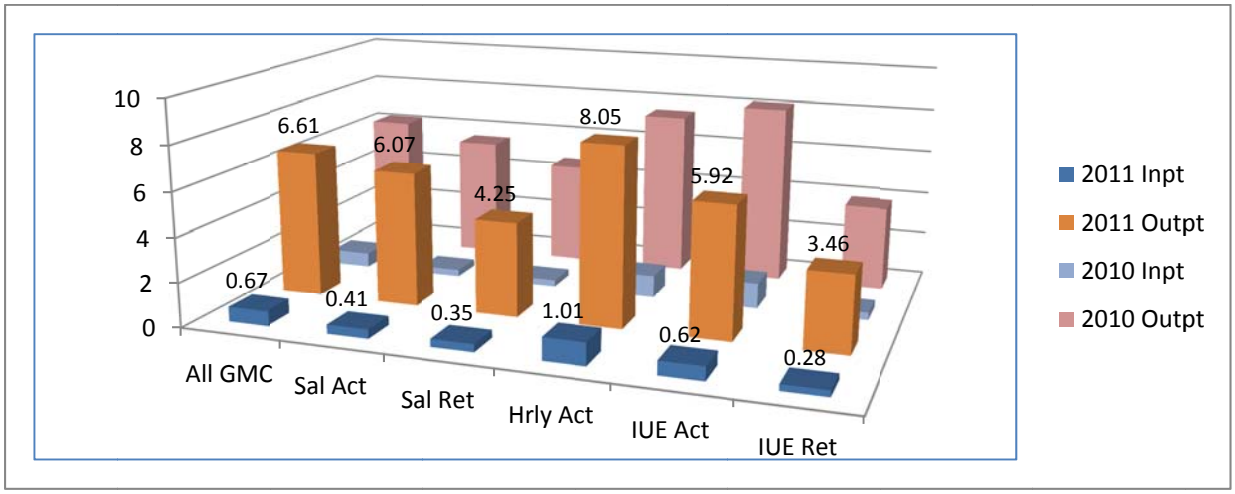
Client XXX Executive Summary

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.

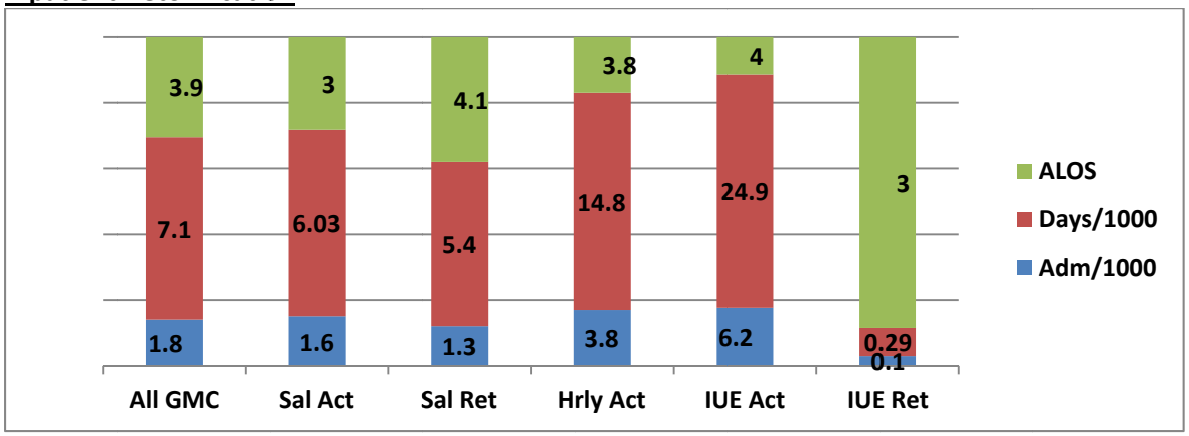


Client XXX overall penetration rate for 2011 was 7.28 percent representing 13,992 unique members seeking professional care. This is an increase from 6.34 (11,645 unique members) in 2010. When compared to ValueOptions 2011 auto Book of Business, the mean rate for outpatient treatment was 3.52 percent. 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

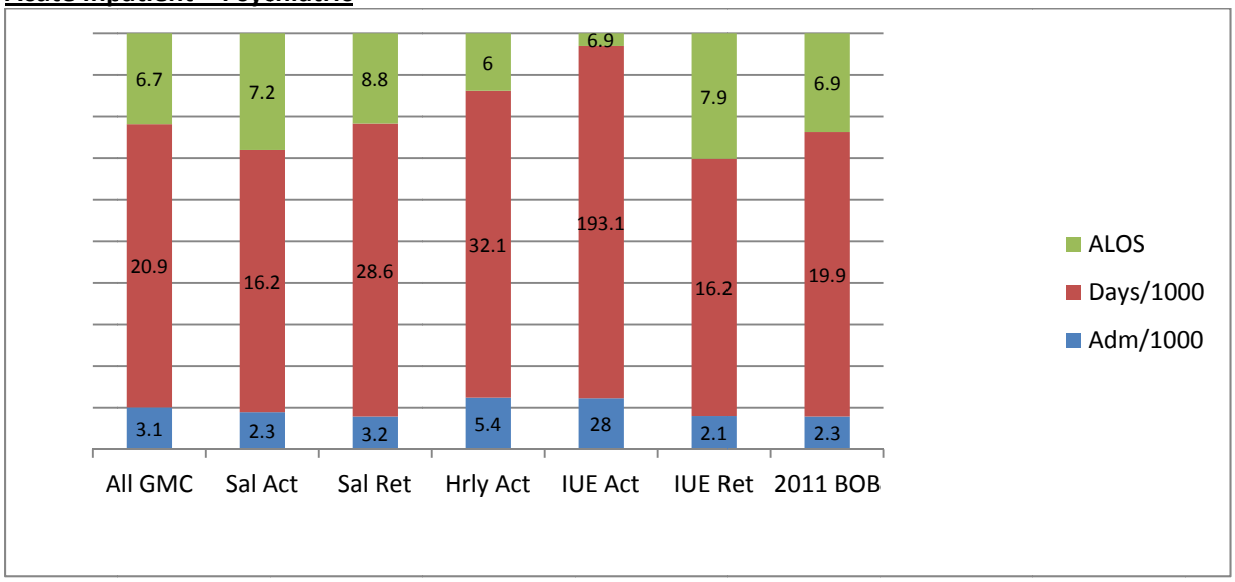
Client XXX Executive Summary

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.

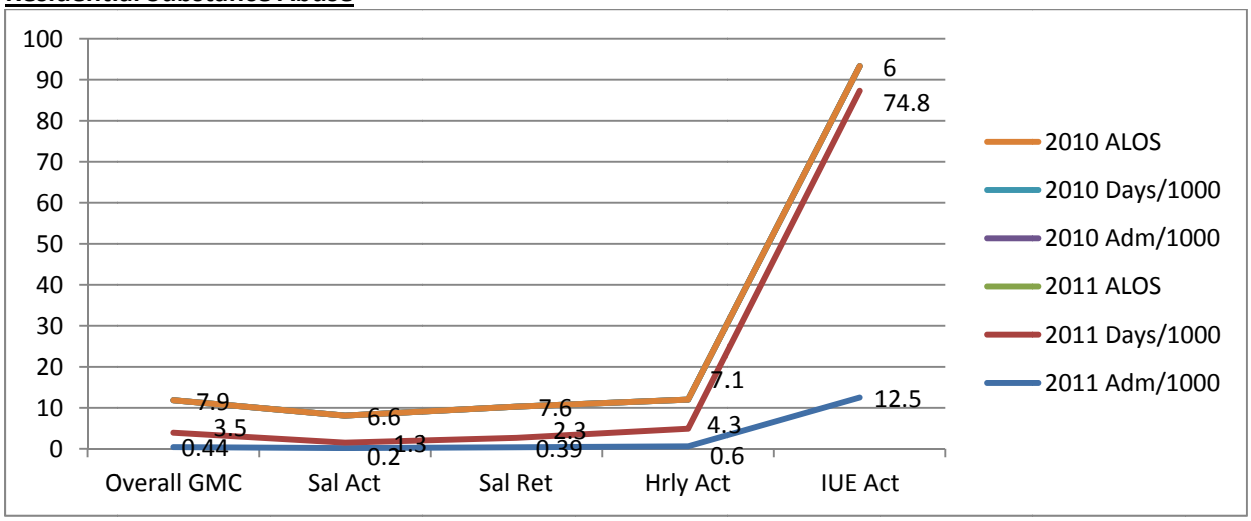
Acute Inpatient – Psychiatric



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.

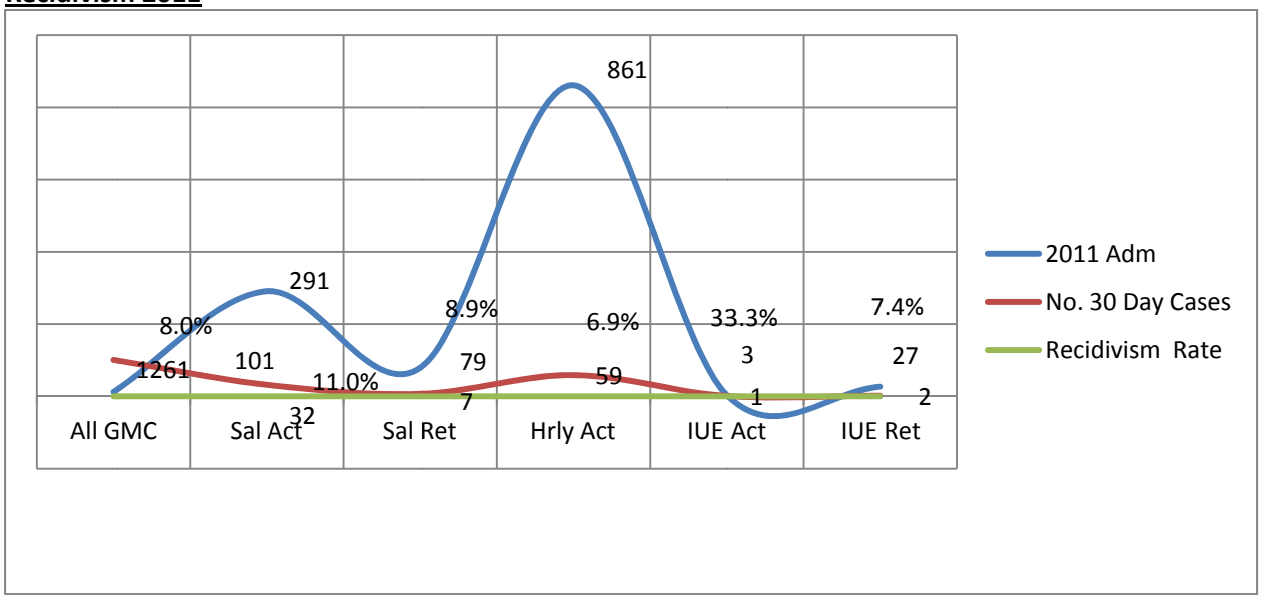
Client XXX Executive Summary

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.

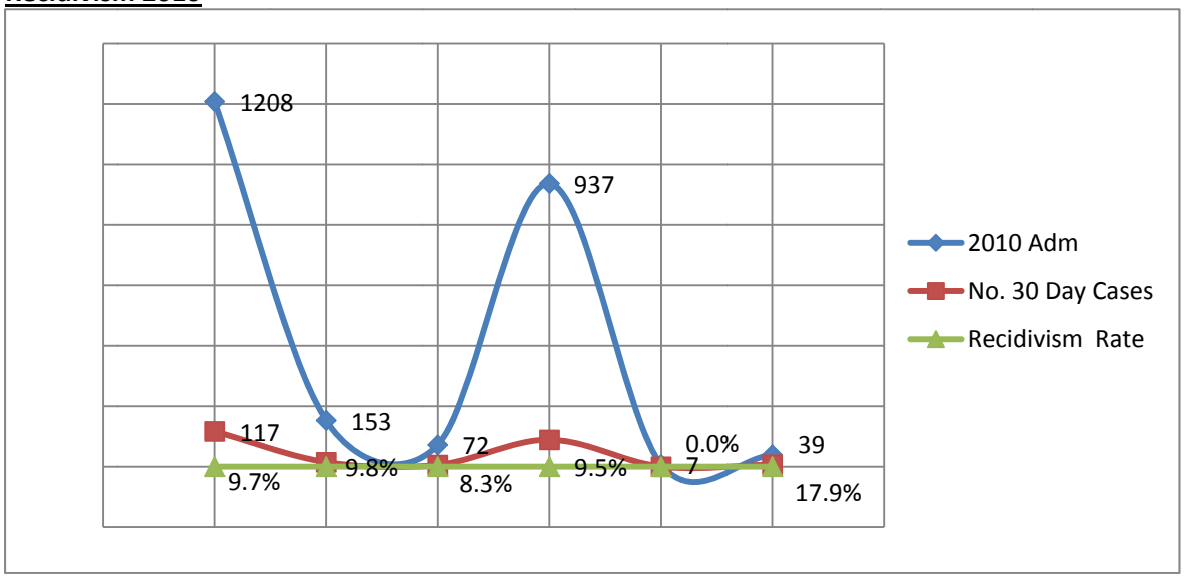
Recidivism 2011



Client XXX Executive Summary

2011

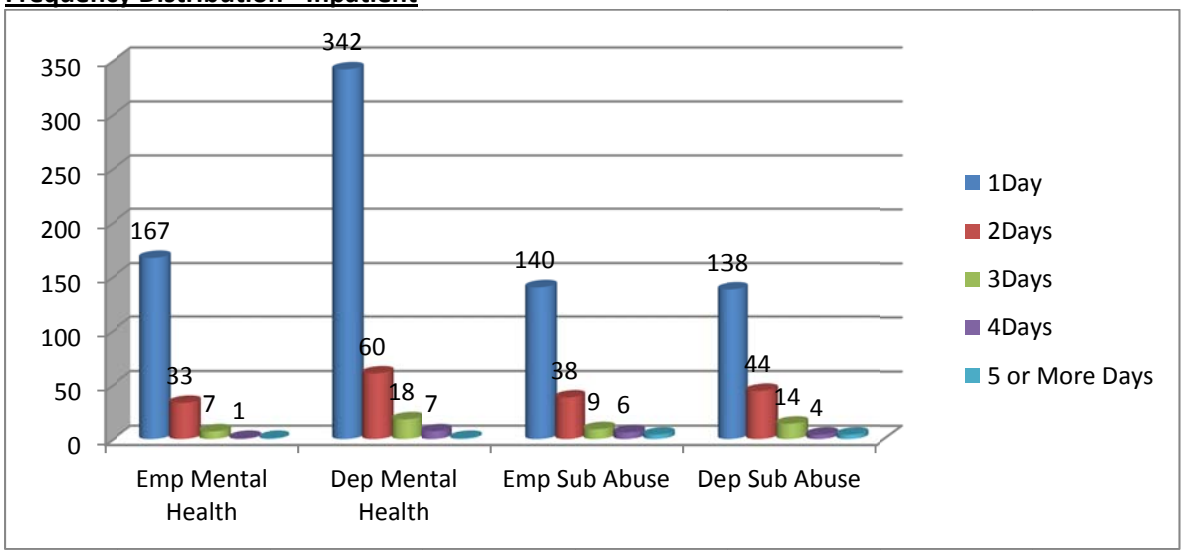
Recidivism 2010



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

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

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.

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

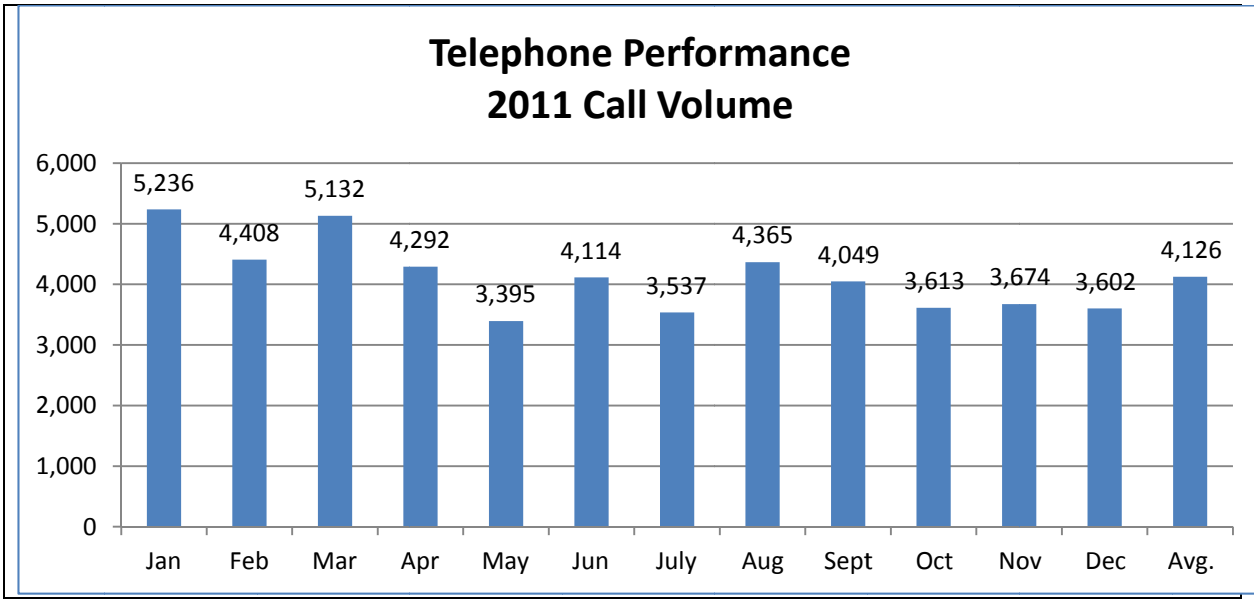
For the 2011 reporting calendar year, ValueOptions received a total of 49,507 calls regarding Client XXX contract holders and their beneficiaries.

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

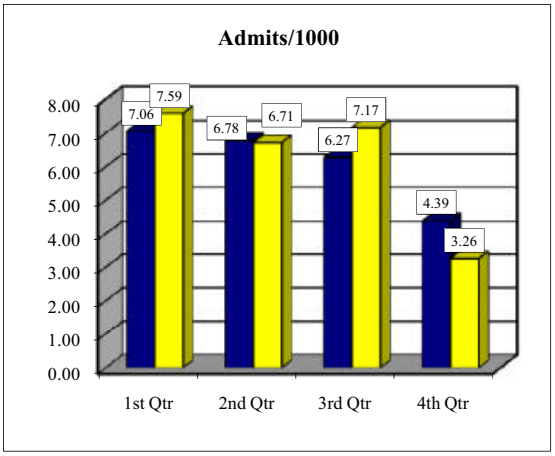
Table of Contents

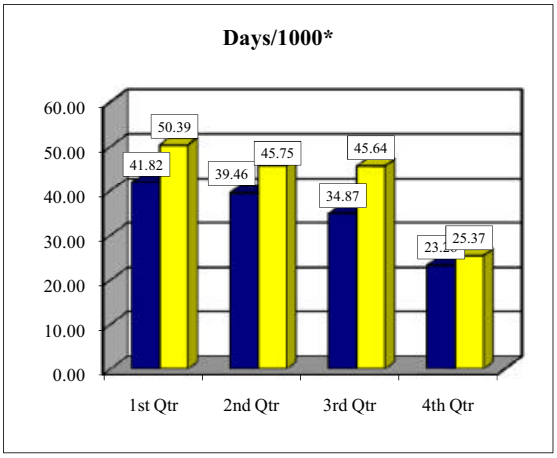
Utilization Highlights

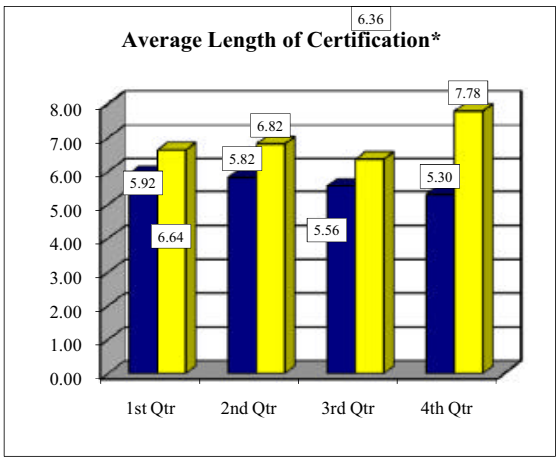
	Page
Acute Inpatient Utilization (Psychiatric vs Substance Abuse) *Includes normalized inpatient utilization*	1
Total Acute Inpatient and Alternative Levels of Care Detail *Includes all inpatient categories including acute inpatient,detox, residential treatment center, partial hospitalization, IOP, Halfway House*	2
Total Outpatient Utilization (Claims Based) *Includes outpatient utilization based on authorization data*	3
Penetration Rate by Beneficiary Type (Claims Based) *Employee, spouse, dependent penetration for inpatient and outpatient*	4
Penetration Rate by Age Category (Claims Based) *Child, adolescent, adult, and 65+ penetration for inpatient and outpatient*	5
Paid Claims Analysis - In-Network versus Out-of-network *Units and dollars paid by level of treatment and network status*	6
Total Paid Distribution by Major Diagnosis Category *Dollars and percent of total paid by major diagnostic category*	7
Paid Claim Analysis - Gender/Dependency *Dollars paid by gender/dependency*	8
Catastrophic Cases Greater than $20,000 *Cases with claims greater than $20,000*	9
Telephone Performance *Call volumes, average speed of answer and abandonment rate*	10

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

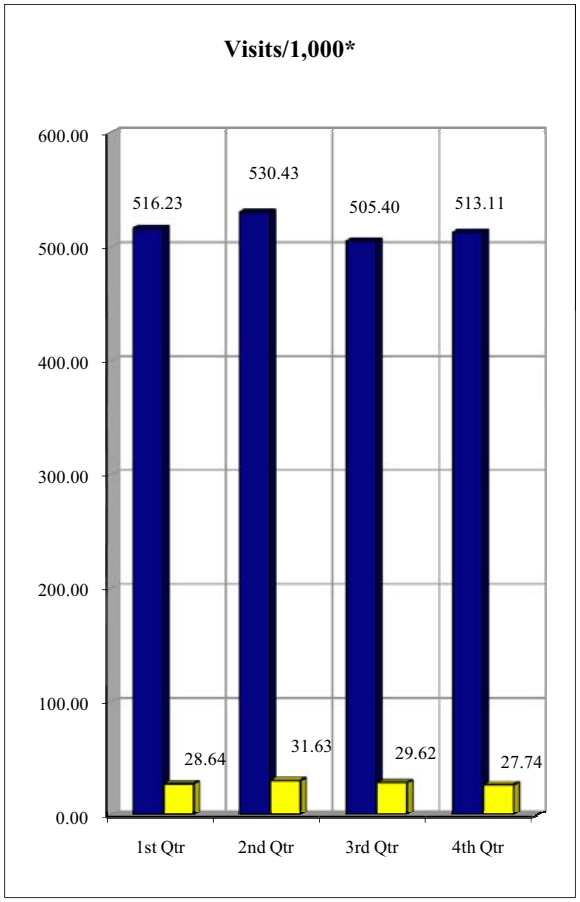
**Alternative Modality Ratios applied*

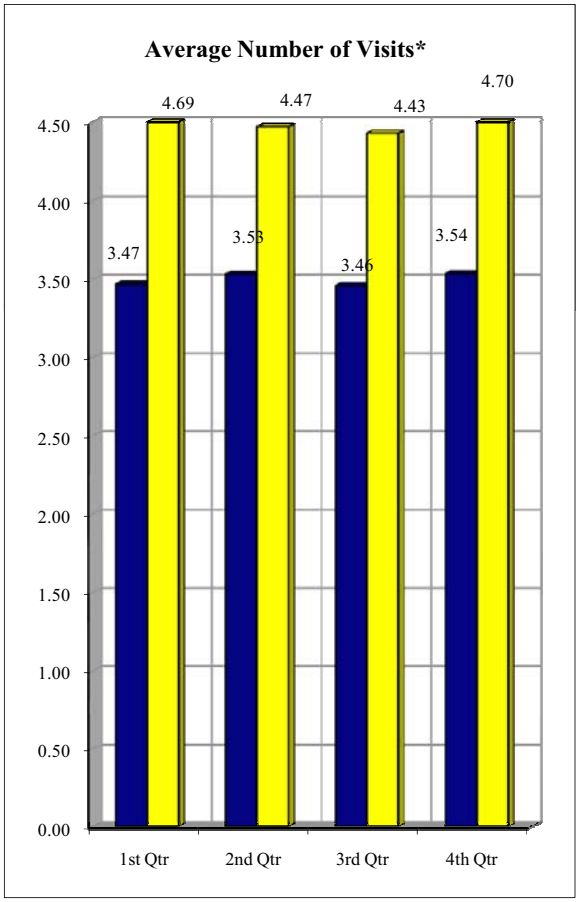
48561 Alpha Drive, Suite 150
Wixom, MI 48393

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

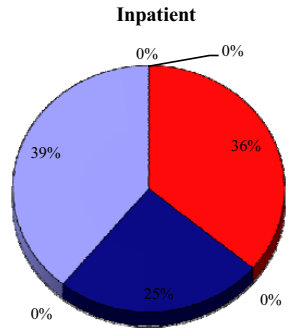
Penetration Rate by Beneficiary Type (Claims)
Inpatient vs Outpatient

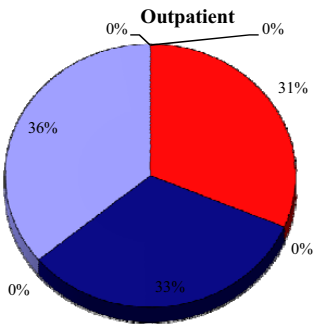
Inpatient

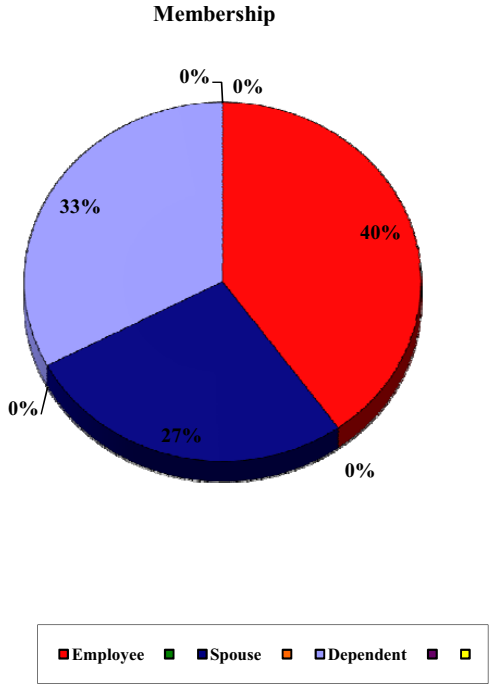
	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	548	254	484	1,286
Membership	76,910	52,035	62,761	192,152
Penetration Rate	0.71%	0.49%	0.77%	0.67%

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%







Penetration Rate by Age Category (Claims)
Inpatient vs Outpatient

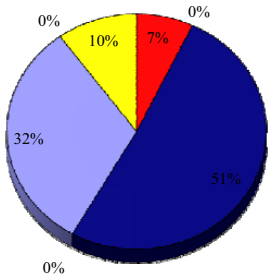
Inpatient

	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%

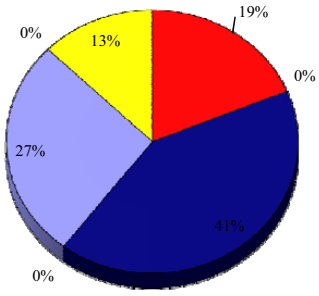
Outpatient

	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%

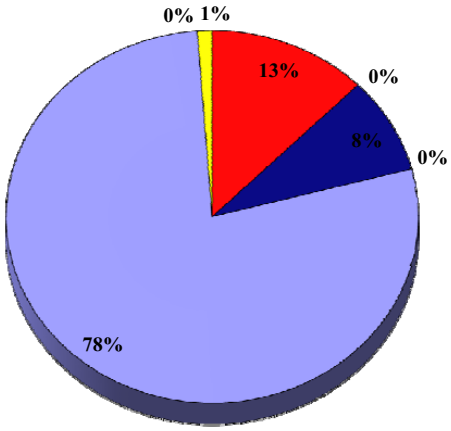
Inpatient



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

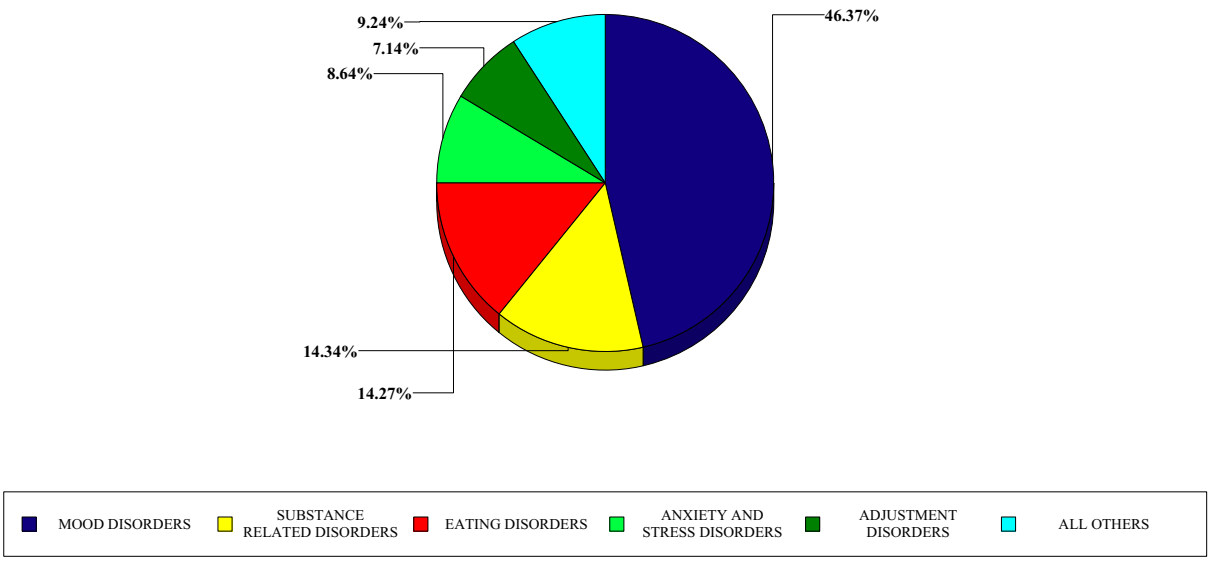
Service Dates: **January 1, 2011 - December 31, 2011**

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

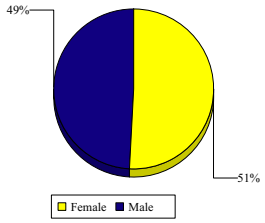
Males

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**

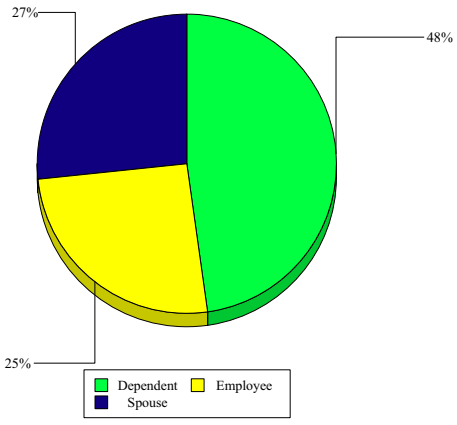
Females

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**

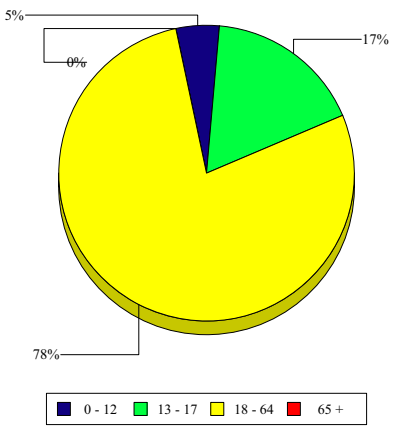
Total Paid % by Gender



Total Paid % by Dependency



Total Paid % by Age Band



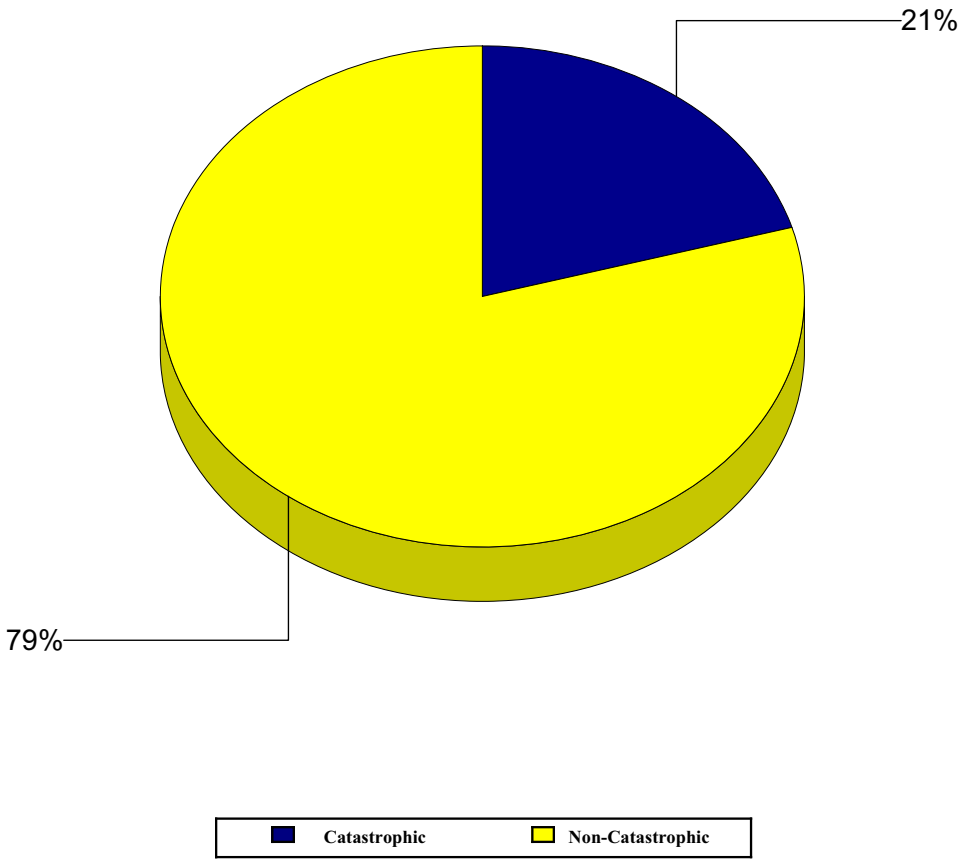
Managed Mental Health and Substance Abuse Activity Report

Service Dates: **January 1, 2011 - December 31, 2011**
Paid Through: **March 31, 2012**

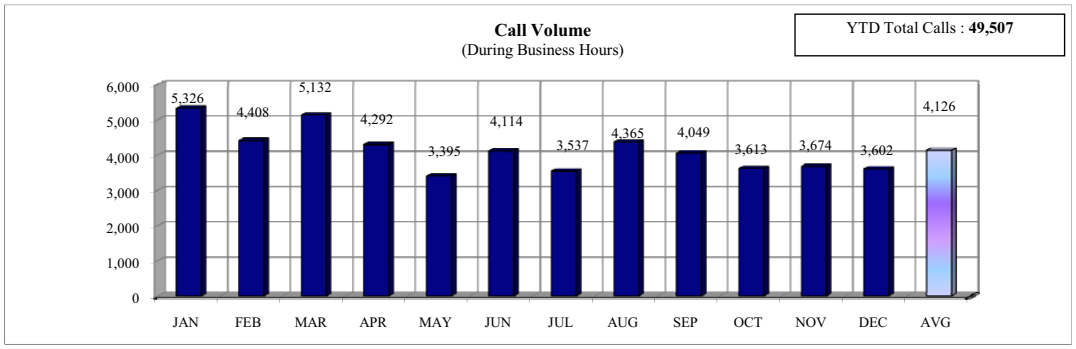
Catastrophic Cases Greater than $20,000

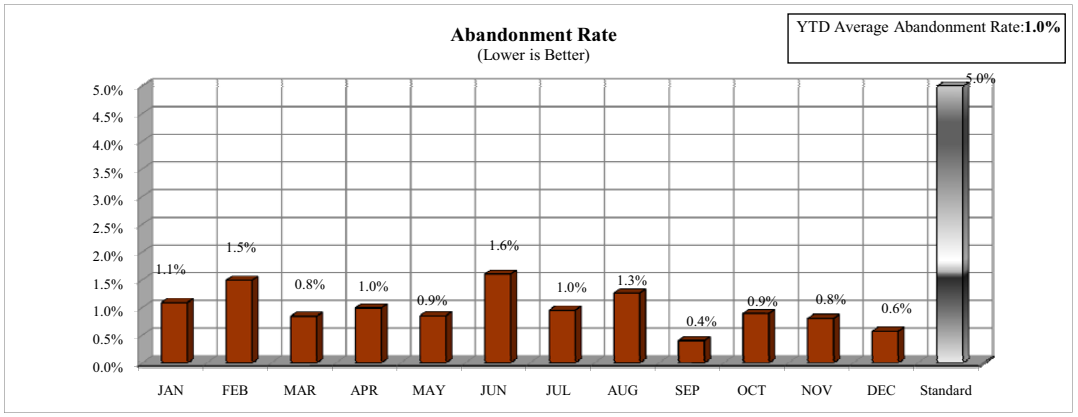
	# of Unduplicated Members	Total Claim Amount	Total Allowed Amount	Total Paid Amount	% of Total
Catastrophic Cases	86	$5,577,753	$3,284,182	$3,098,876	20.58%
Non-Catastrophic Cases	12,828	$27,215,659	$13,766,692	$11,959,554	79.42%
Total	**12,914**	**$32,793,412**	**$17,050,873**	**$15,058,431**	**100.00%**

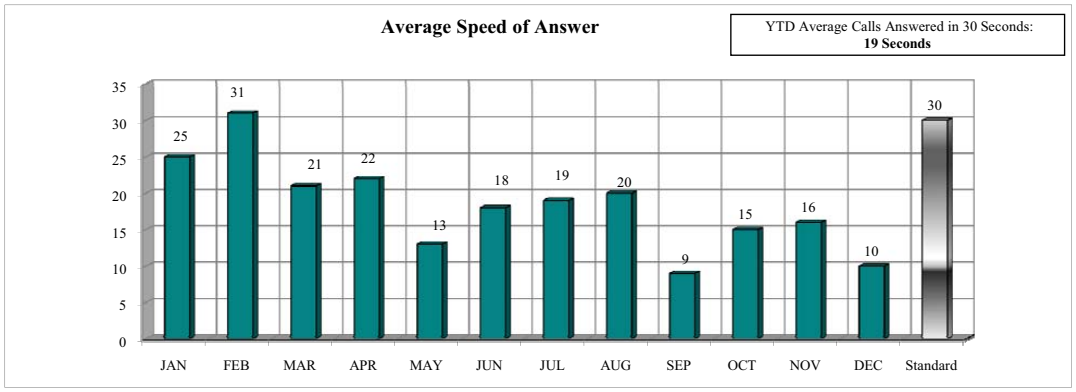
Catastrophic Cases



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.

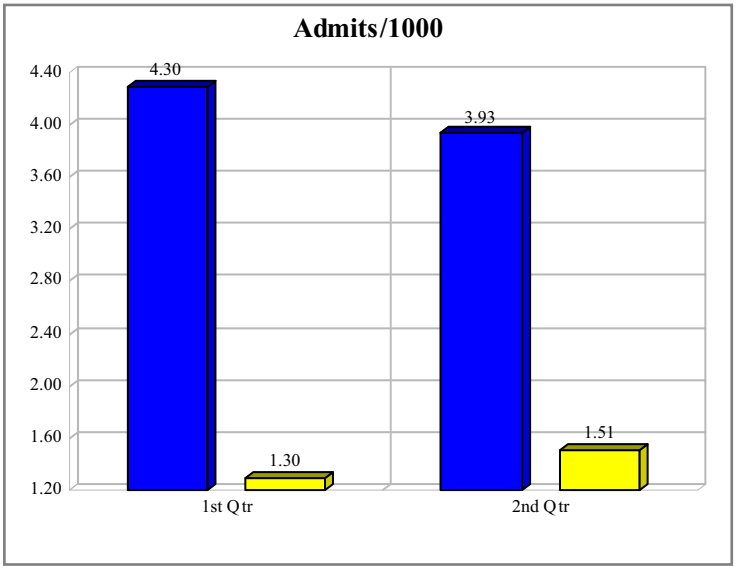
Quarterly Utilization Report

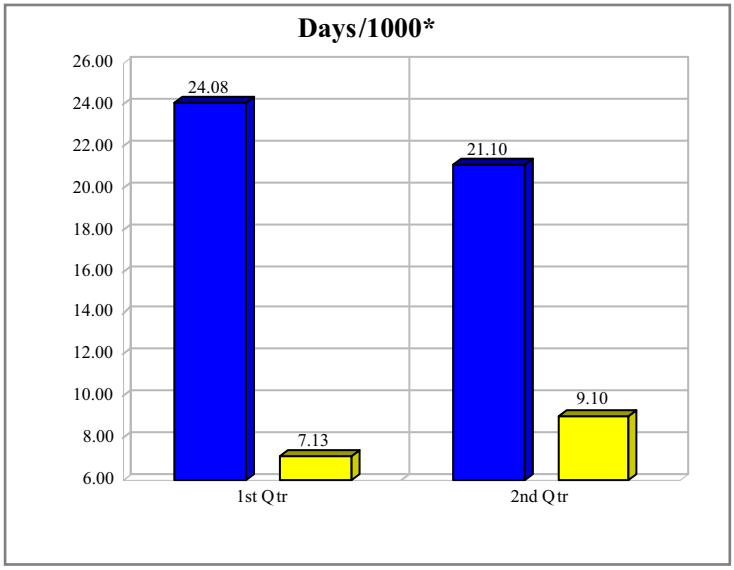
Managed Mental Health and Substance Abuse Activity Report

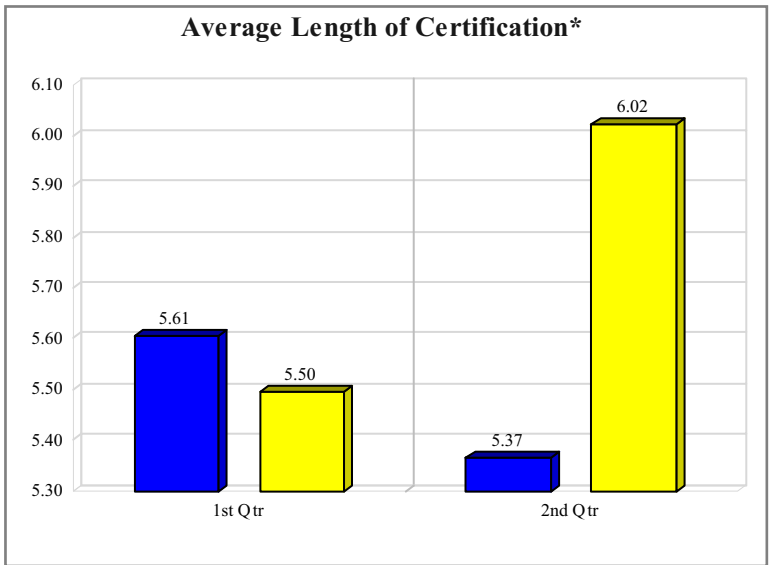
July 1, 2012 - December 31, 2012

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.

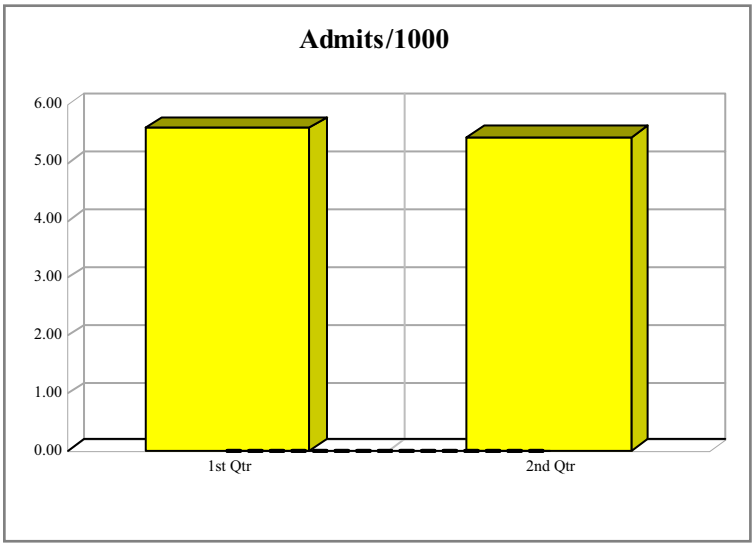
** All data has been annualized.*

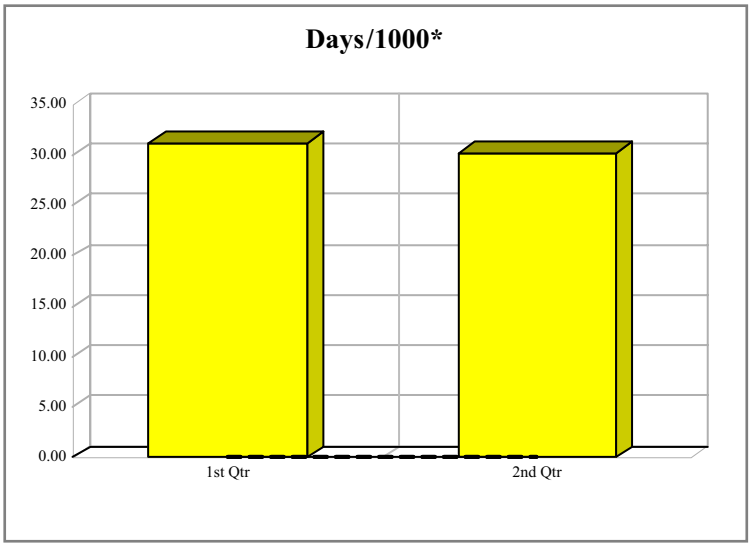
Managed Mental Health and Substance Abuse Activity Report

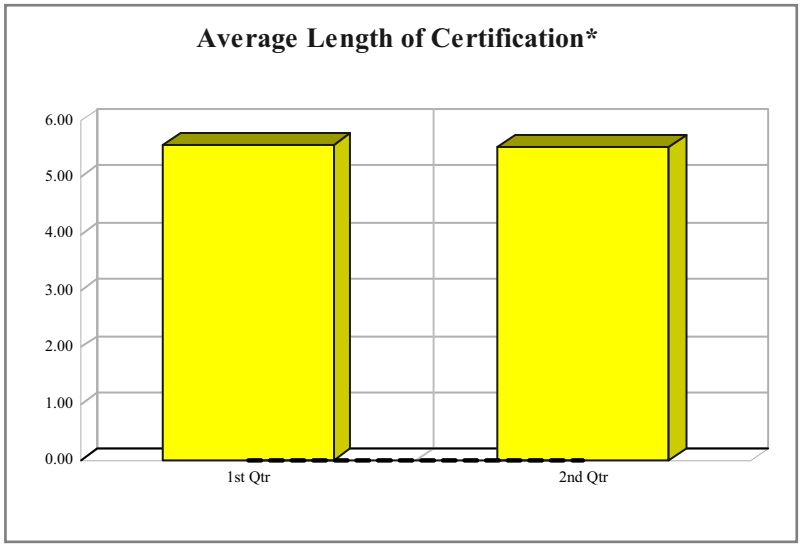
July 1, 2012 - December 31, 2012

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.*

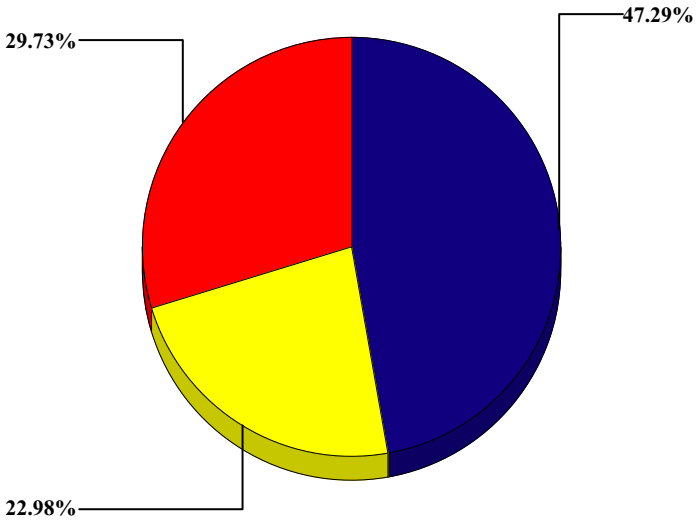
Managed Mental Health and Substance Abuse Activity Report

July 1, 2012 - December 31, 2012

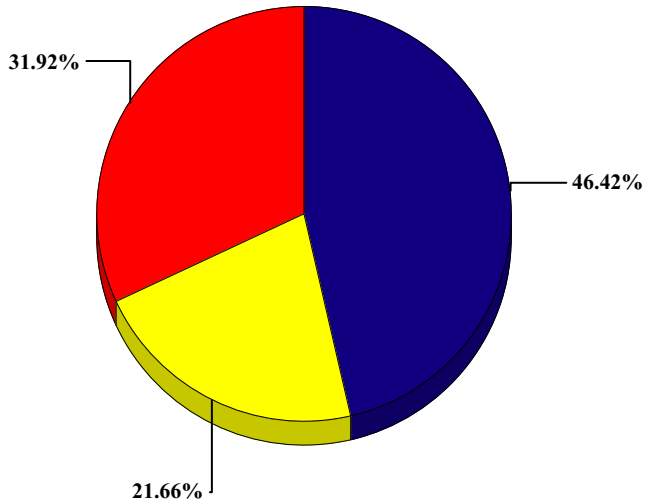
Penetration Rate by Beneficiary Type - Claims Based

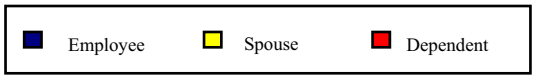
	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	4,494	2,184	2,826	9,504
Membership	83,283	38,862	57,268	179,413
Penetration Rate	5.40%	5.62%	4.93%	5.30%

Unduplicated Members Accessing Care



Membership





Penetration Rate by Beneficiary Type (Claims)

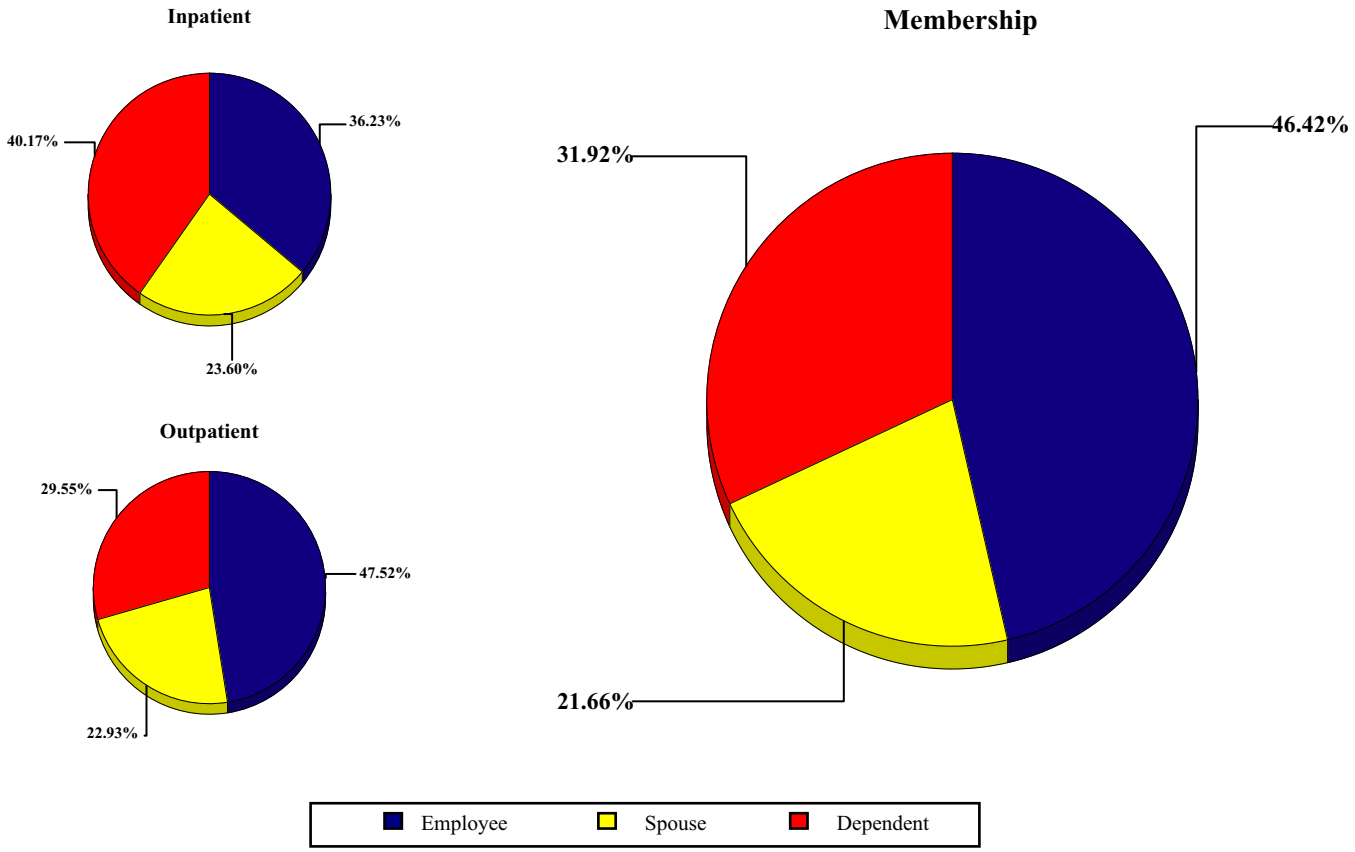
Inpatient and Higher Level of Care vs Outpatient

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

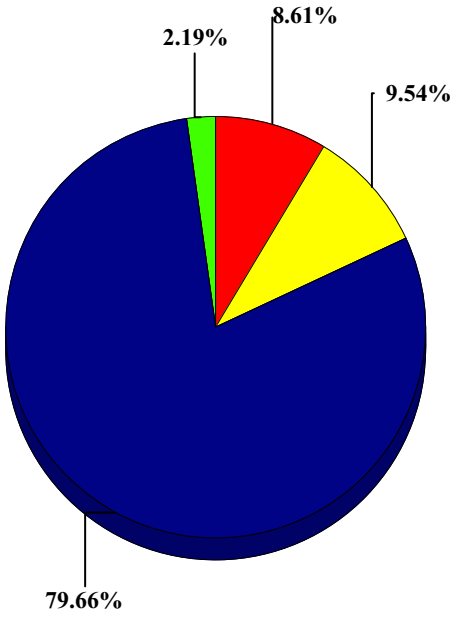
	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	4,446	2,146	2,765	9,357
Average Membership	83,283	38,862	57,268	179,413
Penetration Rate	5.34%	5.52%	4.83%	5.22%



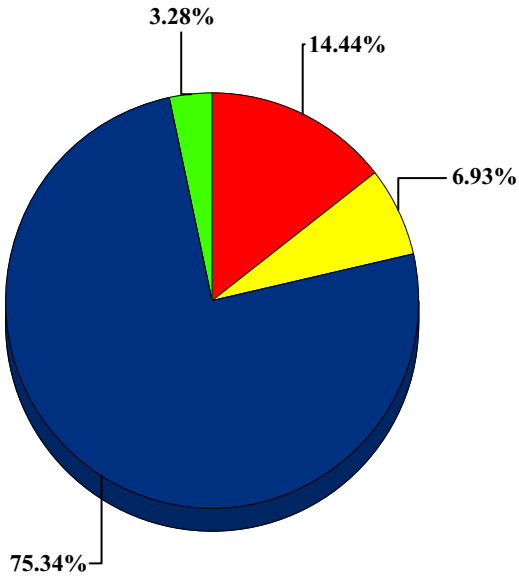
Division Penetration Rate by Age Category (Claims)

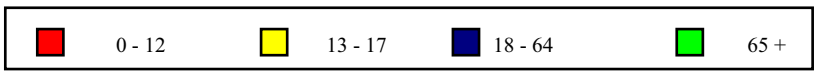
	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	827	916	7650	210	9504
Average Membership	25,911	12,434	135,174	5,894	179,413
Penetration Rate	3.19%	7.37%	5.66%	3.56%	5.30%

Unduplicated Members Accessing Care



Membership





Division Penetration Rate by Age Category (Claims)
Inpatient and Higher Level of Care vs Outpatient

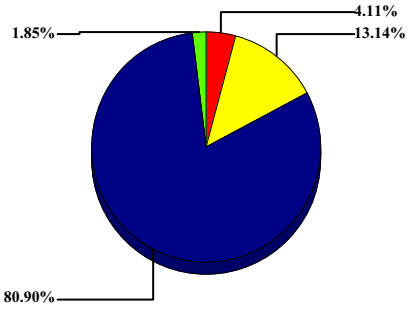
Inpatient

	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%

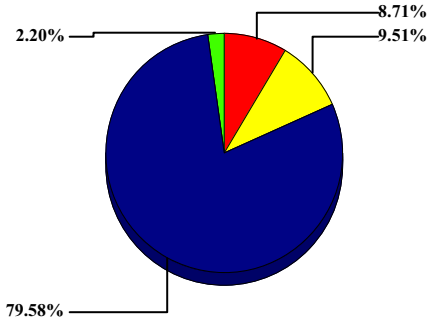
Oupatient

	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%

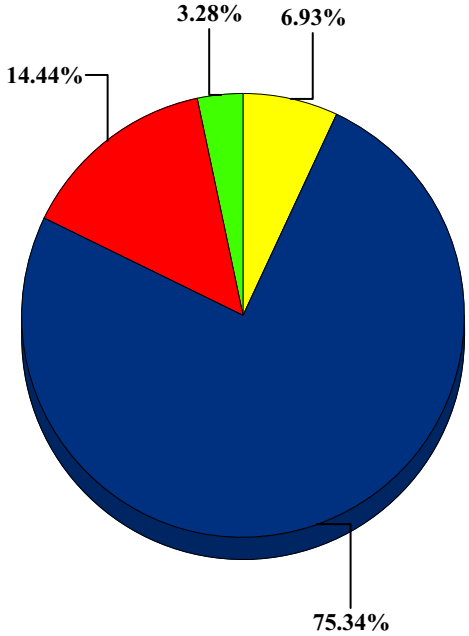
Inpatient

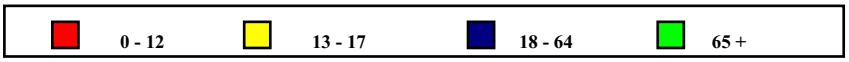


Outpatient



Membership



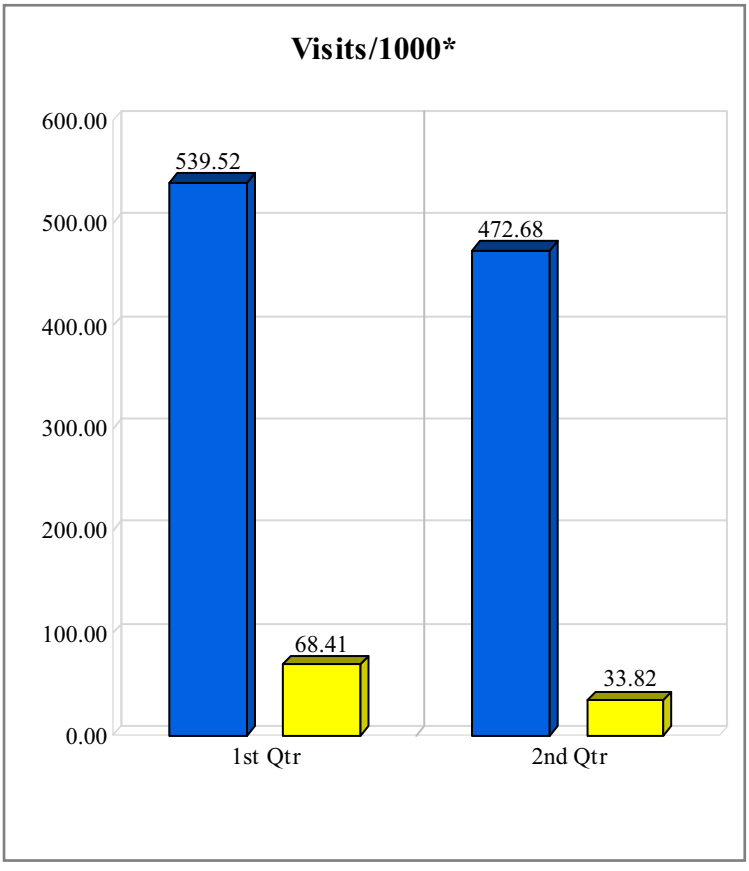


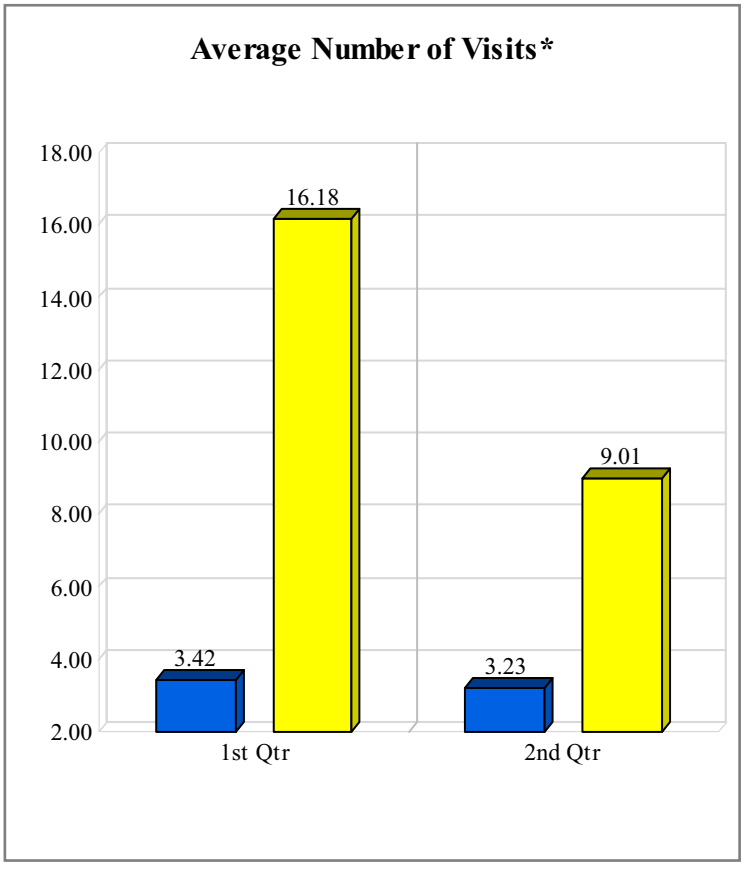
Managed Mental Health and Substance Abuse Activity Report
July 1, 2012 - December 31, 2012

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

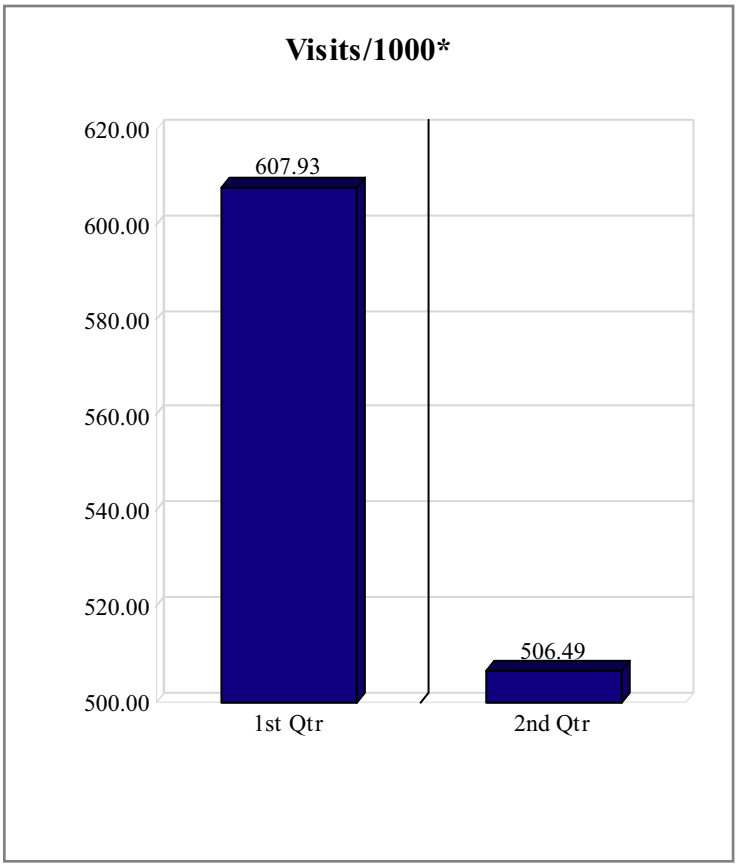
Substance Abuse

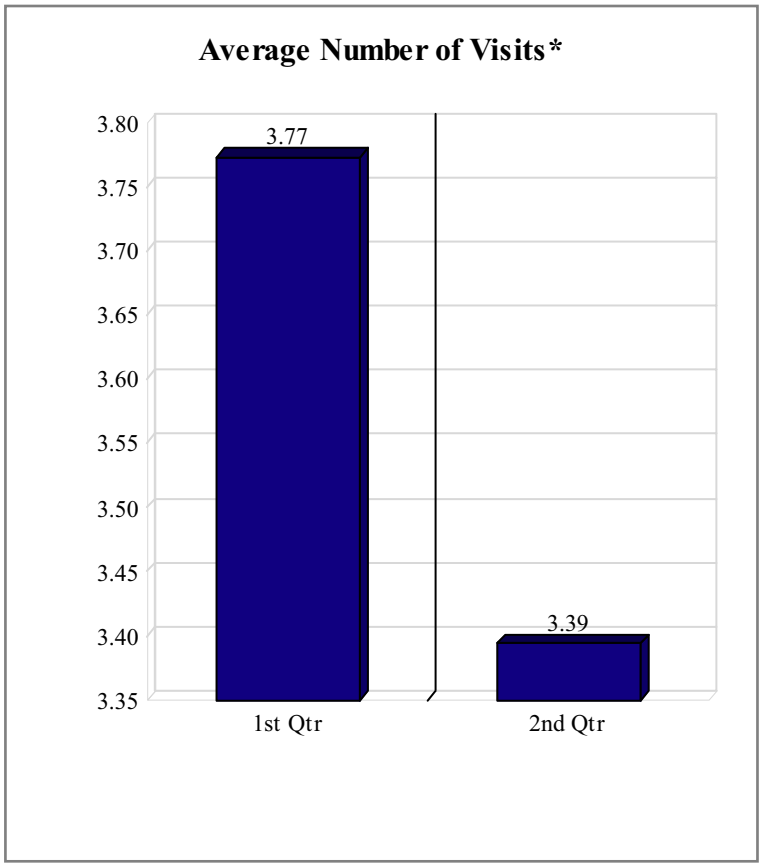
** Data is based on paid claims and has been annualized.*

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

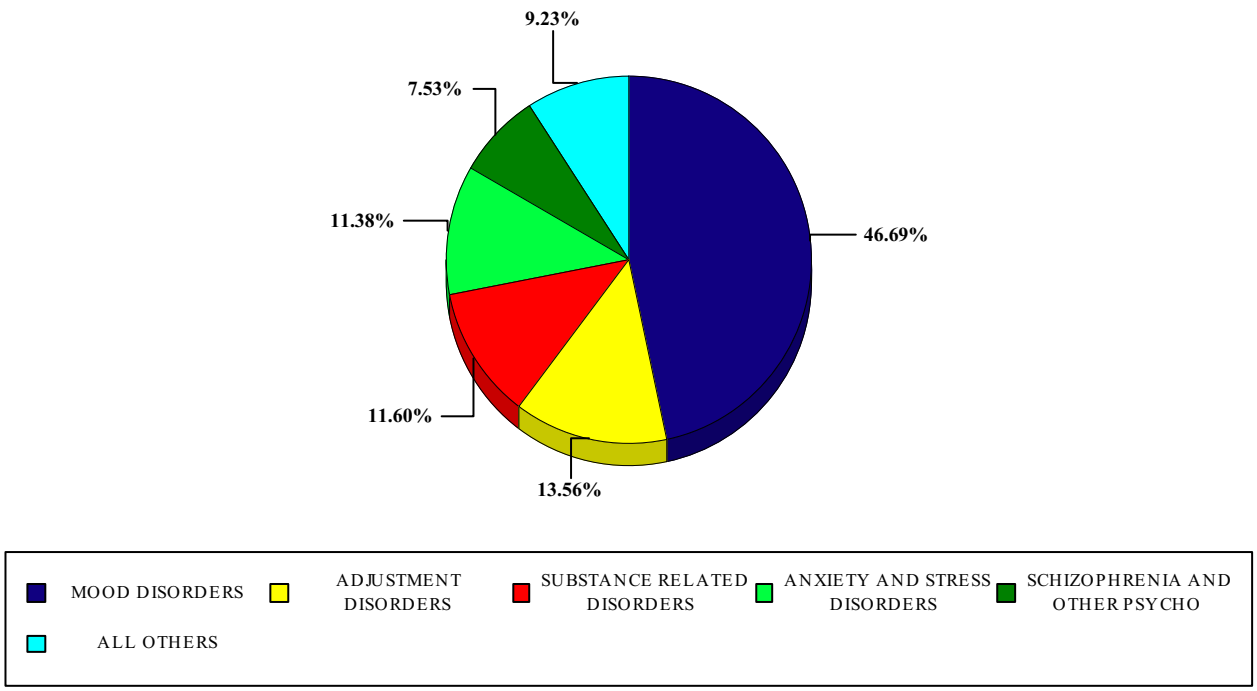
Level of Care	Psych Units	Psych Paid $'s	Substance Abuse Units	Substance Abuse Paid $'s	Total Units	Total Paid $'s	Average Cost per Unit	PEPM	PMPM
Inpatient	1,502	$1,546,051	230	$171,680	1,732	$1,717,730	$991.76	$3.44	$1.60
Residential	0	$0	0	$0	0	$0	$0.00	$0.00	$0.00
Partial Hospitalization	321	$139,687	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.*

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%**

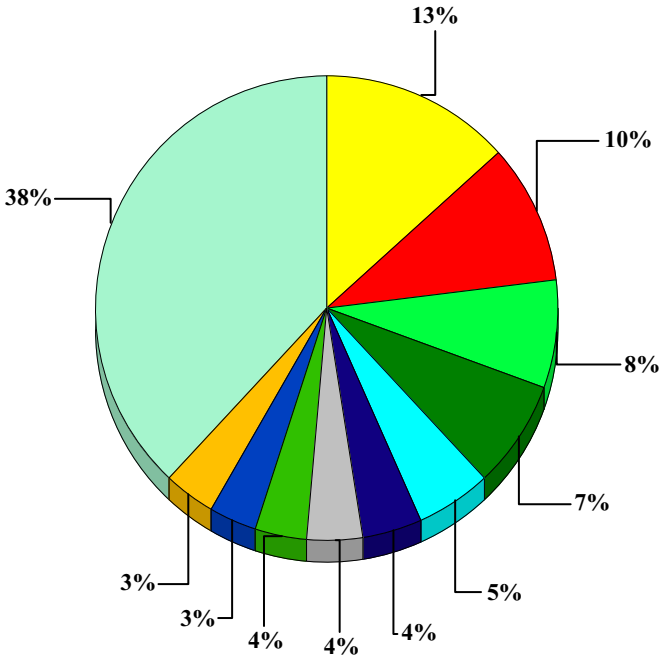
Top Five Diagnosis Categories



Managed Mental Health and Substance Abuse Activity Report
July 1, 2012 - December 31, 2012

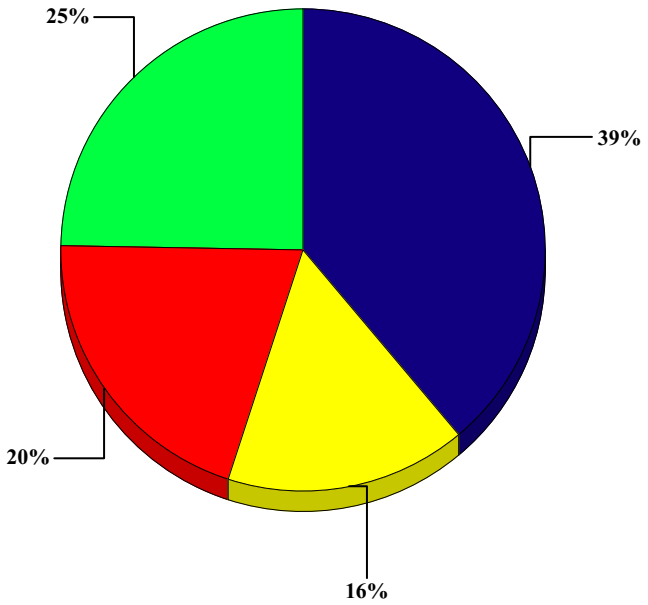
Top Ten High Volume Facilities - Inpatient and Alternative Levels of Care (Division)

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

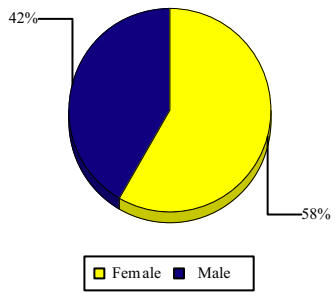
Males

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**

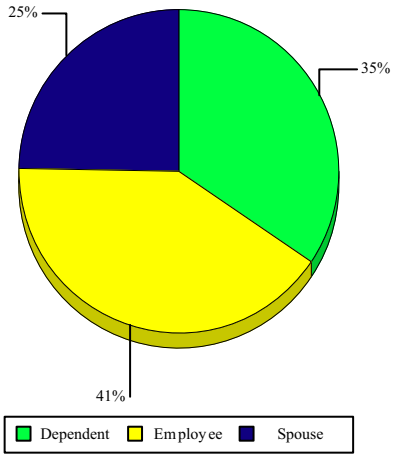
Females

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**

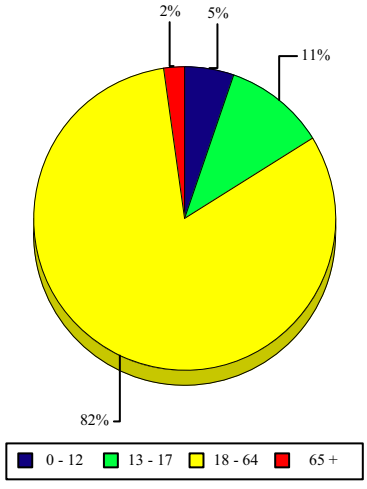
Total Paid % by Gender



Total Paid % by Dependency



Total Paid % by Age Band



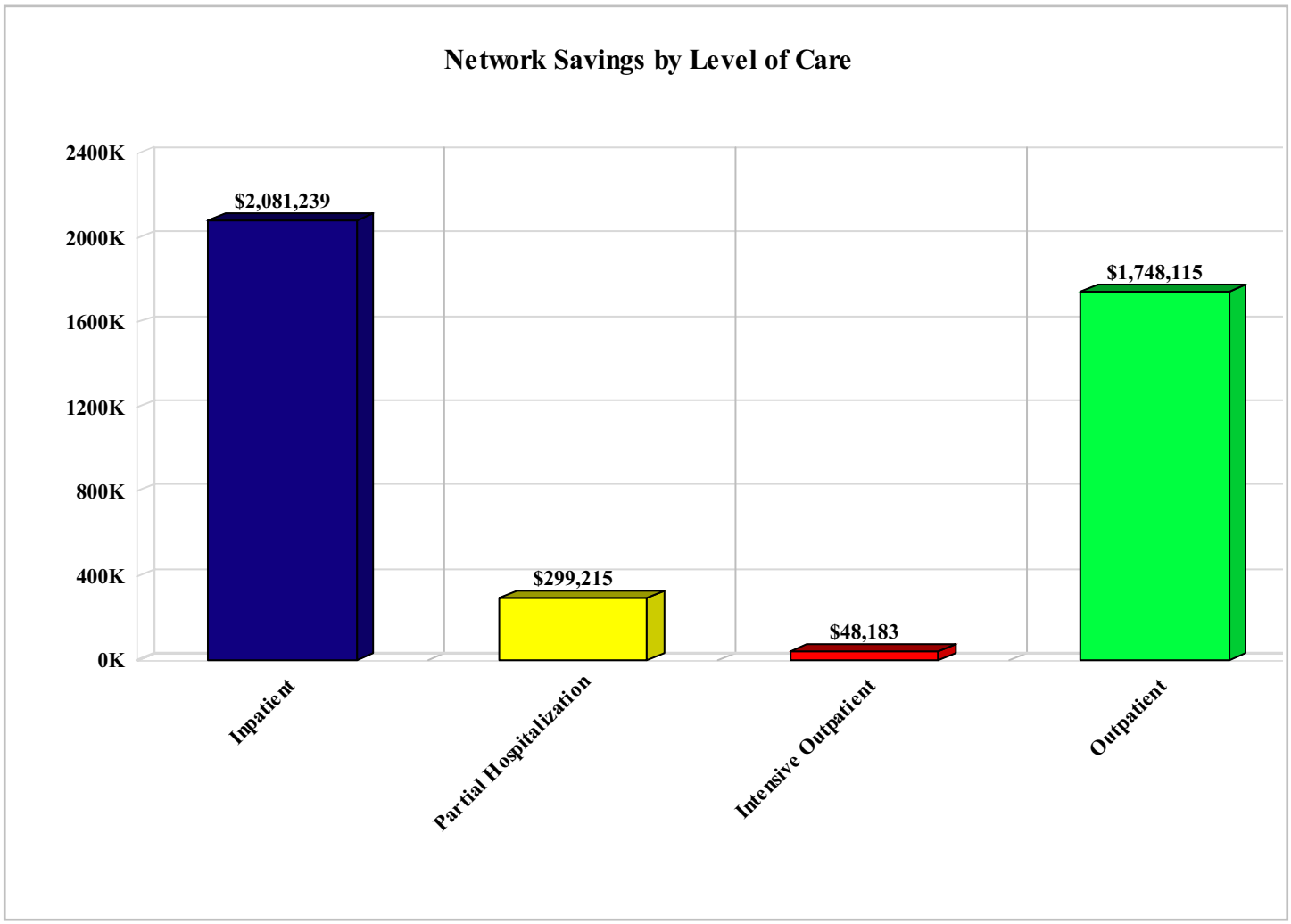
**In-Network Claims Only*

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

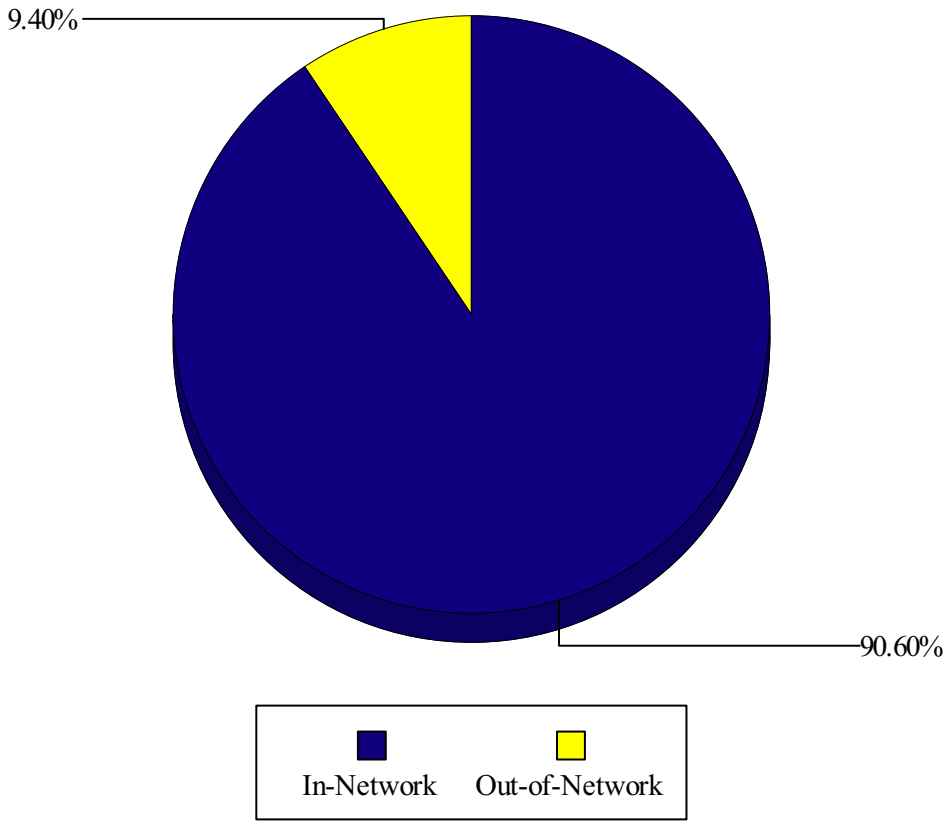
** Network Savings calculated prior to application of benefits.

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.

