ATTACHMENT A.1

A.1 In Attachment A.1 **(no page limit, may include company name and logo in this response)**, the Offeror will provide the following organizational information:

a. The name and address of the Offeror and its corporate headquarters.

ValueOptions, Inc.
240 Corporate Boulevard
Norfolk, VA 23502

b. All names under which the Offeror has done business, including the names of any parent companies.

Proprietary and Confidential

The parent company of ValueOptions, Inc. is FHC Health Systems, Inc. (FHC), formerly known as First Hospital Corporation. We have conducted business under the following names:

- ValueOptions, Inc.
- Options Healthcare, Inc.
- Illinois Mental Health Collaborative for Access and Choice
- Massachusetts Behavioral Health Partnership

c. The date the Offeror began doing business specific to the services required under this Contract.

As a national health improvement company that specializes in behavioral and emotional wellbeing and recovery, we began providing managed behavioral health and intellectual and developmentally disabled (IDD) services to large Medicaid populations in 1995. Currently, we manage Medicaid behavioral health, substance use disorder and IDD programs in 15 states, serving nearly seven million lives. These contracts range from Administrative Services Only arrangements to full-risk contracting.

d. A description of any potential merger, reorganization, or change in ownership of the Offeror's company.

On May 27, 2014, ValueOptions' parent company entered into an agreement to be acquired by Beacon Health Vista, Inc. We expect the transaction to close in late 2014. No changes in ValueOptions' service capabilities or contracts are anticipated.

e. If the Offeror has been named a party in any litigation currently pending or resolved in the last five (5) years that might impact the Offeror's financial status or ability to perform under the Contract, provide information regarding the litigation and its potential impact.

As the legal entity responding to this eRFP, ValueOptions is and has been a defendant in certain types of litigation. The cases generally allege improper denial of benefits, breach of contract or ERISA claims. Amounts in controversy are generally unspecified above jurisdictional thresholds. The claims will have no impact on ValueOptions' financial status or ability to perform under the contract. Additional information on these cases is available from ValueOptions' General Counsel upon request.

ATTACHMENT A.2

A.2 In Attachment A.2 **(no page limit)**, the Offeror will list all BH or IDD-related accreditations (e.g., URAC) that the Offeror currently holds (as well as those held by any proposed Entities that would be applicable to this Contract). For each accreditation, provide the name of the accreditation agency, the accreditation type, the year received, the year of expiration, and the name and location of the Entity that holds the accreditation.

VALUEOPTIONS

The entire infrastructure of ValueOptions' operations is based on adherence to NCQA standards, as well as compliance with other appropriate accrediting agencies such as URAC. To ensure the highest quality services available to individuals, each ValueOptions state-based Engagement Center's core systems and processes are evaluated for quality and compliance, as well as individual satisfaction. We are proud to state that we have never failed an NCQA accreditation and have maintained our URAC accreditation in several Engagement Centers since 1999.

We have held a mega-site accreditation from URAC for Health Utilization Management since March 1, 1999. In addition, we are URAC accredited under Case Management 4.1 and Health Network 7.1 standards for our Jacksonville, Florida Engagement Center. We have used URAC standards as the road map for all operational processes and policies related to clinical, quality, customer service, and data security. We follow URAC's guidelines for ensuring all staff are appropriately licensed prior to interacting with clients/individuals or on a client's behalf. All of our operations, regardless of accreditation status, are required to conduct quality improvement studies that reflect sound design methodology, appropriate interventions, promote continuous quality, and lead to better quality of care and service for our stakeholders.

URAC ACCREDITED CASE MANAGEMENT

URAC ACCREDITED HEALTH NETWORK

URAC ACCREDITED HEALTH UTILIZATION MANAGEMENT

In addition, we are also Fully Certified for 10 out of 10 verification services as a Credentials Verification Organization (CVO). We identify, credential and re-credential all providers, facilities, and programs according to policies and procedures set forth by our National Networks Development and Management Department, and these standards are based on NCQA requirements. We ensure that our policies and procedures comply with the stringent accreditation standards of NCQA and URAC, as well as Federal requirements of CMS. This demonstrates that we have the systems, processes, and personnel in place to thoroughly and accurately verify providers' credentials.

CREDENTIALS VERIFICATION ORGANIZATION NCQA CERTIFICATION

In the table below, we list all of ValueOptions' NCQA and URAC accreditations. Each accreditation and certification is a testament to ValueOptions' commitment to excellence, with programs focused on quality improvement and patient protection to better meet individuals' needs and improve their treatment outcomes. We ensure that our programs follow processes that are clinically sound and respect patients' and providers' rights while giving our health plan clients reasonable guidelines to follow.

ValueOptions Engagement Center	Accreditation Status	Accredited Since	Effective Date
NCQA Accreditation			
Michigan	Full Accreditation – Managed Behavioral Health Organization (MBHO)	11/2/2000	10/25/2012 – 10/25/2015
Latham, NY	Full Accreditation – MBHO	10/24/2013	10/24/2013 – 10/25/2015
Massachusetts	Full Accreditation – MBHO	6/25/2012	6/25/2012 – 6/25/2015
New York City	Full Accreditation – MBHO	12/19/2011	12/19/2011 – 12/19/2014
North Carolina Commercial	Full Accreditation – MBHO	6/24/2008	6/2/2011 – 6/2/2014
ValueOptions, Inc.	Credentials Verification Organization (CVO) – Fully Certified for 10 out of 10 verification services	12/17/2012	12/17/2012 – 12/17/2014
URAC Accreditation			
California	Full Accreditation – Health Utilization Management (HUM) 7.0	5/1/2009	3/1/2013 – 3/1/2016
Colorado	Full Accreditation – HUM 7.0	3/1/1999	3/1/2013 – 3/1/2016
Jacksonville, Florida	Full Accreditation – HUM 7.0; Case Management 4.1; Health Network 7.1	9/1/2013 9/1/2013 9/1/2013	9/1/2013 – 9/1/2016 9/1/2013 – 9/1/2016 9/1/2013 – 9/1/2016
Michigan	Full Accreditation – HUM 7.0	3/1/1999	3/1/2013 – 3/1/2016
New York City	Full Accreditation – HUM 7.0	3/1/1999	3/1/2013 – 3/1/2016
North Carolina Commercial	Full Accreditation – HUM 7.0	3/1/1999	3/1/2013 – 3/1/2016
Tampa, Florida	Full Accreditation – HUM 7.0	3/1/1999	3/1/2013 – 3/1/2016
Texas Commercial	Full Accreditation – HUM 7.0	10/1/2011	3/1/2013 – 3/1/2016
Texas Public Sector	Full Accreditation – HUM 7.0	3/1/1999	3/1/2013 – 3/1/2016

DELMARVA FOUNDATION FOR MEDICAL CARE, INC. (DELMARVA FOUNDATION)

As a key partner in the ASO, Delmarva Foundation is also accredited by URAC for Health Utilization Management for their Columbia, Maryland site. This accreditation serves as a symbol of excellence in the health care industry and validates Delmarva Foundation's commitment to quality. Delmarva Foundation has full accreditation under the Health Utilization Management 7.2 standards since July 1, 2011 and is currently effective through July 1, 2014.

In addition, Delmarva Foundation's Quality Management System became ISO 9001:2008 certified in July 2011 and recertified in 2013. Their certifying body is UL Registrar, LLC. Obtaining and maintaining the ISO 9001:2008 certification validates Delmarva's commitment to meeting the globally recognized ISO (International Organization for Standardization) Quality Management System requirements and regulations. This designation demonstrates our focused commitment to quality within all levels of the organization and indicates what clients can expect when entrusting their business to us. The ISO standards process approach provides a standard approach to business and fosters customer satisfaction, efficient use of resources and decision making based on factual evidence. Delmarva abides by the ISO quality management system as it promotes a standardized approach to quality management, measurement and monitoring to assure achievement of requirements.

DELMARVA FOUNDATION
FOR MEDICAL CARE, INC.
REGISTERED TO ISO 9001:2008
AND 10012312

CRISIS ACCESS HOLDINGS, LLC d/b/a BEHAVIORAL HEALTH LINK

As another key partner in the ASO, Crisis Access Holdings, LLC d/b/a Behavioral Health Link comprises two partner companies: Integrated Health Resources, LLC and ProtoCall Services, Inc. (ProtoCall). Below are the current accreditations by location held by Integrated Health Resources and ProtoCall.

Accreditation	Accreditation Status	Accredited Since	Effective Date
Integrated Health Resources: Atlanta, Georgia			
URAC	Full Accreditation – Health Call Center 5.0	10/1/2004	10/1/2013 – 10/1/2016
CARF International	Full Accreditation – Crisis Intervention, Assessment and Referral, and Crisis and Information Call Center* (Integrated AOD/MH Adults, Children and Adolescents) ***Behavioral Health Link was the first CARF-accredited Crisis and Information Call Center in the U.S.***	9/2007	8/2013 – 8/2016
AAS (American Association of Suicidology)	Accredited – Crisis Intervention Program	12/2002	12/2010 – 12/2015
Contact USA	Full Accreditation – OES (Online Emotional Support)	10/2012	10/2012 – 10/2014
ProtoCall Services: Portland, Oregon			
CARF International	Full Accreditation –Crisis and Information Call Center (Integrated AOD/MH Adults)	6/2012	6/2013 – 6/2016
AAS (American Association of Suicidology)	Accredited – Crisis Intervention Program	10/2002	9/2010 – 9/2015

ATTACHMENT A.3

A.3 In Attachment A.3 **(no page limit)**, if the Offeror has been sanctioned or penalized due to poor or non-performance of contractual obligations in the last five (5) years, provide information regarding the sanction or penalty (e.g., nature of failure to perform, sanction, corrective action plans, penalty type and amount, time to cure). Do not include performance guarantees here.

Of the course of the last five years, ValueOptions, Inc. has had corrective action plans (CAPs) associated with one of our state Medicaid contracts. Details for each CAP are provided in the table below.

State	CAP Detail
Arkansas	**Nature of the problem:** Percent of staff interviews on Inspections of Care (IOC) did not meet minimum requirements. **Corrective action:** It was identified that this deviation was a training deficiency of our Quality Reviewers. It was not clear as to the total scope of the Quality Reviewers responsibility when reviewing Inspections of Care. To that end, all inpatient reviewers met to discuss this requirement, the findings of the review, and ways to meet this requirement. ValueOptions' Compliance Auditor will continue to monitor all Inpatient Inspections of Care reports to verify that this requirement is being met. **Penalty:** No penalty assessed. **Time to cure:** There is no specific time to cure required by the State; however, ongoing monitoring is in place to ensure this requirement is continually being met. **Nature of the problem:** Wrong regulation on a denial letter. **Corrective action:** Denial statement templates were updated to reflect the correct regulation. **Penalty:** No penalty assessed. **Time to cure:** There was no specific time to cure require by the State; however, ValueOptions corrected the issue within one day of being notified. **Nature of the problem:** Inspections of Care reports exceeded 14-day turnaround time. **Corrective action:** The Quality Manager trained an additional staff member to provide backup for IOC reporting. The Quality Manager scheduled 10 hours per week to ensure reports where completed on time. The Executive Director meets with the Quality Manager once a week to ensure that IOCs are being completed on time. A focus group was convened to make recommendations on reducing report length to reduce time spent by the reviewer but still meet contractual requirements. **Penalty:** No penalty assessed. **Time to cure:** There was no specific time to cure required by the State; however, all reporting turnaround times were met within two months. **Nature of the problem:** Some criminal background checks had been obtained but not through the Arkansas State Police central registry and no Adult Abuse or Child Maltreatment Registry checks had been completed. **Corrective action:** Criminal background checks were submitted to the Arkansas State Police and Adult Abuse and Child Maltreatment Registry check were completed.

State	CAP Detail
	Penalty: No penalty assessed. **Time to cure:** There was no specific time to cure required by the State; however, all checks were completed within two months of notification. **Nature of the problem:** An employee queried ValueOptions' care management system for three beneficiaries' review history in order to "substantiate that the family was in need" prior to taking up an in-office donation of clothing, backpacks, etc. **Corrective action:** In order to prevent a re-occurrence of this type of incident, the supervision will conduct monthly coaching for a minimum of six months and audit the employee's activity within the care management system. In addition to the annual HIPAA training required by ValueOptions, the employee and other staff will have a refresher HIPAA training by the Compliance Department. The employee has been notified that any further violation may lead to termination. **Penalty:** No penalty assessed. **Time to cure:** Time to cure was immediate.

ATTACHMENT A.4

A.4 In Attachment A.4 **(limit two (2) pages)**, provide two examples when the Offeror did not meet a performance guarantee, the type of performance guarantee not met, the reason the performance guarantee wasn't met, the corrective action required, and the amount of time that elapsed before the performance guarantee was eventually met.

ValueOptions administers mental health and addiction services for the Connecticut Behavioral Health Partnership (CT BHP). The CT BHP comprises the Department of Children and Families, the Department of Social Services and the Department of Mental Health and Addiction Services. The program collaborates with providers and community stakeholders in providing appropriate services and support for the state's 627,000 Medicaid recipients. It was created in 2006 to manage children, adolescents, parents and their families and expanded in 2011 to include the adult Medicaid population. Below are two examples of how we identified a deficiency in meeting a performance guarantee and successfully addressed it.

EXAMPLE ONE
Exceeding Minimum Downtime for Call Center Operations

The CT BHP call center, or Engagement Center, located in Rocky Hill, Connecticut, utilizes Voice over Internet Protocol (VoIP) technology for telecommunications services. This service is provided by Avaya (software/hardware) and MCI (T1connectivity). Major services provided include: incoming calls (switchboard and direct dial), outgoing calls (local and long distance), voicemail, and call management services. A toll-free number is available for providers and members to access our Engagement Center. Per our contract, the Engagement Center is under a performance guarantee to ensure no telecommunications outage occurs during normal business hours that exceeds 15 minutes and to provide continuous operations (i.e., no break in member and provider telecommunications and authorization services of more than 30 minutes).

On July 10, 2006 at 9:05 a.m., the Engagement Center was notified by a provider that the provider was unable to complete a call via the toll-free number. The provider received an "unable to complete call as dialed" response. The CT BHP local IT department quickly assessed the situation and was unable to ascertain the cause or an immediate solution. At 9:10 a.m., business recovery procedures (i.e., re-routing calls to ValueOptions' Colorado Engagement Center) were initiated. These procedures included contacting our Colorado Engagement Center to inform staff there of the situation to prepare the Engagement Center for the re-routing of calls and notifying the clinical and customer service staff of the business recovery action. Simultaneously, a priority one ticket was placed to ValueOptions' National Technology Center for assistance.

During a day-long evaluation/investigation and numerous technical conference calls among local IT, national telecommunications, MCI and Avaya, as well as on-site visits from AT&T/ SBC (MCI's sub-contractor) and Avaya technicians it became apparent that a system design flaw had occurred. During the configuration process, three of the circuits were designed incorrectly as a

result of a miscommunication between MCI and its subcontractor. This caused all 70 of the Long Distance trunk circuits used to deliver calls to the Engagement Center's toll-free number to be removed from service and made unavailable. This resulted in any call to the toll-free number to receive a response of "unable to complete call as dialed" until business recovery was activated.

Through extensive testing, the problem was correctly identified. Once identified, the vendor began rewiring and re-optioning to resolve the issue. At 11:00 p.m. on Monday, July 10, 2006, remediation was completed and CT BHP was removed from business recovery. The system was tested in normal state and passed.

EXAMPLE TWO
Failure to Send Authorization Letters to Members within an Eligibility Group

Our CT BHP contract also includes a performance guarantee related to "The timeliness of UM Decision Written Notification – Authorization letter extract." As the ASO, ValueOptions is required to generate a report on the number and percentage of cases that met the required timeframe for written notification. For those cases that did not meet the goal, the report includes the average timeframe for completion, including initial and continued stay reviews for favorable and adverse decisions. A $3,000 per quarter penalty is associated with not meeting the standard.

Through an internal audit process it was discovered a number of authorization letters were not printed and sent to providers. The root cause of the error was a combination of a system error and a flaw in the workflow associated with letter generation. An immediate change was made in the workflow to prevent future letter print errors and the system error was corrected.

The potential for the error existed from the go-live date, January 1, 2006, until the reconciliation report was implemented on April 30, 2007. The error prevented a number of authorization letters from being printed and delivered to providers. The error was limited to letters associated with concurrent reviews and did not prevent providers from receiving reimbursement for their services. It was estimated that 8,000 authorization letters were inappropriately prevented from being printed as a direct result of this problem.

A reconciliation report was developed and implemented in April 2007 to enable Engagement Center staff to monitor the production of the authorization letters. The report is now produced on a weekly basis and reviewed by the Director of IT and Reporting to verify that all authorization letters are being appropriately printed. Authorization letters not previously mailed were sent to providers with a letter of explanation. Since implementing the change, we have consistently achieved the required performance guarantee.

ATTACHMENT A.5

A.5 In Attachment A.5 **(no page limit)**, the Offeror will provide a list of all subsidiary organizations, affiliates, or subcontractors (collectively, Entities) that would be associated with the performance of this Contract.

For each Entity, identify the date upon which the Offeror first began doing business with the Entity, and the functions that each Entity will perform. Describe Offeror's authority or oversight to be provided to each Entity during this Contract.

ValueOptions will be subcontracting with two leading statewide entities to deliver our **"High Assurance"** program:

1. **Crisis Access Holdings, LLC d/b/a Behavioral Health Link:** Crisis Access Holdings, LLC d/b/a Behavioral Health Link will provide telephonic and mobile crisis single point of entry services for the Georgia Crisis and Access Line (GCAL) as well as all other ongoing operational elements of the GCAL program.
2. **Delmarva Foundation for Medical Care, Inc. (Delmarva Foundation):** Delmarva Foundation will conduct Person-Centered Reviews, Quality Enhancement Provider Reviews and other quality oversight and reporting services relevant to the IDD program requirements of the contract deliverables.

Together, we offer the advantages of a mature, nationally recognized behavioral health improvement company with superior information technology and experience building effective systems of care, joining two locally managed organizations with proven success working with the State and its providers.

While this will be our initial opportunity to do business with each of these organizations, both of them are well known to DBHDD as they currently hold the contracts for GCAL and the Developmental Disability Quality Management Organization.

"High Assurance" is our comprehensive approach to ensuring high-quality, appropriate behavioral health and IDD services and administrative efficiencies in support of the Georgians we serve. This unique approach provides:

- Faster access to crisis services and streamlined authorization of services
- The highest possible level of person-centered clinical oversight, including treatment history, with a special focus on individuals with IDD
- Enhanced engagement and treatment outcomes through the use of Peer Support Specialists and Intensive Care Managers
- Ease of transition among all levels of care, backed by the highest level of quality assurance
- Sophisticated and effective discharge planning and connectivity to care
- Consistent delivery of evidenced-based practices among network providers

- Qualitative and quantitative outcome measures
- Robust analytics and reporting to assist providers in ensuring each individual's assessed needs are met
- State-of-the-art information systems and new technologies to streamline providers' administrative burden and promote transparency

OVERSIGHT OF SUBCONTRACTOR PERFORMANCE

ValueOptions' Chief Executive Officer for the Georgia Collaborative ASO (the ASO) will have ultimate accountability for contract and regulatory compliance, and all other work performed under this contract, including the performance of all subcontracted and delegated entities. Behavioral Health Link, Delmarva Foundation and ValueOptions share a philosophy and practice of designing systems thoughtfully, hiring the most qualified staff, and operating within a paradigm of "doing it right the first time." As such, our organizations have earned a reputation for seamless implementations and commitment to customer service. Of equal importance in our ability to work cooperatively as one unified contractor, is that all three of our organizations share a common goal of providing "a behavioral health recovery-oriented system of care and an IDD person-centered habilitative system of care."

The GCAL Director will report to the ASO's Chief Executive Officer and the DD Director will report to the ASO's Vice President of Quality Management. Similar to the department directors employed by ValueOptions, each subcontractor will be held accountable for the timely completion of each of their specific responsibilities. Through multiple avenues, including verbal and written status reports, DBHDD will routinely be provided an honest and accurate appraisal of the services being delivered to individuals. We will rely on our collective successful experience implementing and managing Medicaid programs, interfacing with multiple fiscal agents and achieving significant improvement in provider scores as a result of comprehensive audits and training to implement and operationalize a successful program for the State and citizens of Georgia.

As integral partners within the Georgia Collaborative ASO, Delmarva Foundation and BHL have extensive, local experience administering behavioral health and IDD programs and services. These two subcontractors are well known to the State and have successfully demonstrated their commitment to the DBHDD and the community it serves. We will engage all stakeholders and encourage open dialogue; listening to recommendations and opportunities for change from all parties involved. We will depend on individuals and family members throughout the state to hold us accountable to provide and maintain a service delivery system that allows individuals to focus on recovery, resiliency and independence to maximize their own skills and abilities.

ATTACHMENT A.6

A.6 In Attachment A.6 **(no page limit)**, provide the following information for each Entity listed in A.5. Repeat as needed to complete the response.

CRISIS ACCESS HOLDINGS, LLC D/B/A BEHAVIORAL HEALTH LINK

a. The name and address of the Entity and its corporate headquarters.

Crisis Access Holdings, LLC d/b/a Behavioral Health Link
260 Peachtree Street
Suite 1900
Atlanta, GA 30303

b. All names under which the Entity has done business, including the names of any parent companies.

The parent company of Crisis Access Holdings, LLC is Integrated Health Resources, LLC d/b/a Behavioral Health Link in partnership with ProtoCall Services, Inc.

c. The date the Entity began doing business related to the services required under this Contract.

Behavioral Health Link began providing telephonic crisis/access and single point of entry services in 1995 and GCAL services specifically in Georgia in July 2006. ProtoCall Services began behavioral health call center services in 1992 and statewide crisis and access services in New Mexico in 2012 and Idaho in 2013.

d. A complete description of the ownership (e.g., public, private), age, and scope of the Entity's company.

Crisis Access Holdings, LLC is a private, for-profit Georgia-based company and qualifies as a small business in Georgia. Crisis Access Holdings, LLC is owned by Behavioral Health Link (66.67 percent) and ProtoCall Services (33.33 percent). Originally formed in 1995, Behavioral Health Link's business scope is to provide telephone and Web-based crisis, access and referral services to individuals of all ages seeking assistance for mental health, addictive disease and IDD issues.

e. A description of any potential merger, reorganization, or change in ownership of the Entity's company.

There are no potential activities related to merger, reorganization, or change in ownership of Crisis Access Holdings, LLC or their parent companies at this time.

f. If the Entity has been named a party in any litigation currently pending or resolved in the last five (5) years that might impact the Entity's financial status or ability to perform under the Contract, provide information regarding the litigation and its potential impact.

Crisis Access Holdings, LLC d/b/a Behavioral Health Link, Integrated Health Resources nor ProtoCall Services, Inc. has not had any litigation in the last five years, nor is any litigation pending.

g. If the Entity has been sanctioned or penalized due to non-performance of contractual obligations in the last five (5) years, provide information regarding the sanction or penalty (i.e., nature of failure to perform, sanction/penalty type and amount, time to cure).

There have been no sanctions or penalties due to non-performance of contractual obligations in the last five years for Crisis Access Holdings, LLC d/b/a Behavioral Health Link, Integrated Health Resources d/b/a Behavioral Health Link, or ProtoCall Services, Inc.

h. Number and percentage of Entity personnel, full- and part-time, that would be assigned to this Contract by function and job title.

The number of Behavioral Health Link's staff, full time and part time, assigned to this contract is provided in the table below. These staff account approximately 57 percent of Behavioral Health Link's total staff.

Job Function	FTE
Clinical Oversight:	
Medical Director	0.6
GCAL Director	1.0
Clinical Oversight Subtotal	**1.6**
IDD:	
IDD Outcomes Manager	1.0
IDD Supervisor	1.0
IDD Clinicians	10.0
IDD Subtotal	**12.0**

Job Function	FTE
Behavioral Health:	
Engagement Center Operations Manager	1.0
Behavioral Health Outcomes Manager	1.0
Engagement Center Supervisor	2.0
Performance and Outcomes Administrator	1.0
Assistant Supervisor/Shift Clinical Team Leads	7.0
Engagement Center Clinicians/Crisis Intervention Specialists	56.6
Engagement Center Care Consultants/Certified Peer Specialists	28.2
Behavioral Health Subtotal	**96.8**
Support Staff:	
IT/Tech Support	2.0
QM/Training	1.0
Support Staff Subtotal	**3.0**
Behavioral Health Link Total	**113.4**

i. Percentage of Entity's business that is a result of a business relationship with the Offeror.

Behavioral Health Link's subcontractor relationship with ValueOptions for the Georgia Collaborative ASO represents 50 percent of Behavioral Health Link's total business revenue.

DELMARVA FOUNDATION FOR MEDICAL CARE, INC. (DELMARVA FOUNDATION)

a. The name and address of the Entity and its corporate headquarters.

Delmarva Foundation for Medical Care, Inc.
9240 Centreville Road
Easton, MD 21601

b. All names under which the Entity has done business, including the names of any parent companies.

Delmarva Foundation has conducted business as Delmarva Foundation for Medical Care, Inc. with Quality Health Strategies, Inc. as the parent company.

c. The date the Entity began doing business related to the services required under this Contract.

Since 1973, Delmarva Foundation has been dedicated and committed to ensuring people with disabilities receive high quality person-centered services. Delmarva Foundation provides critical feedback to states regarding the effectiveness of local and statewide service delivery systems. Since 2008, Delmarva Foundation has partnered with DBHDD to improve the quality of support services for Georgia's citizens with developmental disabilities.

d. A complete description of the ownership (e.g., public, private), age, and scope of the Entity's company.

Delmarva Foundation is a non-profit organization established in 1973 as a Professional Standards Review Organization. Since then, the organization has grown extensively in size, mission, and impact, and is now a recognized leader in quality assurance and quality improvement. Delmarva Foundation is designated by CMS as a Quality Improvement Organization (QIO) in the state of Maryland, and performs external quality review and other services to Medicaid agencies across the United States. The organization provides quality assurance and quality management products and services for all health care provider sectors, as well as home- and community-based waiver support providers. Delmarva Foundation also has current contracts for Medicaid Developmental Disability quality assurance/quality management, utilization review, quality improvement, external quality review, and patient safety quality improvement programs.

e. A description of any potential merger, reorganization, or change in ownership of the Entity's company.

There are no potential activities related to merger, reorganization, or change in ownership of Delmarva Foundation or their parent company at this time.

f. If the Entity has been named a party in any litigation currently pending or resolved in the last five (5) years that might impact the Entity's financial status or ability to perform under the Contract, provide information regarding the litigation and its potential impact.

Delmarva Foundation has neither any litigation in the last five years nor pending litigation.

g. If the Entity has been sanctioned or penalized due to non-performance of contractual obligations in the last five (5) years, provide information regarding the sanction or penalty (i.e., nature of failure to perform, sanction/penalty type and amount, time to cure).

There have been no sanctions or penalties due to non-performance of contractual obligations in the last five years for Delmarva Foundation.

h. Number and percentage of Entity personnel, full- and part-time, that would be assigned to this Contract by function and job title.

The number of Delmarva Foundation's staff, full time and part time, assigned to this contract is provided in the table below. These staff account for 16.13 percent of Delmarva Foundation's total staff.

Job Function	FTE
Programmatic Oversight:	
Vice President, Disability Programs	0.34
DD Administrative Director	1.0
Regional Manager	4.0
Programmatic Oversight Subtotal	**5.34**
Analysis and Reporting:	
Senior Scientist	0.30
Health Analyst	1.0
Analysis and Reporting Subtotal	**1.3**
Administrative Support:	
Administrative Assistant	1.0
Administrative Manager of Mail and Copy Room	0.02

Job Function	FTE
Lead Project Support	0.03
Project Support	0.02
Administrative Support Subtotal	**1.07**
IDD Project Staff:	
Quality Improvement Consultants	14.83
Registered DD Nurse	0.1
IDD Project Staff Subtotal	**14.93**
IT Support:	
Director Data Management	0.08
Director Network Infrastructure	0.01
Director Application Development	0.01
Application Developer	0.16
Systems Administrator	0.02
Network System Engineer	0.01
Data Architect	0.16
Business Systems Analyst I	0.04
Business Systems Analyst II	0.06
Webmaster	0.04
IT Support Subtotal	**0.59**
Delmarva Foundation Total	**23.23**

i. Percentage of Entity's business that is a result of a business relationship with the Offeror.

Delmarva Foundation's subcontractor relationship with ValueOptions for the Georgia Collaborative ASO represents 12.26 percent of Delmarva Foundation's total business revenue.

ATTACHMENT A.7

A.7 In Attachment A.7 **(limit three (3) page)**, the Offeror will provide a description of the Offeror's authority or oversight to be provided to the Entity during this Contract.

Should ValueOptions be awarded this contract, we will provide an integrated, person-centric, whole-person approach to recovery for behavioral health and an IDD person-centered habilitative system of care. This **"High Assurance"** approach offers DBHDD a pairing of the best of a mature, nationally recognized behavioral health organization with superior information technology capabilities and deep experience in providing innovative programs for Medicaid and State-funded behavioral health programs with the existing Georgia GCAL and IDD quality review contractors. This combination will provide DBHDD with a high degree of confidence that the new contract will be implemented on-time and meet or exceed all program requirements.

As stated in our response to *Section A.5*, the ASO's Chief Executive Officer will have ultimate accountability for contract and regulatory compliance and all other work performed under this contract, including the performance of all subcontracted and delegated entities. The GCAL Director will report to the ASO's Chief Executive Officer and the DD Director will report to the ASO's Vice President of Quality Management. Similar to the department directors employed by ValueOptions, these subcontractors will be held accountable for the timely completion of each of their specific responsibilities.

To ensure we incorporate the experience and expertise of all participating organizations, we propose to have an Integrated Steering Committee that will comprise the leadership of ValueOptions, BHL, Delmarva, and the ASO. This committee will review reports from the ASO's various committees, discuss new strategic initiatives, address any issues identified by DBHDD, and ensure the ASO is receiving the full resources and support from each of the participating organizations.

ENSURING ACCOUNTABILITY OF THE PROGRAM

We will draw upon our experience across the country in the development and implementation of similar methods and systems to ensure accountability of the program. As graphically depicted on the following page, the Integrated Steering Committee will be responsible for oversight of our committees that are charged with ensuring that compliance, quality management, clinical, financial, reporting, data and IT, and other administrative and clinical activities are conducted in accordance with the applicable regulations and contract for the program. These functions are assigned to core committees for monitoring and oversight at the direction of the Integrated Steering Committee. These core committees include:

- Quality Management Committee
- Utilization Management/Utilization Review Committee
- Consumer Rights Subcommittee
- Compliance Committee

The committees may establish subcommittees or task groups to assist them in completing their associated tasks. To facilitate oversight, minutes of each committee, with the exception of the Corporate Compliance Committee, will be submitted monthly to the Integrated Steering Committee, as well as reports representing quality, clinical, IT, finance, and compliance activities. Compliance issues identified in any of the areas described that result in corrective action recommendations will be presented to the Integrated Steering Committee for review, evaluation and recommendations. Quarterly compliance reports and minutes from the Corporate Compliance Committee will be submitted to the Integrated Steering Committee for approval and enforcement of corrective action plans.

ATTACHMENT A.8

A.8 In Attachment A.8 **(limit three (3) page)**, the Offeror will provide a description of a scenario relevant to the work in this RFP with a subcontractor in which the subcontractor's performance was deficient and how the Offeror provided oversight to ensure the deficiency was corrected. Include a description of the issue, how the issues were identified, and how the subcontractor's performance was brought into compliance.

Due to the complexity in the scope of work of our large state contracts, ValueOptions often elects to bring in specific external expertise to support our management staff and operational processes. The scope of work of each subcontractor's contract is developed by the leadership of the local Engagement Center it serves. The language of the final contract is then developed and approved by our corporate legal staff. However, no matter what services we delegate to a subcontractor, it is ValueOptions' policy to maintain full accountability and responsibility for the actions of any subsidiary organization, affiliate, or subcontractor. Our experience engaging a subcontractor to assist operating a combined physical/behavioral health care management program in Massachusetts provides a relevant example of how we address and monitor deficient subcontractor performance.

ValueOptions' Massachusetts Behavioral Health Partnership (MBHP) manages a comprehensive system of behavioral health care management support services and specialty services for more than 350,000 members in MassHealth's Primary Care Clinician Plan (a Massachusetts Medicaid program). In 1996, MBHP and the State collaborated to build a nationally recognized public behavioral health system; an innovative contract between MBHP and the State that promotes access to quality care and fiscal accountability.

In 2012, we successfully re-procured the contract and expanded services to encompass a comprehensive, integrated physical and behavioral health care system in which medical and mental health providers collaborate in managing each member's total health. MBHP subcontracted with a nationally recognized care coordination organization to deliver a seamless and enhanced Integrated Care Management Program (ICMP). The subcontractor provided additional expertise in predictive modeling that integrates behavioral health, medical and pharmacy claims to identify individuals who would benefit from the program. It also provided care management nursing staff to address members with a physical health primary diagnosis, while ValueOptions' care managers were responsible for members with a behavioral health primary diagnosis. The goals of the ICMP are to improve patient outcomes and patient health-related quality of life, reduce psychotropic poly-pharmacy, reduce physical health and behavioral health inpatient days, and increase patient satisfaction.

In our proposal, we identified the number of individuals we would successfully recruit and enroll in the program as well as the staffing we would commit to the program. As a result, our contract with the State required us to:

- Provide a tiered model to address the diversity and range of enrollees' health care needs. A minimum of two Tiers were required with a maximum of four Tiers. At least one tier needed to be designed for enrollees with the most complex needs and at the highest risk for poor health outcomes.
- Assign the agreed upon, appropriate staffing resources to each Tier of the ICMP. For at least the highest Tier of enrollees, we were required to assign a registered nurse as the primary care manager who may oversee a care coordination team.
- Propose a minimum Outreach Target and Engagement Target for each Tier based on the predictive modeling stratification of enrollees. The Engagement Target would then be used in assessing the contractor's eligibility for Care Management Performance Incentive payments.

During the first contract year period (October 2012 through September 2013) for the care management program, the contract contained a minimum annual engagement target for the care management program. However, at the end of the first year this target was not achieved. The failure to achieve this target was significantly impacted by the subcontractor's challenges in retaining nursing staff throughout the first year of the program.

The first three months of the care management program was a ramp-up period; however, the subcontractor was only able to hire 21 out of the 42 nursing staff positions we committed to in our RFP response. By month three, the nursing turnover escalated and the subcontractor had difficulty maintaining a nurse staff of 20 at any given time. Also, after the third month of the contract, which was the peak month that the program gained the greatest number of engaged members, a steady leveling off and decline in the engagement rate became evident. The nurses who were working in the program had consistently high caseloads due to an inadequate number of nurses to meet volume demands.

ValueOptions raised the low staffing issue with the contractor as soon as it was apparent that it was having a negative impact on the engagement process. Since we had a longer tenure in the state than the subcontractor and were familiar with the health sector labor market, we offered several suggestions on how to improve recruitment and retentions efforts. We also continued to monitor the nurse attrition and engagement rate issues via weekly and monthly reports. We reviewed the data and communicated with the subcontractor on a regular basis in operational, quality and executive meetings.

As part of our plan to address the operational shortfall of our subcontractor, we restructured the contract to allow us to conduct an annual assessment, audit and evaluation of the services delegated to the subcontractor, including a review of all applicable policies and procedures. We also included language that imposed financial penalties for excess caseloads and failure to meet engagement targets and gave us the right to require a corrective action plan from the subcontractor, if warranted. This change provided us a process to correct any deficiencies resulting from the assessments, audits and evaluations we intended to conduct. Should the subcontractor fail to perform the delegated services as required under the subcontract or fail to correct deficiencies pursuant to a corrective action plan agreed to by the parties, language was added to allowed us to terminate the contract.

In addition to adding sanctions to the contract, we also established a joint program review committee to improve collaboration. The subcontractor has improved in the following areas:

- The number of registered nurses increased to 37 (from 17) in approximately 60 days
- The subcontractor has offered six month bonus incentives to lessen staff turnover
- There has only been one nurse resignation (new hire) in the past 60 days
- Caseloads decreased from more than 190 to under 120

MBHP staff continues to monitor the subcontractor experience. We require monthly reports on staffing numbers and have regularly scheduled oversight meetings where we collectively strategize on improving coordination between our respective staff. While all ValueOptions subcontracts, including those associated with this proposal, include specific oversight/monitoring activities, corrective action plan requirements, and financial penalties as applicable, we primarily rely on working collaboratively to address performance deficiencies.

ATTACHMENT A.9

A.9 In Attachment A.9 **(no page limit)**, for each management team and key position submit a job description, with the associated minimum qualifications and training requirements. If the Offeror plans to propose specific individuals to fill management or key positions as part of its Offer, also include the resume/curricula vitae of proposed candidates and the associated position for which he or she is a candidate.

The cornerstone of our workforce development initiative is an integrated approach to talent management that focuses on building organizational capacity and performance through employees who have the knowledge, skills, talent, and motivation to achieve success. It guides our initiatives to organize, attract, acquire, engage, train and educate, as well as develop and retain the talent needed to support our mission and achieve business goals. In the table below we have identified those positions that we will hire for and those position that will be filled by existing staff.

Position	Proposed Staff
Management Team	
Chief Executive Officer	To be hired
Chief Medical Officer	To be hired
Behavioral Health Administrative Director	To be hired
Developmental Disabilities Administrative Director (DD Project Director)	Marion Olivier
Key Positions	
Director of Management IS	To be hired
Quality Management Director	To be hired
Director of Independence and Recovery Advocacy	To be hired
Director of Data Management and Reporting	To be hired
Corporate Compliance Officer	To be hired
GCAL Director	Wendy Martinez Schneider, M.S., LPC
Director of Utilization Management and Review	To be hired

On the following pages, we have included resumes for:

- GCAL Director – Wendy Martinez Schneider, MS, LPC
- Developmental Disabilities Administrative Director (DD Project Director) – Marion Olivier

WENDY MARTINEZ SCHNEIDER, M.S., LPC
GCAL Director/Chief Clinical Officer

PROFESSIONAL EXPERIENCE

Behavioral Health Link **2011 – Present**
Chief Clinical Officer **Atlanta, GA**

- Responsible for the overall clinical operation of crisis call center and mobile crisis services in conjunction with the Medical Director
- Develops and executes a variety of community outreach and public relations programs to support the company's mission
- Assists with business procurement and development for clinical programs

Director of Community Services for Georgia

- Managed the protocol documentation process including the evaluation and continuous improvement of provider services, implementation of contracted obligations, and formulation of relevant policies and procedures
- Collaborated with key stakeholders to identify informational opportunities for providers and the behavioral health community

Universal Health Services SummitRidge Hospital **2008 – 2011**
Director of Outpatient Services/Patient Advocate **Lawrenceville, GA**

- Responsible for the clinical and administrative operations of the ECT, intensive outpatient, and partial hospital programs for adults and adolescents
- Recruited, trained, and supervised all masters-level interns from multiple universities
- Served as the Patient Advocate responsible for resolving patient and family grievances, overseeing implementation of the patient rights policies, and making recommendations for appropriate staff training/discipline and policy revisions
- Compiled monthly and quarterly reports to identify trends in patient satisfaction and grievances to identify performance improvement opportunities for the facility
- Assisted the Risk Manager with identifying areas of increased risk for patients, staff, and the facility

Director of Assessment/Patient Advocate

- Supervised the operation of 24/7 Assessment/Intake Department for a 78 bed, private psychiatric facility serving adults, adolescents, and senior adults in intensive outpatient, partial hospital, and inpatient services
- Managed the assessment, pre-authorization, registration, physician assignment, bed management, and census reconciliation processes to ensure accessibility
- Recruited and trained clinical staff to allow 24-hour assessment capacity
- Supervised the Mobile Assessment Team serving the Gwinnett Medical Center Emergency Departments and Clinical Nurse Specialists providing psychiatric evaluations to inpatients in Duluth and Lawrenceville 24/7

Adult Inpatient Program Manager
- Responsible for the overall clinical operation of a 35 bed adult inpatient unit
- Ensured appropriate staffing ratios for patient care
- Supervised Registered Nurses, Social Services Staff, and Mental Health Technicians
- Led interdisciplinary treatment team to plan and evaluate client care and progress

Behavioral Health Link **2005 – 2008**
Director of Mobile Crisis Services **Atlanta, GA**
- Provided overall clinical and administrative supervision for the operations of the Augusta, Atlanta, and Northwest Georgia Mobile Crisis Teams and the Atlanta Crisis Intervention contract with the Georgia Department of Human Resources
- Ensured accessible, responsive, and quality crisis services 24/7 to the three most populous regions in Georgia (a total of 40 counties)
- Supervised Mobile Crisis Coordinators responsible for three regions
- Ensured program compliance with CARF and MHDDAD Guidelines
- Responsible for the management of an annual budget of 3 million dollars
- Implemented Region 1 Mobile Crisis Team serving 25 counties with the ability to respond to residences, facilities and the street 24/7 surpassing contract expectations for contacts and response time in the first full month of service with an 85% State Hospital Diversion Rate

Coordinator Mobile Crisis Services – Region 2
- Served as Program Coordinator for mobile crisis services in 13 counties of the East Central Georgia Region
- Conducted face-to-face clinical assessments for consumers in crisis to screen for eligibility for services at emergency rooms and other healthcare facilities
- Recruited and trained clinical assessment staff to allow 24-hour crisis intervention and assessment availability
- Instrumental in implementing a System of Care approach to serving children in crisis involving schools, families, DJJ, DFCS, Law Enforcement, Emergency Departments and local mental health providers

Community Mental Health of East Central Georgia **2001 – 2005**
(Now Serenity Behavioral Health) **Augusta, GA**
Social Services Coordinator II
- Served on the Leadership Team as the clinical program manager for programs serving adults with severe and persistent mental illness including Day Services, Community Support Services, Supported Employment, Supported Living, Outpatient Services, and PATH Outreach Services
- Supervised 45 professional, paraprofessional, and clerical employees
- Ensured program compliance with CARF, Medicaid, Medicare, and Department of Human Resources standards
- Served as Co-Chair of the Rights, Ethics, and Compliance Committee
- Secured funding and operated a federal grant funded PATH program with an annual award of $100,000 for assisting the homeless in transition to mainstream mental health services

Social Services Coordinator
- Managed Day Services, Supported Living, and Supported Employment
- Supervised fifteen professional and paraprofessional employees
- Ensured program compliance with JCAHO, Medicaid, and Human Resources standards
- Spearheaded program philosophy change from the medical to the recovery model

Social Services Provider II
- Served as team leader for the Day Services Program, and supervised six employees
- Conducted assessments and wrote treatment plans for a caseload of 150 clients
- Monitored program for compliance with JCAHO, Medicaid and Human Resources standards

Rogers Memorial Hospital **2000 – 2001**
Patient Care Specialist **Oconomowoc, WI**

Intake Specialist

Life Resource CMHC (Now Spindle Top MHMR) **1998 – 1999**
Caseworker I- Family Preservation Daybreak Youth Services **Beaumont, TX**

Interim Therapist- Daybreak Residential Services

PROFESSIONAL LICENSES AND CERTIFICATIONS

- Licensed Professional Counselor (LPC), Georgia **2007**
- Certified Psychiatric Rehabilitation Practitioner (CPRP) **2005 – 2008**
- Certified NAMI Family to Family Educator **2003**

EDUCATION

Marquette University **1998**
Master of Science, Clinical Psychology **Milwaukee, WI**

Marquette University **1994**
Bachelor of Arts, Psychology **Milwaukee, WI**

MARION OLIVIER
DD Project Director

PROFESSIONAL EXPERIENCE

Delmarva Foundation **2003 – Present**
Project Director **Atlanta, GA**

- Ongoing responsibilities include managing a $3.7 million dollar annual budget and providing direct support and supervision of an administrative assistant, five regional managers, and oversight for 18 field staff
- Ensures all contract deliverables are met by facilitating status meetings with State personnel
- Manages and monitors a sub-contract with the project to ensure the quality and timeliness of their deliverables
- Develops and maintains relationships with all stakeholders and state advocacy groups
- Assisted in the design and continues to ensure the maintenance of three Web-based applications and two websites
- Creates and supports recommendations generated through quarterly and annual reports based upon data collected throughout the annual review activity
- Supports, encourages, and advocates for continuous quality improvement practices at the State, regional, and provider levels, as well as internally for this project

Independent Consultative Review Expert **2013 – Present**

- Responsibilities include conducting individual and staff interviews, observations, record reviews, and data analysis based upon the Immediate Care Facilities regulations
- Conducts ongoing monthly monitoring of implementation of action plan, which includes such activities as development of review tools, and review and evaluation of governing body, client protections, facility staffing, active treatment, client behavior and facility practices, health care services, physical environment, and dietetic services

Regional Manager **2003 – 2008**
Tallahassee, FL

- Accountable for the design, development, modifications, and implementation of the newest review process, the Collaborative Outcomes Review and Enhancement (CORE), including policies and procedures
- Responsible for the Provider Performance Review process updates and modifications to instruments and policy and procedures
- Worked closely with the computer application professionals to assist in the design and updates to the review process applications
- Provided supervision, coaching and reliability activities for six Quality Improvement Consultants
- Regularly participates in statewide presentations and training sessions related to the area of Developmental Disabilities
- Participates in stakeholder monthly/quarterly meetings
- Periodically conducts reviews or assists other consultants during their review

Joint Commission for the Accreditation of Healthcare Organizations — **2001 – 2003, Tallahassee, FL**
Quality Assurance Reviewer

- Performed quality assurance reviews for solo and agency providers who provide Medicaid Waiver services to persons with developmental disabilities
- Reviewed the monitoring of services through interviews with the provider, individuals served, and any other necessary persons
- Thoroughly reviewed the provider's documentation and analysis of all of the gathered information in order to identify areas needing improvement
- Provided technical assistance and recommendations to assist providers in improving their quality of supports and services
- Participated in the development of the policy and procedures for the Quality Improvement Plan and Follow Up Review process

Camelot Community Cares — **2000 – 2001, Tallahassee, FL**
In-Home Counselor

Middle Tennessee Regional Office — **1998 – 2000, Nashville, TN**
Regional Monitor

Arlington Developmental Center, — **1996 – 1998, Arlington, TN**
Assistant Director of Therapeutic Services

Specialized Services Unit of Tallahassee, — **1995 – 1996, Tallahassee, FL**
Leon County, Human Services
Assistant Director

Supervisor, Residential Targeted Case Manager — **1995**

Residential Targeted Case Manager — **1994 – 1995**

DISC Village, Inc., Regional Adolescent Female Treatment Center — **1993 – 1994, Tallahassee, FL**
Counselor

EDUCATION

Florida State University — **1993, Tallahassee, FL**
Master of Social Work, Clinical Track

University of Louisiana — **1990, Lafayette, LA**
Bachelor of Arts, Sociology

In addition, we have included job descriptions on the following pages that include minimum qualifications and training requirements for the following positions:

- Chief Executive Officer
- Chief Medical Officer/Medical Director
- Behavioral Health Administrative Director
- Director of Management IS
- Quality Management Director
- Director of Independence and Recovery Advocacy
- Director of Data Management and Reporting
- Corporate Compliance Officer
- Director of Utilization Management and Review

THE GEORGIA COLLABORATIVE ASO

Job Description

Title: Chief Executive Officer	**Reports To:**
Exempt/Non-Exempt: Exempt	**Effective Date: May 2014**
Location: Atlanta, Georgia	**Department: Executive**

General Summary: Responsible for day-to-day and overall management of the Georgia Collaborative ASO and its contracts including: development and implementation of policy and procedures, overall fiscal responsibility to ensure budgetary goals are met, and successfully meeting client's performance standards and maintaining client relationships.

Essential Duties and Responsibilities:

1. Operational and administrative oversight of management services for the ASO program, and ValueOptions, Inc. geographic region, working in conjunction with the Chief Medical Officer/Medical Director who has clinical oversight and responsibility for case management services.
2. Execution of ValueOptions Corporate policy as it relates to particular regional requirements and execution of Georgia Collaborative ASO policy as it relates to Program activities.
3. Management of overall internal operational functions in regional office.
4. Administrative and operational oversight of ASO program departments: Information Systems, Clinical Operations, Clinical Support, Reporting, Compliance, Utilization Management, and Quality Management
5. Coordinates with the Chief Medical Officer/Medical Director who has clinical oversight and supervision of the Georgia Collaborative ASO program departments: GCAL, Utilization Management, Quality Management, and Clinical Operations.
6. Provide strategic leadership for the Georgia Collaborative ASO and regional planning, budgeting, and clinical operations to ensure the delivery of high quality service within a targeted budget.
7. Routinely initiating contact with State agencies to ascertain existing service levels and any problematic areas
8. Implementation of the Georgia Collaborative ASO and ValueOptions, Inc. national goals/policies and procedures;
9. Meeting with management team (collectively and individually on a weekly/routine basis) to offer support and guidance for: process improvement; attention to DBHDD and account related issues; consideration of staff issues, concerns and ideas; and contract renewal.
10. Fostering growth in management team to develop sales/marketing skills and consultative skills for account renewal and revenue growth

THE GEORGIA COLLABORATIVE ASO

Minimum Qualifications:

- **Education:** Bachelor's Degree in health care or business management related field. Master's Degree preferred.
- **Licensures:**
- **Relevant Work Experience:** At least ten years of management experience in a health care related field(s) with increasing levels of responsibility. Interpersonal, organizational, and communications qualities are necessary, as are skills in financial management, operations management, and marketing.
- **Supervise Staff?** ☒ **YES** ☐ **NO**

Knowledge, Skills and Abilities

Basic Computer Skills Required? ☒ **YES** ☐ **NO**

Specific Computer Skills

Software
- Microsoft Word
- Microsoft Excel
- Microsoft Outlook

Hardware
-
-
-

Databases
-
-
-

Operating Systems
-
-
-

Other Job Specific Skills
-
-
-

-
-
-

THE GEORGIA COLLABORATIVE ASO

Access to Confidential Information

Employees in this position have access to verbal, written and/or electronic protected health information, as defined by HIPAA and ValueOptions. (X) Yes ( ) No

If yes, check all areas below which the employee will require access in order to perform job related functions.

Please check all that apply:

- ☒ Members/clients
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☒ Employees
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☒ Providers
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☐ Others as identified: _____
- ☐ None

Market Business Unit

Please check one or all market business unit (MBU) that this position is assigned:

- Employer Services Group
- ✓ Public Sector
- Health Plan
- Federal
- Corporate

Physical Requirements

Please see attached sheet entitled "Physical/Mental Abilities and Working Conditions."

The physical requirements described on the above mentioned template are representative of those which must be met by an employee to successfully perform the primary functions of this job. Reasonable accommodations may be made to enable individuals with disabilities, who are otherwise qualified, to perform the primary functions.

Manager Compliance Related Criteria

- Promotes and adheres to the components of the Compliance Program.
- Provides education to employees on state, federal, and local laws, regulations, and guidelines and related company policies.
- Ensures that area of supervision performs in a legal and ethical manner.
- Actively assesses department for non-compliance issues and notifies appropriate senior manager or Ethics Hotline.
- Adheres to compliance training requirements; understands that training is a required condition of employment; and institutes disciplinary process to employees who do not comply.

Disclaimer

The preceding job description has been designed to indicate the general nature and level of work performed by employees within this classification. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

Preparer's Signature: _____ **Date:** _____

Engagement Center or Dept. Vice President: _____ **Date:** _____

Local HR Representative: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Physical/Mental Abilities and Working Conditions

Check the box preceding each functional requirement and each environmental factor that are necessary in performing the essential functions of the job title listed above:

Functional Requirements:

- ☒ Lifting (0-15 lbs) (16–44 lbs) (45+lbs)
- ☒ Carrying (0-15 lbs) (16–44 lbs) (45+ lbs)
- ☒ Pulling (_____ hours)
- ☒ Pushing (_____ hours)
- ☒ Walking (_____ hours)
- ☒ Standing (_____ hours)
- ☐ Crawling (_____ hours)
- ☐ Kneeling (_____ hours)
- ☐ Repeated Bending (_____ hours)
- ☐ Climbing (_____ hours)
- ☒ Reaching above shoulders.
- ☒ Both hands required.
- ☒ Both legs required.
- ☒ Use of fingers.
- ☒ Near vision.
- ☒ Far vision.
- ☐ Specific visual requirement (specify)
- ☒ Ability to distinguish colors.
- ☒ Ability to distinguish shades of color.
- ☒ Hearing (aid permitted)
- ☐ Hearing without aid.
- ☒ Specific hearing requirement (specify)
- ☒ Ability to sit for long periods of time.
- ☒ Ability to make notes/write.

Mental Abilities

- ☒ Ability to concentrate for long periods of time.
- ☒ Ability to communicate concisely and understandably.
- ☒ Ability to shift priorities readily.
- ☒ Ability to ask questions to gather information.
- ☒ Ability to access circumstances/info and make sound decisions.
- ☒ Ability to receive negative or emotion-laden feedback without reacting negatively or emotion.
- ☒ Ability to access procedures and follow them.
- ☒ Ability to work with minimal supervision and maintain a high degree of productivity.
- ☒ Emotional and mental stability.

Environmental Conditions:

- ☐ Works: (outside) (outside & inside)
- ☐ Exposed to: (excessive heat) (excessive cold)
- ☐ Excessive: (humidity) (dampness) (chilling)
- ☐ Excessive noise.
- ☒ Constant noise.
- ☒ Dust
- ☐ Radioactive materials
- ☐ Infectious patient elements or specimens
- ☐ Hazardous materials
- ☐ Odorous chemicals
- ☐ Steam
- ☐ Fumes, smoke or gas
- ☐ Solvents
- ☐ Grease and oils
- ☐ Radiant energy
- ☐ Electric energy
- ☐ Slippery or uneven walking surfaces
- ☐ Working around machinery with moving parts
- ☐ Working around moving objects or vehicles
- ☐ Working on ladders or scaffolding
- ☐ Working with hands in water
- ☐ Vibration
- ☒ Working closely with others
- ☒ Working alone
- ☐ Irregular hours/rotating shifts
- ☐ Working weekends
- ☐ Subject to unusual fatigue (explain)

Comments:

Preparer's Signature: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Job Description

Title: Chief Medical Officer/Medical Director	**Reports To: Chief Executive Officer**
Exempt/Non-Exempt: Exempt	**Effective Date: May 2014**
Location: Atlanta, Georgia	**Department: Executive**

General Summary: Serves as the Chief Medical Officer for the Georgia Collaborative ASO to ensure access and delivery of cost-effective, quality care and service to individuals.

Essential Duties and Responsibilities:

- Directs and oversees the development and ongoing medical management of the Medical Affairs Department. Serves as the principal medical resource for all components of the behavioral health and IDD programs including GCAL, program design, network management, member services, quality management, clinical operations, utilization management, and provider relations.
- Develops organizational, human resource, budget, and other resource allocation needs for the Medical Affairs Department. Establishes a plan of departmental organization, ongoing reporting, performance indicators, and measurement systems.
- In conjunction with key State staff, establishes medical management goals and objectives to support program priorities and strategic objectives. Keeps ValueOptions and DBHDD management informed and updated on programmatic, medical utilization, and administrative performance.
- Develops an effective, collaborative relationship with key State agencies. Establishes communication, reporting and accountability processes to ensure the effective and efficient flow of information and organizational performance.
- Works closely with DBHDD's medical management staff on the development, communication, and training on clinical policies and procedures, quality improvement initiatives, medical protocols, and utilization management priorities.
- Provides and maintains adequate physician coverage to provide oversight of the Medical Affairs Department, review clinical complaints and critical incidences, provider appeals, review and approval of denials, and the provision of clinical/medical consultation to care managers.
- Educates network providers about State behavioral health and IDD policies and procedures. Works with clinical staff to identify providers whose utilization and/or practice patterns are aberrant and participates in developing and communicating corrective action plans.
- Assists in the formulations of clinical utilization and costs forecasts. Monitors and executes controls to meet budgeted targets.
- Recruits, trains, supervises, and appraises assigned staff. Provides leadership and technical assistance to functional managers on key initiatives, new program developments, and regulatory developments.

THE GEORGIA COLLABORATIVE ASO

Minimum Qualifications:

- **Education:** M.D. or D.O. degree from an accredited medical school. Board certified in psychiatry as defined by the American Board of Psychiatrists and Neurology required.
- **Licensures:** Active, unencumbered Georgia license to practice medicine
- **Relevant Work Experience:** At least five years of clinical practice and board certification. Three years direct managed care experience, preferably in behavioral health. Experience at a mental health facility with inpatient and outpatient care required.
- **Supervise Staff?** ☒ **YES** ☐ **NO**

Knowledge, Skills and Abilities

Basic Computer Skills Required? ☒ **YES** ☐ **NO**

Specific Computer Skills

Software
- Microsoft Word
- Microsoft Excel
- Microsoft Outlook

Hardware
-
-
-

Databases
-
-
-

Operating Systems
-
-
-

Other Job Specific Skills
-
-
-

-
-
-

THE GEORGIA COLLABORATIVE ASO

Access to Confidential Information

Employees in this position have access to verbal, written and/or electronic protected health information, as defined by HIPAA and ValueOptions. (X) Yes ( ) No

If yes, check all areas below which the employee will require access in order to perform job related functions.

Please check all that apply:

- ☒ Members/clients
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☒ Providers
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☐ None
- ☒ Employees
  - ☒ Financial Data
  - ☐ Demographic Data
  - ☐ Clinical Data
- ☐ Others as identified: _____

Market Business Unit

Please check one or all market business unit (MBU) that this position is assigned:

- Employer Services Group
- ✓ Public Sector
- Health Plan
- Federal
- Corporate

Physical Requirements

Please see attached sheet entitled "Physical/Mental Abilities and Working Conditions."

The physical requirements described on the above mentioned template are representative of those which must be met by an employee to successfully perform the primary functions of this job. Reasonable accommodations may be made to enable individuals with disabilities, who are otherwise qualified, to perform the primary functions.

Manager Compliance Related Criteria

- Promotes and adheres to the components of the Compliance Program.
- Provides education to employees on state, federal, and local laws, regulations, and guidelines and related company policies.
- Ensures that area of supervision performs in a legal and ethical manner.
- Actively assesses department for non-compliance issues and notifies appropriate senior manager or Ethics Hotline.
- Adheres to compliance training requirements; understands that training is a required condition of employment; and institutes disciplinary process to employees who do not comply.

