Redacted Technical Proposal

Submitted To:
New York State Department of Civil Service
RFP #2013 MH-1

Subject:
Management of the Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and the Student Employee Health Plan

Submitted By:
Magellan Behavioral Health, Inc.
55 Nod Road
Avon, CT 06001

Submission Date:
April 16, 2013

A. PROGRAM ADMINISTRATION

1. EXECUTIVE SUMMARY

The Offeror must describe its capacity to administer the Department's Mental Health and Substance Abuse Program (also hereafter collectively referred to as the "MHSA Program").

A. REQUIRED SUBMISSION

The Offeror must submit an Executive Summary that describes its capacity to administer the Department's MHSA Program. The Executive Summary must include:

(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;

MAIN AND BRANCH OFFICES

Magellan Behavioral Health is headquarted at the following location:

55 Nod Road
Avon CT 06001

Magellan's NCQA and URAC accredited Tristate Care Management Center, located at the address below, will provide management oversight of the Albany, New York-based dedicated Empire Plan Service Center.

10101 Alliance Road, Suite 201
Cincinnati OH 45242

Reporting into our Tristate Care Management Center will be a dedicated Empire Plan Service Center staffed with Empire Plan-dedicated program management, supervisory, clinical, customer services, reporting, field network, and quality improvement staff. **This service center will be located in Albany, New York.**

Magellan's Centralized Enrollment and Claims Processing Center, located at the address below, will manage enrollment/eligibility and claims processing for the Empire Plan.

14100 Magellan Plaza
Maryland Heights MO 63043

MAGELLAN SENIOR OFFICER RESPONSIBLE FOR THE EMPIRE PLAN

Lynn Hamilton Senior Vice President, Employer Solutions will serve as the Executive Sponsor and senior officer who will be responsible for the Empire Plan. Ms. Hamilton is responsible for the oversight of all existing account relationships and new business development between Magellan and our employer customers. Responsibilities include overall account profit and loss, product strategies, relationship management, and service delivery. She has been at Magellan since January, 2010. Prior to joining Magellan, she was Vice President at CIGNA Healthcare where she held a variety of leadership roles with increasing responsibility during her 10-year tenure including financial roles and account management and business development oversight. Before CIGNA, she held senior financial roles at MedPartners in the physician practice management industry. Ms. Hamilton received her B.S. in Accounting from Fairfield University and a Masters Degree in Finance and Healthcare from the University of Connecticut. She holds a CPA certificate in the State of Connecticut and began her career at Ernst & Young, LLP.

(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 OF RFP REQUIREMENTS

Magellan has conducted a thorough review of the entire Empire Plan RFP, as well as all RFP Amendments. We can attest to a sound understanding of the Department's requirements as detailed in the RFP and Amendments. As requested, we included the required attestations and documentation demonstrating satisfaction of the Department's minimum mandatory requirements in response to *Section III. Administrative Proposal Requirements.* We have also submitted all the required Statements, Formal Certifications, and Exhibits required to determine Magellan's compliance with all relevant rules, laws, regulations, and executive orders as described in the RFP. Additionally, Magellan has addressed our ability to meet each Program requirement presented in the *Duties and Responsibilities* portion of each section (e.g. *1: Account Team*, 2: *Premium Development Services,* 3: *Implementation*, etc.) of the Technical Proposal.

As described in detail in response to *Question 3*, below, Magellan has the qualifications, experience in New York State, and commitment to serving public sector clients to serve as a trusted partner to the Department.

ASSISTING THE DEPARTMENT ON ACCOMPLISHING ITS OBJECTIVES

Magellan is fully prepared to assist the Department in accomplishing your objectives with regard to assuring that the highest quality behavioral health services are delivered to Empire Plan enrollees. Magellan understands the need for a tailored approach to meet the Department's goals, and we believe the groundwork is set within our organization to exceed your expectations. With decades of experience in the behavioral health industry, Magellan developed many of the service standards now embraced in the industry. We continue to lead the industry in such areas as clinical quality and outcomes, accreditation of service centers (NCQA and URAC), breadth of network resources, and command of behavioral health data. We offer a broad continuum of comprehensive services that are easily packaged and priced. At Magellan, we differentiate ourselves through the following advantages that will assist the Department in accomplishing your objectives:

We are a thought leader in behavioral health expertise, research, and medical economics that improve health care outcomes. We partner with industry leaders to ensure our services exceed market standards. For example, in cooperation with the nationally renown outcomes management vendor, QualityMetric Group, Magellan has developed an outpatient outcomes management tool—the Consumer Health Inventory (CHI), an assessment form, that we believe is unmatched in the industry today in its ability to detect enrollee risk in outpatient care as early as possible and deliver that risk information to Care Managers and treating providers.

At Magellan, we also apply solid research outcomes, health risk assessment, and advanced data warehousing to *continually improve the quality of care for our enrollees*, enhance strategic support for our customers, and demonstrate overall cost savings. Our numerous Quality Improvement Activities (QIAs), proprietary online clinical screening tools (provided at no additional cost to our enrollees), and outcomes studies have demonstrated significant positive outcomes in improved enrollee health, enhanced productivity, and increased return-on-investment (ROI). We conduct research with some of the world's leading research organizations to positively influence decision-making and program development throughout the industry.

We provide seamless access to more treatment options, delivered at the most appropriate level, in the least restrictive way. Our well-established network of behavioral health providers is the largest of any vendor that we are aware of. We offer centralized access to the most appropriate type of care, delivered in the most clinically appropriate, least restrictive setting. This translates into more appropriate enrollee/provider matches, optimal benefit utilization, positive treatment gains and the maintenance of those treatment gains. We apply progressive quality management processes which afford a variety of benefits for both providers and enrollees.

Because of the breadth and scope of services we offer, and how those services support providers as they deliver care, Magellan is also able to attract the highest quality providers. Our negotiated contracts with network providers and facilities help control the cost of care, while our administrative efficiencies enable us to empower treating providers to serve enrollees well.

Another important differentiator at Magellan is that we are strongly committed to and believe we lead the market in accreditations. Driven by on-going commitment to provide quality-driven, cost-effective care that is clinically appropriate and improves health care outcomes, we have achieved outstanding levels of accreditation. We currently hold more accreditations than any other MBHO. As an industry leader, we have had sites accredited by URAC since 1992, and assisted NCQA in shaping its MBHO standards. In fact, we were the first MBHO to have earned this distinction.

It is also important to note that Magellan has a strong commitment to working with New York's Minority and Women Owned Business (MWBE) community and has put together a strong, experienced team of outstanding MWBE partners including:

- Genesys Consulting Services, Inc. to assist with the sourcing of customer service staff and care managers who will be employed in our Albany based Empire Plan Service Center.
- Unique Computer Inc. (UCI) to assist with the procurement of telecommunications equipment, technology equipment, technology services, and software licenses for our New York based staff
- HEOPS, a patient access company that assists with the development of network operations services, to assist in the development of a robust network that exceeds the Department's service standards.

Magellan will continue to work to identify additional opportunities throughout the term of our contract to insure that the MWBE goals continue to be met and/or exceeded.

You will notice as you read this proposal that the Magellan clinical and account team also offers longevity—our staff enjoys working at Magellan and will grow to know and be trusted by your plan representatives. The average length of service of our Care Managers is five years, and our proposed Senior Manager of Implementation for the program transition, Ms. Sandra Morter, has over 14 years of experience at Magellan. We believe the longevity of our staff speaks to our corporate commitment to the continuing education and clinical development of our staff. Care Managers, for example, are offered free CEU credits and education support, and we also compensate staff for appropriate advanced credentials and licensures. In addition, we support our staff through a competitive benefits package with features like adoption assistance, tuition assistance, a generous paid time off schedule, multiple health care options, and paid vacation time.

We also *take the time* to promote mutually beneficial strategic medical integration partnerships. We develop strategic medical integration partnerships that will help your health plans in their overall mission. We integrate our behavioral health experts with the health plan's medical experts to achieve medical integration at multiple levels in various areas. Our medical integration activities apply our best practices and provide the necessary links to integrate primary care with solid behavioral health care, achieving overall holistic care which is characterized by enhanced patient outcomes and reduced utilization costs. These differentiators form the platform upon which Magellan will operate into the future, making us well-positioned to help customers like the Department as you plan new ways to control health care costs for enrollees, without sacrificing care, and without neglecting the ways medical and behavioral health conditions interact with one another.

Further details about how Magellan will assist the Department in accomplishing your objectives in the following key areas is provided in response to *Question a.4*, below.

- Account Team
- Premium Development Services
- Implementation
- Customer Service
- Enrollee Communication Support
- Enrollment Management
- Reporting
- Consulting
- Transition and Termination of Contract
- Network Management
- Claims Processing
- Clinical Management/Utilization Review

(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

MAGELLAN EXPERIENCE

Magellan Behavioral Health, Inc. is a subsidiary of Magellan Health Services, the country's leading diversified specialty health care management organization providing services in behavioral health, radiology, and pharmacy. Headquartered in Avon, Connecticut, Magellan Health Services (Nasdaq: MGLN) has been in business for more than 40 years. Magellan Behavioral Health (Magellan) was incorporated in 1998 upon acquiring Human Affairs International in 1997, Green Spring Health Services in 1998, and Merit Behavioral Care in 1998.

Magellan brings over four decades of experience in behavioral health programming to our approach to serving customers like the Department. Our behavioral health services currently cover **33.8 million enrollees across the country, over 1.7 million of whom reside in New York**. Our customers include large and small government agencies, health plans, and corporations. Today, Magellan has direct contracts with 920 employers. We also manage programs for more than **20 percent of Fortune 500** companies. Our union, government and State experience is highlighted below.

Magellan Behavioral Health employs 3,482 employees (Magellan Health Services employs nearly 5,000 employees). We operate fifteen care management centers (The dedicated Albany Empire Plan Service Center will be the sixteenth.) across the United States and contract with over 74,325 behavioral health providers and facilities to ensure that each of our customers receives the superior service and results it takes to maintain a productive workforce.

Magellan Behavioral Health Division's mission is to:

> *Maximize the power of our behavioral health expertise to support individuals and families at the most sensitive moments of their lives. We deliver trusted and innovative solutions to our customers and collaborate with our providers to positively influence individuals' total health and well-being and increase value for all our stakeholders.*

Magellan is driven each day by a continued commitment to create an organization that provides quality-driven, cost-effective care management for the benefit of our customers.

Our overarching objective is to provide individuals with high-quality, clinically appropriate, affordable behavioral health care that is tailored to each employee's needs.

EXPERIENCE IN NEW YORK

Magellan has extensive New York State experience especially in the mental health arena. We will bring to this project an experience team that is located in and has experience working with New York State and its unions. Our strong presence in New York State dates more than 20 years. **Through 63 customer contracts, Magellan covers 1.7 million lives in New York.** Because of the breadth of our membership in New York, Magellan has resources in place, such as our New York-based provider network management team, to assist with your program transition. Some of the large customers we serve today whose membership resides in New York include:

Magellan has a history of going above and beyond the call of service when New Yorkers need help. In the days and weeks following the devastating events of Super Storm Sandi, Magellan responded to an unusually high level of demand for support, crisis response, and critical incident stress management (CISM) services, from both customers and non-customers. In a typical month, Magellan responds to approximately 310 (2012 average) requests for CISM services across the

country. In the three month period following the hurricane, Magellan responded to over 570 requests for services in the New York area alone. To respond effectively to this volume of requests for help, Magellan was able to mobilize approximately 300 affiliates and members of the Magellan deployment team to provide services in New York. Additionally, these Magellan deployment teams provided on the ground services for four to six weeks immediately following the events of September 11, 2001 (100 CISM services in September and 750 in October) and returned to provide additional assistance throughout the year culminating in another round of targeted support services at the one year anniversary.

In additional to our commercial experience in the State of New York referenced above, Magellan is one of five BHOs (Behavioral Health Organization) in New York State under contract with the New York State Office of Mental Health and Alcoholism and Substance Abuse Services. Through this contract, won by Magellan through a competitive bidding process, we are charged with working with inpatient behavioral health providers (mental health and substance use) within our respective region (Central New York Region of 20 counties) to improve care coordination with both behavioral and physical health services; improve rates of engagement in outpatient treatment post discharge; reduce behavioral health inpatient readmission rates; work collaboratively with Health Homes, and gather data on the clinical conditions of children with a serious emotional disturbance who are receiving treatment in an Office of Mental Health (OMH) licensed specialty clinic. Following implementation in late 2011, for the first nine months working with providers, we served 3,775 individuals (420 on a monthly basis); of that number, we particularly focused on 280 high-needs individuals working with providers to improve outcomes for these highest end users, particularly their engagement in their care. Because of our workaround treatment and discharge planning, we saw an increase of 37 percentage points (from 25% to 62%) of consumer involvement in their plans.

OUR PARTNERSHIP WITH THE UNIONS

As part of Magellan's history, we have significant experience administering behavioral health services for unions, as well as Taft-Hartley plans, serving approximately **109 union customers**. These customer industries include government employers, airlines, transportation, health and welfare funds, hospitals, utilities, public administration, forestry and logging, food services, hotels, and utilities. This experience in providing service to union trusts translates into a strong understanding of the work environments and challenges facing unions, union representation, and their membership. Our experience enables us to successfully manage services within the cultures and the diverse workforces of customers like the Department that often require unique program design and features to meet the needs of their enrollees. We have an overall customer retention rate well exceeding 90% and an average tenure of more than 10 years with our employer/union customers.

Magellan's experience in providing direct service to union trusts translates into a strong understanding of the work environments and challenges facing unions, union representation, and their membership. Below is a partial listing of Union organizations that Magellan has worked with either through direct, employer or health plan contracts:

Magellan's EAP for the AlaskaCare health benefit program offers confidential assessment, counseling and referral services to covered employees and their family members. Magellan also provides targeted on-site training and CISM services to address particular identified needs for the diverse union groups that are covered under AlaskaCare. An example of this support is the two days of training provided in 2012 for members of the CEA that were undergoing a complete reorganization of the department that manages retirement and benefit services for all State of Alaska employees. Sessions focusing on managing change and building personal resiliency were proactively provided to ease the transition for all employees impacted by the organizational change.

IBU and MEBA members that operate the Alaska Marine Highway (ferry) System presented a special challenge because of their floating work environment. A special teleconference that described the features of their Magellan EAP program and answered their questions was conducted.

STATE AND OVERALL GOVERNMENT EXPERIENCE

Magellan will leverage our experience working with other states' MHSA programs when planning and implementing the Empire Plan program.

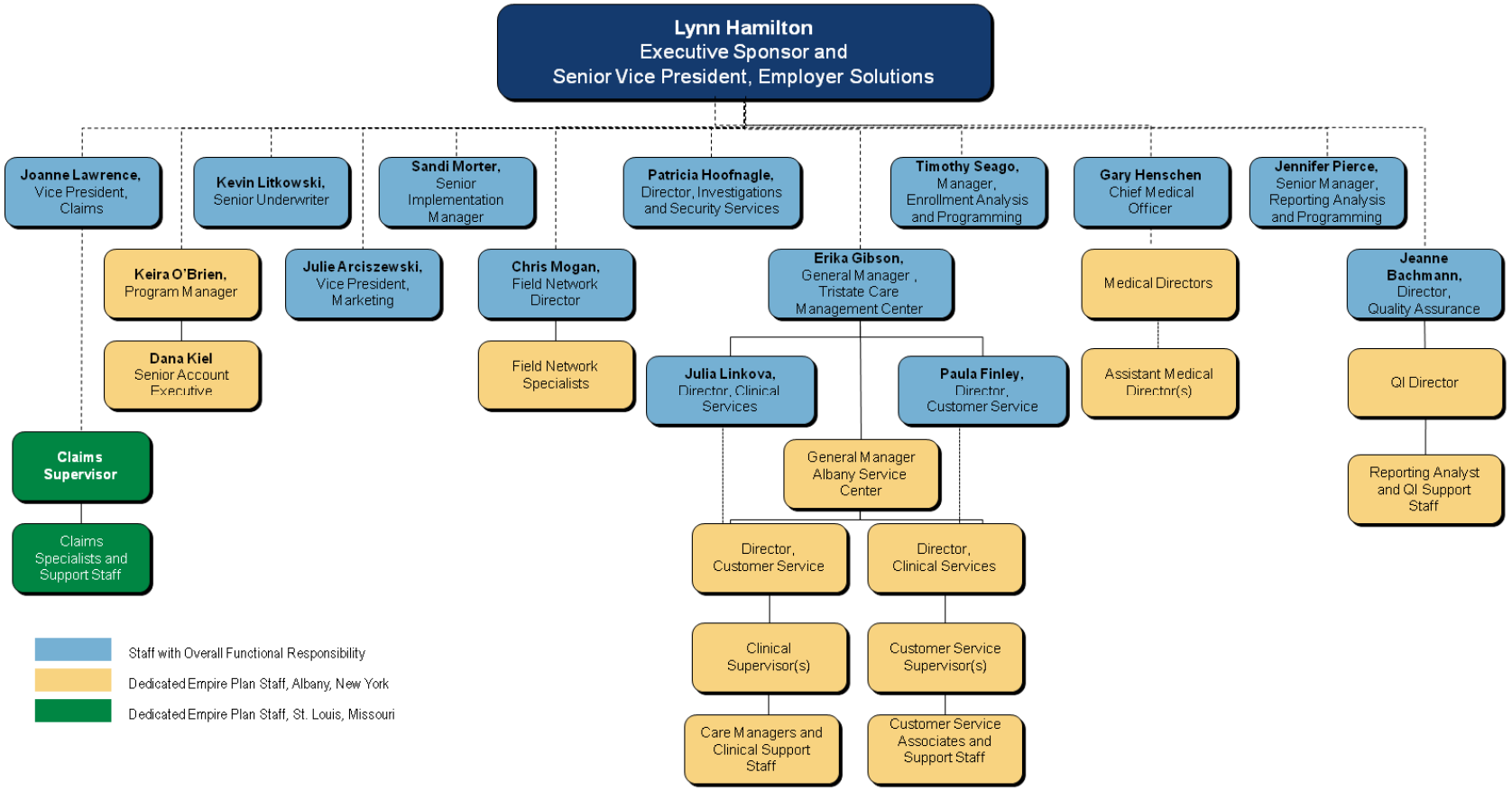
4) An explanation of how the following administrative and operational components will be performed by the Offeror. Include an organizational chart explicitly detailing responsibility for the following functions;

Below, Magellan as provided a description of how we will perform the components listed in **Table A.1.a**. Additionally, **Table A.1.a** includes the Magellan employee with responsibility for each component. We have also provided the requested organization chart below as **Figure A.1.a**.

Table A.1.a: Empire Plan Account Team

Component	Person Responsible
Account Team	Keira O'Brien, Program Manager/Senior Account Leader
Premium Development Services	Kevin Litkowski, Senior Underwriter
Implementation	Sandi Morter, Senior Implementation Manager
Customer Service	Paula Finley, Director, Customer Services
Enrollee Communication Support	Julie Arciszewski, Vice President, Marketing
Enrollment Management	Timothy Seago Manager, Enrollment Analysis and Programming
Reporting	Jennifer Pierce, Manager, Reporting Analysis and Programming
Consulting	Lynn Hamilton, Executive Sponsor and Senior Vice President, Employer Solutions
Transition and Termination of Contract	Keira O'Brien, Program Manager and Senior Account Leader
Network Management	Chris Mogan, Field Network Director
Claims Processing	Joanne Lawrence, Vice President, Claims
Clinical Management/Utilization Review	Julia Linkova, Director, Clinical Services

Figure A.1.a: Empire Plan Account Team



(a) Account Team

The fully dedicated Empire Plan account team will consist of a Program Manager and Senior Account Executive in the Albany, New York area who are qualified and experienced individuals, acceptable to the Department and who will have the necessary access and positional authority within Magellan to ensure that the operational, clinical, and financial resources are in place to implement and operate the MHSA Program in an efficient manner.

Keira O'Brien will serve as the dedicated **Program Manager** for the Empire Plan and will be supported by **Dana Kiel, Senior Account Executive**, who will also be dedicated to the Empire Plan.

Keira O'Brien will serve as the primary point of contact for the Department, serving as the advocate within the company to ensure a successfully managed contract. She is currently responsible for successful management of the Preferred Drug List and ancillary programs for the largest Medicaid Program in the country as well as the New York Elderly Pharmaceutical Insurance Coverage Program. She was previously responsible for fiscal viability and property maintenance of an Office of Mental Health certified residential facility for individuals living with mental illness. She managed all aspects of a Pharmacy Benefit Program for participants diagnosed with mental illness; customer service, claims processing, formulary management, finance, provider relations, and eligibility/enrollment. She received her MBA from Rensselaer Polytechnic Institute and her BA from Russell Sage College. More recently, she obtained Lean Six Sigma Green Belt certification and Accounting Certificate from Siena College.

Dana Kiel is currently the Senior Account Executive on the Horizon State of New Jersey Account (SHBP) and has worked on the account for the past two years. The account covers close to 600,000 members. She works as a team with the Horizon Account Executives to support the State Educators, Local Government and State Government employees. Her support covers Horizon interactions with the Department of Pension and Benefits, the State Department of Banking and Insurance as well as the State Commission that serves as an external appeal in matters of behavioral health coverage. She has been with Magellan since 2011 and brings to Magellan more than 20 years experience in behavioral health, national account management, sales and EAP clinical supervisory roles. Ms. Kiel holds a Masters in Social Work (MSW) and is also a Certified Employee Assistance Professional (CEAP). Her postgraduate training was concentrated in chemical dependency at the Psychoanalytic Psychotherapy Study Center; couples and family training at the Ackerman Institute; and critical incident/disaster training with the American Red Cross. Prior to joining Magellan, Ms. Kiel was national account manager with CIGNA Health Solutions, a role she held for six years. As

national account manager, she managed 10 national accounts. Her main customers were JP Morgan Chase, Honeywell, BASF and CIGNA Corporation. Ms. Kiel'a experience with large national employers and the State of New Jersey account has given her an understanding of complex service delivery systems and the importance of understanding the diverse needs of members from different groups within a customer. In addition, her clinical background and previous work with individuals and groups with mental health and chemical dependency problems has contributed to her abilities as a member advocate. This combination of these macro and micro view points will make her a successful Senior Account Executive for the State of New York.

Magellan demonstrates our full commitment to the success of the Empire Plan MHSA Program by offering the Department a service model that combines the URAC and NCQA accreditation of Magellan's Tristate Care Management Center in Cincinnati, Ohio with an **Albany-based dedicated Empire Plan Service Center** and team. This service center will be opened in the Albany area as a branch of our Tristate Care Management Center, which has held NCQA accreditation since it's first survey in 1999; thus, assuring full NCQA accreditation. Magellan will provide a **full-time dedicated program manager on-site in New York, who will be supported by a dedicated senior account executive.** Both the program manager and the senior account executive will report to Lynn Hamilton, Senior Vice President, Employer Solutions, which will assure that they have direct access to senior level management and can quickly resolve Empire Plan issues. Dedicated program management, supervisory, clinical, customer services, reporting, field network, and quality improvement personnel will be on-site in the Albany-based Empire Plan Service Center. Finally, claims will be paid by dedicated Empire Plan claims processors/adjusters in our centralized claims office in St. Louis (Maryland Heights), Missouri.

Our service approach allows us to provide a significant New York State presence for the Empire Plan while taking advantage of proven centers for excellence already in place. Our account management model is designed for an environment in which program managers and account executives work in tandem with Operations but report directly to the client and to senior leadership within Magellan. This approach ensures that the Magellan account team can fully advocate for the Department, resolve issues quickly and effectively, and provide the highest level of service.

(b) Premium Development Services

Magellan will provide 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.

Kevin Litkowski, Senior Underwriter will assist the Department in the determination of Initial Premium and subsequent Renewal Premium Rates. As a Senior Underwriter at Magellan, Mr. Litkowski is involved in the transformation of Client Data into projections of Care. He also coordinates the input of Clinical Operations, Finance and Network and Claims Operations areas into determining a Final Premium Rate. Mr. Litkowski has been employed as an Underwriter at Magellan for five years, during which time he has underwritten for all manner of Magellan products, specializing in behavioral health and radiology benefit management. Prior to Magellan, Mr. Litkowski worked for MAMSI Health Care, which later became part of United Health Care. During his 12 years, he worked in the Underwriting and Actuarial Analysis Departments.

(c) Implementation

Magellan will commence an implementation period beginning on or around October 1, 2013 following approval of the Agreement by the New York State Office of the State Comptroller (OSC). During the implementation period, Magellan will undertake and complete all implementation activities, including but not limited to those specific activities set forth in Section IV.B.3.a.2a-2e. Such implementation activities will be completed no later than December 31, 2013 so that the MHSA Program is fully operational on January 1, 2014.

Communication during transition from the incumbent vendor to Magellan will be critical. Magellan has developed a comprehensive plan (provided as **Appendix C**) to ensure that all parties, the state, the unions and the individuals utilizing the services are aware of what is happening during the transition and can be assured that there will be no interruption of services. Managing a smooth transition with no interruption in care will be of particular importance to enrollees covered through the Empire Plan who were affected by Hurricane Sandy and the severe damage it caused in New York and New Jersey. With the trials this vulnerable population has already suffered in mind, Magellan will work with the Department to make the transition from the Program's current vendor as smooth as possible. Magellan also recognizes the importance of a seamless transition to the many vital and influential unions involved with the Empire Plan. Accordingly, Magellan will have, in place, a robust network of providers on day one. We will begin immediately working with the existing network as soon as the award is made ensuring that those currently receiving services will not experience any disruption.

Magellan has appointed a highly qualified team of account management, administrative, and clinical personnel with significant experience with large accounts to manage the program transition and implementation of the Empire Plan MHSA Program and ensure a seamless change in service for the Department, Empire Plan enrollees, and providers.

This seasoned team, led by **Sandra Morter, Senior Implementation Manager** will share behavioral health best practices, provide strategic consultation, attend promptly to issues requiring action, and make any adjustments necessary to ensure a successful implementation.

As Senior Implementation Manager, Ms. Morter plays an integral role in implementing Magellan accounts and products for our customers. Ms. Morter has experience implementing Health Plans, Public Sector and Commercial accounts as well as experience with government and military implementations. She has more than fourteen years' tenure with Magellan. Prior to undertaking her current responsibilities, she served as clinical manager for one of Magellan's largest customers, supervising inpatient, outpatient, and drug-free workplace staff. She also provided on-site EAP services and training for a large government-based account. A graduate of the University of Missouri (St. Louis), she has a master's degree in counseling, a master's degree in rehabilitation counseling and has worked in the field of general counseling and substance abuse for 25 years. Ms. Morter has led or participated in the implementation of several large complex contract include programs for the State of Tennessee, the State of Louisiana, WellCare, Blue Shield of California, and Magellan Complete Care of Florida (Magellan's full service Medicaid health plan that includes coverage for physical health, behavioral health, dental services, transportation, and eye care).

Our long history of providing MHSA programs has afforded us the depth and breadth of experience to keep pace with the evolving needs of our new and existing customers. We have designed our infrastructure (i.e., information systems, telecommunication systems, and staffing patterns) to accommodate flexibility in new business implementation. Magellan currently supports more than 520 unique interfaces with our customers' vendors and their subsequent information systems. Our extensive national provider network and excellent customer service record further support our capability to quickly respond to the dynamic needs of our current and potential customers.

One of Magellan's notable strengths is our implementation and account management experience and success rate. Over the years, we have successfully implemented numerous programs for large customers like the Department. Through these implementations, we have met new business requests, demonstrated flexibility in program design, and accommodated unique requirements to meet the business needs of each customer. **We have met all performance guarantees related to client implementations and have scored an overall 100% implementation satisfaction rating from our clients for the past six years.**

(d) Customer Service

Magellan will provide quality customer service to enrollees who will access care by contacting dedicated Empire Plan customer service associates at the Empire Plan Service Center in Albany.

This service center will be operational Day One with the goal of providing answers to concerns at the "Level One" contact. This communication center will be monitored constantly to ensure that common concerns or questions are resolved on the enterprise level.

Customer service associates (CSA) will respond to questions involving MHSA Program benefits, network providers, claim status, complaints, and other topics. When a call involves a clinical matter, the CSA will warm-transfer the caller to the Clinical Referral Line. Magellan will staff this line to meet or exceed the customer service performance guarantees and reflect our commitment to quality customer service. Magellan CSAs and clinical staff also have 24 access to translation services through vendor relationship with Pacific Interpreters.

The customer service team at the Albany Empire Plan Service Center will report into **Paula Finley, Director of Customer Service**. As Director of Customer Service at Magellan's Tristate Care Management Center, Ms. Finley is responsible for the performance of a team of employees that includes customer service supervisors, associates, a care assist team, and support associates. Ms. Finley establishes performance goals and quality standards for staff and ensures they are met. She leads customer service teams in the successful delivery and execution of services to meet client commitments and contractual obligations. She also develops and implements creative processes and service solutions that address performance issues and enhance efficiency and service excellence. Ms. Finley has been a valued employee of Magellan since 1995, assuming progressively more responsible positions ranging from claims auditor to customer service manager to her current position. Ms. Finley graduated from Covenant College in Georgia with a B.S. in Organizational Management.

Reporting to Ms. Finley will be a Director of Customer Service based onsite at the Albany Empire Plan Service Center. This onsite Director will lead a team consisting of an on-site Customer Service Supervisor and 17 customer service associates (CSAs) and one senior CSA. Qualifications for these individuals are provided below.

DIRECTOR OF CUSTOMER SERVICE QUALIFICATIONS

The Director of Customer Service must have a Bachelor's degree, at least five years of experience in call center management (preferably in the healthcare industry), experience leading large teams in a dynamic industry, and a demonstrated track record of managing change with proven results in the achievement of goals (financial and performance). Other qualifications include:

- Knowledge of managed healthcare principles and call center operations
- Ability to develop, articulate and measure performance of a large, diverse team

- Ability to collaborate with colleagues in the Care Management Center and in other Care Management Centers to achieve mutual performance goals Excellent negotiation, leadership and communication skills

CUSTOMER SERVICE SUPERVISOR

The Customer Service Supervisor must have a Bachelor's degree and at least two years of supervisory experience (preferably in the healthcare industry). Other qualifications include:

- Previous hiring experience
- Scheduling experienced
- Proven customer service experience
- Excellent customer service skills
- Strong time management and organizational skills
- Ability to work in a team environment
- Excellent verbal and written communication skills

CUSTOMER SERVICE ASSOCIATE QUALIFICATIONS

Magellan's CSAs must have at least two years of experience in a managed care or a health-related setting. A high school diploma is required and a college degree is preferred. Candidates must also be a proficient typist and able to maneuver through various computer platforms while verifying demographic information on all calls. Further qualifications include:

- Excellent verbal and written communication, organizational and multi-tasking skills
- Must recognize customer service as an ever-changing environment—this causes one to be flexible in scheduling and having the ability to accept change
- Responsible for meeting call handling requirements and daily telephone standards as set forth by the Care Management Center
- Must agree to observing service for the purpose of training and quality control
- Ability to work with Magellan's translation vendor to serve enrollees whose first language is not English

(e) Enrollee Communication Support

Magellan offers a breadth of organizational resources for the purposes of delivering meaningful enrollee communications for Department. Two departments within Magellan are solely focused, on a full-time basis, on the development of innovative enrollee communications to meet your plan's needs. First, Magellan has an award-winning in-house Marketing, Public Relations, and Communications Department, staffed with experts specializing in strategic communications, branding, graphic design, program promotion planning, implementation, copywriting, creative development, art direction, and customer order fulfillment. Members of this Department will be available to consult and work with the Department from program transition through program delivery to ensure all of your program communications needs are met.

Second, Magellan also houses a Website Work Team within our IT Department staffed by content managers, IT programmers, and Web communications specialists and this team will steer the Department's customized website and web content, as specified by the Department. These two organizational work teams have extensive experience supporting large employer and public sector customers, and have developed custom communications for clients including Federal Occupational Health (FOH), the United States Postal Service (USPS), the State of Tennessee, the State of Illinois, the State of Michigan, and the State of New Jersey, to name just a few.

Julie Arciszewski, Vice President, Marketing will have overall responsibility for all marketing and communications activities for the Empire Plan. As Vice President of Marketing, Ms. Arciszewski oversees all communications, marketing, education and consultative services related to building awareness and utilization including print, email, event, and web marketing. In addition, her team can provide marketing consultative services to support educational campaigns as required. Ms. Arciszewski uses market research, proven marketing techniques and information obtained in partnership with clients to create marketing plans and campaigns that drive program awareness and utilization. Her team is responsible for marketing that supports over 30 million individuals in varied industries including retail, technology and service as well as a number of government agencies. Ms. Arciszewski has over 25 years experience marketing to individuals and groups. Prior to joining Magellan, she worked in the financial services industry marketing insurance products, annuities and 401(k) plans. She has both an undergraduate and graduate degree in marketing.

(f) Enrollment Management

Magellan 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 will be used by Magellan to process claims, provide customer service, identify individuals in the enrollment file for whom Medicare is primary, and produce management reports and data files.

Tim Seago, Manager of Enrollment Analysis and Programming will have overall responsibility for all functions related to enrollment/eligibility for the Empire Plan. Mr. Seago brings over 25 years of IBM Midrange application development experience to his team. He has served in all areas of application development including: programming, systems analysis, systems design, technical design, and quality assurance. Mr. Seago has currently been with Magellan 10 years and reports to Tim Hoffman, VP, IT. In his current role, he has oversight of the membership (eligibility) application development team. His team supports customers representing over 40 million lives, including several governmental agencies. Mr. Seago has been involved in several business areas within IT, such as telephone company billing, manufacturing, and electric company billing. His past IT management experience has included serving as application manager of IT Rental Systems with Enterprise Rent-A-Car, where he was responsible for the management of IT projects related to Enterprise's rental divisions.

(g) Reporting

Magellan recognizes the critical importance of data for program management and compliance, utilization review, outcome evaluation, costs, and to respond to questions associated with special populations and particular concerns. Magellan will commit to providing not only the data files and management reports required in the RFP but will work actively with the Department to address ad hoc reporting needs and to advance the state's own data analysis capabilities. We have reviewed the requirements for financial and utilization reporting, as outlined by the Department, and has included a set of examples of our standard reports as **Appendix N**. Our robust reporting and sophisticated data analysis capabilities provide customers with essential information for monitoring Magellan's performance and evaluating the cost of behavioral health care.

Magellan understands the power of data collection as the foundation of meaningful reports that allow for thorough monitoring of a behavioral health program. Utilization, claims data, financials, performance guarantees, media usage analysis and other summaries are enhanced by thorough data collection and management. Magellan's Information Technology (IT) systems are completely integrated, allowing for immediate retrieval and sharing of data between applications.

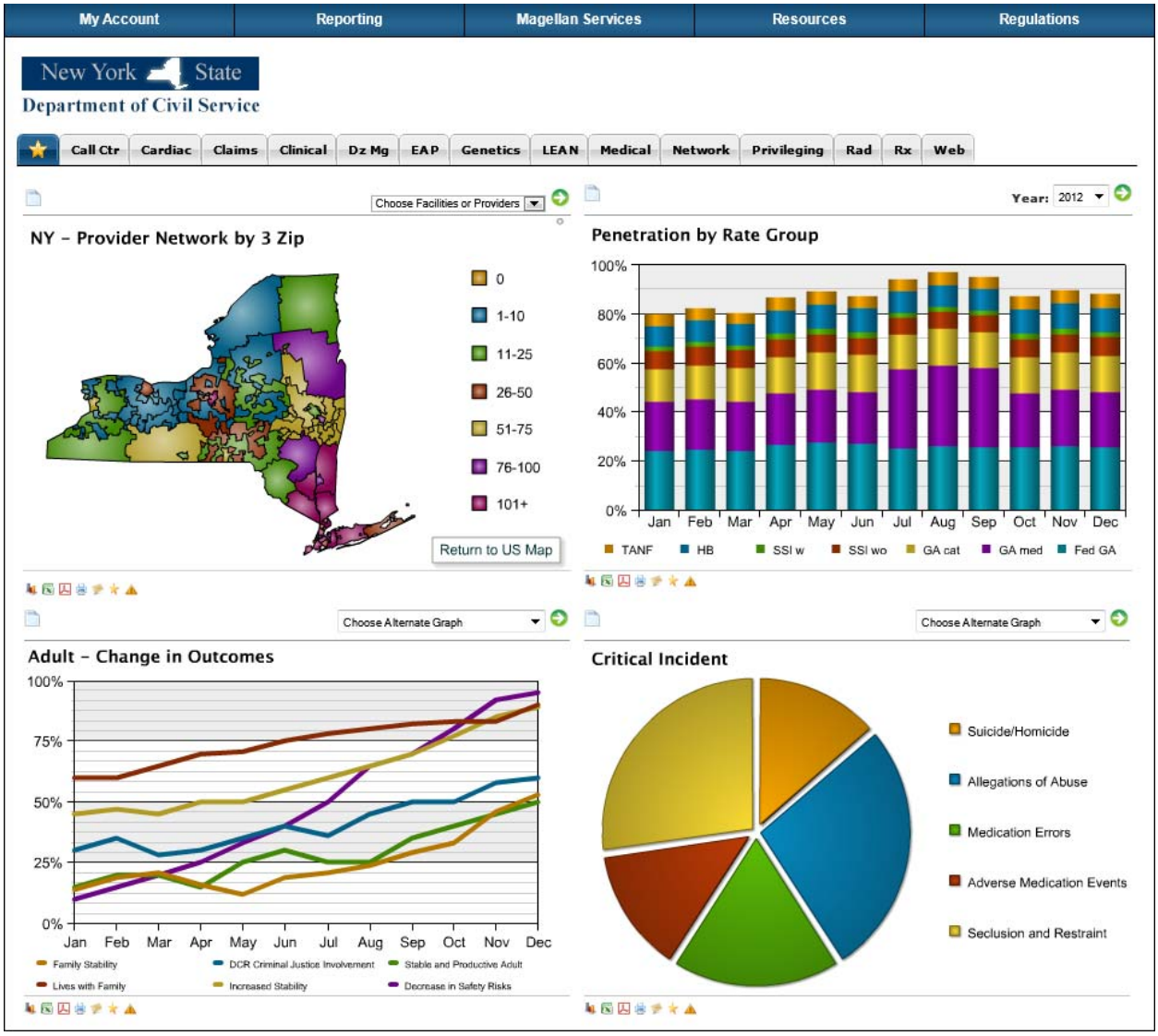
We understand that without quality program reporting, the Department cannot learn about the value of your MHSA services and share successes with the State of New York. Magellan will empower the Department through a meaningful reporting suite that is also available online 24 hours a day, 7 days

a week with drill down capability. Magellan delivers a robust set of reports that meet core information requirements for our customers. Our Enterprise Data Warehouse includes information for more than 60 million enrollees that includes over 140 million claim lines and 19 million authorizations. In total, we hold more than 10 years of data.

Magellan draws upon this vast Data Warehouse (governed by Magellan security protocols and in alignments with all legislation pertaining to privacy) to deliver business information to customers. The Magellan Data Warehouse collects information in the form of clinical data; authorizations; claims and encounters; provider-based information; membership-related data; marketing-focused information; financial information; and data on customers, products, and services. The Data Warehouse transforms this data into an easily accessible format that makes business information available to the enterprise and to Magellan customers.

Magellan also posts reports on a secure, password-controlled Web site that the Department can view on a timely basis—the *Magellan Customer Dashboard*. Through the Dashboard, we provide actionable information so that the Department can monitor current utilization trends and predict future trends. The reports are available via the Internet and are password protected. Online summary information includes provider network data, services requested, claims payment timeliness, authorization summaries and norms, and utilization data by demographic categories. A Dashboard screenshot is provided below as **Figure A.1.b**.

Figure A.1.b: Magellan Customer Dashboard Screen Shot – Welcome Page



During implementation, Magellan will work closely with the Department to review available reports, develop customized reports the meet the Department's requirements. During the ongoing contract, the dedicated quality analyst working with the dedicated program manager, will further refine reports and information needs for the Department to ensure timely, relevant and accurate information is available to Department.

Magellan's reporting capabilities also support fraud and abuse detection. Magellan invests in ensuring that the infrastructure used to analyze data and review claims information is the best in the industry.

Jennifer Pierce, Senior Manager, Analytics and Programming will have overall responsibility for report development, enhancements and ad hoc reporting for the Empire Plan. Ms. Pierce manages a group of business analysts within the Analytic Services Department's Information Delivery group. This team partners with resources across the organization to gather, refine and document business requirements, test and validate automated reporting solutions, create and deliver ad hoc reports, and provide support to reporting analysts in other departments and worksites within Magellan. Ms. Pierce has over 19 years of experience in the managed care industry, with 18 of those years in IT, and 12 years with Magellan. Prior to joining Magellan, she held IT positions as a business analyst, and as a manger, with Sierra Military Health Services, United HealthCare of the Mid-Atlantic, and Chesapeake Health Plan.

(h) Consulting

EXPERT CONSULTATION

Magellan invests in maintaining industry expertise and leadership in identifying improvements in clinical quality, services, and cost management, and is continually evaluating improvements to benefit design in response to industry trends and to population needs. Magellan will work proactively with the state and with other industry experts to communicate and provide consultation on these trends and needs and work with the Department to develop advancements in benefit design.

To demonstrate our total commitment to assisting the Department with regard to consultation services needed, Magellan offers support through our organization's most experienced thought leaders via an Empire Plan-specific State Strategic Advisory Group (EPSAG), which will contribute strategically in an advisory capacity to the Department. Magellan's Empire Plan State Strategic Advisory Group will meet twice a year to strategically map the evolving needs of the Empire Plan and ensure that Magellan's products and services continue to be responsive to changing market forces. The members of Magellan's EPSAG will bring to the table over 200 years of combined health care involvement with provision of services for state employees and their family members, as well as for Medicare/Medicaid beneficiaries. The EPSAG will be led by Lynn Hamilton, SVP, Employer Solutions. Ms. Hamilton has nearly 20 years of health care experience which includes leadership roles in finance, account management, and business develop. She holds a Masters Degree

in Finance and Healthcare from the University of Connecticut and a CPA certificate in the State of Connecticut). Joining Ms. Hamilton in the EPSAG will be:

- Keira O'Brien, Magellan/Empire Plan Program Manager (Ms. O'Brien is currently responsible for successful management of the Preferred Drug List and ancillary programs for the largest Medicaid Program in the country as well as the New York Elderly Pharmaceutical Insurance Coverage Program. She was previously responsible for fiscal viability and property maintenance of an Office of Mental Health certified residential facility for individuals living with mental illness. She has an MBA from Rensselaer Polytechnic Institute and Lean Six Sigma Green Belt certification)
- Anne McCabe, Senior Vice President, Public Sector Solutions (Ms. McCabe, based in New York, has more than 30 years of working for provider organizations, state government, and private companies focusing on the behavioral health needs of individuals. She has held roles as Director of Managed Care and Governmental Relations and as Chief Of Staff Operations and Governmental Relations in the Commissioner's Office of the New York State Office of Mental Health. Ms. McCabe holds a master's degree in social welfare administration from the State University of New York, Albany and a bachelor's degree in psychology from Rutgers University.)
- Laurie Gondek, SVP Product Innovation (Ms. Gondek has nearly 30 years of health care experience which includes leadership roles in product development, marketing, sales and account management, strategy, mergers and acquisitions and operations.)
- Gary Henschen, M.D., Chief Medical Officer, Behavioral Health (Dr. Henschen has many years of experience in the behavioral health care field. He has previously held positions as an attending physician, as well as several senior medical leadership positions in hospital and managed care organizations.)
- Joann Albright, PhD., Senior Vice President of Quality Improvement and Outcomes and Research (Ms. Albright is a licensed psychologist in Pennsylvania and Colorado and a member of the National Council on Quality Assurance's Behavioral Health Measurement Advisory Panel.)
- Karen Friedman, Vice President, Account Management, Direct Contract Employer Accounts. (Ms. Friedman oversees a team of seasoned regional directors responsible for all account management functions. In addition, Ms Friedman has functioned as a dedicated account manager to the Federal Express MHSA and EAP account and has also worked as a director of clinical management as well as a clinical care manager.

Ms. Friedman holds a Masters of Social Work and has co-authored two parenting books published by Viking Penguin and Harper Collins and has been a contributing writer to Working Mother Magazine.)

Each of these EPSAG members would be pleased to offer full consultative services to the Department and key New York State employer representatives if the Department finds this agreeable. For example, Dr. Henschen will be available to provide updates regarding trends and the latest advancements in behavioral health treatment. He will also offer consultation regarding plan design changes and overall industry changes such as the recent changes to ICD-10 codes or issues related to Mental Health Parity. Ms. Gondek also has extensive expertise related to autism and the treatment of young adults, which she would be please to share with the Department in a consultative role.

In addition to the members of the EPSAG listed above, Magellan would be pleased to offer the Department access to Magellan professionals serving our other State clients to share successes and lessons learned.

Magellan would also be pleased to discuss including representation from the Department, the Office of Mental Health, and the Office of Alcohol and Substance Abuse Services.

Lynn Hamilton, Senior Vice President, Employer Solutions, whose bio is provided in response to *Question 1*, above, will have overall responsibility for Magellan's consultation services.

(i) Transition and Termination of Contract

Magellan understands the importance of seamlessly transitioning behavioral health care programs from one vendor to another with a focus on providing enrollees with uninterrupted access to their MHSA benefits and associated clinical and customer services. We assure the Department that in the event it decides to terminate services with Magellan we will provide seamless, proactive, responsive and helpful service throughout contract termination and program transition period, so that your enrollees will receive the highest customer service and your administrators will have the information needed to enable services smoothly with another vendor as needed. Of course, we also seek to work closely with the Department so that your needs are consistently met throughout the proposed contract period, as well.

Magellan has comprehensive written policies, guidelines, and account management tools available to all program managers and account executives regarding the specific tasks required both internally and in conjunction with our customers to assure all services are coordinated regarding contract

termination. Upon account termination, Magellan's dedicated program manager and senior account executive for the Empire Plan would work with the Department to develop a detailed, custom program termination and transition plan.

Keira O'Brien, Program Manager whose bio is provided in response to *Section A*, above, will have overall responsibility for functions related to transition and contract termination.

(j) Network Management

Magellan is proposing to provide a MHSA provider network that that meets or exceeds the Department's access standards by December 2013. We understand that the current MHSA Program includes a nationwide provider network through which enrollees can obtain all covered MHSA Program services. Magellan has the network oversight and development resources to insure that all access standards are met so that each enrollee can obtain the level and quality of care that Department expects. Magellan will dedicate a **team of locally based in the Albany Empire Plan Service Center** to manage the stability of the network as well as all aspects of provider relations. This team will be lead by **Christopher Mogan, Field Network Director**, who is also based in New York. Mr. Mogan already works daily to ensure New York provider satisfaction with Magellan and looks forward to supporting New York providers as they serve the Department and Empire Plan enrollees in 2014. Mr. Mogan oversees provider network composition and definition as well as provider relations and education. In his role, Mr. Mogan ensures the provider network meets the needs of the plan membership as well as maintaining a high quality and satisfied provider network. Mr. Mogan has over 14 years of managed care provider contracting and provider relations experience all of which have been at Magellan. Mr. Mogan began his career with Magellan as a Field Network Coordinator for New York State.

Magellan is pleased to offer the Department, and your enrollees, access to what we believe is the most comprehensive and responsive behavioral health provider network in the industry. Our national network is comprised of more than 74,200 licensed, credentialed providers and facilities—including psychiatrists, psychologists, licensed clinical social workers, marriage and family therapists, licensed nurse practitioners, other behavioral health care professionals, and Magellan-contracted facility-based behavioral health treatment programs—who provide care in all 50 states and Puerto Rico. This network offers comprehensive network coverage for Empire Plan enrollees and, in the few areas where increased coverage is necessary Magellan will execute our highly successful Network Development Plan to ensure timely recruitment in any underserved areas. In these areas, we have already begun to identify facility recruitment resources based on disruption analysis between Magellan's network and the current vendor's, and we are certainly willing to target recruitment efforts based on those analysis.

We will focus recruitment efforts and resources on current high volume facilities used by enrollees in these locations and conduct on-going continuous outreach efforts to secure contracts and achieve optimal geo-access results.

Magellan supports our provider network through localized orientation, contracting support, online informational and administrative tools, regional and local network management activities, and free access to continuing education.

Magellan notes that our behavioral health network is wholly owned and managed, therefore we have full control over the quality of the services that our providers and facilities deliver. Magellan contracts directly with all providers and facilities; we do not have intermediary contracts. Our single source network, which is managed by Magellan according to strict industry-established quality guidelines, offers true ease of service administration for the Department and improves quality of care by ensuring that enrollees are treated by appropriate qualified providers. In addition, Magellan is certified by the National Committee on Quality Assurance (NCQA) as a Credentials Verification Organization (CVO). The steps in Magellan's credentialing process include:

- **Completion of Network Application:** Prospective providers submit their applications in coordination with the Magellan field network staff.
- **Primary Source Verification of Credentials:** All information submitted is primary source verified by Magellan for initial applicants. Magellan's in-house legal staff thoroughly investigates any legal actions or sanctions imposed by licensing and or certification boards or professional societies.
- **Approval of Credentials:** Once primary source verification is completed, the provider's information is forwarded to a RNCC. The RNCC reviews the provider's application and pertinent Primary Source Verification information and renders a decision to accept the provider in Magellan networks

Provider quality assurance is of paramount importance and will be a major focus during the life of the contract. Magellan will provide a top level corporate resource to conduct periodic quality assurance reviews with the State. There will be constant feedback between New York State and Magellan on program delivery and support.

Maintenance of a robust fraud and abuse control program is also a key part of Magellan's administration of our programs and assurance of the highest integrity of the provider network. Magellan invests in ensuring that our protocols and techniques used to analyze data and review claims information are the best in the industry. Magellan has a mature provider oversight program and protocol for identifying risk areas and audit targets, developing audit plans, and quickly taking

action when warranted. Within our Security Department, Magellan maintains a sophisticated Special Investigations Unit (SIU), which is a member of the National Health Care Anti-Fraud Association (NHCAA). The SIU of the Security Department is responsible for detecting, preventing, and investigating suspected claims fraud and abuse by enrollees, providers or other entities. The SIU investigates allegations of provider claims fraud, including:

- Billing for services not rendered
- "Upcoding" (exaggerating diagnosis of services rendered)
- Unbundling
- Misrepresentation of non-covered services
- Duplicate billing

Every open case of detected offenses is monitored by the Director of the SIU every 30 days until resolution. This includes the development and monitoring of corrective action initiatives related to any confirmed instance of non-compliance, fraud, and abuse.

Because of our dedication and commitment to our network, we have a 90 percent provider satisfaction rate for 2012.

(k) Claims Processing

Magellan processes all claims through our Claims Adjudication and Payment System (CAPS), located at our Care Management Center in Maryland Heights, Missouri. Our CAPS system is developed and maintained by our in-house team of IT professionals. It is a system that supports all eligibility, benefit, and claim functions. Magellan supports the system internally and owns the source code, which allows maximum flexibility to modify the application as our business needs evolve. CAPS is linked to Magellan's clinical system, IP. This integration between the applications allows eligibility information to display in IP, ensuring appropriate authorizations. In addition, clinical authorizations load automatically to CAPS, facilitating timely and accurate claims processing and payment.

CAPS supports claims payment to authorized providers based on the authorizations stored in the clinical information system and can support payment to non-participating or non-authorized services as supported by the benefit plan. CAPS supports auto-adjudication of clean claims that are received electronically or submitted on paper.

The system and processes are tested and audited on an annual basis to meet Sarbanes-Oxley and Statement on Standards for Attestation Engagements 16 (SSAE 16) Service Organizations Controls 1 (SOC1) report requirements and demonstrates that Magellan has rigorous controls and safeguards in place.

Maintenance of Magellan's system is coordinated and performed by an in-house team of IT professionals. Because Magellan owns the source code to all our systems, it allows for complete control over the change management and maintenance processes, as well as a high degree of customization of the systems to match customer requirements.

The Department, Empire Plan enrollees and providers can look to Magellan for outstanding performance in behavioral health claims processing. Magellan's success in claims management is a function of both our long-standing industry experience and our current organizational claims volume. We process nearly 8 million claims per year at Magellan on behalf of thousands of large, complex customers that offer all models of benefit design. In this complex claims processing environment, where thousands of customers seek wholly unique plan designs and network allowances, **Magellan routinely meets our corporate standard of processing 99 percent of claims within 30 days**, and will meet the Department' performance guarantees pertaining to claims processing, noted throughout this proposal, as well. This experience, supported by our advanced Claims Adjudication and Payment System (CAPS)—which supports electronic billing and is now used for Magellan accounts nationwide —enables Magellan to process provider claims accurately and quickly for the Empire Plan. CAPS is a commercially developed claims system that supports all eligibility, benefit, and claim functions. Magellan supports the system internally and owns the source code, which allows maximum flexibility to modify the application as our business needs evolve. CAPS is linked to our clinical system (IP). This integration between the applications allows eligibility information to display in IP, ensuring appropriate authorizations. In addition, clinical authorizations load automatically to CAPS, facilitating timely and accurate claims processing and payment. CAPS is a robust claims pre-processing, adjudication, and administration system that Magellan has used since 1994. It allows for complete fraud protection, protection against duplicate payment, and many other key features. Essentially, it allows us to meet all of the Department' claims performance expectations with ease. In addition, Magellan's *MHSA-specific claims system* supports detailed analysis of the unique types of and levels of service within MHSA treatment, thus supporting much more sophisticated analysis and recommendations for Department' program and treatment modifications.

Magellan claims infrastructure and system capabilities allows us to meet stringent claims processing performance standards. Magellan's performance against claims standards in 2012 is provided in **Table A.1.b** below:

Joanne Lawrence, Vice President, Claims will have overall responsibility for claims payment and processing for the Empire Plan. As Vice President of Claims Operations, Ms. Lawrence oversees Claims Administration, Manual Eligibility, the Service Operations Mailroom and the Correspondence Production Unit. In her role, Ms. Lawrence establishes internal productivity and quality standards, ensures that Magellan's claims processing functions meet all contractual requirements, and manages benefits configuration and testing along with internal system conversions and new business implementations. Ms. Lawrence has over 26 years of insurance experience, of which 14 have been with Magellan. She began her career with Magellan as a Claims Manager. Prior to joining Magellan, Ms. Lawrence held numerous claims management and supervisory positions with Kirke-Van Orsdel, Inc., a Third Party Administrator.

(l) Clinical Management/Utilization Review

The clinical delivery of MHSA services reflects Magellan's "sweet spot" as a specialty BH vendor. We have more than 40 years of experience providing behavioral health services and our team of Magellan professionals has years of experience serving enrollees covered through government employer sponsored plans. We understand the unique nature of these enrollees and varied stresses serving as employees with government agencies that often have very public roles. We propose to meet the need of these enrollees through our clinical model, which is designed to create clinically efficient and effective solutions for improving behavioral health. We consider the enrollee's varying emotional needs – from general stress, parenting concerns, situational behavioral issues, and chronic behavioral disorders. Regardless of the nature of the enrollee's situation, we assist them in navigating the system and in clearly understanding their specific issue(s), which then allows us to connect them with the most appropriate services and/or providers. In addition, today's difficult economic environment potentially creates an additional barrier to services.

For this reason, it is more important than ever that we offer real-time services and referrals in multiple modalities; accordingly, in addition to providing telephonic programs and a comprehensive continuum of care management services, we also provide online clinical modules and online self-assessments to steer the enrollee to programs that meet their individual needs.

Magellan recognizes the complexity of the Mental Health needs for both the patient and the family members. A successful initial call to the Clinical Referral Line can literally mean the difference between life and death. Clinical Management is an important strength that Magellan brings with our outstanding team of medical professionals. The clinical referral line will be staffed with the most qualified professionals in the field to ensure that critical situations are triaged as soon as possible. Follow up clinical monitoring will ensure that the coordination of care is meeting its intended purpose.

Magellan offers the Department a team of fully dedicated licensed clinicians who will handle calls to the CRL 24 hours a day/seven days a week, determine the medical appropriateness of care and direct enrollees to the most appropriate network provider and level of care. All clinical staff and Magellan providers will follow formal procedures to determine medical necessity in advance of inpatient and alternative level of care admissions whenever Magellan receives advance notice of the admission.

The clinical team serving the Empire Plan will consist of three care managers based in the Albany Empire Plan Service Center who will primarily handle calls to the Clinical Referral Line and provide clinical support to customer service associates. This team will be supported by a larger clinical team that will also handle Clinical Referral Line calls and perform care management activities in Magellan's Tristate Care Management Center. All clinical staff serving the Empire Plan will ultimately report to **Julia Linkova, Clinical Director**. As Clinical Director, Ms. Linkova oversees care management, appeals, and ambulatory follow up teams. In her role, Ms. Linkova is responsible for the clinical results of the Tristate Care Management Center, including all utilization and care management programs and outcomes, assuring the delivery of high quality and cost effective care and services that meet contractual obligations. Ms. Linkova has been with Magellan for over 10 years assuming progressively more responsible positions ranging from care manager to care management supervisor to her current position. Ms. Linkova has over 25 years of experience in the mental health field. She also completed a three-year Organizational Development program at the University of Cincinnati.

The dedicated Albany Empire Plan Service Center will employ the Avaya S8700 system for phone and for voice services. Monitoring of call center activity is achieved by utilizing CMS real-time and historical reports, which allows Magellan to make staffing and call routing changes intraday based on the performance of the calls. Further, these reports are also stored in a file that allow for viewing,

printing or scheduled for printing at a later time. Call data tracked includes caller identification, service parameters including all performance guarantee parameters related to call handling, internal call transfers, outgoing calls, and agent activity. Real-time reports can be updated as often as every five seconds and summarized every 30 minutes.

At the center of all the behavioral health programs offered by Magellan is our commitment to providing superior clinical care based on sound protocols, cutting edge research, and a sincere desire not only to bring enrollees to levels of optimum health, but also to support our health plan customers as they evolve and grow. Here are the reasons Magellan's clinical services will add value to the Empire Plan:

- **Specialized care management:** All clinical management functions at the Albany, New York Service Center and Tristate Care Management Center are delivered by highly qualified, experienced behavioral care managers or peer advisors, all of whom are licensed mental health professionals who will welcome enrollees into the program and sensitively guide them to the most appropriate type and level of care they need.
- Magellan **assesses real-time clinical outcomes and risk** information using the Consumer Health Inventory (CHI) assessment tool (the industry leading tool for comprehensive, enrollee-centered outcomes measurement data) assessments, given to enrollees during the course of their behavioral care. Feedback on the forms is electronically tracked, showing real-time enrollee engagement and risk.
- Our program offers **Welcome Home Call** designed to ensure enrollees have everything in place for an effective discharge from higher levels of care and will successfully transition to their next care setting.
- Our **outpatient utilization review process** applies a number of clinically derived algorithms to outpatient registration data that when triggered, alert our clinical staff to possible under- or over-utilization or quality of care issues that require further review, consultation and/or care advocacy.
- Case review also includes our unique **Intensive Care Management (ICM)** program that identifies at-risk enrollees and barriers to engagement within higher levels of care.
- All Empire Plan enrollees can perform **self-assessment using screening tools available on our Web site**, MagellanHealth.com/member. The site then refers enrollees to Magellan and other resources.
- Magellan will establish **formal cross-referral protocols** with each of the Empire Plan's relevant vendors or work teams with the goal being creating ways to ensure enrollees have access to all applicable services in the most seamless fashion.

Continuous quality improvement is an important component of Magellan's clinical and adjunct programs. Magellan's Quality Improvement (QI) Program includes systematic monitoring of the quality and safety of services and care provided to the enrollees of our customer organizations. The Magellan QI program accomplishes its mission and promotes its vision through the implementation of a results-oriented focus on Continuous Quality Improvement. The QI Program Description is a dynamic document that is responsive to the voices of stakeholders, flexible in its actions, and readily modifiable as conditions warrant. Magellan also has over 10 years of experience with supporting our partner health plan's **HEDIS** reporting. Our centralized HEDIS support services, dedicated operations, IT and clinical staff, along with our dynamic HEDIS measure support products have proven success.

Jeanne Bachmann, **Quality Improvement Director** will have overall responsibility for the Empire Plan Quality Improvement Program. Ms. Bachmann is responsible for the monitoring and reporting performance on quality improvement indicators, the development of Quality Improvement Activities, compliance with accreditation standards, and the entire customer reporting process. With more than 25 years of experience in behavioral health care, including several positions at the senior management level, Ms. Bachmann has expert knowledge of the quality improvement process, from top to bottom. Prior to joining Magellan, Ms. Bachmann advanced through a series of more challenging positions in the behavioral health industry, including Director of Client Services, Director of Quality Management, and Assistant Vice President of Operations. Ms. Bachmann earned her master's degree in social work from the University of Michigan, and has a dual B.S. degree in psychology and sociology from Central Michigan University. She is a licensed social worker in the State of Michigan, accredited through the Academy of Certified Social Workers (ACSW), and a member of National Association of Social Workers (NASW).

If the proposed organizational structure has been used in administering the program of another client, provide the client's name and include the client as a reference as required in Exhibit I.V.

Magellan has a similar structure in place for the State of Tennessee including dedicated account management and dedicated customer service and clinical teams. We have included the State of Tennessee as a reference in *Exhibit I.V*.

2. General Qualifications of the Offeror

The MHSA Program covers over one million lives and incurs costs in excess of $160 million annually. The Offeror/ Contractor must have the experience, reliability and integrity to ensure that each Enrollees' mental health and substance abuse care needs are addressed in a clinically appropriate and cost effective manner. The terms of the Offeror's proposal must demonstrate explicit acceptance of and responsiveness to the MHSA Program's duties and responsibilities set forth in the RFP, ensuring full compliance with the MHSA Program Services.

A. Required Submission

The Offeror must demonstrate that it has the wherewithal to administer the MHSA Program as required by this RFP. Please provide detailed responses to the following:

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

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

As evidenced in the organizational chart provided at the end of this response, the implementation process and ongoing account management is designed to ensure a seamless administrative, operational, and clinical program for the Department and a smooth transition for your enrollees.

Keira O'Brien, Program Manager, will own the business relationship with the Department and serve as the Department's single point of contact for all organization support needs on a day to day basis. She will serve as a liaison between the Department and the wealth of resources and support provided by Magellan's various operating/support services units. She will coordinate all services for the Department, ensuring excellence in service delivery and rapid response to all inquiries. The Department will also have ongoing contact with key Magellan operations leaders through face-to-face meetings.

Magellan also believes that the key to a successful partnership with the Department lies with our ability to integrate our programs and services and to communicate frequently and effectively. We would be please to work with the Department discuss implement one or more of the following committees:

- Strategic Council Meetings – This is an executive level committee that meets face to face on a semi-annual basis. The role of this group is to review overall results of the behavioral health program, review industry trends/direction and, most importantly, to review and discuss the strategic direction of both organizations to ensure continued alignment of our goals.
- Clinical Collaboration Committee – This clinically focused group would meet quarterly to review the performance of all of the clinical programs supporting the Department. Our clinical programs are the heart and soul of Magellan's offering and we must continue to evaluate the relevance of our programs for the Empire Plan membership on an ongoing basis, jointly discuss and commit to program enhancements, and to ensure that program innovation remains strong and on target to meet the Department's goals and objectives.
- Joint Operating Committee (JOC) -- These face-to-face meetings will serve as an important communication vehicle for the program and a resource for discussing program issues, reporting data, new products, and any other important Department account matters.

We propose holding monthly Joint Operating Committee meetings during the first year of the Department/Magellan relationship— moving to quarterly meetings in the second year.

These meetings will be scheduled and chaired by Keira O'Brien, Program Manager.

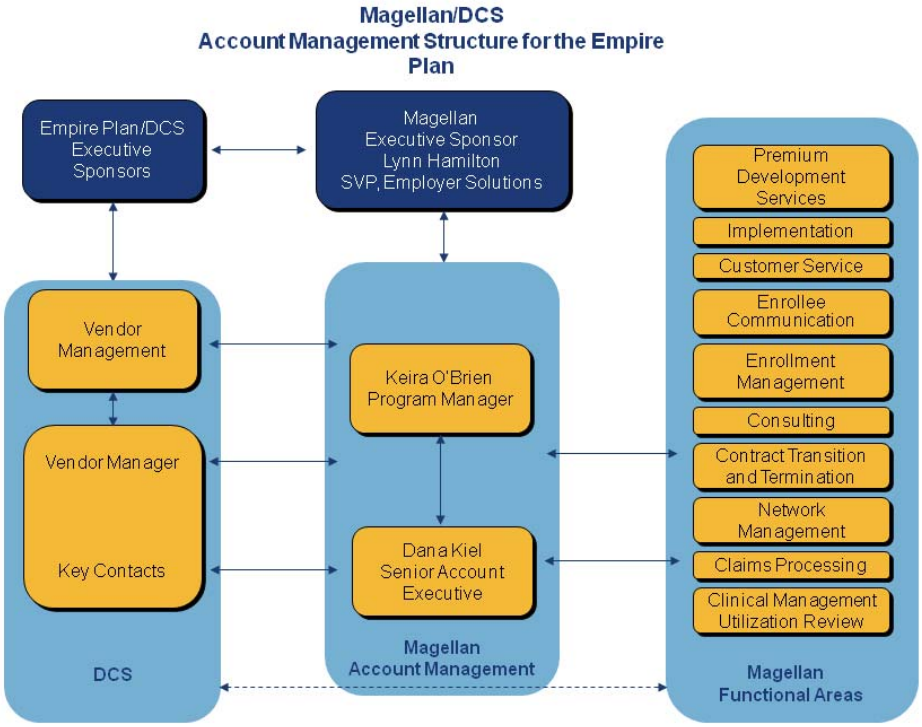
OVERLAP OF IMPLEMENTATION AND ACCOUNT TEAMS

Magellan's account team members are always part of the implementation team as well. Keira O'Brien will play a central role in the implementation of the Department Account. Ms. O'Brien will work closely with the Department implementation lead to lay the foundation for an effective implementation. She will be involved in the implementation kick-off meeting, implementation status update meetings, and appropriate functional workgroup meetings with subject matter experts. She will work in conjunction with the Sandi Morter, Senior Implementation Manager on all implementation activities, thus ensuring a structured, proven implementation process.

To further illustrate the overlap between implementation and account management, it is important to note that the implementation team will continue to meet and coordinate with the account management and operations team for six to nine months following the program start date.

An overview of Magellan's Account Management Structure is provided in **Figure A.2.a** below.

Figure A.2.a: Magellan's Account Management Structure



(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?

MAGELLAN AUDITS AND OVERSIGHT

Magellan will ensure smooth financial, legal and audit oversight of this contract through regularly established communication from the Magellan Program Manager, based on site in the Albany Service Center The Magellan Program Manager will always serve as the Department's first point of contact for any of the above concerns.

Magellan will ensure all financial, legal and audit measures are undertaken to ensure compliance at all times in accordance with the contract and with all applicable law. Magellan has many systems in place to ensure quality, compliant services for our customers, many of whom are states. This includes the following:

INTERNAL AUDITS

Magellan maintains a fully staffed internal audit department. The department is responsible for ensuring an effective evaluation of internal controls, assessing risks and executing an internal audit plan based on the assessment of those risks. Magellan complies with the requirements of the Sarbanes Oxley act of 2002, which significantly expanded the rules for corporate governance, disclosures and reporting. The act requires management of a public company and the company's independent auditor to each issue a report at the end of every fiscal year. Magellan's management must report annually on the effectiveness of the company's internal control over financial reporting, and, in conjunction with the audit of the company's financial statements, Magellan's independent auditor must also issue a report on internal control over financial reporting. The auditor's opinion is included in the Form 10K filed with the Securities and Exchange Commission. Further, as a publicly traded company, Magellan is subject to an independent audit of the financial statements by external auditors.

CORPORATE COMPLIANCE

Magellan also has a comprehensive and thorough compliance program to ensure that the organization acts in accordance with all state and federal laws and with the interpretation of those laws by state and federal regulatory agencies. Magellan has developed a full range of policies and procedures that guide our compliance efforts.

Magellan's compliance program has the following features in place:

- Corporate Compliance Handbook
- Corporate Compliance Employee Certification (requiring employee signatures)
- Corporate Compliance Helpline
- Special Investigations Unit—Active for internal investigations, as well as provider and customer investigations for fraud
- Fraud Hotline
- Implementation of a point of contact (POC) model and establishment of privacy contacts (with a direct reporting relationship to the Chief Compliance Officer), which complies with HIPAA regulations).

Magellan has a Chief Compliance Officer, who is responsible for compliance and privacy at each Care Management Center, as well as regional compliance officers. In addition, Magellan has specific POCs with the Corporate Compliance Department, who have monthly meetings with each Care Management Center in which issues are discussed and handled as they arise.

COMPLIANCE DEPARTMENT FUNCTIONS

The Chief Compliance Officer at Magellan in turn reports to the Magellan Compliance Committee, which consists of Magellan's executive vice presidents, and to the Board of Directors' Audit/Compliance Committee. Auditing activities performed by Compliance Department involve monthly customer audits and quarterly audits from government agencies, with ERISA and HIPAA driving the primary functions. (Magellan's auditing contacts from such agencies as CMS are infrequent due to our subcontractor status with health plans.) Audits cover a wide range of assessments—from payment issues, to the speed of answer in Customer Service, to the adequacy of physician and provider coverage for a given geographic area. Magellan also is audited by state agencies that are Magellan customers.

All of Magellan's compliance specialists/points of contact have been cross-trained in the areas of claims, auditing, correspondence, and appeals, as well as being prepared for conducting proper audits. The same individual in each region manages the compliance specialist and point-of-contact roles.

OTHER AUDITS AND REVIEWS

Magellan customers are continuously auditing and reviewing Magellan's services, creating the need for Magellan maintain a fluid audit relationship with our customers. The Magellan Compliance Department routinely receives requests for audits. When this happens, the Chief Compliance Officers in the Care Management Centers are able to pull the appropriate information for the audits and work directly with customers' or agencies' to process audit requests. Such services as creating computer spreads, sampling, and conducting a review of parameters can be provided for customers if there is requested information on audits that affects their business.

As a leading national managed care company, Magellan is subject to continuous reviews, audits, notices, claims, and communications from federal and state agencies and third-party payors. If at any time Magellan is found by an internal audit or an external reviewing party to be out of compliance, a corrective action plan is immediately developed and submitted to the party as appropriate.

Magellan is also able to accommodate audits by the Department at any time.

MAGELLAN COMMUNICATION WITH THE DEPARTMENT

As part of program implementation, Magellan will ensure that all staff responsible for audit and compliance functions within Magellan provide direct reporting to both the Magellan Program Manager and Magellan's Empire Plan Quality Improvement Committee (QIC) so that the Program

Manager and the QIC can track all audit outcomes and determine if and when any corrective action is needed. The Magellan Program Manager will communicate any issues of concern to the Department immediately.

B. Proposed Empire Plan MHSA Program Services

In this section, the Offeror must demonstrate its capacity to provide the required services for administration of the MHSA Program.

1. Account Team

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.

a. Duties and Responsibilities

(1) The Contractor must maintain an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the MHSA Program during implementation and operation.

Magellan confirms we meet this requirement.

(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;

Magellan confirms we meet this requirement.

(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.

Magellan confirms we meet this requirement.

(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;

Magellan confirms we meet this requirement.

(b) immediately notify the Department in writing of actual or anticipated events impacting MHSA Program costs and/or delivery of services to Enrollees such as but not limited to, legislation, class action settlements, and operational issues).

Magellan confirms we meet this requirement.

(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.

Magellan confirms we meet this requirement.

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

Magellan confirms we meet this requirement.

B. REQUIRED SUBMISSION

(1) Provide an organizational chart and description illustrating how you propose to administer, manage, and oversee all aspects of the MHSA Program. Include the following:

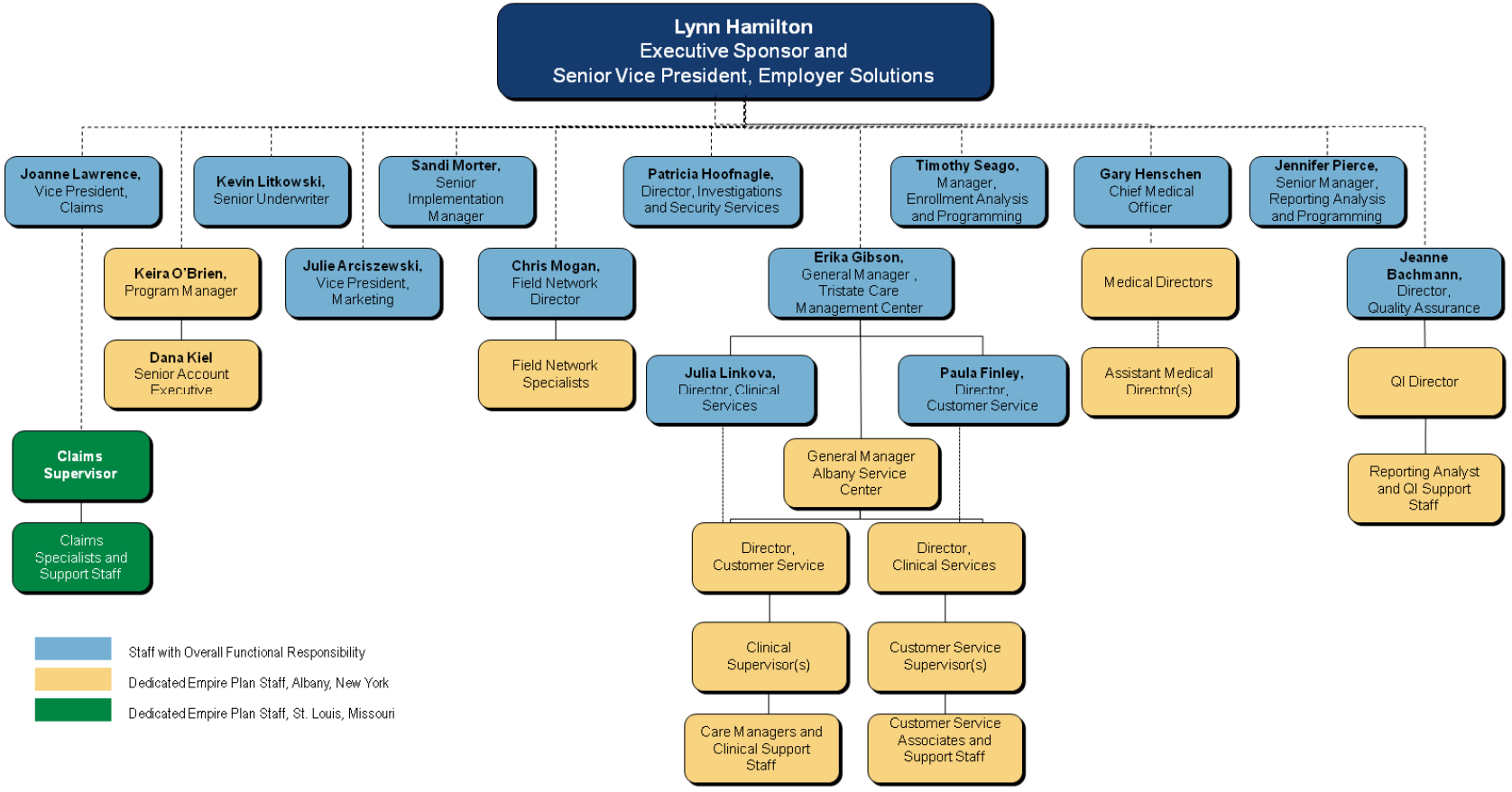
(a) Reporting relationships and the responsibilities of each key position of the account management team; and how the team will interact with other departments such as the call center, clinical services, reporting, auditing, and network management within your organization. Describe how the account management team interfaces with senior management and ultimate decision makers within your organization;

ADMINISTRATION, MANAGEMENT, AND OVERSIGHT OF YOUR PROGRAM

Magellan agrees with our customers that a strong, responsive account administration team is central to the success of any managed behavioral health program. For the Empire Plan, Magellan plans to provide primary account administration via a successful account management team based in the State of New York. Magellan offers significant experience working with public employer customers like the Department and helping many of those customers transition easily and successfully to our programs.

Magellan has carefully thought about how to structure your account service team and align the program with our highest qualified staff while taking into consideration your need for local service in New York. We provide an organizational chart on the following page that illustrates the proposed Magellan account management structure, key positions within the proposed account management team, and direct reporting relationships. We agree with the Department that your account management and program administration approach inherently needs to combine direct interface with all operations departments, so that any service issues and program planning can be accomplished quickly and seamlessly. To that end, our organizational chart demonstrates how our account management team includes key organizational leaders at Magellan, who will handle all operational aspects of this account, and whose work teams would be responsible for executing some of the Empire plan's most critical program activities. This team of senior leaders and account management executives within Magellan will work with all operational work teams as needed from point of program transition to contract delivery and throughout the length of the relationship.

Figure B.1.a: Account Team Organizational Chart



Responsibilities of your Program Manager include the following:

Advocate and Liaison

- Spearheads all program implementation activities and coordinates Magellan teams as needed
- Coordinates all aspects of contracting and associated activities, including contract renewal
- Gathers, maintains, updates, and distributes the Empire Plan information to all relevant Magellan departments in a timely and continuous manner
- Addresses and resolves all service delivery issues in a timely and comprehensive manner
- Ensures that all aspects of Magellan's services continually add value to the Empire Plan's program
- Facilitates strategic activities to support the Empire Plan's objectives and key initiatives
- Formulates new ways to enhance the value of services
- Provides timely program reporting and quality oversight
- Provides New-York based service and accessibility
- Directs the Empire Plan feedback into Magellan's product development activities

Strategic Consultation

- Coordinates Empire Plan administrators' consultation with Magellan leadership
- Provides expert consultation on relevant industry and workplace issues, for example, Threats of Violence, Mental Health Parity Legislation, HIPAA, DOT regulations, Drug-Free Workplace
- Assists the Empire Plan with both routine and crisis-related needs
- Develops an annual Customer Business Plan that outlines Magellan activities aligning with the Empire Plan's business objectives, to continue to achieve high levels of customer satisfaction among the Empire Plan employees and family members
- Communicates with the Empire Plan on Magellan initiatives and enhancements

Utilization and Claims Reporting Review

- Coordinates reporting elements based on the Empire Plan's needs

- Ensures timely delivery of all utilization reports, including online Customer Dashboard access, to the Empire Plan
- Provides consultation on the Empire Plan trends vis-à-vis Magellan's book of business, market sector utilization, overall industry direction, and other relevant areas
- Offers strategic guidance highlighting opportunities to help the Empire Plan maximize the value of Magellan's services
- Works with Magellan's in-house Medical Economics team and the proposed full time Empire Plan Research Analyst to provide timely, meaningful reports for the Department

Program Promotion and Workplace Training

- Offers guidance around effective use of promotional materials
- Provides consultation on relevant workplace training topics
- Coordinates and facilitate the delivery of on-site or online training events and health fair participation
- Offers specialized communication materials in response to natural disasters or other events that impact the workforce

ACCOUNT TEAM INTERACTION WITH MANAGEMENT AND OTHER DEPARTMENTS

To simplify activities for the Department, we do recommend that Magellan's dedicated Program Manager serve as the *initial* point-of-contact for the Department for all of your questions, needs, and concerns. Once the Magellan Program Manager receives notification from the Department regarding any issue, Magellan offers full, fast response regarding the issue. The Magellan Program Manager will work collectively with members of Magellan's clinical, customer service, claims or other operations staff within Magellan to ensure timely resolution of any concern and will prove follow-up on all issues.

Operational leadership, listed within the organizational chart provided in this proposal section, is also available to the Department for program consultation and review as needed. With significant health care and leadership experience, Magellan operations leadership, including claims, networks, clinical and legal management, is confident in our ability to assist the Department in a seamless and smooth program transition and program delivery. Interface between the Magellan Program Manager and lead operations staff at Magellan will occur telephonically, via e-mail and in person as needed, based on the scope of the situation needing attention.

The Magellan program manager is *centrally positioned within the account service organizational structure* to afford optimal interaction with other departments such as the Magellan Empire Plan Service Center, clinical services, reporting, quality, and network management. Efficient internal interface with other departments and areas of expertise allows for a quick response to the needs of the Department and for harnessing creative programmatic solutions for the Department and for all Empire Plan enrollees.

The Empire Plan's Account Management Team interface with senior operations management will also occur via an Empire Plan Quality Improvement Committee that will be put into place at Magellan as part of this new program implementation.

We understand that quality and performance are of the utmost concern. The Magellan account management team has a wealth of resources available to monitor the Empire Plan program's performance daily. For example, through Magellan's internal clinical and customer service intranet Web site, called "MagIC" (Magellan Information Center), the Program Manager and call center operations team can monitor daily, weekly or monthly call activity and performance at a glance and a click of the mouse, among a host of other features. We are certainly able to demonstrate this tool for the Department should we be fortunate enough to be selected as a finalist in the bidding process. In addition, your account management team will also receive regular operational program reporting regarding all aspects of program service and performance to track your programs' success. Account Executives also have an online (internally used) "Tools and Resource" kit that provides them with one-click access to the latest program promotional materials to share with customers, updates on policies and procedures, information on trends in healthcare and legislation, and templates for the development of customer-specific communications.

(b) Names, qualifications, and job descriptions of those individuals selected to comprise the operational and clinical account and management team for the Offeror. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key members of the proposed account and management team;

ACCOUNT MANAGEMENT PERSONNEL

Magellan proposes to implement a team approach to account management for the best service of the Empire Plan, with Magellan's internal account management and operations teams executing on all key deliverables for the program. At Magellan, each large employer customer benefits from the combined and focused services of their Program Manager and a Senior Account Executive. Our service model is tailored to allow the Program Manager to work alongside senior members of our medical and behavioral clinical leadership, as well as our quality and network management team, to

consult with customers on complex issues such as benefit design, network education, provider services, enrollee outreach and education and program development.

We have provided the names, titles, and biographies of key Magellan individuals who will comprise the operational and clinical account and management team for the Empire Plan below. Qualifications of these individuals are also provided in the completed Biographical Sketch Forms (Exhibit I.B) provided as **Appendix A**. Job descriptions are provided as **Appendix D**.

- **Lynn Hamilton Senior Vice President, Employer Solutions** will serve as the Executive Sponsor and senior officer who will be responsible for the Empire Plan. Ms. Hamilton is responsible for the oversight of all existing account relationships and new business development between Magellan and our employer customers. Responsibilities include overall account profit and loss, product strategies, relationship management, and service delivery. She has been at Magellan since January, 2010. Prior to joining Magellan, she was Vice President at CIGNA Healthcare where she held a variety of leadership roles with increasing responsibility during her 10-year tenure including financial roles and account management and business development oversight. Before CIGNA, she held senior financial roles at MedPartners in the physician practice management industry. Ms. Hamilton received her B.S. in Accounting from Fairfield University and a Masters Degree in Finance and Healthcare from the University of Connecticut. She holds a CPA certificate in the State of Connecticut and began her career at Ernst & Young, LLP.

- **Keira O'Brien, Program Manager** will serve as the primary point of contact for the Department, serving as the advocate within the company to ensure a successfully managed contract. She is currently responsible for successful management of the Preferred Drug List and ancillary programs for the largest Medicaid Program in the country as well as the New York Elderly Pharmaceutical Insurance Coverage Program. She was previously responsible for fiscal viability and property maintenance of an Office of Mental Health certified residential facility for individuals living with mental illness. She managed all aspects of a Pharmacy Benefit Program for participants diagnosed with mental illness; customer service, claims processing, formulary management, finance, provider relations, and eligibility/enrollment. She received her MBA from Rensselaer Polytechnic Institute and her BA from Russell Sage College. More recently, she obtained Lean Six Sigma Green Belt certification and Accounting Certificate from Siena College. She actively follows industry and healthcare trends via various trade publications and seminars.

- **Dana Kiel, Senior Account Executive** is currently the Senior Account Executive on the Horizon State of New Jersey Account (SHBP) and has worked on the account for the past two years. The account covers close to 600,000 members. She works as a team with the Horizon Account Executives to support the State Educators, Local Government and State Government employees. Her support covers Horizon interactions with the Department of

Pension and Benefits, the State Department of Banking and Insurance as well as the State Commission that serves as an external appeal in matters of behavioral health coverage. She has been with Magellan since 2011 and brings to Magellan more than 20 years experience in behavioral health, national account management, sales and EAP clinical supervisory roles. Ms. Kiel holds a Masters in Social Work (MSW) and is also a Certified Employee Assistance Professional (CEAP). Her postgraduate training was concentrated in chemical dependency at the Psychoanalytic Psychotherapy Study Center; couples and family training at the Ackerman Institute; and critical incident/disaster training with the American Red Cross. Prior to joining Magellan, Ms. Kiel was national account manager with CIGNA Health Solutions, a role she held for six years. As national account manager, she managed 10 national accounts. Her main customers were JP Morgan Chase, Honeywell, BASF and CIGNA Corporation. Ms. Kiel's experience with large national employers and the State of New Jersey account has given her an understanding of complex service delivery systems and the importance of understanding the diverse needs of members from different groups within a customer. In addition, her clinical background and previous work with individuals and groups with mental health and chemical dependency problems has contributed to her abilities as a member advocate. This combination of these macro and micro view points will make her a successful Senior Account Executive for the State of New York.

- **Kevin Litkowski, Senior Underwriter** will assist the Department in the determination of Initial Premium and subsequent Renewal Premium Rates. As a Senior Underwriter at Magellan, Mr. Litkowski is involved in the transformation of Client Data into projections of Care. He also coordinates the input of Clinical Operations, Finance and Network and Claims Operations areas into determining a Final Premium Rate. Mr. Litkowski has been employed as an Underwriter at Magellan for five years, during which time he has underwritten for all manner of Magellan products, specializing in behavioral health and radiology benefit management. Prior to Magellan, Mr. Litkowski worked for MAMSI Health Care, which later became part of United Health Care. During his 12 years, he worked in the Underwriting and Actuarial Analysis Departments.

- **Joanne Lawrence, Vice President, Claims** will have overall responsibility for claims payment and processing for the Empire Plan. As Vice President of Claims Operations, Ms. Lawrence oversees Claims Administration, Manual Eligibility, the Service Operations Mailroom and the Correspondence Production Unit. In her role, Ms. Lawrence establishes internal productivity and quality standards, ensures that Magellan's claims processing functions meet all contractual requirements, and manages benefits configuration and testing along with internal system conversions and new business implementations. Ms. Lawrence has over 26 years of insurance experience, of which 14 have been with Magellan.

She began her career with Magellan as a Claims Manager. Prior to joining Magellan, Ms. Lawrence held numerous claims management and supervisory positions with Kirke-Van Orsdel, Inc., a Third Party Administrator.

- **Sandra Morter, Senior Implementation Manager** plays an integral role in implementing Magellan accounts and products for our customers. Ms. Morter has experience implementing Health Plans, Public Sector and Commercial accounts as well as experience with government and military implementations. She has more than fourteen years' tenure with Magellan. Prior to undertaking her current responsibilities, she served as clinical manager for one of Magellan's largest customers, supervising inpatient, outpatient, and drug-free workplace staff. She also provided on-site EAP services and training for a large government-based account. A graduate of the University of Missouri (St. Louis), she has a master's degree in counseling, a master's degree in rehabilitation counseling and has worked in the field of general counseling and substance abuse for 25 years. Ms. Morter has led or participated in the implementation of several large complex contract include programs for the State of Tennessee, the State of Louisiana, WellCare, Blue Shield of California, and Magellan Complete Care of Florida (Magellan's full service Medicaid health plan that includes coverage for physical health, behavioral health, dental services, transportation, and eye care).

- **Gary Henschen, M.D., Chief Medical Officer, Behavioral Health** will supervise the two Albany based Medical Directors and the consulting peer advisors. As chief medical officer of behavioral health, Gary Henschen, M.D. oversees all clinical programs within Magellan Health Services. He is responsible for updating medical necessity criteria, maintaining liaisons with partner health plans, and coordinating quality improvement and prevention activities with all care management centers. Developing training programs for primary care physicians in behavioral health issues, and expanding programs in medical-behavioral health integration are primary assignments for Dr. Henschen. Formerly Dr. Henschen served as the Medical Director for Magellan's Southeast Care Management Center. In this role, he coordinated mental health prevention and quality improvement activities with health plan medical directors. He also provided ongoing clinical supervision to Magellan's physician advisors. Dr. Henschen has many years of experience in the behavioral health care field. He has previously held positions as an attending physician, as well as several senior medical leadership positions in hospital and managed care organizations. Dr. Henschen obtained his medical degree from the University of North Carolina School Of Medicine, and completed his residency in psychiatry at Duke Medical Center. He received board certification in 1983 and is licensed in Pennsylvania, New Jersey, North Carolina, Georgia, Iowa, and Tennessee. Dr. Henschen is a member of the American College of Physician Executives; the American Psychiatric Association; The American College of Psychiatrists; and the American Psychoanalytic Association.

- **Erika Gibson, General Manager, Tristate Care Management Center** will provide management oversight of the Albany-based Empire Plan Service Center and supervision of the Albany Care Management Center General Manager. Dr. Gibson joined Magellan in 2012. Prior to her career at Magellan she served as Director of Operations for APS Healthcare where she was responsible for leadership to oversee and ensure operational compliance with business, financial, quality, and employment objectives. Dr. Gibson has also held executive positions with Matria Healthcare and the Coca-Cola Company. She holds a Bachelor of Science in Biology from Dillard University, a Master of Science in Health Science Administration from Central Michigan University and is a Doctor of Chiropractic Medicine.

- **Julia Linkova, Clinical Director** oversees care management, appeals, and ambulatory follow up teams. In her role, Ms. Linkova is responsible for the clinical results of the Tristate Care Management Center, including all utilization and care management programs and outcomes, assuring the delivery of high quality and cost effective care and services that meet contractual obligations. Ms. Linkova has been with Magellan for over 10 years assuming progressively more responsible positions ranging from care manager to care management supervisor to her current position. Ms. Linkova has over 25 years of experience in the mental health field. She also completed a three-year Organizational Development program at the University of Cincinnati.

- **Jeanne Bachmann**, **Quality Improvement Director** will have overall responsibility for the Empire Plan Quality Improvement Program. Ms. Bachmann is responsible for the monitoring and reporting performance on quality improvement indicators, the development of Quality Improvement Activities, compliance with accreditation standards, and the entire customer reporting process. With more than 25 years of experience in behavioral health care, including several positions at the senior management level, Ms. Bachmann has expert knowledge of the quality improvement process, from top to bottom. Prior to joining Magellan, Ms. Bachmann advanced through a series of more challenging positions in the behavioral health industry, including Director of Client Services, Director of Quality Management, and Assistant Vice President of Operations. Ms. Bachmann earned her master's degree in social work from the University of Michigan, and has a dual B.S. degree in psychology and sociology from Central Michigan University. She is a licensed social worker in the State of Michigan, accredited through the Academy of Certified Social Workers (ACSW), and a member of National Association of Social Workers (NASW).

- **Paula Finley, Director of Customer Service** is responsible for the performance of a team of employees that includes customer service supervisors, associates, a care assist team, and support associates. Ms. Finley establishes performance goals and quality standards for staff and ensures they are met. She leads customer service teams in the successful delivery and execution of services to meet client commitments and contractual obligations. She also

develops and implements creative processes and service solutions that address performance issues and enhance efficiency and service excellence. Ms. Finley has been a valued employee of Magellan since 1995, assuming progressively more responsible positions ranging from claims auditor to customer service manager to her current position. Ms. Finley graduated from Covenant College in Georgia with a B.S. in Organizational Management. Reporting to Ms. Finley will be a Director of Customer Service based onsite at the Albany Empire Plan Service Center.

- **Christopher Mogan, Field Network Director** is also based in New York. Mr. Mogan already works daily to ensure New York provider satisfaction with Magellan and looks forward to supporting New York providers as they serve the Department and Empire Plan enrollees in 2014. Mr. Mogan oversees provider network composition and definition as well as provider relations and education. In his role, Mr. Mogan ensures the provider network meets the needs of the plan membership as well as maintaining a high quality and satisfied provider network. Mr. Mogan has over 14 years of managed care provider contracting and provider relations experience all of which have been at Magellan. Mr. Mogan began his career with Magellan as a Field Network Coordinator for New York State.

- **Julie Arciszewski, Vice President, Marketing** will have overall responsibility for all marketing and communications activities for the Empire Plan. As Vice President of Marketing, Ms. Arciszewski oversees all communications, marketing, education and consultative services related to building awareness and utilization including print, email, event, and web marketing. In addition, her team can provide marketing consultative services to support educational campaigns as required. Ms. Arciszewski uses market research, proven marketing techniques and information obtained in partnership with clients to create marketing plans and campaigns that drive program awareness and utilization. Her team is responsible for marketing that supports over 30 million individuals in varied industries including retail, technology and service as well as a number of government agencies. Ms. Arciszewski has over 25 years experience marketing to individuals and groups. Prior to joining Magellan, she worked in the financial services industry marketing insurance products, annuities and 401(k) plans. She has both an undergraduate and graduate degree in marketing.

- **Patricia Hoofnagle, Senior Director, Investigations** will be responsible for working with all operations staff at Magellan to ensure all fraud information and reporting is conveyed in accordance with the Empire MHSA contract. Ms. Hoofnagle is responsible for conducting investigations at Magellan concerning corporate compliance issues, security violations, and infractions of company policy. She is also responsible for Magellan's physical and personnel security programs as well as the Special Investigations Unit that is responsible for the identification and investigation of alleged fraud and abuse by providers and members. Ms. Hoofnagle has been with Magellan in various roles since 1995. Prior to joining Magellan, she

worked in direct care with children and adolescents with chronic mental illness. She has her BS in Social Work and her MS in Computer and Information Sciences. Ms. Hoofnagle is an active member of the Maryland Association of Certified Fraud Examiners (CFE-MD) and a Corporate Representative to the National Health Care Anti-Fraud Association (NHCAA), for which she participates in NHCAA's behavioral health standards development workgroup.

- **Jennifer Pierce, Senior Manager, Reporting Analytics and Programming** will have overall responsibility for report development, enhancements and ad hoc reporting for the Empire Plan. Ms. Pierce manages a group of business analysts within the Analytic Services Department's Information Delivery group. This team partners with resources across the organization to gather, refine and document business requirements, test and validate automated reporting solutions, create and deliver ad hoc reports, and provide support to reporting analysts in other departments and worksites within Magellan. Ms. Pierce has over 19 years of experience in the managed care industry, with 18 of those years in IT, and 12 years with Magellan. Prior to joining Magellan, she held IT positions as a business analyst, and as a manger, with Sierra Military Health Services, United HealthCare of the Mid-Atlantic, and Chesapeake Health Plan.
- **Tim Seago, Manager of Enrollment Analysis and Programming** will have overall responsibility for all functions related to enrollment/eligibility for the Empire Plan. Mr. Seago brings over 25 years of IBM Midrange application development experience to his team. He has served in all areas of application development including: programming, systems analysis, systems design, technical design, and quality assurance. Mr. Seago has currently been with Magellan 10 years and reports to Tim Hoffman, VP, IT. In his current role, he has oversight of the membership (eligibility) application development team. His team supports customers representing over 40 million lives, including several governmental agencies. Mr. Seago has been involved in several business areas within IT, such as telephone company billing, manufacturing, and electric company billing. His past IT management experience has included serving as application manager of IT Rental Systems with Enterprise Rent-A-Car, where he was responsible for the management of IT projects related to Enterprise's rental divisions.

(c) Where individuals are not named, include qualifications of the individuals that you would seek to fill the positions; and

In addition to the key staff members listed above, Magellan has provided job descriptions, including qualifications, for the following unnamed leadership staff that will be dedicated to the Empire Plan as **Appendix GG**.

- Medical Director
- Clinical Director
- Customer Service Director,
- Quality Improvement Director
- Customer Supervisor
- Clinical Supervisor
- Claims Supervisor

(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?

As summarized in **Table B.1.a** below, the dedicated Magellan/Empire Plan Program Manager and Senior Account Executive along with dedicated supervisory, clinical, customer services, reporting, field network, and quality improvement staff will be located in the dedicated Albany, New York-based Empire Plan Service Center. This service center will be opened as a branch of our Tristate Care Management Center in Cincinnati, Ohio, which has held NCQA accreditation since it's first survey in 1999; thus, assuring full NCQA accreditation. Claims processing and enrollment management will be managed from our centralized claims and enrollment management office in St. Louis (Maryland Heights), Missouri.

(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 account team to manage the MHSA Program?

ACCOUNT TEAM TOOLS AND RESOURCES

Because Magellan employs a team-based approach to account management that makes key operations leadership staff part of the overall account management team, your Magellan Program Manager will have **easy access to larger corporate resources** and upper level management at Magellan. Tools that Magellan program managers and senior account executives routinely use to maintain contact with corporate resources and staff include the following:

- Regular, customer-specific internal joint account management and operations meetings, such as account management debriefs with clinical teams and depression disease management teams serving customer accounts
- Regular non-customer-specific joint account management and operations meetings
- Implementation and program transition meetings (as applicable)
- Marketing and Communications meetings through which program managers are updated on the latest program promotions and materials that are available for use by customers
- Magellan corporate Intranet, called "MAGnet" through which operations teams make new and useful information available to one another, including information regarding new policies and procedures, new communications collateral for customer use, and more
- Magellan's customer and clinical services Intranet, called "MagIC," through which program managers can track daily call performance for their accounts and post account-specific customer service information for use by customer service and clinical teams
- One-on-one telephone consultations, telephonic meetings, e-mail and web conferences
- Internal account management reporting, provided directly to program managers by Magellan's in-house reporting and clinical teams, and used by program managers to track program performance and standards and proactively address trends or concerns
- Communications and Program Promotion "toolkit" where program managers can easily find the latest newsletters, posters, and promotional materials to share with customers
- Monthly e-mailed information, sent by Magellan's Communications Department to program managers, for further electronic distribution to customers

- Regular meetings of Magellan's Empire Plan Quality Improvement Committee (QIC) which will commence upon program "go live" date.

All of these resources will support the proposed program manager in her work and make communication, information exchange, and feedback processes efficient and timely for all constituents.

THE DEPARTMENT'S TOOL AND RESOURCES

Magellan is committed to ensuring our customers feel well connected to both organizations. Tools that Magellan will make available to the Department throughout delivery of this program include the following. *Should the Department have suggestions for additional tools or resources, we welcome your suggestions.* Based on our experience serving similar customers, we have found the following tools to be useful.

- Weekly program transition update and planning meetings with the Magellan Program Manager
- Bi-weekly and/or monthly program update meetings with Magellan account management as needed
- Quarterly and annual program review meetings with clinical and QI leadership participation
- Customer web site at www.MagellanHealth.com, which includes timely Customer Dashboard Reports showing claims, utilization and other key program activity in near real time as well as satisfaction reports, updates on laws, trends and accreditation, and more
- Consultation with Magellan's quality improvement department for purposes of program trend review and outcomes analysis

(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.

Magellan currently has the following active accreditations and certifications:

- National Committee for Quality Assurance (NCQA): Managed Behavioral Healthcare Organization Accreditation and Credentials Verification Organization Certification
- URAC Health Utilization Management Accreditation
- URAC Case Management Accreditation

NCQA MBHO Accreditation

Magellan has made an organizational commitment to incorporate National Committee for Quality Assurance (NCQA) standards into our service delivery system. We have been proactive in seeking NCQA accreditation, having volunteered to be one of the beta sites for the NCQA MBHO standards in 1996. Magellan currently has six Care Management Centers that have achieved "Full" three-year MBHO accreditation, including our Tristate and Midwest Care Management Centers that will serve the Department and the Empire Plan. Our dedicated Empire Customer Service Call Center in Albany, New York will also have NCQA accreditation as it will function as an extension of our Tristate Care Management Center.

A summary of Magellan's NCQA accreditation information is shown below.

Table B.1.b: Magellan NCQA Accreditation

Care Management Center / Unit	City, State	Accreditation Type	Initial Date of Accreditation	Current Expiration Date	Next Accreditation Schedule
Northeast	Parsippany, NJ	MBHO- Full	4/24/00	12/13/14	11/17/14
Southeast	Alpharetta, GA	MBHO- Full	5/28/99	12/31/13	12/02/13
Tristate	**Cincinnati, OH**	**MBHO- Full**	**12/29/99**	**7/19/13**	**6/10/13**
California	El Segundo, CA	MBHO- Full	12/11/06	11/26/15	10/19/15
Iowa	Des Moines, IA	MBHO- Full	11/16/11	11/16/14	10/20/14
Midwest	**St. Louis, MO**	**MBHO-Full**	**1/04/13**	**1/04/16**	**11/30/15**
Magellan CVO	Columbia, MD	CVO Certification- Full	2006	05/24/14	04/21/14

To prepare for re-accreditation, Magellan's Corporate Quality and Outcomes Department provides continuous support during the preparation phase to each Care Management Center in its re-accreditation efforts to make sure it attains re-accreditation in a timely manner. Magellan also monitors NCQA's expanding product accreditation categories to determine if the company should pursue accreditation for any of our new products.

NCQA CVO Certification

On May 07, 2012, Magellan again earned certification as a Credentials Verification Organization (CVO) by NCQA. NCQA evaluated Magellan's internal processes for verifying that physicians and other health care providers have the proper credentials to care for patients and found that the

company's system provides the protections required by NCQA's rigorous standards for managed behavioral health care organizations. Magellan is fully certified by the NCQA in all 10 verification services and was the first managed behavioral health care organization in the nation to earn certification as a credentials verification organization. Magellan's CVO certification is valid until May 2014.

URAC Accreditation

In addition to NCQA accreditation, nine Magellan sites have been awarded Re-Accreditation by URAC under the Health Utilization Management Standards, version 6.0, and five of those sites have also been awarded Re-Accreditation under the Case Management Standards, version 4.0. Two additional Magellan sites were granted accreditation as initial sites under the Health Utilization Management, version 6.0 Standards, bringing the total number of Magellan behavioral health units accredited to 11.

Magellan pursues URAC accreditation as a multi-site organization. One over-arching application that encompasses the information and data from the Care Management Centers is submitted by Magellan corporate, and the individual Care Management Centers are then selected by URAC for site visits to determine level of adherence to the URAC Standards. **As a result of the 2010 URAC review, Magellan was awarded a "Full" re-accreditation under both the Health Utilization Management Standards and the Case Management Standards**. Based on this performance, Magellan applied for and was approved for a three year extension of this accreditation. Effective dates for the Health UM Accreditation are through June 1, 2013 and Case Management Accreditation through September 1, 2013.

Table B.1.c: URAC Accreditation

Care Management Center	City, State	Health UM Standards Version 6.0 Accreditation Type	Initial Date	Expiration Date	Case Management Standards Version 4.0 Accreditation Type	Initial Date	Expiration Date
Northeast	Parsippany, NJ	Full	3/23/95	6/01/13	Full	9/01/02	9/01/13
Southeast	Alpharetta, GA	Full	10/01/98	6/01/13	Full	9/01/02	9/01/13
Tristate	Cincinnati, OH	Full	10/14/92	6/01/13	Full	9/01/02	9/01/13
California	El Segundo, CA	Full	6/01/07	6/01/13	Full	9/01/07	9/01/13
Michigan	Farmington Hills, MI	Full	6/01/96	6/01/13	Full	9/01/02	9/01/13

Care Management Center	City, State	Health UM Standards Version 6.0 Accreditation Type	Initial Date	Expiration Date	Case Management Standards Version 4.0 Accreditation Type	Initial Date	Expiration Date
Florida	Miami, FL	Full	6/01/07	6/01/13	N/A	N/A	N/A
Iowa	West Des Moines, IO	Full	11/01/97	6/01/13	N/A	N/A	N/A
Nebraska	Lincoln, NE	Full	6/01/02	6/01/13	N/A	N/A	N/A
Midwest	Maryland Heights, MO	Full	11/01/97	6/01/13	N/A	N/A	N/A
Biodyne	Phoenix, AZ	Full	12/01/11	06/01/13	N/A	N/A	N/A
Magellan of AZ	Phoenix, AZ	Full	10/01/10	10/01/13	N/A	N/A	N/A

Please note also that in addition to achieving "Full" URAC accreditation, Magellan met all six Leading Indicators under the HUM Program and all seven Leading Indicators under the CM Program. The Lead URAC Reviewer pointed out during the last visit at one of our Care Management Centers that very few organizations meet these standards. Seventy-five percent of organizations actually withdraw their accreditation requests before or during their reviews, and very few are actually fully able to demonstrate implementation. The reviewer indicated that this places Magellan in a much stronger position in relation to all other HUM and CM Accredited Organizations.

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

Magellan confirms that we meet this requirement.

2. PREMIUM DEVELOPMENT SERVICES

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.

A. DUTIES AND RESPONSIBILITIES

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

(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;

Magellan confirms we will meet this requirement.

(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

Magellan confirms we will meet this requirement.

(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.

Magellan confirms we will meet this requirement.

B. REQUIRED SUBMISSION

(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.

Because of Magellan's three decade long history serving large risk customers like the Department, Magellan underwriting staff is more than fully prepared to provide expert underwriting services throughout the proposed contract period.

Kevin Litkowski, Senior Underwriter will provide premium rate development services for the MHSA Program. As a Senior Underwriter at Magellan, Mr. Litkowski is involved in the transformation of Client Data into projections of Care. He also coordinates the input of Clinical Operations, Finance and Network and Claims Operations areas into determining a Final Premium Rate. Mr. Litkowski has been employed as an Underwriter at Magellan for five years, during which time he has underwritten for all manner of Magellan products, specializing in behavioral health and radiology benefit management. Prior to Magellan, Mr. Litkowski worked for MAMSI Health Care, which later became part of United Health Care. During his 12 years, he worked in the Underwriting and Actuarial Analysis Departments.

A completed Biographical Sketch Form for Mr. Litkowski is provided as **Appendix 1**.

(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.

Magellan would develop the annual premiums, for both the first year premium and subsequent year premiums, based on actual behavioral health claims experience, as provided by the Department, for the respective populations. The actual behavioral health claims experience will be based on defined criteria, as agreed to by the Parties, which include, but are not limited to the following: diagnosis code, revenue codes, procedure codes, place of service, and provider type. Based on actual behavioral health claims experience Magellan will develop historical, annual per member per month (PMPM) costs in order to evaluate annual cost trends for both utilization and unit cost.

With this historical trend experience Magellan will develop behavioral health PMPM projections for the respective current benefit (premium) period and will develop subsequent period projections for use within the premium recommendations.

(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.

Note: *The responses to the above three Required Submissions should be general descriptions of the financial methodology you intend to use for assisting and supporting the Department with the MHSA Program. Responses may NOT include any specific cost information or values relative to the development of cost/rate projections and trends for the MHSA Program; that information must be restricted to your Cost Proposal.*

Magellan confirms its commitment to work with the Department and its contracted actuarial consultant on the annual premium renewal recommendation and it will be available to present such recommendation to the Department, Division of the Budget and GOER.

3. IMPLEMENTATION

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

A. DUTIES AND RESPONSIBILITIES

(1) The Contractor must commence an implementation period beginning on or around October 1, 2013 following approval of the Agreement by OSC. During the implementation period, the Contractor must undertake and complete all implementation activities, including but not limited to those specific activities set forth in Section IV.B.3.a.2a-2e. Such implementation activities must be completed no later than December 31, 2013 so that the MHSA Program is fully operational on January 1, 2014.

Magellan confirms we meet this requirement.

(2) Implementation and Start-up Guarantee: The Contractor must guarantee that all Implementation and Start-up activities will be completed no later than December 31, 2013 so that, effective January 1, 2014, the Contractor can assume full operational responsibility for the MHSA Program. For the purpose of this guarantee, the Contractor must, on January 1, 2014, have in place and operational;

(a) A contracted Provider network (including Certified Behavior Analysts) that meets or exceeds the access standards set forth in Section IV.B.10 of this RFP;

Magellan confirms we meet this requirement.

(b) A fully operational call center, including a Clinical Referral Line, providing all aspects of customer support and clinical services as set forth in Section IV.B.4 and Section IV.B.12 of this RFP;

Magellan confirms we meet this requirement.

(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;

Magellan confirms we meet this requirement.

(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

Magellan confirms we meet this requirement.

(e) A fully functioning customized MHSA Program website with a secure dedicated link from the Department's website able to provide Enrollees with on-line access to the specific website requirements as set forth in Section IV. B.4 of this RFP.

Magellan confirms we meet this requirement.

B. Required Submission

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

A Dedicated Implementation Approach

Magellan understands the challenges inherent in transitioning a managed care program wherein multiple State employer entities are involved, union populations are affected, and provider networks are different. We also recognize that change is inevitably accompanied by some uncertainty and instability. As a result, Magellan is dedicating a full-time, experienced Program Manager and a Senior Account Executive to the management of your program transition and implementation.

In addition, to further ensure smooth transition for the Empire Plan, Magellan also offers customer service representatives to begin responding to enrollee and provider questions about the new program beginning one month prior to the program start date.

Our approach to program implementation is outlined in a proposed project plan provided as **Appendix C**. This plan includes roles and responsibilities, estimated timeframes, testing dates, processes related to enrollee and provider communications, training of customer service and clinical staff, report generation, and network expansion.

Of course, the plan will be revised to reflect any additions made by the Department upon review of the document, and based on additional discussions, should Magellan be selected as a finalist. The plan will also be fleshed out into more refined sub-plans for each key operational area.

At Magellan, the transition/implementation will begin prior to contract award. This will be particularly important to New York State since transitioning this critical program to a new vendor may cause concerns to enrollees, their dependents and their unions. Magellan has a long history of implementing large new business well, and based on our experience, we find it makes most sense to begin key implementation activities even before a contract is awarded, so that we can ensure we make the most of the time available to serve our potential customers. Key activities for your implementation have already included soliciting growth in our provider network in areas that need additional access as indicated within the Department-specific geo access reporting, and planning for claims systems interface as specified within the proposal.

Upon contract award, implementation continues with a face-to-face kick-off meeting in which we assign task groups, identify unique contractual requirements or nuances, clarify expectations and plan for regular meetings with task group leaders. **Your Senior Implementation Manager, Sandi Morter** and other dedicated Magellan implementation leaders then conduct weekly meetings with the Department and internally at Magellan, throughout the Implementation, to ensure key tasks are on target. As Senior Implementation Manager, Ms. Morter plays an integral role in implementing Magellan accounts and products for our customers. Ms. Morter has experience implementing Health Plans, Public Sector and Commercial accounts as well as experience with government and military implementations. She has more than fourteen years' tenure with Magellan. Prior to undertaking her current responsibilities, she served as clinical manager for one of Magellan's largest customers, supervising inpatient, outpatient, and drug-free workplace staff. She also provided on-site EAP services and training for a large government-based account. A graduate of the University of Missouri (St. Louis), she has a master's degree in counseling, a master's degree in rehabilitation counseling and has worked in the field of general counseling and substance abuse for 25 years.

Ms. Morter has led or participated in the implementation of several large complex contract include programs for the State of Tennessee, the State of Louisiana, WellCare, Blue Shield of California, and Magellan Complete Care of Florida (Magellan's full service Medicaid health plan that includes coverage for physical health, behavioral health, dental services, transportation, and eye care).

Activities will include ensuring the Department understands how to interface with Magellan, recruitment of all new staff and setup of the Magellan New York Empire Plan Service Center, planning for announcement of new benefits and answering of enrollee and vendor questions, arranging for the Department's Magellan Web site and customer reporting dashboard, ensuring appropriate communications vehicles for fraud and abuse reporting, review of benefit plan designs and testing of benefits in Magellan systems, communications development, education about promotion of the program, and establishing relationships with labor contacts. Magellan will have a strong presence both Upstate and Downstate (New York City) New York with a particular emphasis on geographic areas with strong enrollee presence.

Our implementation team will also seek to make arrangements for and conduct cross trainings with all of the Department's selected external or internal vendors (i.e. Medical, Disability, DM, Case Management, EAP, FMLA, and/or Work/Life) to ensure they understand how the program can help enrollees, how to refer enrollees to the program, or how to connect with any Magellan services and vice versa. The team will be available to provide similar information at regional meetings of agency health benefit administrators and at selected meetings of public sector retiree organizations. The Magellan implementation team would work directly with previous and future vendors to identify transition plans and create smooth transition processes.

The implementation team will also continue to target high volume providers or suggested non-Magellan providers for recruitment and provider training and development. Magellan's New York-based Network Relations staff will continue to be mobilized from contract award forward to work directly with providers for purposes of education, further recruitment, and training. We recommend that our dedicated Empire Plan MHSA service line open at least one month prior to go live to handle enrollee and provider questions. These are just a few key activities we will undertake as part of the Implementation; more are outlined in the proposed Implementation Plan.

During program implementation, various departments across Magellan will also be identified to implement key tasks. Within each Department an Empire Plan implementation leader will be selected to hold all in that Department accountable for implementation deliverables. Each task group leader will be responsible for convening regular meetings and teleconferences as necessary to successfully achieve the task group's objectives and complete specific tasks. This occurs in partnership with the Director of Implementation and the Department as needed.

Magellan will gather agenda items from each implementation area and provide minutes of each implementation meeting in order to assure that each key operational area is on top of its tasks.

We provide a diagram, depicting key tasks within our program implementation, as **Appendix E**.

(2) The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in Section B.3.a.(2) will be in place on or before December 31, 2013. The Offeror shall propose the forfeiture of a percentage of the 2014 Administrative Fee (prorated on a daily basis) for each day that all Implementation and Start-Up requirements are not met.

The Standard Credit Amount for each day that all Implementation and Start-Up requirements for the MHSA Program are not met is a minimum of fifty percent (50%) of the 2014 Administrative Fee (prorated on a daily basis). However, Offerors may propose higher percentages.

The Offeror's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is _____ percent (%) of the 2014 Administrative Fee (prorated on a daily basis).

Magellan confirms we meet this requirement with the understanding that delays not caused by Magellan will not result in any forfeitures.

Magellan's quoted percent to be credited for each day that all implementation and start-up requirements are not met is 50 percent (%) of the 2014 Administrative Fee (prorated on a daily basis).

4. CUSTOMER SERVICE

The MHSA Program requires that the Contractor provide quality customer service to Enrollees. The MHSA Program provides access to customer service representatives through The Empire Plan's consolidated toll-free number. Through this toll-free number Enrollees access representatives who respond to questions, complaints and inquiries regarding MHSA Program benefits, Network Providers, claim status etc., and, when a call involves a clinical matter, refer the caller to the Contractor's Clinical Referral Line. In 2011, the customer service line received 139,072 calls and the Clinical Referral Line received 112,758 calls for a total of 251,830 calls. For the first 6 months of 2012, the customer service line received 68,652 calls and the Clinical Referral Line received 54,419 calls for a total of 123,071 calls. The Offeror/Contractor is required to agree to customer service performance guarantees that reflect strong commitments to quality customer service. Exhibit II.I provides the number of Enrollees who have utilized the current DCS customized MHSA Program website from October 2011 through October 2012.

A. DUTIES AND RESPONSIBILITIES

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

(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;

Magellan confirms we will meet this requirement.

(2) The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's medical carrier/third party administrator and is available to callers twenty-four (24) hours a Day, 365 Days a year. The Contractor must establish and maintain a transfer connection with AT&T (T-1 line), including a back-up system which will transfer calls to the Offeror's line at their call center service site. The Contractor must sign a shared service agreement with the Empire Plan's medical carrier/third party administrator (currently UnitedHealthcare) and AT&T. In addition, the Contractor is also required to provide twenty-four (24) hours a Day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The TTY number must provide the same level of access to call center service as required by this Section of the RFP;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(b) Provides access to fully trained customer service representatives and supervisors available between the hours of 8:00AM.to 5:00PM., Monday through Friday, except for legal holidays observed by the State;

Magellan confirms we will meet this requirement.

(c) Meets the Contractor's proposed call center telephone guarantees set forth in Section IV.B.4b (8) of this RFP.

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(5) Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to; MHSA Program benefits levels, status of pre-certification requests, eligibility and claim status and be able to identify calls requiring transfer to a Clinician;

Magellan confirms we will meet this requirement.

(6) Maintaining a designated backup customer service staff located in the United States with MHSA Program-specific training to handle any overflow when the dedicated customer service center is unable to meet the Contractor's proposed customer service performance guarantees. This back-up system would also be utilized in the event the primary customer service center becomes unavailable;

Magellan confirms we will meet this requirement.

(7) Maintaining and timely updating a secure online customized website accessible by Enrollees, which is available twenty-four (24) hours a Day, 365 Days a year, except for regularly scheduled maintenance, which will provide, at a minimum access to information regarding; MHSA Program benefits, Network Provider locations, eligibility, Copayment information, pre-authorization information, claim status and clinically-based educational material. The Department shall be notified of all regularly scheduled maintenance at least one (1) Business Day prior to such maintenance being performed. The Contractor must establish a dedicated link to the customized website for the MHSA Program from the Department's website with content subject to the approval of the Department and limited to information that pertains to the MHSA Program. Links bringing a viewer back to the Department website must be provided. No other links are permitted without the written approval of the Department. Access to the online Network Provider locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the website or establishing a dedicated link for the MHSA Program shall be borne solely by the Contractor. Also, the Contractor shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal; and

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(b) Call Center Telephone Response Time: The MHSA Program's service level standard requires that, at the least, ninety percent (90%) of the incoming calls to the Contractor's telephone line will be answered by a customer service representative within thirty (30) seconds. Response time is defined as the time it takes incoming calls to the Contractor's telephone line to be answered by a customer service representative or a Clinical Manager, if after hours. The call center telephone response time shall be reported monthly and calculated annually;

Magellan confirms we will meet this requirement.

(c) Telephone Abandonment Rate: The MHSA Program's service level standard requires that the percentage of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative or Clinical Manager, if after hours will not exceed three percent (3%). The telephone abandonment rate shall be reported monthly and calculated annually.

Magellan confirms we will meet this requirement.

(d) Telephone Blockage Rate: The MHSA Program's service level standard requires that the Contractor guarantee that not more than zero percent (0%) of incoming calls to the customer service telephone line be blocked by a busy signal. The telephone blockage rate shall be reported monthly and calculated annually.

Magellan confirms we will meet this requirement.

B. Required Submission

(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.

Magellan confirms that it 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.

Magellan has been providing 24/7 telephonic access to close to 100% of our behavioral health customers as a standard for decades in a timely manner as exemplified through the following 2012 performance metrics for the customer service unit serving our employer lines of business:

For the Empire Plan, upon selecting the behavioral health option from the consolidated toll-free number, callers will have access to Magellan care managers 24 hours a day/seven days a week and access to Magellan customer service associates (CSAs) from 8:00 a.m. to 5:00 p.m. Monday through Friday, 365 days per year. As is true for our current customers, your fully dedicated Empire team team is immediately accessible to address issues from crisis intervention to provision of benefit information. We are committed to a holistic approach that not only addresses each caller's immediate question or concern, but also evaluates for other needs that might include information and/or referral to the array of benefits and resources available to the caller, decision support around selection of behavioral health treatment providers, suggestions for educational material that is easily accessible via the Web, and, of course, telephonic consultation by our licensed clinical staff to identify options and develop next steps.

(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.

Magellan confirms it will enter into a shared service agreement with the Empire Plan medical carrier/ third party administrator, or other party designated by the Department, and AT&T. We 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.

Magellan Health Services currently employs an Avaya S8730 call server for voice services in our call centers. Callers dialing into our call centers are routed in on network carrier T-1 facilities that utilize caller identification for each call. The toll free numbers that come in to us on the carrier network T-1 utilize routing controls that allows Magellan to control the call for daytime, night time, disaster and holiday call routing. With respect to our support of TTY, Magellan has effectively made TTY available to the hearing and speech impaired for over 20 years and continues to do so.

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

Magellan confirms that it will maintain a Dedicated Call Center for the MHSA Program located in the Albany, New York, employing a staff of clinicians and a staff of fully trained customer service associates (CSAs) and supervisors. Magellan confirms that customer service associates will be available, at a minimum, for the MHSA Program between the hours of 8:00AM to 5:00PM ET, Monday through Friday except for legal holidays observed by the State. Access to Clinical Managers through the Clinical Referral Line will be 24 hours a Day, 365 Days a year.

Whether or not precertification for a particular treatment is required, Magellan strongly encourages enrollees to contact our licensed clinicians to optimize their decision making regarding treatment options. First and foremost, our staff ensures all callers are fully educated about their MHSA program and all the benefits available. Our care managers have expertise in listening with an experienced clinical ear and teasing out relevant information with probing questions. They may suggest providers with particular credentials or areas of specialty based on the callers needs, and will filter their search of providers further based on factors such as preferred gender, location, language and other elements of importance to the caller. While network provider information, including the filters mentioned, is available online, telephonic assistance offers assessment and the support that can promote enrollee engagement and commitment that will ultimately encourage follow through with the appointment. In addition, care manages will assess for any potential barriers to care and work to address those – this too promotes follow through. Where assistance in making an appointment is requested, our Magellan team does the leg work in locating an appointment time with the right provider to meet the caller's needs.

(4) Describe the information, resources and system capabilities that are available for the customer service representatives to address and resolve member inquiries. Include:

RESOURCES AND SYSTEM CAPABILITIES AVAILABLE TO CUSTOMER SERVICE ASSOCIATES

At Magellan, CSAs are viewed as front-line personnel, deserving of the best resources possible to support Enrollees. CSAs will assist callers with all administrative services associated with the

Department's program including explanation of MHSA benefits with immediate access to eligibility and benefit plan design detail, review of other benefits available to the caller as appropriate to the issue using our Customer Summary application which houses this data and is readily accessible to our CSAs, claims inquiries through their immediate access to view the enrollee's claims activity and all authorization activity, network provider questions using our continuously updated provider search with filters of not only areas of expertise and credentials but preferences around gender, language, location and other issues important to enrollees. With access to Magellan's Contact Tracking and our Integrated Program, CSAs can view the history and detail of calls, requests for services, treatment history and with ease. Whatever the concern or question, Magellan CSAs understand the importance of resolving the issues at hand and through our desk top system have all tools readily available to do so.

To drive first-call resolution to the highest level possible and to ensure the highest level of quality service, Magellan also has a number of positions that are designed to support CSAs. Roles of our Albany-based Empire dedicated CSA support staff are described below:

- **Care Assist Team**— This unique and innovative team, which we believe few MBHOs currently offer, if any, is designed to provide fast, helpful peer support for CSRs when they need to expedite first call resolution. The Magellan Care Assist Team (CAT) is a group of senior CSRs whose knowledge and experience makes them a valuable resource for CSRs to contact regarding complicated questions, problem cases, and escalated customer calls. CAT team members provide technical and process expertise and strive to help CSRs resolve customer questions and concerns at the initial point of contact. This team serves as the first point of escalation for customer issues that may not be able to be addressed by CSRs or require extensive research. Care Assist Team members also serve as mentors to newly hired CSRs. Data relative to why CSRs contact the Care Assist Team are collected and used as a basis for recurrent training and process enhancement. Your dedicated CSR team has immediate access to CAT expertise and support to further assist them in meeting your enrollees needs and providing first call resolution even for the more complicated concerns.
- **Customer Service Supervisors**— Your Customer Service Supervisor will ensure that The Empire Plan CSAs are providing the best possible service to callers. Their focus is to coach and help develop the skills of CSA team members to ensure they are highly proficient in customer plan designs, system applications, processes, and service techniques. Supervisors are actively engaged in service, observing CSA and Care Assist Team Enrollee calls. Through this process they are able to coach CSAs to improve their performance and offer positive feedback to those making great contributions. Magellan front-line customer service supervisors have a superior command of customer programs and serve as subject matter experts to both CSAs and others in the Care Management Center. They are responsible for conducting route cause analyses on issues creating service barriers and subsequently

reporting those findings to the appropriate Magellan parties in an effort to optimize customer satisfaction and CSA success. In the rare situation when a Care Assist Team member cannot resolve a customer issue, the dedicated Empire Plan customer service supervisor will serve as the next point of escalation.

- **Director of Customer Service**—This individual is responsible for the day-to-day management of the Customer Service Department and for providing leadership to its team members. The director holds responsibility for achieving all service performance commitments and ensuring that the highest quality of work is delivered to callers. To this end, the director analyzes service barriers, problems, workflows, and customer complaints to create action plans for ensuring that customer satisfaction is optimized. Additionally, the director uses this information to improve training efforts for CSAs and enhance the overall quality of service for our customers. The director is also responsible for coaching and developing the supervisors and ensuring that they receive the needed support to drive CSA performance success.
- **Operations "Hub"**—This Magellan work team is responsible for managing service level achievement for all operating units within the Northeast and (proposed) Empire Plan Care Management Center, including Customer Service. The Operations Hub Team, led by an Operations Hub Specialist, monitors the ASA, service level, and productivity for the Customer Service Team on a real-time basis. In coordination with the customer service supervisors and director, the Operations Hub will make adjustments to staffing levels and work schedules to ensure consistent achievement of service goals. This team is also responsible for long-term call volume forecasting and anticipating staffing needs as membership and or services change over time.

INTRANET TOOLS FOR MAGELLAN STAFF

In addition to the above peer and leadership resources, Magellan staff also has quick access to valuable desktop resources for serving Enrollees well. LearnIt and MagIC, both employee Intranet tools used by Magellan Customer Service and other staff, store internal clinical and administrative management process information on for our staff, so they have easy, immediate electronic access to timely information regarding management of a client contract. Tools available on these Intranet web resources include employee handbooks, training documents, specific guidelines for Enrollee service, special criteria, care and vendor coordination information, and more.

(a) Whether any Interactive Voice Response (IVR) system is proposed;

Magellan is proposing use of our Interactive Voice Response (IVR) system, which is just one way in which we leverage technology to improve service delivery and efficiency for our Enrollees and providers. The IVR system gives Magellan's Enrollees and providers self-service access to information 24 hours a day, 7 days a week, including weekends and holidays, using speech recognition technology (instead of the older "touch tone" input). Using natural speech recognition technology with a supporting touch-tone option, this next-generation IVR offers the following benefits:

- Members and providers can check on the status of authorizations and claims.
- Members can locate MHSA providers in their areas. The search can be a general ZIP code provider search, or it can include filtering technology to appropriately match Enrollees with network providers who meet Enrollee-defined criteria, such as specialty, gender, language, or ethnicity.
- Providers are able to request initial outpatient authorizations.

The system, which is HIPAA-compliant, enables providers to gain access to key practice information.

To access the IVR, Enrollees and providers call their toll-free number, and can subsequently make use of the IVR by using ordinary voice commands to direct the flow of information. In cases where the Enrollee has a clinical emergency or the provider needs assistance, Magellan offers a soft-exit from the IVR so that the caller can elect to speak with a "live" associate at any point in the IVR call flow.

Upon request, we will be happy to arrange a demonstration of Magellan's IVR system.

(b) A sample of the IVR script and a description of customizable options, if any, you propose for the MHSA Program;

IVR Script

A sample IVR script is provided below:

Thank you for calling Magellan Behavioral Health. For quality purposes your call may be monitored or recorded. If you are a patient in crisis or treating a patient in crisis and need emergency mental

health or substance abuse care, press 1. If you are calling about the status of benefits, claims or in need of services from your medical plan, press 9. If you are a provider calling for an inpatient concurrent review, press 4. Please note that services are authorized based on plan eligibility, medical necessity, plan provisions, and limitations in place at the time of service. For 24 hour access to educational information, screening and assessment tools, please visit our website, at magellanhealth.com/member. If you are a member, press 2. If you are a provider, press 3.

CUSTOMIZABLE OPTIONS

Magellan's IVR system is flexible enough to meet almost any customer need. Personalized greetings, custom menus and multi-lingual options are only a few examples of the custom features available.

(c) A description of the management reports and information available from the system including the key statistics you propose to report;

Magellan's dedicated Albany Empire Plan Service Center will employ the Avaya S8700 system for phone and for voice services. Monitoring of call center activity is achieved by utilizing CMS real-time and historical reports, which allows Magellan to make staffing and call routing changes intraday based on the performance of the calls. Further, these reports are also stored in a file that allow for viewing, printing or scheduled for printing at a later time.

Call data tracked includes caller identification, service parameters including all performance guarantee parameters related to call handling, internal call transfers, outgoing calls, and agent activity. Real-time reports can be updated as often as every five seconds and summarized every 30 minutes. Historical summary reports are available in intervals of 30 minutes, daily; weekly; and monthly. Integrated reports include data for a specified start time in the past 24 hours up to and including the moment the report is generated. We also have the ability to create custom reports that capture an even wider range of call center activities that allow us to manage call volume and staff today, as well as forecast for future needs.

Included in Magellan's set of standard reports are statistics on Call Center performance, including call volume, average speed of answer and call abandonment rate. Magellan will also provide all performance guarantees reporting in accordance with the Department contract.

(d) A description of the capabilities of your phone system to track call types, reasons and resolutions;

All Magellan staff is able to log and track call issues within our Integrated Product (IP) information management system. Within IP, our preauthorization system, is the IP Contact Tracking (IPCT)

module. IPCT captures basic contact information such as contact type, reason, and resolution. It documents incoming and outgoing calls, and receipt of written or electronic information. Contact transactions can be transferred as needed to other employees for further investigation and resolution. The module allows issues, activities, and outcomes to be tracked for both incoming and outgoing calls, thereby providing a source for capturing customer service data—in particular, rates of first-call resolution.

(5) Describe the training that is provided to CSR and Clinical Referral Line staff before they go "live" on the phone with Enrollees. Include:

TRAINING FOR CSAS AND CARE MANAGERS

New Magellan Clinical Referral Line staff and CSAs receive rigorous training to orient them to our mission and to introduce them to our services. Magellan learning specialists collaborate with the new employee's immediate supervisor to facilitate training over a period of two to four weeks following hire.

The program consists of a series of discrete, task-focused modules that blend policy, procedure, and systems instruction. Small-group discussion, self-directed study, research, role play and simulations, and online learning are tools used to accustom new employees to the call center environment and the specific duties of their job. After classroom training, an experienced peer serves as a role model, resource, and learning coach to assist in transitioning the new employee into his job role and serve as a mentor for ongoing professional progression.

A summary of our Learning Program follows.

FOUNDATION MODULES (COMPLETED IN 1–2 WEEKS)

Both Clinical Referral Line staff and CSAs complete the following modules:

- Managed Care Orientation
- Clinical Operations Orientation
- Tele-Professionalism
- Call Types
- Crisis Calls
- Privacy Orientation

- Compliance Handbook Training
- Security and Fraud
- Systems Orientation
- iSeries IP Orientation
- Magellan's Provider Network.

In addition, Clinical Referral Line staff complete the following position-specific modules:

- Intake and Referral Process
- General Call Inquiries
- Outpatient Concurrent Review.

CSAs complete the following position-specific modules:

- Initial Provider List and CSA Links
- Preparing a Case for Clinical Review
- Complex Calls and Complaints.

INTERMEDIATE MODULES (COMPLETED IN 3–4 WEEKS)

Both Clinical Referral Line staff and CSAs generally complete the following set of modules:

- Modifying Authorizations
- Managing Quality
- After-Hours Solutions Group
- Disaster Recovery
- Information Technology (IT) Support Center.

Clinical Referral Line staff also complete the following position-specific modules:

- Intensive Care Management
- Exchange of Contractual Benefits.

CSAs complete the following position-specific modules:

- Claims Inquiry
- Authorization Inquiries.

ADVANCED MODULES (COMPLETED IN 5+ WEEKS)

Both newly hired Clinical Referral Line staff and CSAs complete the following final set of modules:

- Performance Management
- Patient Safety.

Clinical Referral Line staff complete the following position-specific module:

- Complex Benefits Cases.

CSAs complete the following position-specific module:

- MagellanHealth.com - Provider and Member Web sites

CUSTOMER-SPECIFIC TRAINING

As part of all classroom training, customer-specific benefit information is provided to each Clinical Referral Line staff member and CSA. Such benefit information includes plan design, covered lives, risk arrangements and product and program nuances.

In addition to classroom training, all CSAs and Clinical Referral Line staff for your plan will attend Empire-specific workflow and Empire-specific account training modules with the Supervisor and/or Learning Coaches. Customer Service Associates will also regularly review Empire-specific training alerts posted to the Magellan Information Center, MagIC, which often include various topics including but not limited to the following:

- Specific benefit plan information
- Program information
- Union information
- Plan nuances for all account types
- Program services available through other vendors

- Account or service exclusions
- Medicare plan information
- Workflow and account specific guidelines
- Claim processing guidelines, processes and workflows
- Performance and service expectations and guarantees.

Our Learning Specialist will work with each learner regarding education, development and coaching needed to ensure all staff serving the Empire plan has the tools they need to perform at their best.

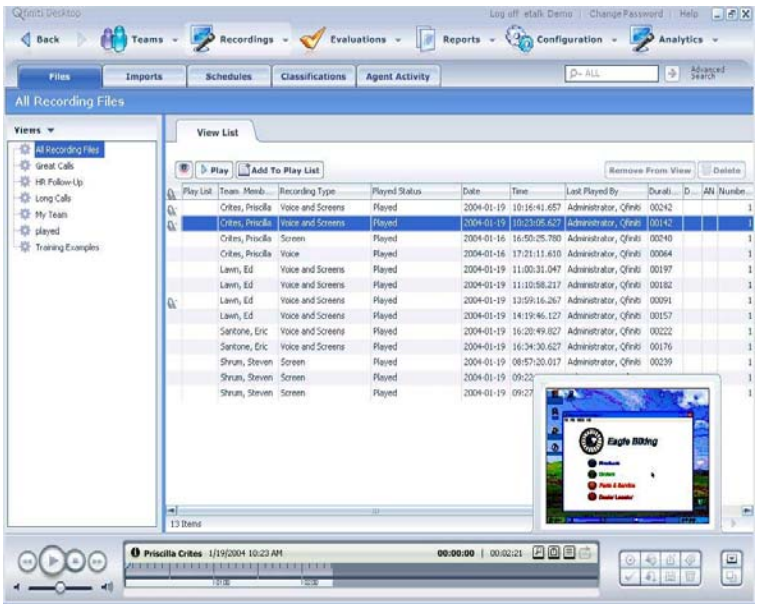
New staff are also encouraged to pursue personal development available to them via Magellan's online learning management system, LearnIt!, where soft and hard skills courses are offered. LearnIt! can be accessed from the employee's home (if the course is not directly work-related) or during work hours, once approved by the Supervisor and incorporated into the staff member's performance management individual development plan.

AT Magellan, training is ongoing to support sharpening the performance management of new Clinical Referral Line staff and CSRs includes frequent service observation (call monitoring) and data integrity (documentation audits). Based on the results of individual performance, the CSR or Care Management Supervisor delivers coaching and feedback, and at the request of the Supervisor, the Care Management Center Learning & Performance Specialist may develop a customized and individualized training program.

(a) A description of the internal reviews that are performed to ensure quality service is being provided to Enrollees;

INTERNAL QUALITY REVIEWS

Magellan uses the innovative **Qfiniti Enterprise** suite, a comprehensive and integrated system designed to enable Magellan to deploy proven, scalable quality monitoring and customer service agent evaluation programs. The Tristate Care Management Center uses **Qfiniti Observe** to record voice and screen interactions, **Qfiniti Advise** to provide agent evaluations and **Qfiniti Expert** to provide eLearning to our customer service associates to ensure that they provide continuous quality services for all customers served at this service center. Our dedicated Albany-based customer service unit will also use Qfiniti.



- Part of the Qfiniti Suite of quality monitoring tools, **Qfiniti Observe** provides a powerful range of call monitoring options that include transaction-based recording of voice, screens, or both. This will allow our customer service supervisors to monitor contacts for performance, accuracy of information as well as examine processes for best practices. This system will also allow for a quick search of past recordings based on defined parameters. This program also allows supervisors an efficient and effective way to provide agent coaching by allowing coaching notes, voice comments, and screen edits.

- **Qfiniti Advise** is a centralized evaluation and analysis solution that enhances coaching and eLearning effectiveness for our staff, as well as streamlined quality management tasks and improved scoring consistency. This tool allows supervisors a quick and efficient way to identify opportunities sooner and improve the quality of coaching efforts. Qfiniti Advise uses a variety of scoring and navigation features to make evaluations simple and relevant to each type of transaction monitored. Some of these features include the following:
  - User-defined questions and scoring
  - Drop-down boxes
  - Radio buttons
  - Auto Answer/Auto Fail
  - Edit boxes
  - Spell check
  - Weighting options
  - Advanced scoring options

In addition to evaluation and scoring features, this program allows for online calibration as well as trending and analysis by evaluator. Qfiniti Advise allows Magellan supervisors to track and analyze

processes to help uncover the root cause of problem performance, productivity and/or operations. The evaluation also allows staff to complete self-evaluations and reinforce supervisor coaching.

- **Qfiniti Expert is a powerful eLearning tool that automates customer service associate education** through the targeted, intelligent delivery of online training programs. This will provide the tools needed to build skills and knowledge, to enhance performance and to improve agent retention and productivity. Qfiniti Expert online training courses can immediately be assigned to agents or can be synchronized across the unit. Qfiniti Expert also gives each supervisor the ability to track progress of agents and retention of agents. This will assist Magellan Supervisors in identifying trends and training gaps. This will be used as a great supplement to new-hire training, as well as recurring training programs that polish key skills, encourage professional development and train employees on hot topics.

Through these tools Magellan is able to fully ensure all call issues are quickly resolved and that we are able to track and trend calls by type and timeliness of resolution.

(b) The first call resolution rate for the proposed call center;

(c) The turnover rate for customer service and Clinical Referral Line employees;

(d) Ratio of management and supervisory staff to customer service representatives; and

(e) Proposed staffing levels including the logic used to arrive at the proposed staffing levels;

PROPOSED STAFFING LEVELS

Magellan proposed staffing levels for the dedicated Empire Plan customer service team include the following

LOGIC USED TO ARRIVE AT PROPOSED STAFFING LEVELS

Magellan has based our proposed staffing levels on a number of factors including the type of service model to be implemented for the Empire Plan, the intensity of services to be provided, expected utilization, and forecasted call volumes based on company experience and data provided by the Department in the RFP.

Upon implementation and on an ongoing basis thereafter, Magellan will ensure that the Midwest Care Management Center is adequately staffed so that service is delivered in accordance with the Program's performance standards. To ensure adequate staffing levels, our Care Management Centers maintain an Operations Hub team that is responsible for managing service level achievement for their operating units. The Operations Team, led by an Operations Hub Specialist, monitors the average speed of answer (ASA), service level, and productivity for the call center on a real-time basis. In a short-term surge in call volume, the call center maintains designated backup staff (with the same qualifications and training as full-time staff) that are available to handle calls. When the call surge falls, backup staff log out.

Additionally, in coordination with the operations management, the Operations Hub will make adjustments to staffing levels and work schedules to ensure consistent achievement of service goals. This team is also responsible for long-term call volume forecasting and anticipating staffing needs as membership and/or services change over time.

Magellan also has system safeguards in place to ensure our operational and staffing structure meets evolving business needs so that your performance expectations never suffer as a result of increased business or call volume. Magellan operational leadership performs regular call analysis, forecasting and trending activities utilizing our IEX Totalview Workforce Management software to ensure call and service volumes are supported by the appropriate number of staff.

(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;

Magellan has taken steps, to the extent possible, to eliminate or reduce to a minimum, unplanned data and telecommunication systems outages. Magellan optimizes our circuit capacity so that generally 50 percent to 99 percent of trunks are unused while servicing hundreds of client companies and millions of enrollees.

Magellan operates call centers across the continental United States. In the event of an emergency in which telephone services are disrupted, incoming telephone calls are diverted to the designated back-up service center office until services are restored. Care Management Center General Managers are notified by the Emergency Management Team of the nature of the disaster and the need to divert calls. In situations where the diversion exceeds one day, the Care Management Center General Manager notifies all program managers and senior account executives regarding communication with clients affected by the disaster and contacts the Emergency Management Team for authorization to reassign incoming calls. This includes coverage for such disasters that have short time frames as fire alarms or disaster drills.

To maintain consistent high quality customer services during temporary telecommunication disruptions or office closures, Magellan has the ability to reroute telephone traffic from any Magellan CMC, including After Hours, to an alternate call center restoring critical customer services within a matter of minutes.

Magellan has a target Recovery Time Objective (RTO) of 72 hours from the point of disaster declaration for all business critical systems. During the recovery period, Magellan handles interactions with Enrollees as follows:

- Requests for emergency or urgent services are authorized, pending eligibility verification upon system restoration.
- Requests for preauthorization of routine services are coordinated through the designated Magellan backup service center office.

We route calls away from a center during power outages, inclement weather (such as snow storms, ice storms and tornado warnings) and during fire drills.

Magellan's Tristate Care Management Center has utilized Magellan's back-up system one time over the past two years in 2011. The back-up system was not used in 2012.

Magellan confirms that backup staff will have MHSA Program specific training. Additionally, Magellan confirms that calls will be handled exclusively by our Dedicated Empire Plan Service Center and that the backup call center would only be used in case of system failure or call overflow.

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

Magellan confirms that we will customize a Web portal for the Department, with single sign on capability, offering services for enrollees of the MHSA Program, available through www.MagellanHealth.com/member. This site will include the ability for the Department to post custom content and resources exclusively for their membership. Our Custom Messaging feature will enable the Department to place and manage time-sensitive messages such as announcements under an Announcements portal. Our standard Web site features can be enabled or disabled to allow the Department to customize the site to meet the unique needs of the program.

Members will have the ability to establish a password-protected user account to securely access information about their program, including program benefits, a Provider Search tool, eligibility information, details on applicable copayments and claims status. Through MagellanHealth.com/member, users are taken directly to a customized page, "My Magellan," that includes information on their program as well as links to frequently used functions, featured articles, interactive tools and online seminars. The site also provides confidential and convenient access to valuable resources such as self-assessment tools, up-to-date articles, professional resources, life

management plans, as well as listings and locations of providers. A sample screenshot is provided as **Figure B.4.a** below.

Figure B.4.a: Sample MagellanHealth.com Screen Shot

Some of the innovative features available for enrollees include the following:

- **Provider Search** gives users eligible for this function the ability to search for Magellan providers online, by provider name or ZIP code radius. Optional search filters offer enrollees the flexibility to narrow their search by gender, provider specialties, ethnicity, ages treated, and languages spoken. MapQuest links allow enrollees who have access to the Provider Search function to see a map of their provider's location and obtain driving directions.

In the third quarter of 2013 we will be adding provider photos and personal statements and enrollees with the ability to rate providers based on predetermined factors and leave comments.

- **Online Chat** provides quick messaging capability for enrollees with a Customer Service Associate.
- **Secure Email** provides the ability to send questions directly to Magellan.
- **Wellness Tools** offer interactive calculators that can be personalized by the user. From "Nutrition" and "Ideal Weight" to "Calorie Burner" and "Body Mass Index," these tools help recipients access health information so they can lead healthy lifestyles and maximize their workplace productivity.
- **Drug Interaction Database** helps people understand which medications could, when taken together, produce unwanted side effects.
- **Comprehensive Library** of thousands of up-to-date resources, news and events, and articles on numerous topics cover a wealth of behavioral health, wellness, personal, legal, and financial concerns (including access to interactive personal, home, and investment financial calculators).
- **Spanish Language Materials** offer helpful information on a variety of wellness topics.
- **Self-Assessment** programs offer recommendations for addressing daily living and behavioral health concerns in interactive sessions lasting approximately 15 minutes.
- **Personal Plan** programs offer online exercises, personalized feedback, and a plan for practicing new skills.
- **Free, Interactive, Online Seminars** offer innovative information on a variety of topics.

We invite the Department to visit and experience our suite of Web services at www.magellanhealth.com/member. Under "Sign In," located on the right side of the screen, enter the user name: *demo11* and password: *Solutions1*.

(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;

(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.

Magellan agrees to this guarantee. Magellan'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%) that Magellan's telephone line is not operational and available to Enrollees, Dependents and Providers during Magellan's Call Center Hours calculated on an annual basis is $100,000 per year.

(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, Offerers 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;

Magellan agrees to this guarantee. Magellan's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to Magellan's telephone line below the standard of ninety percent (90%)that is not answered by a customer service or Clinical Referral Line representative within thirty (30) seconds, calculated on an annual basis, is $25,000 per year.

(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

Magellan agrees to this guarantee. Magellan's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to Magellan'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%), calculated on an annual basis, is $25,000 per year.

(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.

Magellan agrees to this guarantee. Magellan's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to Magellan's telephone line that is blocked by a busy signal, in excess of the standard of zero percent (0%), calculated on an annual basis, is $25,000 per year.

5. ENROLLEE COMMUNICATION SUPPORT

The Department regularly provides information regarding MHSA Program benefits to Enrollees through various publications, the Department's website and attendance at various meetings. The Contractor will be required to assist the Department with the creation, review and presentation of MHSA Program materials that will enhance an Enrollee's understanding of MHSA Program benefits. Please see Exhibit II.J for a summary of MHSA Program presentations that took place in the past 12 month period.

A. DUTIES AND RESPONSIBILITIES

(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.

Magellan confirms that we will meet this requirement.

(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;

Magellan confirms that we will meet this requirement.

(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;

Magellan confirms that we will meet this requirement.

(c) Timely reviewing and commenting on proposed MHSA Program communication material developed by the Department;

Magellan confirms that we will meet this requirement.

(e) Paying a portion of the Shared Communication Expenses, the cost of all production, distribution and mailing costs incurred to disseminate Program communication materials to Enrollees. The Empire Plan's medical carrier/third party administrator will bill the Contractor on a quarterly basis for a portion of the Programs' Shared Communication Expenses. The Department agrees that these costs are not included in Administrative Fees and that the Contractor will be reimbursed for these costs as set forth in Article XV of Section VII of the RFP.

Magellan confirms that we will meet this requirement.

(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.

Magellan confirms that we will meet this requirement.

(4) The Contractor must work with the Department to develop appropriate customized forms and letters for the MHSA Programs, including but not limited to Enrollee claim forms and certification letters. All such communications must be approved by the Department, in writing, prior to distribution.

Magellan confirms that we will meet this requirement.

B. Required Submission

(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

Magellan offers a breadth of organizational resources for the purposes of delivering meaningful enrollee communications for the Department. Two departments within Magellan are solely focused, on a full-time basis, on the development of innovative enrollee communications to meet your plan's needs. First, Magellan has an award-winning in-house Marketing, Public Relations, and Communications Department, staffed with experts specializing in strategic communications, branding, graphic design, program promotion planning, implementation, copywriting, creative development, art direction, and customer order fulfillment. Members of this Department will be available to consult and work with the Department from program transition through program delivery to ensure all of your program communications needs are met.

Second, Magellan also houses a Website Work Team within our IT Department staffed by content managers, IT programmers, and Web communications specialists and this team will steer the Department's customized website and web content, as specified by the Department. These two organizational work teams have extensive experience supporting large employer and public sector customers, and have developed custom communications for clients including Federal Occupational Health (FOH), the United States Postal Service (USPS), the State of Tennessee, the State of Illinois, and the State of Michigan, and the State of New Jersey, to name just a few.

Magellan's marketing and communications organization works with customers in developing a communications plan to engage and educate enrollees. Magellan reviews all material with the necessary experts within the organization including legal counsel, product, and clinical staff.

Some of our marketing and communication campaigns have included:

- Targeted monthly campaigns including a newsletter and poster for specific and relevant topics;
- Informational Tip Sheet articles providing information and resources about behavioral health conditions; and
- Resources and tools that are available through our Magellan enrollee website including; self-assessments, library of articles, calculators and other helpful resources.

All MHSA program communications developed by Magellan will be sent to the Department for approval prior to utilization.

PROCESS UTILIZED TO DEVELOP ENROLLEE COMMUNICATIONS

The process to develop enrollee communication materials for the Empire Plan will include meetings and/or consultation with the Department regarding designing and producing any desired materials with the understanding that all enrollee communications are subject to the Department's review and prior written approval.

Based on these meetings and a clear needs assessment, the Magellan Senior Account Executive will work with Magellan's internal marketing and communications team to produce draft materials for review by the Department. Once the draft materials have been reviewed by the Department, Magellan will make any necessary changes to the materials based on the Department's review prior to final production and distribution. Among the key advantages that Magellan offers the Department is our expertise in designing and implementing clear, credible, effective communications for nearly 1,000 current employer customers including many States and other public sector employers. As noted above, we also are able to offer the Department expert consultation by our most senior Marketing leadership.

Magellan is guided by the philosophy that communication materials are key components of enrollee education and program utilization. We will work jointly with the Department with regard to the following:

- Development of language describing the Program for inclusion in the NYSHIP General Information Book and Empire Plan Certificate including plan summary; questions and answers; covered services; and enrollee rights and obligations
- Development of articles on behavioral health for inclusion in Empire Plan Reports and other publications on an "as needed" basis, detailing Program benefit features and/or highlighting trends in MHSA utilization

- Development of the Empire Plan-specific Depression Management Program brochure for electronic distribution to enrollees and treating providers. The brochure can follow the layout of the existing one in use by the current vendor, if preferred by the Department.
- Review and comment on proposed Empire Plan communication materials developed by the Department

SAMPLES

Magellan has provided sample MHSA Program communications as **Appendix F**.

(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.

Magellan's marketing and communications organization is available to provide consultative marketing assistance for the development and ongoing needs of your program.

Magellan's legal department is involved in the development and review of communication materials through representation on Magellan's multi-disciplinary Editorial Review Board (ERB). To make sure that our communication materials meet rigorous standards for quality, accuracy, clarity, and consistency, they are reviewed by the ERB. In addition to representation by our legal department, Magellan's ERB includes members of our Clinical, Medical, Communications, Operations, Account Management, and Member Services Departments; thus assuring that our communication materials are also monitored and updated regularly to reflect industry trends, legislative changes, and program updates.

During implementation, the Magellan Senior Account Executive dedicated to the Empire Plan will meet with the Department representatives to discuss communication materials needs. As applicable, the Magellan Senior Account Executive will obtain thorough legal review of all applicable documents by both the Insurer's and BHA's legal and compliance teams prior to releasing any draft communications for review by the Department.

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

Magellan confirms that we will meet this requirement.

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

Magellan confirms that we will meet this requirement.

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

Magellan confirms commitment to work with the Department to develop appropriate customized forms, letters and SBCs for the MHSA Program.

(6) Confirm that upon Enrollee request, the Offeror will distribute SBCs to Enrollees in a timely manner. The MHSA Program requires the Contractor to ensure the timely addition of enrollment data as well as cancellation of benefits in accordance with the Program's eligibility rules. EBD utilizes a web-based enrollment system for the administration of Employee benefits known as the New York Benefits Eligibility & Accounting Systems (NYEBEAS). NYEBES is the source of eligibility information for all Empire Plan, Excelsior Plan, and SEHP Enrollees and Dependents. Enrollment information is set forth in Exhibits II.A through II.A4.

Magellan confirms that we will meet this requirement.

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:

(1) Initial Testing:

(a) Performing an initial enrollment load to commence upon receipt of the enrollment file from the Department during the MHSA Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or 834 (005010x220)), fixed length ASCII text file, or a custom file format. The determination will be made by the Department;

Magellan confirms that we will meet this requirement.

(b) Testing to determine if the enrollment file and enrollment transactions loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The Contractor shall submit enrollment test files to the Department for auditing, provide the Department with secure, online access required to ensure accurate loading of the MHSA Program enrollment data, and promptly correct any identified issues to the satisfaction of the Department;

Magellan confirms that we will meet this requirement.

(2) Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions fully loaded to the claims processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Contractor shall immediately notify the Department of any delay in loading enrollment transactions. In the event the Contractor experiences a delay due to the quality of the data supplied by the Department, the Contractor shall immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will release enrollment changes to the Contractor in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a twenty-four (24) hour period. The Contractor must be capable of loading both files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 transaction set in the format specified by the Department. The latest transaction format is contained in Exhibit II.H. The Contractor must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required;

Magellan confirms that we will meet this requirement.

(3) Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee data contained in the enrollment file. Any transfers of enrollment data within the Contractor's system or to external parties must be completed via a secured process;

Magellan confirms that we will meet this requirement.

(4) Providing a back-up system or have a process in place where, if enrollment information is unavailable; Enrollees can obtain Clinical Referral Line services without interruption;

Magellan confirms that we will meet this requirement.

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

Magellan confirms that we will meet this requirement.

(6) Maintaining a read only connection to the NYBEAS enrollment system for the purpose of providing the Contractor's staff with access to current MHSA Program enrollment information. Contractor's staff must be available to access enrollment information through NYBEAS, Monday through Friday, from 8:00 am to 5:00 pm, with the exception of NYS holidays as indicated on the Department's website;

Magellan confirms that we will meet this requirement.

(7) Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Contractor must make payment for covered benefits or reimbursement directly to such party. The Contractor will be required to store this information in its system(s) so that any claim payments or any other plan communication distributed by the Contractor, including access to information on the Contractor's website would go to the person designated in the QMCSO; and

Magellan confirms that we will meet this requirement.

(8) Enrollment Management Guarantee: The Contract must guarantee that one hundred percent (100%) of all MHSA Program enrollment records that meet the quality standards for loading will be loaded into the Contractor's enrollment system within twenty-four (24) hours of release by the Department.

Magellan confirms that we will meet this requirement.

B. REQUIRED SUBMISSION

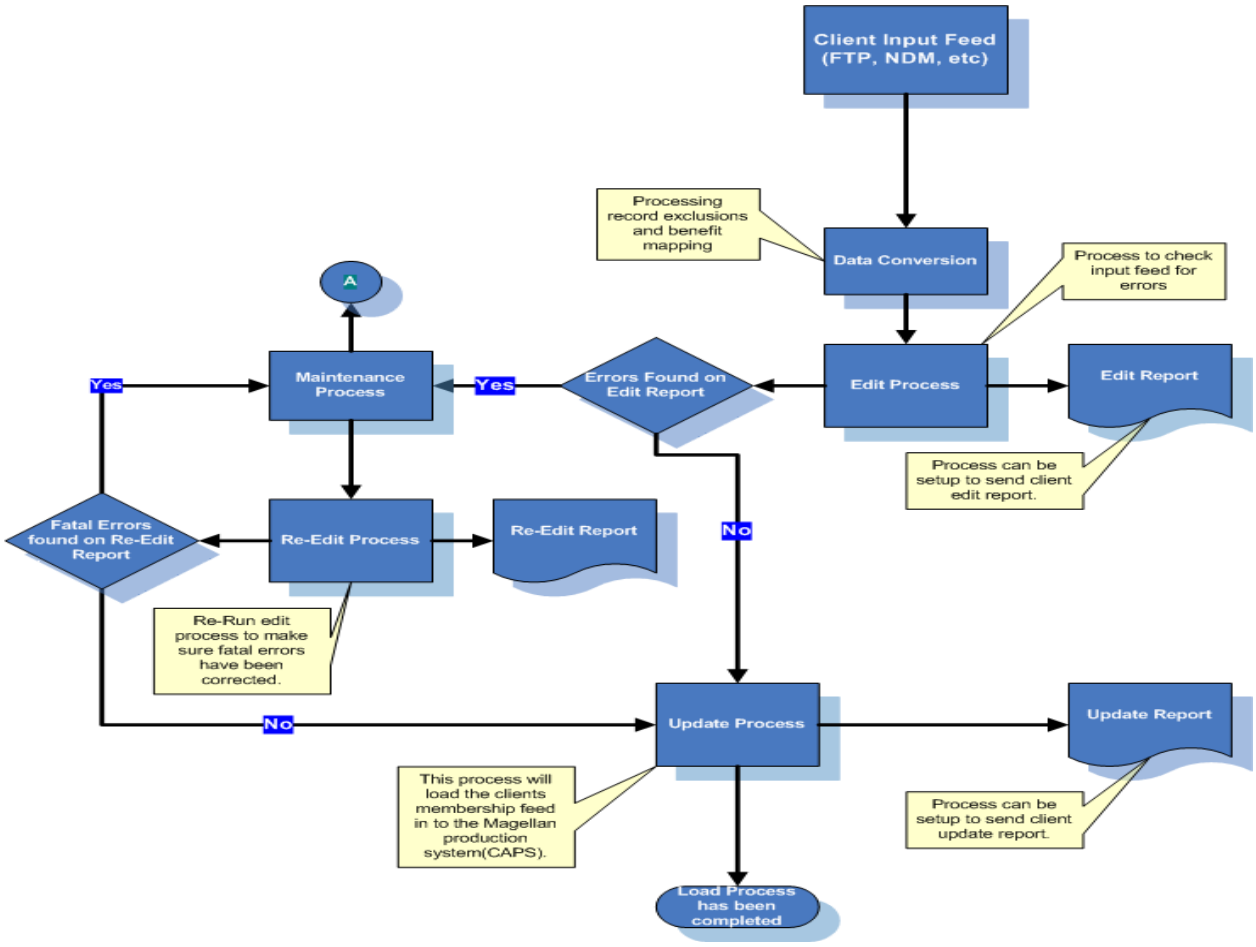
(1) Describe your testing plan to ensure that the initial enrollment loads for the MHSA Program are accurately updated to your system and that they interface correctly with your claims system.

(a) What quality controls are performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system?

During implementation, Magellan's team will meet with the Department to establish the data interfaces required to transmit eligibility data. Interfaces will undergo at least two cycles of user-acceptance testing to ensure proper transmission.

The initial load of the Department membership data will follow the same flow as subsequent loads. All enrollment feeds are processed through a translation-and-edit phase prior to updating Magellan's core system. Our eligibility data workflow is described in **Figure B.6.a.** below:

Figure B.6.a. Eligibility Data Workflow



Membership files are processed through Magellan's EDI certification environment and follow this flow:

- Encrypted files are sent via FTP to Magellan's external FTP server and then transferred to the internal FTP server, where they are decrypted.
- The elements of Magellan's file validation process are as follows:
  - Systems monitor the internal FTP server and transfer the decrypted files to trading partner-specific folders on the production EDI server.
  - Opens the files and confirms they can be read. If required by the contract, a TA1 response is transmitted back to the trading partner indicating whether a file has been accepted or rejected. If the file is rejected, all processing on the file stops, and the trading partner is required to submit a corrected file.

- Confirms the trading partner information.
- Completes HIPAA/X12 validation by processing the files through EDIFECS.
- Creates a 997 response file (for those trading partners that require it) that reports back all non-compliant transactions. 834-files are processed as a whole, so if a transaction fails, the file fails and is rejected, and no further processing will occur at Magellan.
- Sends the accepted enrollment records through the Message Queue. The Message Queue collects input statistics and then manages the translation of the enrollment data into the host file format. Membership data is not stored in the transaction database.

- During the translation, a count of the number of transaction sets is maintained, and if this count does not equal the number in GE1 (the number of transaction sets included), the host file is not sent via FTP. If the counts are equal, then no transaction sets are bad, and it initiates the transmission of the file to the host system.
- File receipt is logged into the Membership Load Tracking Database.
- Conversion program is run, mapping enrollment to system defined plan/divisions based upon indicators defining population segments and benefits.
- Edit is run, producing a report listing errors and summary information. Error checking includes validation of dates, checking for duplicates, and ensuring that key fields are not blank (name, address, for example).
- Edit report is analyzed.
- Any errors are corrected or removed (as defined by protocol for that client).
- Re-edit is run if changes or removals have been made.
- File is updated to our Claims Adjudication and Payment System (CAPS).

(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?

Magellan uses strict internal processes, procedures, and controls to maintain the quality and integrity of data received for and data conveyed to our customers. Magellan systems validate transactions at various control points through loads, audits, reconciliation processes, and cross-reference reports. Operations staff monitors process outputs and reports to validate data integrity, including omitting

or correcting errors as specified by the client, or requesting that the data transmission be repeated. These procedural and automated controls operate at appropriate points throughout the cycle.