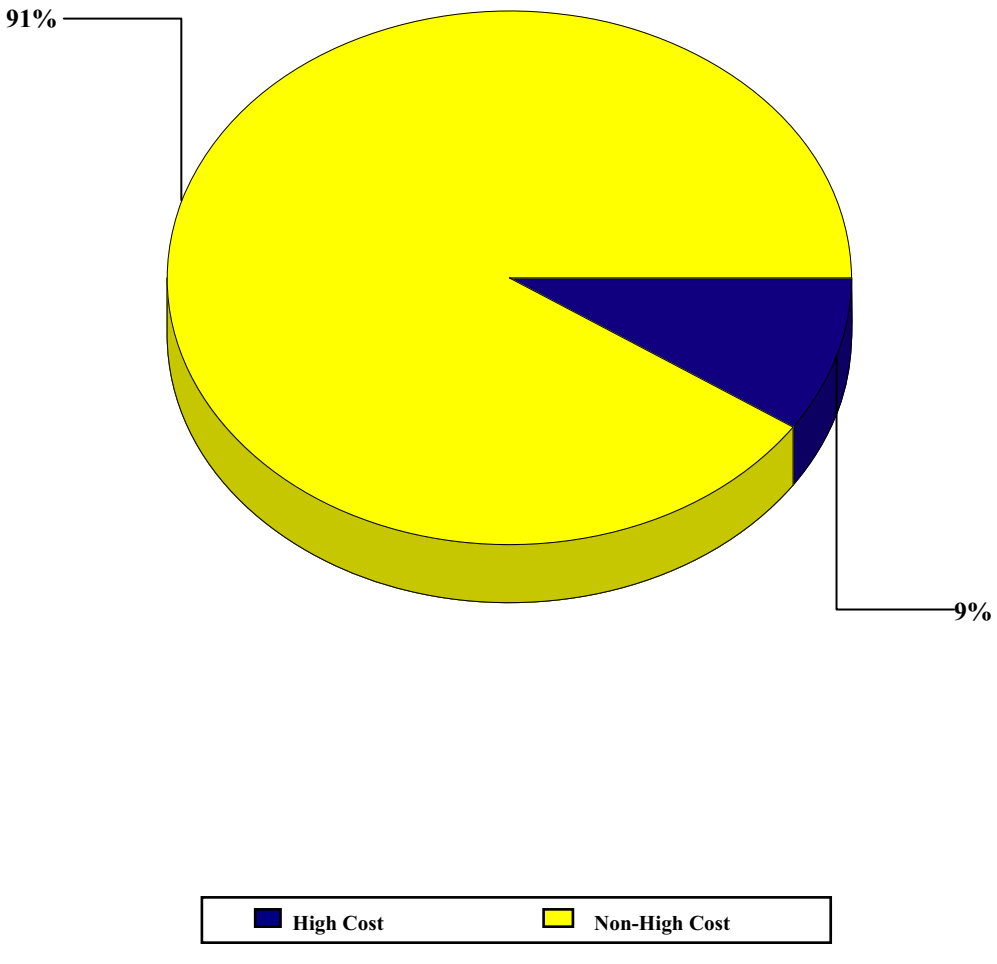
Managed Mental Health and Substance Abuse Activity Report

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

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

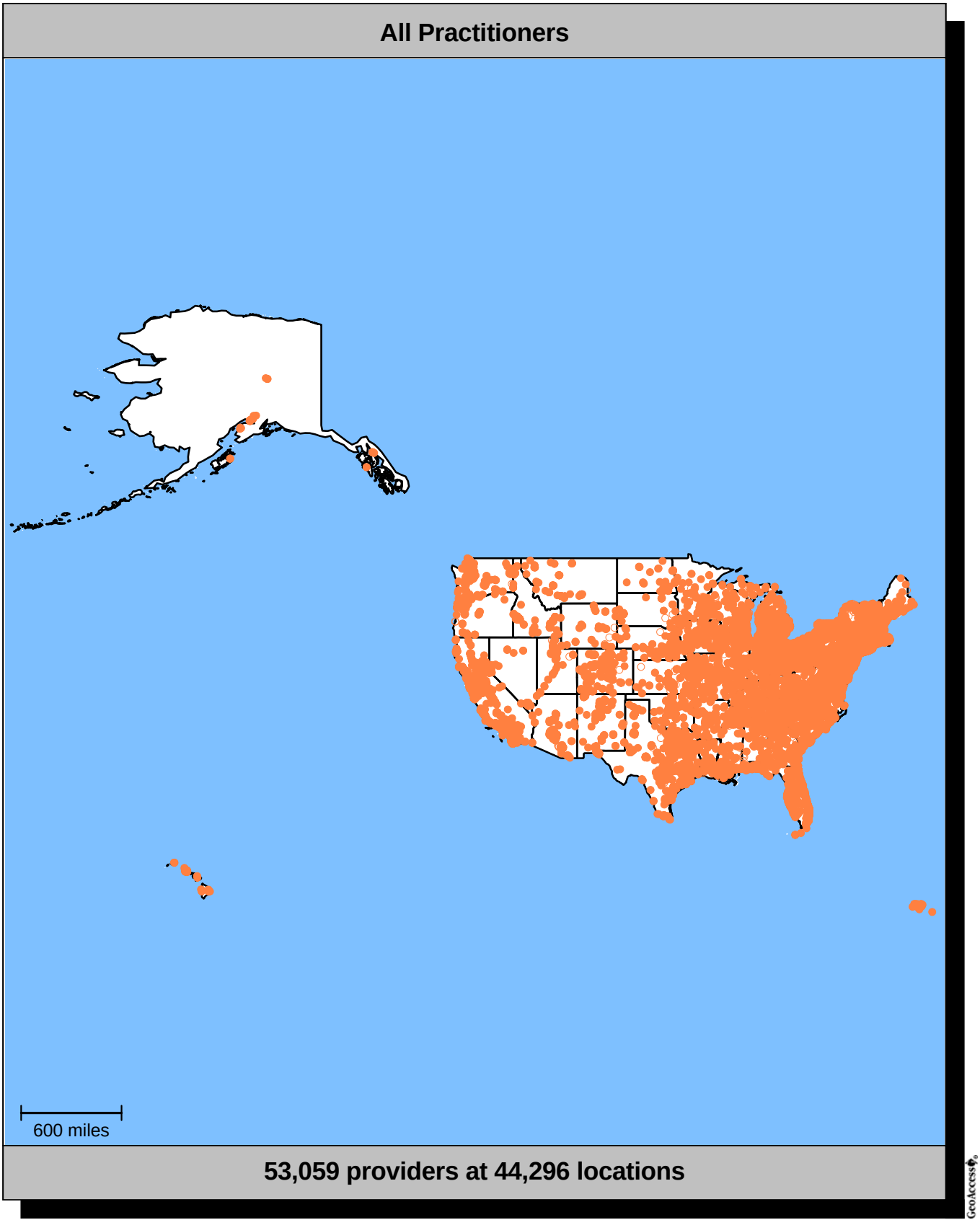
A report on the accessibility of the

ValueOptions MHSA Provider Network

for the covered lives of

Offeror's Proposed MHSA Provider Network File

Provider locations



- Single provider locations
- Multiple 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

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

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						
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

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
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

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	$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

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	$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**

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	$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

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
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.

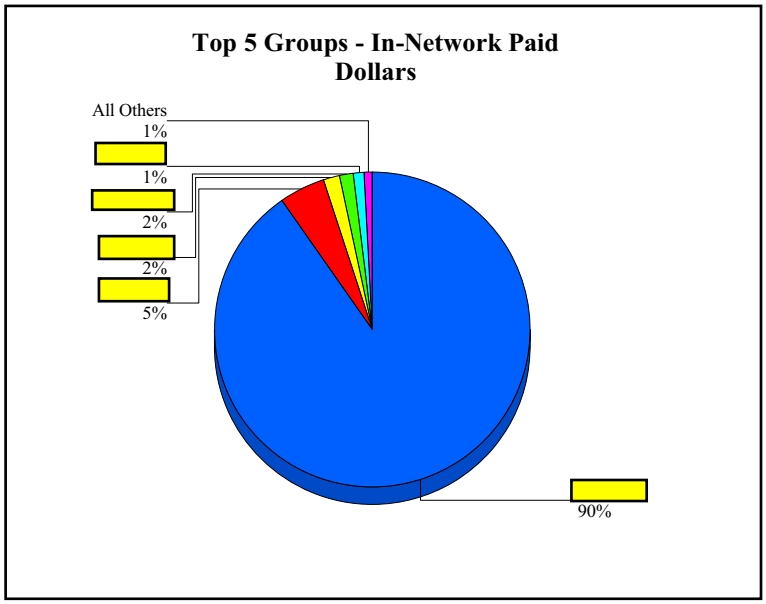
Member ID	Member Name		BILLED	ALLOWED	COBAMT	RCVAMT	PAID
123456789	Member's name here		$-6,033.00	-1,938.00	$-2,752.56	$0.00	$0.00
PRAIRIE STATES		Totals:	**$-6,033.00**	**$-1,938.00**	**$-2,752.56**	**$0.00**	**$0.00**
RISK MANAGEMENT SERVICE C							
123456789	Member's name here		$344.98	266.66	$195.99	$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**

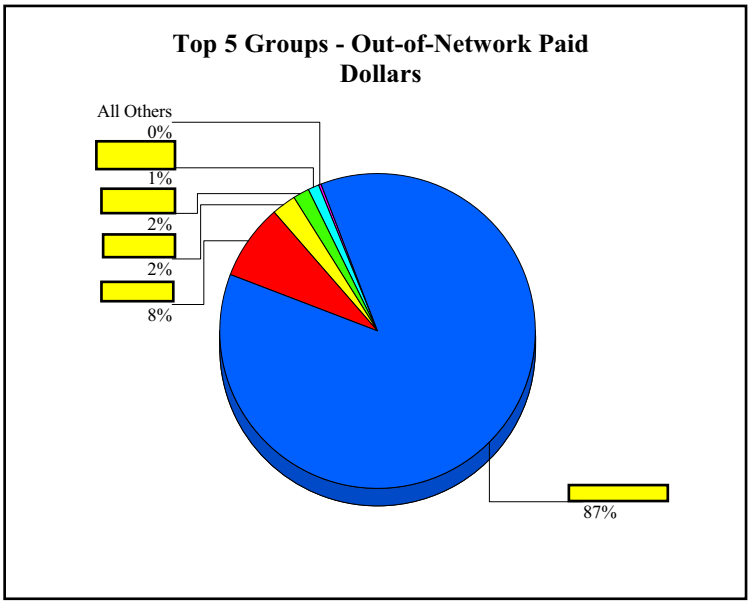
Quarterly Participating Agency Claims

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

VALUEOPTIONS®

(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

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	4,819.11
+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	4,819.11

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, 6/27/13	**Page 1 of 4**	**Original Date of Issue: 8/12/05**
Functional Area: Compliance Department	**Date(s) Revised: 8/21/06, 11/13/08, 6/27/13**	
Service Center/Operating Unit: All	**Subject: Business Associate Agreements**	

Approval Signatures:

Brett Shrader
Assistant Legal Counsel/Privacy Officer

Elizabeth Harken
Vice President of Compliance

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 that comply with the HIPAA standards for BAA's;

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

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

State of New York - Empire Plan

MHSA Program

First Quarter Financial 2014

		Page(s)
Introduction	Cover Letter & Report Narrative	
A-1	Experience of Current Quarter and Year-to-Date	1
B-1	Current Year Projected Experience - Combined & Core	2
B-2	Current Year Projected Experience - NY Enhancement & PA Enhancement	3
C-1	Projected Components of Dividend/(Loss) for the 2014 Contract Year	4
D-1	2014 Claim Reserve Recommendation	5
E-1	Triangle Report - In Network 2014	6
E-2	Triangle Report - Out of Network 2014	7
E-3	Triangle Report - Combined 2014 (In Network + Out of Network)	9
F-1	Development of 2015 Experience and Rates: Ratified Rates	10
F-2	Development of 2015 Experience and Rates: Not Ratified Rates	11
F-3	Development of 2015 Experience and Rates: Blended	12
G-1	Trend Statistics	13
H-1	Trend Analysis - YTD In-Network - Provider Status and Benefit Level	14
H-2	Trend Analysis - YTD Out-of-Network - Provider Status	15
H-3	Trend Analysis - YTD Total - Provider Status	16
H-4	Trend Analysis - YTD In-Network - Benefit Level	17
H-5	Trend Analysis - YTD Out-of-Network - Benefit Level	18
H-6	Trend Analysis - YTD Total - Benefit Level	19
I-1	Projected 2014 Retention	20
J-1	Reconciliation of Experience Projection for Prior Year (2013) - **NOT APPLICABLE FOR 2014 REPORTING**	21

EXHIBIT A-1

Experience of Current Quarter and Year-to-Date 2014

In (000's)

$ Figures provided on this Exhibit are for illustrative purposes only; the figures are not intended to reflect actual 2014 experience.

	CORE			NY ENHANCEMENT			PA ENHANCEMENT			COMBINED		
	Estimated YTD Prior Qtr Rpt	Estimated Experience Current Qtr	Estimated YTD Experience	Estimated YTD Prior Qtr Rpt	Estimated Experience Current Qtr	Estimated YTD Experience	Estimated YTD Prior Qtr Rpt	Estimated Experience Current Qtr	Estimated YTD Experience	Estimated YTD Prior Qtr Rpt	Estimated Experience Current Qtr	Estimated YTD Experience
1 Level Set Funding (1) (2 tier)	**$ -**	**$ 39,830**	**$ 39,830**	**$ -**	**$ 3,500**	**$ 3,500**	**$ -**	**$ 3,720**	**$ 3,720**	**$ -**	**$ 47,050**	**$ 47,050**
2a. Paid Claims	$ -	$ 22,300	$ 22,300	$ -	$ 1,800	$ 1,800	$ -	$ 1,900	$ 1,900	$ -	$ 26,000	$ 26,000
2b. Surcharges and Assessments	$ -	$ 400	$ 400	$ -	$ 32	$ 32	$ -	$ 33	$ 33	$ -	$ 465	$ 465
2c. Liability of Outstanding Claims at End of Reporting Period*	$ -	$ 14,000	$ 14,000	$ -	$ 1,400	$ 1,400	$ -	$ 1,500	$ 1,500	$ -	$ 16,900	$ 16,900
2d. Liability of Outstanding Claims at Beginning of Reporting Period*	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2e. Total Incurred Claim Cost (2a+2b+2c-2d)	**$ -**	**$ 36,700**	**$ 36,700**	**$ -**	**$ 3,232**	**$ 3,232**	**$ -**	**$ 3,433**	**$ 3,433**	**$ -**	**$ 43,365**	**$ 43,365**
3a. Administrative Expenses	$ -	$ 2,975	$ 2,975	$ -	$ 256	$ 256	$ -	$ 270	$ 270	$ -	$ 3,500	$ 3,500
3b. Shared Communications Expenses	$ -	$ 113	$ 113	$ -	$ 10	$ 10	$ -	$ 10	$ 10	$ -	$ 133	$ 133
3c. Audit/Performance Adjustment and Other Credits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3f. Total Administrative Expenses (3a+3b+3c)	**$ -**	**$ 3,088**	**$ 3,088**	**$ -**	**$ 265**	**$ 265**	**$ -**	**$ 280**	**$ 280**	**$ -**	**$ 3,633**	**$ 3,633**
4 Experience Gain/(Loss) (1-2e-3f)	**$ -**	**$ 42**	**$ 42**	**$ -**	**$ 3**	**$ 3**	**$ -**	**$ 7**	**$ 7**	**$ -**	**$ 52**	**$ 52**
5a. 5 - Tier Premium	$ -	$ 39,810	$ 39,810	$ -	$ 3,500	$ 3,500	$ -	$ 3,710	$ 3,710	$ -	$ 47,020	$ 47,020
5b. 2 - Tier Premium	$ -	$ 39,830	$ 39,830	$ -	$ 3,500	$ 3,500	$ -	$ 3,720	$ 3,720	$ -	$ 47,050	$ 47,050
5c. Adjustment to Experience Gain/(Loss)(5a-5b)	$ -	$ (20)	$ (20)	$ -	$ -	$ -	$ -	$ (10)	$ (10)	$ -	$ (30)	$ (30)
6 Net Receivable/(Payable) (4+5c)	$ -	$ 22	$ 22	$ -	$ 3	$ 3	$ -	$ (3)	$ (3)	$ -	$ 22	$ 22

*includes O&U for Surcharges & Assessments

NY Enh 2-Tier Prem should always equal NY Enh 5 Tier Premium

EXHIBIT B-1
Current Year Projected Experience - 2014

Renewal projections are accurate; DCS' actual projections

1st Qtr $ Figures provided on this exhibit are for illustrative purposes only; the figures are not intended to reflect actual 2014 experience.

COMBINED

		Projected at Renewal (1)	1st Q Report	2nd Q Report	3rd Q Report	4th Q Report	YE Report
1	**Level Set Funding (1) (2 tier)**	**$ 179,987,000**	**$ 180,600,000**				
2a.	Paid Claims	$ 138,375,024	$ 138,700,000				
2b.	Surcharges and Assessments	$ 2,634,384	$ 2,618,000				
2c.	Liability of Outstanding Claims at End of Reporting Period*	$ 24,494,592	$ 24,007,000				
2d.	Liability of Outstanding Claims at Beginning of Reporting Period*	$ -	$ -				
2e.	**Total Incurred Claim Cost (2a+2b+2c-2d)**	**$ 165,504,000**	**$ 165,325,000**				
3a.	Administrative Expenses	$ 13,986,277	$ 14,025,000				
3b.	Shared Communications Expenses	$ 532,000	$ 532,000				
3c.	Audit/Performance Adjustment and Other Credits	$ -	$ -				
3f.	**Total Retention(3a+3b+3c)**	**$ 14,518,277**	**$ 14,557,000**				
4	**Experience Gain/(Loss) (1-2e-3f)**	**$ (35,277)**	**$ 718,000**				
5a.	5 - Tier Premium	$ 180,252,083	$ 180,550,000				
5b.	2 - Tier Premium	$ 180,252,083	$ 180,600,000				
5c.	Adjustment to Experience Gain/(Loss) (5a-5b)	**$ -**	**$ (50,000)**				
6	Amount Due to/(from) NYS (5b+6c)	**$ (35,277)**	**$ 668,000**				

CORE

		Projected at Renewal (1)	1st Q Report	2nd Q Report	3rd Q Report	4th Q Report	YE Report
1	**Level Set Funding (1) (2 tier)**	**$ 158,426,000**	**$ 159,000,000**				
2a.	Paid Claims	$ 121,799,364	$ 122,000,000				
2b.	Surcharges and Assessments	$ 2,319,144	$ 2,300,000				
2c.	Liability of Outstanding Claims at End of Reporting Period*	$ 21,560,492	$ 21,126,160				
2d.	Liability of Outstanding Claims at Beginning of Reporting Period*	$ -	$ -				
2e.	**Total Incurred Claim Cost (2a+2b+2c-2d)**	**$ 145,679,000**	**$ 145,426,160**				
3a.	Administrative Expenses	$ 12,310,833	$ 12,350,000				
3b.	Shared Communications Expenses	$ 468,268	$ 470,000				
3c.	Audit/Performance Adjustment and Other Credits	$ -	$ -				
3f.	**Total Retention(3a+3b+3c)**	**$ 12,779,101**	**$ 12,820,000**				
4	**Experience Gain/(Loss) (1-2e-3f)**	**$ (32,101)**	**$ 753,840**				
5a.	5 - Tier Premium	$ 158,426,000	$ 158,970,000				
5b.	2 - Tier Premium	$ 158,426,000	$ 159,000,000				
5c.	Adjustment to Experience Gain/(Loss) (5a-5b)	**$ -**	**$ (30,000)**				
6	Amount Due to/(from) NYS (5b+6c)	**$ (32,101)**	**$ 723,840**				

EXHIBIT B-2
Current Year Projected Experience - 2014

Renewal projections are accurate; DCS' actual projections

1st Qtr $ Figures provided on this exhibit are for illustrative purposes only; the figures are not intended to reflect actual 2014 experience.

NY ENHANCEMENT	Projected at Renewal (1)	1st Q Report	2nd Q Report	3rd Q Report	4th Q Report	YE Report
1 **Level Set Funding (1) (2 tier)**	**$ 9,913,000**	**$ 10,000,000**				
2a. Paid Claims	$ 7,621,140	$ 7,700,000				
2b. Surcharges and Assessments	$ 144,840	$ 146,000				
2c. Liability of Outstanding Claims at End of Reporting Period*	$ 1,349,020	$ 1,320,385				
2d. Liability of Outstanding Claims at Beginning of Reporting Period*	$ -	$ -				
2e. Total Incurred Claim Cost (2a+2b+2c-2d)	**$ 9,115,000**	**$ 9,166,385**				
3a. Administrative Expenses	$ 770,311	$ 775,000				
3b. Shared Communications Expenses	$ 29,302	$ 29,600				
3c. Audit/Performance Adjustment and Other Credits	$ -	$ -				
3f. Total Retention(3a+3b+3c)	**$ 799,613**	**$ 804,600**				
4 Experience Gain/(Loss) (1-2e-3f)	**$ (1,613)**	**$ 29,015**				
5a. 5 - Tier Premium	$ 9,913,000	$ 10,000,000				
5b. 2 - Tier Premium	$ 9,913,000	$ 10,000,000				
5c. Adjustment to Experience Gain/(Loss) (5a-5b)	$ -	$ -				
6 Amount Due to/(from) NYS (5b+6c)	**$ (1,613)**	**$ 29,015**				

PA ENHANCEMENT	Projected at Renewal (1)	1st Q Report	2nd Q Report	3rd Q Report	4th Q Report	YE Report
1 **Level Set Funding (1) (2 tier)**	**$ 11,648,000**	**$ 11,600,000**				
2a. Paid Claims	$ 8,954,520	$ 9,000,000				
2b. Surcharges and Assessments	$ 170,400	$ 172,000				
2c. Liability of Outstanding Claims at End of Reporting Period*	$ 1,585,080	$ 1,560,455				
2d. Liability of Outstanding Claims at Beginning of Reporting Period*	$ -	$ -				
2e. Total Incurred Claim Cost (2a+2b+2c-2d)	**$ 10,710,000**	**$ 10,732,455**				
3a. Administrative Expenses	$ 905,133	$ 900,000				
3b. Shared Communications Expenses	$ 34,430	$ 32,400				
3c. Audit/Performance Adjustment and Other Credits	$ -	$ -				
3f. Total Retention(3a+3b+3c)	**$ 939,563**	**$ 932,400**				
4 Experience Gain/(Loss) (1-2e-3f)	**$ (1,563)**	**$ (64,855)**				
5a. 5 - Tier Premium	$ 11,913,083	$ 11,580,000				
5b. 2 - Tier Premium	$ 11,913,083	$ 11,600,000				
5c. Adjustment to Experience Gain/(Loss) (5a-5b)	$ -	**$ (20,000)**				
6 Amount Due to/(from) NYS (5b+6c)	**$ (1,563)**	**$ (84,855)**				

EXHIBIT C-1
Dividend/(Loss) Components for the 2014 Contract Year
In (000's)

Figures provided are for illustrative purposes only;
the figures are not intended to reflect actual 2014 experience.

	1st Quarter Report	2nd Quarter Report	3rd Quarter Report	4th Quarter Report	Final Experience
Change in Projected 2014 Earned Premium	$ 613				
Change in 2014 Claim Experience	$ 179				
Change in Retention	$ (39)				
2-Tier / 5-Tier Adjustment	$ (50)				
Loss Built into 2014 RR	$ (35)				
Net Receivable/(Payable)	$ 668				

Total Net Receivable/(Payable) per Financial Experience Statement (Line 6) $ 668

EXHIBIT D-1
2014 Claim Reserve Recommendation

Figures provided are for illustrative purposes only;
the figures are not intended to reflect actual 2014 experience.

A. Reserve and Paid Claims Reconciliation

In 2015, the 2014 time period will be moved over a column (to Excel Column F) and the 2015 time period will be presented where the 2014 time period is currently situated (i.e., Excel Column E).

	Total Projected Incurred Claims (excludes S&A)*	Projected Claims Paid (a) 1/1/2014 - 12/31/2014					Outstanding Reserve at 12/31/2014
2014	$ 161,554	$ 138,700					22,854
2015							-
2016							-
TOTAL	$ 161,554	$ 138,700	$ -	$ -	$ -	$ -	$ 22,854

(a) Each year's final paid claims should correspond to the paid claim totals reported in the Monthly 1A Paid Claim Access files (before application of any credits).

*Excludes Surcharges & Asessments (i.e., BD&C)

In 2015, the 2014 time period will be moved over a column (to Excel Column F) and the 2015 time period will be presented where the 2014 time period is currently situated (i.e., Excel Column E).

	Total Projected Incurred S&A	Projected S&A Paid 1/1/2014 - 12/31/2014					Outstanding Reserve at 12/31/2014
2014	$ 3,300	$ 2,618					682
2015							-
2016							-
TOTAL	$ 3,300	$ 2,618	$ -	$ -	$ -	$ -	$ 682

B. 12/31/2014 Open & Unreported Reserve

I.	Projected Incurred But Unpaid Claims @ 12/31/2014		$ 22,854
	Projected Incurred But Unpaid Surcharges & Assessments @ 12/31/2014		$ 682
	Projected Total Incurred But Unpaid Claim Cost @ 12/31/2014		$ 23,536
II.	Margin (2.0%)	**Please use 2.0% margin**	$ 471
III.	Total Open & Unreported Reserve @ 12/31/2014		**$ 24,007**

EXHIBIT E-1 - 2014

**Figures provided are for illustrative purposes only;
the figures are not intended to reflect actual 2014 experience.**

State of New York - Empire Plan *
Triangle Report - In-Network

Optum Behavioral Health Solutions Mental Health and Substance Abuse Program

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Total
Jan-14	$ 2,200,000												$ 2,200,000
Feb-14	$ 4,400,000	$ 2,400,000											$ 6,800,000
Mar-14	$ 2,200,000	$ 4,700,000	$ 2,000,000										$ 8,900,000
Apr-14													$ -
May-14													$ -
Jun-14													$ -
Jul-14													$ -
Aug-14													$ -
Sep-14													$ -
Oct-14													$ -
Nov-14													$ -
Dec-14													$ -
													$ -
Total	$ 8,800,000	$ 7,100,000	$ 2,000,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 17,900,000

Completion Factors are solely for illustrative purposes; the %s are not intended to be accurate

Completion Factor	0.8902	0.6901	0.1953
Incurred Claims	$ 9,885,419	$ 10,288,364	$ 10,240,655
Incurred Claims Subtotal	$ 30,414,438		
Seasonality Factor	3.50		
2014 Projected Claims	$ 106,450,534		

* Includes Empire, Excelsior & SEHP claims

EXHIBIT E-2 - 2014

Figures provided are for illustrative purposes only;
the figures are not intended to reflect actual 2014 experience.

State of New York - Empire Plan*
Triangle Report - Out-of-Network

Optum Behavioral Health Solutions Mental Health and Substance Abuse Program

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Total
Jan-14	$ 900,000												$ 900,000
Feb-14	$ 1,700,000	$ 1,100,000											$ 2,800,000
Mar-14	$ 800,000	$ 2,000,000	$ 700,000										$ 3,500,000
Apr-14													$ -
May-14													$ -
Jun-14													$ -
Jul-14													$ -
Aug-14													$ -
Sep-14													$ -
Oct-14													$ -
Nov-14													$ -
Dec-14													$ -
													$ -
Total	$ 3,400,000	$ 3,100,000	$ 700,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,200,000

Completion Factors are solely for illustrative purposes; the %s are not intended to be accurate

Completion Factor	0.8669	0.6711	0.1891
Incurred Claims	$ 3,922,021	$ 4,619,282	$ 3,701,745
Incurred Claims Subtotal	$ 12,243,048		
Seasonality Factor	4.50		
2014 Projected Claims	$ 55,093,715		

* Includes Empire, Excelsior & SEHP claims

EXHIBIT E-1 - 2014

**Figures provided are for illustrative purposes only;
the figures are not intended to reflect actual 2014 experience.**

State of New York - Empire Plan*
Triangle Report - Combined (In-Network + Out-of-Network)

Optum Behavioral Health Solutions Mental Health and Substance Abuse Program

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Total
Jan-14	$ 3,100,000												$ 3,100,000
Feb-14	$ 6,100,000	$ 4,400,000											$ 10,500,000
Mar-14	$ 3,000,000	$ 6,700,000	$ 2,700,000										$ 12,400,000
Apr-14													$ -
May-14													$ -
Jun-14													$ -
Jul-14													$ -
Aug-14													$ -
Sep-14													$ -
Oct-14													$ -
Nov-14													$ -
Dec-14													$ -
													$ -
Total	$ 12,200,000	$ 11,100,000	$ 2,700,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,000,000

2014 Projected Claims	**$ 161,544,250**

* Includes Empire, Excelsior & SEHP claims

EXHIBIT F-1
DEVELOPMENT OF 2015 EXPERIENCE AND RATES: RATIFIED RATES
In (000's)

Figures provided are for illustrative purposes only;
the figures are not intended to reflect actual 2014 experience.

Enrollment is Based on the Premise that All Enrollees Have Ratified Benefits & Ratified Rates

Enrollment figures are illustrative only (simplified)

2014 Rates are accurate

A. EXPERIENCE PROJECTION

Trend & Surch & Assmts %s are illustrative only; they are not intended to be accurate

Margin Percentage is accurate; margin should = 0%

		Normalized 2014 Claims Inc	2015 Trend 6.0%	2015 Benefit Changes	2015 Claims Inc	Margin 0.0%	Surcharges & Assessments 2.0%	Admin Expense	2015 Required Premium	2014 Annual Premium	2015 Renewal Action(%)	2014 Rate	Enrollment	Excelsior 2014 Rate	Excelsior Enrollment
CORE	ee	51,000	3,060	0	54,060	0	1,081	4,223	59,364	56,209	5.6%	$8.97	522,000	$8.64	200
	dep	91,000	5,460	0	96,460	0	1,929	7,536	105,925	100,711	5.2%	$29.03	289,000	$29.20	100
	total	142,000	8,520	0	150,520	0	3,010	11,759	165,289	156,920	5.3%	$38.00		$37.84	
NY ENH	ee	3,000	180	0	3,180	0	64	248	3,492	3,383	3.2%	$0.87	324,000		
	dep	5,900	354	0	6,254	0	125	489	6,868	6,508	5.5%	$3.19	170,000		
	total	8,900	534	0	9,434	0	189	737	10,360	9,890	4.7%	$4.06			
PA ENH	ee	2,900	174	0	3,074	0	61	240	3,376	3,312	1.9%	$1.38	200,000		
	dep	7,500	450	0	7,950	0	159	621	8,730	8,482	2.9%	$5.94	119,000		
	total	10,400	624	0	11,024	0	220	861	12,106	11,794	2.6%	$7.32			
SEHP	ee	1,700	102	0	1,802	0	36	141	1,979	1,904	3.9%	$29.38	5,400		
	dep	160	10	0	170	0	3	13	186	176	6.0%	$18.31	800		
	total	1,860	112	0	1,972	0	39	154	2,165	2,080	4.1%	$47.69			
Total	ee	58,600	3,516	0	62,116	0	1,242	4,853	68,211	64,807	5.3%		527,600	including Excelsior	
	dep	104,560	6,274	0	110,834	0	2,217	8,658	121,709	115,877	5.0%		289,900	including Excelsior	
	total	163,160	9,790	0	172,950	0	3,459	13,511	189,920	180,684	5.1%				

ADJUSTMENTS

Trend	6.00%	illustrative % only
Benefit change	0.00%	illustrative % only, but no benefit chg anticipated for 2015
Margin	0.00%	
Surcharges & Assessments	2.00%	illustrative % only

2015 Admin $2.05 per contract per month
Also: $532,000 Annual Shared Communciation Expenses

B. RATE RECOMMENDATION

2014 Rates are accurate

EMPIRE	CORE EE	CORE DEP	CORE FAM	NY ENHANCEMENT EE	NY ENHANCEMENT DEP	NY ENHANCEMENT FAM	PA ENHANCEMENT EE	PA ENHANCEMENT DEP	PA ENHANCEMENT FAM
2014 Rate	$8.97	$29.03	$38.00	$0.87	$3.19	$4.06	$1.38	$5.94	$7.32
Projected 2015 Rates:									
Optimistic (-3%)	$9.19	$29.61	$38.80	$0.87	$3.27	$4.14	$1.37	$5.93	$7.30
Realistic	$9.47	$30.53	$40.00	$0.90	$3.37	$4.27	$1.41	$6.11	$7.52
Pessimistic(+3%)	$9.75	$31.45	$41.20	$0.93	$3.47	$4.40	$1.45	$6.29	$7.74

2014 Rates are accurate

EXCELSIOR	EE	DEP	FAM
2014 Rate	$8.64	$29.20	$37.84
Projected 2015 Rates:			
Optimistic (-3%)	$8.81	$29.67	$38.48
Realistic	$9.08	$30.59	$39.67
Pessimistic(+3%)	$9.35	$31.51	$40.86

Excelsior rate: Equal to 83.5% of the Combined Core + PA Enhancement Rate for the Ratified Group

2014 Rates are accurate

SEHP	EE	DEP	FAM
2014 Rate	$29.38	$18.31	$47.69
Projected 2015 Rates:			
Optimistic (-3%)	$29.62	$18.82	$48.44
Realistic	$30.54	$19.40	$49.94
Pessimistic(+3%)	$31.46	$19.98	$51.44

EXHIBIT F-2
DEVELOPMENT OF 2015 EXPERIENCE AND RATES: NOT RATIFIED RATES
In (000's)

Figures provided are for illustrative purposes only;
the figures are not intended to reflect actual 2014 experience.

Enrollment is Based on the Premise that All Enrollees Have Not Ratified Benefits & Not Ratified Rates
Enrollment figures are illustrative only (simplified)
2014 Rates are accurate

A. EXPERIENCE PROJECTION

Trend & Surch & Assmts %s are illustrative only; they are not intended to be accurate
Margin Percentage is accurate; margin should = 0%

		Normalized 2014 Claims Inc	2015 Trend 6.0%	2015 Benefit Changes	2015 Claims Inc	Margin 0.0%	Surcharges & Assessments 2.0%	Admin Expense	2015 Required Premium	2014 Annual Premium	2015 Renewal Action(%)	2014 Rate	Enrollment	Excelsior 2014 Rate	Excelsior Enrollment
CORE	ee	53,000	3,180	0	56,180	0	1,124	4,206	61,509	58,714	4.8%	$9.37	522,000	$8.64	200
	dep	95,000	5,700	0	100,700	0	2,014	7,539	110,253	105,150	4.9%	$30.31	289,000	$29.20	100
	total	148,000	8,880	0	156,880	0	3,138	11,745	171,762	163,865	4.8%	$39.68		$37.84	
NY ENH	ee	3,200	192	0	3,392	0	68	254	3,714	3,538	5.0%	$0.91	324,000		
	dep	6,200	372	0	6,572	0	131	492	7,195	6,793	5.9%	$3.33	170,000		
	total	9,400	564	0	9,964	0	199	746	10,909	10,331	5.6%	$4.24			
PA ENH	ee	3,100	186	0	3,286	0	66	246	3,598	3,312	8.6%	$1.38	200,000		
	dep	7,900	474	0	8,374	0	167	627	9,168	8,482	8.1%	$5.94	119,000		
	total	11,000	660	0	11,660	0	233	873	12,766	11,794	8.2%	$7.32			
SEHP	ee	1,700	102	0	1,802	0	36	135	1,973	1,904	3.6%	$29.38	5,400		
	dep	160	10	0	170	0	3	13	186	176	5.6%	$18.31	800		
	total	1,860	112	0	1,972	0	39	148	2,159	2,080	3.8%	$47.69			
Total	ee	61,000	3,660	0	64,660	0	1,293	4,841	70,794	67,468	4.9%		527,600	including Excelsior	
	dep	109,260	6,556	0	115,816	0	2,316	8,670	126,802	120,601	5.1%		289,900	including Excelsior	
	total	170,260	10,216	0	180,476	0	3,610	13,511	197,596	188,070	5.1%				

ADJUSTMENTS

Trend	6.00%	illustrative % only
Benefit change	0.00%	illustrative % only, but no benefit chg anticipated for 2015
Margin	0.00%	
Surcharges & Assessments	2.00%	illustrative % only

2015 Admin	$2.05	per contract per month
Also:	$532,000	Annual Shared Communciation Expenses

B. RATE RECOMMENDATION

2014 Rates are accurate

EMPIRE	CORE EE	CORE DEP	CORE FAM	NY ENHANCEMENT EE	NY ENHANCEMENT DEP	NY ENHANCEMENT FAM	PA ENHANCEMENT EE	PA ENHANCEMENT DEP	PA ENHANCEMENT FAM
2014 Rate	$9.37	$30.31	$39.68	$0.91	$3.33	$4.24	$1.38	$5.94	$7.32
Projected 2015 Rates:									
Optimistic (-3%)	$9.53	$30.83	$40.36	$0.93	$3.42	$4.35	$1.46	$6.23	$7.69
Realistic	$9.82	$31.78	$41.60	$0.96	$3.53	$4.49	$1.50	$6.42	$7.92
Pessimistic(+3%)	$10.11	$32.73	$42.84	$0.99	$3.64	$4.63	$1.55	$6.61	$8.16

2014 Rates are accurate

EXCELSIOR	EE	DEP	FAM
2014 Rate	$8.64	$29.20	$37.84
Projected 2015 Rates:			
Optimistic (-3%)	$8.81	$29.67	$38.48
Realistic	$9.08	$30.59	$39.67
Pessimistic(+3%)	$9.35	$31.51	$40.86

Excelsior Rate: Equal to 83.5% of the Combined Core + PA Enhancement Rate for the Ratified Group

2014 Rates are accurate

SEHP	EE	DEP	FAM
2014 Rate	$29.38	$18.31	$47.69
Projected 2015 Rates:			
Optimistic (-3%)	$29.62	$18.82	$48.44
Realistic	$30.54	$19.40	$49.94
Pessimistic(+3%)	$31.46	$19.98	$51.44

SEHP Rate: Notwithstanding the above Required Premium Development Figures for SEHP as presented above, the SEHP Rates will be based solely on the calculations presented based on the Ratified Group Rates in Exhibit F-1. Therefore, the SEHP rates on this page equal those presented on Exh F-1

EXHIBIT F-3
DEVELOPMENT OF 2015 EXPERIENCE AND RATES: BLENDED RATES
In (000's)

Figures provided are for illustrative purposes only;
the figures are not intended to reflect actual 2014 experience.

Enrollment below is total enrollment. Claims Incurred for this Blended Sht is based upon the actual enrollment mix: Ratified vs not Ratified (as of 1/2/14 99.62% of Ind Cov was Ratif & 98.88% of Fam Cov was Ratif; the balance = Not Ratif)

The Total Normalized 2014 Claims Inc as presented on this exhibit, Exh F-3 (Blended), should be similar to the 2014 incurred claims amt presented on Exh D-1

A. EXPERIENCE PROJECTION

Trend & Surch & Assmts %s are illustrative only; they are not intended to be accurate
Margin Percentage is accurate; margin should = 0%

Enrollment figures are illustrative only (simplified)
2014 Rates are accurate

		Normalized 2014 Claims Inc	2015 Trend 6.0%	2015 Benefit Changes	2015 Claims Inc	Margin 0.0%	Surcharges & Assessments 2.0%	Admin Expense	2015 Required Premium	2014 Annual Premium	2015 Renewal Action(%)	2014 Rate	Enrollment	Excelsior 2014 Rate	Excelsior Enrollment
CORE	ee	51,008	3,060	0	54,068	0	1,081	4,222	59,372	56,209	5.6%	$8.97	522,000	$8.64	200
	dep	91,045	5,463	0	96,507	0	1,930	7,536	105,974	100,711	5.2%	$29.03	289,000	$29.20	100
	total	142,052	8,523	0	150,576	0	3,012	11,759	165,346	156,920	5.4%	$38.00		$37.84	
NY ENH	ee	3,001	180	0	3,181	0	64	248	3,493	3,383	3.3%	$0.87	324,000		
	dep	5,903	354	0	6,258	0	125	489	6,871	6,508	5.6%	$3.19	170,000		
	total	8,904	534	0	9,438	0	189	737	10,364	9,890	4.8%	$4.06			
PA ENH	ee	2,901	174	0	3,075	0	61	240	3,376	3,312	1.9%	$1.38	200,000		
	dep	7,504	450	0	7,955	0	159	621	8,735	8,482	3.0%	$5.94	119,000		
	total	10,405	624	0	11,030	0	221	861	12,111	11,794	2.7%	$7.32			
SEHP	ee	1,700	102	0	1,802	0	36	141	1,979	1,904	3.9%	$29.38	5,400		
	dep	160	10	0	170	0	3	13	186	176	6.0%	$18.31	800		
	total	1,860	112	0	1,972	0	39	154	2,165	2,080	4.1%	$47.69			
Total	ee	58,609	3,517	0	62,126	0	1,243	4,851	68,220	64,807	5.3%		527,600	including Excelsior	
	dep	104,613	6,277	0	110,889	0	2,218	8,659	121,767	115,877	5.1%		289,900	including Excelsior	
	total	163,222	9,793	0	173,015	0	3,460	13,511	189,986	180,684	5.1%				

B. RATE RECOMMENDATION

2014 Rates are accurate

EMPIRE	CORE EE	CORE DEP	CORE FAM	NY ENHANCEMENT EE	NY ENHANCEMENT DEP	NY ENHANCEMENT FAM	PA ENHANCEMENT EE	PA ENHANCEMENT DEP	PA ENHANCEMENT FAM
2014 Rate	$8.97	$29.03	$38.00	$0.87	$3.19	$4.06	$1.38	$5.94	$7.32
Projected 2015 Rates:									
Optimistic (-3%)	$9.19	$29.63	$38.82	$0.87	$3.27	$4.14	$1.37	$5.94	$7.31
Realistic	$9.47	$30.55	$40.02	$0.90	$3.37	$4.27	$1.41	$6.12	$7.53
Pessimistic(+3%)	$9.75	$31.47	$41.22	$0.93	$3.47	$4.40	$1.45	$6.30	$7.75

ADJUSTMENTS

Trend	6.00%	illustrative % only
Benefit change	0.00%	illustrative % only, but no benefit chg anticipated for 2015
Margin	0.00%	
Surcharges & Assessments	2.00%	illustrative % only

2015 Admin $2.05 per contract per month
Also: $532,000 Annual Shared Communciation Expenses

2014 Rates are accurate

EXCELSIOR	EE	DEP	FAM
2014 Rate	$8.64	$29.20	$37.84
Projected 2015 Rates:			
Optimistic (-3%)	$8.81	$29.67	$38.48
Realistic	$9.08	$30.59	$39.67
Pessimistic(+3%)	$9.35	$31.51	$40.86

Excelsior Rate: Equal to 83.5% of the Combined Core + PA Enhancement Rate for the Ratified Group

2014 Rates are accurate

SEHP	EE	DEP	FAM
2014 Rate	$29.38	$18.31	$47.69
Projected 2015 Rates:			
Optimistic (-3%)	$29.62	$18.82	$48.44
Realistic	$30.54	$19.40	$49.94
Pessimistic(+3%)	$31.46	$19.98	$51.44

SEHP Rate: Notwithstanding the above Required Premium Development Figures for SEHP as presented above, the SEHP Rates will be based solely on the calculations presented based on the Ratified Group Rates in Exhibit F-1. Therefore, the SEHP rates on this page equal those presented on Exh F-1

EXHIBIT G-1

Trend Statistics

(PROJECTED FOR THE YEAR END)

	In & Out of Network Total	In Network Total	Out of Network Total
2014			
# of Charges	0		
$ Claims Incurred	$ -		
# of Contracts		0	0
Cost/charge	#DIV/0!	#DIV/0!	#DIV/0!
# Charges/1000 Contracts	#DIV/0!	#DIV/0!	#DIV/0!
Cost/Contract	#DIV/0!	#DIV/0!	#DIV/0!

2013 (2013 Figures are accurate figures per Prior Carrier 2013 4th Qtr Experience Report)					
# of Charges		1,481,658		1,136,187	345,471
$ Claims Incurred	$	138,962,666	$	89,830,877	$ 49,131,788
# of Contracts		524,246		524,246	524,246
Cost/charge	$	93.79	$	79.06	$ 142.22
# Charges/1000 Contracts		2,826		2,167	659
Cost/Contract	$	265.07	$	171.35	$ 93.72

% Change 2014 over 2013			
Cost/Charge	#DIV/0!	#DIV/0!	#DIV/0!
# Charges/1000 Contracts	#DIV/0!	#DIV/0!	#DIV/0!
Cost/Contract	#DIV/0!	#DIV/0!	#DIV/0!

Note: In Network vs Out-of-Network based on the contracted status of the Provider.

EXHIBIT H-1
Trend Analysis - YTD 2013 - In Network - Provider Status

	Days or Services***		Days/Visits Per 1000			Amount Paid		Average Unit Cost			Cost PMPM		
	2013*	2014**	2013*	2014**	% Change	2013*	2014**	2013*	2014**	% Change	2013*	2014**	% Change
In-Network (Provider Status)													
Inpatient Services	Jul-05 not applicable		Jul-05 not applicable			Jul-05 not applicable		Jul-05 not applicable			Jul-05 not applicable		
Mental Health					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Substance Abuse					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Alcohol Rehab***					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Alternate Levels of Care					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Weighted Average Facility Charge	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
% of Total	#DIV/0!	#DIV/0!											
Outpatient Services	Jul-05 not applicable		Jul-05 not applicable			Jul-05 not applicable		Jul-05 not applicable	Jul-05 not applicable		Jul-05 not applicable		
Professional Inpatient Services													
Physician					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Psychologist					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Health Professional					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Outpatient Visits													
Physician					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Psychologist					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Health Professional					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Substance Abuse and Structured Outpatient Programs and Clinics (SOPS)					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Services Not Included Above					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Weighted Average Professional Charge	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
% of Total	#DIV/0!	#DIV/0!											
Total In-Network	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!

*Incurred 1/1/13 - 12/31/13, claims paid through 3/31/14 (average members: 1,100,000)
**Incurred 1/1/14 - 3/31/14, claims paid through 3/31/14 (average members: 1,100,000)
***Include zero paid claims

avg monthly membership (covered lives) figures are illustrative only (simplified); not intended to be accura

EXHIBIT H-2
Trend Analysis - YTD 2013 - Out-of-Network - Provider Status

	Days or Services***		Days/Visits Per 1000			Amount Paid		Average Unit Cost			Cost PMPM		
	2013*	2014**	2013*	2014**	% Change	2013*	2014**	2013*	2014**	% Change	2013*	2014**	% Change
Out of Network (Provider Status)													
	Jul-05		Jul-05			Jul-05		Jul-05			Jul-05		
Inpatient Services	not applicable		not applicable			not applicable		not applicable			not applicable		
Mental Health					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Substance Abuse					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Alcohol Rehab***					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Alternate Levels of Care					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Weighted Average Facility Charge	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
% of Total	#DIV/0!	#DIV/0!											
Outpatient Services	Jul-05		Jul-05			Jul-05		Jul-05	Jul-05		Jul-05		
	not applicable		not applicable			not applicable		not applicable	not applicable		not applicable		
Professional Inpatient Services													
Physician					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Psychologist					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Health Professional					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Outpatient Visits													
Physician					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Psychologist					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Health Professional					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Substance Abuse and Structured Outpatient Programs and Clinics (SOPS)					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Services Not Included Above					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Weighted Average Professional Charge	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
% of Total	#DIV/0!	#DIV/0!											
Total Out-of-Network	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!

*Incurred 1/1/13 - 12/31/13, claims paid through 3/31/14 (average members: 1,100,000)
**Incurred 1/1/14 - 3/31/14, claims paid through 3/31/14 (average members: 1,100,000)
***Include zero paid claims

EXHIBIT H-3
Trend Analysis - YTD 2013 - Total - Provider Status

	Days or Services***		Days/Visits Per 1000			Amount Paid		Average Unit Cost			Cost PMPM		
	2013*	2014**	2013*	2014**	% Change	2013*	2014**	2013*	2014**	% Change	2013*	2014**	% Change
In and Out of Network (Provider Status)													
	Jul-05		Jul-05			Jul-05		Jul-05			Jul-05		
Inpatient Services	not applicable		not applicable			not applicable		not applicable			not applicable		
Mental Health	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Substance Abuse	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Alcohol Rehab***	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Alternate Levels of Care	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Weighted Average Facility Charge	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
% of Total	#DIV/0!	#DIV/0!											
Outpatient Services	Jul-05		Jul-05			Jul-05		Jul-05	Jul-05		Jul-05		
	not applicable		not applicable			not applicable		not applicable	not applicable		not applicable		
Professional Inpatient Services													
Physician	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Psychologist	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Health Professional	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Outpatient Visits													
Physician	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Psychologist	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Health Professional	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Substance Abuse and Structured Outpatient Programs and Clinics (SOPS)	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Services Not Included Above	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Weighted Average Professional Charge	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
% of Total	#DIV/0!	#DIV/0!											
Total Combined	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!

*Incurred 1/1/13 - 12/31/13, claims paid through 3/31/14 (average members: 1,100,000)
**Incurred 1/1/14 - 3/31/14, claims paid through 3/31/14 (average members: 1,100,000)
***Include zero paid claims

EXHIBIT H-4
Trend Analysis - YTD 2013 - In-Network - Benefit Level

	Days or Services***		Days/Visits Per 1000			Amount Paid		Average Unit Cost			Cost PMPM		
	2013*	2014**	2013*	2014**	% Change	2013*	2014**	2013*	2014**	% Change	2013*	2014**	% Change
In-Network (Provider Status)													
	Jul-05		Jul-05			Jul-05		Jul-05			Jul-05		
Inpatient Services	not applicable		not applicable			not applicable		not applicable			not applicable		
Mental Health					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Substance Abuse					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Alcohol Rehab***					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Alternate Levels of Care					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Weighted Average Facility Charge	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
% of Total	#DIV/0!	#DIV/0!											
Outpatient Services	Jul-05		Jul-05			Jul-05		Jul-05	Jul-05		Jul-05		
	not applicable		not applicable			not applicable		not applicable	not applicable		not applicable		
Professional Inpatient Services													
Physician					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Psychologist					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Health Professional					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Outpatient Visits													
Physician					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Psychologist					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Health Professional					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Substance Abuse and Structured Outpatient Programs and Clinics (SOPS)					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Services Not Included Above					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Weighted Average Professional Charge	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
% of Total	#DIV/0!	#DIV/0!											
Total In-Network	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!

*Incurred 1/1/13 - 12/31/13, claims paid through 3/31/14 (average members: 1,100,000)
**Incurred 1/1/14 - 3/31/14, claims paid through 3/31/14 (average members: 1,100,000)
***Include zero paid claims

EXHIBIT H-5
Trend Analysis - YTD 2013 - Out-of-Network - Benefit Level

	Days or Services***		Days/Visits Per 1000			Amount Paid		Average Unit Cost			Cost PMPM		
	2013*	2014**	2013*	2014**	% Change	2013*	2014**	2013*	2014**	% Change	2013*	2014**	% Change
Out of Network (Provider Status)													
	Jul-05		Jul-05			Jul-05		Jul-05			Jul-05		
Inpatient Services	not applicable		not applicable			not applicable		not applicable			not applicable		
Mental Health					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Substance Abuse					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Alcohol Rehab***					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Alternate Levels of Care					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Weighted Average Facility Charge	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
% of Total	#DIV/0!	#DIV/0!											
Outpatient Services	Jul-05		Jul-05			Jul-05		Jul-05	Jul-05		Jul-05		
	not applicable		not applicable			not applicable		not applicable	not applicable		not applicable		
Professional Inpatient Services													
Physician					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Psychologist					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Health Professional					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Outpatient Visits													
Physician					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Psychologist					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Health Professional					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Substance Abuse and Structured Outpatient Programs and Clinics (SOPS)					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Services Not Included Above					#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Weighted Average Professional Charge	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
% of Total	#DIV/0!	#DIV/0!											
Total Out-of-Network	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!

*Incurred 1/1/13 - 12/31/13, claims paid through 3/31/14 (average members: 1,100,000)
**Incurred 1/1/14 - 3/31/14, claims paid through 3/31/14 (average members: 1,100,000)
***Include zero paid claims

EXHIBIT H-6
Trend Analysis - YTD 2013 - Total - Benefit Level

	Days or Services***		Days/Visits Per 1000			Amount Paid		Average Unit Cost			Cost PMPM		
	2013*	2014**	2013*	2014**	% Change	2013*	2014**	2013*	2014**	% Change	2013*	2014**	% Change
In and Out of Network (Provider Status)													
	Jul-05		Jul-05			Jul-05		Jul-05			Jul-05		
Inpatient Services	not applicable		not applicable			not applicable		not applicable			not applicable		
Mental Health	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Substance Abuse	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Alcohol Rehab***	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Alternate Levels of Care	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Weighted Average Facility Charge	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
% of Total	#DIV/0!	#DIV/0!											
Outpatient Services	Jul-05		Jul-05			Jul-05		Jul-05	Jul-05		Jul-05		
	not applicable		not applicable			not applicable		not applicable	not applicable		not applicable		
Professional Inpatient Services													
Physician	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Psychologist	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Health Professional	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Outpatient Visits													
Physician	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Psychologist	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Health Professional	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Substance Abuse and Structured Outpatient Programs and Clinics (SOPS)	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Other Services Not Included Above	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
Weighted Average Professional Charge	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!
% of Total	#DIV/0!	#DIV/0!											
Total Combined	-	-	-	-	#DIV/0!	$0	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00	#DIV/0!

*Incurred 1/1/13 - 12/31/13, claims paid through 3/31/14 (average members: 1,100,000)
**Incurred 1/1/14 - 3/31/14, claims paid through 3/31/14 (average members: 1,100,000)
***Include zero paid claims

EXHIBIT I-1
Projected 2014 Administrative Expenses, Other Retention and Interest

These amounts should equal those reported on Exhibit B-1 (Projected Program Year Experience - Total)

	Charge	Basis of Charge
Administrative Fee (Excludes Shared Communication Expense)		Projected Total Monthly Enrollment Avg of X,XXX,XXX * 12 Months X $2.(
		should = the Exh B-1 Total Amt
Communication Expenses (Shared Expenses)		Per Amendment XXXX
		should = the Exh B-1 Total Amt
Audit/Performance Penalty		identify each (if applicable)
Audit/Performance Penalty		identify each (if applicable)
Total Audit/Performance Penalties	$ -	should = the Exh B-1 Total Amt
Total Administrative Expense	$ -	should = the Exh B-1 Total Amt

Note: Paid claims is the method of allocation to Core, NY Enhancement and PA Enhancement.

EXHIBIT J-1
Reconciliation of Experience Projection for Prior Year (2013)

NOT APPLICABLE FOR 2014 REPORTING

COMBINED	**CORE**		**NY ENH**		**PA ENH**		**COMBINED**	
	Renewal	Financial	Renewal	Financial	Renewal	Financial	Renewal	Financial
1 Earned Premium (2 tier)								
2a. Paid Claims								
2b. Surcharges and Assessments								
2c. Liability of Outstanding Claims at End of Reporting Period*								
2d. Liability of Outstanding Claims at Beginning of Reporting Period*								
2e. Total Incurred Claim Cost (2a+2b+2c-2d)								
3a. Administrative Expense								
3b. Shared Communications Expenses								
3c. Audit/Performance Adjustment and Other Credits								
3f. Total Retention(3a+3b+3c)								
4 Experience Gain/(Loss) (1-2e-3f)								

2014 Qtrly Reports				
2c. 1st Qtr Ending Outstanding Claims	N/A	N/A	N/A	N/A
4 Experience Gain/(Loss)	change in what the 12/31/13 reserve would have been with new data	change in what the 12/31/13 reserve would have been with new data	change in what the 12/31/13 reserve would have been with new data	change in what the 12/31/13 reserve would have been with new data
2c. 2nd Qtr Ending Outstanding Claims	N/A	N/A	N/A	N/A
4 Experience Gain/(Loss)	change in what the 12/31/13 reserve would have been with new data	change in what the 12/31/13 reserve would have been with new data	change in what the 12/31/13 reserve would have been with new data	change in what the 12/31/13 reserve would have been with new data
2c. 3rd Qtr Ending Outstanding Claims	N/A	N/A	N/A	N/A
4 Experience Gain/(Loss)	change in what the 12/31/13 reserve would have been with new data	change in what the 12/31/13 reserve would have been with new data	change in what the 12/31/13 reserve would have been with new data	change in what the 12/31/13 reserve would have been with new data
2c. 4th Qtr Ending Outstanding Claims	N/A	N/A	N/A	N/A
4 Experience Gain/(Loss)	change in what the 12/31/13 reserve would have been with new data	change in what the 12/31/13 reserve would have been with new data	change in what the 12/31/13 reserve would have been with new data	change in what the 12/31/13 reserve would have been with new data

FORMAT: Access

DATABASE NAME: MHSA Value Options.mdb (or MHSA Value Options.accdb)

TABLE NAME: YYYY 4G

DESCRIPTION: Annual paid claims by agency code

Field	Field Name	Format – Field Size	Description
1	YEAR PAID	Text - 4	year paid (YYYY)
2	AGENCY CODE	Text – 5	5 digit NYBEAS agency code
3	YEAR INC	Text - 2	year incurred (YY)
4	NETWORK	Text – 1	Network P = In-network (Par Provider) N= Non-network
5	EEDEP	Text – 1	E = enrollee D = child/dependent /spouse/domestic partner
6	AMOUNT PAID	Number - Double	$ amount paid
7	CLAIMS	Number - Double	# of claims
8	AGENCY TYPE	Text – 1	agency type N = NY Group (NYS agency or Participating Employer) P = Participating Agency
9	CARRIER	Text - 10	CONSTANT (each record): C-MHSA

EMPIRE PLAN

Managed Mental Health and Substance Abuse Program - Customer Service Report

March 01, 2014 to March 31, 2014

	ValueOptions Performance Standard	Standard	Monthly Measure
1.	Call Center Operational	>= **99.6%**	100%
2.	% Calls with ASA < 30 Seconds	>= **91%**	99.9%
3.	Abandonment Rate	< **2%**	0%
4.	Call Blockage	**0%**	0%
5.	Claims Financial Accuracy	>= **99.1%**	100%
6.	Claims Non-Financial Accuracy	>= **95.1%**	100%
7.	TAT for member submitted claims	>= **99.6%**	100%
8.	Enrollment Files Processed within 24 hours	= **100%**	100%

FORMAT: Access

DATABASE NAME: MHSA Value Options.mdb (or MHSA Value Options.accdb)

TABLE NAME: YYYY 1A

DESCRIPTION: Monthly summary of claims paid by month of incurral

Field	Field Name	Format	Description
1	MONTH PAID	Text – 2	month paid (MM)
2	YEAR PAID	Text – 4	year paid (YYYY)
3	MONTH INC	Text – 2	month incurred (MM)
4	YEAR INC	Text – 4	year incurred (YYYY)
5	BENEFIT PROGRAM	Text – 3	benefit program
6	BENEFIT TYPE	Text – 1	Core/Enhancement 1 = Core 2 = NY Enh 3 = PA Enh 4 = Core + Enh (Total)
7	NETWORK	Text – 1	Network P = In-network (Par Provider) N= Non-network
8	MEDICARE	Text - 1	Medicare enrolled? (Y/N)
9	EE SERVICES	N	# of services – enrollees
10	EE PAID	N	$ amount paid – enrollees
11	DEP SERVICES	N	# of services – dependents
12	DEP PAID	N	$ amount paid - dependents
13	TOTAL SERVICES	N	# of services – total (enrollees + dependents)
14	TOTAL PAID	N	$ amount paid – total (enrollees + dependents)

FORMAT: Access

DATABASE NAME: MHSA Value Options.mdb (or MHSA Value Options.accdb)

TABLE NAME: YYYY 1B

DESCRIPTION: Quarterly summary of Participating Agency (PA) claims paid by medicare status.

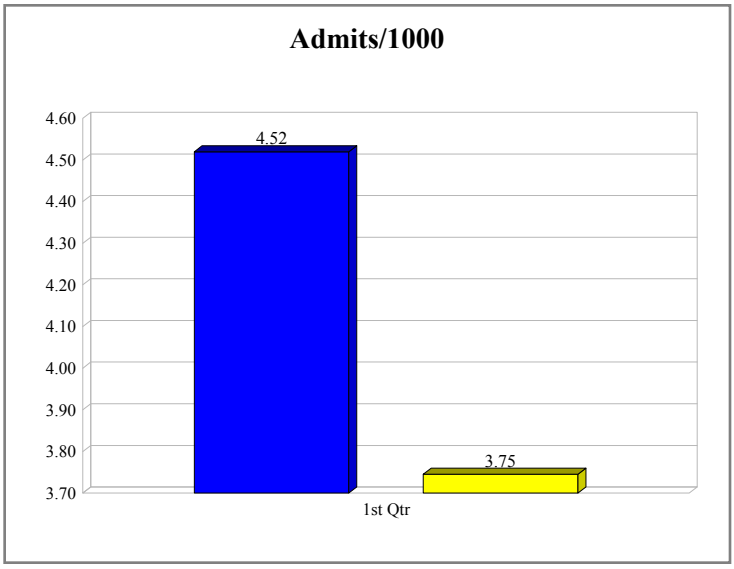
Field	Field Name	Format	Description
1	QTRPD	Text – 3	quarter paid (YYQ) YYA = 1st quarter YYB = 2nd quarter YYC = 3rd quarter YYD – 4th quarter
2	YEAR INC	Text – 4	year incurred (YYYY)
3	BENEFIT TYPE	Text – 1	Core/Enhancement 1 = Core 2 = NY Enhancement 3 = PA Enhancment 4 = Core + Enh (Total)
4	NETWORK	Text – 1	Network P = In-network (Par Provider) N= Non-network
5	AGENCY CODE	Text – 6	5 digit NYBEAS agency code
6	COV	Text – 1	coverage type I = individual F = family
7	MEDICARE	Text – 1	Y = medicare N = non-medicare
8	EE SERVICES	N	# of services – enrollees
9	EE PAID	N	$ amount paid – enrollees
10	DEP SERVICES	N	# of services – dependents
11	DEP PAID	N	$ amount paid - dependents
12	TOTAL SERVICES	N	# of services – total (enrollees + dependents)
13	TOTAL PAID	N	$ amount paid – total (enrollees + dependents)

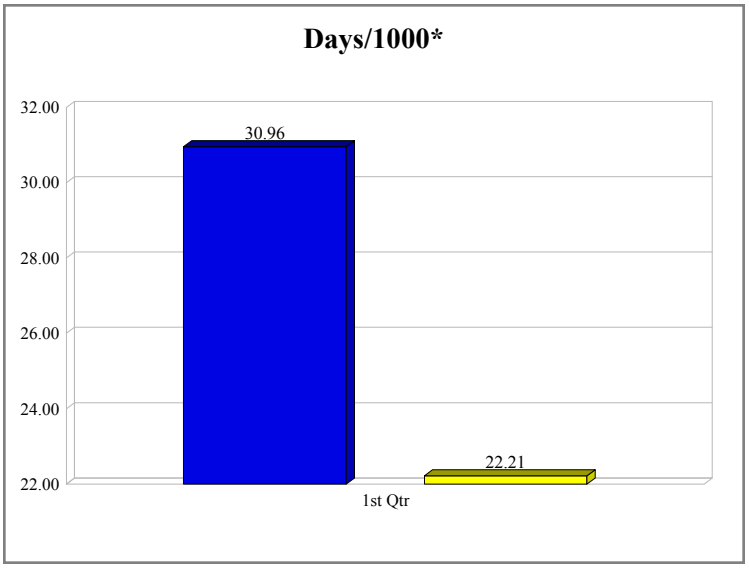
New York State Empire Plan
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

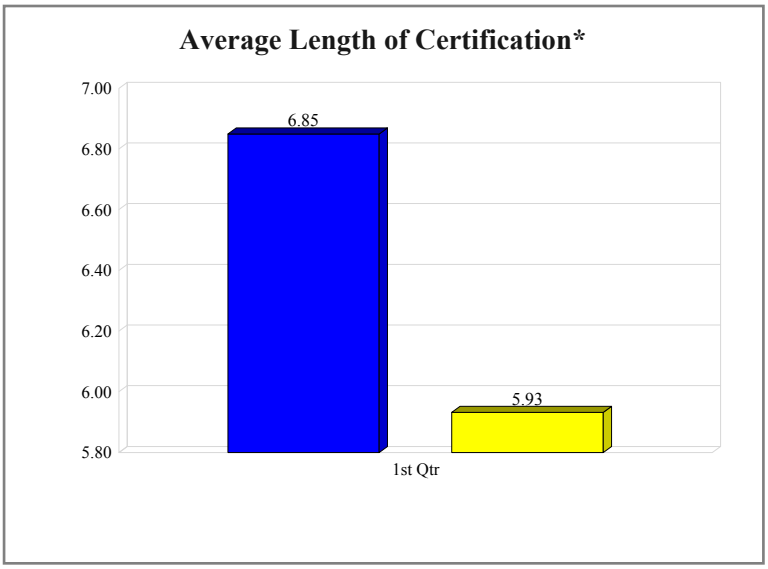
Acute Inpatient & Alternative Levels of Care Utilization
Psychiatric vs Substance Abuse

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	1,094,786	0	0	0	1,094,786

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	1,237	1,025	0	0	0	0	0	0	1,237	1,025
Days*	8,473	6,080	0	0	0	0	0	0	8,473	6,080
Admissions/1000 Lives	4.52	3.75	0.00	0.00	0.00	0.00	0.00	0.00	4.52	3.75
Days/1000 Lives*	30.96	22.21	0.00	0.00	0.00	0.00	0.00	0.00	30.96	22.21
Avg Length of Certification*	6.85	5.93	0.00	0.00	0.00	0.00	0.00	0.00	6.85	5.93







Alternative Modality Ratios have been applied.

** All data has been annualized.*

New York State Empire Plan
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

Total Acute Inpatient & Alternative Levels of Care Detail
Psychiatric vs Substance Abuse

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	1,094,786	0	0	0	1,094,786

ACUTE INPATIENT

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	811	402	0	0	0	0	0	0	811	402
Days*	6,692	3,238	0	0	0	0	0	0	6,692	3,238
Admissions/1000 Lives	2.96	1.47	0.00	0.00	0.00	0.00	0.00	0.00	2.96	1.47
Days/1000 Lives*	24.45	11.83	0.00	0.00	0.00	0.00	0.00	0.00	24.45	11.83
Avg Length of Certification*	8.25	8.05	0.00	0.00	0.00	0.00	0.00	0.00	8.25	8.05

RESIDENTIAL TREATMENT PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	27	51	0	0	0	0	0	0	27	51
Days*	348	342	0	0	0	0	0	0	348	342
Admissions/1000 Lives	0.10	0.19	0.00	0.00	0.00	0.00	0.00	0.00	0.10	0.19
Days/1000 Lives*	1.27	1.25	0.00	0.00	0.00	0.00	0.00	0.00	1.27	1.25
Avg Length of Certification*	12.89	6.70	0.00	0.00	0.00	0.00	0.00	0.00	12.89	6.70

PARTIAL HOSPITALIZATION PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	213	222	0	0	0	0	0	0	213	222
Days*	1,146	1,390	0	0	0	0	0	0	1,146	1,390
Admissions/1000 Lives	0.78	0.81	0.00	0.00	0.00	0.00	0.00	0.00	0.78	0.81
Days/1000 Lives*	4.19	5.08	0.00	0.00	0.00	0.00	0.00	0.00	4.19	5.08
Avg Length of Certification*	5.38	6.26	0.00	0.00	0.00	0.00	0.00	0.00	5.38	6.26

IOP/GROUP HOME/HALFWAY HOUSE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	186	350	0	0	0	0	0	0	186	350
Days*	287	1,111	0	0	0	0	0	0	287	1,111
Admissions/1000 Lives	0.68	1.28	0.00	0.00	0.00	0.00	0.00	0.00	0.68	1.28
Days/1000 Lives*	1.05	4.06	0.00	0.00	0.00	0.00	0.00	0.00	1.05	4.06
Avg Length of Certification*	1.55	3.17	0.00	0.00	0.00	0.00	0.00	0.00	1.55	3.17

TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	1,237	1,025	0	0	0	0	0	0	1,237	1,025
Days*	8,473	6,080	0	0	0	0	0	0	8,473	6,080
Admissions/1000 Lives	4.52	3.75	0.00	0.00	0.00	0.00	0.00	0.00	4.52	3.75
Days/1000 Lives*	30.96	22.21	0.00	0.00	0.00	0.00	0.00	0.00	30.96	22.21
Avg Length of Certification*	6.85	5.93	0.00	0.00	0.00	0.00	0.00	0.00	6.85	5.93

**Alternative Modality Ratios have been applied.*

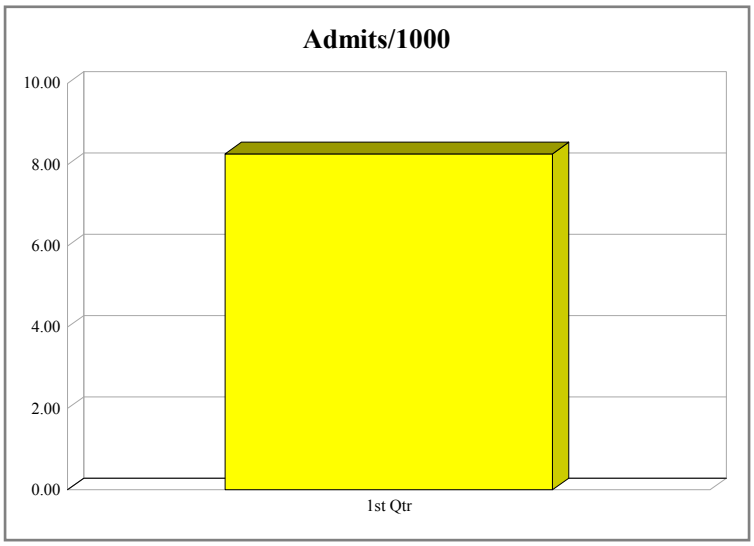
*** All data has been annualized.*

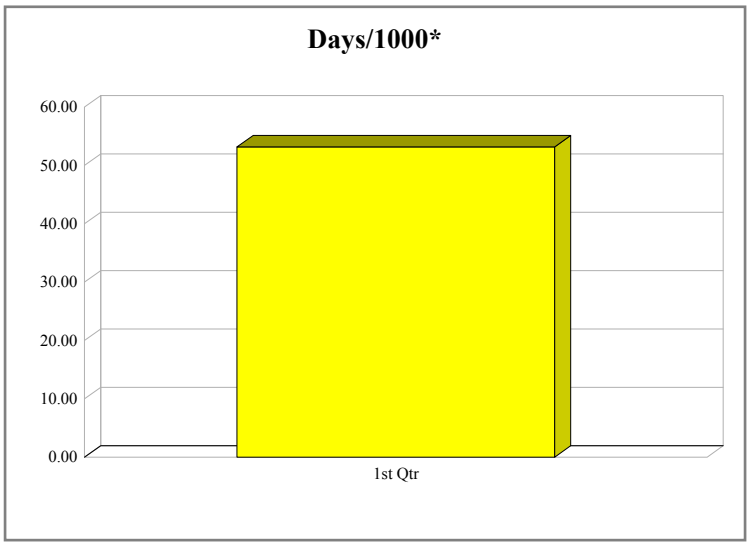
New York State Empire Plan
Managed Mental Health and Substance Abuse Activity Report

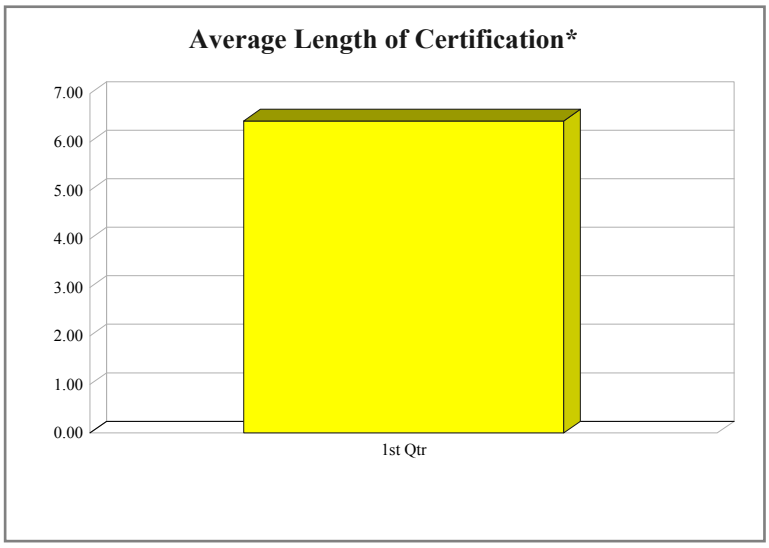
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	1,094,786	0	0	0	1,094,786
Admissions	2,262	0	0	0	2,262
Days*	14,553	0	0	0	14,553
Admissions/1000 Lives	8.26	0.00	0.00	0.00	8.26
Days/1000 Lives*	53.17	0.00	0.00	0.00	53.17
Avg Length of Certification*	6.43	0.00	0.00	0.00	6.43







*Alternative Modality Ratios have been applied.

** All data has been annualized.

New York State Empire Plan
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

Total Acute Inpatient and Alternative Levels of Care Detail

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	1,094,786	0	0	0	1,094,786
ACUTE INPATIENT					
Admissions	1,213	0	0	0	1,213
Days*	9,930	0	0	0	9,930
Admissions/1000 Lives	4.43	0.00	0.00	0.00	4.43
Days/1000 Lives*	36.28	0.00	0.00	0.00	36.28
Avg Length of Certification*	8.19	0.00	0.00	0.00	8.19
RESIDENTIAL TREATMENT PROGRAM					
Admissions	78	0	0	0	78
Days*	690	0	0	0	690
Admissions/1000 Lives	0.28	0.00	0.00	0.00	0.28
Days/1000 Lives*	2.52	0.00	0.00	0.00	2.52
Avg Length of Certification*	8.84	0.00	0.00	0.00	8.84
PARTIAL HOSPITALIZATION PROGRAM					
Admissions	435	0	0	0	435
Days*	2,536	0	0	0	2,536
Admissions/1000 Lives	1.59	0.00	0.00	0.00	1.59
Days/1000 Lives*	9.26	0.00	0.00	0.00	9.26
Avg Length of Certification*	5.83	0.00	0.00	0.00	5.83
IOP/GROUP HOME/HALFWAY HOUSE					
Admissions	536	0	0	0	536
Days*	1,398	0	0	0	1,398
Admissions/1000 Lives	1.96	0.00	0.00	0.00	1.96
Days/1000 Lives*	5.11	0.00	0.00	0.00	5.11
Avg Length of Certification*	2.61	0.00	0.00	0.00	2.61
TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE					
Admissions	2,262	0	0	0	2,262
Days*	14,553	0	0	0	14,553
Admissions/1000 Lives	8.26	0.00	0.00	0.00	8.26
Days/1000 Lives*	53.17	0.00	0.00	0.00	53.17
Avg Length of Certification*	6.43	0.00	0.00	0.00	6.43

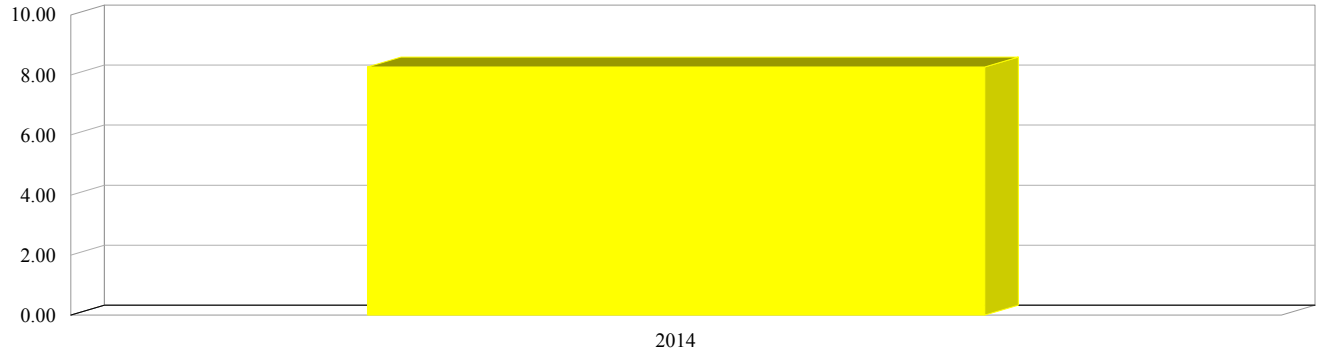
**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

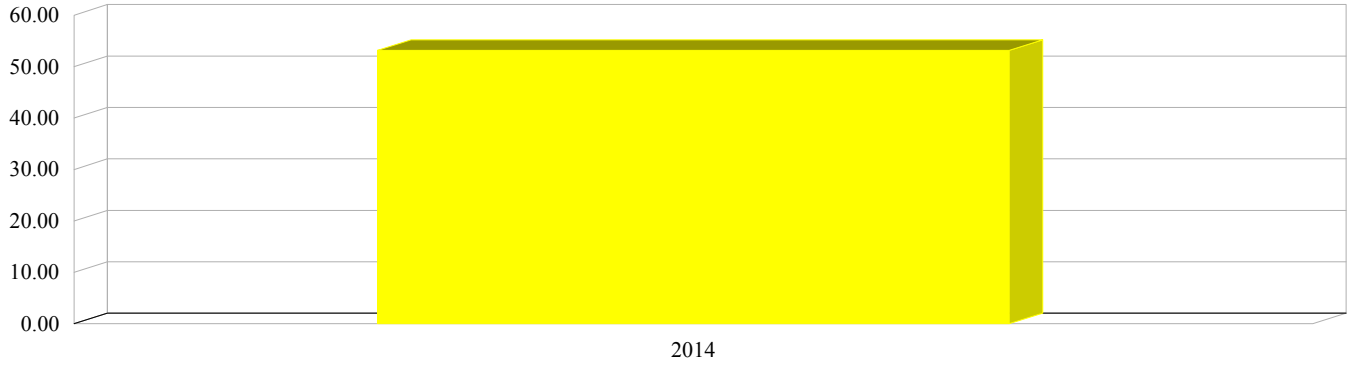
New York State Empire Plan
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

Utilization Trends - Inpatient and Higher Level of Care

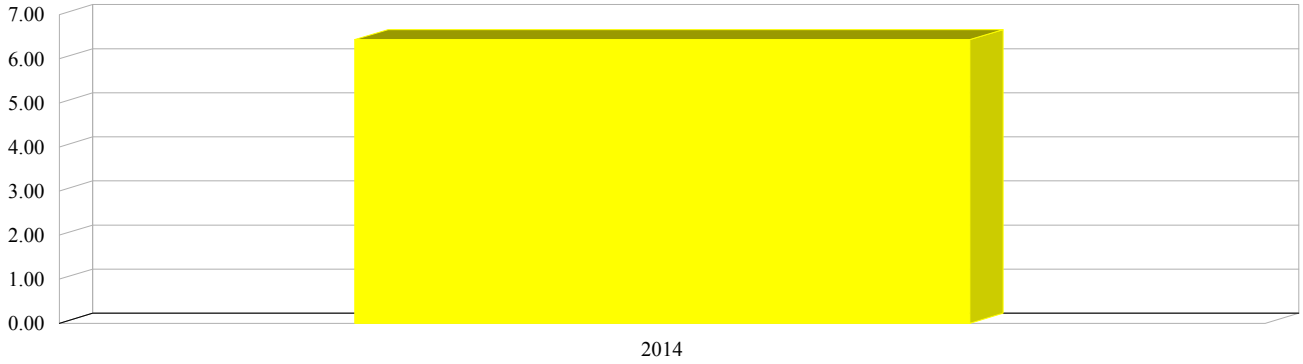
Admissions/1000 Lives



Days/1000 Lives*



Average Length of Certification*



*Alternative Modality Ratios have been applied.

** All data has been annualized.

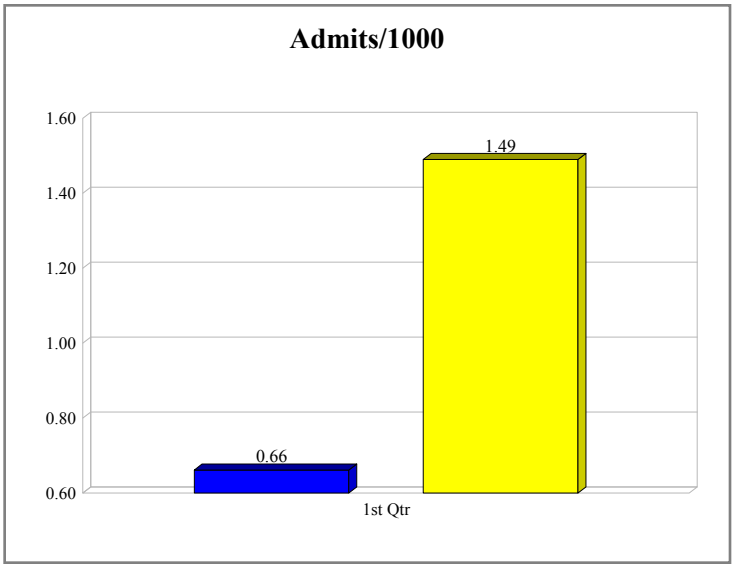
*** The last column represents the reporting period only, not necessarily the full year.

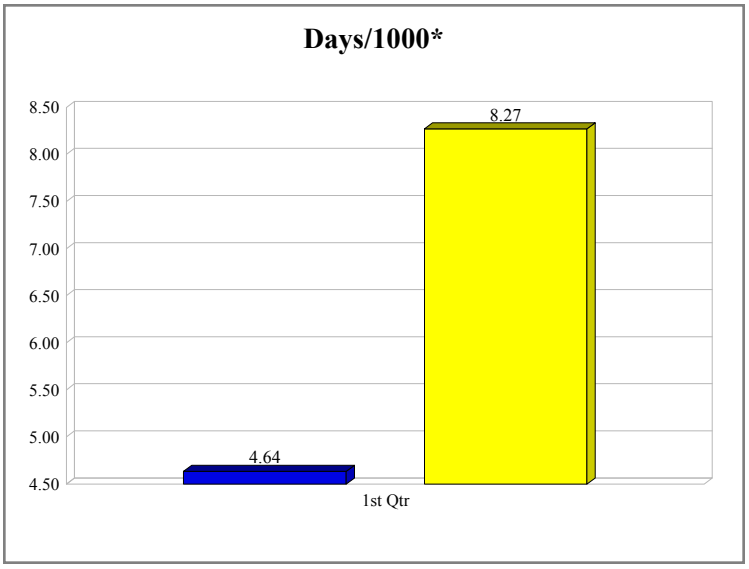
New York State Empire Plan
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

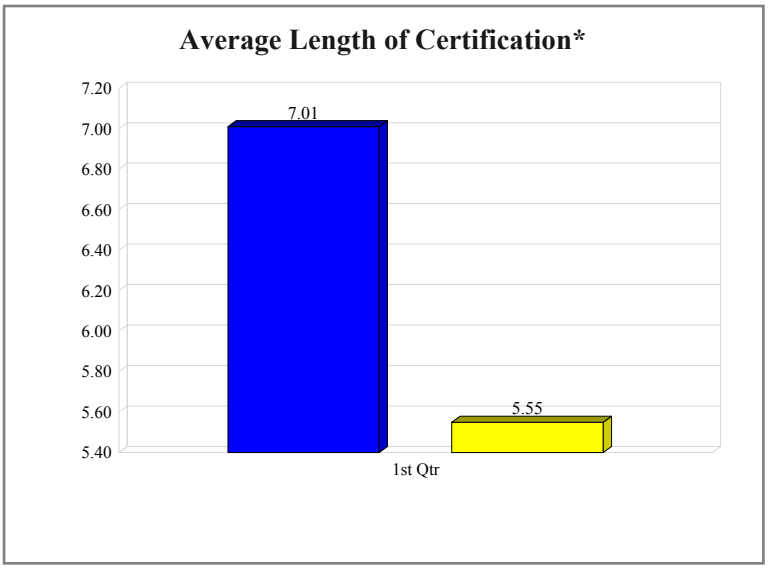
Acute Inpatient & Alternative Levels of Care Utilization - Out of Network
Psychiatric vs Substance Abuse

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	1,094,786	0	0	0	1,094,786

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	181	408	0	0	0	0	0	0	181	408
Days*	1,269	2,264	0	0	0	0	0	0	1,269	2,264
Admissions/1000 Lives	0.66	1.49	0.00	0.00	0.00	0.00	0.00	0.00	0.66	1.49
Days/1000 Lives*	4.64	8.27	0.00	0.00	0.00	0.00	0.00	0.00	4.64	8.27
Avg Length of Certification*	7.01	5.55	0.00	0.00	0.00	0.00	0.00	0.00	7.01	5.55







Alternative Modality Ratios have been applied.