Disclaimer

The preceding job description has been designed to indicate the general nature and level of work performed by employees within this classification. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

Preparer's Signature: _____ **Date:** _____

Engagement Center or Dept. Vice President: _____ **Date:** _____

Local HR Representative: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Physical/Mental Abilities and Working Conditions

Check the box preceding each functional requirement and each environmental factor that are necessary in performing the essential functions of the job title listed above:

Functional Requirements:

- ☒ Lifting (0-15 lbs) (16–44 lbs) (45+lbs)
- ☒ Carrying (0-15 lbs) (16–44 lbs) (45+ lbs)
- ☒ Pulling (_____ hours)
- ☒ Pushing (_____ hours)
- ☒ Walking (_____ hours)
- ☒ Standing (_____ hours)
- ☐ Crawling (_____ hours)
- ☐ Kneeling (_____ hours)
- ☐ Repeated Bending (_____ hours)
- ☐ Climbing (_____ hours)
- ☒ Reaching above shoulders.
- ☒ Both hands required.
- ☒ Both legs required.
- ☒ Use of fingers.
- ☒ Near vision.
- ☒ Far vision.
- ☐ Specific visual requirement (specify)
- ☒ Ability to distinguish colors.
- ☒ Ability to distinguish shades of color.
- ☒ Hearing (aid permitted)
- ☐ Hearing without aid.
- ☒ Specific hearing requirement (specify)
- ☒ Ability to sit for long periods of time.
- ☒ Ability to make notes/write.

Mental Abilities

- ☒ Ability to concentrate for long periods of time.
- ☒ Ability to communicate concisely and understandably.
- ☒ Ability to shift priorities readily.
- ☒ Ability to ask questions to gather information.
- ☒ Ability to access circumstances/info and make sound decisions.
- ☒ Ability to receive negative or emotion-laden feedback without reacting negatively or emotion.
- ☒ Ability to access procedures and follow them.
- ☒ Ability to work with minimal supervision and maintain a high degree of productivity.
- ☒ Emotional and mental stability.

Environmental Conditions:

- ☐ Works: (outside) (outside & inside)
- ☐ Exposed to: (excessive heat) (excessive cold)
- ☐ Excessive: (humidity) (dampness) (chilling)
- ☐ Excessive noise.
- ☒ Constant noise.
- ☒ Dust
- ☐ Radioactive materials
- ☐ Infectious patient elements or specimens
- ☐ Hazardous materials
- ☐ Odorous chemicals
- ☐ Steam
- ☐ Fumes, smoke or gas
- ☐ Solvents
- ☐ Grease and oils
- ☐ Radiant energy
- ☐ Electric energy
- ☐ Slippery or uneven walking surfaces
- ☐ Working around machinery with moving parts
- ☐ Working around moving objects or vehicles
- ☐ Working on ladders or scaffolding
- ☐ Working with hands in water
- ☐ Vibration
- ☒ Working closely with others
- ☒ Working alone
- ☐ Irregular hours/rotating shifts
- ☐ Working weekends
- ☐ Subject to unusual fatigue (explain)

Comments:

Preparer's Signature: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Job Description

Title: Vice President, Behavioral Health (Behavioral Health Administrative Director)	**Reports To: Chief Executive Officer**
Exempt/Non-Exempt: Exempt	**Effective Date: May 2014**
Location: Atlanta, Georgia	**Department: Clinical**

General Summary: Responsible for the overall management and supervision of clinical operations for the Georgia Collaborative ASO. This includes day-to-day clinical operations, policies and procedures related to behavioral health concerns. Oversees the development of policies and procedures and the training of staff in these departments. Interfaces with internal Georgia Collaborative ASO departments and external stakeholders regarding clinical operations.

Essential Duties and Responsibilities:

1. Ensures that daily clinical operations run smoothly and meet contractual and operational standards.
2. Ensures that the Customer Service Department and Eligibility Department meets performance standards and that staff are appropriately trained and supported in their job functions.
3. Oversees the development of clinical policy and procedures necessary to fulfill contract obligations and ensure appropriate clinical care to consumers.
4. Monitors the operational and contractual performance regarding utilization management for the Georgia Collaborative ASO operations.
5. Supervises the Clinical Services, Utilization Management, PASRR, and Peer Specialists
6. Sets utilization management goals and ensures these goals are met in conjunction with the Chief Medical Officer and the Medical Management Committee.
7. Conducts liaison activities with contractor and stakeholder agencies and the community.
8. Oversees operations that ensure individuals receive the appropriate levels of care.
9. Responsible for ensuring that all departments under the auspices of Clinical Operations, develop and produce reports which track and trend the areas for which they are responsible

THE GEORGIA COLLABORATIVE ASO

Minimum Qualifications:

- **Education:** Master's degree in social work, counseling or clinical psychology
- **Licensures:** License to independently practice as a Behavioral Health professional (e.g., LPC, LCSW, LMFT) in the state of Georgia
- **Relevant Work Experience:** At least seven years of experience in a health care related field(s) with increasing levels of responsibility, including behavioral health service delivery for adults with SPMI and SUD. Interpersonal, organizational, and communications qualities are necessary, as are skills in financial management, operations management, and marketing.
- **Supervise Staff?** ☒ **YES** ☐ **NO**

Knowledge, Skills and Abilities

Basic Computer Skills Required? ☒ **YES** ☐ **NO**

Specific Computer Skills

Software
- Microsoft Word
- Microsoft Excel
- Microsoft Outlook

Hardware
-
-
-

Databases
-
-
-

Operating Systems
-
-
-

Other Job Specific Skills
- Knowledge of behavioral health delivery systems, preferably Medicaid
- Competence in clinical care management and utilization
- Skills in organizational management
- Strong written and verbal communication skills
- Thorough knowledge of managed care organizations
-

THE GEORGIA COLLABORATIVE ASO

Access to Confidential Information

Employees in this position have access to verbal, written and/or electronic protected health information, as defined by HIPAA and ValueOptions. (X) Yes ( ) No

If yes, check all areas below which the employee will require access in order to perform job related functions.

Please check all that apply:

- ☒ Members/clients
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☒ Employees
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☒ Providers
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☐ Others as identified: _____
- ☐ None

Market Business Unit

Please check one or all market business unit (MBU) that this position is assigned:

- Employer Services Group
- ✓ Public Sector
- Health Plan
- Federal
- Corporate

Physical Requirements

Please see attached sheet entitled "Physical/Mental Abilities and Working Conditions."

The physical requirements described on the above mentioned template are representative of those which must be met by an employee to successfully perform the primary functions of this job. Reasonable accommodations may be made to enable individuals with disabilities, who are otherwise qualified, to perform the primary functions.

Manager Compliance Related Criteria

- Promotes and adheres to the components of the Compliance Program.
- Provides education to employees on state, federal, and local laws, regulations, and guidelines and related company policies.
- Ensures that area of supervision performs in a legal and ethical manner.
- Actively assesses department for non-compliance issues and notifies appropriate senior manager or Ethics Hotline.
- Adheres to compliance training requirements; understands that training is a required condition of employment; and institutes disciplinary process to employees who do not comply.

Disclaimer

The preceding job description has been designed to indicate the general nature and level of work performed by employees within this classification. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

Preparer's Signature: _____ **Date:** _____

Engagement Center or Dept. Vice President: _____ **Date:** _____

Local HR Representative: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Physical/Mental Abilities and Working Conditions

Check the box preceding each functional requirement and each environmental factor that are necessary in performing the essential functions of the job title listed above:

Functional Requirements:

- ☒ Lifting (0-15 lbs) (16–44 lbs) (45+lbs)
- ☒ Carrying (0-15 lbs) (16–44 lbs) (45+ lbs)
- ☒ Pulling (_____ hours)
- ☒ Pushing (_____ hours)
- ☒ Walking (_____ hours)
- ☒ Standing (_____ hours)
- ☐ Crawling (_____ hours)
- ☐ Kneeling (_____ hours)
- ☐ Repeated Bending (_____ hours)
- ☐ Climbing (_____ hours)
- ☒ Reaching above shoulders.
- ☒ Both hands required.
- ☒ Both legs required.
- ☒ Use of fingers.
- ☒ Near vision.
- ☒ Far vision.
- ☐ Specific visual requirement (specify)
- ☒ Ability to distinguish colors.
- ☒ Ability to distinguish shades of color.
- ☒ Hearing (aid permitted)
- ☐ Hearing without aid.
- ☒ Specific hearing requirement (specify)
- ☒ Ability to sit for long periods of time.
- ☒ Ability to make notes/write.

Mental Abilities

- ☒ Ability to concentrate for long periods of time.
- ☒ Ability to communicate concisely and understandably.
- ☒ Ability to shift priorities readily.
- ☒ Ability to ask questions to gather information.
- ☒ Ability to access circumstances/info and make sound decisions.
- ☒ Ability to receive negative or emotion-laden feedback without reacting negatively or emotion.
- ☒ Ability to access procedures and follow them.
- ☒ Ability to work with minimal supervision and maintain a high degree of productivity.
- ☒ Emotional and mental stability.

Environmental Conditions:

- ☐ Works: (outside) (outside & inside)
- ☐ Exposed to: (excessive heat) (excessive cold)
- ☐ Excessive: (humidity) (dampness) (chilling)
- ☐ Excessive noise.
- ☒ Constant noise.
- ☒ Dust
- ☐ Radioactive materials
- ☐ Infectious patient elements or specimens
- ☐ Hazardous materials
- ☐ Odorous chemicals
- ☐ Steam
- ☐ Fumes, smoke or gas
- ☐ Solvents
- ☐ Grease and oils
- ☐ Radiant energy
- ☐ Electric energy
- ☐ Slippery or uneven walking surfaces
- ☐ Working around machinery with moving parts
- ☐ Working around moving objects or vehicles
- ☐ Working on ladders or scaffolding
- ☐ Working with hands in water
- ☐ Vibration
- ☒ Working closely with others
- ☒ Working alone
- ☐ Irregular hours/rotating shifts
- ☐ Working weekends
- ☐ Subject to unusual fatigue (explain)

Comments:

Preparer's Signature: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Job Description

Title: Director, Management Information System	**Reports To: Chief Executive Officer**
Exempt/Non-Exempt: Exempt	**Effective Date: May 2014**
Location: Atlanta, Georgia	**Department: Information Technology**

General Summary: Plans, organizes, and oversees information and data management/ reporting resources for the Georgia Collaborative ASO and to serve as the primary liaison with ValueOptions' corporate IT department. Will manage communications and IT equipment/operations and oversee quality control processes and the implementation of a standardized approach to delivery of DBHDD information. Will manage a team of analysts and will collaborate with State personnel to ensure all IT deliverables requirements of the contract are achieved.

Essential Duties and Responsibilities:

1. Oversees the day-to-day operations of the Information Technology (IT) department to include technology operations, end user technical support, telecommunications, quality control processes.
2. Determines specific information and technology requirements of management and prepares plans and budgets for implementation, production, and operations.
3. Works with Business Systems Support to develop and implement end user reports and business intelligence solutions for the Georgia Collaborative ASO. Develops desktop and Web-based applications that support the information needs of the ASO.
4. Works with the national information systems staff to develop long-term strategic plans and to maximize and leverage the information resources for the ASO.
5. Coordinates the allocation of computing capacity and operating time to maximize systems availability and efficiency of operations.
6. Oversees management of local and wide area information/communication networks. Manages the inventory of all personal computers and related equipment and reviews and monitors all hardware and software needs of the ASO.
7. Participates in strategic planning with the Chief Executive Officer on the overall planning and direction of the Georgia Collaborative ASO's systems and software applications.
8. Develops a plan of departmental organization and recruits, orients, trains, and appraises assigned personnel.
9. Maintains and improves documentation of all department processes, including quality assessment processes required to substantiate Balance Budget Act of 1997's data authentication process.
10. Initiates projects to improve analytic integrity of various applications.

THE GEORGIA COLLABORATIVE ASO

Minimum Qualifications:

- **Education:** At least a Bachelor's degree in Information Technology, business or related field
- **Licensures:**
- **Relevant Work Experience:** At least five years of experience in data management for a health care related field(s) with increasing levels of responsibility. Strong leadership, project management, and facilitation skills are required to work effectively within the Engagement Center with national matrix leads and external stakeholders. Interpersonal, organizational, and communications qualities are necessary, as are skills in financial management, operations management, and marketing.
- **Supervise Staff?** ☒ **YES** ☐ **NO**

Knowledge, Skills and Abilities

Basic Computer Skills Required? ☒ **YES** ☐ **NO**

Specific Computer Skills

Software
- Microsoft Office Suite
- Microsoft Project
- E-mail technologies

Hardware
- Networks (WAN/LAN)
-
-

Databases
- Oracle
-
-

Operating Systems
-
-
-

Other Job Specific Skills
- Project management
- Ability to work with clinical and non-clinical colleagues
- Presentation/speaking skills
- Ability to teach/lead senior staff
- Ability to effectively manage conflicting requests from end users

THE GEORGIA COLLABORATIVE ASO

Access to Confidential Information

Employees in this position have access to verbal, written and/or electronic protected health information, as defined by HIPAA and ValueOptions. (X) Yes ( ) No

If yes, check all areas below which the employee will require access in order to perform job related functions.

Please check all that apply:

- ☒ Members/clients
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☒ Employees
  - ☐ Financial Data
  - ☒ Demographic Data
  - ☐ Clinical Data
- ☒ Providers
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☐ Others as identified: _____
- ☐ None

Market Business Unit

Please check one or all market business unit (MBU) that this position is assigned:

- Employer Services Group
- ✓ Public Sector
- Health Plan
- Federal
- Corporate

Physical Requirements

Please see attached sheet entitled "Physical/Mental Abilities and Working Conditions."

The physical requirements described on the above mentioned template are representative of those which must be met by an employee to successfully perform the primary functions of this job. Reasonable accommodations may be made to enable individuals with disabilities, who are otherwise qualified, to perform the primary functions.

Manager Compliance Related Criteria

- Promotes and adheres to the components of the Compliance Program.
- Provides education to employees on state, federal, and local laws, regulations, and guidelines and related company policies.
- Ensures that area of supervision performs in a legal and ethical manner.
- Actively assesses department for non-compliance issues and notifies appropriate senior manager or Ethics Hotline.
- Adheres to compliance training requirements; understands that training is a required condition of employment; and institutes disciplinary process to employees who do not comply.

Disclaimer

The preceding job description has been designed to indicate the general nature and level of work performed by employees within this classification. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

Preparer's Signature: _____ **Date:** _____

Engagement Center or Dept. Vice President: _____ **Date:** _____

Local HR Representative: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Physical/Mental Abilities and Working Conditions

Check the box preceding each functional requirement and each environmental factor that are necessary in performing the essential functions of the job title listed above:

Functional Requirements:

- ☒ Lifting (0-15 lbs) (16–44 lbs) (45+lbs)
- ☒ Carrying (0-15 lbs) (16–44 lbs) (45+ lbs)
- ☒ Pulling (_____ hours)
- ☒ Pushing (_____ hours)
- ☒ Walking (_____ hours)
- ☒ Standing (_____ hours)
- ☐ Crawling (_____ hours)
- ☐ Kneeling (_____ hours)
- ☐ Repeated Bending (_____ hours)
- ☐ Climbing (_____ hours)
- ☒ Reaching above shoulders.
- ☒ Both hands required.
- ☒ Both legs required.
- ☒ Use of fingers.
- ☒ Near vision.
- ☒ Far vision.
- ☐ Specific visual requirement (specify)
- ☒ Ability to distinguish colors.
- ☒ Ability to distinguish shades of color.
- ☒ Hearing (aid permitted)
- ☐ Hearing without aid.
- ☒ Specific hearing requirement (specify)
- ☒ Ability to sit for long periods of time.
- ☒ Ability to make notes/write.

Mental Abilities

- ☒ Ability to concentrate for long periods of time.
- ☒ Ability to communicate concisely and understandably.
- ☒ Ability to shift priorities readily.
- ☒ Ability to ask questions to gather information.
- ☒ Ability to access circumstances/info and make sound decisions.
- ☒ Ability to receive negative or emotion-laden feedback without reacting negatively or emotion.
- ☒ Ability to access procedures and follow them.
- ☒ Ability to work with minimal supervision and maintain a high degree of productivity.
- ☒ Emotional and mental stability.

Environmental Conditions:

- ☐ Works: (outside) (outside & inside)
- ☐ Exposed to: (excessive heat) (excessive cold)
- ☐ Excessive: (humidity) (dampness) (chilling)
- ☐ Excessive noise.
- ☒ Constant noise.
- ☒ Dust
- ☐ Radioactive materials
- ☐ Infectious patient elements or specimens
- ☐ Hazardous materials
- ☐ Odorous chemicals
- ☐ Steam
- ☐ Fumes, smoke or gas
- ☐ Solvents
- ☐ Grease and oils
- ☐ Radiant energy
- ☐ Electric energy
- ☐ Slippery or uneven walking surfaces
- ☐ Working around machinery with moving parts
- ☐ Working around moving objects or vehicles
- ☐ Working on ladders or scaffolding
- ☐ Working with hands in water
- ☐ Vibration
- ☒ Working closely with others
- ☒ Working alone
- ☐ Irregular hours/rotating shifts
- ☐ Working weekends
- ☐ Subject to unusual fatigue (explain)

Comments:

Preparer's Signature: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Job Description

Title: Vice President, Quality Management (Director of Quality Management)	**Reports To: Chief Executive Officer**
Exempt/Non-Exempt: Exempt	**Effective Date: May 2014**
Location: Atlanta, Georgia	**Department: Quality Management**

General Summary: Responsible for developing and implementing policies and procedures related to continuous quality improvement for the Georgia Collaborative ASO. This includes, but is not limited to, developing quality monitors, outcome measures, conducting clinical audits, analyzing data, clinical interventions, and management of services. Works closely with the Chief Executive Officer, Chief Medical Officer/Medical Director and Vice President of Behavioral Health in making recommendations for and implementation of improvements for the Georgia Collaborative ASO.

Essential Duties and Responsibilities:

1. Responsible for directing and supervising quality management operations including overall contract compliance, complaints and grievances, clinical record monitoring, internal and external quality management, and data evaluation and reporting.
2. Works to recruit, hire, and train staff, coordinates employee development and supervision/ appraisal process, and ensures quality management functions are carried out in accordance with DBHDD's contractual requirements.
3. Develops collaborative relationships with DBHDD staff and other stakeholders and serves as key contact on quality management issues.
4. Develops policies and procedures related to monitoring of clinical records within the behavioral health and IDD program. Ensures that the program adheres to internal and external performance standards.
5. Completes statistical reports regarding audits. Completes other written and verbal reports analyzing data and making recommendations for improvements within the Georgia Collaborative ASO.
6. Communicates findings related to quality issues to the Chief Medical Office/Medical Director, Chief Executive Officer, Vice President of Behavioral Health, and other department directors.
7. Develops and implements corrective actions to resolve quality issues identifies as a results of audits.
8. Performs other duties as requested or assigned.

Minimum Qualifications:

- **Education:** Master's Degree in behavioral health discipline required.
- **Licensures:** Preferable licensed clinician in a behavioral health discipline (e.g., LPC, LCSW, LMFT) but is not required.
- **Relevant Work Experience:** At least five years of recent evidence-based quality management model experience in behavioral health and/or IDD with extensive exposure to data management, statistical analysis, program development and evaluation, clinical monitoring, methodology development, compliance management, familiarity with URAC and NCQA standards, and reporting. Strong organizational, planning and presentation skills are required.
- **Supervise Staff?** ☒ **YES** ☐ **NO**

Knowledge, Skills and Abilities

Basic Computer Skills Required? ☒ **YES** ☐ **NO**

Specific Computer Skills

Software
- Microsoft Word
- Microsoft Excel
- Microsoft Outlook

Hardware
-
-
-

Databases
-
-
-

Operating Systems
-
-
-

Other Job Specific Skills
- Excellent written and verbal communication skills
-
-

-
-
-

THE GEORGIA COLLABORATIVE ASO

Access to Confidential Information

Employees in this position have access to verbal, written and/or electronic protected health information, as defined by HIPAA and ValueOptions. (X) Yes ( ) No

If yes, check all areas below which the employee will require access in order to perform job related functions.

Please check all that apply:

- ☒ Members/clients
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☒ Providers
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☐ None
- ☒ Employees
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☐ Others as identified: _____

Market Business Unit

Please check one or all market business unit (MBU) that this position is assigned:

- Employer Services Group
- ✓ Public Sector
- Health Plan
- Federal
- Corporate

Physical Requirements

Please see attached sheet entitled "Physical/Mental Abilities and Working Conditions."

The physical requirements described on the above mentioned template are representative of those which must be met by an employee to successfully perform the primary functions of this job. Reasonable accommodations may be made to enable individuals with disabilities, who are otherwise qualified, to perform the primary functions.

Manager Compliance Related Criteria

- Promotes and adheres to the components of the Compliance Program.
- Provides education to employees on state, federal, and local laws, regulations, and guidelines and related company policies.
- Ensures that area of supervision performs in a legal and ethical manner.
- Actively assesses department for non-compliance issues and notifies appropriate senior manager or Ethics Hotline.
- Adheres to compliance training requirements; understands that training is a required condition of employment; and institutes disciplinary process to employees who do not comply.

Disclaimer

The preceding job description has been designed to indicate the general nature and level of work performed by employees within this classification. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

Preparer's Signature: _____ **Date:** _____

Engagement Center or Dept. Vice President: _____ **Date:** _____

Local HR Representative: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Physical/Mental Abilities and Working Conditions

Check the box preceding each functional requirement and each environmental factor that are necessary in performing the essential functions of the job title listed above:

Functional Requirements:

- ☒ Lifting (0-15 lbs) (16–44 lbs) (45+lbs)
- ☒ Carrying (0-15 lbs) (16–44 lbs) (45+ lbs)
- ☐ Pulling (_____ hours)
- ☐ Pushing (_____ hours)
- ☒ Walking (_____ hours)
- ☐ Standing (_____ hours)
- ☐ Crawling (_____ hours)
- ☐ Kneeling (_____ hours)
- ☐ Repeated Bending (_____ hours)
- ☐ Climbing (_____ hours)
- ☐ Reaching above shoulders.
- ☒ Both hands required.
- ☐ Both legs required.
- ☒ Use of fingers.
- ☒ Near vision.
- ☐ Far vision.
- ☐ Specific visual requirement (specify)
- ☒ Ability to distinguish colors.
- ☒ Ability to distinguish shades of color.
- ☒ Hearing (aid permitted)
- ☐ Hearing without aid.
- ☐ Specific hearing requirement (specify)
- ☒ Ability to sit for long periods of time.
- ☒ Ability to make notes/write.

Mental Abilities

- ☒ Ability to concentrate for long periods of time.
- ☒ Ability to communicate concisely and understandably.
- ☒ Ability to shift priorities readily.
- ☒ Ability to ask questions to gather information.
- ☒ Ability to access circumstances/info and make sound decisions.
- ☒ Ability to receive negative or emotion-laden feedback without reacting negatively or emotion.
- ☒ Ability to access procedures and follow them.
- ☒ Ability to work with minimal supervision and maintain a high degree of productivity.
- ☒ Emotional and mental stability.

Environmental Conditions:

- ☐ Works: (outside) (outside & inside)
- ☐ Exposed to: (excessive heat) (excessive cold)
- ☐ Excessive: (humidity) (dampness) (chilling)
- ☐ Excessive noise.
- ☐ Constant noise.
- ☐ Dust
- ☐ Radioactive materials
- ☐ Infectious patient elements or specimens
- ☐ Hazardous materials
- ☐ Odorous chemicals
- ☐ Steam
- ☐ Fumes, smoke or gas
- ☐ Solvents
- ☐ Grease and oils
- ☐ Radiant energy
- ☐ Electric energy
- ☐ Slippery or uneven walking surfaces
- ☐ Working around machinery with moving parts
- ☐ Working around moving objects or vehicles
- ☐ Working on ladders or scaffolding
- ☐ Working with hands in water
- ☐ Vibration
- ☒ Working closely with others
- ☒ Working alone
- ☐ Irregular hours/rotating shifts
- ☐ Working weekends
- ☐ Subject to unusual fatigue (explain)

Comments:

Preparer's Signature: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Job Description

Title: Director, Independence and Recovery Advocacy	**Reports To: Vice President, Behavioral Health (Behavioral Health Admin Director)**
Exempt/Non-Exempt: Exempt	**Effective Date: May 2014**
Location: Atlanta, Georgia	**Department: Clinical/Peer Support**

General Summary: The Director of Independence and Recovery Advocacy will provide advocacy and representation of the lived experience voice in shaping the Georgia Collaborative ASO's practices, policies and outcomes. This staff member will provide family and adult consumer support; help individuals create a support network; do outreach; promote recovery and resilience by knowing how to share their own story and by being a role model helping to promote hope, skill development, strength, stability, safety, and independence.

Essential Duties and Responsibilities:

1. Telephone and/or face to face support to members and families from "someone who's been there" to hear their issues and offer support and information. Individuals may need help navigating the system, filling out applications, explaining individual rights, dealing with feelings of shame, guilt and overwhelming stress, and locating non–traditional supports, and learning about self-advocacy skills.
2. Participate in a Regional Network Team approach to care management to enhance individual treatment by identifying resources, access to care, identifying barriers to care and gaps in service.
3. Work closely with the Regional Network Managers and Peer Support Specialists in identification of gaps and barriers in service within designated regions.
4. Work closely with the Intensive Care Manager to give individual perspectives, to obtain Release of Information when needed to directly support the family and/or individual.
5. Collaborate with DBHDD as necessary to support individuals.
6. Conduct training for Georgia Collaborative ASO staff, providers, individuals, families, and others across the state of Georgia.
7. Build, develop and maintain a positive and collaborative relationship with providers and adult consumer and family organizations by establishing a local presence via telephone interactions and by attending meetings.
8. Outreach to, and work with family and adult consumer advocacy groups across the state
9. Provide technical assistance to adult consumer and family groups.
10. Identify self-help groups/networks of adult consumers and families. Assist in starting up new groups when need is identified.
11. Maintain a 40 hour work week with travel to community meetings and events.
12. Develop and train Peer Support Specialists to work with diverse teams that require independent work initiatives.

THE GEORGIA COLLABORATIVE ASO

Minimum Qualifications:

- **Education:**
- **Licensures:**
- **Relevant Work Experience:** Family member or adult consumer or former family member or adult consumer. Five year' experience in grassroots advocacy or community organizing required. Some combination of the following experiences required. Experience in supervising and training. Experience in writing training curriculum. Good communicational and organizational skills. Computer skills a must.
- **Supervise Staff?** ☒ **YES** ☐ **NO**

Knowledge, Skills and Abilities

Basic Computer Skills Required? ☒ **YES** ☐ **NO**

Specific Computer Skills

Software
- Microsoft Word
- Microsoft Excel
- Microsoft Outlook

Hardware
-
-
-

Databases
-
-
-

Operating Systems
-
-
-

Other Job Specific Skills
- Good communications skills
-
-

-
-
-

Access to Confidential Information

Employees in this position have access to verbal, written and/or electronic protected health information, as defined by HIPAA and ValueOptions. (X) Yes ( ) No

If yes, check all areas below which the employee will require access in order to perform job related functions.

Please check all that apply:

- ☒ Members/clients
  - ☒ Educational/Legal Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☒ Providers
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☐ None
- ☒ Employees
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☐ Clinical Data
- ☐ Others as identified: _____

Market Business Unit

Please check one or all market business unit (MBU) that this position is assigned:

- Employer Services Group
- ✓ Public Sector
- Health Plan
- Federal
- Corporate

Physical Requirements

Please see attached sheet entitled "Physical/Mental Abilities and Working Conditions."

The physical requirements described on the above mentioned template are representative of those which must be met by an employee to successfully perform the primary functions of this job. Reasonable accommodations may be made to enable individuals with disabilities, who are otherwise qualified, to perform the primary functions.

Manager Compliance Related Criteria

- Promotes and adheres to the components of the Compliance Program.
- Provides education to employees on state, federal, and local laws, regulations, and guidelines and related company policies.
- Ensures that area of supervision performs in a legal and ethical manner.
- Actively assesses department for non-compliance issues and notifies appropriate senior manager or Ethics Hotline.
- Adheres to compliance training requirements; understands that training is a required condition of employment; and institutes disciplinary process to employees who do not comply.

Disclaimer

The preceding job description has been designed to indicate the general nature and level of work performed by employees within this classification. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

Preparer's Signature: _____ **Date:** _____

Engagement Center or Dept. Vice President: _____ **Date:** _____

Local HR Representative: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Physical/Mental Abilities and Working Conditions

Check the box preceding each functional requirement and each environmental factor that are necessary in performing the essential functions of the job title listed above:

Functional Requirements:

- ☐ Lifting (0-15 lbs) (16–44 lbs) (45+lbs)
- ☐ Carrying (0-15 lbs) (16–44 lbs) (45+ lbs)
- ☐ Pulling (_____ hours)
- ☐ Pushing (_____ hours)
- ☐ Walking (_____ hours)
- ☐ Standing (_____ hours)
- ☐ Crawling (_____ hours)
- ☐ Kneeling (_____ hours)
- ☐ Repeated Bending (_____ hours)
- ☐ Climbing (_____ hours)
- ☐ Reaching above shoulders.
- ☐ Both hands required.
- ☐ Both legs required.
- ☐ Use of fingers.
- ☐ Near vision.
- ☐ Far vision.
- ☐ Specific visual requirement (specify)
- ☐ Ability to distinguish colors.
- ☐ Ability to distinguish shades of color.
- ☐ Hearing (aid permitted)
- ☐ Hearing without aid.
- ☐ Specific hearing requirement (specify)
- ☐ Ability to sit for long periods of time.
- ☒ Ability to make notes/write.

Mental Abilities

- ☒ Ability to concentrate for long periods of time.
- ☒ Ability to communicate concisely and understandably.
- ☒ Ability to shift priorities readily.
- ☒ Ability to ask questions to gather information.
- ☒ Ability to access circumstances/info and make sound decisions.
- ☒ Ability to receive negative or emotion-laden feedback without reacting negatively or emotion.
- ☒ Ability to access procedures and follow them.
- ☒ Ability to work with minimal supervision and maintain a high degree of productivity.
- ☒ Emotional and mental stability.

Environmental Conditions:

- ☒ Works: (outside) (outside & inside)
- ☐ Exposed to: (excessive heat) (excessive cold)
- ☐ Excessive: (humidity) (dampness) (chilling)
- ☐ Excessive noise.
- ☐ Constant noise.
- ☐ Dust
- ☐ Radioactive materials
- ☐ Infectious patient elements or specimens
- ☐ Hazardous materials
- ☐ Odorous chemicals
- ☐ Steam
- ☐ Fumes, smoke or gas
- ☐ Solvents
- ☐ Grease and oils
- ☐ Radiant energy
- ☐ Electric energy
- ☐ Slippery or uneven walking surfaces
- ☐ Working around machinery with moving parts
- ☐ Working around moving objects or vehicles
- ☐ Working on ladders or scaffolding
- ☐ Working with hands in water
- ☐ Vibration
- ☒ Working closely with others
- ☒ Working alone
- ☒ Irregular hours/rotating shifts
- ☒ Working weekends
- ☐ Subject to unusual fatigue (explain)

Comments:

Preparer's Signature: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Job Description

Title: Director, Data Management & Reporting	**Reports To: Chief Executive Officer**
Exempt/Non-Exempt: Exempt	**Effective Date: May 2014**
Location: Atlanta, Georgia	**Department: Information Technology**

General Summary: This position's core responsibility will be to foster a team environment for all analysts while proactively developing new and innovative reporting models to support the Georgia Collaborative ASO and DBHDD. They will be responsible for working closely with Engagement Center management across multiple locations to ensure all reporting deliverables are met. It will be their responsibility as well for the timely delivery of all production reports while addressing and meeting ad hoc reporting requests.

Essential Duties and Responsibilities:

1. Gathers, organizes and analyzes behavioral health and IDD data and trends in support of a variety of projects and operational processes, including conducting longitudinal analyses. Consults on data analysis. Compile reports, charts and tables based on fundamental statistical methods. Interprets and summarizes analysis results. Draws practical conclusions from the data. Prepares written and/or oral presentations of results.
2. Responsible for managing expectations, deliverables and personnel across multiple locations.
3. Responsible for the personnel development of assigned analyst. Responsible for ensuring they receive training necessary for job functioning.
4. Responsible for the timely delivery of all assigned production reports by meeting the agreed upon threshold for timely measurement.
5. Responsible for the timely delivery of all assigned ad hoc reports by meeting the agreed upon threshold for timely measurement.
6. Responsible for employee retention and satisfaction.
7. Responsible for the coordination of efforts between reporting department and Engagement Center departments on all local initiatives. Will ensure that Data Management is properly represented.
8. Assist the Director of Management Information Systems as needed in development of the department.

THE GEORGIA COLLABORATIVE ASO

Minimum Qualifications:

- **Education:** At least a Bachelor's degree in Information Technology, business or related field
- **Licensures:**
- **Relevant Work Experience:** Experience in analyzing and interpreting data using inferential statistics. At least five years of diverse experience in data analysis, applied research, program evaluation or statistics for behavioral health and/or IDD data and trends, preferable for public sector/Medicaid populations. Proficiency in using software and tools for data analysis and other office computing software applications (word processing/spreadsheet) is required. Experience in the use of databases.
- **Supervise Staff?** ☒ **YES** ☐ **NO**

Knowledge, Skills and Abilities

Basic Computer Skills Required? ☒ **YES** ☐ **NO**

Specific Computer Skills

Software
- Microsoft Office Suite
- Business Objects Enterprise
- Crystal Reports

Hardware
- ACD Telephony
-
-

Databases
- Oracle
- Sequel Server
- Microsoft Access

Operating Systems
- Windows platform
-
-

Other Job Specific Skills
- Analytical/problem solving
- Understanding of managed health care principals
- Ongoing supervision
-
-

THE GEORGIA COLLABORATIVE ASO

Access to Confidential Information

Employees in this position have access to verbal, written and/or electronic protected health information, as defined by HIPAA and ValueOptions. (X) Yes ( ) No

If yes, check all areas below which the employee will require access in order to perform job related functions.

Please check all that apply:

- ☒ Members/clients
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☒ Employees
  - ☒ Financial Data
  - ☐ Demographic Data
  - ☐ Clinical Data
- ☒ Providers
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☐ Others as identified: _____
- ☐ None

Market Business Unit

Please check one or all market business unit (MBU) that this position is assigned:

- Employer Services Group
- ✓ Public Sector
- Health Plan
- Federal
- Corporate

Physical Requirements

Please see attached sheet entitled "Physical/Mental Abilities and Working Conditions."

The physical requirements described on the above mentioned template are representative of those which must be met by an employee to successfully perform the primary functions of this job. Reasonable accommodations may be made to enable individuals with disabilities, who are otherwise qualified, to perform the primary functions.

Manager Compliance Related Criteria

- Promotes and adheres to the components of the Compliance Program.
- Provides education to employees on state, federal, and local laws, regulations, and guidelines and related company policies.
- Ensures that area of supervision performs in a legal and ethical manner.
- Actively assesses department for non-compliance issues and notifies appropriate senior manager or Ethics Hotline.
- Adheres to compliance training requirements; understands that training is a required condition of employment; and institutes disciplinary process to employees who do not comply.

Disclaimer

The preceding job description has been designed to indicate the general nature and level of work performed by employees within this classification. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

Preparer's Signature: _____ **Date:** _____

Engagement Center or Dept. Vice President: _____ **Date:** _____

Local HR Representative: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Physical/Mental Abilities and Working Conditions

Check the box preceding each functional requirement and each environmental factor that are necessary in performing the essential functions of the job title listed above:

Functional Requirements:

- ☒ Lifting (0-15 lbs) (16–44 lbs) (45+lbs)
- ☒ Carrying (0-15 lbs) (16–44 lbs) (45+ lbs)
- ☒ Pulling (_____ hours)
- ☒ Pushing (_____ hours)
- ☒ Walking (_____ hours)
- ☒ Standing (_____ hours)
- ☐ Crawling (_____ hours)
- ☐ Kneeling (_____ hours)
- ☐ Repeated Bending (_____ hours)
- ☐ Climbing (_____ hours)
- ☒ Reaching above shoulders.
- ☒ Both hands required.
- ☒ Both legs required.
- ☒ Use of fingers.
- ☒ Near vision.
- ☒ Far vision.
- ☐ Specific visual requirement (specify)
- ☒ Ability to distinguish colors.
- ☒ Ability to distinguish shades of color.
- ☒ Hearing (aid permitted)
- ☐ Hearing without aid.
- ☒ Specific hearing requirement (specify)
- ☒ Ability to sit for long periods of time.
- ☒ Ability to make notes/write.

Mental Abilities

- ☒ Ability to concentrate for long periods of time.
- ☒ Ability to communicate concisely and understandably.
- ☒ Ability to shift priorities readily.
- ☒ Ability to ask questions to gather information.
- ☒ Ability to access circumstances/info and make sound decisions.
- ☒ Ability to receive negative or emotion-laden feedback without reacting negatively or emotion.
- ☒ Ability to access procedures and follow them.
- ☒ Ability to work with minimal supervision and maintain a high degree of productivity.
- ☒ Emotional and mental stability.

Environmental Conditions:

- ☐ Works: (outside) (outside & inside)
- ☐ Exposed to: (excessive heat) (excessive cold)
- ☐ Excessive: (humidity) (dampness) (chilling)
- ☐ Excessive noise.
- ☒ Constant noise.
- ☒ Dust
- ☐ Radioactive materials
- ☐ Infectious patient elements or specimens
- ☐ Hazardous materials
- ☐ Odorous chemicals
- ☐ Steam
- ☐ Fumes, smoke or gas
- ☐ Solvents
- ☐ Grease and oils
- ☐ Radiant energy
- ☐ Electric energy
- ☐ Slippery or uneven walking surfaces
- ☐ Working around machinery with moving parts
- ☐ Working around moving objects or vehicles
- ☐ Working on ladders or scaffolding
- ☐ Working with hands in water
- ☐ Vibration
- ☒ Working closely with others
- ☒ Working alone
- ☐ Irregular hours/rotating shifts
- ☐ Working weekends
- ☐ Subject to unusual fatigue (explain)

Comments:

Preparer's Signature: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Job Description

Title: Corporate Compliance Officer	**Reports To: Chief Executive Officer**
Exempt/Non-Exempt: Exempt	**Effective Date: May 2014**
Location: Atlanta, Georgia	**Department: Program Integrity**

General Summary: Implements the Compliance Plan and all related activities for the Georgia Collaborative ASO under the direction of the National Director of Compliance, Program Integrity, and the Georgia Collaborative ASO Chief Executive Officer. Responsible for performance of internal audit procedures, including documenting, evaluating and assessing internal controls; managing fraud and abuse related audits and reviews; and presenting results to audited providers. Conducts investigations of reported, alleged or suspected fraud, waste or abuse, as required. Chairs the Georgia Collaborative ASO Compliance Committee and is responsible for the Committee's administrative functions and activities. Operates as the primary resource and contact for all fraud, waste and abuse investigation and prevention, provider monitoring and audit related activities with the state of Georgia, OIG and Attorney General's Office – MFCU.

Essential Duties and Responsibilities:

1. Responsible for the coordination and implementation of all Georgia Collaborative ASO program integrity monitoring activities, including the fraud, waste and abuse prevention program and audit program activities with State and Federal agencies (e.g., OIG, AG, MFCU). Responsible for the implementation and coordination of the Georgia Collaborative ASO's audit program and the development of audit objectives and programs.
2. Responsible for oversight, administration and implementation of the Georgia Collaborative ASO's fraud, waste and abuse prevention program. Functions as the senior onsite official, available to all employees and is the designated and recognized authority to access records and make independent referrals to DBHDD, OIG, and the Attorney General's Office – MFCU.
3. Responsible for oversight, administration and implementation of the Georgia Collaborative ASO's Compliance Committee and acts as the committee chairperson. Coordinates and communicates all auditing; fraud, waste and abuse prevention program; and state coordination activities to the Committee, including performance measures, trend analysis, corrective actions, contract compliance, and technical assistance. Coordinates and assists the Committee in completing and/or updating risk assessments by evaluating the adequacy and effectiveness of internal controls and Engagement Center operating procedures. Recommends and implements appropriate changes to operating policies and procedures relative to such internal controls.
4. Implements State-required audit and review procedures and conducts appropriate financial, compliance and performance audit examinations. Includes preparing detailed audit reports of findings, discussing findings with MFCU, OIG and other State and/or Federal agencies, as

required, and providing recommendations for correcting unsatisfactory conditions, improving operations and reducing costs.

5. Performs compliance audits on contracted providers to ensure the accurate and reliable reporting of service claims and encounters. Includes ensuring encounter validation testing meets State contract requirements and that national coding guidelines, policies, Federal and State regulations and coding conventions per contractual agreements for providers are applied to audits, reports, etc.
6. Develops and presents compliance training that includes fraud prevention awareness. Serves as a technical advisor in the design of new reports and enhancements to existing reporting systems.
7. Testifies in criminal and civil legal proceedings, if required.
8. Stays abreast of and conforms to all applicable audit standards and code of ethics. Develops expertise in managed health care operations and attends anti-fraud training seminars as required.

Minimum Qualifications:

- **Education:** Bachelor's degree in a health care, accounting, management, or law enforcement field. Master's degree preferred.

- **Certifications:** Preference will be given to candidates with certifications related to their professional training, to include: Association of Certified Fraud Examiners (CFE); Certified Internal Auditor (CIA); Professional Coding through AAPC (CPC) (CPC-H) CPC-P) or AHIMA (CCS) (CCS-P); Healthcare Compliance certification (CHC).

- **Relevant Work Experience:** Minimum of two years' experience in overseeing compliance with Medicaid requirements. Accounting (public or private), or health care coding and auditing is preferred, with preference given to candidates with this experience in a managed care environment. In addition, at least three years of experience is required in fraud and abuse and/or white collar crime investigations and two to three years' experience in health care claims preferred.

- **Supervise Staff?** ☐ **YES** ☐ **NO**

Knowledge, Skills and Abilities

Basic Computer Skills Required? ☒ **YES** ☐ **NO**

Specific Computer Skills

Software	**Hardware**
• Microsoft Word	•
• Microsoft Excel	•
• Microsoft Outlook	•

Databases

-
-
-

Operating Systems

-
-
-

Other Job Specific Skills

- Knowledge of state and federal guidelines and regulations
- Demonstrated ability to interact with individuals at all levels of the organization and external sources (i.e. state, federal and local law enforcement agencies)

Access to Confidential Information

Employees in this position have access to verbal, written and/or electronic protected health information, as defined by HIPAA and ValueOptions. (X) Yes ( ) No

If yes, check all areas below which the employee will require access in order to perform job related functions.

Please check all that apply:

☒ Members/clients
- ☒ Financial Data
- ☒ Demographic Data
- ☒ Clinical Data

☐ Employees
- ☐ Financial Data
- ☐ Demographic Data
- ☐ Clinical Data

☒ Providers
- ☒ Financial Data
- ☒ Demographic Data
- ☒ Clinical Data

☐ Others as identified: _____

_____

_____

☐ None

Market Business Unit

Please check one or all market business unit (MBU) that this position is assigned:

Employer Services Group
✓ Public Sector
Health Plan
Federal
Corporate

Physical Requirements

Please see attached sheet entitled "Physical/Mental Abilities and Working Conditions."

The physical requirements described on the above mentioned template are representative of those which must be met by an employee to successfully perform the primary functions of this job. Reasonable accommodations may be made to enable individuals with disabilities, who are otherwise qualified, to perform the primary functions.

Manager Compliance Related Criteria

- Promotes and adheres to the components of the Compliance Program.
- Provides education to employees on state, federal, and local laws, regulations, and guidelines and related company policies.
- Ensures that area of supervision performs in a legal and ethical manner.
- Actively assesses department for non-compliance issues and notifies appropriate senior manager or Ethics Hotline.
- Adheres to compliance training requirements; understands that training is a required condition of employment; and institutes disciplinary process to employees who do not comply.

Disclaimer

The preceding job description has been designed to indicate the general nature and level of work performed by employees within this classification. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

Preparer's Signature: _____ **Date:** _____

Engagement Center or Dept. Vice President: _____ **Date:** _____

Local HR Representative: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Physical/Mental Abilities and Working Conditions

Check the box preceding each functional requirement and each environmental factor that are necessary in performing the essential functions of the job title listed above:

Functional Requirements:

- ☒ Lifting (0-15 lbs) (16–44 lbs) (45+lbs)
- ☒ Carrying (0-15 lbs) (16–44 lbs) (45+ lbs)
- ☐ Pulling (_____ hours)
- ☐ Pushing (_____ hours)
- ☒ Walking (_____ hours)
- ☐ Standing (_____ hours)
- ☐ Crawling (_____ hours)
- ☐ Kneeling (_____ hours)
- ☐ Repeated Bending (_____ hours)
- ☐ Climbing (_____ hours)
- ☐ Reaching above shoulders.
- ☒ Both hands required.
- ☐ Both legs required.
- ☒ Use of fingers.
- ☒ Near vision.
- ☐ Far vision.
- ☐ Specific visual requirement (specify)
- ☒ Ability to distinguish colors.
- ☒ Ability to distinguish shades of color.
- ☒ Hearing (aid permitted)
- ☐ Hearing without aid.
- ☐ Specific hearing requirement (specify)
- ☒ Ability to sit for long periods of time.
- ☒ Ability to make notes/write.

Mental Abilities

- ☒ Ability to concentrate for long periods of time.
- ☒ Ability to communicate concisely and understandably.
- ☒ Ability to shift priorities readily.
- ☒ Ability to ask questions to gather information.
- ☒ Ability to access circumstances/info and make sound decisions.
- ☒ Ability to receive negative or emotion-laden feedback without reacting negatively or emotion.
- ☒ Ability to access procedures and follow them.
- ☒ Ability to work with minimal supervision and maintain a high degree of productivity.
- ☒ Emotional and mental stability.

Environmental Conditions:

- ☐ Works: (outside) (outside & inside)
- ☐ Exposed to: (excessive heat) (excessive cold)
- ☐ Excessive: (humidity) (dampness) (chilling)
- ☐ Excessive noise.
- ☐ Constant noise.
- ☐ Dust
- ☐ Radioactive materials
- ☐ Infectious patient elements or specimens
- ☐ Hazardous materials
- ☐ Odorous chemicals
- ☐ Steam
- ☐ Fumes, smoke or gas
- ☐ Solvents
- ☐ Grease and oils
- ☐ Radiant energy
- ☐ Electric energy
- ☐ Slippery or uneven walking surfaces
- ☐ Working around machinery with moving parts
- ☐ Working around moving objects or vehicles
- ☐ Working on ladders or scaffolding
- ☐ Working with hands in water
- ☐ Vibration
- ☒ Working closely with others
- ☒ Working alone
- ☐ Irregular hours/rotating shifts
- ☐ Working weekends
- ☐ Subject to unusual fatigue (explain)

Comments:

Preparer's Signature: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Job Description

Title: Director, Utilization Management & Review	**Reports To: Vice President, Behavior Health (Behavioral Health Admin Director)**
Exempt/Non-Exempt: Exempt	**Effective Date: May 2014**
Location: Atlanta, Georgia	**Department: Clinical**

General Summary: Responsible for utilization management of the Georgia Collaborative ASO and network providers. Provides technical assistance and monitoring of Georgia Collaborative ASO clinical staff and provider agencies as it relates to Utilization Management and Review. Ensures that Georgia Collaborative ASO and DBHDD policies and procedures support effective utilization management including protection against under- and over-utilization.

Essential Duties and Responsibilities:

1. Responsible for the development and implementation of the annual Utilization Management Plan, Utilization Management Work Plan and conducting the UM Plan Evaluation.
2. Responsible for submission of the Utilization Management Plan, Utilization Management Work Plan and Evaluation of the Utilization Management Plan to the Medical Management Committee, DBHDD and to the ValueOptions Management Business Unit for approval within contracted time frames.
3. Develops and implements training and technical assistance to direct service staff and providers.
4. In conjunction with the Chief Medical Officer/Medical Director and Vice President of Behavioral Health, develops and implements policies and procedures to effectively manage utilization in accordance with contractual requirements.
5. Provides clinical supervision to Utilization Management staff.
6. Responsible for monitoring over- and under-utilization and reporting trends regarding such to the Medical Management Committee.
7. Responsible for developing, implementing, and monitoring corrective action plans in conjunction with recommendation on the part of the Medical Management Committee, Chief Medical Officer, and the Vice President of Behavioral Health.
8. Work as a collaborative member with other departments, providers and stakeholders to provide recovery-oriented individual care.
9. Report to the Georgia Collaborative ASO management personnel and corporate UM with regards to utilization management.
10. Provides clinical input into educational programs, consultation, public forums, public awareness and professional workshops/seminars.

THE GEORGIA COLLABORATIVE ASO

Minimum Qualifications:

- **Education:** Master's degree in behavioral health discipline required.
- **Licensures:** Active, licensed clinician in the state of Georgia in a behavioral health discipline (e.g., APRN, LPC, LCSW, LMFT).
- **Relevant Work Experience:** At least three years' supervisory experience in utilization management for behavioral health services or more than five years' experience in utilization management of behavioral health services.
- **Supervise Staff?** ☒ **YES** ☐ **NO**

Knowledge, Skills and Abilities

Basic Computer Skills Required? ☒ **YES** ☐ **NO**

Specific Computer Skills

Software
- Microsoft Word
- Microsoft Excel
- Microsoft Outlook

Hardware
-
-
-

Databases
-
-
-

Operating Systems
-
-
-

Other Job Specific Skills
- Excellent written and verbal communication skills
- Knowledge of DSM-IV (and 5)
-
- Knowledge of Utilization Management procedures
- Extensive clinical skills
-

Access to Confidential Information

Employees in this position have access to verbal, written and/or electronic protected health information, as defined by HIPAA and ValueOptions. (X) Yes ( ) No

If yes, check all areas below which the employee will require access in order to perform job related functions.

Please check all that apply:

- ☒ Members/clients
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☒ Providers
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☐ None
- ☒ Employees
  - ☒ Financial Data
  - ☒ Demographic Data
  - ☒ Clinical Data
- ☐ Others as identified: _____

Market Business Unit

Please check one or all market business unit (MBU) that this position is assigned:

- Employer Services Group
- ✓ Public Sector
- Health Plan
- Federal
- Corporate

Physical Requirements

Please see attached sheet entitled "Physical/Mental Abilities and Working Conditions."

The physical requirements described on the above mentioned template are representative of those which must be met by an employee to successfully perform the primary functions of this job. Reasonable accommodations may be made to enable individuals with disabilities, who are otherwise qualified, to perform the primary functions.

Manager Compliance Related Criteria

- Promotes and adheres to the components of the Compliance Program.
- Provides education to employees on state, federal, and local laws, regulations, and guidelines and related company policies.
- Ensures that area of supervision performs in a legal and ethical manner.
- Actively assesses department for non-compliance issues and notifies appropriate senior manager or Ethics Hotline.
- Adheres to compliance training requirements; understands that training is a required condition of employment; and institutes disciplinary process to employees who do not comply.

Disclaimer

The preceding job description has been designed to indicate the general nature and level of work performed by employees within this classification. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities and qualifications required of employees assigned to this job.

Preparer's Signature: _____ **Date:** _____

Engagement Center or Dept. Vice President: _____ **Date:** _____

Local HR Representative: _____ **Date:** _____

THE GEORGIA COLLABORATIVE ASO

Physical/Mental Abilities and Working Conditions

Check the box preceding each functional requirement and each environmental factor that are necessary in performing the essential functions of the job title listed above:

Functional Requirements:

- ☒ Lifting (0-15 lbs) (16–44 lbs) (45+lbs)
- ☒ Carrying (0-15 lbs) (16–44 lbs) (45+ lbs)
- ☐ Pulling (_____ hours)
- ☐ Pushing (_____ hours)
- ☒ Walking (_____ hours)
- ☐ Standing (_____ hours)
- ☐ Crawling (_____ hours)
- ☐ Kneeling (_____ hours)
- ☐ Repeated Bending (_____ hours)
- ☐ Climbing (_____ hours)
- ☐ Reaching above shoulders.
- ☒ Both hands required.
- ☐ Both legs required.
- ☒ Use of fingers.
- ☒ Near vision.
- ☐ Far vision.
- ☐ Specific visual requirement (specify)
- ☒ Ability to distinguish colors.
- ☒ Ability to distinguish shades of color.
- ☒ Hearing (aid permitted)
- ☐ Hearing without aid.
- ☐ Specific hearing requirement (specify)
- ☒ Ability to sit for long periods of time.
- ☒ Ability to make notes/write.

Mental Abilities

- ☒ Ability to concentrate for long periods of time.
- ☒ Ability to communicate concisely and understandably.
- ☒ Ability to shift priorities readily.
- ☒ Ability to ask questions to gather information.
- ☒ Ability to access circumstances/info and make sound decisions.
- ☒ Ability to receive negative or emotion-laden feedback without reacting negatively or emotion.
- ☒ Ability to access procedures and follow them.
- ☒ Ability to work with minimal supervision and maintain a high degree of productivity.
- ☒ Emotional and mental stability.

Environmental Conditions:

- ☐ Works: (outside) (outside & inside)
- ☐ Exposed to: (excessive heat) (excessive cold)
- ☐ Excessive: (humidity) (dampness) (chilling)
- ☐ Excessive noise.
- ☐ Constant noise.
- ☐ Dust
- ☐ Radioactive materials
- ☐ Infectious patient elements or specimens
- ☐ Hazardous materials
- ☐ Odorous chemicals
- ☐ Steam
- ☐ Fumes, smoke or gas
- ☐ Solvents
- ☐ Grease and oils
- ☐ Radiant energy
- ☐ Electric energy
- ☐ Slippery or uneven walking surfaces
- ☐ Working around machinery with moving parts
- ☐ Working around moving objects or vehicles
- ☐ Working on ladders or scaffolding
- ☐ Working with hands in water
- ☐ Vibration
- ☒ Working closely with others
- ☒ Working alone
- ☐ Irregular hours/rotating shifts
- ☐ Working weekends
- ☐ Subject to unusual fatigue (explain)

Comments:

Preparer's Signature: _____ **Date:** _____

ATTACHMENT A.10

A.10 In Attachment A.10, describe the Offeror's plan to hire and otherwise include Individuals with lived experience receiving services from a BH and/or DD service system and/or their family/caretakers.

ValueOptions creates and supports systems of care that embrace recovery, resiliency and independence. We weave this approach throughout our behavioral health and IDD services—from program components to innovative alternatives for individuals and their families, to our own corporate culture. Our commitment as champions of hope, recovery and independence goes beyond managing clinical care. We recognize that individuals with mental illness or IDD benefit greatly from working with others who have lived similar experiences and reached a significant level of recovery.

PEER/FAMILY PEER SPECIALISTS

We offer unmatched experience serving Medicaid and indigent populations across the country with innovative program designs emphasizing peer-to-peer supports and individual-driven care. More than 31 states currently recognize peers as eligible Medicaid providers and we currently or have provided managed behavioral health and IDD services that included peers as providers in a third of those.

From Texas to Massachusetts, we have developed specific credentialing and contracting requirements that take into account that persons providing these services have a lived experience that far exceeds their professional credentials. Working with our State partners, we are able to use State-approved trainings and innovative networking strategies to integrate these services into the professionally driven delivery systems. This system of care approach ensures that peer and family support services are a central and core component of the best practice delivery of behavioral health and IDD care to support and encourage individuals toward recovery and personal independence. This network and program development, which are driven by individuals and family members, offers the widest possible array of service and support options to the individuals we serve—whether through extensive peer support networks, peer run crisis diversion programs, or our nationally recognized housing and vocational programs.

ValueOptions has worked with a number of the nation's thought leaders and national organizations to promote and expand the use of peer services. For example, we have participated with the Association for Behavioral Health and Wellness to gather data on the scope and availability of peer services nationally. Additionally, we have worked with SAMHSA on a set of national competencies for peer specialists.

Moreover, we have collaborated with many state mental health offices to develop state-specific peer certification programs. In Tennessee, Colorado and New Jersey, we are actively engaged with peer organizations to help meet specific training needs for certification.

ValueOptions reached out to both the Georgia Mental Health Consumer Network (GMHCN) and the Georgia Council on Developmental Disabilities (GCDD) to ensure our approach is aligned with the latest developments in Georgia. As an organization that is singularly focused on the emotional wellbeing of the individual's we serve across the country, we know that services and supports must be person-centered, responsive to individual needs, and capable of tapping into local sources of support. We will work with both of these organizations to enlist their assistance in training and recruiting of qualified peer specialists.

Both our GCAL and field-based regional teams will staff Peer Support Specialists. These peers empower individuals served by the program to define and pursue their own recoveries, connect them with community-based resources, and work collaboratively with clinicians. They engage, educate and empower individuals and their families to connect with support services, community resources and advocacy assistance. GCAL will employ certified peer specialists to provide telephone support to callers to the crisis response line, including follow-up calls to those callers who do not require a mobile crisis response to ensure the caller is stabilized and the appropriate linkage is provided. For frequent high utilizers of emergency department services who fail to engage in community treatment, we will send our Peer Support Specialists to the emergency department to meet with the individual and provide peer support during the crisis.

Peer Specialists are essential to support and enhance the good works of a fully integrated behavioral health and IDD delivery system. In addition, and just as important, they are essential to support and nurture a recovery and independence- minded culture within our local Engagement Centers. These talented individuals not only support and challenge individuals within the community to engage in care; but also, they inspire their co-workers and ensure that a recovery and independence culture is established and nurtured within our day-to-day work environment.

ATTACHMENT A.11

A.11 In Attachment A.11, submit a proposed organizational chart for administration of this Contract, which demonstrates that the Offeror has the human resources necessary to perform the Contract functions, including the numbers and locations of staff members.

