STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
1 of 2	08/29/16
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2071380

VENDOR ADDRESS:

MAGELLAN BEHAVIORAL
HEALTH OF NEBRASKA INC
1221 N ST STE 700
LINCOLN NE 68508-2018

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2013 THROUGH AUGUST 31, 2016

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 4166 Z1

Contract to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care for a period effective September 1, 2013 through August 31, 2016. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: John W. Wendling
Phone: 402-437-4214
E-Mail: JWwendling@magellanhealth.com

Vendor Contact: Anne McCabe
Phone: 860-507-1932
E-Mail: ammccabe@magellanhealth.com

(2/28/13 knj)

AMENDMENT TWO (2) AS ATTACHED. (12/024/13 ld)

AMENDMENT THREE (3) AS ATTACHED. (05/30/14 ld)

AMENDMENT FOUR (4) AS ATTACHED. (08/28/2014 ked)

AMENDMENT FIVE (5) AS ATTACHED. (12/18/14 djo)

AMENDMENT SIX (6) AS ATTACHED. (03/11/15 djo)

AMENDMENT SEVEN (7) AS ATTACHED. (05/20/15 djo)

AMENDMENT EIGHT (8) AS ATTACHED. (02/22/16 djo)

AMENDMENT NINE (9) AS ATTACHED. (08/26/16 djo)

DHHS DIVISION DIRECTOR

9/2/16 PK

BUYER

9-2-16

5/2/16

MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2071380	

CONTRACT NUMBER
55286 O4

AMENDMENT TEN (10) AS ATTACHED. (08/26/16 djo)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	CAPITATION PAYMENT FEDERAL 55% 09/01/2013-06/30/2014	49,389,803.0000	$	1.0000	49,389,803.00
2	CAPITATION PAYMENT STATE 45% 09/01/2013-06/30/2014	40,409,839.0000	$	1.0000	40,409,839.00
3	CAPITATION PAYMENT FEDERAL 55% 07/01/2014-06/30/2015	62,052,351.0000	$	1.0000	62,052,351.00
4	CAPITATION PAYMENT STATE 45% 07/01/2014-06/30/2015	50,770,106.0000	$	1.0000	50,770,106.00
5	CAPITATION PAYMENT FEDERAL 55% 07/01/2015-06/30/2016	64,974,241.0000	$	1.0000	64,974,241.00
6	CAPITATION PAYMENT STATE 45% 07/01/2015-06/30/2016	53,160,743.0000	$	1.0000	53,160,743.00
7	CAPITATION PAYMENT FEDERAL 55% 07/01/2016-08/31/2016	10,828,989.0000	$	1.0000	10,828,989.00
8	CAPITATION PAYMENT STATE 45% 07/01/2016-08/31/2016	8,860,081.0000	$	1.0000	8,860,081.00
9	CAPITATION PAYMENT 09/01/2016-12/31/2016	29,710,611.0000	$	1.0000	29,710,611.00
	Total Order				**370,156,764.00**

MT 9-2-16
BUYER INITIALS

AMENDMENT TEN
Contract 55286 O4
Medicaid Managed Care Behavioral Health Services for the State of Nebraska
Between
The State of Nebraska and Magellan Behavioral Health of Nebraska, Inc.

This Amendment (the "Amendment") is made by the State of Nebraska and Magellan Behavioral Health of Nebraska, Inc., parties to Contract 55286 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree that effective September 1, 2016 to include line 9.

Line	Description	Estimated Quantity	Unit of Measure	Unit Price
9	CAPITATION PAYMENT 9/1/2016 – 12/31/2016	29,710,611.00	$	1.00

This amendment will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Name: Bo Botelho

Title: Materiel Administrator

Date: 9/8/16

Magellan Behavioral Health of Nebraska, Inc.

By: _____

Name: Anne McCabe

Title: Senior Vice President

Date: 8-19-16

Department of Health and Human Services

By: _____

Name: CALDER LYNCH

Title: DIRECTOR

Date: 9/2/16

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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CONTRACT NUMBER
55286 O4

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BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2071380

VENDOR ADDRESS:

MAGELLAN BEHAVIORAL
HEALTH OF NEBRASKA INC
1221 N ST STE 700
LINCOLN NE 68508-2018

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2013 THROUGH AUGUST 31, 2016

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 4166 Z1

Contract to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care for a period effective September 1, 2013 through August 31, 2016. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

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Phone: 402-437-4214
E-Mail: JWwendling@magellanhealth.com

Vendor Contact: Anne McCabe
Phone: 860-507-1932
E-Mail: ammccabe@magellanhealth.com

(2/28/13 knj)

AMENDMENT TWO (2) AS ATTACHED. (12/024/13 ld)

AMENDMENT THREE (3) AS ATTACHED. (05/30/14 ld)

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AMENDMENT FIVE (5) AS ATTACHED. (12/18/14 djo)

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AMENDMENT NINE (9) AS ATTACHED. (08/26/16 djo)

DHHS DIVISION DIRECTOR

9/7/16 PK Michelle Thompson 9-2-16
BUYER

9/7/16
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2071380	

CONTRACT NUMBER
55286 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	CAPITATION PAYMENT FEDERAL 55% 09/01/2013-06/30/2014	49,389,803.0000	$	1.0000	49,389,803.00
2	CAPITATION PAYMENT STATE 45% 09/01/2013-06/30/2014	40,409,839.0000	$	1.0000	40,409,839.00
3	CAPITATION PAYMENT FEDERAL 55% 07/01/2014-06/30/2015	62,052,351.0000	$	1.0000	62,052,351.00
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5	CAPITATION PAYMENT FEDERAL 55% 07/01/2015-06/30/2016	64,974,241.0000	$	1.0000	64,974,241.00
6	CAPITATION PAYMENT STATE 45% 07/01/2015-06/30/2016	53,160,743.0000	$	1.0000	53,160,743.00
7	CAPITATION PAYMENT FEDERAL 55% 07/01/2016-08/31/2016	10,828,989.0000	$	1.0000	10,828,989.00
8	CAPITATION PAYMENT STATE 45% 07/01/2016-08/31/2016	8,860,081.0000	$	1.0000	8,860,081.00
	Total Order				**340,446,153.00**

MT 9-2-16
BUYER INITIALS

AMENDMENT NINE
Contract 55286 O4
Medicaid Managed Care Behavioral Health Services for the State of Nebraska
Between
The State of Nebraska and Magellan Behavioral Health of Nebraska, Inc.

This Amendment (the "Amendment") is made by the State of Nebraska and Magellan Behavioral Health of Nebraska, Inc., parties to Contract 55286 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. ADDITIONS: The following section is hereby added effective upon execution by the parties hereto:

Section IV. Q. Completion of Contract and Post-Operations Requirements is added.

A. Completion of Contract

1. The completion of contract process will begin, one hundred twenty (120) days prior to the contract termination date. During this period, the Contractor is responsible for meeting all contract requirements and for working in cooperation with DHHS to ensure a successful completion of contract.

2. The period from 07/01/2015 to 12/31/2016 will encompass a full 18 month period resulting in a single aggregate settlement of incentives and profit corridor.

3. The Contractor will continue to honor all provider network agreements during this period and maintain communication with network providers on completion of contract and post-operation requirements.

4. The Contractor will continue to provide care management services to managed care members enrolled during this period.

5. The Contractor will provide DHHS, upon request, a list of all managed care members enrolled in care management, a list of clients with active service authorizations including details of the service authorization, and any other information deemed relevant by DHHS and the Contractor to assure a successful transition of the managed care clients to the Nebraska Medicaid Managed Care Program to Heritage Health.

6. All information provided to DHHS by the Contractor will include letters of attestation, signed by the responsible authority, certifying the information is true, accurate and complete.

7. The Contractor will submit all information within the timeframes specified by DHHS and the contract.

8. DHHS reserves the right to request periodic updates and perform on-site audits at any time during the completion of contract process.

B. Post-Operations Period

The post-operations period will begin following the contract termination date, and will end twelve (12) months following.

1. On or before October 1, 2016, the Contractor will submit to DHHS for approval a plan describing the Contractor's plans for compliance with post-operations period requirements.

2. The Contractor will provide telephone and electronic access to DHHS, providers, members, and other stakeholders for one year following contract termination date.

3. The Contractor will adjudicate all claims submitted to Contractor on or before December 31, 2017.

4. The Contractor will continue to submit to DHHS all encounter data resulting from claims adjudication.

5. The Contractor will resolve all timely filed grievances, appeals, and State Fair Hearings for claims received on or before December 31, 2017 related to dates of service prior to December 31, 2016.

6. The Contractor will make all cost settlement payments to Hastings Regional Center and Lincoln Regional Center for PRTF services per the policy that has been mutually agreed upon by the parties.

7. The Contractor shall work with DHHS to finalize all performance measures and risk corridor calculations and cost settlements on or before December 31, 2017.

8. The Contractor will settle with DHHS all payments and/or refunds resulting from changes in capitation rates, changes in clients' eligibility status, and reconciliation of Health Insurance Provider Fee payments on or before December 31, 2017.

9. The Contractor will submit the following reports identified in the table below.

Reporting for Post-Operations
Monthly Report
Claims Processing Reports
Third Party Liability (COB and Subrogation) Reports
Quarterly Report
Client Grievance Report: Complaints, Appeals, Expedited Appeals & State Fair Hearings
Provider Grievance: Complaints, Appeals, & State Fair Hearings
TPL Subrogation

Quarterly Financial Report
Legislative Reports: to include 4th Quarter 2016 Data
LB 1063-Children's Health and Treatment Act
LB 1160-Legislative Report

10. The Contractor will refer Medicaid Managed Care members enrolled in Heritage Health to the Heritage Health Enrollment Broker.

11. DHHS reserves the right to request periodic updates and to perform on-site audits at any time during the post-operations period.

12. The Contractor will identify a Representative of the Contractor and contact information that DHHS can contact after contract termination, regarding any issues related to the contract between DHHS and the Contractor.

C. Administration/Staffing for Completion of Contract and Post-Operations Period

For the Completion of Contract, as set forth herein, the Contractor is responsible for maintaining key positions that must be maintained through the contract termination date:

i. Administrator/CEO/COO;
ii. Chief Financial Officer (CFO);
iii. Medical Director/CMO;
iv. Corporate Compliance Officer;
v. Clinical Director/Manager;
vi. Grievance and Appeals System Director/Manager;
vii. Care Management/Utilization Review Director/Manager;
viii. Quality Management Director/Manager;
ix. Network Services Director/Manager;
x. Tribal Network Liaison; and
xi. Provider Network Liaison.

1. Post Operations Period- The contractor is required to maintain sufficient administrative personnel to support required post operations functions.

2. Supporting Staff

In addition to the Required Administrative Personnel, the Contractor shall have sufficient number of qualified supporting staff to meet the responsibilities of the Contract.

3. Human Resources/Staffing Plan

The Contractor shall provide a Human Resources and Staffing Plan that describes how the Contractor will maintain the functions through the end of the contract. The Contractor must provide a human resources/staffing plan to

maintain operations through the contract termination date and the post operations period that combines positions and functions outlined in the RFP with other positions as long as the Contractor describes how the Table of Organization and staff roles delineated in the RFP will be addressed.

II. MODIFICATIONS: The following sections are hereby modified effective upon execution by the parties hereto:

A. Attachment B, Capitation Rate Schedule is hereby modified:
Capitation Rate Schedule: The capitation rates for the Contractor have been adjusted for the time periods of July 1, 2016 through December 31, 2016 and are set forth in Revised Attachment B attached hereto.

B. Section IV.O.11.c.i.a-i. Failure to Perform

a. Established Damages

In the event the Contractor fails to meet the contract performance standards outlined here, the below ascertained, designated damages may be assessed. If assessed, the designated and ascertained damages below will be used to reduce MLTC's payments to the Contractor or if the damages exceed amounts due from MLTC, the Contractor will be required to make cash payments for the amount in excess.

a) Timely Reports and Data Delivery Performance Requirement
This Performance Requirement applies to all reports and data, excluding encounter data, to be delivered to MLTC or designee as defined in the RFP or by MLTC. Reports and data shall be timely and produced in the format and media approved by MLTC. Encounter data shall be provided in the MLTC- required formats. One thousand dollars ($1,000) shall be assessed for each calendar day, at MLTC's discretion, that each report or data delivery is late, includes less than the required copies, or is not in the approved format.

b) Accuracy of Reports and Data Performance Requirement
The Contractor shall be responsible for the accuracy of all reports, including calculations and completeness of data, excluding encounter data, used as input. If the report is not corrected within five calendar days of the notice of failure to meet the reporting accuracy requirements, then one thousand dollars ($1,000) per day shall be, at MLTC's discretion, assessed for each report that has been identified as inaccurate from the date of notification until the date the MLTC-approved corrected report is delivered.

c) Contract Termination or Expiration: In the event that a Contractor is terminated or its contract expires, the Contractor shall provide services through the end of the contract term and pay for all covered services for all members for the period for which monthly prepayment has been received prior to the date of contract termination. The Contractor shall provide MLTC and/or its designee with all materials and information related to the Program, members and the services provided to those members, to ensure a smooth transition to a follow-on Contractor and uninterrupted services. The Contractor shall notify all members who have received services within the past year of the upcoming transition. The notification shall be approved by MLTC and shall be developed in conjunction with a follow-on Contractor, if applicable.

d) The Contractor must submit for approval by September 31, 2016 a detailed plan to include the following:

1). The Contractor shall:

i) Make provisions for continuing all management and administrative services and the provision of direct services to Members until the transition of all Members is completed and all other requirements of the current contract are satisfied;

ii) Designate a person with appropriate training to act as the transition coordinator. The transition coordinator shall interact closely with the Department and the staff from the follow-on Contractor to ensure a safe and orderly transition; and

iii) Provide all reports set forth in this Agreement and necessary for the transition process. This includes providing to the Department, until the Department is satisfied that the Contractor has completed all outstanding obligations, the following additional reports. These reports shall be due on the fifteenth (15th) day of each succeeding month for the prior month.

1. Monthly claims aging report by provider/creditor including IBNR amounts;
2. A monthly summary of cash disbursements; and
3. List of all outstanding obligations necessary to complete the contract.

2). Notify subcontractors of contract termination or expiration as directed by the Department;

3). Notify all Members that the Contractor will no longer serve as the Member's managed care organization. The Contractor shall be financially responsible for all costs associated with this notification. The notification is subject to MLTC approval;

4). Notify each Participating Provider in writing that the Contractor's contract with MLTC (NE Medicaid) has ended. The written notice shall include the contract end date and shall explain to the Participating Provider how the provider can continue participating in the Medicaid program. The Contractor shall be financially responsible for all costs associated with this notification. The notification is subject to MLTC approval;

5). Complete payment of all outstanding obligations for covered services rendered to Members. The Contractor shall cover continuation of services to Members for dates of service until the contract termination date. No payments will be made for dates of service that occur after the contract termination date.

6). Cooperate with indentified follow-on managed care organizations during transition period including, at minimum, sharing and transferring Member information and records directly to MLTC. MLTC will notify the Contractor with specific instructions and required actions at the time of transfer;

7). Return any funds advanced to the Contractor for coverage of Members for periods after the contract end date to MLTC within thirty (30) calendar days of the expiration or termination of the contract;

8). Supply all information necessary for reimbursement of outstanding claims; and

9). Provide MLTC, in a format prescribed and approved by the Department:

i) A list of each Participating Provider, including Providers who are not contracted with MLTC;
ii) A list of Members who are receiving case management services;
iii) A list of all services requiring Contractor prior authorization; and
iv) A list of all Members receiving prior authorized services, the approved duration of which extends beyond the contract termination date.

This amendment will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Name: Bo Botelho

Title: Materiel Administrator

Date: 9/8/16

Contractor: Magellan Behavioral Health of Nebraska, Inc.

By: _____

Name: Anne McCabe

Title: Senior Vice President

Date: 8-19-16

State of Nebraska
Department of Health and Human Services

By: _____

Name: CALOCK LYNCH

Title: DIRECTOR

Date: 9/2/16

Revised Attachment B

July 1, 2016 through December 31, 2016

Category of Aid	Capitation Rate	Health Insurance Providers Fee	Final Rate
Aged	$ 10.82	$ 0.32	$ 11.14
Blind/Disabled	$ 129.63	$ 3.83	$ 133.46
Blind/Disabled/Katie Beckett	$ 54.16	$ 1.60	$ 55.76
CHIP	$ 19.67	$ 0.58	$ 20.25
Families 0-5	$ 3.44	$ 0.10	$ 3.54
Families 6-18	$ 32.62	$ 0.96	$ 33.58
Families 19+	$ 31.85	$ 0.94	$ 32.79
Foster Care/Ward/Subsidized Adoption	$ 159.46	$ 4.71	$ 164.17

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1 of 2	02/22/16
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VENDOR NUMBER: 2071380

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HEALTH OF NEBRASKA INC
1221 N ST STE 700
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THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2013 THROUGH AUGUST 31, 2016

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Original/Bid Document 4166 Z1

Contract to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care for a period effective September 1, 2013 through August 31, 2016, with the option to renew for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

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Phone: 402-437-4214
E-Mail: JWwendling@magellanhealth.com

Vendor Contact: Anne McCabe
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E-Mail: ammccabe@magellanhealth.com

(2/28/13 knj)

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AMENDMENT EIGHT (8) AS ATTACHED. (02/22/16 djo)

DHHS Division Director

3/2/16 pk Michelle Thompson 3.1.16
BUYER

MATERIEL ADMINISTRATOR
3/2/16

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8	CAPITATION PAYMENT STATE 45% 07/01/2016-08/31/2016	8,860,081.0000	$	1.0000	8,860,081.00
	Total Order				**340,446,153.00**

MT 3.1.16
BUYER INITIALS

AMENDMENT EIGHT
Contract 55286 O4
Medicaid Managed Care Behavioral Health Services for the State of Nebraska
Between
The State of Nebraska and Magellan Behavioral Health of Nebraska, Inc.

This Amendment (the "Amendment") is made by the State of Nebraska and Magellan Behavioral Health of Nebraska, Inc., parties to Contract 55286 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. ADDITIONS: The following section is hereby added effective upon execution by the parties hereto:

A. Section IV.P.5.d.ix. Legislative Appropriation for Rate Increases under the Medical Assistance Act is hereby added:

Contractor shall ensure that any legislative appropriation for rate increases for providers of services under the Medical Assistance Act shall be passed on in their entirety to participating providers.

B. Section IV.P.5.d.x. Psychiatric Residential Treatment Centers is hereby added:

The contractor shall make Psychiatric Residential Treatment Facility (PRTF) payment to the Hastings Regional Center and the Lincoln Regional Center Whitehall Campus utilizing interim per diem rates calculated by DHHS with an annual year-end cost settlement. The annual year-end cost settlement occurs at the end of each PRTF's fiscal year. DHHS and the contractor will develop a mutually agreed upon policy that outlines the cost settlement process. The mutually agreed upon policy will outline that the cost settlement process will occur before the determination of forfeited funds to reinvestment.

II. MODIFICATIONS: The following section is hereby modified effective upon execution by the parties hereto:

A. Section IV.N. 8. j. Third Party Resources

The Contractor shall identify the existence of potential TPL to pay for services in the basic benefits package through the use of diagnosis and trauma code editing. This editing should, at a minimum, identify claims with a diagnosis of S02.0XXA through T88.8XXA or T88.9XXA International Classification of Disease, 10th revision (ICD-10-CM) and any other applicable trauma codes, including but not limited to V, W, X, and Y Codes in accordance with 42 CFR 433.138(e). ICD-10-CM code T75.3XXA may be excluded from the edits.

B. Attachment B, Capitation Rate Schedules, is hereby modified:

Capitation Rate Schedules. The capitation rates for the Contractor have been adjusted for the time periods of July 1, 2015 to September 30, 2015; October 1, 2015 to December 31, 2015; and January 1, 2016 to June 30, 2016 and are set forth in Revised Attachment B attached hereto.

This amendment will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Name: Marilyn Bottrell

Title: Materiel Administrator

Date: 3-2-16

Contractor: Magellan Behavioral Health of Nebraska, Inc.

By: _____

Name: Anne McCabe

Title: Senior Vice President

Date: 02/17/16

State of Nebraska
Department of Health and Human Services

By: _____

Name: CALDER LYNCH

Title: DIRECTOR MLTC

Date: 2/29/16

Revised Attachment B

July 1, 2015 through September 30, 2015

Category of Aid	Capitation Rate	Health Insurance Providers Fee	Final Rate
Aged	$ 11.14	$ 0.32	$ 11.46
Blind/Disabled	$ 130.05	$ 3.79	$ 133.84
Blind/Disabled/Katie Beckett	$ 56.08	$ 1.63	$ 57.71
CHIP	$ 19.45	$ 0.57	$ 20.02
Families 0-5	$ 3.22	$ 0.09	$ 3.31
Families 6-18	$ 31.35	$ 0.91	$ 32.26
Families 19+	$ 30.94	$ 0.90	$ 31.84
Foster Care/Ward/Subsidized Adoption	$ 181.75	$ 5.29	$ 187.04

October 1, 2015 through December 31, 2015

Category of Aid	Capitation Rate	Health Insurance Providers Fee	Final Rate
Aged	$ 11.13	$ 0.32	$ 11.45
Blind/Disabled	$ 129.93	$ 3.79	$ 133.73
Blind/Disabled/Katie Beckett	$ 62.16	$ 1.63	$ 63.79
CHIP	$ 25.76	$ 0.57	$ 26.33
Families 0-5	$ 9.73	$ 0.09	$ 9.82
Families 6-18	$ 37.31	$ 0.91	$ 38.23
Families 19+	$ 31.07	$ 0.90	$ 31.97
Foster Care/Ward/Subsidized Adoption	$ 187.64	$ 5.29	$ 192.93

January 1, 2016 through June 30, 2016

Category of Aid	Capitation Rate	Health Insurance Providers Fee	Final Rate
Aged	$ 10.40	$ 0.28	$ 10.68
Blind/Disabled	$ 123.52	$ 3.28	$ 126.80
Blind/Disabled/Katie Beckett	$ 58.62	$ 1.61	$ 60.23
CHIP	$ 26.97	$ 0.77	$ 27.74
Families 0-5	$ 10.35	$ 0.30	$ 10.64
Families 6-18	$ 38.85	$ 1.09	$ 39.95
Families 19+	$ 32.30	$ 0.86	$ 33.16
Foster Care/Ward/Subsidized Adoption	$ 157.14	$ 4.19	$ 161.33

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508
Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 3	05/20/15
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

CONTRACT NUMBER
55286 O4

VENDOR NUMBER: 2071380

VENDOR ADDRESS:

MAGELLAN BEHAVIORAL
HEALTH OF NEBRASKA INC
1221 N ST STE 700
LINCOLN NE 68508-2018

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2013 THROUGH AUGUST 31, 2016

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 4166 Z1

Contract to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care for a period effective September 1, 2013 through August 31, 2016, with the option to renew for two (2) additional one (1) year periods as mutually agreed upon by all parties.

The State may request that payment be made electronically instead of by state warrant. ACH/EFT Enrollment Form can be found at: http://www.das.state.ne.us/accounting/forms/achenrol.pdf

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system mean the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

The contractor certifies that the contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The contractor also agrees to include the above requirements in any and all subcontracts into which it enters. The contractor shall immediately notify the Department if, during the term of this contract, contractor becomes debarred. The Department may immediately terminate this contract by providing contractor written notice if contractor becomes debarred during the term of this contract.
If the Contractor is an individual or sole proprietorship, the following applies:
1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at: www.das.state.ne.us.
2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation require to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

Courtney Phillips
Chief Executive Officer
Department of Health and Human Services

6/10/15 PK Michelle Thompson 6.8.15
BUYER

6-11-15
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508
Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 3	05/20/15
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2071380	

CONTRACT NUMBER
55286 O4

The contract shall incorporate the following previously submitted documents:
1. Contract Award;
2. Any Contract Amendments, in order of significance;
3. Any Request for Proposal Addenda and/or Amendments to include Questions and Answers;
4. The original RFP document;
5. The signed Request for Proposal form; and
6. The Contractor's Proposal.

Vendor Contact: John W. Wendling
Phone: 402-437-4214
E-Mail: JWwendling@magellanhealth.com

Vendor Contact: Anne McCabe
Phone: 860-507-1932
E-Mail: ammccabe@magellanhealth.com

(2/28/13 knj)

AMENDMENT TWO (2) AS ATTACHED. (12/024/13 ld)

AMENDMENT THREE (3) AS ATTACHED. (05/30/14 ld)

AMENDMENT FOUR (4) AS ATTACHED. (08/28/2014 ked)

AMENDMENT FIVE (5) AS ATTACHED. (12/18/14 djo)

AMENDMENT SIX (6) AS ATTACHED. (03/11/15 djo)

AMENDMENT SEVEN (7) AS ATTACHED. (05/20/15 djo)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	CAPITATION PAYMENT FEDERAL 55% 09/01/2013-06/30/2014	49,389,803.0000	$	1.0000	49,389,803.00
2	CAPITATION PAYMENT STATE 45% 09/01/2013-06/30/2014	40,409,839.0000	$	1.0000	40,409,839.00
3	CAPITATION PAYMENT FEDERAL 55% 07/01/2014-06/30/2015	62,052,351.0000	$	1.0000	62,052,351.00
4	CAPITATION PAYMENT STATE 45% 07/01/2014-06/30/2015	50,770,106.0000	$	1.0000	50,770,106.00
5	CAPITATION PAYMENT FEDERAL 55% 07/01/2015-06/30/2016	64,974,241.0000	$	1.0000	64,974,241.00

MT 6.8.15
BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

PAGE	ORDER DATE
3 of 3	05/20/15
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2071380	

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508
Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
55286 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
6	CAPITATION PAYMENT STATE 45% 07/01/2015-06/30/2016	53,160,743.0000	$	1.0000	53,160,743.00
7	CAPITATION PAYMENT FEDERAL 55% 07/01/2016-08/31/2016	10,828,989.0000	$	1.0000	10,828,989.00
8	CAPITATION PAYMENT STATE 45% 07/01/2016-08/31/2016	8,860,081.0000	$	1.0000	8,860,081.00
	Total Order				**340,446,153.00**

MT 6.8.15
BUYER INITIALS

AMENDMENT SEVEN
Contract 55286 04
Medicaid Managed Care Behavioral Health Services for the State of Nebraska
Between
The State of Nebraska and Magellan Behavioral Health of Nebraska, Inc.

This Amendment (the "Amendment") is made by the State of Nebraska and Magellan Behavioral Health of Nebraska, Inc., parties to Contract 55286 04 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows effective July 1, 2015:

I. MODIFICATIONS: The following section is hereby modified effective upon execution by the parties hereto:

A. Attachment B, Capitation Rate Schedules, is hereby modified:
Capitation Rate Schedules. The capitation rates for the Contractor have been adjusted for the time period July 1, 2015 to December 31, 2015 and are set forth in Revised Attachment B attached hereto.

This amendment will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Name: Bo Botelho

Title: Materiel Administrator

Date: 6-1-15

Contractor: Magellan Behavioral Health of Nebraska, Inc.

By: Anne M McCabe

Name: Anne M. McCabe

Title: Senior Vice President

Date: 5/14/15

State of Nebraska
Department of Health and Human Services

By: _____

Name: Courtney N. Phillips

Title: CEO, NE DHHS

Date: 5/31/2015

Revised Attachment B
July 1, 2015 through December 31, 2015

Category of Aid	Capitation Rate	Heatlh Insurance Providers Fee	Final Rate
Aged	$ 11.11	$ 0.32	$ 11.43
Blind/Disabled	$ 129.71	$ 3.79	$ 133.51
Blind/Disabled/Katie Beckett	$ 55.94	$ 1.63	$ 57.57
CHIP	$ 19.40	$ 0.57	$ 19.97
Families 0-5	$ 3.21	$ 0.09	$ 3.30
Families 6-18	$ 31.27	$ 0.91	$ 32.18
Families 19+	$ 30.86	$ 0.90	$ 31.76
Foster Care/Ward/Subsidized Adoption	$ 181.29	$ 5.29	$ 186.57

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
1 of 3	03/11/15
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2071380

VENDOR ADDRESS:

MAGELLAN BEHAVIORAL
HEALTH OF NEBRASKA INC
1221 N ST STE 700
LINCOLN NEBRASKA 68508-2018

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2013 THROUGH AUGUST 31, 2016

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 4166 Z1

Contract to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care for a period effective September 1, 2013 through August 31, 2016, with the option to renew for two (2) additional one (1) year periods as mutually agreed upon by all parties.

The State may request that payment be made electronically instead of by state warrant. ACH/EFT Enrollment Form can be found at: http://www.das.state.ne.us/accounting/forms/achenrol.pdf

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system mean the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

The contractor certifies that the contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The contractor also agrees to include the above requirements in any and all subcontracts into which it enters. The contractor shall immediately notify the Department if, during the term of this contract, contractor becomes debarred. The Department may immediately terminate this contract by providing contractor written notice if contractor becomes debarred during the term of this contract.
If the Contractor is an individual or sole proprietorship, the following applies:
1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at: www.das.state.ne.us.
2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation require to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

Joseph M. Acierno, MD, JD
Acting Chief Executive Officer
Chief Medical Officer
Director, Division of Public Health
Department of Health and Human Services

3/27/15 pic Michelle Thompson 3-26-15
BUYER

3-30-15
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
2 of 3	03/11/15
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2071380	

The contract shall incorporate the following previously submitted documents:
1. Contract Award;
2. Any Contract Amendments, in order of significance;
3. Any Request for Proposal Addenda and/or Amendments to include Questions and Answers;
4. The original RFP document;
5. The signed Request for Proposal form; and
6. The Contractor's Proposal.

Vendor Contact: John W. Wendling
Phone: 402-437-4214
E-Mail: JWwendling@magellanhealth.com

Vendor Contact: Anne McCabe
Phone: 860-507-1932
E-Mail: ammccabe@magellanhealth.com

(2/28/13 knj)

AMENDMENT TWO (2) AS ATTACHED. (12/024/13 ld)

AMENDMENT THREE (3) AS ATTACHED. (05/30/14 ld)

AMENDMENT FOUR (4) AS ATTACHED. (08/28/2014 ked)

AMENDMENT FIVE (5) AS ATTACHED. (12/18/14 djo)

AMENDMENT SIX (6) AS ATTACHED. (03/11/15 djo)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	CAPITATION PAYMENT FEDERAL 55% 09/01/2013-06/30/2014	49,389,803.0000	$	1.0000	49,389,803.00
2	CAPITATION PAYMENT STATE 45% 09/01/2013-06/30/2014	40,409,839.0000	$	1.0000	40,409,839.00
3	CAPITATION PAYMENT FEDERAL 55% 07/01/2014-06/30/2015	62,052,351.0000	$	1.0000	62,052,351.00
4	CAPITATION PAYMENT STATE 45% 07/01/2014-06/30/2015	50,770,106.0000	$	1.0000	50,770,106.00
5	CAPITATION PAYMENT FEDERAL 55% 07/01/2015-06/30/2016	64,974,241.0000	$	1.0000	64,974,241.00
6	CAPITATION PAYMENT STATE 45% 07/01/2015-06/30/2016	53,160,743.0000	$	1.0000	53,160,743.00

MT 3.26.15
BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
3 of 3	03/11/15
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2071380

CONTRACT NUMBER
55286 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
7	CAPITATION PAYMENT FEDERAL 55% 07/01/2016-08/31/2016	10,828,989.0000	$	1.0000	10,828,989.00
8	CAPITATION PAYMENT STATE 45% 07/01/2016-08/31/2016	8,860,081.0000	$	1.0000	8,860,081.00
	Total Order				**340,446,153.00**

MT 3.26.15
BUYER INITIALS

AMENDMENT SIX
55286 O4
Medicaid Managed Care program for Mental Health and Substance Use Disorder for the State of Nebraska
Between
The State of Nebraska and Magellan Behavioral Health of Nebraska Inc

This Amendment (the "Amendment") is made by the State of Nebraska and Magellan Behavioral Health of Nebraska Inc, parties to Contract 55286 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

The current vendor contacts are removed in their entirety and replaced with:

Vendor Contact: John W. Wendling
Phone: 402-437-4214
E-Mail: JWwendling@magellanhealth.com

Vendor Contact: Anne McCabe
Phone: 860-507-1932
E-Mail: ammccabe@magellanhealth.com

This amendment and any attachments hereto will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska	Contractor: Magellan Behavioral Health of Nebraska Inc
By: _____	By: _____
Name: Bo Botelho	Name: JOHN W. WENDLING
Title: Materiel Administrator	Title: CHIEF EXECUTIVE OFFICER
Date: 3-30-15	Date: 3/3/15

State of Nebraska Department of Health and Human Services

By: _____

Name: Joseph M. Acierno, MD, JD

Title: Acting Chief Executive Officer

Chief Medical Officer

Director, Division of Public Health

Date: 3/15/15

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
1 of 3	12/18/14
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2071380

VENDOR ADDRESS:

MAGELLAN BEHAVIORAL
HEALTH OF NEBRASKA INC
1221 N ST STE 700
LINCOLN NEBRASKA 68508-2018

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2013 THROUGH AUGUST 31, 2016

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.riginal Contract/Bid Document 4166 Z1

Original/Bid Document 4166 Z1

Contract to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care for a period effective September 1, 2013 through August 31, 2016, with the option to renew for two (2) additional one (1) year periods as mutually agreed upon by all parties.

The State may request that payment be made electronically instead of by state warrant. ACH/EFT Enrollment Form can be found at: http://www.das.state.ne.us/accounting/forms/achenrol.pdf

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system mean the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

The contractor certifies that the contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The contractor also agrees to include the above requirements in any and all subcontracts into which it enters. The contractor shall immediately notify the Department if, during the term of this contract, contractor becomes debarred. The Department may immediately terminate this contract by providing contractor written notice if contractor becomes debarred during the term of this contract.
If the Contractor is an individual or sole proprietorship, the following applies:
1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at: www.das.state.ne.us.
2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation require to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

Joseph M. Acierno, MD, JD
Acting Chief Executive Officer
Chief Medical Officer
Director, Division of Public Health
Department of Health and Human Services

12/24/14 PK Michelle Thompson 12.24.14
BUYER
RS/DD 12-24-14
12-24-14
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
2 of 3	12/18/14
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2071380	

The contract shall incorporate the following previously submitted documents:
1. Contract Award;
2. Any Contract Amendments, in order of significance;
3. Any Request for Proposal Addenda and/or Amendments to include Questions and Answers;
4. The original RFP document;
5. The signed Request for Proposal form; and
6. The Contractor's Proposal.

Vendor Contact: Sue Mimick, General Manager
Phone: 402-437-4214
Cell: 402-981-3547
Fax: 888-656-4925
E-Mail: smimick@magellanhealth.com

Vendor Contact: Glenn Stanton, Senior Vice President Business Development
Phone: 410-953-1242
Cell: 410-591-8085
Fax: 410-953-2427
E-Mail: gstanton@magellanhealth.com

(2/28/13 knj)

AMENDMENT TWO (2) AS ATTACHED. (12/024/13 ld)

AMENDMENT THREE (3) AS ATTACHED. (05/30/14 ld)

AMENDMENT FOUR (4) AS ATTACHED. (08/28/2014 ked)

AMENDMENT FIVE (5) AS ATTACHED. (12/18/14 djo)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	CAPITATION PAYMENT FEDERAL 55% 09/01/2013-06/30/2014	49,389,803.0000	$	1.0000	49,389,803.00
2	CAPITATION PAYMENT STATE 45% 09/01/2013-06/30/2014	40,409,839.0000	$	1.0000	40,409,839.00
3	CAPITATION PAYMENT FEDERAL 55% 07/01/2014-06/30/2015	62,052,351.0000	$	1.0000	62,052,351.00
4	CAPITATION PAYMENT STATE 45% 07/01/2014-06/30/2015	50,770,106.0000	$	1.0000	50,770,106.00
5	CAPITATION PAYMENT FEDERAL 55% 07/01/2015-06/30/2016	64,974,241.0000	$	1.0000	64,974,241.00

MT 12.24.14
BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

PAGE	ORDER DATE
3 of 3	12/18/14
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2071380	

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
55286 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
6	CAPITATION PAYMENT STATE 45% 07/01/2015-06/30/2016	53,160,743.0000	$	1.0000	53,160,743.00
7	CAPITATION PAYMENT FEDERAL 55% 07/01/2016-08/31/2016	10,828,989.0000	$	1.0000	10,828,989.00
8	CAPITATION PAYMENT STATE 45% 07/01/2016-08/31/2016	8,860,081.0000	$	1.0000	8,860,081.00
	Total Order				**340,446,153.00**

MT 12.24.14
BUYER INITIALS

AMENDMENT FIVE
Contract 55286 O4
Medicaid Managed Care Behavioral Health Services for the State of Nebraska
Between
The State of Nebraska and Magellan Behavioral Health of Nebraska, Inc.

This Amendment (the "Amendment") is made by the State of Nebraska and Magellan Behavioral Health of Nebraska, Inc., parties to Contract 55286 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows effective December 16, 2014:

I. MODIFICATIONS: The following section is hereby modified effective upon execution by the parties hereto:

A. Attachment B, Capitation Rate Schedules, is hereby modified:
Capitation Rate Schedules. The capitation rates for the Contractor have been adjusted for the time periods October 1, 2014 to December 31, 2014 and January 1, 2015 to June 30, 2015 and are set forth in Revised Attachment B attached hereto.

This amendment will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Name: Bo Botelho

Title: Materiel Administrator

Date: 12-24-14

Contractor: Magellan Behavioral Health of Nebraska, Inc.

By: Anne M McCabe

Name: Anne M. McCabe

Title: Senior Vice President

Date: 12/17/14

State of Nebraska
Department of Health and Human Services

By: _____

Name: Dr. Joe Acierno

Title: Interim Chief Executive Officer

Date: 12/23/14

October 1, 2014 through December 31, 2014

October 1, 2014 - December 31, 2014 Behavioral Health Capitation Rates	
Category of Aid	**Capitation Rate**
Aged	$11.03
Blind/Disabled	$125.77
Blind/Disabled/Katie Beckett	$59.47
CHIP	$20.02
Families 0-5	$3.13
Families 6-18	$33.55
Families 19+	$30.76
Foster Care/Ward/Subsidized Adoption	$204.81

January 1, 2015 through June 30, 2015

January 1, 2015 – June 30, 2015 Behavioral Health Capitation Rates	
Category of Aid	**Capitation Rate**
Aged	$11.12
Blind/Disabled	$126.60
Blind/Disabled/Katie Beckett	$59.94
CHIP	$20.16
Families 0-5	$3.15
Families 6-18	$33.80
Families 19+	$30.94
Foster Care/Ward/Subsidized Adoption	$206.33

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
1 of 3	08/28/14
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2071380

VENDOR ADDRESS:

MAGELLAN BEHAVIORAL
HEALTH OF NEBRASKA INC
1221 N ST STE 700
LINCOLN NEBRASKA 68508-2018

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2013 THROUGH AUGUST 31, 2016

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 4166 Z1

Contract to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care for a period effective September 1, 2013 through August 31, 2016, with the option to renew for two (2) additional one (1) year periods as mutually agreed upon by all parties.

The State may request that payment be made electronically instead of by state warrant. ACH/EFT Enrollment Form can be found at: http://www.das.state.ne.us/accounting/forms/achenrol.pdf

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system mean the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

The contractor certifies that the contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The contractor also agrees to include the above requirements in any and all subcontracts into which it enters. The contractor shall immediately notify the Department if, during the term of this contract, contractor becomes debarred. The Department may immediately terminate this contract by providing contractor written notice if contractor becomes debarred during the term of this contract.
If the Contractor is an individual or sole proprietorship, the following applies:
1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at: www.das.state.ne.us.
2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation require to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

9/3/2014
CHIEF EXECUTIVE OFFICER
DEPARTMENT OF HEALTH AND HUMAN SERVICES

9/5/14 PL Michelle Thompson 9.5.14 SP
BUYER

9/10/14
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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2 of 3	08/28/14
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25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2071380	

The contract shall incorporate the following previously submitted documents:
1. Contract Award;
2. Any Contract Amendments, in order of significance;
3. Any Request for Proposal Addenda and/or Amendments to include Questions and Answers;
4. The original RFP document;
5. The signed Request for Proposal form; and
6. The Contractor's Proposal.

Vendor Contact: Sue Mimick, General Manager
Phone: 402-437-4214
Cell: 402-981-3547
Fax: 888-656-4925
E-Mail: smimick@magellanhealth.com

Vendor Contact: Glenn Stanton, Senior Vice President Business Development
Phone: 410-953-1242
Cell: 410-591-8085
Fax: 410-953-2427
E-Mail: gstanton@magellanhealth.com

(2/28/13 knj)

AMENDMENT TWO (2) AS ATTACHED. (12/024/13 ld)

AMENDMENT THREE (3) AS ATTACHED. (05/30/14 ld)

AMENDMENT FOUR (4) AS ATTACHED. (08/28/2014 ked)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	CAPITATION PAYMENT FEDERAL 55% 09/01/2013-06/30/2014	49,389,803.0000	$	1.0000	49,389,803.00
2	CAPITATION PAYMENT STATE 45% 09/01/2013-06/30/2014	40,409,839.0000	$	1.0000	40,409,839.00
3	CAPITATION PAYMENT FEDERAL 55% 07/01/2014-06/30/2015	62,052,351.0000	$	1.0000	62,052,351.00
4	CAPITATION PAYMENT STATE 45% 07/01/2014-06/30/2015	50,770,106.0000	$	1.0000	50,770,106.00
5	CAPITATION PAYMENT FEDERAL 55% 07/01/2015-06/30/2016	64,974,241.0000	$	1.0000	64,974,241.00
6	CAPITATION PAYMENT STATE 45%	53,160,743.0000	$	1.0000	53,160,743.00

MT 9.5.14
BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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PAGE	ORDER DATE
3 of 3	08/28/14
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2071380

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	07/01/2015-06/30/2016				
7	CAPITATION PAYMENT FEDERAL 55% 07/01/2016-08/31/2016	10,828,989.0000	$	1.0000	10,828,989.00
8	CAPITATION PAYMENT STATE 45% 07/01/2016-08/31/2016	8,860,081.0000	$	1.0000	8,860,081.00
	Total Order				**340,446,153.00**

MT 9.5.14
BUYER INITIALS

AMENDMENT FOUR
Contract 55286 04
Medicaid Managed Care Behavioral Health Services for the State of Nebraska
Between
The State of Nebraska and Magellan Behavioral Health of Nebraska, Inc.

This Amendment (the "Amendment") is made by the State of Nebraska and Magellan Behavioral Health of Nebraska, Inc., parties to Contract 55286 04 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. ADDITIONS: The following section is hereby added effective upon execution by the parties hereto:

A. Section IV.P.d.5. viii. Health Insurer Fee is hereby added:

Health Insurer Fee under Section 9010 of the Patient Protection and Affordability Act of 2010. The State of Nebraska will compensate Magellan Behavioral Health of Nebraska, Inc. the cost of the Health Insurer Fee that Magellan Behavioral Health of Nebraska, Inc. incurs and becomes obligated to pay pursuant to Section 9010 of the Patient Protection and Affordability Act of 2010 due to its receipt of Nebraska Medicaid premiums pursuant to the Contract. The full cost of the Health Insurer Fee will include both the health insurer fee and the allowance to reflect the federal income tax liability related to the health insurer fee occurred. Payment to Magellan Behavioral Health of Nebraska, Inc. shall be made as part of the monthly capitation payment following the submission of sufficient documentation detailing liability for such fee. Documentation of liability shall be due to the State no later than 60 days from IRS Notification.

II. MODIFICATIONS: The following section is hereby modified effective upon execution by the parties hereto:

A. Attachment B, Capitation Rate Schedules, is hereby modified:
Capitation Rate Schedules. The capitation rates for the Contractor have been adjusted for the time period July 1, 2014 to September 30, 2014 and are set forth in Revised Attachment B attached hereto.

III. REMOVED: The following sections are removed effective upon execution by the parties hereto:

A. Section IV.M.1.a.iii. is hereby deleted in its entirety.

B. Section IV.P.6.g.xi. is hereby deleted in its entirety.

July 1, 2014 – September 30, 2014 Behavioral Health Capitation Rates	
Category of Aid	**Capitation Rate**
CHIP	$16.49
Aged	$9.03
Blind/Disabled/Katie Beckett	$49.03
Blind/Disabled	$113.14
Families 0-5	$2.60
Families 6-18	$27.71
Families 19+	$27.10
Foster Care/Ward/Subsidized Adoption	$199.79

This amendment will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Name: Bo Botelho

Title: Materiel Administrator

Date: 9/12/14

Contractor: Magellan Behavioral Health of Nebraska, Inc.

By: _____

Name: Anne M. McCabe

Title: Senior Vice President

Date: August 22, 2014

State of Nebraska
Department of Health and Human Services

By: _____

Name: Kenny T Winteren

Title: CEO

Date: 9/3/2014

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
1 of 3	05/30/14
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2071380

VENDOR ADDRESS:

MAGELLAN BEHAVIORAL
HEALTH OF NEBRASKA INC
1221 N ST STE 700
LINCOLN NEBRASKA 68508-2018

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2013 THROUGH AUGUST 31, 2016

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

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Contract to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care for a period effective September 1, 2013 through August 31, 2016, with the option to renew for two (2) additional one (1) year periods as mutually agreed upon by all parties.

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3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

6/10/2014
CHIEF EXECUTIVE OFFICER
DEPARTMENT OF HEALTH AND HUMAN SERVICES

6/13/14 Michelle Thompson 6-13-14
BUYER

6/16/14
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
2 of 3	05/30/14
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2071380	

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(2/28/13 knj)

AMENDMENT TWO (2) AS ATTACHED. (12/024/13 ld)

AMENDMENT THREE (3) AS ATTACHED. (05/30/14 ld)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
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2	CAPITATION PAYMENT STATE 45% 09/01/2013-06/30/2014	40,409,839.0000	$	1.0000	40,409,839.00
3	CAPITATION PAYMENT FEDERAL 55% 07/01/2014-06/30/2015	62,052,351.0000	$	1.0000	62,052,351.00
4	CAPITATION PAYMENT STATE 45% 07/01/2014-06/30/2015	50,770,106.0000	$	1.0000	50,770,106.00
5	CAPITATION PAYMENT FEDERAL 55% 07/01/2015-06/30/2016	64,974,241.0000	$	1.0000	64,974,241.00
6	CAPITATION PAYMENT STATE 45% 07/01/2015-06/30/2016	53,160,743.0000	$	1.0000	53,160,743.00
7	CAPITATION PAYMENT FEDERAL	10,828,989.0000	$	1.0000	10,828,989.00

MT
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PAGE	ORDER DATE
3 of 3	05/30/14
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2071380

CONTRACT NUMBER
55286 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	55% 07/01/2016-08/31/2016				
8	CAPITATION PAYMENT STATE 45% 07/01/2016-08/31/2016	8,860,081.0000	$	1.0000	8,860,081.00
	Total Order				**340,446,153.00**

MT
BUYER INITIALS

AMENDMENT THREE
Contract 55286 04
Medicaid Managed Care Behavioral Health Services for the State of Nebraska
Between
The State of Nebraska and Magellan Behavioral Health of Nebraska, Inc.

This Amendment (the "Amendment") is made by the State of Nebraska and Magellan Behavioral Health of Nebraska, Inc., parties to Contract 55286 04 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. The following sections are hereby modified effective upon execution by the parties hereto:

A. Section IV.M.12.a.ix.a) 3). i) is hereby modified:

i) All of the metrics involved in the performance incentives described in the Financial Section;

B. Section IV.N.3.b. is hereby modified:

b. Be submitted accurately and meet the Performance Measures for Submission and Acceptance as outlined in numbers 18. and 19. in the table under Section IV.O.11.a.v, Performance Reporting; and

II. The following sections are hereby deleted in entirety, replaced with the following, and effective upon execution by the parties hereto:

A. Section IV.O.11.a. is hereby deleted in its entirety, and replaces with the following:

a. PERFORMANCE REPORTING

i. The Contractor agrees performance incentives shall become effective on the contract start date and remain in effect for a period of twelve (12) consecutive calendar months. In accordance with quality improvement goals, MLTC reserves the right to reevaluate, reset and add to the current performance incentives and their corresponding threshold levels annually. The Contractor shall receive advance written notice of any changes in performance incentive measures, thresholds, goals and related requirement in accordance with terms in the contract. Unless otherwise modified, performance incentives shall automatically renew at the start of each new contract year;
ii. The Contractor shall submit performance reports on established metrics to DHHS on a month-by-month basis or upon DHHS' request, as well as quarter-by-quarter basis and year-to-date annualized reports. The Contractor shall submit reports in accordance with the established metrics in the contract, with all methods subject to review and approval by the State;
iii. Once submitted to and approved by the State, such metrics should also be posted publicly on the Contractor's website for the program;

iv. The Contractor shall meet and require its Subcontractors to meet the MLTC Minimum Performance Standards and Goals for services delivered to members. The table in Attachment 1 of this amendment identifies the Minimum Performance Standards and Goals for each required aspect of performance. If the Contractor's performance falls below an identified standard or goal or previous performance levels, the Contractor shall develop and implement a corrective action plan that must be approved by MLTC. The Contractor's corrective action plan shall define the problem, describe recommended interventions to improve performance, describe interim monitoring to measure the effectiveness of the interventions, and set a measurable threshold for discontinuation of the corrective action plan. The Contractor shall require a corrective action plan from any Subcontractor that fails to meet the MLTC Minimum Performance Standards; and

v. The Contractor shall cooperate with any MLTC reviews or other audits to verify compliance. If the Contractor does not comply with the corrective action plan, MLTC may impose any available remedy under the Contract.

B. Section IV.O.11. Performance Measurement Chart is hereby deleted in its entirety and replaced with Attachment 1: Performance Measurement Chart as included with this amendment.

C. Section IV.O.11.b. is hereby deleted in its entirety, and replaces with the following:

b. PERFORMANCE ASSESSMENT

i. The penalty and incentives will be calculated annually based on a calculation of the contract year's performance. Forfeited funds will be determined upon submission of performance reports per Section IV.O.b.11.a;

ii. Proceeds from any penalties assessed, unearned incentives, MLR and/or risk corridor rebates not realized shall be transferred to the Reinvestment Fund, described in more detail in Section IV.P.4;

iii. In the event of contract termination, the Contractor shall pay any monies owed with respect to the forfeited incentives, MLR rebates, and risk corridor rebates into the Reinvestment Fund within one hundred and twenty (120) days of the termination of the contract. Alternatively, if at the time of termination Contractor has earned performance incentives in accordance with provisions of this Contract, such earned incentives will become the property of the Contractor. The Contractor will cease, and MLTC will assume, all duties and responsibilities associated with administration and management of the Reinvestment Fund;

iv. The Contractor shall cooperate with MLTC in its verification and audit of all performance measurement results. Unless otherwise approved by MLTC, the Contractor's maximum error rate for submitted data shall be five percent (5%). The Contractor shall pay the full penalty and unearned incentives based on the applicable metric when its submitted data does not meet these thresholds for accuracy; and

v. The Contractor shall cooperate with MLTC if, in its sole discretion, MLTC decides to perform an independent audit each year, covering a three (3) or more month period of the contract year. If the results of the

independent audit are below the Contractor's self-reported results for the period under review, the Contractor shall agree to the independent audit results as the basis for performance measurement for the full year as the final determination or until the Contractor demonstrates to the State's satisfaction (at the State's sole discretion) that the reliability of its reported results are consistent with independent audit results.

D. Section IV.P.4. is hereby deleted in its entirety, and replaced with the following:

4. REINVESTMENT PLAN

a. A Reinvestment Fund shall be developed and managed by the Contractor for the purpose of subsidizing additional behavioral health services for children, families and adults according to a plan (the "Service Plan") developed with input from stakeholders and MLTC staff, including consumers, family members, the Office of Consumer Affairs, and the Contractor. The Service Plan shall address the behavioral health needs of adults and children, including filling service gaps and providing system improvements. Both the Reinvestment Fund and Service Plan must be approved by MLTC.

b. The Reinvestment Fund will be funded by the following:

i. The MLR Rebate as calculated in accordance with Section IV.P.1;
ii. The Risk Corridor Rebate as calculated in accordance with Section IV.P.3; and
iii. Unearned Contract Incentives as outlined in IV.O.11.

c. The Reinvestment Fund will be structured as follows:

i. The Contractor shall establish two express trust accounts to manage the Reinvestment Funds. The express trust accounts shall be created and named as follows:

a) Reinvestment Holding: The Reinvestment Holding account shall be created as a separate account to hold the 1.5% contract incentive, and any other funds forfeited in accordance with the provisions of this Contract. Funds held in the Reinvestment Holding account are not eligible to be expended in accordance with the Service Plan.

b) Reinvestment Distribution: The Reinvestment Distribution account shall be created as a separate account to hold the remaining funds forfeited to the Reinvestment Fund once the Federal share has been reimbursed in accordance with Section IV.P.4.d. Once funds have been deposited into the Reinvestment Distribution account they are eligible to be expended in accordance with the Service Plan.

c) Both the Reinvestment Holding and Reinvestment Distribution accounts shall:

1) Be separate from other accounts required by the contract;
2) Be separate from any other accounts that may be required by State or Federal law;
3) Have no risk bearing investments; and,
4) Be created and operated in full compliance with the Nebraska Uniform Trust Code (Neb. Rev. Stat. §30-3801 to 30-38110).

d. The Contractor shall be held responsible to ensure that:

i. The 1.5% unearned incentive payment paid each month concurrently with the monthly capitated rate payment, is deposited into the Reinvestment Holding account, and held pending determination of the portion of the incentive that is earned by the Contractor. Such determination shall be made within 6 months after the end of each Contract year. All earned incentives become the property of the Contractor. All unearned incentives are forfeited, and remain in the Reinvestment Holding account.

ii. Forfeited amounts resulting from the annual MLR rebate calculation made under Section IV.P.1 are deposited into the Reinvestment Holding account within 6 months after the end of each Contract year, per IV.P.1-5.

iii. Forfeited amounts resulting from the Risk Corridor calculation made under Section IV.P.3 are deposited into the Reinvestment Holding account within 6 months after the end of each Contract year, per IV.P.1-5.

iv. The annual financial reporting package in its entirety per IV.P.1-5 is submitted by the Contractor 6 months of the end of each Contract year.

v. Upon written approval of the annual financial reporting package by the Department, the Contractor shall transfer to the State all funds held in the Reinvestment Holding account.

vi. Once the State has reimbursed the Federal share in accordance with Section IV.P.4.d, Contractor shall accept the remaining State share for re-deposit into the Reinvestment Distribution account.

e. The State shall be held responsible to ensure that:

i. The annual financial reporting package, including the MLR Rebate calculation, Risk Corridor Calculation, and unearned incentives is reviewed, and written approval is provided, within 45 days after receipt from Contractor.

ii. All funds deposited into the Reinvestment Holding account are transferred to the State of Nebraska by the Contractor for

reconciliation and reimbursement of the Federal share via reporting on CMS Form 64.

iii. The Federal share of such dollars is determined and reimbursed to the Federal government, including any interest accrued.

iv. The remaining State share and any accrued interest, is returned to the Contractor for deposit into the Reinvestment Distribution account, managed by the Contractor, yet subject to contractual requirements.

f. The Contractor will be held responsible and accountable for the necessary fiduciary duties and functions required to administer the Reinvestment Fund. Oversight of the financial accounting will be determined in accordance with the financial management reporting definitions and mechanisms outlined in Section IV.P.1- IV.P. 5.

E. Section IV.P.5.a.is hereby deleted in its entirety, and replaced with the following:

a. In addition to any other reports discussed in the RFP, MLT will require a Quarterly and Annual Financial reporting package. The details and timing of the reports will be developed with the input of the Contractor. Examples of reports include, but are not limited to:

i. Certification Statement;
ii. Balance Sheet;
iii. Income Statement;
iv. LAG (IBNR) Report – Summary;
v. Medical Loss Ratio Calculation Report;
vi. Profit/Risk Corridor Calculation Reports;
vii. Related-Party Statements;
viii. Run Rate Income Statement;
ix. Auditor's Report and Report on Internal Controls;
x. Performance Measurement Calculation Reports;
xi. Annual Disclosure Reports; and
xii. Enrollment/Revenue Reconciliation

F. Attachment A Medicaid Covered Services is hereby deleted in its entirety, and replaced with Attachment A as included with this amendment.

This amendment will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Name: Bo Botelho

Title: Material Administrator

Date: 6/16/14

Contractor: Magellan Behavioral Health of Nebraska, Inc.

By: Anne M McCabe

Name: Anne M. McCabe

Title: President, Public Sector Solutions

Date: 5/22/14

State of Nebraska
Department of Health and Human Services

By: _____

Name: KERRY T WINTERER

Title: CEO

Date: 6/9/14

Contract 55286-04

Attachment 1

PERFORMANCE MEASUEMENT CHART

PERFORMANCE MEASUREMENT CHART		Contract Incentive Threshold	
Item#	**Measures**	**Threshold**	**Percent Allocation**
	Claims Administration		
1	Financial payment (dollar) accuracy: % of audited claim dollars paid accurately - Calculated as the total audited "paid" dollars minus the absolute value of over- and/or under- payments, divided by the total audited paid dollars. - Measurement using monthly system-generated reports.	98%	10%
2	Procedural accuracy: % of audited claims processed without procedural error - Calculated as the total number of audited claims minus the number of claims processed with procedural error, divided by the total number of audited claims. - Measurement using monthly system generated reports.	98%	10%
3	Turn Around Time (TAT) 99% of all provider claims paid within 90 days	100% of incentive awarded when 99% of claims paid at or before 60 days; prorated from 90 days	10%
	Telephone responsiveness		
4	Call Abandonment Rate: Member/ Provider calls less than 5 percent. Percentage of calls that reach the 800 line and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<3%	10% (15% year one)
5	Average Speed to Answer (ASA): Member/Provider Services Line(s) all calls answered within 30 seconds - Measured using annual system-generated reports from first ring to live answer on 24/7 single point of entry 800 line.	30 seconds	10% (15% year one)
	Clinical-measures not applicable for contract incentive but still require measurement and reporting		
6	Ambulatory follow up within 7 days of discharge from 24-hour facility (inclusive of acute inpatient only) - Report percent of individuals discharged from a 24-hour facility with an ambulatory follow-up appointment within 7 days of discharge. - Measurement using current NCQA HEDIS specifications. - Measurement using system-generated report. - Reported annually as percent with follow-up within specified timeframe.	N/A	N/A
7	Ambulatory follow up within 30 days of discharge from 24-hour facility (inclusive of acute inpatient only) - Report percent of individuals discharged from a 24 hour facility with an ambulatory follow-up appointment within 30 days of discharge of discharge. - Measurement using current NCQA HEDIS specifications. - Measurement using system-generated report. - Reported annually as percent with follow-up within specified timeframe.	N/A	N/A

PERFORMANCE MEASUREMENT CHART		Contract Incentive Threshold	
Item#	Measures	Threshold	Percent Allocation
8	Readmission Rate: Members readmitted within 30 days to inpatient level of care (inclusive of acute facilities only) - Measurement using system-generated reports. - Percentage of Members readmitted (to the same level of care) within 30 days of the discharge date from an acute level of care for any psychiatric or substance use disorder diagnosis.	N/A	N/A
9	30 Day Post-Admit ED Visits: Percent of Members presenting to hospital Emergency Departments (ED) within 30 days of the discharge date from an acute level of care for any psychiatric or substance use disorder diagnosis without an admission. - Baseline data will be collected for the second contract period.	N/A	N/A
10	Follow-Up Care for children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medications [HEDIS measure] - Percentage of children newly prescribed ADHD medication that had at least three follow-up care visits within a10-month period, one of which was within 30 days from the time the first ADHSD medication was dispensed, including two rates: one for the initiation phase and one for the continuation and maintenance phase.	N/A	N/A
11	Initiation and Engagement of Alcohol and Other Drug – 004 NCQA- The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization with 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.- Dependence Treatment: (a) Initiation, (b) Engagement.	N/A	N/A
12	Adherence to Antipsychotics for Individuals with Schizophrenia. [HEDIS measure] - Report percent of Medicaid enrollees ages 19 to 64 with schizophrenia that were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period. - Measurement using current NCQA HEDIS specifications. - Measurement using system-generated report. - Reported annually as percent with follow-up within specified timeframe.	N/A	N/A
	Satisfaction		
13	Annual Member Satisfaction Survey: % positive response rate - Members shall rate "satisfied" or better on the annual Member satisfaction survey approved by the State; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options and no neutral option (not applicable can be an option, as appropriate). - Survey domains to include consumer and family involvement and choice in treatment planning. - Sampling must include both adult consumers and parents/caregivers of child consumers, in proportions deemed by the State to be comparable to the distribution of Members served. - The sampling methodology must yield a 95% confidence level with 5% margin of error, including response rate as a factor.	90%; 100% of incentive awarded at 90% or higher; prorated between 80% and 90%	10%

PERFORMANCE MEASUREMENT CHART		Contract Incentive Threshold	
Item#	Measures	Threshold	Percent Allocation
14	Annual Professional Providers Satisfaction Survey: 80% positive response rate - Providers shall rate "satisfied" or better on the annual provider satisfaction survey; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options and no neutral option (not applicable can be an option, as appropriate). - Sampling must include (1) child and adult providers, and (2) urban and rural providers. The sampling methodology must yield a 95% confidence level with 5% margin of error, including response rate as a factor. - The survey must specifically address Contractor education to providers on administrative (e.g., claims submission) and clinical issues, promotion of administrative simplification in provider interface with the health plan, timely payment of claims, and use of due process in denied or disputed claims.	90%; 100% of incentive awarded at 90% or higher; prorated between 80% and 90%	10%
15	Annual Facility Satisfaction Survey: - Providers shall rate "satisfied" or better on the annual provider satisfaction survey; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options and no neutral option (not applicable can be an option, as appropriate). - Sampling must include (1) inpatient and outpatient providers, and (2) urban and rural providers. - At least 30% of the facilities must respond. - The survey must specifically address Contractor education to providers on administrative (e.g., claims submission) and clinical issues, promotion of administrative simplification in provider interface with the health plan, timely payment of claims, and use of due process in denied or disputed claims.	N/A	N/A
16	Timely completion of Implementation or Annual Plan Milestones: - Compliance measured as the number of milestones satisfactorily completed according to MLTC by the date specified in the implementation schedule or annual project schedule as a percent of all milestones that were due under the implementation plan during the quarter. - Contractor to provide specific plans for review and approval by MLTC - Milestones not met in one quarter carry over into next quarter for evaluation. Milestones carried over. - Milestones missed due to factors beyond Contractor control will not be counted in measurement.	90%	10%
	Encounters		
17	Encounter Submission Rate:The Contractor must maintain an information system that includes the capability to collect data on potential enrollee and provider characteristics, and claims information through an encounter data system. The Contractor must submit encounter data to the Medicaid Management Information System (MMIS) monthly per Departmental specifications.Encounter data submission must:a) Be submitted on a monthly basis;b) Include 90% of all clean claims adjudicated by the Contractor;c) Annual written report analyzing encounters not being submitted along with improvement plan	95%; 100% of incentive awarded at 95% or higher; prorated between 90% and 95% (starting in year 2)	5%

PERFORMANCE MEASUREMENT CHART		Contract Incentive Threshold	
Item#	Measures	Threshold	Percent Allocation
18	Encounter Acceptance Rate: a) 90% of encounters submitted need to be accepted by MLTC's Medicaid Management Information System (MMIS) pursuant to Departmental specifications. b) Annual written report analyzing encounters not being submitted along with improvement plan	95%; 100% of incentive awarded at 95% or higher; prorated between 90% and 95% (starting in year 2)	5%
	Grievances		
19	Appeals: % of appeals will be resolved as expeditiously as the enrollee's health condition requires from the date the Contractor received the appeal	90% within 14 days	5%
20	Grievances: % of grievances will be resolved as expeditiously as the enrollee's health condition requires from the date the Contractor received all information necessary to resolve the grievance.	90% within 14 days	5%
	TOTALS		100%

Contract 55286-04

Attachment A

BEHAVIORAL HEALTH BENEFITS PACKAGE

Medicaid covered behavioral health services for children under age 19:

Crisis Stabilization Services (includes Treatment Crisis Intervention)
Inpatient Psychiatric Hospital (Acute and Sub-Acute)
Psychiatric Residential Treatment Facility (PRTF)
Telehealth Transmission

Outpatient Assessment and Treatment:
Partial Hospitalization
Day Treatment
Intensive Outpatient
Medication Management
Outpatient (Individual, Family, Group)
Injectable Psychotropic Medications
Substance Use Disorder Treatment
Psychological Evaluation and Testing
Initial Diagnostic Interviews
Sex Offender Risk Assessment
Community Treatment Aide (CTA)
Comprehensive Child and Adolescent Assessment (CCAA)
Comprehensive Child and Adolescent Assessment Addendum
Hospital Observation Room Services (23:59)

Rehabilitation Services:
Day Treatment/Intensive Outpatient
Community Treatment Aide (CTA)
Professional Resource Family Care (PRFC)
Therapeutic Group Home (ThGH)

Medicaid covered services for Adults 19 and over:

Crisis Stabilization Services (includes Treatment Crisis Intervention)
Inpatient Psychiatric Hospital Services (Acute and Sub-Acute)
Telehealth Transmission

Outpatient Assessment and Treatment:
Partial Hospitalization
Social Detox
Day Treatment
Intensive Outpatient
Medication Management
Outpatient (Individual, Family, Group)
Injectable Psychotropic Medications
Substance Use Disorder Treatment

Psychological Evaluation and Testing
Electroconvulsive Therapy – ECT
Initial Diagnostic Interviews
Ambulatory Detoxification
In-home Psychiatric nursing

Rehabilitation Services:
Dual Disorder Residential
Intermediate Residential – (SUD) substance abuse
Short-Term Residential
Halfway House
Therapeutic Community – (SUD only)
Community Support
Psychiatric Residential Rehabilitation
Secure Residential Rehabilitation
Assertive Community Treatment (ACT) and Alternative ACT (Alt. ACT)
Community Support (MH)
Day Rehabilitation

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
301 Centennial Mall South, 1st Floor
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-2401
Fax: (402) 471-2089

CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
1 of 3	02/28/13
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2071380

VENDOR ADDRESS:

MAGELLAN BEHAVIORAL HEALTH OF NEBRASKA
1221 N ST STE 700
LINCOLN NEBRASKA 68508-2018

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2013 THROUGH AUGUST 31, 2016

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original Contract/Bid Document 4166 Z1
Contract to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care for a period effective September 1, 2013 through August 31, 2016, with the option to renew for two (2) additional one (1) year periods as mutually agreed upon by all parties.

The State may request that payment be made electronically instead of by state warrant. ACH/EFT Enrollment Form can be found at: http://www.das.state.ne.us/accounting/forms/achenrol.pdf

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system mean the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

The contractor certifies that the contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The contractor also agrees to include the above requirements in any and all subcontracts into which it enters. The contractor shall immediately notify the Department if, during the term of this contract, contractor becomes debarred. The Department may immediately terminate this contract by providing contractor written notice if contractor becomes debarred during the term of this contract.
If the Contractor is an individual or sole proprietorship, the following applies:
1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at: www.das.state.ne.us.
2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation require to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

The contract shall incorporate the following previously submitted documents:
1. Contract Award;

CHIEF EXECUTIVE OFFICER
DEPARTMENT OF HEALTH AND HUMAN SERVICES

BUYER

MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
301 Centennial Mall South, 1st Floor
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
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CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
2 of 3	02/28/13
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2071380	

2. Any Contract Amendments, in order of significance;
3. Any Request for Proposal Addenda and/or Amendments to include Questions and Answers;
4. The original RFP document;
5. The signed Request for Proposal form; and
6. The Contractor's Proposal.

Vendor Contact: Sue Mimick, General Manager
Phone: 402-437-4214
Cell: 402-981-3547
Fax: 888-656-4925
E-Mail: smimick@magellanhealth.com

Vendor Contact: Glenn Stanton, Senior Vice President Business Development
Phone: 410-953-1242
Cell: 410-591-8085
Fax: 410-953-2427
E-Mail: gstanton@magellanhealth.com

(2/28/13 knj)

AMENDMENT TWO (2) AS ATTACHED. (12/024/13 ld)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	CAPITATION PAYMENT FEDERAL 55% 09/01/2013-06/30/2014	49,389,803.0000	$	1.0000	49,389,803.00
2	CAPITATION PAYMENT STATE 45% 09/01/2013-06/30/2014	40,409,839.0000	$	1.0000	40,409,839.00
3	CAPITATION PAYMENT FEDERAL 55% 07/01/2014-06/30/2015	62,052,351.0000	$	1.0000	62,052,351.00
4	CAPITATION PAYMENT STATE 45% 07/01/2014-06/30/2015	50,770,106.0000	$	1.0000	50,770,106.00
5	CAPITATION PAYMENT FEDERAL 55% 07/01/2015-06/30/2016	64,974,241.0000	$	1.0000	64,974,241.00
6	CAPITATION PAYMENT STATE 45% 07/01/2015-06/30/2016	53,160,743.0000	$	1.0000	53,160,743.00
7	CAPITATION PAYMENT FEDERAL 55% 07/01/2016-08/31/2016	10,828,989.0000	$	1.0000	10,828,989.00

MT 12712
BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

PAGE	ORDER DATE
3 of 3	02/28/13
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 2071380	

State Purchasing Bureau
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OR
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Telephone: (402) 471-2401
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CONTRACT NUMBER
55286 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
8	CAPITATION PAYMENT STATE 45% 07/01/2016-08/31/2016	8,860,081.0000	$	1.0000	8,860,081.00
	Total Order				**340,446,153.00**

MT 12713
BUYER INITIALS

AMENDMENT TWO
Contract 55286 04
Medicaid Managed Care Behavioral Health Services for the State of Nebraska
Between
The State of Nebraska and Magellan Behavioral Health of Nebraska, Inc.

This Amendment (the "Amendment") is made by the State of Nebraska and Magellan Behavioral Health of Nebraska, Inc., parties to Contract 55286 04 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. The definition of Incentive Withhold, in the Glossary of Terms, is hereby deleted.

II. Section III.DD is hereby deleted in its entirety, and replaced with the following:

DD. PROFIT/LOSS CAP AND REINVESTMENT

_____
Accept & Initial

Total profit by an PIHP shall not exceed three percent (3%) per year and losses shall not exceed three percent (3%) per year as an aggregate of all income and revenue earned by the Contractor and related parties, including parent and subsidy companies and risk-bearing partners, under contract. The PIHP must create a Reinvestment Fund in accordance with Section IV.P.4, which will fund additional behavioral health services for children, families and adults according to a plan developed with input from stakeholders, consumers and their family members, the Office of Consumer Affairs within MLTC, and the Regional Behavioral Health Authority. Such plan must be approved by MLTC. The following funds will be forfeited to the Reinvestment Fund:

1. The Risk Corridor Rebate as calculated in accordance with Section IV.P.3;
2. The MLR Rebate as calculated in accordance with Section IV.P.1;
3. Performance Guarantees that have not been met as outlined in Section IV.O.11; and,
4. Unearned Contract Incentives as outlined in IV.O.11.

Forfeited amounts shall be deposited into the Reinvestment Fund, and paid to the Department in accordance with Section IV.P.4. The Department will reimburse the Federal share of the forfeited funds to the Centers for Medicare & Medicaid Services in accordance with Section IV.P.4. The remaining State share of the forfeited funds will be returned to the PIHP for deposit back into the Reinvestment Fund, and to be used in accordance with purposes outlined herein.

Section IV.O.11.b.ii. is hereby deleted in its entirety, and replaced with the following:

ii. Proceeds from any penalties assessed, unearned incentives, unearned performance guarantees, MLR and/or risk corridor rebates not realized shall be transferred to the Reinvestment Fund, described in more detail below;

Section IV.O.11.b.iii. is hereby deleted in its entirety, and replaced with the following:

iii. In the event of contract termination, the Contractor shall pay any monies owed with respect to the forfeited guarantees and incentives, MLR rebates, and risk corridor rebates into the Reinvestment Fund within one hundred and twenty (120) days of the termination of the contract. Alternatively, if at the time of termination Contractor has earned incentives or performance guarantees in accordance with provisions of this Contract, such earned incentives and performance guarantees will become the property of the Contractor. The Contractor will cease, and MLTC will assume, all duties and responsibilities associated with administration and management of the Reinvestment Fund;

Section IV.O.11. Performance Measurement Chart is hereby deleted in its entirety and replaced with Attachment 1: Performance Measurement Chart.

Section IV.P.4. is hereby deleted in its entirety, and replaced with the following:

4. REINVESTMENT PLAN

a. A Reinvestment Fund shall be developed and managed by the Contractor for the purpose of subsidizing additional behavioral health services for children, families and adults according to a plan (the "Service Plan") developed with input from stakeholders and MLTC staff, including consumers, family members, the Office of Consumer Affairs, and the Contractor. The Service Plan shall address the behavioral health needs of adults and children, including filling service gaps and providing system improvements. Both the Reinvestment Fund and Service Plan must be approved by MLTC.

b. The Reinvestment Fund will be funded by the following:

i. The MLR Rebate as calculated in accordance with Section IV.P.1;
ii. The Risk Corridor Rebate as calculated in accordance with Section IV.P.3;
iii. Performance Guarantees that have not been met as outlined in Section IV.O.11; and,
iv. Unearned Contract Incentives as outlined in IV.O.11.

c. The Reinvestment Fund will be structured as follows:

i. The Contractor shall establish two express trust accounts to manage the Reinvestment Fund. The express trust accounts shall be created and named as follows:

a) Reinvestment Holding: The Reinvestment Holding account shall be created as a separate account to hold the 1.5% contract incentive, and any other funds forfeited in accordance with the provisions of this Contract. Funds held in the Reinvestment Holding account are not eligible to be expended in accordance with the Service Plan.

b) Reinvestment Distribution: The Reinvestment Distribution account shall be created as a separate account to hold the remaining funds forfeited to the Reinvestment Fund once the Federal share has been reimbursed in accordance with Section IV.P.4.d. Once funds have been deposited into the Reinvestment Distribution account they are eligible to be expended in accordance with the Service Plan.

c) Both the Reinvestment Holding and Reinvestment Distribution accounts shall:

1) Be separate from other accounts required by the contract;
2) Be separate from any other accounts that may be required by State or Federal law;
3) Have no risk bearing investments; and,
4) Be created and operated in full compliance with the Nebraska Uniform Trust Code (Neb. Rev. Stat. §30-3801 to 30-38110).

d. The Contractor shall be held responsible to ensure that:

i. The 1.5% unearned incentive payment and 0.5% unearned performance guarantee, paid each month concurrently with the monthly capitated rate payment, is deposited into the Reinvestment Holding account, and held pending determination of the portion of the incentive and performance guarantee that is earned by the Contractor. Such determination shall be made within 6-9 months after the end of each Contract year. All earned incentives and performance guarantees become the property of the Contractor. All unearned incentives and performance guarantees are forfeited, and remain in the Reinvestment Holding account.

ii. Forfeited amounts resulting from the annual MLR rebate calculation made under Section IV.P.1 are deposited into the Reinvestment Holding account within 6-9 months after the end of each Contract year, per IV.P.1-5.

iii. Forfeited amounts resulting from the Risk Corridor calculation made under Section IV.P.3 are deposited into the Reinvestment Holding account within 6-9 months after the end of each Contract year, per IV.P.1-5.

iv. The annual financial reporting package in its entirety per IV.P.1-5 is submitted by the Contractor 6-9 months of the end of each Contract year.

v. Upon written approval of the annual financial reporting package by the Department, the Contractor shall transfer to the State all funds held in the Reinvestment Holding account.

vi. Once the State has reimbursed the Federal share in accordance with Section IV.P.4.d, Contractor shall accept the remaining State share for re-deposit into the Reinvestment Distribution account.

e. The State shall be held responsible to ensure that:

i. The annual financial reporting package, including the MLR Rebate calculation, Risk Corridor Calculation, and unearned incentives is reviewed, and written approval is provided, within 45 days after receipt from Contractor.

ii. All funds deposited into the Reinvestment Holding account are transferred to the State of Nebraska by the Contractor for reconciliation and reimbursement of the Federal share via reporting on CMS Form 64.

iii. The Federal share of such dollars is determined and reimbursed to the Federal government, including any interest accrued.

iv. The remaining State share and any accrued interest, is returned to the Contractor for deposit into the Reinvestment Distribution account, managed by Magellan, yet subject to contractual requirements.

f. The Contractor will be held responsible and accountable for the necessary fiduciary duties and functions required to administer the Reinvestment Fund. Oversight of the financial accounting will be determined in accordance with the financial management reporting definitions and mechanisms outlined in Section IV.P.1- IV.P. 5.

This amendment will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska	Contractor: Magellan Behavioral Health of Nebraska, Inc.
By: _____	By: Anne M. McCabe
Name: Bo Botelho	Name: Anne M. McCabe
Title: Medicaid Administrator	Title: Senior Vice President
Date: 12-30-13	Date: 12/17/13

State of Nebraska
Department of Health and Human Services

By: _____

Name: KERRY T WINSTEAD

Title: CGO

Date: 12/26/13

Contract 55286-O4
Attachment 1
PERFORMANCE MEASUREMENT CHART

PERFORMANCE MEASUREMENT CHART		Performance Guarantees Threshold		Contract Incentive Threshold	
Item#	Measures	Threshold	Percent Allocation	Threshold	Percent Allocation
	Claims Administration				
1	Financial payment (dollar) accuracy: % of audited claim dollars paid accurately - Calculated as the total audited "paid" dollars minus the absolute value of over- and/or under- payments, divided by the total audited paid dollars. - Measurement using monthly system-generated reports.	97%	10%	98%	10%
2	Procedural accuracy: % of audited claims processed without procedural error - Calculated as the total number of audited claims minus the number of claims processed with procedural error, divided by the total number of audited claims. - Measurement using monthly system generated reports.	97%	10%	98%	10%
3	Turn Around Time (TAT) 99% of all provider claims paid within 90 days	99% within 90 days	5%	100% of incentive awarded when 99% of claims paid at or before 60 days; prorated from 90 days	10%
	Telephone responsiveness				
4	Call Abandonment Rate: Member/ Provider calls less than 5 percent. Percentage of calls that reach the 800 line and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<5%	5%	<3%	10%
5	Average Speed to Answer (ASA): Member/Provider Services Line(s) all calls answered within 30 seconds - Measured using annual system-generated reports from first ring to live answer on 24/7 single point of entry 800 line.	45 seconds	5%	30 seconds	10%
	Clinical				
6	Ambulatory follow up within 7 days of discharge from 24-hour facility (inclusive of acute inpatient only) - Report percent of individuals discharged from a 24-hour facility with an ambulatory follow-up appointment within 7 days of discharge. - Measurement using current NCQA HEDIS specifications. - Measurement using system-generated report. - Reported annually as percent with follow-up within specified timeframe.	Above HEDIS 50th percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass	5%	N/A	N/A
7	Ambulatory follow up within 30 days of discharge from 24-hour facility (inclusive of acute inpatient only) - Report percent of individuals discharged from a 24 hour facility with an ambulatory follow-up appointment within 30 days of discharge of discharge. - Measurement using current NCQA HEDIS specifications. - Measurement using system-generated report. - Reported annually as percent with follow-up within specified timeframe.	Above HEDIS 50th percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass	5%	N/A	N/A
8	Readmission Rate: Members readmitted within 30 days to inpatient level of care (inclusive of acute facilities only) - Measurement using system-generated reports. - Percentage of Members readmitted (to the same level of care) within 30 days of the discharge date from an acute level of care for any psychiatric or substance use disorder diagnosis.	<20%	10%	N/A	N/A
9	30 Day Post-Admit ED Visits: Percent of Members presenting to hospital Emergency Departments (ED) within 30 days of the discharge date from an acute level of care for any psychiatric or substance use disorder diagnosis without an admission. - Baseline data will be collected for the first contract period of the risk-based contract. - Based on this, in contract Year Two, a Risk Allocation Threshold equal to the baseline year will be set for a penalty of at least 10% of the risk amount and an incentive goal of a substantial reduction in ED use will be set for an incentive of at least 12% of the incentive set aside.	Year Two monitor only; Year Three set at Year Two baseline	N/A	N/A	N/A
10	Follow-Up Care for children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medications [HEDIS measure] - Percentage of children newly prescribed ADHD medication that had at least three follow-up care visits within a10-month period, one of which was within 30 days from the time the first ADHSD medication was dispensed, including two rates: one for the initiation phase and one for the continuation and maintenance phase.	Year Two monitor for behavioral health providers that are linked to a member with a diagnosis of ADHD only; Year Three set at Year Two baseline	N/A	N/A	N/A

Contract 55286-O4
Attachment 1
PERFORMANCE MEASUREMENT CHART

PERFORMANCE MEASUREMENT CHART		Performance Guarantees Threshold		Contract Incentive Threshold	
Item#	Measures	Threshold	Percent Allocation	Threshold	Percent Allocation
11	Initiation and Engagement of Alcohol and Other Drug – 004 NCQA - The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization with 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit. - Dependence Treatment: (a) Initiation, (b) Engagement.	Year Two monitor only; Year Three marginal improvement	N/A	N/A	N/A
12	Adherence to Antipsychotics for Individuals with Schizophrenia. [HEDIS measure] - Report percent of Medicaid enrollees ages 19 to 64 with schizophrenia that were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period. - Measurement using current NCQA HEDIS specifications. - Measurement using system-generated report. - Reported annually as percent with follow-up within specified timeframe.	Year Two monitor only; Year Three marginal improvement	N/A	N/A	N/A
	Satisfaction				
13	Annual Member Satisfaction Survey: % positive response rate - Members shall rate "satisfied" or better on the annual Member satisfaction survey approved by the State; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options and no neutral option (not applicable can be an option, as appropriate). - Survey domains to include consumer and family involvement and choice in treatment planning. - Sampling must include both adult consumers and parents/caregivers of child consumers, in proportions deemed by the State to be comparable to the distribution of Members served. - The sampling methodology must yield a 95% confidence level with 5% margin of error, including response rate as a factor.	80%	10%	90%; 100% of incentive awarded at 90% or higher; prorated between 80% and 90%	10%
14	Annual Professional Providers Satisfaction Survey: 85% positive response rate - Providers shall rate "satisfied" or better on the annual provider satisfaction survey; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options and no neutral option (not applicable can be an option, as appropriate). - Sampling must include (1) child and adult providers, and (2) urban and rural providers. The sampling methodology must yield a 95% confidence level with 5% margin of error, including response rate as a factor. - The survey must specifically address Contractor education to providers on administrative (e.g., claims submission) and clinical issues, promotion of administrative simplification in provider interface with the health plan, timely payment of claims, and use of due process in denied or disputed claims.	80%	10%	90%; 100% of incentive awarded at 90% or higher; prorated between 80% and 90%	10%
15	Annual Facility Satisfaction Survey: - Providers shall rate "satisfied" or better on the annual provider satisfaction survey; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options and no neutral option (not applicable can be an option, as appropriate). - Sampling must include (1) inpatient and outpatient providers, and (2) urban and rural providers. - At least 30% of the facilities must respond. - The survey must specifically address Contractor education to providers on administrative (e.g., claims submission) and clinical issues, promotion of administrative simplification in provider interface with the health plan, timely payment of claims, and use of due process in denied or disputed claims.	Year One monitor only; Year Two set at Year One baseline	N/A	N/A	N/A
16	Timely completion of Implementation or Annual Plan Milestones: - Compliance measured as the number of milestones satisfactorily completed according to MLTC by the date specified in the implementation schedule or annual project schedule as a percent of all milestones that were due under the implementation plan during the quarter. - Contractor to provide specific plans for review and approval by MLTC - Milestones not met in one quarter carry over into next quarter for evaluation. Milestones carried over. - Milestones missed due to factors beyond Contractor control will not be counted in measurement.	85%	15%	90%	10%

Contract 55286-O4
Attachment 1
PERFORMANCE MEASUREMENT CHART

PERFORMANCE MEASUREMENT CHART		Performance Guarantees Threshold		Contract Incentive Threshold	
Item#	Measures	Threshold	Percent Allocation	Threshold	Percent Allocation
17	Encounter Submission Rate: The Contractor must maintain an information system that includes the capability to collect data on potential enrollee and provider characteristics, and claims information through an encounter data system. The Contractor must submit encounter data to the Medicaid Management Information System (MMIS) monthly per Departmental specifications. Encounter data submission must: a) Be submitted on a monthly basis; b) Include 90% of all clean claims adjudicated by the Contractor; c) Annual written report analyzing encounters not being submitted along with improvement plan	90% and written analysis	5%	95%; 100% of incentive awarded at 95% or higher; prorated between 90% and 95%	5%
18	Encounter Acceptance Rate: a) 90% of encounters submitted need to be accepted by MLTC's Medicaid Management Information System (MMIS) pursuant to Departmental specifications. b) Annual written report analyzing encounters not being submitted along with improvement plan	90% and written analysis	5%	95%; 100% of incentive awarded at 95% or higher; prorated between 90% and 95%	5%
19	Appeals: % of appeals will be resolved as expeditiously as the enrollee's health condition requires from the date the Contractor received the appeal	N/A	N/A	90% within 14 days	5%
20	Grievances: % of grievances will be resolved as expeditiously as the enrollee's health condition requires from the date the Contractor received all information necessary to resolve the grievance.	N/A	N/A	90% within 14 days	5%
	TOTALS		100%		100%

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
301 Centennial Mall South, 1st Floor
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-2401
Fax: (402) 471-2089

CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
1 of 3	11/05/13
BUSINESS UNIT	BUYER
25710178	MICHELLE MUSICK (AS)

VENDOR NUMBER: 2071380

VENDOR ADDRESS:

MAGELLAN BEHAVIORAL HEALTH OF NEBRASKA
1221 N ST STE 700
LINCOLN NEBRASKA 68508-2018

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2013 THROUGH AUGUST 31, 2016

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original Contract/Bid Document 4166 Z1
Contract to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care for a period effective September 1, 2013 through August 31, 2016, with the option to renew for two (2) additional one (1) year periods as mutually agreed upon by all parties.

The State may request that payment be made electronically instead of by state warrant. ACH/EFT Enrollment Form can be found at: http://www.das.state.ne.us/accounting/forms/achenrol.pdf

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system mean the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

The contractor certifies that the contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The contractor also agrees to include the above requirements in any and all subcontracts into which it enters. The contractor shall immediately notify the Department if, during the term of this contract, contractor becomes debarred. The Department may immediately terminate this contract by providing contractor written notice if contractor becomes debarred during the term of this contract.
If the Contractor is an individual or sole proprietorship, the following applies:
1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at: www.das.state.ne.us.
2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation require to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

The contract shall incorporate the following previously submitted documents:
1. Contract Award;

CHIEF EXECUTIVE OFFICER
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Michelle Musick 11 20 13
BUYER RAU/AS/13
11-22-13
MATERIEL ADMINISTRATOR

R4350(III5)H0003 Iu0416

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
301 Centennial Mall South, 1st Floor
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-2401
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CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
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25710178	MICHELLE MUSICK (AS)
VENDOR NUMBER: 2071380	

2. Any Contract Amendments, in order of significance;
3. Any Request for Proposal Addenda and/or Amendments to include Questions and Answers;
4. The original RFP document;
5. The signed Request for Proposal form; and
6. The Contractor's Proposal.

Vendor Contact: Sue Mimick, General Manager
Phone: 402-437-4214
Cell: 402-981-3547
Fax: 888-656-4925
E-Mail: smimick@magellanhealth.com

Vendor Contact: Glenn Stanton, Senior Vice President Business Development
Phone: 410-953-1242
Cell: 410-591-8085
Fax: 410-953-2427
E-Mail: gstanton@magellanhealth.com

(2/28/13 knj)

AMENDMENT ONE (1) AS ATTACHED. (11/05/13 sc)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	CAPITATION PAYMENT FEDERAL 55% 09/01/2013-06/30/2014	49,389,803.0000	$	1.0000	49,389,803.00
2	CAPITATION PAYMENT STATE 45% 09/01/2013-06/30/2014	40,409,839.0000	$	1.0000	40,409,839.00
3	CAPITATION PAYMENT FEDERAL 55% 07/01/2014-06/30/2015	62,052,351.0000	$	1.0000	62,052,351.00
4	CAPITATION PAYMENT STATE 45% 07/01/2014-06/30/2015	50,770,106.0000	$	1.0000	50,770,106.00
5	CAPITATION PAYMENT FEDERAL 55% 07/01/2015-06/30/2016	64,974,241.0000	$	1.0000	64,974,241.00
6	CAPITATION PAYMENT STATE 45% 07/01/2015-06/30/2016	53,160,743.0000	$	1.0000	53,160,743.00
7	CAPITATION PAYMENT FEDERAL 55% 07/01/2016-08/31/2016	10,828,989.0000	$	1.0000	10,828,989.00

MM 11.2013
BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
301 Centennial Mall South, 1st Floor
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-2401
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PAGE	ORDER DATE
3 of 3	11/05/13
BUSINESS UNIT	BUYER
25710178	MICHELLE MUSICK (AS)
VENDOR NUMBER: 2071380	

CONTRACT NUMBER
55286 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
8	CAPITATION PAYMENT STATE 45% 07/01/2016-08/31/2016	8,860,081.0000	$	1.0000	8,860,081.00
	Total Order				**340,446,153.00**

MM 11.20.13
BUYER INITIALS

R42500(N15)80003 100416

AMENDMENT ONE
Contract 55286 04
Medicaid Managed Care Behavioral Health Services for the State of Nebraska
Between
The State of Nebraska and Magellan Behavioral Health of Nebraska, Inc.

This Amendment (the "Amendment") is made by the State of Nebraska and Magellan Behavioral Health of Nebraska, Inc., parties to Contract 55286 04 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

A. The following sections are added effective September 1, 2013, as follows:

Section IV.J.13. is hereby amended to add new subparagraph "o." as follows:
Service Verification
The Contractor must have in place a method for verifying that services were actually provided. Minimum sampling criteria to ensure a representative sample must be included. The Contractor must report the results of monitoring to the State quarterly.

Section IV.J.13. is hereby amended to add new subparagraph "p." as follows:
State Conflict of Interest Safeguards
Prior to execution, the Contractor shall provide evidence to the State that safeguards are in place to prevent any conflict of interest. Contractor's safeguards must, at a minimum, meet the requirements of the federal safeguards as outlined in 41 USC 423, Section 27.

Section IV.J. is hereby amended to add new subparagraph "14" as follows:
Enrollment Discrimination Prohibited
The Contractor will not discriminate against individuals eligible to enroll on the basis of:

a. Health status or need for health care services;
b. Race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

All individuals eligible for enrollment are to be accepted in the order in which they apply, without restriction.

Section IV.J. is hereby amended to add new subparagraph "15." as follows:
Sub-Contractual Relationships And Delegation
The Contractor must provide or assure the provision of all services in the Behavioral Health Benefits package specified in Attachment A. The Contractor may provide these services directly or may enter into subcontracts with providers who will provide the services outlined in Attachment A to the members in exchange for payment by the Contractor. Any plan to delegate responsibilities of the Contractor to a major subcontractor shall be submitted to DHHS for approval.

The Contractor is responsible for oversight and will be the party held accountable for any functions and responsibilities that it delegates to any subcontractor, including:

a) Meeting the Federal requirements defined 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract;

b) The prospective subcontractor's ability to perform the activities to be delegated;

c) A written agreement between the Contractor and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate; and

d) Assurance that when the Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor must take corrective action.

Section IV.J. is hereby amended to add the new subparagraph "16." as follows:
Prohibited Affiliations with Individuals Debarred by Federal Agencies - General Requirement
A PIHP may not knowingly have a relationship with the following:

a. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of:
i. A director, officer, or partner of the MCO.
ii. A person with beneficial ownership of five percent or more of MCO equity.
iii. A person with an employment, consulting or other arrangement with the PIHP under its contract with the state.

Section IV.J. is hereby amended to add new subparagraph "17." as follows:
Physician Incentive Plan (PIP)
a. Regulations. The MCO's PIP must meet the requirements in 42 CRF 422.208 and 422.210.

b. Prohibition. The MCO may operate a PIP only if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

c. Disclosure to State. The disclosure to the State includes the following:
i. The MCO must report whether services not furnished by physicians/groups are covered by an incentive plan. No further disclosure is required if the PIP does not cover services not furnished by physician/group.
ii. The MCO must report the type of incentive arrangement, e.g. withhold, bonus, capitation.
iii. The MCO must report the percent of withhold or bonus (if applicable).
iv. The MCO must report the panel size, and if patients are pooled, and the approved method used.
v. If the physician/group is at substantial financial risk, the MCO must report proof that the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

d. Substantial Financial Risk - If the physician/group is put at substantial financial risk for services not provided by the physician/group, the MCO must ensure adequate stop-loss protection to individual physicians and conduct annual enrollee surveys.

e. Disclosure to Beneficiaries - The MCO must provide information on its PIP to any Medicaid beneficiary upon request (this includes the right to adequate and timely information on a PIP).

f. Disclosure to State - Survey - If required to conduct beneficiary survey, the survey results must be disclosed to the State and, upon request, disclosed to beneficiaries.

Section IV.J. is hereby amended to add new subparagraph "18." as follows:
Rights to Inventions made under a contract or agreement
Contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention.

Section IV.J. is hereby amended to add new subparagraph "19." as follows:
Clean Air Act and Federal Water Pollution Control Act
All contracts shall contain a provision that requires the recipient to agree to comply with all applicable standards, orders or regulations.

Section IV.J. is hereby amended to add new subparagraph "20." as follows:
Byrd Anti-Lobbying Amendment
Contractors who apply or bid shall file the require certification that each tier will not use Federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any Federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the recipient (45 CFR part 93). The contract contains a statement that Federal funds have not been used for lobbying.

Section IV.J. is hereby amended to add new subparagraph "21." as follows:
Requirements for record retention and access to records for awards to recipients
Financial records, supporting documents, statistical records, and all other records pertinent to an award shall be retained for a period of ten years from the date of submission of the final expenditure report or, for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report. The only exceptions are the following:

1. If any litigation, claim, financial management review, or audit is started before the expiration of the 10-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.

2. Records for real property and equipment acquired with Federal funds shall be retained for 10 years after final disposition.

3. When records are transferred to or maintained by the HHS awarding agency, the 10-year retention requirement is not applicable to the recipient.

4. Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 CFR 74.53(g).

Section IV.K.1.a. is hereby amended to add new subparagraphs "i.", "ii.", "iii.", "iv.", and "v." as follows:

i. Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

ii. Each managed care enrollee is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

iii. Each managed care enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

iv. Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

v. Each managed care enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected as specified in 45 CFR Part 164.

Section IV.K.1.i.ii.a. is hereby amended to add new subparagraphs "5)" follows:
5). The recipient's physician prescribes the change in the level of medical care;

Section IV.K.1. is hereby amended to add new subparagraph "j." as follows:
The contractor will provide automatic reenrollment of an enrollee who is disenrolled because of their loss of Medicaid eligibility for a period of 2 months or less.

Section IV.K.1. is hereby amended to add subparagraph "k." as follows:
Free Exercise of Rights
Each enrollee is free to exercise his or her rights and entitled to a guarantee that the exercise of those rights does not adversely affect the enrollee's treatment by the MCO and its providers or the State agency.

Section IV.L.1. is hereby amended to add new subparagraph "l." as follows:
The contractor may not discriminate against any provider who is acting within the scope of their license or certification concerning their participation, reimbursement or indemnification, solely on the basis of that license or certification. If the contractor determines not to include a provider in the network, they must give the provider written notice of the reason why.

Section IV.L.2. is hereby amended to add new subsection "b." as follows:
Provider Discrimination

i. The Contractor may not discriminate against the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

ii. Declining Providers
If The Contractor declines to include an individual or group provider in its network, it must give the affected providers written notice of the reason for its decision. Federal requirements of 42 CFR 438.12(a) may not be construed to:

a) Require the Contractor to contract with providers in its network beyond the number necessary to meet the needs of its enrollees.

b) Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

c) Preclude the Contractor from establishing measures that are designed to maintain
quality of services and control costs consistent with its responsibilities to enrollees.

Section IV.L.7.b. is hereby amended to add new subparagraph "ix." as follows:
The Contractor must ensure that the services offered under the contract are in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid. This does not disallow the Contractor to place appropriate limits on a service:

a) On the basis of criteria applied under the State plan, such as medical necessity, or
b) For the purpose of utilization control, provided the services funished can reasonable be expected to achieve their purpose.

Section IV.O.11.c.i. is hereby amended to add new subparagraph "j)" as follows:
State Approval
The Contractor shall not distribute directly or indirectly through any agent or independent contract, marketing materials that have not been approved by the State or that contain false or materially misleading information. The Contractor must submit all marketing material to the State for approval prior to distribution.

B. The following sections are removed, or replaced effective September 1, 2013, as follows:

Section IV.J.5.b. is hereby deleted in its entirety, and replaced with the following:
Federal Access to Records
The HHS awarding agency, the U.S. Comptroller General, or any representatives, shall have access to any books, documents, papers, and records of the contractor which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions. HHS awarding agencies, the HHS Inspector General, the U.S. Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of contractor that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents. The rights of access in this paragraph are not limited to the required retention period, but shall last as long as records are retained.

Section IV.K.1.a. is hereby deleted in its entirety and replaced with the following:
Member Rights
The Contractor shall fully inform behavioral health recipients and family members about their rights and responsibilities and how to exercise them upon enrollment. The Contractor shall comply with any applicable Federal and State requirements that relate to member rights and require its staff and contracted providers to comply with the above requirements when delivering services to NE BH recipients and their families. The Contractor shall comply with all other applicable Federal and State laws such as: Title VI of the Civil Rights Act of 1964, 42 CFR 438.100; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the

Rehabilitation Act of 1973; and the Americans with Disabilities Act and other laws regarding privacy and confidentiality. The Contractor must comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees. The contractor must allow enrollees to choose his or her health professional to the extent possible and appropriate.

Section IV.K.1.f. is hereby deleted in its entirety and replaced with the following:
The Contractor shall furnish the information as specified in this section to each of its members or member households within a reasonable time but no more than 30 calendar days after the Contractor receives notice of the member's enrollment. The Contractor shall also provide each member or member household written notice of any change (that the State defines as "significant") in the information specified in this section at least 30 days before the intended effective date of the change. The Contractor shall notify all enrollees of their right to request and obtain the information listed in Section IV.K.1.f. at least once a year

i. A Provider Directory containing names, locations, telephone numbers, and non-English languages spoken by current contracted providers in the member's service area. This must include identification of providers that are not accepting new patients. The Provider Directory must be available on-line as well as in paper format. The on-line Directory must be updated monthly and the paper formats no less than annually.

ii. Any restrictions on the member's freedom of choice among network providers.

iii. Member rights and protections including grievances, appeals and State Fair Hearing procedures and timeframes.

iv. The amount, duration and scope of benefits available under the contract to ensure that members understand the benefits to which they are entitled as required in 42 CFR 438.10(b)(3) and 42 CFR 438.10(f – h).

v. Procedures for obtaining benefits, including authorization requirements.

vi. How after-hours and emergency coverage are provided, including what constitutes an emergency behavioral health medical condition, services, and post stabilization services, with reference to the definitions contained herein and the following:
   - **a)** The fact that prior authorization is not required for emergency services;
   - **b)** The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; and
   - **c)** The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract.

vii. The fact that, subject to the provisions of this section, the enrollee has the right to use any hospital or other setting for emergency care.

a) The post stabilization care services rules set forth as defined in 42 CFR 422.113(c);

b) Policy referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;

c) How and where to access any benefits that are available under the State Plan but are not covered under the contract, including any cost sharing, and how transportation is provided for those State Plan services; and

d) For a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.

viii. The Contractor shall provide information on the structure and operation of the PIHP

ix. The Contractor shall provide additional information on Physician Incentive Plans to include the associated federal definitions, applicability, basic requirements, determination of financial risk, prohibition for private MA fee-for-service plans, stop-loss protection requirements and pooling of patients. Upon request of the enrollee the contractor will disclose whether a Physician Incentive Plan that affects the use of referral services is used, and if so, the type of incentive arrangement it is, and whether stop-loss protection is provided.

Section IV.K.1.i.xv.a) is hereby deleted in its entirety and replaced with the following:
Grievance Process - Procedures
The member is allowed to file a grievance (complaint) with the Contractor or with the State. The contractor shall track the types of grievances and complaints and report quarterly to MLTC.

Section IV.L.1.g. is hereby deleted in its entirety and replaced with the following:
The Contractor shall make good faith efforts to ensure that all network providers from the current behavioral health Medicaid ASO Contractor that meet credentialing requirements participate in the Contractor's Provider Network and either develop, renew or amend service contracts prior to the contract start date.

Section IV.L.9.a.iii.a) is deleted revised in its entirety and replaced with the following:
Access standards are the standards for the timeliness of response for the assessment of Member need and the provision of services necessary to resolve the situation. The assessment of Member needs must be done in a manner that is consistent with applicable clinical practices, timelines and meets the needs for the Member. The timeliness of response will meet the requirements as defined in the emergent, urgent, or routine criteria for individuals already in service as well as individuals not currently in services.
The Contractor shall:

1). Establish mechanisms to ensure that network providers comply with the timely access requirements;

2). Shall monitor network providers regularly to determine compliance

3). Shall take corrective action if there is a failure to comply.

Section IV.L.12.a is hereby deleted in its entirety and replaced with the following:
The Contractor shall maintain and continually update a Network Provider Database that contains, at a minimum, the following information on network providers:

i. Network provider name;
ii. Contracted services;
iii. Site address(s) (street address, town, ZIP code, region of the state);
iv. Site telephone numbers;
v. Site hours of operation
vi. Emergency/after-hours provisions;
vii. Professional qualifications and licensing;
viii. Area of specialty relating to behavioral health conditions;
ix. Cultural and linguistic capabilities;
x. Malpractice insurance coverage and malpractice history;
xi. Credentialing status; and
xii. Profiling indicators.

Section IV.L.15.c.x. is hereby deleted in its entirety and replaced with the following:
Provide a newsletter that includes articles covering topics of interest for providers who work both with children and adults, that appropriate medical professionals are involved in writing the assigned articles, and that the newsletters are posted to the Contractor's website; and

Section IV.M.1. is hereby deleted in its entirety and replaced with the following:

1. REQUIRED CANDIDATES FOR CARE MANAGEMENT
   Care management will be provided, but not limited to, the following members with the attendant characteristics:
   a. CHILDREN:
      i. Hospitalized, recently released, and less than 12 years old;
      ii. Receiving sub-acute level of care and discharged back to a community setting; or
      iii. With mental health or substance use disorder diagnoses and at risk of out of home treatment or becoming a state ward.
   b. ADOLESCENTS:
      i. Pregnant adolescents with substance use disorder diagnoses
      ii. Ages 13 to 18 with two or more admissions within 60 days to inpatient or residential treatment with a diagnosis of bipolar or schizophrenia;
   c. HIGH RISK CANDIDATES:
      Adult, children, and adolescent high risk candidates

Section IV.M.3 is hereby deleted in its entirety and replaced with the following:
Clinical Advisory Committee
The Contractor shall develop, establish and maintain a Clinical Advisory Committee to facilitate regular consultation with experts who are familiar with standards and practices of mental health and/or substance use disorder treatment for adults, children and adolescents in Nebraska. The Clinical Advisory Committee must provide input into all policies, procedures and practices

associated with care management and utilization management functions, including utilization management criteria, clinical guidelines, and practice guidelines to ensure that they reflect up – to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in Nebraska. The committee shall meet on an as needed basis, but at least twice a year.

Section IV.M.9.c. is hereby deleted in its entirety and replaced with the following:
The Contractor and its subcontractors shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services. The Contractor shall develop these policies and procedures with the input, review and approval of the Clinical Advisory Committee, subject to approval by MLTC, and it shall implement such procedures as of the start date of the contract. The Contractor shall:

i. Incorporate the definition of medical necessity as specified in the Medicaid State Plan for covered behavioral health services, inclusive of service definitions and levels of care, into Contractor documents, where applicable;

ii. Place appropriate limits on service delivery (applying criteria, such as clinical guidelines for utilization control), provided the services that are delivered can be reasonably expected to achieve their purpose;

iii. Not arbitrarily deny a required service solely because of the Member's diagnosis, type of illness, or condition (this also applies to the Contractor's subcontracts);

iv. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

v. Consult with the requesting network provider, when appropriate; and

vii. Make authorization decisions and provide notice as follows:

a) Emergencies do not require prior authorization; and

b) For standard authorization decisions, make a decision and provide notice of any denial or decision to authorize services in an amount, duration, or scope that is less than requested as expeditiously as the Member's health condition requires and within the following timeframes:

1). For outpatient and rehabilitation services, as well as any non-24-hour diversionary service, the Contractor shall make a decision within fourteen (14) business days of the request, and shall provide a written notice to both the Member and the network provider on the next business day after the decision is made. To the extent possible, the Contractor shall develop provisions to notify providers electronically via secure means of authorization decisions;

2). For expedited service authorization decisions, where the network provider indicates and the Contractor determines that following the standard timeframe outlined immediately above could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum

function, or would cause a prudent layperson, possessing an average knowledge of medicine and health, reason to believe that their condition is of such a nature that failure to obtain immediate medical care could result in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, the Contractor shall make a decision and provide notice no later than three (3) business days after receipt of the request for service. The Contract may extend the three (3) business days' time period by up to fourteen (14) calendar days if the Member requests an extension, or if the Contractor justifies a need for additional information and documents how the extension is in the Member's interest (available for review upon MLTC request). For non-emergent expedited service authorization decisions, the Contractor shall make a decision as expeditiously as the Member's health condition requires, with a routine expectation that decisions are made within 24 hours in 50% of cases, 48 hours in 90% of cases, and never any longer than within three (3) business days after receipt of the request for service, other than in cases in which an extension to fourteen (14) calendar days is made. Such an extension to fourteen (14) calendar days shall be allowed only if:

i) The Member has had necessary treatment authorized to address the immediate needs of their health condition; and either

ii) The Member or the network provider requests an extension; or

iii) The Contractor can justify (to MLTC upon request) that (a) the extension is in the Member's interest, and (b) there is a need for additional information where there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

c) The Contractor shall notify the network provider orally and notify both the Member and the network provider in writing of any denial or decision to authorize services in an amount, duration, or scope that is less than requested on the day that the decision is made;

d) The Contractor shall not structure compensation to individuals or entities that conduct UM activities to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member, according to federal regulations at 42 CFR 210(e);

e) The Contractor shall require providers to maintain medical record content consistent with the utilization and control requirements of 42 CFR 456. For medical records and any other health and enrollment information that identifies a particular Member, the Contractor shall establish and implement procedures consistent with confidentiality requirements in 45 CFR parts 160 and 164; and

f) The Contractor shall develop procedures to provide for expedited resolution of appeals. The Contractor shall establish and maintain an expedited review process for appeals, when the Contractor determines (for a request from the Member) or the provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. The procedure shall incorporate the following requirements:

1). Protections against punitive action. The Contractor shall ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's appeal;

2). Action following denial of a request for expedited resolution. If the Contractor denies a request for expedited resolution of an appeal, it shall: (a) Transfer the appeal to the timeframe for standard resolution in accordance with the terms of this section; (b) Make reasonable efforts to give the Member oral notice (generally within 24 hours of the denial), and follow up within two (2) calendar days with a written notice;

3). This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an action or require a notice of action. The Member may file an appeal in response to this decision;

4). Failure to make a timely decision. Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the Contractor's decision. If a determination is not made by the above timeframes, the Member's request will be deemed to have been approved as of the date upon which a final determination should have been made;

5). The Contractor is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The Member or provider may file an expedited appeal either orally or in writing. No additional follow-up may be required; and

6). The Contractor shall inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

g) The Contractor shall develop or adopt clinical guidelines to govern the authorization of services provided under the contract. All clinical guidelines shall be in compliance with the requirements of Nebraska Administrative Codes and federal requirements:

1). Title 471 NAC 20-000 (Psychiatric Services) and Title 471, NAC 35-000 (Rehabilitation Services) for Members 21 years of age and older; and

2). Title 471, NAC 32-000 (Mental Health and Substance Use Disorder Treatment Services) for Members 20 years of age and younger.

h) The Contractor shall establish an internal UM Committee that focuses on oversight of clinical service delivery trends across individual Members, including evaluating utilization/patterns of care and key utilization indicators such as, but not limited to, re-hospitalizations within seven (7) days, high cost, high service utilization cases, high and low service use outliers, and access to care concerns. The UM Committee is chaired or co-chaired by the Medical Director and reports its findings to the Quality Assessment and Performance Improvement (QAPI) Committee. The UM Committee shall review, at a minimum:

1). Need for and approve any changes in UM policies, standards and procedures, including approval and implementation of clinical guidelines, and approving and monitoring the UM program description and work plan;
2). Grievances and appeals (including expedited appeals and State Fair Hearings) related to UM activities to address required changes;
3). Information from UM/CM operations relevant to system gaps are identified and shared with provider network staff through this committee; and
4). Results from internal audits of CM/UM (e.g., live call monitoring and documentation reviews) to effect changes in policies and procedures and plan training events.

i) The Contractor shall develop a UM Plan and shall implement service authorization procedures for specific behavioral health Covered Services, including, but not limited to the following categories of services:

1). Inpatient Service Authorization
The Contractor shall develop inpatient service authorization policies and procedures, submit them to MLTC for review and approval no later than one month prior to the contract start date, and implement them on the contract start date. Unless the Contractor proposes and MLTC approves alternative policies and procedures, the policies and procedures shall include, at a minimum, the following:

i) A plan and system in place to direct Members to the least intensive clinically appropriate service;

ii) A system for ensuring that, to the extent permitted by law, authorizations for inpatient admissions occur following a crisis assessment and determine that the admission of the Member is medically necessary;

iii) Processes to ensure placement for Members who require behavioral health inpatient services when no inpatient beds are available;

iv) A system for authorizing and assigning an initial length of stay for all admissions, and communicating information on the assigned length of stay to the Member, facility and attending physician;

v) A system of concurrent review for inpatient services to monitor the medical necessity of the need for continued stay and achievement of behavioral health inpatient treatment goals that includes provisions for multiple day approvals when the episode of care is reasonably expected to last more than one day, based on the medical necessity determination;

vi) A system for addressing discharge planning during initial authorization and concurrent review;

vii) A system to ensure post inpatient services is in place to support a safe, timely discharge plan;

viii) A system for conducting retrospective reviews of the medical records of selected inpatient authorizations, to assess the medical necessity, clinical appropriateness, and appropriateness of the level of care and duration of the stay; and

ix) A system for ensuring that the inpatient services network provider asks for the Member's consent to notify the Member's PCP that the Member has been hospitalized and to request from the NE PH-MCO's assignment of a PCP if the Member does not currently have one.

2). Outpatient and Rehabilitation Service Authorization.
The Contractor shall develop outpatient and rehabilitation service authorization policies and procedures, submit them to MLTC for review no later than one month prior to the contract start date, and implement them on the service start date. Unless the Contractor proposes alternative policies and procedures, the policies and procedures shall include, at a minimum, a system that operates 24 hours a day, seven days a week for:

i) Outpatient services;

1. A policy and system that reviews the initial treatment service request based on clinical guidelines and medical necessity and then authorizes up to 24 sessions without variance for the type of provider performing the service;

2. A policy and system that reviews and authorizes the need for additional services based on clinical guidelines and medical necessity, beyond 12 sessions; and

3. A policy and system for conducting retrospective review of cases to ensure medical necessity;

ii) Rehabilitation services:

1. A policy and system for reviewing provider requests for medical necessity and authorization of services for up to

six (6) months based on clinical guidelines and medical necessity;

2. A policy and system that reviews and authorizes the need for additional rehabilitation services beyond 6 months, based on clinical guidelines and medical necessity;

3. A policy and system for conducting retrospective review of cases to ensure medical necessity; and;

4. A policy and system for generally informing network providers of the Contractor's protocols for approving outpatient and rehabilitation services, such as including such protocols in the provider manual.

viii. The Contractor shall include a definition of "medically necessary services" in a manner that is no more restrictive than the State Medicaid program, and shall address the extent to which the Contractor is responsible for covering services related to the following:

(a). The prevention, diagnosis, and treatment of health impairments.

(b). The ability to achieve age-appropriate growth and development.

(c). The ability to attain, maintain, or regain functional capacity.

Section IV.M.12.a. is hereby deleted in its entirety and replaced with the following:
The Contractor must have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. The Contractor's QAPI program shall include constant evaluation of the Contractor's operations and the specialized behavioral health systems of care under its management. The Contractor's QAPI program shall be consistent with and responsive to the State physical health Medicaid managed care program, and the Contractor must be able to incorporate relevant variables from the State's Quality of Care Reporting System. At a minimum, the Contractor will utilize a quality improvement strategy to detect both under-utilization and over utilization of services and to assess the quality and appropriate ness of care furnished to Members with special health care needs. The Contractor's annual Quality Management Work Plan must be approved by the State of Nebraska

i. Compliance with State and Federal Requirements
The Contractor shall develop, implement, and maintain a comprehensive program for QAPI consistent with federal requirements at 42 CFR 438.204, and with the utilization management(UM) program required by CMS for MLTC's overall Medicaid program, as described in 42 CFR 456 – Utilization Control.

ii. Accreditation
The Contractor must either have NCQA accreditation, or another national certification, or it must show significant progress toward the establishment of NCQA accreditation, or another national certification. Official documentation must be submitted at the time of submission. In addition, the Contractor must have the capacity to report required HEDIS measures and performance measures.

The Contractor must include QM processes to assess, measure, and improve the QOC provided to Members in accordance with:

a) All QM requirements identified in the contract;
b) The DHHS CMS Quality Strategy;
c) All state and federal regulatory requirements;
d) Other applicable documents incorporated by reference;
e) Identify and resolve systems issues consistent with a continuous quality improvement (CQI) approach;
f) Disseminate information to MLTC, Members, providers, and key stakeholders, including families/caregivers, and promote public availability of data regarding performance;
g) Solicit feedback and recommendations from key stakeholders, subcontracts, Members, and families/caregivers, and use the feedback and recommendations to improve the quality of care and system performance; and
h) Track progress in implementation of, as well as measure and enforce adherence to, the Principles of Care defined in the Contract. Measurement and compliance with adherence to these principles shall be promoted and enforced through the following strategies, at a minimum:

1). Use of QAPI findings to improve practices at the subcontract and Contractor levels;
2). Timely reporting of findings and improvement actions taken and their effectiveness; and
3). Dissemination of findings and improvement actions taken and their effectiveness to key stakeholders, committees, Members, families/caregivers, and posting on the Contractor's website.

iii. Data Collection

The Contractor shall collect data and conduct data analysis with the goal of improving the quality of care within the behavioral health system. The Contractor's information system will support the QAPI process by collecting, analyzing, integrating, and reporting data necessary to the State's Quality Strategy. All collected data shall be available to the MLTC. The data shall provide information on areas including, but not limited to, utilization, grievances and appeals. The system shall also collect data on Member and provider characteristics as specified by the state and on services furnished to Members through an encounter data system. The Contractor shall ensure that data received from providers is accurate and complete by:

a) Verifying the accuracy and timeliness of reported data;
b) Screening the data for completeness, logic, and consistency;
c) Collecting service information in standardized formats to the extent feasible and appropriate;
d) The Contractor shall participate in the review of QI findings and shall take action as directed by MLTC;

e) The Contractor shall have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program;

f) The Contractor shall participate in developing, implementing, and reporting on performance measures and topics for performance improvement projects (PIPs) for Medicaid Members, as required by other state or federal agencies, including performance improvement (PI) protocols or other measures, as directed by MLTC; and

g) The Contractor shall report performance data to DHHS in formats approved, in advance, by MLTC.

h) The Contractor must report on performance measures and topics for performance improvement projects specified by CMS, in consultation with States and other stakeholders.

iv. Quality Improvement Staffing

The Contractor shall have a sufficient number of qualified personnel to comply with all QM requirements in a timely manner, including external quality review activities, and avoid review and monitoring activities unlikely to affect service delivery or quality of care.

v. Methodology

The Contractor shall further develop, operationalize and implement the outcome and quality performance measures listed above with the QAPI Committee, with appropriate input from, and the participation of, MLTC, Members, family members, and other stakeholders. The Contractor shall report to MLTC the results and findings of its outcome and performance measures compared to expected results and findings from performance improvement efforts and activities planned/taken to improve outcomes. The Contractor shall use an industry-recognized methodology, such as SIX SIGMA or another method(s) for analyzing data. The Contractor shall demonstrate inter-rater reliability testing of evaluation, assessment, and utilization management (UM) decisions.

vi. Satisfaction

The Contractor shall conduct an annual Member and provider satisfaction survey as directed and prior approved by MLTC, and it shall report complete results to MLTC. Satisfaction surveys shall include input from the QAPI Committee and the Contractor shall indicate to MLTC, in its attempt to obtain MLTC approval, specifically how family members, youth, and adult consumers have employed the design and methodology of each survey. In addition, surveys shall be conducted within the following guidelines:

a) Frequency

The Contractor shall measure the satisfaction of all Members served, Members with complex needs, and providers once during each contract year.

b) Implementation

The Contractor shall commence the collection of data on Members, Members with complex needs, and provider satisfaction via survey by the

end of the first year of operations and annually thereafter. The Contractor shall complete the data collection, analysis, interpretation and final reporting to MLTC by the end of the first year of the contract and annually thereafter.

c) Methodology of the Member Surveys
The methodology utilized by the Contractor shall be based on proven research methods ensuring an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of at least 95% and scaling that results in a clear positive or negative finding (neutral response categories should in general be avoided). The Contractor shall utilize measures that are based on current scientific knowledge and clinical experience. The survey shall specifically address satisfaction with and perceived utility of the appeal and grievance process for Members, their families, and providers. The Member survey will also include questions about perceptions of the utility of services, including:

1). Whether Members and guardians of child Members reported that they received the services they believed they needed;
2). Perceptions regarding participation in treatment; and
3). Access to prevention interventions.

d) Methodology of the provider Survey
The Contractor shall conduct a provider satisfaction survey using a provider survey instrument approved by MLTC. The methodology utilized by the Contractor shall be based on proven research methods ensuring an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of at least 95% and scaling that results in a clear positive or negative finding (neutral response categories should in general be avoided). The Contractor shall utilize measures that are based on current scientific knowledge and clinical experience. The survey shall, at a minimum, address the provider's satisfaction with the Contractor's services and other administrative services provided by the State or its agents, including but not limited to authorization, courtesy and professionalism, network management services, provider appeals, provider education, referral assistance, coordination, claims processing and the perceived administrative burden experienced by providers providing behavioral health services.

vii. Respondent Groups
a) Members and Members with special needs
Samples of Members 18 years of age and older and caregivers/family members of children and youth should be included in all Member surveys. Samples should be representative of Members and caregivers / family members based on the type of question asked.
b) Providers
For the provider survey, all providers should be administered the survey who are active in the claims system.

viii. Consumer – Led and Family – Led Evaluations
The Contractor shall include consumer-led and family-led evaluation methods in its quality monitoring system, involving as researchers: adult consumers, youth over the age of 17, and family members/guardians of child Members served. Methods may include participatory action research. There should be at least two focuses:

a) A consumer-driven evaluation of adult service issues;
b) A family- and youth-driven evaluation of child and young adult service issues; and
c) The consumer- and family-led evaluation component must be approved by MLTC prior to implementation. The evaluations should include appropriate incentives to promote consumer, youth and family participation in the evaluations. These evaluations should be:

1). Operated independently by consumers and family members and not administratively managed by the Contractor; and
2). Focused on evaluation to learn about the experiences of people served by the Contractor.

d) The Contractor must have a contract or a written and signed agreement with each organizational entity conducting consumer- and family-led evaluation that delineates roles and responsibilities of all parties;
e) Under the contract or written agreement, the consumer- and family-led evaluation team members will act as agents of the Contractor, and are, therefore, to have the same access to consumers and family members as the Contractor and network providers, insofar as it is necessary to perform their responsibilities;
f) Consumer- and family-led evaluation team members must be paid at least as much as other persons in the broader workforce doing similar work in the same community;
g) The consumer- and family-led evaluation team must be independent from any provider of behavioral health services or any other agency that might create a conflict of interest. If a team does not have accounting capabilities, it may contract with a provider as its fiduciary, provided the contract safeguards the independence of the evaluation team for program direction, including budget priorities, satisfaction surveys, findings, and recommendations;
h) The Contractor shall work with the consumer- and family-led evaluation teams to establish an annual plan for conducting evaluations;
i) The Contractor will ensure that the consumer- and family-led evaluation teams have adequate financial resources, training, support, and necessary equipment for the program to produce high quality quarterly reports;
j) The Contractor will identify and ensure that the consumer- and family-led evaluation teams conduct outreach efforts to under-served or un-served groups of consumers and families in order to identify system improvements that will increase the access, engagement and retention of these individuals in needed behavioral health services;

k) All employees of consumer- and family-led evaluation programs must comply with applicable state and federal laws, regulations, and rules regarding the confidentiality of mental health consumers and recipients of drug and alcohol treatment services;

l) The contract or written agreement will address confidentiality requirements;

m) Consumer- and family-led evaluation teams must provide feedback to the Contractor through written quarterly reports and regular problem resolution meetings that allow for dialogue and review of findings. The Contractor is responsible for timely reports back to the consumer- and family-led evaluation teams on specific actions and problem resolution resulting from identified issues, concerns and problems;

n) The Contractor will ensure that consumer- and family-led evaluation team members have both an initial orientation and on-going training in the following areas:

1). Basic knowledge of mental illness and addictive diseases and an understanding of the concept of recovery and resilience in relation to both adults and children and adolescents. Persons performing youth and family evaluation activities must also have an understanding of severe emotional disturbance and substance use disorders for children and adolescents;

2). Confidentiality regulations for mental health and substance use disorder services. Family and youth evaluation team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance use disorder services. Training must include an understanding of responsibilities, as applicable, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 CFR Part II; and

3). Orientation/training on the Contractor's managed care operations, policies and procedures for satisfaction team members.

o) Quarterly Reports. The Contractor shall provide MLTC with the consumer- and family-led evaluation teams' quarterly report summarizing consumer and family evaluation findings, as well as improvement actions and system changes implemented by the Contractor in response to those findings; and

p) The Contractor shall monitor and evaluate qualified service providers in order to promote improvement in the quality of care provided to Members. The Contractor shall detail a provider monitoring plan in the required Annual Quality Management Plan.

ix. Quality Reporting

a) Quality Management and Utilization Management Reporting
The Contractor shall monitor and report QM and UM data and other performance improvement activities to MLTC. The Contractor shall submit, in writing to MLTC, in a format collaborated with and approved by MLTC, the following, but not limited to, QM/UM deliverables related to the quality of care and services in the health plan:

1). The Contractor shall report results of measuring or assessing outcomes and quality, and shall incorporate these performance indicators into performance improvement projects. To the extent possible, results should be posted publicly on the Contractor's website immediately after being accepted by the QAPI Committee and reported to MLTC;

2). Any outcomes and quality indicators based on a sample of the overall Member, family, and/or provider population must include demonstration that the samples are representative and statistically valid. .Whenever data are available, outcomes and quality indicators should be reported in comparison to past performance and to national benchmarks; and

3). Outcomes and quality indicators will include to the extent practicable, but are not limited to, the following:

i) All of the metrics involved in the performance guarantees and incentives described in the Financial Section;

ii) Call center performance;

iii) Service utilization, including trends, outliers, expenditures, and length of stay in each service by level of care, including new services developed (for example, peer support and respite). This will include standard measures, such as use/days per 1000
Members and penetration rates overall and by level of care. This will also include breakouts by age group;

iv) Seven and 30-day post-discharge (residential and acute care) ambulatory follow-up appointments; and

v) Racial and ethnic disparities (e.g., under-utilization of services by particular racial/ethnic groups) and cultural and linguistic competency. The Contractor is encouraged to utilize indicators consistent with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to include, but not limited to:

1. Racial & Ethnic Disparities: PRTF admissions over 90 days; and
2. Differences in service penetration rates across population groups.

vi) Access – Differences in service penetration rates across population groups;

vii) Perceptions of Care – Differences across population groups' perceptions that services are effective, understandable and respectful (this includes consumer satisfaction);

viii) Restraint and seclusion use – Track by provider the number of incidents of restraints and seclusion by program location. Involve consumer and family advocates, along with inpatient and residential providers, in the development of restraint and seclusion reporting requirements;

ix) Provider network adequacy;
x) Results of targeted quality assurance network activities for high volume providers;
xi) Monitoring psychotropic medications for children ages 12 years and under, including vulnerable populations such as children in foster care or in state custody, when the BH MCO has such information;
xii) Performance related to grievances and appeals, including types, resolution time frames, and analysis of trends. This will include reporting of individual provider appeal rates and outcomes by level of care;
xiii) The actual number and percentage of Members involuntarily presenting for Mental Health and Substance Use Disorder treatment to 24- hour inpatient settings;
xiv) The actual number and percentage of Members presenting to hospital emergency departments (ED) within thirty (30) days of the discharge date from an acute level of care for any psychiatric or substance use disorder diagnosis – without an admission;
xv) Proportion of youth in PRTF and other residential settings with lengths of stay under 90 days;
xvi) Wait times for residential placement that measure time from initial referral to authorization to actual placement;
xvii) Admissions and readmissions to psychiatric inpatient (including PRTF) and residential facilities;
xviii) Continuity of care measures (within 7 days) from psychiatry inpatient facilities to community services;
xix) Number of children placed in residential treatment settings, relative to number of Medicaid Members, and relative to national benchmarks;
xx) Screening for Clinical Depression and Follow Up Plan;
xxi) Antidepressant Medication Management;
xxii) Adherence to Antipsychotics for Individuals with Schizophrenia;
xxiii) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment;
xxiv) Crisis services utilization, relative to number of persons (broken out by child/adolescent and adult) served and to national benchmarks; and
xxv) Emergency department utilization, using benchmarks and age breakouts.

x. External Quality Reviews

External Quality Reviews (EQR) /Independent Assessments. The Contractor and its subcontracts shall cooperate with annual, external, independent reviews performed by an EQR organization (EQRO) or independent assessor of quality outcomes, timeliness of and access to services, upon MLTC request. The Contractor shall include in its QM Work Plan, to be approved by MLTC, plans for addressing problem areas identified by the EQRO in its assessment.

b. MLTC QUALITY REVIEWS

The Contractor shall make available records and other documentation, and ensure Subcontractors' participation in and cooperation with, the annual on-site operation review of the Contractor, and any additional QM reviews. This may include participation in staff interviews and facilitation of Member/family/caregiver and subcontract interviews.

The Contractor shall use QM review findings to improve quality of care. The Contractor shall take action to address identified issues, as directed by MLTC, which may require a plan of correction, if the Contractor is determined by MLTC to be performing below quality standards.

The Contractor and its subcontractors shall cooperate with DBH and participate, as necessary, in SAMHSA core reviews of services and programs used by Members that are funded by DBH through the SAPT and CMHS Performance Partnership Grants, and are also enrolled in the Managed Medicaid program. Core review findings shall be communicated to the Contractor's QM program and shall be used by the Contractor to enhance and improve the delivery of grant related services for Members. The development and implementation of a corrective action plan with specific, measurable, and time-limited corrective action steps is also required if weaknesses/challenges are identified during the core review. The corrective action plan shall be approved and accepted by SAMHSA and/or MLTC.

c. PERFORMANCE IMPROVEMENT

As part of its QAPI program, the Contractor shall conduct at least two (2) performance improvement projects outlined in its annual Quality Management Work Plan that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on behavioral health outcomes and Member satisfaction. The Contractor shall report the status and results of each project to the state as requested and as outlined in the most recent Nebraska MLTC Quality Strategy Plan.

Each performance improvement project shall be completed in a reasonable time period, so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

At a minimum, the performance improvement projects shall involve the following:

i. Measurement of performance using objective quality indicators;
ii. Implementation of system interventions to achieve improvement in quality;
iii. Evaluation of the effectiveness of the interventions;
iv. Planning and initiation of activities for increasing or sustaining improvement; and
v. The Contractor shall include among its performance improvement projects at least one clinical issues study each contract year. The Contractor may submit more than one study idea, among which MLTC and the QAPI Committee will select one for approval.

a) During each year of the contract, propose to MLTC the scope of the clinical issues studies, by date TBD;
b) Submit to MLTC by date TBD or such other date as agreed to by MLTC and the Contractor, for their review and approval, a draft of the study

report for each clinical issue study. The study report shall, at a minimum, include recommendations for intervention;

c) Implement the report recommendations upon approval by MLTC and the QAPI Committee; and

d) Use a methodology based on accepted research practices ensuring an adequate sample size and statistically valid and reliable data collection practices. The Contractor shall use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate.

d. QUALITY IMPROVEMENT COMMITTEE

i. Quality Improvement Committee. The Contractor shall provide a mechanism for the input and participation of Members, Families/caretakers, MLTC and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.

ii. The Contractor shall form a QAPI Committee. The Contractor's Medical Director shall serve as either the chairperson or co-chairperson of the QAPI Committee. The number of committee members and required associated knowledge or field experience necessary to serve on the committee shall be determined by policy in the required Policy and Procedures material for this contract.

iii. The Contractor's QAPI Committee shall:

a) Review for approval prior to implementation the Contractor's QM Work Plan and program description that incorporates its initiatives, strategies, staff time and organization, methodologies for on-going quality assurance, quality improvement, and concurrent system for identifying issues that require immediate attention of MLTC;

b) Require the Contractor to study and evaluate issues that the MLTC may from time to time identify;

c) Establish annual performance targets as described in the Performance Targets and Withhold section;

d) Review for approval all Member and provider surveys;

e) Define the role and guidelines for the QAPI Committee, set agendas, and produce meeting summaries;

f) Annually, and as requested, provide data to the MLTC Quality Committee, which meets annually to review data and information relevant to the MLTC Quality Strategy. The Contractor shall incorporate into its QAPI program and annual QM Work Plan the recommendations from the MLTC Quality Committee concerning performance improvement projects, study methodologies, improvement goals, and interventions to achieve improvement goals.

iv. Additional required committees shall include:

a) Clinical Advisory Committee;
b) Corporate Compliance Committee;
c) Provider Advisory Committee; and
d) Utilization Management Committee.

The additional required committees will report on at least a quarterly basis to the QAPI Committee, and the QAPI Committee will monitor their performance as part of its annual quality management work plan.

Section IV.N.1. is hereby revised in its entirety and replaced with the following:
Health Information Systems - Requirements
The Contractor must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. Reporting formats will be determined by the State after contract award. Contractor must provide documentation on its Health Information System that ensure data received from providers is accurate and complete by:

a. Verifying the accuracy and timeliness of reported data;

b. Screening the data for completeness, logic, and consistency; and

c. Collecting service information in standardized formats to the extent feasible and appropriate.

Section IV.O.8. is hereby revised in its entirety and replaced with the following:
The Contractor shall designate its Key Personnel no later than before the Staffing Adequacy Readiness Review. Prior to the contract start date, the Contractor shall submit to MLTC the resumes of each Key Personnel position for MLTC approval and updated organizational charts. The Contractor shall have sufficient personnel working and operating in Nebraska during the transition period and implementation period in order to be fully compliant with the terms of the contract.

Attachment B
Capitation Rate Schedules. The capitation rates for the Contractor have been adjusted for the time period September 1, 2013, to June 30, 2013, and are set forth in Revised Attachment B, attached hereto.

C. The following sections are removed effective September 1, 2013, as follows:

Section IV.L.3.b.i. is hereby deleted in its entirety.

Section IV.L.9. a.iii.b)3). is hereby deleted in its entirety.

Section IV.L.10.a.ii.d. is deleted in its entirety.

D. NAME CHANGE: The parties agree to and hereby amend the Vendor Number and Vendor Name as follows:

Vendor Number: 2071380

Vendor Name: Magellan Behavioral Health of Nebraska, Inc

This amendment will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Name: Bo Botelho

Title: Material Administrator

Date: 11-27-13

Contractor: Magellan Behavioral Health of Nebraska, Inc.

By: _____

Name: Anne M. McCabe

Title: President, Public Sector Behavioral Services

Date: 10/31/13

State of Nebraska, Department of Health and Human Services

By: _____

Name: KERRY T WINTERER

Title: CEO

Date: 11/15/13

September 1, 2013 – June 30, 2014 Behavioral Healthcare Capitation Rates		
Rating Category	**FY11 Member Months**	**Capitation Rate**
CHIP	358,005	$15.92
Aged	211,207	$8.27
Blind / Disabled 18 and under / Katie Beckett	46,544	$51.20
Blind / Disabled 19 and over	365,053	$96.98
Families 0 through 5	690,381	$1.93
Families 6 through 18	671,424	$21.78
Families 19 and over	347,151	$19.58
Foster Care / Ward / Subsidized Adoption	138,482	$235.16
All Rating Categories Combined	**2,828,247**	**$35.55**

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
301 Centennial Mall South, 1st Floor
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-2401
Fax: (402) 471-2089

CONTRACT NUMBER
55286 O4

PAGE	ORDER DATE
1 of 2	02/28/13
BUSINESS UNIT	BUYER
25710178	RUTH GRAY (AS)

VENDOR NUMBER: 1544827

VENDOR ADDRESS:

MAGELLAN HEALTH QIO LLC
1221 N ST STE 700
LINCOLN NEBRASKA 68508-2018

AN AWARD HAS BEEN MADE TO THE VENDOR/CONTRACTOR NAMED ABOVE FOR THE SERVICES AS LISTED BELOW FOR THE PERIOD:

SEPTEMBER 01, 2013 THROUGH AUGUST 31, 2016

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 4166 Z1
Contract to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care for a period effective September 1, 2013 through August 31, 2016, with the option to renew for two (2) additional one (1) year periods as mutually agreed upon by all parties.

The State may request that payment be made electronically instead of by state warrant. ACH/EFT Enrollment Form can be found at: http://www.das.state.ne.us/accounting/forms/achenrol.pdf

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system mean the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

The contractor certifies that the contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The contractor also agrees to include the above requirements in any and all subcontracts into which it enters. The contractor shall immediately notify the Department if, during the term of this contract, contractor becomes debarred. The Department may immediately terminate this contract by providing contractor written notice if contractor becomes debarred during the term of this contract.
If the Contractor is an individual or sole proprietorship, the following applies:
1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at: www.das.state.ne.us.
2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation require to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

The contract shall incorporate the following previously submitted documents:
1. Contract Award;
2. Any Contract Amendments, in order of significance;
3. Any Request for Proposal Addenda and/or Amendments to include Questions and Answers;
4. The original RFP document;
5. The signed Request for Proposal form; and

CHIEF EXECUTIVE OFFICER
DEPARTMENT OF HEALTH AND HUMAN SERVICES

RK 3/11/13
BUYER 3/12/13
3-12-13
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
301 Centennial Mall South, 1st Floor
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Telephone: (402) 471-2401
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	02/28/13
BUSINESS UNIT	BUYER
25710178	RUTH GRAY (AS)

VENDOR NUMBER: 1544827

CONTRACT NUMBER
55286 O4

6. The Contractor's Proposal.

Vendor Contact: Sue Mimick, General Manager
Phone: 402-437-4214
Cell: 402-981-3547
Fax: 888-656-4925
E-Mail: smimick@magellanhealth.com

Vendor Contact: Glenn Stanton, Senior Vice President Business Development
Phone: 410-953-1242
Cell: 410-591-8085
Fax: 410-953-2427
E-Mail: gstanton@magellanhealth.com

(2/28/13 knj)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	CAPITATION PAYMENT FEDERAL 55% 09/01/2013-06/30/2014	49,389,803.0000	$	1.0000	49,389,803.00
2	CAPITATION PAYMENT STATE 45% 09/01/2013-06/30/2014	40,409,839.0000	$	1.0000	40,409,839.00
3	CAPITATION PAYMENT FEDERAL 55% 07/01/2014-06/30/2015	62,052,351.0000	$	1.0000	62,052,351.00
4	CAPITATION PAYMENT STATE 45% 07/01/2014-06/30/2015	50,770,106.0000	$	1.0000	50,770,106.00
5	CAPITATION PAYMENT FEDERAL 55% 07/01/2015-06/30/2016	64,974,241.0000	$	1.0000	64,974,241.00
6	CAPITATION PAYMENT STATE 45% 07/01/2015-06/30/2016	53,160,743.0000	$	1.0000	53,160,743.00
7	CAPITATION PAYMENT FEDERAL 55% 07/01/2016-08/31/2016	10,828,989.0000	$	1.0000	10,828,989.00
8	CAPITATION PAYMENT STATE 45% 07/01/2016-08/31/2016	8,860,081.0000	$	1.0000	8,860,081.00
	Total Order				**340,446,153.00**

BG (RK)
BUYER INITIALS

4166Z1
Response for Question 95

Potentional Eligibles* by Rating Category for RFP Response;
by County

*Based on June 2012 actual membership

County	Members
Adams	4,560
Antelope	724
Arthur	13
Banner	56
Blaine	59
Boone	417
Box Butte	1,669
Boyd	240
Brown	386
Buffalo	5,377
Burt	842
Butler	722
Cass	2,288
Cedar	637
Chase	438
Cherry	681
Cheyenne	938
Clay	860
Colfax	1,589
Cuming	888
Custer	1,212
Dakota	3,939
Dawes	1,050
Dawson	4,083
Deuel	215
Dixon	446
Dodge	5,289
Douglas	78,937

4166Z1
Response for Question 95

Potentional Eligibles* by Rating Category for RFP Response;
by County

*Based on June 2012 actual membership

County	Members
Dundy	221
Fillmore	602
Franklin	382
Frontier	259
Furnas	687
Gage	2,995
Garden	258
Garfield	230
Gosper	188
Grant	78
Greeley	261
Hall	9,976
Hamilton	831
Harlan	356
Hayes	61
Hitchcock	399
Holt	1,370
Hooker	56
Howard	583
Jefferson	1,049
Johnson	500
Kearney	755
Keith	973
Keya Paha	70
Kimball	472
Knox	1,175
Lancaster	33,562

4166Z1
Response for Question 95

Potentional Eligibles* by Rating Category for RFP Response;
by County

*Based on June 2012 actual membership

County	Members
Lincoln	4,864
Logan	62
Loup	56
Madison	5,145
McPherson	38
Merrick	972
Morrill	743
Nance	466
Nemaha	835
Nuckolls	499
Otoe	1,777
Out of State	2,488
Pawnee	310
Perkins	202
Phelps	1,008
Pierce	656
Platte	3,433
Polk	461
Red Willow	1,395
Richardson	1,201
Rock	144
Saline	1,623
Sarpy	12,927
Saunders	1,848
Scotts Bluff	6,536
Seward	1,196
Sheridan	696

4166Z1
Response for Question 95

Potentional Eligibles* by Rating Category for RFP Response;
by County

*Based on June 2012 actual membership

County	Members
Sherman	327
Sioux	61
Stanton	350
Thayer	576
Thomas	55
Thurston	2,236
Valley	490
Washington	1,352
Wayne	856
Webster	525
Wheeler	49
York	1,536
TOTAL	**236,898**

4166Z1

Response for Question 87

Eligibles by Rating Category for RFP Response; MHSA Plan only

	Jul 2011	Aug 2011	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012
Rate Cell	Members	Members	Members	Members	Members	Members	Members	Members	Members	Members	Members	Members
CHIP	28,108	28,479	29,086	29,314	29,303	29,754	29,913	30,142	29,682	28,518	28,803	29,113
Aged	8,497	8,420	8,550	8,532	8,473	8,430	8,425	8,424	8,491	8,246	8,385	8,407
Blind / Disabled 18 and under / Katie Beckett	3,381	3,401	3,413	3,463	3,459	3,492	3,489	3,502	3,522	3,507	3,520	3,531
Blind / Disabled 19 and over	22,694	22,741	22,973	23,016	22,981	22,977	23,040	23,125	23,106	22,608	23,019	23,204
Families 0 through 5	51,403	51,684	51,961	51,476	50,723	50,902	51,243	51,326	51,071	49,399	49,845	50,315
Families 6 through 18	51,673	52,132	52,826	52,360	51,717	51,998	52,802	52,999	52,716	51,208	51,829	52,769
Families 19 and over	24,495	24,833	25,203	24,755	24,132	24,264	24,551	24,501	24,382	23,631	23,982	24,127
Foster Care / Ward / Subsidized Adoption	11,327	11,337	11,238	11,184	11,167	11,195	11,155	11,177	11,265	11,220	11,196	11,040
Total	201,578	203,027	205,250	204,100	201,955	203,012	204,618	205,196	204,235	198,337	200,579	202,506

NEBRASKA
Administrative Services
Dave Heineman, Governor

Carlos Castillo, Jr.
Director

ADDENDUM FOUR

DATE: December 11, 2012

TO: All Vendors

FROM: Ruth Gray, Buyer
State Purchasing Bureau

RE: Second Round Questions and Answers for RFP Number 4166Z1
to be opened January 7, 2013

Following is an amended answer to Question 86 submitted for the above mentioned Request For Proposal. This Addendum is to be considered as part of the Request For Proposal.

QUESTIONS	ANSWERS
1. RFP Page 25; Project Description and Scope of Work; IV.D and IV.E Section D.3 states the Aged are eligibles within the scope of work, while Section E.6 states clients with Medicare are excluded. Please clarify the inclusion/exclusion of dual eligibles.	Medicare Savings Program/Qualified Medicare Benefits (MSB/QMB) are the only Medicare eligible clients excluded from Behavioral Health Managed Care. See NAC 469 Chapter 11 for additional information. All other Medicare beneficiaries are included in Behavior Health Managed Care.

QUESTIONS	ANSWERS
2. RFP Page 26; Substitute or Value-Added Behavioral Health Services; G. May a proposed Value Added service include a service that the BH-MCO provides directly (such as on-line education material on self-help methods for treating depression) or must it be a provider-based treatment in which a claim for a specific Medicaid member is generated?	A proposed Value Added service could be one that is directly provided by the Behavior Health Managed Care Organization.
3. RFP Page 37; Member Rights and Responsibilities; K.1.f.vii.b and c These sections require member education on benefits not furnished by the enrollee's PCP and also on benefits not covered under the contract. Please clarify the kinds of services you see the behavioral health Contractor educating the enrollee about, other than behavioral health services.	Per 42 CFR 438.10 Information Requirements, the BH MCO must provide information to enrollees on the BH MCO's referral policies for specialty Behavioral Health Services. In addition, the BH MCO must provide enrollees with information about how and where to access any benefits available under the State Plan.
4. RFP Page 51; Provider Network Development and Management Will vendors be permitted to accept accreditation reports from providers in lieu of a site visit for the purpose of credentialing?	The RFP is amended to read: Section IV. L.2.a.iii: Ensure that all facility providers are credentialed prior to becoming network providers.

QUESTIONS	ANSWERS
5. RFP Page 57; Care Utilization and Quality Management; M.8.a.iii This section requires the Contractor to cover services from a non-network provider if the network provider or other provider determines the services are needed and not all of the services are available within Network. Please claify that this is subject to prior authorization by the Contractor.	The BH MCO policy could include prior authorization of services from a non-network provider and subject to approval by MLTC.
6. RFP Page 57 and 59; Provider Network; L9.a.i and L.9.b.i.a Requires the Contractor to coordinate emergency and rural services at the regional level with each RBHA. Please clarify the intent of these sections.	The RFP is amended to remove “Delivery of emergency services should be coordinated the regional level with each RBHA” from Section IV.L.9.a.i. Additionally the RFP is amended to remove “and in coordination with the DBH RBHA for that region” from Section IV.L.9.b.i.a.
7. RFP Page 59; Care Utilization and Quality Management; M.9.c.i Requires that post stabilization services remain covered until the Contractor contacts the Emergency Room and takes responsibility for the enrollee. Please clarify that the physical health MCO is responsible for all Emergency Room services, regardless of whether they are post-stabilization.	No, the BH MCO is responsible for coverage and payment of emergency behavioral health services and post stabilization care.

QUESTIONS	ANSWERS
8. RFP Page 60; Care Utilization and Quality Management; M.9.c.ix It appears it is the intent to allow network providers to to pre-approve post stabilization services. Please clarify this approval is limited to the Contractor.	The intent of Section IV.M.9.c. is to comply with 42 CFR 438.114.
9. RFP Page 60; Care Utilization and Quality Management; M.9.c.vi This section implies that screening and treatment for an enrollee after they are stabilized from the emergency condition are required to be covered by the Contractor. Please clarify.	Please see response to question #7.
10. RFP Page 60; Care Utilization and Quality Management; M.9.c.vii Please clarify that it is intended that an enrollee in an Emergency Room setting is determined to be stable by a provider that is not part of the ER setting.	Please see response to question #8.
11. RFP Page 61; Provider Network; L.9.c.xii Please clarify that any of the listed condictions would end the contractor's financial responsibility for post-stabilization care. This means that item c would have an "or" instead of an "and".	Yes, item c should have an "or" instead of an "and".

QUESTIONS	ANSWERS
12. RFP Page 62; Provider Network; L.10.a.ii.d This section requires the Contractor's Care Management program to manage the member's care througout treatment. Please clarify that care management is not required for services that are not determined to be medically necessary.	Per L.10.a.ii.d, the BHMCO is required to provide care coordination throughout the member's treatment (as long as eligibility is maintained) to transition the member to a service that is medically necessary and appropriate to meet the member's needs.
13. RFP Page 76; Care Utilization and Quality Management; M.5.c.iii This section requires expedited access to Medicaid services following discharge from care coordination by the physical health plans. Please clarify. Do you really mean that the Contractor must collaborate with the physical health plans to ensure appropriate and expedited access for members that receiving care coordination services from the physical health plans, community health plans and FQHCs?	Section IV.M.5.c.iii. requires the BH MCO to support expedited access to covered and medically necessary behavioral health services, which means collaboration with the physical health MCO's.

QUESTIONS	ANSWERS
14. RFP Page 76; Care Utilization and Quality Management; M.5.c.iv and v These sections required expedited access to covered and medically necessary Medicaid service after discharge from the federal Indian Health Service and the Nebraska Pharmacy Program. To our knowledge, there were not be an occasion when the member would be discharged from these services and remain eligible for Medicaid. Please clarify.	The RFP is amended to remove Section IV.M.5.c.iv and v.
15. RFP Page 77; Care Utilization and Quality Management; M.5.a.ii The RFP states: "At the time when a BH provider initiates an evaluation and/or treatment for the member, the PH MCO is no longer responsible for a BH-related service. Authorization for BH services from that point forward must be obtained from the BH-MCO." Will a PCP prescribing psychotropic medication be required to receive authorization from the BH-MCO?	No.
16. RFP Page 79; Care, Utilization & QM, Utilization Management; IV.M.9.c Will the state allow the BH-MCO to request that ERs, providers, or hospitals contact the BH-MCO for initial authorization prior to admission to inpatient hospitals?	The BH MCO policy could include this requirement, and is subject to approval by MLTC.

QUESTIONS	ANSWERS
17. RFP Page 91; Care Utilization and Quality Management; 12.a.vi.a This section indicates the Contractor will survey all members and members with complex needs. Please clarify that two member surveys are required, as one is a subset of the other.	Yes, two member surveys are required; one for all members and one for all members with complex needs.
18. RFP Page 96; Care Utilization and Quality Management; M.12.ix.a.xxv This section requires reporting on ER utilziation, using benchmarks and age breakouts. Since the Contractor is not responsible for ER services, please clairfy how this information will be obtained.	Reporting of ER utilization is required as clarified in response to question #7.
19. RFP Page 98; Care Utilization and Quality Management; M.12.d.ii The RFP outlines a QAPI Committee containing 22 individuals (6 of whom are non voting). Since this big of a committee indicates the meeeting will be informational instead of a working committee, much of the work will need to be done in sub-committees. Please clarify that all identified individuals must participate in the QAPI Committee instead of subcommittes to the QAPI Committee.	The QAPI committee members and tasks are based on the policies and procedures of the BHMCO and must be approved by MLTC.

QUESTIONS	ANSWERS
20. RFP Page 102; Care Management and Coordination Information; 5.b.i Question 65 of the Q&As has a response to ammend the language in 5.b.i. Did the State mean to strike the sentence "if medications are prescribed, the Contractor must obtain a list of medications prescribed by primary care providers (PCPs) and other specialists for a complete and reconciled medication list that is updated every 90 days."?	Yes.
21. RFP Page 112 and 113; Quality Management Pages 112 and 113 reference Ambulatory follow up within 7 and 30 days of discharge from 24-hour facility (inclusive of acute inpatient, PRTF and residential) and requires measurement using current NCQA HEDIS specifications. Current HEDIS specifications does not use PRTF and residential in the calculation of Ambulatory follow up with 7 or 30 days. Will the behavioral health organization be required to provide a modified HEDIS measure (inclusive of acute inpatient, PRTF and residential) or the current NCQA HEDIS technical specification using acute inpatient only? Additionally, if the intent is to use a modified HEDIS definiton, please clarify how the benchmarks will be modified.	The performance measure specification will be developed in collaboration with the awarded bidder after contract award.

QUESTIONS	ANSWERS
22. RFP Page 113 and 95; Performance Measurement; n.11.v.9 and M.12.ix.a.3.xiv This section requires Emergency Room data not collected by the contractor because the contractor does not pay ER claims. Please clarify that the physical health plans will be required to provide detailed ER claim data in order that the Contractor may perform this calculation.	Please see response to question # 18.
23. RFP Page 114; Performance Measurement; N.111.v.10 This measure requires the Contractor to tract involuntary admissions. Please clarify what is meant by "involuntary admissions" and the source of such data.	The RFP is amended to remove Section IV N.11.a. Item # 10.
24. RFP Page 114 and 115; Quality Management Pages 114 and 115 reference HEDIS measures for Prescribed Attention Deficit Hyperactivity Disorder (ADHD) and Initiation and Engagement of Alcohol and Other Drug. Will the managed behavioral health organization only be responsible for the performance of the behavioral health providers with respect to these indicators?	See response to question # 21.

QUESTIONS	ANSWERS
25. RFP Page 117; Performance Guarantees and Incentives; IV.N.11.a.16 The gurantees and Incentives require an "Annual Facility Survey", yet on page 91 requires a "Provider Survey". We would interpert a provider survey to include satisfaction of all providers, an a facility survey to only include hospitals, residential centers, etc. Please clarify what is meant by facility in this context.	The IV.N.11.a. Performance Guarantees and Incentives require an annual professional provider satisfaction survey and an annual facility satisfaction survey. These two surveys meet the provider survey requirements on page 91.

QUESTIONS	ANSWERS
26. RFP Page 134; IV.J - Business Requirements: Describe your BH MCO's policies and procedures to ensure safeguards are in place which are at least equal to the Federal Safeguards of 41 USC 423, section 27; IV.J. - Business Requirements: Describe your BH MCO's policies and procedures to ensure safeguards are in place which are at least equal to the Federal Safeguards of 41 USC 423, section 27. We request clarification on what the State wants to see in response to the following provision under standard IV.J – Business Requirements from the RFP: "Describe your BH MCO's policies and procedures to ensure safeguards are in place which are at least equal to the Federal Safeguards of 41 USC 423, section 27." These sections of the US Code are applicable to the State when it contracts with a vendor to provide Medicaid Managed Care services and are not directly applicable to the vendor. Is the State seeking information on what our procedures are regarding Conflicts of Interest that concern State employees?	It is the intent of MLTC that comply with the State Conflict of Interest Safeguards in that the BH MCO may not contract with the state unless such safeguards at least equal to federal safeguards (41 USC 423, section 27) are in place.

QUESTIONS	ANSWERS
Question 26 continued: Is the State also seeking information on what our procedures are with regard to any current relationship or potential acquisition or any interest that gives the appearance of a conflict of interest related to this Request for Proposal or project?	
27. RFP Page 134; Methodology and Work Satement; IV.L. 7th on the page This question refers to 41 USC 423, Section 27 which relates to "Restrictions on disclosing and obtaining contractor bid or proposal information or source selection information". How is this applicable to the potential vendor?	Please see response to question # 26.
28. RFP Page 136; Provider Network Development and Management; 12 "Describe the timelines for credentialing and contracting and reports demonstrating your BH MCO's performance in compliance with these timelines..." Is this asking for the vendor to produce reports demonstrating compliance? Or is this asking for the vendor to describe reports that will be used to demonstrate compliance in the future?	Bidders must describe reports that will be used to demonstrate compliance in the future.

QUESTIONS	ANSWERS
29. RFP Page 137; Provider Network Development and Management; 26 Please confirm that the "network provider protocols" you would like addressed in this section refer to the items listed on page 65-66, Item 14.	Yes
30. RFP Page 138; Provider Network Development and Management; 32 "...describe you BH MCO's process to insure appropriate communication with the provider, follow-up communication with the member's PCP, and follow-up care for the member." Does the reference to PCP in this question refer to the member's primary behavioral health provider rather than medical PCP?	The reference to PCP in this question refers to the members medical PCP.

QUESTIONS	ANSWERS
31. RFP Page 141; Care, Utilization and QM The RFP states: Describe the content of your BH MCO's BH medical record, including the utilization control requirements and compliance with 42 CFR 456.42 CFR 456 describes utilization control requirements for facilities and includes a section on requirements for the facilities' written plan of care. Would the state like us to describe the content of the bidder's care management record (which contains the BH MCO's authorization information and description of treatment provided by the provider) or the content of the providers' medical record (which contains the providers notes about the treatment of the member)?	Bidders must describe the content of the BH MCO's care management record, including compliance with 42 CFR 456.42.
32. Attachment A; Medicaid Covered Services Under Adult Outpatient Assessment and Treatment, there is coverage provided for Psychiatric Nursing (in-home). Please clarify when the services are covered by the behavioral health contractor and when in-home nursing is covered by the physical health or in-home services vendor.	When the service is the Psychiatric Nursing service (which is a 1915(b)(3) waiver service), it is covered by the BH MCO.

QUESTIONS	ANSWERS
33. Q&A; Questions and Answers; 116 The response to Question 116 indicates the Contractor is expected to incldue PCPs in its provider network. In other instances, Q&As have clairified that PCPs are not required in the network. Please clarify.	The Behavioral Health MCO must cover services outlined in Attachment A when medically necessary. When these services are provided by the PCP, the BH MCO must cover. (For example when Invega Sustenna is administered by the PCP, it would be covered by the BH MCO.)
34. Questions and Answers; Questions and Answers; #44 re: RFP Page 73; Section: Care Management, M.4.b.ii.(e) The response states "The State requires more information to respond to this question, as the response to this question would depend on the type of care management support function." To clarify, could certified peer specialists working as part of the contractors Care Management/Care Coordination program provide interventions such as programs to support shared decision making with patients, their families, and the patient's representatives, activities to prevent avoidable hospitalizations, education and participation in self-management programs, wellness and health promotion activities, supports to promote empowerment, and advocacy, be considered care management support activities and therefore meet criteria for the QI Admin Charge described on RFP pg. xv 1.a. and c.?	Peer specialists are considered value-added services and would not be considered care management support activities and would not meet the criteria for the QI Administrative Charge.

QUESTIONS	ANSWERS
35. Questions and Answers; Sue Mimick The response states that "services provided by primary care or medical providers are not excluded." This is a double negative - please clarify the exclusion/inclusion of primary care and physical health provider services.	See response to question #33.
36. Questions and Answers; Questions and Answers; 112 This response suggests that behavioral health services provided by physical health providers are covered by the BHO. Is this response limited to the services in Attachment A? If so, will the vendor be permitted to hold a physical health provider to the same credentialing standards we have for traditional behavioral health providers and psychiatrists?	See response to question #33. Yes, the BH MCO will have to meet the credentialing standard outlined in IV.L.2.
37. Questions and Answers; Questions and Answers; 116.a Does the PCP here mean a behavioral health primary practitioner as suggested by the response to question #32? Or does it refer to the definition of PCP in the defined terms?	PCP refers to the PCP definition in the GLOSSARY OF TERMS.

QUESTIONS	ANSWERS
38. Questions and Answers; Questions and Answers; 32 Your response clarifying that the term primary care as used in this RFP suggests that throughout the RFP, references to the PCP may be the primary behavioral health provider rather than the physical health provider. Please identify any instances where the intent of the RFP is to refer to the medical PCP.	See response to question #37.
39. Round 1 Question; RFP Page 100; Section: Health Information Systems-Encounter Data, N.3.c. Should "all services provided to the member" instead read, "all covered services provided to the member?"; Round 1 State Response: Yes Round 2 Question: Please clarify that the MBHO would not be required to send denied claim information in the encounter files. For example, if the MBHO denies claims for non-covered services, wouldn't the State want to see those too?	The BH MCO is required to send denied claims information in the encounter file.

QUESTIONS	ANSWERS
40. Round 1 Question 65; RFP Page 102; Section Care Management and Care Coordination Information Will the State require the PH plans to obtain the signed Authorization to Disclose statement from the member to disclose MH/SA disorder treatment to PCPs that would allow the Contractor to fulfill this duty in compliance with State and Federal Law?; Round 1 State Response: The RFP is hereby amended to read: Section IV.N.5.b.i: The Contractor shall have the capacity to populate the Members' care management records with prescribed medications as identified through pharmacy data provided by DHHS. The RFP is hereby amended to remove e., f. and g. in Section IV.N.5. Round 2 Question: We understand that the State is providing monthly downloads of pharmacy data to the contractor. In order to provide the most optimal level of concurrent care coordination the State is requesting, we would like to receive this data on a daily basis. Would that be possible? If not, how often could it be provided?	The pharmacy data file can be provided weekly as claims are adjudicated in the MMIS on a weekly basis.

QUESTIONS	ANSWERS
41. Round 1 Question 66; RFP Page 103; Section: Claims Payment, N.7.a.i; Round 1 State Response: Yes. The contractor will be responsible for paying Medicaid covered behavioral health claims and any substitute or value added services. Round 2 Question: Please clarify that this refers to those services provided by behavioral health providers only and that processing claims payments to PH providers (PCPs and freestanding lab claims would be processed by the PH MCO).	The Behavioral Health MCO must cover services outlined in Attachment A when medically necessary.
42. Round 1 Question 99; Section: Do members sign a coordination form during the enrollment process so that coordination of care is managed efficiently across all levels of care?; Round 1 State Response: No. The member does not sign a coordination form during the enrollment process. Round 2 Question: Can this be added to the State's process with the inception of the new contract as a best practice to ensure coordination of care from the onset of treatment?	MLTC will consider implementing this process in the future.

QUESTIONS	ANSWERS
43. Round 1 Question 33; RFP Page 32; Section: Section Business Requirements, J.12 Clinical Laboratory Improvement Amendment – please clarify the relevance of this section for this behavioral health RFP; Round 1 State Response: Laboratory results prepared by clinical laboratories, as ordered by Contractor providers and paid using Medicaid funding, must provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Round 2 Question: In the States response to question 106, lab is not included in the cap. Will this be removed from the RFP since the MBHO is not responsible for freestanding lab services?	Laboratory services are included in the capitation rate. See Attachment D.

QUESTIONS	ANSWERS
44. Round 1 Question 100; Section: Section: Data Accuracy It is stated that the incurred dollars have been reconciled; however, there may be inaccuracies in the underlying data. Can you quantify the variance for each FY? If data inaccuracies may be present, please indicate the likely category/area of any discrepancy? Are services represented only for BH providers or are there PCP services included that may not traditionally be risk for MBHOs.; Round 1 State Response: The Data Book represents the State's best efforts to present the historical membership, utilization and cost levels by rating category and service category. The variance will not be quantified and the State cannot opine on the likely category / area of potential discrepancies. As stated, the data was reconciled. Round 2 Question: You have indicated the data represents services provided by behavioral healthcare providers only (no PCP or lab utilization). The State contradicts itself in Round One answers by stating lab and PCP BH services are both in and not in the cap.	See Attachment D for the listing of services included in the capitation rate. Also see page 4 of Attachment C. See also response to question # 33.

QUESTIONS	ANSWERS
Question 44 continued: Please confirm that BH services provided by a PCP and lab work performed by free-standing labs (i.e., not in the provider's offices) are excluded from the capitation to be consistent with the exclusion of this data from the Data Book.	Answer on previous page.
45. Round 1 Question 109; Round 1 State Response: The response lists 10 categories of Medicaid clients excluded under the current ASO contract with Magellan. Round 2 Question: Will these 10 categories of clients also be excluded under the new managed Medicaid program?	No. The category of clients excluded from Behavioral Health Managed Care are listed in section IV.E
46. Will developmentally disabled individuals who are living in the community be included in the covered population? If not, what is the cutoff definition for eligibility/ineligibility?	Yes, clients receiving services through the 1915(c) waiver are included in Behavioral Health Managed Care.
47. Can MBHO negotiate rates with providers for less than the Medicaid fee schedule?	Yes.

NEBRASKA
Administrative Services
Dave Heineman, Governor

Carlos Castillo, Jr.
Director

ADDENDUM THREE

DATE: November 21, 2012

TO: All Vendors

FROM: Ruth Gray, Buyer
State Purchasing Bureau

RE: **Revised Question and Answer for RFP Number 4166Z1**
Question 86
to be opened January 7, 2013

Following is an amended answer to Question 86 submitted for the above mentioned Request For Proposal. This Addendum is to be considered as part of the Request For Proposal.

QUESTIONS	ANSWERS
86. Attachment C This does not recognize incentive that is discussed on page 16 item CC. Is the incentive provided outside of the stated capitation payment?	No, the incentive is considered in the stated capitation rates.

ADDENDUM TWO

DATE: November 20, 2012

TO: All Vendors

FROM: Ruth Gray, Buyer
State Purchasing Bureau

RE: Questions and Answers for RFP Number 4166Z1
to be opened January 7, 2013

Following are the questions submitted and answers provided for the above mentioned Request For Proposal. The questions and answers are to be considered as part of the Request For Proposal.

QUESTIONS	ANSWERS
1. We did review 44-4701 which led to my question below. We understand the list of items, however, one of the items is an application on a "form prescribed by the director". We were not able to locate the application form on the "Forms" section of the website, which prompted my question to you. Are you able to provide us with the application form needed for the PLHSO license?	Bidders must acquire the necessary forms from the Department of Insurance.

QUESTIONS	ANSWERS
2. RFP Section: Glossary of Terms Per the definition of "licensing" on page "X" of the RFP, please confirm any Bidder not licensed as required by the Nebraska Department of Insurance (DOI) at the time of proposal submittal may (i) submit an attestation that the appropriate licensure will be obtained prior to a executing a contract with MLTC and (ii) provide verification that the licensure is not suspended, revoked, denied or found to be noncompliant by Nebraska DOI at the time of contracting, if awarded.	ADDENDUM ONE is rescinded. The RFP is hereby amended to: a. Remove Licensing from Glossary of Terms, page x; b. Remove II.L.5 (page 6); and c. Add the following language to IV.J.2. Managed Care Organization Licensure: Bidders must acquire appropriate Nebraska licensure and provide proof-of-licensure with the proposal. If the Bidder is not licensed as required by the Nebraska Department of Insurance (DOI) at the time of proposal submittal, the Bidder shall attest that the appropriate licensure shall be obtained prior to executing a contract with the State. The Bidder shall provide verification that the licensure is not suspended, revoked, denied or found to be noncompliant by Nebraska DOI at the time of contracting.
3. RFP Section: B. Provider Network; Page 130 This section references “The following deliverables, at a minimum, will be due under a contract resulting from this procurement.” However, there are no deliverables listed below the question. Please clarify where these deliverables are listed in the RFP.	The referenced sentence, “iv. The following deliverables, at a minimum, will be due under a contract resulting from this procurement”, should be a stand-alone sentence. It refers to the following sections: **c. Member Communications** through **j. Policies and Procedures**. The bidder must acknowledge and demonstrate an understanding of sections c. – j. in their proposal response.
4. RFP Section: 12.a.II. Management; Page 89 In the Scope of Work (SOW), the RFP states that “The Contractor must include QM processes to assess, measure, and improve the QOC provided to Members in accordance with: a) All QM requirements identified in the contract; Is the reference indicating the SOW or is there a sample contract? If this is referring to a sample contract, please provide the sample contract.	Section 12.a.ll is referencing the Scope of Work. There is not a sample contract provided with the RFP. Reference Section III. A. General which outlines the components of the final contract.

	QUESTIONS	ANSWERS
5.	RFP Section: III. Terms and Conditions; Page 16 Please clarify in section DD. if the 1.5% of incentives is included in the 3% profit limitation or separate.	The 1.5% of potential contract incentives is considered separate from the 3.0% profit limit calculation.
6.	RFP Section: III. Terms and Conditions; Page 18 The RFP states in section II. that the contract is for a pre-paid contractor. Please clarify if section II. Invoices is applicable.	In Section III. Terms and Conditions; "Invoices" are part of the standard RFP boilerplate. Invoices are not applicable to this Request for Proposal.
7.	RFP Section: IV. Project Description and Scope of Work; Page 25 Does item 1 in section E. Excluded Populations mean that the contractor will not be at-risk for any members who gain retroactive eligibility, or just Medicaid?	The Contractor will be responsible for members enrolled during the month of enrollment. The Contractor is not at risk for the period of retroactive Medicaid eligibility.
8.	RFP Section: O. Transition and Implementation; Page 110 Please provide the current metrics for the performance measures in number 11 under Performance Measurement.	The metrics will be developed in collaboration with the awarded bidder.

QUESTIONS	ANSWERS
9. RFP Section: k. Methodology/ Work Statement; Page 133 In section k. Methodology/Work Statement, letter i. states that: "In addition to the specific requirements outlined in the text of this document, bidders must respond to the statements and questions contained in the chart below. Responses must be complete and succinct. These statements and questions relate directly to the major program elements described in Section IV Project Description and Scope of Work." Further, letter ii. States: "The bidder's responses to these statements/questions are in addition to information requested in other sections of the RFP. It is expected that the bidder not limit its proposal to just responding to these questions/statements. Referencing to requirements section F. SUBMISSION OF PROPOSALS, the proposal states that "Elaborate and lengthy proposals are neither necessary nor desired." Is the bidder expected to answer in full both the requirements and questions or is it the state's desire that the bidder incorporate the requirements outlined in Section IV. Project Description and SOW into section k. Methodology/Work Statement questions?	The bidder is expected to respond in detail to both the requirements and questions in Section IV. and also incorporate responses into Section K.Methodology/Work Statement.
10. RFP Section: k. Methodology/Work Statement; Page 133 The questions in the table are broken out with denotation of the SOW section they reference only. Some of the SOW sections have multiple questions. Is it the state's wish for the bidder to respond to these questions in the table format? If the state prefers a narrative response, not in the table layout, does the state allow the bidder to further number the questions (i.e. IV.J.1, IV.J.2, IV.J.3) so that the layout of questions is clear?	The bidder must respond to all questions/statements/comments in Section IV. It is at the bidders discretion to choose either a narrative or table format. No, the bidder must not further number the questions.

QUESTIONS	ANSWERS
11. RFP Section: k. Methodology/Work Statement; Page 139 In section IV.L under Provider Network Development and Management, the following question is repeated "If your BH MCO proposes to use Subcontractors to provide any of the services provide a listing of those Subcontractors with their experience in providing care to Medicaid members and a description of the services they will provider if not already described." If it is not the state's intention for the bidder to respond to the same question twice, than should one of these items be omitted?	Section IV.L under Provider Network Development and Management, the RFP is hereby amended to eliminate the duplication statement that reads: "If your BH MCO proposes to use Subcontractors to provide any of the services provide a listing of those Subcontractors with their experience in providing care to Medicaid members and a description of the services they will provider if not already described."
12. RFP Section: IV. Project description and Scope of Work; Page 25 Is the state expecting a full narrative response to requirements such as E. Excluded Populations?	The bidder must provide a response to all areas outlined in the RFP requiring a response. Excluded Populations is an example of an area not requiring a response.
13. RFP Section: V. Proposal Instructions; Page 147 If it is the state's desire that the bidder respond to each of the requirements as outlined in Section IV Project Description and Scope of Work separately in a full and complete narrative, than please clarify where this is to be included in the Technical Proposal submission layout.	The bidder is to respond to each of the requirements as outlined in Section IV Project Description and Scope of Work as part of their technical proposal response.
14. RFP Section: V. Proposal Instructions; Page 147 In section V. letter I. Technical Approach ii. please provide clarification. Is the "Proposed Implementation Approach" identified referring to the questions in k. Methodology/Work Statement beginning on page 133?	Yes, the proposed implementation approach is referring to the questions in k. Methodology/Work Statement.
15. RFP Section: V. Proposal Instructions; Page 147 Please clarify whether section V. letter I. Technical Approach i. is the "Understanding of the Scope of Work" referring to the response to the requirements outlined in section IV. Project Description and Scope of Work? Or is this intended to be a summarized restatement of understanding?	Section V. Technical Approach is referring to the requirements outlined in Section IV. It is not intended to be a summarized restatement of understanding.

QUESTIONS	ANSWERS
16. RFP Section: P. Finance, Reporting Requirements and Rate-Setting; Page 132 In section h. under Quarterly Reporting to MLTC, the following questions are repeated as c) and d) "a) Crisis services utilization, relative to number of persons (broken out by child/adolescent and adult) served and to national benchmarks;" and "b) Emergency department utilization, again using benchmarks and age breakouts;" If it is not the state's intention for the bidder to respond to the same questions twice, than should one of these items be omitted?	No, it is not the state's intention that the bidders answer the same questions twice. Section IV. P. is amended to remove c.) and d.).
17. Can MLTC please provide a list of bidders who have submitted questions or otherwise indicated that they might possibly bid? Can MLTC also provide contact information for the bidder and their lead representative?	The State can only release those documents subject to a public records request and in accordance with Neb. Rev. Stats. §§84-712 et seq.
18. RFP Section: III. Terms and Conditions; Page 16 Please clarify in section DD if the max is 4.5% including incentives or if the 1.5% is already included in the 3% profit corridor.	See response to question #5.
19. Section: General There are multiple references to other state agencies and some specific requirements regarding data sharing, reporting and care coordination. Since Medicaid funds may not be used for a non-Medicaid purpose, please confirm that the contractor is responsible only for information and reporting for the enrolled Medicaid members for which we receive data and that care coordination is limited to those Medicaid members who may be receiving services through other State agencies in addition to Medicaid funded services	It is correct that the contractor is responsible only for information and reporting for the enrolled Medicaid members.

QUESTIONS	ANSWERS
20. Page 1; Section: Scope of the request for proposal States that the initial term is three years effective from the date of contract award through June 30, 2016. If contract award is April 15, 2013, the amount of time transpiring from contract award through June 30, 2016 is three years and two and one-half months. The amount of time transpiring from contractor start date, September 1, 2013 through June 30, 2016 is two years and ten months. Could you please clarify the three year initial term?	The RFP is hereby amended to read as follows: A contract resulting from this Request for Proposal will be for a period of three (3) years effective from Contractor start date with the option to renew for two (2) additional one (1) year periods as mutually agreed upon by all parties.
21. Page 6; Section: Procurement Procedures, N Are the capitation rates subject to premium tax? If so, what is the premium tax rate and will the capitation rate be adjusted to include this tax?	The bidder should verify with the Department of Insurance any requirements for a premium tax. Premium taxes are not included in the capitation rate.
22. Page 8 and 143; Section: Terms and Conditions Page 8 of the RFP requests the bidder to "... provide a binding signature of intent to comply." Pages 8-23 include the Terms and Conditions and provide a place for Accept & Initial. However, page 143 does not include the terms and conditions as a section to be submitted. Please confirm that these pages must be initialed and submitted.	By signing the "Request For Proposal For Contractual Services" form, the bidder guarantees compliance with the provisions stated in the Request for Proposal, agrees to the terms and conditions and certifies bidder maintains a drug free work place environment. Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. Bidder should return the Terms and Conditions in Section III of the RFP with its proposal response. Bidder should accept and initial the Terms and Conditions in Section III of the RFP and return with its proposal response.

QUESTIONS	ANSWERS
23. Page 16 and Data Book; Section: Administrative Spending Cap What is the process of obtaining approval or acceptance of administrative costs greater than 7%?	Administrative costs can only exceed 7% for approved QI expenses defined on RFP page xv. MLTC will answer any questions related to QI and Non QI expenses during the Operational and Financial Readiness Review as outlined on RFP page 109. As part of the Quarterly and Annual Financial Reporting Package (RFP pages 16 and 126), the Contractor will submit reports related to the Risk Corridor calculation (which will include the administration expenses itemized by functional areas for purposes of meeting the administration expense tests on RFP page 125). MLTC then reserves the right of audit (RFP Page 29) to ensure administrative expenses were categorized pursuant to the Contract.
24. Page 16; Section: Terms and Conditions, Penalties This item states the State may withhold all monies due and payable to the contractor. Does this include the claims portion of the capitation? If so, what will be the cash source for the contractor to continue to be able to pay claims?	In the event that the contractor fails to perform any obligation under the contract, the State may withhold all monies due and payable to the contractor, without penalty, until such failure is cured or otherwise adjudicated. In the extraordinary event monies are deemed necessary to withhold, amounts withheld will be commensurate with the obligation being unmet.
25. Pages 16 and AttC; Section: Terms and Conditions – Administrative Spending Cap If Administrative expenses can be up to, but not exceed, 10% of contractual cap due to necessary administrative spending used to improve the health status of members served, why was this not taken into consideration in the development of the offered capitation rate? Attachment C states that an administration load of 7% was considered.	It is the expectation of the State that the capitation rate being offered is appropriate for an Contractor to achieve appropriate profits with an administrative expense load to accommodate both QI and Non-QI expenses. The capitation rate being offered has 10% retention built in for administration and profit; in addition, 1.5% of potential contract incentives are being offered.
26. Page 16; Section: Terms and Conditions This section refers to Contractor Incentives of at least 1 ½ % - is this outside of the capitation rates? Can you also clarify the maximum value, when it says 'at least'? How does this relate to those items in the Performance Measurement section?	See responses to questions #5 and #67.

QUESTIONS	ANSWERS
27. Page 17; Section: Terms and Conditions – Performance Bond Performance Bond – would state consider parental guarantee in lieu of a performance bond?	No, the State will not consider a parental guarantee in lieu of a performance bond.
28. Page 20; Section: Best and Final Offer Is this intended to be an opportunity to improve on the technical proposal, since the capitation rates are offered?	No, the Best and Final Offer is part of the RFP standard boilerplate and is not relevant to this RFP.
29. Page 26; Section: Covered Services, F. Page 26 indicates the "Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition;" Is this indicating that diagnoses such as Pervasive Developmental Disorder (including Autism) will now be covered?	The successful Contractor will be responsible to provide the medically necessary Behavioral Health services listed in Attachment A. These services do not included Pervasive Developmental Disorder or Autism.
30. Page 29; Section: Reinsurance Is a plan of self-insurance subject to an approval process? If so, what are the criteria for evaluation and approval?	The RFP is hereby amended to read in Section IV.J.4: "The Contractor shall provide MLTC the risk analysis, assumptions, cost estimates, and rationale supporting its proposed reinsurance agreements." (4th paragraph.)
31. Page 31; Section: Administration Staffing, 9.xi Is the Tribal Network Liaison required to be a full-time position? In some sections of the RFP it suggests it is and in others it suggests a function to be performed by a staff person to be identified.	The decision to determine the full or part time status of the Tribal Network Liaison is at the discretion of the BH MCO as long as the duties are successfully performed in accordance with the job descriptions and the work is performed in compliance with the Contract.
32. Page 32; Section: Business Requirements, J.9.10.a Adequate Capacity, a. Appropriate range of preventive, **primary care** and specialty services that is adequate for the anticipated number of enrollees for the service area… As this is a behavioral health managed care contract, please clarify.	For the purposes of this RFP, preventive, primary care, and specialty services are those behavioral health services reflected in Attachment A.

QUESTIONS	ANSWERS
33. Page 32; Section Business Requirements, J.12 Clinical Laboratory Improvement Amendment – please clarify the relevance of this section for this behavioral health RFP.	Laboratory results prepared by clinical laboratories, as ordered by Contractor providers and paid using Medicaid funding, must provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process.
34. Page 33; Section: Fraud Waste and Abuse, J.13.i Section 13(i) requests our methodology to recover overpayments and sanction providers. However 13(f) requires a policy for referral of suspected fraud and abuse to MLTC Program Integrity. This section also requires reports of all cases that require preliminary investigation, including the disposition of the case, implying that contractor will handle the investigation and disposition. This is contradicted by Item (m) which states that MLTC "will seek all appropriate remedies for fraud.." What remedies for fraud, waste, and abuse will be available to the MCO and which will be reserved for MLTC?	It is expected that the Contractor have policies and procedures for investigation and disposition of fraud, waste, and abuse. It is also required that the Contractor report such cases to MLTC for determination of any further action.
35. Page 43-44; Section: State Fair Hearing, K.vii.a)(1) Section (vii)(a)(1) requires the member to exhaust the contractor appeal process before requesting a state fair hearing. On the next page (vii)(a)(4) specifically permits the member or provider to request a state fair hearing at the same time a contractor appeal is filed. The next item again states that the appeal process must first be exhausted. The bottom of p. 46, section (xiv)(b) again states that a state fair hearing may be requested at the same time an appeal is filed. Please clarify.	A member may request a State Fair Hearing within ninety days from the date on the original notice of action. The RFP is hereby amended to remove Section (vii)(a)(1) requiring the member to exhaust the contractor appeal process before requesting a state fair hearing.

QUESTIONS	ANSWERS
36. Page 48; Section: Establishing the Network There is a requirement that the MBHO have a network of crisis response providers available 24/7. Crisis response is not listed as a covered benefit in Attachment A and is currently a non-Medicaid service covered by the Division of Behavioral Health. Please clarify the expectations for the Medicaid program as crisis stabilization services are not identical to crisis response.	The RFP is hereby amended to remove Section IV. L.1.b. requiring the MBHO to have a network of crisis response providers available 24/7.
37. Page 63; Section Provider Quality Management Strategy, 11.f Implement and submit subject to MLTC approval, a network management strategy to engage with primary care providers, specialty providers, high-volume prescribers, and hospital emergency departments to improve access for Members who may be under- or over-utilizing behavioral health services. Please clarify how this addresses access as this would be a coordination of care, to ensure that services are appropriate and timely.	The State considers this requirement to be a key component of Provider Quality Management Strategy by identifying access issues through the over/under utilization of services.
38. Page 64; Section: Network Provider Policy and Procedure Manual/Handbook, 13.a.ii.h) Administrative and billing instructions, including a list of procedure codes, units and payment rates. As the MCO would be negotiating and establishing rates, this information be proprietary. Is it necessary to include this information in the handbook?	No, it is not necessary for this information to be included in the handbook.
39. Page 66; Section: Network Provider Protocols, 14.a.v.a) Inform MLTC immediately upon enrolling any provider who is not also a NE **PH** Medicaid provider in its Provider Network. Should this read a “NE BH Medicaid provider”? If not, please clarify.	Yes, the statement should read a “NE BH Medicaid provider”.

QUESTIONS	ANSWERS
40. Page 66: Section: Network Provider Protocols, 14.a.ii.c. The requirement to coordinate care for members receiving services from other state agencies is listed under requirements for reporting adverse incidents. This appears to be an error. Please clarify.	The RFP is hereby amended to remove 14.a.ii.c).
41. Page 67, Section: Provider Advisory Committee, L.15.b There are a large number of examples of "major provider organizations" and other potential members. Please confirm that making invitations to these organizations is sufficient to meet the requirement as participation can not be promised by the MBHO.	The Contractor is expected to extend invitations, provide examples of the benefits of participation, assure collaborative communication processes and generally provide a good faith effort to establish ongoing and seamless communication.
42. Page 71; Section: General Requirements for Care Management, M.1.b.iii Section b, item iii. Why are adults listed with Adolescents? Is this a typographical error or will adults not be expected to be a covered Care Management population?	Adults are considered to be a covered Care Management population. They were included with “Adolescents” in this category in error.
43. Page 72; Section: Care, Utilization and Quality Management, M.4.b.ii.a) States that the clinicians that authorize services must be LIMHP, psychologists or psychiatrists. Would RNs be acceptable, particularly with the expectations regarding coordination with co-morbid physical health conditions? Additionally, LMHP clinicians would appear to meet the intent of this section.	The Contractor shall ensure that only professionals acting within the scope of all applicable state laws and their professional licenses shall make final decisions regarding medical necessity determinations.
44. Page 73; Section: Care Management, M.4.b.ii.(e) Would the care management support functions relevant to peers and family members be reimburseable as a Medical Cost or a QI Admin charge?	The State requires additional information to answer this question, as the response to this question would depend on the type of care management support function. Please refer to page xv. Quality Improvement (QI) Expenses and the definition for substitute or value added behavioral health services, page 26.

QUESTIONS	ANSWERS
45. Page 74; Section: Care Management, M.4.I This requires that the MBHO determine if the care management member has PCP and if not refer them to the Medicaid PH provider. Since every member is enrolled with a Medicaid PH Health Plan responsible for physical health care, would not the responsibility for assigning a PCP be their responsibility?	The RFP is hereby amended to remove IV.M.4.b.ii.I.1.2.3.4.5.6.7.8. and 11.).
46. Page 74; Section: Care Management, M.4.i.1) It would seem reasonable to allow psychologists to deny psychological testing, can this be modified to accomidate?	When a psychologist is practicing within their scope of practice, they may deny psychological testing.
47. Page 75; Section: Care Management, M.4.I.6, 7 and 8. Please confirm that the responsibility for care coordination for members who are receiving DBH, DCFS and DDD services are those Medicaid members also receiving services from those entities. Please inform on how the Contractor will be notified, or have access to DBH, DCFS and DDD data to indicate that coordiantion is needed.	See response to question #45.
48. Page 75; Section: Care Management, M.4.I.11 How is the MBHO going to be alerted to Children with SED or with behavioral challenges in contact with multiple agencies serving children as we will only receive Medicaid data?	See response to question #45.

QUESTIONS	ANSWERS
49. Page 77; Section: Care, Utilization, and Quality Management, M.6.a.ii Regarding the statement, "At the time when a BH provider initiates an evaluation and/or treatment for the member, the PH MCO is no longer responsible for a BH-related service. Authorization for BH services from that point forward must be obtained from the BH-MCO" how does this impact the authorization and payment of psychotropic medication prescribed by a PCP while the member is receiving psychotherapy from a BH provider?	It is expected that care between the PH MCO and the BH MCO is coordinated and each provider is providing treatment, as medically necessary.
50. Page 86, Section: Retrospective Utilization and Review of Network Providers, M.10.h.c. Please confirm that the requirement for tracking the utilization of out-of-home placements for children is limited to those that have been admitted as a result of a behavioral health authorization as a Medicaid member.	Yes.
51. Page 88; Section: EPSDT, M.11.e Please clarify the requirement that "The contractor shall perform EPSDT services and access to EPSDT exams under the NMMPH program. This RFP is not for the NMMPH.	The RFP is hereby amended to remove IV.M.11.e.
52. Page 90; Section: Quality Mangement, M.12.a.iii.f Are PIPs limited to improving the health care of Medicaid Members?	PIPs are focused on health-related benefits, services, care and processes provided to Medicaid members.
53. Page 91; Section: Quality Assurance and Performance Improvement Requirements, M.12.a.iv.c) 4 Please clarify that the contractor is required to include a question in the member satisfaction survey regarding transportation, but is not responsible for address the transportation system issues as there is an independent vendor for that service.	The Contractor is not required to include a question in the member satisfaction survey regarding transportation.

QUESTIONS	ANSWERS
54. Page 95; Section: Quality Reporting, M.12.a.ix.3) xi Monitoring psychotropic medications for children ages 12 years and under, including vulnerable populations such as children in foster care or in state custody; is required. Unless these children are Medicaid members and the contractor has authorized the out of home placement for behavioral care, the contractor would not know about the out-of-home or if they are a ward of the State. Is this reporting limited to just those Medicaid members for which we have information?	Yes, this reporting is limited to just those Medicaid members for which BH MCO has information.
55. Page 96; Section: MLTC Quality Reviews, M.12.b – 2nd paragraph Please clarify that the participation regarding SAMHSA grant funding is limited to only the experience of Medicaid members and that the focus of QI efforts by the contractor would be specific to improved care coordination, but not Block Grant service delivery.	The interpretation is correct.
56. Page 98; Section: Quality Improvement Committee, M.12.d.a) through h) Is the expected number of members at least 24 individuals, 6 of whom are non-voting?	Please refer to Page 98; Section: Quality Improvement Committee, M.12.d.a) through h) for the number of members required on the Quality Improvement Committee.
57. Page 99; Section: Information Systems, N.3. Please define the population referenced as “potential member and provider…” and how they would interface with the MCO to enable the collection of the data requested in the RFP. Wouldn't data only pertain to eligible members who were sent over on the enrollment file?	Yes, data would only pertain to eligible members who were sent on the enrollment files. Section IV.N.3 (second paragraph), the RFP is hereby amended to remove the word “potential”.
58. Page 100; Section: Health Information Systems- Encounter Data, N.3.c. Should "all services provided to the member" instead read, "all covered services provided to the member?"	Yes.

QUESTIONS	ANSWERS
59. Page 100; Section: Information Systems, N.4.n. State and Federal Requirements. Should this be understood to mean the MCO will capture DBH data elements for those persons that are Medicaid members receiving services that are also funded through DBH, or is the expectation the MCO will obtain the required data on -Medicaid eligible persons receiving those services as well?	The RFP is amended to remove Section IV.N.4.n.
60. Page 101; Section: Health Information Systems – Encounter Data, N.4.q.ii. Please identify with more specificity the non-Medicaid services that will be required to be included in the IS system and the expected data elements.	The RFP is amended to remove Section IV.N.4.q.ii.
61. Page 101; Section: Health Information Systems – Encounter Data, N.4.q.iv. Will the entire data set be transferred to the state monthly, or is this requirement referring to the monthly encounter data file?	It is referring to the encounter data file. This file can be submitted to the State more frequently than monthly.
62. Page 101; Section: Information Systems, N.4.q.ii Please clarify the anticipated source(s) of information regarding services received by members through publically financed non-Medicaid services, and the expectation(s) for the use of that information for the coordination of those non-Medicaid services.	See response to question #60.
63. Page 106; Section: Information Systems, N.8.f Third Party Liability. Please explain how the coinsurance, co-payments or deductibles required by a member's TPL coverage that are considered the responsibility of the Contractor are factored into the PMPM calculations in Attachments B and D.	See Attachment C-Adjustments to the FFS Base Data.

QUESTIONS	ANSWERS
64. Page 101; Section: Health Information Systems Page 101, Section 4,q.ii requires the IS system to include data to allow coordination with publically financed, non-Medicaid services provided to the Contractor's Members as reported by other NE state agencies. How will the contractor receive this electronic information from other State Agencies?	See response to question #60.
65. Page 102; Section: Care Management and Care Coordination Information This section requires the Contractor to notify member PCPs of prescriptions and new services. Will the State require the Physical Health plans to obtain the signed Authorization to Disclose statement from the member to disclose mental health and substance use disorder treatment to PCPs that would allow the Contractor to fulfill this duty in compliance with State and Federal Law? The member approval for the disclosure would have to be renewed for as long as the member's authorization is valid for, and at least annually.	The RFP is hereby amended to read: Section IV.N.5.b.i: The Contractor shall have the capacity to populate the Members' care management records with prescribed medications as identified through pharmacy data provided by DHHS. The RFP is hereby amended to remove e.f. and g. in Section IV.N.5.
66. Page 103; Section: Claims Payment, N.7.a.i This Section requires us to manage claims for Medicaid and all State funding sources, which would include DBH and CFS. Please clarify that the contractor will only be responsible for paying the Medicaid behavioral health claims.	Yes, The contractor will be responsible for paying Medicaid covered behavioral health claims and any substitute or value added services.

QUESTIONS	ANSWERS
67. Page 110; Section: Performance Measurement/Performance Guarantees, O.11.a The table in this section identifies a Percent Allocation for both Performance Guarantee and Contract Incentive. Please identify and explain what the percent allocation is applied to (percent of what amount?)	One half of one percent (0.5%) of the capitation will be subject to the Performance Guarantee Metrics outlined on page 110 of the RFP. Failure to meet these metrics will result in forfeiture of up to 0.5% of the capitation based on the Percent Allocations (of the 0.5%) listed in the table starting on RFP page 110. An additional amount of one and one half percent (1.5%) of the capitation will be made available to the Contractor if they meet the Contract Incentive Metrics outlined on page 110 of the RFP. The Contract Incentive metrics and Percent Allocation (of the 1.5%) can be found on RFP page 110.
68. Page 111; Section: Performance Measurement/Performance Guarantees Are the Claims Performance Guarantee Standards reversed? It is Industry Standard that Financial Accuracy be higher than Procedural Accuracy, since the amount paid can be correct, without following every procedure. Herefore payment accuracy should be 99% and Procedural Accuracy should be 97%.	The Financial payment accuracy threshold should read 99% and the Procedural accuracy should read 97%.
69. Page 114; Section: Performance Measurement, O.11.item 11 Will the denominator for this measure be limited to only those members whose prescriber was a behavioral health care practitioner? Any delay in receiving pharmacy data from the state or from a health plan for pediatrician prescribers will leave us at a disadvantage in targeting outreach to members, particularly for the 30-day appointment.	See response to question #8.
70. Page 120; Section: Performance Assessment, O.11.b.iv Performance Assessment – if the target is still met, but has an error rate > 5%, will the contractor still be awarded the incentive? This section states the Contractor will pay the full penalty and earn no incentive.	If the Contractor's error rate is greater than 5%, that metric will not be calculated; therefore, the Contractor shall pay the full risk penalty and earn no incentive based on that metric.

QUESTIONS	ANSWERS
71. Page 126; Section: Reinvestment Plan; P.4 It is unclear how the first escrow account, the Reinvestment Holding account, becomes funded. Is it a requirement that the entire capitation get deposited into the account, or the amount less contractor's administration, or a specified portion of the capitation? Please explain in more detail the flow of funds to the contractor and the funding of this first escrow account. Also does a separate Escrow Administrator mean separate bank account?	Yes, there is an expectation that there be two separate accounts. The "Reinvestment Holding Account" is designed as a repository for the 0.5% Performance Guarantees and the 1.5% Contract Incentives to be held upon receipt of the payment from MLTC. Monthly payments by MLTC to the Contractor will include the Capitation rates (listed in Appendix B) plus an additional 1.5% of the capitation rate for potential Contractor Incentives. After the actual metrics are compared to the benchmarks, MLTC will instruct the Contractor the amount to transfer to the second "Reinvestment Account" and the amount to transfer to the Contractor's general accounts. Forfeited MLR rebates and/or forfeited profits (per MLTC's risk corridor calculations) will go directly from the Contractor's general accounts to the "Reinvestment Account". During the contract year if the Contractor anticipates and/or projects a MLR rebate or excessive profits, this should be accounted for according to generally accepted accounting practices and principles.
72. Page 130; Section: Deliverables, P.6.b.i The provider types required do not seem to apply to this contract. Should this instead refer to behavioral health provider types?	Section IV.P.6.b.i. is amended to read: Individual GeoAccess maps for all services listed in Attachment A following the Geographical Standards outlined in Section IV.L.9.ii.

QUESTIONS	ANSWERS
73. Page 134; Section: Business Requirements, P.6.k.ii.item IV.B We request clarification on what the State wants to see in response to this question. These sections of the US Code are applicable to the State when it contracts with a vendor to provide Medicaid Managed Care services and are not directly applicable to the vendor. Is the State seeking information on what our procedures are regarding Conflicts of Interest that concern State employees? Is the State also seeking information on what our procedures are with regard to any current relationship or potential acquisition or any interest that gives the appearance of a conflict of interest related to this Request for Proposal or project?	The State does not understand the question as relates to IV.B which is Principles of Care. Please restate question.
74. Page 136; Section: Methodology/Work Statement, P.6.k.ii.item IV.L. Please define the acronym, "NMPHC".	This acronym should read “NMMPH”: Nebraska Medicaid Managed Physical Health.
75. Page 137; Section: Methodology/Work Statement, P.6.k.ii Item IV.L. Please clarify the use of the phrase "potential membership" as it pertains to eligibility and enrollment files. We assume the 834 files transmitted prior to the first of the month will contain only recipients who are expected to be enrolled on the first of the month. We understand that some recipients will lose eligibility prior to the first of the month. Is this the entirety of the meaning of "potential membership" used here?	Yes. The State does not expect the Contractor to track or monitor “potential’ enrollees.
76. Page 137; Section: Provider Network Development and Management, P.6.k.ii item IV.L Page 137, Item IV.I – 8th from the top requires the Contractor to manage potential membership. This is defined as a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet and enrollee of a specific MCO, PIHP PAHP,HIO or PCCM. Please explain further it's application to this program.	See response to question #75.

QUESTIONS	ANSWERS
77. Page 140; Section: k. Methodology/Work Statement In the Work Statement item, "Describe the process and criteria used for case management, including how you will case manage and what services you will provide" can you explain what you mean by "case management?" Our understanding is that providers provide case management and the BH MCO will provide care management. Do you mean care management?	Yes, the work statement item is referring to care management.
78. Page 140; Section: Care, Utilization and Quality Management, p.6.k.ii.item IV.M Page 140, Section IV.M, 4th from bottom requires MCO to coordinate care management for members receiving disease management from Physical Health plan for diabetes, asthma, hypertension and obesity at a minimum. Please confirm that the health plans will be required to provide this level of collaboration.	The BH MCO is required to coordinate care with the PH MCO.
79. Page 142; Section: Transition and Implementation, page 6.k.ii item IV.O Page 142, Section Iv.O, 3rd O item requires the Contractor to attend all court or administrative proceedings during transition. Please confirm that this would only include those proceedings in which the current MBHO is involved with for Medicaid members at the time of the new contract.	Yes, this only includes proceedings for Medicaid members that are transitioning into the BH MCO's service provision.

QUESTIONS	ANSWERS
80. Page 143 & 145; Section: Proposal Instructions Section A, on page 143, describes 4 sections for the Technical Proposal: including the Form, the executve summary, the coproarte overview and the technical approach. The Technical Approach includes 1) Understanding theScope of Work, 2) Proposed Implementation Approach, 3) Technical Considerations, and 4) Detailed Project Work Plan. Please confirm that subsection 2 on Implementation Approach are the questions on pages 133-142. What is expected to be submitted for subsection 3 technical considerations? How is this different than the Executive Summary and/or Describing the understanding of the Scope of Work, or the responses to Implementation Approach (subsection 2)?	Bidders are responsible for reading the RFP in its entirety and determining the format for which they choose to proceed with in their proposal response.
81. Attachment B Can you provide a summary of the programs and member counts in FY11 that make up this member month count? Are there members in this count that are not part of the current managed care programs?	The membership data shown in Attachment B is the level of detail available. All of the members listed are part of the managed care program. Individuals that are excluded from the managed care program are not included in Attachment B.
82. Attachment B, C and D We are unable to replicate the capitation rate offered, and in fact arrive at a rate significantly higher when using the Restated FY11 data as a base, applying the noted trend, managed care savings and administrative costs adjustment. The offered rates appear to be understated by $3.3 - $3.6 million. Can an additional exhibit be provided with steps through this calculation?	An additional exhibit will not be provided. Actuarially sound rate ranges were developed for each rate cell. The capitation rates in Attachment B are each within the actuarially sound rate range.

QUESTIONS	ANSWERS
83. Attachment C; Section: Trend and managed care savings It appears that the assumptions may be double counting the managed care assumptions in addition to the trend assumptions. The care is currently managed and due to that management a reason for the historical negative trends. It appears duplicative to not only continue to assume this level of trend decline, but to then also apply a managed care factor on data that is currently managed. What is the rational for applying negative trends forward for over a three year projected period (FY11 midpoint of 12/30/10 to initial rate period 9/1/13-6/30/14 midpoint 1/30/14 = 3.086 years) and then additionally applying moderate to significant managed care assumptions?	The rationale for applying negative trends forward is that historical costs and utilization have been declining (in some cases significantly). For the rate cells with negative aggregate assumed trends, the assumed trend is less negative than actual trend levels experienced. Trend assumptions were developed by rate cell and service category from historical utilization and cost patterns. Prior to analyzing the cost patterns the fee schedule changes were incorporated to avoid basing assumptions off of cost levels that were affected by fee schedule changes. The trend assumptions were set assuming no additional management or implementation of a risk-based contract. The managed care assumptions were set by comparing utilization and cost levels to those of other state Medicaid managed care programs and to other benchmarks levels to determine if additional managed care savings were achievable by service category and rate cell. In setting the managed care savings assumptions, there was a focus on the use of more cost-effective alternatives to inpatient and residential services which would decrease use of care in more acute settings and increase the utilization of less intensive services.
84. Attachment C Please provide explanation of the factors that were considerations in determining the managed care impact assumptions as well as the reasons for differences between the various rating categories. Are higher levels of care deemed to receive a higher factor than lower levels of care?	See response to question #83.
85. Attachment C; Section: Administrative Cost This does not recognize the Quality Improvement Administrative Rate that was discussed in the RFP. How is it possible for Quality Improvement Administration costs to be recovered if they are not provided for in the rate?	See responses to questions #23 and #25.
86. Attachment C This does not recognize incentive that is discussed on page 16 item CC. Is the incentive provided outside of the stated capitation payment?	Yes.

QUESTIONS	ANSWERS
87. Attachment C; Section: Data Book Would the State provide membership for FY 12 as well as each month subsequent to current for each rating category?	Membership information will be posted on December 11, 2012 with second round questions and answers.
88. Att. D; Section: Data book Please provide count of claims adjudicated for the three historical periods reflected in Attachment D.	Claim units can be developed from the membership and utilization rates provided in Attachment D.
89. Attachment C; Section: Data book Please provide explanation of the factors that were considerations in determining the managed care impact assumptions as well as the reasons for differences between the various rating categories. Are higher levels of care deemed to receive a higher factor than lower levels of care?	See response to question #83.
90. Page xii What is LAE as used to define net qualified medical expense?	Loss Adjustment Expense (LAE) is an administrative reserve in the event an insurance company must pay for the adjudication of outstanding claims at the end of a contract period.
91. Page 16; Section SG&A It is stated that SG&A cannot exceed 7% of costs unless the admin is spent on programs that may improve the health status of the underlying population. • It is possible that startup costs of implementing clinical and cost programs exceed 7%? • What outcomes measures qualify for increasing the % SG&A to 10%?	Outcome measures are not considered when determining whether the Contractor's administrative expenses will be considered either QI or Non QI (see answer to question 23). Amortization of first year administrative expenses is subject to generally accepted accounting practices and principles.
92. Page 25; Section: E.1. Excluded populations How would the exclusion of retroactive members work? Does this mean that the State never would send a retroactive effective date on a member?	See response to question #7.
93. Page 29; Section: 4. Reinsurance As a stand alone MBHO, re-insurance is not needed. What plans of self-insurance would be acceptable?	See response to question #30.

QUESTIONS	ANSWERS
94. Page 109; Section: 10: The RFP does not state when the readiness review(s) would take place. Please elaborate on the timeline for these reviews.	The readiness review(s) timeline will be determined in collaboration with the awarded bidder after contract award.
95. Page 121; Section: d: Network Performance Requirement How far in advance of go-live will the Contractor know where the members are in order to avoid this penalty?	The State will provide potential enrollee numbers by county and this information will be posted on December 11, 2012 with second round questions and answers.
96. Page 128; Section: Attachment C and 5.d.vi 1. The utilization data did not take into account the CPT code changes effective for 1/1/2013. We expect the addition of modifiers to adversely impact utilization. Will the state and/or M&R adjust the proposed CAP rates to take these coding changes into account? 2. M&R's methodology assumes a great impact from the implementation of managed care. However, the impact of managed care in the first year will not immediately have its full impact on costs and utilization. Would the state consider adjusting the CAP rates to take into consideration the fact that full impact of managed care will not be realized until well into the first year of the contract? 3. The start of the contract is being delayed by 2 months and the first period is being shortened from 12 months to 10 months, thus reducing the time in the first year for managed care to effect the savings projected in M&R's calculations. Will the state adjust the CAP rates for this later start?	The rates presented in Attachment B are those intended for use in the initial rate period.
97. Page 136; Section: iv.L Please define the acronym "NMPHC"	See response to question #74.

QUESTIONS	ANSWERS
98. Pages 130 and 138; Section: 6.b.i. and iv.L Several references to geo-access maps of providers for whom the BHMCO has received a Letter of Intent. Does the State want only providers on LOIs or should the health plan include those for whom it has a fully executed contract? Same question for the list of providers – only those on LOIs or do we include those who are fully contracted?	GeoAccess mapping must be provided which identify both LOI and fully executed providers. This also applies to the list of providers.
99. Do members sign a coordination form during the enrollment process so that coordination of care is managed efficiently across all levels of care?	No, the member does not sign a coordination form during the enrollment process.
100. Section: Data Accuracy It is stated that the incurred dollars have been reconciled; however, there may be inaccuracies in the underlying data. • Can you quantify the variance for each FY? • If data inaccuracies may be present, please indicate the likely category/area of any discrepancy? • Are services represented only for BH providers or are there PCP services included that may not traditionally be risk for MBHOs.	The Data Book represents the State's best efforts to present the historical membership, utilization and cost levels by rating category and service category. The variance will not be quantified and the State cannot opine on the likely category / area of potential discrepancies. As stated, the data was reconciled. The data represents services provided by behavioral healthcare providers only.
101. Section: Trend A number of negative trends were used. • Please provide a breakdown of trends by utilization & unit cost? • If the utilization component of trend is negative please provide rationale? • Please explain any negative unit cost trends?	Aggregate trend values by rating category are presented in the Data Book. No additional breakdown will be provided. Negative trends were only assumed for unit costs where the State identified opportunities for increased use of lower cost providers. Trends were developed based on a review of historical utilization and cost levels for each rate cell and service category.
102. Section: Managed Care • To what extent was the population managed in each of the 3 FYs? • What clinical and/or cost programs were assumed in the managed care savings factors?	Nebraska Medicaid provided managed care for behavioral health services by contracting with Magellan Behavioral Health, an Administrative Service Organization (ASO) through a non-risk based contract. Magellan coordinated, managed and provided access to mental health and substance abuse services to Medicaid eligible clients during this 3 year period. See response to question #83.

QUESTIONS	ANSWERS
103. Section: Program Changes • Where there any operation or administrative changes to the MCD behavioral health program in any of the FYs that would have impacted the spend? • Were programs added to encourage BH therapies? • Is the state considering adding any programs in the projection year that may not be reflected in the rates?	See RFP Attachment C.
104. Section: Public Policy • Please explain in detail the differences between FY11 and FY12 for public policy. • What is the impact of IBNR on FY11 & FY12?? for public policy?	The State does not understand the question; therefore, a response cannot be provided. Please provide additional information in Round Two questions.
105. Will there be accommodation for the 7% SG&A CAP for the first year start-up costs?	See response to question #23.
106. Who will be responsible for outpatient labs? Generally the MBHO doesn't contract with lab service providers and MHNet excludes this from its financial responsibility.	The PH MCO will be responsible for outpatient lab services.
107. How many years has incumbent (Magellan) managed the behavioral care?	Since 2002.
108. What is the incumbent (Magellan) ASO fee for the current managed care populations?	$1.78 per member per month.