** All data has been annualized.*

New York State Empire Plan

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient & Alternative Levels of Care Detail - Out of Network
Psychiatric vs Substance Abuse

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	1,094,786	0	0	0	1,094,786

ACUTE INPATIENT

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	123	102	0	0	0	0	0	0	123	102
Days*	1,143	768	0	0	0	0	0	0	1,143	768
Admissions/1000 Lives	0.45	0.37	0.00	0.00	0.00	0.00	0.00	0.00	0.45	0.37
Days/1000 Lives*	4.18	2.81	0.00	0.00	0.00	0.00	0.00	0.00	4.18	2.81
Avg Length of Certification*	9.29	7.53	0.00	0.00	0.00	0.00	0.00	0.00	9.29	7.53

PARTIAL HOSPITALIZATION PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	14	154	0	0	0	0	0	0	14	154
Days*	66	966	0	0	0	0	0	0	66	966
Admissions/1000 Lives	0.05	0.56	0.00	0.00	0.00	0.00	0.00	0.00	0.05	0.56
Days/1000 Lives*	0.24	3.53	0.00	0.00	0.00	0.00	0.00	0.00	0.24	3.53
Avg Length of Certification*	4.71	6.27	0.00	0.00	0.00	0.00	0.00	0.00	4.71	6.27

IOP/GROUP HOME/HALFWAY HOUSE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	44	152	0	0	0	0	0	0	44	152
Days*	60	531	0	0	0	0	0	0	60	531
Admissions/1000 Lives	0.16	0.56	0.00	0.00	0.00	0.00	0.00	0.00	0.16	0.56
Days/1000 Lives*	0.22	1.94	0.00	0.00	0.00	0.00	0.00	0.00	0.22	1.94
Avg Length of Certification*	1.36	3.49	0.00	0.00	0.00	0.00	0.00	0.00	1.36	3.49

TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	181	408	0	0	0	0	0	0	181	408
Days*	1,269	2,264	0	0	0	0	0	0	1,269	2,264
Admissions/1000 Lives	0.66	1.49	0.00	0.00	0.00	0.00	0.00	0.00	0.66	1.49
Days/1000 Lives*	4.64	8.27	0.00	0.00	0.00	0.00	0.00	0.00	4.64	8.27
Avg Length of Certification*	7.01	5.55	0.00	0.00	0.00	0.00	0.00	0.00	7.01	5.55

**Alternative Modality Ratios have been applied.*

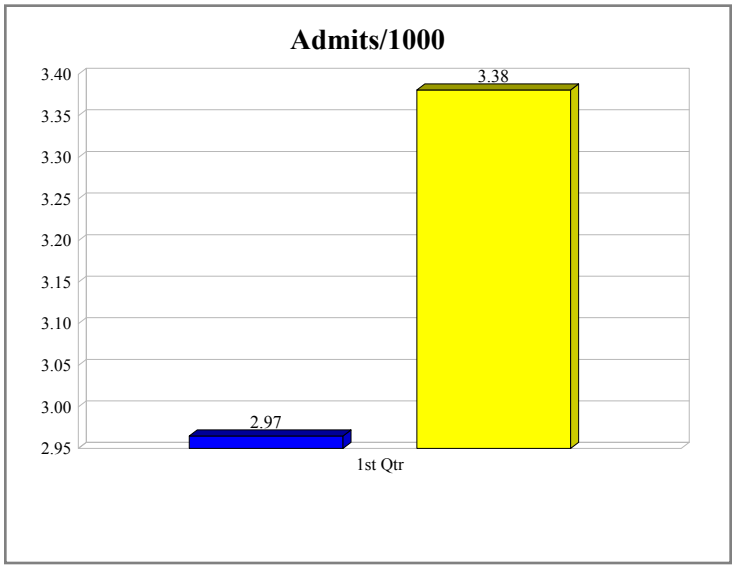
*** All data has been annualized.*

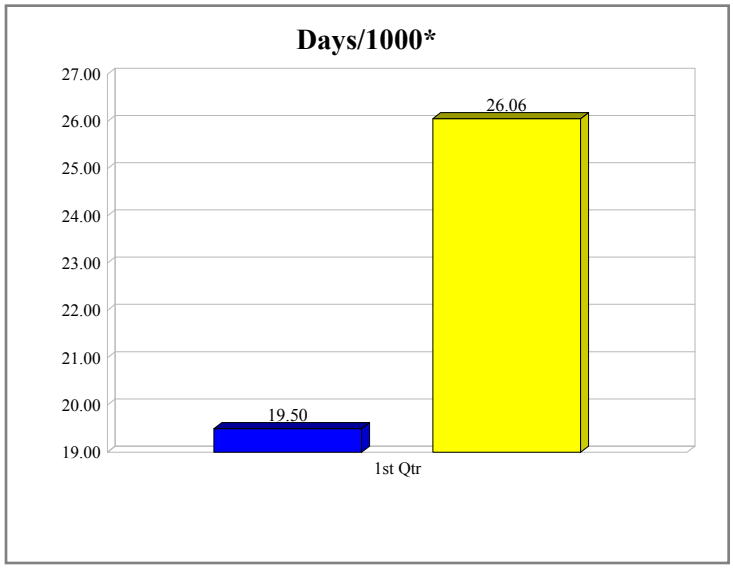
New York State Empire Plan - CENTRAL NY
Managed Mental Health and Substance Abuse Activity Report

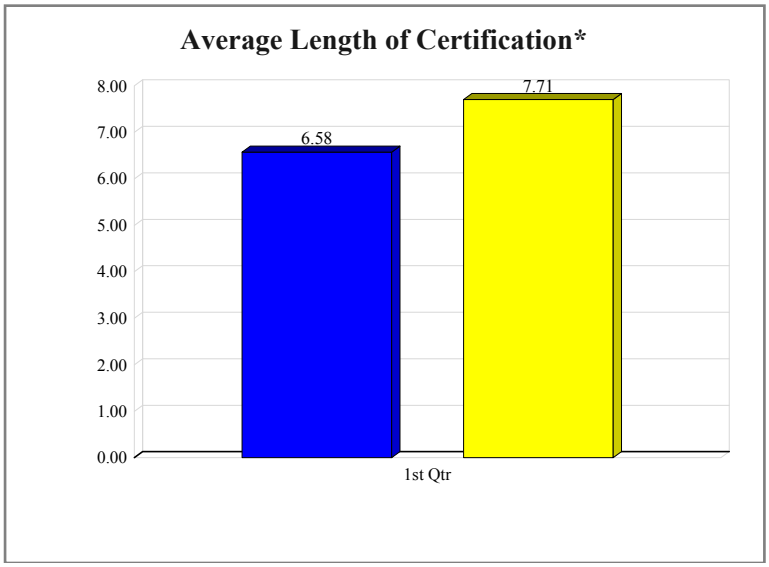
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization
Psychiatric vs Substance Abuse - By Group

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Year to Date	
Avg Covered Lives	153,791		0		0		0		153,791	
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	114	130	0	0	0	0	0	0	114	130
Days*	750	1,002	0	0	0	0	0	0	750	1,002
Admissions/1000 Lives	2.97	3.38	0.00	0.00	0.00	0.00	0.00	0.00	2.97	3.38
Days/1000 Lives*	19.50	26.06	0.00	0.00	0.00	0.00	0.00	0.00	19.50	26.06
Avg Length of Certification*	6.58	7.71	0.00	0.00	0.00	0.00	0.00	0.00	6.58	7.71







Alternative Modality Ratios have been applied.

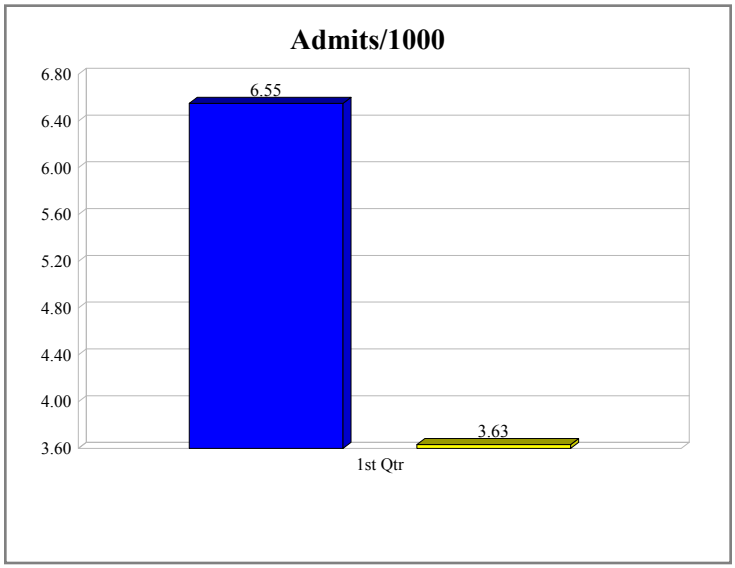
*** All data has been annualized.*

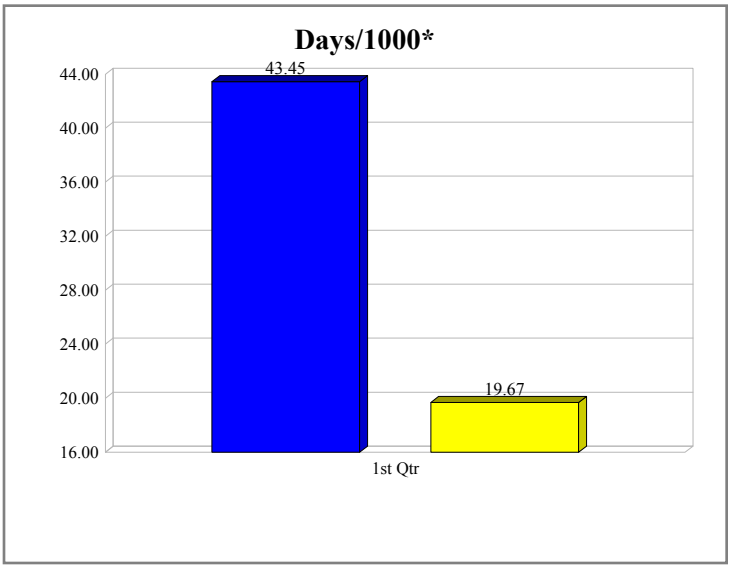
New York State Empire Plan - HUDSON VALLEY
Managed Mental Health and Substance Abuse Activity Report

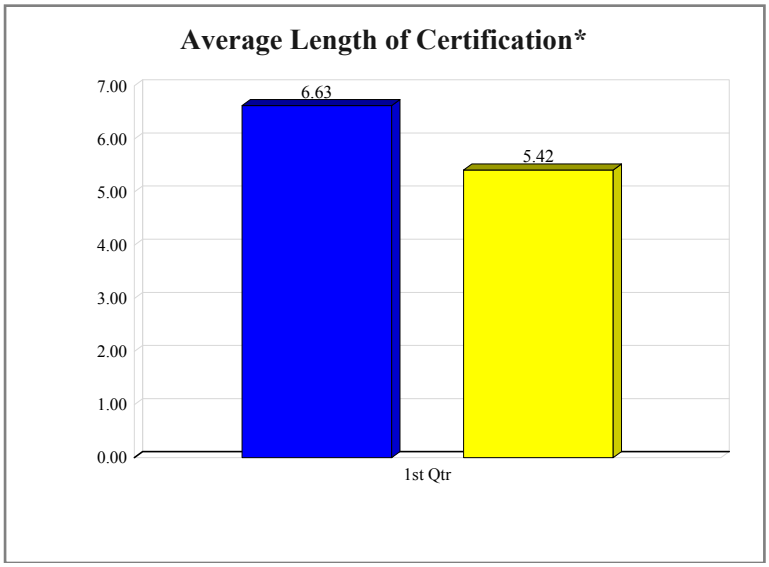
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization
Psychiatric vs Substance Abuse - By Group

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Year to Date	
Avg Covered Lives	290,648		0		0		0		290,648	
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	476	264	0	0	0	0	0	0	476	264
Days*	3,157	1,430	0	0	0	0	0	0	3,157	1,430
Admissions/1000 Lives	6.55	3.63	0.00	0.00	0.00	0.00	0.00	0.00	6.55	3.63
Days/1000 Lives*	43.45	19.67	0.00	0.00	0.00	0.00	0.00	0.00	43.45	19.67
Avg Length of Certification*	6.63	5.42	0.00	0.00	0.00	0.00	0.00	0.00	6.63	5.42







*Alternative Modality Ratios have been applied.

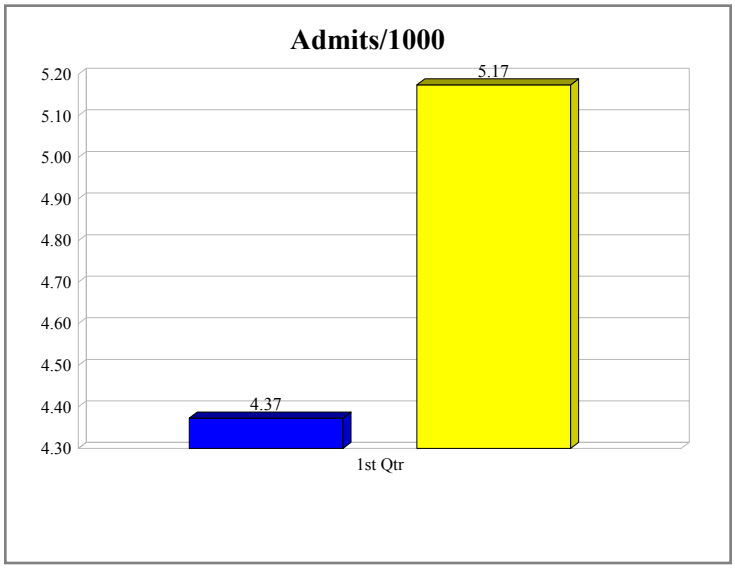
** All data has been annualized.

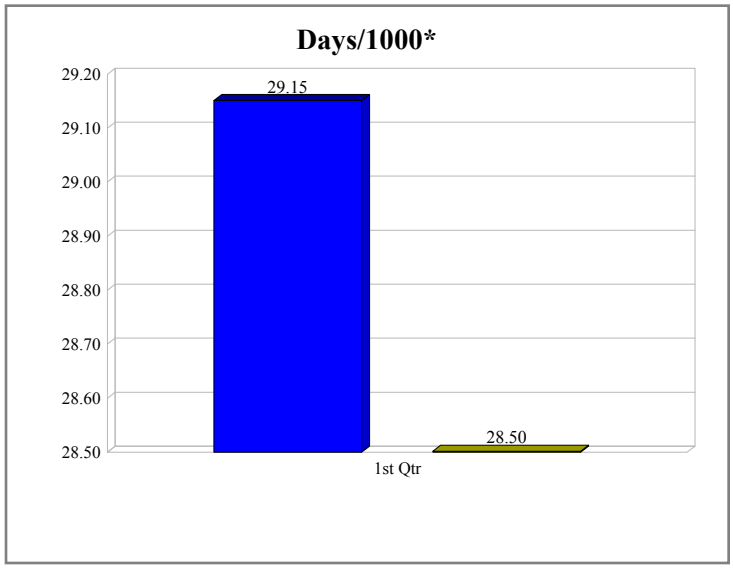
New York State Empire Plan - LONG ISLAND
Managed Mental Health and Substance Abuse Activity Report

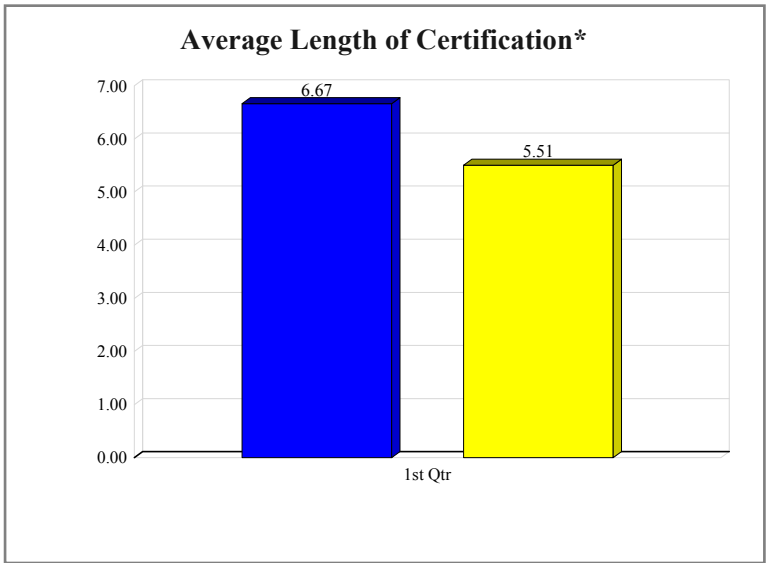
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization
Psychiatric vs Substance Abuse - By Group

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Year to Date	
Avg Covered Lives	364,058		0		0		0		364,058	
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	398	471	0	0	0	0	0	0	398	471
Days*	2,653	2,594	0	0	0	0	0	0	2,653	2,594
Admissions/1000 Lives	4.37	5.17	0.00	0.00	0.00	0.00	0.00	0.00	4.37	5.17
Days/1000 Lives*	29.15	28.50	0.00	0.00	0.00	0.00	0.00	0.00	29.15	28.50
Avg Length of Certification*	6.67	5.51	0.00	0.00	0.00	0.00	0.00	0.00	6.67	5.51







Alternative Modality Ratios have been applied.

** All data has been annualized.*

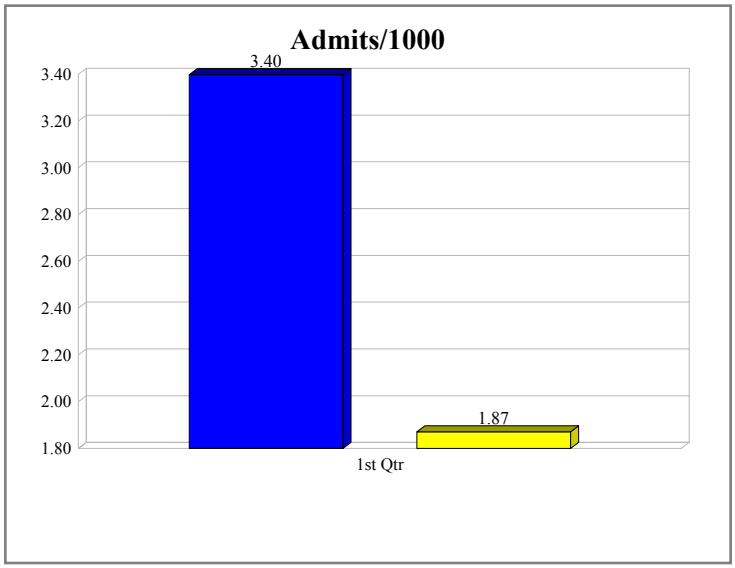
Report # 2001.1.02

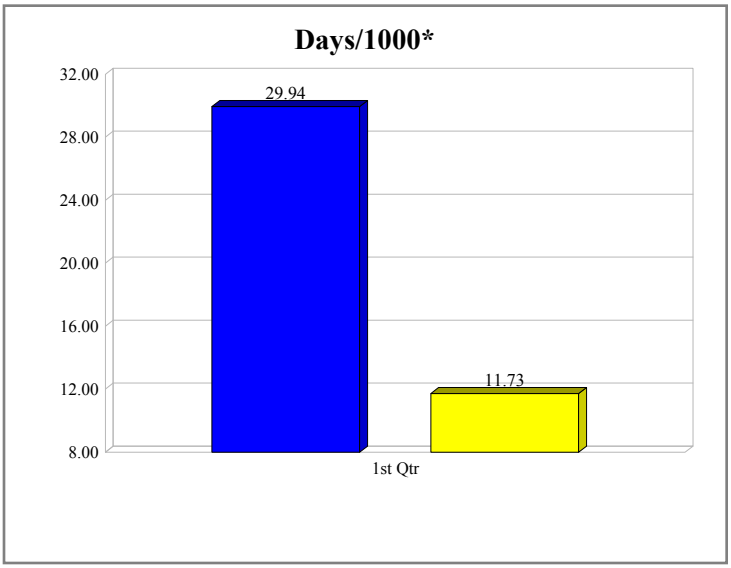
New York State Empire Plan - NY CITY
Managed Mental Health and Substance Abuse Activity Report

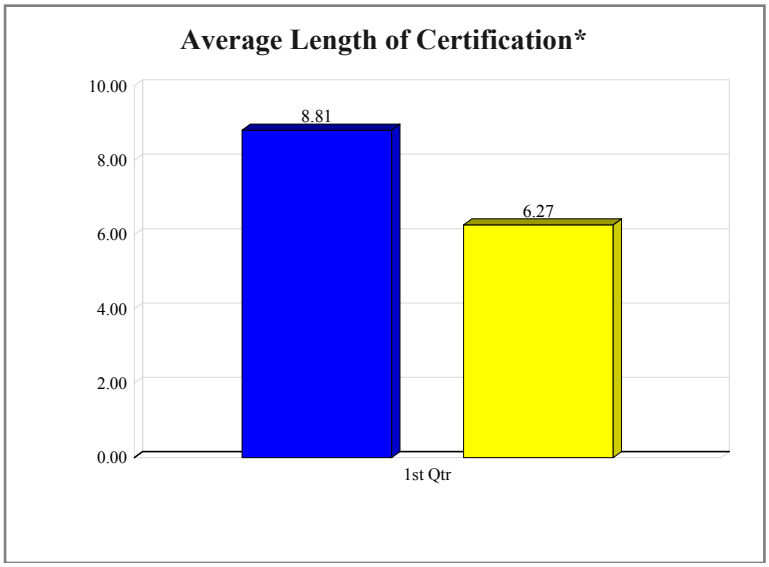
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization
Psychiatric vs Substance Abuse - By Group

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Year to Date	
Avg Covered Lives	104,749		0		0		0		104,749	
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	89	49	0	0	0	0	0	0	89	49
Days*	784	307	0	0	0	0	0	0	784	307
Admissions/1000 Lives	3.40	1.87	0.00	0.00	0.00	0.00	0.00	0.00	3.40	1.87
Days/1000 Lives*	29.94	11.73	0.00	0.00	0.00	0.00	0.00	0.00	29.94	11.73
Avg Length of Certification*	8.81	6.27	0.00	0.00	0.00	0.00	0.00	0.00	8.81	6.27







Alternative Modality Ratios have been applied.

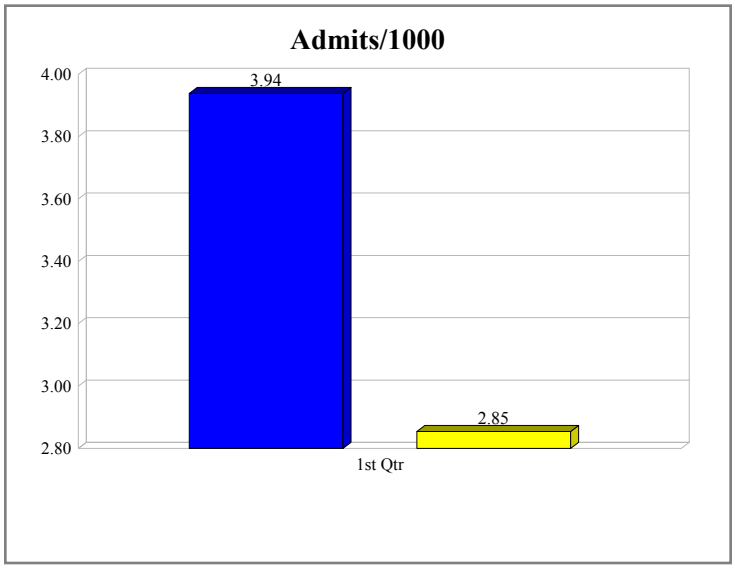
** All data has been annualized.*

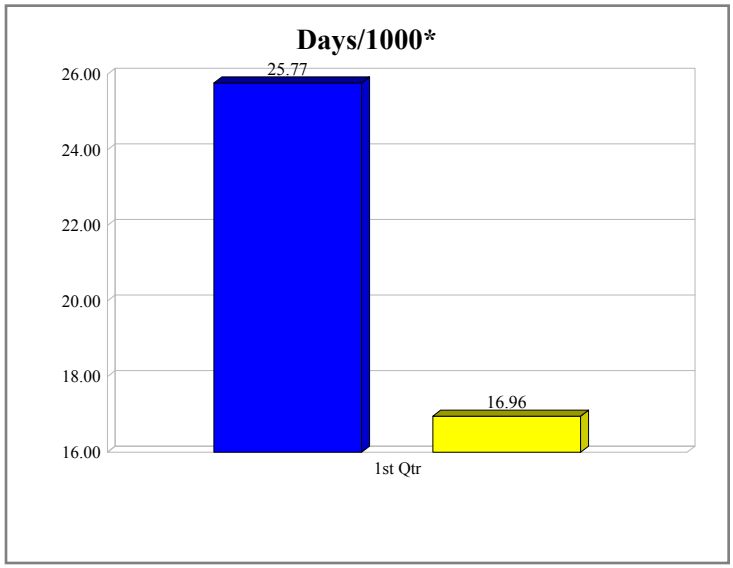
New York State Empire Plan - OUT OF STATE
Managed Mental Health and Substance Abuse Activity Report

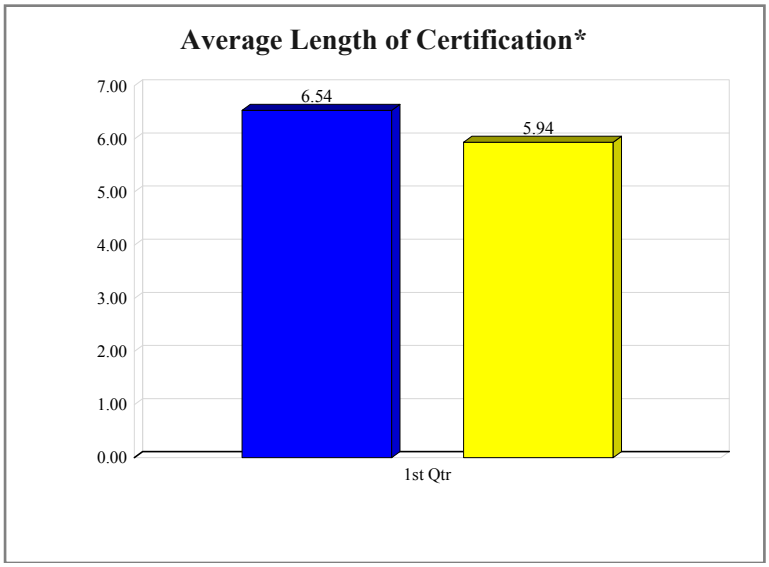
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization
Psychiatric vs Substance Abuse - By Group

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Year to Date	
Avg Covered Lives	110,686		0		0		0		110,686	
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	109	79	0	0	0	0	0	0	109	79
Days*	713	469	0	0	0	0	0	0	713	469
Admissions/1000 Lives	3.94	2.85	0.00	0.00	0.00	0.00	0.00	0.00	3.94	2.85
Days/1000 Lives*	25.77	16.96	0.00	0.00	0.00	0.00	0.00	0.00	25.77	16.96
Avg Length of Certification*	6.54	5.94	0.00	0.00	0.00	0.00	0.00	0.00	6.54	5.94







Alternative Modality Ratios have been applied.

*** All data has been annualized.*

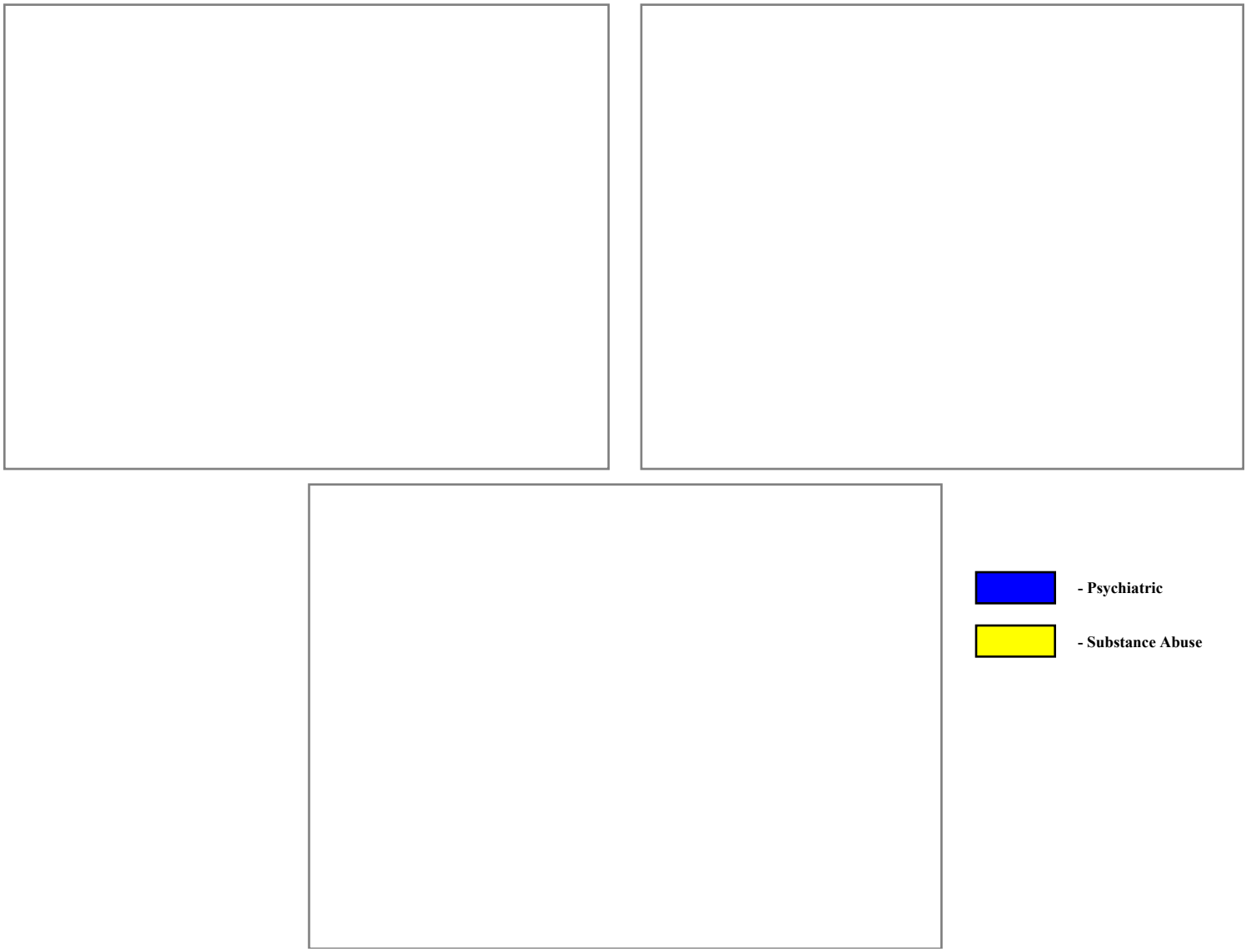
Report # 2001.1.02

New York State Empire Plan - UNKNOWN
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization
Psychiatric vs Substance Abuse - By Group

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Year to Date	
Avg Covered Lives	668		0		0		0		668	
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	0	0	0	0	0	0	0	0	0	0
Days*	0	0	0	0	0	0	0	0	0	0
Admissions/1000 Lives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Days/1000 Lives*	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Avg Length of Certification*	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



Alternative Modality Ratios have been applied.

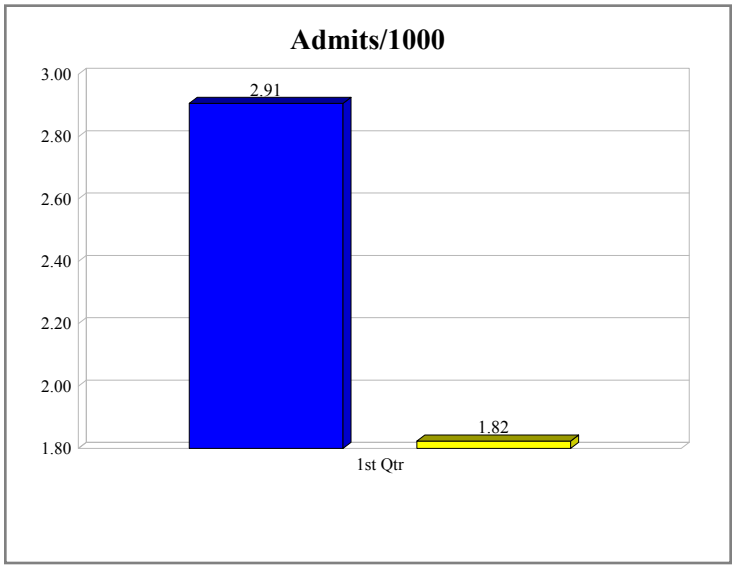
** All data has been annualized.*

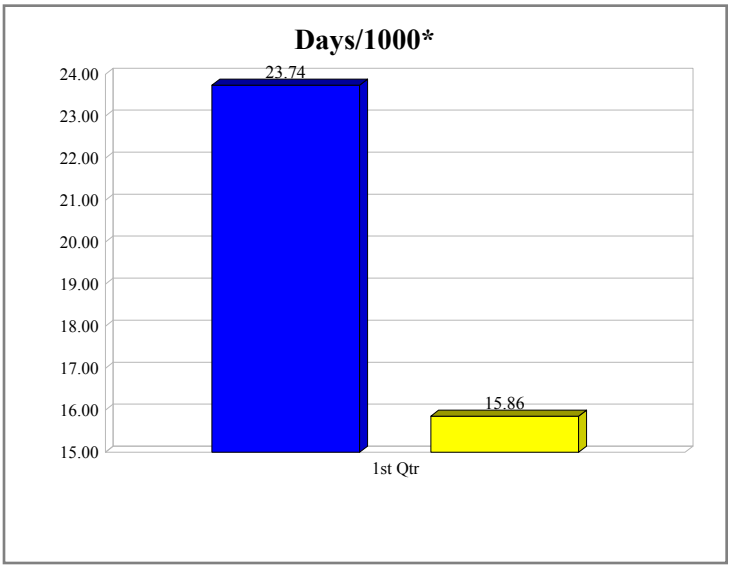
New York State Empire Plan - WESTERN NY
Managed Mental Health and Substance Abuse Activity Report

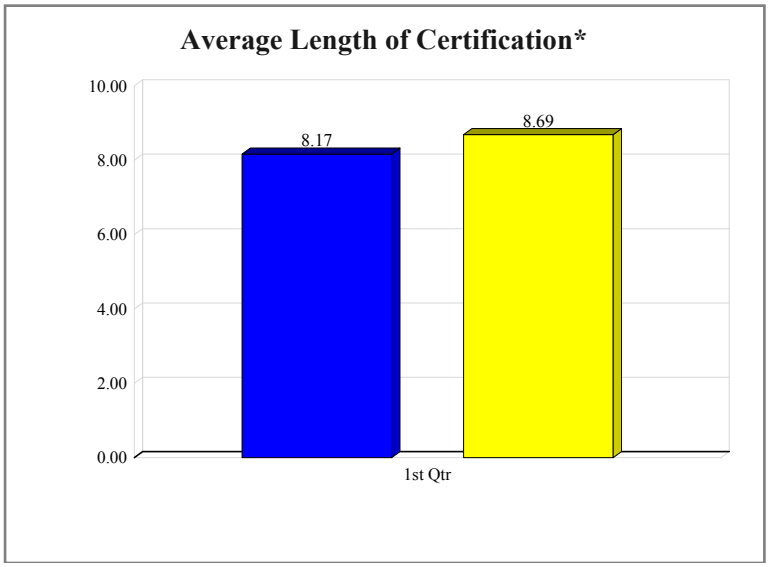
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization
Psychiatric vs Substance Abuse - By Group

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		Year to Date	
Avg Covered Lives	70,186		0		0		0		70,186	
	Psych	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**	**Psych**	**SA**
Admissions	51	32	0	0	0	0	0	0	51	32
Days*	417	278	0	0	0	0	0	0	417	278
Admissions/1000 Lives	2.91	1.82	0.00	0.00	0.00	0.00	0.00	0.00	2.91	1.82
Days/1000 Lives*	23.74	15.86	0.00	0.00	0.00	0.00	0.00	0.00	23.74	15.86
Avg Length of Certification*	8.17	8.69	0.00	0.00	0.00	0.00	0.00	0.00	8.17	8.69







Alternative Modality Ratios have been applied.

*** All data has been annualized.*

New York State Empire Plan - CENTRAL NY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient & Alternative Levels of Care Detail by Group

Psychiatric vs Substance Abuse

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	153,791	0	0	0	153,791

ACUTE INPATIENT

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	99	66	0	0	0	0	0	0	99	66
Days*	673	722	0	0	0	0	0	0	673	722
Admissions/1000 Lives	2.57	1.72	0.00	0.00	0.00	0.00	0.00	0.00	2.57	1.72
Days/1000 Lives*	17.50	18.78	0.00	0.00	0.00	0.00	0.00	0.00	17.50	18.78
Avg Length of Certification*	6.80	10.94	0.00	0.00	0.00	0.00	0.00	0.00	6.80	10.94

RESIDENTIAL TREATMENT PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	1	6	0	0	0	0	0	0	1	6
Days*	16	32	0	0	0	0	0	0	16	32
Admissions/1000 Lives	0.03	0.16	0.00	0.00	0.00	0.00	0.00	0.00	0.03	0.16
Days/1000 Lives*	0.42	0.83	0.00	0.00	0.00	0.00	0.00	0.00	0.42	0.83
Avg Length of Certification*	16.00	5.33	0.00	0.00	0.00	0.00	0.00	0.00	16.00	5.33

PARTIAL HOSPITALIZATION PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	5	21	0	0	0	0	0	0	5	21
Days*	41	128	0	0	0	0	0	0	41	128
Admissions/1000 Lives	0.13	0.55	0.00	0.00	0.00	0.00	0.00	0.00	0.13	0.55
Days/1000 Lives*	1.07	3.33	0.00	0.00	0.00	0.00	0.00	0.00	1.07	3.33
Avg Length of Certification*	8.20	6.10	0.00	0.00	0.00	0.00	0.00	0.00	8.20	6.10

IOP/GROUP HOME/HALFWAY HOUSE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	9	37	0	0	0	0	0	0	9	37
Days*	20	120	0	0	0	0	0	0	20	120
Admissions/1000 Lives	0.23	0.96	0.00	0.00	0.00	0.00	0.00	0.00	0.23	0.96
Days/1000 Lives*	0.51	3.12	0.00	0.00	0.00	0.00	0.00	0.00	0.51	3.12
Avg Length of Certification*	2.20	3.24	0.00	0.00	0.00	0.00	0.00	0.00	2.20	3.24

TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	114	130	0	0	0	0	0	0	114	130
Days*	750	1,002	0	0	0	0	0	0	750	1,002
Admissions/1000 Lives	2.97	3.38	0.00	0.00	0.00	0.00	0.00	0.00	2.97	3.38
Days/1000 Lives*	19.50	26.06	0.00	0.00	0.00	0.00	0.00	0.00	19.50	26.06
Avg Length of Certification*	6.58	7.71	0.00	0.00	0.00	0.00	0.00	0.00	6.58	7.71

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

Report # 2003.1.02

New York State Empire Plan - HUDSON VALLEY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient & Alternative Levels of Care Detail by Group

Psychiatric vs Substance Abuse

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	290,648	0	0	0	290,648

ACUTE INPATIENT

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	292	118	0	0	0	0	0	0	292	118
Days*	2,502	795	0	0	0	0	0	0	2,502	795
Admissions/1000 Lives	4.02	1.62	0.00	0.00	0.00	0.00	0.00	0.00	4.02	1.62
Days/1000 Lives*	34.43	10.94	0.00	0.00	0.00	0.00	0.00	0.00	34.43	10.94
Avg Length of Certification*	8.57	6.74	0.00	0.00	0.00	0.00	0.00	0.00	8.57	6.74

RESIDENTIAL TREATMENT PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	8	13	0	0	0	0	0	0	8	13
Days*	119	89	0	0	0	0	0	0	119	89
Admissions/1000 Lives	0.11	0.18	0.00	0.00	0.00	0.00	0.00	0.00	0.11	0.18
Days/1000 Lives*	1.63	1.22	0.00	0.00	0.00	0.00	0.00	0.00	1.63	1.22
Avg Length of Certification*	14.81	6.85	0.00	0.00	0.00	0.00	0.00	0.00	14.81	6.85

PARTIAL HOSPITALIZATION PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	82	50	0	0	0	0	0	0	82	50
Days*	410	280	0	0	0	0	0	0	410	280
Admissions/1000 Lives	1.13	0.69	0.00	0.00	0.00	0.00	0.00	0.00	1.13	0.69
Days/1000 Lives*	5.64	3.85	0.00	0.00	0.00	0.00	0.00	0.00	5.64	3.85
Avg Length of Certification*	4.99	5.60	0.00	0.00	0.00	0.00	0.00	0.00	4.99	5.60

IOP/GROUP HOME/HALFWAY HOUSE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	94	83	0	0	0	0	0	0	94	83
Days*	127	266	0	0	0	0	0	0	127	266
Admissions/1000 Lives	1.29	1.14	0.00	0.00	0.00	0.00	0.00	0.00	1.29	1.14
Days/1000 Lives*	1.75	3.66	0.00	0.00	0.00	0.00	0.00	0.00	1.75	3.66
Avg Length of Certification*	1.35	3.20	0.00	0.00	0.00	0.00	0.00	0.00	1.35	3.20

TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	476	264	0	0	0	0	0	0	476	264
Days*	3,157	1,430	0	0	0	0	0	0	3,157	1,430
Admissions/1000 Lives	6.55	3.63	0.00	0.00	0.00	0.00	0.00	0.00	6.55	3.63
Days/1000 Lives*	43.45	19.67	0.00	0.00	0.00	0.00	0.00	0.00	43.45	19.67
Avg Length of Certification*	6.63	5.42	0.00	0.00	0.00	0.00	0.00	0.00	6.63	5.42

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

New York State Empire Plan - LONG ISLAND

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient & Alternative Levels of Care Detail by Group

Psychiatric vs Substance Abuse

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	364,058	0	0	0	364,058

ACUTE INPATIENT

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	245	157	0	0	0	0	0	0	245	157
Days*	1,992	1,150	0	0	0	0	0	0	1,992	1,150
Admissions/1000 Lives	2.69	1.72	0.00	0.00	0.00	0.00	0.00	0.00	2.69	1.72
Days/1000 Lives*	21.89	12.64	0.00	0.00	0.00	0.00	0.00	0.00	21.89	12.64
Avg Length of Certification*	8.13	7.32	0.00	0.00	0.00	0.00	0.00	0.00	8.13	7.32

RESIDENTIAL TREATMENT PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	10	22	0	0	0	0	0	0	10	22
Days*	124	126	0	0	0	0	0	0	124	126
Admissions/1000 Lives	0.11	0.24	0.00	0.00	0.00	0.00	0.00	0.00	0.11	0.24
Days/1000 Lives*	1.36	1.38	0.00	0.00	0.00	0.00	0.00	0.00	1.36	1.38
Avg Length of Certification*	12.35	5.70	0.00	0.00	0.00	0.00	0.00	0.00	12.35	5.70

PARTIAL HOSPITALIZATION PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	88	114	0	0	0	0	0	0	88	114
Days*	465	762	0	0	0	0	0	0	465	762
Admissions/1000 Lives	0.97	1.25	0.00	0.00	0.00	0.00	0.00	0.00	0.97	1.25
Days/1000 Lives*	5.10	8.37	0.00	0.00	0.00	0.00	0.00	0.00	5.10	8.37
Avg Length of Certification*	5.28	6.68	0.00	0.00	0.00	0.00	0.00	0.00	5.28	6.68

IOP/GROUP HOME/HALFWAY HOUSE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	55	178	0	0	0	0	0	0	55	178
Days*	73	557	0	0	0	0	0	0	73	557
Admissions/1000 Lives	0.60	1.96	0.00	0.00	0.00	0.00	0.00	0.00	0.60	1.96
Days/1000 Lives*	0.80	6.12	0.00	0.00	0.00	0.00	0.00	0.00	0.80	6.12
Avg Length of Certification*	1.33	3.13	0.00	0.00	0.00	0.00	0.00	0.00	1.33	3.13

TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	398	471	0	0	0	0	0	0	398	471
Days*	2,653	2,594	0	0	0	0	0	0	2,653	2,594
Admissions/1000 Lives	4.37	5.17	0.00	0.00	0.00	0.00	0.00	0.00	4.37	5.17
Days/1000 Lives*	29.15	28.50	0.00	0.00	0.00	0.00	0.00	0.00	29.15	28.50
Avg Length of Certification*	6.67	5.51	0.00	0.00	0.00	0.00	0.00	0.00	6.67	5.51

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

Report # 2003.1.02

New York State Empire Plan - NY CITY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient & Alternative Levels of Care Detail by Group

Psychiatric vs Substance Abuse

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	104,749	0	0	0	104,749

ACUTE INPATIENT

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	62	18	0	0	0	0	0	0	62	18
Days*	601	157	0	0	0	0	0	0	601	157
Admissions/1000 Lives	2.37	0.69	0.00	0.00	0.00	0.00	0.00	0.00	2.37	0.69
Days/1000 Lives*	22.95	6.00	0.00	0.00	0.00	0.00	0.00	0.00	22.95	6.00
Avg Length of Certification*	9.69	8.72	0.00	0.00	0.00	0.00	0.00	0.00	9.69	8.72

RESIDENTIAL TREATMENT PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	5	4	0	0	0	0	0	0	5	4
Days*	63	44	0	0	0	0	0	0	63	44
Admissions/1000 Lives	0.19	0.15	0.00	0.00	0.00	0.00	0.00	0.00	0.19	0.15
Days/1000 Lives*	2.39	1.68	0.00	0.00	0.00	0.00	0.00	0.00	2.39	1.68
Avg Length of Certification*	12.50	11.00	0.00	0.00	0.00	0.00	0.00	0.00	12.50	11.00

PARTIAL HOSPITALIZATION PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	17	7	0	0	0	0	0	0	17	7
Days*	104	49	0	0	0	0	0	0	104	49
Admissions/1000 Lives	0.65	0.27	0.00	0.00	0.00	0.00	0.00	0.00	0.65	0.27
Days/1000 Lives*	3.97	1.85	0.00	0.00	0.00	0.00	0.00	0.00	3.97	1.85
Avg Length of Certification*	6.12	6.93	0.00	0.00	0.00	0.00	0.00	0.00	6.12	6.93

IOP/GROUP HOME/HALFWAY HOUSE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	5	20	0	0	0	0	0	0	5	20
Days*	17	58	0	0	0	0	0	0	17	58
Admissions/1000 Lives	0.19	0.76	0.00	0.00	0.00	0.00	0.00	0.00	0.19	0.76
Days/1000 Lives*	0.63	2.20	0.00	0.00	0.00	0.00	0.00	0.00	0.63	2.20
Avg Length of Certification*	3.32	2.88	0.00	0.00	0.00	0.00	0.00	0.00	3.32	2.88

TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	89	49	0	0	0	0	0	0	89	49
Days*	784	307	0	0	0	0	0	0	784	307
Admissions/1000 Lives	3.40	1.87	0.00	0.00	0.00	0.00	0.00	0.00	3.40	1.87
Days/1000 Lives*	29.94	11.73	0.00	0.00	0.00	0.00	0.00	0.00	29.94	11.73
Avg Length of Certification*	8.81	6.27	0.00	0.00	0.00	0.00	0.00	0.00	8.81	6.27

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

New York State Empire Plan - OUT OF STATE

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient & Alternative Levels of Care Detail by Group

Psychiatric vs Substance Abuse

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	110,686	0	0	0	110,686

ACUTE INPATIENT

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	72	25	0	0	0	0	0	0	72	25
Days*	570	223	0	0	0	0	0	0	570	223
Admissions/1000 Lives	2.60	0.90	0.00	0.00	0.00	0.00	0.00	0.00	2.60	0.90
Days/1000 Lives*	20.60	8.06	0.00	0.00	0.00	0.00	0.00	0.00	20.60	8.06
Avg Length of Certification*	7.92	8.92	0.00	0.00	0.00	0.00	0.00	0.00	7.92	8.92

RESIDENTIAL TREATMENT PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	2	2	0	0	0	0	0	0	2	2
Days*	19	15	0	0	0	0	0	0	19	15
Admissions/1000 Lives	0.07	0.07	0.00	0.00	0.00	0.00	0.00	0.00	0.07	0.07
Days/1000 Lives*	0.69	0.52	0.00	0.00	0.00	0.00	0.00	0.00	0.69	0.52
Avg Length of Certification*	9.50	7.25	0.00	0.00	0.00	0.00	0.00	0.00	9.50	7.25

PARTIAL HOSPITALIZATION PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	14	24	0	0	0	0	0	0	14	24
Days*	73	135	0	0	0	0	0	0	73	135
Admissions/1000 Lives	0.51	0.87	0.00	0.00	0.00	0.00	0.00	0.00	0.51	0.87
Days/1000 Lives*	2.64	4.86	0.00	0.00	0.00	0.00	0.00	0.00	2.64	4.86
Avg Length of Certification*	5.21	5.60	0.00	0.00	0.00	0.00	0.00	0.00	5.21	5.60

IOP/GROUP HOME/HALFWAY HOUSE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	21	28	0	0	0	0	0	0	21	28
Days*	51	97	0	0	0	0	0	0	51	97
Admissions/1000 Lives	0.76	1.01	0.00	0.00	0.00	0.00	0.00	0.00	0.76	1.01
Days/1000 Lives*	1.84	3.51	0.00	0.00	0.00	0.00	0.00	0.00	1.84	3.51
Avg Length of Certification*	2.43	3.47	0.00	0.00	0.00	0.00	0.00	0.00	2.43	3.47

TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	109	79	0	0	0	0	0	0	109	79
Days*	713	469	0	0	0	0	0	0	713	469
Admissions/1000 Lives	3.94	2.85	0.00	0.00	0.00	0.00	0.00	0.00	3.94	2.85
Days/1000 Lives*	25.77	16.96	0.00	0.00	0.00	0.00	0.00	0.00	25.77	16.96
Avg Length of Certification*	6.54	5.94	0.00	0.00	0.00	0.00	0.00	0.00	6.54	5.94

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

New York State Empire Plan - UNKNOWN

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient & Alternative Levels of Care Detail by Group

Psychiatric vs Substance Abuse

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	668	0	0	0	668

TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	0	0	0	0	0	0	0	0	0	0
Days*	0	0	0	0	0	0	0	0	0	0
Admissions/1000 Lives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Days/1000 Lives*	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Avg Length of Certification*	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

New York State Empire Plan - WESTERN NY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient & Alternative Levels of Care Detail by Group

Psychiatric vs Substance Abuse

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	70,186	0	0	0	70,186

ACUTE INPATIENT

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	41	18	0	0	0	0	0	0	41	18
Days*	354	191	0	0	0	0	0	0	354	191
Admissions/1000 Lives	2.34	1.03	0.00	0.00	0.00	0.00	0.00	0.00	2.34	1.03
Days/1000 Lives*	20.18	10.89	0.00	0.00	0.00	0.00	0.00	0.00	20.18	10.89
Avg Length of Certification*	8.63	10.61	0.00	0.00	0.00	0.00	0.00	0.00	8.63	10.61

RESIDENTIAL TREATMENT PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	1	4	0	0	0	0	0	0	1	4
Days*	9	37	0	0	0	0	0	0	9	37
Admissions/1000 Lives	0.06	0.23	0.00	0.00	0.00	0.00	0.00	0.00	0.06	0.23
Days/1000 Lives*	0.48	2.08	0.00	0.00	0.00	0.00	0.00	0.00	0.48	2.08
Avg Length of Certification*	8.50	9.13	0.00	0.00	0.00	0.00	0.00	0.00	8.50	9.13

PARTIAL HOSPITALIZATION PROGRAM

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	7	6	0	0	0	0	0	0	7	6
Days*	54	37	0	0	0	0	0	0	54	37
Admissions/1000 Lives	0.40	0.34	0.00	0.00	0.00	0.00	0.00	0.00	0.40	0.34
Days/1000 Lives*	3.08	2.08	0.00	0.00	0.00	0.00	0.00	0.00	3.08	2.08
Avg Length of Certification*	7.71	6.08	0.00	0.00	0.00	0.00	0.00	0.00	7.71	6.08

IOP/GROUP HOME/HALFWAY HOUSE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	2	4	0	0	0	0	0	0	2	4
Days*	0	14	0	0	0	0	0	0	0	14
Admissions/1000 Lives	0.11	0.23	0.00	0.00	0.00	0.00	0.00	0.00	0.11	0.23
Days/1000 Lives*	0.00	0.81	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.81
Avg Length of Certification*	0.00	3.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.55

TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Admissions	51	32	0	0	0	0	0	0	51	32
Days*	417	278	0	0	0	0	0	0	417	278
Admissions/1000 Lives	2.91	1.82	0.00	0.00	0.00	0.00	0.00	0.00	2.91	1.82
Days/1000 Lives*	23.74	15.86	0.00	0.00	0.00	0.00	0.00	0.00	23.74	15.86
Avg Length of Certification*	8.17	8.69	0.00	0.00	0.00	0.00	0.00	0.00	8.17	8.69

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

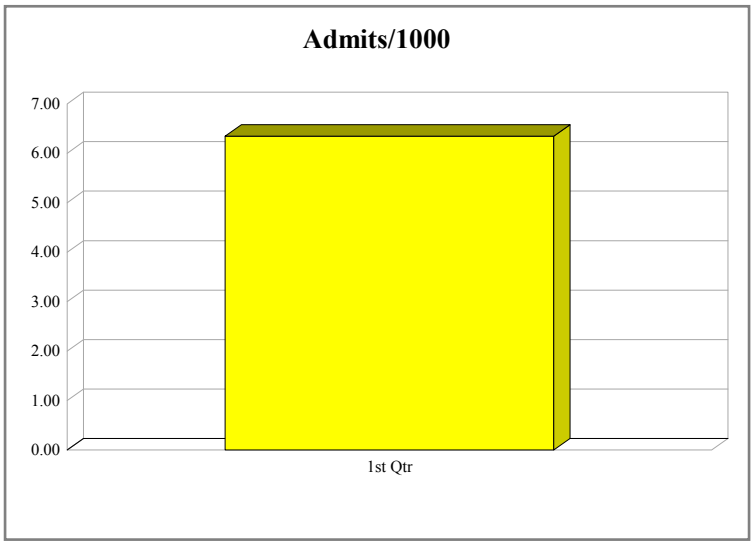
New York State Empire Plan - CENTRAL NY

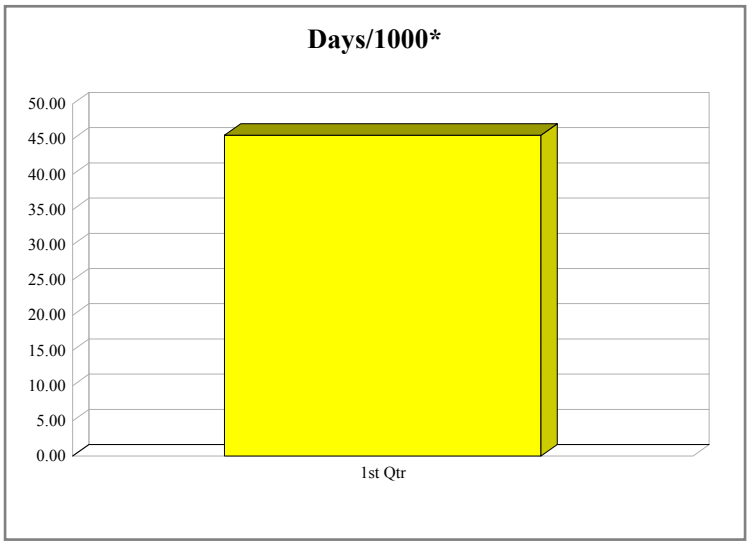
Managed Mental Health and Substance Abuse Activity Report

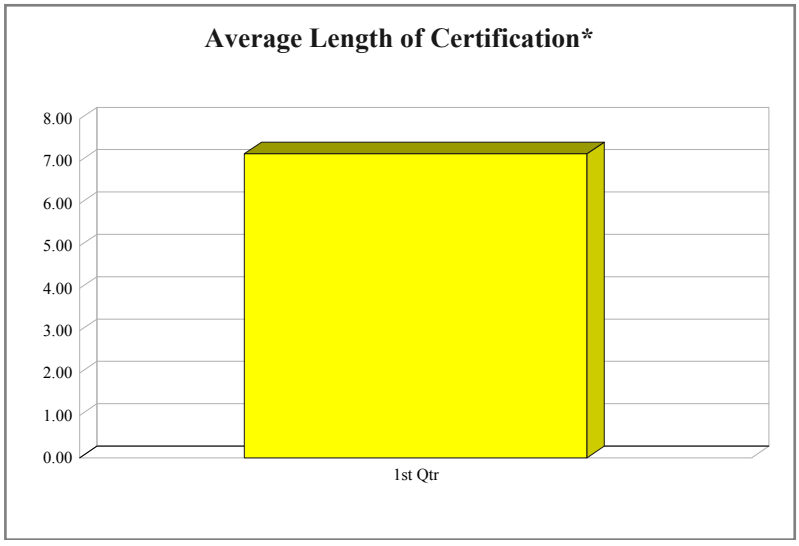
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	153,791	0	0	0	153,791
Admissions	244	0	0	0	244
Days*	1,752	0	0	0	1,752
Admissions/1000 Lives	6.35	0.00	0.00	0.00	6.35
Days/1000 Lives*	45.57	0.00	0.00	0.00	45.57
Avg Length of Certification*	7.18	0.00	0.00	0.00	7.18







	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	290,648	0	0	0	290,648

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

Report # 2002.1.02

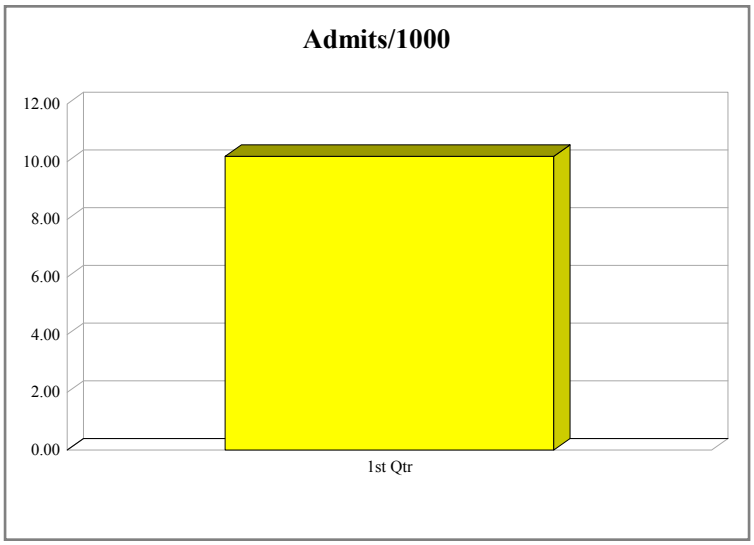
New York State Empire Plan - HUDSON VALLEY

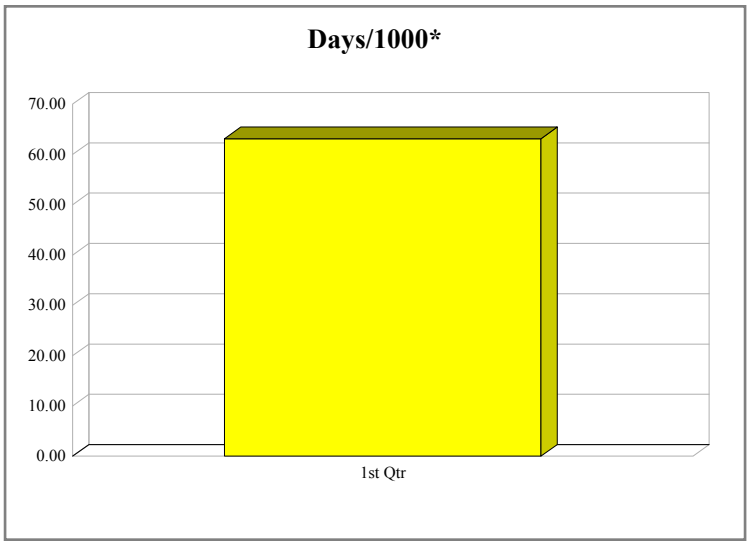
Managed Mental Health and Substance Abuse Activity Report

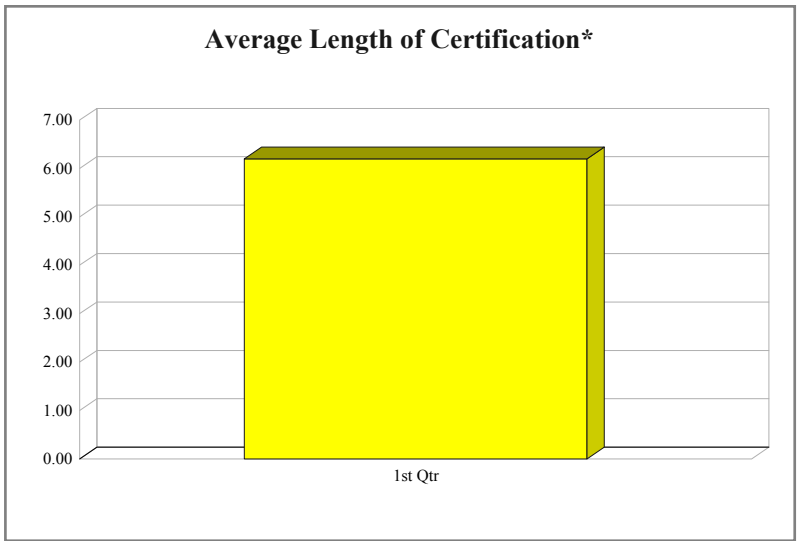
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization by Group

Admissions	740	0	0	0	740
Days*	4,635	0	0	0	4,635
Admissions/1000 Lives	10.18	0.00	0.00	0.00	10.18
Days/1000 Lives*	63.78	0.00	0.00	0.00	63.78
Avg Length of Certification*	6.26	0.00	0.00	0.00	6.26







	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	364,058	0	0	0	364,058

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

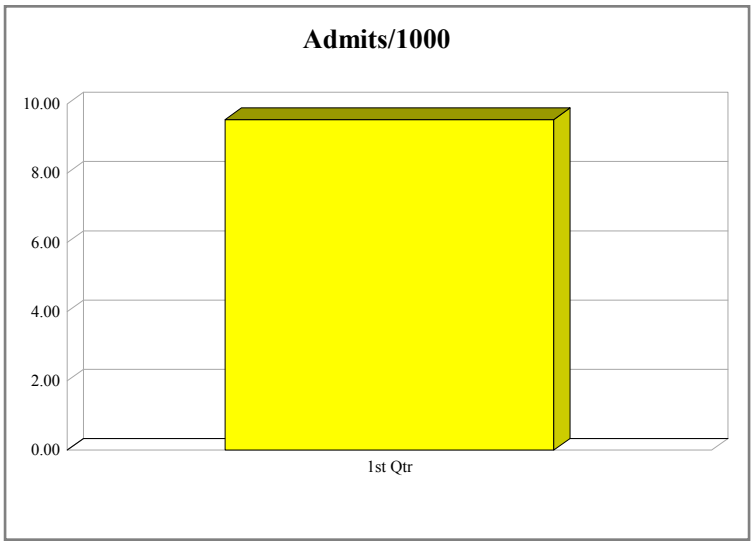
New York State Empire Plan - LONG ISLAND

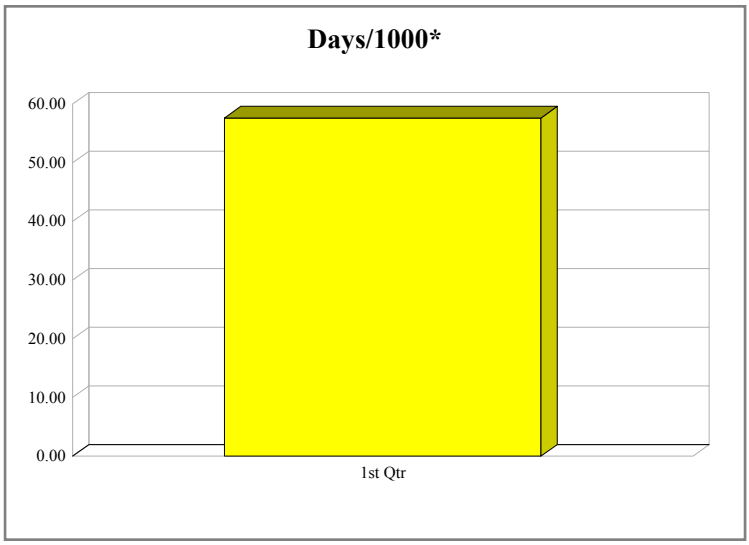
Managed Mental Health and Substance Abuse Activity Report

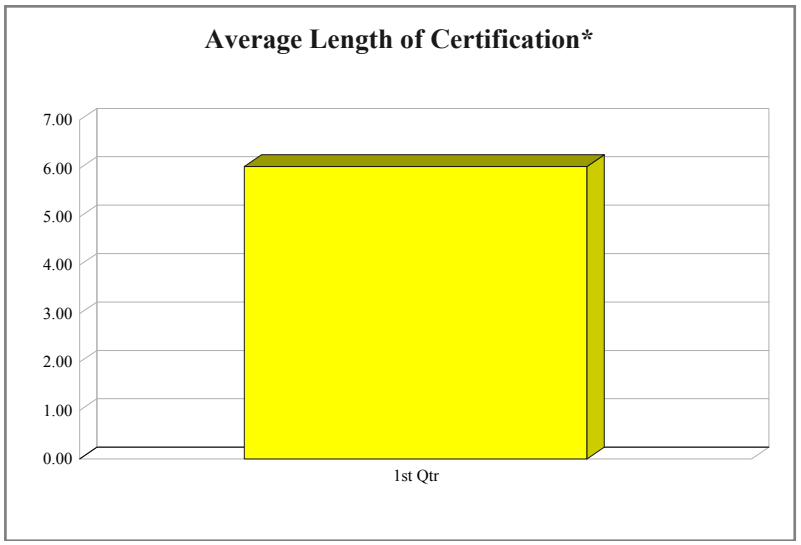
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization by Group

Admissions	869	0	0	0	869
Days*	5,274	0	0	0	5,274
Admissions/1000 Lives	9.55	0.00	0.00	0.00	9.55
Days/1000 Lives*	57.95	0.00	0.00	0.00	57.95
Avg Length of Certification*	6.07	0.00	0.00	0.00	6.07







	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	104,749	0	0	0	104,749

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

Report # 2002.1.02

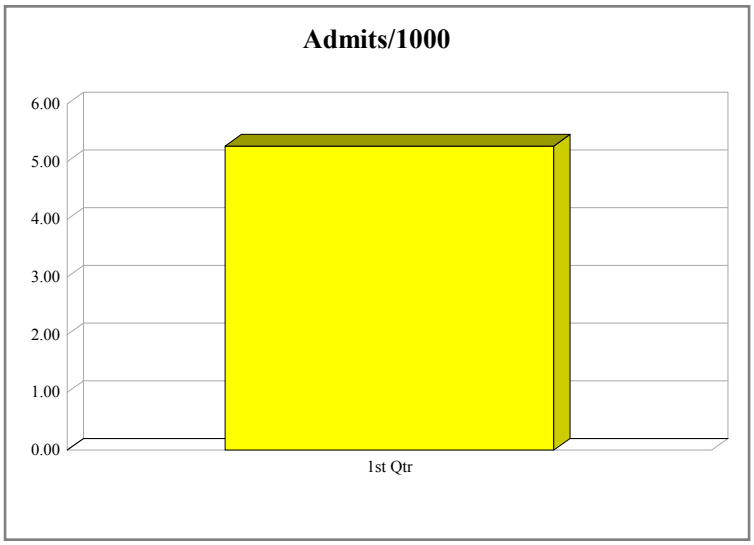
New York State Empire Plan - NY CITY

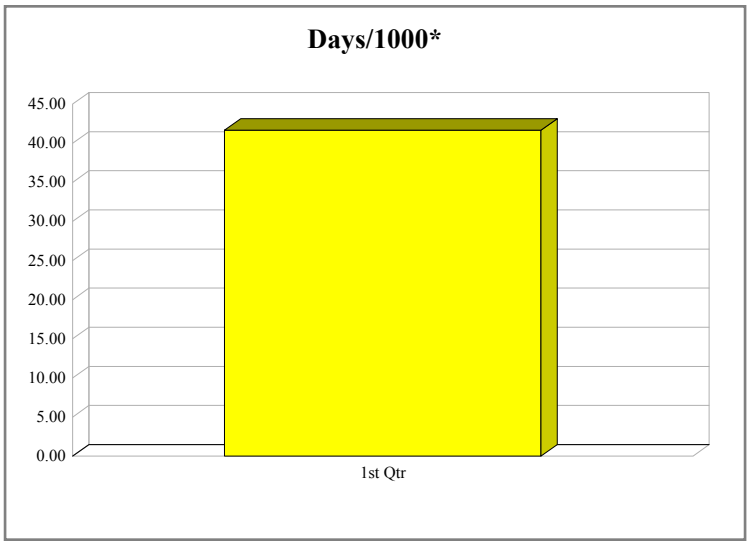
Managed Mental Health and Substance Abuse Activity Report

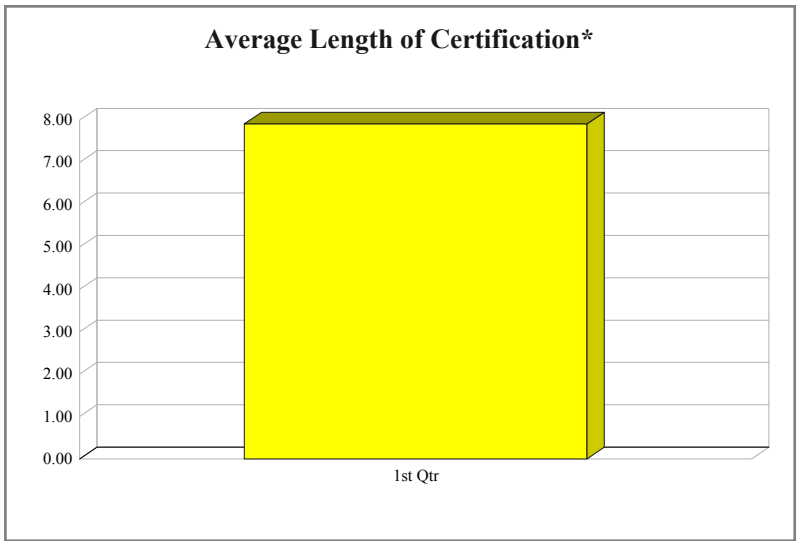
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization by Group

Admissions	138	0	0	0	138
Days*	1,091	0	0	0	1,091
Admissions/1000 Lives	5.27	0.00	0.00	0.00	5.27
Days/1000 Lives*	41.67	0.00	0.00	0.00	41.67
Avg Length of Certification*	7.91	0.00	0.00	0.00	7.91







	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	110,686	0	0	0	110,686

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

Report # 2002.1.02

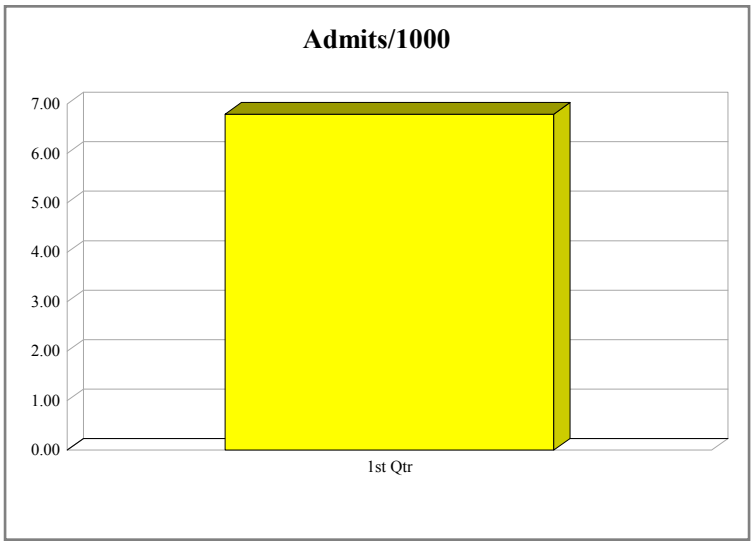
New York State Empire Plan - OUT OF STATE

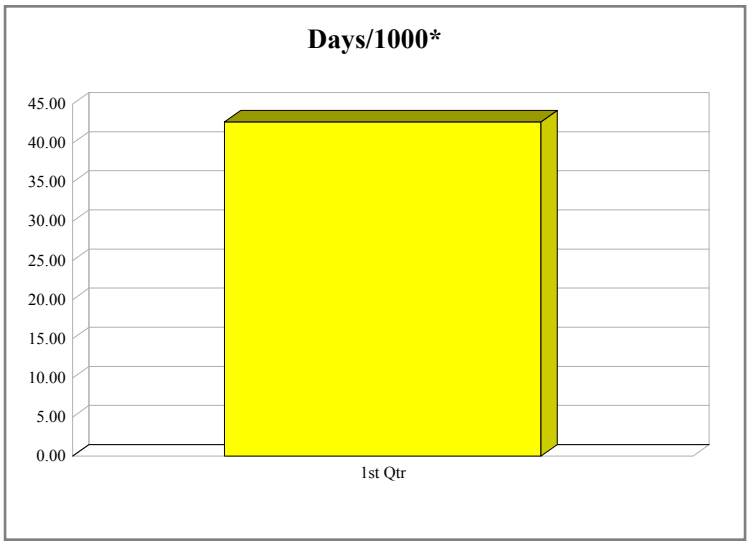
Managed Mental Health and Substance Abuse Activity Report

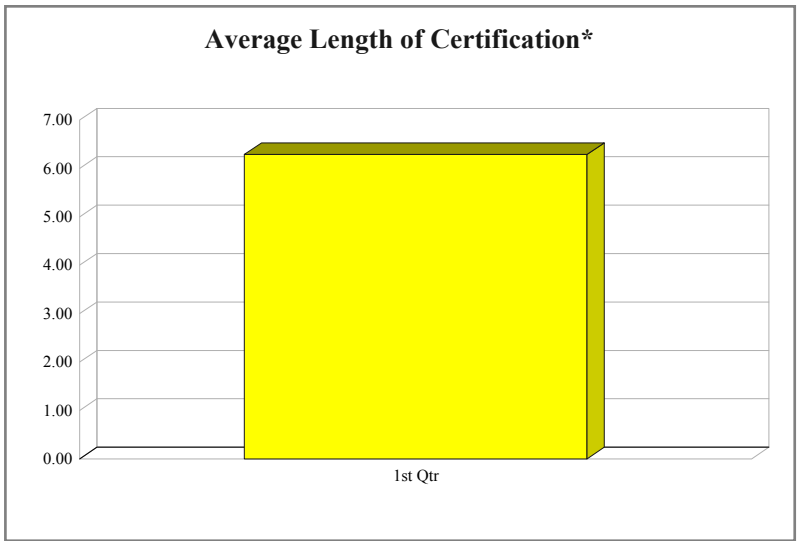
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization by Group

Admissions	188	0	0	0	188
Days*	1,182	0	0	0	1,182
Admissions/1000 Lives	6.79	0.00	0.00	0.00	6.79
Days/1000 Lives*	42.72	0.00	0.00	0.00	42.72
Avg Length of Certification*	6.29	0.00	0.00	0.00	6.29







	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	668	0	0	0	668

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

Report # 2002.1.02

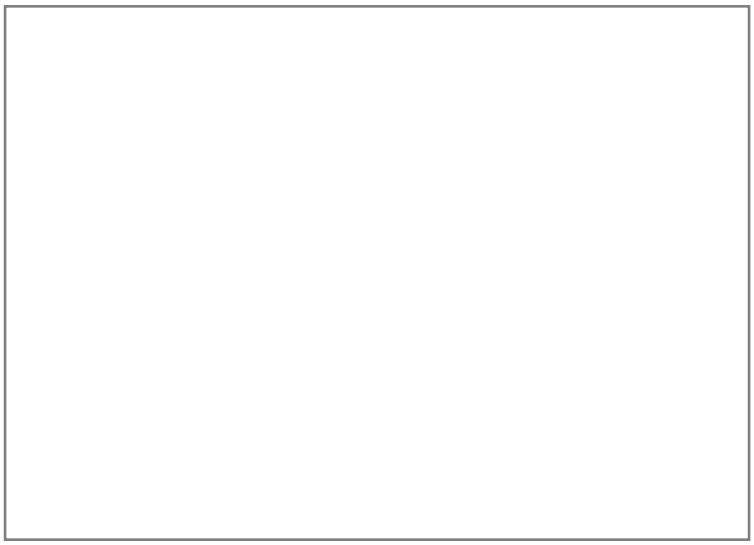
New York State Empire Plan - UNKNOWN

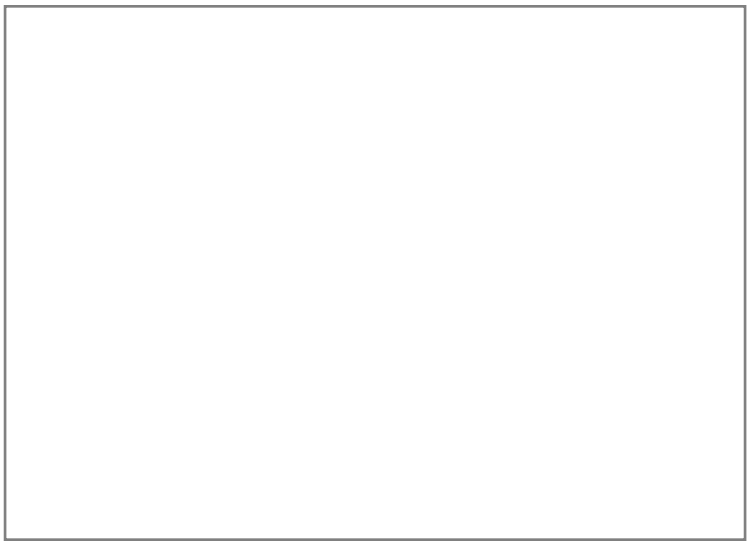
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization by Group

Admissions	0	0	0	0	0
Days*	0	0	0	0	0
Admissions/1000 Lives	0.00	0.00	0.00	0.00	0.00
Days/1000 Lives*	0.00	0.00	0.00	0.00	0.00
Avg Length of Certification*	0.00	0.00	0.00	0.00	0.00





	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	70,186	0	0	0	70,186

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

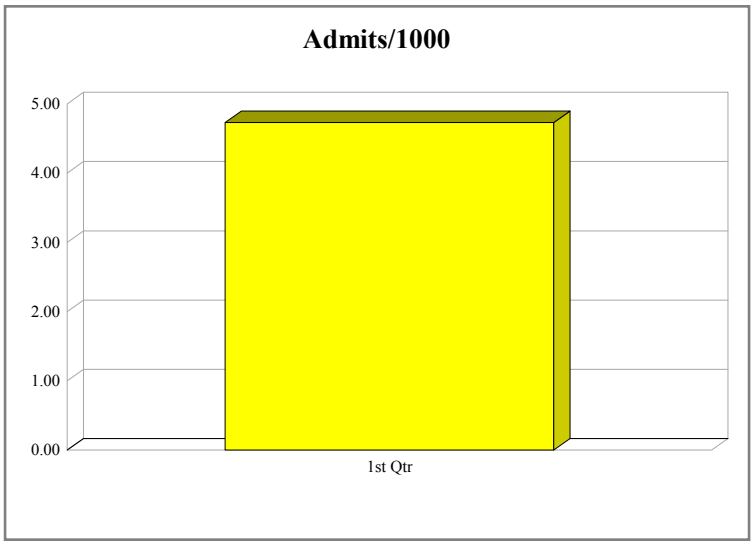
New York State Empire Plan - WESTERN NY

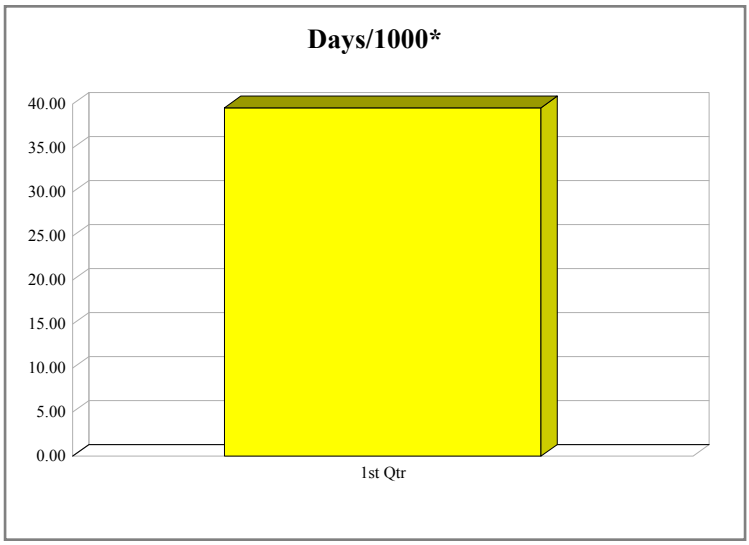
Managed Mental Health and Substance Abuse Activity Report

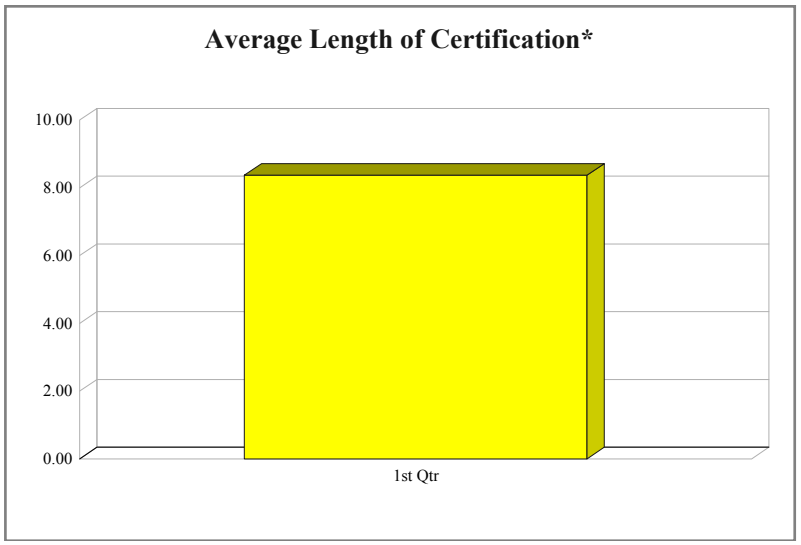
January 1, 2014 - March 31, 2014

Acute Inpatient & Alternative Levels of Care Utilization by Group

Admissions	83	0	0	0	83
Days*	696	0	0	0	696
Admissions/1000 Lives	4.73	0.00	0.00	0.00	4.73
Days/1000 Lives*	39.65	0.00	0.00	0.00	39.65
Avg Length of Certification*	8.38	0.00	0.00	0.00	8.38







*Alternative Modality Ratios have been applied.