Magellan's standard data exchanges include the building of quality and monitoring measures using header, trailer, file counts, record counts, totals, etc. whenever available. Header and trailer records are utilized to track the completeness of any feed. Record level edits track and report all data additions, deletions, and changes.

Some of the many procedures Magellan uses to ensure data quality and maintain the integrity of reference information include the following safeguards for processing inbound files:

- restricting critical fields to appropriate data types
- restricting critical fields to pre-defined lists of values
- linking associated fields to ensure data follows business rules
- comparing inbound files, prior to loading, against file specifications to confirm:
  - proper formatting
  - presence of required fields
  - number of records sent matches number received
  - using secure transmissions to ensure against data loss.

Safeguards for outbound files include the following:

- define formats according to appropriate data types, pre-defined lists, and business rules
- compare outbound files, prior to release, against file specifications to confirm:
  - proper formatting
  - presence of required fields
  - number of records selected for sending matches number processed
  - job transmission completion and statistics.

Magellan complies with all HIPAA Transaction and Code Set standards for the electronic processing of covered transactions. Magellan commits to maintaining compliance with HIPAA, industry-standards, and client data quality standards throughout the term of the contract.

(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?

Magellan's security initiatives include monitoring all systems for activity and maintaining audit trails on all systems that process sensitive information, including our enrollment system. All production application systems that handle sensitive Magellan information generate logs that indicate every addition, modification and deletion to such sensitive information. We regularly back up all audits/management trails and store them in a secure location for review.

To support internal completeness and customer-initiated audits, we complete the following:

- log inbound and outbound files
- retain a copy of received and sent files
- retain records of items that required editing prior to filing or sending
- retain audit trails of critical data edited
- retain records of implementation of system changes, including requirements gathering through deployment of a new interface
- perform two full cycles of user acceptance testing prior to deployment of any system changes.

Magellan maintains enrollment history in our Enterprise Data Warehouse indefinitely and is made available for data tracking and reporting. The Data Warehouse is constantly monitored for file size and space limitations and additional file capacity is added when needed.

(b) How your system handles retroactive changes and corrections to enrollment data;

Magellan's eligibility system can accept information relating to retroactive eligibility. Upon receipt of a retrospective service authorization request, our clinical team will perform a retrospective clinical review. A care manager will perform the initial review using guidelines specific to the type of service. If the care manager is unable to authorize the care based on the guidelines, a physician advisor will

review the request and make the final determination. Claims for that care will be paid appropriately. All requests will be processed and completed within twenty business days of the initial request.

Magellan will perform periodic reconciliations of enrollment data for the Department on a schedule determined at implementation. In order to perform reconciliation, Our IT staff receives a full eligibility and provider file. Magellan loads the full file immediately after the normal update load. Once the full fresh is completed, a report of all changes provides the information to analyze differences. This information is passed to the Account Executive, who will work with the Department to make enrollee termination recommendations. The typical turnaround time for Magellan to provide a report identifying any errors is two business days after the receipt of the data feed.

Magellan monitors activity associated with enrolleess seeking services that are not located in our systems as eligible, enrollees. Magellan performs periodic file matches to reconcile data. For example, we track the number of eligibility discrepancies for trends and uses those trends to establish the need for reconciliation. In addition Magellan annual compares the prior year capitation to the processed 834 files. Discrepancies are researched and when necessary, Magellan will contact Department staff to discuss the record discrepancies.

Enrollment and disenrollment data is stored to our Enterprise Data Warehouse, where it is made available for reporting. Magellan generates and shares reports with the Department regarding any discrepancies identified in the enrollment file. We work with our customers to maintain accurate enrollment records and minimize any service or claims issues. Each enrollment record loaded into our system will contain the necessary information to maintain, track, and report on the eligibility categories contained in the Department RFP. In addition, Magellan will create subcategories to allow us to drill down to the lowest level of enrollment category or aid type and to identify trends.

Magellan produces enrollment reports by category and can break down any clinical or claims reports based on these categories. We can determine the types of services that are used by different categories of enrollment. Understanding these data trends allows Magellan to work with providers on the general service characteristics and needs of enrollees so that providers can be alert to possible issues that might arise in the course of treatment.

(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;

Magellan's enrollment, clinical decision support and claims systems are fully integrated and will capture the necessary data to produce these reports. The data elements outlined in Exhibit II.F. are required data to adjudicate claims and will be available for the Claims and Credits Paid by Agency and Quarterly Participating Agency Claims reports, as described in the Reporting Section of this proposal.

(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;

Magellan's enrollment and claims processing systems will accept alternate identification numbers, including a Social Security Number, Employee identification number and an alternate identification number if so desired by the Department. There are no special requirements to use any or all of those numbers as a means to identify enrolleess of the Department's program.

The eligibility system maintains relevant enrollees and Dependent profile data, including enrollment per eligibility date spans, benefit plans (e.g., types of coverage), historical data (e.g., enrollment audit trail), and demographic data (e.g., ID number, social security number, date of birth, and gender). Enrollment data is received and uploaded into the eligibility system. Once loaded, eligibility information is used by the clinical/authorization system for establishing benefit plans and approving services. Members and Dependents can be located within the system using various search elements, including enrollees number, name, and social security number.

Because our eligibility system resides within our Claims Adjudication and Payment System (CAPS), information regarding Dependents that is part of the Member record will be accessible to issue authorizations and to facilitate claims payment. (3) Describe how your enrollment system, data transfers, and procedure for handling enrollment data are HIPAA compliant.

Magellan has reviewed the requirements stated in A, Duties and Responsibilities regarding HIPAA-compliant transfer of enrollment data and confirms that all our data transfer methods are compliant with that standard. We support Electronic Data Interface (EDI), File Transfer Protocol (FTP),

SOAP/XML, and Network Data Mover (NDM). FTP with PGP Encryption is Magellan's preferred process for transmitting and receiving files. Magellan accepts and transmits data as often as required by the customer.

Magellan has developed and tested all the HIPAA-compliant transactions (including the components for COB), routinely receiving and sending data to providers. Available transaction sets include the 837P, 837I, 820, 835, 834, 270, 271, 276 277, and 278 transactions. We use the TA1 and the version 5010 999 (for 5010 837 claims) standard responses and the version 5010 277CA (for 5010 837 claims). Our fully functional HIPAA validator, EDIFECS, provides WEDI level-1 through level-6 validations, as well as level-7 companion guide edits.

We can accommodate the Department' desire to use either the 834(ANSI x.12 834 standard, either 834 (4010x095A1) or 834 (005010x220)), fixed length ASCII text file, or we can work with the Department to establish a custom file format.

(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.

In the event that enrollment information is not available electronically at the time a enrollees calls to request an authorization of services, our Operations Team will employ a manual process to collect the required information from the enrollees, issue an appropriate authorization or denial, then expedite the request as required.

When enrollment information is once again available online, the Call Center representative will verify the information provided by the enrollees and update any systems as needed.

(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.

Magellan confirms that we will cooperate fully with any State initiatives to use new technologies, process and methods to improve the efficiencies of maintaining enrollment data, including requests for enrollment file conformance testing.

(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.

Magellan has extensive experience working with state Medicaid MMIS systems to validate eligibility information online and then inputting data into our IP system. We confirm that we will implement a similar process enabling our staff to access the NYBEAS enrollment system during the required business 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.

Magellan's Integrated Product (IP) clinical system has the capacity to capture information for National Medical Support Orders. This information would be captured during the initial call from the enrollees and then stored as an alternate payee in our Claims system. Information about the Dependent would then be released only to the individual named in the QMCSO.

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

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

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

Magellan agrees to this guarantee.

Our 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 Magellan enrollment system, is $5,000.

7. REPORTING

Reporting must be structured to provide assurances that member, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with Network Providers and the terms of the Agreement. The Contractor may on occasion be requested to provide ad-hoc reporting and analysis within very tight time frames.

In order to fulfill its obligations to enrolled members and ensure contract compliance, the MHSA Program requires that the Contractor provide detailed claims data on a monthly basis, as well as specific summary reports concerning the administration of the MHSA Program in an accurate manner.

All electronic files received by the Department are first validated for compliance with the specified file structure. Files that fail to adhere to this structure are rejected in their entirety.

A. DUTIES AND RESPONSIBILITIES

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

(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;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(3) Supplying reports in paper format and/or in an electronic format including but not limited to Microsoft, Access, Excel and/or Word as determined by the Department. The reports include, but are not limited to, reports and data files listed in Article XVI "Reports and Claim Files" section of this Agreement;

Magellan confirms we will meet this requirement.

(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

Magellan confirms we will meet this requirement.

(b) Utilization data

Magellan confirms we will meet this requirement.

(c) Utilization review savings

Magellan confirms we will meet this requirement.

(d) Benefit design modeling analysis

Magellan confirms we will meet this requirement.

(e) Reports to meet clinical program review needs

Magellan confirms we will meet this requirement.

(f) Reports segregating claims experience for specific populations

Magellan confirms we will meet this requirement.

(g) Reports to monitor Agreement compliance

Magellan confirms we will meet this requirement.

(5) Providing direct, secure access to the Contractor's claims system and any online and web-based reporting tools to authorized Department representatives;

Magellan confirms we will meet this requirement.

(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

Magellan confirms we will meet this requirement.

(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:

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 Calendar Year. This statement must detail, at minimum, claims paid during the year, projected incurred claims not yet paid administration costs, performance credits, audit credits, etc. Such detail must include all charges by the Contractor to the MHSA Program;

Annual Premium Renewal Report: The Contractor must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This report must detail all assumptions utilized to support recommended premium level necessary for the following Plan Year. The report must included, but not be limited to: paid claim amounts, projected incurred claims, trend, Administrative Fees and changes in enrollment;

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;

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;

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;

Quarterly Performance Guarantee Report: The Contractor must submit quarterly the MHSA Program's Performance Guarantee report that details the Contractor's compliance with all of the 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;

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;

Quarterly Coordination of Benefit Report: The Contractor must submit a report that details the amount received as a result of coordinating benefits with other health plans including Medicare. The Contractor's report should identify the COB source, the Enrollee, the original claim amounts, and the amount received from the other insurance carriers or Medicare. The final format of this report will be determined by the Department in consultation with the Contractor. The report is due thirty (30) Days after the end of the quarter;

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;

Quarterly Website Analytics Report: The Contractor must submit a quarterly report that provides comprehensive performance information for the Contractor's customized MHSA Program website as set forth in Section IV.B.4.a.(7) of this RFP. The report must include summarized and detailed website performance information and statistics, as well as proposed modifications to the 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.

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;

MHSA Program Customer Service Monthly Reports: Each month the Contractor must submit a customer service report that measures the Contractor's customer service performance including call center availability, call center telephone response time, the telephone abandonment rate, the telephone blockage rate, claims processing, enrollment, and claims turnaround. The final format of these reports will be determined by the Department in consultation with the Contractor. The reports are due fifteen (15) Days after the end of the month. For the first two months of the Agreement, these reports will be due on a weekly basis. After two months, the Department will re-examine the required frequency of these reports and establish due dates with the Contractor; and

Monthly/Periodic Reports

Detailed Claim File Data: The Contractor must transmit to the Department and/or its Decision Support System (DSS) Vendor a computerized file via secure transfer, containing detailed claim records using data elements acceptable to the Department to support the claims processed each reporting period and invoiced to the Department. The Department requires that all claims processed and/or adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the MHSA Program. The Contractor must securely forward the required claims data to the Department and/or its DSS vendor within fifteen (15) Days after the end of each month and submit a summarized report by month utilizing a format acceptable to the Department.

Magellan confirms we will meet each of these requirements.

B. Required Submission

(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.

Magellan has reviewed the requirements for financial and utilization reporting, as outlined by the Department, and has included a set of examples of our standard reports as Attachment N. Our robust reporting and sophisticated data analysis capabilities provide customers with essential information for monitoring Magellan's performance and evaluating the cost of behavioral health care.

Magellan understands the power of data collection as the foundation of meaningful reports that allow for thorough monitoring of a behavioral health program. Utilization, claims data, financials, performance guarantees, media usage analysis and other summaries are enhanced by robust data collection and management. Magellan's Information Technology (IT) systems are completely integrated, allowing for immediate retrieval and sharing of data between applications.

System Driven Data Analytics

The foundation of our information resources is our Enterprise Data Warehouse. The Data Warehouse collects information that includes clinical data, authorizations, claims and encounters, provider-based information, membership-related data, financial information, and products and services data.

Our integrated suite of MIS systems provides state-of-the art performance in gathering and processing data in order to fulfill the reporting requirements outlined in the RFP for the MHSA Program. Magellan systems contributing to the Data Warehouse include:

- **Claims Adjudication and Payment System (CAPS)** supports all eligibility, benefit, and claim functions. Our Enrollment System resides on CAPS. Because claims and enrollment data are housed and monitored within one unified system, Magellan staff are fully able to verify enrollment online during phone conversations with enrollees or providers while also validating enrollment during claims processing.
- **Integrated Product (IP)**. This system provides intake staff with online access to information relating to care management support, such as intake and referral data, employer information such as location and division, presenting problem, diagnosed problem and provider demographics.
- **Integrated Provider Database (IPD)** supports the contracting and credentialing process and subsequent data, including but not limited to, network participation status, licensure, reimbursement schedules, billing relationships, rates and electronic funds transfer (EFT) information.
- **Magellan's Web Site**, www.magellanhealth.com, enables providers to enter claims information through our provider portal.
- **Interactive Voice Response (IVR)** system provides call center statistics and data on telephonic services usage.

Magellan's reporting services operate on an information self-service model. The model works by having the Corporate IT team provide the following functionality to the business: the core, quality data; standardized, flexible enterprise reports; the deployment of technology that allows the business to easily see and explore data; an infrastructure where business and IT can partner to use the right information tool for the job.

The empowerment of the business with the data and tools necessary to work with the data keeps Magellan moving toward the goal of making information available to all that can use it. The current environment supports the production of over 14,000 standardized reports a month with over 1,400 users accessing the reports relevant to their role. In addition to the enterprise reports, users have access to our OLAP and Ad hoc reporting tools. Existing reports, templates and ad hoc processes can be modified to meet the unique needs of each customer.

The following reporting and analytic tools are currently available within Magellan:

In summary, Magellan's Enterprise Data Warehouse and suite of reporting tools provide a substantial core infrastructure we will use to meet the current and future reporting requirements of the Department. Magellan's systems have been designed to work with standardized code sets that are compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

SAMPLE REPORTS

Magellan has provided the following reports as Appendices:

Annual Reports

- Annual Financial Experience Report (**Appendix H**)
- Annual Premium Renewal Report (**Appendix I**)
- Annual Summary Reporting (**Appendix J**)
- Annual Report of Claims and Credits Paid by Agency (**Appendix K**)

Quarterly Reports

- Quarterly Financial Summary Reports (**Appendix L**)
- Quarterly Performance Guarantee Reports (**Appendix M**)
- Quarterly Utilization Report (**Appendix N**)
- Quarterly Network Access Report (Please refer to **Appendix J** and **Exhibit I.Y.3** in the Administrative Proposal)
- Quarterly Coordination of Benefit Report (**Appendix O**)
- Quarterly Participating Agency Report Claims (Magellan has not supplied a sample report as we will comply with format required in the RFP)
- Quarterly Website Analytics Report (**Appendix P**)
- Quarterly Provider Audit Report (**Appendix Q**)

Monthly Reports

- Monthly Report of Paid Claims by Month of Incurral (**Appendix R**)
- MHSA Program Customer Service Monthly Reports (Please refer to **Appendix M.** Magellan will provide a monthly version of this report.)

Monthly/Periodic Reports

- Detailed Claim File Data (**Appendix S**)

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

Magellan delivers reports in either hard copy or electronic file formats. We support delivery in MS Word, Access, Excel or PDF formats, through secure email or via download from our secure Web site, the Customer Dashboard.

(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;

Magellan confirms that we will provide the Department staff with a secure, online portal in order to view enrollee claims data. We will also provide the Department with access to our Customer Dashboard.

DASHBOARD REPORTING PORTAL

Magellan recognizes that secure, online access to report data is growing in importance to our customers. We have responded with our Customer Dashboard, a password-protected portal that provides updated and actionable report data, accessible through a Web browser.

Through the Dashboard, we will provide information from our Data Warehouse regarding our operations relevant to this contract in order for the Department to easily monitor current utilization trends and predict future trends. The graphical elements of the Dashboard allow the user to drill down to the specific data of interest, such as a bar on a graph. Tabs located across the top of the screen present the data organized by category.

DATA SHARING AGREEMENT

Magellan typically would not execute a data sharing agreement with individuals within the Department as such terms would be addressed in the contract between the Department and Magellan; however, if Magellan's rights are not adequately protected in any future contract, Magellan will draft appropriate terms for review by the Department.

(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.

Magellan confirms that we will produce ad hoc reports and other data analyses as required. Any information that Magellan collects but does not display on the standard report set can be made available on an ad hoc basis.

Examples of types of ad hoc reports we have produced for our customers:

- A substance abuse analysis for a specified state
- Customer utilization comparison to commercial benchmarks
- Normative statistics by diagnosis
- High-risk patient analysis

For ad hoc reports, the estimated production time for delivery depends on the complexity of the report. Magellan's team will work with the Department staff to work out a mutually agreed-upon deliverable date.

Ad hoc reports will be provided to the Department at no additional charge. If it is determined that there is an on-going need for the report, Magellan will pursue turning the request into an enterprise, reoccurring solution.

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

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

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

Magellan agrees to this guarantee. Our 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 $1,000 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.

8. CONSULTING

The Department requires the Contractor to be an expert in the MHSA industry, thus, the Department requires the Contractor to provide the Department with up-to-date developments in the MHSA industry and may be requested by the Department to provide advice and recommendations related to such developments. The Department expects the Contractor to proactively provide advice and recommendations that are related to the clinical quality and cost management of the MHSA Program. Such recommendations must, at a minimum include preliminary analysis of financial, therapeutic and Enrollee impact of proposed and contemplated benefit design changes.

A. DUTIES AND RESPONSIBILITIES

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

(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

Magellan confirms that we will meet this requirement.

(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.

Magellan confirms that we will meet this requirement.

B. Required Submission

(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?

Communicating Trends and Industry Information to the Program

As described in more detail below, Magellan, as an industry leader in behavioral health, has programs in place to constantly stay abreast of the many changes in today's complicated health care environment including regulatory changes.

The Department's dedicated Empire Plan Program Manager, Keira O'Brien will serve as the liaison between the Department and Magellan's consulting resources. She will serve as a consultant during the Department's assessment process of new clinical advancements and technologies. In this role, she, with support or Magellan's departmental experts, would make recommendations regarding the potential consideration and inclusion of new technologies in the Empire Plan MHSA Program.

Ms. O'Brien will identify trends in the executive summary that accompanies each quarterly utilization report, discuss them during a regularly scheduled telephone or in-person contact, or initiate contact specifically to discuss the trend. Depending on the findings, she may recommend—for example—training, organizational intervention, or specific communication materials.

Our clinicians are another source of early, first-hand information about emerging trends. When a clinician shares trend information, Ms. O'Brien will pass the information on to the Department without breaching confidentiality, and will make recommendations to address the trend.

Ms. O'Brien will take a proactive approach in providing the Department with information related to behavioral health care, including legislative, market, and industry initiatives. He/she will be in regular contact with Magellan's Utilization Management Committee, Quality Improvement Committee, MHSA Underwriting Unit, Legal Department, Medical Economics Unit, and Magellan's Technology Assessment Committee to ensure that he/she is well equipped to consult with the Department on all important areas affecting the Empire Plan.

Additional initiatives Magellan will undertake to communicate trends and industry information to the Department include the following:

- In cooperation with the Department, scheduling meetings between the Department and our dedicated Medical Directors to discuss behavioral trends and advancements.
- In cooperation with the Department, provide trainings to key Department staff on timely MHSA issues.
- Meet with the Empire Plan medical vendor to offer consultation regarding behavioral health issues.
- Host quarterly or semi-annual briefings to discuss the following with the Department:
  - key State and Federal legislation developments pertaining to behavioral health care
  - plan utilization with an emphasis on intensive case management and the CHI, a enrollee self assessment tool
  - return on investment findings (e.g., average inpatient days for enrollees not enrolled in Magellan's intensive care management program versus average days for enrollees enrolled).
- Offer an annual consultation related to the implications of changes to the CPT code list and make recommendations regarding coverage.
- Inviting the Department to attend scheduled online seminars/conferences offered to our State and other public sector clients to discuss behavioral health management issues specific to public sector clients.

RESOURCES UTILIZED TO KEEP ABREAST OF MHSA DEVELOPMENTS

Magellan is fully committed to providing the most responsive, timely, and meaningful consultative services to the Department and all New York employers participating in the NYSHIP plan, throughout the course of the proposed contract. At Magellan, we employ a consistent and systematic process to ensure that our organization and our clients are always kept abreast of the latest developments in the mental health and substance abuse (MHSA) field. Our assessment of such developments may be initiated in conjunction with the results of Magellan-focused research and analysis, release of a newly published evidence-based clinical advancement, a provider request, a request from an external source, or the release of a new code for a code set applicable to a claim, among others. By virtue of our position as the largest and most experienced specialty health care company in the management and delivery of MHSA services, Magellan is *uniquely equipped to provide actionable, norm and experience-based consulting* on issues of benefit design, clinical services, program development, cost-containment strategies and new behavioral health technologies. Magellan provides behavioral management and associated claims adjudication services for 22.9 million lives

(an addition 10.0 million lives are covered through our employee assistance program services). Magellan has been managing health care services for a broad array of public and private sector clients for more than 40 years and is a nationally recognized expert and innovator in serving nearly 1,000 employer groups, 30 health plans, and federal, state, and local government agencies; accordingly, we believe we have amassed very broad and meaningful data related to the impact of various benefit designs on utilization, cost, and clinical outcomes.

Magellan's process for staying abreast of the latest developments in the MHSA field includes, but is not limited to the following:

- Review of information from appropriate government regulatory agencies and published scientific literature.
- Solicitation of input from relevant specialists and professionals with expertise in the area being assessed.
- Analysis and trending of our own exhaustive and proprietary Medical Economics warehouse of behavioral health data to identify burgeoning trends ahead of the rest of the industry.
- Frequent account discussions with our human resource and benefits manager contacts in our base of nearly 1,400 total customers to assess their needs and developing trends/innovations in the corporate benefits space.
- Regularly planned meetings and polling of the behavioral management consulting houses and broker community.
- Active participation with industry associations, university think tanks, and industry conferences.
- Review of press releases, legal and regulatory notices, and newsletters from organization such as the Association of Behavioral Health and Wellness (ABHW), an association of the nation's leading behavioral health and wellness companies, and Open Minds, a national behavioral health and social service industry market research and management consulting firm.
- Assigning designated Magellan contacts to obtain and provide updates from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Committee for Quality Assurance (NCQA).
- Analysis of trends, themes, and issues as seen in incoming proposals across all market segments within managed behavioral health (e.g., employer, health plan and public sector).

- Book of business continuous quality monitoring and data analysis driven by Magellan's Corporate Quality Improvement Plan and nine continuous corporate quality improvement committees (QICs), as well as by plan-specific QICs— such as the proposed Empire Plan Quality Improvement Committee.
- Regular book of business and customer-specific analysis of data collected via Magellan's Consumer Health Inventory (CHI) to trend clinical program performance both at the customer and organizational level. The CHI was developed in cooperation with *Quality Metric*.

Using a combination of data and analysis from all of the above resources, Magellan stays at the forefront in the development of innovative, outcomes-driven care management approaches and in the evidenced based evaluation of new behavioral health care technologies; thus assuring that our programs remain "cutting-edge." Leveraging the power of these resources, Magellan has a structure of in-house committees and internal departments prepared to partner with the Department to identify trends in behavioral healthcare, make the latest advancements in cost containment and technological improvements available, and assure continuous compliance with State and Federal legislation. These efforts have one goal in mind: improve treatment and outcomes for enrollees served through Magellan.

Our commitment to ensuring that the Department and New York employers have assess to the most current/up-to-date information is also evidenced by the following active Magellan committees/units:

MAGELLAN'S MEDICAL ECONOMICS UNIT

Through analysis of the benefit plan designs and clinical outcomes of our customers, Magellan's in-house, fully staffed Medical Economics Unit compiles norms and trend reporting; thus allowing our customers to understand how their MHSA benefit designs compare to those offered by other similar entities/competitors. Currently the Medical Economics unit has access to Magellan's HIPAA compliant data warehouse, allows for accurate and useful program comparison, analysis and benchmarking. The mission of the Medical Economics Unit is to leverage Magellan's extensive data warehouse to analyze, study and monitor the results of our various products. Magellan employs a threefold approach to benchmarking and assuring that our services are best in class.

- **Internal Benchmarks:** By virtue of Magellan's number of covered lives, variety of product configurations, and three decades of experience in the behavioral health field, Magellan's data is arguably the norm for the U.S. commercial managed behavioral health industry (although, of course, Magellan takes great care to ensure that all entries do not contain

personally identifiable information). Given this, Magellan's Medical Economics Unit has developed a normative data mart and corresponding normative report capability that permit comparison of critical data across a range of Magellan products. The Medical Economics Unit undertakes various studies of our own performance for various customers and product configurations and benchmarks it to similar customers. Variances are analyzed and the drivers of any significant differences are studied. Frequently the findings from these internal studies form the basis of quality improvement activities as well as the promulgation of best practice initiatives.

- **External Benchmarks:** Magellan also obtains and participates in external benchmarking efforts. We regularly participate in HEDIS, NCQA Quality Compass, and other benchmarking projects by the larger consulting houses. These external data sources give Magellan an external standard by which we can measure our performance to assure that we are delivering best-in-class services for our customers.

- **External Accreditation Bodies:** Magellan openly, transparently, and regularly undergoes scrutiny by various relevant accreditation bodies to demonstrate our commitment to quality services. These external accrediting bodies include NCQA, URAC, and COA. Magellan has an unparalleled record of positive results that demonstrates to our customers that we do in fact offer the best in class services as vetted by intense external scrutiny both of our process and our results.

MAGELLAN'S TECHNOLOGY ASSESSMENT COMMITTEE

Magellan also has an internal **Technology Assessment Committee (TAC)**, comprised of an interdisciplinary team of clinicians—sometimes including customer organization representatives and primary care physicians—which is responsible for conducting the new advancement/technology assessment. In the event of simultaneous requests for review, Magellan's Technology Assessment Committee prioritizes and rank which new technologies are to be assessed. Within the process, the Technology Assessment Committee applies Magellan's new advancement/technology assessment criteria. The criteria were developed by a multi-disciplinary team of licensed physicians and clinical psychologists—selected by Magellan's Chief Medical Officer—and are reviewed and updated as appropriate. The technology is reviewed according to the following criteria:

- the technology is as safe and effective as existing alternative treatments
- the technology improves the net health outcome, that is, provides evidence that the benefits outweigh the risks
- the improvement in health outcomes is reliably attainable outside investigative settings

- scientific evidence is present that sufficiently defines conclusive effects of the technology on health outcomes, as indicated by the following levels of evidence:
  - Randomized trials that demonstrated a statistically significant health outcome
  - Randomized trials with results that were not statistically significant, but in which a larger trial might have shown a clinically important difference
  - Nonrandomized concurrent cohort comparisons between contemporaneous patients
  - Nonrandomized historical cohort comparisons between current patients and former
  - patients (from the same institution or from the literature)
  - Case series without control subjects

The Technology Assessment Committee then categorizes the new advancement/technology as follows:

- **Future:** in a conceptual stage, anticipated, or in the earliest stage of development
- **Experimental:** undergoing bench or laboratory testing using animals or other models
- **Investigational**: undergoing initial clinical (that is, in human) evaluation for a particular condition or indication
- **Established:** considered by providers to be a standard approach to a particular condition or indication and diffused into general use
- **Obsolete/outmoded/abandoned:** superseded by other technologies or demonstrated to be ineffective or harmful

As appropriate, the technology has final approval from the appropriate government regulatory bodies. Following the assessment, the Technology Assessment Committee submits its findings and determination to the National Clinical Management Committee, within Magellan, who reviews the determination for consistency with clinical criteria, current enrollee and provider materials, applicable clinical practice guidelines, and care management processes. Under the direction of the Technology Assessment Committee, the assessment and determination is then distributed to the Magellan Care Management Centers and relevant customer organizations.

MHSA Focused Legal Department

Magellan assures that our organization complies with all relevant State and Federal legislation through our internally-based Compliance Department, which conducts routine research on new

State and Federal requirements using a variety of resources. As issues are discovered, each is researched and responded to as appropriate. All impacted internal and external stakeholders—including our customers—are contacted to provide input, feedback, and/or action as appropriate.

Magellan's Legislative Analysts perform searches in legal and state databases to find bills and regulations applicable to Magellan and distribute that information to the Compliance Attorneys and Compliance Directors on a timely basis. Compliance Attorneys perform a legal analysis and determine the applicability to corporate operations. The Compliance Directors facilitate compliance by working with the Magellan regional office and other corporate departments to implement the statutory and regulatory requirements. Magellan constantly monitors changes in New York State law and regulations to make certain that we are compliance.

Corporate policies are used to demonstrate evidence of compliance with accreditation standards including NCQA, Department of Labor laws, CMS, and HIPAA requirements and any other applicable federal law that may impact Magellan. The Senior Vice President for each Magellan corporate department oversees the writing of department applicable policies. Magellan regional offices (Care Management Centers) review and draft customized corporate policies to meet state specific and customer specific legal requirements. A corporate content expert and Compliance Attorney review each policy against any applicable accreditation standards, State and Federal laws. The Corporate Compliance Officer and General Counsel review and approve every corporate and customized policy prior to implementation.

Magellan would be pleased to communicate legislative changes to the extent that those changes impact the services to be delivered by Magellan under the terms of any service agreement with the Department; however, Magellan will not act as legal counsel for the Department.

MHSA Premium Development Assistance

Magellan has a highly experienced underwriter, Kevin Litkowski readily available to work with the Department and Ms. O'Brien with regard to the cost of any benefit plan changes and other issues related to underwriting. Supported by our underwriting team, Mr. Litkowski will work with the Department to provide a preliminary analysis of all associated costs of proposed benefit design changes necessary to accommodate Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the Department.

Any preliminary cost analysis would be made using the following:

- Utilization rates
- Average cost of care and counseling provided

- Level of services requested, such as in-person training, in-person Critical Incident Stress Management, etc.
- Vendor service costs, when applicable
- Care Management Center costs for calls and cases
- Costs including network, claims, reporting, and communication materials
- Care cost and administrative cost inflation trends
- Overhead and profit loads

We include biographical and experience information for Magellan's lead underwriter for the Empire Plan within the required **Exhibit I.B** forms (provided as **Appendix A**) as part of the Technical Proposal.

EMPIRE PLAN QUALITY IMPROVEMENT COMMITTEE (QIC)

Magellan, through our proposed Empire Plan Quality Improvement Committee, will also evaluate our success in meeting program goals through qualitative and quantitative analyses of the results of program activities and ongoing program modifications. Magellan uses the QIC model across our organization for assuring quality services for all customers. For the Empire Plan QIC, aggregated work plan performance indicator results are analyzed for achievement of goals/benchmarks, patterns or trends in data across the current year as well as compared to previous years, the impact of program activities on care and service to consumers, and opportunities for improvement. For measures that do not show optimal performance during the year, an annual evaluation includes root cause/barrier analyses and recommendations for interventions to address barriers.

Magellan's QIC establishes performance goals based on previous monitoring experience, external data, contractual requirements, accreditation and regulatory requirements, and/or industry standards and benchmarks. Performance is measured and indicators that do not meet goals may be identified as opportunities for improvement within a region or across the company.

Magellan also routinely monitors a set of core performance measures, including satisfaction—of our clients, their supervisors and employees, and our providers—with the objective of improving the quality of our services and programs. The Quality Improvement Committee reviews these measures regularly to verify that they are in compliance with Magellan's standards and to evaluate trends.

Satisfaction results may point to a need for a Quality Improvement Activity (QIA). A QIA is a method for identifying a process to be improved, studying the barriers that have prevented

improvement, making targeted interventions, and tracking whether the interventions have led to the desired improvement. A workflow or schedule modification, a policy enhancement, provider recruitment or training—these are examples of interventions. In 2012, **92.3 percent of Magellan enrollees reported overall satisfaction with Magellan services.**

UTILIZATION MANAGEMENT COMMITTEE (UMC)

It is the responsibility of the Utilization Management Committee (UMC) at Magellan to ensure that Magellan's Medical Necessity Criteria and clinical practice guidelines (CPGs) are continually updated to reflect the latest scientific and outcomes data available in behavioral health care. We also adopt Clinical Practice Guidelines from the American Psychiatric Association (APA), including:

- Practice Guideline for the Assessment and Treatment of Substance Use Disorders (SUD) and accompanying Quick Reference Guide
- Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Post-Traumatic Stress Disorder
- Practice Guideline for the Treatment of Patients with Major Depressive Disorder
- Practice Guideline for the Treatment of Patients with Bipolar Disorder
- Practice Guideline for the Treatment of Patients with Eating Disorders
- Practice Guideline for the Treatment of Patients with Panic Disorder
- Practice Guideline for the Treatment of Patients with Schizophrenia

Finally, Magellan has adopted a Practice Guideline for the Treatment of Patients with Obesity from "The National Institute of Health (NIH) Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, The Evidence Report."

Once Magellan adopts a practice guideline, each of Magellan's care management centers evaluates the guideline for its appropriateness in terms of meeting customer expectations, benefit plans, enrollee populations, and adherence to any customized utilization management criteria. To comply with NCQA requirements, the Magellan Care Management Centers annually monitor provider compliance with at least two of these guidelines. This is accomplished via Treatment Record Review audits of high-volume providers. The UMC also partners with other Magellan committees, such as the Technology Assessment Committee, to regularly evaluate the success of clinical technologies Magellan uses to promote improved care. Within this scope, for example, Intensive Case Management (ICM) programs are evaluated. Results drive program refinements as needed. In addition, as these committees notice trends in served populations, refinements are made to our

provider network as well. For example, for some of Magellan's public sector customers, we found it helpful to credential providers such as therapeutic foster homes and resiliency programs. These were added to our network to facilitate the best support for long term, complex MHSA cases.

EMPIRE PLAN-SPECIFIC STATE STRATEGIC ADVISORY GROUP

To demonstrate our total commitment to assisting the Department with regard to consultation services needed, Magellan will also consolidate the subject matter expertise available above and represent our organization's most experienced thought leaders via an **Empire Plan-specific State Strategic Advisory Group (EPSAG),** which will contribute strategically in an advisory capacity to the Department. Magellan's Empire Plan State Strategic Advisory Group will meet twice a year to strategically map the evolving needs of the Empire Plan and ensure that Magellan's products and services continue to be responsive to changing market forces. The enrollees of Magellan's EPSAG will bring to the table over 200 years of combined health care involvement with provision of services for state employees and their family members, as well as for Medicare/Medicaid beneficiaries. The EPSAG will be led by Lynn Hamilton, SVP, Employer Solutions. Ms. Hamilton has nearly 20 years of health care experience which includes leadership roles in finance, account management, and business develop. She holds a Masters Degree in Finance and Healthcare from the University of Connecticut and a CPA certificate in the State of Connecticut). Joining Ms. Hamilton in the EPSAG will be:

- Keira O'Brien, Magellan/Empire Plan Program Manager (Ms. O'Brien is currently responsible for successful management of the Preferred Drug List and ancillary programs for the largest Medicaid Program in the country as well as the New York Elderly Pharmaceutical Insurance Coverage Program. She was previously responsible for fiscal viability and property maintenance of an Office of Mental Health certified residential facility for individuals living with mental illness. She has an MBA from Rensselaer Polytechnic Institute and Lean Six Sigma Green Belt certification)
- Anne McCabe, Senior Vice President, Public Sector Solutions (Ms. McCabe, based in New York, has more than 30 years of working for provider organizations, state government, and private companies focusing on the behavioral health needs of individuals. She has held roles as Director of Managed Care and Governmental Relations and as Chief Of Staff Operations and Governmental Relations in the Commissioner's Office of the New York State Office of Mental Health. Ms. McCabe holds a master's degree in social welfare administration from the State University of New York, Albany and a bachelor's degree in psychology from Rutgers University.)

- Laurie Gondek, SVP Product Innovation (Ms. Gondek has nearly 30 years of health care experience which includes leadership roles in product development, marketing, sales and account management, strategy, mergers and acquisitions and operations.)
- Gary Henschen, M.D., Chief Medical Officer, Behavioral Health (Dr. Henschen has many years of experience in the behavioral health care field. He has previously held positions as an attending physician, as well as several senior medical leadership positions in hospital and managed care organizations.)
- Joann Albright, PhD., Senior Vice President of Quality Improvement and Outcomes and Research (Ms. Albright is a licensed psychologist in Pennsylvania and Colorado and a member of the National Council on Quality Assurance's Behavioral Health Measurement Advisory Panel.)
- Karen Friedman, Vice President, Account Management, Direct Contract Employer Accounts. (Ms. Friedman oversees a team of seasoned regional directors responsible for all account management functions. In addition, Ms Friedman has functioned as a dedicated account manager to the Federal Express MHSA and EAP account and has also worked as a director of clinical management as well as a clinical care manager. Ms. Friedman holds a Masters of Social Work and has co-authored two parenting books published by Viking Penguin and Harper Collins and has been a contributing writer to Working Mother Magazine.)

Each of these EPSAG members would be pleased to offer full consultative services to the Department and key New York State employer representatives if the Department finds this agreeable. For example, Dr. Henschen will be available to provide updates regarding trends and the latest advancements in behavioral health treatment. He will also offer consultation regarding plan design changes and overall industry changes such as the recent changes to ICD-10 codes or issues related to Mental Health Parity. Ms. Gondek also has extensive expertise related to autism and the treatment of young adults, which she would be please to share with the Department in a consultative role.

In addition to the members of the EPSAG listed above, Magellan would be pleased to offer the Department access to Magellan professionals serving our other State clients to share successes and lessons learned.

Magellan would also be pleased to discuss including representation from the Department, the Office of Mental Health, and the Office of Alcohol and Substance Abuse Services.

(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.

Magellan confirms that we 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.

9. TRANSITION AND TERMINATION OF AGREEMENT

The Contractor shall ensure that upon termination of the Agreement, any transition to another organization be done in a way that provides Enrollees with uninterrupted access to their MHSA benefits and associated customer services through the final termination of the Agreement . This includes, but is not limited to: ensuring Enrollees can continue to receive services from Network Provider, the processing of all claims; verification of enrollment; providing sufficient staffing to ensure members continue to receive good customer service and clinical management service even after the termination date of the Agreement; and developing a strategy for addressing the treatment needs of those members in treatment with Providers that are not in the successor contractor's network. It is also imperative that the MHSA Program continue to have dialogue with key personnel of the Contractor's dedicated account team, maintain access to online systems and receive data/reports and other information regarding the MHSA Program after the termination date of the Agreement. In addition, the Contractor and the successor contractor shall fully cooperate with the Department to create and establish a transition plan in a timely manner.

A. DUTIES AND RESPONSIBILITIES

(1) The Contractor must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the MHSA Program;

Magellan confirms that we will meet this requirement.

(2) The Contractor must, within one hundred twenty (120) Days prior to the end of the Agreement, or within forty-five (45) Days of notification of termination, if the Agreement is terminated prior to the end of its term, provide the Department with a detailed written transition plan, which outlines, at a minimum, the tasks, milestones and deliverables associated with:

(a) Transition of MHSA Program data, including but not limited to a minimum of one year of historical Enrollee claim data including providers' telephone numbers, names, addresses, zip codes and tax identification numbers, detailed COB data, report formats, pre-certification/prior authorization, approved - through dates, disability determination approved-through dates, any exceptions that have been entered into the adjudication system on behalf of the Enrollee, as well as other data the successor contractor may request and the Department approves during implementation of the MHSA Program in the format acceptable to the Department. The transition or pre-certification/prior authorization files should include but not be limited to the following;

(i) Providing a test file to the successor contractor in advance of the implementation date to allow the successor contractor to address any potential formatting issues;

Magellan confirms that we will meet this requirement.

(ii) Providing one or more pre-production files at least four 4 weeks prior to implementation that contains pre-certification/prior authorization approved - through dates and one year of claims history as specified by the Department working in conjunction with the successor contractor;

Magellan confirms that we will meet this requirement.

(iii) Providing a second production file to the successor contractor by the close of business January 2nd (or 2 days after the Agreement terminates) that contains all pre-certification/prior authorization approved – through dates specified by the Department working in conjunction with the successor contractor.

Magellan confirms that we will meet this requirement.

(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;

Magellan confirms that we will meet this requirement.

(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;

Magellan confirms that we will meet this requirement.

(5) The Contractor shall be responsible for transitioning the MHSA Program in accordance with the approved Transition Plan;

Magellan confirms that we will meet this requirement.

(6) To ensure that the transition to a successor contractor provides Enrollees with uninterrupted access to MHSA benefits and associated customer services, and to enable the Department to effectively manage the Agreement, the Contractor must provide the following obligations and deliverables to the MHSA Program through the final financial settlement of the Agreement, including but not limited to:

(a) Provide all Contractor-provided services associated with claims incurred on or before the scheduled termination date of the Agreement, including but not limited to paying network claims, manual submit claims including but not limited to: Medicaid, out-of-network claims, foreign claims, in-network claims, COB claims, and Medicare, reimbursing late filed claims if warranted, repaying or recovering monies on behalf of the MHSA Program for Medicare claims, retaining NYBEAS access and continuing to provide updates on pending litigation and settlements that the Contractor or the NYS Attorney General's Office has/may file on behalf of the MHSA Program. In addition, the Contractor must continue to provide the Department access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Department notifies the Contractor that access may be ended at an earlier date;

Magellan confirms that we will meet this requirement.

(b) Complete all reports required in Section IV.B.7.a.(7) of this RFP;

Magellan confirms that we will meet this requirement.

(c) Provide the MHSA Program with sufficient staffing in order to address State audit requests and reports in a timely manner;

Magellan confirms that we will meet this requirement.

(d) Agree to fully cooperate with all Department and/or OSC audits consistent with the requirements of Article XXIII of the Agreement and Appendices A and B;

Magellan confirms that we will meet this requirement.

(e) Perform timely reviews and responses to audit findings submitted by the Department and the Comptroller's audit unit in accordance with the requirements set forth in Article XXIII "Audit Authority", Section VII, Contract Provisions and Appendices A and B; and

Magellan confirms that we will meet this requirement.

(f) Remit reimbursement due the MHSA Program within fifteen (15) days upon final audit determination consistent with the process specified in Article XXIII, "Audit Authority" and Article – "Payments/credits) to/from the Contractor" of Section VII, Contract Provisions and Appendices A and B.

Magellan confirms that we will meet this requirement.

(7) The Contractor must receive and apply enrollment updates, keep dedicated phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of the Agreement, adjust phone scripts, and transfer calls to the successor contractor's lines during the transition period;

Magellan confirms that we will meet this requirement.

(8) The Contractor must work cooperatively with the successor 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;

Magellan confirms that we will meet this requirement.

(9) The Contractor must prepare, on a case by case basis, a plan to extend and manage the care of high risk Enrollees who are nearing the end of a course of treatment beyond the transition period;

Magellan confirms that we will meet this requirement.

(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;

Magellan confirms that we will meet this requirement.

(11) The Contractor must continue to manage and pay for Covered Services of Enrollees who are confined on or before December 31, 2018 until the earlier of the step down of care or midnight on the 90th day subsequent to December 31, 2018; and

Magellan confirms that we will meet this requirement.

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

Magellan confirms that we will meet this requirement.

B. Required Submission

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

Magellan confirms that we will meet this requirement.

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

Transition Plan Key Elements and Tasks

Magellan understands the importance of seamlessly transitioning behavioral health care programs from one vendor to another with a focus on providing enrollees with uninterrupted access to their MHSA benefits and associated clinical and customer services. We assure the Department that in the event you decide to terminate services with this Offeror we will provide seamless, proactive, responsive and helpful service throughout contract termination and program transition period, so that your enrollees will receive the highest customer service and your administrators will have the information needed to enable services smoothly with another vendor as needed. Of course, we also seek to work closely with the Department so that your needs are consistently met throughout the proposed contract period, as well.

Magellan has comprehensive written policies, guidelines, and account management tools) available to all program managers and account executives regarding the specific tasks required both internally and in conjunction with our customers to assure all services are coordinated regarding contract termination. Upon account termination, Magellan's dedicated Program Manager for the Empire Plan would work with the Department to develop a detailed, custom program termination and transition plan that will include, at a minimum, the tasks, milestones and deliverables associated with:

- Notifying the Magellan network regarding new Insurer contact information.
- Consulting with the Department regarding internal communications to announce Insurer changes and transition protocols to enrollees.
- Transitioning all relevant program data to the Department and its selected vendor in a timeline acceptable to the Department.

- Transferring clinical information necessary to ensure the safety and continuity of a enrollee's on-going treatment or future treatment.
- Providing all services associated with claims incurred on or before the scheduled termination date of the Agreement.
- Providing the Department access to any online claims processing data and history and online reporting systems.
- Completing all required reports.
- Performing timely reviews and responses to audit findings submitted by the Department and the Comptroller's audit unit.
- Remitting any applicable reimbursement due the Program in a timely manner upon final audit determination.
- Reaching agreement with the Department on receiving and applying enrollment updates, keeping dedicated phone lines open for up to thirty days post termination (if desired) with adequate available staffing, and transferring calls to a new Insurer.
- Working with the Department and its selected vendor to execute a method to identify and notify enrollees who are receiving care from Magellan Network Providers, which are not a part of the new provider network, of their financial responsibilities at the end of the transition period should enrollees continue care with a Non-Network Provider.
- Maintaining and managing all inpatient and higher level of care authorizations at point of contract termination until step down level of care (see below for more information).
- Developing an approach to ensure a smooth transition for enrollees who must change Providers to maintain the network level of benefits.
- Preparing, on a case by case basis, a plan to extend and manage the care of high-risk patients beyond the transition period for high risk enrollees who are nearing the end of a course of treatment.
- Assisting the successor Insurer with its attempts to incorporate Providers currently being used by enrollees into the successor Insurer's network.
- Retaining liability for enrollees determined to be disabled at the end of the Agreement as a result of this RFP, for 90 Days or until the disability ends, whichever occurs first.

ACCOMPLISHING REQUIRED DUTIES AND RESPONSIBILITIES

Magellan's primary goal following an account termination is to ensure that enrollees receive the behavioral health care services they need with no gaps or delays in treatment. Prior to the new Insurer's "go live" date, Magellan will prepare a list of enrollees currently in certified MH/SA treatment (all levels of care except outpatient), and will fax or e-mail the list to the new Insurer and/or the Department as preferred.

The enrollee list will include the following:

- Member (patient) name
- Social Security Number or Identifier
- Hospital/Treatment Facility Name
- Hospital/Treatment Facility contact person (name & telephone number)
- Expected date of discharge

This list will serve as a starting point for coordinating with the new Insurer and facilitating a seamless transition for enrollees who remain in treatment after the Agreement termination date.

INPATIENT, PARTIAL HOSPITAL, RESIDENTIAL OR INTENSIVE OUTPATIENT (IOP) CARE

For enrollees who are currently in Inpatient, Partial Hospital, Residential or Intensive Outpatient (IOP) treatment upon termination, Magellan will be responsible for concurrent authorization of treatment begun prior to termination, and through step down/discharge to a less restrictive level of care or for 30 days post termination date, whichever comes first. Claims for these services will be handled in the same manner as claims were handled prior to the termination date

Magellan will instruct the facility providing the treatment to contact the new Insurer and will offer appropriate contact information during discharge planning. This will alert the facility that there has been a change in Insurers and also inform the facility to call the new Insurer to assist with discharge planning and authorizations for additional services as appropriate.

Magellan will provide the facility with the new Insurer's phone number and will instruct the enrollee/facility to contact the new Insurer to receive the appropriate benefits for treatment services upon step down/discharge/30 days post termination. Services received from a non-network provider after step down to a less restrictive level of care or after the expiration of the grace period may be subject to a lower benefit level, depending on benefit plan design.

If requested by the Department, Magellan will assist in preparing, on a case by case basis, a plan to extend and manage the care of high risk patients beyond the transition period for all high risk enrollees who are nearing the end of a course of treatment. For example, we might suggest that if the Magellan Care Manager and the patient's treatment team agree that a high risk enrollee is expected to end their course of treatment within 30 days of the Agreement termination date, Magellan will continue to manage that patient's care until discharge.

OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

For enrollees receiving outpatient treatment, Magellan's authorizations will end on the termination date of the contract and enrollees will typically be notified by the customer that they will have a 60-day grace period from the new Insurer to obtain continued authorization with that Insurer for ongoing outpatient treatment begun with their current outpatient provider. Magellan can certainly assist the Department by providing language for a enrollee educational letter regarding what enrollees should do to transition their outpatient care.

We generally recommend that enrollees who are already in outpatient treatment prior to termination call the new Insurer within a specified number of days of the termination in order to request continued care authorization and verify their treating provider is in the new network. If the enrollee's current provider is not a new Insurer network provider, then the enrollee can: 1) switch to a new Insurer network provider or 2) continue to see the out-of-network provider at a reduced benefit if allowed by he benefit plan, so long as that care is determined to be medically necessary.

Certification for outpatient treatment past the termination date is the responsibility of the new Insurer and enrollee.

CLAIMS PROCESSING

With regard to claims processing following client termination, Magellan's standard is to continue to process claims with incurred dates of service prior to the date of termination for the total of the timely filing period. In addition, claims processing will be available to any appeals submitted up to 180 days past the last day of the account's timely filing period. This timetable allows for all claims for services incurred pre-termination to be processed, and, where applicable, appealed.

MEMBER COMMUNICATION

Magellan will consult with the Department on how best to inform enrollees in care of the change in Insurer and transition policy. Communications sent to enrollees which describe the transition period should emphasize that a grace period is being provided to allow (if applicable) participants to

complete treatment, or to make decisions about treatment to be received after the expiration of the transition period. These decisions include:

- Changing to a new Insurer network provider to maintain enhanced benefits.
- Remaining with an out-of-network provider and receiving reduced benefits (dependent upon benefit plan coverage for out-of-network care).
- The communication should emphasize the enrollee's responsibility in making choices according to the new benefit plan.

NETWORK PROVIDERS

As noted above, Magellan recognizes that a change in Insurers may, in a small number of cases, affect enrollees who are receiving care from a Magellan network provider who may not be a network provider for the new insurer. Identifying these enrollees would require the cooperation of the new Insurer and their willingness to make network data available to Magellan or the Department. With access to the new Insurer's network data, Magellan can generate a report presenting the enrollees who are in treatment with a Magellan network provider who is not contracted with the new Insurer's network (or the Department can have a non-affiliated vendor contractor, such an Ingenix, run a network disruption and comparison). This report would allow Magellan and the Department to share the appropriate information about these providers with the new Insurer to assist them in recruiting these providers; thus, allowing the patient to remain in treatment with their current provider at the in network level of benefits.

Magellan would be pleased to help facilitate the process of enrollees transferring to an in network provider with the new Insurer, if the enrollee wishes, by warm-transferring them to the new insurer's call center for a referral.

DATA AND REPORTING

Magellan will work with the Department and the new Insurer to see that all relevant data, including clinical information necessary to ensure the safety and continuity of a enrollee's on-going treatment or future treatment, is provided to the new Insurer in a timely fashion. We will also provide the DC with all required reports and access to any online claims processing data/history and our online reporting systems for mutually agreeable timeframe after Agreement termination.

Additionally, Magellan will also make available any necessary historical patient claim data, detailed COB data, report formats, prior authorization files, appeal data and exceptions that have been

entered into the adjudication system on behalf of the patient, to the new Insurer. The open claim and open benefit authorization files will include but not be limited to the following:

- Providing a test file in advance of the implementation to allow the new Insurer to address any potential formatting issues.
- Providing a pre-production file due a few weeks prior to implementation that contains open benefit authorizations for enrollees as specified by the Department working in conjunction with the selected Insurer.
- Providing a production file to the successor Insurer that contains all open benefit authorizations as specified by the Department working in conjunction with the selected Offeror.

The Magellan dedicated Empire Plan Program Manager, Keira O'Brien will coordinate all services needed by the Department related to contract termination.

(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.

CUSTOMER AND CLINICAL MANAGEMENT SERVICE AFTER TERMINATION DATE

Magellan is fully committed to continuing to provide all necessary and appropriate customer service and clinical management services after the termination date of the Agreement resulting from this RFP. Magellan will continue to process all relevant claims; verify enrollment; and provide sufficient staffing to ensure all Empire Plan enrollees continue to receive quality customer service and clinical management service following the termination date of the Agreement.

Furthermore, all key Magellan personnel will be available to the Department to resolve any issues that may arise after termination; Magellan will continue to provide any necessary data/reports, and Magellan will continue to offer the Department appropriate access to online systems.

Magellan telephonic services will continue to be active for the first 30 days post termination to allow any communications regarding cases in process, or unresolved inquiries upon termination to be resolved. Licensed Care Managers will be available to manage active inpatient/ALOC cases and assist with discharging planning and/or with transitioning patients to lower levels of care that will be covered by the new Insurer. Customer Service Associates will also be available to answer benefit and claims inquiries.

If the Department finds it acceptable, after 30 days, the dedicated toll free number will no longer be answered "live," but will be answered by an automated service. A script may be designed according to the needs of the Empire Plan which will include contact information for the new Insurer for inquiries about services accessed after the termination date and an option to speak with a Magellan Customer Service Associate regarding services accessed prior to the termination date. It may also include information for submitting a claim for services accessed prior to the termination date.

In most cases, after 90 days, the phone line is disconnected; however Magellan would be willing to discuss continuing phone service longer if necessary.

(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.

Magellan confirms that we will meet this requirement.

10. NETWORK MANAGEMENT

Empire Plan Enrollees reside throughout the United States and are guaranteed access to Network Providers under the design of the MHSA Program. The Contractor must have a comprehensive, nationwide Provider Network in place to allow adequate access for Enrollees to obtain all covered MHSA services through the Provider Network. Through this RFP, the Department MHSA Program is seeking a Provider Network that delivers cost-effective clinically appropriate MHSA services, while meeting the minimum guarantees for Network Provider access.

Provider Network

The current MHSA Program includes a nationwide Provider Network through which Enrollees can obtain all covered MHSA Program services. The Offeror must propose and the Contractor must provide a MHSA Provider Network that meets or exceeds the MHSA Program's minimum access guarantees at the time of proposal submission that is credentialed and contracted for participation in the MHSA Program's Provider Network commencing on January 1, 2014. The Contractor may choose to enter into MHSA Program-specific Provider contracts that are contingent on award and/or utilize existing Provider agreements that can be made applicable to the MHSA Program to meet the MHSA Program's requirement that the Contractor have executed contracts with all the Network Providers included in the Contractor's proposed provider Network File upon the submission date of their Proposal.

A. DUTIES AND RESPONSIBILITIES

(1) The Contractor must maintain a credentialed and contracted MHSA Provider Network that meets or exceeds the MHSA Program's minimum access standards throughout the term of the Agreement.

Magellan confirms we will meet this requirement.

(2) The MHSA Program requires that the Contractor have available to Enrollees on January 1, 2014 its proposed MHSA Provider Network in accordance with the requirements set forth in Section IV.B.3.a.(2)(a) guaranteeing effective implementation of their proposed Provider Network.

Magellan confirms we will meet this requirement.

(3) The Contractor shall offer participation in its MHSA Provider Network to any Provider who meets the Contractor's credentialing criteria upon the Department's request where such inclusion is deemed necessary by the Department to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees outlined below.

Magellan confirms we will meet this requirement.

(4) In developing its proposed MHSA Provider Network, the Contractor is expected to use its best efforts to substantially maintain the composition of Network Providers included in the MHSA Program's current Provider Network. The Contractor's proposed MHSA Provider Network must be composed of an appropriate mix of licensed and/or certified psychiatrists, and psychologists, licensed and registered Clinical Social Workers (CSW) (in NYS social workers must have an "R" number issued by the State Education Department), Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists and registered nurse practitioners, Certified Behavioral Analysts, Structured Outpatient Programs and Partial Hospitalization Programs including: residential treatment centers, group homes, hospitals and alternative treatment programs such as day/night centers, half-way houses and treatment programs for dually diagnosed individuals (e.g., mental health diagnosis and substance abuse diagnosis). Programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) must be included in the MHSA Provider Network. The MHSA Provider Network must include Providers throughout New York State and in areas with high concentrations of active and/or retired employees living outside of New York State such that the network access guarantees established by the terms of the Agreement are fully satisfied;

Magellan confirms we will meet this requirement.

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

Magellan confirms we will meet this requirement.

(6) Network Provider Access Guarantee: The Contractor must guarantee that, throughout the term of the Agreement, the Contractor's MHSA Provider Network meets or exceeds the Department's minimum access guarantees as follows;

a) Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Facility within five (5) miles;

Magellan confirms we will meet this requirement.

b) Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Facility within fifteen (15) miles;

Magellan confirms we will meet this requirement.

c) Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Facility within forty (40) miles;

Magellan confirms we will meet this requirement.

d) Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Practitioner within three (3) miles;

Magellan confirms we will meet this requirement.

e) Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Practitioner within fifteen (15) miles; and,

Magellan confirms we will meet this requirement.

f) Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Practitioner within forty (40) miles.

Note: In calculating whether the Offeror meets the minimum access guarantees, all Enrollees must be counted; no enrollee may be excluded even if a Provider is not located within the minimum access area.

Offerors should propose a guarantee for each of the three (3) areas (urban, suburban and rural) for each of the following two Provider types: Network Facility (Inpatient and ALOC) and Network Practitioner types (Psychiatrist; Psychologist; Licensed Clinical Social Worker) for a total of six separate guarantees. These guarantees are based on the distance, in miles, from a MHSA Program Enrollee's home (zip code) to the nearest MHSA Provider Network Provider location.

Urban, suburban and rural are based on US Census Department classifications, as determined by GeoAccess. Offerors may guarantee better access than the minimums, but the guarantee must follow the same structure as the above minimum (i.e., access guarantees for each two Provider groups for each of the six (6) Provider type/area combinations based on the entire MHSA Program population).

Magellan confirms we will meet this requirement.

B. Required Submission

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

% of Enrollees with Access to Network Facilities	Enrollee Location	Access Guarantee – 1 Network Facility at least within
95 %	Urban	5 miles
95 %	Suburban	15 miles
95 %	Rural	40 miles

% of Enrollees with Access to Network Practitioners	Enrollee Location	Access Guarantee – 1 Network Practitioner at least within
95 %	Urban	3 miles
95 %	Suburban	15 miles

% of Enrollees with Access to Network Practitioners	Enrollee Location	Access Guarantee – 1 Network Practitioner at least within
95___%	Rural	40__miles

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

Magellan has a network of Autism program providers who deliver these services which are traditionally provided to the enrollee either in their home or school; therefore, since providers will be traveling to the enrollees' location, a traditional access standard based on enrollees' time/distance travel to a provider would be not be applicable. This is also consistent with other home based services including Home Health and DME. Due to the recent emergence of this service, the industry lacks enough experience with providing autism services to set a standard population/provider ratio or other numerical standard. Magellan currently has 46 providers in New York consisting of both professional Certified Behavior Analysts(CBA's) and paraprofessionals to provide services to enrollees and is committed to ensuring that services will be rendered to enrollees in a timely manner, by the appropriately qualified and credentialed individuals in accordance with enrollees' prescribed treatment plans. Magellan will continuously monitor access needs via enrollee and care manager feedback, satisfaction surveys, and other methods. We will recruit additional providers as necessary to meet the needs of the enrollees. Magellan strongly believes that no one should be denied access to quality services. We have repeatedly demonstrated our expertise in identifying and using all available treatment resources needed to effectively care for our customers' employees, wherever they work or live.

% of Enrollees with Access to Certified Behavior Analysts	Enrollee Location	1 Certified Behavior Analyst at least within
__N/A___%	Urban	N/A___miles
__N/A___%	Suburban	N/A___miles
__N/A___%	Rural	N/A___miles

(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.

Magellan has provided a completed **Exhibit I.Y.4** as **Appendix T**.

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

Magellan confirms we will meet this requirement.

(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.

We have recruited providers along the entire continuum of MHSA care:

- Licensed, vendor-eligible mental health and substance abuse professionals
  - Psychiatrists
  - Doctoral-level psychologists
  - Licensed clinical social workers(LCSW)
  - Registered Nurse Clinical Specialists and Nurse Practitioners
  - Certified Behavioral Analysts
- Licensed and accredited facilities and programs Note: all facility programs included in the provider file (exhibit I.Y.2) meet the requirements for OASAS
  - Inpatient psychiatric and substance abuse facilities
  - Outpatient psychiatric and substance abuse programs
  - Adolescent treatment centers

- Residential treatment centers
- Partial hospital and day treatment facilities
- Alternative Levels of Care

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

Magellan will work closely with the Department to ensure that enrollees have access to a full range of services. Chris Mogan, Field Network Director will lead **a team in the dedicated Empire Plan Service Center in Albany New York** in the further development and overall maintenance of our already comprehensive network in New York State.

Magellan evaluates enrollees' access to services using GeoAccess reports, starting with the initial reports run during this bid/implementation process, to identify any areas where enhancing the network would better serve the plan's enrollees. We plan to begin provider recruitment prior to award in order to maximize our efforts in meeting enrollee needs. Subsequent GeoAccess reports are run on an agreed upon frequency to ensure network stability and to identify any new gaps associated with provider terminations, relocations, or other issues.

In addition, Magellan will pay particular attention to recruiting the providers in the current MHSA network to minimize enrollee disruption of services during transition.

Magellan casts a wide net when identifying qualified providers to recruit into our network. We access community resources, professional association directories, and referrals from current credentialed network providers. Magellan will also recruit key providers recommended by enrollees, plan sponsors, and other appropriate stakeholders

A Sample Network Recruitment Plan is outlined below. This plan will, of course, be modified with a specific timetable for each provider type and geography.

SAMPLE NETWORK RECRUITMENT PLAN

- **Week 1-2: Outreach begins.** Activities consist of a minimum of three calls (placed by regionally-located Field Network Managers) and a recruitment mailing. Credentialing and contracting documents will be sent immediately to any professional or group provider accepting invitation to join the network.

- **Week 3: Invite all targeted professional providers to attend informational Webinars.** These will highlight the ease of doing business with Magellan, Magellan's Provider Value Proposition, establish positive relationships with key providers, and communicate important information about Magellan policies and procedures. For facilities, contract negotiations and credentialing begins.
- **Week 5-6: Informational Webinars begin.** Webinars will be held on multiple days at varying times in order to maximize the potential attendees. Provider Relations visits begin/offered for the key high volume providers (both facility and professional) that have accepted invitation to join the network. During this period, contract negotiations (for facilities) continue. Credentialing continues for professional providers.
- **Week 8: Facility contract negotiations concluded.** All recruited individual providers are also in the credentialing process.
- **Week 14: Individual providers targeted for recruitment are contracted.** All relevant systems are updated including provider search systems.

In the event that an enrollee has a specialized need which is not addressed by the existing network, Magellan quickly locates an appropriate provider for that enrollee and makes an ad hoc arrangement with that provider to serve the client. Magellan and the provider establish a single case agreement under which services to the enrollee are provided at the in-network benefit level.

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

Magellan recognizes that continuity of care is important to timely and successful completion of treatment. Therefore, as part of the implementation process, Magellan will utilize the disruption report submitted as part of our proposal as well as a current claims report from the Department, to target key providers, providers who see a large number of enrollees and providers who serve enrollees in underserved areas. Magellan will of course respond to specific nominations from enrollees, unions and other parties.

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

Magellan's account management team works closely with our network and clinical teams to ensure that the Magellan network meets the clinical needs of each plan sponsor. Magellan utilizes several touch points to identify any areas where additional recruitment might be indicated. As noted previously Magellan will utilize regular GeoAccess reports to identify any gaps that might impair network composition. Magellan also monitors the number of ad hoc arrangements that are put in place and evaluates those arrangements to identify opportunities to enhance the network.

Magellan's network team works closely with our network providers to ensure that quality of care is high and that enrollees have access to care. This information is also used to identify areas for targeted recruitment. Additionally, we believe providing thorough, accessible and timely services from Magellan is a critical means for providers to serve enrollees and be satisfied with their experience with Magellan.

Following are several key services and tools that support our providers on an ongoing process within our current New York network:

- **Provider Communication and Training:** Magellan delivers comprehensive, frequent communications to our providers to help them stay in touch with our organization and changes in service, clinical or administrative policy. Whenever there is a substantial change in policy or procedure, Magellan alerts providers via mail. Policy and procedure changes also are announced in our netletter, *Provider Focus*, which is posted quarterly on our Web Site. Providers are also alerted via e-mail and a postcard mailing that the current issue of *Provider Focus* is available. News regarding policies and procedures also can be posted in a "Spotlight" item in the provider area of the Web site. Further, changes are incorporated into the annual update to the Magellan *Provider Handbook,* and these changes are highlighted in a postcard mailing to providers announcing the handbook update.
- **Handbook**—Distributed in hard-copy to Magellan providers upon request and also available online, the Magellan *Provider Handbook* gives an overview of Magellan's vision and values, outlines credentialing standards and procedures, explains our provider reimbursement procedures, and includes our clinical practice guidelines, among other things.
- **Netletter**—Current behavioral health activities and programs are discussed in *Provider Focus,* Magellan's online provider netletter. This publication appears quarterly on our Web site and includes interviews and other articles of interest to our providers. Both national and regional quality initiatives are frequent features.

- **Training**—We believe that staying abreast of the latest health care research and sharing best practices yields improved outcomes for the enrollees we serve. Therefore, Magellan created the Learning Advisory Board, which is made up of some of the company's most experienced clinical thought leaders and serves to identify, develop, and facilitate the delivery of a wide variety of relevant training programs for our network providers. Taking this strategic approach ensures formalized, consistent training and accountability aligned with Magellan's corporate philosophy, resulting in the most effective care for our enrollees while also saving providers time and money. Providers may earn CEUs by participating in the more than 25 free online courses offered by Magellan through our Web site, https://www.magellanprovider.com/MHS/MGL/education/online_training.asp. We also offer an innovative online training program—our Provider Orientation module—that provides an overview of providers' responsibilities in our network, how Magellan encourages care coordination and reviews quality, how providers can properly maintain credentialing status, and how they can effectively work with Magellan in submitting claims and receiving payment. Available to providers upon login to the Magellan provider site, the program is helpful for both new and experienced Magellan providers. Clinical and administrative training is also delivered via our Provider Forum events held in select markets.
- **Provider Support Line**—Our Provider Services Line is staffed to respond to provider telephonic inquiries, compliments, and complaints. Provider Services Line employees are available to answer questions Monday through Friday during regular business hours. They can assist providers with address changes, claims, and credentialing questions. In addition, they connect providers with more complex questions to the local network team for assistance.
- **IVR Response Line**—Magellan also offer Interactive Voice Response information for providers, which can help simplify information access for busy providers.
- **Provider Site Visits**-Magellan regularly visits high volume providers to maintain ongoing communication and build upon the relationship

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

Magellan's provider agreements require that all "active" providers be available to see patients in accordance with Magellan's appointment availability standards as defined below.

Any providers who are not available (due to leave of absence, practice volume, etc.) are required to notify Magellan of their status. These providers' status with Magellan is updated so that the providers do not receive any new referrals.

For referring staff, the following levels of urgency are identified with response-time standards:

- Enrollees requiring services for what is determined to be a life-threatening emergency are seen immediately.
- Enrollees requiring services for what is determined to be a non life-threatening emergency are seen by a participating (PAR) and appropriately credentialed provider within six hours of the request for services.
- Enrollees requiring services for what is determined to be an urgent need are seen by a network and appropriately credentialed provider within 48 hours of the request for services.
- Enrollees requiring services for what is determined to be a routine need have access to an appointment with a network and appropriately credentialed provider within ten business days of first contact.

Additionally, 200 providers from the New York network are audited each quarter. New York Field Network Management staff outreach telephonically to randomly selected providers (if a provider has been audited within the previous two quarters another provider is randomly selected in their place). Field Network staff will continue outreaching until able to speak with the provider. Field Network staff will inquire when the provider's first available appointment currently is and if the provider has an available appointment slot within 10 business days from the date on which they are able to speak with the provider.

(10) Network Composition Guarantee: The MHSA Program's service level standard requires that at the least ninety percent (90%) of the total Providers counts in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologist, Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse Practitioner, Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist), listed on Exhibit I.Y.2; will be maintained throughout the five-year term of the Agreement. Providers who are no longer actively practicing will be excluded from the annual calculation and guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the guarantee. The Standard Credit Amount for each .01 to 1.0% below the MHSA Program's service level standard requiring that at least ninety-percent (90%) of the total Providers counts in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologist, Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse Practitioner, Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist) listed on Exhibit I.Y.2 will be maintained is $25,000 per year. However, Offerors may propose higher or lesser amounts.

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

Magellan agrees to this requirement. The quoted amount to be credited against the Administrative Fee is $25,000 per year for each .01 to1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) of the total Providers counts in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologist, Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse Practitioner, Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist) listed on Exhibit I.Y.2 as calculated on an quarterly annual basis is $6,250. Providers who are no longer actively practicing will be excluded from the annual calculation and guarantee.

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

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

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

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

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

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

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

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

The Offeror's quoted amount to be credited against the Administrative

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

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

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

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

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

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.

Magellan agrees to these requirements.

Magellan's quoted amount to be credited against the Administrative Fee is $6,000 ($36,000 total) for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the:

- Network Facility Access-for Urban Areas Guarantee is not met
- Network Facility Access-for Suburban Areas Guarantee is not met

- Network Facility Access-for Rural Areas Guarantee is not met
- Network Practitioner Access-for Urban Areas Guarantee is not met
- Network Practitioner Access-for Suburban Areas Guarantee is not met
- Network Practitioner Access-for Rural Areas Guarantee is not met

PROVIDER CREDENTIALING

The Contractor must ensure that MHSA Network Providers meet the licensing standards required by the state in which they operate. MHSA Network Providers are also required to meet the credentialing criteria established by the Contractor. These criteria should be designed to ensure quality MHSA care.

A. DUTIES AND RESPONSIBILITIES

(1) The Contractor must assure its MHSA Provider Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

Magellan confirms we will meet this requirement.

(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.

Magellan confirms we will meet this requirement.

(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.

Magellan confirms we will meet this requirement.

(4) The Contractor must maintain a Provider Relations staff presence within New York State.

Magellan confirms we will meet this requirement.

(5) The Contractor must maintain credentialing records and make them available for review by the Department upon request.

Magellan confirms we will meet this requirement.

(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.

Magellan confirms we will meet this requirement.

B. REQUIRED SUBMISSION

(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.

Magellan confirms we will meet this requirement.

(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?

Magellan ensures that network providers meet the applicable state licensing requirements and are in compliance with all other federal and state laws, rules and regulations through a comprehensive credentialing process. Magellan has been certified by the National Committee for Quality Assurance (NCQA) for all 10 verification services meeting NCQA's credentialing standards for the Accreditation of Managed Care Organizations. In addition, Magellan is responsible for all aspects of

the credentialing and network management processes, including qualitative and (when needed) legal review of provider performance. Magellan's Regional Network and Credentialing Committees (RNCCs) make all final credentialing determinations and conduct qualitative reviews and site visits as part of our network oversight practices. Additionally, Magellan retains our responsibility for network development, provider relations, provider education and outreach, rate negotiations and contracting. The steps in Magellan's credentialing process include:

1. Completion of Network Application

Prospective providers submit their applications in coordination with the Magellan field network staff. For providers who meet the basic criteria for inclusion in Magellan's provider network, an application is submitted to the Magellan Credentialing department for criteria verification. Detailed information regarding professional competencies, practice history, and areas of specialization is submitted on the application. Providers are asked to provide with the application supplementary information pertaining to clinical specialties, including treatment modalities, client populations served and experience with specific disorders. Providers can monitor the status of their application via a secure Web site.

2. Primary Source Verification of Credentials

All information submitted is primary source verified by Magellan for initial applicants. Magellan's in-house legal staff thoroughly investigates any legal actions or sanctions imposed by licensing and or certification boards or professional societies.

3. Approval of Credentials

Once primary source verification is completed, the provider's information is forwarded to a RNCC. The RNCC reviews the provider's application and pertinent Primary Source Verification information and renders a decision to accept the provider in Magellan networks. Following the RNCC decision, the provider's network participation status is updated, contracts are executed, and a copy of the executed agreement and letter of eligibility is sent to the provider. The referral information solicited with the application is entered online, analyzed, and incorporated into a provider profile. This referral information becomes available to clinical staff who make referral and authorization decisions on behalf of patients, and via Magellan's enrollee Web site where enrollees can conduct self-searches for providers in their area.

4. Recredentialing

Every three years (except where client requirements are every two years), providers must complete the process of recredentialing. Recredentialing includes administrative updates and reverifications as

well as clinical and quality review. The provider updates relevant documentation such as evidence of licensure and malpractice coverage, updated responses to general liability questions and attestation, and reverification of selected credentialing data elements. Administrative credentialing information, which is completed centrally, is considered with quality data maintained at the care management center. Quality data may consist of complaints, treatment record review results, satisfaction survey (if applicable) and other appropriate quality data. The information is reviewed by the regional RNCC to determine ongoing network and contract status.

DATABASE

All information submitted is primary-source verified by Magellan for initial applicants. Magellan's in-house legal staff thoroughly investigates any legal actions or sanctions imposed by licensing and/or certification boards or professional societies.

(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?

Magellan is fully accredited by NCQA as a Credentials Verification Organization (CVO). In our last NCQA audit, we achieved a 100 percent score with no opportunities for improvement. Magellan's Director of Professional Credentialing, Nadine Coy, holds ultimate responsibility for provider credentialing.

On May 07, 2012, Magellan again earned certification as a Credentials Verification Organization (CVO) by NCQA. NCQA evaluated Magellan's internal processes for verifying that physicians and other health care providers have the proper credentials to care for patients and found that the company's system provides the protections required by NCQA's rigorous standards for managed behavioral health care organizations. Magellan is fully certified by the NCQA in all 10 verification services and was the first managed behavioral health care organization in the nation to earn certification as a credentials verification organization. Magellan's CVO certification is valid until May 2014.

(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?

Magellan tracks actions on network providers' licenses and other credentials taken by state or federal agencies through an ongoing sanctions monitoring process. Reports from state licensing boards, the Medicaid/Medicare Sanctions report and GSA's Excluded Parties List System are queried continuously to identify any whose licenses have been officially sanctioned, disciplined or revoked as well as monitor for other actions taken against the provider. This information is then compared to our database of network providers. Those whose licenses have been suspended, surrendered or revoked are terminated immediately from the Magellan network and notified of their termination and appeals rights (as applicable). Enrollees in active treatment with the provider are notified of the provider's removal as soon as possible and given instructions for immediate transfer to another provider. A provider whose license has been disciplined, short of suspension or revocation, is contacted for an explanation and Magellan obtains official documentation from the sanctioning authority. The provider's explanation must be received within 30 days of request. Materials received are subjected to clinical and legal review through the PPRC and a decision made about the provider's ongoing network participation status. Should the review result in a decision to terminate the provider from the network, enrollees in active treatment are notified and instructed about transfer of care to another provider.

Magellan notifies our customers of the termination of a provider from our network as required by contract and within the limits of enrollee and provider confidentiality and relevant peer review regulations. Magellan would work with the Department to inform them of the status of both the provider and affected enrollees, again, within the context noted above.

(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?

Magellan maintains a number of programs designed to stay closely aligned with provider network changes including the following:

- **Communication with key state provider organizations** including the New York State Psychiatric Association and the National Association of Social Workers, among others;

- **Provider Participation and Feedback:** Magellan's Care Management Centers maintain Provider Advisory Groups (PAGs) comprised of network practitioners and enrollees. The panels, which meet quarterly and are chaired by the Chief Clinical Officer of the Care Management Center, collaborate on quality improvement and key clinical and service areas. This groups provide an important forum for feedback on clinical practice guidelines, continuity and coordination of care, and prevention services.
- Network staff holds periodic **Provider Forums,** which generally include live or teleconferenced presentations on current educational and preventive health activities and provide opportunities for providers to ask questions and discuss concerns with Magellan staff.
- **Provider Focus Groups** are held on an as needed to basis to obtain input into specific planned changes in Magellan services and programs (e.g. changes to the provider website)
- **Provider Satisfaction Surveys**-Annually, Magellan measures our providers' satisfaction regarding our business relationships with them through a 32-question Provider Satisfaction Survey. The surveys are mailed to our participating network providers who have received one or more authorizations during the first six months of the calendar year. Providers may return the completed surveys to us via mail, e-mail, fax, or Web.
- **Provider Relations and Network Management Staff:** Magellan offers providers personalized access to regionally-based staff to assist them with a host of needs. Under the direction of our Field Network Management staff, based locally in New York, Magellan's network staff is responsible for conducting ongoing face-to-face meetings with providers in their offices and in forum settings. They orient providers on new initiatives, train them on various tools Magellan has developed to simplify transactions with Magellan, and obtain feedback on Magellan's performance. Local network staff also visit with high-volume providers on a regular basis to focus on maximizing technological resources, addressing any day-to-day operational issues, and fostering positive provider relationships. Regular provider education forums are also conducted in high-volume market areas in order to reach the broader network of participating providers.

PROVIDER INFORMATION INFRASTRUCTURE

Magellan maintains communication and support for providers through a number of critical information tools as follows:

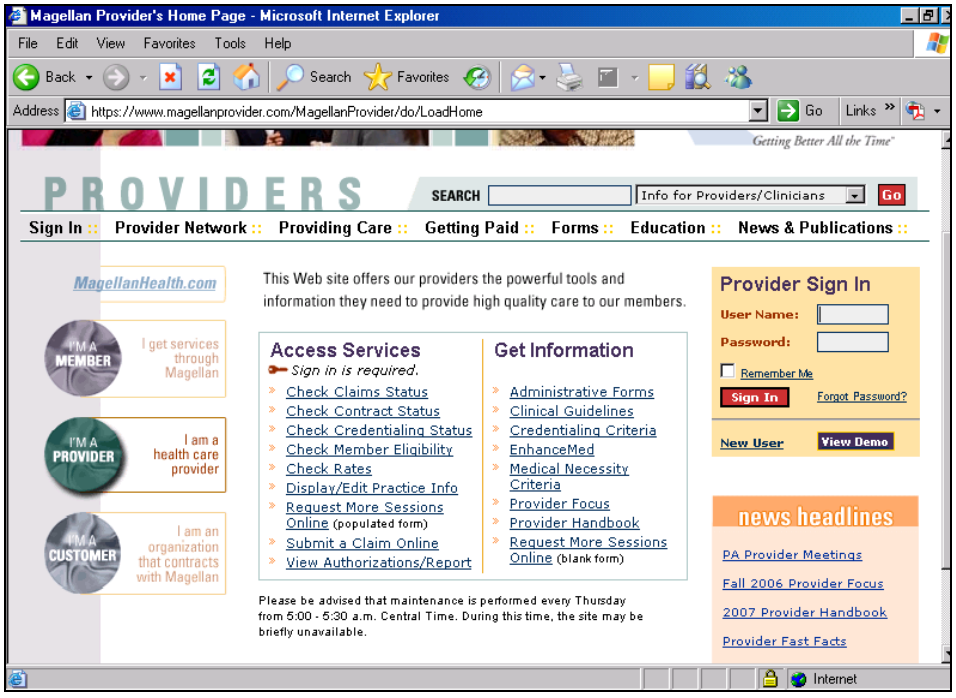
AWARD-WINNING WEB TECHNOLOGIES

As our primary tool for provider communication, our Web Site offers a wealth of resources for providers. Our Web site contains the following resources for providers' use:

- Magellan's *Provider Handbook*. The handbook:
  - Clearly and concisely defines Magellan's guidelines for network participation
  - Offers detail on guidelines relating to specific tasks such as executing the provider contract, submitting documents for credentialing/recredentialing review, providing access to care, conducting an initial assessment, completing an outpatient treatment request form, and numerous other processes integral to network participation
- Copies of Magellan's Medical Necessity Criteria and Clinical Practice Guidelines
- *Provider Focus*, Magellan's provider netletter
- "Ask Magellan," a guide of frequently asked questions offering specific information, resources, and Magellan contacts
- Information on HIPAA code sets

Additionally, our Web site offers value-added services that enable our providers to easily enhance their professional development, clinical knowledge, and overall service to our enrollees. Providers can access a variety of up-to-date, electronic enrollee education materials developed by Magellan's clinical team. Prevention program and general mental health brochures are designed to educate enrollees about a range of common behavioral health and wellness concerns, and can be e-mailed to enrollees or printed for hard-copy distribution or display in providers' offices.

Figure B.10.a: Online Provider Web Portal



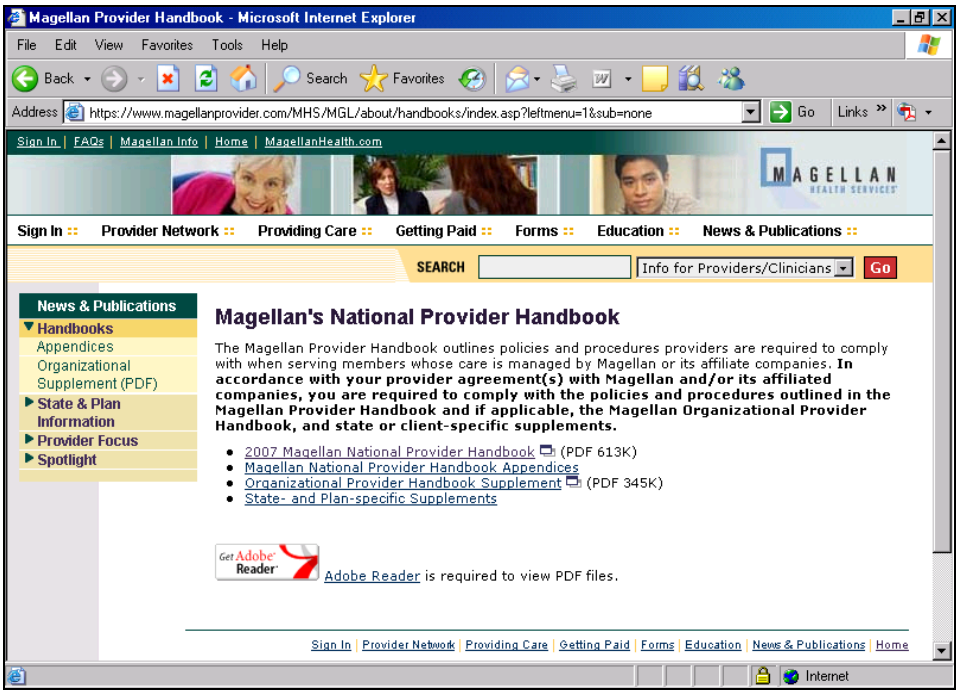
Providers who do not have Internet access may also request that essential documents be sent to them via U.S. mail.

PROVIDER COMMUNICATION AND TRAINING

Magellan delivers comprehensive, frequent communications to our providers to help them stay in touch with our organization and changes in service, clinical, or administrative policy. In addition to keeping in touch with providers when changes occur, Magellan offers standard communication and educational opportunities as follows:

- Handbook—Distributed in hard-copy to Magellan providers upon request and also available online, the Magellan Provider Handbook gives an overview of Magellan's vision and values, outlines credentialing standards and procedures, explains our provider reimbursement procedures, and includes our clinical practice guidelines, among other things.

Figure: B.10.b: Online Provider Handbook Provides Tools and Information



- **Netletter**—Current behavioral health activities and programs are discussed in *Provider Focus,* Magellan's online provider netletter. This publication appears quarterly on our Web site and includes interviews and other articles of interest to our providers. Both national and regional quality initiatives are frequent features.

- **Training**—We believe that staying abreast of the latest health care research and sharing best practices yields improved outcomes for the enrollees we serve. Therefore, Magellan created the Learning Advisory Board, which is made up of some of the company's most experienced clinical thought leaders and serves to identify, develop, and facilitate the delivery of a wide variety of relevant training programs for our network providers. Taking this strategic approach ensures formalized, consistent training and accountability aligned with Magellan's corporate philosophy, resulting in the most effective care for our enrollees while also saving providers time and money. Providers may earn CEUs by participating in the more than 25 free online courses offered by Magellan through our Web site, https://www.magellanprovider.com/MHS/MGL/education/online_training.asp. We also offer an innovative online training program—our Provider Orientation module—that provides an overview of providers' responsibilities in our network, how Magellan encourages care coordination and reviews quality, how providers can properly maintain credentialing

status, and how they can effectively work with Magellan in submitting claims and receiving payment..

- **Provider Support Line**—Our Provider Services Line is staffed to respond to provider telephonic inquiries, compliments, and complaints. . They can assist providers with address changes, claims, and credentialing questions. In addition, they connect providers with more complex questions to the local network team for assistance.
- **IVR Response Line**—Magellan also offer Interactive Voice Response information for providers, which can help simplify information access for busy providers.

(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?

Magellan offers our providers training and Web based resources to assist them in providing patient-centered care and ensure they have access to the best available scientific knowledge. Information about the latest health care research and best practices are also included in Magellan's provider netletter.

We believe that staying abreast of the latest health care research and sharing best practices yields improved outcomes for the enrollees we serve. Therefore, Magellan created the Learning Advisory Board, which is made up of some of the company's most experienced clinical thought leaders and serves to identify, develop, and facilitate the delivery of a wide variety of relevant training programs for our network providers. Taking this strategic approach ensures formalized, consistent training and accountability aligned with Magellan's corporate philosophy, resulting in the most effective care for our enrollees while also saving providers time and money.

Magellan has the ability to customize training topics for Empire Plan providers For example, in December 2011, Magellan conducted a substance abuse facility forum for a large Northeastern Health Plan client with the goal of engaging providers in discussions on out-of-network utilization challenges and our medical necessity criteria, while also providing educational opportunities that afforded continuing education credits to providers on medication assisted treatment and recovery/resiliency. Medication assisted treatment (MAT) has been an area of clinical focus for Magellan in improving enrollee outcomes and recovery. This topic was also an area of focus in our ongoing facilities meetings.

Providers may earn CEUs by participating in the more than 25 free online courses offered by Magellan through our Web site, https://www.magellanprovider.com/MHS/MGL/education/online_training.asp. We also offer an innovative online training program—our Provider Orientation module—that provides an overview of providers' responsibilities in our network, how Magellan encourages care coordination and reviews quality, how providers can properly maintain credentialing status, and how they can effectively work with Magellan in submitting claims and receiving payment..

CLINICAL PRACTICE GUIDELINES

In addition to training activities, Magellan assists our providers in offering patient centered care through distribution of our clinical practice guidelines (CPGs), which support quality- and evidence-based decision making. CPGs supplement *Medical Necessity Criteria* and assist providers in the assessment and treatment of common behavioral health disorders. Magellan's standard approach to selecting guidelines dictates that prior to the adoption of each guideline relevant scientific literature is reviewed by a multi-disciplinary panel that includes board-certified psychiatrists, with input from providers in Magellan's clinical network, from consumers, and from community agencies. The Magellan CPG Task Force reviews Clinical Practice Guidelines at least every two years and provides updates as necessary.

The guidelines developed by Magellan are as follows:

- Practice Guideline for the Treatment of Patients with Attention Deficit/Hyperactivity Disorder
- Practice Guideline for Assessment and Management of the Suicidal Patient.

Clinical Practice Guidelines adopted from external industry-recognized behavioral health expert panels, such as the American Psychiatric Association (APA), cover the most prevalent behavioral health disorders. Magellan has specifically adopted the following Clinical Practice Guidelines from the American Psychiatric Association (APA), which can be downloaded from the APA Web site at www.appi.org.

- Practice Guideline for the Assessment and Treatment of Substance Use Disorders (SUD) and accompanying Quick Reference Guide
- Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Post-Traumatic Stress Disorder
- Practice Guideline for the Treatment of Patients with Major Depressive Disorder

- Practice Guideline for the Treatment of Patients with Bipolar Disorder
- Practice Guideline for the Treatment of Patients with Eating Disorders
- Practice Guideline for the Treatment of Patients with Panic Disorder
- Practice Guideline for the Treatment of Patients with Schizophrenia.
- Practice Guideline for the Management of Children with Autism Spectrum Disorders

Finally, Magellan has adopted a guideline:

- Practice Guideline for the Treatment of Patients with Obesity—last review, September 2007 from The National Institute of Health (NIH) Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, The Evidence Report.

Once Magellan adopts a practice guideline, each of Magellan's care management centers evaluates the guideline for its appropriateness in terms of meeting customer expectations, benefit plans, enrollee populations, and adherence to any customized utilization management criteria. To comply with NCQA requirements, Magellan care management centers annually monitor provider compliance with at least two of these guidelines.

AUDITS OF PROVIDER ADHERENCE TO THE MAGELLAN CLINICAL PRACTICE GUIDELINES

Guidelines include those for the treatment of major depressive disorder, treatment and management of the suicidal patient, and the treatment of substance abuse disorders. CPG reviews are conducted by clinical reviewers within the QI department for those providers and cases identified above under the Treatment Record Review process. Selected cases are identified by clinical diagnosis and undergo additional scrutiny through use of the CPG audit tool specific to the targeted diagnostic category.

CONSUMER HEALTH INVENTORY

Magellan offers a unique tool that helps providers understand in real-time how their outpatient care is progressing from the enrollee's perspective. As part of our integrated and behavioral health outpatient services, Magellan has begun requesting that enrollees complete our unique Consumer Health Inventory during the assessment and counseling process so that risk and enrollee progress can be tracked in real-time by both Magellan and the treating provider. The form is completed by the enrollee electronically and shared with treating providers via our provider Web portal and with our clinical staff via flags in our clinical systems so that any enrollee self-reported outliers or risk indicators are shared immediately. This strengthens our ability to detect enrollee risk early on, even in cases where enrollees have self-referred to a provider.

CARE COORDINATION

Magellan prefers to approach joint care management and care coordination from the perspective of being the primary care provider for MHSA care and fully integrating our services with the primary care physician (PCP) and other medical providers in our joint treatment approach. We fully involve the PCP and medical providers in our treatment processes whenever possible and inform our enrollees of this preference. However, this decision is the enrollee's to make. We request the enrollee fill out an authorization to disclose confidential information form to facilitate this process. We would work closely with the Department and your medical vendor to develop coordination protocols that meet the needs of your program.

If the presenting problem is a substance abuse case, we request that the primary care manager retain the information in a separate location, as required by federal guidelines. Additionally, we work with PCPs, providing training regarding MHSA cases, encouraging them to make appropriate referrals and to seek authorization to disclose and receive clinically relevant information from Magellan.

We also require our network providers to be in direct contact with the PCP, given patient authorization to disclose confidential information, regarding the diagnosis; course of treatment; hospitalizations; and medications, effectiveness, and side effects. We routinely require that the network provider continue to provide the PCP with information about the extent to which treatment goals were met, the nature of termination, prognosis, and follow-up recommendations.

Cases of unusual complexity may require implementation of a formalized joint care management process. To ensure the right care the first time, Magellan coordinates our behavioral health system with the medical-surgical managed care system. Protocols will be developed to implement an effective relationship with the Department's medical care management teams. Criteria will established by which each health manager can readily determine the necessity of including the other when appropriate. The following are recommended minimum criteria:

- The Department's medical-surgical utilization review program notifies Magellan care management of medical cases that either are receiving concurrent behavioral care or whose diagnosis, treatment, transfer, or discharge plan indicates a need for behavioral care
- The Magellan Care Management team leader notifies the medical-surgical review program of behavioral care cases that are either receiving concurrent medical services or whose assessment, treatment, transfer, or discharge planning indicates the need for such
- In any emergency case where a possibility exists that both medical-surgical and behavioral care may be needed, the programs will contact each other
- All initial contacts will be by telephone and conducted with necessary release authorizations

Use of these protocols reduces the type of diagnostic errors and treatment omissions that can make health care ineffective and unnecessarily costly. Both the behavioral and medical/surgical needs of enrollees are addressed.

Magellan's Medical Director will work with the Department's medical vendor(s) to continue to ensure a smooth coordination process for the care of patients with significant and complicated health care and MHSA problems. In addition, the Medical Director can participate in medical leadership meetings.

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

Magellan confirms we will meet this requirement.

(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).

Magellan agrees to this guarantee. Our quoted amount to be credited against the Administrative Fee is $1,500 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.

PROVIDER CONTRACTING

Contracts with Providers must be written to utilize the MHSA Program's market strength to obtain competitive reimbursement rates with high quality Providers while also ensuring MHSA Program access guarantees are met. Contracting staff should keep abreast of current market conditions and have the wherewithal to adjust contracts with Providers that reflect the best interests of the MHSA Program. The Contractor must ensure that all Network Providers contractually agree and comply with the MHSA Program's requirements and benefit design. Contracts must be consistent with and support proposed access guarantees to ensure long-term stability of the Provider network. The Contactor may choose to enter into MHSA Program specific Provider contracts that are contingent on award and/or utilize existing Provider agreements that can be made applicable to the MHSA Program to meet the MHSA Program's requirement that the Contractor have executed contracts with all the Network Providers included in the Contractor's Proposed Provider Network File upon the submission date of its proposal.

A. DUTIES AND RESPONSIBILITIES

The Contractor will be responsible for providing Provider contracting services including but not limited to:

(1) Negotiating pricing arrangements that utilize the MHSA Program's size to optimize the Provider fee schedule;

Magellan confirms we will meet this requirement.

(2) Ensuring that all MHSA Network Providers contractually agree to and comply with all of the MHSA Program's requirements and benefit design specifications;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(6) Negotiating agreements on a case-by-case basis, with prior approval from the Department, with Licensed Marriage and Family Therapists (LMFTs) and Licensed Mental Health Counselors (LMHCs) when an LMFT or LMHC possess a particular subspecialty that is clinically appropriate or to address guaranteed access issues; and

Magellan confirms we will meet this requirement.

(7) Establishing a tiered MHSA Provider Network and incentives including but not limited to financial, administrative and continuing professional education to enhance Provider performance and clinical outcomes.

Magellan confirms we will meet this requirement.

B. REQUIRED SUBMISSION

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

Magellan's reimbursement methodologies are preferred by most providers, as well as by Magellan and our customers. Our fee schedules are comparable to those of other high-quality payers in a region.

More than 99 percent of Magellan's MHSA outpatient providers are contracted using fee-for-service (FFS) reimbursement arrangements. Reimbursement is based on the lower of reasonable and customary (R&C) rates and negotiated fee schedules. We set fee-for-service rate schedules based on provider type (psychiatrist, psychologist, social worker, etc.), Current Procedural Terminology (CPT) codes, and geographic (state-by-state) location. These reimbursement arrangements are seldom negotiated with individual providers.

More than 99 percent of our MHSA inpatient providers (facilities and alternate level of care organizations) are contracted using per diem reimbursement arrangements. Magellan's Network Development managers negotiate individual, all-inclusive per diems for facility-based services and programs. Occasionally, professional services for inpatient care are negotiated separately. We require separate per diem rates for each type of service and program (i.e., hospital inpatient, intermediate care, residential treatment, partial hospitalization, day treatment, and intensive outpatient programs). The actual rates negotiated are a function of a number of variables, including the facility's billed charge levels, a provider's Medicare or Medicaid rates as a benchmark, prevailing market rates, R&C rates, and the volume of referrals Magellan anticipates being able to offer given current and anticipated business in the local area.

Magellan's professional fee schedules are updated periodically based upon market conditions, client requirements, and other factors. Inpatient facility rates are often based upon contractual provisions.

Psychologists and other non psychiatrist provider types are generally reimbursed at 85 percent and 70 percent of the psychiatrist rates, respectively

Magellan is willing to work with the Department to implement alternative reimbursement arrangements with providers that meet the needs of the market including incentive based programs and quality based initiatives.

We have several such arrangements in place today which have demonstrated success in enhancing both quality and utilization measures as well as cost containment.

(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.

Magellan has provided a copy or our proposed provider contract for both facilities and practitioners as **Appendix U**.

(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.

Magellan confirms that network providers accept as payment-in-full, Magellan's 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.

Magellan confirms we 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.

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

Data related to voluntary terminations of Magellan network providers is provided in **Table B.10.a** below.

*Magellan's termination reason codes do not include these descriptions.

(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.

If no providers, who are currently in our network, meet an enrollee's needs in a geographically appropriate area, a single case agreement will be made. For a large client (over 2 million enrollees) served from Magellan's Tristate Care Management Center, Magellan completed 82 single case agreements with non-network providers in 2012. We expect that, due to Magellan's comprehensive network that will meet all Empire Plan access requirements, single case agreements for the Empire Plan MHSA Program would be similarly rare.

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

TIERING CRITERIA AND INCENTIVES

Magellan's ultimate goal related to provider tiering/provider profiling and high performance networks is to assure that our network is a key asset in the delivery of cost effective, high quality care to our enrollees. We recognize that our network is not a commodity, but rather a key strategic partner in cost, quality, and supporting our services.

Magellan is currently in the process of implementing a behavioral health provider tiering/profiling initiative. This program will provide incentives to providers for following best practices by referring a higher proportion of enrollees to our higher performing providers.

While we do not yet have a national behavioral health high-performance network, we do have experience creating preferred behavioral health provider networks for many customers, wherein a selection of locally-based and/or regionally-based providers are stratified as a high performance providers within the network just for the customer that receives referrals first (based on profiling results including positive enrollee outcomes). Magellan creates customized provider inclusion criteria with customers for these preferred networks. Magellan will expand on this experience to create a high performance network nationally.

To create a high-performance network for the behavioral health benefit, Magellan has started utilizing provider profiling benchmark data. The profiles will ultimately stratify providers based on a number of key metrics, including positive enrollee outcomes. One potential incentive for high performing providers would be reimbursing those providers with higher rates. This would lead to increased unit costs on one hand. However, we do believe that enrollees under the care of high-performing behavioral health providers would potentially receive improved care with less recidivism, thus passing cost of care savings to our customers and possibly reducing medical costs.

An adequate volume of cases will be necessary to determine "preferred provider" status for this network. High performing individual providers will be identified by:

- Provider chart audits
- Treatment Record Review (TRR) data
- CHI use and positive trends in results
- Positive enrollee satisfaction data
- No enrollee complaints
- Adherence to evidence-based guidelines and Magellan Medical Necessity Criteria
- Provider profiles (wherein we will be looking at indicators including recidivism, length of stay, utilization, access, how well providers maintain enrollees outside of higher levels of care, and more)

With regard to facility profiling Magellan is also rapidly expanding this capability through use of a facility score card that will include a variety of metrics such as average length of stay, case-mix adjusted length of stay, bed availability, readmission rate, 7- and 30-day ambulatory follow-up rates,

use of evidence based practices, and facility feature/services. Our facility profile is used to focus referrals and guide our facility contracting process and negotiations. The facility profile is also used to rewards facilities for sustained quality performance.

PROVIDER AUDIT AND QUALITY ASSURANCE

The Contractor must support a high quality and cost-effective MHSA Program. The protection of MHSA Program assets must be a top priority of the Contractor. The Contractor must have a strong audit presence throughout its organization. The Contractor shall be responsible for the oversight and audit of Providers that provide MHSA services to MHSA Program Enrollees

The Contractor must support and encourage quality MHSA care through the following audit and quality assurance duties and responsibilities.

A. DUTIES AND RESPONSIBILITIES

(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;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(d) Remitting 100% of Provider and Enrollee audit recoveries to the Department as applicable within thirty (30) Days of receipt consistent with the process specified in Section X.V, "Payments/ (credits) to/from the Contractor," of the Agreement resulting from this RFP; and

Magellan confirms we will meet this requirement.

(e) Utilizing the auditing tools and performance measures proposed by the Contractor to identify fraud and abuse by Network Providers and/or Enrollees.

Magellan confirms we will meet this requirement.

(2) The Contractor must conduct a comprehensive quality assurance program which includes, but is not limited to:

(a) Monitoring the quality of care provided by Network Providers;

Magellan confirms we will meet this requirement.

(b) Monitoring technical competency and customer service skills of Network Provider staff;

Magellan confirms we will meet this requirement.

(c) Network Provider profiling;

Magellan confirms we will meet this requirement.

(d) Peer review procedures;

Magellan confirms we will meet this requirement.

(e) Outcome and Quality Measurement analysis; and

Magellan confirms we will meet this requirement.

(f) Maintaining an ongoing training and education program that will be offered to Network Providers.

Magellan confirms we will meet this requirement.

B. Required Submission

(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 Audits

Magellan directs our MHSA provider clinical chart audits at the regional level and includes, at a minimum, all high-volume providers, groups, and facilities. Chart audits include assessment of diagnostic accuracy, use of multidisciplinary team approach, coordination of care, matching of treatment modalities to presenting problem and treatment goals, and assessment of risk indicators.

Each Magellan Care Management Center, in conjunction with the appropriate Regional Network and Credentialing Committee (RNCC), identifies high-volume providers for their book of business. While the local region determines which providers are high-volume, the category generally includes providers, groups, and facilities that are in the top five percent of the region in number of Magellan enrollees seen and/or those that have treated fifty or more Magellan enrollees over a two-year period.

Whenever possible, the reviewers audit a random sample of all Magellan patient charts within the region by using the following guideline:

A minimum of three charts randomly selected per high-volume provider, plus one randomly selected chart for every 100 enrollees treated over and above the first 100 enrollees treated by the provider.

The audit of high-volume providers is conducted bi-annually upon recredentialing and is factored into the recredentialing decision.

Typically, Magellan begins the audit process by systematically generating a random list of case numbers. We ask providers to submit a sanitized version of the charts (that is, versions in which the enrollee name and other identifiable information has been concealed or removed).

To review the randomly selected charts, Magellan employs either a staff or contracted clinician who meets the same credentialing requirements as the provider being audited, and who has completed training on Magellan's audit tool. (If needed, psychiatric RNs who have appropriate behavioral health experience also conduct audits.)

Magellan uses a standard tool, the Treatment Record Documentation Worksheet, to audit MBH provider charts. The Treatment Record Documentation Worksheet contains 52 items, with each item having a point value ranging from 0.5 to 8 points, with all items cumulatively totaling 100 points. Audit categories and examples of audit items in each category are as follows:

General Information

- Patient demographics, consent, release of information and HIPAA forms.

Initial Clinical Evaluation

- Psychiatric history, relevant medical history;
- Psychosocial information, including patient support systems, legal history, educational history;

- Mental status examination;
- Risk factors are documented, including suicidal/homicidal ideation, noncompliance with treatment, elopement potential, prior behavioral health inpatient admissions, and history of multiple behavioral diagnoses;
- Five-axis DSM-IV-TR diagnosis.

Treatment Plan

- Individualized treatment plan with objective, measurable goals;
- Enrollee understanding of treatment plan.

Progress Noted in Treatment

- Progress notes: progress towards goals;
- Coordination with PCP and with ancillary providers/services, referrals for medication, as applicable;
- Discharge note, including achievement of goals, referrals to assist in final attainment of goals.

Medication

- Current psychotropic medications, dosages, and date(s) of dosages;
- Enrollee education regarding reason for medication;
- If DEA-schedule drugs are to be avoided if the enrollee has a history of substance abuse.

Referral/Outreach

- Preventive services (as appropriate) such as relapse prevention, stress management, wellness programs, lifestyle changes, referrals to community resources;
- The record shows that enrollees who become suicidal, homicidal, or unable to conduct daily activities are referred to appropriate level of care (if applicable).

Following an audit, the reviewer communicates the results to the provider, including a description of strengths and weaknesses.

Results are presented to the RNCC for review and feedback about performance and adherence to standards of care. Results are also given to each provider. If results are below acceptable standards, a provider is asked to develop and adhere to a corrective action plan and is then reviewed on a regular basis, including additional chart audits, until the RNCC is satisfied that the deficiencies have been corrected or other action is necessary, up to and including termination from the network.

For example, if audit results indicate, Magellan staff may follow-up with the provider, or require a corrective action plan, as follows:

- Score of 90-100 (minimum deficiencies): Letter sent asking the provider to incorporate the auditor's suggestions into his/her record keeping practices.
- Score of 80-89 (moderate deficiencies): Letter sent asking provider to send Magellan a letter acknowledging that they are aware of the auditor's recommendations and intend to adopt them.
- Score of 70-79 (major deficiencies): Letter send informing provider that he/she must send in a formal corrective action plan outlining specific steps he/she will implement to correct deficiencies. The plan must be implemented within three months and the provider must send in a chart demonstrating the improvements within six months.
- Score of 0-69 (serious deficiencies): Same as for major deficiencies, except that the Regional Network and Credentialing Committee (RNCC), at its discretion, may put a hold on referrals during the three-month corrective period. During the three months, Magellan performs another random audit to assess improvement.

The regional Quality Improvement Director maintains a provider quality file for each provider who is audited. This file includes the audit documentation, along with any follow-up letters or corrective action plans.

POSSIBLE FRAUDULENT ACTIVITY

Most possible fraudulent activity is identified post-payment. On a routine basis, Magellan's claims processors screen all paper submitted claims for indicators of fraudulent submission. Additionally, Magellan completes retrospective reviews to analyze claims that fall outside the utilization boundaries established by our routine claims experience reports. Magellan audits an average of 2 percent of all completed claims. In addition to a post-pay audit, pre-pay audits are conducted on all high-dollar claims. These high-dollar claims are systemically placed on audit hold by CAPS, our claims processing system.

Magellan has a zero-tolerance policy against fraud and abuse perpetrated by employees, providers, or enrollees. Magellan has established specific objectives to prevent and detect provider fraud and abuse through an ongoing, nationwide fraud awareness, detection, and prevention training program which performs the following:

- Enables claim and managed care personnel to identify and handle potentially fraudulent claim situations
- Results in consistent referrals of potentially fraudulent claims to the Magellan Special Investigations Unit (SIU)
- Educates Magellan personnel and the public at large about health care insurance fraud and its effect on the cost of insurance
- Conducts thorough and prompt investigations of all potentially fraudulent claims to obtain the necessary information for use in making informed decisions on the meritorious nature of the claims
- Confirms Magellan's reputation with insurers, plan sponsors, health care providers and law enforcement personnel as a company which is committed to combating the health care insurance fraud problem
- Establishes a professional liaison with other companies, plan sponsors, health care providers, law enforcement agencies, and other governmental agencies involved in the prevention of health care insurance fraud.

Within Magellan's Security Department, Magellan maintains a sophisticated Special Investigations Unit (SIU), which is a member of the National Health Care Anti-Fraud Association (NHCAA). *Magellan is proud to be the first managed behavioral health care organization in the United States that was a member of the NHCAA.* The SIU of the Security Department is responsible for detecting, preventing, and investigating suspected claims fraud and abuse by enrollees, providers or other entities.

The SIU investigates allegations of provider claims fraud, including the following:

- Billing for services not rendered
- "Upcoding" (exaggerating diagnosis of services rendered)
- Unbundling
- Misrepresentation of non-covered services
- Duplicate billing.

Overall, the unit strives to protect enrollees' benefits, adhere to state regulatory requirements, and meet contractual obligations. The SIU also conducts training for other Magellan departments to educate staff and assist them in detecting and reporting fraud and abuse. These training sessions involve the following:

- Education about the SIU and its functions
- Employees' responsibilities for reporting fraud and abuse
- Descriptions of the types of fraud and their impact
- Red flag indicators of potential fraud
- Process of referring potential fraud or abuse cases to the SIU.

REQUIRED FRAUD REPORTING

Magellan's SIU reports any suspicion or knowledge of enrollee fraud or abuse to the Office of the Inspector General (OIG) or other oversight agency as appropriate. The SIU will allocate a designated Magellan representative, Ms. Patricia Hoofnagle, to manage appropriate reporting and communications for the Department under the proposed contract arrangement. We provide biographical information for Ms. Hoofnagle in **Appendix A**.

(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?

Magellan's procedures for network quality oversight are designed to ensure provider accountability for services rendered, compliance with Magellan's expectations, standards of contract compliance, and compliance with national standards issued by accrediting bodies such as the National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation of Health Care Organizations (JCAHO), and the Certification and Accreditation of Rehabilitation Facilities (CARF), as well as the standards mandated by the Centers for Medicare and Medicaid Services (CMS) for External Quality Review Organization (EQRO) audits.

Magellan continuously seeks to maintain the quality of the provider network and to this end Magellan takes proactive measures to assure compliance with contractual agreements. Prior to the implementation of the Empire Plan program, Magellan will conduct provider education forums

where Magellan's clinical and administrative (including claims processing) policies and procedures are presented to assure providers are aware of the various program requirements. After implementation of the program, Magellan routinely conducts retrospective audits (as described above) to identify trends in compliance with clinical practice guidelines, communication with primary medical providers, and other quality of care or administrative issues.

When a provider performance concern is identified from any source—an enrollee, a Magellan care manager, provider relations staff, the Magellan SIU, or any other party—Magellan will conduct an inquiry and take action appropriate to the nature and severity of the concern.

Complaints about providers regarding fairly routine compliance concerns are often addressed easily with a phone call from the Magellan provider network specialist to the provider. Many times an issue can be attributed to a misunderstanding of Magellan processes and can be easily resolved with a collegial conversation. All complaints and their resolution are formally documented and tracked.

For more serious situations, Magellan protocols stipulate that a Provider Incident Report be completed whenever there is evidence of a clinical or administrative problem with a network provider. An inquiry is then conducted, and findings are presented to the Quality Improvement Committee (QIC) and Professional Provider Review Committee (PPRC), which review and address any unresolved issues and render a final determination or recommendation.

Determination options include:

- Development of a plan of corrective action, continued monitoring, and follow-up to ensure maintenance of desired change in practice patterns
- Modification in provider privileges, maintained until the next recredentialing period or until corrective action demonstrates that specific privileges can be reinstated
- Change in provider network status from active to one of the following:
  - Pending—a concern has been identified, but the provider may receive referrals
  - Inactive—suspend new referrals to that provider
  - Terminated—the provider's participation in the network is terminated

If network management determines that the incident is serious enough to warrant termination, Magellan's Provider Performance Review Committee will review the case. Provider incidents that would require such review include:

- Patterns of deficient clinical performance

- Continual non-compliance with policies and procedures
- Involvement in a malpractice suit
- Adverse action by a licensing authority
- A critical incident involving a high-risk case
- Information that the provider no longer meets credentialing standards
- Conviction of a crime of moral turpitude.

If, based on case evaluation, the committee finds cause to terminate the provider's contract, it sends written notice of termination, which is effective in 30 days. The termination notice does include appeal rights. If the provider is currently treating any persons referred by Magellan, the cases are transitioned to another network provider. In some situations, Magellan is required to notify other entities such as state licensing boards and the National Provider Data Bank (NPDB) and does so accordingly. In accordance with the Department's needs we will also supply reporting to the Department.

MONITORING OF FRAUD CASES

Every open case of detected fraud or abuse offenses is monitored by the Magellan Director of the SIU every 30 days until resolution. This includes the development and monitoring of corrective action initiatives related to any confirmed instance of non-compliance, fraud, and abuse. All systems activity, including user activity, is monitored in accordance with policy. All deviations from accepted practices outlined in policy are investigated and risks associated with these events are mitigated accordingly.

In accordance with regulatory guidelines, any provider who is suspended, resigns or voluntarily withdraws after initiation of an investigation into suspected fraud and abuse shall be immediately reported to the appropriate oversight agency after consultation with, and approval of, Magellan's General Counsel or a designee. In addition, results of investigations are shared with Magellan networks and the Professional Provider Review Committee so that appropriate corrective actions may be applied. In accordance with the Department's needs Magellan would also provide appropriate provider fraud and abuse reporting to the Department.

CLAIMS FRAUD MONITORING

Magellan manages all cases of claims fraud through established policy and procedure. The initial responsibility for recognition of a potentially fraudulent claim rests with Magellan claim supervisors, processors, cost containment personnel, managed care personnel, and customer relations representatives who first receive the information regarding a possible fraud situation. Each individual who subsequently participates in the evaluation of the claim (i.e., supervisors, SIU investigators, and managers) share this responsibility.

All Magellan claims personnel (claim supervisors, processors, cost containment personnel, managed care personnel, and enrollee relations representatives) involved in the initial review of the claim are trained to recognize fraud indicators or issues that may warrant additional investigation by the Magellan SIU. Fraud profile indicators are published on Magellan's internal SIU Web site. Additionally, they are provided to claim personnel during various training sessions. These indicators are used to assist our claim personnel in identifying claims that merit further investigation. In addition, Magellan's claims processing system, CAPS, has built-in indicators for detecting fraud and claims supervisors follow up on all flagged cases identified electronically.

Suspected fraudulent claims are referred to the Magellan SIU for investigation. Claim personnel are instructed to refer to the published fraud profile indicators. The following conditions may warrant a referral to the Magellan SIU:

- Those cases which have definite indicators of fraud or other objective evidence of fraud, regardless of the number of indicators
- Any claim which involves contact with, or by, an informant
- Suspicious information obtained from third party sources, such as National Health Care Anti-Fraud Association (NHCAA), police reports, State Boards, FBI, or Fraud Bureaus, etc.
- The Magellan SIU does not handle cases involving employees, agents or vendors. All internal fraud or dishonesty cases are referred to the Chief Security Officer for investigation. The SIU will, however, assist in file preparation and technical concerns relative to an internal fraud referral
- To ensure prompt and complete investigations, suspect claims are referred to the SIU immediately upon recognition of any indicator of possible fraud.

Once the claim has been referred to the Magellan SIU, claims personnel do not pursue investigation into the fraudulent aspects of the claim unless so directed by the Magellan SIU.

Cases involving health care providers are typically identified post-payment. In most instances after the initial allegation is referred to the Magellan SIU, subsequent claims are processed until the allegation is proven or unless otherwise directed by the Department. In certain instances, for example, providers submitting claims for services after license revocation, the subsequent claims are denied until the investigation is completed.

On a routine basis, Magellan's claims processors screen all paper submitted claims for indicators of fraudulent submission. Additionally, Magellan completes retrospective reviews to analyze claims that fall outside the utilization boundaries established by our routine claims experience reports.

Magellan audits an average of two percent of all completed claims. In addition to a post-pay audit, pre-pay audits are conducted on all high-dollar claims. These high-dollar claims are systemically placed on audit hold by CAPS.

Provider Illegal Activity

Any extreme case of potentially illegal provider activity identified by the SIU is immediately reported to Magellan's Chief Security Officer who in turn reports this information to Magellan's General Counsel. Investigative action is taken immediately by the SIU as noted above.

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

Please see **Appendix U** for a copy of Magellan's standard provider agreement, which contains audit language.

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

Magellan confirms we will meet this requirement.

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

Magellan aggressively pursues allegations of health care fraud, waste, and abuse. Magellan ensures that the identities of individuals reporting instances of suspected fraud or abuse are protected and

ensures that no retaliation be brought against any individual who reports plan violations or suspected fraud or abuse. As part of our Fraud and Abuse program, Magellan has established specific objectives to prevent and detect fraud, waste, and abuse. They are to:

- Establish an ongoing nationwide awareness and training program that:
  - enables personnel to identify and handle suspected fraud, waste, and abuse
  - results in consistent referrals of suspected fraud, waste, and abuse to the SIU
  - educates personnel and the public about fraud, waste, and abuse, and its effect on the cost of insurance.
- Conduct thorough investigations of suspected fraud, waste, and abuse to obtain the necessary information for use in making informed decisions on the meritorious nature of the allegations.
- Confirm Magellan's reputation with insurers, plan sponsors, health care providers and law enforcement personnel as a company that is committed to combating the health care insurance fraud, waste, and abuse problem.
- Establish a professional liaison with other companies, plan sponsors, health care providers, law enforcement agencies, and other governmental agencies involved in the prevention of health care insurance fraud, waste, and abuse.

The foundation for monitoring and auditing is Magellan's Special Investigations Unit (SIU). The SIU is responsible for protecting the assets of Magellan and our clients by detecting, identifying, and deterring fraud, waste, and abuse by conducting audits of internal and external sources of information. The mission of the SIU is the aggressive pursuit of suspected health care fraud, waste, and abuse (for example behavioral health care, radiology, or prescription drug).

Magellan uses the Perspective Case Management System from PPM 2000, Inc. to capture and track investigations. Procedures for investigation, documentation, evidence handling, and reporting guide investigators to create an accurate work product. The SIU works closely with other departments including Provider Networks, Legal, and Cost Containment to adjudicate investigative findings. The SIU aims to prevent and deter the perpetration of fraud, waste, and abuse by employees, enrollees, providers, and other entities through education. Our training program for all employees requires a new employee and annual training that:

- Educates personnel on who commits fraud and how, and provides specific examples
- Quantifies the impact on fraud on the industry and individuals

- Outlines the responsibilities of all employees in relation to the detection, prevention, and reporting of suspected fraud, waste, and abuse
- Defines the responsibilities of the SIU
- Lists 'red flag' indicators of potential fraud, waste, and abuse
- Establishes a procedure for the reporting of suspected fraud, waste, and abuse to the SIU
- Discusses policies regarding fraud and abuse
- Educates personnel on potential Medicaid and Medicare fraud, (for example facility, professional, and prescription drug), and on the Federal False Claims Act and state false claims laws.

Magellan is a corporate member of the National Health Care Anti-Fraud Association (NHCAA). Membership in this organization provides management and training opportunities and information-sharing with member organizations that include law enforcement and other SIUs. Magellan maximizes quality referrals of fraud and abuse by using the resources available in the NHCAA Special Investigations Resource and Information System (SIRIS), Requests for Investigation Assistance (RIA) from law enforcement, distribution of published news articles, and other information-sharing initiatives.

Magellan's Recovery Unit (a section of the Cost Containment Department) responds to overpayment issues. These issues are identified through various methods or departments including claims and resolution units, the contracts and rates department, legal, the internal audit department, the SIU, and various reports. Magellan diligently pursues recovery of overpayments, taking into account compliance with contractual and regulatory requirements.

The Corporate Compliance Handbook includes information on conflict of interest, Anti-Kickback regulations, federal false claims laws, including civil or criminal penalties for making false claims and statements, "whistleblower" protections afforded under such laws, and the role of such laws in preventing and detecting fraud and abuse.

Magellan recognizes the importance of education and training as a systematic means to identify and report suspected cases of fraud and abuse. The corporate Compliance and Human Resources Departments are responsible for coordinating the training efforts for the Compliance Program. Magellan conducts and documents compliance training sessions for all new employees. All Magellan employees must complete separate, annual trainings on the Health Insurance Portability and Accountability Act (HIPAA), the Corporate Compliance Handbook, and Fraud Identification and Recognition Education (FIRE) training.

11. CLAIMS PROCESSING

The Contractor must process all claims submitted under the MHSA Program according to the benefit design, including Network Provider claims and manual submit claims including but not limited to Medicaid, out-of-network claims, foreign claims, in-network manual claims and COB including Medicare primary claims. The claims processing system shall include controls to identify questionable claims, prevent inappropriate payments, and ensure accurate reimbursement of claims in accordance with the benefit design MHSA Program provisions and negotiated, agreements with Providers. All MHSA Program provisions for benefit design and other utilization or clinical management programs must be adhered to for all claims.

Enrollee Submitted Claims are required to be submitted to the Contractor no later than one hundred twenty (120) Days after the end of the Calendar Year in which the MHSA service was rendered, or one hundred twenty (120) Days after another plan processes the claim, unless it was not reasonably possible for the Enrollee to meet this deadline. The MHSA Program count of claims can be found in Exhibit II.G3 of this RFP.

A. DUTIES AND RESPONSIBILITIES

(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;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(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 utilized approved by the Department. The Contractor's system must ensure that payments are made only for authorized services;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(f) Maintaining the security of the claim files and ensuring HIPAA compliance;

Magellan confirms we will meet this requirement.

(g) Adjusting all attributes of claim records processed in error crediting the MHSA Program for the amount of the claim processed in error;

Magellan confirms we will meet this requirement.

(h) Agreeing that all claims data is the property of the State. Upon the request of the Department, the Contractor shall share claims data with other MHSA Program carriers and consultants for various programs (e.g. Disease Management, Centers of Excellence) and the Department's Decision Support System vendor. The Contractor cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Department;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(k) Developing and securely routing a MHSA daily claims file that reports claims incurred to date which have been applied to the shared Deductible and Coinsurance Maximums between the Empire Plan Hospital Program, Medical Program and MHSA Program;

Magellan confirms we will meet this requirement.

(l) Loading a daily claims file from the Empire Plan medical carrier/third party administrator and hospital carrier that reports shared Deductible and Coinsurance Maximums;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(n) Pursuing collection of up-to-date coordination of benefit information that is integrated into the claims processing edits and pursuing collection of any money due the MHSA Program from other payers or Enrollees who have primary MHSA coverage through another carrier;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(p) Establishing a process through which Providers can verify eligibility of Enrollees and Dependents during Call Center Hours;

Magellan confirms we will meet this requirement.

(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.C of this RFP; and

Magellan confirms we will meet this requirement.

(r) Updating the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year.

Magellan confirms we will meet this requirement.

(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%);

Magellan confirms we will meet this requirement.

(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%);

Magellan confirms we will meet this requirement.

(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 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 Explanation of Benefits is received by the U.S. Post Office or Contractor's mailing agent; and

Magellan confirms we will meet this requirement.

(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 fivetenths 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.

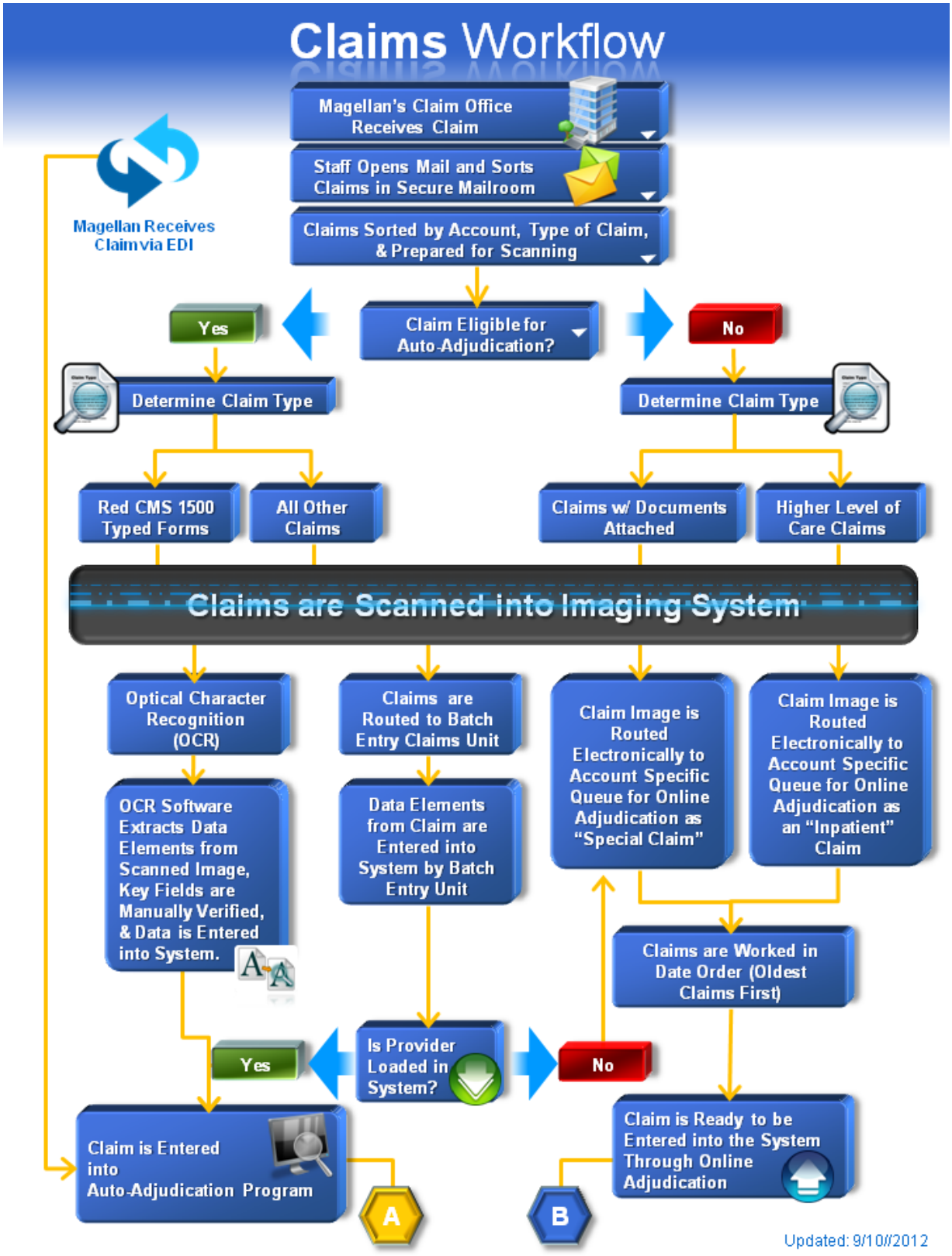
Magellan confirms we will meet this requirement.

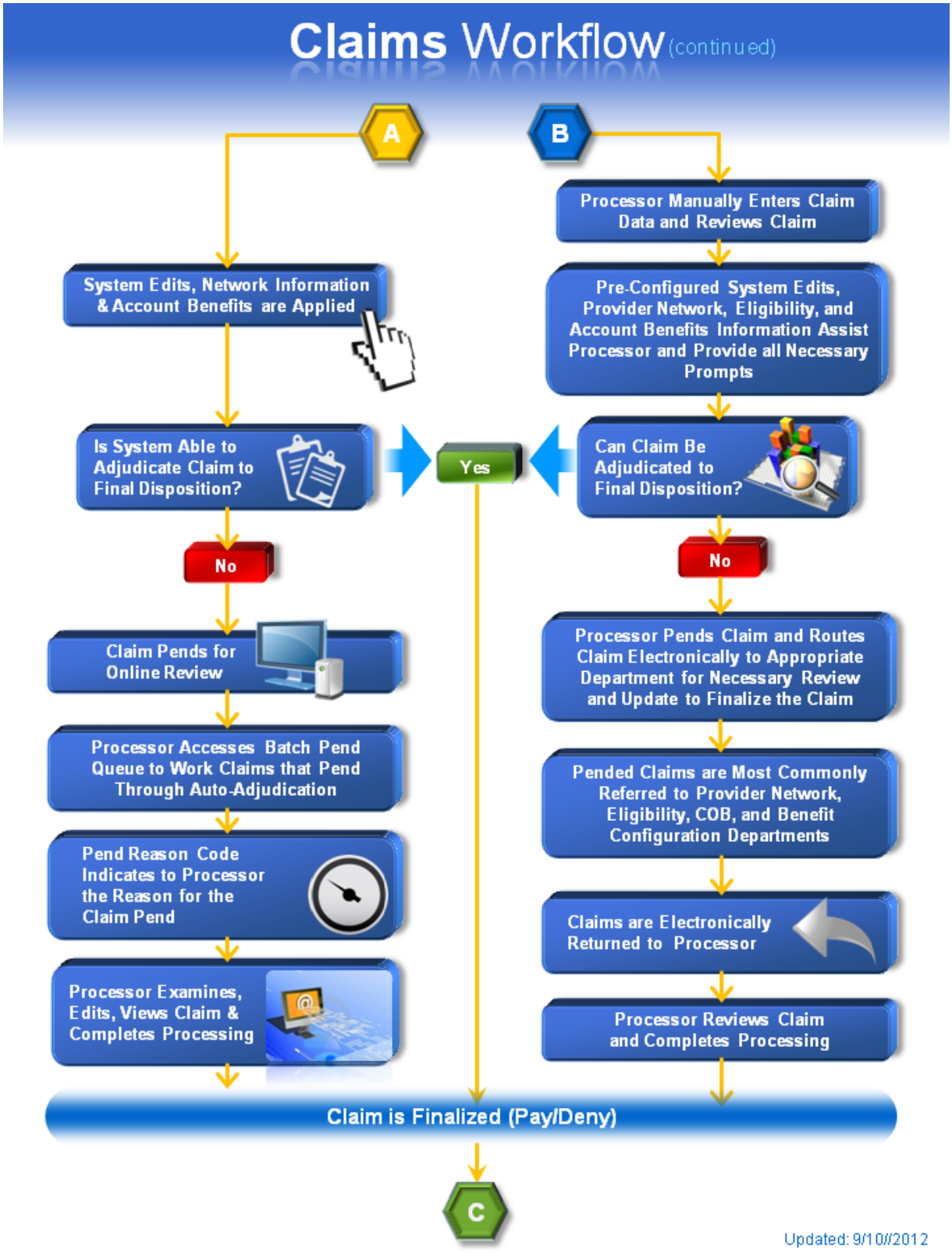
B. REQUIRED SUBMISSION

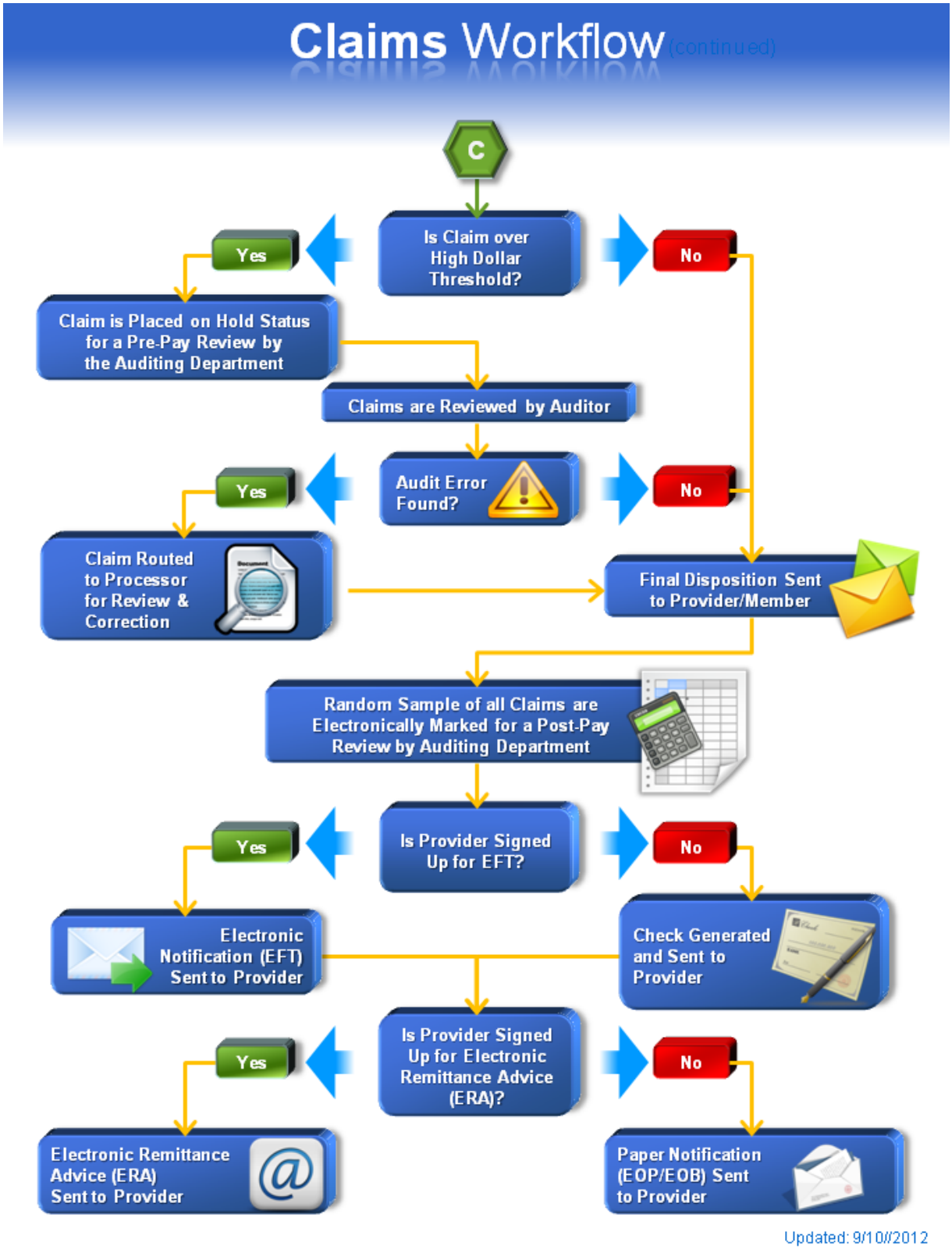
(1) Provide a flow chart and step-by-step description of your proposed claims processing methodology for adjudicating Non-Network and Network claims. Provide a description of the comprehensive edits you propose to ensure proper claim adjudication.

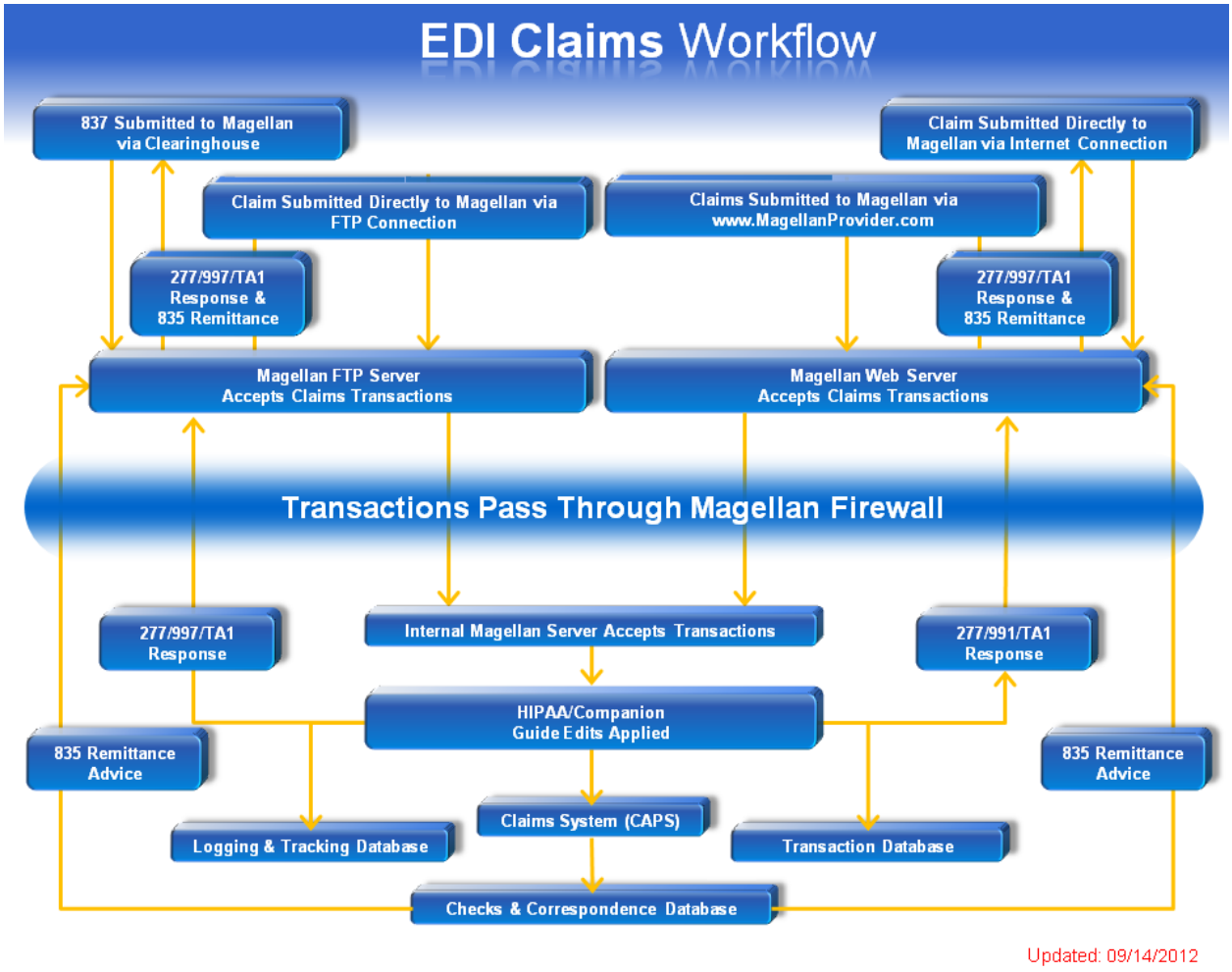
Magellan processes all claims through our Claims Adjudication and Payment System (CAPS), an electronic claims processing system that is highly configurable for the unique requirements of customer contracts and operates in a paper-free environment. Network and Non-Network claims are all processed through CAPS.

The following set of figures outlines our claims adjudication and payment process, from receipt of claims information (both electronic and on paper), to final disposition and payment.


Claims Workflow
Magellan's Claim Office Receives Claim
Staff Opens Mail and Sorts Claims in Secure Mailroom
Claims Sorted by Account, Type of Claim, & Prepared for Scanning
Magellan Receives Claim via EDI
Claim Eligible for Auto-Adjudication?
Yes
No
Determine Claim Type
Determine Claim Type
Red CMS 1500 Typed Forms
All Other Claims
Claims w/ Documents Attached
Higher Level of Care Claims
Claims are Scanned into Imaging System
Optical Character Recognition (OCR)
Claims are Routed to Batch Entry Claims Unit
Claim Image is Routed Electronically to Account Specific Queue for Online Adjudication as "Special Claim"
Claim Image is Routed Electronically to Account Specific Queue for Online Adjudication as an "Inpatient" Claim
OCR Software Extracts Data Elements from Scanned Image, Key Fields are Manually Verified, & Data is Entered into System.
Data Elements from Claim are Entered into System by Batch Entry Unit
Claims are Worked in Date Order (Oldest Claims First)
Yes
Is Provider Loaded in System?
No
Claim is Entered into Auto-Adjudication Program
Claim is Ready to be Entered into the System Through Online Adjudication
A
B
Updated: 9/10//2012


Claims Workflow (continued)
A
B
Processor Manually Enters Claim Data and Reviews Claim
System Edits, Network Information & Account Benefits are Applied
Pre-Configured System Edits, Provider Network, Eligibility, and Account Benefits Information Assist Processor and Provide all Necessary Prompts
Is System Able to Adjudicate Claim to Final Disposition?
Yes
Can Claim Be Adjudicated to Final Disposition?
No
No
Claim Pends for Online Review
Processor Pends Claim and Routes Claim Electronically to Appropriate Department for Necessary Review and Update to Finalize the Claim
Processor Accesses Batch Pend Queue to Work Claims that Pend Through Auto-Adjudication
Pended Claims are Most Commonly Referred to Provider Network, Eligibility, COB, and Benefit Configuration Departments
Pend Reason Code Indicates to Processor the Reason for the Claim Pend
Claims are Electronically Returned to Processor
Processor Examines, Edits, Views Claim & Completes Processing
Processor Reviews Claim and Completes Processing
Claim is Finalized (Pay/Deny)
C
Updated: 9/10//2012


Claims Workflow (continued)
C
Is Claim over High Dollar Threshold?
Yes
No
Claim is Placed on Hold Status for a Pre-Pay Review by the Auditing Department
Claims are Reviewed by Auditor
Audit Error Found?
Yes
No
Claim Routed to Processor for Review & Correction
Final Disposition Sent to Provider/Member
Random Sample of all Claims are Electronically Marked for a Post-Pay Review by Auditing Department
Is Provider Signed Up for EFT?
Yes
No
Electronic Notification (EFT) Sent to Provider
Check Generated and Sent to Provider
Is Provider Signed Up for Electronic Remittance Advice (ERA)?
Yes
No
Electronic Remittance Advice (ERA) Sent to Provider
Paper Notification (EOP/EOB) Sent to Provider
Updated: 9/10//2012



CONTROLS FOR TIMELY ENTRY OF RECEIVED CLAIMS

Magellan's claims department operates in a paperless environment. All paper claims forms received are time and date stamped by the Magellan mail room. The mail room staff opens and prepares all mail for scanning. Upon receipt, each mail bin is logged onto a control sheet, which is monitored and signed off by the mailroom supervisor or manager. Desk checks are performed and constant supervision ensures that all claims received are batched and scanned. Claims are assigned to worker queues according to account and type of claim.

After logging the receipt of these claims, they are imaged in-house and routed electronically within the department, eliminating paper handling. This improves the efficiency of claims processing and enhances the storage and retrieval process. Red-type CMS 1500 forms are scanned directly into the system. All non-red-type paper claims eligible for auto-adjudication are electronically routed to the appropriate data entry workflow queue or the optical character recognition (OCR) transformation

process. Claims that are successfully read by OCR are electronically transferred to the claims system. Claims that do not pass the OCR transformation process are routed to a processor responsible for data verification. Those claims that can be successfully verified are transferred to the claims system; otherwise, they are routed to the appropriate data entry workflow queue. Magellan's batch entry claim unit uses a desktop application (Image Worker) to view the image of the claim within the data entry workflow queue and enter the claim into the claims system.

Scanned versions of claims are stored indefinitely. After claims are scanned, they are available for viewing immediately. The turnaround time for retrieval of hard copy is 48 hours. Expedited retrievals also are possible.

Magellan's batch entry claim unit uses a desktop application (Image Worker) to view the image of the claim within the data entry workflow queue and enter the claim into the claims system. EDI claims are loaded directly into the system, and, along with the data-entered claims, are run through scheduled batch adjudication cycles during which standard edits are applied.

Document Control Numbers (DCN) are assigned to each claim. The DCNs remain on the report until either a match is found in the claim system or the status of the distribution queue claim is changed to something other than "entered in system." The status can only be changed with the proper security. The report is worked and claims are closely monitored.

Scanned versions of claims are stored indefinitely. After claims are scanned, they are available for viewing immediately. Magellan's system has the flexibility to run additional jobs on an as-needed basis without adversely affecting system availability or performance.

ELECTRONIC CLAIMS EDITS

Magellan's systems are highly configurable and can be programmed with account specific system edits and algorithms. These edits will stop a claim from completing auto-adjudication should manual intervention by a resolution specialist staff member be required. For example, these safeguards include the ability to automatically determine:

- whether an individual was an eligible enrollee of the benefit plan at the time of service
- the guidelines for each benefit plan so that the claims processing application can determine whether the guidelines were met (this ensures a proper pay, pend, or deny outcome)
- benefit maximums for varying types of benefit periods (contract year, calendar year)
- whether a provider meets credentialing criteria (the system also provides demographic information regarding the provider)

- the specific provider financial arrangements indicating the correct amount to allow claims for a particular service based on considerations such as level of treatment, geographic location, and provider participating/nonparticipating status.
- enrollee and provider-on-review functionality to automatically pend claims for additional investigation
- quality control reports that are automatically produced prior to the completion of the payables process and release of checks
- overpayment, audit, and fraud recovery.

Some of the edits that will continue to be in place specific to the delivery of behavioral health services for DCS are shown in **Table B.11.a**.

Table B.11.a. Claims System Edits

Edit Category	Description
Member Eligibility	If the enrollee listed as receiving services is not reflected as eligible on the date of service, the claim is pended for manual review. The claim may then be routed to the eligibility unit to research the enrollee eligibility prior to making a final determination.
Covered Services / Benefits Eligibility	If the benefits and services on the claim do not match with system benefits configuration, the claim is pended for manual review. The claim may then be routed to the benefits unit to research the enrollee's plan benefits prior to making a final determination.
Provider Eligibility	If the servicing provider is not eligible to be reimbursed based on either network status or degree level, the claim is pended for manual review. The claim may then be pended to route it to the Provider Network department to research the provider prior to making a final determination.
Rate Issues	If rates for the servicing provider are not loaded in the system or are not otherwise available to the processor through standard procedures, the claim is pended for manual review.
Prior Authorization Issues	If a matching prior authorization is not available in the system as required by plan benefits, the claim is pended for manual review. The claim may then be pended to route it to Network to research the provider prior to making a final determination.
Third Party Liability (TPL)/ Coordination of Benefits (COB)	Claims which require coordination of benefits are pended for manual review. Such claims may include data indicating prior payment by another payer, or an attached EOB from a primary payer.
Missing or Incomplete Information	If required fields are not completed in accordance with CMS and Department guidelines for a clean claim and as described in the Magellan Provider Handbook, the system will pend for manual review. If after reviewing the original claim image the claim is still incomplete, it will be denied and returned to the claimant for correction.

Edit Category	Description
Duplicate Claims	If a claim matches another claim already in the system for enrollee, provider, dates of service and services rendered, it will pend for manual review to determine if it is a duplicate claim. A claims processor can override a potential duplicate where not all elements match; however, only a supervisor can override a duplicate where all elements match.
Timely Provision Requirements	Some groups edit if Received Date is greater than the "to" Date Of Service by a specific number of days. Can be set on an in or out of network basis.
Appropriateness of Services	Magellan's claims system is currently able to determine the appropriateness of services/procedures given based on an enrollee's age. An additional edit can be applied to track services given an enrollee's sex as well as other characteristics that are desired by the Department.
Coding Validation	Magellan's claims system has built-in, integrated ICD-9, CPT-4, and mental health UCR tables, which claims are checked against to ensure appropriate claims processing.
Multiple Funding Arrangements	The system will be configured to recognize when one benefit code/funding arrangement has been exhausted.

Once the adjudication process applies the system edits, a claim either adjudicates to a pay/deny status or is pended for additional review. The system supports an online pended queue that can be assigned to staff using multiple rules. Once a claims processor opens the pended queue, claims are presented to the processor using a first-in/first-out rule. The processor examines the edits and has access to view the claim image, provider, and authorization information. The processor then is able to finalize the pended claim using the online adjudication process. Those claims that are not entered by batch, for example, CMS 1500 with attachments and UB04s, are routed electronically to the appropriate claim unit for online adjudication by claims processors.

Claims processors are assigned to specific contracts and claim types. Processors are trained to recognize the specific requirements of the individual contracts. The local claims resolution staff member collaborates with network, quality management, and other claims processors in the identification of provider issues and in the training of providers.

(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.

The Claims Adjudication and Payment System (CAPS) is a commercially developed claims system that supports all eligibility, benefit, and claim functions. Magellan supports the system internally and owns the source code, which allows maximum flexibility to modify the application as our business needs evolve. CAPS is linked to Magellan's clinical system, IP. This integration between the

applications allows eligibility information to display in IP, ensuring appropriate authorizations. In addition, clinical authorizations load automatically to CAPS, facilitating timely and accurate claims processing and payment.

CAPS supports claims payment to authorized providers based on the authorizations stored in the clinical information system and can support payment to non-participating or non-authorized services as supported by the benefit plan. CAPS supports auto-adjudication of clean claims that are received electronically or submitted on paper. The system and processes are tested and audited on an annual basis to meet Sarbanes-Oxley and Statement on Standards for Attestation Engagements 16 (SSAE 16) Service Organizations Controls 1 (SOC1) report requirements and demonstrates that Magellan has rigorous controls and safeguards in place.

Development and maintenance of Magellan's systems is coordinated and performed by an in-house team of IT professionals. Magellan owns the source code to all its systems, allowing for complete control over the change management and maintenance processes, as well as a high degree of customization of the systems to match customer requirements.

Magellan accepts paper claims (such as CMS 1500 and UB04 forms), as well as claims submitted electronically from our providers. Providers have three options to submit their claims in an electronic format:

- **Interactive Claims Courier**—Professional claims (CMS 1500) are submitted electronically on our Web site through the interactive, Web-based submissions tool, Claims Courier. This tool is available at no cost and provides immediate notification of the potential errors in claims submission—allowing providers to resolve the errors quickly and resubmit their claims in a timely manner.
- **Direct Submit**—Providers can submit claims through a secure FTP server or post files directly to Magellan's Web site.
- **Clearinghouse**—Magellan obtains support from multiple clearinghouses in order to provide redundancy and to offer a broad range of options for our providers.

Claims are paid based on the reimbursement methodology defined within each provider's contracts, the majority being fee for service. Fee-for-service (FFS) claims are paid based on a standard fee schedule which correlates to the rendering provider's licensure or degree level. Facility claims are paid by FFS or other contracted methodologies such as case rate or sub-capitation payment arrangements. In this manner, both CMS 1500 and UB04 claims can be processed through the system as FFS.

The only difference in claims processing procedures between FFS, case rate, and sub-capitation arrangements is that, upon final adjudication, CAPS will automatically apply the appropriate service counts and, in the case of FFS or case rate arrangements, finalize and issue payment for approved claims.

After claims are finalized and assigned a pay/deny status, Magellan initiates a scheduled check run to issue checks and EOBs to providers and enrollees. This communication provides the details of Magellan's payment and/or denial of payment.

AUTO-ADJUDICATION CAPABILITIES

The following functions are automatically administered and maintained by the Magellan claims system:

- online eligibility maintenance and verification process
- application of plan provisions (i.e., deductible, out-of-pocket limit, benefit maximums)
- coordination of benefits calculation
- network provider profile
- reasonable and customary edits
- payment authority limits
- precertification/concurrent review verification
- identification of potential duplicate submissions
- system tracking of pended claims
- application of payment discounts
- identification of network providers
- provider fee schedules.

Magellan's system has the flexibility to run additional jobs on an as-needed basis without adversely affecting system availability or performance.

COMPLIANCE WITH SARBANES-OXLEY AND SSAE CONTROLS

Magellan's systems and processes are tested and audited on an annual basis to meet Sarbanes-Oxley and Statement on Standards for Attestation Engagements 16 (SSAE 16) Service Organizations

Controls 1 (SOC 1) report requirements and demonstrate that Magellan has rigorous controls and safeguards in place. Magellan's external auditors complete an annual SSAE 16 SOC 1 report over the Claims Processing functions, demonstrating the accuracy and integrity of claims processing and the effectiveness of those controls.

DISASTER RECOVERY PLAN

Magellan's Disaster Recovery Plan provides detail on the physical security of our Data Center, service disruption prevention for our call centers and telecommunications system, backup and offsite storage of all data, the data recovery plan summary and results of recent testing. A copy of our Disaster Recovery Plan is included as **Attachment V**.

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

Magellan processes all claims through our Claims Adjudication and Payment System (CAPS), located at our Care Management Center in Maryland Heights, Missouri. Our CAPS system is developed and maintained by our in-house team of IT professionals.

MAGELLAN CLAIMS PROCESSOR TRAINING

The Claims Trainee Performance Policy provides guidelines that will be used during the ninety (90) day introductory period to govern trainee performance, evaluation, and graduation to a standard claims associate position.

STANDARDS:

The key area to evaluate trainee performance is quality. Every trainee receives formal classroom training with a timeframe based upon the task being trained. Quality audit standards must be attained while in the classroom. Trainees will be released to the unit upon meeting the quality audit standards and begin processing claims according to the guidelines listed later in this document.

ATTENDANCE:

New Service Operations associates are not granted PTO during the first 90 probationary days. The first 90 days of employment consists of a large amount of training that is critical to the trainee's future success. Any unscheduled days will follow the procedures outlined in the Service Operations Attendance Progressive Performance Guideline.

LENGTH OF TRAINING:

The length of training classes differs depending on the complexity of the tasks.

CAPS:

- Batch Entry: two weeks of classroom training or less
- Claims Specialist - No Experience: six to eight week of classroom training
- Claims Specialist - Experienced: four to six weeks of classroom training
- Inpatient Training: three to four weeks of classroom training

TRAINING QUALITY AND PRODUCTION GUIDELINES:

The training department will focus on education and quality processing prior to focusing on production.

The training department will train new associates to achieve the minimum quality requirements, based on position, as defined in the Progressive Performance Improvement Plan guidelines.

- **Batch Entry Training:** During the designated training period the batch entry trainee will process up to 50 claims per day. This number may fluctuate to acquire skill set.
- **Claims Specialist Training:** During the designated training period, the claims specialist trainee will process up to 30 claims per day.
- **Inpatient Training:** During the designated training period, the inpatient trainee will process up to 15 claims per day.

Feedback will be given to the trainee by the trainer within 24 to 48 hours after processing the claim. The auditing of claims will be done by either the quality management department or the training department based on need.

PERFORMANCE COUNSELING FOR CLAIM TRAINEES:

Trainees who are not at the minimum performance level at the end of a designated period may be counseled following the procedures outlined in the Service Operations Progressive Performance Guidelines. These steps will be followed with modified time frames.

CAPS RE PROGRESSION PLAN:

Claims production requires time and experience. Once a trainee has been released to the floor production requirements will be measured weekly and will be phased in over a period of time. Graduated production requirements are based upon the complexity of the task that was trained.

Batch Entry				
Week 1	**Week 2**	***Week 3***	***Week 4***	***Week 5***
25%	45%	65%	85%	100%

Claims Specialist - Experienced			
Week 1	***Week 2***	***Week 3***	***Week 4***
50%	65%	80%	95%

Claim Specialist – No Experience					
Week 1	***Week 2***	***Week 3***	***Week 4***	***Week 5***	***Week 6***
50%	55%	65%	75%	85%	95%

Inpatient			
Week 1	***Week 2***	***Week 3***	***Week 4***
50%	65%	80%	95%

Employees must maintain quality and show improvement in production based on the RE Progression Plan. If the trainee is not progressing according to plan they may be placed on disciplinary action up to and including termination.

Employees must maintain quality and show improvement in production based on the RE Progression Plan. If the trainee is not progressing according to plan they may be placed on disciplinary action up to and including termination.

(4) Describe the capabilities of your claims processing system to integrate each of the following required MHSA Program components:

(a) Prior authorization for inpatient services, psychological testing and electro-convulsive treatment and concurrent review of outpatient services;

Magellan's clinical, eligibility and claims processing systems are all fully integrated to ensure that the clinical intake and service authorization process is performed using the most recent enrollee information possible. This system integration allows data to be available during regular call center hours and through our IVR system and Web site 24 hours a day, 7 days a week.

Magellan's Integrated Product (IP) System is designed to meet Magellan's complex interface requirements and to collect and store the types of data needed to meet reporting requirements of organizations such as the National Committee for Quality Assurance and the Centers for Medicare and Medicaid Services.

IP provides intake staff with online access to information relating to care management support, such as intake and referral data, employer information such as location and division, presenting problem, diagnosed problem and provider demographics. The data handling features allow for comprehensive data capture, internal data linkages, external interfaces and queuing. IP has the flexibility to be configured to capture data elements according to customer need. Authorizations for services, including inpatient services, psychological testing and electro-convulsive treatment and concurrent review of outpatient services can be issued from IP.

Specific functions include Member and family eligibility information, provider search, ZIP code matching, certification, correspondence generation, evaluation and assessment information and case management. IP provides inquiry capability such as membership eligibility look-up (patient address, home phone, eligibility dates for current and historical records), online benefits, and provider search.

IP is a proprietary preauthorization system developed by an internal team of developers. Magellan is the sole owner of this application's source code. As with all of Magellan's systems, IP is flexible and can be designed to match customer-specific data elements, formats, and file layouts.

IP is compliant with current HIPAA standards for the protection of Member privacy. It is fully integrated with Magellan's CAPS system and interfaces with Magellan's Web site.

(b) Eligibility verification;

Magellan's enrollment system resides on CAPS. This system is reliable, efficient, and fast; it supports all Magellan's customers. Because claims and enrollment data are housed and monitored within one unified system, Magellan staff is fully able to verify enrollment online during phone conversations with enrollees or providers while also validating enrollment during claims processing.

When providers or enrollees visit Magellan's Web site, they are able to view enrollment information online to ensure coverage. Magellan's enrollment system has complete flexibility to maintain enrollment and benefit information by variables such as specific groups, divisions, or other categories.

(c) Customized edits for variations in benefits required various employee groups;

In *Question 1* we provided an outline of the standard claims edits within the CAPS system. CAPS is fully customizable and we can accommodate additional edits that will be specific to the Department contract, such as edits covering variations in benefits between employee groups.

During implementation, Magellan's IT team will meet with the Department to establish the types and range of electronic edits that will be resident in CAPS on behalf of the Department. All changes to our systems are fully tested and will be ready for go-live.

(d) Historic look up capability for claims and clinical information; and

Our IP system pulls information from the Data Warehouse for historical review of claims and clinical information. The Data Warehouse retains up to ten years of claims and clinical data for immediate retrieval and our data archives retain historical information indefinitely.

(e) Multi-level cost sharing (Deductibles, Co-insurance, Co-payments).

CAPS includes standard edits to identify multiple funding arrangements and can apply custom plan provisions such as deductibles, co-insurance coverage and co-payments for services.

(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.

Magellan routinely delivers claims/encounter data, including shared accumulator information, to administrative entities on behalf of our customers. During implementation, our IT team will work with the Department to establish a format and a schedule for the daily transfer of this information.

(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.

Magellan will also receive a daily claims file of shared accumulator information from those administrative entities specified by the Empire Plan. We confirm that we can establish a common interface for this data and will load that data in a timely manner.

(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.

Magellan follows a unidirectional software development life cycle (SDLC) for all of our applications. Each solution is developed in a development environment, then promoted to a staging environment for testing, then promoted to the production environment for use. This ensures each environment is properly updated as changes are made.

All system maintenance and repairs follow procedures outlined in our Software/ Hardware/ Data Change Management Policy. The purpose of the policy is to ensure updates made to applications, systems, direct accessed data, and hardware are:

- documented in a clear, concise manner
- managed to prevent system/performance conflicts
- scheduled to minimize impact on normal business operations
- approved and communicated effectively to all IT departments and the user community
- implemented to support efficient and stable updates in the future.

Even minor changes to our systems follow the procedures outlined in our policy. This allows us the ability to track all aspects of the work for systems management and budgeting.

We execute projects in distinct phases, each having specific activities and deliverables and following a formal, customized work plan that controls every step. System changes made on behalf of a customer contract (such as edits to our Claims system for the MHSA Program), are developed and tested in a manner to ensure that those changes do not affect those of other customers.

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

While Magellan does not currently participate in Medicare Crossover, Magellan is able to accept claims data files from the Department and will work with the Department in order to understand its requirements for handling that data. Magellan can accept this data in a standard 837 format or a proprietary format if desired.

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

Our Cost Containment Department is dedicated to identifying and investigating cost reduction opportunities, including the development of methods for detecting "Other" or Third Party Liability (TPL). They also use legal resources to determine primary and secondary payment status which include:

- National Association of Insurance Commissioners (NAICA) Model COB Regulations are used to determine primary payer for commercial insurance.
- Centers for Medicare and Medicaid Services (CMS) Guidelines are used for Medicare.
- State and federal laws are adhered to where applicable.