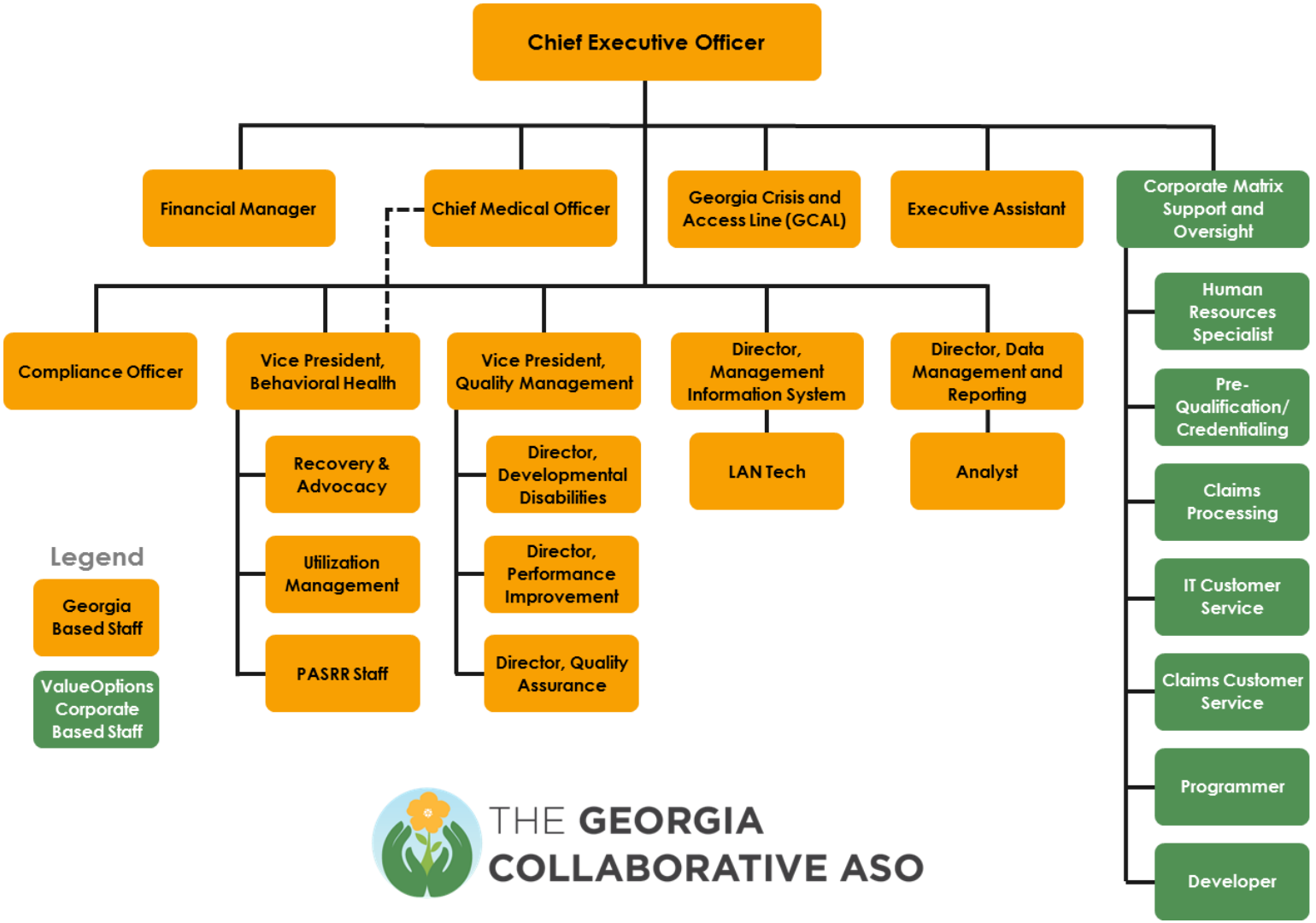
We have provided our proposed organizational chart for the administration of this contract on **page 79**. Specific staff numbers and locations are listed in the table below.

Job Function	Location	FTEs
Engagement Center Administration		
Chief Executive Office (Program Director)	Atlanta	1.0
Chief Medical Officer	Atlanta	1.0
Associate Medical Director (IDD)	Atlanta	0.25
Compliance Officer	Atlanta	1.0
Finance Manager	Atlanta	1.0
Executive Assistant	Atlanta	1.0
Administrative Assistant/Human Resources	Atlanta	1.0
Clinical Department		
Vice President, Clinical (Behavioral Health Director)	Atlanta	1.0
Utilization Management Director	Atlanta	1.0
Recovery & Advocacy Director	Atlanta	1.0
Community Transition Specialist	Atlanta	4.0
PASRR Team Lead	Atlanta	1.0
Recovery & Advocacy Team Lead	Field Based in Georgia	1.0
Peer Specialist	Field Based in Georgia	4.0
Utilization Management Team Lead	Field Based in Georgia	1.0
Clinical Care Manager (CCM)	Field Based in Georgia	10.0
Clinical Support Specialists	Field Based in Georgia	3.0
Intensive Care Management Team Lead	Field Based in Georgia	1.0
Intensive Care Management	Field Based in Georgia	5.0
PASRR staff/CCM	Field Based in Georgia	6.0
Quality Department		
Vice President of Quality	Atlanta	1.0
Director of Quality Assurance	Atlanta	1.0
Director of Performance Improvement	Atlanta	1.0
Grievance Coordinator	Atlanta	1.0
Quality Administrative Assistant	Atlanta	1.0
Quality Team Lead	Field Based in Georgia	2.0
Auditor	Field Based in Georgia	17.0

Job Function	Location	FTEs
Regional Network Manager	Field Based in Georgia	4.0
Support Departments		
Analysts	Atlanta	3.0
Director of Reporting & IT	Atlanta	1.0
IT Manager	Atlanta	1.0
LAN Tech	Atlanta	1.0
Provider Relations Manager	Atlanta	1.0
Provider Trainer	Atlanta	1.0
Reporting Manager	Atlanta	1.0
Technical Administrative Security	Atlanta	0.5
Peer Review Scheduler	Atlanta	0.22
Denials & Appeals Coordinator	Atlanta	0.09
Claims Customer Service	New York	1.0
Claims Processor	New York	1.0
Claims Specialist	New York	0.6
Customer Service Manager	New York	1.0
IT Customer Service	New York	1.0
Credentialing Specialist	Virginia	2.0
Developer	Virginia	1.0
Programmer	Virginia	1.0
ValueOptions Subtotal		**91.66**
Delmarva Foundation Subtotal		**23.23**
Behavioral Health Link Subtotal		**113.4**
Georgia Collaborative ASO Total		**228.29**

Georgia Collaborative ASO Organizational Chart

Proprietary and Confidential



ATTACHMENT B.1

B.1 In Attachment B.1, **(limit four (4) pages)**, describe the Offeror's approach to prudently managing DBHDD's financial resources to ensure the support of individuals in need of BH and IDD services and supports while managing different funding streams and priority population requirements.

As the ASO, we share DBHDD's vision of providing a fully integrated system of services for individuals and families that includes services from various funding streams. Our approach to prudently managing DBHDD's financial resources is to guide the delivery of superior clinical quality and social support services that are individual and recovery-focused, clinically appropriate, cost-effective, and culturally competent. Such a system allows for and supports the healthy development and recovery of individuals while maintaining the integrity of service delivery through a seamless system of benefit provisions for behavioral health and IDD services. Most of all, it ensures that the financial resources of the program are best used to improve the lives of the individuals the program was designed to serve.

The core requirements of an integrated system include:

- Immediate categorization and identification of funding stream per individual
- Comprehensive assessment tools
- Organization and reporting of outcome data
- Claim identification and payment per benefit/funding/agency
- Reporting per funding stream
- Accounting per funding stream/service/agency

Our Braided Funding[SM] system designed within ValueOptions' CONNECTS technology platform enables us to flag individuals as having a 'Braided Funding' status by associating each individual with a single, unique CID number. Each individual is then associated with multiple, active eligibility records. Each eligibility record represents a different funding stream, including Medicaid and non-Medicaid eligibility data. Updates to the individual's record for non-Medicaid funding streams are added when requested by a provider registering the individual.

FUNDING STREAM HIERARCHY

In our Braided Funding system, all funding streams are part of a hierarchy, and each funding stream is assigned a priority. The hierarchy determines the order of payment primacy among the various funding streams for which each individual is registered. This hierarchy is applied to both the authorization and claim payment process. Providers will no longer be required to provide funding stream information on their claim submissions. As a result, the DBHDD administrative processes associated with our Braided Funding system are significantly simplified. However, to enhance communication with providers, we will retain the funding stream information submitted on a claim if and when a provider gives us this information. The Provider Summary Voucher communicated to the provider will list the funding stream submitted by the provider and which funding stream was applied to the claim based on the hierarchy within the system.

REGISTRATION PARAMETERS

Through ProviderConnect, providers will have access to any prior registrations they have submitted for a given individual. Providers will be required to re-register the individual according to the parameters set for each non-Medicaid funding stream. Termination dates applicable to non-Medicaid funding streams are controlled by the Registration Parameters module. The termination dates for Medicaid are dependent upon the eligibility feed that we receive from DBHDD.

All registration updates processed through the online Consumer Registration Module are automatically updated within the CONNECTS platform, including our claims adjudication system, and are immediately available to all staff for authorization and claims processing. Within our Braided Funding system, each eligible individual is assigned a unique identification number that is associated with the Medicaid or non-Medicaid funding stream and the benefit plan for which the individual has been registered.

An individual can be associated with multiple, active eligibility records. The effective date and termination date(s) for each funding stream (including DBHDD eligibility data) are displayed in our system and each eligibility record represents a different funding stream. Each funding stream is linked to a unique benefit plan, which is then linked to each associated identification number. If an individual is first registered for a non-Medicaid funding stream, the individual will be assigned a CID. If the same individual later becomes eligible for Medicaid, he or she will then receive a Medicaid ID. Both identification numbers will be linked to the single individual record in our system.

REPORTING

We track utilization and report financial results by funding stream through the use of our general ledger system and the finance reporting engines that are contained within CONNECTS. We have extensive experience providing this type of reporting for clients.

In order to complete this reporting, we set up a separate general ledger coding and accounts to represent each funding stream. We then leverage our data warehouse to segregate authorization/ utilization information by funding stream.

For our contract with the state of Pennsylvania, we report revenues and medical utilization by seven different funding streams and over 15 defined levels of care. In our contract with the state of Texas, we report revenues and the medical split between Title XIX Medicaid and State indigent appropriations.

Additionally, ValueOptions maintains a robust internal control system to ensure that reporting by funding stream is accurate. Our National Revenue Reconciliation teams analyze the payment received from our client and split the payment into key data sets, such as distinct funding streams. Once completed, the payment and funding stream information accompanying the payment is compared and reconciled with the eligibility data for which the payment is to be based. As in the examples above, this information is provided to ValueOptions by the state's MMIS via an 820, Payment Order/Remittance Advice electronic transaction. If any discrepancies are discovered, our Revenue Reconciliation team will work directly with the

appropriate State and local staff to make the necessary corrections. In addition, we will work with our external auditors to complete additional analysis of the data or audits that DBHDD may request to verify reporting at the funding stream level.

ATTACHMENT B.2

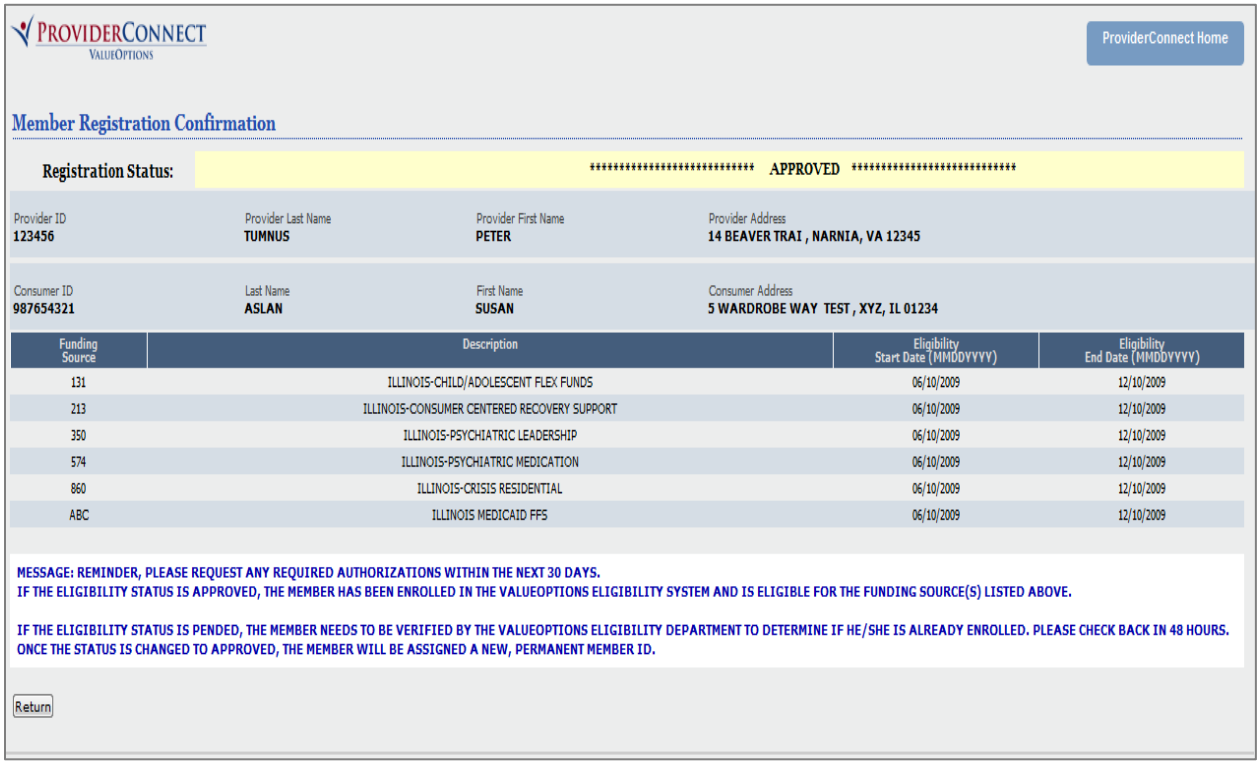
B.2 In Attachment B.2, (limit four (4) pages), describe the Offeror's proposed online process for eligibility and cost-sharing determinations for BH and IDD State-funded services.

Our provider portal, ProviderConnect, is designed specifically for use by providers and is fully integrated with additional modules of our CONNECTS application platform, which houses the eligibility data for Medicaid and non-Medicaid individuals. The Consumer Registration Module, described in our response to *Section B.1*, loads or updates the eligibility files as providers register the individual in real time for all stakeholders.

The Consumer Registration Module features flexible configurations that make it easy for authorized providers to register individuals for non-Medicaid funding streams. Once the provider enters the individual's specific demographic and clinical information, the Consumer Registration Module will generate a list of appropriate funding streams for which the individual may be registered.

The Consumer Registration Module includes a provider authentication process that filters the list of available funding streams down to only those for which the provider is contracted. The provider can then select the funding stream(s) in which he or she wants to register the individual. The system will then prompt the provider to complete specific forms within the module in order to complete the registration and prior authorization process. The forms to be completed will vary based on the funding stream(s) selected for each individual.

When all required forms are completed, the confirmation page will be displayed to the provider, as illustrated in the screenshot on the following page. The confirmation page includes the status of the registration, lists the funding stream(s) and the effective and termination dates for which the individual is registered. The confirmation results in the individual being added/updated in our CONNECTS application platform.



PROVIDERCONNECT
VALUEOPTIONS

ProviderConnect Home

Member Registration Confirmation

Registration Status: ********** APPROVED **********

Provider ID	Provider Last Name	Provider First Name	Provider Address
123456	TUMNUS	PETER	14 BEAVER TRAI , NARNIA, VA 12345

Consumer ID	Last Name	First Name	Consumer Address
987654321	ASLAN	SUSAN	5 WARDROBE WAY TEST , XYZ, IL 01234

Funding Source	Description	Eligibility Start Date (MMDDYYYY)	Eligibility End Date (MMDDYYYY)
131	ILLINOIS-CHILD/ADOLESCENT FLEX FUNDS	06/10/2009	12/10/2009
213	ILLINOIS-CONSUMER CENTERED RECOVERY SUPPORT	06/10/2009	12/10/2009
350	ILLINOIS-PSYCHIATRIC LEADERSHIP	06/10/2009	12/10/2009
574	ILLINOIS-PSYCHIATRIC MEDICATION	06/10/2009	12/10/2009
860	ILLINOIS-CRISIS RESIDENTIAL	06/10/2009	12/10/2009
ABC	ILLINOIS MEDICAID FFS	06/10/2009	12/10/2009

MESSAGE: REMINDER, PLEASE REQUEST ANY REQUIRED AUTHORIZATIONS WITHIN THE NEXT 30 DAYS.
IF THE ELIGIBILITY STATUS IS APPROVED, THE MEMBER HAS BEEN ENROLLED IN THE VALUEOPTIONS ELIGIBILITY SYSTEM AND IS ELIGIBLE FOR THE FUNDING SOURCE(S) LISTED ABOVE.

IF THE ELIGIBILITY STATUS IS PENDED, THE MEMBER NEEDS TO BE VERIFIED BY THE VALUEOPTIONS ELIGIBILITY DEPARTMENT TO DETERMINE IF HE/SHE IS ALREADY ENROLLED. PLEASE CHECK BACK IN 48 HOURS.
ONCE THE STATUS IS CHANGED TO APPROVED, THE MEMBER WILL BE ASSIGNED A NEW, PERMANENT MEMBER ID.

Return

Consumer Registration Confirmation Screen

Our Braided Funding system includes individual 'best match' logic that identifies potential duplicate entries by comparing demographic information such as last name, first name or nickname, date of birth, Social Security Number, and gender. When a potential duplicate entry is identified, the Consumer Registration Module assigns the entry a 'pending' status and a unique identification number. The registration confirmation page will display a status of 'pending' for that registration. This process automatically generates an inquiry to our National Eligibility Department staff member, who will research the individual's information, determine if this is a new individual or an individual already on file and assign the appropriate permanent ID. The provider will receive notification through ProviderConnect that the individual's registration status was changed from 'pending' to 'approved,' along with the individual's permanent ID.

Additionally, providers with third-party clinical management systems can submit batch files that automatically integrate with our clinical system. The batch registration process runs hourly during regular business hours and incorporates extensive front-end editing to confirm all required information's validity. Providers who submit batches during regular business hours receive acceptance or rejection notification within one hour. Providers submitting batch files after hours or on a holiday or weekend receive notification the next business day.

ProviderConnect automatically routes reporting information on the batch process to the registering provider. Provider feedback reports include a summary in addition to accept/reject notification. Summary reports include any deficiencies in an individual's registration, allowing

providers to correct and resubmit errant registrations for reconsideration. Providers can also verify the registration for a particular individual in ProviderConnect.

ATTACHMENT B.3

B.3 In Attachment B.3, **(limit four (4) pages)**, describe the Offeror's experience in conducting eligibility assessments for non-Medicaid programs and services consistent with requirements in Section 4.0 of the RFP. Include the following:

a. Experience implementing financial and program eligibility criteria.
b. Your proposed approach for making accurate eligibility determinations with simultaneous application to Medicaid and non-Medicaid benefit programs and services and experience with this approach.
c. The protections available to the individual being assessed to ensure that determinations are based on established criteria and protocols and not on the availability of resources to serve the individual.
d. Technology supports to automate the process, including the application process, eligibility determinations, links to Medicaid eligibility platforms, and tracking eligibility for reporting purposes.

A. – EXPERIENCE

We operate an eligibility determination process for non-Medicaid programs and services for several of our state clients that closely matches the requirements sought by DBHDD. For example, our Maryland program processes approximately 14,000 non-Medicaid eligibility determinations a year. We serve as the ASO for the Maryland Department of Health and Mental Hygiene (DHMH)/Mental Hygiene Administration (MHA). We work closely with DHMH and MHA to deliver a cost effective, recovery-oriented mental health service delivery system. This relationship ensures that Medicaid and eligible uninsured individuals embark upon their individual journeys of healing and transformation, while receiving access to behavioral health care within the community.

Our contract with the DHMH requires us to assess an individual's financial and program eligibility prior to providing state-funded, non-Medicaid behavioral health services. Requests for services for non-Medicaid eligible individuals can come from the provider or the individual by accessing our Web-based application, or by calling our Maryland Engagement Center's customer service line. Our online uninsured registration module was developed based on DHMH's uninsured eligibility or "non-Medicaid" requirements to solicit information from the provider concerning the individual's eligibility. Providers or individuals are prompted to enter the individual's specific demographic and eligibility information. Once the "uninsured" criteria are met, the provider is prompted to complete the registration process.

The provider is required to select a 'yes' or 'no' response to each eligibility question and based on those responses the individual will be granted uninsured coverage for six months or denied eligibility if they do not meet the criteria. The online form requires the provider to complete additional questions to determine if the individual is a veteran; a response of 'yes' will change the criteria needed to be met for coverage. Once the provider completes the online registration

form, eligibility is instantaneously determined and the provider is presented with either an approval or denial of coverage. If approved, the coverage is updated in real time in our integrated information system, the individual is automatically assigned a unique identification number and all operations areas have access to that information. The provider can then seamlessly and instantaneously move from an eligibility request to a request for services.

If an individual does not meet the criteria for the uninsured coverage, the provider has the option of filling out an exception request and submitting it to the individual's county of residence explaining why this person should receive uninsured coverage even though they do not meet the criteria. These requests are usually submitted due to a crisis event. These county offices, or Core Service Agencies, will approve or deny coverage. If approved the updated approval is sent to us to load the coverage into our system. A provider has the option to register an uninsured individual by phone as well through our customer service line during regular business hours.

In the event the individual does not meet uninsured criteria, the provider is notified that the individual requesting services does not qualify and that a review of determination may be requested from a Core Service Agency. Our Eligibility Specialists work closely with the Core Service Agencies for uninsured exceptions. The Core Service Agency reviews the request and determines if the exception should be granted. If approved, the Core Service Agency provides our Eligibility Specialist with the effective date of uninsured coverage. Our staff updates the system with the coverage and informs the provider and Core Service Agency of the individual's uninsured ID. The number of exceptions we have processed since 2012 are provided below:

Fiscal Year	Uninsured Consumer Registration	Uninsured Consumer Exceptions	Total	Exceptions as a Percent of Total
2012	13,131	879	14,010	6.27%
2013	13,769	996	14,765	6.75%
2014 (Q1)	2,971	235	3,206	7.33%

Through the Braided Funding system, as stated in our response to *Section B.2*, our eligibility determination process includes individual 'best match' logic that identifies potential duplicate entries by comparing demographic information such as last name, first name or nickname, date of birth, Social Security Number, and gender. When a potential duplicate entry is identified, the registration module assigns the entry a 'pending' status and a temporary identification number. The registration confirmation page will display a status of 'pending' for that registrant. This automatically generates an inquiry to our National Eligibility Department, which will research the individual's information, determine if this is a new individual or an individual already on file, and assign the appropriate permanent ID. The provider will receive notification through our Web-based provider portal that the individual's registration status was changed from 'pending' to 'approved.' The provider will then receive the individual's permanent ID that is maintained in our system.

When all required forms are completed, the confirmation page will be displayed to the provider. The confirmation page includes the status of the registration, list the funding stream(s), and the

effective and termination dates for which the individual is registered. This confirmation also results in the individual being added or updated in our eligibility platform. All approval spans for uninsured individuals are maintained in our system to ensure that duplicate entries are prevented.

At the direction of DHMH, we also audit a sample of records for randomly selected Outpatient Mental Health Clinics and Psychotherapeutic Rehabilitation Programs. We conduct a minimum of 70 provider audits each year with a typical sample size of 20 records to determine if the documentation in the medical record supports the uninsured eligibility criteria. To improve provider understanding of and compliance to our auditing process, we:

- Post the instructions about the auditing process and State requirement on our website
- Post the audit tool question(s) on our website
- Conduct training on the auditing process in each of the four regional provider forums
- Conduct one-on-one education for each audited provider during the exit interview
- Include specific instructions in our reports to each provider on how to improve compliance with State documentation requirements
- Give detailed and aggregated data to the State on audited results

B. – PROPOSED APPROACH

We are dedicated to ensuring each individual receives the proper level of care at the appropriate time, and recognize the importance of maintaining consistent clinical protocols from the outset in support of this aim. Our existing technological infrastructure unifies individual registration into one-step for every individual, on a non-provider-specific statewide basis, with only a limited expenditure of time and resources.

During the implementation period, in partnership with DBHDD, we will develop a customized, highly effective, automated registration process for the DBHDD program. The process will provide online capabilities to collect all standardized criteria necessary to make a simultaneous determination of access to Medicaid or State-funded BH programs and services. The process will support the verification of:

- Age and financial eligibility
- Program eligibility
- Diagnostic and function eligibility
- Service eligibility

Our process will also include:

- Confirming that eligibility and enrollment determination were appropriately conducted
- Verifying Medicaid eligibility through GAMMIS
- Determining availability of third-party insurance coverage for all populations (e.g., Medicare, Tricare, Veterans Health Administration benefits, commercial insurance)
- Noting when an individual is potentially eligible for Medicaid, but not enrolled in Medicaid, and prompt the referring provider to facilitate Medicaid application and enrollment

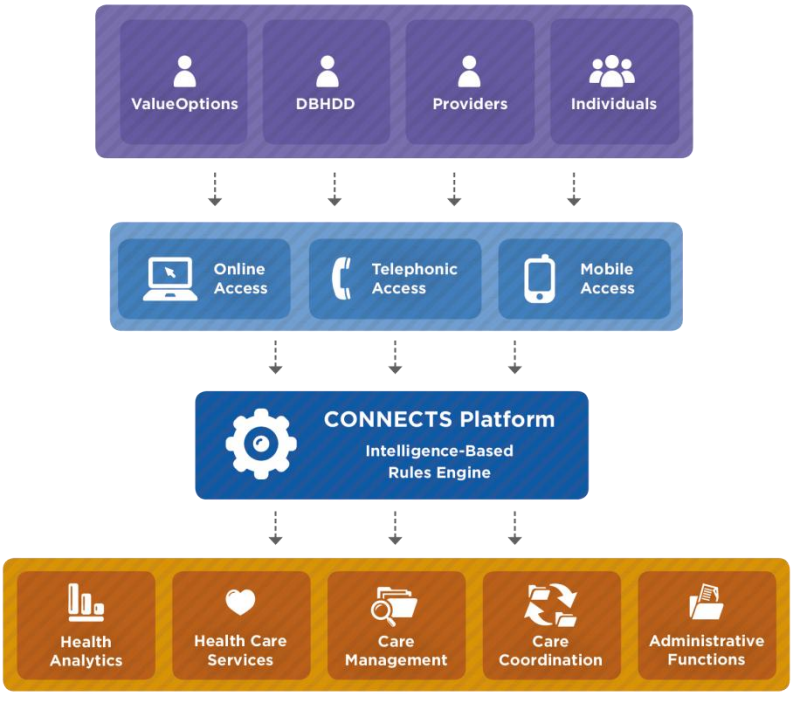
- Reviewing other qualifying characteristics for service eligibility (e.g., place of residence, membership in ADA target population)
- Assessing CBAY Program functional eligibility through a level of care determination process and make a recommendation to DBHDD

C. – DETERMINATIONS

We will protect individuals from being denied access to services by implementing an eligibility determination process that is rule-driven using DBHDD-approved functional, diagnostic and financial eligibility criteria. In other sections of our response, we discuss our strategy to make the most efficient use of available resources to serve the identified needs of program qualified individuals. Our eligibility identification process continues independent of any determination of the availability of these resources. Our overall goal is to accurately identify, verify and document the program eligibility status of individuals and connect them to recovery-focused, clinically appropriate, cost-effective, and culturally competent care. Our eligibility determination and utilization management processes ensure that appropriate care is delivered to eligible individuals according to DBHDD's protocols, as well as the established clinical care criteria.

D. – TECHNOLOGY

Within CONNECTS, the eligibility database is fully integrated into our information management system. Eligibility information, such as Medicaid status, automatically feeds into our other administrative and clinical systems to ensure rapid and accurate payment of claims. It also ensures that eligibility and enrollment determinations reserve State-funding as a last payment option (or a complementary payment option) as Federal and State law permits. This fully integrated application, augmented with data (including data regarding other coverage), provider fee schedules, benefit configurations, authorization requirements, open inquiries, and data allow customized claims edits, which can be configured to meet DHMDD's tracking and reporting requirements.



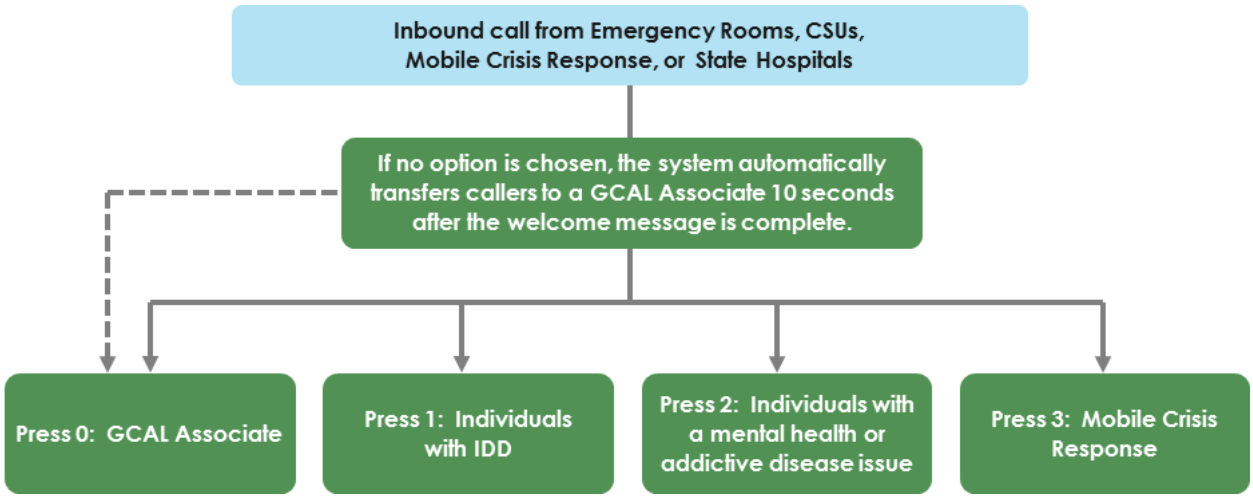
ATTACHMENT C.1

C.1 In Attachment C.1 **(limit four (4) pages)**, indicate the city/state of each service center location(s) proposed for the GCAL. Include service center locations of subcontractor(s) providing any proposed GCAL services. If the Offeror lists more than one (1) location, indicate what services will be provided at each location and the days and hours of operation. At a minimum, include the following:

a. Peak Hours (7 am–7 pm Monday through Friday) GCAL Service Center.
b. Non-Peak Hours GCAL Service Center(s).
c. If the Offeror is proposing more than one (1) call center for the GCAL, describe how the call centers will be linked. Address how calls are routed and how information on specific cases is shared when a call is handled by more than one (1) location. Describe the management of the remote call center and how continuity of services and standards were maintained.

As part of our **"High Assurance"** approach to ensuring a continuum of high-quality, appropriate behavioral health and IDD services, ValueOptions' key partner, Crisis Access Holdings, LLC d/b/a Behavioral Health Link (BHL) will continue to operate the Georgia Crisis and Access Line (GCAL). BHL, the current GCAL contractor, answers all calls from individuals in Georgia with a behavioral health or IDD-related crisis, condition or problem, regardless of individual resources, 24 hours a day, seven days a week. ***All calls to the published GCAL number are live answered and will not be sent through an automated attendant.*** BHL accomplishes this by utilizing DBHDD's existing toll-free crisis and access line telephone number (1-800-715-4225), a public line for accessing routine, urgent, or emergency services using two Georgia Engagement Center locations in Atlanta and Cordele.

As the ASO, we will also operate a private line that provides a direct connection between GCAL and crisis and inpatient services providers (e.g., 911, emergency rooms, contracted private hospitals, core providers, CSUs, MCTs, state hospitals) to coordinate referrals. All calls through the private line are now and will be managed through an automated call distribution system. This system, depicted on the follow page, has three options with a default option to sending callers directly to a GCAL Associate in the event that no option is chosen.



If no option is chosen, callers are automatically redirected to a live GCAL Associate.

PEAK AND NON-PEAK HOURS FOR THE GCAL SERVICE CENTER

Our Atlanta Engagement Center operates 24 hours a day, seven days a week with ***all GCAL calls managed exclusively in Georgia*** except in the event of a natural or man-made disaster or significant and unexpected spike in call volume as noted in our response to *Section C.8*.

In addition to the 24/7 Atlanta Engagement Center, the Cordele Engagement Center operates the GCAL line for southern Georgia Monday through Friday, 7:00 a.m. to 7:00 p.m. This gives GCAL Associates in Cordele a higher volume of calls from the southern part of Georgia and our Atlanta GCAL Associates more calls from northern Georgia. All GCAL Associates are trained for all regions in Georgia; however, our experience has shown that this arrangement provides a "nice touch" and builds rapport with community providers in the area.

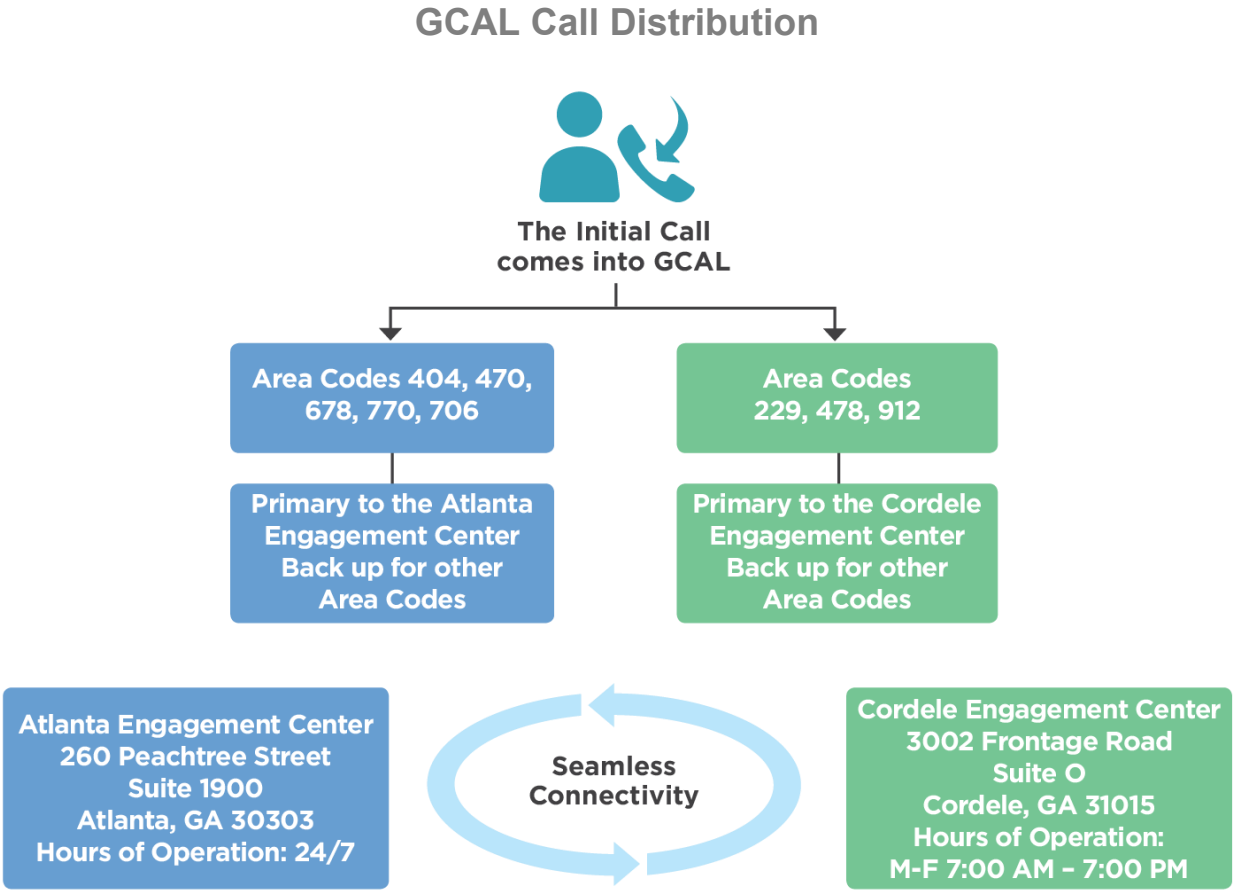
CONTINUITY ACROSS MULTIPLE ENGAGEMENT CENTERS

There are currently two Engagement Centers located in Georgia that provide services for GCAL. Both Engagement Centers have been working in tandem since 2013. As previously mentioned and depicted in the graphic on the following page, callers are routed to the appropriate Engagement Center based on the time and location of the call. All data is seamlessly shared via VPN access, and all processes are identical across Engagement Centers. Both sites provide all GCAL services for behavioral health and IDD, including telephonic crisis intervention, screening, referral to services, single point of entry services, and mobile crisis dispatch services.

Individuals calling the GCAL line are unable to make a distinction between calls answered in Cordele and calls answered in Atlanta.

To provide the best possible service for Georgians calling the GCAL line, our hiring, training, and supervision guidelines and provisions are identical for Cordele and Atlanta GCAL Associates. Onsite training occurs at both Engagement Centers to ensure Associates are effectively trained to understand the cultural nuances in northern and southern Georgia. It is truly one Engagement Center identically connected and supervised onsite and virtually. GCAL Associates continuously use instant messaging software and a HIPAA-compliant Web

conferencing system to conduct face-to-face staffing of cases and clinical supervision. Secure, HIPAA-complaint Web cameras in Atlanta and Cordele allow monitoring of all Engagement Center staff from either location. GCAL Associates utilizing computer-based phones in remote locations are also monitored in the same manner when necessary.



During peak hours, calls originating in southern Georgia are routed seamlessly to our Engagement Center in Cordele, Georgia to ensure the highest possible level of service is provided to callers.

ATTACHMENT C.2

C.2 In Attachment C.2 **(limit three (3) pages)**, outline the Offeror's experience in providing an in-bound crisis and access line call center similar to GCAL. Provide a description of the call center operations and identify the location(s).

BHL has more than 12 years of experience operating an inbound crisis and access call line to help individuals with behavioral health and developmental disability needs. We detail our experience with multiple inbound crisis and access lines below:

- **The Georgia Crisis and Access Line:** BHL currently operates two Georgia-based Engagement Centers with seamless connectivity in Atlanta and Cordele to manage GCAL. Since July 2006, GCAL has received more than two million calls to the public line and completed more than 1 million triages with more than 260,000 of those urgent or emergent. This service is provided 24/7/365 and has maintained very high service delivery standards.

- **SAMHSA National Suicide Prevention Lifeline (800) 273-TALK:** BHL has answered the (800) SUICIDE national hotline since 2002 and the (800) 273-TALK hotline since its inception on January 1, 2005. BHL's partner, David Covington, has served as the National Suicide Prevention Lifeline Steering Committee Vice-Chair since 2005. Callers in Georgia contacting the Lifeline are routed to BHL during agreed upon time periods and managed closely with the national network to ensure that Lifeline calls do not interfere with GCAL service standards. BHL's membership in the Lifeline network and American Association of Suicidology (AAS) certification ensure our responders are on the cutting-edge of suicide risk assessment standards and that best practices are followed including active rescue in cases where there is imminent danger. As part of the Lifeline network, BHL also works very closely with the Veterans Crisis Line in Canandaigua, New York and participates in regular training with the Lifeline to ensure BHL staff is well prepared to assist Georgia's military personnel and veterans in crisis.

"BHL is a national model for how public health authorities can effectively use crisis centers to provide 24/7 support for anyone in emotional distress. They also reduce unnecessary emergency department visits by efficiently linking persons to necessary community behavioral health services. Model programs such as the Georgia Crisis & Access Line set a quality standard for better ensuring continuity of care and getting help to people where and when they need it."

John Draper, Ph.D. – Project Director, National Suicide Prevention Lifeline

- **DHR MHDDAD Crisis Line/Single Point of Entry:** Prior to the introduction of the statewide Georgia Crisis & Access Line, BHL operated Single Point of Entry contracts in three of the former DHR DMHDDAD Regions II, III and V that cover 35 counties. These 24/7 toll-free lines were staffed exclusively by licensed professionals who offered crisis intervention and access/linkage for all State-funded services. BHL received more than 525,000 crisis and access calls on a variety of crisis and access lines, including the 40-year old Fulton County (404) 730-1600 hotline. Service delivery standards were outstanding with an average speed of answer of 18 seconds and an abandonment rate of 1.4 percent. Services were provided for the 13 counties in Greater Augusta from 1998 to 2006, Fulton and Clayton counties from 2002 to 2006, and the 20 counties comprising Coastal Georgia from 2002 through 2004.

- **North Carolina MR/DD Diversion:** This statewide 24/7/365 toll-free "diversion" hotline was operated by BHL from 2002 to 2004 for providers and community agencies throughout North Carolina. Its purpose was to link individuals with MR/DD in crisis with the most appropriate intensive services following a standardized protocol and using established patient placement criteria. This was in response to Senate Bill 859 designed to divert individuals from inappropriate inpatient psychiatric hospitalizations at state facilities. This service was integrated into the Local Management Entities as part of the state reform process in 2004.

- **National Suicide Prevention Lifeline Disaster Distress Helpline (2012):** Through a one-year grant from SAMHSA, Link2Health Solutions established the Disaster Distress Helpline, a free, confidential, 24/7 crisis support service for U.S. residents who are experiencing psychological distress as a result of a disaster, either natural or man-made. Using the existing infrastructure of SAMHSA's National Suicide Prevention Lifeline (NSPL) telephone system, BHL worked to develop this new Disaster Distress Helpline network and collect evaluation data. BHL was one of four crisis call centers in the U.S. selected to receive a grant from Link2Health Solutions. This enabled BHL to become one of four "Core Region Centers" that comprised the initial pilot of the Disaster Distress Helpline. Specifically, BHL served as the Core Region Center for Region 3 answering calls and texts 24/7 from individuals in distress within this multi-state region.

- **National Suicide Prevention Lifeline Chat Intervention Grant (2012):** On December 15, 2011, BHL was awarded grant funding from the National Suicide Prevention Lifeline. As part of the NSPL network, BHL was chosen to receive supplemental funding to collaborate with the NSPL network in the development of instant message/chat-based services in an effort to increase community access to online crisis intervention services. BHL is the only agency in Georgia accredited by Contact USA to provide chat/instant message/text online emotional support and crisis intervention.

ATTACHMENT C.3

C.3 In Attachment C.3, **(limit two (2) pages)**, for each location identified in C.2., indicate annual volume of inbound calls for the last twelve (12) calendar months for the following metrics:
a. Call volume.
b. Volume of (separately) crisis, routine, information and/or other calls.
c. Access and referral call volume.

Currently there is only one GCAL telephone number for all calls, including crisis, routine, information requests, and referral and/or access services. Our telephony system is structured so that GCAL calls originating in southern Georgia are primarily directed to our Engagement Center in Cordele and calls originating in northern Georgia are primarily directed to our Engagement Center in Atlanta. However, the system also redirects callers to the first available call agent regardless of location to ensure the fastest possible response to a crisis call. As such, our telephony system does not break down call volume by location or by requested metrics. Under the new contract, we will reconfigure our system to capture volume data as required by the State.

Overall BHL call volume metrics for the past 12 months (May 1, 2013 through April 30, 2014) are provided in the table below:

Metric	Number of Calls
Total Call Volume	207,708
Volume of:	
Crisis – Emergent	52,476
Crisis – Urgent	73,228
Routine*	82,004

**Routine call volume reflects the total number calls received for routine, information requests, access, and referral calls.*

In addition, for the purposes of this procurement ProtoCall Services (ProtoCall) will serve as our back-up in the event of sudden, unexpected call spike or in the case of a natural or man-made disaster. ProtoCall has more than 200 contracts with several different functions (e.g., crisis lines, referral lines, after hour lines, back-up for crisis lines, back up for providers) with a multitude of expectations for contract performance. Though ProtoCall utilizes remote call agents and three Engagement Center locations in New Mexico, Michigan, and Oregon, they also have one "virtual" Engagement Center using an automated call distribution system that looks for the next available agent regardless of location. For this reason, the software does not break down the call volume by location.

Overall ProtoCall call volume metrics for the past 12 months (May 1, 2013- April 30, 2014) are provided in the table on the following page.

Metric	Number of Calls
Total Call Volume**	448,348
Volume of:	
Urgent, Emergent, Routine Clinical Calls	115,145
Facility, Law Enforcement, Non-Clinical Calls from Individuals	288,425
Referral/Access Calls	44,778

***ProtoCall's volume metrics reflect a total picture for over 200 separate contracts with varying contract requirements.*

ATTACHMENT C.4

C.4 In Attachment C.4, for each location identified in C.2., indicate annual values for the last twelve (12) calendar months for the following metrics and provide indicate the contract performance measures or goals associated with each metric:

a. Speed of answer for crisis or emergency line.
b. Percent crisis or emergency calls answered within fifteen (15) seconds.
c. Call abandonment percentage for the crisis or emergency line.
d. Speed of answer for access and referral line.
e. Percent of access and referral calls answered within thirty (30) seconds.
f. Call abandonment percentage for the access and referral line.

As previously mentioned in our response to *Section C.3*, there is only one GCAL telephone number for all calls, including crisis, routine, information requests, and referral and/or access services. Our telephony system is structured so that GCAL calls originating in southern Georgia are primarily directed to our Engagement Center in Cordele and calls originating in northern Georgia are primarily directed to our Engagement Center in Atlanta. However, the system also redirects callers to the first available call agent regardless of location to ensure the fastest possible response to crisis call. As such, our telephony system does not break down call performance by location or by requested metrics. Under the new contract, we will reconfigure our system to capture call performance data as required by the State.

Overall BHL call performance statistics for the past 12 months (May 1, 2013 through April 30, 2014) are provided in the table below:

BHL Performance Measure/Metric (Atlanta and Cordele Combined)	Contract Expectation	Actual 12-Month Average
Speed of answer	30 seconds	15 seconds
*Percent of calls answered within 15 seconds	N/A	99.64%
Call abandonment rate	5%	2.7%

**The percentage of calls answered within 15 seconds is measured for latest 10-week period to the GCAL line.*

As stated previously, for the purposes of this procurement, ProtoCall will serve as our back-up in the event of sudden, unexpected call spike or in the case of a natural or man-made disaster. ProtoCall has more than 200 contracts with several different functions (e.g., crisis lines, referral lines, after hour lines, back-up for crisis lines, back up for providers) with a multitude of expectations for contract performance. Though ProtoCall uses remote call agents and three Engagement Center locations in New Mexico, Michigan, and Oregon, they also have one "virtual" Engagement Center using an automated call distribution system that looks for the next

available agent regardless of location. For this reason, the software does not break down the call metrics by location.

Overall ProtoCall call performance statistics for the past 12 months (May 1, 2013 through April 30, 2014) are provided in the table below:

Performance Measure/Metric All ProtoCall Call Centers Combined	Actual 12-Month Average
Average speed of answer for crisis lines	17 seconds
Percent of crisis calls answered within 15 seconds	80%
Abandonment rate for crisis lines	3.9%
Percent of access and referrals calls answered within 30 seconds	87%
Abandonment rate for access and referral lines	3.9%

ATTACHMENT C.5

C.5 In attachment C.5, **(text description limited to six (6) pages, graphic presentation unlimited)**, describe and provide proposed triage protocols, graphic workflows, and decision trees to be used by call center staff specific to BH, IDD, and co-occurring needs. At a minimum, description should address workflows related to:

a. Routine calls
b. Urgent and Emergent calls
c. Mobile Crisis dispatch

Our goal in serving all GCAL callers is to always know how to locate an individual; to never lose contact; and to ensure and verify that the hand-off to a third-party provider or service is safely made. Our key partner, BHL, uses state-of-the-art technology and an integrated software infrastructure for tracking all callers to ensure a warm hand-off with their tools and teams. Our approach is very different from the traditional system and reduces the challenges and failures evident in other systems.

Our Vision: Supporting and responding to Georgians in crisis while creating a new paradigm for safety and recovery.

BHL has received millions of crisis calls from individuals, their families and the social service agencies that have worked with them over the last decade. The software systems that our staff utilize to assess and engage those at risk track individuals throughout the process, where they are, how long they have been waiting, and what specifically is needed to advance them to linkage, safety and support. Their names are highlighted on the pending linkage board in green, white, yellow or red depending on how long they have been waiting for service. When an individual contacts the Engagement Center for crisis or mobile crisis services, we never relinquish responsibility until we have confirmation that the individual has been successfully connected with another agency/entity that will have clinical responsibility. If there is a referral to mobile crisis, law enforcement, or an emergency department, we ensure they are connected with care. **We are the safety net for Georgians.**

WHAT DISTINGUISHES OUR SERVICES AND APPROACH

In keeping with the **"High Assurance"** approach, our proposed services are very different from the traditional system. Our system:

- Embraces key objectives for safety and recovery seamlessly
- Empowers the individual and does not re-traumatize them
- Perpetuates the individual's strengths, not failures and instilling hope
- Promotes accountability with a track record that is data driven, including technology to inform and ensure success
- Provides services grounded in a specific expertise in crisis intervention for behavioral health and developmental disabilities

Faces and voices of lived experience instill hope and provide a real example that recovery is possible.

- Shifts focus from the system to the individual
- Uses Peers as a key strategy of engagement and follow through

TRIAGE, REFERRAL AND LINKAGE TO ONGOING CARE OR SERVICES

In short, our mission and primary goal is to identify the needs of the individual (i.e., acuity/ urgency, disability and level of care needed) and to quickly link that individual to the level of care that best meets that need as close to home and community as possible. Using DBHDD-approved assessment tools, protocols and decision trees developed and refined over the past several years, we quickly assess and refer callers to the most appropriate and least restrictive level of care taking into account the individual's strengths, needs, abilities, support network, and preferences whenever possible.

Presentation of Current Crisis, Level of Care and Referral Decisions

The building blocks of the screening, triage and referral process are the:

- Risk assessment, shown on **page 101**
- Acuity guidelines for behavioral health and IDD, shown on **pages 102** and **103**
- LOCUS/CALOCUS tool, shown on **pages 104** and **105**

These tools, which are already built into our system, help us determine the urgency of the services required, level of care need and in many cases, guide our clinicians in determining the primary presentation of the crisis (i.e., mental health, substance use disorder, or IDD). The tools also assist in making service choices based on the most pressing need. Within the newly integrated program, BHL will be fully integrated into ValueOptions' care management system, allowing for an immediate and more holistic view of the individual in crisis. This will allow GCAL staff to better shape and respond to an individual in a rapid, personal and comprehensive fashion, including the ability to fully address secondary and tertiary concerns. This new level of integration enables BHL to more efficiently and effectively coordinate and access services for individuals with co-morbid conditions and dual diagnoses.

Stabilization through Collaboration

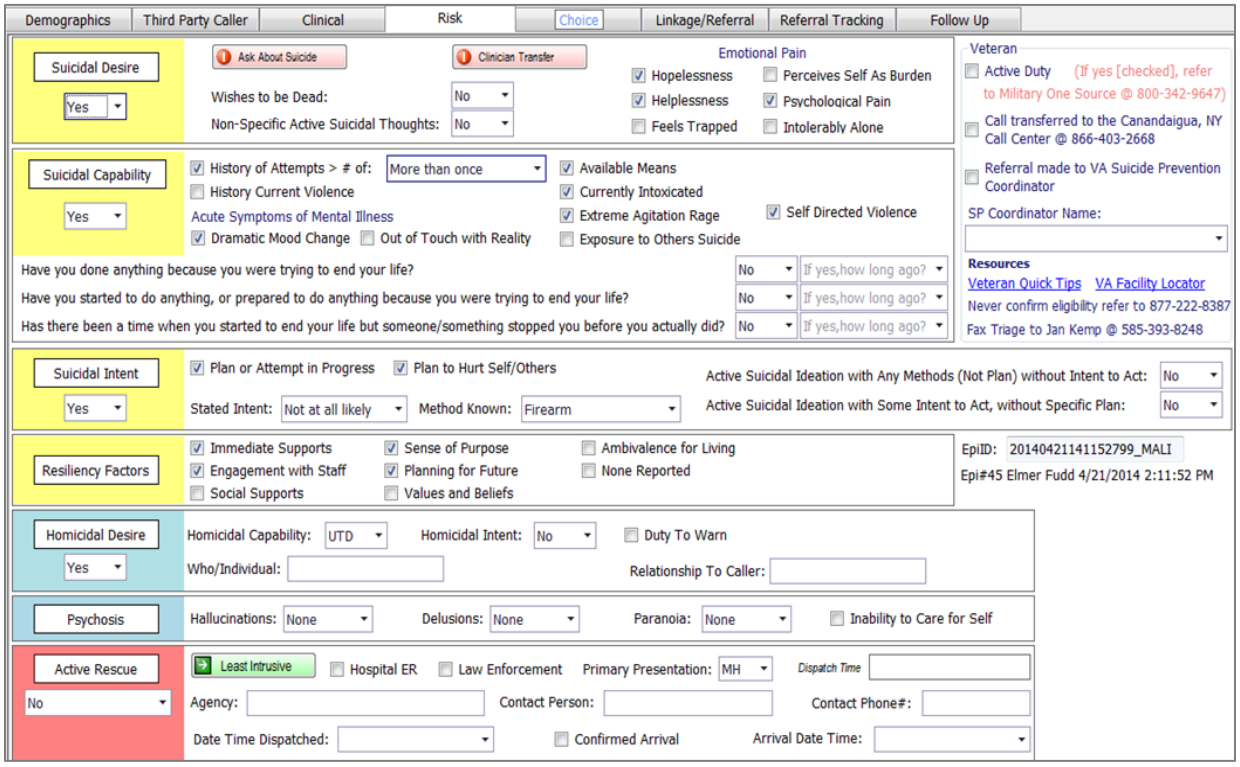
We will continue to collaborate with network providers, crisis service providers (e.g., ACT, MCT, CSUs), Medicaid care management organizations, and first responders (e.g., police, sheriff, fire, 911) to ensure that individuals gain access to the services they need while taking into account potential funding sources, such as Medicaid FFS, private insurance, and/or State-funds, including proposed FFS funding under the Core Provider Redesign.

Until now, the system has been at a disadvantage when it comes to identifying current services in place, the wishes of the individual served and eligibility considerations. Collaboration with individuals, crisis services, providers and natural supports will be more effective with the benefit of ValueOptions' integrated care management system to help inform GCAL Associate's decision making process and how we guide and support the individual to utilize benefits available for their care. For individuals already served in the DBHDD network, over time and in collaboration with the individuals we serve, we will create Crisis Prevention Plans that will be available in our care management system. GCAL Associates will then have access and refer to

these established plans to assist in reconnecting the individual with his or her current or prior service providers and ensure that their stated preferences are honored.

Through this new system of care, we will stabilize individuals' symptoms as quickly as possible and assist them in returning to their pre-crisis level environment. Our Georgia model of care provides a recovery-oriented intervention designed to avoid unnecessary hospitalization, incarceration, institutionalization, and out-of-home placement.

Risk Assessment Webpage



Behavioral Health Acuity Guidelines

Acuity	Intensity (One or more of the following is present)	Appointment Timeframe
Emergent	A life threatening condition exists as caller presents: • Suicidal/homicidal intent • Actively psychotic • Active withdrawal (alcohol, barbiturates, benzodiazepine) • Disorganized thinking or reporting hallucinations which may result in harm to self/others • Imminent danger to self/others • Unable to care for self	For an emergency crisis: • Immediately arrange to be seen within two hours • If suicidal/homicidal with weapon, call 911/police • If active withdrawal, send to nearest emergency room for medical clearance
Urgent	• No suicidal/homicidal intent • Denies suicidal plan/means • Expresses hopelessness, helplessness, sense of burdensomeness, disconnectedness or anger • May develop suicidal intent without immediate help • Potential to progress to need for emergent services • May express distress/impairments that compromise functioning, judgment and/or impulse control • May have withdrawal signs/symptoms from non-life threatening substances: cocaine, methadone, heroin • Dependence on alcohol, benzodiazepines or barbiturates, but not in active withdrawal and no history of withdrawal seizures or DTs	For severe situation: • Offer an appointment within 24 hours (48 hours at the maximum) • Instruct caller to re-contact GCAL if condition worsens • May include crisis plan with available supports
Routine	• Impacts caller's ability to participate in daily living • Markedly decreased the caller's quality of life • Caller acknowledges some distress/concerns • No evidence of danger of harm to self/others • No marked impairments in judgment or impulse control • Severity warrants assessment and possibly services • Substance use issues with possibility of substance dependence	For distressed callers: • Offer first available appointment within five days • Re-contact GCAL if condition worsens
Referral Only (Non-Core Customer)	• Presenting problems do not rise to clinical acuity required for State-funded services, which require Severe and Persistent Mental Illness	• Offer appropriate referral or resource
Warm-Line (Support Only)	• Caller is already linked with community services and does not have urgent or emergent needs	• Encourage to contact current provider
Information Only	• No identified consumer for clinical triage; simply a request for basic information	• Provide requested information
Business Call	• Request for an administrative staff person or in regard to an administrative matter	• Link to appropriate GCAL staff
Inappropriate Call	• Wrong number, prank or sexually inappropriate call	• No action necessary
No Disposition	• Situations in which it is not possible to determine or facilitate a linkage to necessary services	• Consult with supervisory staff

IDD Acuity Guidelines

Acuity	Intensity (One or more of the following is present)	Appropriate Linkage
EMERGENT • **Mobile crisis team referral/e-mail** • **I&E referral/e-mail** **(possibly both)**	A life threatening condition exists as caller presents: • Imminent risk of harm to self (current severe self-injurious behaviors) or others (e.g., choking someone) due to crisis behaviors • Immediate risk due to medical problems or injury • Suicidal/homicidal intent • Disorganized thinking or reporting hallucinations which may result in harm to self/others (i.e. command in nature)	**For an Emergency Crisis**: • Call 911/Police • If law enforcement is on the scene, ask if they want the assistance of IDD mobile crisis team
URGENT **Determine if:** • **Mobile crisis team referral/e-mail** • **I&E referral/e-mail** **(possibly both)**	• Presence of self-injurious behaviors that are not severe enough to require medical attention at this time (e.g., banging head, biting self, pulling hair) • Presence of potentially dangerous behaviors toward others (e.g., throwing things, hitting, kicking) • History of self-injury/attempts or physical aggression • Potential to progress to need for emergent services if behaviors continue to escalate • May express distress/impairments that compromise functioning, judgment and/or impulse control • No suicidal/homicidal intent, plan or means **Snapshot for Telephonic Resolution:** • Assist caller to utilize interventions and supports from behavior support plan, ISP or individual's crisis plan • Provide continuous telephonic support • Develop follow-up plan if the behavioral health crisis escalates	**For Severe Situations:** • Dispatch IDD mobile crisis team if severity of crisis prevents telephonic resolution • If individual is in the emergency room, assist with mobile crisis team dispatch and/or placement
ROUTINE • **Telephonically** • **Resolution notification via e-mail**	• Caller acknowledges some distress/ concerns • No evidence of danger of harm to self/ others • No marked impairments in judgment or impulse control • **IF NOT IN CONNECTS:** Let the caller know that in order to determine eligibility for IDD services an individual must be evaluated through an intake and evaluation team that serves the area that the individual lives • **IF IN CONNECTS:** Redirect the caller back to their provider or Support Coordinator	• **IF NOT IN CONNECTS:** If they meet IDD eligibility, refer to I&E team in their region • **IF IN CONNECTS:** Redirect the caller back to their provider or Support Coordinator
Warm-Line (Support Only) • **Telephonic** • **Resolution e-mail**	• Caller is already linked with community services and does not have urgent or emergent needs • Caller may need additional supports for individual and/or resources for items (e.g., equipment)	• Provide support • Offer appropriate referral or resource (Regional Office) • Encourage to contact Support Coordinator
Information Only • **Telephonic** • **Resolution e-mail**	• Request for basic information (e.g., how to get in contact with the Regional Office)	• Provide requested information

LOCUS – Level of Care Utilization System

I. Risk of Harm	II. Functional Status	III. Medical, Addictive, and Psychiatric Co-Morbidity	IV. A. Recovery Environment/Stressors	IV. B. Level of Support	V. Treatment and Recovery	VI. Engagement

I. Risk of Harm: 3

1. Minimal Risk of Harm -

a - No indication of suicidal or homicidal thoughts or impulses, and no history of ideations, and no indication of significant distress.
b - Clear ability to care for self now and in past.