** All data has been annualized.

New York State Empire Plan - CENTRAL NY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient and Alternative Levels of Care Detail By Region

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	153,791	0	0	0	153,791
ACUTE INPATIENT					
Admissions	165	0	0	0	165
Days*	1,395	0	0	0	1,395
Admissions/1000 Lives	4.29	0.00	0.00	0.00	4.29
Days/1000 Lives*	36.28	0.00	0.00	0.00	36.28
Avg Length of Certification*	8.45	0.00	0.00	0.00	8.45
RESIDENTIAL TREATMENT PROGRAM					
Admissions	7	0	0	0	7
Days*	48	0	0	0	48
Admissions/1000 Lives	0.18	0.00	0.00	0.00	0.18
Days/1000 Lives*	1.25	0.00	0.00	0.00	1.25
Avg Length of Certification*	6.86	0.00	0.00	0.00	6.86
PARTIAL HOSPITALIZATION PROGRAM					
Admissions	26	0	0	0	26
Days*	169	0	0	0	169
Admissions/1000 Lives	0.68	0.00	0.00	0.00	0.68
Days/1000 Lives*	4.40	0.00	0.00	0.00	4.40
Avg Length of Certification*	6.50	0.00	0.00	0.00	6.50
IOP/GROUP HOME/HALFWAY HOUSE					
Admissions	46	0	0	0	46
Days*	140	0	0	0	140
Admissions/1000 Lives	1.20	0.00	0.00	0.00	1.20
Days/1000 Lives*	3.63	0.00	0.00	0.00	3.63
Avg Length of Certification*	3.03	0.00	0.00	0.00	3.03
TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE					
Admissions	244	0	0	0	244
Days*	1,752	0	0	0	1,752
Admissions/1000 Lives	6.35	0.00	0.00	0.00	6.35
Days/1000 Lives*	45.56	0.00	0.00	0.00	45.56
Avg Length of Certification*	7.18	0.00	0.00	0.00	7.18

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

New York State Empire Plan - HUDSON VALLEY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient and Alternative Levels of Care Detail By Region

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	290,648	0	0	0	290,648
ACUTE INPATIENT					
Admissions	410	0	0	0	410
Days*	3,297	0	0	0	3,297
Admissions/1000 Lives	5.64	0.00	0.00	0.00	5.64
Days/1000 Lives*	45.37	0.00	0.00	0.00	45.37
Avg Length of Certification*	8.04	0.00	0.00	0.00	8.04
RESIDENTIAL TREATMENT PROGRAM					
Admissions	21	0	0	0	21
Days*	208	0	0	0	208
Admissions/1000 Lives	0.29	0.00	0.00	0.00	0.29
Days/1000 Lives*	2.86	0.00	0.00	0.00	2.86
Avg Length of Certification*	9.88	0.00	0.00	0.00	9.88
PARTIAL HOSPITALIZATION PROGRAM					
Admissions	132	0	0	0	132
Days*	690	0	0	0	690
Admissions/1000 Lives	1.82	0.00	0.00	0.00	1.82
Days/1000 Lives*	9.49	0.00	0.00	0.00	9.49
Avg Length of Certification*	5.22	0.00	0.00	0.00	5.22
IOP/GROUP HOME/HALFWAY HOUSE					
Admissions	177	0	0	0	177
Days*	392	0	0	0	392
Admissions/1000 Lives	2.44	0.00	0.00	0.00	2.44
Days/1000 Lives*	5.40	0.00	0.00	0.00	5.40
Avg Length of Certification*	2.22	0.00	0.00	0.00	2.22
TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE					
Admissions	740	0	0	0	740
Days*	4,586	0	0	0	4,586
Admissions/1000 Lives	10.18	0.00	0.00	0.00	10.18
Days/1000 Lives*	63.12	0.00	0.00	0.00	63.12
Avg Length of Certification*	6.20	0.00	0.00	0.00	6.20

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

New York State Empire Plan - LONG ISLAND

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient and Alternative Levels of Care Detail By Region

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	364,058	0	0	0	364,058
ACUTE INPATIENT					
Admissions	402	0	0	0	402
Days*	3,142	0	0	0	3,142
Admissions/1000 Lives	4.42	0.00	0.00	0.00	4.42
Days/1000 Lives*	34.52	0.00	0.00	0.00	34.52
Avg Length of Certification*	7.82	0.00	0.00	0.00	7.82
RESIDENTIAL TREATMENT PROGRAM					
Admissions	32	0	0	0	32
Days*	249	0	0	0	249
Admissions/1000 Lives	0.35	0.00	0.00	0.00	0.35
Days/1000 Lives*	2.74	0.00	0.00	0.00	2.74
Avg Length of Certification*	7.78	0.00	0.00	0.00	7.78
PARTIAL HOSPITALIZATION PROGRAM					
Admissions	202	0	0	0	202
Days*	1,227	0	0	0	1,227
Admissions/1000 Lives	2.22	0.00	0.00	0.00	2.22
Days/1000 Lives*	13.48	0.00	0.00	0.00	13.48
Avg Length of Certification*	6.07	0.00	0.00	0.00	6.07
IOP/GROUP HOME/HALFWAY HOUSE					
Admissions	233	0	0	0	233
Days*	630	0	0	0	630
Admissions/1000 Lives	2.56	0.00	0.00	0.00	2.56
Days/1000 Lives*	6.92	0.00	0.00	0.00	6.92
Avg Length of Certification*	2.70	0.00	0.00	0.00	2.70
TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE					
Admissions	869	0	0	0	869
Days*	5,247	0	0	0	5,247
Admissions/1000 Lives	9.55	0.00	0.00	0.00	9.55
Days/1000 Lives*	57.65	0.00	0.00	0.00	57.65
Avg Length of Certification*	6.04	0.00	0.00	0.00	6.04

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

New York State Empire Plan - NY CITY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient and Alternative Levels of Care Detail By Region

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	104,749	0	0	0	104,749
ACUTE INPATIENT					
Admissions	80	0	0	0	80
Days*	758	0	0	0	758
Admissions/1000 Lives	3.05	0.00	0.00	0.00	3.05
Days/1000 Lives*	28.95	0.00	0.00	0.00	28.95
Avg Length of Certification*	9.48	0.00	0.00	0.00	9.48
RESIDENTIAL TREATMENT PROGRAM					
Admissions	9	0	0	0	9
Days*	107	0	0	0	107
Admissions/1000 Lives	0.34	0.00	0.00	0.00	0.34
Days/1000 Lives*	4.07	0.00	0.00	0.00	4.07
Avg Length of Certification*	11.83	0.00	0.00	0.00	11.83
PARTIAL HOSPITALIZATION PROGRAM					
Admissions	24	0	0	0	24
Days*	153	0	0	0	153
Admissions/1000 Lives	0.92	0.00	0.00	0.00	0.92
Days/1000 Lives*	5.82	0.00	0.00	0.00	5.82
Avg Length of Certification*	6.35	0.00	0.00	0.00	6.35
IOP/GROUP HOME/HALFWAY HOUSE					
Admissions	25	0	0	0	25
Days*	74	0	0	0	74
Admissions/1000 Lives	0.95	0.00	0.00	0.00	0.95
Days/1000 Lives*	2.83	0.00	0.00	0.00	2.83
Avg Length of Certification*	2.97	0.00	0.00	0.00	2.97
TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE					
Admissions	138	0	0	0	138
Days*	1,091	0	0	0	1,091
Admissions/1000 Lives	5.27	0.00	0.00	0.00	5.27
Days/1000 Lives*	41.67	0.00	0.00	0.00	41.67
Avg Length of Certification*	7.91	0.00	0.00	0.00	7.91

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

New York State Empire Plan - OUT OF STATE

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient and Alternative Levels of Care Detail By Region

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	110,686	0	0	0	110,686
ACUTE INPATIENT					
Admissions	97	0	0	0	97
Days*	793	0	0	0	793
Admissions/1000 Lives	3.51	0.00	0.00	0.00	3.51
Days/1000 Lives*	28.66	0.00	0.00	0.00	28.66
Avg Length of Certification*	8.18	0.00	0.00	0.00	8.18
RESIDENTIAL TREATMENT PROGRAM					
Admissions	4	0	0	0	4
Days*	34	0	0	0	34
Admissions/1000 Lives	0.14	0.00	0.00	0.00	0.14
Days/1000 Lives*	1.21	0.00	0.00	0.00	1.21
Avg Length of Certification*	8.38	0.00	0.00	0.00	8.38
PARTIAL HOSPITALIZATION PROGRAM					
Admissions	38	0	0	0	38
Days*	208	0	0	0	208
Admissions/1000 Lives	1.37	0.00	0.00	0.00	1.37
Days/1000 Lives*	7.50	0.00	0.00	0.00	7.50
Avg Length of Certification*	5.46	0.00	0.00	0.00	5.46
IOP/GROUP HOME/HALFWAY HOUSE					
Admissions	49	0	0	0	49
Days*	148	0	0	0	148
Admissions/1000 Lives	1.77	0.00	0.00	0.00	1.77
Days/1000 Lives*	5.36	0.00	0.00	0.00	5.36
Avg Length of Certification*	3.02	0.00	0.00	0.00	3.02
TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE					
Admissions	188	0	0	0	188
Days*	1,182	0	0	0	1,182
Admissions/1000 Lives	6.79	0.00	0.00	0.00	6.79
Days/1000 Lives*	42.72	0.00	0.00	0.00	42.72
Avg Length of Certification*	6.29	0.00	0.00	0.00	6.29

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

New York State Empire Plan - UNKNOWN

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient and Alternative Levels of Care Detail By Region

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	668	0	0	0	668
Admissions	0	0	0	0	0
Days*	0	0	0	0	0
Admissions/1000 Lives	0.00	0.00	0.00	0.00	0.00
Days/1000 Lives*	0.00	0.00	0.00	0.00	0.00
Avg Length of Certification*	0.00	0.00	0.00	0.00	0.00

TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE

Admissions	0	0	0	0	0
Days*	0	0	0	0	0
Admissions/1000 Lives	0.00	0.00	0.00	0.00	0.00
Days/1000 Lives*	0.00	0.00	0.00	0.00	0.00
Avg Length of Certification*	0.00	0.00	0.00	0.00	0.00

New York State Empire Plan - WESTERN NY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Acute Inpatient and Alternative Levels of Care Detail By Region

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	70,186	0	0	0	70,186
ACUTE INPATIENT					
Admissions	59	0	0	0	59
Days*	545	0	0	0	545
Admissions/1000 Lives	3.36	0.00	0.00	0.00	3.36
Days/1000 Lives*	31.06	0.00	0.00	0.00	31.06
Avg Length of Certification*	9.24	0.00	0.00	0.00	9.24
RESIDENTIAL TREATMENT PROGRAM					
Admissions	5	0	0	0	5
Days*	45	0	0	0	45
Admissions/1000 Lives	0.28	0.00	0.00	0.00	0.28
Days/1000 Lives*	2.56	0.00	0.00	0.00	2.56
Avg Length of Certification*	9.00	0.00	0.00	0.00	9.00
PARTIAL HOSPITALIZATION PROGRAM					
Admissions	13	0	0	0	13
Days*	91	0	0	0	91
Admissions/1000 Lives	0.74	0.00	0.00	0.00	0.74
Days/1000 Lives*	5.16	0.00	0.00	0.00	5.16
Avg Length of Certification*	6.96	0.00	0.00	0.00	6.96
IOP/GROUP HOME/HALFWAY HOUSE					
Admissions	6	0	0	0	6
Days*	14	0	0	0	14
Admissions/1000 Lives	0.34	0.00	0.00	0.00	0.34
Days/1000 Lives*	0.81	0.00	0.00	0.00	0.81
Avg Length of Certification*	2.37	0.00	0.00	0.00	2.37
TOTAL ACUTE INPATIENT AND ALTERNATIVE LEVELS OF CARE					
Admissions	83	0	0	0	83
Days*	695	0	0	0	695
Admissions/1000 Lives	4.73	0.00	0.00	0.00	4.73
Days/1000 Lives*	39.59	0.00	0.00	0.00	39.59
Avg Length of Certification*	8.37	0.00	0.00	0.00	8.37

**Alternative Modality Ratios have been applied.*

*** All data has been annualized.*

New York State Empire Plan

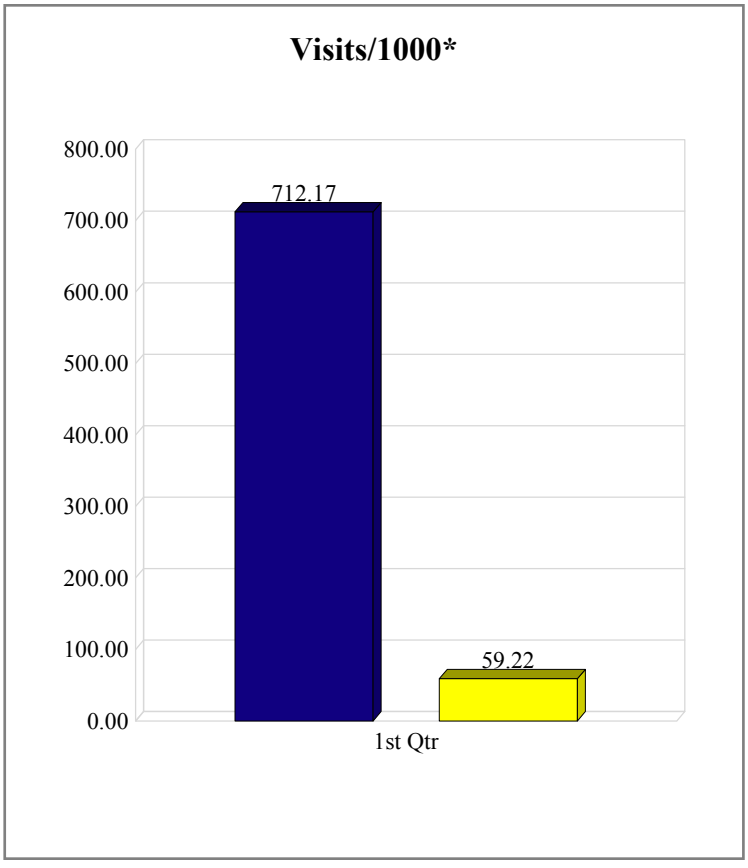
Managed Mental Health and Substance Abuse Activity Report

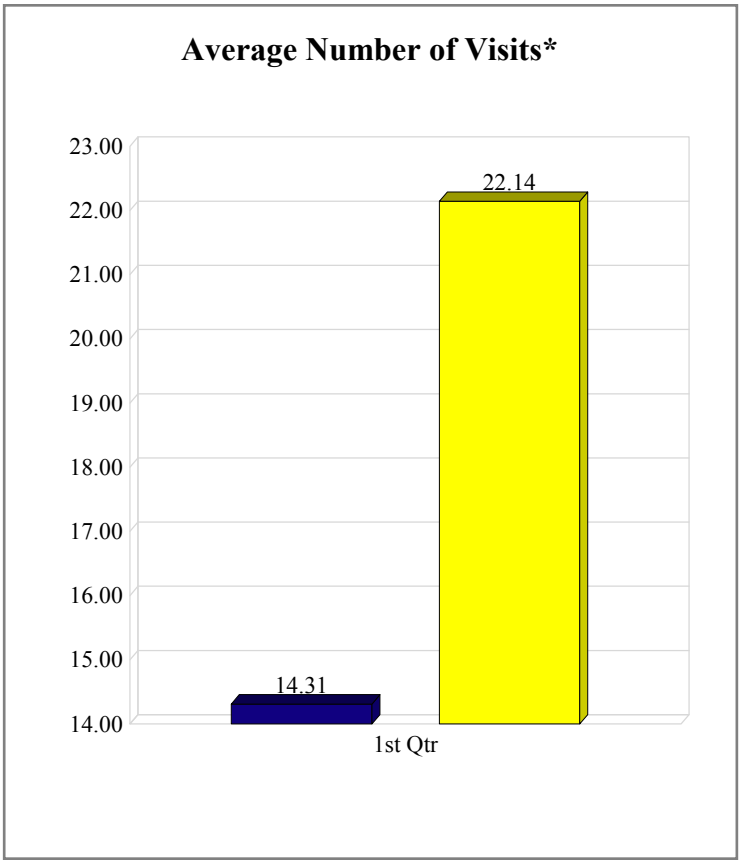
January 1, 2014 - March 31, 2014

Total Outpatient Utilization by Psychiatric/Substance Abuse (Authorizations)

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	1,094,786	0	0	0	1,094,786

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Visits *	194,918	16,209	0	0	0	0	0	0	194,918	16,209
Members Seen	13,620	732	0	0	0	0	0	0	13,620	732
Visits/1000 Lives*	712.17	59.22	0.00	0.00	0.00	0.00	0.00	0.00	712.17	59.22
Avg Number of Visits*	14.31	22.14	0.00	0.00	0.00	0.00	0.00	0.00	14.31	22.14





Psych

Substance Abuse

** Data is based on authorizations and has been annualized.*

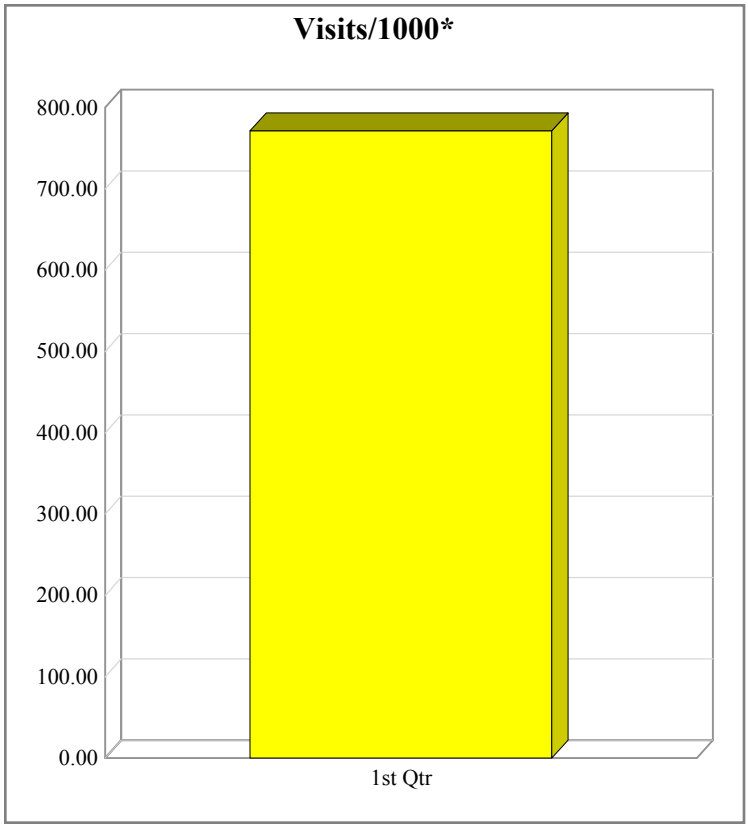
New York State Empire Plan

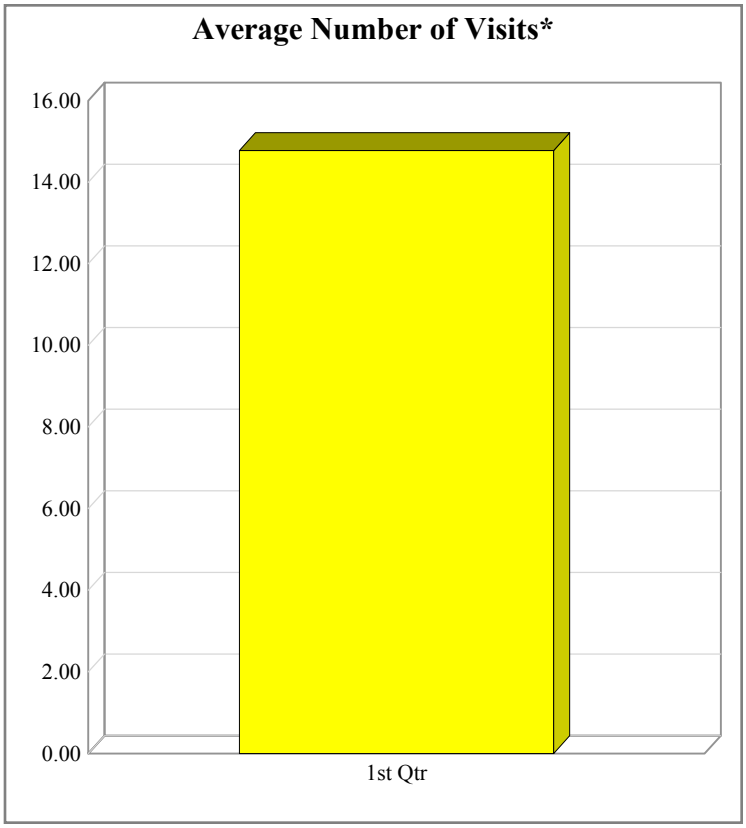
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Outpatient Utilization (Authorizations)

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	1,094,786	0	0	0	1,094,786
Visits *	211,127	0	0	0	211,127
Members Seen *	14,286	0	0	0	14,286
Visits/1000 Lives*	771.39	0.00	0.00	0.00	771.39
Avg Number of Visits*	14.78	0.00	0.00	0.00	14.78





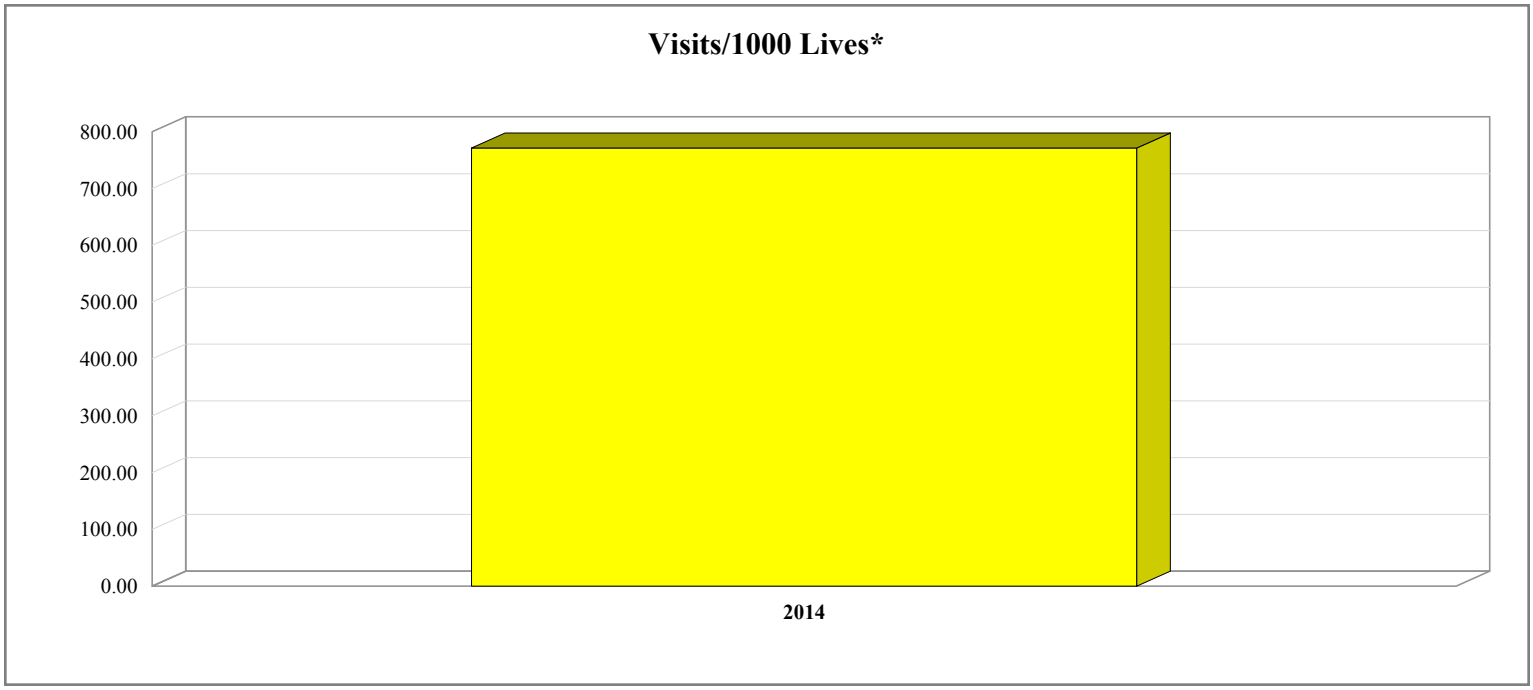
** Data is based on certifications and has been annualized.*

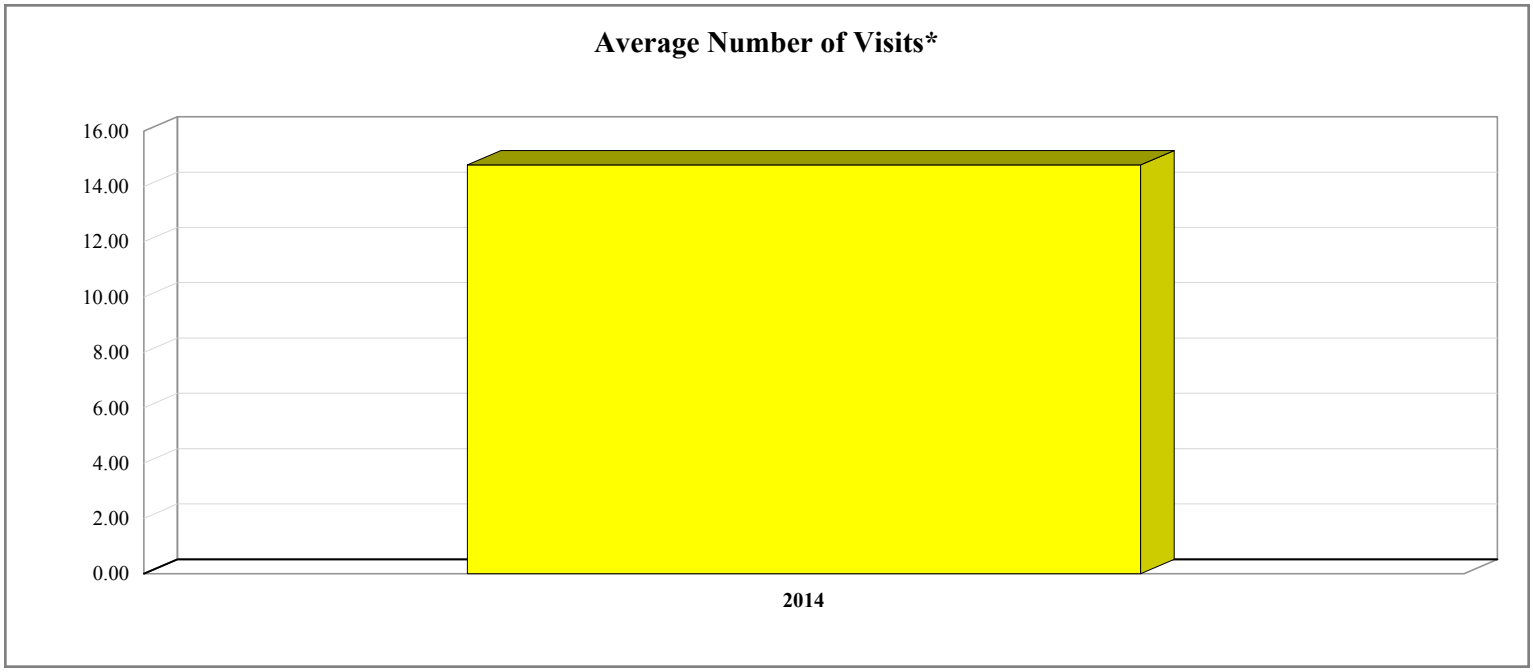
NEW YORK STATE EMPIRE PLAN

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Utilization Trends - Outpatient - Certification Data





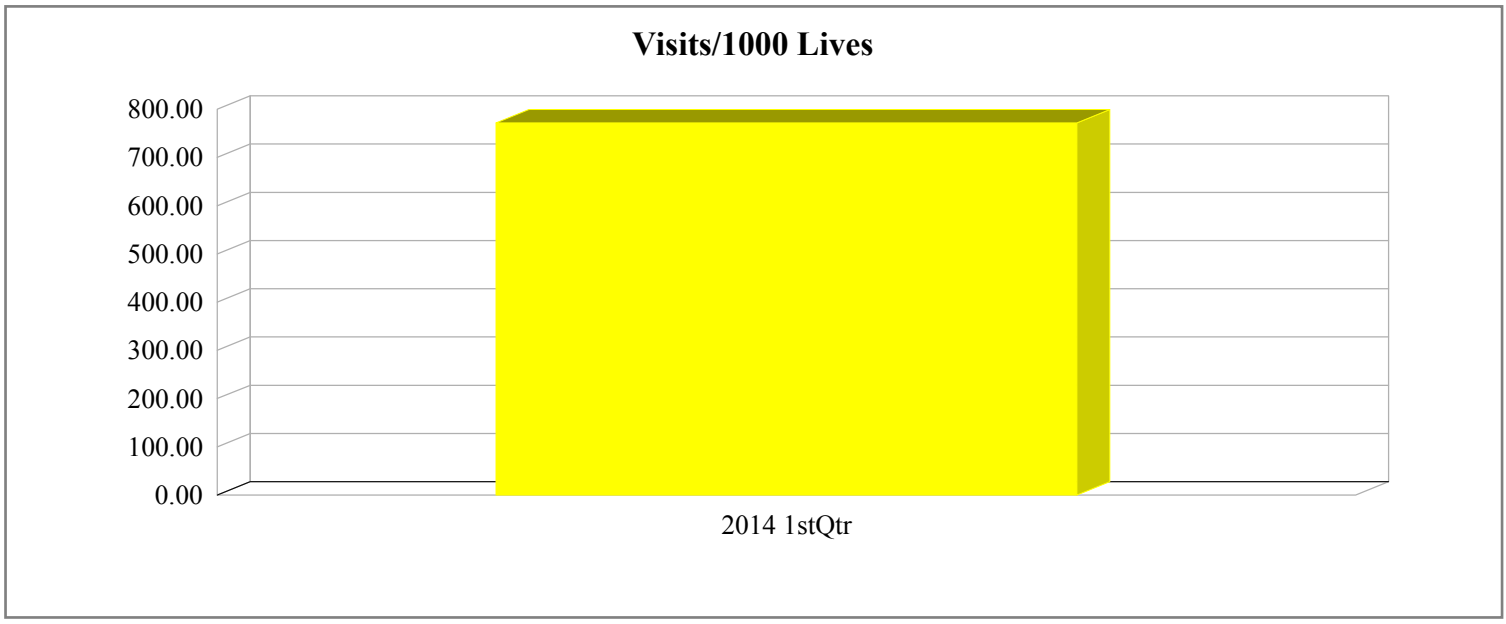
** All data has been annualized.*

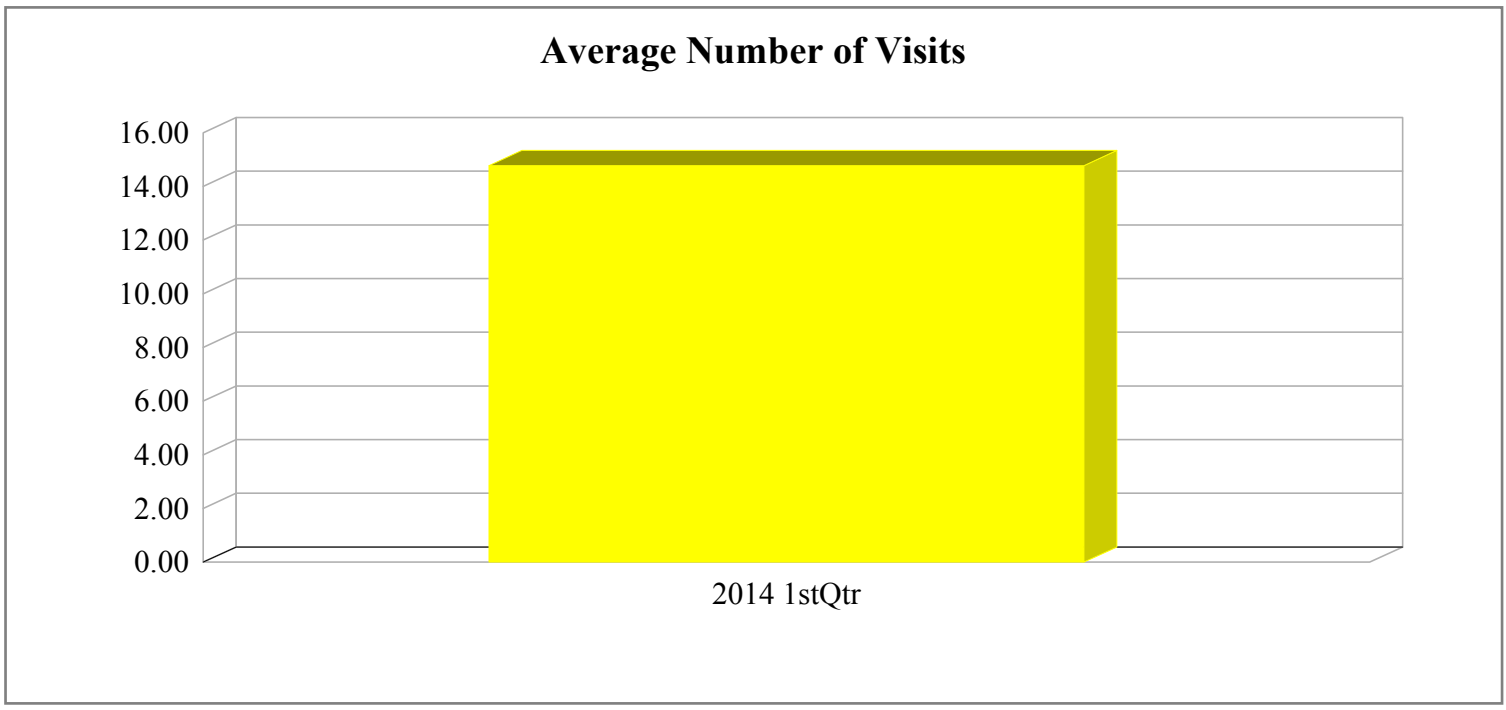
Report # 2006.1.01

*** The last column represents the reporting period only, not necessarily the full year.*

NEW YORK STATE EMPIRE PLAN
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

Utilization Quarterly Trends - Outpatient Certification Data





** All data has been annualized.*

New York State Empire Plan

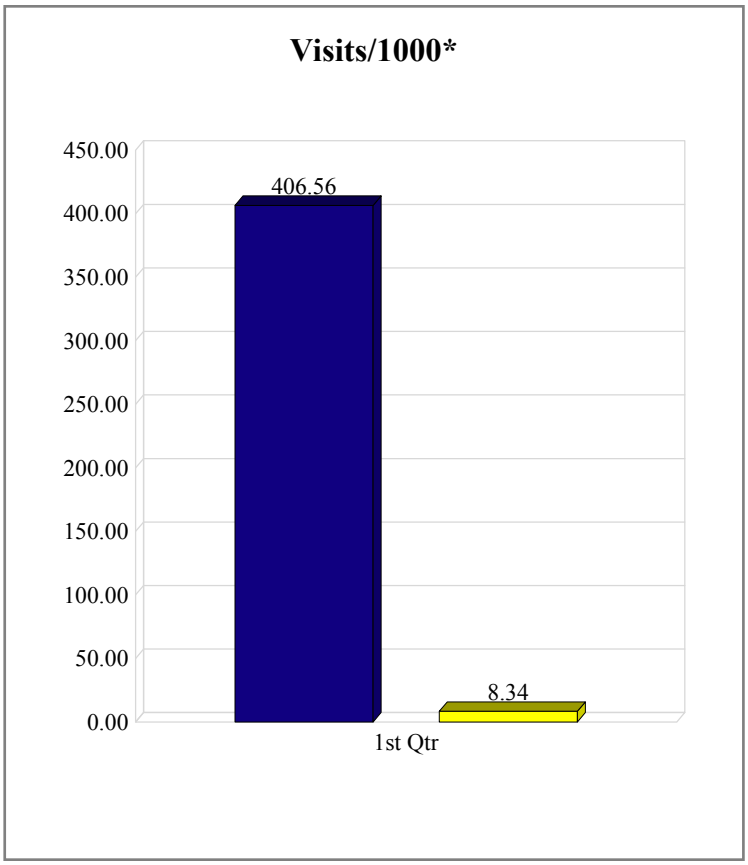
Managed Mental Health and Substance Abuse Activity Report

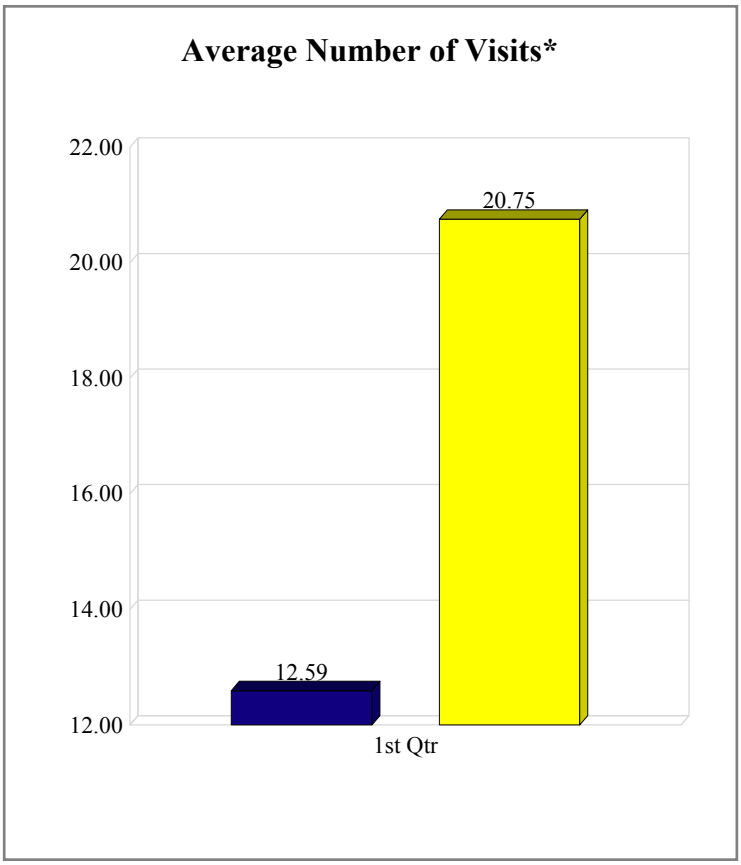
January 1, 2014 - March 31, 2014

Total Outpatient Utilization by Psychiatric/Substance Abuse (Authorizations)
Out of Network

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	1,094,786	0	0	0	1,094,786

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Visits *	111,273	2,283	0	0	0	0	0	0	111,273	2,283
Members Seen	8,835	110	0	0	0	0	0	0	8,835	110
Visits/1000 Lives*	406.56	8.34	0.00	0.00	0.00	0.00	0.00	0.00	406.56	8.34
Avg Number of Visits*	12.59	20.75	0.00	0.00	0.00	0.00	0.00	0.00	12.59	20.75





Psych

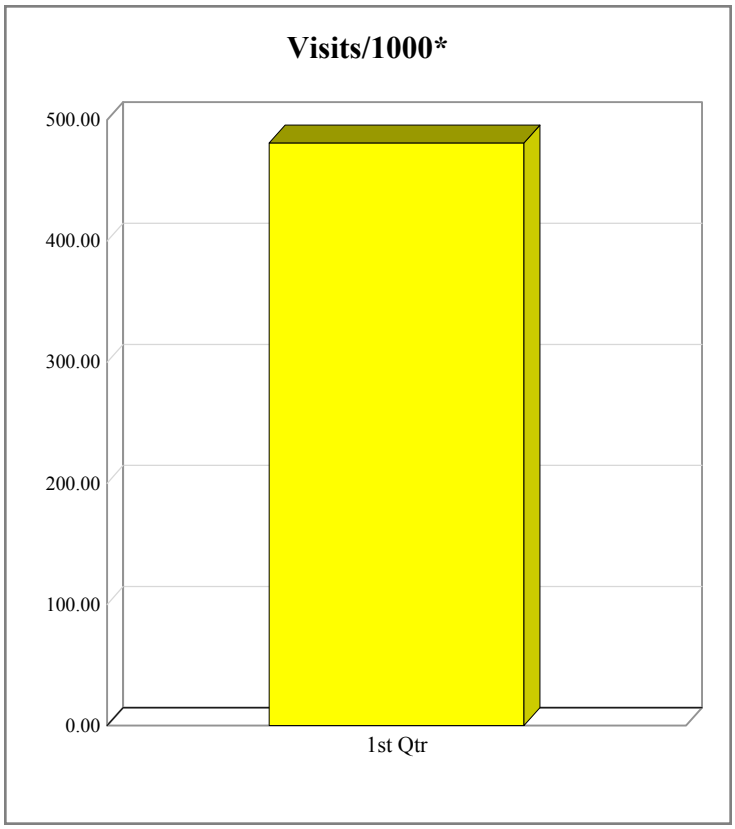
Substance Abuse

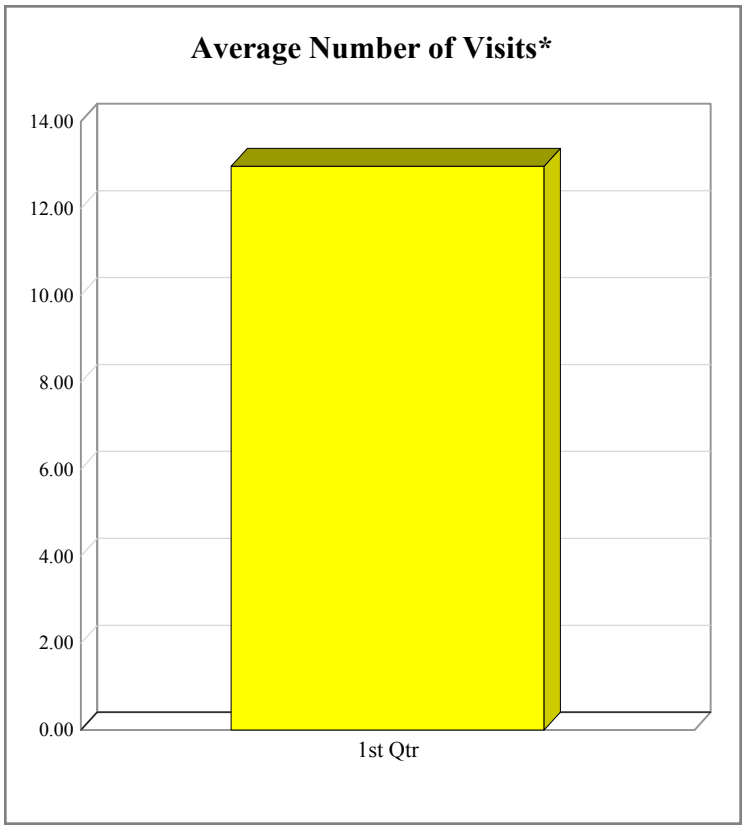
** Data is based on authorizations and has been annualized.*

New York State Empire Plan - CENTRAL NY
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

Total Outpatient Utilization by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	153,791	0	0	0	153,791
Visits *	18,488	0	0	0	18,488
Members Seen *	1,425	0	0	0	1,425
Visits/1000 Lives*	480.86	0.00	0.00	0.00	480.86
Avg Number of Visits*	12.97	0.00	0.00	0.00	12.97



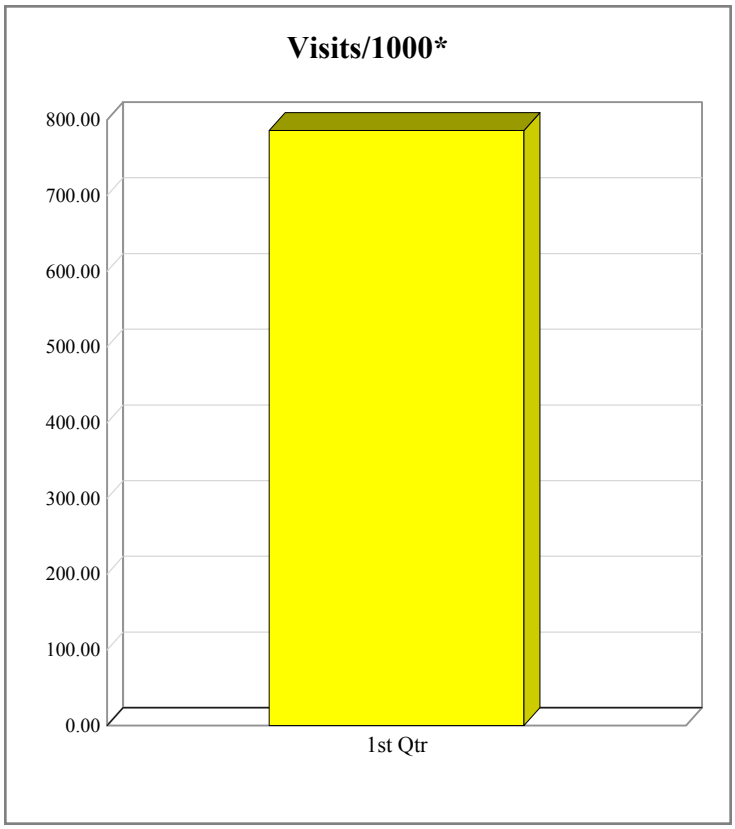


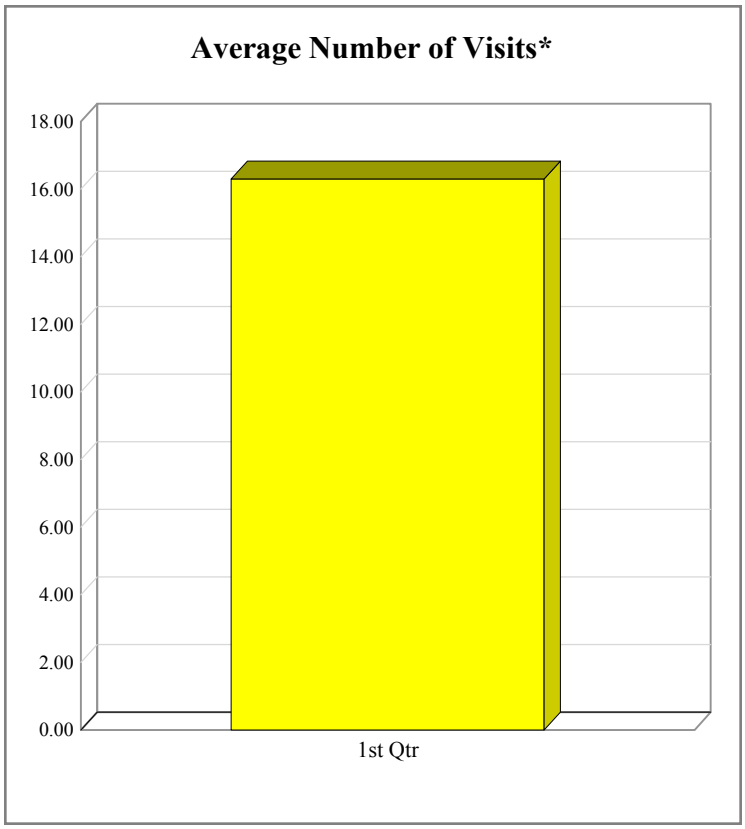
** Data is based on certifications and has been annualized.*

New York State Empire Plan - HUDSON VALLEY
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

Total Outpatient Utilization by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	290,648	0	0	0	290,648
Visits *	57,109	0	0	0	57,109
Members Seen *	3,503	0	0	0	3,503
Visits/1000 Lives*	785.96	0.00	0.00	0.00	785.96
Avg Number of Visits*	16.30	0.00	0.00	0.00	16.30



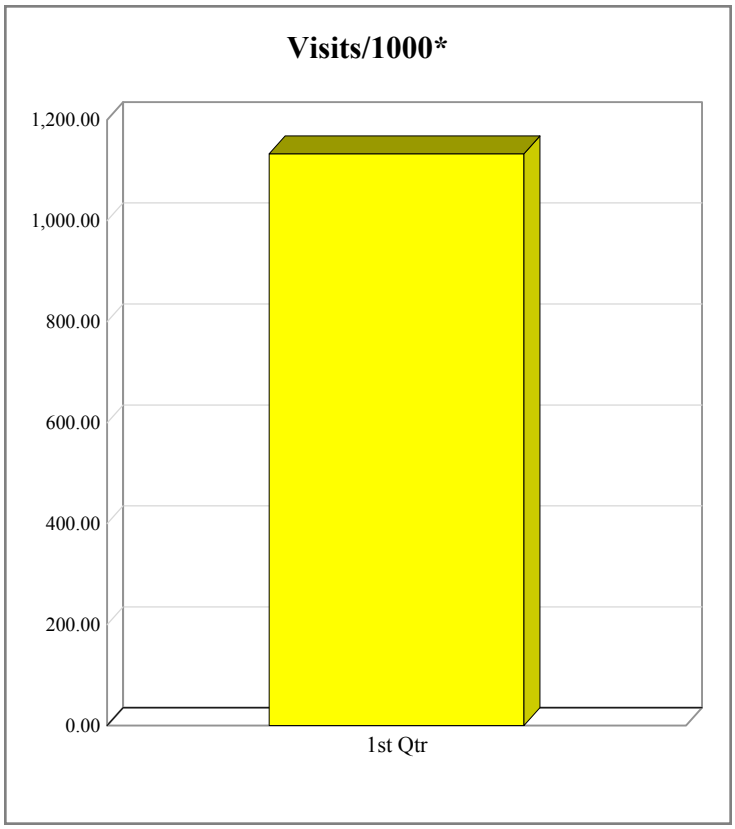


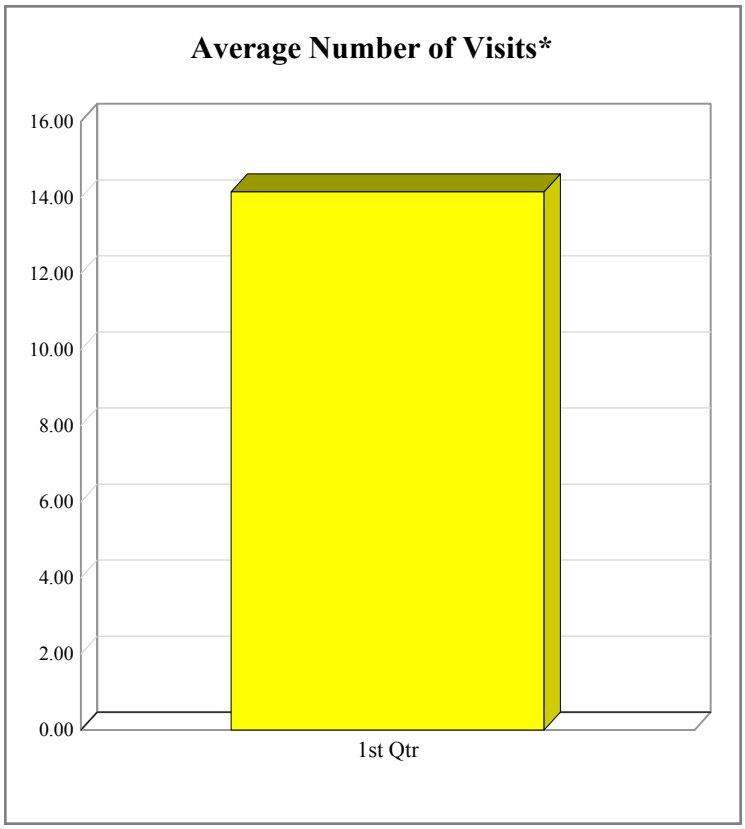
** Data is based on certifications and has been annualized.*

New York State Empire Plan - LONG ISLAND
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

Total Outpatient Utilization by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	364,058	0	0	0	364,058
Visits *	103,085	0	0	0	103,085
Members Seen *	7,280	0	0	0	7,280
Visits/1000 Lives*	1,132.62	0.00	0.00	0.00	1,132.62
Avg Number of Visits*	14.16	0.00	0.00	0.00	14.16



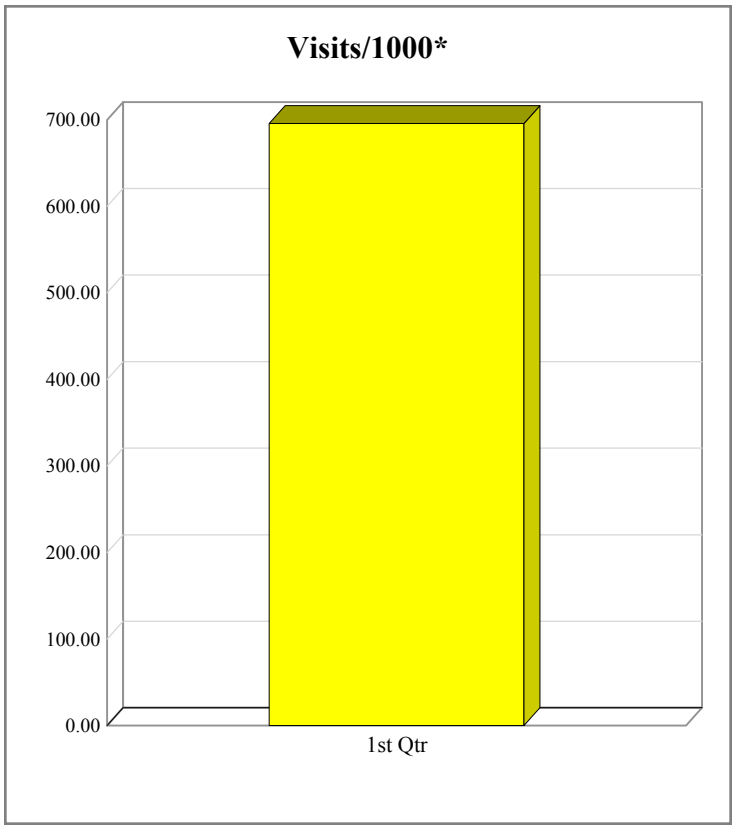


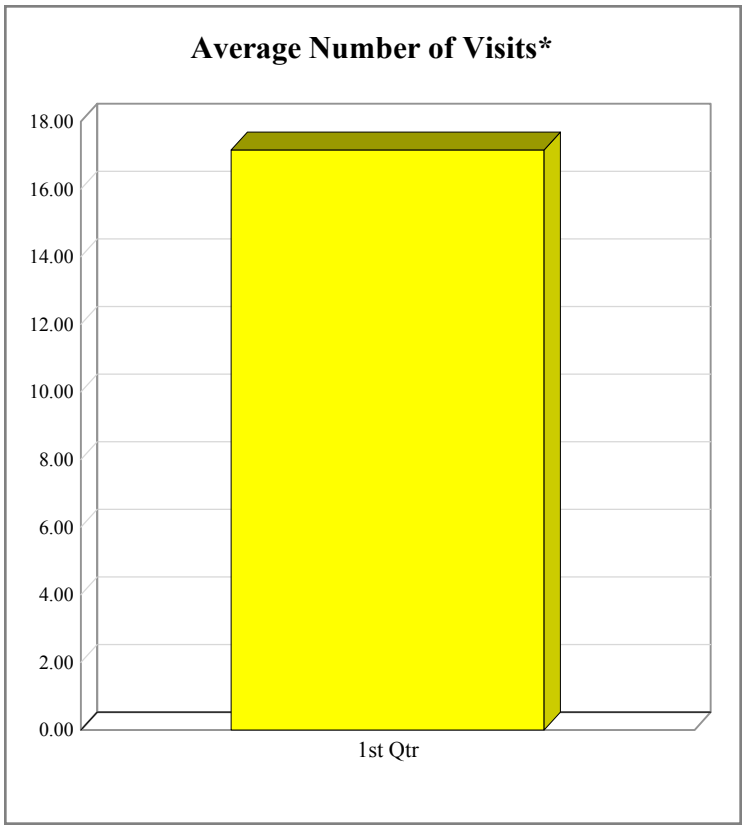
** Data is based on certifications and has been annualized.*

New York State Empire Plan - NY CITY
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

Total Outpatient Utilization by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	104,749	0	0	0	104,749
Visits *	18,225	0	0	0	18,225
Members Seen *	1,062	0	0	0	1,062
Visits/1000 Lives*	695.95	0.00	0.00	0.00	695.95
Avg Number of Visits*	17.16	0.00	0.00	0.00	17.16





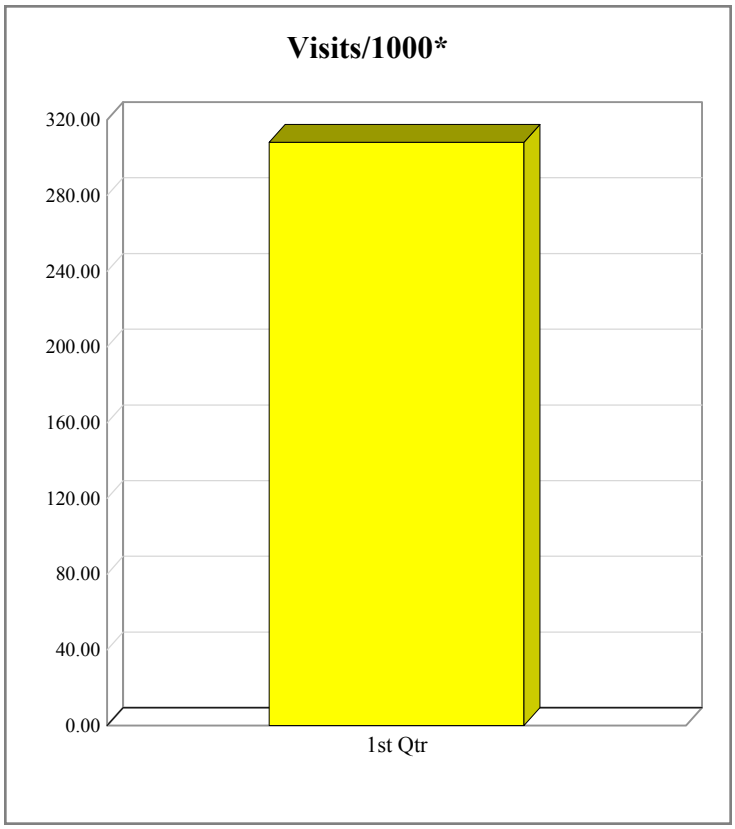
** Data is based on certifications and has been annualized.*

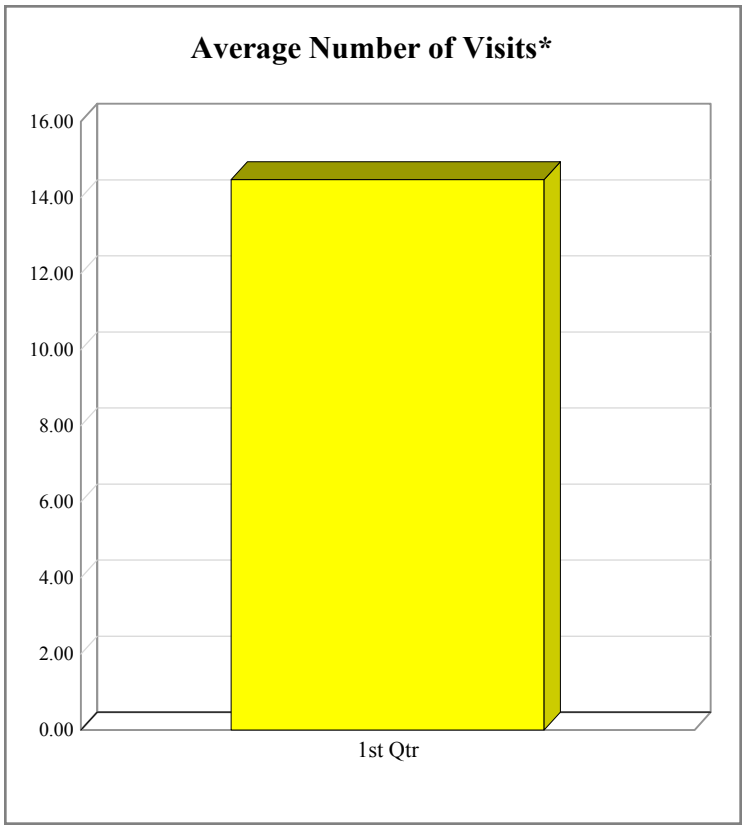
New York State Empire Plan - OUT OF STATE
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Outpatient Utilization by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	110,686	0	0	0	110,686
Visits *	8,526	0	0	0	8,526
Members Seen *	589	0	0	0	589
Visits/1000 Lives*	308.11	0.00	0.00	0.00	308.11
Avg Number of Visits*	14.48	0.00	0.00	0.00	14.48



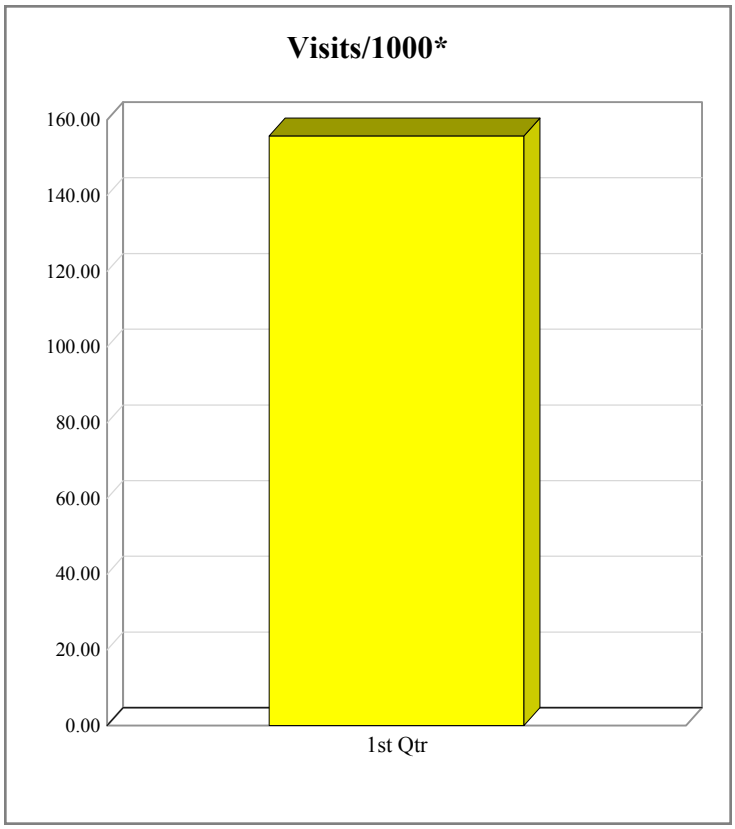


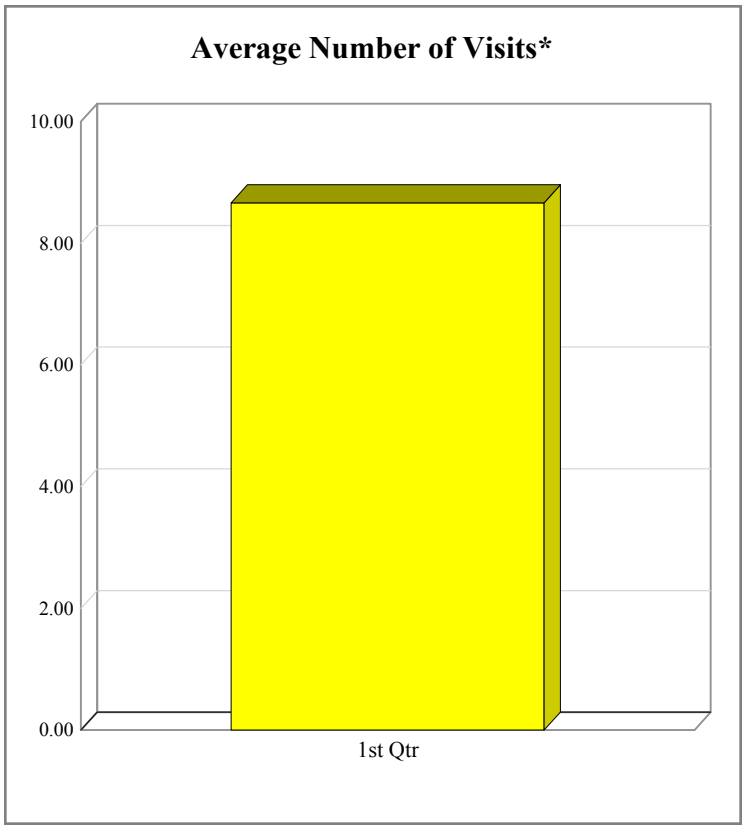
** Data is based on certifications and has been annualized.*

New York State Empire Plan - UNKNOWN
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

Total Outpatient Utilization by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	668	0	0	0	668
Visits *	26	0	0	0	26
Members Seen *	3	0	0	0	3
Visits/1000 Lives*	155.77	0.00	0.00	0.00	155.77
Avg Number of Visits*	8.67	0.00	0.00	0.00	8.67





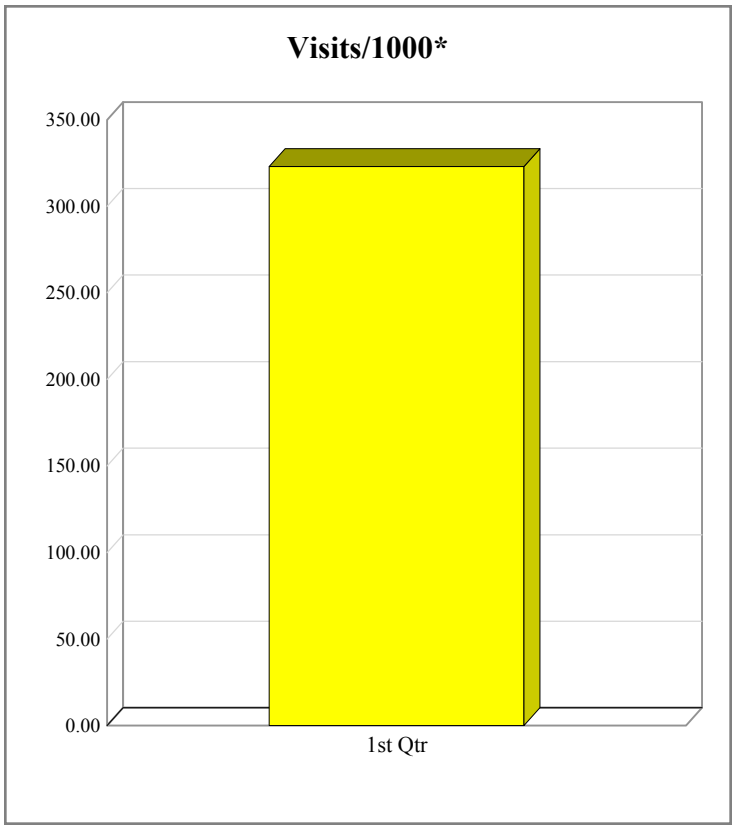
** Data is based on certifications and has been annualized.*

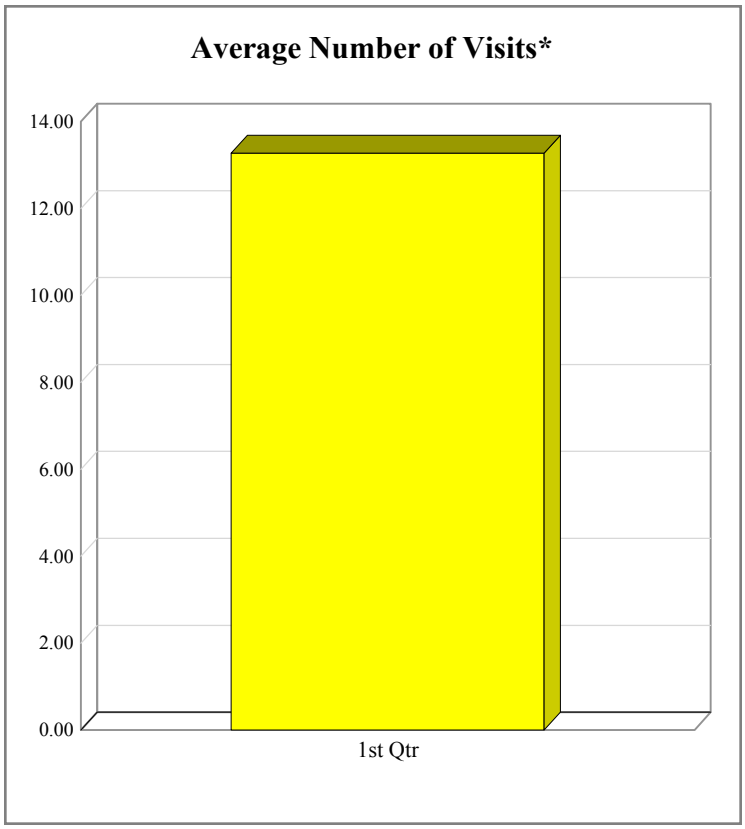
Report # 2008.1.02

New York State Empire Plan - WESTERN NY
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

Total Outpatient Utilization by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	70,186	0	0	0	70,186
Visits *	5,668	0	0	0	5,668
Members Seen *	427	0	0	0	427
Visits/1000 Lives*	323.03	0.00	0.00	0.00	323.03
Avg Number of Visits*	13.27	0.00	0.00	0.00	13.27





** Data is based on certifications and has been annualized.*

Report # 2008.1.02

New York State Empire Plan

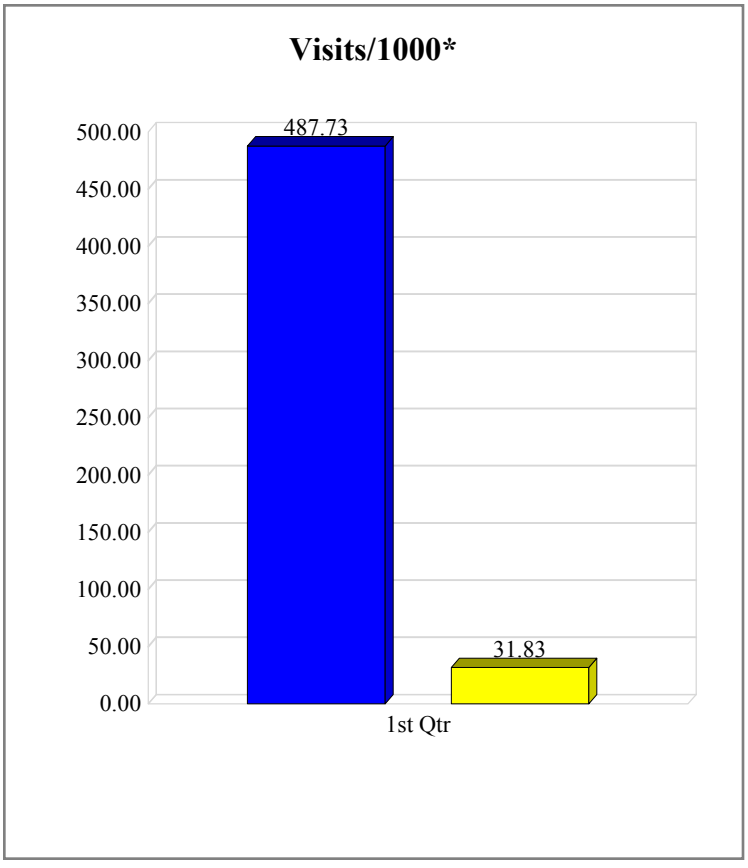
Managed Mental Health and Substance Abuse Activity Report

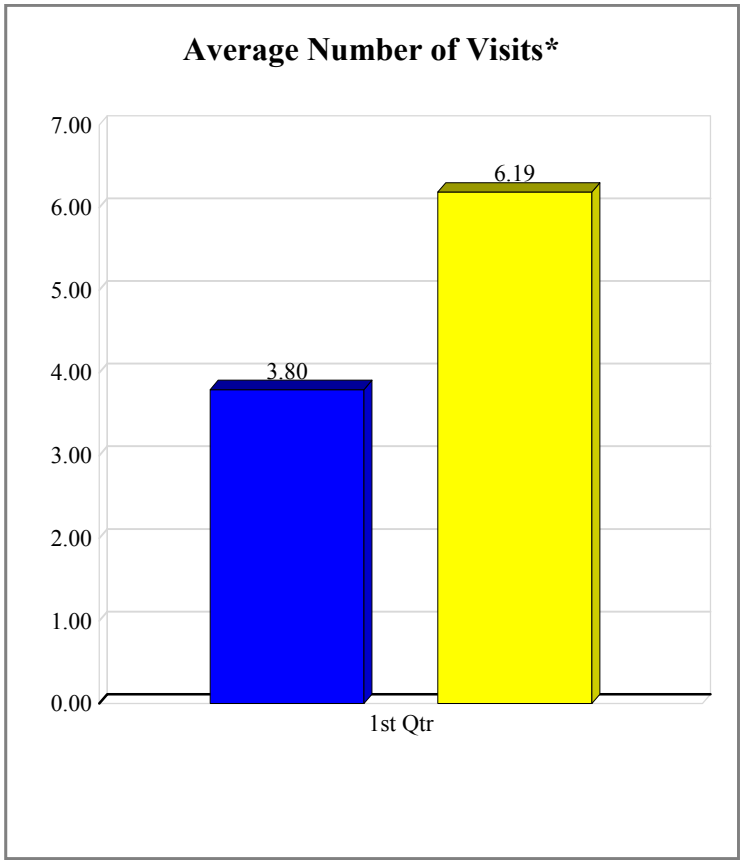
January 1, 2014 - March 31, 2014

Total Outpatient Utilization by Psychiatric/Substance Abuse (Paid Claims)

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	1,094,786	0	0	0	1,094,786

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Visits *	133,491	8,713	0	0	0	0	0	0	133,491	8,713
Members Seen	35,144	1,408	0	0	0	0	0	0	35,144	1,408
Visits/1000 Lives*	487.73	31.83	0.00	0.00	0.00	0.00	0.00	0.00	487.73	31.83
Avg Number of Visits*	3.80	6.19	0.00	0.00	0.00	0.00	0.00	0.00	3.80	6.19





Psych

Substance Abuse

** Data is based on paid claims and has been annualized.*

New York State Empire Plan

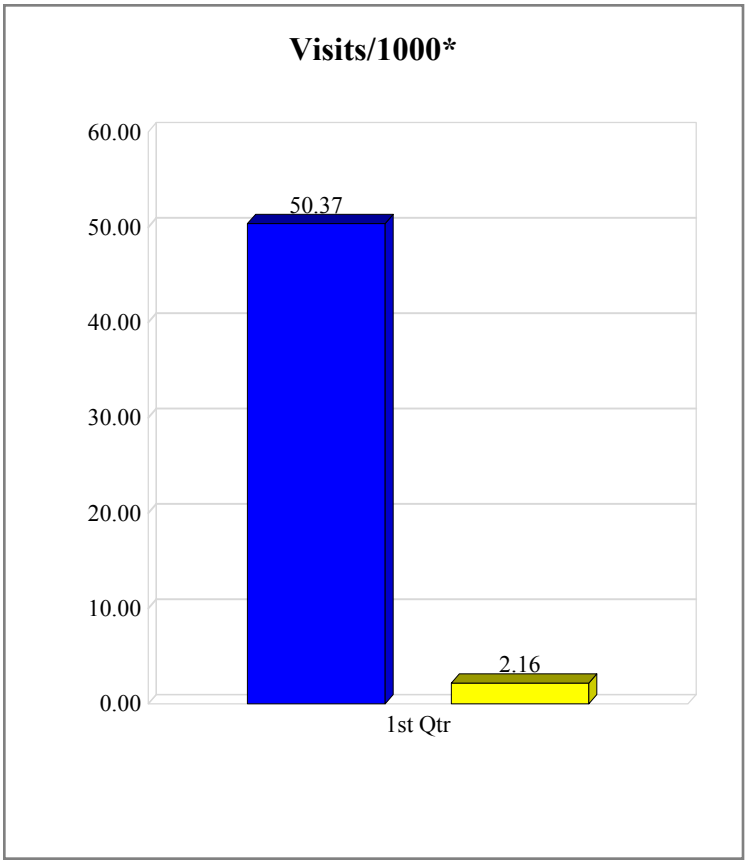
Managed Mental Health and Substance Abuse Activity Report

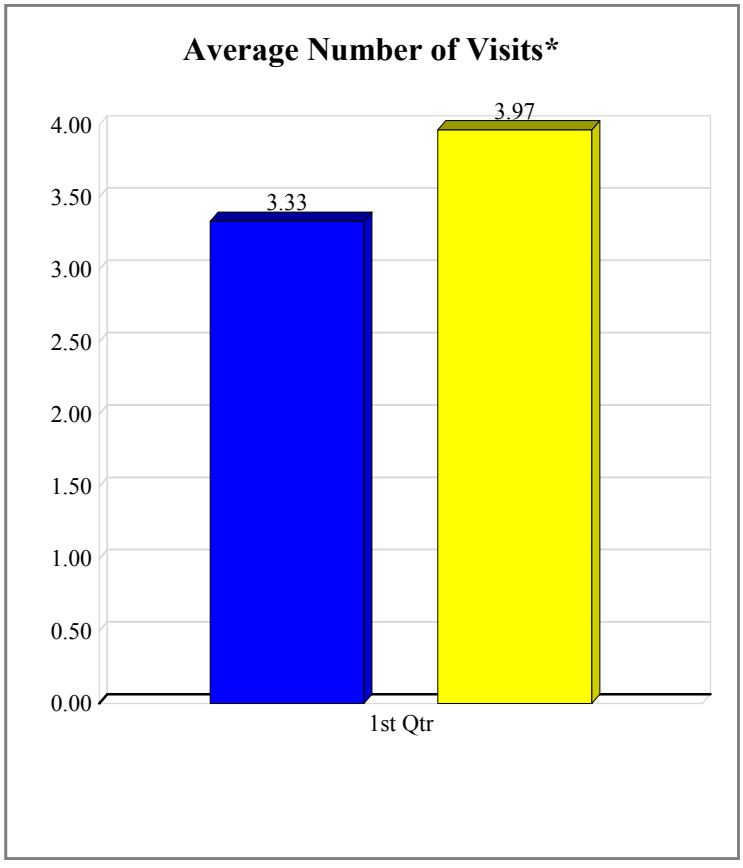
January 1, 2014 - March 31, 2014

Total Outpatient Utilization by Psychiatric/Substance Abuse (Paid Claims) - Out of Network

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	1,094,786	0	0	0	1,094,786

	Psych	SA	Psych	SA	Psych	SA	Psych	SA	Psych	SA
Visits *	13,787	591	0	0	0	0	0	0	13,787	591
Members Seen	4,135	149	0	0	0	0	0	0	4,135	149
Visits/1000 Lives*	50.37	2.16	0.00	0.00	0.00	0.00	0.00	0.00	50.37	2.16
Avg Number of Visits*	3.33	3.97	0.00	0.00	0.00	0.00	0.00	0.00	3.33	3.97





Psych

Substance Abuse

** Data is based on paid claims and has been annualized.*

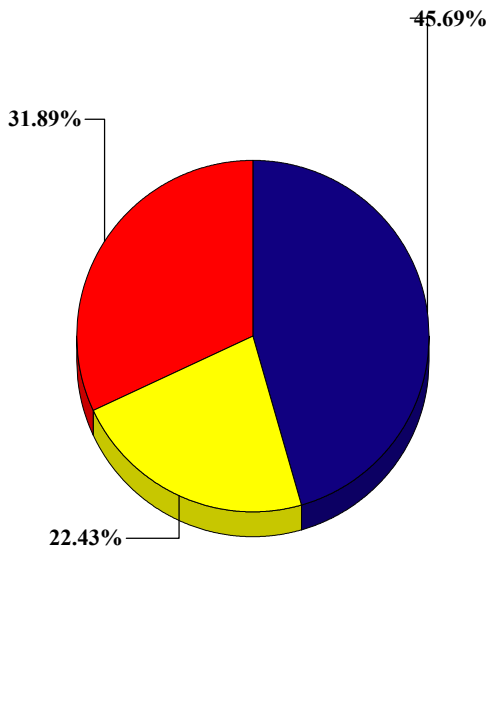
New York State Empire Plan
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

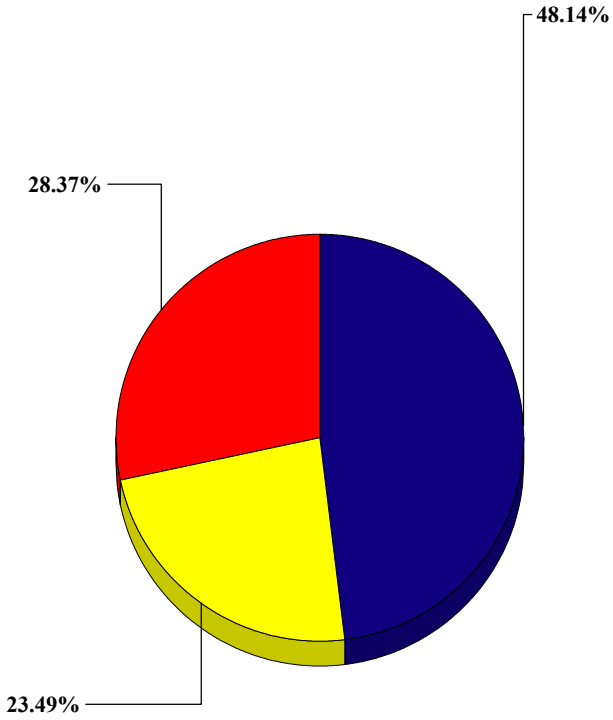
Penetration Rate by Beneficiary Type - Claims Based