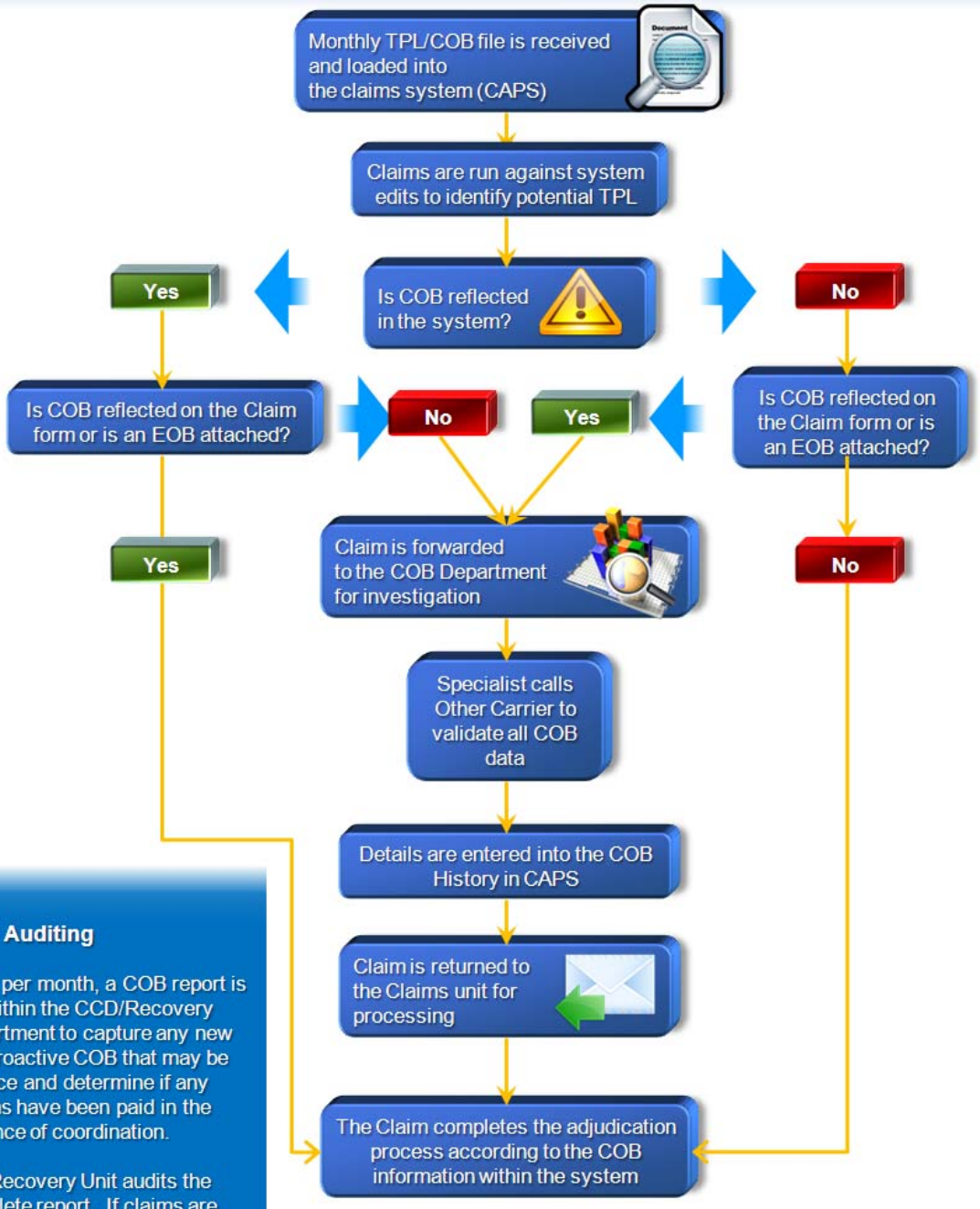
CAPS has the ability to record third-party coverage down to the dependent level. The system carries effective and termination dates for coverage so that there is a historical record for claims payment purposes. The other insurance data is captured in one of two methods. Horizon may provide third party coverage as part of the membership feed, in which case the other insurance database is updated with the membership load. TPL is entered on a claim by a checked box on the claim form indicating coverage or by money amount entered in the other insurance field, or an EOB is attached. When other insurance is identified in this manner, the data captured to coordinate benefits is manually entered by the Cost Containment Department.

Magellan supports COB investigation in several ways. Magellan is able to pay and pursue, pursue and pay, or administer Magellan's standard, which is to pursue and pay for inpatient and alternative levels of care and to pay and pursue for outpatient services.

When a claim comes in with no information about other primary or secondary insurance, and we do not have information in our database, CAPS automatically generates a letter requesting this information. Claims examiners also forward COB leads and discrepancies based on EOBs that are attached to claims to the Claims Recovery Department for final determination. New leads for primary coverage, determined as a result of investigation or received on returned COB letters, are entered into the claims processing system, which will then flag future claims for COB. Regardless of how the data is initially captured, the system will generate a follow-up COB letter to the enrollee after 365 days, requesting updated information.

The following figure outlines our COB/TPL Workflow.

COB/TPL Workflow



COB Auditing

Once per month, a COB report is run within the CCD/Recovery Department to capture any new or retroactive COB that may be in place and determine if any Claims have been paid in the absence of coordination.

The Recovery Unit audits the complete report. If claims are found paid without COB, the recovery process is started.

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

Magellan's Cost Containment Department reconciles claim payment errors for overpayments and underpayments through a referral process. Claim errors are routed to the Cost Containment Department by the auditing team, the claim processing team, customer service team, or through report analysis. Underpayment errors are referred to the claim processing team to facilitate claim adjustments, unless overpayments for a particular provider/enrollee are also identified, in which case underpayment may be used to offset overpayments. Overpayment errors that are identified follow a standardized recovery process that includes tracking and monitoring in our Claims Recovery Management System (CRMS). The process requires notification via letter to the provider that allows 30 days for the provider to refund or appeal our request. If the provider has not contacted Magellan within 45 days to make arrangements or appeal the decision, an automated retraction is initiated. The Cost Containment Department unit routinely reconciles outstanding recoveries through the use of reports from the CRMS database.

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

As outlined previously, Magellan's systems are fully integrated in order to provide a continuous flow of accurate data throughout the clinical intake, authorization and claims adjudication process. All data immediately feeds into our Enterprise Data Warehouse, where it is made available for reporting and analysis.

Information on claims that do not complete the adjudication process is held in the Data Warehouse and reported to the Claims Department through our claims inventory reports.

(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.

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

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

Magellan's electronic claims edits, outlined in Question 1, are highly efficient at identifying errors in submitted claims or elements that indicate possible fraud and abuse.

FRAUD INVESTIGATION INITIATIVES

In addition to system edits to identify inappropriate provider claims, within our corporate Security Department, Magellan maintains a sophisticated Special Investigations Unit (SIU), which is a member of the National Health Care Anti-Fraud Association (NHCAA). The SIU is responsible for detecting, preventing, and investigating suspected claims for fraud and abuse by consumers, providers or other entities. The SIU investigates allegations of provider claims fraud, including billing for services not rendered, upcoding, unbundling, misrepresentation of non-covered services and duplicate billing.

Magellan's SIU reports any suspicion or knowledge of consumer fraud or abuse to the Office of the Inspector General (OIG) or other oversight agency(s), including client-specific state agencies, as appropriate. Every open case of detected offenses is monitored by Magellan's Director of the SIU every 30 days until resolution. This includes the development and monitoring of corrective action initiatives related to any confirmed instance of non-compliance, fraud, and/or abuse.

(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.

Magellan confirms that we update our Claims Adjudication and Payment System with FAIR Health, Inc's database twice each year.

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

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

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

Magellan agrees to this guarantee. Our quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine percent (99%) that the MHSA Program's financial accuracy isn't achieved as calculated on an annual basis is $10,000.

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

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

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

Magellan agrees to this guarantee. Our quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) all claims processed and paid during the first contract year (ninety-seven percent (97%) 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 $10,000.

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

The standard credit amount for each .01 to 1.0% below ninety-nine and fivetenths 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 $_____.

Magellan agrees to this guarantee. Our 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%) 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 Magellan'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 $6,000.

(18) 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 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 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 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 $_____.

Magellan agrees to this guarantee. Our 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%) of enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by Magellan and not turned around within eighteen (18) Business 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 $6,000.

12. CLINICAL MANAGEMENT

Quality Clinical Management techniques help to control costs and ensure that Enrollees are receiving safe, effective treatment in the least restrictive setting. The Department requires the Contractor to provide clinical management that is MHSA parity compliant through three Utilization Review (UR) methods that are currently used for the medical component of the Empire Plan: Pre-certification, Concurrent review and Retrospective review. The Contractor must, at a minimum, provide UR as described further in this Section; however, Offerors are not prevented from offering other value oriented UR methods, provided that they are parity compliant and implementation is at the sole discretion of the Department.

Both inpatient hospital and MHSA admissions are subject to pre-certification, except in Emergencies, concurrent review and retrospective review. Recurring outpatient therapy visits under the medical program, such as physical therapy, occupational therapy and chiropractic care, are certified based on clinical assessment of the member by the provider. The determination occurs after there has been a clinical assessment by the provider and the clinical assessment can occur after one or more visits. Services rendered by "tier 1" in-network providers for physical therapy, occupational therapy and chiropractic services do not need to be certified. The following are the options related to when a Provider is expected to seek authorization for these services:

1. *No contact at all*
2. *Prior to the first contact*
3. *After the first contact*
4. *After the tenth visit*

Under the MHSA Program, recurring outpatient therapy visits may be reviewed prior to the 11th visit, but services may not be denied prior to the 11th visit.

For the period January 1, 2011 through December 31, 2011 clinical management of the MHSA Program resulted in authorization of approximately 1,117,000 outpatient visits and the certification of nearly 4,300 inpatient and alternate level of care admissions.

Pre-Certification of Care

The MHSA Program is designed to strongly encourage members to seek clinical referral prior to receiving MHSA services. This is accomplished through the use of a Clinical Referral Line (CRL). The CRL is staffed by clinicians who determine the medical appropriateness of MHSA care and direct members to the most appropriate Network Provider and level of care. Also, the pre-certification process includes procedures to determine medical necessity in

advance of non-emergent inpatient admissions and for out-patient benefits for "recurrent therapy visits". "Recurrent Therapy Visits" are defined as treatment modalities or services that are dependent on the provider and patient interaction during the patient encounter as the major form of treatment, reoccur on a regular basis, and the total number of which are determined by a specific treatment plan based on the patient's clinical presentation. The current Contractor requires pre-certification for ECT, psychological testing and Applied Behavioral Analysis (effective January 1, 2013).

A. DUTIES AND RESPONSIBILITIES

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;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(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

Magellan confirms we will meet this requirement.

(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.

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(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;

Magellan confirms we will meet this requirement.

(5) Promptly loading into the clinical management and/or claims processing system approved authorizations determined by the Contractor;

Magellan confirms we will meet this requirement.

(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 care if transferred to rehab;

Magellan confirms we will meet this requirement.

(7) Loading into the Contractor's clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once acceptable files are received; and

Magellan confirms we will meet this requirement.

(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.

Magellan confirms we will meet this requirement.

(b) Emergency Care CRL Guarantee: The Program's service level standard requires one hundred percent (100%) of Enrollees who call the CRL in need of life-threatening emergency care be referred to the nearest emergency room and be contacted within (thirty) minutes to assure their safety. Additionally, one hundred percent (100%) of Enrollees in need of non life-threatening emergency care shall be contacted by a Network Provider or recontacted by the CRL clinician within thirty (30) minutes of the Enrollee's call to the CRL.

Magellan confirms we will meet this requirement.

(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 Network Provider Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the Enrollee's call to the CRL.

Magellan confirms we will meet this requirement.

B. Required Submission

(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.

Clinical Referral Line (CRL)

Enrollees and providers will access behavioral health clinical services by contacting Magellan through the Empire-specific dedicated toll-free phone line, which operates 24 hours a day, 7 days a week, 365 days per year. For any clinical referral, authorization, crisis/emergency, or concurrent review needs, the call with be handled by a licensed Clinician at our Empire Plan Service Center, who determines the severity of the caller's situation and the level of care required.

Magellan Clinicians are trained extensively in crisis intervention and in techniques for engaging callers who pose a danger to self or others; they are proficient at quickly assessing level of danger and degree of pathology.

For non-urgent or routine outpatient service requests, Clinicians assist enrollees in locating suitable Magellan network providers by using our Provider Search application. Using Provider Search, care managers can identify providers by a number of criteria including:

- Mileage radius
- Discipline
- Specialty (e.g., personality disorders, marriage/family, anxiety disorders)
- Language proficiencies and ethnic origin
- Practice information
- Levels of care
- Gender
- American Sign Language
- And other criteria.

Once the Clinician and caller agree on a set of provider referrals, the Clinician will generate an initial authorization for care, which adheres to the enrollee's benefit plan and Magellan's Medical Necessity Criteria. For inpatient service needs, the Clinician authorizes care based on Magellan's Medical Necessity Criteria and Clinical Practice Guidelines.

PROPOSED PRECERTIFICATION PROCESS

As described in more detail in response to *Question b1.b.,* in the *Concurrent Review* section below, Magellan does not require precertification for outpatient care. Instead we employ a 100 percent systemic claims review of all outpatient cases to identify those cases that can benefit from our consultation and care advocacy approach.

Prior to patients' admission to inpatient or an alternative level of care, a precertification process is conducted in accordance with federal/state regulations, contract requirements and accreditation requirements. Network providers are notified of this process via the Magellan Behavioral Health Provider Handbook, which we would be pleased to share with the Department for your reference. The clinical urgency of the situation determines whether the process will be expedited or standard. This process includes review by a Care Manager. The care manager will gather clinical information to assess the urgency of the situation and perform review of requested services, including:

- Presenting problem (situation and/or symptoms)
- Mental health treatment history including medications
- Substance use treatment history
- Medical history including medications and current treatment regimes
- Mental status (as reported by a practitioner)
- Risk potential
- Current support systems
- Diagnosis (as reported by a practitioner)
- Treatment plan

The care manager applies the medical necessity criteria against the clinical features of the individual as reported by an enrollee or attending/treating provider and the evaluation/treatment setting resources available within the local behavioral healthcare delivery system. Following this review the care manager may authorize the services requested or refer the request to a Physician Advisor for a

medical necessity determination if the requested service does not appear to meet medical necessity criteria, or other concerns about the quality or appropriateness of care are identified.

CRITERIA USED TO IDENTIFY SERVICES FOR PRE-CERTIFICATION

Magellan's detailed Medical Necessity Criteria is the criteria used to identify the services that require pre-certification or prior authorization. Magellan care managers, physician advisors, and network providers all use Magellan's Medical Necessity Criteria as a tool for determining whether care is medically necessary and, if so, the level of care needed to treat DSM-IV-TR disorders.

Magellan's proprietary clinical criteria has been in place for more than 20 years. Developed in 1988, the criteria are based on a combination of clinical observations and research findings. Our clinical criteria are an objective and evidence-based decision support tool for behavioral health services that constitutes the basis of medical necessity for behavioral health services. The criteria do not specify fixed minimum or maximum inpatient lengths of stay or numbers of visits within specific diagnostic categories. Further, all the criteria need not be used; the specifics of the customer contract and benefit design would determine which ones apply. Their appropriate use and exceptions based on resource availability and other unique circumstances of the health care service consumer and his or her support system can achieve the utilization management program goal of optimizing the use of health care resources.

Medical Necessity Criteria contains detailed, evidence-based criteria for behavioral health disorders listed in the DSM-IV-TR manual that cover the full range of services settings:

- Inpatient, both acute and non-acute levels
- Intermediate ambulatory settings, including partial hospitalization and intensive outpatient programs
- Ambulatory settings, including supervised living environments

These settings also have specific criteria that address the needs of distinct populations such as children, adolescents, geriatric adults, and those with substance use or eating disorders. In addition, the criteria cover services unique to behavioral health evaluation and treatment services such as psychological testing and electroconvulsive treatment.

Levels of care covered in the criteria are as follows:

- Hospitalization, Psychiatric, Adult
- Hospitalization, Psychiatric, Child and Adolescent

- Hospitalization, Psychiatric, Geriatric
- Hospitalization, Eating Disorders
- Hospitalization, Substance Use Disorders, Detoxification
- Hospitalization Substance Use Disorders, Rehabilitation Treatment, Adult and Geriatric
- Hospitalization, Substance Use Disorders, Rehabilitation Treatment, Adolescent
- Subacute Hospitalization, Psychiatric, Adult
- Subacute Hospitalization, Psychiatric, Geriatric
- Subacute Hospitalization, Psychiatric, Child and Adolescent
- 23-Hour Observation
- Residential Treatment, Psychiatric, Adult and Geriatric
- Residential Treatment, Psychiatric, Child and Adolescent
- Residential Treatment, Eating Disorders
- Residential Treatment, Substance Use Disorders, Detoxification Residential Treatment, Substance Use Disorders, Rehabilitation, Adult and Geriatric
- Residential Treatment, Substance Use Disorders, Rehabilitation, Child and Adolescent
- Supervised Living, Psychiatric, Adult and Geriatric
- Supervised Living, Psychiatric, Child and Adolescent Supervised Living,
- Substance Use Disorders, Rehabilitation, Adult and Geriatric
- Supervised Living, Substance Use Disorders, Rehabilitation, Child and Adolescent
- Partial Hospitalization, Psychiatric, Adult and Geriatric
- Partial Hospitalization, Psychiatric, Child and Adolescent
- Partial Hospitalization, Eating Disorders
- Partial Hospitalization, Substance Use Disorders, Rehabilitation Adult and Geriatric
- Partial Hospitalization, Substance Use Disorders, Rehabilitation, Child and Adolescent
- Intensive Outpatient Treatment, Psychiatric, Adult and Geriatric

- Intensive Outpatient Treatment, Psychiatric, Child and Adolescent
- Intensive Outpatient Treatment, Eating Disorders
- Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation, Adult and Geriatric
- Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation, Child and Adolescent
- Ambulatory, Substance Use Disorders, Detoxification
- Outpatient Treatment, Psychiatric and Substance Use Disorders, Rehabilitation
- Psychological Testing
- Therapeutic Leave of Absence Documentation
- Outpatient Electroconvulsive Treatment
- Inpatient Electroconvulsive Treatment

Annual review of the *Medical Necessity Criteria* is conducted with the oversight of the Medical Director's office. Appropriately licensed, actively practicing physicians with current clinical knowledge and expertise in applicable specialties as well as board-certified psychiatrists participate in the development and annual review process.

Information gathered as part of the development and annual review is assessed in order to maintain objective clinical criteria based on clinical evidence as well as guidance for applying the clinical criteria.

Magellan promotes an open process of encouraging and reviewing feedback from the clients it serves, its clinical and medical staff, and the behavioral health practitioner community throughout the year.

The annual review process includes input from:

- Magellan individuals who have utilized the criteria in the process of utilization review, and participating providers who respond to periodic surveys,
- The latest scientific and medical data in the field of psychiatry and substance abuse,
- Salient information from professional organizations, such as the American Psychiatric Association,

- Provider Advisory Boards whose membership includes locally or nationally recognized, actively practicing experts in the fields of substance abuse and mental health and represents the perspectives of academic institutions and professional associations,
- The senior clinical and medical leadership of Magellan, including psychiatrists board-certified in the areas of addictionology, child and adolescent psychiatry, and geriatric psychiatry.

An appointed *Medical Necessity Criteria* Review Work Group, comprised of Magellan staff from a variety of behavioral health disciplines, reviews the information collected from these individuals and groups and makes recommendations for changes. The revised criteria are presented to the Behavioral Health Quality Improvement Committee for acceptance and review. At the conclusion of this process, the *Medical Necessity Criteria* are forwarded to the National Network and Credentialing Committee for review in order to maintain consistency with other clinical practice guidelines, enrollee and provider materials, other relevant clinical information, and when appropriate, interpretations of benefits.

CLINICAL PRACTICE GUIDELINES

Magellan clinical staff also relies on the following clinical practice guidelines (CPGs) to support quality- and evidence-based decision making. Magellan recognizes the value of evidence-based clinical practice guidelines for providing standards with which to review care, promoting consistency of practice and facilitating care management decisions that conform to best practices. Magellan encourages use of practice guidelines when care managers review treatment plans, when provider and facility site visits are conducted, and when clinical record reviews are conducted.

Clinical Practice Guidelines (CPGs) supplement *Medical Necessity Criteria* and assist providers in the assessment and treatment of common behavioral health disorders. Magellan's standard approach to selecting guidelines dictates that prior to the adoption of each guideline relevant scientific literature is reviewed by a multi-disciplinary panel that includes board-certified psychiatrists, with input from providers in Magellan's clinical network, from consumers, and from community agencies. The Magellan CPG Task Force reviews Clinical Practice Guidelines at least every two years and provides updates as necessary.

The guidelines developed by Magellan are as follows:

- Practice Guideline for the Treatment of Patients with Attention Deficit/Hyperactivity Disorder
- Practice Guideline for Assessment and Management of the Suicidal Patient.

Clinical Practice Guidelines adopted from external industry-recognized behavioral health expert panels, such as the American Psychiatric Association (APA), cover the most prevalent behavioral health disorders. Magellan has specifically adopted the following Clinical Practice Guidelines from the American Psychiatric Association (APA), which can be downloaded from the APA Web site at www.appi.org.

- Practice Guideline for the Assessment and Treatment of Substance Use Disorders (SUD) and accompanying Quick Reference Guide
- Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Post-Traumatic Stress Disorder
- Practice Guideline for the Treatment of Patients with Major Depressive Disorder
- Practice Guideline for the Treatment of Patients with Bipolar Disorder
- Practice Guideline for the Treatment of Patients with Eating Disorders
- Practice Guideline for the Treatment of Patients with Panic Disorder
- Practice Guideline for the Treatment of Patients with Schizophrenia.
- Practice Guideline for the Management of Children with Autism Spectrum Disorders

Finally, Magellan has adopted a guideline:

- Practice Guideline for the Treatment of Patients with Obesity—last review, September 2007 from The National Institute of Health (NIH) Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, The Evidence Report.

Once Magellan adopts a practice guideline, each of Magellan's care management centers evaluates the guideline for its appropriateness in terms of meeting customer expectations, benefit plans, enrollee populations, and adherence to any customized utilization management criteria. To comply with NCQA requirements, Magellan care management centers annually monitor provider compliance with at least two of these guidelines.

(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 STAFFING

Magellan will offer the Department a fully dedicated clinical referral team based in our dedicated Albany Empire Plan Service Center to provide services for Program enrollees.

Care managers coordinate the assessment, care authorization, referral, and ongoing care monitoring for Magellan enrollees. Magellan's care managers are psychologists, social workers, psychiatric nurses, and licensed professional counselors who must meet the following minimum qualifications:

- master's degree or doctorate from an accredited program, or a licensed registered nurse
- current licensure with appropriate state agencies
- three to eight years (depending on the position level) of previous postgraduate experience in a psychiatric and/or substance abuse setting
- managed care experience preferred
- knowledge of utilization management procedures, mental health and substance abuse community resources, and providers
- knowledge and experience with care in an inpatient setting
- knowledge of DSM-IV or most current diagnostic edition.

To support this care management staff, Magellan ensures rapid access to its own in-house board certified psychiatrists (the medical director and associate medical directors, as well as physician advisors, whose qualifications are each listed below) onsite during all normal business hours, as well as during after hours. Magellan's medical staff provides consultation for complex cases, perform inpatient peer review, and review of other authorization and referral decisions.

MEDICAL DIRECTOR QUALIFICATIONS

The two Albany-based Empire medical directors role is to review clinically complex medical cases, including those of patients having serious and persistent conditions, instability with their illnesses, frequent and long inpatient stays, and those needing focused resources to assist with their conditions. Working with attending physicians (consulting "doctor-to-doctor") on cases to ensure

appropriate care is another role that the medical director fulfills. The medical director and associate medical directors also conduct daily clinical rounds to facilitate care manager access to psychiatric consultation.

Typically, each Magellan regional operation has its own Medical Director, who interfaces with the Senior Vice President/Corporate Medical Director and Senior Vice President/Chief Medical Officer. All Magellan medical directors must meet the following qualifications:

- graduation from an American or Canadian medical school accredited by the Accreditation Council for Medical Education (ACME) or equivalent training in a foreign medical school with successful completion of the ECFMG and FLEX examinations
- full training in a residency program in the United States or Canada that is approved by the ACME
- board certification by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry certification is preferred; for foreign medical graduates, board certification through the Royal College of Physicians and Surgeons of Canada or the Royal College of Psychiatrists (England) is preferred
- post-residency experience of five to 10 years
- clinical orientation to short-term treatment in an acute care setting
- minimum of 10 years of experience in both clinical and administrative positions
- previous managed care experience (preferred)
- current licensure in the state in which practicing for Magellan
- clinical experience pertinent to the patient populations being managed
- familiarity with current research and use of psychopharmacologic and psychotherapeutic modalities of treatment
- current active license to practice medicine.

PHYSICIAN ADVISOR QUALIFICATIONS

Physician Advisors are available 24/7 to consult with care managers on cases and review complex cases, to perform inpatient peer review and appeals case review. All Magellan physician advisors must meet the following requirements:

- current licensure in the state in which they practice and ability to meet all Magellan credentialing criteria
- graduate of an American or Canadian medical school accredited by the Accreditation Council for Medical Education (ACME) or equivalent training in a foreign medical school with successful completion of the ECFMG and FLEX examinations
- completion of a psychiatric residency program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association
- certification by the American Board of Psychiatry and Neurology or American Osteopathic Board of Neurology and Psychiatry certification which is preferred; for foreign medical graduates, board-certification through the Royal College of Physicians and Surgeons of Canada or the Royal College of Psychiatrists (England) is preferred
- minimum of five years of relevant post-residency clinical experience in the field in which they are reviewing
- familiarity with current research and use of psychopharmacologic and psychotherapeutic modalities of treatment
- if reviewing substance abuse cases, as qualified as psychiatrists as above or board certified in a primary care specialty or successful completion of a residency program approved by a primary care specialty board (internal medicine, family practice, pediatrics, or ob-gyn), and more than five years experience treating substance abuse patients; American Society of Addiction
- possess demonstrated specialties, including substance abuse and child, adolescent, adult, and geriatric psychiatry.

Magellan is careful to select physician advisors who demonstrate the ability to negotiate and interact positively and effectively with their peers. Magellan has four New York-licensed physician advisors for our Empire Plan Service Center, each of whom maintains an active practice.

DENIALS OF CARE

Non-authorization decisions and denials of care are based on a Magellan physician advisor's application of Magellan Medical Necessity Criteria for mental health and substance abuse related diagnoses, in conjunction with a verbal discussion with the enrollee's attending physician or provider. Only Magellan's board-certified physician advisors may render non-authorization decisions. Magellan maintains a well-tested, regulatory-compliant and accredited process for the

authorization and non-authorization of behavioral health services. Non-authorization decisions are made with great care, following our clinical policies and procedures that cover all aspects of job responsibilities and functions. These policies/procedures are routinely reviewed, and updated. Clinical operations staff are required to review and sign off on all updated policies/procedures to ensure accountability and adherence.

A formalized appeals process is available to enrollees and providers who may wish to dispute non-authorization determinations.

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

Three percent of Enrollees who called the CRL in 2012 and received a referral at a different level of care from the one initially requested.

(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

As described in more detail in response to *Question b1.b.* in the *Concurrent Review* section below, Magellan does not require precertification for outpatient care. Instead we employ a 100 percent systemic claims review of all outpatient cases to identify those cases that can benefit from our consultation and care advocacy approach.

Prior to admission to inpatient or alternative levels of care a precertification process is conducted in accordance with federal/state regulations, contract requirements and accreditation requirements. Network providers are notified of this process via the Magellan Behavioral Health Provider Handbook. The clinical urgency of the situation determines whether the process will be expedited or standard. This process includes review by a Care Manager.

TYPE OF SERVICES SUBJECT TO PRECERTIFICATION

Services/levels of care subject to precertification include but are not limited to the following:

- Hospitalization
- Subacute Hospitalization
- 23-Hour Observation
- Residential Treatment
- Supervised Living
- Substance Use Rehabilitation,
- Partial Hospitalization
- Intensive Outpatient Treatment
- Ambulatory Detoxification
- Psychological Testing
- Outpatient Electroconvulsive Treatment
- Inpatient Electroconvulsive Treatment

STAFFING LEVELS

Approximate clinical staffing levels are provided in Table B.12.a below.

TIMELINE FOR COMPLETION

The turn-around time for pre-certification decisions varies by level of request. Magellan defines four levels of request, as explained below.

EXPEDITED PRE-AUTHORIZATION REQUEST

The care manager receives complete clinical information that does not appear to meet medical necessity criteria for the requested expedited pre-authorization.

In this case, the care manager documents the time of request once complete clinical has been received. The care manager must provide verbal notification of the physician advisor's authorization determination to the requestor, the client and the treating provider within 3 hours from the time of request.

STANDARD PRE-AUTHORIZATION REQUEST

The care manager receives complete clinical information that does not appear to meet medical necessity criteria for the requested standard pre-authorization.

In this case, the care manager documents the time of request once complete clinical information has been received. The care manager must provide verbal notification of the physician advisor's authorization determination to the requestor, the client and the treating provider within the shorter of one 1 business day or 72 hours from the time of request.

CLINICAL INFORMATION REQUESTED

The care manager will gather clinical information to assess the urgency of the situation and perform review of requested services, including:

- Presenting problem (situation and/or symptoms)
- Mental health treatment history including medications
- Substance use treatment history
- Medical history including medications and current treatment regimes
- Mental status (as reported by a practitioner)
- Risk potential
- Current support systems

- Diagnosis (as reported by a practitioner)
- Treatment plan

The care manager applies the medical necessity criteria against the clinical features of the individual as reported by an enrollee or attending/treating provider and the evaluation/treatment setting resources available within the local behavioral healthcare delivery system. Following this review the care manager may authorize the services requested or refer the request to a Physician Advisor for a medical necessity determination if the requested service does not appear to meet medical necessity criteria, or other concerns about the quality or appropriateness of care are identified.

SIMILAR CLIENT CASES

Magellan has provided the number of cases reviewed, approved, and declined for another large state client in **Table B.12.b** below.

SAMPLE FORMS

Magellan has provided prints of the screen used by Magellan clinical staff during the precertification process as **Appendix W**.

(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?

Magellan will provide seamless customer service 24 hours a day, 365 days a year to the Department enrollees. As a result, callers will receive the same services regardless of the day or time that they call their toll-free number.

Licensed care managers handle all calls requesting information, referrals, authorization, and crisis intervention around the clock. Using our Provider Search program, Magellan staff has access to the following basic provider information when making referrals:

- Provider Name and Address
- Office accessibility
- Specialty credential
- Discipline(s)
- Education/Degrees
- Gender
- Language
- Ethnic Origin (if listed by provider)
- Treatment Modality, and
- Preferred provider status (if applicable for a customer).

As an important part of the credentialing process, Magellan gathers self-reported specialty information from providers and maintains it online and within its clinical systems so that Magellan staff can offer enrollees the widest choice possible in choosing provider type and specialty. Providers in Magellan's MHSA network may indicate a specialty in children and/or adolescents and geriatrics, and such specialties are tracked in our provider referral system.

When long-term or inpatient care is clinically indicated, and the enrollee would benefit from a provider with a specialty in adolescents or geriatrics, Magellan makes the appropriate referral. In all cases, Magellan clinical staff helps enrollees select the most appropriate types of outpatient providers and treatment based on their presenting concerns, medical necessity and severity of condition.

Specialty information Magellan also collects for providers and by which enrollees may choose outpatient care includes:

- Adult (18-64)
- Adolescent (13-17)
- Grief/Bereavement
- Older Child (6-12)
- Borderline Personality
- Mental Health
- Marriage/Family
- Geriatrics (65+)
- Abuse
- Substance Abuse

- Short-Term Resolution Counsel
- Gay/Lesbian Issues
- Domestic Violence
- Younger Child (0-5)
- Sexual Disorders
- Psychological Testing
- Community Referral
- Developmental Disorders
- HIV/AIDS
- Formal/Mandatory Referral
- Substance Abuse Professional (SAP)
- Fitness-for-Duty
- Autism
- Employee Orientation
- Neuropsychological Testing
- Electro-Convulsive Therapy
- Cancer
- Cardiovascular Disease
- Jewish Counseling
- Muslim Counseling
- Bariatric Support Services
- Hearing Impaired Services.
- Eating Disorders
- Group Psychotherapy
- EAP Assessment & Referral
- Medical Comorbidity
- Critical Incident Stress Debriefing
- Medications Management
- Workplace Violence
- Management/Supervisor Consultation
- Harassment
- Wellness/Supervisor Training
- Mental Retardation
- Christian Counseling
- Worker's Compensation/Disability
- Mobile Crises/Home-based Services
- Neuropsychiatric Assessment
- Obesity
- Diabetes
- Childhood Medical Conditions
- LDS Counseling
- Hindu Counseling
- Buprenorphine

Regardless of an enrollee's condition, he or she also always has the right to change providers. Magellan believes the patient (enrollee)-provider relationship is critical to the success of treatment outcomes. In all cases, Magellan Care Managers work to understand why an enrollee feels a change is necessary, and if a quality of care or customer service concern is expressed, Magellan pursues action through formal processes.

Magellan also spends time educating enrollees about what to expect from therapy or treatment and how treatment can become successful.

Magellan consistently meets NCQA requirements for enrollee services, including linguistic and special needs capabilities. Special needs capabilities include:

TDD/TTY

Magellan maintains a responsive customer service system that accommodates the special needs of enrollees. Magellan has full TDD (telecommunications device for the deaf)/TTY (text telephone) capacity for hearing- and speech-impaired callers. When a hearing- or speech-impaired enrollee places a call from his or her TDD/TTY to our toll-free line, the procedure is as follows:

- Magellan CSA staff is trained to recognize tones originating from TDD/TTY calls.
- When such a call is received, the staff member transfers the call to a TDD/TTY.
- The staff member moves to the TDD/TTY station, reads the message sent by the caller on the TDD/TTY terminal screen, and types a response, which appears on both the caller's and our screens. Two-way communication proceeds in this fashion.

LANGUAGE TRANSLATION

Magellan has a vendor relationship with Pacific Interpreters to provide language translation services for enrollees who do not speak English. The staff at Magellan care management centers has the ability to communicate with non-English speaking enrollees—regardless of their language preferences—through the use of the Pacific Interpreters language translation service. Pacific Interpreters employs skilled professional interpreters who are specially trained in customer service and in medical, insurance, legal, financial, and emergency services terminology. Through the relationship with Pacific Interpreters, Magellan staff and enrollees have instant, round-the-clock access to accurate, clear, and culturally sensitive interpretation of more than 200 languages.

A partial sampling of those languages is included below. Languages are subject to change depending upon needs and specific client requests.

Sample Languages			
Afghan	Estonian	Iranian	Persian
Afrikaans	Ethiopian	Italian	Polish
Albanian	Farsi	Japanese	Portuguese
Armenian	Fijiian	Khmer	Romanian
Assyrian	Filipino	Kiwanda	Russian
Belorussian	Finnish	Korean	Somalian
Bengali	French	Kurdish	Spanish

Sample Languages			
Bosnian	Georgian	Laotian	Swahili
Bulgarian	German	Latvian	Swedish
Burmese	Greek	Lebanese	Taiwanese
Cambodian	Gujarati	Lithuanian	Thai
Chinese	Haitian	Macedonian	Tibetan
Creole	Hebrew	Malay	Turkish
Croatian	Hindi	Malayam	Ukrainian
Czech	Hmong	Mandarin	Urdu
Danish	Hungarian	Marshallese	Vietnamese
Dari	Icelandic	Nepali	Wolof
Dutch	Ilocano	Norwegian	Yiddish
Egyptian	Indonesian	Oromo	Yoruba

When a Magellan call center receives a call from an enrollee who does not speak English, staff calls the Pacific Interpreters number and requests an interpreter for the caller's language. If intake staff does not recognize the language, the Pacific Interpreters operator helps determine it and "conferences in" an interpreter within seconds after the language is identified.

Additionally, enrollees of Magellan's Customer Service, Care Management, and Quality Improvement Departments are conversant in a number of foreign languages. Magellan tracks a total of 61 languages, including American Sign Language, in its provider and clinical databases; of those languages, over 40 are spoken by active providers in Magellan's national networks. Translation services in the treatment setting may be arranged including American Sign Language interpretation.

(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.

Customer Service Associates (CSAs) are trained to identify urgent and emergent callers using protocols for active listening and those presenting with slurred speech. In any case where a CSA suspects a caller may be at risk, he or she conferences in a licensed care manager to assist the caller. No caller in crisis is ever placed on hold. Care Managers then make determinations about the best course of action to follow to manage the caller's urgent or emergent need.

Magellan's appointment standards require an immediate assessment for emergency situations. As governed by Magellan's national clinical/medical policies, life-threatening emergencies require immediate face-to-face assessment, and non-life-threatening emergencies require face-to-face assessment within six hours. The care manager performs a lethality assessment using our clinical assessment form to determine whether to notify police, request assistance from a psychiatrist, or make an emergency referral.

In cases where there is an immediate threat, the care manager acts without delay to avoid injury and to preserve life and safety. To stabilize the situation, the care manager makes every effort to keep the caller on the phone by compassionately acknowledging the caller's acute distress and conveying a sense of safety, concern, and action. As a front-line contact, the goal of the care manager is to ensure the safety of the caller and help him or her receive necessary assistance, as described below:

- If inpatient services are indicated, the care manager will make arrangements to ensure that the caller can be seen at the closest inpatient facility. This may require calling 911 or an ambulance to facilitate the caller's safe transport to appropriate care. Once the enrollee has been evaluated, the destination facility calls the toll-free number for authorization.
- If the caller is not in imminent danger, the care manager will arrange for a face-to-face assessment, as necessary and as specified by the caller's benefit, within the same day or evening. This determination is based on the care manager's discussion with and assessment of the caller. The care manager will schedule the appointment directly with the provider and/or warm transfer the caller to the provider in order for them to schedule the appointment. The care manager will follow up with the provider following the appointment to determine what other follow up activities are needed. In such instances, the caller nonetheless feels the need for immediate assistance and benefits from talking to a caring clinician and learning that he or she can schedule an appointment the same day or the next day.

After securing the safety of the caller and any other persons involved, the care manager thoroughly documents the incident, entering information into our online care management system. The Magellan clinical management system has built in flags to alert care managers to high risk cases and to remind them to follow up with critical cases/enrollees daily until all resources have been provided. As part of ongoing quality review processes, Magellan also reviews adherence to urgent/emergent appointment timeliness.

(g) An explanation of the procedures followed in cases where a Network Provider is contacted directly by an Enrollees seeking treatment.

In these instances, Magellan providers are encouraged to register the care on behalf of the enrollee. Providers wishing to register the care for new patients who have contacted them first may contact Magellan by phone or online at MagellanHealth.com to register the care. When the provider calls Magellan by phone, the Magellan Empire Plan care manager confirms the eligibility and benefits of the enrollee and registers the care in the system. The provider is informed of Magellan's outpatient outcomes program and is encouraged to share that information with the enrollee in order for the enrollee to benefit from the self assessment outcomes tool.

Enrollees often present directly to the emergency room when they are in crisis for mental health or substance abuse problems. Magellan always approves emergency procedures. Once the enrollee has been assessed and the emergency situation has been stabilized, the facility contacts Magellan for authorization. Magellan approves any services that were provided as part of the emergency evaluation and gathers clinical information to determine the medical necessity of the level of care being requested. Depending on the enrollee's benefits, the facility may receive partial payment if services post crisis stabilization were not certified in a timely manner. Magellan's administration of such benefits complies with all applicable state regulations.

(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?

ENCOURAGING THE USE OF THE TOLL-FREE NUMBER FOR REFERRALS

As described in detail in our response to Section IV.B.5 Enrollee Communication Support, Magellan will implement a comprehensive communication/awareness campaign for the new Empire Plan MHSA Program. The senior account executive dedicated to The Empire Plan will work with the Department to ensure that a key aspect of our campaign will be to encourage the use of the toll-free number for referrals to minimize self-referrals to network providers. Some initiatives we typically suggest to reach this goal include the following:

- Including the toll-free number and an article about the Magellan Clinical Referral Line (CRL) in the Empire Plan Report and other relevant publications, including Union newsletters and EAP pamphlets.

- Providing the toll-free number, a brief description of the CRL, and the advantages of accessing the CRL for network referrals in the NYSHIP General Information Book and Empire Plan Certificate.
- Including the CRL toll-free number in all supplemental or program communication materials, including:
  - New Benefit or Open Enrollment Announcement Letter
  - Health Observances
  - eCampaigns
  - Program Flyers and Posters
  - MHSA benefits brochure
  - Monthly Push E-Mails
- Educating attendees about the CRL at health fairs (including Empire Plan Health Benefit Fairs), conferences, and benefit design information sessions in New York State and elsewhere in the United States.
- Prefacing the "Find a Provider" section of MagellanHealth.com with the toll-free number and a statement suggesting enrollees contact the CRL for customized referrals.
- Including periodic advertising as articles in Union newsletters
- Presenting the toll-free number with the results of Magellan's on-line screening tools and a recommendation that enrollees contact the CRL if their results suggest a need for further assistance.
- CRL number included on benefits card or other documents as appropriate
- Customer Service Associates warm transfer enrollees to the CRL for a possible referral as indicated by the enrollee.

Whenever possible, communication materials, Web prompts, and Magellan Customer Service Associates will stress the following advantages of the accessing the CRL:

- Screening is conducted by Magellan Care Managers who are licensed mental health professionals.
- Care Managers are trained to find enrollees the most appropriate referral based on location, provider specialty, discipline, licensure, gender, language capabilities, and a number of other criteria.

- The CRL is available 24 hours a day/7 days a week/365 days per year.
- Contacting the CRL assures that enrollees will receive referrals to current network providers, who are knowledgeable about Magellan's protocols, and prepared to handle all necessary certification requirements and claims submission procedures. Enrollees will not have to worry about out of network charges.
- All calls are confidential.

ENCOURAGING USE OF NETWORK PROVIDERS

Magellan has significant experience assisting our customers in managing benefits under parity laws. Magellan would encourage the use of network providers through enrollee education. We will partner with the Department to deliver enrollee communications (SPD language, benefits announcement language, online information on the NYSHIP or MagellanHealth.com Web site, etc.) that emphasize a rich, quality-assured benefit for those who use network providers. Typically, within enrollee communications pieces around this issue, Magellan emphasizes the broad array of network providers offered and their specialties.

COMMUNITY RESOURCES AND REFERRALS

Magellan has found that the most effective tool for identifying up-to-date community resource referrals is the Internet. Magellan has also developed an internally-used "site map," enabling Magellan Care Managers and Follow-Up Specialists to quickly link to useful national Web sites concerned with chemical dependency, depression, anxiety, family and domestic violence, gambling and addiction, bipolar disorder, and many other issues. Frequently, a national site offers staff the option of clicking a state or city name to identify local agencies that handle the same concern. All Magellan staff has been trained on Internet searching strategies. At the regional level, one of the duties of Magellan's network affiliate managers is maintaining regional and localized resource lists, consulting with local providers about referrals, and doing referral research for individual cases, if needed. Additionally, support staff will research for specific resources as needed or requested in a particular area or community.

(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).

MEASURING THE EFFECTIVENESS OF THE CLINICAL REFERRAL LINE AND PRE-CERTIFICATION SERVICES

Magellan uses a multi-dimensional approach to evaluate the effectiveness of its pre-certification protocols. This approach includes the following:

ONGOING QUALITY ANALYSIS APPROACH

Magellan's national Quality and Outcomes Research Program provides measurement and assessment services for our Clinical Referral Line and pre-certification services. Magellan's Quality and Outcomes Research Program is supported by corporate staff, as well as by teams from other corporate departments such as Finance, Medical Economics, Analytical Services, Product Development, in addition to outcomes reporting functions embedded in each of Magellan's Care Management Centers, all of them virtually integrated with the national outcomes program's focus and objectives.

The program tracks "core indicators" that measure the effectiveness of the pre-certification program. These core indicators are tracked, trended and acted upon (as needed) through Magellan's corporate Quality Improvement Program. Ineffective pre-certification manifests itself with poor patient follow-through, ineffective treatment, disagreements about medical necessity, poor clinical outcomes and enrollee and provider dissatisfaction. Those manifestations of ineffective pre-certification are measured through the following core indicators:

- Excessive appeal activity
- Excessive readmissions
- Inadequate ambulatory follow-up after hospitalization
- Adverse incidents
- Complaints
- Admits/1000
- Days/1000

TARGETED OUTCOMES MEASUREMENT AND MANAGEMENT INITIATIVES

Our outcomes program, the Magellan Outcomes360 system, so named to reflect the breadth of our measurement program, supports evidence-based practice and a comprehensive approach to outcomes reporting. Magellan worked closely with industry leaders to design scientifically sound and clinically useful measurement instruments for the Outcomes360 system. The end result is reliable data reflecting the functional health status of individuals. The tools in Magellan's Outcomes360 Program produce immediate feedback reports for both the enrollee and provider and are:

- Web-based and secure
- Free to enrollees and providers
- Easy-to-use and administer
- Available in English and Spanish
- Completed by the enrollee

Our clinical programs incorporate routine, periodic measurement, the results of which are available to enrollees and/or providers in real time to support self-monitoring and treatment planning by allowing adjustments in the course of treatment based on self-reported data. The primary tools used by Magellan include the Consumer Health Inventory™ (CHI) and the Consumer Health Inventory for Children™ (CHI-C).

THE CONSUMER HEALTH INVENTORY™ (CHI)

A key feature of *Outcomes360* is Magellan's unique approach to outcomes reporting—the Consumer Health Inventory™ (CHI) tool. Magellan co-developed the CHI in close collaboration with QualityMetric. It expands the scope of the SF-12 Health Survey—which is nationally recognized as the leading assessment tool that measures changes in physical functioning and mental well-being—to include new, evidence-based behavioral health assessment questions. These questions address the presence and impact of behavioral health symptoms, substance abuse patterns, personal strengths, therapeutic relationships, and workplace productivity.

The CHI contains the two scale scores of the SF-12 that optimally position behavioral health services within the larger health care delivery system—the Physical Health Score (PH) to measure changes in the enrollee's physical health functional status, and the Emotional Health Score (EH) to measure changes in the enrollee's mental health functional status.

The CHI is a patient-reported outcome (PRO) instrument, which makes it unique in the industry. Unlike most outcome reports that providers complete, enrollees in outpatient therapy complete this

outcomes tool themselves, either on the MagellanHealth.com Web site or in their providers' offices. They respond to the CHI at intake to create a baseline score, and then periodically during treatment and again at discharge. Once Magellan obtains the baseline score, enrollees and providers can compare the results of subsequent administrations, facilitating provider discussions with enrollees regarding changes in their health and recovery status. Enrollees are encouraged to continue what is working and to consider alternatives to what does not appear to be working.

For children up to age 17, the parent or primary caregiver completes the Consumer Health Inventory for Children (CHI-C), developed by QualityMetric for Magellan to support children and their caretakers as they work to build the child's resiliency. Based in part on the SF-10 for Children, the CHI-C measures key functional indicators—physical and psychosocial health, school participation, distress symptoms, and strengths. It provides an assessment of the child's physical and psychosocial health status from his or her caretaker's perspective.

CONSUMER HEALTH INVENTORY FOR CHILDREN™ (CHI-C)

The CHI-C™ is the child/adolescent version of the CHI™. It is completed by the parent or primary caregiver for children up to age 17. The CHI-C was developed by QualityMetric for Magellan Health Services to support children and their caretakers (parents or guardians) during the process of building the child's resiliency. It was constructed with provider and consumer input and is based, in part, on the SF-10™ Health Survey for Children (SF-10; Saris-Baglama et al., 2007). Like the CHI, the CHI-C measures key functional indicators and is available in English and Spanish versions.

The CHI-C provides an assessment of a child's physical and psychosocial health status from his or her caretaker's perspective. The CHI-C measures key functional indicators:

- Physical health
- Psychosocial health
- School participation
- Distress symptoms
- Strengths

(j) How you will transition Enrollees with existing precertifications with a Network Provider into your system. Confirm you will load one or more files of pre-certifications and Prior Authorizations approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once acceptable files are received.

TRANSITIONING ENROLLEES WITH EXISTING PRECERTIFICATIONS

Magellan confirms our systems have complete flexibility to grandfather benefits for patients currently receiving services that would require pre-certification. We will load one or more files of pre-certifications and prior authorizations approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once acceptable files are received.

Our primary goal during program implementation is to ensure that enrollees receive the behavioral health care services they need with no gaps or delays in treatment. Magellan's guidelines for transitioning patients who are in treatment with a provider when the Department's contract begins are described below. We are certainly available to review these important procedures and gather feedback from the Department regarding these processes at any time.

PLAN FOR ENROLLEES IN INPATIENT, PARTIAL HOSPITAL, RESIDENTIAL OR INTENSIVE OUTPATIENT (IOP) TREATMENT BEFORE CONTRACT START DATE

For these enrollees, Magellan typically encourages the following transition procedures. Magellan takes a partnership approach with other vendors to ensure the best in quality service for all who are in care.

- The previous vendor is generally responsible for concurrent authorization of treatment begun prior to the contract start date and through stepdown/discharge to a less restrictive level of care or for 30 days post-transition—whichever comes first.
- In accordance with industry standards, the previous vendor should instruct the facility to contact Magellan during discharge planning from the levels of care noted above. This will alert the facility that there is a change of behavioral health administrators and also facilitate the facility calling Magellan to assist with discharge planning and authorizations for additional services as appropriate.
- It is expected that the previous vendor will provide the facility with the Magellan phone number and instructions on the Explanation of Benefits documentation, as well as through its telephonic authorization process. The message should instruct the enrollee/facility to contact Magellan to receive the appropriate benefits for treatment services.

Services received from an out-of-network provider after step down to a less restrictive level of care or after the expiration of the grace period may be subject to a lower benefit level, depending on benefit plan design.

- The Department is responsible for informing enrollees in care of the change in vendor and transition policy. Magellan will fully support the Department in creating any communications for your enrollees about the program change. Communications sent to enrollees that describe the transition period emphasize that a grace period is being provided to allow participants to complete treatment with the current provider. The communications ideally will emphasize the enrollee's responsibility in making choices according to the new benefit plan.

Four days prior to the contract start date, it is expected that the previous vendor will prepare a list of the Department's enrollees currently in certified MHSA treatment (all levels of care except outpatient), and will fax or e-mail the list to the Department or assigned Magellan account executive.

The enrollee list ideally will include:

- Patient name
- Patient Social Security Number
- Hospital/Treatment Facility name
- Hospital/Treatment Facility contact person name and telephone number
- Expected date of discharge

Note: Enrollees in the levels of care defined above who are still in treatment after thirty days will be transferred to Magellan for case management. It is expected that the previous vendor will instruct the enrollee/enrollee representative to notify Magellan of continued care.

PLAN FOR ENROLLEES RECEIVING OUTPATIENT TREATMENT BEFORE CONTRACT START DATE

For enrollees in outpatient care the following transition protocols generally apply:

- The previous vendor's authorizations end on the termination date of the contract.
- Enrollees typically have a grace period to complete current outpatient treatment begun with their current outpatient provider prior to the contract start date. This may be modified by the customer and/or the current vendor as desired.

- All enrollees who are already in outpatient treatment prior to the contract start date with a Magellan network provider do not need to call Magellan to register their care. If the enrollee is not in care with a Magellan network provider the enrollee must call during the transition and register their care. Following the transition period, the enrollee can check network status of their current outpatient provider and arrange transfer to an in-network provider as appropriate. If the enrollee's current provider is not a Magellan network provider, then the enrollee can: 1) switch to a Magellan network provider, or 2) continue to see the out of network provider at a reduced benefit if allowed by the benefit plan, so long as that care is determined to be medically necessary.
- Outpatient services will be covered at the in-network benefit level during the grace period.
- Magellan must certify all treatment beginning on or after the contract start date.
- Care will not be retroactively certified.

Occasionally it is helpful for Magellan to receive a list of the Department enrollees currently certified for MHSA outpatient treatment. It is especially helpful if the enrollee list also includes provider information. If an enrollee list cannot be provided, a list of the outpatient providers currently certified to provide enrollee care would be acceptable. Receipt of the list allows Magellan the opportunity to conduct network analysis of providers currently providing certified services to participants. The list can be faxed or emailed to the Department assigned Magellan account executive.

We understand that the Department will need collaborative, attentive support in ensuring a smooth clinical transition for any enrollee in care. Magellan's experienced account team, led by Vice President of Account Services, Ms. Phyllis Crawford, stands ready to assist in any way needed to make clinical care transition easy for your enrollees.

(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.

Magellan confirms that we 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.

(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.

Magellan confirms that we will promptly load into the clinical management and/or claims processing system approved pre-certification and prior authorizations. Approved pre-certification and prior authorizations are loaded in real-time immediately after the decision is rendered.

(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.

Magellan will use the precertification process described in response to *Question 12.b.1* in the *Pre-certification of Care* section, above, to pre-certify inpatient hospital admissions for alcohol detox. We have provided the response again for ease of review below.

PROPOSED PRECERTIFICATION PROCESS

Magellan does not require precertification for outpatient care. Instead we employ a 100 percent systemic claims review of all outpatient cases to identify those cases that can benefit from our consultation and care advocacy approach.

Prior to patients' admission to inpatient or an alternative level of care, a precertification process is conducted in accordance with federal/state regulations, contract requirements and accreditation requirements. Network providers are notified of this process via the Magellan Behavioral Health Provider Handbook, which we would be pleased to share with the Department for your reference. The clinical urgency of the situation determines whether the process will be expedited or standard. This process includes review by a Care Manager. The care manager will gather clinical information to assess the urgency of the situation and perform review of requested services, including:

- Presenting problem (situation and/or symptoms)
- Mental health treatment history including medications
- Substance use treatment history
- Medical history including medications and current treatment regimes
- Mental status (as reported by a practitioner)
- Risk potential

- Current support systems
- Diagnosis (as reported by a practitioner)
- Treatment plan

The care manager applies the medical necessity criteria against the clinical features of the individual as reported by an enrollee or attending/treating provider and the evaluation/treatment setting resources available within the local behavioral healthcare delivery system. Following this review the care manager may authorize the services requested or refer the request to a Physician Advisor for a medical necessity determination if the requested service does not appear to meet medical necessity criteria, or other concerns about the quality or appropriateness of care are identified.

REHABILITATION MANAGEMENT

Magellan will use the same concurrent review process described in response to *Question 12.b.1* in *Concurrent Review* section, below, to manage the patient's care if transferred to rehab. We have provided the response again for ease of review below.

Magellan's care managers closely monitor treatment progress to determine the extent to which patients in care are meeting treatment plan goals and to verify that the care being delivered is of superior quality. If an inpatient or immediate care admission is necessary following initial intake, the care manager establishes a schedule for telephonic concurrent review. If there are concerns regarding care, the care manager may initiate an on-site review. The care manager also establishes an automated record that includes all demographic, case history, and provider information pertinent to the patient.

When patients are admitted to a hospital or alternative level of care, the care manager works with the treatment team to develop a treatment plan, evaluate the appropriateness of continued stay, and discuss discharge planning and transition to alternative care when necessary and appropriate. Magellan's team of psychiatrists and care managers assess patient progress throughout the course of treatment via our concurrent review process.

Each treatment plan developed is specific to the individual enrollee, the facility, and the team providing the care.

(5) Confirm the Contractor will load into the clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once acceptable files are received.

Magellan confirms that we will load into the clinical management and/or claims processing system one or more files of prior authorization and pre-certification approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once acceptable files are received.

(6) Non-Network CRL Guarantee: The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non-emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate Non-Network Provider within two (2) Business Days of the call in at least ninety percent (90%) of cases. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of cases where Enrollees are referred to Non-Network Providers within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) of cases (or the Offeror's proposed guarantee) when an Enrollee is referred to a Non-Network Provider within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available, is _____per year..

Magellan agrees to this guarantee. Our quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) of cases when an Enrollee is referred to a Non-Network Provider within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available, is $10,000 per year.

(7) Emergency CRL Guarantee: The MHSA Program's service level standard requires that when one hundred percent (100%) of Enrollees who call the CRL in need of life- threatening emergency care be referred to the nearest emergency room and be contacted within thirty (30) minutes to assure their safety. Additionally, one hundred percent (100%) of Enrollees in need of non-life threatening emergency care shall be contacted within thirty (30) minutes by a Network Provider or the CRL. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below one hundred percent (100%) of Enrollees who call the CRL in need of emergency care will be contacted by either the Network Provider or the clinicians within 30 minutes of the Enrollee's call to the Clinical Referral Line, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of one hundred percent (100%) when an Enrollee requires emergency care , contact will be made by either the Network Provider or the Contractor's Clinicians within thirty (30) minutes of the Enrollee's call to the Clinical Referral Line is $_____per year.

Magellan agrees to this guarantee. Our quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of one hundred percent (100%) when an Enrollee requires emergency care , contact will be made by either the Network Provider or the Contractor's Clinicians within thirty (30) minutes of the Enrollee's call to the Clinical Referral Line is $10,000 per year.

(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 the Network Provider 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 Network Provider 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 Network Provider Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the call to the CRL, is $_____per year.

Magellan agrees to this guarantee. Our quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine percent (99%) when an Enrollee requires urgent care, contact will be made by the Network Provider Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the call to the CRL, is $10,000 per year.

CONCURRENT REVIEW

The Program's concurrent utilization review process assists the Provider in identifying MHSA care that is medically necessary and cost effective, without compromise to the quality of care.

A. DUTIES AND RESPONSIBILITIES

(1) To safeguard Enrollee health and ensure adherence with the MHSA Program's benefit design and requirements on mental health parity, the Contractor must administer a concurrent utilization review program in the United States which:

(a) Enforces the MHSA Program's benefit design features and ensures that Network Providers use the latest MHSA care protocols for Enrollees;

Magellan confirms that we will meet this requirement.

(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;

Magellan confirms that we use 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. Magellan requires that the network provider's proposed treatment plan and goals be in writing for outpatient services. Magellan reviews the treatment plan for an enrollee when the enrollee's visits to the network provider exceed the expected duration of services for the Enrollee's clinical diagnosis. Magellan created and implemented an Outpatient Solutions program that is designed to use evidence-based clinical algorithms to target enrollee/providers case pairs whose claims suggest that their case is high risk; is outside of utilization norms (e.g., the enrollee's visits to the network provider exceed the expected duration of services for the Enrollee's clinical diagnosis), or shows a pattern that is consistently outside clinical practice guidelines or norms. One hundred percent of outpatient cases are reviewed by claims algorithms for both network and non-network providers. When a case is triggered, a Magellan Care Manager will contact the provider to review the treatment plan and, based on the results of the review, might either approve continued treatment or send the case for a peer advisor review. Care management interventions are focused on improving the quality of treatment and managing the cost of outpatient services effectively.

(c) is conducted in a manner which is parity compliant as required by the Mental Health Parity and Addiction Equity Act;

Magellan confirms that we will meet this requirement.

(d) The Contractor must perform concurrent review of outpatient and inpatient care rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider;

Magellan confirms that we will meet this requirement.

(e) For inpatient admissions, the Contractor must recognize when to utilize more appropriate and less restrictive levels of care when medically appropriate. The Contractor must have procedures for identifying when transfer to an alternate inpatient or outpatient setting is appropriate and for arranging such transfers;

Magellan confirms that we will meet this requirement.

(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;

Magellan confirms that we will meet this requirement.

(g) Employs appropriately skilled clinicians to review treatment plans in a manner that does not disrupt or delay treatment; and

Magellan confirms that we will meet this requirement.

(h) Renders certification decisions on a timely basis and requires that Peer Advisors render non-certification decisions.

Magellan confirms that we will meet this requirement.

(2) For Enrollees admitted to non-network facilities, the Contractor must have procedures to either arrange to transfer the Enrollee to a Network Facility as soon as medically appropriate, or manage the care as if the facility was in the network, including negotiating discounts with the facility;

Magellan confirms that we will meet this requirement.

(3) The Contractor must perform appropriate discharge planning by identifying when discharge from an inpatient network setting is appropriate and by directing the Enrollee to appropriate outpatient network care following discharge, including scheduling the initial appointment. Discharge planning must include continual review of the progress of aftercare treatment with the Provider by a care manager, as follows:

(a) Care managers must obtain and review, as part of the discharge plan, specifics that include, at a minimum: the name of the follow-up Provider; date and time of initial follow-up appointment; and the names of responsible family members; and

Magellan confirms that we will meet this requirement.

(b) Care managers must assist Providers in locating aftercare services. The Contractor must maintain a database of local community resources to assist Providers in locating aftercare services or alternative care in their areas.

Magellan confirms that we will meet this requirement.

(4) The Contractor must provide 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 guidelines established by the Department. Under those guidelines, in cases where there is both a medical and a psychiatric diagnosis, responsibility for case management is determined by the unit (medical or psychiatric) to which the admission is made and the specialty of the attending physician. When those guidelines are insufficient to determine case management responsibility, the Empire Plan hospital carrier and the Contractor must come to an agreement using other factors such as the condition causing the person to remain hospitalized and the proposed treatment plan;

Magellan confirms that we will meet this requirement.

(5) The Contractor must use care managers or Peer Advisors to manage the care of members;

Magellan confirms that we will meet this requirement.

(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;

Magellan confirms that we will meet this requirement.

(7) Outpatient Treatment UR Guarantee: The Offeror must guarantee that, at the least, ninety percent (90%) of outpatient treatment plans be reviewed and the Provider notified within twelve (12) Business Days of receipt of the report as calculated on an annual basis; and

Magellan agrees that, at least, ninety percent (90%) of outpatient treatment plans triggered by our claims algorithms review process as requiring care manager intervention will be reviewed and the provider will be notified within 12 business days of receipt of the report as calculated on an annual basis.

(8) Inpatient Treatment UR Guarantee: The Offeror must guarantee that, at least, ninety percent (90%) of requests for authorization of inpatient care be reviewed within twenty-four (24) hours from the receipt of the request and the Enrollee or Provider be notified within one (1) Business Day of the determination calculated on an annual basis.

Magellan confirms that we will meet this requirement.

B. Required Submission

(1) Please detail the full scope of the concurrent UR program that you are proposing to utilize for the Program, including:

Magellan offers the Department a team of licensed clinicians who will handle calls to the CRL, who determine the medical appropriateness of care and direct enrollees to the most appropriate network provider and level of care.

All clinical staff and Magellan providers will follow formal procedures to determine medical necessity in advance of inpatient and alternative level of care admissions whenever Magellan receives advance notice of the admission.

Magellan has a formal Utilization Management (UM) program in place, which encompasses all activities associated with the review and authorization of behavioral health care services for covered enrollees. These activities includes the provision of enrollee and provider information; pre-certification, assessment, and referral to the provider network; as well as concurrent review; care coordination; case management; discharge after-care planning; interface and coordination with preventative care and medical providers; appeals processing; and development and review of clinical decision support tools.

Magellan's UM program promotes the development of individualized and medically necessary treatment plans that use resources efficiently while producing the best possible clinical outcomes for patients and giving providers the support needed to effectively deliver the best care. UM activities are conducted by licensed Magellan clinicians applying clinically sound, research-based decision-making tools to promote the delivery of high-quality treatment in the least restrictive treatment setting possible. Further details are provided below.

(a) The qualifications of the staff responsible for oversight of your concurrent UR program;

QUALIFICATIONS OF UTILIZATION REVIEW (UR) STAFF

Under our proposed services for the Department, all Utilization Review (UR) services for enrollees will be provided by Magellan Behavioral Health, Inc. (Magellan). The qualifications of the staff responsible for Magellan's oversight of its concurrent UR program are provided below:

CARE MANAGER QUALIFICATIONS

Care managers at Magellan coordinate the assessment, care authorization, referral, and ongoing care monitoring for enrollees. Magellan's care managers are psychologists, social workers, psychiatric nurses, and licensed professional counselors who must meet the following minimum qualifications:

- hold master's degree or doctorate from an accredited program, or be a licensed registered nurse
- hold current licensure with appropriate state agencies

- have three to eight years (depending on the position level) of previous postgraduate experience in a psychiatric and/or substance abuse setting
- managed care experience preferred
- demonstrate knowledge of utilization management procedures, mental health and substance abuse community resources, and understand how to work with diverse body of providers
- demonstrate knowledge and experience with care in an inpatient setting
- possess knowledge of DSM-IV or most current diagnostic edition.

MEDICAL DIRECTOR QUALIFICATIONS

The two Empire dedicated medical directors based in Albany will interface with the Senior Vice President/Corporate Medical Director and Senior Vice President/Chief Medical Officer. All Magellan medical directors must meet the following qualifications:

- graduation from an American or Canadian medical school accredited by the Accreditation Council for Medical Education (ACME) or equivalent training in a foreign medical school with successful completion of the ECFMG and FLEX examinations
- full training in a residency program in the United States or Canada that is approved by the ACME
- board certification by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry certification is preferred; for foreign medical graduates, board certification through the Royal College of Physicians and Surgeons of Canada or the Royal College of Psychiatrists (England) is preferred
- post-residency experience of five to 10 years
- clinical orientation to short-term treatment in an acute care setting
- minimum of 10 years of experience in both clinical and administrative positions
- previous managed care experience (preferred)
- current licensure in the state in which practicing for Magellan
- clinical experience pertinent to the patient populations being managed

- familiarity with current research and use of psychopharmacologic and psychotherapeutic modalities of treatment
- current active license to practice medicine.

PHYSICIAN ADVISOR QUALIFICATIONS

Magellan assigns pre-certification and concurrent review cases to physician advisors for review when care cannot be authorized by a care manager, when there is a quality-of-care concern, or when a case requires expert medical consultation. All Magellan physician advisors must meet the following requirements:

- current licensure in the state in which they practice and ability to meet all Magellan credentialing criteria
- graduate of an American or Canadian medical school accredited by the Accreditation Council for Medical Education (ACME) or equivalent training in a foreign medical school with successful completion of the ECFMG and FLEX examinations
- completion of a psychiatric residency program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association
- certification by the American Board of Psychiatry and Neurology or American Osteopathic Board of Neurology and Psychiatry certification which is preferred; for foreign medical graduates, board-certification through the Royal College of Physicians and Surgeons of Canada or the Royal College of Psychiatrists (England) is preferred
- Minimum of five years of relevant post-residency clinical experience in the field in which they are reviewing.
- Familiarity with current research and use of psychopharmacologic and psychotherapeutic modalities of treatment.
- if reviewing substance abuse cases, as qualified as psychiatrists as above or board certified in a primary care specialty or successful completion of a residency program approved by a primary care specialty board (internal medicine, family practice, pediatrics, or ob-gyn), and more than five years experience treating substance abuse patients; American Society of Addiction.
- Demonstration of specialties including substance abuse and child, adolescent, adult, and geriatric psychiatry.
- Ability to negotiate and interact positively and effectively with their peers.

Magellan offers four New York-licensed physician advisors for the oversight of the Empire Plan, one of whom has special expertise in child and adolescent treatment. These physician advisors also each maintain a private practice and are available to consult on-site at the proposed Empire Plan service office in New York.

(b) Review of outpatient care;

Magellan's approach to care management of routine outpatient psychotherapy is focused on ensuring maximum access to high quality, effective and evidence-based interventions. Magellan reviews 100 percent of outpatient cases through application of clinically-derived claims algorithms to identify enrollees in outpatient care where the enrollee could benefit from specialized consumer education, support and advocacy. Additionally, the algorithms identify enrollees whose progress in psychotherapy falls outside of normative utilization patterns or where the treatment being provided is inconsistent with established clinical practice guidelines. Based on these proprietary algorithms, Magellan provides case consultation directly to the provider, and when appropriate, also directly to the enrollee. Case consultation includes a clinical discussion with the provider regarding treatment goals, effective, evidence-based treatments, additional resources available to the enrollee and their family to support treatment goals, and efficient use of benefits.

Magellan's case management intervention triggers can be categorized into three general areas which identify:

- **Care Advocacy and Shaping:** With highly complex conditions such as substance abuse, eating disorders, autism, and serious mental illnesses, Magellan understands the importance of quickly accessing the right treatment interventions and providing care management supports to achieve an optimal outcome for the patient. Magellan works with both providers and enrollees to identify necessary supports and provide information and consultation for high quality treatment leveraging the full resources available to the enrollee and family.
- **Aberrant Provider Practice Patterns**. Magellan is able to identify providers where variance from clinical practice guidelines and utilization norms suggests the need for intervention at the provider practice level. Case management will focus on consultation and treatment shaping for the Magellan enrollees treated by the provider, with additional network management/action intervention, which at times may include special investigation for fraud or benefit abuse where appropriate.
- **Care not progressing according to norms**. In such situations, Magellan will work with providers to help identify issues impacting the effectiveness of treatment and opportunities to support a successful treatment outcome.

In situations where an enrollee may be over-utilizing outpatient care for a specific diagnosis, Magellan works with providers to negotiate appropriate treatment and goals and achieve treatment resolution.

Magellan utilizes precertification and concurrent review protocols for non-routine outpatient treatments that are more intensive intervention or are associated with some level of risk for the patient. Examples of non-routine outpatient treatments which would require preauthorization before the first session include intensive outpatient programs, outpatient electroconvulsive therapy (ECT), psychological testing, Repetitive Transcranial Magnetic Stimulation (rTMS) and Applied Behavioral Analysis (ABA). With such treatments, Magellan's care management team works with the provider to ensure that care accessed is clinically appropriate and necessary and that appropriate treatment supports are in place for the best outcome.

(c) Review of inpatient care;

REVIEW OF INPATIENT CARE

Magellan's care managers closely monitor treatment progress to determine the extent to which patients in care are meeting treatment plan goals and to verify that the care being delivered is of superior quality. If an inpatient or immediate care admission is necessary following initial intake, the care manager establishes a schedule for telephonic concurrent review. If there are concerns regarding care, the care manager may initiate an on-site review. The care manager also establishes an automated record that includes all demographic, case history, and provider information pertinent to the patient.

When patients are admitted to a hospital, the care manager works with the treatment team to develop a treatment plan, evaluate the appropriateness of continued stay, and discuss discharge planning and transition to alternative care when necessary and appropriate. Magellan's team of psychiatrists and care managers assess patient progress throughout the course of treatment via our concurrent review process.

Each treatment plan developed is specific to the individual enrollee, the facility, and the team providing the care. As such, there is no set standard for review frequency or maximum of days approved between inpatient treatment reviews. However, for a typical inpatient stay, reviews occur every 2-5 days depending on the course of treatment recommended and needs of the individual enrollee.

(d) Discharge planning and follow-care; and

DISCHARGE PLANNING

The successful transition of patients from an intensive treatment setting to an appropriate after-care program is an important step in minimizing relapse and is a key element of Magellan's care management process.

Magellan follows clinical model best practices of initiating discharge planning at the beginning of the treatment episode in order to facilitate a coordinated transition to the next level of care regardless of the type of behavioral health disorder, mental health, or alcohol and other drug condition. Part of the discharge and follow-up process is active, real-time support of aftercare (follow-up) treatment plan adherence and the arrangement of necessary services.

The care management team actively collaborates with the treating provider at admission as well as throughout the treatment episode to develop a comprehensive follow-up plan appropriate to the enrollee's biopsychosocial needs.

Elements of discharge plans may involve:

- follow-up care for mental health or substance abuse treatment
- referrals for psychopharmacology and medical services
- identification of a need for patient education
- cultivation of personal and community resources
- development of realistic expectations with the patient regarding self care, vocational, educational, and social functioning
- coordination of any needed support services

Magellan has defined specific enrollee clinical-risk predictors such as the presence of comorbid conditions. Upon admission and during acute service episodes, we assess the enrollee's family/significant other and social supports as well as recent or current treatment episodes. Additionally, we also consider the enrollee for the potential application of other types of more focused case management activities such as intensive care management (ICM), referrals to primary care, and appropriate application of behavioral health service benefits to best fit the enrollee's needs.

Magellan generates quantifiable performance measure results on a monthly basis from our care management system, which enables us to promptly evaluate our staff's conformance with our discharge and follow-up treatment model. This model increases treatment engagement which has a positive impact on behavioral health-related HEDIS® measures: *Follow-Up After Hospitalization for Mental Illness* (FUH), *Antidepressant Medication Management* (ADMM) and *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* (IET).

(e) Case management of high risk cases.

CASE MANAGEMENT OF HIGH RISK CASES

Magellan maintains a proactive, highly effective Intensive Case Management (ICM) program to assist all high-risk enrollees who struggle with readmissions and/or compliance with their treatment plans. Magellan's ICM program consists of expanded care management outreach, support and coordination of services with family, providers, PCPs, and community-based agencies and resources. Magellan's ICM case managers specialize in managing care for high-risk or high-cost cases. ICM offers the utmost in support for Empire Plan enrollees.

All enrollees under contract for management of behavioral health care service coordination by Magellan are eligible for intensive case management (ICM) services unless specifically noted otherwise by their plan. Magellan's ICM program provides the following:

- 24-hour-a-day/7-day-a-week/365-day-a-year telephonic access to a highly specialized Magellan ICM case manager, who acts as an advocate for each ICM participant.
- Access to Magellan's diverse network of behavioral health providers, both individual practitioners and organizational providers, which meet credentialing requirements and encompass industry-recognized behavioral health care levels of care.
- Clinically sound, research-based decision making tools to promote utilization of appropriate behavioral health care resources for high-risk cases in an efficient and effective manner.
- Access to the full continuum of care from inpatient to partial and outpatient.
- Timely ambulatory/outpatient treatment for behavioral health disorders which contributes to expedient symptom reduction.
- Specialized coordination of care and high-touch advocacy through ICM case managers, which includes sharing of timely relevant clinical information between behavioral health care and medical care as necessitated by the enrollee's health needs. This information exchange is done with appropriate respect for privacy and consistent with all Magellan policy and applicable laws governing patient confidentiality.
- Ongoing customer-specific ICM program evaluation and reporting, which will demonstrate to the Empire Plan the value of this service.
- ICM program data used to assess clinical quality for the Empire Plan and to establish quality improvement mechanisms (if needed).

Individual ICM Plan and Documentation

Following consent, each enrollee admitted to the ICM program must have an individual ICM Plan developed and documented soon after admission into the ICM program. An individual enrollee's ICM Plan may also include one or more routine care management activities.

ICM Service Delivery and Staffing

The Magellan ICM program primarily delivers intensive case management services through use of telephonic clinical review process. In this process, clinical review decision support tools (i.e., adopted clinical/medical necessity review criteria, clinical practice guidelines and new technology

assessments) are referenced and consultation is sought when indicated from appropriate specialty clinicians (including physician advisors) to assist with intensive care management activities. Daily operation of the ICM Program will be supervised by the dedicated Empire Plan Clinical Director. All ICM case managers report to this position.

CRITERIA FOR ADMISSION TO THE ICM PROGRAM

The goals of Magellan's ICM program are to increase community tenure, reduce readmissions and improve treatment efficacy for enrollees. To meet these goals most effectively, it is essential to target the appropriate population that is at highest risk for readmission, and use objective, data-driven criteria that allow us to measure outcomes and demonstrate program effectiveness.

ICM admission criteria are based on extensive data analysis to determine what populations were most vulnerable to readmission and therefore could most benefit from ICM. Examining enrollee data collected within Magellan's vast data warehouse, Magellan examined the impact of readmissions, diagnosis, age and gender, among other variables, on treatment for these high risk cases. Key findings included:

- The probability of an additional inpatient admission increases after each subsequent admission. The largest increase in this rate occurs after the second admission. The earlier a high-risk patient is identified for intervention, the better.
- Of those patients with two admissions, 58 percent of readmissions occur within sixty days of first admission.
- Children have a higher readmission rate than adults. Of children age 12 and under who are admitted to an inpatient level of care, 25 percent are subsequently readmitted, as compared to 21 percent of children aged 13-17 and 22 percent of adults 18 and older.
- Children are more likely to readmit soon after their initial admissions than older age groups.
- Research on lifetime prevalence and age of onset of DSM IV disorders found that half of all lifetime cases begin by age 14; therefore, interventions need to focus on early treatment for all youth.
- Although there is generally a low number of patients who are hospitalized within health plans for eating disorders, this diagnosis ranks as the highest-cost diagnosis for our customers.

As a result of these findings, Magellan's ICM program admission criteria include the following:

- Enrollees with two or more admissions to an acute inpatient or residential level of treatment within 60 days.
- Children age 12 and under who are hospitalized for behavioral health disorders.
- Enrollees who are hospitalized for eating disorders.

Through ICM, which will be provided to the Empire Plan at no additional cost, Magellan supports the goals of helping children and adolescents as fully as possible as well as providing evidence-based substantive clinical support and advocacy for the most at-risk cases.

CRITERIA FOR DISCHARGE FROM THE ICM PROGRAM

When it is believed ICM discharge criteria have been met, the enrollee's case is reviewed with the ICM Program Lead for a final determination of continued participation or discharge from the ICM program. Discharge criteria include:

- Community tenure of at least 90 days since discharge from last hospitalization
- Enrollee met ICM clinical/treatment goals
- Enrollee is non-responsive to case management interventions despite repeated outreach attempts
- Enrollee eligibility terminated/benefits exhausted
- Enrollee requests termination from the case management program
- Enrollee death.

(2) Describe the software you will utilize to administer the concurrent UR program and any other technologies that will be used to apply UR.

Magellan supports the administration of the UR program through robust information technology. Our clinical, eligibility and claims processing systems are all fully integrated to ensure that the administrative data is needed for these tasks is continually updated and highly available. This system integration allows data to be accessible during regular call center hours and through our IVR system and Web site 24 hours a day, 7 days a week. Magellan systems contributing to the administrative management of the UR program include the following:

INTEGRATED PRODUCT

Magellan's Integrated Product (IP) System is designed to meet Magellan's complex interface requirements and to collect and store the types of data needed to meet reporting requirements of organizations such as the National Committee for Quality Assurance and the Centers for Medicare and Medicaid Services.

IP provides intake staff with online access to information relating to care management support, such as intake and referral data, employer information such as location and division, presenting problem, diagnosed problem and provider demographics. The data handling features allow for comprehensive data capture, internal data linkages, external interfaces and queuing. IP has the flexibility to be configured to capture data elements according to customer need.

Specific functions include Enrollee and family eligibility information, provider search, ZIP code matching, certification, correspondence generation, evaluation and assessment information and case management. IP provides inquiry capability such as membership eligibility look-up (patient address, home phone, eligibility dates for current and historical records), online benefits, and provider search.

IP is a proprietary preauthorization system developed by an internal team of developers. Magellan is the sole owner of this application's source code. As with all of Magellan's systems, IP is flexible and can be designed to match customer-specific data elements, formats, and file layouts.

IP is compliant with current HIPAA standards for the protection of Enrollee privacy. It is fully integrated with Magellan's Claims Adjudication and Payment System (CAPS) and interfaces with Magellan's Web site.

INTEGRATED PROVIDER DATABASE

Magellan's provider system, the Integrated Provider Database (IPD) is the single provider data repository that is capable of housing and differentiating between Magellan and client provider networks. It supports the contracting and credentialing process and subsequent data, including but not limited to, network participation status, licensure, reimbursement schedules, billing relationships, rates and electronic funds transfer (EFT) information.

IPD is internally developed; Magellan owns the source code to IPD, allowing us to add and enhance modules as we expand our systems to keep pace with emerging industry trends and specific customer needs. IPD is a secured application with the ability to display and/or modify provider information and is restricted by function.

The provider data in IPD is utilized and tightly integrated with all other functions within Magellan, including IP, provider search, CAPS, reporting and Magellan's Web site.

IP CONTACT TRACKING (IPCT)

The IPCT application captures basic contact information such as contact type, reason, and resolution. It is used to document incoming and outgoing calls, and receipt of written or electronic information. The application interfaces with IP to auto-fill most of the client information, such as client/enrollee ID and name, account name, and case number. Contact transactions can be transferred as needed to other employees for further investigation and resolution. This application also interfaces with Magellan's Customer Comment Module. The module allows issues, activities, and outcomes to be tracked for both incoming and outgoing calls, thereby providing a source for capturing customer service data—in particular, rates of first-call resolution.

ENROLLMENT SYSTEM

Magellan's enrollment system resides on CAPS and supports all of Magellan's customers. Because claims and enrollment data are housed and monitored within one unified system, Magellan staff members are fully able to verify enrollment online during phone conversations with enrollees or providers while also validating enrollment during claims processing.

When providers or enrollees visit Magellan's Web site, they are able to view enrollment information online to ensure coverage. Magellan's enrollment system has complete flexibility to maintain enrollment and benefit information by variables such as specific groups, divisions, locations, work sites, by enrollees versus dependents, or other categories.

(3) Completely describe the criteria used to establish medical necessity as defined by the Program and how medical necessity is determined.

Medical necessity is determined through the use of Magellan's detailed Medical Necessity Criteria. Magellan care managers, physician advisors, and network providers all use Magellan's Medical Necessity Criteria as a tool for determining whether care is medically necessary and, if so, the level of care needed to treat DSM-IV-TR disorders.

Magellan's proprietary clinical criteria, has been in place for more than 20 years. Developed in 1988, the criteria are based on a combination of clinical observations and research findings. Our clinical criteria are an objective and evidence-based decision support tool for behavioral health services that constitutes the basis of medical necessity for behavioral health services. The criteria do not specify

fixed minimum or maximum inpatient lengths of stay or numbers of visits within specific diagnostic categories. Further, all the criteria need not be used; the specifics of the customer contract and benefit design would determine which ones apply. Their appropriate use and exceptions based on resource availability and other unique circumstances of the health care service consumer and his or her support system can achieve the utilization management program goal of optimizing the use of health care resources.

Medical Necessity Criteria contains detailed, evidence-based criteria for behavioral health disorders listed in the DSM-IV-TR manual that cover the full range of services settings:

- Inpatient, both acute and non-acute levels
- Intermediate ambulatory settings, including partial hospitalization and intensive outpatient programs
- Ambulatory settings, including supervised living environments

These settings also have specific criteria that address the needs of distinct populations such as children, adolescents, geriatric adults, and those with substance use or eating disorders. In addition, the criteria cover services unique to behavioral health evaluation and treatment services such as psychological testing and electroconvulsive treatment.

Levels of care covered in the criteria are as follows:

- Hospitalization, Psychiatric, Adult
- Hospitalization, Psychiatric, Child and Adolescent
- Hospitalization, Psychiatric, Geriatric
- Hospitalization, Eating Disorders
- Hospitalization, Substance Use Disorders, Detoxification
- Hospitalization Substance Use Disorders, Rehabilitation Treatment, Adult and Geriatric
- Hospitalization, Substance Use Disorders, Rehabilitation Treatment, Adolescent
- Subacute Hospitalization, Psychiatric, Adult
- Subacute Hospitalization, Psychiatric, Geriatric
- Subacute Hospitalization, Psychiatric, Child and Adolescent
- 23-Hour Observation

- Residential Treatment, Psychiatric, Adult and Geriatric
- Residential Treatment, Psychiatric, Child and Adolescent
- Residential Treatment, Eating Disorders
- Residential Treatment, Substance Use Disorders, Detoxification Residential Treatment, Substance Use Disorders, Rehabilitation, Adult and Geriatric
- Residential Treatment, Substance Use Disorders, Rehabilitation, Child and Adolescent
- Supervised Living, Psychiatric, Adult and Geriatric
- Supervised Living, Psychiatric, Child and Adolescent Supervised Living,
- Substance Use Disorders, Rehabilitation, Adult and Geriatric
- Supervised Living, Substance Use Disorders, Rehabilitation, Child and Adolescent
- Partial Hospitalization, Psychiatric, Adult and Geriatric
- Partial Hospitalization, Psychiatric, Child and Adolescent
- Partial Hospitalization, Eating Disorders
- Partial Hospitalization, Substance Use Disorders, Rehabilitation Adult and Geriatric
- Partial Hospitalization, Substance Use Disorders, Rehabilitation, Child and Adolescent
- Intensive Outpatient Treatment, Psychiatric, Adult and Geriatric
- Intensive Outpatient Treatment, Psychiatric, Child and Adolescent
- Intensive Outpatient Treatment, Eating Disorders
- Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation, Adult and Geriatric
- Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation, Child and Adolescent
- Ambulatory, Substance Use Disorders, Detoxification
- Outpatient Treatment, Psychiatric and Substance Use Disorders, Rehabilitation
- Psychological Testing
- Therapeutic Leave of Absence Documentation

- Outpatient Electroconvulsive Treatment
- Inpatient Electroconvulsive Treatment

Annual review of the *Medical Necessity Criteria* is conducted with the oversight of the Medical Director's office. Appropriately licensed, actively practicing physicians with current clinical knowledge and expertise in applicable specialties as well as board-certified psychiatrists participate in the development and annual review process.

Information gathered as part of the development and annual review is assessed in order to maintain objective clinical criteria based on clinical evidence as well guidance for applying the clinical criteria.

Magellan promotes an open process of encouraging and reviewing feedback from the clients it serves, its clinical and medical staff, and the behavioral health practitioner community throughout the year.

The annual review process includes input from:

- Magellan individuals who have utilized the criteria in the process of utilization review, and participating providers who respond to periodic surveys
- the latest scientific and medical data in the field of psychiatry and substance abuse
- salient information from professional organizations, such as the American Psychiatric Association
- Provider Advisory Boards whose membership includes locally or nationally recognized, actively practicing experts in the fields of substance abuse and mental health and represents the perspectives of academic institutions and professional associations
- the senior clinical and medical leadership of Magellan, including psychiatrists board-certified in the areas of addictionology, child and adolescent psychiatry, and geriatric psychiatry.

An appointed *Medical Necessity Criteria* Review Work Group, comprised of Magellan staff from a variety of behavioral health disciplines reviews the information collected from these individuals and groups and makes recommendations for changes. The revised criteria are presented to the Behavioral Health Quality Improvement Committee for acceptance and review. At the conclusion of this process, the *Medical Necessity Criteria* are forwarded to the National Network and Credentialing Committee for review in order to maintain consistency with other clinical practice guidelines, enrollee and provider materials, other relevant clinical information, and when appropriate, interpretations of benefits.

CLINICAL PRACTICE GUIDELINES

Magellan clinical staff also relies on the following clinical practice guidelines (CPGs) to support quality- and evidence-based decision making. Magellan recognizes the value of evidence-based clinical practice guidelines for providing standards with which to review care, promoting consistency of practice and facilitating care management decisions that conform to best practices. Magellan encourages use of practice guidelines when care managers review treatment plans, when provider and facility site visits are conducted, and when clinical record reviews are conducted.

Clinical Practice Guidelines (CPGs) supplement *Medical Necessity Criteria* and assist providers in the assessment and treatment of common behavioral health disorders. Magellan's standard approach to selecting guidelines dictates that prior to the adoption of each guideline, relevant scientific literature is reviewed by a multi-disciplinary panel that includes board-certified psychiatrists, with input from providers in Magellan's clinical network, from consumers, and from community agencies. The Magellan CPG Task Force reviews Clinical Practice Guidelines at least every two years and provides updates as necessary.

The guidelines developed by Magellan are as follows:

- Practice Guideline for the Treatment of Patients with Attention Deficit/Hyperactivity Disorder
- Practice Guideline for Assessment and Management of the Suicidal Patient.

Clinical Practice Guidelines adopted from external industry-recognized behavioral health expert panels, such as the American Psychiatric Association (APA), cover the most prevalent behavioral health disorders. Magellan has specifically adopted the following Clinical Practice Guidelines from the American Psychiatric Association (APA), which can be downloaded from the APA Web site at www.appi.org.

- Practice Guideline for the Assessment and Treatment of Substance Use Disorders (SUD) and accompanying Quick Reference Guide
- Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Post-Traumatic Stress Disorder
- Practice Guideline for the Treatment of Patients with Major Depressive Disorder
- Practice Guideline for the Treatment of Patients with Bipolar Disorder
- Practice Guideline for the Treatment of Patients with Eating Disorders
- Practice Guideline for the Treatment of Patients with Panic Disorder

- Practice Guideline for the Treatment of Patients with Schizophrenia.
- Practice Guideline for the Management of Children with Autism Spectrum Disorders

Finally, Magellan has adopted a guideline:

- Practice Guideline for the Treatment of Patients with Obesity—last review, September 2007 from The National Institute of Health (NIH) Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, The Evidence Report.

Once Magellan adopts a practice guideline, each of Magellan's care management centers evaluates the guideline for its appropriateness in terms of meeting customer expectations, benefit plans, enrollee populations, and adherence to any customized utilization management criteria. To comply with NCQA requirements, Magellan care management centers annually monitor provider compliance with at least two of these guidelines.

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

UTILIZATION REVIEW PROCESS

Magellan's utilization review process is described below.

Magellan confirms that it our utilization review process is parity compliant as required by MHPAEA

OUTPATIENT UTILIZATION REVIEW PROCESS

Magellan's approach to care management of routine outpatient psychotherapy is focused on ensuring maximum access to high quality, effective and evidence-based interventions. Magellan reviews 100 percent of outpatient cases through application of clinically-derived claims algorithms to identify enrollees in outpatient care where the enrollee could benefit from specialized consumer education, support and advocacy. Additionally, the algorithms identify enrollees whose progress in psychotherapy falls outside of normative utilization patterns or where the treatment being provided is inconsistent with established clinical practice guidelines. Based on these proprietary algorithms, Magellan provides case consultation directly to the provider, and when appropriate, also directly to the enrollee. Case consultation includes a clinical discussion with the provider regarding treatment goals, effective, evidence-based treatments, additional resources available to the enrollee and their family to support treatment goals, and efficient use of benefits.

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- **Aberrant Provider Practice Patterns**. Magellan is able to identify providers where variance from clinical practice guidelines and utilization norms suggests the need for intervention at the provider practice level. Case management will focus on consultation and treatment shaping for the Magellan enrollees treated by the provider, with additional network management/action intervention, which at times may include special investigation for fraud or benefit abuse where appropriate.
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Magellan utilizes precertification and concurrent review protocols for non-routine outpatient treatments that are more intensive intervention or are associated with some level of risk for the patient. Examples of non-routine outpatient treatments which would require preauthorization before the first session include intensive outpatient programs, outpatient electroconvulsive therapy (ECT), psychological testing, Repetitive Transcranial Magnetic Stimulation (rTMS) and Applied Behavioral Analysis (ABA). With such treatments, Magellan's care management team works with the provider to ensure that care accessed is clinically appropriate and necessary and that appropriate treatment supports are in place for the best outcome.

INPATIENT CARE UTILIZATION REVIEW PROCESS

Magellan's care managers closely monitor treatment progress to determine the extent to which patients in care are meeting treatment plan goals and to verify that the care being delivered is of superior quality. If an inpatient or immediate care admission is necessary following initial intake, the care manager establishes a schedule for telephonic concurrent review. If there are concerns regarding care, the care manager may initiate an on-site review.

The care manager also establishes an automated record that includes all demographic, case history, and provider information pertinent to the patient.

When patients are admitted to a hospital, the care manager works with the treatment team to develop a treatment plan, evaluate the appropriateness of continued stay, and discuss discharge planning and transition to alternative care when necessary and appropriate. Magellan's team of psychiatrists and care managers assess patient progress throughout the course of treatment via our concurrent review process.

Each treatment plan developed is specific to the individual enrollee, the facility, and the team providing the care. As such, there is no set standard for review frequency or maximum of days approved between inpatient treatment reviews. However, for a typical inpatient stay, reviews occur every 2-5 days depending on the course of treatment recommended and needs of the individual enrollee.

DISCHARGE PLANNING

The successful transition of patients from an intensive treatment setting to an appropriate after-care program is an important step in minimizing relapse and is a key element of Magellan's care management process.

Magellan follows clinical model best practices of initiating discharge planning at the beginning of the treatment episode in order to facilitate a coordinated transition to the next level of care regardless of the type of behavioral health disorder, mental health, or alcohol and other drug condition. Part of the discharge and follow-up process is active, real-time support of aftercare (follow-up) treatment plan adherence and the arrangement of necessary services.

The care management team actively collaborates with the treating provider at admission as well as throughout the treatment episode to develop a comprehensive follow-up plan appropriate to the enrollee's biopsychosocial needs.

Elements of discharge plans may involve:

- follow-up care for mental health or substance abuse treatment
- referrals for psychopharmacology and medical services
- identification of a need for patient education
- cultivation of personal and community resources

- development of realistic expectations with the patient regarding self care, vocational, educational, and social functioning
- coordination of any needed support services

Magellan has defined specific enrollee clinical-risk predictors such as the presence of comorbid conditions. Upon admission and during acute service episodes, we assess the enrollee's family/significant other and social supports and recent or current treatment episodes. Additionally, we also consider the enrollee for the potential application of other types of more focused case management activities such as intensive care management (ICM), referrals to primary care, and appropriate application of behavioral health service benefits to best fit the enrollee's needs.

Magellan generates quantifiable performance measure results on a monthly basis from our care management system, which enables us to promptly evaluate our staff's conformance with our discharge and follow-up treatment model. This model increases treatment engagement which has a positive impact on behavioral health-related HEDIS® measures: *Follow-Up After Hospitalization for Mental Illness* (FUH), *Antidepressant Medication Management* (ADMM) and *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* (IET).

(5) Describe the methods you utilize to measure Program effectiveness (Do not include any reference to specific monetary savings).

METHODS YOU UTILIZE TO MEASURE PROGRAM EFFECTIVENESS

Magellan has a national and client-specific outcomes measurement program that utilizes various outcomes tools and instruments to produce measures used in evaluating the effectiveness of Magellan's clinical care management and health coaching initiatives. Most of these programs have common measures, such as ones related to assessing functional health, quality of life, and productivity (absenteeism, presenteeism), while other programs have unique program-specific outcomes measures such as the rate of women seeking treatment after having a positive postpartum depression screen. Additional outcomes measures are generated from Magellan's claims and authorization systems, such as ambulatory follow up after hospitalization for mental illness and hospital readmissions within 30 days. Magellan has an in-house, fully staffed Medical Economics team, whose researchers are available to consult with the Department regarding development of outcomes reports and measures for your program, and whose staff works daily to leverage the power of extensive clinical data to ensure the safety, clinical progress, and well-being of all membership.

TARGETED OUTCOMES MEASUREMENT AND MANAGEMENT INITIATIVES

Our outcomes program, the Magellan Outcomes360 system, so named to reflect the breadth of our measurement program, supports evidence-based practice and a comprehensive approach to outcomes reporting. Magellan worked closely with industry leaders to design scientifically sound and clinically useful measurement instruments for the Outcomes360 system. The end result is reliable data reflecting the functional health status of individuals. The tools in Magellan's Outcomes360 Program produce immediate feedback reports for both the enrollee and provide and are:

- Web-based and secure
- Free to enrollees and providers
- Easy-to-use and administer
- Available in English and Spanish
- Completed by the enrollee

Our clinical programs incorporate routine, periodic measurement, the results of which are available to enrollees and/or providers in real time to support self-monitoring and treatment planning by

allowing adjustments in the course of treatment based on self-reported data. The primary tools used by Magellan include the Consumer Health Inventory™ (CHI) and the Consumer Health Inventory for Children™ (CHI-C).

THE CONSUMER HEALTH INVENTORY™ (CHI)

A key feature of *Outcomes360* is Magellan's unique approach to outcomes reporting—the Consumer Health Inventory™ (CHI) tool. Magellan co-developed the CHI in close collaboration with QualityMetric. It expands the scope of the SF-12 Health Survey—which is nationally recognized as the leading assessment tool that measures changes in physical functioning and mental well-being—to include new, evidence-based behavioral health assessment questions. These questions address the presence and impact of behavioral health symptoms, substance abuse patterns, personal strengths, therapeutic relationships, and workplace productivity.

The CHI contains the two scale scores of the SF-12 that optimally position behavioral health services within the larger health care delivery system—the Physical Health Score (PH) to measure changes in the enrollee's physical health functional status, and the Emotional Health Score (EH) to measure changes in the enrollee's mental health functional status.

The CHI is a patient-reported outcome (PRO) instrument, which makes it unique in the industry. Unlike most outcome reports that providers complete, enrollees in outpatient therapy complete this outcomes tool themselves, either on the MagellanHealth.com Web site or in their providers' offices. They respond to the CHI at intake to create a baseline score, and then periodically during treatment and again at discharge. Once Magellan obtains the baseline score, enrollees and providers can compare the results of subsequent administrations, facilitating provider discussions with enrollees regarding changes in their health and recovery status. Enrollees are encouraged to continue what is working and to consider alternatives to what does not appear to be working.

For children up to age 17, the parent or primary caregiver completes the Consumer Health Inventory for Children (CHI-C), developed by QualityMetric for Magellan to support children and their caretakers as they work to build the child's resiliency. Based in part on the SF-10 for Children, the CHI-C measures key functional indicators—physical and psychosocial health, school participation, distress symptoms, and strengths. It provides an assessment of the child's physical and psychosocial health status from his or her caretaker's perspective.

CONSUMER HEALTH INVENTORY FOR CHILDREN™ (CHI-C)

The CHI-C™ is the child/adolescent version of the CHI™. It is completed by the parent or primary caregiver for children up to age 17. The CHI-C was developed by QualityMetric for Magellan Health Services to support children and their caretakers (parents or guardians) during the

process of building the child's resiliency. It was constructed with provider and consumer input and is based, in part, on the SF-10™ Health Survey for Children (SF-10; Saris-Baglama et al., 2007). Like the CHI, the CHI-C measures key functional indicators and is available in English and Spanish versions.

The CHI-C provides an assessment of a child's physical and psychosocial health status from his or her caretaker's perspective. The CHI-C measures key functional indicators:

- Physical health
- Psychosocial health
- School participation
- Distress symptoms
- Strengths

Utilization and Cost Data and Outcomes Measures

Magellan's utilization management/utilization review (UM/UR) process also includes comprehensive tracking of utilization measures that serve as leading and lagging indicators for outcomes measures. Magellan reports the following mental health/substance abuse indicators, including cost data, when it pays claims for an account:

- Total admissions
- Days per 1,000 covered lives
- Admissions per 1,000 covered lives
- Average length of stay
- Initial outpatient authorizations
- Outpatient units authorized
- Visits and units per 1,000 covered lives
- Utilization by demographic categories: authorization-based
- Quarterly and annualized utilization trends (admits, units, penetration rate, cost per covered life)
- Costs by provider type: participating versus non-participating

- Paid claim amounts: participating versus non-participating provider
- Utilization by demographic categories
- Percent of benefits paid by primary diagnostic category
- Readmission rates
- Post-hospitalization ambulatory follow-up rates

BENCHMARKING AT MAGELLAN

As mentioned above, Magellan's in-house Analytic Services Department includes a dedicated Medical Economics Unit, whose mission is to leverage Magellan's extensive data warehouse to analyze, study and monitor the results of our various products and services. Magellan employs a threefold approach to benchmarking to ensure that our services are best in class:

1) **Use of Internal Benchmarks:** By virtue of Magellan's number of covered lives (over forty two million), variety of product configurations, and three decades of experience in the behavioral health field, Magellan's collected behavioral data is arguably the norm for the U.S. commercial managed behavioral health industry. Given this, Magellan's Medical Economics Unit has developed a normative data mart and corresponding normative report capability that permit comparison of critical data across a range of Magellan products. The Medical Economics Unit undertakes various studies of Magellan's own performance for various customers and product configurations and benchmarks it to similar customers. Variances are analyzed and the drivers of any significant differences are studied. Frequently the findings from these internal studies form the basis of quality improvement activities as well as the promulgation of best practice initiatives.

2) **Use of External Benchmarks:** Magellan also obtains and participates in external benchmarking efforts. Magellan participates in HEDIS, NCQA Quality Compass, and other benchmarking projects steered by the larger industry consulting houses. These external data sources give Magellan an external standard by which we can measure our performance to assure that we are delivering best-in-class services for our customers.

3) **External Accreditation Bodies:** Magellan openly, transparently, and regularly undergoes scrutiny by various relevant accreditation bodies to demonstrate our commitment to quality services. These external accrediting bodies include NCQA, URAC, and COA. Magellan has an unparalleled record of positive results that demonstrates to our customers that we do in fact offer the best in class services as vetted by intense external scrutiny both of our process and our results.

In summary, through this comprehensive outcomes management system, Magellan is able to do the following:

- Provide predictive models for early interventions
- Demonstrate measurable improvement in Empire Plan enrollees' symptoms, well-being, functioning and productivity
- Offer providers, enrollees and Magellan care managers clinically useful screening and assessment tools
- Deliver near real-time enrollee well-being reports to care managers and providers to support improved care delivery and enrollee involvement in treatment planning
- Provide enrollees themselves with real-time reports that help them understand the challenges they may be facing and how to get the most out of their outpatient treatment.

We have provided a sample outcomes report as **Appendix FF.**

(6) Outpatient Treatment UR Guarantee: The MHSA Program's service level standard requires that, at least, ninety percent (90%) of outpatient treatment plans be reviewed and the Provider and Enrollee notified within twelve (12) Business Day of receipt of the report, calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of outpatient treatment plans that the Offeror reviews and does not notify the Provider within twelve (12) Business Day of receipt of the report is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) of outpatient treatment plans not reviewed and the Provider notified within twelve (12) Business Day of receipt of the report, is $_____.per year.

Magellan agrees to this guarantee. Our quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) of outpatient treatment plans not reviewed and the Provider notified within twelve (12) Business Day of receipt of the report, is $10,000 per year.

(7) Inpatient Treatment UR Guarantee: The MHSA Program's service level standard requires that at least ninety percent (90%) of requests for authorization of inpatient care be reviewed and completed within twenty-four (24) hours from the receipt of the request and the Enrollee or Provider be notified within one (1) Business Day of the determination calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of requests for authorization of inpatient care that are not reviewed within twenty-four (24) hours from the receipt of the request the Enrollee or Provider notified within one (1) Business Day of the determination, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee of requests for authorization of inpatient care that are not reviewed within twenty-four (24) hours from the receipt of the request the Enrollee or Provider notified within one (1) Business Day of the determination, is $_____per year.

Magellan agrees to this guarantee. Our quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of 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.

DISABLED DEPENDENT DETERMINATIONS

During the term of the Contract, the Contractor shall be responsible for making Disabled Dependent Determinations for dependents with a disability that is Mental Health and Substance Abuse related. Disabled dependents of NYSHIP enrollees are entitled to be covered under the Enrollee's family coverage beyond the normal age-out limits if those dependents are incapable of self support. For The Empire Plan, the medical component contractor determines disability status for those with physical disabilities and the mental health Contractor determines disabled status for mental health and substance abuse related disabilities. 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, the Enrollee's employer and then evaluated by the Contractor to determine if the Dependent is disabled. All determinations are subject to review by the Contractors on a periodic basis. The following guidelines are used for all disabled dependent reviews:

If improvement of the dependent's condition is:

"Expected," the case will be normally reviewed within six to eight months, unless the Contractor determines a need for a more frequent review.

Possible," the case will be normally reviewed no sooner than three years, unless the Contractor determines a need for a more frequent review.

"Not expected," the case will normally be reviewed no sooner than seven years, unless the Contractor determines a need for a more frequent review.

A. DUTIES AND RESPONSIBILITIES

(1) The Contractor must establish a process to perform reviews of the PS-451 form and all additional medical information for mental health and substance abuse-related dependent disabilities. The review must be completed in the United States and clinical determination must be completed within 10 Business Days of receipt of a complete form.

Magellan confirms that we will meet this requirement.

(2) The Contractor must send a determination letter, approved in advance by the Program, to the Enrollee and to the Department advising of the determination within 3 Business Days of determination.

Magellan confirms that we will meet this requirement.

B. REQUIRED SUBMISSION

(1) Provide a description of your process when determining disabled dependent status. Confirm that the Offeror will review the PS-451 form and all additional medical information required to make a clinical determination within 10 Business Days.

Currently Magellan determines disabled dependent status for another large client company. The dependent disability review process is assigned to a specific care manager, giving those families a specific contact to assist them with the process. Families are initially instructed to have the dependent's attending provider complete this client's disability determination form and send it to the assigned disability assessment care manager. Once the form is received and reviewed initially for completeness, it is then reviewed by the disability assessment team, consisting of the assigned care manager, the Clinical Officer, and often the Medical Director. These peer reviews take place within

three business days of receiving the completed form. All decisions are then communicated to the family within 10 business days of receipt of the completed form.

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

Magellan confirms that we will send a letter to the Enrollee and to the Department advising of the determination within 3 Business Days of the determination.

APPEAL PROCESS

When UR results in a decision to deny authorization or reduce the level of services authorized, and the denial is based on medically necessary, experimental or investigational treatment, members may appeal to the Contractor any utilization review decisions. The appeals committee shall make a determination within 10 Business Days of the receipt of the necessary medical records. The Contractor will comply with the utilization review process requirements and external appeal process found in Article 49 of NYS Insurance Law, as amended.

A. DUTIES AND RESPONSIBILITIES

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;

Magellan confirms that we will meet this requirement.

(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;

Magellan confirms that we will meet this requirement.

(b) Reviewing clinical appeals for medical necessity and experimental or investigational treatment and preparing communications to notify Enrollees of the outcome of appeals; and

Magellan confirms that we will meet this requirement.

(c) Integrating the appeal decisions into the clinical management and claims processing systems.

Magellan confirms that we will meet this requirement.

(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

Magellan confirms that we will meet this requirement.

(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.

Magellan confirms that we will meet this requirement.

(c) Clinical Appeals must be completed in a timely manner consistent with NYS and federal laws:

(i) For a second level clinical appeal of a post-service claim, within 30 days of the member's request;

Magellan confirms that we will meet this requirement.

(ii) For a second level clinical appeal of a pre-service request for benefits, within 15 days of the member's request; and

Magellan confirms that we will meet this requirement.

(iii) For clinical appeals involving urgent situations, in no more than seventy-two hours following receipt of the appeal.

Magellan confirms that we will meet this requirement.

(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;

Magellan confirms that we will meet this requirement.

(5) Interface with the New York State Department of Financial Services' External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal where denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service;

Magellan confirms that we will meet this requirement.

(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

Magellan confirms that we will meet this requirement.

(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.

Magellan confirms that we will meet this requirement.

B. REQUIRED SUBMISSION

(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.

Magellan confirms that a Magellan employee with problem-solving authority above that of the original reviewer will perform administrative (non-clinical) appeals in a timely manner.

(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.

Magellan confirms that we will administer an expeditious, HIPAA and PPACA compliant internal clinical appeal process which allows Providers and/or Enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment.

(3) Describe in detail how you would administer the required appeal processes for the Program, including:

Every Magellan-covered enrollee or provider has the right to submit an appeal if he or she disagrees with a clinical, claims, or administrative decision. Uniform appeals policies and procedures apply regardless of the specific type of appeal or the status of the person who initiates the appeal (i.e.,

patient or provider). Magellan's appeals process distinguishes between the following types of appeals:

- **Clinical appeals**, which relate to treatment (for example, disagreements regarding medical necessity of a particular treatment plan, clinical care issues, experimental or investigational procedures/treatments etc.)
- **Administrative appeals**, which relate to non-authorizations based on noncompliance with plan procedure or specifications (for example, exhaustion of benefits, ineligibility, a request for a non-covered benefit, etc.)
- **Claims appeals**, which relate to claims denials.

Magellan's standard appeals processes adhere to stringent timeliness standards and are compliant with New York state regulations and accrediting body standards. Our appeals processes can be customized to meet special requirements of particular plans or customers. When delegated by our customer, a formalized, two-tiered appeals process is available to enrollees and providers who wish to challenge authorization determinations. Magellan can adapt our own processes to accommodate a customer's preferred appeals process.

A patient/provider/facility may appeal a determination by contacting Magellan's Appeals Department within 180 days of the date that the initial non-authorization determination, explanation of benefits (EOB), or explanation of payment (EOP) was issued. A second-level appeal must be received by Magellan within 60 days of the enrollee's receipt of the first-level appeal determination. Except for urgent appeals, appeal requests must be submitted in writing.

Clinical non-authorization decisions are reviewed on each level of appeal by a licensed physician and, in connection with an appeal of an adverse determination, a licensed physician who is in the same or similar specialty as the health care provider who typically manages the medical condition, procedure or treatment under review. In the case of non-physician reviewers, a health care professional who is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition, procedure or treatment under review. Administrative and claims adverse decisions are reviewed on appeal by appeals department staff who are a mix of clinicians (Appeal Specialists) and trained appeal and comment coordinators. Second-level clinical appeals are decided by a panel of clinical and operations staff, chaired by the Medical Director and including a board certified psychiatrist representative from MVP. In each level of appeal review, the reviewer(s) who conduct a first-level appeal or second-level appeal have had *no prior involvement* in the case and are not the direct report of any person who made the original determination or, in the case of second-level appeals, of the first-level appeal reviewer.

APPEALS PROCESS AND WORKFLOW

"Initial review" is the initial process by which all care decisions are rendered; before any decisions become part of an appeals process. Initial inpatient review determinations for medical necessity are conducted by our physician advisors. All non-authorization decisions are communicated verbally to the attending physician within 24 hours. The physician advisor conducts a peer-to-peer conversation with applicable treating physicians; which is important to ensure that Magellan obtains all relevant information related to the patient's condition and treatment plan and that the attending physician or provider understands the reason for the determination which is rendered. Written notification is sent to the attending physician, facility, and enrollee (or guardian) within the shorter of one business day or 48 hours of the decision, and within 1 business day for providers' written Treatment Request Forms (TRFs) seeking continued outpatient authorization. This communication informs all parties of the decision, explains their right to appeal, and provides the procedures for expediting an appeals process in accordance with federal and statue regulation and accrediting body standards. Each decision is documented in our clinical information system and includes information related to evaluation of the severity of the enrollee's condition, diagnostic information, requested service setting and type, and proposed treatment plan. Failure by Magellan to make a determination within the state regulated time periods as outlined in Article 49 shall be deemed to be a reversal of Magellan's adverse determination.

FIRST-LEVEL APPEAL (EXPEDITED AND STANDARD)

When benefits for care cannot be authorized, the provider, facility, or enrollee may appeal that decision through a "first-level" appeals process. An expedited appeal process is available for an adverse determination involving continued or extended health care services, procedures, or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider or an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. Requests for expedited appeals may be made orally or in writing. Upon request for an expedited appeal, Magellan has a second physician advisor, of the same or similar specialty, who has not previously been involved in the case review the case telephonically with the enrollee's attending physician or provider according to Magellan's *Medical Necessity Criteria*, and recommends authorization or non-authorization of benefits. This telephonic peer review is scheduled within one business day of receiving notice of the appeal request. When an expedited appeal is reviewed and coverage cannot be authorized by the second physician advisor, the physician advisor immediately notifies the attending physician of the decision and of the second-level appeal process when applicable. The physician advisor's decision regarding an expedited appeal is reported to the enrollee and provider or facility in writing as well as telephonically. Expedited appeals shall be determined within one

business day of receipt of necessary information to conduct such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process or through the external appeal process provided by the State of NY under Article 49.

For non expedited level 1 appeal requests, there is a standard first level appeal process. Requests for standard appeals may be made orally or in writing. Standard clinical appeals involve a physician advisor review of the medical records or clinical documentation related to the services in question. The clinical peer reviewer renders the determination and the written response is issued within one business day for inpatient and two business days for all other levels of care of receipt of the appeal request. The decision letter is sent to the insured, the insured's designee and, where appropriate, the insured's health care provider.

The written decision letter for both expedited and standard level 1 appeals will include: the reasons for the determination, including a detailed clinical rationale; and a notice of the insured's right to an external appeal together with a description and application for the New York external appeal process.

Administrative and claims appeals are decided on the basis of the appellant's argument regarding the denial reason and any relevant documentation available to the reviewer.

SECOND-LEVEL APPEAL COMMITTEE

When a non-authorization of benefits is further appealed after a first-level appeal decision, the appeal decision is based on a review of the entire medical record submitted by the facility and any additional material that the enrollee, attending physician, and/or facility believes may be pertinent to the second-level appeal process. All second-level clinical and administrative appeals are decided by a committee of clinical and operations staff, chaired by the Medical Director (a board certified psychiatrist) and including a board certified psychiatrist from the Insurer, MVP. In each level of appeal review, the reviewer(s) who conduct a first-level appeal or second-level appeal have had no prior involvement in the case and is not the direct report of the person who made the original determination or, in the case of second-level appeals, of the first-level appeal reviewer. Enrollees or their designated representatives are entitled to appear in person or telephonically to provide supporting information. The Committee is scheduled on a weekly basis but may meet more frequently or less frequently in order to address timeframe requirements and volume. The second level process will be completed within 10 business days of receipt of the necessary clinical information to conduct the review.

INDEPENDENT EXTERNAL REVIEW AND CUSTOMER-BASED REVIEW

External Appeals through the State of New York are available if the non-authorization decision was based on medical necessity or because the services were deemed experimental and/or investigational.

To be eligible for an external appeal, the enrollee or their designee must have received a final adverse determination (FAD) as part of Magellan's appeal process or the enrollee and Magellan have jointly agreed to waive the internal clinical appeal. A health care provider will have the right to the State's external appeal process if the determination rendered was a retrospective adverse determination. A retrospective adverse determination means a determination for which utilization review was initiated after health care services have been provided.

The application for external appeal must be made within 45 days of the enrollee's receipt of the notice of final adverse determination or within 45 days of when the enrollee and Magellan agreed to waive the clinical appeal process. The enrollee loses their right to file an external appeal if they do not file an application within the 45 days timeframe.

The enrollee will be provided with the instructions and application for filing an external appeal with the Final Adverse Determination letter.

In the event that the Magellan non-authorization determination is overturned by the IRO, Magellan promptly facilitates the provision or payment of the services that was the basis for the independent review, within the time frame, if any, specified by the IRO.

Magellan's UM decision-making process evaluation through the QI program includes information obtained from the IRO on IRO appeal cases.

(a) Turnaround time;

APPEALS REVIEW TIMELINESS

For each level of appeal, following review of the available information and rendering of an appeal decision by the assigned appeal reviewer, notice of the appeal determination and any additional appeals is furnished to the enrollee, the treating clinician, and, if applicable, the facility, as follows:

- Urgent appeals: Verbal notice is furnished to the attending or treating clinician within one business day of Magellan's receipt of the appeal request.

Written notification of first and, where applicable, second-level appeal decisions is sent to the enrollee, the treating clinician and/or facility within the shorter of one business day or 72 hours of the verbal appeal decision notification.

- Standard Level 1 Pre-Service Appeals: When an appeal request is received prior to the enrollee having services rendered and an urgent appeal is not necessary, written notice is furnished to the enrollee, the treating clinician, and/or facility, as applicable, as soon as possible but no later than 1 business day for inpatient care and two business days for outpatient care of Magellan's receipt of the appeal request.
- Standard Level 1 Post-Service Appeals: When an appeal request received is for services already rendered, written notice is furnished to the enrollee, the treating clinician, and/or facility, as applicable, as soon as possible but no later than 1 business day for inpatient care and two business days for outpatient care of Magellan's receipt of the appeal request.
- Second Level Appeals: When an appeal request is received for a second level appeal, the decision will be rendered by the Second level appeal committee, chaired by the Medical Director, within 10 business days of receipt of the necessary information.

The written notices contain information required by New York State Insurance Law.

(b) Qualifications of the staff that would conduct the reviews for administrative and level 1 and level 2 clinical appeals;

Non-authorization decisions and appeal denials of care are based only on a Magellan Physician Advisor (Clinical Peer Reviewer) application of Magellan Medical Necessity Criteria (for mental health related diagnoses) or American Society of Addiction Medicine (ASAM) Criteria (for substance abuse care and treatment) in conjunction with a verbal discussion with the enrollee's attending physician or provider. Only Magellan's board-certified physician advisors may render clinical appeal determinations. Magellan maintains a well-tested, New York regulatory-compliant and accredited process for the appeal review of non-authorization of behavioral health services. Non-authorization and appeal decisions are made with great care, following our clinical policies and procedures by a licensed physician and, in connection with an appeal of an adverse determination, a licensed physician who is in the same or similar specialty as the health care provider who typically manages the medical condition, procedure or treatment under review. In the case of non-physician reviewers, a health care professional who is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition, procedure or treatment under review. Administrative and claims adverse decisions are reviewed on appeal by appeals department staff who are a mix of clinicians (Appeal Specialists) and trained appeal and comment coordinators.

The second-level clinical and administrative appeals are decided by a panel of clinical and operations staff, which is chaired by the Medical Director and may also include representation from the Health Plan/Insurer.

(c) Description of the criteria that would be used to determine whether the care is medically necessary or experimental and/or investigational;

APPEALS DECISION CRITERIA

Appeals decision review is done in all cases by using the Medical Necessity Criteria as a tool for determining whether care is medically necessary and, if so, the level of care needed to treat DSM-IV-TR disorders. These criteria assign the least restrictive level of care that can provide safe and effective treatment. They do not specify fixed minimum or maximum lengths of stay or numbers of visits within specific diagnostic categories. Rather, all decisions for length of stay are based on the combined medical necessity and appropriateness of delivering any care, and subsequently on whether that care is delivered in the most appropriate available setting. Magellan's Medical Necessity Criteria is reviewed and updated on an annual basis. This ensures that the criteria incorporate best practices and latest developments derived from expert clinical consensus and peer-reviewed scientific literature. A copy of our Medical Necessity Criteria is furnished in **Appendix X**.

(d) Do you currently administer an appeals process as described above for MHSA? If yes, provide the number of appeals you review annually and the approval and denial rates for a client similar to the Program (for the most recent calendar year); and

Yes, Magellan currently administers an appeals process as described above for MHSA. The requested appeals statistics for a large client with 2.4 millions lives managed from our Tristate Care Management Center on an ASO basis are provided in **Table B.12.c** below.

(e) How is the Enrollee's care handled during the appeal process?

Magellan makes every effort to ensure that the best care for all enrollees is provided in all cases, so that the need to file an appeal becomes unnecessary. Should an enrollee or provider have a concern about a care decision, he or she is encouraged to discuss concerns with a Magellan representative or liaison. In our experience, many clinical, claims and administrative issues can be successfully resolved through a discussion or "reconsideration" process without necessarily resulting in a formal appeal. Despite the availability of informal discussions with Magellan, the enrollee or provider always has the right to an appeal.

Our appeals prevention approach begins even before a clinical non-authorization is issued:

- Whenever a Magellan care manager believes that a request for new or continued care at a particular level cannot be certified, the case is reviewed by a Magellan staff psychiatrist (physician advisor) prior to a decision.
- If the psychiatrist concurs with the care manager's recommendation, we immediately notify the provider of the pending non-authorization prior to the decision. We offer the provider the opportunity to discuss the case with our reviewing psychiatrist within 24 hours. During this discussion, our psychiatrist presents alternatives to the requested care, along with the medical reasons for not approving the care request; the provider also presents his or her reasons for the original certification request.
- If agreement is reached, the provider and Magellan psychiatrist work collegially to transition the enrollee to appropriate care. If agreement is not reached, Magellan then issues a formal non-authorization.
- If agreement is not reached and an enrollee or provider wishes to contest a Magellan non-authorization decision, he or she may pursue an appeal.

(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.

Magellan confirms that we will interface with the New York State Department of Financial Services' External Appeals Process to provide an opportunity for Enrollees and Dependents to appeal denied

coverage on the basis that a service is not medically necessary or is an experimental or investigational service.

(5) Inpatient Appeal Guarantee: The MHSA Program's service level standard requires that, at the least, ninety-five percent (95%) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Offeror having made and documented three (3) aggressive attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95%) of level one appeals for inpatient care that are not be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Offeror's proposed guarantee) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal, is $_____.per year.

Magellan agrees to this guarantee. Our quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of 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, is $10,000 per year.

(6) Outpatient and ALOC Appeal Guarantee: The MHSA Program's service level standard requires that, at the least, ninety-five percent (95%) of Outpatient Care and Alternative Levels of Care level one appeals must be reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Offeror having made and documented three (3) aggressive attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95%) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Offeror's proposed guarantee) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal, is $_____

Magellan agrees to this guarantee. Our quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of 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.

13. Other Clinical Management Programs

A. Duties and Responsibilities

(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;

Magellan confirms that we will meet this requirement.

(b) methods to educate members about the symptoms, effects and treatment of depression, eating disorders and ADHD;

Magellan confirms that we will meet this requirement.

(c) accepting referrals to Network Providers;

Magellan confirms that we will meet this requirement.

(d) telephonic support, coordination with treating providers and referrals to community services; and

Magellan confirms that we will meet this requirement.

(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.

Magellan confirms that we will meet this requirement.

(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.

Magellan understands that we may propose other voluntary opt-in programs which are available at no additional cost. We understand that the Department reserves the right to not participate in any program offered and the right to opt out of any program at any time.

B. REQUIRED SUBMISSION

(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.

(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.

Please refer to our response to *Question B.13.1*, above, for a description of our behavioral health disease management for depression, eating disorders and attention deficit hyperactivity disorder. Sample eating disorder management program communication materials are provided as **Appendix AA**. We have also included our Practice Guideline for the Treatment of Patients with Eating Disorders as **Appendix BB**.

(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.

Please refer to our response to *Question B.13.1*, above for a description of our behavioral health disease management for depression, eating disorders and attention deficit hyperactivity disorder (ADHD). Sample ADHD program communication materials are provided as **Appendix CC**. We have also included our Practice Guideline for the Treatment of Patients with Attention Deficit/Hyperactivity Disorder as **Appendix DD**.

(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.

Other than the behavioral health disease management program (described in response to *Question B.13.1*above), our standard utilization review program (described in *Section B.12. Clinical Management*), and our intensive care management program (also described *Section B.12 Clinical Management),* Magellan is not proposing any other voluntary clinical management or utilization review programs

A. Exhibit I.B

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Western New England College	MBA	2006	Marketing
Bryant College	BS	1987	Marketing

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
4-2012 to present	Magellan Health Services	VP, Marketing
4-2011 to 4-2012	ING	Project Management Consultant
9-1989 to 5-2009	MassMutual	Various – Second Vice President, Marketing

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted] will have overall responsibility for all marketing and communications activities for the Empire Plan. As [redacted] oversees all communications, marketing, education and consultative services related to building awareness and utilization including print, email, event, and web marketing. In addition, her team can provide marketing consultative services to support educational campaigns as required. [redacted] uses market research, proven marketing techniques and information obtained in partnership with clients to create marketing plans and campaigns that drive program awareness and utilization. Her team is responsible for marketing that supports over 30 million individuals in varied industries including retail, technology and service as well as a number of government agencies. [redacted] has over 25 years experience marketing to individuals and groups.\ Prior to joining Magellan, she worked in the financial services industry marketing insurance products, annuities and 401(k) plans. She has both an undergraduate and graduate degree in marketing.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Michigan, Ann Arbor, MI	MSW	1985	Social Work
Central Michigan University, Mt. Pleasant, MI	BS	1973	Psychology & Sociology

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
10-1997 - Present	Magellan Health Services	Quality Improvement Director
7-1997 - 10-1997	Care Management Resources	Director of Operations
6-1996 - 6-1997	Preferred Health Systems	Vice President of Operations
3-1993 - 6-1996	Value Behavioral Health	Director of Quality Management
9-1991 - 3-1993	Preferred Health Care	EAP Coord./Clinical Specialist
2-1974 - 9-1991	State of Michigan	Various - Director of Client Services

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted] has over 25 years of experience in behavioral health care, including several positions at the senior management level, and has been with Magellan since 1997. She received her MSW degree from the University of Michigan, and is a licensed social worker in the State of Michigan. She is accredited through the ACSW, is a member of NASW, and is a certified Lean Six Sigma Green Belt.

In her role as Quality Improvement [redacted] is responsible for the development and implementation of Magellan's Tristate Care Management Center's Quality Improvement Program, monitoring and reporting performance on quality improvement indicators, development of Quality Improvement Activities, ensuring compliance with URAC and NCQA accreditation standards, and for customer reporting.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Chattanooga State Technical College	A.A.S	2003	Business Management
Covenant College	B.S.	2008	Organizational Mngmt
Keller Graduate School of Mngmt	M.B.A	2013	Human Resources

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
1995-Current	Magellan Behavioral Health	Director of Cust Svc
		Manager of Cust Svc
		Cust Svc Supervisor
		Data Reporting Analyst
		Claims Specialist
		Customer Service Assoc
1994-1995	Chubb Life	Customer Service Assoc
1990-1994	Blue Cross Blue Shield TN	Sr Claims Processor

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

As [redacted] at Magellan's Southeast Care Management Center, [redacted] is responsible for the performance of several teams in various states throughout the Magellan enterprise. She manages over 70 employees that include customer service supervisors, associates, care assist team, workforce management, and support associates. [redacted] establishes performance goals and quality standards for staff and ensures compliance. She leads customer service teams in the successful delivery and execution of services to meet client commitments and contractual obligations. She also develops and implements creative processes and service solutions that address performance issues and enhance efficiency and service excellence. She also has significant experience with the operations aspects of implementing new accounts and processes.

[redacted] has been a valued employee of Magellan since 1995, assuming progressively more responsible positions ranging from claims auditor to customer service manager to her current role as customer service director.

[redacted] received a B.S. in Organizational Management from Covenant College and a Masters Degree in Business Administration with a concentration in Human Resources from Keller Graduate School of Management.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Dillard University	B.S.Degree	1991	Biology/Pre-Medicine
Central Michigan Univerity	MSA Degree	2002	Health Science Administration
Life University	Doctorate Degree	1999	Chiropractic Medicine / Neuromuscular Physiology

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
8-2012 - Present	Magellan Health Services	SE/ Tristate General Manager
2-2008 - April 2012	APS Healthcare	Director of Clinical Ops/Director of Ops
2006 - 2008	Matria Healthcare	Director of Quality

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted] has 12+ years of experience providing leadership to companies representing a variety of industries and organizational cultures. Her specialized expertise includes, process redesign, strategic planning and organizational transformation. She has managed medicaid contracts in Disease and Case Management for the State of Georgia and Alabama. [redacted] also has experience overseeing and ensuring operational compliance with business financial and quality of service provided to members. She is skilled in ensuring that cost-effective member and employee responsive operations are developed and maintained throughout the SE and Tristate Care Management Center.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Fairfield University, CN	B.S	1990	Accounting
University of Connecticut	MBA	1999	Finance and Health Care

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2010 - Present	Magellan Behavioral Health	Senior Vice President,
1999 - 2009	CIGNA Healthcare	Vice President
1993 - 1999	MedPartners	Vice President
1990 - 1993	Ernst & Young, LLP	Senior Accountant

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted] is the [redacted] of Behavioral Health for Magellan's direct to Employer and Federal Government business. In her current role, [redacted] is responsible for the oversight of all existing account relationships and new business development between Magellan and its employer customers, which includes multiple State Employer Behavioral Health and Employee Assistance Programs, Federal Government customers, and Military Behavioral Health. Responsibilities include overall account profit and loss, product strategies, relationship management, and service delivery.

[redacted] has been at Magellan since January, 2010. Prior to joining Magellan, she was [redacted] Healthcare where she held a variety of leadership roles with increasing responsibility during her 10-year tenure including financial roles and account management and business development oversight. Before [redacted] she held senior financial roles at MedPartners in the physician practice management industry.

[redacted] received her B.S. in Accounting from Fairfield University and a Masters Degree in Finance and Healthcare from the University of Connecticut. She holds a CPA certificate in the State of Connecticut and began her career at Ernst & Young, LLP.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Hood College, Frederick, MD	Master of Science	2002	Computer & Info Srvs
University of Pittsburgh (Main)	Bachelor of Science	1994	Child Dev & Child Care

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2003 - Current	Magellan Health Services,Inc.	Sr Director, Investigations
2002 - 2003	Magellan Health Services,Inc.	Database Security Manager
2001 - 2002	Maryland Health Partners, LLC	Technical Operations Manager
1999 - 2001	Maryland Health Partners, LLC.	Senior Business Analyst
1998 - 1999	Merit Behavioral Care,Inc.	Systems Implement.Specialist
1997 - 1998	CMG Health, Inc. Provider	Networks Specialist
1996 - 1997	CMG Health, Inc.	Recruitment Assistant
1995 - 1996	CMG Health, Inc.	Intake Coordinator

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted] has ten years in management of Special Investigations Unit, [redacted] is an Accredited Healthcare Fraud Investigator

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]
Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location		Degree	Year Conferred	Discipline
Alfred University, NY	BA		1986	Applied Clinical Psychology
New York University	MSW		1990	Social Work

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2011 - present	Magellan Behavioral Health	Senior Account Executive
2005 - 2011	CIGNA Health Solutions	National Account Manager
1997 - 2005	CIGNA Health Solutions National	EAP Manager
1995 - 1997	CIGNA Health Solutions	Program Manager
1993 - 1995	CIGNA Health Solutions	Mental Health Therapist
1992 - 1995	International Center for the Disabled	Counselor, Chemical Dependency Prog
1992 - 1993	Bellevue Hospital Center	Social Worker Supervisor,
1992	Psychiatric Emergency Admitting Services Bellevue Hospital Center	

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted] is currently the [redacted] State of New Jersey Account (SHBP) and has worked on the account for the past two years. The account has close to 600,000 members. [redacted] works as a team with the [redacted] Account Executives to support the State Educators, Local Government and State Government employees. Her support covers [redacted] interactions with the Department of Pension and Benefits, the State Department of Banking and Insurance as well as the State Commission that serves as an external appeal in matters of behavioral health coverage. She has been with Magellan since 2011 and brought to Magellan more than 20 years experience in behavioral health, national account management, sales and EAP clinical supervisory roles. [redacted] holds a Masters in Social Work (MSW) and is also a Certified Employee Assistance Professional (CEAP). Her postgraduate training was concentrated in chemical dependency at the Psychoanalytic Psychotherapy Study Center; couples and family training at the Ackerman Institute; and critical incident/disaster training with the American Red Cross. Prior to joining Magellan, [redacted] was national account manager with [redacted] Health Solutions, a role she held for six years. As national account manager, she managed 10 national accounts. Her main customers were JP Morgan Chase, Honeywell, BASF and [redacted] Corporation. [redacted] believes that her experience with large national employers and the State of New Jersey account has given her an understanding of complex service delivery systems and the importance of understanding the diverse needs of members from different groups within a customer. In addition, her clinical background and previous work with individuals and groups with mental health and chemical dependency problems has contributed to her abilities as a member advocate. This combination of these macro and micro view points will make her a successful Account Executive for the State of New York.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Moscow State University Moscow, Russia	BS	1981	Clinical Psychology
Moscow State University, Moscow, Russia	MS	1982	Clinical Psychology
University of Cincinnati, Cincinnati, OH	MA	Education 1997	Clinical Counseling

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
7-2012 - present	Magellan Health Services	Director of Clinical Services
8-2008 - 6-2012	Magellan Health Services	Care Management Supervisor
2-2002 - 8-2008	Magellan Health Services	Inpatient Care Manager
11-1998 - 11-2002	NorthKey Comm.Care Outpatient t	therapist

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted] is over 20 year experience in mental health and substance abuse field and over ten years of managed care experience. An independently-licensed clinician with supervisory privileges, [redacted] is also licensed as a case manager. She has experience in supervising both utilization management and intensive case management teams. [redacted] completed a three year sequence in organizational development at University of Cincinnati. Since 2004, she has taught undergraduate and graduate level courses in various educational settings.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Penn State University	BS	1989	Finance

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
4-2008 - Present	Magellan Health Services	Underwriter
1996 - April 2008	MAMSI/United Health Care	Underwriter/Actuarial Analyst

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

As an Underwriter at Magellan, [redacted] has been responsible for Underwriting for Radiology Management and Behavioral Health Management of Large and Small Health Plans as well as Employer Groups. As an Actuarial Analyst at United, [redacted] was responsible for analysis of Healthcare Trends, and projections,

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]

Job Title: [redacted]

Relationship to Project:Overssees all Field Network Management and Provider Relations activities including network composition and definition, provider education, and provider satisfaction.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Trinity College	BS	1997	Psychology

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
11-1998-present	Magellan Behavioral Health	Field Network Coordinator

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted] has over 14 years of provider network management and provider relations experience. [redacted] has steadily increased the scope of positions. He progressed from Network Coordinator to Senior Network Coordinator and then to Network Manager. More recently, he served as Network Director and now serves as Regional Director.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]

Job Title: [redacted]
Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Arkansas State University	BSE	1988	Education
University of Missouri	MEd	1990	Educatio n/Counseling
University of Missouri	MS	1992	Rehabilitation Counseling

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
1999 –Present	Magellan Behavioral Health	Multiple positions: Care Manager, Clinical Manager, Federal EAP - St Louis, Federal Trainer, Sr. Manager Implementation
1995 - 1999	Creve Coeur Medical Diagnostics and Rehab	Counselor/Program Manager
1992 - 1995	England and Company Rehab	Rehabilitation Counselor
1990 - 1993	Metropolitan Employment and Rehabilitation	Head Trauma Specialis

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted] is the [redacted] In her current roll [redacted] is responsible for the successful implementation of commercial, health plan, military and public sector accounts as well as the Magellan Complete Care Medicaid Health Plan. Her responsibilities include overall responsibilities include oversight of all implementation stakeholders, timelines, and performance guarantees associated with implementation. [redacted] has over 14 years tenure with Magellan. Prior to undertaking her current responsibilities, she served as clinical manager for one of Magellan's largest customers, supervising inpatient, outpatient and drug-free workplace staff. She provided onsite EAP services and training for a consortium of over 900 government accounts. A graduate of the University of Missouri (St. Louis), she has a master's degree in counseling, a master's degree in rehabilitation counseling and has worked in the field of general counseling and substance abuse for 25 years.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]
Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Russell Sage College, Troy, NY	BA	1996	Bus Admin, Marketing
Rensselaer Polytechnic Institute, Troy, NY	MBA 1	1999	Finance
Siena College, Loudonville, NY	Certificate	2009	Accounting

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
5-2011 - Present	Magellan Health Services	Director, NY Medicaid Preferred Drug Program and the NY EPIC Program
6-2007 - 4-2011	Magellan Health Services	Manager, Medication Grant Program (Kendra's Law)
9-2000 - 6/2007	Magellan Health Services ,	Financial Analyst, NY EPIC Program
10-1999 - 8-2000	Mohawk Opportunities (Mental Health),	Director of Finance and Property
7-1998- 9-1999	Albany County Opportunity	Fiscal Officer
7-1996 - 7-1998	AIDS Council of Northeastern New York	Financial Admin Assistant

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted] is the primary point of contact for the customer serving as the client advocate within the company to ensure a successfully managed contract. She is currently responsible for successful management of the Preferred Drug List and ancillary programs for the largest Medicaid Program in the country as well as the NY Elderly Pharmaceutical Insurance Coverage Program (EPIC).

[redacted] was previously responsible for fiscal viability and property maintenance of an Office of Mental Health certified residential facility for individuals living with mental illness. She managed all aspects of a Pharmacy Benefit Program for participants diagnosed with mental illness; customer service, claims processing, formulary management, finance, provider relation, member enrollment. values continuous education, she received her MBA from Rensselaer Polytechnic Institute and her BA from Russell Sage College. More recently, she obtained Lean Six Sigma Green Belt certification and Accounting Certificate from Siena College. She actively follows industry and healthcare trends via various trade publications and seminars.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted] K
Job Title: [redacted]

Relationship to Project: Manage Information Delivery Business Analysts Manage Information Delivery Business Analysts r

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Maryland College Park	BA	1987	English

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
9-2000 - present	Magellan Health Services	Project Manager
		Manager
		Senior Manager
3-2000 – 8-2000	Sierra MiltaryHealth Svcs	Provider Services Representative
		Business Analyst
		Project Manager
		MIS Manager
1988 - 11-1993	McClean Brothers Marine Supplies	

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)
[redacted] has nearly 20 years of experience in the health care industry,with 18 years in information technology, gathering requirements for system enhancements and project management, testing, and researching regulatory requirements and industry standardds. [redacted] has worked on numerous commercial and public sector accounts.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

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

Name: [redacted]
Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Hannibal LaGrange College	BS	1988	Information Systems

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
11-2002 - Present	Magellan Health Services	Manager
9-2000 -10-2002	StellarRad Systems	Systems Analyst
11-1995 - 9-2000	Mallinkrodt Medical	Consultant'
2-1993 -11-1995	Enterprise Rent - A – Car	Applications Manager

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted] has oversight of membership application development. His team supports customers representing over 40 million lives.

B. Exhibit I.C

C. Implementation Plan

D. Job Descriptions

Magellan Health Services
Job Description

JOB TITLE: Director of Clinical Services	FLSA STATUS: Exempt
DEPARTMENT TITLE: Director, Clinical Services	DEPARTMENT: Clinical
REPORT TO: VP Clinical Services	JOB CODE: CN5201E
LOCATION: Region	GRADE: 40
DATE CREATED:	DATE REVISED:

JOB SUMMARY (Please write 2-3 sentences summarizing the purpose of this position)
Under the supervision of the VP of Clinical Services, the Director of Clinical Services is responsible for the direction and management of Magellan Behavioral Health clinical operations at a satellite office of a Regional Service Center or within a large RSC that is responsible for the management of multiple accounts. Assists in the development and implementation of the organizational and operational plans for the effective delivery of clinical services within Magellan's policy guidelines. Supervises and directs the care management staff.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
20	Clinical program implementation
20	Staff development and management including recruitment, supervision and training.
20	Implementation of corporate clinical philosophy and clinical policies and procedures.
15	Quality improvement activities as assigned by the VP of Clinical Services
15	Participation in provider relations activities
10	Monitoring, analyzing, trending and reporting of utilization data; provides input into the development of budgets.

NON-ESSENTIAL FUNCTIONS (Lists additional tasks necessary to meet overall performance standards)

Manages within the established Magellan clinical quality standards and quality management plan protocols. Provides leadership to the clinical team for member care review and appropriate placement. Maintains professional relationships with network providers.

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom this position has a direct reporting relationship.

			VP Clinical Svcs	Supervisor Title
		Dir Clinical Services	Supervisor Title	
		Job Title		Supervisor Name
	Employee Title		Supervisor Name	
Employee Title		**Name**		
	Employee Name			
Employee Name				

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☐ MA/MS/MBA ☒ PHD ☐

Field(s) of study: Behavioral Health

Experience: 0 yrs. ☐ 1-3yrs. ☐ 3-5yrs. ☐ 5-8yrs. ☒ > 8yrs. ☐

Industry:

Job Specific: Six years experience to include five years of administrative and clinical experience post licensure. Two years managed care experience and supervisory experience at a minimum. At a minimum, meets Magellan Behavioral Health credentialing criteria for Masters level therapist.

*Equivalent combination of experience and education ☐

*Education and/or experiences may run concurrent ☒

Knowledge, Skills, Abilities:

☐WPM ☐KSPH

Other:

Computer Skills:

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education:

Experience:

Knowledge, Skills, Abilities:

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☒ Standing ☐ Lifting ☐ _____lbs.

Typing ☒ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____

Supervisor Co mpensation Analyst

Customer Service Director

JOB TITLE: **Customer Service Director**	FLSA STATUS: Exempt
DEPARTMENT TITLE: Customer Service	DEPARTMENT: ***TBD***
REPORT TO: General Manager, CMC	JOB CODE: CS5013E
LOCATION: Care Management Center (locations vary)	GRADE: 40
DATE CREATED: 7/15/03	DATE REVISED:

JOB SUMMARY: Senior leader of the CMC customer service and administrative functions. Responsible for the performance of Customer Service Supervisors, Associates, Care Assist Team and Support Associates in the delivery of the highest quality and most efficient service. Responsible for ensuring the service team meets client contractual obligations and commitments. Manage customer service operating budget and achieve unit cost objectives and other customer service financial objectives including performance guarantees/incentives. Develop processes to drive first call resolution, call avoidance strategies and other service objectives.

% of TIME (Total 100%)	ESSENTIAL FUNCTIONS
30%	Responsible for performance of Customer Service Supervisors, Associates, Support Associates and Customer Service Care Assist Team in the delivery of the highest quality and most efficient service. ➢ Develop and communicate customer service team objectives ➢ Establish performance goals for customer service staff and ensure continuous feedback to all associates ➢ Set service quality standards and put processes in place to regularly and consistently measure qualitative performance ➢ Develop methods to recognize top performers and improve performance of team members not achieving performance goals ➢ Put processes in place to identify developmental needs of team members and a means of addressing those needs ➢ Provide leadership to ensure the highest level of performance, professional development, job satisfaction, and customer delight. ➢ Build and develop an excellent supervisory leadership team ➢ Ensure ongoing and annual performance assessment process is conducted in a meaningful and timely manner, incorporating individual development planning as appropriate. Utilize performance management tools to quantify and document performance coaching.
25%	Lead custom er service teams in the s uccessful delivery and ex ecution of ser vices to meet client commitments, and contractual obligations. ➢ Create a work environment that achieves a healthy balance between qualitative and quantitative performance results ➢ Maximize utilization of tools and resources (i.e. ACD, satisfaction surveys, reporting tools, IEX, etc.). ➢ Manage the implementation, maintenance and achievement of customer service client operational/service commitments including service levels, performance

	guarantees and incentives. ➢ Ensure regulatory compliance amongst the customer service team and manage the associated risk.
25%	Manage customer service department's financial performance on a unit cost and operating basis. Manage to achieve the most effective financial performance while ensuring appropriate service levels. ➢ Manage within customer service operating budget. ➢ With the Operations Team, manage to unit cost objectives ➢ Share in the responsibility of avoiding payment of performance penalties and optimize opportunities to earn incentives ➢ Manage customer service attrition effectively
20%	Put processes in place in the customer services unit that are consistent with overall CMC and corporate objectives ➢ Facilitate first call resolution and call avoid strategies ➢ Work closely with the Operations Team to create balanced processes that meet both financial and associate satisfaction goals ➢ Develop and implement creative process and service solutions that address performance issues and/or enhance efficiency and service excellence. ➢ Work with the National Service Development team to create Magellan standard processes and tools ➢ Participate as needed in CMC leadership meetings and with other internal/external audiences as warranted. ➢ Serve as customer service expert as required for the development of new processes, products, and request for proposal responses.

Performs related duties as required.

NON-ESSENTIAL FUNCTIONS

REPORTING RELATIONSHIPS

SVP, Operations Supervisor Title
Supervisor Title

General Manager,
CMC

Customer Service

Employee Title

Employee Title

Employee Name

Employee Name

Job Title

Supervisor Name

Supervisor Name

Name

(Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐

Field(s) of study: Business, Healthcare or related field

Experience: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. ☒ > 8yrs.☐

Industry:

Job Specific: Five years or more experience in call center management, preferably in the healthcare industry. Experience leading large teams in a dynamic industry. A demonstrated track record of managing change with proven results in the achievement of goals (financial and performance).

.

*Equivalent combination of experience and education ☐

*Education and/or experiences may run concurrent ☒

Knowledge, Skills, Abilities:

☐WPM ☐KSPH

Other: Knowledge of managed healthcare principles and call center operations. Ability to develop, articulate and measure performance of a large, diverse team. Ability to collaborate with colleagues in the CMC and in other CMC to achieve mutual performance goals. Excellent negotiation, leadership and communication skills.

Computer Skills:

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: BA/BS required. MBA preferred.

Experience:

Knowledge, Skills, Abilities: "One Magellan" Thinking; Quantifiable Business Results; Leadership of People; Service Orientation (External and Internal); Flexible and Adaptable; Management of Projects, Tasks and People; Teamwork; Expert Knowledge

WORKING ENVIRONMENT (This position may include the following situations)
Sitting ☐ Standing ☐ Lifting ☐ _____lbs.

SIGNATURES OF APPROVAL

_____ _____

Supervisor Compensation Analyst

Director, Quality Assurance

JOB TITLE: **Director, Quality Assurance**	FLSA STATUS: Exempt
DEPARTMENT TITLE: Director, Quality Assurance	DEPARTMENT: ***TBD***
REPORTS TO: CMC General Manager	JOB CODE: QA5301E
LOCATION: Care Management Center (locations vary)	GRADE: 41
DATE CREATED: 7/18/03	DATE REVISED:

JOB SUMMARY

Leads the Magellan Medicaid Administration (MMA) quality assurance and quality control teams and all aspects of the quality programs required to meet our contractual requirements. Serves as a member of the leadership team in designing, implementing, monitoring, and enhancing quality operations and compliance for MMA. Responsible for quality compliance oversight, software quality control testing against business requirements, performance measurements and analytics, quality reporting, policies and procedures, accreditation preparation, coordination of satisfaction surveys, performance guarantee tracking, and integration of quality improvement processes within MMA.

% Of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
65%	➢ Lead the Quality Assurance and Quality Control teams and projects to meet MMA goals, including providing team leadership, the management policies, procedures and activities to meet multiple contractual requirements and state/federal regulations. ➢ Develop and communicate team objectives ➢ Establish performance goals for quality and compliance team and ensure continuous feedback to all associates ➢ Set performance standards and put processes in place to regularly and consistently measure qualitative performance ➢ Develop methods to recognize top performers and improve performance of team members not achieving performance goals ➢ Put processes in place to identify developmental needs of team members and a means of addressing those needs ➢ Provide leadership to ensure the highest level of performance, professional development, job satisfaction, and customer delight. ➢ Build and develop an excellent supervisory leadership team ➢ Ensure ongoing and annual performance assessment process is conducted in a meaningful and timely manner, incorporating individual development planning as appropriate. Utilize performance management tools to quantify and document performance coaching ➢ Team with the Training Department in development and presentation of training programs and user documentation for team and customers.
20%	Ensure that quality assurance and quality control key functions and activities are

	conducted with appropriate feedback from customer organizations, MMA departments, business unit stakeholders and member and provider input.
10%	In consultation with MMA and SBU leadership, set priorities for improving operations based on data from performance indicators, compliance audits and quality improvement activities.
10%	Serve as liaison with department managers to ensure that needs are met for internal and external reporting and analytics and the development of decision support tools.
5%	Oversee internal and external audit procedures to meet customer requirements, contract standards, and goals of the MMA.

NON-ESSENTIAL FUNCTIONS (Lists additional tasks necessary to meet overall performance standards)

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom you have a direct reporting relationship.

Leader of multiple QI personnel, including but not limited to QI Managers, compliance manager, coordinators, clinical reviewers and/or accreditation project manager.

Supervisor Title

Supervisor Title

Supervisor Name

Your Title

Employee Title

Supervisor Name

Employee Title

Your Name

Employee Name

Employee Name

MINIMUN REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS X☐ MA/MS/MBA PHD ☐

Field(s) of study:

Experience: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. ☒ > 8yrs.☐

Industry:
Job Specific: 5 – 8 years of experience with leadership and supervisory experience
*Equivalent combination of experience and education ☒
*Education and/or experiences may run concurrent ☐

Knowledge, Skills, Abilities:
☐WPM ☐KSPH

Other: Knowledge of quality improvement processes, performance measurement, CQI tools and data reporting applications. Knowledge of CQI training and QIA methodology.

Computer Skills: Expertise in data management software including spreadsheet development and use.

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education:. Advanced degree preferred

Experience: Prior experience in health services organizations preferred.

Knowledge, Skills, Abilities: Knowledge of Software testing standards and tools preferred. Knowledge of Operational quality control measurement/tracking best practices. Knowledge of customer satisfaction methodology and tools. Knowledge of statistical analysis procedures and software preferred.

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☒ Standing ☐ Lifting ☐ _____lbs.

Typing ☐ Other Alternative work hours (Between 5:00p.m–8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____

Supervisor Compensation Analyst

Magellan Health Services
Job Description

JOB TITLE: Regional Field Network Director	FLSA STATUS: Exempt
DEPARTMENT TITLE: Field Network	DEPARTMENT: Field Network Management
REPORT TO: Regional Service Center President(s)	JOB CODE: NW5801E
LOCATION: Various	GRADE: 40
DATE CREATED: 10/10/01	DATE REVISED:

JOB SUMMARY: The incumbent is responsible for the strategic and tactical direction of all activities for the assigned region related to developing and maintaining the physician, practitioner, facility, MPPS and organization services delivery system. The incumbent is responsible for developing and implementing a regional plan that meets the customer requirements within budget plan and assures access to a network of services that supports member access and the RSCs are within cost of care plans.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
35%	Establishes overall direction and plan and working processes between Network Management and Network Administration staff, including credentialing, communication (provider services line, letters, website, etc), database integrity and maintenance, regular reports, and rate loading.
15%	In conjunction with Regional Service Center Presidents, develops and implements a Network strategy to assure long term mutually successful physician, practitioner and facility, MPPS and organization provider relationships. Directs all provider (physician, practitioner, MPPS, facility and organizations) recruitment activities.
15%	Provides supervision, development and mentoring of the Field Network Management Department in meeting objectives and functions.
15%	Manage financial goals (e.g., control care cost trends, profitability) as defined by the business operations and RSC senior management team, including assuring that the network is cost effective, marketable, stable and offers appropriate access and RSCs meet cost of care plan.
10%	Directs network reimbursement and negotiation strategies in conjunction with business operating unit senior management team to assure RSC is within cost of care plan
10%	Establishes programs to develop and maintain positive relationships between MBH and providers, and to influence and change behavior of providers in accordance with business operations goals and objectives

NON-ESSENTIAL FUNCTIONS (Lists additional tasks necessary to meet overall performance standards)

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom this position has a direct reporting relationship.

			RSC	President
			RSC President	Supervisor Title
		Field Network Director	Supervisor Title	Barbara Leadholm
		Job Title	Louise Haddock	Supervisor Name
	Employee Title		Supervisor Name	
Employee Title		**Name**		
	Employee Name			
Employee Name				

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS X MA/MS/MBA ☐ PHD ☐

Field(s) of study:
Experience: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. ☐ >8y rs. ☒
Industry:
Job Specific:

*Equivalent combination of experience and education ☒
*Education and/or experiences may run concurrent ☐

Knowledge, Skills, Abilities:
☐WPM ☐KSPH

Other: Proven ability to strategically lead an organization toward the attainment of its goals and objectives, mission and values. Excellent communication and negotiation skills. Demonstrated teambuilding skills to promote an environment of diversity, collaboration and recognition.

Computer Skills: Microsoft office: Word, Excel and Access

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: MBA or MPH

Experience: At least 5 years of progressively more responsible health care administration experience (finance/contract administration, physician/provider relations) with strong preference for managed care experience. A minimum of three years experience in a leadership role. Demonstrates broad-scope financial expertise, with financial modeling experience preferred.

Knowledge, Skills, Abilities

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☐ Standing ☐ Lifting ☐ ___lbs.

Typing ☐ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____

Supervisor Com pensation Analyst

Magellan Health Services
Job Description

JOB TITLE: **General Manager, CMC**	FLSA STATUS: Exempt
DEPARTMENT TITLE: CMC Operations	DEPARTMENT: ***TBD***
REPORT TO: Operations, SVP	JOB CODE: OP3107E
LOCATION: Regional Care Management Center	GRADE: 43N
DATE CREATED: 6/4/3	DATE REVISED:

JOB SUMMARY

Provide the leadership to oversee and ensure operational compliance with business financial, quality, and employee objectives. Partners with account managers to achieve a high degree of customer service. Ensures cost effective, member and employee responsive operations are developed and maintained throughout the CMC.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS
	Manages CMC financial performance, operating budget and variances from plan to ensure cost effective delivery of service. Responsible for development and implementation of CMC annual operating budget.
	Oversees compliance to all operations performance standards, develop and activate action plans to bring back in compliance when standards are not met.
	Responsible for developing and fulfilling service level agreement with Account Management.
	Ensures that CMC call center and clinical staff provide appropriate and efficient services. Continually monitors services and programs to ensure that client needs and contract obligations are being met in accordance with MHS policies and procedures.
	Directs the delivery of high-quality services with in the CMC and ensures that quality management plans and protocols are implemented and that services are delivered in accordance with MHS policies and procedures. Monitors quality assurance indicators and provides quality oversight.
	Manages high-risk cases and utilization trends. Provides required management reports to internal and external customers and clients.
	Coordinate CMC network provider activities.
	Directs CMC administrative and infrastructure operations activities such as lease negotiations, staffing plans, supervision of non-clinical staff, telephone systems, etc.
	Oversees all area clinical and operations personnel with respect to recruitment, hiring, promotion and dismissal; ensures adequate training and orientation of new staff and ongoing professional development of existing staff. Ensures CMC adherence to MHS's human resources policies and procedures.

NON-ESSENTIAL FUNCTIONS Performs related duties as required.

REPORTING RELATIONSHIPS

SVP, Operations
Supervisor Title

Supervisor Title

General Manager, CMC
Job Title

Supervisor Name

Employee Title

Supervisor Name

Employee Title

Name

Employee Name

Employee Name

(Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐

Field(s) of study: Business, Healthcare or related field

Experience: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. ☐ > 8yrs.☒
Industry:
Job Specific: Six- eight years experience in healthcare with a clinical and/or operations management focus. Four years management level experience in the managed healthcare industry required.

*Equivalent combination of experience and education ☐
*Education and/or experiences may run concurrent ☒

Knowledge, Skills, Abilities:
☐WPM ☐KSPH

Other: Thorough knowledge of managed healthcare principles and call center operations. Understands financial and quantitative information and has ability to manage operations within budgets. Ability to identify problems, recognize symptoms and causes; establish and implement solutions. Ability to develop effective teams, through awareness of opinions, resolving conflicts and building collaboration among all levels in the organization. Ability to achieve organizational goals through development of effective teams. Motivates and empowers others to attain personal and team goals. Demonstrates excellent negotiation and communication skills.

Computer Skills:

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: MBA, MHA
Experience:

Knowledge, Skills, Abilities:"One Magellan" Thinking; Quantifiable Business Results; Leadership of People; Service Orientation (External and Internal); Flexible and Adaptable; Management of Projects, Tasks and People; Teamwork; Expert Knowledge

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☐ Standing ☐ Lifting ☐ _____lbs.

Magellan Health Services
Job Description

JOB TITLE: Senior Manager, Program Implementation	FLSA STATUS: Exempt
DEPARTMENT TITLE: Implementation and Program Development (under Account Management)	DEPARTMENT: ES Account Mgmt.
REPORTS TO: Regional Director, Implementation and Program Development	JOB CODE: MS6209E
LOCATION: STL	GRADE: 39
DATE CREATED: 9.24.07	DATE REVISED:

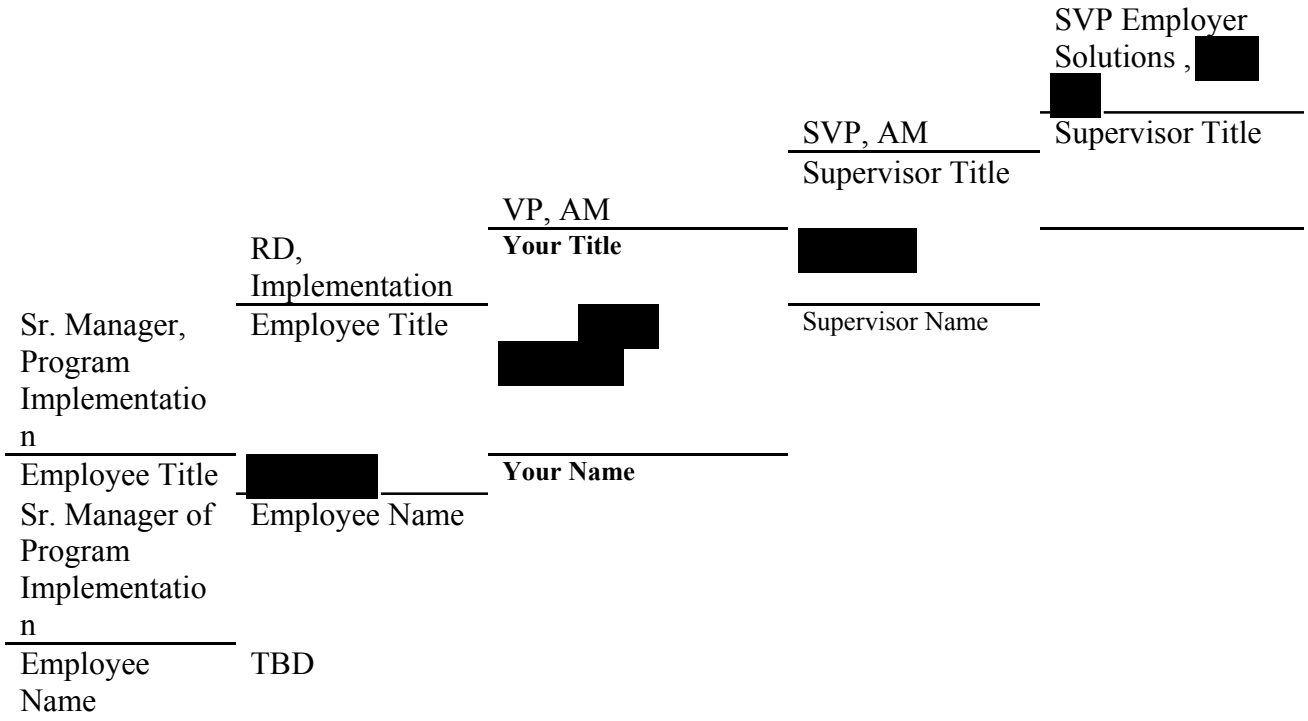
JOB SUMMARY (Please write 2-3 sentences summarizing the purpose of this position) This position is responsible for program development and implementation and expansion for Employer Solutions business. This includes providing leadership and management of program development and project development. Position is also responsible for reviewing potential vendor partnerships, assisting in decision making in vendor selection, management of vendor relationships, and products they deliver. Position is also responsible for projects assigned by supervisor, including maintenance of product feature standardization grid across lines of business. Position also will have responsibilities for account implementation under guidance of director.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
30%	Act as key facilitator/lead in the implementation of programs for new ES customers including current programs core to Magellan's service delivery as well as new services requiring program development. Activity includes Interface with all operational areas as needed.
20%	Facilitate expansion of programs for current customers including expansion of services to new populations, addition of new services to current offerings, development of new services added to current customer program
25%	Assist in vendor selection and manage external vendors involved in service delivery, including all issues from contract development, program operations, and quality oversight; establish corrective action plans as necessary
10%	Interface with sales and marketing to accurately describe/train on program specifications and positioning. Support Sales initiatives through RFP responses and Sales presentations
15%	Special projects – such as product /feature standardization grid, interface with CBOR, utilization report development

NON-ESSENTIAL FUNCTIONS Account implementation support as needed.

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom you have a direct reporting relationship.



MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)
Master's Degree preferred. Bachelors required in health/human services related field. Clinical operations work experience. Project management work experience *Education*: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐ Field(s) of study: Health or Business related field *Experience*: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. ☒ > 8yrs. ☐ Industry:

*Equivalent combination of experience and education ☐
*Education and/or experiences may run concurrent ☐

Knowledge, Skills, Abilities:
☐WPM ☐KSPH

Other:

Very organized, detail oriented person. Proven skills in problem solving and multi-tasking. Experience negotiating on behalf of customers. Exhibits leadership and team management skills. Good written and interpersonal communication. Familiarity with Magellan's customer database system and other commonly used business software, including Microsoft Access and other Microsoft applications. Understanding of web applications and functionality.

Computer Skills: Microsoft office

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: Bachelors required, Masters Degree preferred

Experience: 5+ years of operations; project management expertise; leadership and negotiating skills. Knowledge of operations/systems interfaces and interdependencies is crucial.

Knowledge, Skills, Abilities: Strong decision making, strong creative problem solving, and management of details to closure

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☒ Standing ☐ Lifting ☐ _____lbs.

Typing ☒ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____

Supervisor Co mpensation Analyst

Magellan Health Services
Job Description

JOB TITLE: Manager Analysis & Programming	FLSA STATUS: Exempt
DEPARTMENT TITLE:	DEPARTMENT: I.T.
REPORT TO:	JOB CODE: IT6225E
LOCATION:	GRADE: 40
DATE CREATED: 8/8/2001	DATE REVISED:

JOB SUMMARY (Please write 2-3 sentences summarizing the purpose of this position)
This position will be primarily focused on ensuring all resources are working up to their maximum potential to ensure the project dates are met while following all of the proper policies and procedures. In addition, this position will be expected to hold some programming and analysis duties themselves.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
45%	Acts as the primary focal point for both internal and external customers as to software development tasks. This includes estimates of feasibility, time and effort of tasks. This also includes providing updates to both the user community and the programmers. This person also monitors projects, determines potential problems and guides them to a successful completion. This person focuses on a larger picture, and pushes toward the strategic vision for their products.
35%	Ensures that all work is getting accomplished by making assignments and monitoring tasks. This includes balancing work between programmer/analysts, and ensuring that the proper policies and procedures are being followed.
10%	Is a key participant in hiring and firing decisions of programmer/analysts.
5%	Helps prepare and manage budgets.
5%	Reviews and evaluates work of subordinate staff and prepares performance reports.
NON-ESSENTIAL FUNCTIONS	(Lists additional tasks necessary to meet overall performance standards)

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom this position has a direct reporting relationship.