QUESTIONS	ANSWERS
109. What populations are managed by the incumbent MBHO under the current ASO agreement?	The Medicaid eligible clients in 482 NAC 5-001.01 are required to participate in Behavioral Health managed care unless excluded. The following clients are excluded from participation: 1) Clients residing in nursing facilities; 2) Clients residing in Intermediate Care Facilities for the Mentally Retarded (ICF/MR); 3) Aliens who are eligible for Medicaid for an emergency condition only; 4) Clients participating in the Refugee Resettlement Program; 5) Clients receiving services through a Home and Community-Based Waiver (HCBS); 6) Clients who have excess income; 7) Clients participating in the State Disability Program; 8) Clients during the period of presumptive eligibility; 9) Transplant recipients; and 10) Clients who have received a waiver of enrollment.
110. Can you please explain why the persons classified as Katie Beckett eligible had $0 behavioral spending in FY10 and FY11?	There were no expenditures for Katie Beckett clients in FY10 and FY11 for Behavioral Health services.
111. Can you please clarify Disproportionate Share Hospital Payments? How is this process handled?	Disproportionate Share Hospital payments are handled outside this RFP.
112. Please clarify whether the behavioral services provided by primary care or medical providers are excluded from the MBHO responsibility?	No, Behavioral Health services provided by primary care or medical providers are not excluded.
113. Across all products the average managed care savings factor is -8.4%. Given that these members have been under a managed care program, please provide the rationale for the high managed savings calculation used for the cap rate development.	See response to question #83. Additionally, the current ASO program is not a risk-based contract arrangement.
114. Section: 4.d. Escrow account administration May the costs to administer the escrow accounts be paid out of Escrow funds?	The costs to administer the escrow accounts are expected to be de minimis and a requirement of the contract; therefore will be paid for by the Contractor as a general administrative expense.

QUESTIONS	ANSWERS
115. Section: 5.d.vii Annual CAP rate changes The RFP states that any annual adjustments will be determined by the state and its actuaries. Will the state consider allowing the MCO to be a party to these rate determinations?	MLTC has developed monthly capitation rates that will be offered to bidders on a "take it or leave it" basis. MLTC will collaborate with the BH MCO before the capitation rates are finalized.
116. Section: 6.b. Provider Network a. Item i. Mentions the inclusion of PCPs. Is the BMCO expected to include PCPs in its provider network? b. Item iv. Refers to "The following Deliverables…" There is nothing following this statement. Did the state intend to include additional text here?	a. Yes b. See response to Question 3.
117. Section: 6.c. Member Communication Is the state requesting a draft Nebraska Member Handbook or will an example of a current "model" member handbook be acceptable?	The State will be reviewing and approving a NE member handbook as part of the Member Communication deliverable that will be due under a contract resulting from this procurement.
118. Section: Attachment C Under "Adjustments to the Fee For Service Base Data" states that, "…Treatment Crisis Intervention would be entirely eliminated for persons ages 19 and 20 who will no longer be eligible to receive this service." These individuals are not eligible for this service because they are now considered adults and, under the M&R workup, adults are not eligible for "Treatment Crisis Intervention". However, Attachment A lists Crisis Assessment as a covered service for both adults and children. a. Is this a covered service for all age groups? b. If so, should the CAP rates be adjusted to reflect the inclusion of this service for adults?	a. Yes, Crisis intervention is a covered service for adults. b. No as this service is reflected in the "Other" category for adults in Attachment E.
119. Section: Glossary of Terms; Page v-xviii Are the definitions provided in the "Glossary of Terms", if applicable in the context of provider agreements, required to be incorporated into a plan's provider agreements?	The definitions provided in the "Glossary of Terms" are required to be incorporated into a plan's provider agreements if necessary to comply with the terms of the RFP/contract.

QUESTIONS	ANSWERS
120. Section: Glossary of Terms; Page vi, xii The RFP includes definitions for a Bid Bond and a Performance Bond, but the RFP only references a Performance Bond. We were unable to find any requirements in the RFP for a Bid Bond. Is this correct?	Yes. There is not a requirement for a Bid Bond for RFP 4166Z1.
121. Section: Glossary of Terms; Page xiii The definition of a PIHP cites to 44 NAC Section 4701-4727. This statute is titled "Prepaid Limited Health Service Organization". Can you please clarify whether the program anticipates operation of a PLHSO, rather than a PIHP?	In addition to operation of a PLHSO, the bidder must meet the requirements of Section IV.J.2.
122. Section: III.FF; Page 17 If an MCO has already provided a Performance Bond under the physical health managed care program, is it required to provide the full amount of the Performance Bond under this agreement?	Yes, it is required to furnish the full amount of ten million dollars ($10,000,000.00) for RFP 4166Z1.
123. Section: III.xx; Page 22 Is the copy of the disaster recovery and backup plan expected at the time of proposal?	A copy of the “Disaster Recovery/Back Up Plan” should be provided with bidder’s proposal response.
124. Section: IV.B.1; Page 24 The RFP requires the respondent to describe how the BH MCO will operate as a part of a System of Care in Nebraska to serve persons with mental health/illness and substance use disorder needs without defining the capitalized term. Are there state-specific nuances to the concept that require further clarification?	No.
125. Section: IV.J.9; Page 31 For Admin/Staffing positions listed on the same line (ie, Administrator/CEO/COO)- does this mean those positions could be combined?	Yes, as long as the duties are successfully performed in accordance with the job descriptions and the work is performed in compliance with the Contract, multiple responsibilities can be combined within one position.
126. Section: IV.M.1.b.iii; Page 71 Does MLTC have a definition of "high risk" or is the Contractor free to definite the term as a part of the Clinical criteria?	MLTC will develop the definition of” high risk” in collaboration with BH MCO after contract award.

QUESTIONS	ANSWERS
127. Section: iv.o.11; Page 110 Can the state please offer clarification as to the potential financial incentive and/or financial penalty associated with achievement of the performance guarantees?	See response to question #67.
128. Section: IV.P.5.d.vi; Page 128 Given certain program changes between 2010 and 2011 (e.g. change in coverage by Medicaid vs. Div. of Children and Family Services vs. Div. of Behavioral Health, cessation of funding for Institutions for Mental Disease), how are these changes reflected in the data book and the proposed rates? In addition, the RFP may be imposing new responsibilities of the Contractor that were not required of the ASO, i.e. the repeated requirements to coordinate or consult with a host of stakeholders including the Regional Behavioral Health Agencies. How are those Medicaid program changes accounted for in the capitated rates?	All adjustments made to account for programmatic changes in the rate development are included in RFP Attachment C.
129. Section: I.V.P.6.b.iv; Page 130 This appears to be a format issue or incomplete clause. The clause note "The following deliverables, at a minimum, will be due under a contract resulting from this procurement" without a subsequent list of items. Also, please clarify those deliverables that will be due at the time of Technical Proposal submission vs. those deliverables that will be due under a contract resulting from this procurement.	See response to question #3. Deliverables due at the time of technical proposal submission include 6.a.b. Deliverables, at a minimum, will be due under a contract resulting from procurement include 6c-j.
130. Section: V; Page 143 The Proposal Instructions specify that Bidders should identify the subdivisions of "Project Description and Scope of Work". Can the State please clarify which sections of the Proposal the State would like separated into the "Project Description" sections versus the "Scope of Work" sections.	Bidders should identify the subdivisions of “Project Description and Scope of Work” clearly in their proposals. Bidders are expected to submit proposals that reflect their proposed service capabilities in the format requested in the RFP.

QUESTIONS	ANSWERS
131. Section: V.A.3.I; Page 147 It appears that subsection "Technical Approach" should be noted as subsection 4, versus V.A.3.I, to correspond to the order of the Technical proposal noted on page 143, V.A.	This is correct.
132. Section: Attachment B – Behavioral Healthcare Capitation Rates Using the restated FY11 data book experience along with the trend, managed care, and 90% medical loss ratio assumptions outlined in the data book, we were unable to reproduce the rates provided in Attachment B. Each rate cell seems to be low by about 3.5%. Were other adjustments applied to get to the rates in Attachment B? Please provide more detail on these other adjustments.	See response to question #82.
133. Section: Attachment C – Data Book – Statewide Managed Behavioral Healthcare; Page 12 The rate development uses negative medical cost trends from FY11 to the contract period of -1.5% per year overall. FY12 data should be available, even if it just at a summary level. Please provide more recent experience and demonstrate how it supports the negative trend assumptions.	FY12 data was not used in the development of the capitation rates outlined in Attachment B. The State requires additional detail as to the type of summary level data being requested. See response to question #83.
134. Section: Attachment D – Behavioral Health Managed Care Datafile; Pages 19-23 Please explain the material fluctuations in enrollment during the 3 years of experience provided in the data book for some of the rating categories. For example, the Member Months for the Families 0-5 category changed from 684,592 in FY09, to 727,660 in FY10, and 690,381 in FY11.	The Data Book represents the State's best efforts to present the historical membership, utilization and cost levels by rating category and service category. Additional detail on enrollment fluctuations will not be provided.

QUESTIONS	ANSWERS
135. Section: M. CARE, UTILIZZTION AND QUALITY MANAGEMENT; Page 80 The RFP states the following in section vi. “Provide a mechanism in which a Member may submit, whether verbally or in writing, a service authorization request for the provisions of services.” Please clarify if requests for services can come from the member on behalf of the provider.	The RFP is hereby amended to remove provision IV.M.9.vi.
136. Section: P. FINANCE, REPORTING REQUIREMENTS AND RATE-SETTING; Page 130 Per the statement in section b. i. please clarify if the contractor is expected to include PCPs, urgent care centers and ancillary providers in GeoAccess or only those that offer behavioral health services.	See response to question #72.

NEBRASKA
Administrative Services
Dave Heineman, Governor

Carlos Castillo, Jr.
Director

ADDENDUM ONE

DATE: November 6, 2012

TO: All Vendors

FROM: Ruth Gray, Buyer
State Purchasing Bureau

RE: RFP Number 4166Z1

SCOPE OF ADDENDUM

RFP 4166Z1 is hereby amended as follows:

Glossary of Terms
Revise the definition of "Licensing" to read:

Licensing: Bidders must acquire appropriate Nebraska licensure and provide proof-of-licensure with the proposal. ~~If the Bidder is not licensed as required by the Nebraska Department of Insurance (DOI) at the time of proposal submittal, the Bidder shall attest that the appropriate licensure shall be obtained prior to a executing a contract with MLTC.~~ The Bidder shall provide verification that the licensure is not suspended, revoked, denied or found to be noncompliant by Nebraska DOI at the time of contracting.

Section II Procurement Procedures, L. Mandatory Requirements
Remove the word "Act" under #5.

5. The applicant's Prepaid Limited Health Service Organization ~~Act~~ certificate of authority, pursuant to Nebraska Revised Statute 44-4701 et.seq.

This addendum will become part of the proposal and should be acknowledged with the RFP.

Attachment E
Behavioral Health Services Mapping

RFP - Medicaid covered services for children under age 19 [1]	Data Book Service Category
Crisis Stabilization Services:	
Crisis Assessment	Treatment Crisis Intervention
Inpatient Services (Acute and Sub-Acute):	
Acute Inpatient Hospital	Inpatient Hospital Services and Inpatient Services provided in an IMD
Residential Services:	
Psychiatric Residential Treatment Facility (PRTF) (through age 18)	Residential Treatment Center [2]
Therapeutic Group Home (ThGH)	Treatment Group Home [3]
Professional Resource Family Care (PRFC)	Treatment Foster Care [4]
Outpatient Assessment and Treatment:	
Partial Hospitalization	Day Treatment
Day Treatment (MH and SA)	Day Treatment
Intensive Outpatient (MH)	Intensive Outpatient Services
Intensive Outpatient (SA)	Intensive Outpatient Services
Medication Management	Medication Checks
Outpatient (Individual, Family, Group) (MH, SA, or Dual MH/SA)	Family Assessment,Family Psychotherapy Services,Family Substance Abuse Counseling,Group Psychotherapy,Group Substance Abuse Counseling,Individual Psychotherapy,Individual Substance Abuse Counseling
Injectable Psychotropic Medications	Physician Administered Outpatient Drugs
Substance Abuse Assessment	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing
Psychological Evaluation and Testing	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing
Initial Diagnostic Interviews	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing
Home-based MST	Other
Biopsychosocial Assessment and Addendum (currently in policy but maybe eliminated by June 30, 2013)	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing
Sex Offender Risk Assessment	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing
Community Treatment Aide (CTA)	Other
Client Assistant Program (CAP) (managed care benefit only)	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing
Comprehensive Child and Adolescent Assessment (CCAA)	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing
Comprehensive Child and Adolescent Assessment Addendum	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing
Conferences with family or other responsible persons	Conferences with family or other responsible persons advising them on how to assist the client
Hospital Observation Room Services (23:59)	Other
Support Services:	
Interpreter Services for MH/SA services	Other
Telehealth Transmission	Other

RFP - Medicaid covered services for Adults 19 and over [1]	Data Book Service Category
Crisis Stabilization Services:	
Crisis Assessment	Other
Inpatient Services (Acute and Sub-Acute):	
Acute Inpatient Hospital	Adult Inpatient Hospital Psychiatric Services/Inpatient Hospital Services for 65+ in Institutions for Mental Disease
Sub-acute Hospital	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)
Outpatient Assessment and Treatment:	
Partial Hospitalization	Adult Day Treatment Psychiatric Services
Social Detox	Other
Day Treatment (MH)	Adult Day Treatment Psychiatric Services
Intensive Outpatient (SA)	Adult Day Treatment Psychiatric Services
Medication Management	Medication Checks
Outpatient (Individual, Family, Group) (MH, SA, or Dual MH/SA)	Family Assessment,Family Psychotherapy Services,Family Substance Abuse Counseling,Group Psychotherapy,Group Substance Abuse Counseling,Individual Psychotherapy,Individual Substance Abuse Counseling
Injectable Psychotropic Medications	Physician Administered Outpatient Drugs
Substance Abuse Assessment	Psychiatric Evaluation/Psychological Evaluation/Testing
Psychological Evaluation and Testing	Psychiatric Evaluation/Psychological Evaluation/Testing
Electroconvulsive Therapy – ECT	Electroconvulsive therapy
Initial Diagnostic Interviews	Psychiatric Evaluation/Psychological Evaluation/Testing
Biopsychosocial Assessment and Addendum (currently in policy but maybe eliminated by June 30, 2013)	Psychiatric Evaluation/Psychological Evaluation/Testing
Crisis Outpatient Services	Family Psychotherapy Services,Family Substance Abuse Counseling,Group Psychotherapy,Group Substance Abuse Counseling,Individual Psychotherapy,Individual Substance Abuse Counseling
Client Assistant Program (CAP) (managed care benefit only)	Psychiatric Evaluation/Psychological Evaluation/Testing
Ambulatory Detoxification	Other
Psychiatric nursing (in-home)	Other
Rehabilitation Services:	
Dual Disorder Residential	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)
Intermediate Residential – (SA) substance abuse	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)
Short-Term Residential	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)
Halfway House	Adult Day Treatment Psychiatric Services
Therapeutic Community – (SA only)	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)
Community Support (SA)	MHSA Community Treatment/Support/Psychosocial Rehab
Support Services:	
Interpreter Services for MH/SA services	Other
Telehealth Transmission	Other
Medicaid Rehabilitation Option (MRO) services supplemented by Department of Behavioral Health (DBH), which are moving to Medicaid paid services only:	
Rehabilitation Services:	
Psychiatric Residential Rehabilitation	MHSA Community Treatment/Support/Psychosocial Rehab
Secure Residential Rehabilitation	MHSA Community Treatment/Support/Psychosocial Rehab
Assertive Community Treatment (ACT) and Alternative ACT (Alt. ACT)	Adult Day Treatment Psychiatric Services
Community Support (MH)	MHSA Community Treatment/Support/Psychosocial Rehab
Day Rehabilitation	MHSA Community Treatment/Support/Psychosocial Rehab

Databook Contents

Tab Names: Aged
Blind,Disabled,KatieBeck_0-18
Blind,Disabled_19+
CHIP
Families_0-5
Families_6-18
Families_19+
FosterCare,Ward,SubsidizedAdopt

Headings:	FY09	Experience metrics for state fiscal year 2009 (July 1, 2008 - June 30, 2009) with IBNR completion factors applied
	FY10	Experience metrics for state fiscal year 2010 (July 1, 2009 - June 30, 2010) with IBNR completion factors applied
	FY11	Experience metrics for state fiscal year 2011 (July 1, 2010 - June 30, 2011) with IBNR completion factors applied
	FY11 Restated for Public Policy	Metrics for fiscal year 2011, adjusted for programmatic changes implemented post FY11
Columns:	Member Months	Monthly count of enrolled members
	Members	Number of enrollees
	Utilizers	Number of recipients by service category
	Penetration Rate	Proportion of enrollees receiving services
	Annual Utilization per 1,000	Average number of units per thousand members
	Average LOS	Average length of stay per admission
	Average Cost Per Unit	Average cost per unit of service
	Average Cost Per Day	Average cost per day of admission
	PMPM Cost	Average per member per month cost

Tab Name:	Claims_Summary	
Columns:	Rating Category	Eligibility category (see Rating Category Mapping tab)
	Member Months	Sum of the number of eligible members for each month in the fiscal year
	Fiscal Year	Nebraska fiscal year corresponding to claim start date
	MH/SA	Primary diagnosis of mental health or substance abuse
	Detailed Service Category	See Service Category Mapping tab
	Utilizers	Unique count of members with at least one claim
	Paid Dollars	Net paid amount, not adjusted for IBNR
	Paid Units	Total number of units for paid claims
	Units Measure	See Units Descriptions tab
	Paid Days	Total number of days for paid claims (inpatient only)
	Cost per Unit	Paid dollars / units
	Cost per Day	Paid dollars / days
	PMPM Cost	Paid dollars per member per month

Tab Name:	Member_Months	Membership by month
Columns:	Rating Category	Eligibility category (see Rating Category Mapping tab)
	Month	Month of eligibility
	Member Months	Number of members with eligibility

Additional Reference:
Rating_Category_Mapping
Service_Category_Mapping
Units_Descriptions

Experience Report

Aged

			FY09							FY10						
			Member Months =	210,791			Unique Members =		21,032	Member Months =	210,940			Unique Members =		21,062
Service Category	Units Measure	MH/SA	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
All Service Categories	N/A	MH	2,126	10.1%					$ 9.86	2,126	10.1%					$ 8.88
		SA	40	0.2%					$ 0.08	31	0.1%					$ 0.06
		Total	2,139	10.2%					$ 9.94	2,144	10.2%					$ 8.94
Inpatient Acute Psychiatric	Admits	MH	13	0.1%	1.02	19.00	$ 10,256.18	$ 539.80	$ 0.88	15	0.1%	0.97	17.76	$ 8,291.76	$ 466.75	$ 0.67
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	13	0.1%	1.02	19.00	$ 10,256.18	$ 539.80	$ 0.88	15	0.1%	0.97	17.76	$ 8,291.76	$ 466.75	$ 0.67
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	92	0.4%	5.75	14.53	$ 1,562.12	$ 107.48	$ 0.75	69	0.3%	4.21	16.62	$ 1,187.01	$ 71.42	$ 0.42
		SA	2	0.0%	0.11	2.50	$ 1,027.04	$ 410.82	$ 0.01	-	0.0%	-				$ -
		Total	94	0.4%	5.86	14.30	$ 1,551.73	$ 108.51	$ 0.76	69	0.3%	4.21	16.62	$ 1,187.01	$ 71.42	$ 0.42
Professional Inpatient Visits	Units	MH	247	1.2%	102.81		$ 20.78		$ 0.18	203	1.0%	71.96		$ 23.07		$ 0.14
		SA	17	0.1%	2.33		$ 30.42		$ 0.01	8	0.0%	1.76		$ 38.87		$ 0.01
		Total	260	1.2%	105.15		$ 20.99		$ 0.18	208	1.0%	73.73		$ 23.45		$ 0.14
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	45	0.2%	2.85	39.96	$ 3,416.58	$ 85.50	$ 0.81	39	0.2%	2.33	34.19	$ 2,243.40	$ 65.61	$ 0.44
		SA	1	0.0%	0.06	26.00	$ 359.46	$ 13.83	$ 0.00	-	0.0%	-				$ -
		Total	46	0.2%	2.90	39.69	$ 3,356.64	$ 84.58	$ 0.81	39	0.2%	2.33	34.19	$ 2,243.40	$ 65.61	$ 0.44
Professional Inpatient SubAcute Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	2	0.0%	0.40		$ 165.38		$ 0.01	4	0.0%	0.40		$ 168.50		$ 0.01
		Total	2	0.0%	0.40		$ 165.38		$ 0.01	4	0.0%	0.40		$ 168.50		$ 0.01
Residential Treatment Center	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Group Home	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional RTC/Group Home Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Foster Care	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Adult Day Treatment Psychiatric Services	Cases	MH	71	0.3%	56.99		$ 98.75		$ 0.47	42	0.2%	107.87		$ 59.09		$ 0.53
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	71	0.3%	56.99		$ 98.75		$ 0.47	42	0.2%	107.87		$ 59.09		$ 0.53
Day Treatment	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Intensive Outpatient Services	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -

Experience Report

Aged

Service Category	Units Measure	MH/SA	FY09 Member Months = 210,791 Unique Members = 21,032						FY10 Member Months = 210,940 Unique Members = 21,062					
			Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	19	0.1%	66.09		$ 13.09		$ 0.07	16	0.1%	70.07		$ 14.96		$ 0.09
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	19	0.1%	66.09		$ 13.09		$ 0.07	16	0.1%	70.07		$ 14.96		$ 0.09
Treatment Crisis Intervention	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Medication Checks	Units	MH	862	4.1%	211.03		$ 23.05		$ 0.41	779	3.7%	180.90		$ 24.38		$ 0.37
		SA	6	0.0%	0.57		$ 26.25		$ 0.00	2	0.0%	0.11		$ 28.90		$ 0.00
		Total	866	4.1%	211.60		$ 23.06		$ 0.41	780	3.7%	181.02		$ 24.38		$ 0.37
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	1,013	4.8%	107.94		$ 79.90		$ 0.72	976	4.6%	111.16		$ 78.45		$ 0.73
		SA	9	0.0%	0.85		$ 89.36		$ 0.01	9	0.0%	0.74		$ 107.59		$ 0.01
		Total	1,018	4.8%	108.79		$ 79.98		$ 0.73	982	4.7%	111.90		$ 78.64		$ 0.73
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	763	3.6%	548.39		$ 55.26		$ 2.53	754	3.6%	535.77		$ 56.16		$ 2.51
		SA	3	0.0%	0.34		$ 40.65		$ 0.00	3	0.0%	0.57		$ 43.72		$ 0.00
		Total	765	3.6%	548.73		$ 55.25		$ 2.53	756	3.6%	536.34		$ 56.15		$ 2.51
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	9	0.0%	11.78		$ 16.56		$ 0.02	10	0.0%	8.59		$ 16.92		$ 0.01
		SA	2	0.0%	0.63		$ 31.80		$ 0.00	-	0.0%	-				$ -
		Total	11	0.1%	12.41		$ 17.33		$ 0.02	10	0.0%	8.59		$ 16.92		$ 0.01
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	33	0.2%	6.26		$ 76.13		$ 0.04	21	0.1%	6.77		$ 81.67		$ 0.05
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	33	0.2%	6.26		$ 76.13		$ 0.04	21	0.1%	6.77		$ 81.67		$ 0.05
Family Assessment	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	110	0.5%	638.57		$ 45.45		$ 2.42	111	0.5%	722.88		$ 39.06		$ 2.35
		SA	5	0.0%	1.94		$ 224.06		$ 0.04	5	0.0%	2.05		$ 227.40		$ 0.04
		Total	115	0.5%	640.50		$ 45.99		$ 2.45	116	0.6%	724.93		$ 39.59		$ 2.39
Physician Administered Outpatient Drugs	Units	MH	12	0.1%	50.95		$ 3.49		$ 0.01	17	0.1%	192.40		$ 2.61		$ 0.04
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	12	0.1%	50.95		$ 3.49		$ 0.01	17	0.1%	192.40		$ 2.61		$ 0.04
Outpatient Lab/Path/Other	Units	MH	46	0.2%	19.30		$ 19.87		$ 0.03	39	0.2%	12.30		$ 24.74		$ 0.03
		SA	-	0.0%	-				$ -	4	0.0%	1.19		$ 16.57		$ 0.00
		Total	46	0.2%	19.30		$ 19.87		$ 0.03	42	0.2%	13.49		$ 24.02		$ 0.03
Other	Units	MH	387	1.8%	245.70		$ 26.15		$ 0.54	439	2.1%	255.60		$ 24.50		$ 0.52
		SA	2	0.0%	2.85		$ 35.50		$ 0.01	1	0.0%	0.28		$ 31.68		$ 0.00

Experience Report

Aged

			FY09							FY10						
			Member Months =	210,791			Unique Members =	21,032		Member Months =	210,940			Unique Members =	21,062	
Service Category	Units Measure	MH/SA	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
		Total	388	1.8%	248.55		$ 26.26		$ 0.54	440	2.1%	255.88		$ 24.51		$ 0.52

Experience Report

Aged

			FY11							FY11 Restated for Public Policy						
			Member Months =	211,207			Unique Members =		21,304	Member Months =	211,207			Unique Members =		21,304
Service Category	Units Measure	MH/SA	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
All Service Categories	N/A	MH	2,102	9.9%					$ 8.21	2,102	9.9%					$ 8.00
		SA	35	0.2%					$ 0.09	35	0.2%					$ 0.09
		Total	2,120	10.0%					$ 8.29	2,120	10.0%					$ 8.08
Inpatient Acute Psychiatric	Admits	MH	12	0.1%	0.80	13.86	$ 6,859.58	$ 495.02	$ 0.46	12	0.1%	0.80	13.86	$ 6,737.25	$ 486.19	$ 0.45
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	12	0.1%	0.80	13.86	$ 6,859.58	$ 495.02	$ 0.46	12	0.1%	0.80	13.86	$ 6,737.25	$ 486.19	$ 0.45
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	66	0.3%	4.10	12.89	$ 1,359.87	$ 105.47	$ 0.47	66	0.3%	4.10	12.89	$ 1,328.29	$ 103.02	$ 0.45
		SA	2	0.0%	0.11	1.00	$ 1,116.04	$ 1,116.04	$ 0.01	2	0.0%	0.11	1.00	$ 1,090.12	$ 1,090.12	$ 0.01
		Total	68	0.3%	4.22	12.57	$ 1,353.27	$ 107.65	$ 0.48	68	0.3%	4.22	12.57	$ 1,321.84	$ 105.15	$ 0.46
Professional Inpatient Visits	Units	MH	174	0.8%	63.43		$ 21.66		$ 0.11	174	0.8%	63.43		$ 21.32		$ 0.11
		SA	17	0.1%	1.48		$ 34.99		$ 0.00	17	0.1%	1.48		$ 34.44		$ 0.00
		Total	188	0.9%	64.91		$ 21.96		$ 0.12	188	0.9%	64.91		$ 21.62		$ 0.12
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	9	0.0%	0.57	31.49	$ 777.24	$ 24.68	$ 0.04	9	0.0%	0.57	31.49	$ 775.68	$ 24.63	$ 0.04
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	9	0.0%	0.57	31.49	$ 777.24	$ 24.68	$ 0.04	9	0.0%	0.57	31.49	$ 775.68	$ 24.63	$ 0.04
Professional Inpatient SubAcute Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	2	0.0%	4.38		$ 167.50		$ 0.06	2	0.0%	4.38		$ 165.13		$ 0.06
		Total	2	0.0%	4.38		$ 167.50		$ 0.06	2	0.0%	4.38		$ 165.13		$ 0.06
Residential Treatment Center	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Group Home	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional RTC/Group Home Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Foster Care	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Adult Day Treatment Psychiatric Services	Cases	MH	52	0.2%	91.65		$ 53.27		$ 0.41	52	0.2%	91.65		$ 52.45		$ 0.40
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	52	0.2%	91.65		$ 53.27		$ 0.41	52	0.2%	91.65		$ 52.45		$ 0.40
Day Treatment	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Intensive Outpatient Services	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -

Experience Report

Aged

Service Category	Units Measure	MH/SA	FY11 Member Months = 211,207 Unique Members = 21,304 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 211,207 Unique Members = 21,304 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	18	0.1%	309.21		$ 6.42		$ 0.17	18	0.1%	309.21		$ 6.34		$ 0.16
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	18	0.1%	309.21		$ 6.42		$ 0.17	18	0.1%	309.21		$ 6.34		$ 0.16
Treatment Crisis Intervention	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Medication Checks	Units	MH	772	3.6%	177.21		$ 26.30		$ 0.39	772	3.6%	177.21		$ 26.04		$ 0.38
		SA	4	0.0%	0.51		$ 22.76		$ 0.00	4	0.0%	0.51		$ 22.53		$ 0.00
		Total	776	3.6%	177.72		$ 26.29		$ 0.39	776	3.6%	177.72		$ 26.03		$ 0.39
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	1,027	4.8%	117.30		$ 76.22		$ 0.74	1,027	4.8%	117.30		$ 73.72		$ 0.72
		SA	9	0.0%	1.02		$ 74.28		$ 0.01	9	0.0%	1.02		$ 71.85		$ 0.01
		Total	1,035	4.9%	118.32		$ 76.20		$ 0.75	1,035	4.9%	118.32		$ 73.70		$ 0.73
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	813	3.8%	634.17		$ 54.68		$ 2.89	813	3.8%	634.17		$ 52.52		$ 2.78
		SA	4	0.0%	0.97		$ 32.08		$ 0.00	4	0.0%	0.97		$ 30.82		$ 0.00
		Total	814	3.8%	635.14		$ 54.64		$ 2.89	814	3.8%	635.14		$ 52.49		$ 2.78
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	8	0.0%	6.08		$ 15.63		$ 0.01	8	0.0%	6.08		$ 14.95		$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	8	0.0%	6.08		$ 15.63		$ 0.01	8	0.0%	6.08		$ 14.95		$ 0.01
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	33	0.2%	7.00		$ 81.62		$ 0.05	33	0.2%	7.00		$ 80.56		$ 0.05
		SA	1	0.0%	0.11		$ 82.82		$ 0.00	1	0.0%	0.11		$ 81.75		$ 0.00
		Total	34	0.2%	7.11		$ 81.64		$ 0.05	34	0.2%	7.11		$ 80.58		$ 0.05
Family Assessment	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	103	0.5%	618.32		$ 38.34		$ 1.98	103	0.5%	618.32		$ 37.76		$ 1.95
		SA	1	0.0%	0.06		$ 228.56		$ 0.00	1	0.0%	0.06		$ 225.10		$ 0.00
		Total	104	0.5%	618.37		$ 38.35		$ 1.98	104	0.5%	618.37		$ 37.77		$ 1.95
Physician Administered Outpatient Drugs	Units	MH	11	0.1%	36.57		$ 2.61		$ 0.01	11	0.1%	36.57		$ 2.61		$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	11	0.1%	36.57		$ 2.61		$ 0.01	11	0.1%	36.57		$ 2.61		$ 0.01
Outpatient Lab/Path/Other	Units	MH	43	0.2%	13.79		$ 20.73		$ 0.02	43	0.2%	13.79		$ 20.44		$ 0.02
		SA	2	0.0%	0.23		$ 9.87		$ 0.00	2	0.0%	0.23		$ 9.73		$ 0.00
		Total	44	0.2%	14.02		$ 20.56		$ 0.02	44	0.2%	14.02		$ 20.27		$ 0.02
Other	Units	MH	404	1.9%	220.69		$ 25.88		$ 0.48	404	1.9%	220.69		$ 25.52		$ 0.47
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -

Experience Report

Aged

			FY11							FY11 Restated for Public Policy						
			Member Months =	211,207			Unique Members =	21,304		Member Months =	211,207			Unique Members =	21,304	
Service Category	Units Measure	MH/SA	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
		Total	404	1.9%	220.69		$ 25.88		$ 0.48	404	1.9%	220.69		$ 25.52		$ 0.47

Experience Report

Blind,Disabled,KatieBeckett_0-18

			FY09							FY10						
			Member Months =	43,068			Unique Members =	4,520		Member Months =	44,961			Unique Members =	4,671	
Service Category	Units Measure	MH/SA	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
All Service Categories	N/A	MH	1,213	26.8%					$ 92.35	1,182	25.3%					$ 76.40
		SA	19	0.4%					$ 1.69	17	0.4%					$ 0.18
		Total	1,216	26.9%					$ 94.04	1,187	25.4%					$ 76.58
Inpatient Acute Psychiatric	Admits	MH	99	2.2%	35.39	12.62	$ 6,300.64	$ 499.18	$ 18.58	99	2.1%	39.52	7.91	$ 3,993.70	$ 505.21	$ 13.15
		SA	2	0.0%	0.56	8.00	$ 4,147.55	$ 518.44	$ 0.19	-	0.0%	-				$ -
		Total	101	2.2%	35.94	12.55	$ 6,267.26	$ 499.37	$ 18.77	99	2.1%	39.52	7.91	$ 3,993.70	$ 505.21	$ 13.15
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient Visits	Units	MH	99	2.2%	311.51		$ 52.61		$ 1.37	102	2.2%	211.12		$ 64.04		$ 1.13
		SA	1	0.0%	3.34		$ 38.49		$ 0.01	-	0.0%	-				$ -
		Total	100	2.2%	314.85		$ 52.46		$ 1.38	102	2.2%	211.12		$ 64.04		$ 1.13
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient SubAcute Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Residential Treatment Center	Admits	MH	30	0.7%	41.79	26.31	$ 7,385.35	$ 280.74	$ 25.72	30	0.6%	35.24	26.89	$ 7,819.20	$ 290.83	$ 22.96
		SA	2	0.0%	1.95	28.57	$ 6,644.54	$ 232.56	$ 1.08	-	0.0%	-				$ -
		Total	32	0.7%	43.75	26.41	$ 7,352.32	$ 278.42	$ 26.80	30	0.6%	35.24	26.89	$ 7,819.20	$ 290.83	$ 22.96
Treatment Group Home	Admits	MH	21	0.5%	22.01	24.67	$ 4,437.52	$ 179.87	$ 8.14	18	0.4%	13.35	24.98	$ 4,595.23	$ 183.96	$ 5.11
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	21	0.5%	22.01	24.67	$ 4,437.52	$ 179.87	$ 8.14	18	0.4%	13.35	24.98	$ 4,595.23	$ 183.96	$ 5.11
Professional RTC/Group Home Visits	Units	MH	30	0.7%	49.87		$ 59.06		$ 0.25	34	0.7%	48.31		$ 56.11		$ 0.23
		SA	1	0.0%	2.51		$ 107.11		$ 0.02	-	0.0%	-				$ -
		Total	31	0.7%	52.38		$ 61.36		$ 0.27	34	0.7%	48.31		$ 56.11		$ 0.23
Treatment Foster Care	Days	MH	4	0.1%	127.89		$ 106.52		$ 1.14	8	0.2%	265.03		$ 107.67		$ 2.38
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	4	0.1%	127.89		$ 106.52		$ 1.14	8	0.2%	265.03		$ 107.67		$ 2.38
Adult Day Treatment Psychiatric Services	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Day Treatment	Cases	MH	40	0.9%	251.05		$ 139.64		$ 2.92	55	1.2%	304.02		$ 145.22		$ 3.68
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	40	0.9%	251.05		$ 139.64		$ 2.92	55	1.2%	304.02		$ 145.22		$ 3.68
Intensive Outpatient Services	Cases	MH	21	0.5%	242.97		$ 109.22		$ 2.21	14	0.3%	133.98		$ 105.03		$ 1.17
		SA	2	0.0%	23.13		$ 97.92		$ 0.19	-	0.0%	-				$ -
		Total	23	0.5%	266.09		$ 108.23		$ 2.40	14	0.3%	133.98		$ 105.03		$ 1.17

Experience Report

Blind,Disabled,KatieBeckett_0-18

Service Category	Units Measure	MH/SA	FY09 Utilizers	FY09 Penetration Rate	FY09 Annual Utilization per 1,000	FY09 Average LOS	FY09 Average Cost Per Unit	FY09 Average Cost Per Day	FY09 PMPM Cost	FY10 Utilizers	FY10 Penetration Rate	FY10 Annual Utilization per 1,000	FY10 Average LOS	FY10 Average Cost Per Unit	FY10 Average Cost Per Day	FY10 PMPM Cost
			FY09 Member Months = 43,068						FY09 Unique Members = 4,520	FY10 Member Months = 44,961						FY10 Unique Members = 4,671
Electroconvulsive Therapy	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Crisis Intervention	Days	MH	1	0.0%	13.10		$ 336.61		$ 0.37	1	0.0%	0.80		$ 341.57		$ 0.02
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	1	0.0%	13.10		$ 336.61		$ 0.37	1	0.0%	0.80		$ 341.57		$ 0.02
Medication Checks	Units	MH	441	9.8%	456.95		$ 39.54		$ 1.51	454	9.7%	525.79		$ 39.73		$ 1.74
		SA	1	0.0%	0.28		$ 36.19		$ 0.00	-	0.0%	-				$ -
		Total	442	9.8%	457.23		$ 39.54		$ 1.51	454	9.7%	525.79		$ 39.73		$ 1.74
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	818	18.1%	534.69		$ 116.94		$ 5.21	774	16.6%	549.28		$ 116.64		$ 5.34
		SA	8	0.2%	6.13		$ 188.11		$ 0.10	10	0.2%	4.80		$ 114.35		$ 0.05
		Total	822	18.2%	540.82		$ 117.75		$ 5.31	778	16.7%	554.09		$ 116.62		$ 5.38
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	795	17.6%	2,791.33		$ 60.96		$ 14.18	725	15.5%	2,148.82		$ 62.29		$ 11.15
		SA	10	0.2%	14.77		$ 60.32		$ 0.07	10	0.2%	15.48		$ 64.19		$ 0.08
		Total	799	17.7%	2,806.09		$ 60.96		$ 14.25	729	15.6%	2,164.30		$ 62.30		$ 11.24
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	3	0.1%	3.06		$ 14.04		$ 0.00	3	0.1%	17.62		$ 23.33		$ 0.03
		SA	3	0.1%	7.24		$ 23.62		$ 0.01	-	0.0%	-				$ -
		Total	6	0.1%	10.31		$ 20.77		$ 0.02	3	0.1%	17.62		$ 23.33		$ 0.03
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	504	11.2%	1,227.09		$ 80.64		$ 8.25	465	10.0%	1,003.28		$ 82.00		$ 6.86
		SA	-	0.0%	-				$ -	3	0.1%	0.80		$ 83.00		$ 0.01
		Total	504	11.2%	1,227.09		$ 80.64		$ 8.25	466	10.0%	1,004.08		$ 82.00		$ 6.86
Family Assessment	Units	MH	1	0.0%	0.28		$ 68.34		$ 0.00	3	0.1%	0.80		$ 69.35		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	1	0.0%	0.28		$ 68.34		$ 0.00	3	0.1%	0.80		$ 69.35		$ 0.00
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	13	0.3%	11.70		$ 16.04		$ 0.02	10	0.2%	6.94		$ 20.16		$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	13	0.3%	11.70		$ 16.04		$ 0.02	10	0.2%	6.94		$ 20.16		$ 0.01
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	36	0.8%	734.47		$ 31.55		$ 1.93	20	0.4%	312.81		$ 31.10		$ 0.81
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	36	0.8%	734.47		$ 31.55		$ 1.93	20	0.4%	312.81		$ 31.10		$ 0.81
Physician Administered Outpatient Drugs	Units	MH	2	0.0%	429.93		$ 4.73		$ 0.17	2	0.0%	580.05		$ 4.76		$ 0.23
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	2	0.0%	429.93		$ 4.73		$ 0.17	2	0.0%	580.05		$ 4.76		$ 0.23
Outpatient Lab/Path/Other	Units	MH	116	2.6%	188.63		$ 22.88		$ 0.36	115	2.5%	202.41		$ 19.43		$ 0.33
		SA	4	0.1%	6.41		$ 16.13		$ 0.01	5	0.1%	9.88		$ 51.24		$ 0.04
		Total	120	2.7%	195.04		$ 22.65		$ 0.37	119	2.5%	212.29		$ 20.91		$ 0.37
Other	Units	MH	21	0.5%	397.61		$ 1.15		$ 0.04	22	0.5%	116.37		$ 6.37		$ 0.06
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	21	0.5%	397.61		$ 1.15		$ 0.04	22	0.5%	116.37		$ 6.37		$ 0.06

Experience Report

Blind,Disabled,KatieBeckett_0-18

Service Category	Units Measure	MH/SA	FY11 Member Months = 46,544 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 46,544 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
			Unique Members = 4,842							Unique Members = 4,842						
All Service Categories	N/A	MH	1,243	25.7%					$ 56.55	1,243	25.7%					$ 55.17
		SA	28	0.6%					$ 1.54	28	0.6%					$ 1.52
		Total	1,250	25.8%					$ 58.09	1,250	25.8%					$ 56.68
Inpatient Acute Psychiatric	Admits	MH	86	1.8%	28.98	6.44	$ 3,354.82	$ 521.16	$ 8.10	86	1.8%	28.98	6.44	$ 3,307.99	$ 513.89	$ 7.99
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	86	1.8%	28.98	6.44	$ 3,354.82	$ 521.16	$ 8.10	86	1.8%	28.98	6.44	$ 3,307.99	$ 513.89	$ 7.99
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	1	0.0%	0.26	5.00	$ 1,100.00	$ 220.00	$ 0.02	1	0.0%	0.26	5.00	$ 1,084.65	$ 216.93	$ 0.02
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	1	0.0%	0.26	5.00	$ 1,100.00	$ 220.00	$ 0.02	1	0.0%	0.26	5.00	$ 1,084.65	$ 216.93	$ 0.02
Professional Inpatient Visits	Units	MH	94	1.9%	146.91		$ 64.79		$ 0.79	94	1.9%	146.91		$ 63.99		$ 0.78
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	94	1.9%	146.91		$ 64.79		$ 0.79	94	1.9%	146.91		$ 63.99		$ 0.78
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient SubAcute Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Residential Treatment Center	Admits	MH	15	0.3%	20.15	27.33	$ 7,860.42	$ 287.57	$ 13.20	15	0.3%	20.15	27.33	$ 7,288.78	$ 266.66	$ 12.24
		SA	2	0.0%	0.52	3.50	$ 1,083.58	$ 309.62	$ 0.05	2	0.0%	0.52	3.50	$ 1,004.77	$ 287.11	$ 0.04
		Total	17	0.4%	20.67	26.74	$ 7,691.22	$ 287.65	$ 13.25	17	0.4%	20.67	26.74	$ 7,131.88	$ 266.73	$ 12.28
Treatment Group Home	Admits	MH	13	0.3%	10.84	26.71	$ 4,742.42	$ 177.53	$ 4.28	13	0.3%	10.84	26.71	$ 4,673.64	$ 174.95	$ 4.22
		SA	1	0.0%	2.06	27.00	$ 4,591.17	$ 170.07	$ 0.79	1	0.0%	2.06	27.00	$ 4,524.58	$ 167.60	$ 0.78
		Total	14	0.3%	12.90	26.76	$ 4,718.22	$ 176.32	$ 5.07	14	0.3%	12.90	26.76	$ 4,649.79	$ 173.77	$ 5.00
Professional RTC/Group Home Visits	Units	MH	18	0.4%	40.78		$ 55.96		$ 0.19	18	0.4%	40.78		$ 55.09		$ 0.19
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	18	0.4%	40.78		$ 55.96		$ 0.19	18	0.4%	40.78		$ 55.09		$ 0.19
Treatment Foster Care	Days	MH	4	0.1%	143.70		$ 106.20		$ 1.27	4	0.1%	143.70		$ 104.72		$ 1.25
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	4	0.1%	143.70		$ 106.20		$ 1.27	4	0.1%	143.70		$ 104.72		$ 1.25
Adult Day Treatment Psychiatric Services	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Day Treatment	Cases	MH	43	0.9%	306.51		$ 138.18		$ 3.53	43	0.9%	306.51		$ 137.10		$ 3.50
		SA	1	0.0%	2.58		$ 176.76		$ 0.04	1	0.0%	2.58		$ 175.38		$ 0.04
		Total	44	0.9%	309.09		$ 138.50		$ 3.57	44	0.9%	309.09		$ 137.42		$ 3.54
Intensive Outpatient Services	Cases	MH	23	0.5%	218.90		$ 106.75		$ 1.95	23	0.5%	218.90		$ 105.23		$ 1.92
		SA	6	0.1%	42.58		$ 99.86		$ 0.35	6	0.1%	42.58		$ 98.44		$ 0.35
		Total	29	0.6%	261.48		$ 105.63		$ 2.30	29	0.6%	261.48		$ 104.12		$ 2.27

Experience Report

Blind,Disabled,KatieBeckett_0-18

Service Category	Units Measure	MH/SA	FY11 Member Months = 46,544 Unique Members = 4,842 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 46,544 Unique Members = 4,842 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Crisis Intervention	Days	MH	1	0.0%	14.70		$ 208.08		$ 0.25	1	0.0%	14.70		$ 205.18		$ 0.25
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	1	0.0%	14.70		$ 208.08		$ 0.25	1	0.0%	14.70		$ 205.18		$ 0.25
Medication Checks	Units	MH	542	11.2%	602.76		$ 39.45		$ 1.98	542	11.2%	602.76		$ 39.06		$ 1.96
		SA	1	0.0%	0.52		$ 42.13		$ 0.00	1	0.0%	0.52		$ 41.71		$ 0.00
		Total	543	11.2%	603.27		$ 39.46		$ 1.98	543	11.2%	603.27		$ 39.06		$ 1.96
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	786	16.2%	524.24		$ 115.17		$ 5.03	786	16.2%	524.24		$ 112.54		$ 4.92
		SA	24	0.5%	11.10		$ 103.09		$ 0.10	24	0.5%	11.10		$ 100.74		$ 0.09
		Total	796	16.4%	535.33		$ 114.92		$ 5.13	796	16.4%	535.33		$ 112.30		$ 5.01
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	698	14.4%	1,805.98		$ 63.83		$ 9.61	698	14.4%	1,805.98		$ 63.33		$ 9.53
		SA	15	0.3%	33.30		$ 63.09		$ 0.18	15	0.3%	33.30		$ 62.60		$ 0.17
		Total	709	14.6%	1,839.28		$ 63.82		$ 9.78	709	14.6%	1,839.28		$ 63.32		$ 9.70
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	4	0.1%	6.71		$ 23.62		$ 0.01	4	0.1%	6.71		$ 22.62		$ 0.01
		SA	2	0.0%	10.07		$ 24.09		$ 0.02	2	0.0%	10.07		$ 23.07		$ 0.02
		Total	6	0.1%	16.78		$ 23.90		$ 0.03	6	0.1%	16.78		$ 22.89		$ 0.03
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	426	8.8%	786.17		$ 82.60		$ 5.41	426	8.8%	786.17		$ 83.53		$ 5.47
		SA	1	0.0%	0.26		$ 83.42		$ 0.00	1	0.0%	0.26		$ 84.36		$ 0.00
		Total	427	8.8%	786.42		$ 82.60		$ 5.41	427	8.8%	786.42		$ 83.53		$ 5.47
Family Assessment	Units	MH	2	0.0%	0.52		$ 69.70		$ 0.00	2	0.0%	0.52		$ 68.26		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	2	0.0%	0.52		$ 69.70		$ 0.00	2	0.0%	0.52		$ 68.26		$ 0.00
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	20	0.4%	11.36		$ 21.97		$ 0.02	20	0.4%	11.36		$ 22.70		$ 0.02
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	20	0.4%	11.36		$ 21.97		$ 0.02	20	0.4%	11.36		$ 22.70		$ 0.02
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	14	0.3%	134.56		$ 33.14		$ 0.37	14	0.3%	134.56		$ 32.64		$ 0.37
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	14	0.3%	134.56		$ 33.14		$ 0.37	14	0.3%	134.56		$ 32.64		$ 0.37
Physician Administered Outpatient Drugs	Units	MH	3	0.1%	469.30		$ 4.91		$ 0.19	3	0.1%	469.30		$ 4.91		$ 0.19
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	3	0.1%	469.30		$ 4.91		$ 0.19	3	0.1%	469.30		$ 4.91		$ 0.19
Outpatient Lab/Path/Other	Units	MH	89	1.8%	150.51		$ 22.32		$ 0.28	89	1.8%	150.51		$ 22.01		$ 0.28
		SA	3	0.1%	6.98		$ 31.30		$ 0.02	3	0.1%	6.98		$ 30.86		$ 0.02
		Total	91	1.9%	157.49		$ 22.72		$ 0.30	91	1.9%	157.49		$ 22.41		$ 0.29
Other	Units	MH	11	0.2%	21.15		$ 27.51		$ 0.05	11	0.2%	21.15		$ 27.12		$ 0.05
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	11	0.2%	21.15		$ 27.51		$ 0.05	11	0.2%	21.15		$ 27.12		$ 0.05

Experience Report

Blind,Disabled_19+

			FY09							FY10						
			Member Months =	332,072				Unique Members =	32,089	Member Months =	348,146			Unique Members =	33,492	
Service Category	Units Measure	MH/SA	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
All Service Categories	N/A	MH	11,885	37.0%					$ 105.98	12,381	37.0%					$ 102.68
		SA	716	2.2%					$ 5.11	792	2.4%					$ 6.32
		Total	12,083	37.7%					$ 111.09	12,614	37.7%					$ 109.00
Inpatient Acute Psychiatric	Admits	MH	674	2.1%	43.62	8.62	$ 4,488.85	$ 521.02	$ 16.32	720	2.1%	46.08	8.38	$ 4,201.59	$ 501.21	$ 16.13
		SA	1	0.0%	0.04	4.00	$ 1,916.78	$ 479.20	$ 0.01	1	0.0%	0.03	3.00	$ 1,310.90	$ 436.97	$ 0.00
		Total	674	2.1%	43.65	8.61	$ 4,486.72	$ 521.00	$ 16.32	720	2.1%	46.11	8.38	$ 4,199.43	$ 501.19	$ 16.14
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	744	2.3%	34.58	11.62	$ 1,461.59	$ 125.74	$ 4.21	784	2.3%	34.97	11.11	$ 1,481.33	$ 133.29	$ 4.32
		SA	1	0.0%	0.04	9.00	$ 1,068.00	$ 118.67	$ 0.00	2	0.0%	0.07	29.52	$16,343.66	$ 553.68	$ 0.09
		Total	745	2.3%	34.62	11.62	$ 1,461.18	$ 125.73	$ 4.22	786	2.3%	35.04	11.15	$ 1,510.59	$ 135.49	$ 4.41
Professional Inpatient Visits	Units	MH	1,634	5.1%	612.26		$ 34.40		$ 1.76	1,664	5.0%	564.49		$ 36.73		$ 1.73
		SA	96	0.3%	11.74		$ 40.16		$ 0.04	79	0.2%	8.27		$ 41.34		$ 0.03
		Total	1,679	5.2%	624.01		$ 34.51		$ 1.79	1,704	5.1%	572.76		$ 36.80		$ 1.76
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	84	0.3%	3.47	25.14	$ 6,705.10	$ 266.76	$ 1.94	67	0.2%	2.79	20.59	$ 5,987.92	$ 290.81	$ 1.39
		SA	113	0.4%	8.17	16.86	$ 5,285.40	$ 313.52	$ 3.60	121	0.4%	5.45	54.04	$10,978.33	$ 203.16	$ 4.98
		Total	195	0.6%	11.64	19.33	$ 5,708.67	$ 295.39	$ 5.54	185	0.6%	8.24	42.70	$ 9,286.36	$ 217.49	$ 6.38
Professional Inpatient SubAcute Visits	Units	MH	46	0.1%	9.29		$ 272.32		$ 0.21	39	0.1%	6.24		$ 400.14		$ 0.21
		SA	112	0.3%	23.31		$ 107.75		$ 0.21	128	0.4%	12.82		$ 173.95		$ 0.19
		Total	152	0.5%	32.60		$ 154.64		$ 0.42	162	0.5%	19.06		$ 247.98		$ 0.39
Residential Treatment Center	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	4	0.0%	0.54	8.73	$ 2,713.55	$ 310.71	$ 0.12	2	0.0%	0.21	25.17	$ 6,175.12	$ 245.37	$ 0.11
		Total	4	0.0%	0.54	8.73	$ 2,713.55	$ 310.71	$ 0.12	2	0.0%	0.21	25.17	$ 6,175.12	$ 245.37	$ 0.11
Treatment Group Home	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional RTC/Group Home Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	1	0.0%	0.07		$ 159.52		$ 0.00	4	0.0%	0.17		$ 144.79		$ 0.00
		Total	1	0.0%	0.07		$ 159.52		$ 0.00	4	0.0%	0.17		$ 144.79		$ 0.00
Treatment Foster Care	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Adult Day Treatment Psychiatric Services	Cases	MH	708	2.2%	1,957.13		$ 46.26		$ 7.54	774	2.3%	2,480.85		$ 44.19		$ 9.14
		SA	74	0.2%	43.76		$ 80.79		$ 0.29	71	0.2%	30.40		$ 78.76		$ 0.20
		Total	774	2.4%	2,000.89		$ 47.02		$ 7.84	833	2.5%	2,511.25		$ 44.61		$ 9.34
Day Treatment	Cases	MH	9	0.0%	1.55		$ 181.68		$ 0.02	11	0.0%	2.00		$ 157.03		$ 0.03
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	9	0.0%	1.55		$ 181.68		$ 0.02	11	0.0%	2.00		$ 157.03		$ 0.03
Intensive Outpatient Services	Cases	MH	2	0.0%	0.54		$ 157.69		$ 0.01	2	0.0%	0.90		$ 87.72		$ 0.01
		SA	-	0.0%	-				$ -	1	0.0%	0.03		$ 26.76		$ 0.00
		Total	2	0.0%	0.54		$ 157.69		$ 0.01	3	0.0%	0.93		$ 85.47		$ 0.01

Experience Report

Blind,Disabled_19+

			FY09						FY10					
			Member Months = 332,072				Unique Members = 32,089		Member Months = 348,146				Unique Members = 33,492	
Service Category	Units Measure	MH/SA	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	61	0.2%	473.83		$ 5.91		$ 0.23	65	0.2%	420.54		$ 8.96		$ 0.31
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	61	0.2%	473.83		$ 5.91		$ 0.23	65	0.2%	420.54		$ 8.96		$ 0.31
Treatment Crisis Intervention	Days	MH	4	0.0%	0.83		$ 278.07		$ 0.02	2	0.0%	1.14		$ 332.50		$ 0.03
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	4	0.0%	0.83		$ 278.07		$ 0.02	2	0.0%	1.14		$ 332.50		$ 0.03
Medication Checks	Units	MH	5,819	18.1%	1,011.07		$ 30.58		$ 2.58	6,354	19.0%	1,181.16		$ 31.64		$ 3.11
		SA	40	0.1%	3.14		$ 31.79		$ 0.01	52	0.2%	4.52		$ 28.34		$ 0.01
		Total	5,836	18.2%	1,014.21		$ 30.58		$ 2.58	6,381	19.1%	1,185.67		$ 31.63		$ 3.13
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	6,843	21.3%	529.76		$ 88.71		$ 3.92	6,284	18.8%	495.83		$ 87.07		$ 3.60
		SA	155	0.5%	6.61		$ 128.08		$ 0.07	214	0.6%	9.62		$ 132.93		$ 0.11
		Total	6,917	21.6%	536.38		$ 89.20		$ 3.99	6,384	19.1%	505.44		$ 87.95		$ 3.70
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	198	0.6%	15.54		$ 113.34		$ 0.15	217	0.6%	15.10		$ 112.01		$ 0.14
		SA	2	0.0%	0.25		$ 96.28		$ 0.00	7	0.0%	0.24		$ 166.92		$ 0.00
		Total	199	0.6%	15.79		$ 113.06		$ 0.15	220	0.7%	15.34		$ 112.87		$ 0.14
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	7,692	24.0%	4,704.46		$ 52.72		$ 20.67	7,467	22.3%	3,982.26		$ 54.72		$ 18.16
		SA	135	0.4%	30.64		$ 55.73		$ 0.14	130	0.4%	24.06		$ 57.43		$ 0.12
		Total	7,765	24.2%	4,735.10		$ 52.74		$ 20.81	7,541	22.5%	4,006.32		$ 54.73		$ 18.27
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	270	0.8%	156.36		$ 17.00		$ 0.22	200	0.6%	89.89		$ 17.41		$ 0.13
		SA	63	0.2%	21.97		$ 19.63		$ 0.04	57	0.2%	13.30		$ 24.19		$ 0.03
		Total	330	1.0%	178.33		$ 17.32		$ 0.26	256	0.8%	103.20		$ 18.28		$ 0.16
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	762	2.4%	185.20		$ 77.93		$ 1.20	598	1.8%	128.64		$ 79.82		$ 0.86
		SA	2	0.0%	0.18		$ 47.50		$ 0.00	-	0.0%	-				$ -
		Total	763	2.4%	185.38		$ 77.90		$ 1.20	598	1.8%	128.64		$ 79.82		$ 0.86
Family Assessment	Units	MH	2	0.0%	0.07		$ 68.34		$ 0.00	2	0.0%	0.07		$ 69.47		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	2	0.0%	0.07		$ 68.34		$ 0.00	2	0.0%	0.07		$ 69.47		$ 0.00
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	3	0.0%	0.11		$ 16.48		$ 0.00	2	0.0%	0.10		$ 22.38		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	3	0.0%	0.11		$ 16.48		$ 0.00	2	0.0%	0.10		$ 22.38		$ 0.00
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	2,431	7.6%	16,691.98		$ 29.67		$ 41.27	2,519	7.5%	15,876.19		$ 29.87		$ 39.52
		SA	94	0.3%	25.19		$ 211.95		$ 0.44	97	0.3%	19.96		$ 226.59		$ 0.38
		Total	2,501	7.8%	16,717.17		$ 29.95		$ 41.72	2,600	7.8%	15,896.15		$ 30.12		$ 39.90
Physician Administered Outpatient Drugs	Units	MH	339	1.1%	8,321.93		$ 4.40		$ 3.05	324	1.0%	8,236.93		$ 4.68		$ 3.21
		SA	2	0.0%	0.14		$ 1.94		$ 0.00	1	0.0%	0.03		$ 3.44		$ 0.00
		Total	340	1.1%	8,322.07		$ 4.40		$ 3.05	324	1.0%	8,236.96		$ 4.68		$ 3.21
Outpatient Lab/Path/Other	Units	MH	653	2.0%	273.27		$ 17.22		$ 0.39	752	2.2%	258.67		$ 18.33		$ 0.40
		SA	113	0.4%	34.66		$ 21.13		$ 0.06	146	0.4%	44.18		$ 20.60		$ 0.08
		Total	753	2.3%	307.92		$ 17.66		$ 0.45	872	2.6%	302.85		$ 18.66		$ 0.47
Other	Units	MH	487	1.5%	235.97		$ 13.67		$ 0.27	502	1.5%	257.48		$ 12.39		$ 0.27
		SA	8	0.0%	4.99		$ 174.92		$ 0.07	3	0.0%	0.93		$ 2.35		$ 0.00
		Total	495	1.5%	240.96		$ 17.01		$ 0.34	505	1.5%	258.41		$ 12.36		$ 0.27

Experience Report

Blind,Disabled_19+

Service Category	Units Measure	MH/SA	FY11 Member Months = 365,053 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 365,053 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
			Unique Members = 35,104							Unique Members = 35,104						
All Service Categories	N/A	MH	12,957	36.9%					$ 101.03	12,957	36.9%					$ 99.00
		SA	823	2.3%					$ 4.85	823	2.3%					$ 4.81
		Total	13,204	37.6%					$ 105.88	13,204	37.6%					$ 103.81
Inpatient Acute Psychiatric	Admits	MH	750	2.1%	45.88	8.10	$ 4,172.13	$ 515.34	$ 15.95	750	2.1%	45.88	8.10	$ 4,097.72	$ 506.15	$ 15.67
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	750	2.1%	45.88	8.10	$ 4,172.13	$ 515.34	$ 15.95	750	2.1%	45.88	8.10	$ 4,097.72	$ 506.15	$ 15.67
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	813	2.3%	33.64	11.14	$ 1,615.22	$ 145.04	$ 4.53	813	2.3%	33.64	11.14	$ 1,577.71	$ 141.67	$ 4.42
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	813	2.3%	33.64	11.14	$ 1,615.22	$ 145.04	$ 4.53	813	2.3%	33.64	11.14	$ 1,577.71	$ 141.67	$ 4.42
Professional Inpatient Visits	Units	MH	1,733	4.9%	585.81		$ 38.46		$ 1.88	1,733	4.9%	585.81		$ 37.86		$ 1.85
		SA	114	0.3%	7.51		$ 59.58		$ 0.04	114	0.3%	7.51		$ 58.64		$ 0.04
		Total	1,798	5.1%	593.31		$ 38.73		$ 1.91	1,798	5.1%	593.31		$ 38.12		$ 1.88
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	73	0.2%	3.27	11.16	$ 4,779.17	$ 428.18	$ 1.30	73	0.2%	3.27	11.16	$ 4,769.58	$ 427.33	$ 1.30
		SA	137	0.4%	6.09	36.24	$ 6,964.41	$ 192.19	$ 3.53	137	0.4%	6.09	36.24	$ 6,950.43	$ 191.80	$ 3.53
		Total	206	0.6%	9.35	27.48	$ 6,201.59	$ 225.65	$ 4.83	206	0.6%	9.35	27.48	$ 6,189.14	$ 225.19	$ 4.82
Professional Inpatient SubAcute Visits	Units	MH	52	0.1%	11.29		$ 325.87		$ 0.31	52	0.1%	11.29		$ 321.27		$ 0.30
		SA	174	0.5%	16.53		$ 169.54		$ 0.23	174	0.5%	16.53		$ 167.14		$ 0.23
		Total	216	0.6%	27.82		$ 233.00		$ 0.54	216	0.6%	27.82		$ 229.71		$ 0.53
Residential Treatment Center	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	3	0.0%	0.30	28.00	$ 5,194.51	$ 185.52	$ 0.13	3	0.0%	0.30	28.00	$ 4,816.74	$ 172.02	$ 0.12
		Total	3	0.0%	0.30	28.00	$ 5,194.51	$ 185.52	$ 0.13	3	0.0%	0.30	28.00	$ 4,816.74	$ 172.02	$ 0.12
Treatment Group Home	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional RTC/Group Home Visits	Units	MH	1	0.0%	0.10		$ 110.00		$ 0.00	1	0.0%	0.10		$ 108.09		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	1	0.0%	0.10		$ 110.00		$ 0.00	1	0.0%	0.10		$ 108.09		$ 0.00
Treatment Foster Care	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Adult Day Treatment Psychiatric Services	Cases	MH	819	2.3%	2,362.20		$ 44.92		$ 8.84	819	2.3%	2,362.20		$ 44.23		$ 8.71
		SA	84	0.2%	35.26		$ 76.97		$ 0.23	84	0.2%	35.26		$ 75.79		$ 0.22
		Total	892	2.5%	2,397.46		$ 45.39		$ 9.07	892	2.5%	2,397.46		$ 44.69		$ 8.93
Day Treatment	Cases	MH	12	0.0%	1.19		$ 181.80		$ 0.02	12	0.0%	1.19		$ 180.38		$ 0.02
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	12	0.0%	1.19		$ 181.80		$ 0.02	12	0.0%	1.19		$ 180.38		$ 0.02
Intensive Outpatient Services	Cases	MH	1	0.0%	1.58		$ 84.34		$ 0.01	1	0.0%	1.58		$ 83.14		$ 0.01
		SA	3	0.0%	1.87		$ 86.80		$ 0.01	3	0.0%	1.87		$ 85.57		$ 0.01
		Total	4	0.0%	3.46		$ 85.68		$ 0.02	4	0.0%	3.46		$ 84.46		$ 0.02

Experience Report

Blind,Disabled_19+

Service Category	Units Measure	MH/SA	FY11 Member Months = 365,053 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Unique Members = 35,104 Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 365,053 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Unique Members = 35,104 Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	65	0.2%	401.06		$ 7.52		$ 0.25	65	0.2%	401.06		$ 7.41		$ 0.25
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	65	0.2%	401.06		$ 7.52		$ 0.25	65	0.2%	401.06		$ 7.41		$ 0.25
Treatment Crisis Intervention	Days	MH	2	0.0%	0.26		$ 343.28		$ 0.01	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	2	0.0%	0.26		$ 343.28		$ 0.01	-	0.0%	-				$ -
Medication Checks	Units	MH	6,734	19.2%	1,178.99		$ 32.03		$ 3.15	6,734	19.2%	1,178.99		$ 31.70		$ 3.11
		SA	64	0.2%	5.63		$ 34.81		$ 0.02	64	0.2%	5.63		$ 34.46		$ 0.02
		Total	6,767	19.3%	1,184.62		$ 32.04		$ 3.16	6,767	19.3%	1,184.62		$ 31.72		$ 3.13
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	6,383	18.2%	483.30		$ 83.76		$ 3.37	6,383	18.2%	483.30		$ 81.01		$ 3.26
		SA	229	0.7%	9.84		$ 126.99		$ 0.10	229	0.7%	9.84		$ 122.83		$ 0.10
		Total	6,503	18.5%	493.14		$ 84.62		$ 3.48	6,503	18.5%	493.14		$ 81.85		$ 3.36
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	233	0.7%	16.65		$ 108.03		$ 0.15	233	0.7%	16.65		$ 105.04		$ 0.15
		SA	4	0.0%	0.13		$ 84.54		$ 0.00	4	0.0%	0.13		$ 82.20		$ 0.00
		Total	237	0.7%	16.78		$ 107.85		$ 0.15	237	0.7%	16.78		$ 104.86		$ 0.15
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	7,673	21.9%	3,821.96		$ 54.97		$ 17.51	7,673	21.9%	3,821.96		$ 52.81		$ 16.82
		SA	149	0.4%	32.45		$ 58.64		$ 0.16	149	0.4%	32.45		$ 56.33		$ 0.15
		Total	7,758	22.1%	3,854.41		$ 55.00		$ 17.67	7,758	22.1%	3,854.41		$ 52.84		$ 16.97
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	165	0.5%	69.37		$ 18.42		$ 0.11	165	0.5%	69.37		$ 17.62		$ 0.10
		SA	47	0.1%	12.67		$ 24.21		$ 0.03	47	0.1%	12.67		$ 23.16		$ 0.02
		Total	209	0.6%	82.04		$ 19.31		$ 0.13	209	0.6%	82.04		$ 18.47		$ 0.13
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	549	1.6%	105.55		$ 79.65		$ 0.70	549	1.6%	105.55		$ 78.62		$ 0.69
		SA	4	0.0%	0.30		$ 79.11		$ 0.00	4	0.0%	0.30		$ 78.09		$ 0.00
		Total	553	1.6%	105.85		$ 79.65		$ 0.70	553	1.6%	105.85		$ 78.62		$ 0.69
Family Assessment	Units	MH	6	0.0%	0.20		$ 69.68		$ 0.00	6	0.0%	0.20		$ 68.24		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	6	0.0%	0.20		$ 69.68		$ 0.00	6	0.0%	0.20		$ 68.24		$ 0.00
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	2,611	7.4%	15,073.79		$ 31.53		$ 39.61	2,611	7.4%	15,073.79		$ 31.06		$ 39.01
		SA	79	0.2%	15.93		$ 228.10		$ 0.30	79	0.2%	15.93		$ 224.65		$ 0.30
		Total	2,679	7.6%	15,089.72		$ 31.74		$ 39.91	2,679	7.6%	15,089.72		$ 31.26		$ 39.31
Physician Administered Outpatient Drugs	Units	MH	358	1.0%	7,302.35		$ 4.58		$ 2.79	358	1.0%	7,302.35		$ 4.58		$ 2.79
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	358	1.0%	7,302.35		$ 4.58		$ 2.79	358	1.0%	7,302.35		$ 4.58		$ 2.79
Outpatient Lab/Path/Other	Units	MH	701	2.0%	215.98		$ 18.08		$ 0.33	701	2.0%	215.98		$ 17.83		$ 0.32
		SA	137	0.4%	41.95		$ 19.75		$ 0.07	137	0.4%	41.95		$ 19.48		$ 0.07
		Total	821	2.3%	257.93		$ 18.35		$ 0.39	821	2.3%	257.93		$ 18.09		$ 0.39
Other	Units	MH	456	1.3%	181.98		$ 14.58		$ 0.22	456	1.3%	181.98		$ 14.38		$ 0.22
		SA	5	0.0%	0.30		$ 22.85		$ 0.00	5	0.0%	0.30		$ 22.54		$ 0.00
		Total	457	1.3%	182.28		$ 14.60		$ 0.22	457	1.3%	182.28		$ 14.39		$ 0.22

Experience Report

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Service Category	Units Measure	MH/SA	FY09 Member Months = 316,561 Unique Members = 49,234							FY10 Member Months = 316,573 Unique Members = 46,219						
			Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
All Service Categories	N/A	MH	3,913	7.9%					$ 18.93	3,773	8.2%					$ 15.75
		SA	157	0.3%					$ 0.66	167	0.4%					$ 1.02
		Total	3,988	8.1%					$ 19.59	3,849	8.3%					$ 16.77
Inpatient Acute Psychiatric	Admits	MH	185	0.4%	8.83	8.48	$ 4,378.51	$ 516.55	$ 3.22	180	0.4%	8.61	7.11	$ 3,751.72	$ 527.98	$ 2.69
		SA	1	0.0%	0.04	4.00	$ 1,916.78	$ 479.20	$ 0.01	-	0.0%	-				$ -
		Total	185	0.4%	8.87	8.46	$ 4,367.99	$ 516.48	$ 3.23	180	0.4%	8.61	7.11	$ 3,751.72	$ 527.98	$ 2.69
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	1	0.0%	0.04	49.00	$28,574.04	$ 583.14	$ 0.09
		Total	-	0.0%	-				$ -	1	0.0%	0.04	49.00	$28,574.04	$ 583.14	$ 0.09
Professional Inpatient Visits	Units	MH	194	0.4%	54.44		$ 56.86		$ 0.26	184	0.4%	43.93		$ 65.58		$ 0.24
		SA	2	0.0%	0.19		$ 71.33		$ 0.00	1	0.0%	0.04		$ 86.07		$ 0.00
		Total	195	0.4%	54.62		$ 56.91		$ 0.26	185	0.4%	43.97		$ 65.60		$ 0.24
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient SubAcute Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Residential Treatment Center	Admits	MH	34	0.1%	4.44	25.41	$ 6,944.92	$ 273.31	$ 2.57	24	0.1%	3.79	27.74	$ 7,634.62	$ 275.22	$ 2.41
		SA	8	0.0%	0.53	19.57	$ 4,907.35	$ 250.74	$ 0.22	12	0.0%	1.06	17.43	$ 4,481.25	$ 257.12	$ 0.40
		Total	42	0.1%	4.97	24.79	$ 6,727.17	$ 271.41	$ 2.78	36	0.1%	4.85	25.48	$ 6,944.96	$ 272.51	$ 2.81
Treatment Group Home	Admits	MH	24	0.0%	3.49	26.23	$ 4,770.44	$ 181.88	$ 1.39	12	0.0%	1.48	25.00	$ 4,522.28	$ 180.89	$ 0.56
		SA	4	0.0%	0.49	23.38	$ 3,886.79	$ 166.21	$ 0.16	6	0.0%	0.42	26.45	$ 4,292.03	$ 162.24	$ 0.15
		Total	28	0.1%	3.98	25.88	$ 4,661.04	$ 180.13	$ 1.55	18	0.0%	1.90	25.32	$ 4,471.63	$ 176.60	$ 0.71
Professional RTC/Group Home Visits	Units	MH	37	0.1%	6.56		$ 68.93		$ 0.04	27	0.1%	6.06		$ 66.28		$ 0.03
		SA	2	0.0%	0.08		$ 146.64		$ 0.00	9	0.0%	0.49		$ 78.65		$ 0.00
		Total	39	0.1%	6.63		$ 69.82		$ 0.04	36	0.1%	6.56		$ 67.21		$ 0.04
Treatment Foster Care	Days	MH	10	0.0%	31.43		$ 105.24		$ 0.28	3	0.0%	15.12		$ 109.12		$ 0.14
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	10	0.0%	31.43		$ 105.24		$ 0.28	3	0.0%	15.12		$ 109.12		$ 0.14
Adult Day Treatment Psychiatric Services	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Day Treatment	Cases	MH	103	0.2%	64.97		$ 170.59		$ 0.92	84	0.2%	43.34		$ 155.85		$ 0.56
		SA	5	0.0%	2.43		$ 104.72		$ 0.02	6	0.0%	1.21		$ 121.53		$ 0.01
		Total	108	0.2%	67.40		$ 168.22		$ 0.94	90	0.2%	44.55		$ 154.92		$ 0.58
Intensive Outpatient Services	Cases	MH	54	0.1%	56.44		$ 111.27		$ 0.52	45	0.1%	52.35		$ 113.71		$ 0.50
		SA	20	0.0%	12.13		$ 98.86		$ 0.10	28	0.1%	22.29		$ 99.50		$ 0.18
		Total	73	0.1%	68.57		$ 109.08		$ 0.62	71	0.2%	74.64		$ 109.47		$ 0.68

Experience Report

CHIP

Service Category	Units Measure	MH/SA	FY09 Member Months = 316,561 Unique Members = 49,234						FY10 Member Months = 316,573 Unique Members = 46,219					
			Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Crisis Intervention	Days	MH	2	0.0%	0.61		$ 336.61		$ 0.02	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	2	0.0%	0.61		$ 336.61		$ 0.02	-	0.0%	-				$ -
Medication Checks	Units	MH	724	1.5%	80.86		$ 39.74		$ 0.27	787	1.7%	104.24		$ 40.21		$ 0.35
		SA	5	0.0%	0.38		$ 41.31		$ 0.00	6	0.0%	0.49		$ 41.92		$ 0.00
		Total	728	1.5%	81.24		$ 39.74		$ 0.27	793	1.7%	104.73		$ 40.22		$ 0.35
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	2,543	5.2%	213.65		$ 124.98		$ 2.23	2,428	5.3%	217.92		$ 124.15		$ 2.25
		SA	77	0.2%	4.97		$ 149.20		$ 0.06	97	0.2%	6.60		$ 127.34		$ 0.07
		Total	2,591	5.3%	218.61		$ 125.53		$ 2.29	2,486	5.4%	224.52		$ 124.24		$ 2.32
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	2,710	5.5%	872.70		$ 62.55		$ 4.55	2,351	5.1%	702.59		$ 64.82		$ 3.80
		SA	72	0.1%	11.22		$ 61.02		$ 0.06	68	0.1%	13.95		$ 62.76		$ 0.07
		Total	2,756	5.6%	883.92		$ 62.54		$ 4.61	2,413	5.2%	716.54		$ 64.78		$ 3.87
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	18	0.0%	5.34		$ 23.46		$ 0.01	23	0.0%	9.97		$ 28.18		$ 0.02
		SA	13	0.0%	8.60		$ 23.96		$ 0.02	25	0.1%	10.05		$ 23.80		$ 0.02
		Total	31	0.1%	13.95		$ 23.77		$ 0.03	48	0.1%	20.01		$ 25.99		$ 0.04
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	1,514	3.1%	344.54		$ 81.97		$ 2.35	1,403	3.0%	286.38		$ 83.98		$ 2.00
		SA	4	0.0%	0.23		$ 83.49		$ 0.00	10	0.0%	0.61		$ 83.08		$ 0.00
		Total	1,517	3.1%	344.77		$ 81.97		$ 2.36	1,413	3.1%	286.99		$ 83.98		$ 2.01
Family Assessment	Units	MH	4	0.0%	0.15		$ 68.46		$ 0.00	4	0.0%	0.15		$ 69.35		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	4	0.0%	0.15		$ 68.46		$ 0.00	4	0.0%	0.15		$ 69.35		$ 0.00
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	8	0.0%	1.10		$ 16.68		$ 0.00	14	0.0%	0.76		$ 23.32		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	8	0.0%	1.10		$ 16.68		$ 0.00	14	0.0%	0.76		$ 23.32		$ 0.00
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	43	0.1%	76.72		$ 32.52		$ 0.21	16	0.0%	31.84		$ 34.44		$ 0.09
		SA	1	0.0%	0.15		$ 32.18		$ 0.00	-	0.0%	-				$ -
		Total	44	0.1%	76.88		$ 32.51		$ 0.21	16	0.0%	31.84		$ 34.44		$ 0.09
Physician Administered Outpatient Drugs	Units	MH	1	0.0%	5.72		$ 4.86		$ 0.00	1	0.0%	26.16		$ 4.91		$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	1	0.0%	5.72		$ 4.86		$ 0.00	1	0.0%	26.16		$ 4.91		$ 0.01
Outpatient Lab/Path/Other	Units	MH	173	0.4%	40.86		$ 21.76		$ 0.07	149	0.3%	32.47		$ 25.11		$ 0.07
		SA	33	0.1%	10.20		$ 19.85		$ 0.02	29	0.1%	8.08		$ 24.50		$ 0.02
		Total	203	0.4%	51.06		$ 21.38		$ 0.09	176	0.4%	40.54		$ 24.99		$ 0.08
Other	Units	MH	58	0.1%	146.13		$ 2.01		$ 0.02	44	0.1%	12.66		$ 17.34		$ 0.02
		SA	2	0.0%	0.64		$ 6.41		$ 0.00	2	0.0%	0.64		$ 6.47		$ 0.00
		Total	60	0.1%	146.78		$ 2.03		$ 0.02	46	0.1%	13.30		$ 16.82		$ 0.02

Experience Report

CHIP

Service Category	Units Measure	MH/SA	FY11 Member Months = 358,005 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Unique Members = 51,371 Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 358,005 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Unique Members = 51,371 Average Cost Per Unit	Average Cost Per Day	PMPM Cost
All Service Categories	N/A	MH	4,126	8.0%					$ 15.04	4,126	8.0%					$ 14.79
		SA	194	0.4%					$ 1.33	194	0.4%					$ 1.28
		Total	4,237	8.2%					$ 16.36	4,237	8.2%					$ 16.07
Inpatient Acute Psychiatric	Admits	MH	229	0.4%	9.65	6.30	$ 3,334.73	$ 529.37	$ 2.68	229	0.4%	9.65	6.30	$ 3,288.18	$ 521.98	$ 2.64
		SA	2	0.0%	0.07	2.50	$ 1,036.57	$ 414.65	$ 0.01	2	0.0%	0.07	2.50	$ 1,022.10	$ 408.86	$ 0.01
		Total	231	0.4%	9.72	6.27	$ 3,318.85	$ 529.05	$ 2.69	231	0.4%	9.72	6.27	$ 3,272.52	$ 521.67	$ 2.65
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	1	0.0%	0.03	2.00	$ 691.10	$ 345.55	$ 0.00	1	0.0%	0.03	2.00	$ 681.45	$ 340.73	$ 0.00
		Total	1	0.0%	0.03	2.00	$ 691.10	$ 345.55	$ 0.00	1	0.0%	0.03	2.00	$ 681.45	$ 340.73	$ 0.00
Professional Inpatient Visits	Units	MH	233	0.5%	44.93		$ 67.36		$ 0.25	233	0.5%	44.93		$ 66.53		$ 0.25
		SA	2	0.0%	0.27		$ 61.57		$ 0.00	2	0.0%	0.27		$ 60.81		$ 0.00
		Total	235	0.5%	45.20		$ 67.33		$ 0.25	235	0.5%	45.20		$ 66.50		$ 0.25
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient SubAcute Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Residential Treatment Center	Admits	MH	19	0.0%	2.55	25.74	$ 7,753.79	$ 301.27	$ 1.65	19	0.0%	2.55	25.74	$ 7,189.90	$ 279.36	$ 1.53
		SA	15	0.0%	1.17	16.43	$ 4,762.98	$ 289.91	$ 0.47	15	0.0%	1.17	16.43	$ 4,416.59	$ 268.82	$ 0.43
		Total	33	0.1%	3.73	22.81	$ 6,811.87	$ 298.69	$ 2.12	33	0.1%	3.73	22.81	$ 6,316.48	$ 276.97	$ 1.96
Treatment Group Home	Admits	MH	16	0.0%	1.81	24.04	$ 4,166.22	$ 173.32	$ 0.63	16	0.0%	1.81	24.04	$ 4,105.80	$ 170.81	$ 0.62
		SA	9	0.0%	1.07	25.53	$ 4,091.88	$ 160.26	$ 0.37	9	0.0%	1.07	25.53	$ 4,032.54	$ 157.93	$ 0.36
		Total	24	0.0%	2.89	24.59	$ 4,138.56	$ 168.28	$ 1.00	24	0.0%	2.89	24.59	$ 4,078.54	$ 165.84	$ 0.98
Professional RTC/Group Home Visits	Units	MH	22	0.0%	7.45		$ 59.30		$ 0.04	22	0.0%	7.45		$ 58.38		$ 0.04
		SA	12	0.0%	0.91		$ 84.44		$ 0.01	12	0.0%	0.91		$ 83.13		$ 0.01
		Total	34	0.1%	8.35		$ 62.03		$ 0.04	34	0.1%	8.35		$ 61.06		$ 0.04
Treatment Foster Care	Days	MH	2	0.0%	2.65		$ 110.56		$ 0.02	2	0.0%	2.65		$ 109.02		$ 0.02
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	2	0.0%	2.65		$ 110.56		$ 0.02	2	0.0%	2.65		$ 109.02		$ 0.02
Adult Day Treatment Psychiatric Services	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Day Treatment	Cases	MH	114	0.2%	62.12		$ 169.41		$ 0.88	114	0.2%	62.12		$ 168.08		$ 0.87
		SA	10	0.0%	4.27		$ 178.58		$ 0.06	10	0.0%	4.27		$ 177.18		$ 0.06
		Total	124	0.2%	66.38		$ 170.00		$ 0.94	124	0.2%	66.38		$ 168.67		$ 0.93
Intensive Outpatient Services	Cases	MH	58	0.1%	59.88		$ 112.90		$ 0.56	58	0.1%	59.88		$ 111.29		$ 0.56
		SA	41	0.1%	21.72		$ 97.12		$ 0.18	41	0.1%	21.72		$ 95.74		$ 0.17
		Total	99	0.2%	81.59		$ 108.70		$ 0.74	99	0.2%	81.59		$ 107.15		$ 0.73

Experience Report

CHIP

Service Category	Units Measure	MH/SA	FY11 Member Months = 358,005 Unique Members = 51,371 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 358,005 Unique Members = 51,371 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Crisis Intervention	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Medication Checks	Units	MH	907	1.8%	105.07		$ 40.37		$ 0.35	907	1.8%	105.07		$ 39.96		$ 0.35
		SA	9	0.0%	0.47		$ 42.13		$ 0.00	9	0.0%	0.47		$ 41.71		$ 0.00
		Total	912	1.8%	105.54		$ 40.37		$ 0.36	912	1.8%	105.54		$ 39.97		$ 0.35
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	2,668	5.2%	222.97		$ 120.59		$ 2.24	2,668	5.2%	222.97		$ 117.84		$ 2.19
		SA	125	0.2%	8.19		$ 136.13		$ 0.09	125	0.2%	8.19		$ 133.03		$ 0.09
		Total	2,748	5.3%	231.16		$ 121.14		$ 2.33	2,748	5.3%	231.16		$ 118.38		$ 2.28
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	2,545	5.0%	657.09		$ 65.06		$ 3.56	2,545	5.0%	657.09		$ 64.55		$ 3.53
		SA	75	0.1%	16.91		$ 62.86		$ 0.09	75	0.1%	16.91		$ 62.37		$ 0.09
		Total	2,605	5.1%	674.01		$ 65.01		$ 3.65	2,605	5.1%	674.01		$ 64.50		$ 3.62
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	20	0.0%	6.28		$ 24.10		$ 0.01	20	0.0%	6.28		$ 23.09		$ 0.01
		SA	27	0.1%	12.18		$ 24.03		$ 0.02	27	0.1%	12.18		$ 23.01		$ 0.02
		Total	46	0.1%	18.46		$ 24.05		$ 0.04	46	0.1%	18.46		$ 23.04		$ 0.04
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	1,582	3.1%	282.25		$ 84.32		$ 1.98	1,582	3.1%	282.25		$ 85.27		$ 2.01
		SA	18	0.0%	1.78		$ 82.16		$ 0.01	18	0.0%	1.78		$ 83.08		$ 0.01
		Total	1,600	3.1%	284.03		$ 84.30		$ 2.00	1,600	3.1%	284.03		$ 85.25		$ 2.02
Family Assessment	Units	MH	1	0.0%	0.03		$ 69.70		$ 0.00	1	0.0%	0.03		$ 68.26		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	1	0.0%	0.03		$ 69.70		$ 0.00	1	0.0%	0.03		$ 68.26		$ 0.00
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	28	0.1%	1.81		$ 22.26		$ 0.00	28	0.1%	1.81		$ 22.99		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	28	0.1%	1.81		$ 22.26		$ 0.00	28	0.1%	1.81		$ 22.99		$ 0.00
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	22	0.0%	28.91		$ 33.61		$ 0.08	22	0.0%	28.91		$ 33.11		$ 0.08
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	22	0.0%	28.91		$ 33.61		$ 0.08	22	0.0%	28.91		$ 33.11		$ 0.08
Physician Administered Outpatient Drugs	Units	MH	2	0.0%	41.70		$ 6.31		$ 0.02	2	0.0%	41.70		$ 6.31		$ 0.02
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	2	0.0%	41.70		$ 6.31		$ 0.02	2	0.0%	41.70		$ 6.31		$ 0.02
Outpatient Lab/Path/Other	Units	MH	116	0.2%	21.76		$ 21.77		$ 0.04	116	0.2%	21.76		$ 21.46		$ 0.04
		SA	24	0.0%	11.33		$ 20.17		$ 0.02	24	0.0%	11.33		$ 19.89		$ 0.02
		Total	140	0.3%	33.08		$ 21.22		$ 0.06	140	0.3%	33.08		$ 20.92		$ 0.06
Other	Units	MH	51	0.1%	20.11		$ 14.15		$ 0.02	51	0.1%	20.11		$ 13.95		$ 0.02
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	51	0.1%	20.11		$ 14.15		$ 0.02	51	0.1%	20.11		$ 13.95		$ 0.02

Experience Report

Families_0-5

			FY09							FY10						
			Member Months =	684,592				Unique Members =	82,791	Member Months =	727,660			Unique Members =	80,770	
Service Category	Units Measure	MH/SA	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
All Service Categories	N/A	MH	2,159	2.6%					$ 2.45	2,093	2.6%					$ 1.95
		SA	37	0.0%					$ 0.10	30	0.0%					$ 0.01
		Total	2,192	2.6%					$ 2.55	2,112	2.6%					$ 1.97
Inpatient Acute Psychiatric	Admits	MH	31	0.0%	0.63	5.31	$ 2,618.36	$ 493.51	$ 0.14	21	0.0%	0.36	5.91	$ 3,060.50	$ 517.99	$ 0.09
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	31	0.0%	0.63	5.31	$ 2,618.36	$ 493.51	$ 0.14	21	0.0%	0.36	5.91	$ 3,060.50	$ 517.99	$ 0.09
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient Visits	Units	MH	46	0.1%	3.45		$ 62.12		$ 0.02	30	0.0%	1.70		$ 72.15		$ 0.01
		SA	3	0.0%	0.26		$ 92.25		$ 0.00	-	0.0%	-				$ -
		Total	49	0.1%	3.72		$ 64.25		$ 0.02	30	0.0%	1.70		$ 72.15		$ 0.01
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient SubAcute Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Residential Treatment Center	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	3	0.0%	0.28	28.88	$ 3,716.81	$ 128.72	$ 0.09	1	0.0%	0.02	31.00	$ 4,185.00	$ 135.00	$ 0.01
		Total	3	0.0%	0.28	28.88	$ 3,716.81	$ 128.72	$ 0.09	1	0.0%	0.02	31.00	$ 4,185.00	$ 135.00	$ 0.01
Treatment Group Home	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional RTC/Group Home Visits	Units	MH	2	0.0%	0.07		$ 49.83		$ 0.00	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	2	0.0%	0.07		$ 49.83		$ 0.00	-	0.0%	-				$ -
Treatment Foster Care	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Adult Day Treatment Psychiatric Services	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Day Treatment	Cases	MH	82	0.1%	51.64		$ 123.32		$ 0.53	36	0.0%	14.73		$ 127.07		$ 0.16
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	82	0.1%	51.64		$ 123.32		$ 0.53	36	0.0%	14.73		$ 127.07		$ 0.16
Intensive Outpatient Services	Cases	MH	7	0.0%	3.66		$ 113.25		$ 0.03	9	0.0%	3.18		$ 115.54		$ 0.03
		SA	5	0.0%	1.28		$ 67.37		$ 0.01	2	0.0%	0.26		$ 51.12		$ 0.00
		Total	11	0.0%	4.94		$ 101.37		$ 0.04	11	0.0%	3.45		$ 110.61		$ 0.03

Experience Report

Families_0-5

Service Category	Units Measure	MH/SA	FY09 Member Months = 684,592 Unique Members = 82,791							FY10 Member Months = 727,660 Unique Members = 80,770						
			Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Crisis Intervention	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Medication Checks	Units	MH	195	0.2%	10.01		$ 39.91		$ 0.03	216	0.3%	11.16		$ 40.45		$ 0.04
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	195	0.2%	10.01		$ 39.91		$ 0.03	216	0.3%	11.16		$ 40.45		$ 0.04
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	1,706	2.1%	60.54		$ 129.60		$ 0.65	1,752	2.2%	65.85		$ 121.71		$ 0.67
		SA	8	0.0%	0.25		$ 152.00		$ 0.00	4	0.0%	0.12		$ 132.74		$ 0.00
		Total	1,714	2.1%	60.79		$ 129.69		$ 0.66	1,755	2.2%	65.96		$ 121.73		$ 0.67
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	740	0.9%	84.61		$ 61.29		$ 0.43	612	0.8%	71.65		$ 62.82		$ 0.38
		SA	9	0.0%	0.51		$ 59.73		$ 0.00	10	0.0%	0.63		$ 61.25		$ 0.00
		Total	748	0.9%	85.12		$ 61.28		$ 0.43	619	0.8%	72.28		$ 62.80		$ 0.38
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	1	0.0%	0.11		$ 23.62		$ 0.00	3	0.0%	0.71		$ 30.38		$ 0.00
		SA	5	0.0%	0.46		$ 22.02		$ 0.00	6	0.0%	0.66		$ 24.18		$ 0.00
		Total	6	0.0%	0.56		$ 22.32		$ 0.00	9	0.0%	1.37		$ 27.39		$ 0.00
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	859	1.0%	82.75		$ 81.37		$ 0.56	780	1.0%	77.71		$ 82.77		$ 0.54
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	859	1.0%	82.75		$ 81.37		$ 0.56	780	1.0%	77.71		$ 82.77		$ 0.54
Family Assessment	Units	MH	2	0.0%	0.04		$ 68.34		$ 0.00	2	0.0%	0.03		$ 69.35		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	2	0.0%	0.04		$ 68.34		$ 0.00	2	0.0%	0.03		$ 69.35		$ 0.00
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	1	0.0%	0.02		$ 16.10		$ 0.00	5	0.0%	0.16		$ 22.40		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	1	0.0%	0.02		$ 16.10		$ 0.00	5	0.0%	0.16		$ 22.40		$ 0.00
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	12	0.0%	13.30		$ 30.66		$ 0.03	11	0.0%	11.18		$ 35.13		$ 0.03
		SA	-	0.0%	-				$ -	2	0.0%	0.07		$ 227.42		$ 0.00
		Total	12	0.0%	13.30		$ 30.66		$ 0.03	13	0.0%	11.25		$ 36.25		$ 0.03
Physician Administered Outpatient Drugs	Units	MH	1	0.0%	0.02		$ 2.80		$ 0.00	1	0.0%	0.12		$ 11.26		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	1	0.0%	0.02		$ 2.80		$ 0.00	1	0.0%	0.12		$ 11.26		$ 0.00
Outpatient Lab/Path/Other	Units	MH	60	0.1%	5.80		$ 16.62		$ 0.01	50	0.1%	4.26		$ 24.63		$ 0.01
		SA	12	0.0%	1.56		$ 17.98		$ 0.00	12	0.0%	0.74		$ 15.39		$ 0.00
		Total	72	0.1%	7.36		$ 16.90		$ 0.01	62	0.1%	5.00		$ 23.26		$ 0.01
Other	Units	MH	31	0.0%	88.22		$ 0.79		$ 0.01	22	0.0%	2.66		$ 7.35		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	31	0.0%	88.22		$ 0.79		$ 0.01	22	0.0%	2.66		$ 7.35		$ 0.00

Experience Report

Families_0-5

			FY11							FY11 Restated for Public Policy						
			Member Months =	690,381			Unique Members =	79,695		Member Months =	690,381			Unique Members =	79,695	
Service Category	Units Measure	MH/SA	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
All Service Categories	N/A	MH	1,870	2.3%					$ 1.82	1,870	2.3%					$ 1.80
		SA	1	0.0%					$ 0.00	1	0.0%					$ 0.00
		Total	1,871	2.3%					$ 1.82	1,871	2.3%					$ 1.80
Inpatient Acute Psychiatric	Admits	MH	12	0.0%	0.30	4.53	$ 2,340.88	$ 516.80	$ 0.06	12	0.0%	0.30	4.53	$ 2,308.20	$ 509.59	$ 0.06
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	12	0.0%	0.30	4.53	$ 2,340.88	$ 516.80	$ 0.06	12	0.0%	0.30	4.53	$ 2,308.20	$ 509.59	$ 0.06
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient Visits	Units	MH	12	0.0%	1.08		$ 65.08		$ 0.01	12	0.0%	1.08		$ 64.27		$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	12	0.0%	1.08		$ 65.08		$ 0.01	12	0.0%	1.08		$ 64.27		$ 0.01
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient SubAcute Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Residential Treatment Center	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Group Home	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional RTC/Group Home Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Foster Care	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Adult Day Treatment Psychiatric Services	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Day Treatment	Cases	MH	27	0.0%	18.90		$ 126.76		$ 0.20	27	0.0%	18.90		$ 125.76		$ 0.20
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	27	0.0%	18.90		$ 126.76		$ 0.20	27	0.0%	18.90		$ 125.76		$ 0.20
Intensive Outpatient Services	Cases	MH	7	0.0%	3.41		$ 116.12		$ 0.03	7	0.0%	3.41		$ 114.47		$ 0.03
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	7	0.0%	3.41		$ 116.12		$ 0.03	7	0.0%	3.41		$ 114.47		$ 0.03

Experience Report

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Service Category	Units Measure	MH/SA	FY11 Member Months = 690,381 Unique Members = 79,695 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 690,381 Unique Members = 79,695 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Crisis Intervention	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Medication Checks	Units	MH	208	0.3%	11.50		$ 40.16		$ 0.04	208	0.3%	11.50		$ 39.76		$ 0.04
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	208	0.3%	11.50		$ 40.16		$ 0.04	208	0.3%	11.50		$ 39.76		$ 0.04
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	1,591	2.0%	63.26		$ 120.70		$ 0.64	1,591	2.0%	63.26		$ 117.95		$ 0.62
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	1,591	2.0%	63.26		$ 120.70		$ 0.64	1,591	2.0%	63.26		$ 117.95		$ 0.62
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	444	0.6%	51.81		$ 63.04		$ 0.27	444	0.6%	51.81		$ 62.55		$ 0.27
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	444	0.6%	51.81		$ 63.04		$ 0.27	444	0.6%	51.81		$ 62.55		$ 0.27
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	771	1.0%	79.34		$ 84.04		$ 0.56	771	1.0%	79.34		$ 84.99		$ 0.56
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	771	1.0%	79.34		$ 84.04		$ 0.56	771	1.0%	79.34		$ 84.99		$ 0.56
Family Assessment	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	23	0.0%	0.78		$ 22.01		$ 0.00	23	0.0%	0.78		$ 22.73		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	23	0.0%	0.78		$ 22.01		$ 0.00	23	0.0%	0.78		$ 22.73		$ 0.00
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	8	0.0%	3.90		$ 34.98		$ 0.01	8	0.0%	3.90		$ 34.45		$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	8	0.0%	3.90		$ 34.98		$ 0.01	8	0.0%	3.90		$ 34.45		$ 0.01
Physician Administered Outpatient Drugs	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Outpatient Lab/Path/Other	Units	MH	21	0.0%	1.59		$ 25.87		$ 0.00	21	0.0%	1.59		$ 25.51		$ 0.00
		SA	1	0.0%	0.07		$ 10.57		$ 0.00	1	0.0%	0.07		$ 10.42		$ 0.00
		Total	22	0.0%	1.66		$ 25.23		$ 0.00	22	0.0%	1.66		$ 24.88		$ 0.00
Other	Units	MH	12	0.0%	4.83		$ 7.77		$ 0.00	12	0.0%	4.83		$ 7.66		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	12	0.0%	4.83		$ 7.77		$ 0.00	12	0.0%	4.83		$ 7.66		$ 0.00

Experience Report

Families_6-18

Service Category	Units Measure	MH/SA	FY09 Member Months = 541,244 Unique Members = 69,126 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY10 Member Months = 632,372 Unique Members = 75,536 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
All Service Categories	N/A	MH	9,115	13.2%					$ 27.82	10,001	13.2%					$ 23.45
		SA	453	0.7%					$ 1.85	526	0.7%					$ 1.95
		Total	9,357	13.5%					$ 29.67	10,267	13.6%					$ 25.40
Inpatient Acute Psychiatric	Admits	MH	401	0.6%	10.97	8.21	$ 4,166.11	$ 507.44	$ 3.81	477	0.6%	11.72	6.90	$ 3,547.16	$ 514.10	$ 3.46
		SA	5	0.0%	0.11	6.80	$ 3,855.37	$ 566.97	$ 0.04	4	0.0%	0.08	10.00	$ 3,063.35	$ 306.39	$ 0.02
		Total	406	0.6%	11.09	8.20	$ 4,163.00	$ 507.93	$ 3.85	481	0.6%	11.79	6.92	$ 3,544.04	$ 512.17	$ 3.48
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	1	0.0%	0.02	42.00	$ 23,134.02	$ 550.81	$ 0.04	1	0.0%	0.02	15.00	$ 3,925.20	$ 261.68	$ 0.01
		SA	4	0.0%	0.09	1.75	$ 1,444.16	$ 825.23	$ 0.01	1	0.0%	0.02	7.00	$ 3,213.38	$ 459.05	$ 0.01
		Total	5	0.0%	0.11	9.80	$ 5,782.13	$ 590.01	$ 0.05	2	0.0%	0.04	11.00	$ 3,569.28	$ 324.48	$ 0.01
Professional Inpatient Visits	Units	MH	400	0.6%	66.20		$ 55.40		$ 0.31	507	0.7%	61.82		$ 64.97		$ 0.33
		SA	8	0.0%	0.89		$ 51.14		$ 0.00	8	0.0%	0.97		$ 69.50		$ 0.01
		Total	405	0.6%	67.09		$ 55.34		$ 0.31	515	0.7%	62.79		$ 65.04		$ 0.34
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient SubAcute Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Residential Treatment Center	Admits	MH	72	0.1%	6.58	26.20	$ 7,021.05	$ 268.03	$ 3.85	68	0.1%	4.97	25.27	$ 6,941.21	$ 274.71	$ 2.88
		SA	33	0.0%	1.66	22.00	$ 5,183.20	$ 235.60	$ 0.72	31	0.0%	1.76	21.67	$ 5,366.76	$ 247.69	$ 0.79
		Total	105	0.2%	8.25	25.35	$ 6,650.52	$ 262.35	$ 4.57	99	0.1%	6.74	24.32	$ 6,528.80	$ 268.41	$ 3.67
Treatment Group Home	Admits	MH	61	0.1%	4.43	24.95	$ 4,382.21	$ 175.64	$ 1.62	52	0.1%	3.11	24.67	$ 4,501.61	$ 182.47	$ 1.17
		SA	34	0.0%	1.77	20.60	$ 3,423.12	$ 166.17	$ 0.51	26	0.0%	1.67	24.53	$ 4,131.59	$ 168.40	$ 0.57
		Total	95	0.1%	6.21	23.71	$ 4,108.18	$ 173.29	$ 2.13	77	0.1%	4.78	24.62	$ 4,372.40	$ 177.57	$ 1.74
Professional RTC/Group Home Visits	Units	MH	73	0.1%	8.25		$ 59.90		$ 0.04	79	0.1%	7.48		$ 64.26		$ 0.04
		SA	7	0.0%	0.18		$ 94.40		$ 0.00	29	0.0%	0.93		$ 98.73		$ 0.01
		Total	80	0.1%	8.43		$ 60.63		$ 0.04	108	0.1%	8.41		$ 68.07		$ 0.05
Treatment Foster Care	Days	MH	23	0.0%	56.69		$ 106.25		$ 0.50	17	0.0%	42.24		$ 109.10		$ 0.38
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	23	0.0%	56.69		$ 106.25		$ 0.50	17	0.0%	42.24		$ 109.10		$ 0.38
Adult Day Treatment Psychiatric Services	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Day Treatment	Cases	MH	223	0.3%	96.31		$ 156.83		$ 1.26	271	0.4%	88.82		$ 155.77		$ 1.15
		SA	9	0.0%	1.40		$ 76.90		$ 0.01	12	0.0%	1.25		$ 140.47		$ 0.01
		Total	232	0.3%	97.71		$ 155.69		$ 1.27	282	0.4%	90.08		$ 155.55		$ 1.17
Intensive Outpatient Services	Cases	MH	157	0.2%	104.25		$ 107.73		$ 0.94	154	0.2%	87.40		$ 111.28		$ 0.81
		SA	76	0.1%	32.46		$ 96.75		$ 0.26	91	0.1%	27.02		$ 98.10		$ 0.22
		Total	228	0.3%	136.71		$ 105.12		$ 1.20	240	0.3%	114.43		$ 108.17		$ 1.03

Experience Report

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Service Category	Units Measure	MH/SA	FY09 Member Months = 541,244 Utilizers	FY09 Penetration Rate	FY09 Annual Utilization per 1,000	FY09 Average LOS	FY09 Unique Members = 69,126 Average Cost Per Unit	FY09 Average Cost Per Day	FY09 PMPM Cost	FY10 Member Months = 632,372 Utilizers	FY10 Penetration Rate	FY10 Annual Utilization per 1,000	FY10 Average LOS	FY10 Unique Members = 75,536 Average Cost Per Unit	FY10 Average Cost Per Day	FY10 PMPM Cost
Electroconvulsive Therapy	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Crisis Intervention	Days	MH	4	0.0%	5.25		$ 298.37		$ 0.13	2	0.0%	1.67		$ 302.13		$ 0.04
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	4	0.0%	5.25		$ 298.37		$ 0.13	2	0.0%	1.67		$ 302.13		$ 0.04
Medication Checks	Units	MH	1,636	2.4%	115.33		$ 39.27		$ 0.38	2,025	2.7%	136.86		$ 39.66		$ 0.45
		SA	7	0.0%	0.35		$ 41.23		$ 0.00	14	0.0%	0.82		$ 41.85		$ 0.00
		Total	1,643	2.4%	115.69		$ 39.28		$ 0.38	2,037	2.7%	137.67		$ 39.68		$ 0.46
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	6,471	9.4%	327.65		$ 124.34		$ 3.40	6,999	9.3%	324.64		$ 123.05		$ 3.33
		SA	220	0.3%	8.82		$ 154.01		$ 0.11	287	0.4%	10.08		$ 135.80		$ 0.11
		Total	6,622	9.6%	336.47		$ 125.12		$ 3.51	7,182	9.5%	334.72		$ 123.44		$ 3.44
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	6,365	9.2%	1,484.87		$ 60.99		$ 7.55	6,508	8.6%	1,208.29		$ 62.80		$ 6.32
		SA	230	0.3%	25.16		$ 59.92		$ 0.13	205	0.3%	25.26		$ 59.06		$ 0.12
		Total	6,527	9.4%	1,510.03		$ 60.97		$ 7.67	6,659	8.8%	1,233.55		$ 62.73		$ 6.45
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	51	0.1%	7.80		$ 24.19		$ 0.02	67	0.1%	14.59		$ 27.62		$ 0.03
		SA	78	0.1%	18.09		$ 21.84		$ 0.03	76	0.1%	15.56		$ 22.36		$ 0.03
		Total	124	0.2%	25.90		$ 22.55		$ 0.05	140	0.2%	30.15		$ 24.91		$ 0.06
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	3,502	5.1%	507.28		$ 79.89		$ 3.38	3,449	4.6%	394.74		$ 81.46		$ 2.68
		SA	37	0.1%	1.82		$ 75.02		$ 0.01	39	0.1%	2.14		$ 74.06		$ 0.01
		Total	3,536	5.1%	509.09		$ 79.87		$ 3.39	3,485	4.6%	396.89		$ 81.42		$ 2.69
Family Assessment	Units	MH	9	0.0%	0.20		$ 63.15		$ 0.00	20	0.0%	0.40		$ 69.35		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	9	0.0%	0.20		$ 63.15		$ 0.00	20	0.0%	0.40		$ 69.35		$ 0.00
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	27	0.0%	1.49		$ 16.81		$ 0.00	47	0.1%	1.82		$ 21.16		$ 0.00
		SA	1	0.0%	0.09		$ 16.48		$ 0.00	-	0.0%	-				$ -
		Total	28	0.0%	1.57		$ 16.79		$ 0.00	47	0.1%	1.82		$ 21.16		$ 0.00
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	126	0.2%	181.87		$ 29.99		$ 0.45	77	0.1%	78.45		$ 33.98		$ 0.22
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	126	0.2%	181.87		$ 29.99		$ 0.45	77	0.1%	78.45		$ 33.98		$ 0.22
Physician Administered Outpatient Drugs	Units	MH	2	0.0%	13.08		$ 4.99		$ 0.01	2	0.0%	5.29		$ 4.99		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	2	0.0%	13.08		$ 4.99		$ 0.01	2	0.0%	5.29		$ 4.99		$ 0.00
Outpatient Lab/Path/Other	Units	MH	353	0.5%	49.49		$ 22.69		$ 0.09	377	0.5%	38.90		$ 25.95		$ 0.08
		SA	81	0.1%	13.88		$ 16.88		$ 0.02	95	0.1%	17.93		$ 18.93		$ 0.03
		Total	427	0.6%	63.37		$ 21.42		$ 0.11	462	0.6%	56.83		$ 23.74		$ 0.11
Other	Units	MH	157	0.2%	197.79		$ 3.08		$ 0.05	145	0.2%	42.45		$ 10.95		$ 0.04
		SA	-	0.0%	-				$ -	3	0.0%	0.65		$ 5.66		$ 0.00
		Total	157	0.2%	197.79		$ 3.08		$ 0.05	147	0.2%	43.09		$ 10.87		$ 0.04

Experience Report

Families_6-18

Service Category	Units Measure	MH/SA	FY11 Member Months = 671,424 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 671,424 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
			Unique Members = 80,371							Unique Members = 80,371						
All Service Categories	N/A	MH	10,422	13.0%					$ 21.62	10,422	13.0%					$ 21.24
		SA	534	0.7%					$ 1.63	534	0.7%					$ 1.58
		Total	10,697	13.3%					$ 23.25	10,697	13.3%					$ 22.82
Inpatient Acute Psychiatric	Admits	MH	508	0.6%	11.78	6.89	$ 3,534.70	$ 513.11	$ 3.47	508	0.6%	11.78	6.89	$ 3,485.36	$ 505.95	$ 3.42
		SA	5	0.0%	0.09	4.60	$ 2,382.49	$ 517.89	$ 0.02	5	0.0%	0.09	4.60	$ 2,349.23	$ 510.67	$ 0.02
		Total	513	0.6%	11.87	6.87	$ 3,526.01	$ 513.14	$ 3.49	513	0.6%	11.87	6.87	$ 3,476.79	$ 505.97	$ 3.44
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient Visits	Units	MH	535	0.7%	60.05		$ 66.72		$ 0.33	535	0.7%	60.05		$ 65.90		$ 0.33
		SA	11	0.0%	0.45		$ 110.23		$ 0.00	11	0.0%	0.45		$ 108.87		$ 0.00
		Total	541	0.7%	60.50		$ 67.05		$ 0.34	541	0.7%	60.50		$ 66.22		$ 0.33
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient SubAcute Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Residential Treatment Center	Admits	MH	61	0.1%	4.26	26.23	$ 7,321.21	$ 279.07	$ 2.60	61	0.1%	4.26	26.23	$ 6,788.78	$ 258.78	$ 2.41
		SA	27	0.0%	1.16	21.35	$ 5,926.68	$ 277.53	$ 0.57	27	0.0%	1.16	21.35	$ 5,495.67	$ 257.35	$ 0.53
		Total	88	0.1%	5.43	25.19	$ 7,022.17	$ 278.79	$ 3.18	88	0.1%	5.43	25.19	$ 6,511.49	$ 258.52	$ 2.94
Treatment Group Home	Admits	MH	39	0.0%	2.74	25.11	$ 4,591.15	$ 182.83	$ 1.05	39	0.0%	2.74	25.11	$ 4,524.57	$ 180.18	$ 1.03
		SA	20	0.0%	1.09	23.89	$ 3,975.19	$ 166.42	$ 0.36	20	0.0%	1.09	23.89	$ 3,917.54	$ 164.01	$ 0.36
		Total	59	0.1%	3.83	24.76	$ 4,415.55	$ 178.32	$ 1.41	59	0.1%	3.83	24.76	$ 4,351.51	$ 175.73	$ 1.39
Professional RTC/Group Home Visits	Units	MH	57	0.1%	8.34		$ 57.19		$ 0.04	57	0.1%	8.34		$ 56.30		$ 0.04
		SA	16	0.0%	0.55		$ 79.17		$ 0.00	16	0.0%	0.55		$ 77.94		$ 0.00
		Total	73	0.1%	8.89		$ 58.56		$ 0.04	73	0.1%	8.89		$ 57.65		$ 0.04
Treatment Foster Care	Days	MH	12	0.0%	22.61		$ 117.18		$ 0.22	12	0.0%	22.61		$ 115.55		$ 0.22
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	12	0.0%	22.61		$ 117.18		$ 0.22	12	0.0%	22.61		$ 115.55		$ 0.22
Adult Day Treatment Psychiatric Services	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Day Treatment	Cases	MH	262	0.3%	76.47		$ 155.64		$ 0.99	262	0.3%	76.47		$ 154.42		$ 0.98
		SA	11	0.0%	2.88		$ 187.37		$ 0.05	11	0.0%	2.88		$ 185.90		$ 0.04
		Total	273	0.3%	79.35		$ 156.79		$ 1.04	273	0.3%	79.35		$ 155.57		$ 1.03
Intensive Outpatient Services	Cases	MH	151	0.2%	82.74		$ 108.11		$ 0.75	151	0.2%	82.74		$ 106.57		$ 0.73
		SA	105	0.1%	37.65		$ 98.49		$ 0.31	105	0.1%	37.65		$ 97.09		$ 0.30
		Total	252	0.3%	120.39		$ 105.10		$ 1.05	252	0.3%	120.39		$ 103.61		$ 1.04

Experience Report

Families_6-18

Service Category	Units Measure	MH/SA	FY11 Member Months = 671,424 Unique Members = 80,371 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 671,424 Unique Members = 80,371 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Crisis Intervention	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Medication Checks	Units	MH	2,302	2.9%	159.06		$ 40.12		$ 0.53	2,302	2.9%	159.06		$ 39.71		$ 0.53
		SA	22	0.0%	0.81		$ 39.77		$ 0.00	22	0.0%	0.81		$ 39.37		$ 0.00
		Total	2,320	2.9%	159.87		$ 40.12		$ 0.53	2,320	2.9%	159.87		$ 39.71		$ 0.53
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	7,231	9.0%	323.75		$ 120.89		$ 3.26	7,231	9.0%	323.75		$ 118.14		$ 3.19
		SA	322	0.4%	10.57		$ 127.71		$ 0.11	322	0.4%	10.57		$ 124.80		$ 0.11
		Total	7,421	9.2%	334.32		$ 121.11		$ 3.37	7,421	9.2%	334.32		$ 118.35		$ 3.30
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	6,531	8.1%	1,040.50		$ 63.42		$ 5.50	6,531	8.1%	1,040.50		$ 62.93		$ 5.46
		SA	242	0.3%	27.52		$ 61.05		$ 0.14	242	0.3%	27.52		$ 60.57		$ 0.14
		Total	6,715	8.4%	1,068.03		$ 63.36		$ 5.64	6,715	8.4%	1,068.03		$ 62.87		$ 5.60
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	35	0.0%	4.98		$ 23.66		$ 0.01	35	0.0%	4.98		$ 22.66		$ 0.01
		SA	75	0.1%	15.49		$ 23.11		$ 0.03	75	0.1%	15.49		$ 22.13		$ 0.03
		Total	108	0.1%	20.47		$ 23.24		$ 0.04	108	0.1%	20.47		$ 22.26		$ 0.04
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	3,705	4.6%	378.60		$ 82.75		$ 2.61	3,705	4.6%	378.60		$ 83.68		$ 2.64
		SA	48	0.1%	1.84		$ 78.38		$ 0.01	48	0.1%	1.84		$ 79.27		$ 0.01
		Total	3,751	4.7%	380.44		$ 82.73		$ 2.62	3,751	4.7%	380.44		$ 83.66		$ 2.65
Family Assessment	Units	MH	19	0.0%	0.34		$ 69.70		$ 0.00	19	0.0%	0.34		$ 68.26		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	19	0.0%	0.34		$ 69.70		$ 0.00	19	0.0%	0.34		$ 68.26		$ 0.00
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	70	0.1%	2.65		$ 21.56		$ 0.00	70	0.1%	2.65		$ 22.27		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	70	0.1%	2.65		$ 21.56		$ 0.00	70	0.1%	2.65		$ 22.27		$ 0.00
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	66	0.1%	54.41		$ 32.25		$ 0.15	66	0.1%	54.41		$ 31.76		$ 0.14
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	66	0.1%	54.41		$ 32.25		$ 0.15	66	0.1%	54.41		$ 31.76		$ 0.14
Physician Administered Outpatient Drugs	Units	MH	3	0.0%	26.14		$ 5.04		$ 0.01	3	0.0%	26.14		$ 5.04		$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	3	0.0%	26.14		$ 5.04		$ 0.01	3	0.0%	26.14		$ 5.04		$ 0.01
Outpatient Lab/Path/Other	Units	MH	259	0.3%	30.55		$ 19.89		$ 0.05	259	0.3%	30.55		$ 19.62		$ 0.05
		SA	53	0.1%	11.56		$ 20.06		$ 0.02	53	0.1%	11.56		$ 19.78		$ 0.02
		Total	310	0.4%	42.11		$ 19.94		$ 0.07	310	0.4%	42.11		$ 19.66		$ 0.07
Other	Units	MH	121	0.2%	43.04		$ 10.63		$ 0.04	121	0.2%	43.04		$ 10.49		$ 0.04
		SA	4	0.0%	0.97		$ 6.91		$ 0.00	4	0.0%	0.97		$ 6.81		$ 0.00
		Total	123	0.2%	44.00		$ 10.55		$ 0.04	123	0.2%	44.00		$ 10.40		$ 0.04

Experience Report

Families_19+

Service Category	Units Measure	MH/SA	FY09 Member Months = 234,270 Utilizers	FY09 Penetration Rate	FY09 Annual Utilization per 1,000	FY09 Average LOS	FY09 Average Cost Per Unit	FY09 Average Cost Per Day	FY09 PMPM Cost	FY09 Unique Members = 34,383 Utilizers	FY09 Penetration Rate	FY09 Annual Utilization per 1,000	FY09 Average LOS	FY09 Average Cost Per Unit	FY09 Average Cost Per Day	FY09 PMPM Cost
All Service Categories	N/A	MH	4,982	14.5%					$ 22.78	5,311	12.6%					$ 19.96
		SA	666	1.9%					$ 6.46	761	1.8%					$ 5.99
		Total	5,334	15.5%					$ 29.24	5,765	13.6%					$ 25.95
Inpatient Acute Psychiatric	Admits	MH	316	0.9%	19.46	5.85	$ 3,039.01	$ 519.26	$ 4.93	340	0.8%	18.68	5.74	$ 2,904.35	$ 506.37	$ 4.52
		SA	-	0.0%	-				$ -	2	0.0%	0.09	18.99	$ 4,349.83	$ 229.04	$ 0.03
		Total	316	0.9%	19.46	5.85	$ 3,039.01	$ 519.26	$ 4.93	341	0.8%	18.77	5.80	$ 2,911.09	$ 502.14	$ 4.55
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	8	0.0%	0.41	26.50	$ 3,141.75	$ 118.56	$ 0.11	4	0.0%	0.22	10.60	$ 4,142.62	$ 390.84	$ 0.08
		SA	-	0.0%	-				$ -	1	0.0%	0.04	16.00	$ 9,504.00	$ 594.00	$ 0.03
		Total	8	0.0%	0.41	26.50	$ 3,141.75	$ 118.56	$ 0.11	5	0.0%	0.26	11.50	$ 5,035.79	$ 437.94	$ 0.11
Professional Inpatient Visits	Units	MH	389	1.1%	93.12		$ 64.35		$ 0.50	399	0.9%	82.28		$ 69.39		$ 0.48
		SA	23	0.1%	3.53		$ 68.20		$ 0.02	20	0.0%	1.75		$ 80.32		$ 0.01
		Total	404	1.2%	96.66		$ 64.49		$ 0.52	412	1.0%	84.03		$ 69.62		$ 0.49
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	10	0.0%	0.51	12.50	$ 5,730.25	$ 458.42	$ 0.24	7	0.0%	0.35	12.88	$ 5,811.57	$ 451.26	$ 0.17
		SA	111	0.3%	6.86	54.31	$ 8,175.12	$ 150.52	$ 4.68	116	0.3%	6.95	47.87	$ 7,232.65	$ 151.10	$ 4.19
		Total	120	0.3%	7.38	51.41	$ 8,005.34	$ 155.72	$ 4.92	122	0.3%	7.30	46.19	$ 7,164.52	$ 155.11	$ 4.36
Professional Inpatient SubAcute Visits	Units	MH	10	0.0%	1.43		$ 275.42		$ 0.03	18	0.0%	1.75		$ 321.98		$ 0.05
		SA	73	0.2%	16.08		$ 69.48		$ 0.09	59	0.1%	4.77		$ 173.36		$ 0.07
		Total	82	0.2%	17.52		$ 86.34		$ 0.13	75	0.2%	6.51		$ 213.25		$ 0.12
Residential Treatment Center	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	13	0.0%	1.49	20.97	$ 3,032.56	$ 144.65	$ 0.38	12	0.0%	1.31	21.53	$ 3,416.87	$ 158.68	$ 0.37
		Total	13	0.0%	1.49	20.97	$ 3,032.56	$ 144.65	$ 0.38	12	0.0%	1.31	21.53	$ 3,416.87	$ 158.68	$ 0.37
Treatment Group Home	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional RTC/Group Home Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	5	0.0%	0.36		$ 161.47		$ 0.00	2	0.0%	0.09		$ 168.86		$ 0.00
		Total	5	0.0%	0.36		$ 161.47		$ 0.00	2	0.0%	0.09		$ 168.86		$ 0.00
Treatment Foster Care	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Adult Day Treatment Psychiatric Services	Cases	MH	70	0.2%	36.68		$ 128.43		$ 0.39	83	0.2%	40.63		$ 115.76		$ 0.39
		SA	79	0.2%	53.94		$ 78.99		$ 0.36	86	0.2%	50.15		$ 78.36		$ 0.33
		Total	147	0.4%	90.61		$ 99.00		$ 0.75	168	0.4%	90.78		$ 95.10		$ 0.72
Day Treatment	Cases	MH	4	0.0%	0.72		$ 226.04		$ 0.01	2	0.0%	0.83		$ 105.85		$ 0.01
		SA	1	0.0%	0.05		$ 123.15		$ 0.00	-	0.0%	-				$ -
		Total	5	0.0%	0.77		$ 219.18		$ 0.01	2	0.0%	0.83		$ 105.85		$ 0.01
Intensive Outpatient Services	Cases	MH	1	0.0%	0.41		$ 97.92		$ 0.00	1	0.0%	0.39		$ 99.36		$ 0.00
		SA	2	0.0%	1.13		$ 85.73		$ 0.01	4	0.0%	1.09		$ 73.48		$ 0.01
		Total	3	0.0%	1.54		$ 88.98		$ 0.01	5	0.0%	1.49		$ 80.33		$ 0.01

			FY10 Member Months = 274,466 Utilizers	FY10 Penetration Rate	FY10 Annual Utilization per 1,000	FY10 Average LOS	FY10 Average Cost Per Unit	FY10 Average Cost Per Day	FY10 PMPM Cost	FY10 Unique Members = 42,273 Utilizers	FY10 Penetration Rate	FY10 Annual Utilization per 1,000	FY10 Average LOS	FY10 Average Cost Per Unit	FY10 Average Cost Per Day	FY10 PMPM Cost
All Service Categories	N/A	MH	5,311	12.6%					$ 19.96							
		SA	761	1.8%					$ 5.99							
		Total	5,765	13.6%					$ 25.95							
Inpatient Acute Psychiatric	Admits	MH	340	0.8%	18.68	5.74	$ 2,904.35	$ 506.37	$ 4.52							
		SA	2	0.0%	0.09	18.99	$ 4,349.83	$ 229.04	$ 0.03							
		Total	341	0.8%	18.77	5.80	$ 2,911.09	$ 502.14	$ 4.55							
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	4	0.0%	0.22	10.60	$ 4,142.62	$ 390.84	$ 0.08							
		SA	1	0.0%	0.04	16.00	$ 9,504.00	$ 594.00	$ 0.03							
		Total	5	0.0%	0.26	11.50	$ 5,035.79	$ 437.94	$ 0.11							
Professional Inpatient Visits	Units	MH	399	0.9%	82.28		$ 69.39		$ 0.48							
		SA	20	0.0%	1.75		$ 80.32		$ 0.01							
		Total	412	1.0%	84.03		$ 69.62		$ 0.49							
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	7	0.0%	0.35	12.88	$ 5,811.57	$ 451.26	$ 0.17							
		SA	116	0.3%	6.95	47.87	$ 7,232.65	$ 151.10	$ 4.19							
		Total	122	0.3%	7.30	46.19	$ 7,164.52	$ 155.11	$ 4.36							
Professional Inpatient SubAcute Visits	Units	MH	18	0.0%	1.75		$ 321.98		$ 0.05							
		SA	59	0.1%	4.77		$ 173.36		$ 0.07							
		Total	75	0.2%	6.51		$ 213.25		$ 0.12							
Residential Treatment Center	Admits	MH	-	0.0%	-				$ -							
		SA	12	0.0%	1.31	21.53	$ 3,416.87	$ 158.68	$ 0.37							
		Total	12	0.0%	1.31	21.53	$ 3,416.87	$ 158.68	$ 0.37							
Treatment Group Home	Admits	MH	-	0.0%	-				$ -							
		SA	-	0.0%	-				$ -							
		Total	-	0.0%	-				$ -							
Professional RTC/Group Home Visits	Units	MH	-	0.0%	-				$ -							
		SA	2	0.0%	0.09		$ 168.86		$ 0.00							
		Total	2	0.0%	0.09		$ 168.86		$ 0.00							
Treatment Foster Care	Days	MH	-	0.0%	-				$ -							
		SA	-	0.0%	-				$ -							
		Total	-	0.0%	-				$ -							
Adult Day Treatment Psychiatric Services	Cases	MH	83	0.2%	40.63		$ 115.76		$ 0.39							
		SA	86	0.2%	50.15		$ 78.36		$ 0.33							
		Total	168	0.4%	90.78		$ 95.10		$ 0.72							
Day Treatment	Cases	MH	2	0.0%	0.83		$ 105.85		$ 0.01							
		SA	-	0.0%	-				$ -							
		Total	2	0.0%	0.83		$ 105.85		$ 0.01							
Intensive Outpatient Services	Cases	MH	1	0.0%	0.39		$ 99.36		$ 0.00							
		SA	4	0.0%	1.09		$ 73.48		$ 0.01							
		Total	5	0.0%	1.49		$ 80.33		$ 0.01							

Experience Report

Families_19+

Service Category	Units Measure	MH/SA	FY09 Member Months = 234,270 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Unique Members = 34,383 Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY10 Member Months = 274,466 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Unique Members = 42,273 Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	7	0.0%	19.98		$ 35.74		$ 0.06	10	0.0%	11.15		$ 63.26		$ 0.06
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	7	0.0%	19.98		$ 35.74		$ 0.06	10	0.0%	11.15		$ 63.26		$ 0.06
Treatment Crisis Intervention	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Medication Checks	Units	MH	1,156	3.4%	183.02		$ 38.71		$ 0.59	1,510	3.6%	218.83		$ 39.32		$ 0.72
		SA	7	0.0%	0.87		$ 41.31		$ 0.00	9	0.0%	0.70		$ 40.92		$ 0.00
		Total	1,159	3.4%	183.89		$ 38.72		$ 0.59	1,514	3.6%	219.52		$ 39.33		$ 0.72
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	3,382	9.8%	351.59		$ 133.60		$ 3.91	3,466	8.2%	341.55		$ 123.45		$ 3.51
		SA	216	0.6%	12.81		$ 187.69		$ 0.20	268	0.6%	13.82		$ 165.83		$ 0.19
		Total	3,518	10.2%	364.40		$ 135.50		$ 4.11	3,647	8.6%	355.37		$ 125.10		$ 3.70
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	228	0.7%	21.56		$ 134.80		$ 0.24	256	0.6%	23.61		$ 126.77		$ 0.25
		SA	9	0.0%	0.67		$ 227.45		$ 0.01	17	0.0%	1.09		$ 127.29		$ 0.01
		Total	235	0.7%	22.23		$ 137.58		$ 0.25	266	0.6%	24.70		$ 126.80		$ 0.26
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	3,246	9.4%	1,661.88		$ 62.64		$ 8.67	3,292	7.8%	1,371.58		$ 64.50		$ 7.37
		SA	194	0.6%	47.59		$ 61.96		$ 0.25	256	0.6%	51.29		$ 62.53		$ 0.27
		Total	3,392	9.9%	1,709.46		$ 62.62		$ 8.92	3,490	8.3%	1,422.87		$ 64.42		$ 7.64
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	52	0.2%	29.09		$ 23.58		$ 0.06	40	0.1%	16.79		$ 25.37		$ 0.04
		SA	125	0.4%	58.45		$ 24.09		$ 0.12	152	0.4%	63.83		$ 24.51		$ 0.13
		Total	176	0.5%	87.54		$ 23.92		$ 0.17	188	0.4%	80.62		$ 24.69		$ 0.17
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	500	1.5%	162.38		$ 80.85		$ 1.09	376	0.9%	98.02		$ 82.54		$ 0.67
		SA	5	0.0%	0.31		$ 81.69		$ 0.00	4	0.0%	0.17		$ 83.02		$ 0.00
		Total	505	1.5%	162.68		$ 80.85		$ 1.10	379	0.9%	98.20		$ 82.54		$ 0.68
Family Assessment	Units	MH	8	0.0%	0.41		$ 68.34		$ 0.00	19	0.0%	0.83		$ 69.37		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	8	0.0%	0.41		$ 68.34		$ 0.00	19	0.0%	0.83		$ 69.37		$ 0.00
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	209	0.6%	465.67		$ 39.72		$ 1.54	227	0.5%	422.79		$ 36.40		$ 1.28
		SA	79	0.2%	15.57		$ 209.89		$ 0.27	82	0.2%	13.90		$ 225.22		$ 0.26
		Total	288	0.8%	481.24		$ 45.22		$ 1.81	308	0.7%	436.69		$ 42.41		$ 1.54
Physician Administered Outpatient Drugs	Units	MH	4	0.0%	303.70		$ 4.62		$ 0.12	14	0.0%	266.48		$ 4.68		$ 0.10
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	4	0.0%	303.70		$ 4.62		$ 0.12	14	0.0%	266.48		$ 4.68		$ 0.10
Outpatient Lab/Path/Other	Units	MH	379	1.1%	126.01		$ 18.32		$ 0.19	428	1.0%	105.51		$ 22.08		$ 0.19
		SA	89	0.3%	40.98		$ 19.54		$ 0.07	120	0.3%	45.84		$ 20.81		$ 0.08
		Total	455	1.3%	166.99		$ 18.62		$ 0.26	539	1.3%	151.35		$ 21.69		$ 0.27
Other	Units	MH	81	0.2%	200.13		$ 4.26		$ 0.07	63	0.1%	124.82		$ 5.64		$ 0.06
		SA	4	0.0%	2.10		$ 57.36		$ 0.01	-	0.0%	-				$ -
		Total	85	0.2%	202.23		$ 4.81		$ 0.08	63	0.1%	124.82		$ 5.64		$ 0.06

Experience Report

Families_19+

Service Category	Units Measure	MH/SA	FY11 Member Months = 347,151 Unique Members = 48,162 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 347,151 Unique Members = 48,162 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
All Service Categories	N/A	MH	5,946	12.3%					$ 16.91	5,946	12.3%					$ 16.43
		SA	880	1.8%					$ 4.74	880	1.8%					$ 4.66
		Total	6,433	13.4%					$ 21.64	6,433	13.4%					$ 21.10
Inpatient Acute Psychiatric	Admits	MH	402	0.8%	16.68	5.32	$ 2,722.91	$ 511.40	$ 3.79	402	0.8%	16.68	5.32	$ 2,674.35	$ 502.28	$ 3.72
		SA	1	0.0%	0.03	2.00	$ 691.10	$ 345.55	$ 0.00	1	0.0%	0.03	2.00	$ 678.77	$ 339.39	$ 0.00
		Total	403	0.8%	16.72	5.32	$ 2,718.69	$ 511.27	$ 3.79	403	0.8%	16.72	5.32	$ 2,670.21	$ 502.16	$ 3.72
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	3	0.0%	0.10	4.67	$ 1,132.00	$ 242.66	$ 0.01	3	0.0%	0.10	4.67	$ 1,105.71	$ 237.02	$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	3	0.0%	0.10	4.67	$ 1,132.00	$ 242.66	$ 0.01	3	0.0%	0.10	4.67	$ 1,105.71	$ 237.02	$ 0.01
Professional Inpatient Visits	Units	MH	476	1.0%	67.31		$ 72.11		$ 0.40	476	1.0%	67.31		$ 70.98		$ 0.40
		SA	20	0.0%	1.25		$ 82.23		$ 0.01	20	0.0%	1.25		$ 80.94		$ 0.01
		Total	491	1.0%	68.56		$ 72.30		$ 0.41	491	1.0%	68.56		$ 71.16		$ 0.41
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	11	0.0%	0.38	18.36	$ 7,051.57	$ 384.08	$ 0.22	11	0.0%	0.38	18.36	$ 7,037.42	$ 383.31	$ 0.22
		SA	126	0.3%	5.92	36.34	$ 6,044.06	$ 166.32	$ 2.98	126	0.3%	5.92	36.34	$ 6,031.92	$ 165.98	$ 2.98
		Total	137	0.3%	6.30	35.25	$ 6,105.03	$ 173.18	$ 3.21	137	0.3%	6.30	35.25	$ 6,092.77	$ 172.83	$ 3.20
Professional Inpatient SubAcute Visits	Units	MH	17	0.0%	2.29		$ 310.61		$ 0.06	17	0.0%	2.29		$ 306.22		$ 0.06
		SA	98	0.2%	12.70		$ 97.31		$ 0.10	98	0.2%	12.70		$ 95.93		$ 0.10
		Total	113	0.2%	14.98		$ 129.85		$ 0.16	113	0.2%	14.98		$ 128.01		$ 0.16
Residential Treatment Center	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	10	0.0%	1.45	22.69	$ 3,461.15	$ 152.53	$ 0.42	10	0.0%	1.45	22.69	$ 3,209.44	$ 141.44	$ 0.39
		Total	10	0.0%	1.45	22.69	$ 3,461.15	$ 152.53	$ 0.42	10	0.0%	1.45	22.69	$ 3,209.44	$ 141.44	$ 0.39
Treatment Group Home	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional RTC/Group Home Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	3	0.0%	0.17		$ 148.52		$ 0.00	3	0.0%	0.17		$ 145.94		$ 0.00
		Total	3	0.0%	0.17		$ 148.52		$ 0.00	3	0.0%	0.17		$ 145.94		$ 0.00
Treatment Foster Care	Days	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Adult Day Treatment Psychiatric Services	Cases	MH	122	0.3%	27.30		$ 148.66		$ 0.34	122	0.3%	27.30		$ 146.38		$ 0.33
		SA	123	0.3%	60.09		$ 76.36		$ 0.38	123	0.3%	60.09		$ 75.19		$ 0.38
		Total	244	0.5%	87.39		$ 98.94		$ 0.72	244	0.5%	87.39		$ 97.43		$ 0.71
Day Treatment	Cases	MH	3	0.0%	0.45		$ 162.74		$ 0.01	3	0.0%	0.45		$ 161.46		$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	3	0.0%	0.45		$ 162.74		$ 0.01	3	0.0%	0.45		$ 161.46		$ 0.01
Intensive Outpatient Services	Cases	MH	3	0.0%	1.28		$ 99.86		$ 0.01	3	0.0%	1.28		$ 98.44		$ 0.01
		SA	7	0.0%	2.18		$ 78.43		$ 0.01	7	0.0%	2.18		$ 77.32		$ 0.01
		Total	10	0.0%	3.46		$ 86.36		$ 0.02	10	0.0%	3.46		$ 85.13		$ 0.02

Experience Report

Families_19+

Service Category	Units Measure	MH/SA	FY11 Member Months = 347,151 Unique Members = 48,162 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 347,151 Unique Members = 48,162 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	12	0.0%	8.69		$ 76.72		$ 0.06	12	0.0%	8.69		$ 75.64		$ 0.05
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	12	0.0%	8.69		$ 76.72		$ 0.06	12	0.0%	8.69		$ 75.64		$ 0.05
Treatment Crisis Intervention	Days	MH	2	0.0%	0.21		$ 343.28		$ 0.01	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	2	0.0%	0.21		$ 343.28		$ 0.01	-	0.0%	-				$ -
Medication Checks	Units	MH	1,714	3.6%	207.66		$ 39.44		$ 0.68	1,714	3.6%	207.66		$ 39.04		$ 0.68
		SA	22	0.0%	1.28		$ 38.73		$ 0.00	22	0.0%	1.28		$ 38.34		$ 0.00
		Total	1,728	3.6%	208.94		$ 39.43		$ 0.69	1,728	3.6%	208.94		$ 39.04		$ 0.68
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	3,978	8.3%	317.74		$ 117.70		$ 3.12	3,978	8.3%	317.74		$ 113.84		$ 3.01
		SA	325	0.7%	14.43		$ 146.53		$ 0.18	325	0.7%	14.43		$ 141.73		$ 0.17
		Total	4,197	8.7%	332.17		$ 118.95		$ 3.29	4,197	8.7%	332.17		$ 115.05		$ 3.18
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	288	0.6%	20.83		$ 120.00		$ 0.21	288	0.6%	20.83		$ 116.68		$ 0.20
		SA	26	0.1%	1.31		$ 128.45		$ 0.01	26	0.1%	1.31		$ 124.89		$ 0.01
		Total	308	0.6%	22.15		$ 120.50		$ 0.22	308	0.6%	22.15		$ 117.16		$ 0.22
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	3,700	7.7%	1,161.92		$ 64.78		$ 6.27	3,700	7.7%	1,161.92		$ 62.23		$ 6.03
		SA	303	0.6%	58.56		$ 63.37		$ 0.31	303	0.6%	58.56		$ 60.88		$ 0.30
		Total	3,943	8.2%	1,220.48		$ 64.71		$ 6.58	3,943	8.2%	1,220.48		$ 62.16		$ 6.32
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	51	0.1%	18.24		$ 24.58		$ 0.04	51	0.1%	18.24		$ 23.51		$ 0.04
		SA	190	0.4%	58.46		$ 24.56		$ 0.12	190	0.4%	58.46		$ 23.50		$ 0.11
		Total	236	0.5%	76.70		$ 24.57		$ 0.16	236	0.5%	76.70		$ 23.50		$ 0.15
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	375	0.8%	63.51		$ 83.31		$ 0.44	375	0.8%	63.51		$ 82.24		$ 0.44
		SA	6	0.0%	0.24		$ 83.26		$ 0.00	6	0.0%	0.24		$ 82.18		$ 0.00
		Total	381	0.8%	63.75		$ 83.31		$ 0.44	381	0.8%	63.75		$ 82.24		$ 0.44
Family Assessment	Units	MH	17	0.0%	0.59		$ 69.71		$ 0.00	17	0.0%	0.59		$ 68.28		$ 0.00
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	17	0.0%	0.59		$ 69.71		$ 0.00	17	0.0%	0.59		$ 68.28		$ 0.00
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	212	0.4%	328.12		$ 38.66		$ 1.06	212	0.4%	328.12		$ 38.08		$ 1.04
		SA	74	0.2%	8.69		$ 227.65		$ 0.16	74	0.2%	8.69		$ 224.21		$ 0.16
		Total	285	0.6%	336.80		$ 43.54		$ 1.22	285	0.6%	336.80		$ 42.88		$ 1.20
Physician Administered Outpatient Drugs	Units	MH	6	0.0%	37.31		$ 4.98		$ 0.02	6	0.0%	37.31		$ 4.99		$ 0.02
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	6	0.0%	37.31		$ 4.98		$ 0.02	6	0.0%	37.31		$ 4.99		$ 0.02
Outpatient Lab/Path/Other	Units	MH	353	0.7%	71.65		$ 21.14		$ 0.13	353	0.7%	71.65		$ 20.85		$ 0.12
		SA	95	0.2%	21.95		$ 17.97		$ 0.03	95	0.2%	21.95		$ 17.72		$ 0.03
		Total	438	0.9%	93.60		$ 20.40		$ 0.16	438	0.9%	93.60		$ 20.11		$ 0.16
Other	Units	MH	73	0.2%	73.12		$ 8.25		$ 0.05	73	0.2%	73.12		$ 8.14		$ 0.05
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	73	0.2%	73.12		$ 8.25		$ 0.05	73	0.2%	73.12		$ 8.14		$ 0.05

Experience Report

FosterCare,Ward,SubsidizedAdopt

Service Category	Units Measure	MH/SA	FY09 Member Months = 139,574 Unique Members = 15,938							FY10 Member Months = 139,147 Unique Members = 15,703						
			Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
All Service Categories	N/A	MH	8,237	51.7%					$ 359.81	8,015	51.0%					$ 306.28
		SA	1,460	9.2%					$ 70.09	1,264	8.0%					$ 52.08
		Total	8,630	54.1%					$ 429.90	8,329	53.0%					$ 358.36
Inpatient Acute Psychiatric	Admits	MH	519	3.3%	63.71	13.96	$ 6,518.42	$ 466.82	$ 34.61	520	3.3%	64.71	10.98	$ 5,345.17	$ 486.75	$ 28.83
		SA	7	0.0%	0.60	9.86	$ 3,859.84	$ 391.58	$ 0.19	5	0.0%	0.43	5.80	$ 2,818.26	$ 485.90	$ 0.10
		Total	522	3.3%	64.31	13.93	$ 6,493.54	$ 466.32	$ 34.80	524	3.3%	65.15	10.95	$ 5,328.44	$ 486.75	$ 28.93
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	1	0.0%	0.09	69.00	$ 38,380.39	$ 556.24	$ 0.27	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	2	0.0%	0.17	2.50	$ 1,795.87	$ 718.35	$ 0.03
		Total	1	0.0%	0.09	69.00	$ 38,380.39	$ 556.24	$ 0.27	2	0.0%	0.17	2.50	$ 1,795.87	$ 718.35	$ 0.03
Professional Inpatient Visits	Units	MH	543	3.4%	602.69		$ 46.80		$ 2.35	599	3.8%	545.90		$ 62.61		$ 2.85
		SA	7	0.0%	2.58		$ 48.79		$ 0.01	6	0.0%	2.16		$ 205.34		$ 0.04
		Total	547	3.4%	605.27		$ 46.81		$ 2.36	604	3.8%	548.05		$ 63.17		$ 2.89
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient SubAcute Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Residential Treatment Center	Admits	MH	457	2.9%	214.25	26.74	$ 6,881.46	$ 257.31	$ 122.86	392	2.5%	171.13	26.52	$ 7,075.41	$ 266.84	$ 100.90
		SA	272	1.7%	75.83	23.35	$ 6,383.02	$ 273.32	$ 40.34	214	1.4%	58.58	23.52	$ 6,732.89	$ 286.27	$ 32.87
		Total	708	4.4%	290.08	25.86	$ 6,751.16	$ 261.09	$ 163.20	599	3.8%	229.71	25.75	$ 6,988.06	$ 271.36	$ 133.77
Treatment Group Home	Admits	MH	504	3.2%	198.26	25.87	$ 4,919.52	$ 190.17	$ 81.28	451	2.9%	167.48	25.24	$ 4,787.93	$ 189.68	$ 66.82
		SA	196	1.2%	61.21	23.34	$ 3,828.68	$ 164.01	$ 19.53	108	0.7%	34.84	23.61	$ 3,920.05	$ 166.04	$ 11.38
		Total	691	4.3%	259.48	25.27	$ 4,662.17	$ 184.47	$ 100.81	550	3.5%	202.32	24.96	$ 4,638.48	$ 185.83	$ 78.20
Professional RTC/Group Home Visits	Units	MH	497	3.1%	439.08		$ 42.02		$ 1.54	484	3.1%	298.48		$ 63.45		$ 1.58
		SA	67	0.4%	15.05		$ 77.43		$ 0.10	77	0.5%	15.78		$ 75.96		$ 0.10
		Total	558	3.5%	454.12		$ 43.19		$ 1.63	556	3.5%	314.26		$ 64.08		$ 1.68
Treatment Foster Care	Days	MH	96	0.6%	1,024.57		$ 108.19		$ 9.24	92	0.6%	798.84		$ 113.09		$ 7.53
		SA	1	0.0%	22.61		$ 104.89		$ 0.20	-	0.0%	-				$ -
		Total	97	0.6%	1,047.19		$ 108.12		$ 9.43	92	0.6%	798.84		$ 113.09		$ 7.53
Adult Day Treatment Psychiatric Services	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Day Treatment	Cases	MH	320	2.0%	845.23		$ 135.77		$ 9.56	336	2.1%	772.67		$ 140.16		$ 9.02
		SA	32	0.2%	77.38		$ 121.70		$ 0.78	31	0.2%	55.46		$ 132.72		$ 0.61
		Total	350	2.2%	922.61		$ 134.59		$ 10.35	367	2.3%	828.12		$ 139.66		$ 9.64
Intensive Outpatient Services	Cases	MH	337	2.1%	882.97		$ 102.08		$ 7.51	347	2.2%	888.61		$ 106.99		$ 7.92
		SA	260	1.6%	528.92		$ 95.31		$ 4.20	240	1.5%	396.79		$ 96.65		$ 3.20
		Total	583	3.7%	1,411.90		$ 99.54		$ 11.71	571	3.6%	1,285.40		$ 103.79		$ 11.12

Experience Report

FosterCare,Ward,SubsidizedAdopt

Service Category	Units Measure	MH/SA	FY09 Utilizers	FY09 Penetration Rate	FY09 Annual Utilization per 1,000	FY09 Average LOS	FY09 Average Cost Per Unit	FY09 Average Cost Per Day	FY09 PMPM Cost	FY10 Utilizers	FY10 Penetration Rate	FY10 Annual Utilization per 1,000	FY10 Average LOS	FY10 Average Cost Per Unit	FY10 Average Cost Per Day	FY10 PMPM Cost
			Member Months =	139,574			Unique Members =	15,938		Member Months =	139,147			Unique Members =	15,703	
Electroconvulsive Therapy	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Crisis Intervention	Days	MH	28	0.2%	297.13		$ 297.34		$ 7.36	23	0.1%	281.14		$ 297.40		$ 6.97
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	28	0.2%	297.13		$ 297.34		$ 7.36	23	0.1%	281.14		$ 297.40		$ 6.97
Medication Checks	Units	MH	2,087	13.1%	801.81		$ 38.86		$ 2.60	2,127	13.5%	866.19		$ 39.65		$ 2.86
		SA	46	0.3%	7.05		$ 35.97		$ 0.02	33	0.2%	5.61		$ 39.82		$ 0.02
		Total	2,123	13.3%	808.86		$ 38.83		$ 2.62	2,150	13.7%	871.80		$ 39.65		$ 2.88
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	1	0.0%	0.17		$ 140.14		$ 0.00	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	1	0.0%	0.17		$ 140.14		$ 0.00	-	0.0%	-				$ -
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	6,409	40.2%	1,807.21		$ 152.23		$ 22.93	5,980	38.1%	1,774.64		$ 147.63		$ 21.83
		SA	676	4.2%	143.06		$ 183.54		$ 2.19	761	4.8%	148.42		$ 151.28		$ 1.87
		Total	6,728	42.2%	1,950.28		$ 154.53		$ 25.11	6,236	39.7%	1,923.06		$ 147.91		$ 23.70
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	6,245	39.2%	7,349.99		$ 60.54		$ 37.08	5,517	35.1%	6,291.54		$ 61.65		$ 32.32
		SA	813	5.1%	374.25		$ 59.33		$ 1.85	455	2.9%	256.74		$ 60.65		$ 1.30
		Total	6,742	42.3%	7,724.25		$ 60.48		$ 38.93	5,784	36.8%	6,548.27		$ 61.61		$ 33.62
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	203	1.3%	191.55		$ 22.94		$ 0.37	173	1.1%	171.88		$ 23.64		$ 0.34
		SA	194	1.2%	180.21		$ 22.01		$ 0.33	139	0.9%	123.67		$ 23.09		$ 0.24
		Total	380	2.4%	371.76		$ 22.49		$ 0.70	297	1.9%	295.54		$ 23.41		$ 0.58
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	3,611	22.7%	2,515.91		$ 79.43		$ 16.65	3,233	20.6%	2,157.63		$ 80.18		$ 14.42
		SA	101	0.6%	28.37		$ 76.49		$ 0.18	100	0.6%	23.80		$ 79.20		$ 0.16
		Total	3,693	23.2%	2,544.28		$ 79.40		$ 16.83	3,320	21.1%	2,181.44		$ 80.17		$ 14.57
Family Assessment	Units	MH	46	0.3%	4.04		$ 68.29		$ 0.02	20	0.1%	1.72		$ 69.30		$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	46	0.3%	4.04		$ 68.29		$ 0.02	20	0.1%	1.72		$ 69.30		$ 0.01
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	62	0.4%	30.61		$ 15.28		$ 0.04	27	0.2%	4.66		$ 21.55		$ 0.01
		SA	1	0.0%	0.17		$ 16.48		$ 0.00	-	0.0%	-				$ -
		Total	63	0.4%	30.78		$ 15.28		$ 0.04	27	0.2%	4.66		$ 21.55		$ 0.01
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	171	1.1%	993.62		$ 33.42		$ 2.77	111	0.7%	487.17		$ 35.05		$ 1.42
		SA	1	0.0%	0.95		$ 6.96		$ 0.00	-	0.0%	-				$ -
		Total	172	1.1%	994.57		$ 33.40		$ 2.77	111	0.7%	487.17		$ 35.05		$ 1.42
Physician Administered Outpatient Drugs	Units	MH	3	0.0%	71.88		$ 7.54		$ 0.05	2	0.0%	32.77		$ 4.25		$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	3	0.0%	71.88		$ 7.54		$ 0.05	2	0.0%	32.77		$ 4.25		$ 0.01
Outpatient Lab/Path/Other	Units	MH	642	4.0%	398.41		$ 17.64		$ 0.59	521	3.3%	326.32		$ 19.07		$ 0.52
		SA	237	1.5%	179.35		$ 10.94		$ 0.16	203	1.3%	183.91		$ 11.00		$ 0.17
		Total	834	5.2%	577.76		$ 15.56		$ 0.75	704	4.5%	510.22		$ 16.16		$ 0.69
Other	Units	MH	201	1.3%	909.88		$ 1.87		$ 0.14	124	0.8%	115.73		$ 11.81		$ 0.11
		SA	8	0.1%	27.68		$ 1.58		$ 0.00	14	0.1%	11.64		$ 6.36		$ 0.01
		Total	208	1.3%	937.57		$ 1.86		$ 0.15	137	0.9%	127.38		$ 11.32		$ 0.12

Experience Report

FosterCare,Ward,SubsidizedAdopt

Service Category	Units Measure	MH/SA	FY11 Member Months = 138,482 Unique Members = 15,498 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	FY11 Restated for Public Policy Member Months = 138,482 Unique Members = 15,498 Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
All Service Categories	N/A	MH	7,813	50.4%					$ 241.35	7,813	50.4%					$ 234.60
		SA	1,192	7.7%					$ 54.99	1,192	7.7%					$ 51.92
		Total	8,172	52.7%					$ 296.34	8,172	52.7%					$ 286.52
Inpatient Acute Psychiatric	Admits	MH	456	2.9%	56.17	10.30	$ 5,235.73	$ 508.14	$ 24.51	456	2.9%	56.17	10.30	$ 5,162.65	$ 501.04	$ 24.16
		SA	6	0.0%	0.52	7.83	$ 4,159.99	$ 531.10	$ 0.18	6	0.0%	0.52	7.83	$ 4,101.92	$ 523.69	$ 0.18
		Total	461	3.0%	56.69	10.28	$ 5,225.84	$ 508.30	$ 24.69	461	3.0%	56.69	10.28	$ 5,152.89	$ 501.20	$ 24.34
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	1	0.0%	0.09	2.00	$ 691.10	$ 345.55	$ 0.00	1	0.0%	0.09	2.00	$ 681.45	$ 340.73	$ 0.00
		Total	1	0.0%	0.09	2.00	$ 691.10	$ 345.55	$ 0.00	1	0.0%	0.09	2.00	$ 681.45	$ 340.73	$ 0.00
Professional Inpatient Visits	Units	MH	509	3.3%	421.72		$ 62.32		$ 2.19	509	3.3%	421.72		$ 61.55		$ 2.16
		SA	10	0.1%	3.56		$ 77.47		$ 0.02	10	0.1%	3.56		$ 76.52		$ 0.02
		Total	514	3.3%	425.27		$ 62.45		$ 2.21	514	3.3%	425.27		$ 61.68		$ 2.19
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Professional Inpatient SubAcute Visits	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Residential Treatment Center	Admits	MH	275	1.8%	109.94	25.93	$ 6,999.90	$ 269.97	$ 64.13	275	1.8%	109.94	25.93	$ 6,490.84	$ 250.34	$ 59.47
		SA	169	1.1%	45.18	26.07	$10,376.38	$ 397.97	$ 39.07	169	1.1%	45.18	26.07	$ 9,621.77	$ 369.03	$ 36.23
		Total	441	2.8%	155.12	25.97	$ 7,983.35	$ 307.40	$ 103.20	441	2.8%	155.12	25.97	$ 7,402.77	$ 285.05	$ 95.69
Treatment Group Home	Admits	MH	332	2.1%	122.31	25.02	$ 4,770.00	$ 190.64	$ 48.62	332	2.1%	122.31	25.02	$ 4,700.83	$ 187.88	$ 47.91
		SA	75	0.5%	24.55	23.05	$ 3,883.13	$ 168.43	$ 7.95	75	0.5%	24.55	23.05	$ 3,826.81	$ 165.99	$ 7.83
		Total	404	2.6%	146.87	24.69	$ 4,621.73	$ 187.18	$ 56.56	404	2.6%	146.87	24.69	$ 4,554.71	$ 184.46	$ 55.74
Professional RTC/Group Home Visits	Units	MH	316	2.0%	182.55		$ 61.84		$ 0.94	316	2.0%	182.55		$ 60.88		$ 0.93
		SA	62	0.4%	14.59		$ 73.53		$ 0.09	62	0.4%	14.59		$ 72.39		$ 0.09
		Total	375	2.4%	197.14		$ 62.70		$ 1.03	375	2.4%	197.14		$ 61.73		$ 1.01
Treatment Foster Care	Days	MH	42	0.3%	613.31		$ 116.85		$ 5.97	42	0.3%	613.31		$ 115.22		$ 5.89
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	42	0.3%	613.31		$ 116.85		$ 5.97	42	0.3%	613.31		$ 115.22		$ 5.89
Adult Day Treatment Psychiatric Services	Cases	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Day Treatment	Cases	MH	294	1.9%	928.42		$ 131.37		$ 10.16	294	1.9%	928.42		$ 130.34		$ 10.08
		SA	17	0.1%	31.32		$ 145.96		$ 0.38	17	0.1%	31.32		$ 144.82		$ 0.38
		Total	311	2.0%	959.74		$ 131.85		$ 10.54	311	2.0%	959.74		$ 130.81		$ 10.46
Intensive Outpatient Services	Cases	MH	314	2.0%	817.20		$ 103.59		$ 7.05	314	2.0%	817.20		$ 102.11		$ 6.95
		SA	226	1.5%	401.14		$ 95.74		$ 3.20	226	1.5%	401.14		$ 94.38		$ 3.16
		Total	528	3.4%	1,218.35		$ 101.00		$ 10.25	528	3.4%	1,218.35		$ 99.57		$ 10.11

Experience Report

FosterCare,Ward,SubsidizedAdopt

			FY11							FY11 Restated for Public Policy						
			Member Months =	138,482			Unique Members =	15,498		Member Months =	138,482			Unique Members =	15,498	
Service Category	Units Measure	MH/SA	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost	Utilizers	Penetration Rate	Annual Utilization per 1,000	Average LOS	Average Cost Per Unit	Average Cost Per Day	PMPM Cost
Electroconvulsive Therapy	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Treatment Crisis Intervention	Days	MH	20	0.1%	247.19		$ 299.33		$ 6.17	20	0.1%	247.19		$ 295.15		$ 6.08
		SA	1	0.0%	0.52		$ 343.28		$ 0.01	1	0.0%	0.52		$ 338.49		$ 0.01
		Total	21	0.1%	247.71		$ 299.42		$ 6.18	21	0.1%	247.71		$ 295.25		$ 6.09
Medication Checks	Units	MH	1,988	12.8%	761.59		$ 40.03		$ 2.54	1,988	12.8%	761.59		$ 39.63		$ 2.52
		SA	44	0.3%	8.85		$ 37.69		$ 0.03	44	0.3%	8.85		$ 37.31		$ 0.03
		Total	2,021	13.0%	770.44		$ 40.01		$ 2.57	2,021	13.0%	770.44		$ 39.60		$ 2.54
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	MH	-	0.0%	-				$ -	-	0.0%	-				$ -
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	-	0.0%	-				$ -	-	0.0%	-				$ -
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	MH	5,846	37.7%	1,777.24		$ 148.97		$ 22.06	5,846	37.7%	1,777.24		$ 145.57		$ 21.56
		SA	772	5.0%	160.76		$ 144.67		$ 1.94	772	5.0%	160.76		$ 141.37		$ 1.89
		Total	6,135	39.6%	1,938.01		$ 148.61		$ 24.00	6,135	39.6%	1,938.01		$ 145.23		$ 23.45
Individual Psychotherapy Individual Substance Abuse Counseling	Units	MH	5,308	34.2%	5,957.33		$ 62.62		$ 31.09	5,308	34.2%	5,957.33		$ 62.13		$ 30.84
		SA	435	2.8%	303.65		$ 60.98		$ 1.54	435	2.8%	303.65		$ 60.50		$ 1.53
		Total	5,626	36.3%	6,260.98		$ 62.54		$ 32.63	5,626	36.3%	6,260.98		$ 62.05		$ 32.37
Group Psychotherapy Group Substance Abuse Counseling	Units	MH	134	0.9%	113.84		$ 24.95		$ 0.24	134	0.9%	113.84		$ 23.90		$ 0.23
		SA	155	1.0%	118.86		$ 23.48		$ 0.23	155	1.0%	118.86		$ 22.49		$ 0.22
		Total	279	1.8%	232.70		$ 24.20		$ 0.47	279	1.8%	232.70		$ 23.18		$ 0.45
Family Psychotherapy Services Family Substance Abuse Counseling	Units	MH	3,141	20.3%	2,068.51		$ 81.49		$ 14.05	3,141	20.3%	2,068.51		$ 82.41		$ 14.21
		SA	126	0.8%	27.59		$ 75.82		$ 0.17	126	0.8%	27.59		$ 76.68		$ 0.18
		Total	3,255	21.0%	2,096.09		$ 81.42		$ 14.22	3,255	21.0%	2,096.09		$ 82.34		$ 14.38
Family Assessment	Units	MH	21	0.1%	1.82		$ 69.70		$ 0.01	21	0.1%	1.82		$ 68.26		$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	21	0.1%	1.82		$ 69.70		$ 0.01	21	0.1%	1.82		$ 68.26		$ 0.01
Conferences with family or other responsible persons advising them on how to assist the client	Units	MH	54	0.3%	9.46		$ 22.19		$ 0.02	54	0.3%	9.46		$ 22.92		$ 0.02
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	54	0.3%	9.46		$ 22.19		$ 0.02	54	0.3%	9.46		$ 22.92		$ 0.02
MHSA Community Treatment/Support/Psychosocial Rehab	Units	MH	90	0.6%	343.43		$ 34.84		$ 1.00	90	0.6%	343.43		$ 34.31		$ 0.98
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	90	0.6%	343.43		$ 34.84		$ 1.00	90	0.6%	343.43		$ 34.31		$ 0.98
Physician Administered Outpatient Drugs	Units	MH	3	0.0%	13.96		$ 5.25		$ 0.01	3	0.0%	13.96		$ 5.25		$ 0.01
		SA	-	0.0%	-				$ -	-	0.0%	-				$ -
		Total	3	0.0%	13.96		$ 5.25		$ 0.01	3	0.0%	13.96		$ 5.25		$ 0.01
Outpatient Lab/Path/Other	Units	MH	450	2.9%	290.62		$ 20.18		$ 0.49	450	2.9%	290.62		$ 19.90		$ 0.48
		SA	141	0.9%	135.49		$ 14.17		$ 0.16	141	0.9%	135.49		$ 13.97		$ 0.16
		Total	577	3.7%	426.11		$ 18.27		$ 0.65	577	3.7%	426.11		$ 18.01		$ 0.64
Other	Units	MH	102	0.7%	69.42		$ 19.41		$ 0.11	102	0.7%	69.42		$ 19.14		$ 0.11
		SA	14	0.1%	18.83		$ 6.91		$ 0.01	14	0.1%	18.83		$ 6.81		$ 0.01
		Total	115	0.7%	88.25		$ 16.74		$ 0.12	115	0.7%	88.25		$ 16.51		$ 0.12

Statewide Claims Summary for FY09-FY11

Does not include IBNR adjustments.

Rating Category	Member Months	Fiscal Year	MH/SA	Detailed Service Category	Utilizers	Paid Dollars	Paid Units	Units Measure	Paid Days	Cost per Unit	Cost per Day	PMPM Cost
Aged	210,791	09	MH	Adult Day Treatment Psychiatric Services	71	$ 98,843.88	1,001	Cases		$ 98.75		$ 0.47
Aged	210,791	09	MH	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	45	$ 170,828.93	50	Admit	1,998	$ 3,416.58	$ 85.50	$ 0.81
Aged	210,791	09	MH	Electroconvulsive Therapy	19	$ 15,195.34	1,161	Units		$ 13.09		$ 0.07
Aged	210,791	09	MH	Family Psychotherapy Services	33	$ 8,374.10	110	Units		$ 76.13		$ 0.04
Aged	210,791	09	MH	Group Psychotherapy	9	$ 3,427.75	207	Units		$ 16.56		$ 0.02
Aged	210,791	09	MH	Individual Psychotherapy	763	$ 532,352.89	9,633	Units		$ 55.26		$ 2.53
Aged	210,791	09	MH	Inpatient Acute Psychiatric	13	$ 184,611.29	18	Admit	342	$ 10,256.18	$ 539.80	$ 0.88
Aged	210,791	09	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	92	$ 157,774.00	101	Admit	1,468	$ 1,562.12	$ 107.48	$ 0.75
Aged	210,791	09	MH	MHSA Community Treatment/Support/Psychosocial Rehab	110	$ 509,850.99	11,217	Units		$ 45.45		$ 2.42
Aged	210,791	09	MH	Medication Checks	862	$ 85,445.58	3,707	Units		$ 23.05		$ 0.41
Aged	210,791	09	MH	Other	387	$ 112,865.18	4,316	Units		$ 26.15		$ 0.54
Aged	210,791	09	MH	Physician Administered Outpatient Drugs	12	$ 3,127.15	895	Units		$ 3.49		$ 0.01
Aged	210,791	09	MH	Outpatient Lab/Path/Other	46	$ 6,736.13	339	Units		$ 19.87		$ 0.03
Aged	210,791	09	MH	Professional Inpatient Visits	247	$ 37,527.42	1,806	Units		$ 20.78		$ 0.18
Aged	210,791	09	MH	Psychiatric Evaluation/Psychological Evaluation/Testing	1,013	$ 151,496.27	1,896	Units		$ 79.90		$ 0.72
Aged	210,791	09	SA	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	1	$ 359.46	1	Admit	26	$ 359.46	$ 13.83	$ 0.00
Aged	210,791	09	SA	Group Substance Abuse Counseling	2	$ 349.82	11	Units		$ 31.80		$ 0.00
Aged	210,791	09	SA	Individual Substance Abuse Counseling	3	$ 243.92	6	Units		$ 40.65		$ 0.00
Aged	210,791	09	SA	Inpatient Mental Health and Inpatient Services Delivered in an IMD	2	$ 2,054.08	2	Admit	5	$ 1,027.04	$ 410.82	$ 0.01
Aged	210,791	09	SA	MHSA Community Treatment/Support/Psychosocial Rehab	5	$ 7,618.04	34	Units		$ 224.06		$ 0.04
Aged	210,791	09	SA	Medication Checks	6	$ 262.54	10	Units		$ 26.25		$ 0.00
Aged	210,791	09	SA	Other	2	$ 1,775.13	50	Units		$ 35.50		$ 0.01
Aged	210,791	09	SA	Professional Inpatient SubAcute Visits	2	$ 1,157.68	7	Units		$ 165.38		$ 0.01
Aged	210,791	09	SA	Professional Inpatient Visits	17	$ 1,247.10	41	Units		$ 30.42		$ 0.01
Aged	210,791	09	SA	Psychiatric Evaluation/Psychological Evaluation/Testing	9	$ 1,340.33	15	Units		$ 89.36		$ 0.01
Aged	210,940	10	MH	Adult Day Treatment Psychiatric Services	42	$ 112,019.78	1,896	Cases		$ 59.08		$ 0.53
Aged	210,940	10	MH	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	39	$ 91,992.32	41	Admit	1,402	$ 2,243.72	$ 65.62	$ 0.44
Aged	210,940	10	MH	Electroconvulsive Therapy	16	$ 18,420.75	1,231	Units		$ 14.96		$ 0.09
Aged	210,940	10	MH	Family Psychotherapy Services	21	$ 9,719.17	119	Units		$ 81.67		$ 0.05
Aged	210,940	10	MH	Group Psychotherapy	10	$ 2,555.66	151	Units		$ 16.92		$ 0.01
Aged	210,940	10	MH	Individual Psychotherapy	754	$ 528,910.08	9,418	Units		$ 56.16		$ 2.51
Aged	210,940	10	MH	Inpatient Acute Psychiatric	15	$ 140,959.75	17	Admit	302	$ 8,291.75	$ 466.75	$ 0.67
Aged	210,940	10	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	69	$ 87,839.57	74	Admit	1,230	$ 1,187.02	$ 71.41	$ 0.42
Aged	210,940	10	MH	MHSA Community Treatment/Support/Psychosocial Rehab	111	$ 496,274.63	12,707	Units		$ 39.06		$ 2.35
Aged	210,940	10	MH	Medication Checks	779	$ 77,524.53	3,180	Units		$ 24.38		$ 0.37
Aged	210,940	10	MH	Other	439	$ 110,100.29	4,493	Units		$ 24.50		$ 0.52
Aged	210,940	10	MH	Physician Administered Outpatient Drugs	17	$ 8,842.73	3,382	Units		$ 2.61		$ 0.04
Aged	210,940	10	MH	Outpatient Lab/Path/Other	39	$ 5,344.40	216	Units		$ 24.74		$ 0.03
Aged	210,940	10	MH	Professional Inpatient Visits	203	$ 29,181.24	1,265	Units		$ 23.07		$ 0.14
Aged	210,940	10	MH	Psychiatric Evaluation/Psychological Evaluation/Testing	976	$ 153,291.97	1,954	Units		$ 78.45		$ 0.73
Aged	210,940	10	SA	Individual Substance Abuse Counseling	3	$ 437.23	10	Units		$ 43.72		$ 0.00
Aged	210,940	10	SA	MHSA Community Treatment/Support/Psychosocial Rehab	5	$ 8,186.49	36	Units		$ 227.40		$ 0.04
Aged	210,940	10	SA	Medication Checks	2	$ 57.80	2	Units		$ 28.90		$ 0.00
Aged	210,940	10	SA	Other	1	$ 158.39	5	Units		$ 31.68		$ 0.00
Aged	210,940	10	SA	Outpatient Lab/Path/Other	4	$ 347.86	21	Units		$ 16.56		$ 0.00
Aged	210,940	10	SA	Professional Inpatient SubAcute Visits	4	$ 1,179.52	7	Units		$ 168.50		$ 0.01
Aged	210,940	10	SA	Professional Inpatient Visits	8	$ 1,205.05	31	Units		$ 38.87		$ 0.01
Aged	210,940	10	SA	Psychiatric Evaluation/Psychological Evaluation/Testing	9	$ 1,398.71	13	Units		$ 107.59		$ 0.01
Aged	211,207	11	MH	Adult Day Treatment Psychiatric Services	52	$ 85,781.71	1,611	Cases		$ 53.25		$ 0.41
Aged	211,207	11	MH	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	9	$ 7,774.59	10	Admit	315	$ 777.46	$ 24.68	$ 0.04
Aged	211,207	11	MH	Electroconvulsive Therapy	18	$ 34,876.27	5,425	Units		$ 6.43		$ 0.17
Aged	211,207	11	MH	Family Psychotherapy Services	33	$ 10,039.30	123	Units		$ 81.62		$ 0.05
Aged	211,207	11	MH	Group Psychotherapy	8	$ 1,672.31	107	Units		$ 15.63		$ 0.01
Aged	211,207	11	MH	Individual Psychotherapy	813	$ 609,471.98	11,147	Units		$ 54.68		$ 2.89
Aged	211,207	11	MH	Inpatient Acute Psychiatric	12	$ 96,023.12	14	Admit	194	$ 6,858.79	$ 494.96	$ 0.45
Aged	211,207	11	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	66	$ 97,890.00	72	Admit	928	$ 1,359.58	$ 105.48	$ 0.46
Aged	211,207	11	MH	MHSA Community Treatment/Support/Psychosocial Rehab	103	$ 416,697.23	10,869	Units		$ 38.34		$ 1.97
Aged	211,207	11	MH	Medication Checks	772	$ 81,933.81	3,115	Units		$ 26.30		$ 0.39
Aged	211,207	11	MH	Other	404	$ 100,411.61	3,880	Units		$ 25.88		$ 0.48
Aged	211,207	11	MH	Physician Administered Outpatient Drugs	11	$ 1,676.53	643	Units		$ 2.61		$ 0.01
Aged	211,207	11	MH	Outpatient Lab/Path/Other	43	$ 5,016.21	242	Units		$ 20.73		$ 0.02
Aged	211,207	11	MH	Professional Inpatient Visits	174	$ 24,149.42	1,115	Units		$ 21.66		$ 0.11
Aged	211,207	11	MH	Psychiatric Evaluation/Psychological Evaluation/Testing	1,027	$ 157,164.33	2,062	Units		$ 76.22		$ 0.74
Aged	211,207	11	SA	Family Substance Abuse Counseling	1	$ 165.64	2	Units		$ 82.82		$ 0.00
Aged	211,207	11	SA	Individual Substance Abuse Counseling	4	$ 545.50	17	Units		$ 32.09		$ 0.00
Aged	211,207	11	SA	Inpatient Mental Health and Inpatient Services Delivered in an IMD	2	$ 2,232.00	2	Admit	2	$ 1,116.00	$1,116.00	$ 0.01
Aged	211,207	11	SA	MHSA Community Treatment/Support/Psychosocial Rehab	1	$ 228.56	1	Units		$ 228.56		$ 0.00

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Does not include IBNR adjustments.

Rating Category	Member Months	Fiscal Year	MH/SA	Detailed Service Category	Utilizers	Paid Dollars	Paid Units	Units Measure	Paid Days	Cost per Unit	Cost per Day	PMPM Cost
Aged	211,207	11	SA	Medication Checks	4	$ 204.82	9	Units		$ 22.76		$ 0.00
Aged	211,207	11	SA	Outpatient Lab/Path/Other	2	$ 39.49	4	Units		$ 9.87		$ 0.00
Aged	211,207	11	SA	Professional Inpatient SubAcute Visits	2	$ 12,897.20	77	Units		$ 167.50		$ 0.06
Aged	211,207	11	SA	Professional Inpatient Visits	17	$ 909.77	26	Units		$ 34.99		$ 0.00
Aged	211,207	11	SA	Psychiatric Evaluation/Psychological Evaluation/Testing	9	$ 1,337.18	18	Units		$ 74.29		$ 0.01
Blind,Disable	43,068	09	MH	Conferences with family or other responsible persons advising them on how to assist the client	13	$ 673.88	42	Units		$ 16.04		$ 0.02
Blind,Disable	43,068	09	MH	Day Treatment	40	$ 125,814.62	901	Cases		$ 139.64		$ 2.92
Blind,Disable	43,068	09	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	818	$ 224,416.89	1,919	Units		$ 116.94		$ 5.21
Blind,Disable	43,068	09	MH	Family Assessment	1	$ 68.34	1	Units		$ 68.34		$ 0.00
Blind,Disable	43,068	09	MH	Family Psychotherapy Services	504	$ 355,133.59	4,404	Units		$ 80.64		$ 8.25
Blind,Disable	43,068	09	MH	Group Psychotherapy	3	$ 154.44	11	Units		$ 14.04		$ 0.00
Blind,Disable	43,068	09	MH	Individual Psychotherapy	795	$ 610,683.68	10,018	Units		$ 60.96		$ 14.18
Blind,Disable	43,068	09	MH	Inpatient Acute Psychiatric	99	$ 800,181.26	127	Admit	1,603	$ 6,300.64	$ 499.18	$ 18.58
Blind,Disable	43,068	09	MH	Intensive Outpatient Services	21	$ 95,236.34	872	Cases		$ 109.22		$ 2.21
Blind,Disable	43,068	09	MH	MHSA Community Treatment/Support/Psychosocial Rehab	36	$ 83,174.30	2,636	Units		$ 31.55		$ 1.93
Blind,Disable	43,068	09	MH	Medication Checks	441	$ 64,845.85	1,640	Units		$ 39.54		$ 1.51
Blind,Disable	43,068	09	MH	Other	21	$ 1,640.05	1,427	Units		$ 1.15		$ 0.04
Blind,Disable	43,068	09	MH	Physician Administered Outpatient Drugs	2	$ 7,298.16	1,543	Units		$ 4.73		$ 0.17
Blind,Disable	43,068	09	MH	Outpatient Lab/Path/Other	116	$ 15,487.14	677	Units		$ 22.88		$ 0.36
Blind,Disable	43,068	09	MH	Professional Inpatient Visits	99	$ 58,813.29	1,118	Units		$ 52.61		$ 1.37
Blind,Disable	43,068	09	MH	Professional RTC/Group Home Visits	30	$ 10,571.04	179	Units		$ 59.06		$ 0.25
Blind,Disable	43,068	09	MH	Residential Treatment Center	30	$ 1,107,802.93	150	Admit	3,946	$ 7,385.35	$ 280.74	$ 25.72
Blind,Disable	43,068	09	MH	Treatment Crisis Intervention	1	$ 15,820.67	47	Days		$ 336.61		$ 0.37
Blind,Disable	43,068	09	MH	Treatment Foster Care	4	$ 48,893.19	459	Units		$ 106.52		$ 1.14
Blind,Disable	43,068	09	MH	Treatment Group Home	21	$ 350,564.31	79	Admit	1,949	$ 4,437.52	$ 179.87	$ 8.14
Blind,Disable	43,068	09	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	8	$ 4,138.52	22	Units		$ 188.11		$ 0.10
Blind,Disable	43,068	09	SA	Group Substance Abuse Counseling	3	$ 614.13	26	Units		$ 23.62		$ 0.01
Blind,Disable	43,068	09	SA	Individual Substance Abuse Counseling	10	$ 3,196.81	53	Units		$ 60.32		$ 0.07
Blind,Disable	43,068	09	SA	Inpatient Acute Psychiatric	2	$ 8,295.12	2	Admit	16	$ 4,147.56	$ 518.45	$ 0.19
Blind,Disable	43,068	09	SA	Intensive Outpatient Services	2	$ 8,127.36	83	Cases		$ 97.92		$ 0.19
Blind,Disable	43,068	09	SA	Medication Checks	1	$ 36.19	1	Units		$ 36.19		$ 0.00
Blind,Disable	43,068	09	SA	Outpatient Lab/Path/Other	4	$ 371.05	23	Units		$ 16.13		$ 0.01
Blind,Disable	43,068	09	SA	Professional Inpatient Visits	1	$ 461.93	12	Units		$ 38.49		$ 0.01
Blind,Disable	43,068	09	SA	Professional RTC/Group Home Visits	1	$ 963.99	9	Units		$ 107.11		$ 0.02
Blind,Disable	43,068	09	SA	Residential Treatment Center	2	$ 46,511.76	7	Admit	200	$ 6,644.54	$ 232.56	$ 1.08
Blind,Disable	44,961	10	MH	Conferences with family or other responsible persons advising them on how to assist the client	10	$ 524.10	26	Units		$ 20.16		$ 0.01
Blind,Disable	44,961	10	MH	Day Treatment	55	$ 165,401.32	1,139	Cases		$ 145.22		$ 3.68
Blind,Disable	44,961	10	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	774	$ 240,037.86	2,058	Units		$ 116.64		$ 5.34
Blind,Disable	44,961	10	MH	Family Assessment	3	$ 208.05	3	Units		$ 69.35		$ 0.00
Blind,Disable	44,961	10	MH	Family Psychotherapy Services	465	$ 308,243.64	3,759	Units		$ 82.00		$ 6.86
Blind,Disable	44,961	10	MH	Group Psychotherapy	3	$ 1,540.04	66	Units		$ 23.33		$ 0.03
Blind,Disable	44,961	10	MH	Individual Psychotherapy	725	$ 501,478.35	8,051	Units		$ 62.29		$ 11.15
Blind,Disable	44,961	10	MH	Inpatient Acute Psychiatric	99	$ 591,074.39	148	Admit	1,170	$ 3,993.75	$ 505.19	$ 13.15
Blind,Disable	44,961	10	MH	Intensive Outpatient Services	14	$ 52,726.46	502	Cases		$ 105.03		$ 1.17
Blind,Disable	44,961	10	MH	MHSA Community Treatment/Support/Psychosocial Rehab	20	$ 36,444.19	1,172	Units		$ 31.10		$ 0.81
Blind,Disable	44,961	10	MH	Medication Checks	454	$ 78,272.77	1,970	Units		$ 39.73		$ 1.74
Blind,Disable	44,961	10	MH	Other	22	$ 2,776.44	436	Units		$ 6.37		$ 0.06
Blind,Disable	44,961	10	MH	Physician Administered Outpatient Drugs	2	$ 10,336.02	2,172	Units		$ 4.76		$ 0.23
Blind,Disable	44,961	10	MH	Outpatient Lab/Path/Other	115	$ 14,726.73	758	Units		$ 19.43		$ 0.33
Blind,Disable	44,961	10	MH	Professional Inpatient Visits	102	$ 50,658.30	791	Units		$ 64.04		$ 1.13
Blind,Disable	44,961	10	MH	Professional RTC/Group Home Visits	34	$ 10,156.41	181	Units		$ 56.11		$ 0.23
Blind,Disable	44,961	10	MH	Residential Treatment Center	30	$ 1,032,112.02	132	Admit	3,549	$ 7,819.03	$ 290.82	$ 22.96
Blind,Disable	44,961	10	MH	Treatment Crisis Intervention	1	$ 1,024.71	3	Days		$ 341.57		$ 0.02
Blind,Disable	44,961	10	MH	Treatment Foster Care	8	$ 106,912.02	993	Units		$ 107.67		$ 2.38
Blind,Disable	44,961	10	MH	Treatment Group Home	18	$ 229,761.58	50	Admit	1,249	$ 4,595.23	$ 183.96	$ 5.11
Blind,Disable	44,961	10	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	10	$ 2,058.34	18	Units		$ 114.35		$ 0.05
Blind,Disable	44,961	10	SA	Family Substance Abuse Counseling	3	$ 249.00	3	Units		$ 83.00		$ 0.01
Blind,Disable	44,961	10	SA	Individual Substance Abuse Counseling	10	$ 3,723.08	58	Units		$ 64.19		$ 0.08
Blind,Disable	44,961	10	SA	Outpatient Lab/Path/Other	5	$ 1,896.80	37	Units		$ 51.26		$ 0.04
Blind,Disable	46,544	11	MH	Conferences with family or other responsible persons advising them on how to assist the client	20	$ 966.72	44	Units		$ 21.97		$ 0.02
Blind,Disable	46,544	11	MH	Day Treatment	43	$ 163,991.07	1,187	Cases		$ 138.16		$ 3.52
Blind,Disable	46,544	11	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	786	$ 233,906.97	2,031	Units		$ 115.17		$ 5.03
Blind,Disable	46,544	11	MH	Family Assessment	2	$ 139.40	2	Units		$ 69.70		$ 0.00
Blind,Disable	46,544	11	MH	Family Psychotherapy Services	426	$ 251,506.73	3,045	Units		$ 82.60		$ 5.40
Blind,Disable	46,544	11	MH	Group Psychotherapy	4	$ 614.00	26	Units		$ 23.62		$ 0.01
Blind,Disable	46,544	11	MH	Individual Psychotherapy	698	$ 446,545.28	6,996	Units		$ 63.83		$ 9.59
Blind,Disable	46,544	11	MH	Inpatient Acute Psychiatric	86	$ 375,767.66	112	Admit	721	$ 3,355.07	$ 521.18	$ 8.07

Statewide Claims Summary for FY09-FY11

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Blind,Disable	46,544	11	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	1	$ 1,100.00	1	Admit	5	$ 1,100.00	$ 220.00	$ 0.02
Blind,Disable	46,544	11	MH	Intensive Outpatient Services	23	$ 90,516.11	848	Cases		$ 106.74		$ 1.94
Blind,Disable	46,544	11	MH	MHSA Community Treatment/Support/Psychosocial Rehab	14	$ 17,263.28	521	Units		$ 33.13		$ 0.37
Blind,Disable	46,544	11	MH	Medication Checks	542	$ 92,126.74	2,335	Units		$ 39.45		$ 1.98
Blind,Disable	46,544	11	MH	Other	11	$ 2,255.52	82	Units		$ 27.51		$ 0.05
Blind,Disable	46,544	11	MH	Physician Administered Outpatient Drugs	3	$ 8,915.27	1,816	Units		$ 4.91		$ 0.19
Blind,Disable	46,544	11	MH	Outpatient Lab/Path/Other	89	$ 12,992.27	582	Units		$ 22.32		$ 0.28
Blind,Disable	46,544	11	MH	Professional Inpatient Visits	94	$ 36,866.58	569	Units		$ 64.79		$ 0.79
Blind,Disable	46,544	11	MH	Professional RTC/Group Home Visits	18	$ 8,841.60	158	Units		$ 55.96		$ 0.19
Blind,Disable	46,544	11	MH	Residential Treatment Center	15	$ 613,054.78	78	Admit	2,132	$ 7,859.68	$ 287.55	$ 13.17
Blind,Disable	46,544	11	MH	Treatment Crisis Intervention	1	$ 11,860.68	57	Days		$ 208.08		$ 0.25
Blind,Disable	46,544	11	MH	Treatment Foster Care	4	$ 59,152.63	557	Units		$ 106.20		$ 1.27
Blind,Disable	46,544	11	MH	Treatment Group Home	13	$ 199,184.29	42	Admit	1,122	$ 4,742.48	$ 177.53	$ 4.28
Blind,Disable	46,544	11	SA	Day Treatment	1	$ 1,767.60	10	Cases		$ 176.76		$ 0.04
Blind,Disable	46,544	11	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	24	$ 4,432.46	43	Units		$ 103.08		$ 0.10
Blind,Disable	46,544	11	SA	Family Substance Abuse Counseling	1	$ 83.42	1	Units		$ 83.42		$ 0.00
Blind,Disable	46,544	11	SA	Group Substance Abuse Counseling	2	$ 939.57	39	Units		$ 24.09		$ 0.02
Blind,Disable	46,544	11	SA	Individual Substance Abuse Counseling	15	$ 8,138.73	129	Units		$ 63.09		$ 0.17
Blind,Disable	46,544	11	SA	Intensive Outpatient Services	6	$ 16,476.90	165	Cases		$ 99.86		$ 0.35
Blind,Disable	46,544	11	SA	Medication Checks	1	$ 84.26	2	Units		$ 42.13		$ 0.00
Blind,Disable	46,544	11	SA	Outpatient Lab/Path/Other	3	$ 845.17	27	Units		$ 31.30		$ 0.02
Blind,Disable	46,544	11	SA	Residential Treatment Center	2	$ 2,167.36	2	Admit	7	$ 1,083.68	$ 309.62	$ 0.05
Blind,Disable	46,544	11	SA	Treatment Group Home	1	$ 36,735.12	8	Admit	216	$ 4,591.89	$ 170.07	$ 0.79
Blind,Disable	332,072	09	MH	Adult Day Treatment Psychiatric Services	708	$ 2,505,419.08	54,159	Cases		$ 46.26		$ 7.54
Blind,Disable	332,072	09	MH	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	84	$ 643,689.66	96	Admit	2,413	$ 6,705.10	$ 266.76	$ 1.94
Blind,Disable	332,072	09	MH	Conferences with family or other responsible persons advising them on how to assist the client	3	$ 49.44	3	Units		$ 16.48		$ 0.00
Blind,Disable	332,072	09	MH	Day Treatment	9	$ 7,812.43	43	Cases		$ 181.68		$ 0.02
Blind,Disable	332,072	09	MH	Electroconvulsive Therapy	61	$ 77,456.72	13,112	Units		$ 5.91		$ 0.23
Blind,Disable	332,072	09	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	198	$ 48,734.88	430	Units		$ 113.34		$ 0.15
Blind,Disable	332,072	09	MH	Family Assessment	2	$ 136.68	2	Units		$ 68.34		$ 0.00
Blind,Disable	332,072	09	MH	Family Psychotherapy Services	762	$ 399,383.68	5,125	Units		$ 77.93		$ 1.20
Blind,Disable	332,072	09	MH	Group Psychotherapy	270	$ 73,549.22	4,327	Units		$ 17.00		$ 0.22
Blind,Disable	332,072	09	MH	Individual Psychotherapy	7,692	$ 6,863,529.89	130,185	Units		$ 52.72		$ 20.67
Blind,Disable	332,072	09	MH	Inpatient Acute Psychiatric	674	$ 5,418,043.28	1,207	Admit	10,399	$ 4,488.85	$ 521.02	$ 16.32
Blind,Disable	332,072	09	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	744	$ 1,398,739.92	957	Admit	11,124	$ 1,461.59	$ 125.74	$ 4.21
Blind,Disable	332,072	09	MH	Intensive Outpatient Services	2	$ 2,365.32	15	Cases		$ 157.69		$ 0.01
Blind,Disable	332,072	09	MH	MHSA Community Treatment/Support/Psychosocial Rehab	2,431	$ 13,705,464.37	461,912	Units		$ 29.67		$ 41.27
Blind,Disable	332,072	09	MH	Medication Checks	5,819	$ 855,585.67	27,979	Units		$ 30.58		$ 2.58
Blind,Disable	332,072	09	MH	Other	487	$ 89,279.45	6,530	Units		$ 13.67		$ 0.27
Blind,Disable	332,072	09	MH	Physician Administered Outpatient Drugs	339	$ 1,014,127.01	230,290	Units		$ 4.40		$ 3.05
Blind,Disable	332,072	09	MH	Outpatient Lab/Path/Other	653	$ 130,203.30	7,562	Units		$ 17.22		$ 0.39
Blind,Disable	332,072	09	MH	Professional Inpatient SubAcute Visits	46	$ 69,987.12	257	Units		$ 272.32		$ 0.21
Blind,Disable	332,072	09	MH	Professional Inpatient Visits	1,634	$ 582,792.72	16,943	Units		$ 34.40		$ 1.76
Blind,Disable	332,072	09	MH	Psychiatric Evaluation/Psychological Evaluation/Testing	6,843	$ 1,300,537.03	14,660	Units		$ 88.71		$ 3.92
Blind,Disable	332,072	09	MH	Treatment Crisis Intervention	4	$ 6,395.59	23	Days		$ 278.07		$ 0.02
Blind,Disable	332,072	09	SA	Adult Day Treatment Psychiatric Services	74	$ 97,836.52	1,211	Cases		$ 80.79		$ 0.29
Blind,Disable	332,072	09	SA	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	113	$ 1,194,500.68	226	Admit	3,810	$ 5,285.40	$ 313.52	$ 3.60
Blind,Disable	332,072	09	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	2	$ 673.99	7	Units		$ 96.28		$ 0.00
Blind,Disable	332,072	09	SA	Family Substance Abuse Counseling	2	$ 237.51	5	Units		$ 47.50		$ 0.00
Blind,Disable	332,072	09	SA	Group Substance Abuse Counseling	63	$ 11,932.95	608	Units		$ 19.63		$ 0.04
Blind,Disable	332,072	09	SA	Individual Substance Abuse Counseling	135	$ 47,254.85	848	Units		$ 55.73		$ 0.14
Blind,Disable	332,072	09	SA	Inpatient Acute Psychiatric	1	$ 1,916.78	1	Admit	4	$ 1,916.78	$ 479.20	$ 0.01
Blind,Disable	332,072	09	SA	Inpatient Mental Health and Inpatient Services Delivered in an IMD	1	$ 1,068.00	1	Admit	9	$ 1,068.00	$ 118.67	$ 0.00
Blind,Disable	332,072	09	SA	MHSA Community Treatment/Support/Psychosocial Rehab	94	$ 147,730.53	697	Units		$ 211.95		$ 0.44
Blind,Disable	332,072	09	SA	Medication Checks	40	$ 2,766.02	87	Units		$ 31.79		$ 0.01
Blind,Disable	332,072	09	SA	Other	8	$ 24,139.60	138	Units		$ 174.92		$ 0.07
Blind,Disable	332,072	09	SA	Physician Administered Outpatient Drugs	2	$ 7.77	4	Units		$ 1.94		$ 0.00
Blind,Disable	332,072	09	SA	Outpatient Lab/Path/Other	113	$ 20,260.29	959	Units		$ 21.13		$ 0.06
Blind,Disable	332,072	09	SA	Professional Inpatient SubAcute Visits	112	$ 69,496.33	645	Units		$ 107.75		$ 0.21
Blind,Disable	332,072	09	SA	Professional Inpatient Visits	96	$ 13,050.63	325	Units		$ 40.16		$ 0.04
Blind,Disable	332,072	09	SA	Professional RTC/Group Home Visits	1	$ 319.04	2	Units		$ 159.52		$ 0.00
Blind,Disable	332,072	09	SA	Psychiatric Evaluation/Psychological Evaluation/Testing	155	$ 23,437.99	183	Units		$ 128.08		$ 0.07
Blind,Disable	332,072	09	SA	Residential Treatment Center	4	$ 40,703.27	15	Admit	131	$ 2,713.55	$ 310.71	$ 0.12
Blind,Disable	348,146	10	MH	Adult Day Treatment Psychiatric Services	774	$ 3,180,631.46	71,972	Cases		$ 44.19		$ 9.14
Blind,Disable	348,146	10	MH	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	67	$ 485,011.79	81	Admit	1,668	$ 5,987.80	$ 290.77	$ 1.39
Blind,Disable	348,146	10	MH	Conferences with family or other responsible persons advising them on how to assist the client	2	$ 67.14	3	Units		$ 22.38		$ 0.00
Blind,Disable	348,146	10	MH	Day Treatment	11	$ 9,107.30	58	Cases		$ 157.02		$ 0.03

Statewide Claims Summary for FY09-FY11

Does not include IBNR adjustments.

Rating Category	Member Months	Fiscal Year	MH/SA	Detailed Service Category	Utilizers	Paid Dollars	Paid Units	Units Measure	Paid Days	Cost per Unit	Cost per Day	PMPM Cost
Blind,Disable	348,146	10	MH	Electroconvulsive Therapy	65	$ 109,263.91	12,195	Units		$ 8.96		$ 0.31
Blind,Disable	348,146	10	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	217	$ 49,060.47	438	Units		$ 112.01		$ 0.14
Blind,Disable	348,146	10	MH	Family Assessment	2	$ 138.93	2	Units		$ 69.47		$ 0.00
Blind,Disable	348,146	10	MH	Family Psychotherapy Services	598	$ 297,905.08	3,732	Units		$ 79.82		$ 0.86
Blind,Disable	348,146	10	MH	Group Psychotherapy	200	$ 45,404.28	2,608	Units		$ 17.41		$ 0.13
Blind,Disable	348,146	10	MH	Group Substance Abuse Counseling	1	$ 24.79	1	Units		$ 24.79		$ 0.00
Blind,Disable	348,146	10	MH	Individual Psychotherapy	7,467	$ 6,321,523.05	115,534	Units		$ 54.72		$ 18.16
Blind,Disable	348,146	10	MH	Inpatient Acute Psychiatric	720	$ 5,613,515.28	1,336	Admit	11,200	$ 4,201.73	$ 501.21	$ 16.12
Blind,Disable	348,146	10	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	784	$ 1,502,058.17	1,014	Admit	11,269	$ 1,481.32	$ 133.29	$ 4.31
Blind,Disable	348,146	10	MH	Intensive Outpatient Services	2	$ 2,280.84	26	Cases		$ 87.72		$ 0.01
Blind,Disable	348,146	10	MH	MHSA Community Treatment/Support/Psychosocial Rehab	2,519	$ 13,758,146.63	460,603	Units		$ 29.87		$ 39.52
Blind,Disable	348,146	10	MH	Medication Checks	6,354	$ 1,084,299.59	34,268	Units		$ 31.64		$ 3.11
Blind,Disable	348,146	10	MH	Other	502	$ 92,567.22	7,470	Units		$ 12.39		$ 0.27
Blind,Disable	348,146	10	MH	Physician Administered Outpatient Drugs	324	$ 1,118,178.73	238,933	Units		$ 4.68		$ 3.21
Blind,Disable	348,146	10	MH	Outpatient Lab/Path/Other	752	$ 137,466.33	7,500	Units		$ 18.33		$ 0.39
Blind,Disable	348,146	10	MH	Professional Inpatient SubAcute Visits	39	$ 72,424.61	181	Units		$ 400.14		$ 0.21
Blind,Disable	348,146	10	MH	Professional Inpatient Visits	1,664	$ 601,529.61	16,377	Units		$ 36.73		$ 1.73
Blind,Disable	348,146	10	MH	Psychiatric Evaluation/Psychological Evaluation/Testing	6,284	$ 1,252,541.71	14,385	Units		$ 87.07		$ 3.60
Blind,Disable	348,146	10	MH	Treatment Crisis Intervention	2	$ 10,972.39	33	Days		$ 332.50		$ 0.03
Blind,Disable	348,146	10	SA	Adult Day Treatment Psychiatric Services	71	$ 69,464.95	882	Cases		$ 78.76		$ 0.20
Blind,Disable	348,146	10	SA	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	121	$ 1,734,576.82	158	Admit	8,538	$ 10,978.33	$ 203.16	$ 4.98
Blind,Disable	348,146	10	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	7	$ 1,168.44	7	Units		$ 166.92		$ 0.00
Blind,Disable	348,146	10	SA	Group Substance Abuse Counseling	57	$ 9,313.83	385	Units		$ 24.19		$ 0.03
Blind,Disable	348,146	10	SA	Individual Substance Abuse Counseling	130	$ 40,084.93	698	Units		$ 57.43		$ 0.12
Blind,Disable	348,146	10	SA	Inpatient Acute Psychiatric	1	$ 1,310.90	1	Admit	3	$ 1,310.90	$ 436.97	$ 0.00
Blind,Disable	348,146	10	SA	Inpatient Mental Health and Inpatient Services Delivered in an IMD	2	$ 32,666.44	2	Admit	59	$ 16,333.22	$ 553.67	$ 0.09
Blind,Disable	348,146	10	SA	Intensive Outpatient Services	1	$ 26.76	1	Cases		$ 26.76		$ 0.00
Blind,Disable	348,146	10	SA	MHSA Community Treatment/Support/Psychosocial Rehab	97	$ 131,194.46	579	Units		$ 226.59		$ 0.38
Blind,Disable	348,146	10	SA	Medication Checks	52	$ 3,712.78	131	Units		$ 28.34		$ 0.01
Blind,Disable	348,146	10	SA	Other	3	$ 63.56	27	Units		$ 2.35		$ 0.00
Blind,Disable	348,146	10	SA	Physician Administered Outpatient Drugs	1	$ 3.44	1	Units		$ 3.44		9.88E-06
Blind,Disable	348,146	10	SA	Outpatient Lab/Path/Other	146	$ 26,382.09	1,281	Units		$ 20.59		$ 0.08
Blind,Disable	348,146	10	SA	Professional Inpatient SubAcute Visits	128	$ 64,709.37	372	Units		$ 173.95		$ 0.19
Blind,Disable	348,146	10	SA	Professional Inpatient Visits	79	$ 9,921.06	240	Units		$ 41.34		$ 0.03
Blind,Disable	348,146	10	SA	Professional RTC/Group Home Visits	4	$ 723.96	5	Units		$ 144.79		$ 0.00
Blind,Disable	348,146	10	SA	Psychiatric Evaluation/Psychological Evaluation/Testing	214	$ 37,086.53	279	Units		$ 132.93		$ 0.11
Blind,Disable	348,146	10	SA	Residential Treatment Center	2	$ 37,050.70	6	Admit	151	$ 6,175.12	$ 245.37	$ 0.11
Blind,Disable	365,053	11	MH	Adult Day Treatment Psychiatric Services	819	$ 3,223,057.05	71,765	Cases		$ 44.91		$ 8.83
Blind,Disable	365,053	11	MH	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	73	$ 473,165.03	99	Admit	1,105	$ 4,779.44	$ 428.20	$ 1.30
Blind,Disable	365,053	11	MH	Day Treatment	12	$ 6,545.61	36	Cases		$ 181.82		$ 0.02
Blind,Disable	365,053	11	MH	Electroconvulsive Therapy	65	$ 91,489.28	12,163	Units		$ 7.52		$ 0.25
Blind,Disable	365,053	11	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	233	$ 54,663.92	506	Units		$ 108.03		$ 0.15
Blind,Disable	365,053	11	MH	Family Assessment	6	$ 418.06	6	Units		$ 69.68		$ 0.00
Blind,Disable	365,053	11	MH	Family Psychotherapy Services	549	$ 255,428.44	3,207	Units		$ 79.65		$ 0.70
Blind,Disable	365,053	11	MH	Group Psychotherapy	165	$ 38,820.35	2,108	Units		$ 18.42		$ 0.11
Blind,Disable	365,053	11	MH	Individual Psychotherapy	7,673	$ 6,383,533.05	116,124	Units		$ 54.97		$ 17.49
Blind,Disable	365,053	11	MH	Inpatient Acute Psychiatric	750	$ 5,803,115.60	1,391	Admit	11,261	$ 4,171.90	$ 515.33	$ 15.90
Blind,Disable	365,053	11	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	813	$ 1,647,688.66	1,020	Admit	11,360	$ 1,615.38	$ 145.04	$ 4.51
Blind,Disable	365,053	11	MH	Intensive Outpatient Services	1	$ 4,049.01	48	Cases		$ 84.35		$ 0.01
Blind,Disable	365,053	11	MH	MHSA Community Treatment/Support/Psychosocial Rehab	2,611	$ 14,442,013.51	457,993	Units		$ 31.53		$ 39.56
Blind,Disable	365,053	11	MH	Medication Checks	6,734	$ 1,147,272.50	35,821	Units		$ 32.03		$ 3.14
Blind,Disable	365,053	11	MH	Other	456	$ 80,639.05	5,530	Units		$ 14.58		$ 0.22
Blind,Disable	365,053	11	MH	Physician Administered Outpatient Drugs	358	$ 1,015,485.74	221,725	Units		$ 4.58		$ 2.78
Blind,Disable	365,053	11	MH	Outpatient Lab/Path/Other	701	$ 118,391.90	6,549	Units		$ 18.08		$ 0.32
Blind,Disable	365,053	11	MH	Professional Inpatient SubAcute Visits	52	$ 111,780.29	343	Units		$ 325.89		$ 0.31
Blind,Disable	365,053	11	MH	Professional Inpatient Visits	1,733	$ 684,559.46	17,798	Units		$ 38.46		$ 1.88
Blind,Disable	365,053	11	MH	Professional RTC/Group Home Visits	1	$ 330.00	3	Units		$ 110.00		$ 0.00
Blind,Disable	365,053	11	MH	Psychiatric Evaluation/Psychological Evaluation/Testing	6,383	$ 1,230,015.59	14,685	Units		$ 83.76		$ 3.37
Blind,Disable	365,053	11	MH	Treatment Crisis Intervention	2	$ 2,746.24	8	Days		$ 343.28		$ 0.01
Blind,Disable	365,053	11	SA	Adult Day Treatment Psychiatric Services	84	$ 82,437.43	1,071	Cases		$ 76.97		$ 0.23
Blind,Disable	365,053	11	SA	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	137	$ 1,288,783.62	185	Admit	6,706	$ 6,966.40	$ 192.18	$ 3.53
Blind,Disable	365,053	11	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	4	$ 338.15	4	Units		$ 84.54		$ 0.00
Blind,Disable	365,053	11	SA	Family Substance Abuse Counseling	4	$ 711.94	9	Units		$ 79.10		$ 0.00
Blind,Disable	365,053	11	SA	Group Substance Abuse Counseling	47	$ 9,319.46	385	Units		$ 24.21		$ 0.03
Blind,Disable	365,053	11	SA	Individual Substance Abuse Counseling	149	$ 57,820.98	986	Units		$ 58.64		$ 0.16
Blind,Disable	365,053	11	SA	Intensive Outpatient Services	3	$ 4,947.75	57	Cases		$ 86.80		$ 0.01
Blind,Disable	365,053	11	SA	MHSA Community Treatment/Support/Psychosocial Rehab	79	$ 110,398.23	484	Units		$ 228.10		$ 0.30

Statewide Claims Summary for FY09-FY11

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Rating Category	Member Months	Fiscal Year	MH/SA	Detailed Service Category	Utilizers	Paid Dollars	Paid Units	Units Measure	Paid Days	Cost per Unit	Cost per Day	PMPM Cost
Blind,Disable	365,053	11	SA	Medication Checks	64	$ 5,952.40	171	Units		$ 34.81		$ 0.02
Blind,Disable	365,053	11	SA	Other	5	$ 205.69	9	Units		$ 22.85		$ 0.00
Blind,Disable	365,053	11	SA	Outpatient Lab/Path/Other	137	$ 25,121.74	1,272	Units		$ 19.75		$ 0.07
Blind,Disable	365,053	11	SA	Professional Inpatient SubAcute Visits	174	$ 85,105.08	502	Units		$ 169.53		$ 0.23
Blind,Disable	365,053	11	SA	Professional Inpatient Visits	114	$ 13,582.13	228	Units		$ 59.57		$ 0.04
Blind,Disable	365,053	11	SA	Psychiatric Evaluation/Psychological Evaluation/Testing	229	$ 37,969.14	299	Units		$ 126.99		$ 0.10
Blind,Disable	365,053	11	SA	Residential Treatment Center	3	$ 46,761.57	9	Admit	252	$ 5,195.73	$ 185.56	$ 0.13
CHIP	316,561	09	MH	Conferences with family or other responsible persons advising them on how to assist the client	8	$ 483.74	29	Units		$ 16.68		$ 0.00
CHIP	316,561	09	MH	Day Treatment	103	$ 292,386.99	1,714	Cases		$ 170.59		$ 0.92
CHIP	316,561	09	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	2,543	$ 704,360.20	5,636	Units		$ 124.98		$ 2.23
CHIP	316,561	09	MH	Family Assessment	4	$ 273.82	4	Units		$ 68.46		$ 0.00
CHIP	316,561	09	MH	Family Psychotherapy Services	1,514	$ 745,028.81	9,089	Units		$ 81.97		$ 2.35
CHIP	316,561	09	MH	Group Psychotherapy	18	$ 3,308.25	141	Units		$ 23.46		$ 0.01
CHIP	316,561	09	MH	Individual Psychotherapy	2,710	$ 1,440,129.44	23,022	Units		$ 62.55		$ 4.55
CHIP	316,561	09	MH	Inpatient Acute Psychiatric	185	$ 1,020,193.29	233	Admit	1,975	$ 4,378.51	$ 516.55	$ 3.22
CHIP	316,561	09	MH	Intensive Outpatient Services	54	$ 165,683.66	1,489	Cases		$ 111.27		$ 0.52
CHIP	316,561	09	MH	MHSA Community Treatment/Support/Psychosocial Rehab	43	$ 65,811.56	2,024	Units		$ 32.52		$ 0.21
CHIP	316,561	09	MH	Medication Checks	724	$ 84,759.17	2,133	Units		$ 39.74		$ 0.27
CHIP	316,561	09	MH	Other	58	$ 7,752.11	3,855	Units		$ 2.01		$ 0.02
CHIP	316,561	09	MH	Physician Administered Outpatient Drugs	1	$ 733.58	151	Units		$ 4.86		$ 0.00
CHIP	316,561	09	MH	Outpatient Lab/Path/Other	173	$ 23,459.66	1,078	Units		$ 21.76		$ 0.07
CHIP	316,561	09	MH	Professional Inpatient Visits	194	$ 81,645.98	1,436	Units		$ 56.86		$ 0.26
CHIP	316,561	09	MH	Professional RTC/Group Home Visits	37	$ 11,924.54	173	Units		$ 68.93		$ 0.04
CHIP	316,561	09	MH	Residential Treatment Center	34	$ 812,556.10	117	Admit	2,973	$ 6,944.92	$ 273.31	$ 2.57
CHIP	316,561	09	MH	Treatment Crisis Intervention	2	$ 5,385.76	16	Days		$ 336.61		$ 0.02
CHIP	316,561	09	MH	Treatment Foster Care	10	$ 87,244.34	829	Units		$ 105.24		$ 0.28
CHIP	316,561	09	MH	Treatment Group Home	24	$ 438,880.90	92	Admit	2,413	$ 4,770.44	$ 181.88	$ 1.39
CHIP	316,561	09	SA	Day Treatment	5	$ 6,701.78	64	Cases		$ 104.72		$ 0.02
CHIP	316,561	09	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	77	$ 19,544.81	131	Units		$ 149.20		$ 0.06
CHIP	316,561	09	SA	Family Substance Abuse Counseling	4	$ 500.93	6	Units		$ 83.49		$ 0.00
CHIP	316,561	09	SA	Group Substance Abuse Counseling	13	$ 5,439.53	227	Units		$ 23.96		$ 0.02
CHIP	316,561	09	SA	Individual Substance Abuse Counseling	72	$ 18,063.13	296	Units		$ 61.02		$ 0.06
CHIP	316,561	09	SA	Inpatient Acute Psychiatric	1	$ 1,916.78	1	Admit	4	$ 1,916.78	$ 479.20	$ 0.01
CHIP	316,561	09	SA	Intensive Outpatient Services	20	$ 31,634.22	320	Cases		$ 98.86		$ 0.10
CHIP	316,561	09	SA	MHSA Community Treatment/Support/Psychosocial Rehab	1	$ 128.70	4	Units		$ 32.18		$ 0.00
CHIP	316,561	09	SA	Medication Checks	5	$ 413.10	10	Units		$ 41.31		$ 0.00
CHIP	316,561	09	SA	Other	2	$ 108.90	17	Units		$ 6.41		$ 0.00
CHIP	316,561	09	SA	Outpatient Lab/Path/Other	33	$ 5,338.62	269	Units		$ 19.85		$ 0.02
CHIP	316,561	09	SA	Professional Inpatient Visits	2	$ 356.63	5	Units		$ 71.33		$ 0.00
CHIP	316,561	09	SA	Professional RTC/Group Home Visits	2	$ 293.28	2	Units		$ 146.64		$ 0.00
CHIP	316,561	09	SA	Residential Treatment Center	8	$ 68,702.96	14	Admit	274	$ 4,907.35	$ 250.74	$ 0.22
CHIP	316,561	09	SA	Treatment Group Home	4	$ 50,528.28	13	Admit	304	$ 3,886.79	$ 166.21	$ 0.16
CHIP	316,573	10	MH	Conferences with family or other responsible persons advising them on how to assist the client	14	$ 466.35	20	Units		$ 23.32		$ 0.00
CHIP	316,573	10	MH	Day Treatment	84	$ 178,124.50	1,143	Cases		$ 155.84		$ 0.56
CHIP	316,573	10	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	2,428	$ 713,737.92	5,749	Units		$ 124.15		$ 2.25
CHIP	316,573	10	MH	Family Assessment	4	$ 277.40	4	Units		$ 69.35		$ 0.00
CHIP	316,573	10	MH	Family Psychotherapy Services	1,403	$ 634,499.81	7,555	Units		$ 83.98		$ 2.00
CHIP	316,573	10	MH	Group Psychotherapy	23	$ 7,412.09	263	Units		$ 28.18		$ 0.02
CHIP	316,573	10	MH	Individual Psychotherapy	2,351	$ 1,201,414.07	18,535	Units		$ 64.82		$ 3.80
CHIP	316,573	10	MH	Inpatient Acute Psychiatric	180	$ 851,630.08	227	Admit	1,613	$ 3,751.67	$ 527.98	$ 2.69
CHIP	316,573	10	MH	Intensive Outpatient Services	45	$ 157,036.70	1,381	Cases		$ 113.71		$ 0.50
CHIP	316,573	10	MH	MHSA Community Treatment/Support/Psychosocial Rehab	16	$ 28,926.32	840	Units		$ 34.44		$ 0.09
CHIP	316,573	10	MH	Medication Checks	787	$ 110,578.11	2,750	Units		$ 40.21		$ 0.35
CHIP	316,573	10	MH	Other	44	$ 5,792.65	334	Units		$ 17.34		$ 0.02
CHIP	316,573	10	MH	Physician Administered Outpatient Drugs	1	$ 3,390.60	690	Units		$ 4.91		$ 0.01
CHIP	316,573	10	MH	Outpatient Lab/Path/Other	149	$ 21,497.67	856	Units		$ 25.11		$ 0.07
CHIP	316,573	10	MH	Professional Inpatient Visits	184	$ 76,005.16	1,159	Units		$ 65.58		$ 0.24
CHIP	316,573	10	MH	Professional RTC/Group Home Visits	27	$ 10,605.15	160	Units		$ 66.28		$ 0.03
CHIP	316,573	10	MH	Residential Treatment Center	24	$ 763,438.60	100	Admit	2,774	$ 7,634.39	$ 275.21	$ 2.41
CHIP	316,573	10	MH	Treatment Foster Care	3	$ 43,540.31	399	Units		$ 109.12		$ 0.14
CHIP	316,573	10	MH	Treatment Group Home	12	$ 176,368.93	39	Admit	975	$ 4,522.28	$ 180.89	$ 0.56
CHIP	316,573	10	SA	Day Treatment	6	$ 3,888.83	32	Cases		$ 121.53		$ 0.01
CHIP	316,573	10	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	97	$ 22,156.66	174	Units		$ 127.34		$ 0.07
CHIP	316,573	10	SA	Family Substance Abuse Counseling	10	$ 1,329.26	16	Units		$ 83.08		$ 0.00
CHIP	316,573	10	SA	Group Substance Abuse Counseling	25	$ 6,308.29	265	Units		$ 23.80		$ 0.02
CHIP	316,573	10	SA	Individual Substance Abuse Counseling	68	$ 23,094.11	368	Units		$ 62.76		$ 0.07
CHIP	316,573	10	SA	Inpatient Mental Health and Inpatient Services Delivered in an IMD	1	$ 28,574.04	1	Admit	49	$ 28,574.04	$ 583.14	$ 0.09

Statewide Claims Summary for FY09-FY11

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CHIP	316,573	10	SA	Intensive Outpatient Services	28	$ 58,507.52	588	Cases		$ 99.50		$ 0.18
CHIP	316,573	10	SA	Medication Checks	6	$ 544.96	13	Units		$ 41.92		$ 0.00
CHIP	316,573	10	SA	Other	2	$ 110.03	17	Units		$ 6.47		$ 0.00
CHIP	316,573	10	SA	Outpatient Lab/Path/Other	29	$ 5,219.11	213	Units		$ 24.50		$ 0.02
CHIP	316,573	10	SA	Professional Inpatient Visits	1	$ 86.07	1	Units		$ 86.07		$ 0.00
CHIP	316,573	10	SA	Professional RTC/Group Home Visits	9	$ 1,022.46	13	Units		$ 78.65		$ 0.00
CHIP	316,573	10	SA	Residential Treatment Center	12	$ 125,474.95	28	Admit	488	$ 4,481.25	$ 257.12	$ 0.40
CHIP	316,573	10	SA	Treatment Group Home	6	$ 47,212.38	11	Admit	291	$ 4,292.03	$ 162.24	$ 0.15
CHIP	358,005	11	MH	Conferences with family or other responsible persons advising them on how to assist the client	28	$ 1,201.99	54	Units		$ 22.26		$ 0.00
CHIP	358,005	11	MH	Day Treatment	114	$ 313,337.43	1,850	Cases		$ 169.37		$ 0.88
CHIP	358,005	11	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	2,668	$ 801,209.16	6,644	Units		$ 120.59		$ 2.24
CHIP	358,005	11	MH	Family Assessment	1	$ 69.70	1	Units		$ 69.70		$ 0.00
CHIP	358,005	11	MH	Family Psychotherapy Services	1,582	$ 709,092.98	8,410	Units		$ 84.32		$ 1.98
CHIP	358,005	11	MH	Group Psychotherapy	20	$ 4,507.20	187	Units		$ 24.10		$ 0.01
CHIP	358,005	11	MH	Individual Psychotherapy	2,545	$ 1,273,898.22	19,579	Units		$ 65.06		$ 3.56
CHIP	358,005	11	MH	Inpatient Acute Psychiatric	229	$ 957,099.99	287	Admit	1,808	$ 3,334.84	$ 529.37	$ 2.67
CHIP	358,005	11	MH	Intensive Outpatient Services	58	$ 201,408.20	1,784	Cases		$ 112.90		$ 0.56
CHIP	358,005	11	MH	MHSA Community Treatment/Support/Psychosocial Rehab	22	$ 28,943.00	861	Units		$ 33.62		$ 0.08
CHIP	358,005	11	MH	Medication Checks	907	$ 126,384.80	3,131	Units		$ 40.37		$ 0.35
CHIP	358,005	11	MH	Other	51	$ 8,480.77	599	Units		$ 14.16		$ 0.02
CHIP	358,005	11	MH	Physician Administered Outpatient Drugs	2	$ 7,842.31	1,242	Units		$ 6.31		$ 0.02
CHIP	358,005	11	MH	Outpatient Lab/Path/Other	116	$ 14,082.20	647	Units		$ 21.77		$ 0.04
CHIP	358,005	11	MH	Professional Inpatient Visits	233	$ 90,205.99	1,339	Units		$ 67.37		$ 0.25
CHIP	358,005	11	MH	Professional RTC/Group Home Visits	22	$ 13,165.71	222	Units		$ 59.31		$ 0.04
CHIP	358,005	11	MH	Residential Treatment Center	19	$ 589,239.19	76	Admit	1,956	$ 7,753.15	$ 301.25	$ 1.65
CHIP	358,005	11	MH	Treatment Foster Care	2	$ 8,734.24	79	Units		$ 110.56		$ 0.02
CHIP	358,005	11	MH	Treatment Group Home	16	$ 224,981.40	54	Admit	1,298	$ 4,166.32	$ 173.33	$ 0.63
CHIP	358,005	11	SA	Day Treatment	10	$ 22,673.07	127	Cases		$ 178.53		$ 0.06
CHIP	358,005	11	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	125	$ 33,213.49	244	Units		$ 136.12		$ 0.09
CHIP	358,005	11	SA	Family Substance Abuse Counseling	18	$ 4,354.19	53	Units		$ 82.15		$ 0.01
CHIP	358,005	11	SA	Group Substance Abuse Counseling	27	$ 8,721.33	363	Units		$ 24.03		$ 0.02
CHIP	358,005	11	SA	Individual Substance Abuse Counseling	75	$ 31,683.35	504	Units		$ 62.86		$ 0.09
CHIP	358,005	11	SA	Inpatient Acute Psychiatric	2	$ 2,073.30	2	Admit	5	$ 1,036.65	$ 414.66	$ 0.01
CHIP	358,005	11	SA	Inpatient Mental Health and Inpatient Services Delivered in an IMD	1	$ 691.10	1	Admit	2	$ 691.10	$ 345.55	$ 0.00
CHIP	358,005	11	SA	Intensive Outpatient Services	41	$ 62,837.55	647	Cases		$ 97.12		$ 0.18
CHIP	358,005	11	SA	Medication Checks	9	$ 589.82	14	Units		$ 42.13		$ 0.00
CHIP	358,005	11	SA	Outpatient Lab/Path/Other	24	$ 6,796.80	337	Units		$ 20.17		$ 0.02
CHIP	358,005	11	SA	Professional Inpatient Visits	2	$ 492.54	8	Units		$ 61.57		$ 0.00
CHIP	358,005	11	SA	Professional RTC/Group Home Visits	12	$ 2,280.26	27	Units		$ 84.45		$ 0.01
CHIP	358,005	11	SA	Residential Treatment Center	15	$ 166,682.91	35	Admit	575	$ 4,762.37	$ 289.88	$ 0.47
CHIP	358,005	11	SA	Treatment Group Home	9	$ 130,923.85	32	Admit	817	$ 4,091.37	$ 160.25	$ 0.37
Families_0-5	684,592	09	MH	Conferences with family or other responsible persons advising them on how to assist the client	1	$ 16.10	1	Units		$ 16.10		$ 0.00
Families_0-5	684,592	09	MH	Day Treatment	82	$ 363,294.39	2,946	Cases		$ 123.32		$ 0.53
Families_0-5	684,592	09	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	1,706	$ 447,636.35	3,454	Units		$ 129.60		$ 0.65
Families_0-5	684,592	09	MH	Family Assessment	2	$ 136.68	2	Units		$ 68.34		$ 0.00
Families_0-5	684,592	09	MH	Family Psychotherapy Services	859	$ 384,152.47	4,721	Units		$ 81.37		$ 0.56
Families_0-5	684,592	09	MH	Group Psychotherapy	1	$ 141.72	6	Units		$ 23.62		$ 0.00
Families_0-5	684,592	09	MH	Individual Psychotherapy	740	$ 295,836.69	4,827	Units		$ 61.29		$ 0.43
Families_0-5	684,592	09	MH	Inpatient Acute Psychiatric	31	$ 94,261.12	36	Admit	191	$ 2,618.36	$ 493.51	$ 0.14
Families_0-5	684,592	09	MH	Intensive Outpatient Services	7	$ 23,668.44	209	Cases		$ 113.25		$ 0.03
Families_0-5	684,592	09	MH	MHSA Community Treatment/Support/Psychosocial Rehab	12	$ 23,270.73	759	Units		$ 30.66		$ 0.03
Families_0-5	684,592	09	MH	Medication Checks	195	$ 22,789.68	571	Units		$ 39.91		$ 0.03
Families_0-5	684,592	09	MH	Other	31	$ 3,992.97	5,033	Units		$ 0.79		$ 0.01
Families_0-5	684,592	09	MH	Physician Administered Outpatient Drugs	1	$ 2.80	1	Units		$ 2.80		4.09E-06
Families_0-5	684,592	09	MH	Outpatient Lab/Path/Other	60	$ 5,499.99	331	Units		$ 16.62		$ 0.01
Families_0-5	684,592	09	MH	Professional Inpatient Visits	46	$ 12,238.25	197	Units		$ 62.12		$ 0.02
Families_0-5	684,592	09	MH	Professional RTC/Group Home Visits	2	$ 199.30	4	Units		$ 49.83		$ 0.00
Families_0-5	684,592	09	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	8	$ 2,128.02	14	Units		$ 152.00		$ 0.00
Families_0-5	684,592	09	SA	Group Substance Abuse Counseling	5	$ 572.62	26	Units		$ 22.02		$ 0.00
Families_0-5	684,592	09	SA	Individual Substance Abuse Counseling	9	$ 1,732.12	29	Units		$ 59.73		$ 0.00
Families_0-5	684,592	09	SA	Intensive Outpatient Services	5	$ 4,918.22	73	Cases		$ 67.37		$ 0.01
Families_0-5	684,592	09	SA	Outpatient Lab/Path/Other	12	$ 1,599.84	89	Units		$ 17.98		$ 0.00
Families_0-5	684,592	09	SA	Professional Inpatient Visits	3	$ 1,383.73	15	Units		$ 92.25		$ 0.00
Families_0-5	684,592	09	SA	Residential Treatment Center	3	$ 59,468.98	16	Admit	462	$ 3,716.81	$ 128.72	$ 0.09
Families_0-5	727,660	10	MH	Conferences with family or other responsible persons advising them on how to assist the client	5	$ 224.00	10	Units		$ 22.40		$ 0.00
Families_0-5	727,660	10	MH	Day Treatment	36	$ 113,476.03	893	Cases		$ 127.07		$ 0.16
Families_0-5	727,660	10	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	1,752	$ 485,994.88	3,993	Units		$ 121.71		$ 0.67

Statewide Claims Summary for FY09-FY11

Does not include IBNR adjustments.