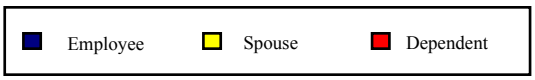
	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	16,698	8,196	11,654	36,548
Membership	527,069	257,171	310,546	1,094,786
Penetration Rate	3.17%	3.19%	3.75%	3.34%

Unduplicated Members Accessing Care



Membership





New York State Empire Plan

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

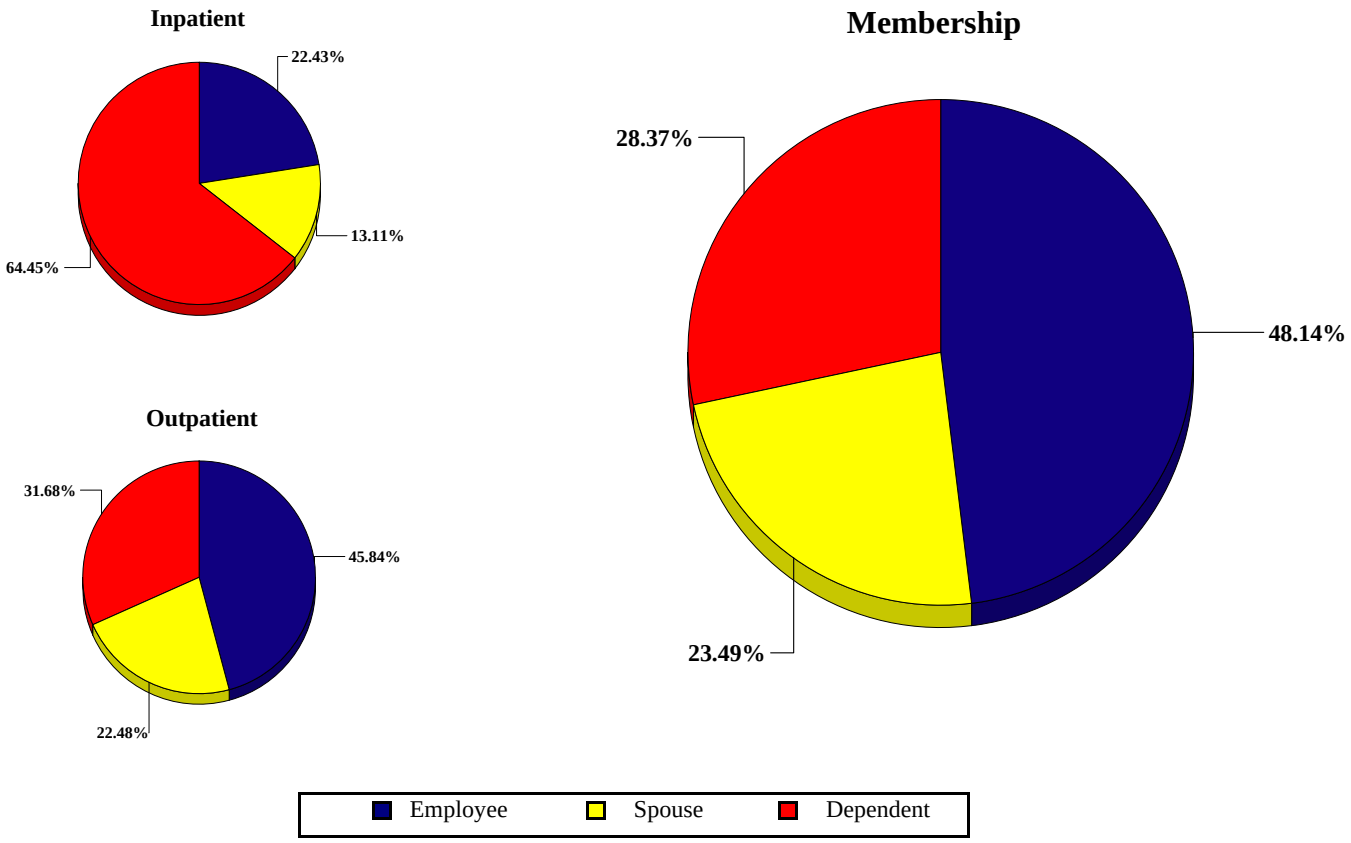
Penetration Rate by Beneficiary Type (Claims)
Inpatient vs. Outpatient

Inpatient

	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	142	83	408	633
Average Membership	527,069	257,171	310,546	1,094,786
Penetration Rate	0.03%	0.03%	0.13%	0.06%

Outpatient

	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	16,652	8,166	11,507	36,325
Average Membership	527,069	257,171	310,546	1,094,786
Penetration Rate	3.16%	3.18%	3.71%	3.32%



New York State Empire Plan

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

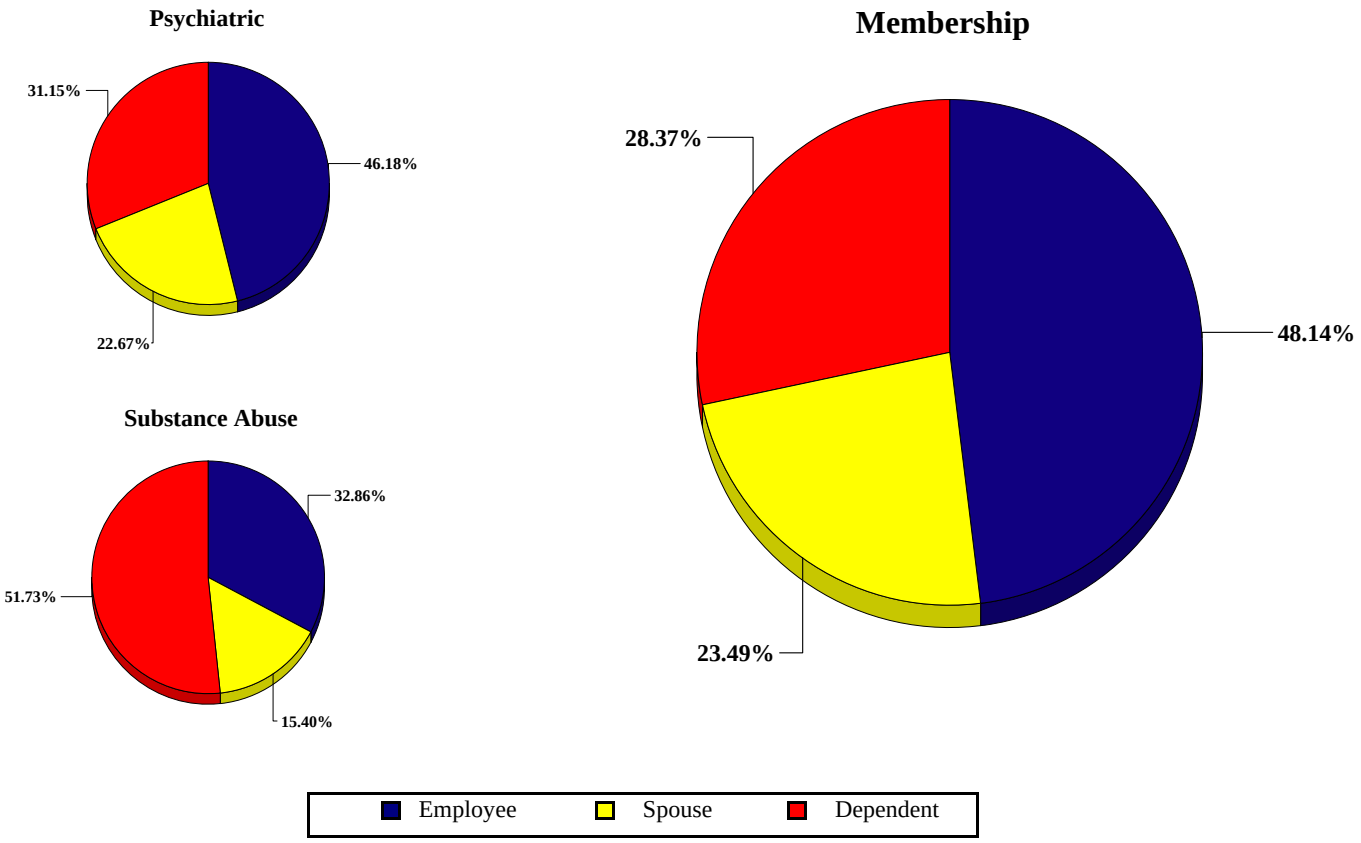
Penetration Rate by Beneficiary Type (Claims)
Psychiatric vs. Substance Abuse

Psychiatric

	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	16,281	7,994	10,981	35,256
Average Membership	527,069	257,171	310,546	1,094,786
Penetration Rate	3.09%	3.11%	3.54%	3.22%

Substance Abuse

	Employee	Spouse	Dependent	Total
Unduplicated Members Accessing Care	512	240	806	1,558
Average Membership	527,069	257,171	310,546	1,094,786
Penetration Rate	0.10%	0.09%	0.26%	0.14%

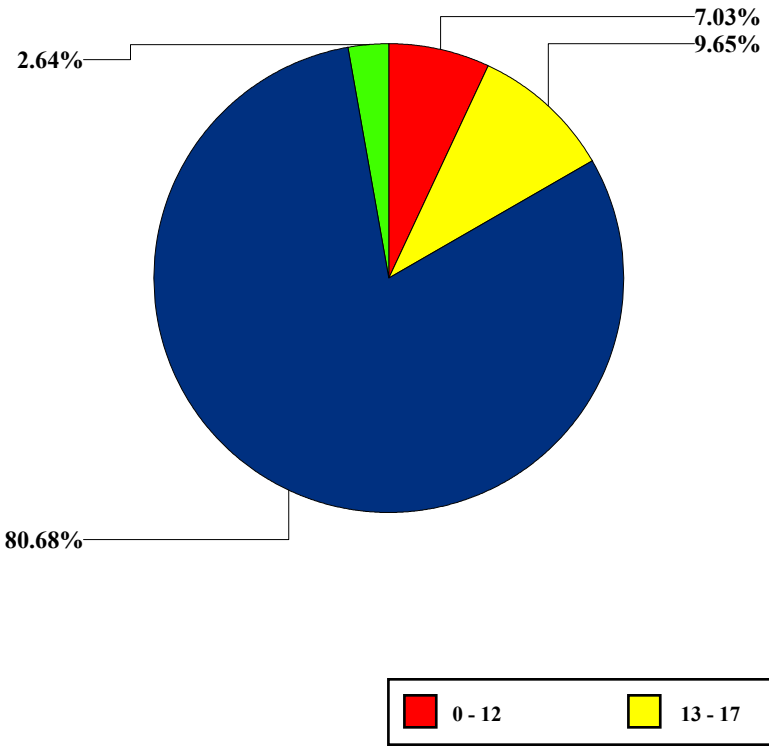


New York State Empire Plan
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

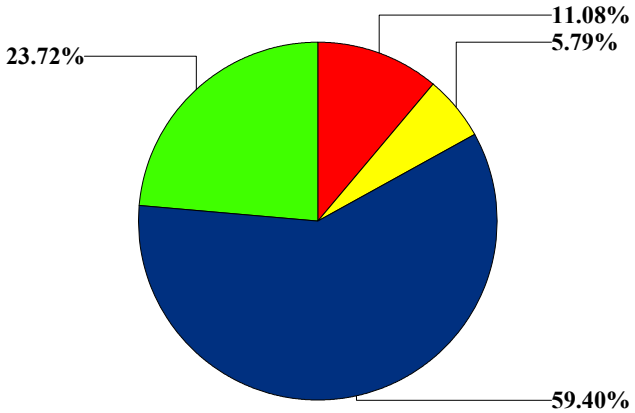
Penetration Rate by Age Category (Claims)

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	2577	3538	29587	969	36,548
Average Membership	121,332	63,429	650,299	259,725	1,094,786
Penetration Rate	2.12%	5.58%	4.55%	.37%	3.34%

Unduplicated Members Accessing Care



Membership



New York State Empire Plan

Managed Mental Health and Substance Abuse Activity Report

January 01, 2014 - March 31, 2014

Penetration Rate by Age Category (Claims)
Inpatient and Higher Level of Care vs Outpatient

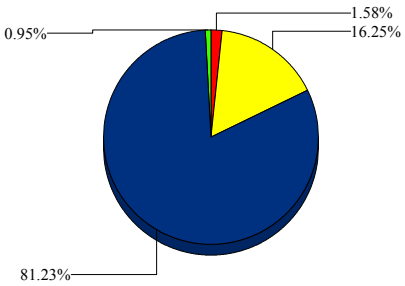
Inpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	10	103	515	6	633
Average Membership	121,332	63,429	650,299	259,725	1,094,786
Penetration Rate	0.01%	0.16%	0.08%	0.00%	0.06%

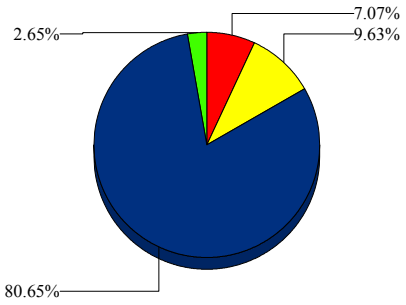
Outpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	2,577	3,511	29,394	965	36,325
Average Membership	121,332	63,429	650,299	259,725	1,094,786
Penetration Rate	2.12%	5.54%	4.52%	0.37%	3.32%

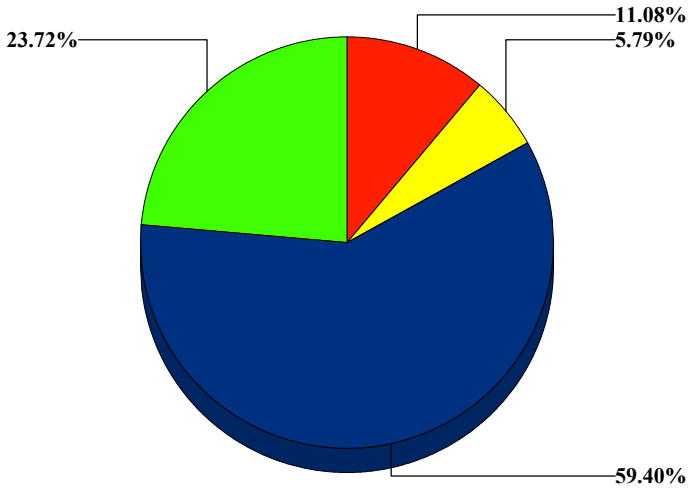
Inpatient

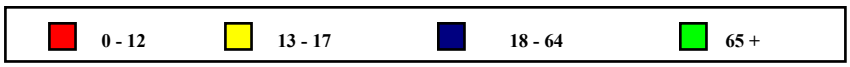


Outpatient



Membership





EMPIRE PLAN

Managed Mental Health and Substance Abuse Activity Report

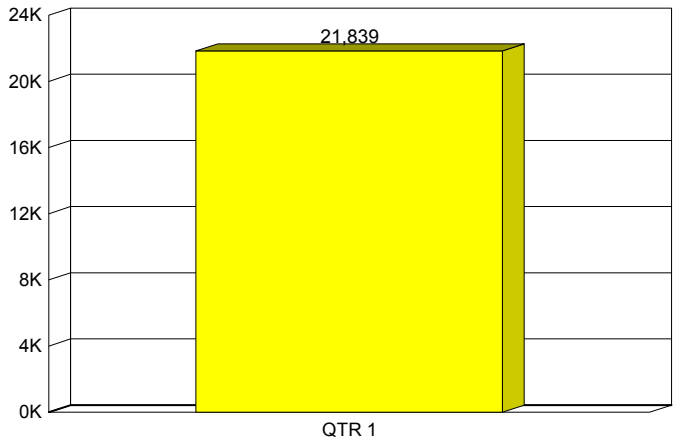
January 1, 2014 - March 31, 2014

Internal Appeals

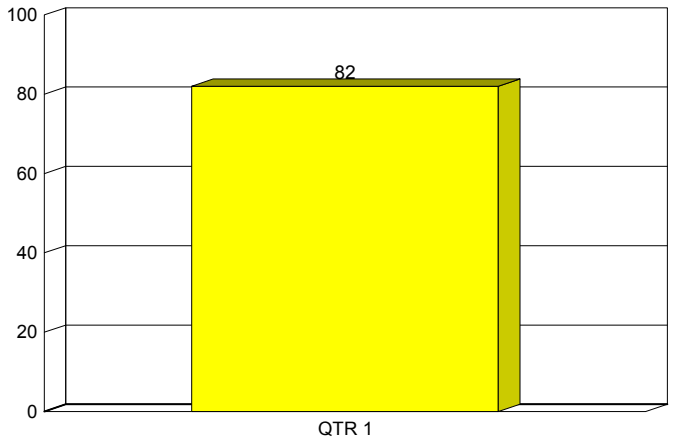
First and Second Level Appeals

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
# of Reviews	21,839	0	0	0	21,839
# of Appeals	82	0	0	0	82
# of Appeals / # of Reviews	0.4%	0.0%	0.0%	0.0%	0.4%
% of Successful Appeals*	22.0%	0.0%	0.0%	0.0%	22.0%

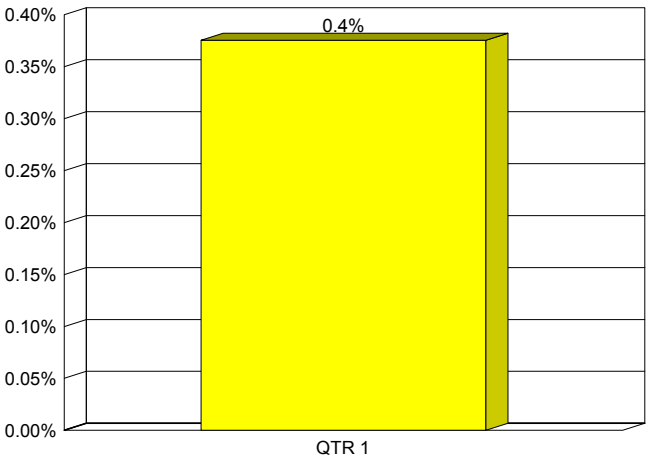
Number of Reviews



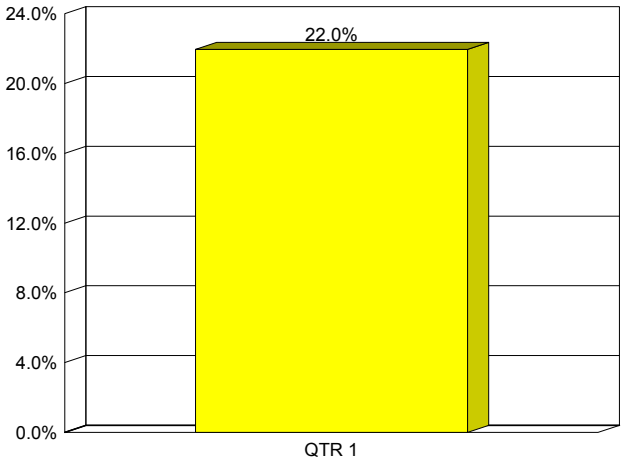
Number of Appeals



Number of Appeals / Number of Reviews



% Successful Appeals



*Successful Appeals are those in which the therapist's treatment plan is approved without modification or approved with modification.

EMPIRE PLAN

Managed Mental Health and Substance Abuse Activity Report

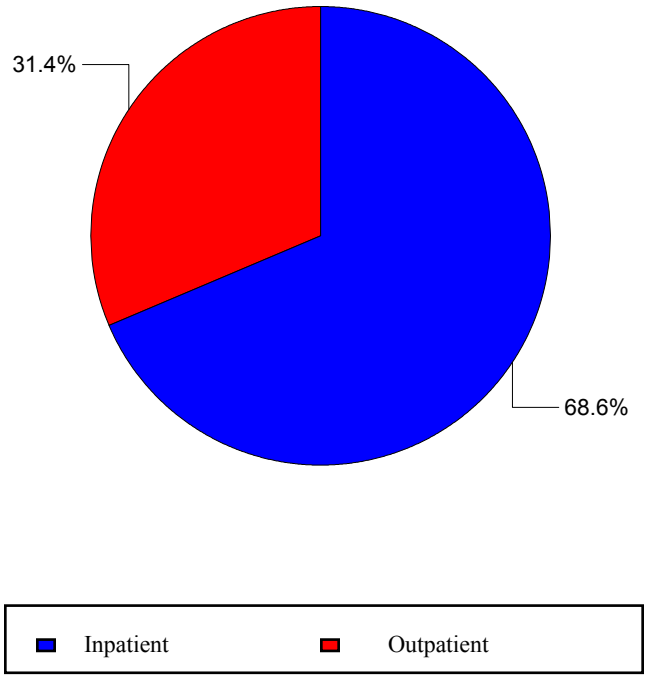
January 1, 2014 - March 31, 2014

Internal Appeals

First and Second Level Appeals

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
# of First Level Appeals	70	0	0	0	70
# of Inpatient	48	0	0	0	48
# of Outpatient & ALOC	22	0	0	0	22
# of Second Level Appeals	12	0	0	0	12

% of First Level Appeals: Inpatient vs Outpatient



EMPIRE PLAN
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

Internal Appeals

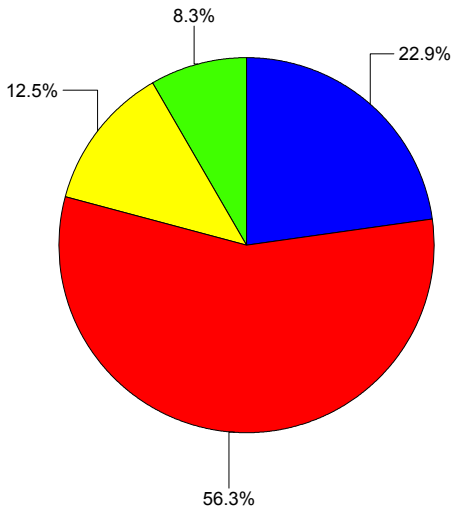
Inpatient First Level Appeals Turnaround Time

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
% reviewed within 1 day	79.2%	0.0%	0.0%	0.0%	79.2%
Same Day	11	0	0	0	11
One Day	27	0	0	0	27
Two Days	6	0	0	0	6
Three or More Days - VO	4	0	0	0	4
Three or More Days - Provider*	0	0	0	0	0
Total Inpatient First Level	48	0	0	0	48

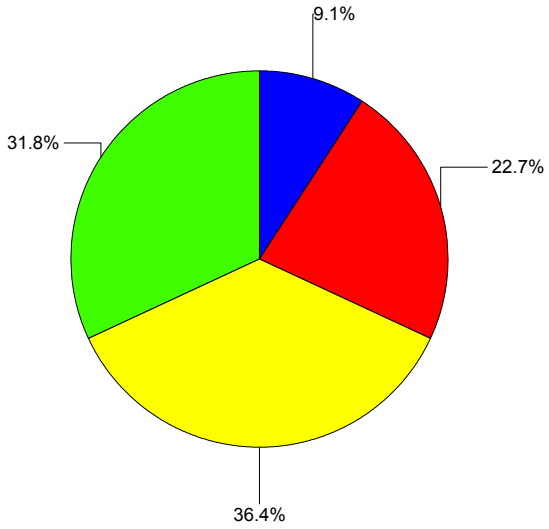
Outpatient and ALOC First Level Appeals Turnaround Time

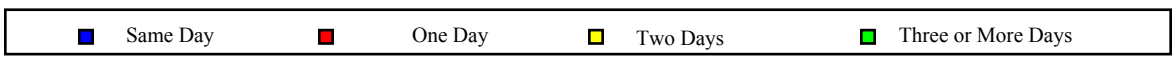
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
% reviewed within 2 days	68.2%	0.0%	0.0%	0.0%	68.2%
Same Day	2	0	0	0	2
One Day	5	0	0	0	5
Two Days	8	0	0	0	8
Three or More Days - VO	7	0	0	0	7
Three or More Days - Provider*	0	0	0	0	0
Total Outpatient First Level	22	0	0	0	22

Inpatient First Level Appeals Turnaround Time



Outpatient and ALOC First Level Appeals Turnaround Time





* Practitioner requested review outside the standard or ValueOptions tried to contact the provider 3 or more times.

**In the tables above, the term "Day" = business day

EMPIRE PLAN

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Internal Appeals

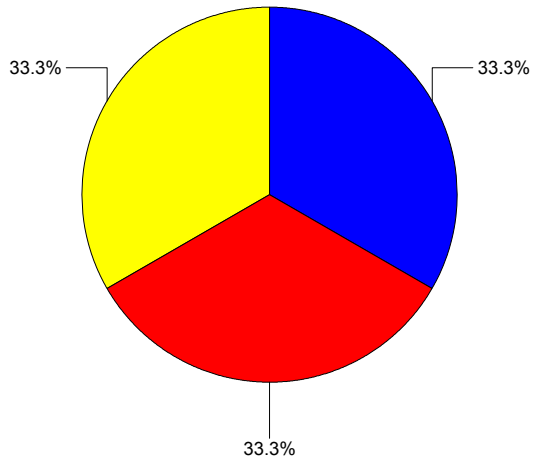
Inpatient Second Level Appeals Turnaround Time

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
% reviewed within 10 days	66.7%	0.0%	0.0%	0.0%	66.7%
0 to 5 Days	1	0	0	0	1
6 to 10 Days	1	0	0	0	1
11 to 15 Days	1	0	0	0	1
16 or More Days	0	0	0	0	0
Total Inpatient Second Level	3	0	0	0	3

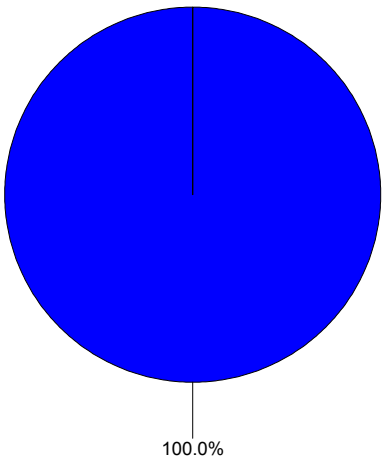
Outpatient & ALOC Second Level Appeals Turnaround Time

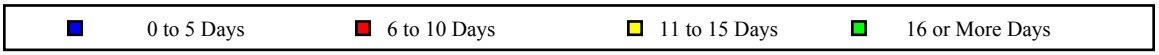
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
% reviewed within 10 days	100.0%	0.0%	0.0%	0.0%	100.0%
0 to 5 Days	9	0	0	0	9
6 to 10 Days	0	0	0	0	0
11 to 15 Days	0	0	0	0	0
16 or More Days	0	0	0	0	0
Total Outpatient Second Level	9	0	0	0	9

Inpatient Second Level Appeals Turnaround Time



Outpatient & ALOC Second Level Appeals Turnaround Time





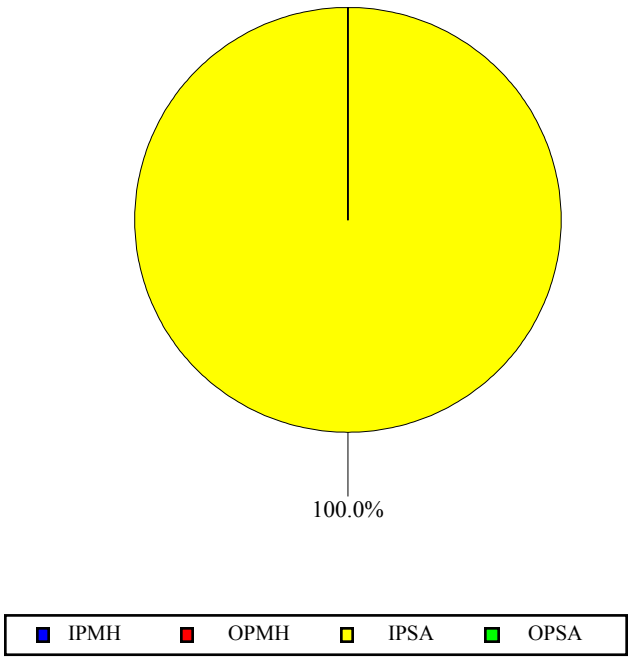
* In the tables above, the term "Day" = business day

EMPIRE PLAN
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

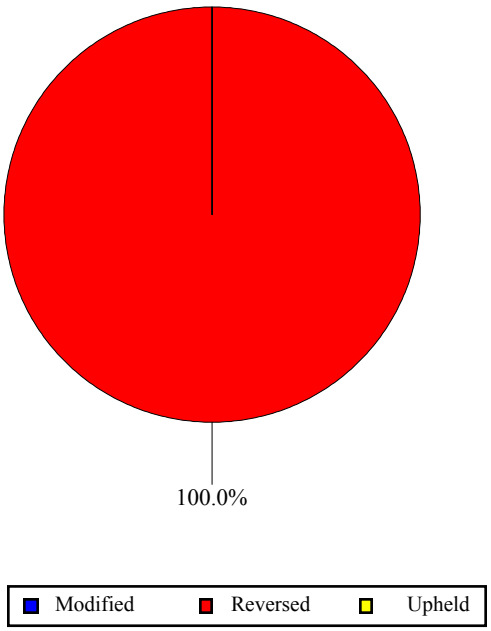
EXTERNAL APPEALS

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
# of External Appeal Requests	2	0	0	0	2
# of IPMH Requests	0	0	0	0	0
# of IPSA Requests	0	0	0	0	0
# of OPMH Requests	2	0	0	0	2
# of OPSA Requests	0	0	0	0	0
# of Reviews Overturned	2	0	0	0	2
# of Reviews Modified	0	0	0	0	0
# of Reviews Reversed	2	0	0	0	2
Percentage of Reviews Overturned	100.0%	0.0%	0.0%	0.0%	100.0%
# of Reviews Upheld	0	0	0	0	0
Percentage of Reviews Upheld	0.0%	0.0%	0.0%	0.0%	0.0%

External Appeals



External Appeal Determination

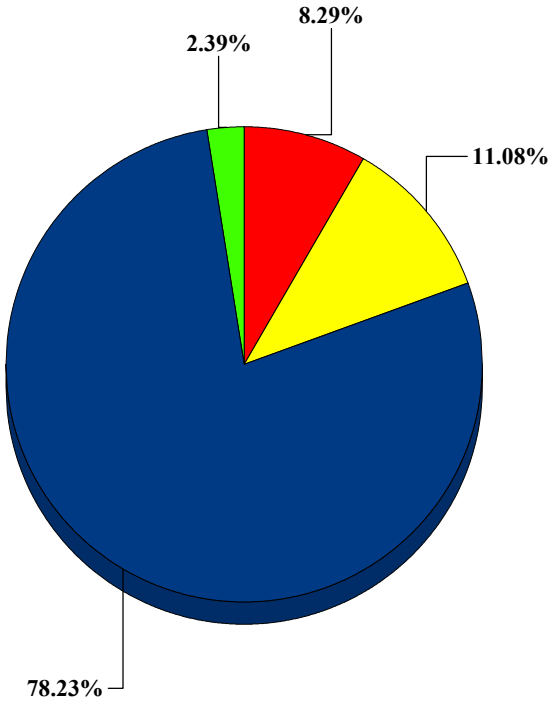


New York State Empire Plan - CENTRAL NY
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

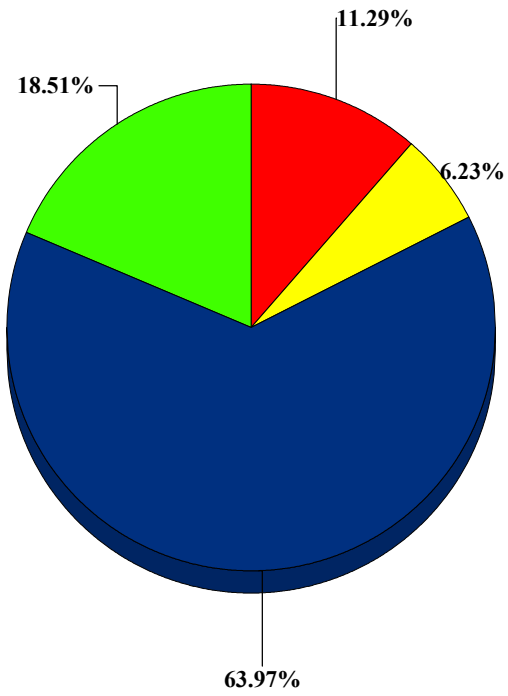
Regional Penetration Rate by Age Category (Claims)

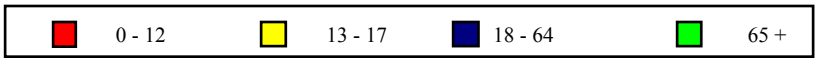
	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	354	473	3339	102	4258
Average Membership	17,358	9,587	98,386	28,461	153,791
Penetration Rate	2.04%	4.93%	3.39%	0.36%	2.77%

Unduplicated Members Accessing Care



Membership



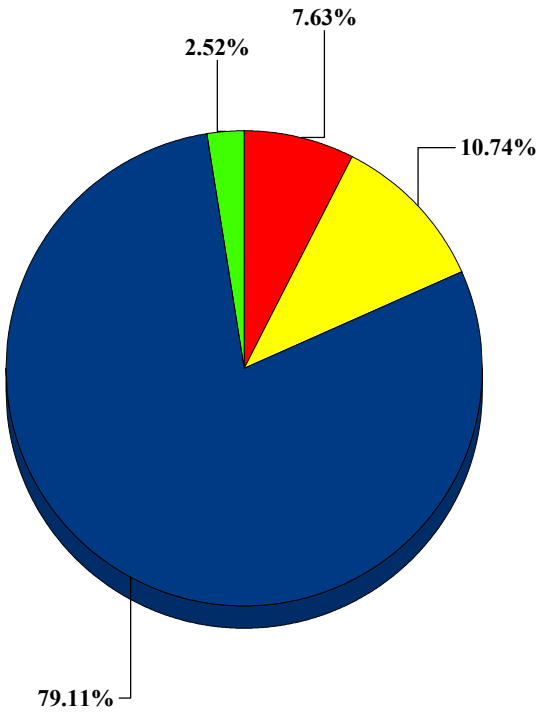


New York State Empire Plan - HUDSON VALLEY
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

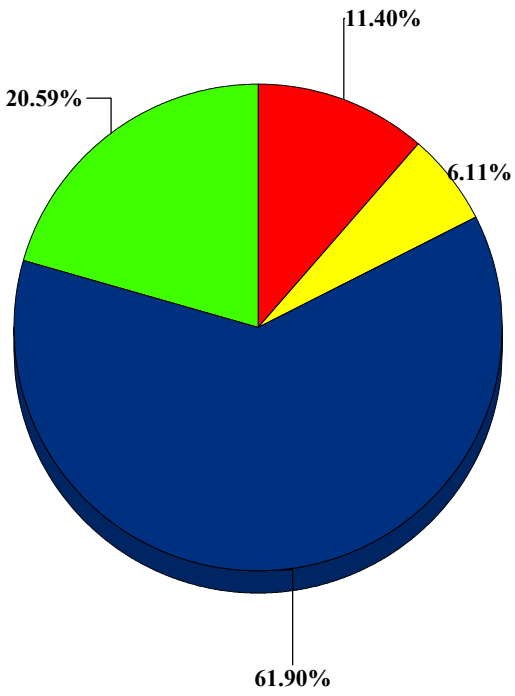
Regional Penetration Rate by Age Category (Claims)

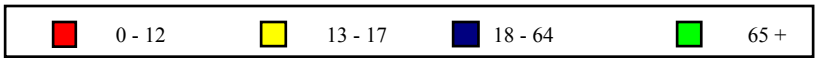
	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	868	1221	8997	287	11329
Average Membership	33,120	17,764	179,915	59,848	290,648
Penetration Rate	2.62%	6.87%	5.00%	0.48%	3.90%

Unduplicated Members Accessing Care



Membership



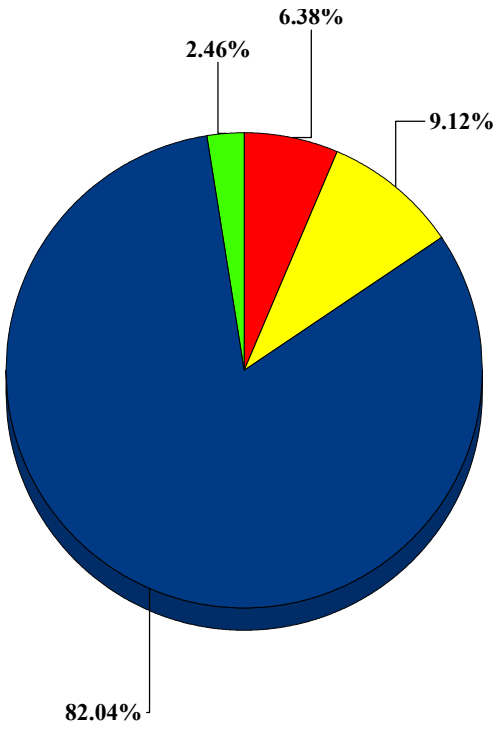


New York State Empire Plan - LONG ISLAND
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

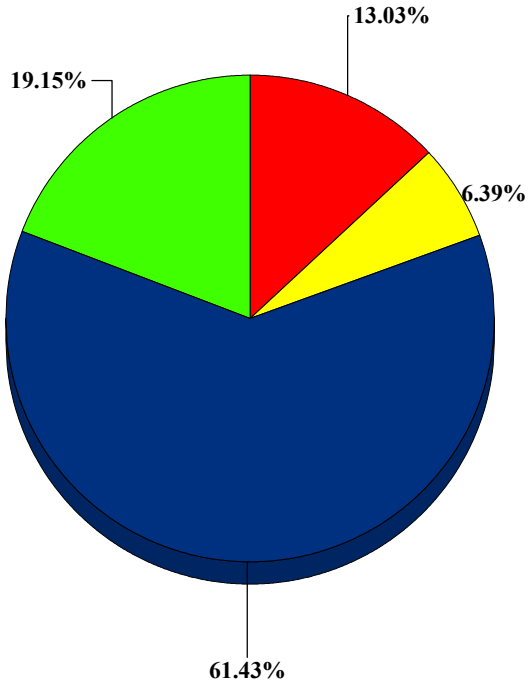
Regional Penetration Rate by Age Category (Claims)

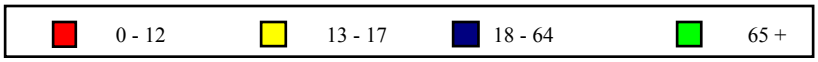
	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	987	1410	12682	380	15408
Average Membership	47,430	23,268	223,630	69,730	364,058
Penetration Rate	2.08%	6.06%	5.67%	0.54%	4.23%

Unduplicated Members Accessing Care



Membership



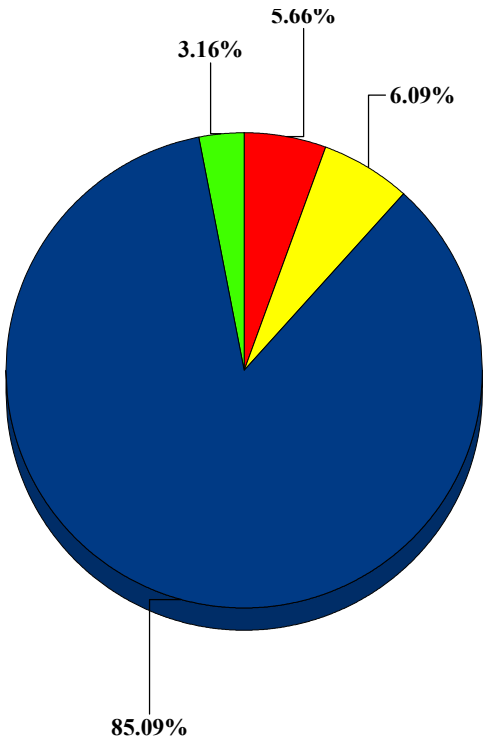


New York State Empire Plan - NY CITY
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

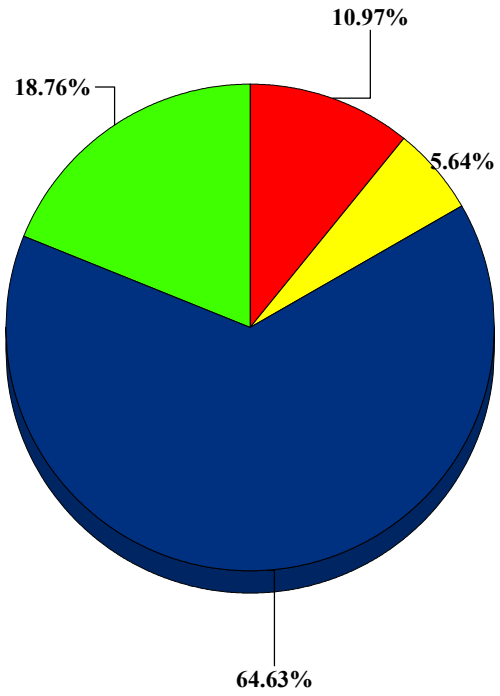
Regional Penetration Rate by Age Category (Claims)

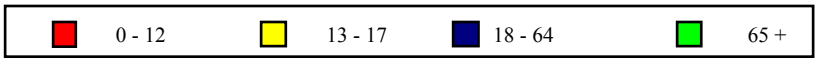
	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	147	158	2208	82	2587
Average Membership	11,488	5,908	67,703	19,650	104,749
Penetration Rate	1.28%	2.67%	3.26%	0.42%	2.47%

Unduplicated Members Accessing Care



Membership



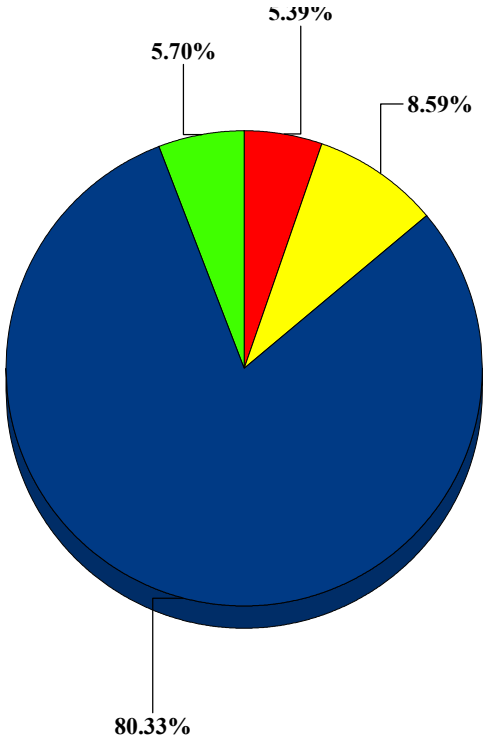


New York State Empire Plan - OUT OF STATE
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

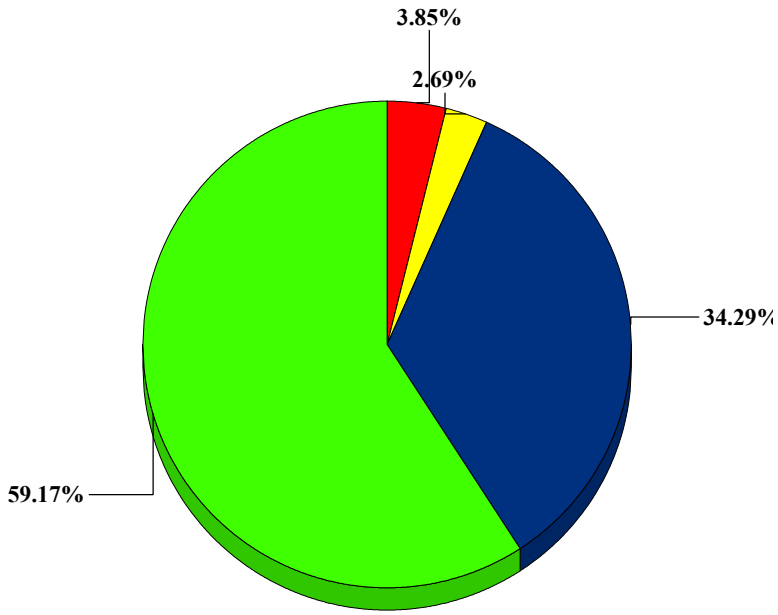
Regional Penetration Rate by Age Category (Claims)

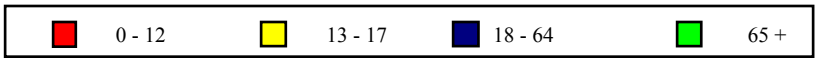
	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	69	110	1029	73	1277
Average Membership	4,257	2,975	37,957	65,498	110,686
Penetration Rate	1.62%	3.70%	2.71%	0.11%	1.15%

Unduplicated Members Accessing Care



Membership



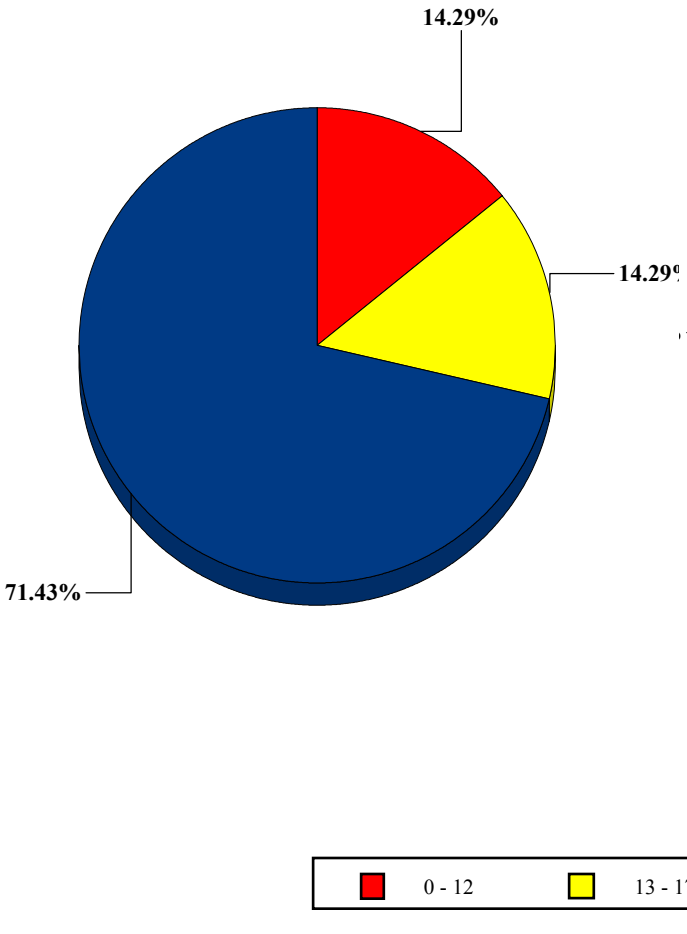


New York State Empire Plan - UNKNOWN
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

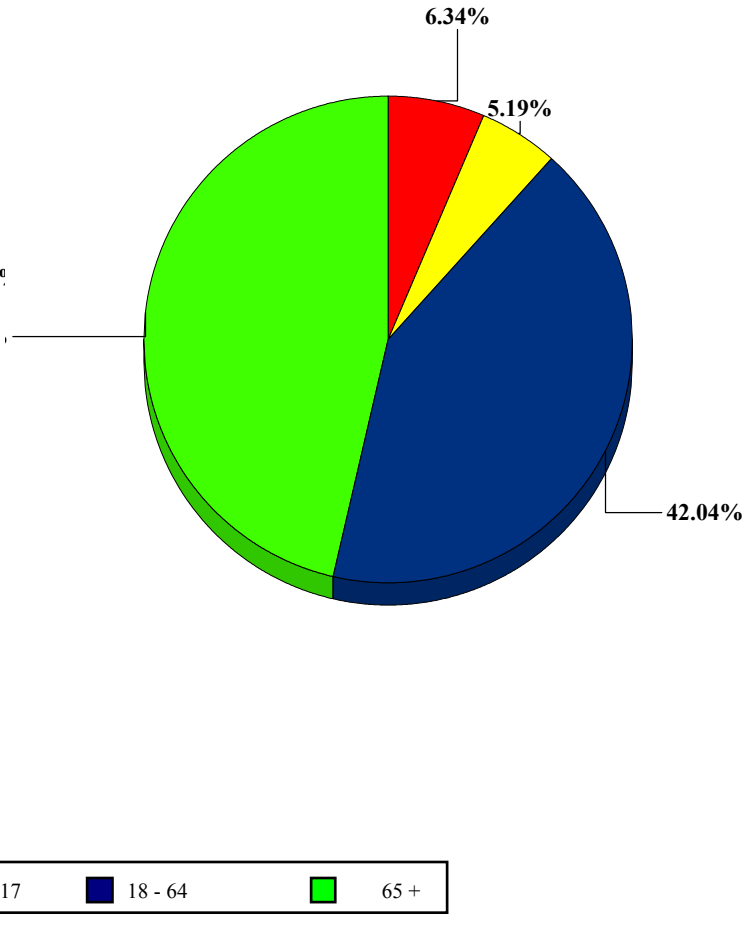
Regional Penetration Rate by Age Category (Claims)

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	1	1	5	0	7
Average Membership	42	35	281	310	668
Penetration Rate	2.36%	2.88%	1.78%	0.00%	1.05%

Unduplicated Members Accessing Care



Membership

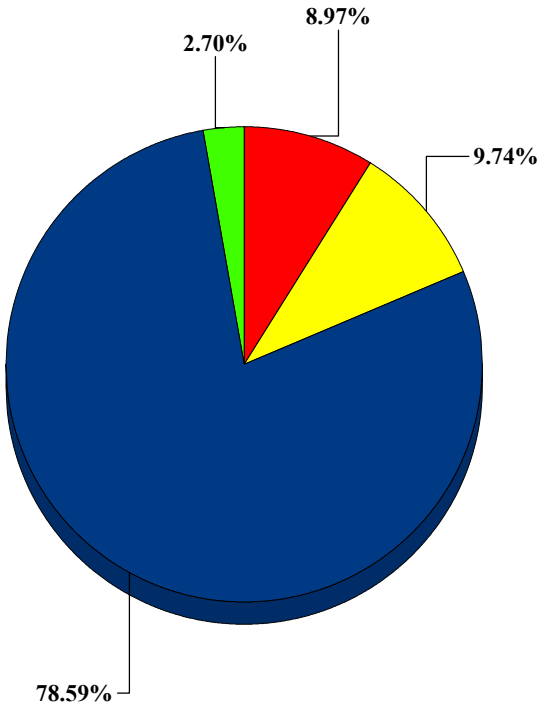


New York State Empire Plan - WESTERN NY
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

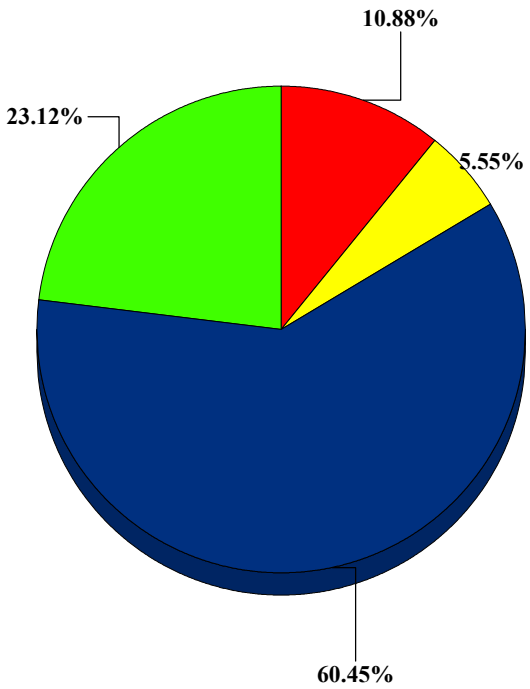
Regional Penetration Rate by Age Category (Claims)

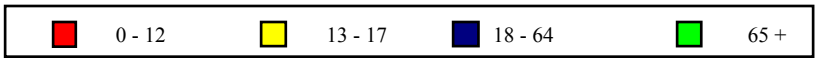
	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	153	166	1340	46	1699
Average Membership	7,638	3,892	42,428	16,228	70,186
Penetration Rate	2.00%	4.26%	3.16%	0.28%	2.42%

Unduplicated Members Accessing Care



Membership





New York State Empire Plan - CENTRAL NY
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

Inpatient paid claims as of 3/31/2014

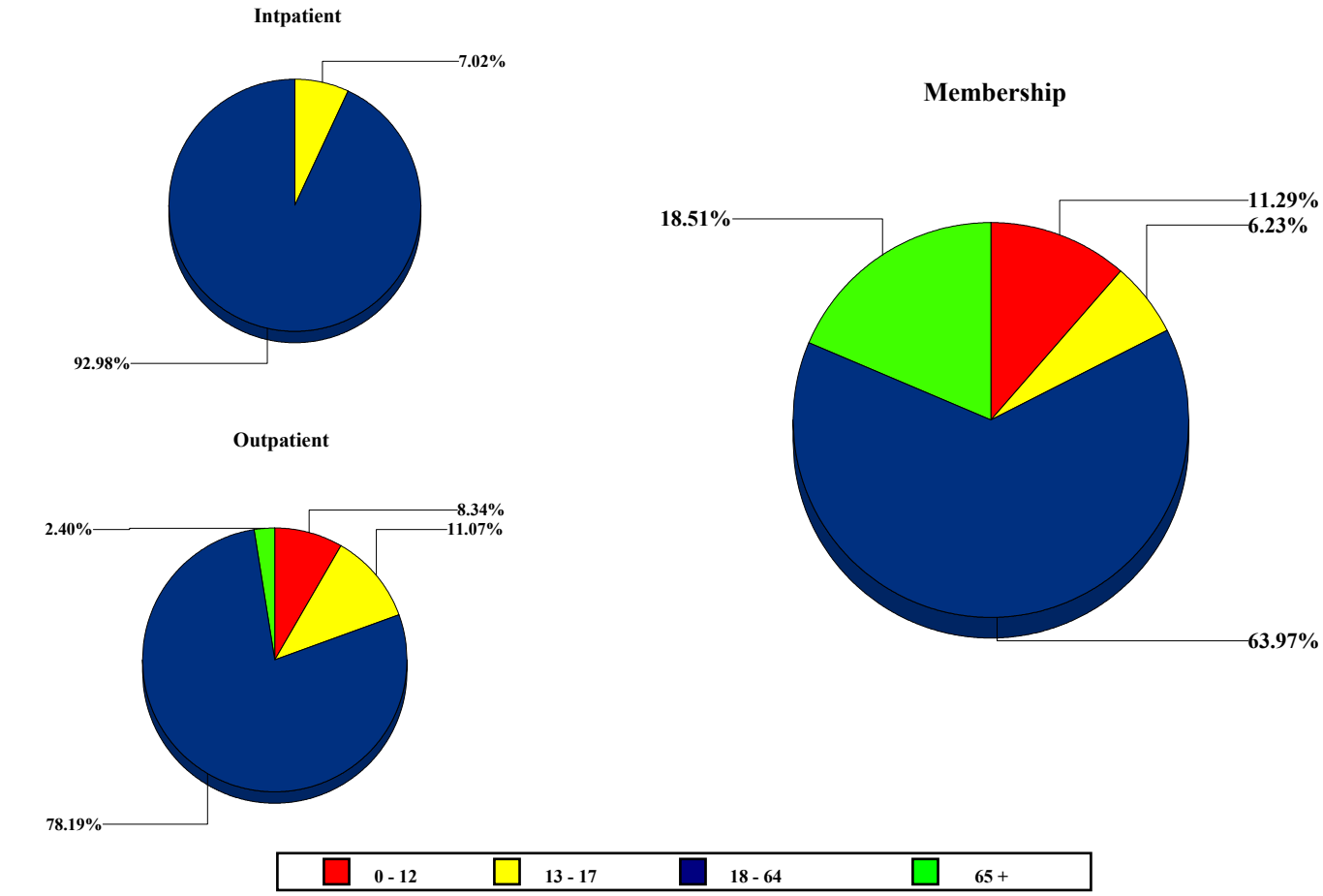
Group Penetration Rate by Age Category (Claims)
Inpatient and Higher Level of Care vs Outpatient

Inpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	0	4	53	0	57
Average Membership	17,358	9,587	98,386	28,461	153,791
Penetration Rate	0.00%	0.04%	0.05%	0.00%	0.04%

Outpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	354	470	3,320	102	4,236
Average Membership	17,358	9,587	98,386	28,461	153,791
Penetration Rate	2.04%	4.90%	3.37%	0.36%	2.75%



New York State Empire Plan - HUDSON VALLEY
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

Inpatient paid claims as of 3/31/2014

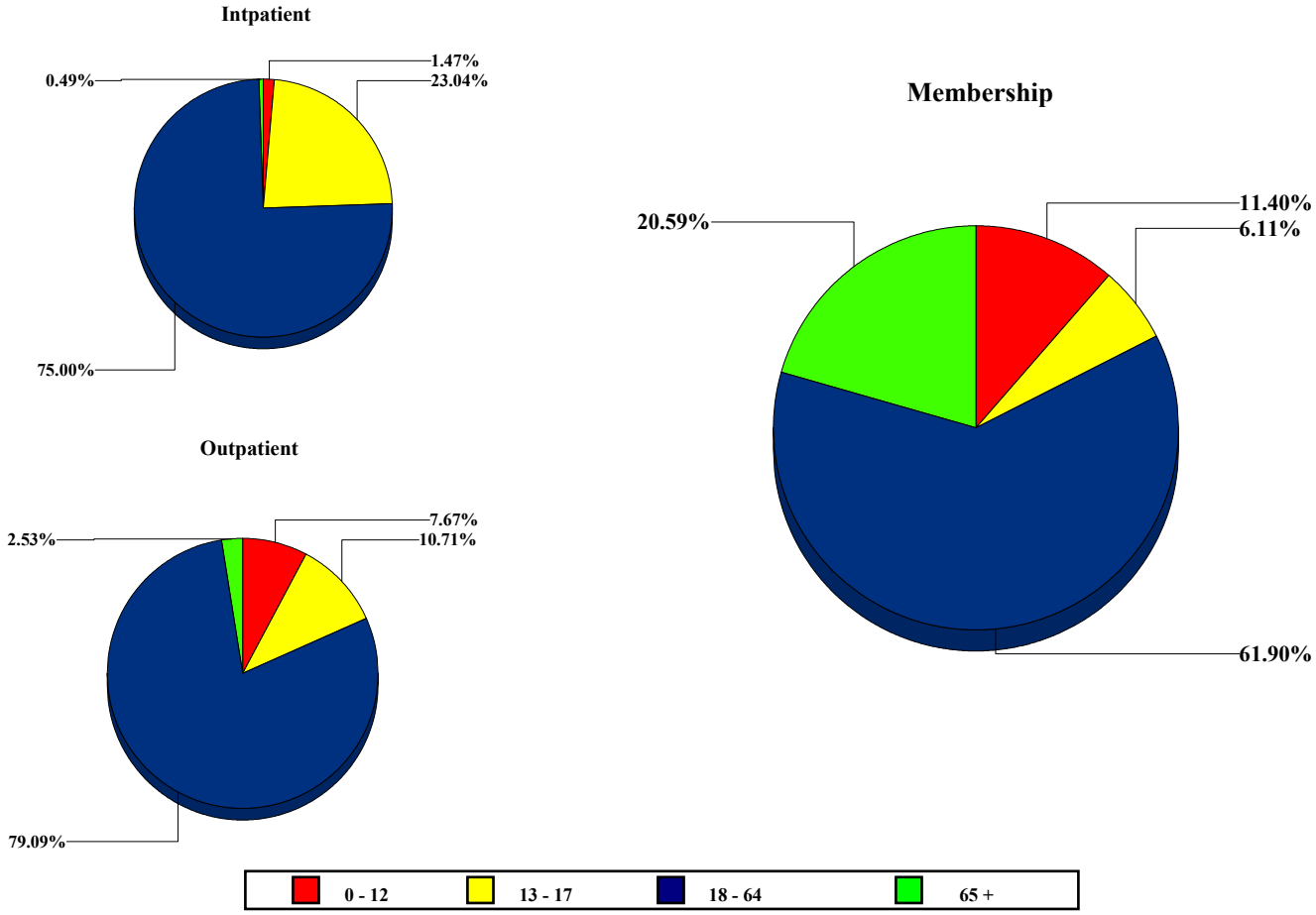
Group Penetration Rate by Age Category (Claims)
Inpatient and Higher Level of Care vs Outpatient

Inpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	3	47	153	1	204
Average Membership	33,120	17,764	179,915	59,848	290,648
Penetration Rate	0.01%	0.26%	0.09%	0.00%	0.07%

Outpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	868	1,212	8,948	286	11,270
Average Membership	33,120	17,764	179,915	59,848	290,648
Penetration Rate	2.62%	6.82%	4.97%	0.48%	3.88%



New York State Empire Plan - LONG ISLAND
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

Inpatient paid claims as of 3/31/2014

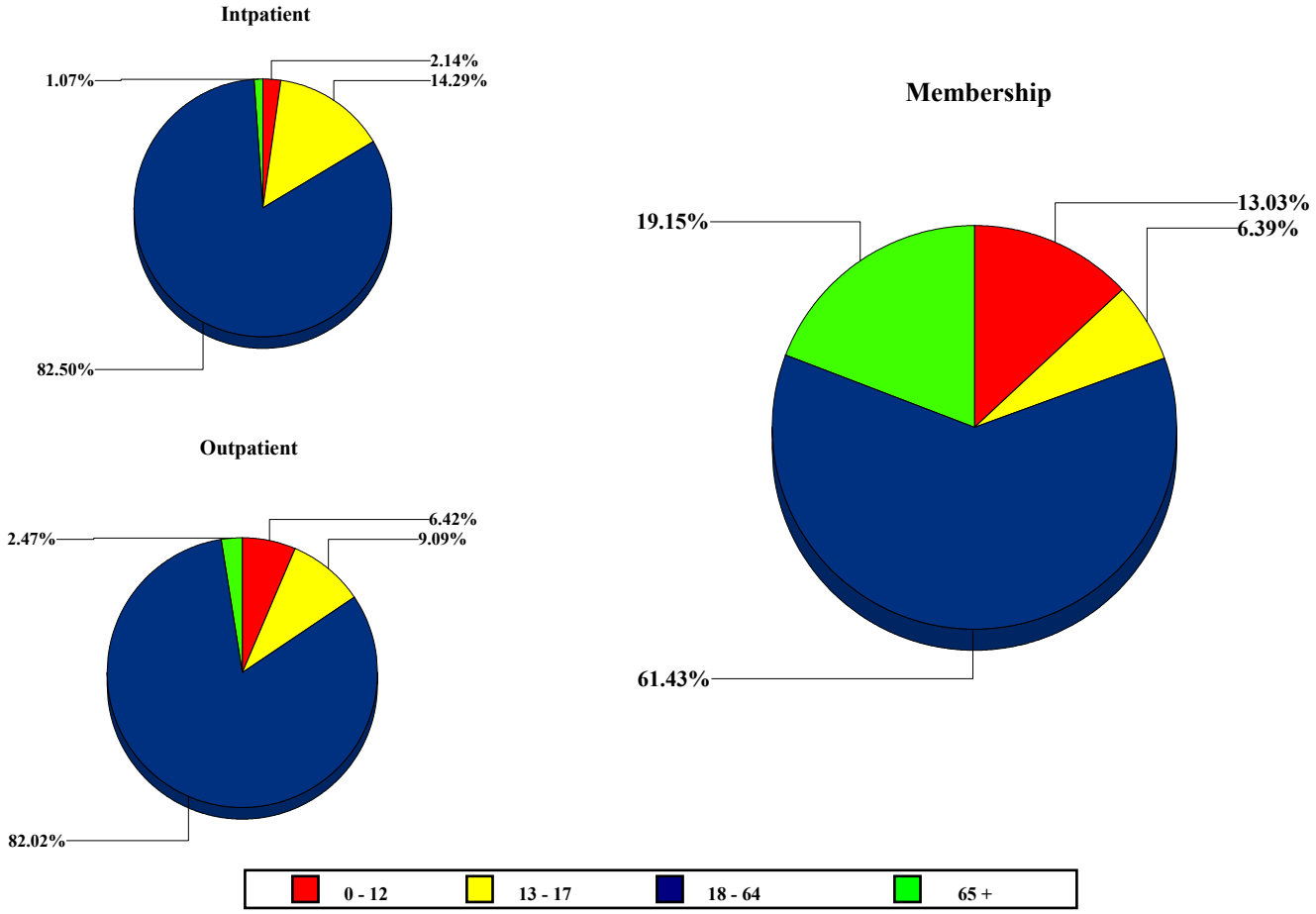
Group Penetration Rate by Age Category (Claims)
Inpatient and Higher Level of Care vs Outpatient

Inpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	6	40	231	3	280
Average Membership	47,430	23,268	223,630	69,730	364,058
Penetration Rate	0.01%	0.17%	0.10%	0.00%	0.08%

Outpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	987	1,397	12,603	379	15,315
Average Membership	47,430	23,268	223,630	69,730	364,058
Penetration Rate	2.08%	6.00%	5.64%	0.54%	4.21%



New York State Empire Plan - NY CITY
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

Inpatient paid claims as of 3/31/2014

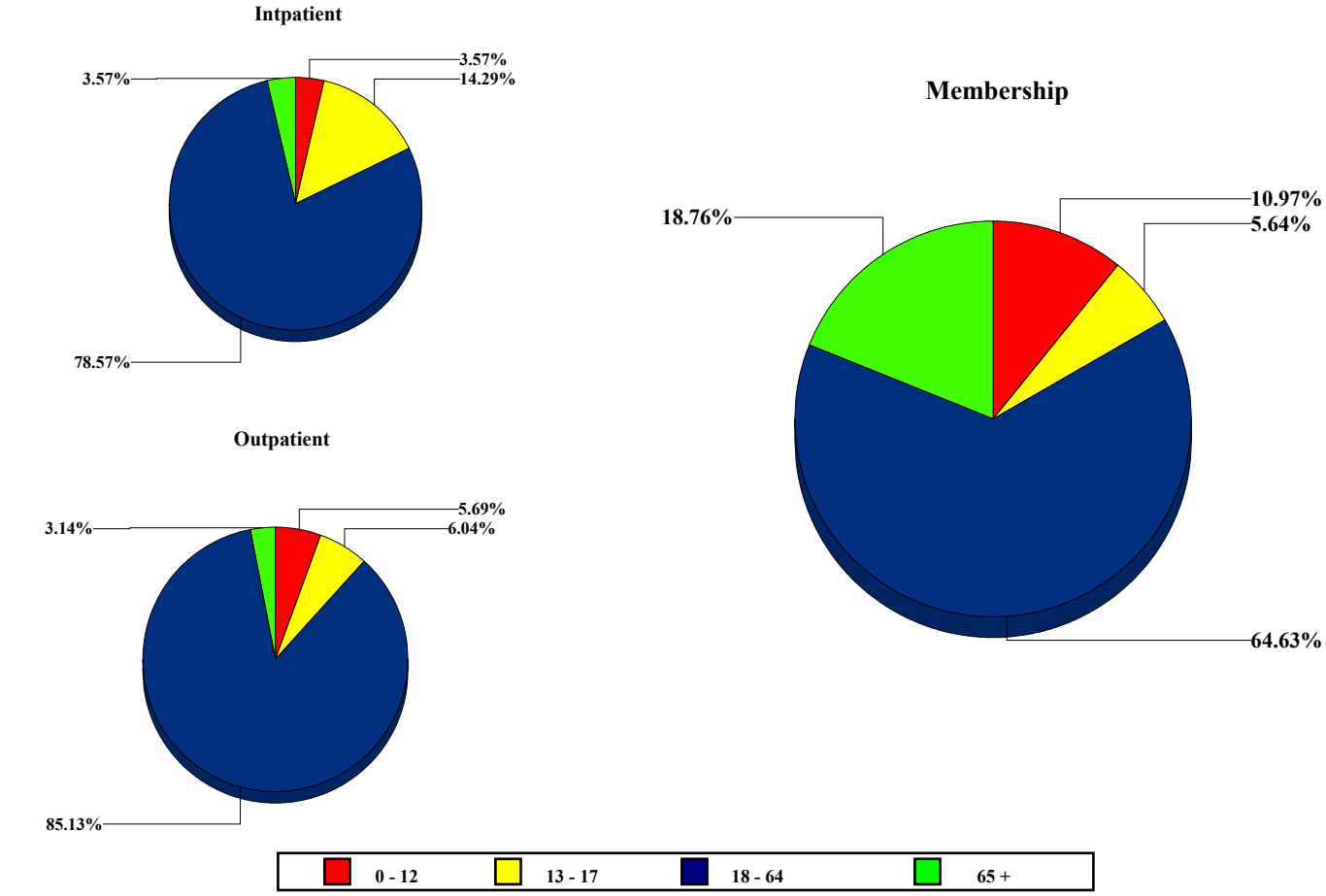
Group Penetration Rate by Age Category (Claims)
Inpatient and Higher Level of Care vs Outpatient

Inpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	1	4	22	1	28
Average Membership	11,488	5,908	67,703	19,650	104,749
Penetration Rate	0.01%	0.07%	0.03%	0.01%	0.03%

Outpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	147	156	2,199	81	2,575
Average Membership	11,488	5,908	67,703	19,650	104,749
Penetration Rate	1.28%	2.64%	3.25%	0.41%	2.46%



New York State Empire Plan - OUT OF STATE
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

Inpatient paid claims as of 3/31/2014

Group Penetration Rate by Age Category (Claims)
Inpatient and Higher Level of Care vs Outpatient

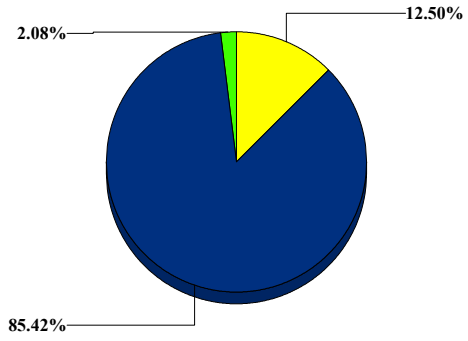
Inpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	0	6	41	1	47
Average Membership	4,257	2,975	37,957	65,498	110,686
Penetration Rate	0.00%	0.20%	0.11%	0.00%	0.04%

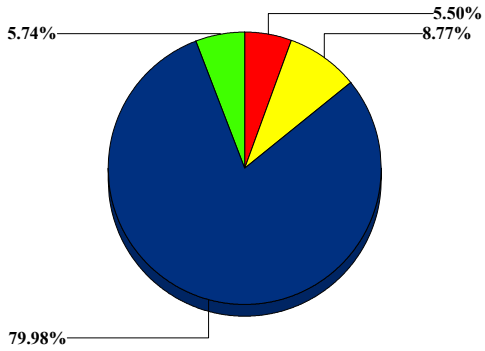
Outpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	69	110	1,003	72	1,251
Average Membership	4,257	2,975	37,957	65,498	110,686
Penetration Rate	1.62%	3.70%	2.64%	0.11%	1.13%

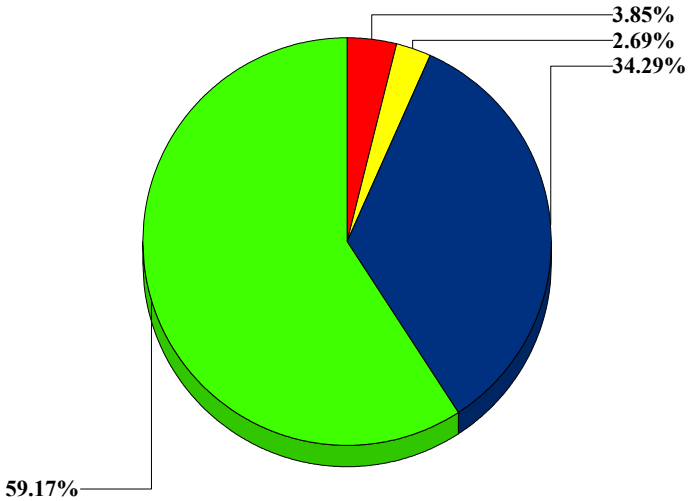
Intpatient



Outpatient



Membership



New York State Empire Plan - UNKNOWN
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

Inpatient paid claims as of 3/31/2014

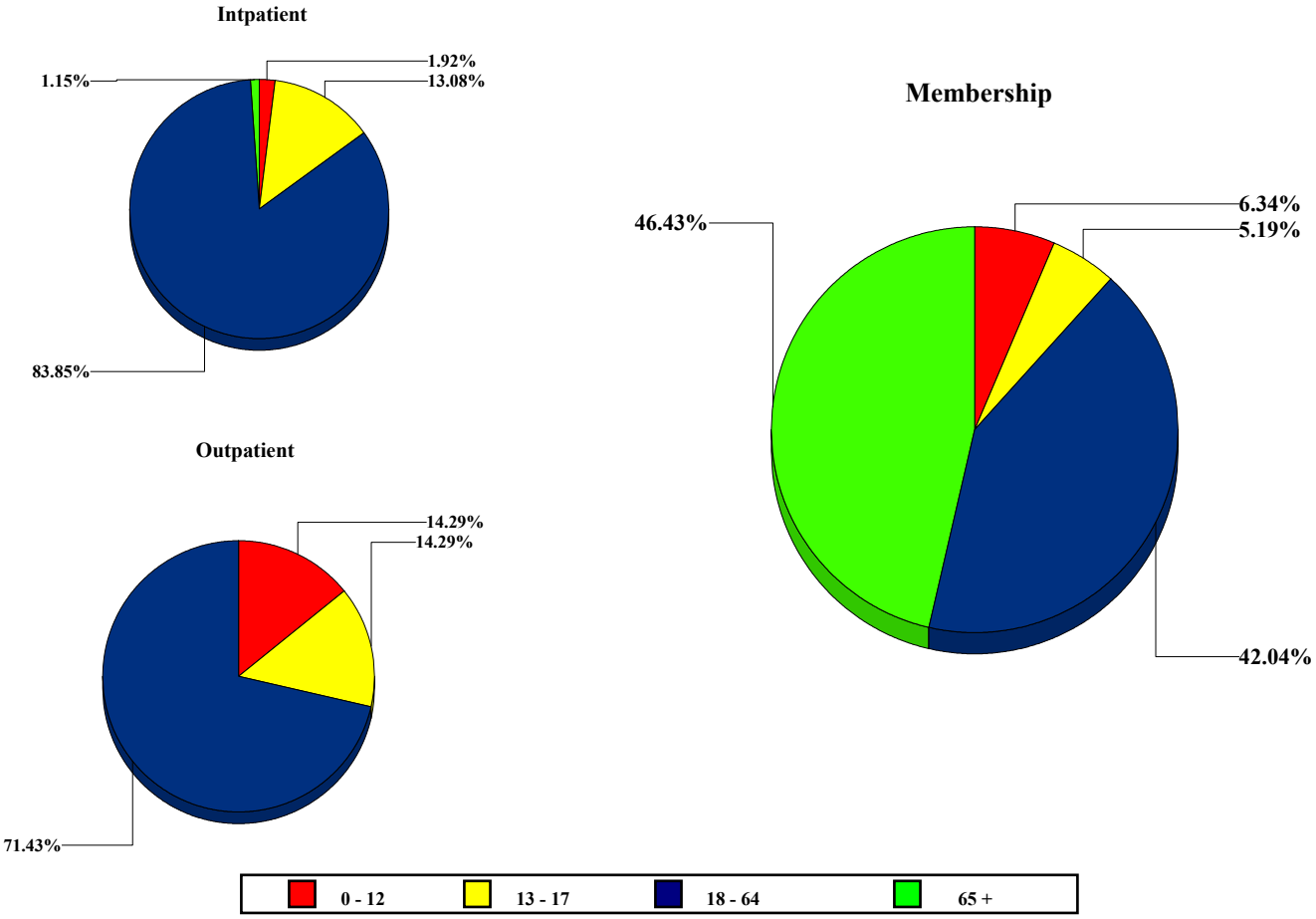
Group Penetration Rate by Age Category (Claims)
Inpatient and Higher Level of Care vs Outpatient

Inpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	5	34	218	3	260
Average Membership	42	35	281	310	668
Penetration Rate	11.81%	98.08%	77.67%	0.97%	38.94%

Outpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	1	1	5	3	7
Average Membership	42	35	281	310	668
Penetration Rate	2.36%	2.88%	1.78%	0.97%	1.05%



New York State Empire Plan - WESTERN NY
Managed Mental Health and Substance Abuse Activity Report
January 01, 2014 - March 31, 2014

Inpatient paid claims as of 3/31/2014

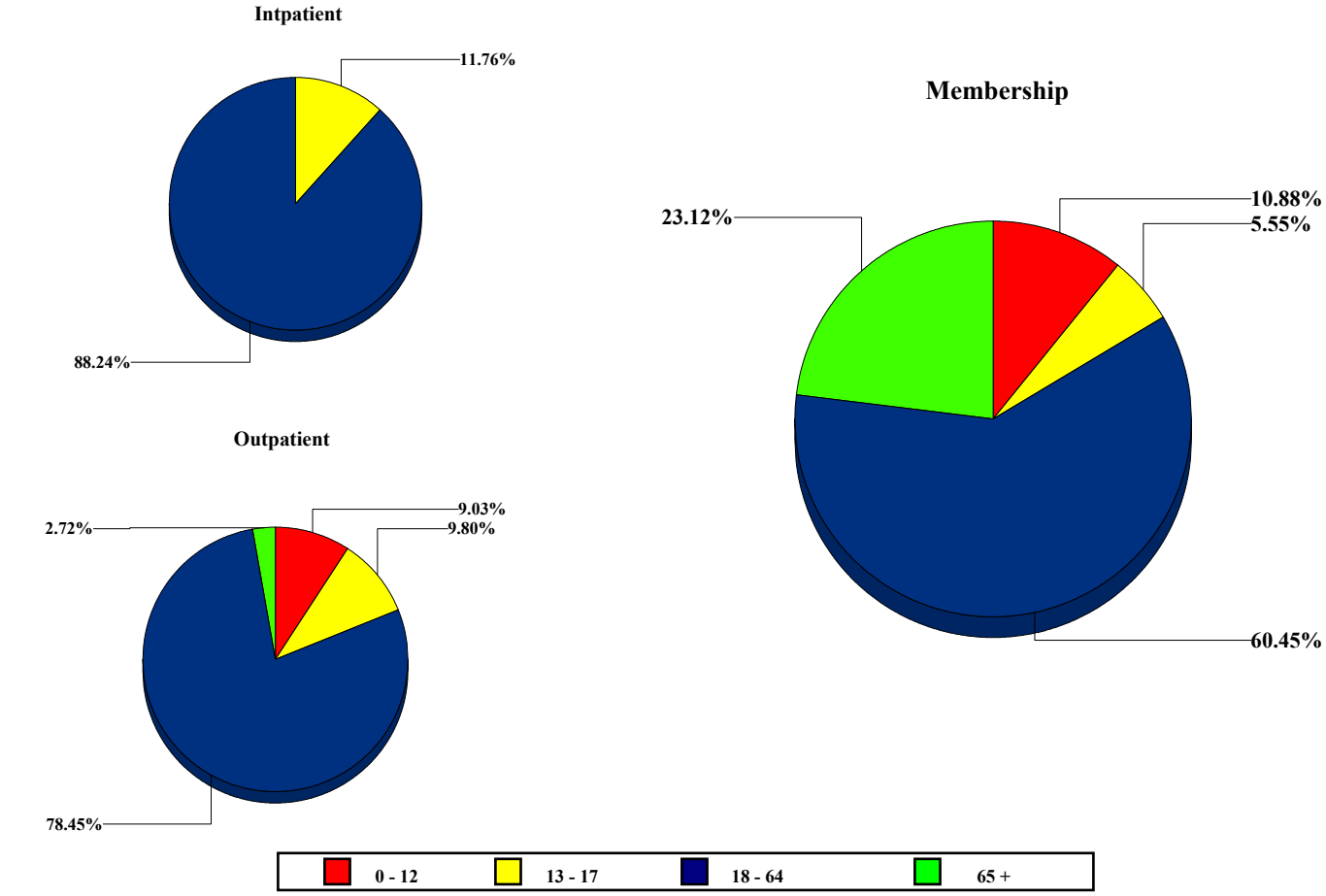
Group Penetration Rate by Age Category (Claims)
Inpatient and Higher Level of Care vs Outpatient

Inpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	0	2	15	0	17
Average Membership	7,638	3,892	42,428	16,228	70,186
Penetration Rate	0.00%	0.05%	0.04%	0.00%	0.02%

Outpatient

	0 - 12	13 - 17	18 - 64	65 +	Total
Unduplicated Members Accessing Care	153	166	1,329	46	1,688
Average Membership	7,638	3,892	42,428	16,228	70,186
Penetration Rate	2.00%	4.26%	3.13%	0.28%	2.41%