2. Low Risk of Harm -

a - No current suicidal or homicidal ideations, plan, intentions or severe distress, but may have had transient or passing thoughts recently or in past.
b - Substance use without significant episodes of potentially harmful behaviors.
c - Periods in the past of self-neglect without current evidence of such behavior.

3. Moderate Risk of Harm -

a - Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
b - No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
c - History of chronic impulsive suicidal/homicidal behavior or threats and current expressions does not represent significant change from baseline.
d - Binge or excessive use of substances resulting in potentially harmful behaviors without current involvement in such behavior.
e - Some evidence of self neglact and/or compromise in ability to care for oneself in current environment.

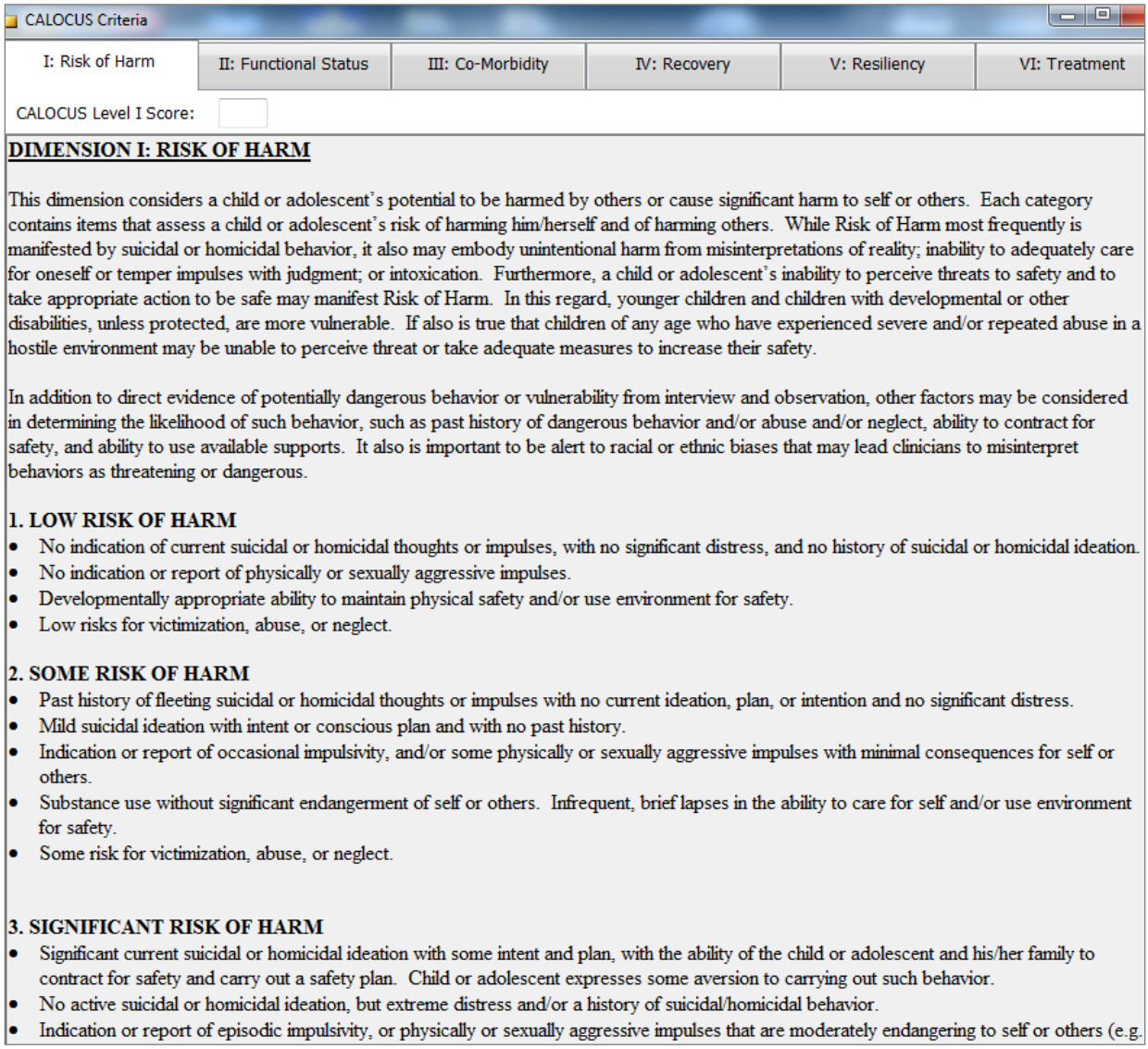
4. Serious Risk of Harm -

a - Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
b - History of chronic impulsive suicidal/homicidal behavior or threats with current expressions of behavior representing a significant elevation frome baseline.
c. - Recent pattern of excessive subtance use resulting in disinhibition and clearly harmful behaviors with no demonstrated ability to abstain from use.
d. - Clear compromise of ability to care adequately for oneself or to be adequately aware of environment.

5. Extreme Risk of Harm -

a - Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior...
- without expressed ambivalence or significant barriers to doing so, or
- with a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or
- in presence of command hallucinations or delusions which threaten to override usual impulse control

CALOCUS – Child and Adolescent Level of Care Utilization System



CALOCUS Criteria

I: Risk of Harm | II: Functional Status | III: Co-Morbidity | IV: Recovery | V: Resiliency | VI: Treatment

CALOCUS Level I Score:

DIMENSION I: RISK OF HARM

This dimension considers a child or adolescent's potential to be harmed by others or cause significant harm to self or others. Each category contains items that assess a child or adolescent's risk of harming him/herself and of harming others. While Risk of Harm most frequently is manifested by suicidal or homicidal behavior, it also may embody unintentional harm from misinterpretations of reality; inability to adequately care for oneself or temper impulses with judgment; or intoxication. Furthermore, a child or adolescent's inability to perceive threats to safety and to take appropriate action to be safe may manifest Risk of Harm. In this regard, younger children and children with developmental or other disabilities, unless protected, are more vulnerable. If also is true that children of any age who have experienced severe and/or repeated abuse in a hostile environment may be unable to perceive threat or take adequate measures to increase their safety.

In addition to direct evidence of potentially dangerous behavior or vulnerability from interview and observation, other factors may be considered in determining the likelihood of such behavior, such as past history of dangerous behavior and/or abuse and/or neglect, ability to contract for safety, and ability to use available supports. It also is important to be alert to racial or ethnic biases that may lead clinicians to misinterpret behaviors as threatening or dangerous.

1. LOW RISK OF HARM

- No indication of current suicidal or homicidal thoughts or impulses, with no significant distress, and no history of suicidal or homicidal ideation.
- No indication or report of physically or sexually aggressive impulses.
- Developmentally appropriate ability to maintain physical safety and/or use environment for safety.
- Low risks for victimization, abuse, or neglect.

2. SOME RISK OF HARM

- Past history of fleeting suicidal or homicidal thoughts or impulses with no current ideation, plan, or intention and no significant distress.
- Mild suicidal ideation with intent or conscious plan and with no past history.
- Indication or report of occasional impulsivity, and/or some physically or sexually aggressive impulses with minimal consequences for self or others.
- Substance use without significant endangerment of self or others. Infrequent, brief lapses in the ability to care for self and/or use environment for safety.
- Some risk for victimization, abuse, or neglect.

3. SIGNIFICANT RISK OF HARM

- Significant current suicidal or homicidal ideation with some intent and plan, with the ability of the child or adolescent and his/her family to contract for safety and carry out a safety plan. Child or adolescent expresses some aversion to carrying out such behavior.
- No active suicidal or homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior.
- Indication or report of episodic impulsivity, or physically or sexually aggressive impulses that are moderately endangering to self or others (e.g.

PROPOSED TRIAGE PROTOCOLS

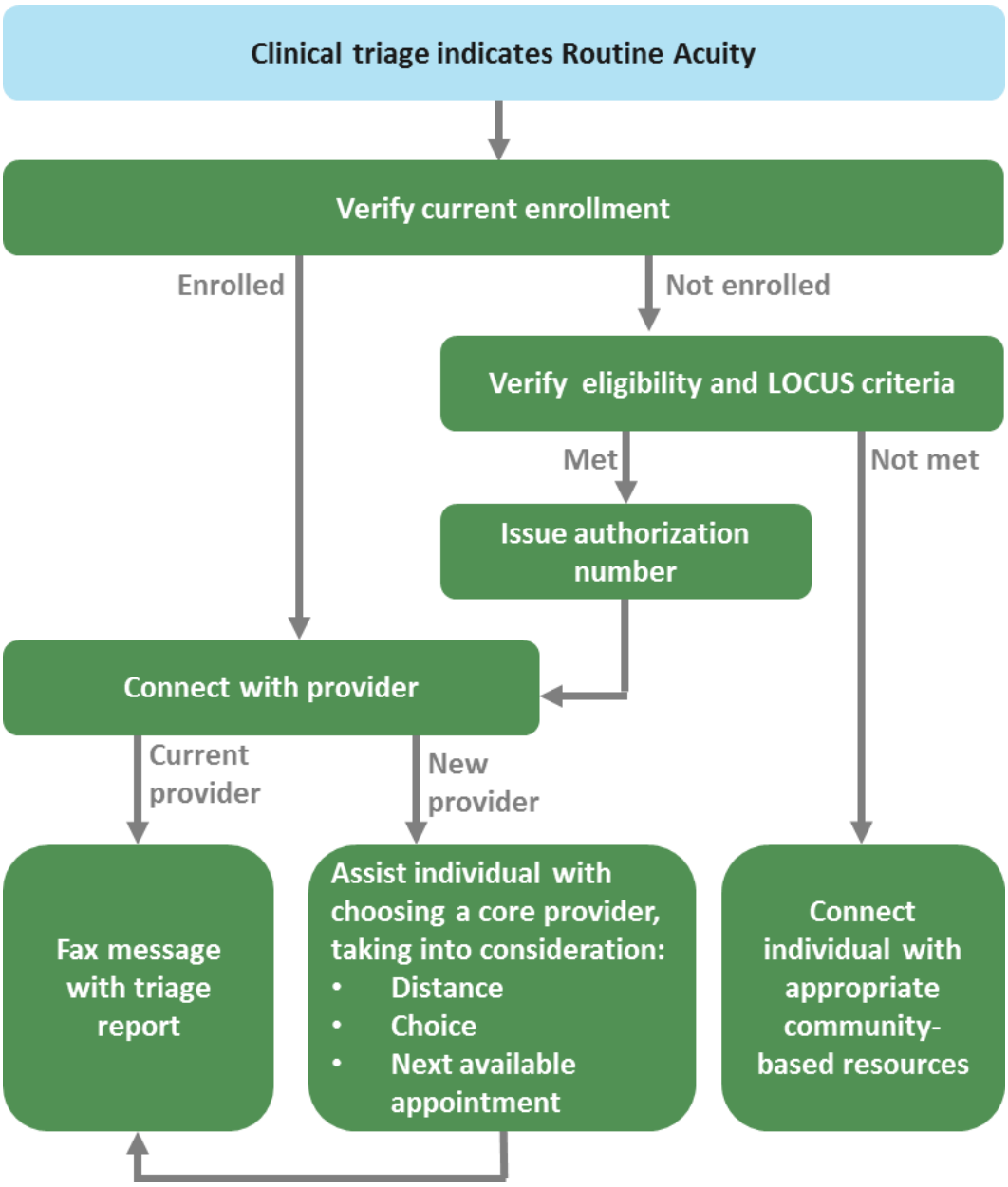
A. – Routine Calls

The functionality of the new ASO system, coupled with the ability to refer individuals who do not appear to meet criteria for State-funded services, Medicaid or non-DBHDD services, will result in more appropriate routine dispositions and be a welcome change for the provider community. ValueOptions will provide information to individuals about other available services and resources (e.g., homeless shelters, United Way, domestic violence programs, Alcoholics Anonymous).

If an individual is triaged and determined to have routine behavioral health needs, likely meets eligibility criteria and is not currently enrolled, we will offer a choice of provider when more than one provider is available based on location and preferences, and offer callers assistance via warm transfer to the provider of his or her choice during regular business hours. For routine IDD needs, we will provide warm transfer to the appropriate Regional Office during business hours. Authorizations and/or registrations for care will occur at point of presentation and available for the receiving provider.

For routine after hour needs, callers will be provided with contact information for scheduling appointments with the provider(s) of his or her choice. For routine IDD needs after hours, we will inform the appropriate Regional Office about the callers' needs within one business day of the request. A workflow for routine calls is provided on the following page.

Routine GCAL Call Workflow



B. – Urgent/Emergent Calls

ValueOptions will provide telephonic crisis intervention for individuals with urgent and emergent needs and make every effort to resolve the situation telephonically. If the crisis cannot be resolved telephonically, we will:

- Implement crisis interventions and provider referrals/authorization based on the individual's acuity and information contained in the client record (if applicable), including open authorizations and current providers
- Work with providers to develop mechanisms to connect the individual to the providers' on-call service, when appropriate
- Assign the individual to pre-determined urgent appointments offered by a subset of network providers while supported by our Certified Peer Specialist (CPS)
- If indicated, dispatch the appropriate first responders, such as mobile crisis, ACT, police and/or EMS, making every effort to choose the least intrusive intervention possible
- If indicated, we will authorize and refer individuals with urgent or emergent needs to CSUs, Behavioral Health Crisis Centers or inpatient facilities
- Callers needing inpatient services who are not accepted by either a CSU or a contracted inpatient facility will be referred to the most appropriate State-operated facility

Callers identified as needing intensive services will be reviewed by a GCAL clinical supervisor to confirm the most appropriate crisis service setting/modality has been made available. For those individuals referred and accepted into the CSUs and network inpatient psychiatric hospitals, an authorization number will be assigned and made available to the provider for billing purposes. We provide a workflow for urgent/emergent GCAL calls on the following page.

Follow-up and Engagement with a Certified Peer Specialist (CPS)

Using the unique skills of CPS, we will provide telephone support to callers to the crisis response line, including follow-up calls to those callers who do not require a mobile crisis response to ensure the caller is stabilized and the appropriate linkage is provided. Continuous care following a crisis is an essential component of the **"High Assurance"** model.

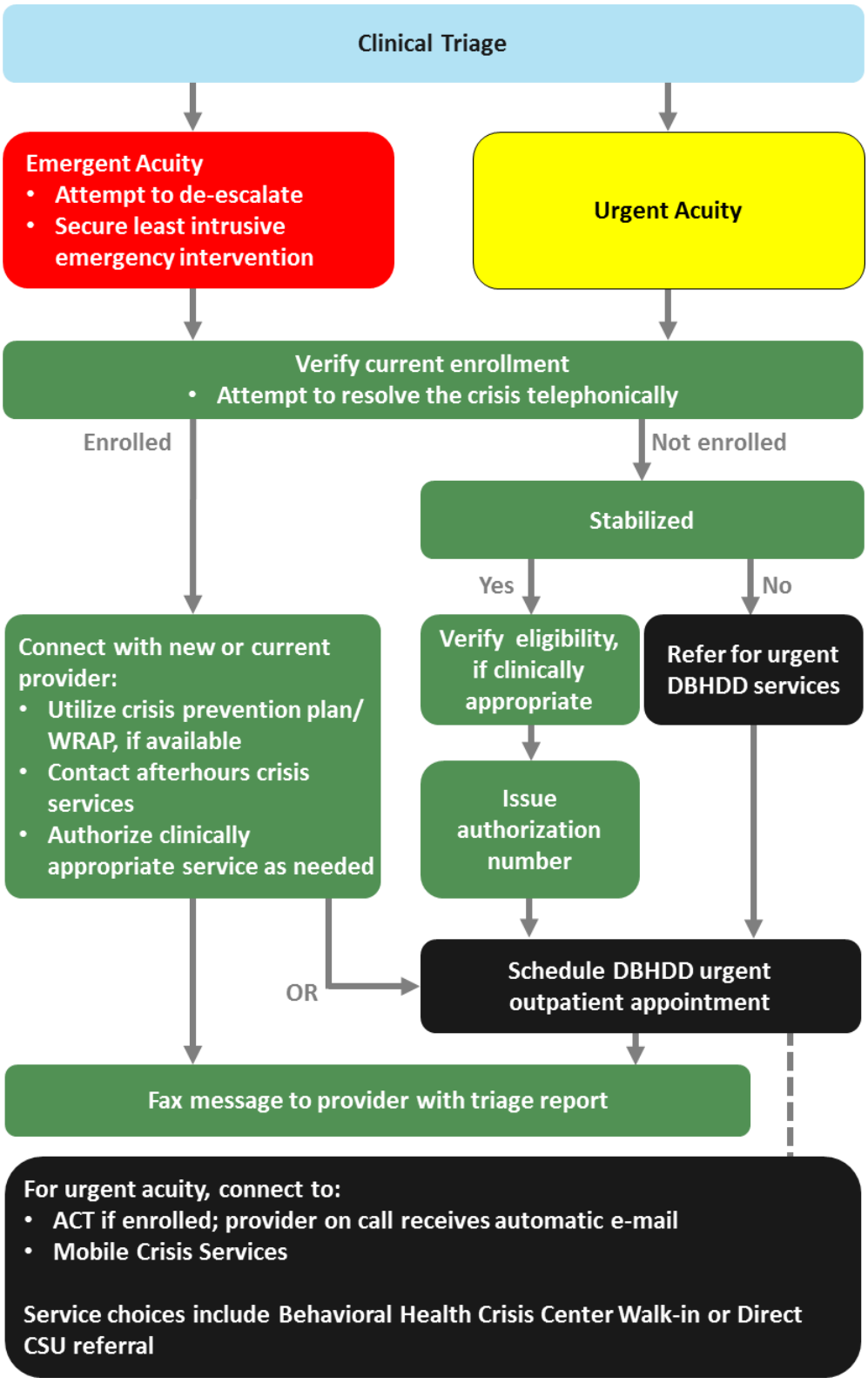
C. – Mobile Crisis Dispatch and Single Point of Entry (SPOE) Processes

As ValueOptions' key partner, BHL will continue to operate GCAL as the Single Point of Entry for mobile crisis services for behavioral health and IDD. In collaboration with Benchmark Human Services over the last year, we will continue to dispatch statewide mobile crisis.

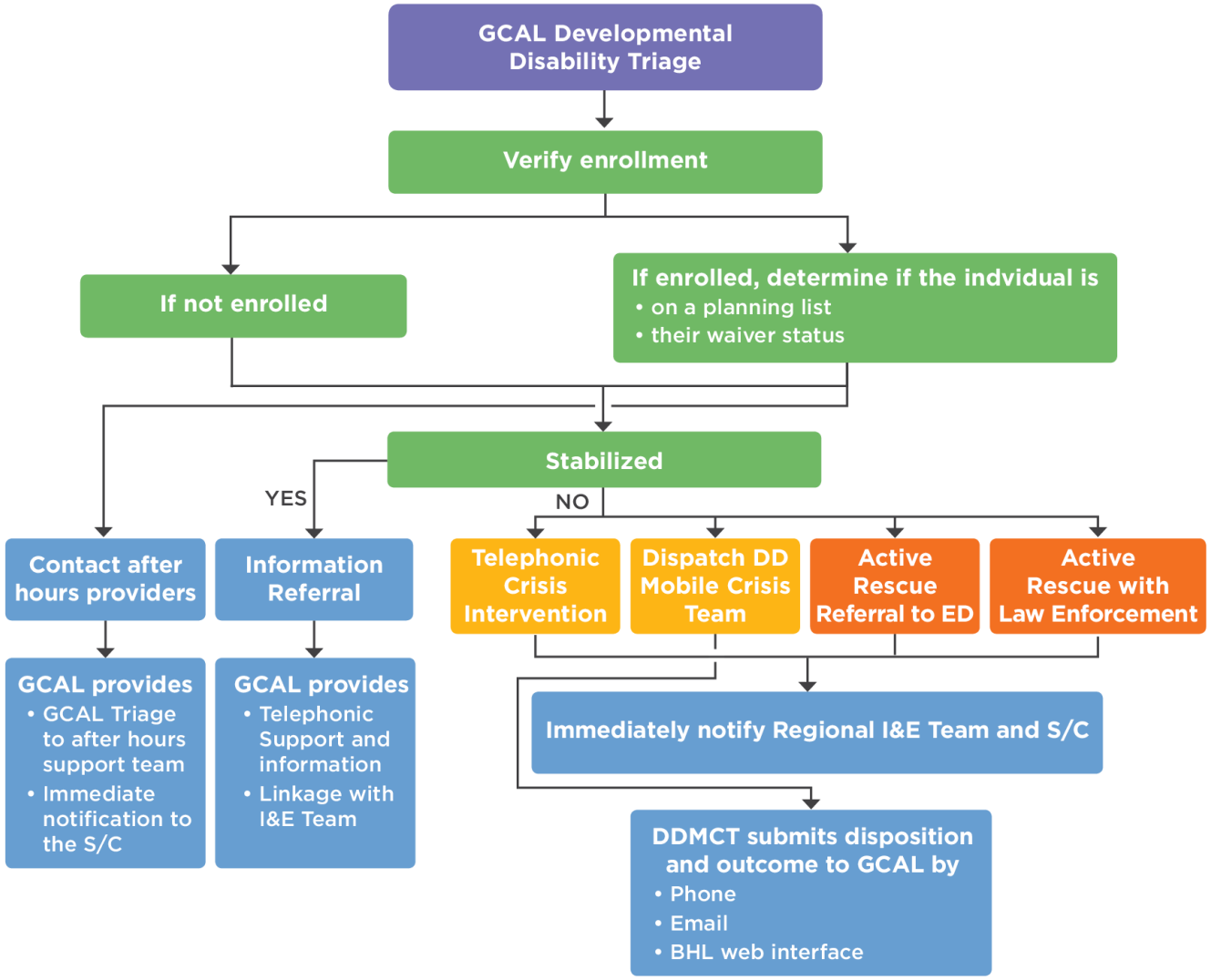
We have continued to improve managing the dispatch process for IDD and mental health mobile crisis by refining our tools over the last year. We have standardized as much of the dispatch process as possible and maintained a philosophy and practice designed to ensure the safety of the individuals we serve and their families and providers. Workflow diagrams and guidelines for mobile crisis dispatch are provided on **pages 110** through **113**.

In addition, BHL will continue to operate GCAL as the preferred SPOE for state hospitals, CSUs in SPOE-designated regions, and for DBHDD-contracted inpatient psychiatric facilities for the uninsured. We propose that this process be used across the entire state, to include all state hospitals. Workflow diagrams for SPOE processes are provided on **pages 114** and **115**.

Urgent/Emergent GCAL Call Workflow



IDD Single Point of Entry Triage/Referral Linkage



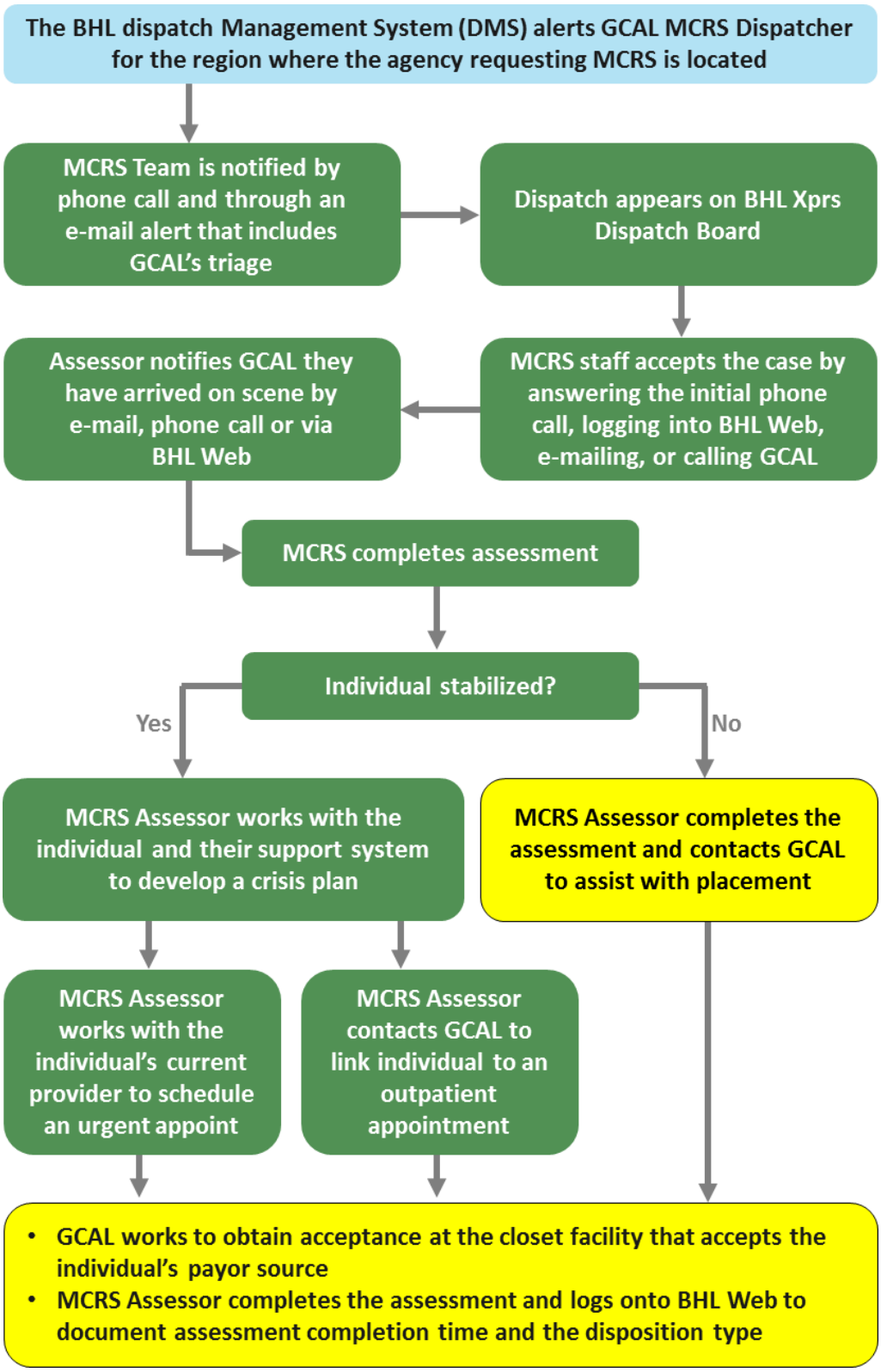
Behavioral Health Mobile Crisis Dispatch Guidelines

Assessment	Criteria
Meets Criteria for Dispatch	• Individuals ages five and up with urgent or emergent acuity with LOCUS levels 4 to 6 in a behavioral health crisis or in a situation likely to turn into a behavioral health crisis if supportive services are not provided • When mobile crisis is requested by or on behalf of any individual who appears to be part of population covered by the ADA Settlement Agreement. Individuals with Severe and Persistent Mental Illness (SPMI) who are: ○ Frequently readmitted to inpatient psychiatric facilities ○ Frequently seen in emergency rooms ○ Chronically homeless ○ Being released from jails or prisons ○ Individuals with IDD and co-occurring mental illness at risk of hospitalization in an inpatient psychiatric facility ○ Specific requests for MCRS dispatch directly from DBHDD or DBHDD Regional Offices
Requests to be staffed with a Supervisor prior to dispatch	• Requests from emergency departments covered by a private mobile team or a request from an emergency department that has not previously requested mobile crisis response • Emergency department request for mobile crisis when an urgent outpatient appointment is appropriate and available within established acuity guideline timeframes • Law enforcement or judicial (Probate) requests for mobile crisis response for individuals with LOCUS scores of 3 or less or routine acuity • Requests from child welfare agencies (DFCS) or children' shelters for individuals with LOCUS scores of 3 or less or routine acuity
Does Not Meet Criteria	• Routine cases in which an intake and evaluation within five business days with a DBHDD core provider is appropriate • Requests for individuals **in emergency departments or inpatient medical facilities who** are not medically cleared or for individuals with exclusionary criteria for admission to a CSU and/or state hospital (e.g., presenting symptoms are due to a Traumatic Brain Injury). Individuals with a mental illness prior to suffering a brain injury may be eligible for mental health services. **Mobile crisis can respond for crisis intervention in these cases if it is needed; however, the hospital must understand that the MCRS staff cannot refer the individual to a State facility if the individual has exclusionary medical criteria for admission to those facilities** • Requests for individuals with Severe and Profound Intellectual Disability or individuals with IDD whose presenting crisis is "behavioral" in nature. • Individuals with the following conditions are excluded from MCRS unless there is an identified mental illness that is the foremost consideration for this psychiatric intervention: ○ Mild mental retardation ○ Moderate mental retardation: (In the case of a crisis, refer to IDD MCRS Dispatch Guidelines) ○ Autistic Disorder

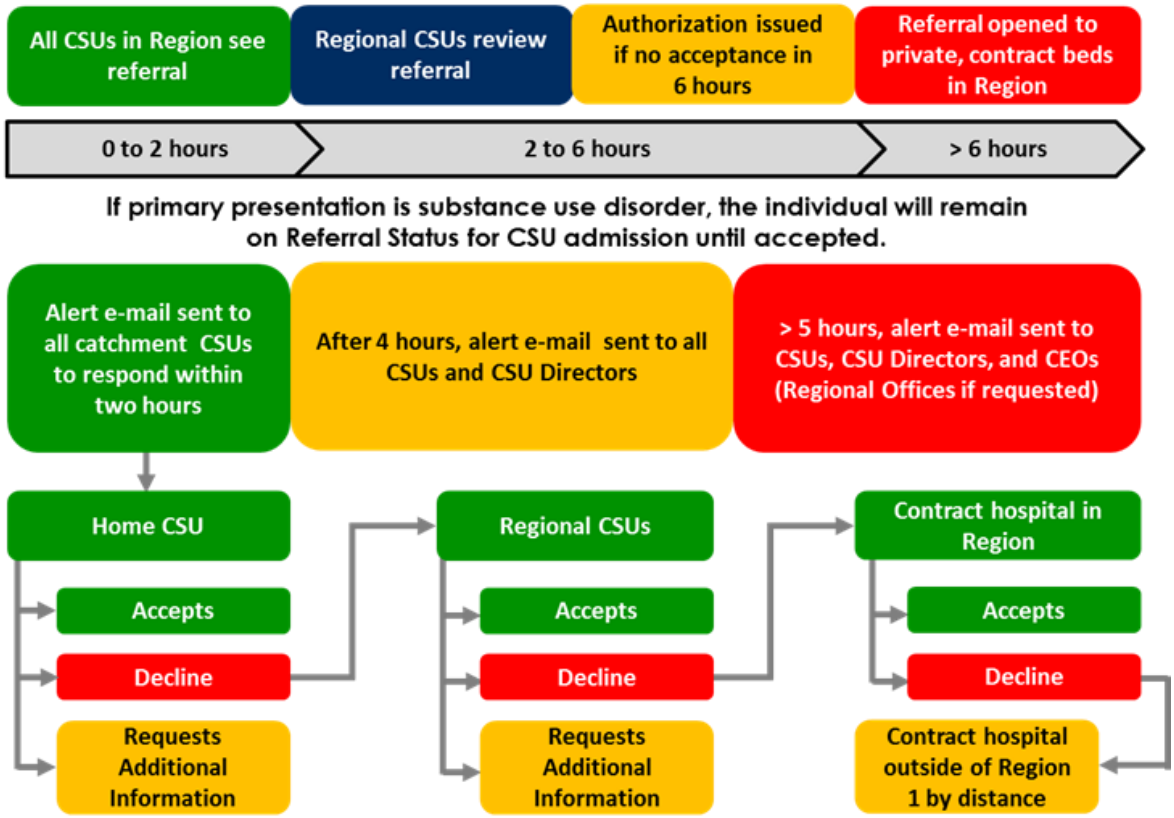
GCAL Mobile Crisis Dispatch Levels

Level	MCRS Involvement	Criteria
Level 1	**Law Enforcement Leads** (Mobile Crisis Team accompanying or following behind) The team must head police instructions and respond as the scene is deemed safe for entry.	The level indicates situations that are too dangerous to deploy without the environment first being secured by law enforcement. It is also key in these situations to have a response within the shortest time possible. GCAL initiates rescue protocol and does not dispatch the Mobile Crisis Team as sole responder if the caller is in imminent danger to self and/or others as evidenced by any of the following: • "Likely" or "Very Likely" intent for suicide attempt (more than desire/ideations and capability alone) • "Likely" or "Very Likely" intent for homicide attempt • Threat to staff • Possession of weapon
Level 2	**Mobile Crisis Team Leads** (Law enforcement in the background or following behind but on the scene)	Caller reports any of one of the following: • History of aggression • Recent acts of aggression • Self-injury The level indicates situations where our staff enters in to the environment first but law enforcement is immediately available if needed.
Level 3	**Mobile Crisis Team Lifeline** (Law enforcement on standby by phone)	All "emergent" cases and certain "urgent" cases (where clinical judgment suggests that a call to apprise law enforcement of this situation is prudent)
Level 4	**Mobile Crisis Team Alone** (No law enforcement)	"Urgent" cases in which the absence of clinical intervention suggests the advancement to greater risk or other cases where children or adolescents are being referred to the State hospital or LOC.
Level 5	**Secure Location** (Hospital, Jail, Social Service Agency, etc.)	These cases are in a safe location so a clinician may respond alone without a Field Care Consultant. Calls to residences (apartments, homes, etc.) are not "safe sites." With supervisory permission, a Clinician may be sent alone if another mental health or social services professional is already on site (i.e., DFCS, CSB employee).

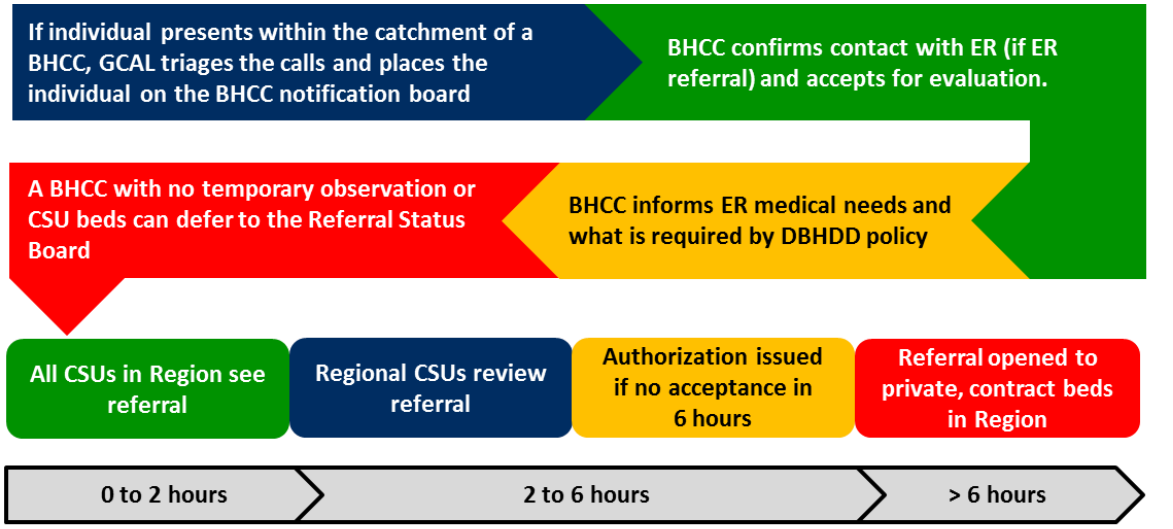
GCAL Mobile Crisis Response Dispatch Process Workflow



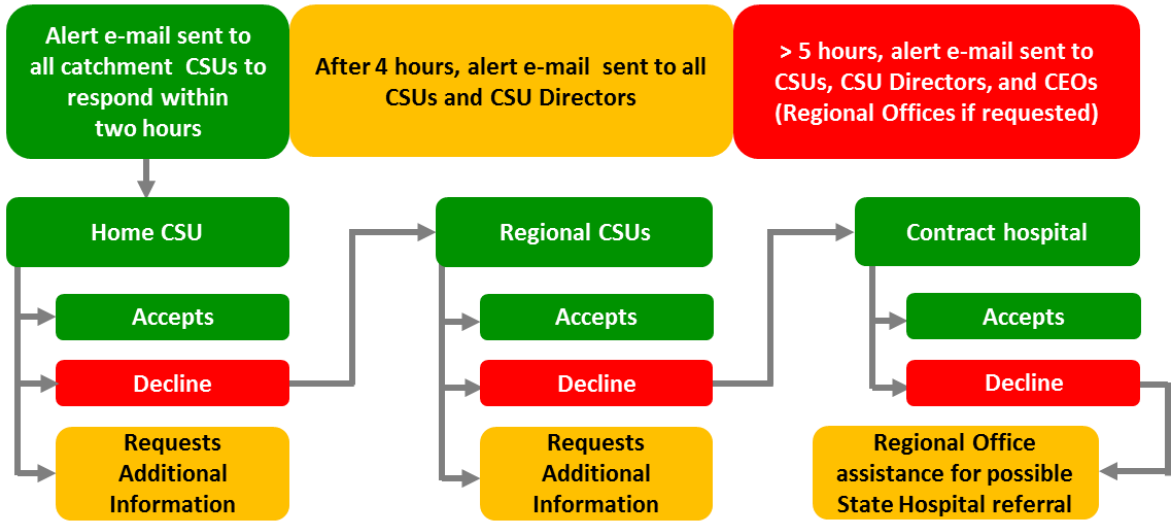
Single Point of Entry Workflow Diagrams for Region One



Single Point of Entry Workflow Diagrams for Regions Four and Six



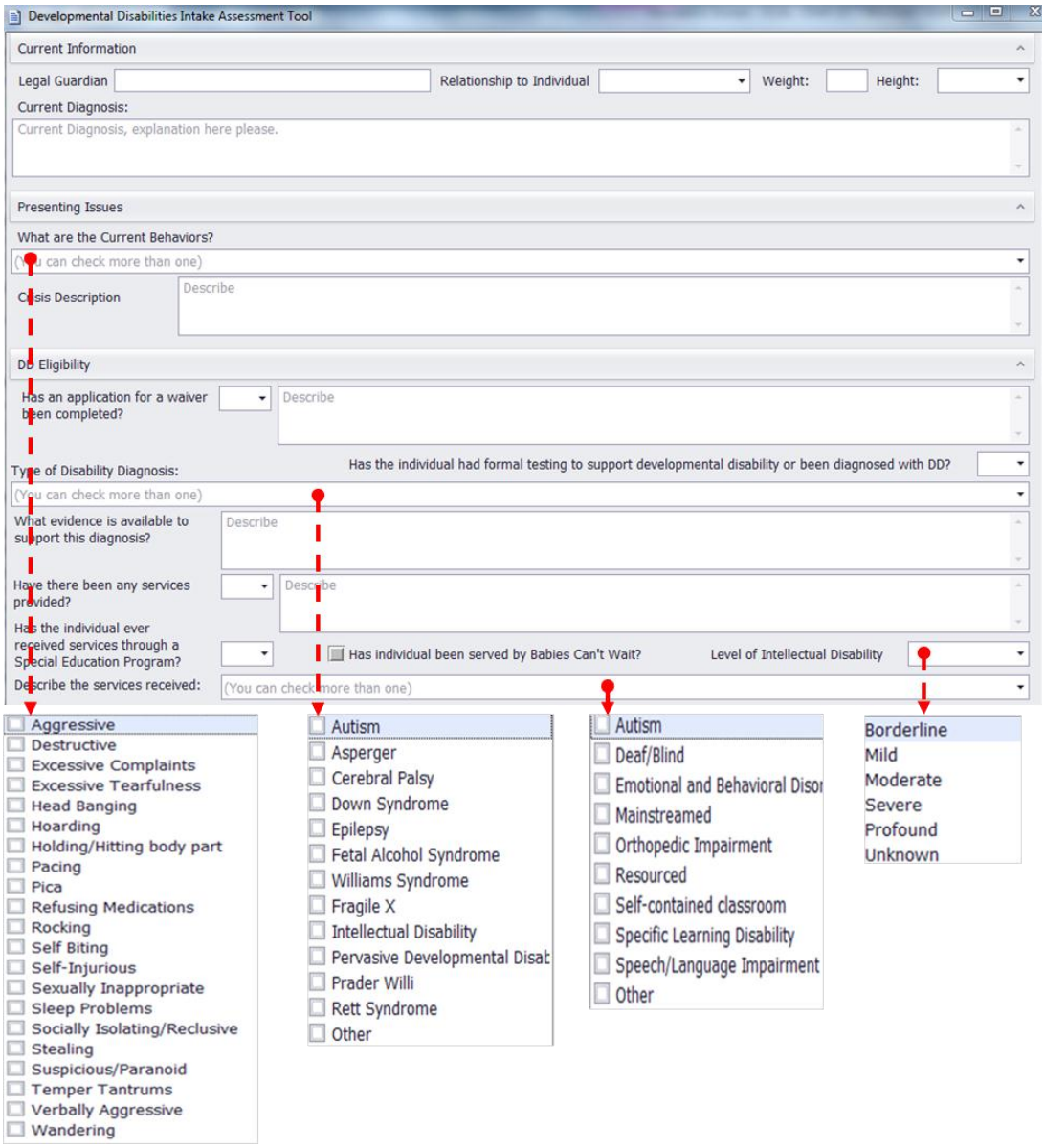
If primary presentation is substance use disorder, the individual will remain on Referral Status for CSU admission until accepted.

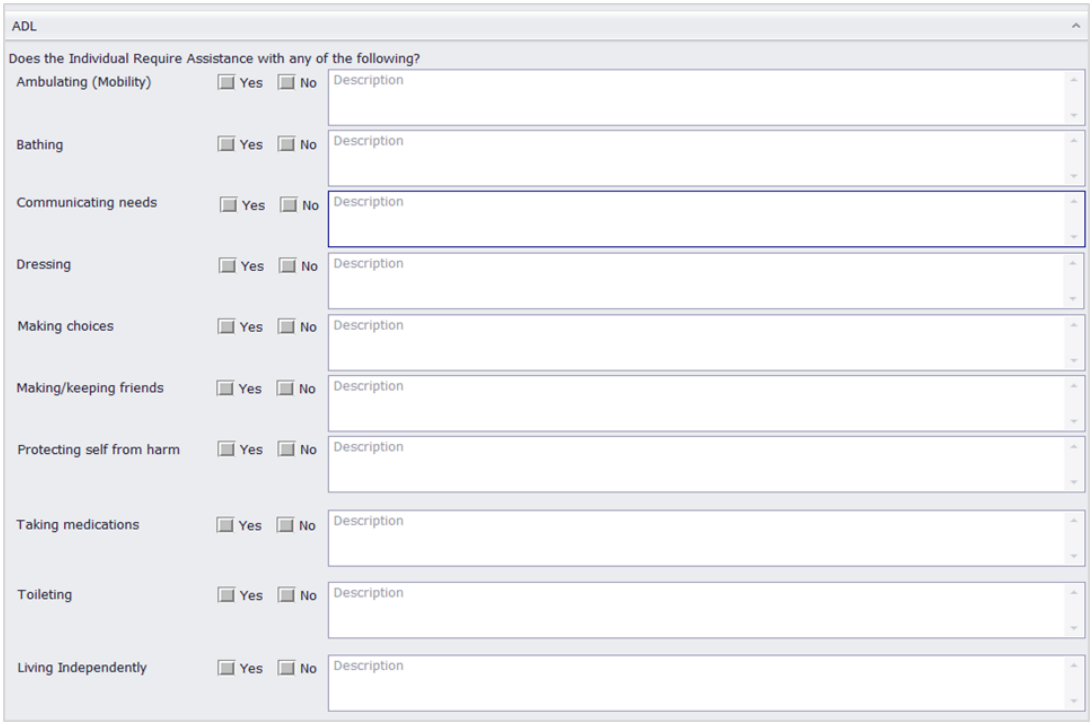


ATTACHMENT C.6

C.6 In Attachment C.6, **(limit four (4) pages)**, describe and provide a proposed triage tool specific to dispatch of IDD Mobile Crisis Services.

The IDD screening tool, pictured below and on the following page, is a result of several years of work between BHL and DBHDD. This is the most current version but can be amended at any time in response to the needs of DBHDD and other stakeholders. This tool was not only designed to capture details about the current crisis but also to describe specifics on functional capacity. This information is critical when linking individuals with IDD, particularly those with co-occurring behavioral health diagnoses, to appropriate crisis and stabilization services.





Having detailed information on functional status assists us in removing inappropriate barriers to care when individuals with IDD, specifically those with mild to moderate levels IDD, are denied clinically appropriate behavioral health services simply due to IDD status. The detail is also vital when we are working to prevent unnecessary psychiatric hospitalization of individuals with moderate to severe IDD when they may carry a behavioral health diagnosis, but the individual is not clinically appropriate for psychiatric hospitalization. Using the acuity guidelines below, our clinicians will use the information to advocate for the most appropriate crisis service to meet their unique needs.

ACUITY GUIDELINES FOR IDD

Developmental Disabilities Acuity Guidelines		
Acuity	**Intensity (One or more of the following is present)**	**Appropriate Linkage**
EMERGENT • **Mobile crisis team referral/ e-mail** • **I&E referral/ e-mail** **(possibly both)**	A life threatening condition exists as caller presents: • Imminent risk of harm to self (current severe self-injurious behaviors) or others (e.g., choking someone) due to crisis behaviors • Immediate risk due to medical problems or injury • Suicidal/homicidal intent • Disorganized thinking or reporting hallucinations which may result in harm to self/others (i.e. command in nature)	**For an Emergency Crisis**: • Call 911/Police • If law enforcement is on the scene, ask if they want the assistance of IDD mobile crisis team

Developmental Disabilities Acuity Guidelines		
Acuity	**Intensity (One or more of the following is present)**	**Appropriate Linkage**
URGENT **Determine if:** • **Mobile crisis team referral/ e-mail** • **I&E referral/ e-mail** **(possibly both)**	• Presence of self-injurious behaviors that are not severe enough to require medical attention at this time (e.g., banging head, biting self, pulling hair) • Presence of potentially dangerous behaviors toward others (e.g., throwing things, hitting, kicking) • History of self-injury/attempts or physical aggression • Potential to progress to need for emergent services if behaviors continue to escalate • May express distress/impairments that compromise functioning, judgment and/or impulse control • No suicidal/homicidal intent, plan or means **Snapshot for Telephonic Resolution:** • Assist caller to utilize interventions and supports from behavior support plan, ISP or individual's crisis plan • Provide continuous telephonic support • Develop follow-up plan if the behavioral health crisis escalates	**For Severe Situations:** • Dispatch IDD mobile crisis team if severity of crisis prevents telephonic resolution • If individual is in the emergency room, assist with mobile crisis team dispatch and/or placement
ROUTINE • **Telephonically** • **Resolution Notification via e-mail**	• Caller acknowledges some distress/ concerns • No evidence of danger of harm to self/ others • No marked impairments in judgment or impulse control • **IF NOT IN CONNECTS:** Let the caller know that in order to determine eligibility for IDD services an individual must be evaluated through an intake and evaluation team that serves the area that the individual lives • **IF IN CONNECTS:** Redirect the caller back to their provider or Support Coordinator	• **IF NOT IN CONNECTS:** If they meet IDD eligibility, refer to I&E team in their region • **IF IN CONNECTS:** Redirect the caller back to their provider or Support Coordinator
Warm-Line (Support Only) • **Telephonic** • **Resolution e-mail**	• Caller is already linked with community services and does not have urgent or emergent needs • Caller may need additional supports for individual and/or resources for items (e.g., equipment)	• Provide support • Offer appropriate referral or resource (Regional Office) • Encourage to contact Support Coordinator
Information Only • **Telephonic** • **Resolution e-mail**	• Request for basic information (e.g., how to get in contact with the Regional office etc.)	• Provide requested information

ATTACHMENT C.7

C.7 In Attachment C.7, **(limit two (2) pages)**, provide a detailed targeted GCAL marketing plan, with timelines, that meets the requirements of Section 6.

GCAL TARGETED MARKETING PLAN

ValueOptions will develop and implement an annual targeted marketing plan that educates and informs community stakeholders such as citizens, health care providers, law enforcement personnel, the legal community (e.g., judges and lawyers), and human service organizations, about GCAL and its services.

Listening to Stakeholders

Having been members of the DBHDD Crisis Steering Committee issuing recommendations for the behavioral health crisis services continuum in July 2013, our partner, BHL, is intimately aware that one message sent clearly by stakeholders is that GCAL and its services cannot be over publicized. The table below comes directly from the Committee's report and will serve as the foundation of the initial targeted marketing plan.

Reduce public reliance on 911/EMS/ER/Law Enforcement for behavioral health intervention shifting to an easily accessible crisis response system

- Educate public on GCAL
  - Interface with Georgia Hospital Association; EMS/ER/Law Enforcement to provide GCAL cards to individuals they serve
- Using Poison Control Protocol as an example develop an agreement between 911 and GCAL
  - Research protocols; develop protocol; meetings with 911 and GCAL vendor

Improve marketing and individual/family and community education regarding crisis and crisis services

- Improve marketing of GCAL
  - Have information available where people are , such as: fast food restaurants, grocery stores, etc.

Marketing Materials and Methods

As it has been a very successful tool, BHL will continue to use the wallet card as one of the primary marketing materials; however, it will also be translated into Spanish as will all other marketing materials. All proposed materials for providers, individuals, law enforcement, schools, and other partner agencies will contain the GCAL phone number and will first be submitted to DBHDD for approval. We will publicize the single, toll-free crisis and access number throughout Georgia and include it prominently on our website, recipient and individual materials, provider resource directory, and as a listing in telephone books.

Deaf and Hard of Hearing Population

ValueOptions' crisis services are trauma informed and sensitive to the needs of the Deaf and individuals who are hard of hearing. These individuals historically experience a disproportionate number of incidences involving trauma. We will ensure that the Deaf and individuals who are hard of hearing are not re-traumatized when reaching out for help in the event of a crisis. We will continue to build upon the strong relationship already developed with DBHDD Office of Deaf Services and are committed to helping them fulfill their mission to provide the Deaf, individuals who are hard of hearing and those that are deaf-blind access to behavioral health and IDD services. We will work closely with the Office of Deaf Services to develop effective marketing tools and accessibility measures to ensure that GCAL services remain accessible and that more individuals in the deaf community are aware of GCAL services. In addition to the strong relationship with Georgia Relay, we are exploring the use of videophone and video relay/ telemedicine technologies as the prevalence of interpreters with behavioral health training improves.

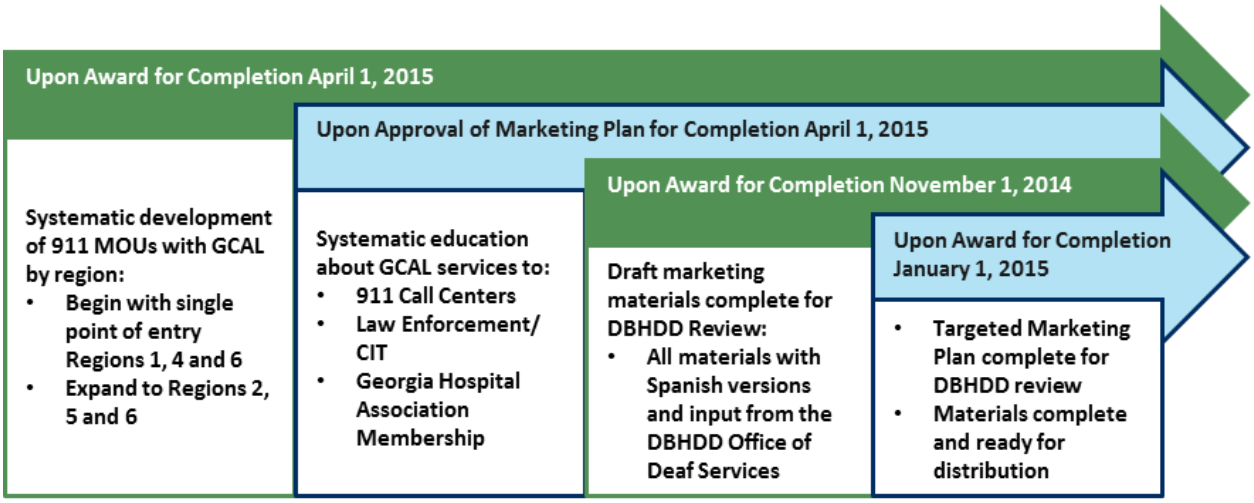
Limited English Proficiency

We use the Language Line when trained professionals proficient in the appropriate language are unavailable. We will publicize GCAL services and facilitate enhanced awareness of the existence of the crisis and access line for all stakeholders, including those whose primary language is Spanish. As previously mentioned, all GCAL marketing materials will be developed and distributed in English and Spanish.

Underserved Populations

We have worked closely with DBHDD Regional Office staff to ensure that rural and otherwise underserved populations in Georgia who may not have adequate exposure to mainstream advertising/marketing mediums receive information about GCAL. For example, BHL recently worked with a rural utility department to send GCAL cards with utility bills in an area with a particularly high suicide rate.

GCAL MARKETING TIMELINE



ATTACHMENT C.8

C.8 In Attachment C.8, **(limit two (2) pages)**, describe strategies and protocols to address operations and increased call volume to the GCAL line due to unexpected events such as natural or man-made disasters while ensuring that the operations are maintained and adhering to call center performance metrics.

We will ensure that back-up coverage is available to maintain contracted performance standards.

Every effort is made to provide all GCAL services in Georgia with Georgia-based staff, even in the event of a natural or man-made disaster. GCAL Associates continuously use instant messaging and a HIPAA-compliant Web conferencing system to conduct face-to-face staffing of cases and clinical supervision. In addition, secure, HIPAA-complaint Web cameras in our Atlanta and Cordele Engagement Centers enable monitoring of all Engagement Center staff from either location.

When an unexpected event arises, we employ incremental capacity in Cordele, progressing to work from home capacity using ProtoCall, and then using ProtoCall's three national Engagement Centers if the disaster is widespread. This process ensures that operations are continuous and allows us to manage increased call volume in the event of a disaster. ProtoCall has a highly specialized approach to serving more than 200 contracts, many of them for after hours or back-up coverage of crisis lines and provider lines. In the event of a widespread disaster, Web conferencing and other technology mentioned above are used with ProtoCall's staff in Michigan, Oregon and New Mexico.

As part of our disaster recovery plan, ProtoCall staff members located in other states will receive sufficient training regarding GCAL policies and procedures. We assure DBHDD that GCAL callers will be seamlessly and transparently engaged with a ProtoCall call agent with no degradation in service delivery and quality regardless of the disaster recovery situation.

We will ensure all that call agents providing back-up services will:

- Comply with all laws that govern professional practices for the state in which agents are answering calls
- Meet experience and professional requirements comparable to Georgia's licensing laws
- Successfully complete employee training that ensures adequate knowledge of Georgia's behavioral health and IDD service delivery system and other community resources

In the table on the following page, we provide our protocols for threat scenarios that may affect GCAL services.

Threat	Scenario and Protocols
Phone System Failure	**Engagement Center Accessible and Local Staff Available**
	• Primary phone system is housed at ProtoCall's Central Site connected to BHL Engagement Center through MPLS connection • If MPLS connection is lost, calls continue to route to BHL's Survivable Remote Gateway through "Divert on Failure" to BHL's LD circuits allowing BHL agents to continue to take calls • BHL uses two LD Circuits and one Local Circuit for voice services • LD Circuits are programmed to failover to each other if one circuit goes down • In the event of a spike in calls or if the Survivable Remote Gateway goes down, a blended mix of ProtoCall and BHL VPN agents will take calls until MPLS circuits are back online
Engagement Center Inaccessible	**Servers and Phones Operable and Local Staff Available**
	• If there is no access to the local server room, building, etc., then VPN and Web portal will allow agents access to the BHL Engagement and Data Center from any location with Web access • Engagement Center and Private Cloud are accessible via VPN, Web portal and VOIP softphones • If MPLS connection is active, ProtoCall's Engagement Centers and secondary in-state centers will provide overflow in the event of a disaster recovery situation to main office. No loss of calls in this situation.
Engagement Center Inaccessible; Server and Phones Down	**Local Staff Available**
	• ProtoCall's Engagement Center agents trained to handle GCAL calls will access the BHL Call Group taking calls and BHL agents will be able to take calls through VPN phones and softphones • BHL and ProtoCall agents will use VPN or Web portal through BHL's Private Cloud and/or (DRaaS) center to work remotely
Engagement Center Inaccessible; Server and Phones Down	**Local Staff Available but Out-of-State Support Needed**
	• If total disaster recovery situation is in effect due to no access to building, Remote Survivable Gateway is down, and MPLS circuits are down, then calls will be re-routed to ProtoCall's back-up Engagement Centers where non-Georgia agents will take calls from their Engagement Center while Georgia agents will be able to connect via VPN. A mixture of out-of-state and local agents will take calls during an emergency or unusual spike in call volume until sufficient in-state agents are active.
Engagement Center Inaccessible; Server and Phones Down; Georgia Staff Unavailable	**Local Staff Not Available/Total Reliance on Out-of-State Agents**
	• ProtoCall's Engagement Center staff will take calls from ProtoCall's main Call Center and BHL's work from home agents and secondary Georgia location will take calls via VPN and softphones. • ProtoCall's Engagement Center staff are accustomed to answering calls for more than 200 different clients across the U.S., each with different protocols for every contract. During this time, BHL agents will log in via the Internet through VPN into ProtoCall's system to a standby GCAL call group. • In the event of a last resort disaster recovery situation where multiple points of failure between BHL and ProtoCall Services occur, BHL has a standby third party VOIP service "Virtual PBX" dedicated GCAL call group and 25 agents available. Calls will be delivered via Web softphone to any device such as a laptop, tablet and smartphone at any location. Secondary Georgia office, designated temporary office and work from home agents can be activated for this service • Data services will be accessed via VPN and Web portal at BHL's Private Cloud and or (DRaaS) center

ATTACHMENT C.9

C.9 In Attachment C.9, **(limit two (2) pages)**, describe how the Offeror's proposed GCAL processes will prevent unnecessary institutionalization/ hospitalization of individuals, limit emergency room use, and otherwise promote crisis stabilization and community integration.