Rating Category	Member Months	Fiscal Year	MH/SA	Detailed Service Category	Utilizers	Paid Dollars	Paid Units	Units Measure	Paid Days	Cost per Unit	Cost per Day	PMPM Cost
Families_0-5	727,660	10	MH	Family Assessment	2	$ 138.70	2	Units		$ 69.35		$ 0.00
Families_0-5	727,660	10	MH	Family Psychotherapy Services	780	$ 390,006.33	4,712	Units		$ 82.77		$ 0.54
Families_0-5	727,660	10	MH	Group Psychotherapy	3	$ 1,306.29	43	Units		$ 30.38		$ 0.00
Families_0-5	727,660	10	MH	Individual Psychotherapy	612	$ 272,940.08	4,345	Units		$ 62.82		$ 0.38
Families_0-5	727,660	10	MH	Inpatient Acute Psychiatric	21	$ 67,341.36	22	Admit	130	$ 3,060.97	$ 518.01	$ 0.09
Families_0-5	727,660	10	MH	Intensive Outpatient Services	9	$ 22,299.22	193	Cases		$ 115.54		$ 0.03
Families_0-5	727,660	10	MH	MHSA Community Treatment/Support/Psychosocial Rehab	11	$ 23,816.11	678	Units		$ 35.13		$ 0.03
Families_0-5	727,660	10	MH	Medication Checks	216	$ 27,384.91	677	Units		$ 40.45		$ 0.04
Families_0-5	727,660	10	MH	Other	22	$ 1,182.90	161	Units		$ 7.35		$ 0.00
Families_0-5	727,660	10	MH	Physician Administered Outpatient Drugs	1	$ 78.83	7	Units		$ 11.26		$ 0.00
Families_0-5	727,660	10	MH	Outpatient Lab/Path/Other	50	$ 6,354.28	258	Units		$ 24.63		$ 0.01
Families_0-5	727,660	10	MH	Professional Inpatient Visits	30	$ 7,431.82	103	Units		$ 72.15		$ 0.01
Families_0-5	727,660	10	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	4	$ 929.19	7	Units		$ 132.74		$ 0.00
Families_0-5	727,660	10	SA	Group Substance Abuse Counseling	6	$ 967.34	40	Units		$ 24.18		$ 0.00
Families_0-5	727,660	10	SA	Individual Substance Abuse Counseling	10	$ 2,327.61	38	Units		$ 61.25		$ 0.00
Families_0-5	727,660	10	SA	Intensive Outpatient Services	2	$ 817.97	16	Cases		$ 51.12		$ 0.00
Families_0-5	727,660	10	SA	MHSA Community Treatment/Support/Psychosocial Rehab	2	$ 909.68	4	Units		$ 227.42		$ 0.00
Families_0-5	727,660	10	SA	Outpatient Lab/Path/Other	12	$ 692.44	45	Units		$ 15.39		$ 0.00
Families_0-5	727,660	10	SA	Residential Treatment Center	1	$ 4,185.00	1	Admit	31	$ 4,185.00	$ 135.00	$ 0.01
Families_0-5	690,381	11	MH	Conferences with family or other responsible persons advising them on how to assist the client	23	$ 990.35	45	Units		$ 22.01		$ 0.00
Families_0-5	690,381	11	MH	Day Treatment	27	$ 137,649.11	1,086	Cases		$ 126.75		$ 0.20
Families_0-5	690,381	11	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	1,591	$ 438,763.92	3,635	Units		$ 120.71		$ 0.64
Families_0-5	690,381	11	MH	Family Psychotherapy Services	771	$ 383,158.81	4,559	Units		$ 84.04		$ 0.55
Families_0-5	690,381	11	MH	Individual Psychotherapy	444	$ 187,679.97	2,977	Units		$ 63.04		$ 0.27
Families_0-5	690,381	11	MH	Inpatient Acute Psychiatric	12	$ 39,793.70	17	Admit	77	$ 2,340.81	$ 516.80	$ 0.06
Families_0-5	690,381	11	MH	Intensive Outpatient Services	7	$ 22,759.52	196	Cases		$ 116.12		$ 0.03
Families_0-5	690,381	11	MH	MHSA Community Treatment/Support/Psychosocial Rehab	8	$ 7,834.84	224	Units		$ 34.98		$ 0.01
Families_0-5	690,381	11	MH	Medication Checks	208	$ 26,548.23	661	Units		$ 40.16		$ 0.04
Families_0-5	690,381	11	MH	Other	12	$ 2,160.31	278	Units		$ 7.77		$ 0.00
Families_0-5	690,381	11	MH	Outpatient Lab/Path/Other	21	$ 2,353.87	91	Units		$ 25.87		$ 0.00
Families_0-5	690,381	11	MH	Professional Inpatient Visits	12	$ 4,034.69	62	Units		$ 65.08		$ 0.01
Families_0-5	690,381	11	SA	Outpatient Lab/Path/Other	1	$ 42.27	4	Units		$ 10.57		$ 0.00
Families_19+	234,270	09	MH	Adult Day Treatment Psychiatric Services	70	$ 91,958.99	716	Cases		$ 128.43		$ 0.39
Families_19+	234,270	09	MH	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	10	$ 57,302.44	10	Admit	125	$ 5,730.24	$ 458.42	$ 0.24
Families_19+	234,270	09	MH	Day Treatment	4	$ 3,164.54	14	Cases		$ 226.04		$ 0.01
Families_19+	234,270	09	MH	Electroconvulsive Therapy	7	$ 13,937.51	390	Units		$ 35.74		$ 0.06
Families_19+	234,270	09	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	228	$ 56,752.03	421	Units		$ 134.80		$ 0.24
Families_19+	234,270	09	MH	Family Assessment	8	$ 546.72	8	Units		$ 68.34		$ 0.00
Families_19+	234,270	09	MH	Family Psychotherapy Services	500	$ 256,285.91	3,170	Units		$ 80.85		$ 1.09
Families_19+	234,270	09	MH	Group Psychotherapy	52	$ 13,395.68	568	Units		$ 23.58		$ 0.06
Families_19+	234,270	09	MH	Individual Psychotherapy	3,246	$ 2,032,248.64	32,444	Units		$ 62.64		$ 8.67
Families_19+	234,270	09	MH	Inpatient Acute Psychiatric	316	$ 1,154,824.51	380	Admit	2,224	$ 3,039.01	$ 519.26	$ 4.93
Families_19+	234,270	09	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	8	$ 25,134.03	8	Admit	212	$ 3,141.75	$ 118.56	$ 0.11
Families_19+	234,270	09	MH	Intensive Outpatient Services	1	$ 783.36	8	Cases		$ 97.92		$ 0.00
Families_19+	234,270	09	MH	MHSA Community Treatment/Support/Psychosocial Rehab	209	$ 361,071.19	9,091	Units		$ 39.72		$ 1.54
Families_19+	234,270	09	MH	Medication Checks	1,156	$ 138,311.70	3,573	Units		$ 38.71		$ 0.59
Families_19+	234,270	09	MH	Other	81	$ 16,656.48	3,907	Units		$ 4.26		$ 0.07
Families_19+	234,270	09	MH	Physician Administered Outpatient Drugs	4	$ 27,368.57	5,929	Units		$ 4.62		$ 0.12
Families_19+	234,270	09	MH	Outpatient Lab/Path/Other	379	$ 45,056.01	2,460	Units		$ 18.32		$ 0.19
Families_19+	234,270	09	MH	Professional Inpatient SubAcute Visits	10	$ 7,711.75	28	Units		$ 275.42		$ 0.03
Families_19+	234,270	09	MH	Professional Inpatient Visits	389	$ 116,983.82	1,818	Units		$ 64.35		$ 0.50
Families_19+	234,270	09	MH	Psychiatric Evaluation/Psychological Evaluation/Testing	3,382	$ 917,000.59	6,864	Units		$ 133.60		$ 3.91
Families_19+	234,270	09	SA	Adult Day Treatment Psychiatric Services	79	$ 83,180.52	1,053	Cases		$ 78.99		$ 0.36
Families_19+	234,270	09	SA	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	111	$ 1,095,465.99	134	Admit	7,278	$ 8,175.12	$ 150.52	$ 4.68
Families_19+	234,270	09	SA	Day Treatment	1	$ 123.15	1	Cases		$ 123.15		$ 0.00
Families_19+	234,270	09	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	9	$ 2,956.84	13	Units		$ 227.45		$ 0.01
Families_19+	234,270	09	SA	Family Substance Abuse Counseling	5	$ 490.14	6	Units		$ 81.69		$ 0.00
Families_19+	234,270	09	SA	Group Substance Abuse Counseling	125	$ 27,489.71	1,141	Units		$ 24.09		$ 0.12
Families_19+	234,270	09	SA	Individual Substance Abuse Counseling	194	$ 57,560.81	929	Units		$ 61.96		$ 0.25
Families_19+	234,270	09	SA	Intensive Outpatient Services	2	$ 1,886.16	22	Cases		$ 85.73		$ 0.01
Families_19+	234,270	09	SA	MHSA Community Treatment/Support/Psychosocial Rehab	79	$ 63,806.62	304	Units		$ 209.89		$ 0.27
Families_19+	234,270	09	SA	Medication Checks	7	$ 702.20	17	Units		$ 41.31		$ 0.00
Families_19+	234,270	09	SA	Other	4	$ 2,351.56	41	Units		$ 57.36		$ 0.01
Families_19+	234,270	09	SA	Outpatient Lab/Path/Other	89	$ 15,632.75	800	Units		$ 19.54		$ 0.07
Families_19+	234,270	09	SA	Professional Inpatient SubAcute Visits	73	$ 21,816.80	314	Units		$ 69.48		$ 0.09
Families_19+	234,270	09	SA	Professional Inpatient Visits	23	$ 4,705.97	69	Units		$ 68.20		$ 0.02
Families_19+	234,270	09	SA	Professional RTC/Group Home Visits	5	$ 1,130.32	7	Units		$ 161.47		$ 0.00

Statewide Claims Summary for FY09-FY11

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Families_19+	234,270	09	SA	Psychiatric Evaluation/Psychological Evaluation/Testing	216	$ 46,923.46	250	Units		$ 187.69		$ 0.20
Families_19+	234,270	09	SA	Residential Treatment Center	13	$ 87,944.29	29	Admit	608	$ 3,032.56	$ 144.65	$ 0.38
Families_19+	274,466	10	MH	Adult Day Treatment Psychiatric Services	83	$ 107,523.81	929	Cases		$ 115.74		$ 0.39
Families_19+	274,466	10	MH	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	7	$ 46,479.32	8	Admit	103	$ 5,809.92	$ 451.26	$ 0.17
Families_19+	274,466	10	MH	Day Treatment	2	$ 2,010.98	19	Cases		$ 105.84		$ 0.01
Families_19+	274,466	10	MH	Electroconvulsive Therapy	10	$ 16,128.57	255	Units		$ 63.25		$ 0.06
Families_19+	274,466	10	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	256	$ 68,457.64	540	Units		$ 126.77		$ 0.25
Families_19+	274,466	10	MH	Family Assessment	19	$ 1,318.11	19	Units		$ 69.37		$ 0.00
Families_19+	274,466	10	MH	Family Psychotherapy Services	376	$ 185,053.86	2,242	Units		$ 82.54		$ 0.67
Families_19+	274,466	10	MH	Group Psychotherapy	40	$ 9,742.19	384	Units		$ 25.37		$ 0.04
Families_19+	274,466	10	MH	Group Substance Abuse Counseling	1	$ 123.95	5	Units		$ 24.79		$ 0.00
Families_19+	274,466	10	MH	Individual Psychotherapy	3,292	$ 2,023,278.53	31,371	Units		$ 64.50		$ 7.37
Families_19+	274,466	10	MH	Inpatient Acute Psychiatric	340	$ 1,240,101.50	427	Admit	2,449	$ 2,904.22	$ 506.37	$ 4.52
Families_19+	274,466	10	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	4	$ 20,713.52	5	Admit	53	$ 4,142.70	$ 390.82	$ 0.08
Families_19+	274,466	10	MH	Intensive Outpatient Services	1	$ 894.24	9	Cases		$ 99.36		$ 0.00
Families_19+	274,466	10	MH	MHSA Community Treatment/Support/Psychosocial Rehab	227	$ 351,973.33	9,670	Units		$ 36.40		$ 1.28
Families_19+	274,466	10	MH	Medication Checks	1,510	$ 196,808.02	5,005	Units		$ 39.32		$ 0.72
Families_19+	274,466	10	MH	Other	63	$ 16,099.38	2,855	Units		$ 5.64		$ 0.06
Families_19+	274,466	10	MH	Physician Administered Outpatient Drugs	14	$ 28,545.20	6,095	Units		$ 4.68		$ 0.10
Families_19+	274,466	10	MH	Outpatient Lab/Path/Other	428	$ 53,253.39	2,412	Units		$ 22.08		$ 0.19
Families_19+	274,466	10	MH	Professional Inpatient SubAcute Visits	18	$ 12,879.10	40	Units		$ 321.98		$ 0.05
Families_19+	274,466	10	MH	Professional Inpatient Visits	399	$ 130,595.56	1,882	Units		$ 69.39		$ 0.48
Families_19+	274,466	10	MH	Psychiatric Evaluation/Psychological Evaluation/Testing	3,466	$ 964,403.35	7,812	Units		$ 123.45		$ 3.51
Families_19+	274,466	10	SA	Adult Day Treatment Psychiatric Services	86	$ 89,883.24	1,147	Cases		$ 78.36		$ 0.33
Families_19+	274,466	10	SA	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	116	$ 1,149,991.50	159	Admit	7,611	$ 7,232.65	$ 151.10	$ 4.19
Families_19+	274,466	10	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	17	$ 3,182.14	25	Units		$ 127.29		$ 0.01
Families_19+	274,466	10	SA	Family Substance Abuse Counseling	4	$ 332.08	4	Units		$ 83.02		$ 0.00
Families_19+	274,466	10	SA	Group Substance Abuse Counseling	152	$ 35,662.49	1,455	Units		$ 24.51		$ 0.13
Families_19+	274,466	10	SA	Individual Substance Abuse Counseling	256	$ 73,347.54	1,173	Units		$ 62.53		$ 0.27
Families_19+	274,466	10	SA	Inpatient Acute Psychiatric	2	$ 8,702.80	2	Admit	38	$ 4,351.40	$ 229.02	$ 0.03
Families_19+	274,466	10	SA	Inpatient Mental Health and Inpatient Services Delivered in an IMD	1	$ 9,504.00	1	Admit	16	$ 9,504.00	$ 594.00	$ 0.03
Families_19+	274,466	10	SA	Intensive Outpatient Services	4	$ 1,837.04	25	Cases		$ 73.48		$ 0.01
Families_19+	274,466	10	SA	MHSA Community Treatment/Support/Psychosocial Rehab	82	$ 71,619.66	318	Units		$ 225.22		$ 0.26
Families_19+	274,466	10	SA	Medication Checks	9	$ 654.72	16	Units		$ 40.92		$ 0.00
Families_19+	274,466	10	SA	Outpatient Lab/Path/Other	120	$ 21,803.37	1,048	Units		$ 20.80		$ 0.08
Families_19+	274,466	10	SA	Professional Inpatient SubAcute Visits	59	$ 18,895.86	109	Units		$ 173.36		$ 0.07
Families_19+	274,466	10	SA	Professional Inpatient Visits	20	$ 3,212.88	40	Units		$ 80.32		$ 0.01
Families_19+	274,466	10	SA	Professional RTC/Group Home Visits	2	$ 337.72	2	Units		$ 168.86		$ 0.00
Families_19+	274,466	10	SA	Psychiatric Evaluation/Psychological Evaluation/Testing	268	$ 52,401.67	316	Units		$ 165.83		$ 0.19
Families_19+	274,466	10	SA	Residential Treatment Center	12	$ 102,506.15	30	Admit	646	$ 3,416.87	$ 158.68	$ 0.37
Families_19+	347,151	11	MH	Adult Day Treatment Psychiatric Services	122	$ 117,112.37	788	Cases		$ 148.62		$ 0.34
Families_19+	347,151	11	MH	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	11	$ 77,549.14	11	Admit	202	$ 7,049.92	$ 383.91	$ 0.22
Families_19+	347,151	11	MH	Day Treatment	3	$ 2,115.51	13	Cases		$ 162.73		$ 0.01
Families_19+	347,151	11	MH	Electroconvulsive Therapy	12	$ 19,248.02	251	Units		$ 76.69		$ 0.06
Families_19+	347,151	11	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	288	$ 72,238.86	602	Units		$ 120.00		$ 0.21
Families_19+	347,151	11	MH	Family Assessment	17	$ 1,185.11	17	Units		$ 69.71		$ 0.00
Families_19+	347,151	11	MH	Family Psychotherapy Services	375	$ 152,881.97	1,835	Units		$ 83.31		$ 0.44
Families_19+	347,151	11	MH	Group Psychotherapy	51	$ 12,954.01	527	Units		$ 24.58		$ 0.04
Families_19+	347,151	11	MH	Individual Psychotherapy	3,700	$ 2,174,616.87	33,571	Units		$ 64.78		$ 6.26
Families_19+	347,151	11	MH	Inpatient Acute Psychiatric	402	$ 1,309,687.61	481	Admit	2,561	$ 2,722.84	$ 511.40	$ 3.77
Families_19+	347,151	11	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	3	$ 3,396.00	3	Admit	14	$ 1,132.00	$ 242.57	$ 0.01
Families_19+	347,151	11	MH	Intensive Outpatient Services	3	$ 3,694.82	37	Cases		$ 99.86		$ 0.01
Families_19+	347,151	11	MH	MHSA Community Treatment/Support/Psychosocial Rehab	212	$ 366,560.92	9,482	Units		$ 38.66		$ 1.06
Families_19+	347,151	11	MH	Medication Checks	1,714	$ 236,621.59	6,000	Units		$ 39.44		$ 0.68
Families_19+	347,151	11	MH	Other	73	$ 17,438.80	2,113	Units		$ 8.25		$ 0.05
Families_19+	347,151	11	MH	Physician Administered Outpatient Drugs	6	$ 5,373.17	1,078	Units		$ 4.98		$ 0.02
Families_19+	347,151	11	MH	Outpatient Lab/Path/Other	353	$ 43,679.05	2,066	Units		$ 21.14		$ 0.13
Families_19+	347,151	11	MH	Professional Inpatient SubAcute Visits	17	$ 20,501.74	66	Units		$ 310.63		$ 0.06
Families_19+	347,151	11	MH	Professional Inpatient Visits	476	$ 140,263.22	1,945	Units		$ 72.11		$ 0.40
Families_19+	347,151	11	MH	Psychiatric Evaluation/Psychological Evaluation/Testing	3,978	$ 1,080,610.38	9,181	Units		$ 117.70		$ 3.11
Families_19+	347,151	11	MH	Treatment Crisis Intervention	2	$ 2,059.68	6	Days		$ 343.28		$ 0.01
Families_19+	347,151	11	SA	Adult Day Treatment Psychiatric Services	123	$ 132,554.68	1,736	Cases		$ 76.36		$ 0.38
Families_19+	347,151	11	SA	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	126	$ 1,033,791.48	171	Admit	6,216	$ 6,045.56	$ 166.31	$ 2.98
Families_19+	347,151	11	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	26	$ 4,881.53	38	Units		$ 128.46		$ 0.01
Families_19+	347,151	11	SA	Family Substance Abuse Counseling	6	$ 582.84	7	Units		$ 83.26		$ 0.00
Families_19+	347,151	11	SA	Group Substance Abuse Counseling	190	$ 41,489.36	1,689	Units		$ 24.56		$ 0.12
Families_19+	347,151	11	SA	Individual Substance Abuse Counseling	303	$ 107,222.53	1,692	Units		$ 63.37		$ 0.31

Statewide Claims Summary for FY09-FY11

Does not include IBNR adjustments.

Rating Category	Member Months	Fiscal Year	MH/SA	Detailed Service Category	Utilizers	Paid Dollars	Paid Units	Units Measure	Paid Days	Cost per Unit	Cost per Day	PMPM Cost
Families_19+	347,151	11	SA	Inpatient Acute Psychiatric	1	$ 691.10	1	Admit	2	$ 691.10	$ 345.55	$ 0.00
Families_19+	347,151	11	SA	Intensive Outpatient Services	7	$ 4,941.77	63	Cases		$ 78.44		$ 0.01
Families_19+	347,151	11	SA	MHSA Community Treatment/Support/Psychosocial Rehab	74	$ 57,140.00	251	Units		$ 227.65		$ 0.16
Families_19+	347,151	11	SA	Medication Checks	22	$ 1,433.12	37	Units		$ 38.73		$ 0.00
Families_19+	347,151	11	SA	Outpatient Lab/Path/Other	95	$ 11,374.95	633	Units		$ 17.97		$ 0.03
Families_19+	347,151	11	SA	Professional Inpatient SubAcute Visits	98	$ 35,702.05	367	Units		$ 97.28		$ 0.10
Families_19+	347,151	11	SA	Professional Inpatient Visits	20	$ 2,960.33	36	Units		$ 82.23		$ 0.01
Families_19+	347,151	11	SA	Professional RTC/Group Home Visits	3	$ 742.43	5	Units		$ 148.49		$ 0.00
Families_19+	347,151	11	SA	Psychiatric Evaluation/Psychological Evaluation/Testing	325	$ 61,102.27	417	Units		$ 146.53		$ 0.18
Families_19+	347,151	11	SA	Residential Treatment Center	10	$ 145,365.32	42	Admit	953	$ 3,461.08	$ 152.53	$ 0.42
Families_6-18	541,244	09	MH	Conferences with family or other responsible persons advising them on how to assist the client	27	$ 1,126.16	67	Units		$ 16.81		$ 0.00
Families_6-18	541,244	09	MH	Day Treatment	223	$ 681,286.19	4,344	Cases		$ 156.83		$ 1.26
Families_6-18	541,244	09	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	6,471	$ 1,837,552.27	14,778	Units		$ 124.34		$ 3.40
Families_6-18	541,244	09	MH	Family Assessment	9	$ 568.31	9	Units		$ 63.15		$ 0.00
Families_6-18	541,244	09	MH	Family Psychotherapy Services	3,502	$ 1,827,870.72	22,880	Units		$ 79.89		$ 3.38
Families_6-18	541,244	09	MH	Group Psychotherapy	51	$ 8,514.98	352	Units		$ 24.19		$ 0.02
Families_6-18	541,244	09	MH	Individual Psychotherapy	6,365	$ 4,084,631.29	66,973	Units		$ 60.99		$ 7.55
Families_6-18	541,244	09	MH	Inpatient Acute Psychiatric	401	$ 2,062,224.12	495	Admit	4,064	$ 4,166.11	$ 507.44	$ 3.81
Families_6-18	541,244	09	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	1	$ 23,134.02	1	Admit	42	$ 23,134.02	$ 550.81	$ 0.04
Families_6-18	541,244	09	MH	Intensive Outpatient Services	157	$ 506,547.18	4,702	Cases		$ 107.73		$ 0.94
Families_6-18	541,244	09	MH	MHSA Community Treatment/Support/Psychosocial Rehab	126	$ 245,977.54	8,203	Units		$ 29.99		$ 0.45
Families_6-18	541,244	09	MH	Medication Checks	1,636	$ 204,297.15	5,202	Units		$ 39.27		$ 0.38
Families_6-18	541,244	09	MH	Other	157	$ 27,502.03	8,921	Units		$ 3.08		$ 0.05
Families_6-18	541,244	09	MH	Physician Administered Outpatient Drugs	2	$ 2,942.05	590	Units		$ 4.99		$ 0.01
Families_6-18	541,244	09	MH	Outpatient Lab/Path/Other	353	$ 50,654.90	2,232	Units		$ 22.69		$ 0.09
Families_6-18	541,244	09	MH	Professional Inpatient Visits	400	$ 165,420.27	2,986	Units		$ 55.40		$ 0.31
Families_6-18	541,244	09	MH	Professional RTC/Group Home Visits	73	$ 22,282.87	372	Units		$ 59.90		$ 0.04
Families_6-18	541,244	09	MH	Residential Treatment Center	72	$ 2,085,251.37	297	Admit	7,780	$ 7,021.05	$ 268.03	$ 3.85
Families_6-18	541,244	09	MH	Treatment Crisis Intervention	4	$ 70,714.17	237	Days		$ 298.37		$ 0.13
Families_6-18	541,244	09	MH	Treatment Foster Care	23	$ 271,690.52	2,557	Units		$ 106.25		$ 0.50
Families_6-18	541,244	09	MH	Treatment Group Home	61	$ 876,441.46	200	Admit	4,990	$ 4,382.21	$ 175.64	$ 1.62
Families_6-18	541,244	09	SA	Conferences with family or other responsible persons advising them on how to assist the client	1	$ 65.92	4	Units		$ 16.48		$ 0.00
Families_6-18	541,244	09	SA	Day Treatment	9	$ 4,844.73	63	Cases		$ 76.90		$ 0.01
Families_6-18	541,244	09	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	220	$ 61,294.52	398	Units		$ 154.01		$ 0.11
Families_6-18	541,244	09	SA	Family Substance Abuse Counseling	37	$ 6,151.43	82	Units		$ 75.02		$ 0.01
Families_6-18	541,244	09	SA	Group Substance Abuse Counseling	78	$ 17,819.44	816	Units		$ 21.84		$ 0.03
Families_6-18	541,244	09	SA	Individual Substance Abuse Counseling	230	$ 68,009.65	1,135	Units		$ 59.92		$ 0.13
Families_6-18	541,244	09	SA	Inpatient Acute Psychiatric	5	$ 19,276.83	5	Admit	34	$ 3,855.37	$ 566.97	$ 0.04
Families_6-18	541,244	09	SA	Inpatient Mental Health and Inpatient Services Delivered in an IMD	4	$ 5,776.64	4	Admit	7	$ 1,444.16	$ 825.23	$ 0.01
Families_6-18	541,244	09	SA	Intensive Outpatient Services	76	$ 141,642.38	1,464	Cases		$ 96.75		$ 0.26
Families_6-18	541,244	09	SA	Medication Checks	7	$ 659.66	16	Units		$ 41.23		$ 0.00
Families_6-18	541,244	09	SA	Outpatient Lab/Path/Other	81	$ 10,568.17	626	Units		$ 16.88		$ 0.02
Families_6-18	541,244	09	SA	Professional Inpatient Visits	8	$ 2,045.68	40	Units		$ 51.14		$ 0.00
Families_6-18	541,244	09	SA	Professional RTC/Group Home Visits	7	$ 755.20	8	Units		$ 94.40		$ 0.00
Families_6-18	541,244	09	SA	Residential Treatment Center	33	$ 388,740.25	75	Admit	1,650	$ 5,183.20	$ 235.60	$ 0.72
Families_6-18	541,244	09	SA	Treatment Group Home	34	$ 273,849.20	80	Admit	1,648	$ 3,423.12	$ 166.17	$ 0.51
Families_6-18	632,372	10	MH	Conferences with family or other responsible persons advising them on how to assist the client	47	$ 2,030.90	96	Units		$ 21.16		$ 0.00
Families_6-18	632,372	10	MH	Day Treatment	271	$ 728,938.02	4,680	Cases		$ 155.76		$ 1.15
Families_6-18	632,372	10	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	6,999	$ 2,105,208.26	17,108	Units		$ 123.05		$ 3.33
Families_6-18	632,372	10	MH	Family Assessment	20	$ 1,456.35	21	Units		$ 69.35		$ 0.00
Families_6-18	632,372	10	MH	Family Psychotherapy Services	3,449	$ 1,694,610.05	20,802	Units		$ 81.46		$ 2.68
Families_6-18	632,372	10	MH	Group Psychotherapy	67	$ 21,237.26	769	Units		$ 27.62		$ 0.03
Families_6-18	632,372	10	MH	Individual Psychotherapy	6,508	$ 3,998,918.81	63,674	Units		$ 62.80		$ 6.32
Families_6-18	632,372	10	MH	Inpatient Acute Psychiatric	477	$ 2,188,472.41	617	Admit	4,257	$ 3,546.96	$ 514.09	$ 3.46
Families_6-18	632,372	10	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	1	$ 3,925.20	1	Admit	15	$ 3,925.20	$ 261.68	$ 0.01
Families_6-18	632,372	10	MH	Intensive Outpatient Services	154	$ 512,547.62	4,606	Cases		$ 111.28		$ 0.81
Families_6-18	632,372	10	MH	MHSA Community Treatment/Support/Psychosocial Rehab	77	$ 140,467.31	4,134	Units		$ 33.98		$ 0.22
Families_6-18	632,372	10	MH	Medication Checks	2,025	$ 286,059.10	7,212	Units		$ 39.66		$ 0.45
Families_6-18	632,372	10	MH	Other	145	$ 24,486.63	2,237	Units		$ 10.95		$ 0.04
Families_6-18	632,372	10	MH	Physician Administered Outpatient Drugs	2	$ 1,391.91	279	Units		$ 4.99		$ 0.00
Families_6-18	632,372	10	MH	Outpatient Lab/Path/Other	377	$ 53,177.09	2,049	Units		$ 25.95		$ 0.08
Families_6-18	632,372	10	MH	Professional Inpatient Visits	507	$ 211,674.15	3,258	Units		$ 64.97		$ 0.33
Families_6-18	632,372	10	MH	Professional RTC/Group Home Visits	79	$ 25,317.73	394	Units		$ 64.26		$ 0.04
Families_6-18	632,372	10	MH	Residential Treatment Center	68	$ 1,818,510.14	262	Admit	6,620	$ 6,940.88	$ 274.70	$ 2.88
Families_6-18	632,372	10	MH	Treatment Crisis Intervention	2	$ 26,587.85	88	Days		$ 302.13		$ 0.04
Families_6-18	632,372	10	MH	Treatment Foster Care	17	$ 242,850.03	2,226	Units		$ 109.10		$ 0.38
Families_6-18	632,372	10	MH	Treatment Group Home	52	$ 738,264.27	164	Admit	4,046	$ 4,501.61	$ 182.47	$ 1.17

Statewide Claims Summary for FY09-FY11

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Rating Category	Member Months	Fiscal Year	MH/SA	Detailed Service Category	Utilizers	Paid Dollars	Paid Units	Units Measure	Paid Days	Cost per Unit	Cost per Day	PMPM Cost
Families_6-1	632,372	10	SA	Day Treatment	12	$ 9,269.88	66	Cases		$ 140.45		$ 0.01
Families_6-1	632,372	10	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	287	$ 72,111.39	531	Units		$ 135.80		$ 0.11
Families_6-1	632,372	10	SA	Family Substance Abuse Counseling	39	$ 8,369.19	113	Units		$ 74.06		$ 0.01
Families_6-1	632,372	10	SA	Group Substance Abuse Counseling	76	$ 18,338.07	820	Units		$ 22.36		$ 0.03
Families_6-1	632,372	10	SA	Individual Substance Abuse Counseling	205	$ 78,602.50	1,331	Units		$ 59.06		$ 0.12
Families_6-1	632,372	10	SA	Inpatient Acute Psychiatric	4	$ 12,254.02	4	Admit	40	$ 3,063.51	$ 306.35	$ 0.02
Families_6-1	632,372	10	SA	Inpatient Mental Health and Inpatient Services Delivered in an IMD	1	$ 3,213.38	1	Admit	7	$ 3,213.38	$ 459.05	$ 0.01
Families_6-1	632,372	10	SA	Intensive Outpatient Services	91	$ 139,688.14	1,424	Cases		$ 98.10		$ 0.22
Families_6-1	632,372	10	SA	Medication Checks	14	$ 1,799.43	43	Units		$ 41.85		$ 0.00
Families_6-1	632,372	10	SA	Other	3	$ 192.54	34	Units		$ 5.66		$ 0.00
Families_6-1	632,372	10	SA	Outpatient Lab/Path/Other	95	$ 17,867.22	944	Units		$ 18.93		$ 0.03
Families_6-1	632,372	10	SA	Professional Inpatient Visits	8	$ 3,544.56	51	Units		$ 69.50		$ 0.01
Families_6-1	632,372	10	SA	Professional RTC/Group Home Visits	29	$ 4,837.71	49	Units		$ 98.73		$ 0.01
Families_6-1	632,372	10	SA	Residential Treatment Center	31	$ 499,086.11	93	Admit	2,015	$ 5,366.52	$ 247.69	$ 0.79
Families_6-1	632,372	10	SA	Treatment Group Home	26	$ 363,579.63	88	Admit	2,159	$ 4,131.59	$ 168.40	$ 0.57
Families_6-1	671,424	11	MH	Conferences with family or other responsible persons advising them on how to assist the client	70	$ 3,191.03	148	Units		$ 21.56		$ 0.00
Families_6-1	671,424	11	MH	Day Treatment	262	$ 664,608.71	4,271	Cases		$ 155.61		$ 0.99
Families_6-1	671,424	11	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	7,231	$ 2,187,323.83	18,093	Units		$ 120.89		$ 3.26
Families_6-1	671,424	11	MH	Family Assessment	19	$ 1,324.30	19	Units		$ 69.70		$ 0.00
Families_6-1	671,424	11	MH	Family Psychotherapy Services	3,705	$ 1,750,621.18	21,156	Units		$ 82.75		$ 2.61
Families_6-1	671,424	11	MH	Group Psychotherapy	35	$ 6,577.29	278	Units		$ 23.66		$ 0.01
Families_6-1	671,424	11	MH	Individual Psychotherapy	6,531	$ 3,687,816.67	58,145	Units		$ 63.42		$ 5.49
Families_6-1	671,424	11	MH	Inpatient Acute Psychiatric	508	$ 2,322,304.55	657	Admit	4,526	$ 3,534.71	$ 513.10	$ 3.46
Families_6-1	671,424	11	MH	Intensive Outpatient Services	151	$ 499,908.77	4,624	Cases		$ 108.11		$ 0.74
Families_6-1	671,424	11	MH	MHSA Community Treatment/Support/Psychosocial Rehab	66	$ 98,035.88	3,040	Units		$ 32.25		$ 0.15
Families_6-1	671,424	11	MH	Medication Checks	2,302	$ 356,600.69	8,889	Units		$ 40.12		$ 0.53
Families_6-1	671,424	11	MH	Other	121	$ 25,574.66	2,405	Units		$ 10.63		$ 0.04
Families_6-1	671,424	11	MH	Physician Administered Outpatient Drugs	3	$ 7,353.36	1,460	Units		$ 5.04		$ 0.01
Families_6-1	671,424	11	MH	Outpatient Lab/Path/Other	259	$ 33,894.42	1,704	Units		$ 19.89		$ 0.05
Families_6-1	671,424	11	MH	Professional Inpatient Visits	535	$ 223,927.71	3,356	Units		$ 66.72		$ 0.33
Families_6-1	671,424	11	MH	Professional RTC/Group Home Visits	57	$ 26,650.38	466	Units		$ 57.19		$ 0.04
Families_6-1	671,424	11	MH	Residential Treatment Center	61	$ 1,742,293.41	238	Admit	6,244	$ 7,320.56	$ 279.03	$ 2.59
Families_6-1	671,424	11	MH	Treatment Foster Care	12	$ 148,116.91	1,264	Units		$ 117.18		$ 0.22
Families_6-1	671,424	11	MH	Treatment Group Home	39	$ 702,455.62	153	Admit	3,842	$ 4,591.21	$ 182.84	$ 1.05
Families_6-1	671,424	11	SA	Day Treatment	11	$ 30,163.19	161	Cases		$ 187.35		$ 0.04
Families_6-1	671,424	11	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	322	$ 75,479.44	591	Units		$ 127.71		$ 0.11
Families_6-1	671,424	11	SA	Family Substance Abuse Counseling	48	$ 8,073.55	103	Units		$ 78.38		$ 0.01
Families_6-1	671,424	11	SA	Group Substance Abuse Counseling	75	$ 20,009.29	866	Units		$ 23.11		$ 0.03
Families_6-1	671,424	11	SA	Individual Substance Abuse Counseling	242	$ 93,894.75	1,538	Units		$ 61.05		$ 0.14
Families_6-1	671,424	11	SA	Inpatient Acute Psychiatric	5	$ 11,911.40	5	Admit	23	$ 2,382.28	$ 517.89	$ 0.02
Families_6-1	671,424	11	SA	Intensive Outpatient Services	105	$ 207,233.31	2,104	Cases		$ 98.49		$ 0.31
Families_6-1	671,424	11	SA	Medication Checks	22	$ 1,789.38	45	Units		$ 39.76		$ 0.00
Families_6-1	671,424	11	SA	Other	4	$ 373.14	54	Units		$ 6.91		$ 0.00
Families_6-1	671,424	11	SA	Outpatient Lab/Path/Other	53	$ 12,938.24	645	Units		$ 20.06		$ 0.02
Families_6-1	671,424	11	SA	Professional Inpatient Visits	11	$ 2,756.12	25	Units		$ 110.24		$ 0.00
Families_6-1	671,424	11	SA	Professional RTC/Group Home Visits	16	$ 2,454.08	31	Units		$ 79.16		$ 0.00
Families_6-1	671,424	11	SA	Residential Treatment Center	27	$ 385,119.03	65	Admit	1,388	$ 5,924.91	$ 277.46	$ 0.57
Families_6-1	671,424	11	SA	Treatment Group Home	20	$ 242,467.20	61	Admit	1,457	$ 3,974.87	$ 166.42	$ 0.36
FosterCare,W	139,574	09	MH	Conferences with family or other responsible persons advising them on how to assist the client	62	$ 5,439.03	356	Units		$ 15.28		$ 0.04
FosterCare,W	139,574	09	MH	Day Treatment	320	$ 1,334,795.59	9,831	Cases		$ 135.77		$ 9.56
FosterCare,W	139,574	09	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	6,409	$ 3,199,898.39	21,020	Units		$ 152.23		$ 22.93
FosterCare,W	139,574	09	MH	Family Assessment	46	$ 3,209.84	47	Units		$ 68.29		$ 0.02
FosterCare,W	139,574	09	MH	Family Psychotherapy Services	3,611	$ 2,324,337.56	29,263	Units		$ 79.43		$ 16.65
FosterCare,W	139,574	09	MH	Group Psychotherapy	203	$ 51,114.58	2,228	Units		$ 22.94		$ 0.37
FosterCare,W	139,574	09	MH	Individual Psychotherapy	6,245	$ 5,175,278.30	85,489	Units		$ 60.54		$ 37.08
FosterCare,W	139,574	09	MH	Inpatient Acute Psychiatric	519	$ 4,830,146.72	741	Admit	10,347	$ 6,518.42	$ 466.82	$ 34.61
FosterCare,W	139,574	09	MH	Inpatient Mental Health and Inpatient Services Delivered in an IMD	1	$ 38,380.39	1	Admit	69	$ 38,380.39	$ 556.24	$ 0.27
FosterCare,W	139,574	09	MH	Intensive Outpatient Services	337	$ 1,048,325.08	10,270	Cases		$ 102.08		$ 7.51
FosterCare,W	139,574	09	MH	MHSA Community Treatment/Support/Psychosocial Rehab	171	$ 386,268.47	11,557	Units		$ 33.42		$ 2.77
FosterCare,W	139,574	09	MH	Medication Checks	2,087	$ 362,399.96	9,326	Units		$ 38.86		$ 2.60
FosterCare,W	139,574	09	MH	Other	201	$ 19,749.10	10,583	Units		$ 1.87		$ 0.14
FosterCare,W	139,574	09	MH	Physician Administered Outpatient Drugs	3	$ 6,304.50	836	Units		$ 7.54		$ 0.05
FosterCare,W	139,574	09	MH	Outpatient Lab/Path/Other	642	$ 81,743.57	4,634	Units		$ 17.64		$ 0.59
FosterCare,W	139,574	09	MH	Professional Inpatient Visits	543	$ 328,064.74	7,010	Units		$ 46.80		$ 2.35
FosterCare,W	139,574	09	MH	Professional RTC/Group Home Visits	497	$ 214,603.47	5,107	Units		$ 42.02		$ 1.54
FosterCare,W	139,574	09	MH	Psychiatric Evaluation/Psychological Evaluation/Testing	1	$ 280.28	2	Units		$ 140.14		$ 0.00
FosterCare,W	139,574	09	MH	Residential Treatment Center	457	$ 17,148,607.07	2,492	Admit	66,647	$ 6,881.46	$ 257.31	$ 122.86

Statewide Claims Summary for FY09-FY11

Does not include IBNR adjustments.

Rating Category	Member Months	Fiscal Year	MH/SA	Detailed Service Category	Utilizers	Paid Dollars	Paid Units	Units Measure	Paid Days	Cost per Unit	Cost per Day	PMPM Cost
FosterCare,W	139,574	09	MH	Treatment Crisis Intervention	28	$ 1,027,618.28	3,456	Days		$ 297.34		$ 7.36
FosterCare,W	139,574	09	MH	Treatment Foster Care	96	$ 1,289,274.49	11,917	Units		$ 108.19		$ 9.24
FosterCare,W	139,574	09	MH	Treatment Group Home	504	$ 11,344,408.05	2,306	Admit	59,653	$ 4,919.52	$ 190.17	$ 81.28
FosterCare,W	139,574	09	SA	Conferences with family or other responsible persons advising them on how to assist the client	1	$ 32.96	2	Units		$ 16.48		$ 0.00
FosterCare,W	139,574	09	SA	Day Treatment	32	$ 109,534.12	900	Cases		$ 121.70		$ 0.78
FosterCare,W	139,574	09	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	676	$ 305,417.42	1,664	Units		$ 183.54		$ 2.19
FosterCare,W	139,574	09	SA	Family Substance Abuse Counseling	101	$ 25,241.67	330	Units		$ 76.49		$ 0.18
FosterCare,W	139,574	09	SA	Group Substance Abuse Counseling	194	$ 46,133.97	2,096	Units		$ 22.01		$ 0.33
FosterCare,W	139,574	09	SA	Individual Substance Abuse Counseling	813	$ 258,265.47	4,353	Units		$ 59.33		$ 1.85
FosterCare,W	139,574	09	SA	Inpatient Acute Psychiatric	7	$ 27,018.91	7	Admit	69	$ 3,859.84	$ 391.58	$ 0.19
FosterCare,W	139,574	09	SA	Intensive Outpatient Services	260	$ 586,349.26	6,152	Cases		$ 95.31		$ 4.20
FosterCare,W	139,574	09	SA	MHSA Community Treatment/Support/Psychosocial Rehab	1	$ 76.61	11	Units		$ 6.96		$ 0.00
FosterCare,W	139,574	09	SA	Medication Checks	46	$ 2,949.34	82	Units		$ 35.97		$ 0.02
FosterCare,W	139,574	09	SA	Other	8	$ 508.27	322	Units		$ 1.58		$ 0.00
FosterCare,W	139,574	09	SA	Outpatient Lab/Path/Other	237	$ 22,830.34	2,086	Units		$ 10.94		$ 0.16
FosterCare,W	139,574	09	SA	Professional Inpatient Visits	7	$ 1,463.75	30	Units		$ 48.79		$ 0.01
FosterCare,W	139,574	09	SA	Professional RTC/Group Home Visits	67	$ 13,550.84	175	Units		$ 77.43		$ 0.10
FosterCare,W	139,574	09	SA	Residential Treatment Center	272	$ 5,629,820.01	882	Admit	20,598	$ 6,383.02	$ 273.32	$ 40.34
FosterCare,W	139,574	09	SA	Treatment Foster Care	1	$ 27,586.48	263	Units		$ 104.89		$ 0.20
FosterCare,W	139,574	09	SA	Treatment Group Home	196	$ 2,726,017.15	712	Admit	16,621	$ 3,828.68	$ 164.01	$ 19.53
FosterCare,W	139,147	10	MH	Conferences with family or other responsible persons advising them on how to assist the client	27	$ 1,163.96	54	Units		$ 21.55		$ 0.01
FosterCare,W	139,147	10	MH	Day Treatment	336	$ 1,255,625.98	8,959	Cases		$ 140.15		$ 9.02
FosterCare,W	139,147	10	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	5,980	$ 3,038,003.48	20,578	Units		$ 147.63		$ 21.83
FosterCare,W	139,147	10	MH	Family Assessment	20	$ 1,385.99	20	Units		$ 69.30		$ 0.01
FosterCare,W	139,147	10	MH	Family Psychotherapy Services	3,233	$ 2,006,057.61	25,019	Units		$ 80.18		$ 14.42
FosterCare,W	139,147	10	MH	Group Psychotherapy	173	$ 47,110.72	1,993	Units		$ 23.64		$ 0.34
FosterCare,W	139,147	10	MH	Individual Psychotherapy	5,517	$ 4,497,829.82	72,954	Units		$ 61.65		$ 32.32
FosterCare,W	139,147	10	MH	Inpatient Acute Psychiatric	520	$ 4,008,889.78	750	Admit	8,236	$ 5,345.19	$ 486.75	$ 28.81
FosterCare,W	139,147	10	MH	Intensive Outpatient Services	347	$ 1,102,383.48	10,304	Cases		$ 106.99		$ 7.92
FosterCare,W	139,147	10	MH	MHSA Community Treatment/Support/Psychosocial Rehab	111	$ 197,972.16	5,649	Units		$ 35.05		$ 1.42
FosterCare,W	139,147	10	MH	Medication Checks	2,127	$ 398,211.49	10,044	Units		$ 39.65		$ 2.86
FosterCare,W	139,147	10	MH	Other	124	$ 15,853.65	1,342	Units		$ 11.81		$ 0.11
FosterCare,W	139,147	10	MH	Physician Administered Outpatient Drugs	2	$ 1,615.70	380	Units		$ 4.25		$ 0.01
FosterCare,W	139,147	10	MH	Outpatient Lab/Path/Other	521	$ 72,115.36	3,782	Units		$ 19.07		$ 0.52
FosterCare,W	139,147	10	MH	Professional Inpatient Visits	599	$ 396,306.94	6,330	Units		$ 62.61		$ 2.85
FosterCare,W	139,147	10	MH	Professional RTC/Group Home Visits	484	$ 219,596.78	3,461	Units		$ 63.45		$ 1.58
FosterCare,W	139,147	10	MH	Residential Treatment Center	392	$ 14,037,261.35	1,984	Admit	52,608	$ 7,075.23	$ 266.83	$ 100.88
FosterCare,W	139,147	10	MH	Treatment Crisis Intervention	23	$ 969,516.79	3,260	Days		$ 297.40		$ 6.97
FosterCare,W	139,147	10	MH	Treatment Foster Care	92	$ 1,047,521.36	9,263	Units		$ 113.09		$ 7.53
FosterCare,W	139,147	10	MH	Treatment Group Home	451	$ 9,298,168.08	1,942	Admit	49,021	$ 4,787.93	$ 189.68	$ 66.82
FosterCare,W	139,147	10	SA	Day Treatment	31	$ 85,331.10	643	Cases		$ 132.71		$ 0.61
FosterCare,W	139,147	10	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	761	$ 260,351.29	1,721	Units		$ 151.28		$ 1.87
FosterCare,W	139,147	10	SA	Family Substance Abuse Counseling	100	$ 21,860.00	276	Units		$ 79.20		$ 0.16
FosterCare,W	139,147	10	SA	Group Substance Abuse Counseling	139	$ 33,106.69	1,434	Units		$ 23.09		$ 0.24
FosterCare,W	139,147	10	SA	Individual Substance Abuse Counseling	455	$ 180,541.87	2,977	Units		$ 60.65		$ 1.30
FosterCare,W	139,147	10	SA	Inpatient Acute Psychiatric	5	$ 14,090.71	5	Admit	29	$ 2,818.14	$ 485.89	$ 0.10
FosterCare,W	139,147	10	SA	Inpatient Mental Health and Inpatient Services Delivered in an IMD	2	$ 3,591.71	2	Admit	5	$ 1,795.86	$ 718.34	$ 0.03
FosterCare,W	139,147	10	SA	Intensive Outpatient Services	240	$ 444,670.34	4,601	Cases		$ 96.65		$ 3.20
FosterCare,W	139,147	10	SA	Medication Checks	33	$ 2,588.09	65	Units		$ 39.82		$ 0.02
FosterCare,W	139,147	10	SA	Other	14	$ 858.73	135	Units		$ 6.36		$ 0.01
FosterCare,W	139,147	10	SA	Outpatient Lab/Path/Other	203	$ 23,441.35	2,131	Units		$ 11.00		$ 0.17
FosterCare,W	139,147	10	SA	Professional Inpatient Visits	6	$ 5,133.45	25	Units		$ 205.34		$ 0.04
FosterCare,W	139,147	10	SA	Professional RTC/Group Home Visits	77	$ 13,900.56	183	Units		$ 75.96		$ 0.10
FosterCare,W	139,147	10	SA	Residential Treatment Center	214	$ 4,571,382.95	679	Admit	15,969	$ 6,732.52	$ 286.27	$ 32.85
FosterCare,W	139,147	10	SA	Treatment Group Home	108	$ 1,583,699.45	404	Admit	9,538	$ 3,920.05	$ 166.04	$ 11.38
FosterCare,W	138,482	11	MH	Conferences with family or other responsible persons advising them on how to assist the client	54	$ 2,418.29	109	Units		$ 22.19		$ 0.02
FosterCare,W	138,482	11	MH	Day Treatment	294	$ 1,405,499.04	10,700	Cases		$ 131.36		$ 10.15
FosterCare,W	138,482	11	MH	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	5,846	$ 3,051,599.60	20,485	Units		$ 148.97		$ 22.04
FosterCare,W	138,482	11	MH	Family Assessment	21	$ 1,463.70	21	Units		$ 69.70		$ 0.01
FosterCare,W	138,482	11	MH	Family Psychotherapy Services	3,141	$ 1,942,912.52	23,841	Units		$ 81.49		$ 14.03
FosterCare,W	138,482	11	MH	Group Psychotherapy	134	$ 32,732.22	1,312	Units		$ 24.95		$ 0.24
FosterCare,W	138,482	11	MH	Individual Psychotherapy	5,308	$ 4,299,715.65	68,665	Units		$ 62.62		$ 31.05
FosterCare,W	138,482	11	MH	Inpatient Acute Psychiatric	456	$ 3,382,499.55	646	Admit	6,657	$ 5,236.07	$ 508.11	$ 24.43
FosterCare,W	138,482	11	MH	Intensive Outpatient Services	314	$ 975,789.70	9,420	Cases		$ 103.59		$ 7.05
FosterCare,W	138,482	11	MH	MHSA Community Treatment/Support/Psychosocial Rehab	90	$ 137,848.66	3,957	Units		$ 34.84		$ 1.00
FosterCare,W	138,482	11	MH	Medication Checks	1,988	$ 351,405.67	8,778	Units		$ 40.03		$ 2.54
FosterCare,W	138,482	11	MH	Other	102	$ 15,526.33	800	Units		$ 19.41		$ 0.11

Statewide Claims Summary for FY09-FY11

Does not include IBNR adjustments.

Rating Category	Member Months	Fiscal Year	MH/SA	Detailed Service Category	Utilizers	Paid Dollars	Paid Units	Units Measure	Paid Days	Cost per Unit	Cost per Day	PMPM Cost
FosterCare,W	138,482	11	MH	Physician Administered Outpatient Drugs	3	$ 844.46	161	Units		$ 5.25		$ 0.01
FosterCare,W	138,482	11	MH	Outpatient Lab/Path/Other	450	$ 67,453.28	3,343	Units		$ 20.18		$ 0.49
FosterCare,W	138,482	11	MH	Professional Inpatient Visits	509	$ 302,922.79	4,861	Units		$ 62.32		$ 2.19
FosterCare,W	138,482	11	MH	Professional RTC/Group Home Visits	316	$ 130,107.33	2,104	Units		$ 61.84		$ 0.94
FosterCare,W	138,482	11	MH	Residential Treatment Center	275	$ 8,860,548.99	1,266	Admit	32,826	$ 6,998.85	$ 269.92	$ 63.98
FosterCare,W	138,482	11	MH	Treatment Crisis Intervention	20	$ 852,775.09	2,849	Days		$ 299.32		$ 6.16
FosterCare,W	138,482	11	MH	Treatment Foster Care	42	$ 826,108.09	7,070	Units		$ 116.85		$ 5.97
FosterCare,W	138,482	11	MH	Treatment Group Home	332	$ 6,725,840.66	1,410	Admit	35,280	$ 4,770.10	$ 190.64	$ 48.57
FosterCare,W	138,482	11	SA	Day Treatment	17	$ 52,690.73	361	Cases		$ 145.96		$ 0.38
FosterCare,W	138,482	11	SA	Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	772	$ 268,052.62	1,853	Units		$ 144.66		$ 1.94
FosterCare,W	138,482	11	SA	Family Substance Abuse Counseling	126	$ 24,113.09	318	Units		$ 75.83		$ 0.17
FosterCare,W	138,482	11	SA	Group Substance Abuse Counseling	155	$ 32,163.59	1,370	Units		$ 23.48		$ 0.23
FosterCare,W	138,482	11	SA	Individual Substance Abuse Counseling	435	$ 213,417.55	3,500	Units		$ 60.98		$ 1.54
FosterCare,W	138,482	11	SA	Inpatient Acute Psychiatric	6	$ 24,961.23	6	Admit	47	$ 4,160.21	$ 531.09	$ 0.18
FosterCare,W	138,482	11	SA	Inpatient Mental Health and Inpatient Services Delivered in an IMD	1	$ 691.10	1	Admit	2	$ 691.10	$ 345.55	$ 0.00
FosterCare,W	138,482	11	SA	Intensive Outpatient Services	226	$ 442,723.87	4,624	Cases		$ 95.74		$ 3.20
FosterCare,W	138,482	11	SA	Medication Checks	44	$ 3,844.83	102	Units		$ 37.69		$ 0.03
FosterCare,W	138,482	11	SA	Other	14	$ 1,499.33	217	Units		$ 6.91		$ 0.01
FosterCare,W	138,482	11	SA	Outpatient Lab/Path/Other	141	$ 22,074.80	1,559	Units		$ 14.16		$ 0.16
FosterCare,W	138,482	11	SA	Professional Inpatient Visits	10	$ 3,176.45	41	Units		$ 77.47		$ 0.02
FosterCare,W	138,482	11	SA	Professional RTC/Group Home Visits	62	$ 12,354.06	168	Units		$ 73.54		$ 0.09
FosterCare,W	138,482	11	SA	Residential Treatment Center	169	$ 5,393,341.08	520	Admit	13,557	$ 10,371.81	$ 397.83	$ 38.95
FosterCare,W	138,482	11	SA	Treatment Crisis Intervention	1	$ 2,059.68	6	Days		$ 343.28		$ 0.01
FosterCare,W	138,482	11	SA	Treatment Group Home	75	$ 1,098,849.93	283	Admit	6,524	$ 3,882.86	$ 168.43	$ 7.93

Statewide Member Months for FY09-FY11

Rating Category	Month	Member Months
Aged	200807	17,560
Aged	200808	17,610
Aged	200809	17,650
Aged	200810	17,678
Aged	200811	17,629
Aged	200812	17,608
Aged	200901	17,569
Aged	200902	17,513
Aged	200903	17,484
Aged	200904	17,504
Aged	200905	17,490
Aged	200906	17,496
Aged	200907	17,549
Aged	200908	17,611
Aged	200909	17,653
Aged	200910	17,642
Aged	200911	17,582
Aged	200912	17,541
Aged	201001	17,567
Aged	201002	17,527
Aged	201003	17,601
Aged	201004	17,587
Aged	201005	17,551
Aged	201006	17,529
Aged	201007	17,591
Aged	201008	17,630
Aged	201009	17,628
Aged	201010	17,625
Aged	201011	17,605
Aged	201012	17,564
Aged	201101	17,580
Aged	201102	17,651
Aged	201103	17,650
Aged	201104	17,580
Aged	201105	17,540
Aged	201106	17,563
Blind,Disabled,KatieBeckett_0-18	200807	3,529
Blind,Disabled,KatieBeckett_0-18	200808	3,536
Blind,Disabled,KatieBeckett_0-18	200809	3,545
Blind,Disabled,KatieBeckett_0-18	200810	3,541
Blind,Disabled,KatieBeckett_0-18	200811	3,560
Blind,Disabled,KatieBeckett_0-18	200812	3,570
Blind,Disabled,KatieBeckett_0-18	200901	3,593
Blind,Disabled,KatieBeckett_0-18	200902	3,612
Blind,Disabled,KatieBeckett_0-18	200903	3,619
Blind,Disabled,KatieBeckett_0-18	200904	3,620
Blind,Disabled,KatieBeckett_0-18	200905	3,656
Blind,Disabled,KatieBeckett_0-18	200906	3,689
Blind,Disabled,KatieBeckett_0-18	200907	3,676
Blind,Disabled,KatieBeckett_0-18	200908	3,690
Blind,Disabled,KatieBeckett_0-18	200909	3,698
Blind,Disabled,KatieBeckett_0-18	200910	3,701

Statewide Member Months for FY09-FY11

Rating Category	Month	Member Months
Blind,Disabled,KatieBeckett_0-18	200911	3,719
Blind,Disabled,KatieBeckett_0-18	200912	3,720
Blind,Disabled,KatieBeckett_0-18	201001	3,758
Blind,Disabled,KatieBeckett_0-18	201002	3,777
Blind,Disabled,KatieBeckett_0-18	201003	3,770
Blind,Disabled,KatieBeckett_0-18	201004	3,797
Blind,Disabled,KatieBeckett_0-18	201005	3,825
Blind,Disabled,KatieBeckett_0-18	201006	3,829
Blind,Disabled,KatieBeckett_0-18	201007	3,839
Blind,Disabled,KatieBeckett_0-18	201008	3,862
Blind,Disabled,KatieBeckett_0-18	201009	3,858
Blind,Disabled,KatieBeckett_0-18	201010	3,868
Blind,Disabled,KatieBeckett_0-18	201011	3,856
Blind,Disabled,KatieBeckett_0-18	201012	3,856
Blind,Disabled,KatieBeckett_0-18	201101	3,878
Blind,Disabled,KatieBeckett_0-18	201102	3,897
Blind,Disabled,KatieBeckett_0-18	201103	3,905
Blind,Disabled,KatieBeckett_0-18	201104	3,910
Blind,Disabled,KatieBeckett_0-18	201105	3,899
Blind,Disabled,KatieBeckett_0-18	201106	3,915
Blind,Disabled_19+	200807	27,401
Blind,Disabled_19+	200808	27,386
Blind,Disabled_19+	200809	27,390
Blind,Disabled_19+	200810	27,491
Blind,Disabled_19+	200811	27,536
Blind,Disabled_19+	200812	27,643
Blind,Disabled_19+	200901	27,698
Blind,Disabled_19+	200902	27,775
Blind,Disabled_19+	200903	27,773
Blind,Disabled_19+	200904	27,891
Blind,Disabled_19+	200905	27,985
Blind,Disabled_19+	200906	28,101
Blind,Disabled_19+	200907	28,241
Blind,Disabled_19+	200908	28,413
Blind,Disabled_19+	200909	28,473
Blind,Disabled_19+	200910	28,653
Blind,Disabled_19+	200911	28,743
Blind,Disabled_19+	200912	28,947
Blind,Disabled_19+	201001	29,099
Blind,Disabled_19+	201002	29,240
Blind,Disabled_19+	201003	29,432
Blind,Disabled_19+	201004	29,559
Blind,Disabled_19+	201005	29,634
Blind,Disabled_19+	201006	29,714
Blind,Disabled_19+	201007	29,865
Blind,Disabled_19+	201008	30,035
Blind,Disabled_19+	201009	30,171
Blind,Disabled_19+	201010	30,253
Blind,Disabled_19+	201011	30,320
Blind,Disabled_19+	201012	30,407
Blind,Disabled_19+	201101	30,542
Blind,Disabled_19+	201102	30,516

Statewide Member Months for FY09-FY11

Rating Category	Month	Member Months
Blind,Disabled_19+	201103	30,618
Blind,Disabled_19+	201104	30,712
Blind,Disabled_19+	201105	30,771
Blind,Disabled_19+	201106	30,844
CHIP	200807	26,161
CHIP	200808	26,350
CHIP	200809	26,878
CHIP	200810	27,319
CHIP	200811	27,415
CHIP	200812	27,551
CHIP	200901	27,438
CHIP	200902	27,009
CHIP	200903	26,118
CHIP	200904	25,349
CHIP	200905	24,684
CHIP	200906	24,289
CHIP	200907	24,219
CHIP	200908	24,447
CHIP	200909	25,259
CHIP	200910	25,913
CHIP	200911	26,323
CHIP	200912	26,549
CHIP	201001	27,036
CHIP	201002	26,940
CHIP	201003	27,146
CHIP	201004	27,331
CHIP	201005	27,442
CHIP	201006	27,968
CHIP	201007	28,171
CHIP	201008	28,593
CHIP	201009	29,170
CHIP	201010	29,756
CHIP	201011	29,955
CHIP	201012	30,163
CHIP	201101	30,469
CHIP	201102	30,416
CHIP	201103	30,439
CHIP	201104	30,352
CHIP	201105	30,206
CHIP	201106	30,315
Families_0-5	200807	55,466
Families_0-5	200808	55,692
Families_0-5	200809	55,427
Families_0-5	200810	55,417
Families_0-5	200811	55,372
Families_0-5	200812	55,629
Families_0-5	200901	56,369
Families_0-5	200902	57,184
Families_0-5	200903	58,411
Families_0-5	200904	59,308
Families_0-5	200905	59,768
Families_0-5	200906	60,549

Statewide Member Months for FY09-FY11

Rating Category	Month	Member Months
Families_0-5	200907	61,173
Families_0-5	200908	61,910
Families_0-5	200909	62,293
Families_0-5	200910	62,771
Families_0-5	200911	62,988
Families_0-5	200912	63,010
Families_0-5	201001	62,847
Families_0-5	201002	61,920
Families_0-5	201003	57,359
Families_0-5	201004	57,150
Families_0-5	201005	57,116
Families_0-5	201006	57,123
Families_0-5	201007	57,244
Families_0-5	201008	57,596
Families_0-5	201009	57,626
Families_0-5	201010	57,538
Families_0-5	201011	57,613
Families_0-5	201012	57,689
Families_0-5	201101	57,812
Families_0-5	201102	57,815
Families_0-5	201103	57,903
Families_0-5	201104	57,613
Families_0-5	201105	56,979
Families_0-5	201106	56,954
Families_19+	200807	19,055
Families_19+	200808	19,281
Families_19+	200809	19,299
Families_19+	200810	19,403
Families_19+	200811	19,283
Families_19+	200812	19,351
Families_19+	200901	19,521
Families_19+	200902	19,687
Families_19+	200903	19,916
Families_19+	200904	19,828
Families_19+	200905	19,720
Families_19+	200906	19,925
Families_19+	200907	20,409
Families_19+	200908	20,812
Families_19+	200909	20,945
Families_19+	200910	21,011
Families_19+	200911	21,076
Families_19+	200912	21,186
Families_19+	201001	21,658
Families_19+	201002	22,175
Families_19+	201003	25,982
Families_19+	201004	26,341
Families_19+	201005	26,327
Families_19+	201006	26,543
Families_19+	201007	27,013
Families_19+	201008	28,155
Families_19+	201009	28,391
Families_19+	201010	28,530

Statewide Member Months for FY09-FY11

Rating Category	Month	Member Months
Families_19+	201011	28,586
Families_19+	201012	28,987
Families_19+	201101	29,433
Families_19+	201102	29,656
Families_19+	201103	29,841
Families_19+	201104	29,727
Families_19+	201105	29,391
Families_19+	201106	29,441
Families_6-18	200807	43,561
Families_6-18	200808	44,125
Families_6-18	200809	43,886
Families_6-18	200810	43,627
Families_6-18	200811	43,358
Families_6-18	200812	43,594
Families_6-18	200901	44,278
Families_6-18	200902	44,884
Families_6-18	200903	46,068
Families_6-18	200904	47,179
Families_6-18	200905	47,943
Families_6-18	200906	48,740
Families_6-18	200907	49,682
Families_6-18	200908	50,838
Families_6-18	200909	51,394
Families_6-18	200910	52,007
Families_6-18	200911	52,498
Families_6-18	200912	52,877
Families_6-18	201001	53,292
Families_6-18	201002	53,474
Families_6-18	201003	53,958
Families_6-18	201004	54,027
Families_6-18	201005	54,178
Families_6-18	201006	54,147
Families_6-18	201007	54,726
Families_6-18	201008	55,367
Families_6-18	201009	55,262
Families_6-18	201010	55,236
Families_6-18	201011	55,563
Families_6-18	201012	55,833
Families_6-18	201101	56,294
Families_6-18	201102	56,635
Families_6-18	201103	56,879
Families_6-18	201104	56,803
Families_6-18	201105	56,393
Families_6-18	201106	56,432
FosterCare,Ward,SubsidizedAdopt	200807	11,692
FosterCare,Ward,SubsidizedAdopt	200808	11,596
FosterCare,Ward,SubsidizedAdopt	200809	11,570
FosterCare,Ward,SubsidizedAdopt	200810	11,587
FosterCare,Ward,SubsidizedAdopt	200811	11,709
FosterCare,Ward,SubsidizedAdopt	200812	11,712
FosterCare,Ward,SubsidizedAdopt	200901	11,568
FosterCare,Ward,SubsidizedAdopt	200902	11,562

Statewide Member Months for FY09-FY11

Rating Category	Month	Member Months
FosterCare,Ward,SubsidizedAdopt	200903	11,644
FosterCare,Ward,SubsidizedAdopt	200904	11,623
FosterCare,Ward,SubsidizedAdopt	200905	11,622
FosterCare,Ward,SubsidizedAdopt	200906	11,689
FosterCare,Ward,SubsidizedAdopt	200907	11,618
FosterCare,Ward,SubsidizedAdopt	200908	11,602
FosterCare,Ward,SubsidizedAdopt	200909	11,541
FosterCare,Ward,SubsidizedAdopt	200910	11,444
FosterCare,Ward,SubsidizedAdopt	200911	11,573
FosterCare,Ward,SubsidizedAdopt	200912	11,563
FosterCare,Ward,SubsidizedAdopt	201001	11,548
FosterCare,Ward,SubsidizedAdopt	201002	11,572
FosterCare,Ward,SubsidizedAdopt	201003	11,652
FosterCare,Ward,SubsidizedAdopt	201004	11,711
FosterCare,Ward,SubsidizedAdopt	201005	11,650
FosterCare,Ward,SubsidizedAdopt	201006	11,673
FosterCare,Ward,SubsidizedAdopt	201007	11,638
FosterCare,Ward,SubsidizedAdopt	201008	11,613
FosterCare,Ward,SubsidizedAdopt	201009	11,580
FosterCare,Ward,SubsidizedAdopt	201010	11,525
FosterCare,Ward,SubsidizedAdopt	201011	11,552
FosterCare,Ward,SubsidizedAdopt	201012	11,530
FosterCare,Ward,SubsidizedAdopt	201101	11,493
FosterCare,Ward,SubsidizedAdopt	201102	11,450
FosterCare,Ward,SubsidizedAdopt	201103	11,576
FosterCare,Ward,SubsidizedAdopt	201104	11,510
FosterCare,Ward,SubsidizedAdopt	201105	11,514
FosterCare,Ward,SubsidizedAdopt	201106	11,501

Rating Category Mapping

Rating Category	Age	Identification Criteria
CHIP	All	SPI_CODE = F (CHIP)
Aged	All	Payee Series Code = 10
Blind/Disabled/Katie Beckett	≤ 18	Payee Series Code = 20,30,39 or SPI_CODE = K (Katie Beckett)
Blind/Disabled	>18	Payee Series Code = 20,30,39
Families	0-5	Payee Series Code = 40,50,65,66,78
Families	6-18	Payee Series Code = 40,50,65,66,78
Families	>18	Payee Series Code = 40,50,65,66,78
Foster Care/Ward/Subsidized Adoption	All	Payee Series Code = 40,50,65,66,78

Payee Series Code	Payee Series Description
10	Aged
20	Blind
30	Disabled
39	State Disability
40	ADC Regular
50	ADC-UP
61	Foster Care Program, Department Ward (Title IV-E)
62	Foster Care Program, Subsidized Guardianship
63	Foster Care Program, Department Ward (non-IV-E)
64	Child not NDSS related: Ward of the court or Department of Corrections
65	Ribicoff/Former Ward/EMAC/School Age Medical
66	Medical Assistance for Children (MAC)
68	Subsidized Adoption IV-E
69	Subsidized Adoption Non IV-E
78	Refugee Resettlement (non-categorical)

Service Category Mapping

Note: Facility and professional claims are categorized separately. Member age is calculated as of incurred date. Each row of logic applies to the subset of claims not mapped by earlier rows (i.e., order matters). If a field is blank, it may take on any value.

Facility Claims for Members 21 or older

Revenue Code (any claim line)		Place of Service / Provider Type / Type of Service	Service Category
1001,1002,0192,0193	OR	Place of Service = 21 and Provider Type ≠ 10	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)
		Type of Service = 16	Inpatient Acute Psychiatric
		Place of Service = 21	Inpatient Mental Health and Inpatient Services Delivered in an IMD
0901			Electroconvulsive Therapy
0905,0906,0521,0582,0900,0904,0907,0912,0913,0914,0915, 0916,0917,0918,0919			Adult Day Treatment Psychiatric Services
0300,0301,0302,0305,0306,0307,0309,0310,0311,0312,0320, 0324,0341,0343,0350,0351,0352,0402,0403,0460,0480,0483, 0610,0611,0730,0731,0732,0740,0750,0771,0920,0921,0450, 0459,0762	AND	Place of Service = 22	Outpatient Lab/Path/Other
0250,0252,0258,0259,0260,0636,0761	AND	Place of Service = 22	Physician Administered Outpatient Drugs
			Other

Facility Claims for Members under 21

Revenue Code (any claim line)		Place of Service / Provider Type / Type of Service	Service Category
1001,1002			Residential Treatment Center
		Type of Service = 16	Inpatient Acute Psychiatric
		Place of Service = 21	Inpatient Mental Health and Inpatient Services Delivered in an IMD
0901,0905,0906			Intensive Outpatient Services
0521,0582,0900,0904,0907,0912,0913,0914,0915,0916,0917, 0918,0919			Day Treatment
0300,0301,0302,0305,0306,0307,0309,0310,0311,0312,0320, 0324,0341,0343,0350,0351,0352,0402,0403,0460,0480,0483, 0610,0611,0730,0731,0732,0740,0750,0771,0920,0921,0450, 0459,0762	AND	Place of Service = 22	Outpatient Lab/Path/Other
0250,0252,0258,0259,0260,0636,0761	AND	Place of Service = 22	Physician Administered Outpatient Drugs
			Other

Professional Claims for Members 21 or older

Diagnosis Code		Procedure Code		Place of Service / Provider Type	Service Category
		90862			Medication Checks
		G0177,H2015,H2016,H2017,H2018			MHSA Community Treatment/Support/Psychosocial Rehab
		H0018,H0019	AND	Provider type = 46,82 or Place of service = 55,56	Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)
				Provider type = 46,82 or Place of service = 55,56	Professional Inpatient SubAcute Visits
		H2012,S9480,H0015,H2034,H0040	OR	Provider type = 45,77	Adult Day Treatment Psychiatric Services
				Place of service = 21,51	Professional Inpatient Visits
		90801,90802,H0031,H0001,H0002,H2000, 96101,96118,H0032,96116,96119,99203, 99204,99205,96102,96103,96150,90810, 99201,99499,96151,99211,99212,99213, 99214,99215,99241,99242,99243,99244, 99245,H0046			Psychiatric Evaluation/Psychological Evaluation/Testing
29100-29299, 30300-30599	AND	90804,90805,90806,90807,90808,90809, H2019,96152,90899			Individual Substance Abuse Counseling
		90804,90805,90806,90807,90808,90809, H2019,96152,90899			Individual Psychotherapy
29100-29299, 30300-30599	AND	90846,90847,96154,90849,90887			Family Substance Abuse Counseling
		90846,90847,96154,90849,90887			Family Psychotherapy Services
29100-29299, 30300-30599	AND	90853			Group Substance Abuse Counseling
		90853			Group Psychotherapy
		H0005			Group Substance Abuse Counseling
		JXXXX, 96372,90772,C9255			Physician Administered Outpatient Drugs
		H1011			Family Assessment
		90870			Electroconvulsive Therapy
					Other

Service Category Mapping

Note: Facility and professional claims are categorized separately. Member age is calculated as of incurred date. Each row of logic applies to the subset of claims not mapped by earlier rows (i.e., order matters). If a field is blank, it may take on any value.

Professional Claims for Members under 21

Diagnosis Code		Procedure Code		Place of Service / Provider Type	Service Category
		90862			Medication Checks
		G0177,H2015,H2016,H2017,H2018			MHSA Community Treatment/Support/Psychosocial Rehab
		S9485	OR	Provider type = 79	Treatment Crisis Intervention
				Provider type = 81	Treatment Group Home
				Provider type = 80	Treatment Foster Care
		H0018,H0019	AND	Provider type = 46,82 or Place of service = 55,56	Residential Treatment Center
				Provider type = 46,82 or Place of service = 55,56	Professional RTC/ Group Home Visits
		H2012,H0040	OR	Provider type = 45,77	Day Treatment
		S9480,H0015,90870			Intensive Outpatient Services
				Place of Service = 21,51	Professional Inpatient Visits
		90801,90802,H0031,H0001,H0002,H2000, 96101,96118,H0032,96116,96119,99203, 99204,99205,96102,96103,96150,90810, 99201,99499,96151,99211,99212,99213, 99214,99215,99241,99242,99243,99244, 99245,H0046			Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing
29100-29299, 30300-30599	AND	90804,90805,90806,90807,90808,90809, H2019,96152,90899			Individual Substance Abuse Counseling
		90804,90805,90806,90807,90808,90809, H2019,96152,90899			Individual Psychotherapy
29100-29299, 30300-30599	AND	90846,90847,96154,90849			Family Substance Abuse Counseling
		90846,90847,96154,90849			Family Psychotherapy Services
29100-29299, 30300-30599	AND	90853			Group Substance Abuse Counseling
		90853			Group Psychotherapy
		H0005			Group Substance Abuse Counseling
		90887			Conferences with family or other responsible persons advising them on how to assist the client
		JXXXX,96372,90772			Physician Administered Outpatient Drugs
		H1011			Family Assessment
					Other

Units Descriptions

Service Category	Units Measure	Method for counting units
Adult Day Treatment Psychiatric Services	Cases	Count all services provided on the same day as one case
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)	Admits	Count admissions, where all services for an admission are bundled into one stay associated with the admission date
Conferences with family or other responsible persons advising them on how to assist the client	Units	Count units as provided in the claim record
Day Treatment	Cases	Count all services provided on the same day as one case
Electroconvulsive Therapy	Units	Count units as provided in the claim record
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	Units	Count units as provided in the claim record
Family Assessment	Units	Count units as provided in the claim record
Family Psychotherapy Services	Units	Count units as provided in the claim record
Family Substance Abuse Counseling	Units	Count units as provided in the claim record
Group Psychotherapy	Units	Count units as provided in the claim record
Group Substance Abuse Counseling	Units	Count units as provided in the claim record
Individual Psychotherapy	Units	Count units as provided in the claim record
Individual Substance Abuse Counseling	Units	Count units as provided in the claim record
Inpatient Acute Psychiatric	Admits	Count admissions, where all services for an admission are bundled into one stay associated with the admission date
Inpatient Mental Health and Inpatient Services Delivered in an IMD	Admits	Count admissions, where all services for an admission are bundled into one stay associated with the admission date
Intensive Outpatient Services	Cases	Count all services provided on the same day as one case
Medication Checks	Units	Count units as provided in the claim record
MHSA Community Treatment/Support/Psychosocial Rehab	Units	Count units as provided in the claim record
Other	Units	Count units as provided in the claim record
Physician Administered Outpatient Drugs	Units	Count units as provided in the claim record, imposing a maximum of 1 unit per claim record
Outpatient Lab/Path/Other	Units	Count units as provided in the claim record
Professional Inpatient SubAcute Visits	Units	Count units as provided in the claim record
Professional Inpatient Visits	Units	Count units as provided in the claim record
Professional RTC/Group Home Visits	Units	Count units as provided in the claim record
Psychiatric Evaluation/Psychological Evaluation/Testing	Units	Count units as provided in the claim record
Residential Treatment Center	Admits	Count admissions, where all services for an admission are bundled into one stay associated with the admission date
Treatment Crisis Intervention	Days	Count per diem units as provided in the claim record
Treatment Foster Care	Days	Count per diem units as provided in the claim record
Treatment Group Home	Admits	Count admissions, where all services for an admission are bundled into one stay associated with the admission date

Milliman

RFP 4116Z1
Attachment C

DATA BOOK – STATEWIDE MANAGED BEHAVIORAL HEALTHCARE

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID AND LONG-TERM CARE

October 19, 2012

Introduction

The State of Nebraska's Department of Health and Human Services, Division of Medicaid and Long Term Care (Department) retained Milliman to develop Medicaid behavioral health managed care capitation rates for September 1, 2013 – June 30, 2014 for the purpose of contracting with a statewide Behavioral Healthcare Organization (BHO). The Department contracted with Milliman to develop the proposed capitation rates and to certify that they are within an actuarially sound rate range for the purpose of seeking rate approval by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR 438.6(c). Milliman is not aware of any Nebraska specific regulations pertaining to managed behavioral healthcare capitation rate development.

The intent of this Data Book is to provide interested parties with summarized fee-for-service (FFS) behavioral healthcare data on the cost and utilization patterns who will be enrolled in the managed behavioral healthcare program.

Contents of the Data Book

The data contained in the Excel file which accompanies this document, reflect the relevant FFS experience for the entire State of Nebraska for the populations which will be enrolled in the managed behavioral healthcare program. The data also contain the services which have been covered under the FFS delivery system. The data was provided by the State of Nebraska and has been summarized to include data by:

- Incurred fiscal year (FY) (July 1 through June 30) 2009, 2010, 2011 and a restatement of FY11 based on programmatic changes which occurred after the historical experience shown. Restatement in this context refers to the adjustments made to the FY11 historical data to reflect the programmatic changes which were implemented after FY11. These adjustments are described beginning on Page 7 of this Data Book.
- Service Category
- Rating Category

The Excel file contains a Databook_Contents tab which describes in detail what is contained in the file.

DATA SOURCES AND DATA PROCESSING

The Department provided Milliman with detailed claim and membership data for FY09, FY10, and FY11 for all healthcare services. Milliman's data processing of this claim and eligibility data to prepare the behavioral healthcare Data Book included the following key components:

1. Apply the behavioral claim identification logic provided by the Department to identify the subset of claims from the complete Medicaid claims dataset for FY09 – FY11 which were for behavioral healthcare services.
2. Exclude any claims for eligibility groups who will not be part of the managed behavioral healthcare contract.
3. Assign each claim to a rating category based on the rating category mapping approved by the Department.
4. Assign each claim to a behavioral healthcare service category based on the service categories contained in Chapters 20, 32, and 35 from Title 471 of Nebraska Medicaid in effect during FY09 – FY11 based on age of Medicaid eligible.
5. Assign each claim to either mental health (MH) or substance abuse (SA) based on diagnosis code.
6. Calculate members by month and rating category.
7. Calculate utilizers, paid dollars, paid units of service, paid days (where appropriate), cost per unit, cost per day (where appropriate) and per-member-per-month (PMPM) cost by rating category, incurred month/year and behavioral healthcare service category.

COVERED SERVICES

Service Category Assignment

Generally speaking, the behavioral healthcare service categories which claims were mapped into for the purpose of data summarization and capitation rate development were those contained in Chapters 20, 32, and 35 from Title 471 of Nebraska Medicaid based on the age of the individual and Nebraska Medicaid policies in place at the time services were rendered. We did supplement these categories and combined or sub-divided some of them where it made sense to do so. Please note that the RFP lists six general categories of covered services whereas the Data Book contains much more detailed service categories. The level of detail included in the Data Book is the level of detail used in the capitation rate development.

Using a combination of our knowledge of behavioral healthcare claim coding and the fee-schedules for Nebraska Medicaid, we mapped claims into service categories using a combination of CPT / HCPCS /

REVENUE / PLACE OF SERVICE / PROVIDER TYPE codes. The specific combinations of these codes which we mapped into the particular service categories are included in in the Excel file.

Tables 1 and 2 below display the list of covered services included by age group for FY09 – FY11.

Table 1 – Service Categories for Members Age 21 and Over
Inpatient Acute Psychiatric
Inpatient Mental Health and Inpatient Services Delivered in an IMD
Professional Inpatient Visits
Adult SubAcute Inpatient Hospital Psychiatric Services
Professional Inpatient SubAcute Visits
Adult Day Treatment Psychiatric Services
Electroconvulsive Therapy
Medication Checks
Psychiatric Evaluation/Psychological Evaluation/Testing
Individual Psychotherapy
Individual Substance Abuse Counseling
Group Psychotherapy
Group Substance Abuse Counseling
Family Psychotherapy Services
Family Substance Abuse Counseling
Family Assessment
MHSA Community Treatment/Support/Psychosocial Rehab
Physician Administered Outpatient Drugs
Outpatient Lab/Path/Other
Other

Table 2 – Service Categories for Members Age 20 and Under
Inpatient Acute Psychiatric
Inpatient Mental Health and Inpatient Services Delivered in an IMD
Professional Inpatient Visits
Residential Treatment Center
Treatment Group Home
Professional RTC/Group Home Visits
Treatment Foster Care
Day Treatment
Intensive Outpatient Services
Treatment Crisis Intervention
Medication Checks
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing
Individual Psychotherapy
Individual Substance Abuse Counseling
Group Psychotherapy
Group Substance Abuse Counseling
Family Psychotherapy Services
Family Substance Abuse Counseling
Family Assessment
Conferences with family or other responsible persons advising them on how to assist the client
MHSA Community Treatment/Support/Psychosocial Rehab
Physician Administered Outpatient Drugs
Outpatient Lab/Path/Other
Other

Determination of Units Counts

Milliman used a combination of the reported units in the detailed claim data and other algorithms, when needed, to develop unit counts by service category from the detailed claim data.

Outpatient Professional Services – The outpatient professional services were the simplest to map into the service categories using CPT/HCPCS codes. Furthermore, counting units of service for these categories was also straightforward because the claim data contained reliable units of service on each claim record. We created different categories for MH and SA services for psychotherapy and counseling services. Following is a listing of outpatient professional services whose units of service were counted directly from units reported on the claim records:

Conferences with family or other responsible persons advising them on how to assist the client
Electroconvulsive Therapy
Evaluation by a supervising practitioner / Psychiatric evaluation / Psychological evaluation / Testing
Family Assessment
Family Psychotherapy Services
Family Substance Abuse Counseling
Group Psychotherapy
Group Substance Abuse Counseling
Individual Psychotherapy
Individual Substance Abuse Counseling
Medication Checks
MHSA Community Treatment / Support / Psychosocial Rehab
Psychiatric Evaluation/Psychological Evaluation / Testing

Outpatient Facility and Day Treatment Services – The outpatient facility services and day treatment services (i.e. intensive outpatient, partial hospitalization) were more complicated to map and count due to the different claim reporting methods used by the providers. In some instances, claims were reported for each individual day of service, and in other instances, claims were reported and billed for 'courses of treatment' which spanned multiple days. Furthermore, some claims were mapped from the professional file using CPT/HCPCS codes while other claims were mapped from the facility file using REVENUE codes.

We were able to identify claims in the data files we would consider outpatient facility and day treatment services using the combination of CPT / HCPCS / REVENUE / PROVIDER TYPE fields. Our approach to counting these services was to treat each day of service as a 'case' and the units metric reported in the Data Book is cases. All claims associated with a case were bundled together to obtain the total dollars. For example, if someone received intensive outpatient services and while at the facility also received psychotherapy and drugs, we combined all of the dollars incurred on that particular day in the case. Following is a listing of outpatient facility and day treatment service categories whose units of services were reported as cases:

Adult Day Treatment Psychiatric Services
Day Treatment
Intensive Outpatient Services

There were also claims reported in the data which appeared to be provided on an outpatient basis which were not associated with any day treatment services. These claims were outpatient drugs and outpatient pathology and laboratory services. We mapped these claims into either Physician Administered Outpatient Drugs or Outpatient Path/Lab/Other based on the codes reported on the claim records. The units counted were those reported on the claim record.

Inpatient, Residential Treatment Center and Group Home Services – Inpatient, residential treatment center, and group home services were relatively straightforward to map and count units of service. For any admission to an inpatient facility, residential treatment center, or placement into a group home, we identified the 'admission' and counted the number of admissions. We also counted days per admission and report that metric as well so that average lengths of stays can be calculated. Because residential treatment center is not listed as a separate service category for individuals 21 and older in Title 471 Chapter 20, we included all residential treatment in the Adult Sub-Acute Inpatient service category for this age group.

One important thing to note is the dollars for all services incurred during an admission were bundled together to calculate the cost of the entire stay, not just the room and board charges. The exception to this would be any professional visits from outside providers who visited the admitted individual or group home resident. It is common for these services to be billed separately by the individual provider and reported separately. We separated these services into their own service categories and called them Professional Inpatient Visits, Professional Inpatient Sub-Acute Visits, and Professional RTC/Group Home Visits. The admission based service categories follow:

Inpatient Acute Psychiatric
Inpatient Mental Health and Inpatient Services Delivered in an IMD
Professional Inpatient Visits
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)
Professional Inpatient Sub-Acute Visits
Residential Treatment Center
Treatment Group Home
Professional RTC/Group Home Visits

Foster Care Treatment and Crisis Intervention Treatment – Claims for these two service categories were reported in the claim data on a per diem basis. We counted the days of service using the units reported on the claim records and reported them as days.

Other Services – In the rare case where a claim could not be mapped into one of the service categories mentioned above, they were mapped into an 'other' category and the units of service were taken from the claim records.

COVERED POPULATIONS AND RATE STRUCTURE

All Nebraska Medicaid eligibles will be included in the managed behavioral healthcare program except for the following individuals:

1. Medicaid members for any period of retroactive eligibility
2. Aliens who are eligible for Medicaid for an emergency condition only
3. Members who have excess income or who are designated to have a premium due
4. Members eligible during the period of presumptive eligibility
5. Participants in an approved DHHS PACE program
6. Clients with Medicare coverage where Medicaid only pays co-insurance and deductibles

These individuals were excluded from the data. The non-excluded populations were grouped into 8 different rating categories as shown in Table 3 below. A detailed description of each eligibility category which forms each rating category is included in the Excel file. As seen in this table, some eligibility categories were grouped together for rate development purposes, while other eligibility categories were divided into multiple rating categories based on age.

Table 3 – Listing of Rating Categories
CHIP
Aged
Blind / Disabled 18 and under / Katie Beckett
Blind / Disabled 19 and over
Families 0 through 5
Families 6 through 18
Families 19 and over
Foster Care / Ward / Subsidized Adoption

Persons classified as Katie Beckett eligible had $0 in behavioral spending in FY10 and FY11. We chose to group them with the Blind / Disabled 18 and under population for the purposes of this work. Both males and females are included in each rating category; there are no differences in rates by gender. As this is a statewide contract, there are no differences in rates by region.

Note that persons who become Medicaid eligible under the Medicaid expansion provisions of the Patient Protection and Affordable Care Act are not included in these rating categories and the rates developed are not appropriate for them.

DATA ACCURACY

In the course of developing the Data Book, we reconciled incurred claim dollars with the Department to ensure consistency with reported spending. Data inaccuracies could be present in the underlying data.

Users of this Data Book are cautioned against relying solely on the data contained herein. The State and Milliman provide no guarantee, either written or implied, that this Data Book is 100% accurate or error free.

Adjustments to the FFS Base Data

The Excel file displays summarized data by rating category and service category for FY09, FY10, and FY11. It also displays summarized data for FY11 which has been adjusted / restated to reflect programmatic changes which occurred after the historical experience period ended. This restated period is what was used to project costs into the period from September 1, 2013 – June 30, 2014.

Base Period Data Adjustments

The only adjustment made to the FY09 – FY11 data as displayed in the Excel file was for claim completion. Claim completion factors were developed using the developmental or lag methodology. Table 4 below displays the claim completion factors which were applied to dollars, units, and days.

Table 4 – Claims Completion Factors

Incurred Fiscal Year	Facility Claims	Professional Claims
FY11	1.0034	1.0012
FY10	1.0005	1.0000
FY09	1.0000	1.0000

Adjustments Reflected in the Restated FY11 Data

The following is a list of all data considerations and adjustments made to the completed FY11 claims and eligibility data to arrive at the restated FY11 data which is used to project costs into the period from September 1, 2013 through June 30, 2012.

Data Smoothing – No data smoothing adjustments were applied. Due to the nature of the services covered for mental health and substance abuse disorders, it is unlikely that large claims would cause significant distortion. Furthermore, the underlying populations are sufficiently large to be credible.

Population Bias Selection – No adjustment was necessary, since enrollment into the BHO program will be mandatory.

Eligibility Adjustments – Under the capitation arrangement, the BHO will not be held financially responsible for claims incurred while a Medicaid client is not enrolled in managed behavioral healthcare. There is typically a lag between when Medicaid eligibility is established and enrollment in managed care takes place. It was assumed that there is no utilization or cost differences during the period between when Medicaid eligibility is established and enrollment in managed behavioral healthcare begins and therefore no adjustment was necessary.

Disproportionate Share Hospital (DSH) – These are paid outside the capitation rate; no adjustment was necessary.

Graduate Medical Education (GME) – No GME payments are made to behavioral healthcare providers; no adjustment was necessary.

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) – There are no reimbursement differences for FQHCs and RHCs for behavioral healthcare services, therefore no adjustment was necessary.

Lincoln and Hastings Regional Center – This state-operated facility is paid based on reasonable costs. An interim per diem is established annually and then there is a cost settlement at FY end. The cost settlement was not factored into the rate development and will be the responsibility of Nebraska Medicaid.

Third Party Liability (TPL) – An adjustment of -0.4% was made to reflect additional TPL recoveries not reflected in the FFS data received. This adjustment was based on data received from the Department.

Risk Adjustment - Milliman believes that the rating categories provide sufficient variation to account for differences in risk so that additional risk adjustment is not necessary.

Cost Sharing – Beginning in October of 2011, the following co-payments were added for clients ages 19 and over and the restated FY11 data reflects the addition of these copays:

- $15 copay added to inpatient psychiatric hospital stays
- $2 copay added to outpatient mental health and substance abuse visits for the following procedure codes / provider type combinations: 90801 (01, 02, 13, 19, 29, 67); 90804 (13, 39); 90805 and 90807 (01,13); 90806 (01, 13, 39, 67); 90808 (13, 39, 67); 90847 (01, 13, 39, 67); 90853 (67); 99213, 99214, 99215 and 99243 (01, 13); 99241 and 99244 (13) and substance abuse codes 90806 HF and 90847 HF (provider type 47)

The impact of the addition of these copays is displayed by service category below in Table 5. These impacts were only applied to the rating categories comprised of clients age 19 and over.

Table 5 – Copay Adjustment Factors

Service Category	Factor
Inpatient Acute Psychiatric	-0.39%
Inpatient Mental Health and Inpatient Services Delivered in an IMD	-0.94%
Professional Inpatient Visits	-0.34%
Adult SubAcute Inpatient Hospital Psychiatric Services	-0.25%
Professional Inpatient SubAcute Visits	-0.02%
Residential Treatment Center	0.00%
Treatment Group Home	0.00%
Professional RTC/Group Home Visits	-0.19%
Treatment Foster Care	0.00%
Adult Day Treatment Psychiatric Services	0.00%
Day Treatment	0.00%
Intensive Outpatient Services	0.00%
Electroconvulsive Therapy	0.00%
Treatment Crisis Intervention	0.00%
Medication Checks	0.00%
Psychiatric Evaluation/Psychological Evaluation/Testing	-0.70%
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	-0.50%
Individual Psychotherapy	-3.17%
Individual Substance Abuse Counseling	-3.17%
Group Psychotherapy	-0.13%
Group Substance Abuse Counseling	-0.13%
Family Psychotherapy Services	-2.39%
Family Substance Abuse Counseling	-2.39%
Family Assessment	0.00%
Conferences with family or other responsible persons advising them on how to assist the client	0.00%
MHSA Community Treatment/Support/Psychosocial Rehab	0.00%
Physician Administered Outpatient Drugs	0.00%
Outpatient Lab/Path/Other	0.00%
Other	0.00%

Fee Changes – In July 2011 (beginning of FY12), the fee-schedule was revised. The fee schedule was then revised again in July 2012 (beginning of FY13). In general, there was a rate reduction implemented in the FY12 fee schedule with a partial rate restoration implemented in the FY13 fee schedule. The restated FY11 data reflects these changes. The combined impact of both fee schedule changes by service category is shown below in Table 6.

Table 6 – Fee Schedule Impact Adjustments	
Service Category	**Adjustment**
Inpatient Acute Psychiatric	-1.00%
Inpatient Mental Health and Inpatient Services Delivered in an IMD	-1.00%
Professional Inpatient Visits	-0.84%
Adult SubAcute Inpatient Hospital Psychiatric Services	0.45%
Professional Inpatient SubAcute Visits	-1.00%
Residential Treatment Center	0.00%
Treatment Group Home	-1.05%
Professional RTC/Group Home Visits	-1.16%
Treatment Foster Care	-1.00%
Adult Day Treatment Psychiatric Services	-1.14%
Day Treatment	-0.38%
Intensive Outpatient Services	-1.03%
Electroconvulsive Therapy	-1.00%
Treatment Crisis Intervention	-1.00%
Medication Checks	-0.61%
Psychiatric Evaluation/Psychological Evaluation/Testing	-2.20%
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	-1.89%
Individual Psychotherapy	-0.38%
Individual Substance Abuse Counseling	-0.38%
Group Psychotherapy	-3.84%
Group Substance Abuse Counseling	-3.84%
Family Psychotherapy Services	1.53%
Family Substance Abuse Counseling	1.53%
Family Assessment	-1.67%
Conferences with family or other responsible persons advising them on how to assist the client	3.72%
MHSA Community Treatment/Support/Psychosocial Rehab	-1.12%
Physician Administered Outpatient Drugs	-0.44%
Outpatient Lab/Path/Other	-1.00%
Other	-1.00%

Reimbursement Restructuring and Service Category Changes – The reimbursement methods for some service categories were restructured and, in some instances, service categories were changed with some procedure codes becoming obsolete and replaced with others. Below is a listing of the changes and the aggregate impact assumed (if any) which is reflected in the restated FY11 experience shown in Attachment 1. We provide this restatement of FY11 experience to show what we estimate the impact would have been had these changes been in place during all of FY11, the base year for the September 1, 2013 through June 30, 2012 projections.

- Intensive Outpatient Services (IOP) – Effective July 1, 2011, Medicaid "unbundled" the services provided under a per diem IOP code and added a new procedure code for the unlicensed staff who were supervised by licensed program staff. A modifier was assigned to the practitioners' services and a separate provider number assigned. No adjustment was made to the children's IOP services for this change.
- Day Treatment Services – Effective July 1, 2011, these services were "unbundled" similarly to the IOP services described above. No adjustment was made to the children's day treatment services for this change.

- Treatment Foster Care (TFC) – Effective July 1, 2011, TFC services for children ended and Professional Resource Family Care (PRFC) was initiated. While similar to TFC, services are also "unbundled" with a procedure code assigned for PRFC parent services as well as licensed staff provider psychotherapy. No adjustment was made to the treatment foster care services for this change.
- Treatment Group Home (TGH) – Effective July 1, 2011, TGH services ended and were replaced by Therapeutic Group Home services, which are unbundled with modifiers for psychotherapy services and a new procedure code for unlicensed staff who are supervised by licensed staff. No adjustment was made to the children's treatment group home services for this change.
- Residential Treatment Centers (RTC) – Effective July 1, 2011, RTC services ended and were replaced by Psychiatric Residential Treatment Facility services (PRTFs). PRTF services are a bundled service where room and board is paid by Medicaid. The adjustment to the residential treatment services for this change is -6.9%.

Definition of a Child Based on Age – The historical data we relied on was for FY09 – FY11. During this period, a Child according to Nebraska Medicaid was anyone under 21 years of age. Going forward, according to Nebraska Medicaid, a Child will be anyone under 19 years of age. Because the historical data was summarized using Chapters 20, 32, and 35 of Title 471 in effect during the historical data period (which defined covered services differently for the 0-20 year olds and those 21+), there is a natural disconnect between the services which were available to those persons ages 19 and 20 in FY09 – FY11 and those services available to persons ages 19 and 20 under this new contract. Below is a listing of services from Chapters 20 and 32 from Title 471 which had non-zero costs in FY11 which was used as the basis of our projections.

- Treatment Crisis Intervention
- Intensive Outpatient Services
- Day Treatment
- Residential Treatment Center
- Professional RTC Visits
- Evaluation by a supervising practitioner/Psychiatric Evaluation/Psychological Evaluation/Testing

For all services in this list, with the exception of Treatment Crisis Intervention, there are analogous covered Adult services (e.g. Adult Sub-Acute for Residential Treatment Center) and therefore no adjustment was made. We believe Treatment Crisis Intervention would be entirely eliminated for persons ages 19 and 20 who will no longer be eligible to receive this service. Therefore, in the FY11 restated data, we have eliminated the costs for Treatment Crisis Intervention for the Blind / Disabled 19 and over and the Families 19 and over rating categories. These are the only two rating categories which contain people who would have been considered a Child during the historical data period and would now be considered Adults.

Capitation Rate Range Development

According to CMS regulations, the capitation rates must be within actuarially sound rate ranges. Milliman will certify the actuarial soundness of the rate ranges which were developed using generally accepted actuarial practices and principles.

This section describes the additional adjustments which have not yet been mentioned to calculate the final capitation rate rages. These adjustments are not reflected in the restated FY11 data which was used to project costs into the period from September 1, 2013 through June 30, 2014.

Trend

Milliman reviewed detailed utilization and cost patterns by service category and rating category for the FY09 – FY11 experience period to develop trend rates to forecast September 1, 2013 through June 30, 2014 utilization and cost levels. This was done after removing the impact of any fee-schedule changes which took place during the historical data period. CMS requires that the fee-for-service data be trended forward from the base period to the contract period, and that actual experience is used to the extent possible. Milliman also reviewed CPI indices, Milliman trend reports, and behavioral healthcare trends in other states to establish trend assumptions that were applied to project the base data from the midpoint of the restated base period (FY11) to the midpoint of the contract period (September 1, 2013 through June 30, 2014), which is February 1, 2014. The trend rates used in this rate development vary by both service category and rating category. Milliman believes that the trend rates that were developed are both reasonable and appropriate. The resulting aggregate rounded annualized trend assumptions across all service categories by rating category are shown in Table 7.

Table 7 – Aggregate Annualized Trend Assumptions by Rating Category

Rating Category	Annualized Trend Assumption
CHIP	0.0%
Aged	0.6%
Blind / Disabled 18 and under / Katie Beckett	-2.3%
Blind / Disabled 19 and over	-0.5%
Families 0 through 5	0.0%
Families 6 through 18	-1.7%
Families 19 and over	-1.8%
Foster Care / Ward / Subsidized Adoption	-2.7%

Managed Care Savings

Milliman developed adjustments to account for the difference between a fee-for-service program and a managed care program for behavioral healthcare services. For example, service utilization for some services are reduced, such as inpatient hospital care and PRTF, as managed care organizations implement their medical necessity criteria and add utilization management protocols. Additionally, more use of cost-effective alternatives to inpatient and residential services are also common, and our managed care assumptions reflect increased use of certain services. These assumptions are based on our knowledge of managed behavioral healthcare and internal Milliman Medicaid data. These adjustments vary by both service category and rating category. The resulting aggregate rounded managed care assumptions applied to the trended costs by rating category are shown in Table 8.

Table 8 – Aggregate Managed Care Impact Assumptions by Rating Category	
Rating Category	**Managed Care Impact Assumption**
CHIP	-9.5%
Aged	-8.4%
Blind / Disabled 18 and under / Katie Beckett	-11.4%
Blind / Disabled 19 and over	-13.4%
Families 0 through 5	-2.1%
Families 6 through 18	-8.2%
Families 19 and over	-10.4%
Foster Care / Ward / Subsidized Adoption	-18.6%

Administrative Costs

CMS regulations require an administrative load for costs directly related to the provision of approved Medicaid State Plan services. Further, Nebraska Bill 1158 requires all contracts and agreements relating to the medical assistance program governing at-risk managed care service delivery for behavioral health services entered into by the Department on or after July 1, 2012 shall provide:

(1) a definition and cap on administrative spending that (a) shall not exceed 7% unless the implementing department includes detailed requirements for tracking administrative spending to ensure (i) that administrative expenditures do not include additional profit and (ii) that any administrative spending is necessary to improve the health status of the population to be served and (b) shall not under any circumstances exceed 10%;

(2) provide a definition of annual contractor profits and losses and restrict such profits and losses under the contract so that (a) profit shall not exceed three percent per year and (b) losses shall not exceed three percent per year, as a percentage of the aggregate of all income and revenue earned by the contractor and related parties, including parent and subsidy companies and risk-bearing partners under the contract.

Thus, the capitation rates include a 7% administrative load and a 3% risk margin.

September 1, 2013 – June 30, 2014 Behavioral Healthcare Capitation Rates		
Rating Category	**FY11 Member Months**	**Capitation Rate**
CHIP	358,005	$15.57
Aged	211,207	$8.09
Blind / Disabled 18 and under / Katie Beckett	46,544	$50.08
Blind / Disabled 19 and over	365,053	$94.85
Families 0 through 5	690,381	$1.89
Families 6 through 18	671,424	$21.29
Families 19 and over	347,151	$19.15
Foster Care / Ward / Subsidized Adoption	138,482	$229.99
All Rating Categories Combined	**2,828,247**	**$34.77**

Attachment A

Medicaid Covered Services

Request for Proposal Number 4166Z1

Medicaid covered services for children under age 19:

Crisis Stabilization Services:
Crisis Assessment

Inpatient Services (Acute and Sub-Acute):
Acute Inpatient Hospital

Residential Services:
Psychiatric Residential Treatment Facility (PRTF) (through age 18)
Therapeutic Group Home (ThGH)
Professional Resource Family Care (PRFC)

Outpatient Assessment and Treatment:
Partial Hospitalization
Day Treatment (MH and SA)
Intensive Outpatient (MH)
Intensive Outpatient (SA)
Medication Management
Outpatient (Individual, Family, Group) (MH, SA, or Dual MH/SA)
Injectable Psychotropic Medications
Substance use disorder Assessment
Psychological Evaluation and Testing
Initial Diagnostic Interviews
Home-based MST
Biopsychosocial Assessment and Addendum (currently in policy but maybe eliminated by June 30, 2013)
Sex Offender Risk Assessment
Community Treatment Aide (CTA)
Client Assistant Program (CAP) (managed care benefit only)
Comprehensive Child and Adolescent Assessment (CCAA)
Comprehensive Child and Adolescent Assessment Addendum
Conferences with family or other responsible persons
Hospital Observation Room Services (23:59)

Support Services:
Interpreter Services for MH/SA services
Telehealth Transmission

Medicaid covered services for Adults 19 and over:

Crisis Stabilization Services:

Crisis Assessment
Inpatient Services (Acute and Sub-Acute):
Acute Inpatient Hospital
Sub-acute Hospital

Outpatient Assessment and Treatment:
Partial Hospitalization
Social Detox
Day Treatment (MH)
Intensive Outpatient (SA)
Medication Management
Outpatient (Individual, Family, Group) (MH, SA, or Dual MH/SA)
Injectable Psychotropic Medications
Substance use disorder Assessment
Psychological Evaluation and Testing
Electroconvulsive Therapy – ECT
Initial Diagnostic Interviews
Biopsychosocial Assessment and Addendum (currently in policy but maybe eliminated by June 30, 2013)
Crisis Outpatient Services
Client Assistant Program (CAP) (managed care benefit only)
Ambulatory Detoxification
Psychiatric nursing (in-home)

Rehabilitation Services:
Dual Disorder Residential
Intermediate Residential – (SA) substance abuse
Short-Term Residential
Halfway House
Therapeutic Community – (SA only)
Community Support (SA)

Support Services:
Interpreter Services for MH/SA services
Telehealth Transmission

Medicaid Rehabilitation Option (MRO) services supplemented by Department of Behavioral Health (DBH), which are moving to Medicaid paid services only:

Rehabilitation Services:
Psychiatric Residential Rehabilitation
Secure Residential Rehabilitation
Assertive Community Treatment (ACT) and Alternative ACT (Alt. ACT)
Community Support (MH)
Day Rehabilitation

State of Nebraska (State Purchasing Bureau)

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

RETURN TO:
State Purchasing Bureau
301 Centennial Mall South, 1st Fl
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Phone: 402-471-2401
Fax: 402-471-2089

SOLICITATION NUMBER	RELEASE DATE
RFP 4166Z1	**October 24, 2012**
OPENING DATE AND TIME	PROCUREMENT CONTACT
January 7, 2013 2:00 p.m. Central Time	**Ruth Gray**

This form is part of the specification package and must be signed and returned, along with proposal documents, by the opening date and time specified.

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska, Administrative Services (AS), Materiel Division, Purchasing Bureau, is issuing this Request for Proposal, RFP Number 4166Z1 for the purpose of selecting a qualified contractor to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care.

First round written questions are due no later than November 6, 2012, and should be submitted via e-mail to matpurch.dasmat@nebraska.gov. Written questions may also be sent by facsimile to (402) 471-2089.

Bidder should submit one (1) original and seven (7) copies of the entire proposal. In the event of any inconsistencies among the proposals, the language contained in the original proposal shall govern. Proposals must be submitted by the proposal due date and time.

PROPOSALS MUST MEET THE REQUIREMENTS OUTLINED IN THIS REQUEST FOR PROPOSAL TO BE CONSIDERED VALID. PROPOSALS WILL BE REJECTED IF NOT IN COMPLIANCE WITH THESE REQUIREMENTS.

1. Sealed proposals must be received in State Purchasing by the date and time of proposal opening indicated above. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.
2. This form "REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES" MUST be manually signed, in ink, and returned by the proposal opening date and time along with bidder's proposal and any other requirements as specified in the Request for Proposal in order to be considered for an award.
3. It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://www.das.state.ne.us/materiel/purchasing/
4. It is understood by the parties that in the State of Nebraska's opinion, any limitation on the contractor's liability is unconstitutional under the Nebraska State Constitution, Article XIII, Section 3, and that any limitation of liability shall not be binding on the State of Nebraska despite inclusion of such language in documents supplied with the contractor's bid or in the final contract.

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request For Proposal For Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions (see Section III) and certifies bidder maintains a drug free work place environment.

FIRM: _____

COMPLETE ADDRESS: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

SIGNATURE: _____ DATE: _____

TYPED NAME & TITLE OF SIGNER: _____

TABLE OF CONTENTS

GLOSSARY OF TERMS

Acceptance Test Procedure: Benchmarks and other performance criteria, developed by the State of Nebraska or other sources of testing standards, for measuring the effectiveness of products or services and the means used for testing such performance.

Action: is defined in the contract as the:

1. Denial or limited authorization of a requested service, including the type or level of service;
2. Reduction, suspension, or termination of a previously authorized service;
3. Denial, in whole or in part, of payment for a service;
4. Failure to provide services in a timely manner, as defined by the State;
5. Failure of the Contractor to act within the timeframes; or
6. For a rural area resident with only one MCO to choose from, the denial of a Medicaid enrollee's request to obtain services outside the network:

    a. From any other provider (in terms of training, experience, and specialization) not available within the network;
    b. From a provider not part of the network who is the main source of a service to the recipient - provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days;
    c. Because the only plan or provider available does not provide the service because of moral or religious objections;
    d. Because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network; and
    e. The State determines that other circumstances warrant out-of-network treatment.

Addendum: Something added or deleted.

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any officer or agency established by the Constitution of Nebraska.

Agent: A person authorized by a superior or organization to act on their behalf.

Amend: To alter or change by adding, subtracting, or substituting. A contract can be amended only by the parties participating in the contract. A written contract can only be amended in writing.

Amendment: Written correction or alteration.

Appeal: As defined in 42 CFR 438.400(b). A request for review of an "action". Action means, in the case of an MCO or PIHP:

1. The denial or limited authorization of a requested service, including the type or level of service;

2. The reduction, suspension, or termination of a previously authorized and covered service;
3. The denial, in whole or part, of a payment for a properly authorized and covered service;
4. The failure to provide services in a timely manner, as defined by the State;
5. The failure of a Managed Care Contractor to act within the established timeframes for grievance and appeal disposition; and
6. For a resident of a rural area with only one Medicaid health plan, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.

Appropriation: Legislative authorization to expend public funds for a specific purpose. Money set apart for a specific use.

Award: All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

Behavioral Health - Managed Care Organization (BH-MCO): An organization that provides behavioral health services using managed care techniques.

Best and Final Offer (BAFO): A second-stage bid in a public procurement for services.

Bid: The executed document submitted by a bidder in response to a Request for Proposal.

Bid Bond: A bond given by a surety on behalf of the bidder to ensure that the bidder will enter into the contract as bid and is retained by the State from the date of the bid opening to the date of contract signing.

Bidder: Any person or entity submitting a competitive bid response to a solicitation.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, excepting public holidays.

Calendar Day: Every day shown on the calendar; Saturdays, Sundays and State/Federal holidays included. Not to be confused with "Work Day".

Capitation Payment: A monthly payment by the State to the Contractor on behalf of each enrollee for the provision of behavioral health services under the Contract. Payment is made regardless of whether the particular enrollee receives services during the period covered by the payment.

Children's Health Insurance Program (CHIP): Nebraska is currently a combination Medicaid CHIP state with a Medicaid CHIP (MCHIP) expansion program under Title XXI called "Kid's Connection". Kid's Connection provides health care coverage to targeted low-income uninsured children, from birth through age 18, in families with incomes at or below 200 percent of the Federal Poverty Level (FPL). The separate CHIP (SCHIP) program established July 19, 2012 provides Medicaid coverage for the unborn children of pregnant women that are otherwise not Medicaid eligible.

Claims Incurred: Amounts paid for claims incurred by the BH-MCO in the contract year. Amounts paid for claims should be net of any and all patient liabilities (e.g. copays), Third Party Liabilities (e.g. coordination of benefits or subrogation), and any rebates received from any party that reduces the BH-MCO's claims expense. Only claims paid for benefits under the Nebraska Medicaid Managed Care Program (NMMCP) shall be included.

Clean Claim: A claim received by the Contractor for adjudication that requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the Contractor.

CMS: Centers for Medicare and Medicaid Services, a U.S. federal agency that administers Medicare, Medicaid, and Children's Health Insurance Programs.

Cold Call Marketing: Any unsolicited personal contact by the Contractor with a potential enrollee for the purpose of marketing.

Collusion: A secret agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful or unlawful purpose.

Competition: The process by which two or more vendors vie to secure the business of a purchaser by offering the most favorable terms as to price, quality, delivery and/or service.

Complaint: A written or verbal expression of dissatisfaction from a member about an action taken by the Contractor or service provider other than an adverse action. The Contractor shall not treat anything as a complaint that falls within the definition of action.

Comprehensive Risk Contract: A risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

1. Outpatient hospital services;
2. Rural health clinic services;
3. FQHC services;
4. Other laboratory and X-ray services;
5. Nursing facility (NF) services;
6. Early and periodic screening, diagnosis, and treatment (EPSDT) services;
7. Family planning services;
8. Physician services; and
9. Home health services.

Confidential Information: Unless otherwise defined below, "Confidential Information" shall also mean proprietary trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Nebraska Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would provide.

Contract: An agreement between two or more persons to perform a specific act or acts.

Contract Administration: The Management of various facets of contracts to assure that the contractor's total performance is in accordance with the contractual commitments and obligations to the purchaser are fulfilled.

Contract Management: Includes reviewing and approving of changes, executing renewals, handling disciplinary actions, adding additional users, and any other form of action that could change the contract.

Contractor: Any person or entity that supplies goods and/or services.
Conversion Period: A period of time not to exceed six (6) months, during which the State converts to a new Operating System under "Conversion" as per this RFP.

Coordinated Care Management: The overall system of medical and psychosocial management of care encompassing, but not limited to, utilization management, care coordination, discharge planning following restrictive levels of care, continuity of care, care transition, and quality management.

Copyright: A grant to a writer/artist that recognizes sole authorship/creation of a work and protects the creator's interest(s) therein.

CPU: (Central Processing Unit.) Any computer or computer system that is used by the State to store, process, or retrieve data or perform other functions using Operating Systems and applications software.

Critical Program Error: Any Program Error, whether or not known to the State, which prohibits or significantly impairs use of the Licensed Software as set forth in the documentation and intended in the contract.

Default: The omission or failure to perform a contractual duty.

Deviation: Any proposed change(s) or alteration(s) to either the contractual language or deliverables within the scope of this Request for Proposal.

Documentation: The user manuals and any other materials in any form or medium customarily provided by the contractor to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

Earned Revenue: All capitation (gross of all MLTC withholds, reinsurance premiums, or any ceded revenue paid by MLTC related to members eligible for NE Medicaid services during the contract year less federal and state premium taxes. Excludes any capitation received in the contract year related to members eligible for services not in the contract year. This includes any revenue reserves for capitation related to members eligible for services in the contract year but not received in the contract year.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; (3) Serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient and outpatient services that are either furnished by a provider that is qualified to furnish these services under Title 42 CFR or the services needed to evaluate or stabilize an emergency medical condition.

Encounter Data: Line-level utilization and expenditure data for services furnished to enrollees through the MCO.

Enrollee: A Medicaid recipient who is currently enrolled in an MCO in a given managed care program. This term is used interchangeably with member.

Enrollment Report: A proprietary data file provided by the State to the MCO Administrator. The enrollment report is the basis for monthly payments to the MCO.

Evaluation Committee: A committee (or committees) appointed by the requesting agency that advises and assists the procuring office in the evaluation of proposals.

Evaluation of Proposal: The process of examining a proposal after opening to determine the bidder's responsibility, responsiveness to requirements, and to ascertain other characteristics of the proposal that relate to determination of the successful bidder.

Extension: A provision, or exercise of a provision, of a contract that allows a continuance of the contract (at the option of the State of Nebraska) for an additional time according to contract conditions. Not to be confused with "Renewals."

Federally Qualified HMO: An HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

F.O.B. Destination: Free on Board. The delivery charges have been included in the quoted price and prepaid by the vendor. Vendor is responsible for all claims associated with damages during delivery of product.

Foreign Corporation: A foreign corporation is a corporation that was formed (i.e. incorporated) in another state but transacting business in Nebraska pursuant to a certificate of authority issued by the Nebraska Secretary of State.

Generally Accepted Accounting Principles (GAAP): The common set of accounting principles, standards and procedures that companies use to compile their financial statements. GAAP are a combination of authoritative standards (set by policy boards) and the commonly accepted means of recording and reporting accounting information.

Grievance: An expression of dissatisfaction about any matter other than an action as defined above. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO level and access to the State Fair Hearing process.

Healthcare Effectiveness Data and Information Set (HEDIS): The most widely used set of standardized performance measures used in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is sponsored, supported, and maintained by the National committee of Quality Assurance (NCQA).

Health Care Practitioner: As defined at §71 NAC 6215.

Health Care Professional: A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

HIO: Health insuring organization. A county-operated entity that in exchange for capitation payments, covers services for recipients:

1. Through payments to, or arrangements with, providers;
2. Under a comprehensive risk contract with the State; and
3. Meets the following criteria – (i) First became operational prior to January 1, 1986; or (ii) Is described in section 9517(e)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990).

Incentive Withhold: In accordance with Nebraska law, is defined as funds that are withheld from payment in order to incentivize achievement of agreed upon terms. In addition to potential profit, the withhold amount will be at least one and one-half percent of the Earned Revenue. This amount shall be withheld from monthly capitation payments.

Incurred But Not Paid (IBNP): An estimate by a credentialed actuary of claims Incurred But Not Paid (IBNP). This estimate should include no implicit or explicit margin and be developed in accordance with actuarial standards of practice.

Information System(s): A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data which may include digitized audio and video) and documents as well as non-digitized audio and video; and/or (b) the processing of information and non-digitized audio and video for purposes of enabling and/or facilitating a business process or related transaction.

Installation Date: The date when the procedures described in "Installation by Contractor, and Installation by State", as found in the RFP, are completed.

Late Proposal: A proposal received at the place specified in the solicitation after the date and time designated for all proposals to be received.

Licensing: Bidders must acquire appropriate Nebraska licensure and provide proof-of-licensure with the proposal. If the Bidder is not licensed as required by the Nebraska Department of Insurance (DOI) at the time of proposal submittal, the Bidder shall attest that the appropriate licensure shall be obtained prior to a executing a contract with MLTC. The Bidder shall provide verification that the licensure is not suspended, revoked, denied or found to be noncompliant by Nebraska DOI at the time of contracting.

Licensed Software: Any and all software and documentation by which the State acquires or is granted any rights under the contract.

Lock-In: A method used by the State to limit the medical services and pharmaceuticals provided to NE Medicaid members who have been determined to be abusing or inappropriately utilizing services provided by NE Medicaid. In some complex health conditions, a second treating provider may be added to the member's "locked-in" profile for medication prescription. This usually occurs with psychiatry or pain management once confirmation is received from both providers.

Managed Care Organization (MCO): An organization that is, or is seeking to, qualify for a comprehensive risk contract to provide services to Medicaid managed care enrollees. An entity that has, or is seeking to qualify for, a comprehensive risk contract , and that is – (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of Chapter 438 of the Code of Federal Regulations Title 42; or (2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (i) Makes the

services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity; and (ii) Meets the solvency standards of 42 CFR 438.116.

Mandatory: Required, compulsory or obligatory.

Marketing: Any communication, from the Contractor to a Medicaid recipient who is not enrolled in the BH MCO and can reasonably be interpreted as intended to influence the recipient to enroll in the Contractor's BH program, or either to not enroll in, or to disenroll from, another BH MCO's Medicaid product.

Marketing Materials: Materials: that are produced in any medium, by or on behalf of the Contractor and can be reasonably be interpreted as intended to market to potential enrollees.

May: Denotes discretion.

Medicaid Abuse: Abuse is defined by Federal law (42 CFR 455.2) as "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program."

Medicaid Fraud: Fraud is defined by Federal law (42 CFR 455.2) as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."

Medicaid Waste: Excessive or improper use of services or actions that is inconsistent with acceptable business or medical practice. Medicaid Waste refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss.

Medical Incentive Bonuses: Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings with contracted providers (that are not related parties).

Medical Loss Ratio (MLR): MLR shall be defined as Medical Expenses divided by Earned Revenue as they relate to eligible members and services under this contract. Nebraska law requires all contracts and agreements relating to the medical assistance program governing at-risk managed care service delivery for behavioral health service shall provide for a minimum medical loss ratio of eighty five percent of the aggregate of all income and revenue earned by the Contractor and related parties under the contract.

Medical Necessity: As defined in 471 NAC 1-002.02A.

Member: An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act and under the rules for participation in NE Medicaid. This term is used interchangeably with enrollee.

Module: A collection of routines and data structures that perform a specific function of the Licensed Software.

Must: Denotes the imperative, required, compulsory or obligatory.

National Drug Code (NDC): The universal product identifier for human drugs.

Nebraska (NE) Medicaid Program (NE Medicaid or Medicaid): NE Medicaid provides health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children and parents. NE Medicaid also includes the MCHIP and SCHIP programs, non-institutional home and community-based services for individuals qualified for Medicaid waivers, the aged, adults and children with disabilities and infants and toddlers with special needs. NE Medicaid is administered by the Medicaid and Long Term Care (MLTC) division of the Department of Health and Human Services (DHHS).

Net Qualified Medical Expense: The amount of medical expenses that is allowed for purposes of calculating the Medical Loss Ratio and Risk Corridor. This amount is defined as the summation of the following items:

1. Claims Incurred;
2. IBNP (plus PAD, and LAE);
3. Medical Incentive Bonuses; and
4. Less "Related-Party" Medical margin.

NMES: (The Nebraska Medicaid Eligibility System.) An automated eligibility verification system for use by Medicaid service providers.

Non-Quality Improvement (QI) Administrative Rate: Non-QI Administrative Expenses are Total Administrative Expenses less QI Administrative Expenses. The Non-QI Administrative Rate equals Non-QI Expenses divided by Earned Revenue. The Allowed Non-QI Administrative Rate equals the rate allowed by MLTC for Risk Corridor calculations.

Opening Date: Specified date and time for the public opening of received, labeled and sealed formal proposals. Not to be confused with "Release Date".

Operating System: The control program in a computer that provides the interface to the computer hardware and peripheral devices, and the usage and allocation of memory resources, processor resources, input/output resources, and security resources.

Outsourcing: Acquiring computing or related services from a source outside of the State of Nebraska which may include programming and/or executing the State's Licensed Software on the State's CPU's, programming, and/or executing the State's programs and Licensed Software on the contractor's CPU's or any mix thereof.

Outsourcing Company: A company that provides Outsourcing Services under contract to the State.

Performance Bond: A bond given by a surety on behalf of the contractor to ensure the timely and proper (in sole estimation of the State) performance of a contract.

Performance Withhold: In accordance with Nebraska law, is defined as funds that are withheld from payment and are at risk as a penalty if the Contractor fails to meet the minimum performance metrics. The withhold amount at risk will be at least a minimum of one-quarter percent of the Earned Revenue. This amount shall be withheld from the monthly capitation payments.

PAHP: Prepaid ambulatory health plan. An entity that:

1. Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;

2. Does not provide or arrange for, or is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
3. Does not have a comprehensive risk contract.

PCCM: Primary care case manager. A physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:

1. A physician assistant;
2. A nurse practitioner; and
3. A certified nurse-midwife.

PIHP (Prepaid Inpatient Health Plan): As defined by 44 NAC Sections 4701 to 4727, and 42 CFR 438.2, is an entity that

1. Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
2. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
3. Does not have a comprehensive risk contract.

Platform: A specific hardware and Operating System combination that is different from other hardware and Operating System combinations to the extent that a different version of the Licensed Software product is required to execute properly in the environment established by such hardware and Operating System combination.

Post Stabilization Care Services: Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 438.114(e), to improve or resolve the enrollee's condition.

Potential Enrollee: A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, HIO or PCCM. (Potential enrollee definition is applicable to the Information Requirements - 438.10, not to the Marketing section - 438.104.)

Pre-Proposal Conference: A meeting scheduled for the purpose of providing clarification regarding a Request for Proposal and related expectations.

Primary Care Case Management: A system under which a PCCM contracts with the State to furnish case management services (which include the locations, coordination and monitoring of primary health care services) to Medicaid recipients.

Primary Care Provider (PCP): A medical professional chosen by the member or assigned to provide primary care services. Provider types that can be PCPs are Medical Doctors (MDs) or Doctors of Osteopathy (DOs) from any of the following practice areas: General Practice, Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology (OB/GYN), Advanced Practice Registered Nurses (APRNs) and Physician Assistants (when APRNs and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this contract).

Primary Care: All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Services: All health care services and laboratory services customarily furnished by a PCP or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Prior Authorization: The act of authorizing specific services or activities before they are rendered or occur.

Product: A module, a system, or any other software-related item provided by the contractor to the State.

Program Error: Code in Licensed Software which produces unintended results or actions, or which produces results or actions other than those described in the specifications. A program error includes, without limitation, any "Critical Program Error."

Program Set: The group of programs and products, including the Licensed Software specified in the RFP, plus any additional programs and products licensed by the State under the contract for use by the State.

Project: The total of all software, documentation, and services to be provided under this contract.

Proposal: The executed document submitted by a bidder in response to a Request for Proposal.

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Protest: A complaint about a governmental action or decision related to a Request for Proposal or the resultant contract, brought by a prospective bidder, a bidder, a contractor, or other interested party to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Provider: Either of the following:

1. For the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; and
2. For the managed care program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services.

Provision for Adverse Deviation (PAD): This is an explicit margin that is allowed to be reserved in addition to the IBNP to account for deviations assuming moderately adverse conditions. This amount shall be developed in accordance with actuarial standards of practice and shall not exceed 7.5% of the IBNP.

Public Proposal Opening: The process of opening proposals, conducted at the time and place specified in the Request for Proposal, and in the presence of anyone who wishes to attend.

Quality Improvement (QI) Expenses: These are expenses for the direct interaction of the insurer, providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined below. This category can include costs for associated activities such as:

1. Effective case management, Care coordination, and Chronic Disease Management, including:

- **a.** Patient centered intervention such as:
  - **i.** Making/verifying appointments;
  - **ii.** Medication and care compliance initiatives;
  - **iii.** Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center);
  - **iv.** Programs to support shared decision making with patients, their families and the patient's representatives;
  - **v.** Reminding insured of provider appointment, lab tests or other appropriate contact with specific providers;
  - **vi.** Incorporating feedback from the insured to effectively monitor compliance;
  - **vii.** Providing coaching or other support to encourage compliance with evidence based medicine;
  - **viii.** Activities to identify and encourage evidence based medicine;
  - **ix.** Activities to prevent avoidable hospital admissions;
  - **x.** Education and participation in self-management programs; and
  - **xi.** Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance.
- **b.** Improve patient safety;
- **c.** Wellness and health promotion activities;
- **d.** Health Information Technology (HIT) expenses related to Quality Improvement Activities:
  - **i.** Data extraction, analysis and transmission in support of the activities described above; and
  - **ii.** Activities designed to promote sharing of medical records to ensure that all clinical providers and accurate records from all participants in a patient's care.

2. The following items are broadly excluded as not meeting the definitions above:

- **a.** All retrospective and concurrent Utilization Review;
- **b.** Fraud Prevention activities;
- **c.** The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- **d.** Provider Credentialing;
- **e.** Marketing expenses;
- **f.** All Accreditation Fees;

g. Costs associated with establishing or maintaining a claims adjudication system;
h. Costs associated with calculating and administering individual enrollee or employee incentives; and
i. Any function or activity not expressly listed as approved.

Quality Improvement (QI) Administrative Rate: Equals the QI Expenses divided by the Earned Revenue.

Recommended Hardware Configuration: The data processing hardware (including all terminals, auxiliary storage, communication, and other peripheral devices) to the extent utilized by the State as recommended by the contractor.

Related-Party: Parties are considered to be related if the BH-MCO, or its parent company, partially or wholly owns another entity or subsidiary that receives any revenue from the BH-MCO for Medicaid contracted services. The BH-MCO's parent company is also considered a related party. An example of "Related Party" includes the BH-MCO or its parent company owning (wholly or partially) a clinic which provides NE Medicaid services. Another example would include the BH-MCO sub-contracting services to be provided by the BH-MCO's parent company or subsidiary.

Reinsurance: Also known as stop-loss insurance, risk control, or excess insurance, is a product that provides protection against catastrophic or unpredictable losses. Specifically, this is insurance that a MCO purchases to protect itself against part or all of the losses incurred in the process of honoring the claims of members.

"Related-Party" Administrative Margin: BH-MCO contract year administrative expenses must reflect the costs that would have been incurred in the contract year in the absence of any related-party relationship. Any difference is considered "Related-Party" Administrative Margin for contract year. "Related-Party" administrative expenses are fees paid by the BH-MCO, or any of its subsidiaries, to a related party such as a parent organization.

"Related-Party" Administrative Margin equals "Related Party" Administration divided by Earned Revenue.

"Related-Party" Medical Margin: Medicaid Medical expenses must reflect the costs that would have been incurred in the absence of any related-party relationship. Any difference is considered "Related-Party" Medical Margin. An example of "Related Party" includes the BH-MCO owning (wholly or partially) a clinic which provides Medicaid services. Income statements for Medicaid services performed in the contract year shall be provided to MLTC of any "Related Party" contract that exists. The BH-MCO shall disclose and provide a written description of the related party agreement in conjunction with the related party income statements. MLTC will use these "related party income statements to verify the BH-MCO's "Related-Party" Medical Margin. MLTC reserves the right to discount any amounts in these "Related Party" contracts that it deems excessive (e.g. salaries, parent fees, overhead, etc.).

Reinsurance: Also known as stop-loss insurance, risk control, or excess insurance, is a product that provides protection against catastrophic or unpredictable losses. Specifically, this is insurance that a MCO purchases to protect itself against part or all of the losses incurred in the process of honoring the claims of members.

Release Date: Date of release of the Request for Proposal to the public for submission of proposal responses. Not to be confused with "Opening Date".

Renewal: Continuance of a contract for an additional term after a formal signing by the parties.

Representative: Includes an agent, an officer of a corporation or association, a trustee, executor or administrator of an estate, or any other person legally empowered to act for another.

Request for Proposal (RFP): All documents, whether attached or incorporated by reference, utilized for soliciting competitive proposals.

Responsible Bidder: A bidder who has the capability in all respects to perform fully all requirements with integrity and reliability to assure good faith performance.

Responsive Bidder: A bidder who has submitted a bid which conforms in all respects to the solicitation document.

Risk Contract: A contract under which the Contractor: (1) Assumes risk for the cost of the services covered under the contract; and (2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Shall: Denotes the imperative, required, compulsory or obligatory.

Should: Indicates an expectation.

Solicitation: The process of notifying prospective bidders or offerors that the State of Nebraska wishes to receive proposals for furnishing services. The process may consist of public advertising, posting notices, or mailing Request for Proposals and/or Request for Proposal announcement letter to prospective bidders, or all of these.

Solicitation Document: Request for Proposal.

Specifications: The information provided by or on behalf of the contractor that fully describes the capabilities and functionality of the Licensed Software as set forth in any material provided by the contractor, including the documentation and User's Manuals described herein.

Statutory Accounting Principles (STAT): A set of accounting regulations prescribed by the National Association of Insurance Commissioners for the preparation of an insuring firm's financial statements.

Subcontractor: Any organization or person who provides a function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations under the terms of the Agreement. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement.

System: Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the contractor as functioning or being capable of functioning as an entity.

Termination: Occurs when either party pursuant to a power created by agreement or law puts an end to the contract. All obligations which are still executory on both sides are discharged but any right based on prior breach or performance survives.

Third Party Resource (TPR): Any individual, entity, or program that is or may be liable to pay all or part of the cost of any medical services furnished to a member.

Total Administration Expenses: All non-benefit expenses of operating pursuant to the requirements of this contract, other than medical, prescription drugs, DME, and other benefits for the Contract Year one (CY1). Non-benefit, administrative expenses include:

1. Direct Administration: Customer Service, enrollment, medical management, claims administration, etc.;
2. Indirect Administration: accounting, actuarial, legal, human resources, etc.; and
3. Net Cost of Reinsurance: Reinsurance Premium less projected reinsurance recoveries. Net Cost of Related party reinsurance will be excluded.

Trademark: A distinguishing sign, symbol, mark, word, or arrangement of words in the form of a label or other indication, that is adopted and used by a manufacturer or distributor to designate its particular goods and which no other person has the legal right to use.

Trade Secret: Information, including, but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that; (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. §87-502(4)).

Upgrade: Any improvement or change in the Software that improves or alters its basic function.

Value-Added Health Services: Those services a BH-MCO supply as a replacement for a service covered under this Contract because the BH-MCO has determined that the health status and quality of life for the enrollee is expected to be the same or better using the Value-Added Health Service as it would be using the Covered Service.

Vendor: An actual or potential contractor; a contractor.

Waiver of Enrollment: A change in the status of a member from being considered mandatory for participation in Managed Care to being ineligible for participation in Managed Care.

Will: Denotes the imperative, required, compulsory or obligatory.

GLOSSARY OF ACRONYMS

ACT: Assertive Community Treatment

ASO: Administrative Services Organization

BH-MCO: Behavioral Health Managed Care Organization

CAFCON: Children and Families Coalition of Nebraska

CAP: Client Assistant Program

CCAA: Comprehensive Child and Adolescent Assessment

CFR: Code of Federal Regulations

CLAS: Culturally and Linguistically Appropriate Services

CHIP: Nebraska Children's Health Insurance Program

CMHS: Center for Mental Health Services

CQI: Continuous Quality Improvement

CTA: Community Treatment Aide

CY: Calendar Year

DBH: Division of Behavioral Health

DCFS: Division of Children and Family Services

DDD: Division of Developmental Disabilities

DHHS: Nebraska Department of Health and Human Services

DOI: Department of Insurance

DUR: Drug Utilization Review

ECT: Electroconvulsive Therapy

ED: Emergency Department

EPSDT: Early and Periodic Screening, Diagnosis and Treatment

EQR: External Quality Review

EQRO: External Quality Review Organization

FQHC: Federally Qualified Health Center

FTE: Full Time Employee

FY: Fiscal Year

HIT: Health Information Technology

HMO: Health Maintenance Organization

IBNR: Incurred But Not Reported

ICM: Intensive Case Manager

IHS: Indian Health Service

IOP: Intensive Outpatient Program

LEIE: List of Excluded Individual Entities

MCO: Managed Care Organization

MED: Medicare Exclusion Database

MFCU: Medicaid Fraud Control Unit

MLR: Medical Loss Ratio

MLTC: Nebraska DHHS, Division of Medicaid and Long-Term Care

MRO: Medicaid Rehabilitation Option

NAADAC: The Association for Addiction Professionals (National Association of Alcoholism Counselors and Trainers)

NABHO: Nebraska Association of Behavioral Health Organizations

NAC: Nebraska Administrative Code

NCAAPN: Nebraska Chapter of the American Association of Psychiatric Nurses

NCNASW: Nebraska Chapter of the National Association of Social Workers

NCQA: National Committee for Quality Assurance

NE PACE: Nebraska Medicaid Program of All-inclusive Care for the Elderly

NHA: Nebraska Hospital Association

NMA: Nebraska Medical Association

NMMPH: Nebraska Medicaid Managed Physical Health

NPA: Nebraska Psychiatric Society
NPS: Nebraska Psychological Association

OOH: Out of Home

OIG: Office of the Inspector General

PH-MCO: Physical Health Managed Care Organization

PRFC: Professional Resource Family Care

PTRF: Psychiatric Residential Treatment Facilities

QAPI: Quality Assurance and Performance Improvement

QI: Quality Improvement

QM: Quality Management

QOC: Quality of Care

RBHA: Regional Behavioral Health Authority

RHC: Rural Health Clinic

SAMHSA: Substance use disorder and Mental Health Services Administration

SAPT: Substance use disorder Prevention and Treatment

SED: Serious Emotional Disorder

ThGH: Therapy Group Home

TPR: Third Party Resources

TPL: Third Party Liability

UM: Utilization Management

I. SCOPE OF THE REQUEST FOR PROPOSAL

The State of Nebraska, Administrative Services (AS), Materiel Division, Purchasing Bureau (hereafter known as State Purchasing Bureau), is issuing this Request for Proposal, RFP Number 4166Z1 for the purpose of selecting a qualified contractor to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care.

A contract resulting from this Request for Proposal will be issued for a period of three (3) years effective from date of contract award through June 30, 2016, with the option to renew for two (2) additional one (1) year periods as mutually agreed upon by all parties.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT: http://www.das.state.ne.us/materiel/purchasing/rfp.htm

A. SCHEDULE OF EVENTS

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change.

	ACTIVITY	DATE/TIME
1.	Release Request for Proposal	October 24, 2012
2.	Last day to submit first round written questions.	November 6, 2012
3.	State responds to first round written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://www.das.state.ne.us/materiel/purchasing/rfp.htm	November 20, 2012
4.	Last day to submit second round written questions.	November 27, 2012
5.	State responds to second round written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://www.das.state.ne.us/materiel/purchasing/rfp.htm	December 11, 2012
6.	Proposal opening Location: Nebraska State Office Building State Purchasing Bureau 301 Centennial Mall South, Mall Level Lincoln, NE 68508	January 7, 2013 2:00 PM Central Time
7.	Review for conformance of mandatory requirements	January 7, 2013
8.	Evaluation period	January 7 to January 24, 2013
9.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	To Be Determined
10.	Post "Letter of Intent to Contract" to Internet at: http://www.das.state.ne.us/materiel/purchasing/rfp.htm	To Be Determined
11.	Performance bond submission	February 15, 2013
12.	Contract award	April 15, 2013
13.	Contractor start date	September 1, 2013

II. PROCUREMENT PROCEDURES

A. PROCURING OFFICE AND CONTACT PERSON

Procurement responsibilities related to this Request for Proposal reside with the State Purchasing Bureau. The point of contact for the procurement is as follows:

Name: Ruth Gray
Agency: State Purchasing Bureau
Address: 301 Centennial Mall South, Mall Level
Lincoln, NE 68508

OR

Address: P.O. Box 94847
Lincoln, NE 68509
Telephone: 402-471-2401
Facsimile: 402-471-2089
E-Mail: matpurch.dasmat@nebraska.gov

B. GENERAL INFORMATION

The Request for Proposal is designed to solicit proposals from qualified vendors who will be responsible for providing a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care, hereafter referred to as "MLTC", at a competitive and reasonable cost.

Proposals that do not conform to the mandatory items as indicated in the Request for Proposal will not be considered.

Proposals shall conform to all instructions, conditions, and requirements included in the Request for Proposal. Prospective bidders are expected to carefully examine all documentation, schedules and requirements stipulated in this Request for Proposal, and respond to each requirement in the format prescribed.

A fixed-price contract will be awarded as a result of this proposal. In addition to the provisions of this Request for Proposal and the awarded proposal, which shall be incorporated by reference in the contract, any additional clauses or provisions required by the terms and conditions will be included as an amendment to the contract.

C. COMMUNICATION WITH STATE STAFF

From the date the Request for Proposal is issued until a determination is announced regarding the selection of the contractor, contact regarding this project between potential contractors and individuals employed by the State is restricted to only written communication with the staff designated above as the point of contact for this Request for Proposal.

Once a contractor is preliminarily selected, as documented in the intent to contract, that contractor is restricted from communicating with State staff until a contract is signed. Violation of this condition may be considered sufficient cause to reject a contractor's proposal and/or selection irrespective of any other condition.

The following exceptions to these restrictions are permitted:

1. Written communication with the person(s) designated as the point(s) of contact for this Request for Proposal or procurement;

2. Contacts made pursuant to any pre-existing contracts or obligations; and
3. State staff and/or contractor staff present at the Pre-Proposal Conference when recognized by the State Purchasing Bureau staff facilitating the meeting for the purpose of addressing questions; and
4. State-requested presentations, key personnel interviews, clarification sessions or discussions to finalize a contract.

Violations of these conditions may be considered sufficient cause to reject a bidder's proposal and/or selection irrespective of any other condition. No individual member of the State, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this Request for Proposal. The buyer will issue any clarifications or opinions regarding this Request for Proposal in writing.

D. WRITTEN QUESTIONS AND ANSWERS

Any explanation desired by a bidder regarding the meaning or interpretation of any Request for Proposal provision must be submitted in writing to the State Purchasing Bureau and clearly marked "RFP Number 4166Z1; A full-risk capitated rate Medicaid Managed Care Program Questions". It is preferred that questions be sent via e-mail to matpurch.dasmat@nebraska.gov. Questions may also be sent by facsimile to 402-471-2089, but must include a cover sheet clearly indicating that the transmission is to the attention of Ruth Gray, showing the total number of pages transmitted, and clearly marked "RFP Number 4166Z1; A full-risk capitated rate Medicaid Managed Care Program Questions".

Written answers will be provided through an addendum to be posted on the Internet at http://www.das.state.ne.us/materiel/purchasing/rfp.htm on or before the date shown in the Schedule of Events.

E. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The Evaluation Committee(s) may conclude after the completion of the Technical Proposal evaluation that oral interviews/presentations and/or demonstrations are required in order to determine the successful bidder. All bidders may not have an opportunity to interview/present and/or give demonstrations; the State reserves the right to select only the top scoring bidders to present/give oral interviews in its sole discretion. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical Proposals. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Bidders shall not be allowed to alter or amend their proposals. Only representatives of the State and the presenting bidders will be permitted to attend the oral interviews/presentations and/or demonstrations.

Once the oral interviews/presentations and/or demonstrations have been completed the State reserves the right to make a contract award without any further discussion with the bidders regarding the proposals received.

Detailed notes of oral interviews/presentations and/or demonstrations may be recorded and supplemental information (such as briefing charts, et cetera) may be accepted; however, such supplemental information shall not be considered an amendment to a bidders' proposal. Additional written information gathered in this manner shall not constitute replacement of proposal contents.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

F. SUBMISSION OF PROPOSALS

The following describes the requirements related to proposal submission, proposal handling and review by the State.

To facilitate the proposal evaluation process, one (1) original, clearly identified as such, and seven (7) copies of the entire proposal should be submitted. The copy marked "original" shall take precedence over any other copies, should there be a discrepancy. Proposals must be submitted by the proposal due date and time. A separate sheet must be provided that clearly states which sections have been submitted as proprietary or have copyrighted materials. All proprietary information the bidder wishes the State to withhold must be submitted in accordance with the instructions outlined in Section III, Proprietary Information. Proposal responses should include the completed Form A, Bidder Contact Sheet. Proposals must reference the request for proposal number and be sent to the specified address. Container(s) utilized for original documents should be clearly marked "ORIGINAL DOCUMENTS". Please note that the address label should appear as specified in Section II part A on the face of each container or bidder's bid response packet. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. If a recipient phone number is required for delivery purposes, 402-471-2401 should be used. The request for proposal number must be included in all correspondence.

Emphasis should be concentrated on conformance to the Request for Proposal instructions, responsiveness to requirements, completeness and clarity of content. If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming, it is likely that points will be lost in the evaluation process. Elaborate and lengthy proposals are neither necessary nor desired.

The Technical Proposal should be packaged separately (loose-leaf binders are preferred) on standard 8 ½" by 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables must be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text. The Technical Proposal must not contain any reference to dollar amounts. However, information such as data concerning labor hours and categories, materials, subcontracts and so forth, shall be considered in the Technical Proposal so that the Bidder's understanding of the scope of work may be evaluated. The Technical Proposal shall disclose the Bidder's technical approach in as much detail as possible, including, but not limited to, the information required by the Technical Proposal instructions.

G. PROPOSAL OPENING

The sealed proposals will be publicly opened and the bidding entities announced on the date, time and location shown in the Schedule of Events. Proposals will be available for viewing by those present after the proposal opening. Vendors may also contact the State to schedule an appointment for viewing proposals after the opening date.

H. LATE PROPOSALS

Proposals received after the time and date of the proposal opening will be considered late proposals. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. The State is not responsible for proposals that are late or lost due to mail service inadequacies, traffic or any other reason(s).

I. REJECTION OF PROPOSALS

The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

J. EVALUATION OF PROPOSALS

All responses to this Request for Proposal which fulfill all mandatory requirements will be evaluated. Each category will have a maximum possible point potential. The State will conduct a fair, impartial and comprehensive evaluation of all proposals in accordance with the criteria set forth below. Areas that will be addressed and scored during the evaluation include:

1. Executive Summary;
2. Corporate Overview shall include but is not limited to;

- **a.** The ability, capacity and skill of the bidder to deliver and implement the system or project that meets the requirements of the Request for Proposal;
- **b.** The character, integrity, reputation, judgment, experience and efficiency of the bidder;
- **c.** Whether the bidder can perform the contract within the specified time frame;
- **d.** The quality of bidder performance on prior contracts;
- **e.** Such other information that may be secured and that has a bearing on the decision to award the contract, including but not limited to:
  - **i.** Proof of financial stability in the form of audited financial statements, Dunn & Bradstreet reports, or, if these are not available, unaudited or pro-forma statements; and
  - **ii.** Corporate Resolution, Certificate of Good Standing Certificate, together with any and all amendments thereto; Partnership Agreement; or other relevant business organizational documents, as applicable.

3. Technical Approach.

Evaluation criteria will become public information at the time of the Request for Proposal opening. Evaluation criteria and a list of respondents will be posted to the State Purchasing Bureau website at http://www.das.state.ne.us/materiel/purchasing/rfp.htm Evaluation criteria will not be released prior to the proposal opening.

K. EVALUATION COMMITTEE

Proposals will be independently evaluated by members of the Evaluation Committee(s). The committee(s) will consist of staff with the appropriate expertise to conduct such proposal evaluations. Names of the members of the Evaluation Committee(s) will not become public information.

Prior to award, Bidders are advised that only the point of contact indicated on the front cover of this Request For Proposal For Contractual Services Form can clarify issues or render any opinion regarding this Request for Proposal. No individual member of the State, employee of the State or member of the Evaluation Committee(s) is empowered to make binding statements regarding this Request for Proposal.

L. MANDATORY REQUIREMENTS

The proposals will first be examined to determine if all mandatory requirements listed below have been addressed to warrant further evaluation. Proposals not meeting mandatory requirements will be excluded from further evaluation. The mandatory requirement items are as follows:

1. Signed, in ink, Request For Proposal For Contractual Services form;
2. Executive Summary;
3. Corporate Overview:

- **a.** Proof of financial stability in the form of audited financial statements, Dunn & Bradstreet reports, or, if these are not available, unaudited or pro-forma statements; and
- **b.** Corporate Resolution, Certificate of Good Standing Certificate, together with any and all amendments thereto; Partnership Agreement; or other relevant business organizational documents, as applicable.

4. Technical Approach; and
5. The applicant's Prepaid Limited Health Service Organization Act certificate of authority, pursuant to Nebraska Revised Statute 44-4701 et.seq.

M. REFERENCE CHECKS

The State reserves the right to check any reference(s), regardless of the source of the reference information, including but not limited to, those that are identified by the company in the proposal, those indicated through the explicitly specified contacts, those that are identified during the review of the proposal, or those that result from communication with other entities involved with similar projects.

Information to be requested and evaluated from references may include, but is not limited to, some or all of the following: project description and background, job performed, functional and technical abilities, communication skills and timeliness, cost and schedule estimates and accuracy, problems (poor quality deliverables, contract disputes, work stoppages, et cetera), overall performance, and whether or not the reference would rehire the firm or individual. Only top scoring bidders may receive reference checks and negative references may eliminate bidders from consideration for award.

N. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS

All bidders are expected to comply with any statutory registration requirements. It is the responsibility of the bidder who is the recipient of an Intent to Award to comply with any statutory registration requirements pertaining to types of business entities (e.g. a foreign or Nebraska corporation, non-resident contractor, limited partnership, or other type of business entity). The bidder who is the recipient of Intent to Award will be required to certify that it has so complied and produce a true and exact copy of its registration certificate, or, in the case registration is not required, to provide the reason as to why none is required. This must be accomplished prior to the award of contract.

O. VIOLATION OF TERMS AND CONDITIONS

Violation of the terms and conditions contained in this Request for Proposal or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's proposal; and

2. Suspension of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

III. TERMS AND CONDITIONS

By signing the "Request For Proposal For Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal.

A. GENERAL

Accept & Initial

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. The signed Request For Proposal form;
2. The original Request for Proposal document;
3. Any Request for Proposal addenda and/or amendments to include questions and answers;
4. The contractor's proposal;
5. Any contract amendments, in order of significance; and
6. Contract award.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) the contract award, 2) contract amendments with the latest dated amendment having the highest priority, 3) Request for Proposal addenda and/or amendments with the latest dated amendment having the highest priority, 4) the original Request for Proposal, 5) the signed Request For Proposal form, 6) the contractor's proposal.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

Accept & Initial

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.

By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once an intent to award decision has been determined, it will be posted to the Internet at: http://www.das.state.ne.us/materiel/purchasing/rfp.htm

Grievance and protest procedure is available on the Internet at: http://www.das.state.ne.us/materiel/purchasing/agencyservicesprocurementmanual/ProtestGrievanceProcedureForServices.doc

Any protests must be filed by a vendor within ten (10) calendar days after the intent to award decision is posted to the Internet.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

Accept & Initial

The contractor shall comply with all applicable local, State and Federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits contractors of the State of Nebraska, and their subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions or privileges of employment because of race, color, religion, sex, disability, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The contractor shall insert a similar provision in all subcontracts for services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

Accept & Initial

The contractor shall procure and pay for all permits, licenses and approvals necessary for the execution of the contract. The contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Accept & Initial

The State of Nebraska shall have the unlimited right to publish, duplicate, use and disclose all information and data developed or derived by the contractor pursuant to this contract.

The contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks and copyrights that are in any way involved in the contract. It shall be the responsibility of the contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept & Initial

The contractor shall not commence work under this contract until he or she has obtained all the insurance required hereunder and such insurance has been approved by the State. If contractor will be utilizing any subcontractors, the contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all subcontractor(s). Contractor is also responsible for ensuring subcontractor(s) maintain the insurance required until completion of the contract requirements. The contractor shall not allow any subcontractor to commence work on his or her subcontract until all similar insurance required of the subcontractor has been obtained and approved by the contractor. Approval of the insurance by the State shall not limit, relieve or decrease the liability of the contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the contractor elects to increase the mandatory deductible amount, the contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

1. WORKERS' COMPENSATION INSURANCE

The contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the contractor shall require the subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect contractor and any subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the contractor or by any subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury and Contractual Liability coverage. The policy shall include the State, and others as required by the Contract Documents, as an Additional Insured. This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned and Hired vehicles.

3. INSURANCE COVERAGE AMOUNTS REQUIRED

a. WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY

Coverage A	Statutory
Coverage B	
Bodily Injury by Accident	$100,000 each accident
Bodily Injury by Disease	$500,000 policy limit
Bodily Injury by Disease	$100,000 each employee

b. COMMERCIAL GENERAL LIABILITY

General Aggregate	$10,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 any one person
Bodily Injury/Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$5,000 any one person

c. COMMERCIAL AUTOMOBILE LIABILITY

Bodily Injury/Property Damage	$1,000,000 combined single limit

d. UMBRELLA/EXCESS LIABILITY

Over Primary Insurance	$1,000,000 per occurrence

4. EVIDENCE OF COVERAGE

The contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer, Administrative Services, State Purchasing Bureau, 301 Centennial Mall S, 1st Fl, Lincoln, NE 68508 (facsimile 402-471-2089). These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration and amounts and types of coverage afforded. If the State is damaged by the failure of the contractor to maintain such insurance, then the contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

Accept & Initial

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential contractors, if such an arrangement is in the best interest of the State.

2. The contractor shall agree to cooperate with such other contractors, and shall not commit or permit any act which may interfere with the performance of work by any other contractor.

H. INDEPENDENT CONTRACTOR

Accept & Initial

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the contractor, its officers or its agents) shall in no way be the responsibility of the State. The contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

Accept & Initial

The contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the contractor's proposal, and the resulting contract. The contractor shall be the sole point of contact regarding all contractual matters.

If the contractor intends to utilize any subcontractors' services, the subcontractors' level of effort, tasks and time allocation must be clearly defined in the contractor's proposal. The

contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal, in the performance of the contract, without the prior written authorization of the State. Following execution of the contract, the contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept & Initial

The contractor warrants that all persons assigned to the project shall be employees of the contractor or specified subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the contractor to fulfill the terms of the contract shall remain under the sole direction and control of the contractor. The contractor shall include a similar provision in any contract with any subcontractor selected to perform work on the project.

Personnel commitments made in the contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the contractor to reassign or remove from the project any contractor or subcontractor employee.

In respect to its employees, the contractor agrees to be responsible for the following:

1. Any and all employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the contractor's employees, including all insurance required by state law;
3. Damages incurred by contractor's employees within the scope of their duties under the contract;
4. Maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. Determining the hours to be worked and the duties to be performed by the contractor's employees.

Notice of cancellation of any required insurance policy must be submitted to the State when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

K. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept & Initial

The contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project.

L. CONFLICT OF INTEREST

Accept & Initial

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

M. PROPOSAL PREPARATION COSTS

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations, or oral presentations, or in any other activity related to bidding on this Request for Proposal.

_____
Accept & Initial

N. ERRORS AND OMISSIONS

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

_____
Accept & Initial

O. BEGINNING OF WORK

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful contractor. The contractor will be notified in writing when work may begin.

_____
Accept & Initial

P. ASSIGNMENT BY THE STATE

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

_____
Accept & Initial

Q. ASSIGNMENT BY THE CONTRACTOR

The contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

_____
Accept & Initial

R. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal or mandatory requirements. “Deviation”, for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

_____
Accept & Initial

S. GOVERNING LAW

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The contractor must be in compliance with all Nebraska statutory and regulatory law.

_____
Accept & Initial

T. ATTORNEY'S FEES

In the event of any litigation, appeal or other legal action to enforce any provision of the contract, the contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

_____
Accept & Initial

U. ADVERTISING

The contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

_____
Accept & Initial

V. STATE PROPERTY

Accept & Initial

The contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the contractor's use during the performance of the contract. The contractor shall reimburse the State for any loss or damage of such property, normal wear and tear is expected.

W. SITE RULES AND REGULATIONS

Accept & Initial

The contractor shall use its best efforts to ensure that its employees, agents and subcontractors comply with site rules and regulations while on State premises. If the contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the contractor.

X. NOTIFICATION

Accept & Initial

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II, A. Procuring Office and Contact Person of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) days following deposit in the mail.

2. Whenever the contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between contractor and the State regarding the contract shall take place between the contractor and individuals specified by the State in writing. Communication about the contract between contractor and individuals not designated as points of contact by the State is strictly forbidden.

Y. EARLY TERMINATION

Accept & Initial

The contract may be terminated as follows:

1. The State and the contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) days written notice to the contractor. Such termination shall not relieve the contractor of warranty or other service obligations incurred under the terms of the contract. In the event of cancellation the contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:

- **a.** If directed to do so by statute;
- **b.** Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
- **c.** A trustee or receiver of the contractor or of any substantial part of the contractor's assets has been appointed by a court;
- **d.** Fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its contractor, its employees, officers, directors or shareholders;
- **e.** An involuntary proceeding has been commenced by any party against the contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) days; or (ii) the contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the contractor has been decreed or adjudged a debtor;
- **f.** A voluntary petition has been filed by the contractor under any of the chapters of Title 11 of the United States Code;
- **g.** Contractor intentionally discloses confidential information;
- **h.** Second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or

Z. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept & Initial

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the contractor written notice thirty (30) days prior to the effective date of any termination, and advise the contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the contractor be paid for a loss of anticipated profit.

AA. BREACH BY CONTRACTOR

Accept & Initial

The State may terminate the contract, in whole or in part, if the contractor fails to perform its obligations under the contract in a timely and proper manner. By providing a written notice to the Contractor, the State may call for an immediate default, or allow the contractor to cure a failure or breach of contract within a period of thirty (30) days, depending on the gravity and nature of the default. Said notice shall be delivered by Certified Mail, Return Receipt Requested or in person with proof of delivery. Allowing the contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the contractor, the State may contract the service from other sources and hold the contractor responsible for any excess cost occasioned thereby.

BB. ASSURANCES BEFORE BREACH

Accept & Initial

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the contractor shall deliver assurances in the form of additional contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

CC. ADMINISTRATIVE SPENDING CAP

Accept & Initial

The State shall place a contractual cap on administrative spending by an MCO of seven percent (7%) The Contractor is required to track such expenditures and provide a detailed report of Administrative expenditures on a quarterly basis. Administrative expenditures do not include additional profit and any necessary administrative spending used to improve the health status of members served should not at any time exceed ten percent (10%).

DD. PROFIT/LOSS CAP AND REINVESTMENT

Accept & Initial

Total profit by an MCO shall not exceed three percent (3%) per year and losses shall not exceed three percent (3%) per year as an aggregate of all income and revenue earned by the Contractor and related parties, including parent and subsidy companies and risk-bearing partners, under contract. The MCO must provide for reinvestment of any profits in excess of the contracted amount, performance contingencies imposed by the MLTC, and any unearned incentive funds to fund additional behavioral health services for children, families and adults according to a plan developed with input from stakeholders, consumers and their family members, the office of consumer affairs within MLTC, and the Regional Behavioral Health Authority. Such plan must be approved by MLTC. The Reinvestment Plan must address the behavioral health needs of adults and children, including filling service gaps and providing system improvements, provide for a minimum medical loss ratio of eighty-five percent (85%) of the aggregate of all income and revenue earned by the Contractor and related parties under the contract and provide that Contractor incentives, in addition to potential profit, be at least one and one-half percent (1 ½%) of the aggregate of all income and revenue earned by the Contractor and related parties under contract.

EE. PENALTY

Accept & Initial

In the event that the contractor fails to perform any substantial obligation under the contract, the State may withhold all monies due and payable to the contractor, without penalty, until such failure is cured or otherwise adjudicated. Failure to meet the dates stipulated in the contract for the deliverables may result in an assessment of penalty due the State of $1,000.00 dollars per day, until the deliverables are approved. Contractor will be notified in writing when penalty will commence.

FF. PERFORMANCE BOND

Accept & Initial

The Contractor shall obtain and maintain a performance bond, rated at least A by A.M. Best Company, of a standard commercial scope from a surety company or companies holding a certificate of authority to transact surety business in the state. The Contractor shall not leverage the bond as collateral for debt or create other creditors using the bond as security. The Contractor shall be in breach of this contract if it fails to maintain or renew the performance bond as required by this contract.

1. The Contractor shall obtain a certified check or performance bond in an amount equal to ten million dollars ($10,000,000.00). The check or bond will guarantee that the selected contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be grounds for forfeiture of the check or bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond or certified check will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

2. The Contractor agrees that if it is declared to be in default of any term of this contract, MLTC may elect to, in addition to any other remedies it may have under this contract, obtain payment under the performance bond for the following:

- **a.** Making funds available through a consensus proceeding in the appropriate court for payment to subcontracted providers and non-contracted health care providers for reimbursement due to nonpayment of claims by Contractor, in the event of a breach of Contractor's obligation under this contract;
- **b.** Reimbursing MLTC for any payments made by MLTC on behalf of the Contractor;
- **c.** Reimbursing MLTC for any extraordinary administrative expenses incurred by a breach of Contractor's obligations under this contract, including, expenses incurred after termination of this contract by MLTC;
- **d.** Making any payments or expenditures deemed necessary to MLTC, in its sole discretion, incurred by MLTC in the direct operation of the contract pursuant to the terms of this contract and to reimburse MLTC for any extraordinary administrative expenses incurred in connection with the direct operation of the Contractor; and
- **e.** The Contractor shall reimburse MLTC for expenses exceeding the performance bond amount.

GG. FORCE MAJEURE

Accept & Initial

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the contractor. To obtain release based on a Force Majeure Event, the contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

HH. PAYMENT

Accept & Initial

State will render payment to contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the contractor prior to the Effective Date, and the contractor hereby waives any claim or cause of action for any such services.

II. INVOICES

Accept & Initial

Invoices for payments must be submitted by the contractor to the agency requesting the services with sufficient detail to support payment. The terms and conditions included in the contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

JJ. AUDIT REQUIREMENTS

Accept & Initial

All contractor books, records and documents relating to work performed or monies received under the contract shall be subject to audit at any reasonable time upon the provision of reasonable notice by the State. These records shall be maintained for a period of five (5) full years from the date of final payment, or until all issues related to an audit, litigation or other action are resolved, whichever is longer. All records shall be maintained in accordance with generally accepted accounting principles.

In addition to, and in no way in limitation of any obligation in the contract, the contractor shall agree that it will be held liable for any State audit exceptions, and shall return to the State all payments made under the contract for which an exception has been taken or which has been disallowed because of such an exception. The contractor agrees to correct immediately any material weakness or condition reported to the State in the course of an audit.

KK. TAXES

Accept & Initial

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the contractor's equipment which may be installed in a state-owned facility is the responsibility of the contractor.

LL. INSPECTION AND APPROVAL

Accept & Initial

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the contractor or subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

MM. CHANGES IN SCOPE/CHANGE ORDERS

Accept & Initial

The State may, at any time with written notice to the contractor, make changes within the general scope of the contract. Changes in scope shall only be conducted with the written approval of the State's designee as so defined by the State from time to time. (The State retains the right to employ the services of a third party to perform any change order(s)).

The State may, at any time work is in progress, by written order, make alterations in the terms of work as shown in the specifications, require the performance of extra work, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the contractor for any extra work so ordered shall be determined in accordance with the applicable unit prices of the contractor's proposal.

Corrections of any deliverable services or performance of work required pursuant to the contract shall not be deemed a modification requiring a change order.

NN. SEVERABILITY

Accept & Initial

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

OO. CONFIDENTIALITY

Accept & Initial

All materials and information provided by the State or acquired by the contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the contractor on behalf of the State shall be handled in accordance with Federal and State Law, and ethical standards. The contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a contractor; contractor shall notify the State immediately of said breach and take immediate corrective action.

It is incumbent upon the contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

PP. PROPRIETARY INFORMATION

Accept & Initial

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal. The separate package must be clearly marked PROPRIETARY on the outside of the package. Bidders may not mark their entire Request for Proposal as proprietary. Bidder's cost proposals may not be marked as proprietary information. Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific

advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

QQ. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept & Initial

By submission of this proposal, the bidder certifies, that he or she is the party making the foregoing proposal that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted his or her proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

RR. PRICES

Accept & Initial

All prices, costs, terms and conditions outlined in the proposal shall remain fixed and valid commencing on the opening date of the proposal until an award is made (and for bidder receiving award prices shall remain as bid for the duration of the contract unless otherwise so stated in the contract) or the Request for Proposal is cancelled.

SS. BEST AND FINAL OFFER

Accept & Initial

The State will compile the final scores for all parts of each proposal. The award may be granted to the highest scoring responsive and responsible bidder. Alternatively, the highest scoring bidder or bidders may be requested to submit best and final offers. If best and final offers are requested by the State and submitted by the bidder, they will be evaluated (using the stated criteria), scored and ranked by the Evaluation Committee. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

TT. ETHICS IN PUBLIC CONTRACTING

Accept & Initial

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator or employee based on the understanding that the receiving person's vote, actions or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

UU. INDEMNIFICATION

Accept & Initial

1. GENERAL

The contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the contractor, its employees, subcontractors, consultants, representatives, and agents, except to the extent such contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The contractor agrees it will at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the contractor or its employees, subcontractors, consultants, representatives, and agents; provided, however, the State gives the contractor prompt notice in writing of the claim. The contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the contractor has indemnified the State, the contractor shall at the contractor's sole cost and expense promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the contractor, and the State may receive the remedies provided under this RFP.

3. PERSONNEL

The contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the contractor.

VV. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept & Initial

Contractor shall review the Nebraska Technology Access Standards, found at http://www.nitc.nebraska.gov/standards/accessibility/accessibility_standards.pdf and ensure that products and/or services provided under the contract comply with the applicable standards. In the event such standards change during the contractor's performance, the State may create an amendment to the contract to request that contract comply with the changed standard at a cost mutually acceptable to the parties.

WW. ANTITRUST

The contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

Accept & Initial

XX. DISASTER RECOVERY/BACK UP PLAN

The contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under these specifications in the event of a disaster.

Accept & Initial

YY. TIME IS OF THE ESSENCE

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the contractor remaining to be performed.

Accept & Initial

ZZ. RECYCLING

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per state statute (Neb. Rev. Stat. §81-15, 159).

Accept & Initial

AAA. DRUG POLICY

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

Accept & Initial

BBB. NEW EMPLOYEE WORK ELIGIBILITY STATUS

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

Accept & Initial

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at www.das.state.ne.us.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

CCC. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept & Initial

The contractor, by signature to this RFP, certifies that the contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The contractor also agrees to include the above requirements in any and all subcontracts into which it enters. The contractor shall immediately notify the Department if, during the term of this contract, contractor becomes debarred. The Department may immediately terminate this contract by providing contractor written notice if contractor becomes debarred during the term of this contract.

IV. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder must provide the following requested information in response to this Request for Proposal.

A. PROJECT OVERVIEW

The State of Nebraska's Medicaid program, administered through the Department of Health and Human Services, Division of Medicaid & Long-Term Care (MLTC) is seeking proposals to develop a unique and visionary plan for a full-risk capitated Mental Health and Substance Use Disorder Managed Care program for Medicaid and Children's Health Insurance Program (CHIP) members. The program must be integrated and coordinated for multiple Medicaid/CHIP populations within the managed care structure, including but not limited to the developmental disabilities population, state wards, dually Medicare and Medicaid eligible population, and those with severe mental illness and substance abuse.

The purpose of this Request for Proposal (RFP) is to select, through a competitive procurement process, a qualified bidder to operate a pre-paid inpatient health plan (PIHP), as defined in 42 CFR 438.2. The PIHP will provide Mental Health and Substance Use Disorder services to children, youth, and adults enrolled in the Nebraska Medicaid/CHIP programs. The program will be referred to as the Nebraska Behavioral Health (BH) Managed Care program. A qualified vendor will meet the requirements for experience and expertise to perform the services as described throughout this document. MLTC will select one vendor for a statewide program that meets these requirements.

B. PRINCIPLES OF CARE

The following principles will guide the service delivery system to be developed for the Nebraska BH Managed Care program:

1. Services will be part of an overall coordinated System of Care that ensures access to Mental Health and Substance Use Disorder treatment services to improve the overall health of every person served. To the fullest extent possible, services should be provided in the community where the client lives;
2. Services will provide recovery-based care;
3. Services will be trauma informed;
4. Services will be responsive to linguistic, cultural and other unique needs of any client of a cultural, racial, sexual, gender, or linguistic minority, or other special populations;
5. Services will be person-centered, consumer and family driven, age and developmentally appropriate;
6. Medicaid substance use disorder services will be delivered in accord with the principles of recovery-oriented systems of care;
7. Clients will be able to choose their own provider to the fullest extent possible at all levels of treatment;
8. Services will provide a resiliency-based system of care for children and their families; and
9. Services will promote a service array consistent with the current SAMHSA "Guiding Principles or Recovery" http://www.samhsa.gov/newsroom/advisories/1112223420.aspx and the National Wraparound Initiative's "10 Principles of Wraparound." http://www.rtc.pdx.edu/PDF/TenPrincWAProcess.pdf

C. CONTRACTOR PRIMARY RESPONSIBILITIES

The Contractor shall:

1. Apply managed care practices in a manner that results in Medicaid/CHIP members having access to Mental Health and Substance Use Disorder services that:

- **a.** Are recovery oriented and are part of an overall coordinated system of care;
- **b.** Ensure provision of services that are person and family-centered, timely, developmentally appropriate, culturally relevant and evidence-based;
- **c.** Establish an extensive, accessible provider network that offers a choice of providers and a comprehensive array of services; and
- **d.** Are proactive in organizing and administering a delivery system that meets the behavioral health needs of Medicaid/CHIP members, adjusting operations as needed.

D. INCLUDED POPULATIONS

The following categories are eligible for this program:

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups;
2. Blind/Disabled Children, Adults, and Related Populations who are eligible for Medicaid due to blindness or disability;
3. Aged and Related Populations. Those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the 1931 Adult population;
4. Foster Care Children. Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement; and
5. Title XXI CHIP. An optional group of targeted low-income children who are eligible to participate in Medicaid in Nebraska.

E. EXCLUDED POPULATIONS

The following categories are excluded from this program:

1. Medicaid members for any period of retroactive eligibility;
2. Aliens who are eligible for Medicaid for an emergency condition only;
3. Members who have excess income or who are designated to have a Premium Due;
4. Members eligible during the period of presumptive eligibility;
5. Participants in an approved DHHS PACE program; and
6. Clients with Medicare coverage where Medicaid only pays co-insurance and deductibles.

F. COVERED SERVICES

The Contractor, through its network of qualified service providers shall deliver the following covered Medicaid/CHIP Mental Health and Substance Use Disorder services as described in Attachment A, Medicaid/CHIP Covered Services, in sufficient amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are delivered and to achieve the goals in the individualized treatment plan. The categories of Medicaid Covered Services are:

1. Crisis Stabilization Services;
2. Inpatient Services (Acute and Sub-Acute);
3. Residential Services;

4. Outpatient Assessment and Treatment;
5. Rehabilitation Services;
6. Support Services; and
7. Service Coverage.

The Contractor must provide the above services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition; The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

G. SUBSTITUTE OR VALUE-ADDED BEHAVIORAL HEALTH SERVICES

As permitted under 42 CFR 438.6e and to the extent consistent with provisions of State law, the Contractor shall, in its discretion, offer expanded substitute services and benefits to members in addition to those covered services specified above if such services are, in the judgment of the Contractor, medically appropriate and cost-effective. These expanded services may include behavioral health services which are currently non-covered services by the Nebraska Medicaid/CHIP State Plans and/or which are in excess of the amount, duration, and scope in the Nebraska Medicaid/CHIP State Plans.

These services/benefits shall be specifically defined by the Contractor in regard to amount, duration and scope. MLTC will not provide any additional reimbursement for these services /benefits. All substitute or value added services must support the principles of this initiative. Value added services or programs must align with other programs and services to complement and integrate formal and informal resources.

The Contractor shall provide MLTC a description of the expanded or modifications to Substitute Health or value added services/benefits to be offered by the Contractor for approval. Additions, deletions or modifications to Substitute Health or value added services made during the contract period must be submitted to MLTC for prior approval.

H. CONTRACTOR REQUIREMENTS

Contractor must have a minimum of five years' experience and demonstrated success in:

1. Provision of BH-MCO services with complex, publicly-funded Behavioral Health programs; and
2. PIHP, as defined in 42 CFR 438.2, for Mental Health and Substance Use Disorder services provided to children, youth, and adults.

I. THE CONTRACTOR SHALL DEMONSTRATE:

1. Substantial managed care experience and demonstrated success in operating or contracting with complex, publicly-funded behavioral health programs;
2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

a. Flexible, responsive customer service approach that is highly ingrained in the organization;

b. Cohesive, integrated management structure that allows for timely decisions, within a corporate framework that provides access to industry-leading tools, technology, expertise and oversight;

c. Responsive and reliable decision-making based on values consistent with the system delivery principles defined in this RFP;

d. Experience in establishing successful collaborative relationships with governmental customers in the delivery of an integrated system of care;

e. Resource management support necessary to recruit and retain highly-qualified staff;

f. Commitment to provide reinvestment and value added services to enhance behavioral health services;

g. Responsiveness to community needs and soliciting input from stakeholders;

h. Innovative approaches to improve outcomes for members;

i. Experience and success in service delivery to individuals with serious mental illnesses;

j. Experience in successful service delivery to children whose care is provided by multiple, integrated child-serving agencies, specifically experience with children who are Medicaid/CHIP eligible state wards;

k. Experience and successful development, support and monitoring of vertically integrated networks for behavioral health services provided to children, youth, families and adults; and

l. Experience and success in creative approaches to implementing the principles of recovery and resiliency, including evidence of an organizational culture that addresses the following elements:

- **i.** The design of services and supports;
- **ii.** Facilitates the development of consumer-operated programs and use of peer support;
- **iii.** Facilitates the development and use of natural supports;
- **iv.** Facilitates the use of self-management and relapse prevention skills,
- **v.** Supports stable housing;
- **vi.** Supports the development of healthy social networks and skills, employment or school performance;
- **vii.** Demonstrated success in implementing Practice Guidelines that promote an evidence-based culture through provider training, fidelity monitoring and best practices; and
- **viii.** Experience and demonstrated success in implementing program innovations that result in improved clinical outcomes including but not limited to, community tenure, physical/behavioral health integration and service delivery for co-occurring mental illness and substance use disorders and co-occurring mental health disorders and developmental disabilities.

m. A focus on continuous quality improvement with strategies that:

- **i.** Drive accountability and performance;
- **ii.** Contain valid, reliable metrics for outcome measurement;
- **iii.** Monitor the impact of clinical and other service decisions on the member;
- **iv.** Monitor member and provider satisfaction; and
- **v.** Provide adequate oversight of staff through initial orientation, ongoing training and formal clinical supervision to ensure that the skills of staff are consistent with best practices;

vi. Administrative efficiency through technology, including:

a) A supportive and responsive Information Technology (IT) department;
b) Automated systems for detection of suspected fraud and abuse;
c) Data-driven approaches to operationalizing Contract requirements;
d) Experience and demonstrated success in automated linkages to client information for transmission of large data files, such as timely , accurate transmission of encounter files;
e) Safeguards to protect the confidentiality of protected health information;
f) Technology supports that drive accurate, timely claims administration; and
g) Industry-leading reporting capabilities.

n. A proven track record of successful accountability for performance requirements under large, complex contracts, including:

i. Examples of successful achievement of performance thresholds on guarantees that embody the system principles outlined in this RFP; and
ii. The capability to update performance measures as industry standards and program requirements evolve.

J. BUSINESS REQUIREMENTS

1. REGULATION AND GUIDANCE

The Contractor must abide by all relevant provisions found in Chapter 42 of the Code of Federal Regulation (CFR), Part 438 Managed Care; Title 471 Nebraska Administrative Code (NAC) "Nebraska Medical Assistance Program Services"; and Title 482 Nebraska Administrative Code "Nebraska Medicaid Managed Care."

2. MANAGED CARE ORGANIZATION LICENSURE

The Prepaid Inpatient Health Plan (PIHP) must be licensed or certified by the State as a risk-bearing entity (i.e., Certificate of Authority for this behavioral health line of business approved by the Nebraska Department of Insurance for a HMO or Organized Delivery System) or meet the solvency standards established by the State for private health maintenance organizations per Nebraska Revised Statute 44-4701 et seq. The PIHP must make provisions, satisfactory to the Department of Health and Human Services and Department of Insurance, against the risk of insolvency pursuant to 42 CFR 438.116, assure that Medicaid/CHIP enrollees will not be liable for any of the PIHP's debts if it does become insolvent and agree to comply with the requirements outlined in 42 CFR 438.214.

Bidders who submit a proposal with a partnership of risk-bearing must provide a detailed description of how both entities meet the Managed Care Organization Licensure requirements. Bidders must also provide specifics of the relationship including designated functions of each entity, and how delegated functions will be overseen.

3. ACCREDITATION

The State requires the Contractor to have NCQA or another national certification (including URAC accreditation) at the time of proposal submission or become accredited by the end of contract year two. The national certification must be related to the specific functions of Managed Care entities. Bidders shall include specific information related to which national certification they possess including the time period for the current certification.

If the bidder is in the process of becoming accredited, specific information, including the work plan, timeline and critical milestones for plan accreditation must be submitted to MLTC at the time of proposal submission. The successful bidder that is not accredited at the time of contract award must show significant progress during the first and second years of the contract that results in full NCQA accreditation or another national certification by July 30, 2015.

4. REINSURANCE

The Contractor shall hold a Certificate of Authority from the Department of Insurance and file all contracts of reinsurance, or a summary of the plan of self-insurance as required.

All reinsurance agreements or summaries of plans of self-insurance shall be filed and shall remain in full force and effect for at least ninety (90) calendar days following written notice by registered mail of cancellation to either party to MLTC.

The Contractor shall maintain reinsurance agreements throughout the Contract period, including any extension(s) and/or renewal(s). The Contractor shall provide prior notification to MLTC of its intent to purchase or modify reinsurance protection for certain members.

The Contractor shall provide to MLTC the risk analysis, assumptions, cost estimates and rationale supporting its proposed reinsurance agreements for prior approval. If any reinsurance is provided through related parties, disclosure of the entities and details causing the related party relationship shall be specifically disclosed.

5. ACCESS TO RECORDS

a. INSPECTION AND AUDIT OF FINANCIAL RECORDS

The State and the Centers for Medicare and Medicaid Services (CMS) may inspect and audit any financial records of the Contractor or its Subcontractors without restriction on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of service and reasonable costs.

b. FEDERAL ACCESS TO RECORDS

The Contractor must allow federal agencies to require changes, remedies, changed conditions, access and records retention, suspension of work, and other clauses approved by the Office of Federal Procurement Policy. In addition, HHS-awarding agencies, the HHS Inspector General, the US Comptroller General, or any of their duly authorized representatives, have the right to timely and unrestricted access to any books, documents, papers, or other records of Contractor that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents.

6. ADVANCE DIRECTIVES

a. The Contractor must comply with the requirements of 422.128 for maintaining written policies and procedures for advance directives; and

b. In addition, the Contractor must provide adult enrollees with written information on advance directives policies and include a description of applicable NE law.

7. NOTICE OF PROVIDER TERMINATION

The Contractor must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

8. PROVIDER - ENROLLEE COMMUNICATION

a. ANTI-GAG CLAUSE

The Contractor shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient:

i. For the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii. For any information the enrollee needs in order to decide among all relevant treatment options;

iii. For the risks, benefits, and consequences of treatment or non-treatment; and

iv. For the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

b. MORAL OR RELIGIOUS OBJECTIONS

A Contractor that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service is not required to do so if the Contractor objects to the service on moral or religious grounds.

If the Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

i. To the State;

ii. With its application for a Medicaid contract;

iii. Whenever it adopts the policy during the term of the contract;

iv. Consistent with the provisions of 42 CFR 438.10;

v. To potential enrollees before and during enrollment; and

vi. To enrollees within 90 days after adopting the policy with respect to any particular service.

c. MARKETING ACTIVITIES

i. State Approval
The Contractor shall not distribute any marketing materials without first obtaining State approval. The Contractor must submit all marketing material to the State for approval prior to distribution.

ii. Informed Decision
The Contractor must provide assurances to the State that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud recipients or the State. Marketing materials cannot contain any assertion or statement (whether written or oral) that:

a) The member must enroll in the Contractor in order to obtain benefits or in order not to lose benefits; and
b) That the Contractor is endorsed by CMS, the Federal or State government or similar entity.

iii. Marketing Requirements Include the following:

a) That the Contractor distributes the materials to its entire service area;
b) That the Contractor does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and
c) That the Contractor does not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

9. ADMINISTRATION/STAFFING

The Contractor is responsible for maintaining a significant local (within the State of Nebraska) presence. Key positions that must be located in Nebraska are the following:

i. Administrator/CEO/COO;
ii. Chief Financial Officer (CFO);
iii. Medical Director/CMO;
iv. Corporate Compliance Officer;
v. Clinical Director/Manager;
vi. Operations Director/Manager;
vii. Grievance and Appeals System Director/Manager;
viii. Care Management/Utilization Review Director/Manager;
ix. Quality Management Director/Manager;
x. Network Services Director/Manager;
xi. Tribal Network Liaison; and
xii. Provider Network Liaison.

a. PROVIDER NETWORK LIAISON

The Contractor shall identify a Provider Network Liaison, who will be responsible for working collaboratively with the Provider Advisory Committee to establish methodologies for processing and responding to provider concerns; developing provider trainings in response to identified needs or changes in protocols, processes, and forms; and enhancing Contractor-provider communication strategies.

b. SUPPORTING STAFF

In addition to the Required Administrative Personnel, the Contractor shall have sufficient number of qualified supporting staff to meet the responsibilities of the Contract, including sufficient experience and expertise in working with the eligible Members served under the Contract to include but is not limited by the following:1) all children and youth, including those served by multiple child-serving agencies (child-welfare, office of juvenile services, schools, behavioral health) in, or at risk of, out of home placements; 2) adults with serious mental illness, addictive disorders and co-occurring disorders of serious mental illness and addictions.

c. HUMAN RESOURCES/STAFFING PLAN

The Contractor shall provide a Human Resources and Staffing Plan that describes how the Contractor will maintain the staffing level to ensure the successful accomplishment of all duties outlined in the contract. The Key Personnel and Required Personnel listed in the RFP are required. The Contractor may propose a staffing plan that combines positions and functions outlined in the RFP for other positions as long as the Contractor describes how the Table of Organization and staff roles delineated in the RFP will be addressed.

All personnel necessary to carry out the terms, conditions, and obligations of the contract are the responsibility of the Contractor. The Contractor shall recruit, hire, train, supervise and, if necessary, terminate such professional, paraprofessional and support personnel as are necessary to carry out the terms of the contract.

10. ADEQUATE CAPACITY

The Contractor shall submit documentation - upon entry into contract, when a change in operations occurs, change in services, benefits, service area or payment or enrollment of a new State population - to the State to demonstrate, in a format specified by the State, that it offers and maintains a/an:

a. Appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area; and

b. Network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

11. COMPLIANCE

The Contractor shall be responsible for compliance with all Contract requirements, regardless of whether the Contractor enters into a subcontract to delegate performance of the Contract requirements. Prior to selecting a subcontractor, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated. The Contractor shall monitor and formally review a subcontractor's performance on an ongoing basis.

12. CLINICAL LABORATORY IMPROVEMENT AMENDMENT

In compliance with the Clinical Laboratory Improvement Amendment (CLIA) of 1988 and the requirements of 42 CFR §493, Subpart A., MLTC requires all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in either a termination of an active provider ID number or denial of initial registration. These requirements apply to all clinical laboratories. Pass-through billing or other similar activities with the intent of

avoiding the above requirements are prohibited. The Subcontractor may not reimburse providers who do not comply with the above requirements.

13. FRAUD, ABUSE AND WASTE

a. The Contractor must report fraud and abuse information to MLTC;

b. The Contractor shall confirm that its officers understand that the Contract includes the receipt by the Contractor of State and Federal funds. Further, the Contractor shall confirm that its officers understand that they are subject to criminal prosecution, civil action, or administrative actions for any intentional false statements or other fraudulent conduct related to their obligations under the Contract; and

c. The Contractor shall submit its written Fraud and Abuse Compliance Plan to MLTC during the implementation period process for approval and annually thereafter by June 30 each year. Requests for revision(s) to the Plan shall be submitted in writing to and approved in writing by MLTC at least thirty (30) days prior to implementation of such revision(s). The Fraud and Abuse Compliance Plan shall include, but not limited to, the following:

- **i.** A description of the methodology and standard operating procedures used to identify and investigate Fraud and Abuse, and to recover overpayments or otherwise sanction Providers;
- **ii.** A description of specific controls in place for Fraud and Abuse detection, including an explanation of the technology used to identify aberrant billing patterns, Claims edits, post processing review of Claims, and record reviews;
- **iii.** A Fraud and Abuse unit within the organization comprised of experienced Fraud and Abuse reviewers. This unit shall have the primary purpose of preventing, detecting, investigating, and reporting suspected Fraud and Abuse that may be committed by Network Providers, Members, employees, or other third parties with whom the Contractor contracts;
- **iv.** The designation of a Compliance Officer and a Compliance Committee that is accountable to senior management and for requirements for an adequately staffed compliance office;
- **v.** Evidence of completed, effective education for the Compliance Officer and the organization's employees; Contractor providers and Members about fraud and abuse and how to report it;
- **vi.** Effective lines of communication between the compliance officer and the Contractor employees, Contractors, providers and MLTC and/or its designee; and
- **vii.** The Contractor shall maintain a toll-free Provider Compliance Hotline number and ensure that the number and an accompanying explanatory statement for use are distributed to its Members and Providers through its Member and Provider handbooks.

d. The Contractor shall have administrative and management policies and procedures that are designed to prevent, reduce, detect, correct and report known or suspected fraud, abuse, and waste in accordance with the requirements specified in the contract. These written policies, procedures and standards of conduct shall articulate the Contractor's commitment to comply with all applicable federal and state standards and regulations to include the following:

i. Enforcement of standards through well-publicized disciplinary guidelines (e.g., Member/provider manuals, trainings, or newsletters, bulletins);

ii. Provisions for internal monitoring and auditing of the Contractor's providers, Subcontractors, employees, and others;

iii. Provision for prompt response to detected offenses and for development of corrective action initiatives relating to the Contract; and

iv. Procedures for timely and consistent exchange of information and collaboration with MLTC-Program Integrity , Attorney General Medicaid Fraud Control Unit (MFCU), and contracted EQRO regarding suspected fraud and abuse occurrences.

e. The Contractor shall establish written policies for all employees (including management), and any Subcontractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers.

f. The Contractor shall establish a policy for referral of suspected Fraud and Abuse to the MLTC Program Integrity. A standardized referral process will be developed to expedite information for appropriate disposition. At a minimum, the Contractor shall report the number of complaints of fraud and abuse made to the State that warrant preliminary investigation. For each complaint which warrants investigation, supply the name and identification number, source of the complaint, type of provider, nature of complaint, approximate dollars involved, and legal and administrative disposition of the case.

g. The Contractor's Fraud and Abuse policies and procedures shall provide and certify that the Contractor's Fraud and Abuse unit has access to records of providers. These policies along with the designation of the compliance officer and committee shall be submitted to MLTC for approval during the implementation period and then thirty (30) days prior to whenever material changes occur. The Contractor's submission of new or revised policies and procedures for review and approval by MLTC shall not act to void any existing policies and procedures which have been prior approved by MLTC for operation. Unless otherwise required by law, the Contractor may continue to operate under such existing policies and procedures until such time as MLTC approves the new or revised version thereof. The Contractor shall develop a certification process that demonstrates the policies and procedures were reviewed and approved by the Contractor's senior management. The Contractor shall, in order to remain in compliance with the Agreement, comply with its Fraud and Abuse policies and procedures.

h. The Contractor shall create and disseminate written materials for the purpose of educating employees, managers, providers, subcontracts and subcontracts' employees about health care Fraud laws, the Contractor's policies and procedures for preventing and detecting Fraud and Abuse and the rights of employees to act as whistleblowers. The Contractor's education shall comply with all requirements of 1902(a) (68) Employee Education About False Claims Recovery.

i. The Contractor will require that all providers and all subcontracts take such actions as are necessary to permit the Contractor to comply with the Fraud and Abuse requirements listed in the Contract, as well as all Federal and State

requirements. To the extent that the Contractor delegates oversight responsibilities to a third party, the Contractor shall require that such third party complies with provisions above, of the Contract relating to Fraud and Abuse. Although all providers with whom the Contractor subcontracts are enrolled in the program and subject to regulations, the Contractor agrees to require, via contract, that such providers comply with regulations and any enforcement actions directly initiated by MLTC under its regulations, including but not limited to, termination and restitution.

j. The Contractor and its employees shall cooperate fully with centralized oversight agencies responsible for Fraud and Abuse detection and prosecution activities. Such cooperation shall include providing access to all necessary case information, computer files, and appropriate staff. In addition, such cooperation may include participating in periodic Fraud and Abuse training sessions, meetings, and joint reviews of subcontracted Providers or Members.

k. The Contractor shall immediately report to MLTC any suspicion or knowledge of fraud and abuse including, but not limited to, the false or fraudulent filings of claims and the acceptance of or failure to return reimbursement for claims known to be fraudulent.

l. The Contractor must report the following to the State:

- **i.** Number of complaints of fraud and abuse made to State that warrant preliminary investigation
- **ii.** For each which warrants investigation, supply the:
  - **a)** Name.ID number;
  - **b)** Source of complaint;
  - **c)** Type of provider;
  - **d)** Nature of complaint;
  - **e)** Approximate dollars involved; and
  - **f)** Legal & administrative disposition of the case.

m. MLTC will seek all appropriate remedies for fraud, abuse and violation of law if it determines that a Contractor, provider, employee, or subcontractor has committed “Fraud” or “Abuse” as defined in this Agreement or has otherwise violated applicable law.

n. Prohibited affiliations with Individuals Debarred by Federal Agencies. General requirement. The Contractor may not knowingly have a relationship with the following:

- **i.** An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.; or
- **ii.** An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1).

K. MEMBER RIGHTS AND RESPONSIBILITIES

1. MEMBER SERVICES

a. MEMBER RIGHTS

The Contractor shall fully inform behavioral health recipients and family members about their rights and responsibilities and how to exercise them upon enrollment. The Contractor shall comply with any applicable Federal and State requirements that relate to member rights and require its staff and contracted providers to comply with the above requirements when delivering services to NE BH recipients and their families. The Contractor shall comply with all other applicable Federal and State laws such as: Title VI of the Civil Rights Act of 1964, 42 CFR 438.100; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act and other laws regarding privacy and confidentiality.

The Contractor must comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

b. WRITTEN POLICIES

The Contractor shall develop and implement written policies to protect and enforce member rights.

c. MEMBER COMMUNICATION

The Contractor must have in place a mechanism to assist members to understand the requirements and benefits of the plan. All notices, informational materials, and instructional materials relating to members must be provided in a manner and format that is easily understood. Notices, informational materials, and instructional materials relating to members must be provided at the 6th grade level. This would include a score of up to 6.9 on the Flesh-Kincaid reading level.

d. LANGUAGE REQUIREMENTS

The Contractor must make its written information available in the prevalent non-English languages in its particular service area. The State will establish a methodology for identifying the prevalent non-English languages spoken by members and potential members and provide the information to the Contractor. Currently, the prevalent non-English language identified is Spanish. The Contractor must make its written information available in any additional non-English languages identified by the State during the term of the contract.