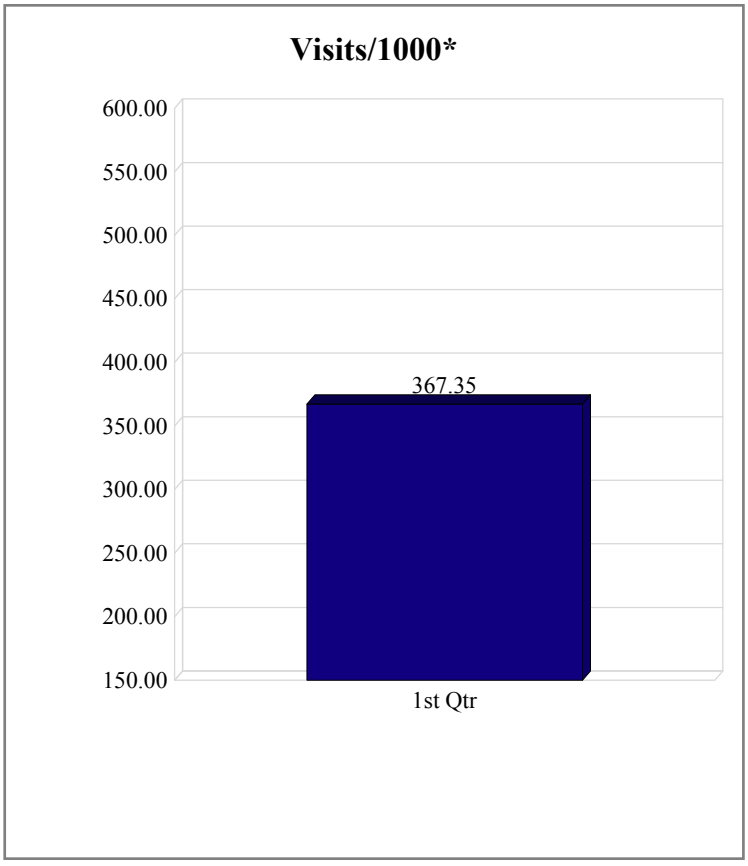
New York State Empire Plan - CENTRAL NY

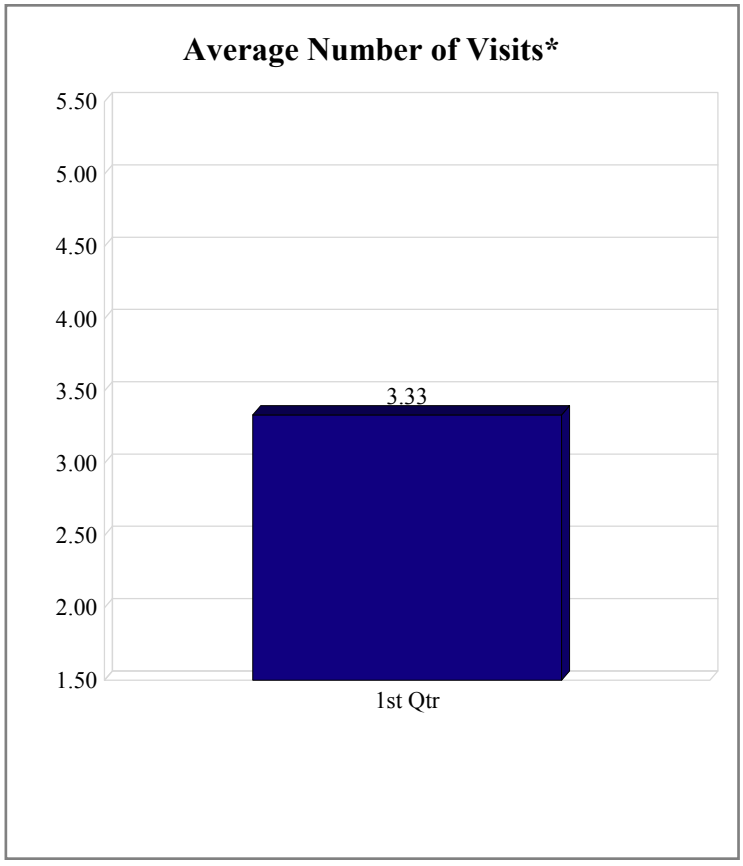
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Outpatient Utilization (Paid Claims) by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	153,791	0	0	0	153,791
Visits *	14,124	0	0	0	14,124
Members Seen	4,236	0	0	0	4,236
Visits/1000 Lives*	367.35	0.00	0.00	0.00	367.35
Avg Number of Visits*	3.33	0.00	0.00	0.00	3.33





** Data is based on paid claims and has been annualized.*

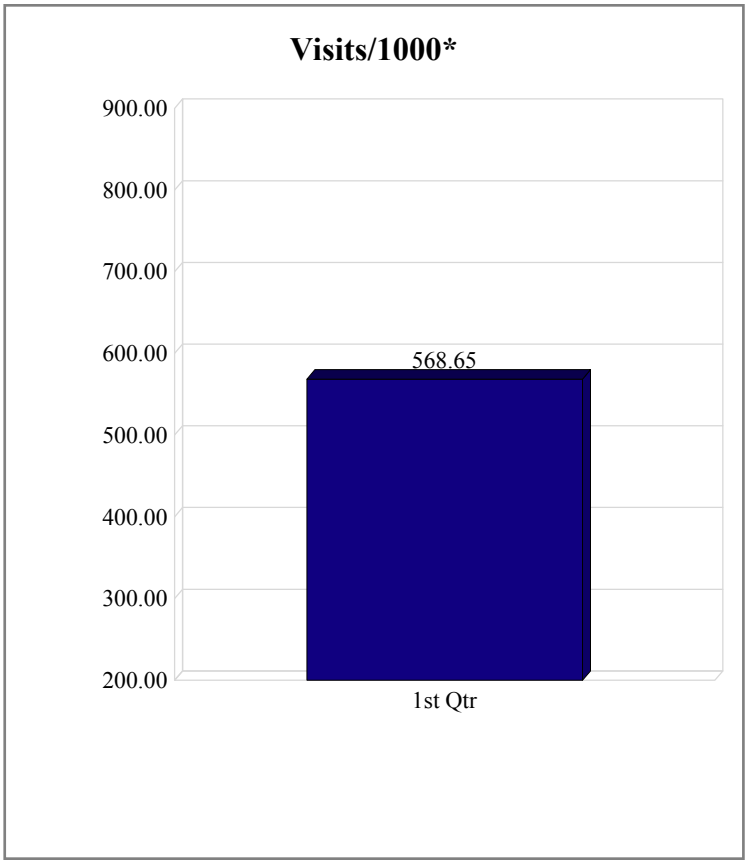
New York State Empire Plan - HUDSON VALLEY

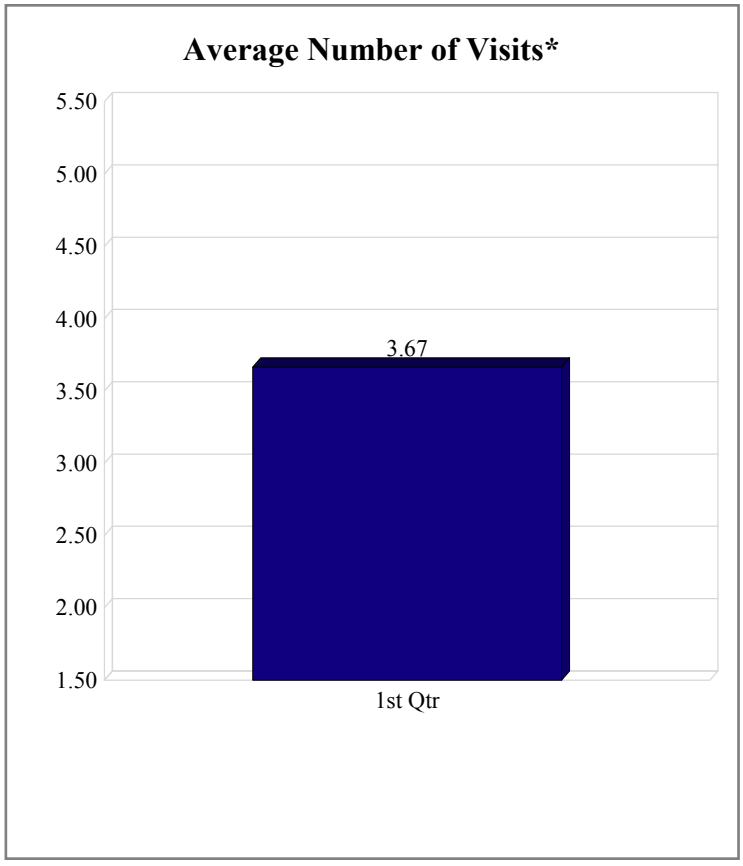
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Outpatient Utilization (Paid Claims) by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	290,648	0	0	0	290,648
Visits *	41,319	0	0	0	41,319
Members Seen	11,270	0	0	0	11,270
Visits/1000 Lives*	568.65	0.00	0.00	0.00	568.65
Avg Number of Visits*	3.67	0.00	0.00	0.00	3.67





** Data is based on paid claims and has been annualized.*

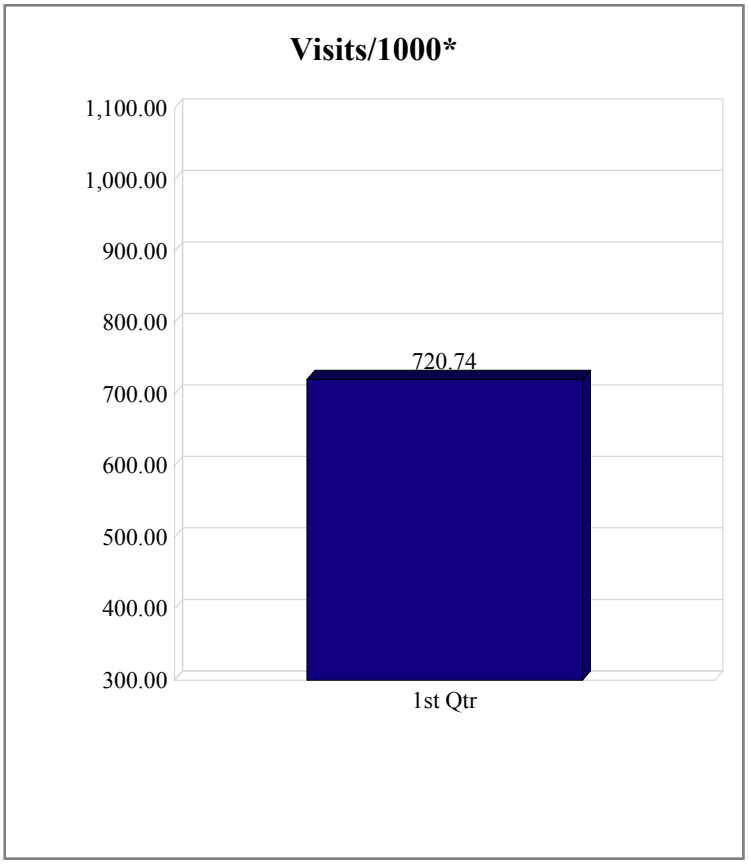
New York State Empire Plan - LONG ISLAND

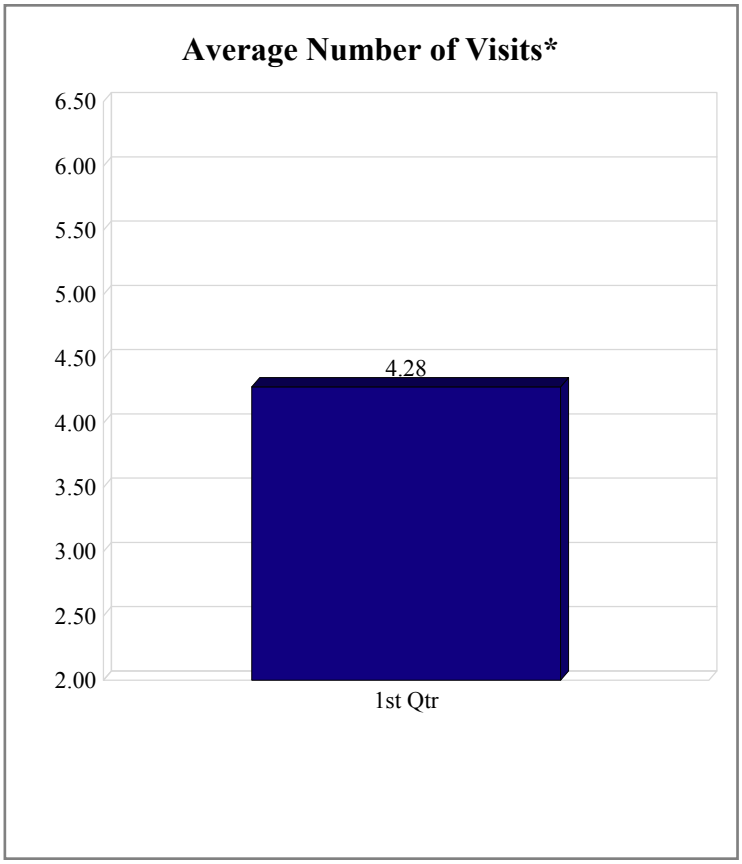
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Outpatient Utilization (Paid Claims) by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	364,058	0	0	0	364,058
Visits *	65,598	0	0	0	65,598
Members Seen	15,315	0	0	0	15,315
Visits/1000 Lives*	720.74	0.00	0.00	0.00	720.74
Avg Number of Visits*	4.28	0.00	0.00	0.00	4.28





** Data is based on paid claims and has been annualized.*

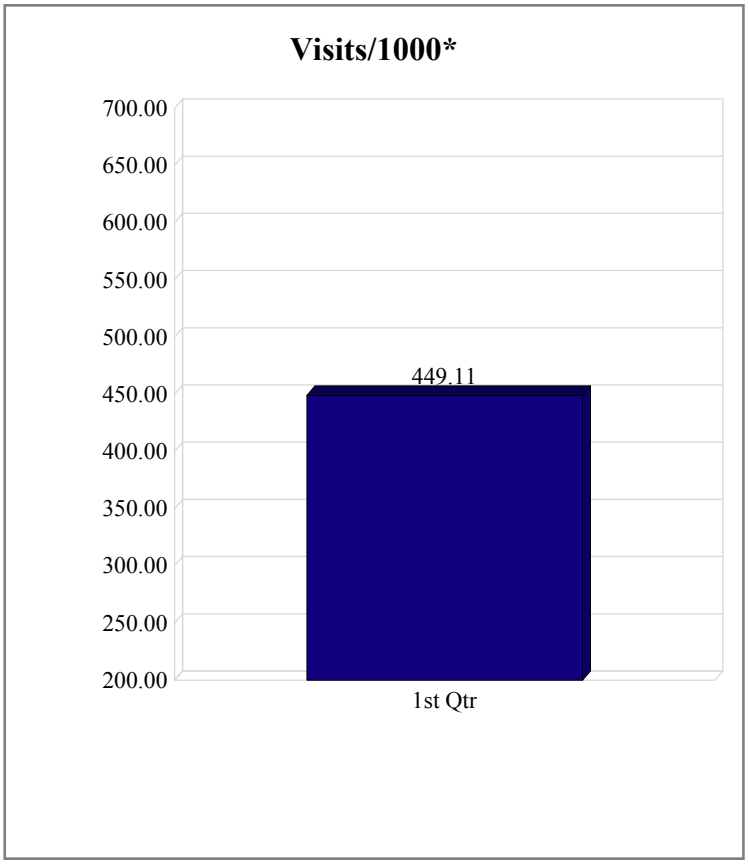
New York State Empire Plan - NY CITY

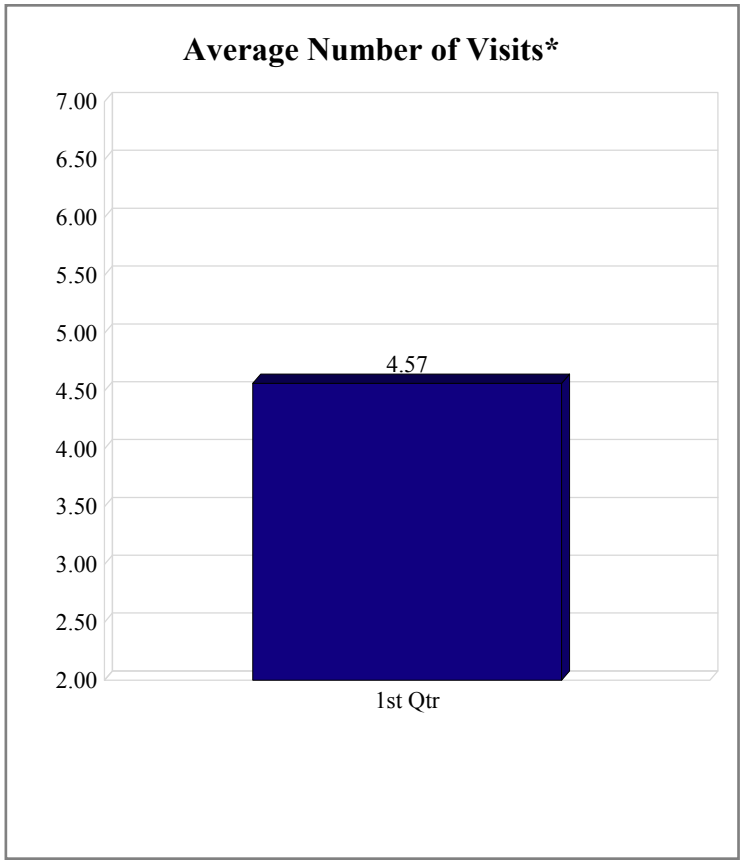
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Outpatient Utilization (Paid Claims) by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	104,749	0	0	0	104,749
Visits *	11,761	0	0	0	11,761
Members Seen	2,575	0	0	0	2,575
Visits/1000 Lives*	449.11	0.00	0.00	0.00	449.11
Avg Number of Visits*	4.57	0.00	0.00	0.00	4.57





** Data is based on paid claims and has been annualized.*

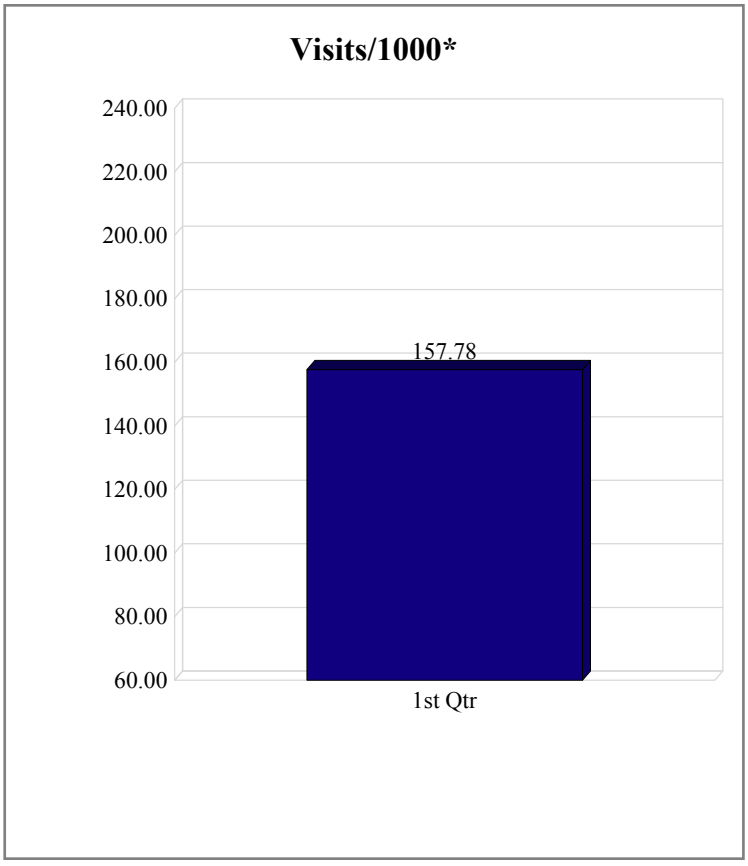
New York State Empire Plan - OUT OF STATE

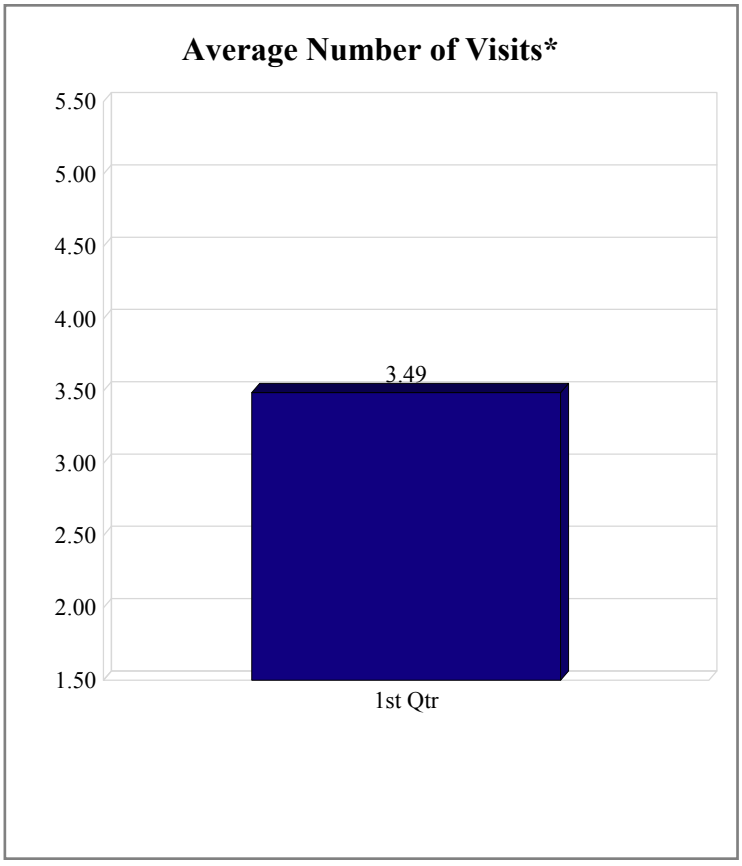
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Outpatient Utilization (Paid Claims) by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	110,686	0	0	0	110,686
Visits *	4,366	0	0	0	4,366
Members Seen	1,251	0	0	0	1,251
Visits/1000 Lives*	157.78	0.00	0.00	0.00	157.78
Avg Number of Visits*	3.49	0.00	0.00	0.00	3.49





** Data is based on paid claims and has been annualized.*

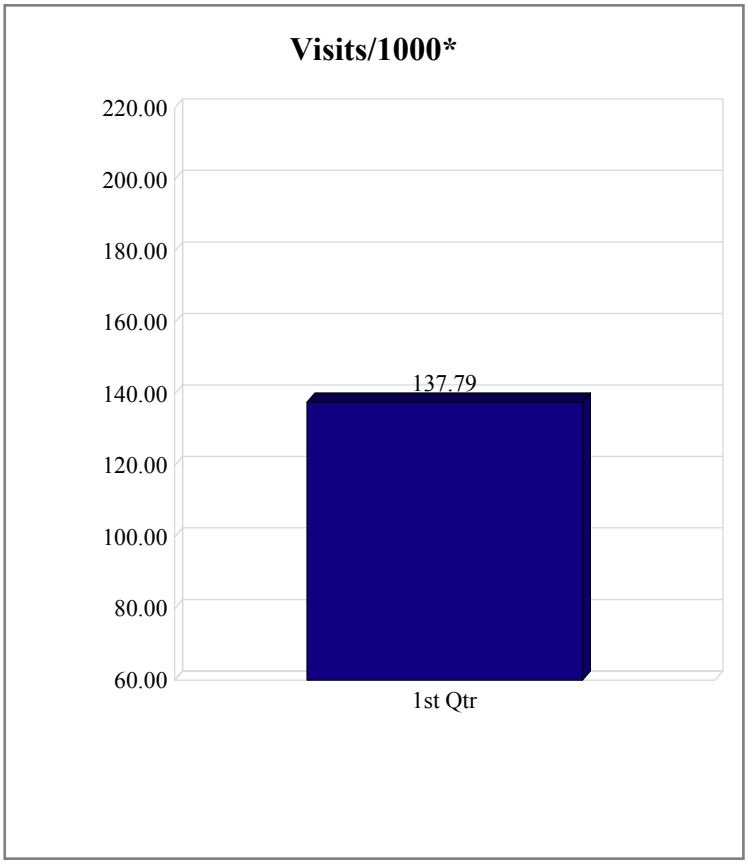
New York State Empire Plan - UNKNOWN

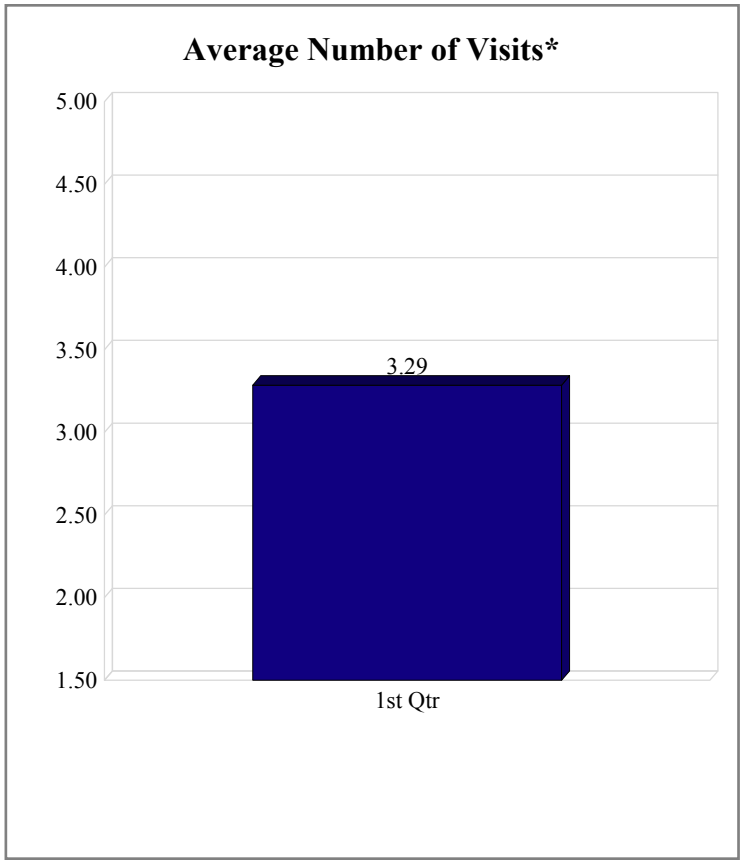
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Outpatient Utilization (Paid Claims) by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	668	0	0	0	668
Visits *	23	0	0	0	23
Members Seen	7	0	0	0	7
Visits/1000 Lives*	137.79	0.00	0.00	0.00	137.79
Avg Number of Visits*	3.29	0.00	0.00	0.00	3.29





** Data is based on paid claims and has been annualized.*

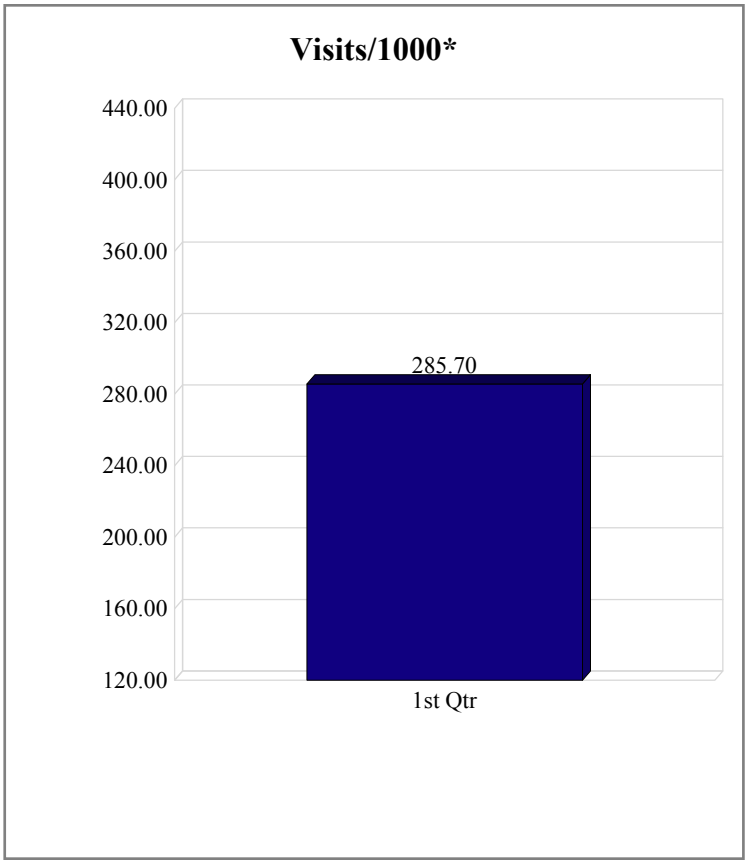
New York State Empire Plan - WESTERN NY

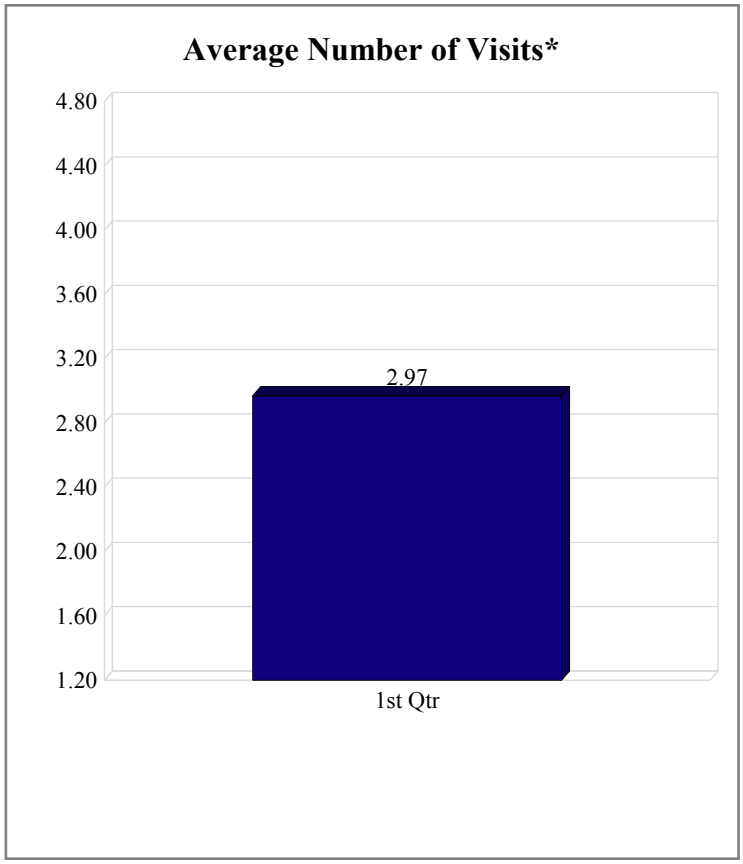
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Total Outpatient Utilization (Paid Claims) by Group

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Avg Covered Lives	70,186	0	0	0	70,186
Visits *	5,013	0	0	0	5,013
Members Seen	1,688	0	0	0	1,688
Visits/1000 Lives*	285.70	0.00	0.00	0.00	285.70
Avg Number of Visits*	2.97	0.00	0.00	0.00	2.97





** Data is based on paid claims and has been annualized.*

New York State Empire Plan - CENTRAL NY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group 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	51	$41,271	157	$76,200	208	$117,471.48	$564.77	$0.54	$0.25
Residential	0	$0	44	$20,596	44	$20,596.00	$468.09	$0.09	$0.04
Partial Hospitalization	54	$19,360	11	$6,767	65	$26,127.00	$401.95	$0.12	$0.06
Intensive Outpatient	17	$3,706	49	$5,225	66	$8,931.00	$135.32	$0.04	$0.02
Outpatient	12,140	$709,492	1,127	$46,479	13,267	$755,971.01	$56.98	$3.49	$1.64
Sub Total	**12,262**	**$773,829**	**1,388**	**$155,268**	**13,650**	**$929,096.49**		**$4.28**	**$2.01**

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	0	$0	74	$137,876	74	$137,876.41	$1,863.19	$0.64	$0.30
Residential	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Partial Hospitalization	0	$0	46	$53,227	46	$53,227.04	$1,157.11	$0.25	$0.12
Intensive Outpatient	0	$0	11	$5,909	11	$5,909.40	$537.22	$0.03	$0.01
Outpatient	777	$10,826	80	$4,361	857	$15,186.10	$17.72	$0.07	$0.03
Sub Total	**777**	**$10,826**	**211**	**$201,373**	**988**	**$212,198.95**		**$0.98**	**$0.46**

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	51	$41,271	231	$214,077	282	$255,347.89	$905.49	$1.18	$0.55
Residential	0	$0	44	$20,596	44	$20,596.00	$468.09	$0.09	$0.04
Partial Hospitalization	54	$19,360	57	$59,994	111	$79,354.04	$714.90	$0.37	$0.17
Intensive Outpatient	17	$3,706	60	$11,134	77	$14,840.40	$192.73	$0.07	$0.03
Outpatient	12,917	$720,317	1,207	$50,840	14,124	$771,157.11	$54.60	$3.56	$1.67
Grand Total	**13,039**	**$784,654**	**1,599**	**$356,641**	**14,638**	**$1,141,295.44**		**$5.26**	**$2.47**

**In-Network Claims include SCA.*

New York State Empire Plan - HUDSON VALLEY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group 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	610	$598,858	197	$111,216	807	$710,073.94	$879.89	$1.72	$0.81
Residential	122	$101,870	25	$9,326	147	$111,196.00	$756.44	$0.27	$0.13
Partial Hospitalization	215	$75,329	17	$3,740	232	$79,068.55	$340.81	$0.19	$0.09
Intensive Outpatient	155	$33,483	164	$22,308	319	$55,791.30	$174.89	$0.14	$0.06
Outpatient	36,032	$2,159,541	2,124	$77,392	38,156	$2,236,932.39	$58.63	$5.42	$2.57
Sub Total	**37,134**	**$2,969,080**	**2,527**	**$223,982**	**39,661**	**$3,193,062.18**		**$7.73**	**$3.66**

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	10	$16,060	78	$156,565	88	$172,624.93	$1,961.65	$0.42	$0.20
Residential	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Partial Hospitalization	0	$0	174	$220,620	174	$220,619.90	$1,267.93	$0.53	$0.25
Intensive Outpatient	0	$0	152	$133,583	152	$133,582.96	$878.84	$0.32	$0.15
Outpatient	3,002	$96,544	161	$23,248	3,163	$119,792.54	$37.87	$0.29	$0.14
Sub Total	**3,012**	**$112,605**	**565**	**$534,015**	**3,577**	**$646,620.33**		**$1.57**	**$0.74**

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	620	$614,918	275	$267,781	895	$882,698.87	$986.26	$2.14	$1.01
Residential	122	$101,870	25	$9,326	147	$111,196.00	$756.44	$0.27	$0.13
Partial Hospitalization	215	$75,329	191	$224,360	406	$299,688.45	$738.15	$0.73	$0.34
Intensive Outpatient	155	$33,483	316	$155,891	471	$189,374.26	$402.07	$0.46	$0.22
Outpatient	39,034	$2,256,085	2,285	$100,640	41,319	$2,356,724.93	$57.04	$5.71	$2.70
Grand Total	**40,146**	**$3,081,685**	**3,092**	**$757,998**	**43,238**	**$3,839,682.51**		**$9.30**	**$4.40**

**In-Network Claims include SCA.*

New York State Empire Plan - LONG ISLAND

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group 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	483	$512,502	377	$247,545	860	$760,046.94	$883.78	$1.59	$0.70
Residential	126	$109,800	48	$19,180	174	$128,980.00	$741.26	$0.27	$0.12
Partial Hospitalization	140	$64,067	156	$65,139	296	$129,205.86	$436.51	$0.27	$0.12
Intensive Outpatient	56	$19,114	352	$62,012	408	$81,126.00	$198.84	$0.17	$0.07
Outpatient	55,330	$3,626,834	3,696	$156,793	59,026	$3,783,626.74	$64.10	$7.90	$3.46
Sub Total	**56,135**	**$4,332,318**	**4,629**	**$550,668**	**60,764**	**$4,882,985.54**		**$10.19**	**$4.47**

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	0	$2,368	83	$159,840	83	$162,208.19	$1,954.32	$0.34	$0.15
Residential	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Partial Hospitalization	0	$0	335	$394,862	335	$394,862.22	$1,178.69	$0.82	$0.36
Intensive Outpatient	0	$0	422	$360,632	422	$360,631.79	$854.58	$0.75	$0.33
Outpatient	6,331	$147,112	241	$32,588	6,572	$179,699.34	$27.34	$0.38	$0.16
Sub Total	**6,331**	**$149,480**	**1,081**	**$947,922**	**7,412**	**$1,097,401.54**		**$2.29**	**$1.00**

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	483	$514,870	460	$407,385	943	$922,255.13	$978.00	$1.92	$0.84
Residential	126	$109,800	48	$19,180	174	$128,980.00	$741.26	$0.27	$0.12
Partial Hospitalization	140	$64,067	491	$460,001	631	$524,068.08	$830.54	$1.09	$0.48
Intensive Outpatient	56	$19,114	774	$422,644	830	$441,757.79	$532.24	$0.92	$0.40
Outpatient	61,661	$3,773,946	3,937	$189,380	65,598	$3,963,326.08	$60.42	$8.27	$3.63
Grand Total	**62,466**	**$4,481,797**	**5,710**	**$1,498,590**	**68,176**	**$5,980,387.08**		**$12.48**	**$5.48**

**In-Network Claims include SCA.*

New York State Empire Plan - NY CITY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group 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	69	$66,847	47	$20,912	116	$87,758.25	$756.54	$0.52	$0.28
Residential	0	$0	41	$15,296	41	$15,296.00	$373.07	$0.09	$0.05
Partial Hospitalization	31	$13,453	0	$0	31	$13,452.60	$433.95	$0.08	$0.04
Intensive Outpatient	5	$1,402	1	$120	6	$1,522.00	$253.67	$0.01	$0.00
Outpatient	8,930	$574,653	446	$18,980	9,376	$593,632.09	$63.31	$3.54	$1.89
Sub Total	**9,035**	**$656,354**	**535**	**$55,307**	**9,570**	**$711,660.94**		**$4.24**	**$2.26**

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	0	$225	15	$28,247	15	$28,471.56	$1,898.10	$0.17	$0.09
Residential	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Partial Hospitalization	24	$22,808	30	$30,326	54	$53,134.47	$983.97	$0.32	$0.17
Intensive Outpatient	14	$11,160	16	$12,356	30	$23,516.20	$783.87	$0.14	$0.07
Outpatient	2,336	$176,432	49	$15,430	2,385	$191,861.99	$80.45	$1.14	$0.61
Sub Total	**2,374**	**$210,625**	**110**	**$86,359**	**2,484**	**$296,984.22**		**$1.77**	**$0.95**

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	69	$67,072	62	$49,158	131	$116,229.81	$887.25	$0.69	$0.37
Residential	0	$0	41	$15,296	41	$15,296.00	$373.07	$0.09	$0.05
Partial Hospitalization	55	$36,261	30	$30,326	85	$66,587.07	$783.38	$0.40	$0.21
Intensive Outpatient	19	$12,562	17	$12,476	36	$25,038.20	$695.51	$0.15	$0.08
Outpatient	11,266	$751,084	495	$34,410	11,761	$785,494.08	$66.79	$4.68	$2.50
Grand Total	**11,409**	**$866,979**	**645**	**$141,666**	**12,054**	**$1,008,645.16**		**$6.01**	**$3.21**

**In-Network Claims include SCA.*

New York State Empire Plan - OUT OF STATE

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group 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	99	$90,197	86	$47,877	185	$138,073.84	$746.35	$0.69	$0.42
Residential	0	$65	29	$14,373	29	$14,437.97	$497.86	$0.07	$0.04
Partial Hospitalization	29	$10,227	42	$14,760	71	$24,987.15	$351.93	$0.13	$0.08
Intensive Outpatient	69	$10,414	49	$6,403	118	$16,817.00	$142.52	$0.08	$0.05
Outpatient	3,380	$222,030	203	$9,643	3,583	$231,673.44	$64.66	$1.16	$0.70
Sub Total	**3,577**	**$332,933**	**409**	**$93,056**	**3,986**	**$425,989.40**		**$2.14**	**$1.28**

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	18	$20,842	6	$11,223	24	$32,065.04	$1,336.04	$0.16	$0.10
Residential	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Partial Hospitalization	0	$0	81	$82,818	81	$82,818.40	$1,022.45	$0.42	$0.25
Intensive Outpatient	0	$0	103	$90,237	103	$90,236.61	$876.08	$0.45	$0.27
Outpatient	741	$21,104	42	$13,069	783	$34,172.86	$43.64	$0.17	$0.10
Sub Total	**759**	**$41,946**	**232**	**$197,347**	**991**	**$239,292.91**		**$1.20**	**$0.72**

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	117	$111,039	92	$59,100	209	$170,138.88	$814.06	$0.86	$0.51
Residential	0	$65	29	$14,373	29	$14,437.97	$497.86	$0.07	$0.04
Partial Hospitalization	29	$10,227	123	$97,578	152	$107,805.55	$709.25	$0.54	$0.32
Intensive Outpatient	69	$10,414	152	$96,640	221	$107,053.61	$484.41	$0.54	$0.32
Outpatient	4,121	$243,134	245	$22,712	4,366	$265,846.30	$60.89	$1.34	$0.80
Grand Total	**4,336**	**$374,879**	**641**	**$290,403**	**4,977**	**$665,282.31**		**$3.35**	**$2.00**

**In-Network Claims include SCA.*

New York State Empire Plan - UNKNOWN

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group 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	0	$0	0	$0	0	$0.00	$0.00		$0.00
Residential	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Partial Hospitalization	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Intensive Outpatient	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Outpatient	23	$1,250	0	$0	23	$1,250.00	$54.35	$1.01	$0.62
Sub Total	**23**	**$1,250**	**0**	**$0**	**23**	**$1,250.00**		**$1.01**	**$0.62**

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	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Residential	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Partial Hospitalization	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Intensive Outpatient	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Outpatient	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Sub Total	**0**	**$0**	**0**	**$0**	**0**	**$0.00**		**$0.00**	**$0.00**

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	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Residential	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Partial Hospitalization	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Intensive Outpatient	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Outpatient	23	$1,250	0	$0	23	$1,250.00	$54.35	$1.01	$0.62
Grand Total	**23**	**$1,250**	**0**	**$0**	**23**	**$1,250.00**		**$1.01**	**$0.62**

**In-Network Claims include SCA.*

New York State Empire Plan - WESTERN NY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group 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	36	$30,414	84	$36,000	120	$66,414.00	$553.45	$0.64	$0.32
Residential	0	$0	17	$3,825	17	$3,825.00	$225.00	$0.04	$0.02
Partial Hospitalization	21	$8,400	0	$241	21	$8,640.50	$411.45	$0.08	$0.04
Intensive Outpatient	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Outpatient	3,862	$222,697	526	$12,922	4,388	$235,619.30	$53.70	$2.26	$1.12
Sub Total	**3,919**	**$261,511**	**627**	**$52,988**	**4,546**	**$314,498.80**		**$3.02**	**$1.49**

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	10	$10,524	12	$28,950	22	$39,474.19	$1,794.28	$0.38	$0.19
Residential	0	$0	0	$0	0	$0.00	$0.00	$0.00	$0.00
Partial Hospitalization	0	$0	7	$7,290	7	$7,290.00	$1,041.43	$0.07	$0.03
Intensive Outpatient	0	$0	15	$11,747	15	$11,746.58	$783.11	$0.11	$0.06
Outpatient	607	$6,466	18	$1,760	625	$8,226.35	$13.16	$0.08	$0.04
Sub Total	**617**	**$16,991**	**52**	**$49,747**	**669**	**$66,737.12**		**$0.64**	**$0.32**

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	46	$40,938	96	$64,950	142	$105,888.19	$745.69	$1.02	$0.50
Residential	0	$0	17	$3,825	17	$3,825.00	$225.00	$0.04	$0.02
Partial Hospitalization	21	$8,400	7	$7,531	28	$15,930.50	$568.95	$0.15	$0.08
Intensive Outpatient	0	$0	15	$11,747	15	$11,746.58	$783.11	$0.11	$0.06
Outpatient	4,469	$229,163	544	$14,682	5,013	$243,845.65	$48.64	$2.34	$1.16
Grand Total	**4,536**	**$278,502**	**679**	**$102,734**	**5,215**	**$381,235.92**		**$3.66**	**$1.81**

**In-Network Claims include SCA.*

New York State Empire Plan - CENTRAL NY

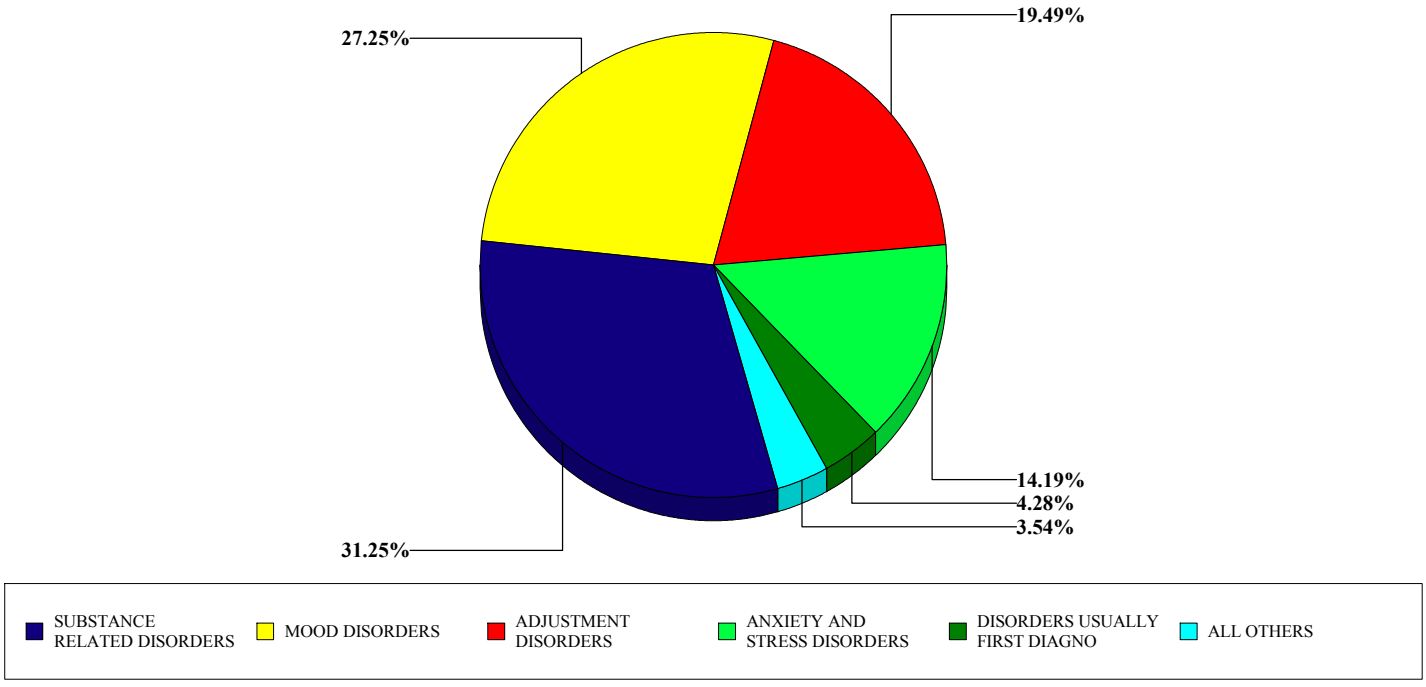
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Major Diagnosis Category

Rank	Diagnosis Category	Total Paid	% of Total Paid
CENTRAL NY			
1	SUBSTANCE RELATED DISORDERS	$356,641.10	31.25%
2	MOOD DISORDERS	$310,971.53	27.25%
3	ADJUSTMENT DISORDERS	$222,483.83	19.49%
4	ANXIETY AND STRESS DISORDERS	$162,005.38	14.19%
5	DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE	$48,814.60	4.28%
6	EATING DISORDERS	$21,955.00	1.92%
7	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	$7,051.00	0.62%
8	OTHER MENTAL DISORDERS	$5,233.00	0.46%
9	DISSOCIATIVE, SOMATOFORM AND FACTITIOUS DISORDERS	$2,385.00	0.21%
10	PERSONALITY DISORDERS	$1,562.00	0.14%
11	MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED	$1,432.00	0.13%
12	DELIRIUM, DEMENTIA, AMNESTIC AND OTHER COGNITIVE DISORDERS	$761.00	0.07%
	ALL OTHER DIAGNOSIS CATEGORIES	$0.00	0.00%
	Total for All Diagnosis Categories	**$1,141,295.44**	**100.00%**

Top Five Diagnosis Categories



New York State Empire Plan - HUDSON VALLEY

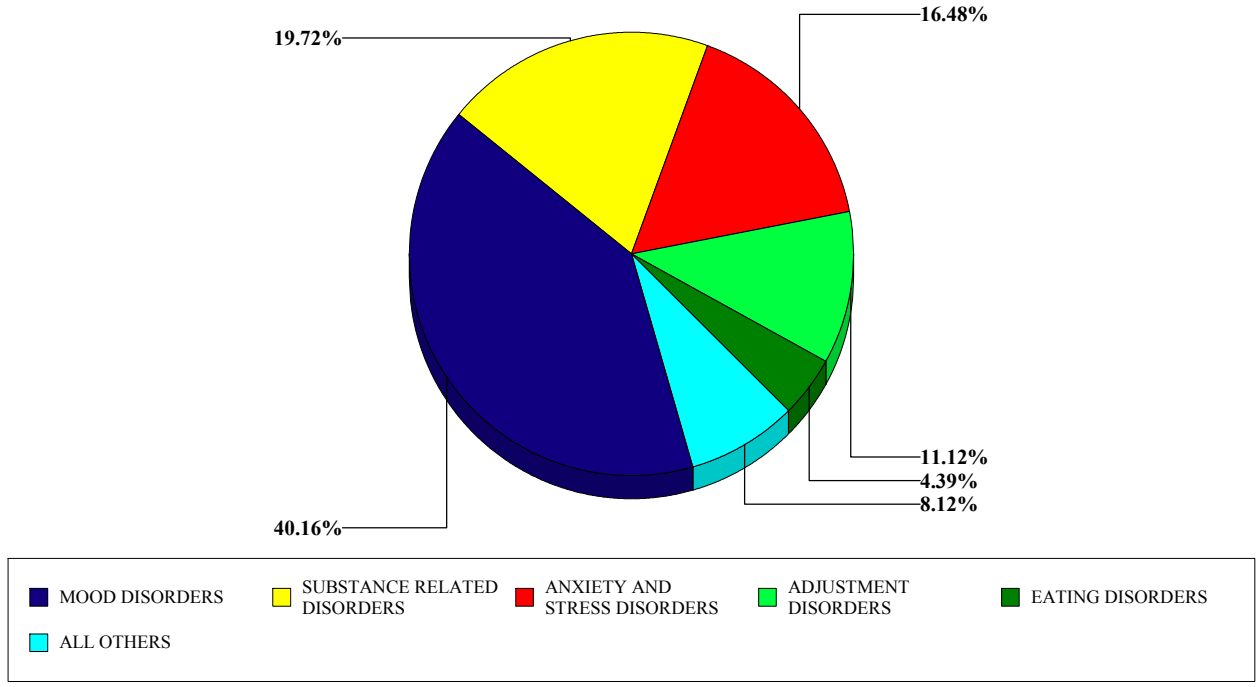
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Major Diagnosis Category

Rank	Diagnosis Category	Total Paid	% of Total Paid
HUDSON VALLEY			
1	MOOD DISORDERS	$1,542,053.07	40.16%
2	SUBSTANCE RELATED DISORDERS	$757,376.63	19.72%
3	ANXIETY AND STRESS DISORDERS	$632,956.35	16.48%
4	ADJUSTMENT DISORDERS	$427,162.85	11.12%
5	EATING DISORDERS	$168,392.85	4.39%
6	DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE	$160,502.74	4.18%
7	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	$105,395.26	2.74%
8	OTHER MENTAL DISORDERS	$28,837.66	0.75%
9	DISSOCIATIVE, SOMATOFORM AND FACTITIOUS DISORDERS	$5,799.00	0.15%
10	MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED	$4,333.56	0.11%
11	PERSONALITY DISORDERS	$4,118.39	0.11%
12	DELIRIUM, DEMENTIA, AMNESTIC AND OTHER COGNITIVE DISORDERS	$2,133.15	0.06%
13	OTHER CONDITIONS THAT MAY BE THE FOCUS OF CLINICAL ATTENTION	$621.00	0.02%
	Total for All Diagnosis Categories	**$3,839,682.51**	**100.00%**

Top Five Diagnosis Categories



New York State Empire Plan - LONG ISLAND

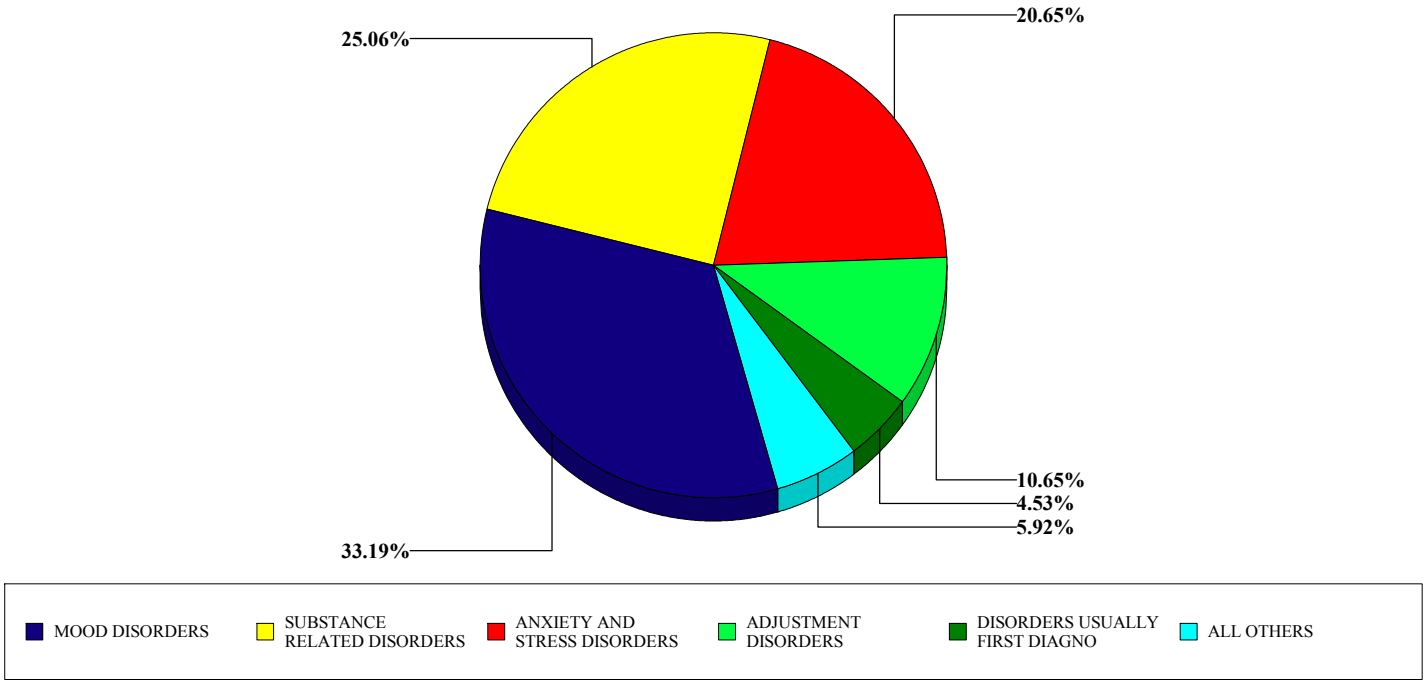
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Major Diagnosis Category

Rank	Diagnosis Category	Total Paid	% of Total Paid
LONG ISLAND			
1	MOOD DISORDERS	$1,985,167.92	33.19%
2	SUBSTANCE RELATED DISORDERS	$1,498,508.33	25.06%
3	ANXIETY AND STRESS DISORDERS	$1,235,043.16	20.65%
4	ADJUSTMENT DISORDERS	$636,711.52	10.65%
5	DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE	$271,187.98	4.53%
6	EATING DISORDERS	$185,343.75	3.10%
7	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	$115,888.84	1.94%
8	PERSONALITY DISORDERS	$19,387.73	0.32%
9	OTHER MENTAL DISORDERS	$18,030.17	0.30%
10	MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED	$8,067.97	0.13%
11	DISSOCIATIVE, SOMATOFORM AND FACTITIOUS DISORDERS	$4,751.70	0.08%
12	DELIRIUM, DEMENTIA, AMNESTIC AND OTHER COGNITIVE DISORDERS	$2,076.47	0.03%
13	OTHER CONDITIONS THAT MAY BE THE FOCUS OF CLINICAL ATTENTION	$221.54	0.00%
	Total for All Diagnosis Categories	**$5,980,387.08**	**100.00%**

Top Five Diagnosis Categories



New York State Empire Plan - NY CITY

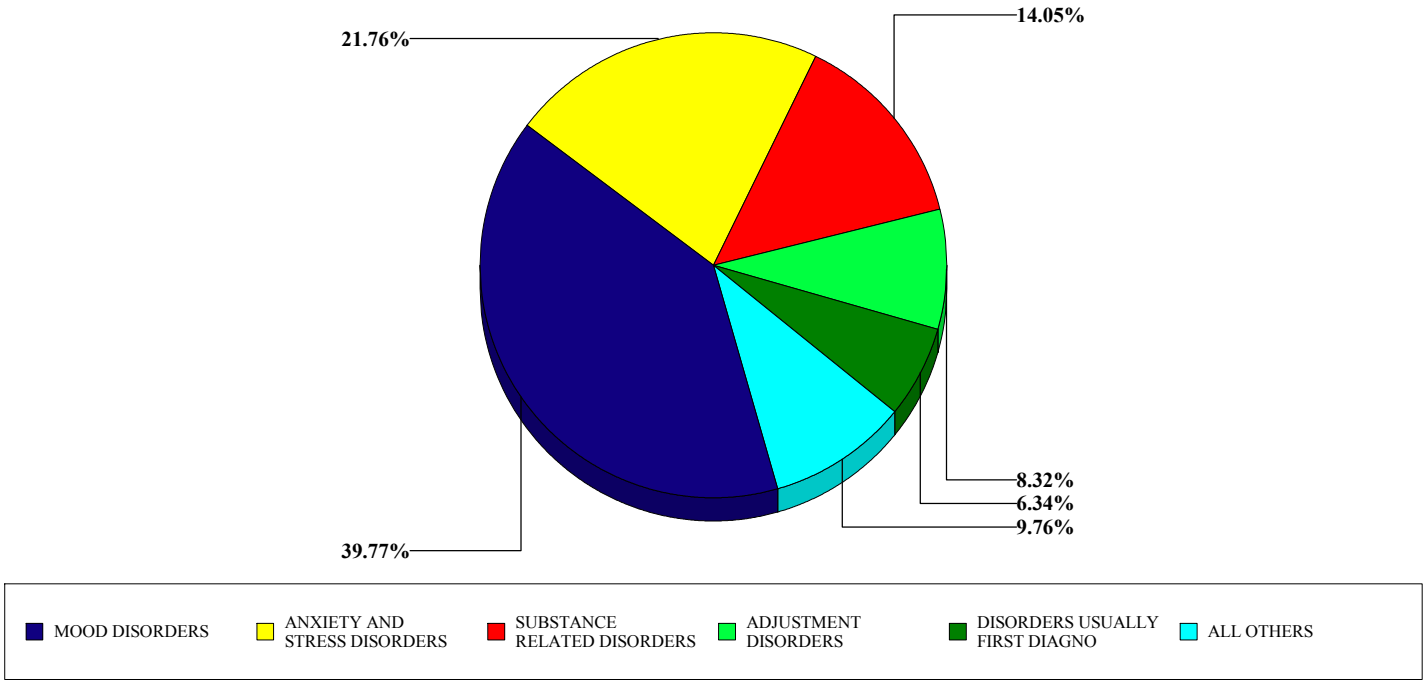
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Major Diagnosis Category

Rank	Diagnosis Category	Total Paid	% of Total Paid
NY CITY			
1	MOOD DISORDERS	$401,139.01	39.77%
2	ANXIETY AND STRESS DISORDERS	$219,481.41	21.76%
3	SUBSTANCE RELATED DISORDERS	$141,665.95	14.05%
4	ADJUSTMENT DISORDERS	$83,880.74	8.32%
5	DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE	$63,989.81	6.34%
6	EATING DISORDERS	$44,422.00	4.40%
7	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	$42,641.24	4.23%
8	DISSOCIATIVE, SOMATOFORM AND FACTITIOUS DISORDERS	$3,754.00	0.37%
9	MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED	$3,394.00	0.34%
10	OTHER MENTAL DISORDERS	$1,864.00	0.18%
11	PERSONALITY DISORDERS	$1,741.00	0.17%
12	OTHER CONDITIONS THAT MAY BE THE FOCUS OF CLINICAL ATTENTION	$470.00	0.05%
13	DELIRIUM, DEMENTIA, AMNESTIC AND OTHER COGNITIVE DISORDERS	$202.00	0.02%
	Total for All Diagnosis Categories	**$1,008,645.16**	**100.00%**

Top Five Diagnosis Categories



New York State Empire Plan - OUT OF STATE

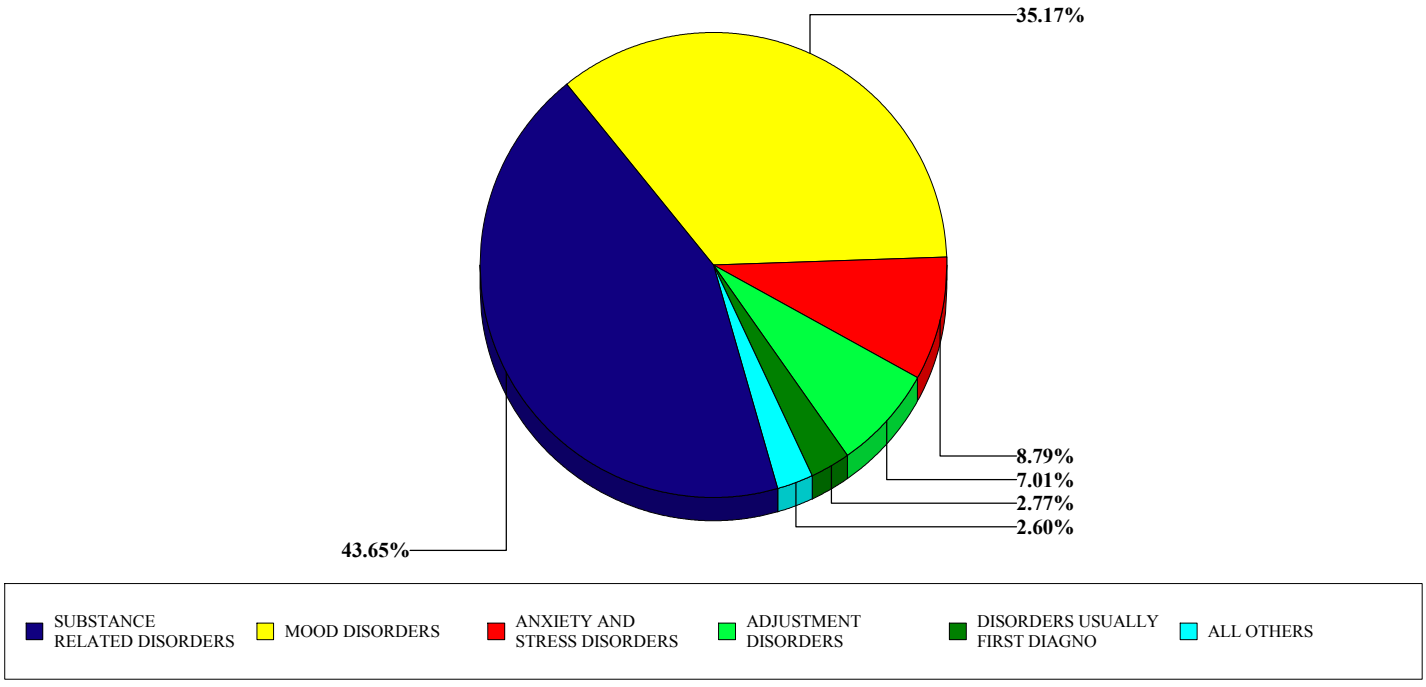
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Major Diagnosis Category

Rank	Diagnosis Category	Total Paid	% of Total Paid
OUT OF STATE			
1	SUBSTANCE RELATED DISORDERS	$290,403.38	43.65%
2	MOOD DISORDERS	$233,969.45	35.17%
3	ANXIETY AND STRESS DISORDERS	$58,503.93	8.79%
4	ADJUSTMENT DISORDERS	$46,652.23	7.01%
5	DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE	$18,439.48	2.77%
6	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	$13,419.04	2.02%
7	DISSOCIATIVE, SOMATOFORM AND FACTITIOUS DISORDERS	$1,513.00	0.23%
8	MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED	$1,159.80	0.17%
9	EATING DISORDERS	$632.00	0.09%
10	OTHER MENTAL DISORDERS	$333.00	0.05%
11	DELIRIUM, DEMENTIA, AMNESTIC AND OTHER COGNITIVE DISORDERS	$251.00	0.04%
12	PERSONALITY DISORDERS	$6.00	0.00%
	ALL OTHER DIAGNOSIS CATEGORIES	$0.00	0.00%
	Total for All Diagnosis Categories	**$665,282.31**	**100.00%**

Top Five Diagnosis Categories



New York State Empire Plan - UNKNOWN

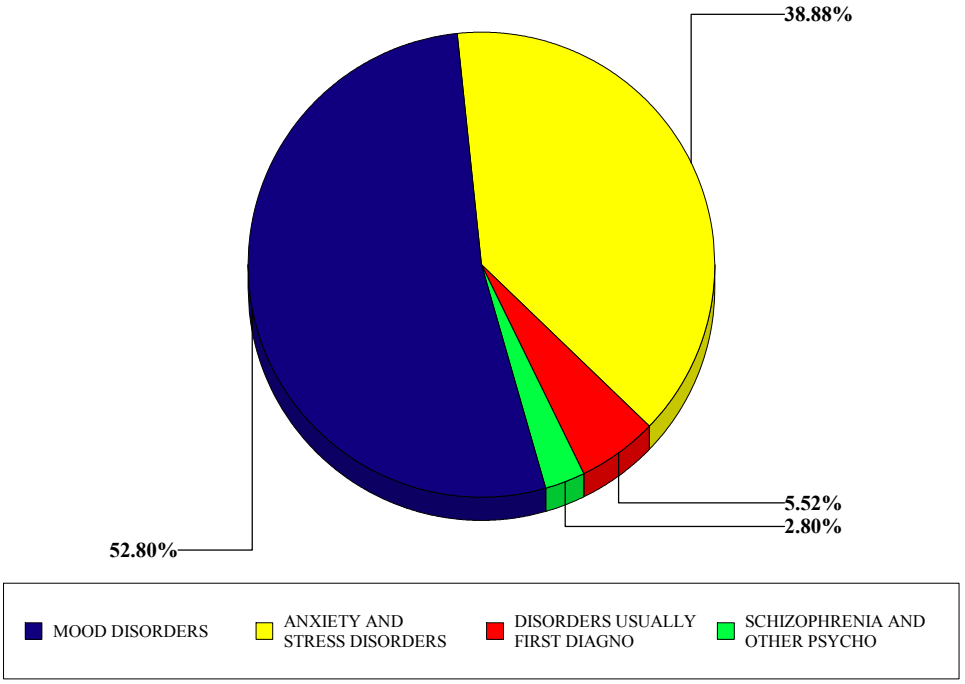
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Major Diagnosis Category

Rank	Diagnosis Category	Total Paid	% of Total Paid
UNKNOWN			
1	MOOD DISORDERS	$660.00	52.80%
2	ANXIETY AND STRESS DISORDERS	$486.00	38.88%
3	DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE	$69.00	5.52%
4	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	$35.00	2.80%
	ALL OTHER DIAGNOSIS CATEGORIES	$0.00	0.00%
	Total for All Diagnosis Categories	**$1,250.00**	**100.00%**

Top Five Diagnosis Categories



New York State Empire Plan - WESTERN NY

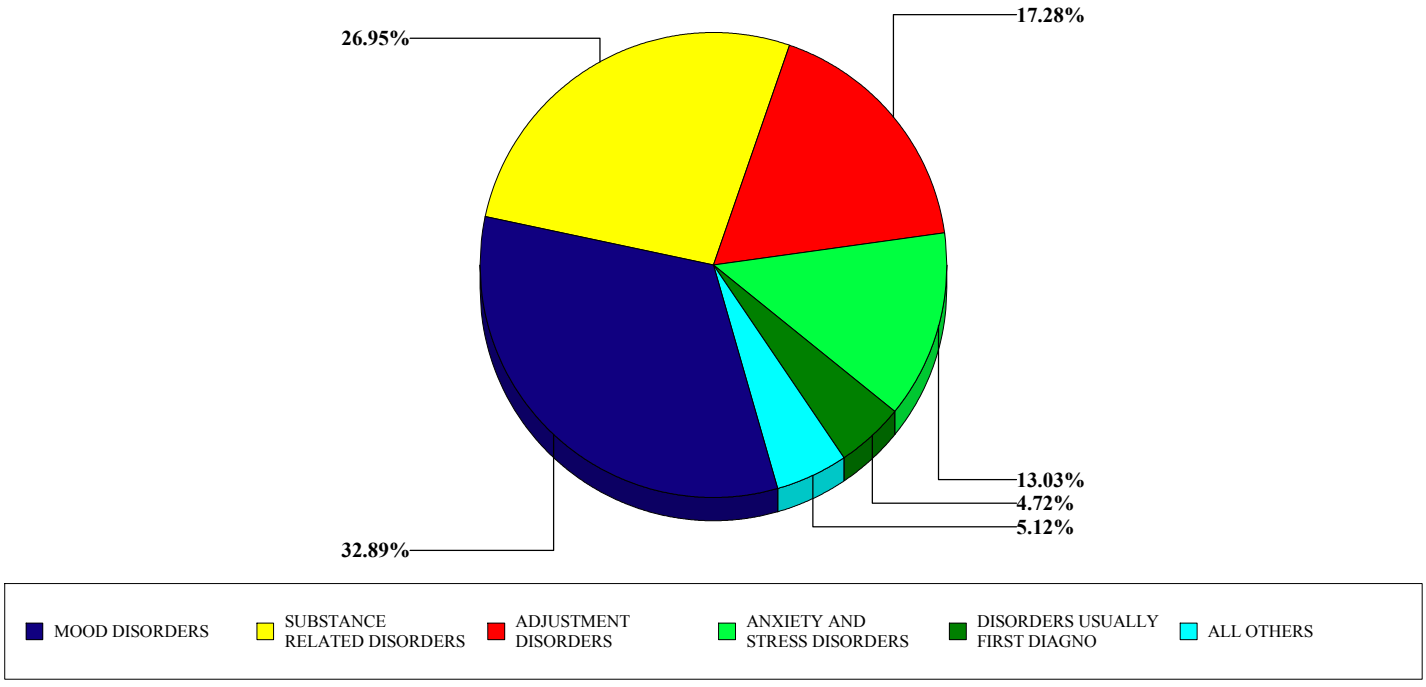
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Major Diagnosis Category

Rank	Diagnosis Category	Total Paid	% of Total Paid
WESTERN NY			
1	MOOD DISORDERS	$125,402.64	32.89%
2	SUBSTANCE RELATED DISORDERS	$102,734.27	26.95%
3	ADJUSTMENT DISORDERS	$65,878.28	17.28%
4	ANXIETY AND STRESS DISORDERS	$49,691.43	13.03%
5	DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE	$17,999.02	4.72%
6	EATING DISORDERS	$10,987.28	2.88%
7	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	$4,213.00	1.11%
8	OTHER MENTAL DISORDERS	$2,368.00	0.62%
9	DISSOCIATIVE, SOMATOFORM AND FACTITIOUS DISORDERS	$1,100.00	0.29%
10	DELIRIUM, DEMENTIA, AMNESTIC AND OTHER COGNITIVE DISORDERS	$516.00	0.14%
11	MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED	$256.00	0.07%
12	PERSONALITY DISORDERS	$90.00	0.02%
	ALL OTHER DIAGNOSIS CATEGORIES	$0.00	0.00%
	Total for All Diagnosis Categories	**$381,235.92**	**100.00%**

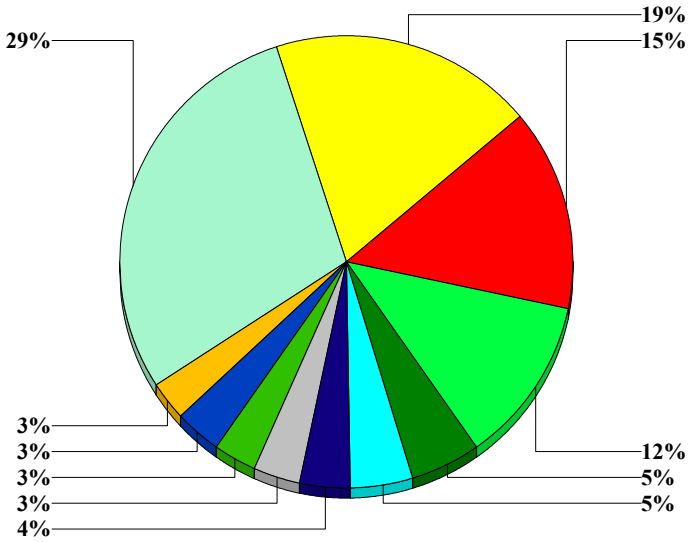
Top Five Diagnosis Categories



New York State Empire Plan - CENTRAL NY
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

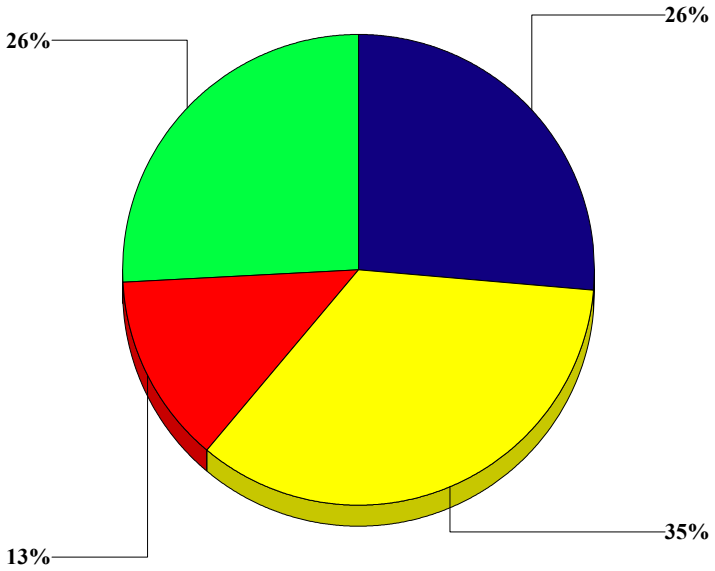
Top Ten High Volume Facilities - Inpatient and Alternative Levels of Care (Group)

Facility	Total Paid	% of Total Paid
LAKEVIEW HEALTH SYSTEMS	$68,020	19%
TULLY HILL CORPORATION	$52,502	15%
THE WATERSHED OF THEPALM BEACHES	$42,650	12%
FORTERUS HEALTHCARE	$17,910	5%
SUNRISE DETOX III, LLC	$16,380	5%
CENTRE SYRACUSE LLC	$13,200	4%
UNITED HEALTH SERVICES HOSPITALS	$11,771	3%
STARTING POINT	$11,700	3%
EBH SUBSIDIARY ACQUISTIONS INC	$11,696	3%
FOUR WINDS OF SARATOGA INC	$10,401	3%
ALL OTHER FACILITIES	$104,938	29%
Total	**$361,168**	**100.00%**



Outpatient Distribution by Provider Discipline

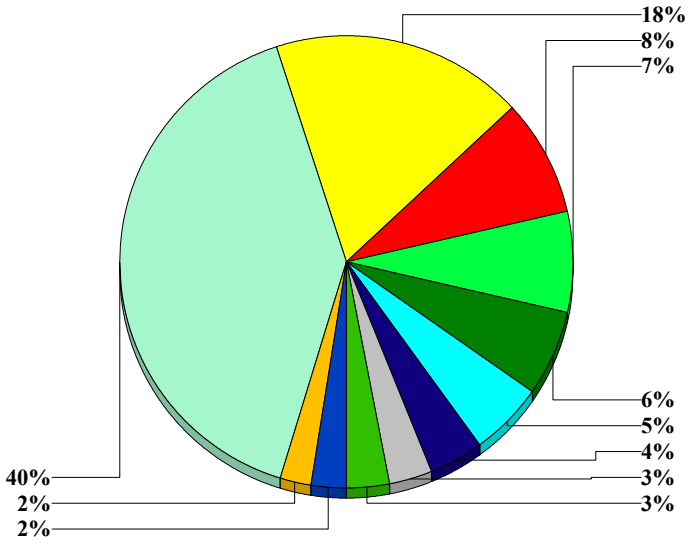
Provider Discipline	Total Paid	% of Total Paid
MD	$100,992	13%
PHD	$199,326	26%
LCSW	$268,334	35%
ALL OTHER DISCIPLINES	$202,506	26%
Total	**$771,157**	**100.00%**



New York State Empire Plan - HUDSON VALLEY
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

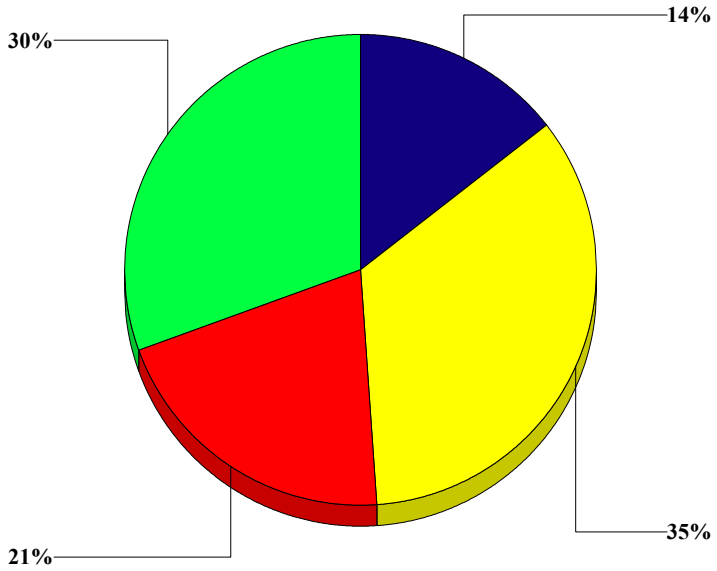
Top Ten High Volume Facilities - Inpatient and Alternative Levels of Care (Group)

Facility	Total Paid	% of Total Paid
FOUR WINDS OF SARATOGA INC	$264,545	18%
DEERFIELD FLORIDA HOUSE	$122,030	8%
FOUR WINDS INC	$109,704	7%
BEHAVIORAL HEALTH OFTHE PALM BEACHE	$90,047	6%
NEW METHOD WELLNESS	$77,300	5%
THE RENFREW CENTER OF PENNSYLVANIA	$54,810	4%
ARMS ACRES INC	$48,033	3%
ADVANCED HEALTH AND EDUCATION	$43,875	3%
ORANGE REGIONAL MEDICAL CENTER	$36,192	2%
BENEDICTINE HOSPITAL	$34,414	2%
ALL OTHER FACILITIES	$590,843	40%
Total	**$1,471,793**	**100.00%**



Outpatient Distribution by Provider Discipline

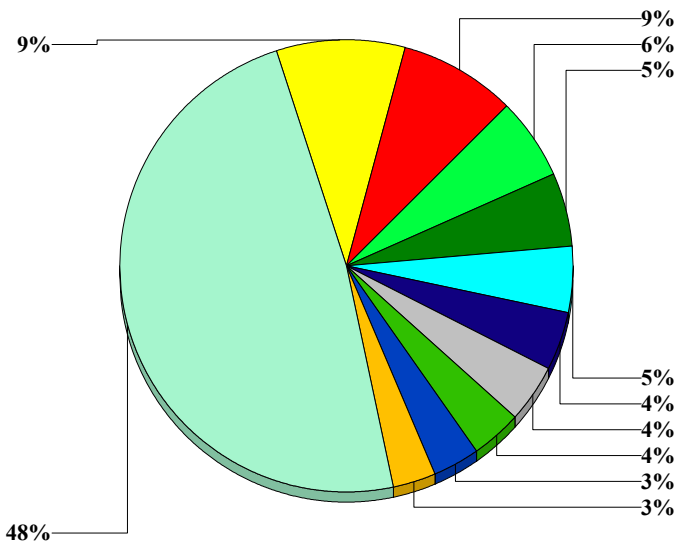
Provider Discipline	Total Paid	% of Total Paid
MD	$484,545	21%
PHD	$717,751	30%
LCSW	$814,209	35%
ALL OTHER DISCIPLINES	$340,220	14%
Total	**$2,356,725**	**100.00%**



New York State Empire Plan - LONG ISLAND
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

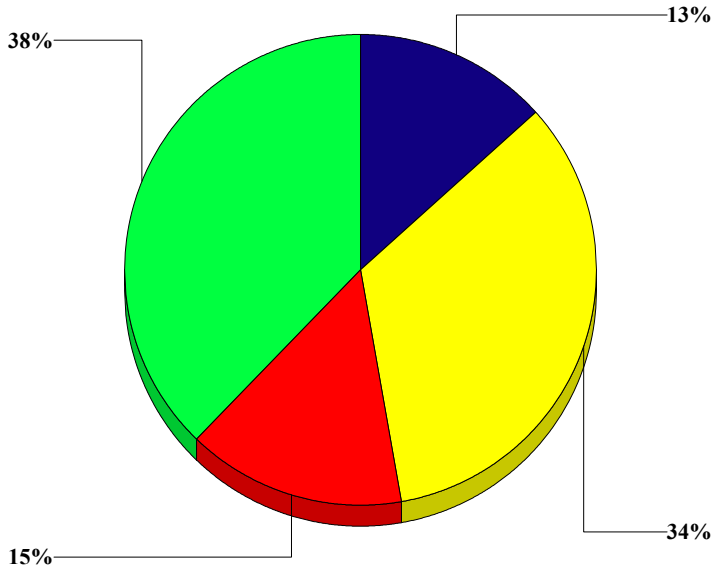
Top Ten High Volume Facilities - Inpatient and Alternative Levels of Care (Group)

Facility	Total Paid	% of Total Paid
THE LONG ISLAND HOME	$179,793	9%
OCEAN BREEZE RECOVERY	$170,547	9%
ADVANCED HEALTH AND EDUCATION	$115,240	6%
DEERFIELD FLORIDA HOUSE	$104,420	5%
THE RENFREW CENTER OF PENNSYLVANIA	$91,620	5%
THE WATERSHED OF THEPALM BEACHES	$86,320	4%
NASSAU UNIVERSITY MEDICAL CENTER	$80,616	4%
LONG ISLAND CENTER FOR RECOVERY INC	$72,217	4%
JOHN T MATHER MEMORIAL HOSPITAL	$68,215	3%
RETREAT AT LANCASTER LLC	$58,421	3%
ALL OTHER FACILITIES	$961,410	48%
Total	**$1,988,817**	**100.00%**



Outpatient Distribution by Provider Discipline

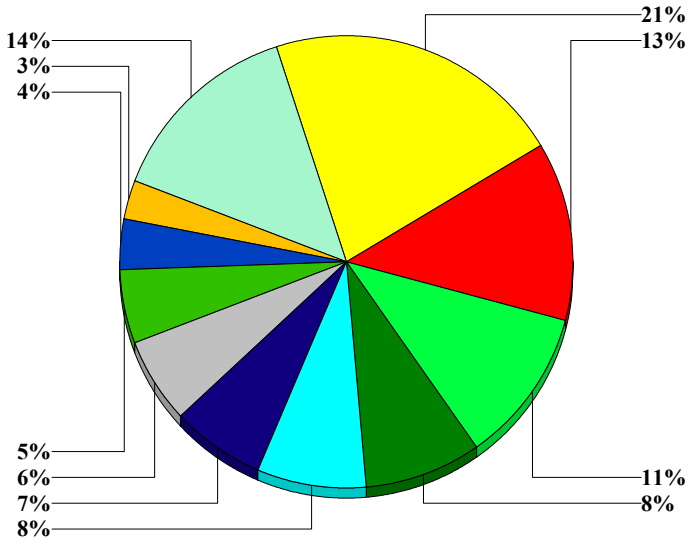
Provider Discipline	Total Paid	% of Total Paid
MD	$600,514	15%
PHD	$1,494,129	38%
LCSW	$1,340,637	34%
ALL OTHER DISCIPLINES	$528,046	13%
Total	**$3,963,326**	**100.00%**