			Supervisor Title	Supervisor Title
		Manager Analysis & Programming		
		Job Title		Supervisor Name
.	Employee Title		Supervisor Name	
Employee Title		**Name**		
	Employee Name			
Employee Name				

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)
Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐
Field(s) of study:

Experience: 0 yrs. ☐ 1-3yrs. ☐ 3-5yrs. ☐ 5-8yrs. ☒ > 8yrs. ☐
Industry:
Job Specific:

*Equivalent combination of experience and education ☒
*Education and/or experiences may run concurrent ☐

Knowledge, Skills, Abilities:
☐WPM ☐KSPH

Other:

Computer Skills:

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)	
Education:	
Require:	Bachelor's degree in Computer Science, Information Systems, or related field, or equivalent work experience.
Prefer:	Master's degree in Computer Science, Information Systems or related field.
Prior work experience:	Minimum of seven years of systems analysis/development experience. Experience in the managed care, health care, or insurance industries a plus.
Knowledge and skills:	Strong development, management and communications skills (verbal and written); experience with systems development lifecycle methodologies (SDLC) and techniques; good project management skills.

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☒ Standing ☐ Lifting ☐ _____lbs.

Typing ☐ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____
Supervisor Compensation Analyst

Program Manager

JOB TITLE: Program Manager	FLSA STATUS: Exempt
DEPARTMENT TITLE: Program Manager	DEPARTMENT: ***TBD***
REPORTS TO: SVP, Employer Solutions	JOB CODE: MS6206E
LOCATION: Varies	GRADE: 40
DATE CREATED: ***TBD***	DATE REVISED:

JOB SUMMARY

Accountable for Profit and Loss of all assigned account(s), with particular emphasis on top tier customers defined by Magellan criteria. Accountable for relationship building at multiple strategic customer touch points to include but limited to day-to-day contacts, senior management, and key decision makers. Responsible for development of ongoing strategy to ensure retention and growth by providing solutions that align with customers' overall business and human capitol management objectives. Develops relationships with internal account stakeholders that support achievement of strategic alignment including operations, IT finance, product innovation, network, vendor management, claims, legal, corporate clinical, etc. and takes the leadership role in coordinating these resources to achieve business objectives, maintain account satisfaction, and ensure that Magellan's products and services support customers' needs while achieving acceptable margins.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
50%	**Customer Management** ▪ Develop and maintain a strategic account management plan that fully reflects global customers' business objectives and how our solutions align with those objectives and specifically guides our operational, financial, network, clinical and relationship initiatives. ▪ Responsible for development of long term profitable relationships based on provision of consultation and effective business solutions. ▪ Develop and implements effective, creative account retention & growth plans that protects and generates revenue and EBITDA. ▪ Fully versed in all aspects of the contracts with assigned customers as well as ensuring ongoing contract performance through risk management activities including: assurance of Service Level Agreement performance in Care Management Centers and Shared Services, assurance of accuracy of claims payment/administrative policies, rate maximization through ongoing benefit analysis and adherence to requirements of the account's legal/regulatory environment. ▪ Own overall account satisfaction with Magellan for all assigned accounts as well as satisfaction with all specific areas particularly account management. Develop strong relationships which penetrate customer at various levels from day to day contacts to senior leadership involving other Magellan staff to maintain multiple connections and strengthen the overall Develop strong relationships and contacts within Magellan that are supportive of the achievement of customer

	service requirements including attainment of performance guarantees and minimization of performance penalty expense. ▪ Ensure all Customer and Account-Facing services are provided in a consistent and timely fashion. ▪ Resolve or appropriately escalate customer service issues in conjunction with operations (claims, service, systems). ▪ Prepare and present customer reports with meaningful analytics, trending and recommendations for program improvement based on findings. ▪ Provide oversight and coaching to Account Service Representatives in effective problem solving and servicing of each account.
25%	**Book of Business/Financial Management** ▪ Ensure revenue goals are met, cost of care and administrative expenses managed, and EBIDTA targets achieved for the assigned account(s). ▪ Ensure contract performance through risk management activities including such items as: assurance of Service Level Agreement performance in Care Management Centers and Shared Services, assurance of claims accuracy payment/administrative policies, rate maximization through ongoing benefit analysis and adherence to requirements of the account's legal/regulatory environment. ▪ Develop and maintain contract compliance tool for periodic assessment of Magellan performance to customer requirements (including performance standards, etc…). Position the assigned book of business strategically to achieve objectives, including growth requirements, retention requirements, customer satisfaction, etc. ▪ Propose final pricing and product description for products sold to existing accounts. ▪ Manage risks and develop opportunities associated with underwritten rates.
25%	**Opportunity Development** ▪ Drive up-sell and renewal activities across assigned account(s). For new business and renewals, negotiate rates and contractual terms with customers that result in improved EBITDA and creatively adjust features and service delivery models through the operation that increase efficiency and improve value to the customer and/or margin for Magellan. ▪ Identify products and services that bring solutions to customers based on a thorough understanding of each customer's strategic business goals and the strategic business. ▪ Demonstrate depth of knowledge of ALL Magellan products and how multiple products are interdependent within the customer contract deliverables and clinical outcomes.

NON-ESSENTIAL FUNCTIONS	(Lists additional tasks necessary to meet overall performance standards)

Other responsibilities to include the following functions:

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom you have a direct reporting relationship.

VP, Account Management
Director, Account Management
Program Manager
Your Title
Employee Title
Employee Title
Your Name
Employee Name
Employee Name

Supervisor Title
Supervisor Title
Supervisor Name
Supervisor Name

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)
Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐ Field(s) of study: Health or Business related field *Experience*: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. > 8yrs. X Industry: Healthcare (preferably behavioral health) Job Specific: 8+ yrs. of broad-based of Health Care experience including account management experience *Equivalent combination of experience and education ☐ *Education and/or experiences may run concurrent ☐ *Knowledge, Skills, Abilities:* ☐WPM ☐KSPH Other: Excellent Leadership, Management of Resources, Communication, Negotiation skills, Business & Organization Knowledge and Teamwork Building skills. *:"One Magellan" Thinking; Quantifiable Business Results; Leadership of People; Service Orientation (External and Internal); Flexible and Adaptable; Management of Projects, Tasks and People; Teamwork; Expert Knowledge* Computer Skills:

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)
Education: Masters Degree *Experience: Operations or* Account Management experience in the behavioral healthcare, Health and Welfare benefits and or health insurance industries. *Knowledge, Skills, Abilities:*

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☐ Standing ☐ Lifting ☐ _____lbs.

Typing ☐ Other Local Travel Required Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____

Supervisor Compensation Analyst

Magellan Behavioral Health
Job Description

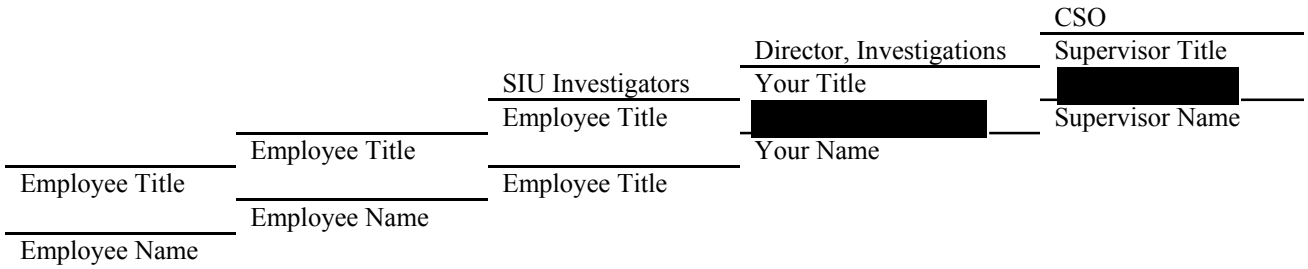
JOB TITLE: Senior Director, Investigations	FLSA STATUS: Exempt
DEPARTMENT TITLE:	DEPARTMENT: Security
REPORTS TO: Chief Security Officer	JOB CODE: IT5605E
LOCATION: Columbia Maryland	GRADE: 41
DATE CREATED: 8/4/10	DATE REVISED:

JOB SUMMARY (Please write 2-3 sentences summarizing the purpose of this position)
Organize, coordinate, and supervise a comprehensive investigations program to protect Magellan assets, detect, identify and deter fraud and abuse.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
60%	Direct the activities of the Special Investigations Unit (SIU) to detect, identify and deter fraud and abuse. Direct investigations, coordinate settlements and supervise SIU investigators. Insure compliance with federal and state regulatory compliance and fraud reporting requirements.
20%	Direct security and human resource personnel in the conduct of investigations concerning corporate compliance issues, security violations, infractions of company policy or any other act that adversely affects Magellan. Maintain liaison with government, local industry security associates, and law enforcement personnel.
10%	Direct the personnel security program including evaluating all policies and procedures as required. Support the evaluation and adjudication of background investigations on applicants and employees seeking or employed in sensitive positions.
10%	Participates in strategic planning as a Senior Management team member. Prepares and presents strategic plan components related to investigations and security. Develops tactical and strategic security plans to satisfy business needs.
NON-ESSENTIAL FUNCTIONS	(Lists additional tasks necessary to meet overall performance standards)

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom you have a direct reporting relationship.



MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐

Field(s) of study: Security Administration, Law Enforcement, Computer Studies, Electrical Engineering, Management.

Experience: 0 yrs. ☐ 1-3yrs. ☐ 3-5yrs. ☐ 5-8yrs. ☐ > 8yrs. ☒
Industry: Experience with large publicly owned or government organizations.
Job Specific: Experience in personnel behavior, investigations, anti-fraud investigations

*Equivalent combination of experience and education ☒
*Education and/or experiences may run concurrent ☐

Knowledge, Skills, Abilities:

☐WPM ☐KSPH

Other: Team oriented, Entrepreneurial, Resourceful, Results-oriented, Integrity for all audiences at all times, Future-oriented, Individual growth Capacity and desire, Change and Challenge-enjoying, Service committed. Knowledge and experience with a variety of security practices in the information systems as well as the physical security requirements.

Computer Skills: Familiarity with Microsoft Operating Systems, Access, email.

Licenses, Certifications, etc.: Certified Fraud Examiner (CFE). Certification as a CFE required within one year of hiring.

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: MS

Experience: Knowledge of a variety of state-of-the-art physical security equipment and devices for planning and implementing protective methods and security procedures.

Knowledge, Skills, Abilities: Program management, leadership, team building, resource planning, and management preferred. Experience with large disparate organizational constructs preferred.

Licenses, Certifications, etc.:
Professional Certified Investigator (PCI)
Certified Protection Professional (CPP)
Certified Information Systems Security Professional (CISSP)

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☒ Standing ☒ Lifting ☐ _____lbs.

Typing ☒ Other Varied Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____

Supervisor Co mpensation Analyst

Magellan Health Services
Job Description

JOB TITLE: Senior Manager, Analysis & Programming	FLSA STATUS: Exempt
DEPARTMENT TITLE:	DEPARTMENT: I.T.
REPORT TO:Varies	JOB CODE: IT6224EI
LOCATION: Varies	GRADE: 41I
DATE CREATED: 06/06/05	DATE REVISED: 06/06/05

JOB SUMMARY

This positions primary focus is to help define the strategic IT objectives and to ensure that all resources are working up to their maximum potential to meet those objectives while following all of the proper policies and procedures. Secondary responsibilities include: administrative duties, staffing, budget preparation and tracking, purchasing of equipment, and conducting performance evaluations. Additional duties include providing guidance and mentoring to staff as required, and working with the Business Owners and IT Management to set priorities of projects and associated tasks.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
35%	Participates in defining strategic IT objectives and leading subordinates toward that strategic vision for their products.
25%	Acts as the primary focal point for both internal and external customers as to software development tasks. This includes estimates of feasibility, time and effort of tasks. This also includes providing updates to both the user community and the programmers. This person also monitors projects, determines potential problems and guides them to a successful completion.
20%	Ensures that all work is getting accomplished by making assignments and monitoring tasks. This includes balancing work between programmers, analysts, project managers, supervisors, and managers, and ensuring that the proper policies and procedures are being followed.
10%	Is a key participant in hiring and firing decisions.
5%	Helps prepare and manage budgets.
5%	Reviews and evaluates work of subordinate staff and prepares performance reports.

NON-ESSENTIAL FUNCTIONS (Lists additional tasks necessary to meet overall performance standards)

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom this position has a direct reporting relationship.

				Supervisor Title
			Supervisor Title	
		Sr. Manager, Analysis & Programming		
		Job Title		Supervisor Name
.	Employee Title		Supervisor Name	
Employee Title		**Name**		
	Employee Name			
Employee Name				

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☐ MA/MS/MBA ☒ PHD ☐

Field(s) of study: Computer Science and Business Administration

Experience: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. ☐ > 8yrs.☒
Industry: Leadership Experience (direct reports)
Job Specific:

*Equivalent combination of experience and education ☒
*Education and/or experiences may run concurrent ☐

Knowledge, Skills, Abilities:
☐WPM ☐KSPH

Other:

Computer Skills:

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)	
Education:	
Require:	Bachelor's degree in Computer Science, Information Systems, or related field, or equivalent work experience. Master's degree in Computer Science, Information Systems or related field.
Prior work experience:	Minimum of eight years of systems analysis/development experience. Experience in the managed care, health care, or insurance industries a plus.
Knowledge and skills:	Strong development, management and communications skills (verbal and written); experience with systems development lifecycle methodologies (SDLC) and techniques; good project management skills.

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☒ Standing ☐ Lifting ☐ _____lbs.

Typing ☐ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____

Supervisor Co mpensation Analyst

Magellan Health Services
Job Description

JOB TITLE: Senior Account Executive	FLSA STATUS: Exempt
DEPARTMENT TITLE: Senior Account Executive	DEPARTMENT: Account Management
REPORT TO: Program Manager	JOB CODE: MS8210E
LOCATION: Varies	GRADE: 33
DATE CREATED: 1/01/04	DATE REVISED:

JOB SUMMARY (Please write 2-3 sentences summarizing the purpose of this position)
The Account Specialist acts as a liaison between accounts and their designated program manager to internal Magellan departments providing the service. The interfacing Magellan departments include operations, quality, customer reporting and databases (ASD), legal, underwriting, member communications and customer training. They also act as the direct customer contact on medium to small customers as assigned. They support customer satisfaction and retention by ensuring customers are serviced consistent with contractual requirements and that concerns and/or issues are addressed and resolved.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
20%	Assists the account management team in researching and responding to inquiries from the customer. Works within Magellan to resolve customer issues. Participate in complaint resolution process.
15%	Handles all customer training and member communication requests.
15%	Compiles and supports the production of customer utilization reports.
15%	Updates required customer forms and information related to new products, contact changes and employee count changes.
10%	Direct customer contact and management on medium to small customers as assigned.
10%	Assists the account management team with renewal accounts by working with Underwriting and processing the required information to get renewal rates. Support RFPs and RFIs as needed.
5%	Compiles and finalizes Performance Guarantee information for program manager so they can be presented to the customer.
5%	Assists with new account/system implementations.
5%	Other duties as assigned.

NON-ESSENTIAL FUNCTIONS (Lists additional tasks necessary to meet overall performance standards)

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom this position has a direct reporting relationship.

			Area/Regional Dir	Supervisor Title
		Account Specialist	Supervisor Title	
		Job Title		Supervisor Name
	Employee Title		Supervisor Name	
Employee Title		**Name**		
	Employee Name			
Employee Name				

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☒ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐

Field(s) of study: HS + additional coursework

Experience: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. ☒ > 8yrs.☐

Industry:

Job Specific: 2-3 yrs related experience (I.e. account management, education, etc.) OR 3-5yrs customer service

*Equivalent combination of experience and education ☐

*Education and/or experiences may run concurrent ☐

Knowledge, Skills, Abilities:

☐WPM ☐KSPH

Other: Prioritizes tasks effectively. Knows Magellan's limitations and effectively manages customer's expectations within those limitations. Expresses ideas, recommendations and solutions clearly, logically and concisely in written, verbal and platform formats. Conveys positive, professional image. Demonstrates strong networking skills. Familiarity with and ability to use various computer programs such as Word, Excel, Outlook. Business and Organization Knowledge: Understands Magellan products and services. Understands organization and effectively works through organization. Understands customer organization and key decision makers. Is an active participant on account management teams. Works effectively in bringing appropriate people together to accomplish a specific task. Demonstrates and actively promotes team work attitude.

Computer Skills: Ability to use Excel and Word.

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: BA in education, health, or business related field

Experience: Sales or account management experience in behavioral healthcare

Knowledge, Skills, Abilities:

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☐ Standing ☐ Lifting ☐ _____lbs.

Typing ☐ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____

Supervisor Co mpensation Analyst

Magellan Health Services
Job Description

JOB TITLE: SVP, Employer Solutions	FLSA STATUS: Exempt
DEPARTMENT TITLE:	DEPARTMENT:
REPORT TO:	JOB CODE: OP2202E
LOCATION:	GRADE: 43N
DATE CREATED: February, 2007	DATE REVISED:

JOB SUMMARY (Please write 2-3 sentences summarizing the purpose of this position)

The SVP, Employer Solutions is responsible for directly overseeing all fiscal and administrative operations, including the areas of finance, human resources, customer service, claims payment and billing, information technology and reporting. Responsible for the overall management of the employer solutions division, including development of policy and procedure, management of community support delivery system within budgetary goals, and coordination of relationships with the state, plan members and members in care, participating providers, partners and the community.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
30%	Directly oversees all fiscal and administrative operations, including the areas of finance, human resources, customer service, claims payment and billing, information technology and reporting. Has authority to commit to expenditures within the authority delegated by the CEO.
40%	Leads business operations which includes collaborating with the clinical and program staffs to ensure that high quality services are delivered within budget, that system principles are supported with financial resources; and determining information technology requirements and overseeing plans and budgets for implementation, production and operation.
20%	Has authority over all daily administrative and fiscal operations. This includes decision-making authority for controlling fiscal expenditures and ensuring that operations support system requirements.
10%	Oversees all areas of human resources with respect to recruitment, hiring, promotion and dismissal; ensures adequate training and orientation of new staff and ongoing professional development of existing staff. Ensures adherence to human resources policies and procedures.
NON-ESSENTIAL FUNCTIONS	(Lists additional tasks necessary to meet overall performance standards)

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom this position has a direct reporting relationship.

				Supervisor Title
			Supervisor Title	
		Job Title		Supervisor Name
	Employee Title		Supervisor Name	
Employee Title		**Name**		
	Employee Name			
Employee Name				

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐

Field(s) of study:

Experience: 0 yrs. ☐ 1-3yrs. ☐ 3-5yrs. ☐ 5-8yrs. ☐ > 8yrs. ☐

Industry:

Job Specific: Ten years experience in healthcare with a clinical and/or operations management focus. Four years management level experience in the managed healthcare industry required.

*Equivalent combination of experience and education ☐

*Education and/or experiences may run concurrent ☐

Knowledge, Skills, Abilities:

☐WPM ☐KSPH

Other: Knowledge of managed healthcare delivery systems to include critical components and interdependencies. Knowledge of the variety of financial and clinical structures viable in the managed care arena. Knowledge of clinical issues unique to the delivery of mental health and substance abuse services, of strategic planning and the budget process. Ability to communicate and advocate at the line through corporate staff levels. Leadership skills. Must posses strong analytical and organizational skills in a multiple site and function environment. Proven ability to manage operations in a clinical healthcare system. Negotiating and contracting skills.

Computer Skills:

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: MBA,MHA or Ph.D. preferred.

Experience:

Knowledge, Skills, Abilities:

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☐ Standing ☐ Lifting ☐ _____lbs.

Typing ☐ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____

Supervisor Co mpensation Analyst

Magellan Health Services
Job Description

JOB TITLE: Senior Underwriter	FLSA STATUS: Exempt
DEPARTMENT TITLE: Senior Underwriter	DEPARTMENT: Corporate Finance
REPORT TO: VP, Underwriting	JOB CODE: FA8505E
LOCATION: Corporate Office – Columbia, MD	GRADE: 38
DATE CREATED: 5-4-05	DATE REVISED:

JOB SUMMARY (Please write 2-3 sentences summarizing the purpose of this position)

Responsible for the development of financial and programmatic cost models. This position will work with various departments within the company as well with employees within the finance department. This position will also assist the Director, Underwriting in fulfilling financial requirements for RFP's.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
25%	Applies underwriting procedures to new and existing business. Achieve overall corporate financial goals by applying appropriate pricing methodologies.
25%	Analyze claims detail data from multiple in-house claims processing systems, as well as analyzing external claims data in various formats.
25%	Meet deadlines and assist with the fulfillment of financial requirements for RFP's (Request for Proposals).
25%	Work with other Magellan employees and respond to requests for other areas in the organization.

NON-ESSENTIAL FUNCTIONS (Lists additional tasks necessary to meet overall performance standards)

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom this position has a direct reporting relationship.

SVP, Actuarial Services and Underwriting
Supervisor Title

VP, Underwriting
Supervisor Title

[redacted]
Supervisor Name

Senior Underwriter
Job Title

[redacted]
Supervisor Name

Employee Title

Name

Employee Name

Employee Title

Employee Name

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐

Field(s) of study: Related healthcare

Experience: 0 yrs. ☐ 1-3yrs. ☐ 3-5yrs. ☐ 5-8yrs. ☐ > 8yrs. ☒
Industry:
Job Specific: Thorough knowledge of the health industry. Knowledge of Managed Mental Health and Substance Abuse products, cost structures, economies and practice of providers.

*Equivalent combination of experience and education ☒
*Education and/or experiences may run concurrent ☒

Knowledge, Skills, Abilities:
☐WPM ☐KSPH

Other: Knowledge of underwriting principles in a managed care environment. Strong financial and analytical skills. Excellent written and communication skills. Ability to self-start and work independently. Good analytical, reasoning and problem solving skills. Strong organizational skills and must be able to adhere to strict deadlines.

Computer Skills: Must have experience with spreadsheet software (i.e. MS Excel)

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: BS in finance or business related degeree and/or equivalent work experience.

Experience:

Knowledge, Skills, Abilities:

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☒ Standing ☐ Lifting ☐ _____lbs.

Typing ☐ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____
Supervisor Co mpensation Analyst

Magellan Health Services
Job Description

JOB TITLE: Vice President, Marketing	FLSA STATUS: Exempt
DEPARTMENT TITLE:VP Marketing	DEPARTMENT: Marketing
REPORT TO: Chief Marketing Officer	JOB CODE: MS4306E
LOCATION: Various Locations	GRADE: 43
DATE CREATED: 8/18/11	DATE REVISED:

JOB SUMMARY (Please write 2-3 sentences summarizing the purpose of this position)
This senior marketing position is responsible for leading all Marketing activity and coordination related to Magellan. This position will lead the development of marketing strategy, planning and execution to drive top line revenue growth, cross sell and retention across a diverse health related product line targeting our key constituencies including, Plan Sponsors (Employers), Managed Care Organizations (MCOs), Government Entities, Brokers, Consumers, Providers and Consultants.

This position develops differentiation strategies, programs, and objectives for all product and service marketing activities for the Magellan organizations. This includes directing market research, strategic coordination, product introduction, and program execution to accomplish program objectives, including the development of marketing programs to increase awareness, preference, retention and purchase.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
	• Client Management, Collaboration and Liaison with executive leadership • Value proposition planning and development • Marketing support for our cross sell of Magellan's diverse product portfolio • Market needs assessment and market research (voice of the markets/health plans on needs, satisfaction, concept testing, etc.) • Coordination of advertising support strategy • Marketing Communications (tactical program support; agency and vendor management for sales collateral, digital coordination, etc.) • Budget and People Management • Collaboration with peer marketing groups and other enterprise marketing assets to deliver initiatives; • Enterprise-wide coordination, alignment and partnering; • Motivating, coaching and serving as a role model for colleagues and employees in a cross-functional team environment. Developing marketing capacity will be a priority; • Providing thought leadership and innovation support for BH segments; • Staying ahead of and informing clients on industry trends, competitive intelligence and the impact to the business and marketing.

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom this position has a direct reporting relationship.

[redacted] Supervisor Title

CMO Supervisor Title

President Supervisor Name

VP, Marketing **Job Title**

[redacted] Supervisor Name

Employee Title

Employee Name

Name

Employee Title

Employee Name

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐

Field(s) of study: Bachelors degree in Journalism, Public Relations, Communications, or related field

Experience: 0 yrs. ☐ 1-3yrs. ☐ 3-5yrs. ☐ 5-8yrs. ☐ > 8yrs. ☒

Industry: 10+ years of communication/marketing experience in large client market;
10+ years of complex project management and product implementation

*Equivalent combination of experience and education ☒
*Education and/or experiences may run concurrent ☒

Other: Skilled in marketing strategy planning; client management; influencing. Prove experience in developing, managing and executing differentiation strategies; proven results in gaining competitive advantate through marketing discipline. Ability to work through a matrix organization.

Knowledge, Skills, Abilities: Detail oriented, analytical problem solve, self-motivated, organized, planning skills, leadership experience and excellent communication skills.

☐WPM ☐KSPH

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: MBA/MS/MA

Experience:

Knowledge, Skills, Abilities:

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☐ Standing ☐ Lifting ☐ _____lbs.

Typing ☐ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

Supervisor Co mpensation Analyst

Magellan Health Services
Job Description

JOB TITLE: Vice President, Claims	FLSA STATUS: Exempt
DEPARTMENT TITLE: VP Claims	DEPARTMENT: Claims
REPORT TO: SVP Claims	JOB CODE: CL4101E
LOCATION: Varies	GRADE: 43
DATE CREATED: 10-01-01	DATE REVISED:

JOB SUMMARY (Please write 2-3 sentences summarizing the purpose of this position)
Responsible for managing multiple service or business departments to meet or exceed customer requirements and business objectives. Responsible for setting strategic direction of department affecting financial operation. Responsible for maintaining supportive work environment. Must conduct activities within guidelines set forth by individual state or federal regulations.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
30%	**Operations**: Assure claims operation is functioning to achieve the requirements with regards to timeliness and quality as established by each state and or federal regulations, accounts and brokers.
20%	**Management and Staffing:** Assure Headcount/FTE is managed responsibly as to support budgetary objectives as well as goals or performance guarantees for each client. Use and maintain consistent staffing models. Develop bench strength of direct reports. Establish effective Matrix partnering relationship. Implement IPD's for all . MJOs completed, discussed and agreed upon with all direct reports. Performance Appraisals completed, delivered and fully discussed with all direct reports. Plans made to address development, which include at least 1-2 actions per person (training, OJT, project assignments). Tie performance/competencies and compensation discussions together during feedback session. Actively participate in achieving office AAP Goals (i.e., hiring, turnover, promotions, and developing people for promotion). Establish and implement consistent orientation to the division for all new hires.
15%	**Budget:** Assure claim unit cost and PMPM is monitored to assure efficient operations and attainment of financial goals. Assure Expense Plans are built and managed in a manner that supports the department objective over the cost center objective
10%	Foster and maintain trusting relationships with clients and Company unit staff.
10%	Demonstrate improvement on business priorities.
3%	Demonstrated ability to identify, initiate, support and drive projects that add value to the operation, to include project plan (owner, support, dates, deliverables, milestones, results and course correction)
2%	Support (i.e. pilot sites, subject matter experts, etc.) the development and final delivery of agreed upon department initiatives.
2%	Lead/Support teams to address action items for Employee Survey. Demonstrates improvement on survey priorities (bottom 5) through effective use of survey work groups.
2%	Discuss diversity with your teams. Act on any concerns/issues within your area.
2%	Conduct interim surveys or focus groups in high impact areas. Ensure fulfillment of local survey action plans.
2%	Achieve expected absenteeism metrics. Achieve expected turnover rate per year.
2%	Effective use of reward/recognition will be measured by number of spot rewards, as well as improved employee survey results in this category

NON-ESSENTIAL FUNCTIONS (Lists additional tasks necessary to meet overall performance standards)

Ensure that decisions made at the VP level are consistent throughout the network and support overall objectives (versus independent center objectives). Support all other Company units with respect to complete and timely dissemination of client information with regards to performance and outstanding issues. Consistent and fair administration of policies/practices based on feedback from HR, related to the number of employee complaints, Peer Review, Legal issues and employee survey results in this category.

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom this position has a direct reporting relationship.

			SVP Claims	Supervisor Title
		VP Claims	Supervisor Title	
		Job Title		Supervisor Name
	Employee Title		Supervisor Name	
Employee Title		**Name**		
	Employee Name			
Employee Name				

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐

Field(s) of study:

Experience: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. ☐ > 8yrs.☒

Industry:

Job Specific: 7-10yrs in service industry or operations and/or progressive supervisory experience

*Equivalent combination of experience and education ☒

*Education and/or experiences may run concurrent ☐

Knowledge, Skills, Abilities:

☐WPM ☐KSPH

Other: Knowledge of and experience in developing and managing budgets required; Excellent organizational, interpersonal, time management and communication skills; Strong leadership skills; Strong independent decision-making ability; Expert process and project management ability; Strong influencing, negotiation and analytical skills; Detail oriented; Critical Success Factors include: Customer/Team Advocate; Flexibility; Positive Attitude; Team Player; Problem Solver; Ability to manage multiple tasks simultaneously; Initiator; Change Agent; Coach; Leader; Risk Taker; Strategic Visionary; Negotiate high stress situations; Tireless and high energy resolve .

Computer Skills: Working knowledge of word processing, spreadsheets and databases

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: Masters preferred

Experience: 4-5yrs healthcare/managed care experience preferred; Experience in managing cross-functional, self-directed teams complex multiple product and task teams preferred

Knowledge, Skills, Abilities: knowledge of Microsoft Office software package preferred

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☒ Standing ☐ Lifting ☐ _____lbs.

Typing ☒ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

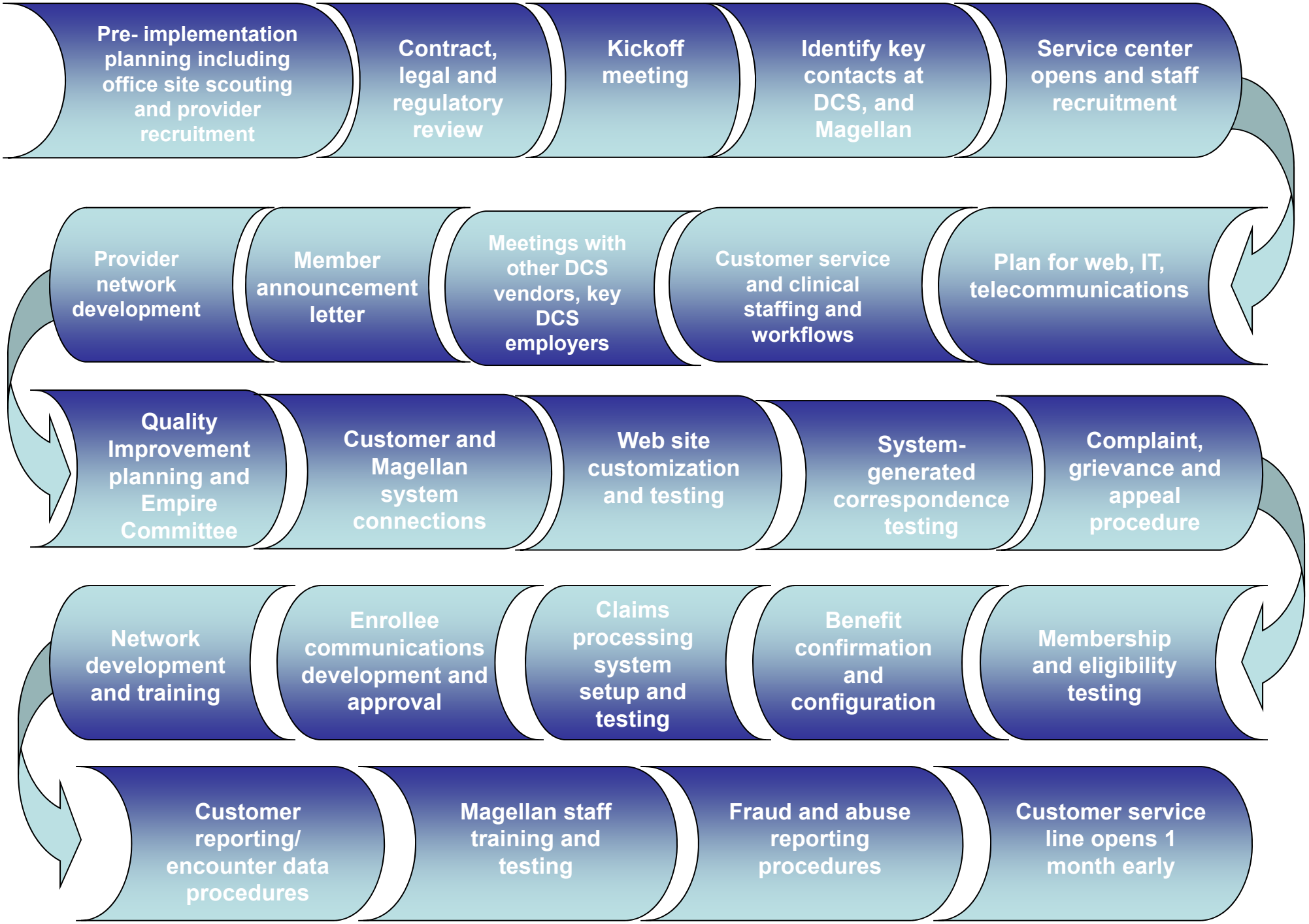
SIGNATURES OF APPROVAL

_____ _____

Supervisor Co mpensation Analyst

E. Implementation Diagram

Magellan Key Implementation Tasks



F. Sample MHSA Program Communications

XYZ company

Customer Program Name

XXX-XXX-XXXX

XYZ company

Customer Program Name

XXX-XXX-XXXX

Living Healthy Working Well®

Your organization has a no-cost, confidential program to provide you with help in managing life's challenges. Call or click now to get information that can help you make positive changes at home and at work!

Magellan Healthyroads® with PHA

Imagine yourself fit, strong and full of energy! Your road to good health starts by taking an online Personal Health Assessment. While online, check out Magellan Healthyroads' interactive wellness tools that make getting healthier empowering—and fun, too!

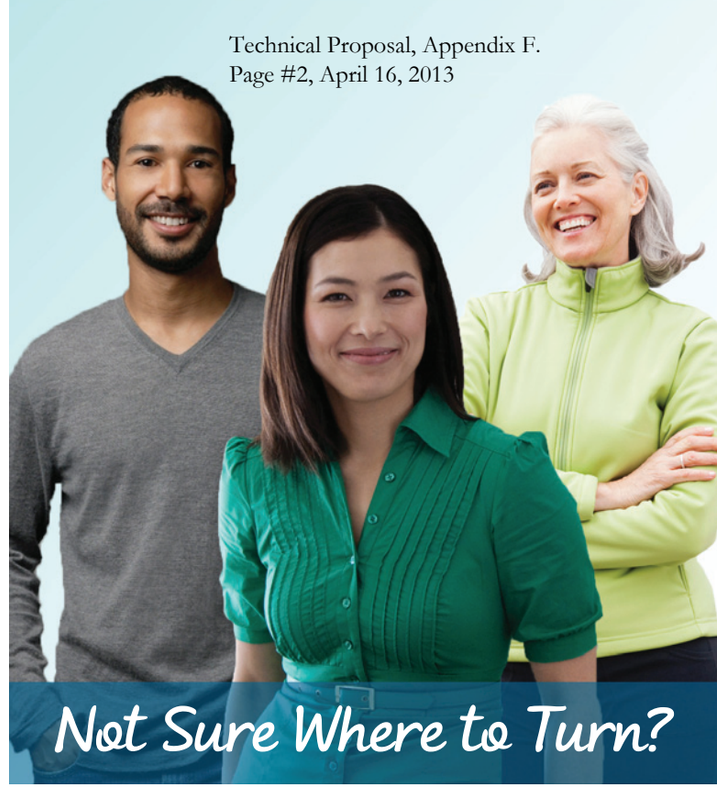
"It was so easy to get an appointment and the person I spoke with was so nice and caring. For the first time I felt like someone really heard me."

MAGELLAN BEHAVIORAL HEALTH

"I wanted to feel better and start doing something with my life. My program helped me take those first steps that I just couldn't seem to do on my own."

IMPORTANT: Can you read this? If not, we can have somebody help you read it. For free help, please call your toll-free number. *IMPORTANTE:* ¿Puede leer esta carta? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta carta escrita en Español. Para obtener ayuda gratuita, llame a su numero gratituo. In California, services are delivered by Magellan subsidiaries: Magellan Health Services of California—Employer Services and Human Affairs International of California.

B-BR10Erev1 (10/12)



Not Sure Where to Turn?

We help people solve everyday problems—every day.

XYZ company

Customer Program Name

XXX-XXX-XXXX

MagellanHealth.com/member

Trusted Solutions to Life's Challenges

From online information to confidential consultations with licensed behavioral health professionals, you and your eligible household members have access to a wealth of practical, solution-focused resources to help you reduce stress, strengthen relationships, increase productivity and improve the overall quality of your life.

We were going through a tough time and needed help to get back on track.

So Much to Do, So Little Time

Life moves fast. These days it seems like everyone is asked to do more in less time and with less help. With all you have to do, it can be hard to focus on everyday matters, let alone issues that are harder to control, such as:

- Changes in your financial situation
- Family or relationship problems
- Overwork or conflicts at work
- Feeling depressed or anxious
- Quitting tobacco, alcohol or drug use
- Caring for children or aging parents
- Losing weight and living healthier

Challenges like these can make life hard. And when you're busy, you might not think there's time to find solutions.

So, it's important to know that your organization offers a program that can help you solve everyday—and not so everyday—problems confidentially, 24 hours a day, seven days a week.

There's no cost to you and your eligible household members to use this program; however, any costs or copayments beyond this program will be your responsibility.

I'd like to learn how to manage my time better.

Easy Access to Services

Your program is here to provide you and your eligible household members with the right help at the right time. You can quickly get help in a way that works best for you:

- **By Phone**—Call to get consultation and solutions to everyday problems as well as help in a crisis. You will get access to resources or a referral to a professional in your community for confidential help.
- **Online**—Log on to locate counselors in your area. Find targeted information and resources that address your everyday concerns as well as more serious issues. Interactive tools help you discover ways to live a healthy lifestyle.

Visit www.MagellanHealth.com/member or call today to get a referral or information on topics such as:

Stress
Work-life balance
Family and relationships
Health and wellness
Grief and loss
Depression and anxiety
Alcohol or drug concerns
Living healthier

Visit www.MagellanHealth.com/member or call today to get a referral or information on topics such as:

Stress
Work-life balance
Family and relationships
Health and wellness
Grief and loss
Depression and anxiety
Alcohol or drug concerns
Living healthier

Tear off the attached cards and keep them handy for quick and easy access to the help your program can provide.

ADHD AND FAMILIES

Learn to Manage ADHD

It's a challenge to the whole family when a family member has attention deficit/hyperactivity disorder. Parents and siblings sometimes get frustrated with the behavior problems ADHD can cause. But the right therapies and medications will help.

Access your program to learn coping strategies that can help your family manage better.

XYZ company

Customer Program Name

XXX-XXX-XXXX

MAGELLAN BEHAVIORAL HEALTH

MagellanHealth.com/member

 P-A50E (2/13)

Living Healthy Working Well®

Stress and Anxiety

XYZ company

Customer Program Name

XXX-XXX-XXXX

Conquer Your Stress and Anxiety

Stress and anxiety—these seem to be everyday parts of modern life. It can be hard to keep up with all the demands on our time and energy. When worry and stress get to be too much, it's time to develop coping strategies.

Your program offers resources to help you stay healthy and better manage the stress in daily life.

MAGELLAN HEALTH SERVICES®
Getting Better All the Time™

www.MagellanHealth.com/member

XYZ company

Su Nombre del Programa

XXX-XXX-XXXX

XYZ company

Su Nombre del Programa

XXX-XXX-XXXX

Vida Saludable Trabajo Sano®

Su organización cuenta con un programa gratuito y confidencial, a fin de proporcionarle ayuda para manejar las dificultades de la vida. ¡Llame o haga clic ahora para obtener información que pueda ayudarlo a realizar cambios positivos en el hogar y en el trabajo!

Magellan Healthyroads® con PHA

¡Imagínese en forma, fuerte y lleno de energía!
Su camino hacia la buena salud comienza realizando una Evaluación personal de salud (PHA, por sus siglas en inglés) en línea. Mientras esté en línea, consulte las herramientas interactivas de bienestar de Magellan Healthyroads, que hacen que llevar una vida más saludable sea productivo y, también, ¡divertido!

"Fue fácil conseguir una cita y la persona con la que hablé fue muy amable y atenta. Por primera vez sentí que alguien realmente me escuchó".

MAGELLAN HEALTH SERVICES®
Getting Better All the Time™

"Quería sentirme mejor y comenzar a hacer algo con mi vida. Mi programa me ayudó a dar los primeros pasos que, simplemente, parecía no poder dar solo".

B-BR10S (11/11)

Ayudamos a las personas a resolver los problemas diarios, todos los días.

XYZ company

Su Nombre del Programa

XXX-XXX-XXXX

Magellanthealth.com/member

Soluciones confiables para las dificultades de la vida

Desde información en línea hasta consultas confidenciales con profesionales licenciados en salud mental, usted y sus miembros de familia elegibles tienen acceso a una gran variedad de recursos prácticos y centrados en brindar soluciones, a fin de ayudarlo a reducir el estrés, afianzar las relaciones, aumentar la productividad y mejorar la calidad general de su vida.

Estamos atravesando una época difícil y necesitamos ayuda para volver a encaminarnos.

Hay tanto por hacer en tan poco tiempo

La vida transcurre rápido. Actualmente, pareciera que a todas las personas se les pide que hagan más cosas en menos tiempo y con menos ayuda. Con todo lo que usted tiene que hacer, puede resultar difícil concentrarse en los asuntos cotidianos, más aún en las cuestiones que son más difíciles de controlar, como:

- Cambios en su situación financiera.
- Problemas familiares o en las relaciones.
- Exceso de trabajo o conflictos en el trabajo
- Sentirse deprimido o ansioso.
- Dejar el tabaco, el alcohol o las drogas.
- Cuidado de niños o de padres mayores.
- Bajar de peso y llevar una vida más saludable.

Las dificultades de este tipo pueden complicar la vida. Y cuando usted está ocupado, podría pensar que no hay tiempo para buscar soluciones.

Por este motivo, es importante saber que su organización ofrece un programa que puede ayudarlo a resolver los problemas cotidianos—y no tan cotidianos—de manera confidencial, las 24 horas del día, los siete días de la semana.

Usar este programa no tiene ningún costo para usted ni para sus miembros de familia elegibles; sin embargo, usted deberá hacerse cargo de los costos o los copagos no contemplados por este programa.

Me gustaría aprender a administrar mejor mi tiempo.

Fácil acceso a los servicios

El objetivo de su programa es proporcionar a usted y a sus miembros de familia elegibles la ayuda adecuada en el momento adecuado. Puede obtener ayuda rápidamente de la manera que mejor se ajuste a sus necesidades:

- **Por teléfono:** Llame a fin de obtener consejos y soluciones para los problemas cotidianos, así como también ayuda en caso de sufrir una crisis. Usted obtendrá acceso a los recursos o una remisión a un profesional en su comunidad, a fin de recibir ayuda confidencial.
- **En línea:** Inicie sesión para ubicar a los consejeros en su área. Encuentre información y recursos personalizados que aborden sus preocupaciones diarias, así como también cuestiones más graves. Las herramientas interactivas lo ayudan a descubrir maneras de llevar un estilo de vida saludable.

Visite www.MagellanHealth.com/member o llame hoy mismo para obtener una remisión o información sobre temas, como:

Estrés.
Equilibrio entre el trabajo y la vida.
Familia y relaciones.
Depresión y ansiedad.
Duelo y pérdida.
Llevar una vida más saludable.
Problemas con el alcohol o las drogas.
Salud y bienestar.

Visite www.MagellanHealth.com/member o llame hoy mismo para obtener una remisión o información sobre temas, como:

Estrés.
Equilibrio entre el trabajo y la vida.
Familia y relaciones.
Depresión y ansiedad.
Duelo y pérdida.
Llevar una vida más saludable.
Problemas con el alcohol o las drogas.
Salud y bienestar.

Retire las tarjetas que se adjuntan y téngalas a la mano para obtener un acceso rápido y fácil a la ayuda que su programa puede proporcionar.

ADHD Y LAS FAMILIAS

Aprenda a manejar el ADHD

Es un reto para toda la familia cuando un miembro de la familia tiene trastorno de déficit de atención/hiperactividad. Algunas veces los padres y los hermanos se frustran con los problemas de comportamiento que el ADHD puede ocasionar. Pero las terapias y medicamentos correctos ayudarán.

Obtenga acceso a su programa para aprender a enfrentar las estrategias que pueden ayudar a su familia a manejarlo mejor.

XYZ company

Su Nombre del Programa

XXX-XXX-XXXX

MAGELLAN BEHAVIORAL HEALTH

MagellanHealth.com/member

 P-A50S (2/13)

Vida Saludable
Trabajo Sano®

El estrés y la ansiedad

Controle su estrés y ansiedad

XYZ company

Su Nombre del Programa
XXX-XXX-XXXX

El estrés y la ansiedad parecen ser parte de la vida cotidiana moderna. Puede ser difícil estar al día con todas las exigencias de nuestro tiempo y energía. Cuando la preocupación y el estrés llegan a ser demasiado, es el momento para desarrollar estrategias que nos permitan sobrellevarlas.

Su programa ofrece recursos para ayudarle a mantenerse saludable y controlar mejor el estrés en su vida diaria.

MAGELLAN HEALTH SERVICES®
Getting Better All the Time™

www.MagellanHealth.com/member

G. Customized Communications for Another Large Client

H. Annual Financial Experience Report

Magellan Behavioral Health
State of New York
Annual Financial Report - 2014
Claims Incurred xx/20xx - xx/20xx Paid through xx/20xx

	Incurred Period				
	Q1 2014	**Q2 2014**	**Q3 2014**	**Q4 2014**	**YTD Qx 2014**
Claims Data:					
Average Membership	-	-	-	-	-
Member Months	-	-	-	-	-
Claims Paid Through xx/20xx	$ -	$ -	$ -	$ -	$ -
Completion Factor	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Estimated Claims Incurred	$ -	$ -	$ -	$ -	$ -
Incurred PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
MLR	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Administration Fees:					
Administration Fee PEPM					
Capitation Paid	$ -	$ -	$ -	$ -	$ -
Performance Credits Applied:					
Performance Guarantee Credits	$ -	$ -	$ -	$ -	$ -
Performance Guarantee 1					$ -
Performance Guarantee 2					$ -
Performance Guarantee 3					$ -

Footnotes:

This report represents claims incurred and paid through (months). All IBNR and data relating to (months) is estimated based on the best information available at the time of report preparation.

Magellan Behavioral Health
State of New York
Quarterly Financial Report - Q1 2014
Claims Incurred xx/20xx - xx/20xx Paid through xx/20xx

	Incurred Period				
	Actuals				
	Q1 2014	**Q2 2014**	**Q3 2014**	**Q4 2014**	**YTD Qx 2014**
Claims Data:					
Average Membership	-	-	-	-	-
Member Months	-	-	-	-	-
Claims Paid Through xx/20xx	$ -	$ -	$ -	$ -	$ -
Completion Factor	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Estimated Claims Incurred	$ -	$ -	$ -	$ -	$ -
Incurred PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
MLR	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Administration Fees:					
Administration Fee PEPM					
Capitation Paid	$ -	$ -	$ -	$ -	$ -
Performance Credits Applied:					
Performance Guarantee Credits	$ -	$ -	$ -	$ -	$ -
Performance Guarantee 1					$ -
Performance Guarantee 2					$ -
Performance Guarantee 3					$ -

	Incurred Period				
	Projected Calendar Year				
	Q1 2014	**Q2 2014**	**Q3 2014**	**Q4 2014**	**2014**
Claims Data:					
Average Membership	-	-	-	-	-
Member Months	-	-	-	-	-
Claims Paid Through xx/20xx					
Completion Factor	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Estimated Claims Incurred	$ -				$ -
Incurred PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
MLR	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Administration Fees:					
Administration Fee PEPM					
Capitation Paid	$ -	$ -	$ -	$ -	$ -
Performance Credits Applied:					
Performance Guarantee Credits	$ -	$ -	$ -	$ -	$ -
Performance Guarantee 1					$ -
Performance Guarantee 2					$ -
Performance Guarantee 3					$ -

Footnotes:
This report represents claims incurred and paid through (months). All IBNR and data relating to (months) is estimated based on the best information available at the time of report preparation.

Magellan Behavioral Health
State of New York
ASO BH Claims Lag
Claims Incurred xx/20xx - xx/20xx Paid through xx/20xx

Paid Month	**Total**	**Prior**	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Jan-14																										
Feb-14																										
Mar-14																										
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Oct-15																										
Nov-15																										
Dec-15																										
Incurred & Paid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Est. Incurred	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Enrollment																										
Pure Premium	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Comp. Factor	-																									
Outstanding	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Entries	**CF**																									
	PP																									

I. Annual Premium Renewal Report

Annual Premium Renewal Report
State Of New York
Prepared by Magellan Health Services
Date:
Data Incurred : April 1, 20xx through March 31, 20xx, Paid through June 30, 20xx

		Product 1				
	YE 3/31/14	Trend	Applied Trend		Renewal Period (CY 2015)	
Member Months	12,000,000		(Projection Period mos)			12,000,000
Members	1,000,000	-		21		1,000,000
IPMH/RTCMH						
Admits /1000	1.20	5%		9%		1.31
Days/1000	6.20	5%		9%		6.75
Average Allowed Per Diem	$ 900	5%		9%	$	980
Average Cost Share Per Diem	$ 180	5%		9%	$	196
Average Paid per Diem	$ 720				$	784
Paid PMPM	$ 0.37	10.25%		18.62%	$	0.44
IPSA/RTCSA						
Admits /1000	1.20	5%		9%		1.31
Days/1000	6.20	5%		9%		6.75
Average Allowed Per Diem	$ 900	5%		9%	$	980
Average Cost Share Per Diem	$ 180	5%		9%	$	196
Average Paid per Diem	$ 720				$	784
Paid PMPM	$ 0.37	10.25%		18.62%	$	0.44
Partial Hospitalization						
Days/1000	6.20	5%		9%		6.75
Average Allowed Per Diem	$ 900	5%		9%	$	980
Average Cost Share Per Diem	$ 180	5%		9%	$	196
Average Paid per Diem	$ 720				$	784

Paid PMPM	$	0.37	10.25%	18.62%	$	0.44
Intensive Outpatient						
Days/1000		6.20	5%	9%		6.75
Average Allowed Per Diem	$	900	5%	9%	$	980
Average Cost Share Per Diem	$	180	5%	9%	$	196
Average Paid per Diem	$	720			$	784
Paid PMPM	$	0.37	10.25%	18.62%	$	0.44
Outpatient						
Days/1000		6.20	5%	9%		6.75
Average Allowed Per Diem	$	900	5%	9%	$	980
Average Cost Share Per Diem	$	180	5%	9%	$	196
Average Paid per Diem	$	720			$	784
Paid PMPM	$	0.37	10.25%	18.62%	$	0.44
Total Cost of Care						
Paid PMPM	$	1.86	10.25%	18.62%	$	2.21

The Full Premium will be calculated upon the Department's addition of the appropriate Administrative Rate Component
IP = Inpatient
RTC = Residential Treatment Center

J. Annual Summary Reporting

Company XYZ

January – December - Annual 20XX

Integrated Employee Assistance, Mental Health and Substance Abuse & Work/Life Program

MAGELLAN

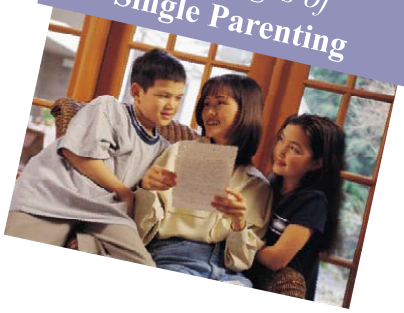
Company XYZ MBH/EAP Supports Employee Life Challenges

Challenges of Caring for an **Elderly Parent**

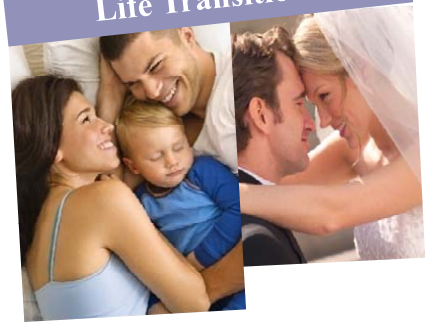
Company XYZ Users of EAP services

- ✓ **90% report improvements at home**
- ✓ **75% Report improvements at work**

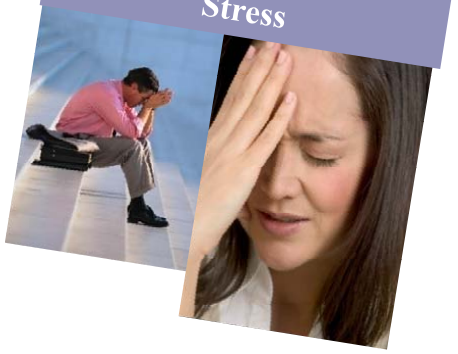
Challenges of **Single Parenting**



Challenges of **Life Transitions**



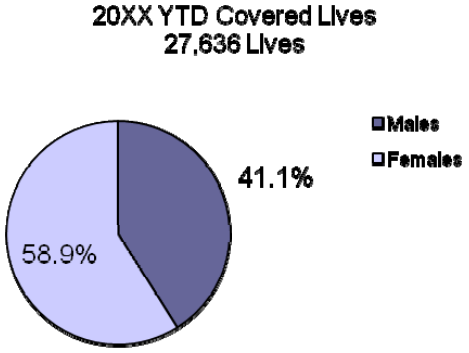
Managing **Stress**

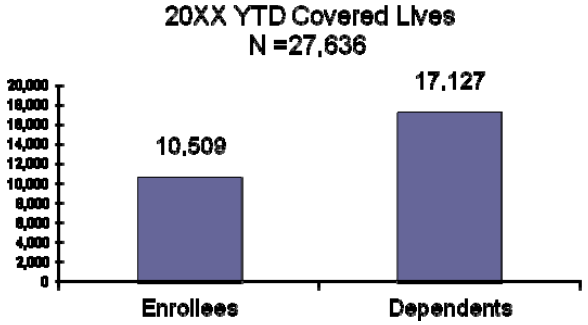


20XX EAP and MBH Program Highlights

- 2.4% decrease in MBH covered lives (20XX = 28,297, 20XX = 27,636)
- Increase in utilization
  - 20XX MBH Overall = 3.8% (BOB= 4.3%), 20XX= 3.47%. This represents an 11% increase in utilization (BOB increased 13.1%)
  - 20XX EAP In-person = 4.2% (BOB= 2.9%), 20XX= 3.3%. This represents a 27.3% increase in utilization (BOB increased 7.4%)
- 20XX MBH Claim dollars paid= $915,527.51, 20XX= $829,585.56
  - Increase of 10.4%, consistent with increased utilization
- MBH Per User costs = $861.27 (BOB $894.24); 2% increase compared to 20XX (BOB increased 5.5%)
- MBH Per Covered Lives costs= $33.12 (BOB= $38.55); 13.0% increase compared to 20XX (BOB increased 19.2%)
- Dependent utilization is 66.3% of MBH claims dollars
- Dependent utilization is 39.7% of EAP usage
- Mood Disorders account for 44.3% of MBH claims dollars & 43.9% of users
- All Performance Guarantees met
- MBH Member Satisfaction= 93.1%
- EAP Member Satisfaction= 100%
- Usage of MagellanHealth.com is twice that of Magellan's BOB

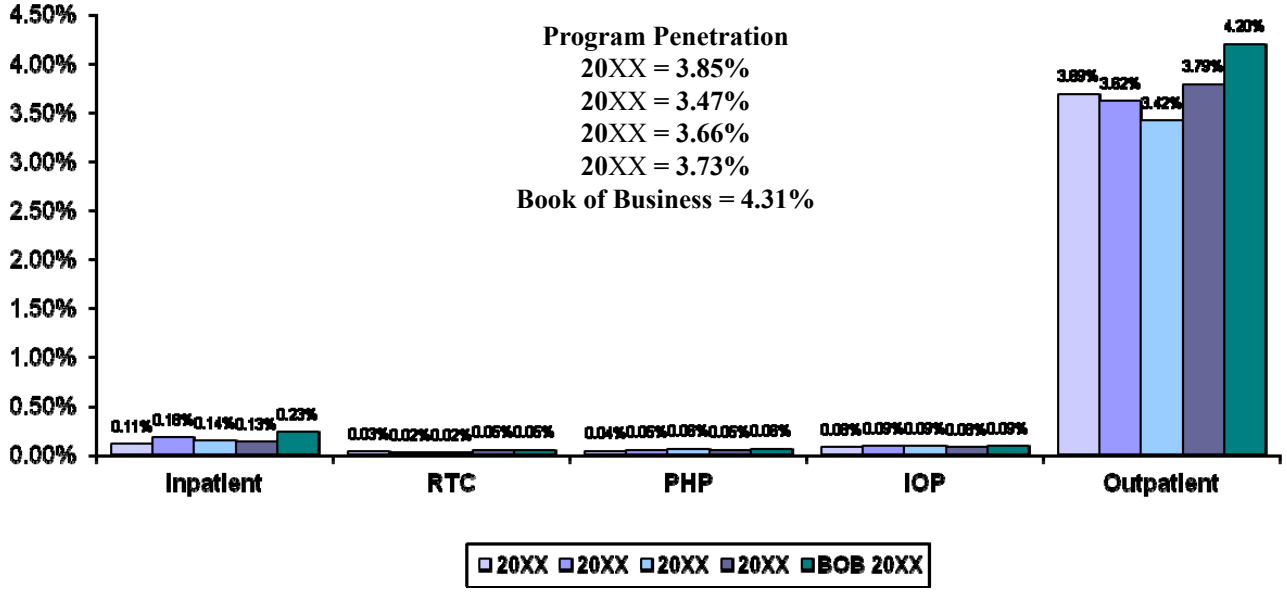
Company XYZ's MBH Population





- 2.4% decrease in covered lives between 20XX (28,297 lives) and 20XX (27,636 lives).
- Dependents account for 62.0% of the covered lives, while Enrollees accounted for 38.0%.
- Females represent 58.9% of the populations

MBH Program Penetration

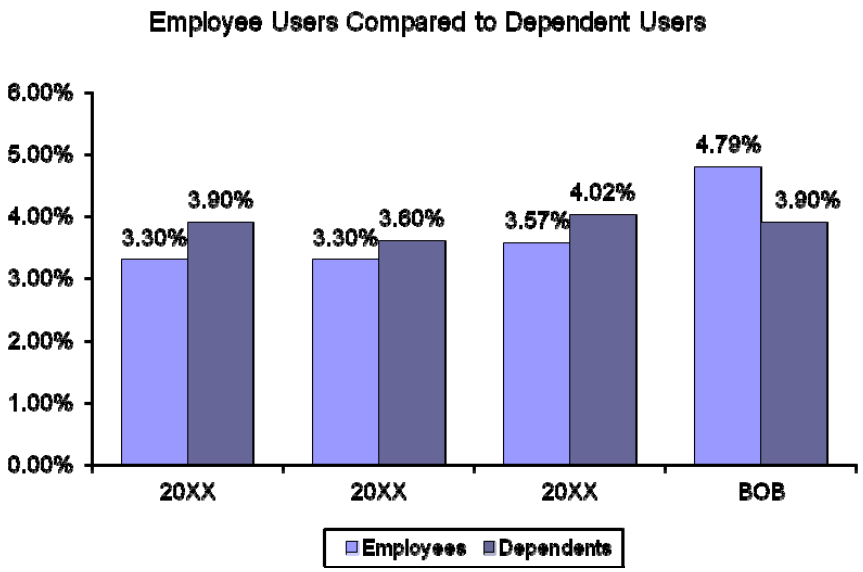


Company XYZ's MBH usage is:

- Stable over time
- Consistently less then Magellan's BOB
- MBH program penetration increased 11%, while
- Magellan's BOB increased 13.1%

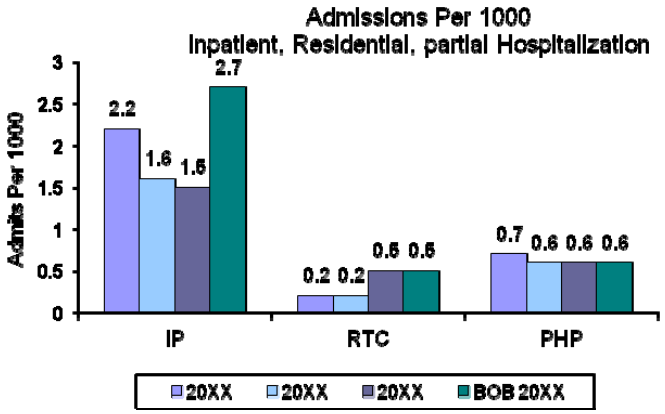
MBH Program Penetration

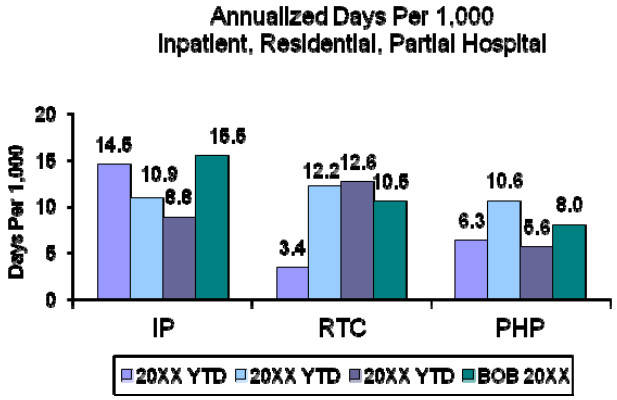
Percent of Employees Users Compared to Dependents Users



- Both employee and dependent utilization increased in 20XX, with the rate of increase being higher among employees.
- Company XYZ's utilization differs from Magellan's BOB in that employee utilization is lower then that of dependents.

MBH Utilization by Level of Care
Inpatient, Residential, Partial Hospital

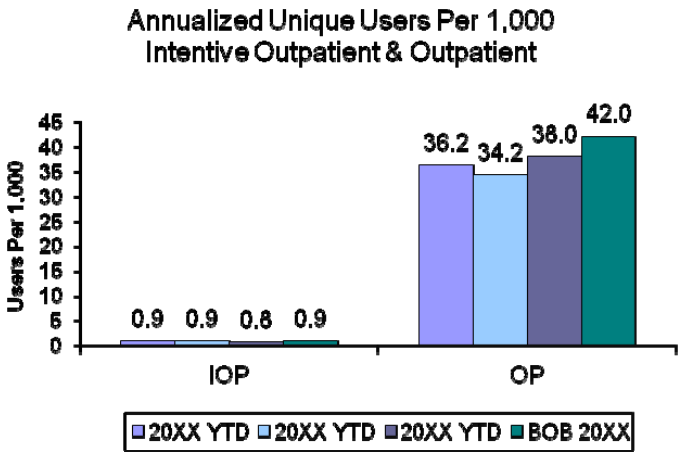


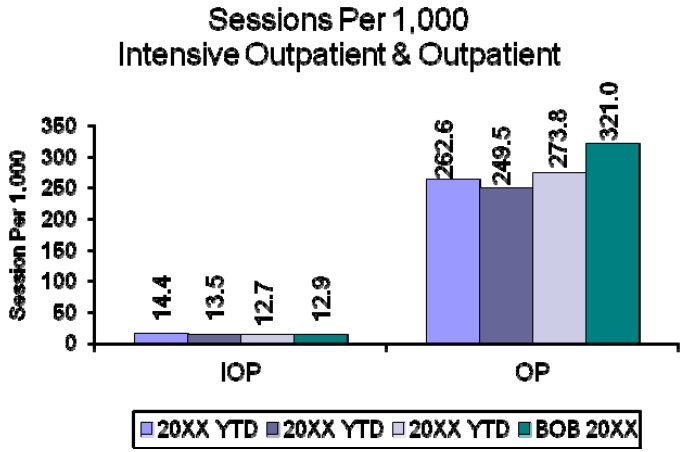


- Company XYZ's inpatient admissions/1000 in 20XX is consistent with that seen in 20XX and remains below the Magellan BOB.
- Admissions per 1000 to residential care in 20XX is over twice that seen in 20XX, but is consistent with the Magellan BOB.
- Admissions per 1000 for partial hospitalization during 20XX is consistent with that seen in 20XX and with the Magellan BOB.
- During 20XX Days/1000 for inpatient care and partial hospitalization decreased in 20XX from that seen in 20XX and are below the Magellan BOB.
- Residential care days/1000 increased slightly from 20XX and is above the Magellan BOB.
- PHP days/1000 decreased significantly in 20XX and remains below Magellan's BOB.

MBH Utilization by Level of Care

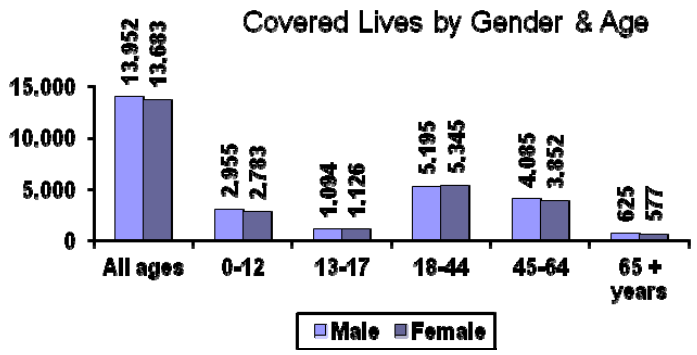
Intensive Outpatient & Outpatient Utilization

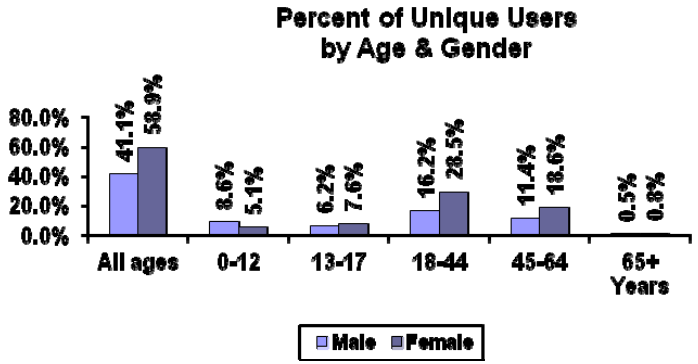




- Company XYZ's users/1000 for IOP remain consistent with that seen in previous years and with Magellan's BOB. During 20XX Outpatient Unique users per 1,000 increased from that seen in 20XX, but remains below the Magellan BOB.
- Company XYZ's outpatient sessions/1000 increased slightly from that seen in previous year, but remains below Magellan's BOB. Intensive Outpatient utilization is consistent with the Magellan BOB.
- Average visits per user of outpatient care is 7.2 sessions and consistent with Magellan's BOB 7.6 sessions.

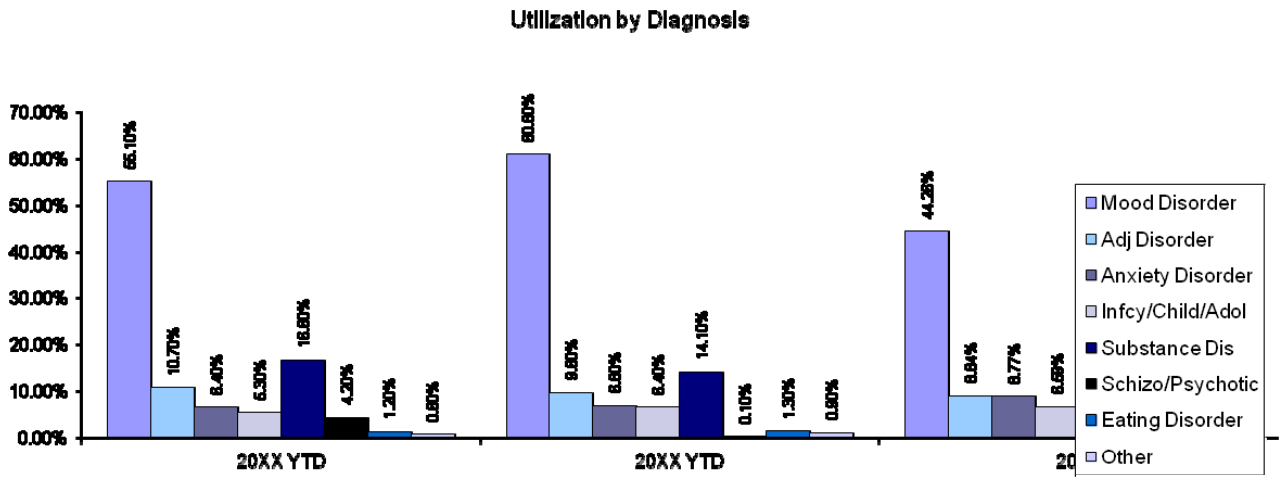
MBH Utilization by Gender and Age





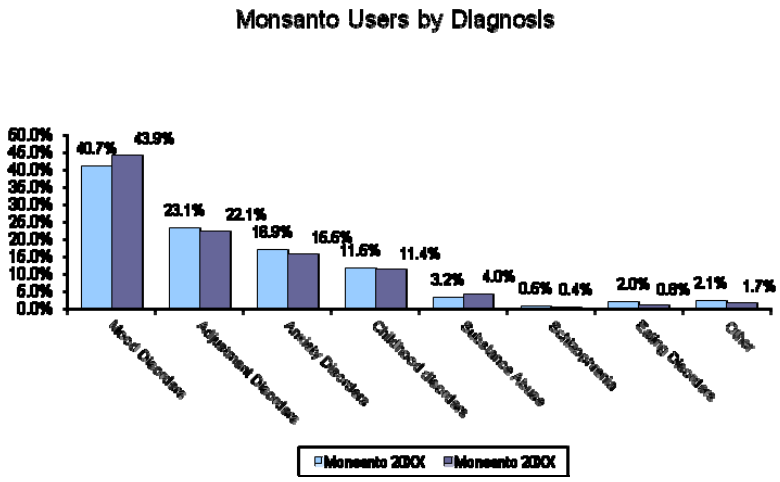
- Males and females are equally represented in each covered lives age group.
- MBH utilization is greater by females in every age category, except 0-12 yrs old. This pattern is consistent over time and consistent with Magellan's BOB.

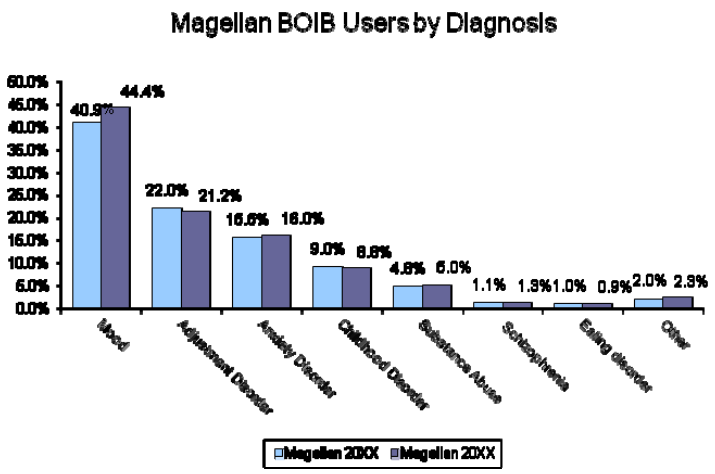
MBH Claims Dollars Paid by Diagnosis



- Mood disorders represent Company XYZ's greatest expense of behavioral health care dollars (44.26%), followed by eating disorders (18.74%) and substance abuse (10.88%).
- The increase in claims dollars for eating disorders is driven by 4 cases which utilized both PHP and Residential levels of care.

MBH Users by Diagnosis





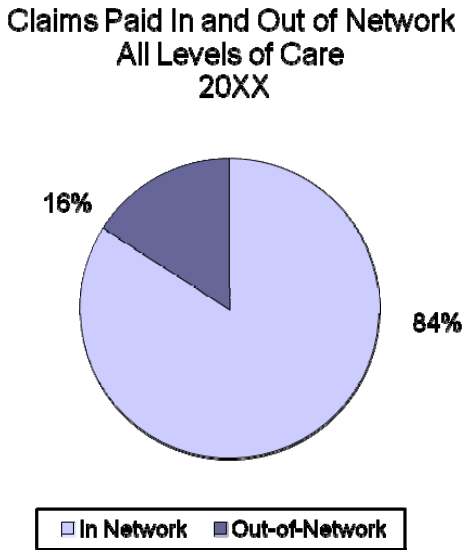
- Company XYZ's distribution of users by diagnosis is very consistent with Magellan's BOB, with the primary difference being Company XYZ's higher rates of childhood disorders and lower rates of substance abuse disorders.
- Company XYZ's volume of depression diagnosis increased in 20XX from 40.7% to 43.9%, however, this increase is consistent with Magellan's BOB experience.

MBH Claims Cost

	20XX	20XX	20XX	Difference 20XX & 20XX	BOB 20XX
Total Claims Pd	$696,777.97	$829,586.56	$915,527.51	↑ 10.4%	N/A
Per User	$757.37	$843.93	$861.27	↑ 2.05%	$894.24
Per Enrollee	$74.49	$77.45	$87.12	↑ 12.5%	$82.71
Per Covered Life	$27.75	$29.32	$33.13	↑ 12.9%	$38.55

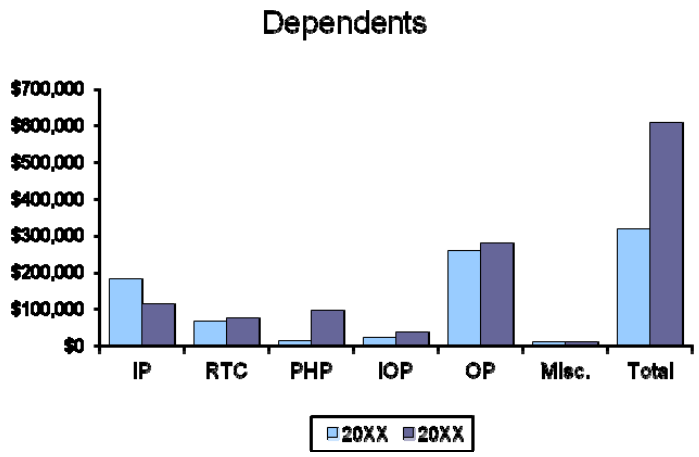
- Total Claims paid during 20XX = $915,527.51 which represents a 10.4% increase from that seen during 20XX. This increase is driven by a 11% increase in overall program penetration.
- Claims cost per user increased 2.05%. This is considerably less then Magellan's BOB cost/user increase of 5.5%
- Cost per enrollee and per covered life also increased in 20XX (12.5% and 12.9% respectively). This is significantly less then Magellan's BOB cost/enrollee and covered life (19.3% and 19.2%)

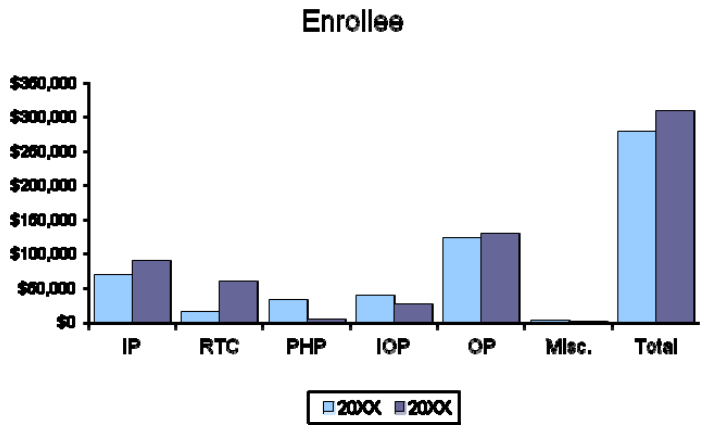
MBH Claims Cost In and Out of Network



- The majority of Company XYZ claims are processed as in-network. This rate has been stable over time.
- 70.7% of Outpatient dollars were paid in 20XX were in-network (20XX= 67.5%).

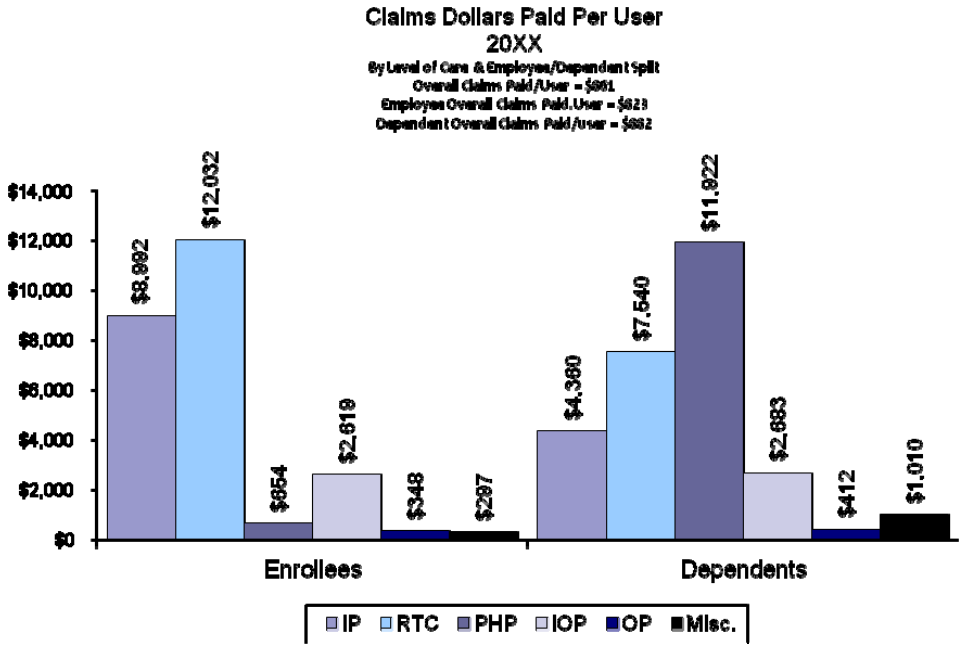
MBH Claims Cost:
Enrollees Compared to Dependents





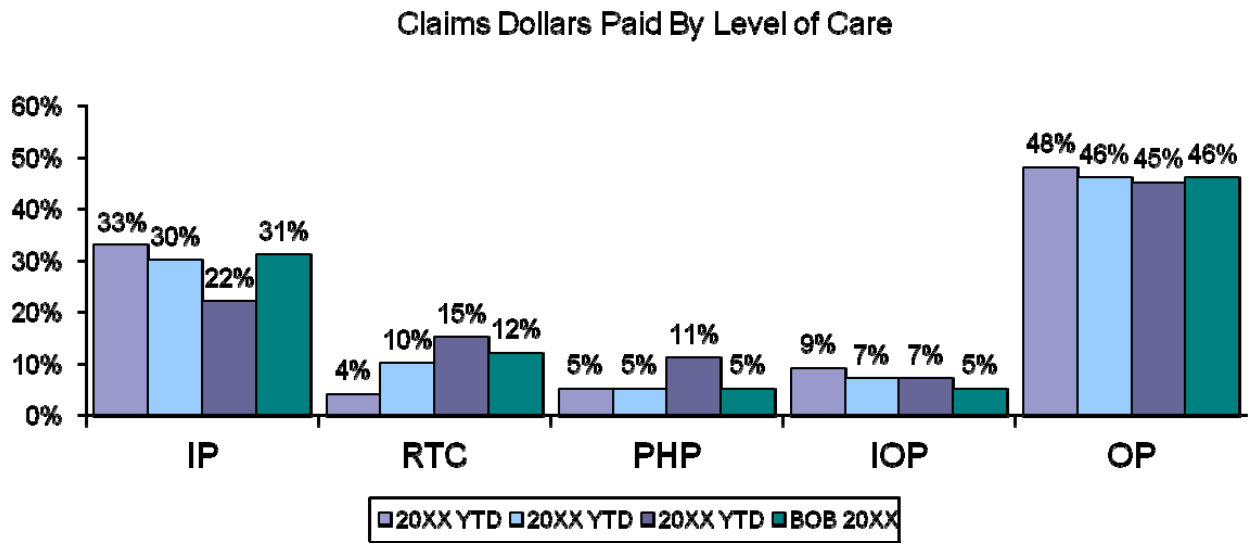
- Dependent utilization accounts for 34% of the total claim dollars paid during 20XX.
- Claims dollars paid during 20XX for dependents ($606,745) is higher than claims paid for enrollees ($308,782). This pattern is typical and is driven by the greater number of dependents (17,127) than enrollees (10,509).
- The increase in Dependent usage of PHP and Enrollee usage of RTC is driven by 4 eating disorder cases.

MBH Claims Cost per User



- Overall costs per user increased from $844 during 20XX to $861 in 20XX. This is considerably less then Magellan's BOB costs per user ($848 in 20XX and $894 in 20XX).
- Enrollee user costs ($823) are lower than dependent user costs ($882). This is driven by enrollee's utilization of less costly levels of care..

MBH Claims Cost by Level of Care (cont.)



- Company XYZ's pattern of claims dollars paid by level of care is stable overtime.
- The majority of Company XYZ's claims dollars are paid for outpatient treatment followed by inpatient.
- Increases in RTC and PHP were driven by 4 eating disorder patients.

MBH Appeals/Reconsiderations

Appeals Summary 20XX YTD						
Company XYZ	**Admin**		**Claims**		**Clinical**	
	Level 1	Level 2	Level 1	Level 2	Level 1	Level 2
# of appeal	6	2	19	0	0	0
# upheld - Retros-Denied	4	1	15	0	0	0
# reversed – Retros - Approved	2	1	4	0	0	0
# partial reversed/Approvals	0	0	0	0	0	0

Company XYZ's MBH Client Satisfaction Survey

Client Satisfaction Survey Report Annual				
	Company XYZ 20XX (# of respondents = 42)	**Company XYZ 20XX** (# of respondents = 51)	**BOB 20XX Midwest CMC** (# respondents=1738)	**BOB 20XX Midwest CMC** (# of respondents=1654)
Your Behavioral Healthcare Company				
Overall quality of phone services	97.0%	85.7%%	92.4%	93.0%
Your Outpatient Therapist And Staff				
Time you waited between calling for your first appointment and day of visit	95.2%	87.8%	91.7%	92.5%
Overall quality of the therapist	92.9%	98.0%	94.2%	95.8%
Your Treatment Facility Program				
Your overall experience	94.1%	87.5%	88.6%	91.3%
Your Overall Treatment Experience				
The overall services you received	95.0%	93.9%	89.6%	91.0%
Magellan compared to other Healthcare Co.'s	94.4%	95.6%	94.4%	95.8%
To what extent has our program met your needs?	92.3%	95.7%	90.9%	92.4%

Network Access 20XX

Psychiatrist	Measure	Performance
Urban	1 Psychiatrist within 10 miles	98%
Suburban	1 Psychiatrist within 25 miles	99%
Rural	1 Psychiatrist within 40 miles	85%

Non-Psychiatrist	Measure	Performance
Urban	1 Non-Psychiatrist within 10 miles	100%
Suburban	1 Non-Psychiatrist within 25 miles	100%
Rural	1 Non-Psychiatrist within 40 miles	97%

In-patient Facility	Measure	Performance
Urban	1 Facility within 25 miles	96%
Suburban	1 Facility within 40 miles	91%
Rural	1 Facility within 60 miles	87%

EAP Providers	Measure	Performance
Urban	2 Provider within 10 miles	100%
Suburban	2 Provider within 25 miles	100%
Rural	2 Provider within 40 miles	95%

Performance Indicators 20XX

Indicator	Performance Standard	20XX
Telephone Access	Customer Service Average Speed of Answer will be ≤ 30 seconds Of first ring	13 seconds
Telephone Abandonment Rate	Customer Service Call Abandonment Rate will be <3.5%	1.5%
Claims Financial Accuracy	Claims financial accuracy will be > 99% YTD measurement	100%
Claims Payment Accuracy	At least 97% of claims will be coded accurately YTD measurement	98.38%
EAP Satisfaction Survey	EAP user satisfaction will be > 85% Minimum of 75 responses	98.9% (n=93) BOB 97.5% (n=11,712)
MC Satisfaction Survey	MC user satisfaction will be > 85% Minimum of 75 Responses Annual measurement	93.9% (n=51) BOB 91.0% (n=1,654)

What's new at Magellan?

Employer Solutions Quarterly Highlights
Program Enhancements/Organizational Updates
4th Quarter 20XX

Monthly Promotional Campaigns

Magellan launched the 20XX *Your Source* monthly campaign schedule and new enhancements, including: Four of the 12 *Your Source* campaigns will be dedicated to management issues. From addressing productivity concerns to creating and sustaining a winning team in a changing environment, these *Your Source* campaigns offer practical, no-nonsense information to help your team do their job even better! Each issue will feature quick read articles and/or facts and stats on the back, truly making *Your Source*, your *one* source for information on issues affecting workplace personnel.

And, for 20XX, we're making registering for live Webinars a breeze. In addition to separate promotional messages with a live registration link, members will be able to access the complete schedule of 20XX Webinars with registration links on our Web site under *Tools, On Demand Learning*. They can find the Webinars they wish to attend and register when it is convenient for them. No waiting!

Webinars

Member Webinar

On December 16, Magellan hosted the live Webinar, *Protecting Your "Techy" Teenagers on the Internet and Beyond!* with member participants. Through this Webinar, members learned about the technology that's available to teens, the risks associated with the Web and how they can help their teens make positive online choices. A recording of this Webinar was posted on MagellanHealth.com/member for those who were unable to attend the live event as part of our expanded Webinar offerings. Magellan began offering live member Webinars in 20XX and continues to offer additional Webinars and recordings available on the member Web site. In 20XX, we look forward to even more Webinars with new ones being made available for supervisors and managers.

Employer Solutions Quarterly Highlights
Program Enhancements/Organizational Updates (continued

4th Quarter Customer Webinar

On December 16, Magellan hosted a special customer Webinar on Comparative Effectiveness in Action, which was co-presented by QualityMetric. Through a joint venture, Magellan and QualityMetric, a well-known measurement company, teamed up to assess health and well-being from the individual's point of view. Through this Webinar, customers learned about:

Disease burden analysis of assessed member to U.S. general population norms
Depression screening results before and after treatment
Measurement of overall health status improvement after treatment
Analysis of cost savings and impact on lost work days

A link to the recorded Webinar was made available to customers that were not able to participate in the live Webinar.

1st quarter 20XX Customer Webinar

Magellan is in the development stage for the upcoming customer Webinar *to be held in early March. Topic and Webinar details are forthcoming. Plan now to attend!*

Employer Solutions Quarterly Highlights
Program Enhancements/Organizational Updates (continued)

Training Updates

Available for Magellan customers with training hours, Magellan's dedicated member training department continues to enhance and develop new training programs to support customers' health and wellness objectives. Some of the recent trainings added in 4th quarter 20XX include:

- *"Understanding and Managing Caregiver Guilt"* is an updated training that includes more current information and a specific focus on caregiver guilt, rather than just guilt as a broad topic
- *"Mind Body Wellness for Professional and Personal Success"* is a new training that emphasizes the importance of overall wellness and the connection between the Mind and the Body.
- *"Healthier Holidays: Emotionally, Physically and Financially"* focuses on three aspects involved in holidays: emotions, physical health and finances.
- *"Parenting and the Power of Positive Discipline"* is an updated training that focuses specifically on discipline and positive parenting.
- *"Learning to Relax"* provides specific relaxation strategies that participants will practice using during the session.
- *"Childhood Stress: Helping Your Child Manage 21st Century Demands"* is a new training that provides participants with tools to help them help their children manage stress.

Magellan also continued to expand our online training offerings. The following courses were added to Magellan's core member Web site under *Online Training*.

Preparing for Life after Deployment
Surviving and Thriving: Living with a Chronic Medical Condition
Solving Workplace Conflicts (manager training)
Creating a Disaster Action Plan

Employer Solutions Quarterly Highlights
Program Enhancements/Organizational Updates (continued)

Influenza A-H1N1 Educational Materials

Influenza A-H1N1 continues to impact customers and members. To support our customers in keeping members informed regarding flu facts and fiction, and providing prevention measures, Magellan provided educational articles for members and their families. In addition, Magellan supported our providers in becoming knowledgeable about Influenza A-H1N1 by developing *Treatments for Influenza and Psychiatric Implications*.

Ongoing Magellan Collaborations and Partnerships

Domestic Violence Research

Magellan participated in an industry evaluation of Domestic Violence services by EAPs conducted by Johns Hopkins University and RTI International Health Social and Economic Research. This paper has not been released to the public yet, but has been made available to Magellan as study participants.

Magellan Presents at S2 Webinar

On November 12, Magellan presented as part of a panel for the Safer, Smarter (S2) Workplace group regarding EAP and employer partnerships to address domestic violence.

Magellan Presents at EAPA's 20XX Annual World EAP Conference

Magellan also presented at EAPA's 20XX Annual World EAP Conference- Meeting the Challenges of a Changing World.

Employer Solutions Quarterly Highlights
Program Enhancements/Organizational Updates (continued)

Dan McCarthy, Magellan's Chief Clinical Officer, presented *Health Care Changes & Employee Assistance Programs: Understanding Mental Health Parity & Consumer-driven Health Plan Opportunities for EAP.* In this session he provided guidance for leveraging the opportunities afforded by consumer-driven plans and Parity in order to increase the reach, relevance and revenue for employee assistance (EA) professionals. With approximately 80 people in attendance, Dan's presentation received a great deal of positive feedback and sparked many intellectual conversations afterward.

Magellan also presented as part of a panel discussion including representatives from Gap, Inc., Johns Hopkins Bloomberg School of Public Health, Department of Health Policy and Management and CIGNA Corporation, focused on domestic violence in the workplace. The panel discussion offered employers and EAPs recommendations on how they can work together to proactively address this issue.

EAPA's annual conference—the world's largest assembly of employee assistance professionals—is a comprehensive learning and networking opportunity dedicated to the development of the employee assistance profession.

Magellan Collaborates with Boston University on Behavioral Health Peer Support Research Study

Magellan regularly collaborates with major universities to conduct research studies in order to further our vision of improving health care and advance our mission of delivering innovative products and services. We're currently partnering in a research project with Boston University's Center for Psychiatric Rehabilitation and Recovery Innovations of Arizona to examine the results of peer support intervention for individuals undergoing court-ordered psychiatric treatment for severe mental illness or substance abuse.

Employer Solutions Quarterly Highlights
Program Enhancements/Organizational Updates (continued)

Results of the study are not yet available, but we expect that they will provide a better understanding of how peer support services help individuals recover and integrate back into their communities while also identifying opportunities for improving the peer support service approach overall. We look forward to using these data to aid us in further developing innovative behavioral health approaches in order to deliver greater value to our members and customers.

Magellan Makes American Heart Association's "Fit-Friendly" List in *Fortune* Magazine

From healthier snacks in Magellan's vending machines to various physical activity programs, Magellan has a commitment to employee wellness. The American Heart Association (AHA) recently took notice of it too and included Magellan on its list of Fit-Friendly Companies, which appeared in *Fortune* magazine's September 28 issue.

The AHA created the list to recognize companies that create healthy lifestyle programs for their employees. Fit-Friendly companies must demonstrate a three-year track record of implementing multiple efforts that promote physical activity, better nutrition and an overall healthy culture.

K. Annual Report of Claims and Credits Paid by Agency

State of NY Empire Plan
Claims and Credits Paid by Agency
Reporting Period: YYYY

					Enrollee Type					
					Active		Retiree		Other	
Year Paid	Year Incurred	Network	Agency Code	Enrollee or Dependend?	# of Claims	Amount Paid	# of Claims	Amount Paid	# of Claims	Amount Paid
2014	2013	In Network	Code 1	Enrollee						
				Dependent						
			Code 2	Enrollee						
				Dependent						
			Code 3	Enrollee						
				Dependent						
			Code 4	Enrollee						
				Dependent						
		Out of Network	Code 1	Enrollee						
				Dependent						
			Code 2	Enrollee						
				Dependent						
			Code 2	Enrollee						
				Dependent						
			Code 4	Enrollee						
				Dependent						
	2012	In Network	Code 1	Enrollee						
				Dependent						
			Code 2	Enrollee						
				Dependent						
			Code 3	Enrollee						
				Dependent						
			Code 4	Enrollee						
				Dependent						
		Out of Network	Code 1	Enrollee						
				Dependent						
			Code 2	Enrollee						
				Dependent						
			Code 2	Enrollee						
				Dependent						
			Code 4	Enrollee						
				Dependent						

* NOTE: This template is based on requirements listed in the RFP. Magellan will work with the Department on the final format.

L. Quarterly Financial Summary Reports

(Please refer to Quarterly Data in attached Annual Report)

Magellan Behavioral Health
State of New York
Annual Financial Report - 2014
Claims Incurred xx/20xx - xx/20xx Paid through xx/20xx

	Incurred Period				
	Q1 2014	**Q2 2014**	**Q3 2014**	**Q4 2014**	**YTD Qx 2014**
Claims Data:					
Average Membership	-	-	-	-	-
Member Months	-	-	-	-	-
Claims Paid Through xx/20xx	$ -	$ -	$ -	$ -	$ -
Completion Factor	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Estimated Claims Incurred	$ -	$ -	$ -	$ -	$ -
Incurred PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
MLR	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Administration Fees:					
Administration Fee PEPM					
Capitation Paid	$ -	$ -	$ -	$ -	$ -
Performance Credits Applied:					
Performance Guarantee Credits	$ -	$ -	$ -	$ -	$ -
Performance Guarantee 1					$ -
Performance Guarantee 2					$ -
Performance Guarantee 3					$ -

Footnotes:

This report represents claims incurred and paid through (months). All IBNR and data relating to (months) is estimated based on the best information available at the time of report preparation.

Magellan Behavioral Health
State of New York
Quarterly Financial Report - Q1 2014
Claims Incurred xx/20xx - xx/20xx Paid through xx/20xx

	Incurred Period				
	Actuals				
	Q1 2014	**Q2 2014**	**Q3 2014**	**Q4 2014**	**YTD Qx 2014**
Claims Data:					
Average Membership	-	-	-	-	-
Member Months	-	-	-	-	-
Claims Paid Through xx/20xx	$ -	$ -	$ -	$ -	$ -
Completion Factor	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Estimated Claims Incurred	$ -	$ -	$ -	$ -	$ -
Incurred PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
MLR	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Administration Fees:					
Administration Fee PEPM					
Capitation Paid	$ -	$ -	$ -	$ -	$ -
Performance Credits Applied:					
Performance Guarantee Credits	$ -	$ -	$ -	$ -	$ -
Performance Guarantee 1					$ -
Performance Guarantee 2					$ -
Performance Guarantee 3					$ -

	Incurred Period				
	Projected Calendar Year				
	Q1 2014	**Q2 2014**	**Q3 2014**	**Q4 2014**	**2014**
Claims Data:					
Average Membership	-	-	-	-	-
Member Months	-	-	-	-	-
Claims Paid Through xx/20xx					
Completion Factor	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Estimated Claims Incurred	$ -				$ -
Incurred PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
MLR	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Administration Fees:					
Administration Fee PEPM					
Capitation Paid	$ -	$ -	$ -	$ -	$ -
Performance Credits Applied:					
Performance Guarantee Credits	$ -	$ -	$ -	$ -	$ -
Performance Guarantee 1					$ -
Performance Guarantee 2					$ -
Performance Guarantee 3					$ -

Footnotes:
This report represents claims incurred and paid through (months). All IBNR and data relating to (months) is estimated based on the best information available at the time of report preparation.

Magellan Behavioral Health
State of New York
ASO BH Claims Lag
Claims Incurred xx/20xx - xx/20xx Paid through xx/20xx

Paid Month	**Total**	**Prior**	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Jan-14																										
Feb-14																										
Mar-14																										
Apr-14																										
May-14																										
Jun-14																										
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Jul-15																										
Aug-15																										
Sep-15																										
Oct-15																										
Nov-15																										
Dec-15																										
Incurred & Paid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Est. Incurred	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Enrollment																										
Pure Premium	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Comp. Factor	-																									
Outstanding	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Entries	**CF**																									
	PP																									

M. Quarterly Performance Guarantee Reports

Performance Guarantees

Indicator	Fourth Quarter 2012
Claims Processing Pay and/or deny 90% of claims w/ in 10 business days or 14 calendar days Pay and/or deny 99% of claims w/ in 20 business days or 30 calendar days	97.73% in 14 CD 99.94% in 30 CD
Claims Processing Accurately pay 99% of claims	100%
Claims Processing Accurately code non-financial information on 96% of claims	100%
Telephone Telephone Service Factor - 90% w/in 30 sec	92%
Telephone Call Abandonment Rate - less than 3% after waiting 10 seconds or more	0.4%
Complaints Resolution of 99% of complaints w/ in 30 days of receipt	7/7 = 100%
Reporting Member utilization w/in 45 days of qtr end, w/ 100% accuracy Paid Claims Extract w/ in 15 days of the end of the prior month	Met

Performance Guarantees

Indicator	Fourth Quarter 2012
Clinical Inpatient re-admission rate - demonstrate overall member IP re-admission rate (w/ in 30 days of discharge) of less than 10%	4.3%
Network Results below measured against a 90% target. 2 Participating Providers (non-facility) within 10 miles (Urban) 2 Participating Providers (non-facility) within 20 miles (Suburban) 2 Participating Providers (non-facility) within 45 miles (Rural) 2 acute care facilities within 30 miles (Urban/Suburban) 1 acute care facility within 60 miles (Rural) **Network Composition** Psychiatrists Psychologists Social Workers Nurses Other Master's Level Therapists Facilities	 100% 100% 99.8% 93.7% 95.3% 7,783 14,733 21,195 1,448 21,242 3,642

Performance Guarantees

Indicator	Annual Measures
Satisfaction Sponsor Achieve 90% overall satisfaction for sponsors w/ score of "4" or "5"	100%
Satisfaction Member Achieve 90% overall satisfaction for users w/ score of "4" or "5"	93.4%
Satisfaction Provider Achieve 90% overall satisfaction for providers w/ score of "4" or "5"	90.6%
Clinical Outcomes Meet improved clinical outcomes on an outpatient treatment basis: -50% of members demonstrate clinically significant improvement in their Emotional Health Score approx 45 days after intake. -Members demonstrate at least a 25% reduction in average days missed from work during the most recent 4 weeks, as measured by the Work-School Participation Score -At least 70% of Members report a strong relationship w/ their Participating provider as measured by their Provider Relationship Score	 55% 15% 76%
Clinical Intensive Care Mgmt - demonstrate at least a 40% increase in overall Emotional Health Score for those participating in intensive care mgmt; measure from date of intake to date of discharge.	Not enough participants

N. Quarterly Utilization Report

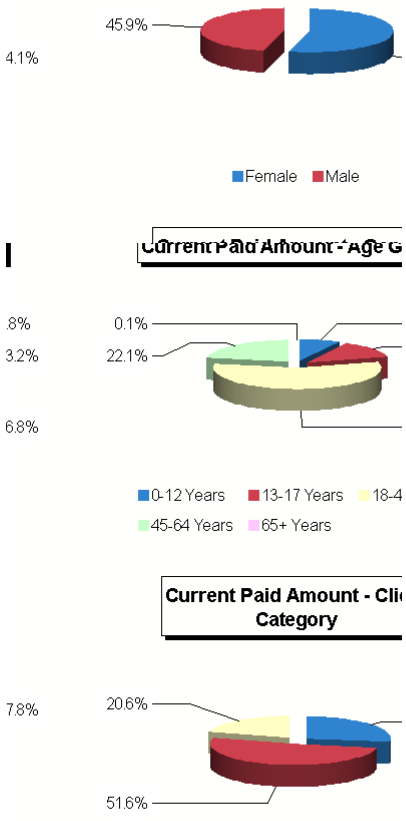
Claims Based Utilization by Demographic Categories

SAMPLE COMPANY

Level of Care Category: All Levels of Care

Current Period
Incurred: 01/01/2010 - 06/30/2010
Paid: 01/01/2010 - 08/31/2010

	Average Membership	Users			Paid Amount		
		Unique Users	% of Unique Users	User/1000	Paid Amount	% of Total Paid	Paid/User
Female							
0-12 Years	14070	208	4.4%	177.40	$137,538	2.7%	$661.24
13-17 Years	5045	242	5.1%	575.62	$248,179	4.9%	$1,025.53
18-44 Years	27746	1664	35.1%	719.67	$1,726,618	34.2%	$1,037.63
45-64 Years	12041	643	13.5%	640.81	$612,055	12.1%	$951.87
65+ Years	347	11	0.2%	380.40	$1,994	0.0%	$181.28
Total - Female	59248	2738	57.7%	554.55	$2,726,385	54.1%	$995.76
Male							
0-12 Years	14497	367	7.7%	303.79	$253,694	5.0%	$691.27
13-17 Years	5030	212	4.5%	505.77	$419,902	8.3%	$1,980.67
18-44 Years	31504	1044	22.0%	397.66	$1,138,778	22.6%	$1,090.78
45-64 Years	12495	401	8.4%	385.11	$504,401	10.0%	$1,257.86
65+ Years	443	4	0.1%	108.35	$531	0.0%	$132.79
Total - Male	63968	2008	42.3%	376.69	$2,317,307	45.9%	$1,154.04
Combined Male/Female							
0-12 Years	28567	575	12.1%	241.54	$391,233	7.8%	$680.40
13-17 Years	10074	454	9.6%	540.80	$668,081	13.2%	$1,471.54
18-44 Years	59250	2708	57.1%	548.46	$2,865,396	56.8%	$1,058.12
45-64 Years	24535	1044	22.0%	510.62	$1,116,456	22.1%	$1,069.40
65+ Years	790	15	0.3%	227.85	$2,525	0.1%	$168.35
Total - Combined	123216	4746	100.0%	462.21	$5,043,692	100.0%	$1,062.72
Eligibility Category							
Dependent	43855	1207	25.4%	330.27	$1,400,649	27.8%	$1,160.44
Spouse	24056	1129	23.8%	563.19	$1,040,807	20.6%	$921.88
Subscriber	55305	2410	50.8%	522.92	$2,602,236	51.6%	$1,079.77
Total - Eligibility Category	123216	4746	100.0%	462.21	$5,043,692	100.0%	$1,062.72



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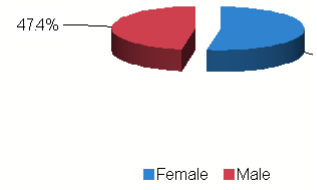
Claims Based Utilization by Demographic Categories

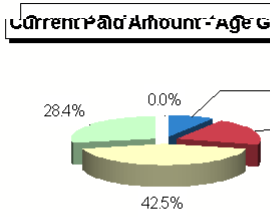
SAMPLE COMPANY

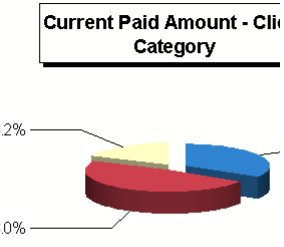
Level of Care Category: Inpatient

Current Period
Incurred: 01/01/2010 - 06/30/2010
Paid: 01/01/2010 - 08/31/2010

	Average Membership	Users			Paid Amount		
		Unique Users	% of Unique Users	User/1000	Paid Amount	% of Total Paid	Paid/User
Female							
0-12 Years	14070	4	1.8%	3.41	$17,969	1.2%	$4,492.27
13-17 Years	5045	13	5.7%	30.92	$113,637	7.7%	$8,741.34
18-44 Years	27746	87	38.2%	37.63	$406,884	27.5%	$4,676.83
45-64 Years	12041	21	9.2%	20.93	$240,983	16.3%	$11,475.37
65+ Years	347	0	0.0%	0.00	$0	0.0%	$0.00
Total - Female	59248	125	54.8%	25.32	$779,474	52.6%	$6,235.79
Male							
0-12 Years	14497	8	3.5%	6.62	$112,494	7.6%	$14,061.80
13-17 Years	5030	16	7.0%	38.17	$186,448	12.6%	$11,653.02
18-44 Years	31504	53	23.2%	20.19	$221,967	15.0%	$4,188.05
45-64 Years	12495	26	11.4%	24.97	$180,130	12.2%	$6,928.07
65+ Years	443	0	0.0%	0.00	$0	0.0%	$0.00
Total - Male	63968	103	45.2%	19.32	$701,039	47.4%	$6,806.21
Combined Male/Female							
0-12 Years	28567	12	5.3%	5.04	$130,463	8.8%	$10,871.96
13-17 Years	10074	29	12.7%	34.54	$300,086	20.3%	$10,347.78
18-44 Years	59250	140	61.4%	28.35	$628,851	42.5%	$4,491.79
45-64 Years	24535	47	20.6%	22.99	$421,113	28.4%	$8,959.85
65+ Years	790	0	0.0%	0.00	$0	0.0%	$0.00
Total - Combined	123216	228	100.0%	22.20	$1,480,513	100.0%	$6,493.48
Eligibility Category							
Dependent	43855	53	23.2%	14.50	$500,619	33.8%	$9,445.63
Spouse	24056	45	19.7%	22.45	$269,165	18.2%	$5,981.44
Subscriber	55305	130	57.0%	28.21	$710,730	48.0%	$5,467.15
Total - Eligibility Category	123216	228	100.0%	22.20	$1,480,513	100.0%	$6,493.48







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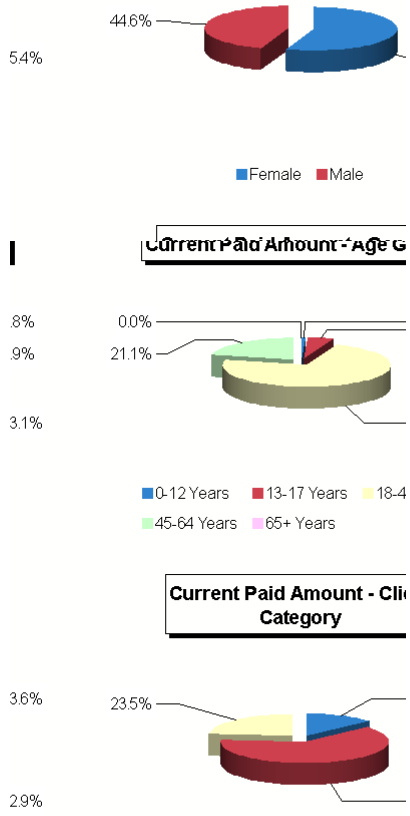
Claims Based Utilization by Demographic Categories

SAMPLE COMPANY

Level of Care Category: Intensive Outpatient

Current Period
Incurred: 01/01/2010 - 06/30/2010
Paid: 01/01/2010 - 08/31/2010

	Average Membership	Users			Paid Amount		
		Unique Users	% of Unique Users	User/1000	Paid Amount	% of Total Paid	Paid/User
Female							
0-12 Years	14070	1	0.8%	0.85	$3,650	0.8%	$3,650.40
13-17 Years	5045	5	4.0%	11.89	$10,158	2.3%	$2,031.66
18-44 Years	27746	60	47.6%	25.95	$203,110	45.3%	$3,385.17
45-64 Years	12041	12	9.5%	11.96	$31,101	6.9%	$2,591.75
65+ Years	347	0	0.0%	0.00	$0	0.0%	$0.00
Total - Female	59248	78	61.9%	15.80	$248,020	55.4%	$3,179.74
Male							
0-12 Years	14497	0	0.0%	0.00	$0	0.0%	$0.00
13-17 Years	5030	2	1.6%	4.77	$11,925	2.7%	$5,962.50
18-44 Years	31504	33	26.2%	12.57	$124,527	27.8%	$3,773.56
45-64 Years	12495	13	10.3%	12.48	$63,560	14.2%	$4,889.25
65+ Years	443	0	0.0%	0.00	$0	0.0%	$0.00
Total - Male	63968	48	38.1%	9.00	$200,013	44.6%	$4,166.93
Combined Male/Female							
0-12 Years	28567	1	0.8%	0.42	$3,650	0.8%	$3,650.40
13-17 Years	10074	7	5.6%	8.34	$22,083	4.9%	$3,154.76
18-44 Years	59250	93	73.8%	18.84	$327,637	73.1%	$3,522.98
45-64 Years	24535	25	19.8%	12.23	$94,661	21.1%	$3,786.45
65+ Years	790	0	0.0%	0.00	$0	0.0%	$0.00
Total - Combined	123216	126	100.0%	12.27	$448,032	100.0%	$3,555.81
Eligibility Category							
Dependent	43855	12	9.5%	3.28	$60,870	13.6%	$5,072.51
Spouse	24056	20	15.9%	9.98	$105,458	23.5%	$5,272.89
Subscriber	55305	94	74.6%	20.40	$281,704	62.9%	$2,996.86
Total - Eligibility Category	123216	126	100.0%	12.27	$448,032	100.0%	$3,555.81



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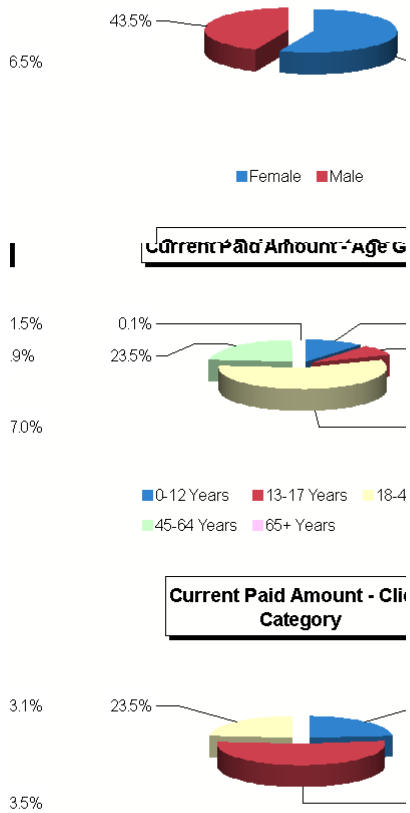
Claims Based Utilization by Demographic Categories

SAMPLE COMPANY

Level of Care Category: Outpatient

Current Period
Incurred: 01/01/2010 - 06/30/2010
Paid: 01/01/2010 - 08/31/2010

	Average Membership	Users			Paid Amount		
		Unique Users	% of Unique Users	User/1000	Paid Amount	% of Total Paid	Paid/User
Female							
0-12 Years	14070	207	4.5%	176.55	$71,327	4.1%	$344.58
13-17 Years	5045	236	5.1%	561.35	$73,919	4.3%	$313.22
18-44 Years	27746	1622	35.0%	701.51	$592,800	34.5%	$365.47
45-64 Years	12041	633	13.7%	630.84	$230,856	13.4%	$364.70
65+ Years	347	11	0.2%	380.40	$1,994	0.1%	$181.28
Total - Female	59248	2679	57.9%	542.60	$970,896	56.5%	$362.41
Male							
0-12 Years	14497	366	7.9%	302.96	$125,637	7.3%	$343.27
13-17 Years	5030	203	4.4%	484.29	$61,486	3.6%	$302.89
18-44 Years	31504	1012	21.9%	385.47	$386,574	22.5%	$381.99
45-64 Years	12495	383	8.3%	367.83	$173,676	10.1%	$453.46
65+ Years	443	4	0.1%	108.35	$531	0.0%	$132.79
Total - Male	63968	1949	42.1%	365.62	$747,904	43.5%	$383.74
Combined Male/Female							
0-12 Years	28567	573	12.4%	240.70	$196,965	11.5%	$343.74
13-17 Years	10074	439	9.5%	522.93	$135,405	7.9%	$308.44
18-44 Years	59250	2634	56.9%	533.47	$979,375	57.0%	$371.82
45-64 Years	24535	1016	22.0%	496.92	$404,531	23.5%	$398.16
65+ Years	790	15	0.3%	227.85	$2,525	0.1%	$168.35
Total - Combined	123216	4628	100.0%	450.72	$1,718,800	100.0%	$371.39
Eligibility Category							
Dependent	43855	1184	25.6%	323.98	$396,381	23.1%	$334.78
Spouse	24056	1104	23.9%	550.71	$403,225	23.5%	$365.24
Subscriber	55305	2340	50.6%	507.73	$919,195	53.5%	$392.82
Total - Eligibility Category	123216	4628	100.0%	450.72	$1,718,800	100.0%	$371.39



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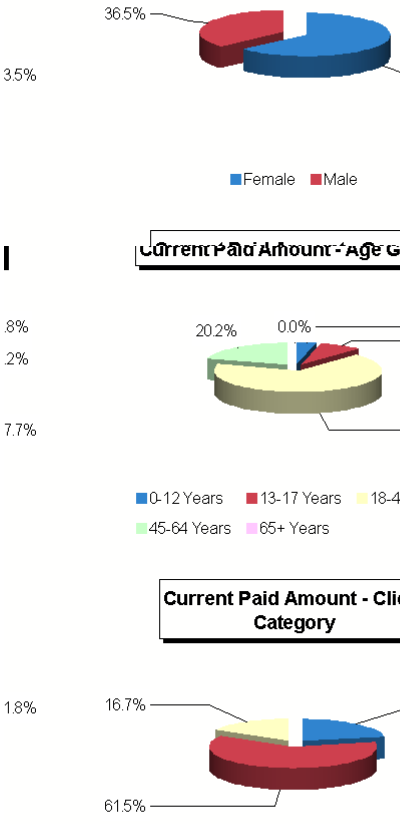
Claims Based Utilization by Demographic Categories

SAMPLE COMPANY

Level of Care Category: Partial Hospitalization

Current Period
Incurred: 01/01/2010 - 06/30/2010
Paid: 01/01/2010 - 08/31/2010

	Average Membership	Users			Paid Amount		
		Unique Users	% of Unique Users	User/1000	Paid Amount	% of Total Paid	Paid/User
Female							
0-12 Years	14070	1	0.8%	0.85	$5,488	1.0%	$5,488.00
13-17 Years	5045	9	7.6%	21.41	$20,368	3.7%	$2,263.16
18-44 Years	27746	48	40.7%	20.76	$250,737	45.7%	$5,223.70
45-64 Years	12041	13	11.0%	12.96	$71,650	13.1%	$5,511.57
65+ Years	347	0	0.0%	0.00	$0	0.0%	$0.00
Total - Female	59248	71	60.2%	14.38	$348,244	63.5%	$4,904.85
Male							
0-12 Years	14497	2	1.7%	1.66	$15,563	2.8%	$7,781.36
13-17 Years	5030	7	5.9%	16.70	$24,736	4.5%	$3,533.68
18-44 Years	31504	28	23.7%	10.67	$120,417	22.0%	$4,300.60
45-64 Years	12495	11	9.3%	10.56	$39,344	7.2%	$3,576.75
65+ Years	443	0	0.0%	0.00	$0	0.0%	$0.00
Total - Male	63968	47	39.8%	8.82	$200,060	36.5%	$4,256.59
Combined Male/Female							
0-12 Years	28567	3	2.5%	1.26	$21,051	3.8%	$7,016.90
13-17 Years	10074	16	13.6%	19.06	$45,104	8.2%	$2,819.01
18-44 Years	59250	76	64.4%	15.39	$371,154	67.7%	$4,883.61
45-64 Years	24535	24	20.3%	11.74	$110,995	20.2%	$4,624.78
65+ Years	790	0	0.0%	0.00	$0	0.0%	$0.00
Total - Combined	123216	118	100.0%	11.49	$548,304	100.0%	$4,646.64
Eligibility Category							
Dependent	43855	25	21.2%	6.84	$119,305	21.8%	$4,772.20
Spouse	24056	16	13.6%	7.98	$91,593	16.7%	$5,724.54
Subscriber	55305	77	65.3%	16.71	$337,406	61.5%	$4,381.90
Total - Eligibility Category	123216	118	100.0%	11.49	$548,304	100.0%	$4,646.64



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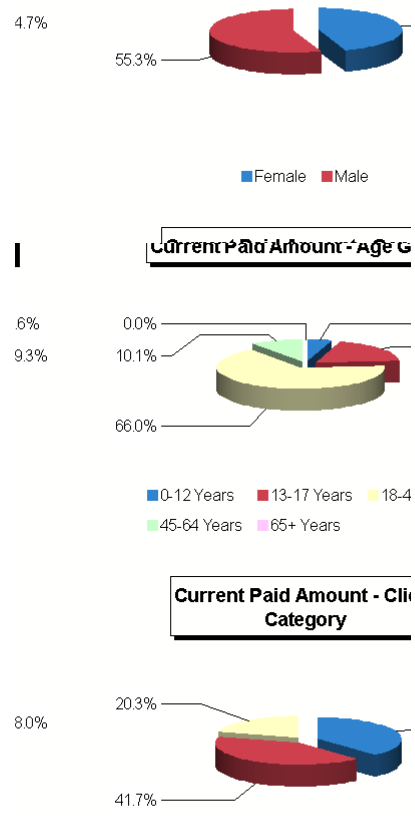
Claims Based Utilization by Demographic Categories

SAMPLE COMPANY

Level of Care Category: Residential

Current Period
Incurred: 01/01/2010 - 06/30/2010
Paid: 01/01/2010 - 08/31/2010

	Average Membership	Users: Unique Users	Users: % of Unique Users	Users: User/1000	Paid Amount: Paid Amount	Paid Amount: % of Total Paid	Paid Amount: Paid/User
Female							
0-12 Years	14070	1	2.2%	0.85	$39,104	4.6%	$39,103.77
13-17 Years	5045	3	6.7%	7.14	$28,254	3.3%	$9,417.99
18-44 Years	27746	14	31.1%	6.05	$273,086	32.3%	$19,506.15
45-64 Years	12041	3	6.7%	2.99	$37,465	4.4%	$12,488.47
65+ Years	347	0	0.0%	0.00	$0	0.0%	$0.00
Total - Female	59248	21	46.7%	4.25	$377,909	44.7%	$17,995.68
Male							
0-12 Years	14497	0	0.0%	0.00	$0	0.0%	$0.00
13-17 Years	5030	2	4.4%	4.77	$135,307	16.0%	$67,653.58
18-44 Years	31504	19	42.2%	7.24	$285,193	33.7%	$15,010.15
45-64 Years	12495	3	6.7%	2.88	$47,691	5.6%	$15,896.97
65+ Years	443	0	0.0%	0.00	$0	0.0%	$0.00
Total - Male	63968	24	53.3%	4.50	$468,191	55.3%	$19,507.96
Combined Male/Female							
0-12 Years	28567	1	2.2%	0.42	$39,104	4.6%	$39,103.77
13-17 Years	10074	5	11.1%	5.96	$163,561	19.3%	$32,712.23
18-44 Years	59250	33	73.3%	6.68	$558,279	66.0%	$16,917.54
45-64 Years	24535	6	13.3%	2.93	$85,156	10.1%	$14,192.72
65+ Years	790	0	0.0%	0.00	$0	0.0%	$0.00
Total - Combined	123216	45	100.0%	4.38	$846,100	100.0%	$18,802.23
Eligibility Category							
Dependent	43855	11	24.4%	3.01	$321,633	38.0%	$29,239.33
Spouse	24056	11	24.4%	5.49	$171,367	20.3%	$15,578.79
Subscriber	55305	23	51.1%	4.99	$353,101	41.7%	$15,352.21
Total - Eligibility Category	123216	45	100.0%	4.38	$846,100	100.0%	$18,802.23



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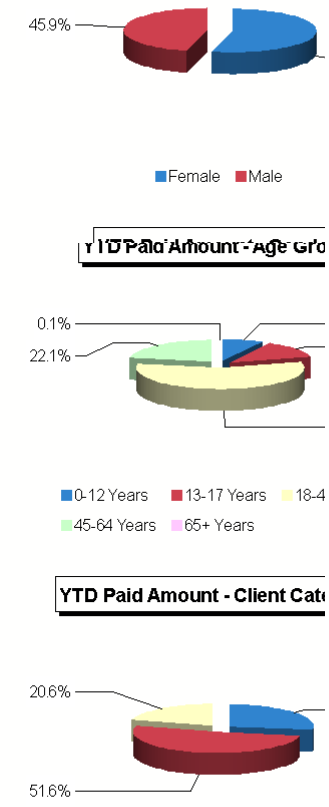
Claims Based Utilization by Demographic Categories

SAMPLE COMPANY

Level of Care Category: All Levels of Care

Year-To-Date
Incurred: 01/01/2010 - 06/30/2010
Paid: 01/01/2010 - 08/31/2010

	Average Membership	Users			Paid Amount		
		Unique Users	% of Unique Users	User/1000	Paid Amount	% of Total Paid	Paid/User
Female							
0-12 Years	14070	208	4.4%	177.40	$137,538	2.7%	$661.24
13-17 Years	5045	242	5.1%	575.62	$248,179	4.9%	$1,025.53
18-44 Years	27746	1664	35.1%	719.67	$1,726,618	34.2%	$1,037.63
45-64 Years	12041	643	13.5%	640.81	$612,055	12.1%	$951.87
65+ Years	347	11	0.2%	380.40	$1,994	0.0%	$181.28
Total - Female	59248	2738	57.7%	554.55	$2,726,385	54.1%	$995.76
Male							
0-12 Years	14497	367	7.7%	303.79	$253,694	5.0%	$691.27
13-17 Years	5030	212	4.5%	505.77	$419,902	8.3%	$1,980.67
18-44 Years	31504	1044	22.0%	397.66	$1,138,778	22.6%	$1,090.78
45-64 Years	12495	401	8.4%	385.11	$504,401	10.0%	$1,257.86
65+ Years	443	4	0.1%	108.35	$531	0.0%	$132.79
Total - Male	63968	2008	42.3%	376.69	$2,317,307	45.9%	$1,154.04
Combined Male/Female							
0-12 Years	28567	575	12.1%	241.54	$391,233	7.8%	$680.40
13-17 Years	10074	454	9.6%	540.80	$668,081	13.2%	$1,471.54
18-44 Years	59250	2708	57.1%	548.46	$2,865,396	56.8%	$1,058.12
45-64 Years	24535	1044	22.0%	510.62	$1,116,456	22.1%	$1,069.40
65+ Years	790	15	0.3%	227.85	$2,525	0.1%	$168.35
Total - Combined	123216	4746	100.0%	462.21	$5,043,692	100.0%	$1,062.72
Eligibility Category							
Dependent	43855	1207	25.4%	330.27	$1,400,649	27.8%	$1,160.44
Spouse	24056	1129	23.8%	563.19	$1,040,807	20.6%	$921.88
Subscriber	55305	2410	50.8%	522.92	$2,602,236	51.6%	$1,079.77
Total - Eligibility Category	123216	4746	100.0%	462.21	$5,043,692	100.0%	$1,062.72



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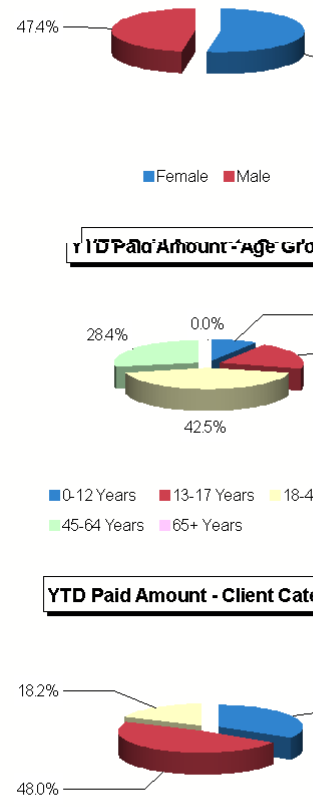
Claims Based Utilization by Demographic Categories

SAMPLE COMPANY

Level of Care Category: Inpatient

	Average Membership	Year-To-Date Users: Unique Users	Users: % of Unique Users	Users: User/1000	Year-To-Date Paid Amount: Paid Amount	Paid Amount: % of Total Paid	Paid Amount: Paid/User
Female							
0-12 Years	14070	4	1.8%	3.41	$17,969	1.2%	$4,492.27
13-17 Years	5045	13	5.7%	30.92	$113,637	7.7%	$8,741.34
18-44 Years	27746	87	38.2%	37.63	$406,884	27.5%	$4,676.83
45-64 Years	12041	21	9.2%	20.93	$240,983	16.3%	$11,475.37
65+ Years	347	0	0.0%	0.00	$0	0.0%	$0.00
Total - Female	59248	125	54.8%	25.32	$779,474	52.6%	$6,235.79
Male							
0-12 Years	14497	8	3.5%	6.62	$112,494	7.6%	$14,061.80
13-17 Years	5030	16	7.0%	38.17	$186,448	12.6%	$11,653.02
18-44 Years	31504	53	23.2%	20.19	$221,967	15.0%	$4,188.05
45-64 Years	12495	26	11.4%	24.97	$180,130	12.2%	$6,928.07
65+ Years	443	0	0.0%	0.00	$0	0.0%	$0.00
Total - Male	63968	103	45.2%	19.32	$701,039	47.4%	$6,806.21
Combined Male/Female							
0-12 Years	28567	12	5.3%	5.04	$130,463	8.8%	$10,871.96
13-17 Years	10074	29	12.7%	34.54	$300,086	20.3%	$10,347.78
18-44 Years	59250	140	61.4%	28.35	$628,851	42.5%	$4,491.79
45-64 Years	24535	47	20.6%	22.99	$421,113	28.4%	$8,959.85
65+ Years	790	0	0.0%	0.00	$0	0.0%	$0.00
Total - Combined	123216	228	100.0%	22.20	$1,480,513	100.0%	$6,493.48
Eligibility Category							
Dependent	43855	53	23.2%	14.50	$500,619	33.8%	$9,445.63
Spouse	24056	45	19.7%	22.45	$269,165	18.2%	$5,981.44
Subscriber	55305	130	57.0%	28.21	$710,730	48.0%	$5,467.15
Total - Eligibility Category	123216	228	100.0%	22.20	$1,480,513	100.0%	$6,493.48



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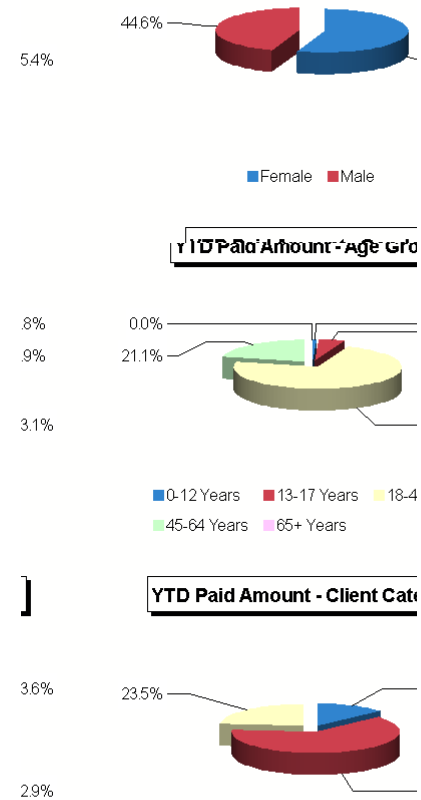
Claims Based Utilization by Demographic Categories

SAMPLE COMPANY

Level of Care Category: Intensive Outpatient

		Year-To-Date Incurred: 01/01/2010 - 06/30/2010 Paid: 01/01/2010 - 08/31/2010					
		Users			Paid Amount		
	Average Membership	Unique Users	% of Unique Users	User/1000	Paid Amount	% of Total Paid	Paid/User
Female							
0-12 Years	14070	1	0.8%	0.85	$3,650	0.8%	$3,650.40
13-17 Years	5045	5	4.0%	11.89	$10,158	2.3%	$2,031.66
18-44 Years	27746	60	47.6%	25.95	$203,110	45.3%	$3,385.17
45-64 Years	12041	12	9.5%	11.96	$31,101	6.9%	$2,591.75
65+ Years	347	0	0.0%	0.00	$0	0.0%	$0.00
Total - Female	59248	78	61.9%	15.80	$248,020	55.4%	$3,179.74
Male							
0-12 Years	14497	0	0.0%	0.00	$0	0.0%	$0.00
13-17 Years	5030	2	1.6%	4.77	$11,925	2.7%	$5,962.50
18-44 Years	31504	33	26.2%	12.57	$124,527	27.8%	$3,773.56
45-64 Years	12495	13	10.3%	12.48	$63,560	14.2%	$4,889.25
65+ Years	443	0	0.0%	0.00	$0	0.0%	$0.00
Total - Male	63968	48	38.1%	9.00	$200,013	44.6%	$4,166.93
Combined Male/Female							
0-12 Years	28567	1	0.8%	0.42	$3,650	0.8%	$3,650.40
13-17 Years	10074	7	5.6%	8.34	$22,083	4.9%	$3,154.76
18-44 Years	59250	93	73.8%	18.84	$327,637	73.1%	$3,522.98
45-64 Years	24535	25	19.8%	12.23	$94,661	21.1%	$3,786.45
65+ Years	790	0	0.0%	0.00	$0	0.0%	$0.00
Total - Combined	123216	126	100.0%	12.27	$448,032	100.0%	$3,555.81
Eligibility Category							
Dependent	43855	12	9.5%	3.28	$60,870	13.6%	$5,072.51
Spouse	24056	20	15.9%	9.98	$105,458	23.5%	$5,272.89
Subscriber	55305	94	74.6%	20.40	$281,704	62.9%	$2,996.86
Total - Eligibility Category	123216	126	100.0%	12.27	$448,032	100.0%	$3,555.81



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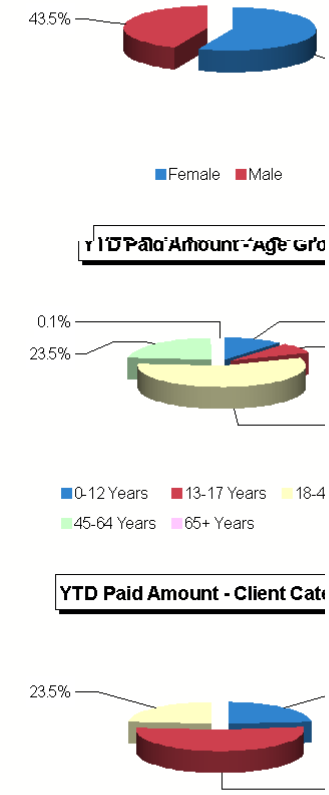
Claims Based Utilization by Demographic Categories

SAMPLE COMPANY

Level of Care Category: Outpatient

Year-To-Date
Incurred: 01/01/2010 - 06/30/2010
Paid: 01/01/2010 - 08/31/2010

	Average Membership	Users			Paid Amount		
		Unique Users	% of Unique Users	User/1000	Paid Amount	% of Total Paid	Paid/User
Female							
0-12 Years	14070	207	4.5%	176.55	$71,327	4.1%	$344.58
13-17 Years	5045	236	5.1%	561.35	$73,919	4.3%	$313.22
18-44 Years	27746	1622	35.0%	701.51	$592,800	34.5%	$365.47
45-64 Years	12041	633	13.7%	630.84	$230,856	13.4%	$364.70
65+ Years	347	11	0.2%	380.40	$1,994	0.1%	$181.28
Total - Female	59248	2679	57.9%	542.60	$970,896	56.5%	$362.41
Male							
0-12 Years	14497	366	7.9%	302.96	$125,637	7.3%	$343.27
13-17 Years	5030	203	4.4%	484.29	$61,486	3.6%	$302.89
18-44 Years	31504	1012	21.9%	385.47	$386,574	22.5%	$381.99
45-64 Years	12495	383	8.3%	367.83	$173,676	10.1%	$453.46
65+ Years	443	4	0.1%	108.35	$531	0.0%	$132.79
Total - Male	63968	1949	42.1%	365.62	$747,904	43.5%	$383.74
Combined Male/Female							
0-12 Years	28567	573	12.4%	240.70	$196,965	11.5%	$343.74
13-17 Years	10074	439	9.5%	522.93	$135,405	7.9%	$308.44
18-44 Years	59250	2634	56.9%	533.47	$979,375	57.0%	$371.82
45-64 Years	24535	1016	22.0%	496.92	$404,531	23.5%	$398.16
65+ Years	790	15	0.3%	227.85	$2,525	0.1%	$168.35
Total - Combined	123216	4628	100.0%	450.72	$1,718,800	100.0%	$371.39
Eligibility Category							
Dependent	43855	1184	25.6%	323.98	$396,381	23.1%	$334.78
Spouse	24056	1104	23.9%	550.71	$403,225	23.5%	$365.24
Subscriber	55305	2340	50.6%	507.73	$919,195	53.5%	$392.82
Total - Eligibility Category	123216	4628	100.0%	450.72	$1,718,800	100.0%	$371.39



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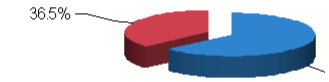
Claims Based Utilization by Demographic Categories

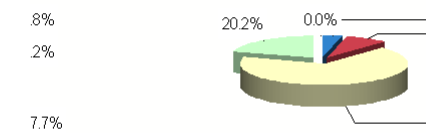
SAMPLE COMPANY

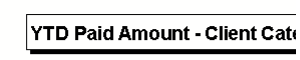
Level of Care Category: Partial Hospitalization

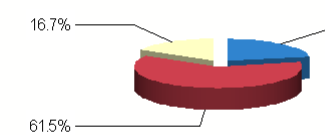
Year-To-Date
Incurred: 01/01/2010 - 06/30/2010
Paid: 01/01/2010 - 08/31/2010

	Average Membership	Users			Paid Amount		
		Unique Users	% of Unique Users	User/1000	Paid Amount	% of Total Paid	Paid/User
Female							
0-12 Years	14070	1	0.8%	0.85	$5,488	1.0%	$5,488.00
13-17 Years	5045	9	7.6%	21.41	$20,368	3.7%	$2,263.16
18-44 Years	27746	48	40.7%	20.76	$250,737	45.7%	$5,223.70
45-64 Years	12041	13	11.0%	12.96	$71,650	13.1%	$5,511.57
65+ Years	347	0	0.0%	0.00	$0	0.0%	$0.00
Total - Female	59248	71	60.2%	14.38	$348,244	63.5%	$4,904.85
Male							
0-12 Years	14497	2	1.7%	1.66	$15,563	2.8%	$7,781.36
13-17 Years	5030	7	5.9%	16.70	$24,736	4.5%	$3,533.68
18-44 Years	31504	28	23.7%	10.67	$120,417	22.0%	$4,300.60
45-64 Years	12495	11	9.3%	10.56	$39,344	7.2%	$3,576.75
65+ Years	443	0	0.0%	0.00	$0	0.0%	$0.00
Total - Male	63968	47	39.8%	8.82	$200,060	36.5%	$4,256.59
Combined Male/Female							
0-12 Years	28567	3	2.5%	1.26	$21,051	3.8%	$7,016.90
13-17 Years	10074	16	13.6%	19.06	$45,104	8.2%	$2,819.01
18-44 Years	59250	76	64.4%	15.39	$371,154	67.7%	$4,883.61
45-64 Years	24535	24	20.3%	11.74	$110,995	20.2%	$4,624.78
65+ Years	790	0	0.0%	0.00	$0	0.0%	$0.00
Total - Combined	123216	118	100.0%	11.49	$548,304	100.0%	$4,646.64
Eligibility Category							
Dependent	43855	25	21.2%	6.84	$119,305	21.8%	$4,772.20
Spouse	24056	16	13.6%	7.98	$91,593	16.7%	$5,724.54
Subscriber	55305	77	65.3%	16.71	$337,406	61.5%	$4,381.90
Total - Eligibility Category	123216	118	100.0%	11.49	$548,304	100.0%	$4,646.64









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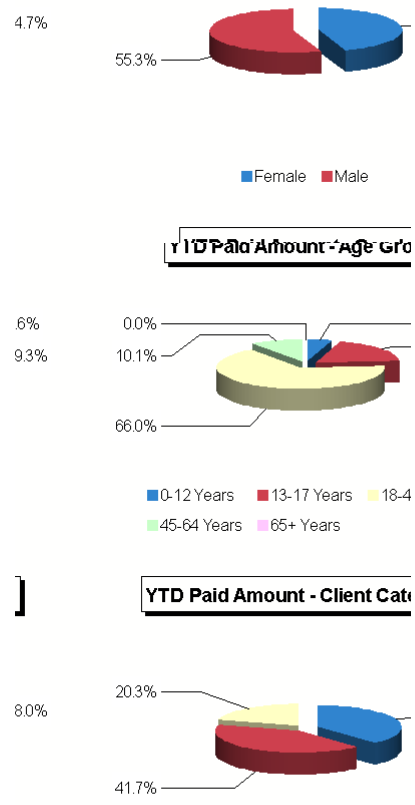
Claims Based Utilization by Demographic Categories

SAMPLE COMPANY

Level of Care Category: Residential

Year-To-Date
Incurred: 01/01/2010 - 06/30/2010
Paid: 01/01/2010 - 08/31/2010

	Average Membership	Users			Paid Amount		
		Unique Users	% of Unique Users	User/1000	Paid Amount	% of Total Paid	Paid/User
Female							
0-12 Years	14070	1	2.2%	0.85	$39,104	4.6%	$39,103.77
13-17 Years	5045	3	6.7%	7.14	$28,254	3.3%	$9,417.99
18-44 Years	27746	14	31.1%	6.05	$273,086	32.3%	$19,506.15
45-64 Years	12041	3	6.7%	2.99	$37,465	4.4%	$12,488.47
65+ Years	347	0	0.0%	0.00	$0	0.0%	$0.00
Total - Female	59248	21	46.7%	4.25	$377,909	44.7%	$17,995.68
Male							
0-12 Years	14497	0	0.0%	0.00	$0	0.0%	$0.00
13-17 Years	5030	2	4.4%	4.77	$135,307	16.0%	$67,653.58
18-44 Years	31504	19	42.2%	7.24	$285,193	33.7%	$15,010.15
45-64 Years	12495	3	6.7%	2.88	$47,691	5.6%	$15,896.97
65+ Years	443	0	0.0%	0.00	$0	0.0%	$0.00
Total - Male	63968	24	53.3%	4.50	$468,191	55.3%	$19,507.96
Combined Male/Female							
0-12 Years	28567	1	2.2%	0.42	$39,104	4.6%	$39,103.77
13-17 Years	10074	5	11.1%	5.96	$163,561	19.3%	$32,712.23
18-44 Years	59250	33	73.3%	6.68	$558,279	66.0%	$16,917.54
45-64 Years	24535	6	13.3%	2.93	$85,156	10.1%	$14,192.72
65+ Years	790	0	0.0%	0.00	$0	0.0%	$0.00
Total - Combined	123216	45	100.0%	4.38	$846,100	100.0%	$18,802.23
Eligibility Category							
Dependent	43855	11	24.4%	3.01	$321,633	38.0%	$29,239.33
Spouse	24056	11	24.4%	5.49	$171,367	20.3%	$15,578.79
Subscriber	55305	23	51.1%	4.99	$353,101	41.7%	$15,352.21
Total - Eligibility Category	123216	45	100.0%	4.38	$846,100	100.0%	$18,802.23



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+*Total User count is a distinct count of users regardless of age groupings. A user is counted only once if falls within more than one age group.

Transfer To Excel

Claims Based Utilization by Demographic Categories

This report was generated with the following parameters :

Current Period:
Incurred Start Date = 01/01/2010
Incurred End Date = 06/30/2010
Paid Start Date = 01/01/2010
Paid End Date = 08/31/2010

Year-To-Date:
Incurred Start Date = 01/01/2010
Incurred End Date = 06/30/2010
Paid Start Date = 01/01/2010
Paid End Date = 08/31/2010

Combine Norm = Y

Norm Reporting Group = ('42037')

Norm Period:
Incurred Start Date = 01/01/2010
Incurred End Date = 06/30/2010
Paid Start Date = 01/01/2010
Paid End Date = 08/31/2010

Level of Care = All Levels Of Care

Reporting Group Name/Reporting Entity Name

123456 – SAMPLE COMPANY

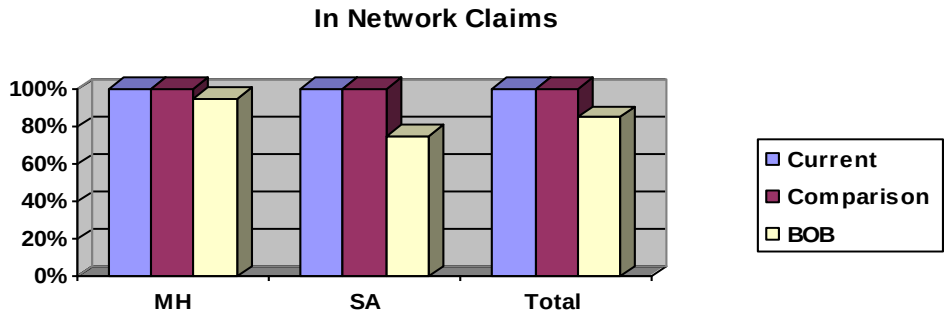
***A User may be counted in more than one age group**

+*Total User count is a distinct count of users regardless of age groupings. A user is counted only once if falls within more than one age group.

Claim Paid Amount – In Network vs. Out of Network by Level of Care

Sample Company

	Reporting Period Incurred: 01/01/2008 - 03/31/2008 Paid: 01/01/2008 - 03/31/2008				Comparison Period Incurred: 01/01/2008 - 03/31/2008 Paid: 01/01/2008 - 03/31/2008				BOB Period Incurred: 01/01/2008 - 03/31/2008 Paid: 01/01/2008 - 03/31/2008
	In Network	Out of Network	Total	% In Network	In Network	Out of Network	Total	% In Network	% In Network
All Levels of Care									
Mental Health Users	$3,060.00	$0.00	$3,060.00	100.0%	$3,060.00	$0.00	$3,060.00	100.0%	**95.0%**
Substance Abuse Users	$2,975.00	$0.00	$2,975.00	100.0%	$2,975.00	$0.00	$2,975.00	100.0%	**75.0%**
Total Paid Amount Users	**$6,035.00**	**$0.00**	**$6,035.00**	**100.0%**	**$6,035.00**	**$0.00**	**$6,035.00**	**100.0%**	**85.0%**



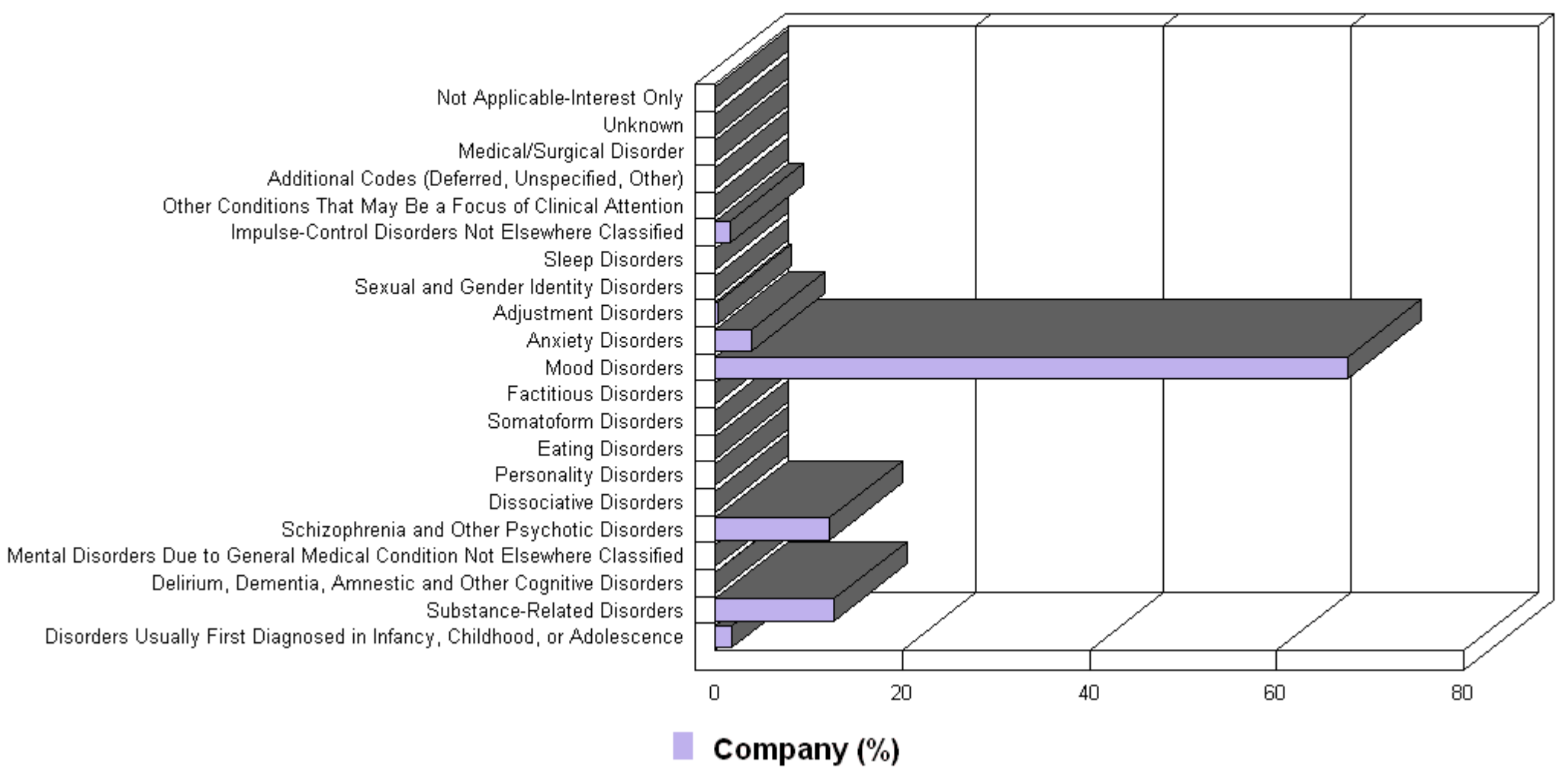
Utilization by Primary Diagnostic Classification by Level of Care - Claim Based

Sample Company

Level of Care Category: Inpatient

Primary Diagnostic Category	Current Period Incurred: 01/01/2006 - 12/31/2006 Paid: 10/01/2006 - 12/31/2006				Year-To-Date Incurred: 01/01/2006 - 12/31/2006 Paid: 01/01/2006 - 12/31/2006			
	Users		Paid Amount		Users		Paid Amount	
	Company		Company		Company		Company	
	Number	%	Amount	%	Number	%	Amount	%
Disorders Usually First Diagnosed in Infancy, Childhood, or	1	2.9%	$9,100.00	4.3%	1	0.9%	$11,243.00	1.7%
Substance-Related Disorders	3	8.8%	$28,907.72	13.7%	15	14.0%	$83,115.98	12.7%
Delirium, Dementia, Amnestic and Other Cognitive Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$350.00	0.1%
Mental Disorders Due to General Medical Condition Not	0	0.0%	$164.00	0.1%	0	0.0%	$164.00	0.0%
Schizophrenia and Other Psychotic Disorders	4	11.8%	$52,103.50	24.7%	6	5.6%	$79,839.90	12.2%
Dissociative Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Personality Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Eating Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Somatoform Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Factitious Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Mood Disorders	22	64.7%	$106,220.99	50.3%	81	75.7%	$442,923.04	67.6%
Anxiety Disorders	3	8.8%	$12,400.42	5.9%	5	4.7%	$25,322.85	3.9%
Adjustment Disorders	1	2.9%	$1,299.53	0.6%	2	1.9%	$1,779.53	0.3%
Sexual and Gender Identity Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Sleep Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Impulse-Control Disorders Not Elsewhere Classified	0	0.0%	$930.00	0.4%	2	1.9%	$10,727.20	1.6%
Other Conditions That May Be a Focus of Clinical Attention	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Additional Codes (Deferred, Unspecified, Other)	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Medical/Surgical Disorder	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Unknown	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Not Applicable-Interest Only	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
+*Total	**34**		**$211,126.16**	**100.0%**	**107**		**$655,465.50**	**100.0%**

YTD Percent of Benefits Paid by Diagnostic Category



* A User may be counted in multiple diagnostic categories.

+* Total User count is a distinct count of users regardless of diagnosis grouping. A user is counted only once if seen for multiple diagnoses.

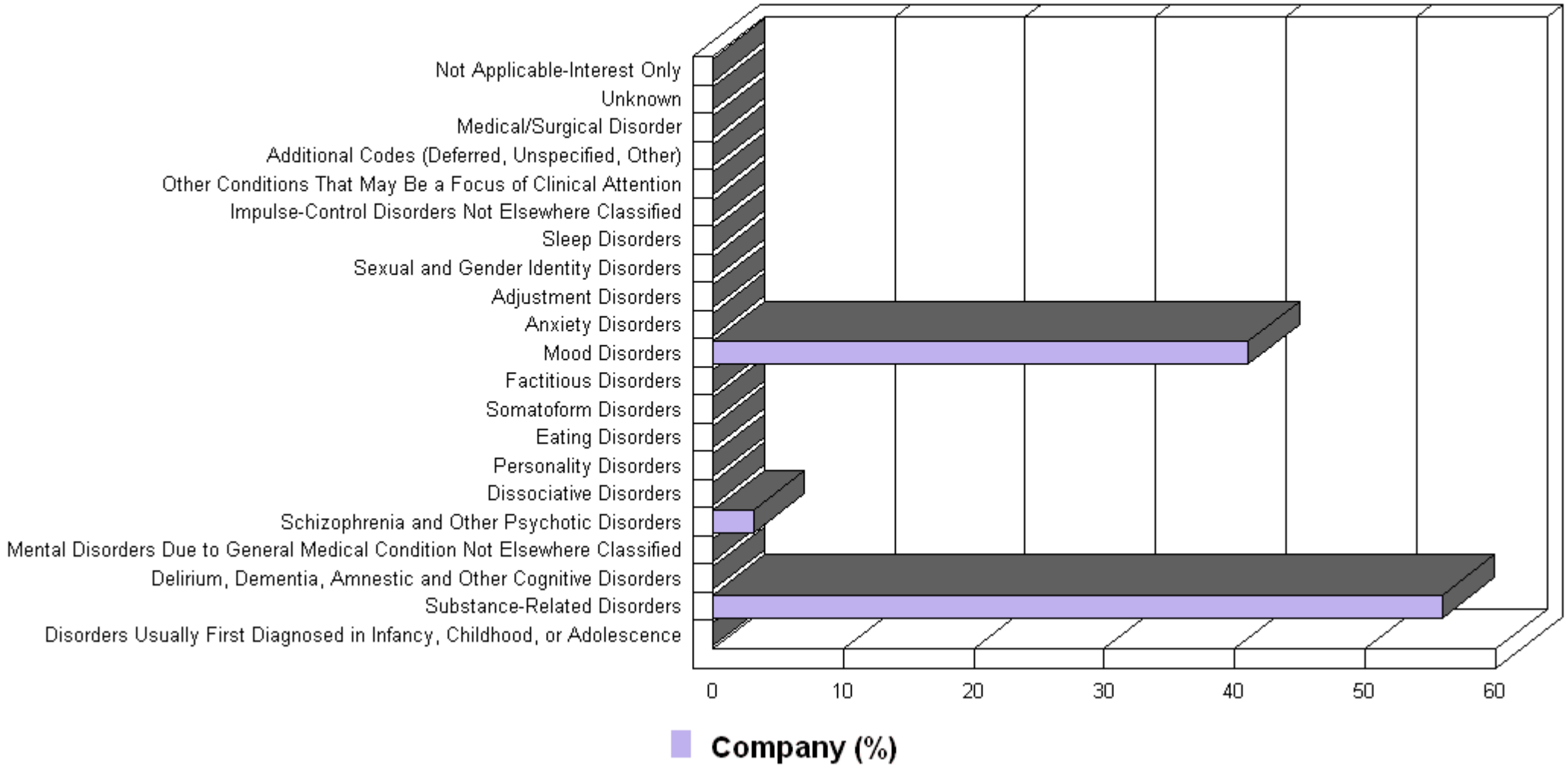
Utilization by Primary Diagnostic Classification by Level of Care - Claim Based

Sample Company

Level of Care Category: Intensive Outpatient

	Current Period Incurred: 01/01/2006 - 12/31/2006 Paid: 10/01/2006 - 12/31/2006				Year-To-Date Incurred: 01/01/2006 - 12/31/2006 Paid: 01/01/2006 - 12/31/2006			
	Users		Paid Amount		Users		Paid Amount	
	Company		Company		Company		Company	
Primary Diagnostic Category	**Number**	**%**	**Amount**	**%**	**Number**	**%**	**Amount**	**%**
Disorders Usually First Diagnosed in Infancy, Childhood, or	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Substance-Related Disorders	11	61.1%	$14,330.60	47.5%	27	57.4%	$56,584.60	55.9%
Delirium, Dementia, Amnestic and Other Cognitive Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Mental Disorders Due to General Medical Condition Not	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Schizophrenia and Other Psychotic Disorders	1	5.6%	$1,500.00	5.0%	1	2.1%	$3,125.00	3.1%
Dissociative Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Personality Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Eating Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Somatoform Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Factitious Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Mood Disorders	6	33.3%	$14,354.80	47.6%	19	40.4%	$41,439.64	41.0%
Anxiety Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Adjustment Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Sexual and Gender Identity Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Sleep Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Impulse-Control Disorders Not Elsewhere Classified	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Other Conditions That May Be a Focus of Clinical Attention	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Additional Codes (Deferred, Unspecified, Other)	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Medical/Surgical Disorder	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Unknown	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Not Applicable-Interest Only	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
+*Total	**18**		**$30,185.40**	**100.0%**	**47**		**$101,149.24**	**100.0%**

YTD Percent of Benefits Paid by Diagnostic Category



* A User may be counted in multiple diagnostic categories.

+* Total User count is a distinct count of users regardless of diagnosis grouping. A user is counted only once if seen for multiple diagnoses.

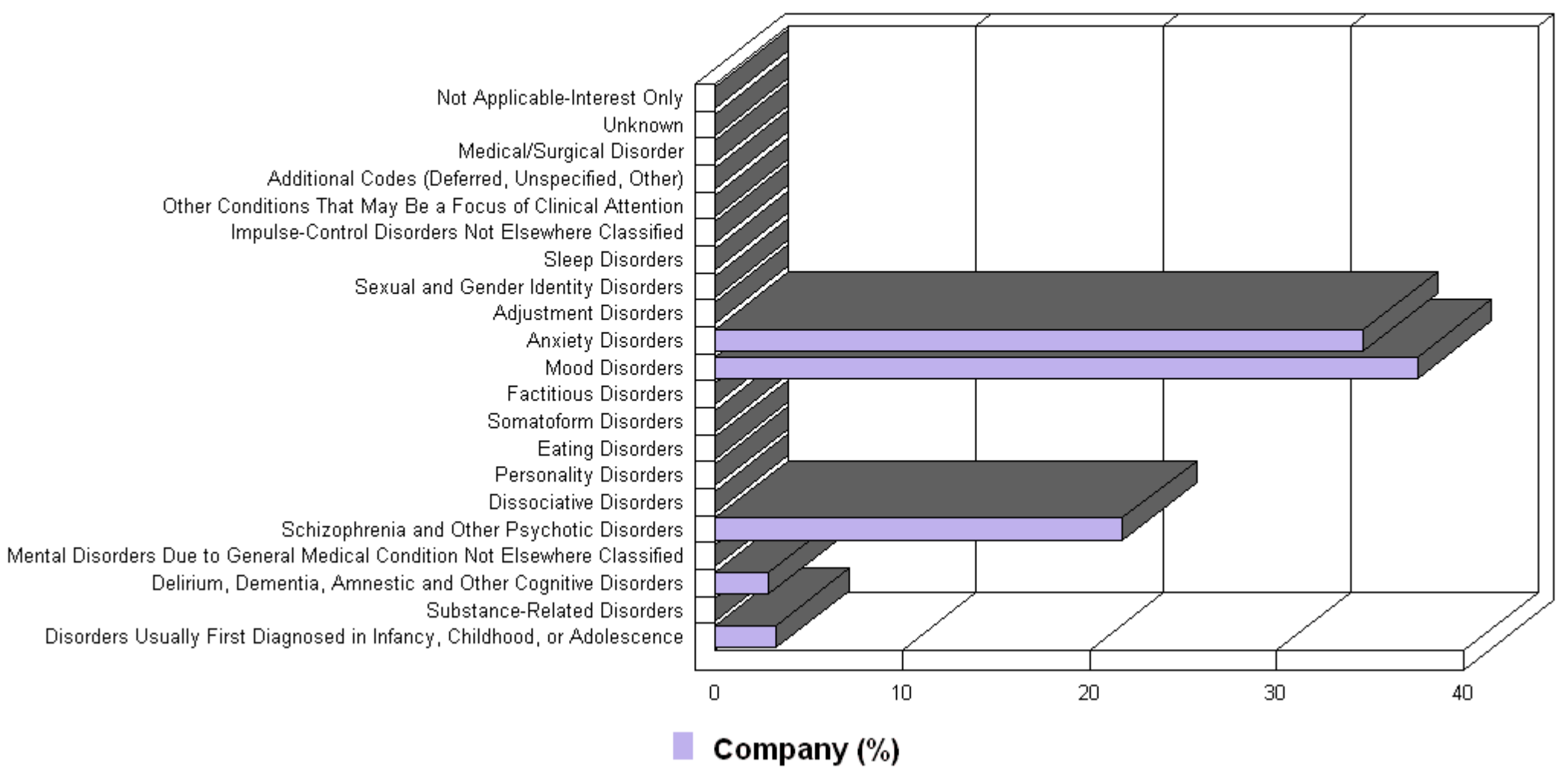
Utilization by Primary Diagnostic Classification by Level of Care - Claim Based

Sample Company

Level of Care Category: Other

Primary Diagnostic Category	Current Period Incurred: 01/01/2006 - 12/31/2006 Paid: 10/01/2006 - 12/31/2006				Year-To-Date Incurred: 01/01/2006 - 12/31/2006 Paid: 01/01/2006 - 12/31/2006			
	Users		Paid Amount		Users		Paid Amount	
	Company		Company		Company		Company	
	Number	%	Amount	%	Number	%	Amount	%
Disorders Usually First Diagnosed in Infancy, Childhood, or	0	0.0%	$82.50	6.8%	0	0.0%	$117.50	3.2%
Substance-Related Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Delirium, Dementia, Amnestic and Other Cognitive Disorders	0	0.0%	$105.00	8.7%	0	0.0%	$105.00	2.9%
Mental Disorders Due to General Medical Condition Not	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Schizophrenia and Other Psychotic Disorders	0	0.0%	$0.00	0.0%	1	25.0%	$794.80	21.8%
Dissociative Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Personality Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Eating Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Somatoform Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Factitious Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Mood Disorders	1	100.0%	$231.50	19.2%	3	75.0%	$1,369.50	37.5%
Anxiety Disorders	0	0.0%	$789.38	65.3%	0	0.0%	$1,263.76	34.6%
Adjustment Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Sexual and Gender Identity Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Sleep Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Impulse-Control Disorders Not Elsewhere Classified	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Other Conditions That May Be a Focus of Clinical Attention	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Additional Codes (Deferred, Unspecified, Other)	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Medical/Surgical Disorder	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Unknown	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Not Applicable-Interest Only	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
+*Total	1		$1,208.38	100.0%	4		$3,650.56	100.0%

YTD Percent of Benefits Paid by Diagnostic Category



* A User may be counted in multiple diagnostic categories.

+* Total User count is a distinct count of users regardless of diagnosis grouping. A user is counted only once if seen for multiple diagnoses.