In addition, written material must use easily understood language and format. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

e. INTERPRETER SERVICES

The Contractor must make oral interpretation services available free of charge to each member. This applies to all non-English languages not just those that the State identifies as prevalent. The Contractor must notify its members that oral interpretation is available for any language, that written information is available in prevalent non-English languages, and how to access those services.

f. REQUIRED INFORMATION TO MEMBERS

The Contractor shall furnish the information as specified in this section to each of its members or member households within a reasonable time but no more than 30 calendar days after the Contractor receives notice of the member's enrollment. The Contractor shall also provide each member or member household written notice of any change (that the State defines as "significant") in the information specified in this section at least 30 days before the intended effective date of the change.

i. A Provider Directory containing names, locations, telephone numbers, and non-English languages spoken by current contracted providers in the member's service area. This must include identification of providers that are not accepting new patients. The Provider Directory must be available on-line as well as in paper format. The on-line Directory must be updated monthly and the paper formats no less than quarterly.

ii. Any restrictions on the member's freedom of choice among network providers.

iii. Member rights and protections including grievances, appeals and State Fair Hearing procedures and timeframes.

iv. The amount, duration and scope of benefits available under the contract to ensure that members understand the benefits to which they are entitled as required in 42 CFR 438.10(b)(3) and 42 CFR 438.10(f – h).

v. Procedures for obtaining benefits, including authorization requirements.

vi. How after-hours and emergency coverage are provided, including what constitutes an emergency behavioral health medical condition, services, and post stabilization services, with reference to the definitions contained herein and the following:

a) The fact that prior authorization is not required for emergency services;

b) The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; and

c) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract.

vii. The fact that, subject to the provisions of this section, the enrollee has the right to use any hospital or other setting for emergency care.

a) The post stabilization care services rules set forth as defined in 42 CFR 422.113(c);

b) Policy referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;

c) How and where to access any benefits that are available under the State Plan but are not covered under the contract, including any cost sharing, and how transportation is provided for those State Plan services; and

d) For a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.

g. MEMBER HANDBOOK

i. The Contractor shall comply with the following requirements:

a) The Contractor shall develop and distribute a Member Handbook in both English and Spanish;

b) The Contractor shall provide the Member Handbook for MLTC review prior to publishing;

c) The Contractor shall distribute the Member Handbook to each new enrollee within thirty (30) days of enrollment;

d) The Contractor shall publish the Member Handbook on the Contractor's website;

e) Unless otherwise instructed by MLTC, the Contractor shall distribute the Member Handbook to enrollees in care at least thirty (30) days prior to the Contract Start Date; and

f) At a minimum, the Contractor shall review and update the Member Handbook annually. The Contractor shall submit the updated Member Handbook to MLTC within 30 days of receiving changes made to the Member Handbook Template. The Contractor's updated Member Handbook must be made available to all enrollees on an annual basis. If the Contractor makes changes to the Member Handbook at a time other than the annual update, the Contractor shall timely distribute the updated Member Handbook to each enrollee and include documentation of the Handbook's distribution in the enrollee's medical record.

h. NOTICE OF PROVIDER TERMINATION

i. The Contractor shall make a good faith effort to provide written notice to any member who is actively receiving services from a provider that has been terminated from the network 15 days after issuance of the provider termination notice.

i. GRIEVANCE, COMPLAINTS AND APPEALS

i. Service Authorizations and Notices of Action

a) Service Authorization

The Contractor must provide a definition of service authorization that, at least, includes the member's request for the provision of a service.

b) Service Authorization Process
The Contractor must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

c) Notice of Adverse Action for Service Authorizations
The Contractor must notify the requesting provider, and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404.

d) Notice of Adverse Action
The Contractor must give the member written notice of any action (not just service authorization actions) within the timeframes for each type of action.

e) Notice of Adverse Action – Content
The notice must explain:

1). The action the Contractor or its Contractor has taken or intends to take;
2). The reasons for the action;
3). The member's or the provider's right to file an appeal;
4). The member's right to request a State Fair Hearing;
5). Procedures for exercising member's rights to appeal or grieve;
6). Circumstances under which expedited resolution is available and how to request it; and
7). The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

f) Notice of Adverse Action – Language and Format
The notice must be in writing and must meet the language and format requirements described in the contract.

ii. Timeframes for Notice of Action

a) Timeframes for Notice of Action Termination, Suspension, or Reduction of Services
The Contractor must provide notice at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services. The period of advanced notice is shortened to 5 days if probable member fraud has been verified. The Contractor must give notice by the date of the action for the following circumstances:

1). In the death of a member;

2). A signed written member statement requesting service termination or giving information requiring termination or reduction of services (where he or she understands that this must be the result of supplying that information);

3). The member's admission to an institution where he or she is ineligible for further services; and

4). The member's address is unknown and mail directed to him or she has no forwarding address.

b) Timeframes for Notice of Action – Denial of Payment
The Contractor must provide notice on the date of action when the action is a denial of payment.

c) Timeframes for Notice of Action – Standard Service Authorization Denial
The Contractor must give notice as expeditiously as the member's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service. Timeframe may be extended up to 14 additional calendar days if the member or the provider requests an extension or the Contractor justifies a need for additional information and how the extension is in the member's interest.

If the Contractor extends the timeframe, the member must be provided written notice of the reason for the decision to extend the timeframe and the right to file an appeal if he or she disagrees with that decision. The Contractor must issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

d) Timeframes for Notice of Action – Expedited Service Authorization Denial
For cases in which a provider indicates or the Contractor determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) working days after receipt of the request for service. The Contractor may extend the time period by up to 14 calendar days if the member requests an extension or if the Contractor justifies a need for additional information and how the extension is in the member's interest.

e) Timeframes for Notice of Action – Untimely Service Authorization Decisions
The Contractor must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited

service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

iii. General Requirements of Grievance Systems

a) The Contractor must have a grievance system for members that meet all regulation requirements, including a grievance process, an appeal process, and access to the State's fair hearing system. The Contractor must distinguish between grievance system, grievance process, and a grievance:

1). A grievance is a member's expression of dissatisfaction with any aspect of care other than the appeal of actions, which is considered an appeal;
2). The grievance system includes a grievance process, an appeal process, and access to the State's fair hearing system. Any grievance system requirements apply to all three components of the grievance system not just to the grievance process; and
3). A grievance process is the procedure for addressing member's grievances.

b) The Contractor must:

1). Give members any reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability;
2). Acknowledge receipt of each grievance and appeal; and
3). Ensure that individuals completing review of grievances and appeals are not the same individuals involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the member's condition or disease if any of the following apply:

i) A denial appeal based on lack of medical necessity;
ii) A grievance regarding denial of expedited resolutions of an appeal; and/or
iii) Any grievance or appeal involving clinical issues.

iv. Information to Providers and Subcontractors
The Contractor must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and Subcontractors at the time of entering into a contract:

a) The member's right to a State Fair Hearing, how to obtain a hearing and representation rules at a hearing;
b) The member's right to file grievances and appeals and the requirements and timeframes for filing;
c) The availability of assistance in filing grievances and appeals;
d) The toll-free numbers to file oral grievances and appeals;

e) The member's right to request continuation of benefits during an appeal or State Fair Hearing filing and, if the Contractor action is upheld in a hearing, that the member may be liable for the cost of any continued benefits; and

f) Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

v. Grievance System – Record Keeping and Reporting
The Contractor must:

a) Maintain records of grievances and appeals; and

b) Submit to the State quarterly data, specified by the State, on grievances and appeals which enables the State to measure the Contractor's performance.

vi. Appeal Process

a) Appeal Process – Authority to File
A member may file a Contractor-level appeal. A provider, acting on behalf of the member and with the member's written consent, may file an appeal.

b) Appeal Process – Timing
The member or provider may file an appeal within 90 days from the date on the Contractor's Notice of Action.

c) Appeal Process – Authority to File
The member or provider may file an appeal either orally or in writing and must follow an oral filing with a written, signed, appeal.

d) Appeal Process – Procedures
The Contractor must:

1). Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the member or the provider requests expedited resolution;

2). Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;

3). Allow the member and representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records; and

4). Consider the member, representative, or estate representative of a deceased member as parties to the appeal.

e) Appeal Process – Resolution and Notification

1). The Contractor must:

i) Resolve each appeal;
ii) Provide notice, as expeditiously as the member's health condition requires, within 45 days from the day the Contractor receives the appeal;
iii) The Contractor may extend the timeframes by up to fourteen (14) calendar days if the member requests the extension or the Contractor shows that there is need for additional information and how the delay is in the member's interest; and
iv) For any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay.

f) Appeal Process – Format and Content of Resolution Notice
The Contractor must provide written notice of disposition. The written resolution notice must include:

1). The results and date of the appeal resolution for decisions not wholly in the member's favor;
2). The right to request a State Fair Hearing;
3). How to request a State Fair Hearing;
4). The right to continue to receive benefits pending a hearing;
5). How to request the continuation of benefits; and
6). If the Contractor action is upheld in a hearing, that the member may be liable for the cost of any continued benefits.

vii. State Fair Hearing

a) Requirements for State Fair Hearings
The Contractor shall comply with all requirements as outlined in the contract and by MLTC.

1). Availability. If the Member has exhausted the Contractor level appeal procedures, the Member may request a State Fair Hearing within ninety (90) days from the date of the Contractor's notice of resolution;
2). Parties. The parties to the State Fair Hearing include the Contractor, as well as the Member and his or her representative or the representative of a deceased Member's estate;
3). Notification of the right to State Fair Hearing. The Contractor shall inform the Member of their right to seek a State Fair Hearing if the Member is not satisfied with the Contractor's decision in response to an appeal;

4). Authority to File. A member may request a State Fair Hearing. The provider may request a State Fair Hearing if the provider is acting as the member's authorized representative. A member or provider may request a State Fair Hearing at the same time a Contractor appeal is filed.

5). A Member may file a grievance and a Contractor level appeal, and may request a State Fair Hearing, once the Contractor's appeals process has been exhausted;

6). A network provider, acting on behalf of the Member and with the Member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a Member; and

7). The Contractor shall not create barriers to timely due process. The Contractor shall be subject to sanctions if it is determined by the State that the Contractor has created barriers to timely due process, and/or, if 10% or more of appeals decisions appealed to a State Fair Hearing level within a twelve (12) month period have been reversed, or otherwise resolved, in favor of the Member. Examples of creating barriers shall include, but not be limited to:

i) Including binding arbitration clauses in Contractor Member choice forms;
ii) Labeling appeals as inquiries or complaints and funneling into an informal review;
iii) Failing to inform Members of their due process rights;
iv) Failing to log and process grievances and appeals;
v) Failure to issue a proper notice, including vague or illegible notices;
vi) Failure to inform of continuation of benefits; or
vii) Failure to inform of right to State Fair Hearing.

viii. Appeal and State Fair Hearing Process – Continuation of Benefits

a) The Contractor must continue the member's benefits if: The appeal is filed timely, meaning on or before the later of the following:

1). Within ten (10) days of the Contractor mailing the Notice of Action; and

2). The intended effective date of the Contractor proposed action.

i) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
ii) The services were ordered by an authorized provider;
iii) The authorization period has not expired; and
iv) The member requests extension of benefits.

ix. Appeal and State Fair Hearing Process – Duration of Continued or Reinstated Benefits must be continued until one of the following occurs:

a) The member withdraws the appeal;
b) The member does not request a fair hearing within 10 days from when the Contractor mails an adverse Contractor decision;
c) A State Fair Hearing decision adverse to the member is made; or
d) The authorization expires or authorization service limits are met.

x. Appeal and State Fair Hearing Process – Member Responsibility for Services Furnished While the Appeal is Pending
The Contractor may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the Contractor action.

xi. Appeal and State Fair Hearing Process – Effectuation When Services Were Not Furnished While Appeal was Pending
The Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires if the services were not furnished while the appeal is pending and the Contractor or the hearing decision reverses a decision to deny, limit, or delay services.

xii. Appeal and State Fair Hearing Process – Effectuation When Services Were Furnished While Appeal Was Pending
The Contractor must pay for disputed services if the Contractor or State Fair Hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.

xiii. Expedited Appeals Process

a) Expedited Appeals Process – General
The Contractor must establish and maintain an expedited review process for appeals when the Contractor determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard appeal regulations for expedited requests except where differences are specifically noted in the regulation for expedited resolution.

b) Expedited Appeals Process – Authority to File
The member or provider may file an expedited appeal either orally or writing. No additional member follow-up is required.

c) Expedited Appeals Process – Procedures
The Contractor must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

d) Expedited Appeal Process – Resolution and Notification
The Contractor must resolve each expedited appeal and provide notice, as expeditiously as the member's health condition requires, within three (3) working days after the Contractor receives the appeal. The Contractor may extend the timeframes by up to fourteen (14) calendar days if the member requests the extension or the Contractor shows that there is need for additional information and how the delay is in the member's interest.

e) Requirements Following Extension
For any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay.

f) Expedited Appeal Process – Format of Resolution Notice
In addition to written notice, the Contractor must also make reasonable efforts to provide oral notice of resolution.

g) Expedited Appeal Process – Punitive Action
The Contractor must ensure that no punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal.

h) Expedited Appeal Process – Action Following Denial of a Request for Expedited Resolution
If the Contractor denies a request for expedited resolution of an appeal, it must:

1). Transfer the appeal to the standard timeframe of no longer than forty-five (45) days from the day the Contractor receives the appeal with a possible fourteen (14) day extension; and

2). Make reasonable effort to give the member prompt oral notice of the denial and a written notice within two (2) calendar days.

xiv. Access to State Fair Hearing

a) State Fair Hearing Process – Contractor Notification of State Procedures
If the Contractor takes action and the member requests a State Fair Hearing, the State (not the Contractor) must grant the member a State Fair Hearing. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member and provider by the Contractor.

b) State Fair Hearing Process – Authority to File
A member may request a State Fair Hearing. The provider may request a State Fair Hearing if the provider is acting as the member's authorized representative. A member or provider may request a State Fair Hearing at the same time a Contractor appeal is filed.

c) State Fair Hearing - Timing
The member or provider may request a State Fair Hearing within 90 days from the date on the Contractor Notice of Action.

d) State Fair Hearing – Resolution
The State must reach its decisions within the specified timeframes:

1). Standard resolution: within ninety (90) days of the date the member filed the appeal with the Contractor if the member filed initially with the Contractor (excluding the days the member took to subsequently file for a State Fair Hearing) or the date the member filed for direct access to a State Fair Hearing; and

2). Expedited resolution (if the appeal was heard first through the Contractor appeal process): within three (3) working days from agency receipt of a hearing request for a denial of a service that:

i) Meets the criteria for an expedited appeal process, but was not resolved using the Contractor expedited appeal timeframes;
ii) Was resolved wholly or partially adversely to the member using the Contractor expedited appeal timeframes; and
iii) Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the Contractor appeal process) within three (3) working days from agency receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

e) State Fair Hearing – Parties
The parties to the State Fair Hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate.

f) State Fair Hearing – Disenrollment Requests
The State ensures that any member dissatisfied with a State agency determination denying a member's request to transfer plans/disenroll is given access to a State Fair Hearing.

xv. Grievance Process

a) Grievance Process – Procedures
The member is allowed to file a grievance (complaint) with the Contractor or with the State. The Contractor shall notify MLTC of all member and provider grievances and complaints within one working day of receipt. The Contractor shall notify MLTC on the findings regarding the complaint and the proposed resolution prior to notifying the member or provider. The Contractor shall track the types of grievances and complaints and report quarterly to MLTC.

b) Grievance Process – Authority to File
A member may file a grievance either orally or in writing. A provider may file a grievance when acting as the member's authorized representative.

c) Grievance Process – Disposition and Notification
The Contractor must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes, not to exceed ninety (90) days from the day the Contractor receives the grievance.

d) Grievance Process – Format of Disposition Notice
The State will establish the method the Contractor will use to notify a member of the disposition of a grievance.

L. PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT

The Contractor shall establish, operate and manage a behavioral health Provider Network to deliver Covered Services and meet the behavioral health needs of Members. The Contractor shall assure timely access for all Members to the full range of Covered Services. The Contractor shall have a sufficient number of network management staff to carry out the functions required in the contract, including staff for network development, contracting, provider relations, network reporting and overall network management.

1. ESTABLISHING THE NETWORK

As of the contract start date, the Contractor shall have in effect and maintain a network of qualified providers for the delivery of Covered Services, in accordance with the terms of the contract. The Contractor shall:

a. Establish a Provider Network of qualified service providers to respond to referrals for immediate, urgent, and routine needs within the following appointment access standards:

- **i.** Emergent appointments within one hour of request, other than in rural areas designated by MLTC, where the standard is two hours;
- **ii.** Urgent appointments within forty-eight (48) hours of referral; and
- **iii.** Routine appointments within fourteen (14) calendar days.

b. Have a fully operational network of crisis response providers available twenty-four (24) hours per day, seven (7) days per week as of the contract start date.

c. In establishing the Provider Network, consider the following:

- **i.** The anticipated enrollment of Members;
- **ii.** The expected utilization of services, taking into consideration the characteristics and health care needs of specific populations enrolled with the Contractor;
- **iii.** The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the Covered Services;
- **iv.** The numbers of network providers who are not accepting new Members;
- **v.** The geographic location of network providers and Members considering distance, travel time, the means and availability of transportation

ordinarily used by Members, and whether each service location provides physical access for Members with disabilities; and

vi. Transitioning the current NE behavioral health provider network to your BH MCO for the contract.

d. Ensure that the Provider Network includes sufficient numbers of network providers with experience and expertise regarding the following behavioral health conditions:

i. Co-occurring mental health and substance use disorders;
ii. Co-occurring mental health and substance use disorders and developmental disabilities;
iii. Serious and persistent mental illness;
iv. Trauma-informed care and trauma-specific treatment (e.g., Trauma-Focused Cognitive Behavioral Therapy), including expertise in care for post-traumatic stress disorder and trauma-related disorders more broadly, for all enrollees;
v. Severe emotional disturbance (SED) among children and adolescents, including coordinated care for children served by multiple state agencies (e.g., child welfare, juvenile justice, developmental disabilities, etc.);
vi. Sex-offending behaviors;
vii. Eating disorders; and
viii. Co-occurring serious mental illness and common chronic physical illnesses.

e. Ensure that the Provider Network includes sufficient numbers of network with the needed experience and expertise to serve all behavioral health clinical populations and diagnoses currently covered by Nebraska's Medicaid program.

i. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

f. Comply with Indian Health Protections: In accordance with Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5, Medicaid Managed Care Organizations (MCOs) must:

i. Permit any Indian who is enrolled in a non-Indian MCO and eligible to receive services from a participating Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the service;
ii. Demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers; and
iii. Provide I/T/U providers, whether participating in the network or not, payment for services in the Basic Benefits package provided to Indian enrollees who are eligible to receive services from such providers either:

a) At a rate negotiated between the MCO and the I/T/U provider; or

b) If there is not negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and

c) Make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR sections 447.45 and 447.46.

g. The Contractor shall make good faith efforts to ensure that all network providers from the current behavioral health Medicaid ASO Contractor, that meet credentialing requirements, participate in the Contractor's Provider Network and either develop or renew service contracts prior to the contract start date;

h. Provide coverage in accordance with access standards set forth in this RFP;

i. The Contractor shall ensure that it promotes the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds;

j. Establish a Provider Advisory Committee representative of contracted providers throughout the state, including all levels of care, to advise the Contractor on provider network operations; and

k. The Contractor shall submit to MLTC for its review and approval a list of initial provider network agreements. Such documentation shall include a listing of fully executed subcontracts as well as submitted, but not yet approved, provider applications. This information shall be included in the implementation plan and be submitted no less than monthly between Letter of Intent to Contract and contract start date.

2. PROVIDER CREDENTIALING

The Contractor's credentialing criteria for providers shall be consistent with the criteria included in the State and Federal regulations, the NE Medicaid State Plan and the applicable waivers.

a. The Contractor shall implement written policies and procedures that comply with the MLTC requirements, NE State law and those set forth below regarding the selection, retention, and exclusion of providers from the Provider Network in compliance with 42 CFR 438.214 (a) (b)(1 & 2). Such written policies and procedures shall, at a minimum:

i. Require network providers to meet credentialing criteria approved by MLTC, unless the Contractor establishes that such criteria should be waived pursuant to the section of this document entitled "Credentialing Waiver Process" below;

ii. Maintain appropriate, documented processes for the credentialing and re-credentialing of providers who participate in the Contractor's Provider Network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant state regulations that may pertain. The Contractor should collaborate with the Provider Advisory Committee in developing these processes. The basic components of these processes shall include the following:

a) Record of continuing professional education;
b) Medicare, Medicaid, federal tax identification number, and Social Security numbers;
c) Location service area and telephone numbers of all offices, hours of operation, and provisions for emergency care and backup;
d) Areas of special experience, skills and training;
e) Cultural and linguistic capabilities;
f) Review of Member satisfaction and any complaints made or grievances filed against the network provider within the past two years;
g) Physical accessibility for persons with disabilities;
h) Reference checks;
i) Criminal history, child and adult abuse data base, sex offender registry;
j) For facility-based network providers, a site visit and evidence of a training program for staff, collaboratively developed with providers, on the appropriate and safe use of restraint and seclusion; and
k) For network providers of 24-hour services, evidence of a training program for staff on the appropriate and safe use of restraint and seclusion.

iii. Ensure that all facility providers are credentialed prior to becoming network providers and that a site visit is conducted with recognized managed care industry standards such as those provided by the NCQA and relevant state regulations;

iv. Ensure that network providers are recredentialed every three years, at a minimum, taking into consideration various forms of data, including but not limited to, grievances, results of quality reviews, results of Member satisfaction surveys, and utilization management information;

v. Ensure that the credentialing process does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, as well as providers that serve cultural and linguistic minority populations;

vi. The Contractor shall check the U.S. Department of Health and Human Services Office of the Inspector General's (OIG) List of Excluded Individual Entities (LEIE) found at: http://www.oig.hhs.gov/exclusions/exclusions_list.asp, as well as Medicare Exclusion Database (MED) websites before the Contractor contracts with a provider to become part of its Provider Network, at the time of a provider's credentialing and recredentialing, and at least monthly.;

vii. As applicable, the Contractor shall notify a network provider within three business days that, due to its NE Medicaid, Medicare, or another state's Medicaid program termination or suspension or a state or federal licensing action, such network provider is terminated or suspended, as appropriate, from the Contractor's Provider Network, and is no longer eligible to treat Members. The Contractor shall have a process in place to immediately effectuate such termination or suspension;

viii. When the Contractor terminates, suspends, or rejects a network provider from its network based on such provider's termination or suspension with NE Medicaid, Medicare, or another state's Medicaid

program, a state or federal licensing action, or based on any other independent action, the Contractor shall notify MLTC of the network provider termination, suspension or rejection within three business days;

ix. This section does not preclude the Contractor from suspending or terminating network providers for cause prior to such network provider's ultimate suspension and/or termination by MLTC from participation in NE Medicaid;

x. Not contract with a provider, or otherwise pay for any items or services furnished, directed or prescribed by a provider that has been excluded from participation in federal health care programs by the OIG under either section 1128 or section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR 1001.1801 and 1001.1901;

xi. Ensure that no network provider engages in any practice with respect to any Member that constitutes unlawful discrimination under any other state or federal law or regulation, including but not limited to, practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90;

xii. Notify MLTC when a network provider fails credentialing or re-credentialing due to breach of program integrity, and/or any of the reasons described in this section ("Credentialing Process") of the contract. Provide the information required by MLTC or state or federal laws, rules, or regulations; and

xiii. Provide annual attestation that all network providers within the Contractor's Provider Network are credentialed according to the contract.

3. NETWORK PROVIDER QUALIFICATIONS

a. The Contractor shall execute provider contracts or enter into other arrangements for the provision of Covered Services individual practitioners and organizational providers. Individual practitioners who may practice only under supervision under the scope of their license must demonstrate adequate supervisory oversight, in accord with the practice requirements of their license.

i. All providers shall meet the following credentialing criteria:

a) Meet educational degree requirements;

b) Conform to all applicable licensing, certification, or other professional standards as set forth in applicable state and federal laws and regulations;

c) Hold a current, valid, unrestricted license to practice the practitioner's profession in the State of Nebraska;

d) Enrolled as a Medicaid provider;

e) Demonstrate that any suit, claim, proceeding, or disciplinary action that occurred in the previous five years involving mental health or substance use disorder services has either been resolved without adverse findings or has been addressed so that the Contractor is assured services will be of acceptable quality;

f) Meet requirements of the credentialing application process, including but not limited to site visits and being able to demonstrate age- and population-appropriate activities,

privileges, and restrictions for all defined specialty population units/programs, unless the Contractor establishes that such criteria should be waived pursuant to this section;

g) Have in place professional liability insurance;

h) Comply with policies and regulations with respect to Member rights and privileges as applicable; and

i) Maintain records consistent with current professional standards and Medicaid regulations, as well as systems for accurately documenting the following included, but not limited to, information for each Member receiving Covered Services:

1). Demographic information;
2). Clinical history;
3). Behavioral health clinical assessments; including Trauma History;
4). Treatment plans;
5). Services provided;
6). Contacts with Members' family, guardians, or significant others;
7). Tracking of treatment outcomes; and
8). Trauma history.

j) Satisfy all federal and state requirements regarding the provider's physical plant and premises;

k) Comply with all applicable anti-discrimination requirements described in 42 CFR 438.6(d) (3) and (4);

l) Comply with all other applicable state and federal laws; and

m) Have been credentialed pursuant to the policies and procedures specified in the Contract.

b. The Contractor shall execute provider contracts or enter into other arrangements for the provision of Covered Services with licensed organizations that satisfy the following additional criteria:

i. Are financially stable, as determined by the Contractor;

ii. Have established and maintain a quality management program, which maintains the essential elements of such programs, as described in the "Quality Management" section of the contract. As an alternative, providers with fewer than 10 full time staff can develop quality management programs in partnership with other providers or can develop enhanced oversight through the Contractor's quality management program to ensure ongoing quality improvement;

iii. Are responsive to linguistic, cultural and other unique needs of any member of a cultural, racial, sexual, gender, or linguistic minority, or other special population in the region in which they provide services;

iv. Have adequate capacity within the network to communicate with Members in Spanish and other languages besides English, when necessary, as well as with those who are deaf, hard of hearing, or hearing-impaired; and

v. Ensure that those facility-based network providers, that are also network providers of inpatient services, comply with the aforementioned contractual terms requirements, as well as the following terms:

a) Comply with Nebraska statutes and CMS regulations concerning restraint and seclusion; and

b) Submit to the Contractor evidence of implementation of training programs associated with appropriate use of seclusion and restraints, as well as other consumer/patient protections as part of the credentialing and recredentialing process.

4. CREDENTIALING WAIVER PROCESS

a. The Contractor shall:

i. Develop a proposal for a credentialing waiver process to allow certain providers that do not meet all of the Contractor's credentialing criteria to be included in the Provider Network when there is an objective need for including those providers (e.g., the provider fills a cultural, linguistic, or geographic access need, or the provider is a peer/consumer provider); and

ii. Ensure that no covered service is rendered at any time during the term of the contract by any person, facility, agency or organization that does not meet all credentialing criteria under the contract, or any applicable law or regulation, unless the Contractor specifically waives in writing an applicable credentialing criterion, to the extent such waiver is within the authority of the Contractor.

5. PROVIDER OUTREACH AND APPLICATION PROCESSING

a. The Contractor shall establish standardized provider application forms and provider contracts for use with all providers, and utilize standardized processes. All applications should be processed (either approved or disapproved) within 90 days of receipt. Declined providers must receive written notification of decision on their application, with a description of their appeal rights for denials.

i. Upon receipt of completed provider application materials, the Contractor shall:

a) Review provider's requested procedure/revenue codes and recommend procedure/revenue codes to be added to the provider's fee schedule;

b) Establish and implement written policies for the selection and retention of providers, consistent with provider credentialing and recredentialing requirements that do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

c) Establish a program of assertive outreach to rural areas where mental health services and substance use disorder services may be less available than in more urban areas;

d) Develop a plan that includes methods to ensure individuals in those areas have access to the full array of services; and

e) Submit to MLTC an annual written assessment of the results of such efforts each contract year.

6. PROVIDER CONTRACTING PRINCIPLES

a. The Contractor shall meet its responsibilities under the contract while adhering to the following key principles of behavioral health provider network management:

i. Promote and implement the Principles of Care for this program, including contracting with providers that demonstrate a commitment to the Principles of Care defined in the contract, including principles of rehabilitation and recovery from mental illness and addiction, a focus on recovery-oriented, trauma-informed services, consumer and family involvement in program management and oversight, a family –driven and strength-based approach to working with children and their families cultural and linguistic competency, and training for staff on such principles;

ii. Use data in decision-making. The Contractor shall develop a data dashboard-type reporting process with defined and ad hoc reporting capabilities, as required in the Data Maintenance and Reporting section of the contract. The Contractor shall obtain the input of MLTC, providers, advocates, Members, and family members on the contents of the data dashboard. The reporting specifications shall include clearly defined data elements and well established time frames for data collection and reporting;

iii. Adhering to a continuous quality improvement process between the Contractor and network;

iv. Promoting collaboration and alignment with state and federally funded services and programs and support of state agency missions, as well as with existing provider organizations;

v. Recognizing the capacity of Members and their families to use and built on their strengths as part of their treatment and eventual recovery;

vi. Promoting a Provider Network that is family-driven and consumer-driven across all levels of care;

vii. Supporting and incorporating MLTC health care reform and integration initiatives as they are developed over time, including support of service delivery approaches that integrate behavioral health and primary care services, in collaboration with Medicaid physical health plans;

viii. Improving the ability of the behavioral health Provider Network to meet all of the health needs of Members through strengthened collaboration with primary care providers, service providers inpatient hospital providers, and consumer/peer providers; and

ix. Actively soliciting best practice models that achieve and exemplify these principles in the Contractor's programs and submitting to MLTC proposals to establish, replicate and financially support the ongoing service delivery of such programs.

7. PROVIDER CONTRACT PROVISIONS

a. The Contractor must execute and maintain, for the term of the contract, written provider contracts with a sufficient number of appropriately credentialed, licensed or otherwise qualified network providers to provide Members with all medically necessary Covered Services. The Contractor's provider contract provisions shall require contracted providers to:

i. Participate in the Contractor's care management/utilization management processes; and

ii. Participate in the Contractor's quality management activities.

b. Ensure that all provider contracts include provisions:

i. Offering hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to the hours of operation defined in the Nebraska Medicaid State Plan, if the Contractor serves only Medicaid enrollees;

ii. Requiring network providers to accept as "payment in full" the Contractor's payment for Covered Services provided to Members;

iii. Prohibiting network providers from charging Members in full or in part for any service provided under the contract or imposing any financial penalties on them, including charges for canceling or missing appointments;

iv. Including the following statement: "Providers shall not seek or accept payment from any Members for any covered service rendered, nor shall providers have any claim against or seek payment from MLTC. Instead, providers shall look solely to the Contractor for payment with respect to Covered Services rendered to Members. Furthermore, providers shall not maintain any action at law or in equity against any Members or MLTC to collect any sums that are owed by the Contractor under the contract for any reason, even in the event that the Contractor fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of the contract (where "contract" refers to the agreement between the Contractor and any Subcontractor and where "provider" refers to the Subcontractor, including network providers and non-network providers with whom the Contractor is contracting);

v. Any cost-sharing imposed on Medicaid members must be in accordance with 42 CFR §447.50 through §447.58 and cannot exceed cost sharing amounts in the Nebraska Medicaid State Plan;

vi. Requiring any network provider to notify the Contractor if it has reason to be considering insolvency or is otherwise financially unsound. The Contractor shall notify MLTC within one working day of receipt of such financial notification;

vii. Prohibiting network providers from engaging in any practice with respect to any Member that constitutes unlawful discrimination on the basis of health status, need for health care, race, color, national origin, or any other basis that violates any state or federal law or regulations, including but not limited to 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90; and

viii. Requiring network providers to collaborate in an ongoing and effective way with primary care providers.

8. NON-NETWORK PROVIDERS

a. Members who are unable to obtain medically necessary covered services from a network provider may obtain them from non-network providers or network providers from other areas of the state, as chosen by the Member, under the following circumstances:

i. The network provider from whom the Member seeks the service is the main source of service to the Member. However, the Member shall have no right to obtain services from a provider outside the Provider Network if the Contractor gave the provider the opportunity to participate in the Provider Network under the same requirements for participation applicable to other providers, and the provider did not meet the necessary requirements to join the Provider Network;

ii. The only network provider available to the Member in the Provider Network does not provide the service the Member seeks because of moral or religious objections; and

iii. The Member's network provider or other provider determines that the Member needs a service(s); the Member would be subjected to unnecessary risk if he/she received the needed services separately; and not all of the related services are available within the Provider Network.

b. Members shall have adequate and timely access to non-network providers for Covered Services when they are unavailable through a network provider, for as long as the Contractor is unable to provide them.

c. The Contractor shall:

i. Negotiate and execute written single-case agreements or arrangements with non-network providers, when necessary, to assure access to Covered Services;

ii. Ensure that service authorizations and utilization management protocols, claims submissions and internal appeals policies for non-network providers are consistent with the terms in the Contractor's network provider contracts;

iii. Develop systematic procedures to work with non-network providers for Members who reside in a rural service area, as identified by MLTC in accordance with the provisions of 42 CFR 412.62(f)(1)(ii); and

iv. Assume responsibility for coverage and payment of services provided by non-network providers if delivered under the terms above, regardless of whether or not the provider that furnishes the services has a contract with the Contractor. The Contractor must pay for those services at rates at least equal to the current fee-for-service rate schedule.

9. ACCESS AND AVAILABILITY OF THE BEHAVIORAL HEALTH PROVIDER NETWORK

a. The Contractor shall indicate how its development and management of the Provider Network will incorporate the following principles into its provider network development and management plans, as well as how these plans are consistent with its overall quality management plan:

i. Acuity of Need:
Members with emergent needs shall be referred to services within one (1) hour generally and within two (2) hours in designated rural areas. Members with urgent needs shall be assessed within forty-eight (48) hours of a request for services. Members with routine needs shall be assessed within fourteen (14) calendar days of the date the services are requested. Delivery of emergency services should be coordinated at the regional level with each RBHA.

Services must be available 24 hours a day, 7 days a week, when medically necessary.

ii. Geographical Standards:

a) Inpatient and Residential Services within 60 miles or 60 minutes' travel time from the Member's residence, whichever requires less travel time; for rural areas, travel time limits may be extended up to 120 miles / 120 minutes if it is determined by MLTC that no inpatient providers are available within the 60 mile / 60 minute travel time requirement. For extremely rural areas of the state, the Contractor shall develop alternative plans for accessing comparable levels of care instead of these services, subject to approval by MLTC;

b) Emergency psychiatric services, in coordination with the crisis networks developed by the DBH RBHAs and the acute care providers previously listed;

c) All other Covered Services within 20 miles or 30 minutes' travel time from the Member's residence, based on a readily accessible mode of transportation; and

d) Accessibility for Members shall be within the identified standards for urban and rural populations. The availability of types of behavioral health programs will vary from area to area, but access problems may be especially acute in rural areas. The Contractor shall establish a program of assertive outreach to rural areas where behavioral health services may be less available than in more urban areas, and shall develop a plan that includes methods to ensure individuals in those areas have access to the full array of services. The Contractor shall monitor utilization in regions across the state and in rural and urban areas to ensure access and availability in all regions, consistent with the requirements of the contract and the needs of Members:

iii. Timeliness:

a) Access standards are the standards for the timeliness of response for the assessment of consumer need and the provision of services necessary to resolve the situation. The assessment of Member needs must be done in a manner that is consistent with applicable clinical practices, timelines and meets the needs of the Member. The timeliness of response will meet the requirements as defined in the emergent, urgent, or routine criteria for individuals already in service as well as individuals not currently in services.

b) The Contractor shall:

1). Ensure Members have access to a choice of at least two network providers who provide Covered Services to the extent that qualified, willing network providers are available. In cases where this is not feasible due to a lack of available providers, the Contractor shall document that it has undertaken assertive efforts to engage any

available providers and shall incorporate this gap into its written plan to take assertive steps to develop adequate provider availability over time;

2). Ensure access to Covered Services in accordance with state and federal laws for persons with disabilities by ensuring that physical and communication barriers do not inhibit them from obtaining services under the contract;

3). Monitor the practice of placing Members who seek outpatient Covered Services on waiting lists. If the Contractor determines that a network provider has established a waiting list and the service is available through another network provider, the Contractor shall stop referrals to the network provider until such time as the network provider has openings, and take action to refer the Member to another appropriate provider; and

4). Assure MLTC that it has the capacity to serve the expected enrollment of Members in accordance with the access standards in the contract.

b. ACCESS TO COVERED SERVICES

i. The Contractor shall execute and maintain provider contracts with network providers to ensure that, at a minimum, 90 percent of Members have access to all medically necessary behavioral health Covered Services according to the following standards:

a) Inpatient and Residential Services within 60 miles or 60 minutes' travel time from the Member's residence, whichever requires less travel time; for rural areas, travel time limits may be extended up to 120 miles / 120 minutes if it is determined by MLTC that no inpatient providers are available within the 60 mile / 60 minute travel time requirement. For extremely rural areas of the state, the Contractor shall develop alternative plans for accessing comparable levels of care instead of these services, subject to approval by MLTC and in coordination with the DBH RBHA for that region; and

b) Emergency psychiatric services, in coordination with the crisis networks developed by the DBH RBHAs and the acute care providers.

All other Covered Services shall be accessible within 20 miles or 30 minutes travel time from the Member's residence, based on a readily accessible mode of transportation.

The Contractor must offer Members who require readmission to inpatient services readmission to the same network provider when there is a bed available in that facility and such admission is not clinically contra-indicated.

c. EMERGENCY SERVICES: COVERAGE AND PAYMENT

i. Emergency and Post Stabilization Care Services
The Contractor is responsible for coverage and payment of emergency behavioral health services and post stabilization care services

regardless of whether the provider that furnishes the services has a contract with the Contractor. Post Stabilization services remain covered until the Contractor contacts the Emergency Room and takes responsibility for the enrollee.

ii. Payment for Emergency for Medical Condition
The Contractor shall not deny payment for treatment obtained when an enrollee had an emergency behavioral health condition. This includes cases in which the absence of immediate medical attention would not have placed the health of the individual in serious jeopardy, impairment or dysfunction.

iii. Emergency Services
The Contractor shall not deny payment for treatment obtained when a representative of the Contractor instructs the enrollee to seek emergency services.

iv. Emergency Medical Condition
The Contractor shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

v. Coverage of Emergency Services
The Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, Contractor, or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

vi. Subsequent Screening
An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

vii. Determination of Stabilization
The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor.

viii. Non-Network Provider
Any provider of emergency services that does not have in effect a contract with the Contractor that establishes payment amounts for services furnished to an enrollee must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the enrollee received medical assistance under Title XIX or Title XXI through an arrangement other than enrollment in the BH-MCO.

ix. Financial Responsibility – Pre-Approval
The Contractor is financially responsible for post stabilization services obtained within or outside the Contractor that are pre-approved by a plan provider or other Contractor representative.

x. Financial Responsibility – Approval Request
The Contractor is financially responsible for post stabilization care services obtained within or outside the Contractor which are not pre-approved by a plan provider or other Contractor representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the Contractor for pre-approval of further post stabilization care services.

xi. Financial Responsibility – No Pre-Approval
The Contractor is financially responsible for post stabilization care services obtained within or outside the Contractor service which are not pre-approved by a plan provider or other Contractor representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if:

a) The Contractor does not respond to a request for pre-approval within one (1) hour;
b) The Contractor cannot be contacted; and
c) The Contractor representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached, or:

1). A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
2). A plan physician assumes responsibility for the enrollee's care through transfer to another place of service;
3). A Contractor representative and the treating physician reach an agreement concerning the enrollee's care; and
4). The enrollee is discharged.

xii. End of Financial Responsibility
The Contractor's financial responsibility for post stabilization care services it has not pre-approved ends when:

a) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
b) A plan physician assumes responsibility for the enrollee's care through transfer to another place of service;
c) A Contractor representative and the treating physician reach an agreement concerning the enrollee's care; and
d) The enrollee is discharged.

10. LINKAGE WITH CONSUMER AND RECOVERY/RESILIENCE INITIATIVES

a. The Contractor shall manage the behavioral health provider network to align with other programs and services that support and complement Members' participation in Covered Services and that promote Members' recovery, empowerment, and use of their strengths and the family's strengths in achieving their clinical goals and improving their health outcomes.

i. The Contractor shall actively manage network providers to complement and integrate with the following formal and informal resources and programs:

a) Rehabilitation programs that promote and provide skill-building, community support, Supported Employment and full competitive employment for Members;
b) Recovery Support services;
c) Natural community supports for Members and their families; and
d) Anonymous recovery programs (e.g., 12-step programs) for Members and their families.

ii. The Contractor shall also work with its network providers to actively collaborate with other MLTC-funded programs, including but not limited to:

a) NE Medicaid physical health Contractors;
b) DBH-funded programs;
c) DCFS-funded programs that support the safety, permanency and well-being of children in the care and custody of the State of Nebraska;
d) In the event that court-ordered services are determined by the Contractor not to be medically necessary, the Contractor's care management program will work with the court and any involved state agencies to determine if alternative Covered Services that do meet medical necessity requirements may be provided and will provide care coordination throughout the member's treatment (as long as eligibility is maintained) to transition the member to a service that is medically necessary and appropriate to meet the member's needs;
e) DDD programs that involve rehabilitative and habilitative services for persons with developmental disabilities (recognizing that habilitative services are not covered by this program); and
f) Other programs and initiatives within MLTC related to primary care and behavioral health integration/coordination and pharmacy management.

iii. The Contractor shall demonstrate through its Network management plan and individual network provider contracts the continued effort to work with network providers to access community resources and supports.

11. PROVIDER QUALITY MANAGEMENT STRATEGY

a. Beginning on the contract start date, the Contractor shall develop and implement a strategy to manage the Provider Network with an emphasis on the following:

i. Implementation of the Principles of Care for the Program;
ii. Access to care for Members;
iii. Quality of care;
iv. Application of principles of rehabilitation, recovery, and resilience to service planning and service delivery;

v. Measurement and promotion of recovery- and resiliency-oriented outcomes for Members over the course of receiving Covered Services;
vi. Integration of covered service delivery with medical services provided by Members' primary care providers or other key health care providers; and
vii. Cost-effectiveness of the delivery of Covered Services.

b. The Contractor shall ensure that its management strategy includes at least the following:

i. A systematic plan for utilizing network provider profiling and benchmarking data to identify and manage network providers who fall below established benchmarks and performance standards, and to reward and replicate practices of network providers who consistently exceed benchmarks and performance standards;
ii. A system for the Contractor and network providers to identify and establish improvement goals and periodic measurements to track network providers' progress toward improvement goals;
iii. Utilization of on-site visits to network providers at all levels of care, to support quality improvement efforts and benchmarking data; and
iv. Steps to ensure network provider compliance with the Contractor's performance specifications for each covered service.

c. The Contractor shall take appropriate management action, including the development and monitoring of corrective action plans for network providers whose performance is determined by the Contractor to be in need of improvement.

d. The Contractor shall take appropriate action related to network providers as follows:

i. Upon the Contractor's awareness of any disciplinary action or sanction taken against a network provider, either internally by the Contractor or an oversight agency or any source outside of the Contractor's organization (such as CMS), immediately inform MLTC of such action taken and work collaboratively with MLTC to maintain a process to share such information; and
ii. If notified that MLTC has taken an action or imposed a sanction against a Medicaid provider, including disenrollment of any such provider from the Medicaid program, review the provider's performance related to the contract and take any action or impose any sanction that the Contractor determines is appropriate, including disenrollment from the Contractor's Provider Network.

e. In collaboration with and as further directed by MLTC, develop and implement network provider quality improvement activities.

f. Implement, subject to MLTC approval, a network management strategy to engage with primary care providers, specialty providers, high-volume prescribers, and hospital emergency departments to improve access for Members who may be under- or over-utilizing behavioral health services.

12. NETWORK ADMINISTRATION

a. The Contractor shall maintain and continually update a Network Provider Database that contains, at a minimum, the following information on network providers:

i. Network provider name;
ii. Contracted services;
iii. Site address(es) (street address, town, ZIP code, region of the state);
iv. Site telephone numbers;
v. Site hours of operation;
vi. Emergency/after-hours provisions;
vii. Professional qualifications and licensing;
viii. Areas of specialty relating to behavioral health conditions;
ix. Cultural and linguistic capabilities;
x. Malpractice insurance coverage and malpractice history;
xi. Credentialing status; and
xii. Profiling indicators.

A list of network providers, sorted by type of service and by network providers' capability to communicate with Members in their primary languages. This list shall be available to the Contractor's clinical staff at all times, and available to network providers, DBH and other interested parties upon their request and at no charge.

13. NETWORK PROVIDER POLICY AND PROCEDURE MANUAL/HANDBOOK

a. The Contractor shall produce a provider handbook 45 days prior to the contract start date and shall make this handbook available on the web site 30 days prior to the contract start date. The provider handbook shall include but may not be limited to the following:

i. Develop a provider policy and procedure manual, and distribute the manual to all network providers following MLTC review; and
ii. The manual shall include, at a minimum, information on:

a) The contract, the Contractor, and program priorities;
b) Acceptance of members without discrimination or regard to the member's health status, need for health care, race, color, national origin, or any other basis that violates any state or federal law or regulations;
c) How to verify a Member's eligibility for NE Medicaid behavioral health Covered Services;
d) Network provider credentialing criteria;
e) Provider network management;
f) Procedures for service authorization, concurrent review, extensions of lengths of stay, and retrospective reviews for all Covered Services;
g) Clinical criteria for admission, continued stay, and discharge for each covered service;
h) Administrative and billing instructions, including a list of procedure codes, units and payment rates;
i) How to appeal payment and service denial decisions;

j) Reporting requirements for serious reportable events and reportable adverse incidents;
k) Contractor corporate information;
l) Confidentiality provisions;
m) Principles of Care;
n) Descriptive process for accessing services;
o) Summary of service and benefit structure;
p) Compliance with the preferred drug list for enrolled Members;
q) Procedures for submitting complaints and appeals;
r) Procedures for service authorization and registration;
s) Procedures for using WEB-based provider services;
t) Summary of utilization management requirements;
u) Summary of claims procedures; and
v) Names and contact information of provider relations staff.

iii. The Contractor shall, as necessary:

a) Modify or supplement the policy and procedure manual by distributing periodic notices to network providers;
b) Review the manual at least bi-annually and amend it, if necessary, in consultation with MLTC and the involvement of consumers, families, providers and other stakeholders in the review and upgrade of the manual; and
c) Redistribute the amended portions of the manual to network providers and Members through a clear process for communicating changes.

14. NETWORK PROVIDER PROTOCOLS

a. The Contractor shall develop, maintain and utilize MLTC-reviewed network provider protocols. The protocols must address the following:

i. How the Contractor intends to ensure, for a particular Member's needs, that a qualified and clinically appropriate network or non-network provider:

a) Is available to provide the particular Covered Service;
b) Is accessible within the access standards required by the contract, taking into account the availability of public transportation;
c) Is accessible to individuals with physical disabilities, if appropriate;
d) Has the ability, either directly or through a skilled medical interpreter, to communicate with the Member in his/her primary language; and
e) How the Contractor intends to facilitate communication between network providers and the Contractor, and between network providers and primary care providers, in a manner that engages the providers and overcomes barriers to communication.

ii. The Contractor shall require network providers to submit to the Contractor a written report of all reportable adverse incidents, according to the following guidelines:

a) Network providers of 24-hour Covered Services shall, within 24 hours of their occurrence, report to the Contractor all reportable adverse incidents involving a Member;

b) Network providers of non-24-hour Covered Services shall, within 24 hours of their occurrence, report to the Contractor all reportable adverse incidents that involve the death of a Member; and

c) The Contractor shall require network providers to coordinate Medicaid Covered Services with the Member's care manager where the Members are receiving care management services through the Contractor and/or the case manager when the Member is receiving case management through a state agency (e.g., DBH, DCFS, and DDD).

iii. The Contractor shall require network providers to comply with MLTC's regulations barring payment for services related to a serious reportable event. The Contractor shall require network providers to comply with all applicable federal and state requirements, including those concerning restraints and seclusion.

iv. The Contractor shall require its network providers to inform Members of their rights under Nebraska regulations.

v. The Contractor shall maintain a unique network provider identification number for each network provider. In addition shall:

a) Inform MLTC immediately upon enrolling any provider who is not also a NE PH Medicaid provider in its Provider Network. Such notification shall include the following data elements:

1). Network provider name, address and telephone number;

2). Legal entity's name, address and phone number of the practice (i.e., "doing business as," or d/b/a, name), if different from the above;

3). Network provider or legal entity's tax identification number; and

4). Effective date of the network provider's enrollment in the Provider Network.

vi. The Contractor shall submit to MLTC all updates to the list or its data elements whenever they occur.

15. NETWORK PROVIDER RELATIONS

a. GENERAL PROVIDER RELATIONS

The Contractor shall develop and maintain positive Contractor-provider relations; communicate with all providers in a professional and respectful manner; promote positive provider practices through communication and mutual education and provide administrative services in the most efficient manner possible in an effort to pose minimal burden on providers.

b. PROVIDER ADVISORY COMMITTEE

The Contractor shall develop, establish and maintain a Provider Advisory Committee. The Contractor shall propose a plan for forming and collaborating with a Provider Advisory Committee. The Provider Advisory Committee shall have representation from MLTC, the major provider organizations (e.g., CAFCON, NAADAC, NABHO, Nebraska Chapter of the American Association of Psychiatric Nurses, and Nebraska Chapter of the NASW, NCA, Nebraska Hospital Association, Nebraska Medical Association, Nebraska Psychiatric Society, and Nebraska Psychological Association) in Nebraska, individual providers, and consumer/peer providers. Whenever feasible, the Contractor will work collaboratively with the Provider Advisory Committee, as well as established provider organizations, to create network development and management strategies, methods, and procedures. MLTC shall review the development plan prior to establishment.

c. NETWORK COMMUNICATION PLAN

The Contractor shall promote on-going and seamless communication between providers and the Contractor. To accomplish this task the Contractor shall:

i. In addition to establishing and working collaboratively with the Provider Advisory Committee, include provider representatives in the Contractor's committee structure, to give providers a direct voice in developing and monitoring clinical policies;

ii. Offer providers consultation with respect to both clinical and administrative issues;

iii. Work with providers to reduce administrative responsibilities through the use of the Contractor's website and information technology;

iv. Provide encryption software upon request from a provider to provide for the exchange of Member data via e-mail;

v. Post all policies and procedures, handbooks and other material on the Contractor's website;

vi. Notify providers and Members of impending policy changes at least 45 days prior to implementation, to the greatest extent possible;

vii. Conduct provider satisfaction survey at least once per contract year, sharing findings with the Provider Advisory Committee and involving the Provider Advisory Committee in implementing corrective action as indicated;

viii. The Contractor shall conduct a provider satisfaction survey using a provider survey instrument approved by MLTC. The survey shall, at a minimum, address the provider's satisfaction with the Contractor's services and other administrative services provided by the State or its agents, including but not limited to authorization, courtesy and professionalism, network management services, provider appeals, provider education, referral assistance, coordination, claims processing and the perceived administrative burden experienced by providers providing behavioral health services;

ix. The survey shall be conducted within the guidelines defined in the Quality Management section of the contract;

x. Provide a monthly newsletter that includes articles covering topics of interest for providers who work both with children and adults, that appropriate medical professionals are involved in writing the assigned articles, and that the newsletters are posted to the Contractor's website; and

xi. Tracking and monitoring all complaints as part of recredentialing, and informing MLTC if intervention is required in an urgent situation.

d. PROVIDER NETWORK LIAISON

The Contractor shall identify a Provider Network Liaison, who will be responsible for working collaboratively with the Provider Advisory Committee to establish methodologies for processing and responding to provider concerns; developing provider trainings in response to identified needs or changes in protocols, processes, and forms; and enhancing Contractor-provider communication strategies.

e. PROVIDER NOTIFICATION

Throughout the term of the contract, the Contractor shall be required to alert providers to modifications in the provider handbook and to changes in provider requirements that are not otherwise communicated by MLTC. To accomplish this task the Contractor shall:

i. Request and obtain from providers an e-mail address, so they can be alerted to access the Contractor's website to download updates to the provider handbook and provider requirements;

ii. E-mail providers and publish on the Contractor's website any clarification or direction on matters not otherwise communicated by the MLTC; and

iii. Post notification of policy or other procedural changes on the Contractor's website. Advance notification of Members and providers of changes that will impact access to and provision of services or payment of services is required. The Contractor will make a good faith effort to provide at least 45 days' advance notice of any necessary changes.

f. PROVIDER ORIENTATION

i. During the first year of the contract, the Contractor shall conduct an initial statewide provider orientation initiative and at least two subsequent rounds of provider orientation sessions;

ii. The Contractor shall work with representatives of the provider community to develop the agenda for the initial statewide provider orientation to identify the most effective ways to encourage attendance;

iii. The Contractor shall alert providers to the various meetings through direct mailings, coordination with professional organizations, notices posted to its website; and

iv. The Contractor shall, following the initial statewide and local provider orientation sessions, determine whether the initial orientation sessions should be repeated at one or more locations to further encourage provider participation.

g. PROVIDER TRAINING AND TARGETED TECHNICAL ASSISTANCE

The Contractor shall:

i. Offer training and technical assistance to providers on clinical topics, including the priority evidence-based and emerging best practices; and

ii. Have available both clinical and administrative staff to provide targeted technical assistance onsite at the request of network providers and also non-network providers seeking to become network providers.

h. PROVIDER INQUIRIES AND COMPLAINTS

The Contractor shall:

i. Track and manage all provider inquiries and complaints related to clinical and administrative services covered under the contract;

ii. Ensure that all inquiries and complaints are addressed in compliance with the Contractor's approved Quality Management (QM) Plan and no later than 30 days from receipt;

iii. Inform MLTC immediately when urgent circumstances require an immediate response from MLTC; and

iv. Provide MLTC with a regular report outlining the Contractor's compliance with required timeframes and notifications related to inquiries and complaints. MLTC and the Contractor shall agree to the form, content and frequency of the report in advance.

i. WEB-BASED COMMUNICATION SOLUTION

i. The Contractor shall develop and implement a website specifically to serve its network providers and Members;

ii. The Contractor shall ensure that the website provides information about the Contractor's services, a link to the MLTC and MLTC primary care vendor websites and related websites, and a link to the Contractor's corporate website (if different); and

iii. The Contractor shall, in collaboration with the MLTC, determine the program content published on the website. The Contractor shall provide web-enabled transactional capabilities through the website. Such capabilities shall include, but may not be limited to:

a) Provider/Member inquiries;

b) Submission of initial authorization and registration; and

c) Web-based referral search system that will allow Contractor's and MLTC' staff, providers, Members and any other interested persons to locate network providers through an online searchable database. The searchable database shall include network providers and facilities with information regarding areas of clinical specialization, race/ethnicity, languages spoken, disciplines, and program types.

16. ANNUAL NETWORK DEVELOPMENT PLAN

a. The Contractor shall submit to MLTC an annual network plan within 60 days of the annual service start date of each year following the first year of the contract.

i. The annual plan shall contain specific action steps and measurable outcomes that are aligned with the goals and principles of MLTC network requirements. The plan shall encompass services for all Members, but contain separate sections for provider networks for Covered Services described in the contract for children/adolescents and adults. The Contractor work plan shall take into account, network-specific goals and objectives developed in collaboration with MLTC:

a) The Contractor shall include in the plan a narrative and statistical analysis consistent with the MLTC assessment methodology. At a minimum, the analysis shall be derived from:

1). Quantitative data, including performance on appointment standards/appointment availability, eligibility/enrollment data, utilization data, the network inventory, demographic (age/gender/race/ethnicity) data, and the number of single case agreements by service type;

2). Qualitative data (including outcomes data), when available; grievance information; concerns reported by eligible or enrolled Members; grievance, appeals, and request for hearings data; behavioral health Member satisfaction survey results, and prevalent diagnoses; and

3). Status of provider network issues within the prior year that were significant or required corrective action by MLTC, including findings from the current Contractor's annual administrative review:

i) A summary of network development efforts conducted during the prior year;
ii) Plans to correct any current material network gaps and barriers to network development;
iii) Priority areas for network development activities for the following year, goals, action steps, timelines, performance targets, and measurement methodologies for addressing the priorities;
iv) The participation of Members, family members/caretakers, providers, including state-operated providers, and other community stakeholders in the annual network planning process; and
v) The Contractor's network development plan shall be approved by MLTC. The Contractor shall submit progress reports as requested by MLTC**.**

M. CARE, UTILIZATION AND QUALITY MANAGEMENT

Care management is the overall system of medical and psychosocial management encompassing, but not limited to, UM, care coordination, discharge planning following restrictive levels of care, continuity of care, care transition, and QM. The major components of care management include assessment, planning, facilitation, coordination, and evaluation. The major activities of care management include advocacy, communication, problem solving, collaboration, and empowerment. Care coordination and referral activities incorporate and identify appropriate methods of assessment and referral for individual Members requiring mental health and/or substance use disorder treatment services, including linkages to primary medical care services. These activities shall include scheduling assistance, monitoring, and follow-up for Members requiring behavioral health services.

1. REQUIRED CANDIDATES FOR CARE MANAGEMENT

Care management will be provided, but not limited to, the following members with the attendant characteristics;

a. CHILDREN:

i. Hospitalized, recently released, and less than 12 years old;
ii. Receiving sub-acute level of care and discharged back to a community setting; or
iii. With mental health or chemical dependency diagnoses and at risk of out of home placement or becoming a state ward.

b. ADOLESCENTS:

i. Pregnant with substance abuse diagnoses;
ii. Ages 13 to 18 with two or more admissions within 60 days to inpatient or residential treatment with a diagnosis of bipolar schizophrenia; or
iii. Adult, children and adolescent high risk candidates.

2. GENERAL REQUIREMENTS FOR CARE MANAGEMENT

Care Management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes. The Contractor shall develop and maintain a care management function that ensures covered Mental Health and Substance Use Disorder treatment services, appropriate to the Member's level of need, are available when and where individuals need them. The Contractor shall provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The care management system shall have sufficient staffing to respond 24 hours per day, seven (7) days per week, and 365 days per year to Members, their families/caregivers, or other interested parties calling on behalf of the Member.

The Contractor shall provide to MLTC for approval a program description, flow diagrams, where appropriate or helpful, and specific policies and procedures pertaining to CM/UM practices, including, but not limited to, care management, service authorization and re-authorization procedures, and utilization review procedures, such as concurrent review, discharge review, retroactive medical necessity review, retrospective utilization review, and retrospective chart reviews. The Contractor's CM/UM policies and procedures, clinical guidelines and practice guidelines, shall be consistent with the MLTC-approved definition of medical necessity. The Contractor shall:

a. Develop clinical guidelines with the input, review and approval of the Clinical Advisory Committee convened for this plan;
b. Submit the CM/UM policies and procedures to MLTC for approval at least one month prior to the service start date; and
c. Annually review, and update as necessary, with the input, review and approval of the Clinical Advisory Committee, the CM/UM policies and procedures and clinical guidelines, and, once approved by the Clinical Advisory Committee, submit any proposed changes to MLTC for prior review and approval. The CM/UM policies and procedures shall be conveyed through staff training and supervision and shared with providers to promote consistency of care provision and to ensure that:

i. Members receive the care that is medically necessary; and
ii. Behavioral Health Covered Services are not underutilized or over utilized or provided without documentation of medical necessity.

3. CLINICAL ADVISORY COMMITTEE

The Contractor shall develop, establish and maintain a Clinical Advisory Committee to facilitate regular consultation with experts who are familiar with standards and practices of mental health and/or substance use disorder treatment for adults, children and adolescents in Nebraska. The Clinical Advisory Committee must provide input into all policies, procedures and practices associated with care management and utilization management functions, including utilization management criteria, clinical guidelines, and practice guidelines to ensure that they reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in Nebraska.

a. The Committee shall consist of experts within the state of Nebraska who are familiar with standards and practices of mental health and/or substance use disorder treatment, including co-occurring disorders, for children, adolescents and adults in Nebraska across a variety of ages and races/ethnicities, including awareness of differences between rural and urban populations and representing a range of service providers.

b. Membership will also include at least two adult consumers who are Medicaid Members and at least two family members/guardians of children or youth who are Medicaid Members with behavioral health service needs. Members shall be chosen in consultation with consumer and family advocacy organizations.

c. In addition to review of the initial guidelines, any significant changes in guidelines shall also be reviewed by this committee prior to adoption by the Contractor.

d. The committee shall meet on an as needed basis, but at least twice a year and preferably quarterly.

e. MLTC shall review the strategy and plan for development of the Clinical Advisory Committee in advance of establishment and receive copies of the input and advice provided in the course of operation.

4. STAFFING

The Contractor shall provide adequate staffing of the CM/UM functions and shall:

a. Employ a multidisciplinary clinical staff at staffing levels that ensure an adequate ratio of staff to Members to perform the CM/UM functions of the contract, including authorizing and coordinating care.

b. Provide CM/UM staffing as follows:

i. Ensure that the Chief Medical Officer or a designee, is available 24 hours per day, seven days a week, for decision-making and consultation with the Contractor's clinical staff and network providers; and

ii. The Contractor shall ensure the following standards for clinicians who authorize services, unless otherwise approved by MLTC:

a) The Contractor shall ensure that only licensed psychologists, LIMHPs and psychiatrists acting within the scope of all applicable state laws and their professional licenses shall make final decisions regarding medical necessity determination;

b) The clinician(s) coordinating and authorizing Mental Health and Substance Use Disorder treatment services for children and adults, including co-occurring disorders, must be licensed and trained in and demonstrate knowledge of the Principles of Care and the full array of services available to Members;

c) The clinician(s) coordinating and authorizing services for Members with a coexisting medical and behavioral health diagnosis must be trained and demonstrate knowledge of co-occurring disorders and have access to appropriate clinical consultation to a physician or registered nurse as needed;

d) The Contractor shall ensure that supervisory clinical staff include subject matter experts in serious and persistent mental illness (SPMI) for adults and in severe emotional disturbances (SED) for children and adolescents; trauma-informed and trauma-specific care, and in developmental disabilities, substance use disorder treatment, and treatment of persons with co-occurring mental illness and substance use disorders, consistent with the Principles of Care defined in this RFP;

e) Appropriately trained paraprofessionals, including peers and family members, may provide care management support functions;

f) The Contractor will include provisions to ensure that conflicts of interest on the part of staff are avoided; and

g) The Contractor shall provide policies and procedures outlining the training and supervision plan for CM/UM staff. The training and supervision plan must address consistency in the application of clinical guidelines and documentation. The plan shall articulate how the following will be accomplished:

1). Promoting implementation of and adherence to the Principles of Care for the program;

2). Ensuring that clinical staff obtain the training needed to maintain their professional licensing;

3). Providing orientation and on-going training on CM/UM and QM policies and procedures;

4). Providing training on evidence-based practices;

5). Conducting live call monitoring or monitoring of recorded CM/UM telephone calls, as well as regular tests of inter-rater reliability, to assess consistency in interpreting clinical guidelines and adherence to policies and procedures; and

6). Conducting regular care management record reviews to monitor:

i) The adequacy of documentation supporting appropriateness of medical necessity;

ii) The adequacy of clinical documentation regarding quality of care, including assessment and treatment information and care management of high risk cases; and

iii) The appropriateness of care management and other Contractor management interventions, including the use of physician or other specialist consultation.

h) By contract start date, the Contractor shall provide to MLTC for approval a program description, flow diagrams, where appropriate or helpful, and specific policies and procedures pertaining to CM/UM practices, including, but not limited to, care

management, service authorization and re-authorization procedures, and utilization review procedures, such as concurrent review, discharge review, retroactive medical necessity review, retrospective utilization review, and retrospective chart reviews.

i) The Contractor shall develop and maintain a care management function that ensures covered Mental Health and Substance Use Disorder treatment services, appropriate to the Member's level of need, are available when and where individuals need them. The Contractor shall provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The care management system shall have sufficient staffing to respond 24 hours per day, 7 days per week, and 365 days per year to Members, their families/caregivers, or other interested parties calling on behalf of the Member.

1). Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a board-certified psychiatrist; and

2). Care managers shall make referrals to qualified network providers, for immediate, urgent, and routine needs within the following appointment access standards:

i) Emergent appointments within one hour of request or two hours in rural areas;
ii) Urgent appointments within 48 hours of referral; and
iii) Routine appointments within fourteen (14) calendar days.

j) The Contractor will ensure that its care managers conduct outreach to Members discharged from institutional care within 72 hours of the discharge, and will monitor and report on steps taken to carry out outreach. The Contractor will develop network capacity with the requirement that outpatient appointments following inpatient and residential stays will be available within three (3) days of discharge optimally and seven (7) days of discharge in all cases to assist with prevention of readmission.

k) The Contractor and its providers shall meet management of care standards specified in the contract for timely access to care and services, taking into account the urgency of need for services. The Contractor is responsible to ensure that provider network capacity is adequate to ensure standards can be met.

l) The Contractor's care management program shall determine if the member has a primary care physician (PCP). If the member does not have a PCP, the Contractor shall refer the individual to Nebraska Medicaid PH for appointment of a PCP and follow up to assure and document the name of the PCP in the care management record. To support this, the Contractor's CM program shall:

1). Document the individual's PCP in the care management record, or if none, follow up on the PCP referral as part of the ongoing care management process;

2). The Contractor shall develop, in collaboration with all Medicaid physical health plans, a data sharing and notification system. When Medicaid Members receive services from the provider network, the notification system will generate supporting communication (preferably electronically) to the member's PCP;

3). If medications are prescribed by the Contractor's provider, use available pharmacy data downloads to obtain a list of medications prescribed by PCP and other specialists for a complete and reconciled medication list that is updated at least every 90 days. MLTC will provide a monthly download of pharmacy claims data to the Contractor for enrolled Members to allow routine monitoring of prescribed medications. This information will be made available in electronic format to providers treating the Member on a regular basis, in accord with data sharing requirements;

4). The Contractor shall monitor psychotropic medications prescribed to children using a protocol that is approved by MLTC. The Contractor will be responsible for identifying medication utilization that is outside of the identified parameters of the protocol and will follow the approved process for addressing with the network provider and/or PCP. The Contractor is responsible for reporting on this process on a quarterly basis in a manner to be determined by MLTC;

5). Implement additional supports as needed to coordinate care with PCPs to promote overall health and wellness;

6). For Members receiving DBH-funded care from RBHAs, coordinate care with the RBHA to promote overall health and wellness;

7). For Members receiving DCFS-funded care, coordinate care with DCFS and its Contractors to promote overall health and wellness;

8). For Members receiving DDD-funded care, coordinate care with DDD and its Contractors to promote overall health and wellness;

9). Ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164;

10). If requested, the Contractor shall offer a second opinion from a qualified health care professional within the network or arrange for a second opinion outside the network at no cost to the Member; and

11). In order to identify Members with special mental health care or substance use treatment needs, the Contractor is required to screen all Members to identify special needs Members who meet the criteria for:

i) Any individual with IV drug use, pregnant substance users, and substance using women with dependent children (including those with co-occurring mental health and substance use disorders);
ii) Children with SED or with behavioral health challenges and are in contact with multiple agencies serving children;
iii) Adults with SPMI, including adults with co-occurring SPMI and substance use disorders; and
iv) Members with co-occurring developmental disabilities and mental health or substance use disorders.

m) The Contractor must proactively seek individuals with special needs. This includes the review by the Contractor of claims and utilization data to identify Members in need and Contractor care management efforts to provide outreach to special needs Members. This also includes the development and use of standardized, best practice screening tools to assess individuals once identified. Such development shall be carried out with the input of the Clinical Advisory Committee.

5. COORDINATION OF CARE WITH STATE AGENCIES AND OTHER SERVICE SYSTEMS

a. The Contractor shall collaborate with other state agencies that serve Members with mental health and substance use conditions, and it shall address and attempt to resolve coordination of care issues with Medicaid physical health plans, other state agencies and their Contractors, and Tribes at the lowest possible level of each organization.

b. The Contractor shall participate in local, regional and statewide planning efforts to help ensure the fullest integration of mental health treatment resources into the overall health care delivery system.

c. The Contractor must support expedited access to covered and medically necessary Medicaid services after discharge from;

i. Enhanced care management resources;
ii. Continuity of care across changes in eligibility status for Members;
iii. Care coordination with other parts of the physical health care system, including Medicaid physical health Contractor plans, community health clinics, and FQHCs;
iv. The federal Indian Health Service and with health initiatives by Tribal Governments in Nebraska; and
v. The Nebraska Medicaid Pharmacy Program.

6. COORDINATION OF PHYSICAL HEALTH AND BEHAVIORAL HEALTH CARE

a. The Contractor shall promote integration of medical and behavioral health care across the Contract by coordinating care with other systems that provide services to the same Member in compliance with Title 482 NAC:

i. When a member is not enrolled in both PH Managed Care and BH Managed Care organization responsible for BH services, the associated service is coordinated with MLTC on a fee-for-service basis;

ii. At the time when a BH provider initiates an evaluation and/or treatment for the member, the PH MCO is no longer responsible for a BH-related service. Authorization for BH services from that point forward must be obtained from the BH-MCO;

iii. When a member who is enrolled in the BH is admitted to an acute care (medical/surgical) facility as an outpatient for a 24 hour observation for purposes of a BH diagnosis, the BH-MCO is responsible for the observation stay; and

iv. The BH-MCO is no longer responsible for the service at the time that a psychiatrist initiates an evaluation and/or treatment of the member and determines that the member does not have a BH diagnosis. Authorization for acute care services from that point forward must be obtained from the PH-MCO.

b. The Contractor shall develop an organizational structure that coordinates the integration of care through:

i. Development of formal agreements and/or arrangements with each of the current MLTC physical health plan Contractors;

ii. Current initiatives to integrate behavioral health and primary care;

iii. Development of communication protocols and processes that facilitate information sharing among PCPs and network providers; and

iv. Aggregation, analysis and dissemination of data on health and integrated health and behavioral health access and outcomes.

c. The Contractor shall develop systemic processes that ensure optimal communication and collaboration between behavioral health and health care systems that serve Members.

d. The Contractor shall conduct the following activities, at a minimum, to promote coordination of behavioral health and physical health care at the broader system level:

i. In collaboration with the PH-MCO Contractors, collaboratively develop education and training mechanisms on integrated care and related issues;

ii. Jointly design, develop and distribute with PH-MCO Contractors (with input from network providers, PCPs and other primary care practitioners) linkages and policies that promote communication, coordination and collaboration across medical and behavioral health care providers; and

iii. Establish within six (6) months following the contract start date an initiative in collaboration with the PH-MCOs to develop a tracking process and data collection process for emergency department (ED) usage and inpatient admissions by Members at acute hospitals for any condition (inclusive of behavioral and other physical health needs) and evaluate the utility of this information, as appropriate for:

a) Notifying the PCPs of a Medicaid PH-MCO Member's ED usage or inpatient admission;

b) Identification of Medicaid physical health Contractor Members;

c) Designing treatment and/or discharge planning with Members; and Identification of trends in ED usage and inpatient admissions;

d) Jointly educate in collaboration with PH-MCOs, PCPs and network providers regarding the need to coordinate and manage prescribed medication use for behavioral health and medical conditions, in coordination with the Nebraska Pharmacy Benefit Manager; and

e) Utilize the Contractor's website to:

1). Provide PCPs and other non-behavioral health providers with easy access to behavioral health referral sources, treatment options and crisis intervention protocols; and

2). Provide behavioral health network providers with information on how to access customer service functions for primary care referral sources, community resources and acute and urgent care services facilities.

f) Attend and participate in all relevant DHHS meetings and workgroups as directed by DHHS, with a particular focus on workgroups targeting medical and behavioral health integration; and

g) Support related required functions through the Contractor's care management and utilization management systems.

7. CARE COORDINATION WITH TRIBES AND TRIBAL ORGANIZATIONS

The Care Coordination Plan shall include procedures for collaboration regarding services for Members with who are Tribal Members or are otherwise eligible for care through the federal Indian Health Services (IHS) or other Tribally-funded health and human services. The Contractor shall establish specific mechanisms for improving coordination with Tribes and Tribal agencies in Nebraska, including:

a. Identify and appoint a Tribal Liaison, to work with IHS and Tribes;

b. Development of processes and procedures to identify, ensure appropriate access to, and monitor the availability and provision of culturally appropriate care within the Contractor's network;

c. Development of processes and procedures to coordinate eligibility and service delivery with Urban Indian Health Centers and provider facilities owned and operated by a Native American Tribe and authorized to provide services pursuant to Public Law 93-638;

d. Inclusion within the broader processes of the Contractor's QAPI Program specific methods to gather and analyze data regarding satisfaction and broader input from Members who are also Tribal Members and from providers owned and/or operated by a Native American Tribe and located in Nebraska; and

e. Develop methods for regular planning to coordinate on at least a quarterly basis with IHS, Veterans Administration, 638 providers, Urban Indian Centers, and other involved agencies to coordinate and facilitate behavioral health service delivery.

8. CARE COORDINATION TO ENSURE CONTINUITY OF CARE DURING KEY TRANSITIONS

The Contractor shall develop, implement, and monitor written policies and procedures consistent with existing state policies and procedures, regarding continuity of care. These written protocols shall be reviewed on an annual basis by the Contractor and updated as needed. In particular, the policies and procedures shall address the following situations:

- **a.** Members whose treating qualified service provider becomes unable to continue service delivery for any reason;
- **b.** Member transitions from the children's system to the adult system;
- **c.** Member transitions to and from IHS or other Tribal agencies;
- **d.** Member discharges from inpatient and residential treatment levels of care; and
- **e.** Member discharges and transitions for children and youth leaving DCFS and other juvenile justice facilities for the continuance of prescribed medication and other behavioral health services prior to reentry into the community.

9. UTILIZATION MANAGEMENT

Utilization Management (UM) is the component of care management that evaluates the medical necessity of health care services according to established criteria and practice guidelines to ensure that the right amount of services are provided when the Member needs them. UM also focuses on individual and system outliers that require review to assess if individual Members are meeting their goals and if service utilization across the system is meeting the goals for delivery of community-based services.

- **a.** The Contractor's UM program shall comply with federal utilization control requirements, including the certification of need and recertification of need for continued stay inpatient settings, including PRTF;
- **b.** The Contractor shall require inpatient hospital and residential treatment providers to comply with federal requirements regarding utilization review plans, utilization review committees, plans of care, and medical care evaluation studies as prescribed in 42 CFR 441 and 456. The Contractor shall actively monitor all of the UM activities it conducts for compliance with federal and State Medicaid requirements and adherence to its QM/UM Plan;
- **c.** The Contractor shall develop service authorization procedures with the input, review and approval of the Clinical Advisory Committee, subject to approval by MLTC, and it shall implement such procedures as of the start date of the contract. The Contractor shall:
    - **i.** Incorporate the definition of medical necessity as specified in the Medicaid State Plan for covered behavioral health services, inclusive of service definitions and levels of care, into Contractor documents, where applicable;
    - **ii.** Place appropriate limits on service delivery (applying criteria, such as clinical guidelines for utilization control), provided the services that are delivered can be reasonably expected to achieve their purpose;
    - **iii.** Not arbitrarily deny a required service solely because of the Member's diagnosis, type of illness, or condition (this also applies to the Contractor's subcontracts);
    - **iv.** Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;
    - **v.** Consult with the requesting network provider, when appropriate;

vi. Provide a mechanism in which a Member may submit, whether verbally or in writing, a service authorization request for the provision of services. This process shall be included in its Member manual and incorporated in the grievance procedures as per 42 CFR §431.201; and

vii. Make authorization decisions and provide notice as follows:

a) Emergencies do not require prior authorization; and

b) For standard authorization decisions, make a decision and provide notice of any denial or decision to authorize services in an amount, duration, or scope that is less than requested as expeditiously as the Member's health condition requires and within the following timeframes:

1). For outpatient and rehabilitation services, as well as any non-24-hour diversionary service, the Contractor shall make a decision within five (5) business days of the request, and shall provide a written notice to both the Member and the network provider on the next business day after the decision is made. To the extent possible, the Contractor shall develop provisions to notify providers electronically via secure means of authorization decisions;

2). For expedited service authorization decisions, where the network provider indicates and the Contractor determines that following the standard timeframe outlined immediately above could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, or would cause a prudent layperson, possessing an average knowledge of medicine and health, reason to believe that their condition is of such a nature that failure to obtain immediate medical care could result in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, the Contractor shall make a decision and provide notice no later than three (3) business days after receipt of the request for service. The Contract may extend the three (3) business days' time period by up to fourteen (14) calendar days if the Member requests an extension, or if the Contractor justifies a need for additional information and documents how the extension is in the Member's interest (available for review upon MLTC request). For non-emergent expedited service authorization decisions, the Contractor shall make a decision as expeditiously as the Member's health condition requires, with a routine expectation that decisions are made within 24 hours in 50% of cases, 48 hours in 90% of cases, and never any longer than within three (3) business days after receipt of the request for service, other than in cases in which an extension to fourteen (14) calendar days is made. Such an extension to fourteen (14) calendar days shall be allowed only if:

i) The Member has had necessary treatment authorized to address the immediate needs of their health condition; and either
ii) The Member or the network provider requests an extension; or
iii) The Contractor can justify (to MLTC upon request) that (a) the extension is in the Member's interest, and (b) there is a need for additional information where there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

c) The Contractor shall notify the network provider orally and notify both the Member and the network provider in writing of any denial or decision to authorize services in an amount, duration, or scope that is less than requested on the day that the decision is made;

d) The Contractor shall not structure compensation to individuals or entities that conduct UM activities to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member, according to federal regulations at 42 CFR 210(e);

e) The Contractor shall require providers to maintain medical record content consistent with the utilization and control requirements of 42 CFR 456. For medical records and any other health and enrollment information that identifies a particular Member, the Contractor shall establish and implement procedures consistent with confidentiality requirements in 45 CFR parts 160 and 164; and

f) The Contractor shall develop procedures to provide for expedited resolution of appeals. The Contractor shall establish and maintain an expedited review process for appeals, when the Contractor determines (for a request from the Member) or the provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. The procedure shall incorporate the following requirements:

1). Protections against punitive action. The Contractor shall ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's appeal;

2). Action following denial of a request for expedited resolution. If the Contractor denies a request for expedited resolution of an appeal, it shall: (a) Transfer the appeal to the timeframe for standard resolution in accordance with the terms of this section; (b) Make reasonable efforts to give the Member oral notice

(generally within 24 hours of the denial), and follow up within two (2) calendar days with a written notice;

3). This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an action or require a notice of action. The Member may file an appeal in response to this decision;

4). Failure to make a timely decision. Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the Contractor's decision. If a determination is not made by the above timeframes, the Member's request will be deemed to have been approved as of the date upon which a final determination should have been made;

5). The Contractor is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The Member or provider may file an expedited appeal either orally or in writing. No additional follow-up may be required; and

6). The Contractor shall inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

g) The Contractor shall develop or adopt clinical guidelines to govern the authorization of services provided under the contract. All clinical guidelines shall be in compliance with the requirements of Nebraska Administrative Codes and federal requirements:

1). Title 471 NAC 20-000 (Psychiatric Services) and Title 471, NAC 35-000 (Rehabilitation Services) for Members 21 years of age and older; and

2). Title 471, NAC 32-000 (Mental Health and Substance Use Disorder Treatment Services) for Members 20 years of age and younger.

h) The Contractor shall establish an internal UM Committee that focuses on oversight of clinical service delivery trends across individual Members, including evaluating utilization/patterns of care and key utilization indicators such as, but not limited to, re-hospitalizations within seven (7) days, high cost, high service utilization cases, high and low service use outliers, and access to care concerns. The UM Committee is chaired or co-chaired by the Medical Director and reports its findings to the Quality Assessment and Performance Improvement (QAPI) Committee. The UM Committee shall review, at a minimum:

1). Need for and approve any changes in UM policies, standards and procedures, including approval and implementation of clinical guidelines, and approving and monitoring the UM program description and work plan;

2). Grievances and appeals (including expedited appeals and State Fair Hearings) related to UM activities to address required changes;

3). Information from UM/CM operations relevant to system gaps are identified and shared with provider network staff through this committee; and

4). Results from internal audits of CM/UM (e.g., live call monitoring and documentation reviews) to effect changes in policies and procedures and plan training events.

i) The Contractor shall develop a UM Plan and shall implement service authorization procedures for specific behavioral health Covered Services, including, but not limited to the following categories of services:

1). Inpatient Service Authorization

The Contractor shall develop inpatient service authorization policies and procedures, submit them to MLTC for review and approval no later than one month prior to the contract start date, and implement them on the contract start date. Unless the Contractor proposes and MLTC approves alternative policies and procedures, the policies and procedures shall include, at a minimum, the following:

i) A plan and system in place to direct Members to the least intensive clinically appropriate service;
ii) A system for ensuring that, to the extent permitted by law, authorizations for inpatient admissions occur following a crisis assessment and determine that the admission of the Member is medically necessary;
iii) Processes to ensure placement for Members who require behavioral health inpatient services when no inpatient beds are available;
iv) A system for authorizing and assigning an initial length of stay for all admissions, and communicating information on the assigned length of stay to the Member, facility and attending physician;
v) A system of concurrent review for inpatient services to monitor the medical necessity of the need for continued stay and achievement of behavioral health inpatient treatment goals that includes provisions for multiple day approvals when the episode of care is reasonably expected to last more than one day, based on the medical necessity determination;
vi) A system for addressing discharge planning during initial authorization and concurrent review;
vii) A system to ensure post inpatient services is in place to support a safe, timely discharge plan;
viii) A system for conducting retrospective reviews of the medical records of selected inpatient authorizations, to assess the medical necessity, clinical

appropriateness, and appropriateness of the level of care and duration of the stay; and

ix) A system for ensuring that the inpatient services network provider asks for the Member's consent to notify the Member's PCP that the Member has been hospitalized and to request from the NE PH-MCO's assignment of a PCP if the Member does not currently have one.

2). Outpatient and Rehabilitation Service Authorization.
The Contractor shall develop outpatient and rehabilitation service authorization policies and procedures, submit them to MLTC for review no later than one month prior to the contract start date, and implement them on the service start date. Unless the Contractor proposes alternative policies and procedures, the policies and procedures shall include, at a minimum, a system that operates 24 hours a day, seven days a week for:

i) Outpatient services;

1. A policy and system that reviews the initial treatment service request based on clinical guidelines and medical necessity and then authorizes up to 24 sessions without variance for the type of provider performing the service;
2. A policy and system that reviews and authorizes the need for additional services based on clinical guidelines and medical necessity, beyond 12 sessions; and
3. A policy and system for conducting retrospective review of cases to ensure medical necessity;

ii) Rehabilitation services:

1. A policy and system for reviewing provider requests for medical necessity and authorization of services for up to six (6) months based on clinical guidelines and medical necessity;
2. A policy and system that reviews and authorizes the need for additional rehabilitation services beyond 6 months, based on clinical guidelines and medical necessity;
3. A policy and system for conducting retrospective review of cases to ensure medical necessity; and;
4. A policy and system for generally informing network providers of the Contractor's protocols for approving

outpatient and rehabilitation services, such as including such protocols in the provider manual.

10. RETROSPECTIVE UTILIZATION AND REVIEW OF NETWORK PROVIDERS

a. The Contractor shall develop a description of its approach to retrospective utilization review of network providers and submit it to MLTC for approval no later than six months after the contract start date;

b. Such approach shall include a system to identify utilization patterns of all network providers by significant data elements and established outlier criteria for both inpatient and outpatient services;

c. The Contractor shall not under any circumstance utilize contingency fee-based, third-party contracts for the retrospective review of medical necessity and coding;

d. The Contractor must also specify a reasonable appeal process that includes: standard communication with reasonable timelines, industry standards that are clearly communicated and developed with provider and other stakeholder review and input, and opportunities for independent peer provider review of denied claims;

e. The Contractor must conduct retrospective and peer reviews of a sample of network providers to ensure that the services furnished by network providers were provided to Members, were appropriate and medically necessary, and were authorized and billed in accordance with the Contractor's requirements.

f. The Contractor shall have the responsibility for conducting provider reviews related to Medicaid compliance issues;

g. Claims denied payment through retrospective review must be denied individually (i.e., that each claim denied must be specifically reviewed) and any denials (both those resulting in repayment and those withheld from a future payment) must be subjected to due process before payment is withheld or repaid. In the absence of a fully denied claim, the provider must be paid in good faith; and

h. The Contractor shall develop and implement utilization review (UR) functions for examining trends, issues, and problems in utilization, particularly over and under-utilization that may need to be addressed programmatically. The Contractor shall:

- **i.** Develop and implement utilization review procedures, based on best practices in the industry, that focus resources on individual and system outliers;
- **ii.** Develop and implement processes (based in part on clinical decision support, claims and outcome data and medical record audits) for each provider that monitor and report for under-and over-utilization of services at all levels of care, including monitoring behavioral health providers' utilization of services by race, ethnicity, gender, and age; and
- **iii.** Review utilization data to ensure services are being provided in a manner consistent with medical necessity for individuals of all ages and the Principles of Care. When the Contractor detects over or under-utilization to the expected level, the Contractor shall specifically monitor and track utilization of the following services:

a) Crisis services;
b) 24 hour levels of care, including inpatient, PRTF and other residential services;
c) Out-of-home placements for children/youth;
d) Other intensive services, such as assertive community treatment and intensive outpatient programs, to ensure utilization is consistent with practice guidelines; and
e) Other indicators of under- or over-utilization based on the Contractor's utilization and clinical data. Pharmacy data for under-and over utilization and potential inappropriate utilization. As part of this monitoring, the Contractor shall use the pharmacy data to identify potential medication side effects, adverse drug interactions, Member adherence, and indications of prescription abuse. MLTC shall provide pharmacy claims data to the Contractor for Members utilizing specialized behavioral health services. In addition, the Contractor shall:

1). Take reasonable steps to ensure that network providers prescribe pharmaceuticals in accordance with the policies and instructions provided by MLTC and reflected in the State of Nebraska's Preferred Drug List, and other Nebraska publications;
2). Provide prescribers with Members' drug utilization data obtained from MLTC and the Nebraska Drug Use Review (DUR) board to inform prescribing activity. As part of this effort, the Contractor shall:

i) Work to improve collaboration across prescribers, thereby reducing conflicting or duplicate prescribing; and
ii) Assist Members in understanding their prescriptions and engage them in education about their medication and efforts to improve their compliance with prescribed medication regimens, including their ability to effectively communicate about their own preferences and needs with their prescribers to promote shared decision-making;
iii) Provide reports to PCPs, other PCP plan providers, and network providers on the patterns of prescription utilization by Members in an effort to increase collaboration across providers and reduce inappropriate prescribing patterns; and
iv) Provide to admitting physicians at behavioral health network inpatient hospitals, and if directed by MLTC, admitting physicians at other acute hospitals, sufficient pharmaceutical claims and utilization data to support medication reconciliation for Members, both at the time the Contractor authorizes admission to a behavioral health network inpatient psychiatric unit, and subsequently, upon request, in order to:

1. Encourage the use of medications that will not require prior authorization if it is

reasonably expected that the Member will continue to use the drug after discharge;
2. Improve consistency in understanding and use of prescribed medications for Members;
3. Reduce disruptions in the Member's medication regimen; and
4. Reduce incidence of harmful drug-to-drug interactions.

3). Manage the prescribing of psychoactive medications to Members age 20 and under.
To support this effort the Contractor shall:

i) Measure psychopharmacology usage and prescribing patterns for the population of Members age 20 and under;
ii) Monitor the use of and the claims related to psychopharmacology for Members age 20 and under to identify target populations (e.g., age subsets) for proposed interventions;
iii) Prepare Member-specific profiles of medication use based on the pharmacy data to inform Contractor interventions with prescribers;
iv) Develop interventions that reduce unsupported atypical antipsychotic prescribing and unsupported prescribing of multiple medications to the same Member:
v) Implement such interventions upon the approval of MLTC; and
vi) Report to MLTC on the results of the intervention;
vii) Support MLTC pharmacy initiatives by promoting and communicating the adoption of clinical policy recommendations to PCP plan providers and behavioral health network providers; and
viii) In consultation with the DUR board, propose to MLTC additional pharmacy interventions focused on Members.

11. PRACTICE GUIDELINES

The Contractor shall adopt, disseminate, and apply practice guidelines developed in collaboration with MLTC for children with SED and adults with SPMI, and other practice guidelines the Contractor chooses to adopt for all Members, consistent with CMS requirements in 42 CFR 438.236. The practice guidelines must be approved by the Clinical Advisory Committee and MLTC.

a. The Contractor shall utilize medical management criteria and practice guidelines that:

i. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
ii. Considers the needs of Members;

iii. Are adopted in consultation with contracted health care professionals; and

iv. Are reviewed and updated periodically as appropriate, but at least annually.

As part of the implementation planning for the contract, the Contractor shall collaborate with MLTC, and with the Clinical Advisory Committee on the development of appropriate practice guidelines.

The Contractor shall use practice guidelines as a basis for decisions regarding UM, Member education, provider education, coverage of services, and other areas to which practice guidelines apply;

b. The Contractor shall implement practice guidelines in a manner that includes steps to maintain and ensure fidelity to the guidelines. At a minimum, the Contractor shall monitor practice guidelines implementation annually through peer review processes and collection of fidelity measures through its Quality Assurance and Performance Improvement (QAPI) Committee;

c. Using information acquired through quality and utilization management activities, the Contractor shall recommend to MLTC each year the implementation of practice guidelines within the behavioral health delivery system, including measures of compliance, fidelity, and outcomes and a process to integrate practice guidelines into care management and utilization reviews, subject to monitoring by the QAPI Committee;

d. The Contractor shall disseminate the practice guidelines to qualified service providers, post them on its website, and, upon request, disseminate them to Members utilizing behavioral health services. The Contractor shall also provide qualified network providers with technical assistance and other resources to implement the practice guidelines;

e. The Contractor shall perform Early Periodic, Screening, Diagnostic, and Treatment (EPSDT) Services and Access to EPSDT Exams under the Medicaid NMMPH Program;

f. The Contractor shall authorize all medically necessary covered behavioral health services that may be recommended or ordered pursuant to an EPSDT periodic or inter-periodic examination; and

g. The Contractor shall facilitate access to medically necessary behavioral health services recommended pursuant to an EPSDT examination when requested by the Member or designated representative or when the Contractor otherwise determines that it is necessary and appropriate as follows.

12. QUALITY MANAGEMENT

a. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) REQUIREMENTS

The Contractor's QAPI program shall include constant evaluation of the Contractor's operations and the specialized behavioral health systems of care under its management. The Contractor's QAPI program shall be consistent with and responsive to the State physical health Medicaid managed care program, and the Contractor must be able to incorporate relevant variables from the state's Quality of Care Reporting System. At a minimum, the Contractor will utilize a quality improvement strategy to detect both under-utilization and over utilization of services and to assess the quality and appropriateness of care

furnished to Members with special health care needs. The Contractor's annual Quality Management Work Plan must be approved by the State of Nebraska.

i. Compliance with State and Federal Requirements
The Contractor shall develop, implement, and maintain a comprehensive program for QAPI consistent with federal requirements at 42 CFR 438.204, and with the utilization management(UM) program required by CMS for MLTC's overall Medicaid program, as described in 42 CFR 456 – Utilization Control.

ii. Accreditation
The Contractor must either have NCQA accreditation, or another national certification, or it must show significant progress toward the establishment of NCQA accreditation, or another national certification. Official documentation must be submitted at the time of submission. In addition, the Contractor must have the capacity to report required HEDIS measures and performance measures.

The Contractor must include QM processes to assess, measure, and improve the QOC provided to Members in accordance with:

a) All QM requirements identified in the contract;
b) The DHHS CMS Quality Strategy;
c) All state and federal regulatory requirements;
d) Other applicable documents incorporated by reference;
e) Identify and resolve systems issues consistent with a continuous quality improvement (CQI) approach;
f) Disseminate information to MLTC, Members, providers, and key stakeholders, including families/caregivers, and promote public availability of data regarding performance;
g) Solicit feedback and recommendations from key stakeholders, subcontracts, Members, and families/caregivers, and use the feedback and recommendations to improve the quality of care and system performance; and
h) Track progress in implementation of, as well as measure and enforce adherence to, the Principles of Care defined in the Contract. Measurement and compliance with adherence to these principles shall be promoted and enforced through the following strategies, at a minimum:

1). Use of QAPI findings to improve practices at the subcontract and Contractor levels;
2). Timely reporting of findings and improvement actions taken and their effectiveness; and
3). Dissemination of findings and improvement actions taken and their effectiveness to key stakeholders, committees, Members, families/caregivers, and posting on the Contractor's website.

iii. Data Collection
The Contractor shall collect data and conduct data analysis with the goal of improving the quality of care within the behavioral health system. The Contractor's information system will support the QAPI process by

collecting, analyzing, integrating, and reporting data necessary to the State's Quality Strategy. All collected data shall be available to the MLTC. The data shall provide information on areas including, but not limited to, utilization, grievances and appeals. The system shall also collect data on Member and provider characteristics as specified by the state and on services furnished to Members through an encounter data system. The Contractor shall ensure that data received from providers is accurate and complete by:

a) Verifying the accuracy and timeliness of reported data;
b) Screening the data for completeness, logic, and consistency;
c) Collecting service information in standardized formats to the extent feasible and appropriate;
d) The Contractor shall participate in the review of QI findings and shall take action as directed by MLTC;
e) The Contractor shall have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program;
f) The Contractor shall participate in developing, implementing, and reporting on performance measures and topics for performance improvement projects (PIPs) required by other state or federal agencies, including performance improvement (PI) protocols or other measures, as directed by MLTC; and
g) The Contractor shall report performance data to DHHS in formats approved, in advance, by MLTC.

iv. Quality Improvement Staffing

The Contractor shall have a sufficient number of qualified personnel to comply with all QM requirements in a timely manner, including external quality review activities, and avoid review and monitoring activities unlikely to affect service delivery or quality of care.

v. Methodology

The Contractor shall further develop, operationalize and implement the outcome and quality performance measures listed above with the QAPI Committee, with appropriate input from, and the participation of, MLTC, Members, family members, and other stakeholders. The Contractor shall report to MLTC the results and findings of its outcome and performance measures compared to expected results and findings from performance improvement efforts and activities planned/taken to improve outcomes. The Contractor shall use an industry-recognized methodology, such as SIX SIGMA or another method(s) for analyzing data. The Contractor shall demonstrate inter-rater reliability testing of evaluation, assessment, and utilization management (UM) decisions.

vi. Satisfaction

The Contractor shall conduct an annual Member and provider satisfaction survey as directed and prior approved by MLTC, and it shall report complete results to MLTC. Satisfaction surveys shall include input from the QAPI Committee and the Contractor shall indicate to MLTC, in its attempt to obtain MLTC approval, specifically how family members, youth, and adult consumers have employed the design and

methodology of each survey. In addition, surveys shall be conducted within the following guidelines:

a) Frequency
The Contractor shall measure the satisfaction of all Members served, Members with complex needs, and providers once during each contract year.

b) Implementation
The Contractor shall commence the collection of data on Members, Members with complex needs, and provider satisfaction via survey by the end of the first year of operations and annually thereafter. The Contractor shall complete the data collection, analysis, interpretation and final reporting to MLTC by the end of the first year of the contract and annually thereafter.

c) Methodology of the Member Surveys
The methodology utilized by the Contractor shall be based on proven research methods ensuring an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of at least 95% and scaling that results in a clear positive or negative finding (neutral response categories should in general be avoided). The Contractor shall utilize measures that are based on current scientific knowledge and clinical experience. The survey shall specifically address satisfaction with and perceived utility of the appeal and grievance process for Members, their families, and providers. The Member survey will also include questions about perceptions of the utility of services, including:

1). Whether Members and guardians of child Members reported that they received the services they believed they needed;
2). Perceptions regarding participation in treatment;
3). Access to prevention interventions; and
4). Whether transportation supports were adequate (particularly in rural areas).

d) Methodology of the provider Survey
The Contractor shall conduct a provider satisfaction survey using a provider survey instrument approved by MLTC. The methodology utilized by the Contractor shall be based on proven research methods ensuring an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of at least 95% and scaling that results in a clear positive or negative finding (neutral response categories should in general be avoided). The Contractor shall utilize measures that are based on current scientific knowledge and clinical experience. The survey shall, at a minimum, address the provider's satisfaction with the Contractor's services and other administrative services provided by the State or its agents, including but not limited to authorization, courtesy and professionalism, network management services, provider

appeals, provider education, referral assistance, coordination, claims processing and the perceived administrative burden experienced by providers providing behavioral health services.

vii. Respondent Groups

a) Members and Members with special needs
Samples of Members 18 years of age and older and caregivers/family members of children and youth should be included in all Member surveys. Samples should be representative of Members and caregivers / family members based on the type of question asked.

b) Providers
For the provider survey, all providers should be administered the survey.

viii. Consumer – Led and Family – Led Evaluations
The Contractor shall include consumer-led and family-led evaluation methods in its quality monitoring system, involving as researchers: adult consumers, youth over the age of 17, and family members/guardians of child Members served. Methods may include participatory action research. There should be at least two focuses:

a) A consumer-driven evaluation of adult service issues;
b) A family- and youth-driven evaluation of child and young adult service issues; and
c) The consumer- and family-led evaluation component must be approved by MLTC prior to implementation. The evaluations should include appropriate incentives to promote consumer, youth and family participation in the evaluations. These evaluations should be:

1). Operated independently by consumers and family members and not administratively managed by the Contractor; and
2). Focused on evaluation to learn about the experiences of people served by the Contractor.

d) The Contractor must have a contract or a written and signed agreement with each organizational entity conducting consumer- and family-led evaluation that delineates roles and responsibilities of all parties;
e) Under the contract or written agreement, the consumer- and family-led evaluation team members will act as agents of the Contractor, and are, therefore, to have the same access to consumers and family members as the Contractor and network providers, insofar as it is necessary to perform their responsibilities;
f) Consumer- and family-led evaluation team members must be paid at least as much as other persons in the broader workforce doing similar work in the same community;

g) The consumer- and family-led evaluation team must be independent from any provider of behavioral health services or any other agency that might create a conflict of interest. If a team does not have accounting capabilities, it may contract with a provider as its fiduciary, provided the contract safeguards the independence of the evaluation team for program direction, including budget priorities, satisfaction surveys, findings, and recommendations;

h) The Contractor shall work with the consumer- and family-led evaluation teams to establish an annual plan for conducting evaluations;

i) The Contractor will ensure that the consumer- and family-led evaluation teams have adequate financial resources, training, support, and necessary equipment for the program to produce high quality quarterly reports;

j) The Contractor will identify and ensure that the consumer- and family-led evaluation teams conduct outreach efforts to under-served or un-served groups of consumers and families in order to identify system improvements that will increase the access, engagement and retention of these individuals in needed behavioral health services;

k) All employees of consumer- and family-led evaluation programs must comply with applicable state and federal laws, regulations, and rules regarding the confidentiality of mental health consumers and recipients of drug and alcohol treatment services;

l) The contract or written agreement will address confidentiality requirements;

m) Consumer- and family-led evaluation teams must provide feedback to the Contractor through written quarterly reports and regular problem resolution meetings that allow for dialogue and review of findings. The Contractor is responsible for timely reports back to the consumer- and family-led evaluation teams on specific actions and problem resolution resulting from identified issues, concerns and problems;

n) The Contractor will ensure that consumer- and family-led evaluation team members have both an initial orientation and on-going training in the following areas:

1). Basic knowledge of mental illness and addictive diseases and an understanding of the concept of recovery and resilience in relation to both adults and children and adolescents. Persons performing youth and family evaluation activities must also have an understanding of severe emotional disturbance and substance use disorders for children and adolescents;

2). Confidentiality regulations for mental health and substance use disorder services. Family and youth evaluation team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance use disorder services. Training must include an understanding of responsibilities, as applicable, under the

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 CFR Part II; and

3). Orientation/training on the Contractor's managed care operations, policies and procedures for satisfaction team members.

o) Quarterly Reports. The Contractor shall provide MLTC with the consumer- and family-led evaluation teams' quarterly report summarizing consumer and family evaluation findings, as well as improvement actions and system changes implemented by the Contractor in response to those findings; and

p) The Contractor shall monitor and evaluate qualified service providers in order to promote improvement in the quality of care provided to Members. The Contractor shall detail a provider monitoring plan in the required Annual Quality Management Plan.

ix. Quality Reporting

a) Quality Management and Utilization Management Reporting
The Contractor shall monitor and report QM and UM data and other performance improvement activities to MLTC. The Contractor shall submit, in writing to MLTC, in a format collaborated with and approved by MLTC, the following, but not limited to, QM/UM deliverables related to the quality of care and services in the health plan:

1). The Contractor shall report results of measuring or assessing outcomes and quality, and shall incorporate these performance indicators into performance improvement projects. To the extent possible, results should be posted publicly on the Contractor's website immediately after being accepted by the QAPI Committee and reported to MLTC;

2). Any outcomes and quality indicators based on a sample of the overall Member, family, and/or provider population must include demonstration that the samples are representative and statistically valid. .Whenever data are available, outcomes and quality indicators should be reported in comparison to past performance and to national benchmarks; and

3). Outcomes and quality indicators will include to the extent practicable, but are not limited to, the following:

i) All of the metrics involved in the performance guarantees and incentives described in the Financial Section;
ii) Call center performance;
iii) Service utilization, including trends, outliers, expenditures, and length of stay in each service by level of care, including new services developed (for example, peer support and respite). This will include standard measures, such as use/days per 1000

Members and penetration rates overall and by level of care. This will also include breakouts by age group;

iv) Seven and 30-day post-discharge (residential and acute care) ambulatory follow-up appointments; and

v) Racial and ethnic disparities (e.g., under-utilization of services by particular racial/ethnic groups) and cultural and linguistic competency. The Contractor is encouraged to utilize indicators consistent with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to include, but not limited to:

    1. Racial & Ethnic Disparities: PRTF admissions over 90 days; and
    2. Differences in service penetration rates across population groups.

vi) Access – Differences in service penetration rates across population groups;

vii) Perceptions of Care – Differences across population groups' perceptions that services are effective, understandable and respectful (this includes consumer satisfaction);

viii) Restraint and seclusion use – Track by provider the number of incidents of restraints and seclusion by program location. Involve consumer and family advocates, along with inpatient and residential providers, in the development of restraint and seclusion reporting requirements;

ix) Provider network adequacy;

x) Results of targeted quality assurance network activities for high volume providers;

xi) Monitoring psychotropic medications for children ages 12 years and under, including vulnerable populations such as children in foster care or in state custody;

xii) Performance related to grievances and appeals, including types, resolution time frames, and analysis of trends. This will include reporting of individual provider appeal rates and outcomes by level of care;

xiii) The actual number and percentage of Members involuntarily presenting for Mental Health and Substance Use Disorder treatment to 24- hour inpatient settings;

xiv) The actual number and percentage of Members presenting to hospital emergency departments (ED) within thirty (30) days of the discharge date from an acute level of care for any psychiatric or substance use disorder diagnosis – without an admission;

xv) Proportion of youth in PRTF and other residential settings with lengths of stay under 90 days;

xvi) Wait times for residential placement that measure time from initial referral to authorization to actual placement;

xvii) Admissions and readmissions to psychiatric inpatient (including PRTF) and residential facilities;
xviii) Continuity of care measures (within 7 days) from psychiatry inpatient facilities to community services;
xix) Number of children placed in residential treatment settings, relative to number of Medicaid Members, and relative to national benchmarks;
xx) Screening for Clinical Depression and Follow Up Plan;
xxi) Antidepressant Medication Management;
xxii) Adherence to Antipsychotics for Individuals with Schizophrenia;
xxiii) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment;
xxiv) Crisis services utilization, relative to number of persons (broken out by child/adolescent and adult) served and to national benchmarks; and
xxv) Emergency department utilization, using benchmarks and age breakouts.

x. External Quality Reviews

External Quality Reviews (EQR) /Independent Assessments. The Contractor and its subcontracts shall cooperate with annual, external, independent reviews performed by an EQR organization (EQRO) or independent assessor of quality outcomes, timeliness of and access to services, upon MLTC request. The Contractor shall include in its QM Work Plan, to be approved by MLTC, plans for addressing problem areas identified by the EQRO in its assessment.

b. MLTC QUALITY REVIEWS

The Contractor shall make available records and other documentation, and ensure Subcontractors' participation in and cooperation with, the annual on-site operation review of the Contractor, and any additional QM reviews. This may include participation in staff interviews and facilitation of Member/family/caregiver and subcontract interviews.

The Contractor shall use QM review findings to improve quality of care. The Contractor shall take action to address identified issues, as directed by MLTC, which may require a plan of correction, if the Contractor is determined by MLTC to be performing below quality standards.

The Contractor and its subcontractors shall cooperate with DBH and participate, as necessary, in SAMHSA core reviews of services and programs used by Members that are funded by DBH through the SAPT and CMHS Performance Partnership Grants. Core review findings shall be communicated to the Contractor's QM program and shall be used by the Contractor to enhance and improve the delivery of grant related services for Members. The development and implementation of a corrective action plan with specific, measurable, and time-limited corrective action steps is also required if weaknesses/challenges are identified during the core review. The corrective action plan shall be approved and accepted by SAMHSA and/or MLTC.

c. PERFORMANCE IMPROVEMENT

As part of its QAPI program, the Contractor shall conduct at least two (2) performance improvement projects outlined in its annual Quality Management Work Plan that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on behavioral health outcomes and Member satisfaction. The Contractor shall report the status and results of each project to the state as requested and as outlined in the most recent Nebraska MLTC Quality Strategy Plan.

Each performance improvement project shall be completed in a reasonable time period, so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

At a minimum, the performance improvement projects shall involve the following:

i. Measurement of performance using objective quality indicators;
ii. Implementation of system interventions to achieve improvement in quality;
iii. Evaluation of the effectiveness of the interventions;
iv. Planning and initiation of activities for increasing or sustaining improvement; and
v. The Contractor shall include among its performance improvement projects at least one clinical issues study each contract year. The Contractor may submit more than one study idea, among which MLTC and the QAPI Committee will select one for approval.

a) During each year of the contract, propose to MLTC the scope of the clinical issues studies, by date TBD;
b) Submit to MLTC by date TBD or such other date as agreed to by MLTC and the Contractor, for their review and approval, a draft of the study report for each clinical issue study. The study report shall, at a minimum, include recommendations for intervention;
c) Implement the report recommendations upon approval by MLTC and the QAPI Committee; and
d) Use a methodology based on accepted research practices ensuring an adequate sample size and statistically valid and reliable data collection practices. The Contractor shall use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate.

d. QUALITY IMPROVEMENT COMMITTEE

i. The Contractor shall provide a mechanism for the input and participation of Members, Families/caretakers, MLTC and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.
ii. The Contractor shall form a QAPI Committee no later than one month following acceptance of the MLTC contract terms, form a QAPI

Committee. The Contractor's Medical Director shall serve as either the chairperson or co-chairperson of the QAPI Committee.

The Contractor shall include as members on the committee, at a minimum, the following:

a) The Contractor's Quality Management Administrator;
b) Contractor managers representing utilization management;
c) Member services;
d) Provider network management;
e) Two family members/guardians of children or youth who are Medicaid Members;
f) Two adult consumers who are Medicaid Members;
g) Six provider members knowledgeable about Mental Health and Substance Use Disorder treatment for children, adolescents and adults in Nebraska across a variety of ages and races/ethnicities, including awareness of differences between rural and urban populations and representing a range of service providers., the MLTC Quality Manager; and a liaison member from the MLTC Quality Committee; and
h) To the extent possible, family members and consumers should be nominated by family and consumer organizations in Nebraska. In addition to the six family, youth, and adult Member representatives, there will be at least two non-voting apprentice members in each category (two family, two youth, two adult members) that participate in the QAPI Committee regularly.

iii. The Contractor's QAPI Committee shall:

a) Review for approval prior to implementation the Contractor's QM Work Plan and program description that incorporates its initiatives, strategies, staff time and organization, methodologies for on-going quality assurance, quality improvement, and concurrent system for identifying issues that require immediate attention of MLTC;
b) Require the Contractor to study and evaluate issues that the MLTC may from time to time identify;
c) Establish annual performance targets as described in the Performance Targets and Withhold section;
d) Review for approval all Member and provider surveys;
e) Define the role and guidelines for the QAPI Committee, set agendas, and produce meeting summaries;
f) Include Members who have received services and family members, supporting them with training, stipends for their participation (if they are not otherwise paid for their participation as staff of an advocacy or other organization), and reimbursement for any travel, child care or other reasonable participation costs (not otherwise reimbursed by another party) to enable their participation; and
g) Annually, and as requested, provide data to the MLTC Quality Committee, which meets annually to review data and information relevant to the MLTC Quality Strategy. The Contractor shall incorporate into its QAPI program and annual QM Work Plan the

recommendations from the MLTC Quality Committee concerning performance improvement projects, study methodologies, improvement goals, and interventions to achieve improvement goals.

iv. Additional required committees shall include:

a) Clinical Advisory Committee;
b) Corporate Compliance Committee;
c) Provider Advisory Committee; and
d) Utilization Management Committee.

The additional required committees will report on at least a quarterly basis to the QAPI Committee, and the QAPI Committee will monitor their performance as part of its annual quality management work plan.

N. INFORMATION SYSTEM (IS) REQUIREMENTS

1. HEALTH INFORMATION SYSTEMS – REQUIREMENTS

The Contractor must maintain a health information system that collects, analyzes, integrates, and reports data. Reporting formats will be determined by the State after contract award. Contractor must provide documentation on its Health Information System that ensures data received from providers is accurate and complete by:

a. Verifying the accuracy and timeliness of reported data;
b. Screening the data for completeness, logic, and consistency; and
c. Collecting service information in standardized formats to the extent feasible and appropriate.

2. HEALTH INFORMATION SYSTEMS – FUNCTIONS

The Contractor must be able to perform the following functions electronically:

a. Receive enrollment verification via a HIPAA compliant 834 format;
b. Receive electronic premium payments remittance advice via a HIPAA compliant 820 format;
c. Provide enrollment verification in a HIPAA compliant 270/271 format;
d. Accept prior authorization requests in a HIPAA compliant 278 format;
e. Allow claims inquiry and response in a HIPAA compliant 276/277 format;
f. Accept HIPAA compliant electronic claims transactions in the 837 format;
g. Generate HIPAA compliant electronic remittance in the 835 format;
h. Submit encounter data via a HIPAA 837 format; and
i. Make claims payments via electronic funds transfer.

3. HEALTH INFORMATION SYSTEMS – ENCOUNTER DATA

The Contractor must collect data on member and provider characteristics as specified by the State and on services furnished to members through an encounter data system. The Contractor must be able to submit encounter data in a format specified by the state. The Contractor must also be capable of submitting encounter data via ASC X12 formats.

The Contractor must maintain an information system that includes the capability to collect data on potential member and provider characteristics, and claims information through an encounter data system. The Contractor must submit encounter data to the

Medicaid Management Information System (MMIS) monthly per Departmental specifications.

Encounter data submission must:

a. Be submitted on a monthly basis;
b. Be submitted accurately and meet the Performance Measures for Submission and Acceptance as outlined in numbers 18. and 19. in the table under Section IV.O.11.a.v, Performance Guarantees; and
c. Include all clean claims adjudicated by the Contractor; and all services provided to the member, contracted or delegated.

Encounter data that does not meet the Submission and Acceptance rate thresholds will be rejected and reported to the Contractor. The Contractor is required to re-submit corrected encounter data in a timely manner. Contractor's which fail to meet compliance standards for submission of encounter data will result in a corrective action plan and monetary penalties, as described in Section IV.O.11.b, Performance Assessment.

4. HEALTH INFORMATION SYSTEMS – INFORMATION AVAILABILITY

The Contractor must make all collected data available to the State and, upon request, to CMS.

The Contractor's IS shall support the following key functions:

a. Twenty-four (24) hour, seven (7) days a week toll free telephone access line with user and technical support;
b. Customer services (including eligibility);
c. Care management;
d. Quality management;
e. Grievances and appeals, and incident reporting;
f. Provider network management;
g. Notification of Member rights and responsibilities;
h. Financial reporting;
i. Claims administration;
j. Utilization;
k. Implementation planning;
l. Business continuity, disaster recovery and emergency preparedness;
m. Performance measurement and accountability;
n. State and federal reporting requirements, including consistency with the MLTC and DBH data dictionaries;
o. Secure electronic data interchange as needed to accomplish the above functions;
p. State access to client-level data; and
q. The IS shall provide the required capacity for electronic data collection, analysis, transfer, error resolution and reporting of data at the client level and will provide the required data to the Medicaid Medical Information System (MMIS) for, reporting, and auditing.

i. The Contractor shall utilize current state and federal standards and procedures (e.g., HL7; HIPAA; NPI; CMS; CPT; ICD-10) for this system and will maintain a uniform service and provider (credentialing) taxonomy for billing and information management purposes. The

Contractor shall provide technical assistance and consultation to providers on establishing the means for effective, ongoing electronic collection and transfer of required data.

ii. The scope of coverage of the IS will be for all programs and services provided through the Contractor, as well as data to allow coordination with publically financed non-Medicaid services provided to the Contractor's Members as reported by other Nebraska state agencies.

iii. The data content will include, but may not be limited to, the following data sets: Client data (socio-demographic and contact information; unique client ID); assessment data (including diagnoses in current DSM format; level of functioning scores); service encounter data (e.g., date, type, duration, recipient, provider); episode data (e.g., service program; unique episode ID; date of first contact; date of admission; date of last contact; date of discharge); programmatic data (e.g., service population and eligibility; payer source; fee schedules); individual claims data; and provider data (e.g., provider agency, name, unique provider ID, discipline). The technical specifications of these data will be in keeping with current state and federal for data content. The Contractor must be able to make modifications to the data system during the term of the contract to reflect changes in the MLTC, and MLTC systems and/or federal reporting requirements. Such updates shall be available at agreed upon intervals, and notice of such updates given to service providers (preferably via electronic means) as soon as determined.

iv. The Contractor will be expected to at least bi-weekly update and monthly transfer this data set in a format and file structure (including requisite documentation) required by MLTC. The Contractor shall document the process and procedures for data management in keeping with the changing reporting requirements of the state and federal government and local programs. The Contractor will be expected to provide MLTC current documentation of the data set, process, and procedures.

v. The Contractor shall be responsible for providing training and support of all provider staff utilizing the data management system.

vi. The Contractor shall perform data quality management, in conjunction with MLTC in order to demonstrate that the data are accurate, appropriate, complete, and reported timely across all program units.

5. CARE MANAGEMENT AND CARE COORDINATION INFORMATION

The Contractor shall have the following IS capacity to facilitate care coordination:

a. PROVIDER INFORMATION

The Contractor shall have the capacity to collect, analyze, electronically and securely transfer, report, and utilize data from multiple service provider sources, and the capacity to adapt and upgrade these functions as necessary with future changes to the service and administrative operations of the program.

b. PHARMACY DATA

MLTC will provide a monthly download of pharmacy claims data to the Contractor for enrolled Members to allow routine monitoring of prescribed medications. The Contractor shall have the ability to accept and analyze electronic pharmacy data from DHHS and report on individual Member and aggregate pharmacy utilization data and provider prescribing practices, as well

as other similar reports on Member pharmacy utilization for quality management purposes.

i. The Contractor shall have the capacity to populate the Members' care management records with prescribed medications as identified through pharmacy data provided by DHHS. If medications are prescribed, the Contractor must obtain a list of medications prescribed by primary care providers (PCPs) and other specialists for a complete and reconciled medication list that is updated every 90 days.

c. Medication information will be made available in electronic format to providers treating the Member on a regular basis, in accord with data sharing requirements. For inpatient and PRTF admissions, current data on pharmacy claims will be shared with the inpatient provider within 24 hours. For other levels of care, current data on pharmacy claims will be shared with the provider within seven calendar days initially and updated regularly thereafter every thirty (30) days.

d. HEALTH PLAN AND PCP ASSIGNMENTS

The Contractor shall have the capacity to electronically accept data on Member health plan assignments from MLTC or the health plan for purposes of identifying PCPs and to incorporate PCP information into the care management record. The Contractor should receive at least monthly (and preferably weekly) data extracts from MLTC or Medicaid health plans documenting current PCPs for all Medicaid Members. The Contractor shall develop in collaboration with MLTC and Medicaid health plans a data sharing and notification system.

e. COORDINATION BETWEEN PCPS AND BH PROVIDERS

Using authorization and claims data, when Medicaid Members receive services from the provider network, the Contractors IS notification capacity will generate supporting communication electronically.

f. MEMBERS ALREADY ASSIGNED PCPS

Two sets of communication (preferably secure email or other secure electronic means) will be generated, one to the network behavioral health provider informing that provider of the name and contact information for the Member's PCP (including the health plan's procedures for emergency contact for that PCP regarding physical health needs) and one to the PCP informing that provider that behavioral health care has been authorized and the name and contact information of the network behavioral health provider.

g. MEMBERS WITHOUT AN ASSIGNED PCP

Two sets of communication (preferably secure email or other secure electronic means) will be generated by the Contractor, one to the Member's health plan requesting a PCP referral (when a Member does not have a PCP) and informing the health plan that behavioral health care has been authorized (along with the name and contact information of the network behavioral health provider) and one to the network behavioral health provider informing that provider of the initiation of a referral to a PCP. The arrangement with the physical health plans will also include provisions for them to notify the Contractor once a PCP assignment has been made, including the provider's name and contact information, and the Contractor will notify the behavioral health network provider.

6. PROVIDER NETWORK MANAGEMENT SYSTEM SUPPORT

The Contractor shall provide information technology support to manage the provider network including, but not limited to, the provider administration, including credentialing, contracting, provider database for referrals, web-based communications, provider manual, and provider complaints, as well as performance requirements defined throughout the contract.

7. CLAIMS PAYMENT

a. CLAIMS PROCESSING REQUIREMENTS

i. The Contractor shall provide an integrated claims processing and payment system for Medicaid services within the managed care program. This system will have the capability to perform eligibility, billing, accounts receivables, accounts payable, remittance advices, prior authorization, fiscal management, provider enrollment, and any other required function to manage claims for Medicaid and all State funding sources.

ii. The Contractor shall maintain a website, with both public and secure access multi-level portals (such as providers, managers and Members), for providing data/measure manuals, web-based training, standard reports, evaluation tool, and data access as needed for the effective management and evaluation of the performance of the Contractor and the service delivery system. The website may be combined with the Member services website required under the Member services requirements of the Contract.

iii. The Contractor shall conform to HIPAA-compliant standards. Transaction types are subject to change and the Contractor shall timely comply with applicable federal and HIPAA standards and regulations as they occur.

iv. The Contractor shall plan for changes such as, but not limited to, the new ANSI 5010 formats and implementation of ICD-10 diagnosis and inpatient procedure codes.

a) Upon request, the Contractor shall provide MLTC with their ICD-9 code mapping to ICD-10 coding equivalents and ICD-10 coding combinations.

v. The Contractor shall require that their providers comply at all times with standardized billing paper forms and electronic formats, and all future updates for Professional and Institutional claims. All data shall be submitted to MLTC in the standard 5010 HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB transaction formats (P - Professional, and I - Institutional).

a) The Contractor shall not revise or modify the standardized forms or formats without agreement of all parties;

b) The Contractor shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms; and

c) The Contractor shall ensure that ninety percent (90%) of clean claims for payment of services delivered to a Member are paid by the Contractor to the provider within thirty (30) calendar days

of the receipt of such claims. Process and if appropriate, pay within ninety (90) calendar days, ninety-nine percent (99%) of all provider claims for Covered Services delivered to a Member.

vi. If a claim is partially or totally denied on the basis the provider did not submit required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all necessary information and documentation that is needed for the claim to be processed. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the timeframe for claims processing.

vii. On every claim processing day, the Contractor shall utilize a randomly selected sample of all processed, adjusted, and paid or denied claims. A minimum sample of two percent of those daily claims shall be audited. Results from the audits shall be collected and reported to MLTC monthly. The minimum attributes to be tested for each claim selected shall include:

a) Claim data correctly entered into the claims processing system with an assigned transaction number;
b) Claim is associated with the correct provider;
c) Service obtained the proper authorization;
d) Authorization limits are not exceeded;
e) Member eligibility at processing date correctly applied;
f) Allowed payment amount agrees with contracted rate;
g) Duplicate payment of the same claim has not occurred;
h) Denial reason applied appropriately;
i) Co-payment application considered and applied;
j) Effect of modifier codes correctly applied;
k) Proper coding consistent with the provider's credentials;
l) Adjustments to claims are properly made with supporting documentation;
m) Payment is coordinated properly when other insurance is applicable; and
n) The results of testing, at a minimum, should be documented to include:

1). Results for each attribute tested for each claim selected;
2). Amount of overpayment or underpayment for each claim processed, adjusted or paid in error;
3). Explanation of the erroneous processing for each claim processed, adjusted or paid in error;
4). Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and
5). Claims processed, adjusted or paid in error have been corrected.

o) The Contractor shall perform front end system edits, including, but not limited to:

1). Confirming eligibility on each Member as claims are submitted on the basis of the eligibility information

provided by MLTC that applies to the period during which the charges were incurred;

2). Medical necessity – the system shall validate that medical necessity was determined;

3). Prior approval – the system shall determine whether a covered service required prior approval and if so, whether the Contractor granted such approval;

4). Duplicate claims – the system shall in an automated manner, flag a claim as being exactly the same as a previously submitted paid claim or a possible duplicate and either deny or pend the claim as needed;

5). Covered Services - ensure that the system can verify that a service is a covered service and is eligible for payment;

6). Provider validation - ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted;

7). Quantity of service - ensure that the system shall evaluate claims for services provided to Members to ensure that any applicable benefit limits are applied; and

8). System edits for valid dates of service, and assures that dates of services are valid dates such as not in the future or outside of a Member's Medicaid eligibility span.

The location of claims processing staff shall be indicated and shall be at minimum located in the continental United States.

b. DATA CERTIFICATIONS

The Contractor must certify encounter data as provided in 42 CFR 438.606.

i. The data must be certified and shall include, but is not limited to, all documents specified by the State, enrollment information, encounter data, and other information contained in contracts, proposals;

ii. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The MCO or PIHP must submit the certification concurrently with the certified data and documents; and

iii. For the data and documents the MCO or PIHP submits to the State, they must be certified by one of the following:

a) The MCO's or PIHP's Chief Executive Officer;

b) The MCO's or PIHP's Chief Financial Officer; or

c) An individual who has delegated authority to sign for, and who reports directly to, the MCO's or PIHP's Chief Executive Officer or Chief Financial Officer.

8. THIRD PARTY RESOURCES (TPR)

A member enrolled in managed care may have active commercial insurance or other TPR. When a member is identified as having Third Party Liability (TPL), the following provisions apply:

a. Pursuant to federal and State law, the Medicaid program is intended to be the payer of last resort. This means all other available Third Party Liability (TPL)

resources must meet their legal obligation to pay claims before the Medicaid/CHIP program pays for the care of an individual eligible for Medicaid/CHIP;

b. The Contractor shall exercise full assignment rights, as applicable, and shall be responsible for making every reasonable effort to determine third parties to pay for services rendered to members under the Contract and cost avoid and/or recover any such liability for the third party;

c. The Contractor shall coordinate benefits in accordance with 42 CFR 133.135 et seq. and 471 NAC 3-004, so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery;

d. The Contractor, or its Subcontractors or providers, must not pursue collection from the member, but directly from the liable third party payers, except as allowed in 468 NAC Chapter 4-002 and 471 NAC Chapter 3-004;

e. Establishing TPL takes place when the Contractor receives confirmation that another party is, by statue, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or services delivered to any member.

If the probable existence of a Third Party Resource (TPR) cannot be established the Contractor must adjudicate the claim. The Contractor must then utilize post-payment recovery;

f. If a Third Party Liability insurer requires the member to pay any co-payment, coinsurance, or deductible, the Contractor is responsible for making this payment even if the services are provided outside of the Contractor network;

g. The Contractor shall treat funds recovered from third parties as offsets to claims payments. The Contractor will report all cost avoidance values to MLTC in accordance with federal guidelines and will be required to include the collections and claims information in the encounter data submitted to MLTC, including any retrospective findings via encounter adjustments. The Contractor must also report third party collection in the aggregates as required by MLTC;

h. The Contractor shall post all third party payments to claim level detail by member;

i. Third party resources will include subrogation recoveries. The Contractor will be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the Contractor outside of the claims processing system will be treated by the Contractor as offsets to medical expenses for the purposes of reporting;

j. The Contractor shall identify the existence of potential TPL to pay for services in the basic benefits package through the use of diagnosis and trauma code editing. This editing should, at a minimum, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) and any other applicable trauma codes, including, but not limited, to E Codes in accordance with 42 CFR 433.138(e);

k. 4The Contractor must provide TPL data to any provider having a claim denied by the Contractor based upon TPL;

l. MLTC will provide the Contractor with a listing of known third party resources for its members via the enrollment file and will contain information made available to MLTC at the time of eligibility determination and/or re-determination. If the Contractor operates or administers any non-Medicaid HMO, health plan or other lines of business, the Contractor shall assist MLTC with the identification of members with access to other insurance;

m. The Contractor shall provide to MLTC any third party resource information necessary in a format and media described by MLTC and shall cooperate in any manner necessary, as requested by MLTC, with MLTC and/or a cost recovery vendor at such time that MLTC acquires said services;

n. MLTC may require a MLTC contracted TPL vendor to review paid claims that are over ninety (90) calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the Contractor's reports encounter data;

o. The Contractor must demonstrate, upon request, to MLTC that reasonable effort has been made to seek, collect and/or report third party recoveries. MLTC shall have the sole responsibility for determining whether reasonable efforts have been demonstrated. Said determination will take into account reasonable industry standards and practices;

p. Any money recovered by third parties shall be retained by the Contractor and identified monthly to MLTC;

q. If MLTC determines that the Contractor is not actively engaged in cost avoidance activities, the Contractor shall be subject to monetary penalties in an amount not less than three times the amount that could have been cost avoided; and

r. MLTC will be solely responsible for estate recovery activities and will retain any and all funds recovered through these activities.

O. TRANSITION AND IMPLEMENTATION

1. TRANSITION PERIOD

The Transition Period for the contract shall begin upon contract award and shall end 90 days after the contract start date. During the Transition Period the Contractor shall implement the terms of the Contract and collaborate with MLTC to facilitate a seamless transition between Contractors, providers and programs in order to prevent interruption of services and to promote continuity of care to Members.

2. PRELIMINARY IMPLEMENTATION PLAN

The Contractor is responsible for submitting a Preliminary Implementation Plan with this proposal. The Preliminary Implementation Plan shall include all the major areas of the contract including:

a. Member services;
b. Network Development and Management;
c. Credentialing;
d. Care Management;
e. Utilization Management;
f. Service Coordination;
g. Information Management;
h. Claims Payment; and
i. Grievance and Appeals.

3. In addition, the Preliminary Implementation plan must include Human Resource Development and Staffing, Customer Service, Facilities and Data/Telephone and other pertinent operational issues as identified in this RFP and the Contractor's proposal. The Preliminary Implementation Plan shall include activities, deliverables and milestones to implement the program.

4. Upon contract award, the Contractor shall immediately begin a collaborative process with MLTC to review the contract, proposal and Preliminary Implementation Plan. The Contractor shall provide MLTC with verbal and written Implementation Plan updates and shall cooperate and communicate with MLTC to resolve transition and implementation issues to MLTC' s satisfaction.

5. The Contractor shall appoint key staff to participate in the transition coordination/collaboration process and must include at a minimum:

- **a.** Administrator/CEO/COO;
- **b.** Medical Director/CMO;
- **c.** Clinical Director/Manager;
- **d.** Operations Manager/Director;
- **e.** Network Services Director/Manager;
- **f.** Information Technology Director/Manager; and
- **g.** Quality Improvement Director/Manager.

6. THE TRANSITION/IMPLEMENTATION PROCESS IN COLLABORATION WITH MLTC SHALL:

- **a.** Define project management and reporting standards;
- **b.** Establish communication protocols between the Contractor, MLTC and existing Providers; and
- **c.** Define expectations for content and format of Contract deliverables.

7. IMPLEMENTATION PERIOD AND PLAN

- **a.** The Contractor shall develop a updated, detailed comprehensive Implementation Plan to monitor progress throughout the Transition and Implementation Periods; and
- **b.** The Contractor shall include in the Implementation Plan a detailed description of its implementation methods, staff assigned to be accountable for completing tasks and timetables, including, at a minimum, the following components:

  - **i.** Staffing Plan;
  - **ii.** Written work plan with tasks, task descriptions and timeline for completion;
  - **iii.** Data Systems Plan including system readiness testing and acceptance testing plan and a data conversion plan to include, at a minimum, intake, closure, eligibility, demographics, encounters, and other file data;
  - **iv.** Network Development Plan;
  - **v.** Clinical Transition Plan, Utilization and Care Management;
  - **vi.** Quality Improvement Plan including Grievance and Appeals;
  - **vii.** Customer Service Plan;
  - **viii.** Member Communication Plan;
  - **ix.** Security, business continuity, disaster recovery, and contingency plan;
  - **x.** Plan to meet other administrative start-up requirements;
  - **xi.** Transfer of electronic data and records;
  - **xii.** Member Handbook and Provider Manual completion;
  - **xiii.** Claims and eligibility interface development;
  - **xiv.** Compliance plan;
  - **xv.** Financial reporting plan;
  - **xvi.** Orientation and training plan; and

xvii. Post-implementation deliverables.

8. PERSONNEL

No later than two (2) months after contract award, the Contractor shall designate its Key Personnel. Prior to the Contract Start Date, the Contractor shall submit to MLTC the resumes of each Key Personnel position for MLTC approval and updated organizational charts. The Contractor shall have sufficient personnel working and operating in Nebraska during the Transition Period and Implementation Period in order to be fully compliant with the terms of the Contract.

9. TRANSITIONING OF BEHAVIORAL HEALTH RECIPIENTS AND OPERATIONS

a. When applicable, the Contractor shall transition behavioral health recipients receiving services so care is not disrupted;

b. The Contractor shall collaborate with the existing Contractor and providers to develop and implement a behavioral health recipient's service plan during the transition and deliver all services contained in the plan;

c. At a minimum, the Contractor shall provide service information, emergency telephone numbers, and instructions on how to obtain additional services to each behavioral health recipient involved in the transition of care;

d. The Contractor shall transition pending grievances, appeals, and customer service cases to assure timely resolution; and

e. The Contractor shall have a sufficient number of qualified staff to meet filing deadlines and attend all court or administrative proceedings.

10. OPERATIONAL AND FINANCIAL READINESS REVIEWS

a. Prior and subsequent to the Contract Start Date, the Contractor shall cooperate with the MLTC Operational and Financial Readiness Review process to assess the Contractor's readiness and ability to provide covered behavioral health services to behavioral health recipients and to resolve any identified operational deficiencies;

b. Upon MLTC's determination, request and approval, the Contractor shall develop and implement a corrective action plan in response to deficiencies identified during the Readiness Review;

c. The Contractor shall commence operations only if the Readiness Review factors and corrective action plan requirements are met to MLTC's satisfaction; and

d. At a minimum, the Contractor shall cooperate with MLTC to review the following areas:

i. Network sufficiency and management including reviews of subcontracts;
ii. Staffing adequacy;
iii. Customer service;
iv. CM/UM/QM;
v. Financial management;
vi. Information processing and system testing;
vii. Transition of behavioral health recipients;
viii. Routine communications with behavioral health recipients;
ix. Continuity of care for behavioral health recipients;
x. Network sufficiency; and
xi. Continuity of pending grievance, appeal, and customer service cases.

e. During the Readiness Review, the Contractor shall provide MLTC with access to staff, documentation and work space as requested by MLTC.

11. PERFORMANCE MEASUREMENT

a. PERFORMANCE GUARANTEES

i. The Contractor agrees performance guarantees and incentives shall become effective on the contract start date and remain in effect for a period of twelve (12) consecutive calendar months. In accordance with quality improvement goals, MLTC reserves the right to reevaluate, reset and add to the current performance guarantees and incentives and their corresponding threshold levels annually. The Contractor shall receive advance written notice of any changes in performance guarantee or incentive measures, thresholds, goals and related requirement in accordance with terms in the contract. Unless otherwise modified, performance guarantees and incentives shall automatically renew at the start of each new contract year;

ii. The Contractor shall submit performance reports on established metrics to DHHS on a month-by-month basis or upon DHHS' request, as well as quarter-by-quarter basis and year-to-date annualized reports. The Contractor shall submit reports in accordance with the established metrics in the contract, with all methods subject to review and approval by the State;

iii. Once submitted to and approved by the State, such metrics should also be posted publicly on the Contractor's website for the program;

iv. The Contractor shall meet and require its Subcontractors to meet the MLTC Minimum Performance Standards and Goals for services delivered to members. The table below identifies the Minimum Performance Standards and Goals for each required aspect of performance. If the Contractor's performance falls below an identified standard or goal or previous performance levels, the Contractor shall develop and implement a corrective action plan that must be approved by MLTC. The Contractor's corrective action plan shall define the problem, describe recommended interventions to improve performance, describe interim monitoring to measure the effectiveness of the interventions, and set a measurable threshold for discontinuation of the corrective action plan. The Contractor shall require a corrective action plan from any Subcontractor that fails to meet the MLTC Minimum Performance Standards; and

v. The Contractor shall cooperate with any MLTC reviews or other audits to verify compliance. If the Contractor does not comply with the corrective action plan, MLTC may impose any available remedy under the Contract.

		Performance Guarantee Threshold		Contract Incentive Threshold	
Item #	Measures	Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	Claims Administration				

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
1.	**Financial payment (dollar) accuracy**: % of audited claim dollars paid accurately • Calculated as the total audited "paid" dollars minus the absolute value of over- and/or under- payments, divided by the total audited paid dollars. • Measurement using monthly system-generated reports.	97%	10%	n/a	n/a
2.	**Procedural accuracy**: 99% of audited claims processed without procedural error • Calculated as the total number of audited claims minus the number of claims processed with procedural error, divided by the total number of audited claims. • Measurement using monthly system generated reports.	99%	10%	n/a	n/a
3.	**Turn Around Time (TAT)** 99% of all provider claims paid within 90 days	99% within 90 days	n/a	100% of incentive awarded when 99% of claims paid at or before 60 days; prorated to 90 days.	10%
	Telephone responsiveness				
4.	**Call Abandonment Rate:** Member/ Provider calls less than 3 percent	< 3%	5%	n/a	n/a

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	• Percentage of calls that reach the 800 line and are placed in queue but are not answered because the caller hangs up before a representative answers the call. • Measured using annual system-generated reports.				
5.	**Average Speed to Answer (ASA):** Member/Provider Services Line(s) all calls answered within 30 seconds • Measured using annual system-generated reports from first ring to live answer on 24/7 single point of entry 800 line.	30 seconds	5%	n/a	n/a
	Clinical				
6.	**Ambulatory follow up within 7 days of discharge from 24-hour facility** (inclusive of acute inpatient, PRTF and residential) - Report percent of individuals discharged from a 24-hour facility with an ambulatory follow-up appointment within 7 days of discharge. - Measurement using current NCQA HEDIS specifications. - Measurement using system-generated report. - Reported annually as percent with follow-up within specified timeframe.	Above HEDIS 50th percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass	5%	Above the HEDIS 60th percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass	10%
7.	**Ambulatory follow up within 30 days of discharge from 24-hour facility** (inclusive of acute inpatient,	Above HEDIS 50th	5%	Above HEDIS 60th	10%

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	PRTF and residential) • Report percent of individuals discharged from a 24 hour facility with an ambulatory follow-up appointment within 30 days of discharge of discharge. • Measurement using current NCQA HEDIS specifications. • Measurement using system-generated report. • Reported annually as percent with follow-up within specified timeframe.	percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass		percentile for Medicaid plans as reported in the most recent version of NCQA Quality Compass	
8.	**Readmission Rate:** less than 12 percent of Members readmitted within 30 days to inpatient level of care (inclusive of acute facilities and PRTF) • Measurement using system-generated reports. • Percentage of Members readmitted (to the same level of care) within 30 days of the discharge date from an acute level of care for any psychiatric or substance use disorder diagnosis.	< 18%	10%	<12%; receive 100% for below 12% (pro rated between 12% and 18%);	10%
9.	**30 Day Post-Admit ED Visits:** Percent of Members presenting to hospital Emergency Departments (ED) within 30 days of the discharge date from an acute level of care for any psychiatric or substance use disorder diagnosis without an admission. • Baseline data will be collected for the first contract period of	Year One monitor only; Year Two set at pre-contract and Year One baseline	n/a	Year One monitor only; Year Two set at marginal improvement over pre-contract / Year One baseline	n/a

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	the risk-based contract. • Based on this, in contract Year Two, a Risk Allocation Threshold equal to the baseline year will be set for a penalty of at least 10% of the risk amount and an incentive goal of a substantial reduction in ED use will be set for an incentive of at least 12% of the incentive set aside.				
10.	**Involuntary Admissions:** The actual number and percent of Members involuntarily presenting for mental health and substance use disorder treatment to 24-hour inpatient settings. • Baseline data will be collected for the first contract period of the risk-based contract. • Based on this, in contract Year Two, a Risk Allocation Threshold equal to the baseline year will be set for a penalty of at least 10% of the risk amount and an incentive goal of a substantial reduction in ED use will be set for an incentive of at least 12% of the incentive set aside.	Year One monitor only; Year Two set at pre-contract and Year One baseline	n/a	Year One monitor only; Year Two set at marginal improvement over pre-contract / Year One baseline	n/a
11.	Follow-Up Care for children **Prescribed Attention Deficit Hyperactivity Disorder (ADHD)** Medications • Percentage of children newly prescribed ADHD medication that had at least three follow-up care visits within a10-month period, one of which was within	Year One monitor only; Year Two set at pre-contract and Year One baseline	n/a	Year One monitor only; Year Two set at marginal improvement over pre-contract / Year One	n/a

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	30 days from the time the first ADHSD medication was dispensed, including two rates: one for the initiation phase and one for the continuation and maintenance phase.			baseline	
12.	**Initiation and Engagement of Alcohol and Other Drug – 004 NCQA** • The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization with 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit. • Dependence Treatment: (a) Initiation, (b) Engagement.	Year One monitor only; Year Two set at pre-contract and Year One baseline	n/a	Year One monitor only; Year Two set at marginal improvement over pre-contract / Year One baseline	n/a
13.	**Discharge Plans:** 90% of all discharge plans written for members being released from a mental health inpatient hospitalization shall be written		n/a	90%	10%
	Satisfaction				
14.	**Annual Member Satisfaction Survey**: % positive response rate • Members shall rate "satisfied" or better on the annual Member satisfaction survey approved by the State; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied	85%	10%	95%; 100% of incentive awarded at 95% or higher; prorated between 85% and	10%

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	response options and no neutral option (not applicable can be an option, as appropriate). • Survey domains to include consumer and family involvement and choice in treatment planning. • Sampling must include both adult consumers and parents/caregivers of child consumers, in proportions deemed by the State to be comparable to the distribution of Members served. • The sampling methodology must yield a 95% confidence interval with +5% error rate, including response rate as a factor.			95%	
15.	**Annual Professional Providers Satisfaction Survey:** 85% positive response rate • Providers shall rate "satisfied" or better on the annual provider satisfaction survey; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options and no neutral option (not applicable can be an option, as appropriate). • Sampling must include (1) child and adult providers, and (2) urban and rural providers.	85%	10%	95%; 100% of incentive awarded at 95% or higher; prorated between 85% and 95%	10%

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	• The sampling methodology must yield a 95% confidence interval with +5% error rate, including response rate as a factor. • The survey must specifically address Contractor education to providers on administrative (e.g., claims submission) and clinical issues, promotion of administrative simplification in provider interface with the health plan, timely payment of claims, and use of due process in denied or disputed claims.				
16.	**Annual Facility Satisfaction Survey**: 85% positive response rate • Providers shall rate "satisfied" or better on the annual provider satisfaction survey; the rating method shall be balanced so that there are an equal number of satisfied and not satisfied response options and no neutral option (not applicable can be an option, as appropriate). • Sampling must include (1) inpatient and outpatient providers, and (2) urban and rural providers. • At least 30% of the facilities must respond. • The survey must specifically address Contractor education to providers on administrative (e.g., claims submission) and	85%	10%	95%; 100% of incentive awarded at 95% or higher; prorated between 85% and 95%	10%

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	clinical issues, promotion of administrative simplification in provider interface with the health plan, timely payment of claims, and use of due process in denied or disputed claims.				
	Account Management				
17.	**Timely completion of Implementation or Annual Plan Milestones:** • Compliance measured as the number of milestones satisfactorily completed according to MLTC by the date specified in the implementation schedule or annual project schedule as a percent of all milestones that were due under the implementation plan during the quarter. • Contractor to provide specific plans for review and approval by MLTC • Milestones not met in one quarter carry over into next quarter for evaluation. Milestones carried over. • Milestones missed due to factors beyond Contractor control will not be counted in measurement.	90%	10%	n/a	n/a
18.	**Encounter Submission Rate:** The Contractor must maintain an information system that includes the capability to collect data on	90% and written analysis	5%	95%; 100% of incentive awarded at	5%

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	potential enrollee and provider characteristics, and claims information through an encounter data system. The Contractor must submit encounter data to the Medicaid Management Information System (MMIS) monthly per Departmental specifications. Encounter data submission must: a) Be submitted on a monthly basis; b) Include 90% of all clean claims adjudicated by the Contractor; c) Annual written report analyzing encounters not being submitted along with improvement plan			95% or higher; prorated between 85% and 95%	
19.	**Encounter Acceptance Rate:** a) 90% of encounters submitted need to be accepted by MLTC's Medicaid Management Information System (MMIS) pursuant to Departmental specifications. b) Annual written report analyzing encounters not being submitted along with improvement plan	90% and written analysis	5%	95%; 100% of incentive awarded at 95% or higher; prorated between 85% and 95%	5%
20.	**Appeals:** 90% of appeals will be resolved as expeditiously as the enrollee's health condition requires and within 14 calendar days from the date the Contractor received the appeal			90% within 14 days	5%
21.	**Grievances:**			90% within	5%

Item #	Measures	Performance Guarantee Threshold		Contract Incentive Threshold	
		Threshold	Percent Allocation[1]	Threshold	Percent Allocation[2]
	90% of grievance will be resolved as expeditiously as the enrollee's health condition requires and within 14 calendar days from the date the Contractor received all information necessary to resolve the grievance, and 100% must be resolved within 90 calendar days of the receipt of all required documentation			14 days; 100% within 90 days	
	TOTALS		100%		100%

b. PERFORMANCE ASSESSMENT

i. The penalty and incentive payments will be calculated quarterly to track progress. Payment will be made annually based on a calculation of the entire year's performance. Payments will be determined 6 months after the end of the contract year to allow the data to complete;

ii. Proceeds from any penalties assessed, incentives, MLR and/or risk corridor not realized shall be transferred from the Reinvestment Holding Escrow Account and added to the Reinvestment Escrow Fund, described in more detail below;

iii. In the event of contract termination, the Contractor or Reinvestment Escrow Fund shall receive/pay any monies owed with respect to the guarantees, incentives, MLR and risk corridor rebates within one hundred and twenty (120) days of the termination of the contract. The Contractor will cease and MLTC will assume duties and responsibilities to both escrow fund administrators for the Reinvestment Holding Escrow Account and the Reinvestment Escrow Fund;

iv. The Contractor shall cooperate with MLTC in its verification and audit of all performance measurement results. For performance guarantee measurement purposes, the Contractor shall submit self-reported results, which are subject to a data integrity analysis. Unless otherwise approved by MLTC, the Contractor's maximum error rate in submitted data shall be five percent (5%). The Contractor shall pay the full risk penalty and earn no incentive based on the applicable metric when its submitted data submission does not meet these thresholds for accuracy; and

v. The Contractor shall cooperate with MLTC if, in its sole discretion, MLTC decides to perform an independent audit each year, covering a three (3) or more month period of the performance guarantee year. If the results of the independent audit are below the Contractor's self-reported results for the period under review, the Contractor shall agree to the independent audit results as the basis for performance guarantee measurement for the full year as the final determination or until the Contractor demonstrates to the State's satisfaction (at the State's sole

discretion) that the reliability of its self-reported results are consistent with independent audit results.

c. FAILURE TO PERFORM

i. Established Damages

In the event the Contractor fails to meet the contract performance standards outlined here, the below ascertained, designated damages may be assessed. If assessed, the designated and ascertained damages below will be used to reduce MLTC's payments to the Contractor or if the damages exceed amounts due from MLTC, the Contractor will be required to make cash payments for the amount in excess.

a) Readiness Review

MLTC will conduct a formal review of the Contractor's readiness to implement managed behavioral health services. To ensure readiness to implement the plan, the Contractor shall meet the pre-implementation deadlines discussed in Section IV.O – Transition and Implementation. Should the Contractor fail to meet the deadline for producing the required Implementation Plan and MLTC determines that the Contractor is responsible for its failure to meet the deadlines. MLTC may assess damages of $5,000 per calendar day. Upon successful completion of the readiness review, MLTC will issue the Contractor an approval letter which authorizes the Contractor to begin operations and authorizes funds for the Medicaid capitation payments for the first month of the contract period.

b) National Accreditation Status

For failure to retain accredited status as required by the terms of the contract, damages of $1,000 for each calendar day of non-compliance shall be assessed.

c) Date of Implementation

Should the Contractor fail to begin full operation of the managed behavioral health plan on September 1, 2013, and should MLTC determine that the Contractor is responsible for the delay, MLTC may assess damages of $150,000 for each month implementation is delayed. The amount of the damages may be prorated, if necessary.

d) Network Performance Requirement

Contractor shall have a contracted provider network in place, sufficient in size and composition to meet the service requirements of the covered population by September 1, 2013. The required attestation of network sufficiency shall be submitted at that time. One thousand dollars ($1,000) shall be assessed, at MLTC' discretion, per calendar day for each day that the provider network is not adequate to meet the service needs of the covered populations.

e) Timely Reports and Data Delivery Performance Requirement
This Performance Requirement applies to all reports and data, excluding encounter data, to be delivered to MLTC or designee as defined in the RFP or by MLTC. Reports and data shall be timely and produced in the format and media approved by MLTC. Encounter data shall be provided in the MLTC- required formats. One thousand dollars ($1,000) shall be assessed for each calendar day, at MLTC's discretion, that each report or data delivery is late, includes less than the required copies, or is not in the approved format.

f) Accuracy of Reports and Data Performance Requirement
The Contractor shall be responsible for the accuracy of all reports, including calculations and completeness of data, excluding encounter data, used as input. If the report is not corrected within five calendar days of the notice of failure to meet the reporting accuracy requirements, then one thousand dollars ($1,000) per day shall be, at MLTC's discretion, assessed for each report that has been identified as inaccurate from the date of notification until the date the MLTC-approved corrected report is delivered.

g) Personnel Performance Requirement
The Contractor shall meet all requirements specified in the Personnel Performance Requirement section of this RFP. One thousand dollars ($1,000) per day per position shall be assessed, at MLTC's discretion, for each day after the thirty allowed calendar days for which a Key Position remains unfilled by a qualified person approved by MLTC. Key Positions include the below positions:

1). Administrator/CEO/COO;
2). Chief Financial Officer (CFO);
3). Medical Director/CMO;
4). Corporate Compliance Officer;
5). Clinical Director/Manager;
6). Operations Director/Manager;
7). Grievance and Appeals System Director/Manager;
8). Care Management/Utilization Review Director/Manager;
9). Quality Management Director/Manager;
10). Information Technology Director/Manager;
11). Provider Network Services Director/Manager;
12). Provider Network Liaison; and
13). Tribal Network Liaison.

h) Contract Termination or Expiration: In the event that a Contractor is terminated or its contract expires, the Contractor shall provide services through the end of the contract term and pay for all covered services for all members for the period for which monthly prepayment has been received prior to the date of contract termination. The Contractor shall provide MLTC and/or its designee with all materials and information related to the Program, members and the services provided to those members,

to ensure a smooth transition to a follow-on Contractor and uninterrupted services. The Contractor shall notify all members who have received services within the past year of the upcoming transition. The notification shall be approved by MLTC and shall be developed in conjunction with a follow-on Contractor, if applicable.

i) The Contractor shall submit for approval a detailed plan for the transition of its Members to a follow-on Contractor which includes the schedule for key activities and milestones.

1). The Contractor shall:

i) Make provisions for continuing all management and administrative services and the provision of direct services to Members until the transition of all Members is completed and all other requirements of the current contract are satisfied;
ii) Designate a person with appropriate training to act as the transition coordinator. The transition coordinator shall interact closely with the Department and the staff from the follow-on Contractor to ensure a safe and orderly transition; and
iii) Provide all reports set forth in this Agreement and necessary for the transition process. This includes providing to the Department, until the Department is satisfied that the Contractor has completed all outstanding obligations, the following additional reports. These reports shall be due on the fifth (5th) day of each succeeding month for the prior month.

1. Monthly claims aging report by provider/creditor including IBNR amounts;
2. A monthly summary of cash disbursements; and
3. List of all outstanding obligations necessary to complete the contract.

2). Notify subcontractors of contract termination or expiration as directed by the Department;

3). Notify all Members that the Contractor will no longer serve as the Member's managed care organization. The Contractor shall be financially responsible for all costs associated with this notification. The notification is subject to MLTC approval;

4). Notify each Participating Provider in writing that the Contractor's contract with MLTC (NE Medicaid) has ended. The written notice shall include the contract end date and shall explain to the Participating Provider how the provider can continue participating in the Medicaid program. The Contractor shall be financially responsible for all costs associated with this notification. The notification is subject to MLTC approval;

5). Complete payment of all outstanding obligations for covered services rendered to Members. The Contractor shall cover continuation of services to Members of the period for which payment has been made, as well as for inpatient admissions up until discharge;

6). Cooperate with a follow-on managed care organization during transition period including, at minimum, sharing and transferring Member information and records. MLTC will notify the Contractor with specific instructions and required actions at the time of transfer;

7). Return any funds advanced to the Contractor for coverage of Members for periods after the contract end date to MLTC within thirty (30) calendar days of the expiration or termination of the contract;

8). Supply all information necessary for reimbursement of outstanding claims; and

9). Provide MLTC, in a format prescribed and approved by the Department:

i) A list of each Participating Provider, including Providers who are not contracted with MLTC;
ii) A list of Members who are receiving case management services;
iii) A list of all services requiring Contractor prior authorization; and
iv) A list of all Members receiving prior authorized services, the approved duration of which extends beyond the contract termination date.

P. FINANCE, REPORTING REQUIREMENTS AND RATE-SETTING

1. MEDICAL LOSS RATIO (MLR) REQUIREMENT FOR CONTRACT YEAR

All contracts and agreements relating to the medical assistance program governing at-risk managed care service delivery for behavioral health service shall provide for a minimum medical loss ratio of eighty five percent (85.0%) of the aggregate of all income and revenue earned by the Contractor and related parties under the contract. The intent of the MLR is to ensure that members receive at least 85% of the developed capitation rate.

MLR shall be defined as Net Qualified Medical Expenses divided by Earned Revenue as they relate to eligible members and services under the contract. The MLR will be defined and calculated on a “run rate” basis (not “booked”). “Run rate” is defined by reporting only incurred expenses and earned revenue that were attributable to activities in the specified contract year. The MLR will be calculated using the BH-Contractor’s submitted “Run Rate” Income Statements. MLTC reserves the right to audit, request additional information, and revise BH-Contractor’s estimates of the MLR calculation.

The MLR shall be calculated after six (6) months, but within nine (9) months of the end of the contract year, based on the formula below. If the CY MLR is less than 85.0%, the BH-Contractor shall forfeit an amount equal to the MLR Rebate formula below.

Medical Loss Ratio Formulas:
MLR = Net Qualified Medical Expenses ÷ Earned Revenue

MLR Rebate = Maximum of $0 and [(85% - MLR) x Earned Revenue]

MLR Rebates will be forfeited to a Reinvestment fund.

2. ADMINISTRATIVE CAP REQUIREMENTS

In compliance with Neb. Rev. Stat. §71-831, 68-908 and 71-801 (2012)., the Contractor's total administrative spending shall not exceed seven percent unless MLTC determines any additional amount above seven percent does not include additional profit and is necessary to improve the health status of the population to be served.

In addition, Total Administration shall not under any circumstances exceed ten percent. To ensure compliance with Neb. Rev. Stat. §71-831, 68-908 and 71-801 (2012), MLTC will separate the Administrative Expense Rate into a Quality Improvement (QI) Administrative Rate and a Non-QI Administrative Rate. The following 2 tests will be calculated within nine (9) months of the end of the contract year based on the formulas below.

a. ALLOWED NON-QI ADMINISTRATION TEST #1

The Non QI Administrative Rate shall not exceed seven percent. The Allowed Non-QI Administrative Rate, therefore shall be the lesser of seven percent or the actual Non-QI Administrative Rate.

b. TOTAL ALLOWED ADMINISTRATION TEST #2

The Total Administrative Rate shall not exceed ten percent (10%). Therefore, the Total Allowed Administrative Rate is the lesser of ten percent or the summation of the items below:

c. ALLOWED NON QI ADMINISTRATION RATE (DEFINED IN TEST #1)
d. ALLOWED QI ADMINISTRATION RATE
e. LESS RELATED PARTY ADMINISTRATIVE MARGIN

3. CY RISK CORRIDOR:

Annual Contractor profits shall not exceed three percent per year and annual losses shall not exceed three percent per year. These profits and losses are calculated as a percentage of the aggregate of all earned revenue by the Contractor and related parties, including parent and subsidy companies and risk bearing partners, under the contract. Excess profits will be forfeited to a Reinvestment Fund.

The Risk Corridor Calculation shall be calculated within nine (9) months of the end of the contract year based on the formula below.

Risk Corridor Calculation:
Risk Corridor Gain/Loss = Earned Premium
- MLR Rebates
- Net Qualified Medical Expenses (calculated for MLR)
- Total Allowed Administration (calculated for Administration Cap)

If the Risk Corridor calculation above produces a gain above three percent, the BH-Contractor shall rebate an amount equal the Risk Corridor Gain less three percent. This risk corridor rebate will be forfeited to the Reinvestment Fund.

If the Risk Corridor calculation produces a loss of more than three percent, the BH-Contractor shall receive an amount equal to any losses above three percent. No monies shall be paid by either party if the Risk Corridor produces an amount between a three percent gain and a three percent loss.

The Risk Corridor and MLR calculations use Earned Premium. These calculations ignore revenue taxes, non-operating income, and forfeited withholds.

4. REINVESTMENT PLAN

a. In compliance with Neb. Rev. Stat. §71-831, 68-908 and 71-801 (2012) and as noted above, a Reinvestment Fund shall be developed and managed by the Contractor for the purpose of subsidizing additional behavioral health services for children, families and adults according to a plan developed with input from stakeholders and MLTC staff, including consumers, family members, the office of consumer affairs, and the Contractor. Such plan shall address the behavioral health needs of adults and children, including filling service gaps and providing system improvements.

b. The Reinvestment Plan will be funded by the following:

- **i.** Forfeited MLR Rebates;
- **ii.** Forfeited Profits above three percent;
- **iii.** Forfeited Performance Guarantees; and
- **iv.** Forfeited Contract Incentives.

c. The Reinvestment Plan and subsequent service provision must be approved by MLTC.

d. The Contractor shall establish two escrow accounts to manage the Reinvestment Fund. The first escrow account, Reinvestment Holding, shall be created as a separate account to hold any funds paid to the Contactor before they become eligible for transfer to the Reinvestment Account. The second escrow account, Reinvestment Account, shall be created separately from other accounts required by the contract, and any other accounts that may be required by State or Federal law, to hold the reinvestment funds once they are eligible for deposit, in accordance with Neb. Rev. §71-831, 68-908 and 71-801 (2012).

A separate Escrow Administrator shall be appointed for each escrow account. Maintenance, accounting and reporting will be collectively determined upon contract award. Funds must be held in accounts that have no risk bearing investments and in accordance with escrow Fund requirements. Any interest accrued on either Fund shall be deposited to the Reinvestment Escrow Fund for use as established in Neb. Rev. Stat. §71-831, 68-908 and 71-801 (2012).

e. The Contractor will be held responsible and accountable for the necessary fiduciary duties and functions required to administer the Reinvestment Fund. Oversight of the financial accounting will be determined by the below financial management reporting.

5. FINANCIAL DATA & REPORTING REQUIREMENTS

a. In addition to any other reports discussed in RFP, MLTC will require a Quarterly and Annual Financial reporting package. The details and timing of the reports

will be developed with the input of the Contractor. Examples of expected reports include, but are not limited to:

i. Certification Statement;
ii. Balance Sheet;
iii. Income Statement;
iv. LAG (IBNR) Report – Summary;
v. Medical Loss Ratio Calculation Report;
vi. Profit/Risk Corridor Calculation Reports;
vii. Related-Party Statements;
viii. Run Rate Income Statement;
ix. Auditor's Report and Report on Internal Controls;
x. Performance/Guarantee/Incentive Calculation Reports;
xi. Annual Disclosure Reports; and
xii. Enrollment/Revenue Reconciliation

b. MLTC will also require the Contractor to electronically provide detailed claims and membership data that ties to the Run Rate Income Statement provided. A data request will be prepared by MLTC that shall include at a minimum, but are not limited to, the following data fields:

i. Rating Category;
ii. Category of Service;
iii. Utilizers;
iv. Paid Dollars;
v. Paid Units;
vi. Units Measure;
vii. Paid Days;
viii. Cost per Unit;
ix. Cost per Day;
x. PMPM Cost;
xi. Member Months;
xii. Month of Service; and
xiii. Month of Payment

The Contractor shall provide for an annual financial audit acceptable to the MLTC for any expenditure of State-awarded funds made by the Contractor. Such audit shall include management letters and audit recommendations. The State Auditors shall have access to all records and accounts for the contract year(s) in which the award was made. The Contractor will comply with Federal and State single audit standards, as applicable. MLTC reserves the right to audit or request an audit (at the Contractor's expense) of any data or report required under the contract.

c. Inspection and audit of financial records. Risk contracts must provide that the MLT and the CMS may inspect and audit any financial records of the Contractor its Subcontractors. There shall be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

d. Insolvency. The Contractor must provide that its Medicaid enrollees are not held liable for

i. The Contractors debts, in the event of the entity's insolvency;
ii. The covered services provided to the enrollee, for which MLTC does not pay the Contractor;
iii. Covered services provided to the enrollee, for which MLTC or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; and
iv. Payment for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the Contractor provided the services directly.

a) Protect Against Liability –Subcontractor and referral providers may not bill enrollees any amount greater than would be owed if the Contractor provided the services directly (i.e., no balance billing by providers;
b) Other Requirements. The Contractor must be licensed or certified by the State as a risk-bearing entity;
c) The Contractor must provide assurances that enrollees will not be liable for the Contractor's debt if the Contractor becomes insolvent; and
d) Disclosure of 5% Ownership – The Contractor must notify State of any person or corporation that has 5% or more ownership or controlling interest in the BH MCO.

v. Capitated Managed Care Rate
MLTC will contract with the Contractor using a full-risk arrangement that will pay the Contractor a prepaid monthly capitation payment to cover all services included in the Contractor contract. Capitation is designed to provide the Contractor with a prospectively determined monthly payment so it may provide services that meet program standards. Capitation payments will be made prospectively and electronically based on the enrollment file. MLTC will develop cost-effective and actuarially sound capitation rates in accordance with generally accepted actuarial principles and practices and are appropriate for the populations covered and the services provided under the Scope of Work described in this RFP. Risk adjusted rates will not be considered under the contract. MLTC will also develop capitation rates according to all applicable CMS rules and regulations.

MLTC has developed monthly capitation rates that will be offered to bidders on a "take it or leave it" basis. The monthly capitation rates offered will be in effect for the initial 10-month contract period. See Attachment B for the table of rates.

vi. Development of Prepaid Capitation Payments
Capitation payments were developed using Fee-For-Service data for the eligible populations from Fiscal 2009, 2010, and 2011 using the following adjustments:

a) Utilization trend;
b) Unit cost trend;
c) Medicaid program changes;
d) Managed care savings; and
e) Contractor administrative allowance

In the event any change occurs in federal law, federal regulations, State law, State regulations, State policies, or State Medicaid plan coverage, and MLTC determines that these changes impact materially on pricing, MLTC reserves the right to amend rates paid to Contractors. The Contractor will be required to accept these changes. All proposals shall be based upon the provisions of Federal and State laws and regulations and MLTC's approved Medicaid State Plan coverage in effect on the issuance date of this RFP, unless this RFP is amended in writing to include changes prior to the closing date for receipt of proposals.

vii. Annual Capitation Rate Determinations

For each Contract year, the State and its actuaries will jointly review the information necessary to develop actuarially sound capitation rates. This review will include an analysis of any anticipated fee schedule changes and/or other programmatic changes to the NMMCP, cost reporting information collected from the Contractor, Department of Insurance (DOI) annual statements, various trend data sources, and administrative experience. The State will require the Contractor to provide certified encounter data or other supplemental information to support rate development for future contract periods. The State will establish rates that allow for sufficient time to obtain CMS approval prior to the effective date of the renewal capitation rates.

Capitation Rates may be adjusted outside of the annual capitation rate determination to assure additional program changes are included in the projection of expenditures as required for actuarially sound capitation rates.

6. DELIVERABLES

All deliverables are subject to review by the State and will not be considered complete until deemed as such by a representative of the State. The format and content of each deliverable shall be defined and agreed upon in detail prior to the onset of work. The State will not review a deliverable, unless the format and content has been approved.

The State may grant approval, reject all or some part of the deliverable, or request that revisions be made by the Contractor. Additional review periods shall be required whenever revisions are requested or a deliverable is rejected. Each deliverable must be consistent with previously approved deliverables. The State reserves the right to require the Contractor to revise deliverables previously approved or to reject current deliverables based on inconsistency with previously approved deliverables.

The following deliverables are due at the time of Technical Proposal submission:

a. GRIEVANCE SYSTEMS

The deliverable must include a description of the proposed grievance system, including the definition of a service authorization, procedures and timelines for grievance, appeal, and fair hearing.

b. PROVIDER NETWORK

- **i.** Individual GeoAccess maps for hospitals, PCP's, High Volume Specialists, FQHCs, Urgent Care Centers, and ancillary providers for whom letters of intent have been signed;
- **ii.** Written provider agreements that provide adequate access for enrollees;
- **iii.** A listing by provider type/specialty of the providers from whom a signed letter of intent to participate in the provider network has been received; and
- **iv.** The following deliverables, at a minimum, will be due under a contract resulting from this procurement.

c. MEMBER COMMUNICATION

Potential enrollee correspondence proposed to send to enrollees, including Member Handbook.

d. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Program descriptions including policies, procedures and mechanisms for:

- **i.** Timely access monitoring;
- **ii.** Documentation of adequate capacity and services;
- **iii.** Primary care and coordination of health care services including promotion of Patient Centered Medical Home;
- **iv.** Policies and procedures for authorizing services;
- **v.** Policies and procedures for the selection and retention of providers;
- **vi.** Policies and procedures for safeguarding enrollee confidentiality;
- **vii.** Documentation of sub contractual relationships and delegation;
- **viii.** Clinical practice guidelines; and
- **ix.** A documented Quality Assessment and Performance Improvement (QAPI) Program including, at a minimum:

    - **a)** Description of Quality Assurance committee structure;
    - **b)** Designation of individuals/departments responsible for the QAPI program;
    - **c)** Description of the network participation in the QAPI program;
    - **d)** Credentialing/re-credentialing procedures;
    - **e)** Standards of Care;
    - **f)** Standards for service accessibility;
    - **g)** Medical records standards;
    - **h)** Mechanisms to detect underutilization and overutilization of services;
    - **i)** Mechanisms to assess quality and appropriateness of care;
    - **j)** QAPI program documentation methods;
    - **k)** Integration of quality assurance with other management functions;
    - **l)** Corrective Action plans; and
    - **m)** A health information system:

        - **1).** Policies and procedures for Care Management, including those for high utilizing participants of services; and
        - **2).** Provider Satisfaction Survey Tool and Methodology

e. CERTIFICATIONS AND PROGRAM INTEGRITY

i. Data certification plan; and
ii. Mandatory Compliance plan to guard against fraud and abuse

f. LEGISLATIVELY REQUIRED REPORTING

The deliverable must acknowledge and demonstrate an understanding of the required reporting called for in the following statutes, signed into law in the Legislature of Nebraska, one hundred and second legislature, second session 2012. MLTC-required reporting has not been fully defined to date in these regulations, but is expected within the upcoming months.

i. Neb. Rev. Stat. §81-3134 (2012); and
ii. Neb. Rev. Stat. §68-2005 (2012)

g. MONTHLY REPORTING TO MLTC

The deliverable must include a description of the following required reports. The final formats and contents will be collaborated with the Contractor and approved by MLTC.

i. Claims Processing Report;
ii. Provider Termination Report;
iii. Third Party Liability Report;
iv. Eligible and Number Authorized for Services;
v. State Wards in Residential Care, Group Homes and Foster Care;
vi. Out of State Placement Report;
vii. ICM Report;
viii. Duplicate Services Report;
ix. Multi-Level Readmit Report;
x. Shifted Authorized/Registered Services Report;
xi. Provider Scorecard;
xii. Average Length of Stay Comparison;
xiii. Outpatient Claims Utilization Report;
xiv. Claims Totals by Month; and
xv. Top Primary Diagnosis by Service

h. QUARTERLY REPORTING TO MLTC

The deliverable must include a description of the following required reports. The final formats and contents will be collaborated with the Contractor and approved by MLTC.

i. Provider network adequacy;
ii. Provider access analysis;
iii. Results of fraud and abuse monitoring;
iv. Geo-mapping reports;
v. Grievance and appeals process compliance;
vi. Timely access standards monitoring; and
vii. Utilization Management, including but not limited to:

a) Crisis services utilization, relative to number of persons (broken out by child/adolescent and adult) served and to national benchmarks;

b) Emergency department utilization, again using benchmarks and age breakouts;

c) Crisis services utilization, relative to number of persons (broken out by child/adolescent and adult) served and to national benchmarks; and

d) Emergency department utilization, again using benchmarks and age breakouts

viii. Results of Service verification monitoring;
ix. Out of network referrals monitoring;
x. Care management results;
xi. Quality Oversight Committee Report.;
xii. Network Expansion/Credentialed and Contracted Providers;
xiii. Contracted Residential Bed Numbers;
xiv. Number of Days on Residential Wait List;
xv. Residential Provider Acceptance Rate;
xvi. Call Center Performance;
xvii. Restraint & Seclusion QIA Report;
xviii. 30-Day Inpatient Readmission Rate;
xix. 7-Day and 30-Day Ambulatory Follow-up Following Residential Discharge;
xx. 7-Day and 30-Day Ambulatory Follow-up Rate Following Hospital Discharges;
xxi. Critical Incident Reporting;
xxii. Admissions and readmissions to psychiatric inpatient (including PTRF) and residential facilities;
xxiii. Continuity of care (within 7 days) from psychiatry inpatient facilities to community services; and
xxiv. Number of children placed in residential treatment settings, relative to number of Medicaid members, and relative to national benchmarks

i. ANNUAL REPORTING TO THE STATE

The deliverable must include a description of the following required reports. The final formats and contents will be collaborated with the Contractor and approved by MLTC.

i. Annual Quality Management Work Plan for Upcoming Year;
ii. Performance Measures data;
iii. Results of Quality Management Work Plan;
iv. Performance Improvement Project data and results;
v. Member Satisfaction Survey Results;
vi. Provider Survey Results; and
vii. Results of any corrective action/sanctions of providers

j. POLICIES AND PROCEDURES FOR THE FOLLOWING

i. Advance Directives;
ii. Member Communications;
iii. Third Party Resource (TPR);
iv. Member Rights;
v. Member Free Exercise of Rights;
vi. Compliance with Federal and State Laws and Regulations;
vii. Coverage of Emergency and Post-Hospitalization Services;

viii. Substitute Health Services;
ix. Disease Management Services;
x. Behavioral Health Screening/ Risk Assessment;
xi. Members with Special Needs;
xii. Indian Health Protections;
xiii. Access to a Second Opinion;
xiv. Provider Credentialing and Re-Credentialing;
xv. Selection and Retention of Providers;
xvi. Subcontractor Oversight;
xvii. Clinical Practice Guidelines;
xviii. Utilization Management;
xix. Member Satisfaction;
xx. Provider Satisfaction Surveys;
xxi. Fraud, Waste, and Abuse Prevention;
xxii. Service Verification; and
xxiii. Provider-Preventable Conditions Including Health Care-Acquired Conditions

k. METHODOLOGY/WORK STATEMENT

i. In addition to the specific requirements outlined in the text of this document, bidders must respond to the statements and questions contained in the chart below. Responses must be complete and succinct. These statements and questions relate directly to the major program elements described in Section IV Project Description and Scope of Work.

ii. The bidder's responses to these statements/questions are in addition to information requested in other sections of the RFP. It is expected that the bidder not limit its proposal to just responding to these questions/statements.

RFP Reference	Area	Statement/Question
IV.B	Principles of Care	Describe how your BH MCO will operate to promote the Principles of Care. How will your BH MCO measure this requirement?
IV.B	Principles of Care	Describe how your BH MCO will ensure that services provided are based on evidence-based care.
IV.B	Principles of Care	Describe how your BH MCO will ensure services provided are developmentally and culturally appropriate.
IV.B	Principles of Care	Describe how your BH MCO will operate as a part of a System of Care in Nebraska to serve persons with mental health/illness and substance use disorder needs.
IV.G	Value-Added or Substitute Services	Describe any value-added or substitute services that your BH MCO will deliver to enhance the service array and the rationale for you decision to include these particular services.
IV.J	Business Requirements	Describe the approach your BH MCO will take to ensure your BH MCO is abiding by all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471 NAC and 482 NAC.
IV.J	Business Requirements	State the status of your BH MCO's accreditation with NCQA.
IV.J	Business Requirements	Describe how your BH MCO meets the Federal definition of a BH MCO. Include a copy of the COA from the Department of Insurance.

RFP Reference	Area	Statement/Question
IV.J	Business Requirements	If applicable, describe your BH MCO's proposed risk bearing partnership/relationship including designated functions of each entity, and how delegated functions will be overseen. Bidders who submit a proposal with a partnership of risk bearing must also provide a detailed description of how both entities meet the Managed Care Organization Licensure Requirements.
IV.J	Business Requirements	Describe the risk analysis, assumptions, cost estimates and rationale supporting your BH MCO's proposed reinsurance arrangements. If any reinsurance is provided through related parties, provide a disclosure of the entities and details causing the related party relationship.
IV.J	Business Requirements	State the intention of your BH MCO to maintain a service office in Nebraska and the staff positions to be located within this service center.
IV.J	Business Requirements	Describe the process your BH MCO will use to ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.
IV.J	Business Requirements	Describe the fraud and abuse program your BH MCO will implement including: ▪ Compliance with the RFP requirements; ▪ Fraud detection methods that will be used; ▪ Steps that will be taken if fraud is detected including DHHS notification; and ▪ Plan for compliance with the Exclusion Program of the U.S. Department of HHS Office of the Inspector General or any provider restrictions imposed by the State.
IV.J	Business Requirements	Describe in detail how your BH MCO will verify that services were actually provided including: ▪ How minimum sampling criteria to ensure a representative sample will be included; and ▪ Results of monitoring will be reported to the State quarterly.
IV.J	Business Requirements	Describe your BH MCO's policies and procedures to ensure safeguards are in place which are at least equal to the Federal Safeguards of 41 USC 423, section 27.
IV.J	Business Requirements	Describe how your BH MCO will comply with the False Claims Act.
IV.J	Business Requirements	Describe the approach your BH MCO will take to provide members with written material that is easily understood including alternate formats.
IV.J	Business Requirements	Describe your approach to compliance and regulatory support, including identification of requirements, process establishment, controls identification, monitoring, correction and ongoing risk management.
IV.J	Business Requirements	Describe how your BH MCO will ensure consistent application of review criteria for authorization decisions and consult with the requesting provider when appropriate; and monitor that denial of service authorization or authorization of a service in an amount, duration, or scope that is less than requested, to be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

RFP Reference	Area	Statement/Question
IV.K	Member Rights and Responsibilities	Describe the approach your BH MCO will take to provide members notification of their rights and responsibilities at enrollment.
IV.K	Member Rights and Responsibilities	Describe the approach your BH MCO will take to provide new members grievance, appeal, and State Fair Hearing information.
IV.K	Member Rights and Responsibilities	Describe the information materials your BH MCO proposes to send to new members. Address language alternatives that will be available and how the BH MCO will ensure that reading levels will be at a sixth grade level.
IV.K	Member Rights and Responsibilities	Describe the process the BH MCO will take to inform members who has received his or her care from a provider who has been terminated from the network.
IV.K	Member Rights and Responsibilities	Describe the approach your BH MCO will take to inform members about covered health services.
IV.K	Member Rights and Responsibilities	Describe your BH MCO's methodology to assess disparities in treatment among disparate races and ethnic groups and correct those disparities.
IV.K	Member Rights and Responsibilities	Describe your BH MCO's policies, procedures, and processes to ensure that in the process of coordinating care, each member's privacy is protected.
IV.K	Member Rights and Responsibilities	Describe your BH MCO's plan to ensure members access to a second opinion.
IV.K	Member Rights and Responsibilities	Describe how your BH MCO will ensure services will be provided that are sufficient in amount, scope, and duration to reasonably be expected to achieve the purpose for which the services are furnished and are equal to those furnished under fee-for-service Medicaid.
IV.K	Member Rights and Responsibilities	Describe your BH MCO's policies, procedures, and processes for processing requests for initial and continuing authorizations of services, and ensuring consistent application of review criteria for authorization decisions.
IV.K	Member Rights and Responsibilities	Provide a listing of services your BH MCO will require to be authorized and describe how your BH MCO will communicate this information to providers and members. Also provide the process by which your BH MCO will communicate authorization information to providers.
IV.K	Member Rights and Responsibilities	Describe the content of your BH MCO's written notice of action that will be provided to members with any adverse action taken by the BH MCO.
IV.K	Member Rights and Responsibilities	Describe how your BH MCO will ensure members will receive written and timely notice of action relating to adverse actions taken by the BH MCO.
IV.K	Member Rights and Responsibilities	Describe your BH MCO's grievance and appeal process specifically addressing: ▪ Compliance with the RFP requirements ▪ Levels of review and timing ▪ Process for expedited review ▪ How complaints and appeals are tracked and trended and how you will use the data to make changes to procedures and processes ▪ Member access to State Fair Hearing
IV.K	Member Rights and Responsibilities	Describe the policies and procedures your BH MCO will put in place to ensure grievance system information is communicated to all providers and Subcontractors.

RFP Reference	Area	Statement/Question
IV.L	Provider Network Development and Management	Describe your BH MCO's approach to develop practices and assure compliance with the Nebraska Medicaid BH Principles of Care.
IV.L	Provider Network Development and Management	Describe your BH MCO's approach to promote open communication among the BH MCO, network providers, NMPHC, and members.
IV.L	Provider Network Development and Management	Describe policies and procedures your BH MCO will put in place to ensure providers are not discriminated for participation, reimbursement, or indemnification for acting within their scope of license or certification.
IV.L	Provider Network Development and Management	Describe how your BH MCO will ensure there are a sufficient number of network providers with expertise in : ▪ Co-occurring substance use, Mental Health and Developmental Disabilities; ▪ Serious and Persistent Mental Illness ▪ Trauma Informed and Trauma Specific Treatment ▪ SED coordinated services ▪ Sex offender services ▪ Co-occurring behavioral and physical health disorders
IV.L	Provider Network Development and Management	Describe your approach to transitioning the current Medicaid provider network to your BH MCO for the contract
IV.L	Provider Network Development and Management	Describe how your BH MCO will develop a Provider Advisory committee.
IV.L	Provider Network Development and Management	Describe how your BH MCO will validate provider training and expertise in specialty areas including but not limited to the following areas: Serving children with SED Serving persons with SPMI The assessment and treatment of Trauma
IV.L	Provider Network Development and Management	Describe the process for conducting site-visits with providers.
IV.L	Provider Network Development and Management	Describe your process for contracting with all provider types described in the contract.
IV.L	Provider Network Development and Management	Describe your process for compliance with Indian Health Protections.
IV.L	Provider Network Development and Management	Describe how the Network Provider data base will be maintained and updated.
IV.L	Provider Network Development and Management	Describe the timelines for credentialing and contracting and reports demonstrating your BH MCO's performance in compliance with these timelines for the contracts that you currently hold and for those you have held within the last five years.
IV.L	Provider Network Development and Management	Describe your BH MCO approach for a credentialing waiver process to allow certain providers that do not meet all of the Contractor's credentialing criteria to be included in the Provider Network.

RFP Reference	Area	Statement/Question
IV.L	Provider Network Development and Management	Describe your BH MCO's credentialing and re-credentialing process including: ▪ Ensuring that providers are enrolled in Medicaid and have a valid identification number ▪ Information on ownership and control ▪ Excluded providers database searches ▪ Disclosure related to persons convicted of crimes
IV.L	Provider Network Development and Management	Describe the processes your BH MCO will utilize to build and maintain positive relationships with the provider network.
IV.L	Provider Network Development and Management	Describe your provider QM strategy and how the BH MCO will involve the provider network in Quality Improvement processes.
IV.L	Provider Network Development and Management	Describe how the BH MCO will provide linkages with consumer and recovery/resilience initiatives.
IV.L	Provider Network Development and Management	Describe how the BH MCO will increase the number of multilingual providers in the network.
IV.L	Provider Network Development and Management	Describe how the BH MCO will monitor compliance with the requirement to provide interpreters/translators when needed.
IV.L	Provider Network Development and Management	Describe how the BH MCO will monitor and ensure network compliance with the use of seclusion and restraint.
IV.L	Provider Network Development and Management	Describe the process your BH MCO will use to utilize the eligibility and enrollment files from DHHS to manage potential membership. Include the process for resolving discrepancies between these files and your internal membership records.
IV.L	Provider Network Development and Management	Describe your BH MCO's approach to creating the Network Development Plan tailored to the NE BH population..
IV.L	Provider Network Development and Management	Describe how your BH MCO will ensure timely access monitoring of network providers, including: ▪ establish mechanisms to ensure that network providers comply with the timely access requirements; ▪ monitor regularly to determine compliance; ▪ take corrective action if there is a failure to comply.
IV.L	Provider Network Development and Management	Describe your BH MCO's approach to creating the Provider Advisory Committee.
IV.L	Provider Network Development and Management	Describe your BH MCO's approach to creating the Network Communication Plan.
IV.L	Provider Network Development and Management	Describe your BH MCO's process for developing, maintaining and utilizing network provider protocols tailored to the NE BH population.
IV.L	Provider Network Development and Management	Describe the written notice providers will be given whom your BH MCO declines to allow participation in the network
IV.L	Provider Network Development and Management	Describe the policies, procedures, and processes your BH MCO will put in place to ensure emergency services are covered regardless of whether the provider that furnishes the services has a contract with the BH MCO.
IV.L	Provider Network Development and Management	Describe the policies, procedures, and processes your BH MCO will put in place to ensure payment for treatment obtained when a member receives emergency services.

RFP Reference	Area	Statement/Question
IV.L	Provider Network Development and Management	Describe the policies, procedures, and processes your BH MCO will put in place to ensure the BH MCO does not limit what constitutes an emergency condition based on lists of diagnoses or symptoms.
IV.L	Provider Network Development and Management	Describe the policies, procedures, and processes your BH MCO will put in place to ensure the member is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.
IV.L	Provider Network Development and Management	Describe your BH MCO's process for insuring that non-participating providers who provide emergency services to members are paid on a timely basis. Also, describe your BH MCO's process to insure appropriate communication with the provider, follow-up communication with the member's PCP, and follow-up care for the member.
IV.L	Provider Network Development and Management	Describe your BH MCO's policies, procedures and processes for provision of services from non-network providers.
IV.L	Provider Network Development and Management	Describe your BH MCO's plan to ensure that your provider network meets the network and access requirements of the program. Describe the method your BH MCO plans to use on an ongoing basis to assess and ensure that DHHS's network standards are maintained, including standards related to: ▪ Distance ▪ Appointment access ▪ Cultural competency ▪ Afterhours access ▪ Inclusion of FQHCs and RHCs ▪ Inclusion of out-of-network and out-of-state providers for medically necessary services ▪ Inclusion of non-hospital urgent and emergent care providers
IV.L	Provider Network Development and Management	Describe how your BH MCO will use GeoAccess mapping to ensure network adequacy. Using providers, with whom you have signed letters of intent, provide individual GeoAccess maps.
IV.L	Provider Network Development and Management	Should your BH MCO be unable to secure an agreement with a key provider type in a given geographic area, what strategies will you use to ensure that potential members have access to care?
IV.L	Provider Network Development and Management	Describe your BH MCO's policies, procedures, and policies to ensure that Indian members are provided the protections listed in the Indian Health Protections Act.
IV.L	Provider Network Development and Management	Provide a listing by provider type/specialty of the providers from whom you have received a signed letter of intent to participate in your provider network.
IV.L	Provider Network Development and Management	Describe any provider incentive programs you plan to implement in order to improve access.
IV.L	Provider Network Development and Management	Describe the mechanisms your BH MCO will use to communicate with providers and the content you anticipate including in communications.
IV.L	Provider Network Development and Management	Describe the approach your BH MCO will take to assess provider satisfaction including tools you plan to use, frequency of assessment, and responsible parties.

RFP Reference	Area	Statement/Question
IV.L	Provider Network Development and Management	Describe your BH MCO's policies, procedures and processes to ensure providers are utilizing evidence-based and best practice approaches. How will this be reported, tracked and what will be the intervention with providers who are not using these practices?
IV.L	Provider Network Development and Management	Explain the process your BH MCO will put in place to maintain your provider file with detailed information on each provider sufficient to support provider payment including issuance of IRS 1099 forms, meets all federal and DHHS reporting requirements, and cross reference to state and federal identification numbers to ensure excluded providers are identified.
IV.L	Provider Network Development and Management	Submit copies of your standard provider contracts.
IV.L	Provider Network Development and Management	Describe your BH MCO's policies and procedures for the selection and retention of providers including selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
IV.L	Provider Network Development and Management	If your BH MCO proposes to use Subcontractors to provide any of the services provide a listing of those Subcontractors with their experience in providing care to Medicaid members and a description of the services they will provider if not already described.
IV.L	Provider Network Development and Management	Describe your Subcontractor oversight program. Specifically describe how your BH MCO will comply with the relevant portions of 42 CFR Part 438 and: ▪ Ensure receipt of all required data including encounter data; ▪ Ensure that utilization of health care services is at an appropriate level; ▪ Ensure delivery of administrative and health care services at an acceptable or higher level of care and meets all standards required by this RFP and your internal standards; ▪ Ensure adherence to required grievance policies and procedures; ▪ Subcontracts do not contain terms for reimbursement at rates that are less than the published Medicaid fee-for-service rate in effect on the date of service unless a request has been submitted to and approved by MLTC.
IV.L	Provider Network Development and Management	If your BH MCO proposes to use Subcontractors to provide any of the services provide a listing of those Subcontractors with their experience in providing care to Medicaid members and a description of the services they will provider if not already described.
IV.L	Provider Network Development and Management	Describe the process your BH MCO will have in place to notify providers of new practice guidelines and to monitor implementation of those guidelines.
IV.M	Care, Utilization and Quality Management	Describe how your BH MCO will ensure that policies and procedures are in place which prevent the structuring of compensation to individuals or entities that conduct utilization management activities in such a way as to provide incentives for the individual or BH MCO to deny, limit, or discontinue medically necessary services to any member.

RFP Reference	Area	Statement/Question
IV.M	Care, Utilization and Quality Management	Describe the Behavioral Health Risk Assessment that your BH MCO proposes to conduct with members.
IV.M	Care, Utilization and Quality Management	Describe your BH MCO's approach to creating the Clinical Advisory Committee.
IV.M	Care, Utilization and Quality Management	Describe the process and criteria used for case management, including how you will case manage and what services you will provide. Address the following issues in your response: ▪ How will you identify potential case management situations ▪ If you use a list of diagnoses to identify cases for management and if so provide the list ▪ Once a case is identified, how will your BH MCO determine whether to pursue the case for management ▪ How will case managers interact with members and the member's PCP, family, and other providers ▪ What procedures and processes are used to ensure that all medically necessary services are provided ▪ Any software you use to identify high risk members and track outcomes including predictive modeling software ▪ Specifically address care coordination for children who are State wards, in foster care placement and programs for members with chronic and/or special health needs.
IV.M	Care, Utilization and Quality Management	For members with special needs, describe the policies, procedures and processes your BH MCO will put in place to ensure coordination of care across the care continuum. Describe how your BH MCO will assist members with special needs in identifying and gaining access to community resources that may provide services that the Medicaid program does not cover.
IV.M	Care, Utilization and Quality Management	Describe how your BH MCO will monitor, report and implement a program to manage the use of psychotropic medication for children.
IV.M	Care, Utilization and Quality Management	Describe your BH MCO's policies, procedures and processes for adequate staffing of CM/UM and assure that staff meet the contract standards.
IV.M	Care, Utilization and Quality Management	Describe your BH MCO's processes to coordinate care with other state agencies, NMMCP, Tribes, and in program transition.
IV.M	Care, Utilization and Quality Management	Describe the policies, procedures, and processes your BH MCO will use to coordinate care management for those members also receiving NMMCP disease management for diabetes, asthma, hypertension, and obesity at a minimum.
IV.M	Care, Utilization and Quality Management	Describe the content of your BH MCO's BH medical record, including the utilization control requirements and compliance with 42 CFR 456.
IV.M	Care, Utilization and Quality Management	Describe how your BH MCO will coordinate with the contracted physical health vendors to meet legislative and the RFP requirements.
IV.M	Care, Utilization and Quality Management	Provide a description of your BH MCO's proposed QAPI program. Include the following in your description:

RFP Reference	Area	Statement/Question
		▪ The lines of accountability for the program ▪ How you will select areas of focus ▪ How you will use evidence based practices in developing your quality assurance program ▪ How you will use data to design and implement your quality assurance program ▪ The staff who will be assigned to this program and their qualifications ▪ Explain how your BH MCO will ensure separation of responsibilities between utilization management and quality assurance staff.
IV.M	Care, Utilization and Quality Management	Describe your BH MCO's process to evaluate its own QAPI program.
IV.M	Care, Utilization and Quality Management	Provide examples of innovative and unique performance improvement projects conducted by your BH MCO including how these projects were selected as a focus of your program.
IV.M	Care, Utilization and Quality Management	Describe the policies and procedures your BH MCO will put in place to control avoidable hospitalizations and hospital readmissions.
IV.M	Care, Utilization and Quality Management	Describe how your BH MCO will identify provider utilization patterns to improve care and reduce costs.
IV.M	Care, Utilization and Quality Management	Describe your approach to utilization management, including: ▪ Lines of accountability for utilization policies and procedures • Timelines for decisions and notices within the service authorization required limits outlined in 42 CFR 438.210(d)(1) ▪ Data sources and processes to determine which services require prior authorization and how often these requirements will be re-evaluated ▪ Process and resources used to develop utilization review criteria from non-participating providers or for members who require expedited prior authorization ▪ Processes to ensure consistent application of criteria by individual clinical reviewers.
IV.N	Health Information Requirements	Describe a general description of your BH MCO's Health Information System, including: ▪ A systems diagram that describes each component of the system; ▪ How each component will support the major functional areas of the NMMCP; ▪ Documentation that ensures data received from providers is accurate and complete; and ▪ How the BH MCO's system will interface with the

RFP Reference	Area	Statement/Question
		State system.
IV.N	Health Information Requirements	Describe modifications or updates to your BH MCO's Health Information system that will be necessary to meet the requirements of this program and your plan for their completion.
IV.N	Health Information Requirements	Describe your BH MCO's approach for ensuring complete encounter data is submitted accurately and timely to DHHS consistent with the required formats. Include in your response how you propose to monitor data completeness and manage the non-submission of encounter data by a provider or a Subcontractor.
IV.N	Health Information Requirements	Describe your BH MCO's data certification process which meets the requirements of the RFP.
IV.N	Health Information Requirements	Describe your claims processing operations including: ▪ The claims processing systems that will support this program ▪ Standards for speed and accuracy of processing and reports of compliance with standards for current contracts and all contracts for the past five years.
IV.O	Transition and Implementation	Describe the staff your BH MCO will appoint for the key staff positions in the transition coordination/collaboration process. Include the names of key personnel already assigned.
IV.O	Transition and Implementation	Describe your BH MCO's transition/implementation process.
IV.O	Transition and Implementation	Describe how your BH MCO will transition behavioral health recipients and operations. Include detail around the receipt of behavioral health to current members receiving services, planned collaboration with the existing Contractor and providers, provision of service information (including integration of current Contractor services), transition of pending grievances, appeals and customer service cases, assurance of adequate, qualified staff to meet filing deadlines and attend all court or administrative proceedings.
IV.P	Finance, Reporting Requirements and Rate-Setting	Describe your process for establishing the Reinvestment Plan including a statement of guiding principles that will aid in selecting input for development, services to be provided, etc., the Plan terms that will allow services to be provided to eligible members, etc.
IV.P	Finance, Reporting Requirements and Rate-Setting	Describe your process for creating the Reinvestment Escrow Holding Account and the Reinvestment Escrow Fund. Explain the process for determining the Escrow Account Administrators for each.
IV.P	Finance, Reporting Requirements and Rate-Setting	Describe your IBNP Reserving process; including (if applicable) methods used for the credible and non-credible periods, inventory backlog, look back analyses, and category of service groupings.
IV.P	Finance, Reporting Requirements and Rate-Setting	Describe your process of evaluating and setting acceptable contract levels as a percentage of State Medicaid fee schedules.
IV.P	Finance, Reporting Requirements and Rate-Setting	Describe your process of developing forecasts and budgets. Describe your process of identifying subsequent variances including analyses to determine causal factors of the variances and corrective action plans.

V. PROPOSAL INSTRUCTIONS

This section documents the mandatory requirements that must be met by bidders in preparing the Technical Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical Proposal are presented separately in the following subdivisions:

A. TECHNICAL PROPOSAL

The Technical Proposal shall consist of four (4) sections:

1. SIGNED, in ink, "State of Nebraska Request For Proposal For Contractual Services" form;
2. Executive Summary;
3. Corporate Overview; and
4. Technical Approach.

1. REQUEST FOR PROPOSAL FORM

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions stated in this Request for Proposal and certifies bidder maintains a drug free work place environment.

The Request for Proposal for Contractual Services form must be signed in ink and returned by the stated date and time in order to be considered for an award.

2. EXECUTIVE SUMMARY

The Executive Summary shall condense and highlight the contents of the solution being proposed by the bidder in such a way as to provide the Evaluation Committee with a broad understanding of the Contractor's Technical Proposal.

Bidders must present their understanding of the problems being addressed by implementing a new system, the objectives and intended results of the project, and the scope of work. Bidders shall summarize how their Technical Proposal meets the requirements of the Request for Proposal, and why they are best qualified to perform the work required herein.

3. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal must consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business, whether the name and form of organization has changed since first organized, and Federal Employer Identification Number and/or Social Security Number.

b. FINANCIAL STATEMENTS

The bidder must provide audited financial statements applicable to the firm. If these are not available, unaudited or pro-forma statements for the past two audited years must be provided. In the latter instance, the bidder must also submit the auditor's letter to management on compliance with internal controls.

If publicly held, the bidder must provide a copy of the corporation's most recent audited financial reports and statements, and the name, address and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded Contractor(s) will require notification to the State.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

e. RELATIONSHIPS WITH THE STATE

The bidder shall describe any dealings with the State over the previous ten (10) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any party named in the bidder's proposal response is or was an employee of the State within the past sixty (60) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after

review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

g. CONTRACT PERFORMANCE

If the bidder or any proposed subcontractor has had a contract terminated for default during the past ten (10) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the Bidders, and Subcontractors in this proposal, submit full details of all terminations for default experienced during the past ten (10) years, including the other party's name, address and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past ten (10) years, so declare.

If at any time during the past ten (10) years, the bidder, or Subcontractor in this proposal, has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope and complexity. The bidder must include those references in which the bidder provided BH services on a capitated, shared-risk or full-risk basis to Medicaid members.

If the bidder currently contracts with a state, county or local Medicaid agency other than Nebraska for a similar set of services, it must include a similar state agency among the references it provides.

The bidder shall also provide three references that are either consumer organizations, advocacy organizations, provider associations, or clinical professional organizations.

The State will review all references and project descriptions, but will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

i. Bidder must provide narrative descriptions to highlight the similarities between their experience and this Request for Proposal by submitting a description of all BH managed care projects performed or completed within the past five (5) years. These descriptions must include:

a) The name of each project;
b) The population served and location of each project;

c) The time period of the project;

d) The scheduled and actual completion dates;

e) A brief summary of the major contract responsibilities the bidder performed, including how it managed its administrative and capitated budgets;

f) Any corrective action plans required by the project client or an external quality review organization (EQRO) relating to contract non-compliance and/or deficient contract performance;

g) Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Bidder was (or is) involved;

h) A customer name, including the name of a contact person responsible for the contract management, a current telephone number, a facsimile number and e-mail address that will represent the bidder's experience;

i) Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor;

j) If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget;

k) If the work was performed by the bidder as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above; and

l) Contractor and Subcontractor(s) experience must be listed separately. A list identifying each Subcontractor and a narrative description of each Subcontractor's organizational history and mission must be submitted.

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

i. The bidder must present a detailed description of its proposed approach to the management of the project.

ii. The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

iii. The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

iv. Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

j. SUBCONTRACTORS

If the bidder intends to subcontract any part of its performance hereunder, the bidder must ensure compliance with the relevant portions of 42 CFR 438. The bidder must provide the same requirements as listed above in 4.h. 1.) i – vii, along with the following:

- **i.** Name, address and telephone number of the Subcontractor(s);
- **ii.** Specific tasks for each Subcontractor(s);
- **iii.** Description of the specific service(s) and/or function(s) to be subcontracted and provide specific references to the corresponding sections, and subsections of the contract;
- **iv.** Evaluation of the prospective Subcontractor's ability to perform the delegated activity;
- **v.** Describe how the subcontract(s) will be managed and monitored within the bidder's organization;
- **vi.** How each Subcontractor's delivery of the service(s) or performance of the function(s) will be coordinated with the bidder's;
- **vii.** Percentage of performance hours intended for each subcontractor;
- **viii.** Total percentage of Subcontractor(s) performance hours; and
- **ix.** A certification statement, signed by both the bidder and the proposed Subcontractor that complies with the requirements of 42 CFR 238.230(b)(2), and states that the proposed Subcontractor is, as of the Service Start Date, ready, willing, and able to perform all such services under the Contract.

k. RELATED PARTY CONTRACTORS

If the bidder is planning to utilize Related Party contracts within the proposed work, the bidder must disclose the following:

- **i.** Name, address and telephone number of the related party;
- **ii.** Specific tasks for each related party;
- **iii.** Percentage of performance hours intended for each related party;
- **iv.** Total percentage of related party performance hours;
- **v.** A written description of the related party agreement; and
- **vi.** The related party income statements.

l. TECHNICAL APPROACH

The technical approach section of the Technical Proposal must consist of the following subsections:

- **i.** Understanding of the Scope of Work: This section of the proposal should provide a summary of the overall understanding of the Contractor's responsibility to provide the services described and comply with the regulations referenced.
- **ii.** Proposed Implementation Approach: This section of the proposal shall describe the Contractor's overall technical approach to the Scope of Work described in the RFP. Bidders must respond to the statements and question contained the Methodology/Work Statement. Bidders must list each statement/question and then follow with the response. Bidders must answer "not applicable" to any item that is not relevant to their proposal.

iii. Technical Considerations: This section should identify any technical considerations that the bidder feels are pertinent to meeting the requirements of the RFP. The bidder should also include a detailed summary of bidder's ability and plan to meet the technical requirements of the RFP and how the bidder will make adjustments to accommodate any technical considerations identified.

iv. Detailed Project Work Plan: This section should include a detailed work plan that identifies the requirements of the RFP, transition, timelines, and key personnel that will be assigned to each area. The work plan should address, at a minimum, priority areas of development and implementation such as provider network, enrollee informational materials, systems-related technologies, and provider and staff training.

m. PAYMENT SCHEDULE

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (see Neb. Rev. Stat. 81-2401 through 81-2408). Payment to the Contractor will be monthly according to the rates offered in Attachment B.

n. ENROLLMENT REPORT

The State will provide the Contractor a monthly enrollment report that will list all enrolled and disenrolled enrollees for the enrollment month. This report will be used as the basis for payment to the Contractor.

o. CAPITATION PAYMENTS

Capitation payments will be calculated as per 42 CFR 438.6(c).

p. PAYMENT RECOVERIES

The State will occasionally request recovery of payments for certain specific situations including, but not limited to: a payment was made on behalf of a deceased enrollee. When payments are made incorrectly, the State and the Contractor will work cooperatively to identify the discrepancy and reconcile payments.

Form A

Bidder Contact Sheet

Request for Proposal Number 4166Z1

Form A should be completed and submitted with each response to this Request for Proposal. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

Each bidder shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

Request for Proposal Number RFP4166 Z1
Contract Number 55286 O4
Proposal Opening: January 7, 2013

In accordance with Nebraska Revised Statutes §84.712.05(3), the following material(s) has not been included due to it being marked proprietary.

Magellan Health QIO LLC

1. 4166Z1 Magellan Technical proposal Attachments-Redacted.
   a. Corporate Organizational Structure
   b. Resumes & Job Descriptions of Key Personnel
   c. Clinical Practice Guidelines Development Review Policy
   d. Model of Member Handbook
   e. Nebraska Provider Directory
   f. Nebraska Second Opinion Policy Draft
   g. Medicaid Service Authorization Determination Policy
   h. At-A-Glance Provider Survey
   i. Nebraska Report to the Community
   j. Nebraska Provider Newsletter
   k. Community Alliance NIATx Summary
   l. Making Trauma Informed Care Real Webinar
   m. Trauma Informed Care Symposium
   n. Sample Denial Letter
   o. Geo Access Maps – Child
   p. Geo Access Maps – Adult
   q. Geo Access Maps – MRO
   r. Sample Individual, Group and Facility Agreements
   s. Project Implementation Plan
   t. RCM Program Workflow
   u. Sample IP Authorization Review
   v. Sample Nebraska Reports
1. 4166Z1 Magellan Proposal-Redacted
   a. Magellan Behavioral Health of Nebraska, Inc. redacted all proprietary and confidential information within their submitted proposal.

In accordance with Federal U.S. Copyright Law Title 17 U.S.C. Section 101 et seq., Title 18 U.S.C. 2319, the following material(s) has not been included due to them being copyrighted.

Magellan Health QIO LLC

1. 4166Z1 Magellan Technical Proposal Attachments-Redacted

Technical Proposal Attachments

2. 4166Z1 Magellan Proposal-Redacted
   a. Title page-Technical Proposal

A Proposal to

State of Nebraska

(State Purchasing Bureau)

RFP 4166Z1

For Medicaid Managed Care Program for Mental Health and Substance Use Disorder Servi

Due date: January 7, 2013

Contents

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Cover Letter

MAGELLAN
HEALTH SERVICES
Getting Better All the Time

Ruth Gray
State Purchasing Bureau
301 Centennial Mall South, Mall Level
Lincoln, Nebraska 68508

December 30, 2012

Dear Ms. Gray,

We are pleased to enclose our response to the Request for Proposal (RFP) Number 4166Z1 issued on October 24, 2012 for the purpose of selecting a qualified contractor to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care.

To put it simply, *Nebraska is our home.* Magellan has been supporting the behavioral health and pharmacy needs of Nebraska citizens since 1995. In 2002, Magellan chose to implement a *Nebraskans serving Nebraskans* model and opened a full service Magellan Care Management Center in Lincoln that currently employs nearly 50 Nebraskans, a number that will expand with the new contract. We are the critical point of connection to match individuals and families with the care and resources they need. At Magellan, we are committed to giving Nebraska our very best. We actively participate in our Nebraska communities. We sponsor local charity events. We raise funds and donate food and clothing to local agencies to support families in our community. *We live here – and we care.*

We are uniquely qualified to transition the current system to a full risk contract. We have long term established relationships with the MLTC, other State agencies, the members, stakeholders, and providers. We will not need to negotiate new provider contracts, learn the Nebraska Medicaid program, or understand the systems of care that serve Nebraska's most vulnerable citizens. We are committed to ensuring that individuals in Medicaid have appropriate access, choice and quality.

This is a new day, with new opportunities. Magellan is the partner that can continue to assist Nebraska meet the challenges of the new day.

Please do not hesitate to contact me if you would like any additional information.

Sincerely,

Anne M McCabe

Anne McCabe, Senior Vice President
Public Sector Solutions

55 Nod Road
Avon, CT 06001
ammccabe@magellanhealth.com
860-507-1932

cc:
Sue Mimick, General Manager, Nebraska CMC
Glenn Stanton, SVP, Business Development

1. State of Nebraska Request for Proposal for Contractual Services Form

State of Nebraska (State Purchasing Bureau)
REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

RETURN TO:
State Purchasing Bureau
301 Centennial Mall South, 1st Fl
Lincoln, Nebraska 68508
OR
P.O. Box 94847
Lincoln, Nebraska 68509-4847
Phone: 402-471-2401
Fax: 402-471-2089

SOLICITATION NUMBER	RELEASE DATE
RFP 4166Z1	**October 24, 2012**
OPENING DATE AND TIME	PROCUREMENT CONTACT
January 7, 2013 2:00 p.m. Central Time	**Ruth Gray**

This form is part of the specification package and must be signed and returned, along with proposal documents, by the opening date and time specified.

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska, Administrative Services (AS), Materiel Division, Purchasing Bureau, is issuing this Request for Proposal, RFP Number 4166Z1 for the purpose of selecting a qualified contractor to provide a full-risk capitated rate Medicaid Managed Care program for Mental Health and Substance Use Disorder services with the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care.

First round written questions are due no later than November 6, 2012, and should be submitted via e-mail to matpurch.dasmat@nebraska.gov. Written questions may also be sent by facsimile to (402) 471-2089.

Bidder should submit one (1) original and seven (7) copies of the entire proposal. In the event of any inconsistencies among the proposals, the language contained in the original proposal shall govern. Proposals must be submitted by the proposal due date and time.

PROPOSALS MUST MEET THE REQUIREMENTS OUTLINED IN THIS REQUEST FOR PROPOSAL TO BE CONSIDERED VALID. PROPOSALS WILL BE REJECTED IF NOT IN COMPLIANCE WITH THESE REQUIREMENTS.

1. Sealed proposals must be received in State Purchasing by the date and time of proposal opening indicated above. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.
2. This form "REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES" MUST be manually signed, in ink, and returned by the proposal opening date and time along with bidder's proposal and any other requirements as specified in the Request for Proposal in order to be considered for an award.
3. It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://www.das.state.ne.us/materiel/purchasing/
4. It is understood by the parties that in the State of Nebraska's opinion, any limitation on the contractor's liability is unconstitutional under the Nebraska State Constitution, Article XIII, Section 3, and that any limitation of liability shall not be binding on the State of Nebraska despite inclusion of such language in documents supplied with the contractor's bid or in the final contract.t

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request For Proposal For Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions (see Section II) and certifies bidder maintains a drug free work place environment.

FIRM: Magellan Behavioral Health of Nebraska, Inc.

COMPLETE ADDRESS: 1221 N Street, Suite 700, Lincoln, NE 68508

TELEPHONE NUMBER: 402-437-4214 FAX NUMBER: 888-656-5057

SIGNATURE: Anne M McCabe DATE: 12-30-12

TYPED NAME & TITLE OF SIGNER: Anne McCabe, Senior Vice President, Public Sector Solutions

Form A: Bidder Contact Sheet

Form A

Bidder Contact Sheet

Request for Proposal Number 4166Z1

Form A should be completed and submitted with each response to this Request for Proposal. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	Magellan Behavioral Health of Nebraska, Inc.
Bidder Address:	1221 N Street, Suite 700 Lincoln, NE 68508
Contact Person & Title:	Susan Mimick, General Manager
E-mail Address:	smimick@magellanhealth.com
Telephone Number (Office):	402-437-4214
Telephone Number (Cellular):	402-981-3547
Fax Number:	888-656-4925

Each bidder shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	Magellan Health Services, Inc.
Bidder Address:	55 Nod Road Avon, CT 06001
Contact Person & Title:	Glenn Stanton, Senior Vice President, Business Development
E-mail Address:	gastanton@magellanhealth.com
Telephone Number (Office):	410-953-1242
Telephone Number (Cellular):	410-591-8085
Fax Number:	410-953-2427

III. TERMS AND CONDITIONS

By signing the "Request For Proposal For Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal.