New York State Empire Plan - NY CITY
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

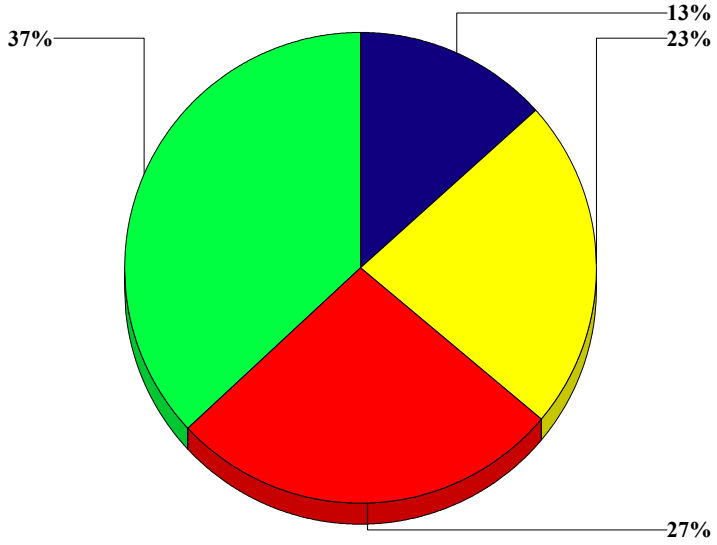
Top Ten High Volume Facilities - Inpatient and Alternative Levels of Care (Group)

Facility	Total Paid	% of Total Paid
THE WATERSHED OF THEPALM BEACHES	$46,466	21%
MILESTONES	$27,900	13%
FOUR WINDS INC	$24,488	11%
ESTATES OF DELRAY BEACH	$18,264	8%
JACOBI MEDICAL CENT ER	$16,545	8%
LONG ISLAND JEWISH MEDICAL CENTER	$14,740	7%
THE RENFREW CENTER OF NEW YORK CITY	$13,242	6%
PHOENIX HOUSES OF NEW YORK INC	$11,900	5%
ARMS ACRES INC	$7,727	4%
SOUTHERN CRESCENT BEHAV HLTH SYS	$6,181	3%
ALL OTHER FACILITIES	$30,724	14%
Total	**$218,178**	**100.00%**



Outpatient Distribution by Provider Discipline

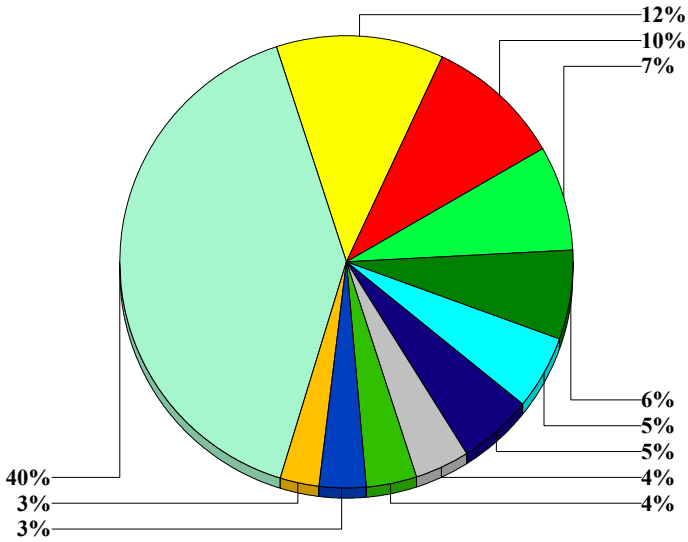
Provider Discipline	Total Paid	% of Total Paid
MD	$212,219	27%
PHD	$290,386	37%
LCSW	$177,598	23%
ALL OTHER DISCIPLINES	$105,291	13%
Total	**$785,494**	**100.00%**



New York State Empire Plan - OUT OF STATE
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

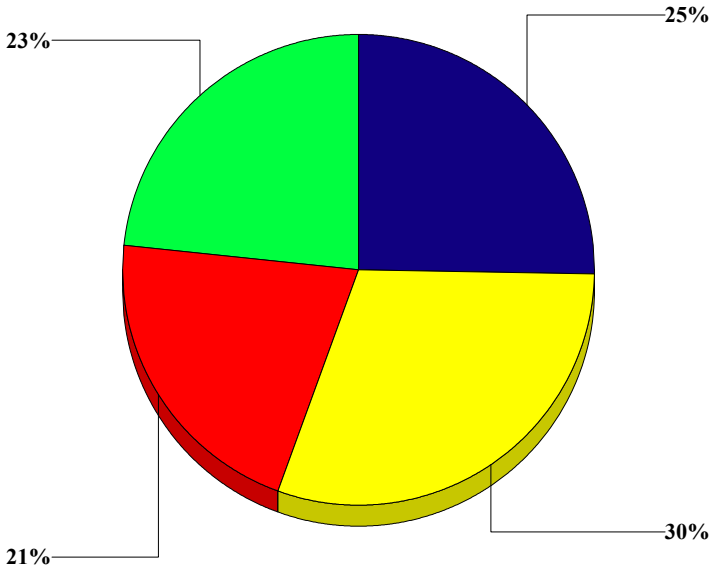
Top Ten High Volume Facilities - Inpatient and Alternative Levels of Care (Group)

Facility	Total Paid	% of Total Paid
BEHAVIORAL HEALTH OFTHE PALM BEACHE	$46,973	12%
PARK BENCH GROUP COUNSELING LLC	$39,400	10%
RETREAT AT LANCASTER LLC	$28,885	7%
OCEAN BREEZE RECOVERY	$25,375	6%
AMBROSIA SUBSTANCE ABUSE TXMT CTR	$21,600	5%
SCHUYLKILL MEDICAL CENTER	$20,842	5%
CENTER FOR ALCOHOL AND DRUG STUDIES	$15,885	4%
WELLINGTON COUNSELING AND ASSOC	$13,918	4%
ST LUKES ROOSEVELT HOSPITAL CENTER	$13,563	3%
FOUR WINDS INC	$11,035	3%
ALL OTHER FACILITIES	$159,462	40%
Total	**$396,937**	**100.00%**



Outpatient Distribution by Provider Discipline

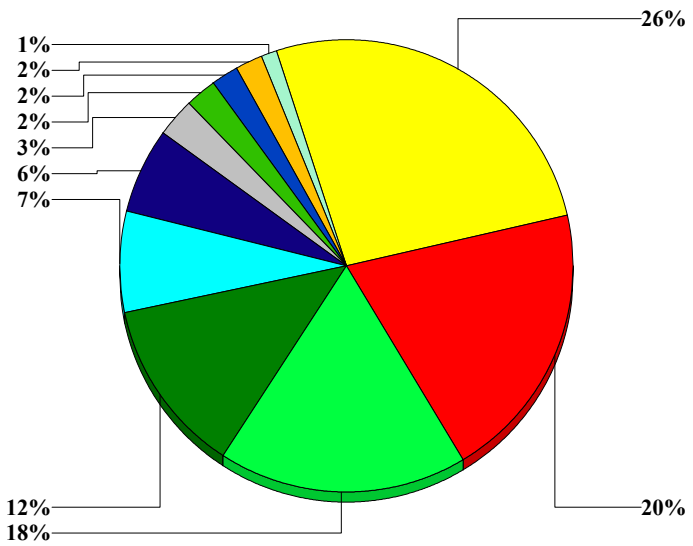
Provider Discipline	Total Paid	% of Total Paid
MD	$55,482	21%
PHD	$62,321	23%
LCSW	$80,653	30%
ALL OTHER DISCIPLINES	$67,390	25%
Total	**$265,846**	**100.00%**



New York State Empire Plan - WESTERN NY
Managed Mental Health and Substance Abuse Activity Report
January 1, 2014 - March 31, 2014

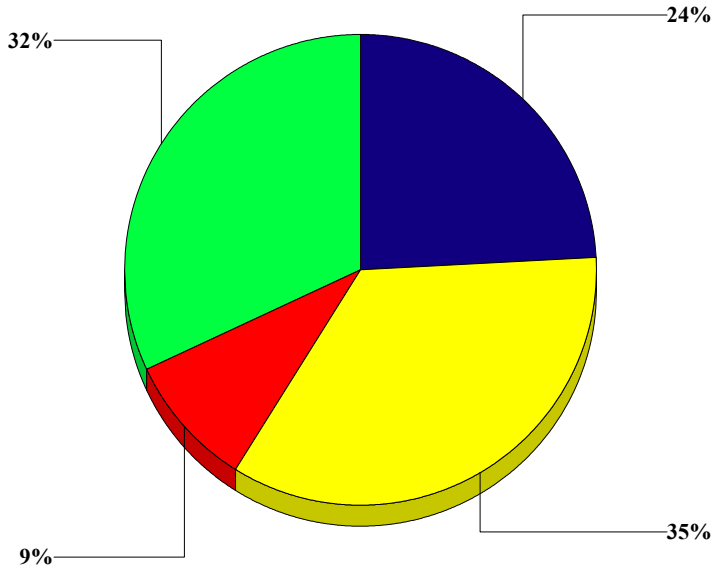
Top Ten High Volume Facilities - Inpatient and Alternative Levels of Care (Group)

Facility	Total Paid	% of Total Paid
TULLY HILL CORPORATION	$36,000	26%
BRYLIN HOSPITALS INC	$27,445	20%
BEHAVIORAL HEALTH OFTHE PALM BEACHE	$24,154	18%
STARTING POINT	$16,800	12%
VOIDLOCKPORT MEMORIAUSE P#736414	$9,954	7%
CENTRE SYRACUSE LLC	$8,400	6%
ITHACA ALPHA HOUSE CENTER, INC	$3,825	3%
RECOVERY ANGEL'S	$3,000	2%
DIVERSE TREATMENT SOLUTIONS	$2,685	2%
FIRST HEALTH OF THE CAROLINAS INC	$2,552	2%
ALL OTHER FACILITIES	$1,589	1%
Total	**$136,403**	**100.00%**



Outpatient Distribution by Provider Discipline

Provider Discipline	Total Paid	% of Total Paid
MD	$22,261	9%
PHD	$78,048	32%
LCSW	$84,542	35%
ALL OTHER DISCIPLINES	$58,995	24%
Total	**$243,846**	**100.00%**



New York State Empire Plan CENTRAL NY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Paid Claim Analysis - Gender/Dependency-By Group

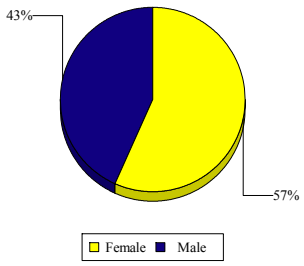
Males

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$34,548	$34,548
13 - 17	$0	$0	$62,376	$62,376
18 - 64	$214,069	$37,405	$140,902	$392,375
65+	$3,170	$1,400	$0	$4,570
Total	**$217,239**	**$38,805**	**$237,826**	**$493,869**

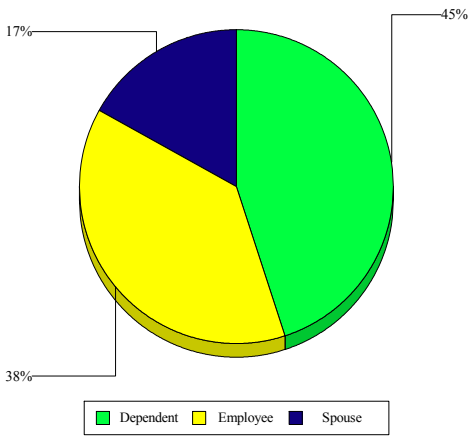
Females

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$27,973	$27,973
13 - 17	$0	$0	$54,990	$54,990
18 - 64	$213,838	$153,899	$192,137	$559,874
65+	$3,545	$1,044	$0	$4,589
Total	**$217,383**	**$154,943**	**$275,100**	**$647,426**

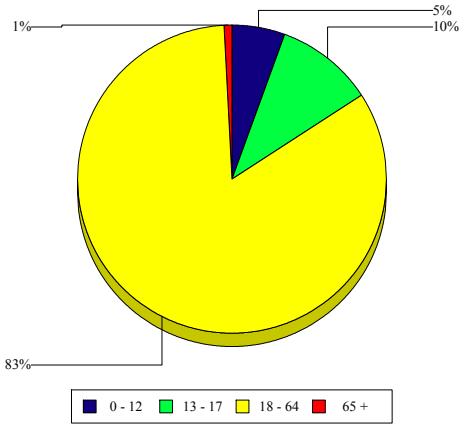
Total Paid % by Gender



Total Paid % by Dependency



Total Paid % by Age Band



New York State Empire Plan HUDSON VALLEY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Paid Claim Analysis - Gender/Dependency-By Group

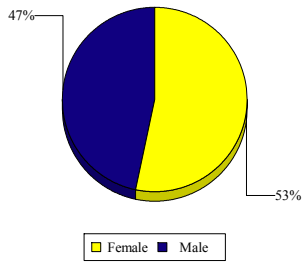
Males

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$153,694	$153,694
13 - 17	$0	$0	$206,096	$206,096
18 - 64	$625,202	$143,656	$642,709	$1,411,567
65+	$9,348	$7,546	$0	$16,894
Total	**$634,550**	**$151,202**	**$1,002,499**	**$1,788,252**

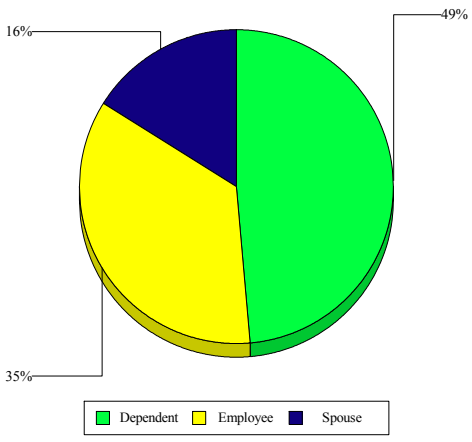
Females

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$71,752	$71,752
13 - 17	$0	$0	$311,752	$311,752
18 - 64	$703,753	$459,392	$485,008	$1,648,153
65+	$15,137	$4,637	$0	$19,773
Total	**$718,890**	**$464,029**	**$868,512**	**$2,051,431**

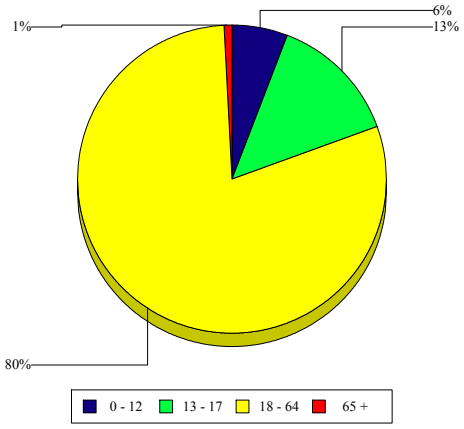
Total Paid % by Gender



Total Paid % by Dependency



Total Paid % by Age Band



New York State Empire Plan LONG ISLAND

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Paid Claim Analysis - Gender/Dependency-By Group

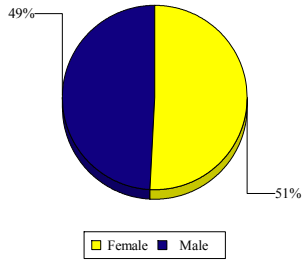
Males

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$193,756	$193,756
13 - 17	$0	$0	$257,421	$257,421
18 - 64	$808,430	$477,795	$1,167,700	$2,453,924
65+	$15,449	$24,687	$0	$40,136
Total	**$823,879**	**$502,482**	**$1,618,876**	**$2,945,237**

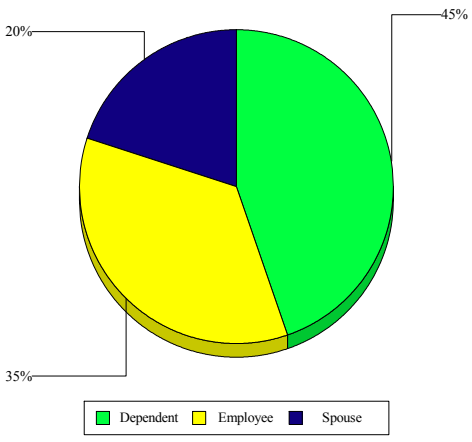
Females

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$113,315	$113,315
13 - 17	$0	$0	$357,538	$357,538
18 - 64	$1,261,965	$681,155	$586,694	$2,529,814
65+	$24,729	$9,754	$0	$34,483
Total	**$1,286,694**	**$690,909**	**$1,057,547**	**$3,035,150**

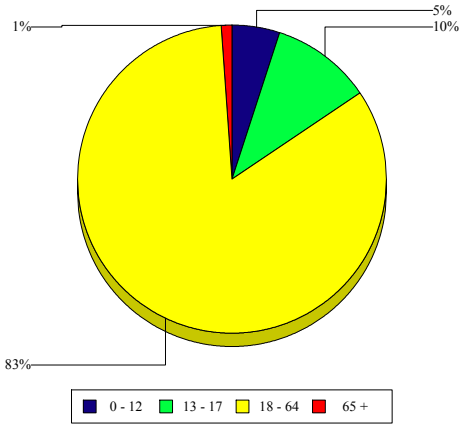
Total Paid % by Gender



Total Paid % by Dependency



Total Paid % by Age Band



New York State Empire Plan NY CITY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Paid Claim Analysis - Gender/Dependency-By Group

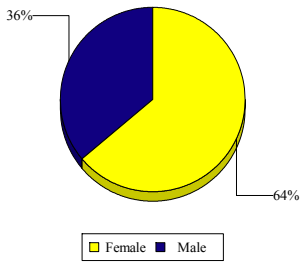
Males

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$37,329	$37,329
13 - 17	$14	$0	$21,885	$21,899
18 - 64	$207,776	$39,931	$44,227	$291,935
65+	$5,577	$8,214	$0	$13,791
Total	**$213,367**	**$48,145**	**$103,441**	**$364,954**

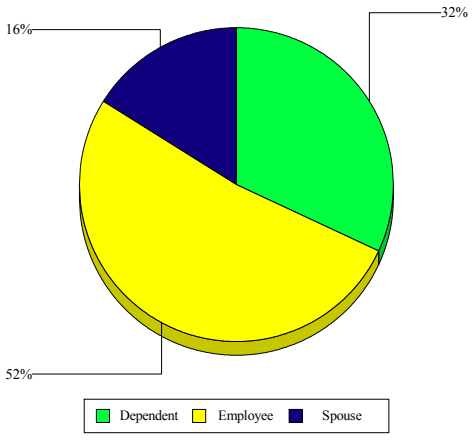
Females

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$14,653	$14,653
13 - 17	$173	$0	$47,115	$47,288
18 - 64	$304,065	$109,143	$157,383	$570,591
65+	$5,802	$5,357	$0	$11,160
Total	**$310,041**	**$114,500**	**$219,151**	**$643,692**

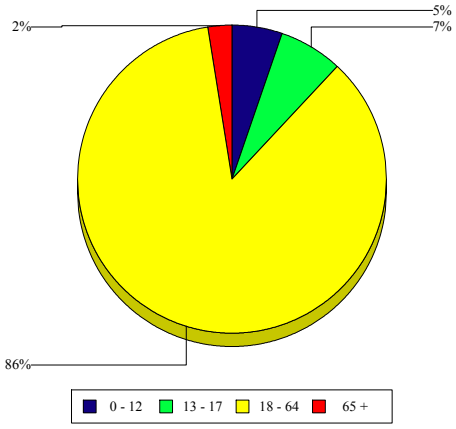
Total Paid % by Gender



Total Paid % by Dependency



Total Paid % by Age Band



New York State Empire Plan OUT OF STATE

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Paid Claim Analysis - Gender/Dependency-By Group

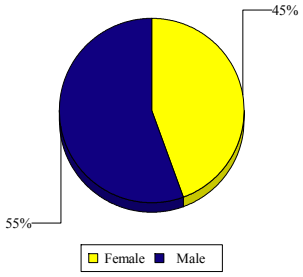
Males

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$9,427	$9,427
13 - 17	$0	$0	$9,380	$9,380
18 - 64	$103,007	$25,085	$219,700	$347,792
65+	$2,014	$460	$0	$2,475
Total	**$105,022**	**$25,545**	**$238,507**	**$369,074**

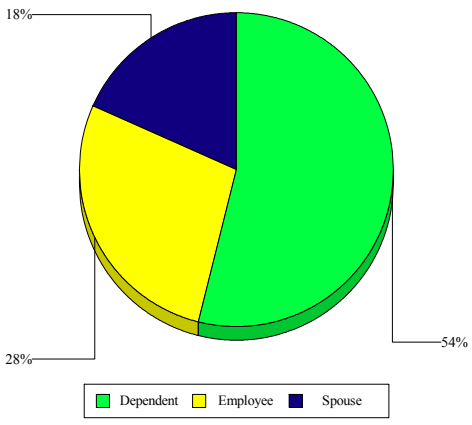
Females

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$8,901	$8,901
13 - 17	$0	$0	$39,478	$39,478
18 - 64	$76,257	$95,366	$72,483	$244,106
65+	$2,832	$891	$0	$3,723
Total	**$79,089**	**$96,257**	**$120,862**	**$296,208**

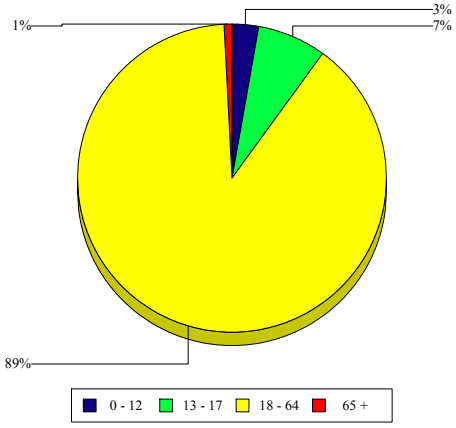
Total Paid % by Gender



Total Paid % by Dependency



Total Paid % by Age Band



New York State Empire Plan UNKNOWN

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Paid Claim Analysis - Gender/Dependency-By Group

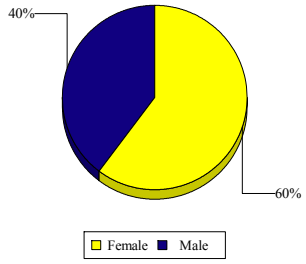
Males

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$0	$0
13 - 17	$0	$0	$63	$63
18 - 64	$433	$0	$0	$433
65+	$0	$0	$0	$0
Total	**$433**	**$0**	**$63**	**$496**

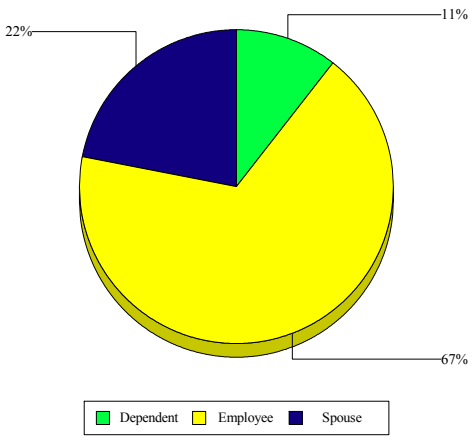
Females

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$69	$69
13 - 17	$0	$0	$0	$0
18 - 64	$409	$276	$0	$685
65+	$0	$0	$0	$0
Total	**$409**	**$276**	**$69**	**$754**

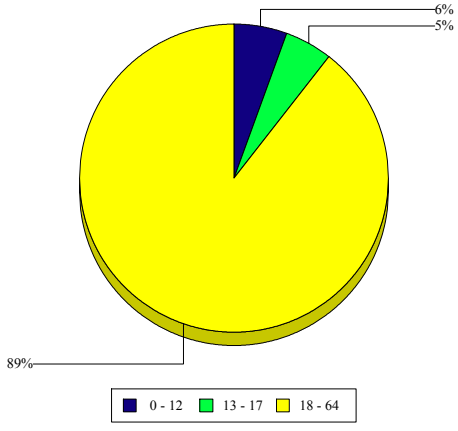
Total Paid % by Gender



Total Paid % by Dependency



Total Paid % by Age Band



New York State Empire Plan WESTERN NY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Paid Claim Analysis - Gender/Dependency-By Group

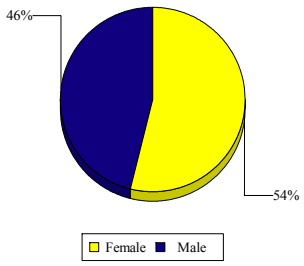
Males

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$12,412	$12,412
13 - 17	$0	$0	$22,905	$22,905
18 - 64	$77,049	$18,016	$44,325	$139,390
65+	$1,213	$265	$0	$1,478
Total	**$78,262**	**$18,281**	**$79,642**	**$176,185**

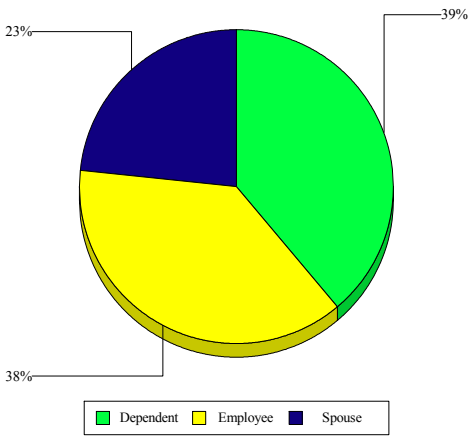
Females

Age Band	Employee	Spouse	Dependent	Total
0 - 12	$0	$0	$7,704	$7,704
13 - 17	$0	$0	$20,877	$20,877
18 - 64	$65,562	$68,646	$39,556	$173,765
65+	$960	$1,747	$0	$2,706
Total	**$66,522**	**$70,393**	**$68,136**	**$205,051**

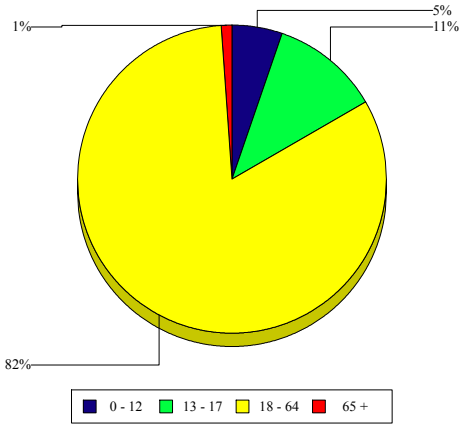
Total Paid % by Gender



Total Paid % by Dependency



Total Paid % by Age Band

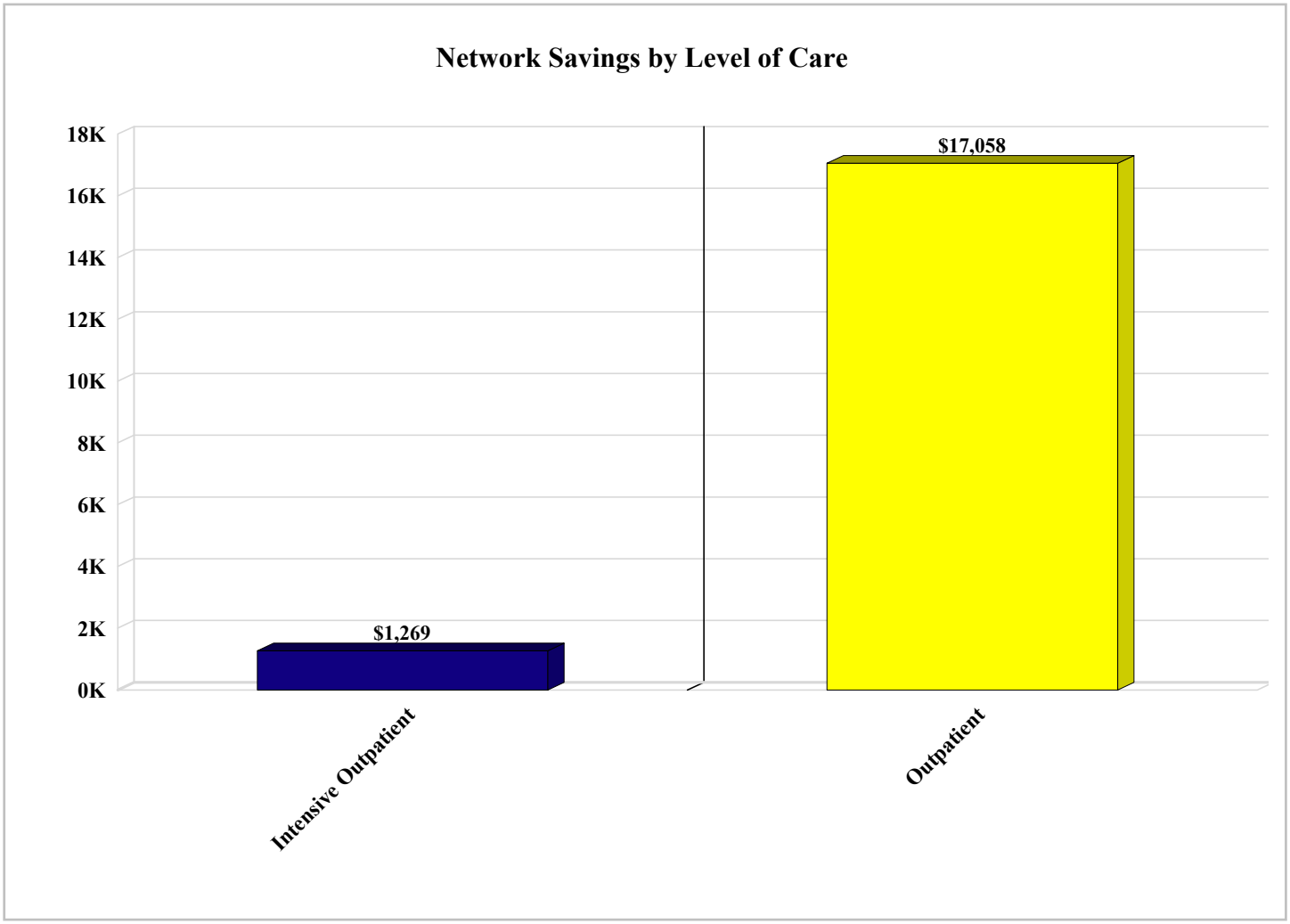


Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS001 - APSU			
Inpatient	$0	$0	$0
Residential	$0	$0	$0
Partial Hospitalization	$0	$0	$0
Intensive Outpatient	$2,700	$1,431	$1,269
Outpatient	$35,963	$18,906	$17,058
Total	**$38,663**	**$20,337**	**$18,327**



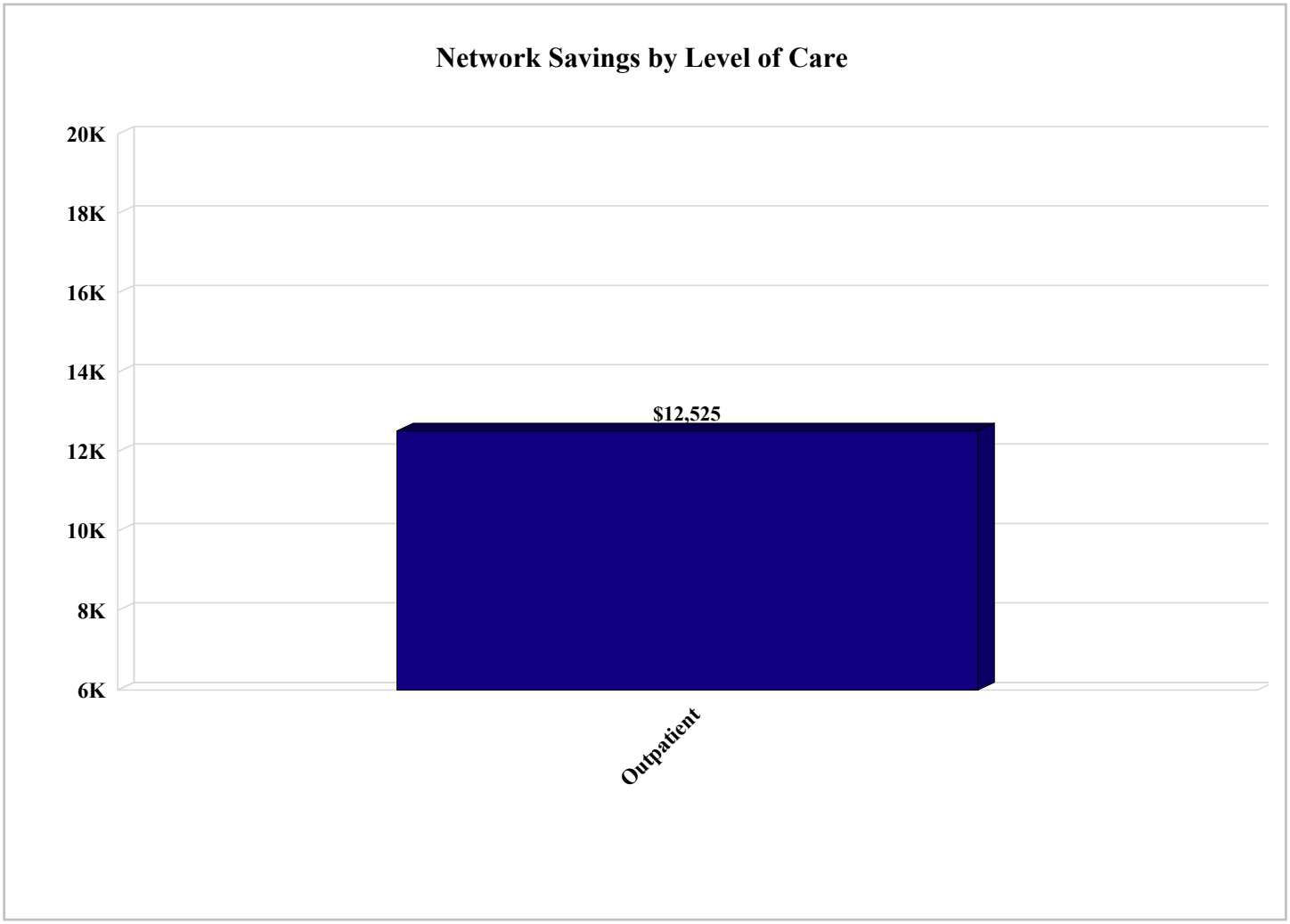
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS002 - COUNCIL 82			
Inpatient	$0	$0	$0
Residential	$0	$0	$0
Partial Hospitalization	$0	$0	$0
Intensive Outpatient	$0	$0	$0
Outpatient	$27,683	$15,158	$12,525
Total	**$27,683**	**$15,158**	**$12,525**



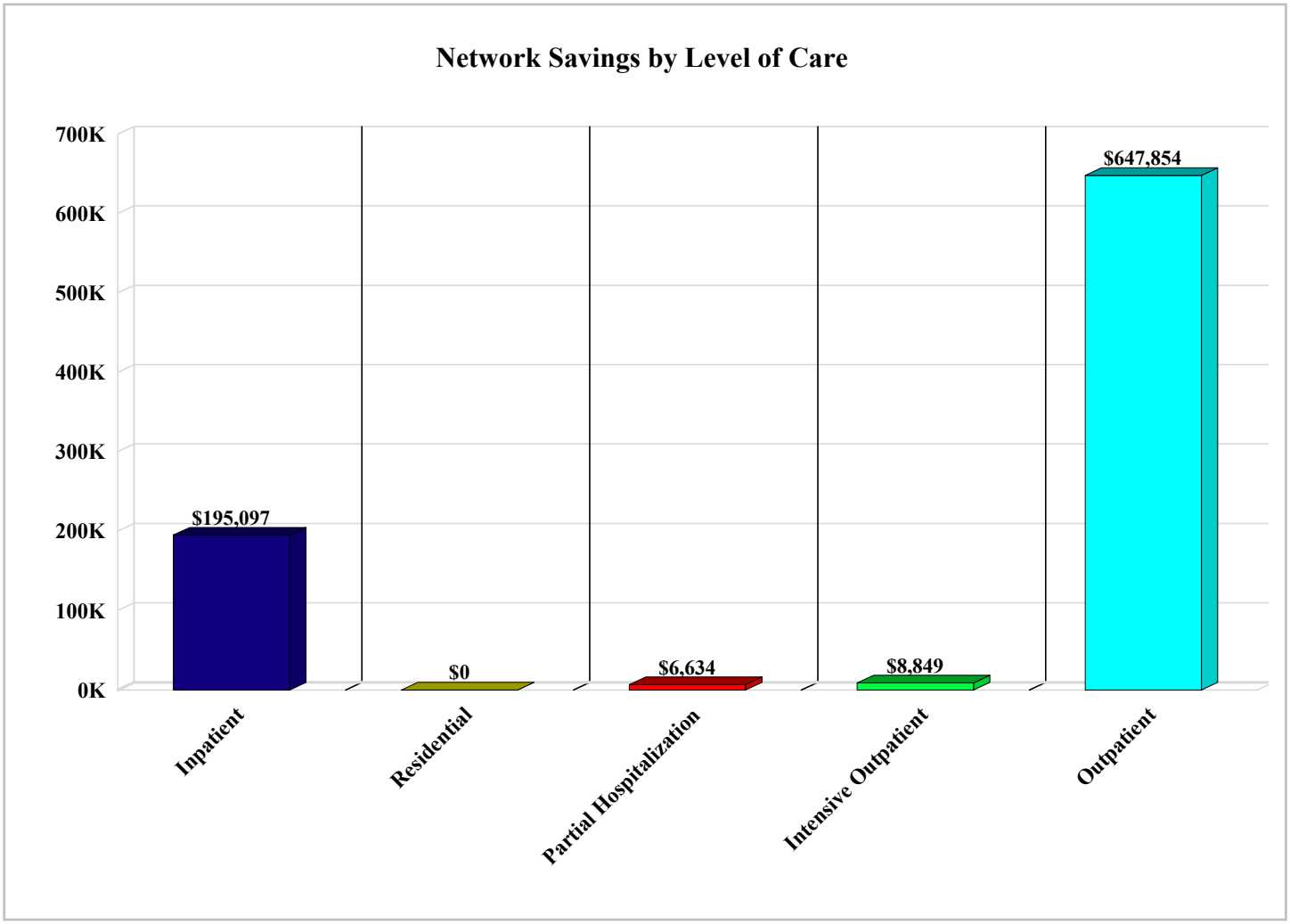
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS003 - CSEA			
Inpatient	$470,424	$275,326	$195,097
Residential	$10,200	$10,200	$0
Partial Hospitalization	$26,639	$20,005	$6,634
Intensive Outpatient	$18,213	$9,364	$8,849
Outpatient	$1,381,524	$733,671	$647,854
Total	**$1,907,000**	**$1,048,566**	**$858,434**



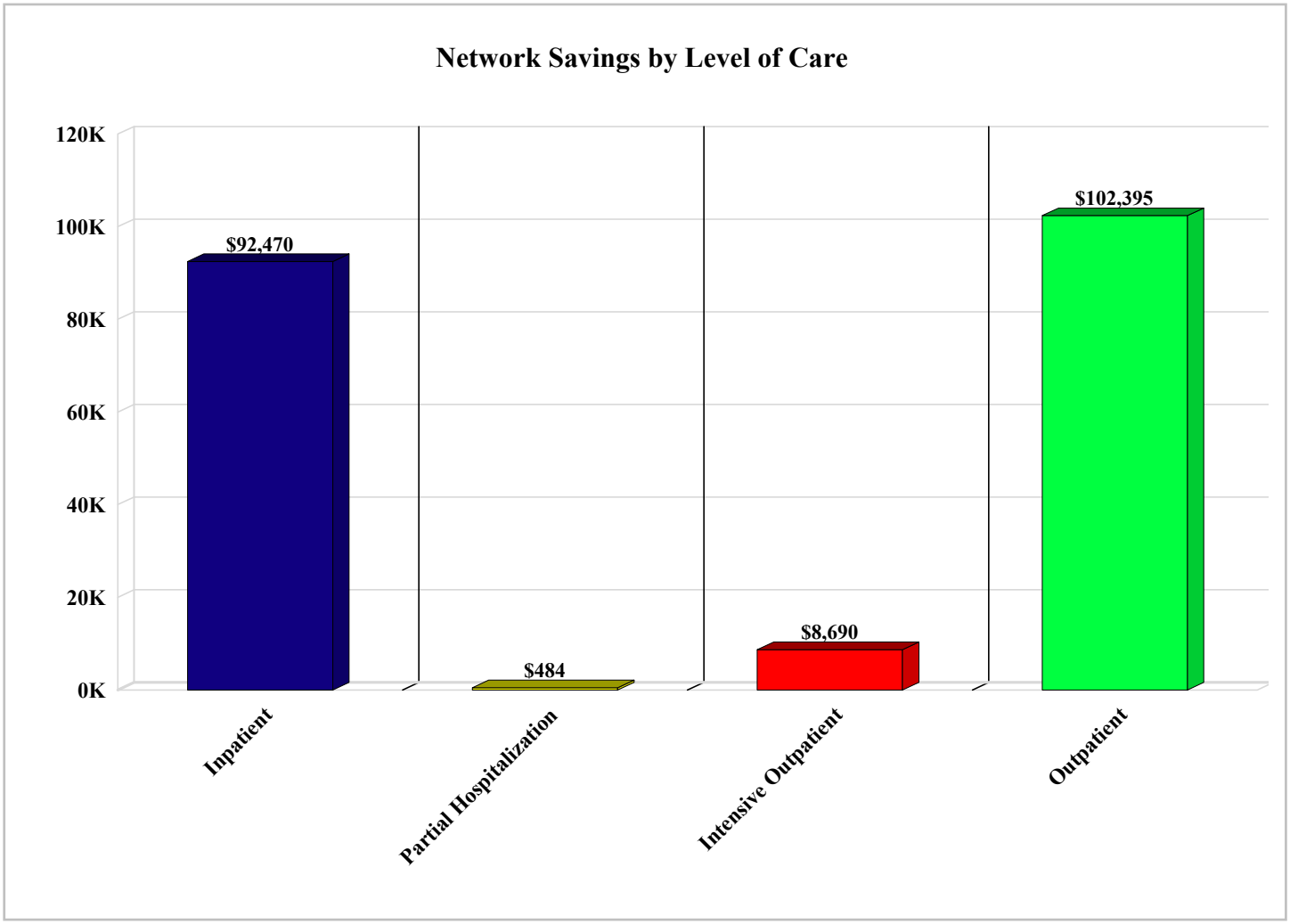
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS004 - CSEA-REDUCED OOPM			
Inpatient	$167,702	$75,232	$92,470
Residential	$0	$0	$0
Partial Hospitalization	$750	$266	$484
Intensive Outpatient	$10,725	$2,035	$8,690
Outpatient	$214,591	$112,196	$102,395
Total	**$393,768**	**$189,729**	**$204,039**



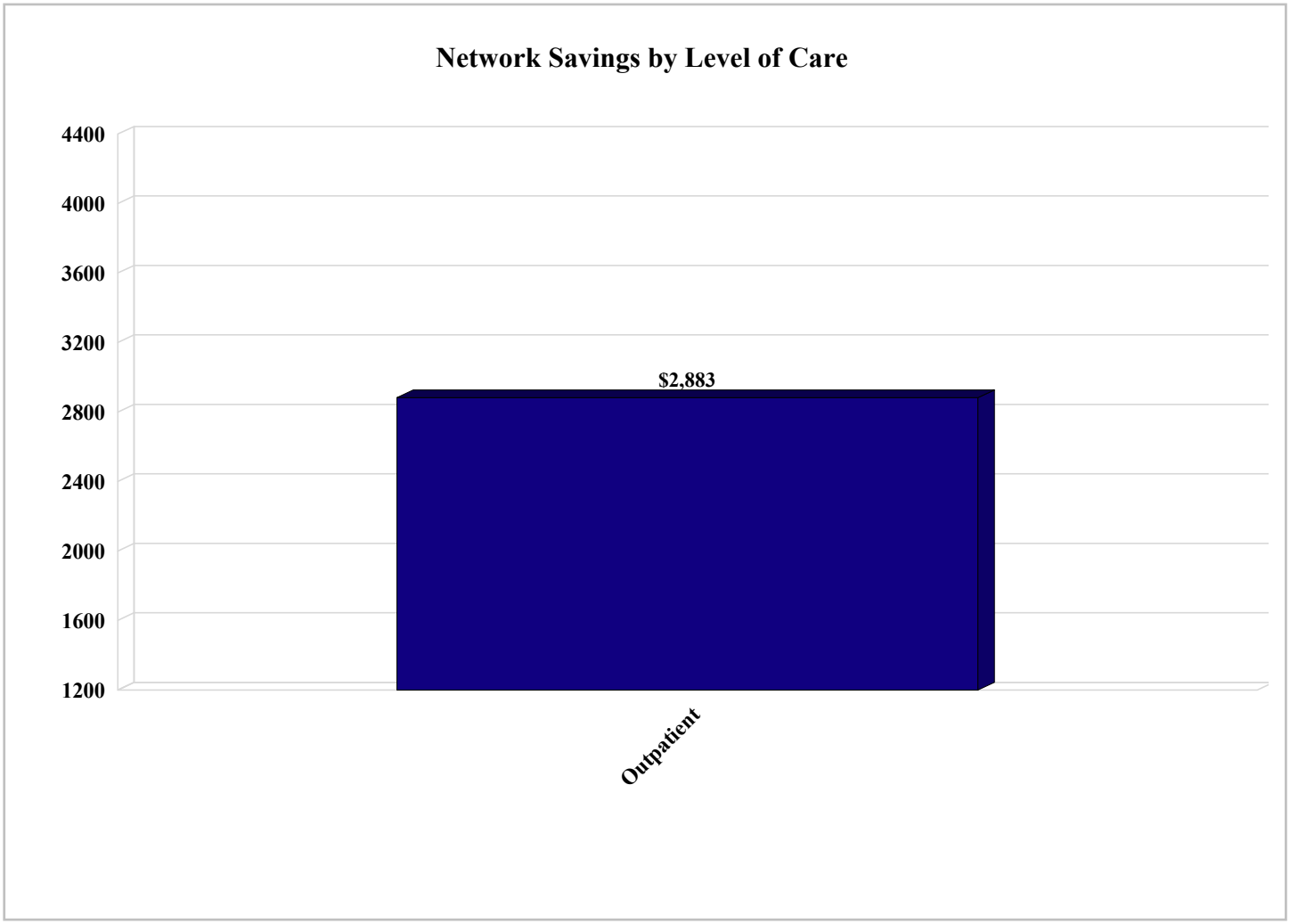
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS005 - DISTRICT COUNCIL 37			
Inpatient	$0	$0	$0
Residential	$0	$0	$0
Partial Hospitalization	$0	$0	$0
Intensive Outpatient	$0	$0	$0
Outpatient	$7,495	$4,612	$2,883
Total	**$7,495**	**$4,612**	**$2,883**



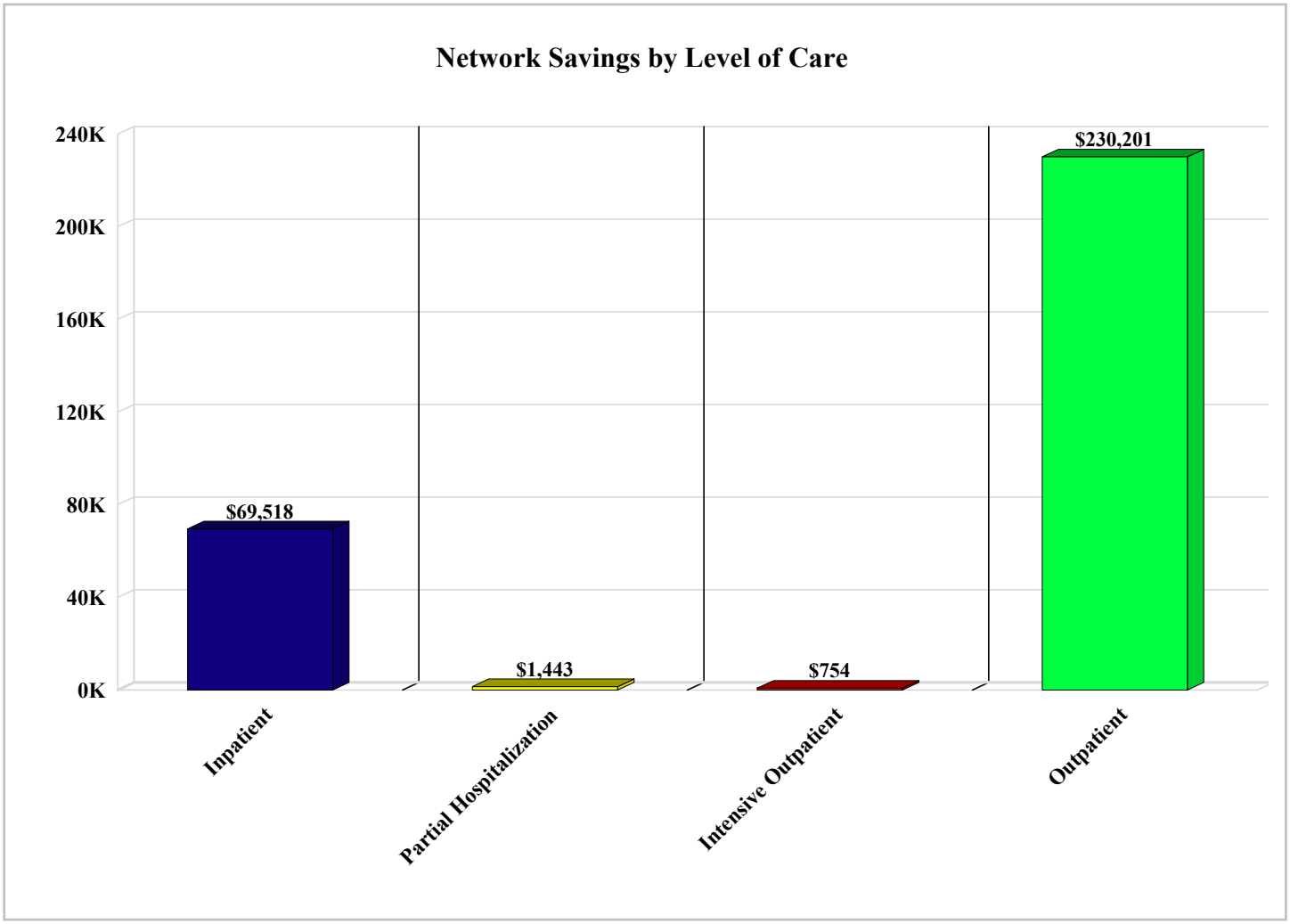
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS007 - MC-MGMT CONFIDENTIAL			
Inpatient	$117,438	$47,920	$69,518
Residential	$0	$0	$0
Partial Hospitalization	$2,500	$1,057	$1,443
Intensive Outpatient	$3,575	$2,821	$754
Outpatient	$573,563	$343,362	$230,201
Total	**$697,076**	**$395,159**	**$301,917**



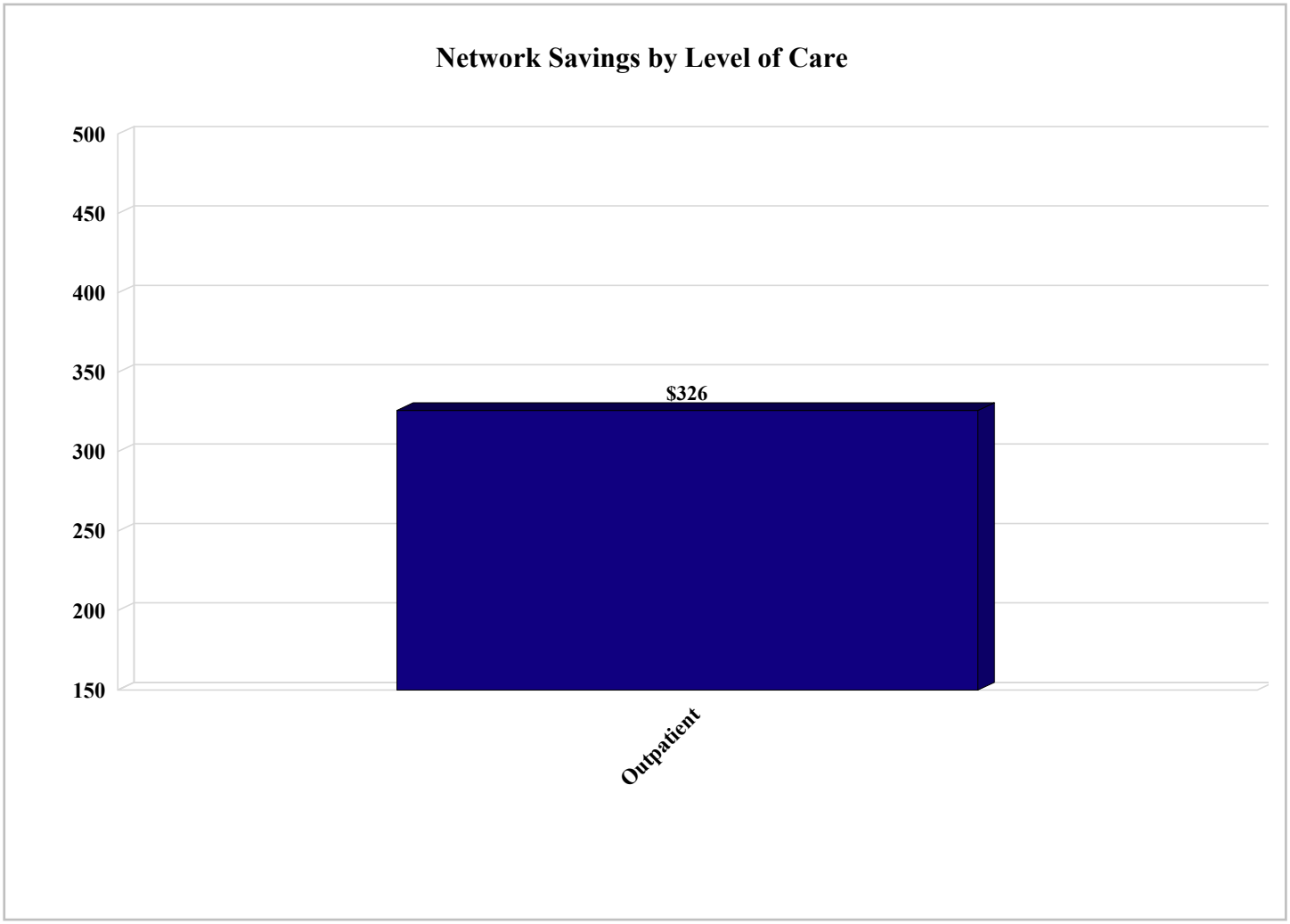
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS008 - MC-MGMT CONF RED OOPM			
Inpatient	$0	$0	$0
Residential	$0	$0	$0
Partial Hospitalization	$0	$0	$0
Intensive Outpatient	$0	$0	$0
Outpatient	$868	$542	$326
Total	**$868**	**$542**	**$326**



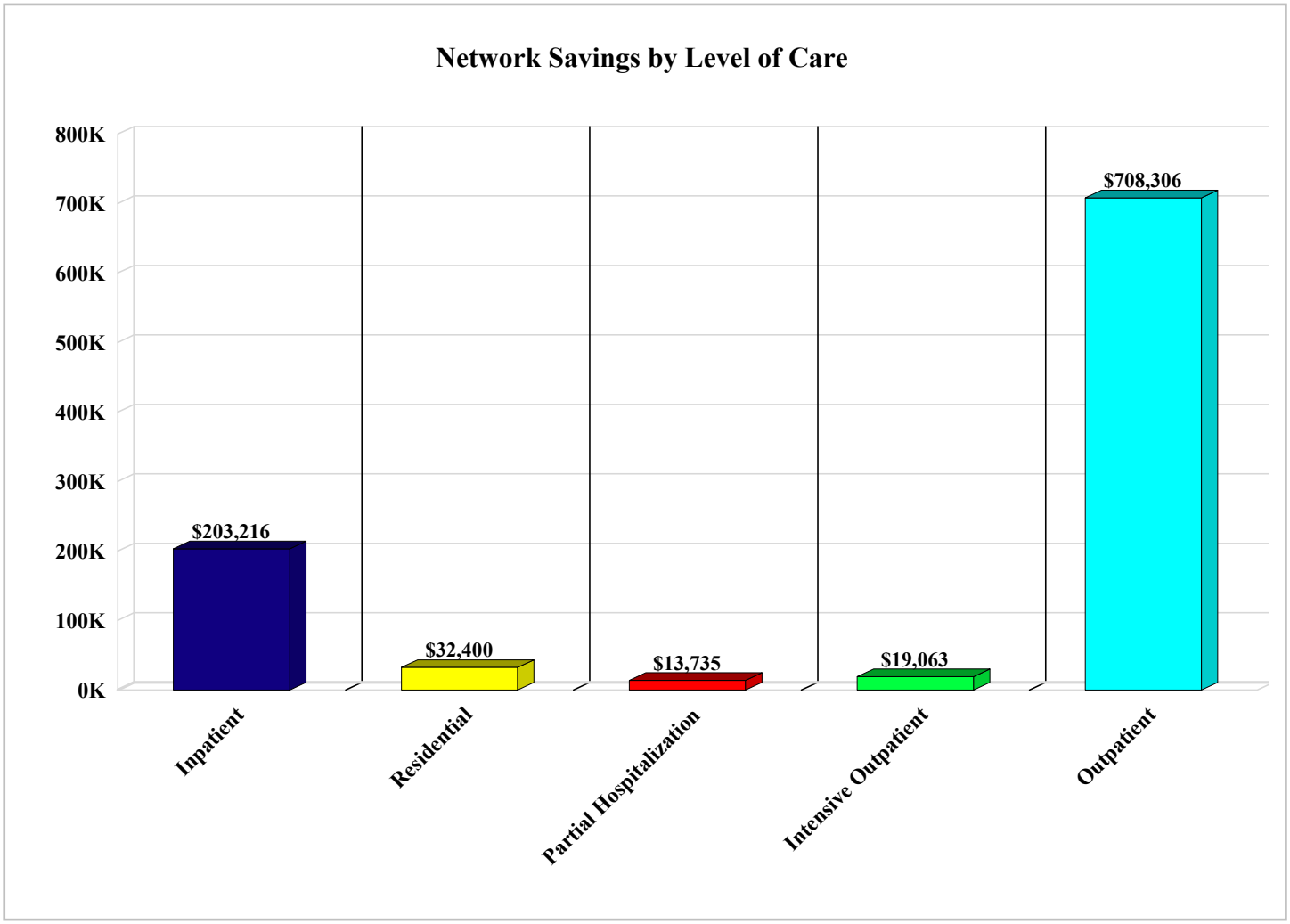
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS009 - NY/PE RETIREE			
Inpatient	$353,166	$149,950	$203,216
Residential	$58,500	$26,100	$32,400
Partial Hospitalization	$25,423	$11,688	$13,735
Intensive Outpatient	$45,081	$26,018	$19,063
Outpatient	$1,526,775	$818,468	$708,306
Total	**$2,008,945**	**$1,032,225**	**$976,720**



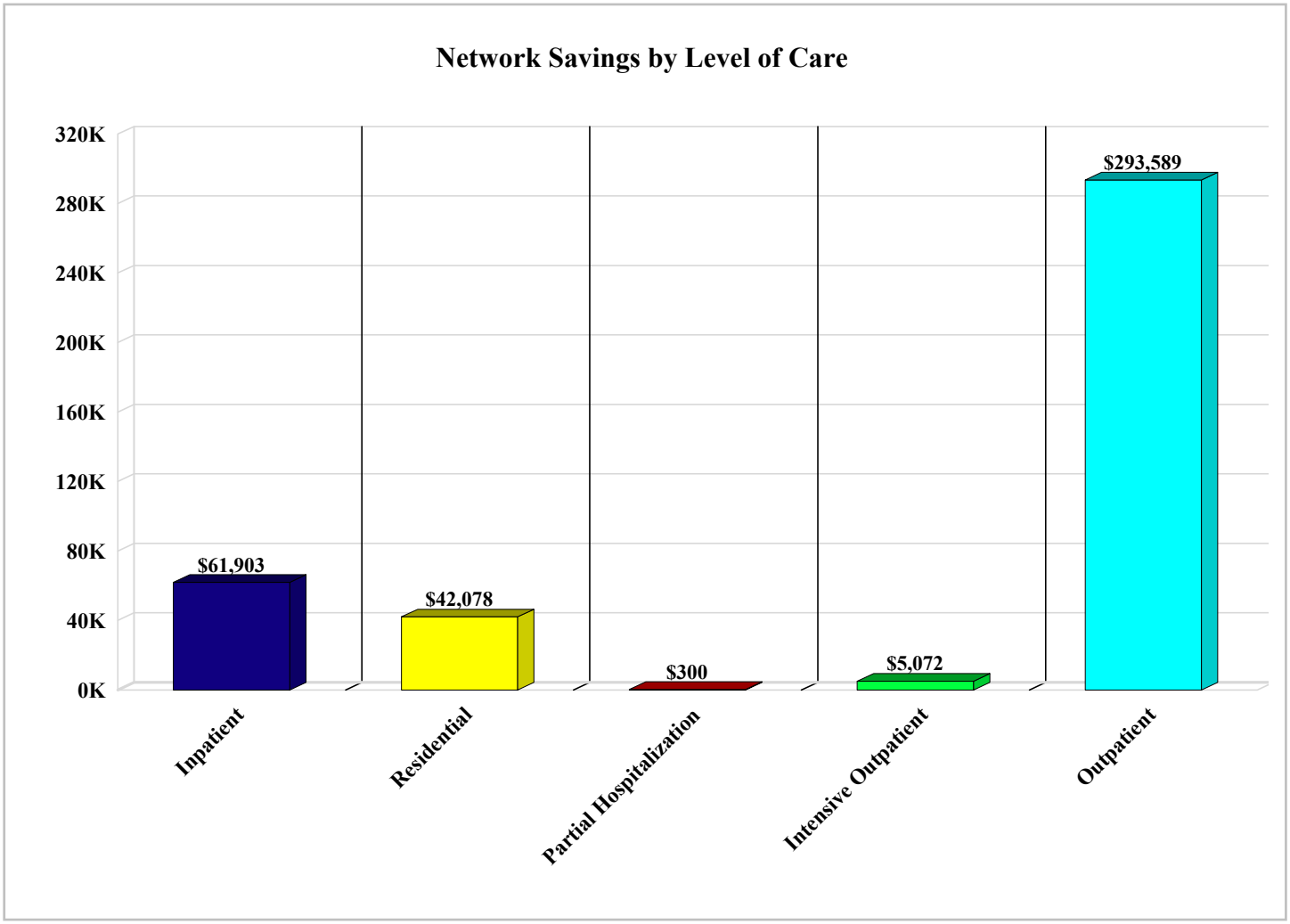
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS010 - NYSCOPBA			
Inpatient	$136,530	$74,627	$61,903
Residential	$81,760	$39,682	$42,078
Partial Hospitalization	$1,800	$1,500	$300
Intensive Outpatient	$12,428	$7,356	$5,072
Outpatient	$625,138	$331,548	$293,589
Total	**$857,655**	**$454,713**	**$402,943**



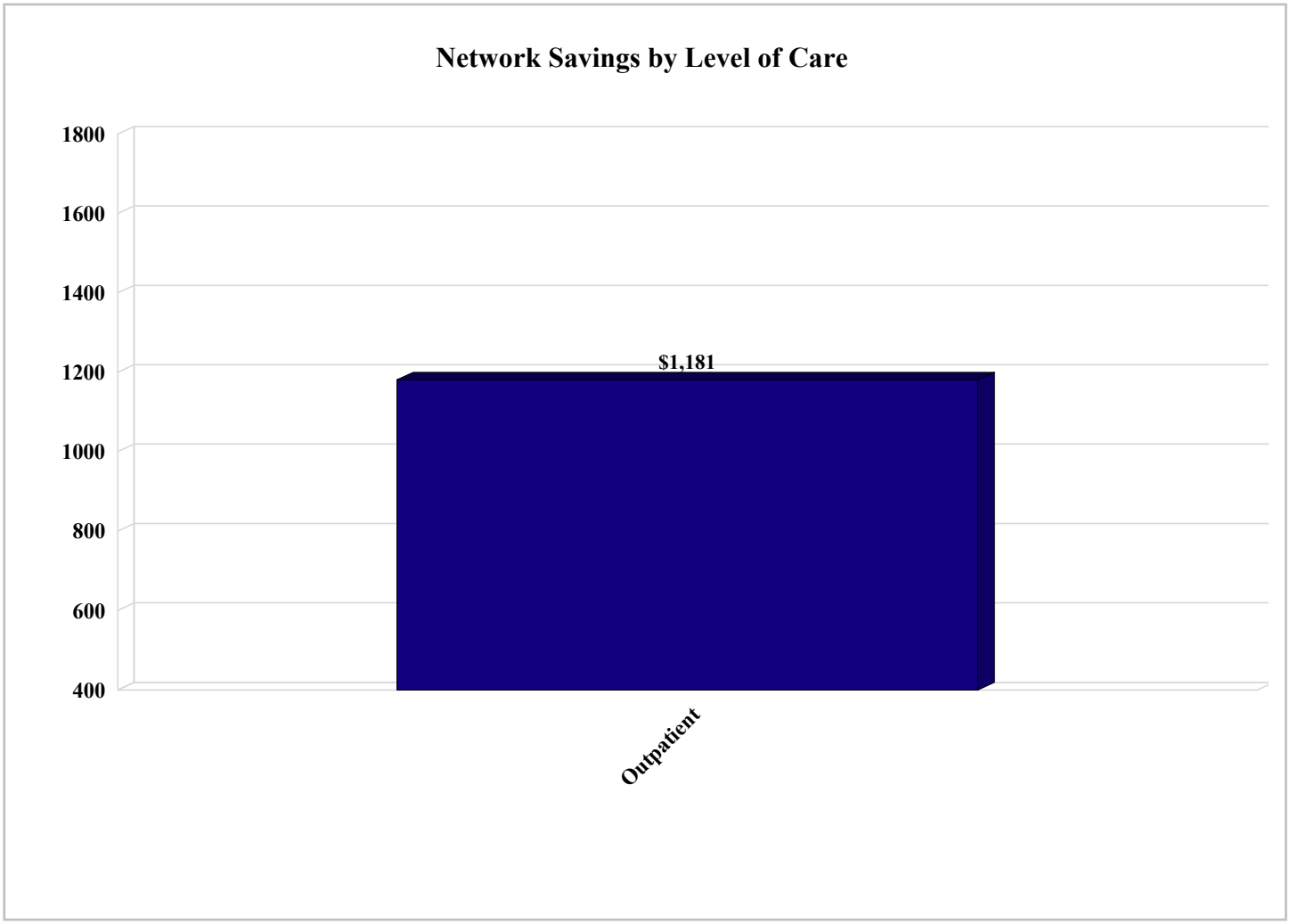
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS011 - NYSCOPBA- REDUCED OOPM			
Inpatient	$0	$0	$0
Residential	$0	$0	$0
Partial Hospitalization	$0	$0	$0
Intensive Outpatient	$0	$0	$0
Outpatient	$2,535	$1,354	$1,181
Total	**$2,535**	**$1,354**	**$1,181**



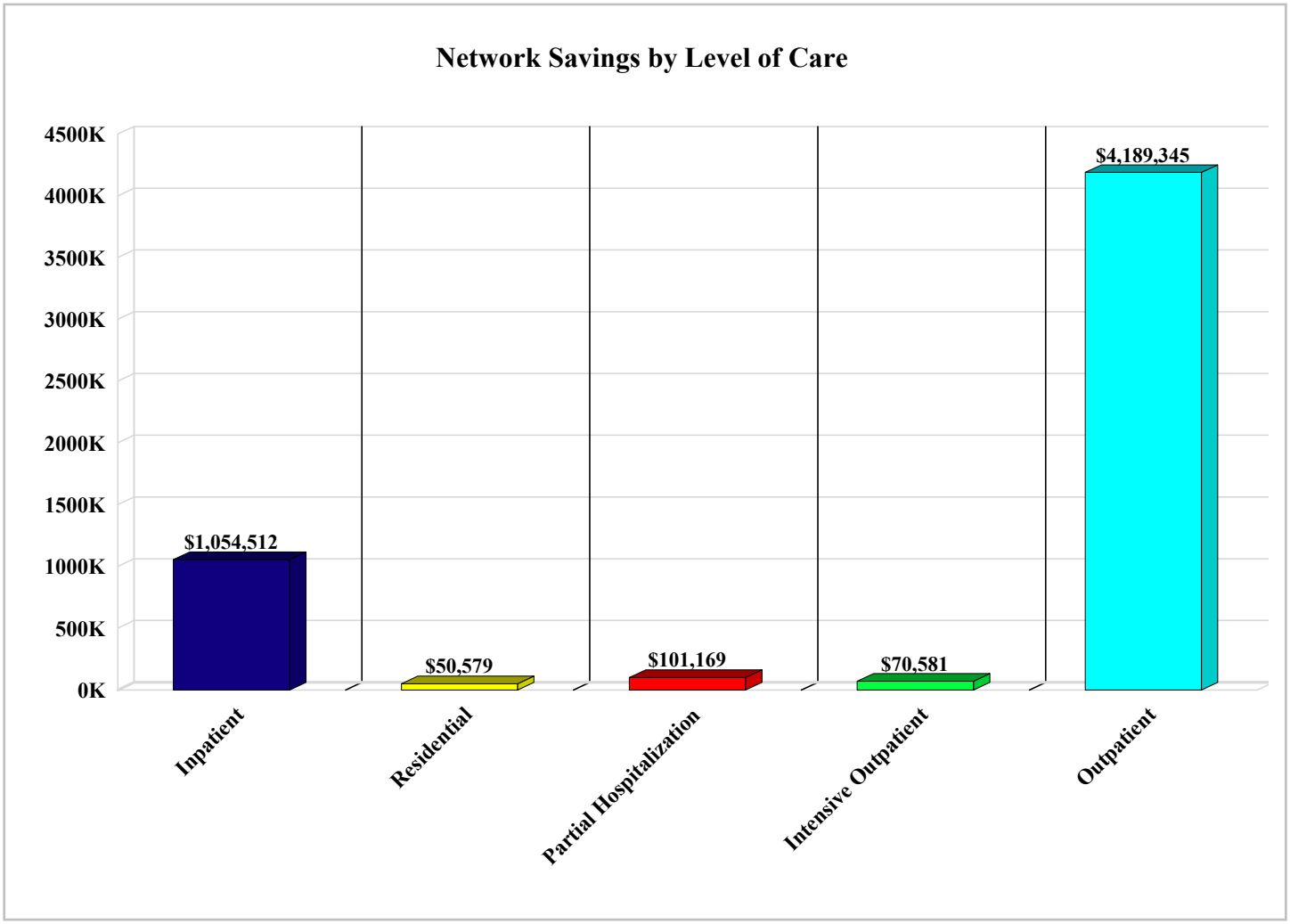
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS012 - PARTICIPATING AGENCIES			
Inpatient	$1,781,979	$727,467	$1,054,512
Residential	$113,570	$62,991	$50,579
Partial Hospitalization	$230,504	$129,335	$101,169
Intensive Outpatient	$145,619	$75,039	$70,581
Outpatient	$9,090,511	$4,901,166	$4,189,345
Total	**$11,362,183**	**$5,895,998**	**$5,466,186**



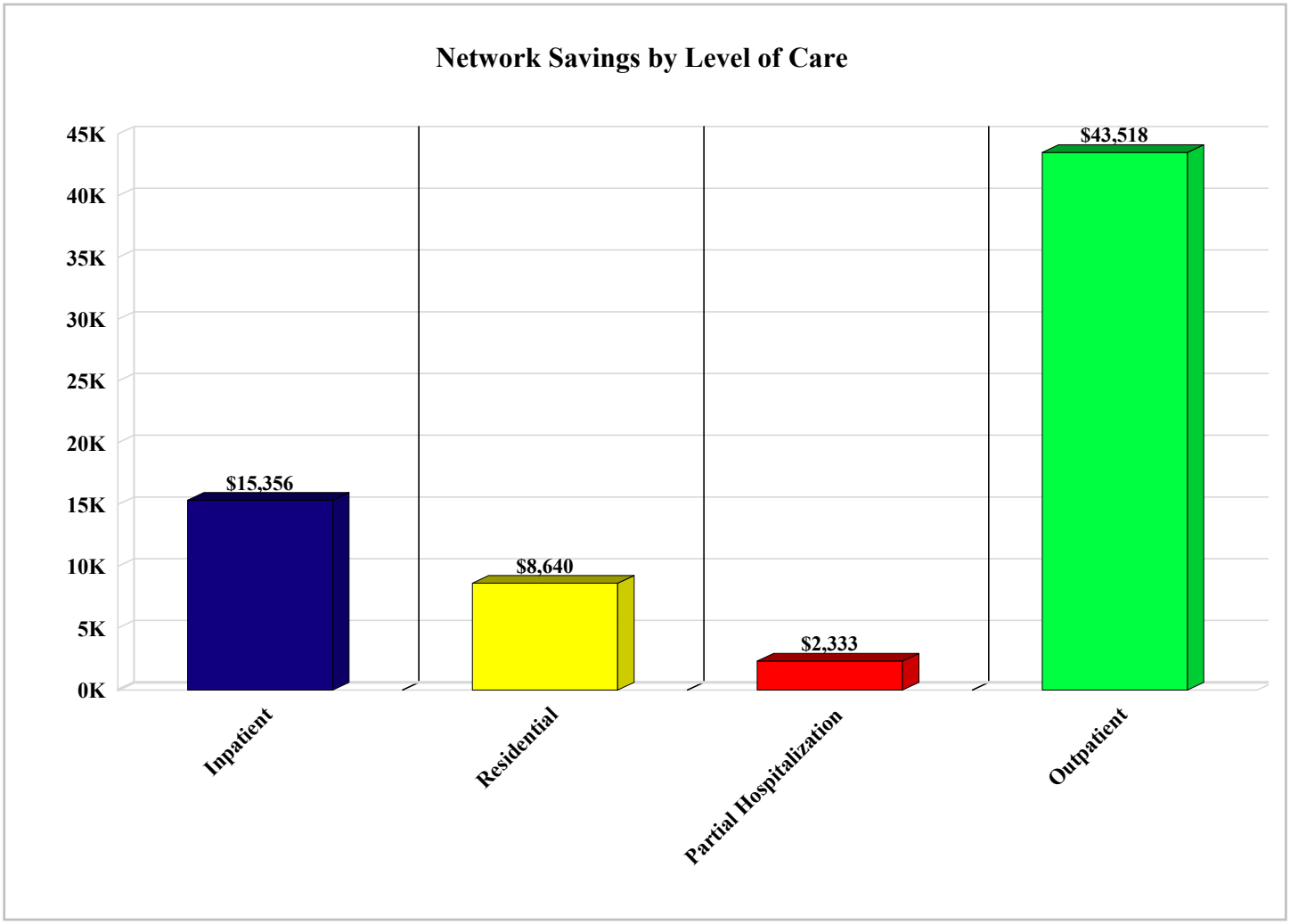
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS013 - PBA			
Inpatient	$33,206	$17,850	$15,356
Residential	$15,600	$6,960	$8,640
Partial Hospitalization	$4,078	$1,746	$2,333
Intensive Outpatient	$0	$0	$0
Outpatient	$105,524	$62,006	$43,518
Total	**$158,408**	**$88,562**	**$69,846**



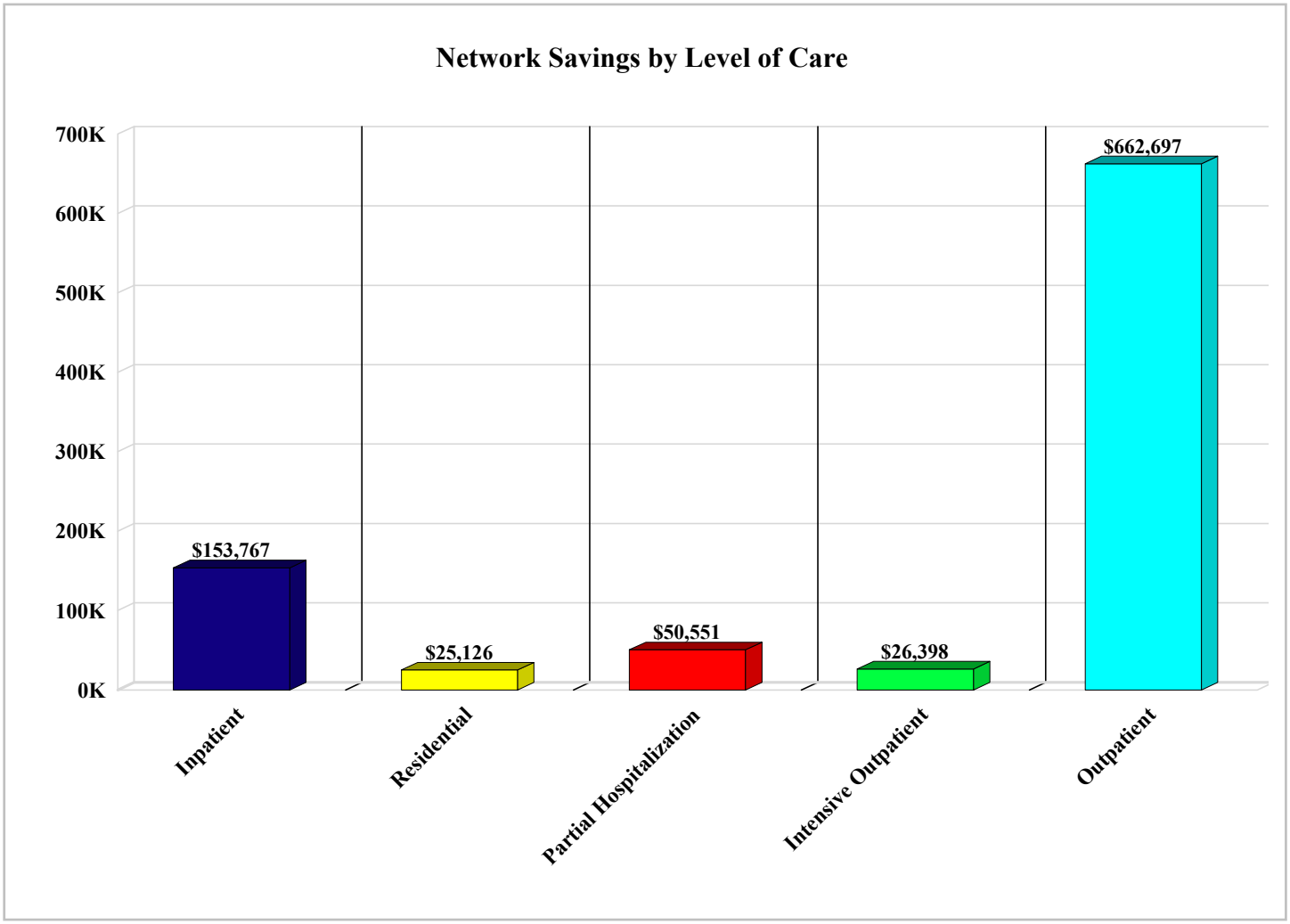
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS014 - PARTICIPATING EMPLOYERS			
Inpatient	$329,051	$175,284	$153,767
Residential	$44,295	$19,169	$25,126
Partial Hospitalization	$89,070	$38,519	$50,551
Intensive Outpatient	$49,560	$23,162	$26,398
Outpatient	$1,458,001	$795,303	$662,697
Total	**$1,969,977**	**$1,051,437**	**$918,540**



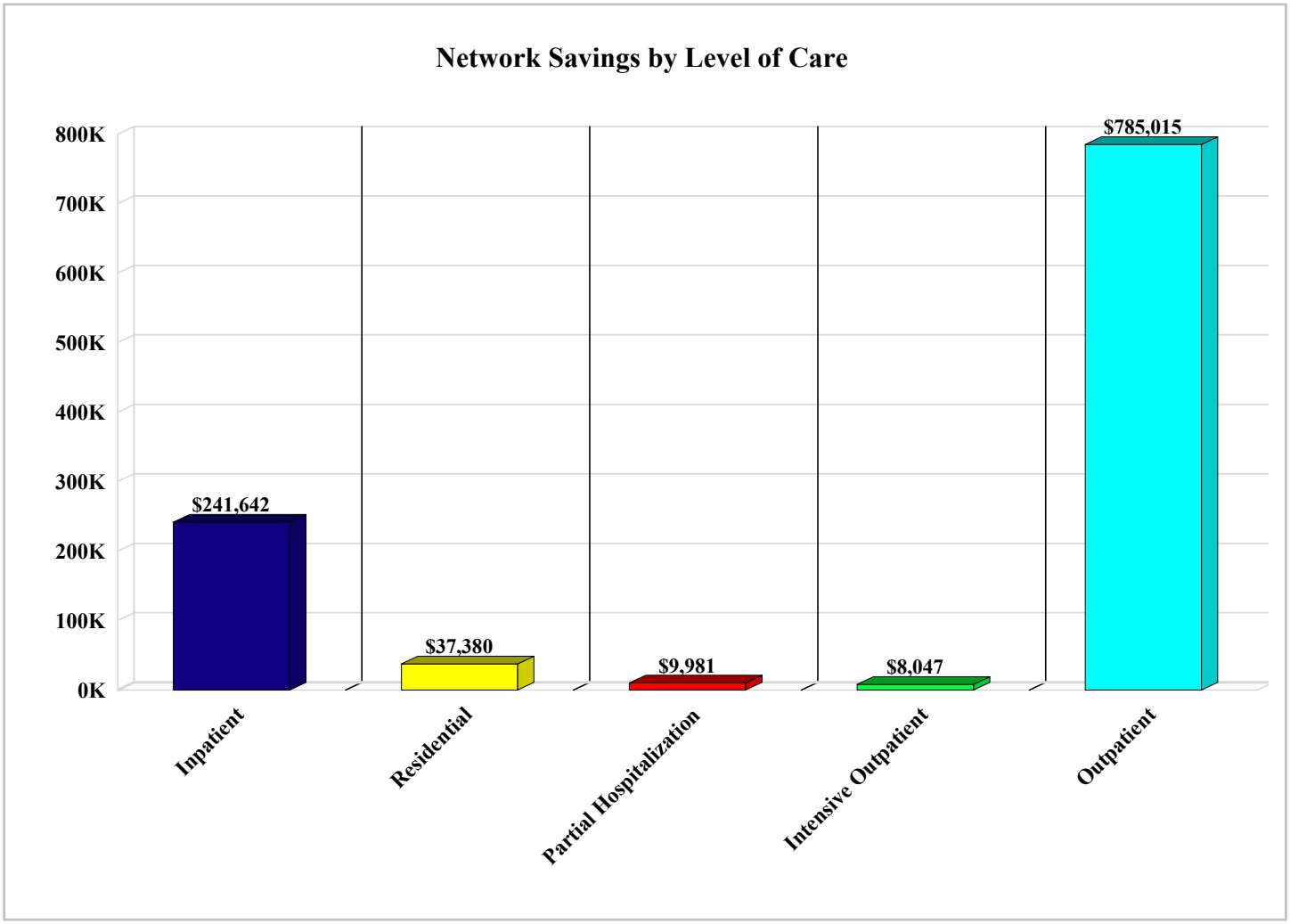
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS015 - PEF			
Inpatient	$422,483	$180,841	$241,642
Residential	$84,800	$47,420	$37,380
Partial Hospitalization	$25,641	$15,660	$9,981
Intensive Outpatient	$29,600	$21,553	$8,047
Outpatient	$1,760,189	$975,174	$785,015
Total	**$2,322,713**	**$1,240,648**	**$1,082,066**