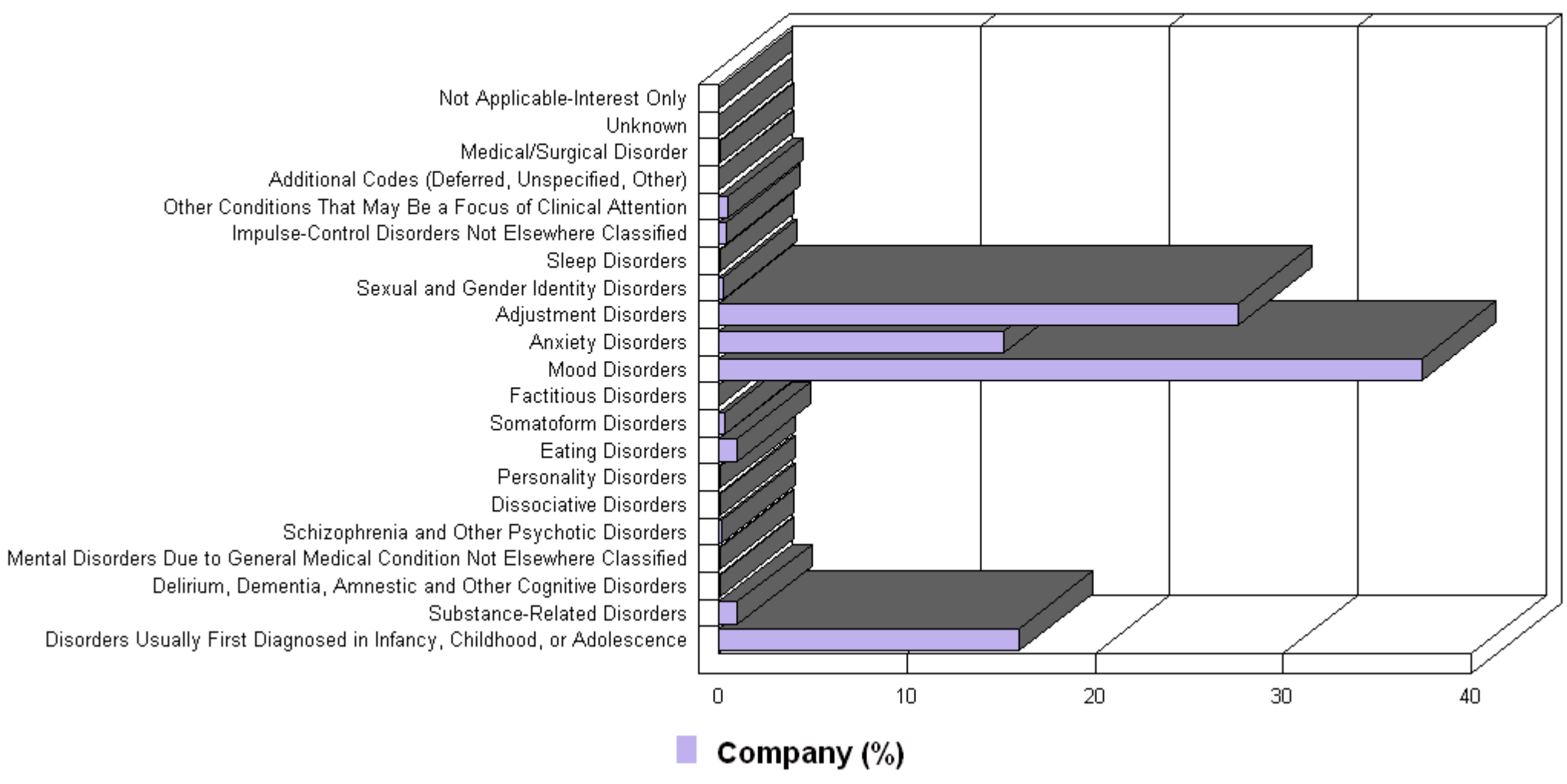
Utilization by Primary Diagnostic Classification by Level of Care - Claim Based

Sample Company

Level of Care Category: Outpatient

Primary Diagnostic Category	Current Period Incurred: 01/01/2006 - 12/31/2006 Paid: 10/01/2006 - 12/31/2006				Year-To-Date Incurred: 01/01/2006 - 12/31/2006 Paid: 01/01/2006 - 12/31/2006			
	Users		Paid Amount		Users		Paid Amount	
	Company		Company		Company		Company	
	Number	%	Amount	%	Number	%	Amount	%
Disorders Usually First Diagnosed in Infancy, Childhood, or	241	11.1%	$90,737.81	15.6%	452	11.7%	$344,388.42	15.9%
Substance-Related Disorders	26	1.2%	$5,454.96	0.9%	71	1.8%	$21,613.31	1.0%
Delirium, Dementia, Amnestic and Other Cognitive Disorders	1	0.0%	$212.50	0.0%	6	0.2%	$891.50	0.0%
Mental Disorders Due to General Medical Condition Not	1	0.0%	$608.00	0.1%	4	0.1%	$832.00	0.0%
Schizophrenia and Other Psychotic Disorders	9	0.4%	$692.50	0.1%	17	0.4%	$3,470.00	0.2%
Dissociative Disorders	2	0.1%	$405.00	0.1%	5	0.1%	$1,785.00	0.1%
Personality Disorders	3	0.1%	$272.50	0.0%	5	0.1%	$2,247.50	0.1%
Eating Disorders	20	0.9%	$5,756.50	1.0%	35	0.9%	$20,312.50	0.9%
Somatoform Disorders	6	0.3%	$1,388.60	0.2%	15	0.4%	$6,432.10	0.3%
Factitious Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Mood Disorders	943	43.4%	$209,291.20	36.0%	1683	43.4%	$807,532.15	37.4%
Anxiety Disorders	415	19.1%	$96,506.72	16.6%	765	19.7%	$328,134.92	15.2%
Adjustment Disorders	658	30.3%	$162,788.71	28.0%	1333	34.4%	$596,694.65	27.6%
Sexual and Gender Identity Disorders	4	0.2%	$789.00	0.1%	9	0.2%	$5,194.00	0.2%
Sleep Disorders	2	0.1%	$310.00	0.1%	6	0.2%	$1,152.50	0.1%
Impulse-Control Disorders Not Elsewhere Classified	15	0.7%	$2,152.60	0.4%	25	0.6%	$8,266.80	0.4%
Other Conditions That May Be a Focus of Clinical Attention	10	0.5%	$3,315.30	0.6%	31	0.8%	$11,390.80	0.5%
Additional Codes (Deferred, Unspecified, Other)	1	0.0%	$90.00	0.0%	7	0.2%	$731.50	0.0%
Medical/Surgical Disorder	3	0.1%	$415.00	0.1%	7	0.2%	$855.00	0.0%
Unknown	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Not Applicable-Interest Only	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
+*Total	**2173**		**$581,186.90**	**100.0%**	**3874**		**$2,161,924.65**	**100.0%**

YTD Percent of Benefits Paid by Diagnostic Category



* A User may be counted in multiple diagnostic categories.

+* Total User count is a distinct count of users regardless of diagnosis grouping. A user is counted only once if seen for multiple diagnoses.

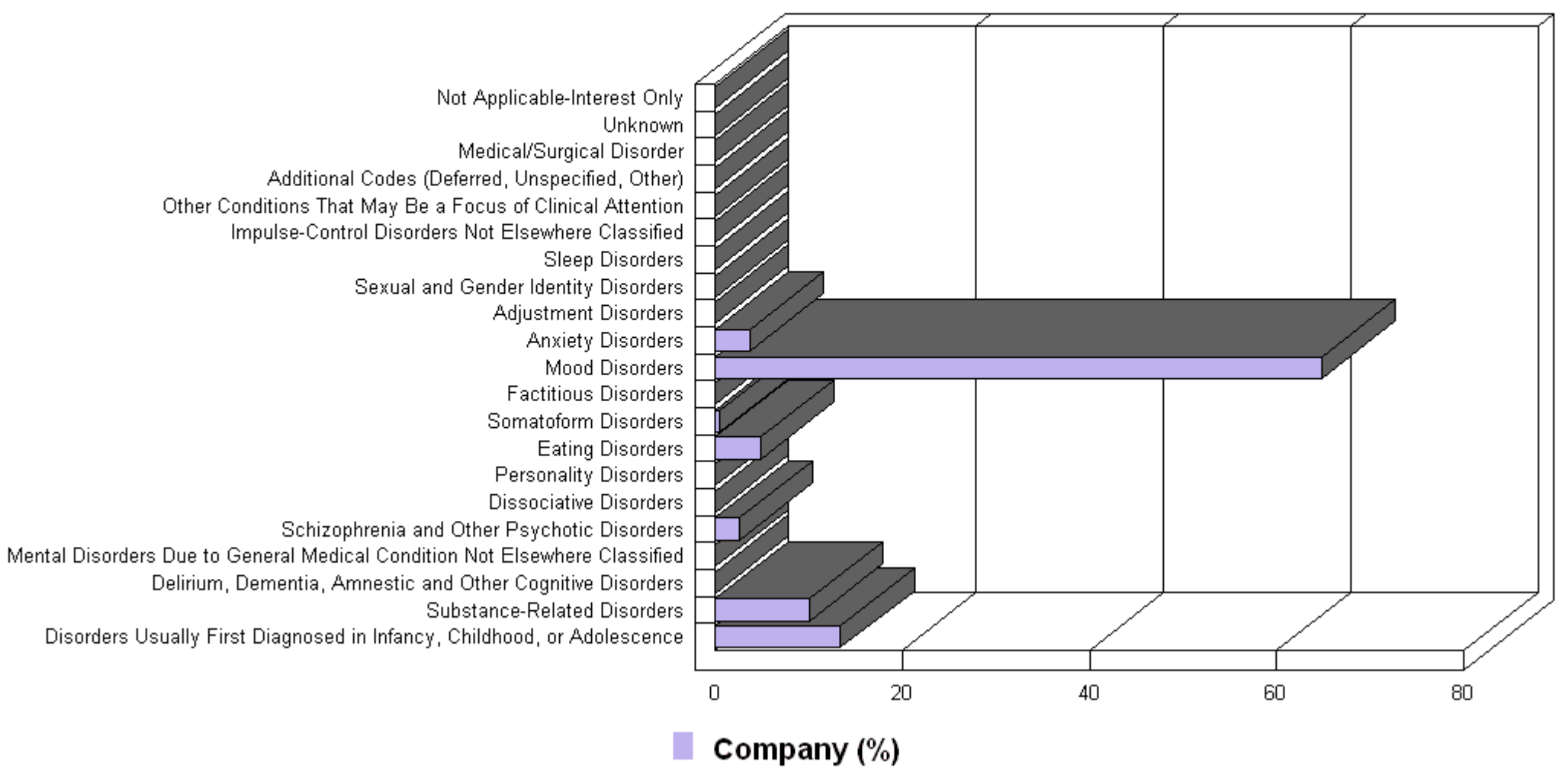
Utilization by Primary Diagnostic Classification by Level of Care - Claim Based

Sample Company

Level of Care Category: Partial

Primary Diagnostic Category	Current Period Incurred: 01/01/2006 - 12/31/2006 Paid: 10/01/2006 - 12/31/2006				Year-To-Date Incurred: 01/01/2006 - 12/31/2006 Paid: 01/01/2006 - 12/31/2006			
	Users		Paid Amount		Users		Paid Amount	
	Company		Company		Company		Company	
	Number	%	Amount	%	Number	%	Amount	%
Disorders Usually First Diagnosed in Infancy, Childhood, or	0	0.0%	$0.00	0.0%	2	4.1%	$23,087.22	13.4%
Substance-Related Disorders	4	28.6%	$2,671.40	7.9%	10	20.4%	$17,236.40	10.0%
Delirium, Dementia, Amnestic and Other Cognitive Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Mental Disorders Due to General Medical Condition Not	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Schizophrenia and Other Psychotic Disorders	0	0.0%	$0.00	0.0%	1	2.0%	$4,485.00	2.6%
Dissociative Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Personality Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Eating Disorders	2	14.3%	$5,649.00	16.8%	2	4.1%	$8,364.00	4.9%
Somatoform Disorders	0	0.0%	$0.00	0.0%	1	2.0%	$912.00	0.5%
Factitious Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Mood Disorders	8	57.1%	$25,311.23	75.3%	34	69.4%	$111,458.83	64.8%
Anxiety Disorders	0	0.0%	$0.00	0.0%	3	6.1%	$6,449.00	3.7%
Adjustment Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Sexual and Gender Identity Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Sleep Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Impulse-Control Disorders Not Elsewhere Classified	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Other Conditions That May Be a Focus of Clinical Attention	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Additional Codes (Deferred, Unspecified, Other)	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Medical/Surgical Disorder	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Unknown	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Not Applicable-Interest Only	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
+*Total	**14**		**$33,631.63**	**100.0%**	**49**		**$171,992.45**	**100.0%**

YTD Percent of Benefits Paid by Diagnostic Category



* A User may be counted in multiple diagnostic categories.

+* Total User count is a distinct count of users regardless of diagnosis grouping. A user is counted only once if seen for multiple diagnoses.

Utilization by Primary Diagnostic Classification by Level of Care - Claim Based

Sample Company

Level of Care Category: Residential

Primary Diagnostic Category	Current Period Incurred: 01/01/2006 - 12/31/2006 Paid: 10/01/2006 - 12/31/2006				Year-To-Date Incurred: 01/01/2006 - 12/31/2006 Paid: 01/01/2006 - 12/31/2006			
	Users		Paid Amount		Users		Paid Amount	
	Company		Company		Company		Company	
	Number	%	Amount	%	Number	%	Amount	%
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence	0	0.0%	$0.00	0.0%	1	5.3%	$16,364.00	6.5%
Substance-Related Disorders	3	100.0%	$14,689.00	100.0%	14	73.7%	$127,655.00	50.6%
Delirium, Dementia, Amnestic and Other Cognitive Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Mental Disorders Due to General Medical Condition Not Elsewhere Classified	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Schizophrenia and Other Psychotic Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Dissociative Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Personality Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Eating Disorders	0	0.0%	$0.00	0.0%	1	5.3%	$32,250.00	12.8%
Somatoform Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Factitious Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Mood Disorders	0	0.0%	$0.00	0.0%	4	21.1%	$69,720.00	27.6%
Anxiety Disorders	0	0.0%	$0.00	0.0%	1	5.3%	$6,528.00	2.6%
Adjustment Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Sexual and Gender Identity Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Sleep Disorders	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Impulse-Control Disorders Not Elsewhere Classified	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Other Conditions That May Be a Focus of Clinical Attention	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Additional Codes (Deferred, Unspecified, Other)	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Medical/Surgical Disorder	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Unknown	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
Not Applicable-Interest Only	0	0.0%	$0.00	0.0%	0	0.0%	$0.00	0.0%
+*Total	**3**		**$14,689.00**	**100.0%**	**19**		**$252,517.00**	**100.0%**

YTD Percent of Benefits Paid by Diagnostic Category

* A User may be counted in multiple diagnostic categories.

+* Total User count is a distinct count of users regardless of diagnosis grouping. A user is counted only once if seen for multiple diagnoses.

Claims Utilization Summary

Sample Company

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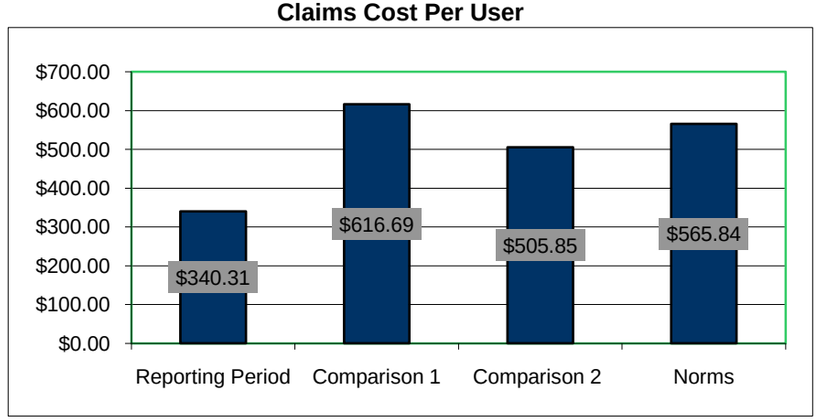
	Reporting Period			Comparison Period 1			Comparison Period 2			Magellan Norm		
Average Number of Subscribers:	9,140			9,061			8,237			423,662		
Average Number of Covered Lives:	24,606			24,435			22,394			890,433		
	Incurred: 04/01/2007-06/30/2007 Paid: 04/01/2007- 09/30/2007			**Incurred: 01/01/2007 - 06/30/2007 Paid: 01/01/2007 - 09/30/2007**			**Incurred: 01/01/2006 - 06/30/2006 Paid: 01/01/2006 - 09/30/2006**			**Incurred: 01/01/2007 - 06/30/2007 Paid: 01/01/2007 - 09/30/2007**		
	Mental Health	**Substance Abuse**	**Total**	**Mental Health**	**Substance Abuse**	**Total**	**Mental Health**	**Substance Abuse**	**Total**	**Mental Health**	**Substance Abuse**	**Total**
All Levels of Care												
New Users	84	6	87	178	14	191	216	14	224	6927	436	7220
Unique Users (for all LOCs)	514	15	526	667	24	684	671	25	690	23755	752	24305
Annualized New Users per 1,000	13.7	1.0	14.1	14.6	1.1	15.6	19.3	1.3	20.0	15.6	1.0	16.2
Annualized Unique Users per 1,000	83.6	2.4	85.5	54.6	2.0	56.0	59.9	2.2	61.6	53.4	1.7	54.6
Penetration Rate	2.09%	0.06%	2.14%	2.73%	0.10%	2.80%	3.00%	11.00%	3.08%	2.67%	8.00%	2.73%
Actual Billed Amount	$323,697	$75,811	$399,508	$774,449	$147,291	$922	$611,119	$100,972	$714,773	$25,729,797	$3,852,644	$29,616,981
Actual Allowed Amount	$184,482	$51,473	$235,955	$462,120	$88,419	$550,888	$398,314	$62,777	$463,610	$15,955,959	$2,458,014	$18,431,476
Actual Paid Amount	$130,418	$48,587	$179,004	$340,933	$80,695	$421,817	$288,513	$58,476	$349,037	$11,558,161	$2,188,171	$13,752,757
Cost Per Subscriber	$14.27	$5.32	$19.58	$37.63	$8.91	$46.55	$35.03	$7.10	$42.37	$27.28	$5.17	$32.46
Cost Per Covered Life	$5.30	$1.97	$7.27	$13.95	$3.30	$17.26	$12.88	$2.61	$15.59	$12.98	$2.46	$15.45
Cost Per Unique User	$253.73	$3,239.10	$340.31	$511.14	$3362.28	$616.69	$429.98	$2,339.04	$505.85	$486056.00	$2,910.60	$565.84

Claims Cost Per User



Paid Claims Utilization by Top Facility - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Facility	Facility TIN	Unique Users	% of Unique Users	Number of Cases	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Days	ALOS
ALEXIAN BROTHERS BEHAVIORAL HL	[redacted]	3	7.0%	4	$28,250.72	$14,583.00	$13,320.60	25	6.3
SAINT MARYS HOSPITAL RACINE		3	7.0%	3	$8,055.22	$6,396.15	$6,838.57	8	2.7
RIDGEVIEW INSTITUTE INCORPORAT		3	7.0%	3	$22,620.00	$13,206.00	$12,858.50	25	8.3
EVANSTON NORTHWESTERN HOSPITAL		2	4.7%	2	$46,213.95	$17,550.00	$17,050.00	27	13.5
ADVOCATE LUTHERAN GENERAL HOSP		2	4.7%	2	$30,061.08	$13,060.00	$10,106.50	17	8.5
ADVOCATE GOOD SHEPARD HOSPITAL		2	4.7%	3	$7,078.20	$1,510.00	$1,330.00	4	1.3
MCLEAN HOSPITAL		1	2.3%	1	$7,440.00	$7,440.00	$4,440.00	10	10.0
STAMFORD HOSPITAL		1	2.3%	1	$6,871.32	$6,621.32	$3,621.32	2	2.0
WOMEN CHRISTIAN ASSOCIATION OF		1	2.3%	1	$3,926.20	$2,800.00	$2,300.00	4	4.0
SUMMIT OAKS HOSPITAL		1	2.3%	1	$36,777.00	$15,600.00	$15,100.00	24	24.0
MEMORIAL MEDICAL CENTER SOUTH		1	2.3%	1	$4,005.75	$2,592.00	$2,246.40	9	9.0
HOLY FAMILY MEDICAL CENTER		1	2.3%	1	$2,597.25	$750.00	$0.00	3	3.0
PRESBYTERIAN HOSPITAL		1	2.3%	1	$8,480.40	$3,948.00	$3,948.00	6	6.0
PARK RIDGE HOSPITAL MAIN SITE		1	2.3%	1	$15,330.57	$5,950.00	$5,450.00	10	10.0
WINNEBAGO MENTAL HEALTH INSTIT		1	2.3%	1	$2,460.00	$2,460.00	$1,230.00	3	3.0
ALL SAINT MEDICAL CENTER WASHI		1	2.3%	1	$5,071.20	$4,800.00	$4,300.00	6	6.0
SAINT LUKES HOSPITAL WI		1	2.3%	1	$5,169.43	$5,169.43	$2,584.72	6	6.0
ROGERS MEMORIAL HOSPITAL MILWA		1	2.3%	1	$14,268.65	$7,434.00	$7,434.00	7	7.0
AURORA PSYCHIATRIST HOSPITAL M		1	2.3%	1	$1,494.65	$700.00	$700.00	2	2.0
LINDEN OAKS HOSPITAL WASHINGTO		1	2.3%	1	$3,223.75	$1,875.00	$1,875.00	5	5.0
SAINT THERESE MEDICAL CENTER		1	2.3%	1	$6,334.90	$3,935.00	$3,435.00	5	5.0
QUEENS MEDICAL CENTER		1	2.3%	1	$5,947.94	$5,947.94	$5,947.94	2	2.0
MEADOWS		1	2.3%	2	$27,213.13	$27,213.13	$24,213.13	21	10.5
SETON SHOAL CREEK HOSPITAL		1	2.3%	1	$5,082.25	$2,550.00	$2,050.00	3	3.0
GLENWOOD REGIONAL MEDCLCTR		1	2.3%	1	$4,882.16	$4,882.16	$4,382.16	4	4.0
WATERSHED ACT II INCORPORATED		1	2.3%	1	$20,280.19	$19,070.22	$19,070.22	11	11.0
CUMBERLAND HEIGHTS FOUNDATION		1	2.3%	1	$17,100.00	$13,020.00	$13,020.00	28	28.0
CYPRESS CREEK HOSPITAL		1	2.3%	1	$2,310.00	$1,890.00	$1,512.00	6	6.0
GREEN OAKS HOSPITAL		1	2.3%	1	$4,250.76	$1,460.00	$1,168.00	2	2.0
TEN BROECK HOSPITAL		1	2.3%	1	$18,459.00	$7,000.00	$7,000.00	14	14.0
SUMMIT RIDGE BEHAVIORAL HEALTH		1	2.3%	1	$2,027.00	$1,525.00	$1,220.00	5	5.0
DUKE UNIVERSITY HOSPITAL		1	2.3%	1	$4,345.61	$3,259.21	$2,759.21	1	1.0
RUSH NORTH SHORE MEDICAL CENTE		1	2.3%	1	$11,637.42	$3,675.00	$3,675.00	7	7.0
RUSH UNIVERSITY MEDICAL CENTER		1	2.3%	1	$185.00	$130.00	$130.00	1	1.0
CEDAR CREST HOSPITAL		1	2.3%	2	$6,000.00	$4,664.00	$4,246.00	8	4.0
GREYSTONE PARK PSYCHIATRIST HO		1	2.3%	1	$6,270.00	$6,270.00	$3,270.00	11	11.0
SAINT CLARES BEHAVIORAL HEALTH		1	2.3%	1	$41,584.00	$10,104.00	$10,104.00	12	12.0

Report ID: CLWO0039A
Report Run Date: 02/19/2007
Report Run Time: 04:00:15 PM

Paid Claims Utilization by Top Facility - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Facility	Facility TIN	Unique Users	% of Unique Users	Number of Cases	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Days	ALOS
TWO RIVERS PSYCHIATRIC HOSPITA	[redacted]	1	2.3%	1	$26,554.48	$8,125.00	$8,125.00	13	13.0
CHILDRENS HOSPITAL MEDICAL CEN		1	2.3%	1	$12,756.69	$12,118.89	$11,618.89	7	7.0
Total of Top 50 Facility		**48**		**52**	**$482,615.87**	**$271,284.45**	**$243,680.16**	**364**	**7.0**
Total of All Other Facility		**0**		**0**	**$0.00**	**$0.00**	**$0.00**	**0**	**0.0**
Total of All Facility		**43**		**52**	**$482,615.87**	**$271,284.45**	**$243,680.16**	**364**	**7.0**

Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
STEVEN PAUL LAMMERS, MD	[redacted]	67	3.1%	85	$6,920.00	$4,340.00	$2,838.00	85	1.3
ELENA FRANKFURT, MD		26	1.2%	42	$6,280.00	$2,705.00	$1,923.58	42	1.6
MICHAEL STEVEN GREENBAUM, MD		23	1.1%	27	$2,280.00	$2,240.00	$1,785.00	27	1.2
DARAM H REDDY, MD		22	1.0%	36	$3,581.52	$2,171.52	$1,372.76	37	1.7
ELISABETH V DE SA PEREIRA, MD		19	0.9%	21	$1,915.00	$1,215.00	$877.50	21	1.1
RUSH BEHAVIORAL HEALTH LAKE FO		17	0.8%	29	$5,595.00	$3,032.00	$2,591.00	38	2.2
JOHN D JOCHEM, PSYD		17	0.8%	58	$8,295.00	$4,771.00	$3,851.00	58	3.4
ROBERT ALLAN GREENDALE, MD		16	0.7%	21	$2,600.00	$1,405.00	$1,090.00	21	1.3
SHAZIA TAYYAB, MD		15	0.7%	22	$2,675.00	$2,450.00	$2,065.00	22	1.5
ELVINA BERMAN, MD		13	0.6%	19	$1,980.00	$1,710.00	$1,425.00	19	1.5
JAMES E DEVINE, PHD		11	0.5%	45	$5,500.00	$3,520.00	$2,885.00	44	4.0
ROBERT S BAKER, MD		11	0.5%	21	$3,742.00	$1,330.00	$992.50	21	1.9
DAVID GATES, MA		10	0.5%	35	$4,750.00	$3,205.00	$2,362.50	46	4.6
ANN M ROHLMAN FLEMING, MSW		10	0.5%	28	$3,300.00	$2,224.00	$1,789.00	29	2.9
GERARD J GIRDAUKAS, PHD		10	0.5%	36	$9,141.25	$3,756.00	$2,902.50	46	4.6
KALPANA RAO, PHD		10	0.5%	35	$6,060.00	$3,260.00	$2,660.00	40	4.0
LEONARD T CARR, MD		10	0.5%	13	$1,430.00	$650.00	$425.00	13	1.3
BARBARA M STOCK, PHD		9	0.4%	13	$6,795.00	$4,015.00	$3,265.00	50	5.6
AHMAD ZIA KHAN, MD		9	0.4%	11	$1,098.00	$585.00	$450.00	9	1.0
R STEPHEN CALLAGHAN, MD		9	0.4%	14	$2,166.00	$1,125.00	$915.00	14	1.6
VANESSA Q CHANG, MD		9	0.4%	14	$2,373.00	$1,230.00	$1,020.00	14	1.6
RONALD RUBIN, MD		9	0.4%	16	$2,600.00	$1,290.00	$1,017.00	16	1.8
MARY INEZ NUNCHUCK, DO		9	0.4%	17	$2,650.00	$1,425.00	$972.50	17	1.9
ALEXIAN BROTHERS BEHAVIORAL HL		9	0.4%	10	$9,555.50	$5,267.00	$4,602.00	28	3.1
LEAH PENDARVIS, PHD		8	0.4%	27	$3,105.00	$2,160.00	$1,755.00	27	3.4
NATALIA FUDIM, MD		8	0.4%	20	$1,890.00	$1,890.00	$1,095.00	21	2.6
PAMELA MEYERSON, MSW		7	0.3%	12	$9,650.00	$9,650.00	$4,825.00	31	4.4
RICHARD BOLNICK, PSYD		7	0.3%	18	$2,800.00	$1,622.00	$1,322.00	20	2.9
JENNIFER R FLUGSTAD, MED		7	0.3%	20	$3,210.00	$2,100.00	$1,710.00	26	3.7
CANDACE J WENDLICK, MSW		7	0.3%	30	$4,290.00	$2,830.00	$2,305.00	35	5.0
SAINT LUKES HOSPITAL WI		7	0.3%	11	$1,227.00	$1,227.00	$613.50	11	1.6
ASHOKKUMAR K SHAH, MD		7	0.3%	8	$1,000.00	$520.00	$400.00	8	1.1
THOMAS M DUFFY, MD		7	0.3%	7	$770.00	$525.00	$420.00	7	1.0
PATRICIA S RYAN, PSYD		7	0.3%	23	$2,590.00	$2,045.00	$1,637.50	25	3.6
WAYNE R GLAD, PHD		7	0.3%	32	$4,325.00	$2,670.00	$2,171.00	33	4.7
BRAD K. GREENSPAN, MD		6	0.3%	18	$2,705.00	$2,705.00	$1,352.50	19	3.2
RICHARD H WAGNER, MD		6	0.3%	12	$900.00	$875.00	$447.50	12	2.0
ROBERT M PASEN, PHD		6	0.3%	22	$3,630.00	$1,933.00	$1,662.00	24	4.0
JULIET J SPELMAN, MD		6	0.3%	9	$1,040.00	$890.00	$512.50	10	1.7
WILLIAM J BJERREGAARD, MD		6	0.3%	11	$1,505.00	$790.00	$625.00	11	1.8
CORRI J FERDMAN, MSW		5	0.2%	8	$800.00	$532.00	$412.00	8	1.6
DANIEL J BRZOSTOWSKI, MS		5	0.2%	14	$3,350.00	$1,730.00	$1,340.00	26	5.2
MARA PHEISTER, MD		5	0.2%	5	$565.00	$565.00	$282.50	5	1.0
CATHERINE A MCCONNELL, PHD		5	0.2%	9	$1,936.00	$1,930.00	$1,670.00	24	4.8
HERBERT ROEHRICH, MD		5	0.2%	6	$940.00	$505.00	$415.00	6	1.2
SUSAN M WILSON, MED		5	0.2%	19	$1,880.00	$1,444.00	$1,099.00	23	4.6
PUSHPARANEE BABUSUKUMAR, MD		5	0.2%	5	$655.00	$430.00	$355.00	5	1.0
NICOLE M JOHNSON, MS		5	0.2%	16	$2,430.00	$1,610.00	$1,310.00	20	4.0
VENKATA K SHARMA, MD		5	0.2%	6	$660.00	$450.00	$360.00	6	1.2
BARRY HOFFMAN, PHD		5	0.2%	10	$1,365.00	$815.00	$665.00	10	2.0
JORI L RISKE, MSW		5	0.2%	18	$2,160.00	$2,160.00	$1,080.00	18	3.6
DONALD E SHERWOOD, PSYD		5	0.2%	7	$3,240.00	$2,205.00	$1,700.00	27	5.4
LISA C ROUFF, PHD		4	0.2%	10	$2,670.00	$1,760.00	$1,430.00	22	5.5
MARINA SHAKHMAN, PSYD		4	0.2%	16	$4,675.00	$2,509.00	$2,044.00	31	7.8
ART POGRE, MD		4	0.2%	10	$1,800.00	$995.00	$667.50	11	2.8
BARBARA R HURWITZ, PSYD		4	0.2%	12	$3,535.00	$2,170.00	$1,765.00	27	6.8
SANDRA R DERKS, MS		4	0.2%	6	$1,650.00	$855.00	$607.50	13	3.3
RONALD H ROSENTHAL, PHD		4	0.2%	6	$2,665.00	$1,680.00	$865.00	21	5.3

Report ID: CLWO0040A
Report Run Date: 02/19/2007
Report Run Time: 04:16:41 PM

Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
MICHAEL L KLESTINSKI, MSW	[redacted]	4	0.2%	10	$3,030.00	$1,787.00	$1,116.50	27	6.8
SARA L ANDERSON, MSW		4	0.2%	13	$1,440.00	$1,070.00	$755.00	12	3.0
CORI M SCHNEIDER, MSW		4	0.2%	11	$1,320.00	$990.00	$825.00	11	2.8
ALAN J HEIGERT, MS		4	0.2%	21	$2,520.00	$1,875.00	$1,560.00	21	5.3
ARLENE ANN MESSNER PETERS, MSW		4	0.2%	11	$1,300.00	$950.00	$725.00	11	2.8
ROBERT DAVENPORT, PHD		4	0.2%	5	$825.00	$825.00	$412.50	5	1.3
PHILLIP G HELDING JR, DO		4	0.2%	5	$675.00	$440.00	$270.00	7	1.8
KATHY L BANDSTRA, MSW		4	0.2%	8	$1,195.00	$638.00	$518.00	8	2.0
THOMAS J GRUNDLE, PHD		4	0.2%	11	$1,766.00	$1,014.00	$816.50	11	2.8
HERBERT ROEHRICH, MD		4	0.2%	5	$991.00	$520.00	$445.00	5	1.3
STEVEN M GOLDBERG, MSW		4	0.2%	11	$1,580.00	$900.00	$705.00	11	2.8
HERBERT ROEHRICH, MD		4	0.2%	5	$804.00	$420.00	$345.00	5	1.3
ROBERT GRAY PERRA, EDD		4	0.2%	8	$798.00	$655.00	$535.00	8	2.0
CHERYL SPIELMAN, PSYD		4	0.2%	10	$2,685.00	$1,544.00	$1,234.00	19	4.8
MICHELE STUDL, PHD		4	0.2%	11	$3,650.00	$2,095.00	$1,649.00	21	5.3
LINDA H SAMPLINER, EDD		4	0.2%	9	$1,100.00	$800.00	$650.00	10	2.5
SCOTT SNYDER, MD		4	0.2%	7	$770.00	$350.00	$195.00	7	1.8
LANA N PETERS, PHD		4	0.2%	5	$425.00	$405.00	$330.00	5	1.3
VICTORIA Y KRANZ, MD		4	0.2%	11	$1,335.00	$1,105.00	$940.00	11	2.8
VETERAN ADMINISTRATION MEDICAL		4	0.2%	17	$2,332.02	$2,332.02	$983.36	17	4.3
ALAN NATHAN MILLER, MD		3	0.1%	3	$300.00	$300.00	$150.00	3	1.0
BRIAN WESTRATE, MA		3	0.1%	7	$1,500.00	$1,500.00	$750.00	12	4.0
DENNIS P COGHLIN, MSW		3	0.1%	5	$1,025.00	$545.00	$407.50	8	2.7
MARK SOLOMON, PSYD		3	0.1%	7	$900.00	$720.00	$585.00	9	3.0
STEPHEN CANN, MD		3	0.1%	3	$880.00	$880.00	$440.00	6	2.0
PATRICIA TAGLIONE, PSYD		3	0.1%	6	$1,460.00	$1,460.00	$1,190.00	18	6.0
RUSH BEHAVIORAL HEALTH DOWNERS		3	0.1%	3	$4,915.00	$2,835.00	$2,850.00	15	5.0
MARLEE HASSON, MSW		3	0.1%	5	$990.00	$990.00	$495.00	8	2.7
MICHELLE B. YAPO, MSW		3	0.1%	9	$3,960.00	$3,960.00	$1,980.00	33	11.0
STEVEN MEYERS, MSW		3	0.1%	8	$1,950.00	$1,268.00	$983.00	19	6.3
EDWARD S RAVINE, MA		3	0.1%	13	$2,560.00	$1,040.00	$660.00	16	5.3
JUDITH A MILLER, PSYD		3	0.1%	6	$1,215.00	$726.00	$591.00	9	3.0
PATRICIA K KIMBEL, PSYD		3	0.1%	6	$2,040.00	$1,360.00	$1,080.00	17	5.7
ATULA SHARMA, MBBC		3	0.1%	3	$300.00	$300.00	$150.00	3	1.0
MOHANAKUMARI K NAIDU, MD		3	0.1%	6	$1,230.00	$750.00	$630.00	8	2.7
BONNIE L WHYTE, PHD		3	0.1%	19	$2,425.00	$1,535.00	$1,250.00	19	6.3
PEGGY L FREEMAN, MSW		3	0.1%	7	$1,300.00	$848.00	$653.00	13	4.3
MEIER CLINIC OF ILLINOIS PC CH		3	0.1%	11	$1,689.00	$805.00	$640.00	11	3.7
FRANCES JEAN PACHECO, PSYD		3	0.1%	16	$2,250.00	$1,375.00	$1,120.00	17	5.7
JAMES S MARKS, MD		3	0.1%	3	$680.00	$680.00	$340.00	5	1.7
PENELOPE A KLESTINSKI, MSW		3	0.1%	5	$1,350.00	$790.00	$575.00	12	4.0
TIMOTHY TSO, MD		3	0.1%	8	$1,530.00	$1,530.00	$765.00	9	3.0
NEIL D MAHONEY, PHD		3	0.1%	12	$1,500.00	$960.00	$780.00	12	4.0
ELIZABETH K MCMASTERS, MD		3	0.1%	4	$525.00	$300.00	$210.00	6	2.0
OON PROVIDER		3	0.1%	15	$4,773.50	$4,773.50	$3,791.80	55	18.3
ALAN P BRAUER, MD		3	0.1%	7	$595.00	$595.00	$490.00	7	2.3
MARK SHUKHMAN, MD		3	0.1%	6	$920.00	$465.00	$352.50	6	2.0
DEBORAH S MILLER, EDD		3	0.1%	5	$540.00	$540.00	$270.00	6	2.0
HAROLD A CRONSON, MD		3	0.1%	4	$480.00	$240.00	$180.00	4	1.3
MONICA C MASON, MS		3	0.1%	8	$1,080.00	$660.00	$515.00	8	2.7
DOREEN D BENJAMIN, PSYD		3	0.1%	7	$2,280.00	$1,310.00	$1,070.00	16	5.3
TERRY ELLIOT PASSMAN, MD		3	0.1%	10	$850.00	$500.00	$350.00	10	3.3
EUGENE V ISYANOV, PHD		3	0.1%	12	$1,800.00	$780.00	$530.00	12	4.0
DENA J KLAPPERICH, PSYD		3	0.1%	6	$1,540.00	$910.00	$745.00	11	3.7
CURTIS R BRYAN, MD		3	0.1%	6	$580.00	$416.00	$257.50	6	2.0
KARL G HESS, PHD		3	0.1%	12	$1,105.00	$806.00	$611.00	13	4.3
THERESE SULENTICH, PSYD		3	0.1%	3	$960.00	$720.00	$510.00	9	3.0
RUTH M SHOEMAKER, PHD		3	0.1%	12	$2,550.00	$1,360.00	$1,105.00	17	5.7

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
LESLIE A KONEK SCHLAX, MSSW	[redacted]	3	0.1%	5	$615.00	$410.00	$335.00	5	1.7
THERESA C POTENTE, MSW		3	0.1%	11	$1,320.00	$880.00	$715.00	11	3.7
MICHAEL R RADKE, MSW		3	0.1%	9	$1,080.00	$720.00	$585.00	9	3.0
VERNA F CHRISTY, MA		3	0.1%	7	$1,430.00	$810.00	$635.00	10	3.3
SUSAN MOORE SCHNEIDER, MSW		3	0.1%	8	$900.00	$608.00	$488.00	8	2.7
DEBRA M JOHANSEN, PHD		3	0.1%	8	$1,120.00	$760.00	$607.50	8	2.7
STEPHANIE B HANSON, MSSW		3	0.1%	7	$980.00	$560.00	$455.00	7	2.3
JEANNE E TRIGUEROS MILLAR, MSW		3	0.1%	8	$1,060.00	$650.00	$530.00	8	2.7
KATHRYN A AALTO, MSW		3	0.1%	5	$580.00	$330.00	$295.00	4	1.3
TOM DEFRANCESCO, MSW		3	0.1%	8	$1,720.00	$810.00	$660.00	10	3.3
MICHAEL ANGELO DEFAZIO, MSSW		3	0.1%	13	$2,408.00	$1,120.00	$910.00	14	4.7
DAWN D DUNK, MSW		3	0.1%	12	$1,440.00	$1,040.00	$770.00	12	4.0
ALL SAINT MEDICAL CENTER WASHI		3	0.1%	3	$5,920.00	$4,095.00	$4,002.50	15	5.0
JOSEPH L KUT, MD		3	0.1%	4	$680.00	$680.00	$340.00	5	1.7
KATHRYN SINGER, MD		3	0.1%	7	$1,800.00	$1,800.00	$900.00	13	4.3
NORMAN A CHAPMAN, MD		3	0.1%	4	$670.00	$670.00	$335.00	4	1.3
MARK A MYERS, MSW		3	0.1%	14	$1,750.00	$930.00	$720.00	14	4.7
MIROSLAW J WALO, MD		3	0.1%	8	$1,050.00	$1,050.00	$585.00	8	2.7
BRADLEY J SAKS, PHD		3	0.1%	4	$930.00	$930.00	$465.00	6	2.0
SUSAN R SMITH, PHD		3	0.1%	7	$2,650.00	$1,695.00	$1,380.00	21	7.0
LYNN J HUGHES, MSW		3	0.1%	5	$580.00	$335.00	$260.00	5	1.7
ABBY L WATEL, MSW		3	0.1%	7	$1,690.00	$985.00	$760.00	15	5.0
HOLLY M SHEAHAN, MSW		3	0.1%	3	$600.00	$390.00	$300.00	6	2.0
WILLIAM BAZAREWSKI, MA		3	0.1%	4	$1,075.00	$570.00	$435.00	9	3.0
EDWARD L SCHACHT, MD		3	0.1%	3	$1,075.00	$374.00	$314.00	4	1.3
KEVIN J BREEN, MD		3	0.1%	4	$480.00	$300.00	$240.00	4	1.3
ANTOINETTE J LYNN, PHD		2	0.1%	2	$2,000.00	$2,000.00	$1,000.00	8	4.0
BONNI RAAB, MSW		2	0.1%	3	$1,200.00	$800.00	$650.00	10	5.0
SHIRLEY A KOSKO, PSYD		2	0.1%	2	$1,485.00	$1,485.00	$742.50	11	5.5
BRAD SACHS, PHD		2	0.1%	6	$1,200.00	$1,200.00	$600.00	6	3.0
STEVEN HURLEY, PSYD		2	0.1%	2	$350.00	$350.00	$175.00	2	1.0
JOAN F HAKIMI, PSYD		2	0.1%	7	$915.00	$575.00	$470.00	7	3.5
KAREN LARKEY, PSYD		2	0.1%	7	$1,050.00	$510.00	$340.00	7	3.5
WILLIAM E WARD, EDD		2	0.1%	2	$980.00	$980.00	$490.00	7	3.5
DEBBIE LAYTON THOLL, PSYD		2	0.1%	14	$3,750.00	$3,750.00	$1,875.00	15	7.5
MARGARET H ROY, MS		2	0.1%	6	$660.00	$372.00	$282.00	6	3.0
CATHERINE ARCE, PHD		2	0.1%	4	$1,400.00	$815.00	$665.00	10	5.0
GREGG E HINTZ, PSYD		2	0.1%	3	$450.00	$450.00	$315.00	3	1.5
BONNIE LESSING, MSW		2	0.1%	2	$6,675.00	$6,675.00	$3,337.50	44	22.0
EMMA WOOD, MS		2	0.1%	2	$190.00	$190.00	$95.00	2	1.0
CAROL A CARUSO, MA		2	0.1%	11	$1,100.00	$660.00	$495.00	11	5.5
POLLY M ROST, PHD		2	0.1%	5	$690.00	$456.00	$366.00	6	3.0
MARK W GIDNEY, PSYD		2	0.1%	5	$1,055.00	$1,055.00	$527.50	8	4.0
MEMORIAL MEDICAL CENTER		2	0.1%	11	$2,255.05	$2,255.05	$1,127.54	16	8.0
GINO GROSSO, MD		2	0.1%	12	$1,200.00	$780.00	$512.50	12	6.0
SUSAN H NIEMANN, PHD		2	0.1%	3	$420.00	$335.00	$275.00	4	2.0
MARY K GARRETT, MSSW		2	0.1%	10	$990.00	$715.00	$550.00	11	5.5
CENTER FOR EATING DISORDER PSY		2	0.1%	4	$550.00	$375.00	$315.00	4	2.0
JOHN S D IMPERIO, MD		2	0.1%	3	$270.00	$180.00	$135.00	3	1.5
VIKKIE A TUCKER, MSW		2	0.1%	9	$5,505.00	$5,505.00	$2,752.50	43	21.5
DALE JOHN GIOLAS, MD		2	0.1%	9	$1,425.00	$750.00	$525.00	15	7.5
WILMER K FURUTA, MD		2	0.1%	11	$1,350.00	$630.00	$365.00	12	6.0
SHARDA K BOBBA, MD		2	0.1%	3	$565.00	$285.00	$240.00	3	1.5
BERNADETTE R GAFFNEY, MSW		2	0.1%	4	$950.00	$650.00	$500.00	10	5.0
STEPHEN CHOU, PSYD		2	0.1%	2	$660.00	$660.00	$330.00	4	2.0
LAURIE B GOLDMAN, MD		2	0.1%	4	$550.00	$550.00	$275.00	4	2.0
SANDRA CAMMARATA, MD		2	0.1%	2	$300.00	$300.00	$150.00	2	1.0
PAUL HRISO, MD		2	0.1%	2	$300.00	$210.00	$180.00	2	1.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
DONALD W. HUDSON, PHD	[redacted]	2	0.1%	5	$625.00	$625.00	$312.50	5	2.5
H. LARA BRAXTON, PHD		2	0.1%	5	$960.00	$960.00	$480.00	6	3.0
JOEL M GRONER, PSYD		2	0.1%	2	$300.00	$240.00	$195.00	3	1.5
HARMEEN AHUJA, PHD		2	0.1%	4	$910.00	$910.00	$455.00	7	3.5
KARA ROONEY, MD		2	0.1%	3	$255.00	$255.00	$210.00	3	1.5
JAMES GALLAGHER, MD		2	0.1%	3	$255.00	$255.00	$127.50	3	1.5
JOHN WILSON, MD		2	0.1%	4	$340.00	$340.00	$140.00	4	2.0
MICHAEL JUDD, MD		2	0.1%	2	$170.00	$170.00	$112.50	2	1.0
CAROLYN M REEDER, PHD		2	0.1%	3	$1,100.00	$674.00	$554.00	8	4.0
PATRICIA BELLENO, MS		2	0.1%	5	$1,110.00	$1,110.00	$555.00	10	5.0
UZOMA OKOLI, MD		2	0.1%	6	$1,060.00	$640.00	$395.00	9	4.5
BRENEE MOORE, MSW		2	0.1%	2	$630.00	$630.00	$315.00	9	4.5
RAHNA CUTTING, MA		2	0.1%	4	$1,170.00	$952.00	$607.00	13	6.5
THERESA SCHULTZ, PHD		2	0.1%	2	$270.00	$270.00	$135.00	2	1.0
WASHOE MEDICAL CENTER		2	0.1%	4	$635.00	$445.00	$275.00	5	2.5
JOHN F JUERN, PHD		2	0.1%	7	$1,350.00	$860.00	$725.00	9	4.5
T J PRICE, PSYD		2	0.1%	2	$1,370.00	$1,036.00	$543.00	12	6.0
HOWARD J ENTIN, MD		2	0.1%	5	$450.00	$350.00	$275.00	5	2.5
TIM W MCGAUGHY, MD		2	0.1%	2	$342.00	$328.00	$217.00	3	1.5
STANFORD HOSPITAL & CLNCS		2	0.1%	6	$1,450.00	$981.57	$891.57	6	3.0
KRISHNA V R SUNKUREDDI, MD		2	0.1%	2	$200.00	$200.00	$100.00	2	1.0
JANE LOISELLE, MSW		2	0.1%	3	$270.00	$238.00	$193.00	3	1.5
ANGELICA P DE LA CRUZ, MSSW		2	0.1%	3	$650.00	$650.00	$325.00	5	2.5
FRANKLIN B MINIRTH, MD		2	0.1%	4	$455.00	$330.00	$270.00	4	2.0
ARNOLD W MECH, MD		2	0.1%	7	$805.00	$510.00	$360.00	7	3.5
MILTON L GEARING II, PHD		2	0.1%	4	$675.00	$408.00	$333.00	5	2.5
JAMES A BUCKINGHAM, MD		2	0.1%	2	$120.00	$115.00	$85.00	2	1.0
BRADLEY WATTS, MDIV		2	0.1%	3	$375.00	$212.00	$167.00	3	1.5
ALAN T FISHER, PHD		2	0.1%	5	$570.00	$394.00	$319.00	5	2.5
MICHAEL G MILLER, PHD		2	0.1%	5	$600.00	$275.00	$275.00	4	2.0
DONALD GILBERT, MD		2	0.1%	10	$1,154.00	$1,154.00	$577.00	10	5.0
WARREN J HEARD JR, PHD		2	0.1%	4	$2,210.00	$2,210.00	$1,105.00	16	8.0
MARY CANANE, MS		2	0.1%	7	$960.00	$480.00	$360.00	8	4.0
LARRY SHRIER, MA		2	0.1%	2	$700.00	$700.00	$350.00	4	2.0
EARL F RECTANUS JR, PHD		2	0.1%	10	$5,455.00	$2,660.00	$2,050.00	38	19.0
CHARLES D DEVINE, MD		2	0.1%	2	$150.00	$100.00	$70.00	2	1.0
MAHENDRA R SHAH, MD		2	0.1%	5	$520.00	$335.00	$260.00	5	2.5
JOHN P STRAETMANS, MD		2	0.1%	2	$200.00	$100.00	$70.00	2	1.0
KENNETH L MOSES, MD		2	0.1%	4	$900.00	$900.00	$450.00	5	2.5
DOLORES KRAFT, PHD		2	0.1%	2	$300.00	$256.00	$211.00	3	1.5
DORIS S DEMATO, PHD		2	0.1%	8	$800.00	$514.00	$394.00	8	4.0
MARILYN G SALASKY, MSW		2	0.1%	9	$900.00	$558.00	$423.00	9	4.5
JONATHAN BLOOMBERG, MD		2	0.1%	3	$390.00	$390.00	$195.00	3	1.5
ANDREA F STUCK, MA		2	0.1%	3	$990.00	$990.00	$495.00	9	4.5
CONSTANCE W VAN DER EB, PHD		2	0.1%	3	$510.00	$335.00	$275.00	4	2.0
JEANNE M VONERDEN, PSYD		2	0.1%	3	$550.00	$370.00	$310.00	4	2.0
AILEEN GRUENDEL, PHD		2	0.1%	3	$670.00	$670.00	$335.00	7	3.5
TAHIR RAHMAN, MD		2	0.1%	5	$630.00	$630.00	$315.00	5	2.5
RALPH J TOBIAS, PHD		2	0.1%	6	$1,155.00	$805.00	$612.50	8	4.0
TERRY SMITH, PHD		2	0.1%	3	$650.00	$650.00	$325.00	5	2.5
ANNE MARIE COOK, MSW		2	0.1%	2	$186.00	$186.00	$141.00	3	1.5
BOB W MEEK, MED		2	0.1%	9	$935.00	$715.00	$550.00	11	5.5
DEBORAH G BURGESS, MS		2	0.1%	4	$650.00	$260.00	$200.00	4	2.0
RAAFEA F MALIK, MD		2	0.1%	4	$402.00	$340.00	$280.00	4	2.0
CHRIS SHANKLIN, PHD		2	0.1%	7	$1,125.00	$1,125.00	$562.50	9	4.5
MARY ANNE E IORIO, MSW		2	0.1%	10	$895.00	$615.00	$465.00	10	5.0
SARAH STREBECK, MD		2	0.1%	2	$170.00	$120.00	$90.00	2	1.0
COVENANT CLINIC PSYCHIATRY WAT		2	0.1%	4	$658.00	$322.00	$221.50	4	2.0

Report ID: CLWO0040A
Report Run Date: 02/19/2007
Report Run Time: 04:16:42 PM

Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
SUZANN OKOON, PHD	[redacted]	2	0.1%	3	$1,100.00	$594.00	$451.50	7	3.5
LAUREN MURPHY PAYNE, MSW		2	0.1%	13	$1,605.00	$1,605.00	$802.50	13	6.5
WILLIAM B LYLES, MD		2	0.1%	3	$500.00	$270.00	$225.00	3	1.5
PATRICIA M. MARCHANT, MSW		2	0.1%	16	$2,340.00	$2,340.00	$1,170.00	18	9.0
KAREN L CASSIDAY, PHD		2	0.1%	2	$893.00	$893.00	$446.50	6	3.0
VENKATA K SHARMA, MD		2	0.1%	2	$250.00	$130.00	$100.00	2	1.0
DEAN E STOLLDORF, PHD		2	0.1%	3	$775.00	$575.00	$485.00	6	3.0
STEPHANY BRACKETT, MSW		2	0.1%	6	$860.00	$490.00	$400.00	6	3.0
KATHERINE J CORCORAN, PHD		2	0.1%	7	$688.00	$380.00	$150.30	4	2.0
VENKATA K SHARMA, MD		2	0.1%	2	$140.00	$130.00	$100.00	2	1.0
CHRISTINE M HANSBURG HOTSON, M		2	0.1%	18	$2,647.00	$1,130.00	$845.00	19	9.5
WENDIE T DALBERG, MSW		2	0.1%	2	$1,520.00	$1,040.00	$800.00	16	8.0
NINA L ANDERSON, MD		2	0.1%	3	$195.00	$150.00	$105.00	3	1.5
TORRE K SWANSON, MS		2	0.1%	2	$1,100.00	$715.00	$445.00	11	5.5
KATHLEEN J ANGELL, MA		2	0.1%	5	$455.00	$455.00	$350.00	7	3.5
SUSAN E KORTLANDER, PHD		2	0.1%	4	$1,200.00	$440.00	$350.00	6	3.0
JON A COLE, PHD		2	0.1%	2	$240.00	$160.00	$130.00	2	1.0
ELEN TYLKIN, MD		2	0.1%	5	$750.00	$375.00	$300.00	5	2.5
ROBERT K HEINRICH, PHD		2	0.1%	2	$440.00	$408.00	$333.00	5	2.5
CONNIE S STANISLAUS, MSW		2	0.1%	9	$860.00	$585.00	$362.50	9	4.5
CLARE J KASEMEIER, MSW		2	0.1%	2	$170.00	$140.00	$110.00	2	1.0
ROBERT P KLEIN, MSW		2	0.1%	8	$680.00	$520.00	$295.00	8	4.0
CURT L WENNERDAHL, MSW		2	0.1%	2	$660.00	$520.00	$400.00	8	4.0
KIMBERLY GARVEY HOEHNE, MA		2	0.1%	2	$1,315.00	$1,315.00	$1,052.00	8	4.0
JONATHAN C GAMZE, MD		2	0.1%	9	$900.00	$900.00	$450.00	9	4.5
DOUGLAS N NEAL, PSYD		2	0.1%	4	$2,750.00	$2,750.00	$1,375.00	22	11.0
DONNA M WOODS, MD		2	0.1%	3	$270.00	$270.00	$135.00	3	1.5
ELEANOR J GROSS, MA		2	0.1%	9	$1,105.00	$585.00	$450.00	9	4.5
PAMELA M RAK, MSW		2	0.1%	2	$700.00	$335.00	$260.00	5	2.5
ALEXIAN BROTHERS BEHAVIORAL HL		2	0.1%	3	$207.00	$158.00	$113.00	3	1.5
BARBARA RITCHKEN, MD		2	0.1%	7	$1,055.00	$490.00	$370.00	8	4.0
DEBRA WOLFF, PSYD		2	0.1%	5	$880.00	$413.00	$323.00	6	3.0
LISA DAUJOTAS, MSW		2	0.1%	2	$300.00	$300.00	$150.00	3	1.5
SUSAN FEINGOLD, PSYD		2	0.1%	4	$2,125.00	$2,125.00	$1,062.50	17	8.5
RAYMOND GOUTTAMA, MD		2	0.1%	5	$700.00	$340.00	$265.00	5	2.5
LINDA L. HINES, PHD		2	0.1%	7	$945.00	$945.00	$472.50	7	3.5
CHRISTINE A OLSON, MD		2	0.1%	3	$430.00	$430.00	$215.00	3	1.5
ASSOCIATE IN FAMILY CARE		2	0.1%	4	$520.00	$520.00	$260.00	4	2.0
DEBBIE ELLIS, MSW		2	0.1%	2	$360.00	$360.00	$180.00	3	1.5
GEORGETTE M HEIN, PSYD		2	0.1%	3	$675.00	$675.00	$337.50	5	2.5
J MICHAEL DALY, MA		2	0.1%	5	$1,060.00	$588.00	$453.00	9	4.5
RANDY J GEORGEMILLER, PHD		2	0.1%	7	$2,300.00	$1,295.00	$1,045.00	7	3.5
BETH I WILNER, PHD		2	0.1%	4	$550.00	$322.00	$262.00	4	2.0
DAVID BUCKMAN, MA		2	0.1%	6	$1,000.00	$1,000.00	$500.00	8	4.0
DONNA GATES, UNKN		2	0.1%	4	$1,450.00	$930.00	$720.00	14	7.0
CAROL L DREYER, MA		2	0.1%	15	$2,100.00	$1,050.00	$735.00	16	8.0
EDWARD D ZEHR, MSW		2	0.1%	4	$1,040.00	$1,040.00	$520.00	9	4.5
JOHN E MOSS, MSW		2	0.1%	8	$960.00	$600.00	$480.00	8	4.0
MARLYS A CONRAD, PHD		2	0.1%	3	$405.00	$270.00	$225.00	3	1.5
INNA DUBINSKY, MD		2	0.1%	2	$170.00	$100.00	$70.00	2	1.0
STEPHEN G GALSTON, MD		2	0.1%	2	$300.00	$300.00	$150.00	3	1.5
AMY R BYRNE, MSW		2	0.1%	6	$720.00	$560.00	$470.00	6	3.0
SUDHIR M GOKHALE, MD		2	0.1%	4	$320.00	$200.00	$130.00	4	2.0
WAYNE A. PREPURA, PHD		2	0.1%	3	$520.00	$520.00	$260.00	3	1.5
JOEL R LEFF, MD		2	0.1%	3	$450.00	$330.00	$285.00	3	1.5
VASSILIKI E TOULIOS, MD		2	0.1%	3	$420.00	$210.00	$165.00	3	1.5
ELIEZER KRUMBEIN, PHD		2	0.1%	8	$1,680.00	$1,680.00	$1,390.00	21	10.5
DICKIE KAY, MD		2	0.1%	2	$220.00	$100.00	$70.00	2	1.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
LANA N PETERS, PHD	[redacted]	2	0.1%	2	$170.00	$165.00	$110.00	2	1.0
GAYLE LYNN SCHULTZ, MSW		2	0.1%	4	$700.00	$455.00	$350.00	7	3.5
SHELLY KEENEY, PSYD		2	0.1%	5	$909.00	$909.00	$744.00	11	5.5
CORINNE GRICHNIK, MSW		2	0.1%	4	$1,625.00	$1,053.00	$778.00	16	8.0
CAROLYN R KUBIAK, PHD		2	0.1%	7	$855.00	$855.00	$427.50	9	4.5
SHARI JACOBSEN, MA		2	0.1%	6	$995.00	$995.00	$497.50	9	4.5
ALINE FIEDOROWICZ, MSW		2	0.1%	5	$1,040.00	$1,040.00	$520.00	8	4.0
GAIL M WEIL, MSW		2	0.1%	6	$1,025.00	$660.00	$510.00	10	5.0
MICHELLE NAVARRO, PHD		2	0.1%	5	$2,110.00	$2,110.00	$1,055.00	13	6.5
MICHAEL E CULLEN, MSW		2	0.1%	8	$1,470.00	$1,470.00	$735.00	11	5.5
JOHN F ZAGOTTA, PHD		2	0.1%	6	$700.00	$499.00	$409.00	6	3.0
TERRY K STRICKLAND, MA		2	0.1%	2	$600.00	$390.00	$300.00	6	3.0
JAMES N WATZKE, PHD		2	0.1%	5	$948.80	$735.00	$542.50	9	4.5
KATHRYN S MURSAU, PSYD		2	0.1%	2	$390.00	$260.00	$200.00	4	2.0
THOMAS F WRIGHT, MA		2	0.1%	3	$1,550.00	$790.00	$610.00	12	6.0
JENIFER R JACOBS, PHD		2	0.1%	3	$460.00	$416.00	$356.00	4	2.0
LINDA H LAND, MSW		2	0.1%	5	$1,254.00	$1,254.00	$627.00	12	6.0
CLINTON S PAYNE, MS		2	0.1%	2	$800.00	$800.00	$400.00	10	5.0
KATHRYN WEEKS, MSW		2	0.1%	4	$480.00	$400.00	$250.00	4	2.0
PETER FELDMAN, DPH		2	0.1%	4	$560.00	$320.00	$235.00	4	2.0
ANN M DRAKE, MA		2	0.1%	5	$500.00	$316.00	$223.50	5	2.5
MARTIN W MURPHY, MFS		1	0.0%	1	$825.00	$825.00	$412.50	4	4.0
PRITI M KOTHAIN, MD		1	0.0%	2	$290.00	$290.00	$145.00	2	2.0
KATHLEEN D MICHAUD, MA		1	0.0%	5	$840.00	$840.00	$420.00	7	7.0
ALYSON G MARSALIS, MA		1	0.0%	1	$65.00	$65.00	$50.00	1	1.0
MATTHEW R FREDERICK, MSW		1	0.0%	4	$550.00	$238.00	$178.00	4	4.0
DAVID C HAAS, MD		1	0.0%	3	$270.00	$144.00	$99.00	3	3.0
SAMANTHA E CARELLA, PSYD		1	0.0%	1	$540.00	$540.00	$270.00	3	3.0
MARIAN H HIGGINS, PHD		1	0.0%	2	$1,125.00	$698.00	$563.00	9	9.0
KENNETH GORFINKLE, PHD		1	0.0%	1	$700.00	$700.00	$350.00	3	3.0
LINDA CAMLIN, PHD		1	0.0%	1	$840.00	$840.00	$420.00	6	6.0
JARED STEVEN PUTNAM, MD		1	0.0%	1	$250.00	$104.00	$89.00	1	1.0
MARK LOVINGER, PHD		1	0.0%	2	$400.00	$160.00	$130.00	2	2.0
EDWARD H PLIMPTON, PHD		1	0.0%	4	$570.00	$415.00	$340.00	5	5.0
DANIEL J FRIEDENSON, MD		1	0.0%	3	$434.00	$225.00	$180.00	3	3.0
MASS GENERAL PHYSICIAN ORG		1	0.0%	1	$509.00	$509.00	$254.50	1	1.0
BAYSTATE MEDICAL CENTER MAIN S		1	0.0%	2	$635.64	$265.00	$205.00	4	4.0
DIANE I DUBE, MA		1	0.0%	4	$670.00	$265.00	$205.00	4	4.0
STAFFIER ASSOCIATE INCORPORATE		1	0.0%	1	$85.00	$50.00	$25.00	1	1.0
NICHOLS ROBERT, MA		1	0.0%	2	$740.00	$740.00	$370.00	4	4.0
ALFRED F CIALFI JR, PHD		1	0.0%	6	$945.00	$945.00	$472.50	7	7.0
MARTIN J GREENGRASS, PHD		1	0.0%	1	$135.00	$70.00	$55.00	1	1.0
JOHN D MCCABE, MSW		1	0.0%	2	$480.00	$480.00	$240.00	6	6.0
MAUREEN ANGELA DESCHLER, MA		1	0.0%	1	$135.00	$135.00	$105.00	2	2.0
MEGAN W SPINKS, MSW		1	0.0%	1	$85.00	$62.00	$47.00	1	1.0
MARY BRIDGE BYRLEY, MA		1	0.0%	5	$485.00	$323.00	$248.00	5	5.0
BRIAN A HICKEY, MSN		1	0.0%	1	$55.00	$55.00	$27.50	1	1.0
NEAL KIRSCHENBAUM, PHD		1	0.0%	1	$840.00	$480.00	$390.00	6	6.0
JENNIFER RADACHOWSKY, BS		1	0.0%	1	$5,793.75	$5,793.75	$4,635.00	29	29.0
CHRISTINA TAYLOR, PHD		1	0.0%	2	$260.00	$220.00	$190.00	2	2.0
ADAM COHEN, MS		1	0.0%	1	$550.00	$550.00	$440.00	6	6.0
ZABRIN INAN, MD		1	0.0%	2	$500.00	$360.00	$315.00	3	3.0
RICHARD I FEINBERG, MSW		1	0.0%	8	$1,360.00	$1,360.00	$680.00	8	8.0
HEATHER J TOLL, PSYD		1	0.0%	2	$495.00	$285.00	$240.00	3	3.0
MARGARET VANDERLIN, RN		1	0.0%	1	$120.00	$56.00	$41.00	1	1.0
SUSAN H WALSH, MSW		1	0.0%	2	$170.00	$149.00	$119.00	2	2.0
DOUGLAS A BERV, MD		1	0.0%	2	$375.00	$195.00	$97.50	2	2.0
MICHAEL N SAREZKY, MD		1	0.0%	3	$615.00	$360.00	$315.00	3	3.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
ROY KENNETH LAFRENIER JR, MD	[redacted]	1	0.0%	3	$490.00	$490.00	$245.00	3	3.0
GALE A LEVIN, MD		1	0.0%	3	$270.00	$225.00	$180.00	3	3.0
BRIAN JOSEPH, MD		1	0.0%	1	$240.00	$240.00	$120.00	2	2.0
SHELLEY FRIEDMAN, MSW		1	0.0%	1	$1,170.00	$1,170.00	$585.00	13	13.0
ANNE GOLDFIELD, PHD		1	0.0%	1	$375.00	$375.00	$187.50	3	3.0
SAMIR GUPTA, MD		1	0.0%	1	$800.00	$800.00	$400.00	5	5.0
NEAL BLACKSTEIN, PHD		1	0.0%	1	$600.00	$600.00	$300.00	6	6.0
RONALD C GOLINGER, MD		1	0.0%	2	$245.00	$160.00	$130.00	2	2.0
GINO GROSSO, MD		1	0.0%	2	$275.00	$190.00	$160.00	2	2.0
KENNETH S KLINE, PHD		1	0.0%	1	$875.00	$475.00	$335.00	5	5.0
CAROL S GEE, PHD		1	0.0%	1	$110.00	$80.00	$65.00	1	1.0
BURTON A KITTAY, PHD		1	0.0%	4	$480.00	$304.00	$152.00	4	4.0
AUDREY FALK, MSW		1	0.0%	1	$570.00	$570.00	$465.00	7	7.0
CHRISTOPHER C DECANIO, PHD		1	0.0%	2	$200.00	$144.00	$72.00	2	2.0
RONALD SHECTMAN, PHD		1	0.0%	1	$110.00	$76.00	$61.00	1	1.0
SUSAN T MARCIANO, PHD		1	0.0%	1	$110.00	$65.00	$50.00	1	1.0
PAUL JAN SCHWARTZ, PHD		1	0.0%	2	$860.00	$575.00	$465.00	7	7.0
KATHERINE C CHAITIN, PSYD		1	0.0%	1	$375.00	$375.00	$300.00	3	3.0
RONALD E SILVERMAN, PHD		1	0.0%	2	$1,125.00	$1,125.00	$562.50	7	7.0
ANITA R SUSSMAN, MSW		1	0.0%	2	$990.00	$990.00	$495.00	9	9.0
DIANE OSTEBEE, MSW		1	0.0%	6	$590.00	$390.00	$300.00	6	6.0
TIFFANY D WILLIAMS JONES, PHD		1	0.0%	1	$160.00	$75.00	$60.00	1	1.0
JOHN F GOTTLIEB, MD		1	0.0%	3	$1,000.00	$1,000.00	$500.00	5	5.0
RONNA RENEE STEELE, PHD		1	0.0%	6	$1,540.00	$1,232.00	$1,022.00	14	14.0
CRAIG IRWIN RICH, PHD		1	0.0%	1	$420.00	$268.00	$223.00	3	3.0
LIZABETH KOLLMORGEN, PSYD		1	0.0%	1	$280.00	$280.00	$140.00	2	2.0
JAMES M DOD, PHD		1	0.0%	1	$150.00	$80.00	$40.00	1	1.0
LYNN L BARNETT, MD		1	0.0%	2	$180.00	$180.00	$90.00	2	2.0
CHRISTOPHER J CORNER, MD		1	0.0%	1	$70.00	$50.00	$35.00	1	1.0
MAXIMILLIAN WACHTEL, PHD		1	0.0%	1	$300.00	$234.00	$189.00	3	3.0
SRISAI GOWDA, MD		1	0.0%	1	$125.00	$65.00	$50.00	1	1.0
ASHAYE OLUROTIMI, MD		1	0.0%	2	$152.00	$152.00	$76.00	2	2.0
ELEONORA SIKIC KLISOVIC, MD		1	0.0%	1	$175.00	$175.00	$87.50	1	1.0
MARY H CASE, MA		1	0.0%	1	$120.00	$120.00	$60.00	1	1.0
DON G ELLIGAN, PHD		1	0.0%	6	$900.00	$480.00	$390.00	6	6.0
PATRICIA CABALLERO, MD		1	0.0%	2	$315.00	$165.00	$135.00	2	2.0
ROBERT PATTERSON, BS		1	0.0%	1	$120.00	$120.00	$60.00	1	1.0
MALLY K NACE, BA		1	0.0%	1	$120.00	$120.00	$60.00	1	1.0
KELLY ORR, MSW		1	0.0%	4	$550.00	$325.00	$232.50	5	5.0
BARLOW SMITH, MD		1	0.0%	3	$300.00	$280.00	$235.00	3	3.0
SORAYA ZANGENEH RADFAR, MD		1	0.0%	2	$180.00	$120.00	$90.00	2	2.0
ANTHONY J CICCONE, MA		1	0.0%	1	$250.00	$137.00	$68.50	2	2.0
MICHAEL S GROVE, PHD		1	0.0%	1	$250.00	$250.00	$125.00	5	5.0
LANE HARMON, MSW		1	0.0%	5	$1,800.00	$1,800.00	$900.00	18	18.0
DONALD MCDEVITT, MA		1	0.0%	3	$1,300.00	$1,300.00	$650.00	13	13.0
ANGELA P TRIPODI, MSW		1	0.0%	1	$170.00	$127.00	$63.50	2	2.0
DAVID GOLDSTEIN, MD		1	0.0%	1	$95.00	$95.00	$47.50	1	1.0
CHRISTOPHER L JOHNSTON, PHD		1	0.0%	3	$1,500.00	$1,500.00	$1,200.00	10	10.0
LINDA D L ABBE, MA		1	0.0%	1	$480.00	$390.00	$195.00	6	6.0
TRACY G BUSHKOFF, EDD		1	0.0%	1	$660.00	$660.00	$330.00	6	6.0
CYNTHIA B SCHWARTZ DEVOL, PHD		1	0.0%	3	$225.00	$225.00	$180.00	3	3.0
MARY KAREN HAMPTON, MSSW		1	0.0%	2	$630.00	$465.00	$360.00	7	7.0
MICHAEL M KEIL, PHD		1	0.0%	3	$295.00	$180.00	$150.00	2	2.0
SHARON LYNN WHITE, MSW		1	0.0%	2	$220.00	$166.00	$136.00	2	2.0
LINDA CHERNEY, MS		1	0.0%	1	$1,265.00	$1,265.00	$632.50	11	11.0
PEGGY WINGO, PHD		1	0.0%	2	$1,570.00	$895.00	$730.00	11	11.0
SARA A MOORE, MA		1	0.0%	2	$244.00	$244.00	$184.00	4	4.0
STEVEN B MASTER, PHD		1	0.0%	1	$200.00	$150.00	$120.00	2	2.0

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Sample Company

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Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
SAUNDRA A BARNETT REYES, MD	[redacted]	1	0.0%	1	$175.00	$125.00	$110.00	1	1.0
DIANA M WATSON, PHD		1	0.0%	3	$390.00	$285.00	$240.00	3	3.0
LAWRENCE B HURWITZ, MD		1	0.0%	2	$400.00	$320.00	$160.00	4	4.0
BENJAMIN N SHAIN, MD		1	0.0%	6	$744.00	$529.00	$314.50	8	8.0
ELIZABETH L BRUMFIELD, MD		1	0.0%	1	$110.00	$110.00	$55.00	1	1.0
JUDITH S TELLERMAN, PHD		1	0.0%	1	$1,250.00	$495.00	$405.00	6	6.0
PAUL G JOSELL, PSYD		1	0.0%	2	$360.00	$240.00	$120.00	3	3.0
EILEEN MCCANN, MSW		1	0.0%	1	$100.00	$70.00	$35.00	1	1.0
JEFFREY A BERGER, PHD		1	0.0%	4	$1,625.00	$1,235.00	$1,040.00	13	13.0
ORA LIMOR, PSYD		1	0.0%	1	$150.00	$95.00	$80.00	1	1.0
GARY J KUSHNER, EDD		1	0.0%	2	$900.00	$900.00	$450.00	6	6.0
SATINDER P BRAR, PSYD		1	0.0%	2	$280.00	$280.00	$140.00	2	2.0
VINCENT ADESSO, MSW		1	0.0%	5	$750.00	$750.00	$375.00	5	5.0
LISE K DEGUIRE, PSYD		1	0.0%	3	$600.00	$475.00	$400.00	5	5.0
CHRISTOPHER G RUSSELL, MSW		1	0.0%	1	$100.00	$62.00	$47.00	1	1.0
FRANK MACRI, MSW		1	0.0%	1	$110.00	$80.00	$65.00	1	1.0
MANUEL ASTRUC, MD		1	0.0%	3	$240.00	$240.00	$120.00	3	3.0
MELISSA M THOMPSON, MSW		1	0.0%	3	$270.00	$240.00	$195.00	3	3.0
TABASSUM KHAN, MD		1	0.0%	1	$105.00	$85.00	$70.00	1	1.0
VICTORIA A RIVERA, MD		1	0.0%	1	$200.00	$130.00	$100.00	2	2.0
HUDSON MOHAWK RECVRY CENTER		1	0.0%	1	$675.00	$475.00	$237.50	9	9.0
ARTHUR STROCK, PHD		1	0.0%	5	$1,000.00	$664.00	$544.00	8	8.0
SHIRLEY LOUGHLIN, MSW		1	0.0%	4	$660.00	$660.00	$330.00	6	6.0
DEBORAH K TYSON, PHD		1	0.0%	1	$150.00	$80.00	$65.00	1	1.0
ALAN FRANCIS JAVEL, MD		1	0.0%	1	$74.82	$74.82	$37.41	1	1.0
TAMSEN THORPE, PHD		1	0.0%	5	$900.00	$570.00	$480.00	6	6.0
AMY E CHARNEY, PSYD		1	0.0%	1	$270.00	$190.00	$95.00	2	2.0
EDWARD BERGER, PHD		1	0.0%	4	$2,550.00	$1,425.00	$712.50	15	15.0
SHEILA T GRACE, MSW		1	0.0%	2	$570.00	$388.00	$298.00	6	6.0
STEPHANIE A ROSS, PHD		1	0.0%	2	$300.00	$300.00	$150.00	2	2.0
EMMA K VIGLUCCI, MA		1	0.0%	6	$2,875.00	$2,875.00	$1,437.50	23	23.0
DEBORAH S HAMM, MD		1	0.0%	8	$5,500.00	$5,500.00	$2,750.00	22	22.0
ELYSE DUBIN, MD		1	0.0%	3	$3,250.00	$3,250.00	$1,625.00	10	10.0
HAROLD A HAMER, MD		1	0.0%	3	$405.00	$375.00	$330.00	3	3.0
SARA T BAUMAN, MSW		1	0.0%	4	$2,125.00	$2,125.00	$1,062.50	17	17.0
MICHAEL M KEIL, PHD		1	0.0%	1	$120.00	$75.00	$60.00	1	1.0
MELISSA D GEIBEL MCKEE, MSW		1	0.0%	4	$665.00	$434.00	$329.00	7	7.0
WENDY WEAVER GRAHAM, PHD		1	0.0%	4	$540.00	$360.00	$270.00	4	4.0
LOUIS K HAUBER, MD		1	0.0%	1	$75.00	$50.00	$35.00	1	1.0
CATHY S MALMON, MSW		1	0.0%	5	$450.00	$310.00	$235.00	5	5.0
JENNIFER P OLDENBURG, PHD		1	0.0%	4	$700.00	$700.00	$565.00	9	9.0
AMELIA GREMELSPACHER, PHD		1	0.0%	2	$200.00	$96.00	$66.00	2	2.0
OSCAR URREA, MD		1	0.0%	1	$100.00	$50.00	$35.00	1	1.0
WILLIAM E COLLINS, PHD		1	0.0%	1	$125.00	$80.00	$65.00	1	1.0
CYNTHIA JEAN SAUBER, MSW		1	0.0%	2	$270.00	$213.00	$168.00	3	3.0
JUDITH D ALEXANDER, MSW		1	0.0%	1	$160.00	$160.00	$130.00	2	2.0
ANN SKILLINGTON, MED		1	0.0%	1	$630.00	$630.00	$315.00	6	6.0
ELIZABETH C HUTCHESON, MSW		1	0.0%	1	$240.00	$240.00	$120.00	2	2.0
MICHELLE G SCOTT, MSW		1	0.0%	2	$270.00	$270.00	$135.00	3	3.0
BALDWIN COUNTY MH MR CENTER		1	0.0%	1	$200.00	$200.00	$100.00	2	2.0
UNITY HOSPITAL LONG POND RD		1	0.0%	1	$2,034.00	$2,034.00	$1,017.00	18	18.0
UNITY HOSPITAL PARKRIDGE		1	0.0%	1	$1,032.00	$1,032.00	$516.00	9	9.0
UNITY HOSPITAL OF ROCHESTER AD		1	0.0%	2	$415.00	$415.00	$207.50	3	3.0
KENNETH YOUNG CENTER IL		1	0.0%	1	$130.00	$130.00	$65.00	1	1.0
ROBERT J WHEELER, MA		1	0.0%	2	$480.00	$480.00	$360.00	8	8.0
THERESA R DISERIO, PHD		1	0.0%	6	$915.00	$514.00	$424.00	6	6.0
VICKI L SHINODA, MSW		1	0.0%	1	$137.00	$137.00	$107.00	2	2.0
MATTHEW A BERGER, MD		1	0.0%	2	$178.00	$110.00	$80.00	2	2.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
MARY ANNE KENNEDY, MASW	[redacted]	1	0.0%	2	$300.00	$160.00	$80.00	2	2.0
TIMBERLAWN LAS COLINAS CLINIC		1	0.0%	1	$180.00	$150.00	$135.00	1	1.0
REBECCA TRUAX, MA		1	0.0%	4	$380.00	$300.00	$240.00	4	4.0
LISA M BLOCK, MD		1	0.0%	2	$292.00	$195.00	$165.00	2	2.0
KENNETH J ZEMANEK, MD		1	0.0%	1	$80.00	$50.00	$25.00	1	1.0
GARY J BELL, MSW		1	0.0%	1	$225.00	$137.00	$107.00	2	2.0
SUSAN L. CABOULI, PHD		1	0.0%	7	$770.00	$665.00	$400.00	7	7.0
THOMAS G BARTLETT, PHD		1	0.0%	3	$330.00	$225.00	$157.50	3	3.0
CATHARINE F TOSO, DSW		1	0.0%	1	$225.00	$75.00	$60.00	1	1.0
DANIEL D YUTZY, MSW		1	0.0%	3	$665.00	$665.00	$332.50	7	7.0
SYDNEY E SLYE, MSW		1	0.0%	3	$390.00	$199.00	$154.00	3	3.0
SHEILA M BAER, PHD		1	0.0%	11	$1,595.00	$975.00	$745.00	12	12.0
JANE A STEINBERG, MA		1	0.0%	2	$1,000.00	$528.00	$408.00	8	8.0
BEATO M CRONIN, PHD		1	0.0%	1	$100.00	$100.00	$50.00	1	1.0
RICHARD HALL CMHC OF SOMERSET		1	0.0%	2	$465.00	$465.00	$375.00	6	6.0
MICHAEL W MANGIS, PHD		1	0.0%	10	$1,905.00	$1,165.00	$692.00	13	13.0
MARY BETH MCGUINN, MSW		1	0.0%	5	$805.00	$415.00	$313.50	5	5.0
GIBBS L ARTHUR JR, MED		1	0.0%	1	$240.00	$240.00	$120.00	3	3.0
AMER H KASHOQA, MD		1	0.0%	1	$135.00	$135.00	$67.50	1	1.0
SUZANNE B. HERRMANN, MSW		1	0.0%	5	$1,000.00	$800.00	$650.00	10	10.0
MICHELLE S HUNT, PSYD		1	0.0%	2	$270.00	$160.00	$130.00	2	2.0
LAURIE LINDNER, PHD		1	0.0%	4	$1,225.00	$1,225.00	$612.50	7	7.0
MARIA VICTORIA ONGSIAKO, MD		1	0.0%	1	$160.00	$130.00	$100.00	2	2.0
JERSEY SHORE MEDICAL CENTER RT		1	0.0%	1	$260.00	$230.00	$200.00	2	2.0
WILLIAM P HAYES, MD		1	0.0%	1	$155.00	$155.00	$77.50	1	1.0
MOUSTAFA H SHAFEY, MD		1	0.0%	1	$140.00	$140.00	$70.00	1	1.0
STEVEN WOODS, MSW		1	0.0%	5	$625.00	$400.00	$275.00	5	5.0
MICHAEL D. ROBINSON, MD		1	0.0%	3	$525.00	$525.00	$262.50	3	3.0
ROSEANN TUCHMAN, MSW		1	0.0%	3	$285.00	$285.00	$142.50	3	3.0
FRED R EISNER, PHD		1	0.0%	3	$840.00	$570.00	$480.00	6	6.0
DAVID GEOFFREY MILLER, MD		1	0.0%	2	$250.00	$250.00	$220.00	2	2.0
DARLENE OSIPUK, MD		1	0.0%	1	$850.00	$850.00	$425.00	4	4.0
NICOLE ALVAREZ, MSW		1	0.0%	1	$450.00	$450.00	$225.00	3	3.0
SHARON RYAN MONTGOMERY, PSYD		1	0.0%	1	$540.00	$540.00	$270.00	3	3.0
MICHAEL ALAN LEOPOLD, MD		1	0.0%	2	$270.00	$270.00	$135.00	2	2.0
JULES TANENBAUM, MD		1	0.0%	1	$80.00	$80.00	$40.00	1	1.0
SUSAN L HOLLANDER, PHD		1	0.0%	1	$780.00	$510.00	$420.00	6	6.0
ELLIOT MARK KRANZLER, MD		1	0.0%	1	$550.00	$550.00	$275.00	2	2.0
EILEEN G IVEY, MSW		1	0.0%	1	$610.00	$323.00	$248.00	5	5.0
DAVID SIEGMAN, PSYD		1	0.0%	1	$380.00	$380.00	$320.00	4	4.0
JOHN HENDERSON, PHD		1	0.0%	7	$665.00	$665.00	$332.50	7	7.0
SARAH E WOOD, PHD		1	0.0%	2	$400.00	$400.00	$200.00	4	4.0
DAVE SHANNON, MSW		1	0.0%	3	$2,000.00	$2,000.00	$1,000.00	16	16.0
PETER DEMUTH, PSYD		1	0.0%	2	$1,500.00	$975.00	$795.00	12	12.0
LYDIA G ROTH LAUBE, PHD		1	0.0%	1	$375.00	$240.00	$195.00	3	3.0
RENEE A SILVERMAN, PHD		1	0.0%	1	$630.00	$455.00	$350.00	7	7.0
BARBARA K PAIGE, PHD		1	0.0%	1	$110.00	$71.00	$56.00	1	1.0
MARY L ST AUBIN, MA		1	0.0%	1	$375.00	$300.00	$225.00	5	5.0
ELIZABETH DALE BLAIR, PHD		1	0.0%	1	$240.00	$150.00	$120.00	2	2.0
KIMBERLY P RAY, PHD		1	0.0%	7	$2,572.95	$2,572.95	$2,058.36	26	26.0
SANDRA TAYLOR, MSSW		1	0.0%	1	$75.00	$65.00	$50.00	1	1.0
KURT D SOELL, MA		1	0.0%	6	$540.00	$540.00	$270.00	6	6.0
HALLIE MCLEOD, MA		1	0.0%	1	$1,100.00	$1,100.00	$550.00	11	11.0
KATHALEEN NEVILLE, MSW		1	0.0%	1	$160.00	$160.00	$80.00	2	2.0
SUSAN A ACKERMAN ROSS, PHD		1	0.0%	1	$125.00	$80.00	$65.00	1	1.0
TERRY A RIFKIN, MSW		1	0.0%	1	$125.00	$66.00	$51.00	1	1.0
CHARLOTTE C HOUSTON, PHD		1	0.0%	1	$125.00	$88.00	$73.00	1	1.0
JENNIFER D GRIMES, MED		1	0.0%	3	$1,320.00	$715.00	$550.00	11	11.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

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Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
RONALD WYMER, MA	[redacted]	1	0.0%	2	$190.00	$190.00	$95.00	3	3.0
RICHARD SCHAPS, MSW		1	0.0%	3	$1,210.00	$725.00	$560.00	11	11.0
JOSEPH F PRIBYL, PHD		1	0.0%	3	$1,200.00	$800.00	$650.00	10	10.0
PHILIP A. GROSSI, MD		1	0.0%	5	$550.00	$550.00	$275.00	5	5.0
LAURA ROSENBERG, MA		1	0.0%	2	$300.00	$300.00	$150.00	3	3.0
SUZANNE WALKER, MA		1	0.0%	7	$840.00	$840.00	$420.00	7	7.0
HARRIET PORTER, MSW		1	0.0%	6	$600.00	$600.00	$300.00	6	6.0
KIM MILLER, MA		1	0.0%	2	$800.00	$800.00	$400.00	10	10.0
SHARON PETERSON, MSW		1	0.0%	6	$1,050.00	$650.00	$500.00	10	10.0
HEIDI MEREDITH, MD		1	0.0%	3	$525.00	$525.00	$262.50	3	3.0
JAMES R DAVIES, MSW		1	0.0%	1	$220.00	$140.00	$110.00	2	2.0
JULEE E BARKAUSKAS, MSW		1	0.0%	2	$360.00	$260.00	$200.00	4	4.0
LYNDA M BEHRENDT, PSYD		1	0.0%	3	$720.00	$480.00	$390.00	6	6.0
LISA SCHAB, MSW		1	0.0%	1	$90.00	$90.00	$45.00	1	1.0
ELEANOR AISENBERG, PSYD		1	0.0%	1	$780.00	$780.00	$390.00	6	6.0
ALBERTO MINZER, MSW		1	0.0%	2	$390.00	$325.00	$250.00	5	5.0
JAN WENDY ITZKOWITZ, MA		1	0.0%	3	$300.00	$300.00	$150.00	3	3.0
SHANNON PURTELL, MA		1	0.0%	2	$180.00	$124.00	$94.00	2	2.0
TERRILYN KERR, PSYD		1	0.0%	4	$1,080.00	$720.00	$585.00	9	9.0
FREDA BARON FRIEDMAN, MSW		1	0.0%	2	$1,120.00	$520.00	$400.00	8	8.0
SUSAN LYNNE EICHMAN PARCELL, M		1	0.0%	3	$390.00	$205.00	$160.00	3	3.0
LINDA SHELLY R AINSWORTH, MSW		1	0.0%	2	$210.00	$130.00	$100.00	2	2.0
PAUL ROHLING, MSW		1	0.0%	4	$520.00	$520.00	$260.00	4	4.0
ALLEN KUO, MD		1	0.0%	1	$90.00	$90.00	$45.00	1	1.0
FELICIA GLICK OBERWISE, MSW		1	0.0%	5	$650.00	$650.00	$325.00	5	5.0
ANNA R FLYNN, MD		1	0.0%	1	($90.00)	($90.00)	($45.00)	-1	-1.0
MICHELLE KUKLA, PSYD		1	0.0%	5	$1,350.00	$1,350.00	$675.00	9	9.0
ALLEN KUO, MD		1	0.0%	1	$250.00	$250.00	$125.00	1	1.0
LINDA M BROWN, PSYD		1	0.0%	2	$390.00	$240.00	$195.00	3	3.0
DAVE T MCKENNA, MA		1	0.0%	1	$660.00	$400.00	$310.00	6	6.0
LINDA M BROWN, PSYD		1	0.0%	1	$280.00	$160.00	$130.00	2	2.0
GLORIA ARFELIS, PSYD		1	0.0%	6	$1,855.00	$1,215.00	$990.00	15	15.0
JOHN F ZAGOTTA, PHD		1	0.0%	5	$550.00	$404.00	$329.00	5	5.0
RENEE M ADOLPHE, MA		1	0.0%	3	$1,500.00	$783.00	$530.50	15	15.0
HOLLY Z ILFELD, PHD		1	0.0%	3	$750.00	$565.00	$475.00	6	6.0
ROBERT W BENNETT JR, PHD		1	0.0%	6	$1,000.00	$704.00	$584.00	8	8.0
HAILING ZHANG, MD		1	0.0%	1	$130.00	$125.00	$110.00	1	1.0
CHERI DEMOSS, MA		1	0.0%	1	$180.00	$180.00	$90.00	2	2.0
CHARLES GREG KRAFT, EDD		1	0.0%	3	$520.00	$394.00	$334.00	4	4.0
AMY K BERNOSKI, MED		1	0.0%	1	$100.00	$62.00	$47.00	1	1.0
CARRIE OVERBEY, MA		1	0.0%	2	$600.00	$600.00	$480.00	8	8.0
MARTIN A GOLDSTEIN, PHD		1	0.0%	2	$500.00	$320.00	$260.00	4	4.0
MICHELE L WILBUR, MSW		1	0.0%	1	$90.04	$62.00	$31.00	1	1.0
KEVIN MATTHEW HAMM, MA		1	0.0%	2	$240.00	$124.00	$62.00	2	2.0
JEAN R DAVIDSON, MSW		1	0.0%	4	$625.00	$310.00	$235.00	5	5.0
DAVID S DOANE, PHD		1	0.0%	2	$280.00	$185.00	$155.00	2	2.0
ELIZABETH WALLACH, MA		1	0.0%	1	$200.00	$124.00	$94.00	2	2.0
PETER ZAFIRIDES, MD		1	0.0%	2	$230.00	$230.00	$115.00	2	2.0
JULIE ANN GUTHRIE, MD		1	0.0%	4	$700.00	$700.00	$350.00	4	4.0
MARJORIE E SULIN, MSW		1	0.0%	17	$2,320.00	$1,191.00	$906.00	19	19.0
ROBERT M SIMMS, MD		1	0.0%	1	$130.00	$70.00	$55.00	1	1.0
CHRISTINE MAYHALL, PHD		1	0.0%	2	$240.00	$240.00	$120.00	2	2.0
ANITA DEMPSEY, MSN		1	0.0%	9	$1,105.00	$1,105.00	$552.50	9	9.0
SOUHAIR A GARAS, MD		1	0.0%	1	$100.00	$50.00	$25.00	1	1.0
ROGER KENNETH MCELROY, PHD		1	0.0%	3	$625.00	$345.00	$285.00	4	4.0
KARA J KARAM, PSYD		1	0.0%	4	$500.00	$320.00	$260.00	4	4.0
KAREN A FLEMING, MED		1	0.0%	2	$285.00	$137.00	$107.00	2	2.0

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Sample Company

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Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
JOHN B HOLLIS, MA	[redacted]	1	0.0%	4	$555.00	$261.00	$201.00	4	4.0
RICHARD C DAVIS, PHD		1	0.0%	1	$135.00	$80.00	$40.00	1	1.0
RALPH LARUE ANKENMAN, MD		1	0.0%	1	$86.00	$86.00	$43.00	1	1.0
MARIBETH E HIBBETT, MSN		1	0.0%	4	$680.00	$261.00	$201.00	4	4.0
FOCUS HEALTH CARE		1	0.0%	3	$870.00	$810.00	$648.00	6	6.0
TIMOTHY KENNEDY, PHD		1	0.0%	4	$360.00	$332.00	$182.00	4	4.0
ROBERT GORDON, PHD		1	0.0%	4	$625.00	$625.00	$312.50	6	6.0
JOAN DURLACHER, PSYD		1	0.0%	2	$1,500.00	$800.00	$650.00	10	10.0
NEHAMA MORTON, MSW		1	0.0%	2	$346.50	$346.50	$173.25	3	3.0
EMILY A HILDNER, MSW		1	0.0%	2	$808.50	$808.50	$404.25	7	7.0
RAYMOND WUNDERLICH, MA		1	0.0%	1	$330.00	$330.00	$165.00	3	3.0
ANTHONY D VERTINO, PSYD		1	0.0%	1	$140.00	$80.00	$40.00	1	1.0
ROMAINE A VANZEYL, MSW		1	0.0%	1	$400.00	$325.00	$250.00	5	5.0
MARY K GARDNER, PSYD		1	0.0%	1	$120.00	$80.00	$40.00	1	1.0
DEBORAH REED, MD		1	0.0%	1	$525.00	$525.00	$262.50	3	3.0
MITCHELL CARY HAYWOOD, DO		1	0.0%	1	$110.00	$110.00	$55.00	1	1.0
PHYLLIS DAWSON, PSYD		1	0.0%	1	$140.00	$80.00	$65.00	1	1.0
LEE DAVID WEISS, MD		1	0.0%	1	$90.00	$90.00	$45.00	1	1.0
SUSAN C JAKSA, PSYD		1	0.0%	1	$130.00	$95.00	$80.00	1	1.0
WILLIAM H ROBERTS, PSYD		1	0.0%	3	$680.00	$320.00	$260.00	4	4.0
DENISE WALT, MD		1	0.0%	1	$250.00	$140.00	$125.00	1	1.0
ANN JULIA GERUT, MSW		1	0.0%	1	$150.00	$75.00	$60.00	1	1.0
LOUIS A MONGILLO, MA		1	0.0%	2	$250.00	$130.00	$100.00	2	2.0
ROSS ROSENBERG, MED		1	0.0%	3	$1,125.00	$585.00	$450.00	9	9.0
SCOTT E STOLARICK, MS		1	0.0%	3	$400.00	$205.00	$160.00	3	3.0
NANCY BELVISI, MSW		1	0.0%	3	$875.00	$464.00	$359.00	7	7.0
GLENN M WEISS, MSW		1	0.0%	1	$0.00	$0.00	$35.00		0.0
KATHLEEN GALLOWAY GREGG, MA		1	0.0%	3	$375.00	$195.00	$150.00	3	3.0
STEPHEN J ROSENBAUM, MSW		1	0.0%	1	$700.00	$700.00	$350.00	5	5.0
JAMAL RAFIQUE, MD		1	0.0%	1	$100.00	$50.00	$35.00	1	1.0
ESHWAR GUMIDYALA, MBBC		1	0.0%	1	$100.00	$50.00	$35.00	1	1.0
THAKSHAKA MANI MADAMALA, MD		1	0.0%	1	$100.00	$50.00	$25.00	1	1.0
CHANDRAGUPTA S VEDAK, MD		1	0.0%	2	$200.00	$100.00	$70.00	2	2.0
HUGH J VANAUKEN SR., PHD		1	0.0%	1	$150.00	$150.00	$75.00	1	1.0
BLAISE J WOLFRUM, MD		1	0.0%	3	$300.00	$150.00	$105.00	3	3.0
MARIE EPLING, MSW		1	0.0%	3	$345.00	$195.00	$150.00	3	3.0
STEPHANIE SMEIR, PSYD		1	0.0%	9	$1,350.00	$1,350.00	$675.00	9	9.0
STEVEN V JONES, MSW		1	0.0%	5	$620.00	$620.00	$310.00	5	5.0
KENNETH P PHILLIPS, MD		1	0.0%	1	$125.00	$125.00	$62.50	1	1.0
JAMES MCTAGUE, PSYD		1	0.0%	9	$1,260.00	$720.00	$385.00	9	9.0
MORRIS N SHAFRAN, PSYD		1	0.0%	7	$1,200.00	$1,200.00	$600.00	8	8.0
MICHAEL S LOSOFF, PHD		1	0.0%	5	$800.00	$640.00	$520.00	8	8.0
PAULA DICANIO, PHD		1	0.0%	2	$340.00	$340.00	$170.00	2	2.0
LEO WEINSTEIN, MD		1	0.0%	1	$315.00	$315.00	$157.50	2	2.0
JOAN FUNK, PHD		1	0.0%	1	$3,900.00	$3,900.00	$1,950.00	30	30.0
KATHY D REGAN, MA		1	0.0%	8	$1,040.00	$1,040.00	$520.00	8	8.0
JENNIFER STEIN, PHD		1	0.0%	6	$810.00	$810.00	$405.00	6	6.0
ROBIN MILLER, MSW		1	0.0%	1	$360.00	$360.00	$180.00	3	3.0
REBECCA J BIER, PSYD		1	0.0%	2	$285.00	$285.00	$142.50	2	2.0
JOLENE M FRAZIER, MA		1	0.0%	1	$100.00	$65.00	$50.00	1	1.0
JOANNE L BRAUN, PHD		1	0.0%	6	$480.00	$480.00	$390.00	6	6.0
JAMES KENNETH SMEDEGARD, MD		1	0.0%	1	$90.00	$50.00	$35.00	1	1.0
GRETCHEN L CROMER, MD		1	0.0%	1	$95.00	$75.00	$37.50	1	1.0
ERIC C SCHIEBER, MD		1	0.0%	1	$1,225.00	$1,225.00	$612.50	7	7.0
SUSAN G MCCRACKEN, PHD		1	0.0%	3	$425.00	$255.00	$210.00	3	3.0
BENJAMIN N SHAIN, MD		1	0.0%	1	$117.00	$117.00	$58.50	1	1.0
CONSTANCE L CARR, MA		1	0.0%	2	$875.00	$467.00	$362.00	7	7.0
EMMANUEL PERAKIS, MD		1	0.0%	2	$180.00	$180.00	$90.00	2	2.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
ELLA KOMAROVSKY, MD	[redacted]	1	0.0%	2	$190.00	$100.00	$70.00	2	2.0
BARRY R FELDMAN, MA		1	0.0%	2	$540.00	$540.00	$270.00	6	6.0
WILLIAM W LEE, EDD		1	0.0%	2	$240.00	$160.00	$130.00	2	2.0
DAN FALLON, PSYD		1	0.0%	5	$950.00	$950.00	$475.00	6	6.0
LISA A MANZINI PACE, MSW		1	0.0%	1	$255.00	$198.00	$153.00	3	3.0
THEODORE A ALLCHIN, MD		1	0.0%	2	$200.00	$200.00	$100.00	2	2.0
ELAINE S SHEPP, MSW		1	0.0%	4	$950.00	$465.00	$360.00	7	7.0
LYNNE H SHEBAN, PHD		1	0.0%	1	$175.00	$95.00	$47.50	1	1.0
BETHANY MITCHELL, MA		1	0.0%	4	$500.00	$500.00	$250.00	4	4.0
BARBARA R HURWITZ, PSYD		1	0.0%	2	$520.00	$320.00	$260.00	4	4.0
JULIA C CASTEN, MA		1	0.0%	1	$130.00	$65.00	$50.00	1	1.0
UNIVERSITY OF CHICAGO HOSPITAL		1	0.0%	4	$712.00	$712.00	$356.00	4	4.0
PETRONILO R COSTA, MD		1	0.0%	1	$750.00	$750.00	$600.00	3	3.0
GARY SCHOCHET, MSW		1	0.0%	3	$840.00	$455.00	$350.00	7	7.0
RONALD W BRENZ, DO		1	0.0%	1	$85.00	$60.00	$45.00	1	1.0
PHILLIP L ELBAUM, MSW		1	0.0%	2	$780.00	$780.00	$600.00	12	12.0
DANA L STEINER, MA		1	0.0%	3	$720.00	$450.00	$360.00	6	6.0
SUSAN J MAYFIELD, PHD		1	0.0%	2	$445.00	$285.00	$240.00	3	3.0
LAURA A RABINOWICZ, PHD		1	0.0%	6	$810.00	$540.00	$450.00	6	6.0
JUDITH N IGLARSH, PHD		1	0.0%	6	$985.00	$645.00	$540.00	7	7.0
FE AQUINO VELASCO, MD		1	0.0%	2	$269.00	$125.00	$95.00	2	2.0
SAPANA R CHOKSHI, MD		1	0.0%	2	$170.00	$100.00	$70.00	2	2.0
QUEENS MEDICAL CENTER		1	0.0%	1	$1,175.00	$1,175.00	$587.50	1	1.0
EBRAHIM HAZANY, MD		1	0.0%	14	$4,250.00	$2,084.00	$1,735.00	17	17.0
JAMES MCCRACKEN, MD		1	0.0%	2	$875.00	$875.00	$437.50	4	4.0
THOMAS OKAMOTO, MD		1	0.0%	3	$330.00	$330.00	$165.00	3	3.0
MARCIA A HOFFMANN, MA		1	0.0%	2	$600.00	$297.00	$237.00	4	4.0
ADIB H BITAR, MD		1	0.0%	1	$400.00	$300.00	$255.00	3	3.0
BRUCE GREGORY, PHD		1	0.0%	1	$1,350.00	$1,350.00	$675.00	6	6.0
JAY GALE, PHD		1	0.0%	2	$370.00	$370.00	$185.00	2	2.0
DUKE VINCENT FISHER, MD		1	0.0%	3	$375.00	$210.00	$105.00	3	3.0
ALMA CARPIO, PSYD		1	0.0%	4	$0.00	$0.00	$137.00		0.0
GREGORY S MCFADDEN, MD		1	0.0%	2	$180.00	$140.00	$70.00	2	2.0
LISA STAAB, PSYD		1	0.0%	1	$990.00	$990.00	$495.00	9	9.0
BILL ARIGI, MA		1	0.0%	2	$1,950.00	$1,950.00	$975.00	15	15.0
TRUDY A HARTMAN, MD		1	0.0%	1	$150.00	$150.00	$75.00	1	1.0
SCOTT F PERNA, PSYD		1	0.0%	6	$1,450.00	$1,098.00	$918.00	12	12.0
KAY BOLTER, PHD		1	0.0%	1	$140.00	$140.00	$70.00	1	1.0
MARY R EDELSTEIN, PHD		1	0.0%	3	$800.00	$800.00	$400.00	4	4.0
GLORIA FLOYD, MA		1	0.0%	4	$1,140.00	$792.00	$612.00	12	12.0
FRANK LLOYD ANNIS, MD		1	0.0%	1	$225.00	$190.00	$175.00	1	1.0
ROBERT B FIELD, PHD		1	0.0%	4	$1,350.00	$1,350.00	$675.00	9	9.0
STEPHEN KRAUSE, MD		1	0.0%	2	$160.00	$140.00	$110.00	2	2.0
ALAN P BRAUER, MD		1	0.0%	1	$85.00	$85.00	$70.00	1	1.0
HENRY THEODORE FREELAND JR, MD		1	0.0%	2	$1,160.00	$964.00	$844.00	8	8.0
LORRAINE L LUFT, PHD		1	0.0%	3	$1,800.00	$1,800.00	$900.00	12	12.0
DOUGLAS M HARPER, MD		1	0.0%	3	$255.00	$200.00	$155.00	3	3.0
EDWIN A SCHWARTZ, PHD		1	0.0%	3	$900.00	$528.00	$438.00	6	6.0
H THERESA CHANG, PHD		1	0.0%	1	$1,317.50	$1,317.50	$658.75	8	8.0
DANIEL F IACOPI, MD		1	0.0%	2	$230.00	$156.00	$78.00	2	2.0
NANCY SKANCHY, MSW		1	0.0%	3	$420.00	$208.00	$163.00	3	3.0
DOUGLAS K HICKS, PHD		1	0.0%	4	$580.00	$382.00	$322.00	4	4.0
ISABEL ROSALES, MD		1	0.0%	3	$490.00	$254.00	$209.00	3	3.0
STEVEN J VINCENT, PSYD		1	0.0%	6	$970.00	$658.00	$553.00	7	7.0
WESTERN PSYCHOLOGICAL & COUNSE		1	0.0%	2	$300.00	$170.00	$136.00	2	2.0
WESTERN PSYCHIATRIST AND COUNS		1	0.0%	2	$1,230.00	$680.00	$544.00	8	8.0
MANOOCHEHR KHATAMI, MD		1	0.0%	1	$100.00	$60.00	$45.00	1	1.0
REBECCA L RICOY, MD		1	0.0%	1	$85.00	$85.00	$42.50	1	1.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
WAYNE C PALMER, PHD	[redacted]	1	0.0%	1	$186.00	$186.00	$171.00	1	1.0
SARAH DUVAL, MSN		1	0.0%	1	$72.00	$72.00	$57.00	1	1.0
LUANNE TURRENTINE, PHD		1	0.0%	2	$260.00	$152.00	$122.00	2	2.0
JOYCE FRANCIS, MS		1	0.0%	2	$240.00	$132.00	$66.00	2	2.0
SUZANNE B CANNING, MD		1	0.0%	2	$340.00	$218.00	$188.00	2	2.0
KARIN LINDEROTH REEP, MA		1	0.0%	2	$1,140.00	$792.00	$612.00	12	12.0
JONATHAN LEVIN, MSW		1	0.0%	3	$330.00	$330.00	$165.00	3	3.0
MERYL E. LIPTON, MD		1	0.0%	1	$110.00	$110.00	$55.00	1	1.0
MARC C SANDROLINI, MD		1	0.0%	1	$300.00	$300.00	$150.00	1	1.0
ROBERT K BURLINGAME, MD		1	0.0%	1	$150.00	$75.00	$60.00	1	1.0
SAMUEL S KEITH, MSN		1	0.0%	1	$85.00	$85.00	$42.50	1	1.0
JON E CHRISTENSEN, PHD		1	0.0%	12	$1,800.00	$1,104.00	$924.00	12	12.0
RICHARD T WEMHOFF, PHD		1	0.0%	1	$195.00	$106.00	$91.00	1	1.0
JESSY A ANG, MD		1	0.0%	1	$250.00	$120.00	$105.00	1	1.0
GRANT TSCHETTER, MA		1	0.0%	1	$110.00	$65.00	$50.00	1	1.0
TERESA A RATTRAY, PHD		1	0.0%	3	$2,160.00	$2,160.00	$1,080.00	18	18.0
BRENDA K ANDERSON, MA		1	0.0%	1	$95.00	$62.00	$47.00	1	1.0
DENISE H BISANZ, MSW		1	0.0%	2	$220.00	$130.00	$100.00	2	2.0
DIANE HERBS, PHD		1	0.0%	1	$225.00	$110.00	$95.00	1	1.0
KAREN LEAH CRUEY, MD		1	0.0%	2	$450.00	$450.00	$225.00	2	2.0
WASHOE MEDICAL CENTER PRINGLE		1	0.0%	1	$130.00	$60.00	$45.00	1	1.0
JOSE M THEKKEKARA, MD		1	0.0%	1	$246.75	$160.00	$145.00	1	1.0
JENNIFER ROCCOFORTE, PHD		1	0.0%	2	$1,350.00	$1,350.00	$675.00	10	10.0
ALOMA P ALCOBER, MD		1	0.0%	3	$350.00	$215.00	$170.00	3	3.0
JUDITH A GILBERT, MA		1	0.0%	5	$630.00	$630.00	$315.00	5	5.0
SHARON L OBRIEN, MS		1	0.0%	1	$270.00	$270.00	$135.00	2	2.0
VIRGINIA SMITH, MA		1	0.0%	2	$240.00	$240.00	$120.00	2	2.0
BARBARA H SMITH, MD		1	0.0%	1	$200.00	$140.00	$125.00	1	1.0
MARCIE EDMONDS, MS		1	0.0%	1	$260.00	$260.00	$130.00	2	2.0
SANDRA A TURSINI, MC		1	0.0%	1	$145.00	$65.00	$50.00	1	1.0
JOSEPH GOTTFRIED, MD		1	0.0%	1	$72.00	$55.00	$40.00	1	1.0
JANA M CYR, MSW		1	0.0%	2	$740.00	$537.00	$417.00	8	8.0
MICHAEL E SHERY, PHD		1	0.0%	5	$2,498.00	$1,535.00	$1,247.00	17	17.0
ROBERT CHINISCI, PHD		1	0.0%	1	$250.00	$156.00	$126.00	2	2.0
MARIAN CHILDS, MA		1	0.0%	3	$700.00	$399.00	$199.50	7	7.0
CHARLES RICE, PHD		1	0.0%	4	$445.00	$373.00	$220.00	4	4.0
TERRY E PAPE, PSYD		1	0.0%	3	$500.00	$460.00	$385.00	5	5.0
ANDREW L OLNES, MD		1	0.0%	2	$180.00	$116.00	$86.00	2	2.0
MARK ALLEN ESCHE, MD		1	0.0%	1	$440.00	$350.00	$305.00	3	3.0
JACQUELINE MOUZON, MD		1	0.0%	3	$350.00	$350.00	$175.00	3	3.0
DAVID DAWES, MD		1	0.0%	1	$60.00	$50.00	$35.00	1	1.0
JOYCE SHATNEY, MSW		1	0.0%	4	$3,600.00	$3,600.00	$1,800.00	24	24.0
REBECCA S VALLA, MD		1	0.0%	2	$180.00	$150.00	$120.00	2	2.0
NANCY MYERS WOODRUFF, PHD		1	0.0%	3	$390.00	$390.00	$195.00	3	3.0
VIRGINIA E KIBLER, PHD		1	0.0%	1	$150.00	$150.00	$75.00	1	1.0
KEVIN T CONATY, MSSW		1	0.0%	3	$596.00	$260.00	$200.00	4	4.0
DONALD C WILLIAMS, PSYD		1	0.0%	1	$160.00	$160.00	$80.00	1	1.0
GENE SCHADLER, MSSW		1	0.0%	3	$360.00	$202.00	$157.00	3	3.0
BEVERLY CLOUD, MSW		1	0.0%	1	$136.00	$136.00	$121.00	1	1.0
JENNIFER A LYMAN, PHD		1	0.0%	1	$125.00	$125.00	$62.50	1	1.0
DOANE M RISING, MD		1	0.0%	1	$840.00	$840.00	$420.00	6	6.0
ROBIN APPLE, PHD		1	0.0%	1	$165.00	$88.00	$73.00	1	1.0
MICHELLE BROWN, PHD		1	0.0%	2	($165.00)	($165.00)	($82.50)	-1	-1.0
VICTOR CARRION, MD		1	0.0%	1	$225.00	$110.00	$95.00	1	1.0
ROBIN APPLE, PHD		1	0.0%	2	$330.00	$176.00	$146.00	2	2.0
ROBERT SOMAN, PHD		1	0.0%	1	$260.00	$260.00	$200.00	4	4.0
DEBORAH L OHANESIAN, PHD		1	0.0%	2	$560.00	$560.00	$32.00	4	4.0
DOUGLAS W TREESE, PHD		1	0.0%	2	$225.00	$190.00	$160.00	2	2.0

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Sample Company

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Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
MADELINE ALFORD, MA	[redacted]	1	0.0%	3	$300.00	$186.00	$141.00	3	3.0
ELIZABETH A HEDDEN, MD		1	0.0%	1	$65.00	$60.00	$45.00	1	1.0
GLENN J BRICKEN, PHD		1	0.0%	2	$600.00	$600.00	$300.00	4	4.0
MARSHALL B LUCAS, MD		1	0.0%	1	$375.00	$270.00	$225.00	3	3.0
CHARLES F GRAY, PHD		1	0.0%	2	$320.00	$320.00	$160.00	2	2.0
LYNN N CORAZAO, MA		1	0.0%	6	$600.00	$372.00	$282.00	6	6.0
MATTHEW N BRAMS, MD		1	0.0%	1	$300.00	$150.00	$135.00	1	1.0
BARBARA W BAINE, MSW		1	0.0%	1	$165.00	$165.00	$82.50	1	1.0
LAWRENCE DAVID GINSBERG, MD		1	0.0%	4	$340.00	$240.00	$180.00	4	4.0
T DENNIS GEARY, PHD		1	0.0%	4	$500.00	$304.00	$244.00	4	4.0
SETH WARREN SILVERMAN, MD		1	0.0%	1	$325.00	$210.00	$180.00	2	2.0
KATHY C. FLANAGAN, MD		1	0.0%	2	$400.00	$400.00	$200.00	2	2.0
DOROTHY CAROL PETTIGREW, PHD		1	0.0%	2	$600.00	$242.00	$197.00	3	3.0
JANEL H MILLER, PHD		1	0.0%	2	$560.00	$560.00	$280.00	4	4.0
CHILDRENS MEDICAL CENTER DALLA		1	0.0%	1	$350.00	$350.00	$175.00	1	1.0
DEBRA RAQUET SAFFORD, MSW		1	0.0%	3	$1,000.00	$650.00	$395.00	10	10.0
MARY BETH GOLDEN, MSW		1	0.0%	3	$935.00	$746.00	$581.00	11	11.0
PETER LOISELLE, MSW		1	0.0%	3	$620.00	$480.00	$325.00	6	6.0
LARISA E NEWELL, PHD		1	0.0%	1	$200.00	$160.00	$130.00	2	2.0
ELLEN N KENEMORE, MSW		1	0.0%	3	$195.00	$195.00	$97.50	3	3.0
FOUNDATION LLC		1	0.0%	5	$16,960.00	$16,960.00	$13,568.00	53	53.0
OK RO HONG, MD		1	0.0%	2	$190.00	$100.00	$50.00	2	2.0
MARIA J VEGA, MD		1	0.0%	1	$180.00	$180.00	$90.00	1	1.0
LAURIE KLEIMAN, MD		1	0.0%	2	$230.00	$125.00	$95.00	2	2.0
MARY PORTER, MSW		1	0.0%	4	$380.00	$380.00	$190.00	4	4.0
LIFE MANAGEMENT RESRC		1	0.0%	4	$1,050.00	$1,000.00	$800.00	10	10.0
SHANNON BROWN, MA		1	0.0%	1	$125.00	$62.00	$47.00	1	1.0
TEXAS TECH UNIVERSITY HCS EL P		1	0.0%	1	$91.00	$91.00	$45.50	1	1.0
REKHA P POLE, MD		1	0.0%	2	$180.00	$120.00	$90.00	2	2.0
LORELE VANZANT, EDD		1	0.0%	1	$130.00	$75.00	$60.00	1	1.0
JOHN BOYLAN, MD		1	0.0%	2	$650.00	$650.00	$325.00	5	5.0
LOUIS E COSTELLO, MD		1	0.0%	1	$90.00	$60.00	$30.00	1	1.0
DAN E STEINFINK, MD		1	0.0%	2	$180.00	$120.00	$90.00	2	2.0
HARRIS METHODIST SPRINGWOOD		1	0.0%	1	$1,052.00	$636.00	$508.80	4	4.0
ROBERTA ALLEN, MSW		1	0.0%	2	$270.00	$199.00	$154.00	3	3.0
LETA ACKER, MA		1	0.0%	1	$100.00	$75.00	$60.00	1	1.0
DANIEL HARTT, MA		1	0.0%	6	$720.00	$372.00	$186.00	6	6.0
CHARLES STEVEN MANLEY, PHD		1	0.0%	1	$95.00	$76.00	$61.00	1	1.0
LESSIE A PERRY, PHD		1	0.0%	1	$90.00	$62.00	$31.00	1	1.0
NORMAN M SHULMAN, EDD		1	0.0%	2	$240.00	$152.00	$122.00	2	2.0
CATHAL P GRANT, MD		1	0.0%	1	$80.00	$60.00	$45.00	1	1.0
BAGYALAKSHMI ARUMUGHAM, MD		1	0.0%	1	$105.00	$65.00	$50.00	1	1.0
CATHERINE H MATTHEWS, PHD		1	0.0%	3	$315.00	$228.00	$183.00	3	3.0
MARTIN BENSON FISHER, MD		1	0.0%	2	$160.00	$120.00	$90.00	2	2.0
REBECCA S JONES, PHD		1	0.0%	1	$75.00	$75.00	$60.00	1	1.0
HAROLD A JEWELL, PHD		1	0.0%	1	$90.00	$76.00	$61.00	1	1.0
ROSEMARY CECIL, MD		1	0.0%	1	$70.00	$60.00	$30.00	1	1.0
KATHLEEN SUE SHEEHAN, MD		1	0.0%	3	$1,200.00	$1,200.00	$600.00	8	8.0
SHAHNAZ SALEEM, MD		1	0.0%	6	$800.00	$520.00	$430.00	6	6.0
JHANSI M RAJ, MD		1	0.0%	1	$85.00	$60.00	$45.00	1	1.0
MILTON L GEARING II, PHD		1	0.0%	1	$125.00	$76.00	$61.00	1	1.0
RODOLFO MOLINA, MD		1	0.0%	3	$2,120.00	$955.00	$940.00	8	8.0
DEBRA K BURTON, MA		1	0.0%	1	$70.00	$62.00	$47.00	1	1.0
JUDITH A CHANEY, MED		1	0.0%	1	$90.00	$62.00	$47.00	1	1.0
DONALD B WEAVER, PHD		1	0.0%	5	$375.00	$375.00	$300.00	5	5.0
ANNE E ANDERSEN, MD		1	0.0%	1	$90.00	$60.00	$30.00	1	1.0
BRYAN SEWING, DO		1	0.0%	1	$120.00	$120.00	$60.00	1	1.0
SHERRY L SHRALLOW, MSW		1	0.0%	5	$575.00	$325.00	$250.00	5	5.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
JOHN NORWOOD SPENCER, MD	[redacted]	1	0.0%	4	$655.00	$655.00	$327.50	4	4.0
RICHARD L REYNOLDS, MSW		1	0.0%	1	$150.00	$75.00	$37.50	1	1.0
CHRISTINE L WARMANN ADAMS, MD		1	0.0%	2	$500.00	$500.00	$250.00	5	5.0
NICHOLAS V CAMPERLENGO, MD		1	0.0%	4	$425.00	$425.00	$212.50	5	5.0
LARRY BOLADO, MSW		1	0.0%	1	$180.00	$75.00	$60.00	1	1.0
KAY TORRES, MSW		1	0.0%	1	($90.00)	($90.00)	($45.00)	-1	-1.0
NELSON CEBALLOS DELACROIX, MD		1	0.0%	1	$150.00	$150.00	$135.00	1	1.0
LETICIA A OCANAS, MA		1	0.0%	4	$325.00	$261.00	$201.00	4	4.0
DANIEL GUTIERREZ, MD		1	0.0%	1	$75.00	$75.00	$60.00	1	1.0
ANNA GONZALEZ SORENSEN, PHD		1	0.0%	6	$1,625.00	$988.00	$793.00	13	13.0
SUE BICKERTON, MSSW		1	0.0%	1	$100.00	$62.00	$47.00	1	1.0
FRANCISCO PEREZ, PHD		1	0.0%	4	$510.00	$318.00	$258.00	4	4.0
AMY B IKELHEIMER, PHD		1	0.0%	1	$500.00	$166.00	$136.00	2	2.0
KIMBERLY KELSAY, MD		1	0.0%	1	$115.00	$55.00	$40.00	1	1.0
BERNARD M GERBER, MD		1	0.0%	1	$85.00	$60.00	$45.00	1	1.0
JEFFERSON E NELSON, MD		1	0.0%	1	$100.00	$100.00	$50.00	1	1.0
SUSAN CARMICHAEL, MA		1	0.0%	2	$800.00	$800.00	$400.00	8	8.0
MARGARET TUNGSETH, MSW		1	0.0%	4	$520.00	$320.00	$260.00	4	4.0
TERRI L KADING WHEELER, MSW		1	0.0%	2	$260.00	$160.00	$130.00	2	2.0
DONALD M JACOBSON, MD		1	0.0%	1	$125.00	$65.00	$50.00	1	1.0
GUSTAVO E RUIZ, MD		1	0.0%	9	$900.00	$744.00	$834.00	6	6.0
LISA YVETTE PIERCE, MD		1	0.0%	1	$95.00	$95.00	$47.50	1	1.0
JOEL S LEITCH, MS		1	0.0%	8	$960.00	$520.00	$400.00	8	8.0
MARJORIE A EDLIS, MS		1	0.0%	10	$900.00	$650.00	$482.50	10	10.0
JANITA M ARDIS, MD		1	0.0%	6	$515.00	$340.00	$230.00	6	6.0
TERRI L WOODLAND, MED		1	0.0%	1	$65.00	$65.00	$32.50	1	1.0
SUSAN T HOWARD, MD		1	0.0%	3	$270.00	$270.00	$135.00	3	3.0
EDWARD E LUCAS, MSW		1	0.0%	3	$375.00	$325.00	$250.00	5	5.0
KEITH B KESSEL, MD		1	0.0%	2	$265.00	$175.00	$97.50	2	2.0
MICHAEL PATRICK DAVENPORT, PHD		1	0.0%	1	$100.00	$80.00	$65.00	1	1.0
SUSAN P HOFFMAN, MSW		1	0.0%	2	$200.00	$130.00	$100.00	2	2.0
JAMES GRAY BARBEE, MD		1	0.0%	6	$690.00	$300.00	$210.00	6	6.0
JUDY ANN PETIT, PHD		1	0.0%	2	$1,500.00	$790.00	$610.00	12	12.0
MARGUERITE P SALLEY, MSW		1	0.0%	2	$200.00	$130.00	$100.00	2	2.0
DONNA LERA, MA		1	0.0%	1	$120.00	$120.00	$60.00	1	1.0
LISA LUANNE SHELOR FLORES, MSW		1	0.0%	1	$110.00	$83.00	$68.00	1	1.0
SHELDON MCWILLIAMS, PHD		1	0.0%	1	$225.00	$200.00	$185.00	1	1.0
DONNIE J HOLDEN, MD		1	0.0%	2	$180.00	$180.00	$150.00	2	2.0
MICHAEL W PARKER, PHD		1	0.0%	1	$221.00	$101.00	$86.00	1	1.0
JACKIE COOMBE MOORE, MD		1	0.0%	1	$250.00	$135.00	$120.00	1	1.0
RICHARD L LIVINGSTON, MD		1	0.0%	1	$160.00	$160.00	$80.00	1	1.0
SANDRA ALLRED, MA		1	0.0%	1	$82.50	$65.00	$32.50	1	1.0
KIMBERLEE A HEDRICK, MSW		1	0.0%	3	$880.00	$715.00	$550.00	11	11.0
ROBERT ERIC ROTH, PSYD		1	0.0%	1	$1,120.00	$397.00	$323.60	5	5.0
LAURIE J PETERS, MD		1	0.0%	3	$355.00	$315.00	$270.00	3	3.0
CAROLYN FLUHART, PHD		1	0.0%	5	$625.00	$400.00	$325.00	5	5.0
FREDERICK PRESCITI, MA		1	0.0%	1	$380.00	$380.00	$190.00	4	4.0
MICHAEL L O L O HARA JR, PSYD		1	0.0%	1	$700.00	$700.00	$350.00	3	3.0
RICHARD DOUYON, MD		1	0.0%	1	$100.00	$50.00	$35.00	1	1.0
MARK R BARNETT, MD		1	0.0%	2	$340.00	$170.00	$112.50	2	2.0
GINA V EATON, MSW		1	0.0%	1	$175.00	$70.00	$55.00	1	1.0
ROBERT MONTES, PHD		1	0.0%	3	$625.00	$625.00	$312.50	4	4.0
WENDY SILVER, PSYD		1	0.0%	1	$450.00	$210.00	$165.00	3	3.0
REACHING POTENTIALS INCORPORAT		1	0.0%	11	$10,590.00	$10,590.00	$8,472.00	50	50.0
MERCEDES LLENIN, PHD		1	0.0%	2	$480.00	$220.00	$175.00	3	3.0
ELY D PELTA, MD		1	0.0%	1	$95.00	$50.00	$25.00	1	1.0
CELSO LOBAO, MD		1	0.0%	2	$190.00	$190.00	$0.00	2	2.0
SNEH KAPILA, MD		1	0.0%	2	$250.00	$130.00	$100.00	2	2.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
TIMOTHY R KELLY, MD	[redacted]	1	0.0%	2	$220.00	$220.00	$110.00	2	2.0
STANLEY C RUSSELL, MD		1	0.0%	2	$200.00	$200.00	$100.00	2	2.0
NELSON CAUTHEN, PHD		1	0.0%	1	$125.00	$95.00	$80.00	1	1.0
MARION C ROSS, MSW		1	0.0%	3	$615.00	$171.00	$126.00	3	3.0
KRISHAN KUMAR GUPTA, MD		1	0.0%	3	$570.00	$295.00	$250.00	3	3.0
MARIA D CHIO, MED		1	0.0%	1	$120.00	$62.00	$47.00	1	1.0
CHARLES MCINTEER, MD		1	0.0%	1	$94.00	$70.00	$55.00	1	1.0
MARION W GRANT, MD		1	0.0%	2	$240.00	$140.00	$110.00	2	2.0
PAMELA RAWDON, MSW		1	0.0%	3	$300.00	$180.00	$135.00	3	3.0
THOMAS S BENNETT, PHD		1	0.0%	1	$675.00	$405.00	$324.00	1	1.0
TIM P FAULK, PHD		1	0.0%	1	$420.00	$420.00	$210.00	4	4.0
R SCOTT HELLARD, MD		1	0.0%	2	$240.00	$220.00	$190.00	2	2.0
BRENDA S DOZIER, PHD		1	0.0%	4	$620.00	$380.00	$290.00	6	6.0
GAYLE S JANZEN, PHD		1	0.0%	4	$480.00	$312.00	$252.00	4	4.0
HALINA W HALE, PHD		1	0.0%	1	$120.00	$78.00	$63.00	1	1.0
ROSEMARY WOOL JONES, PHD		1	0.0%	2	$250.00	$250.00	$125.00	2	2.0
BHC STREAMWOOD MANAGEMENT SERV		1	0.0%	1	$200.00	$200.00	$160.00	2	2.0
ALEXANDER J CHALKO, MD		1	0.0%	2	$180.00	$102.00	$72.00	2	2.0
STEPHEN L TENCH, PHD		1	0.0%	2	$405.00	$265.00	$220.00	3	3.0
GREEN OAKS HOSPITAL		1	0.0%	2	$6,709.01	$5,040.00	$4,935.00	7	7.0
STEPHEN L OWENS, PSYD		1	0.0%	1	$100.00	$80.00	$40.00	1	1.0
ROBERT D FINK, MD		1	0.0%	1	$80.00	$51.00	$36.00	1	1.0
WILLIAM B ALLEN, PHD		1	0.0%	1	$140.00	$140.00	$112.00	2	2.0
KELLEY DENISE WALKER, MD		1	0.0%	1	$104.00	$104.00	$52.00	1	1.0
FRED A STEINBERG, PHD		1	0.0%	3	$900.00	$900.00	$450.00	6	6.0
BRIAN R HUMPHREYS, PSYD		1	0.0%	4	$1,100.00	$880.00	$715.00	11	11.0
JOHN D FENLEY, MD		1	0.0%	1	$245.00	$186.00	$156.00	2	2.0
DOLORES M DIGAETANO, MD		1	0.0%	2	$180.00	$102.00	$72.00	2	2.0
RUSSELL CROUSE, PHD		1	0.0%	4	$570.00	$345.00	$285.00	4	4.0
HARVEY P KAUFMAN, EDD		1	0.0%	1	$115.00	$84.00	$42.00	1	1.0
LAWRENCE LARRY WEITZ, PHD		1	0.0%	3	$375.00	$240.00	$195.00	3	3.0
PETER W ZINKUS, PHD		1	0.0%	1	$160.00	$80.00	$65.00	1	1.0
LEILA TODD, MA		1	0.0%	3	$290.00	$205.00	$160.00	3	3.0
CHRISTOPHER PEKARY, MA		1	0.0%	1	$90.00	$65.00	$50.00	1	1.0
BRENT E STENBERG, PHD		1	0.0%	5	$700.00	$400.00	$325.00	5	5.0
GILBERT W RAULSTON, MD		1	0.0%	3	$270.00	$153.00	$108.00	3	3.0
STEVEN C ALTABET, PHD		1	0.0%	1	$144.00	$84.00	$69.00	1	1.0
PHYLLIS A GORDON, MSSW		1	0.0%	1	$211.00	$105.00	$90.00	1	1.0
JANIS NEECE, PHD		1	0.0%	2	$170.00	$160.00	$130.00	2	2.0
JOHN A NEECE, PHD		1	0.0%	1	$45.00	$45.00	$30.00	1	1.0
JAMES M VELTMAN, MA		1	0.0%	5	$620.00	$400.00	$310.00	6	6.0
DEENA M GANDHI, MD		1	0.0%	1	$100.00	$65.00	$50.00	1	1.0
LAVENIA MICHELE AMBURGEY, MA		1	0.0%	1	$110.00	$75.00	$60.00	1	1.0
BETH ANN PLANZER, MA		1	0.0%	10	$1,350.00	$1,350.00	$675.00	10	10.0
SUZANNE H SUMIDA, MD		1	0.0%	6	$600.00	$600.00	$300.00	6	6.0
BARBARA MULLIGAN, MSW		1	0.0%	1	$100.00	$100.00	$50.00	2	2.0
DONALD R MAY, MSW		1	0.0%	1	$145.00	$75.00	$60.00	1	1.0
A DEWEY SANDERS, PHD		1	0.0%	5	$605.00	$405.00	$330.00	5	5.0
VINCENT E ZIEGLER, MD		1	0.0%	1	$90.00	$60.00	$17.54	1	1.0
PATRICK D. MARTIN, MD		1	0.0%	1	$120.00	$120.00	$60.00	1	1.0
JOE BOB PIERCE, MTS		1	0.0%	1	$160.00	$124.00	$94.00	2	2.0
SEBASTIAN L ORNOPIA, MD		1	0.0%	3	$450.00	$150.00	$75.00	3	3.0
KAREN P HAGEROTT, PHD		1	0.0%	1	$165.00	$165.00	$82.50	1	1.0
MICHAEL E GUTMAN, MD		1	0.0%	2	$163.00	$163.00	$133.00	2	2.0
JUDITH ANN SHELL, PHD		1	0.0%	3	$555.00	$180.00	$135.00	3	3.0
STEPHEN M HAWK, DO		1	0.0%	3	$325.00	$180.00	$135.00	3	3.0
NORMA J VAILLETTE, MA		1	0.0%	4	$450.00	$310.00	$235.00	5	5.0
PIERRE S SAAL, MS		1	0.0%	8	$990.00	$660.00	$470.00	11	11.0

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Sample Company

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Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
JOSEPH G BAUM, PHD	[redacted]	1	0.0%	3	$345.00	$210.00	$165.00	3	3.0
SUHAS V JOSHI, MD		1	0.0%	3	$225.00	$150.00	$105.00	3	3.0
BALINDER S CHAHAL, MD		1	0.0%	2	$170.00	$115.00	$85.00	2	2.0
MAYO CLINIC		1	0.0%	3	$1,116.00	$1,116.00	$558.00	4	4.0
CAM MCCARTHY, PHD		1	0.0%	1	$660.00	$240.00	$180.00	4	4.0
BAYCARE LIFE MANAGEMENT TAMPA		1	0.0%	1	$100.00	$70.00	$55.00	1	1.0
RICHARD SAINI, MD		1	0.0%	2	$150.00	$100.00	$70.00	2	2.0
KARL D JONES, MD		1	0.0%	1	$80.00	$50.00	$35.00	1	1.0
LILLIAN T SAAVEDRA, MD		1	0.0%	1	$165.00	$65.00	$50.00	1	1.0
MARTIN S KANE, MD		1	0.0%	1	$90.00	$50.00	$35.00	1	1.0
MARTIN D COHEN, PHD		1	0.0%	1	$135.00	$80.00	$65.00	1	1.0
JOSE ALMEIDA, MD		1	0.0%	5	$440.00	$285.00	$210.00	5	5.0
TRUDY HUI CHING HU, PHD		1	0.0%	1	$110.00	$106.00	$91.00	1	1.0
LAKEVIEW CENTER MAIN SITE		1	0.0%	1	$110.00	$60.00	$45.00	1	1.0
ANDREW C BISHOP, MD		1	0.0%	1	$120.00	$70.00	$55.00	1	1.0
JOHN E FONTAINE, PHD		1	0.0%	3	$400.00	$251.00	$206.00	3	3.0
BRUCE DUPLICATE SULLIVAN, MA		1	0.0%	12	$1,950.00	$1,950.00	$975.00	15	15.0
MARY B ALEXANDER, MS		1	0.0%	2	$200.00	$140.00	$110.00	2	2.0
JEFFREY H FLATOW, MD		1	0.0%	1	$250.00	$135.00	$120.00	1	1.0
JANET OLSEN HUGHES, MS		1	0.0%	5	$650.00	$332.00	$257.00	5	5.0
CHRISTOPHER B FRENCH, PHD		1	0.0%	1	$150.00	$85.00	$70.00	1	1.0
ROBIN L DAY, MS		1	0.0%	2	$330.00	$272.00	$182.00	6	6.0
ARUN A POL, MD		1	0.0%	2	$280.00	$185.00	$155.00	2	2.0
WARREN J JONES, MDIV		1	0.0%	1	$100.00	$72.00	$57.00	1	1.0
CONNIE L JONES, MSW		1	0.0%	3	$300.00	$195.00	$150.00	3	3.0
SHARMAN D COLOSETTI, MSW		1	0.0%	3	$1,080.00	$585.00	$450.00	9	9.0
KATHY BROWN, MA		1	0.0%	8	$810.00	$585.00	$450.00	9	9.0
SHIRPAL K MAKIM, MD		1	0.0%	1	$80.00	$50.00	$35.00	1	1.0
CORINNE LYNN PALMER, MS		1	0.0%	3	$390.00	$267.00	$207.00	4	4.0
GRACELYN C FRANCO, PHD		1	0.0%	3	$475.00	$255.00	$210.00	3	3.0
TODD M ANTIN, MD		1	0.0%	1	$120.00	$110.00	$95.00	1	1.0
DANIEL A THOMAS JR, PSYD		1	0.0%	6	$1,350.00	$510.00	$420.00	6	6.0
MARY ANN MASSEY, MA		1	0.0%	1	$90.00	$90.00	$45.00	1	1.0
KATHLEEN E GRIMES, PHD		1	0.0%	3	$345.00	$268.00	$223.00	3	3.0
SUSAN L BOWER, MD		1	0.0%	1	$325.00	$210.00	$180.00	2	2.0
JONI EDWARDS PRINCE, PHD		1	0.0%	2	$300.00	$170.00	$140.00	2	2.0
RHONDA G MCMILLIAN, MD		1	0.0%	1	$85.00	$50.00	$35.00	1	1.0
ROBERT M FREDRICK, MSW		1	0.0%	3	$770.00	$455.00	$350.00	7	7.0
DIANE HALL SMITH, MA		1	0.0%	2	$165.00	$137.00	$107.00	2	2.0
WALTER F ANDERSON, MD		1	0.0%	2	$660.00	$300.00	$210.00	6	6.0
JOHN D HUBBARD, MD		1	0.0%	1	$390.00	$390.00	$195.00	2	2.0
ALAN D BRANDIS, PHD		1	0.0%	1	$280.00	$183.00	$153.00	2	2.0
MARK P FEINSILBER, PHD		1	0.0%	4	$650.00	$438.00	$363.00	5	5.0
DANIEL B NAGELBERG, PHD		1	0.0%	4	$500.00	$340.00	$280.00	4	4.0
DAVID C LOTT, MD		1	0.0%	1	$100.00	$50.00	$35.00	1	1.0
WARREN A HINSON, MD		1	0.0%	1	$140.00	$140.00	$70.00	1	1.0
SKYLAND TRAIL		1	0.0%	3	$1,500.00	$1,500.00	$1,500.00	12	12.0
ERIKA LANG, MSW		1	0.0%	2	$660.00	$390.00	$300.00	6	6.0
WILLIAM T MCLARTY JR, MD		1	0.0%	1	$75.00	$50.00	$35.00	1	1.0
LYNDON D WAUGH, MD		1	0.0%	1	$220.00	$220.00	$110.00	1	1.0
BARRY N JONES, MD		1	0.0%	4	$835.00	$465.00	$405.00	4	4.0
KEVIN J WINDERS, MD		1	0.0%	1	$85.00	$50.00	$35.00	1	1.0
JACQUELINE HAIMES, MD		1	0.0%	1	$100.00	$100.00	$50.00	1	1.0
CLAUDIA WONG, MA		1	0.0%	1	$125.00	$125.00	$62.50	1	1.0
ANTOINETTE J LYNN, PHD		1	0.0%	1	$500.00	$500.00	$250.00	2	2.0
DAN J SHEARER, MA		1	0.0%	1	$320.00	$320.00	$160.00	4	4.0
WILLIAM G KEE, PHD		1	0.0%	3	$550.00	$255.00	$210.00	3	3.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
GLENN P ZAEPFEL, PHD	[redacted]	1	0.0%	3	$305.00	$250.00	$205.00	3	3.0
JAMES N. RENTZ, MA		1	0.0%	1	$400.00	$400.00	$200.00	4	4.0
ROBERT M SHOLTES, MD		1	0.0%	1	$90.00	$90.00	$45.00	1	1.0
HARRY R DIAMANT, DSW		1	0.0%	4	$320.00	$320.00	$160.00	4	4.0
DEPARTMENT OF VETERAN AFFAIRS		1	0.0%	1	$187.31	$187.31	$93.66	1	1.0
CLAUDIA SINAY MOSIAS, MA		1	0.0%	1	$2,400.00	$1,968.00	$984.00	20	20.0
ROSEMARY M MADRUGA, MA		1	0.0%	2	$220.00	$165.00	$135.00	2	2.0
KENNETH J DEAVER, MSW		1	0.0%	1	$480.00	$264.00	$204.00	4	4.0
RUTH E CLIFFORD, PHD		1	0.0%	1	$202.00	$202.00	$101.00	1	1.0
GAYE M WEIN SHEPARD, PHD		1	0.0%	1	$420.00	$198.00	$153.00	3	3.0
KENNETH PHILIPP, PSYD		1	0.0%	2	$710.00	$636.00	$546.00	6	6.0
MARIETTA A N ALMAZAN, MD		1	0.0%	4	$705.00	$555.00	$495.00	4	4.0
CHRISTOPHER PINHEY, PHD		1	0.0%	3	$240.00	$240.00	$195.00	3	3.0
SHARI REVILLE, PHD		1	0.0%	4	$900.00	$900.00	$450.00	6	6.0
SHLOMO YAFFE, BS		1	0.0%	1	$225.00	$225.00	$180.00	3	3.0
FELICE L BLOCK, MA		1	0.0%	9	$1,250.00	$597.00	$443.00	9	9.0
JERRY D HESTON, MD		1	0.0%	2	$400.00	$208.00	$178.00	2	2.0
DANA L SIBILSKY, MD		1	0.0%	1	$135.00	$50.00	$35.00	1	1.0
SANDRA MARY STORY, PSYD		1	0.0%	3	$450.00	$240.00	$170.00	3	3.0
MARYANN CROWDER, EDD		1	0.0%	1	$125.00	$60.00	$45.00	1	1.0
RONALD J LEWELLYN, PHD		1	0.0%	2	$250.00	$160.00	$130.00	2	2.0
THOMAS E MATES, PHD		1	0.0%	5	$670.00	$670.00	$335.00	5	5.0
BRYAN HUGH HARRELSON, MD		1	0.0%	1	$80.00	$60.00	$45.00	1	1.0
GREGORY J DRAY, MD		1	0.0%	1	$100.00	$100.00	$50.00	1	1.0
ANDREA BISHOP, MSW		1	0.0%	5	$500.00	$325.00	$250.00	5	5.0
MICHAEL EARL SMITH, MD		1	0.0%	1	$70.00	$60.00	$45.00	1	1.0
EMILY C GORDON, PHD		1	0.0%	3	$875.00	$560.00	$455.00	7	7.0
BARNWELL RHETT MYERS III, MD		1	0.0%	1	$75.00	$50.00	$25.00	1	1.0
WILLIAM T TROST, MD		1	0.0%	2	$885.00	$540.00	$465.00	5	5.0
CARMON K MCGEE, MSW		1	0.0%	5	$1,030.00	$590.00	$455.00	9	9.0
PATRICK LILLARD, MD		1	0.0%	1	$180.00	$140.00	$125.00	1	1.0
JONATHAN SIMONS, PHD		1	0.0%	7	$700.00	$560.00	$455.00	7	7.0
DOREEN G CHARNIN, MA		1	0.0%	1	$750.00	$390.00	$300.00	6	6.0
MICHAEL H. MILLMAN, PHD		1	0.0%	3	$330.00	$264.00	$219.00	3	3.0
RAJAKUMAR THOTAKURA, MD		1	0.0%	2	$270.00	$150.00	$120.00	2	2.0
WILLIAM ALLEN WILLIS JR, MD		1	0.0%	3	$300.00	$240.00	$180.00	4	4.0
DAVID C RUCK, MD		1	0.0%	2	$150.00	$120.00	$90.00	2	2.0
STUART C HUNT, MSW		1	0.0%	5	$600.00	$600.00	$300.00	5	5.0
ELLEN C WILSON, PHD		1	0.0%	1	$210.00	$160.00	$130.00	2	2.0
DANIEL C. BIBER, PHD		1	0.0%	1	$125.00	$80.00	$65.00	1	1.0
DANIEL CHARLES BIBER, PHD		1	0.0%	1	$125.00	$80.00	$65.00	1	1.0
BRYAN E SULLIVAN, MS		1	0.0%	2	$360.00	$260.00	$200.00	4	4.0
BARBARA J HENSLEY, EDD		1	0.0%	3	$520.00	$261.00	$201.00	4	4.0
DAVID L MINEAU, PHD		1	0.0%	1	$2,210.00	$2,210.00	$1,105.00	17	17.0
PHILIP LARTEY, MD		1	0.0%	2	$288.00	$150.00	$120.00	2	2.0
DAVID P FITZGERALD, PHD		1	0.0%	1	$250.00	$250.00	$125.00	1	1.0
SCOTT VANDERZEE, MSW		1	0.0%	1	$700.00	$441.00	$351.00	6	6.0
SUSAN MORES, MS		1	0.0%	1	$575.00	$575.00	$287.50	5	5.0
COREEN L LUCERO PERKINS, MSW		1	0.0%	5	$485.00	$342.00	$267.00	5	5.0
CYNTHIA ROSE FERRERA, PHD		1	0.0%	1	$125.00	$125.00	$110.00	1	1.0
DONALD KERN, MA		1	0.0%	2	$120.00	$120.00	$90.00	2	2.0
STEPHANIE WOLPER, MSW		1	0.0%	6	$900.00	$396.00	$306.00	6	6.0
SANDHYA SHANKAR, MSW		1	0.0%	2	$800.00	$528.00	$282.00	8	8.0
DAVID IVEY, PHD		1	0.0%	6	$600.00	$600.00	$300.00	6	6.0
BILL C MARITN, MA		1	0.0%	2	$600.00	$600.00	$300.00	5	5.0
ROBERT O MC CARTHY, MD		1	0.0%	2	$350.00	$350.00	$175.00	2	2.0
KHIZAR KHAN, MD		1	0.0%	2	$329.00	$190.00	$160.00	2	2.0
PHYLLIS NEWMAN, MSW		1	0.0%	5	$537.00	$335.00	$260.00	5	5.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

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Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
HELENA JAREB, PHD	[redacted]	1	0.0%	4	$480.00	$480.00	$240.00	4	4.0
ANDREA S CAMPBELL, MSW		1	0.0%	1	$295.00	$295.00	$147.50	3	3.0
SHEILA IRICK, MD		1	0.0%	1	$135.00	$135.00	$67.50	1	1.0
DEBORAH S KAUFMAN, MSW		1	0.0%	1	$200.00	$70.00	$55.00	1	1.0
RONNI RITTENHOUSE, PHD		1	0.0%	3	$360.00	$205.00	$160.00	3	3.0
JEAN W WALBRIDGE, MSW		1	0.0%	1	$1,625.00	$1,625.00	$493.61	13	13.0
GEORGE PAPAGEORGE, MA		1	0.0%	1	$1,800.00	$1,800.00	$900.00	15	15.0
RICHARD S JANNEY, MSW		1	0.0%	1	$218.23	$218.23	$109.12	1	1.0
MELISSA KAY, MA		1	0.0%	1	$99.00	$99.00	$84.00	1	1.0
MARCIA A TOYOHARA, MA		1	0.0%	7	$1,320.00	$1,035.00	$840.00	13	13.0
ETHAN STEEVER, PHD		1	0.0%	5	$960.00	$602.00	$497.00	7	7.0
LAWRENCE K MARTIN, MD		1	0.0%	1	$175.00	$175.00	$87.50	1	1.0
DENISE AJALAT THEBERGE, PHD		1	0.0%	3	$910.00	$910.00	$455.00	7	7.0
TERESA WILSHIN, MA		1	0.0%	2	$1,215.00	$1,077.00	$942.00	9	9.0
MARCELLUS R CEPHAS, MD		1	0.0%	15	$2,410.00	$970.00	$541.00	15	15.0
LATA SONPAL, PHD		1	0.0%	1	$350.00	$350.00	$175.00	2	2.0
ANNELISE A PETRY, MSW		1	0.0%	7	$595.00	$438.00	$333.00	7	7.0
ELIZABETH D DUNGEE ANDERSON, M		1	0.0%	3	$405.00	$248.00	$188.00	4	4.0
NANCY W BROCKMAN, MSW		1	0.0%	6	$535.00	$381.00	$291.00	6	6.0
KATHERINE S KILCHER, MA		1	0.0%	3	$270.00	$186.00	$141.00	3	3.0
AMY W ELLIOTT, MS		1	0.0%	7	$1,180.00	$815.00	$519.50	13	13.0
JOHN LYNCH, PHD		1	0.0%	1	$125.00	$81.00	$66.00	1	1.0
RICHARD P LEGGETT, MD		1	0.0%	1	$60.00	$49.00	$24.50	1	1.0
JOSEPH T DUEHL, MSW		1	0.0%	1	$334.59	$334.59	$167.30	1	1.0
JAMES MARK SHADOAN, MSW		1	0.0%	3	$305.00	$197.00	$152.00	3	3.0
JOSEPH IRVING LEIZER, PHD		1	0.0%	1	$210.00	$142.00	$112.00	2	2.0
MICHAEL A HOFFMAN, MD		1	0.0%	1	$80.00	$49.00	$34.00	1	1.0
ANGELINA ROMAN ESPINONA GUANZO		1	0.0%	1	$55.00	$49.00	$34.00	1	1.0
SACHINDER VASUDEVA, MD		1	0.0%	1	$79.00	$49.00	$34.00	1	1.0
STELLA I NDEM, MD		1	0.0%	1	$79.00	$49.00	$34.00	1	1.0
TRACEY W CRISS, MD		1	0.0%	1	$79.00	$49.00	$34.00	1	1.0
SAMIA SABEEN, MD		1	0.0%	1	($127.00)	($127.00)	($15.00)	-1	-1.0
ANITA LOUISE CLAYTON, MS		1	0.0%	1	($127.00)	($127.00)	($15.00)	-1	-1.0
ZACHARIAH C DAMERON, MD		1	0.0%	1	($127.00)	($127.00)	($15.00)	-1	-1.0
WALTER STANLEY JENNINGS JR, MD		1	0.0%	1	$180.00	$110.00	$95.00	1	1.0
RICHARD E CURTIS JR, MD		1	0.0%	2	$250.00	$159.00	$129.00	2	2.0
ROBERT L SEWARD, MD		1	0.0%	1	$70.00	$49.00	$34.00	1	1.0
RAYMOND CHRIS POWER, MA		1	0.0%	1	$215.00	$215.00	$107.50	2	2.0
FAISAL MOHSIN, MD		1	0.0%	1	$60.00	$60.00	$30.00	1	1.0
CENTRAL VIRGINIA COMMUNITY SVC		1	0.0%	1	$105.00	$105.00	$52.50	3	3.0
PATHWAYS TREATMENT CENTER		1	0.0%	1	$825.00	$675.00	$540.00	3	3.0
KAY E MORGAN, MA		1	0.0%	5	$500.00	$500.00	$250.00	5	5.0
LINDA R RADFORD, PHD		1	0.0%	2	$780.00	$780.00	$390.00	5	5.0
MARY E FONTANA, MED		1	0.0%	3	$310.00	$208.00	$140.00	3	3.0
SUE M STEVENS, MSW		1	0.0%	1	$360.00	$360.00	$180.00	4	4.0
ANDREW K. KUMASAKA, MD		1	0.0%	1	$260.00	$260.00	$130.00	4	4.0
GEORGETTE E LEPAGE, MS		1	0.0%	2	$490.00	$490.00	$245.00	5	5.0
LISA LEWIS, MSW		1	0.0%	3	$800.00	$800.00	$400.00	10	10.0
KAMRAN FALLAHPOUR, PHD		1	0.0%	1	$300.00	$300.00	$150.00	3	3.0
LAURIE A WIGGEN, PSYD		1	0.0%	1	$202.00	$202.00	$127.00	2	2.0
DARSI AXFORD, MC		1	0.0%	2	$325.00	$214.00	$169.00	3	3.0
RICHARD BRALLIAR, DO		1	0.0%	1	$100.00	$75.00	$60.00	1	1.0
NICOLETTE S SACHS, MSW		1	0.0%	1	$200.00	$130.00	$100.00	2	2.0
KENNETH S NICKERSON, PHD		1	0.0%	1	$1,200.00	$1,200.00	$600.00	6	6.0
FRANK P URTZ, PHD		1	0.0%	2	$360.00	$190.00	$160.00	2	2.0
PATRICIA F LAMB, MSW		1	0.0%	1	$100.00	$57.00	$28.50	1	1.0
LISA RACHEL HALPERN, MD		1	0.0%	1	$95.00	$46.00	$31.00	1	1.0
RICHARD BACHARACH, MD		1	0.0%	2	$385.00	$150.00	$120.00	2	2.0

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HEATHER LOUISE STANLEY, MSW	[redacted]	1	0.0%	2	$230.00	$114.00	$70.50	2	2.0
MARILYN LYDIA MARTIN, MD		1	0.0%	1	$75.00	$46.00	$31.00	1	1.0
FRANK W GIBSON JR, PHD		1	0.0%	2	$230.00	$132.00	$102.00	2	2.0
JACK MARTIN LONG, PHD		1	0.0%	3	$330.00	$171.00	$85.50	3	3.0
PAULA B RANDANT, MSW		1	0.0%	1	$400.00	$270.00	$210.00	4	4.0
JEAN HINLICKY, MD		1	0.0%	2	$150.00	$150.00	$75.00	1	1.0
KEVIN HARRISON, MD		1	0.0%	2	$260.00	$260.00	$130.00	2	2.0
MARGY COTTLE, PHD		1	0.0%	1	$220.00	$220.00	$110.00	2	2.0
DAVID SCOTT WELLS, PHD		1	0.0%	3	$650.00	$437.00	$362.00	5	5.0
MARK MCCARTHY, MSED		1	0.0%	2	$540.00	$360.00	$270.00	6	6.0
IBIS BRITO, PSYD		1	0.0%	1	$175.00	$175.00	$87.50	1	1.0
CYNTHIA L JOHNSON, MSED		1	0.0%	4	$570.00	$390.00	$300.00	6	6.0
SUSAN P NILSSON WEISKOTT, PHD		1	0.0%	1	$285.00	$185.00	$155.00	2	2.0
GERI KONENKAMP, DMFT		1	0.0%	4	$1,170.00	$1,170.00	$585.00	13	13.0
TINA L BUCKNER, PSYD		1	0.0%	2	$910.00	$616.00	$511.00	7	7.0
MARK J BEIDLE, MSW		1	0.0%	1	$75.00	$75.00	$60.00	1	1.0
GRANT H WOOD, MS		1	0.0%	1	$95.00	$95.00	$47.50	1	1.0
LINDA B KROLL JD, MS		1	0.0%	1	$140.00	$140.00	$70.00	1	1.0
MARY ELIZABETH PAUL, PHD		1	0.0%	1	$260.00	$260.00	$130.00	2	2.0
LUBICA FEDOR, MD		1	0.0%	1	$80.00	$60.00	$45.00	1	1.0
DEBRA E KOENITZ, MA		1	0.0%	4	$1,455.00	$855.00	$590.00	13	13.0
ROBERT M MILLER, MA		1	0.0%	2	$190.00	$120.00	$90.00	2	2.0
JUDITH E FISHER, MSW		1	0.0%	1	$100.00	$62.00	$47.00	1	1.0
ANTHONY B DSOUZA, MD		1	0.0%	2	$300.00	$220.00	$190.00	2	2.0
DONALD R TOWNE, MSW		1	0.0%	2	$1,125.00	$585.00	$450.00	9	9.0
DAVID M DONAHUE, DO		1	0.0%	1	$80.00	$50.00	$35.00	1	1.0
KEITH A WHITE, MA		1	0.0%	2	$270.00	$270.00	$135.00	3	3.0
ELIZABETH F PRIBOR, MD		1	0.0%	1	$100.00	$100.00	$50.00	1	1.0
ELIZABETH CAMPBELL, PH.D.		1	0.0%	1	$360.00	$360.00	$180.00	4	4.0
DONNA L. STEINER, MSW		1	0.0%	1	$180.00	$180.00	$90.00	2	2.0
NANCY L. BREUER, PSYD		1	0.0%	4	$692.00	$692.00	$346.00	4	4.0
ENRIQUE DOS SANTOS, MD		1	0.0%	1	$70.00	$50.00	$25.00	1	1.0
RUTH J STROMBERG, MSW		1	0.0%	4	$525.00	$525.00	$262.50	5	5.0
MICHAEL J EVERSON, MD		1	0.0%	1	$85.00	$50.00	$35.00	1	1.0
LOLITTA E AZNAUROVA, MD		1	0.0%	1	$85.00	$50.00	$35.00	1	1.0
GREGG BASSETT, MD		1	0.0%	1	$105.00	$105.00	$52.50	1	1.0
PROVIDENT COUNSELING		1	0.0%	2	$210.00	$120.00	$90.00	2	2.0
TERI DENISE MAPLES, MS		1	0.0%	2	$350.00	$143.00	$113.00	2	2.0
CARL EDWARD FOUGEROUSSE JR, MD		1	0.0%	1	$180.00	$135.00	$120.00	1	1.0
NATHAN DONALD FEIBELMAN III, M		1	0.0%	1	$110.00	$75.00	$60.00	1	1.0
GONCHIGARI NARAYANA, MD		1	0.0%	2	$221.00	$140.00	$110.00	2	2.0
RICHARD WHITTLESEY, PHD		1	0.0%	3	$417.00	$225.00	$180.00	3	3.0
TONI R BELL, MA		1	0.0%	4	$455.00	$250.00	$190.00	4	4.0
SUSAN M GUENTHER, PHD		1	0.0%	1	$120.00	$90.00	$75.00	1	1.0
TRINA L REITER, MSW		1	0.0%	5	$580.00	$310.00	$235.00	5	5.0
JEFFREY D WILHARM, MD		1	0.0%	3	$240.00	$150.00	$105.00	3	3.0
SUNITA KANTANMENI, MD		1	0.0%	1	$93.00	$50.00	$35.00	1	1.0
COVENANT HOSPITAL E KIMBALL		1	0.0%	1	$93.00	$93.00	$78.00	1	1.0
TOM HANSEN, MD		1	0.0%	3	$249.00	$249.00	$124.50	3	3.0
ELAINA C RILEY, MSW		1	0.0%	1	$110.00	$70.00	$55.00	1	1.0
MARY G PERCIVAL, MA		1	0.0%	1	$110.00	$70.00	$55.00	1	1.0
TERRI E BREWER, PSYD		1	0.0%	3	$330.00	$330.00	$165.00	3	3.0
JAMES N LLOYD, MA		1	0.0%	1	$85.00	$85.00	$70.00	1	1.0
JAMES P MADRY, PHD		1	0.0%	1	$380.00	$260.00	$200.00	4	4.0
MICHELLE R MORAN, MD		1	0.0%	2	$240.00	$230.00	$200.00	2	2.0
EDWARD DONNER, PHD		1	0.0%	3	$525.00	$525.00	$262.50	3	3.0
NANCY VANDYKEN, MSW		1	0.0%	13	$1,950.00	$1,950.00	$975.00	13	13.0
MARILYN MASON, PHD		1	0.0%	1	$125.00	$125.00	$62.50	1	1.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
ELIZABETH S AHLERS, MA	[redacted]	1	0.0%	6	$760.00	$413.00	$323.00	6	6.0
NANCY RAINS, PHD		1	0.0%	1	$246.00	$246.00	$123.00	1	1.0
SCOTT YAROSH, MD		1	0.0%	1	$221.00	$221.00	$110.50	1	1.0
HARVEY J GREEN, MD		1	0.0%	2	$525.00	$235.00	$205.00	2	2.0
LYDIA G ROTH LAUBE, PHD		1	0.0%	1	$250.00	$160.00	$130.00	2	2.0
JODY J SHASKEY SETRIGHT, MS		1	0.0%	4	$600.00	$331.00	$256.00	5	5.0
RONALD L ALLEN, PHD		1	0.0%	1	$120.00	$80.00	$65.00	1	1.0
DEBRA L BUNGER, MD		1	0.0%	1	$85.00	$70.00	$55.00	1	1.0
CLAIRE TOUTANT, MD		1	0.0%	1	$365.00	$299.00	$269.00	2	2.0
ELIZABETH H THOMPSON, PSYD		1	0.0%	1	$150.00	$80.00	$65.00	1	1.0
JON R CHRISTENSEN, MS		1	0.0%	2	$810.00	$410.00	$335.00	5	5.0
RUTH G GIDEON, MD		1	0.0%	1	$1,110.00	$660.00	$570.00	6	6.0
JAMES M UTIC, PHD		1	0.0%	1	$375.00	$264.00	$219.00	3	3.0
JANICE MERTEN, MSW		1	0.0%	2	$1,540.00	$390.00	$300.00	6	6.0
LORETTA HENSON, PHD		1	0.0%	1	$250.00	$195.00	$97.50	2	2.0
KENNAN F HORN, MSSW		1	0.0%	1	$190.00	$90.00	$75.00	1	1.0
INTERGRATED DEVELOPMENT SERVIC		1	0.0%	5	$2,445.00	$2,445.00	$1,956.00	23	23.0
JAMES B WINSTON, MD		1	0.0%	1	$165.00	$65.00	$50.00	1	1.0
LAURA A LEES, PSYD		1	0.0%	1	$150.00	$150.00	$75.00	1	1.0
LAURA E GRAY, MSN		1	0.0%	1	$135.00	$135.00	$67.50	1	1.0
AMY ZOLOT, PHD		1	0.0%	2	$250.00	$250.00	$125.00	2	2.0
MICHAEL R RADKE, MSW		1	0.0%	1	$120.00	$80.00	$65.00	1	1.0
UW MEDICAL FOUNDATION		1	0.0%	1	$210.00	$210.00	$105.00	1	1.0
SUSAN MUELLER, MSW		1	0.0%	1	$440.00	$440.00	$220.00	4	4.0
KEVIN GYOERKOE, PSYD		1	0.0%	1	$190.00	$190.00	$95.00	1	1.0
AMANDA HOLLY, PHD		1	0.0%	1	$165.00	$165.00	$82.50	1	1.0
MYRNA F SOLGANICK, MS		1	0.0%	1	$670.00	$410.00	$335.00	5	5.0
MAREK J HANN, MD		1	0.0%	1	$220.00	$130.00	$115.00	1	1.0
TIMOTHY E TYRE, PHD		1	0.0%	3	$577.00	$290.00	$245.00	3	3.0
DAVID JAMES CIPRIANO, PHD		1	0.0%	6	$900.00	$900.00	$450.00	6	6.0
RACHEL A ROEGLIN, PSYD		1	0.0%	4	$680.00	$455.00	$325.00	4	4.0
PAUL L BARTSCH, MA		1	0.0%	6	$830.00	$426.00	$336.00	6	6.0
AMY B ANDERSON, MSW		1	0.0%	4	$520.00	$320.00	$260.00	4	4.0
DONAL L CROWDER, PHD		1	0.0%	2	$365.00	$195.00	$165.00	2	2.0
MARY T NANTZ, MSW		1	0.0%	2	$270.00	$160.00	$105.00	2	2.0
MAREN C ERICKSON, MSW		1	0.0%	1	$135.00	$80.00	$65.00	1	1.0
LINDA M TISO, MSW		1	0.0%	4	$540.00	$320.00	$260.00	4	4.0
HARRY BORTH, MSW		1	0.0%	1	$135.00	$80.00	$65.00	1	1.0
MICHAEL M PAPIN, MD		1	0.0%	1	$130.00	$70.00	$55.00	1	1.0
LYNN M OLLSWANG, MSW		1	0.0%	5	$550.00	$400.00	$325.00	5	5.0
LINDA STOLTZMAN, MSW		1	0.0%	1	$160.00	$90.00	$75.00	1	1.0
DEE GREENE, MSW		1	0.0%	1	$150.00	$150.00	$75.00	1	1.0
THERESA M CODDINGTON, PHD		1	0.0%	2	$250.00	$162.00	$132.00	2	2.0
ARLYS L SCHWABAUER, MSN		1	0.0%	1	$90.00	$38.00	$23.00	1	1.0
PAUL L KURTZWEIL, PHD		1	0.0%	4	$670.00	$415.00	$340.00	5	5.0
PATSY A DASS, PHD		1	0.0%	5	$690.00	$690.00	$345.00	6	6.0
JAN L SCHWARTZ, MSW		1	0.0%	3	$375.00	$325.00	$162.50	5	5.0
NANCY J ROEPKE, PHD		1	0.0%	2	$275.00	$245.00	$215.00	2	2.0
MARLENE FELDMAN, MSW		1	0.0%	1	$375.00	$375.00	$187.50	3	3.0
BROOKE FOX, MSW		1	0.0%	4	$960.00	$960.00	$480.00	8	8.0
NIKKI LEVINE, MA		1	0.0%	2	$240.00	$240.00	$120.00	2	2.0
RICHARD R HORTON, MD		1	0.0%	1	$100.00	$60.00	$45.00	1	1.0
ROBERT E MCCARTHY, PHD		1	0.0%	2	$285.00	$195.00	$150.00	3	3.0
RAUF A CHEEMA, MD		1	0.0%	1	$110.00	$110.00	$55.00	1	1.0
MICHAEL R BOURBON, MSW		1	0.0%	6	$1,035.00	$585.00	$380.00	9	9.0
JAYASHREE S COCA, MD		1	0.0%	1	$90.00	$90.00	$45.00	1	1.0
DONNA LINDLEY, MA		1	0.0%	9	$1,260.00	$627.00	$492.00	9	9.0
ELIZABETH L EASLEY, MSN		1	0.0%	1	$160.00	$160.00	$80.00	1	1.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
MARTIN W WETZEL, MD	[redacted]	1	0.0%	5	$540.00	$540.00	$270.00	5	5.0
JAMES DUNLAP, MD		1	0.0%	4	$465.00	$275.00	$215.00	4	4.0
AMY E SCHUETT, MD		1	0.0%	2	$170.00	$170.00	$85.00	2	2.0
MARTIN W WETZEL, MD		1	0.0%	2	$0.00	$0.00	$0.00		0.0
JOHN Y DONALDSON, MD		1	0.0%	1	$180.00	$180.00	$90.00	1	1.0
JOYCE MARGARET SVOBODA, MS		1	0.0%	5	$725.00	$325.00	$250.00	5	5.0
HEARTLAND FAMILY SERVICE DAVEN		1	0.0%	3	$455.00	$455.00	$227.50	4	4.0
KATIE E SEWELL, PSYD		1	0.0%	1	$160.00	$80.00	$65.00	1	1.0
MICHAEL D VANCE, PHD		1	0.0%	1	$248.00	$95.00	$80.00	1	1.0
JOSEPH EVANS, PHD		1	0.0%	1	$140.00	$80.00	$65.00	1	1.0
JOAN E WEHMAN, MSSW		1	0.0%	7	$835.00	$571.00	$436.00	9	9.0
BRENDA RUTTENBERG, PHD		1	0.0%	3	$490.00	$334.00	$274.00	4	4.0
DIANNE D DAUBLER, MSW		1	0.0%	3	$665.00	$465.00	$232.50	7	7.0
CHARLES W KELLER, PHD		1	0.0%	2	$180.00	$152.00	$122.00	2	2.0
PATRICIA E WOOD, PHD		1	0.0%	1	$300.00	$242.00	$197.00	3	3.0
JANETTE RICHARDSON, MED		1	0.0%	8	$490.00	$490.00	$370.00	8	8.0
TYLER LEE PELTON, MSSW		1	0.0%	2	$825.00	$509.00	$389.00	8	8.0
K THOMAS VARGHESE, MBBC		1	0.0%	1	$100.00	$60.00	$45.00	1	1.0
JUDY L ALEXANDER, MSW		1	0.0%	1	$1,750.00	$1,750.00	$875.00	14	14.0
DONNA K LEWIS, MSW		1	0.0%	1	$300.00	$195.00	$150.00	3	3.0
SARAH RANDEL, PHD		1	0.0%	1	$280.00	$152.00	$122.00	2	2.0
THOMAS MACKIN, MSW		1	0.0%	4	$765.00	$765.00	$382.50	9	9.0
DIANE W TATEM, MS		1	0.0%	1	$80.00	$62.00	$47.00	1	1.0
CATHERINE FERING, MSW		1	0.0%	1	$750.00	$750.00	$375.00	5	5.0
THOMAS H. ANDERSON, PHD		1	0.0%	1	$300.00	$152.00	$122.00	2	2.0
VALERIE L SCHNEIDER, MSW		1	0.0%	1	$120.00	$120.00	$60.00	1	1.0
CHERYL L BOWIE, MSSW		1	0.0%	6	$650.00	$385.00	$295.00	6	6.0
LEE ANN HART, MSW		1	0.0%	3	$375.00	$366.00	$291.00	5	5.0
SIOMARA I MONGE, MSW		1	0.0%	1	$480.00	$248.00	$188.00	4	4.0
NANCY AMOS, PHD		1	0.0%	5	$875.00	$875.00	$437.50	5	5.0
DIANNA M KINKEAD, MA		1	0.0%	5	$321.00	$321.00	$246.00	5	5.0
MARGARET A SUMMY, MED		1	0.0%	5	$800.00	$496.00	$376.00	8	8.0
DARLEEN GEGICH, MA		1	0.0%	1	$255.00	$255.00	$127.50	3	3.0
PATRICE J JOHNSON, MD		1	0.0%	4	$600.00	$260.00	$200.00	4	4.0
GARY L STERN, DO		1	0.0%	5	$600.00	$440.00	$365.00	5	5.0
JENNIFER MUEHLENKAMP, PHD		1	0.0%	1	$470.00	$470.00	$235.00	3	3.0
JONATHAN E WHALEN, PHD		1	0.0%	1	$225.00	$115.00	$100.00	1	1.0
CHRISTIANNE KNIGHT, MS		1	0.0%	1	$55.00	$55.00	$40.00	1	1.0
VIRGINIA L MCQUISTON, MSW		1	0.0%	1	$95.00	$65.00	$50.00	1	1.0
SARNA SUNSHINE, MSW		1	0.0%	1	$290.00	$290.00	$145.00	2	2.0
MICHAEL DARROW, MSSW		1	0.0%	1	$125.00	$75.00	$37.50	1	1.0
MARY L MIHELICH, PHD		1	0.0%	1	$100.00	$65.00	$50.00	1	1.0
DOROTHY NOLD, MSW		1	0.0%	1	$130.00	$130.00	$65.00	1	1.0
SAINT MARYS HEALTH PSYCHOLOGY		1	0.0%	1	$236.00	$150.00	$120.00	2	2.0
CATHERINE M MACGREGOR, PHD		1	0.0%	3	$960.00	$640.00	$320.00	8	8.0
JOANN K NISHIMOTO, PSYD		1	0.0%	3	$375.00	$375.00	$187.50	3	3.0
FRANK A TRUPIANO, MSW		1	0.0%	1	$120.00	$75.00	$60.00	1	1.0
KAREN G SELENBERG, MSW		1	0.0%	1	$100.00	$65.00	$50.00	1	1.0
GALE T GUCKER, MS		1	0.0%	4	$355.00	$325.00	$250.00	5	5.0
PAUL E VOORHIES, MSW		1	0.0%	1	$240.00	$195.00	$150.00	3	3.0
LAURIE L NUSSBAUM, MSW		1	0.0%	3	$270.00	$195.00	$150.00	3	3.0
BEVERLY L NUGENT, MA		1	0.0%	4	$380.00	$260.00	$200.00	4	4.0
RAY C COXE, PHD		1	0.0%	1	$730.00	$730.00	$365.00	11	11.0
BRAD ROBISON, MD		1	0.0%	3	$200.00	$200.00	$100.00	3	3.0
ASIF HABIB, MBBC		1	0.0%	1	$70.00	$50.00	$35.00	1	1.0
LEESA ABBOTT, PSYD		1	0.0%	2	$500.00	$160.00	$128.00	2	2.0
ROBERTA L STRAIT, MSW		1	0.0%	2	$280.00	$160.00	$130.00	2	2.0
LAURA A SUNN, MD		1	0.0%	2	$300.00	$130.00	$100.00	2	2.0