A. GENERAL

Accept & Initial

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. The signed Request For Proposal form;
2. The original Request for Proposal document;
3. Any Request for Proposal addenda and/or amendments to include questions and answers;
4. The contractor's proposal;
5. Any contract amendments, in order of significance; and
6. Contract award.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) the contract award, 2) contract amendments with the latest dated amendment having the highest priority, 3) Request for Proposal addenda and/or amendments with the latest dated amendment having the highest priority, 4) the original Request for Proposal, 5) the signed Request For Proposal form, 6) the contractor's proposal.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

Accept & Initial

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.

By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once an intent to award decision has been determined, it will be posted to the Internet at: http://www.das.state.ne.us/materiel/purchasing/rfp.htm

Grievance and protest procedure is available on the Internet at: http://www.das.state.ne.us/materiel/purchasing/agencyservicesprocurementmanual/ProtestGrievanceProcedureForServices.doc

Any protests must be filed by a vendor within ten (10) calendar days after the intent to award decision is posted to the Internet.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

Accept & Initial

The contractor shall comply with all applicable local, State and Federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits contractors of the State of Nebraska, and their subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions or privileges of employment because of race, color, religion, sex, disability, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The contractor shall insert a similar provision in all subcontracts for services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

Accept & Initial

The contractor shall procure and pay for all permits, licenses and approvals necessary for the execution of the contract. The contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Accept & Initial

The State of Nebraska shall have the unlimited right to publish, duplicate, use and disclose all information and data developed or derived by the contractor pursuant to this contract.

The contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks and copyrights that are in any way involved in the contract. It shall be the responsibility of the contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept & Initial

The contractor shall not commence work under this contract until he or she has obtained all the insurance required hereunder and such insurance has been approved by the State. If contractor will be utilizing any subcontractors, the contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all subcontractor(s). Contractor is also responsible for ensuring subcontractor(s) maintain the insurance required until completion of the contract requirements. The contractor shall not allow any subcontractor to commence work on his or her subcontract until all similar insurance required of the subcontractor has been obtained and approved by the contractor. Approval of the insurance by the State shall not limit, relieve or decrease the liability of the contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the contractor elects to increase the mandatory deductible amount, the contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

1. **WORKERS' COMPENSATION INSURANCE**
The contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the contractor shall require the subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**
The contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect contractor and any subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the contractor or by any subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury and Contractual Liability coverage. The policy shall include the State, and others as required by the Contract Documents, as an Additional Insured. This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned and Hired vehicles.

3. **INSURANCE COVERAGE AMOUNTS REQUIRED**

a. **WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY**

Coverage A	Statutory
Coverage B	
Bodily Injury by Accident	$100,000 each accident
Bodily Injury by Disease	$500,000 policy limit
Bodily Injury by Disease	$100,000 each employee

b. **COMMERCIAL GENERAL LIABILITY**

General Aggregate	$10,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 any one person
Bodily Injury/Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$5,000 any one person

c. **COMMERCIAL AUTOMOBILE LIABILITY**
Bodily Injury/Property Damage $1,000,000 combined single limit

d. **UMBRELLA/EXCESS LIABILITY**
Over Primary Insurance $1,000,000 per occurrence

4. **EVIDENCE OF COVERAGE**

The contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer, Administrative Services, State Purchasing Bureau, 301 Centennial Mall S, 1st Fl, Lincoln, NE 68508 (facsimile 402-471-2089). These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration and amounts and types of coverage afforded. If the State is damaged by the failure of the contractor to maintain such insurance, then the contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. **COOPERATION WITH OTHER CONTRACTORS**

Accept & Initial

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential contractors, if such an arrangement is in the best interest of the State.
2. The contractor shall agree to cooperate with such other contractors, and shall not commit or permit any act which may interfere with the performance of work by any other contractor.

H. **INDEPENDENT CONTRACTOR**

Accept & Initial

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the contractor, its officers or its agents) shall in no way be the responsibility of the State. The contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay or retirement benefits.

I. **CONTRACTOR RESPONSIBILITY**

Accept & Initial

The contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the contractor's proposal, and the resulting contract. The contractor shall be the sole point of contact regarding all contractual matters.

If the contractor intends to utilize any subcontractors' services, the subcontractors' level of effort, tasks and time allocation must be clearly defined in the contractor's proposal. The

contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal, in the performance of the contract, without the prior written authorization of the State. Following execution of the contract, the contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept & Initial

The contractor warrants that all persons assigned to the project shall be employees of the contractor or specified subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the contractor to fulfill the terms of the contract shall remain under the sole direction and control of the contractor. The contractor shall include a similar provision in any contract with any subcontractor selected to perform work on the project.

Personnel commitments made in the contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the contractor to reassign or remove from the project any contractor or subcontractor employee.

In respect to its employees, the contractor agrees to be responsible for the following:

1. Any and all employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the contractor's employees, including all insurance required by state law;
3. Damages incurred by contractor's employees within the scope of their duties under the contract;
4. Maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. Determining the hours to be worked and the duties to be performed by the contractor's employees.

Notice of cancellation of any required insurance policy must be submitted to the State when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

K. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept & Initial

The contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project.

L. CONFLICT OF INTEREST

Accept & Initial

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

M. PROPOSAL PREPARATION COSTS

Accept & Initial

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations, or oral presentations, or in any other activity related to bidding on this Request for Proposal.

N. ERRORS AND OMISSIONS

Accept & Initial

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

O. BEGINNING OF WORK

Accept & Initial

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful contractor. The contractor will be notified in writing when work may begin.

P. ASSIGNMENT BY THE STATE

Accept & Initial

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

Q. ASSIGNMENT BY THE CONTRACTOR

Accept & Initial

The contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

R. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

Accept & Initial

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal or mandatory requirements. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

S. GOVERNING LAW

Accept & Initial

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The contractor must be in compliance with all Nebraska statutory and regulatory law.

T. ATTORNEY'S FEES

Accept & Initial

In the event of any litigation, appeal or other legal action to enforce any provision of the contract, the contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

U. ADVERTISING

Accept & Initial

The contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

V. STATE PROPERTY

Accept & Initial

The contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the contractor's use during the performance of the contract. The contractor shall reimburse the State for any loss or damage of such property, normal wear and tear is expected.

W. SITE RULES AND REGULATIONS

Accept & Initial

The contractor shall use its best efforts to ensure that its employees, agents and subcontractors comply with site rules and regulations while on State premises. If the contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the contractor.

X. NOTIFICATION

Accept & Initial

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II, A. Procuring Office and Contact Person of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) days following deposit in the mail.

2. Whenever the contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between contractor and the State regarding the contract shall take place between the contractor and individuals specified by the State in writing. Communication about the contract between contractor and individuals not designated as points of contact by the State is strictly forbidden.

Y. EARLY TERMINATION

Accept & Initial

The contract may be terminated as follows:

1. The State and the contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) days written notice to the contractor. Such termination shall not relieve the contractor of warranty or other service obligations incurred under the terms of the contract. In the event of cancellation the contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:

   a. If directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. A trustee or receiver of the contractor or of any substantial part of the contractor's assets has been appointed by a court;
   d. Fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its contractor, its employees, officers, directors or shareholders;
   e. An involuntary proceeding has been commenced by any party against the contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) days; or (ii) the contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the contractor has been decreed or adjudged a debtor;
   f. A voluntary petition has been filed by the contractor under any of the chapters of Title 11 of the United States Code;
   g. Contractor intentionally discloses confidential information;
   h. Second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or

Z. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept & Initial

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the contractor written notice thirty (30) days prior to the effective date of any termination, and advise the contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the contractor be paid for a loss of anticipated profit.

AA. BREACH BY CONTRACTOR

Accept & Initial

The State may terminate the contract, in whole or in part, if the contractor fails to perform its obligations under the contract in a timely and proper manner. By providing a written notice to the Contractor, the State may call for an immediate default, or allow the contractor to cure a failure or breach of contract within a period of thirty (30) days, depending on the gravity and nature of the default. Said notice shall be delivered by Certified Mail, Return Receipt Requested or in person with proof of delivery. Allowing the contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the contractor, the State may contract the service from other sources and hold the contractor responsible for any excess cost occasioned thereby.

BB. ASSURANCES BEFORE BREACH

Accept & Initial

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the contractor shall deliver assurances in the form of additional contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

CC. ADMINISTRATIVE SPENDING CAP

Accept & Initial

The State shall place a contractual cap on administrative spending by an MCO of seven percent (7%) The Contractor is required to track such expenditures and provide a detailed report of Administrative expenditures on a quarterly basis. Administrative expenditures do not include additional profit and any necessary administrative spending used to improve the health status of members served should not at any time exceed ten percent (10%).

DD. PROFIT/LOSS CAP AND REINVESTMENT

Accept & Initial

Total profit by an MCO shall not exceed three percent (3%) per year and losses shall not exceed three percent (3%) per year as an aggregate of all income and revenue earned by the Contractor and related parties, including parent and subsidy companies and risk-bearing partners, under contract. The MCO must provide for reinvestment of any profits in excess of the contracted amount, performance contingencies imposed by the MLTC, and any unearned incentive funds to fund additional behavioral health services for children, families and adults according to a plan developed with input from stakeholders, consumers and their family members, the office of consumer affairs within MLTC, and the Regional Behavioral Health Authority. Such plan must be approved by MLTC. The Reinvestment Plan must address the behavioral health needs of adults and children, including filling service gaps and providing system improvements, provide for a minimum medical loss ratio of eighty-five percent (85%) of the aggregate of all income and revenue earned by the Contractor and related parties under the contract and provide that Contractor incentives, in addition to potential profit, be at least one and one-half percent (1 ½%) of the aggregate of all income and revenue earned by the Contractor and related parties under contract.

EE. PENALTY

Accept & Initial

In the event that the contractor fails to perform any substantial obligation under the contract, the State may withhold all monies due and payable to the contractor, without penalty, until such failure is cured or otherwise adjudicated. Failure to meet the dates stipulated in the contract for the deliverables may result in an assessment of penalty due the State of $1,000.00 dollars per day, until the deliverables are approved. Contractor will be notified in writing when penalty will commence.

FF. PERFORMANCE BOND

Accept & Initial

The Contractor shall obtain and maintain a performance bond, rated at least A by A.M. Best Company, of a standard commercial scope from a surety company or companies holding a certificate of authority to transact surety business in the state. The Contractor shall not leverage the bond as collateral for debt or create other creditors using the bond as security. The Contractor shall be in breach of this contract if it fails to maintain or renew the performance bond as required by this contract.

1. The Contractor shall obtain a certified check or performance bond in an amount equal to ten million dollars ($10,000,000.00). The check or bond will guarantee that the selected contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be grounds for forfeiture of the check or bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond or certified check will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.
2. The Contractor agrees that if it is declared to be in default of any term of this contract, MLTC may elect to, in addition to any other remedies it may have under this contract, obtain payment under the performance bond for the following:

   a. Making funds available through a consensus proceeding in the appropriate court for payment to subcontracted providers and non-contracted health care providers for reimbursement due to nonpayment of claims by Contractor, in the event of a breach of Contractor's obligation under this contract;
   b. Reimbursing MLTC for any payments made by MLTC on behalf of the Contractor;
   c. Reimbursing MLTC for any extraordinary administrative expenses incurred by a breach of Contractor's obligations under this contract, including, expenses incurred after termination of this contract by MLTC;
   d. Making any payments or expenditures deemed necessary to MLTC, in its sole discretion, incurred by MLTC in the direct operation of the contract pursuant to the terms of this contract and to reimburse MLTC for any extraordinary administrative expenses incurred in connection with the direct operation of the Contractor; and
   e. The Contractor shall reimburse MLTC for expenses exceeding the performance bond amount.

GG. FORCE MAJEURE

Accept & Initial

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the contractor. To obtain release based on a Force Majeure Event, the contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

HH. PAYMENT

Accept & Initial

State will render payment to contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the contractor prior to the Effective Date, and the contractor hereby waives any claim or cause of action for any such services.

II. INVOICES

Accept & Initial

Invoices for payments must be submitted by the contractor to the agency requesting the services with sufficient detail to support payment. The terms and conditions included in the contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

JJ. AUDIT REQUIREMENTS

Accept & Initial

All contractor books, records and documents relating to work performed or monies received under the contract shall be subject to audit at any reasonable time upon the provision of reasonable notice by the State. These records shall be maintained for a period of five (5) full years from the date of final payment, or until all issues related to an audit, litigation or other action are resolved, whichever is longer. All records shall be maintained in accordance with generally accepted accounting principles.

In addition to, and in no way in limitation of any obligation in the contract, the contractor shall agree that it will be held liable for any State audit exceptions, and shall return to the State all payments made under the contract for which an exception has been taken or which has been disallowed because of such an exception. The contractor agrees to correct immediately any material weakness or condition reported to the State in the course of an audit.

KK. TAXES

Accept & Initial

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the contractor's equipment which may be installed in a state-owned facility is the responsibility of the contractor.

LL. INSPECTION AND APPROVAL

Accept & Initial

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the contractor or subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

MM. CHANGES IN SCOPE/CHANGE ORDERS

Accept & Initial

The State may, at any time with written notice to the contractor, make changes within the general scope of the contract. Changes in scope shall only be conducted with the written approval of the State's designee as so defined by the State from time to time. (The State retains the right to employ the services of a third party to perform any change order(s)).

The State may, at any time work is in progress, by written order, make alterations in the terms of work as shown in the specifications, require the performance of extra work, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the contractor for any extra work so ordered shall be determined in accordance with the applicable unit prices of the contractor's proposal.

Corrections of any deliverable services or performance of work required pursuant to the contract shall not be deemed a modification requiring a change order.

NN. SEVERABILITY

Accept & Initial

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

OO. CONFIDENTIALITY

Accept & Initial

All materials and information provided by the State or acquired by the contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the contractor on behalf of the State shall be handled in accordance with Federal and State Law, and ethical standards. The contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a contractor; contractor shall notify the State immediately of said breach and take immediate corrective action.

It is incumbent upon the contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

PP. PROPRIETARY INFORMATION

Accept & Initial

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal. The separate package must be clearly marked PROPRIETARY on the outside of the package. Bidders may not mark their entire Request for Proposal as proprietary. Bidder's cost proposals may not be marked as proprietary information. Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific

advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

QQ. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept & Initial

By submission of this proposal, the bidder certifies, that he or she is the party making the foregoing proposal that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted his or her proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

RR. PRICES

Accept & Initial

All prices, costs, terms and conditions outlined in the proposal shall remain fixed and valid commencing on the opening date of the proposal until an award is made (and for bidder receiving award prices shall remain as bid for the duration of the contract unless otherwise so stated in the contract) or the Request for Proposal is cancelled.

SS. BEST AND FINAL OFFER

Accept & Initial

The State will compile the final scores for all parts of each proposal. The award may be granted to the highest scoring responsive and responsible bidder. Alternatively, the highest scoring bidder or bidders may be requested to submit best and final offers. If best and final offers are requested by the State and submitted by the bidder, they will be evaluated (using the stated criteria), scored and ranked by the Evaluation Committee. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

TT. ETHICS IN PUBLIC CONTRACTING

Accept & Initial

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator or employee based on the understanding that the receiving person's vote, actions or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

UU. INDEMNIFICATION

Accept & Initial

1. GENERAL

The contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the contractor, its employees, subcontractors, consultants, representatives, and agents, except to the extent such contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The contractor agrees it will at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the contractor or its employees, subcontractors, consultants, representatives, and agents; provided, however, the State gives the contractor prompt notice in writing of the claim. The contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the contractor has indemnified the State, the contractor shall at the contractor's sole cost and expense promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the contractor, and the State may receive the remedies provided under this RFP.

3. PERSONNEL

The contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the contractor.

VV. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept & Initial

Contractor shall review the Nebraska Technology Access Standards, found at http://www.nitc.nebraska.gov/standards/accessibility/accessibility_standards.pdf and ensure that products and/or services provided under the contract comply with the applicable standards. In the event such standards change during the contractor's performance, the State may create an amendment to the contract to request that contract comply with the changed standard at a cost mutually acceptable to the parties.

WW. ANTITRUST

Accept & Initial

The contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

XX. DISASTER RECOVERY/BACK UP PLAN

Accept & Initial

The contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under these specifications in the event of a disaster.

YY. TIME IS OF THE ESSENCE

Accept & Initial

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the contractor remaining to be performed.

ZZ. RECYCLING

Accept & Initial

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per state statute (Neb. Rev. Stat. §81-15, 159).

AAA. DRUG POLICY

Accept & Initial

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

BBB. NEW EMPLOYEE WORK ELIGIBILITY STATUS

Accept & Initial

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at www.das.state.ne.us.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

CCC. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept & Initial

The contractor, by signature to this RFP, certifies that the contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The contractor also agrees to include the above requirements in any and all subcontracts into which it enters. The contractor shall immediately notify the Department if, during the term of this contract, contractor becomes debarred. The Department may immediately terminate this contract by providing contractor written notice if contractor becomes debarred during the term of this contract.

2. Executive Summary

The Executive Summary shall condense and highlight the contents of the solution being proposed by the bidder in such a way as to provide the Evaluation Committee with a broad understanding of the Contractor's Technical Proposal.

Bidders must present their understanding of the problems being addressed by implementing a new system, the objectives and intended results of the project, and the scope of work. Bidders shall summarize how their Technical Proposal meets the requirements of the Request for Proposal, and why they are best qualified to perform the work required herein.

Understanding the Problems Being Addressed, the Objectives and Intended Results of a New System

Magellan Behavioral Health of Nebraska, Inc. (Magellan) understands from ***RFP 4166Z1*** that: "The State of Nebraska's Medicaid program, administered through the Department of Health and Human Services, Division of Medicaid & Long-Term Care (MLTC) is seeking proposals to develop a ***unique and visionary plan*** for a full-risk capitated Mental Health and Substance Use Disorder Managed Care program for Medicaid and Children's Health Insurance Program (CHIP) members. ***The program must be integrated and coordinated for multiple Medicaid/CHIP populations*** within the managed care structure, including but not limited to the developmental disabilities population, state wards, dually Medicare and Medicaid eligible population, and those with severe mental illness and substance abuse." (Page 24 – Emphasis added)

We understand from page 6 of the ***RFI MH/SA12 (Supplemental)*** issued on May 11, 2012 that: "The overall goal of a new delivery system is to provide **services consistent with best practices** that will:

1. decrease reliance on emergency and inpatient levels of care,
2. increase evidence-based treatment,
3. increase outcome-driven community-based programming and support,
4. increase coordination between service providers,
5. promote a Recovery Oriented System of Care, and
6. increase access to high-quality services to meet the needs of our diverse clients."

RFP 4166Z1 further requires that "The Contractor shall: apply managed care practices in a manner that results in Medicaid/CHIP members having access to Mental Health and Substance Use Disorder services that:

a. Are recovery oriented and are part of an overall coordinated system of care
b. Ensure provision of services that are person and family-centered, timely, developmentally appropriate, culturally relevant and evidence-based

c. Establish an extensive, accessible provider network that offers a choice of providers and a comprehensive array of services

d. Are proactive in organizing and administering a delivery system that meets the behavioral health needs of Medicaid/CHIP members, adjusting operations as needed."

While all of the companies who will submit proposals have access to this information, Magellan has the unique understanding of the need for an evolution of the system of care as a direct result of living and working in Nebraska. We have served as the State's partner, consultant, and administrator of the Medicaid covered behavioral health services for the past 10 years. We have established relationships with the Division of Medicaid and Long Term Care (MLTC), the Division of Behavioral Health (DBH), and the Division of Children and Families Services (CFS). Equally important has been our outreach and engagement of members, their families, advocates, providers, and other stakeholders to understand their perspectives and needs during this same period of time. *We live here and we care.*

We understand that it's a *New Day with New Opportunities* created by the full-risk Nebraska Behavioral Health Managed Care Program. [redacted]

[redacted]

As reflected by the solutions below and throughout our proposal, ***Magellan is that partner***. Magellan understands Nebraska better than any competitor—its people, its culture, its Medicaid program, and the broad system of care. We are one of the leading behavioral health managed care organizations in the country and not a subsidiary company of a Health Maintenance Organization. Being independent from the three health plans operating the medical Medicaid managed care program allows us the ability to work freely with each plan representing the best interests of the member. Competitors who report up through health plan organizations have the interest of the parent company to consider and may have limitations related to that relationship. Others not active in Nebraska will need to learn the system, engage stakeholders, and contract with the entire behavioral health network. Magellan has no such limitation, and is uniquely qualified to accelerate the evolution of the behavioral health system of care.

A Technical Proposal that will *Achieve* the Goals and Objectives of the Nebraska Behavioral Health Managed Care Program – A Summary of Highlights

Corporate Overview

Magellan Behavioral Health of Nebraska, Inc. (Magellan) is authorized and licensed to transact business as a Prepaid Limited Health Service Organization, domiciled in Nebraska. This entity was created for the sole purpose of responding to the requirements of the current Request for Proposals (RFP) including the Division of Medicaid and Long Term Care requirement to accept insurance risk. Magellan of Nebraska's legacy companies have been serving as the State of Nebraska's partner to address the behavioral health needs of its most vulnerable citizens for the past 10 years. Magellan Behavioral Health of Nebraska, Inc., and the ultimate parent company Magellan Health Services, Inc., have no judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization.

A unique and distinguishing feature of our proposal is that Magellan's affiliate, Magellan Medicaid Administration (MMA), has served as MLTC's Pharmacy Point of Sale contractor continually since 2008 and as the manager of the Preferred Drug List since 2009. This is significant as it assures that the data transfer, analytics, and reporting required for the pharmacy and care management requirements of the Nebraska Behavioral Health Managed Care Program will be coordinated and seamless for MLTC thereby improving member care.

Magellan's parent and affiliate companies have significant national expertise in the design, development and operation of managed behavioral health programs serving more than 3 million Americans in direct to governmental contracts and an additional 1.2 million as a subcontractor to health plans. The 3 million members in direct to government contracts involve 15 contracts in 7 states (Arizona, Iowa, Louisiana, Florida, Pennsylvania, Nebraska, and New York). This includes the nation's largest and most complex behavioral health program in Maricopa County,

Arizona and the Louisiana Behavioral Health Program with over 1 million members. Currently only Nebraska and New York are not full-risk programs.

[redacted]

Magellan is in the unique position of offering a seasoned core group of Nebraska experienced key management staff around which an expanded management team will be built for this new business. Our team has demonstrated their effectiveness and has been successful in using their local knowledge of the system of services in Nebraska to improve the care of members. Our approach to managing communication and maximizing collaboration includes establishing and maintaining a single point of accountability to the MLTC. Magellan of Nebraska's Chief Executive Officer, Sue Mimick, will be the primary point of contact with MLTC. As such, she will be responsible for the deliverables of the MCO contract and ensuring that DHHS's vision of care for Medicaid recipients is realized. [redacted]

[redacted]

Our national public sector senior management teams provide oversight and supervision to ensure that contract deliverables are timely, accurate and meet the needs of DHHS and its Divisions [redacted]

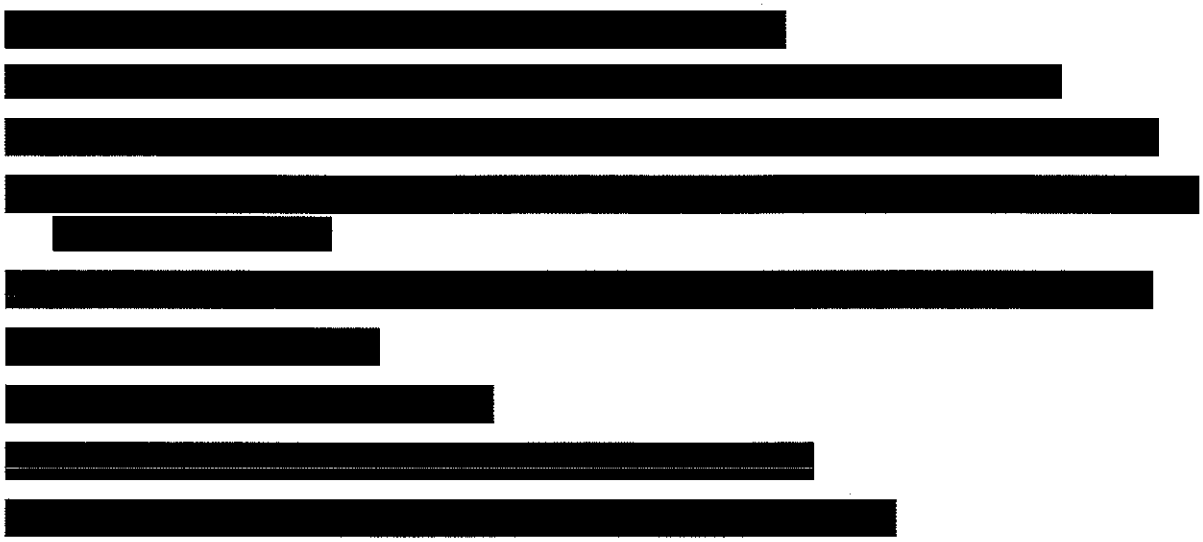
Experience, thought leadership, and a commitment to Nebraska is the Magellan difference.

Principles of Care

While all managed behavioral health companies pledge their commitment to recovery, resiliency, and trauma informed care, Magellan has demonstrated its ability to design our programs and operations to truly deliver these principles. [redacted]

Magellan's Nebraska Governance Board will act as the central decision-making mechanism for Magellan Behavioral Health of Nebraska, Inc., and advise Sue Mimick, our CEO, on issues related to contractual performance. While Magellan will retain ultimate authority and serve as a single point of program and fiscal accountability to the state for the Nebraska Medicaid Behavioral Health Program (Program), Magellan will also institute the Governance Board to involve a full range of stakeholders in providing policy direction and review of all data regarding quality and program operations.

As described in detail in our proposed implementation approach response, Magellan will reflect the principles of care in our words and actions, and will also bring training, resources, tools, and value-added services that will further promote the principles.



[redacted]

[redacted]

Member Rights and Responsibilities

Member choice is a cornerstone of Magellan's approach to service delivery. Magellan has a "no wrong door" approach allowing members to select their own provider based upon their geographic and cultural preferences. Members may select a provider from the provider directory, or may call Magellan's toll free line for assistance in locating a provider in the community where they live. Should no provider be available within the network, Magellan reaches out to the provider to bring them in network as appropriate and/or sets up an ad hoc agreement to assure access by the member and payment to the provider. Choice also includes having access to a second opinion from a network provider at no cost to the member.

In accordance with the Principles of Care in the RFP, access to educational information regarding health and wellness is an important element in our member materials. Extensive health and wellness libraries are available on our MagellanofNebraska.com Web site where members can find information on diseases and conditions, learn about tests and procedures, find information on preparing for a surgery or procedure, check symptoms, and much more. Through our partnership with A.D.A.M. Health Solutions, members have access to the world's largest online consumer health information library through MagellanofNebraska.com. This health information library, which is URAC accredited and continually enhanced, includes over 3,900 unique articles and videos covering conditions, procedures, treatments, surgeries, and tests to educate members and help them understand when to seek care.

Member and provider calls are answered 24/7. The Care Management Center in Lincoln, Nebraska, is open Monday through Friday from 8:00 am to 5:00 pm. A team of clinicians and customer service associates are available in Des Moines, Iowa, to answer urgent and emergent calls and member questions during the remaining hours and on weekends and holidays. Physician Advisors are also available 24/7 to consult with the after-hours team.

Provider Network Development and Management

[redacted] This significant increase was the direct result of focused efforts to address an important issue. The relationship has improved to the point where Magellan was first to come to agreement with the Nebraska Association of Behavioral Health Organizations on a letter of commitment to assist in implementing the new managed care program. We are committed to provider satisfaction because we understand providers are not a commodity; they are key partners in successful outcomes for residents of Nebraska.

[redacted] We are committed to continuously improved outcomes for members served in the Nebraska Medicaid Program through effective support of our provider network. Our provider network is one of our most valuable assets and we will continue to facilitate and support providers in our collective efforts to efficiently enhance the quality of services for members.

[redacted] While other competitors will offer letters of intent to reflect the capacity, we have fully executed contracts. We employ a proven methodology to assess network capacity for all providers, including those serving culturally diverse priority populations and persons with special needs such as older adults and persons with developmental disabilities. [redacted]

We will continue to ensure that our providers meet all local, state and national credentialing and quality standards. We will continue to support treatment that is member/family-centered and community-based. We have reduced out-of-state placements for residential treatment by developing community-based treatment alternatives and will continue to expand the network as needed.

[redacted]

[redacted]

Support to those caring for others when professional help is limited often falls to community members and families. Magellan will provide funding to NAMI of Nebraska and Nebraska's Federation of Families to build volunteer capacity both expanding the numbers of volunteers and increasing the support that volunteers receive in the rural areas of Nebraska.

Providers and MLTC will benefit from our extensive experience in integrated authorizations and claims payment with robust, nimble data systems that use that claims data to report back to providers on their service effectiveness and build targeted quality improvement efforts from a system-wide perspective. We will bring a performance and outcomes dashboard to the MLTC and providers that displays critical data beyond that which can be supported by claims to insure a real, meaningful performance tracking system. This system will be the basis for new contracting approaches that allow us to reward higher performing providers through decreased administrative burden, increased referrals, and financial incentives as reinvestment funds become available.

[redacted]

Care, Utilization and Quality Management

Magellan recognizes that a fundamental shift from utilization management to care management is needed to improve the whole health of members. While assuring behavioral health services provided are medically necessary and of sufficient amount scope and duration to achieve their purpose is an important activity, care coordination for high risk members and care management with primary care physicians, prescribers, and other providers of care is needed as well.

Overview of Magellan's Model of Care Management

Magellan will employ a comprehensive approach to care management to meet the unique needs of Medicaid and CHIP members, and to improve health and quality outcomes. [redacted]

[redacted]

[redacted]

[1] Six Sigma is a disciplined, data-driven approach and methodology for eliminating defects (driving toward six standard deviations between the mean and the nearest specification limit) in any process.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Information System Requirements

We operate three geographically dispersed data centers in Arizona, Missouri, and Maryland, all of which are linked to each of Magellan's field operations through our Wide Area Network (WAN) and include local staff with to assure each customer's unique needs. A comprehensive description of how our IT system meets all of the required elements is found in our response to *Section IV.N Information System Requirements* of the *Proposed Implementation Approach* and we provide selected highlights below.

Magellan has been operating in Nebraska since June 2002, and we are intimately familiar with the contractual operating and reporting requirements of the Medicaid and Long Term Care (MLTC) programs. However, our reporting and other analytic tools go far beyond the basic contractual requirements. They assist managers at multiple levels within the Nebraska system to make decisions that are informed and supported by our extensive data tools and resources.

We look forward to the opportunity to add claims adjudication and payment processing to the list of services Magellan currently provides to the MLTC programs. [redacted]

Magellan has significant experience in the exchange and receipt of data for purposes of supporting a host of medical psychiatric integration initiatives. Owning the source code to our systems gives Magellan the flexibility to support data exchanges in many different formats, whether standard or proprietary, in order to meet State and Federal standards.

MagellanofNebraska.com

MagellanofNebraska.com is dedicated to Nebraska's providers and members, and is currently compliant with Nebraska's Technology Access Standards, as required by Section III.VV of the RFP. The Web site increases the accessibility of information specific to providers and members in Nebraska. Providers and members can obtain information directly from this Web site instead of navigating through Web pages and links on the national Magellan Web site. Staff in the Nebraska Care Management Center are responsible for the content posted on this Web site. This flexibility allows Magellan to provide information to providers and members in a more timely and efficient manner.

IT Support of Integrated Health Initiatives

In support of the Nebraska contract, Magellan will work with the State MMIS as well as Health Plans participating in the Nebraska Medicaid Managed Physical Health program to receive data for integration purposes. Magellan's reporting environment will allow Magellan to use the pharmacy data from DHHS and report on individual Member and aggregate pharmacy utilization data and provider prescribing practices. Pharmacy data provided by DHHS will also be used to populate a member's care management records with prescribed medications, as required.

Data sets we receive are standardized, quality checked and loaded into Magellan's data warehouse. Once loaded, data is made available for reporting and analysis, and will help Magellan in monitoring prescribed medications for members. The integration of pharmacy and medical claims data is a key factor that drives and supports Magellan's integration programs, such as Whole Health Rx℠, further described in *Section IV.M.*

Dashboards to ensure accountability

Magellan will make the **Customer Dashboard** available to the DHHS via the MagellanofNebraska.com Web site. The Dashboards provide the security of password protection and is a convenient resource for the DHHS to view reporting information online.

We summarize and update data for the dashboard on a monthly basis using data gathered from the prior month. Interactive tools allow users to drill down to the current data of interest. Measures on the dashboard reports are table-driven and can be customized to suit the future needs of the MLTC program.

These graphical, interactive reports and other reports loaded to the static dashboard site can be downloaded in PDF format. The graphs can be printed as well. We can make these reports available in hard copy, downloadable from a secure Web site login, or via electronic file. The following diagram is a depiction of our Customer Dashboard.

[redacted]

We will also create a public access **Nebraska Provider Dashboard**. Our Nebraska Dashboard will be posted on the MagellanofNebraska.com Web site and updated at least quarterly with a set of actionable and meaningful measures for consumers, providers, and the community. These measures include well-respected standards, such as length of stay, readmission, discharge to the community, and ambulatory follow-up based on authorizations. What additionally sets Magellan apart is our approach to member education. Member and family education is posted on the Web site on how to use the dashboard from a member or family perspective. For a more in-depth overview of the Provider Dashboard, please refer to our response to the 16th *question* of the *Proposed Implementation Apprach* in *Section IV.L Provider Network.*

Transition and Implementation

Because Magellan has been the administrative services organization for MLTC-funded behavioral health services for the past 10 years, we have the existing knowledge, relationships and infrastructure necessary to not only assure a smooth transition, but to accelerate the move to a full risk program without a disruption in care for members or to the system as a whole. Current members will continue to receive the high-quality services they have come to expect from Magellan and our network providers. We will reach out to providers, current and new, to Magellan Behavioral Health of Nebraska, as well as current members, through regular communication materials (e.g., newsletters, Web site portal for members and providers) to inform them and other stakeholders about the transition of Nebraska's behavioral health Medicaid managed care program to a risk-based contract.

[redacted]

Finance, Reporting Requirements and Rate Setting

A Process for Reinvestment Based Upon Demonstrated Expertise

Magellan's process for establishing the Reinvestment Plan in Nebraska is built upon years of innovation and experience with the concept. Magellan Behavioral Care of Iowa pioneered the concept of reinvestment of managed behavioral care savings into new, innovative community-based services in the Iowa Plan starting in 1995. [redacted]

[redacted]

Magellan recognizes and agrees that the Reinvestment Plan and subsequent service provision must be approved by MLTC. To develop and advance recommendations to MLTC, we propose that our Governance Board be responsible for establishing the plan for reinvestment priorities with input from stakeholders and MLTC staff, including consumers, family members, and representatives from other DHHS departments including the Office of Consumer Affairs, as designated by MLTC. The Governance Board would review and discuss information related to service delivery gaps and recommendations from the Clinical Advisory and Provider Advisory Committees regarding the need for expansion of evidence-based practices. All reinvestment planning and decisions will be made in accordance with the regulations and timeframes established by DHHS and the RFP. Stakeholders will play a central role in the planning for reinvestment funding through their inclusion on the Governance Board, Clinical Advisory, Provider Advisory, Collaborating for Kids, and Quality Assurance Performance Improvement Committees. Once reinvestments plans are approved, we will provide monthly progress updates to DHHS for all reinvestment projects.

Fiscal Solvency Now and in the Future

Magellan Health Services is a publicly traded company governed by the federal Security Exchange Commission, and our financial stability and information is a matter of public record. Magellan Health Services, Inc. has no long-term debt, and the company has unrestricted cash and investments for the quarter ending June 30, 2012 of $179.1 million ($179,100.000).

Magellan Behavioral Health of Nebraska, Inc., and the ultimate parent company Magellan Health Services, Inc., has no judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization. Further, Magellan does not anticipate any change in ownership or control of the company during the 12 months following the proposal due date.

Unlike our competitors who have themselves or their corporate parent companies experienced significant rising medical costs in comprehensive Medicaid programs in states like Kentucky and Texas, Magellan has no intention of leaving any market it currently operates in.

Magellan as the Best Qualified to Perform the Work Required

Magellan has been Nebraska's partner, consultant, and administrator of the Medicaid covered behavioral health services for the past 10 years. We have established relationships with the Divisions of the Department of Health and Human Services, relationships with advocates and stakeholders, and existing contracts with providers. Only Magellan can transition the system of care without disruption or delay. We understand that it's a *New Day with New Opportunities* created by the full-risk Nebraska Behavioral Health Managed Care Program and are uniquely positioned to implement it. We have demonstrated success in modeling the principles of care

and will bring value added and substitute services that will allow MLTC to achieve the objectives of the program. *We live here and we care.*

3. Corporate Overview

The Corporate Overview section of the Technical Proposal must consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business, whether the name and form of organization has changed since first organized, and Federal Employer Identification Number and/or Social Security Number.

The bidder is Magellan Behavioral Health of Nebraska, Inc. (Magellan of Nebraska). Magellan of Nebraska is authorized and licensed to transact business as a Prepaid Limited Health Service Organization, domiciled in Nebraska. (See **Attachment A**). The Employer Identification Number is 46-0856929 and our office is located at 1221N Street, Suite 700, Lincoln, NE 68501-2047.

[redacted]

Magellan's history with the State of Nebraska began in 1994 when one of Magellan's legacy companies, CMG Health, held a contract with the Department of Public Institutions. Magellan Behavioral Health of Nebraska, LLC was originally formed in 1998 to serve as the Administrative Service Organization for behavioral health services. Magellan Health QIO, LLC (dba Magellan Behavioral Health) was formed on March 12, 2008, to address revised requirements of the Nebraska program and its associated RFP.

Magellan Behavioral Health of Nebraska, Inc. is a wholly owned subsidiary of Magellan Behavioral Health, Inc. which is a wholly owned subsidiary of Magellan Health Services, Inc. Magellan Health Services, Inc. as the ultimate parent is a publicly traded company (NASDAQ: MGLN) and is incorporated in the State of Delaware.

b. FINANCIAL STATEMENTS

The bidder must provide audited financial statements applicoble to the firm. If these are not availoble, unaudited or pro-forma statements for the past two audited years must be provided. In the latter instance, the bidder must also submit the auditor's letter to management on compliance with internal controls.

Magellan Behavioral Health of Nebraska, Inc. is a wholly owned subsidiary of Magellan Behavioral Health, Inc. which is a wholly owned subsidiary of Magellan Health Services, Inc. As Magellan Behavioral Health of Nebraska, Inc. has been created specifically to meet the requirements of the RFP, we have submitted the audited financial statements for the ultimate parent – Magellan Health Services, Inc. in **Attachment B**.

If publicly held, the bidder must provide a copy of the corporation's most recent audited financial reports and statements, and the name, address and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

Magellan Behavioral Health of Nebraska, Inc. is a wholly owned subsidiary of Magellan Behavioral Health, Inc. which is a wholly owned subsidiary of Magellan Health Services, Inc. As Magellan Behavioral Health of Nebraska, Inc. has been created specifically to meet the requirements of the RFP, we have submitted the audited financial statements for the ultimate parent – Magellan Health Services, Inc. in **Attachment B**.

The contact information for Magellan's fiscally responsible representative is:

Ms. Renie Shapiro

Senior Vice President, Corporate Finance

Magellan Health Services, Inc.

55 Nod Road

Avon, CT 06001

(860) 507-1912

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

Magellan is a publicly held corporation (NASDAQ: MGLN).

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

Magellan Behavioral Health of Nebraska, Inc. and the ultimate parent Magellan Health Services, Inc. has no judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded Contractor(s) will require notification to the State.

Magellan Behavioral Health of Nebraska, Inc. does not anticipate any change in ownership or control of the company during the 12 months following the proposal due date. We affirm our understanding that any change of ownership will require notification to the State.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

Magellan Behavioral Health of Nebraska, Inc. is currently located at the following address:

Nebraska Care Management Center

1221 North Street, Suite 700

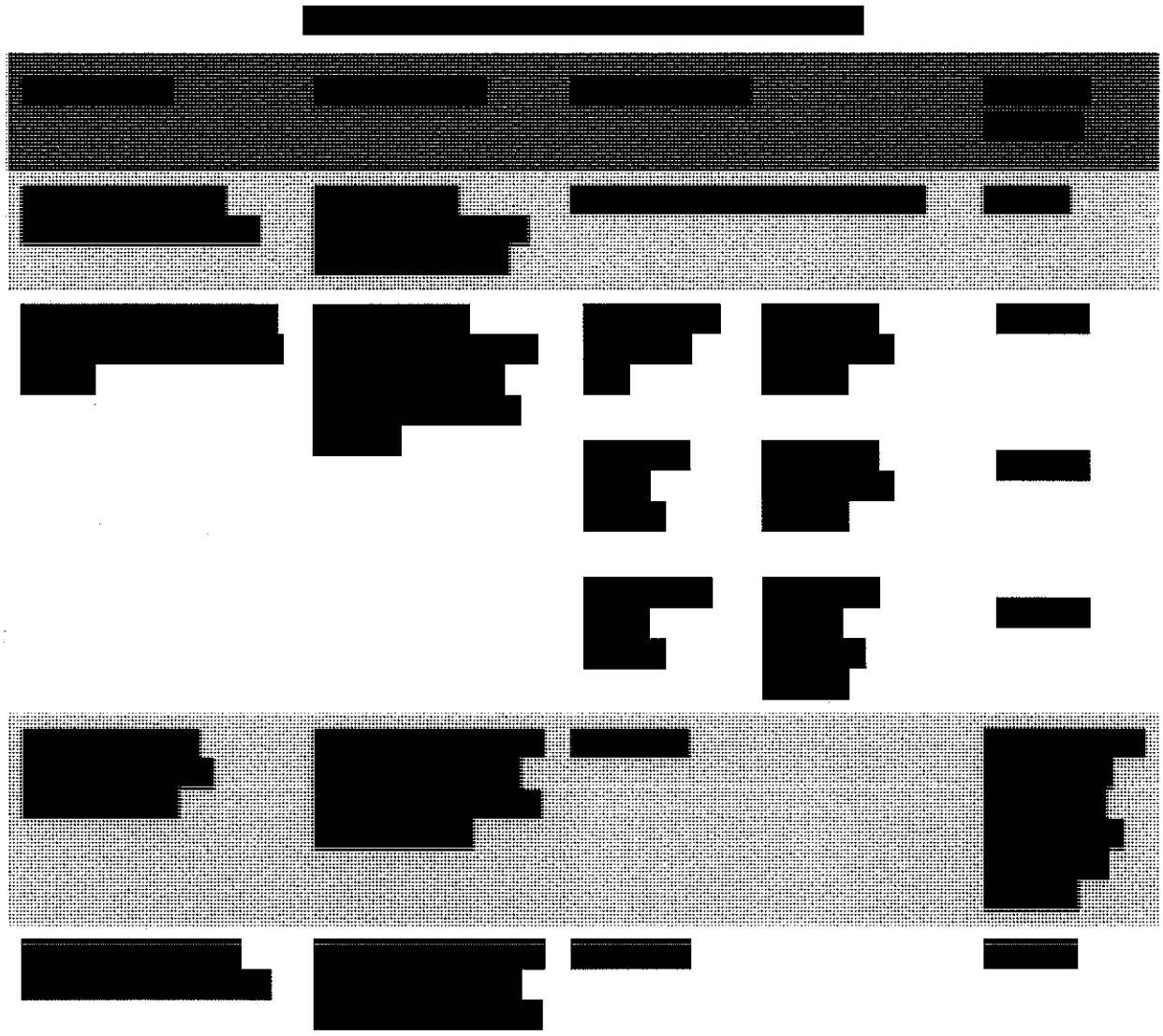
Lincoln, NE 68501-2407

Based upon the expanded requirements of the contract, we are evaluating additional space. Any new location would be in close proximity, preferably walking distance, to the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care.

e. RELATIONSHIPS WITH THE STATE

The bidder shall describe any dealings with the State over the previous ten (10) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

Magellan Behavioral Health of Nebraska, Inc. is the current Administrative Services Organization for Nebraska's Medicaid behavioral health services. A Magellan affiliate (related party contractor), Magellan Medicaid Administration, was previously, and continues to be, a contractor for Nebraska pharmacy administration services. Note that First Health was acquired by Magellan Health Services, Inc and subsequently renamed Magellan Medicaid Administration. A summary of those contracts is provided in Table 3.e.1 below.



3.f. Bidder's Employee Relations to State

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any party named in the bidder's proposal response is or was an employee of the State within the past sixty (60) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

Magellan Behavioral Health of Nebraska, Inc. has conducted a review of its personnel records and had discussions with the existing Nebraska Care Management Center staff and declares that no such relationship exists or has existed.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

Magellan Behavioral Health of Nebraska, Inc. declares that no such relationship exists.

g. CONTRACT PERFORMANCE

If the bidder or any proposed subcontractor has had a contract terminated for default during the past ten (10) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

Magellan Behavioral Health of Nebraska, Inc., nor any of its related parties or subcontractors, have had a contract terminated for default during the past 10 years.

It is mandatory that the Bidders, and Subcontractors in this proposal, submit full details of all terminations for default experienced during the past ten (10) years, including the other party's name, address and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past ten (10) years, so declare.

Magellan Behavioral Health of Nebraska, Inc., declares that no contracts of have been terminated for default in the past 10 years.

If at any time during the past ten (10) years, the bidder, or Subcontractor in this proposal, has had a contract terminated far canvenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such terminatian, including the name and address of the other contracting party.

Neither Magellan Behavioral Health of Nebraska, Inc., nor any of its related parties, have had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason during the past 10 years.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope and complexity. The bidder must include those references in which the bidder provided BH services on a capitated, shared-risk or full-risk basis to Medicaid members.

If the bidder currently contracts with a state, county or local Medicaid agency other than Nebraska for a similar set of services, it must include a similar state agency among the references it provides.

The bidder shall also provide three references that are either consumer organizations, advocacy organizations, provider associations, or clinical professional organizations.

The State will review all references and project descriptions, but will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

i. Bidder must provide narrative descriptions to highlight the similarities between their experience and this Request for Proposal by submitting a description of all BH managed care projects performed or completed within the past five (S) years. These descriptions must include:

a) The name of each project;

b) The population served and location of each project;

c) The time period of the project;

d) The scheduled and actual completion dates;

e) A brief summary of the major contract responsibilities the bidder performed, including how it managed its administrative and capitated budgets;

f) Any corrective action plans required by the project client or an external quality review organization (EQRO) relating to contract non-compliance and/or deficient contract performance;

g) Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Bidder was (or is) involved;

h) A customer name, including the name of a contact person responsible for the contract management, a current telephone number, a facsimile number and e-mail address that will represent the bidder's experience;

i) Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor;

j) If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget;

k) If the work was performed by the bidder as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above; and

l) Contractor and Subcontractor(s) experience must be listed separately. A list identifying each Subcontractor and a narrative description of each Subcontractor's organizational history and mission must be submitted.

In response to this item we provide three sections below:

1. Summary matrix listing of similar projects
2. Three references that are consumer organizations, advocacy organizations, provider associations, or clinical professional organizations
3. Narrative project descriptions that address items (a) through (l) for of all of the behavioral health managed care projects performed or completed within the past five years reflected in the matrix that were based upon a shared or full risk contract model.

Summary Matrix Listing of Similar Projects

[redacted]

[redacted]

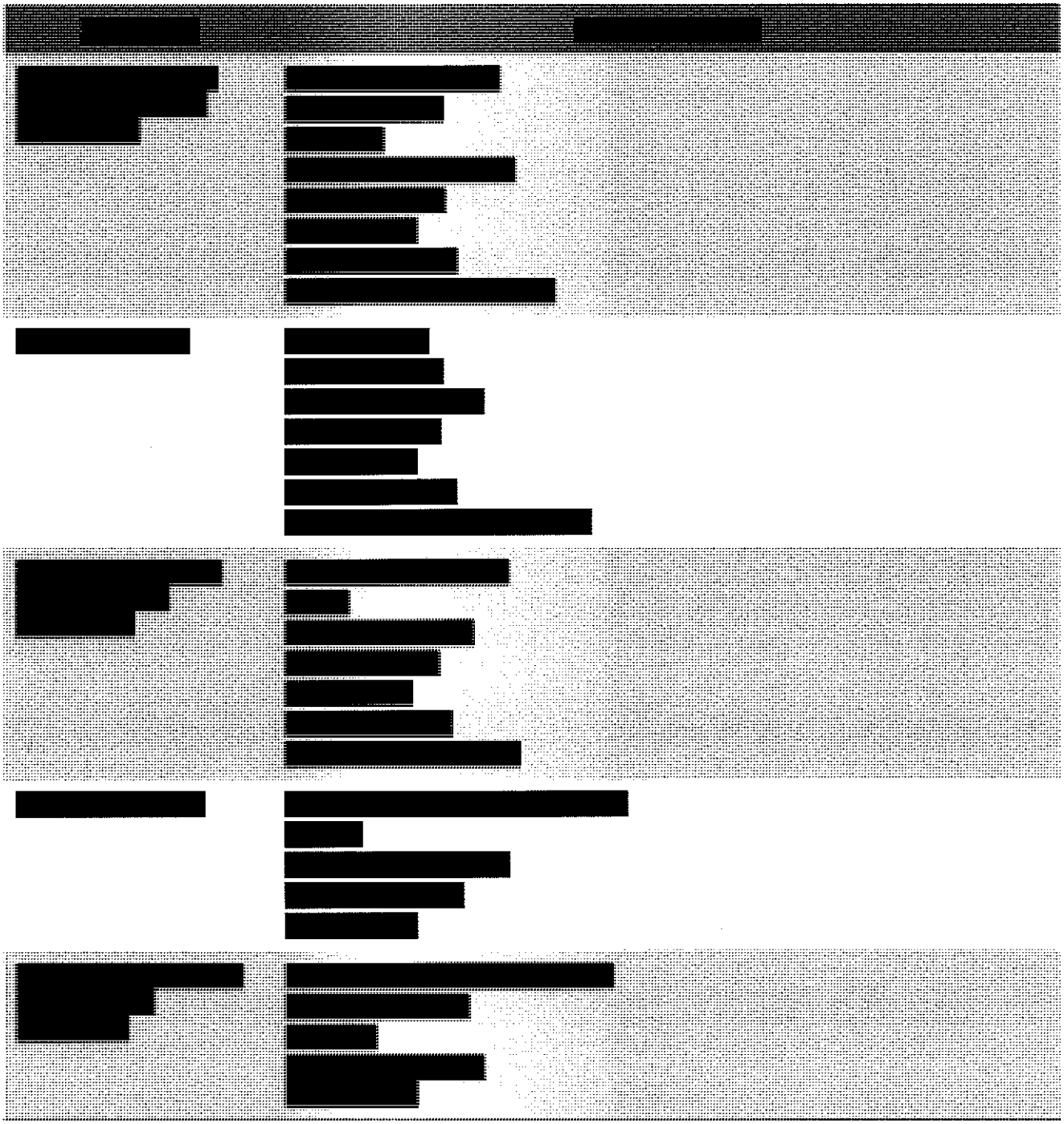
[redacted]

While the contracts below are not currently delivered in a shared-risk or full-risk contract arrangement, the experience and administrative services performed are directly relevant. We provide the summary here, but do not list them in a narrative as they are not currently shared-risk or full-risk contracts.

[redacted]

References that are Consumer Organizations, Advocacy Organizations, Provider Associations, or Clinical Professional Organizations

State Customer contacts and references are included in the narrative below. Local and national references are listed in the table below.



Medicaid Managed Care Experience – Narrative Descriptions

Magellan has an extensive and successful track record of providing behavioral health managed care in Medicaid programs in seven states throughout the country. Of the 15 Medicaid programs Magellan presently manages, 13 have been operating for three or more years and two more programs have been added in the past year in portions of New York State and statewide in

Louisiana. The following are descriptions of the Magellan Medicaid behavioral health programs that have been operating successfully for the past five or more years.

Name of Project: The Iowa Plan - Iowa Department of Human Services for Medicaid and Iowa Department of Public Health for Substance Abuse Block Grant Funds

b) The population served and location of each project;

Since 1995, Magellan has managed behavioral health services for more than 414,500 adults, adolescents and children who are Medicaid eligible and/or eligible for state and non-Medicaid federal funds in the statewide Iowa plan.

c) The time period of the project;

[redacted]

d) The scheduled and actual completion dates;

[redacted]

e) A brief summary of the major contract responsibilities the bidder performed, including how it managed its administrative and capitated budgets;

Magellan has managed behavioral health services for more than 414,500 adults, adolescents and children in Iowa through a full risk contract. Many of the managed behavioral public sector innovations and best practices began with the Iowa Plan. [redacted]

[redacted]

[redacted]

[redacted]

f) Any corrective action plans required by the project client or an external quality review organization (EQRO) relating to contract non-compliance and/or deficient contract performance;

The table below summarizes the corrective actions plans required for the period of CY2008 – CY2012. It has been our experience that each state has its own unique approach and set of standards in conducting audits, reviews and the subsequent development of penalties and recommendations. Below is the information for our Iowa Plan, with only one action plan in the past five years, but more importantly the only one in the past ten.

[redacted]

g) Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Bidder was (or is) involved;

The Iowa Plan has had no adverse contact actions or project-associated litigation.

h) A customer name, including the name of a contact person responsible for the contract management, a current telephone number, a facsimile number and e-mail address that will represent the bidder's experience;

[redacted]

i) Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor;

Magellan was the prime contractor.

j) If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget;

Magellan Health Services is a publicly traded company governed by the federal Security Exchange Commission (SEC) and our financial stability and information is a matter of public record. As part of our required and publicly disclosed financial reporting, our SEC financial filings report displays cost of care and profit by segment, not individual contract. Each individual contract addresses the cost of care and administrative and profit/fund balance requirements uniquely. For example some contracts require a minimum medical loss ratio and others place a cap on admin and profit combined or a cap on profit alone. For the nine months ending September 30, 2012, as reported on SEC Form 10-Q, our Public Sector segment had net revenues of $1,206,289,000 of which $1,058,384,000 was utilized for cost of care. For the Public Sector, net revenues less cost of care and direct expenses, before corporate costs and other operating expenses was $81,890,000.

k) If the work was perfarmed by the bidder as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above; and

l) Contractor and Subcontractor(s) experience must be listed separately. A list identifying each Subcontractor and a narrative description of each Subcontractor's organizational history and mission must be submitted.

Not applicable.

Name of Project: Maricopa County Regional Behavioral Health Authority

b) The population served and location of each project;

Magellan has provided behavioral health management services for approximately 700,000 individuals through the Regional Behavioral Health Authority (RBHA) in Maricopa County, Arizona—the largest and most complex public sector behavioral health contract in the country. The membership includes persons eligible for Medicaid as well as those with serious mental illness and severe emotional disturbance eligible for State funded services and is managed on a full risk basis.

c) The time period of the project;

[redacted]

d) The scheduled and actual completion dates;

[redacted]

e) A brief summary of the major contract responsibilities the bidder performed, including how it managed its administrative and capitated budgets;

Maricopa County is a dramatic case study in managing systems transformation. Following a difficult tenure by the preceding vendor, Magellan of Arizona was named the RBHA for Maricopa County in 2007 to transform a system to a new vision established by the state. When work began in Maricopa County, the goal was to build on the strengths of the mental health care system such as the historic Arizona-based community mental health providers and overcome some of the challenges that were created including the preceding vendor's conflicted role as both the RBHA manager and a major provider of services. Success was achieved in giving the more than 80,000 members, challenged by mental illness and substance abuse, the voice and choice to realize their desired outcomes. By supporting those who seek our help and providing them with caring, unrivaled customer service, which is sensitive to the diversity of our communities, Magellan has delivered on that promise by working collaboratively with the state and the local providers to transfer the responsibility of 23 behavioral health service centers, owned and operated by the incumbent to newly created and community supported Provider Network Organizations (PNOs). The purpose of this transition was to provide increased voice and participation by all stakeholders, including members, providers, families, care-givers, and advocates. A variety of means were utilized to drive marked improvements in the areas of quality management, fiscal management, and, overall, system management. As proof of the success the contract for the Maricopa County RHBA was extended twice.

[redacted]

[redacted]

Unique innovations and services were also added to address the needs of the members and the demands upon the system. These included:

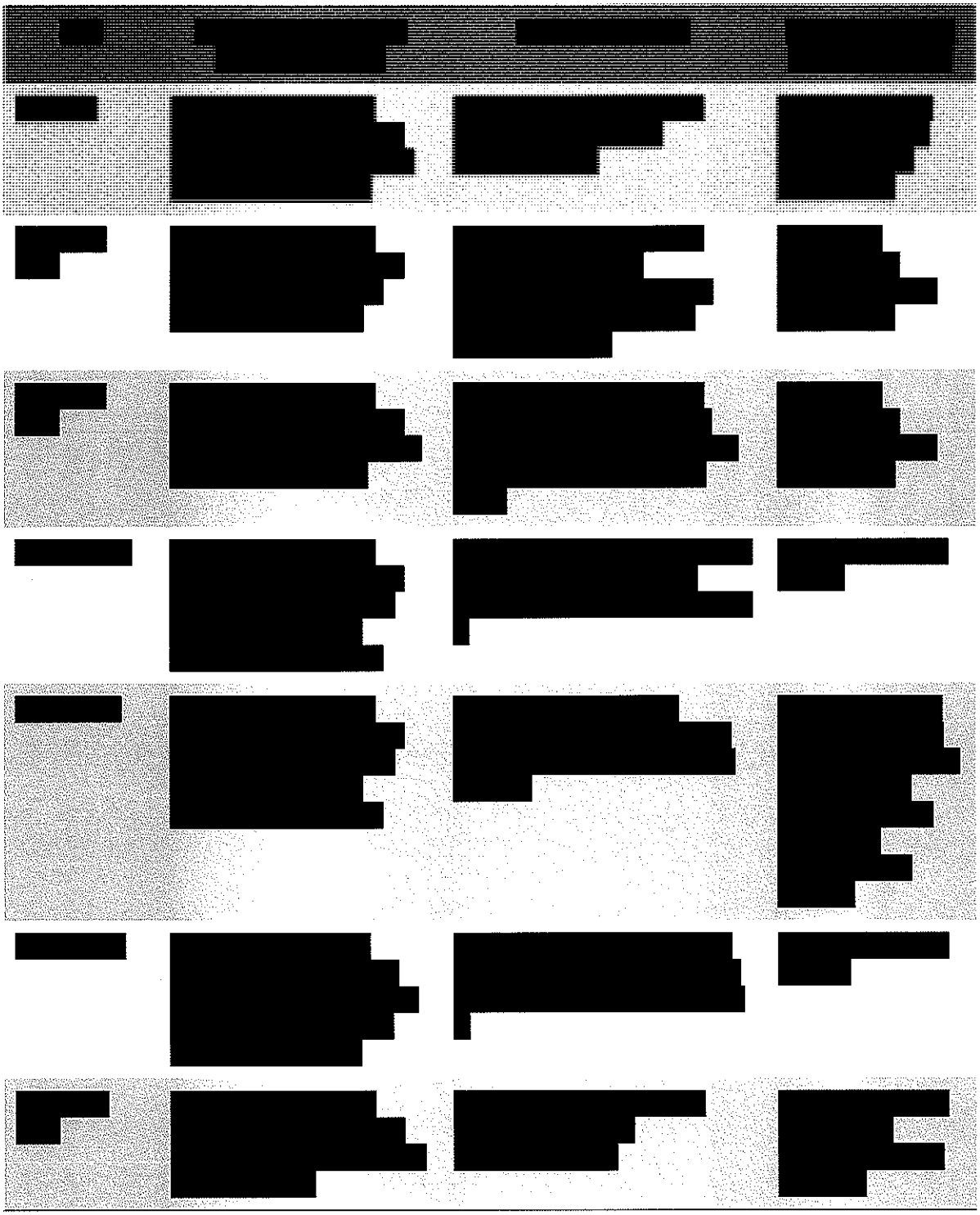
[redacted]

[redacted]

f) Any corrective action plans required by the project client or an external quality review organization (EQRO) relating to contract non-compliance and/or deficient contract performance;

The table below summarizes the corrective actions plans required for the period of CY2008 – CY2012. As a national company with 15 contracts held directly with State or County customers, not as a subsidiary to a parental company holding the contract for comprehensive medical services, it has been our experience that each state has its own unique approach and set of standards in conducting audits, reviews and the subsequent development of penalties and recommendations. Below is the information for our Maricopa County Regional Behavioral Health Authority Plan, the largest and most complex behavioral health program in the country.

[redacted]



g) Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Bidder was (or is) involved;

The Maricopa County Regional Behavioral Health Authority has had no adverse contact actions or project-associated litigation.

h) A customer name, including the name of a contact person responsible for the contract management, a current telephone number, a facsimile number and e-mail address that will represent the bidder's experience;

[redacted]

i) Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor;

Magellan was the prime contractor.

j) If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget;

Magellan Health Services is a publicly traded company governed by the federal Security Exchange Commission and our financial stability and information is a matter of public record. As part of our required and publicly disclosed financial reporting, our SEC financial filings report displays cost of care and profit by segment, not individual contract. Each individual contract addresses the cost of care and administrative and profit/fund balance requirements uniquely. For example some contracts require a minimum medical loss ratio and others place a cap on admin and profit combined or a cap on profit alone. For the nine months ending September 30, 2012, as reported on SEC Form 10-Q, our Public Sector segment had net revenues of $1,206,289,000 of which $1,058,384,000 was utilized for cost of care. For the Public Sector, net revenues less cost of care and direct expenses, before corporate costs and other operating expenses was $81,890,000.

k) If the work was performed by the bidder as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above; and

l) Contractor and Subcontractor(s) experience must be listed separately. A list identifying each Subcontractor and a narrative description of each Subcontractor's organizational history and mission must be submitted.

Not applicable.

Name of Project: The Louisiana Behavioral Health Plan

b) The population served and lacation of each project;

Magellan manages behavioral health services for nearly 270,000 adults and 780,000 children who are Medicaid eligible, as well as more than 35,000 indigent children and adults served by the Louisiana Department of Health and Hospital, the Louisiana Department of Children and Family Services, the Louisiana Office of Juvenile Justice or the Louisiana Department of Education.

c) The time period of the project;

[redacted]

d) The scheduled and actual completion dates;

[redacted]

e) A brief summary of the major contract responsibilities the bidder performed, including how it managed its administrative and capitated budgets;

This contract includes both a full risk and administrative services (ASO). The Children's Coordinated System of Care component is specifically ASO only. The contract in total includes a full range of management services including: 24-hour crisis counseling and referral, management information system, network development, claims payment, utilization management, quality improvement, and reporting.

Through multiple contracts with several Louisiana agencies, including the Department of Health and Hospitals, the Department of Children and Family Services, the Office of Juvenile Justice and

the Department of Education, Magellan serves more than one million enrollees statewide. [redacted]

- [redacted] so they can be eligible for intensive case management services.

f) Any corrective action plans required by the project client or an external quality review organization (EQRO) relating to contract non-compliance and/or deficient contract performance;

The Louisiana Behavioral Health Plan has not had any non-compliance or deficiencies in performance that required corrective actions during this period.

g) Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Bidder was (or is) involved;

The Louisiana Behavioral Health Plan has had no adverse contact actions or project-associated litigation.

h) A customer name, including the name of a contact person responsible for the contract management, a current telephone number, a facsimile number and e-mail address that will represent the bidder's experience;

[redacted]

i) Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor;

Magellan is the prime contractor.

j) If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget;

Magellan Health Services is a publicly traded company governed by the federal Security Exchange Commission and our financial stability and information is a matter of public record. As part of our required and publicly disclosed financial reporting, our SEC financial filings report displays cost of care and profit by segment, not individual contract. Each individual contract addresses the cost of care and administrative and profit/fund balance requirements uniquely. For example some contracts require a minimum medical loss ratio and others place a cap on admin and profit combined or a cap on profit alone. For the nine months ending September 30, 2012, as reported on SEC Form 10-Q, our Public Sector segment had net revenues of $1,206,289,000 of which $1,058,384,000 was utilized for cost of care. For the Public Sector, net revenues less cost of care and direct expenses, before corporate costs and other operating expenses was $81,890,000.

k) If the work was performed by the bidder as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above; and

l) Contractor and Subcontractor(s) experience must be listed separately. A list identifying each Subcontractor and a narrative description of each Subcontractor's organizatianal history and mission must be submitted.

Not applicable.

Name of Project: Florida Prepaid Mental Health Plans (four regional contracts)

b) The population served and location of each project;

While there is a single state customer, the Agency for Health Care Administration (ACHA – the State Medicaid agency), Magellan operates four separate contracts.

AHCA Area 2 Prepaid Mental Health Plan – 44,200 Medicaid members in the panhandle area including Tallahassee

AHCA Area 4 Prepaid Mental Health Plan – 26,800 Medicaid members in the northeast are including Daytona Beach

AHCA Area 9 Prepaid Mental Health Plan – 74,000 Medicaid members in the southeast area including West Palm Beach

AHCA Area 11 Prepaid Mental Health Plan – 81,500 Medicaid members in the Miami-Dade and Monroe County area

c) The time period of the project;

[redacted]

d) The scheduled and actual completion dates;

[redacted]

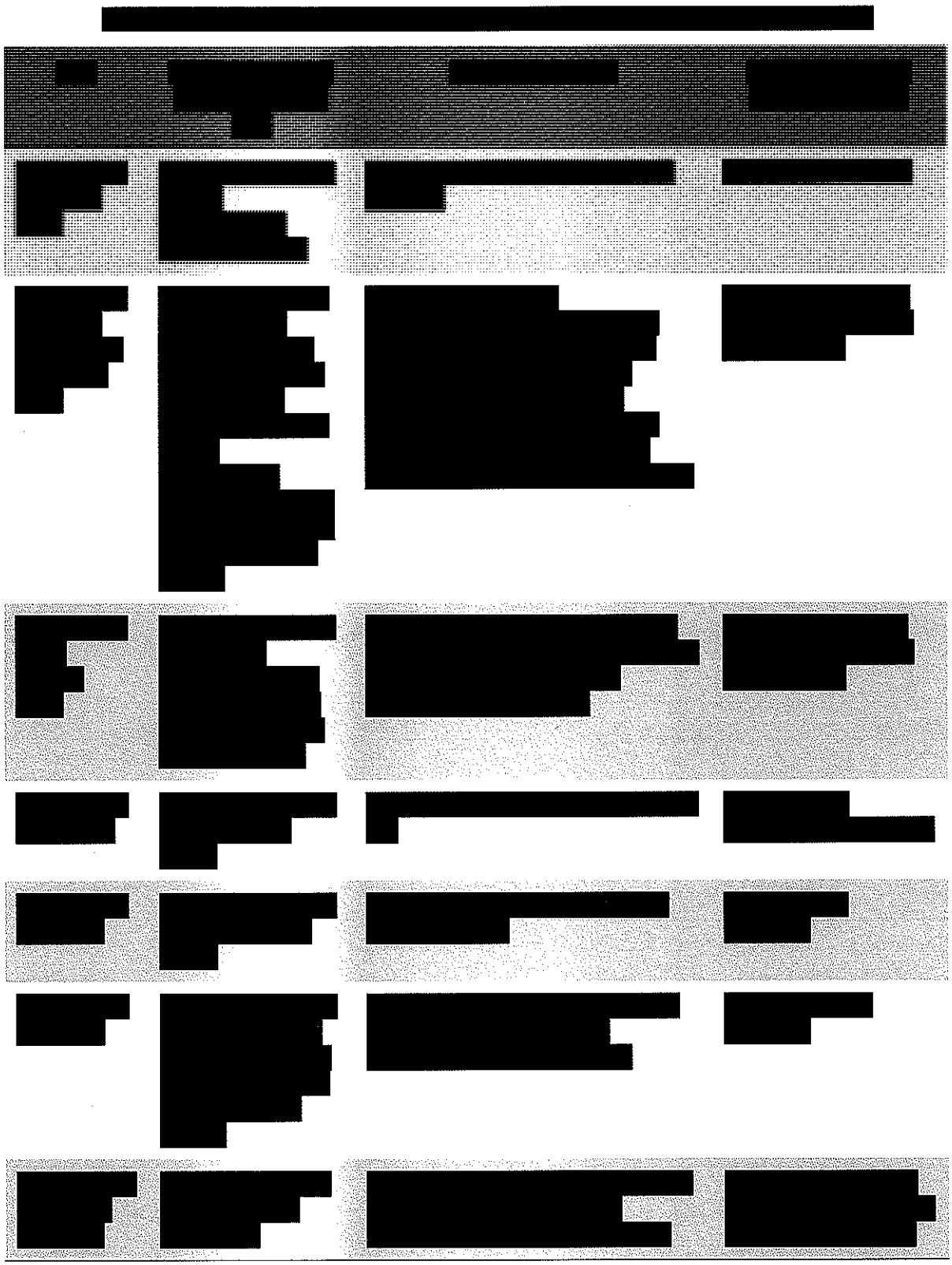
e) A brief summary of the major contract responsibilities the bidder performed, including how it managed its administrative and capitated budgets;

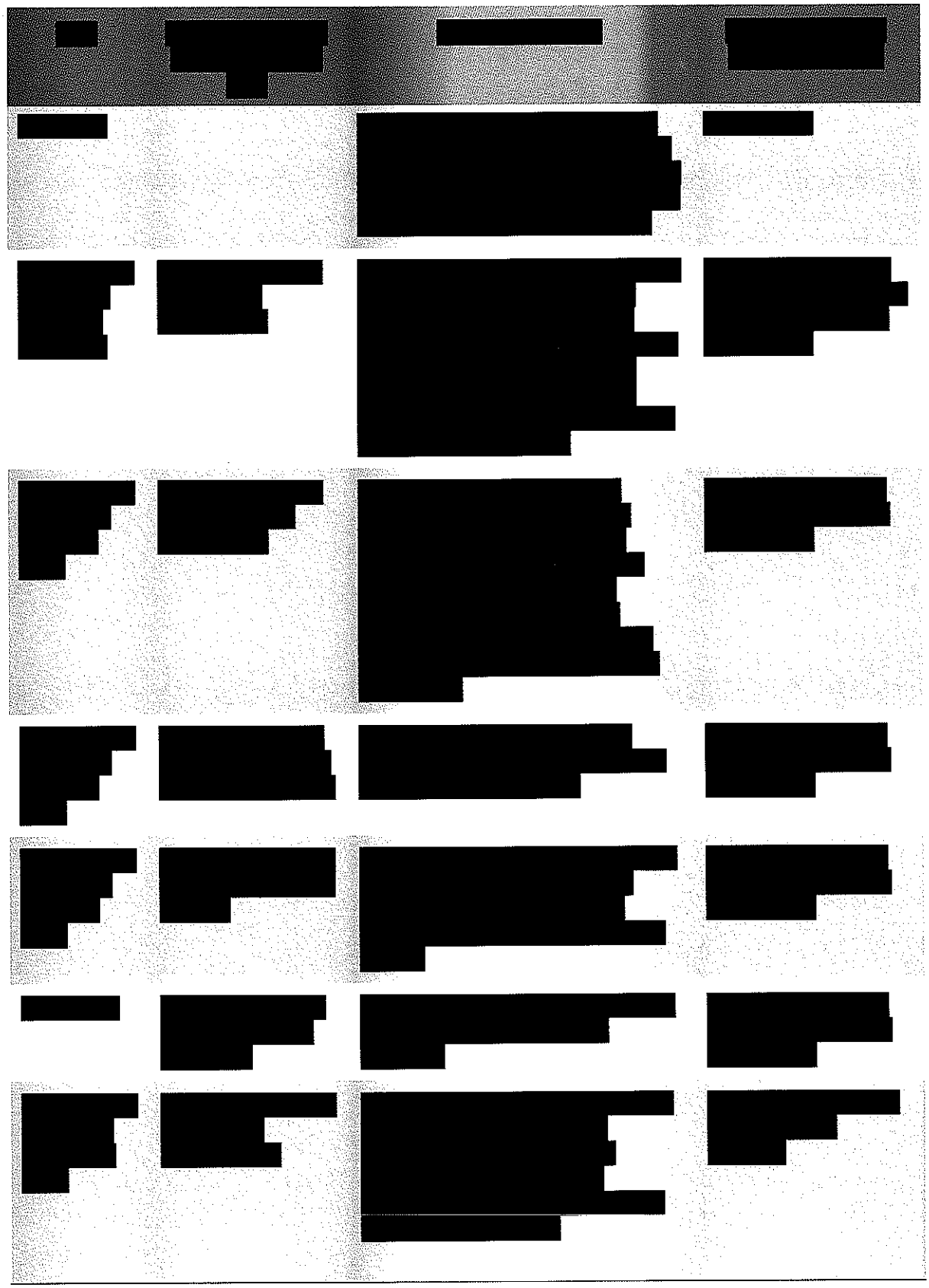
Since 2006 Magellan has managed mental health care for members of Florida's Medipass program (a Primary Care Case Management Program) through the full risk Prepaid Mental Health Plan (PMHP). We provide coverage for more than 225,000 members in 24 counties in four distinct geographic areas that include Tallahassee, Daytona Beach, Miami-Dade and Monroe counties, and West Palm Beach. While each of the Areas has locally based account management and peer/family manager staff, the program is serviced through our Care Management Center in the Miami area. Management Activities include: claims processing/payment; information technology, care management and utilization management including intensive care management, quality improvement, reporting network development and management, coordination with physical health care.

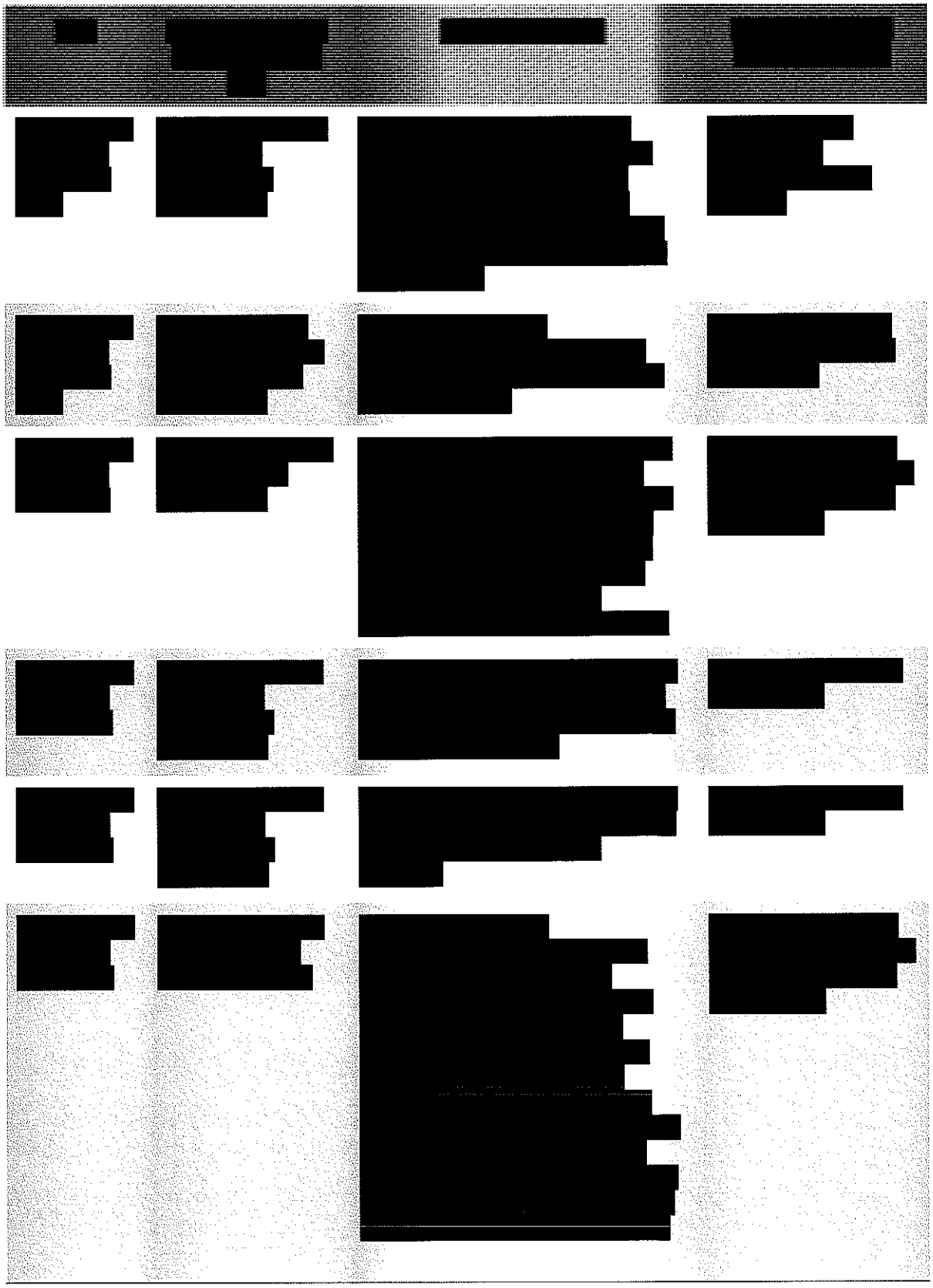
f) Any corrective action plans required by the project client or an external quality review organization (EQRO) relating to contract non-compliance and/or deficient contract performance;

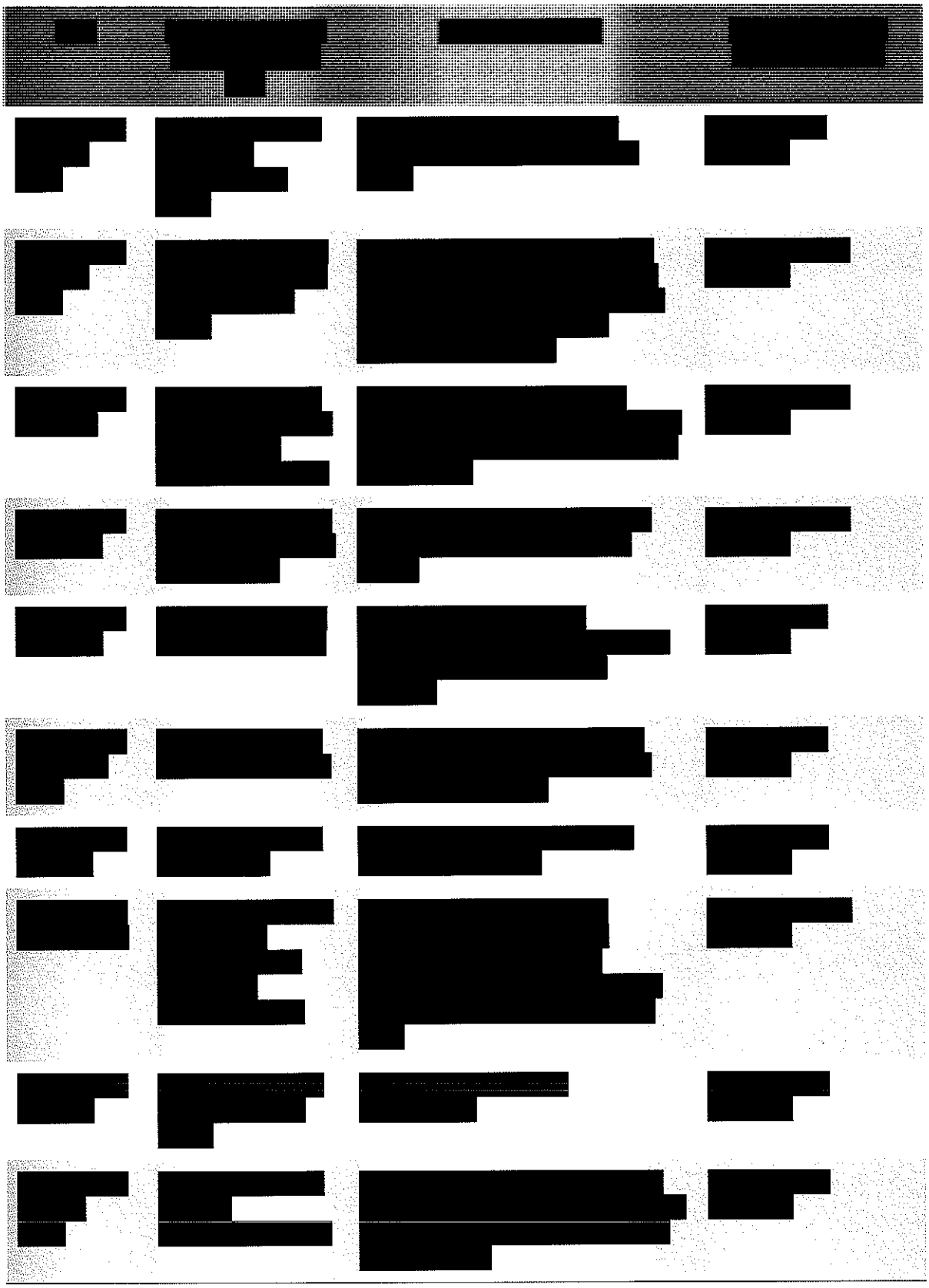
The table below summarizes the corrective actions plans required for the period of CY2008 – CY2012. *It has been our experience that each state has its own unique approach and set of standards in conducting audits, reviews and the subsequent development of penalties and recommendations. As noted below, several of these "corrective action plans" were simply requests*

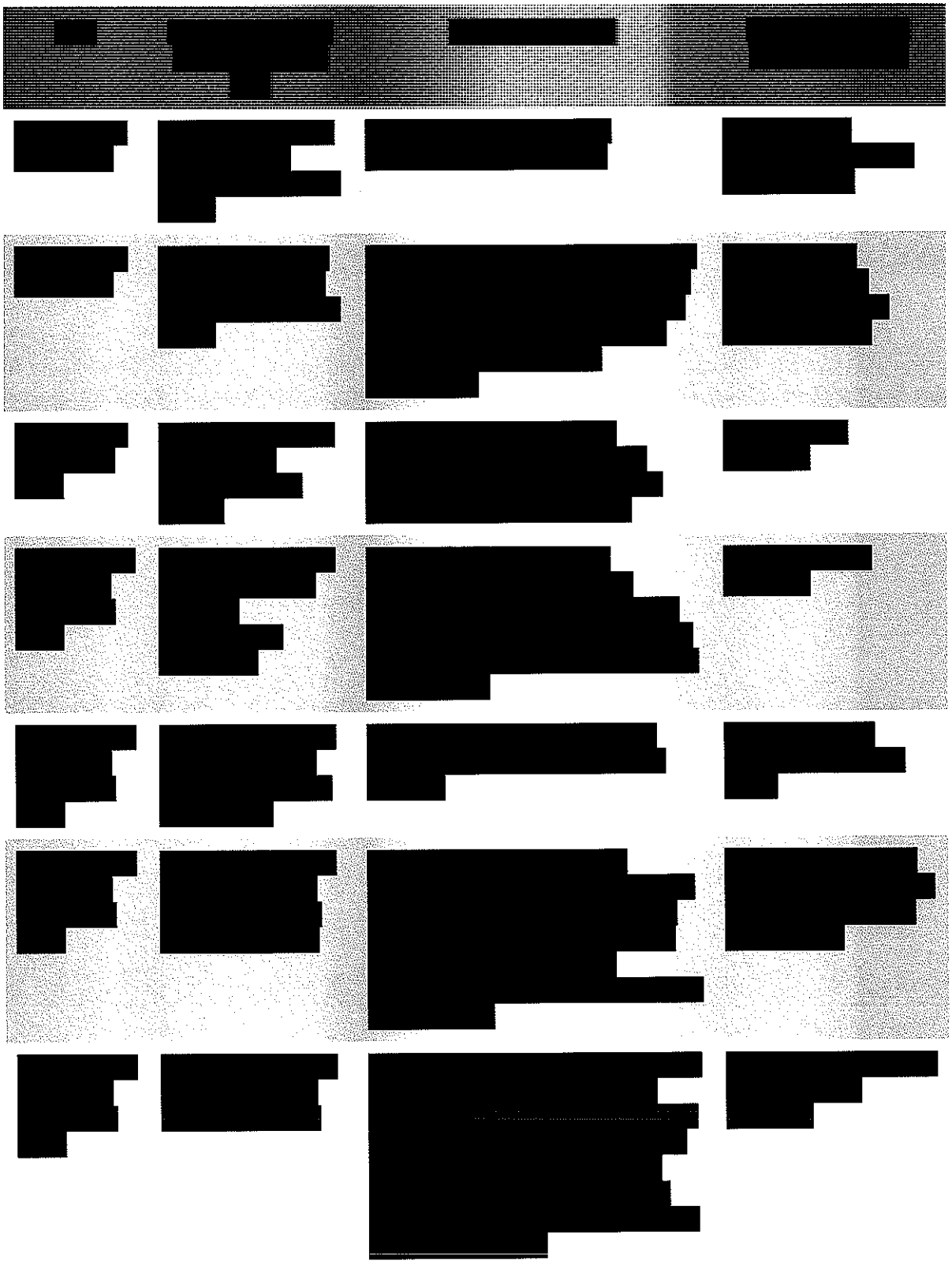
for information, but in the interest of full disclosure we provide detail on every item. Below is the information for our Prepaid Mental Health Plans in Florida and all four areas.

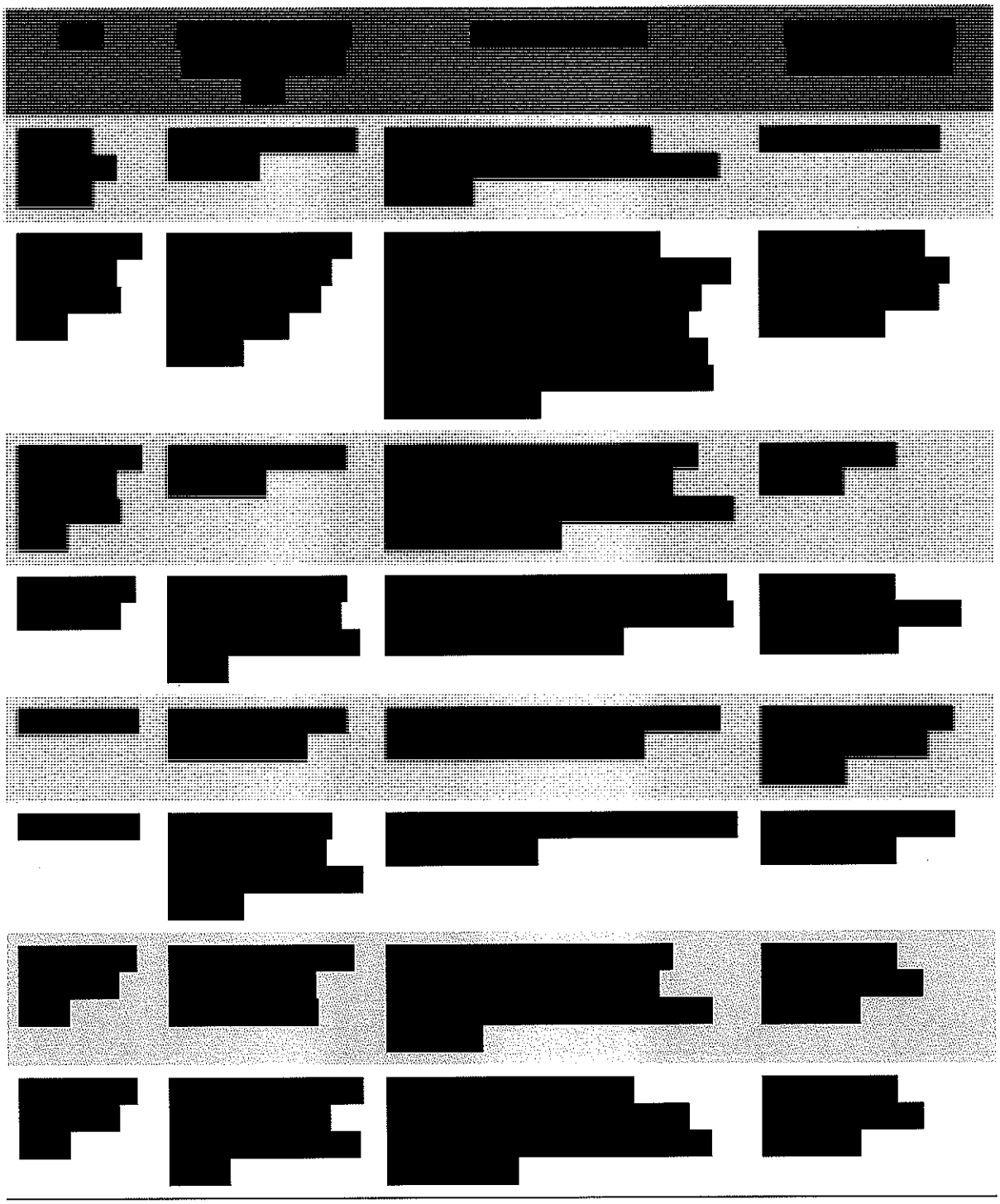












g) Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Bidder was (or is) involved;

The Florida Prepaid Mental Health Plans have had no adverse contact actions or project-associated litigation.

h) A customer name, including the name of a contact person responsible for the contract management, a current telephone number, a facsimile number and e-mail address that will represent the bidder's experience;

[redacted]

i) Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor;

Magellan was the prime contractor.

j) If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget;

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k) If the work was performed by the bidder as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above; and

l) Contractor and Subcontractor(s) experience must be listed separately. A list identifying each Subcontractor and a narrative description of each Subcontractor's organizational history and mission must be submitted.

Not applicable.

Name of Project: The Florida Prepaid Mental Health Plan for Child Welfare

b) The population served and location of each project;

Magellan serves approximately 22,400 children and youth who are Medicaid eligible and engaged in the Child Welfare system. The program operates nearly statewide or in 58 of Florida's 67 counties.

c) The time period of the project;

[redacted]

d) The scheduled and actual completion dates;

[redacted]

e) A brief summary of the major contract responsibilities the bidder performed, including how it managed its administrative and capitated budgets;

In 2007, Community-based Care (CBC) of Seminole County and CBC lead provider agencies throughout Florida selected Magellan as the managed care organization of choice to help manage services to 21,000 children each month in the Florida Child Welfare System. Magellan created the CBC Partnership, LLC, a new legal entity, with the child welfare providers. These providers did not provide mental health services, but were responsible for the child's permanency plan. By creating and implementing shared work flows, effective coordination and communication between the child welfare providers and the providers of mental health services, alignment of mental health treatment and resiliency plans with child welfare permanency plans was ensured. The program is serviced through our Care Management Center in the Miami area. Management activities include: claims processing/payment; information technology, care management and utilization management including intensive care management, quality improvement, reporting network development and management, coordination with child welfare providers.

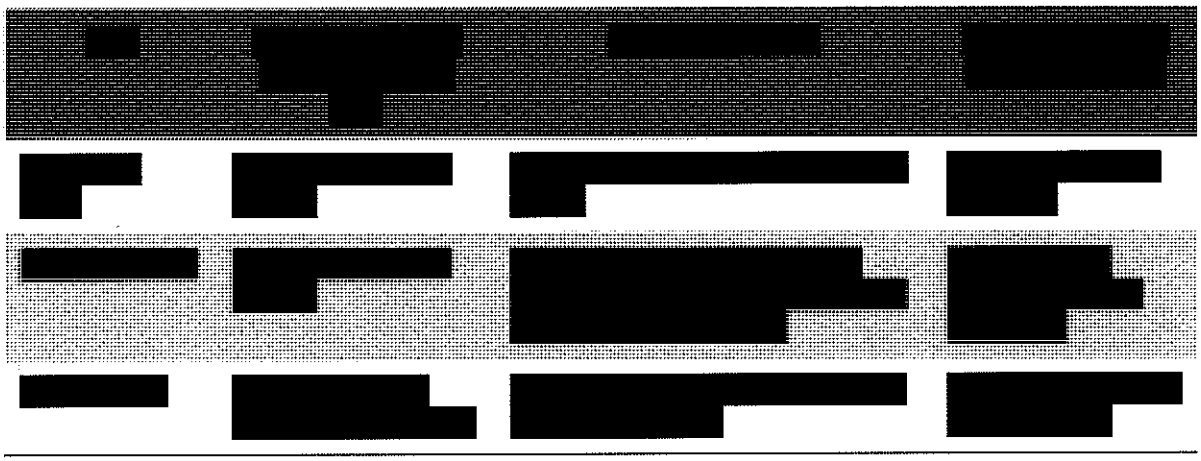
The program is managed on a full risk contract and program has produced improvements in several key areas including:

[redacted]

f) Any corrective action plans required by the project client or an external quality review organization (EQRO) relating to contract non-compliance and/or deficient contract performance;

The table below summarizes the corrective actions plans required for the period of CY2008 – CY2012. It has been our experience that each state has its own unique approach and set of standards in conducting audits, reviews and the subsequent development of penalties and recommendations. Below is the information for our Child Welfare Prepaid Mental Health Plan in Florida.

[redacted]



g) Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Bidder was (or is) involved;

The Florida Prepaid Mental Health Plan for Child Welfare has had no adverse contact actions or project-associated litigation.

h) A customer name, including the name of a contact person responsible for the contract management, a current telephone number, a facsimile number and e-mail address that will represent the bidder's experience;

i) Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor;

Magellan was the prime contractor.

j) If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget;

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l) Contractor and Subcontractor(s) experience must be listed separately. A list identifying each Subcontractor and a narrative description of each Subcontractor's organizational history and mission must be submitted.

Not applicable.

Name of Project: Pennsylvania HealthChoices Behavioral Health Program

b) The population served and location of each project;

The Commonwealth of Pennsylvania offers it's Counties a "right of first opportunity" to manage the behavioral health services and each selects a managed behavioral health organization to take the insurance risk and manage the benefit under the guidance and oversight of the individual county. Through five contracts for HealthChoices in Pennsylvania, Magellan serves more than 260,000 enrollees in Bucks, Delaware, Lehigh, Montgomery, and Northampton counties. Enrollees are largely Medicaid eligible individuals.

c) The time period of the project;

[redacted]

[redacted]

d) The scheduled and actual completion dates;

[redacted]

e) A brief summary of the major contract responsibilities the bidder performed, including how it managed its administrative and capitated budgets;

All of these contracts are managed on a full risk basis and includes a full range of management services including: 24-hour crisis counseling and referral, management information system, network development, claims payment, utilization management, quality improvement, reporting. The contracts are served through two care management centers, one in Newtown and a second in the Lehigh Valley of Pennsylvania.

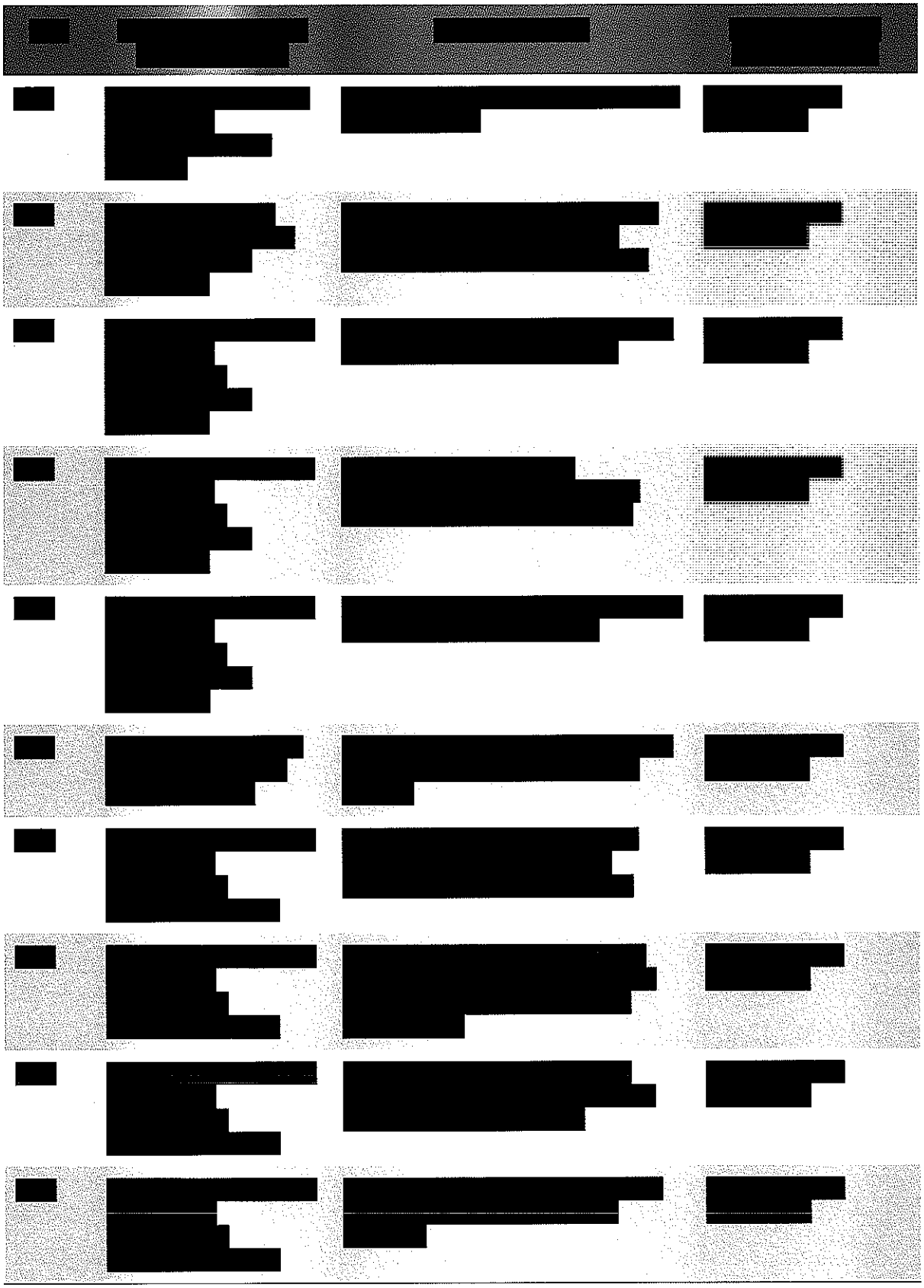
The Pennsylvania HealthChoices program is frequently cited as a leader among states with Medicaid behavioral health "carve outs". The five counties managed by Magellan are frequently at the top of county rankings on quality indicators like hospital ambulatory follow-up rates and hospital 30-day readmission rates. [redacted]

[redacted]

f) Any corrective action plans required by the project client or an external quality review arganization (EQRO) relating to contract non-compliance and/or deficient cantract performance;

The table below summarizes the corrective actions plans required for the period of CY2008 – CY2012. It has been our experience that each state has its own unique approach and set of standards in conducting audits, reviews and the subsequent development of penalties and recommendations. Below is the information for our contracts with five counties in Pennsylvania.

[redacted]



[redacted]

g) Adverse contract actions and/or project-associated litigation (including terminations and/or cancellations) in which the Bidder was (or is) involved;

The Pennsylvania HealthChoices Plans have had no adverse contact actions or project-associated litigation.

h) A customer name, including the name of a contact person responsible for the contract management, a current telephone number, a facsimile number and e-mail address that will represent the bidder's experience;

[redacted]

[redacted]

i) Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor;

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l) Contractor and Subcontractor(s) experience must be listed separately. A list identifying each Subcontractor and a narrative description of each Subcontractor's organizational history and mission must be submitted.

Not applicable.

3.i: Summary of Bidder's Proposed Personnel Management Approach

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

i. The bidder must present a detailed description of its proposed approach to the management of the project.

Magellan Behavioral Health of Nebraska's Management Approach

Magellan has been managing Medicaid services for Nebraska enrollees since July, 2002. We understand the nuances of the provider community and the DHHS organization that will serve this population under a risk contract. We are committed to ensuring that individuals in Medicaid have appropriate access, choice and quality and services shall be designed and delivered in a manner consistent with the Principles of Care for the Nebraska Behavioral Health Managed Care program.

[redacted]

Mission and Operating Tenets

Our management approach is based on a simple Mission - **To be a clinically-driven company.**

To operationalize this Mission, our management approach incorporates the following tenets.

- **Our success as a health plan is ultimately determined by the health outcomes of our members.** Ensuring strong clinical outcomes reduces cost and creates lasting value for our customers.
- **Our provider network is a strategic asset whose performance we understand.** We systemically evaluate the quality of the work our providers perform, and in partnership with them, determine how to improve operations and outcomes, and we reward them differentially on the basis of cost, quality, outcomes and service.
- **Our employed clinicians conducting care and utilization management are a community within the company and a core strategic asset.** We invest in the development of our clinicians and foster and support multi-disciplinary collaboration and continuous learning.
- **Improvements to care management process and provider network composition and performance are interdependent, mutually-reinforcing initiatives.** Success in one area cannot be achieved without success in the others.
- **Quality has an explicit, operational definition that everybody understands and can articulate.** We can measure quality in a valid, reliable, and efficient manner, and we use this information as our primary source of data to guide improvements to the health of our members.
- **Our work must reflect cutting-edge treatments** and we must understand and disseminate these throughout our clinical community. We are tenacious about using evidence in our clinical policies, protocol, criteria, guidelines, and operations.
- **Providers, to remain viable for meeting the members needs nust receive accurate and prompt payment.** We have industry leading claim payment operations and deliver a timely and accurate claim experience for both providers and members.

Magellan of Nebraska Management Team

Magellan is in the unique position of offering a seasoned core group of experienced key management staff around which an expanded management team will be built for the proposed plan. Our team has demonstrated their effectiveness in the current plan and has been successful in acquiring and using local knowledge of the system of services in Nebraska. The team has established key relationships with stakeholders, providers, state department staff, and others that will be a critical factor in moving the new plan forward. Our management approach will be to leverage the talent and experience of our existing team to meet the new challenges inherent in the proposed plan. There is more detail in the next question regarding the key positions that we are proposing for our team. Figure 3.i.1 shows the planned senior management team to be located in our Lincoln, Nebraska Care Management Center.

Magellan's Single Point of Accountability. Our approach to managing communication and maximizing collaboration includes establishing and maintaining a single point of accountability to the MLTC. Magellan of Nebraska's Chief Executive Officer, Sue Mimick, will be the primary

point of contact with MLTC. As such, she will be responsible for the deliverables of the MCO contract and ensuring that DHHS's vision of care for Medicaid recipients is realized and that priorities are communicated to the Care Management Center and achieved. We will develop a structured process for assuring that this interaction takes place on a regular basis in order to maintain clear direction and quick response to any questions and clarifications that may be needed. The figure below presents the organizational structure of our leadership team for the Nebraska Care Management Center under the new contract.

[redacted]

Overall, our management efforts will be focused on maintaining Care Management Center staff that possesses the skills and experience commensurate with the priorities identified by DHHS.

[redacted]

Designated National Operations Support Personnel. Our national public sector senior management teams provide oversight and supervision to ensure that contract deliverables are timely, accurate and meet the needs of DHHS and its Divisions. [redacted]

Additionally, Magellan has a track record for long-term commitments to states that have resulted in positive systems transformation. [redacted]

Structured Data and Process Reviews. We believe "you get what you measure." Performance measures are evaluated at regular intervals. Not only does the Care Management Center report to the State on a quarterly basis on measures and outcomes, the Care Management Center also reports many of the same, and some additional, measures to the Magellan Corporation, which are compared to national standards and goals. The Corporation also routinely reviews the policies and procedures in place for the Care Management Center, and their application. Certain activities, such as provider termination from the network, are required to have national involvement as a matter of policy and procedure. National audits also take place to ensure the appropriate adherence to standards. Lastly, national experts in their respective fields routinely oversee the financial, clinical, quality, provider, compliance and service functions.

The cornerstone to measurement is a solid information system, managed by a competent team of professionals. Magellan has made great strides in improving its management information systems in Nebraska. We have added a highly qualified local Information Systems position dedicated to Nebraska, and will significantly increase the local resources devoted to data management and reporting. With support from the national data management teams, we feel this will markedly improve our analytic capabilities. Further, we will be bringing our nationally successful claims payment system for this contract, and having integrated authorization and claim payments data will also improve our analytic capabilities.

Initial and Ongoing Training. Led by a full-time training staff, and with support from national training resources, Magellan provides initial and annual training for staff that is grounded in evidence-based practices, recovery and resiliency, family-centered care, trauma-

informed care, cultural competency, and other topics identified through the quality improvement process and input from DHHS and other stakeholders. Thus, our training includes, but goes well beyond procedural guidelines.

Providing Back up Though Our Other Care Management Centers. Because Magellan has Medicaid managed behavioral health care experience in a number of states, we have the capacity to utilized trained, experienced personnel from other regions to provide back-up to Nebraska functions utilizing Nebraska policies and procedures should they be needed in the event of a personnel disruption such as a natural disaster. We had occasion to thoroughly test these procedures recently during Hurricane Sandy, for example. After-hours customer service and care management services are provided by the Iowa Care Management Center team, so this is a team already thoroughly trained on Nebraska processes. Additionally, Magellan has a disaster recovery plan that we update on an annual basis, or when a significant change occurs.

On-going Retention of Employees. Our strategies to retain top talent includes open communication, virtual connections, succession planning for promotional opportunities and a rich training program that includes leadership development programs and employee satisfaction surveys. Magellan uses compensation and benefit programs, as well as employee- and family-friendly policies, to retain our employees. Some examples include: competitive benefits, opportunities for promotion, promoting diversity, ongoing training and Service Excellence Reward Program (SERP) to reward non-management employees for excellence in performance.

Understanding that vacancies in staff occur, we engage in developing a succession plan for each key position that includes identifying team members who are potential promotional candidates and working with them on a developmental plan; conducting proactive staff recruitment to create a pool of candidates for consideration in the event of a vacancy; and cross-training staff to prepare them to perform other job functions as necessary.

Magellan's strategies for recruitment, hiring and retention of key staff work. Across our organization, our recruitment efforts result in over 30,000 applications per year, a 90.5 percent offer acceptance rate and a retention rate of 87.5%.

Workforce Satisfaction. [redacted]

All of these practices described above lay the foundation for high customer satisfaction and minimal personnel disruption. In the event that DHHS identifies an MCO employee performance issue, we will welcome DHHS to bring it to our immediate attention so that we can take appropriate steps to resolve the issue.

[redacted]

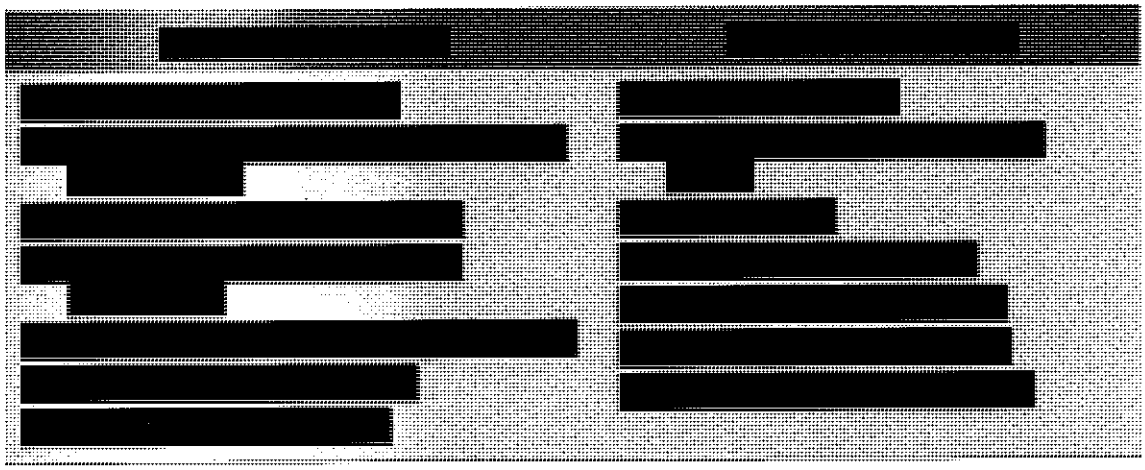
[redacted]

[redacted]

Based upon this positive experience, another Magellan affiliate, Magellan Behavioral Health of Louisiana proposed and implemented a similar model for the Statewide Louisiana Behavioral Health Plan in March of 2012. With the new opportunities available through the new full risk behavioral health program in Nebraska, we propose to bring this demonstrated approach to Nebraska to assure the successful transition to the new model of doing business.

[redacted]

[redacted]



[redacted]

[redacted]

Structure for Collaboration and Communication

[redacted]

[redacted]

Magellan welcomes the opportunity to review and modify this oversight and collaboration structure with the MLTC in a new contract, and a new Magellan of Nebraska organization. We are committed to maintaining a structure that is transparent, keeps the State informed of our operations, and is managed so that there are no surprises to the State about Magellan decisions or operations.

In the spirit of collaboration and partnership, our management approach is to actively engage our external partners in ongoing communication about the operations of our plan. This proactive approach to engaging community partners and stakeholders is described in more detail in a section that follows.

Commitment to Quality, Measurement, Monitoring, Accountability

[redacted]

[redacted]

Customer Dashboard. Our experience, expertise, and relationship with the Department will help to ensure our reporting staff will submit accurate and timely submission of reports required by this new contract. We provide full transparency of data to the Department and have developed innovative technology such as our Dashboard technology which provides real time access to information.

Magellan will make *the Customer Dashboard* available to the Department and at the MagellanofNebraska.com Web site. It provides the security of password protection and is a convenient resource for the MLTC to view reporting information online.

We will summarize and update data for the *Dashboard* on a monthly basis using data gathered from the prior month. Interactive tools allow users to drill down to the current data of interest. Measures on the *Dashboard* reports are table driven and can be customized to suit the future needs of the MLTC.

[redacted]

[redacted]

Active Engagement of and Interaction with Constituents

Our management approach embraces engagement and interaction with stakeholders and constituents because it is an effective way to learn and grow. We partner with external groups by finding common ground and sharing ideas on how best to improve health outcomes for plan members. [redacted]

[redacted]

[redacted]

Trusted Advisor, Thought Leader, Innovator

Our collaboration and partnership with the MLTC has ranged from joint Legislative presentations, to collaborating with individual senators on topics of interest to both the MLTC and Magellan, and working with MLTC on engaging state legislators in discussions on specific draft regulations. Additionally, we have provided clinical and managed care leadership to the State in the revision of regulations describing children's levels of care, as well as regulations governing teleHealth. Furthermore, we have collaborated with the State on many occasions to inform providers of changes to regulation or policies, developing materials for and hosting weekly webinars for children's residential care; developing materials and arranging/hosting webinars to explain transportation changes; and developing materials and hosting webinars to explain CPT code changes to providers. Our management approach for the proposed plan will continue our role as a trusted adviser and collaborator on policy issues and expand this capacity as needed.

In addition to the Nebraska-specific experience highlighted here, Magellan offers Nebraska the benefits of partnering with a national company that has in-depth experience and expertise in the management of publicly funded services for Medicaid and other populations served through public funds throughout the country. [redacted]

[redacted]

Contributor to our Larger Community

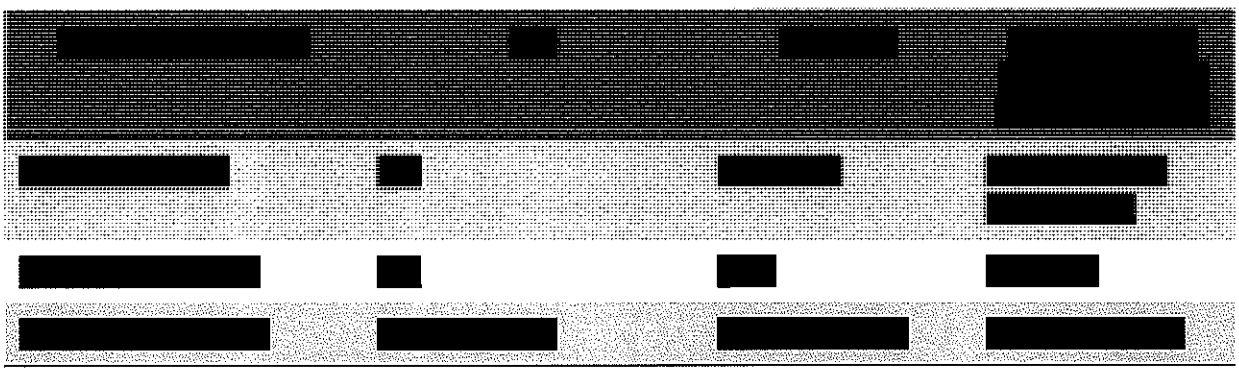
Our management approach encourages and supports active participation in our Nebraska communities. We sponsor local charity events. We raise funds and donate food and clothing to local agencies to support families in our community.

[redacted]

Magellan has been supporting the behavioral health and pharmacy needs of Nebraska citizens since 1995. In 2002, Magellan chose to implement a *Nebraskans Serving Nebraskans* model and opened a full service Magellan Care Management Center in Lincoln that currently employs nearly 50 Nebraskans. The employees of our Nebraska Care Management Center work closely with our provider network and all of our community supports. We are the critical point of connection to match individuals and families with the care and resources they need. At Magellan, we are committed to giving Nebraska our very best. We actively participate in our Nebraska communities. *We live here – and we care.*

ii. The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

Magellan has a strong local commitment to the residents of Nebraska and unparalleled experience serving Nebraska's Medicaid population in partnership with MLTC, local providers and consumer stakeholders. We will adapt our current organizational structure for an administrative service only (ASO) managed care program to be fully responsive to the requirements of the new capitated managed care program. [redacted]



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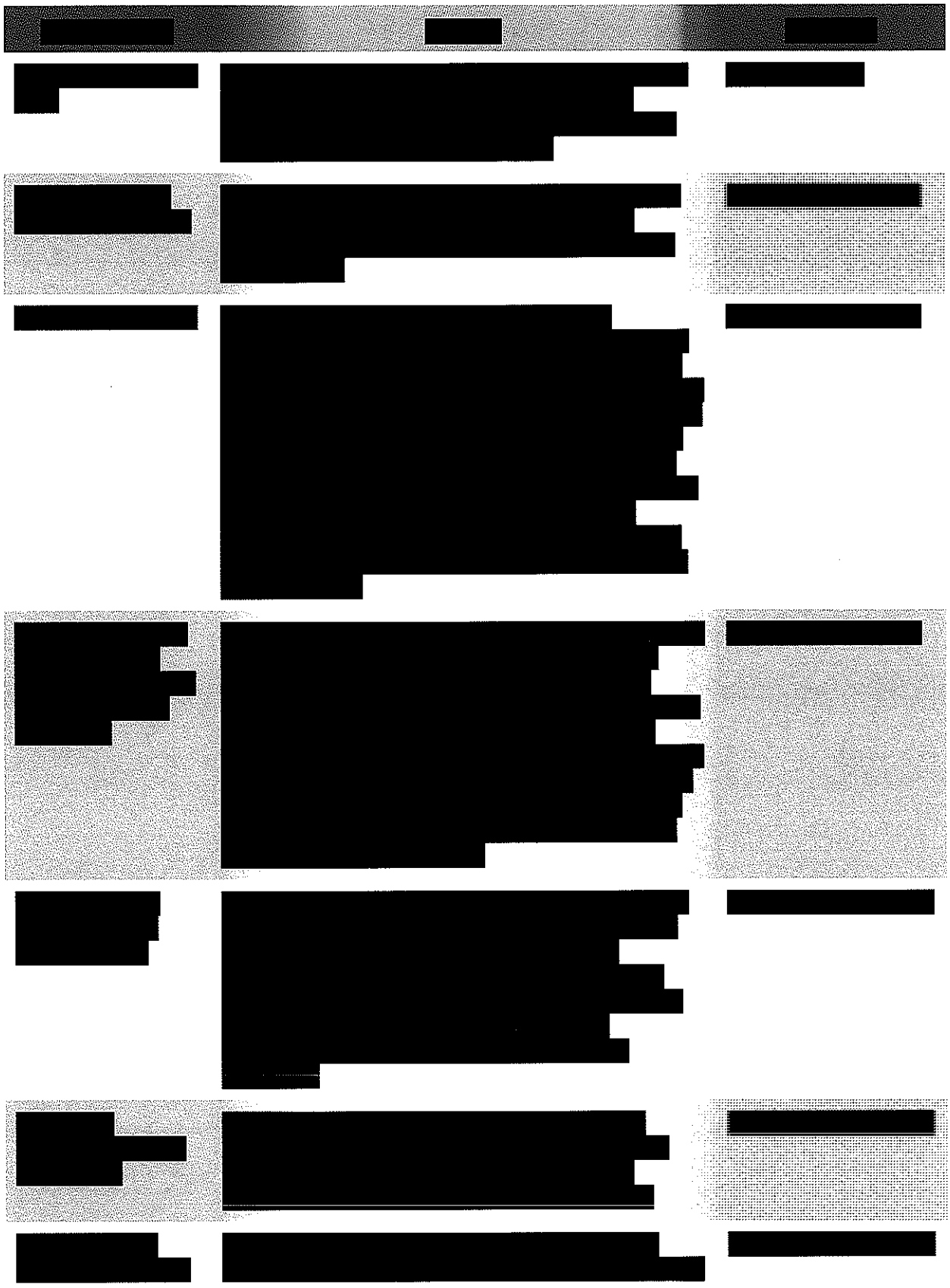


Full Range of Staff Positions and Functions: We have identified the organization and structure to carry Magellan forward with a full range of positions. The organization charts are shown in **Attachment C**, followed by a table containing the roles, functions and reporting relationships of all the staff present in the Nebraska CMC.

iii. The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicatar of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Attachment D includes resumes for the key personnel positions that are currently filled, and as described above, for the professionals responsible for Magellan Behavioral Health of Nebraska. They are seasoned administrators, physicians, clinicians and professionals, with the skills and experience necessary to ensure a successful relationship in meeting or exceeding DHHS expectations, and those of our members. For open positions, we have attached a job description for the position.

iv. Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

Resumes included with this proposal meet the formatting and content requirements of the RFP. We will seek written approval from the State before making personnel changes in any of the key positions currently filled, as outlined above.

3.j. Subcontractors

j. SUBCONTRACTORS

If the bidder intends to subcontract any part of its performance hereunder, the bidder must ensure compliance with the relevant portions of 42 CFR 438. The bidder must provide the same requirements as listed above in 4.h. 1.) i – vii, along with the following:

i. Name, address and telephone number of the Subcontractor(s);

ii. Specific tasks for each Subcontractor(s);

iii. Description of the specific service(s) and/or function(s) to be subcontracted and provide specific references to the corresponding sections, and subsections of the contract;

iv. Evaluation of the prospective Subcontractor's ability to perform the delegated activity;

v. Describe how the subcontract(s) will be managed and monitored within the bidder's organization;

vi. How each Subcontractor's delivery of the service(s) or performance of the function(s) will be coordinated with the bidder's;

vii. Percentage of performance hours intended for each subcontractor;

viii. Total percentage of Subcontractor(s) performance hours; and

ix. A certification statement, signed by both the bidder and the proposed Subcontractor that complies with the requirements of 42 CFR 238.230(b)(2), and states that the proposed Subcontractor is, as of the Service Start Date, ready, willing, and able to perform all such services under the Contract.

Magellan Behavioral Health of Nebraska, Inc. (Magellan) does not intend to subcontract any required element of the program as outlined in this RFP to an outside entity. Magellan does plan to utilize the expertise and resources of related-party contractors as defined in the RFP. As required, those relationships are described below in the Related Party Contractor response.

[redacted]

[redacted]

3.k. Related Party Contractors

k. RELATED PARTY CONTRACTORS

If the bidder is planning to utilize Related Party contracts within the proposed work, the bidder must disclose the following:

i. Name, address and telephone number of the related party;

ii. Specific tasks for each related party;

iii. Percentage of performance hours intended for each related party;

iv. Total percentage of related party performance hours;

v. A written description of the related party agreement; and

vi. The related party income statements.

Per the definitions and requirements of the RFP for Related Party Contractors, Magellan Behavioral Health of Nebraska shall have three related parties as described below:

Related Party – Magellan Health Services, Inc. (MHS - Ultimate Parent)

Name, address and telephone number

Address: 55 Nod Road

Avon CT, 06001

Phone Number: 860-507-1932 [redacted]

Specific tasks for each related party

Per the requirements of the RFP, the Parent is considered a Related Party Contractor. As the ultimate parent, Magellan health Services, Inc. is identified. Tasks included would include legal services, health information system services, human resources support, and communications support.

Percentage of performance hours intended for each related party

[redacted]

Total percentage of related party performance hours

[redacted]

Related party – Magellan Behavioral Health, Inc. (MBH - Immediate Parent)

Name, address and telephone number

Address: 55 Nod Road

Avon CT, 06001

Phone Number: 860-507-1932 [redacted]

Specific tasks for each related party

Per the requirements of the RFP, the Parent is considered a Related Party Contractor. Tasks included would include legal services, corporate finance, compliance, health information services, communications, network, quality and clinical/medical policies and oversight and support.

Percentage of performance hours intended for each related party

[redacted]

Total percentage of related party performance hours;

[redacted]

Related party – Magellan Medicaid Administration (MMA - Affiliate)

Name, address and telephone number

Address: 11013 W. Broad Street, Suite 500

Glen Allen, Virginia 23060-5937

Phone Number: 800-884-2822 [redacted]

Specific tasks for each related party

[redacted]

Percentage of performance hours intended for each related party

[redacted]

Total percentage of related party performance hours

[redacted]

A written description of the related party agreements

[redacted]

The related party income statements

Magellan Health Services, Inc. is a publicly traded company governed by the federal Security Exchange Commission and our financial stability and information is a matter of public record. We have submitted the audited financial statements in **Attachment B**.

Magellan Behavioral Health of Nebraska, Inc. is a wholly owned subsidiary of Magellan Behavioral Health, Inc. which is a wholly owned subsidiary of Magellan Health Services, Inc. As Magellan Behavioral Health of Nebraska, Inc. has been created specifically to meet the requirements of the RFP; we have submitted the audited financial statements for the ultimate parent – Magellan Health Services, Inc. in **Attachment B**.

MMA is a wholly owned subsidiary of Magellan Behavioral Health, Inc. Magellan Behavioral Health Inc. is a wholly owned subsidiary of Magellan Health Services which is a publicly traded company governed by the federal Security Exchange Commission and our financial stability and information is a matter of public record. As part of our required and publicly disclosed financial reporting, our SEC financial filings report displays cost of care and profit by segment, not individual contract. Each individual contract addresses the cost of care and administrative and profit/fund balance requirements uniquely. For example some contracts require a minimum medical loss ratio and others place a cap on admin and profit combined or a cap on profit alone. For the nine months ending September 30, 2012, as reported on SEC Form 10-Q, our Public Sector segment had net revenues of $1,206,289,000 of which $1,058,384,000 was utilized for cost of care. For the Public Sector, net revenues less cost of care and direct expenses, before corporate costs and other operating expenses was $81,890,000. We have submitted the audited financial statements for the ultimate parent – Magellan Health Services, Inc. in **Attachment B**.

Please see responses in 4. Technical Approach.

m. PAYMENT SCHEDULE

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (see Neb. Rev. Stat. 81-2401 through 81-2408). Payment to the Contractor will be monthly according to the rates offered in Attachment B.

Magellan Behavioral Health of Nebraska, Inc. acknowledges that payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act and will be made monthly according to the rates offered in Attachment B.

n. ENROLLMENT REPORT

The State will provide the Contractor a monthly enrollment report that will list all enrolled and disenrolled enrollees for the enrollment month. This report will be used as the basis for payment to the Contractor.

Magellan Behavioral Health of Nebraska, Inc. acknowledges that the State will provide and it will receive a monthly enrollment report that will list all enrolled and disenrolled enrollees for the enrollment month. Further we acknowledge that this report will be used as the basis for payment to the Contractor.

3.o. Capitation Payments

o. CAPITATION PAYMENTS

Capitation payments will be calculated as per 42 CFR 438.6(c).

Magellan Behavioral Health of Nebraska, Inc. acknowledges that capitation payments will be calculated as per 42 CFR 438.6(c).

p. PAYMENT RECOVERIES

The State will occasionally request recovery of payments for certain specific situations including, but not limited to: a payment was made on behalf of a deceased enrollee. When payments are made incorrectly, the State and the Contractor will work cooperatively to identify the discrepancy ond reconcile payments.

Magellan Behavioral Health of Nebraska, Inc. acknowledges that the State will occasionally request recovery of payments for certain specific situations and agrees to cooperatively work with the State to identify the discrepancy and reconcile payments.

i. Understanding of the Scope of Work: This section of the proposal should provide a summary of the overall understanding of the Contractor's responsibility to provide the services described and comply with the regulations referenced.

A. Project Overview

Magellan Experience

For more than a decade, **Magellan Behavioral Health of Nebraska** (Magellan) has partnered with the **Nebraska Division of Behavioral Health Services** and **Division of Medicaid and Long-Term Care** to ensure access to quality, appropriate, necessary behavioral health treatment eligible children and adults across the state. We have worked in partnership with the State to ensure the delivery of behavioral health care to assist individuals and families in achieving their goals. We have worked closely with the Division of Behavioral Health Services and Division of Medicaid and Long-Term Care—as well as with members, providers, families and other stakeholders—to ensure a system of care based on innovation, clinical excellence and a philosophy of wellness that focuses on discovering personal strengths, building hope, and offering choices. Together, we support individuals and families on their journey toward recovery, building resilience in their lives and securing a healthier future.

Magellan has a strong local commitment to the residents of Nebraska, and as the nation's leading manager of behavioral health services, brings significant expertise and innovations adapted to meet the needs of the Nebraska Behavioral Health (BH) Managed Care Program. We will build on our local experience in the State of Nebraska and our national experience serving more than 4 million Medicaid members as the State seeks to transition from an administrative services only (ASO) managed care program to a full-risk program.

Unmatched Nebraska Commitment and Experience

[redacted]

From the very beginning of our relationship with the Nebraska Division of Behavioral Health Services and Division of Medicaid and Long-Term Care, Magellan has demonstrated our belief that for a behavioral health system to be effective, it must be community-driven. From the inception of the program, we have worked to not only support the improvement of behavioral health for Nebraska Medicaid members and residents, but also to encourage the active involvement of Nebraska stakeholders to help design and deliver quality services to members, and their families and to establish Magellan as a respected and contributing member of the overall Nebraska community. As a result, no other managed care organization has the relationships, behavioral health experience, and presence necessary to move to a new full risk model.

Making a Difference in Nebraska

Magellan measures our success by the positive health outcomes of the individuals and families we serve, which creates lasting value for our communities. [redacted]

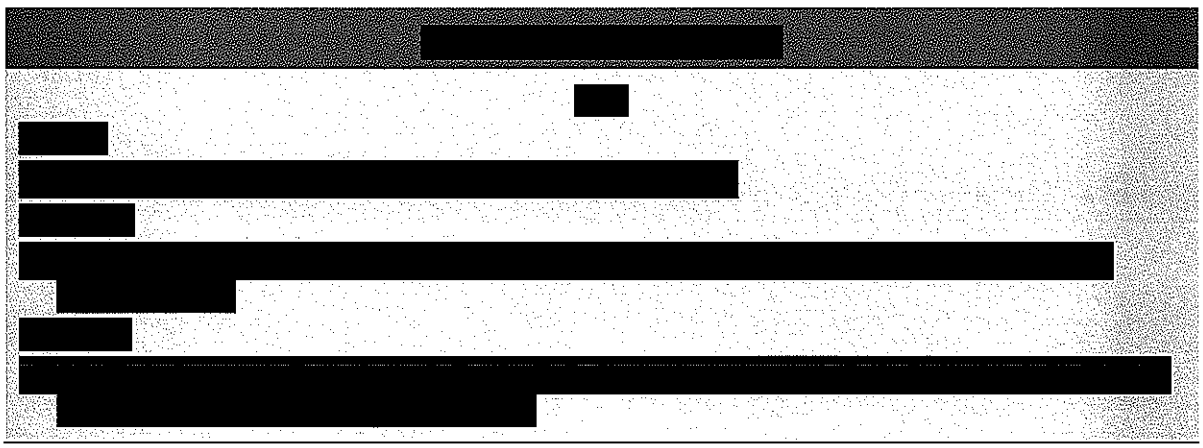
Community Involvement

At Magellan, we are committed to giving Nebraska our very best. We actively participate in our Nebraska communities. We sponsor local charity events. We raise funds and donate food and clothing to local agencies to support families in our community. *We live here—and we care.*

For more than 10 years Magellan has been a sponsor of the **Community Alliance's "Breaking the Silence" event** and began an annual bronze sponsorship of this event in 2010. Magellan staff

members have participated in **Nebraska NAMI Walks** since 2008. Magellan became an official sponsor of Nebraska NAMI Walks in 2010 and has served as a sponsor in subsequent years. Since 2010, we have decorated a Christmas tree with hats and mittens and then donated them to the **People's City Mission.** Since 2010, we have been a regular sponsor of the **Nebraska Juvenile Justice Association Conference**.

[redacted]



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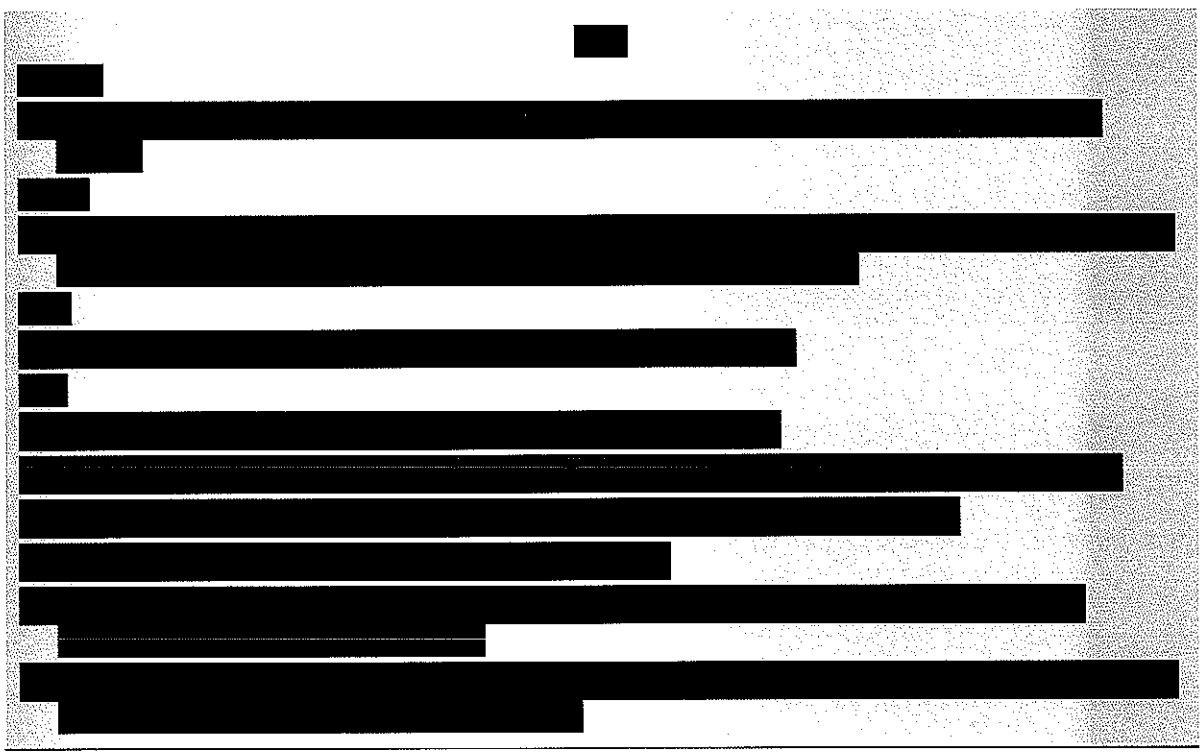
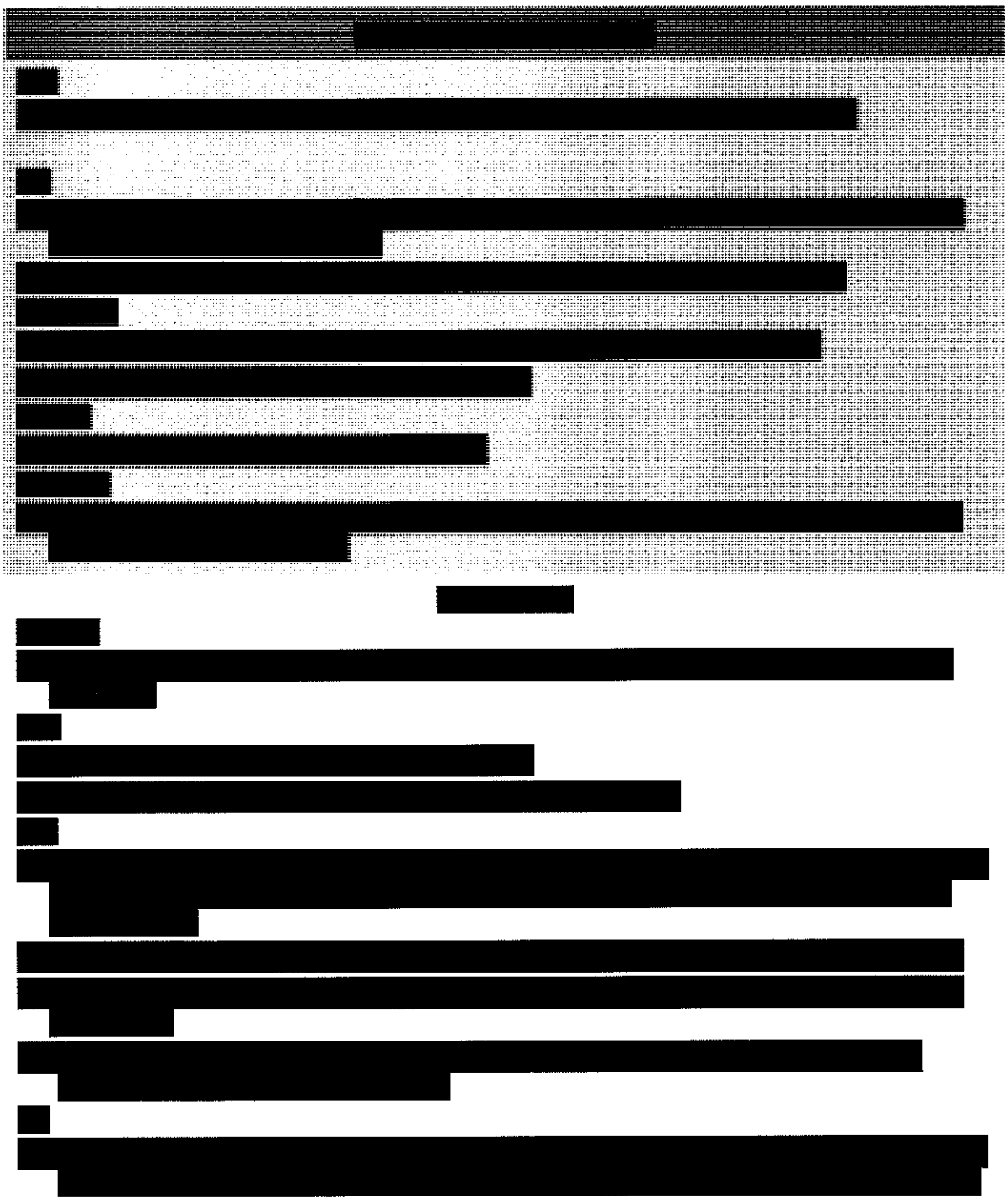




Partnership with Nebraska Providers

Magellan recognizes that its success and the success of the provider community are interdependent. We view our relationship with network providers as a true partnership. As the entity charged with efficient management of available funding, we are able to direct local resources to high quality providers who offer evidence-based treatment options for members

while also offering quality management, training, and network management resources on a national scale. In order to fulfill our role, it is critical that providers have a voice in planning, implementation, and on-going management of the program. In our current ASO contract we involve providers through a Provider Advisory Group that has dedicated membership from ten key Nebraska providers. We communicate with providers regularly via provider Town Halls, monthly newsletters and frequent email messages. Providers have access to a wide range of electronic resources on our MagellanofNebraska.com Web site.

[redacted]

Additional Nebraska Experience

In addition to our experience unique to Nebraska Medicaid recipients, Magellan has an active presence in the State through our commercial division. We have ten employer clients with a significant membership in the State, representing approximately 55,000 commercial members in Nebraska. Additionally, since 2008, through our sister company, Magellan Medicaid Administration (MMA), Magellan has performed the following services for the Nebraska Medicaid program administered by the Division of Medicaid and Long-Term Care:

- Point-of-service pharmacy claim adjudication
- Prospective Drug Utilization Review
- Retroactive Drug Utilization Review (through support from the Nebraska Pharmacy Association)
- Clinical call center/clinical prior authorizations for specifically identified medications

- Technical call center
- Preferred drug list and supplemental rebates recommendations and administration (implemented in early 2009).

In 2011, the State saved $6.6 million through use of a Preferred Drug List ($3.3 million in supplemental rebate savings; $3.3 million in savings due to market shift, price changes, and CMS rebate changes) as a result of Magellan's negotiations of supplemental rebate agreements with drug manufacturers, coding products as "preferred" or "non-preferred" in the system, performing authorizations on claims, and invoicing drug manufacturers for rebate dollars for the state.

National Experience

In addition to the Nebraska-specific experience highlighted above, Magellan offers the State the benefits of partnering with a national company that has in-depth experience and expertise in the management of services for Medicaid and other populations served through public funds throughout the country. Approximately 60 percent of our revenue is derived from public sources of funding. Nationally, Magellan contracts with 28 health plans, and 15 Medicaid and other public sector programs. We began provision of services to Medicaid members in 1995 and currently provide behavioral health care services to about 4.2 million members in Medicaid and other publicly funded programs—1.2 million through health plan contracts and 3.0 million through contracts with states and other government entities in Arizona, Florida, Iowa, Pennsylvania, Louisiana, New York and, of course, Nebraska.

Across our public sector contracts, we offer a core set of services including, but not limited to, administrative services, information technology, utilization management, intensive care management, network development and management, network relations and training, quality improvement, and round-the-clock call center capability. All of these are essential elements of the current procurement.

[redacted]

Awards and Recognition

Magellan measures success through member outcomes and the reports from our members about their life-changing recovery. We are grateful to be recognized by the communities we serve. Over the past decade, Magellan has been the recipient of both local and national awards, a few of which are highlighted below:

[redacted]

Summary

Throughout our relationship with the State, Magellan has demonstrated our commitment to ensuring high-quality care to support individuals and their families on the journey toward resiliency and recovery. We have shared responsibility for the Nebraska system of care as we

built strong relationships with Nebraska's members, families, providers and community stakeholders. Magellan has engaged these stakeholders as partners in the decisions that affect them—and, as a result, empowered more individuals to live healthier, fulfilling lives.

B. Principles of Care

We have read, understand, and will fully comply with the Nebraska Principles of Care that will guide the service delivery system to be developed for the Nebraska Behavioral Health Managed Care program as presented in the RFP.

The Principles of Care provide *the foundation* on which all systems of care must be built. Together with SAMHSA's Guiding Principles of Recovery, the National Wraparound Initiative's 10 Principles of Wraparound, and Magellan core principles of recovery and resiliency, they provide the framework to support improvements along the many dimensions of recovery, resiliency, wellness, and community participation. These principles are critical to individuals and families successfully achieving their goals for health, home, purpose, and community.

Magellan has proven approaches for promoting, integrating and operationalizing these principles in Nebraska and across our other publicly funded behavioral health contracts.

Going forward, we will continue to commit ourselves to putting the Principles of Care into practice through Magellan's culture of caring, knowing our principles of recovery and resilience are not just a poster on the wall, but rather are embedded in all that we do, across all areas of our operations. It is through our experience in developing opportunities for consumer and family inclusion and participation, creating organizational structures, developing tools, resources, trainings, and measuring our own operationalization of Magellan's core principles of recovery and resiliency that we have learned what it takes promote such values. Our commitment to promoting Nebraska's Principles of Care is grounded in this experience. We believe that Magellan, working together with MLTC and the many other systems of care stakeholders, from Members and their families, consumer and family support/advocacy organizations to providers, provider organizations, other health care professionals and a range of State agencies and programs, the Principles of Care can not only be promoted, but become part of the culture of Nebraska's Behavioral Health Managed Care program.

More detailed information on Magellan's Principles of Care is available in *Sub-section IV.B. Principles of Care of the Proposed Implementation Approach.*

IV.C. Contractor Primary Responsibilities

C. Contractor Primary Responsibilities

Magellan is fully prepared to meet the state's requirements for providing Medicaid and CHIP members with access to mental health and substance use disorder services in a managed care practice. As described in the RFP these services:

a. are recovery oriented and are part of an overall coordinated system of care

b. ensure provision of services that are person and family-centered, timely, developmentally appropriate, culturally relevant and evidence-based

c. establish an extensive, accessible provider network that offers a choice of providers and a comprehensive array of services

d. are proactive in organizing and administering a delivery system that meets the behavioral health needs of Medicaid/CHIP members, adjusting operations as needed.

D. Included Populations

Magellan has reviewed the population categories eligible for this program as described in the RFP, and we are fully prepared to provide services to all included populations.

E. Excluded Populations

Magellan has reviewed the population categories that are excluded from this program as described in the RFP, and we understand the categories that will not be served.

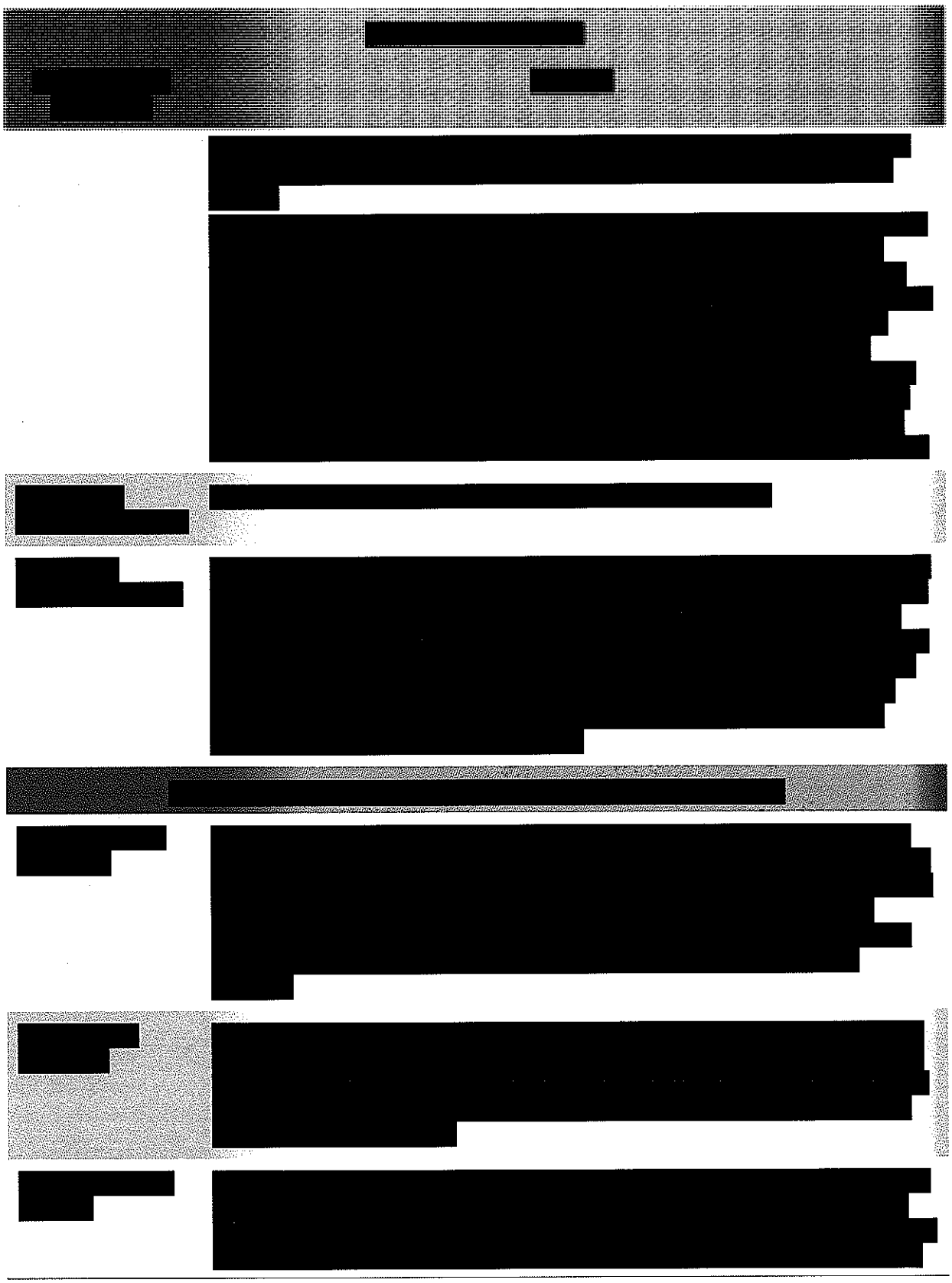
F. Covered Services

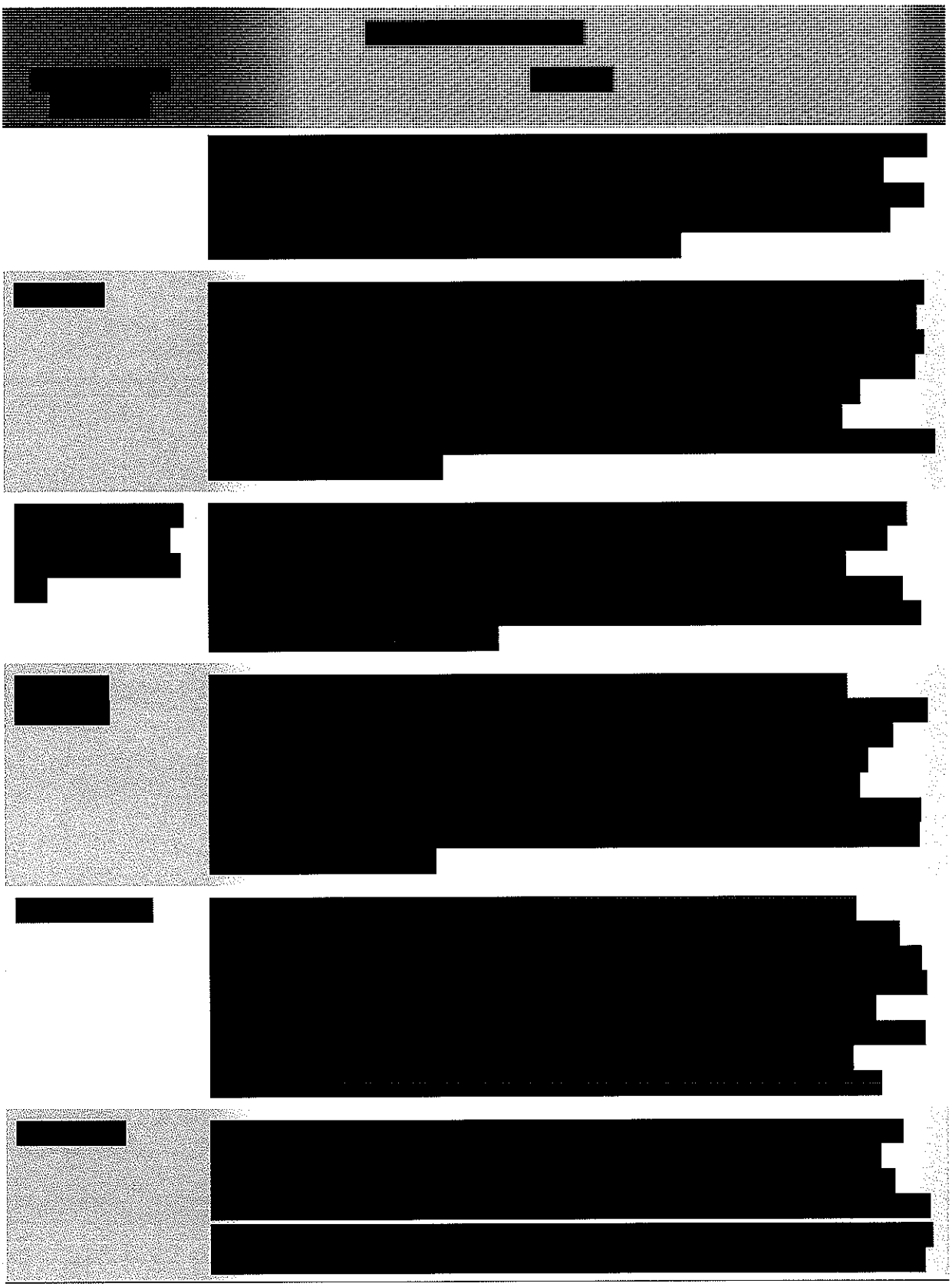
Magellan has reviewed the list of all covered services as enumerated in Attachment A of the RFP, "Medicaid Covered Services," and clarified in Addendum 2, "Questions and Answers for RFP Number 4166Z1," November 20, 2012. Through our network of qualified service providers we are fully prepared to deliver all covered mental health and substance use disorder services to Medicaid and CHIP members.

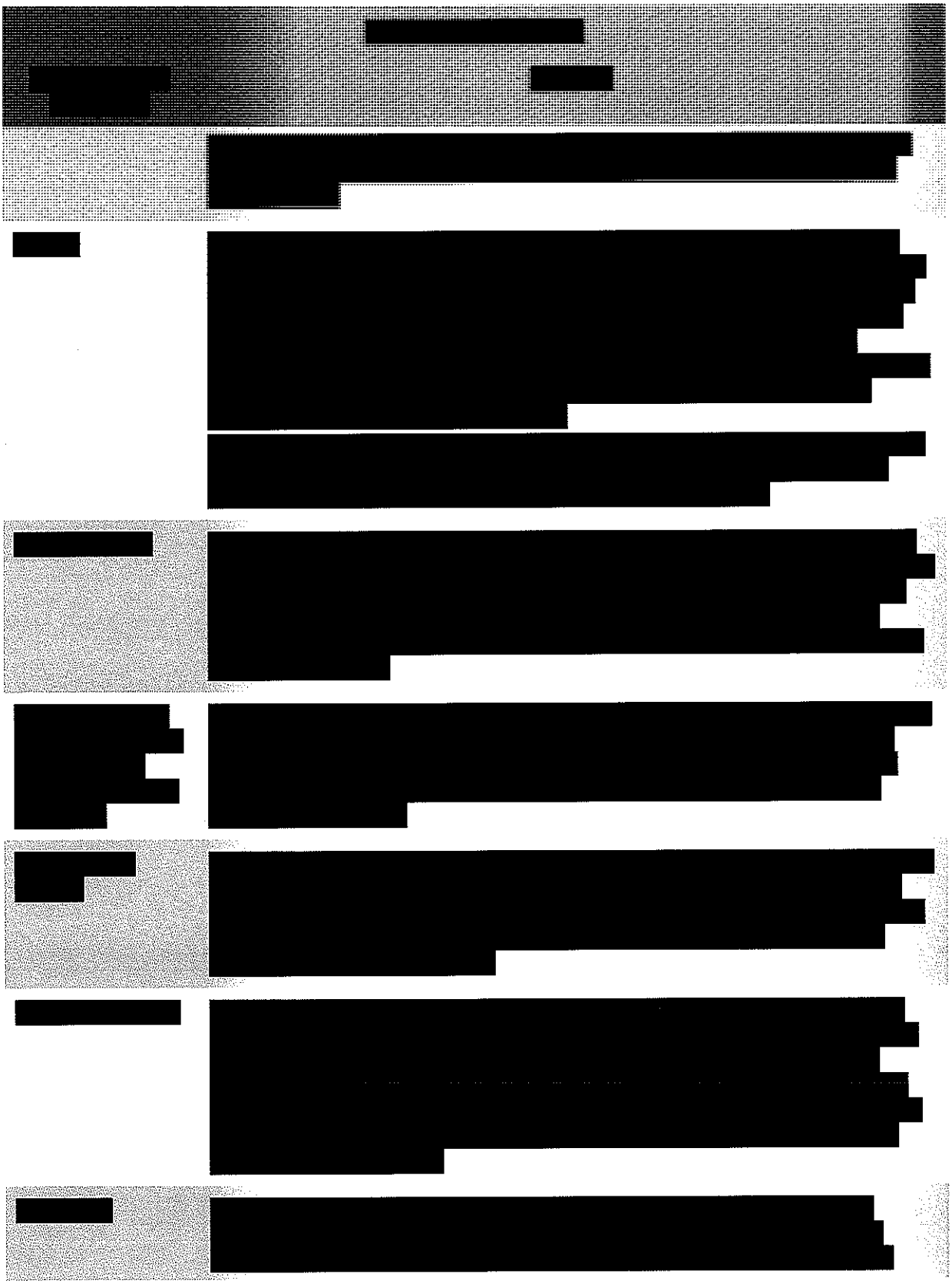
IV.G. Substitute or Value-Added Behavioral Health Services

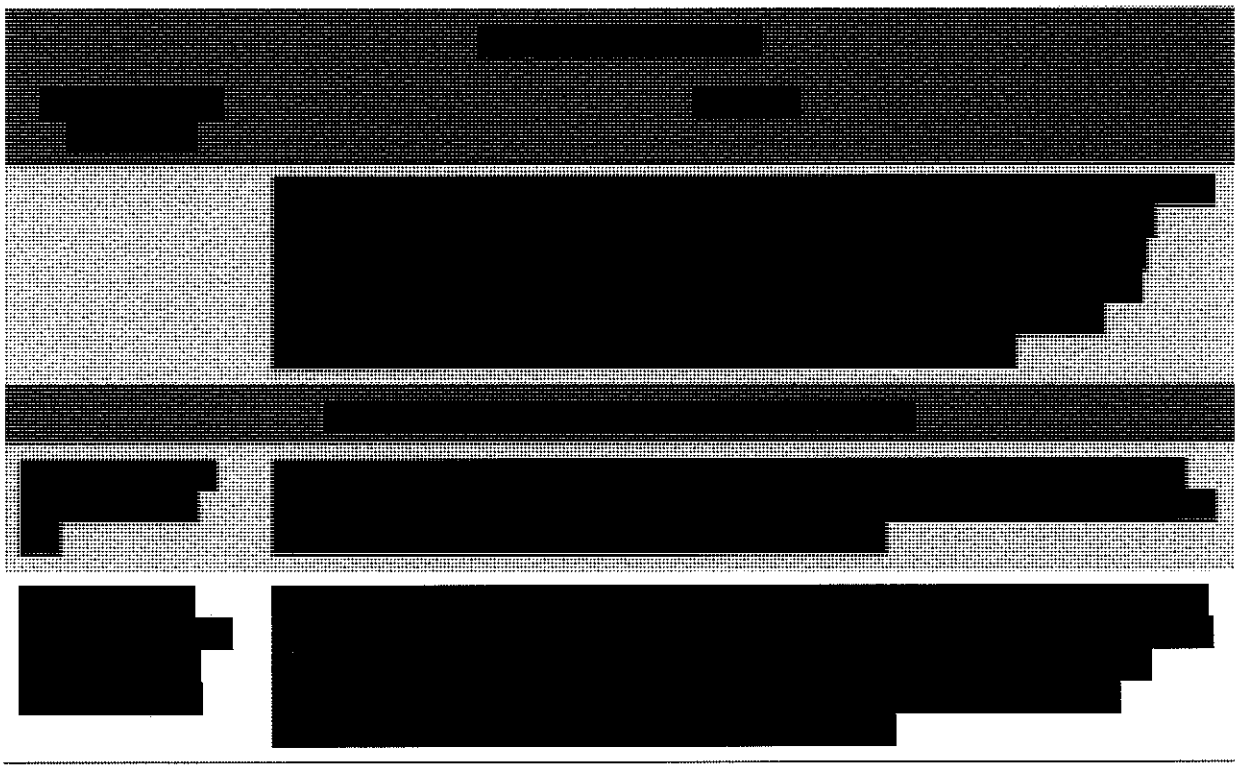
G. Substitute or Value-Added Behavioral Health Services

Our proposed substitute and value-added services reflect continuity with our accomplishments to date in Nebraska. However, they also reflect our knowledge of gaps in the current behavioral health delivery system in the state as well as our parent company's experience nationaly under fully insured contracts. Nebraska's shift to a fully insured model will give Magellan the flexibility, on day one, to leverage our knowledge of the state's delivery system to address these gaps with new services and new approaches to care delivery.









H. Contractor Requirements

Magellan has reviewed the Contractor Requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections.

Magellan has a minimum of five years' experience and demonstrated success in the provision of BH-MCO services with complex, publicly-funded Behavioral Health programs. Magellan's history with the State of Nebraska began in 1994 when one of Magellan's legacy companies CMG Health, held a contract with the Department of Public Institutions. Magellan Behavioral Health of Nebraska, LLC was originally formed in 1998 to serve as the Administrative service organization for behavioral health services. Magellan Health QIO, LLC (dba Magellan Behavioral Health) was formed on March 12, 2008, to address revised requirements of the Nebraska program and its associated RFP.

Magellan Behavioral Health of Nebraska, Inc. is licensed by the State of Nebraska as a Prepaid Limited Health Service Organization, which provides authority to operate as a risk-bearing insurer for Mental Health and Substance Use Disorder services provided to children, youth, and adults. Through this license, we understand our obligation to and agree to abide by all requirements of a managed care entity in Nebraska.

For more information on contractor requirements please refer to *Section 3, Corporate Overview.*

I. The Contractor Shall Demonstrate

1. Substantial managed care experience and demonstrated success in operating or contracting with complex, publicly-funded behavioral health programs;

For more than a decade, **Magellan Behavioral Health of Nebraska** (Magellan) has partnered with the **Nebraska Division of Behavioral Health Services,** and **Division of Medicaid and Long-Term Care** to ensure access to quality, appropriate, necessary behavioral health treatment eligible children and adults across the state. Although supported by a contract for only a brief period, Magellan also has a successful track record of working with the Department of Children and Family Services (CFS) for individuals qualifying for services funded by the Nebraska Division of Behavioral Health Services and the Division of Medicaid and Long-Term Care. We have worked in partnership with the State to ensure the delivery of behavioral health care to assist individuals and families in achieving their goals. We have worked closely with the Division of Behavioral Health Services and Division of Medicaid and Long-Term Care—as well as with members, providers, families and other stakeholders—to ensure a system of care based on innovation, clinical excellence and a philosophy of recovery, resiliency and wellness that focuses on discovering personal strengths, building hope, and offering choices.

In addition to the Nebraska-specific experience highlighted above, Magellan offers the State the benefits of partnering with a national company that has in-depth experience and expertise in the management of services for Medicaid and other populations served through public funds throughout the country. Nationally, Magellan contracts with 28 health plans, and 15 Medicaid and other public sector programs. We currently provide behavioral health care services to 4.2 million members in Medicaid and other publicly funded programs—1.2 million through health plan contracts and 3.0 million through direct contracts with states and other government entities in Arizona, Florida, Iowa, Pennsylvania, Louisiana, New York and, of course, Nebraska. We bring that national expertise to Nebraska.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

a. Flexible, responsive customer service approach that is highly ingrained in the organization

Over the last three years, with new leadership for the Care Management Center, Magellan has demonstrated an improved customer service approach. [redacted]

[redacted]

[redacted]

[redacted]

2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

b. Cohesive, integrated management structure that allows for timely decisions, within a corporate framework that provides access to industry-leading tools, technology, expertise and oversight

Magellan is a national behavioral health company that brings the optimal blend of national and local activities to all public sector programs. Magellan's considerable clinical, technological, and administrative resources support each local office or Care Management Center (CMC). These resources are critical to successful implementation, ongoing program operations, and continual program improvement. National functions that support the CMC include legal, finance, information technology, clinical/medical, network development and management, network relations and training, quality improvement, round-the-clock-call center capability, and recovery and resiliency expertise focused on wellness and members' participation in the community. National Magellan staff provides an oversight function to the CMC to ensure quality of care and contract compliance. Magellan's public sector division clinical, medical, quality, recovery and resiliency, and cultural competency staff participate in a variety of national organizations and share knowledge and experience gained from these forums with local public sector staff. They also share best practices across Magellan public sector programs and CMC's. The centralized Claims Department brings industry best practices to produce superior member and provider satisfaction and the IT Department provides cutting edge member and provider solutions to coordinate care and reduce provider administrative burdens.

As in Nebraska, each CMC is staffed with a dedicated CEO who serves as the single point of contact to the customer and has full accountability and oversight of the local operations. The customer always has immediate access to the CEO whenever there is a need to discuss program operations, or even individual cases. The CEO, on-site in our local CMC, facilitates a rapid response to customer needs and collaborative customer relationships. The leader of each functional area shown on the organizational chart essentially has a dual, or matrixed, reporting relationship – one to the Nebraska CEO, and the second to the national leader for that particular function. It is through this reporting structure that optimal results are achieved—the best practices are implemented geographically where they make sense and serve a need, but only when tailored specifically to the geographic areas needs.

The Magellan model of a local CMC, providing services to the Nebraska Behavioral Health Managed Care Program (NBHMCP), and supported by extensive national resources, creates an effective organization that offers a profound depth of knowledge, experience, administrative efficiencies, and economies of scale, while assuring that the Division of MLTC, members, providers and stakeholders have access to staff to address the local needs.

2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/on:

c. Responsive and reliable decision-making based on values consistent with the system delivery principles defined in this RFP

Magellan as a national company has been a leader in advancing the principles of recovery and resiliency in every program we manage. All of our initiatives and actions in Nebraska will align with and promote the nine principles of care as outlined in the RFP.

While all managed behavioral health companies pledge their commitment to recovery, resiliency and trauma informed care, Magellan has demonstrated its ability to design our programs and operations to truly deliver on these principles. [redacted]

As a company, Magellan holds itself to the highest standards of care for our members nationwide. In 2007, Magellan formalized our values and philosophy around principles of recovery and resiliency as presented below. These align closely with the Nebraska Principles of Care; both emphasize respect and responsiveness to culture and language, and both are consistent with the SAMHSA "Guiding Principles or Recovery" and the National Wraparound Initiative's "10 Principles of Wraparound." For example, Magellan's and SAMHSA's principles support a holistic approach; self-direction and self-determination; valuing peer and allies' supports (e.g., family and natural support), integration and coordination of services; and trauma- informed supports that foster physical and emotional trust. Common tenets of Magellan's core principles and the 10 Principles of Wraparound include family voice and choice, natural supports, collaboration, cultural competence, individualized and strength-based care.

Magellan will further promote and assure adherence, be responsive, and provide reliable decision making consistent with the Principles of Care through Magellan's governance and organizational structures, training, resources, tools, and measurements. Described fully in *Section IV.B Principles of Care* and also in the *Corporate Overview* response we will guide our decision making through the active engagements and shared governance with Nebraska stakeholders through our Governance Board, Quality Assurance and Improvement Program, the Provider Advisory Committee, and the Clinical Advisory Committee. By this involvement of the

MAGELLAN BEHAVIORAL HEALTH

voice and participation of community stakeholders, we can assure responsive and reliable decision making.

2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

d. Experience in establishing successful collaborative relationships with governmental customers in the delivery of an integrated system of care

[redacted]

[redacted]

With our commitment to putting the Principles of Care into practice, and with respect, and appreciation for the power of consumer and recovery/resilience initiatives, rehabilitative services available through provider organizations, unique approach to vocational, supported, and competitive employment (with parallel supported education programs), 12-step programs, and other informal and formal supports to change people's lives, we will pay special attention to continue our success in providing linkages between members and their families, providers, peer and family-run organizations, support groups, and other stakeholders listed, including our State partners.

Lastly, as the Division of MLTC checks references for this response to the RFP, they will discover that strong and customer focused relationships with customers in other states that are collaborative in nature and oriented towards always improving the system of care for the members we serve.

2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

e. Resource management support necessary to recruit and retain highly-qualified staff

[redacted]

Our strategies to retain top talent includes open communication, virtual connections, succession planning for promotional opportunities, and a rich training program that includes leadership development programs and employee satisfaction surveys. Magellan uses compensation and benefit programs, as well as employee- and family-friendly policies, to retain our employees. Some examples include: competitive benefits, opportunities for promotion, promoting diversity, ongoing training and Service Excellence Reward Program (SERP) to reward non-management employees for excellence in performance.

Understanding that vacancies in staff occur, we engage in developing a succession plan for each key position that includes identifying team members who are potential promotional candidates and working with them on a developmental plan; conducting proactive staff recruitment to create a pool of candidates for consideration in the event of a vacancy; and cross-training staff to prepare them to perform other job functions as necessary.

Our Nebraska CMC includes staff dedicated to working directly with providers, members, and other community stakeholders to ensure Magellan is a part of the community and the community is a part of Magellan. Our local staff is also supported by Magellan staff at the regional and national level that brings years of managed care experience to the transition of Nebraska's system to an at-risk, capitated program. [redacted]

Magellan's strategies for recruitment, hiring and retention of key staff work. Across our organization, our recruitment efforts result in year 20,000 applications per year, a 93.5 percent offer acceptance rate and a retention rate of 91.5 percent.

Maintaining a stable workforce within our Care Management Center is important to workforce satisfaction. We routinely survey our workforce to determine their satisfaction with their environment and working conditions. Employee satisfaction with Magellan in Nebraska increased overall from 67 percent in 2009 to 79 percent in 2012.

All of these practices described above lay the foundation for high customer satisfaction and minimal personnel disruption. In the event that DHHS identifies an MCO employee performance issue, we will welcome DHHS to bring it to our immediate attention so that we can take appropriate steps to resolve the issue.

2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

f. Commitment to provide reinvestment and value added services to enhance behavioral health services

[redacted]

[redacted]

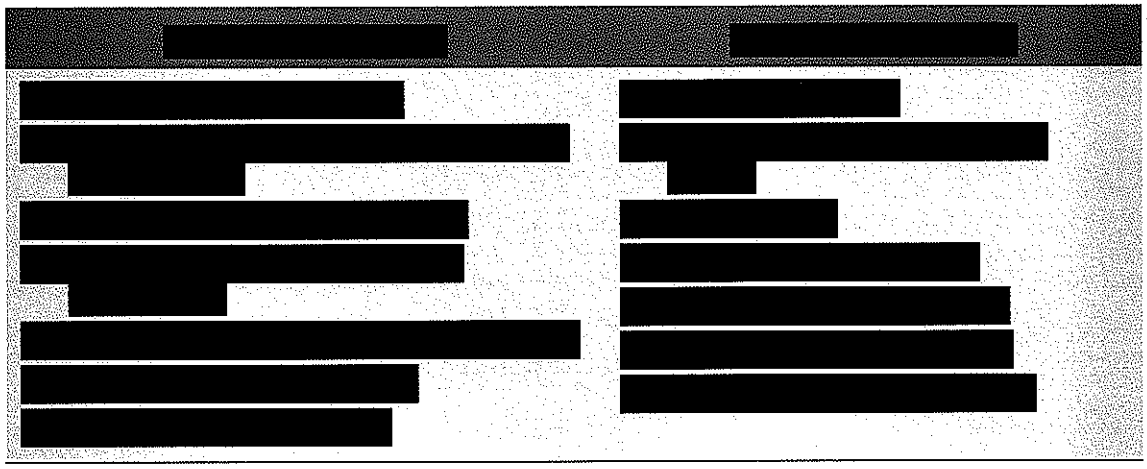
[redacted]

[redacted]

2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

g. Responsiveness to community needs and soliciting input from stakeholders

As discussed in response to the first question in this section, empowering consumers, families, providers, community partners, and local stakeholders was identified early on by Magellan as an essential element in assuring the behavioral health service system was effective. Magellan's affiliate, Magellan Health Services of Arizona (MHSA) **understood** that true empowerment not only meant a focus on the front lines of service delivery, through such practices as active consumer involvement in individual treatment planning, but also needed to be present and real at the governance and policy making level. [redacted]



[redacted]

Consumer-Family Evaluation Teams

The Nebraska Care Management Center recognizes the need to respect and incorporate the preferences of consumers and families as a core strategy for improving the quality and effectiveness of care. Magellan will collaborate with MLTC to develop an approved consumer-family evaluation component prior to implementation. We will establish a contractual

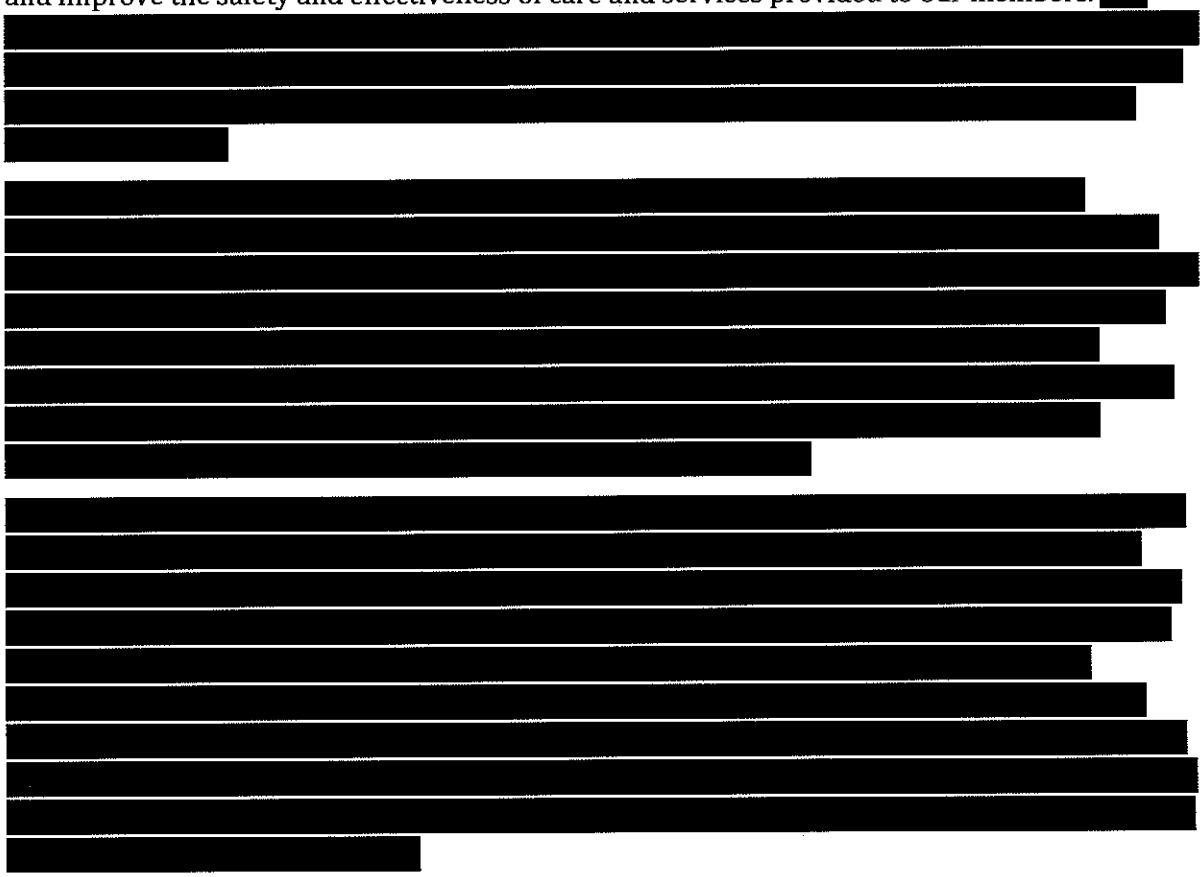
relationship to support independent consumer- family evaluation teams (CFETs) that will focus on a consumer-driven evaluation of adult service issues, and a family and youth-driven evaluation of child and young adult service issues. Magellan has recent experiences with consumer-based teams similar to Consumer and Family Evaluation Teams in other states; we will welcome this new engagement with CFETs. [redacted]

Every stakeholder with an opinion cannot be represented in our committees. An example of how Magellan has developed our partnerships with stakeholders in Nebraska outside of our formal committee structure is our Town Hall meetings. Statewide town hall meetings were initially established as avenues for providers to have open dialogue and face-to-face discussions with Magellan representatives. Initially this included the Network and Clinical Directors. Over the course of time, other Magellan staff such as the Operations Manager, General Manager, Clinical Supervisor and Consumer Manager also participated. Providers have been very receptive to these meetings and appreciate the opportunity to discuss concerns and propose changes to processes. Feedback from these meetings has been used to make changes to current processes, which in turn has resulted in improved provider satisfaction. As time has progressed, Magellan began to include other stakeholders in these meetings. More recent town halls have included CFS personnel and advocacy groups. It is our intent to broaden this participation even further as we move forward with this contract. These meetings have improved collaboration throughout the regions and all stakeholders receive the message: we listen and we care. Further, Magellan has taken significant improvement ideas from these meetings, and always come back from them with more improvement ideas.

2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

h. Innovative approaches to improve outcomes for members;

Measuring clinical outcomes is an important component of delivering high-quality care and is useful in engaging members in treatment planning. It is our policy and practice to use evidenced-based measurement instruments to develop and utilize clinical assessment tools and to monitor and improve the safety and effectiveness of care and services provided to our members. [redacted]



Treatment Record Review: Magellan's Treatment Record Review (TRR) process, which monitors the quality of services we provide through auditing of members' treatment records, is designed to reflect Magellan's core principles of recovery and resiliency. These are also grounded in the Principles of Care related to services that are: responsive to linguistic, cultural and other unique needs; client and person-centered; consumer and family driven; age and developmentally appropriate; recovery-based care. The TRR tool assesses members' treatment records using specific indicators; for example the assessment of a member's strengths is written from the perspective of the Member and focuses on how the member identifies and views his/her own strengths, family and other external supports been explored and either considered or included in treatment as indicated, goals reflect the member's hopes, dreams, and recovery vision while emphasizing increased quality of life and involvement in meaningful community

MAGELLAN BEHAVIORAL HEALTH

activities, including goals related to living, learning, working, and social connectedness, evidence of treatment being provided in a culturally competent manner

New Guideline Evaluation: As new guidelines are made available, our QAPI program will examine them for relevance to a particular population. For example, there were recently adopted HEDIS measures specifically for Medicaid populations with either bipolar disorder or schizophrenia. These reflect a growing awareness of the need for behavioral health practitioners to support primary health colleagues in assisting these vulnerable populations, which help to reduce the significant gap in life expectancy for individuals with Serious Mental Illness.

Satisfaction Surveys: Our member and provider Satisfaction Surveys allow us to assess, from the member's or provider's perspective, their level of satisfaction with the services they receive. Respondents choose whether they agree or disagree with over thirty statements. The surveys promote several Principles of Care, such as services being consumer and family-driven, family voice and choice, responsive to linguistic, cultural and other unique needs of any client of a cultural, racial, sexual, gender, or linguistic minority, or other special populations, services providing recovery-based care and resiliency-based system of care for children and their families. Examples of indicators we measure via the member surveys include whether members like the services they receive, whether agency staff are sensitive to the member's cultural background (race, religion, language, and customs), Whether the member was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).

[redacted]

Integrated Health Home Pilot: The Center for Integrated Health Solutions (a joint venture of SAMHSA and HRSA operated by the National Council for Community Behavioral Healthcare) has begun to emphasize the importance of "reverse co-location" and SAMHSA now is funding grants for co-located primary and specialty care in community-based mental health settings. In fact, Community Alliance in Omaha has received a four year, SAMHSA Primary and Behavioral Health Integrated Care Grant to develop such a setting. [redacted]

[redacted]

2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

i. Experience and success in service delivery to individuals with serious mental illness

For members who have a serious mental illness (SPMI), our processes focus heavily on evaluation, referral to a provider with the relevant expertise and to the appropriate level of care, and determination and provision of any special needs or coordination activities to be considered as part of the treatment plan. As examples, substance use disorder services, traumatic brain injury, and homelessness may complicate access to and engagement in care. These challenges may or may not have been previously diagnosed or dealt with in the course of treatment. We have developed specific care management programs for complex populations such as these, each designed to improve individual outcomes. As discussed above we are proposing a pilot for members with SMI that will integrate behavioral and physical health services.

While our options for adult behavioral health treatment include private psychiatrists and therapists, most services delivered to adults with Serious and Persistent Mental Illness (SPMI) are provided by community mental health centers that specialize in working with adults with Medicaid and other public funding sources. All key providers serving adults with SPMI are already in our network

[redacted]

[redacted]

Minimally, we will monitor contractually-required access to care standards to ensure that sufficient providers are available to meet member needs. We will also monitor grievance data and member outcomes to determine if the network is truly adequate. We understand that while the number of providers may meet standards, the quality of providers who excel in working with members with SPMI needs to be continuously monitored. In those instances where quality issues are identified, we will work directly with providers to improve staff quality and offer training. We will also routinely refer members without established provider relationships to providers who are determined to be higher quality.

[redacted]

2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

j. Experience in successful service delivery to children whose care is provided by multiple, integrated child-serving agencies, specifically experience with children who are Medicaid/CHIP eligible state wards;

[redacted]

Magellan manages behavioral health services for nearly 270,000 adults and 780,000 children who are Medicaid eligible, as well as more than 35,000 indigent children and adults served by the Louisiana Department of Health and Hospital, the Louisiana Department of Children and Family Services, the Louisiana Office of Juvenile Justice or the Louisiana Department of Education. These agencies are all part of the Coordinated System of Care initiative.

The Children's Coordinated System of Care component is specifically ASO only. The contract in total includes a full range of management services including: 24-hour crisis counseling and referral, management information system, network development, claims payment, utilization management, quality improvement, and reporting.

Through multiple contracts with several Louisiana agencies, including the Department of Health and Hospitals, the Department of Children and Family Services, the Office of Juvenile Justice and the Department of Education, Magellan in partnership with numerous state agencies, Magellan and the community have begun the implementation of the Children's' CSoC program, including the development and delivery of waiver services for this special population.

Magellan of Nebraska has a long history working collaboratively with the Nebraska Division of Child and Family Services (CFS), beginning in 2008-2009, when Magellan first contracted with CFS. Under this contract, Magellan provided intensive clinical consultation and medical necessity reviews for youth who were State wards and receiving treatment authorizations under Medicaid and also were funded directly by CFS due to receiving court-ordered treatment. This experience has served Magellan well in developing new services for youth involved in multiple child-serving agencies.

A significant problem facing Nebraska child welfare is the prevalence of children who are State wards (7,000 at any given time) and also the prevalence of State wards placed outside the family home. A majority of these youth are not placed in treatment facilities although many of them present with mental health and/or substance abuse treatment needs. Additionally, of the youth currently residential care in the system, more than 85 percent of them are State wards. Magellan's expertise in providing care coordination for children who are state wards, in foster care or programs for members with special needs includes ensuring that the children and adolescents receive care in a timely manner and benefit from appropriate mental health services. We understand that children and youth may come into Medicaid eligibility either receiving no services or already receiving services from multiple systems of care through several case managers. This can result in youth having *several plans of care* with conflicting goals. The goals of our care management model are to address fragmentation in the delivery system and ideally develop a single plan of care that includes all elements of the treatment plan to ensure the care of special needs children including children who are State wards and in foster care programs is coordinated.

When authorizing services for State wards, Magellan care managers document the guardian of every youth that is authorized for residential treatment. Magellan staff including care workers, follow-up specialists, and the clinical department has ongoing communication with the guardian starting at the time of application to residential treatment. Care managers will outreach to guardians if significant barriers are identified during the course of treatment (for example, if residential provider reports family is not involved in family therapy), or if the youth is nearing the end of the treatment stay.

[redacted]

2. A proven track record in providing superior services ta other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

k. Experience and successful development, support and monitoring of vertically integrated networks for behavioral health services provided to children, youth, families and adults; and

Multiple definitions and constructs exist as they relate to vertically integrated health care and health systems. Some define it as a health delivery system in which the complete spectrum of care, including financial services, is provided within a single organization, such as a health maintenance organization. As a managed behavioral health organization, Magellan would meet that definition. Some have described accountable care organizations (ACO) as contemplated in the federal Accountable Care Act as such a system. A vertically integrated health system provides a full range of services, including ambulatory, acute and non-acute institutional and residential care. It should be geographically located to serve the needs of a defined population and reduce the gaps now present in the health care system. However, that there are two very different perspectives on the elements of a vertically integrated health system. There is an institutional view that focuses on clinical services and sees the institution as the center of the system. This would reflect the ACO view. However, we would subscribe to a broader definition. There is the community view that supports a wellness model that reflects community priorities and needs, in which access to appropriate care is an important issue. This reflects the systems that most governmental customers desire.

As noted in our Corporate Experience response, we have extensive experience and successful development, support and monitoring of vertically integrated networks for behavioral health services provided to children, youth, families and adults serve. This includes serving more than three million members whose services are from public sources, primarily Medicaid. Our success in reflected in many ways, not the least of which has been our tenure in the State of Iowa where we have served as the management behavioral health organization continuously since 1994, through multiple procurements. In addition, customer satisfaction led to contract expansion without procurement as recently as July 1, 2011, to include new behavioral health intervention services and was expanded again on July 1, 2012, to include psychiatric medical institution services.

Success is also driven by the inclusion of the voice and participation of all elements of the system of care, including members, providers, advocates and other stakeholders. We have created governance boards in Arizona and Louisiana and propose to now in Nebraska with the new program. We also subscribe to the Principles of Care as defined in the RFP to guide our renewed efforts to modify the integrated network in Nebraska. We are sure that we can be successful in that regard given our creation of initiatives devoted to promoting recovery and resiliency such as the first self-directed care program for persons with serious mental illness in Iowa and for families with children with autism in Pennsylvania. [redacted]

[redacted]

Magellan is best positioned to ensure the successful transition to the Nebraska behavioral Health Managed Care program as we have knowledge of the system and existing relationships with providers and stakeholders. Others will be trying to understand the unique attributes of the state and its diverse geography and members to begin the change. We have that knowledge and with the national experience with full-risk behavioral health contracts we are fully prepared to develop, support and monitor the system of care under the guidance of MLTC.

2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

I. Experience and success in creative approaches to implementing the principles of recovery and resiliency, including evidence of an organizational culture that addresses the following elements:

i. The design of services and supports;

ii. Facilitates the development of consumer-operated programs and use of peer support;

iii. Facilitates the development and use of natural supports;

iv. Facilitates the use of self-management and relapse prevention skills,

v. Supports stable housing;

vi. Supports the development of healthy social networks and skills, employment or school performance;

vii. Demonstrated success in implementing Practice Guidelines that promote an evidence-based culture through provider training, fidelity monitoring and best practices; and

viii. Experience and demonstrated success in implementing program innovations that result in improved clinical outcomes including but not limited to, community tenure, physical/behavioral health integration and service delivery for co-occurring mental illness and substance use disorders and co-occurring mental health disorders and developmental disabilities.

i. The design of services and supports

[redacted]

[redacted]

ii. Facilitates the development of consumer-operated programs and use of peer support

[redacted]

iii. Facilitates the development and use of natural supports

[redacted]

iv. Facilitates the use of self-management and relapse prevention skills

Self management and crisis and relapse prevention planning to identify when individuals are experiencing difficulties, including signs and symptoms of decomposition, specific interventions to be used by designated individuals in the event of decomposition, who should be contacted for assistance, and follow up plans is a core component of our Individualized and Collaborative Recovery Planning for members. We have successfully implemented this strategy in most of our programs and will do so under the new risk contract. Our employment of peers both facilitates and informs self management and crisis and relapse prevention. [redacted]

v. Supports stable housing

Magellan recognizes that network sufficiency is fundamental to quality, access to care, and the principle of recovery. The underlying assumptions of network sufficiency begin with the qualitative understanding that a responsive and innovative network must recognize that affordable housing accounts for a significant amount of variance in the formula of care that results in improved functioning and recovery.

Magellan evidences a culture that supports stable housing is best illustrated by our success in Nebraska under the current ASO arrangement. A significant majority of adult members receiving services for a mental health and substance use diagnoses have housing issues. In our initial and ongoing staff and provider trainings, we stress the role of all providers in the care coordination process. We provide orientation and outline the requirements regarding coordination with health and human service systems including housing authorities.

[redacted]

vi. Supports the development of healthy social networks and skills, employment or school performance

Magellan evidences a culture that supports the development of healthy social networks and skills, employment and school performance by actively partnering to promote the Principles of collaboration, respect, and recovery-based care. [redacted]

vii. Demonstrated success in implementing Practice Guidelines that promote an evidence-based culture through provider training, fidelity monitoring and best practices;

Magellan currently demonstrates a culture for implementing Practice Guidelines promoting e an evidence-based culture through provider training, fidelity monitoring and best practices. For example, Magellan of Nebraska actively participated in the development of ACT teams and continues to participate in fidelity monitoring of such. We have worked with the Therapeutic Group Homes to ensure they select and monitor fidelity on at least two evidence-based practices (EBPs) in the residential care they provide to Nebraska youth. Magellan also reviews the result

of the fidelity monitoring to ensure the EBPs selected are in fact in place and used appropriately. Magellan will continue to maintain existing initiatives such as the Treatment Record Review program covered in response to item 2.h above that monitors the sue of evidence based guidelines, while implementing new programs based on evidence-based practices that promote the Principles of Care, such as services being strength-based, person-centered, and supporting recovery-based care and a resiliency-based system of care for children and their families. Orientations, trainings, and shared learning opportunities will be designed to promote the use of evidence-based practices. We will include consumers, family members, providers, and other systems of care stakeholders as partners in most of these activities. [redacted]

viii. Experience and demonstrated success in implementing program innovations that result in improved clinical outcomes including but not limited to, community tenure, physical/behavioral health integration and service delivery for co-occurring mental illness and substance use disorders and co-occurring mental health disorders and developmental disabilities.

[redacted]

Through our consistent, innovative approach to care coordination and physical/ behavioral integration. Magellan can accelerate the transformation of the Nebraska service delivery system. [redacted]

[redacted]

2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

m. A focus on continuous quality improvement with strategies that:

i. Drive accountability and performance;

ii. Contain valid, reliable metrics for outcome measurement;

iii. Monitor the impact of clinical and other service decisions on the member;

iv. Monitor member and provider satisfaction; and

v. Provide adequate oversight of staff through initial orientation, ongoing training and formal clinical supervision to ensure that the skills of staff are consistent with best practices;

vi. Administrative efficiency through technology, including:

a) A supportive and responsive Information Technology (IT) department;

b) Automated systems for detection of suspected fraud and abuse;

c) Data-driven approaches to operatianalzing Contract requirements;

d) Experience and demonstrated success in automated linkages ta client information for transmission of large data files, such as timely , accurate transmission of encounter files;

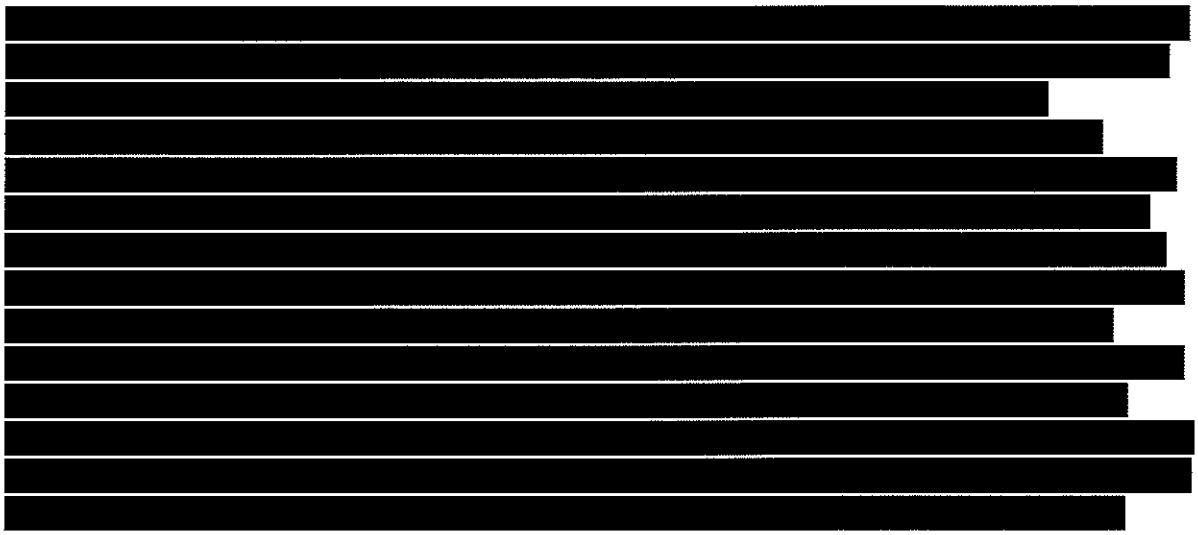
e) Safeguards to protect the confidentiality of protected health infarmation;

f) Technology supports that drive accurate, timely claims administration; and

g) Industry-leading reporting capobilities.

2.m. i. A focus on continuous quality improvement with strategies that drive accountability and performance.

Magellan is a learning organization that has a continual focus on improving our own operations as well as assisting in the improvement of the entire system of care. One mechanism to assure the continual improvement is through the inclusion of the voice and participation of those with lived experience and are stakeholders of the system of care. [redacted]



Magellan synthesizes data across these and other sources using the state-of-the-art Six Sigma "DMAIC" process—Define, Measure, Analyze, Improve, and Control— to guide continuous quality improvement efforts.[1] We use the DMAIC method to identify and implement quality improvement strategies from patient and family member perspectives. In Nebraska, we have used this approach to develop solutions, and it has proven to be a tremendous aid in our effort to raise the level and precision of quality in behavioral health care. The Six Sigma DMAIC process ensures the timely identification of barriers and interventions that lead to improvement.

[1] Six Sigma is a disciplined, data-driven approach and methodology for eliminating defects (driving toward six standard deviations between the mean and the nearest specification limit) in any process.

[redacted]

All aspects of operations including member services, audits, provider performance, clinical processes and outcomes are appropriate areas for performance improvement. Quality staff and others will lead the use of DMAIC tools, including Pareto charts, histograms, and fishbone diagrams, run charts, process maps, and brainstorming techniques, to understand issues and their root causes. Once Customer expectations are defined, data is captured, trended and analyzed for root causes of below-goal performance. Measurable interventions are developed and implemented to improve performance, information is disseminated throughout the organization and feedback received through internal feedback loops including the quality improvement committee structure. The quality committees monitor the progress of assigned areas including performance metrics, stakeholder input and quality project interventions and actions required within each of their respective areas of responsibility. Committees report at intervals designated in the annual quality plan to the QAPI, which oversees the quality program goals and achievements.

Data quality checks are built into all processes that touch data. This includes data integrity and completeness checks as data is loaded and standardized. Quality checks used to verify data integrity include comparisons against expected values, domain analysis, and comparisons to standard code sets/values.

[redacted]

2. m. ii. A focus on continuous quality improvement with strategies that contain valid, reliable metrics for outcome measurement

Measuring clinical outcomes is a key component of the DAMIC process, and ensures Magellan delivers high-quality care and engages members in treatment planning. It is our policy and practice to use evidenced-based measurement instruments to develop and utilize clinical assessment tools and to monitor and improve the safety and effectiveness of care and services provided to our members. Our outcomes initiatives use a suite of evidence-based outcome tools to measure treatment progress and program outcomes. [redacted]

2. m. iii. A focus on continuous quality improvement with strategies that monitor the impact of clinical and other service decisions on the member

- In nearly every case, the impact of the performance improvement efforts is measured by the impact on the member. We monitor all internal and external practices to ensure that our members have equitable access to necessary and appropriate care by preventing, identifying, and correcting intentional and unintentional discriminatory practices by providers, subcontractors and Magellan staff. The primary vehicle for measuring member impact is the member satisfaction survey, which focuses on the experience of receiving care from our system of care. Our monitoring also focuses on identifying practices negatively impacting members including: limiting or denying access to an available facility, providing different services (or in a different manner or timeliness) than those provided to other members, segregating or separating treatment provided to, or restricting privileges or advantages enjoyed by, other members, assigning service times or places on any bases other than medical necessity, treatment efficacy, or documented member preference

2. m. iv. A focus on continuous quality improvement with strategies that monitor member and provider satisfaction

Magellan takes provider and member satisfaction very seriously, and there are policies and procedures that require the monitoring of satisfaction by each Care Management site. Each year, Magellan has conducted an annual provider and two member satisfaction surveys: satisfaction of adult members and satisfaction of minor members. [redacted]

[redacted] We routinely monitor results, and develop action plans for improvement. One of the items our analysis points out from the member most recent survey is that members are very happy with the providers they see, but do not report getting better. This is especially true for minors. This suggests that we need to begin to focus activities on outcome improvements, especially in outpatient settings. Thus, we have adopted a strategy to increase the use of Evidence Based Practices, especially for youth. [redacted]

2. m. v. A focus on continuous quality improvement with strategies that provide adequate oversight of staff through initial orientation, ongoing training and formal clinical supervision to ensure that the skills of staff are consistent with best practices

All Magellan care managers, in every contract or program attend a structured orientation program at the beginning of their employment. Magellan understands that clinical review criteria must not only be based on solid research and clinical expertise, but must be applied consistently to be useful. We utilize many tools that together comprise a comprehensive approach to ensuring consistent application of medical necessity criteria (MNC) in the authorization decisions that clinical reviewers make. We use several techniques, to audit and improve our authorization decision-making for requested services. Continuous quality improvement is central to our approach. [redacted]

2. m. vi. A focus on continuous quality improvement with strategies from administrative efficiency through technology including:

A full description of our Health Information System is included in our response to *Section IV.N Health Information Requirements* of the *Proposed Implementation Approach*.

a. A supportive and responsive *Information Technology (IT) department*

Magellan's state-of-the-art Information Systems and Reporting capacity is a key factor in the success we have had in Nebraska and nationally in achieving high levels of satisfaction with our, members, providers, business partners, customers, and other stakeholders. [redacted]

[redacted] Not only does this include interfaces with MLTC data but incorporating data from outside sources into the Nebraska data and analytical capabilities, such as data from physical health vendors and providers. [redacted]

b. *Automated system for the detection of suspected fraud and abuse*

.As the incumbent ASO, our Compliance Program currently follows a Nebraska Plan policy on the Reporting of Suspected Fraud, Waste, and Abuse (FWA), under which we comply with the use of Nebraska-specific forms and reporting and for which we utilize automated detection systems. Our fraud detection methods include but are not limited to Member service verification sampling, as described below in our response to Section IV. J of the proposed Implementation Plan, thirteenth question, Investigation of member complaints or others' reporting of suspected fraud, waste or abuse, Review of claims and Provider audits and provider self-audit activity utilization data.

c. *Data driven* approaches to operationalzing Contract requirements

Our approach to operationalizing contract requirements will emphasize measurement, performance and accountability. [redacted] These data help the management team ensure outstanding performance and highlights any potential issues as soon as they arise. Our experience, expertise, and relationship with the Department will help to ensure our reporting staff will submit accurate and timely submission of reports required by this new contract. We provide full transparency of data to the Department and have developed innovative technology such as our Dashboard technology which provides real time access to information. Magellan will make *the Customer Dashboard* available to the Department and at the MagellanofNebraska.com Web site. It provides the security of password protection and is a convenient resource for the MLTC to view reporting information online.

d. Experience and demonstrated success in *automated linkages of client information for transmission of large data files, such as timely, accurate transmission of encounter files*

Magellan has extensive interfaces and data exchanges with our many customers' diverse systems and is able to exchange authorization, enrollment, and encounter data files with the State's MMIS and the Health Plans participating in the Nebraska Medicaid Managed Physical Health program as required. Magellan's systems are flexible and can be configured to accommodate a wide range of file formats. We are experienced in working with preferred proprietary formats as well as standard HIPAA-compliant file layouts.

[redacted]

Adjudicated encounters are pulled directly from our claims system, CAPS, once the claims have been finalized. Magellan uses strict internal processes, procedures, and controls to maintain the quality and integrity of data received for and data conveyed to clients. Magellan's 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. These procedural and automated controls operate at appropriate points throughout the cycle. Magellan follows rigorous procedures to ensure the completeness, accuracy, and timeliness of encounter submissions to our clients as detailed further in Section IV.O.

Magellan complies with all HIPAA Transaction and Code Set standards for the electronic processing of covered transactions.

e. Safeguards to protect the confidentiality of Protected Health Information

Protecting the confidentiality of Protected Health Information (PHI) is a core competency of Magellan. Magellan's provider portal operates in a secure, HIPAA-compliant environment to maintain the confidentiality of any member-related information that is communicated through the site. Access to the provider portal is controlled through a secure login function, requiring a unique User ID and Password to gain access. The site incorporates the usage of Secure Socket Layer (SSL) protocol version 3.0 to protect sensitive information. Transport Layer Security (TLS) protocol version 1.0 is also used.

Magellan routinely conducts security assessments and vulnerability testing on our outward facing IP addresses, as well as other systems, and mitigates any issues or risks found in a timely manner. Magellan uses industry standard testing tool-sets and engages third-party, independent agencies to verify the security of our infrastructure.

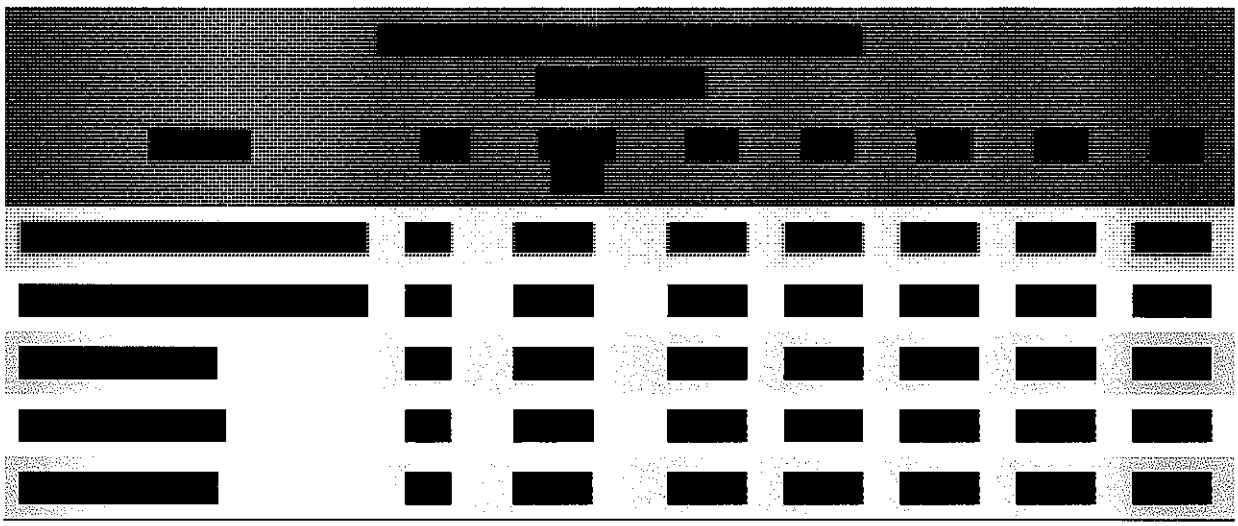
All employees must complete privacy training at hire and annual refresher training, through an online, computer-based training module containing the tenets of HIPAA's privacy and security requirements.

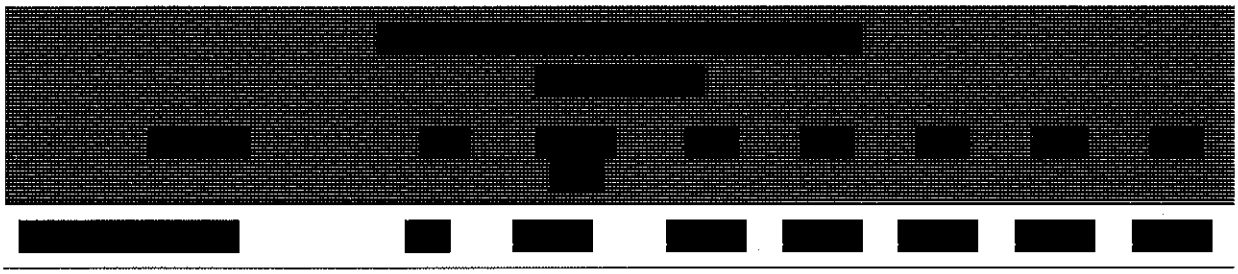
Additionally, we protect the confidentiality of PHI in our day-to-day interactions with providers and consumers. We have developed policies and procedures that serve to protect the privacy of protected health information (PHI) that is used or disclosed by Magellan and Magellan providers. As described in depth in the response to Section IV.K, in the seventh question

regarding protecting member's privacy in coordinating care, major components of our policies and procedures for maintaining members' privacy in the process of coordinating care include: availability of Magellan's authorization and disclosure forms; requirements for provider communication of PHI; and provider and staff education and training on confidentiality rules and requirements.

f. *Technology supports that drive accurate, timely claims administration*

[redacted]





g. *Industry-leading reporting capabilities*

As evidenced by customer satisfaction Magellan's Analytic Services Department (ASD) provides industry-leading reporting capabilities. Our Nebraska Information and Technology Director will serve as a liaison to our national IT organization and project manage changes and report development for Nebraska. This will significantly contribute to ensuring the reporting capabilities are timely and accurate.

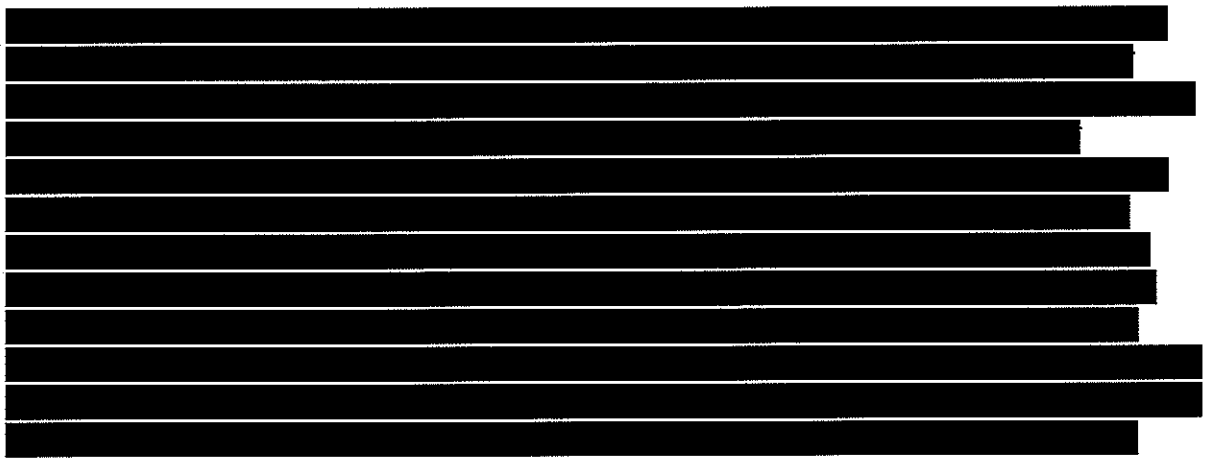
2. A proven track record in providing superior services to other governmental clients and covered populations similar to MLTC and its covered populations, as demonstrated by a/an:

n. A proven track record of successful accountability for performance requirements under large, complex contracts, including:

i. Examples of successful achievement of performance thresholds on guarantees that embody the system principles outlined in this RFP; and

ii. The capability to update performance measures as industry standards and program requirements evolve.

2.n.i. Successful achievement of performance thresholds on guarantees that embody the system principles outlined in this RFP



As a data driven and fiscally responsible organization, it is rare for Magellan Public Sector sites to miss the attainment of incentives or performance guarantees.