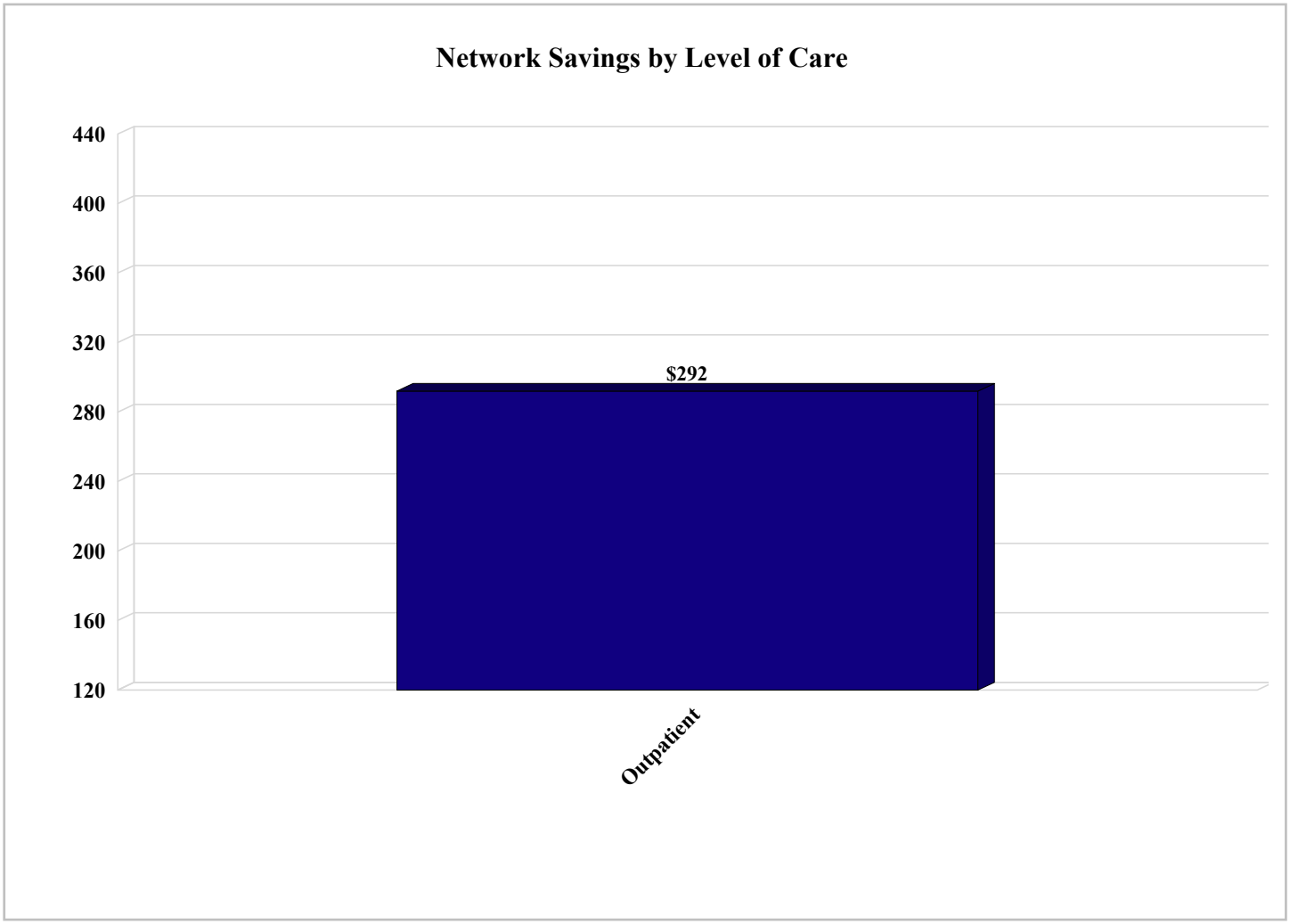
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS016 - PEF-REDUCED OOPM			
Inpatient	$0	$0	$0
Residential	$0	$0	$0
Partial Hospitalization	$0	$0	$0
Intensive Outpatient	$0	$0	$0
Outpatient	$615	$323	$292
Total	**$615**	**$323**	**$292**



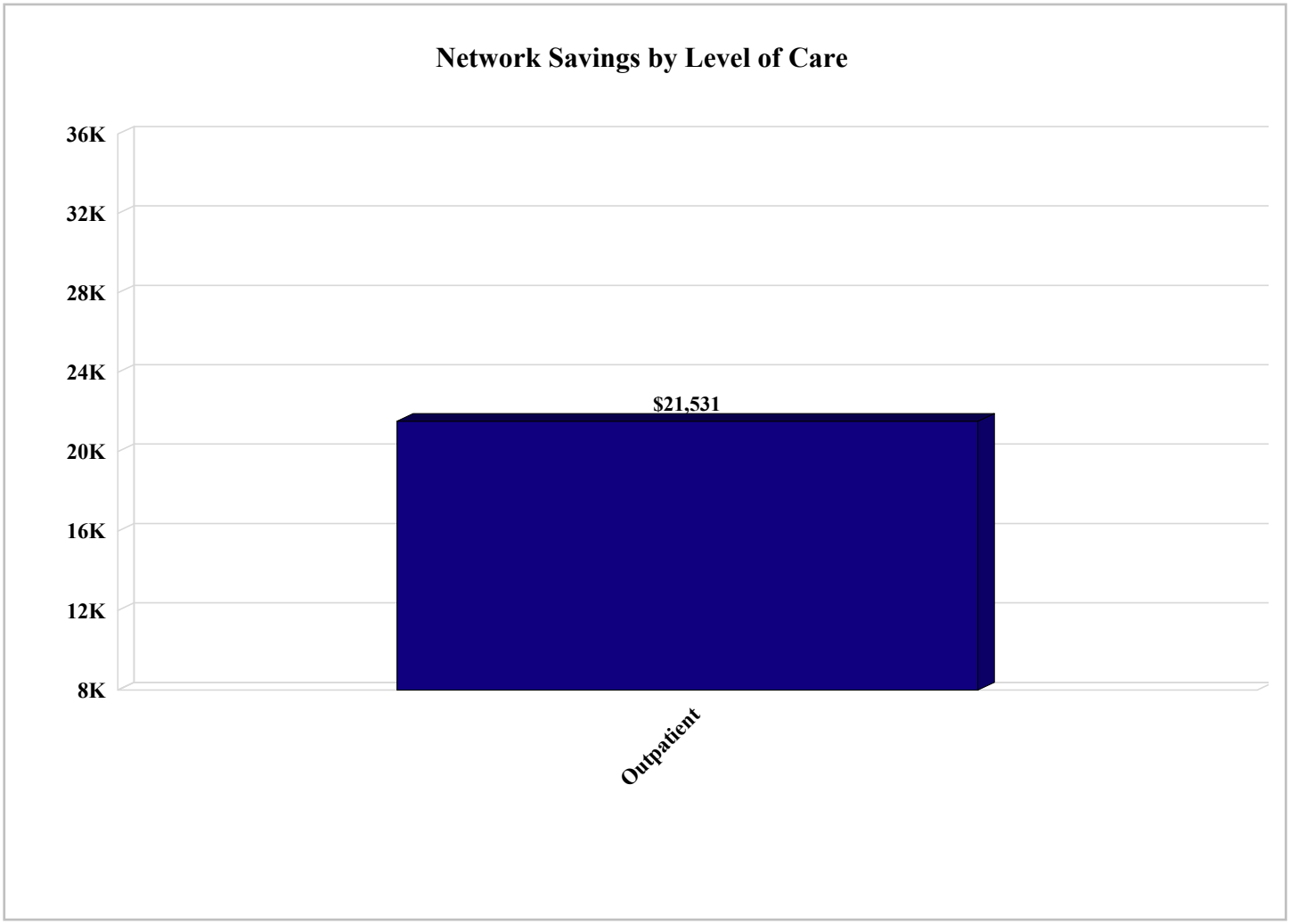
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS017 - PIA			
Inpatient	$0	$0	$0
Residential	$0	$0	$0
Partial Hospitalization	$0	$0	$0
Intensive Outpatient	$0	$0	$0
Outpatient	$46,884	$25,353	$21,531
Total	**$46,884**	**$25,353**	**$21,531**



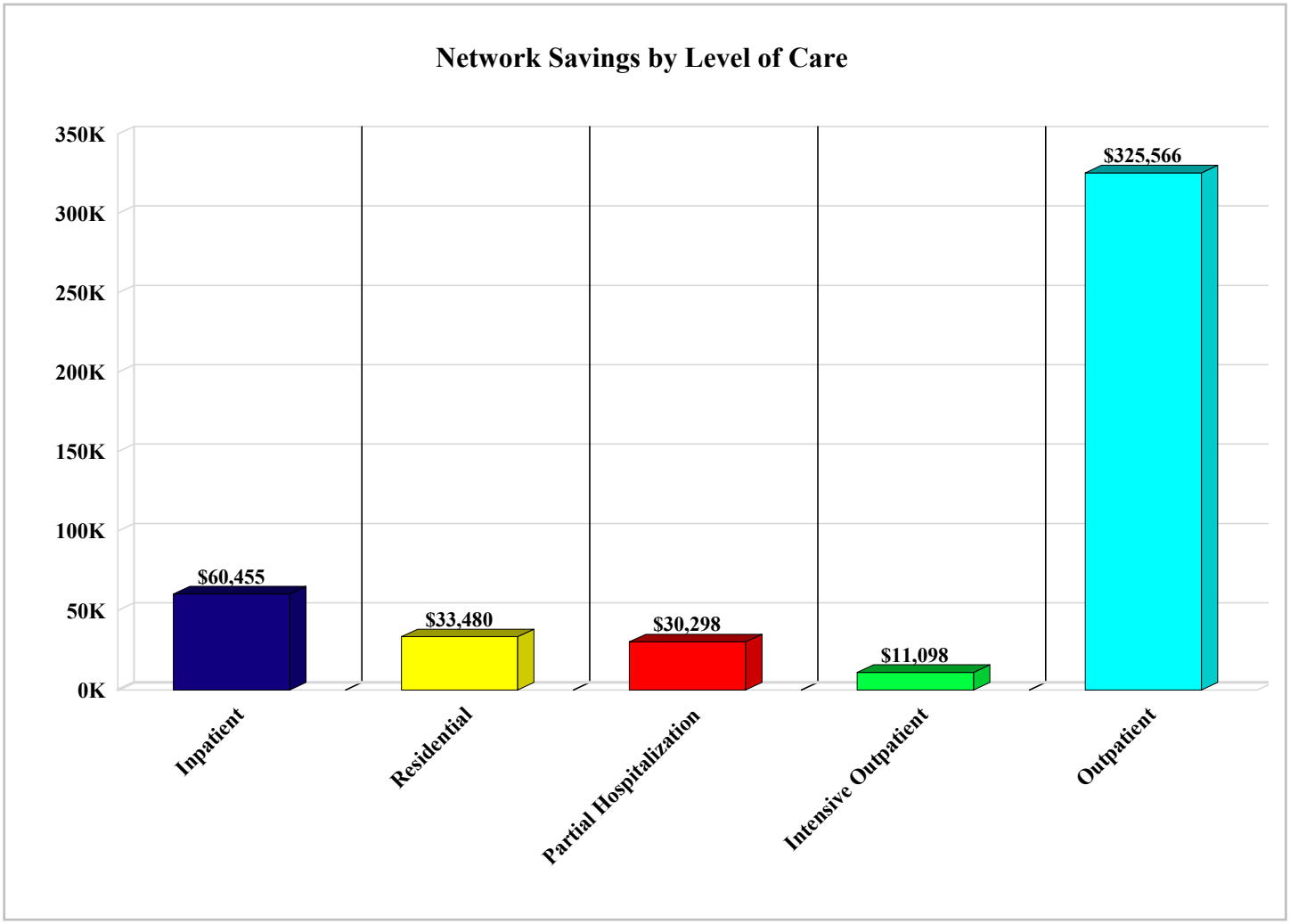
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS018 - UCS			
Inpatient	$123,710	$63,254	$60,455
Residential	$72,350	$38,870	$33,480
Partial Hospitalization	$69,169	$38,871	$30,298
Intensive Outpatient	$20,540	$9,442	$11,098
Outpatient	$770,991	$445,425	$325,566
Total	**$1,056,760**	**$595,862**	**$460,897**



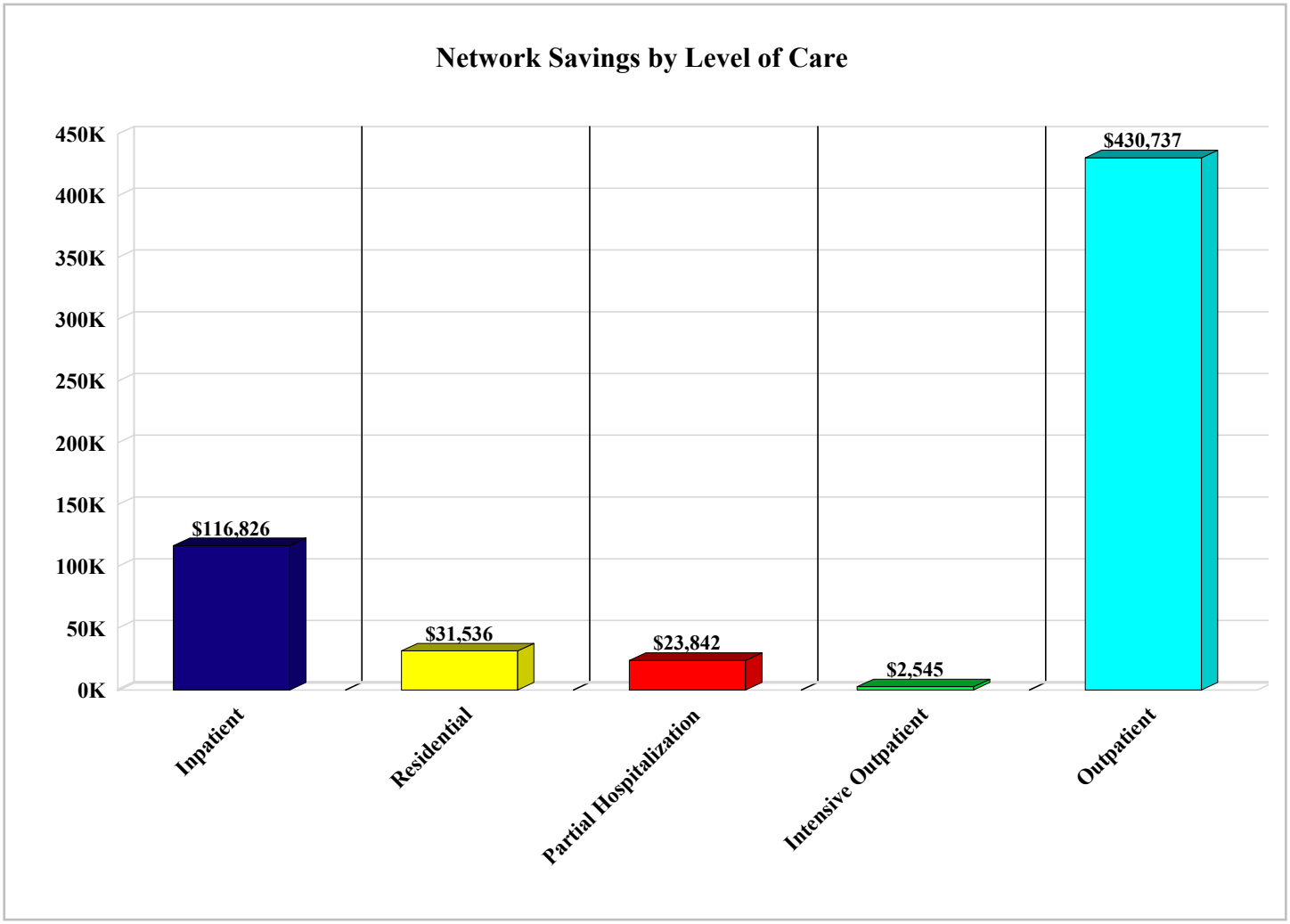
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS020 - UUP			
Inpatient	$208,478	$91,651	$116,826
Residential	$74,475	$42,939	$31,536
Partial Hospitalization	$46,677	$22,835	$23,842
Intensive Outpatient	$6,552	$4,007	$2,545
Outpatient	$1,067,928	$637,191	$430,737
Total	**$1,404,110**	**$798,624**	**$605,486**



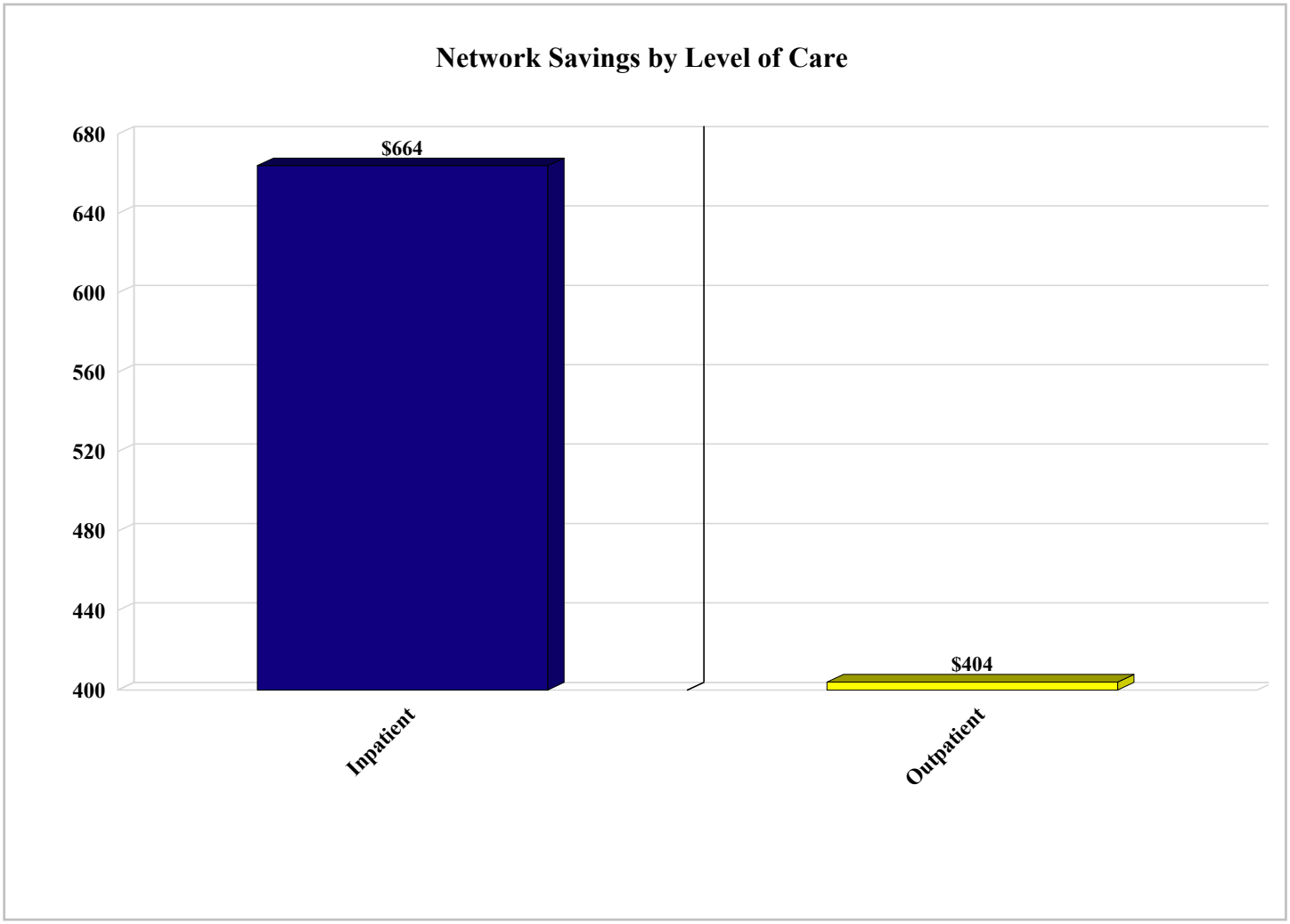
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS021 - UUP-REDUCED OOPM			
Inpatient	$1,100	$436	$664
Residential	$0	$0	$0
Partial Hospitalization	$0	$0	$0
Intensive Outpatient	$0	$0	$0
Outpatient	$956	$552	$404
Total	**$2,056**	**$988**	**$1,068**



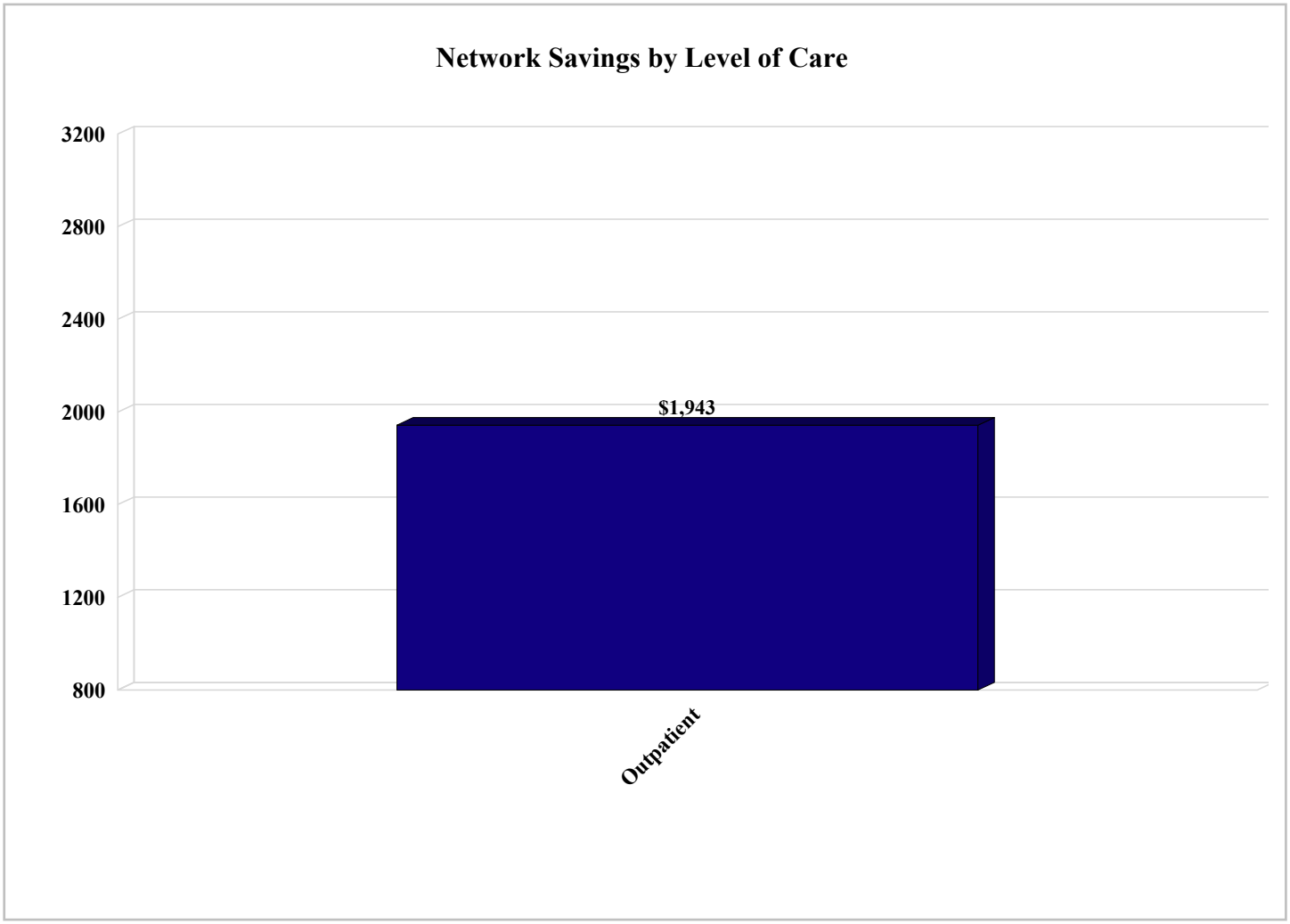
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS022 - THE EXCELSIOR PLAN			
Inpatient	$0	$0	$0
Residential	$0	$0	$0
Partial Hospitalization	$0	$0	$0
Intensive Outpatient	$0	$0	$0
Outpatient	$3,510	$1,567	$1,943
Total	**$3,510**	**$1,567**	**$1,943**



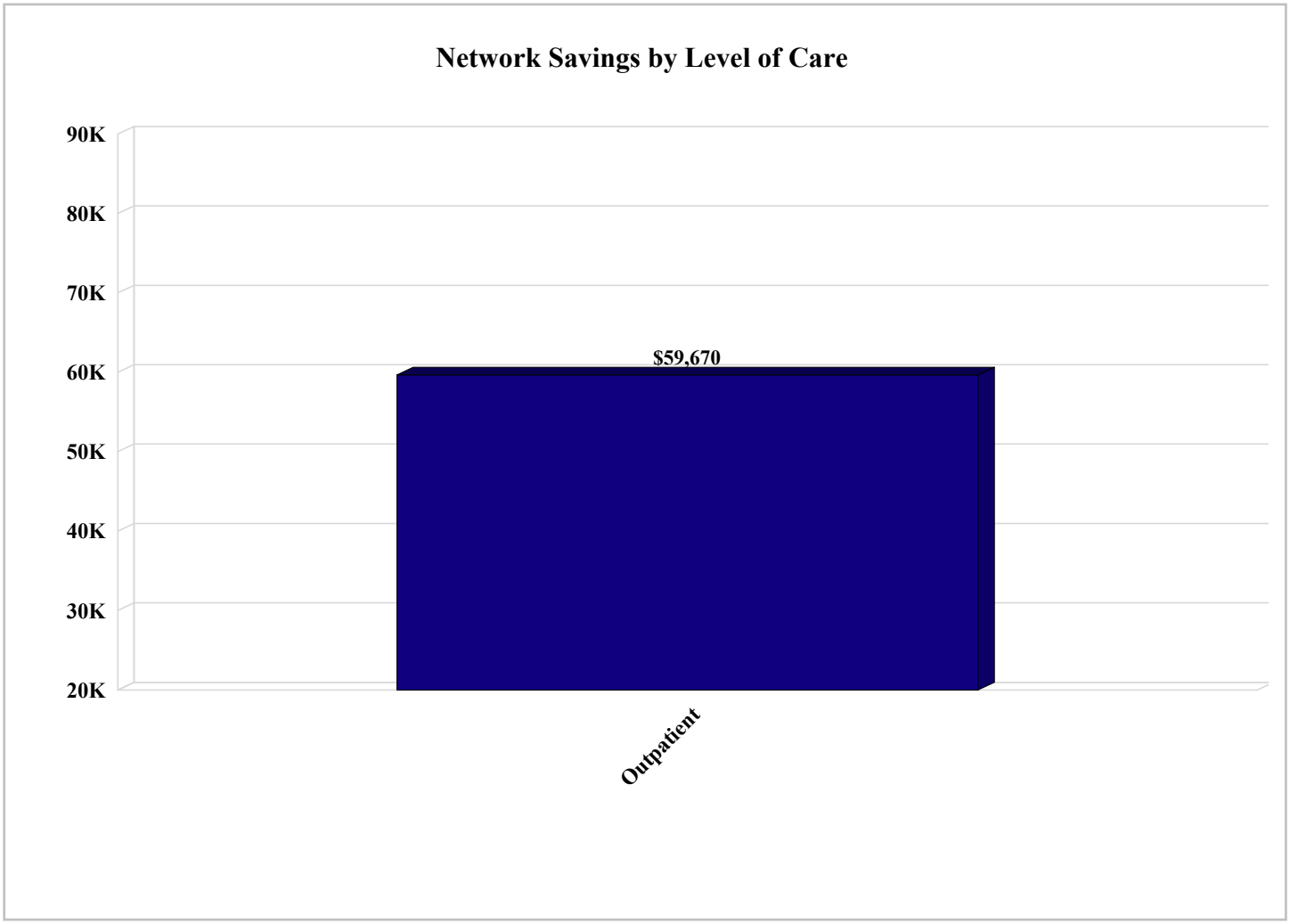
*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Network Savings by Group

Level of Care	Billed Amount	Allowed Amount	*Network Savings
NYS023 - SEHP			
Inpatient	$0	$0	$0
Residential	$0	$0	$0
Partial Hospitalization	$0	$0	$0
Intensive Outpatient	$0	$0	$0
Outpatient	$161,829	$102,159	$59,670
Total	**$161,829**	**$102,159**	**$59,670**



*In-Network Claims Only
**Network Savings calculated prior to application of benefits.

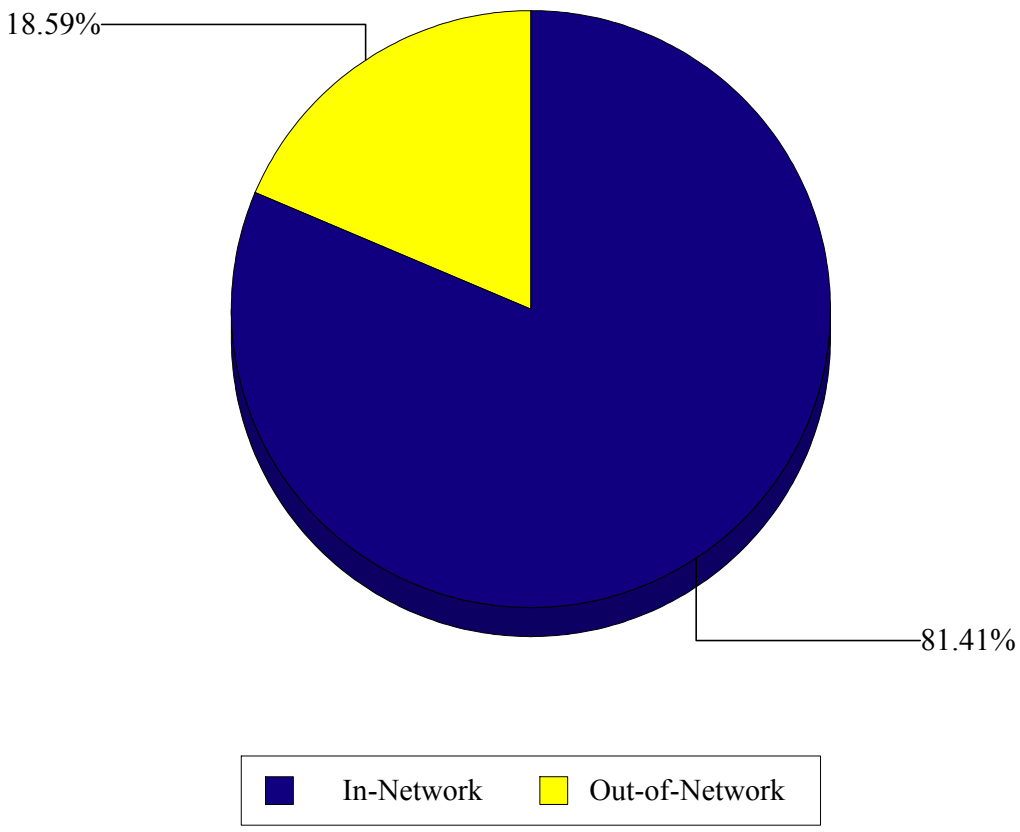
New York State Empire Plan - CENTRAL NY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Provider Status

Network Status	Total Paid	% of Total Paid
In-Network*	$929,096.49	81.41%
Out-of-Network	$212,198.95	18.59%
Unknown Network Status	$0.00	0.00%
Total	**$1,141,295.44**	**100.00%**



**In-Network claims include SCA.*

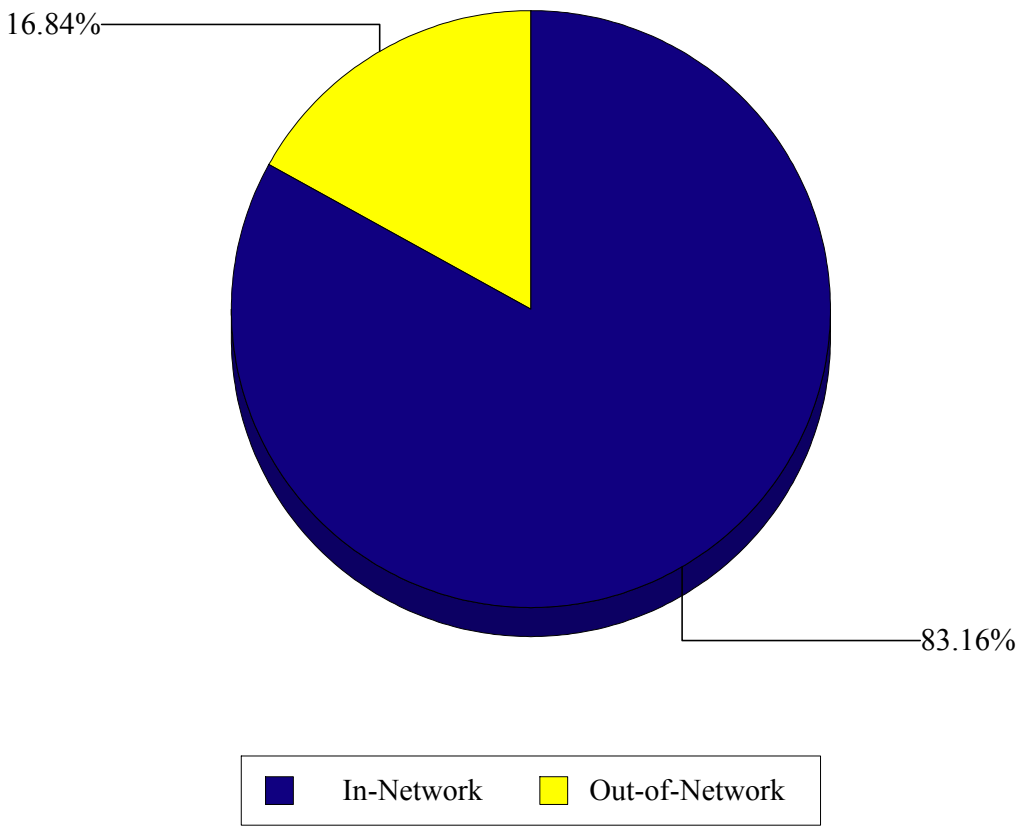
New York State Empire Plan - HUDSON VALLEY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Provider Status

Network Status	Total Paid	% of Total Paid
In-Network*	$3,193,062.18	83.16%
Out-of-Network	$646,620.33	16.84%
Unknown Network Status	$0.00	0.00%
Total	**$3,839,682.51**	**100.00%**



**In-Network claims include SCA.*

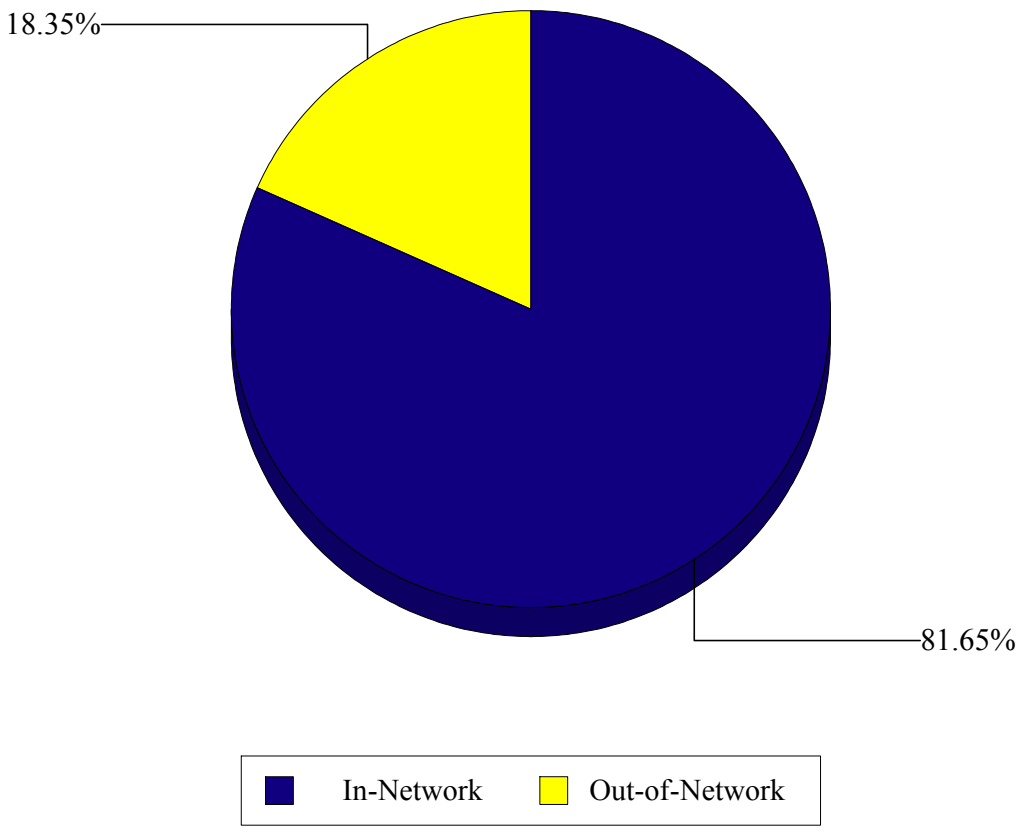
New York State Empire Plan - LONG ISLAND

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Provider Status

Network Status	Total Paid	% of Total Paid
In-Network*	$4,882,985.54	81.65%
Out-of-Network	$1,097,401.54	18.35%
Unknown Network Status	$0.00	0.00%
Total	**$5,980,387.08**	**100.00%**



**In-Network claims include SCA.*

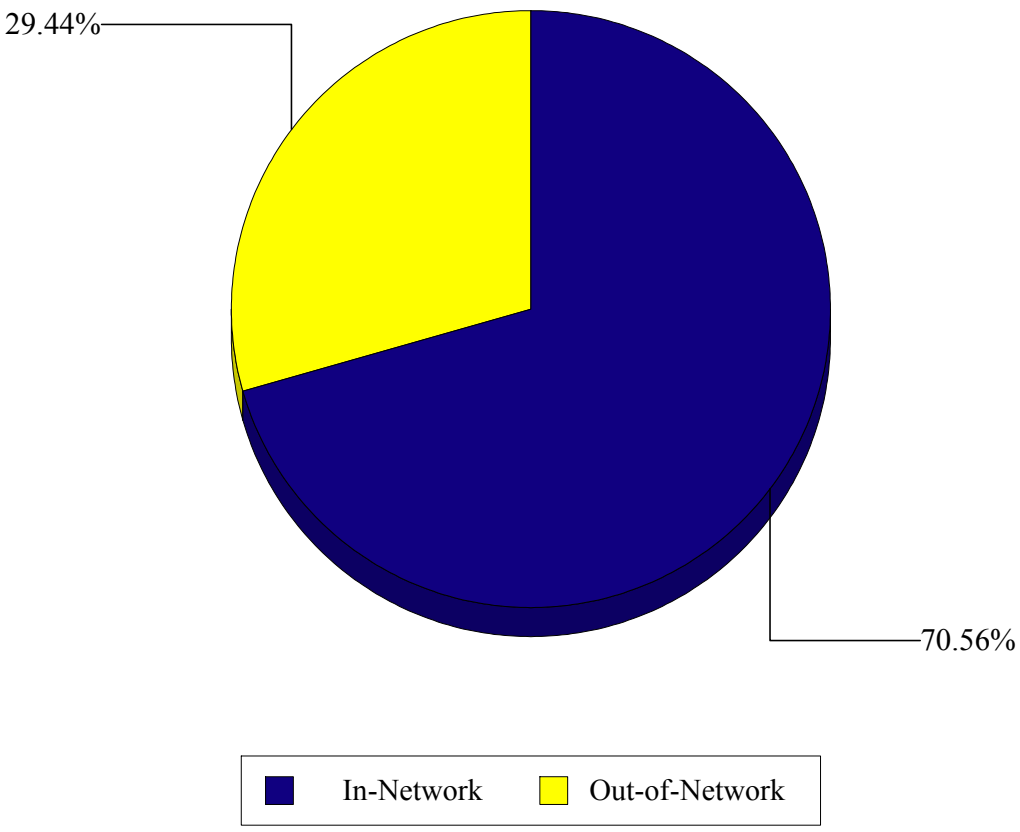
New York State Empire Plan - NY CITY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Provider Status

Network Status	Total Paid	% of Total Paid
In-Network*	$711,660.94	70.56%
Out-of-Network	$296,984.22	29.44%
Unknown Network Status	$0.00	0.00%
Total	**$1,008,645.16**	**100.00%**



**In-Network claims include SCA.*

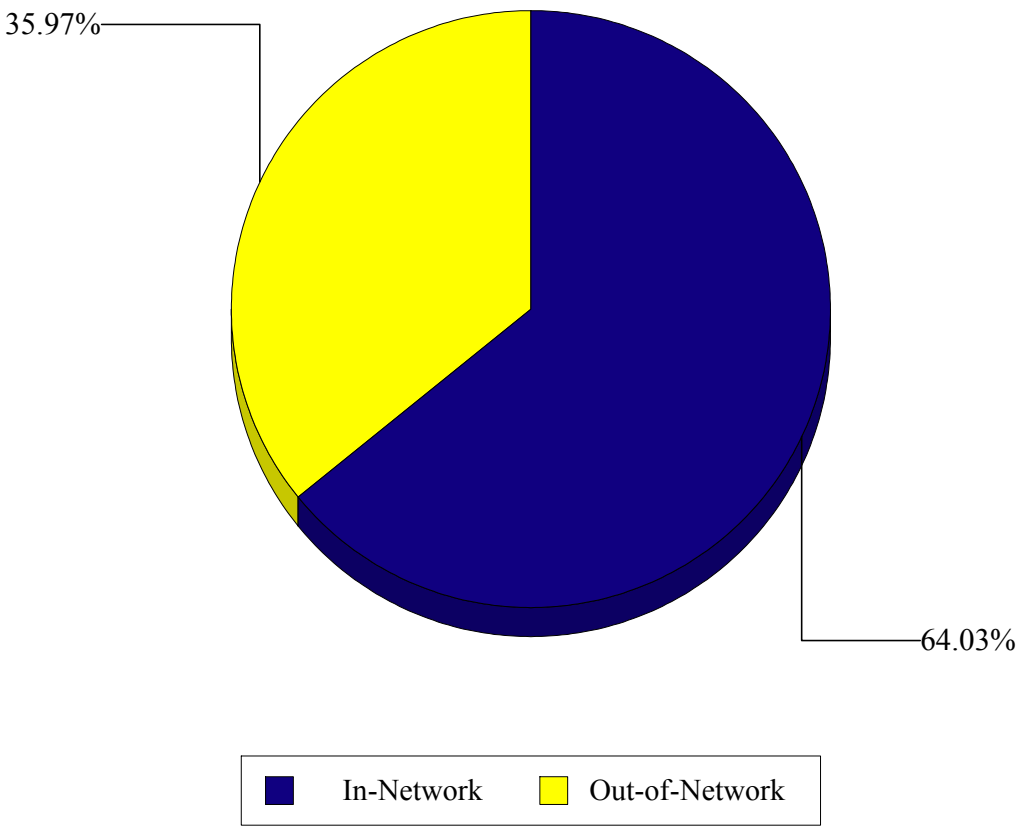
New York State Empire Plan - OUT OF STATE

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Provider Status

Network Status	Total Paid	% of Total Paid
In-Network*	$425,989.40	64.03%
Out-of-Network	$239,292.91	35.97%
Unknown Network Status	$0.00	0.00%
Total	**$665,282.31**	**100.00%**



**In-Network claims include SCA.*

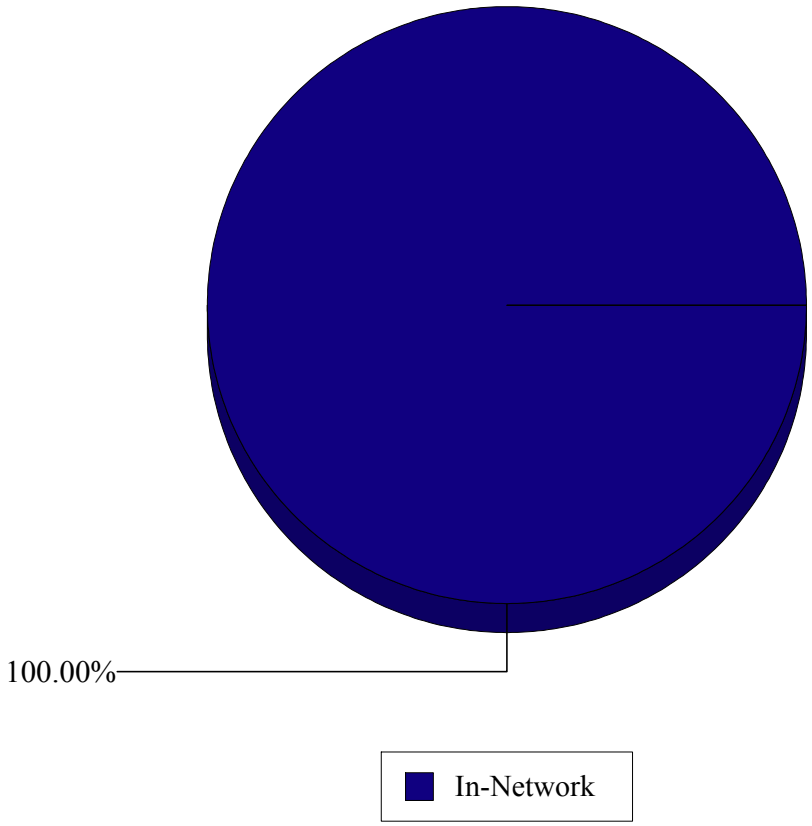
New York State Empire Plan - UNKNOWN

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Provider Status

Network Status	Total Paid	% of Total Paid
In-Network*	$1,250.00	100.00%
Out-of-Network	$0.00	0.00%
Unknown Network Status	$0.00	0.00%
Total	**$1,250.00**	**100.00%**



**In-Network claims include SCA.*

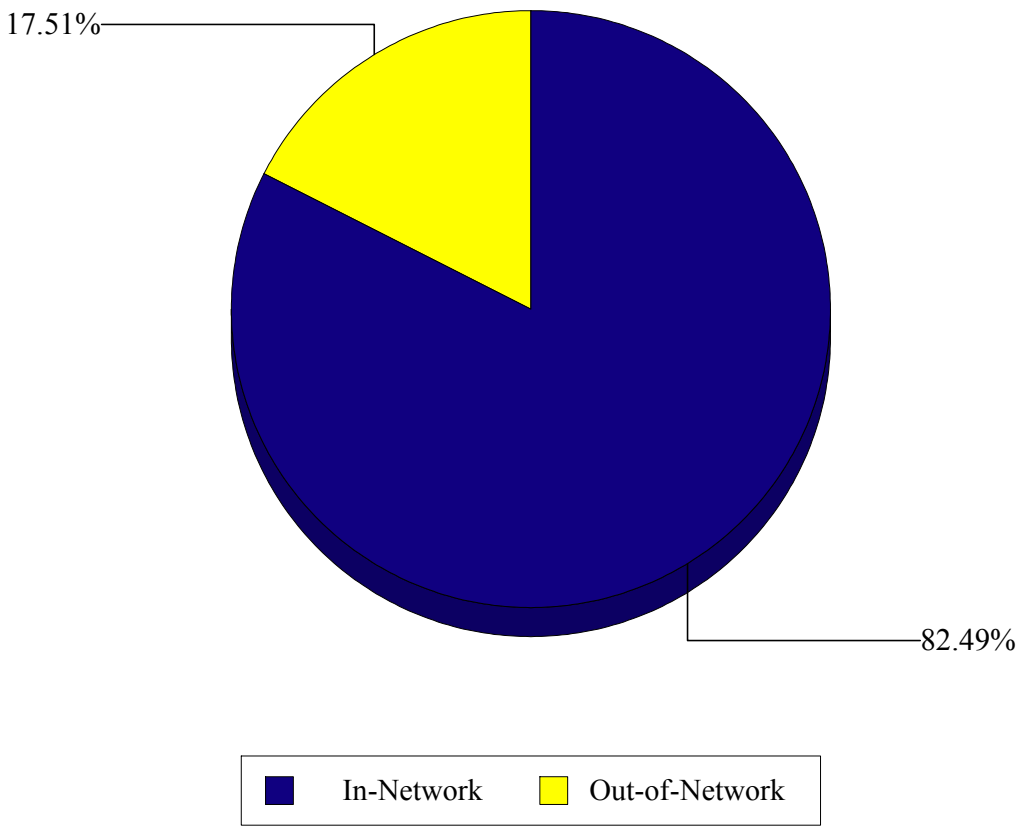
New York State Empire Plan - WESTERN NY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

Group Total Paid Distribution by Provider Status

Network Status	Total Paid	% of Total Paid
In-Network*	$314,498.80	82.49%
Out-of-Network	$66,737.12	17.51%
Unknown Network Status	$0.00	0.00%
Total	**$381,235.92**	**100.00%**



**In-Network claims include SCA.*

New York State Empire Plan - CENTRAL NY

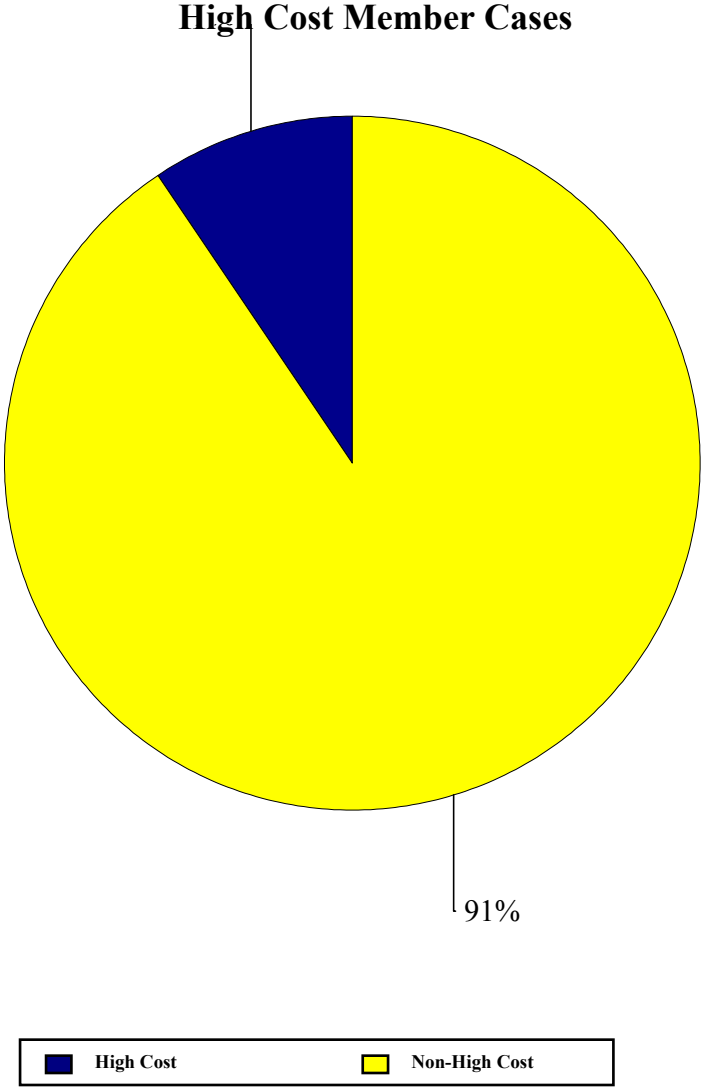
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

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	2	$120,564	$115,406	$107,486	9.42%
Non-High Cost Cases	4,256	$2,331,005	$1,414,016	$1,033,810	90.58%
Total	**4,258**	**$2,451,570**	**$1,529,422**	**$1,141,295**	**100.00%**

High Cost Member Cases



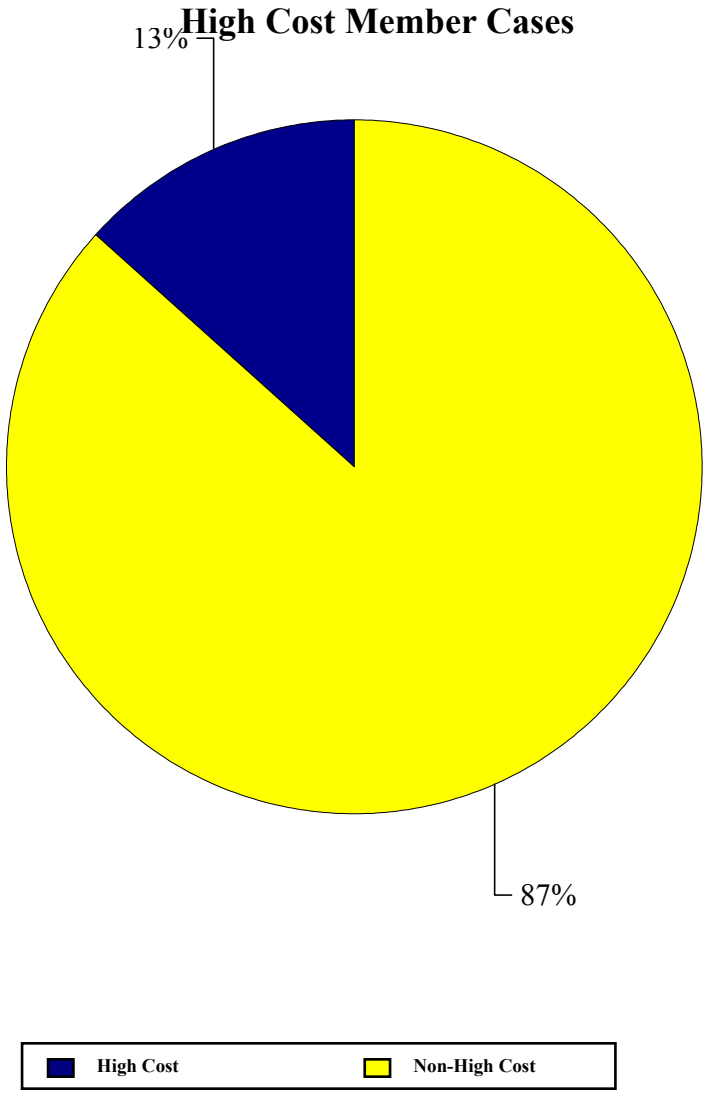
New York State Empire Plan - HUDSON VALLEY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

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	15	$652,701	$544,705	$508,447	13.24%
Non-High Cost Cases	11,314	$10,183,070	$5,981,639	$3,331,236	86.76%
Total	**11,329**	**$10,835,772**	**$6,526,345**	**$3,839,683**	**100.00%**



New York State Empire Plan - LONG ISLAND

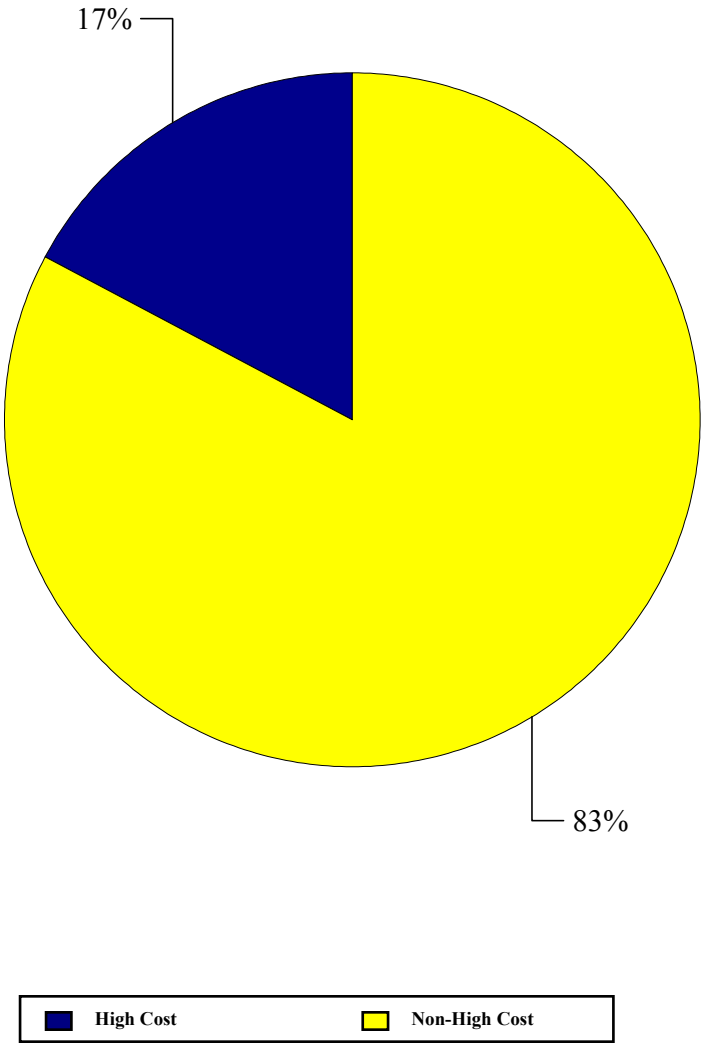
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

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	31	$1,516,660	$1,113,534	$1,033,816	17.29%
Non-High Cost Cases	15,377	$22,850,472	$13,085,930	$4,946,571	82.71%
Total	**15,408**	**$24,367,132**	**$14,199,464**	**$5,980,387**	**100.00%**

High Cost Member Cases



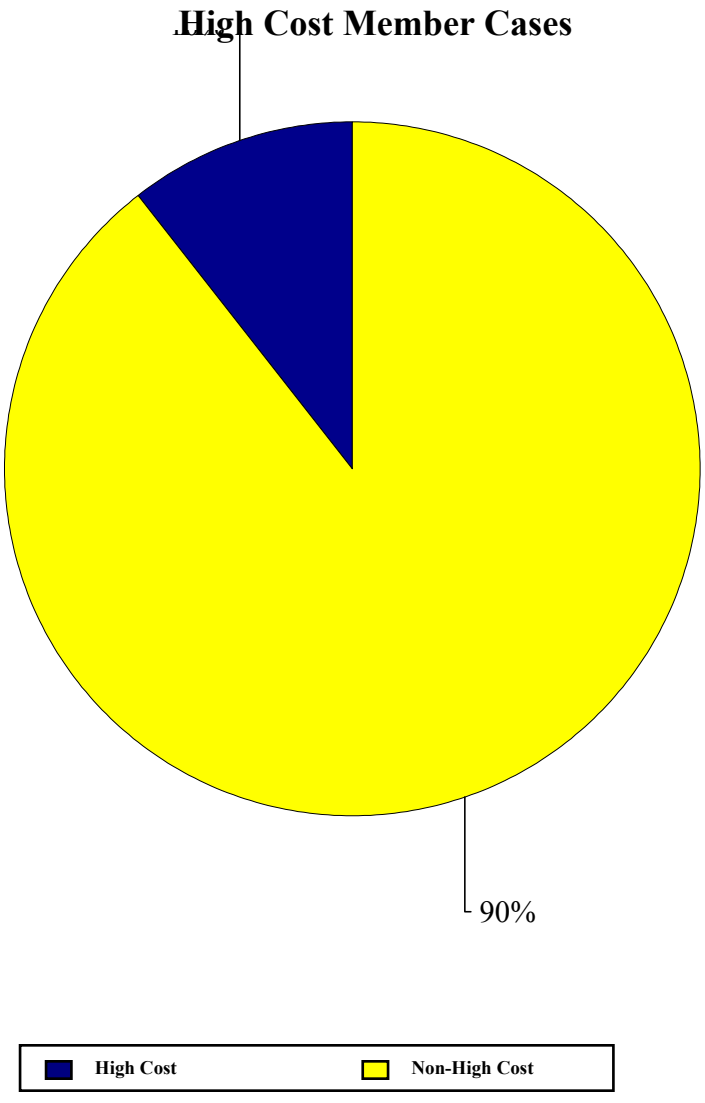
New York State Empire Plan - NY CITY

Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

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	3	$117,496	$116,841	$105,719	10.48%
Non-High Cost Cases	2,584	$24,999,274	$14,473,327	$902,926	89.52%
Total	**2,587**	**$25,116,770**	**$14,590,169**	**$1,008,645**	**100.00%**



New York State Empire Plan - OUT OF STATE

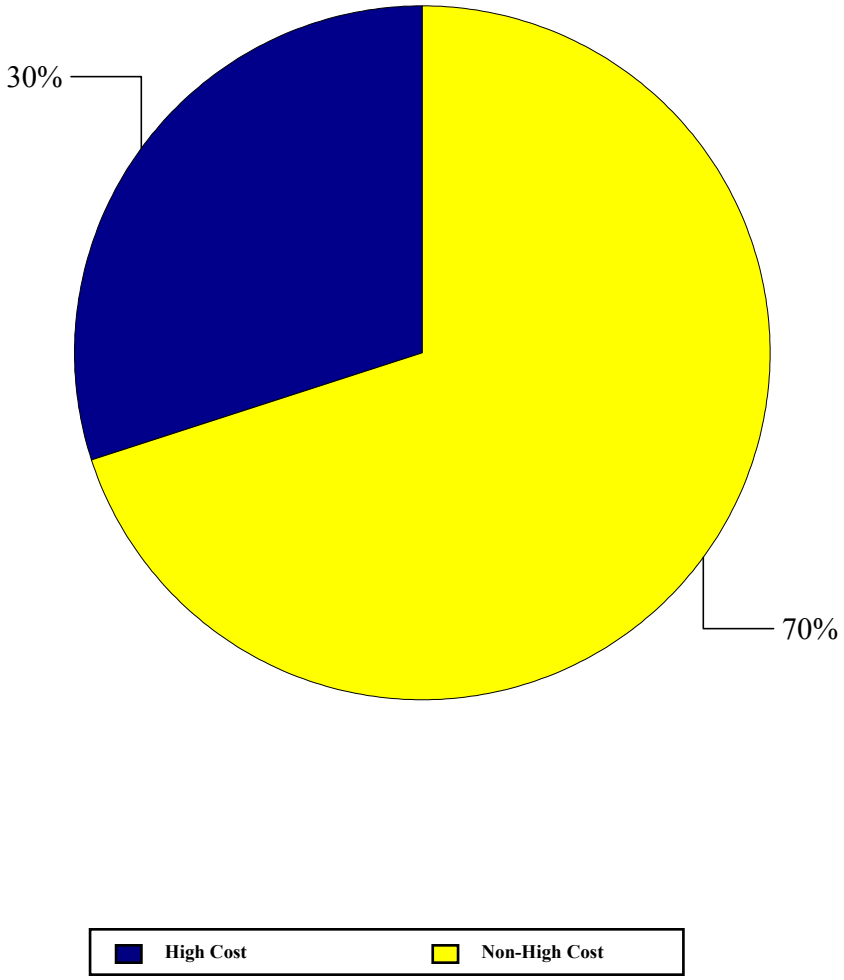
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

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	7	$245,299	$225,838	$199,154	29.94%
Non-High Cost Cases	1,270	$26,201,311	$15,122,233	$466,129	70.06%
Total	**1,277**	**$26,446,610**	**$15,348,071**	**$665,282**	**100.00%**

High Cost Member Cases



New York State Empire Plan - UNKNOWN

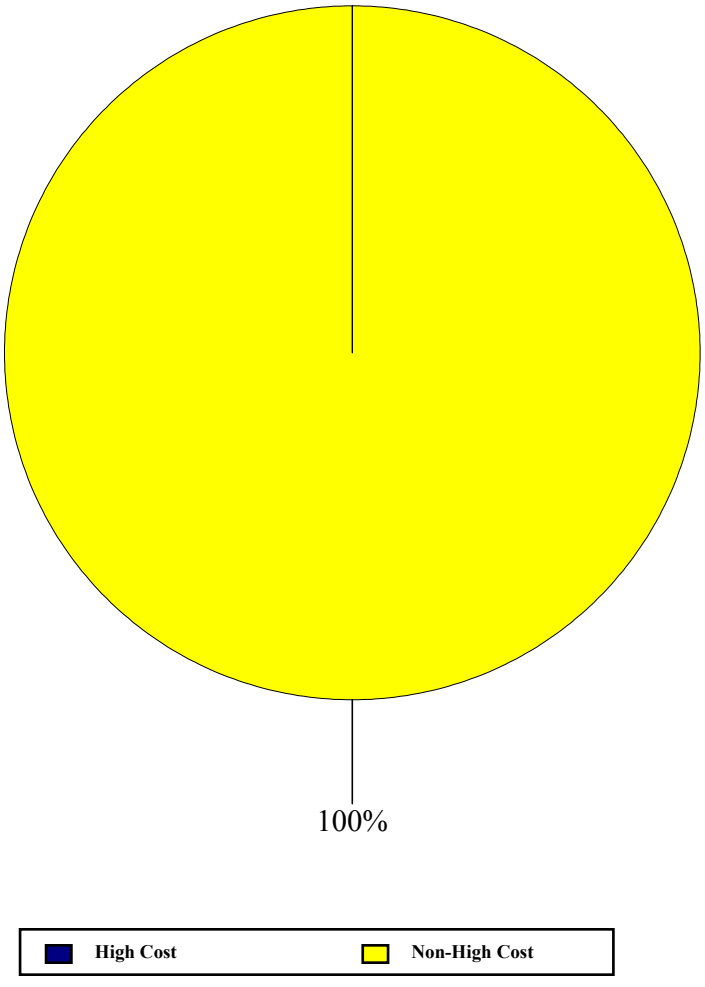
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

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	0	$0	$0	$0	0.00%
Non-High Cost Cases	7	$26,204,946	$15,123,943	$1,250	100.00%
Total	**7**	**$26,204,946**	**$15,123,943**	**$1,250**	**100.00%**

High Cost Member Cases



New York State Empire Plan - WESTERN NY

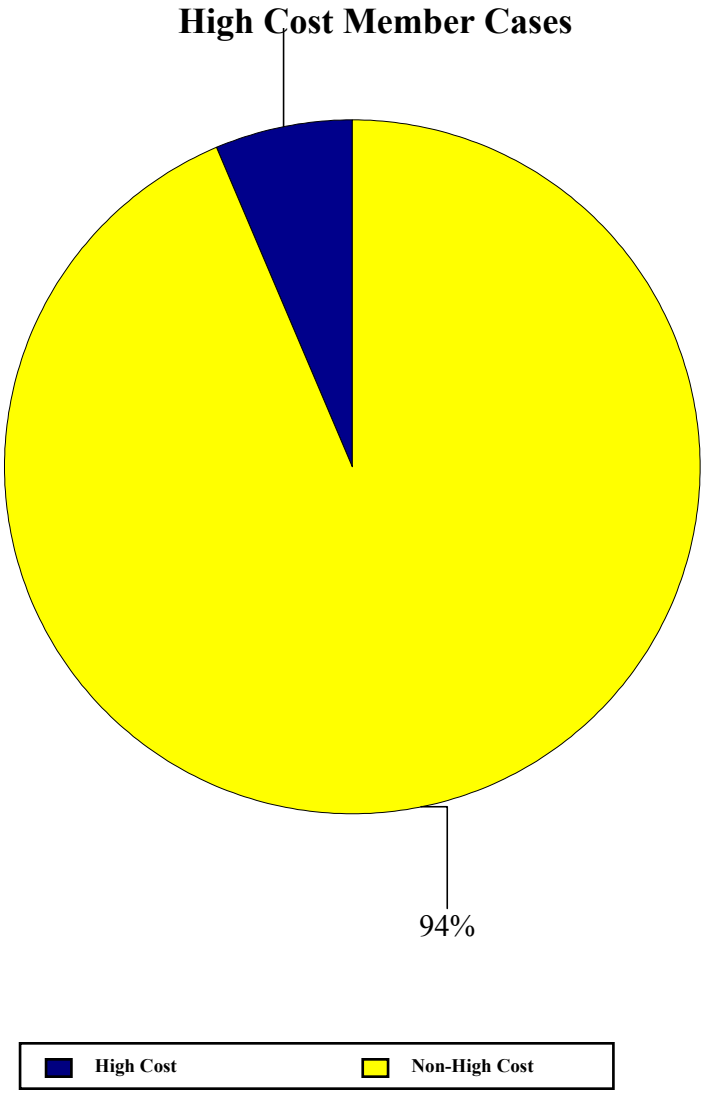
Managed Mental Health and Substance Abuse Activity Report

January 1, 2014 - March 31, 2014

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	1	$27,320	$27,320	$24,154	6.34%
Non-High Cost Cases	1,698	$27,038,689	$15,639,282	$357,082	93.66%
Total	**1,699**	**$27,066,009**	**$15,666,602**	**$381,236**	**100.00%**

High Cost Member Cases



New York State Empire Plan
Web Activity Report
January 1, 2014 - March 31, 2014

Quarterly Website Analytics Report

SUMMARY

	Views	Views - YTD
Total Page Views	44,258	44,258
Total Unique Sessions	9,927	9,927

	Reporting Period		YTD	
MOST FREQUENTLY VISITED TOPICS	**Views**	**% of Page Views**	**Views**	**% of Page Views**
General Health	1,182	13.39 %	1,182	13.39%
Depression	712	8.07 %	712	8.07%
Generalized Anxiety Disorder	389	4.41 %	389	4.41%
Attention-deficit/hyperactivity Disorder (ADHD)	357	4.04 %	357	4.04%
Marriage	309	3.50 %	309	3.50%
Substance Abuse Treatment and Recovery	266	3.01 %	266	3.01%
Chronic Depression	254	2.88 %	254	2.88%
Bipolar Disorder	234	2.65 %	234	2.65%
Panic Disorder	226	2.56 %	226	2.56%
Stress	217	2.46 %	217	2.46%
Alcohol	213	2.41 %	213	2.41%
Depression in Children and Teens	181	2.05 %	181	2.05%
Eating Disorders	173	1.96 %	173	1.96%
Divorce	158	1.79 %	158	1.79%
Acute Stress Disorder	140	1.59 %	140	1.59%
All Others	3,817	43.24 %	3,817	43.24%
Total	**8,828**	**100.00%**	**8,828**	**100.00%**

New York State Empire Plan
Web Activity Report
January 1, 2014 - March 31, 2014

Quarterly Website Analytics Report

MOST FREQUENTLY VIEWED CENTERS	Reporting Period Views	Reporting Period % of Page Views	YTD Views	YTD % of Page Views
Health & Wellness	2,151	24.76%	2,151	24.76%
Depression	1,587	18.27%	1,587	18.27%
Anxiety	1,552	17.87%	1,552	17.87%
Relationships	1,113	12.81%	1,113	12.81%
Alcohol & Other Drugs	912	10.50%	912	10.50%
Family Care & Education	767	8.83%	767	8.83%
Emotional Wellness	351	4.04%	351	4.04%
Work	254	2.92%	254	2.92%
Total	**8,687**	**100.00%**	**8,687**	**100.00%**

CONTENT TYPE	Reporting Period Views	Reporting Period % of Page Views	YTD Views	YTD % of Page Views
Articles	3,230	79.65%	3,230	79.65%
Audio / Video	11	0.27%	11	0.27%
News	93	2.29%	93	2.29%
Quizzes	99	2.44%	99	2.44%
Resources	587	14.48%	587	14.48%
Others	35	0.86%	35	0.86%
Total	**4,055**	**100.00%**	**4,055**	**100.00%**

ValueOptions Inc.

STATE LICENSURE GRID

Acceptable Highest Level of Licensure by State

STATE: ALABAMA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Master's Level Addiction Professional	**MLAP**
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapists	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Certified Social Worker	**LCSW**

STATE: ALASKA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Counselor	**LPC**
LMFT	Licensed Marriage and Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: ARIZONA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapists	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**
Substance Abuse Counselor	LICENSED INDEPENDENT SUBSTANCE ABUSE COUNSELOR	**LISAC**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: ARKANSAS

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol Drug Abuse Counselor	**LADAC**
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapists	Licensed Marriage & Family Therapist	**LMFT**
Pastoral Counselor	Licensed Counselor/Therapist	
Social Worker	Licensed Certified Social Worker-Private Independent Practice	**LCSW-PIP**
Social Worker	Licensed Certified Social Worker	**LCSW**

STATE: CALIFORNIA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LAADC**
Licensed Professional Clinical Counselor .	Licensed Professional Clinical Counselor	**LPCC**
Marriage & Family Therapists	Licensed Marriage & Family Therapists	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: COLORADO

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Addiction Counselor	Licensed Addiction Counselor	**LAC**
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapists	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: CONNECTICUT

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Counselor	**LPC**
Drug Counselor	Licensed Alcohol/Drug Counselor	**LADC**
Marriage & Family Therapists	Licensed Marriage and Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: DELAWARE

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Counselor	Licensed Professional Counselor of Mental Health	**LPCMH**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: DISTRICT OF COLUMBIA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Counselor	Licensed Professional Counselor	**LPC**
Social Worker	Licensed Independent Clinical Social Worker	**LICSW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: FLORIDA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Counselor	Licensed Mental Health Counselor	**LMHC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: GEORGIA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Licensed Professional Counselor	Licensed Professional Counselor	**LPC**
Licensed Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: HAWAII

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Licensed Mental Health Counselor	Licensed Mental Health Counselor	**LHMC**
Licensed Social Worker	Licensed Social Worker	**LSW**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: IDAHO

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**AADC**
Counselor	Licensed Clinical Professional Counselor	**LCPC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Pastoral Counselor	Licensed Pastoral Counselor	
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: ILLINOIS

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Clinical Professional Counselor	**LCPC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: INDIANA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LCAC**
Counselor	Licensed Mental Health Counselor	**LMHC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: IOWA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**IAADC**
Counselor	Licensed Mental Health Counselor	**LMHC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Independent Social Worker	**LISW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: KANSAS

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Clinical Addictions Counselor	**LCAC**
Counselor	Licensed Clinical Professional Counselor	**LCPC**
Marriage & Family Therapist	Licensed Clinical Marriage & Family Therapist	**LCMFT**
Social Worker	Licensed Specialist Clinical Social Worker	**LSCSW**

STATE: KENTUCKY

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Counselor	Licensed Professional Clinical Counselor	**LPCC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: LOUISIANA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Counselor	**LPC**
Licensed Addictions Counselor	Licensed Addictions Counselor	**LAC**
Licensed Marriage and Family Therapist	Licensed Marriage and Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: MAINE

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Pastoral Counselor	**LPC**
Counselor	Licensed Clinical Professional Counselor	**LCPC**
Licensed Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: MARYLAND

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Clinical Professional Counselor	**LCPC**
Licensed Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LCPC-AD**
Marriage & Family Therapist	Licensed Clinical Marriage & Family Therapist	**LCMFT**
Social Worker	Licensed Certified Social Worker-Clinical	**LCSW-C**

STATE: MASSACHUSETTS

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Counselor	Licensed Mental Health Counselor	**LMHC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Independent Clinical Social Worker	**LICSW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: MICHIGAN

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Alcohol and Drug Counselor	**ADC**
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Master's Social Worker	**LMSW**

STATE: MINNESOTA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Counselor	**LPCC**
Licensed Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Independent Clinical Social Worker	**LICSW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: MISSISSIPPI

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol/Drug Counselors	Alcohol/Drug Counselors	**ADC**
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Certified Social Worker	**LCSW**

STATE: MISSOURI

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: MONTANA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LAC**
Counselor	Licensed Clinical Professional Counselor	**LCPC**
Marriage and Family Therapist	Licensed Marriage and Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: NEBRASKA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Independent Mental Health Provider	**LIMHP**
Licensed Alcohol & Drug Counselor	Licensed Alcohol & Drug Counselor	**LADC**

STATE: NEVADA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Clinical Alcohol and Drug Counselor	**LCADC / LADC**
Clinical Professional Counselor	Clinical Professional Counselor	**CPC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: NEW HAMPSHIRE

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Counselor	Licensed Clinical Mental Health Counselor	**LCMHC**
Marriage & Family Therapist	Licensed Marriage & Family Therapists	**LMFT**
Pastoral Counselor	Licensed Psychotherapist	**LPC**
Social Worker	Licensed Independent Clinical Social Worker	**LICSW**

STATE: NEW JERSEY

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Clinical Alcohol and Drug Counselor	**LCADC**
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: NEW MEXICO

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**ADC**
Counselor	Licensed Professional Clinical Mental Health Counselor	**LPCC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Independent Social Worker	**LISW**

STATE: NEW YORK

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Mental Health Counselor	**LMHC**
Counselor	Licensed Professional Counselor	**LPC**
Licensed Clinical Social Worker	Licensed Clinical Social Worker	**LCSW**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Psychoanalyst	Licensed Psychoanalyst	
Social Worker	Licensed Clinical Social Worker	**LCSW-R**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: NORTH CAROLINA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Pastoral Counselor	**PC**
Counselor	Licensed Professional Counselor/Licensed Professional Counselor Supervisor	**LPC/LPCS**
Licensed Clinical Addictions Specialist	Licensed Clinical Addictions Specialist	**LCAS**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: NORTH DAKOTA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Licensed Professional Clinical Counselor	Licensed Professional Clinical Counselor	**LPCC**
Licensed Professional Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Independent Clinical Social Worker	**LICSW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: **OHIO**

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Clinical Counselor	**LPCC**
Counselor	Licensed Professional Clinical Counselor	**LPCC-S**
Marriage & Family Therapist	Licensed Independent Marriage and Family Therapists	**LIMFT**
Social Worker	Licensed Independent Social Worker	**LISW**
Social Worker	Supervising Independent Social Worker	**LISW-S**
Substance Abuse Counselor	Licensed Chemical Dependency Counselor II	**LCDC/LICDC**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: **OKLAHOMA**

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Behavioral Practitioner	Licensed Behavioral Practitioner	**LBP**
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: OREGON

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC/CADC I II III**
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapist	Licensed Marriage& Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: PENNSYLVANIA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapy	Licensed Marriage & Family Therapists	**LMFT**
Social Worker	Licensed Social Worker	**LSW**
Social Worker	Licensed Clinical Social Worker	**LCSW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: RHODE ISLAND

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LCDP/LCDP-S**
Counselor	Licensed Counselor in Mental Health	**LMHC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Independent Clinical Social Worker	**LICSW**

STATE: SOUTH CAROLINA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Independent Social Worker	**LISWCP/LISWAP**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: SOUTH DAKOTA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Counselor-Mental Health	**LPC-MH**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**

STATE: TENNESSEE

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: TEXAS

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Counselor	Licensed Professional Counselor	**LPC**
Drug Counselor	Licensed Chemical Dependency Counselor	**LCDC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: UTAH

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LSAC/SUDC**
Counselor	Licensed Professional Counselor	**LPC/LCMHC**
Licensed Mental Health Counselor	Licensed Mental Health Counselor	**LMHC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: VERMONT

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Counselor	Licensed Clinical Mental Health Counselor	**LCMHC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Independent Clinical Social Worker	**LICSW**

STATE: VIRGINIA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**
Substance Abuse Professional	Licensed Substance Abuse Treatment Professional	**LSATP**

ValueOptions Inc.

STATE LICENSURE GRID

STATE: WASHINGTON

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Mental Health Counselor	**LMHC**
Marriage & Family Therapist	Licensed Marriage& Family Therapy	**LMFT**
Social Worker	Licensed Independent Clinical Social Worker	**LICSW**

STATE: WEST VIRGINIA

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapists	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Independent Clinical Social Worker	**LICSW**

STATE: WISCONSIN

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Alcohol and Drug Counselor	Licensed Alcohol and Drug Counselor	**LADC**
Counselor	Licensed Professional Counselor	**LPC**
Marriage & Family Therapist	Licensed Marriage and Family Therapy	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

STATE: WYOMING

DISCIPLINE	ACCEPTABLE HIGHEST LEVEL OF LICENSURE	ACRONYMS
Counselor	Licensed Professional Counselor	**LPC**
Licensed Addictions Therapist	Licensed Addictions Therapist	**LAT**
Marriage & Family Therapist	Licensed Marriage & Family Therapist	**LMFT**
Social Worker	Licensed Clinical Social Worker	**LCSW**

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.

VALUEOPTIONS®
CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT
COMPLIANCE DEPARTMENT EMPLOYEES AND REPRESENTATIVES

As part of my compliance related duties on behalf of ValueOptions® and its affiliates, I may from time to time receive, prepare, or otherwise may be furnished or exposed to confidential or proprietary company verbal, written, or computerized information including, but not limited to, legal information, minutes, reports, policies and procedures, plans, logs, or financial data ("Confidential Information"). I, _____, hereby agree to not use or disclose any Confidential Information to any person, entity, government agencies, legal authority, or law enforcement agencies without ValueOptions®' written authority, except as may be specifically authorized by this Agreement. I understand that this includes any Confidential Information relating to VALUEOPTIONS® and any other company affiliates (individually and collectively, the "Company").

I agree to not use Confidential Information except in Company directed business and with employees or contractors who have a need to know in order to perform compliance related duties for and on behalf of the Company and who agree to hold such information confidential, consistent with this Agreement. I agree to safeguard Confidential Information against disclosure to others who do not have a need to know.

I understand that I may disclose Confidential Information to consultants or other third parties regarding a specific issue or matter as approved by ValueOptions®. I agree to use at least the same degree of care in safeguarding Confidential Information released to me from a third party as the third party would use to safeguard their own Confidential Information.

I agree that I shall not during or, at any time, after the termination of my employment with ValueOptions®, use for myself or others, or disclose or divulge to others including future employees, any Confidential Information or any other proprietary data or information of the Company or its affiliates in violation of this agreement.

Upon termination of my employment from the Company I shall return to the Company all documents or copies of documents and all property of the Company including but not necessarily limited to: reports, manuals, correspondence, computer programs, plans, and all other material relating in any way to the Company's business, or in any way obtained by me during the course of employ. I further agree that I shall not retain copies, notes or abstracts of the foregoing.

The Company may notify any future or prospective employer or a third party of the existence of this agreement, and shall be entitled to full injunctive relief for any breach.

AGREED AND ACCEPTED BY:

By: _____ Title: _____

Date: _____

Witness: _____ Title: _____

Date: _____