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Sample Company

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Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
MARY JANE WHITMORE, MA	[redacted]	1	0.0%	1	$120.00	$120.00	$105.00	1	1.0
LYNN GAUGER, MSSW		1	0.0%	1	$150.00	$90.00	$75.00	1	1.0
LYNN A VICE, PSYD		1	0.0%	2	$380.00	$380.00	$190.00	2	2.0
CAROL M JUSTIN, MSW		1	0.0%	1	$130.00	$130.00	$65.00	1	1.0
MARY ZOSEL, PHD		1	0.0%	7	$1,200.00	$1,200.00	$600.00	8	8.0
MARY ANDREA KISHLINE, MSW		1	0.0%	2	$344.00	$170.00	$140.00	2	2.0
PAUL M DEFAZIO, MSW		1	0.0%	3	$516.00	$240.00	$195.00	3	3.0
JACK PLATE, MSW		1	0.0%	1	$150.00	$90.00	$75.00	1	1.0
CLAUDIA ROHLING, MSW		1	0.0%	8	$1,080.00	$640.00	$520.00	8	8.0
ROBERTO LOPEZ, PHD		1	0.0%	6	$960.00	$570.00	$480.00	6	6.0
KATHLEEN R ROTHMEYER, MSW		1	0.0%	1	$135.00	$80.00	$65.00	1	1.0
GARRY LIBSTER, EDD		1	0.0%	6	$960.00	$480.00	$390.00	6	6.0
FREDERIC BASIL WILL, MD		1	0.0%	2	$250.00	$250.00	$125.00	2	2.0
JON D CARLSON, PSYD		1	0.0%	5	$750.00	$475.00	$400.00	5	5.0
LINDA BESTOR, PHD		1	0.0%	5	$630.00	$480.00	$405.00	5	5.0
BRIAN A WOLF, PHD		1	0.0%	1	$70.00	$54.00	$39.00	1	1.0
ANTHONY D MEYER, MD		1	0.0%	1	$200.00	$200.00	$100.00	1	1.0
FREDRIC A STEIGER, MD		1	0.0%	1	$130.00	$130.00	$65.00	1	1.0
IKAR J KALOGJERA, MD		1	0.0%	3	$600.00	$600.00	$555.00	3	3.0
ANNA L KAJUCH, MD		1	0.0%	2	$355.00	$195.00	$165.00	2	2.0
TERENCE J YOUNG, PSYD		1	0.0%	5	$1,410.00	$750.00	$608.00	5	5.0
SUSAN FOLEY, MS		1	0.0%	3	$300.00	$240.00	$195.00	3	3.0
LISA HUCK, BA		1	0.0%	6	$3,325.00	$3,325.00	$2,660.00	33	33.0
KAREN OILER, MA		1	0.0%	2	$1,350.00	$1,350.00	$1,080.00	9	9.0
GOODWILL INDUSTRIES OF N CENTR		1	0.0%	5	$1,750.00	$1,750.00	$1,400.00	18	18.0
KRIS DUNLAP, PHD		1	0.0%	1	$125.00	$125.00	$100.00	1	1.0
ROGERS MEMORIAL HOSPITAL KENOS		1	0.0%	2	$6,156.00	$5,244.00	$4,744.00	19	19.0
DONNA BREHM, MD		1	0.0%	1	$155.00	$155.00	$77.50	1	1.0
AMY E BOURNE, MD		1	0.0%	1	$124.00	$124.00	$62.00	1	1.0
GARY SCHNELL, MD		1	0.0%	1	$110.00	$110.00	$55.00	1	1.0
STEVEN PETRIE, MSW		1	0.0%	1	$166.00	$80.00	$65.00	1	1.0
JOSEPH J BURGARINO, MD		1	0.0%	1	$256.00	$130.00	$115.00	1	1.0
AURORA PSYCHIATRIST HOSPITAL M		1	0.0%	2	$3,500.50	$1,950.00	$1,950.00	13	13.0
MERITER HOSPITAL WI		1	0.0%	1	$674.00	$674.00	$102.44	1	1.0
SHELLEY LONDON, MSW		1	0.0%	4	$540.00	$540.00	$270.00	4	4.0
TIMOTHY D MCGIVERN, MA		1	0.0%	1	$115.00	$115.00	$57.50	1	1.0
TIMOTHY D. MCGIVERN, MA		1	0.0%	2	$230.00	$230.00	$115.00	2	2.0
CYNTHIA SAFFELL, MSW		1	0.0%	1	$100.00	$100.00	$50.00	1	1.0
STEVEN C GRIFFIOEN, PSYD		1	0.0%	2	$620.00	$415.00	$340.00	5	5.0
ROBERT S GARCIA, MD		1	0.0%	1	$70.00	$50.00	$35.00	1	1.0
GARY W HOBBS, PHD		1	0.0%	2	$420.00	$400.00	$340.00	4	4.0
JANET T TARKOWSKI, EDD		1	0.0%	12	$1,200.00	$960.00	$730.00	12	12.0
BARBARA C CAIN, MSW		1	0.0%	1	$115.00	$75.00	$60.00	1	1.0
BARRY BINKLEY, MD		1	0.0%	1	$90.00	$50.00	$25.00	1	1.0
JOHN M KOETSIER, MD		1	0.0%	1	$140.00	$140.00	$70.00	1	1.0
NICOLE MERCHANT, MA		1	0.0%	5	$510.00	$335.00	$260.00	5	5.0
SUSAN S PATTISON, PSYD		1	0.0%	2	$192.00	$168.00	$57.00	2	2.0
DEANNA J ROSSER, MSW		1	0.0%	1	$540.00	$390.00	$300.00	6	6.0
WEST MICHIGAN ADDCTN CNSLTS		1	0.0%	2	$192.00	$192.00	$96.00	2	2.0
ROSITA A LOPEZ, MA		1	0.0%	4	$125.00	($110.00)	$15.00	1	1.0
ADVNCD COUNSELING SERVICE		1	0.0%	3	$440.00	$255.00	$210.00	3	3.0
ADVNCD COUNSELING SVCS		1	0.0%	1	$125.00	$80.00	$65.00	1	1.0
ADVNCD COUNSELING SERVICE		1	0.0%	1	$125.00	$80.00	$65.00	1	1.0
MARTA S ELODY, MD		1	0.0%	2	$0.00	($30.00)	$5.00		0.0
FREDERICK T SULIER, EDD		1	0.0%	3	$480.00	$320.00	$260.00	4	4.0
RONALD S RICE, PHD		1	0.0%	3	$640.00	$320.00	$260.00	4	4.0
MARY BAGGERMAN, MA		1	0.0%	9	$1,035.00	$585.00	$450.00	9	9.0
CYNTHIA J BASSETT, MA		1	0.0%	3	$345.00	$195.00	$150.00	3	3.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
MERIDIAN PROFESSIONAL PSYCHOLO	[redacted]	1	0.0%	2	$177.00	$88.50	$43.50	3	3.0
JAN E FIX, MA		1	0.0%	4	$440.00	$440.00	$220.00	4	4.0
DONALD PROUX, MD		1	0.0%	3	$370.00	$290.00	$245.00	3	3.0
DONALD A WALTERS, MSSW		1	0.0%	2	$280.00	$160.00	$130.00	2	2.0
JOHN A MULLEN, PHD		1	0.0%	1	$164.00	$95.00	$80.00	1	1.0
GARY MICHAEL MAJOR, PHD		1	0.0%	6	$980.00	$575.00	$485.00	6	6.0
CRAIG A MODELL, PHD		1	0.0%	8	$1,280.00	$760.00	$640.00	8	8.0
CASSANDRA BRAAM, PHD		1	0.0%	2	$420.00	$300.00	$255.00	3	3.0
VELMA HAAG, MSSW		1	0.0%	4	$460.00	$320.00	$260.00	4	4.0
KIMBERLY R KRAUT ARNETT, MSW		1	0.0%	3	$410.00	$250.00	$205.00	3	3.0
COMMUNITY HEALING CENTER		1	0.0%	2	$3,840.00	$2,400.00	$1,920.00	24	24.0
SUSAN BOHON WARNES, PSYD		1	0.0%	2	$190.00	$130.00	$100.00	2	2.0
MELISSA J SHARP, PSYD		1	0.0%	2	$300.00	$160.00	$130.00	2	2.0
JEROME J WILCZYNSKI, PSYD		1	0.0%	1	$150.00	$95.00	$80.00	1	1.0
CAROLE S RAJAN, MSW		1	0.0%	2	$1,000.00	$490.00	$370.00	8	8.0
THOMAS C MURPHY, MD		1	0.0%	1	$685.00	$685.00	$595.00	6	6.0
HARRY WHITELEY, MD		1	0.0%	1	$130.00	$130.00	$65.00	1	1.0
ALVIN DAVID JR FARMER, PHD		1	0.0%	7	$1,890.00	$720.00	$585.00	9	9.0
THOMAS OWLEY, MD		1	0.0%	1	$160.00	$75.00	$60.00	1	1.0
NAGAMANI N PAVULURI, MBBC		1	0.0%	1	$350.00	$140.00	$125.00	1	1.0
LAURA J MILLER, MD		1	0.0%	2	$460.00	$220.00	$190.00	2	2.0
MARY PEACOCK, MSW		1	0.0%	2	$190.00	$130.00	$100.00	2	2.0
SANDRA L VIOLA, PSYD		1	0.0%	1	$420.00	$255.00	$210.00	3	3.0
LORI LYNNE HALL, MSW		1	0.0%	4	$1,750.00	$910.00	$577.50	14	14.0
LILA KAROUB, MA		1	0.0%	2	$180.00	$132.00	$102.00	2	2.0
GUY T KASHGARIAN, PHD		1	0.0%	5	$700.00	$400.00	$325.00	5	5.0
KEITH V BJORGE, PSYD		1	0.0%	6	$900.00	$492.00	$272.00	6	6.0
MEREDITH ELLEN REID, PHD		1	0.0%	2	$250.00	$160.00	$130.00	2	2.0
SHANI MCLOYD, MSW		1	0.0%	2	$1,380.00	$790.00	$610.00	12	12.0
PETER J ZOUTENDYK, MSW		1	0.0%	1	$85.00	$85.00	$42.50	1	1.0
WENDY J SABBATH, PHD		1	0.0%	1	$150.00	$80.00	$40.00	1	1.0
JANET M BOWLES, PHD		1	0.0%	4	$425.00	$380.00	$320.00	4	4.0
BRUCE L DRESNER, MD		1	0.0%	1	$275.00	$275.00	$137.50	1	1.0
CAROL M SALDINGER, MSW		1	0.0%	1	$420.00	$420.00	$210.00	3	3.0
RUTH M RATTENBURY, PSYD		1	0.0%	1	$180.00	$133.00	$103.00	2	2.0
JOSEPH SHOSHANA, PSYD		1	0.0%	1	$900.00	$900.00	$450.00	6	6.0
ALENA BINDER, PSYD		1	0.0%	2	$1,320.00	$1,320.00	$660.00	11	11.0
PETER R TEMPLE, PSYD		1	0.0%	1	$120.00	$120.00	$60.00	1	1.0
TONI STAPLEY REY, MSW		1	0.0%	1	$100.00	$68.00	$53.00	1	1.0
DEBRA E RODE, MA		1	0.0%	2	$600.00	$180.00	$135.00	3	3.0
ANDREW J HOFFMAN, PSYD		1	0.0%	3	$600.00	$400.00	$325.00	5	5.0
SUZETTE RUSH DRAKE, PSYD		1	0.0%	3	$380.00	$240.00	$170.00	3	3.0
BRIAN T MALINOWSKI, MS		1	0.0%	4	$380.00	$260.00	$200.00	4	4.0
BRETT ALAN SISLER, MSW		1	0.0%	10	$855.00	$660.00	$510.00	10	10.0
GARTH W AMUNDSON, PSYD		1	0.0%	1	$150.00	$95.00	$80.00	1	1.0
STEVEN M YOUSHA, PSYD		1	0.0%	1	$390.00	$255.00	$210.00	3	3.0
PAULA J TIPTON, MA		1	0.0%	1	$750.00	$400.00	$310.00	6	6.0
NAUSHEEN DIN, MD		1	0.0%	1	$1,400.00	$1,400.00	$700.00	7	7.0
PAUL C KREDOW, PSYD		1	0.0%	1	$125.00	$125.00	$62.50	1	1.0
DIANE E COPELAND, PSYD		1	0.0%	3	$1,170.00	$720.00	$585.00	9	9.0
ANGELA H MAHOME, MD		1	0.0%	2	$365.00	$365.00	$182.50	2	2.0
GILLA P DAVIS, MD		1	0.0%	1	$600.00	$600.00	$300.00	3	3.0
JEAN L WALSH, DO		1	0.0%	1	$450.00	$450.00	$225.00	3	3.0
PRADEEP THAPAR, MD		1	0.0%	1	$95.00	$75.00	$60.00	1	1.0
RICHARD CUNNINGHAM, MSW		1	0.0%	1	$150.00	$75.00	$60.00	1	1.0
PAUL P POPERNIK, MA		1	0.0%	2	$480.00	$260.00	$130.00	4	4.0
MARGO JACQUOT, PSYD		1	0.0%	5	$3,375.00	$3,375.00	$1,687.50	25	25.0
DIANE S GEISER, MSW		1	0.0%	2	$980.00	$980.00	$490.00	7	7.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
ZOYA KOSMAN, MD	[redacted]	1	0.0%	2	$400.00	$400.00	$200.00	2	2.0
AMY MILLER, PSYD		1	0.0%	2	$350.00	$350.00	$175.00	3	3.0
PATRICIA RICHTER, MA		1	0.0%	5	$625.00	$325.00	$162.50	5	5.0
JEAN K VARGAS, MSW		1	0.0%	2	$250.00	$140.00	$110.00	2	2.0
NANCY PETERSON WALZ, MSW		1	0.0%	2	$250.00	$130.00	$100.00	2	2.0
ROBERT W BLOOM, MD		1	0.0%	1	$300.00	$300.00	$150.00	1	1.0
JOSEPH M RIPP, PHD		1	0.0%	5	$700.00	$700.00	$350.00	5	5.0
TIMOTHY J RE, PSYD		1	0.0%	5	$840.00	$840.00	$63.60	6	6.0
JANE DYONZAK, PHD		1	0.0%	1	$101.60	$101.60	$86.60	1	1.0
KELLY BEHRENDS, PSYD		1	0.0%	1	$175.00	$175.00	$87.50	1	1.0
MACK E WINN, MSW		1	0.0%	5	$600.00	$325.00	$250.00	5	5.0
RELLY KLARMAN, MSW		1	0.0%	1	$385.00	$205.00	$160.00	3	3.0
NIQUE DWORKIN, PHD		1	0.0%	2	$600.00	$600.00	$300.00	8	8.0
KATHY L STEWART, MS		1	0.0%	6	$455.00	$455.00	$350.00	7	7.0
SLAWOMIR J PUSZKARSKI, MD		1	0.0%	1	$120.00	$120.00	$96.00	1	1.0
DOUGLAS S LABELLE, MSW		1	0.0%	1	$300.00	$300.00	$150.00	2	2.0
NANCY E PECEN, MD		1	0.0%	1	$200.00	$140.00	$125.00	1	1.0
CHRISTOPHER M RHONE, MA		1	0.0%	1	$200.00	$75.00	$60.00	1	1.0
KENNETH J STALL, MSW		1	0.0%	3	$550.00	$325.00	$250.00	5	5.0
CAROLYN NAM, MSW		1	0.0%	3	$360.00	$280.00	$235.00	3	3.0
DEBORAH L MABIN, MA		1	0.0%	2	$240.00	$180.00	$150.00	2	2.0
THOMAS M SCHNATTERBECK, PSYD		1	0.0%	3	$450.00	$300.00	$255.00	3	3.0
JOHN LUTHER SCHULER, PSYD		1	0.0%	4	$600.00	$400.00	$340.00	4	4.0
CHARLOTTE D EDWARDS, PSYD		1	0.0%	8	$750.00	$500.00	$500.00	5	5.0
CHARLES E KAEGI JR, MD		1	0.0%	2	$240.00	$150.00	$105.00	3	3.0
MARY ELLEN MCSHERRY, MA		1	0.0%	3	$345.00	$195.00	$150.00	3	3.0
JODI FALEY, MSW		1	0.0%	7	$1,075.00	$465.00	$360.00	7	7.0
SANJEEV DWIVEDI, MD		1	0.0%	1	$175.00	$75.00	$60.00	1	1.0
PARAGINI K CHANDARANA, MD		1	0.0%	1	$320.00	$320.00	$160.00	1	1.0
HARSHAD M MEHTA, MD		1	0.0%	1	$130.00	$75.00	$60.00	1	1.0
ARTHUR S WEINFELD, EDD		1	0.0%	7	$1,050.00	$1,050.00	$525.00	7	7.0
JOAN MERLO, MSW		1	0.0%	1	$90.00	$90.00	$45.00	1	1.0
M DAVID LIBERMAN, PHD		1	0.0%	2	$540.00	$540.00	$270.00	4	4.0
JOHN BALDWIN, PHD		1	0.0%	1	$405.00	$405.00	$202.50	3	3.0
BALDWIN CENTER FOR PSYCHOLOGIC		1	0.0%	2	$945.00	$945.00	$472.50	7	7.0
HARRY JAMES SOLOWAY, MD		1	0.0%	2	$320.00	$320.00	$160.00	2	2.0
JUDY BAKSHY, PHD		1	0.0%	3	$1,560.00	$1,055.00	$860.00	13	13.0
HARLEY RUBENS, MD		1	0.0%	2	$1,295.00	$1,295.00	$647.50	7	7.0
ARTHUR A HYAMS, MASW		1	0.0%	3	$720.00	$585.00	$450.00	9	9.0
ARLO COMPAAN, PHD		1	0.0%	2	$520.00	$520.00	$260.00	4	4.0
SHELDON S GREENBERG, MD		1	0.0%	1	$95.00	$50.00	$35.00	1	1.0
ELLEN M KEATING, MA		1	0.0%	4	$615.00	$615.00	$307.50	4	4.0
CHARLES HILLENBRAND, MD		1	0.0%	4	$1,000.00	$1,000.00	$500.00	4	4.0
ABRAHAM R FRANKEL, MD		1	0.0%	1	$200.00	$140.00	$125.00	1	1.0
DANIEL ROSENTHAL, MD		1	0.0%	1	$130.00	$130.00	$65.00	1	1.0
SUSHIL BAGRI, MD		1	0.0%	1	$130.00	$130.00	$65.00	1	1.0
MARC H SLUTSKY, MD		1	0.0%	2	$2,160.00	$2,160.00	$1,080.00	12	12.0
HAROLD F MCGRATH, MD		1	0.0%	1	$100.00	$75.00	$60.00	1	1.0
LAURA L ZIEBARTH, PHD		1	0.0%	7	$1,390.00	$915.00	$750.00	11	11.0
ADAM G CRANE, PSYD		1	0.0%	1	$300.00	$95.00	$80.00	1	1.0
MARY CORFMAN, MA		1	0.0%	2	$130.00	$130.00	$100.00	2	2.0
MARCIA BRONTMAN, MD		1	0.0%	3	$375.00	$375.00	$187.50	3	3.0
WILLIAM M CLARK, MD		1	0.0%	1	$125.00	$125.00	$62.50	1	1.0
CENTRAL DUPAGE HOSPITAL DBA BE		1	0.0%	2	$8,209.00	$2,250.00	$1,800.00	15	15.0
BRIGID WOODS, MSED		1	0.0%	1	$100.00	$65.00	$50.00	1	1.0
MITCHELL CARY HAYWOOD, DO		1	0.0%	1	$90.00	$50.00	$25.00	1	1.0
FARAH PATHAN, MD		1	0.0%	2	$235.00	$180.00	$150.00	2	2.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
SUE LIN, MD	[redacted]	1	0.0%	1	$90.00	$90.00	$45.00	1	1.0
MARK KANT, MSW		1	0.0%	3	$424.00	$424.00	$212.00	4	4.0
JOHN BURNS, PHD		1	0.0%	1	$155.00	$155.00	$77.50	1	1.0
MEMORIAL MEDICAL CENTER SOUTH		1	0.0%	1	$1,545.00	$972.00	$817.60	6	6.0
CHRISTINE PETERSEN, PSYD		1	0.0%	3	$574.00	$574.00	$469.00	7	7.0
CHILDRENS MEMORIAL HOSPITAL		1	0.0%	1	$206.00	$129.00	$114.00	1	1.0
PALOS COMMISSION HOSPITAL		1	0.0%	2	$270.00	$130.00	$100.00	2	2.0
LYNN RODGERS, MA		1	0.0%	2	$260.00	$130.00	$100.00	2	2.0
MICHAEL WAGNER, MD		1	0.0%	4	$470.00	$430.00	$225.00	4	4.0
GREGORY A DANA, MA		1	0.0%	9	$1,170.00	$585.00	$292.50	9	9.0
COUNSELING CENTER OF LGH		1	0.0%	2	$260.00	$260.00	$130.00	2	2.0
ADVOCATE LUTHERAN GENERAL HOSP		1	0.0%	1	$2,237.00	$2,237.00	$2,180.00	5	5.0
LAURA VAN DUSEN, MD		1	0.0%	1	$100.00	$100.00	$50.00	1	1.0
BRANKO RADULOVACKI, MD		1	0.0%	2	$200.00	$150.00	$120.00	2	2.0
KATHLEEN V SHEA, PHD		1	0.0%	1	$165.00	$165.00	$82.50	1	1.0
BARBARA A SAMUELS, MSW		1	0.0%	8	$880.00	$520.00	$400.00	8	8.0
RAYMOND A KANE, MSW		1	0.0%	1	$550.00	$550.00	$275.00	5	5.0
MARTIN E WOLFF, EDD		1	0.0%	3	$330.00	$240.00	$170.00	3	3.0
KELLY A PETERS, MA		1	0.0%	1	$280.00	$140.00	$110.00	2	2.0
RICHARD K WILLENS, PSYD		1	0.0%	1	$140.00	$70.00	$55.00	1	1.0
DEBORAH A GUST, MA		1	0.0%	1	$125.00	$75.00	$60.00	1	1.0
ALINE FIEDOROWICZ, MSW		1	0.0%	1	$390.00	$390.00	$195.00	3	3.0
KIMBALL H LADIEN, MD		1	0.0%	1	$80.00	$50.00	$25.00	1	1.0
SUSAN M RICHARDSON, PSYD		1	0.0%	1	$125.00	$82.00	$67.00	1	1.0
LAURETTE M FERRARESI, PHD		1	0.0%	1	$390.00	$240.00	$195.00	3	3.0
ROBERT L RANDALL, PHD		1	0.0%	4	$2,220.00	$960.00	$705.00	12	12.0
SUSAN FIESTER, MD		1	0.0%	2	$350.00	$350.00	$247.50	2	2.0
JAMES V LAFEMINA, PHD		1	0.0%	1	$450.00	$450.00	$225.00	3	3.0
DAVID B ROBERTSON, MA		1	0.0%	1	$100.00	$100.00	$50.00	1	1.0
CAROL S LINDNER, MSW		1	0.0%	1	$95.00	$95.00	$47.50	1	1.0
KEVIN LEE WIELAND, PSYD		1	0.0%	1	$120.00	$105.00	$90.00	1	1.0
KEARN D HINCHMAN, DO		1	0.0%	1	$90.00	$64.00	$32.00	1	1.0
DIANE B CRAWFORD, MSW		1	0.0%	2	$140.00	$76.00	$46.00	2	2.0
DONALD F SMITH, MSW		1	0.0%	6	$455.00	$375.00	$285.00	6	6.0
SAINT MARGARET MERCY HLTHCARE		1	0.0%	2	$260.00	$260.00	$130.00	2	2.0
MARTIN G GROFF, PHD		1	0.0%	1	$125.00	$75.00	$60.00	1	1.0
SHENANDOAH CARDWELL, MA		1	0.0%	7	$630.00	$630.00	$315.00	7	7.0
HOOSHMAND KADKHODAIAN, MD		1	0.0%	1	$1,080.00	$1,080.00	$540.00	9	9.0
LUCILLE MARIE ISAACS, MS		1	0.0%	1	$90.00	$62.00	$47.00	1	1.0
HERBERT P TRIER, MD		1	0.0%	1	$50.00	$50.00	$35.00	1	1.0
GALLAHUE MENTAL HEALTH CENTER		1	0.0%	1	$110.00	$75.00	$60.00	1	1.0
SAINT VINCENT STRESS CENTER		1	0.0%	1	$164.00	$75.00	$60.00	1	1.0
BULBUL BAHUGUNA, MD		1	0.0%	4	$1,050.00	$1,050.00	$525.00	6	6.0
CAROL A GANZER, MSW		1	0.0%	1	$200.00	$130.00	$100.00	2	2.0
KEVIN E BRADLEY, MSW		1	0.0%	6	$720.00	$390.00	$282.50	6	6.0
KENNETH L DALLA COSTA, MA		1	0.0%	3	$1,787.52	$1,787.52	$1,430.02	10	10.0
ROBERT FLYNN, MC		1	0.0%	1	$222.00	$222.00	$111.00	3	3.0
CARLA M SPELLMAN, MS		1	0.0%	5	$600.00	$325.00	$250.00	5	5.0
BETH A BOLLENBACH, MSW		1	0.0%	1	$400.00	$260.00	$200.00	4	4.0
DEBRA N SAFFORD RAQUET, MSW		1	0.0%	1	$625.00	$625.00	$312.50	6	6.0
ANDREW PUNDY, MD		1	0.0%	1	$155.00	$135.00	$120.00	1	1.0
SCOTT E RUDER, MD		1	0.0%	1	$125.00	$60.00	$30.00	1	1.0
EILEEN STEPHENS, EDD		1	0.0%	1	$100.00	$65.00	$50.00	1	1.0
THOMAS CLEALAND, MA		1	0.0%	1	$600.00	$325.00	$250.00	5	5.0
YVONNE HEINS, PHD		1	0.0%	1	$100.00	$80.00	$65.00	1	1.0
MARY E SCALA, MA		1	0.0%	1	$360.00	$360.00	$180.00	3	3.0
SHIRLEY J LANGE, PHD		1	0.0%	3	$375.00	$240.00	$195.00	3	3.0
JEFFREY W HICKEY, MSW		1	0.0%	1	$360.00	$260.00	$182.50	4	4.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
PATSY L ZIKE, MSW	[redacted]	1	0.0%	5	$660.00	$426.00	$351.00	5	5.0
STACEY J AHRONS, PHD		1	0.0%	6	$1,152.00	$594.00	$504.00	6	6.0
LINDA GAYLE GRIFFIN, MSW		1	0.0%	2	$259.50	$194.00	$164.00	2	2.0
THEODORE M VERMONT, MD		1	0.0%	1	$117.00	$87.00	$72.00	1	1.0
MATTHEW ANTHONY CAPEZZUTO, MSS		1	0.0%	2	$650.00	$385.00	$295.00	6	6.0
SAMUEL M TAMBYRAJA, MD		1	0.0%	1	$75.00	$60.00	$45.00	1	1.0
LAUREL A BRISBIN SHEPLER, PHD		1	0.0%	3	$300.00	$240.00	$195.00	3	3.0
DIANNE L HASLINGER, MA		1	0.0%	4	$1,105.00	$434.00	$329.00	7	7.0
LAWRENCE J JOHNSON, PHD		1	0.0%	1	$130.00	$80.00	$65.00	1	1.0
SUSAN B COONROD, MED		1	0.0%	1	$100.00	$62.00	$47.00	1	1.0
STEVEN GRCEVICH, MD		1	0.0%	2	$625.00	$375.00	$187.50	2	2.0
CYNTHIA A SALWAN, MSSA		1	0.0%	3	$330.00	$186.00	$141.00	3	3.0
KAREN T CIMINI, PHD		1	0.0%	4	$770.00	$560.00	$455.00	7	7.0
DALE RALPH LINDSEY, MSW		1	0.0%	1	$150.00	$75.00	$60.00	1	1.0
CHARLES F MISJA, PHD		1	0.0%	2	$220.00	$160.00	$130.00	2	2.0
MICHAEL B SCHACHERE, PHD		1	0.0%	5	$1,470.00	$800.00	$400.00	10	10.0
LINDA K MCGRAW, PHD		1	0.0%	6	$690.00	$505.00	$415.00	6	6.0
LINDA WEISE, MA		1	0.0%	1	$1,200.00	$1,200.00	$600.00	10	10.0
DANA A MEARS, MSSW		1	0.0%	1	$95.00	$62.00	$11.98	1	1.0
KENNETH P BUZZELLI, MSSA		1	0.0%	1	$94.84	$65.00	$50.00	1	1.0
BARB LEMKE, MSW		1	0.0%	2	$840.00	$840.00	$420.00	7	7.0
KRISTINA K AYLOR, MSW		1	0.0%	3	$540.00	$540.00	$405.00	9	9.0
R CRAIG MCKENNA, MD		1	0.0%	1	$80.00	$50.00	$35.00	1	1.0
LYNN H. BARRON, MSW		1	0.0%	1	$260.00	$260.00	$130.00	2	2.0
JUDITH R COHEN, PHD		1	0.0%	1	$378.00	$378.00	$189.00	6	6.0
SANDRA L BWILLIAMS, MSW		1	0.0%	1	$100.00	$65.00	$50.00	1	1.0
DEBORAH MATEKI, MD		1	0.0%	1	$200.00	$200.00	$100.00	1	1.0
MICHAEL E CARNEY, PHD		1	0.0%	1	$240.00	$240.00	$195.00	3	3.0
WILLIAM B BENNINGER, PHD		1	0.0%	2	$180.00	$180.00	$90.00	2	2.0
THOMAS MCGLOSHEN, PHD		1	0.0%	2	$330.00	$195.00	$150.00	3	3.0
LEELAND P JOHANSEN, DO		1	0.0%	4	$355.00	$285.00	$225.00	4	4.0
ELAINE S BERMAN, EDD		1	0.0%	6	$730.00	$505.00	$415.00	6	6.0
WANDA MCENTYRE, PHD		1	0.0%	1	$135.00	$135.00	$67.50	1	1.0
CATHERINE MALKIN, PHD		1	0.0%	1	$150.00	$150.00	$75.00	1	1.0
MARY ANNE ORCUTT, PHD		1	0.0%	1	$150.00	$150.00	$75.00	1	1.0
KIRSTEN DELMORE, MSW		1	0.0%	2	$250.00	$250.00	$125.00	2	2.0
SUZANNE C SAUL, PHD		1	0.0%	2	$300.00	$300.00	$150.00	2	2.0
ALAN LEVY, MD		1	0.0%	4	$1,095.00	$1,095.00	$547.50	5	5.0
PHILIP H BERNE, MASW		1	0.0%	5	$500.00	$310.00	$235.00	5	5.0
RODNEY E VIVIAN, MD		1	0.0%	1	$65.00	$50.00	$35.00	1	1.0
SARA FINN KRIGER, PHD		1	0.0%	3	$940.00	$345.00	$283.00	3	3.0
LAURA I HOLOWICKI, MS		1	0.0%	1	$130.00	$75.00	$60.00	1	1.0
MARCIA DIANE HUHN, MSED		1	0.0%	1	$200.00	$137.00	$107.00	2	2.0
DEBORAH J SHUBOUF, MSW		1	0.0%	2	$180.00	$124.00	$94.00	2	2.0
MARC CLEMENTE, MD		1	0.0%	1	$60.00	$50.00	$25.00	1	1.0
PHILIP R BENNETT, PSYD		1	0.0%	1	$110.00	$80.00	$65.00	1	1.0
C R HILLENBRAND, MD		1	0.0%	1	$240.00	$240.00	$120.00	1	1.0
LEANNE CARLSON, PHD		1	0.0%	2	$250.00	$156.00	$126.00	2	2.0
KATHLEEN M HILTON, PSYD		1	0.0%	1	$200.00	$150.00	$120.00	2	2.0
PAULA A BARD, MA		1	0.0%	3	$1,460.00	$1,460.00	$730.00	12	12.0
BETTY J YOUNG, MA		1	0.0%	2	$180.00	$124.00	$94.00	2	2.0
CAROL A MALONEY, MSW		1	0.0%	3	$875.00	$434.00	$329.00	7	7.0
WILLIAM BAZAREWSKI, MA		1	0.0%	3	$500.00	$250.00	$190.00	4	4.0
KAREN D COGAN, PHD		1	0.0%	1	$750.00	$490.00	$395.00	6	6.0
JAN L FRETLAND, MSW		1	0.0%	2	$780.00	$780.00	$390.00	6	6.0
MICHELLE KLANKE, DO		1	0.0%	2	$150.00	$150.00	$75.00	2	2.0
DOUGLAS SCOTT CUTTING, PHD		1	0.0%	1	$120.00	$80.00	$40.00	1	1.0
CYNTHIA CASSIDY, MA		1	0.0%	2	$220.00	$220.00	$110.00	2	2.0

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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
ROSALIE T APPLEBAUM, MS	[redacted]	1	0.0%	3	$700.00	$455.00	$350.00	7	7.0
LOIS BREGMAN, MSW		1	0.0%	12	$1,760.00	$1,760.00	$880.00	12	12.0
LINDA CERVENY, MSW		1	0.0%	5	$600.00	$525.00	$405.00	8	8.0
JOHN A NADAS, MD		1	0.0%	3	$550.00	$475.00	$400.00	5	5.0
KAREN J WELSH, MA		1	0.0%	1	$110.00	$65.00	$50.00	1	1.0
DEBORAH L DOWNS SPENCER, PHD		1	0.0%	3	$750.00	$420.00	$330.00	6	6.0
KENT D ERNSTING, MA		1	0.0%	1	$125.00	$75.00	$60.00	1	1.0
LAUREN JACKER, MD		1	0.0%	1	$150.00	$150.00	$0.00	1	1.0
PENNY D WINKLE, MSW		1	0.0%	1	$330.00	$261.00	$201.00	4	4.0
S BELINDA GORE, PHD		1	0.0%	2	$220.00	$220.00	$110.00	2	2.0
BARBARA HYATT, MSW		1	0.0%	3	$750.00	$750.00	$375.00	6	6.0
CAROL GORDON, MSW		1	0.0%	1	$90.00	$90.00	$45.00	1	1.0
NEIL I STEINBERG, MD		1	0.0%	4	$406.00	$310.00	$155.00	4	4.0
RICHARD E MINTER, MD		1	0.0%	1	$140.00	$140.00	$70.00	2	2.0
DAVID J KEST, MA		1	0.0%	1	$360.00	$360.00	$270.00	6	6.0
RONALD B BARON, MD		1	0.0%	1	$130.00	$130.00	$65.00	1	1.0
KEVIN JOSEPH FRANKE, PHD		1	0.0%	1	$200.00	$175.00	$145.00	2	2.0
JEFFREY HELLER, PSYD		1	0.0%	15	$1,915.00	$1,915.00	$957.50	15	15.0
DOUGLAS COLE, PHD		1	0.0%	3	$840.00	$840.00	$420.00	7	7.0
CHARLEN MASEY MUSSER, MSW		1	0.0%	2	$875.00	$434.00	$329.00	7	7.0
MARJORIE HIGHTOWER, PHD		1	0.0%	1	$235.00	$140.00	$110.00	2	2.0
GERRY ANNE LENHART, PHD		1	0.0%	6	$1,260.00	$616.00	$366.00	7	7.0
SUSAN L COMPTON, MSW		1	0.0%	4	$400.00	$240.00	$180.00	4	4.0
LES H MCRAE, MSW		1	0.0%	1	$140.00	$140.00	$110.00	2	2.0
COLLEEN FRIDDELL, MD		1	0.0%	2	$180.00	$102.00	$61.50	2	2.0
LESLIE V TOOLE, MA		1	0.0%	3	$1,125.00	$585.00	$397.50	9	9.0
ANN CAROL DANIEL, MA		1	0.0%	2	$225.00	$137.00	$86.00	2	2.0
ROBERT G ARIAS, PHD		1	0.0%	1	$165.00	$80.00	$65.00	1	1.0
MARILYN PUPO GUILLEN, MD		1	0.0%	3	$450.00	$255.00	$210.00	3	3.0
ELLYN L GOLDSTEIN, MSW		1	0.0%	3	$1,000.00	$520.00	$400.00	8	8.0
CHARLES W HEARN, MSSW		1	0.0%	9	$765.00	$585.00	$450.00	9	9.0
LEIGH W BROOKS, PHD		1	0.0%	1	$300.00	$195.00	$150.00	3	3.0
JOSEPH A GREENBERG, PHD		1	0.0%	1	$236.00	$98.00	$83.00	1	1.0
DANIELLE SAUNDERS, MS		1	0.0%	2	$1,320.00	$1,320.00	$660.00	12	12.0
DARLENE B ANTONIO, PHD		1	0.0%	1	$320.00	$150.00	$120.00	2	2.0
SOPHIA SHLAIN, MASW		1	0.0%	6	$1,610.00	$1,610.00	$805.00	6	6.0
KELLI FRANZ, MA		1	0.0%	3	$300.00	$300.00	$150.00	3	3.0
ANNA LIEBLICH, MSW		1	0.0%	1	$700.00	$700.00	$350.00	5	5.0
EMILIO M AMIGO, PSYD		1	0.0%	2	$280.00	$280.00	$140.00	2	2.0
NINA K SCHLACHTER, DO		1	0.0%	1	$130.00	$75.00	$60.00	1	1.0
SARAH WHITE, MA		1	0.0%	1	$325.00	$215.00	$170.00	3	3.0
CAROLYN BURNS, PSYD		1	0.0%	2	$250.00	$250.00	$125.00	2	2.0
CARL L SCHMITZER, MSW		1	0.0%	2	$330.00	$204.00	$159.00	3	3.0
WILLIAM D CIGANEK, MD		1	0.0%	1	$120.00	$120.00	$60.00	1	1.0
SANDRA A TURSINI, MC		1	0.0%	1	$145.00	$65.00	$50.00	1	1.0
KELLY J SHERACK, PHD		1	0.0%	1	$650.00	$415.00	$340.00	5	5.0
PATRICIA A PETERSEN, EDD		1	0.0%	4	$1,265.00	$845.00	$545.00	10	10.0
ROGER A OLSEN, PSYD		1	0.0%	4	$1,002.00	$505.00	$415.00	6	6.0
DOUGLAS A MONTEITH, MD		1	0.0%	4	$570.00	$365.00	$305.00	4	4.0
ROBERT L DAVIS, MSW		1	0.0%	1	$95.00	$65.00	$50.00	1	1.0
CAROLE A CHISHOLM, MSW		1	0.0%	3	$285.00	$195.00	$150.00	3	3.0
TARIQ FARIDI, MD		1	0.0%	2	$140.00	$100.00	$70.00	2	2.0
RICHARD A OLIVER, MS		1	0.0%	3	$327.00	$327.00	$163.50	3	3.0
IAN T WEBBER, MD		1	0.0%	2	$410.00	$410.00	$380.00	2	2.0
CARYN E MEYER, MSW		1	0.0%	1	$420.00	$420.00	$210.00	3	3.0
STEPHANIE SUMMERS, MA		1	0.0%	11	$1,100.00	$1,100.00	$550.00	11	11.0
KELLY DINEEN, PHD		1	0.0%	4	$480.00	$480.00	$240.00	4	4.0

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Sample Company

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Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
CATHERINE A JASELSKIS, DO	[redacted]	1	0.0%	1	$140.00	$140.00	$70.00	1	1.0
RICHARD GERHARDSTEIN, MD		1	0.0%	1	$100.00	$100.00	$50.00	1	1.0
SHAWNA TULLY, MS		1	0.0%	1	$120.00	$75.00	$60.00	1	1.0
MICHAEL R PERELSON, MED		1	0.0%	1	$450.00	$450.00	$225.00	3	3.0
CARLOS F HERNANDEZ, MD		1	0.0%	1	$275.00	$150.00	$135.00	1	1.0
ANGELA KATHLEEN DAWSON, MD		1	0.0%	1	$75.00	$50.00	$35.00	1	1.0
RODRIGO A MANJARRES, MA		1	0.0%	1	$280.00	$133.00	$103.00	2	2.0
FELICIA DEMARKO MAXWELL, MSW		1	0.0%	4	$480.00	$248.00	$188.00	4	4.0
GHADA ALBEHEARY, MD		1	0.0%	1	$275.00	$140.00	$125.00	1	1.0
VICKIE L KILLIAN, MSW		1	0.0%	1	$115.00	$115.00	$57.50	1	1.0
KATE HUME, MSN		1	0.0%	2	$330.00	$135.00	$90.00	3	3.0
THOMAS S BEECHEL, MA		1	0.0%	1	$90.00	$66.00	$51.00	1	1.0
B ALLEGRA MAGRISSO, MSW		1	0.0%	2	$380.00	$380.00	$190.00	4	4.0
GLORIA P SMITH, MA		1	0.0%	1	$75.00	$62.00	$47.00	1	1.0
JULIE WARREN, MD		1	0.0%	3	$441.00	$441.00	$279.00	3	3.0
NANCY L PIERCE, MSN		1	0.0%	1	$70.00	$38.00	$23.00	1	1.0
NANCY C MINSEY, MSW		1	0.0%	1	$125.00	$68.00	$53.00	1	1.0
BRENT O MENNINGER, MD		1	0.0%	1	$90.00	$50.00	$35.00	1	1.0
ROBERT C MCQUEEN JR, MS		1	0.0%	1	$130.00	$70.00	$55.00	1	1.0
CRYSTAL NICHOLS, MA		1	0.0%	2	$1,040.00	$1,040.00	$832.00	10	10.0
DANA TURNBULL, PHD		1	0.0%	9	$1,125.00	$684.00	$526.00	9	9.0
JAMES L THOMASON, MD		1	0.0%	5	$450.00	$315.00	$240.00	5	5.0
CURT DEVENDORF, MA		1	0.0%	6	$870.00	$870.00	$435.00	7	7.0
JAMES OLSEN, PHD		1	0.0%	1	$120.00	$120.00	$60.00	1	1.0
KAUSHIK J RAVAL, MD		1	0.0%	2	$210.00	$150.00	$75.00	3	3.0
EILEEN G WARREN, MA		1	0.0%	1	$250.00	$250.00	$125.00	2	2.0
DEBRA RAQUET SAFFORD, MSW		1	0.0%	1	$125.00	$125.00	$62.50	1	1.0
ROBERT E NELSON, MD		1	0.0%	1	$80.00	$50.00	$35.00	1	1.0
ALIYA A BAKR, MD		1	0.0%	4	$600.00	$600.00	$540.00	4	4.0
KAREN A MAHAN, MSW		1	0.0%	1	$160.00	$80.00	$65.00	1	1.0
STEPHANIE F GREENE, MSW		1	0.0%	1	$120.00	$120.00	$60.00	1	1.0
PEDIATRIC CONSULTATION CENTER		1	0.0%	1	$270.00	$270.00	$135.00	2	2.0
SUSAN J SOIFERMAN, PHD		1	0.0%	3	$630.00	$630.00	$315.00	6	6.0
CURT P PINCHUCK, MD		1	0.0%	3	$195.00	$195.00	$150.00	3	3.0
RONNIE SUE LEITH, MD		1	0.0%	1	$260.00	$260.00	$130.00	2	2.0
THOMAS A REBORI, MD		1	0.0%	1	$95.00	$95.00	$47.50	1	1.0
SHAHZAD M HASHMI, MD		1	0.0%	1	$130.00	$75.00	$60.00	1	1.0
DIANNE S DARROW, MSSW		1	0.0%	7	$770.00	$434.00	$329.00	7	7.0
MICHAEL DARROW, MSSW		1	0.0%	1	$110.00	$62.00	$31.00	1	1.0
JACQUELYN WHITE, MA		1	0.0%	2	$720.00	$496.00	$376.00	8	8.0
LYNNE ZEITLER, MSW		1	0.0%	1	$160.00	$160.00	$130.00	2	2.0
LEONARD J RUBIN, MD		1	0.0%	1	$400.00	$130.00	$100.00	2	2.0
PAUL HANS, MD		1	0.0%	2	$220.00	$150.00	$120.00	2	2.0
ALAN V DUSTMAN, PHD		1	0.0%	1	$675.00	$675.00	$337.50	5	5.0
LAURA D BYKOFSKY, MSW		1	0.0%	4	$360.00	$320.00	$260.00	4	4.0
ROBERT C KORNHABER, PHD		1	0.0%	2	$500.00	$380.00	$320.00	4	4.0
ANNE COUGHLIN, PHD		1	0.0%	1	$625.00	$460.00	$385.00	5	5.0
MIRIAM B GUTMANN, MD		1	0.0%	1	$250.00	$250.00	$125.00	2	2.0
SEAFIELD SVCS ADMINISTRATION S		1	0.0%	2	$3,000.00	$1,443.00	$1,443.00	15	15.0
SEAFIELD SVCS MINEOLA		1	0.0%	1	$800.00	$380.00	$380.00	4	4.0
VIRGINIA K GORDON, MSW		1	0.0%	1	$375.00	$325.00	$162.50	5	5.0
SUSAN WILDER, PHD		1	0.0%	1	$6,000.00	$6,000.00	$3,000.00	30	30.0
DEENA J ROBBINS, PHD		1	0.0%	1	$150.00	$95.00	$80.00	1	1.0
HEDY AUGENBRAUN, PHD		1	0.0%	3	$980.00	$665.00	$560.00	7	7.0
GEORGE SERBAN, MD		1	0.0%	2	$1,560.00	$1,500.00	$1,320.00	12	12.0
MARILYN NISSIM SABAT, MSW		1	0.0%	2	$665.00	$455.00	$350.00	7	7.0
PAMELA A TORRE, MSW		1	0.0%	2	$270.00	$195.00	$150.00	3	3.0
ANITA BARROWS, PHD		1	0.0%	1	$1,040.00	$1,040.00	$520.00	8	8.0

Report ID: CLWO0040A
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Paid Claims Utilization by Top Provider - Combined Levels of Care

Sample Company

Claims Incurred: 01/01/2006 - 12/31/2006

Claims Paid: 10/01/2006 - 12/31/2006

Servicing Provider	Servicing Provider TIN #	Unique Users	% of Unique	Number of Claims	Actual Billed AMT	Actual Allowed AMT	Actual Net Paid AMT	Total Units	Units/ User
ROBERT I BROWNE, MSW	[redacted]	1	0.0%	2	$640.00	$640.00	$520.00	8	8.0
DIANE RAY, PHD		1	0.0%	3	$2,025.00	$1,380.00	$1,155.00	15	15.0
JOYCE L SICHEL, PHD		1	0.0%	2	$245.00	$166.00	$136.00	2	2.0
GLADYS ARAK, MD		1	0.0%	1	$200.00	$83.00	$41.50	1	1.0
LEE NAGEL, PHD		1	0.0%	1	$75.00	$75.00	$60.00	1	1.0
VINCENT LOUIS PASTORE, PHD		1	0.0%	8	$800.00	$640.00	$520.00	8	8.0
SANDRA P CHAMSON, PHD		1	0.0%	3	$1,200.00	$1,200.00	$600.00	8	8.0
JOYCE BLOCK, PHD		1	0.0%	1	$600.00	$450.00	$360.00	6	6.0
MARSHA LUFTIG, MSW		1	0.0%	1	$440.00	$440.00	$220.00	4	4.0
GERALDINE C KRASNER, MSW		1	0.0%	4	$440.00	$440.00	$320.00	8	8.0
THOMAS J CRAIG, MD		1	0.0%	1	$120.00	$120.00	$105.00	1	1.0
MICHELE B RUBIN, EDD		1	0.0%	3	$1,080.00	$590.00	$500.00	6	6.0
SHERIF F SAMI, MD		1	0.0%	1	$240.00	$240.00	$120.00	1	1.0
JOHN R MARTIN, MS		1	0.0%	1	$360.00	$234.00	$189.00	3	3.0
RITA P SUSSMAN, PHD		1	0.0%	2	$700.00	$700.00	$350.00	5	5.0
ANITA E QUINN, MSW		1	0.0%	1	$500.00	$500.00	$250.00	4	4.0
STUART J. BOKSER, MSW		1	0.0%	2	$500.00	$320.00	$260.00	4	4.0
MARTIN KARASCH, MD		1	0.0%	1	$110.00	$110.00	$55.00	1	1.0
ELAINE E DAHL, PHD		1	0.0%	1	$300.00	$210.00	$165.00	3	3.0
VERA B HORNSTEIN, PHD		1	0.0%	1	$750.00	$450.00	$360.00	6	6.0
PAUL S GOGGI JR., MSW		1	0.0%	3	$540.00	$540.00	$270.00	6	6.0
CHARLES R VACHRIS, MSW		1	0.0%	6	$570.00	$570.00	$285.00	6	6.0
ERIC L WHITTALL, PHD		1	0.0%	1	$650.00	$390.00	$330.00	4	4.0
ELLEN KROSNICK ABRAMAN, MED		1	0.0%	1	$375.00	$375.00	$300.00	2	2.0
KATHRYN FORD, MS		1	0.0%	4	$1,400.00	$800.00	$650.00	10	10.0
CHRISTINA ORTIZ, MSW		1	0.0%	1	$250.00	$90.00	$75.00	1	1.0
VADIM OYVIN, MD		1	0.0%	1	$340.00	$210.00	$180.00	2	2.0
KOY ROBERTS, PHD		1	0.0%	1	$1,030.00	$1,030.00	$515.00	6	6.0
STEVEN A ADELMAN, MD		1	0.0%	1	$300.00	$300.00	$150.00	1	1.0
HELENE M HOUSTON, MSN		1	0.0%	1	$75.00	$40.00	$25.00	1	1.0
LARAINE SHORE SUSLOWITZ, MSW		1	0.0%	5	$600.00	$325.00	$250.00	5	5.0
A JOHN DECARLE, MD		1	0.0%	5	$375.00	$300.00	$225.00	5	5.0
ELLEN V AMEL, MSW		1	0.0%	1	$135.00	$80.00	$65.00	1	1.0
JUDITH I CARON, MS		1	0.0%	2	$750.00	$330.00	$255.00	5	5.0
DANIELLE BUCKMAN, MA		1	0.0%	2	$1,650.00	$715.00	$497.50	11	11.0
DAN O IOANITESCU, MD		1	0.0%	2	$240.00	$150.00	$75.00	2	2.0
SHIRLEY NICHOLSON, MA		1	0.0%	9	$1,125.00	$585.00	$450.00	9	9.0
CAROL A MOTT, MA		1	0.0%	4	$440.00	$440.00	$220.00	4	4.0
KATHRYN WEEKS, MSW		1	0.0%	1	$120.00	$80.00	$65.00	1	1.0
BRIAN JON RICHARDSON, PSYD		1	0.0%	3	$450.00	$240.00	$145.00	3	3.0
REBECCA M ASHE, MSW		1	0.0%	3	$1,475.00	$1,045.00	$805.00	16	16.0
LISA MCKEAN, MSW		1	0.0%	6	$750.00	$750.00	$375.00	6	6.0
THOMAS MOYER, PHD		1	0.0%	2	$430.00	$356.00	$296.00	4	4.0
KEVIN MULLARKY, MD		1	0.0%	3	$270.00	$270.00	$135.00	3	3.0
EMANUEL MARTINEZ, MD		1	0.0%	3	$340.00	$215.00	$170.00	3	3.0
MARK R DEARING, MSW		1	0.0%	6	$800.00	$370.00	$280.00	6	6.0
Total of Top 50 Providers		**2,590**		**5,938**	**$1,211,511.69**	**$907,423.43**	**$611,372.30**	**9,179**	**3.5**
Total of All Other Providers		**0**		**0**	**$0.00**	**$0.00**	**$0.00**	**0**	**0.0**
Total of All Providers		**2,180**		**5,938**	**$1,211,511.69**	**$907,423.43**	**$611,372.30**	**9,179**	**4.2**

Report ID: CLWO0041A
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Outpatient CPT/Discipline Report

Sample Company

In and Out-of- Network

Intensive Outpatient

		Current Period Incurred: 01/2006-12/2006 Paid: 10/2006-12/2006									
		Initial Diagnostic Eval 90801	Individual Psychotherapy 90804	Ind. Psych w/Pharmacological Mgmt 90805	Individual Psychotherapy 90806 or 90844	Family/Couples Psych 90846 or 90847	Group Therapy 90849 or 90853 or 90857	Pharmacological Mgmt 90862	Ind. Psych w/Pharmacological Mgmt 90807	All Others	Total
MD											
	Users	0	0	0	0	0	0	0	0	0	0
	Units	0	0	0	0	0	0	0	0	0	0
	% of Tot Units	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Tot Amt Allowed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Avg Rate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PHD											
	Users	0	0	0	0	0	0	0	0	0	0
	Units	0	0	0	0	0	0	0	0	0	0
	% of Tot Units	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Tot Amt Allowed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Avg Rate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Masters											
	Users	0	0	0	0	0	0	0	0	0	0
	Units	0	0	0	0	0	0	0	0	0	0
	% of Tot Units	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Tot Amt Allowed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Avg Rate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other											
	Users	0	0	0	0	0	0	0	0	18	18
	Units	0	0	0	0	0	0	0	0	199	199
	% of Tot Units	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%
	Tot Amt Allowed	$0	$0	$0	$0	$0	$0	$0	$0	$33141	$33141
	Avg Rate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$166.54	$166.54
Total											
	Users	0	0	0	0	0	0	0	0	18	18
	Units	0	0	0	0	0	0	0	0	199	199
	% of Tot Units	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%
	Tot Amt Allowed	$0	$0	$0	$0	$0	$0	$0	$0	$33141	$33141

*Users may be counted multiple times if they change levels of care and/or have claims within the same reporting period that correspond to multiple provider disciplines.

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Run Date: 02/19/2007
Run Time: 04:18:20 PM

Outpatient CPT/Discipline Report

Sample Company

In and Out-of- Network

Intensive Outpatient

		Year-To-Date Incurred: 01/2006-12/2006 Paid: 01/2006-12/2006									
		Initial Diagnostic Eval 90801	Individual Psychotherapy 90804	Ind. Psych w/Pharmacological Mgmt 90805	Individual Psychotherapy 90806 or 90844	Family/Couples Psych 90846 or 90847	Group Therapy 90849 or 90853 or 90857	Pharmacological Mgmt 90862	Ind. Psych w/Pharmacological Mgmt 90807	All Others	Total
MD											
	Users	0	0	0	0	0	0	0	0	0	0
	Units	0	0	0	0	0	0	0	0	0	0
	% of Tot Units	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Tot Amt Allowed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Avg Rate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PHD											
	Users	0	0	0	0	0	0	0	0	0	0
	Units	0	0	0	0	0	0	0	0	0	0
	% of Tot Units	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Tot Amt Allowed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Avg Rate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Masters											
	Users	0	0	0	0	0	0	0	0	0	0
	Units	0	0	0	0	0	0	0	0	0	0
	% of Tot Units	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Tot Amt Allowed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Avg Rate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other											
	Users	0	0	0	0	0	0	0	0	47	47
	Units	0	0	0	0	0	0	0	0	729	729
	% of Tot Units	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%
	Tot Amt Allowed	$0	$0	$0	$0	$0	$0	$0	$0	$111375	$111375
	Avg Rate	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$152.78	$152.78
Total											
	Users	0	0	0	0	0	0	0	0	47	47
	Units	0	0	0	0	0	0	0	0	729	729
	% of Tot Units	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%
	Tot Amt Allowed	$0	$0	$0	$0	$0	$0	$0	$0	$111375	$111375

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Outpatient CPT/Discipline Report

Sample Company

In and Out-of- Network

Outpatient

		Current Period Incurred: 01/2006-12/2006 Paid: 10/2006-12/2006									
		Initial Diagnostic Eval 90801	Individual Psychotherapy 90804	Ind. Psych w/Pharmacological Mgmt 90805	Individual Psychotherapy 90806 or 90844	Family/Couples Psych 90846 or 90847	Group Therapy 90849 or 90853 or 90857	Pharmacological Mgmt 90862	Ind. Psych w/Pharmacological Mgmt 90807	All Others	Total
MD											
	Users	129	2	197	19	9	1	563	99	3	874
	Units	131	5	295	55	13	3	893	298	12	1705
	% of Tot Units	8%	0%	17%	3%	1%	0%	52%	17%	1%	100%
	Tot Amt Allowed	$21230	$390	$27010	$6877	$1729	$750	$58317	$47396	$2145	$165843
	Avg Rate	$162.06	$78.00	$91.56	$125.03	$133.00	$250.00	$65.30	$159.05	$178.75	$97.27
PHD											
	Users	196	12	1	563	87	3	0	0	32	683
	Units	198	14	2	2353	300	6	0	0	98	2971
	% of Tot Units	7%	0%	0%	79%	10%	0%	0%	0%	3%	100%
	Tot Amt Allowed	$21946	$842	$300	$226206	$30904	$780	$0	$0	$16380	$297357
	Avg Rate	$110.84	$60.14	$150.00	$96.14	$103.01	$130.00	$0.00	$0.00	$167.15	$100.09
Masters											
	Users	215	8	2	682	76	12	7	2	11	781
	Units	217	10	6	3015	185	67	8	2	33	3543
	% of Tot Units	6%	0%	0%	85%	5%	2%	0%	0%	1%	100%
	Tot Amt Allowed	$19685	$629	$462	$260607	$15574	$6483	$375	$415	$5133	$309362
	Avg Rate	$90.71	$62.92	$77.00	$86.44	$84.18	$96.75	$46.88	$207.50	$155.55	$87.32
Other											
	Users	34	2	10	79	6	12	41	2	8	151
	Units	35	2	13	296	12	317	62	4	20	761
	% of Tot Units	5%	0%	2%	39%	2%	42%	8%	1%	3%	100%
	Tot Amt Allowed	$5222	$255	$2218	$26897	$1122	$50791	$4513	$738	$9963	$101720
	Avg Rate	$149.20	$127.66	$170.64	$90.87	$93.50	$160.22	$72.79	$184.50	$498.15	$133.67
Total											
	Users	544	24	210	1316	178	25	609	103	52	2173
	Units	581	31	316	5719	510	393	963	304	163	8980
	% of Tot Units	6%	0%	4%	64%	6%	4%	11%	3%	2%	100%
	Tot Amt Allowed	$68082	$2117	$29990	$520586	$49328	$58803	$63205	$48549	$33621	$874282

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Outpatient CPT/Discipline Report

Sample Company

In and Out-of- Network

Outpatient

Year-To-Date
Incurred: 01/2006-12/2006
Paid: 01/2006-12/2006

		Initial Diagnostic Eval 90801	Individual Psychotherapy 90804	Ind. Psych w/Pharmacological Mgmt 90805	Individual Psychotherapy 90806 or 90844	Family/Couples Psych 90846 or 90847	Group Therapy 90849 or 90853 or 90857	Pharmacological Mgmt 90862	Ind. Psych w/Pharmacological Mgmt 90807	All Others	Total
MD											
	Users	479	4	392	47	24	2	1001	204	12	1535
	Units	503	8	1087	217	51	5	3377	1093	29	6370
	% of Tot Units	8%	0%	17%	3%	1%	0%	53%	17%	0%	100%
	Tot Amt Allowed	$81992	$820	$97030	$28240	$7135	$1500	$213955	$165236	$6029	$601936
	Avg Rate	$163.01	$102.50	$89.26	$130.14	$139.90	$300.00	$63.36	$151.18	$207.89	$94.50
PHD											
	Users	677	32	1	1126	189	8	4	2	91	1329
	Units	704	51	2	8942	991	44	5	9	229	10977
	% of Tot Units	6%	0%	0%	81%	9%	0%	0%	0%	2%	100%
	Tot Amt Allowed	$81607	$3340	$300	$848127	$100519	$4169	$530	$840	$56682	$1096113
	Avg Rate	$115.92	$65.49	$150.00	$94.85	$101.43	$94.75	$106.00	$93.33	$247.52	$99.86
Masters											
	Users	744	23	10	1355	213	31	20	5	33	1549
	Units	786	38	22	11222	987	743	46	7	117	13968
	% of Tot Units	6%	0%	0%	80%	7%	5%	0%	0%	1%	100%
	Tot Amt Allowed	$70106	$2376	$1820	$944343	$82903	$88173	$2272	$953	$16408	$1209354
	Avg Rate	$89.19	$62.53	$82.73	$84.15	$84.00	$118.67	$49.40	$136.14	$140.24	$86.58
Other											
	Users	129	7	19	185	19	25	78	5	15	344
	Units	133	11	35	1358	77	1047	191	17	34	2903
	% of Tot Units	5%	0%	1%	47%	3%	36%	7%	1%	1%	100%
	Tot Amt Allowed	$17660	$1286	$5068	$118531	$6648	$144134	$12972	$3094	$14753	$324147
	Avg Rate	$132.78	$116.92	$144.80	$87.28	$86.34	$137.66	$67.92	$181.99	$433.93	$111.66
Total											
	Users	1788	65	416	2575	436	57	1079	214	147	3874
	Units	2126	108	1146	21739	2106	1839	3619	1126	409	34218
	% of Tot Units	6%	0%	3%	64%	6%	5%	11%	3%	1%	100%
	Tot Amt Allowed	$251365	$7822	$104218	$1939240	$197205	$237976	$229729	$170123	$93872	$3231551

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MAGELLAN HEALTH SERVICES "Getting Better All the Time"

CLAIMS PAID PER USERS, ENROLLEES, AND COVERED LIVES

BY ENROLLEE CATEGORY AND ENROLLEE / DEPENDENT

Claims Incurred: 1/1/2009 Through 3/31/2009

Claims Paid: 1/1/2009 Through 6/30/2009

Reporting Group: [redacted].

[redacted]

	TOTAL					PER USER						PER ENROLLEE						PER COVERED LIFE					
	Amt Sub fov Cov Svc	Amount Allowed	Amount Paid	COB Paid	Member Responsibilit	# of Users	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibil	# of Enrollee	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibi	# of Lives	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibi
Inpatient																							
Enrollee	$602,072.75	$320,812.65	$300,156.69	$773.19	$20,249.22	51	$11,805.35	$6,290.44	$5,885.43	$15.16	$397.04							49,067	$12.27	$6.54	$6.12	$0.02	$0.41
Dependent	$875,276.29	$489,264.97	$432,562.00	$3,040.57	$53,632.47	78	$11,221.49	$6,272.63	$5,545.67	$38.98	$687.60							60,387	$14.49	$8.10	$7.16	$0.05	$0.89
Total	$1,477,349.04	$810,077.62	$732,718.69	$3,813.76	$73,881.69	129	$11,452.32	$6,279.67	$5,679.99	$29.56	$572.73	49,067	$30.11	$16.51	$14.93	$0.08	$1.51	109,454	$13.50	$7.40	$6.69	$0.03	$0.68
Residential Treatment																							
Enrollee	$17,850.00	$17,580.00	$9,180.00	$0.00	$8,400.00	3	$5,950.00	$5,860.00	$3,060.00	$0.00	$2,800.00							49,067	$0.36	$0.36	$0.19	$0.00	$0.17
Dependent	$19,290.00	$19,200.00	$10,800.00	$0.00	$8,400.00	3	$6,430.00	$6,400.00	$3,600.00	$0.00	$2,800.00							60,387	$0.32	$0.32	$0.18	$0.00	$0.14
Total	$37,140.00	$36,780.00	$19,980.00	$0.00	$16,800.00	6	$6,190.00	$6,130.00	$3,330.00	$0.00	$2,800.00	49,067	$0.76	$0.75	$0.41	$0.00	$0.34	109,454	$0.34	$0.34	$0.18	$0.00	$0.15
Partial Hospitalization																							
Enrollee	$83,625.85	$42,959.00	$38,869.00	$0.00	$4,090.00	16	$5,226.62	$2,684.94	$2,429.31	$0.00	$255.63							49,067	$1.70	$0.88	$0.79	$0.00	$0.08
Dependent	$103,041.80	$60,193.40	$54,593.40	$0.00	$5,600.00	24	$4,293.41	$2,508.06	$2,274.73	$0.00	$233.33							60,387	$1.71	$1.00	$0.90	$0.00	$0.09
Total	$186,667.65	$103,152.40	$93,462.40	$0.00	$9,690.00	40	$4,666.69	$2,578.81	$2,336.56	$0.00	$242.25	49,067	$3.80	$2.10	$1.90	$0.00	$0.20	109,454	$1.71	$0.94	$0.85	$0.00	$0.09
Intensive Outpatient																							
Enrollee	$13,378.75	$8,205.00	$7,230.00	$0.00	$975.00	6	$2,229.79	$1,367.50	$1,205.00	$0.00	$162.50							49,067	$0.27	$0.17	$0.15	$0.00	$0.02
Dependent	$23,457.48	$16,001.73	$12,441.87	$0.00	$3,559.86	12	$1,954.79	$1,333.48	$1,036.82	$0.00	$296.66							60,387	$0.39	$0.26	$0.21	$0.00	$0.06
Total	$36,836.23	$24,206.73	$19,671.87	$0.00	$4,534.86	18	$2,046.46	$1,344.82	$1,092.88	$0.00	$251.94	49,067	$0.75	$0.49	$0.40	$0.00	$0.09	109,454	$0.34	$0.22	$0.18	$0.00	$0.04
Outpatient																							
Enrollee	$1,534,254.08	$954,825.31	$745,053.83	$9,364.37	$203,808.56	2,902	$528.69	$329.02	$256.74	$3.23	$70.23							49,067	$31.27	$19.46	$15.18	$0.19	$4.15
Dependent	$1,372,054.55	$854,810.98	$649,172.46	$23,208.34	$191,777.90	2,670	$513.88	$320.15	$243.14	$8.69	$71.83							60,387	$22.72	$14.16	$10.75	$0.38	$3.18
Total	$2,906,308.63	$1,809,636.29	$1,394,226.29	$32,572.71	$395,586.46	5,572	$521.59	$324.77	$250.22	$5.85	$71.00	49,067	$59.23	$36.88	$28.41	$0.66	$8.06	109,454	$26.55	$16.53	$12.74	$0.30	$3.61
Miscellaneous																							
Enrollee	$36,844.81	$31,330.12	$29,006.80	$1,010.12	$590.91	50	$736.90	$626.60	$580.14	$20.20	$11.82							49,067	$0.75	$0.64	$0.59	$0.02	$0.01
Dependent	$53,304.04	$51,575.46	$48,019.85	$477.68	$484.18	94	$567.06	$548.68	$510.85	$5.08	$5.15							60,387	$0.88	$0.85	$0.80	$0.01	$0.01
Total	$90,148.85	$82,905.58	$77,026.65	$1,487.80	$1,075.09	144	$626.03	$575.73	$534.91	$10.33	$7.47	49,067	$1.84	$1.69	$1.57	$0.03	$0.02	109,454	$0.82	$0.76	$0.70	$0.01	$0.01
TOTAL																							
Enrollee	$2,288,026.24	$1,375,712.08	$1,129,496.32	$11,147.68	$238,113.69	2,929	$781.16	$469.69	$385.63	$3.81	$81.30							49,067	$46.63	$28.04	$23.02	$0.23	$4.85
Dependent	$2,446,424.16	$1,491,046.54	$1,207,589.58	$26,726.59	$263,454.41	2,730	$896.13	$546.17	$442.34	$9.79	$96.50							60,387	$40.51	$24.69	$20.00	$0.44	$4.36
Total	$4,734,450.40	$2,866,758.62	$2,337,085.90	$37,874.27	$501,568.10	5,659	$836.62	$506.58	$412.99	$6.69	$88.63	49,067	$96.49	$58.43	$47.63	$0.77	$10.22	109,454	$43.26	$26.19	$21.35	$0.35	$4.58

MAGELLAN HEALTH SERVICES "Getting Better All the Time"

CLAIMS PAID PER USERS, ENROLLEES, AND COVERED LIVES

BY ENROLLEE CATEGORY AND ENROLLEE / DEPENDENT

Claims Incurred: 1/1/2009 Through 3/31/2009

Claims Paid: 1/1/2009 Through 6/30/2009

Reporting Group: [redacted].

[redacted]

	TOTAL					PER USER						PER ENROLLEE						PER COVERED LIFE					
	Amt Sub fov Cov Svc	Amount Allowed	Amount Paid	COB Paid	Member Responsibilit	# of Users	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibil	# of Enrollee	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibi	# of Lives	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibi
Inpatient																							
Enrollee	$44,246.91	$16,976.69	$16,270.87	$0.00	$705.82	6	$7,374.49	$2,829.45	$2,711.81	$0.00	$117.64							452	$97.89	$37.56	$36.00	$0.00	$1.56
Dependent	$7,817.80	$5,563.00	$5,563.00	$0.00	$0.00	1	$7,817.80	$5,563.00	$5,563.00	$0.00	$0.00							432	$18.10	$12.88	$12.88	$0.00	$0.00
Total	$52,064.71	$22,539.69	$21,833.87	$0.00	$705.82	7	$7,437.82	$3,219.96	$3,119.12	$0.00	$100.83	452	$115.19	$49.87	$48.31	$0.00	$1.56	884	$58.90	$25.50	$24.70	$0.00	$0.80
Residential Treatment																							
Enrollee	$675.00	$405.00	$405.00	$0.00	$0.00	1	$675.00	$405.00	$405.00	$0.00	$0.00							452	$1.49	$0.90	$0.90	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							432	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$675.00	$405.00	$405.00	$0.00	$0.00	1	$675.00	$405.00	$405.00	$0.00	$0.00	452	$1.49	$0.90	$0.90	$0.00	$0.00	884	$0.76	$0.46	$0.46	$0.00	$0.00
Partial Hospitalization																							
Enrollee	$26,341.25	$11,330.00	$11,330.00	$0.00	$0.00	5	$5,268.25	$2,266.00	$2,266.00	$0.00	$0.00							452	$58.28	$25.07	$25.07	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							432	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$26,341.25	$11,330.00	$11,330.00	$0.00	$0.00	5	$5,268.25	$2,266.00	$2,266.00	$0.00	$0.00	452	$58.28	$25.07	$25.07	$0.00	$0.00	884	$29.80	$12.82	$12.82	$0.00	$0.00
Intensive Outpatient																							
Enrollee	$1,528.00	$1,100.00	$1,100.00	$0.00	$0.00	2	$764.00	$550.00	$550.00	$0.00	$0.00							452	$3.38	$2.43	$2.43	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							432	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$1,528.00	$1,100.00	$1,100.00	$0.00	$0.00	2	$764.00	$550.00	$550.00	$0.00	$0.00	452	$3.38	$2.43	$2.43	$0.00	$0.00	884	$1.73	$1.24	$1.24	$0.00	$0.00
Outpatient																							
Enrollee	$136,004.00	$80,351.75	$61,417.39	$39.18	$18,921.34	213	$638.52	$377.24	$288.34	$0.18	$88.83							452	$300.89	$177.77	$135.88	$0.09	$41.86
Dependent	$14,477.38	$7,618.25	$6,048.24	$329.52	$1,338.86	38	$380.98	$200.48	$159.16	$8.67	$35.23							432	$33.51	$17.63	$14.00	$0.76	$3.10
Total	$150,481.38	$87,970.00	$67,465.63	$368.70	$20,260.20	251	$599.53	$350.48	$268.79	$1.47	$80.72	452	$332.92	$194.62	$149.26	$0.82	$44.82	884	$170.23	$99.51	$76.32	$0.42	$22.92
Miscellaneous																							
Enrollee	$8,404.55	$8,387.47	$8,387.47	$0.00	$0.00	6	$1,400.76	$1,397.91	$1,397.91	$0.00	$0.00							452	$18.59	$18.56	$18.56	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							432	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$8,404.55	$8,387.47	$8,387.47	$0.00	$0.00	6	$1,400.76	$1,397.91	$1,397.91	$0.00	$0.00	452	$18.59	$18.56	$18.56	$0.00	$0.00	884	$9.51	$9.49	$9.49	$0.00	$0.00
TOTAL																							
Enrollee	$217,199.71	$118,550.91	$98,910.73	$39.18	$19,627.16	219	$991.78	$541.33	$451.65	$0.18	$89.62							452	$480.53	$262.28	$218.83	$0.09	$43.42
Dependent	$22,295.18	$13,181.25	$11,611.24	$329.52	$1,338.86	38	$586.72	$346.88	$305.56	$8.67	$35.23							432	$51.61	$30.51	$26.88	$0.76	$3.10
Total	$239,494.89	$131,732.16	$110,521.97	$368.70	$20,966.02	257	$931.89	$512.58	$430.05	$1.43	$81.58	452	$529.86	$291.44	$244.52	$0.82	$46.39	884	$270.92	$149.02	$125.02	$0.42	$23.72

MAGELLAN HEALTH SERVICES "Getting Better All the Time"

CLAIMS PAID PER USERS, ENROLLEES, AND COVERED LIVES
BY ENROLLEE CATEGORY AND ENROLLEE / DEPENDENT
Claims Incurred: 1/1/2009 Through 3/31/2009
Claims Paid: 1/1/2009 Through 6/30/2009

Reporting Group: [redacted]

[redacted]

	TOTAL					PER USER						PER ENROLLEE						PER COVERED LIFE					
	Amt Sub fov Cov Svc	Amount Allowed	Amount Paid	COB Paid	Member Responsibilit	# of Users	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibil	# of Enrollee	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibi	# of Lives	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibi
Inpatient																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Residential Treatment																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Partial Hospitalization																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Intensive Outpatient																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Miscellaneous																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
TOTAL																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00

MAGELLAN HEALTH SERVICES "Getting Better All the Time"

CLAIMS PAID PER USERS, ENROLLEES, AND COVERED LIVES

BY ENROLLEE CATEGORY AND ENROLLEE / DEPENDENT

Claims Incurred: 1/1/2009 Through 3/31/2009

Claims Paid: 1/1/2009 Through 6/30/2009

Reporting Group: [redacted].

[redacted]

	TOTAL					PER USER						PER ENROLLEE						PER COVERED LIFE					
	Amt Sub fov Cov Svc	Amount Allowed	Amount Paid	COB Paid	Member Responsibilit	# of Users	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibil	# of Enrollee	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibi	# of Lives	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibi
Inpatient																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Residential Treatment																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Partial Hospitalization																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Intensive Outpatient																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Miscellaneous																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
TOTAL																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00

MAGELLAN HEALTH SERVICES "Getting Better All the Time"

CLAIMS PAID PER USERS, ENROLLEES, AND COVERED LIVES
BY ENROLLEE CATEGORY AND ENROLLEE / DEPENDENT
Claims Incurred: 1/1/2009 Through 3/31/2009
Claims Paid: 1/1/2009 Through 6/30/2009

Reporting Group: [redacted]

[redacted]

	TOTAL					PER USER						PER ENROLLEE						PER COVERED LIFE					
	Amt Sub fov Cov Svc	Amount Allowed	Amount Paid	COB Paid	Member Responsibilit	# of Users	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibil	# of Enrollee	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibi	# of Lives	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibi
Inpatient																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Residential Treatment																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Partial Hospitalization																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Intensive Outpatient																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
Miscellaneous																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00
TOTAL																							
Enrollee	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Dependent	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00							0	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00

MAGELLAN HEALTH SERVICES "Getting Better All the Time"

CLAIMS PAID PER USERS, ENROLLEES, AND COVERED LIVES

BY ENROLLEE CATEGORY AND ENROLLEE / DEPENDENT

Claims Incurred: 1/1/2009 Through 3/31/2009

Claims Paid: 1/1/2009 Through 6/30/2009

Reporting Group: [redacted]

[redacted]

	TOTAL					PER USER						PER ENROLLEE						PER COVERED LIFE					
	Amt Sub fov Cov Svc	Amount Allowed	Amount Paid	COB Paid	Member Responsibilit	# of Users	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibil	# of Enrollee	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibi	# of Lives	Amt Sub for Cov	Amount Allowed	Amount Paid	COB Paid	Member Responsibi
Inpatient																							
Enrollee	$557,825.84	$303,835.96	$283,885.82	$773.19	$19,543.40	46	$12,126.65	$6,605.13	$6,171.43	$16.81	$424.86							48,615	$11.47	$6.25	$5.84	$0.02	$0.40
Dependent	$867,458.49	$483,701.97	$426,999.00	$3,040.57	$53,632.47	77	$11,265.69	$6,281.84	$5,545.44	$39.49	$696.53							59,955	$14.47	$8.07	$7.12	$0.05	$0.89
Total	$1,425,284.33	$787,537.93	$710,884.82	$3,813.76	$73,175.87	123	$11,587.68	$6,402.75	$5,779.55	$31.01	$594.93	48,615	$29.32	$16.20	$14.62	$0.08	$1.51	108,570	$13.13	$7.25	$6.55	$0.04	$0.67
Residential Treatment																							
Enrollee	$17,175.00	$17,175.00	$8,775.00	$0.00	$8,400.00	2	$8,587.50	$8,587.50	$4,387.50	$0.00	$4,200.00							48,615	$0.35	$0.35	$0.18	$0.00	$0.17
Dependent	$19,290.00	$19,200.00	$10,800.00	$0.00	$8,400.00	3	$6,430.00	$6,400.00	$3,600.00	$0.00	$2,800.00							59,955	$0.32	$0.32	$0.18	$0.00	$0.14
Total	$36,465.00	$36,375.00	$19,575.00	$0.00	$16,800.00	5	$7,293.00	$7,275.00	$3,915.00	$0.00	$3,360.00	48,615	$0.75	$0.75	$0.40	$0.00	$0.35	108,570	$0.34	$0.34	$0.18	$0.00	$0.15
Partial Hospitalization																							
Enrollee	$57,284.60	$31,629.00	$27,539.00	$0.00	$4,090.00	12	$4,773.72	$2,635.75	$2,294.92	$0.00	$340.83							48,615	$1.18	$0.65	$0.57	$0.00	$0.08
Dependent	$103,041.80	$60,193.40	$54,593.40	$0.00	$5,600.00	24	$4,293.41	$2,508.06	$2,274.73	$0.00	$233.33							59,955	$1.72	$1.00	$0.91	$0.00	$0.09
Total	$160,326.40	$91,822.40	$82,132.40	$0.00	$9,690.00	36	$4,453.51	$2,550.62	$2,281.46	$0.00	$269.17	48,615	$3.30	$1.89	$1.69	$0.00	$0.20	108,570	$1.48	$0.85	$0.76	$0.00	$0.09
Intensive Outpatient																							
Enrollee	$11,850.75	$7,105.00	$6,130.00	$0.00	$975.00	5	$2,370.15	$1,421.00	$1,226.00	$0.00	$195.00							48,615	$0.24	$0.15	$0.13	$0.00	$0.02
Dependent	$23,457.48	$16,001.73	$12,441.87	$0.00	$3,559.86	12	$1,954.79	$1,333.48	$1,036.82	$0.00	$296.66							59,955	$0.39	$0.27	$0.21	$0.00	$0.06
Total	$35,308.23	$23,106.73	$18,571.87	$0.00	$4,534.86	17	$2,076.95	$1,359.22	$1,092.46	$0.00	$266.76	48,615	$0.73	$0.48	$0.38	$0.00	$0.09	108,570	$0.33	$0.21	$0.17	$0.00	$0.04
Outpatient																							
Enrollee	$1,398,250.08	$874,473.56	$683,636.44	$9,325.19	$184,887.22	2,779	$503.15	$314.67	$246.00	$3.36	$66.53							48,615	$28.76	$17.99	$14.06	$0.19	$3.80
Dependent	$1,357,577.17	$847,192.73	$643,124.22	$22,878.82	$190,439.04	2,647	$512.87	$320.06	$242.96	$8.64	$71.95							59,955	$22.64	$14.13	$10.73	$0.38	$3.18
Total	$2,755,827.25	$1,721,666.29	$1,326,760.66	$32,204.01	$375,326.26	5,426	$507.89	$317.30	$244.52	$5.94	$69.17	48,615	$56.69	$35.41	$27.29	$0.66	$7.72	108,570	$25.38	$15.86	$12.22	$0.30	$3.46
Miscellaneous																							
Enrollee	$28,440.26	$22,942.65	$20,619.33	$1,010.12	$590.91	44	$646.37	$521.42	$468.62	$22.96	$13.43							48,615	$0.59	$0.47	$0.42	$0.02	$0.01
Dependent	$53,304.04	$51,575.46	$48,019.85	$477.68	$484.18	94	$567.06	$548.68	$510.85	$5.08	$5.15							59,955	$0.89	$0.86	$0.80	$0.01	$0.01
Total	$81,744.30	$74,518.11	$68,639.18	$1,487.80	$1,075.09	138	$592.35	$539.99	$497.39	$10.78	$7.79	48,615	$1.68	$1.53	$1.41	$0.03	$0.02	108,570	$0.75	$0.69	$0.63	$0.01	$0.01
TOTAL																							
Enrollee	$2,070,826.53	$1,257,161.17	$1,030,585.59	$11,108.50	$218,486.53	2,802	$739.05	$448.67	$367.80	$3.96	$77.98							48,615	$42.60	$25.86	$21.20	$0.23	$4.49
Dependent	$2,424,128.98	$1,477,865.29	$1,195,978.34	$26,397.07	$262,115.55	2,708	$895.17	$545.74	$441.65	$9.75	$96.79							59,955	$40.43	$24.65	$19.95	$0.44	$4.37
Total	$4,494,955.51	$2,735,026.46	$2,226,563.93	$37,505.57	$480,602.08	5,510	$815.78	$496.38	$404.10	$6.81	$87.22	48,615	$92.46	$56.26	$45.80	$0.77	$9.89	108,570	$41.40	$25.19	$20.51	$0.35	$4.43

Transfer To Excel

CLAIMS PAID PER USERS, ENROLLEES, AND COVERED LIVES BY ENROLLEE CATEGORY AND ENROLLEE / DEPENDENT

This report was generated using the following parameters:

Incurred Start Date:	01/01/2009
Incurred End Date:	03/31/2009
Paid Start Date:	01/01/2009
Paid End Date:	06/30/2009
Reporting Group(s):	[redacted]

Authorization-based Utilization Summary

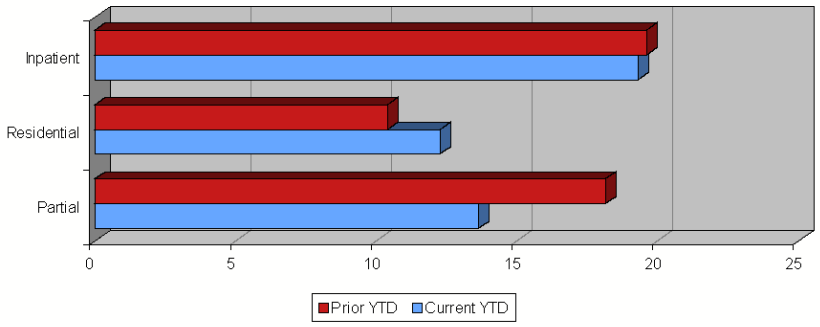
Sample Company

Report ID: COWO0039A
Run Date: 02/19/2007
Run Time: 04:22:26 PM

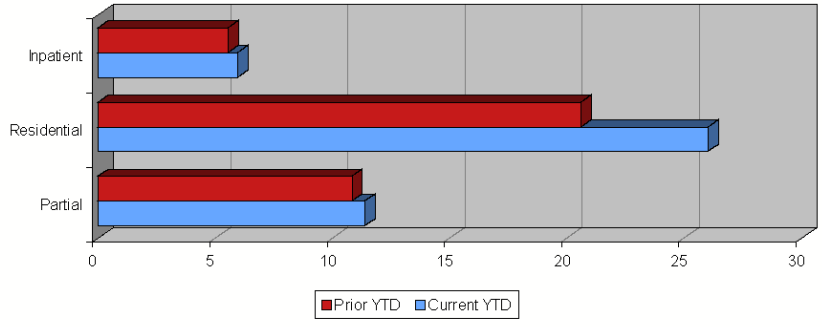
Average Number of Subscribers	**23,987**	**24,299**	**23,386**
Average Number of Covered Lives	**59,361**	**59,355**	**55,463**

	Current Period 10/1/2006 - 12/31/2006				Year-To-Date 1/1/2006 - 12/31/2006				Prior Year-To-Date 1/1/2005 - 12/31/2005			
Inpatient	**Mental Health**	**Substance Abuse**	**Other**	**Total**	**Mental Health**	**Substance Abuse**	**Other**	**Total**	**Mental Health**	**Substance Abuse**	**Other**	**Total**
Users*	30	8	3	41	114	21	8	143	111	31	9	151
Admissions	33	9	3	45	151	36	8	195	152	37	10	199
Number of Days Authorized	228	49	5	282	922	205	19	1146	903	166	20	1089
Discharges	34	8	2	44	150	35	7	192	149	37	10	196
Annualized Users per 1,000 Lives	2.0	0.5	0.2	2.7	1.9	0.4	0.1	2.4	2.0	0.6	0.2	2.7
Annualized Admits per 1,000 Lives	2.3	0.5	0.1	3.0	2.5	0.6	0.1	3.3	2.7	0.7	0.2	3.6
Annualized Days per 1,000 Lives	15.2	3.3	0.3	18.8	15.5	3.5	0.3	19.3	16.3	3.0	0.4	19.6
Average Length of Stay	6.7	6.1	2.5	6.4	6.1	5.9	2.7	6.0	6.1	4.5	2.0	5.6
Residential Treatment												
Users*	1	5	1	7	8	18	1	27	7	19	1	27
Admissions	1	5	1	7	9	18	1	28	9	25	1	35
Number of Days Authorized	0	135	7	142	311	411	7	729	165	409	3	577
Discharges	0	6	1	7	9	18	1	28	6	21	1	28
Annualized Users per 1,000 Lives	0.1	0.3	0.1	0.5	0.1	0.3	0.0	0.5	0.1	0.3	0.0	0.5
Annualized Admits per 1,000 Lives	0.0	0.4	0.1	0.5	0.2	0.3	0.0	0.5	0.1	0.4	0.0	0.6
Annualized Days per 1,000 Lives	0.0	9.0	0.5	9.5	5.2	6.9	0.1	12.3	3.0	7.4	0.1	10.4
Average Length of Stay	0.0	22.5	7.0	20.3	34.6	22.8	7.0	26.0	27.5	19.5	3.0	20.6
Partial Hospitalization												
Users*	12	7	1	20	48	16	5	69	52	17	0	69
Admissions	12	7	1	20	52	16	5	73	71	20	0	91
Number of Days Authorized	164	77	5	246	618	148	43	809	792	216	0	1008
Discharges	14	7	1	22	52	15	4	71	74	19	0	93
Annualized Users per 1,000 Lives	0.8	0.5	0.1	1.3	0.8	0.3	0.1	1.2	0.9	0.3	0.0	1.2
Annualized Admits per 1,000 Lives	0.9	0.5	0.1	1.3	0.9	0.3	0.1	1.2	1.3	0.3	0.0	1.6
Annualized Days per 1,000 Lives	11.0	5.1	0.3	16.4	10.4	2.5	0.7	13.6	14.3	3.9	0.0	18.2
Average Length of Stay	11.7	11.0	5.0	11.2	11.9	9.9	10.8	11.4	10.7	11.4	0.0	10.8

YTD Annualized Days per 1,000 Lives



YTD Average Length Of Stay



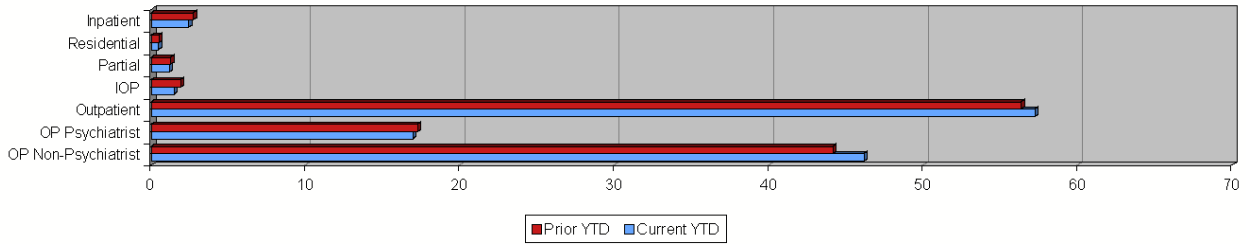
Authorization-based Utilization Summary
Sample Company

Report ID: COWO0039A
Run Date: 02/19/2007
Run Time: 04:22:27 PM

Average Number of Subscribers	**23,987**	**24,299**	**23,386**
Average Number of Covered Lives	**59,361**	**59,355**	**55,463**

	Current Period 10/1/2006 - 12/31/2006				Year-To-Date 1/1/2006 - 12/31/2006				Prior Year-To-Date 1/1/2005 - 12/31/2005			
Intensive Outpatient	**Mental Health**	**Substance Abuse**	**Other**	**Total**	**Mental Health**	**Substance Abuse**	**Other**	**Total**	**Mental Health**	**Substance Abuse**	**Other**	**Total**
Users*	12	13	1	26	45	40	2	87	52	51	3	106
Initial Authorization	12	12	1	25	35	43	2	80	45	55	3	103
Authorizations	20	41	1	62	108	146	2	256	125	151	3	279
Number of Units Authorized	82	220	6	308	397	753	7	1157	485	766	19	1270
Annualized Users per 1,000 Lives	0.8	0.9	0.1	1.7	0.8	0.7	0.0	1.5	0.9	0.9	0.1	1.9
Annualized Initial Auths per 1,000 Lives	0.8	0.8	0.1	1.7	0.6	0.7	0.0	1.3	0.8	1.0	0.1	1.9
Annualized Units per 1,000 Lives	5.5	14.7	0.4	20.6	6.7	12.7	0.1	19.5	8.7	13.8	0.3	22.9
Authorized Units per User	6.8	16.9	6.0	11.8	8.8	18.8	3.5	13.3	9.3	15.0	6.3	12.0
Outpatient-Psychiatrist												
Users*	244	2	18	264	884	9	111	1004	619	8	329	956
Initial Authorization	153	2	19	174	611	9	118	738	391	8	359	758
Authorizations	260	2	20	282	1081	9	122	1212	774	8	367	1149
Number of Units Authorized	2363	16	141	2520	8255	55	838	9148	5189	52	2483	7724
Annualized Users per 1,000 Lives	16.3	0.1	1.2	17.6	14.9	0.2	1.9	16.9	11.2	0.1	5.9	17.2
Annualized Initial Auths per 1,000 Lives	10.2	0.1	1.3	11.6	10.3	0.2	2.0	12.4	7.0	0.1	6.5	13.7
Annualized Units per 1,000 Lives	157.9	1.1	9.4	168.4	139.1	0.9	14.1	154.1	93.6	0.9	44.8	139.3
Authorized Units per User	9.7	8.0	7.8	9.5	9.3	6.1	7.5	9.1	8.4	6.5	7.5	8.1
Outpatient-Non-Psychiatrist												
Users*	769	8	39	816	2116	28	595	2739	1401	33	1014	2448
Initial Authorization	539	8	45	592	1820	27	653	2500	1032	31	1120	2183
Authorizations	882	10	46	938	3480	38	674	4192	2612	59	1164	3835
Number of Units Authorized	7816	76	387	8279	29684	322	5013	35019	21639	435	9056	31130
Annualized Users per 1,000 Lives	51.4	0.5	2.6	54.5	35.6	0.5	10.0	46.1	25.3	0.6	18.3	44.1
Annualized Initial Auths per 1,000 Lives	36.0	0.5	3.0	39.6	30.7	0.5	11.0	42.1	18.6	0.6	20.2	39.4
Annualized Units per 1,000 Lives	522.4	5.1	25.9	553.3	500.1	5.4	84.5	590.0	390.2	7.8	163.3	561.3
Authorized Units per User	10.2	9.5	9.9	10.1	14.0	11.5	8.4	12.8	15.4	13.2	8.9	12.7
Outpatient-Total												
Users*	961	9	53	1023	2681	35	680	3396	1826	39	1260	3125
Initial Authorization	692	10	64	766	2431	36	771	3238	1423	39	1479	2941
Authorizations	1142	12	66	1220	4561	47	796	5404	3386	67	1531	4984
Number of Units Authorized	10179	92	528	10799	37939	377	5851	44167	26828	487	11539	38854
Annualized Users per 1,000 Lives	64.2	0.6	3.5	68.4	45.2	0.6	11.5	57.2	32.9	0.7	22.7	56.3
Annualized Initial Auths per 1,000 Lives	46.2	0.7	4.3	51.2	41.0	0.6	13.0	54.6	25.7	0.7	26.7	53.0
Annualized Units per 1,000 Lives	680.3	6.1	35.3	721.8	639.2	6.4	98.6	744.1	483.7	8.8	208.0	700.5
Authorized Units per User	10.6	10.2	10.0	10.6	14.2	10.8	8.6	13.0	14.7	12.5	9.2	12.4
Other Levels of Care												
Users*	0	0	0	0	0	0	0	0	0	0	0	0
All Levels of Care												
Total Unique Users	980	29	59	1068	2714	92	695	3501	1884	94	1267	3245
Annualized Unique Users per 1,000	65.5	1.9	3.9	71.4	45.7	1.5	11.7	59.0	34.0	1.7	22.8	58.5

YTD Annualized Users Per 1,000 Lives

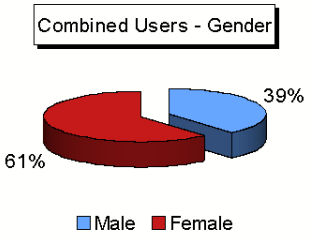


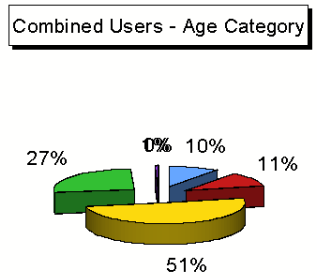
Auth-Utilization by Demographic Categories

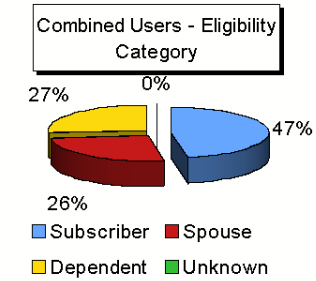
SAMPLE COMPANY

Average Number of Covered Lives **487,318**

	Current Period 4/1/2006 - 6/30/2006											
	Mental Health Users			Substance Abuse Users			Other Users			Combined Unique Users		
	Number	% of Total	/1000 lives	Number	% of Total	/1000 lives	Number	% of Total	/1000 lives	Number	% of Total	/1000 lives
Female												
0-12 Years	658	4.2%	5.4	2	0.6%	0.0	0	0.0%	0.0	660	4.1%	5.4
13-17 Years	952	6.0%	7.8	6	1.7%	0.0	0	0.0%	0.0	954	6.0%	7.9
18-44 Years	5,274	33.4%	43.4	85	23.5%	0.7	0	0.0%	0.0	5,298	33.3%	43.6
45-64 Years	2,763	17.5%	22.7	44	12.2%	0.4	0	0.0%	0.0	2,784	17.5%	22.9
65+ Years	48	0.3%	0.4	0	0.0%	0.0	0	0.0%	0.0	48	0.3%	0.4
Unknown	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Total - Female	**9,695**	**61.5%**	**79.8**	**137**	**37.8%**	**1.1**	**0**	**0.0%**	**0.0**	**9,744**	**61.2%**	**80.2**
Male												
0-12 Years	978	6.2%	8.0	1	0.3%	0.0	0	0.0%	0.0	978	6.1%	8.0
13-17 Years	827	5.2%	6.8	5	1.4%	0.0	0	0.0%	0.0	829	5.2%	6.8
18-44 Years	2,751	17.4%	22.6	135	37.3%	1.1	0	0.0%	0.0	2,799	17.6%	23.0
45-64 Years	1,475	9.3%	12.1	83	22.9%	0.7	0	0.0%	0.0	1,513	9.5%	12.5
65+ Years	50	0.3%	0.4	1	0.3%	0.0	0	0.0%	0.0	50	0.3%	0.4
Unknown	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Total - Male	**6,081**	**38.5%**	**50.1**	**225**	**62.2%**	**1.9**	**0**	**0.0%**	**0.0**	**6,169**	**38.8%**	**50.8**
Combined Female / Male												
0-12 Years	1,636	10.4%	13.5	3	0.8%	0.0	0	0.0%	0.0	1,638	10.3%	13.5
13-17 Years	1,779	11.3%	14.6	11	3.0%	0.1	0	0.0%	0.0	1,783	11.2%	14.7
18-44 Years	8,025	50.9%	66.1	220	60.8%	1.8	0	0.0%	0.0	8,097	50.9%	66.6
45-64 Years	4,238	26.9%	34.9	127	35.1%	1.0	0	0.0%	0.0	4,297	27.0%	35.4
65+ Years	98	0.6%	0.8	1	0.3%	0.0	0	0.0%	0.0	98	0.6%	0.8
Unknown	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Combined Total	**15,776**	**100.0%**	**129.8**	**362**	**100.0%**	**3.0**	**0**	**0.0%**	**0.0**	**15,913**	**100.0%**	**131.0**
Eligibility Category												
Subscriber	7,452	47.2%	61.3	199	55.0%	1.6	0	0.0%	0.0	7,531	47.3%	62.0
Spouse	4,102	26.0%	33.8	118	32.6%	1.0	0	0.0%	0.0	4,138	26.0%	34.1
Dependent	4,222	26.8%	34.8	45	12.4%	0.4	0	0.0%	0.0	4,244	26.7%	34.9
Unknown	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Total	**15,776**	**100.0%**	**129.8**	**362**	**100.0%**	**3.0**	**0**	**0.0%**	**0.0**	**15,913**	**100.0%**	**131.0**







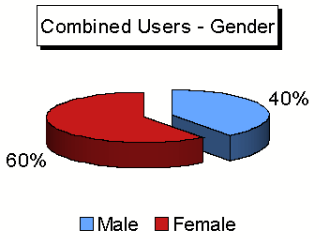
****Users may be counted multiple times if they have MH and SA authorizations during the same reporting period.*

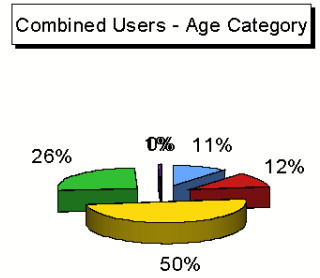
Auth-Utilization by Demographic Categories

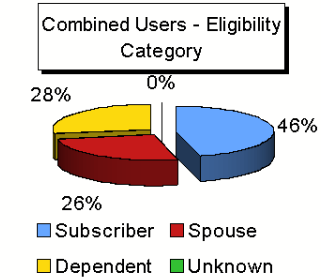
SAMPLE COMPANY

Average Number of Covered Lives **486,951**

	Year-To-Date 1/1/2006 - 6/30/2006											
	Mental Health Users			Substance Abuse Users			Other Users			Combined Unique Users		
	Number	% of Total	/1000 lives	Number	% of Total	/1000 lives	Number	% of Total	/1000 lives	Number	% of Total	/1000 lives
Female												
0-12 Years	1,123	4.3%	4.7	2	0.3%	0.0	0	0.0%	0.0	1,125	4.3%	4.7
13-17 Years	1,630	6.3%	6.8	16	2.4%	0.1	0	0.0%	0.0	1,634	6.2%	6.8
18-44 Years	8,536	32.7%	35.3	151	22.9%	0.6	0	0.0%	0.0	8,565	32.6%	35.5
45-64 Years	4,381	16.8%	18.1	76	11.5%	0.3	0	0.0%	0.0	4,408	16.8%	18.3
65+ Years	79	0.3%	0.3	2	0.3%	0.0	0	0.0%	0.0	81	0.3%	0.3
Unknown	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Total - Female	**15,749**	**60.4%**	**65.2**	**247**	**37.5%**	**1.0**	**0**	**0.0%**	**0.0**	**15,813**	**60.2%**	**65.5**
Male												
0-12 Years	1,803	6.9%	7.5	3	0.5%	0.0	0	0.0%	0.0	1,805	6.9%	7.5
13-17 Years	1,436	5.5%	5.9	11	1.7%	0.0	0	0.0%	0.0	1,439	5.5%	6.0
18-44 Years	4,555	17.5%	18.9	267	40.5%	1.1	0	0.0%	0.0	4,635	17.7%	19.2
45-64 Years	2,440	9.4%	10.1	128	19.4%	0.5	0	0.0%	0.0	2,479	9.4%	10.3
65+ Years	83	0.3%	0.3	3	0.5%	0.0	0	0.0%	0.0	84	0.3%	0.3
Unknown	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Total - Male	**10,317**	**39.6%**	**42.7**	**412**	**62.5%**	**1.7**	**0**	**0.0%**	**0.0**	**10,442**	**39.8%**	**43.2**
Combined Female / Male												
0-12 Years	2,926	11.2%	12.1	5	0.8%	0.0	0	0.0%	0.0	2,930	11.2%	12.1
13-17 Years	3,066	11.8%	12.7	27	4.1%	0.1	0	0.0%	0.0	3,073	11.7%	12.7
18-44 Years	13,091	50.2%	54.2	418	63.4%	1.7	0	0.0%	0.0	13,200	50.3%	54.7
45-64 Years	6,821	26.2%	28.2	204	31.0%	0.8	0	0.0%	0.0	6,887	26.2%	28.5
65+ Years	162	0.6%	0.7	5	0.8%	0.0	0	0.0%	0.0	165	0.6%	0.7
Unknown	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Combined Total	**26,066**	**100.0%**	**107.9**	**659**	**100.0%**	**2.7**	**0**	**0.0%**	**0.0**	**26,255**	**100.0%**	**108.7**
Eligibility Category												
Subscriber	11,989	46.0%	49.6	363	55.1%	1.5	0	0.0%	0.0	12,099	46.1%	50.1
Spouse	6,782	26.0%	28.1	216	32.8%	0.9	0	0.0%	0.0	6,835	26.0%	28.3
Dependent	7,295	28.0%	30.2	80	12.1%	0.3	0	0.0%	0.0	7,321	27.9%	30.3
Unknown	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Total	**26,066**	**100.0%**	**107.9**	**659**	**100.0%**	**2.7**	**0**	**0.0%**	**0.0**	**26,255**	**100.0%**	**108.7**







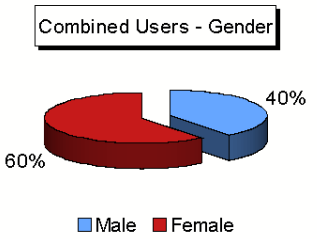
****Users may be counted multiple times if they have MH and SA authorizations during the same reporting period.*

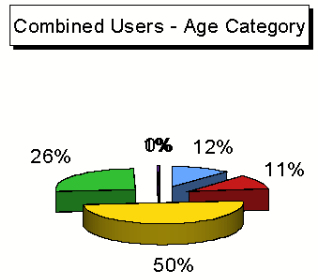
Auth-Utilization by Demographic Categories

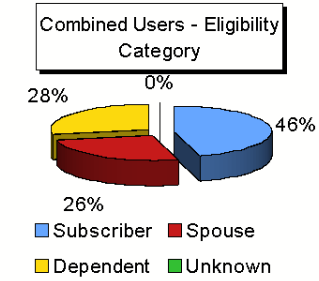
SAMPLE COMPANY

Average Number of Covered Lives **437,326**

	Prior Year -To-Date 1/1/2005 - 6/30/2005											
	Mental Health Users			Substance Abuse Users			Other Users			Combined Unique Users		
	Number	% of Total	/1000 lives	Number	% of Total	/1000 lives	Number	% of Total	/1000 lives	Number	% of Total	/1000 lives
Female												
0-12 Years	1,432	4.6%	6.6	5	0.8%	0.0	0	0.0%	0.0	1,436	4.6%	6.6
13-17 Years	1,916	6.2%	8.8	12	2.0%	0.1	0	0.0%	0.0	1,921	6.2%	8.9
18-44 Years	10,122	32.8%	46.7	133	22.6%	0.6	2	33.3%	0.0	10,160	32.8%	46.8
45-64 Years	5,132	16.6%	23.7	72	12.2%	0.3	1	16.7%	0.0	5,146	16.6%	23.7
65+ Years	82	0.3%	0.4	2	0.3%	0.0	0	0.0%	0.0	83	0.3%	0.4
Unknown	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Total - Female	**18,684**	**60.6%**	**86.2**	**224**	**38.0%**	**1.0**	**3**	**50.0%**	**0.0**	**18,746**	**60.5%**	**86.4**
Male												
0-12 Years	2,272	7.4%	10.5	1	0.2%	0.0	1	16.7%	0.0	2,270	7.3%	10.5
13-17 Years	1,624	5.3%	7.5	13	2.2%	0.1	1	16.7%	0.0	1,625	5.2%	7.5
18-44 Years	5,295	17.2%	24.4	233	39.6%	1.1	1	16.7%	0.0	5,358	17.3%	24.7
45-64 Years	2,878	9.3%	13.3	117	19.9%	0.5	0	0.0%	0.0	2,914	9.4%	13.4
65+ Years	77	0.2%	0.4	1	0.2%	0.0	0	0.0%	0.0	78	0.3%	0.4
Unknown	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Total - Male	**12,146**	**39.4%**	**56.0**	**365**	**62.0%**	**1.7**	**3**	**50.0%**	**0.0**	**12,245**	**39.5%**	**56.5**
Combined Female / Male												
0-12 Years	3,704	12.0%	17.1	6	1.0%	0.0	1	16.7%	0.0	3,706	12.0%	17.1
13-17 Years	3,540	11.5%	16.3	25	4.2%	0.1	1	16.7%	0.0	3,546	11.4%	16.4
18-44 Years	15,417	50.0%	71.1	366	62.1%	1.7	3	50.0%	0.0	15,518	50.1%	71.6
45-64 Years	8,010	26.0%	36.9	189	32.1%	0.9	1	16.7%	0.0	8,060	26.0%	37.2
65+ Years	159	0.5%	0.7	3	0.5%	0.0	0	0.0%	0.0	161	0.5%	0.7
Unknown	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Combined Total	**30,830**	**100.0%**	**142.2**	**589**	**100.0%**	**2.7**	**6**	**100.0%**	**0.0**	**30,991**	**100.0%**	**142.9**
Eligibility Category												
Subscriber	14,063	45.6%	64.8	309	52.5%	1.4	2	33.3%	0.0	14,154	45.7%	65.3
Spouse	8,037	26.1%	37.1	201	34.1%	0.9	1	16.7%	0.0	8,088	26.1%	37.3
Dependent	8,730	28.3%	40.3	79	13.4%	0.4	3	50.0%	0.0	8,749	28.2%	40.3
Unknown	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Total	**30,830**	**100.0%**	**142.2**	**589**	**100.0%**	**2.7**	**6**	**100.0%**	**0.0**	**30,991**	**100.0%**	**142.9**



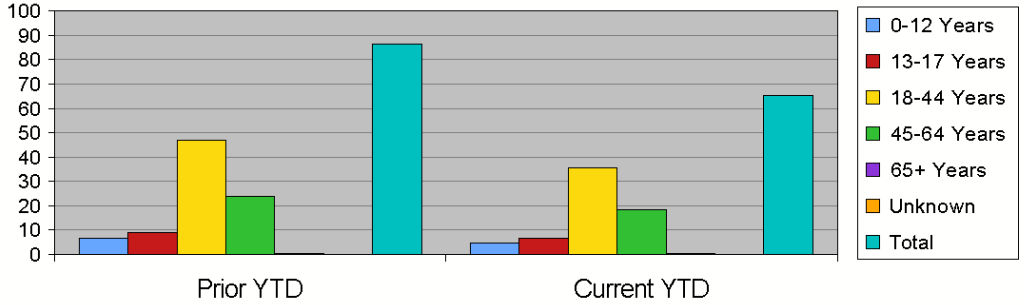




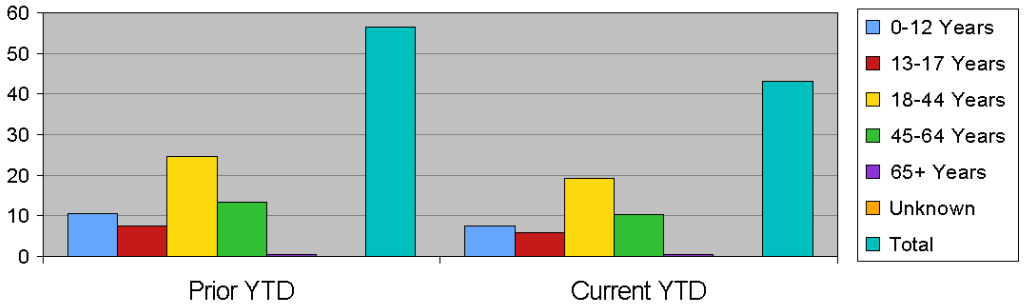
****Users may be counted multiple times if they have MH and SA authorizations during the same reporting period.*

	Prior YTD Annualized Unique Users per 1000 Lives	Current YTD Annualized Unique Users per 1000 Lives
Female		
0-12 Years	6.6	4.7
13-17 Years	8.9	6.8
18-44 Years	46.8	35.5
45-64 Years	23.7	18.3
65+ Years	0.4	0.3
Unknown	0.0	0.0
Total - Female	**86.4**	**65.5**
Male		
0-12 Years	10.5	7.5
13-17 Years	7.5	6.0
18-44 Years	24.7	19.2
45-64 Years	13.4	10.3
65+ Years	0.4	0.3
Unknown	0.0	0.0
Total - Male	**56.5**	**43.2**
Combined Female / Male		
0-12 Years	17.1	12.1
13-17 Years	16.4	12.7
18-44 Years	71.6	54.7
45-64 Years	37.2	28.5
65+ Years	0.7	0.7
Unknown	0.0	0.0
Combined Total	**142.9**	**108.7**

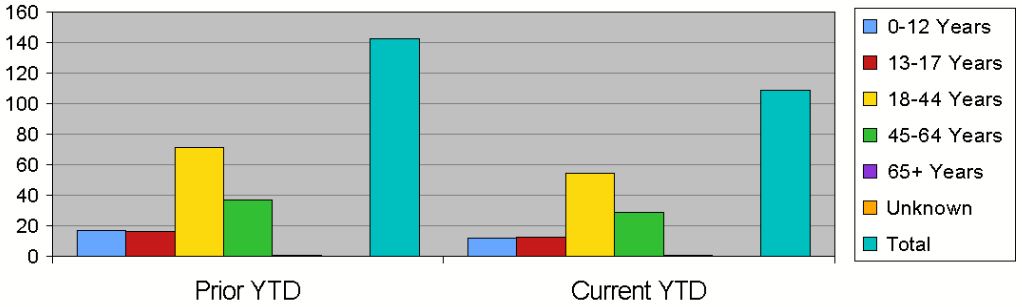
# of Female Users per 1000 Lives by Age-Group



# of Male Users per 1000 Lives by Age-Group



# of Combined Users per 1000 Lives by Age-Group



Input Parameters Selected

Reporting Groups:

- SAMPLE COMPANY

Start Date:	4/1/2006
End Date:	6/30/2006
Start Date YTD:	1/1/2006
Level(s) of Care:	All Levels of Care
Hierarchy Type:	Eligibility

Average # of Covered Lives (To replace # from Database)

Current Period:	No Value Entered
Year-To-Date:	No Value Entered
Prior Year-To-Date:	No Value Entered

Authorizations by Primary Diagnostic Classification

Report ID: COWO0043A
Run Date 04/13/2006
Run Time 11:34:02 AM

Reporting Group Name: SAMPLE COMPANY

Level of Care: Inpatient

	Current Period					Year To Date					Prior Year To Date				
	7/1/2005 - 9/30/2005					7/1/2004 - 9/30/2005					7/1/2003 - 9/30/2004				
Covered Lives	571,830					473,281					210,478				
Primary Diagnosis Class	**Users(*)**	**Number of Units/ Days Authorized**	**Annualized Users per 1,000 Lives**	**Annualized Units/ Days per 1,000 Lives**	**Average Authorized Units/ Length of Stay per User**	**Users(*)**	**Number of Units/ Days Authorized**	**Annualized Users per 1,000 Lives**	**Annualized Units/ Days per 1,000 Lives**	**Average Authorized Units/ Length of Stay per User**	**Users(*)**	**Number of Units/ Days Authorized**	**Annualized Users per 1,000 Lives**	**Annualized Units/ Days per 1,000 Lives**	**Average Authorized Units/ Length of Stay per User**
Additional Codes (Deferred, Unspecified, Other)	**9**	49	0.1	0.3	5.4	**32**	135	0.1	0.2	4.2	**26**	103	0.1	0.4	4.0
Adjustment Disorders	**2**	7	0.0	0.0	3.5	**7**	24	0.0	0.0	3.4	**8**	24	0.0	0.1	3.0
Anxiety Disorders	**3**	21	0.0	0.1	7.0	**5**	33	0.0	0.1	6.6	**8**	35	0.0	0.1	4.4
Delirium, Dementia, Amnestic and Other Cognitive Disorders	**1**	3	0.0	0.0	3.0	**5**	21	0.0	0.0	4.2	**3**	15	0.0	0.1	5.0
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence	**3**	8	0.0	0.1	2.7	**11**	40	0.0	0.1	3.6	**8**	44	0.0	0.2	5.5
Dissociative Disorders	**0**	0	0.0	0.0	0.0	**0**	0	0.0	0.0	0.0	**1**	7	0.0	0.0	7.0
Eating Disorders	**1**	10	0.0	0.1	10.0	**4**	33	0.0	0.1	8.3	**4**	49	0.0	0.2	12.3
Impulse-Control Disorders Not Elsewhere Classified	**0**	0	0.0	0.0	0.0	**4**	37	0.0	0.1	9.3	**1**	6	0.0	0.0	6.0
Mental Disorders Due to General Medical Condition Not Elsewhere	**0**	0	0.0	0.0	0.0	**0**	0	0.0	0.0	0.0	**2**	17	0.0	0.1	8.5
Mood Disorders	**85**	507	0.6	3.6	6.0	**347**	2597	0.6	4.4	7.5	**363**	2691	1.4	10.2	7.4
Other Conditions That May Be a Focus of Clinical Attention	**0**	0	0.0	0.0	0.0	**0**	0	0.0	0.0	0.0	**1**	7	0.0	0.0	7.0
Schizophrenia and Other Psychotic Disorders	**6**	62	0.0	0.4	10.3	**35**	298	0.1	0.5	8.5	**41**	244	0.2	0.9	6.0
Substance-Related Disorders	**26**	167	0.2	1.2	6.4	**144**	917	0.2	1.6	6.4	**138**	893	0.5	3.4	6.5
Totals by Unique Users (+*)	124	834	0.9	5.8	6.7	535	4135	0.9	7.0	7.7	541	4135	2.1	15.7	7.6

*Users may be counted multiple times if they were authorized for Multiple Diagnosis Classes.

+*Totals by Unique Users is a distinct count of users regardless of diagnosis classes. A user is only counted once in each reporting period.

Authorization Utilization by Top Provider - IP

Sample Company

Authorizations with dates of service between: 12/01/2009 - 12/31/2009

Report ID : COWO0059A
Run Date : 02/03/2010
Run Time : 08:18:59 AM

Facility	Facility TIN	Service City/State	Network Status	Unique Users	% of Unique Users	Number of Admissions	% of Admission	Number of Discharges	% of Discharges	Total Authorized Days	ALOS
BELMONT CTR FOR CMPRHNSV TRTMNT		PHILADELPHIA, PA	INN	60	9.67%	53	9.16%	50	9.24%	309	6.18
BROOKE GLEN BHVRL HOSP		FORT WASHINGTON, PA	INN	56	9.03%	45	7.78%	50	9.24%	303	6.06
HORSHAM CLNC MAIN SITE		AMBLER, PA	INN	63	10.16%	57	9.86%	55	10.16%	299	5.43
UHS OF FAIRMOUNT INC		PHILADELPHIA, PA	INN	37	5.96%	36	6.22%	35	6.46%	229	6.54
HAMPTON HOSP		MOUNT HOLLY, NJ	INN	26	4.19%	25	4.32%	23	4.25%	141	6.13
Total of Top 5 Facility				**242**	**37.46%**	**216**	**37.18%**	**213**	**39.30%**	**1281**	**6.01**
Total of All Other Facility:				**404**		**365**		**329**		**1725**	
Total of All Facility:				**646**		**581**		**542**		**3006**	

MAGELLAN HEALTH SERVICES "Getting Better All the Time"

Report ID : COWO0059A
Run Date : 02/03/2010
Run Time : 08:19:00 AM

Authorization Utilization by Top Provider - IP

Sample Company

Authorizations with dates of service between: 12/01/2009 - 12/31/2009

Facility	TIN	Case Number	Auth Type	Network Status	Patient ID	Patient	DOB	Admit Date	Start Date	End Date	Discharge Date	Discharge Entered Date	DxCode	Total Units Authorized	Actual Length of Stay
ABINGTON MEML HOSP MAIN SITE			I	INN				12/12/2009	12/12/2009	12/14/2009	12/15/2009	12/16/2009	311.00	3.00	3.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/16/2009	12/16/2009	12/31/2009	12/31/2009	1/14/2010	296.30	2.00	15.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/16/2009	12/16/2009	12/31/2009	12/31/2009	1/14/2010	296.30	5.00	15.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/16/2009	12/16/2009	12/31/2009	12/31/2009	1/14/2010	296.30	4.00	15.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/5/2009	12/5/2009	12/9/2009	12/10/2009	12/10/2009	296.33	2.00	5.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/10/2009	12/10/2009	12/13/2009	12/14/2009	12/17/2009	296.33	4.00	4.00
ABINGTON MEML HOSP MAIN SITE			C	INN		C		12/21/2009	12/21/2009	12/23/2009	12/24/2009	1/5/2010	298.90	1.00	3.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/24/2009	12/24/2009	12/30/2009	12/31/2009	1/5/2010	296.33	7.00	7.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/26/2009	12/26/2009	1/4/2010	1/12/2010	1/13/2010	296.63	4.00	17.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/14/2009	12/14/2009	12/22/2009	12/23/2009	12/23/2009	296.33	2.00	9.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/14/2009	12/14/2009	12/22/2009	12/23/2009	12/23/2009	296.33	3.00	9.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/14/2009	12/14/2009	12/22/2009	12/23/2009	12/23/2009	296.33	1.00	9.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/1/2009	12/1/2009	12/10/2009	12/11/2009	12/11/2009	295.30	2.00	10.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/1/2009	12/1/2009	12/10/2009	12/11/2009	12/11/2009	295.30	4.00	10.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/1/2009	12/1/2009	12/10/2009	12/11/2009	12/11/2009	295.30	2.00	10.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/13/2009	12/14/2009	12/17/2009	12/18/2009	12/18/2009	311.00	2.00	4.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/13/2009	12/14/2009	12/17/2009	12/18/2009	12/18/2009	311.00	2.00	4.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/26/2009	12/26/2009	1/4/2010	1/12/2010	1/13/2010	296.63	3.00	17.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/20/2009	12/20/2009	12/28/2009	12/28/2009	12/30/2009	311.00	2.00	8.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/20/2009	12/20/2009	12/28/2009	12/28/2009	12/30/2009	311.00	5.00	8.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/20/2009	12/20/2009	12/28/2009	12/28/2009	12/30/2009	311.00	2.00	8.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/7/2009	12/7/2009	12/9/2009	12/10/2009	12/10/2009	294.80	2.00	3.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/7/2009	12/7/2009	12/9/2009	12/10/2009	12/10/2009	294.80	1.00	3.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/1/2009	12/1/2009	12/6/2009	12/7/2009	12/7/2009	298.90	2.00	6.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/1/2009	12/1/2009	12/6/2009	12/7/2009	12/7/2009	298.90	2.00	6.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/18/2009	12/18/2009	12/21/2009	12/22/2009	12/23/2009	296.53	4.00	4.00
ABINGTON MEML HOSP MAIN SITE			C	INN				12/26/2009	12/26/2009	1/4/2010	1/12/2010	1/13/2010	296.63	3.00	17.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/21/2009	12/21/2009	12/23/2009	12/24/2009	1/5/2010	298.90	2.00	3.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/13/2009	12/13/2009	12/14/2009	12/15/2009	12/15/2009	311.00	2.00	2.00
ABINGTON MEML HOSP MAIN SITE			I	INN				12/5/2009	12/5/2009	12/9/2009	12/10/2009	12/10/2009	296.33	3.00	5.00
ABINGTON MEML HOSP MAIN SITE			I	INN		I		12/16/2009	12/16/2009	12/31/2009	12/31/2009	1/14/2010	296.30	3.00	15.00
ADVENTIST BHVRL HLTH			C	OON				12/7/2009	12/7/2009	12/14/2009	12/17/2009	12/17/2009	296.64	2.00	10.00
ADVENTIST BHVRL HLTH			C	OON				12/7/2009	12/7/2009	12/14/2009	12/17/2009	12/17/2009	296.64	3.00	10.00
ADVENTIST BHVRL HLTH			I	OON				12/7/2009	12/7/2009	12/14/2009	12/17/2009	12/17/2009	296.64	3.00	10.00
ALBERT EINSTEIN MEDCL CTR			I	INN				12/15/2009	12/15/2009	12/16/2009	12/17/2009	12/18/2009	296.33	2.00	2.00
ALBERT EINSTEIN MEDCL CTR			I	INN				12/18/2009	12/18/2009	12/21/2009	12/22/2009	12/28/2009	296.33	4.00	4.00
ALBERT EINSTEIN MEDCL CTR			C	INN				12/9/2009	12/9/2009	12/29/2009	1/12/2010	1/14/2010	295.30	5.00	34.00
ALBERT EINSTEIN MEDCL CTR			I	INN				12/9/2009	12/9/2009	12/29/2009	1/12/2010	1/14/2010	295.30	2.00	34.00
ALBERT EINSTEIN MEDCL CTR			C	INN				12/9/2009	12/9/2009	12/29/2009	1/12/2010	1/14/2010	295.30	4.00	34.00
ALBERT EINSTEIN MEDCL CTR			C	INN				12/9/2009	12/9/2009	12/29/2009	1/12/2010	1/14/2010	295.30	2.00	34.00
ALBERT EINSTEIN MEDCL CTR			I	INN				12/24/2009	12/24/2009	12/28/2009	12/29/2009	1/4/2010	311.00	5.00	5.00
ALBERT EINSTEIN MEDCL CTR			C	INN		)		11/9/2009	12/3/2009	12/16/2009	12/17/2009	12/18/2009	295.70	2.00	14.00

Authorization Utilization by Top Provider

Report ID : COWO0059A
Run Date : 02/03/2010
Run Time : 08:19:16 AM

Start Date= 12/01/2009
End Date = 12/31/2009
Level of Care = ('IP')
Sort Facilities in descending order by: DAYS
Number of Facilities to display = 5
Reporting Group(s):

- Sample Company

Authorization Utilization by Top Provider - OP

Sample Company

Authorizations with dates of service between: 12/01/2010 - 12/31/2010

Report ID : COWO0060A
Run Date : 03/28/2011
Run Time : 08:11:22 AM

Servicing Provider	Service City/State	Network Status	Unique Users	% of Unique Users	Total Authorized Days	Units/User
PSYCHIATRIST PROVIDER	,	INN	92	8.21%	806	8.76
CTR FOR FMLY GUIDNC	MARLTON, NJ	INN	26	2.32%	419	16.12
PENN FNDTN MAIN SITE	SELLERSVILLE, PA	INN	21	1.87%	342	16.29
LIFE CNSLNG SVCS	PAOLI, PA	INN	20	1.78%	148	7.40
KEYSTONE QLTY TRNSPRT INC	SPRINGFIELD, PA	INN	18	1.60%	19	1.06
CMNTY TRTMNT OPTIONS	MEDFORD, NJ	INN	14	1.25%	170	12.14
HILDA DANIEL	WAYNE, PA	INN	14	1.25%	128	9.14
CTR FOR ADDICT DISEASES EXTON	EXTON, PA	INN	13	1.16%	115	8.85
CTR FOR FMLY GUIDNC	WOODBURY, NJ	INN	13	1.16%	184	14.15
REHAB AFTER WORK WALNUT ST	PHILA, PA	INN	13	1.16%	107	8.23
Total of Top 10 Facility			**244**		**2438**	**101.82**
Total of All Other Facility:			**918**		**7571**	**4140.31**
Total of All Facility:			**1162**		**10009**	**4242.13**

* Data is inclusive of cases authorized upon appeal and/or retroactively

Authorization Utilization by Top Provider - OP

Sample Company

Authorizations with dates of service between: 12/01/2010 - 12/31/2010

Report ID : COWO0060A
Run Date : 03/28/2011
Run Time : 08:11:23 AM

Provider	TIN	Case Number	Auth Type	Network Status	Patient ID	Patient	DOB	Auth Start Date	Auth End Date	Total Units Authorized

* Data is inclusive of cases authorized upon appeal and/or retroactively

Authorization Utilization by Top Provider

Report ID : COWO0060A
Run Date : 03/28/2011
Run Time : 08:11:29 AM

Start Date= 12/01/2010
End Date = 12/31/2010
Level of Care = ('OP')
Sort Facilities in descending order by: USERS
Number of Facilities to display = 10
Reporting Group(s):

- Sample Company

* Data is inclusive of cases authorized upon appeal and/or retroactively

Magellan Standard Report Package Summary	
Claims Based Utilization by Demographic Categories	Reports by Gender, Age, Eligibility Category (Dependent, Spouse, Subscriber), Average Membership, # of Users, Paid Amount id: CLWO0034A
Paid Claims Utilization by Top Facilities	Summary by Facility including TIN#, # of Unique Users, # of Cases, Actual Billed Amount, Actual Allowed Amount, Actual Net Paid Amount, Total Days, Average Length of Stay id: CLWO0039A
Outpatient CPT/ Discipline Report by In-Network / Out of Network by Degree Level	By Provider Degree Level, report # of users, # of units, Total Dollar Amount Allowed, Average Ratio id: CLWO0041A
Claim Paid Amount - InNetwork vs Out of Network by Level of Care	Reports Current Period and Year-to-Date Includes graphs For each level of care grouping, by Mental Health or Substance Abuse reports paid Amount by InNetwork and Out-of-Network id: CLWO0035A
Claims Paid per Users, Enrollees, and Covered Lives	Reports by level of care and enrollee or dependent categories Provides Amount Submitted, Amount Allowed, Amount Paid, # of users id: CLWO0059A
Utilization by Primary Diagnostic Classification by Level of Care	Reports Current Period and Year-to-Date by the Primary Diagnostic Categories. Provides #users and Paid Amount id: CLWO0036A
Paid Claims Utilization by Top Providers	Summary by Facility including TIN#, # of Unique Users, # of Cases, Actual Billed Amount, Actual Allowed Amount, Actual Net Paid Amount, Total Days, Average Length of Stay id: CLWO0040A
LAG Study Report	Reports Claims by Paid Month/Year and Service Month/Year id: CLWO0061A

Magellan Standard Report Package Summary	
Claims Utilization Summary	Reports Current Period, Year to Date and Magellan Normative data for Mental Health and Substance Abuse. By Level of Care provides # of admissions, # of New Users, # of Unique Users, # of Discharges, # of days, Annualized Admissions per 1,000; Annualized days per 1,000; Annualized new users per 1,000; Average Length of Stay; Penetration ratio; Cost per Covered Life; Actual Billed Amount, Actual Allowed Amount; Actual Paid Amount id: CLWO0037A
Authorization Based Utilization Summary	Reports Current Period, Year to Date and Prior Year to Date. # of users; # admissions; # of days authorized; # discharges; annualized users per 1,000; annualized admits per 1,000; annualized days per 1,000, average length of stay id: COWO0039A
Authorization Based Utilization by Demographic Category	Reports Mental Health and Substance Abuse by gender, eligibility category for the Current Period, Year to Date and Prior Year to Date id: COWO0042A
Authorizations by Primary Diagnostic Classification	Reports by Level of Care and then Primary Diagnostic grouping for Current Period, Year to Date and Prior Year to Date. # of users; # days/units auth'd; annualized users per 1,000; annualized days/units per 1,000 id: COWO0043A
Authorization by Top Provider	Summary by Provider, including Service City/State, Network Status, # and % of unique users, total authorized days and units/user id COWO0060A
Authorization by Top Facility	Summary by Facility, including TIN#, Service City/State, Network Status, # and % of Unique Users, # and % of Admissions, # and % of Discharges, total authorized days, ALOS id COWO0059A

O. Quarterly Coordination of Benefit Report

State of NY Empire Plan
Co-ordination of Benefits
Reporting Period: MM/DD/CCYY - MM/DD/CCYY

Report ID: TBD
Run Date: MM/DD/YYYY
Run Time: HH:MM:SS

COB Source	Enrollee	Claim Number	Paid/Denied Date	Billed Amount	Allowed Amount	Paid by Other Insurance	Paid by Magellan	Insured Responsibility	COB Savings

P. Quarterly Website Analytics Report

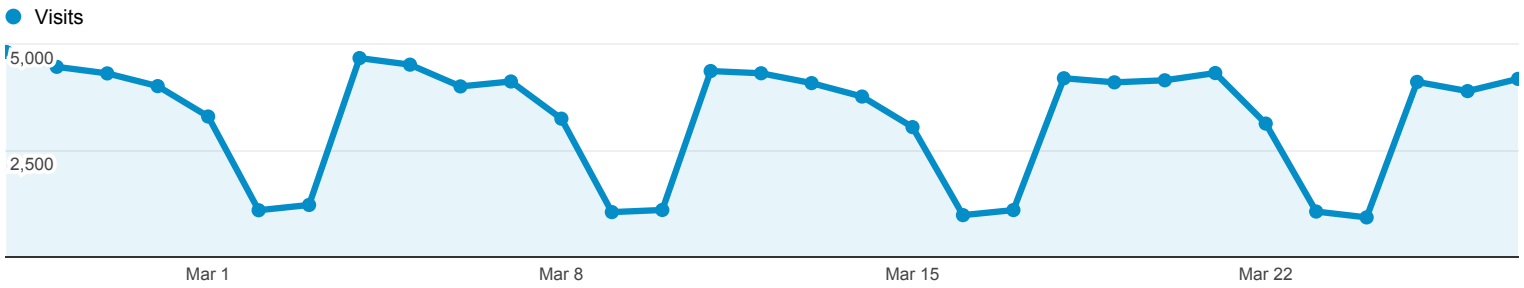
MagellanAssist.com - https://www.magellanassist.com
MagellanAssist [DEFAULT]

Audience Overview

Feb 25, 2013 - Mar 27, 2013

% of visits: 100.00%

Overview



80,546 people visited this site

Visits	101,729
Unique Visitors	80,546
Pageviews	722,395
Pages / Visit	7.10
Avg. Visit Duration	00:06:18
Bounce Rate	33.66%
% New Visits	70.35%

70.44% New Visitor
71,653 Visits

29.56% Returning Visitor
30,076 Visits

	Language	Visits	% Visits
1.	en-us	100,292	98.59%
2.	en	1,188	1.17%
3.	en-gb	65	0.06%
4.	es	40	0.04%
5.	en_us	24	0.02%
6.	es-es	11	0.01%
7.	ja	9	0.01%
8.	zh-cn	9	0.01%
9.	fr	8	0.01%
10.	es-419	7	0.01%

view full report

Q. Quarterly Provider Audit Report

Welcome to the Treatment Record Review Tool for Public Sector
Please follow the instructions on how to correctly fill out the tool and retrieve your results on the Summary Tab.

1. Enter Provider Name, Provider MIS #, Reviewer Name, CMC and Date of Review in the below fields.

Provider: _____
Provider MIS#: _____
Provider Address: _____
_____
Reviewer: _____
CMC: _____
Date of Review: _____

2. To enter results on the TRR PS tab:
   a. Enter the member ID # for each record underneath the Record number header.
   b. Be sure to use the letter "x" to mark the record review
   c. Mark either a yes, a no, or a partial for each question, do not enter more than one x for each
   d. The tool will automatically calculate the totals and averages per record per section.
   e. The summary and graph tab will display the totals

2. Summary Tab
   a. View Results and print if desired.
   b. This document is auto populated and read only.

3. Comments Tab
   a. Comments entered into the TRR PS tool will auto populate onto the Comments tab.
   b. This is a read only document but columns and rows can be expanded to view the entire text.
   c. Print preview before printing to see how many pages include text.
   d. In the print range section of the print menu, choose only the pages that include the comments to avoid wasting paper.

4. To view multi-Provider Results:
   a. Copy and Paste the highlighted data contained below into the spreadsheet entitled Multi-Provider Graph Analysis of TRR Tool.xlsx
   b. Graphs will automatically populate.
   c. Enter the Provider's Name in the Bolded section field provided

Section		Section Content	Score
A		General	
B		Consumer Rights & Confidentiality	
C		Initial Evaluation	
D		Individualized Treatment Plan	
E		Ongoing Treatment	
F		Addendum for Special Populations	
G		Addendum for NCQA Sites Only	
H		CMC Addendum	
		Total	

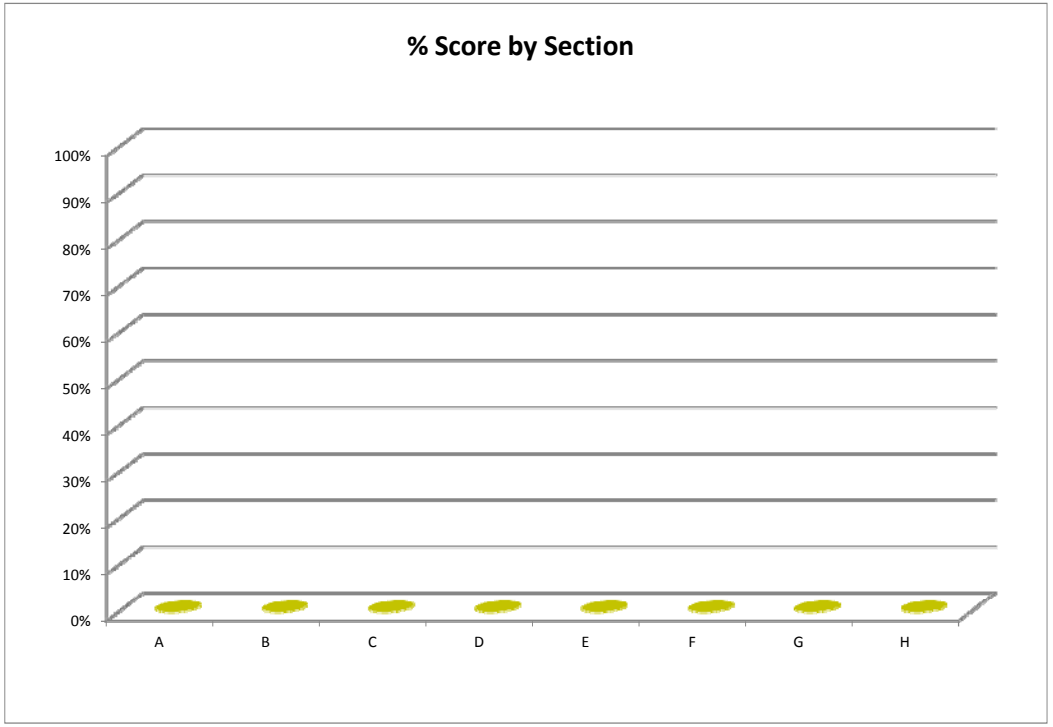
Quarterly Provider Audit Report 1.xlsx

Magellan Behavioral Health

Treatment Record Review
Summary Report for Provider

Provider: 0
Provider MIS#: 0
Reviewer: 0
CMC: 0
Date of Review: 0

Section	Section Content	Score
A	General	
B	Consumer Rights & Confidentiality	
C	Initial Evaluation	
D	Individualized Treatment Plan	
E	Ongoing Treatment	
F	Addendum for Special Populations	
G	Addendum for NCQA Sites Only	
H	CMC Addendum	
	Total	
Recovery and Resiliency Indicators		
C7	Assess of consumer strengths, skills, abilities, motivation etc.	
D6	Crisis plan documented	
E8	Family/support systems contacted/involved as appropriate/feasible	
B5	Appropriate releases for communication w/PCP & other provs signed or patient refusal documented	
1B	The provider delivered education about MDD and its treatment to the patient, and if appropriate, to the family.	
1E	The psychiatrist delivered education about the medication, including signs of new or worsening suicidality and the high risk times for this side effect.	
2A	Assessment for other psychiatric disorders and medical conditions that may cause symptoms and/or complicate treatment	
2B	Delivered education re: schizophrenia and its treatment to the member & family	
Performance Indicator Questions		
E8	Family/support systems contacted/involved as appropriate/feasible	
E10	Discharge planning/linkage to next level of care is occurring (d/c plan documented)	
E11	Discharge plan has been implemented	
H1	Quarterly consultation with practitioner that preformed assessment and/or practitioner providing ongoing therapy.	
H4	Goals/objectives align with consumers Diagnosis/symptoms/day to day functional impairments	
	Overall Record Count	-
	BHIS Record Count	-
	BHIS Group Home Record D/C Count	-



NOTE **You may have a Corrective Action Plan due. Please see TRR & CPG Report tab, beginning with line 105.**

Clinical Practice Guideline Conformance (if applicable)

RECORD #	Member ID#	CPG 1:	CPG 2:	CPG 3:
1	0			
2	0			
3	0			
4	0			
5	0			
6	0			
7	0			
8	0			
9	0			
10	0			
11	0			
12	0			
13	0			
14	0			
15	0			
16	0			
17	0			
18	0			
19	0			
20	0			
21	0			
22	0			
23	0			
24	0			
25	0			

Performance Expectations and Follow-up Requirements	
Final Score	**Requirements**
80-100	**Minimal deficiencies**: no formal follow-up activity required; practitioner is requested to incorporate recommendations from the feedback report as a means to improve documentation practices.
70-79	**Moderate deficiencies**: no formal follow-up activity required; practitioner is requested to submit an informal corrective action plan (CAP).
69-below	**Serious deficiencies**: The practitioner must submit a formal CAP, which includes a plan to remedy deficiencies noted. The corrective actions must be completed within 30-90 days. A follow-up of the CAP, including additional treatment record review, is conducted to confirm the deficiencies are corrected.

Claims:	It is a requirement that file documentation be consistent with Iowa Plan claims data. Inconsistencies found during this review are listed on the TRR & CPG Report tab (beginning with line 112) and will be referred to the Magellan corporate Recovery unit. You will be receiving notice from the Recovery unit regarding necessary repayment. Please do not send any repayment at this time, but instead, wait for that request.

PROVIDER NAME:		TOTALS			Comments/ Percentages
Date of Review:					
Enter an X in the respective column, one per row per record ↘		Y	N	Partial	Comments
SECTION A: GENERAL					
A1	Record is legible	0	0	0	
A2	Consumer name or ID no. noted on each page of record	0	0	0	
A3	Entries are dated & signed by appropriately credentialed prov	0	0	0	
A4	Record contains relevant demographic info including address, employer/school, phone, emergency contact, marital status	0	0	0	
SECTION A SCORE		0	0	0	
SECTION B: CONSUMER RIGHTS & CONFIDENTIALITY (Note: 'Yes' for parent/guardian signature for minor)		Y	N	Partial	Comments
B1	Signed treatment consent form or refusal documented	0	0	0	
B2	Patient Bill of Rights signed or refusal documented	0	0	0	
B3	Psych advance directives or refusal documented	0	0	0	
B4	Informed consent for meds signed or refusal documented	0	0	0	
B5	Appropriate releases for communication w/PCP & other provs signed or patient refusal documented	0	0	0	
SECTION B SCORE		0	0	0	
SECTION C: INITIAL EVALUATION		Y	N	Partial	Comments
C1	Presenting problem and mental status exam	0	0	0	
C2	DSM-IV diagnosis (5 axis)	0	0	0	
C3	History & symptomology consistent w/DSM-IV criteria	0	0	0	
C4	Psychiatric history	0	0	0	
C5	Co-morbid substance induced disorder assessed	0	0	0	

PROVIDER NAME:		TOTALS			Comments/ Percentages
Date of Review:					
Enter an X in the respective column, one per row per record ↘		Y	N	Partial	Comments
C6	Current and past suicide/danger risk assessed	0	0	0	
C7	Assess of consumer strengths, skills, abilities, motivation etc.	0	0	0	
C8	Level of familial/supports assessed and involved as indicated	0	0	0	
C9	Consumer ID'd areas for improvement/outcomes documented	0	0	0	
C10	Medical history	0	0	0	
C11	Exploration of allergies and adverse reactions	0	0	0	
C12	All current medications w/dosages	0	0	0	
C13	Discussion of d/c planning/linkage to next level	0	0	0	
	SECTION C SCORE	0	0	0	
SECTION D: INDIVIDUALIZED TREATMENT PLAN		Y	N	Partial	Comments
D1	Individualized treatment plan is current	0	0	0	
D2	Measurable goals/objectives documented	0	0	0	
D3	Goals/objectives have timeframes for achievement	0	0	0	
D4	Goals/objectives align w/consumer identified areas for improvement/outcomes	0	0	0	
D5	Use of preventive/ancillary services incl. community & peer supports considered	0	0	0	
D6	Crisis plan documented	0	0	0	
SECTION D SCORE		0	0	0	
SECTION E: ONGOING TREATMENT		Y	N	Partial	Comments
E1	Consumer meets MNC for current level of care	0	0	0	
E2	Progress towards measurable consumer identified goals & outcomes evidenced. If not, barriers are being addressed.	0	0	0	
E3	Clinical findings & evaluation for each visit documented	0	0	0	
E4	Substance use assessment is current/ongoing	0	0	0	

PROVIDER NAME:		TOTALS			Comments/ Percentages
Date of Review:					
Enter an X in the respective column, one per row per record ↘		Y	N	Partial	Comments
E5	Suicide/risk assessment is current/ongoing	0	0	0	
E6	Medications are current	0	0	0	
E7	Evidence of treatment being provided in a culturally competent manner	0	0	0	
E8	Family/support systems contacted/involved as appropriate/feasible	0	0	0	
E9	Ancillary/preventive services considered, used & coordinated as indicated	0	0	0	
E10	Discharge planning/linkage to next level of care is occurring (d/c plan documented)	0	0	0	
E11	Discharge plan has been implemented	0	0	0	
SECTION E SCORE		0	0	0	
SECTION F: ADDENDUM FOR SPECIAL POPULATIONS		Y	N	Partial	Comments
F1	Guardianship information noted	0	0	0	
F2	Developmental history for children and adolescents	0	0	0	
SECTION F SCORE		0	0	0	
SECTION G: ADDENDUM FOR NCQA SITES ONLY		Y	N	Partial	Comments
G1	Records are stored securely	0	0	0	
G2	Only authorized personnel have access to records	0	0	0	
G3	Staff receive periodic training in confidentiality of member information	0	0	0	
G4	Treatment records are organized & stored to that allow easy retrieval	0	0	0	
G5	Treatment records are stored in a secured manner that allows access by authorized personnel only	0	0	0	
G6	Is provider aware of Manual authorization suppression	0	0	0	
G7	Does the provider submit claims electronically?	0	0	0	
G8	Is provider aware that appeals may be submitted electronically by either electronic fax or secure email?	0	0	0	
SECTION G SCORE		0	0	0	

PROVIDER NAME:		TOTALS			Comments/ Percentages
Date of Review:					
Enter an X in the respective column, one per row per record ↘		Y	N	Partial	Comments
SECTION H: CMC ADDENDUM (for BHIS required standards)		Y	N	Partial	Comments
H1	Quarterly consultation with practitioner that preformed assessment and/or practitioner providing ongoing therapy.	0	0	0	
H2	Documentation supports services are provided in a location that supports skill building goal. (ex. home, office, school, group home, outpatient hospital, FQHC, and CMHC)	0	0	0	
H3	Evidence that the CHI & CHI-C are being utilized as well as improvement noted.	0	0	0	
H4	Goals/objectives align with consumers Diagnosis/symptoms/day to day functional impairments	0	0	0	
H5	DC plan documented on the day of discharge (group care only)	0	0	0	
H6	Evidence of appropriate clinical supervision (for consumers reviewed)	0	0	0	
SECTION H SCORE		0	0	0	
OVERALL SCORE		0	0	0	
Clinical Practice Guideline Review (If Applicable)					
CPG 1: Major Depression (296.2 or 296.3)		Y	N	Partial	Comments
1A	The provider found sufficient evidence to support the diagnosis of MDD by assessing for medical conditions that may cause depression and/or complicate the treatment	0	0	0	
1B	The provider delivered education about MDD and its treatment to the patient, and if appropriate, to the family.	0	0	0	
1C	If psychotic features were found, the treatment plan includes the use of either antipsychotic medication or ECT, or clear documentation why not	0	0	0	
1D	If MDD was of moderate severity or above, the treatment plan uses a combination of psychotherapy and antidepressant medication, or clear documentation why not.	0	0	0	
1E	The psychiatrist delivered education about the medication, including signs of new or worsening suicidality and the high risk times for this side effect.	0	0	0	
1F	If provider is a non-M.D., there is documentation of a referral for a medical/psychiatric evaluation if any of the following are present: psychotic features, complicating medical/psychiatric conditions, severity level of moderate or above	0	0	0	
1G	If suicidal, access to any weapons or lethal means assessed	0	0	0	
OVERALL SCORE		0	0	0	

PROVIDER NAME:		TOTALS			Comments/ Percentages
Date of Review:					
Enter an X in the respective column, one per row per record ↘		Y	N	Partial	Comments
CPG 2: Schizophrenia – 295 Series		Y	N	Partial	Comments
2A	Assessment for other psychiatric disorders and medical conditions that may cause symptoms and/or complicate treatment	0	0	0	
2B	Delivered education re: schizophrenia and its treatment to the member & family	0	0	0	
2C	If significant risk was found, the provider implemented a plan to manage the risk which included a plan for diminishing access to weapons/lethal means	0	0	0	
2D	If provider is a non-M.D., documentation of a referral for a psychiatric evaluation	0	0	0	
2E	If a psychiatric referral was made, the provider documented the results of that evaluation and any relevant adjustments to the treatment plan	0	0	0	
2F	If provider is an M.D., and if several unsuccessful med trials and/or severe suicidality, he/she considered ECT and/or clozapine	0	0	0	
OVERALL SCORE		0	0	0	
CPG 4: ADHD – 314		Y	N	Partial	Comments
4A	The provider found sufficient evidence to support the diagnosis of ADHD by utilizing a screening tool (e.g.--Connors rating scale) including documentation of information from caregivers (parents, daycare, school, work, other.—at least 2 different site sources, e.g. home and school, or home and daycare or daycare and school) Symptoms in assessment support diagnosis and not just rely upon screening tool	0	0	0	
4B	The provider delivered education about ADHD and its treatment (behavioral intervention, pharmacological intervention, family therapy, etc.) to the patient, and if applicable, to the family	0	0	0	
4C	Evidence of pharmacological intervention if appropriate	0	0	0	
4D	Provider is non-prescriber, there is documentation of a referral for a medical/psychiatric evaluation	0	0	0	
4E	Evidence of continued assessment of treatment benefit and/or barriers to progress. Additional diagnoses identified are incorporated into treatment plan with appropriate referrals	0	0	0	
4F	Evidence of collaboration of care between family, school, medical and other treatment providers	0	0	0	

PROVIDER NAME:	TOTALS			Comments/ Percentages
Date of Review:				
Enter an X in the respective column, one per row per record	Y	N	Partial	Comments
OVERALL SCORE	0	0	0	

PROVIDER NAME:	TOTALS			Comments/ Percentages
Date of Review:				
Enter an X in the respective column, one per row per record	Y	N	Partial	Comments
CORRECTIVE ACTION PLAN (if applicable)				
TECHNICAL ASSISTANCE (if applicable)				
Claims:				
No issues noted. It is a requirement that file documentation be consistent with Iowa Plan claims data. Inconsistencies found during this review will be referred to the Magellan corporate Recovery unit. You will be receiving notice from the Recovery unit regarding necessary repayment. Please do not send any repayment at this time, but instead, wait for that request.				