Additionally, Magellan has reviewed the performance guarantees and incentive thresholds and has discovered current ASO performance is in line with the targets presented in the RFP:

An important aspect of Magellan's work related to performance measures is that the measures be used as system improvement drivers and not just for reporting purposes. Towards this end, Magellan routinely develops "dashboards" that reflect progress towards achieving established targets. This dashboard system being web based provides us with the opportunity to provide MLTC with maximum flexibility in when performance measures require updating. Given our long term tenure in such states as Iowa, Pennsylvania, and Arizona, Magellan can assume the role of "trusted advisor" to MLTC and provide suggestions of updates and changes in performance measures that may be adapted for implementation in Nebraska as informed by these programs in other states.

2.n.ii. **The** *capabilities to update performance measures as industry standards and program requirements evolve*

- Given our industry leadership, our track record of innovation and our innovations in several key states and programs, we posses the thought leadership, systems, flexibility and economies of scale to not only respond to the evolution of industry standards but to inform our customers about these changes. As we do under the current relationship with the MLTC, we will work in partnership to meet and exceed all performance measurements throughout the life of the new contract. We propose monthly oversight/monitoring meetings with discussion of key performance indicators

J. Business Requirements

1. *Regulation and Guidance*

Magellan has reviewed the Regulation and Guidance requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections.

More detailed information on regulation and guidance is available in the Business Requirements section (*Sub-section I.V. J.* of the *Proposed Implementation Approach*).

2. *Managed Care Organization Licensure*

Magellan Behavioral Health of Nebraska, Inc. is licensed by the State of Nebraska as a Prepaid Limited Health Service Organization, which provides authority to operate as a risk-bearing entity. Through this license, we understand our obligation to and agree to abide by all requirements of a managed care entity in Nebraska.

More detailed information on regulation and guidance is available in the Business Requirements section (*Sub-section I.V. J.* of the *Proposed Implementation Approach*).

3. *Accreditation*

Magellan Behavioral Health of Nebraska's Care Management Center has earned full accreditation from URAC for Health Utilization Management. [redacted]

More detailed information on regulation and guidance is available in the Business Requirements section (*Sub-section I.V. J.* of the *Proposed Implementation Approach*).

4. *Reinsurance*

Magellan has reviewed, understands and will fully comply with the requirements for reinsurance. Magellan believes the actuarially sound rate development process for behavioral

health claims and services are adequate to pay all claims under this Medicaid program and benefits. Magellan does not intend to purchase or self-fund a reinsurance policy. Claims associated with this Medicaid program are not of a catastrophic nature and the historical experience and benefits should be captured in the rate development process. Magellan intends to pay all claims from existing capitation payments provided by the State and from cash reserves on hand.

5. Access to Records

Magellan has reviewed the Access to Records requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections.

6. Advance Directives

Magellan is prepared to comply with the requirements of 422.128 for maintaining written policies and procedures for advance directives. We understand the requirement that adult enrollees must be provided with written information on advanced directive policies, which must include a description of applicable Nebraska law. We are prepared to abide by those requirements with no objections.

7. Notice of Provider Termination

Magellan has reviewed the Notice of Provider Termination requirements as described in the RFP. We understand that we must make a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. We are fully prepared to abide by those requirements with no objections.

8. Provider-Enrollee Communication

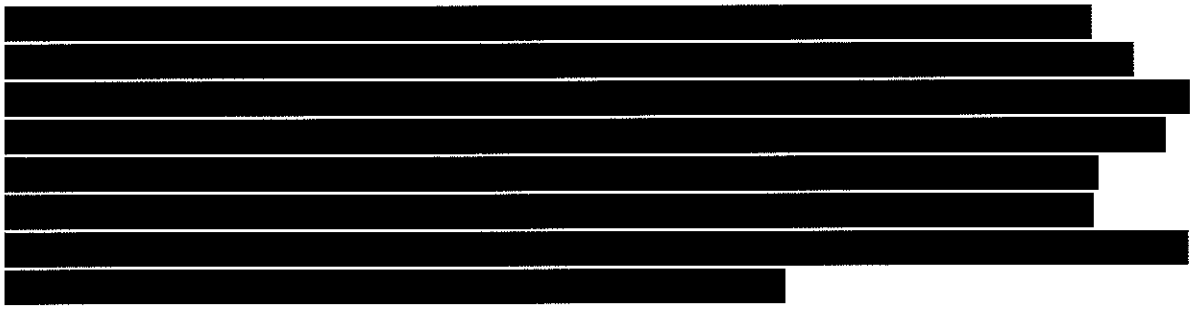
Magellan has reviewed the Provider-Enrollee Communications requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections.

9. Administration/Staffing

Magellan has reviewed the Administration/Staffing requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections.

Magellan will maintain a sufficient number of staff to manage the Nebraska Behavioral Health Managed Care Program). Our approach to management of the program is based upon assuring a

single point of accountability to the Division of Medicaid & Long Term Care supported by a structure that leverages the experience and knowledge of those with lived experiences of the behavioral health system, either as members, their families, advocates, providers, and other community stakeholders.



More detailed information on administration and staffing is available in *Section 3, the Corporate Overview section* of the RFP response.

10. Adequate Capacity

Magellan has reviewed the Capacity requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections.

Retaining Magellan as the vendor for the Nebraska Behavioral Health Managed Care will ensure that Medicaid and CHIPs recipients and providers experience no disruption in service when the new payment structure is implemented. We can take the existing strengths and capacity of the program and move forward quickly, focused on the goals related to enhancing the program and expanding capacity rather than doing initial network development.

11. Compliance

Magellan has reviewed the Compliance requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections

Magellan's Corporate Compliance Department is responsible for the Company's awareness of applicable state and federal laws and regulations. The Corporate Compliance Department includes Regulatory and Legislative Analysts, Regional Compliance Directors, Regulatory Attorneys and paralegals. The Compliance Department monitors changes and revisions to federal and state laws, rulings, regulations and standards and is responsible for reporting changes and revisions to the appropriate senior manager at the Nebraska care management center.

More detailed information on compliance is available in the Business Requirements section (*Sub-section I.V. J.* of the *Proposed Implementation Approach*).

12. Clinical Laboratory Improvement Amendment

Magellan has reviewed the Clinical Laboratory Improvement Amendment as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections.

13. Fraud, Waste and Abuse

Magellan has reviewed the Fraud, Waste and Abuse requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections

Magellan has the following policies and related documents to ensure compliance with the False Claims Act:

- False Claims Laws and Whistleblower Protections policy
- Corporate Compliance Handbook – Pages 8 to 10
- DRA Compliance Statement at http://magellanhealth.com/our-edge/clinical-excellence/compliance/dra-compliance-statement.aspx
- Magellan DRA Compliance Statement and Nebraska Law.

Employees, contractors and providers are notified that they are required to report any suspected cases of fraud, waste, abuse, and overpayments to Magellan.

More detailed information on fraud, waste and abuse is available in the Business Requirements section (*Sub-section I.V. J.* of the *Proposed Implementation Approach*).

K. Member Rights and Responsibilities

1. MEMBER SERVICES

a. Member Rights

Magellan has reviewed, understands, and will fully comply with the Member Rights requirements as described in the Project Description and Scope of Work section of the RFP.

Magellan's approach to providing members notification of their rights and responsibilities at enrollment is to ensure that members can both readily obtain information and easily understand it.

Our primary vehicle for communicating members' rights and responsibilities is our *Member Handbook*, which is mailed to each new member upon enrollment. A cover letter includes information in Spanish and Vietnamese on how to request handbook information in an alternative language format. The *Member Handbook* is available in both English and Spanish.

In addition to the *Member Handbook*, we use other modalities to disseminate information to members about their rights and responsibilities. These include our Web site, customer services, public events, and our network providers' offices.

A detailed description of our approach to member services is included as *Sub-section IV.K* of the *Proposed Implementation Approach* section of this proposal, entitled "Member Rights and Responsibilities." Question 1 presents our procedures for informing members of their rights.

b. Written Policies

Magellan has reviewed, understands, and will fully comply with the Written Policies requirements as described in the Project Description and Scope of Work section of the RFP.

c. Member Communication

Magellan has reviewed, understands, and will fully comply with the Member Communication requirements as described in the Project Description and Scope of Work section of the RFP.

All member material is developed in easily understood language, targeted at less than 6.9 on the Flesch-Kincaid readability scale. To ensure understandability, we review all member materials with our Consumer Stakeholder Committee, prior to distribution. These reviews have proven very helpful in identifying gaps in understandability and changing the way things are presented. Additionally, these reviews have identified areas often misunderstood, such as grievances and appeals. We have developed webinars to address these areas, open especially to advocates, who often are the ones assisting the members at the time the concern exists.

We provide more detailed information about Member Communications in *Sub-section IV.K., Member Rights and Responsibilities* of the *Proposed Implementation Approach* of the RFP response.

d. Language Requirements

Magellan has reviewed, understands, and will fully comply with the Language requirements as described in the Project Description and Scope of Work section of the RFP.

[redacted] The *Member Handbook will be initially available in Spanish and English.* Additionally, through translation, we will make information available to members not speaking either English or Spanish.

e. Interpreter Services

Magellan has reviewed, understands, and will fully comply with the Interpreter Services requirements as described in the Project Description and Scope of Work section of the RFP.

[redacted]

We also utilize a TTY (Telephone Typewriter) or TDD (Telecommunications device for the deaf). Again, the member communicates with the deaf operator, and the operator communicates with the Magellan representative. The Magellan representative responds to the interpreter and the interpreter communicates this with the member.

[redacted] When a provider does not have interpreter services available for a member, we will connect the member to an interpreter through Global Interpreting Network, which provides on-site sign language interpretation or on-site or telephonic language interpretation. Magellan's care management staff will arrange for services when needed.

f. Required Information to Members

Magellan has reviewed, understands, and will fully comply with the Required Information to Members requirements as described in the Project Description and Scope of Work section of the RFP.

Magellan of Nebraska will send a "welcome packet" (member orientation materials) to all new members within 30 days of receiving notice of the member's enrollment. The packet will contain a welcome letter, the *Member Handbook*, the *Provider Directory*, the "Magellan Services At-a-Glance" tip sheet, and materials on specialized programs of interest.

Our *Member Handbook,* which is available in both English and Spanish, provides key information to members about the Magellan Medicaid Managed Care program for mental health and substance abuse services, including information on member rights, and covers all provisions of 42 CFR 438.10(b)(3) and 42 CFR 438.10(f-h).

Information on accessing providers is included in the *Member Handbook* and in the *Provider Directory,* which is included with the *Member Handbook* mailing to new members.

Magellan also produces easy–to-read, one-page "tip sheets" that are designed to provide basic information about behavioral health services and access to care. We distribute these tip sheets during member trainings and distribute them to family organizations and member advocacy groups, as well as at community events. Some tip sheet topics are also included in the member welcome packets.

We provide more detailed information about required information for members in *Sub-section IV.*K of the *Proposed Implementation Approach*, particularly in response to the third question where we describe the information to be sent to new members.

g. Member Handbook

Magellan has reviewed, understands and will fully comply with the *Member Handbook* requirements as described in the Project Description and Scope of Work section of the RFP.

The *Member Handbook* will be available in English and Spanish. It will be maintained on our website. The handbook has historically been updated by Magellan at least annually. When special circumstances have occurred, such as the change of vendors for transportation services, the updates have occurred more frequently. The members are notified of the availability of a new *Member Handbook* any time changes occur, and at least annually.

A detailed description of our *Member Handbook* is included in *Sub-section IV.K* of the *Proposed Implementation Approach* section of our proposal, "Member Rights and Responsibilities."

h. Notice of Provider Termination

Magellan has reviewed, understands, and will fully comply with the Notice of Provider Termination requirements as described in the Project Description and Scope of Work section of the RFP.

Upon a provider termination from the Magellan network, Magellan will generate a list of all members who have seen the provider within the past six months from the claims system. Additionally, Magellan will query for any active, open authorizations for services that might not have resulted in a claim. Magellan's policy is to generate letters to impacted members within five days of the notification of termination. Our standard exceeds the MLTC requirement of the notification to occur within 15 days. We will generate these letters to impacted members to notify them that their provider is no longer a participating network provider with Magellan Behavioral Health of Nebraska.

The process Magellan takes to inform members that their provider has been terminated from the network are fully described in our response to the fourth question within *Sub-section IV.K* of the *Proposed Implementation Approach* section of our proposal, "Member Rights and Responsibilities."

i. Grievance, Complaints and Appeals

Magellan has reviewed, understands, and will fully comply with the Grievance, Complaints and Appeals requirements as described in the Project Description and Scope of Work section of the RFP.

As with all communications, Magellan's approach to providing members information about grievances, appeals, and State Fair Hearings is to make the information easily available and easy to understand.

The grievance, complaints and appeals process provides an opportunity for Magellan to hear from members and providers about what is working and not working for them in the service delivery system. By informing us about gaps in the system, including access issues, as well as quality or compliance issues, the grievance, complaints, and appeal process provides us as an opportunity to make improvements.

A full description of our grievance and appeals process appears in *Sub-section IV.K., Member Rights and Responsibilities* of the *Proposed Implementation Approach* of the RFP response, especially in our response to the fourteenth question of that section.

L. Provider Network and Management

Magellan has reviewed, understands and will fully comply with the Provider Network and Management requirements as described in the Project Description and Scope of Work section of the RFP.

More detailed information regarding our understanding and approach to the Scope of Work Requirements for provider network and management are presented in the responses to the 49 questions in Provider Network Development and Management section (*Sub-section IV.L* of the *Proposed Implementation Approach* section of the RFP response).

We are committed to continuously improved outcomes for members served in the Nebraska Medicaid Program through effective support of our provider network. Our provider network is one of our most valuable assets and we will continue to facilitate and support providers in our collective efforts to efficiently enhance the quality of services for members.

Selecting Magellan as the vendor for the Nebraska Behavioral Health Managed Care Program (NBHMCP) will ensure that Medicaid recipients and providers experience no disruption in service when the new contract structure is implemented. We can take the existing strengths of the program and move forward quickly, focused on the goals related to enhancing the program and expanding capacity rather than doing initial network development. In real terms, this means that we will be fully operational at the start of our contract, while our competitors would spend much of the first year of the contract becoming established and working through implementation issues. Our ability to bring creative solutions through a full risk contract will only enhance the services recipients receive from Medicaid through Magellan today.

Due to our long history of working in Nebraska, our commitment to provider relations, and our awareness of the challenges associated with working in a state with large rural areas, we have forged strong relationships with Nebraska providers and are part of the behavioral health community. We are committed to provider satisfaction because we understand providers are not a commodity; they are key partners in successful outcomes for residents of Nebraska and as a result, ninety percent of our Nebraska provider network reports being satisfied when surveyed.

[redacted]

[redacted]

While a partner of MLTC now with some success as the Administrative Services Organization, the program we bring under NBHMCP will be more than Magellan of Nebraska is now. A full-risk contract is an opportunity to capitalize on flexibility in payment and contracting to further develop a community partnership that gives providers and other stakeholders key roles in the formation, growth, and policy direction of the program. Our commitment to Nebraska is evident in the steps taken under the ASO contract to engage providers, including a Provider Advisory Committee (PAC), the Nebraska provider newsletter and community-based statewide town hall meetings. Under the new program, we will continue and expand the PAC, but we will also create a more formal structure called the Governance Board that will give providers and other community stakeholders' seats at the table in equal proportion to Magellan leadership to ensure that plan decisions are made with the voice of the community.

As the current vendor, Magellan of Nebraska will bring the best of the past along with a renewed focus on innovation made possible through the new structure created by the NMBHP. The state will retain Nebraskans who work and live in Nebraska communities, know the behavioral health community, know Nebraska Medicaid recipients with behavioral health needs, and know the challenges that Magellan and the state have faced successfully as partners for over ten years. However, under the risk-based contract structure, we will have the flexibility to bring the best of our national experience to Nebraska so that we become a full behavioral health managed care organization dedicated to Nebraska Medicaid, exactly what we do best.

Providers and MLTC will benefit from our extensive experience in integrated authorizations and claims payment with robust, nimble data systems that use that claims data to report back to providers on their service effectiveness and build targeted quality improvement efforts from a system-wide perspective. We will bring a performance and outcomes dashboard to the MLTC and providers that displays critical data beyond that which can be supported by claims to have a real, meaningful performance tracking system. [redacted]

Our network is our strength, and we will begin our contract on day one with a fully operational, complete network that includes all key Medicaid-enrolled behavioral health providers, including all inpatient psychiatric hospitals, something that our competitors cannot deliver. However, we know that there are parts of Nebraska that are not well-served by our current network. We also know that the gaps in these rural areas are not due to a lack of contracted providers; the gap is due to a complete lack of providers. We also know that the number of members in these areas who need behavioral health services is, in most cases, too small to attract providers to those

areas. Therefore, we propose behavioral health services using telehealth technology to enhance our delivery system.

The new day with Magellan will also be characterized by building the network though increased training and competency tools. Child-serving providers will be supported by PracticeWise, a technology solution that offers innovative tools and services to help clinicians and organizations improve the quality of health care. We will continue to bring nationally recognized trainers in-person and virtually to our network to ensure that, to the extent possible, behavioral health care delivered to our members will be evidenced-based, trauma-informed, and state of the art. The Principles of Care adopted by Nebraska will guide our training efforts.

At Magellan, we are committed to giving Nebraska our very best. We know Nebraska like none of our competitors; we are local. But, we are also one of the top behavioral health managed care organizations in the country, delivering services directly to state and county governments in seven states as a stand alone Behavioral Health Organization, not a subsidiary of a large health plan. We are committed to delivering the program enhancements identified in this proposal and contemplated by the MLTC as their continued partner. We actively participate in our Nebraska communities. We sponsor local charity events. We raise funds and donate food and clothing to local agencies to support families in our community. *We live here – and we care.*

1. *Establishing the Netwark*

Magellan has reviewed the establishing the network requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections.

Retaining Magellan as the vendor for the Nebraska Behavioral Health Managed Care Program (NBHMCP) will ensure that members and providers experience no disruption in service when the new payment structure is implemented. We can take the existing strengths of the program and move forward quickly, focused on the goals related to enhancing the program and expanding capacity rather than doing initial network development. In real terms, this means that we will be fully operational at the start of our contract, while our competitors would spend the first year of the contract becoming established and working through implementation issues. Our ability to bring creative solutions through a flexible payment system will only enhance the services recipients receive from Medicaid through Magellan today.

Due to our long history of working in Nebraska, our commitment to provider relations, and our awareness of the challenges associated with working in a state with large rural areas, we have forged strong relationships with Nebraska providers and are part of the behavioral health community. Ninety percent of our Nebraska network reports being satisfied when surveyed. We are committed to provider satisfaction because we understand providers are not a commodity; they are key partners in successful outcomes for residents of Nebraska. Our network is our strength, and we will begin our contract on day one with a fully operational, complete network that includes all key Medicaid-enrolled behavioral health providers, including all inpatient psychiatric hospitals, something that our competitors cannot deliver.

Further details about Magellan's approach to establishing the provider network are addressed in the Provider Network Development and Management section (*Sub-section IV.L* of the *Proposed Implementation Approach*), particularly in response to the fourth question, which describes how Magellan will ensure sufficient expertise within its network.

2. *Provider Credentialing*

Magellan has reviewed the Provider Credentialing requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections.

Magellan's credentialing process, and its accompanying written policies and procedures, is consistent with the criteria included in the State and Federal regulations, including 42 CFR 438.214 (a)(b)(1&2). Our credentialing criteria are consistent with the industry standards produced by the National Committee for Quality Assurance (NCQA) and, in fact, we achieved certification under NCQA's Credentials Verification Organization (CVO) Certification Program with a score of 100 percent in all 10 elements in 2012.

Provider credentialing is addressed in the Provider Network Development and Management section (*Sub-section IV.L* of the *Proposed Implementation Approach*), particularly in response to the fourteenth question in Provider Network, describing the credentialing and recredentialing process.

3. *Network Provider Qualifications*

Magellan has reviewed the Network Provider Qualifications requirements as described in the Project Description and Scope of Work section of the RFP, and we address those items during our credentialing and recredentialing process. As stated above in question 2, our credentialing and recredentialing process in described in the fourteenth question in *Section IV.L. Provider Network*. We are fully prepared to abide by the requirements of the Scope of Work with no objections.

4. *Credentialing Waiver Process*

Magellan has reviewed the Credentialing Waiver Process requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections.

Magellan is committed to meeting and exceeding the access and service delivery standards in the RFP. To address these obligations, and in acknowledgement of the role played by community organizations in providing safety net services to Nebraska Medicaid members, Magellan's approach to credentialing is flexible and adaptable, intended to meet the needs of our customers and the members we serve. While our standard credentialing process has proven approaches in place to ensure high quality traditional behavioral health providers, we are able to change our

standard policies and practices to meet the needs and service gaps within local communities and systems of care.

Our waiver process does not allow for unqualified individual providers to circumvent our typical process by requesting waivers. Rather, we will adapt our credentialing standards to include non-traditional providers through the development of expanded credentialing criteria for new provider types and add additional oversight items within the approval process to ensure ongoing quality.

The credentialing waiver process is described in our response to the thirteenth question in the Provider Network Development and Management section (*Sub-section IV.L* of the *Proposed Implementation Approach*).

5. *Provider Outreach and Application Processing*

Magellan has reviewed the Provider Outreach and Application Processing requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections.

Network providers are required to complete an application process to participate in the network, which includes initial credentialing processes. Upon completion of the process and upon approval of the provider to participate in the network, a unique provider identification number is issued. This provider number is maintained in our provider database. Magellan also requires that providers have valid Tax ID numbers.

More details about our approach to provider outreach and application processing are included in the Provider Network Development and Management section (*Sub-section IV.L* of the *Proposed Implementation Approach*). Our response to the twelfth question addresses how we demonstrate performance compliance with the timelines for credentialing and contracting; our response to the fourteenth question provides details on the credentialing process.

6. *Provider Contracting Principles*

Magellan has reviewed the Provider Contracting Principles requirements as described in the Project Description and Scope of Work section of the RFP. We are fully prepared to abide by those requirements with no objections.

More detailed information regarding Magellan's provider contracting principles is presented in the Provider Network Development and Management section (*Sub-section IV.L* of the *Proposed Implementation Approach* section of the RFP response), particularly in our response to the first question where we describe how we will meet the requirements for compliance with the Nebraska Behavioral Health Managed Care Program's Principles of Care.

7. Provider Contract Provisions

Magellan has reviewed, understands and will comply with the Provider Contract Provisions requirements as described in the Project Description and Scope of Work section of the RFP. Our standard provider contract and Nebraska-specific addendum draft are available for review in **Attachment T**, as required in the forty-fourth question of Provider Network.

8. Non-network Providers

Magellan has reviewed, understands and will comply with the Provider Contract Provisions requirements as described in the Project Description and Scope of Work section of the RFP.

If the network does not have an appropriately qualified contracted practitioner and/or organizational provider available to meet a member's specific need, we have the option to refer the member to a non-contracted practitioner or organizational provider using Magellan's ad hoc procedures. Ad hoc agreements are one-time only contractual arrangements with a provider that are used to cover either a one-time service, such as an emergency hospitalization, or one episode of treatment, such as out-of-network care for a member needing culturally-specific services not available within the network. While the ad hoc provider does not complete our credentialing process, our standard ad hoc agreement includes quality standards for the care provided.

9. Access and Availability of the Behavioral Health Provider

Magellan has reviewed, understands, and will comply with the Provider Contract Provisions requirements as described in the Project Description and Scope of Work section of the RFP.

Network adequacy will be a key area for review and revision for the new Nebraska contract. Access standards are more stringent for the new program than they are under our ASO contract. While our network continues to meet the requirements under the new contract, we will modify our policies, procedures, and protocols to monitor the network against the new standards. Network adequacy will be a key area for review and revision for the new Nebraska contract. Access standards are more stringent for the new program than they are under our ASO contract. While our network continues to meet the requirements under the new contract, we will modify our policies, procedures, and protocols to monitor the network against the new standards.

The Provider Network Development and Management section (*Sub-section IV.L* of the *Proposed Implementation Approach* section of the RFP response) addresses these issues. See in particular our response to the thirty-third question on ensuring network and access requirements and policies for provision of services from non-network providers and the twenty-eighth and twenty-ninth questions on coverage for emergency services.

Our network analysis for the new standards, using GeoAccess, demonstrates a 90 percent or higher compliance with requirements. GeoAccess is an industry leading software application used to create maps, charts, and tabular reports that enable a detailed view of network

accessibility. We employ a proven methodology to assess network capacity for all providers, including those serving culturally diverse priority populations and persons with special needs such as older adults and persons with developmental disabilities. [redacted]

10. Linkage with Consumer and Recovery/Resilience Initiatives

Magellan has reviewed, understands, and will comply with the Provider Contract Provisions requirements as described in the Project Description and Scope of Work section of the RFP.

[redacted]

Magellan's approach to providing linkages with consumer and recovery/resiliency initiatives is described in our response to the seventeenth question in the Provider Network Development and Management section (*Sub-section IV.L* of the *Proposed Implementation Approach*).

11. Provider Quality Management Strategy

Magellan has reviewed, understands and will comply with the Provider Contract Provisions requirements as described in the Project Description and Scope of Work section of the RFP.

Our provider Quality Management Strategy is based on the requirement for providers to deliver high quality care according to clinical practice guidelines, incorporating evidence-based practices where possible, and supporting the Principles of Care. Our provider agreement requires that providers cooperate and participate with all utilization review/management, quality improvement, peer review, appeal and grievance procedures, or other similar programs. The provider is required to permit access to medical records for quality of care monitoring and for use as data in quality improvement projects. The provider is also required to cooperate with any on-site reviews.

Providers are involved in our quality management processes and in the development and implementation of Quality Improvement Projects. Quality Improvement will be a standing topic at both the PAC and the Clinical Advisory Committee to ensure that activities are conducted with

full input from key advisors. Final review of the quality management activities will be by the Governance Board, through the QAPI, who will give direction and prioritize resources for efforts.

See the sixteenth question in *Section IV.L. Provider Network* of the *Proposed Implementation Approach* for additional information about the involvement of our providers in the Quality Management Strategy.

12. Network Administration

Magellan has reviewed, understands, and will comply with the Provider Contract Provisions requirements as described in the Project Description and Scope of Work section of the RFP. See the eleventh question in *Section IV.L. Provider Network* of the *Proposed Implementation Approach* for additional information about our provider network database.

13. Network Provider Policy and Procedure Manual/Handbook

Magellan has reviewed, understands, and will comply with the Provider Contract Provisions requirements as described in the Project Description and Scope of Work section of the RFP. Our current provider handbook is available on MagellanofNebraska.com. We will update the handbook to include the provisions in the Scope of Work and to incorporate the features of our new program and produce it at least 45 days prior to the start of the contract. We will also post the revised handbook to our Web site no later than 30 days prior to the start date.

14. Network Provider Protocols

Magellan has reviewed, understands, and will comply with the Provider Contract Provisions requirements as described in the Project Description and Scope of Work section of the RFP.

Magellan's process for developing, maintaining and utilizing network provider protocols is described in our response to the twenty-sixth question in the Provider Network Development and Management section (*Sub-section IV.L* of the *Proposed Implementation Approach*).

15. Network Provider Relations

Magellan has reviewed, understands, and will comply with the Provider Contract Provisions requirements as described in the Project Description and Scope of Work section of the RFP.

Since 2002, we have worked to build strong lasting relationships with all stakeholders in Nebraska. Our team is embedded in the community allowing us the advantage of understanding and responsiveness to identified provider issues. We have seen increasing levels of provider satisfaction over the past three years as the development and execution of our Provider Relations plans gains momentum. An important aspect of our provider communication plan is having a transparent, proactive communication strategy. Through our proactive plan and

experience we show value in being a reliable resource and provide value by supporting and assisting providers in reducing their administrative burden, improving the clinical soundness and the quality of services provided to consumers; and expanding and enhancing the service delivery system through education, training and provider development.

More detailed information regarding the Network Provider Relations requirements is presented in the Provider Network Development and Management section (*Sub-section IV.L* of the *Proposed Implementation Approach* section of the RFP response). Our response to the fifteenth question discusses our process for building and maintaining positive relationships with providers; the twenty-fourth question describes our process for creating a Provider Advisory Committee; the twenty-fifth question addresses our approach to creating the Network Communication Plan.

16. Annual Network Development Plan

Magellan has reviewed, understands, and will comply with the Provider Contract Provisions requirements as described in the Project Description and Scope of Work section of the RFP.

Our approach to creating the network development plan is to implement a regional, strength-based approach that is focused on increasing access, enhancing quality, expanding choice, and improving consumer experience. We understand the critical need to work collaboratively with members, families, providers, advocates, MLTC, and other stakeholders. We will utilize our Nebraska network team to support the goals of the system, and build from the existing strengths within the system. The Plan will be flexible to address the specific needs of the Nebraska Medicaid population, such as improved access in rural communities.

Moving forward, Magellan will continue to promote the Principles of Care with our network providers by establishing Principles of Care guidelines and through an action plan including the elements listed below. This action plan will be part of the broader Provider Network Development Plan.

Our response to the twenty-second question in the Provider Network Development and Management section (*Sub-section IV.L* of the *Proposed Implementation Approach*) describes our approach to creating the Network Development Plan.

M. Care, Utilization and Quality Management

Magellan has reviewed, understands, and will fully comply with the Care, Utilization and Quality Management requirements as described in the Project Description and Scope of Work section of the RFP and its associated addendums. More detailed information regarding our understanding and approach to the Scope of Work Requirements for Care, Utilization & Quality Management are presented in our responses to the questions in *Section IV. M. Care, Utilization & Quality Management* of the *Proposed Implementation Approach.*

Below is an overview of our approach to care management and utilization management for the Nebraska Behavioral Health Managed Care Program, followed by an overall description of our quality management approach.

Care Management and Utilization Management

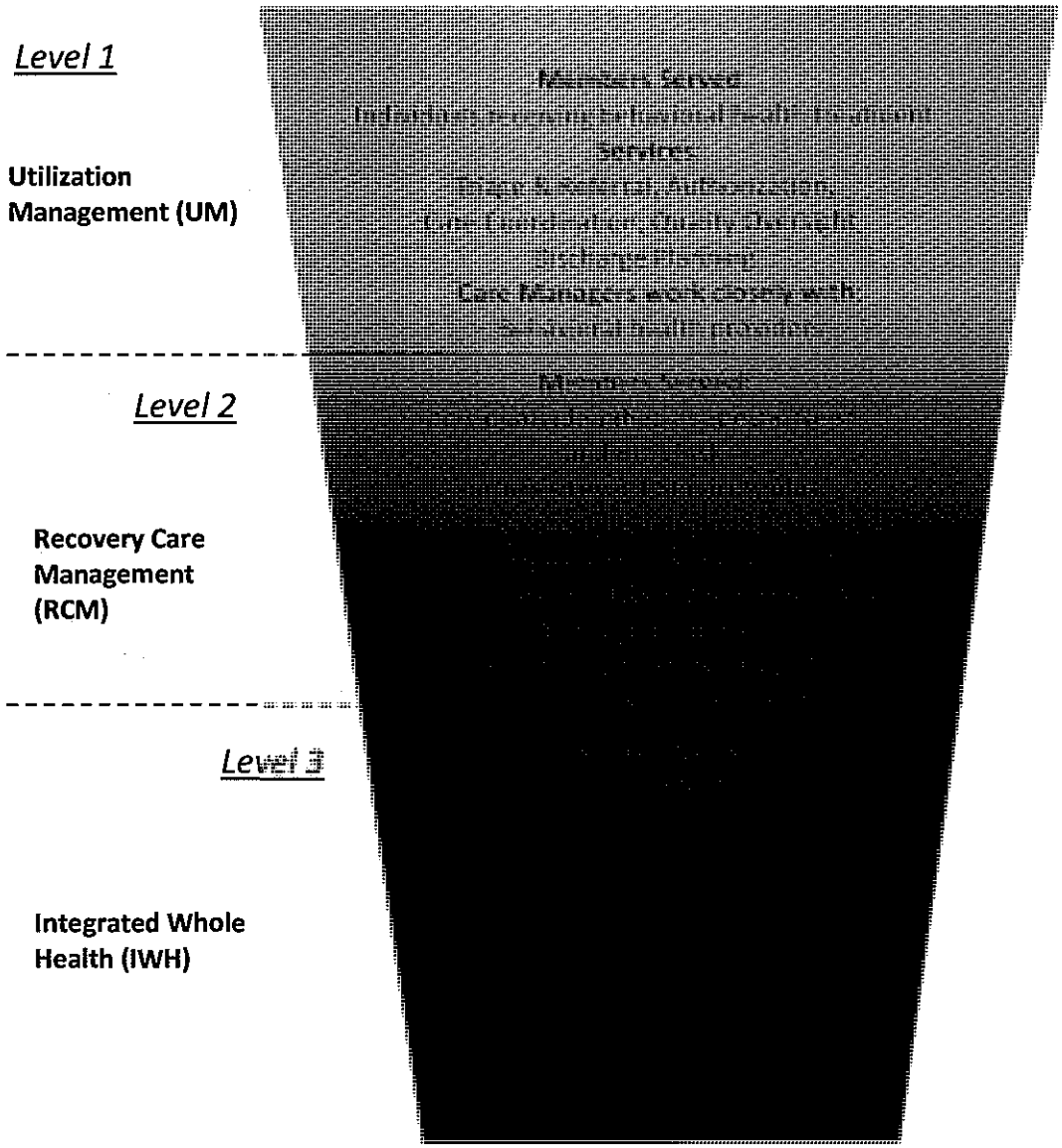
Overview of Magellan's Model of Care Management

Magellan will employ a comprehensive approach to care management to meet the unique needs of Medicaid and CHIP members and to improve health and quality outcomes. We will ensure that care is coordinated across the delivery system and within the state's current managed care structure. Our care management model (Figure i.M.1) is a person-centered, consumer and family-driven model of care that is comprised of three levels of care management:

- Utilization Management
- Recovery/Resiliency Care Management
- Integrated Whole Health.

Our care management model, which is built on the nine Principles of Care, is summarized graphically in the figure below and described in the following narrative to provide context for our response to the specific questions regarding Magellan's processes and the criteria we will use for care management.

Figure i.M.1 - Magellan's Model of Care Management



Level I Care Management: Utilization Management

Utilization Management (UM) is an integral part of our care management model to ensure that members receive care that is medically necessary and covered behavioral health benefits and services are not under- or over-utilized. All members who utilize behavioral health services receive Level I Care Management: Utilization Management services. Our UM care management activities are designed to ensure services delivered to members:

- are medically necessary based on established criteria, as well as practice guidelines
- are provided at the right time, in the right amount, and in the right way
- are provided in the most appropriate, least restrictive setting

- help avoid interventions that have been unsuccessful or have failed to prevent repeated use of restrictive placements
- support person-centered, strengths based individualized goals related to each adult's recovery and each child and family's resiliency.

UM care management extends beyond traditional utilization management functions. Members assigned to Level I care management services also have access to a utilization management team that provides care management activities. These activities include:

- member outreach and education
- care coordination services
- referrals to provider and community resources to address a member's physical health, behavioral health and social support needs
- transition of care activities.

Level II Care Management: Recovery Care Management (RCM)

When more intensive care management is necessary, the member is assigned to Level II Care Management: Recovery Care Management, referred to as RCM. Magellan recognizes that there are high-need, high- risk members who require intensive care management and coordination to support their recovery and resiliency efforts, to assist them to remain in a community setting, and remove barriers to improved outcomes. RCM is a collaborative process in which Magellan assesses, plans, implements, coordinates, monitors, and evaluates options and services required to meet members' needs on an ongoing basis. RCM is designed for adults with serious and persistent mental illness (SPMI) as well as children and adolescents diagnosed with a serious emotional disorder (SED), and other members with special needs who frequently use crisis services, have recurring readmissions to 24-hour levels of care, or have complex needs.

Magellan's RCM is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's clinical and medical needs. The primary focus is on behavioral health needs; the intensity of this process varies based on the individual's needs and situation.

RCM participants show significant improvements in depression, anxiety, as well as coping skills at discharge. In addition, they have experienced a reduction in emergency room visits and admissions to inpatient psychiatric care, fewer crisis calls, and increased community tenure. RCM participants also have fewer missed days from work, school, or other activities due to health reasons. For example, in the five year period after initiation of this program in Lehigh County, Pennsylvania, the percentage of members in the program who were discharged from the program and achieved 90 days of community tenure increased from 72 percent to 95 percent.

Goals and Objectives of the Recovery Care Management Program

The goal of RCM care management is to optimize the physical, social, and mental functioning of high risk special needs members. The overarching objectives of our resiliency based RCM are to:

- increase community tenure
- reduce readmissions and prevent inappropriate hospital re-admissions
- enhance support systems
- improve treatment efficacy through advocacy, communication, and resource management
- develop and implement interventions to support member treatment gains, improve treatment adherence and improve the coordination of care among multiple providers
- decrease suicidal/homicidal gestures and psychotic episodes
- address health complications as part of the behavioral health plan of care
- facilitate substance use disorder treatment
- prevent relapse reduction
- confirm diagnostic accuracy and appropriateness of treatment goals
- facilitate progress in treatment
- coordinate treatment intensity and levels of care to be consistent with the current level of distress.

Level III Care Management: Integrated Whole Health (IWH)

Integrated Whole Health (IWH) care management is designed for members who have both chronic medical conditions **and** serious mental illness, such as serious and persistent mental illness (SPMI) or a serious emotional disorder (SED). Members eligible for the RCM program, due to serious mental illness or special needs, will be eligible for IWH when they are also enrolled in a Physical Health-Managed Care Organization's (PH-MCO's) Disease Management Program, or when they have been identified as having a co-morbid physical health condition. A multi-disciplinary care team will support members in IWH with their care treatment, in planning, goal-setting and follow-up activities as described below.

Nurse Integrated Care Coordinators (NICCs)

The IWH program will be staffed by Nurse Integrated Care Coordinators (NICCs) who are employed by Magellan's Nebraska Care Management Center (CMC) and work under the direction of the Care Management/Utilization Review Director. NICCs are registered nurses with training and experience in both physical and behavioral health care. They are able to address the member's whole health needs and help providers and members achieve a holistic approach to reaching individual health goals. We will assign members enrolled in IWH to an individual NICC who will work in collaboration with the member's PH-MCO's case manager or Disease Management program to help members achieve optimum health and well-being.

Peer Whole Health and Wellness Coach

Peer Recovery Navigators will also participate as another critical member of the IWH multi-disciplinary care team in the role of Peer Whole Health and Wellness Coach. In this role, they will

assist NICCs and care manager as necessary. These staff members will be trained to provide member outreach and education. They will also help members with self-management strategies to cope with their physical health conditions and to improve their adherence to the member's own plan of care. **Magellan believes that the Peer Whole Health and Wellness Coach role is a key part of the multi-disciplinary care we will provide, and will play a significant part in fostering effective integration of behavioral and primary care health care.**

Provider and Member Resources and Tools

Our care management model is designed to engage members, physicians and other providers involved in the care of the member in the care planning process. Magellan has extensive experience in the development and implementation of management resources and tools to support providers in providing effective and coordinated care, helping members navigate the complex delivery system, and supporting members to become more active participants in their own health care. We will offer a myriad of care management tools, resources and supports for the Nebraska Behavioral Health Managed Care Program, including:

- PCP coordination and support
- member support and education
- integration, collaboration and coordination with the PH-MCOs.

Quality Management

Magellan's QAPI Program

The chief goal of Magellan Behavioral Health of Nebraska is to ensure the provision of quality behavioral health care, prevention, and support services in a safe, efficient and effective manner to Nebraska Medicaid and CHIP members. To support this goal, Magellan has developed a governance and quality assurance and performance improvement program designed to continuously improve the quality of care and services provided to all our Medicaid and CHIP members, and to identify and act upon opportunities for improvement. For 10 years, Magellan has been working collaboratively with MLTC in Nebraska in effectively managing and monitoring the quality of care provided to its members.

The Nebraska Governance Board is the umbrella entity that will maintain responsibility for Magellan's Quality Management program. The Governance Board, made up of an equal number of representatives from Magellan and diverse community stakeholders, is fully described in the *Corporate Overview* section (*i. Summary of Bidder's Personnel Management Approach*) and in our response to the first question regarding the Prinicples of Care (*Section IV. B. Principles of Care*) in the *Proposed Implementation Appropach* of this proposal. Reporting to the Governance Board is the Quality Assurance Performance (QAPI) Committee. Six subcommittees will report directly to the QAPI Committee. In addition, Magellan will establish Consumer-Family Evaluation teams that will provide input and link directly to the QAPI Committee. Magellan's governance and quality structures are described below, followed by a brief description of each entity.

Quality Assurance Performance Improvement (QAPI) Committee

The QAPI Committee has oversight of the Nebraska Quality Management program. The COO and Quality and Compliance Director will co-chair the QAPI Committee. Key responsibilities of the QAPI include:

- development and implementation of the Quality Improvement (QI), Utilization Management (UM), Recovery Care Management (RCM), Integrated Whole Health (IWH), and Medical Integration and Recovery/Resiliency programs
- recommendation and approval of key quality activities, including approval of the annual Quality Program Description, with prioritized objectives
- preparation of annual Quality Work Plan, with performance measures
- completion of the Quality Program evaluation.

The QAPI structure ensures a method for providers, consumers, family members, and other stakeholders to have input into the Quality Program.

The QAPI Committee provides oversight, direction and coordination of activities within and between its functional sub-committees. The sub-committees, described below, provide direct oversight of quality functions and facilitate rapid process change when opportunities for improvement are identified. The chairs of the sub-committees are members of the Quality Improvement Committee and serve as owners of sub-committee communications and deliverables. Members of the QAPI Committee include executive representatives from each of the Magellan departments, and designated stakeholders. The Nebraska QAPI Committee meets monthly.

The sub-committees that the QAPI oversees are the following:

Member Services Committee (MSC)

The Member Services Committee (MSC), chaired by COO, has authority over the implementation and ongoing monitoring of member services activities, including complaint and grievance activities. This includes telephonic access, provider accessibility, complaints/grievances, satisfaction surveys, and confidentiality issues.

Regional Network Credentialing Committee (RNCC)

The primary mission of the Nebraska Regional Network Credentialing Committee (RNCC) is to oversee the suitability and quality of providers serving its members. Additionally, for the purposes of credentialing and re-credentialing, the RNCC is responsible for providing a component of local peer review of regionally assigned providers.

Provider Advisory Committee (PAC)

Magellan has successfully implemented a Provider Advisory Committee (PAC) model in Nebraska and has successfully implemented similar provider groups in multiple states. Our PAC exists today and will be expanded and enhanced for the new program. The intent of the PAC is to ensure ongoing collaboration between Nebraska Medicaid Managed Care Plan providers,

Magellan, and the Nebraska Department of Health and Human Services in ongoing efforts to improve the behavioral health service system of Nebraska.

Collaborating for Kids Committee

The Collaborating for Kids Committee provides input from advocates, providers and members about behavioral health care services for youth and families. Meetings will be held at least quarterly. Goals of the group include supporting treatments that respond to the needs of youth and build on their strengths; helping create new ways for youth to stay in or go back to their homes and families; and promoting community services across Nebraska.

Nebraska Corporate Compliance Committee

The Nebraska Corporate Compliance Committee's primary mission is to establish a culture within the Care Management Center (CMC) that promotes adherence to applicable legal, contractual and policy requirements, and promotes the prevention, detection and resolution of conduct that does not conform to those requirements. The Nebraska Corporate Compliance Committee is responsible for reviewing, revising, approving, and implementing policies and standards in accordance with local, state, and federal law; developing operational procedures consistent with the policies and standards; and ensuring compliance with all regulatory, accreditation and MLTC requirements.

Clinical Advisory Committee (CAC)

Pursuant to the RFP requirements, Magellan will develop, establish and maintain a Clinical Advisory Committee (CAC) to facilitate regular consultation with experts who are familiar with standards and practices of mental health and/or substance use disorder treatment for adults, children and adolescents in Nebraska.

N. Information System (IS) Requirements

Magellan has been operating in Nebraska since June 2002, and we are intimately familiar with the contractual operating and reporting requirements of the Medicaid & Long Term Care (MLTC) programs. We have reviewed, understand and will comply with all of the requirements included in Section N of the Scope of Work. **A detailed description of our Health Information Systems (HIS) is included as Sub-section IV.N of the Proposed Implementation Approach section of this proposal, entitled "Health Information Requirements."**

1. Health Information Systems – Requirements

HIS requirements are addressed throughout the Health Information Requirements section (*Sub-section IV.N* of the *Proposed Implementation Approach*), particularly in response to Question 1, where we provide a general description of the HIS.

2. Health Information Systems – Functions

HIS functions are addressed in the Health Information Requirements section (*Sub-section IV.N* of the *Proposed Implementation Approach*), particularly in response to Question 1, where we provide a general description of the HIS, and Question 5, which describes our Claims Processing System.

3. Health Information Systems – Encounter Data

HIS encounter data reporting is addressed in the Health Information Requirements section (*Sub-section IV.N* of the *Proposed Implementation Approach*), particularly in response to Question 3, where we describe our process for ensuring completion of encounter data submissions, and Question 4, where we address the data certification process.

4. Health Information Systems – Information Availability

Magellan's ability to meet the RFP requirements for making all data available to the State is described in our response to Question 1 of the Health Information Requirements section (*Sub-section IV.N* of the *Proposed Implementation Approach*), which includes a discussion of data reporting. Information availability is also addressed in Question 3 regarding encounter data, and Question 4 regarding the data certification process.

5. Care Management and Care Coordination Information

Information on Magellan's IS capacity is described in our response to Question 1 of the Health Information Requirements section (*Sub-section IV.N* of the *Proposed Implementation Approach*), which includes a description of interfacing capabilities, data integration and reporting.

6. *Provider Network Management System Support*

Magellan's HIS provides information technology support to manage the provider network, as described in our response to Question 1 of the Health Information Requirements section (*Sub-section IV.N* of the *Proposed Implementation Approach*), which describes our HIS approach.

7. *Claims Payment*

Magellan plans to use Claims Adjudication and Payment System (CAPS), a commercially developed claims system that supports all eligibility, benefit, and claim functions, to meet the claims processing requirements stated in the RFP. A complete description of CAPS appears in our response to Question 5 of the Health Information Requirements section (*Sub-section IV.N* of the *Proposed Implementation Approach*), which describes our claims processing operation.

8. *Third Party Resources*

Please see our response to Question 5 of the Health Information Requirements section (*Sub-section IV.N* of the *Proposed Implementation Approach*), where we describe our claims processing operation. A complete description of our ability to meet the state's requirements regarding Coordination of Benefits and Third Party Liability appears toward the end of that section.

O. Transition and Implementation

Magellan has been the administrative services organization for MLTC-funded behavioral health services for the past 10 years, and has the existing knowledge, relationships and infrastructure necessary to assure a smooth transition to a full risk program without a disruption in care for members or to the system as a whole. **A detailed description of our proposed transition and implementation process appears in *Sub-section IV.O* of the *Proposed Implementation Approach* section of our proposal.**

1. Transition Period

The timeline presented here highlights critical implementation milestones including the RFP requirements for a 90-day transition period after the start date. [redacted]

2. Preliminary Implementation Plan

Magellan will create a comprehensive implementation plan that clearly defines all strategic milestones met or in development, tactical tasks, responsible parties, dependencies, and timeframes. A preliminary draft of that plan, as referenced in the Transition and Implementation section (*Sub-section IV.O* of the *Proposed Implementation Approach*) can be found as **Attachment U**: Draft Implementation Plan.

4. Preliminary Implementation Plan - process

Magellan will begin a collaborative process with MLTC to develop the Preliminary Implementation Plan as part of the terms of the proposed contract.

5. Personnel

Magellan is committed to providing necessary staff resources to ensure a smooth transition with minimal disruption to members. Transition staffing appears in **Table IV.O.1.1** of the Transition and Implementation section (*Sub-section IV.O* of the *Proposed Implementation Approach*).

6. The Transition/Implementation Process in Collaboration with MLTC

Magellan is committed to clear communication and transparency in developing its transition process. The Transition and Implementation section (*Sub-section IV.O* of the *Proposed Implementation Approach*) describes our approach to collaboration with MLTC.

7. Implementation Period and Plan

A preliminary draft of Magellan's comprehensive implementation plan can be found as **Attachment U: Draft Implementation Plan**. A description of how Magellan finalize the plan, and the critical areas of focus for supporting the transition of the program to a fully integrated model, are included in the Transition and Implementation section (*Sub-section IV.O* of the *Proposed Implementation Approach*)

8. Personnel

Magellan understands the requirement that key personnel must be named no later than two months after the award of the contract, and we are fully prepared to meet that timeline, with many key positions already filled.

9. Transitioning of Behavioral Health Recipients and Operations

Magellan is fully prepared to abide by all requirements described in the RFP regarding the transitioning of behavioral health recipients and operations. As the incumbent with a strong working relationship with MLTC, transition issues should be minimal. Magellan will accommodate the State's requirements for the transition of Nebraska's current fee-for-service behavioral health Medicaid program to a risk-based program.

10. Operational and Financial Readiness Reviews

Magellan understands the state's requirements for Operational and Financial Readiness Review prior and subsequent to the contract start date, described in the RFP. We are fully prepared to abide by those requirements, including providing MLTC with access to staff, documentation and work space as requested.

11. Performance Measurement

Magellan has read, understands, and is prepared to comply with the state's requirements for performance measurement. We acknowledge that performance guarantees and incentives will be effective on the contract start date, and we are fully prepared to submit performance data on the established metrics.

Magellan has reviewed the RFP sections describing performance assessment and failure to perform and we are committed to compliance with those requirements.

P.1. Medical Loss Ratio (MLR) for Contract Year

P. Finance, Reporting Requirements and Rate Setting

1. MLR

Magellan has reviewed, understands, and will fully comply with the Medical Loss Ratio requirements as described in the Project Description and Scope of Work section of the RFP.

2. Administrative Cap Requirements

Magellan has reviewed, understands, and will fully comply with the Adminsitrative Cap requirements as described in the Project Description and Scope of Work section of the RFP.

3. CY Risk Corridor

Magellan has reviewed, understands, and will fully comply with the Risk Corridor requirements as described in the Project Description and Scope of Work section of the RFP.

4. Reinvestment Plan

Magellan has reviewed, understands, and will fully comply with the Reinvestment Plan requirements as described in the Project Description and Scope of Work section of the RFP and clarified in the Addendums, including the funding sources and the Escrow Account elements.

Our approach builds on work we started in Iowa in 1995, where we pioneered the concept of reinvestment of managed behavioral care savings into innovative, community-based services. We have also developed community reinvestment programs in Pennsylvania and Arizona. A complete description of Magellan's process for establishing the Reinvestment Plan in Nebraska can be found in the Proposed Implementation Approach section of this proposal, in our response to the first question in the "Finance, Reporting Requirements and Rate-Setting," in *Section IV.P* of the *Methodology/Work Statement* section of the RFP.

5. Financial Data & Reporting Requirements

Magellan has reviewed, understands, and will fully comply with the Financial Data and Reporting requirements as described in the Project Description and Scope of Work section of the RFP. This includes, in addition to other reports as required by the RFP, a quarterly and annual financial reporting package.

6. Deliverables

a. Grievance Systems

Levels of Review and Timing: Grievances

Magellan Behavioral Health of Nebraska , Inc. will provide a mechanism for members to express grievances—an expression of dissatisfaction. Grievances can concern any matter other than an action, which is an appeal. Grievance topics may include, but are not limited to:

- access to care or service
- quality, timeliness and/or appropriateness of care or service
- Magellan's authorization or utilization process, or any other Magellan function.

The grievance process addresses and thoroughly investigates grievances, and provides the member a comprehensive and professional response to their concerns. Grievances are tracked and trended to facilitate the improvement of operations and staff performance in order to achieve the highest level of stakeholder satisfaction and care.

Magellan processes each grievance using applicable State and Federal law, contractual provisions, and Magellan's written policies and procedures. Magellan will provide members assistance in filing a grievance including completing forms and taking other procedural steps which include but but not limited to providing interpreter services and toll-free numbers that have capabilities for TTY (Text Telephone)/TTD (Telecommunication Device for the Deaf) and interpreter services.

Tracking Complaints and Appeals

A member may designate an authorized representative to request a grievance on his/her behalf. This grievance may be submitted at any time either verbally or in writing. The Magellan Comment System (CART) is used for tracking and maintaining records about the receipt and disposition of grievances. We use this information support performance monitoring and reporting. As part of ongoing quality management activities, the Member Services Committee, which reports to the Quality Assurance Performance Improvement Committee, reviews complaint, grievance and appeal statistics and outcomes as part of its role in monitoring quality and promoting performance improvement of member services.

As a matter of policy, individuals who make decisions on grievances are not involved in any previous level of review or decision-making. They are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding any grievance regarding a denial of a request for expedited resolution of an appeal, or any grievance that involves clinical issues.

Magellan will resolve grievances within State established timeframes not to exceed 90 calendar days from the receipt of the grievance request. **Currently, 100 percent of grievances received in Nebraska are resolved within the Magellan standard processing time of 30 days**. This

compares favorably to a National Magellan percentage of 98 percent with the standard of 30 days for all public sector business.

As directed by the RFP, Magellan will notify MLTC of all member and provider grievances within one working day of receipt, and follow up with the findings regarding the grievance and the proposed resolution prior to notifying the member or the provider. Magellan will track the types of grievances and report quarterly to MLTC during Service Effectiveness meetings. Magellan will comply with the State's established method to notify members or providers of the disposition of a grievance.

Levels of Review and Timing: Appeals

The appeal guidelines are in place to support the utilization review/management process. They are based on 42 CFR §438 regulations for Medicaid Managed Care (MMC) established by the Centers for Medicare & Medicaid Services (CMS) and national utilization review accreditation standards, as well as URAC and NQCA standards.

Members are notified of their rights to seek a reversal of a decision Magellan has made (an appeal) via the written adverse service authorization determination notice. Members can directly request an appeal and participate in the appeal process, or they may appoint a representative to request and/or participate in the process.

The member or provider may file an appeal with Magellan within 90 days from the date on the written notice of action letter. The member or their authorized representative (typically a provider) may file a standard appeal either orally or in writing and must follow an oral filing with a written, signed appeal. The member or the authorized representative may file an expedited appeal either orally or in writing. If the expedited appeal request is made verbally, the receipt date and time of the verbal expedited appeal request shall constitute the receipt date and time of the appeal request, regardless of whether or not a written copy is submitted on the same date or at a later date.

In handling the appeal, Magellan will provide members assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. Magellan will acknowledge receipt of each appeal and ensure that individuals designated to conduct the appeal review are peer clinical reviewers who were not directly involved in any previous decisions regarding the case, or are not a subordinate of any clinical reviewer involved in decision making regarding the case. Peer clinical reviewers for appeals are board-certified psychiatrists, except in one instance. If the appeal is about psychiatric testing, a psychiatrist will review the appeal.

Magellan will treat oral inquiries as an appeal. We will provide the member or their representative an opportunity to present evidence, and allegations of fact or law, orally as well as in writing and provide opportunity, before and during the appeals process, to examine the case file, including medical records, and any other documents and records considered during the appeals process. Magellan will include, as parties to the appeal, the member and his or her authorized representative or the legal representative of a deceased member's estate.

Each appeal is processed in a timely manner consistent with the identified clinical urgency of the member's situation at the time of the request. A thorough review of the substance of the appeal will be conducted, including any aspects of clinical care involved. The appeal process is completed and the notice issued as expeditiously as the member's health condition requires, within State-established time frames that may not exceed the time frames specified in 42 CFR §438.408—45 days from the day Magellan received the appeal. Magellan standards for resolving appeal requests are 14 days from the initiation of the appeal for standard situations, and within 72 hours from the initiation of the appeal for expedited situations.

Process for Expedited Review

An expedited appeal review is conducted when the member or their authorized representative indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Both an expedited appeal review decision and the written notification of the decision are made within three business days of receipt of the initial verbal or written request for appeal review. Magellan also makes a reasonable effort to provide oral notice of the expedited appeal determination within the same business day of the receipt of the initial verbal or written request for appeal review. The three business day time frame may be extended up to 14 calendar days if the member requests the extension and Magellan can document that there is a need for additional information and how the delay is in the member's interest. When Magellan grants an extension, the member shall be notified in writing of the reason(s) for the delay and of the recipient's right to file a grievance if he or she disagrees with the extension.

Appeals are documented in the designated system and other records relevant to the appeal are maintained according to State and Federal standards.

Member Access to State Fair Hearing

Magellan complies with state fair hearing requirements, which are based on 42 CFR §438 regulations for Medicaid Managed Care, as established by CMS and national utilization review accreditation standards.

The member will have up to 90 calendar days from the date of Magellan's original notice of action to request a state fair hearing, which can only be granted by the state. The parties to a state fair hearing include a representative from Magellan, the member, the member's authorized representative or the representative of a deceased member's estate.

Continuation of Benefits

Magellan will continue the member's benefits while the internal Magellan appeal and/or the state fair hearing is in process, if the appeal is filed timely. "Timely" filing means filing on or before the later of the following:

- within ten days of Magellan mailing the Notice of Action
- the intended effective date of Magellan's proposed Action.

Magellan will continue the member's benefits if:

- The member or the provider files the appeal timely.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The original period covered by the original authorization has not expired.
- And if the member requests extension of benefits.

If, at the member's request, Magellan continues or reinstates the member's benefits while the appeal is pending, the benefits will be continued until one of following occurs:

- The member withdraws the appeal.
- Ten days pass after Magellan mails the notice, providing the resolution of the appeal against the member, unless the member, within the 10-day time frame, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.
- A State Fair Hearing Office issues a hearing decision adverse to the member.
- The time period or service limits of a previously authorized service has been met.

b. Provider Network

i. Individual GeoAccess maps for the Magellan provider network are included as **Attachments Q,** R and S.

ii. The standard Magellan provider agreement for individual providers is included as **Attachment T.** The standard Magellan provider agreement for group providers is included as **Attachment T.** The standard Magellan provider agreement for facilities is included as **Attachment T.**

iii. The Magellan Behavioral Health of Nebraska provider directory is included as **Attachment G.**

c. Member Communication

Magellan understands and is prepared to comply with the requirement to provide potential enrollee correspondence for review by the State as part of the deliverables due under the terms of the proposed contract. Under the new contract, Magellan will update the look and feel of the existing Nebraska *Member Handbook* to meet the newest Magellan standards. We have attached a copy of the Louisiana *Member Handbook* that will be used as a model for the new Nebraska *Member Handbook*. See **Attachment F.** Magellan Louisiana Model *Member Handbook* for Nebraska.

d. Quality Assessment and Performance Improvement

Magellan will have written policies and procedures regarding quality assessment and performance improvement as part of the deliverables due under the terms of the proposed contract.

e. Certification and Pragram Integrity

Magellan will have a written data certification plan and Mandatory Compliance plan available as part of the deliverables due under the terms of the proposed contract.

f. Legislatively Required Reporting

Magellan of Nebraska has a long history of meeting requirements developed by the Legislature of Nebraska. Recently, Magellan of Nebraska has developed reporting to comply with new legislation for LB1063 regarding reporting authorizations and denials, and has been helping the MLTC assist Children and Family Services (CFS) in preparing information related to LB1060.

i. Neb. Rev. Stat. §81-3134 (2012); and

This law requires a report be developed of many issues surrounding children with co-occurring conditions of an intellectual disability and mental illness. Magellan would be enthusiastic to work in partnership with MLTC on recommendations to provide more integrated and coordinated treatment for these individuals across the separate and distinct entities of the divisions of DHHS. Once the target population is identified, Magellan of Nebraska can provide the types of treatment services offered, denied, the costs of services that actually took place (when Magellan has paid the claim), We would also be happy to work with the DHHS departments on the services that were available, but not requested to be paid by the Medicaid risk contract. Magellan of Nebraska has worked in partnership with Nebraska Families Collaborative on blended funding approaches to best serve the target population, and this experience would carry forward to this project to ensure this population receives the best possible treatment services.

ii. Neb. Rev. Stat. §68-2005 (2012)

This law requires Magellan of Nebraska to follow the medical necessity criteria that have been adopted and promulgated as rules and regulations pursuant to the Administrative Procedure Act. In LB1063, there are reports required on the number of denials and authorizations in a specific format. Magellan has already created the reports that meet this requirement, and would intend to continue this quarterly reporting requirement into the future. Changes to the current report can certainly be accommodated upon request by MLTC or the Legislature, as would be expected once a new report is created and analyzed.

g. Monthly Reporting to MLTC

Magellan has reviewed the reporting requirements set forth in the RFP. We currently produce the following monthly reports for the State of Nebraska, and we will provide them as part of the monthly reporting requirements under the terms of the proposed contract.

Report Name	Requested Timeframe
Provider Termination	Monthly
Eligible and number authorized for services	Monthly
Youth Wards in Residential Care, Group Homes and Foster Care	Monthly
Out of State Placement Report	Monthly
ICM Report	Monthly
Duplicate Services Report	Monthly
Multi-Level Readmit Report	Monthly
Shifted Authorized/Registered Services Report	Monthly
Provider Scorecard	Monthly
Average Length of Stay Comparison	Monthly
Outpatient Claims Utilization Report	Monthly
Top Primary Diagnosis by Service	Monthly

In addition to the reports currently prepared, Magellan will provide three additional reports as part of the monthly reporting deliverables due under the terms of the proposed contract:

- Claims Processing
- Third Party Liability
- Claims Totals by Month.

h. Quarterly Reporting to MLTC

Magellan has reviewed the quarterly reporting requirements set forth in the RFP. We currently produce the following quarterly reports for the State of Nebraska, and we will provide them as part of the quarterly reporting requirements under the terms of the proposed contract.

Report Name	Required Timeframe
Provider Network Summary	Quarterly
Provider Access Analysis	Quarterly
Geo-mapping report	Quarterly
Grievance and appeals process compliance	Quarterly
Timely access standards monitoring	Quarterly
Utilization Management	Quarterly
Quality Oversight Committee Report	Quarterly
Network expansion/Credentialed and Contracted Providers	Quarterly
Contracted Residential Bed numbers	Quarterly
Number of Days on Residential Wait List	Quarterly
Residential Provider Acceptance Rate	Quarterly
Call Center Performance	Quarterly
Restraint and Seclusion QIA Report	Quarterly
30 day Inpatient Readmission Report	Quarterly
7 and 30 day Ambulatory follow up following residential discharges	Quarterly
7 and 30 day Ambulatory follow up following inpatient discharges	Quarterly
Critical Incident Reporting	Quarterly
Admissions and readmissions to Psych inpatient (including PRTF) and residential facilities Note: We do not currently track on a quarterly basis readmissions to residential.	Quarterly
Continuity of care (within 7 days) from psychiatric inpatient facilities to community services	Quarterly

Report Name	Requested Timeframe
Number of children placed in residential treatment settings, relative to number of Medicaid members and relative to national benchmarks	Quarterly

In addition to the quarterly reports currently prepared, Magellan will provide four additional reports as part of the quarterly reporting deliverables due under the terms of the proposed contract:

- Results of Fraud and Abuse Monitoring
- Results of Service Verification monitoring
- Out of network referrals monitoring
- Care Management Results.

i. Annual Reporting to the State

Magellan has reviewed the annual reporting requirements set forth in the RFP. We currently produce the following annual reports for the State of Nebraska, and we will provide them as part of the annual reporting requirements under the terms of the proposed contract.

Report Name	Required Timeframe
Annual Quality Management Work Plan for Coming Year	Annual
Performance Measures data	Annual
Results of Quality Management Work Plan	Annual
Performance Improvement Project data and results	Annual
Member Satisfaction Survey Results	Annual
Provider Survey results	Annual
Results of any corrective action/sanctions of providers.	Annual

j. Policies and Procedures

In the course of its work with the State of Nebraska Magellan has developed policies and procedures referenced in this RFP. Magellan will provide written policies and procedures for the following areas as part of the deliverables due under the terms of the proposed contract:

- Advance Directives
- Member Communications
- Third Party Resource (TPR)
- Member Rights
- Member Free Exercise of Rights
- Compliance with Federal and State Laws and Regulations
- Coverage of Emergency and Post-Hospitalization Services
- Substitute Health Services
- Disease Management Services
- Behavioral Health Screening/ Risk Assessment
- Members with Special Needs
- Indian Health Protections
- Access to a Second Opinion
- Provider Credentialing and Re-Credentialing
- Selection and Retention of Providers
- Subcontractor Oversight
- Clinical Practice Guidelines
- Utilization Management
- Member Satisfaction
- Provider Satisfaction Surveys
- Fraud, Waste, and Abuse Prevention
- Service Verification
- Provider-Preventable Conditions Including Health Care-Acquired Conditions.

P.6.k.
Methodology/Work Statement
(see ii. Proposed Implementation Approach)

k. Methodology/Work Statement

Please see tab labeled "*ii. Proposed Implementation Approach*" for a description of Magellan's proposed methodology and statement of work.

II. Proposed Implementation Approach Methodology/ Work Statement

ii. Proposed Implementation Approach: This section of the proposal shall describe the Contractor's overall technical approach to the Scope of Work described in the RFP. Bidders must respond to the statements and question contained the Methodology/Work Statement. Bidders must list each statement/question and then follow with the response. Bidders must answer "not applicable" to any item that is not relevant to their proposal.

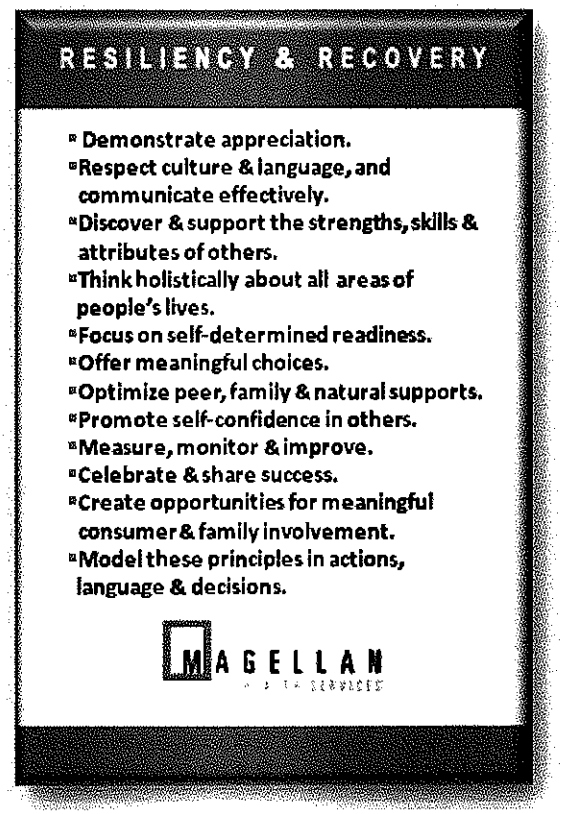
IV.B. Principles of Care

Describe how your BH MCO will operate to promote the Principles of Care. How will your BH MCO measure this requirement?

Magellan as a national company has been a leader in advancing the principles of recovery and resiliency in every program we manage. All of our initiatives and actions in Nebraska will allign with and promote the nine principles of care as outlined in the RFP.

While all managed behavioral health companies pledge their commitment to recovery, resiliency, and trauma informed care, Magellan has demsontrated its ability to design our programs and operations to truly deliever on these principles. [redacted]

As a company, Magellan holds itself to the highest standards of care for our members nationwide. In 2007, Magellan formalized our values and philosophy around principles of recovery and resiliency as presented below. These align closely with the Nebraska Principles of Care; both emphasize respect and responsiveness to culture and language, and both are consistent with the SAMHSA "Guiding Principles or Recovery" and the National Wraparound Initiative's "10 Principles of Wraparound." For example, Magellan's and SAMHSA's principles support a holistic approach; self-direction, and self-determination; valuing peer and allies' supports (e.g., family and natural support), integration and coordination of services; and trauma-informed supports that foster physical and emotional trust. Common tenets of Magellan's core principles and the 10 Principles of Wraparound include family voice and choice, natural supports, collaboration, cultural competence, and individualized and strength-based care.



With the principles closely aligned, MLTC, the members, and stakeholders of the Nebraska system of care can be assured that Magellan Behavioral Health of Nebraska will continue to promote the general principles of recovery and resiliency as well as the established Nebraska principles. [redacted]

How Magellan Behavioral Health has Modeled the Principles in Nebraska

As these core principles are so closely aligned with the Nebraska Principles of Care, we are well on the path toward operationalizing the Nebraska set of principles. Following are examples of our activities in Nebraska during the past two years that have promoted the Principles of Care.

[redacted]

[redacted]

"It is wonderful to have the CANS assessment available. It is a family-friendly and strength-based standardized approach to assisting families"

– Candy Kennedy, Executive Director, Nebraska Federation of Families for Children's Mental Health

[redacted]

[redacted]

Laurie's Story: A Son Returns Home

"After needing out-of-home residential and hospital treatment, our son came home. We are very happy to have him home. His transition has been a very unique experience for each of us. He met two goals of his return: he got a job and got his learner's permit to drive. He was able to accomplish these things after much effort and encouragement. I would say that it has been one of the best summers of my recent years, to simply have him home. I told him that, and I pray this is a message that will sink deep into his own heart someday, because his years away were very difficult for all of us. Now, he sees a therapist and a psychiatrist, and at times I am pretty worn out from all the scurry. But when I see him work through something, and I get a smile and a hug...it is all worthwhile."

– Laurie, Norfolk parent>>)

[redacted] Our connections with parents and caregivers has enriched our efforts, promoting the Principles of resiliency-based system of care for children and their families and family voice and choice. [redacted]

[redacted]

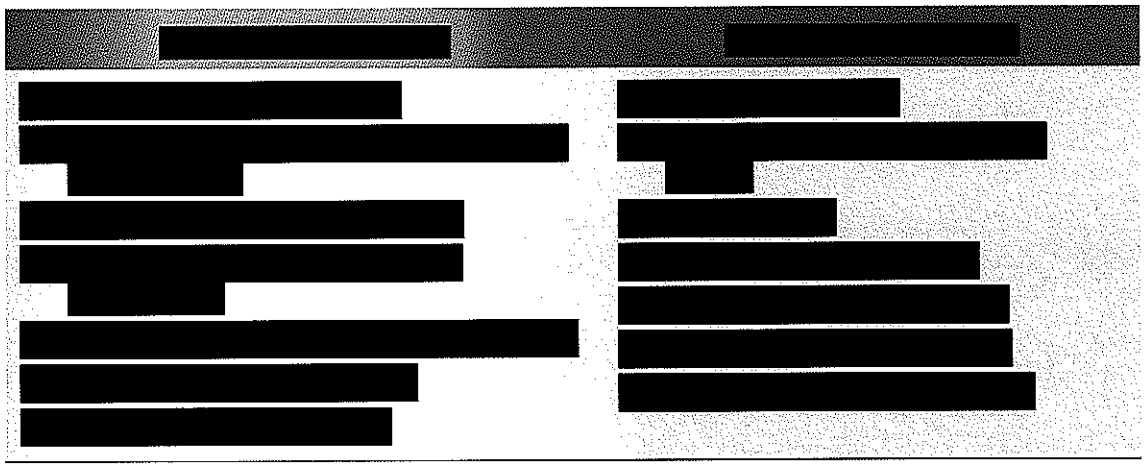
How Magellan will Promote & Operationalize the Principles Going Forward

Magellan will further promote and assure adherence to the Principles of through Magellan's governance and organizational structures, training, resources, tools, and measurements.

Governance, Shared Decision-making and Quality Structures that will Support Principles of Care

[redacted]

[redacted]



[redacted]

[redacted]

[redacted]

Member Choice a Fundamental Right

Member choice is a cornerstone of Magellan's approach to service delivery. Magellan has a "no wrong door" approach allowing members to select their own provider based upon their geographic and cultural preferences. Members may select a provider from the provider directory, or may call Magellan's toll free line for assistance in locating a provider in the community where they live. Should no provider be available within the network, Magellan reaches out to the provider to bring them in network as appropriate and/or sets up an ad hoc agreement to assure access by the member and payment to the provider. Choice also includes having access to a second opinion. Magellan of Nebraska members have the right to request a second opinion from a network provider at no cost to the member.

[redacted]

Training, Resources, Activities, and Services that will Promote Principles of Care

New Webinar Series

Magellan will develop a dedicated webinar series about the Principles of Care, with specific goals and learning objectives for each webinar in the series. The webinars will be presented live and archived for on-demand future viewing, with each webinar's presentation and associated handouts available for download at the MagellanofNebraska.com website. We will work engage the full range of systems of care stakeholders to help shape the overall series. Continuing education credits will be offered to participants attending the live webinar events who meet CE requirements.

As noted above, all webinars are archived for later access. Magellan has already conducted webinars that emphasize and teach the Principles of Care to reach a broad range of Nebraska stakeholders, especially providers, peer and family advocates, leaders in the behavioral health field, and State agency partners. [redacted]

Training on Available Resources

Magellan will conduct regular trainings for providers about resources and tools that can help them put the Principles of Care into practice. We will start with an Outcomes Informed Care summit to train members and providers on the use of consumer -reported outcomes tools, clinical practice guidelines, and quality improvement tools. [redacted]

[redacted]

Training and Shared Learning

Magellan will use a variety of training and shared learning activities to promote fundamental values inherent in Nebraska's Principles of Care and help put them into practice. For example, we will provide access to on-demand, no-cost online courses via our Achieve and Essential Learning management systems for network providers. [redacted]

This is a best practice model addressing stigma and discrimination where trained consumers tell their personal stories of living with mental illnesses, including their recovery journey. The Principle of using trauma-informed services is promoted in our Essential Learning courses including *Does Your Organization Measure Up: Are You Really Trauma Informed*? This course was developed to help organizations assess their trauma-informed capabilities.

[redacted]

[redacted]

Community Engagement Activities

Magellan has relationships with an extensive range of Nebraska stakeholders in systems of care at different levels, particularly with peer and family organizations. We will expand our resources to support community engagement to further promote several of the Principles, including providing community-based and consumer and family-driven care; recovery involving individual, family, and community strengths and responsibility; and care that is supported by peers, allies, relationship, and social networks [redacted]

[redacted]

Substitute and Value Added Services

Our proposed substitute and value-added services reflect continuity with our accomplishments to date in Nebraska. However, they also reflect our knowledge of gaps in the current behavioral health delivery system in the state. The state's shift to a fully insured model will give Magellan the flexibility, on day one, to leverage our knowledge of the state's delivery system to address these gaps with new services and new approaches to care delivery. This proposed array of new

services will provide recovery-based care and add to a resiliency-based system of care for children and their families. These services will actively be promoting all the Principles of Care. A full description of our proposed Substitute and Value Added Services can be found in Section IV. G. [redacted]

[redacted]

Recovery Care Management (RCM)

Magellan recognizes that there are a group of high-need high cost members who require intensive care management and coordination to support their recovery and resiliency efforts, to assist them to remain in a community setting, and remove barriers to improved outcomes, which may result in avoidable hospitalizations. [redacted]

[redacted]

Continuation and Promotion of Best Practices

Magellan will continue to maintain existing initiatives while implementng new programs based on Evidence-Based Practices that promote the Principles of Care, such as services being strength-based, person-centered, and supporting recovery-based care and a resiliency-based system of care for children and their families. Orientations, trainings, and shared learning opportunities will be designed to promote the use of Evidence Based Practices. We will include consumers, family members, providers, and other systems of care stakeholders as partners in these activities. Medicaid substance use disorder services will be delivered using a recovery oriented focus and include a focus on co-occuring treatment models where a member is treated as a whole person and all needs are met.

Tools and Measurements that Ensure Adherence to Principles of Care

Using the methodologies and tools described below, Magellan will monitor how well our services and initiatives promote the Principles of Care. We will analyze the results, refine our operational strategies in order to improve performance. [redacted]

Treatment Record Review

Magellan's Treatment Record Review (TRR) process, which monitors the quality of services we provide through auditing of Members' treatment records, is designed to reflect Magellan's core principles of recovery and resiliency. These are also grounded in the Principles of Care related to services that are: responsive to linguistic, cultural and other unique needs; client and person-centered; consumer and family driven; age and developmentally appropriate; recovery-based care. The TRR tool assesses members' treatment records using specific indicators; for example:

- The assessment of a Member's strengths is written from the perspective of the Member and focuses on how the Member identifies and views his/her own strengths.
- Family and other external supports have been explored and either considered or included in treatment as indicated.
- The 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.

- 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.
- Evidence of treatment being provided in a culturally competent manner.

Moving forward, Magellan will continue to use Magellan's TRR tool as part of our process to monitor quality of care and promote the Principles of Care, and to conduct trainings and provide technical assistance to network providers to improve the quality of services.

[redacted]

Member Surveys

Our Member Satisfaction Surveys allow us to assess, from the Member's perspective, their level of satisfaction with the services they receive. We also administer a similar survey developed to allow us to assess the parent or guardian's perspective regarding their level of satisfaction with

the services received by Members who are minors. Respondents choose whether they agree or disagree with over thirty statements. The surveys promote several Principles of Care, such as services being consumer and family driven, family voice and choice, responsive to linguistic, cultural and other unique needs of any client of a cultural, racial, sexual, gender, or linguistic minority, or other special populations, services providing recovery-based care and resiliency-based system of care for children and their families. [redacted]

Provider Performance Indicator Dashboard

Our Nebraska Provider Performance Indicator Dashboard will be posted on the Magellan of Nebraska Web site and updated quarterlywith a set of actionable and meaningful measures for consumers, providers, and the community. These measures include well-respected standards such as length of stay, readmission, discharge to the community, and ambulatory follow-up based on authorizations. The Dashboard uses authorization-based measures for timely information, analysis, and intervention. Use of the dashboard helps measure success in promoting the Principle of services being provided in the community.

Summary

The Principles of Care provide *the foundation* on which all systems of care must be built. Together with SAMHSA's Guiding Principles of Recovery, the National Wraparound Initiative's 10 Principles of Wraparound, and Magellan core principles of recovery and resiliency, they provide the framework to support improvements along the many dimensions of recovery, resiliency, wellness, and community participation. These principles are critical to individuals and families successfully achieving their goals for health, home, purpose and community.

Magellan has proven approaches for promoting, integrating and operationalizing these principles in Nebraska and across our other publicly funded behavioral health contracts.

Going forward, we will continue to commit ourselves to putting the Principles of Care into practice through Magellan's culture of caring, knowing our principles of recovery and resilience are not just a poster on the wall, but rather are embedded in all that we do, across all areas of our operations. It is through our experience in developing opportunities for consumer and family inclusion and participation, creating organizational structures, developing tools, resources, trainings, and measuring our own operationalization of Magellan's core principles of recovery and resiliency that we have learned what it takes promote such values. Our

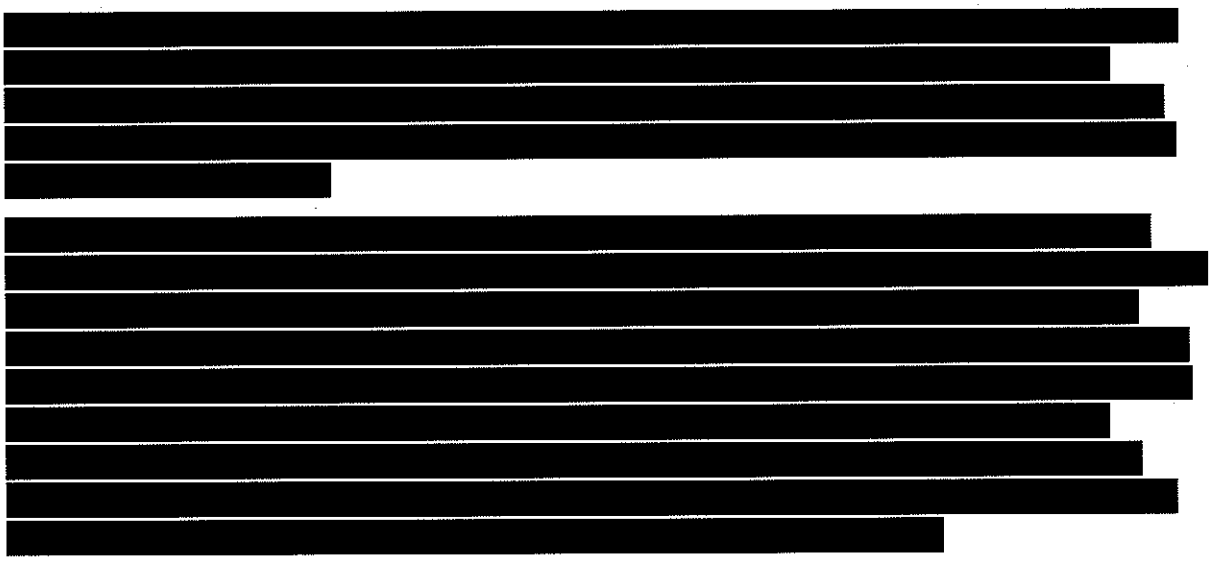
commitment to promoting Nebraska's Principles of Care is grounded in this experience. We believe that Magellan, working together with MLTC and the many other systems of care stakeholders, from Members and their families, consumer and family support/advocacy organizations to providers, provider organizations, other health care professionals and a range of State agencies and programs, the Principles of Care can not only be promoted, but become part of the culture of Nebraska's Behavioral Health Managed Care program.

Describe how your BH MCO will ensure that services provided are based on evidence-based care.

Our Approach for Ensuring Evidence-Based Care

Magellan promotes an evidence-based culture. A myriad of activities ranging from staffing, development and use of policies and procedures, implementation of practice guidelines, dissemination of provider communications, implementation of training, and provider coaching all support our ongoing efforts to sustain creative approaches to ensure that services provided are founded on evidence-based care. We value, seek, and act on input from consumers and family members to continually improve our practices. Engaging and involving consumers, family members, and other system stakeholders in meaningful roles is a key element in guiding and improving practices that promote the Principles of Care. In addition, Magellan believes in utilizing not only best practices for which there is evidence, but in identifying emerging best practices and for operating as a "learning organization" to continually improve provider practices.

Policies and Procedures for Clinical Practice Guidelines



When guidelines are adopted, Magellan writes an introduction to guide providers in the application of the guideline and to give updates to scientific literature when such are available. In addition, each of Magellan's Care Management Centers evaluates the guideline for its appropriateness in terms of meeting customer expectations, benefit plans, member populations,

and adherence to any customized utilization management criteria. As described below in more detail, all of Magellan's CPGs are made available to providers.

During Magellan's service authorization process, care managers review the providers' treatment plans to determine if they are using evidence-based care. If the member is not improving and the provider is not using best practices, the care manager will review various alternative approaches based on practice guidelines to assist the provider. Magellan takes actions for non-adherence to CPG and EBP requirements through provider communication, additional monitoring, and training or sanctions, as appropriate.

Provider Training

As new practices are introduced, Magellan schedules network-wide education sessions for providers. We also offer technical assistance and additional training on an ongoing basis to the provider community as needed. [redacted]

Best practices standards provide a basis from which to review care, promote consistency of practice and facilitate care management decisions. It is therefore not only critical for providers to be aware of such best practices, but to receive assistance in ensuring that service delivery is consistent with the best practice models. [redacted]

Provider Dissemination Mechanisms

Magellan offers several means of sharing CPGs and EBPs to our provider network. Clinical practice guidelines are maintained on our Web site www.MagellanofNebraska.com. [redacted]

[redacted]

Monthly Care Management Meetings

In Nebraska, Magellan offers the opportunity for clinically licensed staff to participate in subject specific training twice per month at care management meetings. Often times, these trainings will be offered by the CMC Medical Director or senior clinical staff regarding clinical issues specifically impacting Nebraska Medicaid members, as well as Nebraska-based providers. Given our relationships with Nebraska behavioral health providers, we become aware of training needs in a timely manner via our Town Hall meetings (discussed below), regularly scheduled meetings with Nebraska-based hospitals, as well as in our daily telephonic, electronic and face-to-face interactions with Nebraska providers.

Additionally, clinical staff from other Magellan CMCs will rotate and take responsibility for training clinically licensed staff from other public sector CMCs on clinical issues specifically impacting Medicaid members across the country.

Free Webinars

Magellan has extensive experience conducting no-cost educational webinars. Often, these Webinars feature nationally recognized subject matter experts addressing a range of topics important to providers, advocates, policy makers, and other stakeholders. All of Magellan's programs have used webinars as a training and education vehicle for providers and stakeholders. On November 19, as part of the 2012 series, Magellan hosted a webinar for Nebraska providers on "Microaggressions & MultiCultural Competence: Practical Strategies for responding to Bias." We had over 70 providers from Nebraska register for this event that offered CEU credits. Monthly webinars will be tailored to provide specific information and resources on topics to providers serving Nebraska members.

In 2012, Magellan has offered webinar training to Nebraska providers on issues related to trauma informed care, as well as changes that were proposed and made to the applications for and regulations of Psychiatric Residential Treatment Facilities.

Magellan has identified internal and external subject matter experts on these topics as presenters. Webinars will be approved for CEU credits by the Association of Social Work Boards, National Association of Alcohol and Drug Abuse Counselors, American Psychological Association, and the National Board for Certified Counselors.

Provider Educational Forums

For providers serving Nebraska Medicaid members, regional quarterly face to face forums will be conducted as part of our Town Hall meetings that are designed to provide information and

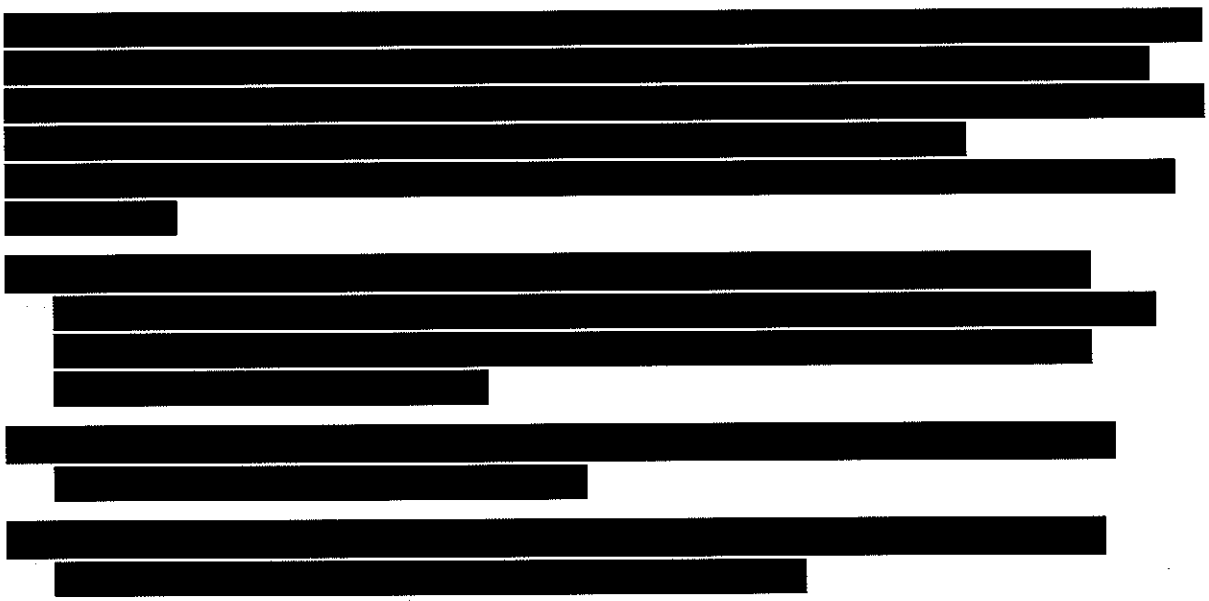
resources on the coordination of medical and behavioral health care services, managing individuals with mental health, substance abuse, and co-occurring disorders. Forums will provide an opportunity for participatory dialogue among providers to improve coordination, communication, and understanding of shared issues and concerns.

Additionally, Magellan clinical staff convenes monthly Child and Adolescent Needs and Strengths tool (CANS) Learning Collaborative meetings with all children's residential providers in an effort to improve communication and service delivery among those involved in planning treatment for a child or adolescent. Magellan produced a video training based upon the live training which allows any Magellan provider to become certified on-line.

Online Learning

The www.MagellanofNebraska.com Web site will also enable providers to earn free CEU credits by participating in online courses. Providers can receive free CEUs upon successful completion of a course. These courses provide concise, practical, and immediate information for busy clinicians, and assist organizations in maintaining the clinical competencies of their staff in a variety of important clinical areas. These courses can also be supplemented by Magellan or provider specific training modules.

Recovery and Resiliency E-Learning Center



Recovery and Resiliency E-Courses and Webinars—Magellan's e-learning courses on recovery, resiliency, and peer support have been viewed more than 13,000 times since their initial launch. Webinars from the 2010, 2011, and 2012 national series, co-sponsored with the College for Behavioral Health Leadership, are archived on the e-Learning Center, along with presentations and other handouts from the series. Course content also covers issues related to employment and economic development opportunities.

[redacted]

"PracticeWise has been an essential tool in disseminating evidence based practices at CHOICE Behavioral Health. It has proven beneficial for the research as well as most importantly the ability to deliver evidence based treatments and therapeutic outcomes. The system is simple yet houses a wealth of valuable information on direct live therapeutic process while allowing clinicians to maintain their own style of treatment. PracticeWise has assisted our therapists in making clinical decisions based on facts and actual data. When utilized in conjunction with an electronic record system and continuous quality improvement programs, PracticeWise is a critical piece of our practice that improves the quality of care we provide to our consumers."

Kim Hess, Tech, LMHP, LPC, NCC, Chief Operating Officer, Choice Behavioral Health, Omaha Nebraska

[redacted]

[redacted]

MAGELLAN BEHAVIORAL HEALTH

"The integration of the best available research with clinical expertise in the context of the patient characteristics, culture, and preferences."

This means that for some members, based on the clinical experience of the therapist, alternative approaches may be more successful for specific members than standard evidence-based treatment due to their background, belief system, or personal desires. [redacted]

Service Authorization Reviews

Whenever Magellan Care Managers review treatment requests, they are trained to confirm that treatment is evidence-based. Part of their review is to inquire about the treatment plan and interventions to ensure the provider is utilizing best practices. With medical oversight, care managers review and authorize continuing care at a review interval determined by the clinical complexity of the case. Magellan's written Medical Necessity Criteria Guidelines assist the care managers in determinations of when more frequent review and/or consultation with a peer advisor may be indicated. [redacted]

Treatment Record Reviews

Fidelity to CPGs is monitored as part of the provider the Treatment Record Review process. Routine Treatment Record Reviews are conducted to monitor network provider documentation and record keeping practices against established standards and to measure network provider performance against important clinical process elements and approved clinical practice guidelines. Treatment record reviews may also be conducted under special circumstances to investigate or follow up on quality of care concerns, adverse incidents, or complaints about the clinical or administrative practices of a provider.

With input from the State, specific CPGs will be selected for annual fidelity audits. Providers in the network are expected to comply with practice guidelines, and tip sheets, and educational supports are provided to support adherence to the guidelines.

Magellan Ensures Individualization of EBPs

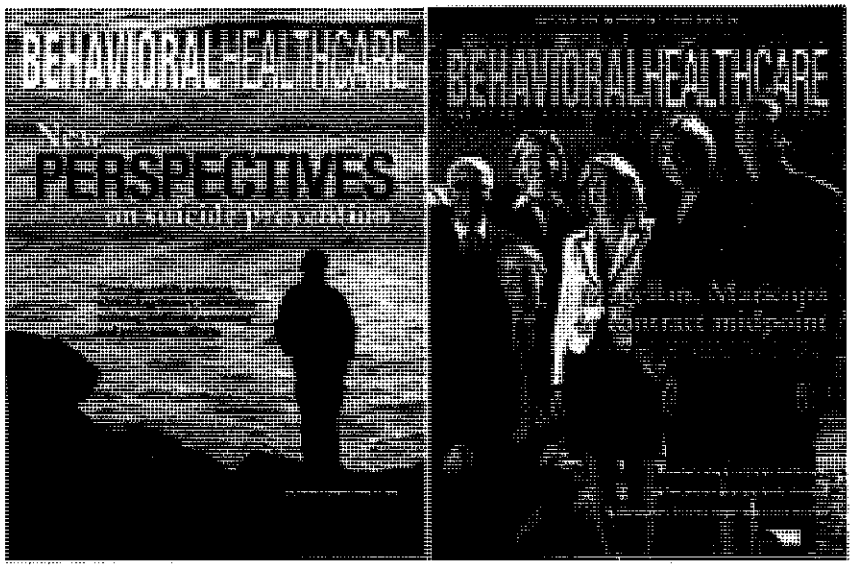
[redacted]

[redacted]

Developing Promising Practices through Clinical Leadership and Innovation

In addition to well established CPGs, Magellan's clinical and medical leadership partner with state mental health authorities to develop emerging "promising practices." Magellan has successfully partnered with state behavioral health departments for three consecutive years to reach the regional finals for the Council of State Governments annual Innovations Awards. Two of these projects were featured in *Behavioral Healthcare* magazine (see feature article thumbnails in Figure IV.B.2.2). [redacted]

Figure IV.B.2.2 - Feature Articles



[redacted]

Consumers and Family Members Help Improve Our Practices

Magellan has a long standing commitment to and experience with the inclusion of the active voice and participation of all persons affected by the behavioral health system of care. We understand the special importance of making sure consumers and family members have opportunities to participate in activities to improve services and supports in the behavioral health system. At Magellan, we have established mechanisms across our public sector programs to support this participation. We have formal structures, such as our quality improvement program committees. Consumer and family members are members of various committees and

are included in activities used to improve services, such as reviewing results from member satisfaction surveys. [redacted] Engaging and involving consumers, family members, and other system stakeholders in meaningful roles is a key element in guiding and improving practices that promote the Principles of Care. [redacted]

The Nebraska Care Management Center recognizes the need to respect and incorporate the preferences of consumers and families as a core strategy for improving the quality and effectiveness of care. Magellan will collaborate with MLTC to develop an approved consumer- and family-led evaluation component prior to implementation. [redacted]

[redacted]

Describe how your BH MCO will ensure services pravided are developmentally and culturally appropriate.

Magellan Behavioral Health is committed to operating a behavioral health delivery system that provides developmentally and culturally appropriate care to Nebraska Medicaid members. We target our practices, programs, network, and staff to best meet the age-specific needs of all members across the lifespan, and addresses the special needs of persons with developmental and intellectual disabilities. Magellan also recognizes the dynamic roles race, ethnicity, religion, socioeconomic status, sexual orientation, homelessness, and other cultural factors play in the ability of each member to access and experience effective behavioral health services. We intensively incorporate cultural sensitivity and competence into our network development, hiring, training, monitoring, and feedback mechanisms. [redacted]

Ensuring Developmentally Appropriate Services

Behavioral health issues and treatment needs change significantly across a person's lifespan. Magellan is committed to maintaining and training a care management workforce and a provider network that is sensitive to these needs and has expertise regarding developmental/intellectual issues. The Magellan of Nebraska provider network already includes providers who specialize in serving infants, children, adolescents, adults, and older adults, as well as those with developmental and intellectual disabilities. We have programs targeted to different populations across the lifespan and to those with co-occurring behavioral and developmental/intellectual issues. Further, Magellan's care management program is organized to serve children and adults with different teams of staff in recognition of the varied expertise needed to ensure care management is developmentally appropriate.

Magellan also assesses network capacity for all providers, including those serving children and persons with special needs such as older adults and persons with developmental/intellectual disabilities. In 2012, Magellan of Nebraska distributed a practitioner questionnaire to assess provider competencies related to the care of members with developmental disabilities and evidence-based practices. The survey allowed us to identify areas in which we had a need to recruit and/or train additional specialized skilled providers and informed our network development priorities

Care Management Programs Structured to Ensure Developmental Competence

Magellan's Care Management Department will specialize in the developmental and clinical needs of both children/adolescents and adults. Our Care Management Supervisors will oversee a cadre of staff who are trained clinical experts with these two distinct populations. They will be responsible to ensure that all care managers are aware of the age-appropriate community-based resources available to all Medicaid members across Nebraska, while developing and maintaining collaborative relationships with specialty providers, community-based organizations, advocacy groups, and local developmental/intellectual disability service agencies.

[redacted]

Special Programs for Children and Youth

Magellan has already implemented numerous activities and programs in Nebraska and elsewhere that specifically target children and adolescents: [redacted]

[redacted]

[redacted]

[redacted]

"It's always so inspirational to hear our youth share truly what they are experiencing and always with amazing solutions to the challenges personally and for our systems they interact with. They absolutely are the experts. Thanks so much for your presentation last night in Nebraska. I walked away with renewed energy!"

posted on Facebook by Candy Kennedy, Executive Director of Nebraska Federation of Families

[redacted]

Additional Programs for Consideration

Following are examples of services we have developed in other states in collaboration with our providers to ensure that we deliver behavioral health services that are appropriate for various different childhood stages. [redacted]

[redacted]

[redacted]

Special Programs for Older Adults

Magellan is sensitive to the special needs of older adults with behavioral health conditions including alcohol and/or drug use concerns and their caregivers. Through our national contracts with public sector and health plan customers, Magellan currently manages services for more than 376,000 persons 65 and older. Our national experience includes working with Dual Eligible members and Medicare Advantage programs. We look forward to leveraging this experience and expertise in collaboration with stakeholders to serve the needs of older adults in Nebraska.

Older adults tend to have a broader array of disabilities such as vision, hearing, psychomotor and cognitive deficits/dementia medical conditions, lower health literacy, greater social

MAGELLAN BEHAVIORAL HEALTH

isolation, poorer nutrition, greater stigma in seeking help for behavioral health issues, more life losses, and other challenges. These problems are compounded in rural areas where access to, availability of, and acceptability of behavioral health services are often lacking.

Providing developmentally appropriate behavioral health services that meet the complex needs of older adults is challenging and requires the collaboration of multiple stakeholders. Sometimes needed services can be provided in a clinic setting, but at other times they need to be available in the person's home. Community awareness of resources is important, so that other departments, services, and members are aware of available programs and can refer individuals in need.

[redacted]

To promote the provision of developmentally appropriate services and outreach to older adults by our provider network, we propose the following program components in Nebraska:

[redacted]

[redacted]

Special Attention to Persons with Mental Health and Developmental/ Intellectual Disabilities

To ensure that members with developmental and intellectual disabilities receive optimal, appropriate behavioral health care, Magellan will work with the Nebraska Association of Behavioral Health Organizations, the Nebraska Planning Council on Developmental Disabilities, Disability Rights Nebraska, and Developmental Services of Nebraska to identify all potential network providers skilled in the treatment of behavioral health issues for members with developmental disabilities to expand our network.

As part of our offering of online training opportunities to our network providers through the [redacted]

More information regarding our network capabilities to provide services to persons with mental health and developmental disabilities is presented in *Section IV.L*, in the fourth question regarding ensuring there are sufficient numbers of providers to meet special needs

Ensuring Culturally Appropriate Services

Inequities in access, availability, service delivery, service quality, and outcomes are often pervasive and long standing for individuals from diverse linguistic, racial, ethnic, socioeconomic and cultural backgrounds. Magellan will utilize the experience we have gained in Nebraska and in other states to ensure that the service delivery system is culturally and linguistically appropriate to the members served. [redacted]

[redacted]

In the 2012 adult member satisfaction survey, 87 percent of respondents felt that staff were sensitive to their cultural background (race, religion, language, customs, etc.). For the latest member satisfaction survey, 93 percent of respondents were satisfied with this same element.

A more detailed description for how we will further ensure culturally competent services follows.

Identifying Needs and Developing a Cultural Competency Plan

A multi-pronged approach to meeting cultural and linguistic needs will include thorough demographic studies and focus groups of members and families to learn about cultural, linguistic, and service needs. We begin by collecting population data from multiple sources such as Tribal Governments/Indian Health Services, local and state governments, in addition to our own data such as race and ethnicity of members, preferred languages, cultural identities preferred, and the types and frequencies of services prescribed and utilized. With the information obtained, we are able to start to identify the unique strengths of each region. Regional cultural mapping will produce an environmental scan of cultural and ethnic demographics.

Once we develop this background information, we will partner with providers, members, community leaders, and stakeholders to create a strategic plan to address the service gaps identified, strengthen weaknesses, and support system strengths. Collectively we prioritize the focus of the plan which includes languages needed, workforce strengths, community assets, effective outreach methods and materials, and programmatic needs. The Cultural Competency Plan builds continuous feedback mechanisms to update identified disparities and actions that need to be taken to best ensure equitable access and care.

Ensuring Cultural Competent and Diverse Provider Network

Magellan is committed to ensuring that our members have access to a culturally and linguistically competent provider network. We assess network capacity for all providers, including those serving culturally diverse priority populations. We implement plans to recruit needed providers to serve culturally diverse populations, as well as special cultural competency training (described below). [redacted]

Magellan takes a comprehensive approach to addressing the social, ethnic, and cultural diversity of the population. We identify the skills needed to reach out to members of various communities such as Hispanic, Native American, and rural communities. We will make every effort to contract with providers fluent in languages common in the community and representative of the membership demographics. We will meet or exceed the current capacity of qualified service providers to ensure culturally and linguistically appropriate services are and remain available to all members who need them. Strategies to maintain and grow the capacity of the provider network will emphasize local outreach to affected communities. [redacted]

Ensuring Cultural Competence through Training and Monitoring

Training and Monitoring Magellan Care Managers

As an important part of their initial and ongoing training, care managers complete annual cultural competence training. [redacted]

Moving forward, we will be increasing the amount of resources, education and training available to our staff and providers in Nebraska through a robust menu of webinars, communication e-blasts, technical assistance, and on site training beginning in 2013. The materials and training are being developed for Magellan by national experts in cultural competence.

At the beginning of their work with Magellan, care managers are oriented to the specific priority and Special Needs Populations that are represented in the populations they will assist. This training includes cultural and other aspects of these members' approaches to medical and behavioral health care, potential obstacles to care that are common in each of the subpopulations (for example, language other than English; issues with health literacy; disabilities such as cognitive, psychomotor or other challenges; greater than usual stigma about receiving care; isolation from supports, and transportation issues in rural communities; and religious beliefs concerning care, among others), culturally-based strengths that can be used to enhance access to care (such as social and religious affiliations that can support care and recovery), how benefits and supplemental services can be used to enhance the delivery of appropriate care, and similar topics. On an ongoing basis, among the trainings that care

managers are exposed to in monthly staff meetings are trainings specifically focused on recovery, resiliency, cultural competence principles, evidence-based practices, and clinical practice guidelines for specialty populations, and Principles of Care.

Training and Monitoring Behavioral Health Providers

The cultural competency provider training curriculum is a critical component of ensuring network success in providing culturally competent services. Magellan provides ongoing cultural competence training for providers and stakeholders in Nebraska, free of charge to attendees. The training offered to providers includes concrete tools for use in the development of culturally appropriate services. Some components of the training include:

- stereotypes, worldview, and personal filters, which are the filters that we are not necessarily aware of that color how we interpret what we see and hear
- disparities in outcomes and reasons for them
- strengths, needs, cultural discovery techniques and resources
- National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards (Federally mandated standards for culturally competent care, language access services and organizational supports for cultural competence, as established by the Office of Minority Health, U.S. Department of HHS)
- introduction to cultural terminology
- cultural sensitivity
- cultural competence skills.

Ongoing training will occur through a variety of methods including traditional classroom presentations, lectures, online/on-demand training, and informal brown bag lunch presentations. Continuing education credits are available for successful course completion. Magellan also offers an online cultural competence toolkit with resources for providers, members, and the general community, available at: https://www.magellanprovider.com/MHS/MGL/education/culturalcompetency/. This information is also accessible through our www.MagellanofNebraska.com Web site. Magellan also recently presented a training session to Nebraska providers and stakeholders on "Micro-aggressions and Multicultural Competence: Practical Strategies for Preventing and Responding to Bias." (Micro-aggressions are brief, everyday exchanges that send denigrating messages to people in traditionally marginalized groups (i.e., people of color, sexual minorities, women, etc.) Over 70 participants registered to attend this training opportunity.

Monitoring Cultural Competence/Developmental Appropriateness of Staff and Behavioral Health Providers

In addition to recruiting and training strategies, Magellan also continually assesses how successful these efforts are and identifies areas for improvement. We assess the culturally competence and sensitivity to diversity and different developmental needs. This assessment is conducted via telephone monitoring, record audits, supervision, and individual performance

reviews. We also pay close attention to any complaints or grievances that contain any element potentially related to these issues. The complaints or grievances are reviewed, and may result in additional supervision or training with the care manager, and/or a performance improvement plan.

We also assess the cultural competency of our network providers. We use several mechanisms to perform this assessment. Magellan conducts treatment record reviews (TRRs) and assesses provider cultural competence through the providers' documentation. Magellan's TRR tools assess for evidence of treatment being provided in a culturally competent manner, and look for provider performance in a variety of ways including an expectation that the record clearly demonstrates consideration and assessment of a member's language, religious and cultural preferences, and that the members' treatment plans reflect sensitivity to their language and culture.

[redacted]

Staff compare the translations requested and provided with the known primary languages of members and local area providers to ensure timely, appropriate, and responsive translations. With this data, staff are able to determine languages needed for effective program delivery. They report information and any action plans that are developed, and are reviewed in the Quality Assurance Performance Improvement Committee.

More information regarding our network capabilities to provide services meeting the linguistic needs of members' health and is presented in *Section IV.L*, in the eighteenth and nineteenth questions regarding multi-lingual and interpreter services of the network.

Enhancing Cultural Sensitivity through Collaboration and Outreach: Magellan's Experience with Tribes

[redacted]

[redacted]

Seeking and Responding to Feedback on Developmental and Cultural Competence

Magellan is continually assessing the adequacy of its behavioral health network to provide developmental and culturally appropriate care. We solicit information from providers regarding the populations they serve, continually seeking to recruit and ensure that we have sufficient numbers of providers to meet the needs of members of all ages and backgrounds in all parts of the state. Magellan also routinely seeks input from members, their families, and communities about the cultural and developmental appropriateness of our service system and care management program on a regular basis.

Our approach to seeking input has been well demonstrated in both the national and local arenas. Magellan checks in with those served formally and periodically in several ways. We seek input on whether individuals served *experience* service delivery as culturally and developmentally appropriate, and that they understand what is communicated and feel that there is adequate accommodation made so that they do.

[redacted]

At the national level, our approach to soliciting member and community input has included developing solutions for issues and 'hot topics' such as the appropriate use of residential and

out-of-home services, and the appropriate use of psychotropic medications with children and youth. In addition to studying research and reviewing our own data and experiences, we reached out to parents and young adults, providers, community stakeholders, judges, school personnel, child welfare, juvenile justice, and others to best understand the challenges associated with the topic and to recommend solutions. Input was gathered through our care management centers via facilitated focus groups, electronic surveys, and ongoing discussions with members and their families. These efforts have yielded many new strategies that incorporate cultural and developmental aspects of care, as well as a 2008 whitepaper on residential and community-based treatment for youth and families to guide a realignment from the over use of residential care and develop more community-based options.

Describe how your BH MCO will operate as a part of a System of Care in Nebraska to serve persons with mental health/illness and substance use disorder needs.

As the behavioral health administrative services organization since 2002, Magellan has been and will continue to operate as a partner within the Nebraska System of Care for its most vulnerable citizens with behavioral health needs. The Nebraska system of care for these persons is multifaceted. It involves state agencies, medical managed care health plans such as United Healthcare's Share Advantage, Coventry's CARES, and Blue Cross's Arbor Health programs, individual health care professionals, advocates, community organizations, and the members and their families; each playing a significant and varied role in the experience of delivering and receiving health care.

Through Magellan's experience of the past 10 years, we have developed first hand relationships within the system. Magellan has held contracts with and provided support to multiple DHHS agencies including the divisions of Medicaid and Long Term Care, Behavioral Health and Children and Family Services. We have executed contracts with hundreds of behavioral health providers throughout the state. We have provided more than administrative services to our state customers; we've provided training, resources, and technical assistance to residents (members and non-members), advocates, providers, and the community at large.

Through these experiences we have learned that there are multiple layers to the system of care. There is a statewide DHHS system where multiple divisions serve citizens through policy guidance and funding that includes the aforementioned entities as well as the Division of Developmental Disabilities. There are also regional systems of care where state funds are allocated to Regional Offices to coordinate and in some cases deliver services directly to members. While all operating under the state level guidance of DHHS, the availability of services and providers varies greatly between Region VI and Region I, and the medical managed care plans also vary by region. These local systems of care also have varied and different social service, community organizations, and faith-based groups that support those in need. Since all health care is experienced by the member at the local level, it is important to recognize the multilayered system and to assist the member in navigating it to receive the care that they need.

Because Magellan currently serves as the statewide managed behavioral health plan, we are uniquely positioned to understand and support the system of care at every level. For each member with mental health/illness and substance use disorder needs, Magellan is and will

continue to be, the single point of connection to ensure that the member can navigate the system of care to meet his or her needs. To achieve this, Magellan will assume three major roles: 1) facilitator; 2) care manager; and 3) resource for the member and family.

Facilitator

Magellan will operate as facilitator to promote communication and coordination at the state, regional, and local level, and among agencies, MCOs, and providers to assure services are delivered within the Principles of Care established for the program.

Care Manager

An important expansion of the new Nebraska behavioral health managed care program is the expectation of care management. Through the identification of special need members and engagement in the Recovery Care Management process and program, Magellan will interact with health plans, primary care providers, prescribers, behavioral health providers, and members. As a statewide organization, not affiliated with a specific medical health plan, Magellan would be best positioned to facilitate dialog among all of the Health Plans, without a vested interest or perceived conflict in meeting an individual member's need. The care management program, described in detail in our response to Section IV.M and elsewhere in the proposal, will assure that those special need members with high risk factors are receiving the care they need to remain in the local communities of their choice

Resource

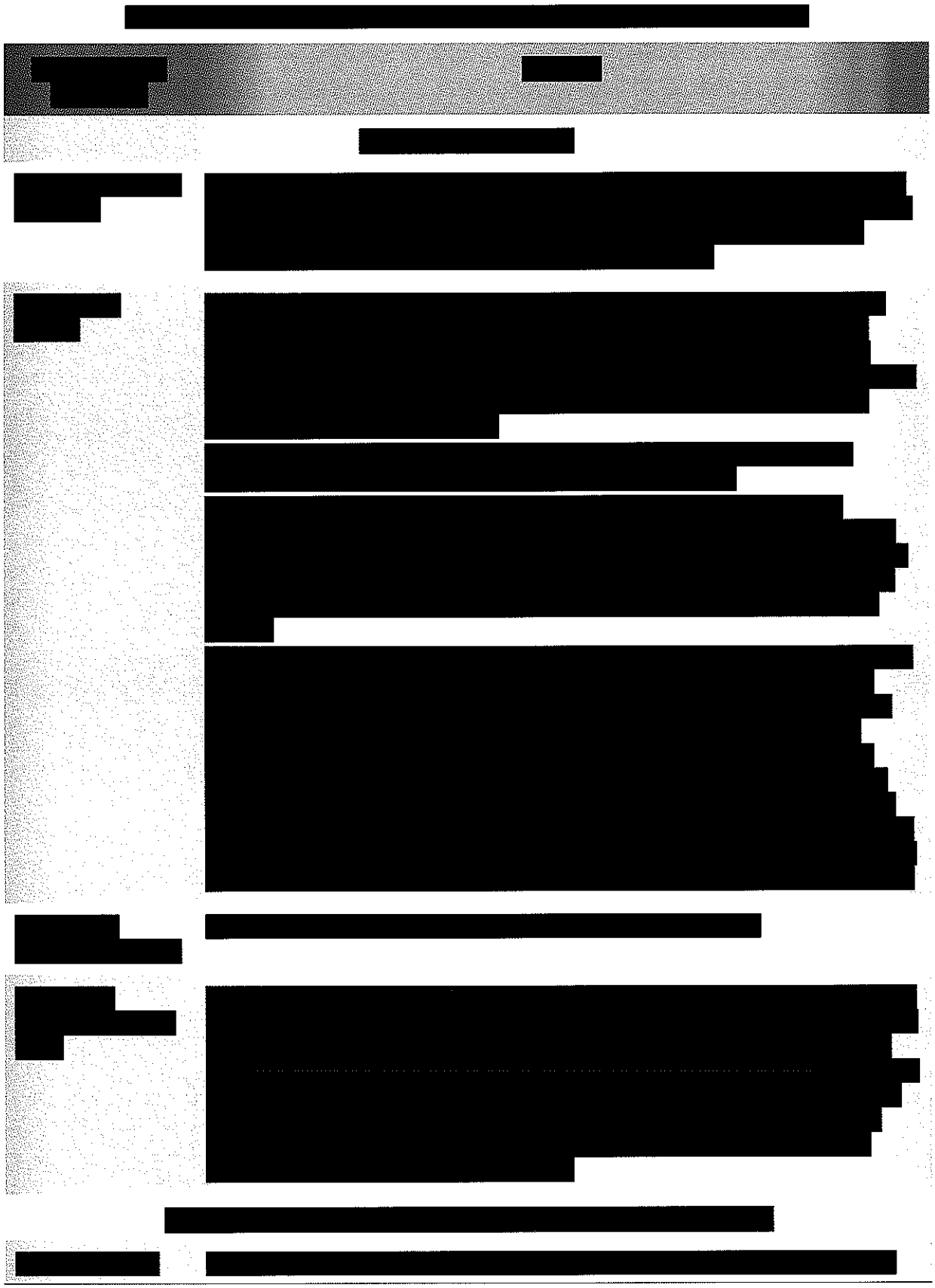
Finally, Magellan will continue to act as a resource for members and families, to help them navigate through their System of Care. We will provide information related to local supports and tools through our call-center, *Member Handbook*, and Nebraska Web site. We will engage and support the local chapters of the advocacy organizations, such as the Federation for Families and NAMI. We will provide individual high risk members with the tools such as the Passport to Care and mobile phones and applications that will support them in the navigation of the system of care addressing both physical and behavioral treatments.

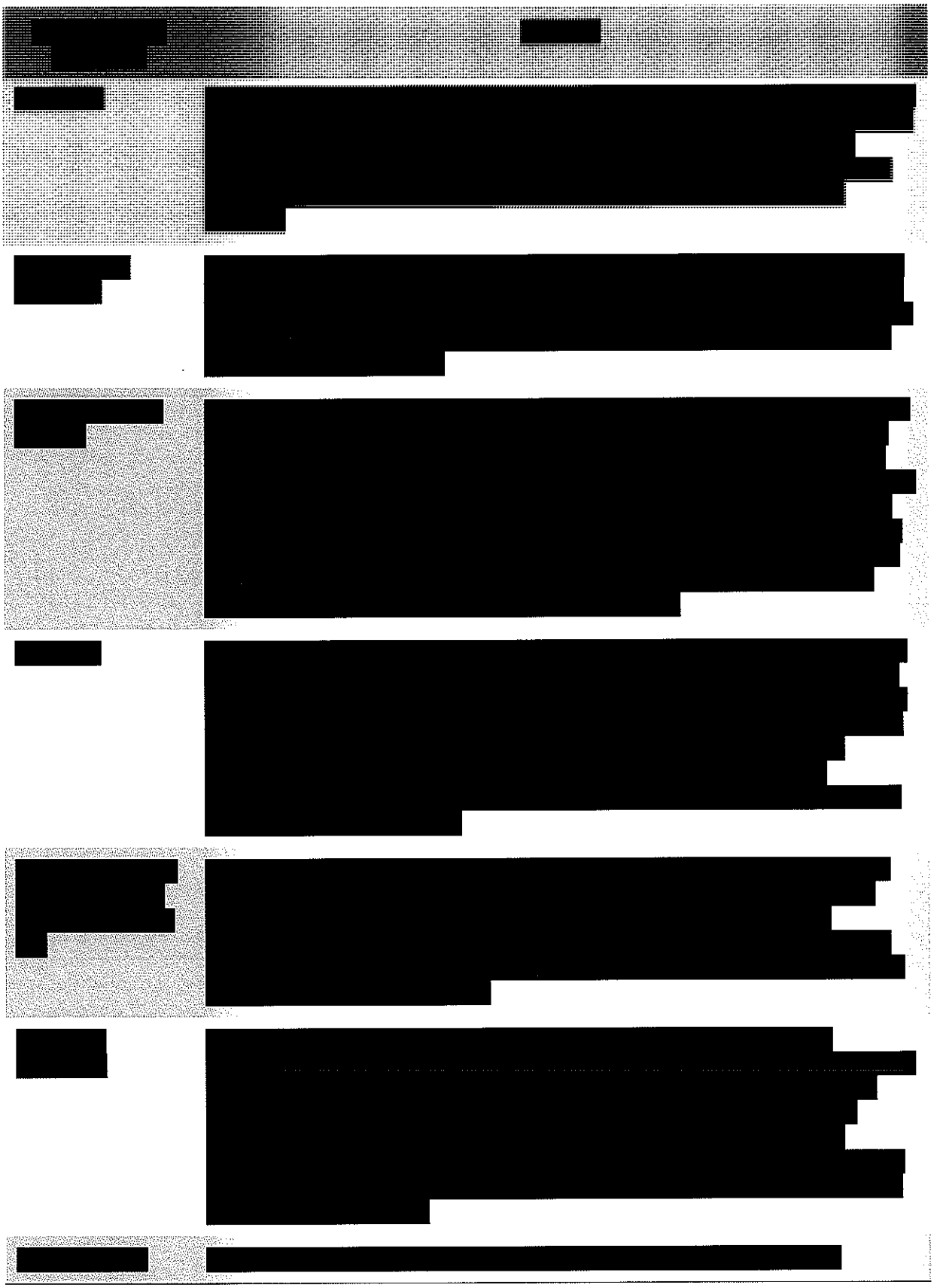
We will also act as resource to the local health care delivery system through the availability of our web-based PCP Toolkit and the toll free PCP Hotline, assisting local PCPs with behavioral health consultation at their request.

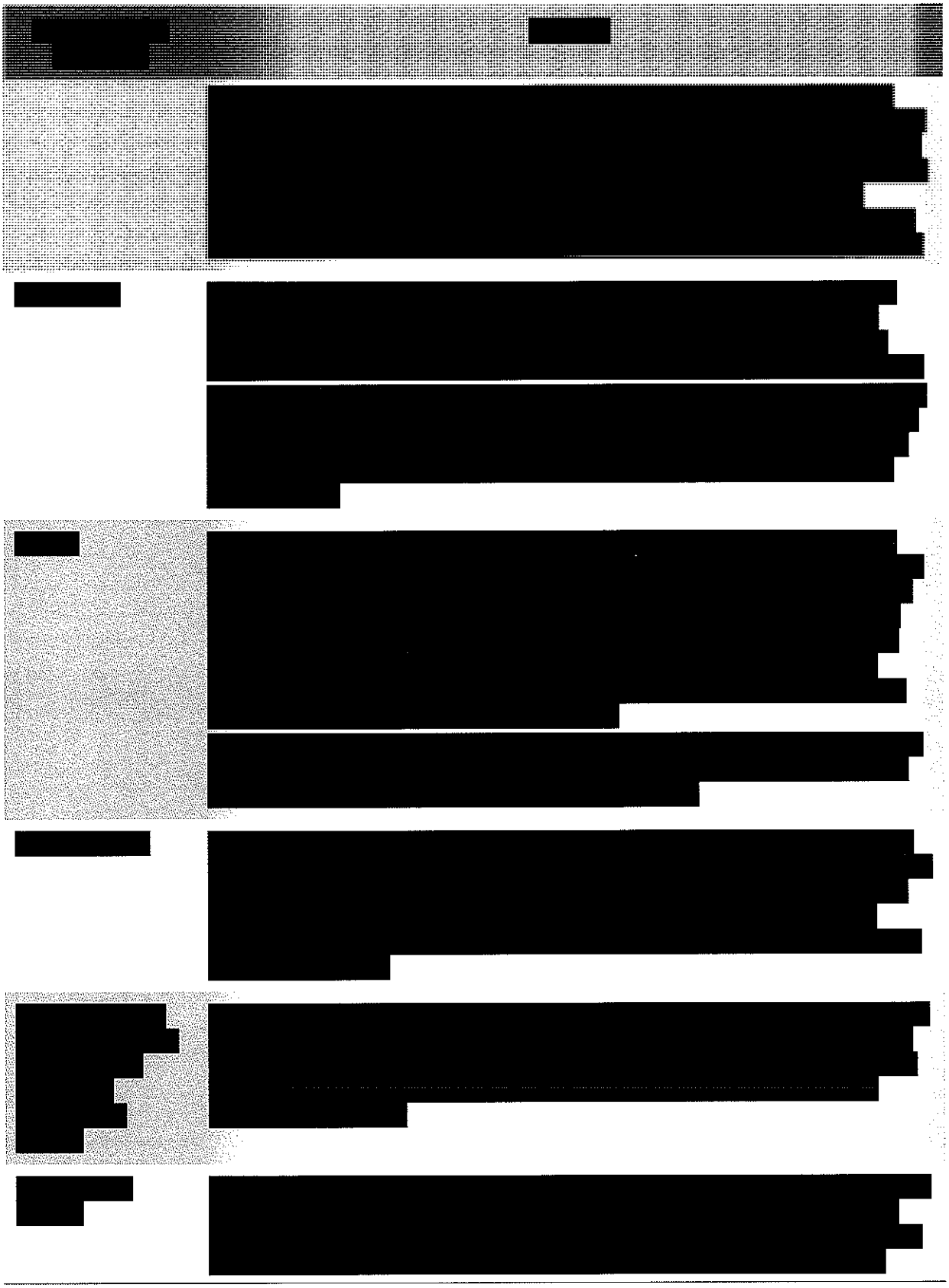
IV.G. Value-Added or Substitute Services

Describe any value-added or substitute services that your BH MCO will deliver to enhance the service array and the rationale for you decision to include these particular services.

[redacted]







[redacted]

What follows below are narrative descriptions which further explain the rationale and outcomes of these services.

[redacted]

[redacted]

[redacted]

[redacted]

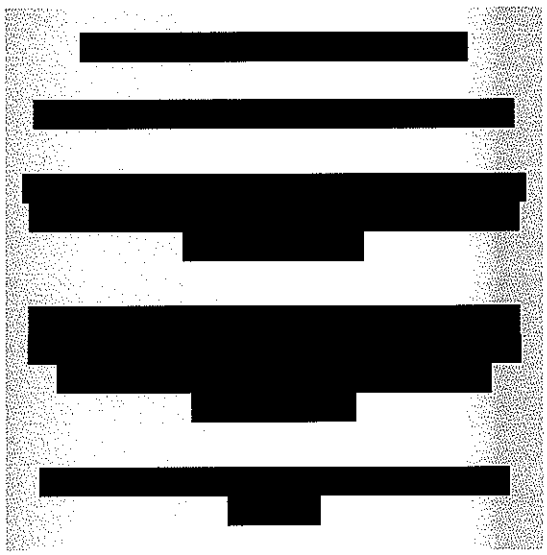
[redacted]

[redacted]

[redacted]

[redacted]

[redacted]



[redacted]

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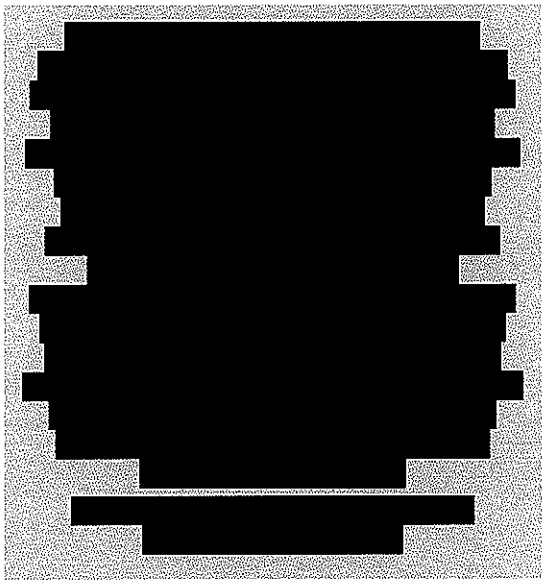

[redacted]

[redacted]

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[redacted]

[redacted]

[redacted]

[redacted]

IV.J. Business Requirements

Describe the approach your BH MCO will take to ensure your BH MCO is abiding by all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471 NAC and 482 NAC.

Magellan has three policies that address relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471 NAC and 482 NAC:

- Regulatory Compliance with Contract Requirements policy
- Policy Development, Review & Dissemination Procedure policy
- Corporate Compliance Structure with Care Management Centers (CMCs), Business Divisions, and Corporate Departments policy.

Magellan Behavioral Health of Nebraska, Inc. is licensed by the State of Nebraska as a Prepaid Limited Health Service Organization, which provides authority to operate as a risk-bearing insurer. Through this license, we understand our obligation to and agree to abide by all requirements of a managed care entity in Nebraska. We also recognize that our contract with the Division of Medicaid and Long-Term Care will incorporate the provisions of the NAC. We agree to maintain compliance with all contract provisions, and we will ensure that we understand the regulations as stated in the NAC as well. Internal quality assurance practices will monitor key provisions such as claims payment timeliness and grievance and appeal practices.

As a nationwide behavioral health managed care organization with multiple Medicaid contracts, we have years of experience operating under the authority of 42 CFR 438, and have been in full compliance. Our internal policies and procedures are designed to ensure compliance with all relevant Federal regulations. Magellan employs executive staffs who have previously worked for the Centers for Medicare and Medicaid Service (CMS), and we continually monitor the activities of CMS to be prepared for changes in regulations.

Magellan's Corporate Compliance Department is responsible for the Company's awareness of applicable state and federal laws and regulations. The Corporate Compliance Department includes Regulatory and Legislative Analysts, Regional Compliance Directors, Regulatory Attorneys, and paralegals. The Compliance Department monitors changes and revisions to federal and state laws, rulings, regulations and standards and is responsible for reporting changes and revisions to the appropriate senior manager at the Nebraska Care Management Center (CMC).

The Regional Compliance Directors work with the care management centers and other operations departments' compliance staff in their assigned regions. The care management centers and other operations departments' compliance staff are responsible for the inclusion of requirements under applicable state and federal law in policies and procedures. The implementation of the new laws and regulations is conducted by the care management center and the applicable operations departments. In addition to the process for reviewing and providing guidance in the implementation of new laws, the Corporate Compliance Department maintains a number of resources on existing laws that impact our business.

Magellan staff members at the corporate and local care management center level cooperate and collaborate along with customer organizations, accrediting organizations, and federal and state agencies to identify issues that may require updates to policies and procedures. The Nebraska CMC will add one local compliance position to assure requirements are met and the staff and leaders monitor relevant resources to identify changes or revisions to applicable standards, laws, and regulations. Account Management staff members are responsible for monitoring customer standards and requirements, and are responsible for reporting changes and revisions to the appropriate senior manager at the Nebraska CMC. The Quality Improvement (QI) Department monitors changes and revisions to accrediting organizations' standards, and is responsible for reporting changes and revisions to the appropriate senior manager at the Nebraska CMC.

State the status of your BH MCO's accreditation with NCQA.

Page 29 of the RFP requires the Contractor to have "NCQA or another national certification (including URAC accreditation) at the time of proposal submission". Magellan Behavioral Health of Nebraska's Care Management Center has earned full accreditation from URAC for Health Utilization Management. This accreditation is directly related to the specific functions of Managed Care entities and this program. Accreditation began June 1, 2010 and expires June 13, 2013. It will be renewed.

[redacted]

Describe how your BH MCO meets the Federal definition of a BH MCO. Include a copy of the COA from the Department of Insurance.

As a Prepaid Limited Health Services Organization, Magellan Behavioral Health of Nebraska, Inc., is authorized to bear risk for those behavioral health services that will be clearly defined through its contract with the Division of Medicaid and Long-Term Care. This arrangement qualifies Magellan as a Prepaid Inpatient Health Plan (PIHP) as defined in 42 CFR 438. The characteristics of a PIHP are that it:

1. Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates

2. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees

3. Does not have a comprehensive risk contract.

A copy of Magellan's Prepaid Limited Health Service Organization certificate can be viewed in **Attachment A**.

If applicable, describe your BH MCO's proposed risk bearing partnership/relationship including designated functions of each entity, and how delegated functions will be overseen. Bidders who submit a proposal with a partnership of risk bearing must also provide a detailed description of how both entities meet the Managed Care Organization Licensure Requirements.

Not applicable.

Describe the risk analysis, assumptions, cost estimates and rationale supporting your BH MCO's proposed reinsurance arrangements. If any reinsurance is provided through related parties, provide a disclosure of the entities and details causing the related party relationship.

Magellan believes the actuarially sound rate development process for Behavioral Health claims and services are adequate to pay all claims under this Medicaid program and benefits. Magellan does not intend to purchase or self-fund a reinsurance policy. Claims associated with this Medicaid program are not of a catastrophic nature and the historical experience and benefits should be captured in the rate development process. Magellan intends to pay all claims from existing capitation payments provided by the State and from cash reserves on hand.

State the intention of your BH MCO to maintain a service office in Nebraska and the staff positions to be located within this service center.

Magellan's Nebraska Care Management Center is currently located at 1221 N St., Suite 700, Lincoln, NE. We acknowledge that additional staff will be required to effectively serve the new contract and its requirements and it is therefore likely we will require a new location.

It is our intent to remain in Downtown Lincoln, preferably within walking distance to the offices of the MLTC. All staff positions shown on the Magellan Nebraska Care Center Organization Chart (**Attachment C**) will be located in Nebraska and nearly all will be located at the service center. Some staff may provide services as telecommuters as their functions are best located in local communities [redacted]

Describe the process your BH MCO will use to ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Magellan's primary goals are to optimize the use of services that support recovery and resiliency, match services to each member's needs that are culturally competent and evidence-based, and ensure that services are provided along the full continuum of care. Our Care Management/Utilization Management (CM/UM) program is designed to provide full access to appropriate quality of care, care. We do this through oversight of routine outpatient care, focused oversight of acute inpatient levels of care (LOCs), and by using clinically-driven triggers to identify those members in need of additional support.

Ensuring that Decisions for Utilization Management are Consistent with Medical Necessity Criteria Guidelines

[redacted]

Care Manager Training

All Magellan care managers attend a structured orientation program at the beginning of their employment. In 2011, after reviewing the results of the provider satisfaction survey, and augmented by information regarding lack of clinical consistency in Town Hall discussions, Magellan created a new *Care Management Training Manual.* Topics in the new manual include:

- clinical treatment philosophy
- medical necessity criteria (MNC)
- initial and concurrent review processes
- clinical and administrative non-authorizations
- referring to physician and peer advisors
- clinical documentation
- coordination of care
- contract-specific considerations.

Care managers also attend monthly care manager staff meetings. Given the focus on improving the consistency of clinical decision making, these staff meetings now include annual training reviews, including:

- MLTC medical necessity criteria
- Magellan *Supplemental Criteria* that our clinical leadership has developed with input from customers, providers, outcomes studies, national professional associations, and care managers
- American Society of Addiction Medicine (ASAM) criteria for children and adolescents with substance abuse issues
- reviews of evidenced-based practice standards
- best practices in psychopharmacology
- recovery/resiliency/cultural competency principles
- clinical practice guidelines for specialty populations.

Many of these trainings are available by webinar for staff who are unable to attend the on-site sessions. Whenever possible, we offer care managers an opportunity to attend trainings on these topics when they are offered in the community.

[redacted]

Consultation with Physician Advisors and Senior Clinical/Medical Leadership

An important element in our clinical supervision process is our access to physician advisors for case-specific consultation as well as for non-authorization of cases that do not meet medical necessity criteria. Every day, care managers have access to senior clinicians and medical directors for support with complex cases. Additionally, the clinical director, medical director,

and other senior clinical staff are available to provide ongoing technical assistance and consultation regarding interpretation and application of medical necessity guidelines.

[redacted]

[redacted]

Ensuring that Decisions for Member Education are Consistent with Medical Necessity Criteria

Magellan has several communication strategies for informing members, initially and throughout each year, about covered services and which services require their provider to first check with Magellan about the medical necessity of the service for that member's situation, and the sources we use to determine medical necessity criteria when their provider requests a service on their or a family member's behalf. [redacted]

Magellan's customer service associates (CSAs) are also trained on medical necessity criteria to provide guidance and support to members by phone, and answer questions about covered services and medical necessity criteria. Complex cases may be transferred to a peer, or the Recovery and Resiliency Services Director. Members and/or a member-authorized representative may request assistance 24 hours a day, seven days a week, using a toll-free telephone number.

For all required written materials to members, such as the *Member Handbook*, Magellan will ensure they are written at a sixth-grade reading level (up to 6.9), using the Flesch-Kincaid readability index.

Ensuring that Covered Services are Consistent with Medical Necessity Criteria

Magellan's develops medical necessity criteria (MNC) and other clinical guidelines at the corporate level and customizes MNC to meet the needs and requirements of individual programs. Magellan of Nebraska's philosophy and approach to UM are detailed in our current UM Program Description and clinical policies and procedures, which we tailor to reflect local

goals and objectives, and requirements of MLTC. [redacted]

The UM Committee will have responsibility for approving and implementing medical necessity criteria each year, and evaluating consistency in their use on a regular basis.

[redacted]

This process ensures that the MNC incorporate best practices, provider feedback, and the latest developments derived from expert clinical consensus and peer-reviewed scientific literature in authorizing covered services that are appropriate in scope, intensity, and frequency or duration.

Describe the fraud and abuse program your BH MCO will implement including:

- *Compliance with the RFP requirements;*
- *Fraud detection methods that will be used;*
- *Steps that will be taken if fraud is detected including DHHS notification; and*
- *Plan for compliance with the Exclusion Program of the U.S. Department of HHS Office of the Inspector General or any provider restrictions imposed by the State.*

Magellan's Comprehensive Compliance Program

Magellan is committed to ensuring ongoing compliance with all contractual and regulatory requirements. Our Compliance Program outlines a comprehensive program for preventing, detecting, monitoring, investigating, and reporting fraud, waste, abuse, and overpayments.

Compliance with All Federal and State Requirements

As part of Magellan's corporate compliance program for the prevention of fraud, waste and abuse, Magellan complies with all state and federal requirements for government-sponsored programs, including the Federal False Claims Act, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act (PPACA) of March 2010, applicable Whistleblower Protection laws, and any state false claims statutes.

Magellan will comply with all fraud, waste, abuse requirements outlined in the RFP through our Compliance Plan. The elements of our Compliance Plan include:

- written policies and procedures
- designation of a Compliance Officer and a Compliance Committee
- conducting effective training and education
- developing effective lines of communication
- enforcement through publicized disciplinary guidelines and policies dealing with ineligible persons
- auditing and monitoring
- responding to detected offenses, developing corrective action initiatives and reporting to government authorities
- *Whistleblower Protection and Non-retaliation Policy.*

Fraud Detection Methods

As the incumbent ASO, our Compliance Program currently follows a Nebraska Plan policy on the Reporting of Suspected Fraud, Waste, and Abuse (FWA), under which we comply with the use of Nebraska-specific forms and reporting.

Our fraud detection methods include but are not limited to the following practices:

- member service verification sampling, as described below
- investigation of member complaints or others' reporting of suspected fraud, waste or abuse
- review of claims and utilization data
- provider audits and provider self-audit activity.

[redacted]

[redacted]

Steps Magellan will Take if Fraud is Detected, including DHHS Notification

Magellan checks the U.S. Department of Health and Human Services (HHS) Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's (GSA) web-based System for Award Management (SAM) Exclusion Database, U.S. Treasury Department Office of Foreign Assets List of Specially Designated Nationals and Blocked Persons and applicable state exclusion lists for names of excluded employees, contractors, providers, and vendors barred from participation in Medicare, Medicaid, other federal health care programs, federal contracts, and state health care programs during credentialing, re-credentialing, and monthly thereafter.

Magellan also created the *Medicaid Disclosure Form,* an interactive web application to comply with the Medicaid disclosure requirements pursuant to 42 CFR 455.104, 105, and 106. These federal regulations require Medicaid providers to disclose information regarding:

- the identity of all individuals and entities with an ownership or control interest of 5 percent or greater in the provider, including the identity of managing employees and agents
- certain business transactions between the provider and subcontractors/wholly owned suppliers
- Tte identity of any individual or entity with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider or disclosing entity that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs.

Upon receipt of the requested disclosure, Magellan reviews the data and runs the names of all the entities/individuals disclosed through the *Medicaid Disclosure Form*/interactive web application against the following lists:

- List of Excluded Individuals/Entitles (LEIE) database (http://exclusions.oig.hhs.gov/)

- General Services Administration's System for Award Management (SAM) Exclusion Database (http://www.sam.gov/)
- any other applicable State exclusion list including other state Medicaid programs.

Any adverse information obtained as a result of the disclosure will be submitted to the MLTC as outlined in the *MCD Reporting of Suspected Fraud, Waste, Abuse & Overpayments Policy.*

Plan for Compliance with the Exclusion Program of the Department of HHS Office of the Inspector General or any provider restrictions imposed by the State.

Magellan maintains the following policies, procedures, and workflows, which detail Magellan's procedures for ensuring that individuals or entities that are excluded from participating in federal health care programs are not contracted to participate in Magellan's Provider Network:

- *Excluded Individuals and Entities (Employees, Contractors, Providers & Vendors) Policy*
- *Medicaid: Fraud, Waste and Abuse Compliance Program Policy* – Section VI.G., on page 13 of 19
- *Provider Network Ongoing Monitoring Policy* – Sections II & III, on pages 2 and 4 of 5
- *Reporting of Fraud, Waste, Abuse and Overpayments – Nebraska Plan Policy* – Section II.F., on Pages 6 and 7 of 10.

Describe in detail how your BH MCO will verify that services were actually provided including:

- *How minimum sampling criteria to ensure a representative sample will be included; and*
- *Results of monitoring will be reported to the State quarterly.*

Member Services Verification Policy and Process

As part of our compliance program activities to verify that services were actually provided, we have developed an ongoing member verification process that we will follow under the new contract.

Minimum Sampling Criteria to Ensure a Representative Sample

On a monthly basis, Magellan Behavioral Health of Nebraska will conduct a survey from a random sample of members for member service verification. Based upon average penetration rates in other Magellan public sector contracts, we estimate that the unique number of members that will access services in a given month is approximately 23,000. Based on this figure, we calculated a sample size of 250 unique members per quarter at a 90 percent confidence level and a 5 percent confidence interval. These members will be randomly chosen so as to select a representative sample. In order to avoid overly burdening members, once a member has been selected for one report, the member is excluded from selection in subsequent reports for a one year period. We will report results quarterly to MLTC.

Magellan Verification of Services Provided to Members Policy

Magellan will comply with applicable state and federal Medicaid Program Integrity requirements, including, but not limited to, the requirement to create and implement a process for verifying with members whether services billed by providers were received. A detailed description regarding the process of verification of services provided to members is outlined in the Magellan corporate policy entitled, *Verification of Services Provided to Members Policy SC.1416.02*, and includes the Member Service Verification Questionnaire. We mail the questionnaire to each member with a postage paid envelope, using an auto-generated, random selection process. Upon request we will share our corporate policy with MLTC.

Reporting Suspected Fraud or Abuse

As returned questionnaires are reviewed, if a member indicates that he or she never received the services outlined in the questionnaire, Magellan will contact the member to verify the member understands the procedure billed. If the member still indicates the service was not received, and if permitted by contract, Magellan will immediately report suspected fraud or abuse to MLTC, and initiate an immediate investigation to gather facts regarding the possible fraud or abuse.

Documentation of the findings of the investigation will be delivered to MLTC in compliance with the reporting requirements for fraud, waste, and abuse as outlined in the RFP and the new Medicaid contract. Magellan will cooperate fully in any State review or investigations, and in any subsequent legal action. If MLTC wishes to retain investigation duties, Magellan will develop relationships and cooperate fully with law enforcement and other government agencies.

Describe your BH MCO's policies and procedures to ensure safeguards are in place which are at least equal to the Federal Safeguards of 41 USC 423, section 27.

Pursuant to the State's response to Question 26 of Addendum 4 on December 11, 2012, regarding "Second Round of Questions and Answers for RFP 4166Z1," we can assure MLTC that contracting with Magellan will in no way present a conflict of interest that would prevent MLTC from being in compliance with State Conflict of Interest Safeguards that are at least equal to the Federal Safeguards of 41 USC 423, section 27.

Describe how your BH MCO will comply with the False Claims Act.

Magellan has established the following policies and related documents to ensure compliance with the False Claims Act:

- False Claims Laws and Whistleblower Protections Policy
- *Corporate Compliance Handbook* – pages 8 to 10
- DRA Compliance Statement, available at http://magellanhealth.com/our-edge/clinical-excellence/compliance/dra-compliance-statement.aspx

- Magellan DRA Compliance Statement and Nebraska Law.

In order to comply with the RFP requirement that "responses must be complete and succinct," we will make these policies available at the request of MTLC.

Employees, contractors and providers are notified that they are required to report any suspected cases of fraud, waste, abuse, and overpayments to Magellan. Information about the applicable federal and state laws regarding fraud, waste, abuse, overpayments and whistleblower protections are provided in the False Claims Laws and Whistleblower Protections policy. Information about these laws in terms of the procedures, controls, and policies implemented by Magellan to ensure compliance are covered in the Medicaid: Fraud, Waste and Abuse Compliance Program policy, *Employee Compliance Handbook* as well as during the annual Compliance Handbook Training, and Fraud, Waste and Abuse Training (Fraud Identification and Recognition Education) which includes information that is consistent with section 6032 of the federal Deficit Reduction Act (DRA) of 2005 that includes information about the following:

- the False Claims Act
- penalties for submitting false claims and statements
- the DRA's role in preventing and detecting fraud, waste and abuse
- each person's responsibility relating to detection and prevention
- the toll-free state telephone numbers for reporting fraud, waste, abuse, overpayments
- applicable federal and state whistleblower protections.

Describe the approach your BH MCO will take to provide members with written material that is easily understood including alternate formats.

Magellan works closely with members, family members, advocates, providers, and other stakeholders through our Quality Assurance Performance Improvement (QAPI) structure, which includes our Member Services Committee, to ensure that the content of member materials are culturally and linguistically appropriate, accurate, comprehensive, and understandable

We will ensure that all written materials for members are available in English and Spanish and other alternative formats to accommodate members with limited English proficiency and those with special needs. All written materials sent to new members will be written at a sixth-grade reading level (up to 6.9), using the Flesch-Kincaid readability index.

A more comprehensive response is presented later in response to the third question in Section IV. K. Member Rights and Responsibilities within our Proposed Implementation Approach.

Describe your approach to compliance and regulatory support, including identification of requirements, process establishment, controls identification, monitoring, correction and ongoing risk management.

Magellan's Corporate Compliance Department

Magellan's Corporate Compliance Department is responsible for the company's awareness of applicable state and federal laws and regulations. The Corporate Compliance Department includes Regulatory and Legislative Analysts, Regional Compliance Directors, Regulatory Attorneys and paralegals.

Identifying Requirements and Establishing Processes

The Regional Compliance Directors work with the care management centers, Strategic Business Units (SBUs), and other operations departments' compliance staff in their assigned regions. The care management center, SBU, and other operations departments' compliance staff are responsible for the inclusion of requirements under applicable state and federal law in policies and procedures. The implementation of the new laws and regulations is conducted by the care management center, SBU, and the applicable operations departments. In addition to the process for reviewing and providing guidance in the implementation of new laws, the Corporate Compliance Department maintains a number of resources on existing laws that impact our business.

Magellan staff members at the national, SBU, and care management center-level cooperate and collaborate with customer organizations, accrediting organizations, and federal and state agencies to identify issues that may require updates to policies and procedures.

Controls Identification and Monitoring

The Nebraska Care Management Center (CMC) monitors relevant resources to identify changes or revisions to applicable standards, laws and regulations. Account Management staff members are responsible for monitoring customer standards and requirements and are responsible for reporting changes and revisions to the appropriate senior manager at the Nebraska CMC.

The Quality Management Department monitors changes and revisions to accrediting organizations' standards and is responsible for reporting changes and revisions to the appropriate senior manager at the Nebraska CMC. The Compliance Department monitors changes and revisions to federal and state laws, rulings, regulations and standards and is responsible for reporting changes and revisions to the appropriate senior manager at the Nebraska CMC.

Correction and Ongoing Risk Management

Part of our ongoing risk management includes several types of internal and external audits to evaluate the level of risk. T hese include but are not limited to the types of audits described below.

- The Corporate Compliance Department may conduct audits of operational compliance with state and/or federal laws and regulations and Magellan policies and procedures.
- Audits may be conducted using existing audit tools when they capture the identified audit elements or audit tools may be developed by the Corporate Compliance Department.
- The Corporate Compliance Department prepares a preliminary summary report of findings and submits the report to the care management center or Corporate Department for review and discussion. The report may include a request for a corrective action plan (CAP) based on findings.
- The Corporate Compliance Department reviews CAPs and provides further guidance and assistance to the care management center or Corporate Department regarding CAP items, as needed.
- The Corporate Compliance Department completes a final summary report of findings, which includes any comments from the care management center or Corporate Department and any agreed upon CAP items.
- The final summary report of findings is submitted to the Corporate Compliance Officer and may be reviewed by the Corporate Compliance Committee or their designees.

Additional information about Magellan's approach to compliance, regulatory support, internal controls, ongoing risk management, and compliance program is outlined in the list of policies below.

Compliance Department Audit Process Policy

Magellan Health Services, Inc., its subsidiaries and affiliates (Magellan), Corporate Compliance Department is led by the Corporate Compliance Officer (CCO) whose responsibility it is to oversee the Corporate Compliance Program, including a review of selected audit results and corrective action plans (CAPs) relating to compliance with applicable federal and state laws and regulations and Magellan's policies and to conduct regulatory audits, as needed.

Regulatory Compliance with Contract Requirements Policy

Magellan Behavioral Health of Nebraska, Inc. (Magellan), an affiliate of Magellan Health Services, updates and implements revised policies and standards upon notice that any customer or accrediting organization's standards or any federal or state statutory or regulatory provisions are materially changed or revised. Such updates and implementations are completed within time frames required by the customer or accrediting organization or the applicable law or regulation.

Policy Development, Review & Dissemination Procedure Policy

Magellan Behavioral Health of Nebraska, Inc. (Magellan), an affiliate of Magellan Health Services, has corporate policies that address standards of practice across the company. These standards are influenced by legislative and regulatory requirements, accreditation standards and

recognized standards of practice. Corporate policies are customized by the local sites, as needed, to reflect regulatory or customer requirements that are different from those of corporate.

Corporate Compliance Structure with Care Management Centers (CMCs), Business Divisions, and Corporate Departments Policy

The properly licensed affiliates and subsidiaries of Magellan Health Services, Inc., (Magellan) have established a Corporate Compliance structure that provides regulatory and policy support to Care Management Centers (CMCs), Business Divisions, and Corporate Departments.

Additional policies supporting Magellan's compliance activities include the following:

- *Excluded Individuals and Entities (Employees, Contractors, Providers & Vendors) Policy*
- *Medicaid: Fraud, Waste and Abuse Compliance Program Policy – Section VI.G.*, on page 13 of 19 and *Section VII.*, which starts from pages 14 to 17
- *Provider Network Ongoing Monitoring Policy.*

In order to comply with the RFP requirement that "responses must be complete and succinct," we will make these policies available at the request of MTLC.

Describe how your BH MCO will ensure consistent application of review criteria for authorization decisions and consult with the requesting provider when appropriate; and monitor that denial of service authorization or authorization of a service in an amount duration, or scope that is less than requested, to be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

Magellan understands that clinical review criteria must not only be based on solid research and clinical expertise, but must be applied consistently to be useful. We utilize many tools that together comprise a comprehensive approach to monitoring and supervising care managers in applying clinical review criteria to make authorization decisions. Our supervisory and auditing activities of care managers emphasize appropriate consultation and communication with the requesting provider, as illustrated in a case example, below.

We use these same monitoring tools and supervisory techniques, described below, to audit and improve communication between care managers and providers when decisions involve denial of authorization, partial authorization, or authorization of services in a lesser amount, over a shorter period of time or of less intensity than a provider requested. Continuous quality improvement is central to our monitoring and supervisory activities.

Monitoring and Supervision of Authorization Decision Outcomes

Clinical supervisors, physician advisors, the medical director, quality improvement staff, and the corporate clinical department each have a role to play in ongoing monitoring and supervision of care management/utilization management staff. Monitoring activities include: live call monitoring, audit documentation, clinical rounds, quality audits of denials, and inter-rater reliability studies—each with their own standards for level of supervision, frequency of

monitoring and follow up, as described below. Clinical supervisors and medical staff conduct case-by-case supervision on a daily basis as needed.

Our supervisory reviews address issues beyond ensuring that medical necessity was appropriately determined. Magellan's supervisors also monitor and promote improved communication, coordination, and integration among providers, as well as evidence-based practices and improved outcomes. Supervisors review care manager decisions to ensure that our clinicians are actively involved in shaping treatment planning in a collaborative manner with providers and members and to ensure that services are aligned with members' preferences and goals. This results in better outcomes and reduced care costs.

[redacted]

Documentation Audits

Documentation audits are incorporated into Qfiniti audit capabilities. Magellan's clinical supervisors complete three clinical documentation audits per care manager, per month, with a target of 90 percent compliance or better on policy, customer-specific, and accreditation requirements. Questions related to the consistent application of medical necessity criteria are included in the audit tool.

Care managers receive copies of their monthly audits and are coached in areas for improvement. On a quarterly basis, our medical director audits 25 percent of each of the physician reviews to ensure that they are documenting the medical necessity criteria, the medical necessity criteria is applied consistently, and which level of care guidelines are met or not met; that they offer an alternative level of care if a request is not authorized; and other requirements. The medical director reviews results with each physician, and implements additional training and/or monitoring as needed. The medical director presents quarterly aggregate results from these audits at the Utilization Management Committee meetings. Issues identified through the audit process are addressed during this meeting, along with recommendations for improvement. The

Utilization Management Committee then has the opportunity to comment on consistency or lack thereof, and identify additional interventions or improvement areas.

Other Oversight Activities that Contribute to Improving Care Managers' Consistency in Applying Medical Necessity Criteria

[redacted]

[redacted]

Consultation with the Requesting Provider when Appropriate

Magellan's clinical review process is structured to include requesting providers' input into the decision-making process about authorizing a service request. The workflow for the authorization of routine outpatient care, illustrated below in Figure IV.J.14.1, shows how the care manager will contact the provider to discuss diagnosis, treatment interventions, frequency of sessions, goals, and progress when one of Magellan's clinically- and empirically-derived algorithms identifies a possible utilization or quality of care issue.

[redacted]

Provider Input in the Authorization Process

Providers have several opportunities to share clinical information with Magellan when a request for services is made. First, the provider making the request shares clinical information during the initial review. This is a dialogue between the caller and Magellan care managers to gather relevant information to authorize the service request. For the majority of requests this dialogue provides sufficient information to authorize the request.

If the information is not sufficient the caller has the opportunity to go back to their clinical team and request additional information so that the service request can be completed. If the Magellan

care manager still cannot authorize the request, the caller is informed that the case will be discussed with a Magellan physician advisor.

Once this discussion has occurred, the dialogue with the provider continues with an opportunity to give further clinical information to the Magellan physician advisor. This input point is known as the peer-to-peer discussion. Many times this discussion supplies critical clinical information and the request is authorized.

This next step for provider input, if the services are not authorized, is the appeal, where the provider once again has the opportunity to share additional clinical information with another Magellan physician for a determination.

Monitoring Denial of Service Authorizations in Amounts or Scope Less than Provider Requested

Whenever an authorization was agreed to that was less than the original request, the Magellan care manager enters the units requested and the agreed upon units authorized. This data is summarized and reported to the Magellan UM Committee for on-going monitoring and analysis.

For example, there are times that the authorization determination renders a "partial" authorization—in a lesser amount, over a shorter period of time or of less intensity than what the provider originally requested. Some of these are "negotiated" requests that occur when the provider conducts the clinical review with the care manager. For example, the request originally may be for inpatient (IP) acute care, however, upon clinical review, the care manager informs the provider that the clinical information supports an authorization for partial hospitalization (PHP) but a request for IP would have to go to peer review. If the provider agrees that PHP is an appropriate recommendation, he or he can amend their request, agree with the PHP authorization, and the care is authorized. This can also happen at any level of appeal in which the provider agrees with the alternative level of care authorized.

Another time that Magellan may authorize "less than" the amount requested is in terms of numbers of units or time period authorized. For example, the provider may want 30 extra days of residential care. The Care Manager (or physician, if taken to appeal) may instead offer 14 days, as the clinical information evidences that the youth is very near discharge and only needs a short period of time to finalize discharge plans. In this case, the authorization for the level of care is still being honored, only the number of units or days is less than what was requested; this is considered an authorization.

In these cases, the provider can always come back to Magellan and make a request for additional units or days once the authorization is exhausted. Thus, if 14 days of residential treatment is authorized, the provider cannot "appeal" the other two weeks that were not authorized, but can come back at the end of the 14 day period and request additional time. In this case, the request would be reviewed independently.

The Figure IV.J.14.2 presents the workflow for the Magellan peer review process from the time of a providers request for authorization to the point of a final determination or a request for reconsideration.

[redacted]

Monitoring the Appropriateness of Denial of Service Authorization

The Grievances and Appeals Lead will audit each non-authorization recommendation a care manager makes to ensure the form is complete. Reports are sent to the care manager supervisors monthly who share it with the care managers. The Grievances and Appeals Coordinator will also evaluate decision access reports monthly to ensure care managers are documenting decision times into our clinical application within required timeframes. The

Grievances and Appeals Lead also audits care managers' requests for additional information from providers to ensure they adhere to required timeframes, and shares findings with the care manager supervisors. [redacted]

Clinical Supervisors monitor Care Manager's authorizations and peer review determinations through Qfiniti audits and Inter Rater Reliability techniques to provide feedback as part of ongoing supervision activities. Additionally, through the course of peer review discussions, physician advisors monitor the Care Manager's interpretation of the medical necessity criteria (MNC) and provide ongoing feedback as well.

Non-authorization is monitored through concordance data monitoring. Concordance is tracked at both the individual care manager and physician advisor levels. These monitoring activities help us identify outliers so that we can provide additional training and supervision when we discover that a care manager is inappropriately referring cases to peer review or a physician advisor is inappropriately denying requests that in fact meet MNC. The Medical Director performs peer review audits on each physician advisor each month as well, in order to continually monitor peer review decisions.

IV.K. Member Rights and Responsibilities

Members are the Center of the Nebraska Behavioral Health Managed Care Program

In line with the nine Principles of Care that the Division of Medicaid & Long-Term Care (MLTC) has outlined in the RFP, recognition, support, respect for, and communication of member rights are among Magellan's core principles of care. We will demonstrate our commitment to member rights in a comprehensive approach to ensure that Magellan Behavioral Health of Nebraska members understand their rights and feel comfortable and confident in exercising them. Knowing, understanding, and being confident in exercising one's rights are both empowering and an important element of recovery. In all cases, we are in compliance with Federal and State laws, including Title VI of the Civil Rights Act of 1964, 42 CFR 438.100, Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act; and other laws regarding privacy and confidentiality.

Magellan maintains policies and procedures about the content, format, and timing of information we provide to members about their rights and responsibilities, and about the methods we use to communicate this information to our members and consumers. These are highlighted in the answers to the questions regarding Member Rights.

In accordance with the Principles of Care in the RFP, access to educational information regarding health and wellness is an important element in our member materials. Extensive health and wellness libraries are available on our MagellanofNebraska.com Web site where members can find information on diseases and conditions, learn about tests and procedures, find information on preparing for a surgery or procedure, check symptoms, and much more. Through our partnership with A.D.A.M. Health Solutions, members have access to the world's largest online consumer health information library through MagellanofNebraska.com. This health information library, which is URAC accredited and continually enhanced, includes over 3,900 unique articles and videos covering conditions, procedures, treatments, surgeries, and tests to educate members and help them understand when to seek care.

Member and provider calls are answered 24/7. The Care Management Center in Lincoln, Nebraska, is open Monday through Friday from 8:00 am to 5:00 pm. A team of clinicians and customer service associates are available in Des Moines, Iowa, to answer urgent and emergent calls and member questions during the remaining hours and on weekends and holidays. Physician advisors are also available 24/7 to consult with the after-hours team.

Describe the approach your BH MCO will take to provide members notification of their rights and responsibilities at enrollment.

Notification of Rights and Responsibilities at Enrollment

Magellan's approach to providing our members notification of their rights and responsibilities at enrollment is to ensure that members both receive real-time information and can readily obtain information and easily understand it at any time.

Our primary vehicle for communicating members' rights and responsibilities is our *Member Handbook*, which is mailed to each new member upon enrollment. The *Member Handbook* is available in both English and Spanish, and other languages are available through translation or in alternative language formats. Members may also download either the English or Spanish version from the Magellan of Nebraska Web site to save it or print it. All information we provide to members, including the *Member Handbook*, will meet a sixth-grade reading comprehension level (not to exceed a grade-level of 6.9), based on the Flesch-Kincaid readability index.

In addition to the *Member Handbook*, we use other modalities to disseminate information to members about their rights and responsibilities. These include our Web site, customer service office, public events, and our network providers' offices.

Magellan Behavioral Health of Nebraska Website

In addition to inclusion in the *Member Handbook*, we make the Statement of Member Rights and Responsibilities easily available to consumers from the homepage of www.MagellanofNebraska Web site, in English and Spanish. Members will also be able to watch and listen to, at their convenience, a webinar in English or Spanish that explains member rights and responsibilities.

Customer Service

Members may also call Magellan Customer Service to request information about their rights. A customer service associate (CSA) will verbally explain member rights related to a particular question or concern of the member. The CSA may also mail the Member Rights Statement or the *Member Handbook* to the member or direct the member to the Magellan of Nebraska Web site, based on the member's preferences.

Members, family members and representatives, customer organizations, and the general public may also call customer service to request a copy of the Statement of Member Rights and Responsibilities, or view it on the Web site.

Public Events

Public events are a cornerstone of our communication strategy in Nebraska. We will continue to distribute the Member Rights and Responsibilities Statement at key consumer and family events, such as the Nebraska "Success, Hopes, and Dreams" Behavioral Health Recovery Conference and the Nebraska Adoption Conference.

Provider Distribution

Magellan's *Provider Handbook* outlines provider responsibilities regarding distribution of member rights. Providers must:

- inform members of their rights and responsibilities
- provide documentation of completing this activity (a statement signed by both the provider and the member) in each member's file
- give members an opportunity to discuss these rights with the provider.

In addition to our *Provider Handbook*, we inform providers about member rights and responsibilities during orientation. This education is reinforced during chart audits that look for documented communication with members regarding their rights.

Annual Updates on Member Rights and Responsibilities

We provide members an Annual Member Notice about how to obtain the most up-to-date information regarding Member Rights and Responsibilities and for requesting other materials, such as the *Member Handbook*. We also notify members of any significant change in the member materials at least 30 days in advance of the change. Magellan will work with the State to define "significant changes."

Magellan Member Rights Statement

Below is Magellan's Member Rights Statement, as shown in the existing *Member Handbook*.

"Members of Magellan's programs have many rights. As a member you have the right:

- to be treated with dignity and respect
- to receive the behavioral services you need in a convenient place and at a time that works well for you
- to ask for a therapist who understands your language and culture, or who speaks American Sign Language (ASL)
- to learn about the mental health and substance abuse services in your program
- to get information about your illness and treatment
- to participate in decisions about your treatment
- to receive information on available treatment options and alternatives
- to request and receive information about Magellan
- to choose an accessible service provider from Magellan's network
- to change your service provider if you are unhappy with your current provider
- to ask questions and get answers before and during treatment
- to refuse treatment and get an explanation of what may happen if you don't get treatment
- to make a grievance about your services and get a timely answer
- to ask for a fair hearing
- to privacy and confidentiality, including to allow or refuse the release of information, except when release is required by law
- to request and receive copies of your records and request that records be amended or corrected
- to make an Advance Directive
- to freely exercise your rights without affecting how you're treated

- to get a second opinion when appropriate."

Nebraska Medicaid enrollees have the following additional rights:

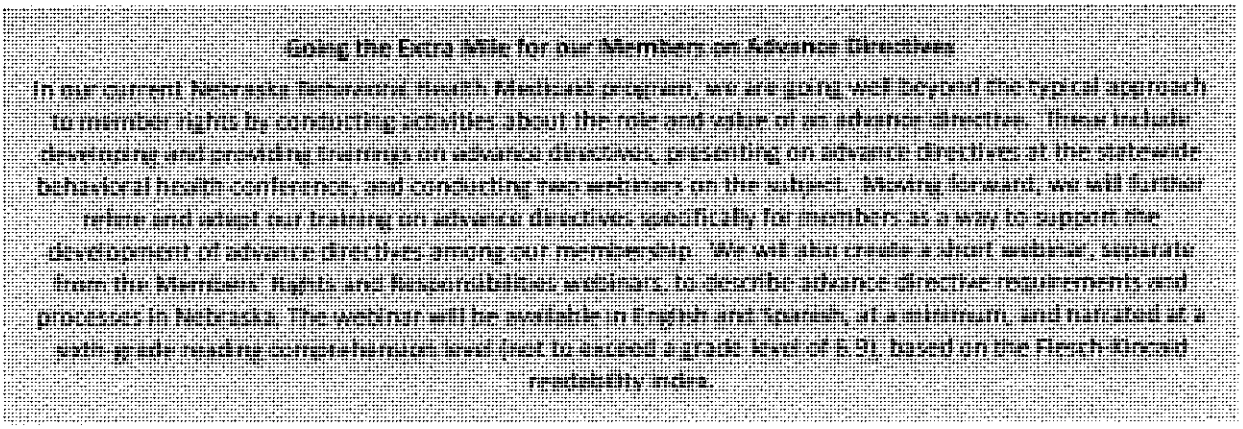
- to be free from restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- to file an appeal or grievance about a Magellan action or decision
- to request a fair hearing from DHHS if they are not satisfied with the outcome of their appeal."

Compliance with Member Rights and Responsibilities

Magellan's approach to accessible and meaningful member rights and responsibilities includes training and communication to support Magellan staff, providers, and contractors in fully understanding member's rights and responsibilities, as outlined in the Quality Improvement Program Description.

Providers are required, by contract, to abide by all policies and procedures contained in the *Member Handbook*. In the new provider orientation, providers are trained on their role to educate members on their rights and responsibilities, and to document such in the member's chart. Providers are encouraged to give members an opportunity to discuss these rights on their first appointment. Provider compliance with obtaining the member's signature on the member rights and responsibilities statements and filing in the medical record is audited during treatment plan reviews.

Magellan also provides annual training on member rights and responsibilities for all employees.



Going the Extra Mile for our Members on Advance Directives

In our current Nebraska Behavioral Health Medicaid program, we are going well beyond the typical approach to member rights by conducting activities about the role and value of an advance directive. These include developing and providing trainings on advance directives, presenting on advance directives at the statewide behavioral health conference, and conducting two webinars on the subject. Moving forward, we will further refine and adapt our training on advance directives specifically for members as a way to support the development of advance directives among our membership. We will also create a short webinar, separate from the Members' Rights and Responsibilities webinars, to describe advance directive requirements and processes in Nebraska. The webinar will be available in English and Spanish, at a minimum, and narrated at a sixth grade reading comprehension level (not to exceed a grade level of 6.9), based on the Flesch-Kincaid readability index.

Describe the approach your BH MCO will take to provide new members grievance, appeal, and State Fair Hearing information.

Providing Members Information on Grievances, Appeals and State Fair Hearings

All procedures related to filing a grievance or appeal or requesting a State Fair Hearing are described in the *Member Handbook,* on our Web site, and within the adverse determination notice

we send to members when a service is not authorized. All information we send to members will meet a sixth-grade reading comprehension level (not to exceed a grade-level of 6.9), based on the Flesch-Kincaid readability index.

Magellan's customer service associates (CSAs) are also trained and available to provide guidance and support to members by phone to answer questions about the filing process, the steps that Magellan will take to respond, and the timeframes for a response. This assistance is available to members 24 hours a day, seven days a week, using a toll-free telephone number. Forms are available to members through the Magellan of Nebraska Web site so that members may file a grievance online; members and/or a member-authorized representative may file a grievance.

We also make information about filing a complaint or grievance available to members by having forms available in providers' offices. Magellan does not require members to use these forms; rather, the forms are intended as a helpful option to members if they choose to use them. We will accept a grievance in whatever format a member chooses and will offer the member assistance with filing a grievance, as requested.

Members may also contact Magellan's Recovery and Resiliency Services staff at a toll-free number to obtain verbal assistance in filing a grievance or appeal. We will include information about how to reach our cuustomer service office, as well as the Recovery and Resiliency Services teams in the *Member Handbook* and on the Magellan Web site, www.MagellanofNebraska.com. The Recovery and Resiliency Services staff is also available during "open hours" that are held via a toll-free conference call each month. Any individual may join this call to ask questions, including how to file a grievance or appeal.

Describe the information materials your BH MCO proposes to send to new members. Address language alternatives that will be available and how the BH MCO will ensure that reading levels will be at a sixth grade level.

Magellan of Nebraska will send a "welcome packet" (member orientation materials) to all new members within 30 days of receiving notice of the member's enrollment. The packet will contain a welcome letter; the *Member Handbook;* the *Provider Directory*; and the "Help for Mental Health and Substance Use Disorders" tip sheet, which provides an overview of Magellan Services at a glance, as described below.

Welcome Letter

Newly eligible members will receive a welcome letter from Magellan, which contains instructions on how to contact Magellan via the toll-free number. This letter also describes how to request handbook information in an alternative language format, and these instructions are in English, Spanish and Vietnamese. Magellan makes all written materials available in English and Spanish and other alternative formats to accommodate members with limited English proficiency and those with special needs. All written materials sent to new members will be written at the sixth-grade reading level (up to 6.9), using the Flesch-Kincaid readability index.

Member Handbook

The primary vehicle for member orientation is our *Member Handbook,* which is available in both English and Spanish. Although included in the Welcome Packet for new members, members may also download this document from the NebraskaMagellanofNebraska.com Web site to save it or print it. The *Member Handbook* provides key information to members about the Magellan Medicaid Managed Care program for mental health and substance abuse services, and covers all provisions of 42 CFR 438.10(b)(3) and 42 CFR 438.10(f-h). This information will include but is not limited to the following:

- How to contact Magellan for assistance and obtain more information about behavioral health treatment options.
- The types of services that are covered in the plan for adults, adolescents and children, and how members may obtain help in understanding their benefits consistent with 42 CFR 438.10(b)(3). Each service included in Attachment A of the RFP is included in the *Member Handbook,* along with a short description of the service. Additionally, the member is informed about how to obtain medical and prescription drug services and transportation services.
- Procedures for obtaining benefits, including authorization requirements. The material also explains that it is the contracted provider's responsibility to obtain such authorizations.
- A glossary with definitions of services and other important terms.
- How to find a provider in the Magellan network or change providers, which includes information on restrictions for selecting providers (they must be in-network providers who are contracted for the desired services). The process members should use should they want to obtain services from non-network providers is also clearly explained.
- How and where to get emergency care and treatment or get services away from home, including the fact that the member may go to *any* emergency room (even those not contracted with Magellan), a definition of what constitutes and emergency and the fact that an authorization is not required for emergency services.
- Information about available post-stabilization services, in compliance with 42 CFR 422.113(c).
- Member rights and responsibilities, including rights to privacy and confidentiality.
- How to get help with completing an advance directive.
- How to file a grievance and appeal a denial decision, and how to obtain a State Fair Hearing, as well as the timeframes for filing a grievance, appeal or State Fair Hearing.
- How to contact the Recovery and Resiliency Services staff.
- How to report Medicaid fraud, waste or abuse.
- A description of services available to members through other vendors for the Medicaid State Plan, and how to access such services.
- Information for locating community-based resources.
- How to contact Magellan for help with items not included in the *Member Handbook..*

There is no counseling or referral service that Magellan does not cover because of moral or religious objections.

Magellan continually updates information in the *Member Handbook*, as new information is available, and as we receive input from stakeholders. The Nebraska *Member Handbook* has been updated annually, with the most recent update completed in March 2012, following approval by the MLTC. Under the new contract, we will also update the look and feel of the *Member Handbook* to reflect the new program. Attached is a copy of the *Louisiana Member Handbook* that will be used as a model for the new *Nebraska Member Handbook*. See **Attachment F.** Model Handbook for Nebraska.

Prior to obtaining MLTC approval of the revised handbook, we will obtain stakeholder input through our new governance and quality structure that includes consumers, advocates and providers. This new structure is described in the *Section IV.M. Quality Management* of our response under *Proposed Implementation Approach*. Following finalization of the *Member Handbook*. Thirty days prior to the start of the new contract, all members will receive a new *Member Handbook*.

Provider Directory

Choice is the key to Magellan's approach to service delivery for our members. Information on accessing providers is included in the *Member Handbook*, as described above, and in the *Provider Directory*, which is included with the welcome packet for new members. Magellan's Medicaid-approved *Provider Directory* currently contains the names, locations, telephone numbers, and non-English languages spoken by contracted providers. Emergency Services is included as a Level of Care in the *Provider Directory*. Additionally, the Directory includes an indicator on whether or not a listed provider is currently accepting new patients. See **Attachment G.** Provider Directory.

Provider Search Features on our Website and via Free Smart Phone Apps

The *Provider Directory* is also available on the Magellan of Nebraska Web site. Using the website's search function, visitors can either download the provider list or search for a particular provider. If they elect to search for a provider, they can search by location or by name. If they search by location, they enter their zip code, and the distance they are willing to drive to a provider location, and the system returns all providers meeting that criteria. These criteria can be narrowed by ethnicity, gender or language of the provider in the advanced search function. Once the search is completed, the system returns the name, address and phone number, the specialty of the provider, the office hours, and other details and maps for the location and driving directions.

Provider-find capabilities are also available on a free Smartphone application. In this application, members can search by zip code, by the distance from their zip code, by specialty, by ages treated, by ethnicity, or by language and gender of the provider.

The provider search features on the Web site and on the Smartphone application contain real-time information. The *Provider Directory* is updated online on the first of every month. Magellan will update printed provider directories quarterly and make them available as requested.

Tip Sheets

Magellan also produces easy–to-read, one- to two-page "tip sheets" that are designed to provide basic information about behavioral health services and access to care. We distribute these tip sheets during member trainings and distribute them to family organizations and member advocacy groups, as well as at community events. As noted above, the tip sheet titled, "Getting Help for Your Mental Health and Substance Use Disorder Needs," provides an easy-to-read overview of how to use Magellan's services, that we include in the welcome packet.

Consistent with the first Principle of Care, to improve the overall health of every person, as outlined in the RFP, Magellan has produced many tip sheets with information on various health and wellness topics, including "Cholesterol and Lifestyle" and "Managing Your Weight with Healthy Eating." Members may call customer service to request a tip sheet or access tip sheets online from our Web site, www.MagellanofNebraska.com. In addition, we distribute tip sheets at local events in Nebraska that Magellan participates in, such as the "Success, Hopes, and Dreams" conference, Nebraska's first statewide mental health recovery conference that the Division of Behavioral Health sponsored and we helped plan. We will make tip sheets available throughout the life of the contract and periodically add new topics.

The "Getting Help for Your Mental Health and Substance Use Disorder Needs" tip sheet is presented below in Figure IV.K.3.1.

Alternative Formats of the Member Handbook to Meet Members' Needs

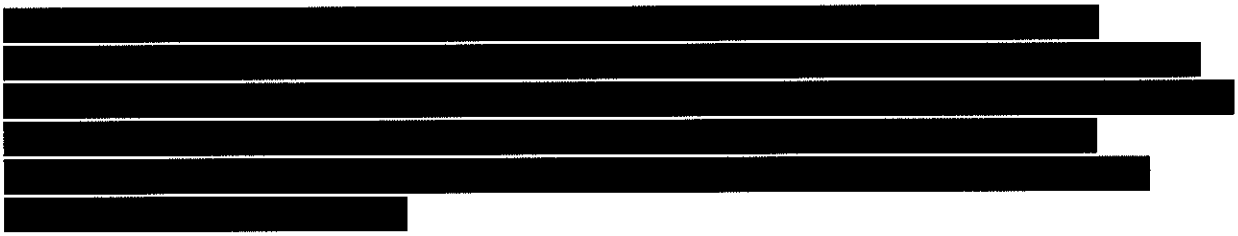
We will translate the *Member Handbook* into any other language spoken by at least 5 percent of the eligible population, or when the State identifies additional non-prevalent languages as outlined in the RFP. The *Member Handbook* will be initially available in Spanish and English.

The *Member Handbook* informs members that they can contact Customer Service at a toll-free number to obtain materials in an alternative format. For example, we currently make large-print versions of the *Member Handbook* available upon request. Additionally, through translation, we will make the information available to members who do not speak English or Spanish. Members receive an Annual Member Notice via postcard that includes information for requesting member materials, including the *Member Handbook.* The postcard also contains instructions in Spanish on how to request member materials.

We also utilize a TTY (Telephone Typewriter) or TDD (Telecommunications device for the deaf). The member communicates with the deaf operator, and the operator communicates with the Magellan representative. The Magellan representative responds and the interpreter communicates this to the member.

All of these services are available to the member free of charge. Providers are also required to provide interpreters and provide services in a culturally competent manner, as noted in the Provider Handbook. The handbook requires providers to have access to interpreters, and the providers may bill for interpretative services. If a provider does not have access to interpretation services, Magellan will help them obtain the interpretation as noted in the *Section IV.L. Provider Network Development and Management.* The provider contract requires that providers adhere to all terms of the *Provider Handbook.* Additionally, the provider contract specifies that providers may not bill members for covered services.

Member and Stakeholder Engagement in Finalizing the Member Handbook



Once MLTC has approved the revised *Member Handbook* for Nebraska Medicaid members, we will post it to Magellan's Web site, www.MagellanofNebraska.com. We will distribute the *Member Handbook* to all Medicaid managed care enrollees currently in care—at least 30 days prior to the contract start date, or two weeks after we are provided the initial eligibility file if we do not have

the eligibility file 45 days prior to the contract start date. We will also distribute hard copies in locations throughout communities in Nebraska where members will be able to take them free of charge. Locations will include provider offices, health centers, human and social service agencies, family and consumer support organizations, faith-based service organizations, and tribal health centers.

Describe the process the BH MCO will take to inform a member who has received his or her care from a provider who has been terminated from the network.

Magellan maintains policies and procedures to ensure that members always have access to appropriate care, including after their provider has been terminated from the Magellan provider network.

Process for Informing Members after His or Her Provider has Terminated from the Network

Upon a provider termination from the Magellan network, Magellan will generate a list from the claims system of all members who have seen the provider within the past 6 months. Additionally, Magellan will query for any active, open authorizations for services that might not have resulted in a claim. Magellan's policy is to generate letters to impacted members within 5 days of the notification of termination. **Our standard of 5 days exceeds the MLTC requirement of the notification to occur within 15 days.**

We will generate these letters to impacted members to notify them that their provider is no longer a participating network provider with Magellan Behavioral Health of Nebraska. The letter will include the following language:

> *"If you need assistance in locating a new provider, please contact Magellan at 1-800-424-0333 to get a referral to a network provider at your earliest convenience. Our trained staff can help you locate another provider who can address your needs."*

When a member chooses to contact Magellan to obtain assistance with a referral to a different provider, a care manager or customer service associate (CSA) will offer the member information over the telephone about several different behavioral health providers in the member's geographical area. The Magellan staff providing assistance will also direct members to provider websites for further information, and will follow up by mailing a letter to the member that offers a complete list of service providers in the member's geographical area. Upon request, we will send a list of providers tailored to a member's criteria to facilitate this transition. For example, if the member prefers a Spanish-speaking, female therapist, we will send the member a list of therapists meeting those criteria.

Describe the approach your BH MCO will take to inform members about covered health services.

Magellan's approach to informing members about covered services is to use as many different communication methods and formats as are appropriate, convenient and effective in reaching our members. Particularly when explaining the types of services available and what they involve, we

consider the member's or family member's perspective. The primary tools that we use to inform members about our covered services are the following:

- *Member Handbook*
- Web site
- quarterly member newsletter
- tip sheets.

As described above, the *Member Handbook* includes brief descriptions of covered behavioral health and other Medicaid covered services; how to access each type of service; and an explanation of specific behavioral health terms. Members may easily access the *Member Handbook* from our Web site to review online or print out information on our covered services and how to access them. To facilitate members' access to our website, we publicize its URL routinely in our newsletters, member and provider handbooks, provider directories, and on all Magellan correspondences.

In addition to having a complete list of behavioral health services and ways to access them, Magellan includes a section in the *Member Handbook* on the following types of medical services and how to access them:

- medical care
- hospital care
- vision care
- hearing care
- prescriptions
- chiropractic care.

Magellan produces a member newsletter each quarter highlighting a specific theme that is relevant to the member population. Past themes have focused on transition-age youth, peer support and bullying. Each issue includes Magellan contact information, a list of state resources and information about the Magellan of Nebraska Web site to help members become and stay engaged in their care. This quarterly newsletter offers another tool for communicating with members about where they can obtain information about covered services and how to access care.

Magellan is experienced in producing customized educational materials called "tip sheets" (described above) for all of our public sector programs nationwide. We will distribute these easy-to-read tip sheets through a number of vehicles, including posting on websites, and handing out at community forums and in targeted presentations to stakeholders. These tip sheets will help to introduce Magellan to the community, and provide basic information about Magellan's behavioral health services and how to access care.

Describe your BH MCO's methodology to assess disparities in treatment among disparate races and ethnic groups and correct those disparities.

Magellan works to identify and address racial and ethnic disparities in health outcomes in every state it operates. We understand that individuals who suffer from a serious mental illness die, on average, 25 years younger compared to the general population. We also know that the cumulative disadvantages of racial or ethnic discrimination, language barriers, and physical disabilities can make this disparity even wider. Magellan takes a systematic approach to reducing barriers to treatment across our entire organization and in each state we serve.

We are aware that 40 percent of children eligible for Medicaid in Nebraska are children of color; therefore, to reduce and eliminate racial disparities, we recognize that it is critical to proactively and systematically identify and eliminate barriers in all aspects of our program including the availability of and access to services, and in communications with members. Evaluating our programs and services is a key aspect of our approach to identifying disparities and addressing barriers.

Magellan's national priorities include the reduction and elimination of disparities for underserved ethnic and racial populations. In Arizona, race and equity, one of our six Leadership Principles, guides the development and execution of all our initiatives, operations, and expected outcomes. Through the Race and Equity Workgroup, we work to continually improve our service to diverse member populations. This work cannot be done without strong collaborations with our provider partners, members, and other community stakeholders. During a climate of fiscal challenges, the workgroup was successful in increasing the number of Latinos receiving behavioral health/substance abuse services from 4 percent in 2007 to 13 percent by December 2011.

[redacted]

[redacted]

We will employ a wide range of processes and tools to prevent, identify, and correct any discriminatory practices, including following established procedures for targeting, selecting, and credentialing subcontracted providers prior to contracting. We will continue to enhance our provider and staff education and communication programs to ensure all providers and staff understand member rights as protected by state and federal regulations, including provisions of Title VI of the Civil Rights Act of 1964 and Executive Order No. 13166 that prohibit discrimination and ensure equitable access to care and services.

In the 2012 adult member satisfaction survey, 87% of respondents felt that staff were sensitive to their cultural background (race, religion, language, customs, etc.) For the minor member satisfaction survey 83% of respondents were satisfied with this same element.

Describe your BH MCO's policies, procedures, and processes to ensure that in the process of coordinating care, each member's privacy is protected.

Confidentiality is a key tenet of Magellan's operations and processes. [redacted]

Magellan's Commitment to Member Privacy through Provider Education

The Magellan *Provider Handbook* starts with our philosophy: "Magellan protects the rights and responsibilities of all members. We are committed to having everyone involved in the delivery of care respect the dignity, worth, and privacy of each member." We are absolutely committed to ensuring member information is protected at every level and in every transaction performed by our organization or by contracted providers.

All providers participate in a thorough orientation to Magellan and the Magellan contract provisions. Respect for member privacy is stressed throughout this training process.

Magellan's Commitment to Member Privacy through Magellan Staff Education

Magellan has a robust training program for all employees regarding the protection of member information, including more specialized training for clinical staff, and further training for any clinical vice-president or compliance officer.

All Employees

All employees must complete training, which is an online, computer-based training module containing the tenets of HIPAA's privacy and security requirements. New employees must complete this training prior to the end of their first thirty days of employment. We also provide an annual HIPAA (including Privacy and Security) refresher training for all employees, which is completed online. If an employee has not taken the necessary applicable HIPAA training, the employee's supervisor is contacted to ensure that the individual completes the training.

The Compliance Department also has a webpage where we display various HIPAA information and resources. In addition to our regular HIPAA training, Magellan also requires all employees to complete mandatory annual training regarding our *Corporate Compliance Handbook*, which contains privacy and security topics as well. Each of these trainings contains a post-training test to ensure the material is understood. A score of 80 percent or higher is required for the employee to receive credit for the coursework. Topics covered in the testing include the following related to protecting member's privacy:

- the six rights members have for privacy protection
- our response to member's request to exercise each right
- examples of when an authorization for use/disclosure is required
- how and when to complete the Authorization for Use/Disclosure Form
- example of use/disclosure of PHI without the member's authorization
- the difference between a "delegate," an "authorized representative," and a "personal representative"
- what is meant by "verification prior to disclosure"
- the steps taken to verify the identity of the requestor.

Occasionally Magellan also writes articles on HIPAA, confidentiality, or security that are printed in our Corporate Compliance Department's monthly newsletter, *Compliance First*, which is distributed to all employees throughout the organization, or in our bi-weekly company newsletter, the *Magellan News*.

Clinical Employees

In addition to completing the all-employee trainings, all clinical employees must complete privacy training specifically targeted to protecting member privacy of clinical records and clinical collaboration. This higher-level training for clinical employees is conducted online via a computer-based training module. Magellan's Compliance Officer and a trainer from the Learning and Performance Department deliver the training.

This training includes HIPPA Tier I and Tier II training. HIPAA Tier I provides a broad overview of all aspects of HIPAA Privacy and Security; HIPAA Tier II trains clinical staff members on the fundamental HIPAA basics but focuses on protecting the rights of our members related to the privacy of Protected Health Information and the security regulations in place to safeguard confidential information from unauthorized disclosure, alteration, loss or destruction.

Clinical VP and Compliance Officer Training

In addition to completing the all employee and clinical training, any clinical vice president and compliance officer must complete the annual HIPAA Tier-III training, which is yet more detailed and conducted in a classroom environment. This training focuses on uses and disclosures, and all aspects of accounting of disclosures. We also provide an annual HIPAA (include Privacy and Security) refresher training to all employees, which is performed online.

Ensuring Training Compliance

If an employee has not taken the necessary applicable HIPAA training, their supervisor is contacted to ensure that the employee completes the training. All employees are required to provide an attestation that they have read and will abide by the terms of the handbook.

In addition to these various required training sessions, we conduct a quarterly compliance conference call attended by the compliance officer of the site where we typically include a HIPAA topic or update. When more targeted information or guidelines are called for, we distribute a memo or a training alert as needed.

Member Privacy Protection in Magellan Policies and Procedures

Magellan Health Services, its subsidiaries and affiliates, are subject to the same programs, policies and procedures for maintaining privacy of Protected Health Information (PHI), data security, data exchange, and other compliance concerns. Magellan has a comprehensive privacy and security program to ensure compliance with the HIPAA standards for privacy and security. We also recognize that the privacy protections are sometimes even more stringent for those members receiving treatment for substance use disorders. Therefore our compliance program includes policies and procedures that contain specific guidelines and requirements covering all areas of the HIPAA Privacy Rule and Security Rule as well as 42 CFR Part 2 covering Alcohol and Drug information.

Magellan has historically held privacy of patient information as a key tenet of our operations and processes. **Magellan has always implemented and maintained policies and procedures for confidentiality that meet or exceed existing state and federal regulations, and has required network providers to do so as well.**

Magellan's many existing policies detailing compliance with HIPAA (including the HITECH Act and its implementing regulations) and other privacy-related requirements include the following, as outlined in Table IV.K.7.1 below.

[redacted]

[redacted]

Corporate Oversight

Magellan's Corporate Compliance Department is charged with overseeing ongoing compliance with the HIPAA regulations. This department is staffed by attorneys, compliance directors, and research analysts who work together to monitor any new developments and coordinate any necessary implementation of updated compliance requirements. An internal auditing department audits corporate departments and regional offices to ensure appropriate compliance measures and procedures are in place.

Describe your BH MCO's plan to ensure members access to a second opinion.

Members' Access to a Second Opinion

Member choice is a cornerstone of Magellan's approach to service delivery. This includes having access to a second opinion. Magellan of Nebraska members have the right to request a second opinion from a network provider at no cost to the member.

Magellan's policies and procedures regarding member rights, which are already incompliance with the RFP requirements for a second opinion, state:

"Each Member has the right to request a second opinion from a qualified health care professional within the provider network. Magellan will provide for a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member. If a qualified health care professional is not available within the network, Magellan will help the member arrange for a second opinion with an out-of-network provider at no cost to the member. However, all out-of-network referrals must have prior authorization from Magellan." See **Attachment H** for a draft of the Nebraska CMC Second Opinion Policy.

Describe how your BH MCO will ensure services will be provided that are sufficient in amount, scope, and duration to reasonably be expected to achieve the purpose for which the services are furnished and are equal to those furnished under fee-for-service Medicaid.

Magellan of Nebraska maintains a philosophy of care to provide the least restrictive, community-based treatment that is safe and effective. As the current ASO contractor for Medicaid behavioral health services in Nebraska, we have been responsible for all managed care and selected fee-for-service (FFS) authorizations within our scope for the past 10 years, and thus have a deep understanding of how it functions. Magellan will ensure that services available to the managed care

population will always be at least as rich as the fee-for-service Medicaid population, in compliance with existing regulations. Moreover, we will be providing additional downward substitution and value-added services, as described in *Section IV. G. Value-Added or Substitute Services* in the *Proposed Implementation Approach*, to the managed care population to promote recovery and resiliency among Medicaid managed care members.

Additionally, member and provider calls are answered 24/7. The Care Management Center in Lincoln, Nebraska, is open Monday through Friday from 8:00 am to 5:00 pm. A team of clinicians and customer service associates are available in Des Moines, Iowa, to answer urgent and emergent calls and member questions during the remaining hours and on weekends and holidays. Physician advisors are also available 24/7 to consult with the after-hours team.

Ensuring that Services are Sufficient in Amount, Scope, and Duration to Achieve their Purpose

The purpose of a service authorization is to ensure that members receive necessary treatment that will help them achieve their recovery goals. Magellan accomplishes this by doing a review to determine medical necessity for some services, and also by confirming that services are person-centered and consistent with best practices in treatment, treatment planning, goal-setting and discharge planning.

[redacted]

[redacted]

Magellan clinical staff will conduct authorization reviews throughout treatment to ensure that it is progressing as expected. The care manager will ensure that treatment is evidence-based and that the member is improving as a result of treatment. As necessary, the care manager will discuss with the provider any barriers to progress or discharge. This discussion may also cover alternative treatment approaches, medication changes, use of natural supports, or other possibilities. More detail on Magellan's authorization process is described below, as part of our response to the eleventh question of this section, *IV.K. Member Rights and Responsibilities.*

Prior Authorization for Routine Outpatient Services

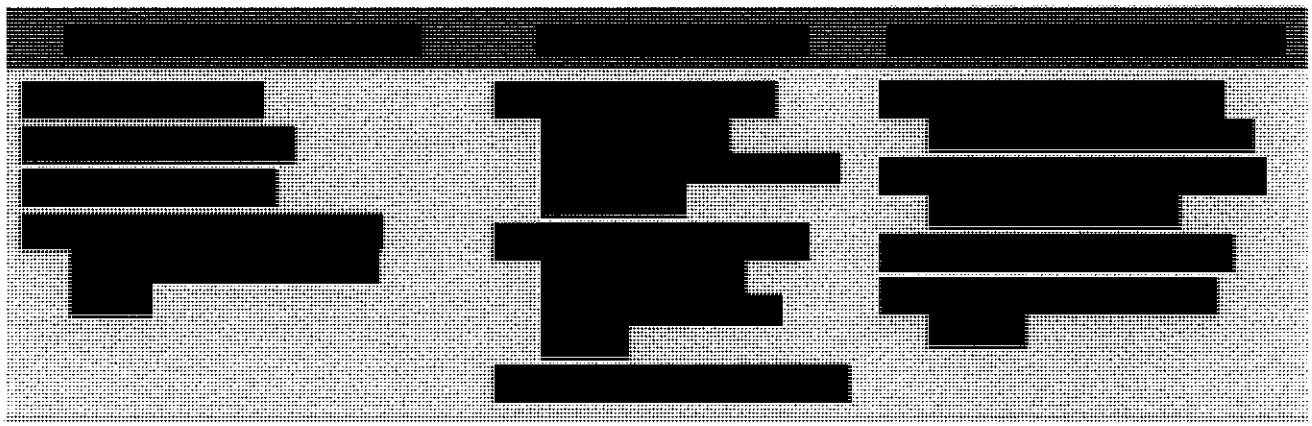
Magellan will update and enhance the current outpatient service authorization process by utilizing *Targeted Outpatient Recovery Management* analytic tools for reviewing requests for routine outpatient services, such as:

- individual therapy
- family therapy
- group therapy
- medication management.

Targeted Outpatient Recovery Management

To minimize barriers for members to receive routine outpatient treatment, Magellan will not require prior authorization. Instead, we will conduct a systematic claims review of all cases to ensure quality and appropriate utilization. We will use clinically- and empirically-derived algorithms that will alert clinical staff, based on the applied criteria, when there may an occurrence of under- or over- utilization, or another kind of quality of care issue that requires further review. Examples of three types of criteria included in these algorithms are shown in the table below.

[redacted]



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Magellan's Proposed Authorization Process for Routine Outpatient Therapy Requests

Based on Magellan of Nebraska's analysis of authorization outcomes over two periods—one for which routine outpatient requests were simply authorized using online or paper forms, and another when Magellan conducted clinical reviews on every outpatient therapy request (except medication management) that met a threshold for the number of previously authorized units of service—with approval from MLTC, Magellan stopped conducting clinical reviews of most routine outpatient therapy requests; providers simply submit a written treatment request form or request sessions online. Magellan's quality improvement (QI) staff regularly sample outpatient charts to conduct retrospective audits.

Sometimes, a clinical review is still warranted. For example, a member may have a primary or secondary diagnosis that is not covered in the benefit plan, along with a covered diagnosis (e.g., a covered mental health diagnosis plus a diagnosis of an intellectual or developmental disability). In these cases, the case record was flagged so that future requests are triggered and a care manager conducts a clinical review. Under the new contract, no clinical review or prior authorization will be conducted unless it is triggered by meeting threshold criteria from a Targeted Outpatient Recovery Management algorithm or from a quality review.

Ensuring that Services Furnished and Equal to those Furnished Under Fee-for-Service Medicaid

Our focus on outcomes is what enables us to determine parity between services furnished under managed care versus fee-for-service. For example, we track outcomes on readmission rates for inpatient, residential, and other levels of care in order to ensure that the initial services achieved their goals. We work in collaboration with providers to provide additional training and tools to improve outcomes, as needed, and when necessary, establish a corrective action plan with individual providers that present as outliers.

Magellan's approach to managing care is clinically-driven whether or not we are financially at risk for managing the care of members. We train care managers and other clinical staff to conduct reviews based on our clinically-driven approach.

[redacted]

[redacted]

Describe your BH MCO's policies, procedures, and processes for processing requests for initial and continuing authorizations of services, and ensuring consistent application of review criteria for authorization decisions.

How Magellan Processes Service Request Authorizations

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Care Manager Training

All Magellan care managers attend a structured orientation program at the beginning of their employment. In 2011, after reviewing the results of the provider satisfaction survey, and augmented by information regarding lack of clinical consistency in Town Hall discussions, Magellan created a new *Care Management Training Manual*. Topics included in the new manual include:

- clinical treatment philosophy
- medical necessity criteria (MNC)
- initial and concurrent review processes
- clinical and administrative non-authorizations
- referring to physician and peer advisors
- clinical documentation
- coordination of care
- contract specific considerations.

Care managers also attend monthly care manager staff meetings. Given the focus on improving the consistency of clinical decision making, these staff meetings now include annual training reviews, including:

- MLTC medical necessity criteria
- Magellan *Supplemental Criteria* that our clinical leadership has developed with input from customers, providers, outcomes studies, national professional associations, and care managers
- American Society of Addiction Medicine (ASAM) criteria for children and adolescents with substance abuse issues.
- reviews of evidenced-based practice standards
- best practices in psychopharmacology
- recovery/resiliency/cultural competency principles
- clinical practice guidelines for specialty populations.

Many of these trainings are available by webinar for staff who are unable to attend the on-site sessions. Whenever possible, we offer care managers an opportunity to attend trainings on these topics when they are offered in the community.

Consultation with Physician Advisors and Senior Clinical/Medical Leadership

An important element in our clinical supervision process is our access to physician advisors for case-specific consultation as well as for non-authorization of cases that do not meet medical necessity criteria. Every day, care managers have access to senior clinicians and medical directors for support with complex cases. Additionally, the clinical director, medical director, and other senior clinical staff are available to provide ongoing technical assistance and consultation regarding interpretation and application of medical necessity guidelines.

[redacted]

[redacted]

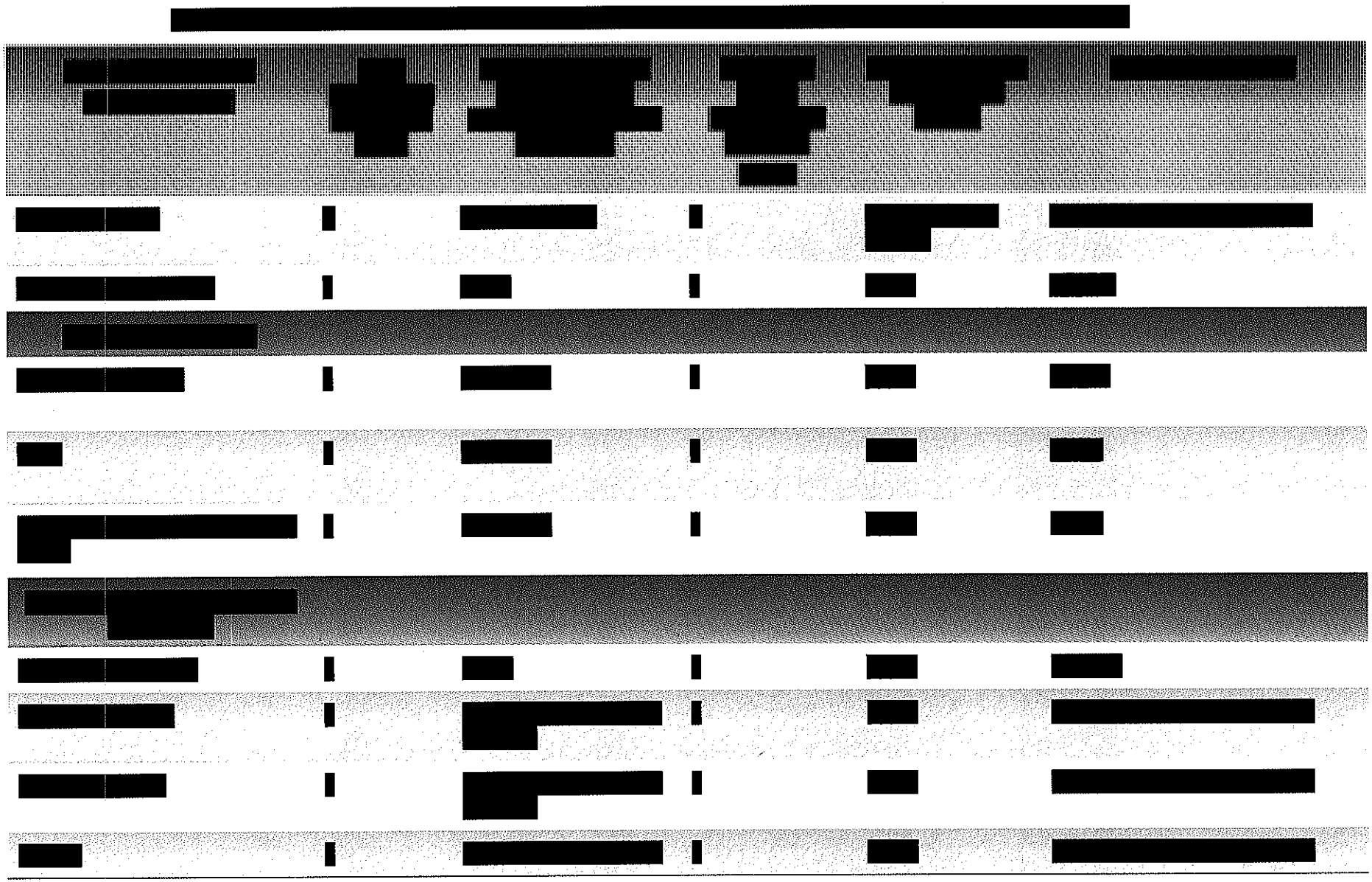
[redacted]

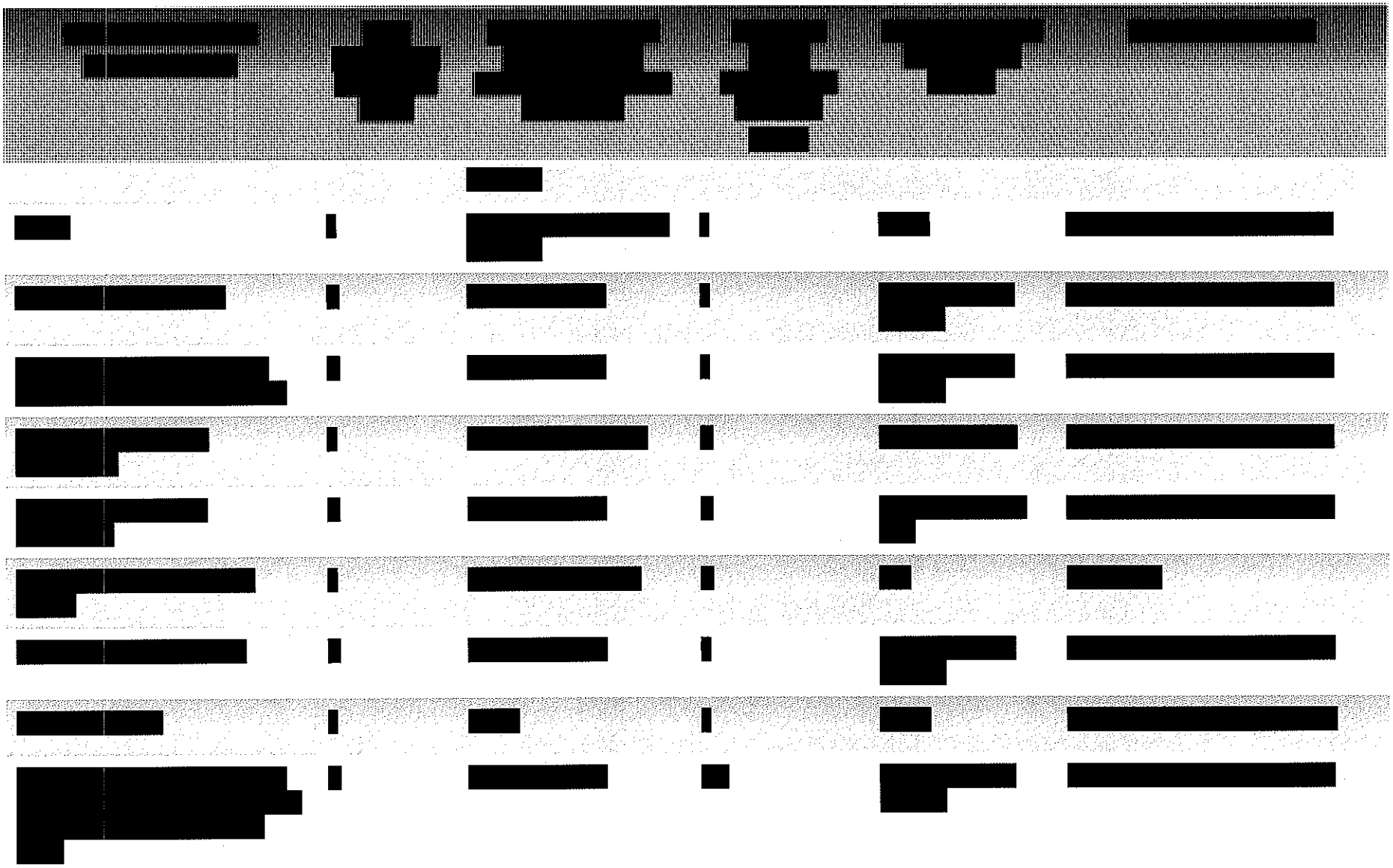
Provide a listing of services your BH MCO will require to be authorized and describe how your BH MCO will communicate this information to providers and members. Also provide the process by which your BH MCO will communicate authorization information to providers.

A complete list of services that require authorization under our current contract is located on our Magellan of Nebraska Web site, www.magellanofnebraska.com, under the "For Providers" tab, within the *National Provider Handbook* and *Nebraska Provider Handbook Supplement.* This list will be updated for the new risk-based contract.