Fostering recovery through choice and the use of the least restrictive level of care has been fundamental to GCAL operations since the program was launched in 2006. GCAL staff have worked diligently to make sure that individuals are safely under the care of caregivers before letting go of responsibility. However, under the current structure, our partner, BHL, has been "flying blind" in some ways, not knowing with certainty where individuals are enrolled and often unable to engage their direct caregivers/providers, in their time of crisis.

AT THE POINT OF CRISIS

With the close integration of GCAL and ASO services, GCAL will be able to act as a true SPOE for High Intensity Mobile Crisis, CSU, and Hospital Services. We will:

- Work closely with all emergency rooms to facilitate transition/discharge to either a hospital/CSU bed or by making an urgent appointment with a community provider
- Track urgent community appointment capacity and presentation rates of the individual served
- Track provider engagement rates of referrals of hospital/CSU discharges and urgent appointments
- Coordinate care with ACT and ICM teams by either making referrals or engaging the team when their member is in crisis
- Use enrollment information and last time served (perhaps even info on next appointment) to inform decisions and carry out short-term crisis plans
- Use crisis plans and psychiatric advanced directives in an individuals' electronic health record to help carry out the wishes of individuals and help keep them on their personal recovery path
- Involve an individual's provider in crisis care; a process that is rarely possible in the current system with disconnected information
- Use medical and treatment history information generated from Medicaid claims state encounters to inform the referral process
- Track state hospital referrals just as CSU referrals are tracked in SPOE regions giving CSUs access to view individuals waiting for state hospital care and the ability to accept these referrals when their beds open to avoid unnecessary admissions and long waits

WHEN THE IMMEDIATE CRISIS IS OVER

Using the excellent follow-up and engagement experience BHL gained from participation in the SAMSHA follow-up grant, as described on the following page, our clinicians will follow up with individuals with urgent needs where mobile crisis services were not engaged. We will also use regional teams that include CPS staff to follow up with, motivate and engage individuals in care.

SAMSHA Follow-Up Grant (2008-2011)

In the first federally funded program of its kind, SAMSHA awarded BHL, one of six crisis centers throughout the country, a three year grant in 2009 to participate in a large scale study investigating the efficacy of clinical, telephonic follow up following crisis calls to the National Suicide Prevention Lifeline. Funded by this grant, BHL staff enrolled nearly 1,500 individuals in a sustained follow-up service, contributing greatly to research being conducted at Columbia University. With this study completed, researchers are compiling results for publication. Preliminary results indicate that follow-up, particularly in the first weeks after the crisis, results in better adherence to aftercare and in the individual's subjective feelings of safety and being cared for.

We will use structured protocols and decision trees as always, but essential to GCAL's approach is core recovery beliefs and principles. At the heart of these core beliefs and principles is a strong desire to:

- Prevent unnecessary institutionalization/hospitalization of individuals
- Limit emergency room use and unnecessary law enforcement intervention
- Promote crisis stabilization and community integration
- Track aftercare appointments scheduled and attended to inform intensive follow-up for individuals at high risk

GCAL provides care based on the following core beliefs and principles:

- **Hope** is the first pathway to recovery and independence.
- **Choice** is the second pathway to recovery. Believing that each individual is the expert in what will work for them and will be a full partner in pursuing their hopes and dreams.
- **Peer Specialists** are a powerful tool for communicating the message of hope and choice. Through personal experience, they are able to engage people who have not been willing to accept services and supports.
- **Person-centered planning** will be used to achieve maximum healthfulness. Recovery is a lifelong process and, therefore, relapse should not be perceived as a "failure" but rather an "opportunity" to learn and grow.
- **Active engagement used to resolve the crisis as close to the home as possible**. Since the level of the crisis often expands to match the intensity of the setting, home-based interventions help reduce the severity and length of the crisis.
- **A philosophy of no-force first** in all services that offer individuals a range of choices before their behavior escalates to a level where coercion and involuntary intervention is required.
- **Inpatient psychiatric hospital care is not central to recovery.** Hospitalization will only be used as the last option. Rigorous relationship-based and peer support efforts to engage each person in voluntary, flexible, choice-based alternatives will reduce the use of hospitalization.
- **Collaboration with the community** emergency response system (e.g., police, fire, emergency rooms) will support rapid transfer of responsibility to DBHDD crisis services.
- **Continuity of care** will be maximized by minimal changes in providers. The services will support ongoing involvement of the same provider despite the treatment site.

ATTACHMENT C.10

C.10 In Attachment C.10, **(limit three (3) pages)**, describe how the Offeror will utilize information from the Offeror's information system to inform and manage crisis and access line call center(s) operations and improve outcomes.

BUILDING EFFICIENCIES AND COHESION INTO A FRAGMENTED SYSTEM

As a partner in the ASO, BHL will have direct access to ValueOptions' full management information system, CONNECTS (described in greater detail in our response to *Section K*), to inform and manage crisis and access line Engagement Center operations and improve outcomes. **This direct level of integration between GCAL services and CONNECTS will provide efficiencies within the behavioral health and IDD crisis operations system that has never existed.**

Imagine a day when an individual walks in to an emergency room and GCAL immediately notifies his or her ACT case manager or the ACT case manager on call via text/e-mail that an individual under their charge is in the emergency room needing assistance or has called the Crisis and Access Line. ***Better yet***, imagine a day when that same individual has such a cohesive and efficient provider and crisis service system that he or she never walks into the emergency room in the first place because he or she contacts the Crisis and Access Line and GCAL is immediately in communication with his or her on-call ACT worker who responds directly to his or her home.

The Crisis Steering Committee convened by DBHDD in 2012 and finishing with recommendations in July of 2013 had this very vision and recommendation in hopes of communicating the need to integrate the crisis and provider systems in a meaningful way to improve outcomes for individuals and families in crisis.

With the ASO and GCAL data fully integrated, individuals will have a better-informed crisis system that can **truly serve as a safety net**. While BHL has worked diligently to become experts in the crisis arena, the addition of basic demographic or treatment-related information to their cadre of tools will allow efficiency and cohesion that have not been experienced before and will result in very positive outcomes for individuals in crisis. For example, with this new integrated system, crisis staff will now be able to access:

- Life-saving medical information about current medications, drug allergies and medical conditions
- Lab work or medical information that will prevent unnecessary trips to emergency departments for medical clearance. Providers, crisis stabilization units and behavioral health crisis centers will have up-to-date information before accepting an individual.
- Known addresses to quickly locate individuals in crisis. Today, GCAL crisis line responders must rely on self-reported locations or old GCAL records. This labor intensive process

wastes precious seconds and community resources to locate an individual in imminent suicide crisis.

- Crisis Prevention Plans. With this vital knowledge in hand, we will be better able to work to telephonically to resolve crises if possible. Knowledge about the individual's wishes during a crisis will help inform care that is truly centered on the strengths, needs, abilities and preferences of the individual.

A Cohesive System that Fosters Self-Advocacy, Recovery and Continuity of Care

Leveraging the technology already built within the GCAL operation, the addition of enrollment information will allow for immediate notification to an individual's provider when that individual interfaces with GCAL. Using the referral status/pending board system and appropriate consent of the individual, the combination of technology and information will allow GCAL staff to connect an individual with a provider and send seamless/automatic notifications.

GCAL, mobile crisis teams and providers will be able to effectively collaborate to ensure individuals in services are cared for by the professionals and providers who know them best and those the individual wants most involved in their care. Family and natural supports will be brought in to assist while all parties work to ensure the record of care is continuous and ultimately available to all caregivers. In addition, with readily accessible enrollment and treatment information, GCAL would easily carry out Crisis Prevention Plans, WRAP plans and other psychiatric advanced directives.

Mitigating Suicide Risk

As reported in the 2011 Continuity of Care for Suicide Prevention and Research report, inpatient psychiatric hospitalization, while central to the country's mental health care system, is not effective in reducing suicidal acts after discharge. In fact, inpatient hospitalization has not shown to be a statistically significant intervention in and of itself to prevent suicide.

The report, commissioned by the Suicide Prevention Resource Center in collaboration with SAMHSA, identified GCAL as an "Exceptional Integrated System of Care" whereby individuals discharged from inpatient care are immediately linked to providers anywhere in the state for an appointment.

GCAL, operated by our partner, BHL, is one of seven crisis programs worldwide to have an "Exceptional Integrated System of Care" as reported in the 2011 Continuity of Care for Suicide Prevention and Research report.

By fully integrating GCAL and the ASO's information system under this new contract, we will be able to further enhance the effectiveness and the efficiency at which we link individuals with a provider. Our triage and assessment capacity links these high-risk individuals with the right provider at the right time to create Crisis Prevention Plans and WRAP plans, which will further mitigate future attempts and surround the individuals with their chosen support system.

Proactive Alerts of Individuals with High-Intensity Needs

With the connection of GCAL and ASO data, we will identify individuals who are frequent GCAL callers or frequent recipients of mobile crisis interventions. This will allow us to identify

individuals needing Intensive Care Coordination and will reduce unnecessary emergency room and law enforcement intervention.

Expansion to SPOE in All Regions and Addition of State Hospitals to the Electronic Pending Board

Mandating referrals to State-funded, high-intensity services will help the system track individuals at great risk and better ensure that they are firmly connected to ongoing care and services at the least restrictive level available. This information is not available currently if referrals to State-funded hospitals and CSUs bypass GCAL. This leaves large gaps in treatment history that could easily be closed. Live bed availability tied to acceptances and denials will be important performance measures for crisis stabilization providers. State hospital admissions in regions where sufficient space is available at CSUs or private contracted hospitals will be scrutinized to ensure appropriate utilization of the state hospital as a true last resort.

Automatic Referrals to Local Peer Specialists Tasked with Engagement

After being authorized for care by GCAL, individuals in need of routine or urgent outpatient services will receive automatic referrals to regional Certified Peer Specialists to ensure that follow-up is scheduled. Certified Peer Specialists will begin the engagement process and follow the individual until they are under the care of an ongoing provider. Attendance at aftercare appointments will be tracked and issue automatic follow-up alerts for individuals at high risk who do not attend their aftercare appointment.

Authorization for Convenience of Providers

GCAL completing authorization for eligible individuals will cut down on redundant assessment and unnecessary paperwork to assist providers and consumers in a seamless transition to care.

ATTACHMENT D.1

D.1 In Attachment D.1, **(limit four (4) pages)**, describe the Offeror's experience in the development of a network adequacy report including development of criteria for determining adequacy and gaps. Indicate the actions the Offeror has taken when the results of network adequacy or sufficiency assessments identified service gap(s). Specify how the gap(s) were identified, the type(s) of service gap(s) identified, the actions taken, and how the impact of the action(s) was measured.

As the ASO for Georgia's behavioral health and IDD program, we offer DBHDD 30 years of nationally recognized leadership in assessing, developing and supporting behavioral health and IDD provider networks that improve individual access to care and quality of life. As a national behavioral health organization, ValueOptions has considerable knowledge in provider recruitment strategies for new and existing contracts. However, our philosophy related to provider recruitment and performance management extends well beyond traditional programs. We actively partner and engage with providers in all elements of the work that we do. We understand that if our provider network is not supported adequately (e.g., not being paid in a timely fashion, not being educated and informed while being expected to provide best-in-class service to the individuals we serve), a competent and responsive system of care cannot be developed and maintained to meet the needs of the individuals we serve.

As we conduct ongoing network adequacy assessments, we will work collaboratively with DBHDD to manage and augment the current statewide network of behavioral health and IDD providers. We will evaluate the network's comprehensiveness by provider count and type, and review provider access. We will help make further enhancements to the Medicaid behavioral health and IDD service delivery system by leveraging our local experience via our geographic teams and Regional Network Management staff using our proven network development and management experience and supported by our fully integrated technology platform for monitoring access needs.

NETWORK ADEQUACY REPORT DEVELOPMENT

Our Network Availability Monitoring and Improvement Activity Report is the foundation for analyzing measures such as network availability, goals and barriers to meeting them, performance measurements, and opportunities for improvement. It compiles several monitoring reports on availability of care, including:

- **Geographic access (Geo Access) reports:** These reports measure our performance against CMS and the State agency's specific geographic access standards for organizational providers and individual practitioners.
- **Network access analysis reports:** These reports map providers across the entire service area. It details the number of providers and individuals in each ZIP code, the average distance to providers and the percentage meeting access standards.

- **Provider network annual report:** These reports detail providers by network status, level of care, region, covered services, contract effective date, credentials, vendor names, and addresses.
- **Provider changes by region quarterly report:** These reports highlight additions, deletions, and network changes within the previous quarter. It also provides an update on credentialing activities.
- **Quality standards and complaint reports:** These reports help identify providers and facilities that may have quality of care and service issues, which may indicate the need for provider education and training, additional providers, or improvements made to the facility.

CRITERIA FOR DETERMINING NETWORK GAPS, ADEQUACY AND ACCESSIBILTY

We determine network adequacy based on access standards for practitioners and programmatic services, practitioner density measures, programmatic services to individual ratios, and network provider availability. This ensures we assess the number, mix and geographic distribution of the provider network to the anticipated needs within the State.

In addition, network gaps and/or adequacy will be identified based on facility ADA compliance, including handicapped parking and entrance ramps, wheelchair accommodating door widths, and bathrooms equipped with handicapped railing. Providers and Mobile Crisis Teams will also be evaluated to ensure appropriate appointment and response time standards are being met. When accessibility gaps are identified, we will present marketing efforts, strategies, and timelines to engage new providers to DBHDD for approval. We detail our network access strategy in the table below:

Network Development Plan	
Step One: Analysis	We will conduct a geo-mapping analysis by ZIP code and a density analysis detailing the individual/provider ratio to ensure appropriate access to a provider.
Step Two: Recruitment	We will target recruitment, including specialty providers, to address identified needs among individuals served.
Step Three: Recommendation for Contracting	Once a provider has successfully passed credentialing/pre-qualification and submits a completed application, we will review and recommend that DBHDD contract with that provider if the provider meets qualifications.
Step Four: Ongoing Maintenance	We will continue to regularly monitor the access and availability of all facilities and provider disciplines in the network to ensure access and ample diversity to meet the needs of Georgia's IDD and behavioral health population. The provider network composition will be analyzed each quarter, and providers will be actively recruited to maintain network integrity and fill any identified gaps. We will use geographical analysis, ease of scheduling, scheduling audits, and individual feedback as the means of monitoring the overall appropriateness of the network.

NETWORK ACCESS ANALYTICAL PRESENTATION

Our network access reports generate key access metrics and present them in table (shown below) and graphic form. The information can be presented by provider type and geographic location. Network accessibility standards can be customized to DBHDD's specific requirements. We also have the ability to drill down and present specific analyses by provider type and/or geographic area. We are able to insert variable availability of care criteria into three geographical category types: urban, suburban and rural. These parameters allow for "availability of care" in a given geographic region. As in the example below, our client requested that we report provider access by urban (10 miles) and suburban/rural (30 miles) regions.

Access Standard	Practitioner Type	Total Number of Practitioners or Facilities	Total Number of Members	Number of Members with Access	Percentage of Members without Access	Number of Members without Access	Percentage of Membership with Access	Standard	Standard Met/Not Met
1:10 miles	All Practitioners	1,882	54,482	54,275	0.4%	207	99.6%	95%	**Met**
1:10 miles	Psychiatrists	271	54,482	53,572	1.7%	910	98.3%	95%	**Met**
1:10 miles	Psychologists	276	54,482	53,470	1.9%	1,012	98.1%	95%	**Met**
1:10 miles	Social Workers	619	54,482	54,121	0.7%	361	99..3%	95%	**Met**
1:10 miles	Other Master's Level Clinicians	293	54,482	54,042	0.8%	440	99.2%	95%	**Met**
1:10 miles	All SA Facilities	74	54,482	53,203	2.3%	1,279	97.7%	95%	**Met**
1:30 miles	All Practitioners	1,882	54,482	54,482	0.0%	0	100.0%	95%	**Met**
1:30 miles	Psychiatrists	271	54,482	54,481	0.1%	1	99.9%	95%	**Met**
1:30 miles	Psychologists	276	54,482	54,482	0.0%	0	100.0%	95%	**Met**
1:30 miles	Social Workers and Other Master's Level Clinicians	619	54,482	54,481	0.1%	1	99.9%	95%	**Met**
1:30 miles	Other Master's Level Clinicians	293	54,482	54,481	0.1%	1	99.9%	95%	**Met**
1:30 miles	All SA Facilities	74	54,482	54,477	0.1%	5	99.9%	95%	**Met**

GAP ASSESSMENT EXAMPLES

Increasing Access to Improve Care

In the last several years, ValueOptions identified the accessibility and availability of psychiatrists, including child psychiatrists, as an issue of concern. For example, in Colorado, psychiatrist availability in Pueblo, Colorado was identified as an issue, specifically for our health plan client headquartered there. After an in-depth review of the network surrounding Pueblo, including outreach to the local community mental health centers for validation, we realized that there was a shortage of psychiatric schedule availability. There were only nine psychiatrists identified, all of whom were already part of our network. Because of our strong provider relationships in the community, we were able to work with key psychiatrists in the area to arrange for individuals to be seen within three days, ensure service level agreements were met and high-quality care was provided.

As another example, in September 2009 ValueOptions began managing behavioral health services for a regional health plan in New York. At that time, the network consisted of 3,162 unique practices and 51 behavioral health facilities. ValueOptions compared our existing network with the health plan's and conducted Geo Access surveys to identify coverage gaps and types of providers we needed to recruit in each region. ValueOptions then began aggressive recruitment to build the network and fill in the gaps. Our efforts more than doubled the number

of available providers throughout the region. Today, the network comprises 8,189 unique practices and 216 unique facilities, serving nearly 500,000 members.

Expedited Recruiting Efforts

In 2011, ValueOptions began a partnership with a two million member health plan in the Northeast and set out to promptly recruit, contract, credential, and complete system set up of behavioral health providers. Prior to the target Go Live date of January 1, 2012, providers that participated with the health plan but not participating with ValueOptions were identified. The goal was to have 100 percent of the health plan's providers who met credentialing criteria and were willing to contract with ValueOptions in ValueOptions' network prior to January 1, 2012, and have a minimum of a 90 percent match to the health plan's original network.

The providers identified in the preliminary data analysis provided by our client included 1,531 practitioners and 72 facilities in the tri-state area of New York, New Jersey, and Connecticut. ValueOptions was successful in meeting all of the recruitment, credentialing and contracting goals by the start date of the contract.

Expanding Access for Specialty Populations

For ValueOptions' previous contract in New Mexico, based on a network adequacy report a systemic network deficiency for the state in meeting the needs of specialty populations and their families, such as access for individuals with dually diagnosed mental health disorders and IDD, brain injury and Autism Spectrum Disorders were identified. Due to the lack of providers in New Mexico with expertise working with individuals with a dual diagnosis of behavioral health and IDD, ValueOptions had to utilize a high proportion (approximately 35 percent) of out-of-state providers to ensure these individuals received appropriate treatment. As ValueOptions was acutely aware of the need to improve access within the state of New Mexico and avoid these out-of-state placements, ValueOptions employed the following three strategies to address this issue and build capacity in New Mexico:

1. Active recruitment and development of alternatives to the limited choices of providers who have traditionally offered these services
2. Expanding expertise through training opportunities
3. Addressing barriers in current licensure requirements

ValueOptions actively recruited providers with expertise in IDD and Autism Spectrum Disorders to serve these individuals. For example, ValueOptions recruited a nationally respected company specializing in treatment for individuals with Autism Spectrum Disorders and IDD. This organization opened a Residential Treatment Center (RTC) with a 39-person capacity within the state. ValueOptions also worked with two in-state providers to develop additional residential services for individuals who were dually diagnosed: an RTC in southwest New Mexico, and another RTC interested in developing group homes in Albuquerque as a step-down treatment setting. In addition, ValueOptions negotiated with a mental health and IDD group home provider that served individuals with mental health and IDD and who were deaf or hard of hearing.

ATTACHMENT D.2

D.2 In Attachment D.2, **(limit five (5) pages)**, describe the processes the Offeror plans to utilize for review and recommendation of Provider prequalification application.

As a NCQA-certified Credentials Verification Organization (CVO), ValueOptions has the expertise, infrastructure and processes in place to managed the DBHDD prequalification and accreditation process. ValueOptions credentials and re-credentials providers, facilities, and programs according to policies and procedures set forth by our National Networks Development and Management Department, which are based on NCQA requirements. We are routinely able to credential and notify the provider of the credentialing decision within 30-60 days of receipt of a completed application

ValueOptions is fully certified for 10 out of 10 verification services through NCQA as a CVO. We have the systems, processes and personnel in place to thoroughly and accurately verify providers' credentials according to the standards for Georgia's providers of mental health, addictive diseases and/or developmental disability services.

We use our internally-developed Web-based credentialing software program, NetworkConnect, that includes imaging, automated forms processing, online faxing, and ad hoc query capabilities. The system automatically feeds into ValueOptions' fully integrated information management system, CONNECTS, to help manage claims payment, referrals to specific providers, provider service inquiries, provider demographic changes, application submission, and/or re-credentialing submission/review activities.

PRE-QUALIFICATION/CREDENTIALING PROCESS

Our Credentialing Department is equipped to conduct DBHDD's provider recruitment and qualifying process. Presented below is a description of ValueOptions standard credentialing process. While this standard process depicts a baseline of compliant procedures that is commonly utilized for our clients, we also have the flexibility to adapt our policies and procedures to specific State requirements. In general, upon receiving the provider's application packet, a Credentialing Specialist reviews the application for completeness and determines if the provider meets DBHDD's license-specific pre-qualification/credentialing criteria. If any of these conditions are not met, the provider is denied network status and offered an opportunity to appeal the decision. Exceptions to this process require a valid reason, substantiation by our National Credentialing Committee (NCC), approval by DBHDD, and documentation of an authorized exception request must be included in the file.

ValueOptions adheres to one of the most stringent credentialing and recredentialing processes in the industry—one proven to ensure that individuals receive excellent service from skilled, highly qualified providers.

Any information missing from the packet is noted in NetworkConnect. The Credentialing Specialist will contact the provider three times to collect missing information. If the information is not received, the credentialing process is terminated and the termination status is noted in NetworkConnect. Once missing information is received, the Credentialing Specialist begins the Primary Source Verification process.

ValueOptions will request a site visit prior to the credentialing decision being made for any facility that is **not** accredited by:

- The Joint Commission
- Council on Accreditation
- Healthcare Facilities Accreditation Program
- The Rehabilitation Accreditation Commission
- Community Health Accreditation Program
- American Osteopathic Association
- Accreditation Association for Ambulatory Health Care
- Det Norske Veritas

It is also our policy that a structured site visit review is conducted:

- For all practitioners' office sites with two or more documented individual complaints in a six-month timeframe relating to physical accessibility, physical appearance, and/or adequacy of waiting/examining room space
- When a quality of care issue indicates a site visit may assist in resolution of an identified quality of care issue
- When contractually obligated

Primary Source Verification

ValueOptions' Credentialing Specialists check providers' credentials through our Primary Source Verification (PSV) process, which verifies the provider's license is current and valid, as well as his/her professional certification, professional liability claim history, and malpractice insurance to ensure the experience and professionalism of our providers. If during the course of PSV the Credentialing Specialist identifies irregularities, he or she engages in further research to reconcile the identified concerns and/or seeks additional information from the provider. ValueOptions conducts Primary Source Verification for 100 percent of providers at initial credentialing, and every three years for recredentialing.

During the credentialing/recredentialing process, ValueOptions determines whether there have been sanctions that might compromise the provider's ability to deliver safe, appropriate care to individuals. At initial credentialing, and monthly thereafter, we query the following to verify that providers have not been excluded from participation in Medicare, Medicaid, or any other Federal health care program:

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

ValueOptions will also accommodate a verification process that includes approved accrediting bodies recognized and required by DBHDD, including:

- Commission on Accreditation of Rehabilitation Facilities
- The Joint Commission
- The Council on Quality and Leadership
- Council on Accreditation of Services for Families and Children

ValueOptions is committed to ensuring a safe network for individuals as evidenced by our thorough process. During our NCQA CVO survey, ValueOptions received the maximum available point value in the Ongoing Monitoring of Sanctions category.

We also query the National Practitioner Data Bank (NPDB) and other applicable licensing boards and agencies to identify providers not listed in good standing. We do not enroll providers who have active sanctions from any of the above-named entities. Prior to terminating an enrolled provider, sanctioned providers will be reviewed with DBHDD.

Recommendation of Network Enrollment

Upon completion of PSV, the Credentialing Specialist renders a recommendation, and forwards the application and documentation to the Network Auditor. The Network Auditor conducts a quality review and forwards the practitioner file as follows:

- Files with recommendations for approval are forwarded to the Medical Director (acting on behalf of the NCC) and then routed to DBHDD for approval. The practitioner is notified of the credentialing decision within 30 to 60 calendar days of the date of the decision.
- Files with recommendations for denial are forwarded to the Medical Director and DBHDD, and the practitioner is notified in writing within five business days of the decision the reason(s) for denial, and is notified of their right to appeal to the Provider Appeals Committee within 30 calendar days from the date on the letter of notification. The NCC Liaison updates the credentialing status in NetworkConnect to reflect denial status.

Cost-Saving Offering for Georgia

ValueOptions participates with the Council for Affordable Quality Healthcare (CAQH) and their Universal Provider Datasource (UPD), which is the trusted source and industry standard for collecting provider data used in credentialing, claims processing, quality assurance, emergency response, member services and more. By streamlining data collection electronically, UPD reduces duplicative paperwork and millions of dollars of annual administrative costs for one million physicians and other health care professionals, and more than 650 participating health plans, hospitals, and other health care facilities. Nearly 95 percent of ValueOptions network providers participate with CAQH. ValueOptions will offer this streamlined credentialing process, if approved by DBHDD, to providers.

We will work directly with DBHDD to ensure that all Medicaid and non-Medicaid providers are licensed and/or credentialed to render services under this contract and applicable State law

and/or regulations. In addition, we will review our credentialing process with DBHDD to ensure our credentialing process meets DBHDD's expectations.

ATTACHMENT D.3

D.3 In Attachment D.3, **(limit one (1) page)**, describe how the Offeror would design the Provider Resource Directory to facilitate use by all stakeholders.

We maintain our entire online provider network database within our fully integrated information management system. To access the online listing, all stakeholders will be directed from our ASO website to our provider search application, ReferralConnect. This Web-based provider resource directory enables individuals, providers and State agencies to find a provider throughout the state 24 hours a day, seven days a week, at their own convenience. It also meets all of the required provider information outlined in *Section 7.5 of Attachment J* of this eRFP.

Our provider resource directory will include complete contact information (i.e., names, addresses, phone numbers, and map), public transportation accessibility, qualifications, populations served, languages spoken, and specialty. Search results offer a listing of providers based upon the search criteria entered as well as all pertinent information about the provider noted above and include a map to their office location. Individuals accessing the online directory also have the option to print the results. Additionally, our staff will discuss provider search results with the individual to enable choices; print and mail the provider information upon request to the individual. The directory is a comprehensive resource for individuals, families, and local communities regarding availability of services and supports. It is a key element of our communications program in promoting self-direction, informed choice, individual and family member involvement in treatment planning, and detailing other important aspects of the behavioral health and IDD system.

Our innovative Web-based provider referral system offers individuals access to the wealth of network resources, both online and in near real-time. It offers the following key features:

- An online provider directory that can be accessed by all stakeholders
- Mapping capabilities to provider locations and a "Help" button for user assistance
- Provider demographics, such as languages spoken and clinical specialties
- Public transportation accessibility and additional information related to accessing services
- Performance profile information, as applicable
- A direct link to our information system, which houses the provider file
- Daily updates that occur in near real-time
- A "Feedback" button that allows the user to provide immediate feedback about changes needed (e.g., address, phone number)

Mobile Referral Application

In addition, we developed a mobile version of our provider referral application. This mobile app offers the same functionalities as they exist on the Web-based version. Individuals are able to search for a provider, view specialties and other helpful demographic information about providers. Mapping capabilities that give individuals directions to their provider of choice are also available. This free, downloadable application is available on the Apple or Google Play store.

ATTACHMENT E.1

E.1 In Attachment E.1, **(limit two (2) pages)**, describe how the Offeror would promote fidelity to practice guidelines and evidence-based practice (EBP) in the utilization management (UM) program.
Specifically: Address how the Offeror would ensure practice guidelines and EBP requirements are properly applied to practice during utilization review (UR) for BH services. Provide a list of the practice guidelines and EBPs used by the Offeror.

Our Utilization Management/Utilization Review (UM/UR) program is designed to provide effective and efficient use of resources, facilitate easy access to appropriate services and promote high quality care. We ensure individuals receive the most appropriate, least restrictive, and most cost-effective recovery-oriented treatments and supports that meet their identified needs and promote independence, consistent with their informed choices and preferences.

PROMOTING FIDELITY TO PRACTICE GUIDELINES

Our practice guidelines are used during clinical rounds to shape treatment for individuals, identify issues for further review, and as teaching tools for staff education. Our clinical staff references these guidelines with providers during reviews, especially those focusing on complex or outlier situations. Providers who fail to comply with these guidelines are identified for additional quality of care education. In such a situation, the provider's practice would be reviewed by our Quality Management/Quality Improvement Committee and/or the Provider Advisory Committee and may be asked to submit a performance improvement or corrective action plan. Depending on the scope of the concern, we would offer the services of our local Regional Network Manager to provide technical assistance and support to assist the provider's improvement efforts.

Mechanisms Used to Ensure Application of Practice Guidelines

We adhere to the clinical treatment record evaluation and guidelines as defined by NCQA. During auditing of network providers' treatment records by our UM Director or quality of care staff, we ensure that the records adhere to national standards of practice and reflect appropriate behavioral health care management, including following evidenced-base care practices. Additionally, our UM Director reviews the care of identified individuals weekly with clinical supervisors for adherence to practice guidelines. Aside from the routine clinical record reviews, conditions under which a treatment record audit may be triggered include: quality of care issues, appeals, review of an individual requiring intensive case management, instances of possible over- or under-utilization, questionable emergency admissions, instances of poly-pharmacy concerns, and suspected or alleged fraud.

Inter-rater reliability audits are also performed to determine the level of consistency among Clinical Care Managers and Peer Advisors in the application of medical necessity criteria and practice guidelines during the process of utilization review. Results are then aggregated and, if necessary, corrective action plans are implemented for staff to focus on areas of inconsistency.

In addition, retrospective reviews take place under conditions in which a facility was unable to determine eligibility because of an individual's mental status, eligibility was approved retrospectively after admission, or the provider/facility was unable to request authorization within expected time frames during an emergency situation. Clinical records are requested in cases of retrospective reviews and referred for peer review when there are questions about medical necessity.

LIST OF BEHAVIORAL HEALTH CLINICAL PRACTICE GUIDELINES

Below are just a few of the behavioral-health related clinical best practices and standards of care that ValueOptions requires of our providers. These are included in our ongoing provider training curriculum and our providers are held accountable for these through regular clinical reviews and quality audits.

- Co-occurring medical conditions and/or substance use conditions have been assessed and addressed in the individual's service plan.
- For biologically based conditions, appropriate pharmacological intervention has been prescribed and/or evaluated by the individual's primary care provider or psychiatrist.
- The treatment process includes one or more evidence-based psychological treatment modalities such as cognitive behavioral therapy, motivational enhancement therapy, illness management skills, family interventions/therapy, and community-based self-help organizations and peer support groups.
- The clinical impairment rating and service plan reflect either the individual's improvement in symptoms within 90 days of treatment onset, or that the condition has been re-evaluated and adjustments made accordingly in the service plan.

Additionally, we supply our providers and Clinical Care Managers with practice guidelines, noted in the table below, that have either been developed by ValueOptions or adopted from nationally recognized sources. Our standards of care are continually reviewed and modified based on scientific evidence, best practices and input from respected industry sources, including providers in our network and other stakeholders.

Guideline and Source	Guideline and Source
Acute Stress Disorder and Post-traumatic Stress Disorder from the APA	**Assessing and Treating Suicidal Behaviors** from the APA
Attention Deficit/Hyperactivity Disorder for Children and Adolescents from the American Academy of Child and Adolescent Psychiatry	**Generalized Anxiety Disorder** from the Canadian Psychiatric Association Anxiety Guidelines with Annotation Page
Autism Spectrum Disorder (ASD) developed internally by ValueOptions	**Co-Occurring Disorders** developed internally by ValueOptions
Eating Disorder from the APA	**Bipolar Disorder** from the APA
Schizophrenia Guideline Watch from the APA with annotation	**Opioid-Related Disorders** from the SAMHSA Guideline – Tip 43
Schizophrenia from the APA with annotation	**Major Depression** from the APA
Treating Substance Use Disorders from the APA	**Transcranial Magnetic Stimulation (TMS)** developed internally by ValueOptions
Suboxone Treatment Guideline from SAMHSA	**Treating Panic Disorder** from the APA

ATTACHMENT E.2

E.2 In Attachment E.2, **(limit six (6) pages)**, describe how the Offeror will use data and clinical decision support systems in UM/UR activities both for individuals with BH conditions who access BH service and individuals with IDD who access BH and/or IDD services:

a. Specify the types of data to be used.
b. Specify which BH and IDD services, levels of care, or populations will be targeted.
c. Specifically address how overutilization of emergency and crisis services will be addressed.
d. List the edits that will identify cases for review and/or clinical consultation, by level of care, or other categories.
e. Describe how the clinical consultations will be utilized.
f. Estimate the percent of cases that will be managed via the information system versus live clinical consultation.

A. – TYPES OF DATA USED

Because collection and transmission of data places increased administrative burden on all parties, it is imperative that clinical and administrative information is transformed into intelligence that leads to action. With this in mind, it is our obligation to return the end product of all data collection back to the provider and other stakeholders. Only essential data points will be obtained to understand more about the populations in need, offer actionable reporting to stakeholders and ensure appropriate use of services. Data points will include: demographic information, insurance, income, English proficiency, communication, presenting circumstances, homelessness, living situation, employment/school, education, legal, ADA population, other special populations, medications, addiction, service history, and diagnostic categories, among others. This data will be integrated with Medicaid claims/State encounters and GCAL contact encounters. Finally, we will be working with Qualifacts and the providers using their electronic medical record to pilot a new paradigm of streamlined information sharing. Now that most large behavioral health providers use an electronic medical record, we believe that data acquisition between providers and our program will be seamless in the near future.

Along with the data available to our clinicians as a result of GCAL contacts and authorizations documented in the CONNECTS system and with the support of DBHDD, we will work with emergency rooms and state and private hospitals to promote a method of documenting transfers to community services and admissions to crisis services. Having timely notification of such crisis events and referral information will allow identification of vulnerable individuals who could benefit from care coordination and transition services. We will use Medicaid claims and encounter data to develop real-time dashboards to inform trends within the delivery system.

Our CONNECTS platform is flexible and customized to meet the needs of this contract. For DBHDD providers, we will customize service request screens that will be accessible via our provider Web portal to request services/service packages for individuals. To decrease any transition issues for providers and continue the use of an accepted assessment tool, the LOCUS will be integrated into the Georgia-specific Request for Services module. For children and

youth, we propose using the CAFAS as a part of the clinical review process to determine the most appropriate level of care.

The collection and the consolidation of new data will create a new paradigm related to the clinical decisions underlying the UM/UR process and ultimately ensure a more robust Quality Management program. The table below contrasts the current model with the enhanced data collection process that will be incorporated into our CONNECTS system:

Currently Collected Data not Integrated into the UM Process	
Call data from the family or individual served obtained by GCAL	Currently collected by BHL but not integrated into the UM process. **Intended Use**: Determine appropriate level of care needed
Mobile crisis encounter and disposition data	Currently collected by BHL but not integrated into the UM process. **Intended Use**: Assist in identifying individuals for intensive care management
Provider and emergency room initiated encounter data obtained by GCAL	Currently collected by BHL in some areas of the state but not integrated into the UM process. **Intended Use:** Assist in expediting follow-up care
Discharge summary data (including community aftercare appointments) obtained from State Hospitals, contracted inpatient units/CSUs	Collected but not utilized. **Intended Use:** Assist in ensuring appropriate transition services and provider effectiveness at engaging individuals post discharge
Homelessness	Obtained on MICP but not utilized for UM/UR purposes. **Intended Use:** Identify need for access to social support services, improved transition planning, and measure provider effectiveness at helping the individual obtain stable housing
Historical LOCUS scores	Current LOCUS score only used. **Intended Use:** Combing historical and current scores will provide clinical trend insight
Medicaid claims and State-funded encounter data provided by DBHDD	Currently not integrated into the UM process. **Intended Use:** Assist in making service history across all providers, emergency rooms and hospitals transparent
Current and historical diagnostic profile	Current diagnosis only used. **Intended Use**; Provide better insight into the assessed needs based on changing diagnoses over time
New Data Sources to be Integrated into the UM Process	
Pharmacy claims data provided by DBHDD	Provided under the new contract. **Intended Use:** Assist in confirming access to medication and forecast potential relapse or destabilization of the person served
Provider generated quality of life assessments	To be collected under new contract. **Intended Use:** Help track clinical improvement
Individual generated Crisis Prevention Plans	To be collected under new contract. **Intended Use:** Help guide GCAL crisis response services – continuity of care
Days in community outside of hospital	Not collected for intensive services. **Intended Use**: Help guide efforts to avoid under-utilization and over-utilization
Provider actions and success in helping the individual obtain benefits	Not collected. **Intended use**: Help monitor benefits attainment for those who qualify
Annual physical	Not collected. **Intended Use**: improve health outcomes
Individuals receiving antipsychotic medications are routinely educated about potential metabolic conditions	Not collected. **Intended Use:** improve provider performance and client knowledge resulting in better health outcomes
Smoking cessation	Not collected. **Intended Use**: improve provider performance and client knowledge resulting in better health outcomes

Coordination with primary care provider	Not collected. **Intended Use**: improve health outcomes

B. – SERVICES, LEVELS OF CARE AND POPULATIONS TARGETED

As Georgia DBHDD's behavioral health and IDD UR/UM ASO, we will focus on promoting timely and appropriate care for the priority populations. Our processes will support:

- Limiting the need for and duration of acute care admissions and other crisis services
- Timely and appropriate transition from crisis care services to community services
- Transitions for individuals who have achieved stability in intensive community services to less intensive levels of care, encouraging the right service at the right time

Specifically, services, levels of care and populations that will be targeted for UM/UR include:

- **Under-utilization of services by an individual identified as high need or with a history of high intensity service utilization**. Examples of under-utilization occur when high-need individuals who frequent emergency rooms or experience multiple crises are not provided rapid access to care in the form of case management, medication, behavioral analysis services, or formulation of a crisis support/safety plan. Our UM/UR process will use the data itemized above and notify providers when a high-need individual qualifies for Assertive Community Treatment (ACT), Intensive Case Management (ICM) or Case Management. The initial authorization will be generated based on analysis of the data made available through the GCAL assessment and referral process, and data resulting from communication with emergency rooms and State Hospitals, thus reducing the administrative burden on community-based providers.
- **Over-utilization of services by an individual who has met appropriate goals and can transition to a higher level of independence and corresponding level of care.** Examples of over-utilization occur when individuals remain in programs such as Psychosocial Rehabilitation or Mental Health Intensive Outpatient services long after established goals on the service plan are obtained. Even services such as ACT, ICM or Case Management should be actively working toward the attainment of goals, such as stable housing, attainment of Medicaid, decreased crisis events/incarceration, independent living skills, and engagement in outpatient services.

  When an individual with a mental illness or substance use disorder is not fully engaged (as evidenced by little or no provider contacts over several months), we will work with providers to classify the individual as "inactive," thereby increasing capacity for new "high-need individuals." In collaboration with the State Support Coordinator/Planning List Administrator and Region, individuals with IDD receiving State-funded services but who refuse these services will also be classified as "inactive." The transition of individuals who are less symptomatic from higher intensity community services to less intensive services will open up availability for the priority populations and, given the provision of needed support, prevent re-admission to acute care and other crisis services.

  As areas of focused review for target populations or provider groups are identified, the CONNECTS system will be modified to pend requests for more intensive review and consultation. Other possible triage guidelines include: severe risk to self or others for a non-

acute level of care request, no psychiatric treatment in the last year and a SPMI diagnosis, and/or all requests for a specific service (e.g., psychosocial rehabilitation).

- **Dually diagnosed individuals with a mental health condition and IDD.** Individuals who are dually diagnosed are especially vulnerable within a non-integrated system of care. The need for care coordination for these individuals should be continually assessed. It is not uncommon for providers of mental health services and IDD services to function independently and attribute lack of progress toward goals only to the disability or diagnosis that they are unaccustomed to treating. As with individuals with exclusively behavioral health concerns, the CONNECTS system will be used to automatically authorize non-acute care requests for service clearly meeting medical necessity guidelines and will highlight the need for closer review of individuals who are deemed to be more vulnerable or at risk. Special attention will be given to individuals receiving psycho-active medication to ensure they have a behavioral health assessment, their medication is appropriate and consents for medication are in place. Upon closer review of requests for dually diagnosed individuals, particular attention will be given to the Individual Support Plan and Plan of Care and follow-up care to ensure that conditions, goals and services are included on each plan and that excluded services are not being requested.
- **Inpatient admissions and continued stays exceeding expected utilization.** Ensuring the State network of DBHDD inpatient and crisis beds maintain adequate capacity and appropriate lengths of stay to decrease delays in care that occur when individuals wait in emergency rooms for an inpatient or crisis bed is critical. Stabilization of an individual experiencing a crisis episode requires rapid assessment by qualified providers, including the attainment of history, precipitating events and the involvement of natural supports. Labs and a medical evaluation can also be helpful in identifying underlying medical conditions and/or substance use disorders. Access to the appropriate psychotropic medications is also critical. Some providers excel at employing a multi-disciplinary treatment team to accomplish these tasks while others may inadvertently contribute to prolonged length of stays due to operational limitations and difficulty accomplishing these tasks. While a number of variables make each episode unique, the utilization of evidence-based treatment practices is essential to high quality outcomes and limited recidivism.

  Additionally, discharge planning from the point of admission is essential to acquiring timely and appropriate follow-up care. As a part of the telephonic clinical review process with each admission and concurrent review, the care coordinator will identify progress on each of these factors, promoting quality care for the individual. In addition to ensuring each individual experiencing a crisis episode receives the best care, we will track 30-day readmission rates as a Key Performance Indicator (KPI) and provide this important data to the provider, highlighting outcomes and performance.

C. – FOCUS ON OVER-UTILIZATION OF EMERGENCY AND CRISIS SERVICES

We understand that the Georgia Hospital Association, representing emergency rooms statewide, seeks relief and assistance to help with an increasing population presenting with a behavioral health crisis. Consequently, we have dedicated considerable thought to this issue and have devised a plan to ensure better utilization of resources, improved communication, and the elimination of silos resulting in repetitive assessment activity and uncoordinated care. Our UM plan is designed to ensure that community providers shift their priorities to increase capacity for

high-need individuals by offering rapid access to urgent appointments, medication, and applying effective engagement techniques when a no-show occurs.

Currently, crisis service utilization data are not collected statewide, resulting in large gaps of intelligence related to tracking the individuals most in need of services. With agreement by DBHDD, we will address over-utilization of emergency and crisis services by:

- Initiating systematic reporting of state hospital admissions and use of the GCAL program by emergency rooms to ensure valid, timely and comprehensive crisis service data. Once this is in place, the GCAL/mobile crisis data, emergency room, CSU, inpatient, and state and state-contracted hospital admissions and discharge data will be consolidated and processes put in place for ongoing tracking. Data will be shared within the delivery system to assure accountability, transparency and as a means to track performance.
- Assigning priority appointments prior to the resolution of a crisis contact to ensure linkage of the individual with a community provider. The appropriate community-based services would also be pre-authorized at time of crisis via GCAL, reducing provider administrative burden.
- Measuring provider engagement rates of recently discharged individuals as a KPI.
- Uploading crisis prevention plans, which will be created by the individual in collaboration with the provider, into our care management system to be used for future crisis calls. This will allow for effective implementation of the crisis plan and, in some cases, de-escalation of the situation, preventing the need for crisis and acute services.
- Tracking crisis and inpatient bed capacity in real time to ensure efficient occupancy rates
- Tracking time to urgent appointments and time for an individual to see a prescriber to obtain medication
- Ensuring ACT teams, Intensive Case Management Teams, and care managers are notified when an enrolled individual presents in crisis to facilitate hospital diversion
- Tracking 30-day re-admission rates to all inpatient beds and CSUs as a KPI. This will promote quality improvements that will reduce recidivism. Since re-admission reports are typically linked to the discharging hospital or CSU, we will be able to identify individuals admitted to a different hospital. This represents a new method of population management.

As indicated above, our top priority will be to ensure that the State network of DBHDD inpatient and crisis beds maintain adequate capacity and appropriate lengths of stay to decrease delayed care that occurs when individuals wait in emergency rooms for an inpatient or crisis bed. Successful implementation of these interventions will enhance emergency room care, improve the efficiency of crisis bed resources, and assure rapid stabilization within those units. It will also ensure sound discharge planning and engagement in aftercare results in sustained recovery and limited readmissions.

D. – EDITS TO IDENTIFY CASES/PROGRAMS FOR REVIEW/CONSULTATION

Our highly customized and flexible applications allow for auto-authorization when guidelines are met, while pending authorization requests for Clinical Care Manager review when a potential concern is pinpointed and allowing for system-generated messages when additional information is required. Edits are designed to identify when there is incongruence between the needs of the individual and the services requested to meet those needs. Finally, based on provider profiling and utilization trends, we are able to pend authorization requests by provider, by a specific service, or by the individual served. Additional edits to identify concerns include:

- Utilizing any of the data points collected and identified above in our response to *Part A* to improve clinical and quality of life outcomes. Some of the primary edits used to identify cases for review and/or clinical consultation include recent emergency room presentations or hospital/CSU admissions
- Increase in number of emergency room presentations or hospital/CSU admissions
- Validating the LOCUS score with the requested level of care to ensure appropriateness
- Diagnostic exclusions (e.g., lack of a SPMI diagnosis for ACT)
- Providers of concern based on specific audit results generated from onsite reviews
- Specific services having excessive utilization or recently modified requirements
- Excessive length of time in a particular level of care (e.g., numerous authorizations such as PSR for two 365-day authorizations and a request for additional services)
- Inpatient admissions and continued stay reviews
- Individuals with a dual diagnosis of IDD and mental health

E. – UTILIZATION OF CLINICAL CONSULTATIONS

Significant attention will be given to ensuring limited administrative burden on the provider by making contact only when a clear need exists, simultaneously promoting quality services for the individual. When an authorization request is pended for review, the provider will first have the opportunity to submit additional information via the CONNECTS system. Our care management staff will contact providers in the following instances to:

- Gain additional information (when what was submitted electronically was insufficient)
- Validate that the goals on the service plan reflect the level of care
- Provide guidance regarding goal attainment when progress is not occurring, possibly suggesting a referral to more intensive services
- Ensure that evidenced-based practices are employed to achieve the best outcome in the shortest period of time

Through our UM/UR program, we will improve service quality and utilization by transforming the data received through the authorization process to identify provider-specific trends related to an individual's achievement of outcomes such as: housing stabilization, decrease in criminal justice involvement, attainment of benefits, coordination with primary care and annual physicals, tobacco use cessation, presence of crisis prevention plans for high-need individuals, and reduction of hospital admissions/readmissions. These performance indicators will be discussed during the clinical consultation process at the individual level and at the aggregate level via provider profiling. Ultimately, consultation and technical assistance will occur with providers for which utilization patterns deviate from norms or practice guidelines, or from recommended type, frequency, and/or intensity of services per the individual's service plan.

F. – PERCENT OF CASES MANAGED

Using the data points and edits described above, we anticipate that 80 to 90 percent of the authorization requests will be managed via our information system versus live clinical consultation. Our own performance goal will be to increase the percentage managed via the information system across time as providers become more informed on our process and solid provider performance on KPIs is evident.

ATTACHMENT E.3

E.3 In Attachment E.3, **(limit three (3) pages)**, propose UM/UR strategies to manage State funds such that State funds are available for the full fiscal year for fee-for-service (FFS) and non-claims based payments in order to avoid disruption in care.

UTILIZATION MANAGEMENT STRATEGIES

We understand that State-funded providers of behavioral health services receive an annual contract that is currently reimbursed in 1/12th payments and that the provider is required to deliver at least 95 percent of the value of their contract through the submission of encounters/claims. The rate at which a provider expends these pre-paid State funds is a product of service volume, individual acuity, frequency of services delivered, and the length of time it takes a provider to help an individual achieve his or her goals. The sophisticated analytical reporting tools used by the ASO will measure the value of State-funded services contrasted with the monthly payments issued to the provider so that under- or over-utilization of funding can be monitored.

Additionally, based on encounter data submitted by the provider, we will calculate the funds used to serve each individual compared to norms and identify outliers for UR review. In such cases, the sum of the funds used should correlate to the identified strengths, needs, abilities, and preferences of the individual, including the number of days since the last crisis episode or inpatient/CSU admission. The product of a successful UM/UR program applied to one individual/provider at a time will result in more efficient use of funding at the aggregate level.

Furthermore, the ability to help individuals obtain Medicaid will influence the rate at which these State funds are consumed. As the payer of last resort, we will only authorize the use of State funds after it is determined that the individual does not have other insurance coverage. If it appears that the individual qualifies for Medicaid/Medicare based on the chronicity of the mental illness, the Clinical Care Manager will encourage and track the provider's progress in aiding the application process for that individual. As mentioned previously, agency contribution toward helping individuals obtain benefits will be a key performance indicator measured as part of the authorization process. Finally, since improved access is also a key objective of DBHDD, we will measure the through-put volume of individuals receiving services by measuring the volume of new individuals receiving care as well as the number of people achieving increased levels of independence. Ultimately, the cornerstone of our UM/UR process is ensuring the ASO is effective at helping more people achieve meaningful and measurable outcomes by striking the appropriate balance between quantity of people served and the quality of care delivered.

Using the same analytical budget reporting tools, we will monitor non-claims-based payments issued for transition or bridge funding, both at the individual level and at the provider level to ensure the appropriate use of funds. The current Georgia system of public behavioral health and IDD services depends upon multiple sources of financing, including Medicaid and non-Medicaid behavioral health, HCBS and State-funded IDD, housing, bridge and transition funding. This

complicated mix of funding streams creates challenges for coordination across providers, can lead to duplication of services, and often results in a system that can be extremely complex for individuals and providers to manage. To overcome these challenges, we use a comprehensive "Braided Funding[SM]" approach that is designed to identify, track and manage unique funding streams across disparate health care and social support delivery systems. In addition to the methods used to manage State funds mentioned above, we are prepared to employ these additional tools to ensure State funds are available for the full fiscal year.

OUR BRAIDED FUNDING APPROACH

Braided Funding combines multiple sources of funds to pay for services while maintaining the administrative ability to track and account for the unique funds. In our Braided Funding module, providers are guided through an intuitive registration process that identifies all available funding sources. Using State-approved fund hierarchy (priority) and system logic, the module assigns individuals to all appropriate and allowable funding sources. It also tracks dollars spent by funding stream to provide accountability for each funding source. Braiding the multiple funding sources increases opportunities for service coordination and continuity of care and creates administrative and economic efficiencies. More important, individual outcomes are improved as the effects of financing silos are removed.

The Registration Process

For individuals in need of behavioral health services, the provider will register them by entering their specific demographic and clinical information within the online Consumer Registration Module. This automatically generates a list of appropriate and approved DBHDD programs for which the individual may be registered and/or receiving services (both Medicaid and State-funded programs). The online Consumer Registration Module includes a provider authentication process that filters the list of available programs to only include those for which the provider is contracted. The provider can then select the programs most appropriate for the individual.

For individuals with IDD, once the person is deemed eligible for services by the Intake Coordinator and Intake and Evaluation (I&E) psychologist, this will be entered into our CareConnect application, which is part of our integrated CONNECTS technology platform. The Intake Coordinator will identify whether the person is designated for the long-term or short-term planning list based upon immediacy of need, including what services are needed by the individual. If the individual is not eligible for waiver funding, State-funded services become the primary option available. The list of individuals who are on the short-term planning list are reviewed often by the Regional I&E teams, including Planning List Administrators, to identify those who have the most immediate need. Based on the data within CareConnect data, the Regional I&E teams and ICMs, using designated criteria established by DBHDD, will generate a list of people under consideration to receive available funded services.

Selecting Funds

The registration process also requires the selection of the funds for which the individual should be registered. Once all funds have been selected, they are automatically verified against the eligibility and business rules as defined by the State. Once a provider has completed the initial steps of assigning fund types, the Consumer Registration Module then prompts the provider to

complete specific forms within the module to complete the registration process. The forms to be completed will vary based on the funding streams selected for each individual and include the required clinical and functional information needed to assign the individual to the appropriate benefits package. When all required information has been submitted, our registration system automatically reviews the submitted information against the State's defined criteria and parameters. If approved, the provider automatically receives a registration confirmation and is allowed to seek authorization of care if needed. If an individual is found not to meet eligibility, fund type, or clinical criteria as specified by DBHDD/DCH, the confirmation page will display the registration status of ineligible. The individual would then be directed to our Customer Service Line to receive advice on other alternatives and information on their right to appeal the decision.

For individuals with IDD whose only option is State-funded services, the Regional I&E team will identify those on the short-term planning list "most in need" of consideration for the available State-funded openings. These openings will be reported to the ASO by the contracted provider via ProviderConnect. In addition, we will examine claims data to capture any possible openings. This list of openings and the list of individuals "most in need" will be compared and used to determine who will receive State-funded services. If the person elects to accept services, this will be reviewed by our Care Coordinator to authorize services and notify the individual and provider. Once the individual begins receiving State-funded services, the State Service Coordinator will ensure the continued coordination of services.

IMPACT OF BRAIDED FUNDING STRATEGIES

In the following table, we provide an overview of the impact of two of our Braided Funding initiatives:

Expanding Financial Resources	
ValueOptions Kansas	Through the braiding of Medicaid and Federal Substance Abuse Prevention and Treatment (SAPT) block grant dollars, we enabled the state to save an estimated $5 million since July 1, 2007 through better tracking of client eligibility and more efficient use of SAPT block grant funds.
ValueOptions of Texas	In support of the Dallas, Texas NorthSTAR Medicaid program, our Braided Funding system manages 15 federal, state, and local funding streams for indigent members. Working collectively with the various stakeholders, we have streamlined agency policies and eligibility criteria to save approximately $60 million in Medicaid funds over the past decade. This successful program offers enrollees a comprehensive benefit package that dramatically improves their access to care and saves them from having to switch providers when their Medicaid eligibility status changes.

In addition to identifying the appropriate funding categories for each individual, our system allows us to track both individual and provider budgets to manage State-funding sources that have annual limits.

ATTACHMENT E.4

E.4 In Attachment E.4, **(limit two (2) pages)**, propose a Medicaid-compliant incentive program for high performing BH and IDD Providers, taking into consideration Medicaid rules and regulations regarding financial or other incentives and prior authorization bypass programs. At a minimum, the proposal will describe the process that would be used to identify Providers eligible for participation, the percentage of Providers for which this approach would be used, and the procedures to ensure continued qualification for the incentive program. Include a methodology to monitor the success of the overall program and the performance of those Providers who receive the incentive.

We will implement an incentive program for high performing behavioral health and IDD providers specifically designed for the Georgia ASO contract based on the success of implementing similar programs for other states. For example, using a combination of provider performance measures developed collaboratively with providers and incentive payments, our Connecticut provider incentive program resulted in decreased total inpatient days, decreased readmission rates, and increased access to both inpatient and outpatient services.

We will work collaboratively with DBHDD and providers to develop and implement a provider performance measurement program to track KPIs. For IDD providers, we recommend performance measures from the Person Centered Index developed by the IDD State Quality Improvement (QI) Council. A measurement tool founded upon evidence-based recovery practices will be designed for behavioral health providers. These measures may include, for example, post-hospital discharge engagement rates, presence of an annual physical or coordination of care with primary care providers, improved identification and service planning for individuals with co-occurring mental health and substance abuse disorders, and improved LOCUS or CAFAS scores. Both tools will score the provider's performance, and may be coupled with other factors, such as substantiated critical incidents, the absence of fraud, waste and abuse, and the absence of any alerts related to the health and safety of individuals served. The selection of final performance measurements and improvement targets will be guided by DBHDD and the Quality Management (QM) Committee. The methods to monitor each provider's progress toward achieving established targets (e.g., the use of case risk-adjusted analysis) will also be finalized in collaboration with DBHDD and the QM Committee. By working closely with DBHDD, we will ensure we take into consideration Medicaid rules and regulations regarding financial or other incentives.

Once the measures, targets and evaluation methods are agreed upon, an ongoing workgroup will be established that includes provider representatives. The workgroup representatives review available utilization data and quality measures, broken out by individual provider, and collaborate to identify additional measures that will help identify the drivers of variation in performance. Ideally, the data is unblended from the beginning, fostering transparency and an environment of active learning. Providers learn from each other with regard to best practices.

Most important, goals for improving performance, including measures other than utilization-based indicators, are agreed upon by all stakeholders and buy in is more easily attained.

For the first phase of the program, we will solicit participation by all of DBHDD's core providers. The program will be managed by our Director of Performance Improvement, with input from providers, with support and consultation from our Regional Network Management (RNM) personnel. The RNMs are seasoned behavioral health and/or IDD clinicians who are comfortable with data and familiar with the systems of care in their assigned region. The RNMs will develop relationships with the providers in their assigned region as well as develop a detailed knowledge of all of the behavioral health and IDD resources available in their region. This is important as provider performance must be understood within the context of the local communities, which vary in terms of access to traditional and non-traditional services, often influencing outcomes. The RNMs will bring detailed provider-specific data to key providers in their regions. They will be joined by ASO clinical staff, quality staff, and State officials from the Regional Offices. These individual meetings allow ASO staff to meet with more members of the provider team of practitioners, gain additional insight into barriers that the provider may be encountering and to identify best practices. Variation between programs and variables that may be responsible for those differences will be identified.

Once the performance measurement aspect of the program is solidly in place and baseline data is established, if resources are available the second phase of the program will involve the attachment of financial incentives to provider performance. Establishing the performance measures and goals annually allows us to add additional measures and goals and to set increasingly demanding target levels of performance to earn the incentive. Our goal for the initial rollout of the program will be to identify and prioritize, in collaboration with DBHDD, critical areas of the delivery system that would benefit from a comprehensive performance improvement program. As an illustration, in 2008, the first pay-for-performance (P4P) initiative was implemented in Connecticut. Early on, the target goals for the child/adolescent inpatient providers focused on utilization measures such as case-mixed length of stay and readmission rates. Hospitals could earn their incentive payment by meeting their case mixed adjusted length of stay target. Partial payment was also offered if a provider made substantial movement toward their goal, but did not fully meet their goal. During the first year of the incentive program, seven of the eight hospitals had either met their goals or made significant movement toward meeting their goals.