PROVIDER NAME:		**TOTALS**		
Date of Review:				
Enter an X in the respective column, one per row per record ⇘		**Y**	**N**	**Partial**
SECTION A: GENERAL				
A1	Record is legible	**0**	**0**	**0**
A2	Consumer full name on every page in the record. Full name/DOB/ ID number noted on one page in the record	**0**	**0**	**0**
A3	Entries are dated & signed by appropriately credentialed provider	**0**	**0**	**0**
A4	Record contains relevant demographic info including address, employer/school, phone, emergency contact, marital status	**0**	**0**	**0**
SECTION A SCORE		**0**	**0**	**0**
SECTION B: CONSUMER RIGHTS & CONFIDENTIALITY **(Note:** 'Yes' for parent/guardian signature for minor)		**Y**	**N**	**Partial**
B1	Signed treatment consent form or refusal documented	**0**	**0**	**0**
B2	Patient Bill of Rights signed or refusal documented	**0**	**0**	**0**
B3	Psych advance directives or refusal documented	**0**	**0**	**0**
B4	Informed consent for meds signed or refusal documented	**0**	**0**	**0**
B5	Appropriate releases for communication w/PCP & other provs signed or patient refusal documented	**0**	**0**	**0**
SECTION B SCORE		**0**	**0**	**0**

PROVIDER NAME:		TOTALS		
Date of Review:				
Enter an X in the respective column, one per row per record ⇘		Y	N	Partial
SECTION C: INITIAL EVALUATION		Y	N	Partial
C1	Presenting problem and mental status exam	0	0	0
C2	DSM-IV diagnosis (5 axis)	0	0	0
C3	History & symptomology consistent w/DSM-IV criteria	0	0	0
C4	Psychiatric history	0	0	0
C5	Co-morbid substance induced disorder assessed	0	0	0
C6	Current and past suicide/danger risk assessed	0	0	0
C7	Assess of consumer strengths, skills, abilities, motivation etc.	0	0	0
C8	Level of familial/supports assessed and involved as indicated	0	0	0
C9	Consumer ID'd areas for improvement/outcomes documented	0	0	0
C10	Medical history	0	0	0
C11	Exploration of allergies and adverse reactions	0	0	0
C12	All current medications w/dosages	0	0	0
C13	Discussion of d/c planning/linkage to next level	0	0	0
SECTION C SCORE		0	0	0

PROVIDER NAME:		TOTALS		
Date of Review:				
Enter an X in the respective column, one per row per record ⇘		Y	N	Partial
SECTION D: INDIVIDUALIZED TREATMENT PLAN		Y	N	Partial
D1	Individualized strengths based treatment plan is current	0	0	0
D2	Measurable goals/objectives documented	0	0	0
D3	Goals/objectives have timeframes for achievement	0	0	0
D4	Goals/objectives align w/consumer identified areas for improvement/outcomes	0	0	0
D5	Use of preventive/ancillary services incl. community & peer supports considered	0	0	0
D6	Crisis plan documented	0	0	0
SECTION D SCORE		0	0	0
SECTION E: ONGOING TREATMENT		Y	N	Partial
E1	Documentation substantiates treatment at the current level of care	0	0	0
E2	Progress towards measurable consumer identified goals & outcomes evidenced. If not, barriers are being addressed.	0	0	0
E3	Clinical findings & evaluation for each visit documented	0	0	0
E4	Substance use assessment is current/ongoing	0	0	0
E5	Suicide/risk assessment is current/ongoing	0	0	0
E6	Medications are current	0	0	0

PROVIDER NAME:		TOTALS		
Date of Review:				
Enter an X in the respective column, one per row per record ⇘		Y	N	Partial
E7	Evidence of treatment being provided in a culturally competent manner	0	0	0
E8	Family/support systems contacted/involved as appropriate/feasible	0	0	0
E9	Ancillary/preventive services considered, used & coordinated as indicated	0	0	0
E10	Discharge planning/linkage to next level of care is occurring (d/c plan documented)	0	0	0
E11	Discharge plan has been implemented	0	0	0
SECTION E SCORE		0	0	0
SECTION F: ADDENDUM FOR SPECIAL POPULATIONS		Y	N	Partial
F1	Guardianship information noted	0	0	0
F2	Developmental history for children and adolescents	0	0	0
SECTION F SCORE		0	0	0
SECTION G: ADDENDUM FOR NCQA SITES ONLY		Y	N	Partial
G1	Records are stored securely	0	0	0
G2	Only authorized personnel have access to records	0	0	0
G3	Staff receive periodic training in confidentiality of member information	0	0	0

PROVIDER NAME:		**TOTALS**		
Date of Review:				
Enter an X in the respective column, one per row per record ⇘		**Y**	**N**	**Partial**
G4	Treatment records are organized & stored to that allow easy retrieval	**0**	**0**	**0**
G5	Treatment records are stored in a secured manner that allows access by authorized personnel only	**0**	**0**	**0**
G6	Is provider aware of Manual authorization suppression	**0**	**0**	**0**
G7	Does the provider submit claims electronically?	**0**	**0**	**0**
G8	Is provider aware that appeals may be submitted electronically by either electronic fax or secure email?	**0**	**0**	**0**
SECTION G SCORE		**0**	**0**	**0**
SECTION H: CMC ADDENDUM (For BHIS Required Standards)		**Y**	**N**	**Partial**
Is this a BHIS Record?		**0**	**0**	**0**
Is this a BHIS Group Home Discharge Record?		**0**	**0**	**0**
H1	Quarterly consultation with practitioner that preformed assessment and/or practitioner providing ongoing therapy.	**0**	**0**	**0**
H2	Documentation supports services are provided in a location that supports skill building goal. (ex. home, office, school, group home, outpatient hospital, FQHC, and CMHC)	**0**	**0**	**0**
H3	Evidence that the CHI & CHI-C are being utilized as well as improvement noted.	**0**	**0**	**0**

PROVIDER NAME:		TOTALS		
Date of Review:				
Enter an X in the respective column, one per row per record ⇘		Y	N	Partial
H4	Goals/objectives align with consumers Diagnosis/symptoms/day to day functional impairments	0	0	0
H5	DC plan documented on the day of discharge (group care only)	0	0	0
H6	Evidence of appropriate clinical supervision (for consumers reviewed)	0	0	0
SECTION H SCORE		0	0	0
OVERALL SCORE		0	0	0
Clinical Practice Guideline Review (If Applicable)				
CPG 1: Major Depression (296.2 or 296.3)		Y	N	Partial
1A	The provider found sufficient evidence to support the diagnosis of MDD by assessing for medical conditions that may cause depression and/or complicate the treatment	0	0	0
1B	The provider delivered education about MDD and its treatment to the patient, and if appropriate, to the family.	0	0	0
1C	If psychotic features were found, the treatment plan includes the use of either antipsychotic medication or ECT, or clear documentation why not	0	0	0

PROVIDER NAME:		TOTALS		
Date of Review:				
Enter an X in the respective column, one per row per record ⇘		Y	N	Partial
1D	If MDD was of moderate severity or above, the treatment plan uses a combination of psychotherapy and antidepressant medication, or clear documentation why not.	0	0	0
1E	The psychiatrist delivered education about the medication, including signs of new or worsening suicidality and the high risk times for this side effect.	0	0	0
1F	If provider is a non-M.D., there is documentation of a referral for a medical/psychiatric evaluation if any of the following are present: psychotic features, complicating medical/psychiatric conditions, severity level of moderate or above	0	0	0
1G	If suicidal, access to any weapons or lethal means assessed	0	0	0
OVERALL SCORE		0	0	0
CPG 2: Schizophrenia – 295 Series		Y	N	Partial
2A	Assessment for other psychiatric disorders and medical conditions that may cause symptoms and/or complicate treatment	0	0	0
2B	Delivered education re: schizophrenia and its treatment to the member & family	0	0	0
2C	If significant risk was found, the provider implemented a plan to manage the risk which included a plan for diminishing access to weapons/lethal means	0	0	0

PROVIDER NAME:		TOTALS		
Date of Review:				
Enter an X in the respective column, one per row per record ⇘		Y	N	Partial
2D	If provider is a non-M.D., documentation of a referral for a psychiatric evaluation	0	0	0
2E	If a psychiatric referral was made, the provider documented the results of that evaluation and any relevant adjustments to the treatment plan	0	0	0
2F	If provider is an M.D., and if several unsuccessful med trials and/or severe suicidality, he/she considered ECT and/or clozapine	0	0	0
OVERALL SCORE		0	0	0
CPG 4: ADHD – 314		Y	N	Partial
4A	The provider found sufficient evidence to support the diagnosis of ADHD by utilizing a screening tool (e.g.--Connors rating scale) including documentation of information from caregivers (parents, daycare, school, work, other.—at least 2 different site sources, e.g. home and school, or home and daycare or daycare and school) Symptoms in assessment support diagnosis and not just rely upon screening tool	0	0	0
4B	The provider delivered education about ADHD and its treatment (behavioral intervention, pharmacological intervention, family therapy, etc.) to the patient, and if applicable, to the family	0	0	0
4C	Evidence of pharmacological intervention if appropriate	0	0	0

PROVIDER NAME:		TOTALS		
Date of Review:				
Enter an X in the respective column, one per row per record ⇲		Y	N	Partial
4D	Provider is non-prescriber, there is documentation of a referral for a medical/psychiatric evaluation	0	0	0
4E	Evidence of continued assessment of treatment benefit and/or barriers to progress. Additional diagnoses identified are incorporated into treatment plan with appropriate referrals	0	0	0
4F	Evidence of collaboration of care between family, school, medical and other treatment providers	0	0	0
OVERALL SCORE		0	0	0

	AUDIT STANDARD	EXPLANATION/INSTRUCTIONS
SECTION A: GENERAL		
A1	Record is legible	* Record is generally readable, understandable * No partial scoring
A2	Consumer full name noted on each page of record. Full name/DOB/ID number on one page in the record	* Consumer full name is noted on each page. Full name/DOB/ID number on one page in the record. * No partial scoring
A3	Entries are dated & signed by appropriately credentialed prov	*All entries are dated and signed by a provider whose credentials are appropriate for providing care at the approved * No partial scoring
A4	Record contains relevant demographic info including address, employer/school, phone, emergency contact, marital status	* All relevant items including address, employer/school, phone, emergency contact, marital/legal status, living circumstances must be present. * Score as partial and comment if key items are missing
SECTION B: CONSUMER RIGHTS & CONFIDENTIALITY		
B1	Treatment consent form signed or refusal documented	* Current consent forms, in the approved and proper format, are signed and available in the record. If no, notes indicate that signing of the consent forms was discussed and the consumer's refusal is documented. * No partial scoring
B2	Patient Bill of Rights signed or refusal documented	*Current Pt Bill of Rights, in the approved and proper format, are signed and available in the record. If no, notes indicate that signing of the Pt Bill of Rights was discussed and the consumer's refusal is documented. * No partial scoring
B3	Psych advance directives or refusal documented	* Current psychiatric advance directives, in the approved and proper format, are signed and available in the record. If no, notes indicate that signing of psychiatric advance directives was discussed and the consumer's refusal is documented. * No partial scoring
B4	Informed consent for meds signed or refusal documented	* Current informed consent for meds form, in the approved and proper format, are signed and available in the record. If no, notes indicate that signing of informed consent for meds form was discussed and the consumer's refusal is documented. * Record indicates education re: meds was provided * Check Yes and insert "NA" in the comment cell if consumer has not using meds * No partial scoring
B5	Release(s) for communication w/PCP & other provs signed or patient refusal documented	* Current release(s) for communication w/PCP & other provs, in the approved and proper format, are signed and available in the record. If no, notes indicate that signing of release(s) for communication w/PCP & other provs was discussed and the consumer's refusal is documented. * No partial scoring
SECTION C: INITIAL EVALUATION		

	AUDIT STANDARD	EXPLANATION/INSTRUCTIONS
C1	Presenting problem and mental status exam	* All aspects of presenting problem and mental status evaluation, along w/relevant psychological and social conditions affecting medical and psychiatric status, are documented. * Mental status exam includes assessment of usual items such as: affect, speech, mood, thought content, judgment, insight, attention/concentration, memory, impulse control * No partial scoring. Both items must be present for credit
C2	DSM diagnosis (5 axis)	* A current 5 axis DSM diagnosis is documented. * Score as partial and comment if any axis is missing.
C3	History & symptomology consistent w/DSM-IV criteria	* DSM diagnosis is consistent with the presenting problems, mental status exam, history, other assessment data. * Score as partial if documentation exists but it does not support the DSM diagnosis.
C4	Psychiatric history	* History includes relevant previous providers, interventions, family info and treatment dates * Score as partial and comment if any of the above items are missing
C5	Co-morbid substance induced disorder assessed	* Documentation contains a thorough substance abuse assessment that includes: * past history of substance use * a description of past SA treatment and outcome * For members age ≥12, an SA evaluation is completed including nicotine, caffeine, alcohol as well as illicit misuse of prescribed and over-the-counter drugs. * No partial scoring
C6	Current and past suicide/danger risk assessed	* Past and current hx of suicidal ideation, gesture, plan or attempt explored and documented. * Risk factors in a suicide assessment may include exploration of: gender ID d/o in teens, advanced age/debilitating illness/gender in seniors, insomnia, substance use/abuse, anxiety, recent IP D/C and/or hx of violence. * No partial scoring
C7	Assess of consumer strengths, skills, abilities, motivation etc.	* Assessment considers inner strengths and social conditions, talents, skills, abilities, preferences, achievements and level of motivation * Assessment of consumer strengths is written from the perspective of the consumer and focuses on how the consumer identifies and views his/her own strengths * Score as partial and comment if key assessment elements are lacking
C8	Level of familial/supports assessed and involved as indicated	* Family and other external supports explored and either considered or included in treatment as indicated. * No partial scoring
C9	Consumer ID'd areas for improvement/outcomes documented	* Provider explored consumer identified areas for improvement and consumer-identified desired outcomes. * Both items must be present for credit

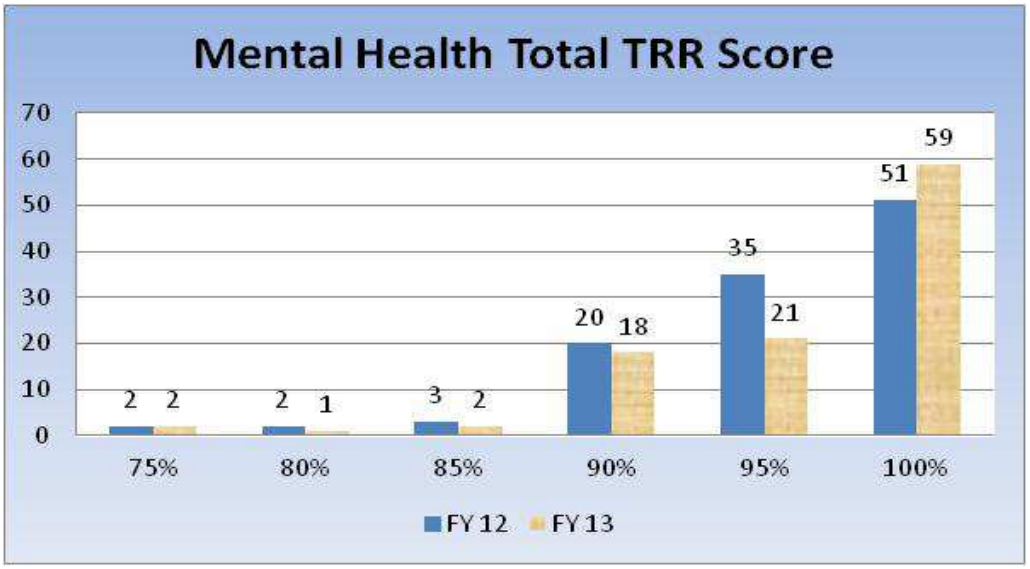
	AUDIT STANDARD	EXPLANATION/INSTRUCTIONS
C10	Medical history	* History includes relevant medical conditions, current providers, relevant past providers and special needs as indicated. * Score as partial and comment if any of the above items are missing
C11	Exploration of allergies and adverse reactions	* Allergies and adverse reactions - or, no known allergies (NKA) or sensitivities - to foods, drugs and other substances documented * No partial scoring
C12	All current medications w/dosages	* Current medications including dosages, relevant dates documented for all prescribed and over the- counter medications. * Changes in medication type and dosage are noted along w/date and rationale * Score as partial and comment if any of the above items are missing
C13	Discussion of d/c planning/linkage to next level	* Documentation indicates discharge plans, or plans for linkage to the next level of care leading to discharge, were considered and discussed with the consumer * No partial scoring
SECTION D: INDIVIDUALIZED TREATMENT		
D1	Individualized strengths-based treatment plan is current	* An up-to-date, strengths-based plan that is consistent w/the consumer's diagnosis, situation and progress is present. * Documentation indicates consumer involvement in, and agreement with, individualized treatment planning * Described interventions consistent with treatment plan goals. * Documentation indicates regular review of the plan w/changes as the consumer progresses. * Record demonstrates concepts relating to recovery and resiliency such as the incorporating of strengths and resiliency factors in the treatment plan and the consistent empowering of the member to achieve mastery, competence and hope * Score as partial and comment if any of the above items are missing
D2	Measurable goals/objectives documented	* All goals/objectives are worded in terms that are measurable and quantifiable * Goals align w/consumer identified areas for improvement and outcomes * Goals reflect the member's hopes, dreams, and recovery vision while emphasizing increased quality of life and involvement in meaningful community activities, including goals related to living, learning, working, and social connectedness. * No partial scoring
D3	Goals/objectives have timeframes for achievement	* All goals/objectives have reasonable, estimated time frames for attainment or problem resolution * No partial scoring

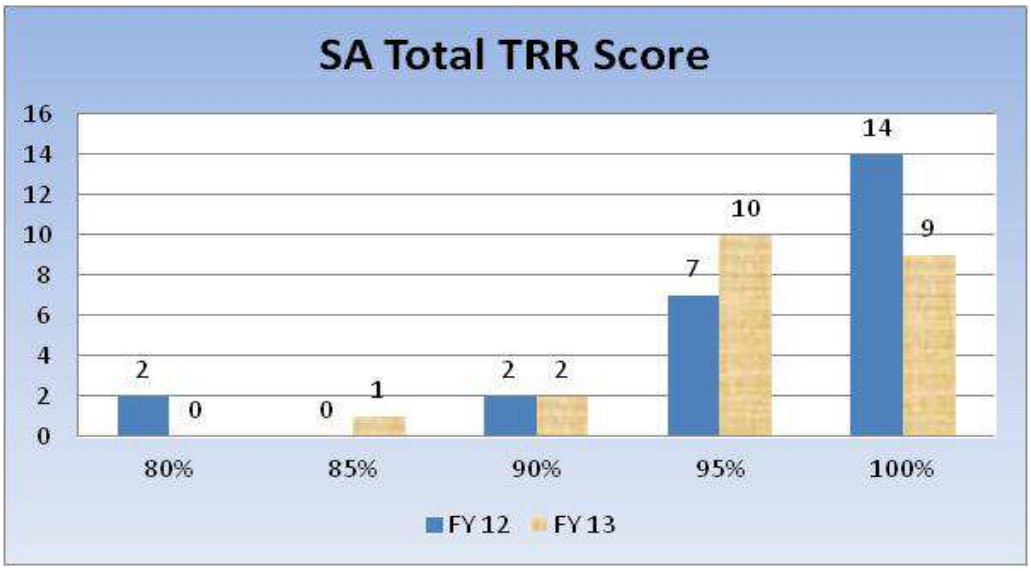
	AUDIT STANDARD	EXPLANATION/INSTRUCTIONS
D4	Goals/objectives align w/consumer identified areas for improvement/outcomes	* Documentation clearly indicates consumer participation in the development and endorsement of treatment plan and plan goals/objectives and timeframes * No partial scoring
D5	Preventive/ancillary services incl. community & peer supports considered	* Documentation indicates discussion w/consumer included exploration/consideration of relevant ancillary services including, but not limited to, community supports, peer supports and preventive services * Score as partial and comment if discussion occurred, but not all relevant ancillary services were considered
D6	Crisis plan documented	* Crisis plan developed with member's input * No partial scoring
SECTION E: ONGOING TREATMENT		
E1	Documentation substantiates treatment at the current level of care	* Documentation clearly supports the consumer's level of care. * No partial scoring
E2	Progress towards measurable consumer identified goals & outcomes evidenced. If not, barriers are being addressed.	* Documentation indicates clear and measurable progress towards goals/objectives and consumer identified outcomes. * Adjustments to the treatment plan are made as a results of review and progress * If no, barriers and reasons for delays were addressed and rectified. * No partial scoring
E3	Clinical assessments & intervention evaluation for each visit documented	* Findings and outcomes for each session are documented * No partial scoring
E4	Complete substance use assessment is current/ongoing	* Relapse or new substance use is being monitored * Score as Yes and comment if this question is not applicable for the consumer/chart in question. * No partial scoring
E5	Suicide/risk assessment is current/ongoing	* Ongoing suicide/risk assessment being conducted as appropriate * Members who become homicidal, suicidal, or unable to conduct activities of daily living, are referred to appropriate level of care * No partial scoring
E6	Medications are current	* Ongoing monitoring of medication effectiveness is occurring * Ongoing monitoring for potential side effects is occurring * Changes in medication type and dosage are noted along w/date and rationale * Score as partial and comment if any of the above items are missing

	AUDIT STANDARD	EXPLANATION/INSTRUCTIONS
E7	Evidence of treatment being provided in a culturally competent manner	* Record clearly demonstrates consideration/assessment of member's language and religious and cultural preferences * There is clear indication that treatment is provided in the consumer's preferred language. * Plans reflect sensitivity to, and are appropriate for, the consumer's language and culture * Score as partial and comment if any of the above items are missing
E8	Family/support systems contacted/involved as appropriate/feasible	* Available family and support systems were explored * If the consumer agrees, provider engaged available family and support systems * No partial scoring *For PMIC level, two family contacts per month are documented.
E9	Ancillary/preventive services considered, used & coordinated as indicated	* Ancillary and preventive services considered throughout the course of treatment. Services include, but not limited to PCPs, other providers, care managers, peer service, culturally preferred services, prevention programs, etc. * Once determined, appropriate releases are obtained and communication is established, care is coordinated as appropriate * Score as partial and comment if any of the above items are missing
E10	Discharge planning/linkage to next level of care is occurring	* Evidence of ongoing discussion of progress towards discharge linkage to the next level of care leading to discharge. * No partial scoring
SECTION F: ADDENDUM FOR SPECIAL POPULATIONS		
F1	Guardianship information noted	* The relationship between the child and the adult responsible for his/her day-to-day care is clearly explained. * If the guardian is not the biological parent, the role of the biological parent in the child's life is explained. * Record contains complete contact information for the guardian * Score as partial and comment if any of the above items are missing * Score as Yes and comment if the consumer is not a child
F2	Developmental history for children and adolescents	* Development history for children and adolescents, including prenatal and perinatal events, are documented * Score as partial and comment if any of the above items are missing * Score as Yes and comment if the consumer is not a child
SECTION G: RECORD STORAGE		The following audit standards only need to be completed once for each provider/site
G1	Records are stored securely	* Records are stored securely * No partial scoring
G2	Only authorized personnel have access to records	* Only authorized personnel have access to records * No partial scoring
G3	Staff receive periodic training in confidentiality of member information	* Staff receive periodic training in confidentiality of member information * No partial scoring

	AUDIT STANDARD	EXPLANATION/INSTRUCTIONS
G4	Treatment records are organized & stored to that allow easy retrieval	* Treatment records are organized & stored to that allow easy retrieval * No partial scoring
G5	Treatment records are stored in a secured manner that allows access by authorized personnel only	* Treatment records are stored in a secured manner that allows access by authorized personnel only * No partial scoring
G6	Electronic Claims submitted	*Electronic claims being submitted * No partial scoring
SECTION H: CMC ADDENDUM (for BHIS required Standards)		
H1	Quarterly consultation with practitioner that preformed assessment and/or practitioner providing ongoing therapy.	*Evidence that provider is consulting with practitioner that preformed the assessment and/or the practitioner that is providing ongoing therapy. * No partial scoring
H2	Documentation supports services are provided in a location that supports skill building goal. (ex. home, office, school, group home, outpatient hospital, FQHC, and CMHC)	*Evidence that services are provided in locations that support skill building treatment goals. * No partial scoring
H3	Evidence that the CHI & CHI-C are being utilized as well as improvement noted.	* Evidence that the CHI/CHI-C or another outcomes tool is being utilized and improvement is noted. *No partial scoring
H4	Goals/objectives align with consumers Diagnosis/symptoms/day to day functional impairments	*Goals/objectives must align with consumers Dx/symptoms/day to day functional impairments. *No partial scoring
H5	DC plan documented on the day of discharge (group care only)	*Discharge planning must be documented on the day of discharge from a group setting. * No partial scoring
H6	Evidence of appropriate clinical supervision (for consumers reviewed)	* There must be written supervision notes with minimum of 4 hours per month. * No partial scoring

Treatment Record Review Results





CAP Put in Place from January 2012 to present

Row Labels	closed	In Network	Pending	Referred to MFCU	RNCC	Grand Total
BHIS		8	10		2	20
CMHC	1	1				2
OUTPATIEN		1				1
FSAT	1	1	19	1	2	24
Group/Agen		5	7		2	14
Individual/Group/Agenc			4			4
Grand Total	**2**	**16**	**40**	**1**	**6**	**65**

88.9% of providers who were placed under a corrective action plan achieved improve scores at the time of their follow-up visit.

Two providers were closed, one remains under investigation

Six providers are under review by the RNCC

R. Monthly Report of Paid Claims by Month of Incurral

Lag Study Report

Reporting Claims Dollars

April 2006 - December 2007

Report ID : CLWO0061A
Run Date : 03/19/2008
Run Time : 07:49:07 PM

Reporting Group: This field would indicate which required breakout is being displayed below - in or out of network; sub-group of population or benefit plan, etc.

All Levels Of Care

	Service Month																						
Paid Month	**04/2006**	**05/2006**	**06**	**/2006**	**07/2006**	**08/2006**	**09/2006**	**10/2006**	**11/2006**	**12/2006**	**01/2007**	**02/2007**	**03/2007**	**04/2007**	**05/2007**	**06/2007**	**07/2007**	**08/2007**	**09/2007**	**10/2007**	**11/2007**	**12/2007**	**Totals**
04/2006	$31,532	$0	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$31,532
05/2006	$119,955	$30,365	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$150,320
06/2006	$57,712	$159,904	$4	0,640	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$258,256
07/2006	$15,616	$42,696	$14	3,612	$29,603	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$231,528
08/2006	$18,986	$48,135	$4	2,807	$122,778	$31,965	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$264,671
09/2006	$13,775	$37,694	$3	0,209	$49,576	$160,727	$29,958	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$321,940
10/2006	$8,945	$11,134	$	8,030	$19,060	$54,845	$144,477	$37,778	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$284,268
11/2006	$2,244	$6,959	$	6,931	$11,275	$25,531	$36,416	$131,533	$15,959	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$236,848
12/2006	$3,382	$8,168	$	6,219	$8,205	$17,997	$29,000	$71,710	$154,527	$25,513	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$324,722
01/2007	$1,491	$2,556	$	3,107	$3,435	$7,347	$11,620	$56,136	$54,196	$120,346	$23,086	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$283,320
02/2007	$2,153	$5,665	$	6,529	$5,161	$4,053	$7,966	$13,619	$27,249	$39,030	$110,035	$19,619	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$241,080
03/2007	$1,981	$2,430	$	2,381	$3,170	$3,068	$3,267	$8,292	$12,814	$23,391	$66,533	$131,138	$47,467	$0	$0	$0	$0	$0	$0	$0	$0	$0	$305,932
04/2007	$1,394	$1,065	$	1,655	$1,737	$4,110	$4,000	$4,384	$5,435	$6,479	$17,737	$34,470	$117,761	$28,287	$0	$0	$0	$0	$0	$0	$0	$0	$228,513
05/2007	$965	$1,325	$882		$894	$1,369	$1,418	$3,381	$6,031	$3,987	$11,002	$22,241	$43,774	$121,566	$26,146	$0	$0	$0	$0	$0	$0	$0	$244,981
06/2007	$1,597	$1,355	$	1,306	$1,063	$652	-$2,273	$2,387	$2,483	$3,720	$5,673	$9,191	$24,079	$43,195	$139,480	$53,893	$0	$0	$0	$0	$0	$0	$287,800
07/2007	$316	$1,088	$273		$469	$692	$668	$2,382	$1,528	$1,511	$4,027	$4,529	$6,208	$13,717	$35,975	$100,816	$17,569	$0	$0	$0	$0	$0	$191,765
08/2007	$0	$165	$712		$604	$1,550	$742	$1,008	$3,675	$3,999	$3,561	$4,670	$8,278	$13,030	$32,680	$50,172	$118,382	$41,618	$0	$0	$0	$0	$284,846
09/2007	$134	$100	$0		$0	$0	$216	$0	$710	$3,492	$1,596	$1,879	$3,572	$7,389	$10,714	$18,611	$32,112	$121,066	$27,858	$0	$0	$0	$229,448
10/2007	$180	$432	$332		$0	$569	$2,736	$3,155	$3,659	$2,398	$5,596	$2,721	$5,103	$5,148	$9,098	$11,898	$16,401	$52,025	$112,879	$34,562	$0	$0	$268,891
11/2007	$380	$960	$	1,080	$1,125	$2,020	$580	$680	$600	$400	$2,010	$3,790	$4,304	$15,413	$11,400	$6,636	$9,362	$20,042	$45,002	$134,416	$25,457	$0	$285,658
12/2007	$0	$0	$	1,825	$136	$888	$496	$1,088	$856	$662	$2,604	$3,152	$2,195	$1,495	$2,837	$3,298	$5,195	$13,586	$13,866	$47,413	$103,975	$26,479	$232,046
Totals	$282,739	$362,196	$29	8,529	$258,290	$317,382	$271,287	$337,533	$289,721	$234,928	$253,460	$237,401	$262,741	$249,238	$268,328	$245,324	$199,022	$248,338	$199,605	$216,390	$129,432	$26,479	$5,188,365

S. Detailed Claim File Data

Claim Extract/Repricing File Layout and Supporting Documentation

Internal Version

Standard "Header" Record Technical Specifications

	Field Layout Information						
Fld #	Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	Description
1	Record Type	1	1	1		A	H = Header Record Header Record will always count as 1 record on file
2	Filler Unused	2	16	15		A	Blank Fill
3	Company Name	17	41	25		A	Magellan/NIA/iCore
4	Creation Date	42	49	8	0	N	CCYYMMDD
5	Filler Unused	50	50	1		A	Blank Fill
6	Frequency	51	51	1	A		Frequency: B = Biweekly W = Weekly M = Monthly S = Semi Annually A = Annually Q = Quarterly D = Daily (Define)
7	Company Control Code	52	56	5		A	Retrieve from CMLEMP
8	Filler	57	800	744	A		Blank Fill

Standard Claims Format "Detail"
Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	R/S	Field Justification	Description	Magellan File Name	Magellan Field Name	Translation Specifications
Claim #	1	9	9	0	N		RJZF	Number that identifies a specific claim.	CLAIMS	CMLCL#	
Claim Line #	10	12	3	0	N		RJZF	Sequential number assigned to a	CLAIMS	CMLLN#	
Replacement Claim #	13	21	9	0	N		RJZF	Replacement Claim #	CLAIMS	CMLRPC	Note: if CMLRPC is populated without a CMLRPL value, then the line is not specifically replacing any line – it's a newly added line (either to add data that was missing the first time or to split the previously line accordingly).
Replacement Line #	22	24	3	0	N		RJZF	Replacement Line#	CLAIMS	CMLRPL	
Plan	25	31	7		A		LJBF	Plan Code as assigned by Magellan	CLAIMS	CMLPLN	
Division	32	36	5		A		LJBF	Division Code as assigned by Magellan	CLAIMS	CMLDIV	
DOS From	37	44	8	0	N		RJZF	Starting Date-Of-Service CCYYMMDD	CLAIMS	CMLFDT	
DOS Thru	45	52	8	0	N		RJZF	Ending Date-Of-Service CCYYMMDD	CLAIMS	CMLTDT	
Admission Date/Confinement Date	53	60	8	0	N	S	RJZF	Date patient was admitted for service. CCYYMMDD	MTBILL CLAIMS	MTADDT CMLNDT	Using CLAIMS/CMLSSN and CLAIMS/CMLCL#, chain to MTBILL/MTMBR# and MTBILL/MTCLM# respectively. If record found retrieve MTBILL/MTADDT and out put to field. If MTADDR blank or no match made, then output value in CLAIMS/CMLNDT. If CMLNDT is blank, use earliest CMLFDT and output this field + system time (HHMM) of CLAIMS file.
Discharge Status Code	61	62	2		A	S	LJBF	Discharge Status Code	CLAIMS MTBILL	CMLDST MTSTAT	If the Admission Date contains data, retrieve and move CLAIMS/CMLDST, otherwise using CLAIMS/CMLSSN and CLAIMS/CMLCL#, chain to MTBILL/MTMBR# and MTBILL/MTCLM# and ouput MTBILL/MTSTAT.
Claim Denied Date	63	70	8	0	N		RJZF	Date the claim was denied CCYYMMDD	CLAIMS	CMLLSD	If blank move 0 (Zeros)
Claim Check Date	71	78	8	0	N		RJZF	The date the claim was paid. CCYYMMDD	CLAIMS	CMLCDT	If blank move 0 (Zeros)
Provider Check No.	79	85	7	0	N		RJZF	Provider Check No.	CLAIMS	CMLPCK	Select only if CMLPPX = "C"
Provider Payment Amt	86	94	9	2	N		RJZF	Provider Payment Amt	CLAIMS	CMLPYP	Select only if CMLPPX = "C"

Standard Claims Format "Detail"
Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	R/S	Field Justification	Description	Magellan File Name	Magellan Field Name	Translation Specifications
Alternate Check No.	95	101	7	0	N		RJZF	Alternate Check No.	CLAIMS	CMLACK	Select only if CMLAPX = "C"
Alternate Payee Amt	102	110	9	2	N		RJZF	Alternate Payee Amt	CLAIMS	CMLAP$	Select only if CMLAPX = "C"
Member Check No.	111	117	7	0	N		RJZF	Member Check No.	CLAIMS	CMLMCK	Select only if CMLMPX = "C" and CMLDPX = ' '
Member Payment Amt	118	126	9	2	N		RJZF	Member Payment Amt	CLAIMS	CMLPYM	Select only if CMLMPX = "C" and CMLDPX = ' '
Dependent Check No.	127	133	7	0	N		RJZF	Dependent Check No.	CLAIMS	CMLDCK	Select only if CMLDPX = "C"
Dependent Payment	134	142	9	2	N		RJZF	Dependent Payment Amt.	CLAIMS	CMLDP$	Select only if CMLDPX = "C"
Billed Amt	143	151	9	2	N		RJZF	Billed Amt	CLAIMS	CMLAMT	
Allowed Amt	152	160	9	2	N		RJZF	Allowed/Eligible Amt. Liability after benefit limitation reductions and Provider Discount have been removed.	CLAIMS	CMLSUP	
Paid Amount	161	169	9	2	N		RJZF	Claim Payment Amount	CLAIMS	CMLPYD	
Deductible Amt	170	178	9	2	N		RJZF	Deductible Amount	CLAIMS	See Notes	Calculate: CMLBPD - CMLBVA
Coinsurance Amt	179	187	9	2	N		RJZF	Coinsurance Amount	CLAIMS	CMLBOP	
CoPay Amt	188	196	9	2	N		RJZF	Co-Payment Amount	CLAIMS	CMLBVA	
Provider Discount	197	205	9	2	N		RJZF	Provider Discount	CLAIMS	CMLPD$	
Not Covered - Insurance	206	214	9	2	N		RJZF	Claim Ln Not Covered Amt Due To Insurance Exclusions	CLAIMS	See Notes	Calculate: (CMLIA1 + CMLIA2 + CMLIA3 + CMLIA4 + CMLIA5 + CMLIA6)
Interest Penalty Amt	215	223	9	2	N		RJZF	Interest Penalty Amount	CLAIMS	CMLCPV	Note: Does not change to a negative on a claim reversal
COB Allowed	224	232	9	2	N		RJZF	COB Allowed	CLAIMS	CMLAWP	If CMLAWP or CMLCPM > 0 (zero), move value in CMLAWP; otherwise, move 0 (zeros).
OIC COB Amt Paid	233	241	9	2	N		RJZF	COB Amount Paid by Other Insurance Carrier (OIC)	CLAIMS	CMLCOP	If CMLAWP or CMLCPM > 0, move CMLCOP to this field; otherwise, move ' ' (spaces)
OIC Allowed Amt	242	250	9	2	N		RJZF	Other Carrier Allowed Amount	CLAIMS	CMLCPM	

Standard Claims Format "Detail"
Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
	Start	End	Fld		Char	R/S	Field		Magellan	Magellan	
Field Name	Pos	Pos	Len	Dec	Num		Justification	Description	File Name	Field Name	Translation Specifications
OIC Deductible	251	257	7	2	N		RJZF	Other Insurance Carrier Deductible	CLMCOB	CDED	If CMLAWP or CMLCPM > 0 (zero) do the following; otherwise, move 0 (zeros). Using CLAIMS/CMLCL#, CLAIMS/CMLLN# and CLAIMS/CMLCAR, chain to CLMCOB/CCL#, CLMCOB/CLN# and CLMCOB/CCOBC respectively. Retrieve CLMCOB/CDED.
OIC Copay	258	264	7	2	N		RJZF	Other Insurance Carrier Copay	CLMCOB	CCOPAY	If CMLAWP or CMLCPM > 0 (zero) do the following; otherwise, move 0 (zeros). Using CLAIMS/CMLCL#, CLAIMS/CMLLN# and CLAIMS/CMLCAR, chain to CLMCOB/CCL#, CLMCOB/CLN# and CLMCOB/CCOBC respectively. Retrieve CLMCOB/CCOPAY.
OIC Co-insurance	265	272	8	2	N		RJZF	Other Insurance Carrier Co-insurance	CLMCOB	CCOINS	If CMLAWP or CMLCPM > 0 (zero) do the following; otherwise, move 0 (zeros). Using CLAIMS/CMLCL#, CLAIMS/CMLLN# and CLAIMS/CMLCAR, chain to CLMCOB/CCL#, CLMCOB/CLN# and CLMCOB/CCOBC respectively. Retrieve CLMCOB/CCOINS.

Standard Claims Format "Detail"
Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
	Start	End	Fld		Char	R/S	Field		Magellan	Magellan	
Field Name	Pos	Pos	Len	Dec	Num		Justification	Description	File Name	Field Name	Translation Specifications
OIC Indicator	273	277	5		A		LJBF	OIC Indicator Medicare Type A = 1 Medicare Type B = 2 Medicare Types A and B = 3 Medicaid = 4 Group = 5 Individual = 6	DEPNDCOB	DCCOBC	If CMLAWP or CMLCPM > 0 (zero) do the following; otherwise, move 0 (zeros). Loop through all records in DEPNDCOB for Member using CLAIMS/CMLSSN and CLAIMS/CMLDEP to chain to equals DEPNDCOB/DCSSN and DEPNDCOB/DCDEP. If DCCOPS = "P", CMLFDT >= DCCOBS and CMLFDT <= DCCOBT, If DCCOBC field of DEPNDCOB file = 'MCREA', output '1', If DCCOBC field of DEPNDCOB file = 'MCREB', output '2' If DCCOBC field of DEPNDCOB file = 'MCARE, output '3' If DCCOBC field of DEPNDCOB file = 'MCAID', output '4' If DCCOBC field of DEPNDCOB file = 'GROUP', output '5' If DCCOBC field of DEPNDCOB file = 'INDIV", output '6' Else, leave blank.
Authorization Indicator	278	278	1		A		LJBF	Authorization Indicator. 'Y' or 'N'	PCTXRF	See Notes	Using CMLCL# and CMLLN# of the CLAIMS file, chain to PCTXRF table and match to their corresponding fields PCXCLM and PCXLIN respectively. Multiple occurrences could exist. Loop thru all occurrences found and retrieve a record that satisfies the following condition: If PCXSTA (Status) = " "(Spaces), and PCXMRD contains data set to "Y" else "N".
Number Of Units	279	281	3	0	N		RJZF	Total number of units	CLAIMS	CMLQTY	
Benefits In/Out Network Indicator	282	282	1		A		LJBF	Benefits In/Out Network Indicator. "Y" = benefits were paid at in-network "N" = benefits were paid at out-of-network (par provider) “C” = benefits were capitated “ “ (blank) = benefits were paid out-of-network (non-par provider)	CLAIMS	CMLPBF	This indicator defines how the claim line was paid. If "Y", benefits were paid at in-network If "N", benefits were paid at out-of-network (par provider) If “C”, benefits were capitated If “ “ (blank) benefits were paid out-of-network (non-par provider)

Standard Claims Format "Detail"
Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
	Start	End	Fld		Char	R/S	Field		Magellan	Magellan	
Field Name	Pos	Pos	Len	Dec	Num		Justification	Description	File Name	Field Name	Translation Specifications
Claim Line Status	283	283	1		A		LJBF	F = Paid D = Denied B = Paid/Adjusted C = Denied/Adjusted A = Reversal/Paid E = Reversal/Denied	CLAIMS	CML@F2	
Place of Service	284	286	3		A		LJBF	Place-Of-Service	CLAIMS	CMLPOS	
Revenue Code	287	290	4	0	N		RJZF	Revenue Code	MTBILLRV	MTRVCD	In professional claim, output blank. If institutional claim, Use CLAIMS/CMLSSN and CLAIMS/CMLCL# to chain to MTBILLRV/MTMBR# and MTBILLRV/MTCLM#. Find a match between CLAIMS/CMLSCD (if CMLSCD <> blanks), CLAIMS/CMLAMT, CLAIMS/CMLQTY and MTBILLRV/MTAHCP, MTBILLRV/MTCHRG and MTBILLRV/MTUNIT. IF match found, output MTBILLRV/MTRVCD.If no match then use CLAIMS/CMLSSN and CLAIMS/CMLCL# to chain to MTBILLRV/MTMBR# and MTBILLRV/MTCLM#. Find a match between CLAIMS/CMLSCD (if CMLSCD <> blanks), CLAIMS/CMLAMT, CLAIMS/CMLQTY and MTBILLRV/MTRVCD, MTBILLRV/MTCHRG and MTBILLRV/MTUNIT. IF match found output MTBILLRV/MTRVCD. If no match then use CLAIMS/CMLSSN and CLAIMS/CMLCL# to chain to MTBILLRRV/MTMBR# MTBILLRV/MTCLM#. Find a match between CLAIMS/CMLSCD (if CMLSCD <> blanks), and MTBILLRV/MTAHCP. IF match found, output MTBILLRV/MTRVCD. If no match then use CLAIMS/CMLSSN and CLAIMS/CMLCL# to chain to MTBILLRV/MTMBR# and MTBILLRV/MTCLM#. Find a match between CLAIMS/CMLSCD (if CMLSCD <> blanks), and MTBILLRV/MTRVCD and output MTBILLRV/MTRVCD.If no match, Use CLAIMS/CMLSSN and CLAIMS/CMLCL# to chain to MTBILLRV/MTMBR# and MTBILLRV/MTCLM#. If matching code not found, output first MTRVCD from listing below. 100, 101, 110, 111, 112, 113, 114, 116, 120, 121, 122, 123, 124, 126, 128, 130, 131, 132, 133, 134, 136, 140, 141, 142, 143, 144, 146, 150, 151, 152, 153, 154, 156, 200, 201, 202, 203, 204, 206, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 1001. Otherwise, output first MTRVCD from MTBILLRV

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Field Layout Information									Magellan Behavioral Health Translation Information		
Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	R/S	Field Justification	Description	Magellan File Name	Magellan Field Name	Translation Specifications
Primary Diag	291	295	5		A		LJBF	Primary Diagnosis Code	CLAIMS	CMLPDI	
2nd Diag	296	300	5		A		LJBF	Secondary Diagnosis Code	CLAIMS	CMLDG2	
3rd Diag Cd	301	305	5		A		LJBF	3rd Diagnosis Code	CLAIMS	CMLDG3	
4th Diag Cd	306	310	5		A		LJBF	4th Diagnosis Code	CLAIMS	CMLDG4	
Procedure Code	311	315	5		A		LJBF	Primary Procedure Code	CLAIMS	CMLSCD	
Procedure CD Modifier 1	316	320	5		A		LJBF	Procedure Code Modifier 1	CLAIMS	CMLMD1	
Procedure CD Modifier 2	321	325	5		A		LJBF	Procedure Code Modifier 2	CLAIMS	CMLMD2	
Procedure CD Modifier 3	326	330	5		A		LJBF	Procedure Code Modifier 3	CLAIMS	CMLMD3	
Procedure CD Modifier 4	331	335	5		A		LJBF	Procedure Code Modifier 4	CLAIMS	CMLSMD	
Denial Code #1	336	337	2		A		LJBF	Denial reason code. See examples in Exhibit B	CLAIMS	CMLPD1	Always verify correct denial descriptions for specific accounts with Claims Department.
Denial Code #2	338	339	2		A		LJBF	Denial reason code. See examples in Exhibit B	CLAIMS	CMLPD2	Always verify correct denial descriptions for specific accounts with Claims Department.
Denial Code #3	340	341	2		A		LJBF	Denial reason code. See examples in Exhibit B	CLAIMS	CMLPD3	Always verify correct denial descriptions for specific accounts with Claims Department.
Ineligible Code #1	342	343	2		A		LJBF	Reason for reduction See examples in Exhibit A	CLAIMS	CMLIR1	Always verify correct ineligible codes for specific accounts with Claims Department.
Ineligible Code #2	344	345	2		A		LJBF	Reason for reduction See examples in Exhibit A	CLAIMS	CMLIR2	Always verify correct ineligible codes for specific accounts with Claims Department.
Ineligible Code #3	346	347	2		A		LJBF	Reason for reduction See examples in Exhibit A	CLAIMS	CMLIR3	Always verify correct ineligible codes for specific accounts with Claims Department.
Ineligible Code #4	348	349	2		A		LJBF	Reason for reduction See examples in Exhibit A	CLAIMS	CMLIR4	Always verify correct ineligible codes for specific accounts with Claims Department.
Ineligible Code #5	350	351	2		A		LJBF	Reason for reduction See examples in Exhibit A	CLAIMS	CMLIR5	Always verify correct ineligible codes for specific accounts with Claims Department.
Ineligible Code #6	352	353	2		A		LJBF	Reason for reduction See examples in Exhibit A	CLAIMS	CMLIR6	Always verify correct ineligible codes for specific accounts with Claims Department.

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Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	R/S	Field Justification	Description	Magellan File Name	Magellan Field Name	Translation Specifications
Member (subscriber) ID	354	383	30		A		LJBF	Member's ID	ELPIDXRL25	ELPIDXRL25/DXALID	***Verify with Eligibility that the below ELPIDXRF values are correct for each client*** ***Use one the of the identifiers to determine what type of member ID will be pulled for this extract. Specify in each individual account's file layout which one they will be using.*** Use CLAIMS/CMLEMP, CLAIMS/CMLSSN, CLAIMS/CMLDEP = 01 to chain to ELPIDXRL25. Match to their corresponding fields ELPIDXRL25/DXGRID, ELPIDXRL25/DXMSSN, ELPIDXRL25/DXFUN. Use ELPIDXRL25/DXIDFR = appropriate id (1 = SSN, 2 = UMI, 3 = Client ID, 4 = Medicare #). Validate that CLAIMS/CMLFDT >= ELPIDXRL25/DXFRDT and CLAIMS/CMLFDT <= ELPIDXRL25/DXTHDT. If record found and ELPIDXRL25/DXALID is not blank, retrieve DXALID and output to field. Otherwise, Use CLAIMS/CMLEMP, CLAIMS/CMLSSN, CLAIMS/CMLDEP = 01 to chain to ELPIDXRL25. Match to their corresponding fields ELPIDXRL25/DXGRID, ELPIDXRL25/DXMSSN, ELPIDXRL25/DXFUN. Use ELPIDXRL25/DXIDFR = appropriate id (1 = SSN, 2 = UMI, 3 = Client ID, 4 = Medicare #). If record found and ELPIDXRL25/DXALID is not blank, output to field.
Member(subscriber) DOB	384	391	8	0	N		RJZF	Member Date-Of-Birth CCYYMMDD	DEPND	DEDOB	Use CLAIMS/CMLSSN to chain to DEPND/DEMSSN. If found, retrieve DEDOB and place into the output field.
Member Gender	392	392	1		A		LJBF	Member Gender	1) CLAIMS 2) MMAST	CMLSEX or MMSEX	If CMLSEX <> blank, output CMLSEX Otherwise, Using CMLSSN, match to MMAST/MMSSN. If a match can be found, retrieve and load MMSEX
Member (subscriber) First Name	393	407	15		A		LJBF	Member First Name	DEPND	DEFNAM	Use CLAIMS/CMLSSN to chain to DEPND/DEMSSN and DEPND/DEFUN = '01'. If found, retrieve DEFNAM and place into the output field.

Standard Claims Format "Detail"
Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	R/S	Field Justification	Description	Magellan File Name	Magellan Field Name	Translation Specifications
Member (subscriber) Last Name	408	432	25		A		LJBF	Member Last Name	DEPND	DELNAM	Use CLAIMS/CMLSSN to chain to DEPND/DEMSSN and DEPND/DEFUN = '01'. If found, retrieve DELNAM and place into the output field.
Member (subscriber) Suffix	433	436	4		A		LJBF	Member (subscriber) Suffix	DEPND	DESUFF	Use CLAIMS/CMLSSN to chain to DEPND/DEMSSN and DEPND/DEFUN = '01'. If found, retrieve DESUFF and place into the output field.
Member (subscriber) Middle Name	437	451	15		A		LJBF	Member (subscriber) Middle Name	DEPND	DEMIDD	Use CLAIMS/CMLSSN to chain to DEPND/DEMSSN and DEPND/DEFUN = '01'. If found, retrieve DEMIDD and place into the output field.
Member (subscriber) Address 1	452	486	35		A		LJBF	Member (subscriber) Address Line 1	MMAST	MMADD1	Using CMLSSN, match to MMAST/MMSSN. If a match can be found, retrieve and load MMADD1
Member (Subscriber) Address 2	487	521	35		A		LJBF	Member (subscriber) Address Line 2	MMAST	MMADD2	Using CMLSSN, match to MMAST/MMSSN. If a match can be found, retrieve and load MMADD2
Member (Subscriber) City	522	541	20		A		LJBF	Member (Subscriber) City	MMAST	MMCITY	Using CMLSSN, match to MMAST/MMSSN. If a match can be found, retrieve and load MMCITY
Member (Subscriber) State	542	543	2		A		LJBF	Member (Subscriber) State	MMAST	MMST	Using CMLSSN, match to MMAST/MMSSN. If a match can be found, retrieve and load MMST
Member (Subscriber) Zip Code	544	553	10		A		LJBF	Member (Subscriber) Zip	MMAST	MMZIP	Using CMLSSN, match to MMAST/MMSSN. If a match can be found, retrieve and load MMZIP
Member (Subscriber) Telephone No.	554	563	10		A		LJBF	Member (Subscriber) Telephone	MMAST	MMPHON	Using CMLSSN, match to MMAST/MMSSN. If a match can be found, retrieve and load MMPHON

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Field Layout Information									Magellan Behavioral Health Translation Information		
	Start	End	Fld		Char	R/S	Field		Magellan	Magellan	
Field Name	Pos	Pos	Len	Dec	Num		Justification	Description	File Name	Field Name	Translation Specifications
Patient Id	564	593	30		A		LJBF	Patient ID	ELPIDXRF	ELPIDXRL25/DXALID	***Verify with Eligibility that the below ELPIDXRF values are correct for each client*** ***Use one the of the identifiers to determine what type of member ID will be pulled for this extract. Specify in each individual account's file layout which one they will be using.*** Use CLAIMS/CMLEMP, CLAIMS/CMLSSN, CLAIMS/CMLDEP to chain to ELPIDXRL25. Match to their corresponding fields ELPIDXRL25/DXGRID, ELPIDXRL25/DXMSSN, ELPIDXRL25/DXFUN. Use ELPIDXRL25/DXIDFR = appropriate id (1 = SSN, 2 = UMI, 3 = Client ID, 4 = Medicare #). Validate that CLAIMS/CMLFDT >= ELPIDXRL25/DXFRDT and CLAIMS/CMLFDT <= ELPIDXRL25/DXTHDT. If record found and ELPIDXRL25/DXALID is not blank, retrieve DXALID and output to field. Otherwise, Use CLAIMS/CMLEMP, CLAIMS/CMLSSN, CLAIMS/CMLDEP to chain to ELPIDXRL25. Match to their corresponding fields ELPIDXRL25/DXGRID, ELPIDXRL25/DXMSSN, ELPIDXRL25/DXFUN. Use ELPIDXRL25/DXIDFR = appropriate id (1 = SSN, 2 = UMI, 3 = Client ID, 4 = Medicare #). If record found and ELPIDXRL25/DXALID is not blank, output to field.

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Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	R/S	Field Justification	Description	Magellan File Name	Magellan Field Name	Translation Specifications
Patient Relationship	594	594	1		A		LJBF	Pat Relationship M = Member S = Spouse C = Child	1) MMAST 2) DEPND 3) ELPIDXRF	1)MMAST/ 'M' 2) DEPND/DEREL 3) ELPIDXRL25/DXREL	If CLAIMS/CMLDEP = '01', use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, output 'M' If CLAIMS/CMLDEP <> '01', use CLAIMS/CMLSSN and CLAIMS/CMLDEP to chain to DEPND/DEMSSN and DEPND/DEFUN. Retrieve DEPND/DEREL and place into output field. "*Verify with Eligibility that the below ELPIDXRF values are correct for each client*** ***Use one of the identifiers to determine what type of member ID will be pulled for this extract. Specify in each individual account's file layout which one they will be using.*** Otherwise, use CLAIMS/CMLEMP, CLAIMS/CMLSSN, CLAIMS/CMLDEP to chain to ELPIDXRL25. Match to their corresponding fields ELPIDXRL25/DXGRID, ELPIDXRL25/DXMSSN, ELPIDXRL25/DXFUN. Use ELPIDXRL25/DXIDFR = appropriate id (1 = SSN, 2 = UMI, 3 = Client ID, 4 = Medicare #). Validate that CLAIMS/CMLFDT >= ELPIDXRL25/DXFRDT and CLAIMS/CMLFDT <= ELPIDXRL25/DXTHDT. If record found and ELPIDXRL25/DXREL is not blank, retrieve DXREL and output to field.
Patient DOB	595	602	8	0	N		RJZF	Pat Date-Of-Birth CCYYMMDD	DEPND	DEDOB	Use CLAIMS/CMLSSN and CLAIMS/CMLDEP to chain to DEPND/DEMSSN and DEPND/DEFUN. If found, retrieve DEPND/DEDOB and place into output field.
Patient Gender	603	603	1		A		LJBF	Patient Gender F = Female M = Male U = Unknown or Blank	CLAIMS	CMLSEX	If CMLSEX is Blank, use CLAIMS/CMLSSN and CLAIMS/CMLDEP to chain to DEPND/DEMSSN and DEPND/DEFUN. If found, retrieve DESEX and place into output field. Otherwise, if DESEX blank, output "U".
Patient First Name	604	618	15		A		LJBF	Patient First Name	DEPND	DEFNAM	use CLAIMS/CMLSSN and CLAIMS/CMLDEP to chain to DEPND/DEMSSN and DEPND/DEFUN. If found, retrieve DEPND/DEFNAM and place into output field.

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Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	R/S	Field Justification	Description	Magellan File Name	Magellan Field Name	Translation Specifications
Patient Last Name	619	643	25		A		LJBF	Patient Last Name	DEPND	DELNAM	uuse CLAIMS/CMLSSN and CLAIMS/CMLDEP to chain to DEPND/DEMSSN and DEPND/DEFUN. If found, retrieve DEPND/DELNAM and place into output field.
Patient Address Line 1	644	673	30		A		LJBF	Patient Address 1	1) DEPADR or 2)MMAST	1) DEPADR/DADAD1 or 2)MMAST/MMADD1	If CLAIMS/CMLDEP = '01', use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, retrieve MMADD1 and place into the output field. If CLAIMS/CMLDEP <> '01', use CLAIMS/CMLSSN and CLAIMS/CMLDEP to chain to DEPADR. If found, retrieve address type (DADTYP) = C and load DADAD1 . If address type C not found, search for address type = A. If found, load DADAD1. If CLAIMS/CMLDEP <> '01' AND not found in DEPADR, use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, retrieve MMADD1 and place into the output field.
Patient Address Line 2	674	703	30		A		LJBF	Patient Address 2	1) DEPADR or 2)MMAST	1) DEPADR/DADAD2 or 2)MMAST/MMADD2	If CLAIMS/CMLDEP = '01', use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, retrieve MMADD2 and place into the output field. If CLAIMS/CMLDEP <> '01', use CLAIMS/CMLSSN and CLAIMS/CMLDEP to chain to DEPADR. If found, retrieve address type (DADTYP) = C and load DADAD2. If address type C not found, search for address type = A. If found, load DADA2. If CLAIMS/CMLDEP <> '01' AND not found in DEPADR, use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, retrieve MMADD2 and place into the output field.
Patient City	704	723	20		A		LJBF	Patient City	1) DEPADR or 2)MMAST	1) DEPADR/DADCTY or 2)MMAST/MMCITY	If CLAIMS/CMLDEP = '01', use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, retrieve MMCITY and place into the output field. If CLAIMS/CMLDEP <> '01', use CLAIMS/CMLSSN and CLAIMS/CMLDEP to chain to DEPADR. If found, retrieve address type (DADTYP) = C and load DADCTY. If address type C not found, search for address type = A. If found, load DADCTY. If CMLDEP <> '01' AND not found in DEPADR, use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, retrieve MMCITY and place into the output field.

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Field Layout Information									Magellan Behavioral Health Translation Information		
Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	R/S	Field Justification	Description	Magellan File Name	Magellan Field Name	Translation Specifications
Patient State	724	725	2		A		LJBF	Patient State	1) DEPADR or 2)MMAST	1) DEPADR/DADSTA or 2)MMAST/MMST	If CLAIMS/CMLDEP = '01', use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, retrieve MMST and place into the output field. If CLAIMS/CMLDEP <> '01', use CLAIMS/CMLSSN and CLAIMS/CMLDEP to chain to DEPADR. If found, retrieve address type (DADTYP) = C and load DADSTA. If address type C not found, search for address type = A. If found, load DADSTA. If CMLDEP <> '01' AND not found in DEPADR, use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, retrieve MMST and place into the output field.
Patient Zip	726	735	10		A		LJBF	Patient Zip Code	1) DEPADR or 2)MMAST	1) DEPADR/DADZIP or 2)MMAST/MMZIP	If CLAIMS/CMLDEP = '01', use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, retrieve MMZIP and place into the output field. If CLAIMS/CMLDEP <> '01', use CLAIMS/CMLSSN and CLAIMS/CMLDEP to chain to DEPADR. If found, load DADZIP and place into the output field. If CLAIMS/CMLDEP <> '01' AND not found in DEPADR, use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, retrieve MMZIP and place into the output field.
Patient Home Phone	736	745	10		A		LJBF	Patient Home Phone	1) DEPADR or 2)MMAST	1) DEPADR/DADHAR + DEPADR/DADHPH or 2)MMAST/MMPHON	If CLAIMS/CMLDEP = '01', use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, retrieve MMPHONE and place into the output field. If CLAIMS/CMLDEP <> '01', use CLAIMS/CMLSSN and CLAIMS/CMLDEP to chain to DEPADR. If found, retrieve address type (DADTYP) = C and concat DADHAR + DADHPH and place into the output field. If address type C not found, search for address type = A. If found, lconcat DADHAR + DADHPH and place into the output field. If CLAIMS/CMLDEP <> '01' AND not found in DEPADR, use CLAIMS/CMLSSN to chain to MMAST/MMSSN. If found, retrieve MMPHONE and place into the output field.
Institution or Professional Provider	746	746	1		A		LJBF	Institution or Professional Provider?	MTBILL	Inclusion of a record in MTBILL designates an institutional provider	Use CLAIMS/CMLSSN and CLAIMS/CMLCL# to match to MTBILL/MTMBR# and MTBILL/MTCLM#. If record found, provider is an Institutional provider. Otherwide the provider is considered a professional provider.
Rendering Provider Name	747	776	30		A		LJBF	Rendering Provider Name	PROVIDER	PRPNAM	Using CLAIMS/CMLPID to chain to PROVIDER/PRTAX#. Retrieve PROVIDER/PRPNAM.

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Field Layout Information									Magellan Behavioral Health Translation Information		
Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	R/S	Field Justification	Description	Magellan File Name	Magellan Field Name	Translation Specifications
Rendering Provider Addr1	777	811	35		A		LJBF	Rendering Provider Address 1	PROVIDER	PRADD1	Using CLAIMS/CMLPID to chain to PROVIDER/PRTAX#. Retrieve and move PROVIDER/PRADD1.
Rendering Provider Addr2	812	846	35		A		LJBF	Rendering Provider Address 2	PROVIDER	PRADD2	Using CLAIMS/CMLPID to chain to PROVIDER/PRTAX#. Retrieve and move PROVIDER/PRADD2.
Rendering Provider City	847	866	20		A		LJBF	Rendering Provider City	PROVIDER	PRCITY	Using CLAIMS/CMLPID to chain to PROVIDER/PRTAX# . Retrieve and move PROVIDER/PRCITY.
Rendering Provider State	867	868	2		A		LJBF	Rendering Provider State	PROVIDER	PRSTAT	Using CLAIMS/CMLPID to chain to PROVIDER/PRTAX# . Retrieve and move PROVIDER/PRSTAT.
Rendering Provider Zip Cd	869	878	10		A		LJBF	Rendering Provider Zip Code	PROVIDER	PRZIP	Using CLAIMS/CMLPID to chain to PROVIDER/PRTAX# . Retrieve and move PROVIDER/PRZIP.
Provider In/Out	879	879	1		A		LJBF	Provider In/Out Network Indicator	CLAIMS	CMLPNT	If CMLPNT <> blank then output "Y" else "N"
Rendering Provider	880	894	15		A		LJBF	Rendering Provider TIN	CLAIMS	CMLPID	Only use first 9 digits
Rendering Provider NPI	895	904	10		A		LJBF	Rendering Provider NPI	CLAIMEXT	EXRNPI	Use CLAIMS/CMLCL# and CLAIMS/CMLLN#, chain to CLAIMEXT/EXCL# and CLAIMEXT/EXLN# . If record found retrieve CLAIMEXT/EXRNPI and out put to field.
Rendering Provider Medicaid ID	905	919	15		A	S	LJBF	Rendering Provider Medicaid ID	CLAIMS NMPCRT	See Notes	Using CLAIMS/CMLPID, match it to its corresponding field PROVIDER/PRTAX#. Retrieve and retain PROVIDER/PRMIS#. Using PROVIDER/PRMIS# and PROVIDER/PRSTAT, match it to its corresponding fields NPCRT/CRTMIS and NMPCRT/CRTSTA. If a match can be made and NMPCRT/CRTCOD = 'MA' (Medicaid), retrieve the first 13 positions of CRTNBR and out put to field, else move " " (spaces). **Note – Always check with the Network Department to confirm logic is correct for each client**

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Field Layout Information									Magellan Behavioral Health Translation Information		
	Start	End	Fld		Char	R/S	Field		Magellan	Magellan	
Field Name	Pos	Pos	Len	Dec	Num		Justification	Description	File Name	Field Name	Translation Specifications
Rendering Provider Medicare ID	920	934	15		A	S	LJBF	Rendering Provider Medicare ID	CLAIMS NMPCRT	CRTNBR	Using CLAIMS/CMLPID, match to PROVIDER/PRTAX#. Retrieve and retain PROVIDER/PRMIS#. Using PROVIDER/PRMIS# match it to its corresponding field NMPCRT/CRTMIS. If a match can be made and NMPCRT/CRTCOD = 'MK' (Medicare), retrieve the first 13 positions of NMPCRT/CRTNBR and out put to field, else move " " (spaces). **Note – check with network to confirm logic is correct for each client**

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Field Layout Information									Magellan Behavioral Health Translation Information		
	Start	End	Fld		Char	R/S	Field		Magellan	Magellan	
Field Name	Pos	Pos	Len	Dec	Num		Justification	Description	File Name	Field Name	Translation Specifications
Rendering Provider Taxonomy Code	935	944	10		A		LJBF	Taxonomy codes are national specialty codes used by providers to indicate their specialty at the claim level		See Notes (please expand entire cell for all mapping)	** Verify if provider file is received from client and taxonomy code matching requirements ***Contact Network to ensure logic is correct for each client*** Primary Logic: Using CLAIMS/CMLPID, match it to its corresponding field PROVIDER/PRTAX#.. Retrieve and retain PROVIDER/PRMIS#. Using PROVIDER/PRMIS#, match it to its corresponding field NMPXRF3XR3MIS. Multiple occurrences could exist. Retrieve the applicable record that meets the following criteria: NMPCRF3/XR3CLT = "ALL" and NMPCRF3XR3TYPE = "300" and NMPXRF3/XR3EFE >= Now (Today's Date) and NMPXRF3XR3VOID<>"Y" If a record could be found and NMPXRF3/XR3VAL <> " " (spaces), move NMPXRF3XR3VAL to this output field; DEFAULT Logic: to be used only if taxonomy code matching is not required by the client (Use standard taxonomy file CIP007MLTX to retrieve default codes) If PROVIDER/PRSPEC = "AMBTR", output 341600000X If PROVIDER/PRSPEC = "AGNCY", output 251S00000X, If PROVIDER/PRSPEC = "COMHC", output 261QM0801X, If PROVIDER/PRSPEC = "GRPHM", output 320800000X, If PROVIDER/PRSPEC = "CORHH", output 324500000X, If PROVIDER/PRSPEC = "CORQH", output 324500000X, If PROVIDER/PRSPEC = "CORSA", output 320800000X, If PROVIDER/PRSPEC = "FOSCR", output 253J00000X, If PROVIDER/PRSPEC = "CHPSY", output 283Q00000X, If PROVIDER/PRSPEC = "FSPSY", output 283Q00000X, If PROVIDER/PRSPEC = "FSSAB", output 276400000X, If PROVIDER/PRSPEC = "CHGEN", output 282N00000X, If PROVIDER/PRSPEC = "GENMS", output 282N00000X, If PROVIDER/PRSPEC = "ICFAC", output 310500000X, If PROVIDER/PRSPEC = "SUBAC", output 323P00000X, If PROVIDER/PRSPEC = "METCL", output 261QM2800X, If PROVIDER/PRSPEC = "UNKWN", output 282N00000X, If PROVIDER/PRSPEC = "CHRHB", output 323P00000X, If PROVIDER/PRSPEC = "RESTC", output 323P00000X,

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Field Layout Information									Magellan Behavioral Health Translation Information		
Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	R/S	Field Justification	Description	Magellan File Name	Magellan Field Name	Translation Specifications
Rendering Provider State License	945	969	25		A		LJBF	Rendering Provider State License	NMP300	LICNBR	Using CMLPID, match it to its corresponding field PRTAX# of the PROVIDER file. Retrieve and retain PRMIS#. Using PRMIS# and value in PRSTAT, match it to its corresponding field LICMIS and LICSTATE of the PDSDATA/NMP300 file. Of the matched records, retrieve the LICNUM record with the largest value in LICSEQ and LICENTTIME, which has a LICSTATUS value of "VE" or "VR",else move " " spaces. ***Contact Network to ensure logic is correct for each client***
Pay-to Provider Name	970	999	30		A		LJBF	Provider Name	PROVIDER	PRPNAM	Using CMLAP# of CLAIMS, match it to its corresponding field PRTAX# of the PROVIDER file. If a match can be made, Retrieve and move PRPNAM. If there is no value in CMLAP#, leave blank.
Pay-to Provider Addr1	1000	1034	35		A		LJBF	Provider Address 1	PROVIDER	PRADD1	Using CMLAP# of CLAIMS, match it to its corresponding field PRTAX# of the PROVIDER file. If a match can be made, Retrieve and move PRADD1. If there is no value in CMLAP#, leave blank.
Pay-to Provider Addr2	1035	1069	35		A		LJBF	Provider Address 2	PROVIDER	PRADD2	Using CMLAP# of CLAIMS, match it to its corresponding field PRTAX# of the PROVIDER file. If a match can be made, Retrieve and move PRADD2. If there is no value in CMLAP#, leave blank.
Pay-to Provider City	1070	1089	20		A		LJBF	Provider City	PROVIDER	PRCITY	Using CMLAP# of CLAIMS, match it to its corresponding field PRTAX# of the PROVIDER file. If a match can be made, Retrieve and move PRCITY. If there is no value in CMLAP#, leave blank.
Pay-to Provider State	1090	1091	2		A		LJBF	Provider State	PROVIDER	PRSTAT	Using CMLAP# of CLAIMS, match it to its corresponding field PRTAX# of the PROVIDER file. If a match can be made, Retrieve and move PRSTAT. If there is no value in CMLAP#, leave blank.

Standard Claims Format "Detail"
Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
	Start	End	Fld		Char	R/S	Field		Magellan	Magellan	
Field Name	Pos	Pos	Len	Dec	Num		Justification	Description	File Name	Field Name	Translation Specifications
Pay-to Provider Zip Cd	1092	1101	10		A		LJBF	Provider Zip Code	PROVIDER	PRZIP	Using CMLAP# of CLAIMS, match it to its corresponding field PRTAX# of the PROVIDER file. If a match can be made, Retrieve and move PRZIP. If there is no value in CMLAP#, leave blank.
Pay-to Provider Tax ID	1102	1116	15		A		LJBF	Alternate Payee Tax ID#	CLAIMS	CMLAP#	Only use first 9 digits If there is no value in CMLAP#, leave blank.
Pay-to Provider NPI	1117	1126	10		A		LJBF	Pay-to Provider NPI	CLAIMEXT	EXPNPI	Note: If the Pay-to Provider is the same as the Rendering Provider, the Rendering Provider Information will be populated and the Pay-to Provider information will be left blank. If Pay to provider is different from Rendering, Use CMLCL# and CMLLN# of the CLAIMS file to chain to CLAIMEXT and match to their corresponding fields EXCL# and EXLN# respectively. If record found retrieve EXPNPI and out put to field. Otherwise, leave blank.

Standard Claims Format "Detail"
Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
	Start	End	Fld		Char	R/S	Field		Magellan	Magellan	
Field Name	Pos	Pos	Len	Dec	Num		Justification	Description	File Name	Field Name	Translation Specifications
Pay-to Provider Taxonomy Code	1127	1136	10		A		LJBF	Taxonomy codes are national specialty codes used by providers to indicate their specialty at the claim level		See Notes	** Verify if provider file is received from client and taxonomy code matching requirements ***Contact Network to ensure logic is correct for each client*** Primary Logic: Using CMLAP# match it to its corresponding field PRTAX# of the PROV file. Retrieve and retain PRMIS# (IPD MIS#). If there is no value in CMLAP#, leave this field blank. Using PRMIS#, match it to its corresponding field XR3MIS of the NMPXRF3 file. Multiple occurrences could exist. Retrieve the applicable record that meets the following criteria: XR3CLT = "ALL" and XR3TYPE = "300" and XR3EFE >= Now (Today's Date) and XR3VOID<>"Y" If a record could be found and XR3VAL <> " " (spaces), move XR3VAL to this output field; DEFAULT Logic: to be used only if taxonomy code matching is not required by the client (Use standard taxonomy file CIP007MLTX to retrieve default codes) If PROVIDER/PRSPEC = "AMBTR", output 341600000X If PROVIDER/PRSPEC = "AGNCY", output 251S00000X, If PROVIDER/PRSPEC = "COMHC", output 261QM0801X, If PROVIDER/PRSPEC = "GRPHM", output 320800000X, If PROVIDER/PRSPEC = "CORHH", output 324500000X, If PROVIDER/PRSPEC = "CORQH", output 324500000X, If PROVIDER/PRSPEC = "CORSA", output 320800000X, If PROVIDER/PRSPEC = "FOSCR", output 253J00000X, If PROVIDER/PRSPEC = "CHPSY", output 283Q00000X, If PROVIDER/PRSPEC = "FSPSY", output 283Q00000X, If PROVIDER/PRSPEC = "FSSAB", output 276400000X, If PROVIDER/PRSPEC = "CHGEN", output 282N00000X, If PROVIDER/PRSPEC = "GENMS", output 282N00000X, If PROVIDER/PRSPEC = "ICFAC", output 310500000X

Standard Claims Format "Detail"
Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
	Start	End	Fld		Char	R/S	Field		Magellan	Magellan	
Field Name	Pos	Pos	Len	Dec	Num		Justification	Description	File Name	Field Name	Translation Specifications
Pay-to Provider State License	1137	1161	25		A		LJBF	Pay-to Provider State License	NMP300	LICNBR	Using CMLAP# match it to its corresponding field PRTAX# of the PROVIDER file. Retrieve and retain PRMIS#. Using PRMIS# and value in PRSTAT, match it to its corresponding field LICMIS and LICSTATE of the PDSDATA/NMP300 file. Of the matched records, retrieve the LICNUM record with the largest value in LICSEQ and LICENTTIME, which has a LICSTATUS value of "VE" or "VR",else move " " spaces. ***Contact Network to ensure logic is correct for each client*** If there is no value in CMLAP#, leave blank.

Standard Claims Format "Detail"
Technical Specifications

Field Layout Information									Magellan Behavioral Health Translation Information		
Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	R/S	Field Justification	Description	Magellan File Name	Magellan Field Name	Translation Specifications
Rendering Provider Degree	1162	1164	3		A		LJBF	Rendering Provider Degree	PROVIDER	PRDGRE	Using CLAIMS/CMLPID, chain PROVIDER/PRTAX#. Ouput PROVIDER/PRDGRE.
Authorization Number	1165	1171	7		A		LJBF	Authorization Number	PCTXRF	PCXMRD	Using CLAIMS/CMLCL# and CLAIMS/CMLLN#, chain to PCTXRF/PCXCLM and PCTXRF/PCXLIN. Multiple occurrences could exist. Loop thru all occurrences found and retrieve a record that satisfies the following condition: If PCTXRF/PCXSTA (Status) = " "(Spaces). Move PCTXRF/PCXMRD.
Auth Number 2	1172	1178	7		A		LJBF	Auth Number 2	PCTXRF	PCXMRD	If more than one auth number is present, send next auth number. See logic for Authorization Number (position 910-916)
Institution (Facility) code value	1179	1179	1		A		LJBF	Institution (Facilty) Code Value	MTBILL	MTBTYP	Use CLAIMS/CMLSSN and CLAIMS/CMLCL# to match to MTBILL/MTMBR# and MTBILL/MTCLM#. If found, output MTBTYP
Attending Provider Name	1180	1204	25		A		LJBF	Attending Provider Name	PROV	PRPNAM	Use CLAIMS/CMLSSN and CLAIMS/CMLCL# to match to MTBILL/MTMBR# and MTBILL/MTCLM#. If found, and MTAPA not blank, retrieve and output MTAPA.
Attending Provider NPI	1205	1214	10		A		LJBF	Attending Provider NPI	MTBILL	MTANPI	Use CLAIMS/CMLSSN and CLAIMS/CMLCL# to match to MTBILL/MTMBR# and MTBILL/MTCLM#. If found, and not blank, output MTANPI
Hopsital Confinement Copay	1215	1223	9	2	N		RJZF	Hospital Confinement Copay	CLAIMS	CMLBCA	Output CMLBCA
Reversal Date	1224	1232	9	2	N		RJZF	Reversal Date	CLAIMS	CMLLDD	
Filler1	1233	1257	25		A		LJBF	Filler			Move ' ' Spaces

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Standard "Trailer" Record Technical Specifications

Field Layout Information							
Fld #	Field Name	Start Pos	End Pos	Fld Len	Dec	Char Num	Description
1	Record Type	1	1	1		A	T = Trailer Record
2	Filler Unused	2	16	15		A	Blank Fill
3	Total Records On File	17	25	9	0	N	Total Records on File(Zero fill if not applicable.) The minimum number of records sent on a file is 2. This will not reflect in the total records field on file. (1 header record + 1 trailer record) Trailer Record will always count as 1 record on file
4	Start Date	26	33	8	0	N	Beginning Selection date CCYYMMDD
5	End Date	34	41	8	0	N	Ending Selection date CCYYMMDD
6	Total Charges	42	54	13	2	N	Total Charges – No total charges – *zero fill
7	Total Allowed Amount	55	67	13	2	N	Total Allowed Amount field – No total - *zero fill
8	Total Paid Amount	68	80	13	2	N	Total Paid Amount – No total - *zero fill
9	Total Deductible Amount	81	93	13	2	N	Total Deductible Amount – No total - *zero fill
10	Total Coinsurance Amount	94	106	13	2	N	Total Coinsurance Amount – No total - *zero fill
11	Total Co-Pay Amount	107	119	13	2	N	Total Co-Pay Amount – No total - *zero fill
12	Total Out-of-Pocket Amount	120	132	13	2	N	Total Out-of-Pocket Amount – No total - *zero fill
13	Total Provider Payment	133	145	13	2	N	Total Provider Payment – No total - *zero fill
14	Total Alternate Payee Dollars	146	158	13	2	N	Total Alternate Payee Dollars – No total - *zero fill
15	Total Member Payment Amt.	159	171	13	2	N	Total Member Payment Amt. – No total - *zero fill
16	Total Dependent Payment Amt.	172	184	13	2	N	Total Dependent Payment Amt. – No total - *zero fill
17	Filler	185	800	616	A		Filler

Exhibit A - Ineligible Code Examples

Always verify with Claims Department which codes are appropriate for each client.

Code	Description
**	Provider Network Discount
A2	This out-of-network inpatient treatment benefit determination.
A3	Exceeds reasonable and customary rate.
IN	Late payment-interest penalty assessed.
M#	Major Medical Quantity Maximum exceeded
MY	Major Medical Yearly Maximum exceeded
MZ	Major Medical Diagnosis-Yearly Maximum exceeded
M4	Major Medical Quarterly Maximum exceeded
NC	Not Covered
P$	Precert Dollar Penalty Applies.
P%	Precert Percent Penalty has been applied
UC	Excess over Usual & Customary charges
01	Limited benefits are available for this type of service.
03	Please see the enclosed letter and/or inquiry.
04	This amount has been applied towards your deductible.
05	Date(s) of service is before precertification.
14	Benefits are reduced due to a previous overpayment.
19	Room and board charges are limited to the semi-private room rate
32	The repriced amount represents our network rate.
33	A portion of these charges was paid by your medical plan.
34	Prescription drugs are covered by your medical plan.
36	Plan does not cover personal convenience items.
49	This charge was previously considered.
57	Please submit the primary carrier's explanation of benefits.
64	Please submit Medicare's explanation of benefits.
66	No certification is on file for this in network provider.
68	Your claim is being denied as there is no pre-certification
70	Confinement exceeds authorized number of days.
72	This service is not covered under this plan.
74	Charges are denied as not medically necessary.
75	Exceeded number of visits pre certified, penalty applies.
78	This should be submitted to your medical carrier.

Exhibit A - Ineligible Code Examples

Always verify with Claims Department which codes are appropriate for each client.

Code	Description
87	Precertification is on file for this in-network provider.
88	No certification is on file for this out-of-network provider
90	Charge reflects previous overpayment.
93	The non covered amount reflects the members co-pay.

Exhibit B - Denial Code Examples

Always verify with Claims Department which codes are appropriate for each client.

Code	Description
AA	Non-covered Service
A1	Deny - DOS does not match cert by network provider.
A2	Deny-Covered under workers comp.
A3	Deny - Bill submitted after filing time allowed.
A5	Requested COB form from member.
BB	Repricing Only--addition to prev considered inpt bill
B1	DENY - Case rate warranty period.
B2	Pend - Referred to COB/Recovery Unit.
B5	Requested additional info from member
B9	No precert with Primary Carrier
C1	Deny for HCFA or UB-92 forms.
C2	Deny - DOS does not match auth span, prov can't balance bill
C3	Deny - duplicate, original in process
D2	Deny - Provider not licensed for service billed
D3	Deny - Submit name/degree of provider
E4	Charges for future dates-Denial
E6	Request Provider's TIN
E8	Patient not eligible
E9	Not a covered service, denial
FA	Deny after review of emergency records
FF	Deny. X-Ray/Lab not covered.
G6	Deny-no $ charge on bill
G7	Denial-Submit Ordering Physician (Labs)
G8	Deny-prior to Plan effective date
G9	Addt'l info requested/no response from provider
H1	Deny-request license info
00	Deny-no cert-in network provider
01	Pend - Independent audit.
02	Requested claim form on pre-disbursement basis.
03	Deny COB information needed.
04	Deny-request original bill

Exhibit B - Denial Code Examples

Always verify with Claims Department which codes are appropriate for each client.

Code	Description
05	Requested primary carrier's EOB.
06	Deny-request prior carrier deductible met.
07	Deny - Draft for benefits due sent to provider.
08	Deny-request date of birth.
09	Pending DRG Review.

V. Disaster Recovery Plan

W. Precertification Screen Prints

CAREplus

```
PBR000                                  CAREplus
Organization:

  2     1=Display 2=Modify/Add

Case#: _______________     Client ID: ____________________


     Client Last Name: ____________________     First,MI: _______________




F1=Cancel  F5=Clear  F6=Partial SSN/ID Search

_____________________________________________________________________________

        04/04  SA     MW     KS     IM     II     KB
```

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Eligibility Verification/Selection

```
PBRELG-Ø3            ELIGIBILITY VERIFICATION/SELECTION

  Case Number:
Eligible for:                                  Network Segment:
 Organization:                                     Organization No:
         Plan:
     Division:
  Client Name:
    Address 1:
    Address 2:                                                Sex:
City,State,Zip:                                       Birth Date:

 Member Benefit Effect Date:                          Client Id:
Priority SMI: N  BH Category:
Other Insurance (Y/N): N

>=Existing Case                    Birth      Eff.       Term                 Med
  Sel First Name                    Date      Date       Date          Note   Rc
 >


                                                                        Bottom
F1=Cancel F4=Eligibility              F8=Bene Usage F11=More Info F12=Previous
F13=Cl Liai   F14=UMI               F16=Othr Ins F20=CAPS Functions
```

Demographics I

```
PBR020   Notes: N                DEMOGRAPHICS I
Organization:
Client Last Name: TEST                    First: TEST
Case#:                  Eps#:     Enc#:                Client#:
                                                        MAT#:
****************************** Client Information ******************************
Birth Date: ________ (YYYYMMDD)   Age: ___
Addr: ____________________________________ ____________________________________
City: ____________________ *St: ____  *Zip: _____ - ____  *Cntry: ___
     Home address was updated by: _________  on: _________
Email Adr: ____________________________________ Contact by Email OK(Y/N): _
Confidential (Y/N): N
Does Client Have Phone Y/N/U: N
Phone#: ____________ Ext: _____  *Of: _____________ Call(Y/N): _  Msg(Y/N:) _
Phone#: ____________ Ext: _____  *Of: _____________ Call(Y/N): _  Msg(Y/N:) _
                                                                    More...


*Date of Joint Case/Discharge Planning: _________ (YYYY/MM/DD)  __:00 (HH:MM)


F1=Cancel                  F3=Exit     F9=Search              F12=Previous
F14=Notes   F15=Addr Hist  F18=DISP PLAN/DIV  F22=SubMenu     F24=MiniMenu

       07/14   SA     MW     KS     IM     II     KB
```

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Demographics II

```
PBR025   Notes: N              DEMOGRAPHICS II
Organization:
Client Last Name: TEST                  First: TEST
Case#:                Eps#:     Enc#:              Client#:


      Telephone#: ____________________  *Relationship: ___
      *Call Date: ________ (YYYY/MM/DD)  Call Time _____ (HH:MM)
********************    All Fields Below Are Searchable    ********************
CLIENT:
Opening Nuances:  Gender                        ___
                  Admission Driver              ___
                  Veteran Status                ___




                                                                        Bottom
F1=Cancel                    F3=Exit          F5=CLgx F7=Pull Thru
F9=Search   F12=Previous F14=Notes         F22=SubMenu    F24=MiniMenu

        11/46   SA      MW      KS      IM      II      KB
```

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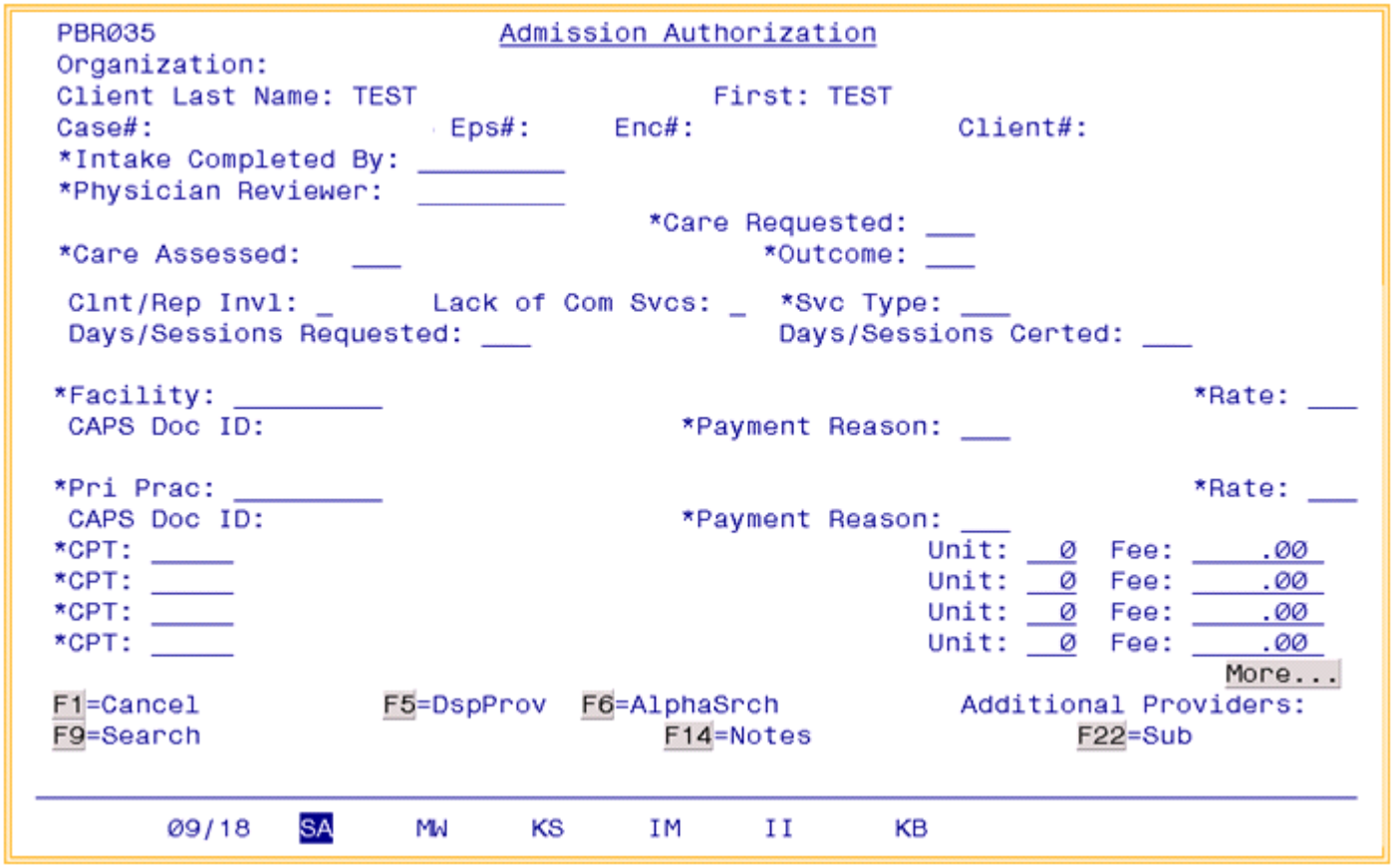
Admission – Authorization



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Admission – Authorization Continued

```
PBR050                Admission Authorization Continued
Organization:
Client Last Name: TEST                    First: TEST
Case#:                  Eps#:     Enc#:                Client#:
                                                            Notes: N

 Administrative Cert: _
 Court Ordered Authorization? Y/N _
*Bed Type:        ___                                  Per Diem: ____.00
*Place of Service:  ___
                                          *Retro-Auth: ___
*Problem Type:    ___
 Days/Sessions Requested:                 Days/Sessions Certified:
*Auth Start Date: __________    *End Date: __________  *Next Review: __________
*Actual Adm/Treatmt St Dt: __________ Time:  _____
*Referral Date:            __________ Time:  _____


*Responsible for Follow-up: _________

 Print(Y/N): N
 Prevent Correspondence to Member(Y/N): N
F1=Cancel           F9=Search
F12=Previous  F14=Notes  F22=SubMenu

_____________________________________________________________________________

       06/24  SA     MW     KS     IM     II     KB
```

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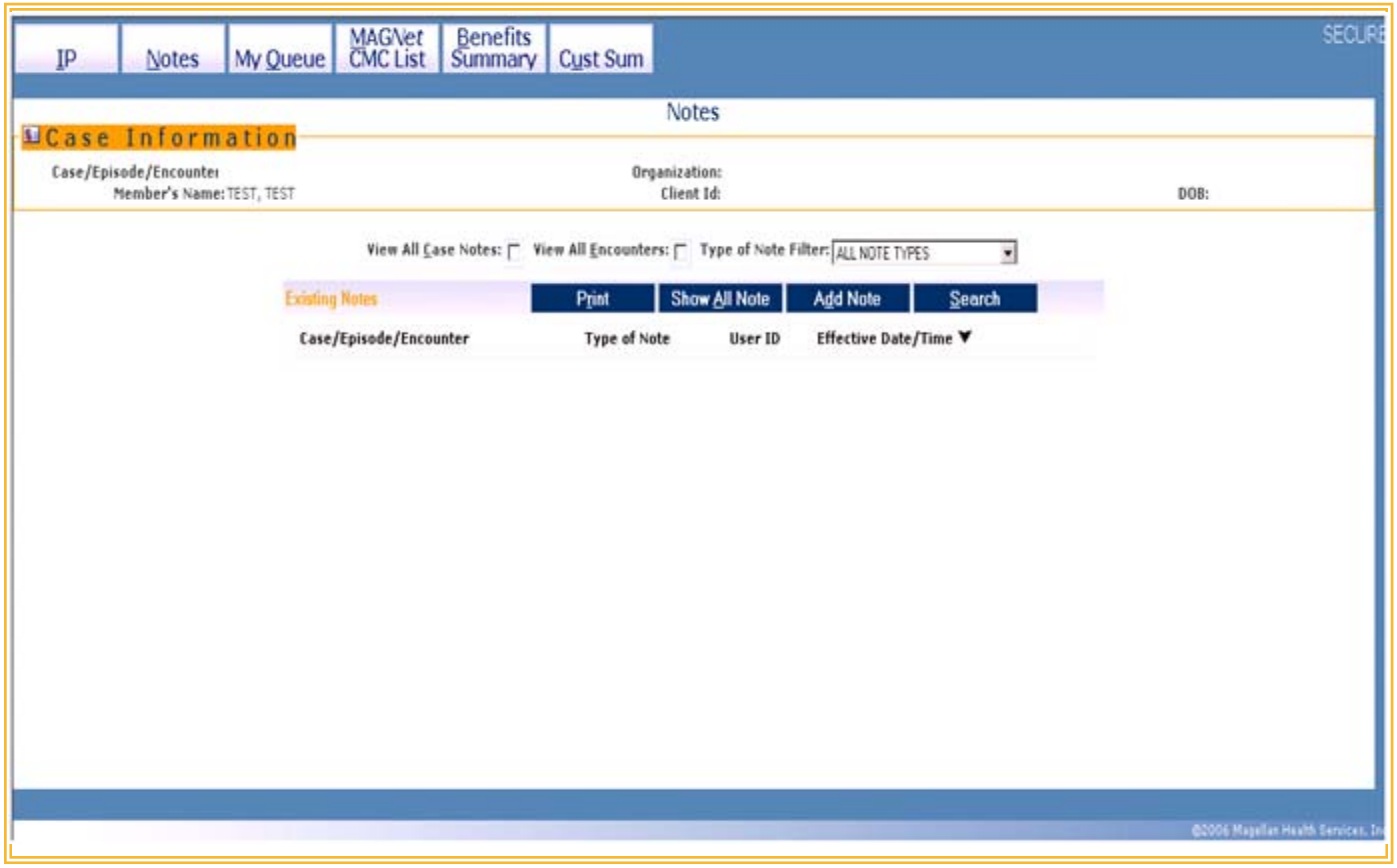
IP Clinical Notes



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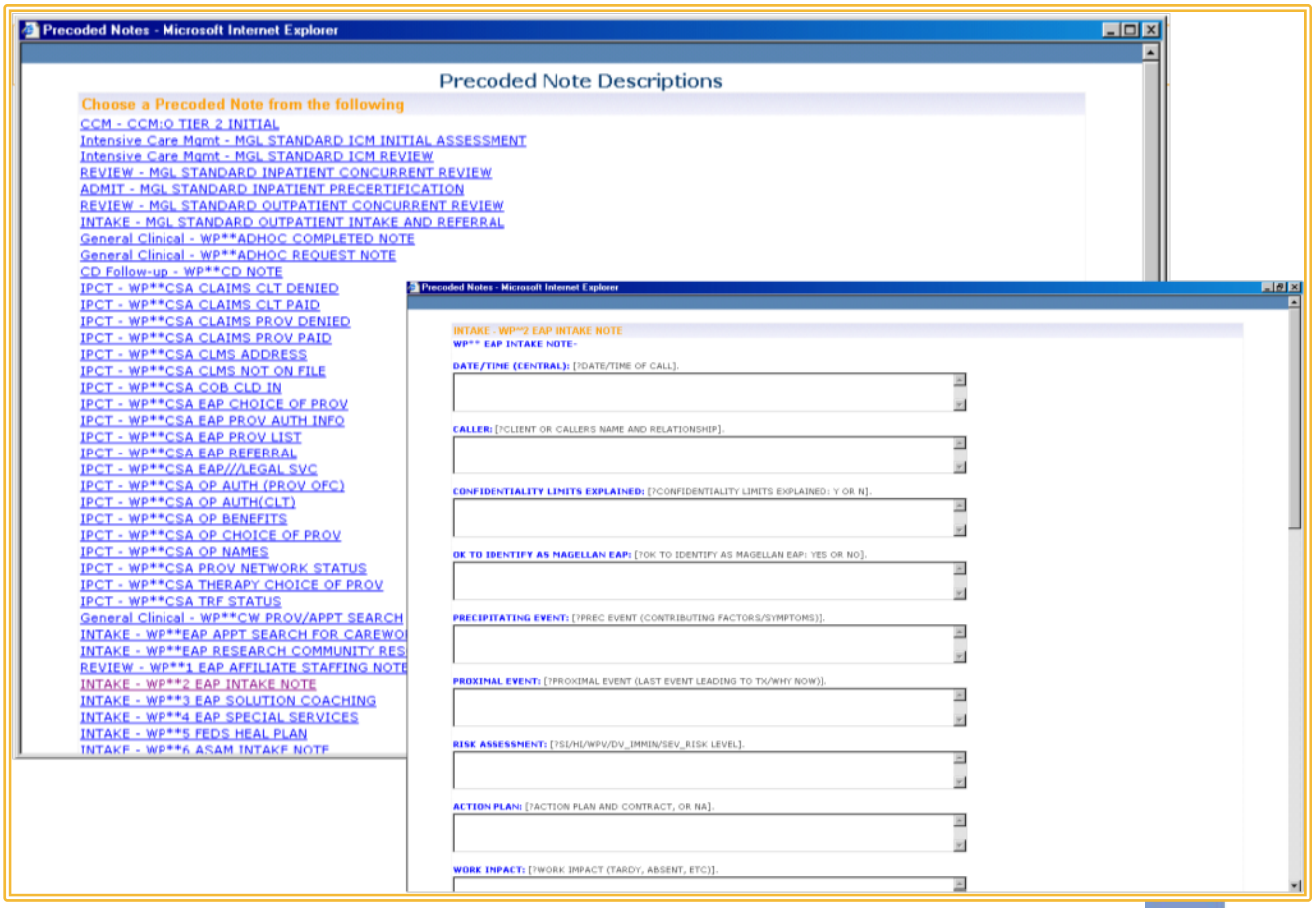
Pre-Coded Notes



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Decision Making and Accessibility of Care

```
IPR033B        Decision Making and Accessibility of Care
Organization:
Client Last Name: TEST                    First: TEST
Case#:                 Eps#:     Enc#:              Client#:
MAT#:                                                    Notes:

  *Service Type:  ___
    Request     (CCYYMMDD HH:MM)          Decision    (CCYYMMDD HH:MM)
    Date/Time: __________ _____ (CT)      Date/Time: __________ _____ (CT)


  *ACCESS LEVEL:  ___
----------------------COMPLETE INFO BELOW ON ADMISSION RECORD ONLY-----------
    1st Appointment Offered: (CCYYMMDD) __________  (HH:MM) _____ (CT)

   *Appt. Outcome: ___                              Outcome Date: __________


    1st Appointment Kept (Date/Time): (CCYYMMDD)  __________ (HH:MM) _____ (CT)

          F3=Exit            F8=PerfStnds      F9=Search  F12=Previous
                                               F14=Notes  F24=MiniMenu

_____________________________________________________________________________

       07/20  SA      MW      KS      IM      II      KB
```

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Discharge – Review/Planning I

```
IPR095  Notes: Y        DISCHARGE - REVIEW/PLANNING I
Organization:
Client Last Name: TEST                    First: TEST
Case#:                 Eps#:    Enc#:                Client#:
 Risk Level:
@Intake Completd by: _________
@Dischrge Compl. by: _________

 Dischrge Review Dt: __.__.__  Discharge Date: _________
*Closing Resolution: ___
*Axis 1A: ______                          *IB: ___.__
*Axis II: ______
 AxisIII: ____________________________________________________
*Axis IV: A Primary support  *Axis V:  Current: ___   Highest Past Year: ___
*ICD-9:   ______
*FAH/Next Service Scheduled:  _________   Term Date of Policy: _________
*FAH Provider MIS#: _________
FAH/Next Provider:  ____________________________
Provider Phone No: ____________                  No. of Days To FAH  :  0
*FAH Coordinator: _________

F1=Cancel  ENTER=Cont.  F3=Exit                              F7=PullThru
          F9=Srch F12=Prev      F14=Notes                    F24=MiniMenu

_____________________________________________________________________________

       06/23  SA      MW      KS      IM      II      KB
```

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X. Medical Necessity Criteria

MAGELLAN BEHAVIORAL HEALTH, INC.

Medical Necessity Criteria Guidelines 2013

Effective Date: January 1, 2013

55 Nod Road
Avon • Connecticut • 06001

Table of Contents

Preamble- Principles of Medical Necessity Determinations

Individualized, Needs-Based, Least-Restrictive Treatment

Magellan Behavioral Health* is committed to the philosophy of providing treatment at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment and meet the individual patient's biopsychosocial needs. We see the continuum of care as a fluid treatment pathway, where patients may enter treatment at any level and be moved to more or less-intensive settings or levels of care as their changing clinical needs dictate.Q3 At any level of care, such treatment is individualized, active and takes into consideration the patient's stage of readiness to change/readiness to participate in treatment.Q1, Q2

The level of care criteria that follow are guidelines for determining medical necessity for DSM-IV-TR disorders. Individuals may at times seek admission to clinical services for reasons other than medical necessity, e.g., to comply with a court order, to obtain shelter, to deter antisocial behavior, to deter runaway/truant behavior, to achieve family respite, etc. However, these factors do not alone determine a medical necessity decision. Further, coverage for services is subject to the limitations and conditions of the member benefit plan. Specific information in the member's contract and the benefit design for the plan dictate which medical necessity criteria are applicable.

Although these Medical Necessity Criteria Guidelines are divided into "psychiatric" and "substance-related" sets to address the patient's primary problem requiring each level of care, psychiatric and substance-related disorders are often co-morbid. Thus, it is very important for all treatment facilities and providers to be able to assess these co-morbidities and address them along with the primary problem.J4,R7,R15

Clinical Judgment and Exceptions

The Magellan Behavioral Health Medical Necessity Criteria Guidelines direct both providers and reviewers to the most appropriate level of care for a patient. While these criteria will assign the safest, most effective and least restrictive level of care in nearly all instances, an infrequent number of cases may fall beyond their definition and scope. Thorough and careful review of each case, including consultation with supervising clinicians, will identify these exceptions. As in the review of non-exceptional cases, clinical judgment consistent with the standards of good medical practice will be used to resolve these exceptional cases.

All medical necessity decisions about proposed admission and/or treatment, other than outpatient, are made by the reviewer after receiving a sufficient description of the current clinical features of the patient's condition that have been gathered from a face-to-face evaluation of the patient by a qualified clinician. Medical necessity decisions about each patient are based on the clinical features of the individual patient relative to the patient's socio-cultural environment, the medical necessity criteria, and the real resources available. We recognize that a full array of services is not available everywhere. When a medically necessary level does not exist (e.g., rural locations), we will support the patient through extra-contractual benefits, or we will authorize a higher than otherwise necessary level of care to ensure that services are available that will meet the patient's essential needs for safe and effective treatment.

**Magellan Behavioral Health, Inc.; Magellan Behavioral Health Systems, LLC, f/k/a Human Affairs International; CMG Health, Inc.; Green Spring Health Services, Inc.; Merit Behavioral Care; Magellan Health Services of Arizona, Inc.; Magellan Health Services of California, Inc.-Employer Services; Human Affairs International of California; Magellan Behavioral Care of Iowa, Inc.: Magellan Behavioral Health of Florida, Inc.; Magellan Behavioral of Michigan, Inc.; Magellan Behavioral Health of New Jersey, LLC; Magellan Behavioral Health of Pennsylvania, Inc.; Magellan Behavioral Health Providers of Texas, Inc.; and their respective affiliates and subsidiaries are affiliates of Magellan Health Services, Inc. (collectively "Magellan").*

Medical Necessity Definition

Magellan reviews mental health and substance abuse treatment for medical necessity. Magellan defines medical necessity as:

"Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are:

1. *consistent with:*
    a. *the diagnosis and treatment of a condition; and*
    b. *the standards of good medical practice;*
2. *required for other than convenience; and*
3. *the most appropriate supply or level of service.*

When applied to inpatient care, the term means: the needed care can only be safely given on an inpatient basis."

Each criteria set, within each level of care category (see below) is a more detailed elaboration of the above definition for the purposes of establishing medical necessity for these health care services. Each set is characterized by admission and continued stay criteria. The admission criteria are further delineated by severity of need and intensity and quality of service.

Particular rules in each criteria set apply in guiding a provider or reviewer to a medically necessary level of care (please note the possibility and consideration of exceptional patient situations described in the preamble when these rules may not apply). For admission, both the severity of need and the intensity and quality of service criteria must be met. The continued stay of a patient at a particular level of care requires the continued stay criteria to be met (Note: this often requires that the admission criteria are still fulfilled). Specific rules for the admission and continued stay groupings are noted within the criteria sets.

Levels of Care & Service Definitions

Magellan believes that optimal, high-quality care is best delivered when patients receive care that meets their needs in the least-intensive, least-restrictive setting possible. Magellan's philosophy is to endorse care that is safe and effective, and that maximizes the patient's independence in daily activity and functioning.

Magellan has defined eight levels of care as detailed below. These levels of care may be further qualified by the distinct needs of certain populations who frequently require behavioral health services. Children, adolescents, geriatric adults and those with substance use and eating disorders often have special concerns not present in adults with mental health disorders alone. In particular, special issues related to family/support system involvement, physical symptoms, medical conditions and social supports may apply. More specific criteria sets in certain of the level of care definitions address these population issues.

The eight levels of care definitions are:

1. Hospitalization

   Hospitalization describes the highest level of skilled psychiatric and substance abuse services provided in a facility. This could be a free-standing psychiatric hospital, a psychiatric unit of general hospital or a detoxification unit in a hospital. Settings that are eligible for this level of care are licensed at the hospital level and provide 24-hour medical and nursing care[1].

   This definition also includes crisis beds, hospital-level rehabilitation beds for substance use disorders and 23-hour beds that provide a similar, if not greater, intensity of medical and nursing care[1]. For crisis and 23-hour programs, the psychiatric hospitalization criteria apply for medical necessity reviews. For hospital-level substance abuse rehabilitation, the Hospitalization, Rehabilitation Treatment, Substance Use Disorder criteria set applies. For subacute hospitalization, the Hospitalization, Subacute criteria set applies.

2. Subacute Hospitalization

   The subacute hospital level of care is designed to meet the needs of a patient with mental health problems that require an inpatient setting due to potential for harm to self or to others or potential for harm to self due to an inability to adequately care for his/her personal needs without presenting an imminent threat to himself/herself or to others.

   The purpose of subacute care programs is to provide rehabilitation and recovery services and to assist in a patient's return to baseline function and transition back into the community. Subacute care programs serve patients who require less-intensive care than traditional acute hospital care, but more intensive care than residential treatment. Typically, length of stay for subacute is longer than acute hospitalization, but shorter than residential. Twenty-four hour monitoring and supervision by a multidisciplinary behavioral health treatment team provide a safe and effective treatment environment.

   Patients in this setting should have adequate impulse control and the ability to cooperate with staff to communicate effectively and accomplish the tasks of daily living with minimal support. Treatment includes daily psychiatric nursing evaluation and intervention, direct services at least three times weekly, direct services by a psychiatrist (including medication management), psychotherapy and social interventions in a structured therapeutic setting. Psychiatric and medical services are available 24-hours a day, seven days a week in the case of emergencies. When indicated (and especially for children and adolescents), families and/or guardians are involved in the treatment process. Patients are ready for discharge from this level of care when they show good impulse

[1] Magellan Medical Necessity criteria do not supersede state or Federal law or regulation concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.

control, medication compliance, effective communication and the ability to accomplish activities of daily living consistent with their developmental capabilities. Subacute is usually provided as a step-down from acute hospitalization.

3. 23-Hour Observation

   The main objective of 23-hour observation is to promptly evaluate and stabilize individuals presenting in a crisis situation. This level of care provides up to 23 hours and 59 minutes of observation and crisis stabilization, as needed. Care occurs in a secure and protected environment staffed with appropriate medical and clinical personnel, including psychiatric supervision and 24-hour nursing coverage.

   Aspects of care include a comprehensive assessment and the development and delivery of a treatment plan. The treatment plan should emphasize crisis intervention services intended to stabilize and restore the individual to a level of functioning that does not necessitate hospitalization. In addition, 23-hour observation may be used to complete an evaluation to determine diagnostic clarification to establish the appropriate level of care. As soon as the risk level is determined, diagnostic clarity is established, and/or crisis stabilization has been achieved, appropriate referral and linkage to follow-up services will occur.

   If clinical history or initial presentation suggested that the individual required a secure and protected inpatient level of care for more than 23 hours and 59 minutes, this level of care would not be appropriate.

4. Residential Treatment

   Residential Treatment is defined as a 24-hour level of care that provides persons with long-term or severe mental disorders and persons with substance-related disorders with residential care. This care is medically monitored, with 24-hour medical and nursing services availability. Residential care typically provides less intensive medical monitoring than subacute hospitalization care. Residential care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential care also includes training in the basic skills of living as determined necessary for each patient. Residential treatment for psychiatric conditions and residential rehabilitation treatment for alcohol and substance abuse are included in this level of care. Settings that are eligible for this level of care are licensed at the residential intermediate level or as an intermediate care facility (ICF). Licensure requirements for this level of care may vary by state.

5. Supervised Living

   Supervised Living for substance-related disorders includes community-based residential detoxification programs, community-based residential rehabilitation in halfway and quarterway houses, group homes, specialized foster care homes which serve a limited number of individuals in community-based, home-like settings, and other residential settings which require abstinence.

   Supervised Living for mentally ill individuals includes community residential crisis intervention units, supervised apartments, halfway houses, group homes, foster care that serves a limited number of individuals (e.g., group homes generally serve up to eight; foster care homes generally serve one or two) in community-based, home-like settings, and other residential settings which provide supervision and other specialized custodial services.

   This level of care combines outpatient treatment on an individual, group and/or family basis (usually provided by outside practitioners) with assistance and supervision in managing basic day-to-day activities and responsibilities outside the patient's home. These settings are often licensed as halfway houses or group homes depending on the state.

6. Partial Hospitalization

   These programs are defined as structured and medically supervised day, evening and/or night treatment programs. Program services are provided to patients at least 4 hours/day and are available at least 3 days/week. The services include medical and nursing[2], but at less intensity than that provided in a hospital setting. The patient is not considered a resident at the program. The range of services offered is designed to address a mental health and/or substance-related disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team.

7. Intensive Outpatient Programs

   Intensive outpatient programs are defined as having the capacity for planned, structured, service provision of at least 2 hours per day and 3 days per week, although some patients may need to attend less often. These encounters are usually comprised of coordinated and integrated multidisciplinary services. The range of services offered are designed to address a mental or a substance-related disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured "crisis intervention programs," "psychiatric or psychosocial rehabilitation," and some "day treatment." (Although treatment for substance-related disorders typically includes involvement in a self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here excludes times spent in these self-help programs, which are offered by community volunteers without charge).

8. Outpatient Treatment

   Outpatient treatment is typically individual, family and/or group psychotherapy, and consultative services (including nursing home consultation). Times for provision of these service episodes range from fifteen minutes (e.g., medication checks) to fifty minutes (e.g., individual, conjoint, family psychotherapy), and may last up to two hours (e.g., group psychotherapy).

[2] Magellan Medical Necessity criteria do not supersede state or Federal law or regulation concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.

Term Definitions

1. Family:

   Individuals identified by an adult as part of his/her family or identified by a legal guardian on behalf of children. Examples would include parents/step-parents, children, siblings, extended family members, guardians, or other caregivers.

2. Support System:

   A network of personal (natural) or professional contacts available to a person for practical, clinical, or moral support when needed. Examples of personal or natural contacts would include friends, church, school, work and neighbors. Professional contacts would include primary care physician, psychiatrist, psychotherapist, treatment programs (such as clubhouse, psychiatric rehabilitation), peer specialists, and community or state agencies.

3. Significant Improvement:

   a) Services provided at any level of care must reasonably be expected to improve the patient's condition in a meaningful and measurable manner. The expectation is that the patient can accomplish the following in the current treatment setting: continue to make measurable progress, as demonstrated by a further reduction in psychiatric symptoms, or
   b) acquire requisite strengths in order to be discharged or move to a less restrictive level of care.

   The treatment must, at a minimum, be designed to alleviate or manage the patient's psychiatric symptoms so as to prevent relapse or a move to a more restrictive level of care, while improving or maintaining the patient's level of functioning. "Significant Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require a move to a more restrictive level of care, this criterion would be met.

   For most patients, the goal of therapy is restoration to the level of functioning exhibited prior to the onset of the illness. For other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable interpretation of "significant improvement."

Hospitalization, Psychiatric, Adult

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and B and one of C, D or E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

C. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:

   1) a current plan or intent to harm self with an available and lethal means, *or*
   2) a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, *or*
   3) an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, *or*
   4) other similarly clear and reasonable evidence of imminent serious harm to self.

D. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:

   1) a current plan or intent to harm others with an available and lethal means, *or*
   2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, *or*
   3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*
   4) other similarly clear and reasonable evidence of imminent serious harm to others.

E. The patient's condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the patient's general medical or mental health.H11

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or other support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.W2 Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.

C. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

D. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*

4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician or admitting qualified and credentialed professional..

B. The current treatment plan includes documentation of diagnosis (DSM-IV-TR axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and ongoing contact with the patient's family and/or other support systems, unless there is an identified, valid reason why it is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.H2, H39, H48

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by a psychiatrist or admitting qualified and credentialed professional.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources. H3, H15

Hospitalization, Psychiatric, Child and Adolescent[3]

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and B, and one of C, D or E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

C. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:

1) a current plan or intent to harm self with an available and lethal means, *or*
2) a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, *or*
3) an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, *or*
4) other similarly clear and reasonable evidence of imminent serious harm to self.

D. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:

1) a current plan or intent to harm others with an available and lethal means, *or*
2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, *or*
3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*
4) other similarly clear and reasonable evidence of imminent serious harm to others.

[3] Experts generally agree that no one chronological age defines the end of adolescence. Rather, it is determined by considering a number of factors including chronological age, maturity, school and social status, family relationships, and living situation. For purposes of consistency, it is suggested that child and adolescent criteria sets be applied to individuals 17 years of age or younger.

E. The patient's condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the patient's general medical or mental health.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or other support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions. Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.

C. The individualized plan of treatment includes plans for at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

E. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*

4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician or admitting qualified and credentialed professional.

B. The current treatment plan includes documentation of diagnosis (DSM-IV-TR axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and intensive family and/or support system's involvement occurring at least once per week, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.W3 This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.I2

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. The evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist or admitting qualified and credentialed professional.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources.

Hospitalization, Psychiatric, Geriatric[4]

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and B, and one of C, D or E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric and nursing staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

C. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:

1) a current plan or intent to harm self with an available and lethal means, *or*
2) a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, *or*
3) an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, *or*
4) other similarly clear and reasonable evidence of imminent serious harm to self.

D. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:

1) a current plan or intent to harm others with an available and lethal means, *or*
2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, *or*
3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*
4) other similarly clear and reasonable evidence of imminent serious harm to others.

[4] These criteria apply to those individuals at or over the age of 65.

E. The patient's condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the patient's general medical or mental health.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment, including a complete history of seizures and detection of substance abuse diagnosis and ongoing medical management to evaluate and manage co-morbid medical conditions. As part of the mental status testing, assessment of cognitive functioning is warranted. Caretakers/guardians/family members should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric and nursing staffing. This psychiatric and nursing staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, fall precautions, ambulation with assistance, assistance with activities of daily living[5], other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions. Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.

C. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

D. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

[5] Activities of daily living (ADLs) defined as those of self-care: feeding oneself, bathing, dressing, grooming

3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*

4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician or admitting qualified and credentialed professional.

B. The current treatment plan includes documentation of diagnosis (DSM-IV-TR axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and ongoing contact with caretakers/guardians/family members, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist or admitting qualified and credentialed professional.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post-hospitalization treatment resources.[G46]

Hospitalization, Eating Disorders[6]

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and one of criteria B, C, D or E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. The illness can be expected to improve and/or not worsen through medically necessary and appropriate therapy, by accepted medical standards. Patients hospitalized because of another primary psychiatric disorder who have a coexisting eating disorder may be considered for admission to an eating disorders hospital level of care based on severity of need relative to both the eating disorder and the other psychiatric disorder that requires active treatment at this level of care.

B. One of the following:

1) the adult patient has physiologic instability that may include but is not limited to: disturbances in heart rate, blood pressure, glucose, potassium, electrolyte balance, temperature, and hydration; clinically significant compromise in liver, kidney, or cardiovascular function; and/or poorly controlled diabetes.F3

2) the child or adolescent patient has physiologic instability that may include but is not limited to: disturbances in heart rate or blood pressure, including orthostatic blood pressure changes; hypokalemia, hypophosphatemia, or hypomagnesemia.F3

3) while admission to this level of care is primarily based on presence of physiologic instability, generally, patients with a body weight significantly below ideal, e.g., 75% of Ideal Body Weight (IBW) or less, or Body Mass Index (BMI) of 16 or below, will have physiologic instability as described above. However, if body weight is equal to or greater than 75% of IBW (or BMI greater than 16), Criterion B can be met if there is evidence of any one of the following:

a) weight loss or fluctuation of greater than 15% in the last 30 days, *or*

b) weight loss associated with physiologic instability unexplained by any other medical condition, *or*

c) the patient rapidly approaching a weight at which physiologic instability occurred in the past, *or*

d) a child or adolescent patient having a body weight less than 85% of IBW during a period of rapid growth.

C. In anorexia, the patient's malnourished condition requires 24-hour medical/nursing intervention to provide immediate interruption of the food restriction, excessive exercise, purging and/or use of laxatives/diet pills/diureticsF13 to avoid imminent, serious harm due to medical consequences *or* to avoid imminent, serious

[6] Because of the severity of co-existing medical disorders, the principal or primary treatment of some eating disorders may be medical/surgical. In these instances, medical/surgical benefits and criteria for appropriateness of care will apply.

complications to a co-morbid medical condition or psychiatric condition (e.g., severe depression with suicidal ideation).

D. In patients with bulimia , the patient's condition requires 24-hour medical/nursing intervention to provide immediate interruption of the binge/purge cycle to avoid imminent, serious harm due to medical consequences *or* to avoid imminent, serious complications to a co-morbid medical condition (e.g., pregnancy, uncontrolled diabetes) or psychiatric condition (e.g., severe depression with suicidal ideation).F79

E. The patient's eating disordered behavior is not responding to an adequate therapeutic trial of treatment in a less-intensive setting (e.g., residential or partial hospital) or there is clinical evidence that the patient is not likely to respond in a less-intensive setting. If in treatment, the patient must:

1) be in treatment that, at a minimum, consists of treatment at least once per week with individual therapy, family and/or other support system involvement (unless there is a valid reason why it is not clinically appropriate or feasible), either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated, *and*
2) have physiologic instability and/or significant weight loss (generally, less than 85% IBW), *and*
3) have significant impairment in social or occupational functioning, *and*
4) be uncooperative with treatment (or cooperative only in a highly structured environment), *and*
5) require changes in the treatment plan that cannot be implemented in a less-intensive setting.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the eating disorder diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. This psychiatric evaluation should also assess for co-morbid psychiatric disorders, and if present, these should be addressed in the treatment plan. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment including but not limited to medication monitoring and administration, nutritional services, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.F13 Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.

C. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and either E or F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*

4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician or admitting qualified and credentialed professional.

B. The current treatment plan includes documentation of diagnosis (DSM-IV-TR axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and intensive family and/or support system's involvement occurring at least once per week, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist or admitting qualified and credentialed professional.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources.

E. The patient's weight remains less than 85% of IBW and he or she fails to achieve a reasonable and expected weight gain despite provision of adequate caloric intake.

F. There is evidence of a continued inability to adhere to a meal plan and maintain control over urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is required.

Hospitalization, Substance Use Disorders, Detoxification[7]

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and B must be met to satisfy the criteria for severity of need.

A. The patient has a recent history of heavy and continuous use of substances that have withdrawal syndromes that can be potentially life threatening or cause serious physical harm, or cause physical withdrawal symptoms that are uncomfortable and disruptive enough to make it highly unlikely that the patient would be able to comply with outpatient treatment. This does not include the patient having mere physical or mental discomfort.

B. Detoxification at a lesser intensive level of care and/or the utilization of an organized support system would potentially be unsafe as evidenced by one of the following:

1) the patient presents with either:

a) signs and symptoms of an impending withdrawal syndrome that has the imminent potential to be life threatening or produce serious physical harm *or*

b) a history of withdrawal seizures, delirium tremens, or other life threatening complications of withdrawal from substances.

or

2) the patient presents with co-morbid medical conditions that are likely to complicate the management of withdrawal to the degree that the patient's life would be endangered.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician prior to, or within 24 hours following the admission.

B. This care must provide an individual plan of active medical treatment that includes 24-hour access to the full spectrum of physician and nurse staffing. This staffing must provide 24-hour services, including skilled observation and medication administration.

C. Documentation of blood and/or urine drug screen is ordered upon admission.

D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs.

[7] It is recognized that life threatening intoxication/poisoning (i.e. endangering vital functions - central nervous system, cardiac, respiratory) may need acute medical attention but that attention is generally not considered detoxification. In such cases, general medical/surgical criteria are applied instead of these criteria for detoxification.

E. Treatment considers the use of medication-assisted treatment where indicated to address cravings and relapse prevention unless medically contra-indicated.

F. Treatment interventions are guided by quantitative measures of withdrawal such as the CIWA-Ar or COWS.

G. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Based on admission criteria the patient continues to need inpatient medical monitoring and treatment.

B. There are continued physical signs and symptoms of acute withdrawal, and/or risk of signs and symptoms of acute withdrawal have not remitted to an extent that intensive nursing and medical interventions on a 24-hour basis are no longer required.

C. Documentation of signs and symptoms must be noted at least three times daily, of which one such notation must be made by a physician.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. The discharge plan receives regular review and revision that includes ongoing plans for timely access to community-based treatment resources that will meet the patient's post-hospitalization treatment needs. This plan includes attempts to link to outpatient primary care after obtaining patient consent.D2, D5

Hospitalization Substance Use Disorders, Rehabilitation Treatment, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for severity of need.

A. The patient has a substance use disorder as defined by DSM-IV-TR that is amenable to active behavioral health treatment.

B. The patient has sufficient cognitive ability at this time to benefit from admission to an inpatient substance rehabilitation treatment program.

C. The patient exhibits a pattern of severe substance abuse/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.

D. The patient's need for detoxification treatment is not of a severity to require a hospital level of detoxification care.

E. One of the following must be met to satisfy this criterion:

1) despite recent (i.e., the past 3 months) appropriate, professional outpatient intervention at a less-intensive level of care, the patient is continually unable to maintain abstinence and recovery, *or*

2) the patient is residing in a severely dysfunctional living environment which would undermine effective outpatient rehabilitation treatment at a less-intense level of care, and alternative living situations are not available or clinically appropriate.

F. One of the following must be met:

1) due to continued abuse of substance(s), the patient is not able to adequately care for a co-morbid medical condition(s) that require(s) medical monitoring or treatment; *or*

2) the patient is in need of substance use disorder rehabilitation treatment and has a co-morbid medical condition(s) that currently require(s) a hospital level of care that can be reasonably and safely delivered on a rehabilitation ward setting rather than requiring a medical/surgical ward setting.

G. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR substance use disorder diagnosis must result from a face-to-face behavioral health evaluation. There must be the availability of an appropriate initial medical assessment, including a complete history of seizures and detection of substance abuse diagnosis and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. The program must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services to monitor the co-morbid medical condition(s) and any ancillary detoxification needs, to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live substance-free outside of a hospital rehabilitation setting.

C. An individualized plan of active behavioral health treatment is provided. This plan must include intensive individual, group and family education and therapy in a hospital rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

E. Treatment considers the use of medication-assisted treatment where indicated to address cravings and relapse prevention unless medically contra-indicated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

   1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

   2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

   3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued inpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the physician at least on a daily basis. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospital treatment needs. This plan will include linkage to outpatient primary care.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

D. There is evidence of at least regular family and/or support system involvement as indicated to promote a successful continuum of less-intense services post discharge, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post-hospitalization treatment resources.

Hospitalization, Substance Use Disorders, Rehabilitation Treatment, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for severity of need.

A. The patient has a substance use disorder as defined by DSM-IV-TR that is amenable to active behavioral health treatment.

B. The patient has sufficient cognitive ability at this time to benefit from admission to an inpatient substance rehabilitation treatment program.

C. The patient exhibits a pattern of severe substance abuse/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.

D. The patient's need for detoxification treatment is not of a severity to require a hospital level of detoxification care.

E. One of the following must be met to satisfy this criterion:

1) despite recent (i.e., the past 3 months) appropriate, professional intervention at a less-intensive level of care, the patient is continually unable to maintain abstinence and recovery, *or*

2) the patient is residing in a severely dysfunctional living environment which would undermine effective rehabilitation treatment at a less-intense level of care, and alternative living situations are not available or clinically appropriate.

F. One of the following must be met:

1) due to continued abuse of substance(s), the patient is not able to adequately care for a substance-related, acute, co-morbid medical condition(s) that require(s) medical monitoring or treatment; *or*

2) the patient is in need of substance use disorder rehabilitation treatment and has a substance-related, acute, co-morbid medical condition(s) that currently require(s) a hospital level of care that can be reasonably and safely delivered on a rehabilitation ward setting rather than requiring a medical/surgical ward setting.

G. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR substance use disorder diagnosis must result from a face-to-face behavioral health evaluation. An appropriate initial medical assessment and ongoing medical management must be available to evaluate and manage co-morbid medical conditions. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. The program must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services to monitor the co-morbid medical condition(s), to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live substance-free outside of a hospital rehabilitation setting.

C. An individualized plan of active behavioral health treatment is provided. This plan must include intensive individual, group and family education and therapy in a hospital rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

   1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

   2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

   3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the substance-related disorder to the degree that would necessitate continued inpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the physician at least on a daily basis. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospital treatment needs. This plan will include linkage to outpatient primary care.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

D. There is evidence of regular family and/or support system involvement as indicated to promote a successful continuum of less-intense services post discharge, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources.

Subacute Hospitalization, Psychiatric, Adult

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of subacute hospitalization treatment.

B. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

C. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include, but is not limited to, medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a subacute hospital setting.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a subacute hospital setting.

C. An individualized plan of active psychiatric treatment is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:

1) at least weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*

2) at least three-times-a-week psychiatric reassessments, *and*

3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*

4) evaluation for current medical problems, *and*

5) evaluation for concomitant substance use issues, *and*

6) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.

D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can be discharged from this level of care.

C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the psychiatrist.

E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate treatment resources after the subacute hospitalization.

Subacute Hospitalization, Psychiatric, Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of subacute hospitalization treatment.

B. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

C. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric and nursing staffing. This psychiatric and nursing staffing must provide 24-hour services in a controlled environment that may include, but is not limited to: medication monitoring and administration, fall precautions, ambulation with assistance, assistance with activities of daily living[8], other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a subacute hospital setting.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission. As part of the mental status testing, assessment of cognitive functioning is warranted.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a subacute hospital setting.

[8] Activities of daily living (ADLs) defined as those of self-care: feeding oneself, bathing, dressing, grooming

C. An individualized plan of active psychiatric treatment is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:

1) at least weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*

2) at least three-times-a-week psychiatric reassessments, *and*

3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*

4) evaluation for current medical problems, *and*

5) ongoing medical services to evaluate and manage co-morbid medical conditions, *and*

6) evaluation for concomitant substance use issues, *and*

7) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his or her regular social environment as soon as possible, unless contraindicated.

D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can be discharged from this level of care.

C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the psychiatrist.

E. There is evidence of at least weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate treatment resources after the subacute hospitalization.

Subacute Hospitalization, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of subacute hospitalization treatment.

B. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

C. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include, but is not limited to, medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a subacute hospital setting.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a subacute hospital setting.

C. An individualized plan of active psychiatric treatment is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:

1) at least weekly family and/or other support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*

2) at least three-times-a-week psychiatric reassessments, *and*

3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*

4) evaluation for current medical problems, *and*

5) evaluation for concomitant substance use issues, *and*

6) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.

D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can be discharged from this level of care.

C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the provider.

E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate treatment resources after the subacute hospitalization.

23-Hour Observation

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected psychiatric and/or substance use disorder. A psychiatric and/or substance use disorder is defined as a disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable Axes (I-V). There may be a lack of a primary definitive DSM-IV-TR diagnosis and/or an incomplete understanding of the patient's clinical needs due to a lack of clinical information or an evolving clinical condition (e.g., intoxication) in which an extended observation period is medically necessary in order to establish a primary, definitive DSM-IV-TR and subsequent treatment plan.

B. Based on the potential risk to self or others, the patient requires an individual plan of extended observation, acute medical and therapeutic crisis intervention and continuity of care services in a facility setting with medical staffing, psychiatric supervision and continuing nursing evaluation. The 23-hour observation must provide immediate services in a facility setting that may include, but are not limited to, diagnostic clarification, assessment of needs, medication monitoring and administration, individual therapy, family and/or other support system involvement, and suicidal/homicidal observation and precautions as needed.

C. Although there is evidence of a potential or current mental health or substance abuse emergency based on history or initial clinical presentation, the need for confinement beyond 23-hours with intensive medical and therapeutic intervention is not clearly indicated.

D. The patient must be medically stable, or there must be appropriate medical services to monitor and treat any active medical condition.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

A. Acute care nursing, medication management and monitoring are available, and all appropriate drug screens, laboratory studies, and medical testing are considered in accordance with accepted medical practice and clinical practice guidelines.

B. A comprehensive evaluation administered by a psychiatrist, which includes a biopsychosocial assessment (based on the available information), mental status examination, and physical examination is completed and appropriate treatment and disposition recommendations are developed.

C. Clinical interventions emphasize crisis intervention, relapse prevention and motivational strategies with the intent to stabilize the patient and enhance motivation for change utilizing medication management, individual therapy and/or family or other support system involvement (the frequency of which will be determined by what the

treatment team believes is needed to stabilize and re-evaluate the patient) with focus on proximal events in a brief solution-focused model.

D. Consultation services are available for general medical, pharmacology and psychological services.

E. Outpatient treatment providers and/or primary care physicians are consulted during the observation period as clinically indicated (and with the patient's documented consent).

F. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in the admission to a 23-hour observation bed, and this discharge plan begins to identify appropriate treatment resources following discharge. Reasonable attempts are made to coordinate the treatment and affect a timely disposition plan in collaboration with current treatment providers.

Criteria for Continued Stay

None

Criteria for Discharge

Criteria A or B must be met to satisfy criteria for discharge:

A. The patient meets admission criteria for inpatient hospitalization.

B. The patient no longer meets admission criteria and can be safely and effectively treated at a less-intensive and restrictive level of care.

Residential Treatment, Psychiatric, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment.

B. There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.

C. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a residential treatment program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a residential setting.

E. The patient's current living environment does not provide the support and access to therapeutic services needed.

F. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation. With the geriatric patient, cognitive functioning is warranted as part of the mental status testing assessment.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.

C. An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:

   1) weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*

   2) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*

   3) ongoing medical services to evaluate and manage co-morbid medical conditions, *and*

   4) evaluation for concomitant substance use issues, *and*

   5) integrated treatment, rehabilitation and support provided by a multidisciplinary team, *and*

   6) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.

D. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

   1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

   2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

   3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued residential treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in weekly progress notes, written and signed by the provider.

E. There is evidence of weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

Residential Treatment, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment.

B. There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.

C. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a residential treatment program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a residential setting.

E. The patient's current living environment does not provide the support and access to therapeutic services needed.

F. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.

C. An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:

   1) intensive family and/or support system involvement occurring at least once per week, or identifies valid reasons why such a plan is not clinically appropriate or feasible, *and*

   2) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*

   3) evaluation for current medical problems, *and*

   4) evaluation for concomitant substance use issues, *and*

   5) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated. School contact should address Individualized Educational Plan/s as appropriate.

D. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

   1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

   2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

   3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued residential treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in weekly progress notes, written and signed by the provider.

E. There is evidence of intensive family and/or support system involvement occurring at least once per week, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

Residential Treatment, Eating Disorders

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

If patient has anorexia, criteria A B, C, D, E and F must be met to satisfy the criteria for severity of need. If patient has bulimia or Eating Disorder Not Otherwise Specified, criteria A, B, C, D and G must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. There is clinical evidence that the patient's condition is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of residential treatment. Patients hospitalized because of another primary psychiatric disorder who have a coexisting eating disorder may be considered for admission to an eating disorder residential level of care based on severity of need relative to both the eating disorder and the other psychiatric disorder that requires active treatment at this level of care.

B. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

C. The patient's eating disordered behavior is not responding to an adequate therapeutic trial of treatment in a less-intensive setting (e.g., partial hospital or intensive outpatient) *or* there is clinical evidence that the patient is not likely to respond in a less-intensive setting. If in a less-intensive setting than residential, the patient must:

   1) be in treatment that, at a minimum, consists of treatment at least once per week with individual therapy, family and/or other support system involvement (unless there is a valid reason why it is not clinically appropriate or feasible), either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated, *and*

   2) have significant impairment in social or occupational functioning, *and*

   3) be uncooperative with treatment (or cooperative only in a highly structured environment), *and*

   4) require changes in the treatment plan that cannot be implemented in a less-intensive setting.

D. The patient's current living environment has severe family conflict and/or does not provide the support and access to therapeutic services needed. Specifically there is evidence that the patient needs a highly structured environment with supervision at or between all meals or will restrict eating or binge/purge. Additionally, the family/support system cannot provide this level of supervision along with a less-intensive level of care setting.

E. If a patient has anorexia, and has a body weight less than 85% of Ideal Body Weight (IBW).[F3] If body weight is equal to or greater than 85% of IBW, this criterion can be met if there is evidence of any one of the following:

   1) weight loss or fluctuation of greater than 10% in the last 30 days, *or*

   2) the patient is within 5-10 pounds of a weight at which physiologic instability occurred in the past, *or*

   3) a child or adolescent patient rapidly losing weight and approaching 85% of IBW during a period of rapid growth.

F. In anorexia, the patient's malnourished condition requires 24-hour residential staff intervention to provide interruption of the food restriction, excessive exercise, purging, and/or use of laxatives/diet pills/diuretics to avoid imminent further weight loss or to continue weight gain from a recent hospital level care.

G. In patients with bulimia or eating disorder not otherwise specified, the patient's condition requires 24-hour residential staff intervention to provide interruption of the binge and/or purge cycle to avoid imminent, serious harm due to medical consequences *or* to avoid imminent, serious complications to a co-morbid medical condition (e.g., pregnancy, uncontrolled diabetes) or psychiatric condition (e.g., severe depression with suicidal ideation).

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family members and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of internal controls to prevent excessive food restricting, binging, purging, exercising and/or use of laxatives/diet pills/diuretics. The program also assists with planning and arranging access to a range of educational, therapeutic and aftercare services and assists with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.

C. An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:

1) at least weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*
2) psychotropic medications, if medically indicated, to be used with specific target symptoms identified, *and*
3) evaluation and management for current medical problems, *and*
4) evaluation and treatment for concomitant substance use issues, *and*
5) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for continued stay. Additionally, if anorectic, criterion H must also be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the eating disorder to the degree that would necessitate continued residential treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

C. There is evidence that the treatment plan is focused on the eating disorder behaviors and precipitating psychosocial stressors that are interfering with the patient's ability to participate in a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in daily progress notes, written and signed by the provider.

E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

F. There is evidence of a continued inability to adhere to a meal plan and maintain control over restricting of food or urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is required.

G. A discharge plan is formulated that is directly linked to the eating behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

H. If anorectic, the patient's weight remains less than 85% of IBW and he or she fails to achieve a reasonable and expected weight gain despite provision of adequate caloric intake.

Residential Treatment, Substance Use Disorders, Detoxification[9]

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, and C must be met to satisfy the criteria for severity of need.

A. The patient has a recent history of heavy and continuous use of substances that have withdrawal syndromes that can be potentially life threatening or cause serious physical harm, or cause physical withdrawal symptoms that are uncomfortable and disruptive enough to make it highly unlikely that the patient would be able to comply with outpatient treatment. This does not include the patient having mere physical or mental discomfort.

B. Detoxification cannot be safely or effectively managed at a less-intensive level of care and/or by an organized support system.

C. Detoxification at an acute inpatient level of care is not required because the patient does not present with:

1) co-morbid medical conditions that are likely to complicate the management of withdrawal to the degree that the patient's life would be endangered, *or*

2) signs and symptoms of an impending withdrawal syndrome that has the imminent potential to be life threatening or produce serious physical harm *or*

3) a history of withdrawal seizures, delirium tremens, or other life threatening complications of withdrawal from substances

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician prior to, or within 24 hours following the admission.

B. This care must provide an individual plan of active medical treatment that includes 24-hour access to the full spectrum of physician and nurse staffing. This staffing must provide 24-hour services, including skilled observation and medication administration.

C. Documentation of blood and/or urine drug screen is ordered upon admission.

D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs.

[9] It is recognized that life threatening intoxication/poisoning (i.e. endangering vital functions - central nervous system, cardiac, respiratory) may need acute medical attention but that attention is generally not considered detoxification. In such cases, general medical/surgical criteria are applied instead of these criteria for detoxification.

E. Treatment considers the use of medication-assisted treatment where indicated to address cravings and relapse prevention unless medically contra-indicated.

F. Treatment interventions are guided by quantitative measures of withdrawal such as the CIWA-Ar or COWS.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, and D must be met to satisfy the criteria for continued stay.

A. Admission criteria continue to be met.

B. There are physical signs and symptoms of acute withdrawal, and/or risk of signs and symptoms of acute withdrawal have not remitted to an extent that intensive nursing and medical interventions on a 24-hour basis are no longer required.

C. Documentation of signs and symptoms must be noted at least three times daily, of which one such notation must be made by a physician.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. The discharge plan receives regular review and revision that includes ongoing plans for timely access to community-based treatment resources that will meet the patient's post-residential treatment needs. This plan includes attempts to link to outpatient primary care after obtaining patient consent.[D2, D5]

Residential Treatment, Substance Use Disorders, Rehabilitation, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The patient has a substance-related disorder as defined by DSM-IV-TR that is amenable to active behavioral health treatment.

B. The patient has sufficient cognitive ability at this time to benefit from admission to a residential treatment program.

C. The patient exhibits a pattern of severe substance abuse/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.

D. One of the following must be met to satisfy criterion D:

1) despite recent (i.e., the past 3 months) appropriate, professional outpatient intervention at a less-intensive level of care, the patient is continually unable to maintain abstinence and recovery, *or*

2) the patient is residing in a severely dysfunctional living environment which would undermine effective rehabilitation treatment at a less-intensive level of care and alternative living situations are not available or clinically appropriate, *or*

3) there is evidence for, or clear and reasonable inference of, serious, imminent physical harm to self or others directly attributable to the continued abuse of substances, which would prohibit treatment in a less-intensive setting.

E. The patient's condition is appropriate for residential treatment, as there is not a need for detoxification treatment at an inpatient hospital level of care.

F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face behavioral health evaluation. With the geriatric patient, cognitive functioning is warranted as part of the mental status testing assessment.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic

and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.

C. Additionally, there is sufficient availability of medical and nursing services to manage this patient's ancillary co-morbid medical conditions.

D. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

E. An individualized plan of active behavioral health treatment and residential living support is provided. This treatment must be medically monitored, with 24-hour medical and nursing services available. This plan must include intensive individual, group and family education and therapy in a residential rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued residential treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the provider at least three times per week. This plan receives regular reviews and revisions that include ongoing plans for timely access to treatment resources that will meet the patient's post--residential treatment needs.

C. There is evidence of regular caretakers'/guardians'/family members' involvement unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

Residential Treatment, Substance Use Disorders, Rehabilitation, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The patient has a substance-related disorder as defined by DSM-IV-TR that is amenable to active behavioral health treatment.

B. The patient has sufficient cognitive ability at this time to benefit from admission to a residential treatment program.

C. The patient exhibits a pattern of severe substance abuse/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.

D. One of the following must be met to satisfy criterion D:

1) despite recent (i.e., the past 3 months), appropriate, professional intervention, at a less-intensive level of care the patient is continually unable to maintain abstinence and recovery, *or*

2) the patient is residing in a severely dysfunctional living environment which would undermine effective rehabilitation treatment and alternative living situations are not available or clinically appropriate, *or*

3) there is actual evidence for, or clear and reasonable inference of serious, imminent physical harm to self or others directly attributable to the continued abuse of substances, which would prohibit treatment in an outpatient setting.

E. The patient's condition is appropriate for residential treatment, as there is not a need for detoxification treatment at an inpatient hospital level of care.

F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face behavioral health evaluation.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.

C. An individualized plan of active behavioral health treatment and residential living support is provided. This treatment must be medically monitored, with 24-hour medical and nursing services available. This plan must include intensive individual, group and family education and therapy in a residential rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

D. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued residential treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the provider at least three times per week. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-residential treatment needs.

C. The individual plan of active treatment includes regular family and/or support system involvement unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

Supervised Living, Psychiatric, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. The patient has a primary DSM-IV-TR diagnosis of a mental illness which is the cause of significant functional and psychosocial impairment and the patient's clinical condition can be expected to be stabilized through the provision of medically necessary supervised residential services in conjunction with medically necessary treatment, rehabilitation and support.

B. The patient's condition requires residential supervision and active support to ensure the adequate, effective coping skills necessary to live safely in the community, participate in self-care and treatment and manage the effects of his/her illness. As a result of the patient's clinical condition (impaired judgment, behavior control, or role functioning) there is a significant current risk of one of the following:

   1) hospitalization or other inpatient care as evidenced by the current course of illness or by the past history of illness, *or*

   2) harm to self or others as a result of the mental illness and as evidenced by the current behavior or by the past history.

C. The patient's own resources and social support system are not adequate to provide the level of residential support and supervision currently needed as evidenced by one of the following:

   1) the patient has no residence and no social support, *or*

   2) the patient has a current residential placement, but the existing placement does not provide adequate supervision to ensure safety and participation in treatment, *or*

   3) the patient has a current residential placement, but the patient is unable to use the relationships in the existing residence to ensure safety and participation in treatment or the relationships are dysfunctional and undermine the stability of treatment.

D. The patient is judged to be medically stable, able to reliably cooperate with the rules and supervision provided, and to reliably plan for safety in the supervised residence.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. Supervised living will provide supervision and support in a residence outside of the patient's own home and provides needed resources and support not sufficiently available within the patient's own existing social support system. Clinical intervention services, including behavioral, psychological and psychosocial therapeutic

interventions, may also be provided within supervised residential settings, in lieu of or in addition to outpatient and other community-based mental health services.

B. At least one responsible staff person must be present or available by telephone at all times when there are patients on the premises.

C. There is the provision of, or coordination with, medical and/or nursing services sufficient to manage this patient's co-morbid medical conditions.

D. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. The patient continues to have significant functional impairment as a result of a mental illness, and the problems that caused the admission persist to a degree that continues to meet the admission criteria.

B. There continues to be a risk of one of the following:

1) inpatient admission, *or*

2) harm to self or others.

C. There is evidence that the resources and social support system which are available to the patient outside the supervised residence continue to be inadequate to provide the level of residential support and supervision currently needed for safety, self-care or effective treatment despite current treatment, rehabilitation and discharge/disposition planning.

D. There is evidence of coordination between the patient's supervisor and the case manager or primary therapist, if applicable.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-supervised living, community-based treatment resources.

Supervised Living, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. The patient has a primary DSM-IV-TR diagnosis of an emotional/psychiatric disturbance and/or significant behavioral problem which is the cause of significant functional and psychosocial impairment and the patient's clinical condition can be expected to be stabilized through the provision of medically necessary supervised residential services in a supportive home environment in conjunction with medically necessary treatment, rehabilitation and support.

B. The patient's condition requires residential supervision and active support to ensure the adequate, effective, coping skills necessary to live safely in the community, participate in self-care and treatment and manage the effects of his/her illness. The patient's family or caregivers demonstrate an inability to adequately care for the patient's physical, emotional, psychosocial and/or supervision needs. As a result of the patient's behavioral problems and/or functional deficits and the family's and/or support system's inability to provide adequate care and supervision of the patient to ensure his/her safety, there is a significant current risk of one of the following:

   1) hospitalization or other inpatient care as evidenced by the current course of the disorder or by the past history of the disorder, *or*

   2) harm to self or others as a result of mental illness as evidenced by the current behavior or by the past history.

C. The patient's home environment, family resources and support network are not adequate to provide the level of residential support and supervision currently needed by the patient.

D. The patient is judged to be able to reliably cooperate with the rules and supervision provided and can be safe in a supervised residence.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

A. Supervised living will provide supervision and support in a residence outside of the patient's own home and provides needed resources and support not sufficiently available within the patient's own existing social support system. Clinical intervention services, including behavioral, psychological and psychosocial therapeutic interventions, may also be provided within supervised residential settings, in lieu of or in addition to outpatient and other community-based mental health services.

B. At least one responsible staff person must be present at all times when there are patients on the premises.

C. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction.

After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. The patient continues to have significant functional impairment as a result of a psychiatric disorder, and the problems that caused the admission persist to a degree that continues to meet the admission criteria.

B. The patient's family or caregivers continue to demonstrate an inability to adequately care for the patient's physical, emotional, psychosocial and/or supervision needs and, as a result, there continues to be a risk of one of the following:

   1) inpatient admission, *or*

   2) harm to self or others.

C. There is evidence that the resources and social support system which are available to the patient outside the supervised residence continue to be inadequate to provide the level of residential support and supervision currently needed for safety, care or effective treatment despite current treatment, rehabilitation and discharge/disposition planning.

D. There is evidence of coordination between the patient's supervisor and the case manager or primary therapist, if applicable.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-supervised living, community-based treatment resources.

Supervised Living, Substance Use Disorders, Rehabilitation, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The patient has a primary DSM-IV-TR diagnosis of a substance-related disorder which is the cause of significant functional and psychosocial impairment and the patient's clinical condition can be expected to be stabilized through the provision of medically necessary supervised residential services in conjunction with medically necessary treatment, rehabilitation and support.

B. The patient's condition requires residential supervision and active support to ensure the adequate, effective coping skills necessary to live safely in the community participate in self-care and treatment and manage the effects of his/her disorder. As a result of the patient's clinical condition (impaired judgment, behavior control, or role functioning) there is a significant current risk of one of the following:

   1) hospitalization or other inpatient care as evidenced by the current clinical course or by the past clinical history, *or*

   2) harm to self or others as a result of the substance-related disorder as evidenced by the current behavior or by the past history.

C. The patient's own resources and social support system are not adequate to provide the level of residential support and supervision currently needed as evidenced by one of the following:

   1) the patient has no residence and no social support, *or*

   2) the patient has a current residential placement, but the existing placement does not provide adequate supervision to ensure safety and participation in treatment, *or*

   3) the patient has a current residential placement, but the patient is unable to use the relationships in the existing residence to ensure safety and participation in treatment or the relationships are dysfunctional and undermine the stability of treatment.

D. The patient is judged to be medically stable, able to reliably cooperate with the rules and supervision provided and able to reliably plan for safety in the supervised residence.

E. The patient's need for detoxification treatment is not of a severity to require an inpatient hospital level of care.

F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. Supervised living will provide supervision and support in a residence outside of the patient's own home and provides needed resources and support not sufficiently available within the patient's own existing social support system. Clinical intervention services, including behavioral, psychological and psychosocial therapeutic interventions, may also be provided within supervised residential settings, in lieu of or in addition to outpatient and other community-based mental health services.

B. There is the provision of or coordination with medical and/or nursing services sufficient to manage this patient's co-morbid medical conditions.

C. At least one responsible staff person must be present or available by telephone at all times when there are patients on the premises.

D. Treatment considers the-use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for continued stay.

A. The patient continues to have significant functional impairment as a result of the substance-related disorder, and the problems that caused the admission persist to a degree that continues to meet the admission criteria.

B. There continues to be a risk of one of the following:

1) inpatient admission, *or*

2) harm to self or others.

C. There is evidence that the resources and social support system which are available to the patient outside the supervised residence continue to be inadequate to provide the level of residential support and supervision currently needed to promote recovery and for safety, self-care or effective treatment despite current treatment, rehabilitation and discharge/disposition planning.

D. There is evidence of coordination between the patient's supervisor and the case manager or primary therapist, if applicable.

E. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. The discharge plan receives regular review and revision that includes ongoing plans for timely access to community-based treatment resources that will meet the patient's post-supervised living treatment needs.

Supervised Living, Substance Use Disorders, Rehabilitation, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The patient has a primary DSM-IV-TR diagnosis of a substance-related disorder which is the cause of significant functional and psychosocial impairment and the patient's clinical condition can be expected to be stabilized through the provision of medically necessary supervised residential services in a supportive home environment in conjunction with medically necessary treatment, rehabilitation and support.

B. The patient's condition requires residential supervision and active support to ensure the adequate, effective, coping skills necessary to live safely in the community, participate in self-care and treatment and manage the effects of his/her illness. The patient's family or caregivers demonstrate an inability to adequately care for the patient's physical, emotional, psychosocial and/or supervision needs. As a result of the patient's behavioral problems and/or functional deficits and the family's and/or support system's inability to provide adequate care and supervision of the patient to ensure his/her safety, there is a significant current risk of one of the following:

   1) hospitalization or other inpatient care as evidenced by the current course of the disorder or by the past history of the disorder, *or*

   2) harm to self or others as a result of the substance-related disorder as evidenced by the current behavior or by the past history.

C. The patient's home environment, family resources and support systems are not adequate to provide the level of residential support and supervision currently needed by the patient.

D. The patient is judged to be medically stable, able to reliably cooperate with the rules and supervision provided, and can be safe in a supervised residence.

E. The patient's need for detoxification treatment is not of a severity to require an inpatient hospital level of care.

F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A and B must be met to satisfy the criteria for intensity and quality of service.

A. Supervised living will provide supervision and support in a residence outside of the patient's own home and provides needed resources and support not sufficiently available within the patient's own existing social support system. Clinical intervention services, including behavioral, psychological and psychosocial therapeutic interventions, may also be provided within supervised residential settings, in lieu of or in addition to outpatient and other community-based mental health services.

B. At least one responsible staff person must be present at all times when there are patients on the premises.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for continued stay.

A. The patient continues to have significant functional impairment as a result of the substance-related disorder, and the problems that caused the admission persist to a degree that continues to meet the admission criteria.

B. The patient's family or caregivers continue to demonstrate an inability to adequately care for the patient's physical, emotional, psychosocial and/or supervision needs and, as a result, there continues to be a risk of one of the following:

   1) inpatient admission, *or*

   2) harm to self or others.

C. There is evidence that the resources and social support system which are available to the patient outside the supervised residence continue to be inadequate to provide the level of residential support and supervision currently needed to promote recovery and for safety, care or effective treatment despite current treatment, rehabilitation and discharge/disposition planning.

D. There is evidence of coordination between the patient's supervisor and the case manager or primary therapist, if applicable.

E. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. The discharge plan receives regular review and revision that includes ongoing plans for timely access to community-based treatment resources that will meet the patient's post-supervised living treatment needs.

Partial Hospitalization, Psychiatric, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. There is clinical evidence that the patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. In addition, safe and effective treatment cannot be provided in a less-intensive outpatient setting at this time, and a partial hospital program can safely substitute for, or shorten, a hospital stay.

C. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a partial hospitalization program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

D. Additionally; either:

1) the patient can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time, *or*

2) the patient is believed to be capable of controlling unsafe behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

E. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours, frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical.

C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team and should include caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. Telephonic family conferences may be appropriate when distance, travel time, participants' work schedules or other difficulties make face-to-face sessions impractical. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the patient to a lesser level of care.

D. A Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria f or Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued partial hospitalization treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.

C. There is evidence of at least weekly family and/or support system therapeutic involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

Partial Hospitalization, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. There is clinical evidence that the patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. In addition, safe and effective treatment cannot be provided in a less-intensive outpatient setting at this time, and a partial hospital program can safely substitute for, or shorten, a hospital stay.

C. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a partial hospitalization program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

D. Additionally, either:

1) the patient can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time, or

2) the patient is believed to be capable of controlling unsafe behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

E. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.W6

B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours and frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. This also includes plans for at least

weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the patient to a lesser level of care.

D. A Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued partial hospitalization treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.

C. The individual plan of active treatment includes at least weekly family therapy and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

Partial Hospitalization, Eating Disorders

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, and D must be met to satisfy the criteria for severity of need. Additionally if anorectic, criterion E must also be met to satisfy the criteria for severity of need.

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. There is clinical evidence that the patient's condition can be expected to improve and/or not worsen through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. The patient can reliably cooperate in a clinically supervised, structured environment for part of the day and has a suitable environment for the rest of the time, *and* the patient is believed to be capable of significantly controlling binging, excessive exercising, purging and overuse of laxatives/diet pills/diuretics outside program hours. Additionally, the patient appears reasonably able to seek professional assistance or other support when not in the partial hospital setting.

C. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

D. The patient's eating disordered behavior is not responding to an adequate therapeutic trial of treatment in a less-intensive setting (e.g., outpatient or intensive outpatient) or there is clinical evidence that the patient is not likely to respond in a less-intensive setting. If in treatment, the patient must:

   1) be in treatment that, at a minimum, consists of treatment at least once per week with individual therapy, family and/or other support system involvement (unless there is a valid reason why it is not clinically appropriate or feasible), either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated, *or*

   2) be uncooperative with treatment (or cooperative only in a highly structured environment), *or*

   3) require changes in the treatment plan that cannot be implemented in a less-intensive setting.

E. The patient has anorexia; he or she is between 75-85 percent of his or her ideal body weight (IBW) and clinical evidence indicates the patient requires a structured program— including medical monitoring and nursing supervision during and between two meals per day to gain weight and/or control eating disorder behaviors— that cannot be provided in a less-intensive outpatient setting.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours, frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. This plan also includes plans for at least weekly family and/or support system involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).

C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. If the patient has anorexia, a specific treatment goal of this team is to help the patient gain weight and develop the capability to continue this weight gain upon returning to a less-intensive level of care. If the patient has bulimia, the goal is to help the patient develop internal controls to limit binging and purging to a degree sufficient to allow the patient to transition to a less-intensive level of care.

D. A Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the eating disorder to the degree that would necessitate continued partial hospitalization treatment.

B. The current or revised treatment plan can be reasonably expected to bring about improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the physician. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.

C. There is evidence of at least weekly family and/or support system therapeutic involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).

D. A discharge plan is formulated that is directly linked to the eating disorder behaviors that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

Partial Hospitalization, Substance Use Disorders, Rehabilitation Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The provider is able to document that the patient has a history of a substance-related disorder meeting DSM-IV-TR criteria and has sufficient cognitive ability at this time to benefit from admission to a partial hospitalization program.

B. The patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. Additionally, the patient requires more intensive multidisciplinary evaluation, treatment and support than can be provided in a traditional outpatient visit setting or an intensive outpatient program.

C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.[E11]

D. The patient is able to seek professional and/or social supports outside of program hours as needed.

E. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. There is a structured program with evaluation by a psychiatrist within 48 hours, frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. Additionally, there is sufficient availability of medical and/or nursing services to manage this patient's ancillary detoxification needs.

C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. Caretakers/guardians/family members should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible. Telephonic family conferences may be appropriate when distance, travel time, participants work schedule or other difficulties make face-to-face sessions impractical. A specific treatment goal of this team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to a less-intensive level of care.

D. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

E. A Urine Drug Screen (UDS) is considered at least once per month on a random basis, or more often as clinically warranted.[10]

Criteria for Continued Stay

III. Continued Stay

Criteria A .B, C, D and E must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued partial hospitalization treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

D. There is evidence of at least weekly family and/or support system therapeutic involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

[10] The UDS should be a standard qualitative screen. A quantitative screen may be necessary after a positive qualitative result. Lab testing is preferred over dipsticks.

Partial Hospitalization, Substance Use Disorders, Rehabilitation, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The provider is able to document that the patient has a history of a substance-related disorder meeting DSM-IV-TR criteria and is mentally competent and has sufficient cognitive ability at this time to benefit from admission to a partial hospitalization program.

B. The patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than3 times weekly nursing or medical assessment, one of which must be medical. Additionally, the patient requires more intensive multidisciplinary evaluation, treatment and support than can be provided in a traditional outpatient visit setting or an intensive outpatient program.

C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.

D. The patient is able to seek professional and/or social supports outside of program hours as needed.

E. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours and frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. This also includes plans for regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible. A specific treatment goal of this team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to a less-intensive level of care.

D. A Urine Drug Screen (UDS) is considered at least once per month on a random basis, or more often as clinically warranted.[11]

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued partial hospitalization treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This treatment plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

D. The individual plan of active treatment includes regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

E. There is evidence of at least weekly family and/or support system therapeutic involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

[11] The UDS should be a standard qualitative screen. A quantitative screen may be necessary after a positive qualitative result. Lab testing is preferred over dipsticks.

Intensive Outpatient Treatment, Psychiatric, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment. The patient's disorder can be expected to improve significantly through medically necessary and appropriate therapy. The patient has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.

B. The impairment results in at least one of the following:

   1) a clear, current risk to the patient's ability to live in his/her customary setting for a patient who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care, *and/or*

   2) a clear, current threat to the patient's ability to be employed or attend school, *and/or*

   3) an emerging/impending risk to the safety or property of the patient or of others.

C. Either:

   1) for patients with persistent or recurrent disorders, the patient's past history indicates that when the patient has experienced similar clinical circumstances, less-intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the patient or others, *or*

   2) for patients with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient or others.

D. The patient requires an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services, and is capable of seeking professional support and/or support from caretakers/guardians/family members outside of program hours as needed.

E. The patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social support and/or support from caretakers/guardians/family members must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.

C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups. The treatment plan actively encourages the coordination of care among the patient's providers.

D. A Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A and B must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) difficulty and/or lack of coordination of a variety of outpatient services by providers/patient/family supports necessitating use of IOP to ensure this missing component, *or*

4) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

Intensive Outpatient Treatment, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment. The patient's disorder can be expected to improve significantly through medically necessary and appropriate therapy. The patient has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.

B. The impairment results in at least one of the following:

   1) a clear, current risk to the patient's ability to live in his/her customary setting for a patient who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care, *and/or*

   2) a clear, current threat to the patient's ability to be employed or attend school, *and/or*

   3) an emerging/impending risk to the safety or property of the patient or of others.

C. Either:

   1) for patients with persistent or recurrent disorders, the patient's past history indicates that when the patient has experienced similar clinical circumstances, less-intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the patient or others, *or*

   2) for patients with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient or others.

D. The patient requires an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services and is capable of seeking professional and/or social supports outside program hours as needed.

E. The patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.

C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups. The treatment plan encourages the coordination of care among the patient's providers.

D. A Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) difficulty and/or lack of coordination of a variety of outpatient services by providers/patient/family supports necessitating use of IOP to ensure this missing component, *or*

4) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

C. The individual plan of active treatment includes at least weekly family and/or support system involvement in therapy, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Intensive Outpatient Treatment, Eating Disorders

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need. Additionally if anorectic, criterion G must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. There is clinical evidence that the patient's condition can be expected to improve through medically necessary and appropriate therapy. The patient has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.

B. The impairment from the eating disorder results in at least one of the following, which requires a more intensive and structured level of care than outpatient:

   1) a clear, current threat to the patient's ability to live in his/her customary setting for a patient who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care, *and/or*

   2) a clear, current threat to the patient's ability to be employed or attend school, *and/or*

   3) an emerging/impending risk to the safety or property of the patient or of others.

C. Either of the following:

   1) for patients with a persistent or recurrent eating disorder, the past history indicates that when the patient has experienced similar clinical circumstances, less-intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing threats to the patient's medical stability, *or*

   2) for patients with an acute eating disorder crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the eating disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient.

D. The patient requires an integrated program of dietary counseling, rehabilitation counseling, education, therapeutic, and/or family/support system services and is capable of seeking professional and/or social supports outside program hours as needed.

E. The patient can reliably cooperate in a clinically supervised, structured environment for part of the day and has a suitable environment for the rest of the time, *and* the patient appears able to seek professional assistance or other support when not in the intensive outpatient setting.

F. The patient is medically stable and does not require 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.

G. If the patient has anorexia and there is clinical evidence that without the structure of an intensive outpatient program, there is a clear current threat to the patient's ability to maintain weight >80% of IBW and a consequent threat to the patient's current medical physiologic stability.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes an integrated program of dietary and exercise counseling, rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.

C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff within a structured program of treatment. One specific treatment goal of this team is helping the patient internalize better control of urges to restrict food, exercise excessively, binge, purge and/or overuse laxatives/diet pills/diuretics. If anorectic, a related goal is further solidifying the stability of weight gain and/or maintenance sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.

D. Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

C. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis(es) of a substance-related disorder meeting DSM-IV-TR criteria, and has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.

B. The patient requires more intensive treatment and support than can be provided in a traditional outpatient visit setting, i.e., an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day. The patient's condition reflects a pattern of severe substance use as evidenced by periods of inability to maintain abstinence over a consistent period of time.

C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.

D. The patient is able to seek professional supports and/or support from caretakers/guardians/family members outside of program hours as needed.

E. For patients with a history of repeated relapses and a treatment history involving multiple treatment attempts in intensive outpatient or partial hospital programs, there must be documentation of the restorative potential for the proposed program admission.

F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional support and/or support from caretakers/guardians/family members must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day. Additionally, there is the provision of or coordination with medical and/or nursing services sufficient to manage this patient's ancillary co-morbid medical conditions.

C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. A specific treatment goal of the treatment

team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.[1,5]

D. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

E. A Urine Drug Screen (UDS) is considered at least once per month on a random basis, or more often as clinically warranted.[12]

Criteria for Continued Stay

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued intensive outpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

[12] The UDS should be a standard qualitative screen. A quantitative screen may be necessary after a positive qualitative result. Lab testing is preferred over dipsticks.

Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis(es) of substance-related disorder meeting DSM-IV-TR criteria, and has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.

B. The patient requires more intensive treatment and support than can be provided in a traditional outpatient visit setting, i.e., an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day. The patient's condition reflects a pattern of severe substance use as evidenced by periods of inability to maintain abstinence over a consistent period of time.

C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.

D. The patient is able to seek professional and/or social supports outside of program hours as needed.

E. For patients with a history of repeated relapses and a treatment history involving multiple treatment attempts in intensive outpatient or partial hospital programs, there must be documentation of the restorative potential for the proposed program admission.

F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission- Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.

C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.

D. A Urine Drug Screen (UDS) is considered at least once per month on a random basis, or more often as clinically warranted.[13]

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued intensive outpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

D. The individual plan of active treatment includes at least weekly family/support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

[13]The UDS should be a standard qualitative screen. A quantitative screen may be necessary after a positive qualitative result. Lab testing is preferred over dipsticks.

Ambulatory, Substance Use Disorders, Detoxification[14]

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B and C must be met to satisfy the criteria for severity of need.

A. The patient has a recent history and pattern of continuous use of substances that have withdrawal syndromes and require medically supervised outpatient treatment to prevent complications. Withdrawal symptoms are such that do they not require 24-hour access to physician and/or nurse monitoring, nor a history of medically complicated withdrawal in the past

B. Presence of mild to moderate withdrawal symptoms may be safely managed outside a residential or inpatient setting as evidenced by:

   1) an absence of a withdrawal history of delirium tremens, seizures, or other life-threatening reactions to long-term substance use, *and*

   2) an absence of complicating psychiatric or medical illness that would require 24-hour inpatient or residential treatment, *and*

   3) a CIWA-Ar score in the mild to moderate range or the equivalent on a standardized scale for assessment of withdrawal symptoms, *and*

   4) family and/or social support is available to assist the patient during detoxification.

C. The patient has expressed a desire to enter or continue rehabilitation treatment or self-help recovery.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician.