Authorization Requirements by Service Type and Population

Using the list of services covered by this contract in Attachment A of the RFP, we have outlined Magellan Behavioral Health of Nebraska's plan for authorizing each type of covered service under the new contract. [redacted]





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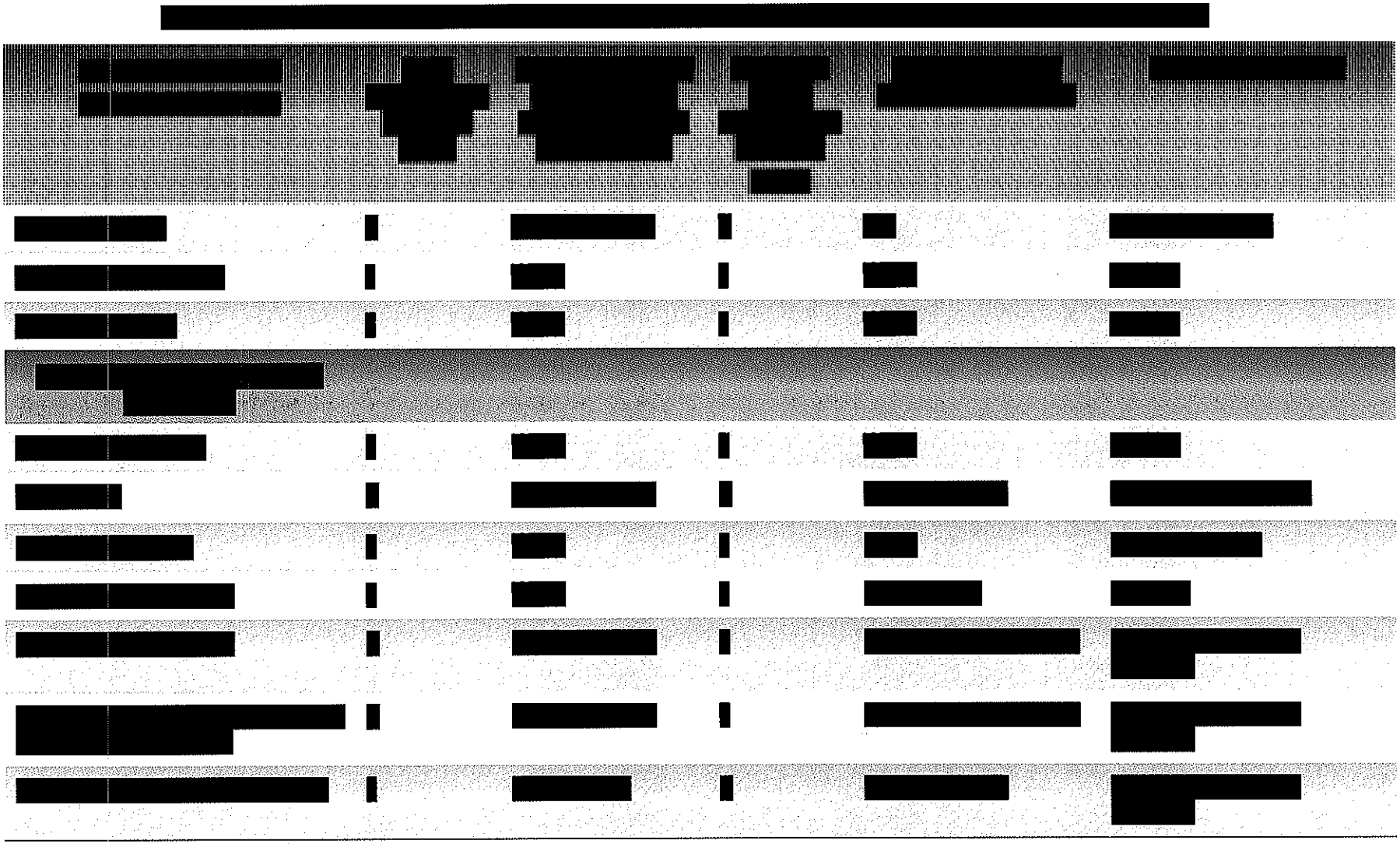
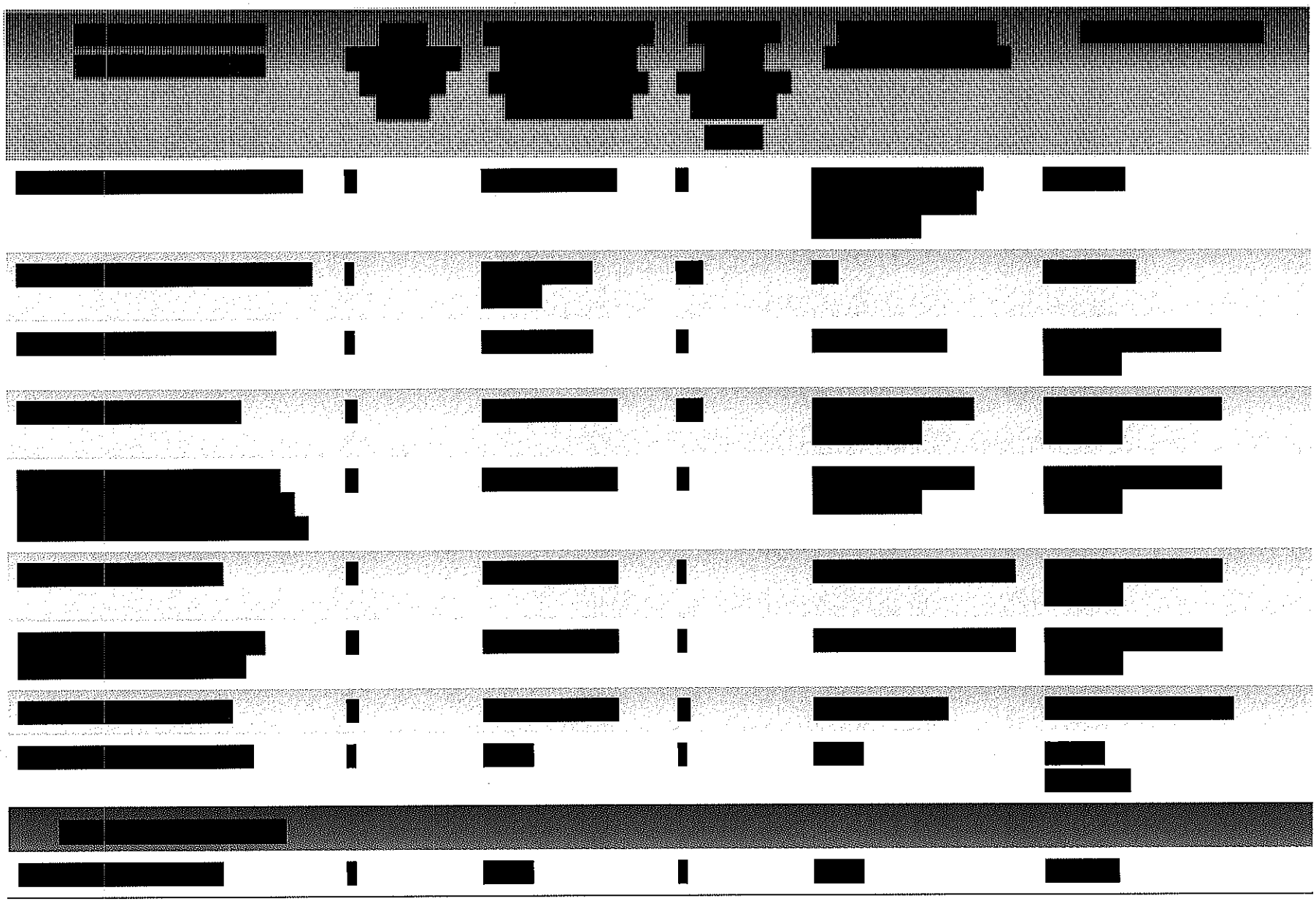
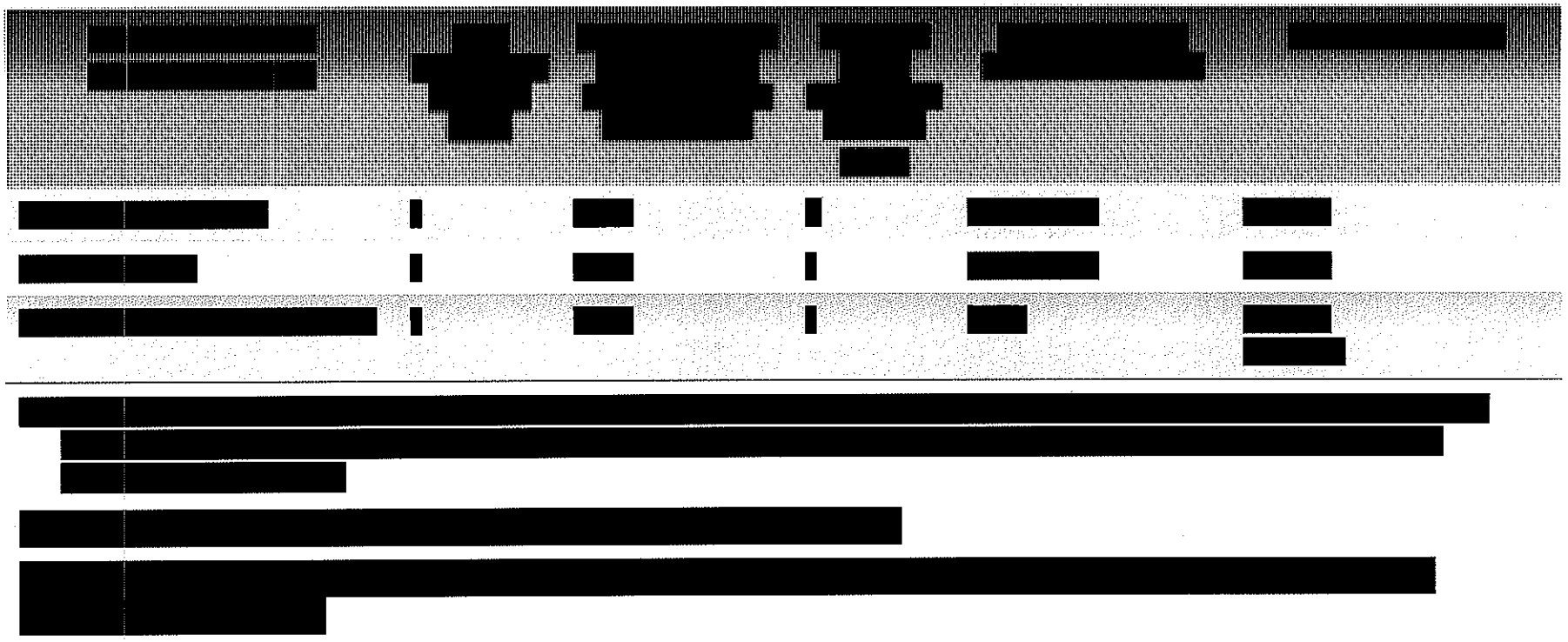






Communication to Providers and Members about Services with Authorization Requirements

Providers

Magellan has many communication strategies for informing providers in Nebraska about which services require a service authorization, how to request a service authorization, and how we will inform them and their patients about authorization determinations.

[redacted]

Members

Magellan also has several communication strategies for informing members, initially and throughout each year, about covered services generally and which services require their provider to first check with Magellan about the medical necessity of the service for that member's situation. Primary communication vehicles include the following:

- *Member Handbook*
- Magellan of Nebraska Web site
- Quarterly Newsletter
- A monthly open line for consumers operated by the Magellan Director of Recovery and Resiliency

- Customized educational materials called Tip Sheets distributed at community and Magellan-sponsored events as well as to network providers and PCPs.

Magellan's customer service associates (CSAs) are also trained and available to provide guidance and support to members by phone, and answer questions about covered services and the service authorization process. Complex cases may be transferred to a peer, or the Director of Recovery and Resiliency. Members and/or a member-authorized representative may request assistance 24-hours a day, seven days a week, using a toll-free telephone number.

[redacted]

[redacted]

[redacted]

[redacted]

In the Nebraska quarterly Access Provider Satisfaction survey for the third quarter of 2012, 89 percent of Magellan network providers were either satisfied or extremely satisfied with the convenience of scheduling a peer-to-peer review for authorizations or appeal.

Describe the content of your BH MCO's written notice of action that will be provided to members with any adverse action taken by the BH MCO.

Written Notice of Action

The grievance system process is initiated when Magellan takes an action that results in the issuance of an adverse action notice to the member and provider. All decisions to deny or limit a requested service are made by a board certified psychiatrist, or in the case of psychiatric testing, by a psychologist. All notices meet the requirements of 43CFR 438.404.

Content of Notice of Action

Magellan provides the member and requesting provider with a written notice of the action that includes the following:

- the action Magellan has taken or intends to take
- the reasons for the decision to not authorize the requested service
- the alternative level of care that would be appropriate for the member, given the clinical information provided to date, and a description of this alternative level of care.
- the procedures for filing an appeal with Magellan
- the member's right to represent themselves or be represented by a person of their choosing
- the member's future right to request a state fair hearing with the MLTC if they are not satisfied with Magellan's resolution of the matter
- the procedures for exercising the rights specified in the notice
- the circumstances under which expedited resolution is available and how to request it
- the member's rights to have benefits continue, pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

Magellan revised this process in 2012 based on feedback from the MLTC, the Legislature, and others.

Describe how your BH MCO will ensure members will receive written and timely notice of actian relating to adverse actions taken by the BH MCO.

Magellan conducts reviews in order to evaluate a Medicaid member's clinical situation and determine the medical necessity of requested treatment services. We apply medical necessity criteria guided by clinical evidence and recovery principles individualized to the member's needs. When a decision is made not to authorize requested treatment, we provide written and timely notice to our members.

Magellan Behavioral Health of Nebraska has been conducting utilization reviews with Nebraska providers since 2002. Over this period we have developed a strong track record for conducting timely reviews and providing timely communication to members about authorization decisions.

Over a recent 12-month period, Magellan of Nebraska conducted 7,316 peer reviews (cases considered by a physician Advisor for possible denial) for which 97% were completed in 72 hours or less. Of 210 appeals, 90 percent were considered in less than 72 hours and 100 percent were completed in 14 days. Over the same 12-month period, we conducted 47 reviews for services to members who became Medicaid eligible retrospectively and completed 100 percent in 30 days.

Magellan's Procedures to Ensure Written and Timely Notice of Action to Members Related to Adverse Actions

For all levels of care, if a psychiatrist reviewer or psychologist, in the case of psychological testing, determines that clinical guidelines are not met for a provider's request for authorization, Magellan mails a written notification to the member and provider within one business day of the decision. The notification process takes 72-hours for all inpatient clinical peer review or expedited appeal, and 14 calendar days for a standard appeal.

Expedited appeals are those that meet the definition contained in the RFP. Timeframes may be extended up to 14 additional calendar days at the request of the member or provider. Magellan does not extend the time frame for its own purpose. In no case shall termination, suspension or reduction of previously authorized services take longer than 10 days.

Magellan also gives notice by the date of the action in the following circumstances:

- in the death of a member
- a request by the member to terminate or reduce services (when requested by a signed, written statement)
- the member's admission to an institution, which is determined by the MLTC to be an institution where members are ineligible for further services (e.g., Institute for Mental Disease or IMD).
- as required by the RFP, the member's address is unknown and mail directed to the member has no forwarding address
- the authorization timeframe expires.

Notification of all claims denials are sent to members and include the same appeal information as contained in the adverse action denial notification explained above, including information about the right to a State Fair Hearing.

[redacted]

To ensure members and providers receive prompt notice of non-authorization determinations related to short-term inpatient services, as well as the options available to them if they do not agree with the decision, Magellan sends the non-authorization letter to the prescribing provider by fax, as well as by mail.

Describe your BH MCO's grievance and appeal process specifically addressing:

- *Compliance with the RFP requirements*
- *Levels of review and timing*
- *Process for expedited review*
- *How complaints and appeals are tracked and trended and how you will use the data to make changes to procedures and processes*
- *Member access to State Fair Hearing*

Compliance with the RFP requirements

Magellan Behavioral Health of Nebraska has reviewed, understands, and will meet or exceed all requirements of 42 CFR 438.404 related to grievances and appeals, and will comply with all grievance and appeal requirements of the RFP as described in *Section IV. K. Member Rights and Responsibilities*. Magellan of Nebraska brings 10 years of experience in successful grievance and appeal resolution in Nebraska, and is currently following URAC standards and regulations. Before the beginning of the new contract, and following MLTC approval of the document, Magellan will send a revised *Member Handbook*, which contains a description of all grievance, appeal and fair hearing procedures and timeframes.

Levels of Review and Timing: Grievances

Magellan Behavioral Health of Nebraska will provide a mechanism for members to express a grievance—an expression of dissatisfaction. Grievances concern any matter other than an action, which is an appeal. Grievance topics may include, but are not limited to:

- access to care or service
- quality, timeliness and/or appropriateness of care or service
- Magellan's authorization or utilization process, or any other Magellan function.

The grievance process addresses and thoroughly investigates grievances, and provides the member a comprehensive and professional response to their concerns. Grievances are tracked and trended to facilitate the improvement of operations and staff performance in order to achieve the highest level of stakeholder satisfaction and care.

Magellan processes each grievance based on applicable State and Federal law, contractual provisions, and Magellan's written policies and procedures. Magellan will provide members assistance in filing a grievance. Assistance may include but not be limited to completing forms and taking other procedural steps such as providing interpreter services and providing toll-free numbers that have capabilities for TTY (Text Telephone)/TTD (Telecommunication Device for the Deaf), and interpreter services.

- *How complaints and appeals are tracked and trended and how you will use the data to make changes to procedures and processes*

Tracking Complaints and Appeals

A member may designate an authorized representative to request a grievance on his/her behalf. This grievance may be submitted at any time either verbally or in writing. The Magellan Comment System (CART) is used for tracking and maintaining records about the receipt and disposition of grievances. We use this information support performance monitoring and reporting. [redacted]

As a matter of policy, individuals who make decisions on grievances are not involved in any previous level of review or decision-making. They are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding any grievance regarding a denial of a request for expedited resolution of an appeal, or any grievance that involves clinical issues.

[redacted]

As directed by the RFP, Magellan will notify MLTC of all member and provider grievances within one working day of receipt, and follow up with the findings regarding the grievance and the proposed resolution prior to notifying the member or the provider. Magellan will track the types of grievances and report quarterly to MLTC during Service Effectiveness meetings. Magellan will comply with the State's established method to notify members or providers of the disposition of a grievance.

In the 2011-2012 contract year, the Nebraska Care Management Center resolved 16 grievances from members or their representatives. The QI department investigated all grievances, providing 100 percent resolution within our standard timeframe of 30 days, including notification to members as to the resolution of their complaints.

Levels of Review and Timing: Appeals

The appeal guidelines are in place to support the utilization review/management process. They are based on 42 CFR §438 regulations for Medicaid Managed Care (MMC) established by the Centers for Medicare & Medicaid Services (CMS) and national utilization review accreditation standards, as well as URAC and NQCA standards.

Members are notified of their rights to seek a reversal of a decision Magellan has made (an appeal) via the written adverse service authorization determination notice. Members can directly request an appeal and participate in the appeal process, or they may appoint a representative to request and/or participate in the process.

The member or provider may file an appeal with Magellan within 90 days from the date on the written notice of action letter. The member or their authorized representative (typically a provider) may file a standard appeal either orally or in writing and must follow an oral filing with a written, signed appeal. The member or the authorized representative may file an expedited appeal either orally or in writing. If the expedited appeal request is made verbally, the receipt date and time of the verbal expedited appeal request shall constitute the receipt date and time of the appeal request, regardless of whether or not a written copy is submitted on the same date or at a later date.

In handling an appeal, Magellan will provide members assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. Magellan will acknowledge receipt of each appeal and ensure that individuals designated to conduct the appeal review are peer clinical reviewers who were not directly involved in any previous decisions regarding the case, or are not a subordinate of any clinical reviewer involved in decision making regarding the case. Peer clinical reviewers for appeals are board-certified psychiatrists, except in one instance. If the appeal is about psychiatric testing, a psychiatrist will review the appeal.

Magellan will treat oral inquiries as an appeal. We will provide the member or their representative an opportunity to present evidence, and allegations of fact or law, orally as well as in writing, and provide opportunity before and during the appeals process, to examine the case file, including medical records, and any other documents and records considered during the appeals process. Magellan will include, as parties to the appeal, the member and his or her authorized representative or the legal representative of a deceased member's estate.

Each appeal is processed in a timely manner consistent with the identified clinical urgency of the member's situation at the time of the request. A through review of the substance of the appeal will be conducted, including any aspects of clinical care involved. The appeal process is completed and the notice issued as expeditiously as the member's health condition requires, within State-established time frames that may not exceed the time frames specified in 42 CFR §438.408—45 days from the day Magellan received the appeal. Magellan standards for resolving appeal requests are 14 days from the initiation of the appeal for standard situations, and within 72 hours from the initiation of the appeal for expedited situations.

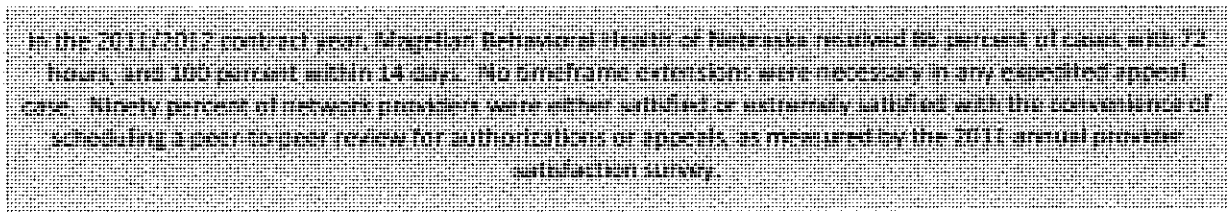
Process for Expedited Review

An expedited appeal review is conducted when the member or his or her authorized representative, or a provider, on behalf of a member, indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Both an expedited appeal review decision and the written notification of the decision are made within 3 business days of receipt of the initial verbal or written request for appeal review.

In the rare case when Magellan would not agree that the appeal is eligible for an expedited review, we would notify the member and provider of this decision within two calendar days, and process the appeal as a standard appeal. As with all other levels of appeal, the person requesting the appeal is notified of timeframes for providing evidence and allegations of fact or law.

Magellan also makes a reasonable effort to provide oral notice of the expedited appeal determination within the same business day of the receipt of the initial verbal or written request for appeal review. The three business day timeframe may be extended up to 14 calendar days if the member requests the extension, and Magellan can document that there is a need for additional information and that the delay is in the member's interest. When Magellan grants an extension, the member shall be notified in writing of the reason(s) for the delay and of the member's right to file a grievance if he or she disagrees with the extension.

Appeals are documented in the designated system and other records relevant to the appeal are maintained according to State and Federal standards. Additionally, no punitive action will be taken against a provider who either requests an expedited appeal or supports a member's appeal.



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Member Access to State Fair Hearing

Magellan complies with State Fair Hearing requirements, which are based on 42 CFR §438 regulations for Medicaid Managed Care, as established by the Centers for Medicare & Medicaid Services (CMS) and national utilization review accreditation standards. These processes are thoroughly explained in the *Member Handbook*, which we will mail to every member at the beginning of the contract, and to each newly enrolled member; this information, including the *Member Handbook* is also available at www.MagellanofNebraska.com. Additionally, we explain State Fair Hearing rights in each notice of adverse determination, and in each letter responding to appeals.

The member or a provider acting on behalf of a member, will have up to 90 calendar days from the date of Magellan's original notice of action to request a State Fair Hearing, which can only be granted by the state. As clarified in the RFP, the member is not required to exhaust the appeal process prior to filing a request for a State Fair Hearing. The parties to a State Fair Hearing include a representative from Magellan, the member, the member's authorized representative, or the representative of a deceased member's estate.

Magellan takes all necessary steps to ensure barriers to timely due process are addressed, and has an exemplary record of resolving grievances and appeals in a timely, thoughtful, and member-focused process. As a result, it is rare to have a case overturned by the State Fair Hearing process in Nebraska.

Magellan's decisions regarding Nebraska Medicaid members have been upheld in 34 of 36 State Fair Hearings since July 2010. This is an agreement rate of 94%.

Any decision by the State Fair Hearing to overrule the decision made by Magellan will result in the services being authorized, as determined by the State Fair Hearing Officer. This will be completed within 72 hours of the receipt of the notice of determination by the Hearing Officer. Claims payment will be made for authorized services upon receipt of a completed claim form.

Continuation of Benefits

Magellan will continue the member's benefits while the internal Magellan appeal and/or the State Fair Hearing is in process, if the appeal is filed timely. "Timely" filing means filing on or before the later of the following:

- within ten days of Magellan mailing the Notice of Action
- the intended effective date of Magellan's proposed action.

Magellan will continue the member's benefits in if the following criteria are met:

- the member or the provider files the appeal timely
- the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- the services were ordered by an authorized provider
- the original period covered by the original authorization has not expired

- and if the member requests extension of benefits.

If, at the member's request, Magellan continues or reinstates the member's benefits while the appeal is pending, the benefits will be continued until one of following occurs:

- the member withdraws the appeal
- ten (10) days pass after Magellan mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10)-day time frame, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached
- a State Fair Hearing Office issues a hearing decision adverse to the member
- the time period or service limits of a previously authorized service has been met.

Any benefits continued during this process will become the responsibility of the member and/or the provider if the Sate Fair Hearing or Magellan appeal affirms the decision being appealed.

Describe the policies and procedures your BH MCO will put in place to ensure grievance system information is communicated to all providers and Subcontractors.

Policies and Procedures to Communicate Grievance System Information

Magellan understands that the process of filing and pursuing a complaint or grievance may be daunting to members. To facilitate the process, Magellan educates primary care providers (PCPs) and community health center personnel about the complaint and grievance process, the appeal process (non-authorization determination cases), and access to a State Fair Hearing so they may act as advocates for our members.

We provide education opportunities to providers throughout the year so that providers can play an active role in ensuring that members are aware of our complaint and grievance processes, and know how to assist members, as needed.

Communication Strategies to Inform Providers

We will continue to provide this education to Nebraska providers about our grievance and appeals system through a variety of provider communication channels, including the following:

- *Magellan Provider Handbook* and Nebraska provider supplement
- New provider orientation
- Quarterly *Provider Focus* articles
- *Magellan of Nebraska News & Updates* newsletter articles
- Semi-annual Town-Hall meetings
- 24/7 availability of the Nebraska provider Web site
- As-needed e-mail blasts

- As-needed mailings
- Daily customer service education and support
- Provider non-authorization letters.

IV.L. Provider Network Development and Management

Magellan has been a part of the Nebraska community for more than a decade; we live and work here, and we see success every day. We are Nebraskans. Although our Care Management Center is located in Lincoln; we also have staff located throughout Nebraska including Bradshaw, Waco, Hampton, Kearney, North Platte, Riverdale, and Omaha. Our diverse locations allow us to be physically available to our entire network. We are committed to continuously improved outcomes for members served in the Nebraska Medicaid Program through effective support of our provider network. Our provider network is one of our most valuable assets, and we will continue to facilitate and support providers in our collective efforts to efficiently enhance the quality of services for members.

Retaining Magellan as the vendor for the Nebraska Behavioral Health Managed Care Program (NBHMCP) will ensure that Medicaid recipients and providers experience no disruption in service when the new payment structure is implemented. We can take the existing strengths of the program and move forward quickly, focused on the goals related to enhancing the program and expanding capacity rather than doing initial network development. In real terms, this means that we will be fully operational at the start of our contract, while our competitors would spend the first year of the contract becoming established and working through implementation issues. Our ability to bring creative solutions through a flexible payment system will only enhance the services recipients receive from Medicaid through Magellan today.

Due to our long history of working in Nebraska, our commitment to provider relations, and our awareness of the challenges associated with working in a state with large rural areas, we have forged strong relationships with Nebraska providers and are part of the behavioral health community. Ninety percent of our Nebraska network providers report being satisfied when surveyed. We are committed to provider satisfaction because we understand providers are not a commodity; they are key partners in successful outcomes for residents of Nebraska.

Highlights of Magellan Behavioral Health of Nebraska

- We cover approximately 265,000 Nebraskans, approximately 230,000 of which are Medicaid-eligible, through more than 1,600 providers in 2,500 service locations.
- We ensure that our providers meet all local, state, and national credentialing and quality standards.
- We support treatment that is member/family-centered and community-based.
- We have reduced out-of-state placements for residential treatment by developing community-based treatment alternatives.
- We are residents of Nebraska but we also leverage national experience with successful innovations developed in other at-risk programs throughout the country.

Despite our success as the Administrative Services Organization (ASO), the program we bring under NBHMCP will be more than Magellan of Nebraska is now. A full-risk contract is an opportunity to capitalize on flexibility in payment and contracting to further develop a community partnership that gives providers and other stakeholders key roles in the formation,

growth, and policy direction of the program. Our commitment to Nebraska is evident in the steps taken under the ASO contract to engage providers, including a Provider Advisory Committee (PAC), the Nebraska provider newsletter and community-based statewide town hall meetings. Under the new program, we will continue and expand the PAC, but we will also create a more formal structure called the Governance Board that will give providers and other community stakeholders seats at the table in equal proportion to Magellan leadership to ensure that plan decisions are made with the voice of the community.

As the current vendor, Magellan of Nebraska will bring the best of the past along with a renewed focus on innovation made possible through the new structure created by the NMBHP. The state will retain Nebraskans who work and live in Nebraska communities, know the behavioral health community, know Nebraska Medicaid recipients with behavioral health needs, and know the challenges that Magellan and the state have faced successfully as partners for over 10 years. However, under the risk-based contract structure, we will have the flexibility to bring the best of our national experience to Nebraska so that we become a full behavioral health managed care organization dedicated to Nebraska Medicaid, exactly what we do best.

Providers and MLTC will benefit from our extensive experience in integrated authorizations and claims payment with robust, nimble data systems that use that claims data to report back to providers on their service effectiveness and build targeted quality improvement efforts from a system-wide perspective. We will bring a performance and outcomes dashboard to the MLTC and providers that displays critical data beyond that which can be supported by claims to have a real, meaningful performance tracking system. This system will be the basis for new quality-based contracting approaches that allow us to reward higher performing providers through decreased administrative burden, increased referrals, and financial incentives as reinvestment funds become available. The "old" Magellan has been successful in building strong provider relationships, a complete network that effectively serves members, and a network that is driven by a culture of recovery and resiliency to ensure members can achieve outcomes that allow them to have the best lives possible. The "new" Magellan will provide all of those things with a data-driven infrastructure that is supported by flexible payment approaches and leadership that is built by providers, members, and experienced managed care professionals working side-by-side to customize a behavioral health managed care plan for Nebraska.

Our network is our strength, and we will begin our contract on day one with a fully operational, complete network that includes all key Medicaid-enrolled behavioral health providers, including all inpatient psychiatric hospitals, something that our competitors cannot deliver. However, we know that there are parts of Nebraska that are not well-served by our current network. We also know that the gaps in these rural areas are not due to a lack of contracted providers; the gap is due to a complete lack of providers. We also know that the number of members in these areas who need behavioral health services is, in most cases, too small to attract providers to those areas. Therefore, we propose behavioral health services using telehealth technology to enhance our delivery system.

[redacted]

[redacted] We will bring nationally recognized trainers in-person and virtually to our network to ensure that, to the extent possible, behavioral health care delivered to our members will be evidenced-based, trauma-informed, and state of the art. The Principles of Care adopted by Nebraska will guide our training efforts.

At Magellan, we are committed to giving Nebraska our very best. We know Nebraska like none of our competitors; we are local. But, we are also one of the top behavioral health managed care organizations in the country, and we are committed to delivering the program enhancements identified in this proposal and contemplated by the MLTC. We actively participate in our Nebraska communities. We sponsor local charity events. We raise funds and donate food and clothing to local agencies to support families in our community. *We live here – and we care.*

Describe your BH MCO's approach to develop practices and assure compliance with the Nebraska Medicaid BH Principles of Care.

Partnering with Providers

Magellan's network providers are our partners in providing mental health and substance abuse treatment services. From access and referral to delivering the right services at the right time in the right amount; linking members and their families to community resources; consumer and recovery/resiliency initiatives; these providers are key partners in systems of care at any level. Over the years, our partnerships have grown stronger, as both Magellan and our network providers work together for the good of our members and their families. We understand network providers are part of the communities they serve, so we have always viewed their participation and involvement in our community engagement activities to be vital. Similarly, we are keenly aware of the importance of ensuring our network providers are participants in orientation, training, and shared learning opportunities. We have succeeded in doing this for years because of our strong partnerships and our strong relationships with the people providing mental health and substance use disorder treatment services.

For many years, Magellan has worked to help shape the service delivery system towards one built on the foundation of the Principles of Care. We have been part of the process, part of the progress to get Nebraska to where we are now. Magellan is best positioned to promote the Principles of Care, particularly with our network providers, because we have worked together to improve services and outcomes for years. We have the most experience.

[redacted]

[redacted]

[redacted]

[redacted] Providers have been very receptive to these meetings and appreciate the opportunity to discuss concerns and propose changes to processes. Feedback from these meetings has been used to make changes to current processes, which in turn has resulted in improved provider satisfaction. Meetings have improved collaboration and providers receive the message: we listen, we care, and we know that providers care about the quality of services they offer our members and their families.

Moving forward, Magellan will continue to promote the Principles of Care with our network providers by establishing Principles of Care guidelines and through an action plan including the elements listed below. This action plan will be part of the broader Provider Network Development Plan.

1. Principles of Care Training

Magellan will provide an initial overview of the Principles of Care via webinar within 90 days of implementation. Thereafter, Magellan will conduct quarterly webinars designed to establish the need for the delivery system to be guided by the Principles of Care. Additional courses will be available in Magellan's Achieve and Essential Learning management system's catalog. The Achieve system allows us to track all network providers that complete the course. While participation will be voluntary, we have the capability to make certain courses mandatory to ensure applicable providers have the appropriate training; we will use the tracking data from our Achieve system to offer preferential referrals to providers that display a commitment to the Principles of Care though participation in our training programs.

[redacted]

[redacted]

Magellan believes this strategy of orientations, trainings, and shared learning has been, and will continue to be, one of the operational cornerstones for promoting the Principles of Care in Nebraska.

2. Provider Surveys

We will conduct surveys with our provider network regarding service delivery/treatment capabilities relevant to:

- trauma-informed care

- cultural and linguistic competence
- age and developmental appropriateness
- levels of treatment available.

Magellan surveyed our network to collect a range of information, including capabilities in over 25 different areas. We also have data about levels of service offered by each provider. We update information during recredentialing and when there are significant changes. We will assess new network providers along these areas and update our information. We will also leverage our partnership with NABHO to obtain additional data regarding provider specialties for their members. Magellan has a guiding principle that clients will be able to choose their provider at all levels of treatment.

3. Resources and Tools

Magellan will conduct regular trainings for providers about resources that can help them put the Principles of Care into practice. For example, we will develop training about Web-based resources developed by a variety of system stakeholders (e.g., academic/research centers, advocacy organizations, adjunct state and federal service/support agencies/organizations, and Magellan). This will include providing updates about the new links and resources available at the MagellanofNebraska.com Web site. [redacted]

4. Provider Engagement and Participation

When services are recovery-oriented, we know that people are more likely to live well in communities of their choice. We know from experience that communities must be a part of any discussion about the systems of care and service delivery system available to them. Similarly, our experience building partnerships with providers to ensure their engagement and participation has helped Magellan learn from their knowledge and expertise. This, in turn, has

helped us work together to improve the systems of care in which our providers fill a key role. In order for this to happen, there must be avenues for providers to be engaged and participate. [redacted]

5. Quality Oversight, Monitoring, and Review

One example of our experience working with network providers on quality improvement projects is our Medical Records Education project. We reviewed over 1,500 treatment records of Nebraska Medicaid members annually from community-based and residential providers. Our Treatment Record Review (TRR) process, which monitors the quality of services we provide through auditing of members' treatment records, is designed to reflect Magellan's core principles of recovery and resiliency, which are grounded in the same tenets, beliefs, and values as the Principles of Care.

The TRR tool assesses whether members' treatment records adhere to the following core principles:

- The assessment of a member's strengths is written from the perspective of the member and focuses on how the member identifies and views his/her own strengths.
- Family and other external supports have been explored and either considered or included in treatment as indicated.
- The 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.
- 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.
- There is evidence of treatment being provided in a culturally competent manner.
- A psychiatric advance directive or documentation of refusal is present.

[redacted]

Magellan Models the Principles of Care

We hold ourselves to the highest standards when it comes to our core values and beliefs around recovery and resiliency. When Magellan developed our twelve core principles of recovery and resiliency, we put them into practice by creating trainings and tools, developing resources,

establishing measures, and monitoring ourselves around these core principles. Our core principles represent values, beliefs, and attitudes that are aligned with the same tenets described in Nebraska's Principles of Care. They are intertwined and connected.

Going forward, we will continue to commit ourselves to putting the Principles of Care into practice through Magellan's culture of caring, knowing our twelve core principles of recovery and resilience are not just a poster on the wall, but rather are embedded in all that we do, across all areas of our operations, in all roles, and in all our work.

We will require our Magellan of Nebraska team to demonstrate compliance with the same orientations and trainings we require of our network providers regarding promoting the Principles of Care.

By providing opportunities for members, their families, peer and consumer advocates, parent, and family advocates to participate in the QAPI program, we are engaging community members and they are engaging us.

Describe your BH MCO's approach to promote open communication among the BH MCO, network providers, NMPHC, and members.

The partnership that Magellan has developed with our provider community is represented in our innovative service development, positive system change, quality clinical outcomes, and overall provider satisfaction in our public sector programs. Magellan promotes open communication among our network providers, Nebraska Medicaid Managed Physical Health, and our members though a variety of avenues including public meetings, advisory councils, a dedicated Magellan of Nebraska Web site, and an annual Report to the Community (see **Attachment K**. Our commitment to open communication is evident in our increased staffing of our Nebraska Care Management Center (CMC) and through our communication media, including our Web site, emails, and reports.

Communication Strategies

Magellan understands the importance of communicating effectively and often about what we do, who we are, and how we can help. We are committed to operating as transparently as possible as evidenced by our 2012 Nebraska Report to the Community (see **Attachment K**). It won a Gold award in the Brochure/Public Relations category of the 2012 MarCom Awards competition, a competition that receives more than 6,000 entries from across the globe in the field of marketing and communication. This is the third year in a row that Magellan has won a Gold Award for one of our public sector behavioral health reports to the community.

[redacted]

Our existing PAC offers a forum to ensure ongoing collaboration between Nebraska Medicaid Managed Care Plan providers, Magellan behavioral health, and the MLTC. For NMBHP, we will strengthen the role of the PAC, and empower the provider community to take a leadership role for the group through the selection of a provider co-chair that will help set the direction of the group, while Magellan retains a co-chair position to facilitate and provide resources to the group.

[redacted]

[redacted]

We will continue hosting statewide Town Hall meetings, and we will increase the frequency to quarterly during the first year of the program. As our PAC becomes more robust, we will determine the best frequency for the Town Hall meetings going forward. We believe it is critically important for providers to see us, know us, and feel comfortable that they have a relationship with the Magellan staff.

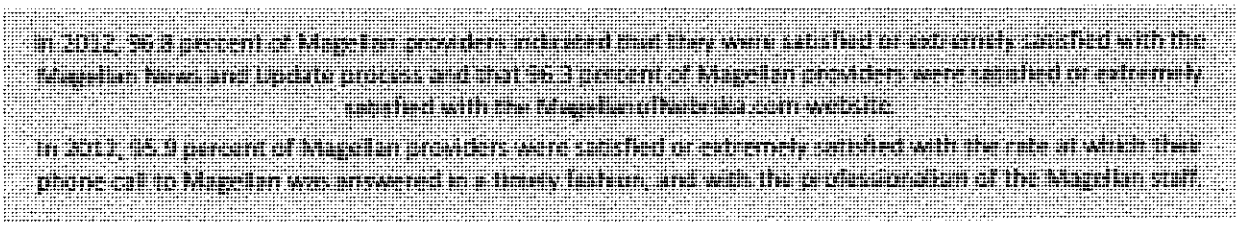
We also produce timely written information for the provider community. We communicate via provider newsletters, quarterly national e-newsletters, frequent email messages, faxes, and hard copy mailings. We offer a quarterly national newsletter to Magellan providers in HTML format on our Web site, www.MagellanHealth.com/provider. Feature articles in Provider Focus

typically include valuable information about Magellan news, claims tips and updates, clinical topics, new products/services, medical services initiatives, quality improvement, and regional news. Providers receive either a postcard or e-mail message announcing the release of each new edition. (Providers without Internet access may request hard-copy printouts.)

Magellan will continue to utilize a monthly newsletter specific to Nebraska. The newsletter will include updates on topics such as: new treatment services; changes in processes; scheduled trainings; and activities of the PAC, the QAPI program, and the Nebraska CMC. Other features for the monthly newsletter include provider spotlights (getting to know providers), Customer Service Corner, Message from the Provider Advisory Committee, Medical Director Corner, and Magellan spotlights (getting to know Magellan staff). The monthly newsletter is posted on MagellanofNebraska.com and electronic notifications are sent to providers, customers, Nebraska Senators and other stakeholders when new editions are posted. Our November 2012 newsletter can be viewed in **Attachment L.**

We post essential and current information on Magellan's Nebraska Web site, www.MagellanofNebraska.com. Keeping providers informed of the most up-to-date information ensures that members receive efficient, quality care. As a nationwide managed behavioral health organization, we bring strong partnerships with leading educational and research organizations to Nebraska. For example, we partner with organizations such as ACHMA – the College for Behavioral Health Leadership, to organize webinars that feature timely topics and national speakers in public sector behavioral health.

We will also continue hosting a monthly toll-free networking call for interested parties in order to share information about upcoming events, activities, or updates relevant to consumer and recovery/resilience initiatives.



In 2012, 96.8 percent of Magellan providers indicated that they were satisfied or extremely satisfied with the Magellan News and Update process and that 96.3 percent of Magellan providers were satisfied or extremely satisfied with the MagellanofNebraska.com website.

In 2012, 96.9 percent of Magellan providers were satisfied or extremely satisfied with the rate at which their phone call to Magellan was answered in a timely fashion, and with the professionalism of the Magellan staff.

Magellan of Nebraska Web Site

MagellanofNebraska.com is dedicated to Nebraska's providers and members, and is currently compliant with Nebraska's Technology Access Standards, as required by Section III.VV of the RFP. The Web site increases the accessibility of information specific to providers and members in Nebraska. Providers and members can obtain information directly from this Web site instead of navigating through Web pages and links on the national Magellan Web site. Staff in the Nebraska CMC are responsible for the content posted on this Web site. This flexibility allows Magellan to provide information to providers and members in a more timely and efficient manner. Our homepage can be viewed in Figure IV.L.2.1 – www.MagellanofNebraska.com.

[redacted]

Members Web Site

MagellanofNebraska.com includes a host of resources relating to communication and connection among providers, members and other community stakeholders. Through the Web site, members are empowered with the information they need to become an active participant in their healthcare, whether they're looking for information on providers, conditions, or resources within the community. Resources available to members through www.MagellanofNebraska.com include:

- A search engine that helps members find providers in their area. Members can use the search engine to find individual providers by name or by ZIP Code radius. Optional search filters allow members to find the provider best suited for them. These filters include gender, specialty, ages treated, ethnicity, languages spoken, and provider type. MapQuest links allow members to see a map of their provider's location and obtain driving directions. Additional icons in the provider search results allow members to easily identify and compare providers who offer handicap accessibility and proximity to public transportation.
- An MLTC-specific provider directory. The directory is updated at the beginning of each month and includes information on all providers in Nebraska participating in the MLTC program at the time of publication. Provider information in the directory is sorted by county, city, provider name, provider type, address, phone number, and includes indicators for evening and weekend office hours as well as languages spoken. A separate and distinct Adult Substance Abuse Outpatient Provider Directory is also available through the site.

The site also includes:

- links to community resources, such as NE211.org, NAMI, Network of Care, and many others
- articles and other information specific to the MLTC population
- information on how to prepare for an appointment
- links to transportation vendor services and Medicaid HMOs.

Providers Web Site and Portal

Magellan of Nebraska's Web site offers Nebraska's providers immediate access to informational materials, education, and self-service tools. Providers are able to perform a host of tasks through our provider portal, ultimately reducing their administrative burden so they can devote their time to what they do best—delivering quality clinical care to Nebraskans. Our provider portal is available 24 hours per day, 7 days per week, so providers have access to the tools and information they need when they need them. With an online provider password and login registration, providers can electronically:

- display and update their practice information
- view their contract status
- request continued sessions (for outpatient mental health or substance abuse treatment, using Magellan's online Treatment Request Form)

- submit authorization requests to Magellan
- submit claims to Magellan
- access managed care treatment authorizations and claims payment status and historical information.
- inquire about benefit programs and member eligibility
- enter Outcomes360℠ assessment tools
- access Outcomes360℠ member and program reports.

Also included on the specialized Web site for providers are:

- any MLTC-specific information we develop for the MLTC programs
- Magellan's *Provider Handbook*
- Magellan's Clinical Practice Guidelines and Medical Necessity Criteria
- information on HIPAA code sets
- "Ask Magellan," a guide of frequently asked questions offering specific information, resources, and Magellan contacts
- Provider Focus, Magellan's provider newsletter
- relevant, up-to-date news headlines
- links to behavioral health and community resource Web sites.

As Magellan begins to process claims, the claims status links on the Web site will produce an invaluable resource for those providers wishing to track claims and eligibility electronically.

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

Our Web services also enable providers to earn free Continuing Education Units (CEUs) by participating in online courses at no charge to the provider. Providers can earn Continuing Medical Education (CME) credits online through a link to Duke University School of Medicine.

We are pleased to report that there has been widespread satisfaction and usage with Magellan's online service for providers. Through MagellanHealth.com/provider, we continue to strengthen our commitment to our providers to reduce the "hassle factor" by offering a wealth of online information, tools, and resources to support them in serving our members and facilitating their professional relationships with Magellan.

[redacted]

[redacted]

[redacted]

Collaboration

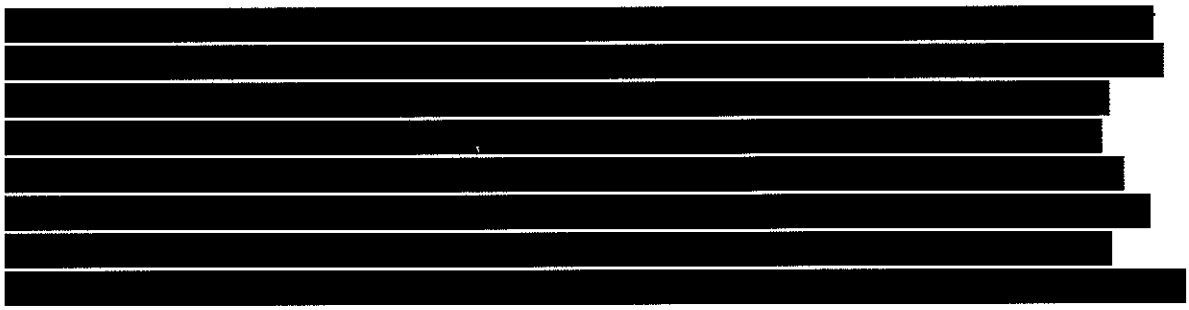
I have worked within the public and private mental health systems for more than 35 years. I have been a Medicaid provider for approximately 20 years. In the course of my work I have been a member of multiple private and public provider networks. I have found Magellan Behavioral Services to be one of the most reliable, trustworthy, flexible, adaptive, and ethical companies.

–Alan I. Smith, Ph.D.

Collaboration with providers is fundamental to the enhancement of the Nebraska service delivery system. The network team will serve as a central point of contact for providers for the Nebraska CMC. Collaboration between Magellan and providers brings everyone together with a common goal; working together to provide quality services for our members. [redacted]

"Our partnership and collaboration with Magellan helps us to meet community standards as well as set goals and measure outcomes for our own agency. Your feedback during the audit is priceless and your time is appreciated. Developing policy and procedure is not one of our favorite things to do but is a necessary function for a behavioral health practice and the guidance we receive not only from you but many key players at Magellan on a daily basis has been a true asset to the growth and development of our organization. Bonnie at the call center, James Parsley (care manager), and all of the Magellan staff set a standard for excellence in customer service exhibiting excellent communication skills and professionalism in addition to appropriate clinical skill leading to a call we are never afraid to make. Through this we have developed several relationships with Magellan staff which has been key to serving patients and program growth. The relationship with you has been pleasant and there have been times when the word "audit" is synonymous with "scary" but your approach and guidance/feedback has created a foundation for development, not criticism or negativity. We will continue to learn, we will continue to grow, and we look forward to doing it at Magellan's side providing services that are patient centered and outcome driven."

–Jared Ray, BA, LADC, Director of Substance Abuse, First Step Recovery & Wellness Center



Magellan initiated joint behavioral health and physical health multi-disciplinary care plan meetings with two of Nebraska's medical HMOs. We developed joint service plans, and outreach extends to network providers to help address the member's medical and behavioral health treatment needs. The process is aimed at reducing unnecessary emergency room utilization and providing appropriate treatment to members with comorbid needs. In 2012, United Healthcare submitted our collaborative to the Medicaid Health Plans of America Second Annual Awards program as a best practice and was an award finalist. Magellan is committed to continuing these joint case planning meetings with United, and we are in the process of initiating the meetings with Nebraska's newest HMO, Arbor. Coventry initially participated, and we will continue our efforts to work with Coventry going forward.

A 63 year-old male diagnosed with depression, schizophrenia, a substance abuse disorder and congestive heart failure was jointly served by Magellan and United Healthcare and was selected for joint service planning. The member visited the Emergency Room frequently for minor complaints, having amassed seven emergency room visits and five visits to his Primary Care Physician in the last six months. The member is in Magellan's Intensive Care Management program and arrangements were made to have him participate in the Partnership for Action and Recovery as well as Community Alliance's ACT Team. The Magellan Clinical Psychologist contacted the ACT Team to request that they address the member's frequent non-emergent ER usage. A plan was established whereby the member now contacts his ACT representative rather than proceeding to the ER for minor problems. He is also seeing his Primary Care Physician on a regular basis to monitor his medical condition. With the coordinated approach from the ACT Team and the Partnership for Action and Recovery, the inappropriate ER usage has stopped and the individual is more stable both physically and mentally at present.

Cross-System Collaboration

While it is Magellan's intent to host various forums to allow open communication between community members, Magellan will also be an active participant in meetings sponsored by other community groups. [redacted] The team addresses housing needs, insurance coverage, support system involvement, and accessibility to treatment services to identify resources and service plans appropriate to meet the needs of youth in this transitional period. Youth who meet ICM criteria are referred for ICM involvement.

We collaborate with CFS lead agency, Nebraska Families Collaborative, to help develop service plans for youth who are referred to residential treatment but who do not meet medical necessity criteria for that level of care. The goal of these specific case conferences is to develop a viable, appropriate treatment option and also to address needs for placement, permanency and supportive services. The plan that all involved parties are in agreement with is then presented to the court as a means to reduce the frequency of non-medically necessary court ordered treatment.

A 16 year old female, having had 13 separate inpatient hospitalizations and nine separate residential episodes over the past 4 years, reported a desire to be back in the community, stating she was desperate to have an opportunity at a "normal" adolescence. The Judge initially overseeing her child welfare case disagreed, stating the youth's behaviors continued to warrant a PRTF level of care, and ordered the youth to be transitioned to a new PRTF facility. However, CFS was unable to locate a facility willing to take her so she was transferred to the community as an interim plan while they continued to search for a PRTF bed. Authorizations were in place and the treating provider was able to implement the service plan immediately. Stakeholders involved participated in multiple case conferences and received daily updates.

The youth has now been in the community for two months, with zero incidents of safety concerns reported. She is has successfully transitioned into a foster home and back into public school; she is actively engaged in treatment and has even started contact with her biological family, something that previously triggered significant feelings for the youth. The Judge changed the Court's recommendation to continuing with community based services as they are currently being provided. This is a huge victory for all involved, but most importantly, for the youth.

To increase collaboration with the juvenile justice system, Magellan's clinical staff provide training to new probation officers on an as needed basis. The trainings include an overview of Magellan's role and responsibilities and provide transparency and education regarding Magellan's role in the system and how we can assist the probation administration.

Magellan staff also participate in an In-Depth Technical Assistance (IDTA) project involving six systems working together to achieve systems integration and coordination for the benefit of children and families. For more information on IDTA, see the fourth question in this section regarding SED Coordinated Services.

Staffing

[redacted]

Describe policies and procedures your BH MCO will put in place to ensure providers are not discriminated for participation, reimbursement, or indemnification for acting within their scope of license ar certification.

Any licensed, Medicaid-enrolled provider is eligible to become a contracted provider with Magellan. Our credentialing policies prohibit discrimination, and our practices are verified by

National Committee for Quality Assurance (NCQA). We are certified by NCQA as a Credentialing Verification Organization (CVO) meeting NCQA's credentialing standards for the accreditation of managed care organizations, including a prohibition against discrimination.

Magellan recognizes that providers in the Medicaid program are serving people with the most serious illnesses and that, often, these providers are critical to the community's system of care. We do not make credentialing decisions based on cost, and we do not discriminate against providers for participation, reimbursement, or indemnification for acting within the scope of their license or certification. We do not make credentialing or recredentialing decisions based solely on the type of procedure or client in which the practitioner specializes. Our selection and retention criteria do not discriminate against providers who serve high-risk populations or specialize in the treatment of costly conditions.

Magellan has several safeguards in place to ensure that discriminatory practices are not used in network decisions. First, Nebraska has a stand-alone credentialing committee comprised of internal Magellan staff and representatives from the provider community. This committee makes decisions to approve or deny participation and also makes determinations based on quality of care concerns to place existing network providers on a hold status or move to terminate them from the network. This ensures that the process is open with no decisions being made by one person who could be unduly influenced. Second, Magellan conducts periodic audits of cases of non-approval of credentialing and recredentialing decisions to confirm that the reason for non-approval was valid and non-discriminatory. Finally, provider complaint activity regarding the credentialing program is reviewed to assess trends, including any complaints regarding discriminatory practices.

Describe how your BH MCO will ensure there are a sufficient number of network providers with expertise in:

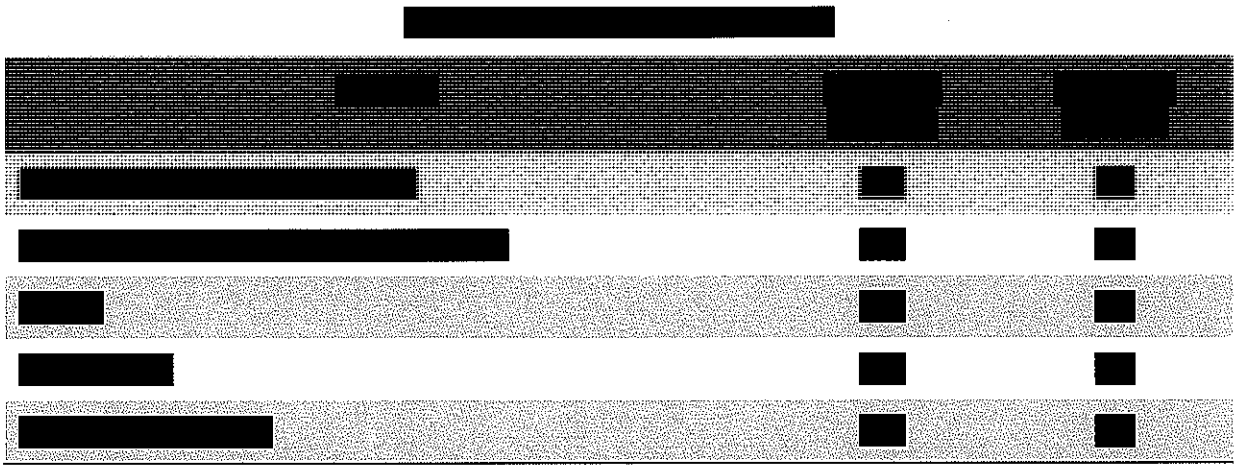
- *Co-occurring substance use, Mental Health and Developmental Disabilities;*
- *Serious and Persistent Mental Illness*
- *Trauma Informed and Trauma Specific Treatment*
- *SED coordinated services*
- *Sex offender services*
- *Co-occurring behavioral and physical health disorders*

Using Technology to Identify Providers and Program Expertise

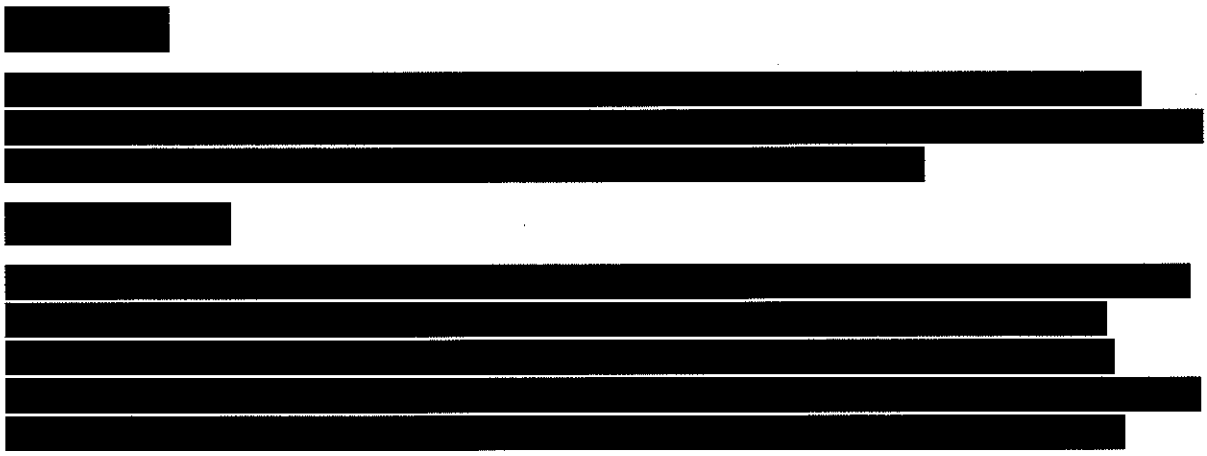
We recognize that the delivery system is ever-changing in response to changes in enrollment levels, health care policy, new and emerging practices, and consumer preference. We are experienced in monitoring network adequacy through data analytics, consumer satisfaction, complaint data, and provider monitoring. We have a robust provider database that allows us to maintain detailed provider information, track information related to expertise, language capabilities, and develop live reports of this information in all areas of Nebraska. IPD is a relational database developed for Magellan's single provider data repository and is capable of

housing and differentiating between Magellan networks which allows us to create distinct state and/or funding source specific networks as needed. It supports the contracting and credentialing process and allows our network staff to collect additional data needed for their network development and management functions, including, but not limited to, network participation status, licensure, and reimbursement schedules, billing relationships, rates and electronic funds transfer (EFT) information. Tracking of programs which each provider delivers can also be collected by location, program, gender, and age group allowing network staff to track the multiple programs and licenses that organizations might have.

During the credentialing process, we ask providers to report areas of specialty, and we maintain that information in our provider database. We use the data to refer members to providers who can meet their specific needs and to track the availability and adequacy of our network to work with members with particular needs. Table IV.L.4.1 displays the specialty information reported by our network as of November 2012.



In 2012, Magellan distributed a practitioner questionnaire to assess provider competencies related to the care of members with developmental disabilities and evidence-based practices. The survey allowed us to identify a number of providers with specialized skills, but also identified the need for additional training within the provider network. This training will be a high priority for the use of our reinvestment funds.



[redacted]

[redacted]

[redacted]

Rural and Underserved Access and Compliance

[redacted]

Co-occurring Substance Use and Mental Health

Clinical research suggests that Integrated Dual Disorder treatment is the recommended evidence-based practice for persons with co-occurring mental health and substance use issues. The existing Magellan network of providers has both the capability and capacity to offer this Integrated Dual Disorder treatment to our members. We recognize that some members will prefer to receive care from separate providers for their mental health and substance use concerns. In those instances, we will ensure that the member has the choice of providers for mental health and substance abuse, and that our network providers will work in tandem with other providers to ensure that care is complementary and coordinated.

Thirty-four percent of our network providers report the ability to provide integrated care to our members for substance use and mental health treatment. While our current network is prepared to deliver integrated care to members with co-occurring conditions, we view this area as an opportunity for growth and development within the network. We will leverage Magellan's national expertise to bring training resources to our network. We will also begin a dialogue on opportunities within the network to increase competency on this issue and create innovative approaches to serving members with multiple needs.

[redacted]

Due to Nebraska licensing requirements, providers were also required to obtain necessary licensure as a Substance Abuse Treatment Center as applicable. Magellan continues to monitor access to these services and adds additional providers to the panel as deemed necessary.

[redacted]

[redacted]

The training program included site visits, conference calls, and individual work between June and December 2011. With coaching on the rapid process improvement method, significant results reported by participating providers included:

[redacted]

Co-occurring Mental Health and Developmental Disabilities

While 29 percent of in-network outpatient practitioners and two organizations, Developmental Services of Nebraska and Omni, report specializing in the treatment of members who are dually diagnosed, our practitioner competency questionnaire highlighted this area as an area of need in the provider network. The responsibility for the provision of mental health services to our members with developmental disabilities will be an area of focus for the NMBHP. We will work with the Nebraska Association of Behavioral Health Organizations, the Nebraska Planning Council on Developmental Disabilities, Disability Rights Nebraska, and Developmental Services of Nebraska to identify all potential network providers skilled in the treatment of members with developmental disabilities to expand our network.

We also offer online training opportunities to our network providers through the Essential Learning training program. Topics that address issues for members with developmental disabilities include:

- Adapted Trauma Focused Cognitive Behavioral Therapy for People with Developmental Disabilities
- Psychotherapy for Persons with Developmental Disabilities
- Introduction to Mental Health/Substance Abuse/Developmental Disabilities for Paraprofessionals.

We have recently entered into discussion with the Division of Developmental Disabilities regarding the need for improved testing services. We will continue to work with them and the provider community to develop a network of providers for high quality assessment services.

Serious and Persistent Mental Illness

While our options for adult behavioral health treatment include private psychiatrists and therapists, most services delivered to adults with Serious and Persistent Mental Illness (SPMI) are provided by community mental health centers that specialize in working with adults with Medicaid and other public funding sources. [redacted]

This list is not inclusive of the many providers serving our members with SPMI, which include Psychiatric Residential Rehabilitation, ACT, and Community Support providers.

Minimally, we will monitor contractually-required access to care standards to ensure that sufficient providers are available to meet member needs. We will also monitor grievance data and member outcomes to determine if the network is truly adequate. We understand that while the number of providers may meet standards, the quality of providers who excel in working with members with SPMI needs to be continuously monitored. In those instances where quality issues are identified, we will work directly with providers to improve staff quality and offer training. We will also routinely refer members without established provider relationships to providers who are determined to be higher quality.

Recovery and Resiliency Modules located on our Web site provide additional information and training for providers as well as for members and their families. Through the Achieve and Essential Learning training systems that we make available to our provider network, providers have access to targeted online training modules to build their skills in treatment members with SPMI, including:

- Coordinating Primary Care Needs for People with SMI
- Crisis Management
- Overview of Severe Persistent Mental Illness
- People with Serious Mental Illness for Paraprofessionals.

Trauma Informed and Trauma Specific Treatment

Any behavioral health provider that has worked in the field of mental health or substance use treatment for some time will report being experienced in working with people who have survived trauma. However, being a trauma informed provider requires more than having experience. Trauma informed care is a specific approach to working with people who have experienced trauma that honors the effect the trauma has had on the person's life.

Magellan is committed to ensuring that our child and adult providers are trained in the delivery of trauma informed care and are able to deliver trauma specific treatment modalities. In 2011, we provided two trainings to our network providers by national experts in trauma informed care. In April, 195 providers attended *Making Trauma Informed Care Real* across one live site and six telehealth sites. In December, 223 providers attended *Trauma Informed Care* across one live site and six telehealth sites. Continuing education credits were available to participants.

Course summaries for the two trainings can be viewed in **Attachment N** - *Making Trauma Informed Care Real* and **Attachment O** - *Trauma Informed Care Symposium.*

For NMBHP, we are committed to continuing to provide high quality in-person and online training programs to our network providers in the area of trauma, to include physical/sexual abuse, violence, and other traumas. We also will target providers who work with adult survivors of abuse and veterans. We have a staff person dedicated to offering training to our network, and we will provide trainings no less than quarterly on topics most beneficial to the network as

determined by input from the provider community. We will also continue to host two symposiums each year.

[redacted]

Our Web site, www.MagellanofNebraska.com, offers providers an online training program on Post-Traumatic Stress Disorder. The Essential Learning program offers various trauma-related courses. Several examples are provided below:

- Adapted Trauma Focused Cognitive Behavioral Therapy for People with Developmental Disabilities
- Calming Children in Crisis
- Cognitive Processing Therapy for PTSD in Veterans & Military Personnel
- Diagnosis and Treatment of PTSD and Interpersonal Trauma: The DM/ID Criteria and IBT
- Does Your Organization Measure Up: Are You Really Trauma-Informed?
- Epidemiology of PTSD in Military Personnel and Veterans
- Helping Children and Adolescents Cope with Violence and Disasters
- Trauma Informed Treatment for Children with Challenging Behaviors.

[redacted]

[redacted]

SED Coordinated Services

Magellan recognizes the importance of working with all child-serving agencies in Nebraska to ensure that services are coordinated and complementary for the best possible outcomes. Although all publicly-funded behavioral health providers serving children with severe emotional disturbance (SED) are participating in our network, we do not solely delegate the responsibility for coordination to the provider. Our network standards include a requirement that providers coordinate care, but Magellan also participates in coordination efforts.

[redacted]

Sex Offender Services

Our current provider network includes two sex offender residential facilities: Lincoln Regional Center/Whitehall Psychiatric Residential Treatment Facility and Child Guidance Center Therapeutic Group Home, both located in Lincoln. We also have one in-network sex offender intensive outpatient provider, Platte Valley Counseling in North Platte. In the event that our

residential facility is unable to accept new members, and as a last resort, we will utilize out-of-state facilities to care for youth in our plan. Magellan supports the use of non-residential, intensive outpatient services to treat youth with sexually offending behaviors when it is safe to do so.

While sex offender services are critical, the history of need for the services is minimal. ASO experience tells us that an expansion of residential facilities would likely result in providers who are not able to generate the necessary business to remain viable, particularly as Magellan continues to support non-residential care for all behavioral health needs whenever possible. For example, in 2012, we only prepared four ad hoc agreements for members who were not able to be served by our network providers. As a result, Magellan will focus expansion efforts on training high quality providers in locations with higher than average need for sex offender services to offer intensive outpatient care. Additionally, Magellan will work with the courts and the justice system to maximize the use of community-based safety strategies, such as curfews and electronic monitoring, to allow youth to remain in their homes while undergoing treatment.

Co-Occurring Behavioral and Physical-Health Disorders

Magellan is experienced in coordinating services with physical health providers and health plans, both as a subcontracted behavioral health vendor to health plans in other states and through coordination efforts as a stand-alone Managed Behavioral Health Organization, as is the case in Nebraska. We hold regular joint meetings with Nebraska's Physical Health Managed Care Organizations to review individuals with complex medical and behavioral health needs and formulate multidisciplinary care plans incorporating the use of community resources.

Behavioral Health/Physical Health Integration

For NMBHP, we will prioritize joint care planning meetings with each of the three managed care plans with the support of MLTC. As discussed in the second question, our meetings with UnitedHealthcare have been successful in providing comprehensive services to members with behavioral health disorders and physical conditions. We will continue to meet regularly with UnitedHealthcare, and we will work with Arbor and Coventry to schedule regular meetings during which we can discuss coordinated approaches to caring for members with complex needs. Additionally, we will ensure that our care managers are working on a day-to-day basis with HMO care managers to address individual service needs as they occur.

Primary Care Provider Coordination

We require our behavioral health network providers to coordinate care with physical health providers, particularly the Primary Care Provider (PCP). Magellan monitors medical records to ensure that the member has signed a release to allow communication with the PCP (or refused) and that coordination occurs with other providers serving the member. If these requirements are not followed, as evidenced by the medical records, Magellan requests the provider to develop a corrective action plan to rectify the lack of compliance. If the provider fails to complete the corrective action plan, or implement steps to rectify the lack of compliance, additional steps may be taken by the Regional Network Credentialing Committee, up to and including termination from the network. Magellan also monitors compliance through site visits

conducted for credentialing and re-credentialing. When it is identified that providers do not have policies and procedures in place to coordinate with members PCP's, they are advised of the need to develop and implement such policies and procedures and must demonstrate evidence that they have complied with this requirement.

We also provide tools to support PCPs when working with our shared members. We offer a Medical Providers' Behavioral Health Toolkit at the following Web address: www.magellanpcptoolkit.com. This Web based tool provides resources on behavioral health conditions that PCPs frequently encounter in their daily practice: Substance Use Disorders, ADHD, Anxiety, and Depression. We also provide information on coordination of care, including a form that the PCP may use to communicate treatment information to Magellan or our network behavioral health providers. The Web site also provides member materials the PCP can use with his or her patients. There is a guide to understanding HEDIS, in particular the behavioral health measures. And, most importantly, the Web site offers instructions to the PCP on how to contact our clinical staff for consultation and referral. [redacted]

[redacted]

[redacted]

[redacted]

In addition to physical health providers like People's Health Center, behavioral health providers within our network are developing and discussing behavioral health homes for persons with serious mental illness and/or co-occurring substance use disorders. One is one being developed by Community Alliance, in collaboration with One World Community Health Center, a Federally Qualified Health Center (FQHC) also in our network. This collaborative effort will result in an integrated health home, with funding from a four year Primary and Behavioral Health Integrated Care Grant from the Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services, to serve as the provider of primary and preventive medical care and behavioral health services for up to 600 persons with mental illness. Key features include Wellness Self-Management and a Health Navigator. Magellan has meet with them to discuss how we might support their efforts given our own experience in integrated health home programs in Iowa and Arizona. Magellan will work closely with these collaborative partners and support the project through its four year duration.

Although Community Alliance and One World Community Health Center received SAMHSA grant funding to create a true health home, all our network FQHCs are full-service providers that specialize in working with Medicaid and uninsured populations and offer both medical and behavioral health services. FQHCs are uniquely positioned to address the needs of Medicaid members with co-occurring physical health and behavioral health needs. We are committed to maximizing the use of providers such as FQHCs that can provide co-located services. Our Nebraska General Manager, Sue Mimick, and other staff worked closely with representatives from Charles Drew Health Center to assist them in development and expansion of behavioral health services in their medical clinics. Network staff provided hands-on technical assistance (telephonic, webinar, and in-person) for credentialing, contracting, obtaining authorizations, and submitting claims. Similar assistance was provided to other FQHCs.

[redacted]

Additional information about the specific approaches that will be used to coordinate care for members with co=morbid behavioral health and physical health conditions can be found in *Section IV.M. Care Utilization and Quality Management.*

Describe your approach to transitioning the current Medicaid provider network to your BH MCO for the contract

Magellan is uniquely positioned to deliver the highest level of clinical and quality excellence that has long been Magellan's hallmark in the behavioral health care system in Nebraska. While other bidders will focus on implementation issues in a new state, establishing new relationships, and informing providers and members of a new organization with which to interact, our focus will be on offering the state the unique advantage of continuity of care to members, providers, family members, state staff, and other stakeholders. It is not uncommon for a new vendor to spend the first year of a contract working through implementation and transition issues. With Magellan, NMBHP begins on day one of the contract. By continuing the relationship with Magellan, Nebraska will reduce its implementation resources both in terms of time and dollars spent.

Because we have existing collaborative relationships, a transition to our plan will be a transition to a new model; not a new vendor. Our relationships are multi-layered. There are relationships throughout the delivery system; at the executive level that will be effective in developing new approaches and systems, between our customer service representatives and provider billing staff, between our care managers and case management providers, and also between provider administrative staff and our network and provider relations staff. These relationships will ensure that as any issues arise, expedient, effective solutions can be enacted without the delay that would be expected if a provider is trying to determine who he or she can call with a new vendor who has recently hired staff.

In preparation for the transition, local and national Magellan staff met with network providers to discuss continued participation in the network and to address opportunities and concerns identified by providers with the new program. [redacted]

Collaboration with the behavioral health community and inclusion of providers and other key stakeholders is critical for a successful implementation of a capitated program. Misunderstandings, confusion, and general apprehension about the transition are expected. Magellan is experienced with system transitions and has successfully transitioned multiple public sector systems, never having been sanctioned for failure to meet deadlines and deliverables.

Under the new full risk behavioral health managed care contract, we will introduce network quality and performance standards through a phased-in approach that will allow us to be good stewards of limited resources by ensuring that high quality providers receive a preferred status in our network. During the time that our competitors would spend building a network, we will be introducing new programs, such as our telehealth, our Governance Board structure, and increase involvement of peer and consumer organizations. NMBHP brings a new day with new opportunities for Magellan of Nebraska. Our partnership with NABHO will ensure that the new managed behavioral health system is an optimal blend of national experience and local design. Magellan will be a strong fiscal steward of the limited funding available for the program while our provider and stakeholder advisors will set the course for the development of the programmatic aspects of our plan. One example of our partnership approach is our Partners in Care Program.

Magellan's Partners in Care Program to Promote High-Performing Providers

Magellan's Partners in Care (PIC) Program uses data to identify inpatient facilities and psychiatric residential treatment facilities that meet certain minimum performance targets to participate in the program. With the success of this program in other states, we propose to adopt the PIC Program in Nebraska to further improve appropriate utilization of services among our members toward reaching their health care goals. We will work with network providers, members, and stakeholders to tailor this program to local strengths and constraints in Nebraska. The PAC and Governance Board will have key roles in the development and implementation of the program.

Performance targets typically include metrics such as average length of stay, readmission rates, and follow-up after hospitalization rates. Qualifying facilities will be permitted to complete fewer inpatient concurrent reviews following the approval of the pre-certification request. We will send all facilities quarterly performance data. All facilities that do not meet the minimum targets on specific metrics will be asked to provide corrective action plans. We will share identified best practices among the PIC participants, as well as with facilities that are not in the program (because they have not met the minimum targets) in order to encourage improvement across all facilities. Typically, we require one year of data to determine which facilities we will invite to join the PIC program.

To assist with transition to NMBHP and to introduce the PIC, we will offer provider orientation sessions initially upon contract award and during two subsequent sessions, in varied geographic locations, in concert with our town hall meeting schedule. We will work with representatives of the provider community to develop the agenda for the orientation and to determine the most effective ways to encourage attendance. Notifications regarding the orientation will utilize all avenues developed in our Provider Communications Plan, including notice on our Web site,

mailings, and announcements at community meetings. We will work with professional organizations to further communicate the availability of the orientation.

Describe how your BH MCO will develop a Provider Advisory committee.

[redacted]

Members represent key geographic areas (urban, suburban, and rural), various professional disciplines and services including inpatient, residential, rehabilitation, community-based and outpatient therapy services for both children and adults. The PAC meets regularly via teleconference to allow provider participation across the state.

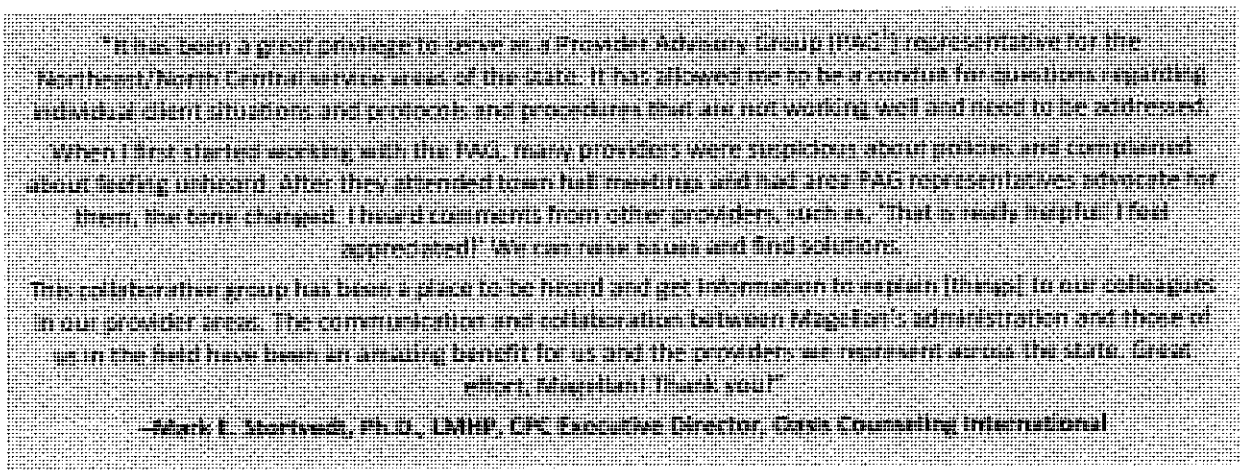
We share proposed changes to Medicaid services with the PAC. For example, we asked the PAC for their input on changes to the outpatient therapy authorization process. After seeking and obtaining approval from the MLTC, we implemented an improved process based on the PAC's recommendations.

[redacted]

[redacted] We will strive to build a membership that is representative of our network, including inpatient and outpatient providers, adult versus child-serving providers, and urban/rural/frontier providers. Providers that represent cultural diversity will also be encouraged to participate. Representatives will be appointed for specific terms to ensure that fresh ideas are continually brought to the group.

The PAC will be a primary source of guidance and direction for our program. We will utilize PAC to review and dispense information regarding any credentialing changes and to obtain feedback on the credentialing process. The PAC will provide input on clinical practice guidelines, network provider protocols, quality management, and any other key plan operational issues that arise.

We affirm that we will submit our PAC development plan for MLTC approval prior to establishment.


"It has been a great privilege to serve as a Provider Advisory Group (PAG)[1] representative for the Northeast/North Central service areas of the state. It has allowed me to be a conduit for questions regarding individual client situations and protocols and procedures that are not working well and need to be addressed.

When I first started working with the PAG, many providers were suspicious about policies and complained about feeling unheard. After they attended town hall meetings and had area PAG representatives advocate for them, the tone changed. I heard comments from other providers, such as, "That is really helpful. I feel appreciated!" We can raise issues and find solutions.

This collaborative group has been a place to be heard and get information to explain [things] to our colleagues in our provider areas. The communication and collaboration between Magellan's administration and those of us in the field have been an amazing benefit for us and the providers we represent across the state. Great effort, Magellan! Thank you!"

–Mark E. Stanhope, Ph.D., LMHP, CPC Executive Director, Care Counseling International

[1] In our existing Administrative Services Organization program, the committee is called the Provider Advisory Group.

Describe how your BH MCO will validate pravider training and expertise in specialty areas including but not limited to the following areas:

- *Serving children with SED*
- *Serving persons with SPMI*
- *The assessment and treatment of Trauma*

Magellan will validate provider training and expertise in specialty areas through:

1. credentialing and verification processes
2. practitioner specialty surveys
3. our provider training tracking system, Achieve
4. quality improvement oversight of care delivered to ensure it meets quality standards.

Magellan's credentialing and verification processes are key to ensuring that individual practitioners, provider organizations, and facilities possess and maintain the qualifications necessary to serve NMBHP members. As part of the credentialing processes, providers are required to sign an attestation verifying the information provided to Magellan (e.g.., licensure, certification, and accreditation status) is valid and accurate. In addition to Magellan's provider application and credentialing verification process, we also distribute a practitioner questionnaires to collect supplemental information to identify populations served, understand provider specialty areas; document cultural and linguistic capacity and potential deficiencies; and, to inform the development of specific plans to fill any identified gaps such as training needs. Through our Achieve system and Essential Learning courses we are also to provide training at no cost to network providers and offer continuing education units in areas designed to address children with SED, persons with SPMI and assure the provision of trauma-informed care. Because we are able to customize training modules that are offered to providers, our training approach is a blend of national expertise and a "Local approach" to training. We are able to work directly with providers and request advice from our PAC on the best training programs for Nebraska. Both online and on-site trainings are available to providers.

Magellan incorporates a learning management system (LMS), Achieve, which is available for use by providers, system stakeholders, and community members. The Achieve site is a customized Web site designed by Magellan in 2007 specifically for our system of care to provide a user-friendly option for engaging in online learning, accessing relevant resources, enrolling in live learning sessions and assigning learning plans to staff members. The site is accessible from home or any other remote computer to support system-wide learning. Achieve is also used for monitoring and reporting of training activities and has a dedicated helpdesk function to assist users as needed.

With a focus on skills development, we have developed several learning catalogs that are available in Achieve to support a continuum of learning.

The learning catalogs include:

- Clinical Innovations – Learning tracks and resources focusing on five key initiatives: Suicide Prevention, Health & Wellness, Crisis Prevention, Clinical Care and Outcomes.
- System Fundamentals – Training topics such as Magellan administrative practices and the Principles of Care.
- Clinical Specialties – Learning tracks and resources that aid in serving distinct populations and programs like Transition Age Youth, ACT, Substance Use Disorders, Child and Family Teams, Birth to Five, SMI, Peer Support, Employment and Rehabilitation, Prevention, Trauma Informed Care, etc.
- Enrichment Catalog – A catalog of topics that are designed to enrich professional development and support continued education. This catalog also provides registered users with access to the Essential Learning website. Individuals who successfully complete courses through our educational partner can earn CEUs recognized by national accreditation and certification bodies.

Achieve also offers users the opportunity for customized instruction. Learning plans are used to assign specialized sets of content and/or development actions appropriate for particular provider types or specialties. The benefit of learning plans is to provide consistent information to groups of providers who perform like functions. Learning plans will be used in Nebraska to assign and report on provider training participation. In addition, training administrators within contracted provider agencies are able to utilize learning plans to track requirements specific to the individual organization. We will partner with the provider agency training administrators to create learning plans in Achieve. The learning plan(s) will then be made available for automatic assignment to new employees of the organization, or for manual assignment by the agency training administrator.

[redacted]

Identifying Providers with Skills or Abilities to Serve Members with Special Needs

All of Magellan' contracted practitioners and personnel in contracted facilities complete a practitioner questionnaire using a Web-based survey tool (see Figure IV.L.7.2 for our online survey).

[redacted]

Given that measuring the true depth of specialty services across our contracted network cannot be analyzed with a single response per agency, we ask that each contracted facility have its individual therapists complete the online survey. This data allows us to measure a more complete picture of the presence of specialty services across the State, by agency, allowing us to appropriately refer members when specialty needs are identified. This ongoing analysis of the data allows us to develop recruitment and training plans to address identified gaps. The survey can be filtered by specialty populations, for example, older adults, and then additionally by language needs, targeted level of care, and even a specific credentialing level.

In addition, Magellan's Quality Improvement Department conducts treatment record reviews and if training and expertise of an EBP is questioned, we send a "help me understand" letter. If a provider was found to have falsified information regarding expertise or if it is determined that a potential issue exists based on our review, a referral is made to the RNCC to make determination for continued network participation.

Magellan also validates provider training and expertise through a review process of program proposals and program descriptions. For all services other than traditional outpatient therapy, providers must submit a description of their program to Magellan for review and approval in order for the service to be considered for network inclusion. The proposals are reviewed by licensed clinical staff to ensure that all of Magellan and MLTC standards and regulations required for the service or program are being met. This includes appropriate staff training and educational requirements.

Serving Children with SED

[redacted]

Serving Persons with SMI

Community mental health centers are best equipped to work with adults with Serious Mental Illness (SMI), and we have all key community mental health centers in our network. However, it is important to monitor the care delivered by individual practitioners within mental health centers in addition to the center itself as competency differs among clinicians. As described earlier, we ask individual treating practitioners to complete our specialty survey, and we will track their performance through quality reviews and their training through our Achieve system. Through the Achieve and Essential Learning training, providers have access to targeted online training modules to build their skills in treatment members with SMI, including:

- Coordinating Primary Care Needs for People with SMI
- Crisis Management
- Overview of Severe Persistent Mental Illness
- People with Serious Mental Illness for Paraprofessionals.

The Assessment and Treatment of Trauma

In children, there is significant overlap between children with SED and children who have experienced trauma. [redacted]

The need for trauma informed care is not limited to children, however. Our network includes practitioners available to treat adults with Acute Stress Reactions and Post-Traumatic Stress Disorder. To enhance our network's capability, we offer the following training programs through Essential Learning related to trauma:

- Adapted Trauma Focused Cognitive Behavioral Therapy for People with Developmental Disabilities
- Calming Children in Crisis
- Cognitive Processing Therapy for PTSD in Veterans & Military Personnel
- Diagnosis and Treatment of PTSD and Interpersonal Trauma: The DM/ID Criteria and IBT
- Does Your Organization Measure Up: Are You Really Trauma-Informed?
- Epidemiology of PTSD in Military Personnel and Veterans
- Helping Children and Adolescents Cope with Violence and Disasters
- Trauma Informed Treatment for Children with Challenging Behaviors.

Describe the process for conducting site-visits with providers.

Our established site visit policy and tools allow us to collect information for a variety of reasons including credentialing, investigation of adverse incidents and quality concerns, investigating complaints related to service delivery, verification that record keeping practices meet standards, and meeting requirements of clients and various accreditation standards that are applied to Magellan. The site review process affords us an opportunity to thoroughly assess provider capabilities.

Our credentialing site review tool addresses the following categories:

- accreditation and state licensure
- governance
- clinical operations
- quality management
- utilization review
- member/consumer rights
- clinical documentation / treatment record practices
- confidentiality
- safety and physical plant
- licensed professional staff / other direct care staff
- access to office-based outpatient services.

We also have a Treatment Record Review tool that is used to assess the clinical care provided to our members through a sampling of medical records. The tool is organized by the following domains:

A. General, with items such as legibility and requirements that all entries are dated and signed.

B. Consumer Rights and Confidentiality

C. Initial Evaluation

D. Individualized Treatment Plan

E. Ongoing Treatment

F. Addendum for Special Populations, with items such as documentation of guardianship and developmental history

G. CMC Addendum, which targets state-specific requirements. For Nebraska, this includes PCP coordination and requirements for the Pretreatment Assessment, among others.

[redacted]

Site visits associated with credentialing activity are conducted as required by accreditation, customer contract or regulation. Site reviews must be current within one year when non-accredited organizational providers are reviewed for credentialing or recredentialing.

The results of provider site visits are reviewed by the RNCC when making decisions about credentialing, disciplinary action, or termination of network providers. Deficiencies identified through a provider site review are followed up by the appropriate staff and reported to the RNCC at least every six months until deficiencies are resolved and any performance thresholds are met. Site reviews are a joint responsibility of network management staff and care management center quality improvement and clinical staff, depending on the cause for the site visit.

Site Review Evaluation: Individual Practitioner and Group Practices

Site reviews to individual practitioner and group practices are conducted when three or more member complaints are received across a rolling six month period for any of the following reasons:

- office physical accessibility
- office physical appearance
- adequacy of waiting and treatment room space.

An office site review is conducted within 60 calendar days of the member complaint threshold being met. An office site review is also conducted as soon as practicable if any single member complaint is received that causes immediate concern for the health and safety of members.

The site visit evaluates compliance to standards established for physical accessibility, physical appearance, adequacy of waiting and treatment room space, appointment availability, treatment record keeping practices, the specific cause for the member complaints, and other elements, as appropriate.

Organizational Provider Site Reviews

Site reviews of organizational providers are conducted and scored utilizing the Magellan Organization Site Review Tool. Accredited organizations are not required to have a site visit for credentialing purposes. Magellan may also substitute a CMS or state licensing/certification review in lieu of the Magellan credentialing site visit for non-accredited organizations. The site visit report must be submitted to verify that the review has been performed and that it meets Magellan's standards. A letter from CMS which shows that the organization was reviewed and passed inspection is acceptable in lieu of the survey report if Magellan reviewed and approved the CMS criteria as meeting Magellan's standards.

Site Reviews Conducted for Investigation or Follow Up of Quality Concerns

The RNCC may initiate a site review in response to reported provider quality concerns when a site visit offers the most appropriate and thorough access to information to complete the inquiry, or when it meets requirements for expedited access to such information. Site reviews related to quality concerns may be administrative, clinical, service, or any combination of the three.

All Magellan staff are responsible for identifying and reporting potential issues concerning the delivery of treatment and quality of care. Magellan staff identify and respond to quality of care concerns according to the type of quality concern and the method by which the staff are notified. Methods of identification of deficiencies may include, but are not limited to, utilization management processes, the customer comments process, provider performance inquiry and review, and adverse incidents.

Site Visit Reviewer Qualifications and Responsibilities

Administrative aspects of provider site reviews may be conducted by non-clinicians who have documented training in the use and scoring of the Magellan Practitioner Office Site Review Tool, the Organization Site Review Tool, or other assessment tool customized for the purpose of the review.

Magellan licensed clinicians evaluate the content of clinical care and service conducted in conjunction with a site visit. They are trained in the administration and scoring of clinical documentation assessment tools.

Site Visit Reports

Timely written reports documenting the results of site reviews are sent to providers and delegates, including a description of both the strengths and opportunities for improvement noted by the reviewer.

Providers who fall into the high range on the administrative site review results are determined to meet general Magellan requirements for office presentation/procedures and treatment record-keeping practices.

Providers who fall into the middle range are asked to produce corrective action plans that address identified opportunities for improvement. The timeline for completion of the corrective action plan should not exceed 30 days. These actions are verified for follow up by attestation of the provider. The CMC follows up to ensure that all such corrective actions are undertaken and complete, as attested to by the provider. Providers who do not attest to successful completion of the corrective action may be subject to additional corrective actions, additional site visits, or suspension of credentialing privileges based upon the determination of the RNCC.

Providers whose results fall into the low range are determined not to meet Magellan requirements for office presentation, procedures, and/or treatment record keeping practices. These providers are asked to produce a formal, written corrective action plan to address the deficiencies. The action plan must contain the timeline for implementation of specific actions. The timeline for completion of the corrective action plan should not exceed 30 days from provider receipt of report.

[redacted]

Describe your process for cantracting with all provider types described in the contract.

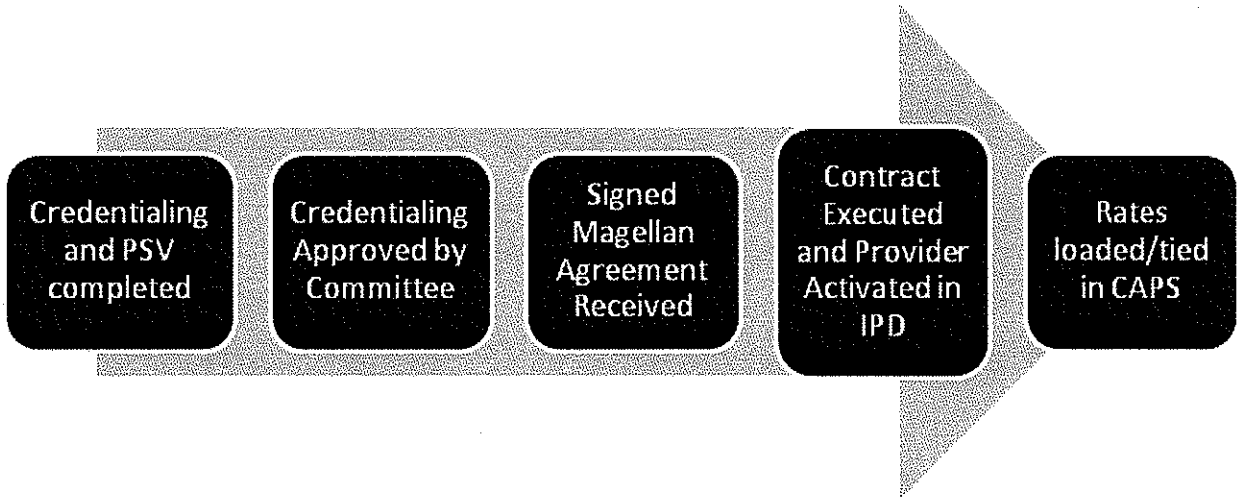
As the only bidder with an active and complete behavioral health provider network in Nebraska, Magellan's contracting efforts for the NMBHP will focus on continued network enhancements and monitoring of adequacy and quality rather than building a network. Providers will experience a transition to a new program that will be seamless with no disruption in continuity of care for members, as potentially could occur with a new vendor.

Magellan will continue to add new interested providers to our network utilizing our standard contracting process. We will also work with organizations such as the Office of Consumer Affairs, the Mental Health Association of Nebraska, and the Nebraska Federation of Families for Children's Mental Health to develop a network of peer support and family peer support providers.

Providers interested in participating in our network contact Magellan network staff to obtain the appropriate credentialing and contracting documents. Prior to us sending out these documents, we verify that the practitioner/organization is enrolled with Medicaid. If they are not, we inform them that they must enroll as a Medicaid provider to participate with Magellan. For NMBHP, providers will be able to complete both enrollments concurrently. We are able to send the documents electronically to expedite providers receiving paperwork.

The provider is instructed to return the completed application along with required support documentation (e.g., copies of license(s), curriculum vitae, and malpractice insurance) and contracts back to Magellan for review. Upon completion of verifications by our credentialing department (CVO), the provider's file is reviewed by our Regional Network Credentialing Committee (RNCC). The RNCC can approve or deny the provider's network participation. Once approved by the RNCC, contracts are executed and the provider is deemed active in our network. If they are denied, they are sent a letter outlining the appeal process. More details regarding our credentialing process can be found in the fourteenth question regarding our credentialing and recredentialing process.

Figure IV.L.9.1 - Credentialing Workflow



We recognize that access in rural areas of Nebraska is limited, and we will bring creative solutions to delivering quality care to members requiring services in those areas. In some of the more rural parts of Nebraska, the issue is not that providers are not contracting to serve Medicaid recipients and/or Magellan members. The issue is that there are no providers to recruit into the network. Telehealth will provide a new option for behavioral health services in those difficult-to-serve locations.

Describe your process for compliance with Indian Health Protections.

Magellan will comply with Indian Health Protections by ensuring that our members have access to providers that meet their cultural needs, but we will also ensure that American Indian members will not be limited to tribal providers and will have access to the full provider network according to their preference. [redacted]

We have found that utilization among those providers is very low. In fact, in some instances, their Medicaid numbers have lapsed from lack of billing.

[redacted]

[redacted] The Liaison will take a lead role in promoting evidenced based practices, best practices, clinical practice guidelines and recovery principles for American Indians within our provider network, bringing particular issues before the PAC for input on implementation.

[redacted]

Both practitioners were asked to submit a written exception request. One of the individual's cultural competence and knowledge in working with this population included: attendance at sweat lodges, ceremony healing, smudge and use of the elements of the earth for cleansing, prayer with Elders, dance and regalia, hand game and gourd dance, drum, traditional talking circles and some knowledge of Lakota language. [redacted]

[redacted]

Magellan's experience in other markets brings national expertise regarding effective partnerships with tribal communities and stakeholders. Magellan of Arizona partnered with two rural Maricopa County Indian Tribes in order to determine the scope of existing services in each tribal community as a basis for expanding and enhancing service accessibility and delivery. Each tribal community varies greatly in program service infrastructure largely due to the lack of community resources and the reservation being located in rural and remote areas.

[redacted]

Describe how the Network Provider data base will be maintained and updated.

Integrated Provider Database

[redacted]

[redacted]

[redacted]

[redacted]

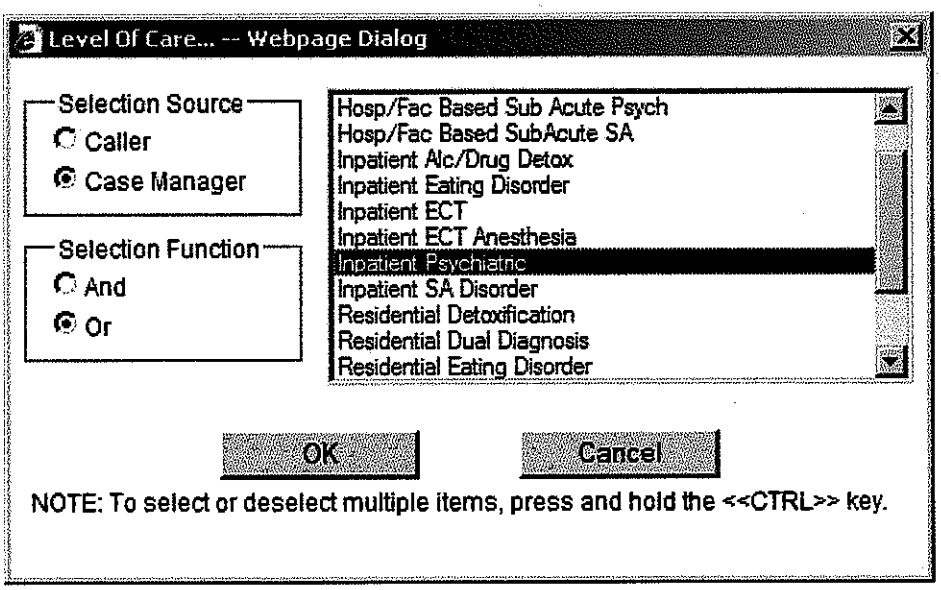
We distribute a practitioner questionnaire as part of the credentialing and recredentialing process. The questionnaire includes a specialty and cultural competency form that collects:

- practitioner/staff name
- degree
- license or certification
- employment status
- ages served (children/adolescents, adults, older adults)
- special populations
- minority specialty
- languages spoken including American Sign Language.

We also track required levels of care (see Figure IV.L.11.2 for a sample of categories of services) including, but not limited to:

- Inpatient Services (Acute and Sub-Acute)
- Crisis Stabilization Services
- Residential Services
- Outpatient Assessment and Treatment
- Support Services
- Rehabilitation Services

Figure IV.L.11.2 - Provider Search Feature – Level of Care



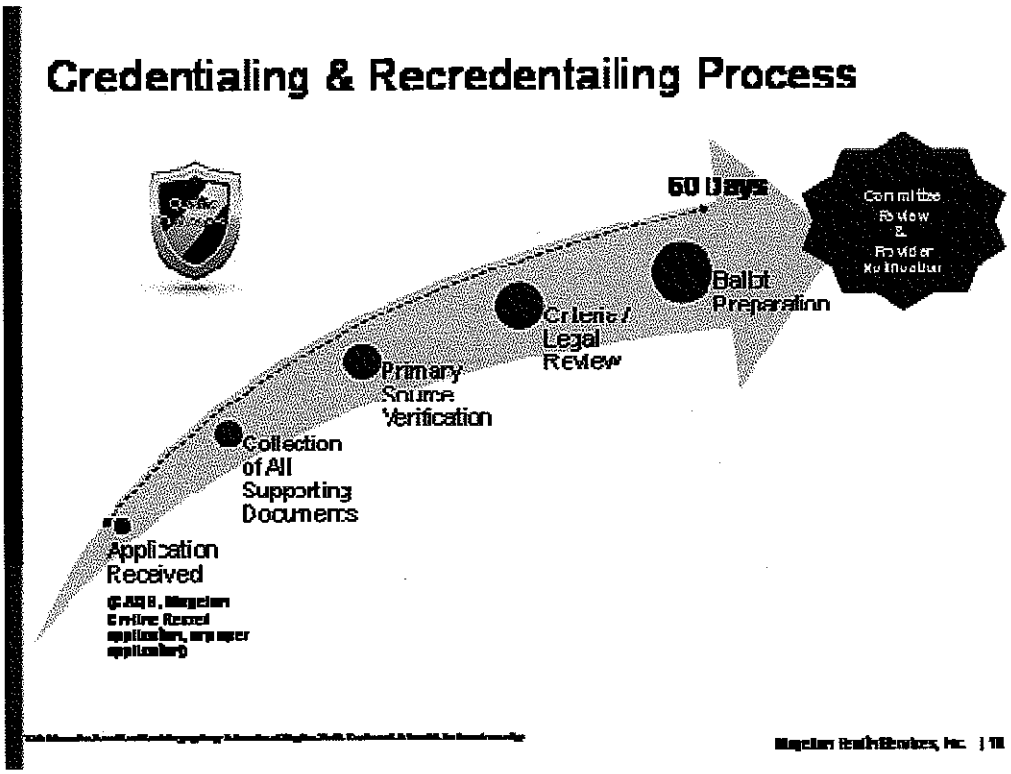
We also collect data on practice specialties (including but not limited to, attention deficit hyperactivity disorder; Alzheimer's/dementia; autism/pervasive developmental disorder; borderline personality disorder; criminal justice; domestic violence; eating disorders; fire setting; HIV/AIDS; intellectual disabilities; neuropsychiatric evaluations; physical disabilities; post-traumatic stress disorder; reactive attachment disorder; sexual abuse victims/offenders; sexual issues; and trauma.

Describe the timelines for credentialing and contracting and reports demonstrating your BH MCO's performance in compliance with these timelines for the contracts that you currently hold and for those you have held within the last five years.

Magellan's credentialing process (Figures IV.L.12.1) and its accompanying written policies and procedures, is consistent with the criteria included in the State and Federal regulations, including 42 CFR 438.214 (a)(b)(1&2). Our credentialing criteria are consistent with the industry standards produced by the National Committee for Quality Assurance (NCQA) and, in

fact, we achieved certification under NCQA's Credentials Verification Organization (CVO) Certification Program with a score of 100 percent in all 10 elements in 2012.

Figure IV.L.12.1 - Credentialing and Recredentialing Process



[redacted]

In Nebraska, we submit a quarterly report to MLTC that includes our Turn Around Time for processing individual applications. We will continue to produce this report for the NBHMCP in the format desired by MLTC.

At the completion of our credentialing process, we will execute a contract with the provider within 10 calendar days. Figure IV.L.12.2 shows the monthly average for contract execution timeframes.

[redacted]

Describe your BH MCO approach for a credentialing waiver process to allow certain providers that do not meet all of the Contractor's credentialing criteria to be included in the Provider Network.

Magellan is committed to meeting and exceeding the access and service delivery standards in the RFP. To address these obligations, and in acknowledgement of the role played by community organizations in providing safety net services to Nebraska Medicaid members, Magellan's approach to credentialing is flexible and adaptable, intended to meet the needs of our customers and the members we serve. While our standard credentialing process has proven approaches in place to ensure high quality traditional behavioral health providers, we are able to change our standard policies and practices to meet the needs and service gaps within local communities and systems of care.

As Nebraska's system continues to transform and evolve into a recovery-oriented and resiliency focused system, Magellan stands ready to work with the community to embrace innovative, non-traditional provider types and service delivery approaches. Our credentialing waiver process is designed to allow close collaboration with MLTC, providers, and the community to identify appropriate providers to enhance our existing network. We will work closely with the PAC to identify providers and provider types that would be appropriate for inclusion in the network through alternative credentialing standards and for the development of appropriate credentialing criteria. We have been successful in partnering with providers and other stakeholders to meet the specific services of a particular service delivery system. In other states, we have modified our credentialing criteria to accommodate state-approved downward substitution services offered by non-traditional providers such as peer specialists.

Our waiver process does not allow for unqualified individual providers to circumvent our typical process by requesting waivers. Rather, we will adapt our credentialing standards to include non-traditional providers through the development of expanded credentialing criteria for new provider types and add additional oversight items within the approval process to ensure ongoing quality. All providers will be credentialed to evaluate them for quality in their own specialty. We affirm that no covered service will be rendered at any time during the term of the contract by any person, facility, agency, or organization that does not meet all credentialing criteria under the contract, or any applicable law of regulation, unless we specifically waive in writing an applicable credentialing criterion, to the extent that such waiver is within the authority of Magellan.

For providers or provider types not meeting traditional standards, the credentialing process is conducted by Magellan clinical, network, or quality staff and includes a review of documentation, program descriptions (if applicable) and, for organizations or agencies, an onsite review similar to the review of traditional providers. This umbrella review examines all applicable documentation including:

- state licenses or certifications (if applicable)
- accreditations (if applicable)
- staff roster and resumes

- employee handbooks
- current liability insurance
- case management documentation
- quality assurance plan.

The decision to approve the provider into the service delivery system will be based on a review of the above. Magellan will continue, with input from the MLTC, PAC, and other stakeholders to further refine these criteria to ensure the needs of our membership and the Principles of Care are implemented, and that member-run and specialized clinicians and organizations that promote individualized and person-centered services are included in the delivery system.

Our process for incorporating new provider types is managed through our national Exceptions Committee. Referrals to the Exceptions Committee are generated by external requests for consideration, such as from the state or the community, and through our own network adequacy analyses. Providers who are included in the network as a result of the exceptions process are subject to the same contractual obligations as all other network providers and, in addition, may be required to participate in site visits and other review activities prior to approval. Examples of the categories of providers who have completed Magellan's exception process in Nebraska include Family Physicians, Licensed Alcohol and Drug Counselors (LADCs), and Provisional Licensed Clinicians, which include psychologists, mental health practitioners (PLMHPs) and alcohol and drug counselors (PLADCs). At the request of the state, Magellan of Nebraska has also developed specific criteria to credential Physician Assistants for network inclusion when working with a psychiatrist in a group practice.

Provisional Licensed Clinicians in Nebraska

In 2002, when Magellan implemented its Administrative Services Organization contract, the community expressed concern that we might not continue to allow provisional licensed clinicians in our network, as was the practice of the incumbent vendor. We utilized this as an opportunity to review the criteria being used to credential them into the network and emphasize the need for quality standards. In response to that concern, we considered provisional licensed clinicians in our Exceptions Committee and determined that we would allow these practitioners in our network within certain parameters. Today and going forward, provisional licensed clinicians are accepted for network inclusion if they are employed by a Magellan contracted group entity located in all Nebraska counties with the exception of Douglas, Lancaster, and Sarpy. The group practice must consist of two or more practitioners (this includes the provisional licensed clinician).

Provisional licensed clinicians that are credentialed by Magellan to work in a group entity in designated counties cannot transfer their eligibility for network participation to a group located in Douglas, Lancaster, or Sarpy counties. However, provisional licensed clinicians who terminate their association with an approved group entity may continue network participation when employed by a contracted organization.

In order to continue network participation in a group entity, provisional licensed clinicians must obtain full licensure within three years of being credentialed by Magellan. Failure to obtain full licensure within the three year timeframe results in termination.

The use of our credentialing exception process for provisional licensed clinicians was successful in continuing to support access in underserved parts of Nebraska while increasing the quality standards for their use.

[redacted]

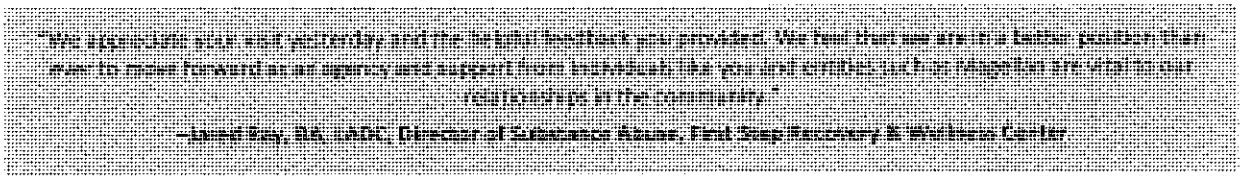
Magellan developed an extensive task work plan for transitioning management of the services on July 1st. Major areas of work included developing appropriate provider credentialing standards, utilization management guidelines, authorization procedures, and trainings.

Because BHIS providers were not credentialed under Medicaid, Magellan had to create credentialing standards. We also modified our site visit tool to compensate for the nature of both the service and the staff providing the services. Our enhanced provider qualifications and clinical guidelines improve the possibility for better outcomes for the people receiving these services. However, because the credentials were enhanced, some providers no longer qualified to provide BHIS services without changes to their practice. We worked with those providers to develop corrective action plans. In some cases, we transitioned members to qualified providers.

[redacted]

Describe your BH MCO's credentialing and re-credentialing process including:

- *Ensuring that providers are enrolled in Medicaid and have a valid identification number*
- *Informatian on ownership and control*
- *Excluded providers database searches*
- *Disclosure related to persons canvicted of crimes*



"We appreciate your partnership and the helpful feedback you provided. We feel that we are in a better position than ever to move forward as an agency and support from individuals like you and entities such as Magellan are vital to our relationships in the community."

–[illegible], Director of Substance Abuse, First Step Recovery & Wellness Center

Credentialing and Recredentialing Process

Magellan is certified by the National Committee for Quality Assurance (NCQA) as a Credentialing Verification Organization (CVO) meeting NCQA's credentialing standards for the accreditation of managed care organizations. Achieving CVO certification from NCQA demonstrates that Magellan has the systems, processes, and personnel in place to thoroughly and accurately verify providers' credentials, including systematic identification and tracking of any special experience or skills a particular provider may have; this includes language skills, specialized clinical skills, and training or expertise working with members from different backgrounds or cultures. We participate in the Council for Affordable Quality Healthcare (CAQH) Web-based UniversalProvider Datasource® to help reduce the amount of administration and paperwork required to complete credentialing. We attest that we comply with all credentialing requirements in the RFP.

[redacted]

Initial Screening and Application

Providers interested in joining the Magellan network are first screened to determine whether they meet minimum standards for participating providers. Providers are asked whether they can meet minimum criteria for licensure and insurance coverage, as well as the appropriate Medicaid or other applicable enrollment criteria. Medicaid enrollment is verified by the local network staff through the State's C1 System. Providers are sent an application packet that

contains details regarding our criteria for provider selection; the responsibilities and agreements involved in joining our network; and a detailed application that collects information needed to verify professional competence, practice history, and specialty areas.

Primary Source Verification of Credentials

Upon receipt of a provider's application, all appropriate credentials submitted by the providers undergo primary source verification by our credentialing staff. Magellan's legal team investigates any adverse action cited in legal documents or taken by licensing or professional societies.

Facility and Organizational Credentialing

Our facility and organizational credentialing process will be utilized for organizations, facilities, and agencies. Magellan follows the current NCQA guidelines in the credentialing of facility and organizational providers such as community mental health centers, community drug and alcohol centers, other community based providers, and 24-hour facilities. Our review criteria include administrative credentialing steps such as verification of licensure, accreditation (Joint Commission on the Accreditation of Healthcare Organizations, American Osteopathic Association, Commission on the Accreditation of Rehabilitation Facilities, or the Council on Accreditation) status, if applicable, claims/liability history, malpractice, and general liability coverage limits. In addition, we utilize an extensive clinical program inventory to evaluate the comprehensiveness of the continuum of care that the facility can offer to members.

Administrative credentialing of organizations includes verification that the applicant:

- is in good standing with state and federal licensing and regulatory agencies, as applicable
- is not on the List of Excluded Individuals and Entities (LEIE)- there are no Medicare and/or Medicaid sanctions
- has current state licensure or certification in accordance with relevant state law, if applicable
- meets Magellan minimum requirements for professional and general liability insurance coverage of $1 million per occurrence and $3 million aggregate
- successfully completes Magellan requirements for malpractice claims history review
- completes and submits all required application materials and related documents, including any documentation of current accreditation
- is not subject to any contingencies or provisions placed on licensure and/or accreditation.

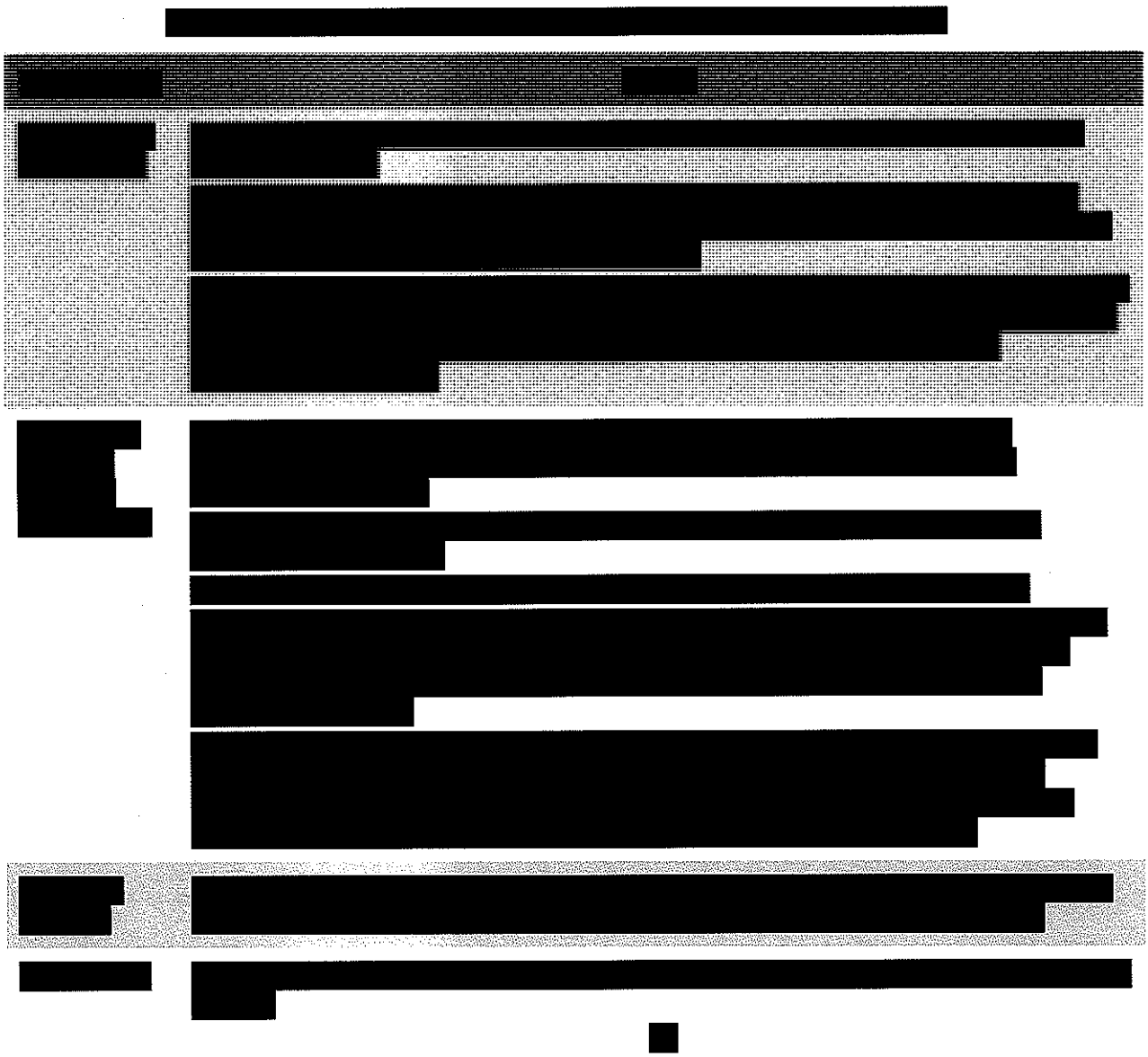
Staff rosters may be requested as part of the credentialing material submitted. Staff rosters are submitted electronically and contain data fields defined by Magellan. If a staff roster is requested and the organization is unable to comply with the above requirement, an exception to the format may be made by Magellan, at its sole discretion.

For facilities without formal accreditation, a more vigorous assessment process, including onsite review of clinical programs, processes, and staffing, quality improvement, and physical plant

attributes is conducted. The final steps in credentialing are the review and approval of our local Regional Network Credentialing Committee (RNCC) and execution of the formal contract between the entity and Magellan. Facilities and organizations are recredentialed on a three-year cycle in keeping with NCQA standards.

Individual Practitioner Credentialing

Magellan recognizes the important role of individual practitioners in the service delivery system. Many of the individual practitioners have specialties such as treating eating disorders, working with members who have co-occurring mental health and developmental disability diagnoses, working with sexual offenders or survivors of abuse, or providing services in rural areas. The credentialing criteria and standards for individual practitioners are described below in Table IV.L.14.1.



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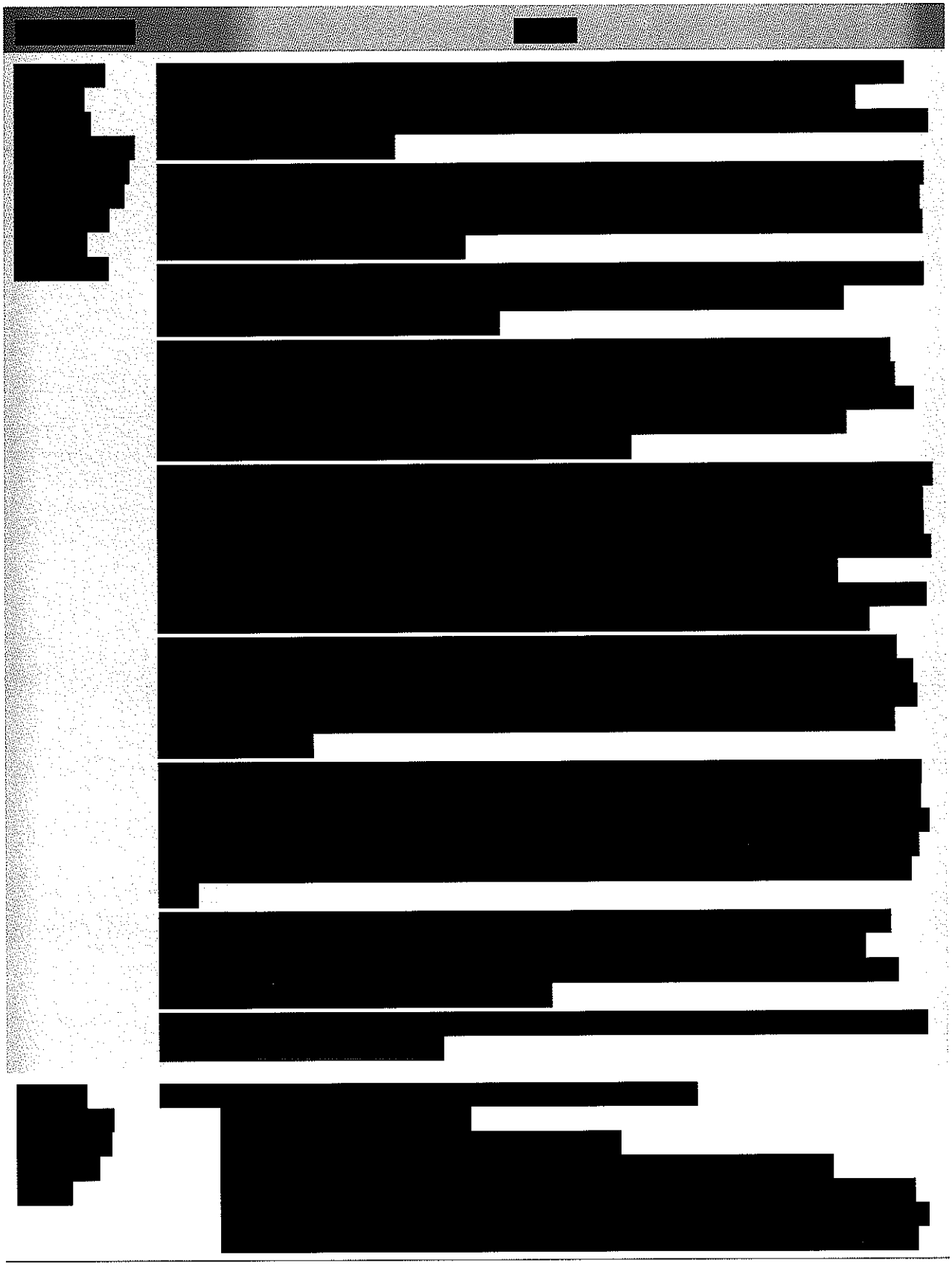


[redacted]

Recredentialing

Magellan recredentials all providers every three years. At the time of recredentialing, providers are required to submit an updated recredentialing application and copies of any expired documents. The application includes updated responses to general liability questions and attestation. Administrative credentialing data elements that are subject to change in status are re-verified at this time.

Upon completion of the verification process, provider files will be forwarded to the local Regional Network Credentialing Committee (RNCC). Administrative credentialing information, which is completed centrally, is combined with quality data maintained at the Nebraska Care Management Center. Quality data consists of profiling data, complaints, medical record review results, enrollee satisfaction data (if applicable), and other appropriate quality data. This information is reviewed by the RNCC to determine ongoing network and contract status.

Ensuring that Providers are Enrolled in Medicaid and Have a Valid Identification Number

All current providers in Magellan's Nebraska network are enrolled in Medicaid. Our provider database stores the Medicaid identification number. Ensuring that a provider is an active Medicaid provider in good standing is a part of our credentialing and recredentialing process.

Providers will continue to be required to maintain active Medicaid enrollment to participate in our network under the new full risk contract. Current practice requires that providers complete the Medicaid enrollment process prior to applying to become a Magellan network provider. This consecutive application process sometimes results in a considerable delay in activating the provider to serve members while each step is completed. For NBHMCP, we propose a streamlined process whereby the provider may submit applications to the state and to Magellan concurrently. The provider will not be authorized to serve members until both processes are complete, but allowing them to run concurrently will significantly reduce the time needed for the administrative processing.

Information on Ownership and Control

Information on ownership and control is collected on the Medicaid disclosure form (see below).

Excluded Providers Database Search

Magellan has established procedures to verify the status of participating providers against the Office of the Inspector General (OIG) list of individuals and entities excluded from participation in federal health care programs. During the initial credentialing process, and each month thereafter, the entire Magellan network is reviewed against the OIG's listings to identify any providers who have been sanctioned or excluded since the last review. In those cases in which

providers are identified, the provider immediately is terminated from the Nebraska network. All such providers are then reviewed by Magellan to determine whether other network affiliations should be terminated based on the nature of the sanction or exclusion.

Disclosure Related to Persons Convicted of Crimes

In 2011, as a proactive approach to meet MLTC's need to comply with requirements pursuant to 42 CFR 455.104, 105, and 106, Magellan of Nebraska implemented a process to comply with the Medicaid disclosure requirements. These federal regulations require Medicaid providers to disclose information regarding (1) the identity of all individuals and entities with an ownership or controlling interest of five percent or greater in the provider, including the identity of managing employees and agents; (2) certain business transactions between the provider and subcontractors/wholly owned suppliers; (3) the identity of any individual or entity with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider or disclosing entity that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs.

In order to make the process efficient and convenient for providers, we created an interactive Medicaid Disclosure Web application to collect the information outlined in the Medicaid Disclosure Form required by CMS. The disclosed information obtained through the interactive Medicaid Disclosure Web application is compared against the following exclusion lists:

- List of Excluded Individuals/Entitles (LEIE) database (http://exclusions.oig.hhs.gov/)
- the General Services Administration's Excluded Parties List System ("EPLS") (http://www.epls.gov/)
- the Nebraska Medicaid Excluded Providers List
- any other database the US Secretary of Health & Human Services may prescribe.

Any adverse information obtained as a result of the Medicaid Disclosure review process is reported to the MLTC, DBH, and any other required regulatory agencies.

Under the NBHMCP, providers will be required to complete the Medicaid Disclosure Form as a condition of network participation.

Describe the processes your BH MCO will utilize to build and maintain positive relationships with the provider network.

Since 2002, we have worked to build strong, lasting relationships with all stakeholders in Nebraska. Our team is embedded in the community allowing us the advantage of understanding and responsiveness to identified provider issues. We have seen increasing levels of provider satisfaction over the past three years as the development and execution of our provider relations plans gains momentum. An important aspect of our provider communication plan is having a transparent, proactive communication strategy. Through our proactive plan and experience we show value in being a reliable resource and provide value by supporting and

assisting providers in reducing their administrative burden, improving the clinical soundness and the quality of services provided to consumers; and expanding and enhancing the service delivery system through education, training and provider development.

There is an ongoing opportunity to strengthen our relationships with the provider community and develop a positive relationship that is built around a high touch provider relations model of network management. Provider relations are the primary responsibility of the Nebraska network team, comprised of our Field Network Director and additional field network staff with various roles and responsibilities with the common goal of supporting our provider relations plan and supporting our provider network. All departments within the Magellan organization will be involved in provider relations activities, recognizing their role in maintaining positive provider relationships and improving provider satisfaction [redacted] The Nebraska network team meets goals through face-to-face meetings and trainings, provider notifications sent through the traditional postal methods, and the use of technology (e-mail and fax blasts, webinar, and Web site tools), timely communications including a monthly newsletter, statewide Town Hall meetings with providers, quarterly satisfaction surveys, the Nebraska PAC and participation in provider sponsored community activities.

[redacted]

Magellan also recognizes the importance of efficient, responsive customer service to the development and maintenance of positive provider relationships. To ensure timely call answering responses, the Nebraska care management center uses a queue system that allows providers the flexibility to call and speak with a care manager as their schedule permits. The all queue system increases provider accessibility and allows them to speak to a care manager to obtain authorizations in a timely manner. When there is a need for a return call, our goal is to

return urgent phone calls within the same half business day the call is received and routine calls by close of business the same business day.

[redacted]

Describe your provider QM strategy and how the BH MCO will involve the provider network in Quality Improvement processes.

Magellan of Nebraska works with network providers to provide quality care to our members. However, for the new program, we will strengthen our existing Provider Quality Management (QM) Strategy beginning on September 1, 2013, to emphasize:

1. implementation of the Principles of Care
2. access to care for members
3. quality of care
4. application of principles of rehabilitation, recovery, and resilience to services planning and service delivery
5. measurement and promotion of recovery- and resilience-oriented outcomes for members over the course of receiving covered services
6. integration of covered service delivery with medical services provided by members' primary care providers or other key health care providers
7. cost-effectiveness of the delivery of covered services.

Our provider QM Strategy is based on the requirement for providers to provide high quality care according to clinical practice guidelines, incorporating evidence-based practices where possible, and supporting the Principles of Care. Our provider agreement requires that providers cooperate and participate with all utilization review/management, quality improvement, peer review, appeal and grievance procedures, or other similar programs. The provider is required to permit access to medical records for quality of care monitoring and for use as data in quality improvement projects. The provider is also required to cooperate with any on-site reviews.

Providers are involved in our quality management processes and in the development and implementation of quality improvement projects. Quality improvement will be a standing topic at both the PAC and the Clinical Advisory Committee to ensure that activities are conducted with full input from key advisors. The Governance Board will conduct the final review of the quality management activities, through the QAPI, to give direction and prioritize resources for efforts.

Measurement is key to any successful QM Strategy to ensure that chosen improvement topics are based on data that supports a need for improvement and to allow for the ability to track the success of chosen interventions. We affirm that our QM Strategy will include:

1. A systematic plan for utilizing network provider profiling and benchmarking data to identify and manage network providers who fall below established benchmarks and performance standards, and to reward and replicate practices of network providers who consistently exceed benchmarks and performance standards.
2. A system for Magellan and network providers to identify and establish improvement goals and periodic measurements to track network providers' progress toward improvement goals.
3. Utilization of on-site visits to network providers at all levels of care, to support quality improvement efforts and benchmarking data.
4. Steps to ensure network provider compliance with Magellan's performance specifications for each covered service.

As described more fully in the eighth question in Section IV.L. Provider Network regarding site visits, we will conduct site visits with providers for the purpose of credentialing and recredentialing and when any quality of care concerns are identified. We will also conduct regular record review audits to determine if providers are complying with our quality of care standards.

Outcomes Informed Care Summit

As part of our commitment to using outcomes, we propose an Outcomes Informed Care Summit led by our national Director of Program Innovation and Outcomes, Barbara Dunn, on-site and through live remote access in the beginning of the implementation. This summit will include training on: access to online web functions for outcomes as described below as well as Clinical Practice Guidelines and quality improvement tools; clinical use of outcomes tools with consumers and in supervision; programmatic use of provider Web reporting for self-evaluation and program improvements; and quality improvement using the provider profiles and dashboards. This summit will also introduce quality practices with provider involvement, such as provider forums and provider learning collaboratives.

[redacted]

[redacted]

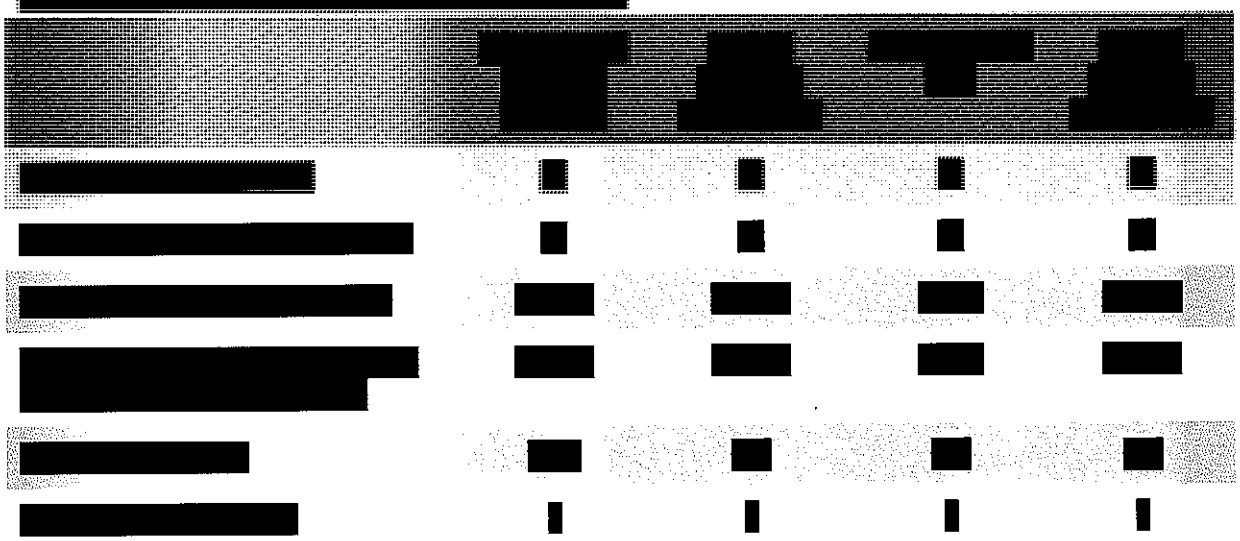
[redacted]

Outcomes-Informed Care

We bring outcomes tools to Nebraska that have been subjected to research and scrutiny, such as the Consumer Health Inventory which has at its core the internationally recognized SF-12 with Emotional and Physical Health Domains with clinically significant change scores and normed scoring. We select outcome tools that are reliable, well researched, and scientifically validated. We value the use of self-reported assessments for members to have a voice in their treatment, as well as clinician-based tools with demonstrated reliability and applicability.

[redacted]

[redacted]



[redacted]

[redacted]

In the spirit of transparency and accountability, we will ask providers to allow public access to their profiles on demographics, paid and denied claims, Reward for Quality measures such as readmission and average length of stay, co-occurring disorders, and outpatient access. The providers will be identified and compared to all other de-identified providers, as well as the aggregate of providers, by level of care. We post the profiles after provider review and agreement. Providers who have consented are rewarded with the additional exposure on our Web site by their willingness to be accountable to the community they serve.

[redacted]

[redacted]

What additionally sets Magellan apart is our approach to member education. We publish on our Web site education on how to use the dashboard from a member or family perspective. Each measure is explained in consumer friendly language and is followed with a suggested action for the member or member family. For example, the 30-Day Readmission definition is followed by an action recommendation for the member or family in bold: "Make an action plan for wellness and engage others to help you reconnect to family, friends, and your community during this time." We will work with members of the Collaborating for Kids Committee, which includes family members and family advocates, to continue to educate families about the dashboards. Consumer members of the QAPI will also be involved in dashboard implementation and development. Figure IV.L.16.4 shows as sample of our consumer and family education on public provider dashboard indicators.

[redacted]

As we continue to develop the Nebraska Provider Dashboard, we will solicit feedback from providers, consumers, and stakeholders to consider the addition of future measures related to recovery and resiliency, outcomes (e.g., clinical, employment, education, and housing), and safety.

[redacted]

Corrective Action Plans and Sanctions for Poor Performance

As described in the eighth question of Section IV.L. Provider Network regarding site visits, we conduct site visits with providers for whom quality of care has become a concern. Each site visit is conducted using standardized tools that review administrative requirements and treatment records. At the conclusion of the site visit, providers will receive a score that represents how well they complied with Magellan's standards. Ranges of scores fall into high, middle, and low ranges, with high scoring providers best meeting our standards.

Providers who fall into the middle range are asked to produce corrective action plans that address identified opportunities for improvement. The timeline for completion of the corrective action plan should not exceed 30 days. These actions are verified for follow-up by attestation of the provider. The care management center follows up to ensure that all such corrective actions are undertaken and complete, as attested to by the provider. Providers who do not attest to successful completion of the corrective action may be subject to additional corrective actions, additional site visits, or suspension of credentialing privileges based upon the determination of the RNCC.

Providers whose results fall into the low range are determined not to meet Magellan requirements for office presentation, procedures, and/or treatment record keeping practices. These providers are asked to produce a formal, written corrective action plan to address the deficiencies. The action plan must contain the timeline for implementation of specific actions. The timeline for completion of the corrective action plan should not exceed 30 days from provider receipt of report.

The RNCC is responsible for the monitoring of corrective action plans developed as a result of provider site reviews. On-going review of identified deficiencies occurs at least every six months and may occur more frequently until identified deficiencies are corrected and threshold performance levels are met. Where actions are not effective in achieving threshold performance, additional corrective actions or additional site visit assessments may be required.

We work with providers collaboratively to improve the quality of care delivered to our members, providing technical assistance as appropriate. If the provider refuses to collaborate, or after the collaboration has ended, the provider still cannot demonstrate that services are provided at the highest possible level, we will take other steps with the provider, which after all steps are exhausted, could result in provider termination from the network.

The results of provider site visits are reviewed by the RNCC when making decisions about credentialing, disciplinary action, or termination of network providers. Deficiencies identified through a provider site review are followed up by the appropriate staff and reported to the RNCC at least every six months until deficiencies are resolved and any performance thresholds are met. Site reviews are a joint responsibility of network management staff and care management center quality improvement and clinical staff, depending on the cause for the site visit.

Under and Over-Utilization

Magellan will develop a network management strategy to engage our network providers to improve access for members who may be under- or over-utilizing behavioral health services, which will be approved by the MLTC.

Monitoring and assessment of over- and under-utilization is a core Magellan quality activity that supports our care management philosophy of assuring our members receive the right care at the right time. We will detect under-utilization and over-utilization of services through use of outlier reports and utilization reports. Findings will be compared to established thresholds to identify outliers and negative trends. Thresholds will be based on national and regional data and standards, and standards set forth by the contract. Utilization data will be reviewed to ensure services are being provided in a manner consistent with medical necessity for members of all ages. We will monitor and track utilization for all levels of care and services including crisis services, 24-hour levels of care (including inpatient and residential), out-of-home placements for children/youth, and other intensive services, to ensure utilization is consistent with practice guidelines.

Our rigorous quality assurance measurement processes allow for careful monitoring of over- or under-utilization of services. Specific indicators, geared towards the identification of aberrant utilization patterns are formally and routinely analyzed by the QAPI where continuous quality improvement method, DMAIC, is applied. Examples of these indicators include:

- inpatient discharges from inpatient mental health services per 1,000 consumers
- average length of stay for mental health inpatient admissions
- rate of readmission within 30 days of discharge from an inpatient admission
- compliance with seven day aftercare follow-up care services
- access to service and care
- analysis of appeals and grievance data related to service access and utilization
- scores on a perception of care question in our consumer satisfaction survey

- utilization trends by level of care
- service penetration rate.

[redacted]

The Utilization Management Committee has primary responsibility for monitoring over- and under-utilization, and the assessment of the quality and appropriateness of care furnished to members including those with special health care needs. The Utilization Management Committee investigates utilization falling outside expected ranges and compares results from one level of care to another. For example, if inpatient admissions appear to be high, we determine whether utilization of community-based care is too low. If so, this may indicate under-utilization of diversions to lower levels of care and over-utilization of inpatient services. If the average length of stay for inpatient services is beyond threshold while partial hospital program average length of stay is below threshold, this may indicate underutilization of partial hospital programs due to premature discharge which, in turn, led to the over-utilization of inpatient services. The Utilization Management Committee also critically analyzes these trends of shifting utilization across levels of care to determine if the trend is intended and benefiting the membership. This may be indicated through reduction in the use of more restrictive levels of care, particularly if they have been over-utilized historically, and appropriate increased use of community-based programming. We outreach to providers who have identified trends to discuss the data and collaboratively develop solutions.

Analysis of utilization data is further supplemented by an examination of other indicators that may support findings. For example, the number and nature of complaints and grievances related to access or the authorization process may further substantiate suspected over- or under-utilization findings while providing insight for analytic purposes. Member and provider satisfaction survey outcomes and access measures may serve a similar purpose.

At contract award, we will work with the QAPI and PAC to identify indicators of over- or under-utilization and corresponding thresholds relevant to the Nebraska member population, provider network, and level of care characteristics.

Describe how the BH MCO will provide linkages with consumer and recovery/resilience initiatives.

[redacted]

[redacted]

Consumer and Recovery/Resilience Initiatives: Part of Systems of Care

Magellan understands the value and importance of initiatives focused on recovery and resiliency, and the unique nature of activities, events, projects, programs, and initiatives driven by consumers. We understand because we partner with consumer and family organizations, as well as providers, other State agencies, and our customers across our public sector programs to support such initiatives, providing funding in some cases. [redacted] This, in turn, can improve people's participation in the community, provide access to peer support and resources, and perhaps, most importantly, provide hope. Magellan also understands our role and responsibility to actively link members ourselves and to communicate and collaborate with consumer and recovery and resiliency initiatives to the greatest extent possible.

[redacted]

[redacted]

Magellan's Nebraska Story: People are the Key to Linkage

Our description of how we will provide linkages to consumer and recovery/resilience initiatives starts with sharing our experience, accomplishments, and success in Nebraska so far. While we use a variety of approaches to linking community partners, it comes down to our team being committed to making sure our members, their families and the communities they live in, along with providers, consumer and family run organizations, mutual self-help groups, and other stakeholders in Nebraska's systems of care are aware of, and have opportunities to, participate in these initiatives. Magellan has been building relationships with the people and organizations driving these initiatives for years, knowing that working together well improves as relationships strengthen over time.

"Magellan has a consumer and family advocate who has shown the true meaning of advocacy. Our experience with Magellan has given us hope and reassurance to our families."

Augusta Carbray, J.D.
Permanency Support Specialist
Right Turn Program

We are part of Nebraska communities and we link with consumer and family organizations, educational programs and support groups. We are part of recovery and resiliency initiatives, in some cases leading projects and training initiatives. We know about meetings around different initiatives, program, events, and activities because we want to share information with others about these opportunities. We know who to call about a specific question, a specific need, a specific solution. We know whose contact information we can provide to a member or family member when there is a need, knowing that person will follow through. We know this and are part of these initiatives because of the relationships we have built.

We do this so we can work together to help people improve their health, wellness, quality of life, and participate in their communities. Magellan understands how important providing linkages to consumer and recovery/resilience initiatives are in supporting these goals. We have helped make Nebraska's citizens' lives better by connecting people, organizations and communities, building systems of care at different levels, and being responsible, accountable stewards of Nebraska's Principles of Care.

Our accomplishments in this area are examples that the Principles of Care developed for the new program and contract are already acculturated in how Magellan operates and what our values

are as a company. [redacted]

Creating Lasting Community Connections

Our Collaborating for Kids Committee brings together a diverse group of children's advocates representing all of Nebraska's geographical areas and all of the members we serve. This group, consisting of parents and other family members, providers and community stakeholders,

> "The topic of whole health in the behavioral health field is buzzing. I feel very fortunate to have had the opportunity to address whole health from the perspective of Peer Support. The focus on person-centered planning and personal responsibility was a theme presented throughout the 2 day training. The presenters were warm, informative and engaging. The Appalachian Group introduced the five keys to success using the IMPACT model. Thanks goes out to Lori our workshop sponsor and to Magellan for keeping Nebraska Peer Support current and supporting an educated Peer work force."
>
> **- Jennifer King Ihle, Supervisor of Peer Services, Community Alliance**

convenes monthly to study key initiatives and policies affecting children and families. Committee members help develop resiliency initiatives, and evaluate materials for family-friendliness. Webinars and teleconferences ensure active participation of committee members from all areas of the state.

[redacted]

[redacted]

"As treatment progressed, I had a lot of questions and didn't know what the next step was. I called the advocate from Magellan, and I felt completely comfortable doing so because of her kindness at the support group meeting. She was so helpful, and I could tell she truly cared about my daughter. From that day on, I talked with her often, and she was a big part of the process; her support is something I will never forget."

-- Beth, parent of a child in Intensive Care Management.

[redacted]

No matter at what level consumer or recovery/resilience initiatives influence and become part of the systems of care they touch, Magellan learns about them, builds relationships with the people involved, and values their contributions. As a result, we have solid personal working relationships that contribute greatly to successfully linkages, connections, and partnerships. When it comes to succeeding in this area, real experience in Nebraska cannot be replaced.

Magellan of Nebraska's Web Site

We have used our MagellanofNebraska.com Web site as a way to provide information and linkages to a range of consumer and recovery/resilience initiatives. Our home page features 'Coming Events,' 'In the News,' and 'Spotlight' areas where visitors can learn about trainings and news. People can view our monthly Magellan of Nebraska e-news, which includes articles about projects, activities, and links to resources that are directly tied to or complement consumer and recovery/resilience initiatives. An archive of our monthly e-news, starting with our February 2010 issue, is available for viewing.

Our Recovery and Resiliency page features links to national organizations, offering a huge amount of information, tools, materials, and programs. We also include links to Magellan's Recovery and Resiliency e-Learning Center, where anyone can access our no-cost e-courses on recovery, resiliency, and peer support. Our Recovery and Resiliency e-Learning Center also includes an archive of webinars produced as part of our three year partnership with ACMHA, the College for Behavioral Health Leadership.

Our Community Resources page includes links to the Nebraska Network of Care Web site, and Nebraska 211. We also feature a link to SAMHSA's Suicide Prevention Research Center's free toolkit for schools, "After a Suicide: A Toolkit for Schools." The toolkit describes common warning signs and causes of suicide, provides best practices on suicide prevention in schools, and provides information about how a school should respond when a suicide has occurred. Topics include crisis response, helping students cope, working with the community, social media, bringing in outside help, and more.

[redacted]

We use our Web site as one of the most effective mechanisms to provide information about and linkages to consumer and recovery/resilience initiatives.

Providing Linkages: Moving Forward

Our approach under a new contract will build on our current activities, with new resources added to increase linkages to consumer and recovery/resilience initiatives. We will continue to strengthen relationships, continue our commitment to partner with others to build healthier communities across Nebraska, and add new team members to support this work.

[redacted]

[redacted]

Magellan of Nebraska knows Nebraska. We are Nebraskans. Our Magellan of Nebraska team lives throughout the state, in Omaha, Lincoln, Kearney, Riverdale, Waco, Grand Island, North Platte, Plattsmouth, and Bradshaw. We've been growing roots into Nebraska communities, large and small, for years. Over the years, Nebraska's Magellan team has grown to know the consumer and family advocacy communities, the consumer and family-run organizations, provider agencies, and State agencies, all offering projects that provide a broad range of supports, services, and programs. We have accumulated years of experience working with these organizations and agencies, along with other community systems of care stakeholders. That experience is complimented by our recognition of the importance of consumer and recovery/resilience initiatives contributing to improved health and quality of life outcomes. We know, for example, peer support is an evidence base practice provided by specially trained peers. Peer support services help people recover, improve self-esteem, feel of empowered, and promote wellness self-management. We want to provide linkages that promote increased access to peer support services as one example of connecting to a consumer initiative.

Building Linkages: Beyond Consumer and Recovery/Resiliency Initiatives

Magellan will reach out to our provider network to establish strong working relationships to manage services that complement and integrate with formal and informal resources and programs that promote members' recovery, empowerment, and use of their strengths and the family's strengths in achieving their clinical goals and improving their health outcomes. [redacted] In keeping with the first Principle of Care, Magellan will continue to strive to ensure services are provided in the communities people live in, to the fullest extent possible. We are fully supportive of the focus Community Support Services has on supporting people living well in communities of their choice and avoiding unnecessary hospitalizations. We have extensive experience supporting members to develop self-directed crisis prevention plans using the WRAP model, another evidence-based practice.

We are equally committed to working with providers, members, other rehabilitation service providers, along with consumer and recovery/resilience initiatives, to advance the range of Day Rehabilitation Services, especially those services that further promote clients' ability to function well in their communities of choice and meet identified rehabilitative needs. These include skills designed to support community participation (e.g. - social skills development, recreational activities, and financial literacy) and decrease the frequency and duration of hospitalization.

Anonymous Recovery Programs

Magellan has a long history across our behavioral health plans, including our public sector programs, of understanding the unique values and influence of anonymous recovery programs like Alcoholics Anonymous. Magellan also feels it is critical we honor the principles of anonymity on which these programs are built. We will take a balanced approached to linking members and their families to these programs by providing information about them on our MagellanofNebraska.com Web site, and by including general information and state-level contact information in our electronic Self-Help and Support Group Guide.

Going forward, Magellan will reach out to Nebraska Alcoholics Anonymous and add a link to their Web site, www.area41.org, to our MagellanofNebraska.com Web site. We will include their contact information in our Member Handbook.

Linkages to other DHHS-Funded Programs

As described more fully in our response to Section M in our description of our care management practices, Magellan will link and coordinate with all key systems that are working with our members, including Medicaid HMOs, DBH-funded programs, DCFS-funded programs that support the safety, permanency, and well-being of children in the care and custody of the State of Nebraska, and DDD programs. We will also work with the courts and juvenile justice systems to address court-ordered treatment that is determined not to be medically necessary. Finally, we will actively participate in any programs or initiatives within MLTC related to primary care and behavioral health integration.

Magellan has established effective working relationships with the Nebraska state agencies that also provide services to members and has employed several different mechanisms for ensuring coordination of care for shared members and the development of new strategies for addressing areas of concern or opportunities for better coordination across the care continuum. Clinical staff at Magellan's Nebraska care management center, for example, have developed close collegial relationships with staff at MLTC, DCFS, DBH and the Regional Behavioral Health Authorities (RBHA) over many years. Collaborative activities between Magellan and the agencies have included joint deliberation over lessons learned and opportunities for collective improvement, the sharing of best practices, identification of programmatic, policy or geographic issues that may have impeded particular members or member populations' access to effective care, and development of solutions.

[redacted]

[redacted]

[redacted]

With our commitment to putting the Principles of Care into practice, and with respect and appreciation for the power of consumer and recovery/resilience initiatives, Rehabilitative Services available through provider organizations, unique approach to vocational, supported, and competitive employment (with parallel supported education programs), 12-step programs, and other informal and formal supports to change people's lives, we will pay special attention to continue our success in providing linkages between members and their families, providers, peer and family-run organizations, support groups, and other stakeholders listed, including our State partners.

Describe how the BH MCO will increase the number of multilingual providers in the network.

All key Medicaid-enrolled providers for behavioral health services are enrolled in our network. We have had no complaints regarding the ability of our members to connect with a multi-lingual provider in our existing program, using our existing network. Our provider search screen allows members to identify providers with staff who are able to meet their linguistic needs or who identify as being from a particular ethnic group. As part of our credentialing process, we obtain information on languages spoken. The information is maintained in our provider database to allow for members to be referred to providers who have similar cultural and linguistic characteristics, when possible and as desired by the member. Members can search for providers on the Magellan of Nebraska Web site by ethnicity or language (see Figure IV.L.18.1 Provider Search).

[redacted]

Although the linguistic capabilities of our network have been sufficient, we will actively recruit multilingual providers through member referrals and through our work with provider and advocacy organizations and other community stakeholders. [redacted]

Describe how the BH MCO will monitor compliance with the requirement to provide interpreters/translators when needed.

While Magellan maintains the ultimate responsibility for ensuring members have access to interpreters and translators when needed, we pass that requirement on to our network providers. Providers must have access to interpreters, referral strategies with community resources and communication materials in other languages applicable to their client population. Hospitals, facilities and groups must have formal policies, strategies and resources addressing the cultural needs of the client population so that all organization staff members are aware of and sensitive to these issues. [redacted]

To ensure that providers are complying with this requirement, we review provider policies and procedures during credentialing and recredentialing to ensure there are appropriate mechanisms in place to obtain assistance for the member. We also monitor complaint data to identify any issues with particular providers or members in need of assistance with particular languages. To date, there have been no identified issues with access to interpreter services.

Magellan connects members to an interpreter service line when they require language assistance when calling our care management center. Interpreter Services are contracted though Pacific Interpreters. This firm is able to translate over 200 languages spoken in 129 different countries. Any time we receive a call or a request for language translation, we connect the member with this interpreter service and our Magellan representative. Once connected, the member communicates with the interpreter, and the interpreter communicates with the member, and vice versa. No advanced scheduling is required; the average wait time to have a qualified translator on the line is under 45 seconds. We currently average 17 calls a month using this interpreter service.

We also utilize a TTY (Telephone Typewriter) or TDD (Telecommunications device for the deaf). Again, the member communicates with the deaf operator, and the operator communicates with the Magellan representative. The Magellan representative responds to the interpreter and the interpreter communicates this with the member.

All of these services are available to the member free of charge. Members are notified of translation services in the *Member Handbook* as follows:

"Magellan has staff members who speak different languages. We also have translators to work with you. We have information in Spanish. We have a Consumer and Family Advocate who can read information to you."

Describe how the BH MCO will monitor and ensure network compliance with the use of seclusion and restraint.

Magellan Behavioral Health of Nebraska proposes a comprehensive approach ensuring network-wide compliance with rules governing the use of seclusion and restraint. All credentialing

monitoring, intervention and reporting activities will be in accord with regulations found in 42 CFR §483 as established by the Centers for Medicare & Medicaid Services (CMS).

Provider Credentialing/Recredentialing Process

Magellan will maintain appropriate, documented processes for the credentialing and re-credentialing of all providers who participate in the Magellan network. Basic components of these processes, collaboratively developed with the PAC, shall mandate that all providers of 24-hour service evidence a robust training program instructing on the appropriate and safe use of restraint and seclusion. Additionally, facility-based network providers will all be subject to a site visit reviewing policies and program training on the appropriate and safe use of restraint and seclusion.

Magellan will ensure that those facility-based network providers of inpatient services will comply with contractual terms and requirements, including all CMS regulations concerning restraint and seclusion. Magellan will require submissions of evidence establishing proper program training associated with the appropriate use of seclusion and restraints, and will review and advocate for other consumer protections as part of the credentialing and recredentialing process.

As part of a restraint and seclusion QIA initiated by Magellan of Nebraska, each credentialed facility-based provider is required by Magellan to have policy specific to restraint and seclusion procedures that are consistent with all standards found in the Federal Medicaid Guidelines from CFR Title 42: Public Health; Part 483 Subpart G. Magellan also requires contracted facilities to have an annually revised policy that includes a mission statement and values directed toward the safe and proper use of seclusion and restraints. These policies must be designed to foster staff knowledge, expertise, and skills concerning the use of seclusion and restraints, and will prescribe multiple measures to avoid inappropriate use.

In 2010, after site visits were conducted at each facility-based program as part of the Nebraska QIA, no provider was found to have policy consistent with all Federal Medicaid Guidelines from CFR Title 42; Part 483 Subpart G standards. Today, 100% of residential facilities have policies in compliance with CFR regulations.

Reporting

Magellan of Nebraska currently provides MLTC with the quarterly Service Effectiveness Report regarding restraint and seclusion, and will work with MLTC, consumer and family advocates, and inpatient/residential providers to develop restraint and seclusion reports that are even more meaningful and useful to them in the new contract period. Our current restraint and seclusion reporting is tracked by provider and it includes the number of incidents of restraints, seclusion and related injuries. It is indexed for program and specific program location. This reporting has been the backbone of Magellan's quality interventions with residential providers, allowing Magellan to generate necessary and meaningful data that is used to directly make significant improvements in our quality care delivery system.

[redacted]

[redacted]

Provider Intervention as a Result of Data Analysis

In 2011, Magellan began collecting quarterly data from facility-based providers including the number of seclusion, restraints, and co-occurring injuries. One facility reported incidents of restraints and seclusions significantly above baseline. That facility provided care to approximately 20 percent of Magellan authorized youth, but accounted for 53 percent of all restraints and 44 percent of all seclusions. This facility was placed on a Corrective Action Plan, with Magellan providing in-depth technical assistance and support. Magellan provided individual assessment and consultation by national experts from the National Association of State Mental Health Program Directors (NASMHPD) Office of Technical Assistance (OTA). These experts have also provided network-wide training on providing Trauma Informed Care in Nebraska. Consequently, the facility has reduced program restraints by 57 percent and seclusions by 19 percent.

Critical Incident Reporting

[redacted]

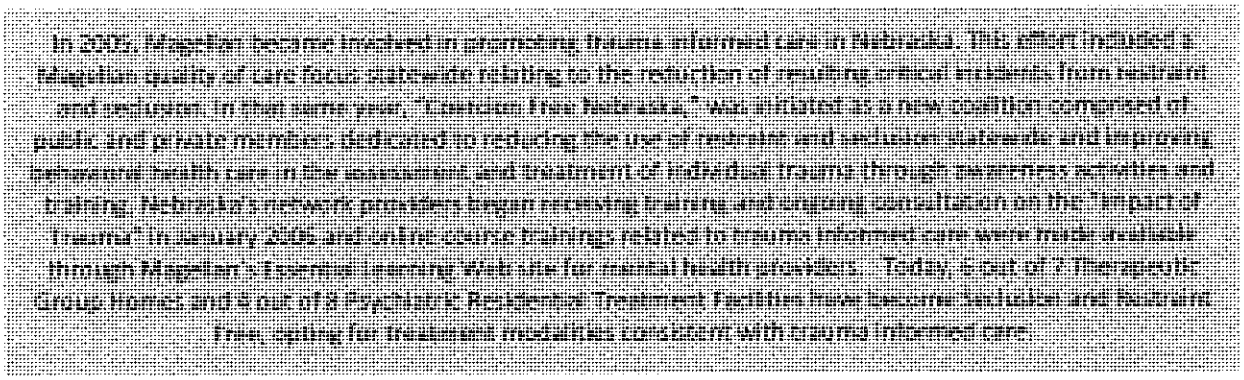
This Quality Improvement Project continues to monitor occurrences of restraint and seclusion and co-occurring injuries. Magellan Behavioral Health of Nebraska monitors and investigates substantial increases and injuries. Magellan senior leadership continues to work with providers who are the highest utilizes of invasive management strategies, as we work toward coercion free facilities in Nebraska.

Injuries related to restraint and seclusion have decreased 48% in the last contract year as a result of Magellan's QIP, and importantly, no major injuries have been reported since that time.

Related Factors

In addition to our commitment to reducing the frequency of provider restraint and seclusion, Magellan has addressed other important factors influencing the physical and emotional safety of

the youth in facility-based care. Magellan has eliminated the use of restraints in a prone position by addressing the risks with providers, and no programs are using this type of restraint any longer. Magellan also addressed the issue of youth unclothed in seclusion, identifying and requiring use of a safe alternative that has been adopted by facilities previously employing that practice. Further, policy requirements include both general and member-specific prevention initiatives aimed at reducing the use of seclusion and restraints, such as the structuring of activities for members during waking hours, a technique which is known to decrease episodes of violence.



Describe the process your BH MCO will use to utilize the eligibility and enrollment files from DHHS to manage potential membership. Include the process for resolving discrepancies between these files and your internal membership records.

Magellan has a strong history of enrollment/eligibility data management for State Medicaid programs across the country. We manage the behavioral health enrollment information of more than 3.0 million Medicaid recipients in States such as Nebraska, Iowa, Pennsylvania, Louisiana, Florida, and Arizona. We have implemented well-defined procedures for the maintenance of enrollment information to ensure the timeliness, completeness, and accuracy of the membership information we maintain. Today, our enrollment system meets the State's needs for a vendor capable of meeting the enrollment maintenance and processing requirements of the MLTC program.

MLTC's membership information will be maintained in Magellan's enrollment system. The enrollment system maintains relevant member profile data, including enrollment per eligibility date spans, benefit plans (i.e., types of coverage), historical data (e.g., enrollment audit trail), and demographic data. The system is tightly integrated with our core processing applications, including clinical, claims, and provider systems, allowing information to be utilized across systems to ensure streamlined data processing. Additionally, the eligibility system is linked to Magellan's Web portal, allowing providers to verify a member's eligibility in real-time through our provider portal.

Today, Magellan receives and processes enrollment (add/change/delete) files from the State on a daily basis in a proprietary format. Complete enrollment files are received and processed each month to ensure Magellan consistently has up-to-date enrollment information for members.

The process for resolving discrepancies between the state's eligibility and enrollment files and our internal membership files is a translation-and-edit phase prior to updating in Magellan's core system. This process allows our system to analyze the files provided by the state to identify any errors. A report of all errors is produced, and Magellan's eligibility analysts review the reports and either omit or correct errors. Files that contain no errors are submitted to update the eligibility master files within the core system.

Magellan will update the enrollment system within 24 hours of receipt and make this data available to other supporting applications to ensure accurate enrollment information is available to participating members, providers, and clinical staff in the Nebraska program.

[redacted]

[redacted]

Magellan's Claims Adjudication and Payment System (CAPS) processes claims based on the eligibility information maintained in the system. Today, Magellan accommodates changes to enrollment and/or potential membership and adjudicates claims based on a member's eligibility

status on any given day. In instances where a member is determined to be retroactively ineligible for a service, documented policies and procedures define the recovery process. Magellan's Cost Containment Department will research the circumstances of the issue and will pursue any necessary recovery of overpayments.

Throughout implementation, we will work with MLTC to determine any additional data requirements and mapping necessities for enrollment files received from MLTC under our future contract. Magellan will receive, process, and update enrollment files sent from MLTC on a daily basis, as required by the RFP and our resulting contract.

Describe your BH MCO's approach to creating the Network Development Plan tailored to the NE BH population.

The Network Development Plan will capitalize on our decade long presence and statewide Medicaid network in Nebraska, allowing us to focus on refining and enhancing the network rather than building a new network. Magellan's network analysis, development, and management activities incorporate awareness of the regional and population diversity within Nebraska. Our service development priorities, which are targeted to meet needs which vary between rural, frontier and urban areas, will include stakeholder input and will utilize targeted outreach strategies, as well as our intent to develop goals in close collaboration with MLTC. We will incorporate all required elements in the RFP.

Our approach to creating the network development plan is to implement a regional, strengths-based approach that is focused on increasing access, enhancing quality, expanding choice, and improving consumer experience. We understand the critical need to work collaboratively with members, families, providers, advocates, MLTC, and other stakeholders. We will utilize our Nebraska network team to support the goals of the system, and build from the existing strengths within the system. The Plan will be flexible to address the specific needs of the Nebraska Medicaid population, such as improved access in rural communities.

We will solicit feedback from a variety of sources including, but not limited to, members and family members, the PAC, NABHO, other committees and workgroups, and the QAPI program. Magellan staff members are also a source of critical service gap information. We invite clinical and customer service staff to participate in these meetings and to share information on specialty cases; this alerts us to potential service gaps in the delivery system.

Identified service issues and utilization trends are examined at the county, region, and state level. Based on feedback received from stakeholders, we will develop and implement strategies to meet the needs of, and set the course for, network expansion and development. We recognize that to effectively serve the community and stakeholders, we need to involve the community and stakeholders in developing creative solutions. We will request specific information from stakeholders and utilize it to be sure we do not repeat unsuccessful past attempts while at the same time bringing a fresh and new perspective to expanding provider capacity. We will maintain open communication with stakeholders via the PAC regarding network development strategies and planned initiatives to ensure community understanding. [redacted]

Rural Access and Innovative Technologies

The Nebraska Network Development Plan, which will be tailored specifically to meet needs in underserved areas, will incorporate the targeted use of innovative technology. The digital revolution is transforming the way providers, consumers and payers engage in healthcare delivery. With over 273 million Internet users in the United States today, people are accessing health related information and services online more than ever before.

Magellan recognizes the importance of meeting members "where they are" to provide optimal support "when they are available" for happier, healthier living. Through our state of the art technologies, we provide choice and flexibility and accommodate member preference with a primary focus on increased access to care and member engagement to promote high quality health care. Ensuring the appropriate service is readily available, when and where the member needs it, can reduce the need for more costly intensive services such as acute hospitalization – ultimately ensuring better member health. Our latest technology innovation to promote member access is telehealth.

Magellan Telehealth Services

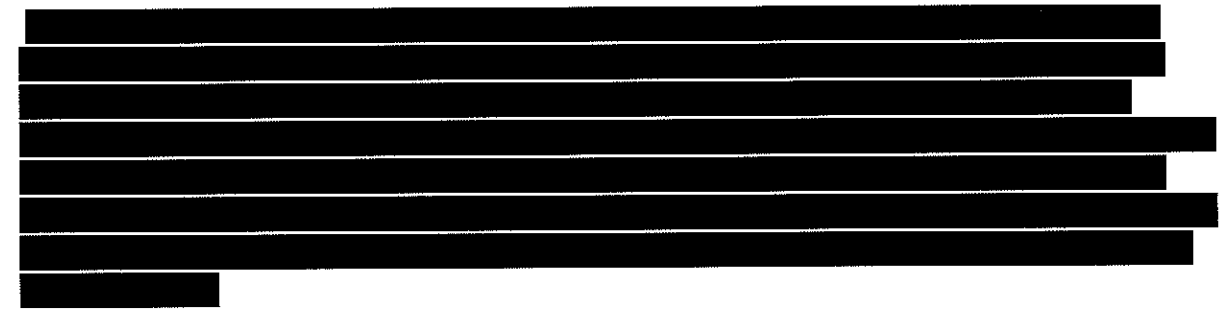
Magellan is working with providers of telehealth technologies to build the next generation of behavioral health service delivery and expand access to care for our members. Options for traditional behavioral health care are dwindling in many communities, especially rural areas.

Magellan's telehealth network connects members to behavioral health providers, regardless of location. Using telehealth technologies, Magellan and its network of behavioral health providers can augment access to care in areas where there exists a shortage of professionals and rising costs. See our response to the fourth question regarding ensuring there are a sufficient number of network providers with particular expertise for a comprehensive description of our telehealth program, American Well.

Expanding Self-Help and Family Support Options

Magellan strongly supports and promotes the principles of care that services should be delivered in home communities whenever possible and that services should be consumer and family-driven. One way to strengthen the consumer and family-centered services available in all regions of the state is to partner with organizations that provide and promote self-help and family support services.

In 2012, Magellan partnered with NAMI of Nebraska to strengthen planning in the provision of support services, particularly in reaching out to rural and frontier communities. This support promoted efforts such as consultation with volunteers, provision of materials, resources and assisting with community development where needed and requested. Magellan will continue to partner with NAMI Nebraska to support a robust network of local chapters across the state which offer vital peer-to-peer and family-to-family support services.



On behalf of NAMI Nebraska I want to express our gratitude for your support of our proposal. Funding at any level to build capacity in grassroots mental health support is not often understood. We appreciate the forward thinking of Magellan in filling gaps in care in communities throughout Nebraska. Again, we thank you for your support.

Tom Adams, Executive Director NAMI Nebraska

Describe how your BH MCO will ensure timely access monitoring of network providers, including:

- *establish mechanisms to ensure that network providers comply with the timely access requirements;*
- *monitor regularly to determine compliance;*
- *take corrective action if there is a failure to comply.*

Mechanisms to Ensure that Network Providers Comply with the Timely Access Requirements

Magellan understands the importance of ensuring providers are available within the time frames mandated in the RFP for emergent, urgent, and routine appointments, and we continually work to improve our network adequacy. We will meet all of the requirements of the RFP Work Statement, and we will maintain the capacity to serve the expected number of members in accordance with access standards for all covered services.

Our provider agreements require that providers maintain the staffing and systems to ensure that their availability remains within the required timeframes, and we have mechanisms in place at the care management center to refer members to alternate providers if one provider is temporarily unavailable. Network providers are required to report non-availability for accepting referrals for any reason. The notification must include the reason and specific timeframe of the period of unavailability. Providers are informed of the notification options and process, to include reporting via the Provider Web Portal, through our provider newsletters and staff interactions.

Under the new full risk program (NBHMCP), we will conduct periodic telephone surveys to providers to inquire about their next available routine and urgent appointments. We will select a sample of our network providers to call with no provider getting a repeat call within the year unless access issues were identified and require follow-up.

Monitor Regularly to Determine Compliance

Magellan's network staff continuously monitor, report, and adjust network sufficiency. Results of the network sufficiency analysis ensure that service types and capacity meet system needs including culturally diverse priority populations and persons with special needs, such as older adults and persons diagnosed with developmental disabilities. Various data points are utilized including, but not limited to:

- GeoAccess analysis results, density analysis, current and anticipated enrollment and penetration data
- demographic data including cultural and linguistic needs
- utilization data
- complaint, grievance, and appeals data

- feedback from the Governance Board, the PAC, and statewide Town Hall meetings
- annual and at-a-glance satisfaction surveys
- recommendations from members, families, parents of children and adolescents, and other stakeholders
- provider onsite reviews, surveys of appointment availability, and provider record reviews
- identification of providers to fill service or geographic gaps. When a care manager identifies a provider that will fill a gap in service, he or she completes a provider nomination form.

We survey the provider network to evaluate the average number of calendar days for appointment availability. The survey requires providers to report on the wait time for crisis, urgent, and routine appointments. They are also asked if they are currently accepting new members, what their in-office wait time is, and if there are any barriers to scheduling appointments with consumers. For the new contract, we will begin making periodic telephone calls to a sample of our network to ask for the next available appointment time for both routine and urgent appointments.

[redacted]

In the event that a member requests an appointment with a provider that does not have current capacity, Magellan member services staff will be available to assist the member in selecting an alternate provider that meets his or her cultural/linguistic needs, is within distance limitations, and possesses other qualifications important to the member.

[redacted]

[redacted]

[redacted]

[redacted]

Take Corrective Action If There is a Failure to Comply

A network provider may only discontinue taking new referrals for a period of sixty days no more than twice per year. If non-availability continues to be an issue, Magellan will perform a provider outreach and document the circumstances surrounding the availability issue, any GeoAccess concerns, and recommendations for action. In situations where ongoing provider capacity issues are apparent, it is utilized as an additional indicator to prompt network development, when other providers are available in the area, or for supportive interventions to assist provider capacity development when no other provider exists in the affected area.

If a member complains to us that they cannot obtain a timely appointment from a provider, we take action. If the member is new to that provider office, the Customer Service Associate will

attempt to find a different provider for the member. If the member is a continuing client at that provider office, the network department will work though the issue with the provider and request that the Customer Service Associate inform the member of the action taken. If the network department discovers there is an on-going issue with appointment availability at that provider office, the network department will engage the provider in a discussion and collaborate with the provider to resolve the issues. If the provider refuses to collaborate, or if the provider cannot resolve the scheduling issues, discussion will take place about the provider's continued participation in the Magellan network.

Describe your BH MCO's approach to creating the Provider Advisory Committee.

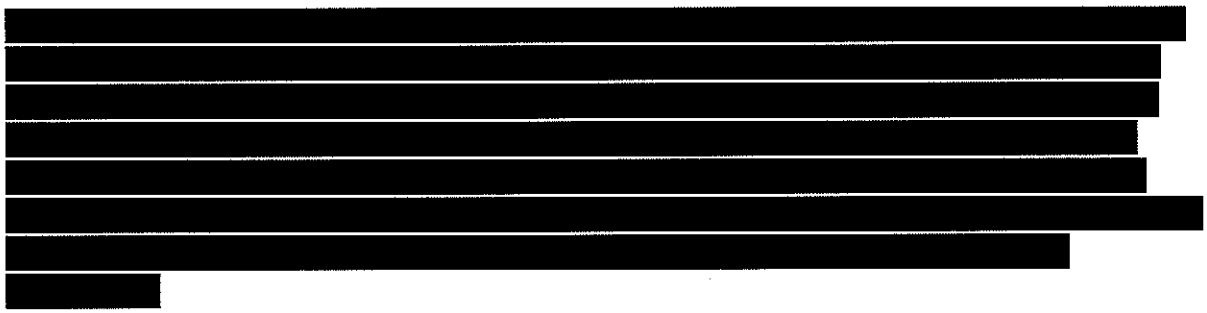
Please see our earlier response to the sixth question in this section, "Describe how your BH MCO will develop a Provider Advisory Committee."

Describe your BH MCO's approach to creating the Network Communication Plan.

We have established relationships with Nebraska's provider community, our network, and have developed effective communication channels during our time as Nebraska's ASO. Our Network Communication Plan for the new program will focus on enhancing our current systems and strengthening our partnerships with providers to effectively serve our members.

Current Communication Strategies

Provider Communication is essential in maintaining a high level of provider satisfaction. The Field Network Director is the central point of contact and coordinates all communications to providers and stakeholders for the Nebraska care management center. This includes mass mailings, Web site postings, e-mail and fax communication, and hard copy mailing methods. Through the continued use of Web-based applications, we will increase the efficiency and frequency of provider communication. Making information available to providers through the Magellan Web site and through the use of e-mail increases the providers' ability to access information at a time convenient to them and on demand. This increase in efficiency reduces the administrative burden on the network department, increases the frequency and timeliness of communication to providers, and reduces costs.



We will continue to expand the current use and frequency of e-mail notifications to increase communication with the provider network. The utilization of this technology provides an efficient method for communicating information to providers. E-mail communication will be

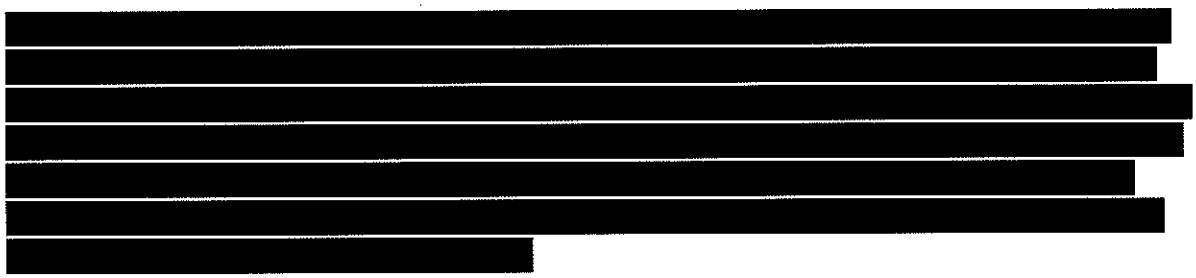
utilized for general notification updates, upcoming trainings, and other pertinent information, as appropriate. Providers will typically receive information the day it is sent, versus a multiple day delay with traditional postal methods. The network department will continue to promote the use of e-mail blasts and encourage providers to update Magellan with their current e-mail address.

Magellan is committed to ensuring that providers receive notifications in a timely manner prior to the implementation of any changes in processes or policies and procedures. We ensure that providers receive notifications within a minimum of 30 days' notice prior to any substantial changes in processes, policies or procedures, which is within the RFP requirement of 45 days.

The Provider Focus is Magellan's national quarterly e-newsletter. It contains articles and information related to Magellan's processes and initiatives, in addition to articles of local interest. The Provider Focus is available on the Magellan Web site and will be promoted at provider trainings, during face to face and site visits, and through all other provider relations activities. The Field Network Director is responsible for submitting articles specific to Nebraska to be included in each Provider Focus throughout the year.

As described more fully previously in the fourth question in the Provider Network section, our Web site is an effective communication method for Nebraska. Magellan is a leader in the development of Web-based communications as evidenced by being a proud recipient of the Standard of Excellence WebAwards since 2005. Sponsored by the Web Marketing Association, the WebAwards are a premier awards competition recognizing the best Web sites in 96 industries. Entries are judged against industry peer sites in the categories of design, innovation, content, technology, interactivity, copywriting and ease of use. We have also been recognized by the Davey Awards, eHealthcare Leadership Awards, W³ Awards, and the American Business Awards.

Network Communication Plan



We will continue to publish a monthly provider newsletter for NBHMP, which will be posted on our Web site and distributed electronically via email. Hard copies will be available upon request. We will include topics relevant to adult and child-serving providers, and authors will include both administrative professionals and clinicians.

We expect that providers will need to consult with Magellan staff on a variety of clinical and administrative issues. Our care management and provider relations staff are available to work with providers as needed on any issues that may arise. We offer scheduled times to meet with providers regularly to address authorizations and claims payment concerns. We also operate a queue system for a call center that allows providers to receive assistance as their schedule

permits. [redacted]

[redacted]

We recognize the importance of communicating upcoming policy changes in a variety of communication formats and with the greatest amount of prior notice possible. We affirm that we will provide at least 45 days' notice prior to changing a policy unless there are significant extenuating circumstances that prevent that notice. In fact, our current practice is to provide 30 days' notice. We will work with the PAC to identify the most effective methods of communication, but, at a minimum, our notices will be posted on our Web site, sent via e-mail blast, and included on Explanation of Benefit notices.

Provider satisfaction surveys will be used to measure the effectiveness of our Network Communication Strategy. As described more fully in the forty-first question in Section IV.L. Provider Network regarding provider satisfaction surveys, we utilize both a national Magellan survey and a local Nebraska survey to ascertain provider satisfaction. The national survey is administered annually and is a more extensive survey than the quarterly at-a-glance Nebraska survey. Results from the survey will be presented to the PAC, and the PAC will develop a corrective action plan in response to any identified deficiencies. Under our current ASO contract, provider satisfaction has been steadily improving over the past three years and is high.

Our Network Communication Plan will also include provisions for communication of key information with MLTC regarding the network. Any quality of care concerns will be communicated to the MLTC, including the intended remedies. Our recredentialing process will include a review of member complaints and grievances against the provider. Any issues that impact quality of care and member safety will be communicated to the MLTC urgently.

Describe your BH MCO's process for developing, maintaining and utilizing network provider protocols tailored to the NE BH population.

Magellan has strong corporate policies regarding provider network management that were developed after years of proven success in providing public sector managed behavioral health care. However, in all markets, we customize our corporate policies to the specific requirements set forth by our state customer and to meet the unique needs of the members and providers within that state. For example, our fraud, waste, and abuse policies have Nebraska-specific addenda.

Our process for developing network provider protocols is one of collaboration, with open communication and transparency as the hallmark of our approach. We believe that protocols developed in collaboration are more successful because they are better adopted by our providers. Our Governance Board will have the final input into the adoption of new protocols, with providers and other community stakeholders, including MLTC, having a seat at the table. Prior to implementing any new policy or protocol, our network will have at least 30 days' notice of the change.

Policies and procedures will be reviewed and updated, if necessary, no less than annually to ensure that they are maintained and comply with any state or federal policy changes. Amendments will be put in place immediately when significant changes occur in state or federal regulations. Staff protocols will be developed to operationalize the policy and procedure documents developed through this process. Review and engagement with the QAPI is part of our annual policy and procedure review process.

Network adequacy will be a key area for review and revision for the new Nebraska contract. Access standards are more stringent for the new program than they are under our ASO contract. While our network continues to meet the requirements under the new contract, we will modify our policies, procedures, and protocols to monitor the network against the new standards.

We have a history of developing protocols that are tailored to the needs of Nebraska, and we will continue to tailor our protocols under the new program. Some examples of Nebraska-specific approaches include the use of Psychiatric Patients in a Medical Bed, the inclusion of Provisional Licensed Clinicians in the network, and the outreach work we have done with our Federally Qualified Health Centers. We understand that each Medicaid program is unique and that we cannot bring a one-size fits all behavioral health managed care organization to Nebraska, or to any state. Having been in Nebraska for over ten years, we are best equipped to customize our plan to Nebraska's Medicaid program.

We affirm that we will develop, maintain, and utilize MLTC-reviewed network provider protocols that address how we will ensure, for a particular member's needs, that a qualified and clinically appropriate network or non-network provider:

a. Is available to provide the particular Covered Service

We discuss our approach to ensuring that adequate providers are available in the fourth question, "Describe how your BH MCO will ensure there are a sufficient number of network providers with expertise."

b. Is accessible within the access standards required by the contract, taking into account the availability of public transportation

We understand that transportation options outside of the urban areas of Omaha and Lincoln are limited, and that access standards that measure distance assume that a member can arrange for transportation by car. Medicaid transportation is available through a transportation vendor, but members do not always wish to use this transportation option to access care. Therefore, we offer two options that do not require the member to come to the provider office. First, members may receive care through our new telehealth program, described earlier in the proposal.

Second, for some services, providers are available to come to the member's home for in-home services.

c. Is accessible to individuals with physical disabilities, if appropriate

Our provider site visits assess provider locations for disability accommodations and compliance with the requirements of the Americans with Disabilities Act. More specific information about our provider site visits can be found in our response to the eighth question in Provider Network, "Describe the process for conducting site-visits with providers."

d. Has the ability, either directly or through a skilled medical interpreter, to communicate with the Member in his/her primary language

Our response to the nineteenth question in Provider Network, "Describe how the BH MCO will monitor compliance with the requirement to provide interpreters/translators when needed," contains information about our interpreter service and requirements for network providers.

e. How the Contractor intends to facilitate communication between network providers and the Contractor, and between network providers and primary care providers, in a manner that engages the providers and overcomes barriers to communication.

Please see our response to the second question regarding open communication for information regarding facilitation of communication among multiple provider types.

Adverse Incident Reporting

Magellan routinely reviews quality-of-care concerns and critical incidents in order to identify opportunities for improvement and to assess potential liability. Network providers must report critical incidents within 72 hours or upon first knowledge of the incident, if the incident involves a member currently in treatment or discharged from treatment within the previous six months. Critical incidents include:

- death
- suicide or serious suicide attempt
- serious complications from a psychotropic medication regimen that require medical intervention
- incident of violence by member
- incident resulting in moderate to severe injury to the member and/or staff.

If such an occurrence is discovered, the provider must contact both the Quality Improvement department in Magellan's Nebraska care management center and MLTC.

There are four defined levels of critical incidents:

- adverse incidents that result in death or seriously jeopardize the safety of the member
- substantial incidents that result in moderate member and/or staff injury
- problematic incidents that result in minor member and/or staff injury

- minor incidents that result in no injury to member or staff.

Providers are asked to make the initial report by phone as soon as possible and provide written documentation of the incident within 72 hours. Problematic and minor incidents do not need to be reported. If a provider is unsure how to classify an incident, it should be reported.

Detailed information related to critical incident reporting is distributed to the network in the *Provider Handbook* as well as on the Magellan of Nebraska Web site.

Payment for Services related to a Serious Reportable Event

Magellan affirms that we do not render payment for services related to a serious reportable event, and we prohibit network providers from seeking or rendering payment for a serious reportable event. Providers are required to comply with all applicable federal and state requirements, including those concerning restraints and seclusion. See the twentieth question in *Section IV.L. Provider Network* for additional information about our policies related to seclusion and restraint.

Informing Members of their Rights under Nebraska Regulations

Magellan will ensure that the *Member Handbook* and the member section of the Magellan of Nebraska Web site include information regarding a member's rights as outlined in Nebraska regulations. Additional information can be found in *Section IV.K. Member Rights and Responsibilities.*

We require our network providers to post member rights in their office waiting room, and we require them to review those rights with the member during the first appointment. We review provider records to ensure that a document signed by the member acknowledging his or her rights is present in the treatment record.

Unique Provider Identification Numbers

Network providers are required to complete an application process to participate in the network, which includes initial credentialing processes. Upon completion of the process and upon approval of the provider to participate in the network, a unique provider identification number is issued. This provider number is maintained in our provider database.

Magellan also requires that providers have valid Tax Identification Numbers. For providers submitting electronic claims, they must also submit their National Provider Identifier.

Notification regarding non-Medicaid Providers

Magellan will only allow a fully enrolled Medicaid provider into their network for the Nebraska Medicaid line of business. Magellan affirms that we will immediately notify the MLTC upon enrolling any provider who is not also a Nebraska PH Medicaid provider in our Provider Network. The notification will include:

- network provider name, address, and telephone number
- legal entity's name, address and phone number of the practice (i.e., "doing business as," or d/b/a name), if different from above

- network provider' or legal entity's tax identification number
- effective date of the network provider's enrollment in the provider network.

Data Submission to MLTC

Magellan agrees to submit to MLTC all updates to the provider list or its data elements whenever they occur. We currently report provider network changes to MLTC through a file transfer process. We intend to continue this process going forward unless otherwise directed by MLTC.

Describe the written notice providers will be given whom your BH MCO declines to allow participation in the network

An initial screening is conducted by Magellan staff for all providers interested in joining the network. During the screening, preliminary information regarding licensure, malpractice insurance, applicable accreditation, and type of services to be provided are reviewed. If it is determined during the initial screening that the provider does not meet criteria for credentialing, the provider is given verbal notification and application documents will not be sent.

When providers complete the Magellan credentialing process, we send a written letter that either welcomes the provider to the network or informs the provider that we have determined that they are ineligible for participation in the network. If they are ineligible, the letter provides a specific reason why they did not meet the requirements to be a credentialed provider. See **Attachment P** for our sample denial letter.

Providers have appeal rights in Nebraska. We provide 33 days for them to submit a letter requesting an appeal, and the letter gives instructions on where to submit the appeal letter and also contact information should they have any questions. Appeals are heard by our National Network Credentialing Committee (NNCC) via teleconference, and the provider is given an opportunity to provide additional information in support of their case. In addition, the NNCC can ask the provider for additional or clarifying information to assist them in rendering a decision to either uphold or overturn the local Regional Network Credentialing Committee's decision. The provider is sent written notification of the NNCC's decision.

Describe the policies, procedures, and processes your BH MCO will put in place to ensure emergency services are covered regardless of whether the provider that furnishes the services has a contract with the BH MCO.

Out-of-Plan Emergency Services Procedures

In an emergency situation, Magellan's priority is always the safety and well-being of the member. Therefore, emergency and post-stabilization care services do not require preauthorization, and members may see any provider, in or out-of-network. Although most emergency facilities are part of our contracted network, there are times when members must

access emergency service from out-of-network providers or facilities, especially when they are out of the area or out of state.

For out-of-network facilities outside Nebraska, it is Magellan's policy to issue authorizations at the time of the initial call. If there is a question about the medical necessity of treatment and a physician advisor review is necessary, the decision is communicated within one hour of notification. If the provider fails to notify Magellan, Magellan will complete a retrospective review of the medical record and will pay only for the time period determined to be required for emergency care.

Although members may receive emergency and post-stabilization mental health services from any provider in- or out-of-network, once the member is stabilized, the facility will be requested to transfer the member to an in-network facility if he or she requires ongoing treatment. Magellan's care manager assists in facilitating the transfer and ensuring that the in-network facility receives all necessary information to continue the member's treatment with minimal disruption.

Describe the policies, procedures, and processes your BH MCO will put in place to ensure payment for treatment obtained when a member receives emergency services.

Magellan's policy regarding emergency services is consistent with state and federal guidelines. We will reimburse both in-network and out-of-network providers for services delivered to a member experiencing a behavioral health emergency as defined below that are needed to screen, diagnose, and stabilize the member. Our provider agreement includes the following statement:

"In an emergency, the provider is not required to obtain prior authorization for any evaluation ordered or performed by provider to diagnose or stabilize a member. "

Describe the policies, procedures, and processes your BH MCO will put in place to ensure the BH MCO does not limit what constitutes an emergency condition based on lists of diagnoses or symptoms.

Magellan affirms that we will not limit what constitutes an emergency condition based on lists of diagnoses or symptoms. Rather, we will consider a member to be experiencing a behavioral health emergency if the onset of the condition is sudden, manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, b) serious impairment to such person's bodily functions, c) serious impairment of any bodily organ or part of such person.

Describe the policies, procedures, and processes your BH MCO will put in place to ensure the member is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

Magellan understands the importance of ensuring that members who seek care for emergency services, even if the provider is outside of the network, will not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member. Our members do not have the financial resources to pay billed balances and should not have the added stress of a provider attempting to collect funds when he or she is coping with a behavioral health emergent condition.

Members have the right to request a second opinion from a network provider at no cost to the member. If a qualified health care professional is not available within the network, we help the member arrange for a second opinion at no cost to the member.

All in-network providers have agreed to consider our payment as payment in full as a condition of their contract. If emergency services are delivered by a non-network provider, we reimburse the provider for screening and stabilization services and arrange appropriate follow-up care from an in-network provider. We negotiate an ad hoc provider agreement with the out-of-network provider for the purposes of reimbursing those emergency services. The ad hoc agreement includes a prohibition against billing the member for any portion of the services that are covered by the ad hoc agreement. The following text is from our ad hoc agreement:

"Facility agrees that these rates are to be accepted as payment in full and the member will not be balance billed for covered services. Facility agrees that in no event, including but not limited to non-payment by Magellan or Payor (the health insurance program, employer or other entity contracting directly or indirectly with Magellan and which has the ultimate responsibility for payment of covered services to members), insolvency of Magellan or Payor, or breach of this Ad Hoc NON PAR Provider Letter of Agreement, shall Facility or its contractors or employees bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any members or any other persons other than Magellan or such Payor, for services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable co-payments or deductibles billed in accordance with member's benefit plan and shall not prohibit collection of fees resulting from member's failure to comply with his/her Benefit Plan."

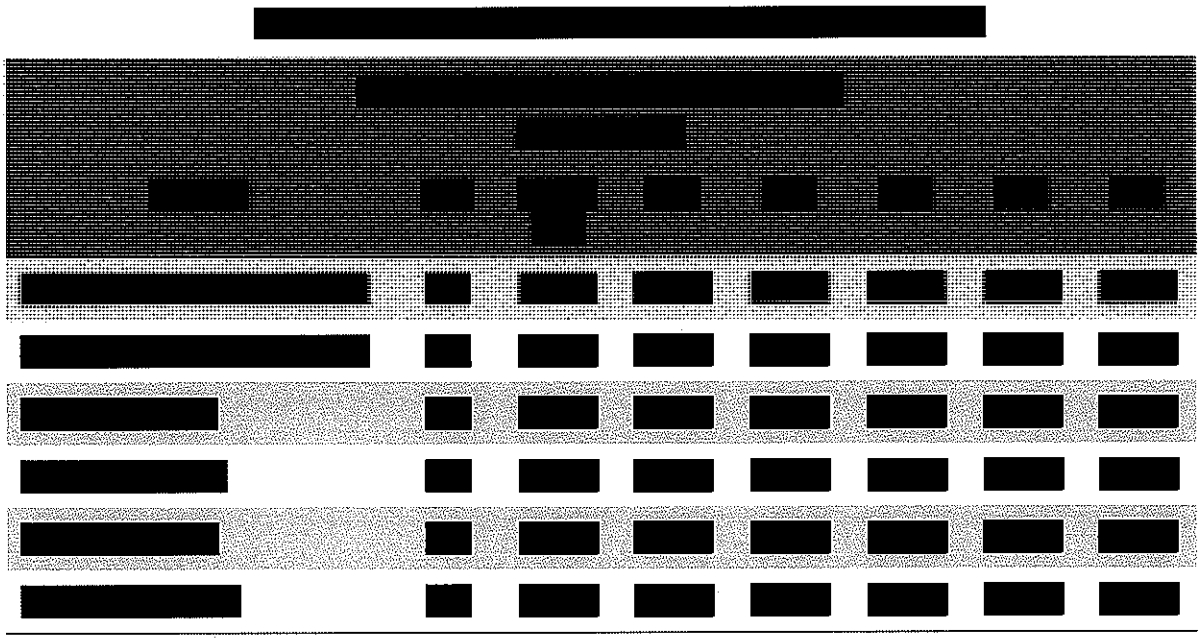
Our member and provider handbooks emphasize our policy that members may not be balanced billed and that our payment is payment in full for all services rendered. If a member receives a bill from the provider for services rendered during the emergency episode, we resolve the issue with the provider on the member's behalf. Members may contact our member services call center for assistance and may also utilize our complaint process if a bill is received.

Describe your BH MCO's process for insuring that non-participating providers who provide emergency services to members are paid on a timely basis. Also, describe your BH MCO's process to ensure appropriate communication with the provider, follow-up communication with the member's PCP, and follow-up care for the member.

Payment for Emergency Services Rendered by non-Participating Providers

We recognize that members experiencing a behavioral health emergency should seek care from any qualified provider who is able to provide the necessary services as quickly as possible. While it is preferable for all services to be delivered by in-network providers, we reimburse out-of-network providers for services required to evaluate and stabilize members experiencing an emergency. Because of the depth and breadth of our network, unless members are traveling out of state, the provider will be in-network in most cases. Under our current ASO contract, our use of non-participating providers has been infrequent, with only 12 instances in 2012. We attribute this low number to our success in contracting with a full network of providers equipped to render emergency care to our members.

In the event that the provider does not participate with Magellan, we will pay the provider promptly through an ad hoc provider agreement initiated upon notification of the member's use of the emergency services. We will attempt to negotiate a mutually acceptable rate. In the event that we are unable to negotiate, we will pay the amount the provider would have received if the member was a Title XIX or Title XXI fee-for-service recipient. Our claims payment timeliness ensures that no provider will experience a delay in receiving payment. Nationally, over 97 percent of in- and out-of-network claims processed within 14 days (Table IV.L.32.1. Claims Processing Timeliness Performance).



Communication and Follow-Up

From the point that a Magellan Care Manager authorizes care, the discharge planning process and collaboration with the treating provider begins. Our care managers assist the treatment provider in contacting and coordinating with the identified PCP and the primary behavioral health provider. Although our process of beginning discharge planning at admission is the same for both in-network and out-of-network providers, out-of-network providers receive greater oversight and assistance from Magellan staff because the provider is not credentialed and established within our system. We typically authorize fewer days during each review and conduct more frequent continued stay reviews to ensure that members are receiving quality care consistent with Magellan's care guidelines. We also use the review process to gather information that is useful in identifying why members were unable to obtain care from an in-network provider. In aggregate, this information can assist with identifying access issues in particular parts of the state or can identify suboptimal care from an outpatient provider that resulted in a member's emergent condition.

Discharge planning is an area where Magellan of Nebraska excels and where a new vendor unfamiliar with the Nebraska community will be challenged to meet member needs. When a member has experienced a behavioral health emergency, particularly if the member lives in a part of Nebraska with limited treatment options, we are creative in developing discharge plans and follow-up care that will allow a member to remain in his or her community. Particularly for child and youth members, intensive outpatient therapy is preferable to residential services when the only residential facility available separates the child from his or her family. Except for rare cases, we find that we are able to meet the member's needs through an individualized discharge plan that maximizes the use of available outpatient services and the mobilization of natural supports.

An example of our successful discharge planning efforts occurred with Alex, a 10 year-old boy who lives with his adoptive grandparents. Following a six month PRTF stay, Alex was reunited with his grandparents. When Alex returned home, the grandparents consented to working with Magellan's Intensive Case Management program. The family was also referred to work with Mid-Plains Multi-Systemic Therapy (MST) and those services were immediately in the home when the Alex was reunited with his grandparents. MST incorporates a series of individual and family therapy units as well as non-therapeutic hours available for supportive services. Alex resumed school with the assistance of MST to ease the transition. MST also worked closely with the family's psychiatrist to discuss important concerns or questions regarding Alex's medication management. The family worked very closely and intensely with MST to understand what triggered Alex's out of home placement as well as to develop safety planning, educate the grandparents on Alex's diagnosis, medications and understanding how to appropriately parent Alex to maintain stability in the home. Alex continues to reside successfully with his grandparents and is free of inpatient admissions with the support of an outpatient provider for therapy and medication management. MST discharged Alex because he is free of aggression, doing extremely well in mainstream school, with a positive relationship with his grandparents. ICM also successfully discharged this case, as Alex and his grandparents had met all ICM goals.

Psychiatric Patient in a Medical Bed

A situation unique to the most rural parts of Nebraska is the lack of inpatient or psychiatric providers within several hours of some members' residences. Because the population of those areas is so small, attracting new providers to the area is impractical as the utilization will be too

low to support development of inpatient psychiatric facilities. Under the current ASO contract, we have utilized a protocol referred to as "Psychiatric Patient in a Medical Bed" to allow members to remain in their community. Although not ideal, this protocol authorizes the member to be admitted to a local hospital under the care of a medical (non-psychiatrist) physician on a medical unit. Members can remain in the local hospital for stabilization or until the member can be transported to the closest psychiatric facility if the member's needs cannot be met by a short stay in the local hospital. A limitation of this current practice is that Nebraska Medicaid prohibits behavioral health providers from treating the member while he or she is hospitalized. Under the NBHMP, we will have the flexibility in payment to modify this practice to allow the member in a local hospital to receive psychiatric care via telehealth and to receive in-person sessions by a local outpatient therapy provider. The local outpatient provider will also visit the member for a transition session to assist with discharge planning. Although the use of the Psychiatric Patient in a Medical Bed is infrequent, it is an important tool to keep members in their local communities, close to their natural support systems.

Describe your BH MCO's policies, procedures and processes for provision of services from non-network providers.

When medically necessary services are not available within the network or the member is outside of the Magellan service area and emergency services are required, Magellan provides authorization and coordination of care and facilitates the provision of emergency services as needed.

Should a member require treatment services that are not available within the Magellan network, we will refer to and authorize an out-of-network or, when needed, an out-of-state provider. When referring to out-of-state providers, whenever possible, we utilize our own database first to search for providers who may be in the Magellan network but under a different line of business. Since they are in the Magellan network, they are credentialed and familiar with our programs and services. If there is a frequently utilized provider, we will consider bringing them in-network for Nebraska.

For situations that warrant immediate review by a psychiatrist, we will capitalize on the expanded availability via the telehealth network. The care manager will make the referral or authorize a referral request based on the Nebraska medical necessity criteria and plan benefit structure. Magellan's network department will negotiate an ad hoc agreement with the provider for claims payment purposes. For practical purposes, these out-of-network/out-of-state providers are considered in network and are paid accordingly. Our claims examiners apply the same criteria to out-of-network/out-of-state services as they do to in-network care. While Magellan does not have the benefit of taking the provider through the credentialing process in these instances, use of a written agreement does require the same quality of care standards and other key provisions from the provider.

Magellan's preference is that members receive all covered services from network providers. In addition to the benefit of a previously negotiated rate, use of in-network providers ensures that members are receiving services from providers that have completed the credentialing process and who are monitored for quality of care and compliance with Magellan policies. Occasionally,

Magellan will authorize a member to receive care from an out-of-network provider if the service that is needed is not available within the network. Most often, this need arises for members who are seeking care outside of Nebraska.

Frequent referrals to particular out-of-network providers will alert Magellan of a possible access issue. Magellan may recruit such providers into the network to allow greater access to all Magellan members if the provider meets Magellan's credentialing standards. Magellan will also examine access to other providers in the geographic area to identify any potential access or quality issues that contribute to the out-of-network use.

Upon determination that there is no in-network treatment service available to meet the needs of a member, Magellan will begin the search for an out of network provider. Ad hoc agreements are generally utilized for Psychiatric Residential Treatment Facilities (PRTF's) and other residential services, and specialized programs such as inpatient eating disorders. We utilize our internal database, web sites, and referrals from other stakeholders to identify potential providers. The Network Director will reach out to identified providers to discuss the feasibility of entering into an ad hoc agreement and requests a description of their program. Prior to entering into an ad hoc agreement with PRTF's and other treatment programs, we conduct a review of the facility's program description to ensure that the program meets Nebraska Medicaid and Magellan standards. Once a decision has been made to utilize an out-of-network provider, we negotiate rates and conditions of the ad hoc agreement, and inform the provider of additional steps to complete Medicaid enrollment and finalize the agreement. When a particular quality provider has been utilized, future referrals may be made to the same facility and ad hoc agreements can be quickly processed.

[redacted]

As there is currently no in-state inpatient eating disorder program, we recently utilized the University of Iowa's program.

While we are in the process of negotiating an ad hoc agreement, we ensure that the member receives appropriate care and in most cases will continue to authorize inpatient services to make certain that no member goes un-served. Under our current ASO contract, we work in collaboration with the state on most ad hoc agreements.

Describe your BH MCO's plan to ensure that your provider network meets the network and access requirements of the program. Describe the method your BH MCO plans to use on an ongoing basis to assess and ensure that DHHS's network standards are maintained, including standards related to:

- *Distance*
- *Appointment access*
- *Cultural competency*
- *Afterhours access*
- *Inclusion of FQHCs and RHCs*
- *Inclusion of out-of-network and out-of-state providers for medically necessary services*
- *Inclusion of non-hospital urgent and emergent care providers*

Magellan understands that there is more to building and maintaining an adequate provider network than recruiting providers and signing contracts. That stage is only the beginning of ensuring that providers are qualified and available to meet the needs of our membership. As Nebraskans ourselves, we take pride in our continual monitoring and oversight of our compliance with network adequacy standards. Recruitment, training, data-driven oversight, on-site monitoring, and contracting and payment structures are all important functions for Magellan's network management processes.

Magellan will assess and ensure that DHHS' network standards are maintained for the following:

Distance

Network Analysis

Our long history of service to Nebraska makes us very much aware of the need to maintain a trusted network that can deliver all covered services to our members in a manner that is geographically, culturally, and linguistically appropriate to their needs. We will continue to devote significant staff and technology resources to our ongoing network sufficiency analysis including identification of gaps and procurement of providers where available, and to our network development strategies. Our approach includes:

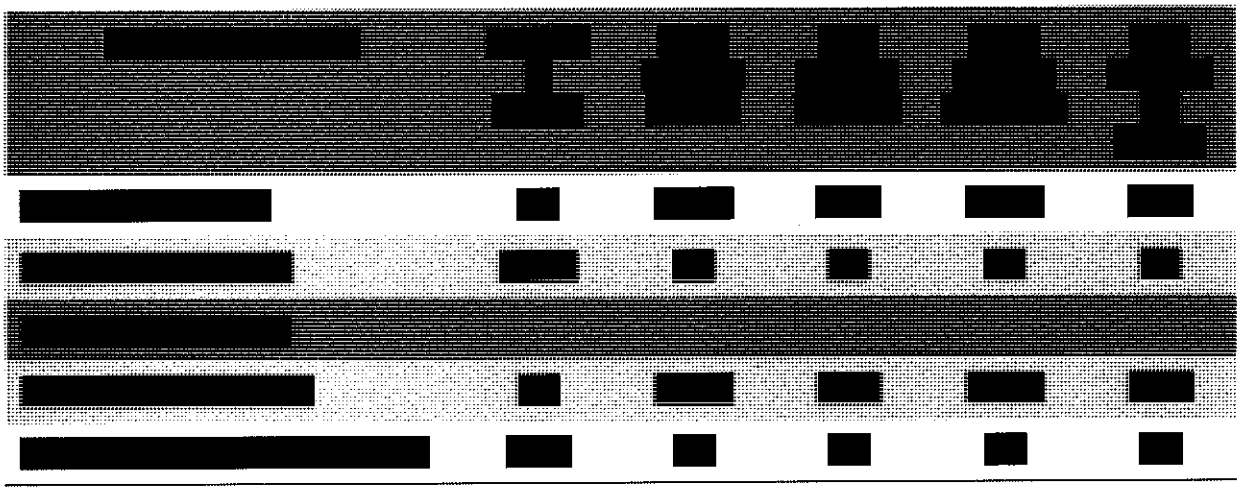
- using GeoAccess to measure distance to all covered benefits and services, including downward substitution services
- determining anticipated enrollment of NBHMCP members by service type including the geographic distribution of membership
- identifying a sufficient number and type of providers to ensure adequate access to covered services under the proposed program, including expected utilization of services taking into consideration the characteristics and needs of the population

- expanding our provider network to include sufficient behavioral health services to improve quality and cost effectiveness.

[redacted]

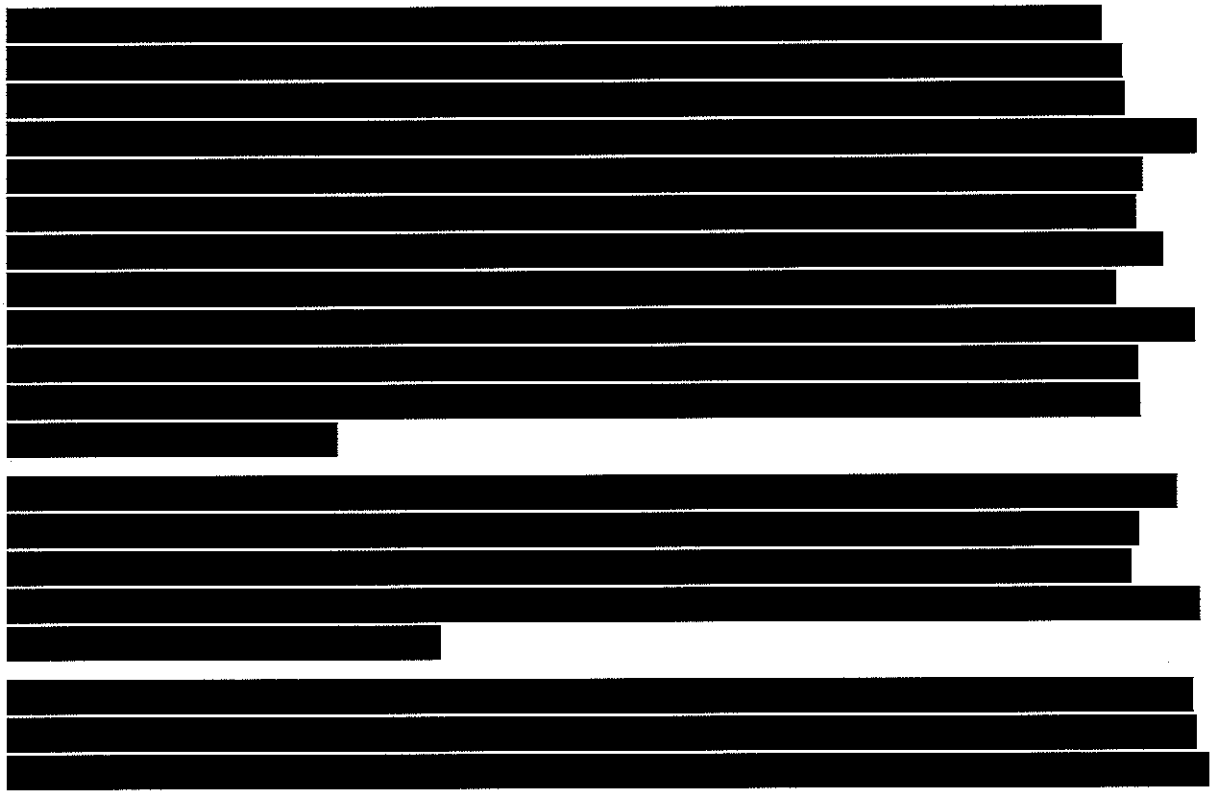
Our network analysis for the new standards, using GeoAccess, demonstrates a 90 percent or higher compliance with requirements. GeoAccess is an industry leading software application used to create maps, charts, and tabular reports that enable a detailed view of network accessibility. We employ a proven methodology to assess network capacity for all providers, including those serving culturally diverse priority populations and persons with special needs such as older adults and persons with developmental disabilities [redacted]

[redacted]



Providing services to members residing in remote rural and frontier areas of the state creates challenges, and we understand the barriers to accessing treatment. There are inherent challenges in extremely rural areas where the population base simply does not support the degree of behavioral health access and specialization seen in larger urban areas, but we have significant experience with expanding network capacity through the utilization of non-traditional providers, through supporting expansion of rural providers to deliver services on an as-needed basis in underserved communities and through the use of telehealth technology. Due to financial constraints and low referral base, providers are not always able to establish practices or develop new services, and members experience hardships due to the amount of

We understand the hardship and barriers to accessing residential services for our members located in rural and frontier areas, and we encourage community-based services whenever appropriate to meet the needs of the youth. As we have been working to reduce the reliance on residential services, there has been a steady decline in utilization of these services. In conjunction with lower utilization, several residential treatment providers have made business decisions to no longer provide services. When a determination has been made that there is not an available provider to meet the needs of our members, we engage in ad hoc agreements with out-of-network providers. Ad hoc agreements are one-time only contractual arrangements with a provider that are used to cover either a one-time service, such as an emergency hospitalization, or one episode of treatment, such as out-of-network care for a member needing culturally-specific services not available within the network.



GeoAccess mapping will allow us to see if there are portions of the state where members reside that do not have geographic access to providers. We know that in the most rural parts of Nebraska, providers are not available for contracting. In those instances, we intend to meet the needs of members through telehealth to avoid the need for extensive travel. Our telehealth proposal is described in detail in the fourth question regarding ensuring access to services.

Appointment Access

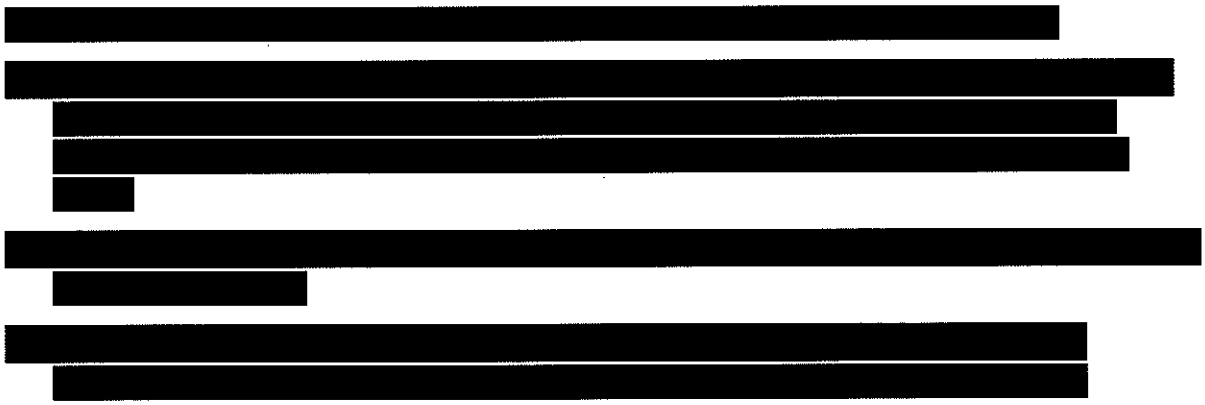
Magellan will ensure that members have access to care within the timeframes required in the RFP, which include an emergent appointment within one hour (two hours in rural areas), an urgent appointment within 48 hours, and a routine appointment within 14 days. Our provider handbook holds our network providers to meeting those access standards, and we monitor compliance with those standards regularly through review of complaint data and regular surveys regarding appointment availability. Under our current contract, we have not received complaints regarding access. As described in the twenty-third question in *Section IV.L. Provider Network,* our network providers are also required to notify us when they reach capacity and are no longer able to accept new members. This is self-reported via our Web site.