We propose a similar evolution in the goal achievement methodology for the provider incentive program we will implement for DBHDD. During the second year of the program, the "making significant movement towards meeting the goal" will be removed and providers will only receive the incentive payment if the designated quality improvement target is achieved. We will continue to work with DBHDD to evolve and improve the program over time by adding and/or replacing measures and promoting greater provider participation.

ATTACHMENT E.5

E.5 In Attachment E.5, **(limit three (3) pages)**, describe an example from another Contract for which the Offeror has detected underutilization and/or overutilization of services at the provider level or network as a whole, and steps taken to impact the utilization, and how the effectiveness of the strategy was measured.

ValueOptions Arkansas is the state of Arkansas' Quality Improvement Organization (QIO) responsible for assisting the Department of Human Services Division of Medical Services in administering the state's mental health care delivery system. Under this agreement, ValueOptions operates two contracts, conducting utilization review for:

1. Inpatient services for beneficiaries under age 21, which includes care coordination
2. Outpatient mental health services for children, adolescents and adults, including substance use disorder services for beneficiaries age 9 through 20 and pregnant females

The Arkansas Engagement Center processes an average of 600 inpatient and outpatient reviews a day. All documentation received is reviewed by a licensed clinician. Registration, prior authorization, certificate of need, and continued stay reviews are conducted using ValueOptions' CONNECTS system. This Web-based utilization management system enables the staff to quickly and efficiently authorize care and communicate with providers. In fact, 97 percent of reviews are submitted online. ValueOptions also conducts approximately 350 onsite Inspection of Care reviews for all inpatient and outpatient providers annually. The goal is to ensure compliance with Medicaid rules and regulations as well as quality of care standards.

During the Inspection of Care (IOC) process, over-utilization and under-utilization of services is identified. The IOC is conducted by licensed clinicians and assesses quality and adequacy of inpatient/outpatient services. A combination of scheduled and random annual audits of all providers is performed to determine whether services conform to professionally recognized standards of care. After completion of the IOC, a detailed report and request for corrective action is mailed to the provider and all applicable parties at the State level. Providers are required to submit and implement a Corrective Action Plan as needed. Through chart reviews, utilization patterns are identified and recommendations are made through monthly IOC meetings with the Department of Human Services, Division of Medical Services, and the Division of Behavioral Health Services.

In 2012, an analysis of the previous year's Inspections of Care for outpatient services was completed. The analysis focused on identified quality elements from the audit tool selected by the Department of Human Services. As a result of this analysis, outlier provider sites were identified and placed on "Desk Review." Desk Review is an intensive in-office review of randomly selected records after the corrective action implementation date. The Desk Review also included review of corrective action plan documentation. Upon completion of the Desk Reviews, recommendations were made based on level of improvement. Recommendations

included mandatory training provided by a member of the ValueOptions team; mandatory meetings with provider administrative staff, DMS, and ValueOptions; and follow up Inspections of Care to continue to monitor for improvement. In working with providers to complete their recommended actions, the trainings and meetings were tailored to the individual provider sites and their specific needs. Through this Desk Review process, providers showed marked improvement on the follow up Inspection of Care. More than 80 percent of provider sites placed on Desk Review returned to the annual IOC. The remaining provider sites continue to receive training and are monitored for corrective action implementation. If improvement does not occur, sanctions have been established as a next step if needed.

Over-utilization of services is also identified through the retrospective review process. Individuals are randomly selected and statistically valid with a 95 percent confidence level and accuracy rate plus or minus three percentage points. Records are reviewed quarterly for compliance with program requirements and conformity with professionally recognized standards of health care. In instances where there is a lack of documentation related to medical necessity, recoupment is initiated.

Records are reviewed using an established retrospective review tool where results are entered in a database. Reporting through the database is efficient and reports are used to identify trends at the provider level as well as overall trends where training may be needed across the provider community. The database also allows for trending of recoupments. Results are presented to the provider community in a semi-annual all-provider meeting. Overall trends are discussed and education provided. When trends are identified on the provider level, outreach is made by ValueOptions to provide necessary education.

One of the trends identified and discussed through ongoing stakeholder meetings is providers not providing services as ordered (under-utilization). Provider feedback suggested that there were many barriers in the system that did not allow for efficient discharge and readmission. Stakeholders worked with DMS and ValueOptions to create a “did not keep appointment” (DNKA) policy to meet the needs of the providers and ensure timely re-entry to services for individuals. After feedback from stakeholders and providers was received, this policy was promulgated.

Working with the provider community has become an integral part of the IOCs and retrospective review. Collaboration with providers as well as DHS allows for continued process improvement, improved outcomes for individuals and enhanced education for providers across the state. These processes continue to assist in creating a provider community that values high quality and cost efficient care in Arkansas that leads to better outcomes for Medicaid beneficiaries.

ATTACHMENT E.6

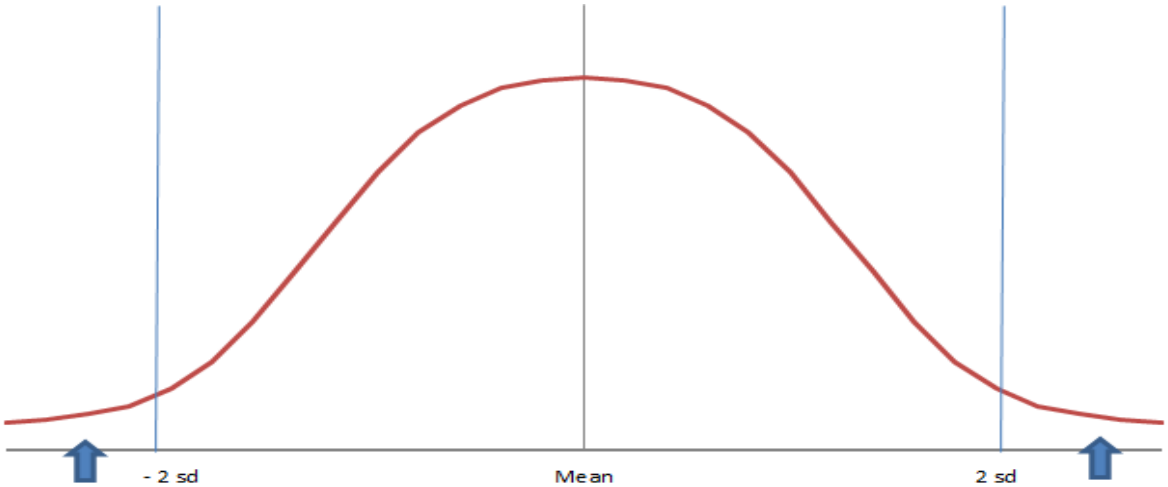
E.6 In Attachment E.6, **(limit two (2) pages)**, propose a mechanism by which IDD utilization can be tracked and reported for purposes of evaluating over and underutilization that supports the current quality management (QM) infrastructure, is consistent with waiver requirements and Medicaid rules and regulations, and does not unnecessarily add administrative burdens to the Provider Network.

As an integral partner within the Georgia Collaborative ASO, Delmarva Foundation has extensive, local experience improving the quality of support services for Georgia's citizens with IDD. In fact, they have been the trusted partner for DBHDD since 2008. Delmarva Foundation will use a statistical analysis of all claims to evaluate over- and under-utilization of services. This innovative approach will allow our team of analysts to identify outliers from both the individual and provider population that has never done before. Comparing utilization of these populations will identify patterns that can be changed through education and technical assistance.

The first step in this process will be to obtain the claims data for the services covered under the waiver. We will work with DBHDD to determine how frequently the analysis will need to be completed, which will dictate how frequently we would expect to refresh the data required for the analysis. It will also be critical to determine the degree to which historical data would be available to evaluate trends and variability that may be observed in the population. The more data available, the more powerful this analysis will be.

Once the data is obtained, we will load the data into a database and clean the data as necessary. The analysis will begin with the goal of identifying the outliers. The data will be analyzed for specific populations based on age, gender, race, services provided, funding source, and other variables of interest. The data will also be analyzed by the provider population. Both individuals and providers will be stratified by geographical location, whether it is statewide, regional, or even rural versus urban status. As an example, if we want to review provider utilization in Region 1 for Supported Employment, the data will be stratified and population means for utilization will be created. All providers in the region will be compared to the population mean for this specific service.

Providers with utilization rates that are two or more standard deviations away from the mean will be selected for further analysis and/or educational opportunities. This process will help determine if the provider is following all the rules and ensuring that services are being offered to individuals they serve. This analysis may also identify services that are being billed but never received, thus exposing potential for fraud. While there may be valid reasons or issues that may result in a provider falling into this target group, the lessons learned from these inquires will be built into meetings and training programs.



To ensure the most effective use of resources, we will provide additional educational opportunities and/or analysis of providers that exhibit outlier utilization rates.

An alternative method to evaluating over- and under-utilization is to work with Regional Offices to determine services that have been authorized and assess the number of claims that have been posted for those services. This technique requires a method for matching service authorizations to the claims. It is dependent on the accuracy of the service authorization process and the ability to link authorizations to the claims.

The statistics for this method will also be slightly different than described on the previous page. The number of claims submitted would be compared to the number authorized. The variability from the expected number of services would be evaluated. Providers with the highest level of variability would be selected for further analysis and educational opportunities. While this may not be as robust as the first method, it will validate the process of authorizing services and effectively identify the need for system improvement(s). Finally, besides a claims-driven identification process, we will leverage on-the-ground surveillance and respond to issues of underserved IDD individuals.

By relying on available data to initially screen for potential over- and under-utilization, we eliminate the administrative burden of a detailed audit for those providers who are not identified through the analysis. There would be no impact on providers unless the results of the analysis fall into the small population outside two standard deviations from the mean. These providers would be identified and referred to DBHDD for further investigation. Furthermore, we will use this information to provide technical assistance to these providers through the Follow Up with Technical Assistance (FUTAC) and Quality Enhancement Provider Review (QEPR) activities.

Our onsite review processes, Person-Centered Reviews (PCRs) and QEPRs are an additional mechanism to detect over- or under-utilization of services. These processes include review of documentation to validate claims, and match authorizations to services being received. For more vulnerable populations (i.e., ADA Settlement and individuals with dual diagnosis), this will be especially beneficial in identifying under-utilization of services which could directly affect their quality of life.

ATTACHMENT E.7

E.7 In Attachment E.7, **(limit four (4) pages)**, describe your specific UM/UR strategies for individuals with co-occurring BH disorders and IDD including:

a. Mechanisms to identify and flag (in the information system) individuals with co-occurring BH conditions and IDD.
b. Verification that Individualized Service Plans and plans of care address all of the services needed in light of the dual diagnoses.
c. UM/UR strategies implemented consistent with the requirements, rules, and regulations associated with the respective service funding sources.
d. Tracking of Provider experience successfully serving individuals with co-occurring disorders.

Approximately one-third of all individuals with IDD served by State DD agencies nationwide have dual behavioral health and IDD diagnoses. The co-existence of intellectual or developmental disabilities and a psychiatric disorder can have serious effects on the person's daily functioning by interfering with educational and vocational activities, by jeopardizing residential placements, and by disrupting family and peer relationships. Public funded programs are hard pressed to provide the levels of assistance, therapy, primary care, long-term medical oversight and individualized supports that people with these co-occurring conditions need to live, work, and thrive in the community.

The populations of people with co-occurring needs are heterogeneous and their support needs change over their lifetimes. Individuals with IDD and co-occurring behavioral health diagnoses require a flexible array of services to help them effectively reside in the community. The lack of behavioral health and primary care providers with the specialized training to diagnose and treat this population contributes to expensive and often unnecessary health care. The result is higher rates of repeated hospitalizations, problematic drug interactions and overuse of psychotropic medications. Individuals with co-occurring challenges should have services that are individualized and person-centered according to their needs and preferences.

A. – MECHANISMS TO IDENTIFY CO-OCCURRING CONDITIONS

The first step in implementing a program to better serve individuals with co-occurring behavioral health and IDD disorders is to establish a process to identify them. The most cost efficient process to identify and flag individuals with co-occurring behavioral health conditions and IDD is through registration/authorization and claims data analysis. We will take advantage of the diagnostic data captured during the registration/authorization process as well as the monthly Medicaid claims feed to identify individuals with an IDD diagnosis who also have one or more behavioral health diagnoses. However, behavioral health issues often go undiagnosed in this population. We will supplement this analysis by also studying pharmacy claims to identify IDD individuals who have been prescribed a psycho-active medication. Since many individuals with IDD have dual eligibility for both the Medicaid and Medicare programs, many of the medical and pharmacy claims for these individuals will not be captured in the monthly Medicaid claims

we receive. We will therefore supplement a claims-based identification process by instructing our chart auditors to identify and flag all individuals whose care plan indicates co-occurring behavioral health and IDD conditions during the PCR chart reviews. Finally, we will also conduct educational outreach to our behavioral health and IDD provider network requesting that they refer individuals with co-occurring conditions to our attention.

B. – VERIFICATION OF INDIVIDUALIZED SERVICE PLANS AND PLANS OF CARE

Most experts agree that treatment requires a comprehensive plan with several components. An interdisciplinary evaluation of the individual is necessary to obtain an accurate diagnosis and to establish habilitation and treatment needs. A thorough medical and neurological evaluation should be included to identify acute or chronic conditions that may need attention. A psychiatric evaluation can determine if medication is appropriate. Evaluation by a non-medical mental health practitioner can identify psychosocial intervention that can effectively meet the individual's needs. Once individuals are identified through the registration/authorization and Medicaid claims analysis, we will identify individuals within this population who have had multiple inpatient or emergency room visits to include in our PCR chart audit survey and potentially for our Intensive Case Management program to provide additional coordination and oversight of the plan of care.

The UM/UR process will look for the following:

- **Psychopharmacology Issues**: Medication treatment is appropriate for many psychiatric disorders (i.e., mood disorders and psychotic disorders). Medication treatment should not be a total treatment approach per se, but rather part of a comprehensive bio-psycho-social-developmental treatment approach. Many IDD individuals are prescribed psycho-active medication by a primary care provider without evidence of a thorough behavioral health assessment.
- **Behavioral Health Outpatient Therapy:** Auditors will check to determine if individual, group and/or family psychotherapy is included in the treatment plan. Other evidence that would indicate habilitation issues are being addressed would include skills training groups such as social skills, assertiveness, and anger management training.

C. – UM/UR STRATEGIES

Our UM/UR approach will focus on developing providers' abilities to offer appropriate, timely and low cost services for this specialty population. We will address the current inefficiencies of service delivery, which include individuals who are medicated for behavioral issues (non-psychiatric) and those individuals who are unnecessarily sent to the emergency room or hospitalized because they have not received timely, relevant services from knowledgeable providers. We propose to do this by offering technical assistance, guidance and training to our providers to better equip them to deliver appropriate care to this underserved population.

We will use information obtained through our UR program to guide providers towards proactive service planning and the most appropriate use of behavioral health and acute care resources. On the basis of this information sharing, providers will be able to identify individuals, families and

agencies that need training on emergency protocols, medications, or psychiatric illness so individuals are not unnecessarily sent to the emergency room. Practitioners can appropriately deploy non-pharmacological approaches (e.g., behavioral shaping, social skills, counseling) when indicated. We will work with providers to determine the educational needs of individuals, families and professional caregivers. We will work with discharge planners and providers to design appropriate after care. This concurrent planning will include developing criteria for the timely and seamless linkage of individuals to provider agencies offering stabilization services.

Results of our UR strategies will inform our UM approach, which will seek to avert unnecessary use of psycho-active medication and presentation to the emergency room, and promote appropriate use of limited and costly acute care resources. We will consult with providers to develop appropriate assessment protocols that ensure flexible provision of services based upon assessed need. We will work with providers to ensure their proficiency in the use of risk assessments (e.g., suicide, violent behavior, sexual offending) and provide tools for decision making in establishing prescribing patterns and developing non-pharmacological approaches, such as behavioral shaping strategies.

We will maintain a special caseload in our ICM program consisting of those individuals who are most at risk for hospitalization due to severity and chronicity of their mental health disorders. We will work with providers through concurrent planning and case review to ensure timely, efficient and appropriate level of services to this most at risk segment of the vulnerable population.

We will make training available that is culturally and linguistically appropriate using multiple formats for delivery. We will use a regularly conducted survey to jointly determine with providers how best to promote their competencies and training needs. We offer continuing education opportunities in the form of live trainings, webinars, printed material, and phone consultation. We will coordinate with relevant State professional and national organizations to make available state-of-the -art guidelines for best practice to providers. Our goals are to maintain a cadre of trained providers who can assist with the timely and efficient delivery of appropriate behavioral health services. To the extent that providers are aware of empirically supported approaches to prescribing and non-medical interventions, they will be in a better position to effectively use behavioral health resources for this special population.

D. – TRACKING OF PROVIDER EXPERIENCE

The primary goal is to avert unnecessary inpatient hospitalization or emergency room visits. IDD providers can look at the range of services delivered and delivery dates to determine if there were gaps in services or delay in provision of services that may have led to an emergency room or inpatient visits. It is also recommended that we identify clinicians who have been credentialed through the National Association for the Dually Diagnosed (NADD) and promote this as a standard in developing a network of clinical providers.

ATTACHMENT E.8

E.8 In Attachment E.8, **(two (2) pages plus report)**, describe the Offeror's experience in using reports to share information and inform UM/UR decisions and provide one example of a UM/UR report.

VALUEOPTIONS' MARYLAND VALUESELECT PROGRAM

ValueOptions created the ValueSelect Program by identifying inpatient service providers through reporting and data who demonstrate a strong, internal utilization management process. These providers are managing their inpatient care to maintain their historic average lengths of stay and keep readmission rates below the state average. Participation in this program decreases the administrative and clinical burden of frequent continued stay reviews. Once the medical necessity for admission has been met, these providers are allowed to ask for the number of days they feel they need to treat the individual successfully. Our Medical Directors and Clinical Care Managers regularly monitor and meet monthly with hospital Medical Directors and administrators to discuss whether or not the provider is maintaining average length of stay and readmission rates and to discuss complex cases. For those who cannot maintain this level of performance without increased assistance from ValueOptions, we discharge them from the ValueSelect program and increase the continued stay review frequency.

Facilities that have been designated by us for this program generally receive an initial block authorization for identified services if the individual meets medical necessity at the time of precertification. The number of days for the block authorization varies by individual need and is based on the individual's clinical condition, a Wellness Recovery Action Plan (WRAP®) or individualized treatment plan, and historical data, which indicates how the facility has been able to manage the stays within certain lengths of stay. Concurrent reviews are not necessary during the block authorization time frames.

We support transparency and sharing data with facilities to assist with their own practice management. ValueSelect program reports are regularly sent to the providers and reviewed together in telephonic or face-to-face meetings with the facility to monitor and discuss the data and/or any other issues which may affect the indicators. We have provided a sample ValueSelect program report starting on **page 159**. We are committed to helping the facility succeed and offer whatever resources are necessary to encourage the continued success of the partnership and the provider's enrollment in the ValueSelect program. If facilities have difficulties maintaining standards, we make every attempt to work with the facility to return to baseline, often providing them with additional specialized reports so that our partnership can continue. For example, if a hospital's recidivism rate is increasing, we will provide the facility with a detailed report of all readmissions so it can look for patterns triggering recidivism. Our experience with this type of program has been quite successful and has proven to benefit our key inpatient facilities/partners and other providers.

The following criteria are monitored for inclusion in the inpatient program noted above:

- Demonstrated history of collaboration with ValueOptions on treatment planning and coordination of care
- Policies and procedures that support individual inclusion in the discharge planning process, including development of a WRAP and crisis plan
- An agreement to contact ValueOptions for the purpose of discharge information on or before the day of discharge
- A minimum threshold number of individuals treated during the previous calendar year
- Facility meets HEDIS standards for discharge
- Facility maintains readmission rates lower than the community standard (a 30-day readmission rate that remains below the established measure)
- Facility or program is not currently on a corrective action plan related to participant complaints, adverse incidents or quality of care concerns
- Compliance with quality improvement audits

In Maryland, 17 hospitals, representing more than 40 percent of all admissions, are currently participating in the ValueSelect program. By decreasing the need for reviews with these programs, our inpatient ValueSelect program allows care management resources to focus additional coordination of care and discharge planning efforts on complex cases, individuals with high admission rates, and inpatient providers who are outliers in readmissions and/or lengths of stay.

QUALITY INCENTIVE PROGRAM

In 2012 and 2013, ValueOptions also developed and implemented a quality incentive program (QuIP) in Maryland. This program increased the Outpatient Mental Health Center's (OMHC) ownership of the overall Public Mental Health System utilization of their participants. Participating OMHCs had access to real-time reporting that identified which of their participants were hospitalized and in which hospitals. This enabled the OMHCs to coordinate care with the inpatient teams and decrease the duration of the admissions. OMHCs also had access to reports that identified which of their participants had visited emergency departments in the previous six months. This additional data gave outpatient providers unprecedented tools for practice management to help decrease unnecessary hospital admissions. The QuIP focuses on increasing participant engagement in OMHC community-based treatment and decreases the need for higher levels of care.

Even though no financial reward was available for those OMHCs that participated, when compared to ValueOptions' predictive model, the overall utilization of their participants decreased by $1.2 million. Through consistent feedback from ValueOptions, providers made process changes that maximized engagement of program-eligible individuals in effective and appropriate outpatient services thereby reducing the need for repetitive inpatient hospitalizations as well as the chances for condition deterioration.

BEST EVER HOSPITAL (54321)

Value Select Program (VSP)

All ValueOptions Service Centers

11/01/2011 - 11/30/2011

AVERAGE LENGTH OF STAY

	# of Members	# of Discharges	# of Days	Average Length of Stay	Year to Date ALOS	Year to Date Discharges	Previous 12 Month ALOS
Acute Inpatient							
MH	54	56	195	3.5	3.8	754	3.9

Service Center:	*CA:*	*CO:*	*CT:*	*FL:*	*GW:*	*IL:*	*MD:*	*MVP:*	*MI:*	*NC:*	*NY:*	*TN:*	*TY:*	*TX:*	*VA:*	*All Others:*
	0	*0*	*0*	*0*	*0*	*0*	*56*	0	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*

30 DAY RECIDIVISM

October 2011 *(one month lag)*

	# of Members	# of Discharges	Re-Admits in 30 Days	Current Rate	Year to Date Rate	Previous 12 Month Rate
Acute Inpatient/Residential						
MH	54	55	3	5.5%	14.5%	16.3%

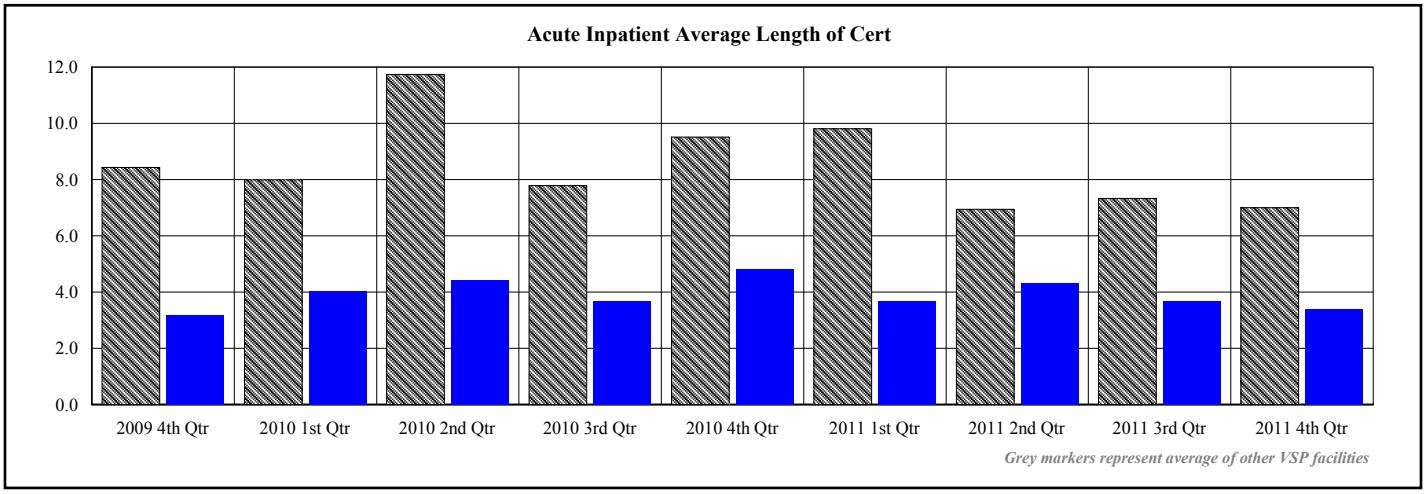
AVERAGE LENGTH OF CERT BY DIAGNOSIS CATEGORY

Acute Inpatient	# of Members	# of Discharges	# of Days	Average Length of Cert	Year to Date ALOC	Previous 12 Month ALOC
1. Adjustment Disorders	0	0	0	0.0	0.0	0.0
2. Anxiety and Stress Disorders	1	1	3	3.0	2.5	2.0
3. Delirium, Dementia, Amnestic and Other Cognitive Disorders	0	0	0	0.0	0.0	0.0
4. Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence	0	0	0	0.0	10.0	7.0
5. Dissociative, Somatoform and Factitious Disorders	0	0	0	0.0	0.0	0.0
6. Eating Disorders	0	0	0	0.0	0.0	0.0
7. Mental Disorders Due to a General Medical Condition not Elsewhere Classified	0	0	0	0.0	5.0	5.0
8. Mood Disorders	36	37	97	2.6	3.3	3.4
9. Other Conditions That May Be The Focus of Clinical Attention	0	0	0	0.0	0.0	0.0
10. Other Mental Disorders	11	11	68	6.2	4.0	3.8
11. Personality Disorders	0	0	0	0.0	0.0	0.0
12. Schizophrenia and Other Psychotic Disorders	7	7	27	3.9	8.1	8.8
13. Substance Related Disorders	0	0	0	0.0	4.5	7.3
14. Other Diagnosis not Categorized	0	0	0	0.0	0.0	0.0
Totals	54	56	195	3.5	3.8	3.9

AVERAGE LENGTH OF CERT BY AGE CATEGORY

Acute Inpatient	# of Members	# of Discharges	# of Days	Average Length of Cert	Year to Date ALOC	Previous 12 Month ALOC
1. Children Ages 0 - 12	1	1	5	5.0	4.0	3.8
2. Adolescents Ages 13 - 17	3	3	8	2.7	3.1	3.1
3. Adults Ages 18 - 64	49	51	179	3.5	3.9	3.9
4. Geriatrics Ages 65 and over	1	1	3	3.0	3.3	3.5

ALOC TRENDING - ROLLING 8 QUARTERS



ATTACHMENT E.9

E.9 In Attachment E.9, **(four (4) pages)**, describe the Offeror's process for making authorization and concurrent review determinations for crisis stabilization, medical detox, and inpatient services. Describe the tools you will use, and the mechanism by which you will request and receive additional information from Providers.

As the ASO, we will implement a 24 hours a day, seven days a week prior authorization process that will effectively manage crisis stabilization, inpatient and medical detoxification services. We anticipate most of the requests for admission will likely come through emergency rooms, some will come from providers, and some could present directly to the few hospitals that are designated as emergency receiving facilities. The delay of care resulting in the boarding of some individuals in unsafe emergency rooms is a growing concern of the Georgia Hospital Association. Thus, our primary objective is to facilitate rapid disposition and transfer to the most appropriate level of care. As a result, our program will form the "connective tissue" between the referring provider or emergency room and the receiving inpatient, CSU, or detox facility.

Additionally, with our partner, BHL, as the hub for all urgent and emergent situations, we will offer real-time insight and reporting on the demand for inpatient, CSU, and medical detox services contrasted with the bed capacity in any given region. Our comprehensive UM/UR program will not just validate clinical needs of each individual, but will oversee the efficient use of bed capacity at the system level. Similar through-put measures used for non-intensive services will be employed for these crisis services. Bed occupancy rates, time to clinical acceptance, length of stay, and readmission rates will all form KPIs for inpatient, CSUs and medical detox providers. Community providers will be measured on success of ACT, ICM, and Case Management teams at diverting emergency room, inpatient, CSU, and medical detox admissions. They will also be measured based on their capacity to accept urgent referrals; engagement rates of individuals post discharge of an emergency room, inpatient or CSU stay; and hospitalization/readmission rates of individuals under their care. By creating alignment between the objectives of inpatient, CSU, medical detox units, and community providers, we will expect to see more diversion of these crisis admissions. Consequently, for those who cannot be diverted, there will be a reduction in the delay of care leading to quicker transfers out of emergency rooms.

At the individual level, our GCAL partner, BHL, will act as the "front door" by either intervening directly with the individual in crisis or with the provider/emergency room contacting BHL on behalf of the individual. GCAL clinical staff will work closely with providers to authorize admissions and facilitate access to the needed crisis services. As intensively managed levels of care, CSU, medical detox and inpatient service requests will be hands-on, real-time reviews managed by the collection and review of assessment information resulting in a final disposition decision.

However, by integrating claims/encounter data that provides a view into service history, previous authorization data that provides clinical information, and access history of the GCAL, a new paradigm is created resulting in better informed decision making.

All authorizations and concurrent reviews for acute care services, including DBHDD-contracted inpatient psychiatric services, crisis stabilization services and medically monitored inpatient detoxification, are performed by master's level clinicians or RNs (under supervision of an MD) trained to manage these most intensive levels of care. This team will render a prior authorization decision within 30 minutes of receipt of a Web-based request and/or within 30 minutes of conducting a telephonic intensive behavioral health services prior authorization review when the Clinical Care Manger determines that the individual meets LOC and admission criteria. Working within our structured CONNECTS system process, the clinician will obtain assessment information, including: current precipitant and nature of the crisis; the level of risk to self or others; clinical impairments; health concerns; substance use history; medication; treatment history, including prior crisis services, high risk behaviors and current providers; and other community agency involvement, including legal and social services.

With the authorization history access, the clinician will be able to determine recent recorded crisis treatment and potentially have access to the individual's crisis management plan. This comprehensive information will allow the clinician to recognize the individual's available supports while making a holistic assessment of the most appropriate disposition. The clinician will ensure that "individuals receive the most appropriate, least restrictive and most cost-effective recovery-oriented treatments and supports" while making a medical necessity decision based on the clinical criteria embedded in the Georgia Community Based Provider Manual service definitions. These criteria include LOCUS, CAFAS or ASAM scores as a part of the guidelines for level of care determination. If the individual does not meet the criteria for inpatient, CSU, or medical detox, a Peer Review will be conducted and a decision will be rendered within 120 minutes of the initiation of the Peer Review process.

REVIEW PROCESS

As the clinician assesses the clinical information provided, whether a result of an individual crisis call or a provider working to access services on the individual's behalf, consideration of the appropriateness of diversion to community services over inpatient acute care will always be assessed. Specifically, the appropriateness of mobile crisis (MCT) intervention will be considered to de-escalate the current crisis and initiate other community-based services as needed. For clinically appropriate scenarios, the MCT will be contacted and dispatched by the GCAL team to assist with de-escalating the situation. In other situations, other first responders, including community providers known to the individual, may be contacted to activate the crisis plan and work with the individual to de-escalate the situation. When an admission is medically necessary, GCAL's role as the hub of crisis management coordination means having ready access to bed availability at contracted facilities. The GCAL clinician will serve as a conduit between the community and the facility as all involved work to have the individual receive the right service at the right time.

There are multiple types of resources available to individuals or community providers contacting GCAL. In cases where there is an alternative lower level of care that meets the needs of the individual, we will recommend this to the provider requesting admission and will give names and contact information for possible Assertive Community Treatment or other community treatment alternatives. An authorization for the service will be offered at the same time, ensuring "no wrong door" for providers and the individuals served. If the individual is identified as a high utilizer, often an indication of a lack of coordination and consistency in care planning or care plan execution, we will refer the individual to our Intensive Care Management program for more intensive coordination assistance and mobilize our Peer Specialist to assist as appropriate and indicated.

The ASO offers a flexible process with the aim of simplifying and minimizing the administrative efforts for providers. For some providers, efficiency will mean requests for crisis services being submitted electronically. Clinical staff will perform focused reviews prior to all inpatient psychiatric admissions. The majority of these reviews are performed with live telephonic interview. Regardless of the method of communicating the request, we will provide a prior authorization decision within 30 minutes of receiving sufficient information to make an intensive clinical review decision. If a request is Web-based, the clinician may call the provider submitting the request to gather additional needed information, establish the current safety of the individual and discuss the appropriateness of alternative community resources. Once an admission to a clinically appropriate level of care has been authorized, staff will communicate the authorization information and needed follow-up instructions to the requestor to facilitate efficient and safe transition to the service/facility authorized. With access to resource information as the hub of crisis management coordination, the GCAL clinician will have ready access to bed or detox center availability and can serve as a conduit between the community and the facility as all involved work to have the individual receive the right service at the right time, with authorization in hand.

CONCURRENT REVIEWS

If an individual requires stabilization beyond the initial authorization for crisis services, the provider may either submit a request electronically or complete a telephonic review to provide the information supporting continued treatment. At the time of the concurrent review, our Clinical Care Managers ensure:

- Continued service eligibility based on medical necessity criteria embedded in the DBHDD Community Provider Service Manual service definitions. Consideration of the presence of co-occurring disorders, culturally relevant factors, and the quality and availability of existing or potential community supports
- Service effectiveness based on clinical improvement and progress toward goals
- Response to medications
- Early initiation of aftercare planning; discharge planning should begin on admission
- Evaluation of the need for a Community Transition Specialist to ensure connection to on-going community treatment and support, both traditional and non-traditional

Individual treatment and rehabilitation plans are reviewed with the provider during the review process. At each review, the provider is expected to give an updated treatment plan noting changes in symptoms, risks, needs, medications, discharge planning, and the individual's own active treatment goals. Our Clinical Care Managers work with individuals and providers on addressing issues and tracking progress toward goals over time. As our clinicians shape care through clinical consultation, our commitment to engaging people in the development of their own aftercare treatment plans will be apparent. We will work with providers and individuals to support and encourage their engagement.

For individuals with multiple recent admissions, Clinical Care Managers will discuss options of alternative treatment and aftercare plans to the inpatient team, ensuring ineffective plans are changed and barriers to continued recovery are addressed. Our Clinical Care Managers often provide quick and useful information from previous hospitalizations documented in the CONNECTS system, which is valuable for treatment, aftercare planning and coordination of care. For example, when our Clinical Care Manager knows that an individual reacted poorly to a medication previously tried in another hospital, we will inform the current provider and minimize the risk of potentially harmful effects to the individual, as well as costly additional hospital days.

Through the concurrent review process, Clinical Care Managers also identify complex cases, outlier lengths of stay and recidivism. These situations receive additional support via referral to ICM, peer services, and psychiatric consultation from our Medical Affairs department. Peer-to-peer consultations often focus on discussions regarding medications and alternative treatment options.

ValueOptions works with providers and individuals in the course of our contacts to gain a mutual understanding of the authorization process, levels of care supported by the information provided and treatment recommendations. When services are requested that cannot be authorized because the information provided does not support medical necessity of the service request, the case will be referred for Peer Review. For inpatient psychiatric services, CSUs and medically supervised detox services requests, an offer of an appointment for a peer review will be offered within 60 minutes of the decision to pend the request for second level review. Our Peer Advisor will be either an M.D. or a Ph.D.-level psychologist and will complete the peer review process within 120 minutes of the initiation of the peer review process. In cases where the provider chooses not to provide a representative for the Peer Review, a Peer Clinical review consisting of a review of all information submitted supporting the service request will be completed and the decision rendered within the same time frame. If an adverse decision is rendered, the decision will be communicated to the provider and the individual. Along with the notification, the individual will be informed of her or her appeal rights.

ATTACHMENT E.10

E.10 In Attachment E.10, **(four (4) pages)**, describe the Offeror's process for making authorization and concurrent review determinations for non-intensive BH services in the web-based system. Describe proposed tools, protocols, programming logic, and algorithms to guide individualized authorization that builds on and enhances current service package approach to authorization (See Appendix 6).

WEB-BASED SYSTEM

Our highly customized and flexible applications allow for auto-authorization when guidelines are met, pending authorization requests for care manager review when a potential concern is pinpointed, and allowing for system-generated messages when additional information is required. This logic is designed to identify when there is incongruence between the needs of the individual and the services requested to meet those needs. This new service will occur as a result of the provider selecting a reportable field that indicates the status of each goal in conjunction with a target date. Reviews are triggered when target dates are expired or when goals are not met over multiple authorization periods. Finally, based on provider profiling and utilization trends, we have the capability of pending an authorization request by provider, by a specific service or by the individual served.

Our integrated approach to utilization management for bundled service packages ensures the right treatment in the most appropriate treatment setting; reduces the administrative burden that providers currently face; and provides meaningful, actionable outcomes data back to providers, DBHDD/DCH and other State stakeholders. This powerful combination of comprehensive assessments, bundled service authorizations based on the LOCUS and performance outcomes will build on the work started in Georgia and enhance current service packages available for individuals accessing the behavioral health and IDD system of care. This strategy fosters enhanced coordination among behavioral health providers, primary care providers, inpatient and residential services, and State agencies. Moreover, we deliver on our mission to promote recovery and resiliency and a program designed to facilitate and promote individual independence in the community by providing services and supports that are preventive, accessible and comprehensive.

SERVICE PACKAGE AUTHORIZATION

Based on an analysis of reporting produced by the current ERO vendor, as many as 30 percent of individuals accessing care receive ***three services or less over an entire year*.** Based on this analysis, we can conclude that individuals either received the help they needed or they were not fully engaged and dropped out of care. However, under the current authorization model, both scenarios contribute significantly to the administrative burden of providers who have to submit a Registration MICP followed by an encounter or claim submission in order to obtain reimbursement. To enhance the current service package approach to authorization while decreasing provider burden, we propose to streamline the authorization process with the payoff being more provider resources dedicated to serving individuals as opposed to serving an overly

burdensome administrative process. With DCH and DBHDD approval, this streamlined approach would waive the need for an authorization required for payment for what we would identify as **"*Essential Engagement Services*."** These services could consist of:

- Addictive Disease Support Services
- Case Management
- Diagnostic Assessment
- Peer Supports (Individual)
- Behavioral Health Assessment
- Crisis Intervention
- Nursing Services
- Service Plan Development

ValueOptions recognizes the importance of collecting demographic data necessary for block grant reporting and of course we are equally interested in analyzing who presents for services and that they meet the DHBDD core consumer criteria. But rather than requiring an authorization for reimbursement for these ***Essential Engagement Services*** for each new admission (a process which is viewed by providers as disruptive to the intake workflow), we seek to create a non-intrusive method of uploading registration information and required data at weekly or monthly intervals. Furthermore, to ensure accurate reporting, we will retrospectively reconcile claims/encounters with the records received in the provider file upload. Utilization management for these engagement services would occur retrospectively via a thorough review of claims/encounters with special attention to outliers that would be reviewed in on-site audits. We are eager to discuss this approach and the best mix of services, or ***Essential Engagement Services***, with DBHDD.

The need for authorization would occur only after these ***Essential Engagement Services*** are delivered, resulting in a fully developed service plan or within 30 days of presentation. At that point, following a review of the LOCUS score, service plan, diagnosis, and other clinical indicators, ValueOptions proposes to issue authorization for the following non-intensive services for a three to nine-month period:

- Psychiatric Treatment
- Medication Administration
- Psychosocial Rehabilitation – Individual (PSR-I)
- Group Outpatient Services (Counseling and Training
- Community Transition Planning (CTP)
- Peer Support Whole Health and Wellness
- Supported Employment
- Psychological Testing
- Community Support – Individual "CSI"
- Individual Outpatient Services (Counseling and Training)
- Family Outpatient Services (Counseling and Training)
- Legal Skills/Competency Training
- Substance Abuse Intensive Outpatient
- Task Oriented Rehabilitation (TORS)

Intensive services would continue to be authorized at the same intervals with pended requests requiring submission of the service plan and clinical consultation occurring as needed. As indicated in our response to the QM section of this proposal, the onsite audits will provide an additional feedback loop as to the validity of attempts and progress achieved toward these outcomes.

Authorization Tools

Our clinical care management application, CareConnect, is a feature-rich, secure, Web-based system designed to reduce the administrative burden imposed on providers and Clinical Care Managers by providing a single integrated platform to gather objective clinical data and perform efficient utilization management. This system will be based on the Georgia Service Class Grid and LOCUS. The result is a system that will allow Clinical Care Managers and providers to concentrate on behavioral health, IDD and other needs of individuals rather than paperwork. The system is flexible and adjusts as provider types, individual eligibility and other business rules change. Finally, in an effort to innovate and ensure a smooth implementation and transition, we will be working with Qualifacts and the CSB providers using their electronic medical record to pilot a new process of streamlined information sharing. Qualifacts CareLogic Enterprise EHR platform is currently used by more than 30 behavioral health providers including 15 CSBs across Georgia. Since 2008, CareLogic has supported a tight integration with MICP functionality. We will work with Qualifacts to ensure a seamless transition from the State's existing system to our CONNECTS platform. Through this relationship, we will deliver an improved provider workflow that minimizes inefficiency and eliminates duplicate data entry. Qualifacts will also streamline the testing and validation process, saving CareLogic customers hundreds of hours of valuable staff time.

Our CONNECTS platform incorporates core clinical components and highly configurable triage rules necessary to process incoming authorization requests. Required clinical elements are consistent for comparable services (e.g., inpatient and residential treatment center), but criteria for endorsement is specific to each level of care. When critical clinical information is missing, automated requests for additional information are forwarded to the provider for completion via the ProviderConnect application. Requests with complete clinical information are processed against triage guidelines and those that meet all required parameters receive automated approvals for specific identified levels of care as approved by DBHDD. Requests indicating the need for additional clinical review are directed to the appropriate Clinical Care Manager for processing.

The Registration Process

To register an individual, the provider enters the individual's specific demographic and clinical information within the online Consumer Registration Module or batch submission. This automatically generates a list of appropriate and approved DBHDD programs for which the individual may be registered (both Medicaid and State-funded programs). The online Consumer Registration Module includes a provider authentication process that filters the list of available programs down to only those for which the provider is contracted. The provider can then select the programs most appropriate for the individual.

Because the entire process is housed within our fully integrated CONNECTS system, data entered into the system flows throughout the entire platform. Individual plans (i.e., care and service plans) are embedded within our system with a summary of the individual's health history; a list of concerns, goals, and strengths; the plan for addressing those concerns or goals; the person(s) responsible for interventions; and the due date for the intervention. This gives providers and coordinators a holistic view of the individual enabling treatment providers to target

interventions that have worked, and change those that have not. This roadmap improves the individual's ability to self-manage their symptoms and lifestyle choices. Once the care/service plan has been implemented, we will regularly evaluate it. This process helps to ensure that the care and/or service plan remains appropriate for the individual's needs and reflects progress, barriers, new priorities, and changing health status. Other programmatic logic resulting in pended authorization requests will include, but is not limited to:

- Use of any of the data points collected and identified in our response to *Section E.2* to improve clinical and quality of life outcomes
- Validation of LOCUS score with the requested level of care to ensure appropriateness
- Diagnostic exclusions (e.g., lack of a SPMI diagnosis for ACT)
- Providers of concern based on specific audit results generated from on-site reviews
- Specific services having excessive utilization or recently modified requirements
- Excessive length of time in a particular level of care (e.g., numerous authorizations such as PSR for two 365-day authorizations and a request for additional services)
- Individuals with a dual diagnosis of IDD and mental health
- Lack of goal attainment based on the provider interventions listed in the service plan over an extended period of time for the level of care

ATTACHMENT E.11

E.11 In Attachment E.11, **(two (2) pages)**, describe how the Offeror's clinical team will incorporate principles of recovery for adults and resilience for children into the clinical review process.

The clinical philosophy of ValueOptions is grounded in the provision of an understanding, compassionate environment in which the unique clinical and social needs of each individual are addressed in the context of hope, recovery, resiliency, and independence. ValueOptions' mission is to help individuals live their lives to their fullest potential. This mission and the values and operational processes that support it are in absolute alignment with the American with Disabilities Act's cornerstone legislation that has illuminated the path to social inclusion for all.

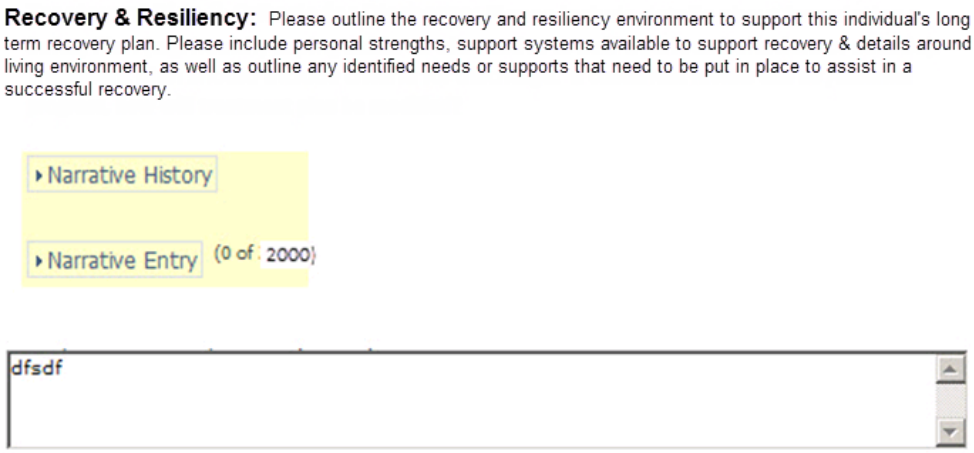
We believe that all individuals deserve access to safe, affordable housing in a community of their choosing; meaningful activity during the day; a sense of security and independence; participation and acceptance based on their unique strengths, attributes and talents. Whether it is recovery from a psychiatric or emotional disorder or social inclusion resulting from a physical or developmental impairment, individuals want and deserve the respect afforded people of all walks of life.

We fully incorporate and are in alignment with the principles of recovery for adults and resilience for children in all our programs. We are well aware of the formative role Georgia organizations have played in developing and promulgating these principles. As defined by Georgians, recovery is a deeply personal, unique, and self-determined journey through which an individual strives to reach his or her full potential. Persons in recovery improve their health and wellbeing by taking responsibility in pursuing a fulfilling and contributing life while embracing the difficulties one has faced. ValueOptions reached out to both the Georgia Mental Health Consumer Network (GMHCN) and the Georgia Council on Developmental Disabilities (GCDD) to ensure our approach is aligned with the latest developments in Georgia. As an organization that is singularly focused on the emotional wellbeing of the individuals we serve across the country, we know that services and supports must be person-centered, responsive to individual needs and capable of tapping into local sources of support. We look forward to working with individuals, advocates and stakeholders across the state of Georgia to further operationalize the promises inherent in a person-centered, recovery and resiliency-oriented system of care.

OPERATIONALIZING THE PRINCIPLES OF RECOVERY AND RESILIENCY

As managers of the behavioral health benefits of 32 million people across the country, we are acutely aware of our responsibility to afford every opportunity for individuals to achieve optimal health outcomes. We are committed to supporting individuals in becoming responsible and active participants in their treatment. Our Director of Advocacy and Recovery will play a key role in setting our recovery and resiliency policies and working with the program's quality improvement council and consumer rights subcommittee to ensure they are enacted and adapted based upon feedback from the individuals we serve, their families and other community stakeholders.

Our regional staff will work with state hospitals, contracted inpatient facilities, and crisis stabilization units to implement a discharge process that collects information on the strengths of the individual that could be leveraged toward the attainment of recovery goals. This will be entered as a free text in our care management platform as noted below.



Our discharge planning process will ascertain if the individual has had contact with a peer. We are aware that many agencies employ Certified Peer Specialists but that engagement can be sporadic. Each of our regional teams will include a Certified Peer Specialist to provide "hands on" support, as well as a Community Transition Specialist to add in care transitions. These peers will reach out to all recently discharged individuals to assist in their transition, support them to adhere to any follow-up appointments, and help them leverage their own strengths. We will also work with each individual in transition to ensure he or she has a crisis prevention plan that is created by the individual with support from the provider. This plan will outline resources, contact information and strategies to help the person work through a potential crisis. Rather than being a passive participant, they become "activated" and more fully engaged in their care and care decisions. Finally, as part of the UM process, we will validate that the individual was involved in their care plan as evidenced by their signature on the plan.

ATTACHMENT F.1

F.1 In Attachment F.1, **(limit two (2) pages)**, describe the Offeror's process for ensuring that PASRR level 2 screens are conducted consistently with federal and State requirements and recommendations regarding placement and that specialized services are appropriately referred back to the State. Describe the Offeror's proposed staffing and qualifications for PASRR level 2 screens.

The Preadmission Screening and Resident Review (PASRR) process is a critical component of a person-centered rehabilitative system of care. PASRR was designed to ensure that individuals are not admitted to or retained in nursing facilities when there are more beneficial alternatives. We will implement a PASRR level 2 review process to determine whether placement or continued stay in the requested or current nursing facility is appropriate. In addition, we will enumerate the mental illness or IDD services the individual needs, including services the nursing facility can provide under its per diem and services that must be arranged separately. The goal of our review process will be to confirm whether the applicant has a behavioral health disorder and/or IDD, assess the applicant's need for nursing facility service and identify any required specialized or rehabilitative services. Our PASRR process will be approved by our Consumers' Rights Subcommittee and reviewed on an annual basis.

CONDUCTING LEVEL 2 PASRR EVALUATIONS

We will establish a link to Alliant GMCF to receive notification that a PASRR level 2 review is required. Our Engagement Center staff will be available for receiving referrals during normal business hours (Monday through Friday, 8:30 a.m. to 5:00 p.m. EST) with the exception of official legal holidays. Once notified, we will conduct PASRR level 2 reviews in compliance with all federal regulations within 48 hours of the date the referral is transmitted.

All notifications received from Alliant GMCF will flow through a PASRR-dedicated clinical support specialist located in our Atlanta office. The specialist will be responsible for logging the request into our system, requesting medical records from the provider and assigning the review to a trained clinician. Our Regional Network Teams will include staff licensed and credentialed in Georgia and trained to conduct the face-to-face PASRR reviews. One trained clinician in each region will be assigned the primary responsibility to ensure each review is conducted in a timely manner. We will also cross-train other regional clinicians to ensure sufficient resources to cover simultaneous requests and allow us to quickly complete multiple reviews.

All reviews will be scheduled and conducted during reasonable hours that accommodate the needs of the individual, family members, and facility staff. We will successfully complete the review and notify Alliant GMCF, the individual or legal representative, the referring hospital (if applicable), and the nursing faculty (once admission has occurred) in writing of all evaluation outcomes, including when halted, deferred or approved without specialized services within the time period specified by DBHDD. Our process will include:

- Completing a psychological and functional evaluations when not available or current
- Finalizing a written report, reviewed by a Georgia licensed psychiatrist

- Assessing intellectual capacity and producing a psychological evaluation that is signed or counter-signed by a licensed psychologist for individuals with IDD
- Conducting a functional evaluation on all individuals assessed. For individuals with mental illness, the functional evaluation will be performed by a qualified mental health professional. For individuals with IDD or a related condition, a licensed psychologist or a qualified IDD professional with functional evaluation experience or training will perform this evaluation.
- Obtaining all relevant medical records and any other pertinent information necessary to complete the evaluation from either the applicant, attending physician, hospital, family members, or other appropriate entities
- Ensuring all assessments/evaluations are adapted to the cultural background, language, ethnicity, and means of communication used by the individual being evaluated

Resident Status Reviews will be conducted if an individual undergoes a significant change in status while residing in a nursing facility. The listed process will be used for the review. Individuals whose functional evaluation indicates they would be more appropriately served in the community will be referred to one of our Community Transitional Specialists to develop a plan of care linking them to community resources and social support agencies.

INFRASTRUCTURE TO SUPPORT EVALUATION PROCESSES

PASRR staff will be available to provide training and technical assistance to nursing facility staff and nursing home associations on procedures to be followed in the PASRR level 2 process.

We will recruit, train and retain a sufficient number of registered nurses, licensed psychologists, physicians, and qualified behavioral health and IDD professionals (assessors) who are licensed and credentialed in Georgia. We will maintain complete documentation verifying each assessor's qualifications and training, including the results of a criminal records check for all staff having direct contact with nursing facility residents. All PASRR related activity will be supported by a quality assurance and improvement process that addresses, at a minimum, clinical training and competency issues, including physician oversight, frequency and type of supervision, agency timeliness related to PASRR performance requirements, and peer review. We will ensure that minimum requirements for conducting preadmission screening and resident reviews for content, timeliness and signatures are met.

We will maintain an electronic and data interface capability necessary to exchange electronic reports with Alliant GMCF, DCH's Division of Medicaid and its rehabilitative services providers, and with DBHDD. System security safeguards will be in place to ensure the confidentiality of all data collected through the evaluation process. These safeguards will comply with applicable Federal and State laws (e.g., HIPAA).

Our PASRR Team Lead will be responsible for generating all reports required by DBHDD, DCH, or CMS, including any formal reports detailing quality assurance and improvement activities, the annual report and any ad hoc reports. All documentation of our PASRR assessment activities will be retained for seven years, including a complete hard copy of all evaluation documentation and final reports.

ATTACHMENT G.1

G.1 In Attachment G.1, **(limit two (2) pages)**, consistent with the requirements of the RFP, describe the Complaint process under which Individual and Provider Complaints regarding the Offeror would be addressed. Describe the assistance that will be provided to Individuals and Providers in completing the procedural steps in the Complaint process. Address the education materials that will explain the Complaint process.

We will develop and implement internal policies and practices to quickly and effectively respond to complaints and grievances regarding our program operations and activities. Our policies and practices will be designed to be transparent and understandable to individuals served, providers and other stakeholders; timely in resolution; and accurate in tracking and reporting. The goal of our process is to ensure that any concerns regarding the operational processes or actions of the ASO are addressed and quickly resolved. We acknowledge that DCH is the responsible authority for all Medicaid grievances and will provide a supportive role in Medicaid grievance processes related to the functions of this contract.

COMPLAINT AND/OR GRIEVANCE PROCESS

We will process, investigate, resolve, and track complaints using DBHDD-approved policies and procedures. An individual, family member, advocate, provider or any individual designated by the complainant can file a grievance/complaint on the individual's behalf. In instances where an individual has disabilities to the degree where they have been assigned a personal representative or guardian, we will ensure all notices of rights and release of information paperwork are available and completed before proceeding. These activities may postpone the filing but will ensure that the individual's rights are not violated in any way. For individuals with a substance use disorder diagnosis, a 42 CFR Part 2-compliant release form will be obtained.

Individuals may file complaints verbally or in writing to ValueOptions, our Consumer Rights Subcommittee for PASRR and GCAL related complaints, to IDD Human Rights Council for individuals with developmental disabilities, or directly to Constituent Services at DBHDD and/or the Regional Offices. Grievances generated through any of these doors will result in a full investigation. Medicaid-eligible individuals may also make a formal request for a Fair Hearing if the individual feels that rules, regulations, and/or laws have not been followed in the course of eligibility determination and/or service delivery.

ENSURING INDIVIDUALS AND FAMILIES KNOW THEIR RIGHTS

Empowerment is the result of education and communication. As such, we will provide information on individual rights through a variety of mechanisms. Individuals' rights will be communicated clearly as outlined in the "Guide to Services" and reinforced through provider interactions before services are rendered and during the course of treatment and support. Because of the direct service nature of the PASRR and GCAL lines of business, we will appoint a Consumers' Rights Subcommittee to review the rights of the individuals receiving services

from these programs. Individual's rights are reviewed at the Consumer Rights Subcommittee to ensure that processes continue to protect individuals receiving service through the ASO.

Educational Materials and Guidance

In addition, our Grievance Coordinator will provide rights education to individuals, such as their right to a Fair Hearing, and assist them throughout the process. We will also post information on our website to remind individuals about the rights and remedies available to them if they believe their rights have been violated, including filing a grievance and being helped to file it. All our customer service staff receive training on our policies and procedures for responding quickly to any complaint about our services and will encourage and assist individuals who are not satisfied with our services to file a complaint or grievance.

GUIDELINES FOR INVESTIGATING AND RESOLVING A GRIEVANCE

The guidelines for investigation and resolving grievances include:

- Ensuring that all paperwork (e.g., Designated Client Representative form, Release of Information) is complete and signed before proceeding with the grievance
- Sending the complainant a DBHDD-approved letter acknowledging receipt of the grievance within five calendar days (or other timeframe approved by DBHDD) of getting the grievance
- Taking the necessary time to do a full investigation of the grievance up to 30 days or DBHDD-approved timeframe. If a full investigation cannot be done, the Grievance Coordinator will request an extension up to 14 days if it is in the individual's best interest.
- Consulting with staff who have the appropriate expertise before deciding on a resolution
- Referring grievances of a clinical nature to a clinician with the appropriate clinical expertise
- Referring grievances that result from a quality of care issue to DBHDD

When the Grievance Coordinator has collected all information, talked to all involved parties, consulted with clinical or other staff, and referenced any relevant contract or regulatory issues, he or she will make a determination. The Grievance Coordinator will send a resolution letter using a template approved by DBHDD that includes details of the investigation, how the resolution was determined, and the individual's right to a Fair Hearing if they are not satisfied with the results of the investigation. It will also include any staff the Grievance Coordinator consulted with and their credentials. In all cases, the Grievance Coordinator will recuse him or herself if there is a conflict of interest. For example, if the grievance is about the advocate or if the individual and Grievance Coordinator have a relationship outside of the issue (e.g., they work together in peer training).

COLLECTING, TRACKING AND MONITORING GRIEVANCES AND COMPLAINTS

To facilitate the efficient collection, tracking and monitoring of grievances and complaints, we will use our grievance database. The database is used to create reports and monitor trends, both individual and systematic, and capture historical data to ensure that the most accurate information is available during the investigation and resolution of a grievance. It allows for the creation of aggregate reports for committees, such as the Quality Management Committee and the Consumer Rights Subcommittee.

ATTACHMENT H.1

H.1 In Attachment H.1, **(limit four (4) pages)**, propose a methodology for Georgia based on previous practice that effectively facilitates the inpatient/institutional care coordination, discharge, and transition planning processes, when the Offeror is not the service provider. Provide one (1) example for BH. Describe the barriers to effective discharge and transition planning, and the strategies employed, and the results.

ValueOptions deploys a "whole-person" philosophy of care management that assists individuals in integrating all health care and recovery goals. Clinical Care Managers work with providers to ensure individuals develop a person-centered care plan that addresses needs and establishes goals, such as those related to behavioral and physical health, housing, employment, family engagement, and peer support. We collaborate with numerous State, local and community organizations as described in our response to *Section H.2* to meet the needs of individuals.

We provide a tailored triage and needs assessment appropriate to the individual's presenting issues at each point of entry into the behavioral health system.