B. This care must provide an individual plan of active medical treatment. Adequate arrangements should be made for treatment of withdrawal symptoms during the times when the treating physician is not available.

C. Documentation of blood and/or urine drug screen is ordered upon commencement of treatment.

[14] It is recognized that life threatening intoxication/poisoning (i.e. endangering vital functions - central nervous system, cardiac, respiratory) may need acute medical attention but that attention is generally not considered detoxification. In such cases, general medical/surgical criteria are applied instead of these criteria for detoxification.

D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs.

E. Treatment considers the use of medication-assisted treatment where indicated to address cravings and relapse prevention unless medically contra-indicated.

F. Treatment interventions are guided by quantitative measures of withdrawal such as the CIWA-Ar or COWS.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Admission criteria continue to be met.

B. The patient's condition does not require a higher level of care.

C. Documentation of signs, symptoms and improvement in withdrawal symptoms are noted, and the treatment plan is re-evaluated and modified as medically appropriate.

D. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in treatment. The discharge plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-detoxification needs. This plan includes attempts to link to outpatient primary care after obtaining patient consent.[D2, D5]

Ambulatory, Substance Use Disorders, Buprenorphine Maintenance

It is recognized that life threatening intoxication/poisoning (i.e., endangering vital functions - central nervous system, cardiac, respiratory) may need acute medical attention but that attention is generally not considered detoxification. In such cases, general medical/surgical criteria are applied instead of these criteria for detoxification.

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B and C must be met to satisfy the criteria for severity of need.

A. The patient has a recent history and pattern of continuous use of opioid substances that have withdrawal syndromes and require medically supervised outpatient treatment to prevent complications. Withdrawal symptoms are such that they do not require 24-hour access to physician and/or nurse monitoring, nor is there a history of medically complicated withdrawal in the past.

B. Presence of mild to moderate withdrawal symptoms may be safely managed outside a residential or inpatient setting as evidenced by:

1) an absence of a withdrawal history of delirium tremens, seizures, or other life-threatening reactions to long-term substance use, *and*

2) an absence of complicating psychiatric or medical illness that would require 24-hour inpatient or residential treatment, *and*

3) a COWS score in the mild to moderate range or the equivalent on a standardized scale for assessment of withdrawal symptoms, *and*

4) family and/or social support is available to assist the patient during detoxification, *and*

5) a history of at least 2 prior failed opioid detoxification experiences (where there is a return to further opioid dependence) either of institutional or personal attempts.

C. The patient has expressed a desire to enter or continue rehabilitation treatment or self-help recovery.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, and E must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician who carries the correct Buprenorphine DEA waiver.

B. This care must provide an individual plan of active medical treatment. Adequate arrangements should be made for treatment of withdrawal symptoms during the times when the treating physician is not available.

C. Documentation of blood and/or urine drug screen is ordered upon commencement of treatment.

D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs, including encouragement of member to participate in substance use disorder counseling and/or appropriate support resources, such as 12-step type formats and cognitive based formats.

E. Treatment interventions are guided by quantitative measures of withdrawal such as COWS.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Admission criteria continue to be met.

B. The patient's condition does not require a higher level of care.

C. Documentation of signs, symptoms and improvement in steadfast opioid sobriety and abstinence with the ongoing assessment and treatment plan addressing, re-evaluating, and modified as medically appropriate to ensure continued sober success.

D. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate. Use of random blood and/or urine drug screen is a component of monitoring for adherence to treatment recommendations.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in treatment. The discharge plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-maintenance needs. This plan includes attempts to link to outpatient primary care and ongoing behavioral health counseling (addressing appropriate mental health and substance disorder needs) after obtaining patient consent).D2, D5

Ambulatory, Substance Use Disorders, Laboratory Screening of Drugs/Substances of Abuse

Purpose: To establish the types of laboratory assays and testing frequency that is reasonable and medically necessary for the diagnosis and treatment of a substance use disorder.

Criteria for Authorization

I. Severity of Need

Criteria A and B must be met. In addition C, D, E and/or F must be met.

A. The patient has a diagnosed or suspected substance use disorder. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. Screening uses a multi-panel qualitative assay screening approach (e.g., 'Drugs of Abuse 10 Panel'[15], corresponding to CPT code 80100, 80101 and 82055 for alcohol).

C. Screenings occur upon admission to the substance use disorder rehabilitation program and at ten (10) day intervals to monitor program compliance. Testing at more frequent intervals must be accompanied by documentation of reasons of medical/clinical necessity.

D. Specific drug quantitation can be performed only when there is an acute change in medical status or drug toxicity must be ruled out.

E. Quantitative testing of serum methadone levels may be performed only under the following circumstances:

1) patient is in stabilization phase and requesting an increase over 80mg of methadone, *or*

2) a patient is in maintenance phase and requesting significant dose changes, *or*

3) clinician suspects that a patient is experiencing a drug-drug interaction involving Methadone, *or*

4) clinician is considering split dosing of methadone for the patient, *or*

5) patient is pregnant, and clinician identifies need to screen for changes in metabolism of methadone.

F. Quantitative testing of a limited number drugs may be performed for the purpose of monitoring therapeutic response when the drug is being used as a mood stabilizer or to control a seizure disorder:

1) Carbamazepine

[15] Elements of the 'Drugs of Abuse10 Panel' vary by provider, but commonly include: marijuana, cocaine, phencyclidine, methamphetamine, methadone, amphetamine (capable of detecting MBDB, MDA, MDEA, MDMA), barbiturates, benzodiazepine, and tricyclic antidepressants.

2) Clozapine
3) Dipropylacetic acid
4) Lithium
5) Phenytoin

II. Exclusions

Specific drug quantitation or confirmation testing are performed for forensic or legal purposes.

Outpatient Treatment, Psychiatric and Substance Use Disorders, Rehabilitation

Criteria for Treatment Status Review

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for the treatment review.

I. Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The patient has, or is being evaluated for, a DSM-IV-TR diagnosis on Axis I and/or Axis II.

B. The presenting behavioral, psychological, and/or biological dysfunctions and functional impairment (occupational, academic, social) are consistent and associated with the DSM-IV-TR psychiatric/substance-related disorder(s) on Axis I and/or Axis II.

C. One of the following:

1) the patient has symptomatic distress and demonstrates impaired functioning due to psychiatric symptoms and/or behavior in at least one of the three spheres of functioning (occupational, scholastic, or social), that are the direct result of an Axis I or Axis II disorder. This is evidenced by specific clinical description of the symptom(s) and specific measurable behavioral impairment(s) in occupational, academic or social areas consistent with a GAF (DSM-IV-TR Axis V) score of less than 71, *or*

2) the patient has a persistent illness described in DSM-IV-TR with a history of repeated admissions to 24-hour treatment programs for which maintenance treatment is required to maintain community tenure, *or*

3) there is clinical evidence that a limited number of additional treatment sessions are required to support termination of therapy, although the patient no longer has at least mild symptomatic distress or impairment in functioning. The factors considered in making a determination about the continued medical necessity of treatment in this termination phase are the frequency and severity of previous relapse, level of current stressors, and other relevant clinical indicators. Additionally, the treatment plan should include clear goals needing to be achieved and methods to achieve them in order to support successful termination (such as increasing time between appointments, use of community resources, and supporting personal success).

D. The patient does not require a higher level of care.

E. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Intensity and Quality of Service

Criteria A, B, C, D, E, F, G, H, I, and J must be met to satisfy the criteria for intensity and quality of service. In addition, K must also be met for substance use disorders.

A. There is documentation of a DSM-IV-TR diagnosis on Axis I and/or Axis II, and there are completed assessments on Axes III, IV, and V. The assessment also includes the precipitating event/presenting issues,

specific symptoms and functional impairments, community and natural resources, personal strengths, and the focus of treatment.

B. There is a medically necessary and appropriate treatment plan, or its update, specific to the patient's behavioral, psychological, and/or biological dysfunctions associated with the DSM-IV-TR psychiatric/substance-related disorder(s) on Axis I and/or Axis II. The treatment plan is expected to be effective in reducing the patient's occupational, academic or social functional impairments and:

   1) alleviating the patient's distress and/or dysfunction in a timely manner, *or*

   2) achieving appropriate maintenance goals for a persistent illness, *or*

   3) supporting termination.

C. The treatment plan must identify all of the following:

   1) treatment modality, treatment frequency and estimated duration;

   2) specific interventions that address the patient's presenting symptoms and issues;

   3) coordination of care with other health care services, e.g., PCP or other behavioral health practitioners;

   4) the status of active involvement and/or ongoing contact with patient's family and/or support system, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible;

   5) the status of inclusion and coordination, whenever possible, with appropriate community resources;

   6) consideration/referral/utilization of psychopharmological interventions for diagnoses that are known to be responsive to medication;

   7) documentation of objective progress toward goals for occupational, academic or social functional impairments, target-specific behavioral, psychological, and/or biological dysfunctions associated with the DSM-IV-TR psychiatric/substance-related disorder(s) being treated. Additionally, specific measurable interim treatment goals and specific measurable end of treatment goals, or specific measurable maintenance treatment goals (if this is maintenance treatment), are identified. Appropriate changes in the treatment plan are made to address any difficulties in making measurable progress;

   8) the description of an alternative plan to be implemented if the patient does not make substantial progress toward the given goals in a specified period of time. Examples of an alternative plan are psychiatric evaluation if not yet obtained, a second opinion, or introduction of adjunctive or different therapies; and

   9) the current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting Severity of Need Criteria (I above). This evolving clinical status is documented by written contact progress notes.

D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

E. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient, and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate.

F. Although the patient has not yet obtained the treatment goals, progress as relevant to presenting symptoms and functional impairment is clearly evident and is documented in objective terms.

G. Treatment is effective as evidenced by improvement in GAF, SF-BH, CHI, and/or other valid outcome measures.

H. Requested services do not duplicate other provided services.

I. Visits for this treatment modality are recommended to be no greater than one session per week, except for: (i) acute crisis stabilization, or (ii) situations where the treating provider demonstrates more than one visit per week is medically necessary.

J. As the patient exhibits sustained improvement or stabilization of a persistent illness, frequency of visits should be decreased over time (e.g., once every two weeks or once per month) to reinforce and encourage self-efficacy, autonomy, and reliance on community and natural supports.

K. For substance use disorders, treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

Outpatient Applied Behavior Analysis

Parameters for the treatment of individuals with Autism Spectrum Disorders

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient applied behavior analysis (ABA)[16].

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

There must be documentation of:

A. An established DSM-IV-TR diagnosis of a Pervasive Developmental Disorder.[17]

B. Presence of deficits or behaviors that:

- Significantly interfere with home or community activities; *and*
- Presents a health or safety risk to self or others (such as self-injury, aggression toward others, destruction of property, stereotyped/repetitive behaviors, elopement, severe disruptive behavior).

C. Less-intensive behavior treatment or other therapy has been seriously considered or has been applied and has not been sufficient to reduce interfering behaviors, to increase pro-social behaviors, or to maintain desired behaviors.

D. The patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission – Intensity and Quality of Service

Criteria A, B, C, D, and E must be met to satisfy the criteria for intensity and quality of service.

A. A reasonable expectation on the part of a qualified treating health care professional[18] who has completed an initial evaluation of the patient, that the individual's behavior will improve significantly with ABA therapy provided by, or supervised by, a Magellan credentialed, certified and contracted ABA provider. The diagnosis must be made by a physician trained in screening and diagnosis of autism spectrum disorders (ASD), and a confirmation and treatment plan must be developed by a board certified professional trained in Applied Behavior Analysis or other treatment modalities.

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[16] Applies to Other Related Structured Behavioral Programs for members of AmeriHealth NJ.

[17] The DSM-IV-TR, Fourth Edition, 2000 has established a category of Pervasive Developmental Disorders, which includes: Autistic Disorder, Asperger's Disorder, Childhood Disintegrative Disorder, Rett's Disorder, and Pervasive Development Disorder Not Otherwise Specified. However, ABA has not been shown to be effective with Rett's Disorder; therefore, Rett's Disorder is excluded from this criterion.

[18] Qualified treating health care professionals are defined as a pediatrician, a provider independently licensed and credentialed by and contracted with Magellan, or as permitted by applicable state and/or federal law.

B. The treatment plan is built upon individualized goals. The treatment plan must delineate both the frequency of baseline behaviors and the treatment development plan to address the behaviors. The treatment plan must include care coordination involving parents or caregiver, school, state disability programs and others as applicable. Treatment plan objectives are measurable, based upon clinical observation, outcome measurement assessment and tailored to the patient.

C. Parent or caregiver training and support is incorporated into the treatment plan and required for generalization of treatment.

D. Interventions emphasize generalization of skills and focus on the development of spontaneous social communication, adaptive skills, and appropriate behaviors.

E. Interventions are consistent with ABA techniques.

Criteria for Continued Stay

III. Continued Stay

Criteria A or B **and** C, D, E and F must be met to satisfy the criteria for continued stay:

A. Patient continues to meet the criteria defined in above admission criteria.

B. New problems or symptoms that meet admission criteria have appeared.

C. A reasonable expectation exists that the patient will benefit from the continuation of ABA services.

D. The treatment plan including care coordination is updated on a frequent basis.

E. Measurable progress is documented or there is a reasonable expectation, based on the patient's clinical history and recent clinical experience that the current treatment is of such benefit to the patient, that withdrawal of treatment will result in the patient's decompensation or the recurrence of signs or symptoms that necessitated treatment.

F. Treatment is not making the symptoms persistently worse.

Exclusion Criteria

IV. Exclusion Criteria

ABA treatment will not be authorized for any of the following purposes:

A. Speech therapy

B. Occupational therapy

C. Vocational rehabilitation

D. Supportive respite care

E. Recreational therapy

F. Orientation and mobility.

Discharge Criteria

V. Discharge Criteria

Criteria A, B, C or D must be met to satisfy the criteria for discharge.

A. No meaningful, measurable improvement has been documented in the patient's behavior(s) for a period of at least six months of optimal treatment. In addition, the patient has reached their cognitive potential, and there is no reasonable expectation that termination of the current treatment would put the patient at risk for decompensation or the recurrence of signs and symptoms that necessitated treatment.

- For changes to be "meaningful" they must be durable over time beyond the end of the actual treatment session, and generalizable outside of the treatment setting to the patient's residence and to the larger community within which the patient resides.

B. Treatment is making the symptoms persistently worse.

C. The patient has achieved adequate stabilization of the deficits and behaviors and can be managed in a less intensive environment e.g., school setting.

D. The patient demonstrates an inability to maintain long-term gains from the proposed plan of treatment.

Psychological Testing

Criteria for Authorization

Prior to psychological testing, the individual must be assessed by a qualified behavioral health care provider. The diagnostic interview determines the need for and extent of the psychological testing. Testing may be completed at the onset of treatment to assist with necessary differential diagnosis issues and/or to help resolve specific treatment planning questions. It also may occur later in treatment if the individual's condition has not progressed since the institution of the initial treatment plan and there is no clear explanation for the lack of improvement.

I. **Severity of Need**

Criteria A, B and C must be met:

A. The reason for testing must be based on a specific referral question or questions from the treating provider and related directly to the psychiatric or psychological treatment of the individual.

B. The specific referral question(s) cannot be answered adequately by means of clinical interview and/or behavioral observations.

C. The testing results based on the referral question(s) must be reasonably anticipated to provide information that will effectively guide the course of appropriate treatment.

II. **Intensity and Quality of Care**

Criteria A and B must be met:

A. A licensed doctoral-level psychologist (Ph.D., Psy.D. or Ed.D.), medical psychologist (M.P.), or other qualified provider as permitted by applicable state and/or federal law, who is credentialed by and contracted with Magellan, administers the tests.

B. Requested tests must be valid and reliable in order to answer the specific clinical question for the specific population under consideration. The most recent version of the test must be used, except as outlined in *Standards for Educational and Psychological Testing.* [CC9]

III. **Exclusion Criteria**

Psychological testing will not be authorized under any of the following conditions:

A. The testing is primarily for educational or vocational purposes.

B. The testing is primarily for the purpose of determining if an individual is a candidate for a specific medication or dosage.

C. Unless allowed by the individual's benefit plan, the testing is primarily for the purpose of determining if an individual is a candidate for a medical or surgical procedure.

D. The testing results could be invalid due to the influence of a substance, substance abuse, substance withdrawal, or any situation that would preclude valid psychological testing results from being obtained (e.g., an individual who is uncooperative or lacks the ability to comprehend the necessary directions for having psychological testing administered).

E. The testing is primarily for diagnosing attention-deficit hyperactive disorder (ADHD), unless the diagnostic interview, clinical observations, and results of appropriate behavioral rating scales are inconclusive.

F. Two or more tests are requested that measure the same functional domain.

G. Testing is primarily for forensic (legal) purposes, including custody evaluations, parenting assessments, or other court or government ordered or requested testing, or testing that is requested by an administrative body (e.g., a licensing board, Worker's Compensation, or criminal or civil litigation).

H. Requested tests are experimental, antiquated, or not validated.

I. The testing request is made prior to the completion of a diagnostic interview by a behavioral health provider, unless pre-approved by Magellan.

J. The testing is primarily to determine the extent or type of neurological impairment as potentially related to a plan of remediation or treatment, unless allowed by the individual's benefit plan.

K. The number of hours requested for the administration, scoring, interpretation and reporting exceeds the generally accepted standard for the specific testing instrument(s), unless justified by particular testing circumstances. CC6

Therapeutic Leave of Absence Documentation

A Therapeutic Leave of Absence (TLOA) is any leave from a facility, which is ordered by a physician, is medically necessary, and is not supervised by staff. A leave for medical reasons (e.g., consultations, evaluations, office visits and treatments) is excluded from this definition.

Documentation Guidelines

To ensure that a TLOA is recognized as meeting the above definition, the medical record must contain the following information:

1) a physician must order each TLOA, identify it as a TLOA, and specify the number of leave hours approved, *and*

2) therapeutic rationale must be included in the ITPs and/or physician progress notes, and/or social worker notes, *and*

3) the nurse, physician, or social worker must document the outcome of the TLOA in the medical record.

Medical Necessity

While these guidelines address the documentation of therapeutic leaves of absence, the medical necessity of each leave of absence continues to be determined by the application of the Psychiatric Hospitalization Criteria.

Outpatient Electroconvulsive Treatment

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient electroconvulsive therapy (ECT). Nothing in the criteria should suggest that electroconvulsive treatment is considered a treatment of "last resort".

I. Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a DSM-IV-TR Axis I diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.[DD1]

B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor. In addition to the patient's medical status, the treatment history and the patient's preference regarding treatment should be considered.

C. One of the following:

1) the patient has a history of inadequate response to adequate trial(s)of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); *or*

2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; *or*

3) the patient has a history of good response to ECT during an earlier episode of the illness, *or*

4) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.

D. The patient's status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.

E. All:

1) the patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, *and*

2) the patient has access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course, *and*

3) the patient can be reasonably expected to comply with post-procedure recommendations that maintain the health and safety of the patient and others, e.g., prohibition from driving or operating machinery, complying with dietary, bladder, bowel, and medication instructions, and reporting adverse effects and/or negative changes in medical condition between treatments.

F. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for intensity and quality of service.

A. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:

1) psychiatric history, including documented past response to ECT, mental status and current functioning; *and*

2) medical history and examination focusing on neurological, cardiovascular, and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT; *and*

B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:

1) the patient's response to prior anesthetic inductions and any current anesthesia complications or risks, *and*

2) required modifications in medications or standard anesthetic technique, if any.

C. There is documentation in the medical record specific to the patient's psychiatric and/or medical conditions, that addresses:

1) specific medications to be administered during ECT, *and*

2) choice of electrode placement during ECT, *and*

3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.

D. There is continuous physiologic monitoring during ECT treatment, addressing:

1) seizure duration, including missed, brief, and/or prolonged seizures, *and*

2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*

3) electrocardiographic activity, *and*

4) vital signs, *and*

5) oximetry, *and*

6) other monitoring specific to the needs of the patient.

E. There is monitoring for and management of adverse effects during the procedure, including:

1) cardiovascular effects, *and*

2) prolonged seizures, *and*

3) respiratory effects, including prolonged apnea, *and*

4) headache, muscle soreness, and nausea.

F. There are post-ECT stabilization and recovery services, including:

1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, *and*

2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.

G. The patient is released in the care of a responsible adult who can monitor and provide supportive care and who is informed in writing of post-procedure behavioral limitations, signs of potentially adverse effects of treatment or deterioration in health or psychiatric status, and post-procedure recommendations for diet, medications, etc.

Criteria for Continued Treatment

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued treatment.

A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:

1) the persistence of problems that meet the outpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; *or*

2) the emergence of additional problems that meet the outpatient electroconvulsive treatment Severity of Need criteria as outlined in I; *or*

3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status.

B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.

C. The treatment plan meets the Intensity and Quality of Service Criteria (II above).

Inpatient Electroconvulsive Treatment

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient electroconvulsive therapy (ECT). Nothing in the criteria should suggest that electroconvulsive treatment is considered a treatment of "last resort."

I. Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a DSM-IV-TR Axis I diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.[DD1]

B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor. In addition to the patient's medical status, the treatment history and the patient's preference regarding treatment should be considered.

C. One of the following:

1) the patient has a history of inadequate response to adequate trial(s) of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); *or*

2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; *or*

1) the patient has a history of good response to ECT during an earlier episode of the illness, *or*

2) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.

D. The patient's status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.

E. All:

1) the patient is medically stable and requires the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, *or*

2) the patient does not have access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course.

F. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

A. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:

1) psychiatric history, including documented past response to ECT, mental status and current functioning; *and*

2) medical history and examination focusing on neurological, cardiovascular and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT.

B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:

1) the patient's response to prior anesthetic inductions and any current anesthesia complications or risks, *and*

2) required modifications in medications or standard anesthetic technique, if any.

C. There is documentation in the medical record specific to the patient's psychiatric and/or medical conditions, that addresses:

1) specific medications to be administered during ECT, *and*

2) choice of electrode placement during ECT, *and*

3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.

D. There is continuous physiologic monitoring during ECT treatment, addressing:

1) seizure duration, including missed, brief and/or prolonged seizures, *and*

2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*

3) electrocardiographic activity, *and*

4) vital signs, *and*

5) oximetry, *and*

6) other monitoring specific to the needs of the patient.

E. There is monitoring for and management of adverse effects during the procedure, including:

1) cardiovascular effects, *and*

2) prolonged seizures, *and*

3) respiratory effects, including prolonged apnea, *and*

4) headache, muscle soreness and nausea.

F. There are post-ECT stabilization and recovery services, including:

1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, *and*

2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.

Criteria for Continued Treatment

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued treatment.

A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:

1) the persistence of problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; *or*

2) the emergence of additional problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I; *or*

3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status.

B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.

C. The treatment plan meets the Intensity and Quality of Service Criteria (II above).

Transcranial Magnetic Stimulation Treatment*

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for transcranial magnetic stimulation (TMS).

I. Severity of Need

Criteria A, B, C, D, E, F, and G must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the adult patient has a DSM-IV-TR Axis I diagnosis of a major depressive disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate TMS treatment.

B. TMS will be used only for adult (age 18-65) patients who are not pregnant.

C. An evidence-based psychotherapy (e.g., cognitive-behavioral therapy) for depression was attempted and not effective.

D. One or more of the following:
1) the patient has demonstrated medication treatment-resistance during the current depressive episode as evidenced by a lack of clinical response to at least one antidepressant trial (of adequate dose and duration as defined by the most current edition of the *Physicians' Desk Reference*); *or*

2) the patient has undergone multiple trials of antidepressants and is unable to tolerate therapeutic dose of the medication; *or*

3) the patient has a history of good response to TMS during an earlier episode of the treatment-resistant major depressive disorder.

E. The patient is medically stable and the patient's status and/or co-morbid medical conditions are not contraindications for TMS.

F. All of the following:
1) electroconvulsive therapy (ECT) would not be clinically superior to TMS unless there is a relative contraindication for ECT or the patient refuses ECT; *and*

2) the patient has access to a suitable environment and professional and/or social supports after recovery from the procedure; *and*

3) the patient can be reasonably expected to comply with post-procedure recommendations.

G. The patient and/or a legal guardian are/is able to understand the purpose, risks and benefits of TMS, and provide(s) consent.

II. Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

A. There is documentation of a clinical evaluation performed by a physician who is appropriately trained to provide TMS, to include:

   1) a psychiatric history, including past response to antidepressant medication(s) and/or TMS and/or ECT, mental status and current functioning; *and*

   2) a medical history and examination when clinically indicated.

B. Treatment interventions are guided by quantitative measures of depression such as the Consumer Health Inventory (CHI). Other measures are used if CHI is not available.[19]

C. The physician utilizing this technique must be a board certified psychiatrist privileged by Magellan and/or payer to perform TMS.

D. An attendant/individual trained in basic life support, the management of complications such as seizures, in addition to training in the application of the TMS apparatus, must be present at all times with the patient while the treatment is applied.

E. Access to emergency equipment such as oxygen and suction is readily available while the patient is receiving TMS.

F. When clinically indicated, the patient is released in the care of a responsible adult who can monitor and provide supportive care as needed.

Criteria for Continued Treatment

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued treatment.

A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:

   1) the persistence of problems that meet the TMS treatment Severity of Need criteria as outlined in I.; *or*

   2) the emergence of additional problems that meet the TMS treatment Severity of Need criteria as outlined in I; *or*

   3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in an exacerbation of the patient's condition and/or status.

B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in progress notes, written and signed by the provider.

[19] Beck Depression Inventory (BDI-II), the Hamilton Rating Scale for Depression (HamD or HamD-7) and/or or Patient Health Questionnaire (PHQ-9).

D. The treatment plan meets the Intensity and Quality of Service Criteria (II above).

***** *Transcranial Magnetic Stimulation Treatment criteria does not take the place of Medicare Local Coverage Determinations (LCDs).*

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Y. Depression Management Program Communication Materials

Antidepressant Medications

Major depression is more than just "the blues." It is the kind of depression that will most likely benefit from treatment with medications. It lasts 2 weeks or more, and interferes with a person's ability to perform daily tasks and enjoy activities that before were fun. Depression is associated with abnormal functioning of the brain. Both a family and life history appears to determine a person's chance of becoming depressed. Episodes of depression may be triggered by:

- Stress
- difficult life events
- side effects of medication
- medication/substance withdrawal
- viral infections that can affect the brain

Depressed people will seem sad, or "down," or may feel:

- unable to enjoy their normal activities
- have no appetite and lose weight (although some people eat more and gain weight when depressed)
- sleep too much or too little, have difficulty going to sleep, sleep restlessly, or awaken very early in the morning
- speak of feeling guilty, worthless, or hopeless
- lack energy or are jumpy and agitated
- think about killing themselves and may even make a suicide attempt
- have delusions (false, fixed ideas) about poverty, sickness or sinfulness related to their depression

Often feelings of depression are worse at a particular time of day, for instance, every morning or every evening.

Not everyone who is depressed has all these symptoms. But everyone who is depressed has at least one or more of them on most days. Depression can range from mild to severe. Depression can co-occur with other medical disorders such as

- Cancer
- heart disease
- stroke
- Parkinson's disease
- Alzheimer's disease
- diabetes

In such cases, the depression is often overlooked and is not treated. If the depression is recognized and treated, a person's quality of life can be greatly improved.

Antidepressants are used most often for serious depressions, but they can also be helpful for some milder depressions. Antidepressants are not "uppers" or stimulants. They take away or reduce the symptoms of depression and help depressed people feel the way they did before they became depressed.

The doctor chooses an antidepressant based on the individual's symptoms. Some people notice improvement in the first couple of weeks. Usually the medication must be taken regularly for at least 6 weeks and, in some cases, as many as 8 weeks before the full effect is felt. If there is little or no change in symptoms after that, the doctor may prescribe a different medication or add a second medication such as lithium, to bump up the action of the original antidepressant. Because there is no way of knowing beforehand which medication will work, the doctor may have to prescribe first one and then another. Medication should be given time to be effective and to prevent a relapse of the depression once the patient is responding. The medication should be continued for 6 to 12 months, or in some cases longer, carefully following the doctor's instructions.

When a patient and the doctor feel that medication can be discontinued, withdrawal should be discussed as to how best to taper off the medication gradually. *Never discontinue medication without talking to the doctor about it.* For those who have had several bouts of depression, long-term treatment with medication is the most effective means of preventing more episodes.

Dosage of antidepressants varies, depending on the type of drug and the person's body chemistry, age, and, sometimes, body weight. Traditionally, antidepressant dosages are started low and raised slowly over time until the desired effect is reached without bad side effects. Newer antidepressants may be started at or near therapeutic doses.

Side Effects of Antidepressant Medications

Antidepressants may cause mild, and often temporary, side effects. Typically, these are not serious. However, any reactions or side effects that are unusual, annoying or that interfere with functioning should be reported to the doctor immediately. The most common side effects of tricyclic antidepressants, and ways to deal with them, are as follows:

- *Dry mouth*--it is helpful to drink sips of water; chew sugarless gum; brush teeth daily.
- *Constipation*--bran cereals, prunes, fruit, and vegetables should be in the diet.
- *Bladder problems*--emptying the bladder completely may be difficult, and the urine stream may not be as strong as usual. Older men with enlarged prostate conditions may be at particular risk for this problem. The doctor should be notified if there is any pain.
- *Sexual problems*--sexual functioning may be impaired; if this is worrisome, it should be discussed with the doctor.
- *Blurred vision*--this is usually temporary and will not need new glasses. Glaucoma patients should report any change in vision to the doctor.
- *Dizziness*--rising from the bed or chair slowly is helpful.
- *Drowsiness as a daytime problem*--this usually passes soon. A person who feels drowsy or sedated should not drive or operate heavy equipment. The more sedating antidepressants are generally taken at bedtime to help sleep and to minimize daytime drowsiness.
- *Increased heart rate*--pulse rate is often elevated. Older patients should have an electrocardiogram (EKG) before beginning tricyclic treatment.

Living Healthy Being Well

Wellness Tips… **ANTIDEPRESSANT MEDICATIONS**

The newer antidepressants, including SSRIs, have different types of side effects, as follows:

- *Sexual problems*--fairly common, but reversible, in both men and women. The doctor should be consulted if the problem is persistent or worrisome.
- *Headache*--this will usually go away after a short time.
- *Nausea*--may occur after a dose, but it will disappear quickly.
- *Nervousness and trouble falling asleep or waking often during the night*--these may occur during the first few weeks; dosage reductions or time will usually resolve them.
- *Feeling jittery*--if this happens for the first time after the drug is taken and is more than temporary, the doctor should be notified.

Any of these side effects may be amplified when an SSRI is combined with other medications. In the most extreme cases, such a combination of medications (e.g., an SSRI and an MAOI) may result in a potentially serious or even fatal "serotonin syndrome," characterized by

- Fever
- confusion
- muscle rigidity
- cardiac, liver, or kidney problems

The small number of people for whom **MAOIs** are the best treatment need to avoid taking decongestants and consuming certain foods that contain high levels of tyramine, such as many cheeses, wines, and pickles. The interaction of tyramine with MAOIs can bring on a sharp increase in blood pressure that can lead to a stroke. The doctor should furnish a complete list of prohibited foods that the individual should carry at all times. Other forms of antidepressants require no food restrictions. MAOIs also should not be combined with other antidepressants, especially SSRIs, due to the risk of serotonin syndrome.

Medications of any kind--prescribed, over-the-counter, or herbal supplements--*should never be mixed without consulting the doctor; nor should medications ever be borrowed from another person.* Other health professionals who may prescribe a drug-such as a dentist or other medical specialist-should be told that the person is taking a specific antidepressant and the dosage. Some drugs, although safe when taken alone, can cause severe and dangerous side effects if taken with other drugs. Alcohol (wine, beer, and hard liquor) or street drugs, may reduce the effectiveness of antidepressants and their use should be minimized or, preferably, avoided by anyone taking antidepressants. Some people who have not had a problem with alcohol use may be permitted by their doctor to use a modest amount of alcohol while taking one of the newer antidepressants. The potency of alcohol may be increased by medications since both are metabolized by the liver; one drink may feel like two.

Your Health Coach can assist you in accessing information for any specific prescribed anti-depressant. If you have additional questions about any antidepressant prescribed, or problems that may be related to the medication, you should discuss it with your doctor and/or pharmacist.

Resources Are Available

Additional information, self-help tools and other resources are available online at www.MagellanHealth.com.

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Coping with Depression

"Depression is the most common of all mental disorders," points out Dr. Robert N. Butler, Professor of Geriatrics at Mount Sinai Medical Center. "And women are almost twice as likely as men to develop depression."

What Is Depression?

Everyone feels sad from time to time; this is a normal part of life. But sometimes feelings of sadness don't go away. And sometimes other symptoms appear, such as loss of interest in life or loss of sleep or appetite. If they stop you from your daily life, depression may be the cause.

The criteria doctors use to diagnose major depression are listed below. You must have feelings of sadness or emptiness and loss of interest and pleasure in life for at least two consecutive weeks before a diagnosis of major depression can be made.

There is no single set of symptoms that indicate major depression. Some depressed people report feeling down in the dumps; others complain predominately about physical symptoms or are excessively worried about their health. Some people have panic attacks. Still others withdraw socially, with problems at work or in their marriage.

Symptoms of Major Depression

- Depressed mood for most of the day
- Decreased interest or pleasure in daily activities
- Significant weight loss or gain
- Significant change in appetite (increase/decrease)
- Almost daily insomnia or hypersomnia
- Observable slowness of movements or agitation
- Almost daily fatigue and loss of energy
- Almost daily feelings of worthlessness or guilt
- Diminished ability to concentrate, indecision
- Frequent thoughts of death or suicide

Recognizing Depression: How Will I Know?

One person's experience of sadness and other symptoms might be different from yours. It's hard to know what is depression and what is not. Perhaps the most important symptoms to watch out for are

- excessive feelings of sadness (different for each individual)
- persistent inability to derive pleasure from those things that one used to enjoy
- difficulty in performing one's usual daily activities

Someone might say, "Oh, you're just getting older." But depression is not a normal part of aging. It is a disease that can strike at any age, and it is usually treatable no matter what the age of the patient.

"Dysthymic disorder" is the technical term for a *milder* form of depression with symptoms that include:

- Low self-esteem
- Poor concentration
- Difficulty with decision making
- Over-eating or poor appetite
- Low energy
- Loss of sleep or too much sleep
- Feelings of hopelessness

You should have these symptoms for at least two years before a diagnosis of this milder form of depression can be made. Although these symptoms are generally less severe than those of major depression, they can still pose a significant and chronic problem.

Who Gets Depressed?

According to a survey of the general population, the lifetime rate of major depression is 21 percent in women and 13 percent in men. (This means that a little over 21 percent of women experience an episode of depression *at some point in their lives*, compared to 13 percent of men.)

As these statistics show, women are almost twice as likely as men to develop depression. Depression appears most often in younger women. The average age of onset is in the early 20s. The highest rate of depression occurs in adult women under the age of 44. Depression decreases with age in both men and women.

Despite the fact that depression usually appears most frequently in the young, *some people experience an episode of depression for the first time in later life.* While symptoms of depression are generally similar in middle-age and older people, studies have shown that older people more frequently report memory problems and physical symptoms such as abdominal complaints and sleep disturbances to their doctors, rather than emotional symptoms such as sadness.

Once it has occurred and passed, depression has a tendency to recur, especially if it was not thoroughly treated the first time around. In fact, the biggest risk factor for major depression is a prior episode of depression. Another major risk factor is a family history of depression.

Getting treatment greatly reduces these risks. And it is important to know that *depression is a highly treatable disease.*

Grief

Grief, or the feelings of sadness one feels after a significant loss, is not the same as major depression. Grieving individuals may have some of the same symptoms as those of major depression -- such as sadness, insomnia, poor appetite, or weight loss. There is a key difference, however. Such symptoms are *normal* grief reactions, so long as they do not become excessive and continue for a long period of time.

Some grief reactions are not considered "normal." For example, when you feel constant guilt because you survived and your loved one did not. Or that you should have died along with your loved one. Not being able to shake these constant feelings is more a symptom of depression than normal grief. Again, depression *can be successfully treated.*

Other losses occurring in later life that may bring on grief or depression are:

- retirement
- loss of income
- failing physical health
- having to give up driving

Older women are at greater risk for grief and depression than men or younger women. They are often in the position of having to live through many losses. Any of these factors can contribute to depression in older women:

- Women who nurse their sick husbands, sometimes for a long period of time.
- Women who help their husbands at the time of their deaths.
- Women are more at risk for chronic illness.
- Women are more likely than men to live out their lives in nursing homes.
- Women are more likely in the very late years to find themselves without the support of close family members.

Women vs. Men

Why women are more prone than men to depression is unknown. Some researchers say that depression appears to be more common in women because doctors tend to diagnose women as being depressed rather than suffering from other disorders. Some say that men actually mask depression with alcohol use, and were it not for this factor; depression rates among men and women would be more equal.

Some say that biological differences between men and women explain the greater rate of depression among women. Hormonal fluctuations that women experience over a lifetime -- starting with menstruation all the way through pregnancy, delivery, breast feeding, and eventually menopause -- are said to contribute to a woman's greater risk for depression over her lifetime.

Depression in women may be related to low levels of the hormone estrogen. One study showed that some women with severe, untreatable depression improved when they received *therapeutic* doses of estrogen. Estrogen *supplementation* has also been associated with a better mood in some studies of older women.

A large study of women age 45 to 55 found that while depressive symptoms may be associated with menopause, these symptoms are usually temporary. In fact, the researchers concluded that as women got past the menopause, their rates of depression actually declined. In this particular study, depression was more related to women's overall health, education, and marital status (widowed, divorced, or separated) than to the menopause itself.

Another theory explaining the higher prevalence of depression among women is that women are more subject to "stressors" that trigger depression than are men. Specifically, women often have poorer job opportunities, lower wages, and greater family responsibilities than do men. Women need to juggle multiple roles, which seem to grow in difficulty throughout the midlife years. In addition, the theory says, women are more likely than men to be victims of violence, which results in lower self-esteem and recurrent depression.

Living Healthy Being Well

Wellness Tips… **COPING WITH DEPRESSION**

Chronic Illness and Depression

Depression can accompany chronic medical illness. Sometimes it is difficult to tell the difference between the symptoms of the illness and symptoms of the accompanying depression. But even in such cases, depression can be treated. Medical conditions that are commonly associated with depression include:

- Coronary artery disease
- Neurologic disorders such as stroke
- Alzheimer's disease and Parkinson's disease
- Metabolic disturbances such as diabetes
- Cancer
- Other problems such as arthritis, chronic pain, hearing impairment, sexual dysfunction, or alcohol abuse

Coping with Depression and Loss

Although the rate of depression is higher in women than in men, women often have more and better ways of coping with it than men do. Women tend to take better care of themselves and use medical services more often than men. This increases the chances that women will turn to a health care provider for treatment if symptoms of depression become a problem. Women are also better than men at making and keeping connections with others. These contacts include family members, friends and resources in the community -- avoiding isolation and separation that can easily cause or add to a depressed mood. Such connections are invaluable. Thus, many women have successfully coped with stressful life events, sadness and even depression because they were able to draw on the support of their social network.

Although it seems very stressful at times, playing multiple roles in life -- as women invariably do -- is beneficial to mental health. We frequently see men who had defined themselves primarily as breadwinners become seriously depressed after retirement, when they no longer have this defined role to play. On the other hand, their wives, whether they had full time careers or were traditional housewives, continue in their role as wife, mother, caregiver, friends, etc., and do not define themselves in this narrow way. In other words, the fuller your life is, the more options you will have when life's changes prevent you from continuing on as before. Women seem to know this instinctively; men need to consciously learn it.

Given life's burdens, it is not strange that anxiety and depression occur. While women often cope successfully alone (or with the support of close friends and family), outside help may sometimes be necessary. Some people, however, feel uncomfortable about reaching out to a professional. Moreover, primary care doctors often do not ask their patients about their feelings. The result is that one-third of all depressed patients seen in primary care settings do not get diagnosed or treated.

Get Help If You Need It

The most common treatments for depression are professional counseling, anti-depression medication, or a combination of the two. Psychologists, social workers, psychiatrists and some members of the clergy offer counseling or psychotherapy. Group therapy can also be beneficial. Antidepressant medication, which can only be prescribed by a medical doctor, can help elevate mood and sustain it while a patient is confronting underlying problems with the help of a counselor.

The most important thing to remember is that depression is a highly treatable disorder.

Resources Are Available

Additional information, self-help tools and other resources are available online at www.MagellanHealth.com.

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Clinical Depression

WHEN IT'S MORE THAN JUST THE BLUES

Clinical Depression Is More Than Just the Blues

Clinical depression, also known as depression, can start as the blues. Everyone gets the blues from time to time, which usually results from stressful events and lasts only a short time. A bad day or an argument can make you feel sad for a while.

If sadness lingers or affects your daily routine, you may have more than just the blues. For some people, sadness or stress can lead to depression and can affect every part of life. Depression interferes with the way we eat, sleep and live our lives. Without treatment, symptoms can last for weeks, months or years. Depression is a serious health problem that affects feelings, thoughts and actions, can be life-threatening and can include symptoms of physical illness such as headache, stomach pain or tiredness.

Every year, more than 19 million Americans suffer from depression. It strikes men, women and children of all races and economic groups. Depression often goes untreated for many reasons. Sometimes people don't recognize the early warning signs or think they have a physical problem. Sometimes people think they should be able to "just get over it." Depression is not something you can "get over." The good news is that most people who get adequate treatment can recover.

Causes of Depression

Researchers do not know the specific cause of depression. There is a theory that some people inherit a tendency to have an imbalance in mood-controlling brain chemicals. Major losses or disappointments can make this imbalance worse, leading to depression.

Depression is not a sign of weakness. People suffering from depression cannot just "snap out of it." Depression is no one's fault.

Depression Checklist

Common signs of depression:

- ❑ Constant feelings of sadness, hopelessness, or emptiness.
- ❑ Loss of interest in activities once enjoyed.
- ❑ Weight gain or loss that is not on purpose.
- ❑ Slowed movement or restlessness.
- ❑ Too much or too little sleep.
- ❑ Loss of energy.
- ❑ Feelings of worthlessness or guilt.
- ❑ Difficulty concentrating, remembering things or making decisions.
- ❑ Thoughts of death or suicide.

If you experience these symptoms for longer than two weeks or if the symptoms interfere with your daily routine, you may be suffering from depression. Contact your health care provider for a thorough evaluation.

Treatment Is Available

The most effective and common treatments for depression are:

- **Psychotherapy**. This involves talking with a behavioral health professional (therapist) about ways to cope with challenges in your life. Research has shown that psychotherapy can be effective within just a few months.
- **Antidepressant medication**. Medicines can help correct an imbalance in the brain chemicals that affect a person's mood. Most medicines can be used safely but should be prescribed by an experienced doctor who knows how it might

affect other medicines you are taking. Be sure to tell your doctors about all of your medical conditions and all of your current medications. Most people will see signs of relief after several weeks.

- **A combination of the two**. This approach combines "talk therapy" with antidepressant medication and can be more effective than either medicine or psychotherapy alone.

Other treatments are available and can be discussed with your health care provider.

What Should I Do If I Think I'm Depressed?

Follow these five steps:

1. **Make a list.** Write down any signs of depression you experience, along with your questions about depression and its treatment.
2. **Talk with a health care provider.** Arrange a visit with your doctor or behavioral health professional. Share your list of signs and questions about depression and its treatment. Review any medications you are currently taking.
3. **Select the right treatment.** Ask your health care provider to describe the risks and benefits of treatment. Also ask him or her to recommend the type of treatment that is most likely to help you.
4. **Learn more about depression.** Your provider or mental health association can provide information on depression and local support groups. You can also get information from:

   National Mental Health Association,
   1-800-969-NMHA (6642) or www.nmha.org

   National Institute of Mental Health,
   1-800-421-4211 or www.nimh.nih.gov

   Depression and Bipolar Support Alliance,
   www.dbsalliance.org

5. **Update your provider about your progress.** Once you are in treatment, make sure that your provider knows if you are feeling better or worse. Ask questions about your progress. Do not stop taking any medicine when you start to feel better. Never stop taking medicine without first talking with your doctor.

Practice Guidelines

Practice guidelines recommend the best treatment for certain medical conditions. Magellan notifies all providers about its adopted practice guidelines. The adopted depression practice guidelines are:

- Magellan's Introduction to Practice Guideline for the Treatment of Patients with Major Depressive Disorder. For more information, log on to www.MagellanHealth.com (click "I'm a Provider"), then click the "Clinical Practice Guidelines" link under Providing Care—Clinical Guidelines.
- American Psychiatric Association's Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Second Edition. For more information, log on to www.appi.org or call 1-800-368-5777.
- American Psychiatric Association's Guideline Watch: Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Second Edition. For more information, log on to www.appi.org or call 1-800-368-5777.

Getting Help

If you think that you may be suffering from depression, call your health care provider or your program's toll-free number.

GET HELP RIGHT AWAY IF YOU ARE THINKING OF HURTING YOURSELF OR OTHERS

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Z. Practice Guideline for the Treatment of Patients with Major Depressive Disorder

Magellan's Introduction to Its Adopted Clinical Practice Guideline for the Treatment of Patients with Major Depressive Disorder

Task Force Membership

Robert Ciaverelli, M.D.
Kathleen K. Frampton, R.N., B.S.N., M.P.H.
Gary Henschen, M.D.
Richard Kamins, Ph.D.
Daniel P. McCarthy, Ph.D.
Anna Scherzer, M.D., F.A.A.P., F.A.A.C.A.P., F.A.P.A
Charles Wadle, R.Ph., D.O., F.A.P.A.

Table of Contents

Purpose of This Document

This document is an introduction to the Magellan Health Services (Magellan) adopted clinical practice guideline (CPG) for the treatment of patients with major depressive disorder. As with all CPGs, this adopted guideline and this introduction are intended to augment, not replace, sound clinical judgment. As a matter of good practice, clinically sound exceptions to this practice guideline should be noted in the member's treatment record, documenting the clinical reasoning used in making the exception. Magellan periodically requests clinical files from providers to monitor compliance with adopted guidelines. Clear documentation of the rationale for exceptions to the guideline's recommendations should be present in the member's treatment record whenever there is evidence of deviation from the guideline.

Additionally, this guideline does not supersede Food and Drug Administration (FDA) determinations or other actions regarding withdrawal or approval of specific medications or devices, and their uses. It is the responsibility of the treating clinician to remain current on medication/device alerts and warnings that are issued by the FDA and other regulatory and professional bodies, and to incorporate such information in his or her treatment decisions.

Introduction

Magellan has adopted the following guideline to augment providers' clinical decision-making with members who have unipolar depression:

- The American Psychiatric Association *Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition* (2010).

This guideline incorporates the rapidly evolving developments in pharmacotherapy and somatic treatments, as well as developments in other areas of clinical management for patients with major depressive disorder. The APA guideline is an evidence-based document that covers all areas of management of patients with this disorder, from understanding the clinical features and screening/surveillance to medical/psychiatric treatment approaches, psychosocial/behavioral interventions, planning and family support.

Obtaining Copies of the Guideline:

Copies of the *Practice Guideline for the Treatment of Patients with Major Depressive Disorder* are available at http://www.psychiatryonline.com/pracGuide/pracGuideTopic_7.aspx.

Provider Feedback

Magellan welcomes feedback on our clinical practice guidelines. We take all suggestions and recommendations into consideration in our ongoing review of guidelines. Comments may be submitted to:

Clinical Operations Coordinator
Re: CPG
Magellan Health Services
6950 Columbia Gateway Dr.
Columbia, Maryland 21046
CPG@MagellanHealth.com

AA. Eating Disorder Management Program Communication Materials

Anorexia Nervosa

What is anorexia nervosa?

Anorexia nervosa is a serious, often chronic, and life-threatening eating disorder. It is defined by a refusal to maintain minimal body weight within 15 percent of an individual's normal weight. Other essential features of this disorder include

- an intense fear of gaining weight
- a distorted body image
- amenorrhea (absence of at least three consecutive menstrual cycles when they are otherwise expected to occur)

In addition to the classic pattern of restrictive eating, some people will also engage in recurrent binge eating and purging episodes. Starvation, weight loss, and related medical complications are quite serious and can result in death. People who have an ongoing preoccupation with food and weight even when they are thin would benefit from exploring their thoughts and relationships with a therapist. The term *anorexia* literally means loss of appetite, but this is a misnomer. In fact, people with anorexia nervosa ignore hunger and thus control their desire to eat. This desire is frequently redirected to something more socially acceptable such as cooking for others or hiding food that they will not eat in their personal space. Obsessive exercise may accompany the starving behavior and cause others to assume the person must be healthy.

Who develops anorexia nervosa?

Like all eating disorders, anorexia nervosa tends to occur in pre- or post-puberty, but can develop at any major life change. Anorexia nervosa predominately affects teenage girls and young adult women, although it also occurs in men and older women. One reason younger women are particularly vulnerable to eating disorders is their tendency to go on strict diets to achieve an "ideal" figure. This obsessive dieting behavior reflects today's societal pressure to be thin, which is seen in advertising and the media. Others especially at risk for eating disorders include athletes, actors, dancers, models and TV personalities for whom thinness has become a professional requirement. For the person with anorexia nervosa, the satisfaction of the control achieved over weight and food becomes very important. Even if the rest of their life is chaotic and emotionally painful.

How many people suffer from anorexia nervosa?

Conservative estimates suggest that one-half to one percent of females in the U.S. develop anorexia nervosa. Because more than 90 percent of all those who are affected are teens and young women, the disorder has been been characterized as primarily a woman's illness. It should be noted, however, that males and children as young as seven years old have been diagnosed; and women 50, 60, 70, and even 80 years of age have fit the diagnosis.

How is the weight lost?

People with anorexia nervosa usually lose weight by reducing their total food intake and exercising excessively. Many persons with this disorder restrict their intake to fewer than 1,000 calories per day. Most avoid fattening, high-calorie foods and eliminate meats. The diet of persons with anorexia nervosa may consist almost completely of low-calorie vegetables like lettuce and carrots, or popcorn.

What are the common signs of anorexia nervosa?

The hallmarks of anorexia nervosa are

- a preoccupation with food

- a refusal to maintain minimally normal body weight

One of the most frightening aspects of the disorder is that people with anorexia nervosa continue to think they look fat even when they are bone-thin. Their nails and hair become brittle, and their skin may become dry and yellow. Depression is common in patients suffering from this disorder. People with anorexia nervosa often complain of feeling cold (hypothermia) because their body temperature drops. They may develop lanugo (a term used to describe the fine hair on a new born) on their body.

Persons with anorexia nervosa develop strange eating habits such as

- cutting their food into tiny pieces
- refusing to eat in front of others
- fixing elaborate meals for others that they themselves don't eat

Food and weight become obsessions as people with this disorder constantly think about their next encounter with food. Generally, if a person fears he or she has anorexia nervosa, a doctor knowledgeable about eating disorders should make a diagnosis and rule out other physical disorders. Other psychiatric disorders can occur together with anorexia nervosa, such as depression and obsessive-compulsive disorder.

What are the causes of anorexia nervosa?

What causes anorexia nervosa is not clear cut, and the causes may be varied. In an attempt to understand and uncover the origins of eating disorders, scientists have studied the personalities, genetics, environments and biochemistry of people with these illnesses. Certain personality traits common in persons with anorexia nervosa are

- low self-esteem
- social isolation (which usually occurs after the behavior associated with anorexia nervosa begins)
- perfectionism

These people tend to be good students and excellent athletes. It does seem clear (although this may not be recognized by the patient), that focusing on weight loss and food allows the person to ignore problems that are too painful or seem unresolvable.

Eating disorders also tend to run in families, with female relatives most often affected. A girl has a 10 to 20 times higher risk of developing anorexia nervosa, for instance, if she has a sibling with the disease. This finding suggests that genetic factors may predispose some people to eating disorders. Behavioral and environmental influences may also play a role. Stressful events are likely to increase the risk of eating disorders as well. In studies of the biochemical functions of people with eating disorders, scientists have found that the neurotransmitters serotonin and norepinephrine are decreased in those with anorexia, which links them with patients suffering from depression. People with anorexia nervosa also tend to have higher than normal levels of cortisol (a brain hormone released in response to stress) and vasopressin (a brain chemical found to be abnormal in patients with obsessive-compulsive disorder).

Are there medical complications?

The starvation experienced by persons with anorexia nervosa can cause damage to vital organs such as the heart and brain. Pulse rate and blood pressure drop, and people suffering from this illness may experience irregular heart rhythms or heart failure. Nutritional deprivation causes calcium loss from bones, which can become brittle and prone to breakage. In the worst-case scenario, people with anorexia can starve themselves to death. Anorexia nervosa is among the psychiatric conditions having the highest mortality rates, killing up to six percent of its victims.

Is treatment available?

Luckily, most of the complications experienced by persons with anorexia nervosa are reversible when they restore weight. People with this disorder should be diagnosed and treated as soon as possible because eating disorders are most successfully treated when diagnosed early. Some patients can be treated as outpatients, but some may need hospitalization to stabilize their dangerously low weight. Weight gain of one to three pounds per week is considered safe and desirable. The most effective strategies for treating a patient have been weight restoration within ten percent of normal, and individual, family and group therapies.

To help people with anorexia nervosa overcome their disorder, a variety of approaches are used.

- **Psychotherapy** can be used to deal with underlying emotional issues.
- **Cognitive-behavioral therapy** is sometimes used to change abnormal thoughts and behaviors.
- **Group therapy** is often advised so people can share their experiences with others.
- **Family therapy** is important particularly if the individual is living at home and is a young teen.
- **Medication** prescribed by a physician or advanced-practice nurse may be needed.
- **A nutritionist** may be necessary to advise the patient about proper diet and eating regimens.
- **Support groups**, where available, can be beneficial to both patients and families.

What about prevention?

New research findings are showing that some of the "traits" in individuals who develop anorexia nervosa are actual "risk factors" that might be treated early on. For example, low self esteem, body dissatisfaction, and dieting may be identified and interventions instituted before an eating disorder develops. Advocacy groups have also been effective in reducing dangerous media stories, such as teen magazine articles on "being thin" that may glamorize such risk factors as dieting.

Resources Are Available

Additional information, self-help tools and other resources are available online at www.MagellanHealth.com.

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Binge Eating Disorders

How Does Someone Know if He or She Has Binge Eating Disorder?

Most of us overeat from time to time, and many people often feel they've eaten more than they should have. Eating a lot of food does not always mean that a person has binge eating disorder.

Doctors generally agree that most people with serious binge eating problems often:

- feel their eating is out of control
- eat what most people would think is an unusually large amount of food
- eat much more quickly than usual during binge episodes
- eat until so full they are uncomfortable
- eat large amounts of food, even when they are not really hungry
- eat alone because they are embarrassed about the amount of food they eat
- feel disgusted, depressed, or guilty after overeating.

Binge eating also takes place in another eating disorder called *bulimia nervosa*. Persons with bulimia nervosa, however, usually purge, fast, or do *strenuous exercise* after they binge eat. Purging means vomiting or using a lot of diuretics (water pills) or laxatives to keep from gaining weight. Fasting is not eating for at least 24 hours. Strenuous exercise, in this case, means exercising for more than an hour just to keep from gaining weight after binge eating. Purging, fasting, and over exercising are dangerous ways to try to control your weight.

How Common Is Binge Eating Disorder, and Who Is at Risk?

Binge eating disorder is probably the most common eating disorder. Most people with this problem are either overweight or obese, but normal-weight people also can have the disorder.

About 2 percent of all adults in the United States (as many as 4 million Americans) have binge eating disorder. About 10 to 15 percent of people who are mildly obese and who try to lose weight on their own or through commercial weight-loss programs have binge eating disorder. The disorder is even more common in people who are severely obese.

Binge eating disorder is a little more common in women than in men; three women for every two men have it. The disorder affects blacks as often as whites. No one knows how often it affects people in other ethnic groups.

People who are obese and have binge eating disorder often became overweight at a younger age than those without the disorder. They might also lose and gain back weight (yo-yo diet) more often.

* The 1998 NIH *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults* define overweight as a body mass index (BMI) of 25 to 29.9 and obesity as a BMI of 30 or more. BMI is calculated by dividing weight (in kilograms) by height (in meters) squared.

What Causes Binge Eating Disorder?

No one knows for sure what causes binge eating disorder. As many as half of all people with binge eating disorder have been depressed in the past. Whether depression causes binge eating disorder or whether binge eating disorder causes depression is not known.

Many people who are binge eaters say that being angry, sad, bored, or worried can cause them to binge eat. Impulsive behavior (acting quickly without thinking) and certain other emotional problems can be more common in people with binge eating disorder.

It is also unclear if dieting and binge eating are related. Some studies show that about half of all people with binge eating disorder had binge episodes before they started to diet.

Researchers also are looking into how brain chemicals and metabolism (the way the body uses calories) affect binge eating disorder. This research is still in the early stages.

What Are the Complications of Binge Eating Disorder?

People with binge eating disorder can get sick because they may not be getting the right nutrients. They usually eat large amounts of fats and sugars, which don't have a lot of vitamins or minerals.

People with binge eating disorder are usually very upset by their binge eating and may become very depressed.

People who are obese and also have binge eating disorder are at risk for

- diabetes
- high blood pressure
- high blood cholesterol levels
- gallbladder disease
- heart disease
- certain types of cancer.

Most people with binge eating disorder have tried to control it on their own, but have not been able to control it for very long. Some people miss work, school, or social activities to binge eat. Persons who are obese with binge eating disorder often feel bad about themselves and may avoid social gatherings.

Most people who binge eat, whether they are obese or not, feel ashamed and try to hide their problem. Often they become so good at hiding it that even close friends and family members don't know they binge eat.

Should People With Binge Eating Disorder Try To Diet?

People who are not overweight should avoid dieting because it sometimes makes their binge eating worse. Dieting here means skipping meals, not eating enough food each day, or avoiding certain kinds of food (such as carbohydrates). These are unhealthy ways to try to change your body shape and weight. Many people with binge eating disorder are obese and have health problems because of their weight. These people should try to lose weight and keep it off. People with binge eating disorder who are obese may find it harder to stay in a weight-loss program. They also may lose less weight than other people, and may regain weight more quickly. (This can be worse when they also have problems like depression, trouble controlling their behavior, and problems dealing with other people.) These people may need treatment for binge eating disorder before they try to lose weight.

How Can People With Binge Eating Disorder Be Helped?

People with binge eating disorder, whether or not they want to lose weight, should get help from a health professional such as a psychiatrist, psychologist, or clinical social worker for their eating behavior. Even those who are not overweight are usually upset by their binge eating, and treatment can help them. There are several different ways to treat binge eating disorder. Cognitive-behavioral therapy teaches people how to keep track of their eating and change their unhealthy eating habits. It also

teaches them how to change the way they act in tough situations. Interpersonal psychotherapy helps people look at their relationships with friends and family and make changes in problem areas. Drug therapy, such as antidepressants, may be helpful for some people.

Researchers are still trying to find the treatment that is the most helpful in controlling binge eating disorder. The methods mentioned here seem to be equally helpful. For people who are overweight, a weight-loss program that also offers treatment for eating disorders might be the best choice.

If you think you might have binge eating disorder, it's important to know that you are not alone. Most people who have the disorder have tried but failed to control it on their own. You may want to get professional help. Talk to your health care provider about the type of help that may be best. The good news is that most people do well in treatment and can overcome binge eating.

Resources Are Available

Additional information, self-help tools and other resources are available online at www.MagellanHealth.com.

BB. Practice Guideline for the Treatment of Patients with Eating Disorders

MAGELLAN HEALTH SERVICES®
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Magellan's Introduction to Its Adopted Clinical Practice Guideline for the Assessment and Treatment of Patients with Eating Disorders

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Magellan Practice Guideline Task Force

Robert Ciaverelli, M.D.
Kathleen K. Frampton, R.N., B.S.N., M.P.H.
Gary Henschen, M.D.
Richard Kamins, Ph.D.
Daniel P. McCarthy, Ph.D.
Anna Scherzer, M.D., F.A.A.P., F.A.A.C.A.P., F.A.P.A
Charles Wadle, D.O., R.Ph., F.A.P.A.

Purpose of This Document

Magellan Behavioral Health has adopted the American Psychiatric Association's (APA) *Practice Guideline for the Treatment of Patients With Eating Disorders, Third Edition* (2006)[1] to serve as an evidence-based framework for practitioners' clinical decision-making with adult patients who have an eating disorder. The adopted guideline indicates that while APA practice guidelines are intended for the care of adults, this particular guideline for eating disorders includes recommendations that apply to adolescents, since anorexia nervosa and bulimia nervosa often begin during this period. This guideline makes special notations when recommendations apply exclusively to a certain age group.

An extensive literature review suggests that the APA guideline is among the most comprehensive, evidence-based clinical practice guidelines (CPGs) for this disorder, and in general, APA guidelines are widely used. The guideline covers most areas of psychiatric management of patients with eating disorders, from clinical features and epidemiology to numerous aspects of treatment approach and planning. Since this guideline is broadly accepted by managed behavioral healthcare organizations (MBHOs), this adoption will minimize the burden on practitioners serving multiple MBHOs.

As with all guidelines, these adopted guidelines and Magellan's Introduction are intended to augment, not replace, sound clinical judgment. As a matter of good practice, clinically sound exceptions to the treatment guidelines should be noted in the member's record. Additionally, this guideline does not supersede Food and Drug Administration (FDA) determinations or other actions regarding withdrawal or approval of specific medications or devices, and their uses. It is the responsibility of the treating clinician to remain current on medication/device alerts and warnings that are issued by the FDA and other regulatory and professional bodies, and to incorporate such information in his or her treatment decisions.

Additional Recommendations Based on Recent Literature Review

The APA guideline is based on a literature review through 2004. Magellan conducted a further review of the clinical literature on assessment and treatment of eating disorders published through December 2010. Key relevant recommendations from this more recent literature review are summarized here. Magellan encourages providers to be familiar with this information, as well as the information discussed in the guideline.

Epidemiology

More recent epidemiological data and trending on eating disorders in the United States have been published since the release of the APA guideline. According to the American Academy of Pediatrics(AAP) *Clinical Report – Identification and Management of Eating Disorders in Children and Adolescent*s, "the epidemiology of eating disorders has gradually changed; there is an increasing prevalence of eating disorders in males and minority populations in the United States as well as in countries in which eating disorders had not been commonly seen. Of particular concern is the increasing prevalence of eating disorders at progressively younger ages. A recent analysis by the Agency for Healthcare Research and Quality revealed that from 1999 to 2006, hospitalizations for eating disorders increased most sharply – 119 percent for children younger than 12 years (AAP, 2010, p. 1240). Other new important information on the determinants of eating disorder symptomatology in adolescents was garnered through a very large epidemiology health survey (n=2,036) conducted in the Portugal school system (Costa et al., 2008). This study concluded that higher body mass index and higher depressive symptomatology were associated with more severe eating disorder symptomatology in both sexes. Additionally, a sex effect on the association between socioeconomic status and eating disorder symptomatology was found. Girls with higher socioeconomic status and boys with lower socioeconomic status presented with more eating disorder symptomatology. These investigators also shared in their report that "in the previous decade, the prevalence of eating disorders has progressively increased, whereas the severity of observed cases has decreased" signaling a substantial number of subclinical and intermediate forms of dieting and eating concerns (Costa et al., 2008, p. 1126).

Anorexia Nervosa

The APA guideline emphasizes that a clinician's decision to use psychotropic medications for weight restoration in a patient with anorexia nervosa (AN) must be based on the patient's individual presentation. The guideline notes that selective serotonin reuptake inhibitors (SSRIs) combined with psychotherapy are widely used in treating anorexia. The guideline also indicates that more research was needed to evaluate the efficacy of the second-generation antipsychotics (SGAs) where initial clinical impressions have suggested that they may be useful in patients with severe, unremitting resistance to gaining weight, severe obsessional thinking and denial of delusional proportions. In regard to this clinical issue, a randomized clinical trial of 34-day hospital patients with anorexia nervosa demonstrated that compared with placebo, a flexible dose regimen of the SGA, olanzapine (2.5 mg/day to 10 mg/day), resulted in a greater rate of increase in weight, earlier achievement of target body mass index and a greater rate of decrease in obsessive symptoms. Researchers reported that they found no serious adverse side effects (e.g., extrapyramidal symptoms, excessive sleepiness, dizziness, or galactorrhea) during weekly medical examinations. Additionally, blood glucose levels were randomly tested each week in all patients showing no evidence of impaired glucose tolerance or *de novo* development of diabetes mellitus in any participant (Bissada et al. 2008).

The APA guideline indicates that for children and adolescents, evidence supports that family treatment is the most-effective intervention. The guideline also emphasizes that for some outpatients, a short-term course of family therapy may be as effective as a long-term course if patients do not have severe obsessive-compulsive features or non-intact families. The efficacy of family therapy for adolescent anorexia was analyzed in a five-year follow-up of 40 patients in the United Kingdom who received either conjoint family therapy (CFT) or separated family therapy

(SFT) – i.e., where the adolescent was seen individually and the parents attending separate sessions with the same therapist. Their analysis showed that overall there was little to distinguish the two treatments at five years, with more than 75 percent of subjects having no eating disorders symptoms. Other findings showed no deaths in the cohort and only 8 percent of those who had achieved a healthy weight by the end of treatment reported any relapse. Researchers suggested that those patients who respond well to outpatient family therapy generally stay well (Eisler et al. 2007).

The APA guideline also indicates that cognitive-behavioral, interpersonal and psychodynamic approaches, or a combination of these approaches, have the most evidence and consensus for use in the treatment of adults with anorexia. In addition, the APA guideline suggests that individual psychotherapy may be required for at least one year or many more, due to the enduring nature of the illness and the need for support during recovery. A more recent clinical trial was conducted to evaluate the relative efficacy of family-based treatment (FBT) versus adolescent-focused individual therapy (AFT) for adolescents with anorexia nervosa. Therapy sessions were conducted in 24 outpatient hours over 12 months (Lock et al., 2010). The FBT modality was designed to focus on several goals: (1) helping parents not feel responsible for causing the disorder (2) reinforcing positive aspects of parenting (3) developing family strategies for weight restoration in the child with anorexia (4) transitioning weight and eating control back to the child and (5) establishing a new and healthy adolescent relationship with the parents. The AFT modality was based on the theory that individuals with anorexia manifest ego deficits and confuse self-control with biological needs. This intervention was designed to help patients learn to identify/define their emotions and to tolerate them, rather than using starvation as a mechanism to numb the affective states. Both treatments led to considerable improvement and were similarly effective in producing full remission at the end of treatment. However, at both the 6- and 12- month follow-up, FBT was significantly superior to AFT in facilitating full remission (Lock et al, 2010).

The issue of relapse in anorexia nervosa is only briefly discussed in the APA guideline. An observation put forth in the guideline is that many clinicians who report seeing patients with chronic anorexia do see these patients experience substantial remission after many years of struggling with their disorder. In light of this, relapse in anorexia was an area of clinical study focusing on body composition as a predictor of relapse. A follow-up analysis of 32 weight-recovered subjects with anorexia nervosa from the New York site of the Fluoxetine to Prevent Relapse in Women With Anorexia Nervosa clinical trial and the Energy Homeostasis in Anorexia Nervosa longitudinal study examined the effect of percent body fat, body mass index (BMI), anorexia nervosa subtype, waist-to-hip ratio, and serum cortisol and leptin levels on treatment outcome. Findings revealed that percent body fat at the time of hospital discharge was the only clinical variable significantly associated with treatment outcome– i.e., lower percent body fat was associated with poorer long-term outcome. Investigators indicated that, while additional data linking percent body fat as a risk factor for relapse is necessary, their findings suggested that increased body fat may be protective against relapse (Mayer et al. 2007).

Bulimia Nervosa

A large systematic review of 47 studies on the efficacy of treatments for bulimia nervosa (BN) was conducted to include studies of medication only, behavioral interventions only, and medication plus behavioral interventions for adults and adolescents. Findings of the review revealed that evidence for medication is strong in the use of fluoxetine (60 mg/day) for reducing core bulimic symptoms. While researchers noted that further studies are needed, preliminary evidence of efficacy exists for other second-generation antidepressants (trazodone and fluvoxamine), an anticonvulsant (topiramate), a tricyclic antidepressant (desipramine) and for a monoamine oxidase inhibitor (MAOI), brofaromine (prescribed with close dietary monitoring) in reducing vomiting in the treatment of bulimia. Similarly, the evidence was strong for the effectiveness of cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) while the data showed promising results for dialectic behavioral therapy (DBT) and guided imagery. However, the supportive evidence for effectiveness of self-help groups was weak. Also, the authors confirmed that the evidence for combined treatments is weak and that outcome differentiation by socio-demographic factors is nonexistent (Shapiro et al. 2007).

The current APA guideline recommends the use of SSRIs for treatment of bulimia and indicates they may be helpful for depression, anxiety, obsessions, certain impulse disorder symptoms, and for those patients with a suboptimal response to appropriate psychosocial therapy. The guideline also specifically cautions prescribers that tricyclic antidepressants (TCAs) should generally be avoided and their potential lethality and toxicity in overdose should be taken into consideration. Similarly, the guideline cautions that MAOIs should be avoided with chaotic binge eating and purging, and also that bupropion should be avoided in patients with bulimia because of seizure risk.

The APA guideline does not address the use of neurostimulation in the treatment of eating disorders. Repetitive Transcranial Magnetic Stimulation (rTMS) has been studied primarily in the treatment of refractory depression. Researchers have just begun to research rTMS in the treatment of bulimia since it is believed to be often associated with depressive symptoms. It is postulated that there is a shared deficient serotonergic transmission in both syndromes and involvement of the left dorsolateral prefrontal cortex in the regulation of eating behavior (Walpoth et al. 2008). A small randomized sample of 14 women with bulimia were submitted to sham treatment, followed by either three weeks of active or sham rTMS. Stimulation was delivered for three weeks with an intensity of 120 percent motor threshold using 20 Hz in one session per day. Ten trains of 10 s, with a train interval of 60 s, were performed per session. Patients got an amount of 2,000 stimuli per session up to a total of 30,000 stimuli in the actively treated group. Results of this study showed that the average number of binges per day declined significantly between baseline and the end of treatment in both groups. There was also no significant difference between sham and active stimulation, in terms of improvements in purging behavior, and depressive or obsessive-compulsive symptoms – indicative of a placebo effect (Walpoth et al. 2008).

CBT is recognized in the APA guideline as the most efficacious short-term intervention in the treatment of bulimia when specifically directed at eating disorder symptoms and underlying maladaptive cognitions. The adopted guideline also suggests that psychodynamic and psychoanalytic approaches in individual or group format are useful once binging and purging symptoms have improved. The guideline indicates that family therapy should be considered whenever possible, especially for adolescents still living with parents or for older patients with ongoing conflicted

interactions with parents. Additionally, the guideline indicates that support groups and 12-step groups may be helpful adjuncts to the initial treatment of bulimia and for subsequent relapse prevention, but are not recommended as the sole initial treatment approach.

Two studies on the effectiveness of family therapy in treating adolescents with bulimia were conducted with mixed results. One clinical trial with 85 study participants conducted in the United Kingdom compared the efficacy and cost-effectiveness of family therapy versus CBT guided self-care. While the study results showed that at six months, binging had undergone a significantly greater reduction in the CBT guided self-care group than in the family therapy group – this difference disappeared at 12 months. There were no other differences between groups in behavioral or attitudinal eating disorder symptoms, but the direct cost of treatment was lower for CBT guided self-care than for family therapy (Schmidt et al. 2007).

Another study of 80 adolescents with bulimia evaluated the relative efficacy of family-based treatment (FBT) and supportive psychotherapy (SPT). In this trial, family therapy showed superior efficacy in that significantly more of these patients were binge-and-purge abstinent at the end of the study and at six months, and showed treatment effects in favor of FBT on all measures of eating pathological features (le Grange et al. 2007). Researchers in this trial conducted a follow-up analysis of these results, which showed that lower eating concerns, as measured by the Eating Disorder Examination (EDE), are the best predictor of remission for adolescents with bulimia. Additionally, FBT may be most effective in those cases with low levels of eating disorder psychopathology (le Grange et al. 2008).

Two transdiagnostic CBT modalities designed for patients with eating disorders (i.e., bulimia nervosa and eating disorder not otherwise specified) were studied in order to compare a treatment (CBT–Ef) focusing solely on eating disorder psychopathology against a more complex treatment (CBT-Eb) that also addressed additional problems– mood, clinical perfectionism, low self-esteem and interpersonal difficulties (Fairburn et al. 2009). Patients in the two treatment conditions exhibited substantial and equivalent change, which was maintained during follow-up. Investigators reported that at the 60-week follow-up assessment, 51.3 percent of the sample had a level of eating disorder features less than one standard deviation above the community mean. Also, the treatment outcome was not dependant upon the specific eating disorder diagnosis and both types appeared to be suitable for the majority of outpatients with eating disorders. Further exploratory analysis conducted by the research team indicated that patients with substantial additional psychopathology, of the type targeted in CBT-Eb, did better with this treatment than the focused form, while the opposite was true for the remaining patients (Fairburn et al., 2009).
Innovative modalities in the area of school-based, peer-led programs to prevent obesity and eating disorders have begun to emerge and gain credence. Two studies in this area were published with positive findings. One study evaluated peer teaching on healthy living (i.e., nutrition, physical activity and healthy body image) from older to younger children ("buddies"). Findings showed that all students improved their knowledge and that weight velocity was decreased in older students. (Stock et al. 2007) Another study demonstrated the effectiveness of an interdisciplinary, school-based obesity prevention intervention where disordered weight control behaviors were reduced by two-thirds for the girls in early adolescence who participated (Austin et al. 2007). Similarly, an eating disorders prevention program using dissonance-inducing activities that reduce thin-ideal internalization showed superiority over another prevention program that promoted healthy weight management. Reductions in eating disorder risk factors, bulimic symptoms and obesity onset were

seen through the 12-month and three-year follow-ups, suggesting public health potential (Stice et al. 2006, Stice et al. 2008).

Eating Disorder Not Otherwise Specified – Binge Eating Disorder

A published clinical review on binge eating disorder (BED) treatments reported that new epidemiological studies have shown BED to be the most common of the eating disorders, with lifetime prevalence estimates in the community of 3.5 percent among women and 2 percent among men (Yager 2008). The author noted that obesity is seen in approximately 65 percent of patients with BED where it increases progressively over time. BED is currently consigned to the "eating disorders not otherwise specified" diagnosis, but it is speculated that it may achieve full status as an independent diagnosis in the future Diagnostic and Statistical (DSM) V Manual.

Since binge eating is prevalent in overweight and obese individuals with type 2 diabetes mellitus, the impact of behavioral weight loss treatments on eating disorders symptomatology has been analyzed by investigators in the Look AHEAD (Action for Health in Diabetes) clinical trial (Gorin et al., 2010). Overweight and obese individuals age 45 to 76 years (n=5,145), with and without BED symptoms, were treated with either intensive lifestyle intervention or to enhanced usual care (a diabetes support/education control condition). Investigators reported that participants who stopped binge eating (BE) appeared to be just as successful at weight loss as non-binge eaters after one year of treatment. Gorin et al. also noted that individuals reporting more BE also reported a more depressed mood and worse physical health than their non-BE peers. Nevertheless, investigators stressed that most individuals who reported BE at baseline stopped BE by one year, and these individuals were just as successful at weight loss as those who reported no BE. Additionally, they indicated that few individuals started BE during the one-year study period. The study team concluded that BE is not exacerbated by behavioral weight loss treatment and may be improved by participating in a structured weight loss program targeting lifestyle changes (Gorin et al., 2010).

The APA guideline specifies that both group and individual formats of CBT, behavior therapy, dialectical behavior therapy, and interpersonal therapy all have been associated with binge frequency reduction and abstinence rates along with evidence of maintenance of this change over a year follow-up. Since publication of the guideline, a more recent study (n=101) of Dialectical Behavior Therapy for Binge Eating Disorder (DBT-BED) by Safer et al. was compared to an active comparison group therapy (ACGT) in order to evaluate it against a credible control group ("active placebo") (Safer et al. 2010). Both interventions used specific manual-based treatment protocols and used the same therapists in both conditions in order to minimize variability. The DBT-BED approach, which was based on Linehan's DBT for borderline personality disorder and modified by Telch et al. for binge eating, consisted of three modules: mindfulness, emotional regulation and distress tolerance, concluding with relapse prevention. The ACGT approach, which was modeled after Markowitz and Sacks' supportive therapy for chronic depression, was modified to address binge eating for the current study while focusing primarily on bolstering self-esteem (Safer et al. 2010). Study results showed that both DBT-BED and ACGT reduced binge eating, but DBT-BED showed significantly fewer dropouts and greater initial efficacy at posttreatment (e.g., 64 percent abstinence rate for DBT-BED vs. 36 percent for ACGT). Investigators reported that these differences, however, did not persist over the 3-, 6-, and 12- month follow-up assessments, e.g., 12-month follow-up abstinence rate equal to 64 percent for DBT versus 56 percent for ACGT (Safer et al. 2010).

Similarly, the adopted guideline acknowledges that CBT with the addition of exercise appears to augment both binge and weight reduction and that some guided self-help CBT programs show promise for binge remission. A more recent clinical study of obese patients with BED (n=205) compared interpersonal therapy (IPT) with behavioral weight loss treatment (BWL) and guided self-help based on cognitive behavior therapy (CBTgsh) where 20 sessions of each modality was conducted over 6 months. Results showed that there was no difference among the three interventions at posttreatment on binge eating, specific eating disorder psychopathology (i.e., body weight, shape and eating concern) or general psychopathology. At the 2-year follow-up, both IPT and CBTgsh were significantly more effective than BWL in eliminating binge eating. Investigators suggested that guided self-help CBT should be considered a first-line treatment for most patients with BED and that IPT be use as the treatment of choice for the subset of individuals with BED with low self-esteem and high level of specific eating disorder psychopathology (Wilson et al., 2010).

Another clinical trial demonstrated that self-help approaches were a viable alternative to therapist-delivered treatment. Findings from a study of 259 adults with BED where therapist-led, therapist-assisted or self-help group treatments were compared to a wait-list condition showed that patients in the therapist-led group had the highest rate of abstinence and fewest dropouts at the end of treatment. However, there were no significant differences between treatment groups at follow-up on any of the primary or secondary outcome measures. Investigators concluded that while the presence of a therapist may enhance short-term abstinence and reduce the likelihood of dropout, they suggested groups for individuals with BED with reduced or no therapist involvement may be used as alternative treatments (Peterson et al., 2009).

The APA guideline discusses the serotonin and norepinephrine reuptake inhibitor (SNRI) and appetite-suppressant drug, sibutramine, as a promising treatment based on findings of preliminary trials. Since release of the guideline, a large clinical trial of 304 patients with BED was conducted comparing sibutramine against placebo. The participants who received sibutramine had significantly greater reductions in weekly binge frequency, binge days, BMI and associated psychopathology (Wilfley et al. 2008). On October 8, 2010, the U.S. Food and Drug Administration (FDA) asked the drug manufacturer to voluntarily withdraw sibutramine from the U.S. market because of clinical trial data indicating an increased risk of cardiovascular adverse events, including heart attack and stroke, in the studied population. The manufacturer complied with the request and sibutramine no longer is available in the United States (FDA MedWatch, 2010).

The APA guideline also presented early positive findings of studies evaluating the efficacy of the anticonvulsant drug topiramate. More recently, findings of a large multi-center clinical trial with 407 patients with BED have been published. Patients receiving topiramate experienced highly significant rates of reduction in binge eating days and binge eating episode frequency, weight, BMI, overall severity and compulsive features of BED, compared with placebo. In addition, topiramate was associated with greater improvement in measures of hunger, impulsive features and disability (McElroy, Hudson et al. 2007). The novel antiepileptic drug agent zonisamide was also studied in a small single-center trial where it was associated with a significantly greater rate of reduction in binge eating episode frequency, body weight and severity of illness than placebo. However, researchers reported that zonisamide was associated with only fair tolerability and a relatively high treatment discontinuation rate (McElroy, Kotwal et al. 2006).

Treatment of BED with antidepressant medications, particularly the SSRIs, was recommended as a treatment option in the APA guideline with the cautionary note that while patients experience a short-term reduction in binge eating, there is usually no accompanying substantial weight loss. The guideline also indicates that use of SSRIs for this disorder is typically at the high end of the recommended dosage range. More recent clinical trials and meta-analyses have produced mixed results in their usage for this indication. A study comparing sertraline and fluoxetine in the treatment of obese patients with BED showed no differences between the two treatments and both demonstrated significant weight loss and improvement in binge eating core symptoms and psychopathology (Leombruni et al. 2008). Similarly, a trial of high-dose escitalopram was shown to be efficacious in reducing weight and global severity illness in obese patients with BED, but not in reducing obsessive-compulsive symptoms of BED (Guerdjikova et al. 2007). Conversely, a meta-analysis of seven antidepressant studies (i.e., fluoxetine, sertraline, citalopram, fluvoxamine and imipramine) concluded that their findings were not supportive in recommending the use of antidepressants as the only and first-choice therapy for remission of binge eating episodes and weight reduction of patients being treated for BED (Stefano et al. 2007). In another systematic review of studies, findings for SSRI antidepressant efficacy (i.e., sertraline, citalopram) were based primarily on a series of short-term, placebo-controlled medication trials. These agents demonstrated greater rates of reduction in target eating, and psychiatric and weight symptoms in individuals with BED than placebo. Researchers noted that these conclusions should be viewed tentatively due to high drop-out rates and placebo response rates (Brownley et al. 2007).

Researchers have indicated that novel drug treatments that reduce binge eating, the associated psychopathology and body weight, and are well-tolerated, are needed for the treatment of BED. Also, several drugs used to treat BED (i.e., orlistat, sibutramine, topiramate and zonisamide) have problematic side effects and relatively high discontinuation rates (McElroy, Guerdjikova et al. 2007). The highly specific norepinephrine reuptake inhibitor, atomoxetine, used in the treatment of attention-deficit hyperactivity disorder (ADHD), is associated with anorexia and weight loss. Since this drug is generally well-tolerated and may have antidepressant properties, it was chosen for study in a placebo-controlled clinical trial in order to determine its possible efficacy in the treatment of BED. Study results found atomoxetine to be superior to placebo in reducing binge frequency, weight and severity of illness. Researchers suggest that further studies of atomoxetine are clearly warranted (McElroy, Guerdjikova et al. 2007).

The APA guideline indicates that although evidence is limited, combined pharmacotherapy and psychotherapy treatment for BED is frequently helpful in clinical practice. The systematic review of studies previously cited by Brownley et al. (2007) revealed that use of cognitive behavioral therapy (CBT) combined with medications (i.e. fluoxetine, orlistat) or medication (desipramine) along with weight loss therapy, was superior to medication or weight loss therapy alone or when combined with placebo in the treatment of patients with BED (Brownley et al. 2007). Similarly, a marked reduction in binge eating, short-term weight loss and a significant decrease in psychopathology were shown in a clinical trial of topiramate (target dose 200 mg) plus CBT in obese patients with BED (Claudino et al. 2007). Another study demonstrated that the combination of cognitive-behavioral weight loss therapy (BWL) and sibutramine, leads to comparable weight loss in individuals suffering from obesity and subclinical binge eating disorder (sBED) as in obese non-bingers. However, BWL alone was an effective treatment in significantly reducing binge eating frequency in sBED without the augmenting effect of sibutramine (Bauer et al. 2006).

Modalities employing new technologies and psychosocial approaches continue to be developed and studied in the area of eating disorders treatment. One clinical trial of 105 male and female high school students examined the effects of an Internet-facilitated, weight management program on reducing binge eating and overeating, and preventing weight gain in a population of students at risk of being overweight. In comparing a 16-week online intervention compared to a wait-list control group, the study group found a strong effect for stabilization of weight gain and reduction in binge eating and overeating at the nine-month follow-up assessment. Researchers were encouraged with these findings using an easily disseminated, Internet-facilitated program (Jones et al. 2008). Adapted motivational interviewing (AMI) that was originally developed for addictive behaviors was studied in 108 women with BED. Both groups, where one was assigned to one session of AMI and use of a self-help handbook, or use of a self-help handbook only, showed improvement in binge eating and associated symptoms. After 16 weeks of intervention, the AMI group had a greater proportion of women who abstained from binge eating and no longer met the binge frequency criterion for BED DSM-V diagnosis (Cassin et al. 2008).

Obtaining Copies of the APA Guidelines

Copies of the APA *Practice Guideline for the Treatment of Patients With Eating Disorders, Third Edition* can be obtained through the APA at http://psych.org/, by calling (800) 368-5777, or by U.S. mail at:

American Psychiatric Publishing, Inc.
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209-3901

Provider Feedback

Magellan welcomes feedback on adopted clinical practice guidelines. We take all suggestions and recommendations into consideration in our ongoing review of the guidelines. Submit your comments to:

Clinical Operations Coordinator
Re: CPG
Magellan Health Services
6950 Columbia Gateway Dr.
Columbia, Maryland 21046
CPG@MagellanHealth.com

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CC. Sample ADHD Program Communication Materials

ADHD – When Both Parent and Child Suffer

Attention Deficit Hyperactivity Disorder (ADHD) is increasingly common in children, and appears more often in boys than girls. Research has shown that siblings of children with ADHD are at higher risk of having the disorder too. Now, because ADHD tends to run in families, researchers are looking more closely at the parent-child connection and the role that genetics play. A recent University of Maryland study[1] found that parents who have children with ADHD are 20 times more likely to be suffering from ADHD themselves. This discovery is important in understanding why some parents may have difficulty coping with or helping their child with ADHD.

Different Ages, Same Problems

ADHD is one of the most inheritable behavioral disorders. It often first appears in school-age children and can continue into adulthood. Symptoms of the disorder include a short attention span and inability to pay attention or organize daily activities. If both parent and child are suffering from the disorder, difficulties are bound to arise.

Overlooking What's Important

Parents with ADHD may forget to give their children much-needed medicine and may miss doctor appointments. A parent who has a short attention span may be unable to follow through on his or her child's prescribed treatment plan. If a parent refuses to be tested and treated for ADHD, the child may be unwilling to accept his or her own diagnosis and treatment.

The Parent-Child Connection

ADHD is truly a family issue. If a parent has ADHD, research shows there's a 20 to 50 percent chance it will be passed to the child, along with the increased likelihood of depression, anxiety and substance abuse. This means that for the sake of both parent and child, parents who have children with ADHD should also be tested for ADHD.

Getting Help

If you believe that you or your child may have symptoms of ADHD, contact your health care provider for more help and information. He or she can help you find the right treatment and can answer any questions you may have about this often disruptive disorder.

Resources Are Available

Additional information, self-help tools and other resources are available online at www.MagellanHealth.com.

1Journal of the American Academy of Child & Adolescent Psychiatry, December 2003

Attention Deficit/Hyperactivity Disorder (ADHD) - Understanding the Three Faces of ADHD

Children and ADHD

ADHD is common in children, and it appears more often in boys than girls. Researchers think biology plays a large role in causing this disorder. Of those diagnosed with ADHD, 30 to 40 percent have relatives with the same disorder. ADHD may be a result of problems in the brain. The disorder may affect the "executive functions" of the brain, which control organization and direction of thought and behavior.

Recognizing ADHD

Ask yourself the following questions. Does my child often…

…fidget or squirm in his or her seat?
…get distracted easily?
…have difficulty waiting his or her turn?
…blurt out answers to questions?
…have difficulty following instructions?
…shift from one uncompleted activity to another?
…have difficulty playing quietly?
…talk excessively or become quiet and withdrawn?
…interrupt or intrude on others?
…seem not to be listening?
…engage in activities that are physically dangerous?

Answering "yes" to six or more of these questions may indicate ADHD in your child. Most children may show signs of a few of these behaviors. If these behaviors are causing major problems, consider having your child screened for ADHD.

Facts About ADHD

- ADHD is the most common psychiatric diagnosis in children. It affects three to five percent of school-age children. ADHD is much more common in boys, but this evens out when children grow older.
- ADHD is not a learning disability, such as difficulty in reading or math. But due to symptoms such as difficulty concentrating or sitting still for a long period of time, ADHD can hinder a child's performance in school.
- ADHD has three "faces":
  - Noisy, hyperactive.
  - Quiet, inattentive.
  - A mixture of hyperactivity and inattention.
- If one child in a family has ADHD, siblings are at a much higher risk for ADHD than other children in the general population.
- It's not the child's or parent's fault if a child has ADHD. There are safe and effective treatments for ADHD, which can help your child(ren) and family.

Types of ADHD

There are three types of ADHD: hyperactive, inattentive or mixed. Symptoms vary depending on which type the child has. Some children with ADHD are overactive and impulsive, and have short attention spans. Others are quiet and inattentive, and unable to focus well. These children are harder to diagnose. Even more confusing are children who display a mixture of inattention and hyperactivity.

Symptoms can also change depending on where the child is and what he or she is doing. A child who is disruptive in the classroom can be fine on the playground. Children with ADHD are sometimes seen as "trouble makers."

Although the symptoms may vary, ADHD often makes life difficult for the child and everyone around the child. Parents often experience frustration, stress and depression, as well as exhaustion.

Family Challenges

Research suggests that ADHD may develop in siblings. However, when one child with ADHD is very hyperactive, ADHD can be harder to detect in less active siblings. If one of your children has been diagnosed for ADHD, it is a good idea to have your other children screened as well.

Treatment Is Available

Your child's health care provider or mental health professional can assess whether your child has ADHD. They can help you find the right treatment. They can also answer any questions you have about your other children who may have ADHD.

There are safe and effective treatments to control the symptoms of ADHD. Treatment can be in the form of medication or behavioral therapies or a combination of both. Treatments can improve attention span and stop restlessness for many children. Without proper care, children with ADHD often suffer in school and can have behavioral and emotional problems through adulthood. Treatment can result in a child who functions better in daily situations.

Work with your child's teacher to help your child become better organized and complete tasks. Keep your child on a daily schedule. Plenty of praise and reassurance at home and at school is helpful.

A child with ADHD needs continuous care. It is important that all children showing signs of ADHD be assessed for treatment.

Helping Yourself

If your child has been diagnosed with ADHD, you are aware of the extra emotional and physical demands of parenting children with this disorder.

Remember to take time for yourself. Try exercising or just taking a few minutes a day for your needs. You may also want to take a parenting class to learn techniques that work for children with ADHD. These things can help you feel better. You will also be better equipped to handle the challenges of parenting children with ADHD.

Getting Help

If you think that your child has ADHD, call your health care provider or your program's toll-free number. GET HELP RIGHT AWAY IF YOUTHINK YOUR CHILD MAY HURT HIM/HERSELF OR OTHERS.

Resources Are Available

Additional information, self-help tools and other resources are available online at www.MagellanHealth.com.

Sources: National Mental Health Association, National Institute of Mental Health

DD. Practice Guideline for the Treatment of Patients with Attention Deficit/Hyperactivity Disorder

Clinical Practice Guideline for Patients with Attention Deficit/Hyperactivity Disorder

Magellan Health Services
Clinical Practice Guideline Task Force

J. Andrew Burkins, M.D.
Robert Ciaverelli, M.D.
Kathleen K. Frampton, R.N., B.S.N., M.P.H.
Gary Henschen, M.D.
Daniel P. McCarthy, Ph.D.
Lawrence J. Nardozzi, M.M.M., M.D., D.F.A.P.A., C.P.E.
Candace Saldarini, M.D.
Anna Scherzer, M.D., F.A.A.P., F.A.A.C.A.P., F.A.P.A.
Charles Wadle, D.O.

MAGELLAN CLINICAL PRACTICE GUIDELINES - ADHD

Effective August 31, 2007, Magellan Health Services re-adopted the *Clinical Practice Guideline for the Treatment of Patients With Attention-Deficit Hyperactivity Disorder, Second Edition,* written by Magellan to serve as an evidence-based framework for practitioners' clinical decision-making with child, adolescent, and adult patients who have a diagnosis of attention-deficit hyperactivity disorder. *In June 2008, we revised the "Medications" section of this document to include the American Heart Association's (AHA) recommendations for screening children who may be vulnerable to sudden cardiac death. In September 2008, Magellan revised this section again to include a joint advisory statement of the American Academy of Pediatrics (AAP) and the AHA, issued as clarification to widespread misinterpretation of the earlier AHA recommendations. These new recommendations were endorsed by the American Academy of Child and Adolescent Psychiatry (AACAP), the American College of Cardiology, Children and Adults with Attention-Deficit/Hyperactivity Disorder, the National Initiative for Children's Healthcare Quality, and the Society for Developmental and Behavioral Pediatrics.* In preparation of the 2010 revision, we conducted another review of the more recently published scientific literature, along with available practitioner input. This guideline covers the main areas of psychiatric management of patients with this disorder, covering topics from clinical features and epidemiology to various aspects of treatment approach and planning. Nonetheless, it is not intended to be exhaustive. In addition, the behavioral health field is rapidly evolving and there are continuous changes in assessment and management techniques, so while this guideline provides a brief overview, the reader is encouraged to review other sources that may incorporate ongoing clinical developments, including the AACAP Practice parameters for ADHD and other sources (citations).

Obtaining Copies of the Guideline

This Magellan *Practice Guideline for the Treatment of Patients with Attention-Deficit Hyperactivity Disorder* is available on the Magellan provider website at www.MagellanHealth.com/provider.

As with all guidelines, the Magellan Guideline is intended to augment, not replace, sound clinical assessment and decision-making. As a matter of good practice, clinically sound exceptions to the treatment guidelines should be noted in the medical record. Additionally, this guideline does not supersede Food and Drug Administration (FDA) determinations or other actions regarding withdrawal or approval of specific medications or devices, and their uses. It is the responsibility of the treating clinician to remain current on medication/device alerts and warnings that are issued by the FDA and other regulatory and professional bodies, and to incorporate such information in his or her treatment decisions.

Providing Feedback on the Guidelines

Magellan welcomes feedback on adopted clinical practice guidelines. All suggestions and recommendations are taken into consideration in our review.

Questions or comments may be submitted via mail or e-mail to:
Clinical Operations Coordinator
Re: CPG
Magellan Health Services
6950 Columbia Gateway Drive
Columbia, Maryland 21046
E-mail: CPG@MagellanHealth.com

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INTRODUCTION

Attention-Deficit/Hyperactivity Disorder (ADHD) is a childhood-onset neurobehavioral syndrome characterized primarily by disorders in attention, concentration, and impulse control. These dysfunctions can lead to behavioral problems in home, school, work, and social settings. Children with ADHD may have difficulty with learning in school, developing appropriate social skills, and managing frustration and aggression (Wilens et al., 2002). ADHD is also a developmental disorder whose presentation may change with maturation. There is often a decrease in overt hyperactivity and impulsivity with age, while attention problems are more likely to persist (Mick et al., 2004). The diagnostic criteria for ADHD are outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR®)* (American Psychiatric Association, 2000). These diagnostic criteria best apply to children and younger adolescents. There continues to be a need for criteria that are more appropriate for older adolescents and adults (Mick et al., 2004; McGough and Barkley, 2004; Spencer and Adler, 2004).

Epidemiology

As stated by Goldman in 1998, "Attention-Deficit/Hyperactivity Disorder is one of the best-researched disorders in medicine, and the overall data on its validity is far more compelling than for most mental disorders and even for many medical conditions" (Goldman et al., 1998). There is a great cost to society from ADHD because of the resulting academic and occupational underachievement, conduct problems throughout the lifespan, higher levels of associated substance abuse, motor vehicle accidents, and interpersonal relationship problems (Wilens et al., 2002; Mick et al., 2004; Wilens 2004).

ADHD appears to be a neurologically heterogeneous disorder, with varying patterns of impairment in different individuals and with significant subtypes. (American Academy of Child and Adolescent Psychiatry, 2007; American Psychiatric Association, 2000; Nutt, 2007). Childhood ADHD is reported as much more prevalent in boys, though some experts argue that girls' ADHD more often is undetected. In contrast to earlier studies in which boys were reported as having poorer functioning, some reports suggest that non-referred boys and girls have similar impairment levels of cognitive, psychosocial, school and family functioning and that the previously described gender differences in functioning are due to referral biases rather than true gender differences (Biederman et al., 2005).

The childhood prevalence of ADHD is similar in every culture studied, and depending on the criteria used, has been reported as ranging from 3-15 percent, with at least 7 percent being a generally accepted average figure. These statistics indicate that it is the most common psychiatric disorder of childhood (American Academy of Child and Adolescent Psychiatry, 2007; Barbaresi et al., 2004). The majority of children with ADHD meet some or all of the criteria for this disorder as adults. For example, at age 25 years, about 15 percent of people diagnosed with ADHD as children meet DSM-IV-TR criteria for the disorder, and about 65 percent meet DSM-IV-TR criteria for ADHD in partial remission (Nutt, 2007; Faraone, 2006). Adult ADHD is both significantly under diagnosed and under treated (Faraone, 2004). The prevalence appears to be about 4-5 percent (Nutt, 2007; American Academy of Child and Adolescent Psychiatry, 2007). A recent unpublished study suggests adult women with ADHD are less likely to be diagnosed despite having more severe symptoms and emotional impairment than male patients (Robison et al., 2005). This finding is of particular concern since women respond at least as well to treatment as men. One study was unable

to demonstrate any differences in co-morbid ity, social functioning and cognitive functioning between adults meeting full diagnostic criteria for ADHD and those having only residual (not full criteria) ADHD symptoms (Mick et al., 2004).

The majority of adults with ADHD have at least one co morbid psychiatric disorder, which may be the clinician's first clue of the diagnosis of ADHD (Wilens et al., 2002; Montano, 2004). Common co-morbidities include anxiety disorders, depressions and substance abuse. Adults with ADHD are less likely to have graduated from high school or to have attended college. They have lower occupational achievement, change jobs more frequently, are more likely to be fired or quit and perform more poorly on the job. They have more psychological maladjustment, more occurrences of multiple marriages and much more substance abuse. In a study of older adolescents and young adults with ADHD, it was shown that the subjects exhibited "no driving knowledge deficits, but compared with controls, they had elevated rates of speeding citations, suspended licenses, crashes, and accidents causing bodily injury." It was also found that "They were more likely to be rated by themselves and others as having poorer driving habits" (Mick et al., 2004).

Despite the multiple issues arising from untreated or partially treated ADHD, it needs to be stressed that there is a broad range of social and occupational outcomes, with many individuals having success in the social and occupational realms despite ongoing symptoms.

The causes of ADHD have not been determined conclusively and continue to be studied. ADHD appears to be the result of a complex interaction of genetic, environmental and biological factors (American Academy of Child and Adolescent Psychiatry, 2007; Nutt DJ 2007; Pliszka 2006). Evidence for the genetic factors includes a pool of 17 twin studies reporting heritability (genetic factors) influence of about 76 percent (Faraone, 2004). In addition, parents of children with ADHD have been reported as being much more likely to have ADHD than are parents of children without ADHD (Faraone, 2004).

Suspected environmental factors include brain injury in utero, perinatal stress, fetal exposure to nicotine and alcohol, low birth weight/prematurity and traumatic brain injury (Nair 2006; Grizenko et al., 2008). More recent data from the 2001-2004 National Health and Nutritional Health Examination Survey (NHANES) have shown that both prenatal tobacco exposure (maternal cigarette use during pregnancy) and childhood lead exposure were associated with ADHD in children (Froehlich et al., 2009). Biological factors have been identified through studies that have employed brain-imaging techniques and neuropsychological testing. Such studies have revealed evidence of structural and functional brain abnormalities in ADHD. Of particular importance are functional abnormalities in the frontal sub-cortical neural circuits, decreases in white matter volume, and widespread brain pathophysiologic abnormalities. Such biological findings suggest that any causality theory must provide a model for understanding broad-based brain dysfunction (Faraone, 2004; Monastra 2005a).

EVALUATION

Children and Adolescents

The diagnosis of ADHD is determined using DSM-IV-TR criteria. The clinician should analyze data from a variety of sources, since no single test, rating scale, or observational finding determines the diagnosis (Cincinnati Children's Hospital Medical Center, 2004). However, the use of structured

rating scales that have been found valid and reliable with large populations is recommended (Nutt, 2007). Any parental concern about inattention, impulsivity, over activity or ADHD should be taken seriously by the clinician and lead to further investigation. A family history of ADHD lends support to suspecting the diagnosis (Faraone, 2004).

At a minimum, data obtained for diagnosing ADHD in children and adolescents should include the following (American Academy of Child and Adolescent Psychiatry, 2007; Nutt 2007):

- Psychiatric, developmental, social, educational, family and medical history from the patient and family. Family history should include questions about parental ADHD and cardiac history
- Review of medical evaluation, including physical exam and lab tests, to rule out medical causes of the signs and symptoms
- Rating scales from the patient and parents (e.g., Brown ADD Scales for Children, Adolescents, and Adults [Brown, 2001]; Conners Parent Rating Scale-Revised [Conners, 1997])
- Reports and rating scales from teachers (e.g., Brown ADD Scales for Children, Adolescents, and Adults [Brown, 2001]; Conners Teacher Rating Scale-Revised [Conners, 1997])
- Comprehensive assessment for co morbid psychiatric disorders
- Clinical observation.

To make a diagnosis of ADHD in a child or adolescent, the symptoms must have been present prior to age seven, and/or prior to age 10 in girls, although there may be significant variation in the age of onset (Biederman and Faraone, 2004; Nutt 2007); and the other DSM-IV-TR criteria must be met . Some experts in the field have suggested that the DSM-IV-TR criteria were developed primarily from observations of boys and problems with attention, a salient feature in girls with ADHD, may not become apparent until they are closer to puberty. It is important to coordinate initial and subsequent evaluations with the patient's teacher(s).

Adults

Adults with ADHD often present for evaluation after one of their children is diagnosed. Reasons for the diagnosis being delayed until adulthood can include: 1) the diagnosis being obscured in childhood by associated problems such as Oppositional Defiant Disorder, Conduct Disorder and Mood Disorder, 2) being erroneously labeled as a "troublemaker" or a "daydreamer," and 3) no one considering the ADHD diagnosis. The DSM-IV-TR criteria form the basis for the diagnosis in adults but some interpretive flexibility may be needed on the part of the clinician, since some have suggested that a lower threshold, such as four or five out of the nine DSM-IV criteria, be considered sufficient in adults (Mick et al., 2004; McGough and Barkley, 2004; Biederman and Faraone, 2004; Wilens et al., 2004; Nutt 2007).

Adults commonly have more cognitive, e.g., inattentive, than hyperactive symptoms. When hyperactivity is present, it tends to become more of a subjective sensation rather than an observable sign. Inattentive symptoms affect executive functions and can manifest in problems with organized planning, multitasking and time management. A variety of self-report and clinician-administered rating scales is available to aid in the assessment for these symptoms in adulthood. Examples of such screening scales are the Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist developed by the World Health Organization (available at http://www.hcp.med.harvard.edu/ncs/asrs.php)

(Kessler et al., in press; Nutt 2007) and the Wender Utah Rating Scale (Ward, 1993). The Brown ADD Scales (Brown, 2001), Wender-Reimherr Adult ADHD Scale (Ward et al., 1993) and others can be used to determine symptom severity. Clinicians make the diagnosis after considering the patient's reported ADHD symptoms from childhood, data from collateral sources, and current symptoms and functioning (Spencer and Adler, 2004; Wilens et al., 2004). As in children, "there must be clear evidence of clinically significant impairment in social, academic or occupational functioning" because of symptoms (DSM-IV-TR, 2000).

Differential Diagnosis

Determine that the symptoms are not better accounted for by another neuropsychiatric or substance abuse diagnosis, such as: adjustment disorder, anxiety disorder, conduct disorder, dissociative disorder, learning disorder, mental retardation, mood disorder, oppositional defiant disorder, personality disorder, pervasive developmental disorder, psychotic disorder, substance use disorder, chronic sleep deprivation such as caused by obstructive sleep apnea and borderline intellectual functioning. Neurobehavioral adverse effects of medication and sexual, physical and emotional abuse can also cause ADHD-like symptoms (DSM-IV-TR, 2000; Spencer and Adler, 2004; Cincinnati Children's Hospital Medical Center, 2004).

When evaluating a patient who presents with symptoms consistent with ADHD, it is recommended that clinicians also evaluate for behavioral health co-morbidity. Significant overlap among symptoms of ADHD and other psychiatric disorders is common, complicating the diagnosis of co-morbidities and the treatment process. Common co-morbid disorders include anxiety disorders, learning disorders, mood disorders and oppositional defiant disorder (Pliszka 2003; Pliszka 2006; Wilens and Dodson, 2004).[19,20] Also, gender and age suggest differing likelihoods of the presence and type of behavioral health co-morbidities. While previous studies reported boys having a greater degree of co-morbidity, more recent reports suggest that psychiatric co-morbidities are similar for both boys and girls in non-referred cases of ADHD (Biederman et al., 2005). [8] One study suggested that ADHD is a stronger risk factor for co-morbid substance use disorders in girls. Regarding age, co-morbid depression in younger children may seem less frequent but could be easy to miss, given the difficulty of accurate diagnosis in this age group.

The presence of certain co-morbidities may suggest the likelihood of different symptom types of the ADHD. Patients with co-morbid anxiety as a group tend to have a greater degree of inattention rather than impulsivity. Conversely, those with co-morbid oppositional defiant disorder or conduct disorder tend to be more impulsive rather than inattentive.

In evaluating for co-morbidity in children, a narrow-band scale, such as the Vanderbilt ADHD Diagnostic Parent and Teacher Scales (Wolraich et al., 2003), which is recommended by the American Academy of Child and Adolescent Psychiatry (American Academy of Child and Adolescent Psychiatry, 2007) and the American Academy of Pediatrics (American Academy of Pediatrics, 2000a; 2000b; Leslie et al., 2004), is sufficient for detecting co-morbidity as well as core ADHD symptoms and impairment (Cincinnati Children's Hospital Medical Center, 2004; Pliszka, 2003; Frazier et al., 2004; Waxmonsky, 2003).

Adults with ADHD have higher rates of co-morbid anxiety disorders, mood disorders, substance use disorders and cigarette smoking than adults without ADHD. Additionally, approximately 15-20 percent of adults with anxiety, bipolar, depressive and substance use disorders also have ADHD (Pliszka, 2003; Wilens, 2004).

Determine that a medical evaluation has occurred during the diagnostic process to rule out medical causes of the symptoms and any contraindications for stimulant medication treatment (Pliszka, 2006). Potential medical causes of inattention include seizures, sequelae of head trauma, acute or chronic medical illnesses, such as lead poisoning, other encephalopathies, poor nutrition, insufficient sleep, and hearing and vision problems.

The following tests are <u>not</u> supported by the evidence for a routine use in the evaluation of ADHD, but may prove helpful in selected cases:

- Lead or thyroid testing
- Brain imaging
- Genetic or chromosomal testing
- Electroencephalogram (EEG)
- Computerized performance tests (CPT).

The latter two lack sufficient specificity and sensitivity for clinical use. In general, complete psychological or neuropsychological testing is not necessary in the absence of indications of low cognitive function or performance significantly below IQ that should be explored further (Cincinnati Children's Hospital Medical Center, 2004).

Psychological testing is indicated when needed to assist in the differential diagnosis, identify possible co-morbidity, help evaluate the extent of ADHD deficits, or to guide treatment modifications. Such testing is appropriate only after initial face-to-face diagnostic evaluation demonstrates one of these needs (Cincinnati Children's Hospital Medical Center, 2004; Frazier et al., 2004).

If psychological testing is suggested to evaluate a child or adolescent for educational purposes, e.g., to establish presence of learning disability, the school usually is the most appropriate agent to conduct the testing. Educational testing and accommodations for learning disabilities are federally mandated by the Individuals with Disabilities Education Act (IDEA) (Frazier et al., 2004; Waxmonsky, 2003).

TREATMENT

Treatment should address neurological dysfunction, and any concomitant behavioral manifestations, learning disabilities, co-morbid disorders and psychosocial issues. Medications are supported by the preponderance of clinical literature as first-line treatments for core ADHD dysfunction and resulting symptoms, but are best administered in the context of a comprehensive treatment plan that considers evidence-based psychosocial interventions (American Academy of Child and Adolescent Psychiatry, 2007). Treatment progress can be assessed by clinical observations and interviews, as well as rating scales completed by parents and teachers. The hallmark of treatment planning in children is a firm alliance with the parents, patient and teachers to make sure that consistent, coordinated efforts are applied across settings (Pliszka, 2003; Wilens and Dodson, 2004; Waxmonsky, 2003).

Medications

Medication strategies should improve targeted ADHD symptoms with minimal adverse effects; address co-morbidity, if any; be appropriate relative to the patient's abuse potential; provide smooth day-long coverage; target dopaminergic and/or noradrenergic systems; be administered in a form that maximizes compliance (e.g., extended release or transdermal patch) and preserve patient safety (Wilens and Dodson, 2004; Pliszka, 2006).[20] Combining medications may be required, but unnecessary polypharmacy should be avoided.

Long-term treatment with medications is necessary for many patients with ADHD. One meta-analysis of 13 studies found that improvements in symptoms from atomoxetine treatment persisted over 24 months with no dosage escalation and no evidence of tolerance or safety concerns (Wilens, 2006; Kratochvil et al., 2006a). Periodic medication-free trials may be useful to determine the need for continuing medication.

Most children and adolescents with ADHD who do not have significant co-morbidity will respond satisfactorily to pharmacological agents (i.e., amphetamine and methylphenidate preparations and atomoxetine) after an adequate length of time at appropriate doses (American Academy of Child and Adolescent Psychiatry, 2007). If a patient does not respond, the physician should carefully review the patient's diagnosis of ADHD and consider any undetected co-morbid conditions or developmental disorders and determine whether these may be primary problems in impairing the patient's attention and/or impulse control. A referral to a child and adolescent psychiatrist may be considered at this point (American Academy of Child and Adolescent Psychiatry, 2007).

In general, when treating a patient with ADHD and suspected or confirmed co-morbidities, it is appropriate to address the ADHD first if the co-morbidity is less severe (e.g., mild to moderate anxiety, mild to moderate depression); or to address the co-morbidity first if it is severe and puts the patient at risk (e.g., severe depression, acute mania). Acute mania, if present, must be stabilized prior to initiation of a stimulant for ADHD symptoms (Pliszka, 2003; Waxmonsky, 2003).

Stimulants

The amphetamines and methylphenidate remain first line treatments and are available in short-acting and slow-release formulations, as well as a transdermal patch for methylphenidate (American Academy of Child and Adolescent Psychiatry, 2006; Nutt 2007; Pliszka et al, 2006; Brown, 2005; King 2006; Gibson, 2006; Banaschewski, 2006). A refined form of methylphenidate, dexmethylphenidate hydrochloride, is long acting and reported to be twice as potent (Weiss, 2004; Wigal et al., 2004; Arnold et al., 2004) with similar or less severe side effects than methylphenidate hydrochloride. Triple-bead mixed amphetamine salts (MAS) is an enhanced extended-release amphetamine formulation designed for duration of action up to 16 hours. It has been shown to be effective in the treatment of adults with ADHD resulting in significant improvements in executive function and quality of life (Spencer et al., 2008). Lisdexamfetamine dimesylate is the first pro-drug stimulant used in the treatment of ADHD. It is a therapeutically inactive molecule that is converted to the essential amino acid, l-lysine and active d-amphetamine after oral ingestion. This drug was developed for its long duration of effect and reduced potential for risk of abuse. At doses of 30, 50 and 70 mg. per day, it demonstrated significant improvements in ADHD symptoms in adults (Adler, Goodman et al., 2008).

Higher stimulant doses are generally associated with better reduction in symptoms (Pliszka, 2006). At least 70 percent of school-aged children with ADHD respond favorably to stimulant medications. Preschool age children also benefit from these medications, although their response may be less robust than that seen in older children and a short-acting form may be needed to achieve appropriate dosing. Teens with co-morbid conduct problems are usually insufficiently treated by stimulants alone, and need psychosocial treatments in combination (Chronis et al., 2006). Many adults, including those never treated in childhood, can benefit from the use of stimulant medications (Adler, Zimmerman et al., 2009).

An algorithm of the Texas Children's Medication Algorithm Project (TCMAP) recommends, for ADHD without co-morbidity, an initial trial of either methylphenidate or amphetamine, and if response is not sufficient, switching to the stimulant not tried initially; if the second stimulant does not produce an acceptable outcome, an alternative medication, such as atomoxetine, can be tried (Pliszka et al., 2006, Newcorn et al., 2008).

The stimulants primarily affect the core symptoms of hyperactivity, impulsivity, inattentiveness and associated aggressiveness. The onset is rapid, the dose easily adjusted and adverse effects are generally mild and easily managed. The optimal dose cannot be predetermined by age, weight, height, gender or severity of the ADHD, and weight-adjusted milligram-per-kilogram-per-day dosing is not supported by evidence and consensus (Pliszka et al., 2006). Rather, a careful milligram-based dose titration is thought to yield the most appropriate dose for a given patient (Pliszka et al., 2006). When medication is used, the prescribing physician, parents and teacher should clearly define the target symptoms. Rating scales may be useful in helping gauge the effectiveness of the medication

on the target symptoms (Cincinnati Children's Hospital Medical Center, 2004; Pliszka, 2003; Steinhoff, 2004; Reeves and Schweitzer, 2004; Biderman and Spencer, 2004).

Selection of short vs. longer-acting preparations of methylphenidate and amphetamines should be based on the individual's symptom profile, history of response to an agent in the patient's family, ease of administration, likelihood of non-compliance if a school-day dose is required (Pliszka, 2006), abuse potential and adverse effects. Also, varying the wear time of the methylphenidate transdermal system or reducing an oral dose of one-daily methylphenidate in children can regulate the duration of the medication effect. This may be done in order to accommodate to the schedules of the patient. This reduction in exposure to methylphenidate results in shorter coverage of ADHD symptoms but fewer late afternoon or early evening drug side effects and insomnia (Wilens et al. 2008; Faraone et al. 2009). Stimulants should be used cautiously or withheld when there is suspicion of untreated mania, psychosis, substance abuse, tic disorder or concern about growth retardation (Pliszka et al., 2006; Steinhoff, 2004; Reeves and Schweitzer, 2004; Biederman and Spencer, 2004).

Stimulants are not effective in relieving core ADHD symptoms for 10 percent to 30 percent of patients, and negative side effects, including headache, insomnia, abdominal pain, blood pressure changes, appetite reduction, tics, weight loss and reductions in growth rate for children are common (Lindsay 2006; Kratochvil et al., 2005; Sadeh et al., 2006; Cortese et al., 2006). There is also some preliminary evidence that long-acting amphetamines or methylphenidate medications may produce rebound effects that may hinder late evening or early morning driving safety in adolescent male drivers (Cox et al., 2008). However, typical parental concerns, e.g., beliefs that there is haphazard diagnosing and over-prescribing, that school alternative programs are being neglected and that the causes of symptoms are only social and cultural, are not supported by research (Safer, 2000).

In a very small number of children (0.16 per million prescriptions and 0.53 per million prescriptions for methylphenidate and amphetamine, respectively) stimulant use has been associated with sudden death, usually from adverse cardiovascular events (Gephart, 2006). In May 2008, a joint advisory statement of the American Academy of Pediatrics (AAP) and the American Hospital Association (AHA), with endorsement by the American Academy of Child and Adolescent Psychiatry, the American College of Cardiology, Children and Adults with Attention-Deficit/Hyperactivity Disorder, the National Initiative for Children's Healthcare Quality and the Society for Developmental and Behavioral Pediatrics, was issued to address controversies in cardiac assessment prior to stimulant treatment for ADHD:

- An AHA Scientific Statement issued in April 2008 included a review of data that show children with heart conditions have a higher incidence of ADHD.
- Because certain heart conditions in children may be difficult (even, in some cases, impossible) to detect, the AAP and AHA feel that it is prudent to carefully assess children for heart conditions, if they need to receive treatment with drugs for ADHD.
- Obtaining a patient and family health history and doing a physical exam focused on cardiovascular disease risk factors (Class I recommendations in the statement) are recommended by the AAP and AHA for assessing the patient before treating with drugs for ADHD.

- Acquiring an ECG is a Class IIa recommendation. This means it is *reasonable* for a physician to *consider* obtaining an ECG as part of the evaluation of children being considered for stimulant drug therapy, but this should be at the physician's judgment, and it is *not mandatory* to obtain one.
- Treatment of a patient with ADHD should not be withheld because an ECG is not done. The child's physician is the best person to make the assessment about whether there is a need for an ECG.
- Medications that treat ADHD have not been shown to cause heart conditions nor have they been demonstrated to cause sudden cardiac death. However, some of these medications can increase or decrease heart rate and blood pressure. While these side effects are not usually considered dangerous, they should be monitored in children with heart conditions as the physician feels necessary. (AHA Newsroom, 2008)

Another previously reported safety concern for treatment with methylphenidate and mixed amphetamine salts was whether these drugs induce chromosomal damage in peripheral blood lymphoctyes of children with ADHD posing an increased risk for cancer. A more recent study found that treatment with these drugs for three months did not induce cryogentic damage (i.e., structural aberration, micronuclei and sister chromatid exchanges) in children, but that longer-term effects of these drugs on chromosomal changes still need to be investigated (Witt et al., 2008).

Concern about the potential for abuse of stimulant medications is legitimate, and there have been reports of children giving or selling their medication to others. Abuse potential can be decreased by using long-acting preparations. Stimulants appear to have a protective effect against the development of a substance use disorder in children and adolescents, with a significant reduction of risk (Wilens et al., 2003).

Atomoxetine

Atomoxetine, a non-stimulant, selective norepinephrine reuptake inhibitor, was introduced in 2002 as an effective first line medication for both childhood and adult ADHD. It is not a controlled substance, making prescribing more convenient for patients and physicians, as well as eliminating abuse potential. Another advantage is that it is relatively long-acting, with once daily dosing in most patients. Clinical research continues to demonstrate the efficacy and tolerability of atomoxetine in treating children and adults with ADHD (Adler, Spencer et al., 2008). Meta-analytic findings from six controlled trials show that atomoxetine is an effective and generally well-tolerated treatment of ADHD in both younger (6-7 years) and older children (8-12 years) (Kratochvil et al., 2008).

Atomoxetine shares some adverse effects with stimulants, but appears to have much less potential for aggravation of tics and insomnia. It is purported to be a good choice when anxiety, depression, tics, substance abuse and Oppositional Defiant Disorder (ODD) symptoms complicate ADHD in children or adults (Cheung et al., 2007; Bangs, Hazel et al., 2008; Wilens et al., 2008). There have been reports of sexual adverse effects. Clinicians have reported using atomoxetine in combination

with stimulants when a patient has not responded adequately to a trial of either alone (Pliszka et al., 2006). For example, if atomoxetine did not remit symptoms during the day and stimulants did not remit symptoms in the evening, the two types of medications might productively be combined. The TCMAP panel included a stimulant-atomoxetine combination as a third line treatment in the absence of controlled data but warned that it should be used only after full monotherapy trials of two stimulants sequentially, and atomoxetine alone, have not provided full remission (Pliszka et al., 2006).

Atomoxetine has been associated with six reported cases of hepatotoxicity but none of these cases resulted in a liver transplant. A Postmarket Review of the FDA cautions both patients and caregivers to be alert to the signs and symptoms of liver injury throughout atomoxetine treatment and directs prescribers to discontinue the drug if a patients presents with jaundice or laboratory evidence of hepatotoxicity (FDA, 2009; Pliszka et al., 2006; Steinhoff, 2004; Reeves and Schweitzer, 2004; Beiderman and Spencer, 2004). In addition, atomoxetine has a black box warning from the FDA regarding possible increased suicidality (Lindsay, 2006). More recent meta-analytic findings also showed that although uncommon, suicidal ideation was significantly more frequent in pediatric ADHD patients treated with atomoxetine compared to those treated with placebo. However, no patients in atomoxetine ADHD clinical trials committed suicide (Bangs, Tauscher-Wisniewski et al. 2008).

Atomoxetine has not been found as effective at treating primary ADHD symptoms as the stimulants and has more recently come to be considered a second-line treatment (American Academy of Child and Adolescent Psychiatry, 2006; Pliszka et al., 2006; King, 2006; Gibson, 2006; Soreff, 2009; Newcorn et al., 2008; Newcorn et al., 2009). New clinical trial data have shown that while both treatment with atomoxetine or osmotically-released methylphenidate produced robust improvements in ADHD symptoms, response to osmotically-released methylphenidate was superior to that for atomoxetine. Also, approximately one-third of the patients in this large (n=516), placebo-controlled, double-blind, cross-over study responded better to one or the other suggesting that there may be preferential responders. Researchers argued that this supports the practice of changing to a different class of medication if there is a poor response to or tolerance of the first agent (Newcorn et al. 2008). Similarly, The Integrated Data Exploratory Analysis Study showed that the clinical response to atomoxetine was bimodal in that most subjects were either responders (47 percent) or non-responders (40 percent) or showing a minimal response (13 percent). No demographic or clinical factors were associated with these divergent profiles of response, but patients who ultimately achieve a good response show at least a partial response by the fourth week of treatment (Newcorn, 2009).

Antidepressants

Third-line medications used to treat ADHD include bupropion and tricyclic antidepressants (TCAs). Bupropion is a weakly dopaminergic and adrenergic agent and is available in slow-release forms. Meta-analytic findings of bupropion clinical trials indicated a beneficial effect compared with placebo for improvement of ADHD symptoms in adult patients (Verbeeck et al., 2009). Additionally, in at least one study, it has shown efficacy comparable to methylphenidate. It may be a useful agent in patients with co-morbid unipolar and bipolar depression, anxiety disorders and/or substance abuse including the diversion of psychostimulant prescriptions (Verbeek, et al., 2009). Bupropion carries a higher risk of seizures than most other antidepressant medications, especially at

higher doses, and should not be used in patients with a history of seizures. It should be used with caution in children with a history of eating disorder (Kratochvil et al., 2006b; Pliszka et al., 2006).

Before the advent of atomoxetine, tricyclic antidepressants (e.g., imipramine and nortriptyline) were the primary alternative to stimulant treatment of ADHD having shown efficacy in symptom reduction in ADHD. Desipramine use in children and adolescents should be avoided due to reports of sudden death (Amitai and Frischer, 2006; Pliszka et al., 2006). TCAs can be lethal in overdose. Children being treated with TCAs should be monitored with electrocardiogram at baseline and on stable dosing. For these reasons, there has been a decline in the use of TCAs for the treatment of ADHD (Schatzberg et al., 2010).

Antidepressants have been the subject of concerns regarding possible increased suicidal behavior in children, adolescents and young adults (Hammad et al., 2006), especially at initiation and around changes in dosing. The FDA identified specific antidepressants in a 2004 analysis and eventually directed manufacturers of all antidepressants to include a boxed warning and expanded warning statements alerting clinicians to an increased risk of suicidal thinking and behavior in children and adolescents being treated with these agents (U.S. Food and Drug Administration, 2004a, 2004b, 2004c; 2005a). Clinical evidence, however, has not been conclusive in guiding clinicians toward or away from use of these agents in children and young adults (Bridge et al., 2007; Hughes et al., 2007).

In the absence of definitive evidence from clinical literature, FDA advisories or other credible sources determining that the risk of increased suicidality for patients treated with antidepressants makes their use inadvisable, Magellan's position remains that clinical evidence strongly supports the use and effectiveness of antidepressant medications in all age groups, and that careful, frequent and proactive monitoring for changes in status that could indicate suicidality is crucial to preserving the safety of these patients (U.S. Food and Drug Administration, 2004a, 2004b; 2004c; 2005a; Hughes et al., 2007; American Academy of Child and Adolescent Psychiatry 2007; Cheung et al., 2007; Williams et al., 2009). When a current or past history of suicidality is present, such monitoring should occur at every session. In addition, Magellan recommends that the clinician contact patients who miss appointments, especially when there are reasonable grounds for concern about safety. Further, prescribing physicians and other clinicians involved in the care of patients taking antidepressants, as well as patients and their families, should stay alert and watchful for warning signs of possible increased suicidality and take prompt action if any adverse effects are observed (Hughes et al., 2007).

Other Medications

Modafinil does not have FDA approval for the treatment of ADHD, but there are reports of its usefulness in children, adolescents, and adults (Pliszka, 2003; Waxmonsky, 2003; Steinhoff, 2004; Biederman and Spencer, 2004; Spencer et al., 2002; Lindsay, 2006; Ballon, 2006; Kahbazi et al., 2009). However, more research is needed to establish the safety and efficacy of this agent for ADHD treatment (Pliszka et al., 2006).

Alpha-adrenergic agonists (e.g., clonidine and guanfacine) effect ADHD symptoms by affecting the noradrenergic system and generally have greater benefit for hyperactivity/ impulsivity symptoms than for inattention. In 2009, the FDA approved guanfacine extended release tablets for the once-daily treatment of ADHD in children and adolescents ages six to 17 years. The approval was based on data from two similarly designed phase three double-blind parallel group trials of 669 children

and adolescents. Significant clinical improvement was demonstrated for patients who were randomized to receive guanfacine once daily and uptitrated by 1 mg/week to a maintenance dose of 1 to 4 mg/day (Waknine, 2009; Biederman et al. 2008). Sedative side effects may limit their usefulness in daytime, but may make them useful at bedtime for assistance with sleep. Abrupt discontinuation of these agents can be associated with rebound hypertension. There are reports of serious cardiac adverse effects with clonidine, especially when used in combination with stimulants. However, a more recent examination of the safety and tolerability of clonidine when used alone or with methylphenidate in children with ADHD reported that it appeared safe and well-tolerated in children with ADHD who do not have a baseline or family history of cardiovascular problems. Nonetheless, these researchers reported that 17 percent of their sample who were treated with clonidine experienced asymptomatic bradycardia (HR < 60 bpm) and underscored the need to regularly monitor changes in blood pressure and heart rate when prescribing clonidine (Waxmonsky, 2003; Steinhoff, 2004; Biederman and Spencer, 2004; Spencer et al., 2002; Pliszka et al., 2006; Daviss et al., 2008).

Pemoline has fallen from use due to a risk of liver failure that is 10-25 times greater than the risk in the general population (Marotta and Roberts, 1998). In 2005, the FDA concluded that the risks associated with this drug outweigh any potential benefits and the manufacturer stopped sales and marketing of the drug in the United States (FDA, 2005).

Psychosocial Treatments

Psychosocial treatments for ADHD include both psycho educational interventions and psychotherapeutic interventions, such as behavior modification, parent behavior training and family therapy.

Psychoeducation, which should be delivered to all patients with ADHD and in the case of minors, to the parents or other caregivers as well, should include information about:

- ADHD, its presentation in the patient, the plan of treatment and rationale, available treatments, including medications and their benefits, risks, side effects and psychotherapeutic interventions
- Co-morbid disorders, if any, and how treatment of these is integrated with ADHD treatment
- Social and peer support available locally for children and adults with ADHD and their families, such as CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder) activities and resources
- Rights to educational needs assessments through the school system, if appropriate, under the Individuals with Disabilities in Education Act (IDEA) and Section 504 of the Civil Rights Act
- Increased risk for suicidal behavior and early warning signs of possible increases in such behavior, if antidepressants or atomoxetine are prescribed.

Although carefully titrated pharmacotherapy with stimulants has been found superior to psychosocial treatments and combination treatments in reducing ADHD core symptoms (MTA Cooperative Group, 1999a, 199b), most patients experience social, familial, occupational and/or educational effects of the disorder that are responsive to psychotherapeutic intervention. Psychotherapeutic interventions can be administered in combination with medications, or, in rare

cases, as the sole intervention, such as after the failure of adequate trials of first, second, third and fourth line medications and/or in response to parental refusal to allow medication or inordinate health and safety risks associated with medication treatment (American Academy of Child and Adolescent Psychiatry, 2007; Pliszka et al., 2006). In child/adolescent patients treated with medication and who have co-morbid mental health disorders and/or unsupportive, chaotic or conflict-ridden family environments, the use of family interventions (American Academy of Child and Adolescent Psychiatry, 2007; Chronis 2006) is recommended.

Family interventions that coach parents on contingency management methods have been shown to be useful in decreasing punitive and ineffective parenting styles that may perpetuate behavioral problems in children and adolescents with ADHD. Behavioral models that focused on parent training specifically for fathers also have resulted in symptom improvement in children along with increased satisfaction and engagement in the treatment process by the fathers (Chronis, 2006; Fabiano et al., 2009). Manual-based parent training has been evaluated in two dozen studies noting that it is associated with less severe parental ratings of problem behavior in their children, and fewer rater-observed, negative child-parent interactions, with an average effect size of .87 (Chronis, 2006).

Classroom behavior-management techniques have been found to be effective, particularly the daily report card intervention that addresses child-specific targeted improvements with measurable goals (Chronis 2006; Evans and Youngstrom, 2006). Teachers are taught to use points and token reward systems, time outs, planned ignoring and response costs, as well as to provide a highly structured environment by setting schedules for the child's use throughout the day. Limiting distraction during class and study, both in school and at home, may be helpful. Academic interventions and special education placement may be necessary.

Particularly in children or adolescents for whom aggressive behavior is a problem or who have a co-morbid conduct disorder, behavioral modification techniques that address social skills should be a component of treatment (Chronis, 2006). The short-term effectiveness of behavioral therapy has been demonstrated, but there is little evidence to show that the gains made during therapy are maintained after treatment is stopped and behavioral modification may be best delivered in combination with medication treatment (Pliszka et al., 2006; MTA Cooperative Group, 1999a, 1999b; 2004a, 2004b).

After-school programs are in early stages of development using manual-based treatment focused on targeted educational, social, and recreational skills, home-work completion, and school and home behavior. In one clinical trial, individual counselors provided support to students in achieving goals and implemented a behavioral-point system to reward both individual and group behaviors. Parents also participated to review program content and to learn skills for managing home behaviors. Preliminary findings for these public middle school students showed modest beneficial effects on behavioral and academic outcomes. Continued research on these types of after-school interventions is necessary (Molina et al., 2008).

Adults

Psychotherapeutic treatment of ADHD has been studied far less in adults than in children, and consensus guidelines are not available. Cognitive behavioral therapy, life-skills coaching and training in organizational skills appear useful, but evidence to support their long-term benefit in reducing

core symptoms of ADHD is lacking. Accepted psychotherapies can be used to treat co-morbid disorders in adults, as well as children, with ADHD (Wilens et al., 2004).

Alternative Therapies

Numerous case and controlled-group studies have been published regarding use of EEG biofeedback (aka neurofeedback) in the treatment of ADHD (Gevensleben, 2009 et al., 2009; Strehl et al., 2006; Monastra 2005a, 2005b; Carmody 2001; Fuchs 2003; Linden 1996; Monastra 2002; Rossiter 1995). EEG biofeedback uses analysis of brain wave patterns (i.e., beta and theta activity, sensorimotor rhythms) and/or EEG polarity (i.e., positive, negative) along with a reward system to help patients with ADHD change patterns of wave activity in their brains. Several published case studies have suggested that EEG biofeedback is an effective treatment for the primary symptoms of ADHD, especially attention, hyperactivity and impulsivity, with no adverse effects and persistence of treatment effects over time (Gevensleben, et al., 2009; Strehl et al., 2006; Monastra 2005a, 2005b; Carmody 2001; Fuchs 2003; Linden 1996; Monastra 2002; Rossiter 1995). However, the limitations of both study size and design create significant questions about the efficacy of this treatment modality (Monastra, 2005a, 2005b) and further research is needed if benefits from this and other alternative treatments are to be established.

Additional alternative treatments including the use of St. John's Wort (Weber et al., 2008), homeopathy (Heirs et al., 2007), dietary sugar reduction and dietary supplementation with herbs and vitamins, have been unsupported by research (American Academy of Child and Adolescent Psychiatry, 2006). Also, there are very limited data supporting the premise that food dyes, preservatives or other additives adversely influence behavior in children (Cruz et al., 2006). Conversely, there have been other more recent studies of alternative treatments that have shown positive results. Findings from a randomized clinical trial conducted in Italy showed that compared to placebo, the nutritional supplement L-acetylcarnitine (LAC) was effective for ADHD symptoms in Fragile X Syndrome Boys. LAC is the acetyl ester of L-carnitine, a fundamental compound that plays an essential role in the metabolism of fatty acids in mitochondria. These results were promising because it is estimated that over 70 percent of FXS boys meet diagnostic criteria for ADHD. Researchers reported previous observations that have shown while FXS boys respond to stimulants, their mood becomes unstable at higher doses necessitating a need for alternative pharmacological treatment (Torrioli et al., 2008).

Another more recent scientific study reported promising results for iron supplementation (80 mg/day) in iron-deficient (30ng/mL) non-anemic children with ADHD where clinical improvements in symptoms were significant. Here authors suggested that careful dietary history and necessary lab work be done and then re-evaluated prior to instituting treatment. (Konofal et al., 2008) Another clinical trial revealed that supplementation with omega-3/omega-6 fatty acids did not result in symptom improvement for the majority of ADHD subjects. There was, however, a distinct subgroup of patients in this study characterized by inattention and associated neurodevelopmental disorders (i.e., Developmental Coordination Disorder, Reading Disorder and Disorder of Written Expression) who responded with meaningful reduction of ADHD symptoms after six months of treatment (Johnson et al., 2009).

Level of Care

It is rare that a patient with a sole diagnosis of ADHD would require a hospital level of care. Usually, the need for an intensive level of care is based on the presence of symptoms associated with a co-morbid condition. Such symptoms would likely be of the hostile or violent type associated with bipolar disorder, conduct disorder, oppositional defiant disorder, psychotic disorder, or adjustment disorder with disturbance of conduct. Alternatively, symptoms requiring a more intensive level of care could be associated with risk of self-harm[4]* or hospitalization for actual injury from being the victim of interpersonal violence, since children and adolescents with ADHD are at higher risk for suicidal behavior and interpersonal violence (Lam 2005). Of these, conduct disorder would present most often with a pattern of violent behavior toward people and/or animals that potentially at times could require the safety of a hospital level of care, although for this population there have been effective multi-focused treatment approaches that include both medication and psychosocial treatments (Connor et al., 2006).

Most often, treatment for ADHD and co-morbidities occurs in an outpatient setting. When aggressive behavior is not responding to outpatient care, in-home treatment may be an adjunctive or alternative course. In-home treatment can be an effective way to deliver family interventions, including modeling ways for parents to deal with their child's aggressive and hostile behaviors and providing problem-solving and social skills training.

* Magellan has adopted a clinical practice guideline that addresses suicidal behavior: the *Magellan Clinical Practice Guideline for Assessing and Managing the Suicidal Patient* (Magellan Health Services, 2010). Clinicians are referred to that document for additional information on managing suicidal behavior in patients with ADHD.

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EE. Sample Customer Audit

FF. Sample Outcomes Report

GG. Unnamed Team Member Qualifications

Magellan Health Services
Job Description

JOB TITLE: Director of Clinical Services	FLSA STATUS: Exempt
DEPARTMENT TITLE: Director, Clinical Services	DEPARTMENT: Clinical
REPORT TO: VP Clinical Services	JOB CODE: CN5201E
LOCATION: Region	GRADE: 40
DATE CREATED:	DATE REVISED:

JOB SUMMARY (Please write 2-3 sentences summarizing the purpose of this position)
Under the supervision of the VP of Clinical Services, the Director of Clinical Services is responsible for the direction and management of Magellan Behavioral Health clinical operations at a satellite office of a Regional Service Center or within a large RSC that is responsible for the management of multiple accounts. Assists in the development and implementation of the organizational and operational plans for the effective delivery of clinical services within Magellan's policy guidelines. Supervises and directs the care management staff.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
20	Clinical program implementation
20	Staff development and management including recruitment, supervision and training.
20	Implementation of corporate clinical philosophy and clinical policies and procedures.
15	Quality improvement activities as assigned by the VP of Clinical Services
15	Participation in provider relations activities
10	Monitoring, analyzing, trending and reporting of utilization data; provides input into the development of budgets.

NON-ESSENTIAL FUNCTIONS (Lists additional tasks necessary to meet overall performance standards)

Manages within the established Magellan clinical quality standards and quality management plan protocols. Provides leadership to the clinical team for member care review and appropriate placement. Maintains professional relationships with network providers.

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom this position has a direct reporting relationship.

			VP Clinical Svcs	Supervisor Title
		Dir Clinical Services	Supervisor Title	
		Job Title		Supervisor Name
	Employee Title		Supervisor Name	
Employee Title		**Name**		
	Employee Name			
Employee Name				

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☐ MA/MS/MBA ☒ PHD ☐

Field(s) of study: Behavioral Health

Experience: 0 yrs. ☐ 1-3yrs. ☐ 3-5yrs. ☐ 5-8yrs. ☒ > 8yrs. ☐

Industry:

Job Specific: Six years experience to include five years of administrative and clinical experience post licensure. Two years managed care experience and supervisory experience at a minimum. At a minimum, meets Magellan Behavioral Health credentialing criteria for Masters level therapist.

*Equivalent combination of experience and education ☐

*Education and/or experiences may run concurrent ☒

Knowledge, Skills, Abilities:

☐WPM ☐KSPH

Other:

Computer Skills:

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education:

Experience:

Knowledge, Skills, Abilities:

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☒ Standing ☐ Lifting ☐ _____lbs.

Typing ☒ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____

Supervisor Co mpensation Analyst

Customer Service Director

JOB TITLE: **Customer Service Director**	FLSA STATUS: Exempt
DEPARTMENT TITLE: Customer Service	DEPARTMENT: ***TBD***
REPORT TO: General Manager, CMC	JOB CODE: CS5013E
LOCATION: Care Management Center (locations vary)	GRADE: 40
DATE CREATED: 7/15/03	DATE REVISED:

JOB SUMMARY: Senior leader of the CMC customer service and administrative functions. Responsible for the performance of Customer Service Supervisors, Associates, Care Assist Team and Support Associates in the delivery of the highest quality and most efficient service. Responsible for ensuring the service team meets client contractual obligations and commitments. Manage customer service operating budget and achieve unit cost objectives and other customer service financial objectives including performance guarantees/incentives. Develop processes to drive first call resolution, call avoidance strategies and other service objectives.

% of TIME (Total 100%)	ESSENTIAL FUNCTIONS
30%	Responsible for performance of Customer Service Supervisors, Associates, Support Associates and Customer Service Care Assist Team in the delivery of the highest quality and most efficient service. ➢ Develop and communicate customer service team objectives ➢ Establish performance goals for customer service staff and ensure continuous feedback to all associates ➢ Set service quality standards and put processes in place to regularly and consistently measure qualitative performance ➢ Develop methods to recognize top performers and improve performance of team members not achieving performance goals ➢ Put processes in place to identify developmental needs of team members and a means of addressing those needs ➢ Provide leadership to ensure the highest level of performance, professional development, job satisfaction, and customer delight. ➢ Build and develop an excellent supervisory leadership team ➢ Ensure ongoing and annual performance assessment process is conducted in a meaningful and timely manner, incorporating individual development planning as appropriate. Utilize performance management tools to quantify and document performance coaching.
25%	Lead custom er service teams in the s uccessful delivery and ex ecution of ser vices to meet client commitments, and contractual obligations. ➢ Create a work environment that achieves a healthy balance between qualitative and quantitative performance results ➢ Maximize utilization of tools and resources (i.e. ACD, satisfaction surveys, reporting tools, IEX, etc.). ➢ Manage the implementation, maintenance and achievement of customer service client operational/service commitments including service levels, performance

	guarantees and incentives. ➢ Ensure regulatory compliance amongst the customer service team and manage the associated risk.
25%	Manage customer service department's financial performance on a unit cost and operating basis. Manage to achieve the most effective financial performance while ensuring appropriate service levels. ➢ Manage within customer service operating budget. ➢ With the Operations Team, manage to unit cost objectives ➢ Share in the responsibility of avoiding payment of performance penalties and optimize opportunities to earn incentives ➢ Manage customer service attrition effectively
20%	Put processes in place in the customer services unit that are consistent with overall CMC and corporate objectives ➢ Facilitate first call resolution and call avoid strategies ➢ Work closely with the Operations Team to create balanced processes that meet both financial and associate satisfaction goals ➢ Develop and implement creative process and service solutions that address performance issues and/or enhance efficiency and service excellence. ➢ Work with the National Service Development team to create Magellan standard processes and tools ➢ Participate as needed in CMC leadership meetings and with other internal/external audiences as warranted. ➢ Serve as customer service expert as required for the development of new processes, products, and request for proposal responses.

Performs related duties as required.

NON-ESSENTIAL FUNCTIONS

REPORTING RELATIONSHIPS

SVP, Operations Supervisor Title
Supervisor Title

General Manager,
CMC

Customer Service

Job Title

Supervisor Name

Employee Title

Employee Title

Supervisor Name

Name

Employee Name

Employee Name

(Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐

Field(s) of study: Business, Healthcare or related field

Experience: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. ☒ > 8yrs.☐

Industry:

Job Specific: Five years or more experience in call center management, preferably in the healthcare industry. Experience leading large teams in a dynamic industry. A demonstrated track record of managing change with proven results in the achievement of goals (financial and performance).

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*Equivalent combination of experience and education ☐

*Education and/or experiences may run concurrent ☒

Knowledge, Skills, Abilities:

☐WPM ☐KSPH

Other: Knowledge of managed healthcare principles and call center operations. Ability to develop, articulate and measure performance of a large, diverse team. Ability to collaborate with colleagues in the CMC and in other CMC to achieve mutual performance goals. Excellent negotiation, leadership and communication skills.

Computer Skills:

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: BA/BS required. MBA preferred.

Experience:

Knowledge, Skills, Abilities: "One Magellan" Thinking; Quantifiable Business Results; Leadership of People; Service Orientation (External and Internal); Flexible and Adaptable; Management of Projects, Tasks and People; Teamwork; Expert Knowledge

WORKING ENVIRONMENT (This position may include the following situations)
Sitting ☐ Standing ☐ Lifting ☐ _____lbs.

SIGNATURES OF APPROVAL

_____ _____

Supervisor Compensation Analyst

Medical Director

Job Summary

The CMC Medical Director provides oversight of a comprehensive medical policy implementation and utilization management services. The Medical Director develops and sustains an interface with member forums and facilitates the delivery of appropriate care. The Medical Director contributes to the development of the clinical mission of the CMC, including the development, implementation, and evaluation of clinical/medical programs.

Essential Functions

- Senior Medical Reviewer: Direct the utilization review process and oversee the quality of utilization determinations. Responsible for the quality of the utilization review determinations made in the CMC. Develop and implement a utilization management program and action plan; Ensure compliance with clinical goals through regular monitoring of care management center performance. Evaluate the effectiveness of the clinical program and modify programs as need to achieve desired results.
- Provide medical leadership, oversight, and consultation for CMC Quality Improvement Program, and CMC Utilization Management Program including: monitoring effectiveness and compliance with goals, prevention programs, network development and management, quality of care concerns and adverse incidents, medical practice of network or sub- capitated providers, clinical service delivery system; coordination with After Hours Team and appeals-panel physicians, oversight of clinical appeals. The Medical Director works collaboratively with QI on the development and implementation of QI activities, UM and QI program descriptions, evaluations, and work plans.
- Develop, implement and interpret Magellan Behavioral Health medical policy for the Care Management Center (including Medical Necessity Criteria, Clinical Practice Guidelines and New Technology Assessments).
- Recruit, train, supervise, mentor, oversee, and evaluate the quality of medical staff and physician advisors utilized by the CMC. Ensure that the CMC has adequate physician advisor resources. Develop and manage the physician advisor budget.

Non-Essential Functions

Other duties and special projects as assigned.

Minimum Requirements

Education: Graduate of an American or Canadian medical school accredited by the Accreditation Council for Medical Education (ACME) or equivalent training in a foreign medical school with successful completion of the ECFMG and FLEX examinations. Full training in a residency program in the United States or Canada that is approved by the ACGME

Experience: 5-8 years Post-residency experience of at least 5 years involving substantial direct patient care during this period at multiple levels of care. Clinical experience pertinent to the patient population(s) being managed.

Licenses, Certifications, etc.: Must have current active license to practice medicine in the U.S. Licensed or licensure eligibility in state of operation. Licensure must be complete within the 1st year of employment. Board certification by the American Board of Psychiatry and Neurology.

Other

Familiarity with current research and use of psychopharmacologic and psychotherapeutic modalities of treatment.

Preferred Qualifications

Experience. Managed care experience preferred, as provider and manager of care. Utilization Review experience preferred. Accreditation experience (NCQA, AAHCC/ URAC) preferred.

Magellan Health Services
Job Description

JOB TITLE: Quality and Process Improvement Director	FLSA STATUS: Exempt
DEPARTMENT TITLE: QI Director	DEPARTMENT: Quality
REPORTS TO: General Manager or VP of Quality	JOB CODE: QA5107E
LOCATION: Care Management Center or Magellan Business Unit	GRADE: 39
DATE CREATED: 4/6/01	DATE REVISED:4/15/11

JOB SUMMARY

Direct a comprehensive quality improvem ent pr ogram with end to end quality controls and monitoring, strong quality structur es, defined processes and m easured outcomes. Duties include responsibilities for: quality program oversi ght, departm ental staffing and leadership, performance measurement and reporting, development and review of policies and procedures to meet contractual and accreditation requirements and integration of CQI processes throughout the operation.

% of TIME	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
25%	Supervise assigned quality and process improvement staff to meet quality and process improvement objectives of the business unit/CMC. Demonstrate operational excellent, process efficiencies, positive health care outcomes and documented processes. Supervise data analyses and reporting for purposes of both quality and process improvement and to meet customer deliverables in a timely manner.
15%	Direct an end to end quality control system built within operations to provide real time feedback, rapid corrections, tracking and reporting of findings, root cause analyses and monitoring of policies, procedures, activities, to meet contractual requirements, accreditation standards, and state/federal regulations. Identify processes needing improvement and use established models for change such as DMAIC and LSS.
15%	Develop and present appropriate and effective CQI training programs and services for staff and customers
15%	Represent the department externally and internally in meetings and presentations. Serve a liaison with department mangers supporting quality operations at all levels.
10%	Ensure that appropriate QI studies and activities are conducted with appropriate feedback from key stakeholders.
10%	Co-chair the Quality Improvement Committee. Make recommendations to senior leadership and the QI Committee for priorities for improving plan operations based on data from performance indicators and quality improvement activities.
10%	Prepare written reports for customers, accreditation and contractual compliance and contribute to writing RFPs and customer presentations as required.

NON-ESSENTIAL FUNCTIONS	(Lists additional tasks necessary to meet overall performance standards)

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom you have a direct reporting relationship.
Supervise assigned QI staff.

				Supervisor Title
			Supervisor Title	
		QI Director-Regional		
		Your Title		Supervisor Name
	Employee Title		Supervisor Name	
Employee Title		**Your Name**		
	Employee Name			
Employee Name				

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐

Field(s) of study: Healthcare or business related

Experience: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. ☒ > 8yrs.☐
Industry:
Job Specific: 5 yrs QI experience

*Equivalent combination of experience and education ☒
*Education and/or experiences may run concurrent ☐

Knowledge, Skills, Abilities:
☐WPM ☐KSPH

Other: Knowledge of quality and process improvement processes, performance measurement, accreditation standards and processes, CQI/TQM tools, and data reporting applications. Experience working within quality improvement and process improvement field. Demonstrated excellence in written and verbal communications, report preparation and the ability to work under deadline requirements.

Computer Skills: Expertise in data management software including spreadsheet development and use. Knowledge of process improvements models and tools.

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: MA heath care management. Licensed clinician.

Experience: Management or supervisory experience preferred.

Knowledge, Skills, Abilities: Experience in preparation and achievement of NCQA and URAC accreditation. Knowledge of statistical analysis procedures and software preferred.

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☒ Standing ☐ Lifting ☐ _____lbs.

Typing ☐ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____

Supervisor Com pensation Analyst

Magellan Health Services
Job Description

JOB TITLE: Supervisor, Claims Operations	FLSA STATUS: Exempt
DEPARTMENT TITLE: Supervisor, Claims Operations	DEPARTMENT: Claims
REPORT TO: Director, Claims Operations	JOB CODE: CL7101E
LOCATION: Varies	GRADE: 35
DATE CREATED: 9/24/01	DATE REVISED:3/11/11

JOB SUMMARY (Please write 2-3 sentences summarizing the purpose of this position)
Responsible for managing team(s) to meet or exceed customer requirements and business objectives; Accountable for team's performance; Serves as subject matter expert and trains new employees; Interfaces directly with customers, members, and/or providers to resolve customer concerns; Assumes additional responsibilities in the absence of the Manager/Director.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
30%	**Operations**: Manages cross-functional team members to meet or exceed service requirements. Independently examines and analyzes the team's performance; develops, recommends and implements plan(s) of action to improve the team's service level. Evaluate multiple reports to assess work distribution/delegation in order to meet client expectations and/or state regulations. Reports performance results to account management. Demonstrate flexibility in assigning resources based on business need and fluctuating inventory. Adheres to budget allocations.
20%	**Performance Management:** Provide ongoing feedback and coaching to ensure appropriate levels of performance. Recognizes and rewards effectively; provides appropriate levels of direction and support; Consistently follows corporate and departmental polices and guidelines; Utilizes corporate tools for performance appraisals; engages team members in development planning and progress. Identifies training needs within the team; works independently and/or through other sources to develop a training plan.
20%	**Team Management:** Maintains a positive work environment that supports self-directed teams; provides a structure to optimize the experience, skill, knowledge and capability of the team; facilitates collaboration among team members.
10%	**Customer Service**: Interfaces with customers (internal and external) by telephone, correspondence and/or in person to answer inquiries and resolve concerns. Assesses, investigates and resolves difficult issues; Assist in preparing and/or conducting customer presentations; Partners with account management to achieve customer satisfaction.
10%	**Communication:** Facilitates regular team meetings, with an agenda and minutes; disseminate information consistently and timely; ensure all claims processing documentation is current and accurate; Interacts professionally, and presents ideas and information with confidence.
10%	**Workforce Management:** Recruits, attracts, develops, motivates and manages a high caliber of employees; Trains employees on products, policies and procedural changes; Orients new employees.

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom this position has a direct reporting relationship.

			Claims Manager	Supervisor Title
		Claims Supervisor	Supervisor Title	
		Job Title		Supervisor Name
	Employee Title		Supervisor Name	
Employee Title		**Name**		

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☒ Associates Degree ☐ BA/BS ☐ MA/MS/MBA ☐ PHD ☐

Field(s) of study:

Experience: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. ☒ > 8yrs.☐

Industry:

Job Specific: 5-6yrs claims processing experience or combination of claims processing and direct customer service experience; or related industry experience

*Equivalent combination of experience and education ☒

*Education and/or experiences may run concurrent ☐

Knowledge, Skills, Abilities:

☐WPM ☐KSPH

Other: Keyboard dexterity and accuracy; Expert knowledge of medical terminology; ICD-9 and CPT-4 coding experience; Expert knowledge of and experience in processing and working with all types of products including HMO,PPO and Indemnity under both fully insured and self-funded arrangements; Expert knowledge of coordination of benefits; Excellent organizational, interpersonal and communication skills; Ability to maintain production levels and quality goals; Strong analytical and problem solving skills; Ability to train employees on all products, procedures and systems; Detail oriented; Customer/Team Advocate; Flexibility; Positive Attitude; Team Player; Problem Solver; Ability to manage multiple tasks simultaneously; Initiator; Change Agent; Coach; Leader

Computer Skills: Working knowledge of word processing, spreadsheets and databases knowledge of Microsoft Office software package

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)

Education: BA preferred

Experience: 1-2yrs supervisory experience preferred

Knowledge, Skills, Abilities:

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☒ Standing ☐ Lifting ☐ _____lbs.

Typing ☒ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

Care Management Supervisor

JOB TITLE: **Supervisor, Care Management**	FLSA STATUS: Exempt
DEPARTMENT TITLE: Care Management Supervisor	DEPARTMENT: ***TBD***
REPORTS TO: CMC Clinical Officer	JOB CODE: CN7202E
LOCATION: Care Management Center (locations vary)	GRADE: 38
DATE CREATED: 3-26-01	DATE REVISED:

JOB SUMMARY
Will have primary responsibility for the management, supervision and coordination of care management staff including intensive care management staff. Provides leadership and subject matter expertise in designated clinical programs.

% of TIME (Total 100)	ESSENTIAL FUNCTIONS (List tasks critical to completion of daily workload)
35%	Manage Care Management team member performance through the review of qualitative and quantitative p erformance results on a regular and on going ba sis. Provi de constructive feedback and set improvement milestones when indicated. ➢ Regularly assess the clinical performance of care management staff via documentation audits, live service observations and other performance management tools. ➢ Set clear performance expectations with team of approximately 10-12 associates (and communicate how performance goals are linked to organizational goals and values. ➢ Motivate and encourage team members to excel. Create a team environment that contributes to a high degree of employee satisfaction. ➢ Monitor individual team member reliability patterns and take corrective steps when indicated. Utilize the workforce management system to monitor schedule adherence and other work habits. ➢ Recruit, interview, and select qualified clinical team members, take corrective actions for team members that do not meet expectations. ➢ Conduct the performance review, merit and bonus processes for team members.
30	Lead the Care Managers in the monitoring and managing inpatient, outpatient and intermediate levels of care related to mental health and substance abuse treatment. Oversee care management review activities consistent with Magellan Behavioral Health policies, procedures, and standards.
15	Manage day to day activity of care manager/care worker team to ensure client commitments and other Magellan performance expectations are achieved: ➢ Develop plans to ensure team achieves specific goals in support of client and overall CMC goals. ➢ Coordinate with Operations Hub in the achievement of service level and resource utilization goal
10	Coordinates Quality Improvement activities under the direction of clinical leadership.
5	Assists clinical management in the development and implementation of strategic and operational goals and plans.
5	Ensures appropriate clinical supervision and case consultation for clinical staff, including psychiatric consultation. Assists, on an as needed basis, in response to peak work periods.
NON-ESSENTIAL FUNCTIONS	(Lists additional tasks necessary to meet overall performance standards) **If Manager has RN qualifications, oversight of TRF reviews are done by Masters or**

Doctoral level supervisor.
Manages within the established Magellan clinical quality standards and quality management plan protocols. Provides clinical leadership for the review and initiation of alternative placements for care.

REPORTING RELATIONSHIPS

Please complete the following chart with the names and titles of subordinates and/or managers with whom you have a direct reporting relationship.

			Mgr, Clinical Services	Supervisor Title
		Supervisor, Care Management	Supervisor Title	
				Supervisor Name
		Your Title		
	Employee Title		Supervisor Name	
Employee Title				
		Your Name		
	Employee Name			
Employee Name				

MINIMUM REQUIREMENTS (Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐

Field(s) of study: BSN, Masters or Doctoral level degree in mental health or related field.

Experience: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☐ 5-8yrs. ☒ > 8yrs.☐
Industry:
Job Specific: 6yrs experience to include 5 years post degree experience in a behavioral healthcare setting and 2 yrs supervisory experience.

*Equivalent combination of experience and education ☐
*Education and/or experiences may run concurrent ☐

Knowledge, Skills, Abilities:
☐WPM ☐KSPH

Other: Reviews and monitors care managers' performance; provides feedback and counseling; and hires clinical staff. Good organization, time management and communication skills. Thorough knowledge of mental health and substance abuse community resources and providers. Ability to function independently as a team member, analyze specific utilization problems, plan and implement solutions that directly influence quality of care and cost efficiency and to supervise the collection of pertinent clinical information while maintaining a good rapport and relationship with mental health and substance abuse providers. Considerable skill in interpreting clinical treatment information and making appropriate referral and triage decisions.

Computer Skills: Ability to use computer systems.

Licenses, Certifications, etc.: Meets Magellan's credentialing criteria for RN, Masters or Doctoral level provider

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)
Education: *Experience*. Three years previous experience in an administrative/supervisory and/or managed care position is preferred. *Knowledge, Skills, Abilities:*

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☒ Standing ☐ Lifting ☐ ____lbs.

Typing ☒ Other Alternative work hours (Between 5:00p.m– 8:00a.m.) ☐

SIGNATURES OF APPROVAL

_____ _____

Supervisor Com pensation Analyst

Customer Service Supervisor

JOB TITLE: **Customer Service Supervisor**	FLSA STATUS: Exempt
DEPARTMENT TITLE: Customer Service Supervisor	DEPARTMENT: ***TBD***
REPORT TO: Customer Service Manager	JOB CODE: CS7103E
LOCATION: Care Management Center (locations vary)	GRADE: 35
DATE CREATED: 7/15/03	DATE REVISED:

JOB SUMMARY

This position is responsible for the coaching and development of Customer Service Associates (CSAs). It is responsible for ensuring CSAs follow appropriate guidelines and processes in delivering a high caliber, efficient level of service to members and providers. The Customer Service Supervisor must create a team environment which motivates CSAs and contributes to operational excellence and self leadership.

% of TIME (Total 100%)	ESSENTIAL FUNCTIONS
40%	Review qualitative and quantitat ive performance with CSA t eam members on a regular and ongoing basis to drive the highest level of per formance. Provide c onstructive feedback and set improvement milestones w hen indicated. Dev elop plans to ensure team achieves specific goals in support of client and overall call center goals.
25%	Identify individual CSA and/or Support Associate developmental needs and, working with the education and care assist teams, take steps to address them. Be a champion for first call resolution strategy. With the Operations Team, monitor team service performance levels on an ongoing basis to ensure targeted goals for service level and average speed of answer are achieved. Create team incentives and foster constructive inter-office team competition to motivate and reward performance excellence.
25%	Set clear performance expectations with t eam of approximately 18 customer service associates (CSAs), and communicate how per formance goals are linked to organizational goals and v alues. Motiv ate and enc ourage team members to excel. Create a team environment that contributes to a high degree of employee satisfaction. Be prepared to answer customer calls in the CSA queue during peak periods.
10%	Monitor individual CSA attendance and reliability patterns and take corrective steps when indicated Utilize the workforce management system to monitor CSA schedule adherence and other work habits.

Performs related duties as required.

NON-ESSENTIAL FUNCTIONS

REPORTING RELATIONSHIPS

CMC Gen Mgr
Supervisor Title

Mgr, Cust Svc
Supervisor Title

Cust Svc Spvr
Job Title

Supervisor Name

Employee Title

Employee Title

Name

Employee Name

Employee Name

(Skills necessary to meet minimum performance standards of the position)

Education: HS/GED ☐ Associates Degree ☐ BA/BS ☒ MA/MS/MBA ☐ PHD ☐

Field(s) of study: Business, Healthcare or related field

Experience: 0 yrs. ☐ 1-3yrs.☐ 3-5yrs. ☒ 5-8yrs. ☐ > 8yrs.☐

Industry:

Job Specific: Three years or more experience in call center management, preferably in the healthcare industry. Experience leading large teams in a dynamic industry. A demonstrated track record of managing change with proven results in the achievement of customer service goals.

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*Equivalent combination of experience and education ☒
*Education and/or experiences may run concurrent ☒

Knowledge, Skills, Abilities:

☐WPM ☐KSPH

Other: Knowledge of managed healthcare principles and call center operations. Ability to identify individual and team developmental needs. Ability to effectively coach and develop team members. Excellent leadership, oral and written communication skills.

Computer Skills:

Licenses, Certifications, etc.:

PREFERRED QUALIFICATIONS (Additional skills necessary to exceed minimum performance standards)
Education: MBA preferred. *Experience:*

Knowledge, Skills, Abilities: Quantifiable Business Results; Leadership of People; Service Orientation (External and Internal); Flexible and Adaptable; Management of Projects, Tasks and People; Teamwork; Expert Knowledge

WORKING ENVIRONMENT (This position may include the following situations)

Sitting ☐ ***Standing*** ☐ ***Lifting*** ☐ ____***lbs.***

SIGNATURES OF APPROVAL

_____ _____

Supervisor Com pensation Analyst