Under our ASO contract, Magellan distributes a quarterly provider survey which asks about appointment timeliness, and we will continue to survey providers under the new contract. Providers must indicate if an initial appointment is available within the contractually required timeframe. In the second quarter of 2012, 96 percent of respondents indicated that they were meeting the access standard for the initial appointment. For the new program, we will enhance our monitoring by making periodic telephone calls to a sample of our network to ask for the next available appointment time for both routine and urgent appointments.

Results are reviewed by the QAPI and appropriate action is taken when access issues are identified. This includes identifying the need for additional provider recruitment in underserved areas. Members are also encouraged to contact us when specific providers indicate they are not accepting new patients and follow-up will be made with the provider to discuss accessibility issues.

When we identify that a provider is not available, we place a "No Appointment Available" indicator in the provider database. We are able to produce ad hoc reports to evaluate the usage of the "No Appointment Available" indicator to track systemic issues with particular providers or in particular geographic areas.

If the network does not have an appropriately qualified contracted practitioner and/or organizational provider available to meet a member's specific need, we may refer the member to a non-contracted practitioner or organizational provider using Magellan's ad hoc procedures.



Cultural Competency

In Nebraska, we take a broad-based approach to defining cultural competency. Being culturally competent is more than having the linguistic capabilities to work with different ethnicities. Nebraska is a large rural state with 90 percent white, 4 percent African-American, 1 percent Native American, and 9 percent Hispanic/Latino population and overall less ethnic diversity than is seen in large urban areas. Given that understanding, our definition of cultural competency also includes the skills needed to reach out to members of various communities such as rural and frontier communities, and the older adult community. We also recognize the dynamic roles race, ethnicity, gender, age, physical and mental ability, culture, socioeconomic status, geography, sexual orientation, homelessness, and other social indicators play in the ability of each member to access and experience effective behavioral health service delivery. Inequities in access, service quality, and outcomes are often pervasive and long standing for individuals from diverse racial, ethnic, socioeconomic and cultural backgrounds. Lack of diversity in health care leadership and workforce results in systems of care poorly designed to meet the needs of diverse populations, and poor communication between providers and members of different racial, ethnic, or cultural backgrounds. Our provider network has the skills needed to meet the specific needs of each of these communities.

[redacted]

Our strategies for maintaining a sufficient number of culturally competent service providers include offering a robust cultural competency training program for providers along with a plan to recruit needed providers to serve the culturally diverse population. Under the NBHMCP, we will train, maintain and grow the capacity of the provider network with an emphasis on local outreach to communities.

[redacted]

The training toolkit allows providers to conduct a self-assessment of provider-level cultural competence, assess organizational strength and growth areas with respect to cultural competence, and carry out consumer evaluations of health care provider cultural competence. In addition, a variety of tools and resources are included to assist provider agencies in developing realistic and incremental organizational cultural competence plans.

The training offered to providers includes concrete tools for use in the development of culturally appropriate individualized service plans for children and their families. Components of the training include the following:

- introduction to cultural tenets
- definitions
- stereotypes, worldview and personal filters
- disparities in outcomes and reasons for them
- strengths, needs, cultural discovery techniques and resources
- Culturally and Linguistically Appropriate Standards (CLAS) standards
- introduction to cultural terminology
- cultural sensitivity
- cultural competence skills.

While online training is an effective delivery mechanism for providers with limited time to attend in-person sessions, we recognize that online training is not sufficient to ensure that all providers gain the necessary knowledge and skills to work effectively with a culturally diverse population. Ongoing training will occur through a variety of methods including traditional classroom presentations, lectures, and webinars.

All providers will be offered the opportunity to complete the online self-assessment tool, and individualized training approaches will be developed in collaboration between Magellan and the provider. As providers grow and develop, we will identify particular provider champions who have been successful at implementing interventions to increase cultural competence within their organization and who are willing to work with their peers to spread knowledge throughout the network.

[redacted]

[redacted]

We integrate cultural and linguistic competency in policies and procedures specific to customer service, quality improvement (QI), utilization management and grievance and appeals programs, as well as other functions in the care management center. Additionally, policies and procedures incorporate the National Culturally and Linguistically Appropriate Services standards (CLAS). Each Magellan department manager or supervisor is accountable for the success of the program through integration of the principles of cultural competency in all aspects of organizational planning to assure cultural competence at each level within the system. Specific performance indicators will be developed in partnership with local input and coordination of key stakeholders and providers in the state. Department managers in the care management center have performance measurements in their annual review scorecards that directly relate to success in achieving the cultural competence goals.

We monitor our network providers for adherence to our standard to provide culturally competent care. Our Treatment Record Review tool includes an item that directs the review to look for, "Evidence of treatment being provided in a culturally competent manner."

The auditor user's guide provides the following instructions for scoring:

- 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.

After Hours Access

Magellan recognizes the importance of alternative service hours to members who work during traditional business hours. Medicaid members who are employed often have work schedules that are not flexible and are not conducive to attending behavioral health appointments during the day. Child care issues only provide further barriers to accessing care. As a result, Magellan supports the use of non-traditional office hours within the provider network. To assist members in locating providers with evening or weekend hours, we capture the operating hours of our network providers in our provider database. This information is available directly to members on our Web site and in our provider directory. See Figure IV.I.34.2 for an example of a provider identified with our search tool that has alternative office hours. If a member calls to request services outside of normal business hours, we are able to identify providers with alternative access options.

[redacted]

While we cannot force providers to offer non-traditional hours, we do encourage it by including an item on our site visit tool that assesses the provider's availability during evenings and weekends. By including the item on the tool, lack of access is noted as an opportunity for improvement. Regardless of a provider's availability during evenings and on weekends, network providers are required to have 24 hour telephone access for urgent or emergent conditions.

Inclusion of FQHCs and RHCs

As full-service providers that specialize in working with Medicaid and uninsured populations, Federally Qualified Health Centers (FQHCs) are uniquely positioned to address the needs of Medicaid members with co-occurring physical health and behavioral health needs. Members

who seek care at FQHCs may receive both physical health and behavioral health services in one location. We are committed to maximizing the use of providers such as FQHCs that can provide co-located services. Our Nebraska General Manager, Sue Mimick, and other staff worked closely with representatives from Charles Drew Health Center to assist them in development and expansion of behavioral health services in their medical clinics. Network staff provided hands-on technical assistance (telephonic, webinar, and in-person) for credentialing, contracting, obtaining authorizations, and submitting claims. We also worked closely with the People's Health Center to ensure that their mental health services were reimbursable under Medicaid and with OneWorld Community Health Centers in Omaha to provide guidance and technical assistance regarding their mental health program.

[redacted]

Inclusion of out-of-network and out-of-state providers for medically necessary services

Magellan has the ability to enter into ad hoc provider agreements with providers who do not participate in our network when it is necessary to do so to meet the needs of our members. However, we make every effort to use in-network providers when possible because when a provider has completed our credentialing process, we are assured that the provider meets minimum quality standards for serving our members. Therefore, we have included several outpatient therapy and inpatient hospital providers in border states that offer additional access for members living in outlying areas. Most notable are Mercy Medical Center in Sioux City, Iowa and Avera McKennan Hospital in Sioux Falls, South Dakota.

Occasionally a member requires specialized care that is not available within Magellan's provider network. In those instances, Magellan will locate a provider who is qualified to provide the needed service and enter into an ad hoc provider agreement to allow the member to receive the necessary care. Magellan also uses this process to provide care to members who have temporarily relocated out-of-state, typically children who have been placed in relative care. When sending a member out-of-state, our process is to first attempt to use a provider that is in the Magellan network for another state Medicaid program or in our commercial network. This approach also ensures that providers have been appropriate credentialed. If such a provider is not available, we will make every effort to review the provider's qualifications prior to approving the use of the provider for our member. In the case of residential services for children and youth, we always conduct a review of program materials prior to approving the placement. Our utilization of out of state services is very low. In the past three years, annual referrals for out-of-state mental health services has not exceeded ten members, with only six members needing services in 2012. Also in 2012, no members required out of state care for dual mental health and substance use services, down from only two members the year prior. Although the number of providers that offer sex offender treatment services is small, only four members required out of state referrals in 2012, with no members in need of dual sex offender and mental health care referred out of state. These results demonstrate the completeness and comprehensiveness of our network.

Inclusion of non-hospital urgent and emergent care providers

Lancaster County Community Mental Health Center in Lincoln provides a unique, non-hospital based crisis service that is offered by no other provider in Nebraska. We contract with them to provide our members access to this service.

All network providers are able to provide crisis sessions to our members without prior authorization. This is an important option because crises are not predictable and it is important that members can access their treating providers as soon as necessary without unnecessary administrative delays. Such delays could result in avoidable emergency department visits or inpatient admissions.

We recognize a need in Nebraska to have additional non-hospital crisis centers and urgent care centers for members with behavioral health needs. We have had discussions with BryanLGH and Alegent hospitals in the past, and they have expressed interest in creating a solution to the lack of options for members in crisis. The at-risk model will allow us to begin these discussions anew with the promise of funding flexibility to explore new options.

Describe how your BH MCO will use GeoAccess mapping to ensure network adequacy. Using providers, with whom you have signed letters of intent, provide individual GeoAccess maps.

GeoAccess is a software package that plots member locations and provider locations in a visual map format that allows for quick identification of gaps in access. Magellan reviews GeoAccess maps quarterly or anytime a significant change occurs in the network composition to ensure that the network continues to meet minimal distance requirements of 60 miles for inpatient and residential services and 20 miles for all other services. Magellan affirms that we meet all access standards required in the RFP.

GeoAccess maps displaying our current contracted provider network according to the access standards in the RFP can be viewed in **Attachments Q, R and S**. Because our provider network is currently under contract, there is no need to rely on letters of intent to demonstrate network adequacy.

Should your BH MCO be unable to secure an agreement with a key provider type in a given geographic area, what strategies will you use to ensure that potential members have access to care?

At the present time, there are no key providers who are not part of our network. Magellan prioritizes access to and choice of high quality providers for our members. In the event that a high quality key provider does not wish to contract with us, we will continue to work with the provider to resolve any hesitations the provider may have until the provider agrees to participate in the network. Until an agreement is reached, we will identify other providers in the area who offer the service and assess their capacity to serve the entire membership. We will also explore the use of alternate service plans for members who may be served as well through a different combination of services. For example, if a bed is not available in a residential

treatment facility, a member may be able to be served as effectively through intensive outpatient services.

In the event that a provider is the sole provider of a critical service and no alternative service plans are appropriate, we will offer the provider an ad hoc provider agreement to ensure that the member has appropriate access to the necessary service.

Describe your BH MCO's policies, procedures, and policies to ensure that Indian members are provided the protections listed in the Indian Health Protections Act.

According to Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, and the Indian Health Care Improvement Act provisions (IHCIA) as reauthorized as part of the Patient Protection and Affordable Health Care Act, American Indians enrolled in managed care organizations are afforded particular rights and protections regarding their healthcare. We affirm that we will provide Indian members with all the protections listed in the Act and ensure that they have unimpeded access to culturally appropriate care from any network provider, including participating tribal providers, or from out of network providers if those providers are able to more appropriately treat the member within his or her culture. [redacted]

We agree to abide by the following provisions and will develop policies that address:

1. We will permit any Indian member that is eligible to receive services from a participating Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in our network, to choose that I/T/U as his or her primary behavioral health provider, as long as that provider has capacity to provide the service.
2. We will ensure and provide evidence that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian members who are eligible to receive services from such providers.
3. We will provide I/T/U providers, whether participating in the network or not, payment for services in the Basic Benefits package provided to Indian members who are eligible to receive services from such providers either:
    a. At a rate negotiated between Magellan and the I/T/U provider; or
    b. If there is not a negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and

c. Make prompt payment to all I/T/U providers in our network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR sections 447.45 and 447.46.

Our Tribal Liaison will be responsible for identifying American Indian members in need of or receiving behavioral health services to monitor their access to providers that meet the provisions of the Act. Outreach to American Indian communities will include education on the Act and members' rights and protections under the Act.

Provide a listing by provider type/specialty of the providers from whom you have received a signed letter of intent to participate in your provider network.

With a fully contracted network, we do not need to rely on Letters of Intent. A list of contracted Magellan providers is provided in **Attachment G**.

Describe any provider incentive programs you plan to implement in order to improve access.

In all of our at risk accounts, Magellan has a proven track record of providing incentives for specialty programs, higher qualified practitioners, and superior clinical outcomes. Magellan is committed to developing incentives that represent our goal to move toward a "preferred provider" model, and also supporting programs with both financial incentives and reduced administrative burden for above-average performance and outcomes. We will develop a customized performance based contracting model with the assistance and guidance from the PAC when dollars become available through reinvestment.

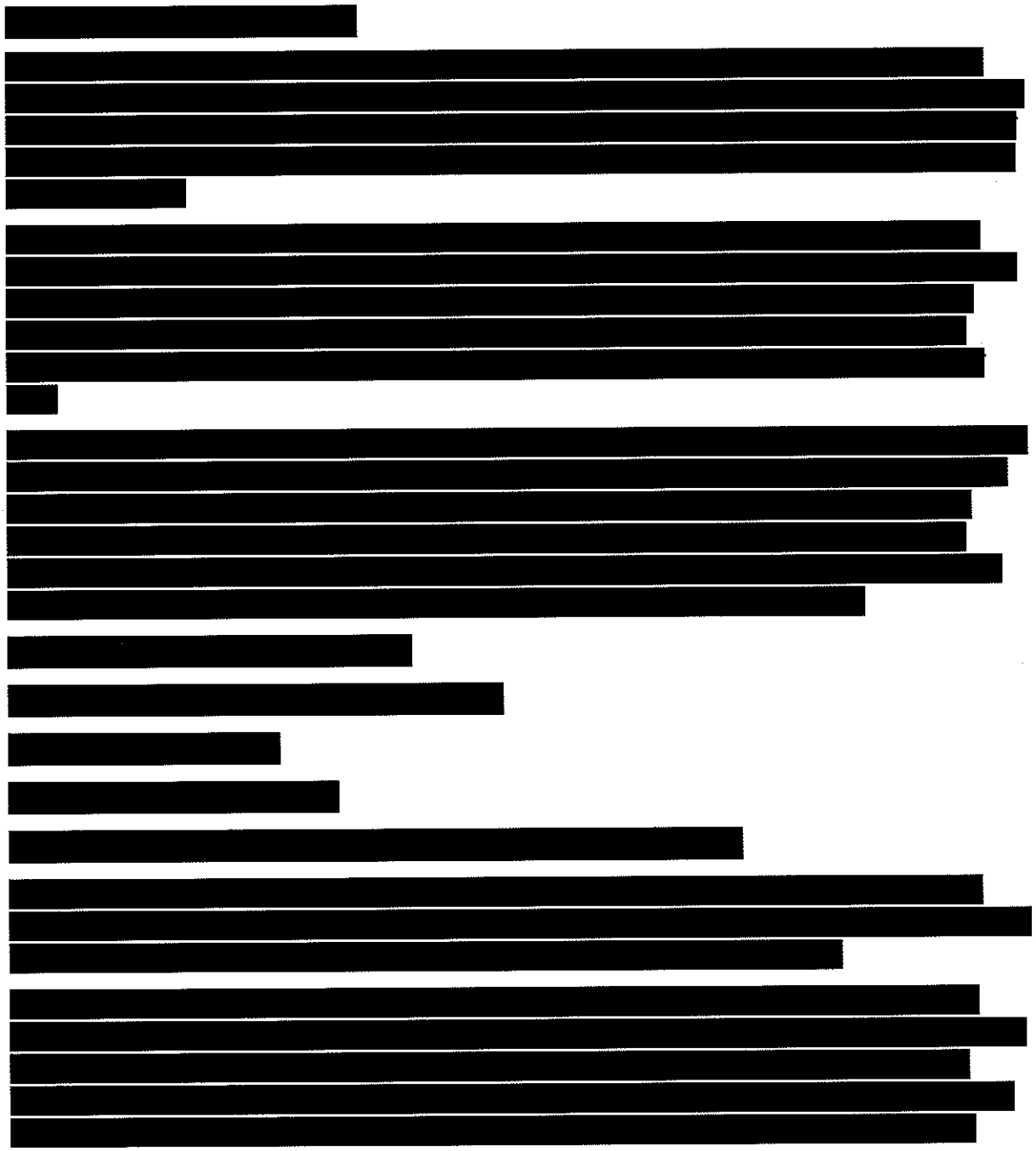
In Nebraska, access is good in urban areas but is limited in some pockets of rural Nebraska. We propose provider incentives to encourage the development of practices in rural communities. We will offer providers an enhanced rate to treat our rural members until the provider establishes a sustainable case load. For some services, we expect that a provider will not be able to establish a full case load because the need is insufficient in those communities. For those instances, we will pay the provider an enhanced rate to provide services in underserved areas on as needed basis.

Our incentive program will also focus on our telehealth initiative and will incentivize providers to use telehealth. This incentive will not be available to our entire network. Rather, we will identify key providers and services that are best served through the telehealth delivery model. Psychiatry is the main service we expect to address with telehealth due to the shortage of psychiatrists located in rural communities. It is not a matter of psychiatrists not joining our network; they do not exist. The use of teleheath technology will be utilized to leverage existing capacity by bringing service directly to consumers in the communities where they reside.

Community Tenure

We will develop innovative approaches to contracting in partnership with MLTC which will incentivize the community based provider system to improve community tenure for members who have had frequent admissions. We will propose contractually collaborative models that

allow large community based providers the opportunity to share in the savings if they are able to improve community tenure through reduced admissions and lowered average length of stay in inpatient settings. We believe that if we target the 20 percent of consumers who are receiving services within the larger programs and who have multiple admissions and longer lengths of stay, we can obtain significant savings. We propose our innovative partners in care for inpatient providers and will work with MLTC to develop other innovative payment strategies for outpatient providers. Examples of similar programs in other states are provided below.

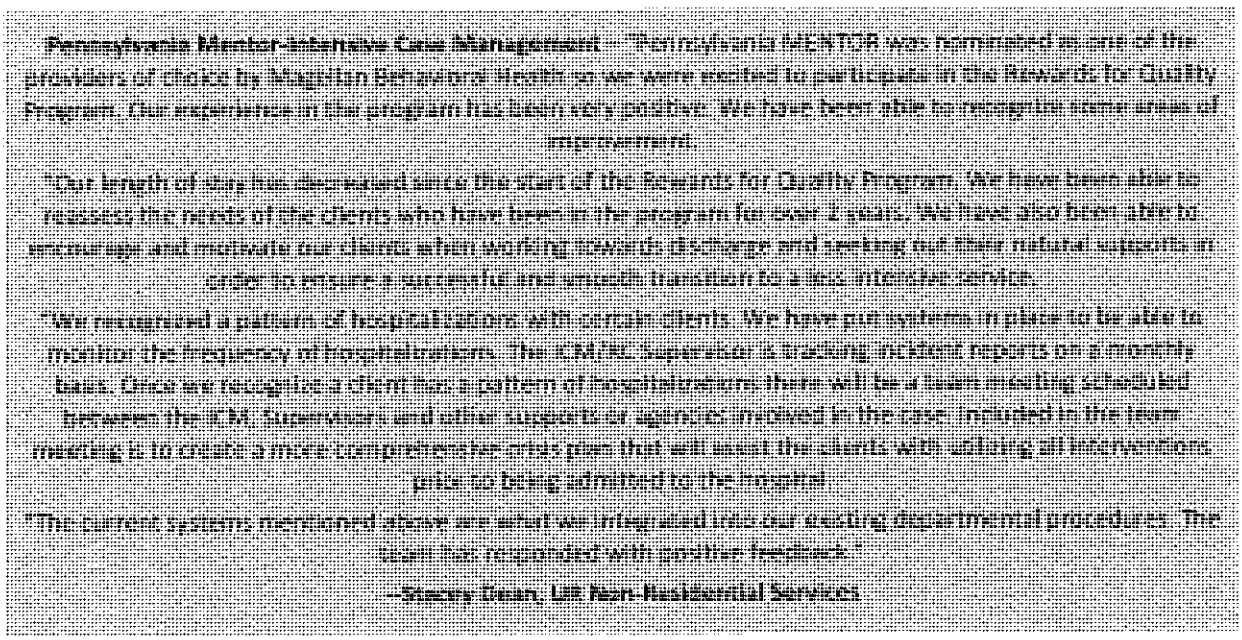


[redacted]

[redacted]

Intermediate Unit 20 (IU 20) Partial Hospitalization Program - "Overall, our experience in the RFQ program has been positive. Referral to our staff was quite simple. In the beginning, I went out and met individually with each of the teams that were to participate in the project. I explained to them that this was an opportunity for them to take credit for the good work they do every day with the very challenging kids that come to these programs. I say take credit because the data points that were to be measured (discharges to lower levels of care, reduction in admissions to inpatient or residential, number of family therapy sessions, coordination of care with outside agencies, use of Evidenced-Based Practices and measuring consumer/family satisfaction) were all tasks/activities that the Partial at IU 20 already subscribed to. I'm sure this had a significant impact on our level of success. We appreciated the opportunity to share our work."

-Jim McDonald, LSW Clinical Supervisor, Resolve Services



Pennsylvania Mentor-Intensive Case Management "Pennsylvania MENTOR was nominated as one of the providers of choice by Magellan Behavioral Health so we were excited to participate in the Rewards for Quality Program. Our experience in the program has been very positive. We have been able to recognize some areas of improvement.

"Our length of stay has decreased since the start of the Rewards for Quality Program. We have been able to reassess the needs of the clients who have been in the program for over 2 years. We have also been able to encourage and motivate our clients when working towards discharge and seeking out their natural supports in order to ensure a successful and smooth transition to a less intensive service.

"We recognized a pattern of hospitalizations with certain clients. We have put systems in place to be able to monitor the frequency of hospitalizations. The ICM/IHC Supervisor is tracking incident reports on a monthly basis. Once we recognize a client has a pattern of hospitalizations there will be a team meeting scheduled between the ICM, Supervisors and other supports or agencies involved in the case. Included in the team meeting is to create a more comprehensive crisis plan that will assist the clients with utilizing all interventions prior to being admitted to the hospital.

"The current systems mentioned above are what we integrated into our existing departmental procedures. The team has responded with positive feedback."

--Stacey Dean, LIR Non-Residential Services

Describe the mechanisms your BH MCO will use to communicate with providers and the content you anticipate including in communications.

Magellan will communicate with providers through a variety of media as described previously in the second and twenty-fifth questions in Provider Network. Our communications include content on:

- policy and procedure changes
- reinforcement of policies when substandard compliance has been identified
- clinical practice guidelines and evidence-based treatment adoptions
- provider trainings.

Our monthly newsletter provides an opportunity for us to highlight important policy, educational, and community information appropriate for a variety of stakeholders in a centralized, attractive format. [redacted]

[redacted]

Our November 2012 edition of Magellan of Nebraska News and Updates can be viewed in **Attachment L**.

Describe the approach your BH MCO will take to assess provider satisfaction including tools you plan to use, frequency of assessment, and responsible parties.

Magellan Provider Satisfaction Survey

As required by the RFP and clarified by the Addendum 4, Q&A number 25, we understand and agree to conduct both an annual provider and annual facility satisfaction survey. Provider satisfaction is owned across the Magellan enterprise, from management to customer service, care managers, and Network staff. It is integral to adopt this approach to ensure that at all provider touch points, we are embracing our stakeholder mentality and collaborative approach. Magellan has a national survey design and implementation/operations team with expertise in providing scientifically valid and reliable member and provider satisfaction surveys and sampling methodologies. Magellan provides this service separate from the Nebraska care management center to enhance the objectivity of analysis of responses and confidentiality of respondents. Magellan measures provider satisfaction annually and shares the results with both internal and external stakeholders. Magellan has an experienced staff of survey, evaluation and outcomes measurement professionals who provide tool design, implementation, data analysis, reporting and interpretation. The staff on this team possess over 50 years of experience in empirically based disciplines including applied statistics, epidemiology, survey research,

evaluation, health communication, and econometrics. In concert with Magellan's quality teams and program managers, the feedback obtained from surveys is reviewed and utilized as a component of the monitoring, quality management and decision support information process.

To enhance program evaluation, performance measurement and improvement efforts, Magellan captures feedback from providers on their experience with Magellan's service and practices. One of the mechanisms used is surveys. A brief battery of actionable questions tailored to the audience include items regarding aspects of their overall experience, utilization management, credentialing, claims payment, communication, accessibility, acceptability, availability of the coordination, consistency of the service Magellan gives its partner service providers. Questionnaires are designed to be brief and invite feedback from provider with whom an authorization or claim has been encountered during the six month survey time frame. The distribution methods mirror Magellan's communication methods through which providers access or receive information, thus either e-mailed URLs for completion online, location on the Web site, mailings and fax are common distribution and collection/completion methods.

The Magellan Behavioral Health Provider Satisfaction Survey questionnaire was designed in collaboration with key stakeholders and industry knowledge of key drivers for providers' satisfaction with their jobs and collaborative utilization management arrangements. Internal stakeholders (Network Operations, Field Network, Credentialing, Claims, Provider Services, Quality departments) and review and feedback from external stakeholders (Provider Advisory Groups, Customers, NCQA) over the past several years of administrations, have been used to keep the questions current and relevant. Core questions are based on extensive literature reviews regarding key factors for provider satisfaction with their job, Magellan's monitoring needs and with the intention of additionally meeting or surpassing standards identified by regulatory bodies such as URAC and NCQA with such evaluation tools. (Note: Magellan has passed all regulatory reviews using its questionnaires.)

Annually, Magellan reviews and if needed updates the questionnaire. A small set of subject specific focus study questions are rotated as needed in and out of the questionnaire in addition to the core questions. Customer requested items may also be added to questionnaires to provide a state-specific version of the questionnaire to support our customer's monitoring strategies. Facilities' and practitioners' survey results can be analyzed and delivered separately. We will work closely with MLTC to ensure any modifications, including separate surveys and/or specific questions targeted for facilities and practitioners, meet requirements of the new program. Please see **Attachment J** for a copy of our most recent survey tool.

Figure IV.L.41.1 displays our Nebraska-specific results for our annual national provider survey. Overall, satisfaction is high. As part of our overall review process of the individual responses to each question, we identify specific opportunities for improvement and develop specific strategies to address each opportunity. Changes made for Nebraska to improve satisfaction are described below in the "Nebraska Improvements" section.

[redacted]

[redacted]

Identifying and addressing issues as they arise will result in increased provider satisfaction. We will continue to administer the quarterly survey until high levels of satisfaction are achieved for three consecutive quarters. At that point, we will adopt a biannual survey that will be conducted

throughout the remainder of the contract term. The Nebraska-specific At-a-Glance survey can be viewed in **Attachment J**.

Use of Results

The use of a provider satisfaction survey is incorporated into our annual Quality Improvement Workplan. Key driver analyses are used to identify opportunities for improvement that are most important to providers. The QAPI will use Continuous Quality Improvement methodology to conduct root cause/barrier analyses, identify and implement interventions, and evaluate the progress of interventions in bringing about improvement in provider satisfaction. When interventions have not had the impact desired, the QAPI will conduct additional barrier analyses and brainstorm further actions to be taken to bring about the desired improvement. The QAPI's actions and progress in monitoring and improving provider satisfaction will be reported to the PAC and Governance Board and will be incorporated into quarterly QI/UM workplan update reports and the annual QI/UM program evaluation. Results will be published in the provider newsletter and posted on Magellan's Web site.

[redacted]

Describe your BH MCO's policies, procedures and processes to ensure providers are utilizing evidence-based and best practice approaches. How will this be reported, tracked and what will be the intervention with providers who are not using these practices?

As Nebraska's BH MCO, Magellan has responsibility for ensuring that its network is of the highest possible quality to ensure that members achieve the best possible outcomes. Although the field of behavioral health emphasizes individualized treatment approaches and a person's own path to recovery, it is important that providers are equipped to provide care using approaches and treatment modalities that are supported by evidence. We will focus on the delivery of EBPs and best practices within our network as fully described in our response to the second question within the Principles of Care and the seventh question in *Sectiom IV.L. Provider Network*. Magellan's role is to identify evidence-based and best practice approaches that are appropriate for Nebraska Medicaid, assess the provider network on their competency to provide those practices, and offering trainings to providers in areas where the network competency can be strengthened.

Training

As the ASO, Magellan of Nebraska has delivered training to network providers on Trauma Informed Care, led by national experts. In 2011, we provided two trainings to our network providers by national experts in trauma informed care. In April, 195 providers attended *Making Trauma Informed Care Real* across one live site and six telehealth sites. In December, 223 providers attended *Trauma Informed Care* across one live site and six telehealth sites. Continuing education credits were available to participants. Course summaries for the two trainings can be viewed in **Attachment N.** Making Trauma Informed Care Real and **Attachment O.**Trauma Informed Care Symposium.

Our Web site, MagellanofNebraska.com, offers providers an online training program on Post-Traumatic Stress Disorder. Online training modalities are useful for providers who cannot attend scheduled in-person or telehealth trainings due to their appointment schedules. Providers will also have access to our Achieve and Essential Learning library that includes training on EBPs such as "Integrated Treatment for Co-Occurring Disorders – EBP" and "Dialectical Behavioral Therapy for Special Populations." The use of our Achieve system allows us to track clinician-level completion dates and test scores for any content we create to support EBPs and best practices, providing an additional tool for validation.

A concrete example of support for adoption of EBPs occurred in August of 2011, when Magellan of Nebraska began working with all of the Therapeutic Group Home providers on the implementation of EBPs in their programs. Each provider identified a minimum of two EBPs and created a plan to complete a fidelity audit. Magellan worked with MLTC to review and approve these plans, and each provider was asked to submit the results of their fidelity audit to Magellan upon completion. In June of 2012, plans to review the fidelity audits were put on hold while Medicaid regulations for Therapeutic Group Home were finalized. The QAPI was provided ongoing updates regarding the status of the work with the Therapeutic Group Homes. Within 90 days of the approval of regulations, providers will be asked to submit fidelity audits. Magellan will review the fidelity audits and report the results to MLTC.

For the new program, we are committed to continuing to provide high quality training programs to our network providers in the area of trauma, to include physical/sexual abuse and violence, among other traumas. We also will target adult serving providers who work with adult survivors of abuse and veterans. Clinical trainings will be available via our Web site, through our Achieve and Essential Learning training programs, and in-person by speakers with national recognition. Training will be offered quarterly with two symposiums offered each year. We will work with the provider community to identify topics that will be most beneficial to increasing network expertise and competence.

After training is provided, Magellan will ensure that providers have access to the tools necessary to implement specific evidence-based or best practices. For example, we will make PracticeWise available to our child serving providers. For adult providers, we will include a link on our Web site to the National Institutes of Health. We will include a post-training survey to evaluate the training, facility, content and usefulness of the training.

[redacted]

[redacted]

Explain the process your BH MCO will put in place to maintain your provider file with detailed information on each provider sufficient to support provider payment including issuance of IRS 1099 forms, meets all federal and DHHS reporting requirements, and cross reference to state and federal identification numbers to ensure excluded providers are identified.

[redacted]

[redacted]

[redacted]

We will work with the State and member agencies in the development of a communication exchange process to ensure that providers not in good standing with member agencies are either placed on hold for future referrals, corrective action to correct status, or terminated from the network based on State and RNCC consensus of doing so.

[redacted]

[redacted]

Submit copies of your standard provider contracts.

Attachment T includes our standard individual, group, and facility base provider contracts and the draft Nebraska addendum. The Nebraska Medicaid addendum is included with all provider contracts to account for the specific requirements identified in the RFP for this program. We affirm that we have included all material provider requirements and will comply with all requirements of the RFP related to provider contractual language. In all of our public sector programs, Magellan's legal department prepares state-specific addenda that include account-specific requirements. This approach to contracting fosters consistency but allows more flexibility in each state to quickly make changes if the state publishes new rules or requirements, if services are added, or if any other changes are needed, without changing the full master contract.

Describe your BH MCO's policies and procedures for the selection and retention of providers including selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

Please see our response to the third question in *Section IV.L. Provider Network*, "Describe policies and procedures your BH MCO will put in place to ensure providers are not discriminated for participation, reimbursement, or indemnification for acting within the scope of license or certification."

If your BH MCO proposes to use Subcontractars to provide any of the services provide a listing of those Subcontractors with their experience in providing care to Medicaid members and a description of the services they will provider if not already described.

Magellan Behavioral Health of Nebraska, Inc. (Magellan) does not intend to subcontract any required element of the program as outlined in this RFP to an outside entity. Magellan does plan to utilize the expertise and experience of a Related Entity – Magellan Medicaid Administration. As required, that relationship is described in the Related Entity Contractor response.

In addition and in the interest of full disclosure, Magellan will purchase or license the services of vendors to support initiatives as outlined in this proposal. This would include telemedicine tools, evidenced-based practice tools for network providers, mobile phones and the associated technology, etc. Further, we will contract with Nebraska based organizations for value-added offerings not required by the contract or RFP. For example, we propose the expansion of a Warm Line in Lincoln (Region 5) in association with the Nebraska Mental Health Association and supporting the Nebraska Federation of Families and the Nebraska NAMI to expand offerings in rural Nebraska. Finally, we will subcontract with an organization as required by the RFP to engage in the Consumer and Family Satisfaction teams, but that entity will not be identified until contract award. Upon request from the Division, we will share any agreements once in place.

Describe your Subcontractor oversight program. Specifically describe how your BH MCO will comply with the relevant portions of 42 CFR Part 438 and:

- *Ensure receipt of all required data including encounter data;*
- *Ensure that utilization of health care services is at an appropriate level;*
- *Ensure delivery of administrative and health care services at an acceptable or higher level of care and meets all standards required by this RFP and your internal standards;*
- *Ensure adherence to required grievance policies and procedures;*
- *Subcontracts do not contain terms for reimbursement at rates that are less than the published Medicaid fee-for-service rate in effect on the date of service unless a request has been submitted to and approved by MLTC.*

Magellan Behavioral Health of Nebraska, Inc. (Magellan) does not intend to subcontract any required element of the program as outlined in this RFP to an outside entity.

~~*If your BH MCO proposes to use Subcontractors to provide any of the services provide a listing of those Subcontractors with their experience in providing care to Medicaid members and a description of the services they will provider if not already described.*~~

Question removed in Q & A.

Describe the process your BH MCO will have in place to notify providers of new practice guidelines and to monitor implementation of those guidelines.

Magellan will use the communication methods developed through the Network Communication Plan (see the twenty-fifth question, "Describe your BH MCO's approach to creating the Network Communication Plan") to ensure that all providers are informed of new practice guidelines. Because we will involve the Clinical Advisory Committee and the PAC in the review and adoption of any new practice guidelines, providers will be aware of the development of the new guideline prior to actual implementation. Upon adoption, we will notify all network providers of the new guidelines through all available communication channels, including the provider newsletter, email and fax blasts, hard copy mailing, postings to our Web site, and any meetings that include a significant number of providers.

An example of our effectiveness in communicating policy changes is the significant change that occurred surrounding Children's Services in Nebraska in 2010 and 2011. The changes were prompted by a desire to ensure that services were not provided in Institutions for Mental Disease, and they resulted in three new levels of care: Psychiatric Residential Treatment Facilities, Therapeutic Group Homes, and Professional Resource Family Care. In order to ensure that all providers and community stakeholders were informed of the changes, Magellan conducted provider and DFS trainings on the changes in July 2011. We also provided a page on our Web site dedicated to the changes with a prominent placement on our home page. Our care

management center staff conducts fidelity audits with providers to ensure compliance with the new regulations and the related clinical practice guidelines.

Like our monitoring of the use of evidence-based practices, we will incorporate the new guidelines into our record review monitoring tools and will assess provider compliance during each review period.

IV.M. Care, Utilization and Quality Management

Describe how your BH MCO will ensure that policies and procedures are in place which prevent the structuring of compensation to individuals or entities that conduct utilization management activities in such a way as to provide incentives for the individual or BH MCO to deny, limit, or discontinue medically necessary services to any member.

Since 1994 Magellan has been managing behavioral health services for Medicaid, CHIP and Medicare beneficiaries, including individuals with developmental disabilities, children in foster care, children who are wards of the state, dually eligible Medicare and Medicaid beneficiaries, and individuals with severe mental illness and substance use disorders. We currently serve over 3 million Medicaid members in seven states, including Nebraska. Our utilization management policies and procedures are designed to ensure our members receive care that is medically necessary according to established criteria and clinical practice guidelines to ensure the right amount of services are provided at the right time and in the right setting.

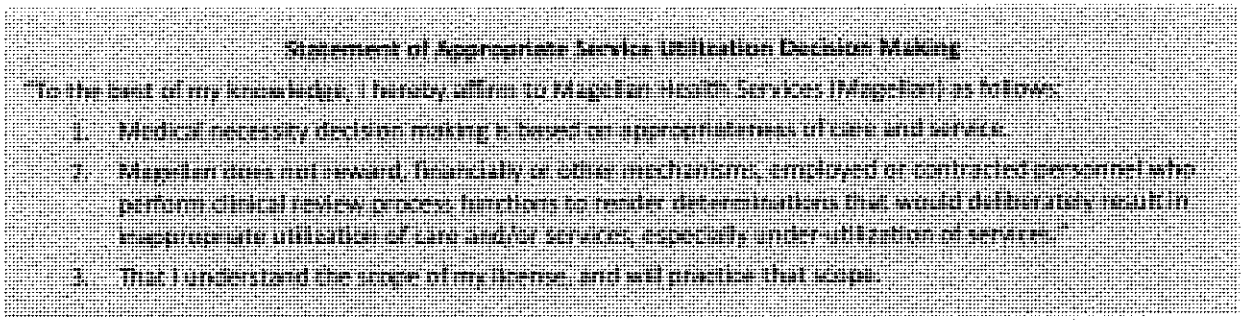
Magellan is a Clinically-driven Organization

The philosophy of our company is clinically-driven; therefore our utilization management decisions are made purely on the basis of our assessment of the treatment needs of the member. Being clinically-driven, we believe cost effectiveness is the natural by-product of providing evidence-based treatment and quality services. Medical necessity according to established criteria and clinical practice guidelines coupled with the clinical needs of the member is a key tenet of our utilization management program that we reinforce through our comprehensive employee training programs and all care management activities.

Magellan has existing policies and procedures in place today to ensure there are no incentives for Magellan as an organization, or any of its individual employees who conduct utilization management activities, to deny, limit, or discontinue medically necessary services to members. First, through our written policy, *Medicaid: Service Authorization Determination Policy,* Magellan unconditionally prohibits employee compensation to be linked to utilization management activities. Further, the policy declares that Magellan does not create incentives to inappropriately deny, limit, or discontinue medically necessary services. In section I.E. General Standards, this policy states:

> *"Compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member."*

Second, to ensure that all licensed clinicians responsible for participating in or making medical necessity and other utilization management decisions are aware that there is no compensation directly related to the performance of is utilization management activities, they are required to sign the attestation of Appropriate Service Utilization Decision Making (in text box below) at the time of hire as part of Magellan's online orientation process, and participate in orientation training sessions that cover this policy explicitly.



Statement of Appropriate Service Utilization Decision Making

"To the best of my knowledge, I hereby affirm to Magellan Health Services (Magellan) as follows:

1. Medical necessity decision making is based on appropriateness of care and service.
2. Magellan does not reward, financially or other mechanisms, employed or contracted personnel who perform clinical review process functions to render determinations that would deliberately result in inappropriate utilization of care and/or services, especially under-utilization of services."
3. That I understand the scope of my license, and will practice that scope.

We believe the steps we have taken demonstrate Magellan's commitment to our primary mission of ensuring that members receive the services they need to achieve recovery and wellness.

Describe the Behavioral Health Risk Assessment that your BH MCO proposes to conduct with members.

Magellan Ensures Completion of Appropriate Risk Assessments at the Point of Care

Determining risk is critical to providing safe and effective care for members. A thorough risk assessment of each member is an essential part of all behavioral health evaluations that providers complete. Magellan does not require providers to use a standardized Behavioral Health Risk Assessment tool, because there is no one recognized instrument in the industry for this purpose.

Rather, Magellan requires network providers to assess members for substance use and dangerousness to self/others at the time of admission and throughout the course of the member's treatment. As an example, Magellan developed a Clinical Practice Guideline (CPG) on assessing and managing the suicidal member. The guideline requires that a member's clinical record reflect that the suicide risk assessment has taken place, what the findings are, and what intervention plans are in place to contain, manage or mitigate the identified suicidal risk. Through our Treatment Record Review (TRR) process we monitor that risk assessments have been completed adequately. If not, we notify providers and follow up with an informal or formal action plan.

Customer Service Associates are Trained to Recognize and Respond Appropriately to Crisis Calls from Members

Because members may contact Magellan for various reasons, we have also trained our staff to detect and respond to risk issues. Our Customer Service Associates (CSAs), who are often the first person at Magellan that a member talks to, have been trained to recognize crisis calls and the need for immediate referral to a care manager. When the CSA hears verbal cues or other indications that suggest an emergency, he or she immediately passes the call "live," to a care manager, using the no-hold conference telephone feature. These calls are given the highest priority, and the CSA immediately routes the member to a care manager who is a licensed behavioral health professional. Instant messages are sent to all care managers, and it is the

expectation that the priority call is immediately answered. The CSA remains on the call until the issue is resolved, in case there is a need to call the police or other emergency services.

Crisis scenarios are included in the CSA training, which includes common indicators for crisis calls, such as the following:

- The caller identifies that the situation is potentially an emergency or crisis situation.
- The caller identifies that he or she is potentially a danger to himself or herself or others.
- The caller exhibits verbal cues that indicate he or she is distressed (for example, angry, tearful, and anxious).

In these situations, the CSA will execute a live, warm transfer to a clinical who will assess and address the immediate needs of the caller.

Risk Assessments through Care Management Programs and Protocols

We will work collaboratively with the Clinical Advisory Committee to identify methods and tools to identify members with special needs. Because of the important nature of identifying and resolving risk, Magellan clinical staff currently does both initial and ongoing risk assessments while members are involved in care management. Magellan has many avenues to assess behavioral health risk for members. The main methods include risk assessment during Utilization Management (UM) Service reviews, and when enrolled in the Recovery andResiliency Care Management (RCM) or the Integrated Whole Health (IWH) Program. In addition, we have several other risk assessment protocols: Pre-Risk Predictive Modeling Program and Whole Health Rx℠, Predictive Modeling using medical and pharmaceutical claims, and pharmacy claims access.

Utilization Management Service Reviews

UM is an integral part of our care management program. UM activities are intended to ensure that services delivered to members:

- are medically necessary based on established criteria, as well as practice guidelines
- are provided at the right time, in the right amount, and in the right way
- are provided in the most appropriate, least restrictive setting
- help avoid interventions that have been unsuccessful or have failed to prevent repeated use of restrictive placements
- support person-centered, strengths-based, individualized goals related to each adult's recovery and each child's and family's resiliency
- are safe and effective.

When a care manager reviews a service request with a provider—in addition to discussing the diagnosis, treatment plan, interventions, and goals—the care manager always inquires about risk. The care manager asks specific questions about danger to self or others. Magellan has

created a template for care managers to use which prompts questions about risk. Areas that care managers explore include:

- suicidal intent, plan, means and access
- previous attempts and family history
- demographic risk factors such as age, race, gender, and ethnicity
- high risk factors such as unemployment, chronic medical conditions, isolation, or recent losses
- major depression, substance use, or psychotic symptoms such as command hallucinations
- aggression, threats to others, history of violence.

Determining risk helps the care manager to establish which level of care is required and which services will be safe. Additional information regarding our UM Program is described in the fourth and eleventh responses to questions within this *Section of IV. M. Care, Utilization and Quality Management.*

[redacted]

[redacted]

[redacted]

[redacted]

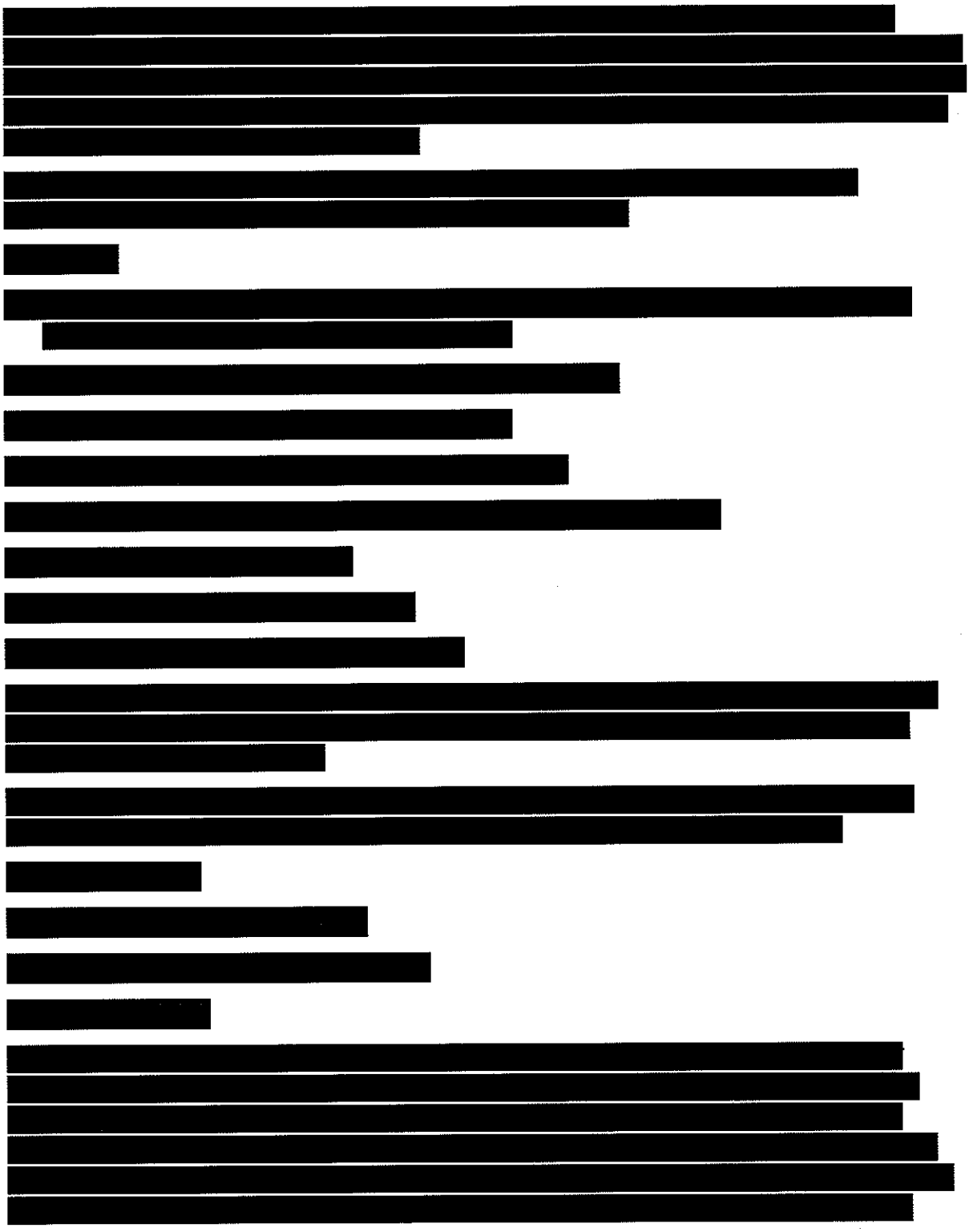
Describe your BH MCO's approach to creating the Clinical Advisory Committee.

Magellan has a long standing commitment to and experience with the inclusion of the active voice and participation of all persons affected by the behavioral health system of care.

[redacted]

Pursuant to the RFP requirements, Magellan shall develop, establish and maintain a Clinical Advisory Committee (CAC) to facilitate regular consultation with experts who are familiar with standards and practices of mental health and/or substance use disorder treatment for adults, children and adolescents in Nebraska. Magellan intends that the CAC will consist of experts and behavioral health service providers within Nebraska who are familiar with standards and

practices of mental health and substance use disorder treatment including co-occurring disorders, for children, adolescents and adults in Nebraska, and have an array of service delivery expertise relative to different age groups, races/ethnicities, and regarding populations in urban, rural and frontier communities.



[redacted]

Once the nominations are received for both sets of members, Magellan will select membership that assures the representation of the required dimensions of the RFP (urban/rural, age group, etc.) for a total membership not to exceed 12 members. Pursuant to the RFP, Magellan will then provide the plan for development of the Clinical Advisory Committee in prior to finalization of membership and committee establishment.

Following contract award and acceptance of invited members, the CAC will have an initial meeting to discuss its role, and rules of governance. Per the RFP, the Committee will be responsible for providing input into all policies, procedures and practices associated with care management and utilization management functions including utilization management criteria, clinical guidelines, and practice guidelines to ensure that they reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in Nebraska. Magellan proposes that a behavioral health service provider who is well-regarded and the Magellan Medical Director will co-chair the meetings of the CAC and will be responsible for determining the agenda and for keeping and disseminating the minutes to CAC members.

The CAC will meet quarterly and additional meetings will be held on an as-needed basis and will be open to the public.

Describe the process and criteria used for ~~case~~ care management, including how you will case manage and what services you will provide. Address the following issues in your response:

- *How will you identify potential care management situations*
- *If you use a list of diagnoses to identify cases for management and if so provide the list*
- *Once a case is identified, how will your BH MCO determine whether to pursue the case for management*
- *How will care managers interact with members and the member's PCP, family, and other providers*
- *What procedures and processes are used to ensure that all medically necessary services are provided*
- *Any software you use to identify high risk members and track outcomes including predictive modeling software*
- *Specifically address care coordination for children who are State wards, in foster care placement and programs for members with chronic and/or special health needs.*

[redacted]

Our care management model is summarized graphically in figure IV.M.4.1 below and then described in narrative to provide context for our response to the specific questions regarding Magellan's processes and the criteria we will use for care management.

In the Scope of Work section on Care, Utilization and Quality Management, we provide a more detailed description of Magellan's comprehensive care management program.

[1] Pursuant to Addendum 2, Questions and Answers for RFP Number 4166Z1, the State clarified in its response to Question 77 (p. 21) that "case" management refers to "care" management.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Attachment V provides a detailed workflow of Magellan's Recovery Care Management program.

Provider and Member Resources and Tools

Our care management model is designed to engage members, physicians and other providers involved in the care of the member in the care planning process. Magellan has extensive experience in the development and implementation of management resources and tools to support providers in providing effective and coordinated care, helping members navigate the complex delivery system, and supporting members to become more active participants in their own health care. We will offer a myriad of care management tools, resources and supports for the Nebraska Behavioral Health Managed Care program, including:

- PCP coordination and support
- member support and education

- integration, collaboration and coordination with the PH-MCOs.

[redacted]

[redacted]

2. Member Support and Education

Nebraska Magellan Web Site – www.magellanofnebraska.com.

While critical that care managers and behavioral health providers are aware of how members can obtain appropriate physical health services, it is equally important that members themselves are aware of their physical health benefits and how to obtain these services. Therefore, on our Web site, we will include a "Physical Health Care" link that lists contact information for all of the PH-MCOs, with phone numbers of their member services and special needs units, as well as their Web sites. To facilitate members' access to the Web site, we include the URL link on member and provider newsletters, the *Member Handbook* and *Provider Handbook*, provider directories, and on all Magellan correspondence.

[redacted]

[redacted]

3. Integration, Collaboration and Coordination with PH-MCOs

[redacted]

[redacted]

- *How will you identify potential care management situations*

Magellan has more than 10 years of experience caring for Nebraskans with mental illness and substance disorder issues. From this experience we have developed proven processes, approaches and methodologies to identify individuals that can benefit from care management interventions. Magellan draws upon members of the care management team, the member and provider community—as well as data and analytic tools—to identify potential care management situations.

Role of Utilization Management in Identifying Members Potentially Eligible for Care Management Interventions

As described at the beginning of this section, care management is a component of our utilization management program and occurs whenever our care managers conduct service authorization

reviews. As such, our utilization management team is well positioned to identify members that may benefit from more intensive care management activities and interventions offered under our Recovery Care Management (RCM) or Integrated Whole Health (IWH) programs. Members identified as potentially being eligible for RCM or IWH are triaged to determine whether they meet the eligibility criteria for participation.

[redacted]

Provider Outreach and Education

We will also rely on our providers to help identify members for care management interventions. To that end, we will conduct initial and ongoing provider outreach and education to raise provider awareness and understanding of our care management programs so they can refer members appropriately for care management. Although most members are referred internally by Magellan staff for more intensive care management, a member may also self-refer, or be referred to RCM or IWH by their behavioral health provider, case manager, primary care

physician (PCP), a state agency representatives, an advocacy organization, one of the PH-MCOs, a family member or other individual.

Criteria and Data Analysis Tools to Assign Members to an Appropriate Level of Care Management

[redacted]

- *If you use a list of diagnoses to identify cases for management and if so provide the list*

[redacted]

- *Once a case is identified, how will your BH MCO determine whether to pursue the case for management*

[redacted]

[redacted]

- *How will care managers interact with members and the member's PCP, family, and other providers*

[redacted]

[redacted]

[redacted]

- *What procedures and processes are used to ensure that all medically necessary services are provided*

The Role of Medical Necessity Criteria and Clinical Practice Guidelines in Medically Necessary Service Provision

Medical Necessity Criteria (MNC) Guidelines

Magellan utilizes Medical Necessity Criteria (MNC) guidelines to ensure that services are medically necessary, and meet MLTC regulations for active treatment. We first began developing MNC guidelines in 1988 and review and update our national guidelines annually. Since the national guidelines do not cover every level of care available to Nebraska Medicaid recipients, we supplemented them with Nebraska-specific MNC Guidelines. Medical Necessity Criteria Guidelines are designed to determine if a member has the necessary severity of need to require the level of care identified with the need, and if the provider is providing the intensity and quality of service to meet the treatment needs of that individual. With the new Governance and Quality Structure we will adopt under the new contract, as described in the twelfth question of this section, Magellan will regularly request provider and other stakeholder input as part of our annual updates. This input will flow from the Clinical Advisory Committee through the Quality Assurance Performance Improvement (QAPI) Committee to the Governance Board, and finally, be submitted to MLTC approval.

Further, Magellan recognizes that every public sector program is unique and that guidelines for one program may not be appropriate for another due to a variety of factors, such as service availability, cultural needs and other relevant clinical and demographic factors. As a result, each of Magellan's Care Management Centers maintains the flexibility to modify existing guidelines, use externally developed guidelines (e.g., ASAM Patient Placement Criteria), or replace the guidelines in their entirety to meet the unique needs of its members in that state. Upon award of the contract, one of the first activities we expect the new Clinical Advisory Committee to undertake is a fresh look at the Medical Necessity Guidelines used at the Nebraska Care Management Center.

Clinical Practice Guidelines (CPGs)

Another method to ensure services are medically necessary is by utilizing Clinical Practice Guidelines (CPGs) to help practitioners provide evidence-based care as determined by national experts and current scientific research. Magellan has used CPGs since 1998 when we implemented them for substance abuse and major depressive disorders. CPGs for specific behavioral health diagnoses and functional levels are reviewed by our corporate clinical department at least every two years and are made available to providers via Magellan's Web site. These documents provide our staff and network providers with the most current standards for evidence-based practices and with clinical decision-making support that promotes the highest quality of clinical care.

Each guideline was either developed or reviewed by a multidisciplinary task force of Magellan senior clinical staff after a thorough review of the relevant current scientific literature.

Consultation by practitioners in Magellan's provider network and Magellan's customers is sought and recommendations are incorporated into the guidelines whenever possible.

When guidelines are adopted from another organization, Magellan writes an introduction to guide providers in the application of the guideline and to give updates to scientific literature when such are available. Providers in our network are expected to comply with our practice guidelines, and tip sheets, and educational supports are provided to support adherence to the guidelines. In addition, high-volume provider treatment records are audited routinely against the guidelines, with scoring and action planning for providers with documented nonconformance.

The Medical Necessity Criteria Guidelines and CPGs are distributed to all providers and available on Magellan's Web site. In addition, the guidelines are made available to members upon request. Input into guidelines is sought through our QAPI structure.

The Utilization Management (UM) Process

Authorization decisions are made only by licensed mental health professionals. A care manager may authorize services, but only Magellan's medical director or physician designee can make a denial determination. Prior authorizations are never required in emergency situations.

Magellan's UM philosophy promotes collaboration and consultation between providers and our clinical management staff, and is focused on providing services that best meet members' and their families' needs. Naturally, even in the best run care management system, denials are inevitable because there will be some requests for services that are not medically necessary. However, in our experience, when providers are trained and knowledgeable regarding medical necessity criteria and their application, and conversations occur in a collaborative mode, the need for denials of coverage decreases. As a result, our denial rates range from only two percent to five percent at all of our public sector care management centers that have been in operation for more than one year. [redacted]

Care Management Activities that Ensure Medically Necessary Care

In addition to authorization reviews, Magellan also ensures that all services are medically necessary through care management activities. Magellan's primary goals are to maximize the use of services that support recovery and resiliency, match services to each member via cultural competence and evidence-based practices, and ensure that services are provided along the full continuum of care. To meet these goals, our UM program guides clinical decision-making that includes the consumer's broader recovery and resiliency needs. Our UM program is designed to provide quality of care, full access to care, oversight of routine outpatient care, focused oversight of acute inpatient level of care (LOC), and use of clinically driven triggers to identify those members in need of additional support.

The UM process allows for facilitating access to in-network providers at the appropriate level of care and tracking movement between different outpatient services. Part of review is not simply authorizing care, but shaping treatment. For intensive outpatient services we conduct initial and

concurrent reviews. During these reviews, we monitor discharge plans and proactively identify and facilitate referrals to in-network providers as one component of the after care plan. For routine outpatient services, Magellan conducts outlier management and assists members in accessing in-network services as needed, for example, making referrals for medication evaluations and second opinions.

UM policies and procedures take into consideration members' long term needs, for example adults with a serious mental illness or children and youth with a serious emotional disturbance who may require intensive and/or several services concurrently. These members may receive services through Magellan's Recovery Care Management (RCM) Program, summarized in our response to the second question above. All of these aforementioned UM and care management activities ensure that members are receiving medically necessary services.

Care management staff also receives training on any updates or revisions to the guidelines. Upon being awarded the Nebraska contract, under Nebraska Medicaid Division of Long Term Care's (MLTC's) direction, Magellan will develop Medical Necessity Criteria Guidelines, with input from providers and Magellan's Clinical Advisory Committee (described in the twelfth question of this section) at least 30 days prior to implementation to help ensure members receive the right care, in the right amount, at the right time.

While essential, service authorization is only one component of UM. Without a focus on service planning beyond a single episode of care, a member's needs, over time, may go unmet and lead to future inpatient and/or residential admissions. At every point during the UM process, our care managers address needs for referral and follow-up services, and collaborate with providers, families, and other significant persons in the member's life to facilitate the most appropriate, coordinated treatment plan. For members with more complex needs, our RCM program provides an intensive level of care management.

Oversight Activities to Ensure Consistent Application of Medical Necessity Criteria Guidelines

Magellan employs a multi-faceted approach to ensuring ongoing, consistent and appropriate application of medical necessity criteria. Our approach includes live call monitoring, documentation audits, clinical rounds and case conferences, quality audits of denials, inter-rater reliability studies, care manager service observation, treatment record reviews, and data analysis including denial rate, overturn rate, and over- and under-utilization. These comprehensive oversight measures are described in detail in our response to the fourteenth and last question of *Section J. Business Requirements* within our *Proposed Implementation Approach* of this proposal.

Provider adherence to the guidelines is monitored as part of the initial and concurrent review process as well as through provider treatment record reviews. Results of these activities are reported to the Quality Assurance and Program Improvement Committee for review and recommendations for improvement. Magellan will limit payment to only those services that have been deemed to be medically necessary.

- *Any software you use to identify high risk members and track outcomes including predictive modeling software*

[redacted]

[redacted]

[redacted]

- *Specifically address care coordination for children who are State wards, in foster care placement and programs for members with chronic and/or special health needs.*

Care Coordination Issues for Children Who are State Wards, or in Foster Care, or in Programs for Members with Chronic or Special Health Needs

A significant problem facing Nebraska child welfare is the prevalence of children who are State wards (has historically been as large as 7000 at points in time) and also the prevalence of State wards placed outside the family home. A majority of these youth are not placed in treatment facilities although many of them present with mental health and/or substance abuse treatment needs. Additionally, of the youth currently receiving residential care services in the system, more than 85 percent of them are State wards. Further, the Division of Children and Family Services (DCFS) funds many youth for residential care who do not meet medically necessity criteria but who are court-ordered for care. These youth typically do not have the mental health or substance abuse treatment needs to warrant this level of intervention or, over the course of multiple/extensive attempts at treatment have shown that they are not responding to this specific type of intervention.

Many of the children Magellan reviews for treatment services are or have been State wards or otherwise are identified as having significant special needs. This population of children has unique and specific resulting from the difficult, sometimes chaotic and even dangerous environments they have been exposed to, and the frequency with which they have been traumatized. Magellan recognizes that many children who are State wards have experienced traumatic events (including having been physically or sexually abused themselves or having been witness to physical or sexual violence) and may have also been subjected to the trauma of being uprooted, in some cases, multiple times, and moved across multiple foster homes or other placements as their families work toward reunification. For the youth remaining or returning to their family of origin, there are often additional struggles: the family is overwhelmed by the many demands and expectations placed on them from the State child welfare and Juvenile Court system, further compounding the stress of attempting to meet the family and child's basic living needs. In addition, issues of generational mental health and substance use that face many of these families create a complex dynamic that often complicates treatment engagement and success.

[redacted]

[redacted]

Magellan's Expertise in Providing Care Coordination for Children Who are State Wards in Foster Care or Programs for Members with Special Needs

To ensure that the children and adolescents who are State wards or in foster care receive care in a timely manner and benefit from appropriate mental health services, we will ensure high quality care coordination. We understand that children and youth may come into the care of the State either receiving no services or already receiving services from multiple systems of care through several case managers. This can result in youth having *several plans of care* with conflicting goals. The goals of our care management model are to address fragmentation in the delivery system and ideally develop a single plan of care that includes all elements of the treatment plan to ensure the care of special needs children including children who are State wards and in foster care programs is coordinated [redacted]

[redacted]

[redacted]

[redacted]

How Magellan Intends to Ensure Care Coordination Under the Nebraska Behavioral Health Managed Care Program

Magellan is committed to building on its experiences in Nebraska and elsewhere in providing effective care coordination to children who are State wards, in foster care, and who are members with special health. Our goal is to enhance the scope and quality of the following activities for members, as described below.

Care Coordination for Children who are Wards of the State

We will provide care coordination to State wards when we are conducting prior authorizations for their care. It is unfortunate when Magellan first becomes aware of children who are State wards and in need of mental health or substance use disorder services when they are admitted to residential programs. We will work with CFS to ensure that this does not occur frequently, and will also work to ensure care coordination occurs for these members, as appropriate. In all cases, we will confirm that discharge plans from residential care are developed and are

appropriate to set the stage for smooth transitions to the community. In addition, for those members who have complex needs and for whom we have determined a Joint Treatment Planning conference will help with care coordination, we will take the lead in convening the JTP conferences. Finally, for those youth who are State wards and are eligible for our RCM program, they will receive the intensive care management that our RCM program affords.

Care Coordination for Children in Foster Care

Magellan recognizes that youth in foster care are among the most vulnerable in the state. These youth have been removed from their home and often from their communities due to familial or environmental factors or, at times, due to the unmet behavioral health needs of the child. Regardless of the factors that result in foster care placement, children in foster care often struggle with the transition into foster care and throughout their stay in the foster care system.

Given these concerns, Magellan initiated a series of meetings in early 2012 in collaboration with the Nebraska Families Collaborative, as well as multiple foster care and behavioral health care providers in the Eastern Service Area in an effort to create an Intensive Foster Care Program. Additionally, Magellan then offered to partner with these providers to make certain that we would authorize the needed treatment services for these children in an effort to assist the foster care providers in securing placements for each child.

Collaborative Agreement with the Division of Child and Families Services

Upon contract execution, Magellan will establish a collaborative agreement with the Division of Child and Family Services (CFS). As part of this agreement, Magellan will provide training and education to the CFS case managers on improving identification of members with behavioral health needs.

When youth in foster care are identified as having mental health or substance disorder treatment needs, Magellan Care Managers can also assist in helping CFS case workers and foster parents (with appropriate releases) to identify appropriate provider options to serve youth. Magellan's provider search database is available online 24/7, as well, and can be accessed by foster parents to help identify providers that are geographically available. Children in foster care who are at high risk for hospitalization or residential treatment will also benefit from participation in the RCM program and the expertise of the RCM care managers. They will ensure that care is coordinated across the behavioral health services continuum and that children will be referred for treatment if or when any unmet behavioral health service needs are identified. For youth in the foster care system or transitioning into the foster care system, foster parents will be encouraged to be actively involved in the RCM process.

Magellan's Recognition and Support of Foster Families in a Child's Care Management Interventions

Treatment interventions can help address the many intense feelings many children have throughout these transitions, especially for youth that move across numerous foster placements on their way to reunification. Sadly, some children are never able to reunite with their family of origin, making foster care the only realistic "permanent" family available. No matter how long a child is in foster care, Magellan recognizes the value and importance of the role of a foster family

in a child's life. Magellan also has immense appreciation for the investment foster parents must make in the children they serve and the support that foster parents need in order to best serve these youth. Magellan encourages the involvement of foster parents in the youth's treatment (unless clinically contraindicated) and will offer the same type of consultation and information sharing as guardians, as long as appropriate releases are on file.

Care Coordination for Children with Chronic/Special Health Needs

Magellan's RCM care managers are aware of Nebraska's care delivery system issues regarding gaps in services and service delivery across the Nebraska child service delivery system.

Magellan's Commitment to Collaboration in Serving Children with Special Needs in Nebraska

We have participated in cross-system collaborative team meetings to focus on children and transition age youth with special needs—as both consultants and collaborators—in developing and finding new ways to better assist such children and youth to remain in a safe community setting.

RCM Care Managers have also participated in Nebraska Region V's Transition Age Review Team's monthly meetings to help consult on treatment accessibility for youth served in the Region V program. The focus is on the needs of particular vulnerable youth nearing the age when the CFS will no longer serve them and attempts to plan for and address the housing needs, insurance coverage, support system involvement and treatment access issues of such youth to identify resources and service plans appropriate to meet their needs in their period of transition and afterward. In some cases, referrals of youth for RCM may evolve from the discussions. Similarly, Magellan has been working in collaboration with the Nebraska Families Collaborative, HHS and the Division of Behavioral Health to develop mechanisms to assist children with special needs who are referred for residential treatment but who do not meet medical necessity criteria for the service. The parties have convened a Permanency and Treatment Review board to conduct case conferences to develop viable, appropriate treatment options that Magellan can authorize and also to address needs for placement, permanency and supportive services (through the Nebraska Family and Children Services continuum). In many cases, plans are developed and presented to the Juvenile Court. They have often resulted in the identification of effective alternatives for some youth enabling them to avoid court-ordered, non-medically necessary treatment. Magellan will continue to expand the use of these specialized case conferences. Additionally, Magellan is committed to continue to work collaboratively with the state agencies around effective special case consultations and conferences for children and youth with special needs.

For members with special needs, describe the policies, procedures and processes your BH MCO will put in place to ensure coordination of care across the care continuum. Describe how your BH MCO will assist members with special needs in identifying and gaining access to community resources that may provide services that the Medicaid program does not cover.

As we have discussed in the Understanding the Scope of Work portion of this proposal and in answers to previous questions within this section, Magellan is committed to ensuring that each member's care is effectively coordinated across the care delivery system. Particularly in the case of members with special needs, effective coordination is the key to ensuring that members will have a full awareness of the comprehensive array of formal and informal supports and services available to them and the most effective way to make use of them. We educate and train care delivery providers on our policies and procedures and reinforce the processes we have in place to support providers in ensuring that service delivery is timely and complimentary in scope and type to best meet members' needs.

Policies, Procedures and Processes to Ensure Coordination of Care across the Care Continuum for Members with Special Needs

Magellan has ten years of experience coordinating care across the treatment continuum for Nebraska Medicaid members. We understand the specific challenges of ensuring multi-disciplinary involvement to improve care for the entire state of Nebraska. We also know the provider landscape, which resources can be called upon to meet individual needs and which systems to enlist on a case-by-case basis.

[redacted]

[redacted]

[redacted]

Supporting our Communities in Making Appropriate Referrals to Magellan

In addition to internal referrals, some special needs referrals come from members, families, providers and other stakeholders. We provide community providers and family organizations materials to remind them to send us referrals when a member with special needs is identified. Magellan's Recovery and Resiliency Director provides ongoing training to members and family organizations regarding the definition of special needs, as well as how to make a referral to Magellan.

Criteria for the identification and referral process for both members with special needs and the RCM Program are core training elements to be covered when Magellan presents to Children and Family Services, the Office or Probation or whenever doing ad-hoc training with providers or other stakeholders training. Members with secial needs and the RCM Program are also topics that we routinely discuss during Magellan's strategic input meetings held several times a year. Special needs and RCM Program criteria and contact information for RCM Care Managers will be included in all training "packets" that we distribute at state wide conferences or stakeholder meetings in which we participate. RCM criteria are also available on our website, www.MagellanofNebraska.com.

Care Management Activities for Members with Special Needs

Whenever a request for services is made and the member meets the criteria a referral is made to our RCM program. Our RCM program staff focuses on the individual needs of the member, regardless of care setting, to identify resources to meet those needs and engage in a coordinated effort across the entire continuum of care to see that those needs are met. It is frequently the case that individuals with special health needs are receiving services through multiple agencies. In such cases, the RCM Care Managers routinely convene Joint Treatment Planning meetings with other state agency care givers. In this process, whichever care manager or organization is responsible for authorization of the member's services, it is the responsibility of that agency to make the decision to schedule a Joint Treatment Planning meeting (described above in the previous response), to review the case, and to identify strengths, needs, and resources across the delivery systems to meet those needs.

[redacted]

[redacted]

When Members with Special Needs Seek Urgent Service Authorizations

Whenever a request is made for an urgent service authorization and the member has special needs and is not yet receiving care management through RCM, Magellan will facilitate a priority admission, while simultaneously enrolling the member in our RCM program. Magellan will also authorize interim services if admission must be delayed for any reason. We will follow up to be sure the member continues to receive the appropriate amount and type of treatment and is admitted as soon as possible, if this level of care is still optimal.

There is an array of community-based resources that members and their families may access that are not part of the formal Medicaid-covered behavioral health system. Having worked in Nebraska for years, Magellan's care managers are expert resources for members and their families both in identifying services a member needs when a community-based resource may provide a service that is needed but not Medicaid-covered, or when a member might not be aware of the breadth of other services that are available in the community but may ultimately prefer, and/or which might augment the services the member is already receiving. Our care managers and peer Recovery Navigators are intimately familiar with other such supportive services and resources available to members and their families across the State of Nebraska. In addition, to make sure we keep abreast of available resources, [redacted]

Describe how your BH MCO will monitor, report and implement a program to manage the use of psychotropic medication for children.

Magellan is uniquely positioned to monitor, report and implement a program to manage the use of psychotropic medication for children because our related-party contractor, Magellan Medicaid Administration (MMA), which has been Nebraska Medicaid's pharmacy benefit manager since 2008. Additionally, Magellan has 27 years' experience in the management of fee-for-service Medicaid and Medicaid managed care pharmacy benefits including behavioral and physical health and pharmacy benefit management. Our services include combining analytical and integration capabilities with clinical expertise and support, as well as having conducted extensive work specific to assuring quality and managing costs of psychotropic medication prescriptions.

Our staff of 100 clinical pharmacists has hands-on experience in Medicaid programs and works collaboratively with our customers to support or manage prescriber academic detailing; comprehensive provider education and outreach; and clinical prior authorization and criteria development. [redacted]

[redacted]

As a leader in behavioral health management, Magellan had already embarked on a comprehensive effort in June, 2011 to lead the behavioral health industry in provider adherence to evidence-based and preferred practices for psychotropic prescribing to children and adolescents. As one example of the local and corporate clinical dedication to youth services Magellan launched the Magellan's Children Champion Initiative. This program leverages the national expertise of eight clients to identify key issues and solutions facing States such as Nebraska.

[redacted]

Managing the Use of Psychotropic Medication for Children through Pharmacy and Care Management Tools

[redacted]

[redacted]

[redacted]

Describe your BH MCO's policies, procedures and processes for adequate staffing of CM/UM and assure that staff meet the contract standards.

At Magellan, we hire a multidisciplinary staff with expertise in mental health and substance use disorders to address the wide-ranging needs of child and adult members. All clinical staff receives extensive orientation and training prior to working and ongoing training as part of their jobs (details immediately below). It is Magellan's policy that all care management and utilization management (CM/UM) staff has access to appropriate clinical consultation with the medical director, associate medical directors, physical advisor or registered nurses needed. Clinicians coordinating and authorizing services for members with a coexisting medical and behavioral health diagnosis will be trained and demonstrate knowledge of co-occurring disorders. The Nebraska Chief Medical Officer or a designee, will be available 24 hours per day, seven days a week, for decision making and consultation with Magellan's clinical staff and network providers.

Training Policies and Processes to Ensure Adherence to Contract Standards

Training offered to Magellan CM/UM staff occurs during orientation and ongoing.

New Employee Orientation

Magellan's orientation and ongoing training ensures that: clinical staff have the training they need to maintain their professional licensing; there is consistency in the application of clinical guidelines, Care management and utilization management as well as quality management

policies, procedures, and documentation; and clinical staff are aware of and kept apprised of evidence-based practices.

All care managers complete Magellan's national and local comprehensive care management orientation. This learning approach comprises classroom instruction, computer based training, small group learning, peer observation and on the job mentoring to orient staff to the key information on clinical standards, programs, and the community based delivery system. All care managers receive ongoing training on many specific topics including diagnostic issues, psychopharmacology, operationalizing recovery/resiliency, special issues of priority populations and rural practice, discharge planning, appropriate documentation, and collaborating with community based resources, among others. Care manager calls are monitored via *Qfiniti* call recording, and staff members receive recognition on quality service delivery as well as coaching on improvement opportunities.

Ongoing Training

As an important part of their initial and ongoing training, care managers complete annual refresher training on all the topics included in initial orientation. Additionally, we conduct annual cultural competence training. We have engaged the services of Miriam Delphin, Ph.D., Co-Director, Cultural Competence and Health Disparities Research and Consultation, Yale University Program for Recovery and Community Health, to develop an online cultural competence toolkit for our staff, providers, members, customers, and general community. This toolkit contains training and reference materials, dictionaries, links to relevant sites, data, and other information pertaining to cultural competency. In addition to the toolkit, Dr. Delphin has created four and eight-hour introductions to cultural competence, training that we provide to all our public sector care management center staff and providers. continuing education credits are provided.

At the beginning of their work with Magellan, care managers are oriented to the specific priority and special needs populations that are represented in the population they will assist. This training includes cultural and other aspects of these members' usual approaches to general and behavioral health care, potential obstacles to care that are common in each of the subpopulations (for example, language other than English; issues with health literacy; disabilities such as cognitive, psychomotor or other challenges; greater than usual stigma about receiving care; isolation from supports and transportation issues in rural communities; and religious beliefs concerning care, among others), culturally-based strengths that can be used to enhance access to care (such as social and religious affiliations that can support care and recovery), how benefits and supplemental services can be used to enhance the delivery of appropriate care, and similar topics.

We assess care managers' competence with regard to cultural sensitivity and attention to pPriority and special needs populations via telephone monitoring, record audits, supervision and individual performance reviews. We also pay close attention to any complaints or grievances that contain an element potentially related to these issues. The complaints or grievances are reviewed, and may result in additional supervision or training with the care manager, and/or a performance improvement plan.

[redacted]

Inter-Departmental Case Consultation/Data Review

Magellan's matrix structure provides the context for inter-departmental decision-making and accountability. Under this structure CM/UM staff meets regularly with the service administration teams to accomplish the following:

- consult on complex cases that require the management and extended coordination with the provider agencies and stakeholder partners
- review audit, tracking and data reports to identify trends and continuous system improvement opportunities
- provide coaching and supervision opportunities for the CM/UM staff.

Magellan UM/CM Staff Requirements for Licensed Staff

Magellan will ensure that the prescribed standards for clinicians who authorize services are met. Only licensed psychologists, Independent Mental Health Practitioners (LIMHPs), and psychiatrists acting within the scope of all applicable state laws and their professional licenses shall make final decisions regarding medical necessity determination, as required by the RFP. Clinicians coordinating and authorizing mental health and substance use disorder treatment services for children and adults, including co-occurring disorders, will be licensed and trained in and demonstrate knowledge of the Principles of Care and the full array of services available to Members.

[redacted]

Our care managers have a minimum of three years experience as a licensed mental health professional and must be an R.N., or have a Master's or Ph.D. degree in an appropriate behavioral science. They have knowledge of UM procedures, mental health and substance abuse community resources, and the ability to analyze, plan, and implement solutions that influence quality of care. All care managers complete annual continuing education as required by their Nebraska State licensing board and professional associations.

Magellan's care managers are supported by Magellan's medical director, associate medical directors, physician advisors, clinical director, care management supervisors and managers, and chief executive officer.

Supervision of CM/UM Staff

Magellan currently ensures and will continue to ensure that supervisory clinical staff consists of subject matter experts in serious and persistent mental illness (SPMI) for adults and in severe emotional disturbances (SED) for children and adolescents; trauma-informed and trauma-specific care, and in developmental disabilities, substance use disorder treatment, and treatment of persons with co-occurring mental illness and substance use disorders.

Magellan ensures consistency in the application of clinical guidelines and documentation for supervision. We will:

- promote implementation of and adherence to the Principles of Care for the program
- conduct live call monitoring or monitoring of recorded CM/UM telephone calls, as well as regular tests of inter-rater reliability, to assess consistency in interpreting clinical guidelines and adherence to policies and procedures;
- conduct regular care management record reviews to monitor:
  - adequacy of documentation supporting appropriateness of medical necessity
  - adequacy of clinical documentation regarding quality of care, including assessment and treatment information and care management of high risk cases
  - appropriateness of care management and other Contractor management interventions, including the use of physician or other specialist consultation.

Ensuring Adequate CM/UM Staffing

To determine adequate staffing for a new account, Magellan utilizes underwriting formulas based on productivity measures. Staffing is activity based and developed based upon following historical utilization factors:

- number of members in service, by level of care
- admission and duration of stay if 24 hour based
- average number of sessions for non-24 hour levels of care
- type of review performed (pre-authorization, concurrent, electronic)
- unit conversion (session are 15 minutes, 1 hour, etc)
- frequency of review
- length of review (correlates to type and frequency of review).

Utilizing the factors noted above, the total number of review hours is derived. Based upon Magellan productivity standards (which allow time for supervision, training, and other job requirements), the review hours are converted to an FTE estimate. Supervisory and support

staff are also calculated. After start-up, if this number does not appear to be accurate, then Magellan immediately will staff to meet the needs of the contract.

Figure IV.N.7.1 shows the reporting relationships of Magellan's care management and utilization management staff under the leadership of the Clinical Director.

[redacted]

Describe your BH MCO's processes to coordinate care with other state agencies, NMMCP, Tribes, and in program transition.

Magellan's commitment to partnership is demonstrated through our outreach to and collaboration with state agencies, physical health managed care organizations (PH-MCOs), tribes and others that serve the Medicaid population in Nebraska. Under the new contract we will strengthen our outreach and efforts to further improve coordination with Nebraska Medicaid stakeholders, beginning in the transition and implementation process.

[redacted]

[redacted]

Magellan's Approach to Coordination of Care Across State Agencies

Magellan believes that optimal care coordination can only be effective through collaboration with providers and other agencies involved with the member. At the systems level, we conduct collaboration activities to ensure that appropriate services are provided and policy barriers are addressed.

We have established effective working relationships with Nebraska state agencies that provide services to our members. We have employed several different mechanisms for ensuring coordination of care and for developing new strategies to improve coordination across the care continuum. Clinical staff at Magellan's Nebraska Care Management Center has developed close collegial relationships with staff at MLTC, the Division of Children and Family Services (CFS), Division of Behavioral Health (DBH) and the Regional Behavioral Health Authorities (RBHA) over many years. Collaborative activities between Magellan and the agencies have included joint deliberation over lessons learned and opportunities for collective improvement, the sharing of best practices, identification of programmatic policy or geographic issues that may have impeded particular member's access to effective care, and development of solutions.

Under the new contract, Magellan will build on its relationships with state agencies and their programs and develop relationships with additional agencies, such as the Regional Department of Developmental Disabilities (DDD) and Aging agencies. [redacted]

[redacted]

[redacted]

How Magellan will Ensure Effective Coordination and Integration of Care with PH-MCOs

Magellan understands that coordination and integration of behavioral and physical health services is essential for recovery and wellness to be maintained. Therefore we have extensive experience in coordinating services with physical health providers and health plans, both as a subcontracted behavioral health vendor to health plans in other states and through coordination efforts as a stand-alone Managed Behavioral Health Organization, as is the case in Nebraska. We have been a national leader in developing effective, innovative models of integrated behavioral and physical health services. When coordination is coupled with the use of data to develop population-specific strategies and interventions, policy decisions are enhanced and the quality of services is improved.

Magellan Uses a Proven Strategy to Coordinate with PH-MCOs

Our behavioral/physical health integration strategy with the physical health managed care organization contractors and physical health providers emphasizes the importance of information sharing and collaboration. We will work collaboratively to provide added focus on those members with co-existing medical/behavioral disorders and complex health problems. Some of the mechanisms we will use include: systems level collaboration, initial orientation and ongoing training, and coordination with physical health plan special needs coordinators. Additional detail on each of these mechanisms can be found later in this section in response to the eleventh question regarding coordination with physical health vendors.

Collaboration at the Systems Level Improves Care

For the Nebraska Behavioral Health Managed Care Program, we will develop and facilitate a Behavioral Health/Physical Health Integration Meeting that includes Magellan and the three physical health managed care organizations in Nebraska: United Healthcare's Share Advantage, Coventry CARES, and Arbor Health Plan. The intent of this meeting will not be to focus on specific members that have co-occurring health conditions, but rather to address larger systems issues that can improve the care delivered to members and to assist both physical health and behavioral health providers to better coordinate care. Separate meetings with each physical health plan will be scheduled to address specific case issues.

Initial Orientation and Ongoing Training

As part of a comprehensive orientation and training, Magellan will work collaboratively with PH-MCOs to ensure that Magellan staff and network providers receive information on the medical plan benefits and how to assist members in obtaining access to needed medical services, including how to contact the physical health managed care organization special needs coordinators.

Coordination with Physical Health Plan Special Needs Coordinators

In developing individualized care plans with members, our care managers will include a discussion of the member's medical needs, which becomes a component of the member's recovery plan. Magellan invites the special needs coordinators and physical health providers to join in the recovery planning process whenever possible. We have a proven track record of implementing these collaborative approaches in Southeastern Pennsylvania and in the Lehigh Valley, most notably in our HealthChoices-HealthConnections program with Keystone Mercy Health Plan. In that program, collaboration occurs in the areas of joint clinical case review and planning for members with special needs, joint training of case managers on physical health resources available for HealthChoices members, and development of referral protocols.

Support for PCPs and Other Providers Improves Coordination

Magellan recognizes the importance of including the member's PCP in the diagnosis and treatment planning process for members receiving behavioral health services and has many years of experience doing so with public sector clients in many states. We have developed a wide range of strategies to coordinate and collaborate with PCPs to accomplish this. Mechanisms Magellan uses to support collaboration with PCPs include:

- identifying and engaging PCPs
- integrated case rounds
- PCP Consultation Line (see section *IV. G. Value-Added or Substitute Services* in the Proposed Implementation Approach)
- PCP Toolkit (see *Section IV. G. Value-Added or Substitute Services* in the *Proposed Implementation Approach*)
- expedited referrals
- online access to standardized screening tools.

[redacted]

[redacted]

How Magellan will Ensure Seamless and Effective Care Coordination During Transition

As the incumbent with a strong working relationship with MLTC, combined with our experienced implementation leadership—as described in section IV. O. Transition and Implementation within the Proposal Implementation Approach—MLTC's selection of Magellan as the Contractor for this project ensures that transition issues will be minimal and that implementation activities will be seamless and effective in transitioning Nebraska's current fee-for-service behavioral health Medicaid program to the Nebraska Behavioral Health Managed Care Program. As a result, members will continue to receive the high-quality services and effective care coordination they have come to expect from Magellan and our network providers.

We intend to maintain and build on our existing relationships with the state agencies, PH-MCOs and Tribes and will reach out to providers, as well as to current members, through regular modes of communication (e.g., newsletters, Web site portal for members and providers) to inform providers, members and other stakeholders about the transition to and implementation of the risk-based Nebraska Behavioral Health Managed Care Program and what it will mean for them.

Describe the policies, procedures, and processes your BH MCO will use to coordinate care management for those members also receiving NMMCP disease management for diabetes, asthma, hypertension, and obesity at a minimum.

Magellan understands well the complex interplay between medical conditions and mental illness. As we discussed earlier in our statement of work, it has been widely reported that persons with Serious Mental Illness (SPMI) die more than 25 years younger than others in the general population, and that in the majority of cases this is due to individuals having a combination of behavioral health issues and physical health conditions such as heart disease, chronic respiratory problems, diabetes and stroke. We also note that not only can symptoms associated with serious mental illness interfere with the effectiveness of primary care services, but primary care providers and others working in medical settings often don't fully understand how best to engage individuals with behavioral health needs in their physical health care, nor do they have adequate time, resources or tools to adequately address the multiple needs of people with serious mental illness.

[redacted]

[redacted]

Describe the content of your BH MCO's BH medical record, including the utilization control requirements and compliance with 42 CFR 456.

Pursuant to the state's clarification in Addendum Four, December 11, 2012, regarding Second Round Question and Answers for RFP Number 4166Z1, Question 31, this question refers to the BH MCO care management record not the Provider's Medical Record. 42 CFR 456 requires in part, "that the State plan provide methods and procedures to safeguard against unnecessary utilization of care and services." Later, it continues with, "the State must have in effect a continuous program of review of utilization of care and services under section 1902(a)(30) whereby each admission is reviewed or screened in accordance with criteria established by medical and other professional personnel."

Our program is designed to meet the requirements. For example, we have established Medical Necessity Criteria Guidelines to assist in safeguarding against unnecessary utilization of services and we hire and train clinical staff to understand that our mission is to provide quality care in a cost effective manner. Our BH MCO care management record will support adherence to the requirements of 42 CFR 456 because it has been designed to assist our clinical staff in making decisions based on medical necessity and quality care.

All care manager activities are documented in Magellan's clinical database (called "*IP*"). This allows the care manager to have a consolidated set of screens in which to document and track care management activities. Many of the care manager activities are documented in a pre-coded note. Customized pre-coded notes ensure that all pertinent case information is captured by the care manager. The template includes prompts for the care manager to document that service planning and care coordination are oriented toward recovery, resiliency, and person-centered approaches to care. For example, the template includes verification that providers know whether or not the member had developed an Advance Directive and if treatment is consistent with the member's stated desires. The pre-coded notes also assist the authorization process is based on medical necessity.

See **Attachment W** for a sample note that is utilized for inpatient psychiatric authorization reviews. The attachment includes both the pre-coded notes for the initial review and subsequent reviews and illustrates the data elements Magellan collects.

The system presents authorization, utilization, and documentation history in a concise, easy-to-access, efficient format. For members in the Recovery Care Management (RCM) program, records are managed and documented in the same system, effectively streamlining the coordination of care process. RCM Care Managers will use this system to identify members that are readmitted to inpatient or 24-hour levels of care and will ensure the course of treatment and discharge plan are adjusted and tailored to each member's individual needs.

We are confident based on our extensive experience that the information we collect in IP safeguards against unnecessary utilization of care and services. Our precoded notes greatly enable the collection of the requisite information to make an informed and proper medical necessity determination. We gather the relevant information from the provider regarding assessment, diagnosis, and treatment plan. Then, we evaluate this information against our medical necessity criteria allowing us to make an effective determination.

Describe how your BH MCO will coordinate with the contracted physical health vendors to meet legislative and the RFP requirements.

[redacted]

[redacted]

[redacted]

Magellan Knows Nebraska

Magellan is experienced in coordinating services with physical health providers and health plans, both as a subcontracted behavioral health vendor to health plans in other states and

through coordination efforts as a stand-alone Managed Behavioral Health Organization, as is the case in Nebraska. We hold regular joint meetings with Nebraska's Physical Health Managed Care Organizations to review individuals with complex medical and behavioral health needs and formulate multidisciplinary care plans incorporating the use of community resources.

We will attend and participate in all relevant MLTC meetings and workgroups as directed by the MLTC to target medical and behavioral health integration. Magellan will also support related required functions through the contractor's care management and UM systems. To promote coordination of behavioral health and physical health care at the broader system level Magellan will, at a minimum, partner with the PH-MCOs (UnitedHealthCare's Share Advantage, Coventry's CARES, andd Blue Cross's Arbor Health) to:

- Provide information to primary care physicians (PCPs) to promote the appropriate diagnosis, treatment and referral of BH disorders commonly seen in primary care;
- Ensure appropriate use of psychopharmacological medications and consistent guidelines for prescribing by behavioral and medical practitioners that includes review of psychopharmacological medication pharmacy benefits and formularies;
- Ensure timely engagement of behavioral health treatment for members with co-existing medical and BH disorders.

Collaboration at the Systems Level Improves Care

For the Nebraska Behavioral Health Managed Care Program, we will develop and facilitate a Behavioral Health/Physical Health Integration Meeting that includes Magellan and the three physical health managed care organizations in Nebraska: UnitedHealthcare, Coventry, and Arbor Health Plan. The intent of this meeting will not be to focus on specific members that have co-occurring health conditions, but, rather, to address larger systems issues that can improve the care delivered to members and to assist both physical health and behavioral health providers to better coordinate care. Individual member issues will be addressed through our care coordination approaches (see the response to the fourth question in this section relating to the processes and criteria for care management).

The goals of the meeting will be to:

- maximize care and clinical integration in order to ensure person centered care
- develop an integrated formal information management process to maximize collection and sharing of appropriate clinical data to maximize care coordination
- develop an operational structure to ensure attainment of all goals, including procedures and work flows.

Magellan will establish relationships with the plans and utilize several mechanisms for coordination between behavioral health and physical health at the system level, and among Magellan's RCM Care Managers and the health plan disease management care managers to ensure effective coordination at the member level.

Collaboration on Policies, Metrics and Training is Essential

Magellan will also establish regular collaborative meetings between Magellan's leadership and the physical health managed care organizations as a group, as well as offer to participate in collaboration with each health plan individually. Magellan has found that group meetings provide a forum for discussing issues that may pertain to quality of care, care coordination or access to services at system wide level. This enables proactive development and implementation of solutions statewide for issues which may have only been identified by one plan or in one area.

We will utilize these joint meetings to:

- develop linkages and policies that will promote effective communication, coordination and collaboration across medical and behavioral health care providers
- agree on metrics for assessing the effectiveness of medical and behavioral health service integration
- develop agreed on education and training mechanisms regarding effective integration of physical and behavioral health care.

We will also invite the health plan medical leadership to participate on the Clinical Advisory Committee. This will provide health plans with another meaningful opportunity to interact with Magellan's clinical staff as well as with our shared members, providers and other stakeholders.

Given that there may also be issues that are particular to one Nebraska region, Magellan may also establish routine meetings by region and include the regional behavioral health authorities. In Nebraska, Magellan has found that meeting with the health plans as a group has yielded multiple opportunities for improved outcomes for Nebraska Medicaid Members. Magellan and PHMCO staffs have been able to more closely examine the complex and co-morbid behavioral health and physical health care issues which are negatively impacting the lives of members and leading to multiple or frequent visits to hospital emergency departments. Many of these members have outpatient behavioral health and/or primary care providers. With the shared goals of improving their quality of life and maintaining their service delivery in community-based settings, we have been able, as a result of these joint meetings, to work closely with these community-based providers to strategically change both treatment and treatment planning for these Members.

Communication across Care Management Programs Achieves Results

Acknowledging that each health plan has its own disease management approach, Magellan will establish regular meetings among Magellan's RCM care managers and each health plan's disease care managers to familiarize our respective care management staff with one another's services and approach and to discuss specific cases and referrals. Discussions will focus on how to better serve individuals with co-existing behavioral and physical health conditions. Feedback from these meetings will help us enhance coordination of services and set and manage to ongoing expectations. Monitoring is then conducted through follow-up meetings and during the course of ongoing care management activity to improve coordination of care.

[redacted]

Provide a description of your BH MCO's proposed QAPI program. Include the following in your description:

- *The lines of accountability for the program*
- *How you will select areas of focus*
- *How you will use evidence based practices in developing your quality assurance program*
- *How you will use data to design and implement your quality assurance program*
- *The staff who will be assigned to this program and their qualifications*
- *Explain how your BH MCO will ensure separation of responsibilities between utilization management and quality assurance staff.*

The chief goal of Magellan Behavioral Health of Nebraska, Inc. (Magellan) is to ensure the provision of quality behavioral health care, prevention, and support services in a safe, efficient and effective manner to Nebraska Medicaid and CHIP members. To support this goal, Magellan has developed a governance and quality assurance and performance improvement program designed to continuously improve the quality of care and services provided to all our Medicaid and CHIP members, and to identify and act upon opportunities for improvement. For ten years,

Magellan has been working collaboratively with MLTC in Nebraska in effectively managing and monitoring the quality of care provided to its members.

> "Magellan has an extensive infrastructure, has nurtured statewide relationships across the spectrum of consumers and providers, has multi-state and Nebraska-specific experience, and seeks to facilitate the highest standards in regards to behavioral health care. Magellan is the only company that has the networks, services, personnel, and values that would build upon our meager resources rather than throw us even deeper into chaos, fragmentation, and confusion."
>
> Alan Smith, PhD, Scottsbluff, Nebraska

[redacted]

[redacted]

[redacted]

Consumer-Family Evaluation Teams

The Nebraska Care Management Center (CMC) recognizes the need to respect and incorporate the preferences of consumers and families as a core strategy for improving the quality and effectiveness of care. Magellan will collaborate with MLTC to develop an approved consumer-family evaluation component prior to implementation. [redacted]

[redacted]

Magellan Behavioral Health of Nebraska will comply with the requirements of the RFP in establishing, educating and training, and financially supporting CFSTs to conduct evaluations and participatory action research, and will comply with reporting requirements. We will build on the CFST models we implemented elsewhere in developing this important resource designed to improve our performance.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Selecting Areas of Focus

Each committee reviews specific performance indicators defined in the annual QAIP Work Plan. Committees will monitor data findings and outcomes and focus on items not meeting standards, outliers, negative trends, and indicators of over- and under-utilization. Committee members perform root cause analyses to identify barriers and strategies for improvement. A committee will refer an issue to a specially-formed work group for further analysis and intervention, when necessary.

Use of Evidence-based Practices in Developing the Quality Assurance Performance Improvement Program

We embrace the basic principle that quality decisions are best made, and processes developed, when based on empirically supported research, and continually assess how our quality programs, internal and external processes are consistent with current evidence-based best practices.

Magellan adopts clinical practice guidelines which are founded upon published evidence-based scientific and clinical literature that is specifically relevant to the needs of our members. Consequently, the guidelines promote high quality care by integrating available empirical research, favoring decision that will support quality outcomes.

From what our care mangers and Physician Advisors assess during clinical reviews, to quality items examined during treatment record reviews, to which provider trainings we offer, to policy development – we continuously strive to educate and to identify barriers to best practice.

[redacted]

[redacted]

[2] Six Sigma is a disciplined, data-driven approach and methodology for eliminating defects (driving toward six standard deviations between the mean and the nearest specification limit) in any process.

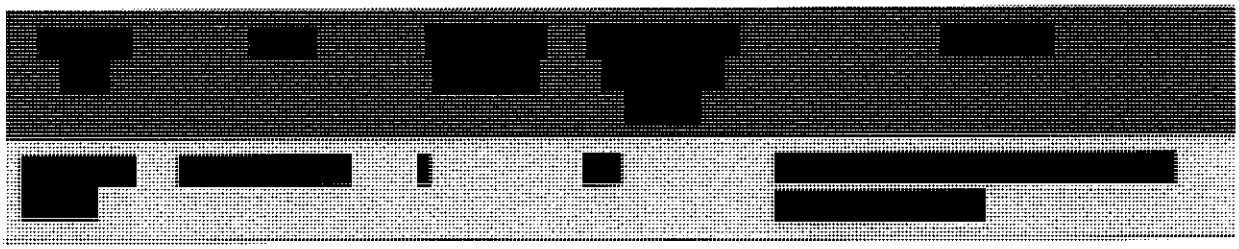
[redacted]

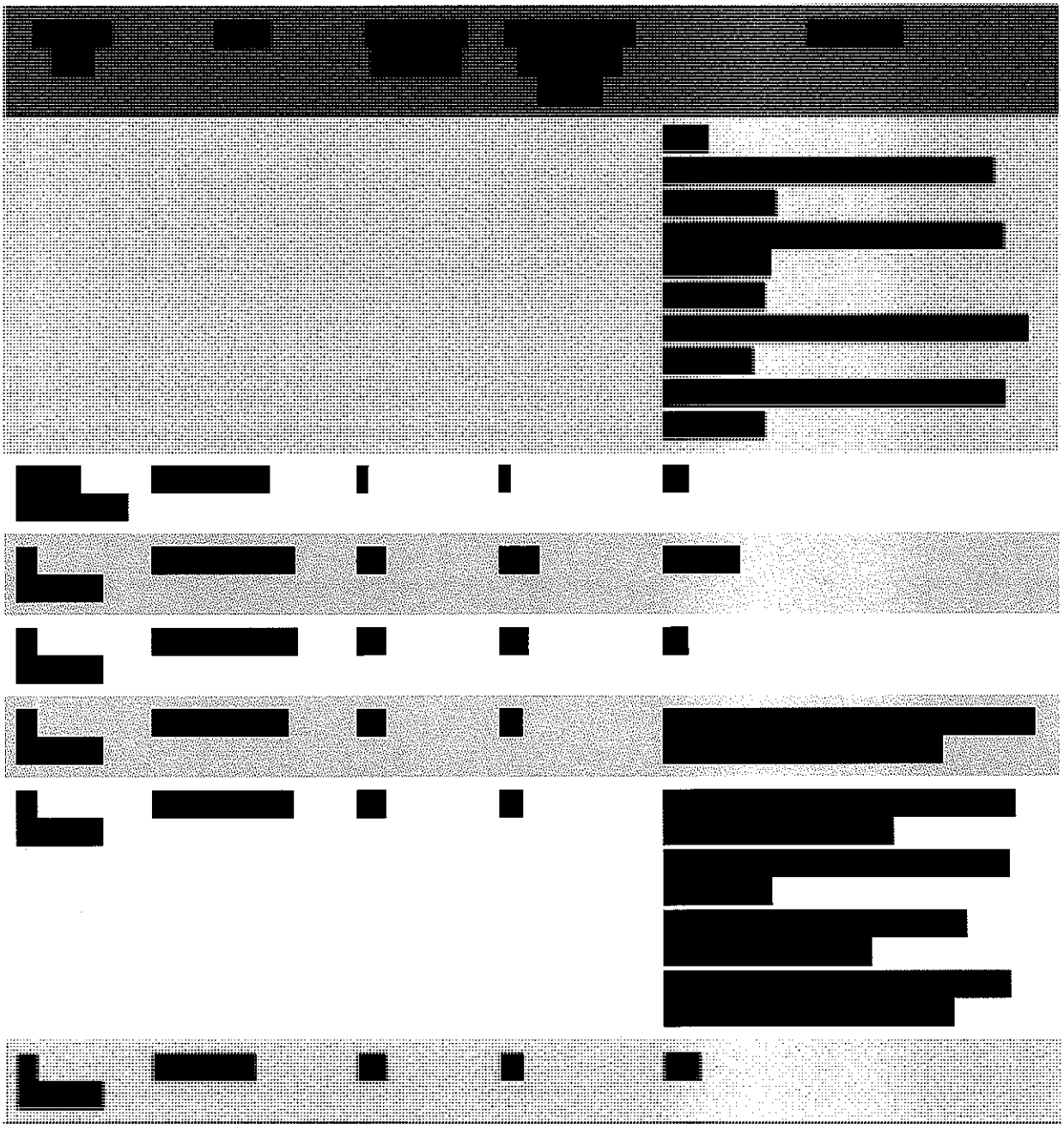
All aspects of operations including member services, audits, provider performance, clinical processes and outcomes are appropriate areas for performance improvement. Quality staff and others will lead the use of DMAIC tools, including Pareto charts, histograms, fish bone diagrams, run charts, process maps, and brainstorming techniques, to understand issues and their root causes. Once customer expectations are defined, data is captured, trended and analyzed for root causes of below goal performance. Measurable interventions are developed and implemented to improve performance, information is disseminated throughout the organization and feedback received through internal feedback loops including the quality improvement committee structure. The quality committees monitor the progress of assigned areas including performance metrics, stakeholder input and quality project interventions and actions required within each of their respective areas of responsibility. Committees report at intervals designated in the annual quality plan to the QAPI, which oversees the quality program goals and achievements.

Data quality checks are built into all processes that touch data. This includes data integrity and completeness checks as data is loaded and standardized. Quality checks used to verify data integrity include comparisons against expected values, domain analysis, and comparisons to standard code sets/values.

[redacted]

[redacted]





Maintaining Separation of Responsibilities between UM and QI Staff

Magellan Behavioral Health of Nebraska has an established Quality Department that is separate and distinct from other CMC departments or programs. Having a Quality Department separate from other departments is designed to reduce bias and provide a system for independent assessment and thorough self-appraisal so that continuous quality improvement is maintained across the entire system. Utilization Management and Quality Improvement staff will work collaboratively on quality improvement projects, but to ensure objectivity, have independent reporting lines up through the organization.

Describe your BH MCO's process to evaluate its own QAPI program.

[redacted]

[redacted]

Service Effectiveness Reporting Enhances Nebraska CMC Accountability to MLTC

In addition to the *Quality Program Description, Quality Program Evaluation,* and *Quality Work Plan,* and under the direction of the MLTC, the Nebraska CMC will report all QAPI program activities and outcomes to the Governance Board, EQC, and MLTC on a quarterly basis through the Service Effectiveness report, following the DMAIC process described above. The Service Effectiveness report contains defined processes key to Nebraska CMC's operations and functions; reports measurements on each process; provides description analysis of quarterly outcomes; identifies areas requiring performance improvement; and specifies actions steps to achieve improved results.

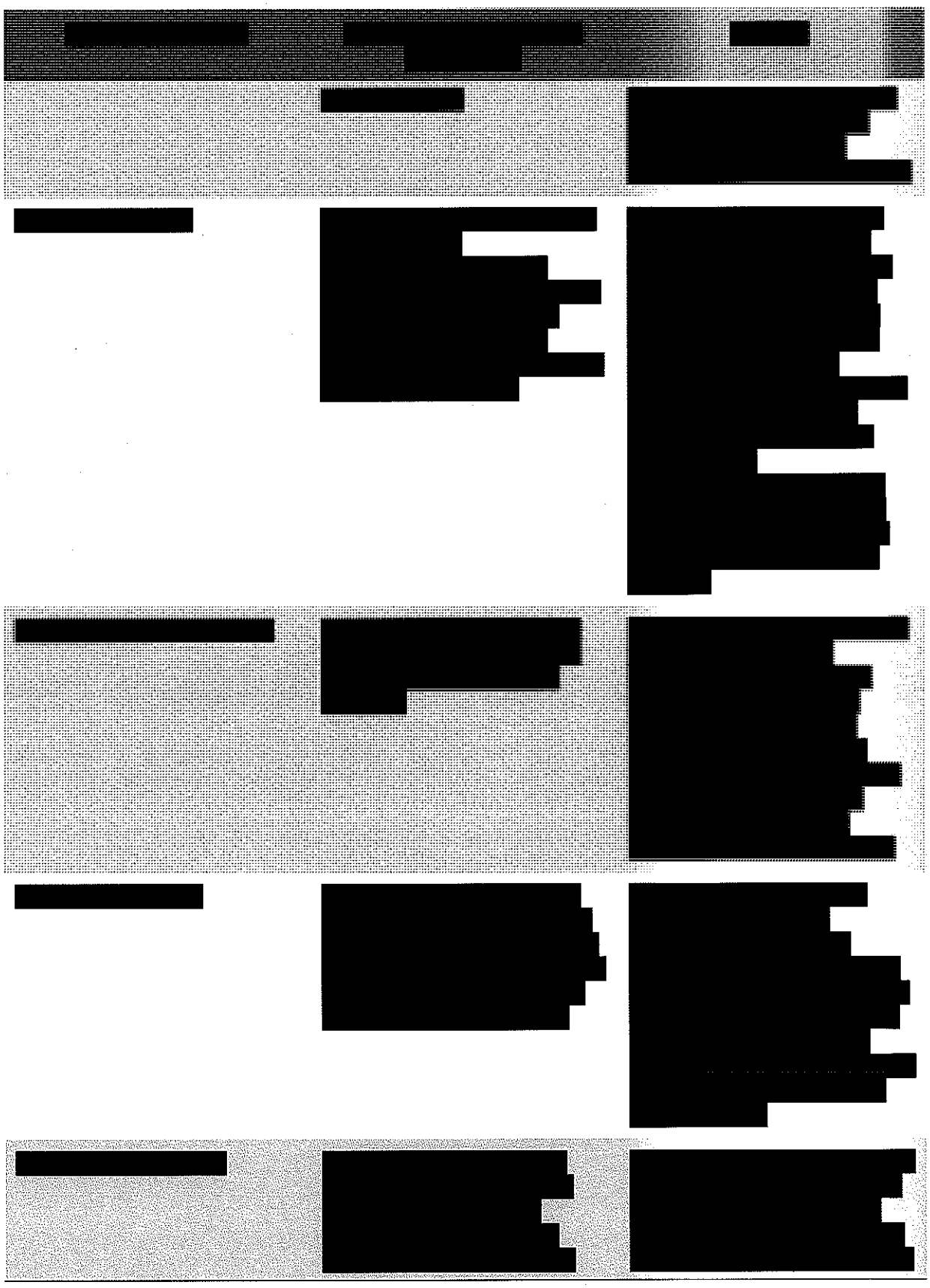
Provide examples of innovative and unique performance improvement projects conducted by your BH MCO including how these projects were selected as a focus of your program.

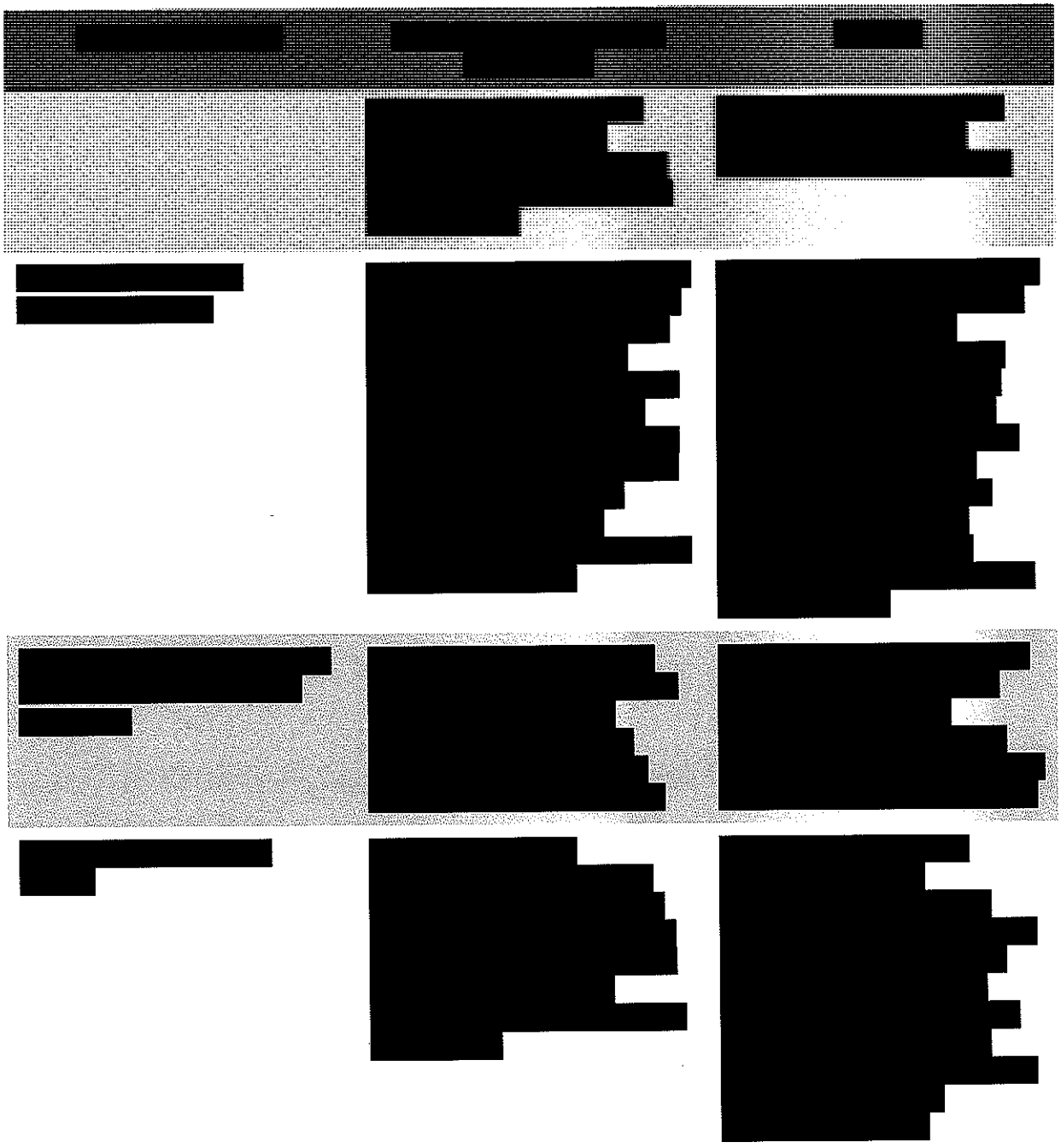
The scope of Magellan's Quality program includes the objective and systematic monitoring of the quality and safety of behavioral health care and services provided to Members. Systematic

quality processes are employed using the DMAIC approach to insure the timely identification of critical variables and their root causes (barriers). The DMAIC approach is summarized above in Figure IV.M.12.2.

Innovative and Unique Performance Review Projects in Nebraska

Magellan of Nebraska has demonstrated expertise in the development and implementation of innovative improvement projects. Examples of 16 projects for which Magellan has shown meaningful improvement are summarized in Table IV.N.14.1 below:





Describe the policies and procedures your BH MCO will put in place to control avoidable hospitalizations and hospital readmissions.

Magellan Behavioral Health of Nebraska maintains a philosophy of care to provide the least restrictive, community-based treatment that is safe and effective. As reflected in our care management policies and procedures, we have designed and will implement our care model to ensure that members obtain timely and appropriate care in the most appropriate setting.

[redacted]

[redacted]

[redacted]

[redacted]

Magellan's Hospital Partnerships to Reduce Unnecessary Admissions and Avoid Readmissions

Magellan Behavioral Health of Nebraska holds monthly meetings with network hospitals and sends out quarterly reports to each hospital that examine 30-day readmission rates and ambulatory follow-up rates. We also meet face-to-face and telephonically each month with the two largest hospitals in Nebraska. Sharing our results on a regular basis with hospital leaders enables us to discuss trends and outliers on readmissions and follow-up rates, and to work collaboratively to develop steps to improve the delivery of care. Examples of recent experiences with Nebraska hospitals to improve 7-day ambulatory follow-up rates and 30-day readmission rates are described below.

[redacted]

[redacted]

Describe how your BH MCO will identify provider utilization patterns to improve care and reduce costs.

We have developed and continue to improve our approaches to identifying provider utilization patterns to improve care and reduce costs. When we improve quality, often cost reduction follows. We systematically analyze utilization data for under- and over-use, and rely on our Utilization Management Committee in fulfilling its monitoring and oversight role to examine utilization patterns and make recommendations for improvement. We also engage providers directly in our efforts to measure, report and improve the quality of care and appropriateness of services. Under our new contract with the state, we will also introduce innovative tools for engaging members in our initiatives to improve the quality and cost-effectiveness of care.

Detecting Under- and Over-utilization

Monitoring and assessment of over- and under-utilization is a core Magellan quality activity that supports our care management commitment to assure that members receive the right amount care at the right level of care. We are equally as concerned with any under-utilization as we are with over-utilization. We detect under- and over-utilization of services through the systematic use of utilization and outlier reports. Findings are compared to established thresholds to identify outliers and negative trends. Thresholds are based on national and regional data and standards set forth by the contract. Analysis of utilization data is supplemented by an examination of other indicators that may support findings. For example, the number and nature of complaints, grievances and appeals related to access or the authorization process may further substantiate suspected over- or under-utilization findings and provide insight for analytic purposes. Member and provider satisfaction survey outcomes and access measures serve a similar purpose. In

addition, we analyze the characteristics of outlier cases in order to determine factors that may impact utilization trends. Examples of indicators used to detect and correct over- or under-utilization of services include the following:

- discharges from inpatient mental health services per 1,000 members,
- average length of stay for mental health inpatient admissions,
- rate of readmission within 30 days of discharge from an inpatient admission (for both mental health and substance abuse),
- compliance with the seven day aftercare follow-up care services requirement,
- access to service and care at urgent, emergent, and routine levels of need,
- analysis of appeals and grievance data related to service access and utilization,
- member and provider satisfaction survey results compared to standards for utilization, authorizations, and access, and the
- number of member and provider complaints related to utilization, authorization, and access.

[redacted]

At contract award, we will meet with MLTC to modify and/or expand the list of indicators used to detect and correct over- or under-utilization of services, as relevant to meet specific local needs.

Engaging Providers and Members In Performance Improvement and Cost-Effectiveness

[redacted]

[redacted]

Member Education in Quality Improvement

What additionally sets Magellan apart from our competitors is our approach of member education. Before proceeding to the Nebraska Dashboard, the user is offered a statement of how to use the dashboard from a member or family perspective. For example, the average length of stay is explained and shows the average length of time individuals have been inpatient and the most common length of time, so that members and family can better plan. Each measure is followed with a suggested action for the member or member family. Once implemented, we will continue to review the Nebraska Dashboard with members and family to improve our consumer education and dashboard usefulness.

[redacted]

[redacted]

Describe your approach to utilization management, including:

- *Lines of accountability for utilization policies and procedures*
- *Timelines for decisions and notices within the service authorization required limits outlined in 42 CFR 438.210(d)(1)*
- *Data sources and processes to determine which services require prior authorization and how often these requirements will be re-evaluated*
- *Process and resources used to develop utilization review criteria from non-participating providers or for members who require expedited prior authorization*
- *Processes to ensure consistent application of criteria by individual clinical reviewers.*

Magellan's approach to utilization management is to maximize the use of services that support recovery and resiliency, match services to each member via cultural competence and evidence-based practices, and ensure that services are provided along the full continuum of care. To meet these goals, our UM program guides clinical decision-making that includes the member's broader recovery and resiliency needs. Our UM program is designed to provide quality of care, full access to care, oversight of routine outpatient care, focused oversight of acute inpatient levels of care (LOC), and use of clinically driven triggers to identify those members in need of additional support.

Magellan's Care Management (CM) staff, as described below, does much more than make LOC determinations. The team provides care coordination and outreach, refers members to appropriate providers and services, works with members and providers in culturally appropriate ways, identifies members who are in need of more intensive monitoring or support, and consults with providers on issues of fidelity to practice guidelines and unmet service needs.

Our philosophy and approach to UM are detailed in our written UM Program Description and clinical policies and procedures which are tailored to the State of Nebraska to reflect local goals, objectives, and requirements.

Lines of Accountability for Utilization Policies and Procedures

Everyone is responsible for assisting in improving care and cost effectiveness from the CEO to administrative staff. Additionally, Magellan uses an effective committee structure, as described above in the twelfth response of this section, with extensive stakeholder input, to promote ongoing communications and collaboration among our clinical and quality programs, other areas of the organization, and external entities that include members, providers, and MLTC.

[redacted]

[redacted]

[redacted]

Timelines for Decisions and Notices Within the Service Authorization Required Limits Outlined in 42 CFR 438.210(d)(1)

Magellan has reviewed, understands, and will meet or exceed all requirements of 42 CFR 438.404 related to grievances, complaints and appeals, authorizations. Magellan currently reviews mental health and/or substance use disorder services for Medicaid care to determine if the service is medically necessary and appropriate for payment, according to the attached flow chart and manual. For acute inpatient services we have a 72-hour turnaround from the time of request to final determination. All other levels of care have a five-day response time from request. We will not do a review when a member is in an emergency. For inpatient admissions, hospitals are required to contact us in the first 24 hours of admission.

[redacted]

Over the ten years of Magellan's operations in managing Medicaid behavioral health services in Nebraska, the Medicaid fee-for-service system for behavioral health care services has evolved through our partnership with MLTC. For example, we made modifications to prior authorization requirements for outpatient services based upon data analyses and discussions with MTLC.

Below is a case study that demonstrates our record in measuring quantifiable outcomes s to improve the prior authorization process to better support our providers in providing appropriate and timely care to our members.

[redacted]

Process and Resources used to Develop Utilization Review Criteria from Non-participating Providers or for Members who Require Expedited Prior Authorization

Utilization Review Criteria for non-Participating Providers

Magellan uses the same utilization review criteria for non-participating providers as for network providers. For acute inpatient services we have a 72-hour turnaround from the time of request to final determination. All other levels of care have a five-day response time from request. We will not do a review when a member is in an emergency. For inpatient admissions, hospitals are required to contact us in the first 24 hours. However, for non-participating inpatient hospitals, we will conduct a retrospective review if the hospital does not contact us in advance of admission.

Expedited UM Service Authorization Review

Magellan conducts expedited service authorization reviews when either of these conditions occurs:

- Magellan identifies the review as an expedited clinical situation.
- The provider, or Magellan, determines that the application of the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
- We complete expedited reviews as expeditiously as the member's health condition requires, but no later than three business days after the receipt of the request.

We consider an expedited review to be complete when:

- A service authorization determination is made in accordance with notification requirements as outlined in the applicable State Medicaid contract, based on a medical necessity decision or an administrative reason.
- In the case of an adverse service authorization determination, written notice is given to the member and provider.

Processes to Ensure Consistent Application of Criteria by Individual Clinical Reviewers

Magellan understands that clinical review criteria must not only be based on solid research and clinical expertise, but must be applied consistently to be useful. We utilize many tools that together comprise a comprehensive approach to ensuring consistent application of medical necessity criteria (MNC) in the authorization decisions that clinical reviewers make. We use the techniques, described below, to audit and improve our authorization decision-making for requested services. Continuous quality improvement is central to our approach.

Local and Magellan National Inter-rater Reliability Review

In order to demonstrate consistent application of medical necessity criteria by care managers, inter-rater reliability audits are completed monthly under the direction of the Nebraska Medical

Director and Clinical Director for the Nebraska CMC clinical staff. Case vignettes are developed to test knowledge and accuracy in applying the medical necessity criteria. Each month, the care management staff processes each vignette and the results are used for training the staff. In this process, each Care Manger reviews a current and actual application (vignette) and determines authorization or need for a peer review. Case vignettes cover all levels of care and treatment specializations.

The Nebraska CMC clinical staff also participates in Magellan's corporate annual Inter-rater Reliability Review. Magellan's clinical policy provides for annual measurement of the consistency of application of medical necessity criteria by clinical care management staff, physician advisor consultants, and medical directors. Magellan's Corporate Clinical Department employs a company-wide, standardized process for the review of inter-rater reliability for our behavioral health programs. The measurement process conforms to customer, National Committee for Quality Assurance, URAC, and licensing requirements. The annual inter-rater reliability study establishes a process with all clinicians reviewing an identical set of vignettes to measure the national inter-rater reliability performance rate.

[redacted]

Documentation Audits

Documentation audits are incorporated into Qfiniti audit capabilities. As described in general terms above, Magellan's clinical supervisors complete three clinical documentation audits per care manager, per month, with a target of 90 percent compliance or better. The audits monitor consistent application of criteria, compliance with policy, customer-specific requirements, and accreditation requirements. Care managers receive copies of their monthly audits and are coached in areas of documentation noncompliance. Also, each month, the medical director audits cases completed by each of the Magellan-contracted external physician advisors to ensure they are documenting the medical necessity criteria and level of care guidelines met/not met and are offering an alternative level of care, if a request is not authorized. Results are reviewed with each physician advisor if non-concordance between the physician advisor's decision and the medical director's review decision is evident. Additional training or monitoring is instituted as needed. Results of the monthly physician advisor audit are presented in the monthly medical director's report to the Quality and Utilization Management Committees.

A member of the QM staff monitors the electronic desktop fax file folders of the care management staff. At least twice weekly, the QM staff accesses each care manager's desktop fax file folder and views the contents to ensure that the documentation (for example, packets or

treatment authorization requests) are being reviewed and clinical determinations are being made within the time frames. If any documents in any of the folders exceed the time frame standards, we inform the clinical supervisor who follows up with the appropriate care manager.

[redacted]

[redacted]

[redacted]

[redacted]

IV.N. Health Information Requirements

Describe a general description of your BH MCO's Health Information System, including:

- *A systems diagram that describes each component of the system;*
- *How each component will support the major functional areas of the NMMCP;*
- *Documentation that ensures data received from providers is accurate and complete; and*
- *How the BH MCO's system will interface with the State system.*

Magellan's Class-Leading Technology Solutions

Magellan's state-of-the-art information systems and reporting capacity is a key factor in the success we have had in Nebraska and nationally in achieving high levels of satisfaction with our members, providers, business partners, customers, and other stakeholders. We operate three geographically dispersed data centers in Arizona, Missouri, and Maryland, all of which are linked to each of Magellan's field operations through our Wide Area Network (WAN).

Magellan has been operating in Nebraska since June 2002, and we are intimately familiar with the contractual operating and reporting requirements of the Medicaid and Long Term Care (MLTC) programs. However, our reporting and other analytic tools go far beyond the basic contractual requirements. They assist managers at multiple levels within the Nebraska system to make decisions that are informed and supported by our extensive data tools and resources.

Magellan brings more than 10 years of experience serving Nebraska's communities, and more than 17 years of information technology experience and expertise serving public sector contracts across the nation, including Maricopa County (Arizona), Pennsylvania, and Iowa. Through these accounts, among many others, we have gained significant experience administering risk-based Medicaid programs across the country. We look forward to the opportunity to add claims adjudication and payment processing to the list of services Magellan currently provides to the MLTC programs.

Magellan supports the MLTC programs locally from our Care Management Center (CMC) located in Lincoln, Nebraska. This CMC is staffed with professionals who are fully dedicated to ensuring the success of the MLTC programs. The Information Technology Director, Patricia Ryan, is responsible for the oversight and coordination of IT and Reporting related projects and functions for Nebraska and will ensure that the State's needs for Information Technology and Reporting are met.

Magellan owns the source code for our applications, allowing our IT team to configure our systems to meet the specific needs of the MLTC program. We do not subcontract any part of our claims adjudication processes, ensuring a single point of accountability and performance.

[redacted]

[redacted]

[redacted]

Over all of these elements of the system are the business intelligence applications such as Cognos, which are used to interrogate the data marts for reporting the data collected to meet the MLTC requirements.

Security is the top priority for Magellan. We are able to control the flow of information to ensure least privileges when making client data available to internal users and external business partners. We employ role-based access protocols to ensure a strict security governance structure is in place to ensure our continued compliance with HIPAA, including the HITECH Act, as well as State and Federal laws.

Supporting Applications

[redacted]

Integrated Product

[redacted]

[redacted]

This data is held within the authorization system indefinitely and the IP system has the ability to provide tracking of prior authorizations for inpatient and outpatient services, as well as concurrent review of services in increments.

[redacted]

[redacted]

In addition, the system automatically schedules activities for concurrent reviews based on the next review date that is assigned at the time an authorization is entered into system. The system presents a list of activities due to the care manager in order of their due dates, in ascending order. However, the care manager can elect to sort or filter these activities based on specific criteria, such as a specific activity, member name, case number, or level of care. The list of activities can easily be expanded to meet Magellan's ongoing needs and/or to address unique activities that may be part of a contractual agreement.

[redacted]

[redacted]

[redacted]

The system includes data elements to track third-party liability payments and receipt dates necessary to calculate claims processing timelines, and all applicable fields required to provide encounter data in accordance with the requirements of the MLTC contract. Provider rates and payment arrangements are entered into CAPS by Magellan's network department staff. The information is accessed during the adjudication process, applying MLTC network rates and discounts as defined by the configuration.

A more detailed discussion of our claims system and claims processing workflow is included in our response to the fourth question below.

Eligibility System

The eligibility system of CAPS maintains relevant MLTC member profile data, including enrollment per eligibility date spans, benefit plans (i.e., types of coverage), historical data (i.e., enrollment audit trail), and demographic data (i.e., member ID number, social security number, date of birth, gender). Enrollment data is received from the State on a daily and monthly basis, and is uploaded into the eligibility system. Once loaded, eligibility information is used by the clinical/authorization system (IP) for establishing benefit plans and approving services. Consumers can be located within the system using various search elements, including member ID number, name, and social security number.

Complaints and Grievances System

Magellan maintains a Complaint and Grievance Tracking System database in Nebraska to capture all non-authorization, complaint, and grievance data required to meet the Department's reporting requirements. From this database, we process grievances and issue automated reminders to staff when decisions and notices are due, based on required timetables. We maintain information in the database regarding the original grievance, the decision made, and the nature of the decision to support performance monitoring and reporting. We use this information to monitor complaint and grievance activities, as well as compliance with Department timeframe requirements. As part of ongoing quality management activities, the complaint and grievance team review and monitor these reports, as does the Member Services Committee to determine if there are any areas that should be targeted for intervention. Adherence to timeframes and any trends is also reported to the Quality Assurance Program Improvement (QAPI) Committee.

[redacted]

Magellan's Accounting Department includes experienced, highly educated financial professionals, including certified public accountants and individuals with bachelors and masters degrees. The staff is trained to separate funds and expense reporting specific to contracts.

State Access to Client-Level Data

Magellan is committed to ensuring the Department has all of the information it needs to effectively monitor the progress and success of the MLTC programs. Magellan has great experience meeting the Department's information needs under the current contract, and we will continue to make client-level data available to the department. Being able to work in an integrated environment with claims and authorizations all part of the same system will greatly enhance the types and kinds of reporting available to MLTC. Magellan understands the importance of timely, relevant information, and we will work with the State throughout the implementation period to determine the availability of any additional information needed to support the Department's efforts.

Magellan's Operating Environment

[redacted]

[redacted]

Magellan's Data Center

Magellan's data center is located on the second floor of a multi-tenant building located at 13500 Riverport Drive in Maryland Heights, Missouri. Entrances to all Magellan occupied spaces are secured with alarm sensor and proximity access control systems that are monitored and controlled by Magellan. The data center computing facility consists of 6,700 square feet of raised floor and air conditioned space. After-hours access to the building is controlled by proximity access control sensors located at each door. Photo ID badges must be worn and displayed at all times while on the premises. Figure IV.N.1.2 presents a depiction of the robust IT framework Magellan's Data Center Operations team manages on a day-to-day basis.

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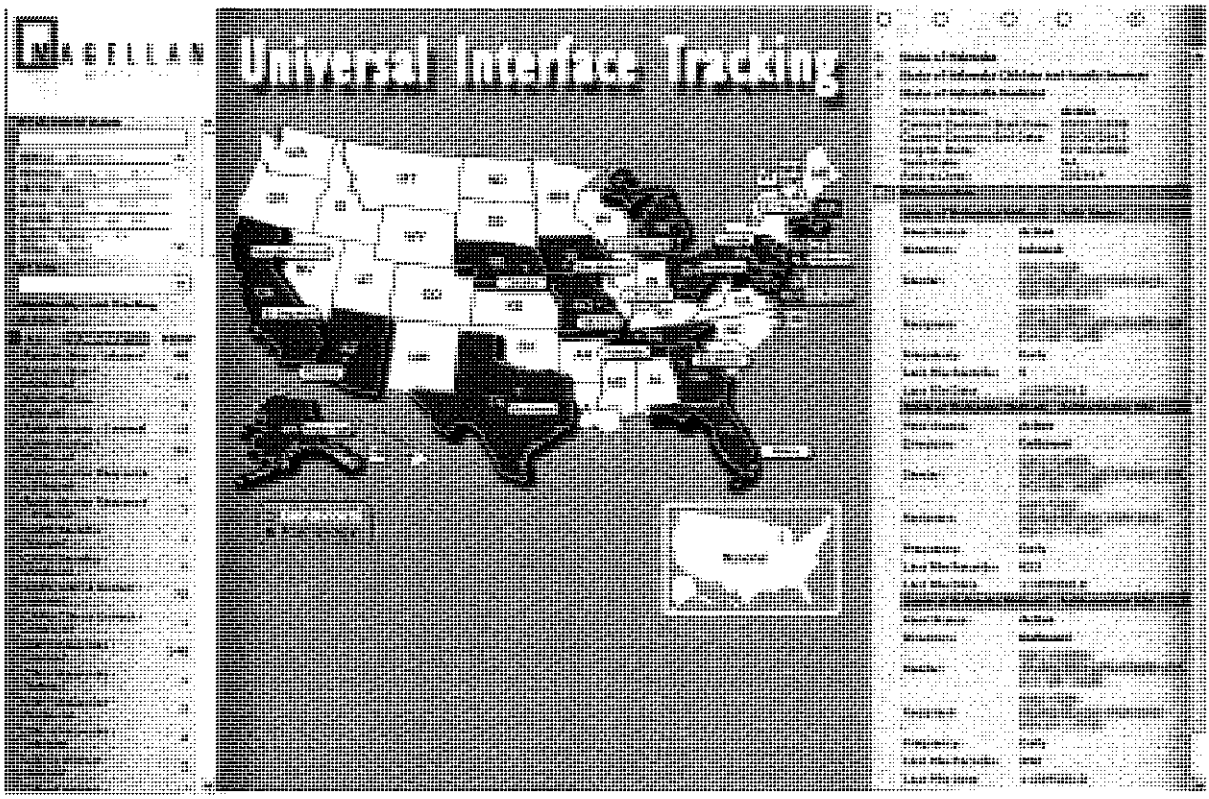

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MagellanofNebraska.com

MagellanofNebraska.com is dedicated to Nebraska's providers and members, and is currently compliant with Nebraska's Technology Access Standards, as required by Section III.VV of the RFP. The Web site increases the accessibility of information specific to providers and members in Nebraska. [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Identifying and Communicating Disasters/Emergencies

Magellan's Emergency Management Team declares emergencies and coordinates disaster recovery efforts. The Management Teams from the Information Services Department support the Emergency Management Team. Updated information is provided to the Administrative Support Team, Information Services Support Center, and the National Vice President of Operations of Magellan every two hours or as warranted.

The following steps are followed in response to an event:

- When identified by a CMC employee, potential disasters are immediately reported to a member of the Emergency Management Team.
- The Damage Assessment Team evaluates the situation and communicates their findings with a recommendation to the Emergency Management Team.
- The Emergency Management Team members confer on the findings from the Damage Assessment Team. The Emergency Management Team meets to assess the scope and impact of the disaster and decides whether to declare a disaster.
- The Recovery Teams review the recovery plans and initiate the recovery action plan with respective team participants.
- The Emergency Management Team reviews recovery progress, as required.

Communication of Status Updates

The Administrative Support Team creates and maintains a voice mail general announcement, with status updates, that all staff are required to call in the event of an emergency. This Service Center Emergency Notification Voice Mail extension provides updates on the current emergency status and directions staff members should follow. The responsible manager and/or designee(s) contact all staff members within four hours of a declared disaster. They are informed of the nature of the emergency and their assigned roles.

Reassignment of Calls to Ancillary Service Center Offices

In the event of an emergency in which telephone services are disrupted, incoming telephone calls are diverted to the designated backup service center office until services are restored. Care Management Center CEOs 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 CEO ensures all impacted customers are notified of the disaster, status of operations, and plans to recover.

The Emergency Management Team is contacted for authorization to reassign incoming calls. This includes coverage for disasters that have short time frames, such as fire alarms or disaster drills.

[redacted]

Though it is rarely required, the plan is continually tested. Each CMC conducts an annual fire drill which launches disaster recovery protocols. Each time it has been executed flawlessly with no dropped calls or system down time.

Data Center Recovery Strategy Overview

Magellan has taken steps, to the extent possible, to eliminate or reduce to a minimum, unplanned data and telecommunication systems outages using current hardware and software technologies. Backup power generation systems, environmental and systems monitoring applications, hardware and network redundancies, mirrored disk, and data replication are some of the technologies utilized to reduce downtime exposure during normal day-to-day operations.

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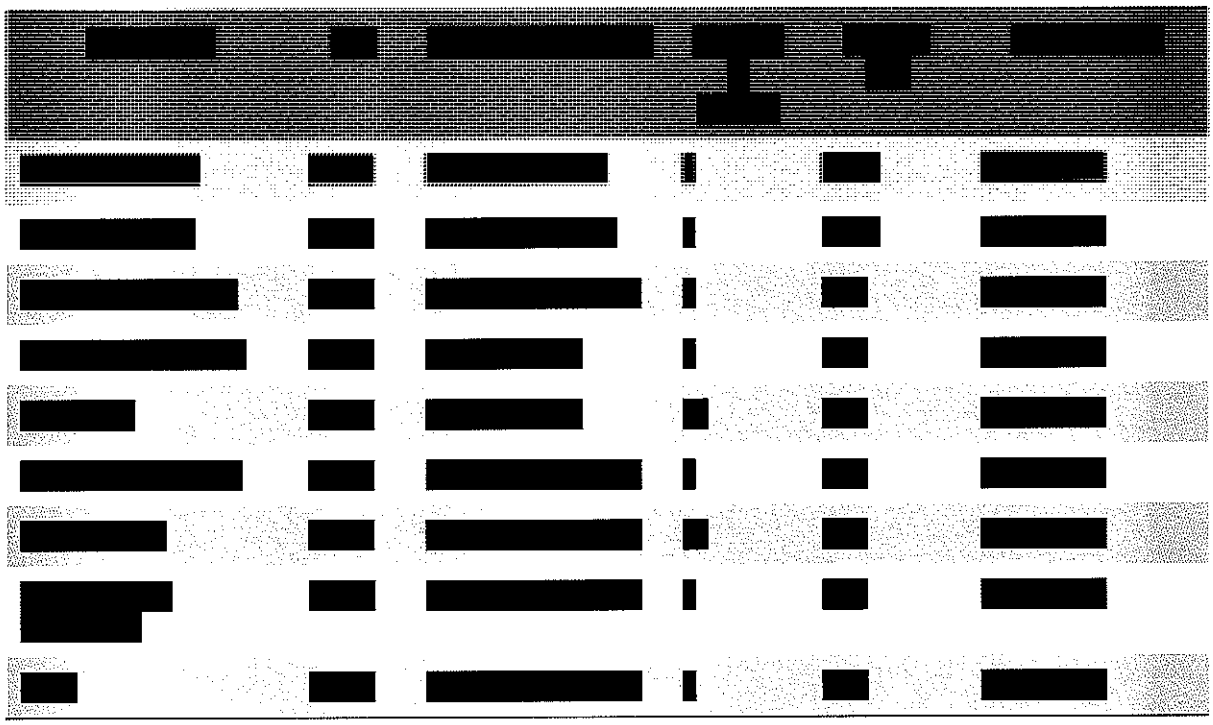

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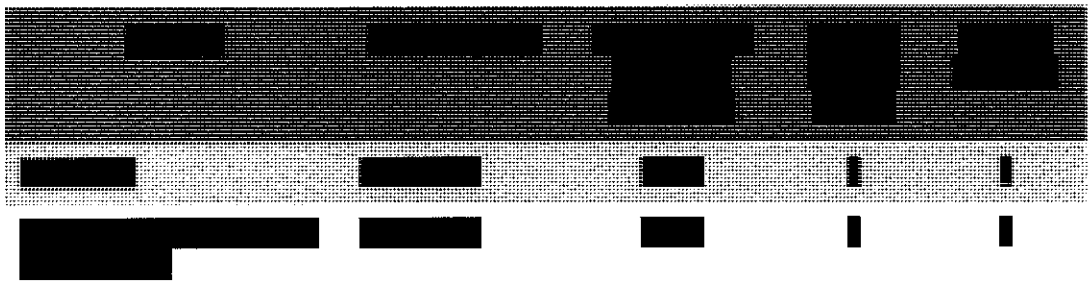

[redacted]

Describe modifications or updates to your BH MCO's Health Information system that will be necessary to meet the requirements of this program and your plan for their completion.

As the incumbent MBHO in Nebraska, Magellan currently has the infrastructure in place to support the revised MLTC program. Under the new contract, Magellan will be able to leverage our existing experience, procedures, and technologies to support the new risk-based program. We have more than 10 years of experience and enhancements built into the systems that support Nebraskans today, and we look forward to the opportunity to expand our offerings to provide the MLTC program with streamlined claims processing, data sharing, and reporting capabilities.

In order to meet program requirements, [redacted]

Given existing experience in Nebraska and the fact that these enhancements already exist for other State customers under full-risk contracts, we anticipate no issues with swift implementation.

[redacted]

[redacted]

Magellan has included a detailed project plan as part of our proposal response. The project plan can be found as **Attachment U**.

Describe your BH MCO's approach for ensuring complete encounter data is submitted accurately and timely to DHHS consistent with the required formats. Include in your response how you propose to monitor data completeness and manage the non-submission of encounter data by a provider or a Subcontractor.

[redacted]

[redacted]

Describe your BH MCO's data certification process which meets the requirements of the RFP.

Magellan will submit encounter data in accordance with the requirements outlined in Section N.7.b of the Statement of Work, and as provided in 42 CFR 4.38.606. Transmission of encounter data to the State's MMIS will occur at least monthly and will be sent in the specified format, as required by MLTC. Magellan will maintain, at a minimum, a 90 percent acceptance rate for all encounters submitted to the MMIS, pursuant to Departmental specifications. Magellan has had great success with encounter acceptance in our commercial and public sector lines of business, routinely achieving a 97 percent acceptance rate for encounter submissions. Magellan acknowledges that contract incentive thresholds award 100 percent of the incentive when the encounter acceptance rate is 95 percent or higher, and we can ensure that Magellan's experience and expertise will allow us to routinely meet the State's expected standards.

Encounter data submitted to the MMIS will be certified by Magellan's CIO, Gary Anderson, who reports directly to the CEO, Barry Smith. The certification attests that, based on best knowledge, information, and belief, the information submitted is accurate, complete, and truthful. This attestation will be submitted concurrently with the encounter data submitted.

Magellan uses strict internal processes, procedures, and controls to maintain the quality and integrity of data received for and data conveyed to clients. Magellan's 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. These procedural and automated controls operate at appropriate points throughout the cycle.

Magellan has an extensive data completeness monitoring plan to ensure that claims and encounters submitted by providers are accurate and timely. This ensures that our submissions to the state are, likewise, accurate and timely. Magellan also has sound procedures to ensure that rejected encounters are resolved and resubmitted promptly and accurately. Magellan routinely audits and tracks our performance and the performance of our providers. The monitoring program ensures compliance with state encounter data reporting requirements.

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

- 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.

On an annual basis, Magellan will provide a written report analyzing encounters not being submitted, which will include plans for improvement in the encounter submission rate. Patricia Ryan, the dedicated Information Technology Director stationed locally at Magellan's Nebraska CMC, will be responsible for the generation and submission of this report to the State.

In order to meet the State's needs for the written report, Magellan will implement a tracking system to track encounter submissions to the State. Magellan has implemented similar tracking systems in our other public sector accounts, including Arizona, Florida, and Pennsylvania, which track and monitor the correct, timely submission of encounters, and the reasons for encounter rejections and/or non-submissions (e.g., duplicate encounters). In each instance, Magellan's approach is to develop a customized solution that meets the reporting and analytical needs of the State. We will work with the DHHS throughout the implementation process to determine the specifications of the annual written report to ensure the appropriate mechanisms are in place to track encounters and improve acceptance rates.

Tracking encounter acceptance and rejection allows Magellan to more efficiently identify trends in encounter submissions and helps to identity points of failure in the encounter process,

whether system-related or provider-related. This allows Magellan to effectively determine corrective actions that can be taken to improve the overall encounter process.

As a general rule, Magellan utilizes the HIPAA-compliant code sets for encounter submissions. Magellan has implemented Sarbanes-Oxley guidelines that ensure accuracy, timeliness, and completeness of encounter data submissions for all Magellan business.

Describe your claims processing operations including:

- *The claims processing systems that will support this program*
- *Standards for speed and accuracy of processing and reports of compliance with standards for current contracts and all contracts for the past five years.*

[redacted]

[redacted]

Controls for Timely Entry of Received Claims

Magellan processes all claims from our Midwest CMC located in Maryland Heights, Missouri. 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 utilizes 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 are also possible.

Magellan's batch entry claim unit utilizes 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 (DCNs) 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.

[redacted]

[redacted]

[redacted]

[redacted]

Claims Systems 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 the following:

- Whether an individual was an eligible member 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)
- 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 level of treatment, geographic location, provider participating/nonparticipating status, etc.

- Member 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.

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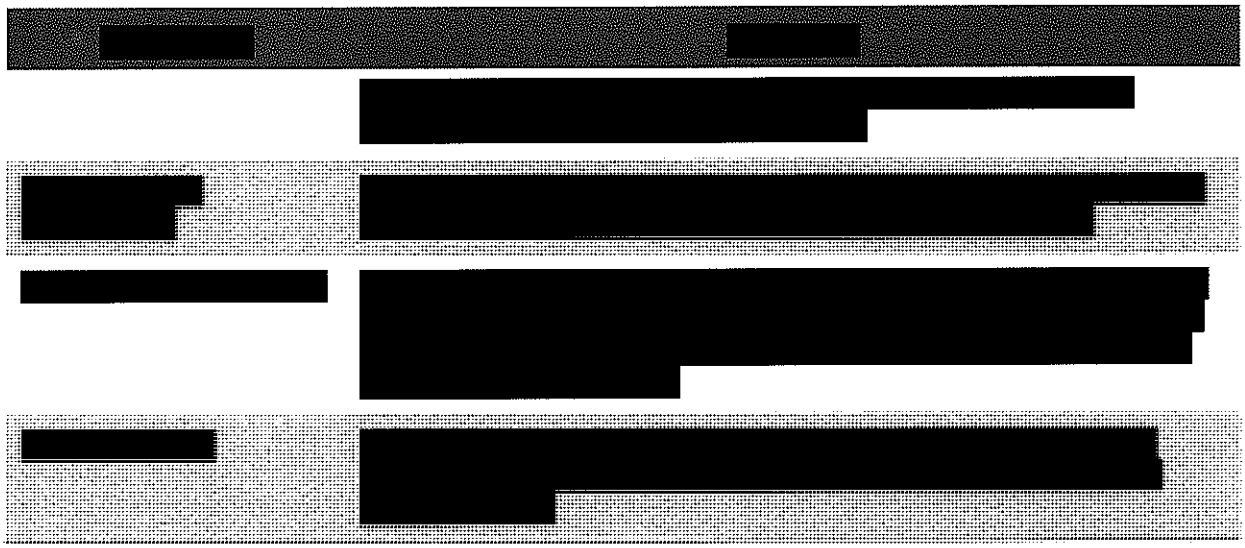


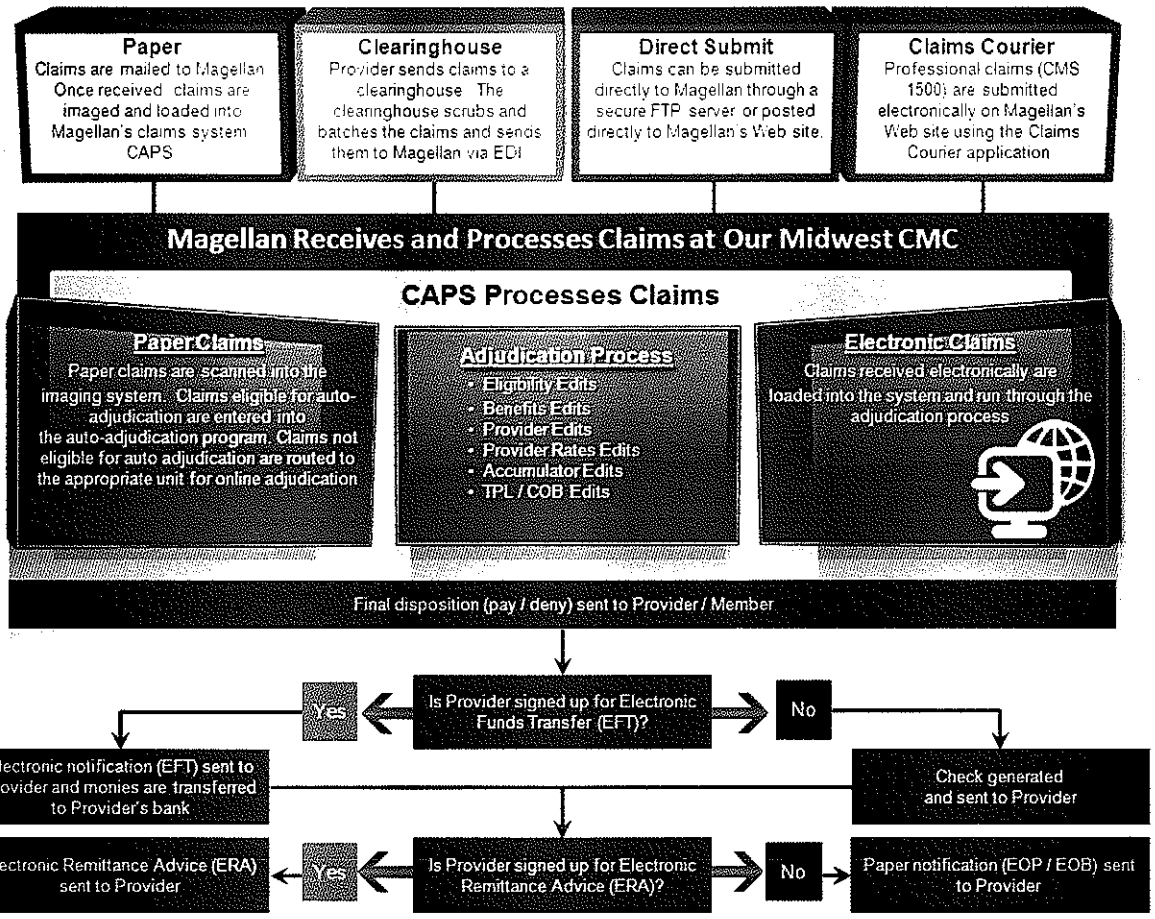
Once the adjudication process applies the system edits, a claim either adjudicates to a pay/deny status or is pended for additional review. The system supports an online pended queue that can be assigned to staff using multiple rules. Once a claims processor opens the pended queue, claims are presented 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 Nebraska Claims Resolution Specialists collaborate with network, quality management, and other claims processors in the identification of provider issues and in the training of 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.

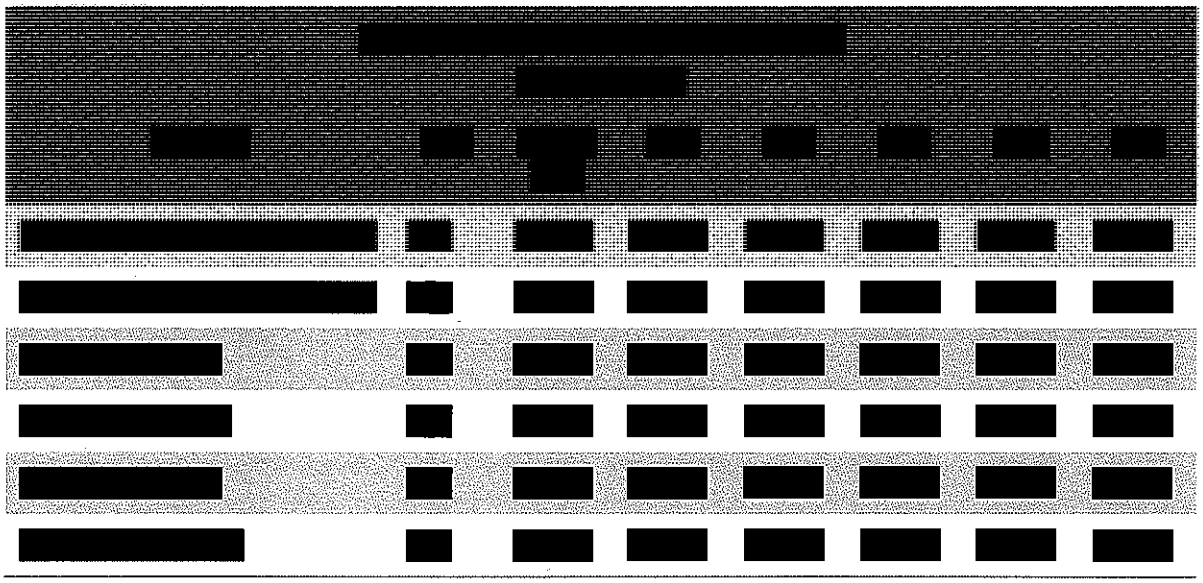
After claims are finalized and assigned a pay/deny status, Magellan initiates a scheduled check run to issue checks and EOBs to providers and members. This communication provides the details of Magellan's payment and/or denial of payment.

[redacted]


Paper
Claims are mailed to Magellan Once received claims are imaged and loaded into Magellan's claims system CAPS
Clearinghouse
Provider sends claims to a clearinghouse The clearinghouse scrubs and batches the claims and sends them to Magellan via EDI
Direct Submit
Claims can be submitted directly to Magellan through a secure FTP server or posted directly to Magellan s Web site.
Claims Courier
Professional claims (CMS 1500) are submitted electronically on Magellan's Web site using the Claims Courier application
Magellan Receives and Processes Claims at Our Midwest CMC
CAPS Processes Claims
Paper Claims
Paper claims are scanned into the imaging system. Claims eligible for auto-adjudication are entered into the auto-adjudication program. Claims not eligible for auto adjudication are routed to the appropriate unit for online adjudication
Adjudication Process
Eligibility Edits
Benefits Edits
Provider Edits
Provider Rates Edits
Accumulator Edits
TPL / COB Edits
Electronic Claims
Claims received electronically are loaded into the system and run through the adjudication process
Final disposition (pay / deny) sent to Provider / Member
Is Provider signed up for Electronic Funds Transfer (EFT)?
Yes
No
Electronic notification (EFT) sent to Provider and monies are transferred to Provider's bank
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

[redacted]

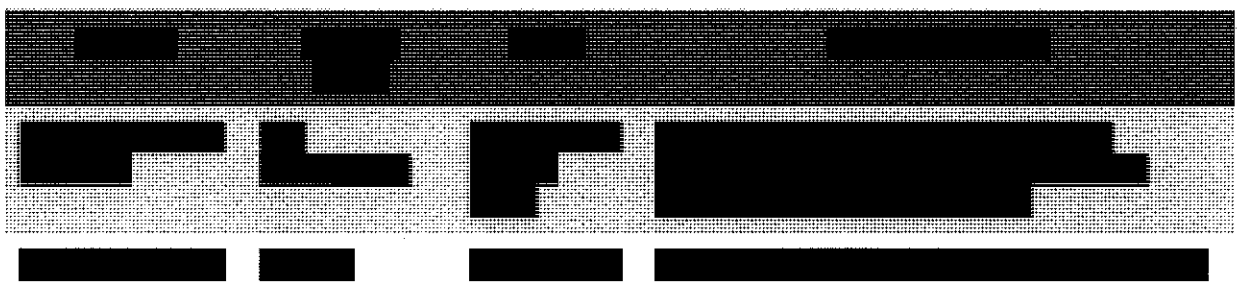
[redacted]

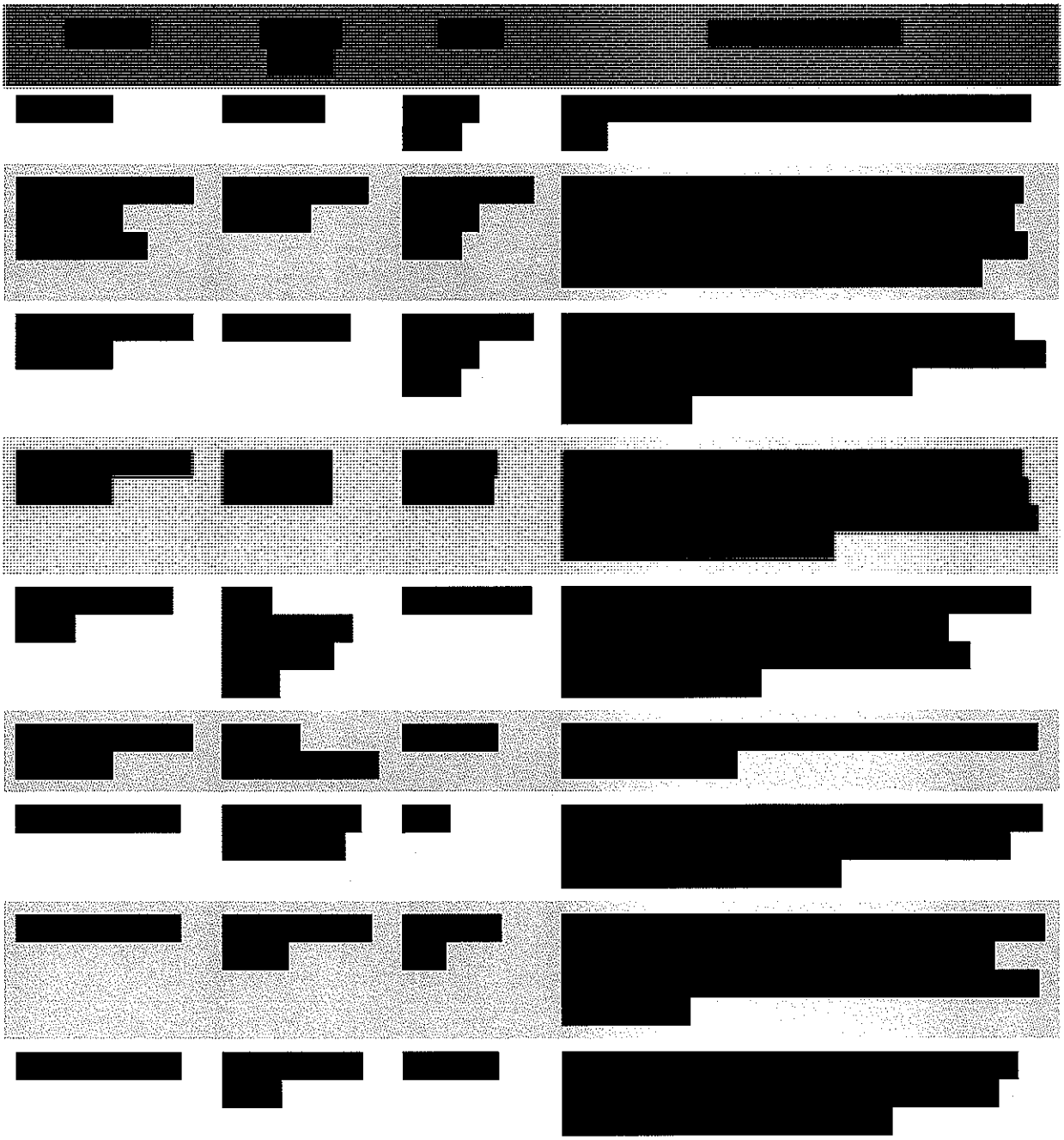


Tracking Claims Payment Timeliness

Claims supervisors monitor the volume and aging of pended claims on a daily basis through online system reports. The claims supervisor monitors the number and age of claims by each system pend reason. Based upon this review, resources are allocated and corrective actions initiated to clear the pend and meet the performance standards required by the individual contracts. Pends are given to individual processors to clear by the claims supervisor based on the competency level of the processor and the complexity of the claim. At the beginning of each week, a Timeliness report is generated to provide a current and accurate assessment of the timeliness for each account so that the appropriate planning ensures timeliness measures are met each month.

[redacted]





Each month, Magellan Service Operations management uses the Monthly Inventory Report that shows beginning and ending claims inventory numbers and age on shelf. (Note: "Age on Shelf" is the date or number of days of the oldest claim on the shelf to be entered into the system. This is the oldest new claim, not the oldest pended claim or the next claim to be processed.) When the claims go through the adjudication process, the system will either: (1) approve, (2) deny or (3) pend the claim. Approved claims are claims that have been approved for disbursement and are put into an entered status within CAPS signifying these claims are ready to be disbursed. Denied claims are claims that have been denied and are put into a denied status within CAPS signifying EOBs, EOPs, and Letters are ready to be printed. Service Operations management also

uses the Monthly Inventory Report to identify and respond to changes in inventory trends. A monthly claims aging report identifying the number of claims by age is incorporated into the monthly management report documenting all of the department metrics. The monthly claims aging report is reviewed during the monthly Service Operations Management meetings. Trend analysis and resulting actions are also incorporated into the document.

[redacted]

Claims Auditing

Magellan's quality auditing team in our Service Operations Department performs quality and adjudication accuracy audits across all claims systems, accounts, payment amounts and levels of care. The auditing unit reports under the National Senior Vice President of Operations who has oversight over all claims activities. Aspects of the audits may vary according to specific client and regulatory requirements.

Adjudication accuracy measurements are based on samples of production. The audit of each claim in the sample is documented through an online checklist and audit tool within the Magellan audit database application. Specific items addressed cover all aspects of the claims adjudication process including Magellan standard practice and regulatory or client specific requirements.

A standard report of each audit is generated by the audit application and is forwarded to the individual processor and supervisor for review and corrective action to include adjustment of the claim for under or overpayment. The auditor monitors timely response to the audit report. Sign-off occurs for each identified error among the auditor, processor, and supervisor. Disagreement on errors is resolved through a formal rebuttal process, which elevates the matter to progressive levels of operations and compliance team management. Audits are validated

based on system information rather than original source information (that is, actual contracts, benefit plans, rate schedules, etc.).

Post-Pay Audits

Post-pay audit criterion is comprised of two major quality assurance processes. These two processes entail an average of 2 percent sample size selection of finalized claims (post disbursement) along with a 100 percent high dollar pre-disbursement audit.

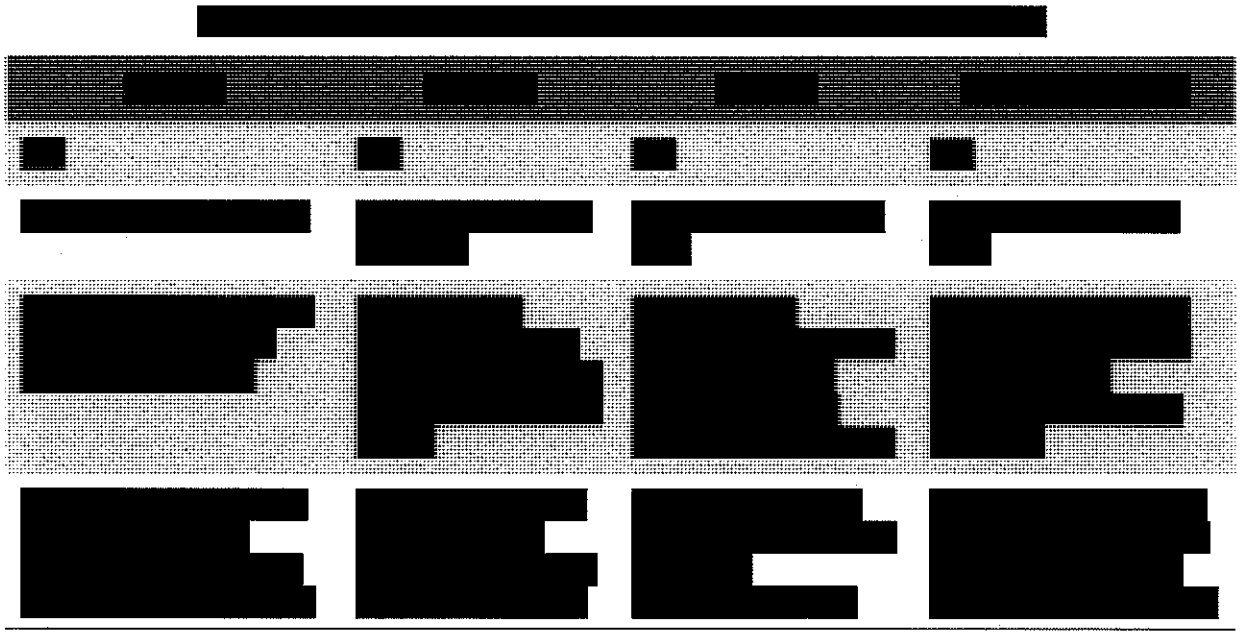
Magellan audits an average of 2 percent of all completed claims. This includes manually processed and auto-adjudicated claims. A daily automated report of finalized claims is utilized for this random audit sample selection process.

Pre-Pay High Dollar Audits

In addition to a post pay audit, pre-pay audits are conducted on all high dollar claims. For this purpose, high dollar claims are defined as those claims with a paid or denied amount of $5,000 or more. Exceptions to this definition are based on account contract standards and can be made according to MLTC needs. These high dollar claims will be systemically placed on audit hold by CAPS, the claims payment system. Claims will have a 48-hour turn-around goal for the auditor to complete the audit and release the claim if there are no errors noted. If errors are noted, the claim will be expedited to the supervisor of the individual for review, corrective action and release of the claim.

Electronic Audit Database

The Magellan audit will also ensure claims quality by calculating statistical, dollar, payment, and processing accuracy ratings. The calculation method of each measurement is shown in Table IV.N.5.4. Audit will incorporate any extra-contractual obligations into our calculations and report results to clients in accordance with contractual performance standards and guarantees.



[redacted]

All quality audit results are documented and reported through a centralized audit database. A specific checklist developed by a user committee is hard-coded into the audit database allowing each Auditor across all Magellan areas to audit the same data elements.

The audit database can produce specific audit reports by account, processor, and detail. Supervisors can run a standard audit report on individual processors but are not required as their main focus at the individual level is their involvement in the error sign-off process. Cumulative audit findings generated by the standard audit report are reviewed on a continuing basis by immediate supervisors and at least monthly by senior management as part of the Service Operations Executive Report in monthly operations meetings. No sign-off of the cumulative audit report occurs either at the supervisor or senior management levels although it is eventually reviewed by the COO. The Quality Audit Department reviews by the top 20 accounts in aggregate as well as individual account performance goals, particularly those accounts where Magellan did not meet the account standards. Quality performance of each processor is a key individual performance measurement. Processors not maintaining required standards are entered into progressive disciplinary steps, which may result in termination for failure to achieve standards.

Second-Level Audit

Magellan's auditing program includes a second-level audit to validate the integrity audit methods and results. Magellan pulls a monthly sample of each auditor's work and performs an additional audit of that claim to measure auditor accuracy and reliability. The goal of this process is to validate the proper decision was made, that all auditors would audit the claim the same way, and that any discrepancies should be surfaced for review and discussion. A secondary goal of the audit is to identify potential Auditor training and performance improvement opportunities and address them in a timely fashion. Auditors are held accountable for errors identified through the rebuttal process. Claims reviewed for the second level audit process focus on those with no errors in order to provide a full spectrum of auditor performance.

[redacted]

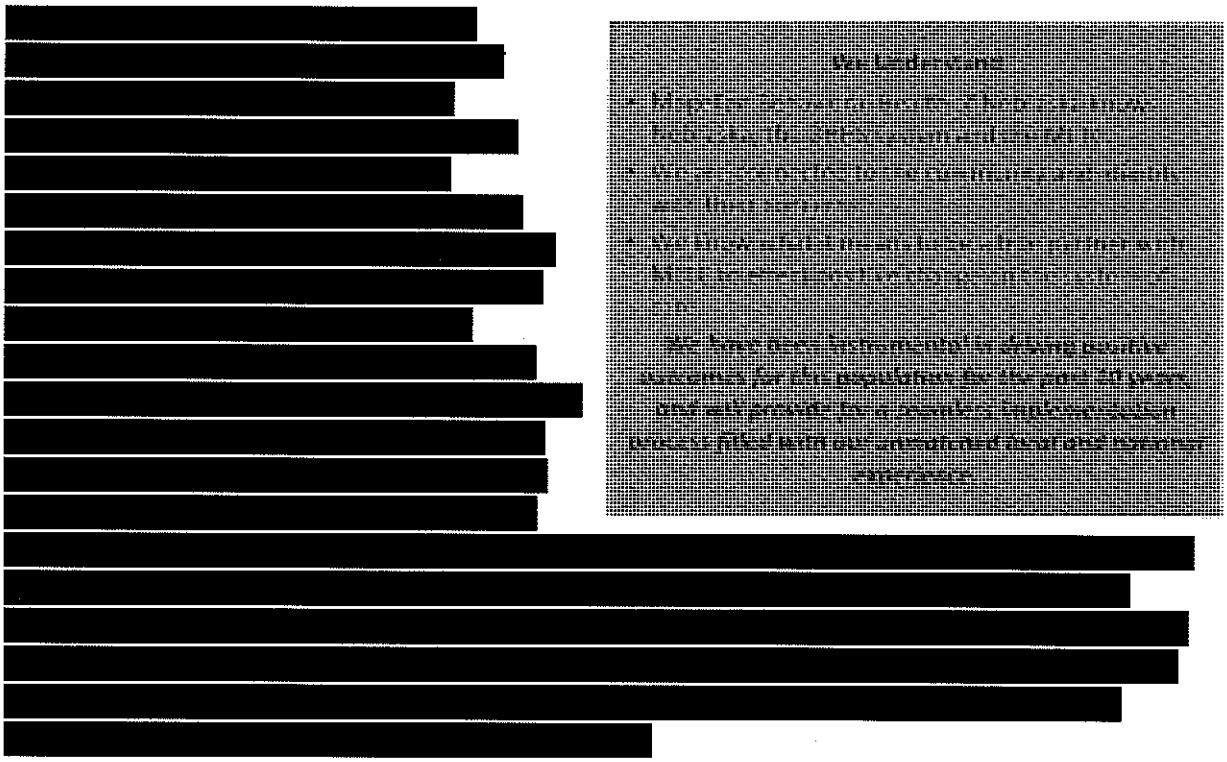
[redacted]

IV.O Transition and Implementation

Describe the staff your BH MCO will appoint for the key staff positions in the transition coordination/collaboration process. Include the names of key personnel already assigned.

Local Team Knowledge Combined with National Support Accelerates Transition

Because Magellan has been the administrative services organization for MLTC-funded behavioral health services for the past 10 years, we have the existing knowledge, relationships, and infrastructure necessary to not only assure a smooth transition, but to accelerate the move to a full risk program without a disruption in care for members or to the system as a whole.



Our national public sector solutions team, along with many other talented individuals already serving in the Nebraska CMC, will support this implementation effort.

National Success in Transition & Implementation

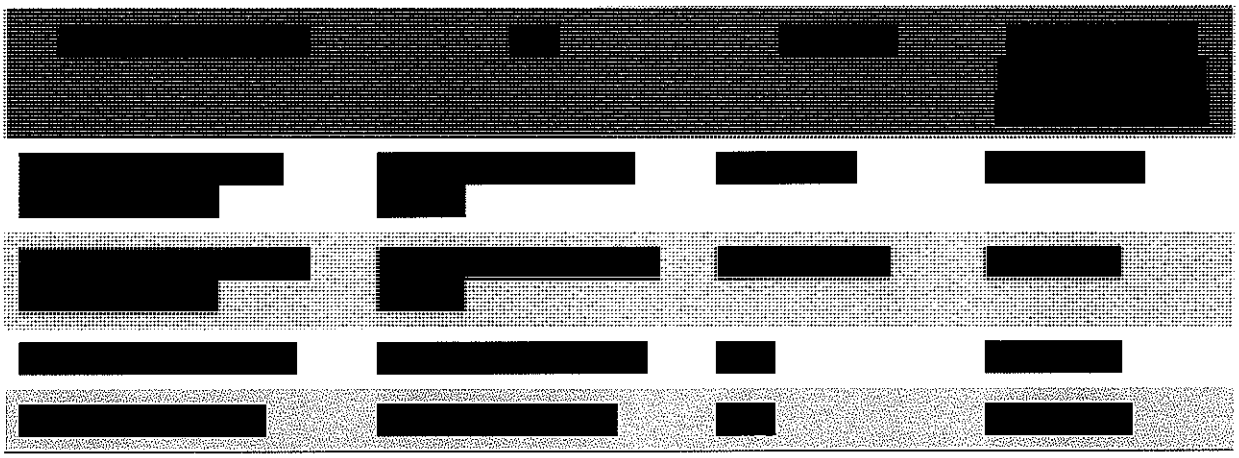
Nationally, Magellan has successfully transitioned Medicaid funded behavioral health services from a fee-for-service to a full risk program in Iowa, Pennsylvania, Florida, and most recently in Louisiana. In September 2011, Magellan was awarded the Statewide contract by the State of Louisiana to manage the its Behavioral Health program, a new managed care structure serving approximately one million members in a State covering a large geographic area including many rural communities. The accomplishments and ongoing activities of this program demonstrate our capability to implement a new managed care system within a short timeframe.

[redacted]

Transition and Implementation Team for Magellan Behavioral Health of Nebraska

We will provide necessary staff resources to ensure that during transition, continuity of care is maintained and member disruption is minimized. Table IV.O.1.1 lists the local leads in Nebraska and the national subject matter experts (SMEs) for transition support for each required position. These local leads will also be responsible for implementation. Some national SMEs will provide day-to-day support for implementation, while others will support specific functional work groups. All national team members will continue to provide ongoing support throughout the life of the contract.

[redacted]



In addition to the key positions requested, we have identified key functional areas outside of the key positions of the RFP. These include the following, as listed in the Table IV.O.1.2.

Magellan Behavioral Health of Nebraska Executive Steering Committee

Our incumbent status allows us to accelerate the implementation of the new program service requirements due to our existing infrastructure, established processes and procedures, and current knowledge and expertise from serving the Medicaid population in Nebraska. We are actively engaged with and well-known to all of the key stakeholders in the system of care. Simply put, Magellan will not face the learning curve that other vendors would experience during implementation.

Experience has also taught us that when senior leadership is involved in implementation activities, obstacles are easily avoided and deadlines are consistently met. Accordingly, a key component of our implementation organizational structure is our internal Magellan Behavioral

Health of Nebraska Executive Steering Committee (Executive Steering Committee). This committee, consisting of the most senior leadership within our organization, as shown below, will be responsible for ensuring a successful transition for the Nebraska program to a full-risk contract.

The organizational infrastructure responsible for ensuring that Magellan's transition and implementation activities are conducted successfully is highlighted in Figure IV.O.1.1.

[redacted]

[redacted]

[redacted]

Describe your BH MCO's transition/implementation process.

Magellan Behavioral Health of Nebraska is uniquely qualified to transition the program from an administrative services arrangement to a full risk contract given its existing knowledge, relationships, and provider network supported by national expertise in claims and underwriting. We adhere to the principle of "no surprises" when it comes to our relationship with MLTC.

Thoughtful transition and implementation planning provides an opportunity to address the concerns of providers, members, advocacy groups, and other stakeholders while ensuring that they have critical information regarding the transition of the current program to risk-based managed care for Medicaid behavioral health services in Nebraska. Magellan has the depth of experience, competencies, and capacities to implement a successful transition to risk-based managed care that is tailored to the needs and objectives of MLTC and Nebraska stakeholders.

Proactive and frequent communication with all stakeholders is critical to the successful implementation process. From the time of contract award to the time of actual implementation, Magellan will partner with MLTC and other stakeholders to establish a risk-based behavioral health Medicaid program that meets or exceeds the contract requirements.

[redacted]

Following contract award, Magellan's public sector implementation team, described above, will be deployed to Nebraska to continue to work with and support Ms. Mimick and the Magellan Nebraska CMC team in building on pre-award implementation activities. This team will be dedicated to ensuring the implementation plan is fully executed in a timely manner. As permanent staff is hired, implementation team members will gradually transition to an ongoing mentorship and oversight role, but will remain actively involved in the project.

Implementation Plan Development

Magellan Behavioral Health of Nebraska (Magellan) is committed to providing the right resources to ensure an ongoing seamless transition from our current model to the new fully integrated model. The transition documentation will begin by providing to MLTC a comprehensive implementation plan which clearly defines all strategic milestones met or in development, tactical tasks, responsible parties, dependencies, and timeframes. We have an established implementation plan and a baseline structure for all implementation activities.

Created in Microsoft Project format and provided to MLTC in printable PDF format, as **Attachment U.** Draft Implementation Plan, this draft plan will be fine-tuned during the RFP review process, and a finalized plan will be submitted for MLTC's approval. Magellan will be fully accountable to MLTC through our implementation plan, which provides a tool for MLTC to monitor Magellan's continual transformation toward our fully implemented behavioral health system of care.

[redacted]

Implementation Plan Updates and Resolution of Issues

With Magellan's track record of successful implementations, we have established best practices that we will apply to implementation in Nebraska. We will work in tandem with MLTC and

customize our processes according to the State's preferences for verbal and written updates/reports on implementation progress.

Our implementation functional workgroup business owners will be responsible for creating agendas and facilitating recurring scheduled meetings and teleconferences to successfully achieve the tasks outlined in the implementation plan. The workgroup owners will participate in a weekly overall project status meeting to provide updates, identify risks, present risk mitigation strategy, and identify any issues requiring escalation to the Executive Steering Committee.

The implementation plan and agendas, which include action items, a decision tracker, issues to be elevated, and a risk assessment matrix are utilized to ensure that all tasks are identified, tracked, monitored, and documented throughout the implementation and transition period. This allows for quick and easy assessment of possible problems, ensures expedited review and action by the team, and gives broad visibility to determined outcomes. If a task or mission critical element is delayed or modified, it is quickly identified, as are all inter-dependent tasks and elements. Items are documented on the "issues to be elevated" log and "open issues" log. They are then entered into the problem escalation process.

Clear Communication and Transparency with MLTC

We take a holistic approach to implementation. We will take steps at every juncture to prevent unexpected issues or problems; however, we have protocols in place to immediately identify and bring issues to resolution. The outcome will be a smooth, planned progression toward "go live" for both members and MLTC alike.

When problems arise, Magellan's implementation team lead, Sue Mimick, CEO, with support from Jim Stringham, VP of Magellan Public Sector Accounts, and Beth Rath, Senior Director of Behavioral Health Implementations, will first evaluate the issue and its impact on any implementation milestones. All issues are brought to the attention of workgroup business owners and discussed openly and quickly. We will then obtain input from both our internal team and MLTC partners before seeking resolution.

Our priority is always to communicate issues related to the transition and implementation with MLTC in a fully cooperative manner, to ensure thorough and timely resolution. Magellan's standard process is to document all discussions and have all parties sign off on decisions in advance of implementation. If necessary, escalated issues are referred to the Magellan Executive Steering Committee. Following resolution of any issues, the implementation project plan will be adjusted as necessary to fully account for all actions and decisions.

[redacted]

Describe how your BH MCO will transition behavioral health recipients and operations. Include detail around the receipt of behavioral health to current members receiving services, planned collaboration with the existing Contractor and providers, provision of service information (including integration of current Contractor services), transition of pending grievances, appeals and customer service cases, assurance of adequate, qualified staff to meet filing deadlines and attend all court or administrative proceedings.

Minimal Disruption for Nebraska Medicaid Behavioral Health Enrollees

As the incumbent with a strong working relationship with MLTC, combined with our experienced implementation leadership as described above, the State's selection of Magellan as the Contractor for this project ensures that transition issues will be minimal and that implementation activities will be seamless and effective in transitioning Nebraska's current fee-for-service behavioral health Medicaid program to a risk-based program.

Current members will continue to receive the high-quality services they have come to expect from Magellan and our network providers. We will reach out to providers, current and new to Magellan Behavioral Health of Nebraska, as well as current members, through regular communication materials (e.g., newsletters, a Web site portal for members and providers) to inform them and other stakeholders about the transition of Nebraska's behavioral health Medicaid managed care program to a risk-based contract.

Member Orientation

Magellan will host a series of member orientation meetings located in several communities and all regions of the state of Nebraska prior to the program start date. Orientation sessions will also be held via teleconference, video conference, and webinar technology for those members residing in rural areas where transportation is not available, or for those members who are unable to attend a scheduled orientation session.

The goal of these meetings will be to introduce Magellan as the new risk contractor, to provide information about available services, and to ensure members and family members know how to access services.

We want to assure members that Magellan will work with their providers so they experience no disruption of services during the transition. Additional sessions will also be held during and after program implementation, as needed. These sessions will be offered in locations and at times convenient for members and families. The specific agenda for the orientation sessions will be developed in partnership with MLTC leadership, the Governance Board, providers, and other stakeholders. The attached detailed draft Implementation Plan (**Attachment U.** Draft Implementation Plan**)** includes a member communication plan.

Provider Communications through Transition and Implementation

Magellan of Nebraska is committed to maintaining and enhancing its strong relationships with our existing providers, and developing close relationships with new providers under the new managed care contract with MLTC. [redacted]

[redacted]

Following initial orientation sessions, and in conjunction with MLTC, we will determine the need for additional information sessions. Our team will look for opportunities to enhance, track, and report on individual and system training needs. Throughout the contract term, we will offer additional value-added training and communications opportunities that will benefit the overall delivery system, including topic-specific provider forums; provider relations liaison site visits, and credentialing and compliance audits.

Transitioning Grievances, Appeals and Customer Service Cases

As the incumbent ASO contractor, there will be no need to transition grievances, appeals, and customer service cases. During our implementation phase, we will continue to provide a superior level of service in these areas while meeting the requirements of the new contract. Again, there will be no need to transition physical health cases where collaboration is in progress, as Magellan is the existing vendor. In all instances, we will fully manage any new grievances, appeals, and customer service cases that arise. Our staffing will be adjusted to meet the additional volume of cases anticipated so that quality and timeliness standards are maintained. With our local presence already in Lincoln, qualified staff will be available to meet filing deadlines, and there will be no need to transition open court or administrative procedures.

IV.P. Finance, Reporting Requirements & Rate Setting

IV.P Finance, Reporting Requirements and Rate-Setting

Describe your process for establishing the Reinvestment Plan including a statement of guiding principles that will aid in selecting input for development, services to be provided, etc., the Plan terms that will allow services to be provided to eligible members, etc.

A Process Based Upon Demonstrated Expertise

Magellan's process for establishing the Reinvestment Plan in Nebraska is built upon years of innovation and experience with the concept. Magellan Behavioral Care of Iowa pioneered the concept of reinvestment of managed behavioral care savings into new, innovative community-based services in the Iowa Plan starting in 1995. For the Iowa Plan, the reinvestment fund consists of a percentage of the Medicaid capitation payments and unspent claims funds. These funds support two categories of projects: beneficiary services and provider development/community outreach. In addition to State of Iowa, Magellan Behvaioral Health of Pennsylvania has community reinvestment programs in five county-based HealthChoices (Medicaid) plans and Magellan Health Service of Arizona has implemented a reinvestment program in Maricopa County.

In Iowa, Magellan utilizes a collaborative process for identifying and funding reinvestment programs. After incorporating feedback from community stakeholders, Magellan works with its State partner, the Iowa Medicaid Exchange, to identify areas for potential funding. RFPs are typically issued to community providers and a committee composed of consumers, family members, and state representatives. Magellan staff reviews and ranks proposals and agrees on which projects to fund. In Pennsylvania and Arizona, Magellan has utilized a similar process to the one developed in Iowa. In Pennsylvania, a county-based Medicaid system, the reinvestment planning process is led by each County Office of Behavioral Health with whom Magellan contracts to manage the HealthChoices program. In Arizona and Maricopa County, the Governance Board for the plan plays an important role in assessing need, setting priorities, and approving the final reinvestment plan.

The stakeholder feedback and consensus prioritization process produces unique, tailored community solutions. For example, Magellan has pioneered the Self-Directed Care (SDC) approach for adults with serious mental illness supported by reinvestment funds in pilot programs in Pennsylvania and Iowa. Participants in this program collaborate with a SDC peer-coach to manage a limited budget for the purchase of goods and services not covered by insurance or existing community resources, but which support the member's recovery. The SDC coach works diligently with each participant to identify resources available in their communities, and to help them problem-solve to maximize the benefit of the SDC funds. "Purchased" services can include transportation to get to appointments, fees for employment-related training or education, costs related to obtaining permanent housing, charges for instructional materials, and other goods or services that support recovery, resiliency, and independence.

Our programs in Iowa, Pennsylvania, and Maricopa County, Arizona have included, but are not limited to:

Iowa Community Reinvestment Programs: *Moving beyond traditional services*

Telehealth in Crisis Situations

The Iowa Plan is expanding telehealth to address crisis situations, using community reinvestment funds to establish services for around-the-clock behavioral health assessments in hospital emergency departments. "Mini-networks" can address the lack of full-time, trained behavioral health personnel available around the clock to assess members in crisis. Providers work with local community mental health centers for next-day outpatient follow-up care if the member is not hospitalized. Magellan will use experiences in Iowa and other Medicaid programs to implement telehealth programs through American Well's Online Care.

Crisis stabilization services: Helping members in crisis stay in the community

For many Iowans experiencing a mental health crisis, the only place to turn for immediate support is a local emergency room (ER) or inpatient facility, especially for those living in rural areas. To address this issue, DHS in Iowa and Magellan established community-based crisis stabilization centers that provide mental health support, and reduce the need for costly inpatient admissions and ER visits. It is a more effective and less restrictive alternative for those whose crises can be resolved through support and care coordination rather than intensive medical interventions.

The centers expedite mental health assessments so individuals in crisis get help more quickly from the facilities and staff best equipped to meet their specific needs. Members receive expert assessment, intervention, and connection with additional community resources. Peer support specialists are available to problem-solve, obtain help, and develop a recovery plan. A main goal is to de-escalate the crisis, so members can remain in a community setting – and stay on track for recovery.

To launch these services, Magellan contracted with Hillcrest Family Centers, a non-profit provider of behavioral health centers in eastern Iowa. Hillcrest, working with community partners, established crisis services for individuals from several surrounding counties. A walk-in urgent crisis center is open daily with a hotline available 24 hours a day, 365 days a year. Therapists, crisis counselors, and peer support specialists are part of the multidisciplinary crisis response teams.

Integrated Health Homes: Removing barriers to whole healthcare for people with SMI

The U.S. Affordable Care Act encourages the development of "health homes" to coordinate physical and behavioral health care for our most vulnerable citizens. Individuals with serious and persistent mental illnesses (SPMI) face multiple barriers to accessing conventional primary care. As a result, they are more likely to die prematurely from chronic physical illnesses that often are treatable or manageable.

The Iowa Plan's Integrated Health Homes (IHH) takes an alternate approach to health homes. Unlike integrated care programs where primary care physicians lead the coordination of care, Iowa's program "begins" with behavioral health providers, who lead the joint treatment teams. Routine physical health services are available at participating community mental health centers. Individuals receive health and wellness assessments and a comprehensive array of medical and behavioral treatment services, and peer specialists help them in their communities.

Funded by community reinvestment dollars, the collaboration between Magellan, Iowa Medicaid Enterprise/DHS, behavioral health agencies, and federally qualified health centers, began in 2011 with providers in five locations. After one year, more than 700 members had enrolled in the program. IHH is expanding throughout the state to adults and to children with serious emotional disturbance.

Pennsylvania Community Reinvestment Programs

Consumer Recovery Investment Fund (CRIF)

CRIF is a three-year research and demonstration project to design, implement, and evaluate a Self-Directed Care (SDC) program for 75 to 85 Delaware County HealthChoices members, ages 18-64 years, with diagnoses of serious mental illness, and who have used services regularly for the previous two-year period. CRIF participants develop Wellness Recovery Action Plans (WRAPs) with the support of a certified peer specialist, a Recovery Coach, and are able to access non-medical supports through their "Freedom Fund" account, in addition to traditional, medical services supported through Medicaid. These funds have supported items like clothes for job interviews, college tuition and books, etc. All non-medical supports must be approved as instrumental in working towards the goals developed for the individualized WRAP. This project is being done in partnership with Delaware County, the Mental Health Association of Southeast Pennsylvania, and Temple University.

Transitional Age Community Residential Rehabilitation

This program was developed to serve a population of transition-aged (between 18 and 22 years old) young adults with mental health conditions who benefit from a structured environment designed to meet their specialized needs including: Mental Health/Substance Abuse, Mental Health/Intellectual/Developmental Disabilities, and other co-occurring disabilities such as hearing and sight impairments. Services are tailored to assist these individuals to acquire the various skills needed to successfully transition from adolescence to adulthood. This expansion initiative increased residential capacity and provides supportive services to individuals transitioning from out-of-home, out-of-county, and Child Welfare, Juvenile Justice, or Mental Health Residential Treatment Facility placements.

Medical Mobile Crisis

Lehigh and Northampton County Medical Mobile Crisis services provide assessment and intervention for individuals in need of medical support to address an acute problem of disturbed thought, behavior, mood, or social relationships. The service is designed to reduce unnecessary hospitalizations and emergency room visits. This program serves adults with serious and

chronic mental illness. From April 2011 through June 2012, the Medical Mobile Team saw a total of 156 HealthChoices consumers from Lehigh and Northampton Counties. Of these consumers, 154 were diverted from a possible hospital admission to a lower level of care.

Extended Acute Care Programs (Closure of Allentown State Hospital)

In January 2010, the announcement was made that Allentown State Hospital would be closing in December 2010. Both Lehigh and Northampton Counties utilized re-investment dollars to develop two Extended Acute Care (EAC) Programs in the Lehigh Valley that served as an alternative treatment to the State Hospital. Lehigh County and Magellan collaborated with Sacred Heart Hospital to develop a 19 bed hospital based EAC Program, and Northampton County and Magellan collaborated with NHS Human Services to develop an 8 bed community based EAC Program. As of August 2012, these programs have served a total of 49 Health Choices consumers. The primary goal of these programs is to empower members with serious mental illness to manage their illness, and assist in their recovery and return to their community.

Expansion of the Delaware County ACT Program

The County expanded its team to address the behavioral health needs of individuals discharging from the State Hospital due to bed closures, and to divert individuals going to the State Hospital. Under this Reinvestment Plan, Delaware County's existing ACT Team, provided by Horizon House (a provider), expanded the number of available Assertive Community Treatment (ACT) slots by 100 to serve a total of 200 Medicaid eligible, adults with serious mental illness. The ACT model has been proven to (1) decrease the time persons with severe and persistent mental illness spend in hospitals, and (2) to facilitate the community living and psychosocial rehabilitation of these individuals. Since its establishment in 2004, data has shown that Horizon House's percentage for the number of individuals admitted to Acute Inpatient Level of Care is considerably lower than the county's admission percentages for other providers. During FY 2010-2011 and in FY 2011-2012 (through March), an average of 93 percent of ACT participants were not admitted for a hospital stay. During the same period, a total of 7 percent were hospitalized with an overall average length of stay of just 11 days. The fidelity rating for the existing ACT team as of July 2011 was 4.09, measured on a scale of 1-5 with 1 being not implemented, and 5 being fully implemented.

Maricopa County, Az. Community Reinvestment Programs: Supporting Whole Health Programs for Adults and Children

Magellan of Arizona is funding innovative programs in Central Arizona that integrate physical health care services with general mental health services for adults, and behavioral health services for children, to provide a whole health approach to health care for those challenged with mental illness. While significant attention has been paid to the life-span disparity and poor health outcomes of adults with a Serious Mental Illness (SMI), integrated care is an important initiative across all behavioral health populations, and the community reinvestment program's goals are to enhance coordination, improve outcomes, and lower costs.

Through community reinvestment, Magellan supports four provider organizations with programs and models of care that strengthen the whole health of adults and children, with a

focus on improving the prevention, early intervention, and self-management of chronic health conditions. The programs chosen for investment were innovative, creative, and incorporated the Magellan of Arizona values including early and enhanced collaboration, shared governance and accountability, voice and participation, and prevention and early intervention.

Magellan's goal is reinvestment in sustainable programs that have long-term, positive, and strategic impact to the system of care in Central Arizona. Additionally, Magellan looked for program proposals that included reliable, valid, and nationally recognized tools for measurement and evaluation of behavioral health, physical health, and the link between the two.

In each of the programs presented, the process begins with an understanding of needs from data and feedback of members, providers, and a wide range of community stakeholders. The identified needs are prioritized and a consensus process determines the focus of the reinvestment.

A Process Developed Specifically for Nebraska

Guiding Principles

Based on our longstanding experience with community reinvestment in fully-insured MBHO contracts, our guiding principles for reinvestment are as follows:

1. Community reinvestment expands access to innovative, recovery-oriented, member-empowering, and community-based services that would otherwise not be available to public sector program enrollees.
2. Reinvestment services are evidence-based and reflect national best practices.
3. Reinvestment strategies are consistent with the established Principles of Care established by MLTC and the RFP.
4. Stakeholders are involved at all stages of the reinvestment planning and decision-making process.

Creation of the Reinvestment Fund

Per the requirements of the RFP, funds allocated to the Reinvestment Fund will come from:

- Forfeited MLR Rebates
- Forfeited Profits above three percent
- Forfeited Performance Guarantees
- Forfeited Contract Incentives.

Recommendations and Decision Making for the Reinvestment Program

Magellan recognizes and agrees that the Reinvestment Plan and subsequent service provision must be approved by MLTC. To develop and advance recommendations to MLTC, we propose that our Governance Board be responsible for establishing the plan for reinvestment priorities

with input from stakeholders and MLTC staff, including consumers, family members, and representatives from other DHHS departments including the Office of Consumer Affairs, as designated by MLTC. The Governance Board made up of seven community stakeholders and seven Magellan Executive staff would review and discuss information related to service delivery gaps and recommendations from the Clinical Advisory and Provider Advisory Committee regarding the need for expansion of evidenced-based practices. All reinvestment planning and decisions will be made in accordance with the regulations and timeframes established by DHHS. Stakeholders will play a central role in the planning for reinvestment funding through their inclusion on the Governance Board, Clinical Advisory, Provider Advisory, Collaborating for Kids, and Quality Assurance Performance Improvement committees. The office of consumer affairs will be consulted as required by the RFP. While the MLTC will be represented on many of these committees, all recommendations will be brought forward by the Magellan CEO for discussion and approval by MLTC as required by the Terms and Condition in the RFP. Once reinvestments plans are approved we will provide monthly progress updates to DHHS for all reinvestment projects.

Describe your process for creating the Reinvestment Escrow Holding Account and the Reinvestment Escrow Fund. Explain the process for determining the Escrow Account Administrators for each.

Magellan will contact several banks that we currently have relationships with that have trust operations, i.e., Wells Fargo, US Bank, and obtain pricing and any documents necessary to establish the accounts. We will also review the Nebraska account management requirements with the banks. Magellan will direct all investments and fund transfers in the accounts. The bank will have no investment authority, and any investments will adhere to Nebraska investment requirements.

We will establish two escrow accounts to manage the Reinvestment Fund. The first escrow account, Reinvestment Holding, will be created as a separate account to hold any funds paid to MBH before they become eligible for transfer to the Reinvestment Account. The second escrow account, Reinvestment Account, will be created separately from other accounts required by the contract, and any other accounts that may be required by State or Federal law, to hold the reinvestment funds once they are eligible for deposit, in accordance with Neb. Rev. §71-831, 68-908 and 71-801 (2012).

A separate Escrow Administrator will be appointed for each escrow account. Maintenance, accounting, and reporting will be collectively determined upon contract award. We understand that funds must be held in accounts that have no risk bearing investments and in accordance with escrow Fund requirements. We also understand that any interest accrued on either Fund shall be deposited to the Reinvestment Escrow Fund for use as established in Neb. Rev. Stat. §71-831, 68-908 and 71-801 (2012).

Describe your IBNP Reserving process; including (if applicable) methods used for the credible and non-credible periods, inventory backlog, look back analyses, and category of service groupings.

Estimating and Tracking Incurred but not paid (IBNP)/Incurred but not reported (IBNR) Claims

Magellan has a dedicated Actuarial Department under the leadership of a Chief Actuary with FSA certification. Through his leadership and direction, a monthly process of evaluating and validating IBNP/IBNR estimates and extraordinary provider reimbursement or claims processing volume fluctuations is performed. The process is broken down into various stages and pieces as follows:

IBNP/IBNRs

Our Claims Adjudication and Payment System (CAPS) claims subsystem is integrated with our clinical system, known as Integrated Product (IP), which contains prior authorization and referral systems. CAPS contain a claims accrual system and a claims payment system. This enables us to report claims by major rate code service groupings on incurred or date of service basis. Our CAPS and IP applications enable us to highlight large outlier cases. It also provides us with internal controls to detect payment errors and the ability to conform to regular payment patterns.

We follow generally accepted actuarial practices as defined by American Institute of Certified Public Accountants. Our methodology includes examination of lag factors, which identify the time between the incurred date of a claim and the date on which a claim payment is made, and completion factors, which represent the ratio of paid to received claims. The calculations use historical paid claims data, organized by incurred and paid month, for the most recent 48 months. Completion factors, claim inventory levels, known outside factors, and seasonal considerations are made to set the final best estimates. In the absence of credible or historical paid claims data, Magellan uses historical payment patterns from similar books of business. Estimates take into account the tendency of incurred claim liabilities to vary in a consistent and predictable manner within the space of a calendar year by considering the following:

- seasonal variations in morbidity, or the rate at which members seek medical care
- calendar effects including variations in monthly claims caused by the differing number of days in each month or differences in the number of working days in a month
- changes in policy, practice, or coverage
- fluctuations in enrollment by behavioral health rating group
- expected inflationary trends
- trends in claims lag time
- trends in the length of hospital inpatient stay by behavioral health rating group

MAGELLAN BEHAVIORAL HEALTH

- changes in behavioral health rating group case mix
- changes in contractual agreements.

Magellan uses two major categories of claims when calculating IBNP/IBNR: inpatient claims liability and outpatient claims liability. Magellan estimates inpatient and outpatient IBNR/IBNP claims on a quarterly basis with additional interim reviews on a monthly basis. The estimate represents a snapshot of the liability on the last day of the quarter. IBNR/IBNP claims include prior authorized services and services that do not require authorization, if any.

Inpatient Claims Liability

This is calculated using a case basis methodology, which uses authorizations as a basis for calculating claims liability. Our monthly census database (utilization management report) collects actual authorization data at average per diem reimbursement rates, allowing us to estimate the utilization expenses by month. We compare open authorizations with claims denied for lack of an authorization. The database is updated daily and tracks changes in authorizations. The final month's open authorization balance, less payments made in the month, produce a resulting change in our IBNP/IBNR. The utilization management report is also compared in retrospect to actual incurred claims per the claim lags to validate the accuracy of this leading indicator and reporting tool.

Outpatient Claims Liability

Outpatient claims liability is calculated via a case-basis methodology, which uses authorizations as a basis for calculating claims liability. Our calculation methodology is presented below:

- paid date of service amounts are entered from our lag reports
- a completion factor liability is calculated using a completion factor percentage based on an average of prior months paid amounts
- an alternative liability, for selected months, is based on an average of prior month's completion factor liabilities
- total estimated expense for each month equals a weighted average completion factor liability and a weighted average alternative liability
- total IBNP/IBNR amount is calculated for each month by subtracting total paid from total estimated expense
- prior estimate less total estimated expense equals current expense for each month.

In addition to the above processes, our chief actuary will review the paid claims history, trends, and any other provider or payment pattern fluctuations in order to set a best estimate of IBNP/IBNR on at least a quarterly basis. The Chief Actuary officially certifies the estimates each quarter, with secondary certification by an external actuary with our public accounting firm. Personnel in the actuarial department review the methodology annually to ensure its continued validity and the actual paid claims lag schedules on at least a quarterly basis to retrospectively adjust the medical costs previously recorded on each contract as needed. The chief actuary

provides a quarterly certification that is also verified and confirmed by an external actuary with the firm of Ernst & Young. The quarterly actuarial estimations and adjustments are further reviewed with our corporate chief financial officer.

As noted earlier in this response, our claims system allows for the tracking of claims costs at the rate cell level, through a group, plan, and division hierarchy structure. This will enable us to capture separately the service costs from the claims system for accounting purposes. Service costs not paid through the claims system will be paid through our Lawson accounts payable system. Our accounts payable system allows for segregated coding that identifies payment to the distinct fund source at the rate cell level.

Magellan's ability to successfully meet population subgroup level reporting requirements is based on the structure of our claims payment system, which is set up to allow for the tracking of claims payments to the lowest level that eligibility data is provided. Magellan will work with the Nebraska Division of Medicaid and Long-Term Care to establish an eligibility categorization system that segregates each population subgroup. The unique consumer identifier will be matched to claims payments and encounter data to allow for the tracking of each population subgroup. Additionally, where necessary, we will develop specialized reporting processes to match payment and encounter data, allowing for a reconciliation and payment validation for any block payment or grant funding we may implement in this program.

Describe your process of evaluating and setting acceptable contract levels as a percentage of State Medicaid fee schedules.

Magellan will match the existing rate structure at 100 percent of current Medicaid fee schedules for all Behavioral Health services or offer an equivalent rate level. Our approach to risk-based contracts is to ensure no adverse effects for providers due to rate reduction. As we assume claims payment responsibility, providers will be issued Magellan fee schedules that match current Medicaid rates. Over time, we may develop innovative rate structures and incentives, including pay for performance. However, these new payment arrangements will be designed so as to avoid adverse impacts on providers relative to existing rates.

Describe your process of developing forecasts and budgets. Describe your process of identifying subsequent variances including analyses to determine causal factors of the variances and corrective action plans.

Magellan follows a very formal process of setting budgets and frequent forecasting. Magellan uses the Hyperion software and Excel modeling to establish financial documents to capture membership, revenue, cost of care, and detailed administrative expenses, including shared service expenses. The budgets are established from underwriting models and State funding appropriations to ensure we have established targets within a fiscally sound range. This information is loaded into Hyperion and used on a monthly and quarterly basis to compare to actual results. Additionally, Magellan performs at least quarterly a re-forecast of results based on actual results to date and projected results based on sound estimates and assumptions of expense or initiatives.

Magellan utilizes both booked and incurred based methods of tracking financial performance. For purposes of analysis and forecasting, the incurred based method is used. This method restates all revenue and expenses to the month incurred, including an estimate of IBNR, so that the actual results of the period can be properly seen and evaluated for causal factors and corrective action plans. These restated financial results allow Magellan to identify trends, unit cost or utilization drivers easily, through the use of detailed medical cost reports that include admission, utilization per 1,000, unit cost averages, per member per month, and total dollars spend, by level of care. Magellan also captures claims data in a data warehouse that is then used as the source for developing detailed reports by provider, member type, service type, or any other variation needed to laser in on the causes of variances or outlier expenses. For the information gleamed from these reports, the Magellan finance, operations, network, and clinical teams meet to set corrective action plans that are then reviewed at least monthly for tracking of results.

iii. Technical Considerations: This section should identify any technical considerations that the bidder feels are pertinent to meeting the requirements of the RFP. The bidder should also include a detailed summary of bidder's ability and plan to meet the technical requirements of the RFP and how the bidder will make adjustments to accommodate any technical considerations identified.

Magellan Behavioral Health of Nebraska, Inc. has no objections to the technical requirements set forth in the RFP and offers no additional technical conditions.

iv. Detailed Project Work Plan: This section should include a detailed work plan that identifies the requirements of the RFP, transition, timelines, and key personnel that will be assigned to each area. The work plan should address, at a minimum, priority areas of development and implementation such as provider network, enrollee informational materials, systems-related technologies, and provider and staff training.

Magellan Behavioral Health of Nebraska, Inc. has provided a detailed work plan that supports the requiements of the RFP in **Attachment U**. The work plan includes a transition plan, timelines, and key personnel that will be assigned in each area.

Attachments
Redacted

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Managed Care Program for Mental Health and Substance Use Disorder Services

y 7, 2013

MAGELLAN
BEHAVIORAL HEALTH

Attachments Contents

A

A. Certificate of Authority

STATE OF NEBRASKA

DEPARTMENT OF INSURANCE

CERTIFICATE OF AUTHORITY

MAGELLAN BEHAVIORAL HEALTH OF NEBRASKA, INC.

DOMICILED IN THE STATE OF NEBRASKA

IS HEREBY AUTHORIZED AND LICENSED TO TRANSACT BUSINESS AS A PREPAID LIMITED HEALTH SERVICE ORGANIZATION IN THE STATE OF NEBRASKA AS DESCRIBED BY CHAPTER 44 ARTICLE 47 OF THE STATUTES OF NEBRASKA.

152231	Sept 28, 2012	Apr 30, 2013
NEBRASKA IDENTIFICATION NUMBER	DATE ISSUED	DATE EXPIRES

SIGNED AT LINCOLN, NEBRASKA

Bruce R. Ramge

DIRECTOR OF INSURANCE

B. Audited Financial Statements

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2011

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 or 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission File No. 1-6639

MAGELLAN HEALTH SERVICES, INC.
(Exact name of registrant as specified in its charter)

Delaware	**58-1076937**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
55 Nod Road, Avon, Connecticut	**06001**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: **(860) 507-1900**

Securities registered pursuant to Section 12(b) of the Act: **None.**

Title of Each Class	Name of Each Exchange on which Registered
Ordinary Common Stock, par value $0.01 per share	The NASDAQ Global Market

Securities registered pursuant to Section 12(g) of the Act: **None.**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities ıange Act of 1934 during the preceding twelve months (or for such shorter period that the registrant was required to file such reports), and (2) nas been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

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Securities registered pursuant to Section 12(g) of the Act: **None.**

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Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. Yes ☐ No ☒

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Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive

C. Corporate Organizational Structure

This attachment has been Redacted in it's entirety.

D. Resumes & Job Descriptions of Key Personnel

This attachment has been Redacted in it's entirety.

E

E. Clinical Practice Guidelines Development Review Policy

This attachment has been Redacted in it's entirety.

F

F. Model of Member Handbook

This attachment has been Redacted in it's entirety.

G. Nebraska Provider Directory

This attachment has been Redacted in it's entirety.

H

H. Nebraska Second Opinion Policy
Draft

This attachment has been Redacted in it's entirety.

I. Medicaid Service Authorization Determination Policy

This attachment has been Redacted in it's entirety.

J. At-A-Glance Provider Survey

This attachment has been Redacted in it's entirety.

K. Nebraska Report to the Community

This attachment has been Redacted in it's entirety.

L. Nebraska Provider Newsletter

This attachment has been Redacted in it's entirety.

M

M. Community Alliance NIATx Summary

This attachment has been Redacted in it's entirety.

N. Making Trauma Informed Care Real Webinar

This attachment has been Redacted in it's entirety.

O. Trauma Informed Care Symposium

This attachment has been Redacted in it's entirety.

P

P. Sample Denial Letter

This attachment has been Redacted in it's entirety.

Q

Q. Geo Access Maps - Child

This attachment has been Redacted in it's entirety.

R

R. Geo Access Maps - Adult

This attachment has been Redacted in it's entirety.

S. Geo Access Maps - Members and Provider Locations/Facilities

This attachment has been Redacted in it's entirety.

T

T. Sample Individual, Group and Facility Agreements

This attachment has been Redacted in it's entirety.

U

U. Project Implementation Plan

This attachment has been Redacted in it's entirety.

V. RCM Program Workflow

This attachment has been Redacted in it's entirety.

W. Sample IP Authorization Review

This attachment has been Redacted in it's entirety.

X. Sample Nebraska Reports

This attachment has been Redacted in it's entirety.