Above all, effective care coordination, especially transition planning, relies on engaging individuals with their own health management process and recovery, encompassing all of their behavioral, physical health and social needs. We know that individuals are more likely to access services and remain engaged in treatment when they feel their priority needs are understood and being addressed and met. Since we are not the service provider, our principal role is to effectively broker services and supports for the individual transitioning from an inpatient/institutional setting through a four-step approach.

1. Our involvement is initiated when the individual, emergency room or provider accesses inpatient/CSU level of care via the GCAL (or mobile crisis team) that will house valuable information about the individual such as previous call, appointment, and no-show history; history of services received extracted from encounters and claims; and other valuable clinical information such as crisis safety plans and data obtained from previous authorization requests. By consolidating all of this information and utilizing it at the point of crisis, we will be able to guide care decisions resulting in improved care coordination between the referring ER/provider and the receiving inpatient/CSU facility.
2. In addition to facilitating access to an inpatient/CSU bed, our GCAL staff will issue the initial authorization for this level of care. Through the concurrent authorization process, we will affirm that discharge planning begins at admission and we will track the progress of the individual through the duration of the inpatient/CSU stay. By gaining an understanding of which interventions successfully led to the stabilization of the individual, we will be better equipped to facilitate the similar interventions upon discharge.
3. Our intensive care management process, described below, is most effective when we are involved in the discharge plan of the individual in the following manner: the discharging inpatient/CSU unit will access our GCAL discharge and appointment module to schedule an

appointment with a community provider within seven days of discharge and complete the discharge screens on the Web portal. We also will explore utilizing the Georgia Mental Health Network Warm Line for discharged individuals to receive peer support as they transition from an inpatient level of care. We will also offer our own care transition staff to ensure the engagement of the individual with their community provider.

4. The key performance indicators, embedded in our QM plan and exhibited in provider profiles, will serve as powerful reinforcements as we monitor and measure provider and institution success at engaging discharged individuals, wait times to appointments for medication, and hospital/CSU readmission rates. Perhaps, the most important indicator of an effective UM/UR program is that inpatient/CSU aftercare capacity is created to serve the most in need at their most vulnerable point. Thus, our highly integrated approach will make these transitions from an inpatient/CSU level of care a paramount goal.

INTENSIVE CARE MANAGEMENT (ICM) PROGRAM

Our ICM program is a component of our overall UM program and is built around proven systems and solutions that include our integrated technology platform clinical protocols. For those individual's identified as most at risk, our ICM program facilitates the development of a comprehensive person-centric and recovery-based treatment plan ensuring a smooth transition for those who are moving between levels of care. It also provides focused coordination of services across service systems and providers.

The Role of the Intensive Care Manager

The primary function of our Intensive Care Managers is to assess any barriers to an individual's treatment progress and recovery and develop interventions with the individual, provider and other community resources to address each barrier. Intensive Care Managers are licensed behavioral health clinicians who intervene in the care of individuals with complex behavioral health care needs or those with co-morbid behavioral and physical health or IDD conditions. This collaboration is accomplished through close partnerships with the individual, acute care facilities, out-patient providers, family members, and other community resources to develop strategies to improve health outcomes and life goals.

ValueOptions ICM workflow increased coordination with hospitals within 24 hours of admission and rounding all cases with our psychiatrists. This contributed to the significant decrease in the utilization of inpatient care for this population.

ICM criteria create algorithms that identify and flag individuals in our information management system who are eligible for the program. Individuals who are identified with patterns of high utilization and/or difficulty engaging in services resulting in barriers to improvement and recovery will be assigned to a designated, regionally based Intensive Care Manager. The Intensive Care Manager clinician is partnered with a Certified Peer Specialist who will outreach to the individual within the community, assisting with engagement and referral to traditional and non-traditional supports and services.

One the following pages, we provide one example of an individual's service experience within our ICM program. We describe the barriers encountered for effective discharge and transition planning, strategies employed, and results of those strategies.

Example of an Individual's Service Experience within our ICM Program

"Charles" is a 45-year old male living in Atlanta, Georgia. He is exhibiting auditory and visual hallucinations. He has had multiple psychiatric hospitalizations, multiple crisis interventions and is resistant to engaging in mental health treatment.

Charles has an extensive history of mental health and substance use disorder treatment between 2000 and 2014. Between 2009 and 2014, Charles was hospitalized at Georgia Regional, Grady, and Dekalb CSU multiple times. He is not currently engaging in, nor has an authorization for, any community mental health related services. He was assessed by a Mobile Crisis Team after his mother contacted them. His mother indicated he suddenly stopped taking care of himself and has been seen talking to himself more frequently. Charles also reported seeing dark shadows in the house. His mother reports Charles is drinking more and believes he may be using drugs again and is afraid he will hurt himself. Following the evaluation from the Mobile Crisis Team, the decision is made that Charles is potentially at risk of harming himself and requires hospital admission. Charles is transported to Grady where he is medically cleared and then transferred to Atlanta Regional Hospital. After a 10-day length of stay, Charles is ready for community re-integration.

The table below outlines current barriers to successful care coordination and how those barriers would be overcome.

Barriers to Successful Care Coordination	Strategies to Overcome those Barriers and Results
In a system that lacks integrated data, no single entity possesses detailed information on the frequency and location of Charles' previous admissions.	GCAL call center data, authorization data, and claims/encounter data analysis accessed via the ASO's integrated care management system would identify Charles as a high need individual. Knowing this information (and PRIOR to his next crisis presentation), outreach could occur and a crisis prevention plan could be developed along with a referral to the appropriate level of case management (i.e., CM, ICM, or ACT)
The emergency rooms and hospitals that treat Charles essentially operate in silos and repeat evaluations with limited understanding of his history, what has worked and what has not.	Care coordination is enhanced when GCAL staff can share treatment history, and previous assessments with emergency rooms and hospitals to improve clinical decision making. Furthermore, multiple hospitals can share discharge summaries and other pertinent clinical information so care can be enhanced.
No entity monitors the effectiveness of the multiple discharge plans associated with each hospitalization. If Charles fails to access community services, engagement efforts are limited.	By knowing that the treatment history contains multiple admissions and failed attempts at community treatment, a referral to ACT, ICM, CST, or CM can occur. While Charles is hospitalized, a member of these services (or a Certified Peer Specialist) would engage with him to support his transition. Furthermore, the Web-

Barriers to Successful Care Coordination	Strategies to Overcome those Barriers and Results
	based discharge summary would be completed by the hospital and monitored by the ICM clinician, assuring that outreach is conducted if there is a lack of follow through.
Community providers may not be able to see Charles within seven days of discharge for follow-up with medication.	Charles is identified as a high priority individual and is assigned to Intensive Care Manager. He/she works to create appointment capacity post discharge so that he does not need to wait to see a prescriber longer than seven days.
The hospital makes post discharge referrals but Charles never successfully links to services.	Outreach is conducted by a Certified Peer Specialist who encourages Charles and even is available to meet Charles when he shows up for his aftercare appointment.
If Charles does not present for community-based follow-up care, the community provider has no commitment to Charles since he may have never had a history with the agency in the first place.	Provider profiles publically report provider engagement rates of hospital/CSU discharges. QI initiatives and technical assistance improves engagement rates.
Charles may never link to community-based services but shows back up in the emergency room at Grady. However, not knowing his recent history, Grady transfers him to Atlanta Medical Center. Atlanta Regional never learns of this readmission.	When Charles shows up in the emergency room, GCAL staff knows that Charles was just discharged from Atlanta Regional, and if clinically appropriate, refer him back. Provider profiles would track 30 readmission rates to the same hospital ***or between*** hospitals.
Charles engages in community-based services and does well; but four months later, he experiences a crisis and presents again to the emergency room. The emergency room (knowing nothing about his history) determines Charles needs inpatient care and transfers him back to Atlanta Regional.	When Charles shows up in the emergency room, GCAL staff will have access to a Crisis Prevention Plan created by Charles with the help of a Peer Specialist and/or the ICM clinician. With the permission of Charles, the Crisis Prevention Plan is uploaded and used by GCAL staff to contact his mother and ACT team, and to talk to Charles about his preferences for care.

Regardless of the level of care, we ensure active, systematic communication and coordination for individuals making transitions across levels of care. We offer an unmatched depth of experience with high-risk, high-need populations. We understand these highly vulnerable individuals require a great deal of support; and we acknowledge our role as system navigators, advocates, and the need for social support networks to connect individuals with the resources they need to access care appropriately and in a timely and proactive way.

ATTACHMENT H.2

H.2 In Attachment H.2, **(limit four (4) pages)**, describe the strategies the Offeror will use to facilitate cross-agency collaboration at the system, not the individual case level. Describe the Offeror's experience in at least two (2) actual examples of collaboration including the actions taken and results

Based upon our extensive experience working with State agencies, we are well aware of the importance of connecting to the network public programs and private resources available to support the individuals we serve. We are also aware of the strong stakeholder community's desire to have voice and input into the functions of vital public programs. To better serve our public sector programs, we have developed an inclusive "knowledge exchange" approach to learning from and collaborating with other agencies that touch the individuals we serve. This knowledge exchange approach suggests that cross-agency collaboration can result in a more cohesive and efficient use of scarce resources. Building upon this approach, we will:

We will ensure that our staff follows the required protocols designed by DBHDD to guide communication with all public and private agencies.

- Work with DBHDD to design and implement policies, procedures and protocols to guide communication and collaboration, recognizing the role of the DBHDD as the decision-maker, with the ASO as an agent charged to facilitate change
- Actively support DBHDD's role in chairing the Behavioral Health Coordinating Council, and actively participate in other cross-agency roles as requested by DBHDD, including DBHDD's DD Advisory Council as requested
- Coordinate with the new vendor of DCH's Care Coordination program to refer high-risk, Medicaid-eligible individuals with co-morbid medical and behavioral health issues
- Share information with Georgia's Care Management Organizations on Medicaid TANF individuals transitioning into care
- Collaborate with DCH, Program Integrity, Provider Performance Unit and DBHDD to limit the amount of overlap and redundancy for reviews of service providers
- Work with self-advocate and parent advocacy groups to solicit barriers and solutions for system improvement and redesign
- Establish collaborative relationships with State and local agencies and other organizations and institutions likely to provide services or supports to recipients and individuals, or be the source of referrals for services including Department of Corrections, Pardons and Paroles, Courts, Sheriff's Association, the Hospital Association, First Responders, the Department of Public Health, Juvenile Justice, Veterans, the Vocational Rehabilitation Agency services, the Department of Education, and social service organizations to provide education and coordinate care

VALUEOPTIONS COLLABORATION EFFORT

The Behavioral Health Partnership (BHP) Oversight Council

The Connecticut BHP comprises the Department of Children and Families, the Department of Social Services and the Department of Mental Health and Addiction Services. The BHP Oversight Council, which includes legislators and their designees, behavioral health consumers and advocates, medical and mental health practitioners, State agencies, and insurers, advises the Departments on the planning and implementation of the program. BHP collaborates with multiple advocacy and peer-run organizations. These include: FAVOR (*Faces and Voices of Recovery*), the National Alliance on Mental Illness *(NAMI)*, Families United for Children's Mental Health (*a chapter of the National Federation of Families for Children's Mental Health*), and others. As the ASO for the state of Connecticut, we sit at the table, actively inform policy and strategy related to the BHP via our extensive reporting, and work collaboratively in our daily operations to advance the vision and direction of the Oversight Council. In addition, we staff a variety of subcommittees that report to the Oversight Council, dedicated to system reform.

One of the program innovations that was implemented as a result of new strategic plans developed in the Council was the Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS). A primary purpose of IICAPS is to assist children to improve functioning so they can remain at home, in their community, and with a reduced reliance on care provided in a hospital inpatient unit or emergency department. In examining the 180 days prior to receiving IICAPS compared to the 180 days following, children receiving the service experienced:

- 37 percent fewer emergency room visits
- 47 percent fewer hospital admissions

BEHAVIORAL HEALTH LINK (BHL) COLLABORATION EFFORTS

BHL has a long history of collaboration with community agencies, State agencies and other stakeholders. At its inception, GCAL had a specific Quality Improvement Advisory Council that comprised stakeholders from the community, including advocates, providers and representatives from DBHDD. This committee worked closely to develop and refine protocols and processes as GCAL was in its infancy. Today, the GCAL contract is closely managed by the Office of Provider Network Management with bi-weekly face-to-face meetings and continuous communication and feedback via telephone and e-mail regarding cases, stakeholder feedback and protocol development. Over time, GCAL has become so embedded in the DBHDD system that GCAL has become an essential member of collaboratives in its own right, and currently serves as a regular member of several collaboratives/committees, including:

- DBHDD Crisis Steering Committee
- DBHDD/Georgia Hospital Association Meetings
- Regional System of Care Meetings
- NAMI CIT Advisory Committee
- Mobile Crisis Collaboratives – Regions I-VI (BHL operates mobile crisis and runs the collaboratives in Regions 3 and 5, bringing together law enforcement, probate court judges, EMS, homeless service agencies, community behavioral health providers, emergency

departments, Children and Family Services, the Department of Juvenile Justice, faith-based groups, schools, etc.)

Collaboration Example: Upstream Crisis Intervention Unit

In 2012, BHL and Grady EMS began working together to develop an Upstream Crisis Intervention Unit that would be a collaboration of Grady EMS, Emory University EMS fellows, Morehouse School of Medicine Psychiatry, GCAL, and the BHL Mobile Crisis Response Services. The basic goal of the project was to identify individuals in need of behavioral health services and provide immediate solutions for linking the individual to the most appropriate care resources. Transportation service, if necessary, was provided to the most appropriate facility, thus avoiding the emergency department to the extent possible.

Grady EMS finalized an MOU with GCAL on February 16, 2013 to allow the 911 call center (PSAP) to directly transfer specific psychiatric triaged calls, National Academy of Emergency Medical Dispatch (NAEMD) 25-omega, to GCAL. This had a similar impact on the Nurse Advice and Georgia Poison Center. The ambulance received a pre-alert, which could be cancelled if GCAL accepted the call. The mobile crisis unit, staffed with one paramedic and a licensed clinical social worker (LCSW), co-responded to 911 medical calls triaged as chief complaint 25 (psychiatric) in the NAEMD protocol system with a Grady EMS transport unit. This crisis team was empowered to offer individuals alternative dispositions (in lieu of the emergency room) and alternate destination transports, where and when appropriate, in conjunction with online medical direction.

Outcomes

The crisis intervention team has assumed a critical role in deploying expertise from the LCSW to de-escalate agitated individuals and resulted in greater understanding of the needs of individuals with behavioral health needs on the part of paramedic staff. **This is reflected in a 45 percent decrease in the use of chemical restraints.** This program is projected to assist 1,200 individuals in behavioral health crisis during the first year with dispositions other than ambulance transport to the emergency room. The program has **provided hospitals** (GHS – 65 percent, AMC – 20 percent, other – 15 percent) with **more than 8,400 hours of available bed space** to improve emergency department throughput times and prevent hospital cost loss.

DELMARVA FOUNDATION COLLABORATION EFFORTS

Data from 2008 through 2009 indicated Georgia IDD providers were struggling with documentation requirements. Providers informally shared the difficulty they were having understanding expectations of different monitoring entities. To address this challenge, Delmarva Foundation facilitated a committee consisting of stakeholders from DCH, Long Term Care Unit & Program Integrity, Department of Behavioral Health, Certification Unit, Delmarva Foundation, DBHDD, a representative from a Regional Office, and a representative from a support coordination agency. The committee developed a Documentation Training focused on assisting providers to develop quality documentation from a holistic, person-centric view, while meeting the criteria for Georgia's IDD policies, procedures and standards.

The Documentation Training was presented by Delmarva Foundation to 703 participants, along with representatives from Program Integrity. During the sessions, a panel of representatives from the Division of Developmental Disabilities, Department of Community Health, and Delmarva fielded questions from participants related to documentation and service implementation. As a result, two separate question and answer documents were developed and posted publicly.

The following year, due to requests from providers and DCH approval, the original workgroup was re-established to develop a template that providers could use to document services and supports. With extensive collaboration from the Division of Developmental Disabilities, DCH, Certification Unit and other stakeholders, the workgroup developed templates that met all billing standards and requirements. Delmarva Foundation trained providers and support coordinators on the new templates and as a result, the templates were incorporated into the NOW and COMP waivers that year as an option for providers to use to document their supports and services.

Stakeholder Collaboration

Based upon recommendations from Delmarva Foundation, the Division of Developmental Disabilities gave Delmarva permission to develop a workgroup representing all stakeholders to revise the ISP process and format. Twenty-nine different leaders and stakeholder representatives attended the workgroup meetings and sub-committees for approximately six months. Actively involved stakeholders included: self-advocates, family members, direct support staff, several small and large provider organizations representing different waiver services, representatives from all four support coordination agencies, and regional staff representation, including Intake and Evaluation Managers, Health Quality Managers, Operations Analysts, and Division of Developmental Disabilities representatives. The workgroup designed a new electronic ISP and process, which is included as a part of this eRFP. Once fully developed, it will be implemented statewide, significantly impacting the person-centered nature of the service delivery system.

Other collaboration efforts include the regional Quality Improvement Councils. As an example, the Region 2 Quality Improvement Council created a project that required collaboration with other regional State agencies and the education community. Data around abuse, neglect, exploitation, and safety demonstrated concern in this region. The Council determined that lack of adequate and effective education being offered to individuals with IDD was the primary cause of these concerns. Consequently, the Council collaborated with the Department of Aging Services and the University of Georgia in Athens to design and develop computer animation story boards depicting several scenarios related to abuse, neglect and exploitation. The scenarios are from real-life situations experienced by self-advocates and family members on the Council. Since these trainings have occurred, the ANE Advocators have trained more than 300 people in Region 2 and around the state of Georgia. These ANE Advocators have made statewide presentations, including a presentation for the Department of Aging Services, and continue to receive requests from providers around the state. As a result of these collaborative efforts, people are more readily identifying abuse and reporting it.

ATTACHMENT I.1

I.1 In Attachment I.1, **(limit two (2) pages)**, list the results for your organization for the two (2) most recent Individual satisfaction surveys. Provide a specific example of how the Offeror has used Individual, family, and Provider feedback (e.g., satisfaction surveys, complaints) to identify systemic problems and improve quality. Describe the feedback, the intervention, and the results.

Incorporating valuable suggestions and recommendations from individuals and providers based on actual experience strengthens the program's overall performance. It also generates an atmosphere conducive to performance improvement and a person-centered system of care for the individuals we serve. The satisfaction surveys used to elicit feedback from individuals measure key indicators of quality care, supports and services. The questionnaires include measurements that track satisfaction ratings of practitioners, access to care and outcomes of services. Specific questions assess:

- Overall satisfaction with services
- Quality of services received from providers
- Accessibility of providers, including location and availability of appointments
- Satisfaction with the number of visits with providers
- Performance of our staff at the toll-free Engagement Center telephone number

Aggregated results across all public sector contracts in states requiring an individual satisfaction survey for the two most recent years, 2012 and 2013, are detailed in the table below:

Satisfaction Metric	2012 Results	2013 Results
Satisfaction with Behavioral Health Services	95.7%	94.6%
Overall Quality of Service	92.9%	91.5%

Delmarva Foundation, a partner in the Georgia Collaborative ASO (the ASO), received 184 feedback surveys between July 2011 and December 2013from Georgia IDD providers, individuals or family members who had participated in a review. Results have been positive, as displayed by fiscal year in the following table.

Satisfaction Metric	FY2012 Results	FY2013 Results	FY2014 Results
Consultant performance was professional	97.2%	96.7%	98.5%
Review process facilitated outcomes and improvement	93.3%	95.2%	96.2%

INTEGRATING FEEDBACK TO IMPROVE QUALITY

ValueOptions' Colorado Health Partnership, a Medicaid program in the 43 counties that comprise the rural South/West Region of Colorado, serves as a prime example of improving quality through our satisfaction survey feedback. For this program, we determine the degree of

individual satisfaction by evaluating perceptions of accessibility, service adequacy, wellbeing, functioning, independence, and outcomes. We rely on four surveys to capture these results:

1. Mental Health Statistics Improvement Program (MHSIP) survey that targets adults
2. Youth Services Survey (YSS) that targets youth and adolescents
3. Youth Services Survey for Families (YSSF) that targets families of young people
4. ValueOptions' member survey (conducted by independent research firm Fact Finders) that targets adults and parents of youth in treatment

Survey results are presented to the Quality Improvement Steering Committee/Clinical Advisory Utilization Management (QISC/CAUM) Committee, the Office of Member and Family Affairs Committee, member and family forums, and the CHP Board. These groups evaluate results to identify areas for further investigation or improvement, and to acknowledge areas in which we are performing well. In addition to evaluating survey results, grievance reports and trends are also reviewed for follow-up and action where warranted.

Intervention based on Member (Fact Finders) Feedback

With the input of individuals and family members, Colorado Health Partnership has developed and included additional questions in our satisfaction survey that yield valuable information on our system performance. Department leads are required to review the results of each survey and develop specific action plans to improve any identified issues. The result has been a steady improvement in our satisfaction rates. Colorado Health Partnership's 2013 Fact Finders survey report shows very strong performance in overall quality and functional status/outcomes of care, averaging scores of more than 90 percent.

Intervention based on MHSIP Survey Feedback

Survey feedback from MHSIP indicated that one area of potential improvement for our Colorado Health Partnership was care coordination between behavioral health and physical health providers. As a result, we initiated a project to evaluate and improve coordination of care between Medicaid physical and behavioral health providers for individuals who are diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder. This population represents a high-risk group who frequently have co-occurring medical conditions. Furthermore, they are at high-risk of early death due to undiagnosed or untreated medical conditions, complications from medications, and behaviors associated with mental health conditions. The aim is to measure and sustain improvement in coordination of care. Colorado Health Partnership has initiated multiple interventions to improve coordination including co-location of behavioral and physical health providers, with onsite access to fully integrated member records. These actions have resulted in a significant increase in physical/ behavioral integration in recent years. A key outcome measure for this improvement project is the number of behavioral health members who have had a physical health visit during the fiscal year. Colorado Health Partnership set its performance goal at 80 percent, then increased it to 85 percent.

ATTACHMENT I.2

I.2 In Attachment I.2, **(limit four (4) pages)**, describe how the Offeror would implement the Provider audits described in Section 12, including opportunities to streamline, reduce duplication, or consolidate audit processes. Address criteria for conducting Provider audits, audit tools, frequency of audits, adding information to Provider Performance Profiles, and how reduced audit frequency could be used as an incentive for high performers.

We have substantial experience conducting provider audits and onsite reviews. Our process adheres to evaluation guidelines as defined by NCQA, quality standards dictated by CMS and state rules and regulations. In preparation for our response to this eRFP, we devoted a significant amount of time to talk with Georgia providers about the current process and their suggestions for redesign. Based on these discussions, we concluded that implementing a review process that adheres to the highest standards is only a first step. The process needs to be placed within the context of a comprehensive system-wide quality improvement structure whose role is understood, non-duplicative, and perceived and accepted as meaningful by the provider community.

STREAMLINING REVIEWS OF INDIVIDUALS WITH IDD AND BEHAVIORAL HEALTH DIAGNOSES

We believe it is essential to use a holistic approach to evaluating quality of supports and services to build a successful Quality Management (QM) program. When possible, it is important not to segregate portions of a person's life based on diagnosis, but to evaluate all supports and services that impact the person's quality of life. In our proposed QM program, both the Person-Centered Review (PCR) and Quality Enhancement Provider Review (QEPR) processes will integrate processes for individuals with a dual diagnosis and for providers offering services through both IDD and behavior health programs. We realize that there are a number of DBHDD providers serving both IDD and behavioral health populations. The largest group of key providers is the Community Service Boards (CSBs). We have met with the CSBs and subsets of the group more than 10 times. As the ASO, we will work closely with DBHDD and other relevant agencies such as DCH, to coordinate audit/review schedules in order to reduce duplication and the amount of time an agency is required to respond to audit/reviews for information. Additionally, exit debriefings will be consolidated for provider leadership and where appropriate the audit/review summaries will be consolidated.

Our current and proposed approach to both review processes is comprehensive and recovery focused, positioning it to best evaluate all supports and services being received through an HCBS waiver and/or State-funded services. This approach is particularly valuable if the person has a dual diagnosis of IDD and behavior health. Reviewing all supports and services concurrently increases our ability to capture all possible areas that may need improvement and provides the opportunity for the individual's service delivery team (through the PCR) and/or provider organization (through the QEPR) to address the challenges. The tools and Web-based

applications are designed to capture the provider's compliance with the rules and regulations dictated by State and federal guidelines for both IDD and behavioral health services. Auditors conducting these review processes will be cross-trained on the IDD and behavioral health provider manuals.

The survey review team will include experts in IDD and behavioral health requirements. Through a stratified sample methodology, individuals receiving behavioral health and IDD waiver or State-funded services are part of the QEPR onsite review sample. The records for all services received are reviewed. In addition, provider staff are interviewed to provide clarification of how services are integrated, rendered collaboratively and in keeping with the individual's support plan. Where possible, recommendations are identified specific to the service rendered to the person in order to target necessary remediation or improvement efforts. Any issues learned from the review processes will be used to drive technical assistance topics and quality improvement initiatives.

NEW INNOVATIONS ENHANCING BEHAVIORAL HEALTH AUDITS

We propose to radically enhance the provider audit process in a manner that aligns with the "Triple Aim" of health care reform, with the SAMHSA National Quality Framework for behavioral health, and with DBHDD's objective of ensuring adherence to the provider manual. While the age-old adage of "if it was not documented, it was not done" still holds true, so does the wisdom of "expect what you inspect." Each year, DBHDD makes a huge financial investment to help Georgia's most vulnerable citizens lead safe, healthy and meaningful lives. However, because measurement of these goals is still an emerging science nationally, we tend to attribute quality solely based on the mechanics of provider documentation. For instance, more emphasis may be given to the assurance that service plans contain S.M.A.R.T. goals (specific, measurable, attainable, realistic, and time limited) than to the efficacy of the goals themselves. Similarly, in the absence of tracking outcome measures, more weight may be given to the format and mechanics of a progress note indicating activity rather than the numerous steps a provider is taking to help the individual lead a healthier life. By placing more emphasis on the ***inspection*** of evidence-based practices, person-centered practices, coordinated care, healthy living for individuals and communities, reduction of adverse events, and cost efficiencies, we will ***expect*** to see provider performance improve related to this quality framework. In keeping with the SAMHSA and DBHDD vision of quality, validation of the interwoven audit processes includes:

- **Most effective prevention, treatment, and recovery practices for behavioral health disorders** as evidenced by the use of evidence-based practices and adherence to DBHDD service guidelines; employment and knowledge of crisis support/safety plans, tobacco use assessment and tobacco cessation intervention; changes in employment status (i.e., increased/no change) or in school status; increase in stable housing status; family communication around drug use; verification that individuals on antipsychotic medications are routinely educated about potential metabolic conditions and the need for screening and monitoring of health conditions; percentage of individuals with a primary care provider, pediatrician or obstetrician/gynecologist; percentage of individuals with dual diagnosis receiving psychiatric services; percent of individuals receiving psychotropic medications without a psychiatric diagnosis.

- **Care is person, family and community centered** as evidenced by the consumer evaluation of care; participation in treatment planning, Individual Support Plan and agreement with these plans; use of tools, services, and outcomes that are recovery oriented and person centered.
- **Effective coordination within behavioral health care and between behavioral health care, community-based health care providers, other recovery and social support services and IDD supports and services** as evidenced by whether organizations have entered into formal written inter/organizational agreements (e.g., MOUs, MOAs) to improve health-related practices/activities; and upon discharge from inpatient facilities, reconciled medication list received by the discharged individual and updated by the community provider; consents exist in individual's records to allow for interactions between the health care provider(s), specialty care and/or IDD providers; diabetes monitoring for people with diabetes and schizophrenia; and medical assistance with smoking and tobacco use cessation.
- **Assists individuals and communities to utilize best practices to enable healthy living** as evidenced by social connectedness to and support from others in the community, such as family, friends, co-workers, classmates, and other natural supports; evidence of prevention models associated with reductions in behavioral health issues, substance use/abuse and co-morbid health conditions; and rates of smoking, obesity, or risky sexual behavior.
- **Care is safer by reducing harm caused in the delivery of care** as evidenced by percentage of organizations with standard procedures for responding to suicide risk; percentage of adults with serious mental illness and/or substance abuse disorders receiving medication management; evidence that providers are utilizing trauma-informed approaches; evidence providers are identifying high-risk individuals who need additional treatment and supports.
- **High-quality behavioral health care is affordable and accessible** as evidenced by methodologies in place to ensure eligible individuals are enrolled in health insurance; re-hospitalization rates for persons served by the agency; rates of behavioral health conditions among those without insurance; wait times for routine, urgent and emergent appointments; and engagement rates of individuals referred by an inpatient unit or CSU and other measures.

Criteria for Audit Frequency and Incentives for High Performers

Hardwiring quality within provider organizations is perhaps best achieved from within the agency. While external audits are necessary, providers must objectively evaluate their own performance, design interventions and measure improvement in order to sustain meaningful outcomes. We recommend that Key Performance Indicators (KPIs) be required for providers to evaluate their own success and remedy performance gaps. KPIs would be based on best practices known to demonstrate high quality services. Some of these KPIs, referenced in the table in our response to *Section I.4,* will be reported by ValueOptions within the provider profiles. Other self assessment indicators could include an evaluation of goal documentation based on assessed needs and treatment planning/progress notes efficacy. The initial portion of a behavioral heath audit and/or QEPR would be a review of the provider's KPI results and the provider's initiatives to improve any substandard KPI. Results will be validated with corresponding corrective action plans to determine their effectiveness toward quality improvement. Providers with self-assessment results that indicate performance improvement upheld by our own audit will receive less frequent audits over time, as will providers with audit results exceeding a certain score.

The process of coaching and monitoring provider efforts toward quality improvement shifts the locus of control away from an external entity and back to the provider. Just as we believe in empowering individuals to draw upon their strengths to achieve goals, we are confident that the majority of providers are capable of instituting performance improvement initiatives to achieve goals resulting in better care for the person served. For these providers, our role revolves around providing data that formulates the KPIs within the provider profile, offering technical assistance as needed, and periodically validating internal performance improvement via onsite audits. By migrating to more of a consultative role with high performing providers, our resources will be better utilized to work closely with the few providers who either do not have an internal quality improvement process or have an ineffective one. For these lower performing providers, onsite audits will occur more frequently as will technical assistance (that in some cases may be required). Finally, audit frequency for these providers (and even higher performing providers) may be influenced by prevalence of complaints, satisfaction survey results and/or negative outcomes. At the direction of the DBHDD, the ASO will also conduct ad hoc audits designed to target specific key performance indicators and/or new regulations.

Audit Tools, Results, and Provider Profiling

Our audit tools will consist of automated questionnaires completed onsite with a preliminary summary issued to the provider at an exit debriefing where dialogue about results occurs and technical assistance is provided. The results will be summarized in a narrative (highlighting provider strengths) with scores representing the following domains:

- Adherence to the programmatic fidelity outlined in the DBHDD and DCH provider manual (including program documentation reviews, staff interviews, individual interviews, onsite observation of the physical environment and service delivery, treatment record reviews, and personnel and training record reviews)
- Verification that billed services were indeed rendered to the individual
- Validation of the quality and accuracy of provider-based quality assurance (QA) initiatives
- Verification of outcomes related to better care, healthy people/healthy communities, and accessible/affordable care detailed above
- Verification of KPI results and improvement based upon corrective actions

Audit findings and KPIs will form the basis of provider performance profiles to be utilized by the program's QM Committee to design initiatives and shape the overarching statewide QM Plan developed annually by the ASO's leadership team. Our regional teams, led by our Regional Network Managers (RNMs), will provide consultation and Follow Up with Technical Assistance (FUTAC) for providers in specific geographic regions and will present analysis and data to providers at regular provider meetings in their respective regions.

ATTACHMENT I.3

I.3 In Attachment I.3, **(limit four (4) pages excluding Provider Performance Profile sample)**, provide a specific example of how the Offeror has used Provider Performance Profiles to improve service delivery. Address how problems were identified, the intervention, and the result. Provide an example of a Provider Performance Profile.

ValueOptions' Connecticut program developed the Provider Analysis and Reporting (PAR) Program as a provider performance profile to assess provider practices and ultimately shape and improve provider performance. This program is unique in its strong emphasis on partnership with the providers in the development of the content of the information collected, tracked and fed back to them. In many instances, the providers themselves have not had the resources available to them to measure their performance or the forum in which to compare their performance with other providers supplying the same services.

The PAR provider performance profiles were developed through the following steps:

- In collaboration with the State and the providers, workgroups were established to identify:
  - Overarching goals
  - Indicators that can be used to measure performance
  - The means of measuring the indicators
  - Case mix issues that influence the indicators
- The workgroup reviewed baseline performance and established performance goals
- Periodic feedback was provided to the individual provider participants as well as to the entire workgroup at specific intervals
- System-wide barriers to improving performance were identified in collaboration with State managers, providers and other stakeholders
- Interventions and best practices were identified to address barriers

ENHANCED CARE CLINIC (ECC) PAR PROGRAM

The ECC PAR program, also implemented in Connecticut, followed a unique progression when compared to other provider profiling programs. In conjunction with the State, ValueOptions identified that there was an issue with Medicaid members accessing outpatient care in a timely manner. Members were complaining about six month long waitlists at outpatient clinics and were resorting to using the emergency rooms instead for more immediate psychiatric care. In order to address this issue, child and adult outpatient clinics were asked to respond to an RFP sponsored by the State whereby the outpatient clinics applied for an enhanced care clinic status. This status would allow the providers to be paid 25 percent more than their current reimbursement rate for treating Medicaid individuals through a special fund set up by the State. The providers were measured and profiled on the following specific requirements:

1. Centralized telephonic access to appointments
2. Timely access to care including:

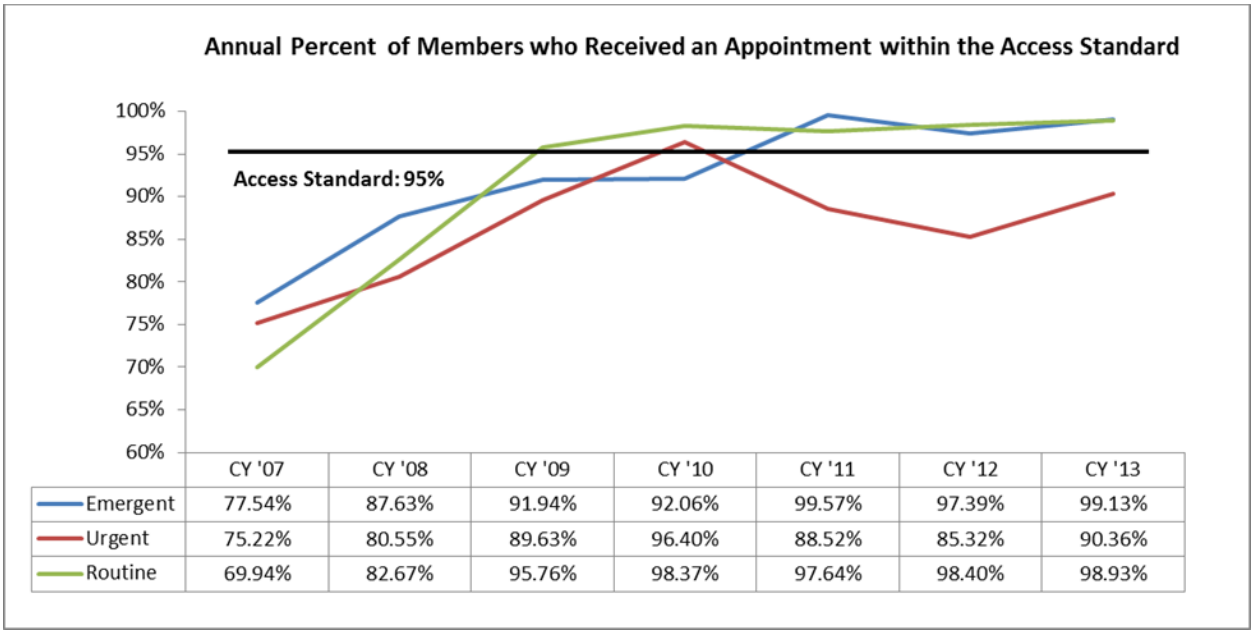
a. Routine appointments offered within 14 days 95 percent of the time
b. Urgent appointments offered within 48 hours 95 percent of the time
c. Emergency evaluations within two hours of arrival at the ECC 95 percent of the time
d. Psychiatric evaluations within two weeks of evaluation when the need for psychiatric evaluation was identified
e. Extended clinic hours

3. A signed MOU with primary care providers or pediatricians in their areas providing consultation and timely access to those providers so that they may provide psychopharmacologic treatment to Medicaid members within their practices
4. Screening for co-occurring mental, developmental, or physical disorders

The Web application used by outpatient providers to register outpatient care was revised to enable provider profile compliance with the timely access requirements. Together with the State, ECC data was analyzed and opportunities for improvement among the ECCs were identified. ValueOptions worked with multiple State agencies to provide each of the ECCs with a consistent profile to give the ECCs timely feedback regarding their compliance with appointment access standards. Statewide ECC meetings were initiated to provide a forum for consistent feedback to ECCs regarding their performance and the State's expectations. Below is one of the tables related to emergency room evaluations from an ECC provider's profile:

Measure Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
ALL					
# Total Emergent Evaluations	***0***	***0***	***0***	***0***	***0***
# Total Urgent Evaluations	***1***	***1***	***0***	***1***	***3***
# Total Routine Evaluations	***213***	***192***	***170***	***172***	***747***
# Total Evaluations	214	193	170	173	750
# Total Evaluations (Total Volume)	***215***	***208***	***174***	***181***	***778***
% Total Emergent Evaluations/Total Evaluations	0.00	0.00	0.00	0.00	0.00
% Total Urgent Evaluations/Total Evaluations	0.47	0.52	0.00	0.58	0.40
% Total Routine Evaluations/Total Evaluations	99.53	99.48	100.00	99.42	99.60
EMERGENT					
Avg. Time Until Receipt of Emergent Evaluations (min.)	0	0	0	0	0
# Receipt Time of Emergent Evaluations within 2hrs.	0	0	0	0	0
% Emergent Evaluations Received within 2hrs.	***0***	***0***	***0***	***0***	***0***
URGENT					
Avg. Time Until Urgent Appointment Offered (days)	1.00	0.00	0.00	0.00	0.33
# Urgent Appointments Offered within 2 days	1	1	0	1	3
% Urgent Appointments Offered within 2 days	***100.00***	***100.00***	***0.00***	***100.00***	***100.00***
Avg. Time Until Receipt of Urgent Evaluations (days)	3.00	0.00	0.00	0.00	1.00
# Receipt Time of Urgent Evaluations within 2 days	0	1	0	1	2
% Urgent Evaluations Received within 2 days	0.00	100.00	0.00	100.00	66.67
# Urgent Appt Offered within 2 days yet Member Requested Later Appt	1	0	0	0	1
# No-shows/Cancellations Prior to First Urgent Evaluation Received	0	0	0	0	0
ROUTINE					
Avg. Time Until Routine Appointment Offered (days)	5.55	4.09	0.36	1.15	2.98
# Routine Appointments Offered within 14 days	212	192	170	171	745
% Routine Appointments Offered within 14 days	***99.53***	***100.00***	***100.00***	***99.42***	***99.73***
Avg. Time Until Receipt of Routine Evaluations (days)	8.52	4.98	0.57	1.41	4.16
# Receipt Time of Routine Evaluations within 14 days	179	184	168	169	700
% Routine Evaluations Received within 14 days	84.04	95.83	98.82	98.26	93.71
# Routine Appt Offered within 14 days yet Member Requested Later Appt	65	27	3	3	98
# No-shows/Cancellations Prior to First Routine Evaluation Received	0	0	0	0	0

As a result of these statewide meetings and the issues raised by the ECCs, an ongoing workgroup of interested ECC representatives was initiated to work on identified issues and barriers to meeting the ECC requirements. The ECC Provider Workgroup on Capacity and Access now meets on a quarterly schedule to review and analyze the impact of capacity on provider compliance for the ECC access standards. As graphically depicted below, since its inception the ECC program has significantly improved the initial access to outpatient care for children, adolescents and adults. Continuation of the program is believed to be essential to maintaining the gains regarding access, coordination with primary care and co-occurring competence.



	CY '07	CY '08	CY '09	CY '10	CY '11	CY '12	CY '13
Emergent	77.54%	87.63%	91.94%	92.06%	99.57%	97.39%	99.13%
Urgent	75.22%	80.55%	89.63%	96.40%	88.52%	85.32%	90.36%
Routine	69.94%	82.67%	95.76%	98.37%	97.64%	98.40%	98.93%

Overall, the annual percent of members who were offered an appointment (routine and urgent) or who were seen within the access standard across all three access measures increased from 2012 to 2013. The percent of members triaged as emergent who were seen within the access standard has been steadily increasing since 2007, excluding 2012 where this number declined to 97.39 percent but still remained above the access standard. Performance on the percent of members triaged as urgent who were offered an appointment within the access standard has fluctuated more than the performance on the other two access standards. The drop in this percentage in 2011 and 2012 can most likely be explained by the addition of adult members. The improvement in performance in 2013 may be explained by the increased focus on meeting urgent and emergent access standards within the context of the new annual compliance measure for 2013, which holds ECCs accountable for all three access standards.

An additional component added to the ECC profiling program to shape provider performance was the "Mystery Shopper" program. This program seeks to assess the performance of the ECCs on their compliance with important aspects of their contract with regard to:

- Providing a centralized intake process
- ECC employees' knowledge of the access standards

- Whether the ECC site has implemented a process to assess the urgency of the clinical situation of the member
- Whether the ECC is compliant with offering the member an appointment within the applicable access standards given the clinical situation of the member

To this end, ValueOptions conducts a series of mystery shopper calls to each of the ECCs over the course of the year. The "mystery shopper" call is a telephone call to the ECC intake number made by a ValueOptions employee acting as a member or the parent/guardian of a member calling for an appointment. Several vignettes representing a routine level of urgency were developed. Additionally, the vignettes incorporate clinical information that is appropriate to the type of treatment supplied by that particular ECC. As a result, vignettes that represent child/adolescent substance abuse, child/adolescent mental health, adult substance abuse and adult mental health were used. At the time of the mystery shopper call, several other indicators are assessed:

- Whether triage protocol/questions are being used by the ECC
- Any barriers to accessing care including but not limited to:
  - Written forms being required before an appointment is given
  - Issues regarding the availability of evaluation in language other than English

Providers are notified of their results from the "mystery shopper" calls and programs that fail are advised to submit a corrective action plan to address the identified issues, including any supporting documentation, training materials, or evidence of implementation.

PERSON CENTERED INDEX PROVIDER PROFILE

As our key partner, Delmarva also has a long and successful history of developing and implementing provider profiles tailored to meet the needs of stakeholders. In September 2009, the State Quality Improvement (QI) Council in Georgia implemented a Person Centered Index (PC Index) project. Based on data collected through the Georgia Quality Management System (GQMS), the Council identified continued issues surrounding the lack of a person-centered approach by service providers. A workgroup, comprising representatives from DBHDD, Delmarva, and the Health Services Research Institute (HSRI), developed the PC Index, also known as the Elements of Positive Performance, from data collected through review tools including the National Core Indicator (NCI) Adult Consumer Survey. We have provided a sample PC Index on the following pages.

The Index was used to rank providers on the use of a person centered focus in their service delivery systems. Results were aggregated to generate an overall percent met by provider, used to rank providers on person centered practices. Providers with PC Index rank participated in face-to-face interviews with state staff who gathered in-depth information about their service delivery systems and best practices. The information was shared with the Division of Developmental Disability's training department and incorporated into training sessions for lower performing providers. In addition, the State QI Council developed "Guidelines for Choice," a comprehensive definition of informed choice that was shared statewide. As a result, we have seen increases in compliance in areas such as choice, ensuring the person directs services and supports, and integrating individuals into the community.

PC Index (Elements of Positive Performance)

Tool	Expectation Number	Expectation
Individual Interview Instrument	1	The person is afforded choices of services and supports.
	2	The person directs the design of the service plan, identifying needed skills and strategies to accomplish their desired goals.
	3	The person participates in the routine review of the service plan and directs changes desired to ensure outcomes/goals are met.
	4	A personal outcome approach is used to design person-centered supports and services.
	5	The person is achieving desired outcomes/goals (e.g. showing an increase in abilities, experiences, choices and increments toward success).
	6	The person actively participates in decisions concerning his or her life.
Provider Record Review Guide	1	Person-centered focus is supported in the documentation.
	9	The individual is afforded choices of services and supports.
	11	The provider has a means of evaluating the quality and satisfaction of services provided for the individual.
	13	The individual is making progress and achieving goals that matter most.
	14	The individual directs the supports and services.
Support Coordinator Record Review Guide	1	Person-centered focus is supported in the documentation.
	5	The support coordinator continuously evaluates supports and services.
	8	Individuals are afforded choices of services and supports.
Staff Provider Interview	2	The individual's progress or lack of progress is evaluated and acted upon and tracked by the provider/staff.
	3	The individual, using the supports and services of the provider, demonstrates an increase in abilities, self-sufficiency, and changes in his/her life, consistent with the service plan.
	4	The provider has methods to determine the individual's satisfaction of supports and services. Any areas of dissatisfaction are addressed to the individual's expectations.
	5	As appropriate to the individual's goals, needs and interests, the provider renders specific training activities that assist the individual to acquire, maintain, or improve skills related to activities of daily living.
	19	Staff members are able to describe roles and responsibilities as they relate to service implementation for the individual.
	20	Staff members are able to describe procedures and responsibilities to establish a person-centered approach to service delivery.
	23	The individual receives service and supports as described in their current ISP and Prior Authorization, including details of the amount, duration and scope of service.

Tool	Expectation Number	Expectation
Observation Guide	5	My Life, My Choice
	6	Celebrating Achievements
ISP QA Checklist		Person Centered Important To/For
		Goals are person centered
Training and Qualifications	8c.	Orientation requirements are specified for all staff. Prior to direct contact with consumers, all staff and volunteer staff shall be trained and show evidence of competence in: Person Centered Values, principles and approaches.
	8d.	Orientation requirements are specified for all staff. Prior to direct contact with consumers, all staff and volunteer staff shall be trained and show evidence of competence in: Holistic Care of the individual.
NCI Adult Consumer Survey	Q1	The proportion of people who have a job in the community.
	Q6, Q11, Q18	The proportion of people indicating that most staff treats them with respect.
	Q19-Q20, Q75-Q77	The proportion of people whose basic rights are respected by others.
	Q21	The proportion of people who report satisfaction with the amount of privacy they have.
	Q22-Q24	The proportion of people who report that they feel safe in their home, neighborhood, workplace, and day program/at other daily activity.
	Q25	The proportion of people who report having someone to go to for help when they feel afraid.
	Q27	The proportion of people who have friends and caring relationships with people other than support staff and family members.
	Q29, Q33	The proportion of people who are able to see their families and friends when they want.
	Q30	The proportion of people who can go out on a date if they want to.
	Q37	The proportion of people who were involved in creating their service plan.
	Q54-Q60	The proportion of people who regularly participate in everyday integrated activities in their communities.
	Q61, Q63-Q67, Q69-Q70, Q72-Q74	The proportion of people who make choices about their everyday lives, including: housing, roommates, daily routines, jobs, support staff or providers, what to spend money on, and social activities.
	Q62, Q68, Q71	The proportion of people who report having been provided options about where to live, work, and go during the day.
	Q78	The proportion of people who have participated in a self-advocacy group meeting, conference, or event.
	Q79	The rate at which people report that they do not get the services they need.
	Q80	The proportion of people who feel their support staff has been appropriately trained to meet their needs.

ATTACHMENT I.4

I.4 In Attachment I.4, **(limit three (3) pages)**, identify recommended outcome measures and instruments for each population served (e.g., adult BH, child/adolescent BH, IDD, Dual BH/DD). Address how these measures would be implemented, how results would be used to impact the quality of care and overall system effectiveness.

ValueOptions and our partners, Delmarva and BHL, understand the value of approaching QA and QI through the utilization of outcome-oriented performance measures. In particular, when services are provided to individuals with behavioral health and/or IDD diagnoses, it is essential to determine if the service delivery systems are not only compliant with state and federal standards (i.e., CMS Assurances) but also address the more person-centered quality of life standards critical for recovery, wellbeing and independence. We ensure our QI program tracks a set of outcome measures that are relevant, methodologically sound, and capable of assessing improvement in the lives of individuals served. The instruments and sources used to collect data to measure outcomes include but are not limited to:

- Claims Data
- Recidivism Rates
- Observations
- Record Reviews
- Crisis Data
- Individual Interviews
- Provider/Staff Interviews
- Satisfaction Surveys
- Critical Incidents
- National Core Indicators
- Health Risk Screening

METHODOLOGY TO SELECT OUTCOME MEASURES

Our goal is to make each step in the process of identifying, operationalizing, and measuring selected outcome measures as inclusive and transparent as possible. Our leadership will establish a QM Committee at the outset of the ASO contract to include providers, individuals, family members, advocates, QI Council representatives, DBHDD representatives, ValueOptions, and our partners. This group will review recommended outcome measures, propose additional measures and help determine the prioritization for implementation. Our selection process will include monitoring of specific performance/outcome measures approved by CMS and SAMHSA.

KEY MEASURES, IMPLEMENTATION AND IMPACT

Aligning with DBHDD's mission, the trend has been to track more outcome-based measures and indicators versus compliance-oriented standards. We will support these efforts by developing performance measures and KPIs that focus on required federal and state measures, including federal DOJ monitoring comments or conclusions; best practices; and outcomes for people being served. We intend to engage the HSRI for their expertise and will work collaboratively with DBHDD to develop new measures and ensure they are captured in the review processes.

We will implement a QM system that assesses outcomes for adult behavioral health, child/ adolescent behavioral health (when appropriate to DBHDD for youth in its system, IDD, and dual behavioral health/IDD using evidence-based tools.

The table below offers some examples of outcome measures for each of the populations listed, the implementation process and the impact value.

Outcome Measures that Apply to All Populations
Measure: Inpatient and CSU length of stay **Implementation:** Length of stay information collected via the authorization process, claims analysis, or via provider reports and used as part of provider profiles. **Impact Value:** Access to beds for individuals in crisis improves with shorter length of stays; lower length of stays reflect the efficiency and effectiveness of the hospital/CSU in stabilizing the individual experiencing a crisis.
Measure: Inpatient/CSU re-admission rates (i.e., seven day, 30 day) **Implementation:** Inpatient/CSU authorization data collected and used as part of provider profiles. **Impact Value:** Improves discharge planning for the individual; measures effectiveness of inpatient/CSU care in stabilizing the individual in crisis.
Measure: Days in community outside of hospital **Implementation:** Collected as part of the UM process for individuals with frequent or lengthy hospital/CSU admissions and reported in provider profiles. **Impact Value:** Institutionalization of the individual is decreased when tenure in the community is measured as a valuable outcome.
Measure: DBHDD funded inpatient, CSU, and residential bed occupancy rate **Implementation:** Census of occupied beds is collected daily and in aggregate for reporting within provider profiles. **Impact Value:** Access to beds for individuals in crisis or in need of residential care improves when the empty bed rate is measured; measures capacity and identifies needs for development of additional inpatient, CSU, or residential beds.
Measure: Engagement rate of inpatient or CSU discharges **Implementation:** Discharge summary and aftercare appointment data collected and used to measure the receiving provider's effectiveness at engagement of an individual post discharge. Performance to be reported in provider profiles. **Impact Value:** Receiving provider appropriately prioritizes inpatient or CSU discharges resulting in the individual receiving care within seven days of discharge; receiving provider improves outreach methods resulting in higher post-discharge engagement of individuals served; decreases the probability that an individual returns to the hospital/CSU via improved collaboration between hospitals/CSUs and community providers since both have measures that impact readmissions.
Outcome Measures that Apply to IDD
Measure: Number and percent of individuals who are developing social roles (e.g., participation in day program) and/or are becoming integrated into their community as desired **Implementation:** Individual Interview, National Core Indicators (NCI), Record Review **Impact Value:** Improved social role development and using this data to identify providers and regions' best practices, and barriers to improvement.
Measure: Number and percent of individuals who receive all preventive health care: dental, female and male preventive exams, annual physical **Implementation:** Individual Interview, NCI, Record Review **Impact Value:** Improved health outcomes for individuals and the ability to evaluate areas of most need and analysis to identify service delivery gaps.
Measure: Number and percent of community providers who take and pass competency-based training based on individualized programming for people transitioning from the hospital **Implementation:** QEPR **Impact Value:** Improve provider competency IDD to facilitate the successful transition of individuals with IDD to a supportive community setting.

Outcome Measures that Apply to Dual Behavioral Health and IDD
Measure: Number and percent of individuals who are receiving psychotropic medications linked to a behavioral health assessment completed by a behavioral health provider **Implementation:** Individual Support Plan, Record Review **Impact Value:** Decrease inappropriate or over-medication of individuals with IDD without a behavioral health assessment.

IMPACT ON THE QUALITY OF CARE AND OVERALL SYSTEM EFFECTIVENESS

Our approach to continuous quality improvement promotes system change through a proven ability to use data analytics and information to drive performance improvement. We propose a quality management process that moves beyond tracking utilization and quality outcomes to one that promotes transparency through information exchange, mutual education, and actively involving all stakeholders, including DBHDD, Regional Offices, individuals, families, advocacy groups, and provider groups. The QM Program is a major mechanism through which key stakeholders provide input on policy, oversight, and evaluation of DBHDD's behavioral health and IDD programs. They are charged with developing and guiding quality improvement, impacting all levels (i.e., individual, provider, regional, statewide) of the service delivery system.

We will track outcome measures quarterly across the system through quality audits, onsite reviews, and trending of available data sets. Quarterly monitoring will allow us to rapidly and regularly evaluate trends and effectiveness of interventions. Results will be analyzed and presented to regional and statewide councils, including the DBHDD's Behavioral Health Coordinating Council and/or DBHDD's task forces on issues for specific populations such as children and adolescents, re-entry from jails and prisons, or provider recruitement. Feedback from these presentations will help guide quality improvement iniatives at the regional and statewide level to impact the quality of care and effectiveness of the service delivery system. We will continue to revisit and redevelop specific outcome measures based on analysis from quality audits and onsite review data (e.g., face-to-face interviews, provider reviews) with input from DBHDD and the ASO's QM committee. Success or failure to meet outcome measures will lead to strategies for quality improvement.

Effective Feedback and Consultation on Outcome Measures

Our QM system is designed to allow providers the ability to experience the connection between the audits, collection of outcome measures, reporting and feedback and quality improvement consultation. To ensure we complete this circle and establish processes with all components of the system to collectively move the bar on these measures, we will utilize geographically based teams to establish a local presence and collaborative relationship with providers, DBHDD and Regional Offices to act as the conduit for information exchange/sharing. Regional teams will include our clinical staff, Peer Support Specialists, Regional Network Managers (RNMs), and Quality Improvement Consultants (QICs) with consultation from quality management and provider relations. Regional network teams will be assigned to designated regions across Georgia to foster increased familiarity and relationships with individuals and families served, providers, and Regional Office staff. RNMs will be responsible for bringing the data back to the community providers and the Regional QI Councils and working collaboratively, as described above, to impact provider performance.

ATTACHMENT I.5

I.5 In Attachment I.5, **(text description limited to twenty (20) pages; examples of tools, graphic representations, charts, etc are unlimited)** describe the detailed approach to meeting the requirements of the statewide HCBS and State IDD QM program and assurances, consistent with approved IDD HCBS waivers.

INTRODUCTION

Our QM program developed specifically for Georgia will integrate the various components of the service delivery systems described in this eRFP. A comprehensive QM program and a team of experts will work with all relevant State agencies to ensure **improved functioning of the overall behavioral health and IDD service delivery systems and outcomes**. Our system will:

- Ensure internal quality assurance processes are practiced across all the populations served
- Provide valid and reliable data to guide quality improvement initiatives
- Improve recovery-focused services for individuals with behavioral health diagnoses
- Improve services related to safety and independent daily activities for individuals with IDD
- Offer state-of-the-art database solutions to efficiently and effectively support the program
- Generate a person-centered atmosphere for all individuals served through our system
- Incoprate all IDD related measures into the provider profile

In this section, we focus on the HCBS and State IDD QM program and assurances. Our QM process to serve these programs will be closely coordinated with the overall ASO QM process to improve the quality of care provided to all individuals with behavioral health and developmental disabilities. We are committed to building a program that follows the principles of the CMS Quality Framework and the DBHDD QM Plan, so that:

- People have ready access to community supports and services
- People are empowered to achieve accomplishments that are personally meaningful
- People have an array of support options and providers of services to choose from
- People are safe in their communities and homes
- People are supported in making choices, exercising their rights, and taking responsibility
- People are satisfied with the supports they receive
- People are an integral part of their communities
- People define quality
- Systems are continuously striving to improve quality

EXPERIENCE

As a key partner in the ASO, Delmarva will bring their extensive experience to the proposed integrated QM program and structure, particularly in developing, implementing and maintaining effective and efficient quality assurance programs for individuals with intellectual and developmental disabilities. Since 2001, Delmarva's approach to QM for services rendered to individuals with IDD has always been to start with the people who are receiving these services.

This approach supports and empowers individuals to share their opinion, preferences and satisfaction about the supports and services they receive. It provides an opportunity for individuals to identify goals that matter most to them and to understand how services are helping support them to reach these goals. In addition, our GCAL partner, BHL, currently assists indiviudals with behavioral health or IDD in crisis through their mobile crisis programs.

Our collective expertise is extenseive, and includes all aspects of a QM program from building Web-based data applications, mobile phone applications and complex database systems to presenting clear, comprehensive results to State agencies, stakeholders, self-advocates, providers and families via our trained and experienced staff. As the current vendor providing oversight in the Georgia Quality Management System (GQMS), HCBS and State-funded IDD programs, Delmarva will build upon our familiarity with the State, regions, QI Councils, providers and individuals receiving services to help provide a seamless transition to the new QM System. By using staff already knowledgeable about DBHDD's goals and objectives—in combination with ValueOptions national experience, depth and resources—we will eliminate the 'learning curve' and deliver an effective, efficient and transparent implementation with minimal disruption to the provider. The structure of the new contract will also allow us to integrate our expertise in this area and provide greater quality oversight of individuals with co-occurring behavioral health and IDD needs.

CRITICAL COMPONENTS OF THE QUALITY REVIEW PROGRAM

Delmarva has designed and built extensive QA programs for HCBS and State-funded IDD populations in Georgia, Florida and South Carolina, and has provided quality improvement and oversight for individuals in Intermediate Care Facilities in California. Through this deep experience of building and running quality review programs, we have identified several components and values critical to the success of any quality review program, namely: collaboration, flexibility, validity/reliability, efficiency, transparency, and a consultative approach to working with providers.

The use of a collaborative approach to develop and revise tools and processes ensures all voices are taken into consideration and all relevant standards of quality supports and services are measured. Maintaining a flexible, efficient, and transparent system ensures ongoing evaluation while incorporating the ever changing needs of all stakeholders. Utilizing a consultative approach when addressing issues identified through the review process supports the State's efforts to implement and sustain quality improvement practices at the service level, ultimately impacting the experience and quality of life of the individuals we serve.

PERFORMANCE MEASURES FOR HCBS AND IDD STATE-FUNDED SERVICES

Our process will be consultative and developed in collaboration with DBHDD. In our experience, using a consultative approach, interacting with providers as essential entities within the delivery system and the individuals being served as the "customer," we support a process that allows for an open and honest exchange of information and experience. Therefore, we will use an interactive, collaborative approach to conduct PCRs, QEPRs and FUTACs, encouraging input from individuals receiving services, family members if present, and providers/staff. This will ensure the following desired outcomes of a quality system of care:

- Access to communities and activities as desired by the individual
- Individual participation in planning and implementing supports and services to meet the expressed and preferred needs of the person
- A sufficient number of qualified HCBS providers to serve individuals
- Individuals are safe and secure in their homes and communities, as per their informed and expressed choices
- Individuals exercise rights, accepting personal responsibility
- Individuals are satisfied with services and are achieving desired outcomes
- The system supports individuals efficiently and effectively, and strives for continuous quality improvement

Review of HCBS Assurances and Sub-assurances Performance Measures

We will continue to work with HSRI to refine and expand IDD-specific performance measures. As part of the National Quality Contractor and the National Quality Enterprise, which was funded by CMS, HSRI consulted to assist states in structuring their QI systems to include valid and reliable performance measures of their home- and community-based waiver services. Delmarva has also provided extensive assistance with development of performance measures in Georgia and Florida, particularly with the CMS assurances. Therefore, we are in an excellent position to assist in further developing and/or refining current performance measures for CMS and DOJ evidentiary reporting and other performance measures the State wishes to track.

Our QM Plan, as presented in this section, includes regular reporting of all performance measures and KPIs, validity checks for a sample of providers in IDD and behavioral health through our KPI validation process described in the Onsite Review section, and regular reports to the State of results on these measures. We have developed tools that identify, to the extent possible, how each standard is associated with a particular performance measure or KPI.

HCBS AND STATE-FUNDED TOOLS AND PROCESSES

Key processes to meet the requirements of this eRFP for the HCBS and State-funded IDD population include the PCR, QEPR and FUTAC. Our partner, Delmarva has provided these services in Georgia since 2008. Feedback from stakeholders has been used to develop the new streamlined, efficient processes presented in this proposal and has been woven into new review tools developed to evaluate both HCBS and State-funded services. We have included an example of one section from each of the new tools on **pages 201** through **208** that shows how we will capture information about key focused outcome areas (i.e., health, safety, rights, choice, community, and person-centered practices) throughout all components of the PCR and QEPR. After contract award, we will work collaboratively with DBHDD to revise each set of tools as needed to meet specific requirements or requests from the State. We will leverage our expertise in this area to support and refine the audit process for the behavioral health providers to ensure consistency in use of technology and resources wherever appropriate.

Provider Record Review Example

PERSON CENTERED PRACTICES			
Expectation: All person centered related issues or concerns have been addressed			
CMS ASSURANCES	**GEORGIA STANDARDS**	**BEST PRACTICE**	**REPORT**
☐ Documentation did not demonstrates review of progress and benefit of goals occurs regularly with the person; e.g., quarterly, semiannually or at other regular intervals ☐ It was not evident that supports and services change if goal or objective(s) are met or lack of progress is occurring with the person. ☐ The individual does not direct his or her supports and services. ☐ Documentation did not include dates of service. ☐ Documentation did not include times of service. ☐ Documentation did not include the person's response to the services, supports, care and treatment is evident. ☐ Documentation does not name the person served.	☐ Progress notes or learning logs does not describe progress toward goals including the individual's response to the intervention or activity based on data. D.III.2k ☐ The individual's response to the services, supports, care and treatment is not a consistent theme in documentation. D.III.3 ☐ There is no process for ongoing communication between staff members working with the same individuals in different programs, activities, schedules, or shifts. D.III.5	☐ Documentation did not reflect preference and/ or personal interests. ☐ Documentation did not reflect talents. ☐ Documentation did not reflect strengths. ☐ Documentation did not reflect communication style. ☐ Documentation did not demonstrate the person is making progress and/or achieving goals. ☐ Documentation did not demonstrate the person is working on goals that matter most to him or her. (At least one goal reflects the personal profile of the ISP). ☐ It is not evident that supports and services change if the needs of the person change. ☐ Documentation did not demonstrate the provider has an effective means of soliciting and/or addressing feedback from people receiving services, i.e., satisfaction surveys, monthly/quarterly discussion	If no checks, report states: All person centered related issues or concerns have been addressed. If checks, report states: The following choice related issues or concerns have been identified as areas needing improvement: <list the information checked off in the PRR Tool, SCR Tool>

Provider Record Review Example (con't)

☐ Documentation does not include specific activities and/or training provided. ☐ Documentation does not include provider credentials. ☐ Documentation is not by service. ☐ Documentation does not include the current ISP. ☐ Documentation does not include authorized services. ☐ Documentation does not reflect the services delivered to be consistent with the person's ISP. ☐ Documentation does not reflect the person making progress for the prior and current year of the ISP.		
Technical Assistance/ Remediation Provided		
☐ 1:1 Training ☐ Brainstorming ☐ Group Training ☐ Individual Discussion with Provider ☐ Group Discussion ☐ Resources – Hard Copy ☐ Resources -Web-Based ☐ Demonstration ☐ Skill Building ☐ Other:	Recommendations: Comments:	

Support Coordinator Record Review Example

PERSON CENTERED PRACTICES			
Expectation: All person centered related issues or concerns have been addressed			
CMS ASSURANCES	GEORGIA STANDARDS	BEST PRACTICE	REPORT
☐ Documentation did not demonstrates review of progress and benefit of goals occurs regularly with the person; e.g., quarterly, semi annually or at other regular intervals ☐ It was not evident that supports and services change if goal or objective(s) are met or lack of progress is occurring with the person.	☐ SC's documentation does not reflect monitoring of the implementation of the ISP (COMP/ NOW Waiver, p 29) ☐ Findings on ISP goals or progress for the participant are not documented (2902: 5h)	☐ Documentation did not reflect preference and/ or personal interests. ☐ Documentation did not reflect talents. ☐ Documentation did not reflect strengths. ☐ Documentation did not reflect communication style. ☐ Documentation did not demonstrate the person is making progress and/or achieving goals. ☐ Documentation did not demonstrate the person is working on goals that matter most to him or her. (At least one goal reflects the personal profile of the ISP). ☐ It is not evident that supports and services change if the needs of the person change. ☐ Documentation did not demonstrate the SC has an effective means of soliciting and/or addressing feedback from people receiving services, i.e., satisfaction surveys, monthly/quarterly discussion. ☐ Documentation shows opportunities to improve supports and services were missed.	If no checks, report states: All person centered related issues or concerns have been addressed. If checks, report states: The following choice related issues or concerns have been identified as areas needing improvement: <list the information checked SCRR Tool>

Support Coordinator Record Review Example (con't)

Technical Assistance/ Remediation Provided	
☐ 1:1 Training ☐ Brainstorming ☐ Group Training ☐ Individual Discussion with Provider ☐ Group Discussion ☐ Resources – Hard Copy ☐ Resources -Web-Based ☐ Demonstration ☐ Skill Building ☐ Other:	Recommendations: Comments:

Support Coordinator Interview Example

PERSON CENTERED PRACTICES		
Expectation: : A personal outcome approach is used to design person-centered supports and services		
Observation (if applicable)	**Support Coordinator Interview**	**Report**
☐ SC interaction does not foster independence. ☐ SC interaction is not person –focused: upbeat, include person's preferences and focuses on abilities of the person. ☐ SC does not promote independence by withholding assistance until it is clear the person needs it or requests it. ☐ SC interactions do not support rendering control to the person, i.e. SC instructs the person rather than promote independence. ☐ Missed opportunity to change a strategy or support to help the person make progress. ☐ SC does not utilize new strategies or supports when the person is not making progress. ☐ Missed opportunity to review progress on goals. ☐ Other:_____	☐ SC is unable to identify the person's current ISP goals and/or objectives relative to the service being provided. ☐ SC is unable to describe the strategies and methods used to support the person to reach goals and objectives. ☐ SC is unable to describe how the person is supported to become more independent and/or maintain a skill. ☐ SC is unable to describe how new things about the person's preferences and needs are continuously identified. ☐ SC is unable to describe how she or he evaluates the person's progress or lack of progress. ☐ SC is unaware of how the person demonstrates an increase in abilities, self-sufficiency or changes in his or her life. ☐ SC is unable to describe training activities that promote independent living skill development. ☐ SC is unaware of his or her role in responding to the individual's concerns. ☐ SC does not formally review the person's progress on goals/objectives with the person. ☐ SC is unable to describe the processes used to provide balance between wants and needs of the person. ☐ Other: _____	If no checks, report states: The person is actively involved in all decisions. If checks, report states: The following areas have been identified concerning the person's participation in all decisions: <list the information checked off in the SCI, OBS>

Support Coordinator Interview Example (con't)

Technical Assistance/ Remediation Provided	
☐ 1:1 Training ☐ Brainstorming ☐ Group Training ☐ Individual Discussion with Provider ☐ Group Discussion ☐ Resources – Hard Copy ☐ Resources -Web-Based ☐ Demonstration ☐ Skill Building ☐ Other:	Recommendations: Comments:

Individual Observation Staff Assessment Example

PERSON CENTERED PRACTICES			
Expectation: A personal outcome approach is used to design person-centered supports and services.			
Individual Interview	**Observations**	**Staff Interview**	**Report**
☐ Person does not feel supported in moving towards desired goals/dreams. ☐ The person is not working on goals/dreams that matter most. ☐ The person cannot identify something new or experienced in the last 6 months. ☐ The person cannot identify something that has been learned in the last 6 months. ☐ Person feels supports do not understand: o personal preferences o talents o strengths o abilities o needs ☐ Person does not feel current preferences are being solicited. ☐ The person's preferences are not taken into consideration in the development of the ISP. ☐ Other:_____	☐ Staff interaction is as a caretaker versus a coach. ☐ Staff interaction is not person – focused: upbeat, include person's preferences and focuses on abilities of the person. ☐ Staff does not promote independence by withholding assistance until it is clear the person needs it or requests it. ☐ Staff interactions do not support rendering control to the person, i.e. staff suggests activities rather than direct the person. ☐ Available activities are not based upon the person's preferences. ☐ Person is not praised or acknowledged when an accomplishment is made. ☐ Other:_____	☐ Staff is unable to identify the person's current ISP goals and/or objectives relative to the service being provided. ☐ Staff is unable to describe the strategies and methods used to support the person to reach goals and objectives. ☐ Staff is unable to describe how the person is supported to become more independent and/or maintain a skill. ☐ Staff is unable to describe training activities that promote independent living skill development. ☐ Staff is unable to describe how new things about the person's preferences and needs are continuously identified. ☐ Other:_____	If no checks, report states: A personal outcome approach is used to design person-centered supports and services. If checks, report states: The following areas have been identified concerning person centered approach to supports and services: <list the information checked off in the II, OBS, SI>

Individual Observation Staff Assessment Example (con't)

Expectation: Supports and services change as the person wants and needs change.			
☐ Person is not able to describe progress on his/her goals. ☐ Person reports no one reviews progress on his/her goals. ☐ Person is not involved in the routine review of progress toward goals. ☐ Person does not feel changes to goals/supports and services can be made. ☐ Other:_____	☐ Missed opportunity to change a strategy or support to help the person make progress. ☐ Staff does not utilize new strategies or supports when the person is not making progress. ☐ Missed opportunity to review progress on goals. ☐ Other:_____	☐ Staff is unable to identify the person's progress on current ISP goals and/or objectives relative to the service being provided. ☐ Staff is unable to describe new techniques/strategies used in the last 6 months to help support the person's objectives/goals. ☐ Staff does not formally review the person's progress on goals/objectives with the person. ☐ Staff is unable to describe what happens when new information and preferences are learned about a person. ☐ Staff is unable to describe the processes used to provide balance between wants and needs of the person. ☐ Other:_____	If no checks, report states: Supports and services change as the person's wants and needs change. If checks, report states: The following areas have been identified concerning supports and services not changing as the person's wants and needs change: <list the information checked off in the II, OBS, SI>

Technical Assistance/ Remediation Provided	
☐ 1:1 Training ☐ Brainstorming ☐ Group Training ☐ Individual Discussion with Provider ☐ Strategic Planning ☐ Group Discussion ☐ Resources – Hard Copy ☐ Resources -Web-Based ☐ Role Play ☐ Demonstration ☐ Skill Building ☐ Other:	Recommendations: Comments:

Person-Centered Review

The PCR encapsulates the Quality Framework by ensuring the individual receiving supports and services is the primary focus. The process starts with the individual. A person-centered approach focuses on the individual's dreams, life, and circumstances and is based upon an individual's abilities rather than disabilities. It evaluates the efforts of others to empower the individual to achieve personal goals within the community. We share in this responsibility by supporting and educating stakeholders, including providers, support coordinators and other supports in utilizing this approach to service delivery. As illustrated below, there are six key areas of service delivery necessary to support a person in leading a good quality of life.

Each of these key areas are incorporated into the review processes developed for this proposal. We promote the philosophy among all stakeholders that people should define expectations for themselves as well as the expectations of the supports and activities in their lives, just as we do. Our QICs share and support this philosophy, reflecting these principles in their actions and their work during review activities and when interfacing with all other stakeholders.

The PCR process comprises sample selection, pre-onsite, onsite, and post-onsite activities. We have provided the PCR process flowcharts on the following page.

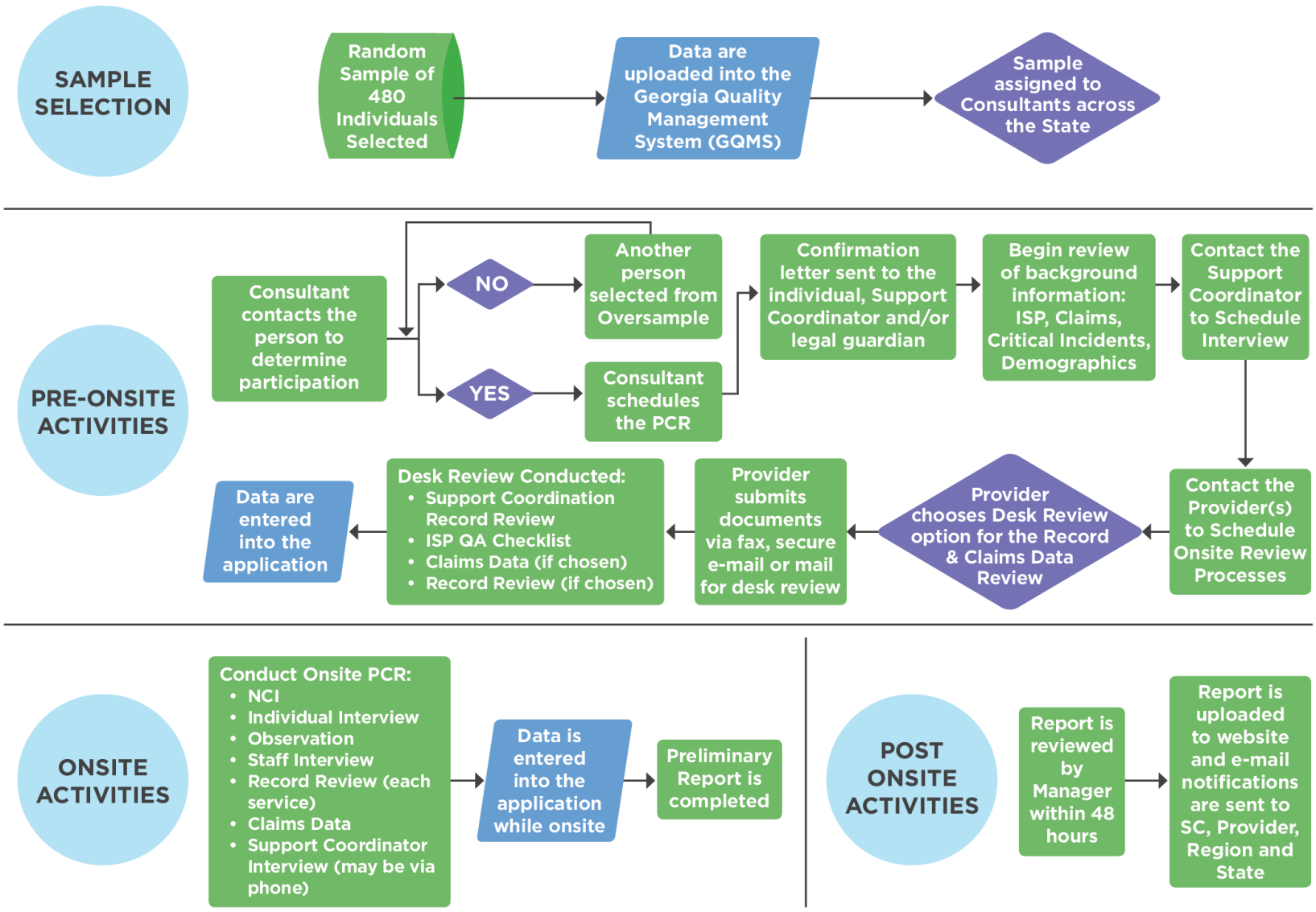
Six Key Functions of Service Delivery

Sample Selection

In Delmarva's current Georgia contract, a "cluster design" was required whereby individuals for the PCR were sampled from a list of 39 providers randomly selected for the QEPR. While this type of cluster sample was appropriate in the first year, in subsequent years providers who had already received a QEPR were removed from consideration in the sample. The sample for the PCR was no longer drawn from the population as a whole, and became less representative each year. Providers felt Delmarva was constantly conducting reviews in their programs because all 480 people came only from those 39 providers. The new sampling methodology we propose will provide a more valid and representative sample of individuals receiving services across the eight years of the ASO contract, offering an improvement from the limitations of the previous years.

Innovative Redesign: The sample methodology will be developed with and approved by DBHDD. Given our experience and the scope of the program in Georgia, we propose to randomly select 480 individuals receiving HCBS Medicaid Waiver or State-funded services. The sampling frame will consist of all individuals receiving services from across the state and will be stratified to ensure proportionate representation in each of the six regions. Further, it will include individuals who transitioned from an institution as a result of the ADA Settlement. We anticipate this will generate data representative of the population with a high degree of confidence and low error rates (i.e., 95 percent confidence, +/- 5 percent confidence interval).

Person-Centered Review Process



Pre-Onsite Activities

Pre-onsite activity consists primarily of scheduling the interview with the individual and the individual's support coordinator, and reviewing web-based records. In addition we will work collaboratively with the behavioral health audit staff, ensuring coordination of activity such that providers experience an integrated single site visit to meet all applicable review expectations.

To minimize the administrative burden for providers, when providers are selected for a QEPR as part of the PCR sample, the PCR will be conducted at the same time as the QEPR and behavioral health audit if appropriate.

For the IDD review, QICs will initiate contact with the person and schedule activities for the PCR, ensuring the individual understands that participation is voluntary, and the interview location and time is chosen by the individual. The QICs will contact the provider(s) including the Support Coordinator or State Support Coordinator/Planning List Administrator (referred to as Support Coordinator from this point forward) to describe the PCR process and arrange interviews. Review of the Web-based records includes the State Support records and monitoring reports, ISPs using the ISP QA Checklist, claims data and other documentation specific to the person.

Innovative Redesign: Over the past five years, feedback from providers has indicated that onsite record reviews are time consuming and burdensome for administrative staff. As such, we will offer a Desk Review, which gives providers an opportunity to submit up to 12 months of records (for behavioral health and/or waiver/State-funded services) to our QICs via fax, secure portal/website, secure e-mail, or U.S. mail to determine compliance and compare to claims data. Any noted discrepancies in the units billed versus the documented services provided will be included in a report made available to the State. The Desk Review serves to reduce the administrative burden for the provider. If the provider declines this option, records will be reviewed while onsite during the PCR. Record review includes verifying documentation of progress notes, level of care, and the ISP.

Onsite Activities

Face-to-Face Interview: The PCR process begins with interviewing the individual receiving services, to first hear the opinions and preferences related to the quality of all support and services being received, including behavior health. The interview has two components, the NCI Adult Consumer Survey and the Individual Interview. QICs will first conduct the NCI Adult Consumer survey created by HSRI and then interview the individual with the more open-ended questions from the Individual Interview designed by Delmarva. Each interview will solicit the person's opinions and preferences in the areas of health, safety, rights, choice, community life, and person-centered practices. Our review tools, presented on **pages 201** through **208**, will have final revisions and DBHDD approval after contract award.

Delmarva's consultants have interviewed more than 6,000 individuals receiving services in Georgia. Many of these individuals use an alternative communication style and may need support during the interviews. If necessary, or at the individual's request, a guardian, a family member, and/or someone who knows the person and the person's communication style best may

participate to support them during the interview. No matter who is present during the interview, **the consultant will always solicit the individual's answer first**.

If at any time during review activity it appears the health and safety of any individual is in jeopardy, DBHDD and other relevant authorities will immediately be notified.

Observation/Staff Interview: The PCR includes an observation at the individual's residential and/or day program sites, identifying how the person is responding to the environment. In addition, interactions with staff and observation of any barriers and challenges that might affect service delivery in the outcome areas of health, safety, rights, choices, community life, and person centered practices are noted. Observations will not be conducted in family homes or while a person is at work.

Innovative Redesign: If the person is identified as being more vulnerable and/or presents with significant challenges that may impact the person's ongoing health and safety, the QIC can refer the person to the Regional Network Team and/or Intensive Care Manager to provide additional technical assistance, coordination, education and/or resources to help sustain the person's health and wellbeing. This will be especially beneficial to individuals included as part of the ADA settlement agreement or those who have a dual diagnosis.

Innovative Redesign: When the GQMS was implemented in 2008, direct support staff were largely unaware of person-centered practices. As hands-on and formal training occurred via Delmarva and DBHDD's efforts, staff have become better able to speak to these concepts and understand the philosophy. However, many continue to struggle with the implementation of person-centered practices. Observation and staff interview scores have consistently showed more than 90 percent compliance; however, based upon additional observation, consultants have indicated this is unrealistic. As a result, we have redesigned the process and tools to conduct observations and staff interviews simultaneously for people who receive day program and/or residential services. The QIC will observe how staff implement a person-centered approach, how they ensure health and safety are maintained and how they ensure rights and choices are upheld and offered. When necessary, QICs will interact with individuals and staff to better evaluate implementation of these practices. These interactions will be conducted in the least intrusive manner possible.

Record Review/Claims Data: The provider's service record and claims data for the individual will be reviewed as described above, but reviewed onsite if preferred by the provider. Onsite review has the advantage of providing a more interactive and consultative approach, and allows providers to locate missing documentation before the review closing.

Support Coordinator Interview (SCI): The Support Coordinator is essential to ensuring the coordination and quality of a person's services and supports including writing a person-centered ISP that reflects and meets the person's needs and goals. The SCI will help QICs determine how well the Support Coordinator evaluates the person's needs and the quality of services received, and ensures supports are meeting the person's expectations. Information from the SCI will be

used to assess the Support Coordinator's knowledge and practices used to deliver quality services, to include:

- Verification of services being delivered
- Appropriate contacts are being made by the Support Coordinator for the person
- Monitoring reports and rating for face-to-face contacts
- Incident reporting
- Fair hearing notifications
- Monthly reporting requirements
- Results of evaluation of quality of services
- Results of interactions with the provider and direct support staff

Innovative Redesign: With the DBHDD's recent initiative to redesign the support coordination system, having data to evaluate its effectiveness will be key. The new SCI tool and interview process will do just that. In the current process, QICs informally contact Support Coordinators to obtain supplemental information, clarify discrepancies and identify mechanisms to improve the person's service delivery system. This information is incorporated into the PCR but there are no specific data available for analysis. The SCI will allow us to better identify the quality of support coordination services and provide data points for analysis to track the effectiveness of Support Coordinators and the redesigned system.

Preliminary report generation: Prior to leaving, the QICs will use the Web-based application to generate a preliminary report for providers, the Support Coordinator and the individual, if requested.

Innovative Redesign: By using laptops or tablets with touch pad capability, data entry during the PCR will be less intrusive and less likely to impact the person-centered approach to the process. Currently it often takes 30 days to generate a PCR report.

New processes and technologies will allow for onsite data entry and real-time data reporting, allowing most data to be available within 48 hours of completion of the review.

Post-Onsite Activities

Report Approval: Managers will review the report to ensure accurate interpretation of the standards, appropriate recommendations have been made, and will make corrections as necessary. The report will be finalized, approved and distributed within 30 days of the PCR date.

Report Dissemination: Along with the PCR process redesign, the report format will be redesigned and developed in conjunction with DBHDD. It will include streamlined results using succinct bullets, tables and graphs; identify specific areas needing improvement; and offer recommendations to be addressed by the person and the support team. An automated system will upload PCR reports to a secure portal/website with e-mail notifications sent to DBHDD, the individual and/or family if requested, provider(s), and support coordination agency.

Quality Enhancement Provider Review

The seven desired outcomes of the HCBS Quality of Care identified on **page 198** are woven into the QEPR process. The QEPR evaluates a provider's capabilities, system effectiveness, and compliance with HCBS Quality of Care and DBHDD's policies and procedures. There are four key components of the QEPR process: Sample Selection, Pre-Onsite, Onsite, and Post-Onsite activities. We have provided the QEPR process flowcharts on **page 215**.

Following CMS's quality framework, data will be collected in a variety of formats (**discovery**). The process will be interactive and identify systems that work well and those that present challenges. Technical guidance will be provided to improve outcomes (**remediation**). The final report to providers will include recommendations for the enhancement of practices and supports and services rendered (**improvement**).

Sample Selection

A random sample of approximately 95 HCBS waiver and State-funded service providers rendering services to individuals selected for the PCR will be selected to participate in a QEPR each year and reviewed at least once every four years. The sample will be stratified by size to ensure large providers are distributed across the four years. One support coordination agency will be selected each year, to include Regional Support Coordinators and Planning List Administrators. This list of selected providers will be shared with DBHDD prior to scheduling activity. We recommend a range of 95 to 100 providers per year, as DBHDD may recommend additional providers for an onsite QEPR.

Innovative Redesign: To reduce the administrative burden, providers who also render supports and services for the behavioral health population will receive a QEPR and onsite behavioral health audit concurrently. To reduce the possibility of crossover with other State audits, a schedule of all provider reviews will be developed for the year and shared with DBHDD and DCH. To ensure the QEPR/behavioral health audit is completed within a five-day period, depending on the number and type of population served, the appropriate number and type (e.g., psychologist, clinical social worker, nurse) of regional reviewers and consultants will be assigned from the Regional Network Team located in the same area as the provider.

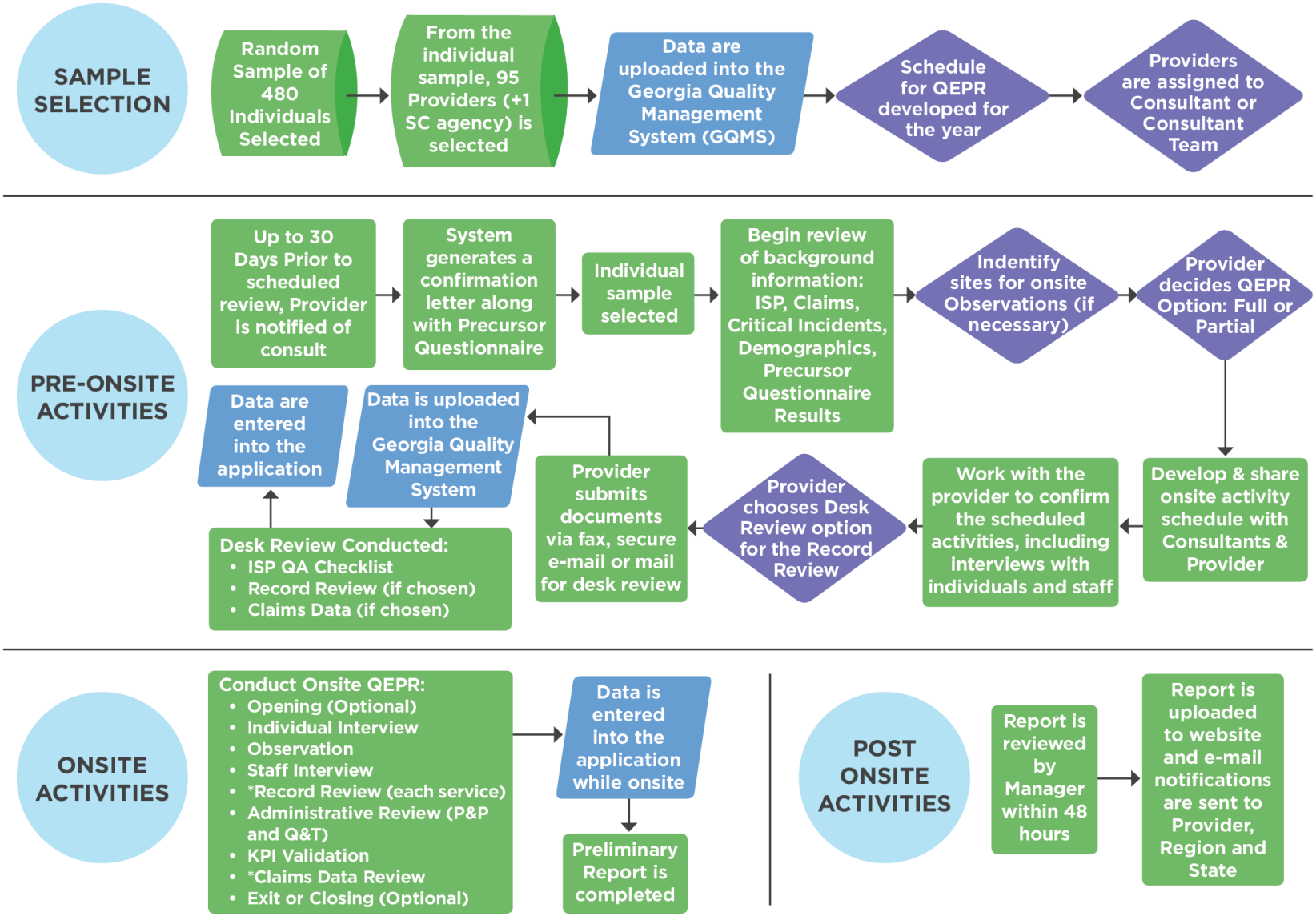
Furthermore, PCRs will be conducted at the same time as the QEPR and infuse the QEPR process with the perspective of the individual and, where appropriate, the behavioral health services as well. PCR data (i.e., ISP QA Checklist, Individual Interview, Record Review, Observation, SCI) will be included as part of the overall findings and recommendations in the final QEPR report.

Pre-Onsite Activities

Collect Background Information: Pursuant to the requirements of DBHDD, the following background information for the provider will be reviewed for up to a 12-month period prior to the review to focus efforts on specific areas of the provider's service delivery system:

- Critical incidents
- Support coordination monitoring reports
- Complaints and grievances
- Claims data
- Corrective Action Plans submitted to the Regional Office

QEPR Review Process



Contact Provider/Develop Onsite Review Schedule: Up to 30 days in advance of the onsite review, providers will be notified via telephone and confirmation letter. The letter includes a brief description of the process and expectations for the review, a description of options, the Precursor Questionnaire, shown on **pages 217** through **223** of this proposal, and a website to access the procedures manual. Options are designed to offer providers more control of the process, minimize the time spent onsite, and include:

- Full: Opening **and** Closing Conference **included**
- Partial: Opening **or** Closing Conference **included**
- Basic: Opening **and** Closing **not** included

The regional team lead will ensure the appropriate reviewers are assigned to conduct the QEPR and designate an IDD Team Lead to organize onsite activities with team members assigned to the QEPR.

QEPR Sample of Individuals: A sample of individuals will be selected for each QEPR and stratified to ensure all services are reviewed, including behavioral health services for individuals with a dual diagnosis. In order to select a representative sample that is statistically valid, the selection process will be random and the probability of selection will be known. This method generates a sample that is representative of the population and suitable for use with standard measures of statistical significance, such as the t-tests used in many types of analyses. Our extensive experience with compliance/record review in Georgia, Florida and South Carolina indicates provider compliance is typically high and records are very similar (i.e., little variance), and there are diminishing returns from over-sampling record reviews.

Using a variance standard based on 85 percent compliance, a 90 percent confidence level and +/- 10 points, sample sizes indicated in the table adequately represent provider organizations. In addition, record review data in both Georgia and Florida have reflected higher compliance scores when the review is completed as part of a PCR because of the prior notification required for this process. The provider has up to a month to gather needed documentation for the person. Therefore, additional record reviews will always be completed as part of the onsite QEPR to ensure adequate representation of the organizational systems. With DBHDD approval, sample sizes in the table presented below will be used for the QEPR:

Provider Caseload	Sample Size		Example
	Min	Max	
<=30	2	10	Serves three: two PCRs completed; review all remaining people
31-100	6	25	Serves 60: 18 PCRs completed; sample seven more
>100	10	34	Serves 200: 50 PCRs completed; sample 10 more

Quality Enhancement Provider Review
Precursor Questionnaire

Thank you for your participation in the Quality Enhancement Provider Review process. Delmarva Foundation is proud to be working in partnership with the State of Georgia Department of Behavioral Health and developmental Disabilities (DBHDD) in improving the quality of supports for Georgia citizens with developmental disabilities. Our mission is to promote a person directed service delivery system through collaborative quality improvement strategies designed to enhance the lives of people. Through our upcoming consultation, our hope is to enhance your service delivery system in order to produce results that reflect communicated choices and preferences that matter most to the people you support.

Please provide responses to the following questions. Your responses will provide information pertinent to the QEPR process, and will assist in generating dialogue beneficial to this consultative quality improvement initiative. Please contact the Quality Improvement Consultant or Delmarva Foundation if you have any additional questions. Once completed, you can mail this questionnaire to the Delmarva Foundation Office at: 5775 Glenridge Drive, NE, Building B, Suite 350, Atlanta, Georgia 30328, or e-mail it to georgia@dfmc.org or fax it to 404-453-9675. Please complete and send back at least ten (10) business days prior to the Quality Enhancement Provider Review (QEPR).

Provider Name	
Provider Address	
Provider Region	
Provider Phone #	
Precursor prepared by	
QEPR Lead Consultant	

1) What is your organization's Mission? What actions do you take on a regular basis to assure you are meeting your mission?

2) What are your organization's goals you are working on this year, and what progress have you been able to make on these goals?

3) What do you expect from the Quality Enhancement Provider Review (QEPR), and how might we support your organization in better achieving its goals?

4) What is one thing you would like to change about your organization's systems or practices that you believe would improve the effectiveness of your service delivery?

5) What type of support, technical assistance, training, resources, etc. would you like for Delmarva to provide you that would benefit your organization's systems and practices?

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6) What is one person centered tool or area of learning, education, support you believe would most benefit your organization in delivering person centered supports?

7) Based on the results of your organization's internal quality improvement self-assessment, what **Strengths** have you identified within your organization? Please complete attachments A.

8) A component of the Quality Enhancement Provider Review (QEPR) is to identify "**What's Working**" and "**Barriers/Challenges to Service Delivery**" within the six focused areas (Health, Safety, Rights, Choice, Community, and Person-centered Practices). Please complete Attachment B describing your organization's systems and practices as it applies to each focused area.

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Attachment A: Identify which **Strengths** describe your organization

	Provider's access to support networks and recourses		Provider's knowledge of community resources
	Provider's accessibility to individuals they are serving		Provider's knowledge of the service delivery system
	Advocacy skills and abilities		Provider's knowledge of sign language
	Providing choices through the use of education, exposure and experience.		Provider's leadership
	Provider's attitude of putting the persons served first		Provider's longevity with the individuals served
	Provider's commitment to person centered approach to service delivery		Provider maintains relationships with the community
	Provider's creative problem solving skills and abilities		Provider's mentoring system
	Provider's creativity in developing programs		Provider's mission statement
	Customer's satisfaction with supports and services		Provider's networking skills
	Dependability of the provider		Provider's organizational skills
	Provider's demonstration of concern for individuals served		Provider's patience
	Provider's developed rapport/relationship with other organizations/providers		Provider's professional approach
	Trust built with the individual(s) served		Provider's prompt service
	Provider's dissemination and communication of information to individuals served		Provider's pursuit of alternative funding
	Provider's education of individuals served		Provider's rapport with the Regional Office
	Provider's emergency response processes		Provider's receptiveness to improving their quality of supports and services
	Provider's emphasis on choice/options		Provider's relationship with individuals served
	Provider's emphasis on health		Provider's respect for individuals served
	Provider's emphasis on independence		Provider's responsiveness to the individuals' needs
	Provider's emphasis on rights		Provider's sensitivity to cultural differences
	Provider's emphasis on safety		The staff working with the individuals
	Provider's emphasis on development of social roles important to the person		The staff's experience
	Provider's documentation used to assess and enhance service delivery		The screening process for staff
	Provider exceeds the training requirements		The processes for staff training and professional development
	Provider's experience in this area		Provider's teamwork approach
	Provider facilitates the individual's involvement in the community		Provider's tracking systems monitoring quality of supports and services
	Provider is flexible		Provider's use of community resources and natural supports
	Provider focuses on goals and outcomes		Provider's varied training
	The provider's self-assessment process enhances service delivery		The provider is well-liked by the individuals served
	Other:		Other:

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Attachment B: The table below identifies the expectations for each Focused Outcome Area. Please review these and in the columns next to each please describe your overall systems and practices you have in place to support the expectations in the "**What's Working**" section. Then, identify any barriers/challenges your organization has to meeting those expectations in the **"Barriers/Challenges to Service Delivery"** section. See each section for examples.

Expectations for Focused Outcome Area Health	What's Working	Barriers/Challenges to Service Delivery
• **People are being supported to manage their own healthcare to the best of their ability.** • **Support staff are knowledgeable about people's diagnosis, current health status and medications.** • **Provider is promoting preventative healthcare and wellness through ongoing education, exposure and experience.** • **Internal procedures reflect current practices and support a holistic approach to healthcare.** • **Documentation reflects people's current diagnosis, health status, medications (purpose & side effects) and supports offered in this area.**	**Ex:** *All preventative care such as annual exams are completed and tracked in the person's record. Monthly training for individuals is provided on different health related topics like nutrition.*	**Ex:** *Family does not always communicate when medical appointments occur or when there are changes in medications.*
Expectations for Focused Outcome Area Safety	**What's Working**	**Barriers/Challenges to Service Delivery**
• **People are continually learning how to be safe, to the best of their ability, in a variety of settings.** • **Individuals are being supported to learn about Abuse, Neglect and Exploitation.** • **Staff are aware of people's safety needs and provide meaningful education, exposure and experience to promote independence.** • **The provider has a solid system in places to track and trend safety measures (including critical incidents, safety drills, corrective action plans, and support coordination ratings).** • **Individual records contain information related to**	*Ex: Staff provides individualized and group training on safety related topics.*	**Ex:** *There is not a uniform means to document a person's safety needs. Need a document that can maintain this information and be updated as needed.*

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safety skills and identified safety needs (i.e. self preservation plans, risk protocols, assessments, behavioral support plans).		
Expectations for Focused Outcome Area Rights	**What's Working**	**Barriers/Challenges to Service Delivery**
• **Individuals are offered ongoing rights education based upon their unique learning style (this includes education about responsibilities).** • **Individuals are supported to experience rights which matter most to them.** • **Staff are able to identify which rights are most important to the person and offer ongoing opportunities for people to experience these rights.** • **Staff incorporate rights education and application into everyday supports.** • **Provider promotes person centered practices related to rights & responsibilities (i.e. Dignity of Risk, Guardianship, Grievance policy, HIPPA Policy, Confidentiality).** • **Provider promotes self advocacy through continued efforts (i.e. "Right" of the month, People's First, committee involvement).** • **Documentation demonstrates opportunities for individuals to experience rights that matter most to them. Documentation demonstrates efforts related to rights education. Documentation includes evidence of rights & responsibilities reviewed annually.**	Ex: *Human Rights are reviewed with individuals annually and include HIPAA and grievance practices.*	Ex: *Difficulty retrieving signed informed consent for psychotropic medications from legal guardians.*

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Expectations for Focused Outcome Area Choice	What's Working	Barriers/Challenges to Service Delivery
• **Individuals are given the opportunity to be informed of and included in <u>all</u> decisions in their life. (provider options, paid support options, daily routine, friendships, community connections, employment opportunities, money management, relationships, living options)** • **Support staff continuously provide new opportunities for meaningful choices (beyond "general/ basic" choice).** • **Support staff promote customized choices based upon what matters most the person.** • **Provider has a means to actively solicit information about personal and individualized preferences.** • **Documentation shows a variety of <u>meaningful</u> choices offered.** • **Documentation demonstrates choices.**	Ex: *Staff continuously offer individuals choices regarding their daily routines and upholding their preferences.*	Ex: *Sometimes it is difficult to identify choices and preferences for individuals with alternative communication styles.*
Expectations for Focused Outcome Area Community Life	**What's Working**	**Barriers/Challenges to Service Delivery**
• **Individuals are developing and maintaining connections to people within their communities.** • **Individuals are making friends in their community with others who share their interests.** • **Staff understands the difference between going out in the community verses becoming a part of the community and promote true connections.** • **Staff continually pursue creative community activities & introduce new activities based upon individuals' preferences.** • **The provider is networking with businesses, clubs, advocacy groups, volunteer opportunities etc. within their community.**	Ex: *Created interest clubs to facilitate community involvement. The clubs bring community resources to the agency, and other club activities occur in the community.*	Ex: *Transportation and funding are often challenges to helping people develop community connections.*

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• **Established relationships are utilized to develop and maintain meaningful connections for both the provider and individuals being supported.** • **Documentation demonstrates the provider's efforts to develop and enhance community connections.** • **Documentation includes the individuals' responses to community integration opportunities.**		
Expectations for Focused Outcome Area Person Centered Practices	**What's Working**	**Barriers/Challenges to Service Delivery**
• **Individuals are working on goals that matter most to them and relate to their hopes and dreams.** • **Individuals are continuously involved in their goal development and ongoing review of the goals (i.e. Pre-ISP meetings and ISP Reviews).** • **Staff support individuals to advocate for goals that are important to them and create individualized training opportunities to help them achieve results.** • **Staff recognize individuals' definition of success and are continually monitoring goal progress and/or lack of progress with them.** • **Systems are in place to evaluate the effectiveness of services and include the persons input (i.e. satisfaction surveys).** • **The provider has a means to recognize and celebrate achievements being made by individuals and staff.** • **Documentation reflects the benefits of the goals and specific progress or lack of progress being made.** • **Documentation reflects follow up efforts when a goal is met (prior to the ISP expiration date) or when there is a lack of progress identified.** • **Provider promotes practical application of person centered tools.**	Ex: *Different satisfaction survey tools are used for individuals, family members, and support coordination to determine satisfaction with supports and services.*	Ex: *Difficult to consistently use person centered thinking tools to determine individuals' preferences and what matter most to them.*

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The provider will assist in scheduling interviews with individuals. Formal interviews will be conducted with staff where observation of supports and services being rendered and interaction with the person and staff are not possible. Interviews will be scheduled with staff providing such services as supported employment and behavioral supports.

Conduct Desk Review Components: Embedded fully in the ASO's Quality Department, Delmarva will have access to ValueOptions' CONNECTS information management system which will house the Individual Service Plan (ISP) as well as the Support Coordinator progress notes and monitoring reports. The reviewing team will review all electronic information including:

- Support Intensity Scale (SIS)
- Individual Service Plan
- Support Coordinator contact notes
- Health Risk Screening Tool (HRST)

While onsite, the QIC will offer the provider an additional opportunity to produce the documents that were not present during the desk review or the onsite review.

To decrease the provider's administrative burden, the option to securely submit additional records required for the record review and claims review portion of the QEPR will be offered. If the provider does not select this option, the records will be reviewed during the onsite QEPR. Electronic reports and other information in the individual's record will be reviewed for up to 12 months retrospectively.

Onsite Activities

Opening Conference: The Opening Conference is the forum in which the ASO's QM team sets the collaborative tone of the QEPR. It is an opportunity to:

- Meet with the provider, staff and/or individuals receiving services to discuss the QEPR process
- Discuss the provider's mission and responses to the precursor questionnaire
- Confirm the agenda and scheduled activities, including individual interviews, record reviews, administrative review, staff interviews, and observations

It will be the provider's responsibility to gather and make available the individuals' comprehensive records related to services and any other relevant records maintained by the provider, to be presented to QICs and made available for the duration of the QEPR. Rather than viewing this onsite consult as an audit, our QICs facilitate an interactive/consultative dialogue with the provider which fosters a positive climate to answer questions and retrieve all required documentation needed.

Individual Interviews: Individuals who give consent will be interviewed to determine their level of satisfaction with supports and services (including behavioral health) they receive from the provider using the same tool and protocols as described in the PCR section. While some interviews will be formally scheduled prior to the onsite review, others may be informal and occur if the person is willing.

Support Coordinator Interviews: A telephonic or face-to-face interview with Support Coordinators will be part of the information gathering process as described in the PCR section.

Observations/Staff Interviews: Observations will be conducted by the consultants during the onsite review activities. This information will be used to identify areas of opportunity or concern including, but not limited to:

- Implementation of person-directed services
- Application of person's outcomes/plan/services
- Informed choice
- Cleanliness
- Rights restrictions
- Privacy, respect and dignity
- Safety and health (including medications)
- Abuse, neglect and exploitation
- Appropriate staffing
- Community integration

The new observation tool developed for this proposal is very thorough and designed to decrease time for staff interviews; however, there will be times when direct questions will offer a more comprehensive understanding of the staff's knowledge and practices. The interview will offer the staff an opportunity to further explain formal and informal practices that reinforce applied provider policies and procedures. The interview with staff will be consultative and completed in the least intrusive manner to minimize disruption of supports and services.

Innovative Redesign: Unannounced observations for individuals who receive day and residential services (in group/host home settings) will be conducted as part of the QEPR. We believe this will add value as providers currently have time to "get ready" for onsite observations. In this new process, the provider will know QICs will be conducting the QEPR during a certain timeframe but not know which locations will be observed or when. All day programs will be observed during the QEPR. Depending on the total number of residential sites, a sample will be selected to observe at various times during the day/evening when individuals are present. The consultants will be mindful and respectful of the individuals living in the home, understanding it is their home. These observations could be compared to data collected from the PCR-announced observations to determine if there is any variance in scoring.

Record Review: Record reviews will be conducted for providers who offer direct services and support coordination. Revised tools for the new contract will be designed to ensure the State's rules and regulations, CMS assurances and sub-assurances and national best practices are addressed. Claims will be reviewed as part of the record review process, as described in the PCR above. Aligning with the overall mission of the Quality Management System, record reviews will focus on the six key functions of service delivery for the person.

For the QEPR conducted for the Support Coordination entity and Regional State Support Coordination/Planning List Administrators, a specific instrument used as part of the PCR will be used to review their records. It will also include the ISP QA Checklist. This tool will be developed and rolled out along with the implementation of the new electronic ISP and process.

Administrative Review: The Administrative Review includes a review of staff records, including subcontractors rendering supports and services, and the provider's policies and

procedures. When needed, this portion of the review will be conducted concurrenty with the behavioral health administrative audit. Review of a sample of staff records will be completed for at least two staff per service or 25 percent, with a maximum of 30, ensuring all services are reviewed. Up to 30 records will be reviewed for support coordination agencies. The review for all providers will include verification of qualifications according to the service rendered, national criminal records check requirements, and compliance and receipt of the training requirements outlined in DBHDD rules and regulations.

The Administrative Review will also include a review of all required policies and procedures. Through interviews, observations and record reviews, QICs will determine if the necessary policies and procedures are being implemented. To reduce the administrative burden on the provider, only policies and procedures deemed necessary based upon the results and findings or as required by DBHDD will be reviewed.

KPI Validation: As identified in *Section I.4*, providers will be required to submit KPI results quarterly and these results will be posted to the Provider Profile website. During the QEPR, the provider's documentation demonstrating how the KPI results were determined and calculated will be reviewed. This process will validate the performance measure data and the results submitted by the provider. If concerns and issues are identified, the provider will be required to correct the results and a member of the Review Network Team will conduct a follow-up to ensure the corrections are accurate.

Data Entry and Preliminary Findings: The use of a Web-based application and laptops/tablets with touch screens will support efforts to maintain the consultative interactive approach of the QEPR while enhancing our ability to complete data entry onsite. The IDD Team Lead will review all data entry to ensure there are no concerns or missing information and generate recommendations in the key focus areas of the consult (i.e., health, safety, rights, choice, community, and person-centered approach). The QEPR lead will prepare the preliminary findings to present at the Exit/Closing Conference. If the provider opts for the full QEPR, the lead will work with the team to prepare a Closing Conference.

Exit/Closing Conference: We will schedule a time with the provider to conduct the Exit/Closing Conference. An Exit interview will be part of all QEPRs but providers may also opt for the more extensive Closing Conference. The IDD lead and behavioral health lead will present the preliminary findings based upon the staff and individual record review results. If the provider selects the Closing Conference, QICs will share the findings and identify opportunities for improvement for individuals served, staff, administrative practices, and documentation.

Members of the review team will discuss each of the six key functions of service delivery to focus on identifying strengths as well as ideas and recommendations to improve organizational practices. Based upon these results, the team will collaborate with the organization to develop a plan to further support quality improvement initiatives and maintain momentum. The provider will be expected to begin working on the identified issues following the onsite QEPR and be prepared to discuss results of improvement initiatives at the time of the FUTAC.

Post-Review Activities

Post-review activities include the **QEPR Report of Findings**. To streamline the reporting process, to the extent possible data entry will occur while onsite and a preliminary report of findings will be completed before leaving the location. A comprehensive QEPR Report will include at a minimum:

- Strengths
- Recommendations for FUTAC
- Issues for Immediate Remediation
- Deficiencies Needing Improvement
- Fraud and Abuse
- Claims/Recoupment Issues

The report will be generated and distributed to the provider and DBHDD within 30 working days of the Exit and/or Closing Conference, by posting on a secure website to be accessed by both parties. The recommendations documented in the report will be used by the provider to develop quality improvement initiatives.

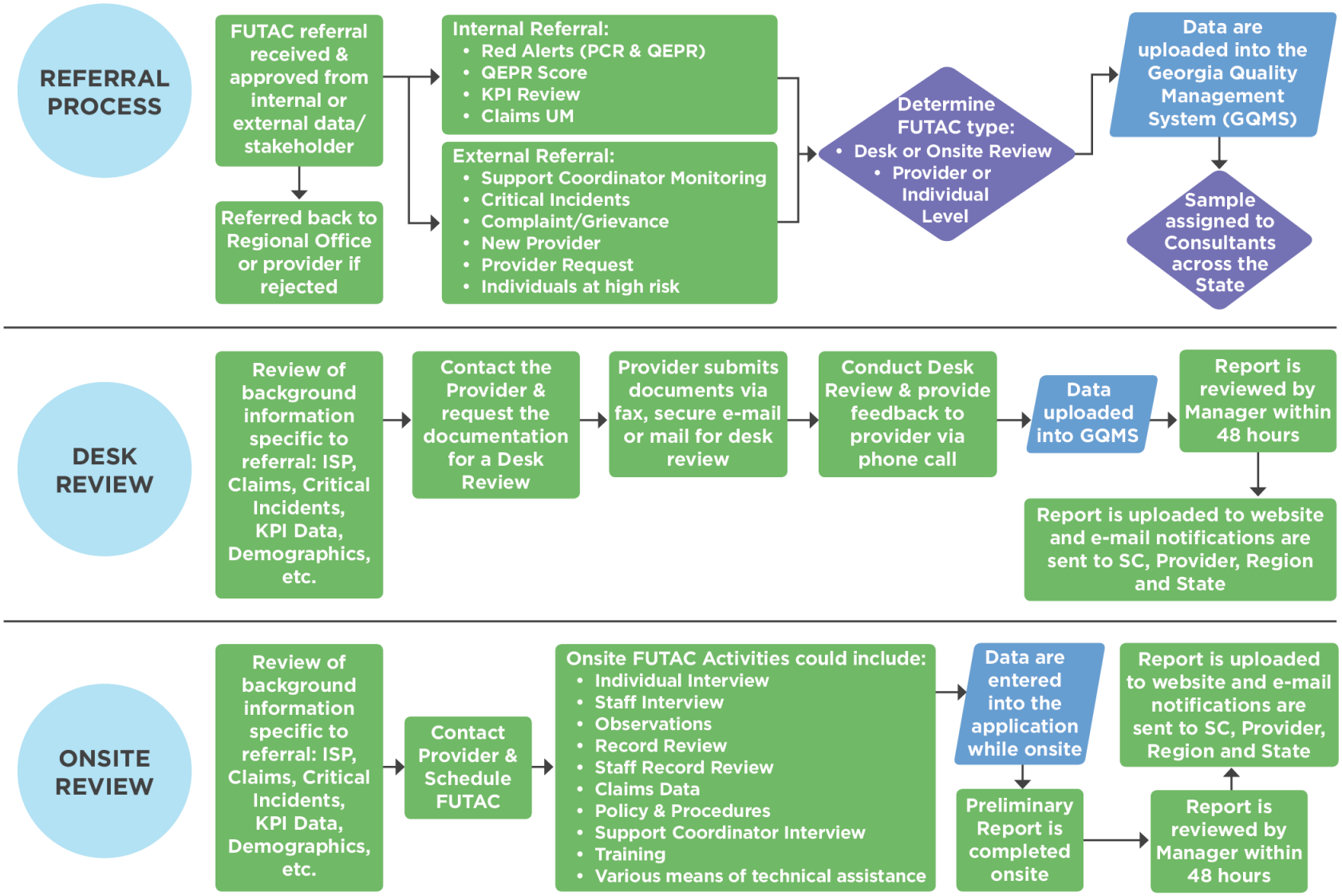
Follow Up with Technical Assistance

The FUTAC began as a process to ensure providers were addressing issues/concerns and responding to recommendations identified in the QEPR process. The FUTAC system was later expanded in response to several issues and concerns identified by DBHDD, including:

1. CMS requirements to document remediation on performance indicator sub-assurances
2. Provider requests for technical assistance
3. Further follow-up on concerns and issues identified through other monitoring entities

In collaboration with DBHDD, we will continue to refine the current process provided on the following page as needs and priorities evolve over time. Results from the FUTAC, in combination with other salient information (i.e., authorization, satisfaction survey results) will be incorporated into provider profiles. These will be designed in conjunction with DBHDD and the providers to ensure relevance and usability. The end goal remains the same—to ensure quality service is provided to individuals.

FUTAC Review Process



Referral Process

The current FUTAC process begins with the referral process. A FUTAC may be requested via any of the QM processes and/or from external quality data collection or other processes resulting in the identification of issues at an individual, provider, or systemic level. These issues typically affect a provider's overall quality of supports and services. The list of current referral triggers includes:

- PCR and QEPR health, safety, and/or rights alerts
- Low Performance (3 and 4) Ratings from Support Coordination monitoring
- Corrective Action Plans based on critical incidents
- Complaints and grievances
- Provider request

Based upon the new review and revised QA/QI processes, additional referral triggers are recommended as follows:

- **Low QEPR Score**: Based upon the QEPR score, this consult will occur approximately 90 days after the QEPR and determine progress made by the provider on QEPR results and recommendations.
- **KPI Validation:** Based on quarterly review of provider's self-reporting of KPIs, a provider may be identified due to discrepancies or concerns identified in the data.
- **Claims Data**: Based upon a review of billing for Medicaid and State-funded services, discrepancies or issues may warrant technical assistance with a provider organization to ensure correct billing.
- **Repeat Acute Episodes Among High-Risk Individuals**: Individuals who have a history of crisis calls, emergency room visits, numerous providers, unable to locate appropriate services.

Pre-onsite/Review Activities

If referrals meet the review criteria, the RNM will allocate resources based on need, nature and urgency of the reason for the referral. The RNM classifies each accepted referral as a "desk review" or "onsite" consultation. If a desk review is identified, the provider will be contacted with a request to submit documentation via a secured fax or provider portal.

If onsite is requested, the QIC will contact the provider to schedule the FUTAC; discuss the purpose of the FUTAC and the reason for the referral; and solicit assistance as needed to schedule interviews with individuals and staff, observations, record reviews and any other relevant activities needed to address the reason for the referral. To prepare, the QIC will review all information specific to the referral reason, including critical incidents, claims data, ISP, crisis data, support coordination notes, and monthly monitoring reports.

FUTAC Desk Reviews

The QIC will thoroughly address the reason for the referral, including other issues or concerns that may be identified through the FUTAC consultation process. Review activities include, but are not limited to the review of:

- Policy and procedures
- Health records
- Support Coordination notes
- Health Risk Screening Tool
- Data sources
- Staff records
- Grievances/complaints
- Monitoring reports
- Claims and billing
- Other documentation
- Progress notes
- Critical incidents
- Individual Service Plan
- Assessments
- KPIs

Review tools used during the PCR and QEPR will be used to evaluate and provide consultation for the provider. Technical assistance activities may include but not be limited to: discussion with the provider via phone interview; identification of resources (i.e., hard copy and/or Web-based); and development of a Performance Improvement Plan with clear goals. This process will ensure support of the provider as well as performance improvement/remediation. In more serious situations, a corrective action plan with clear timeframes and expected activities will be developed. In these instances, we will work closely with the Regional Office for input and direction.

Onsite Review

The FUTAC begins with a brief opening conference to review the process and onsite activities to be conducted specific to the referral reason. As with Desk Reviews, the review activities mentioned above are utilized for onsite reviews as well. The advantage to onsite reviews is that the process is interactive. Technical assistance provided throughout may include: one-on-one training, development of a plan for improvement, brainstorming, group training, role play, and/or remediation support.

During a brief closing, QICs will present findings that will be included in the FUTAC report, including organizational strengths, unmet standards, areas of improvement, and recommendations/action steps for improvement initiatives.

Post Onsite/Offsite Activities

A comprehensive report will be developed and include the reason for the referral, significant findings, recommendations identified during the FUTAC process and the final disposition (i.e., closed, conduct another FUTAC, referred back to the Regional Office for further follow up). The recommendations documented in the report will be sent to the provider for use in developing quality improvement initiatives. The provider will be partnered with a Regional Network Manager if the provider has further questions/concerns.

PROVIDER TRAINING

We believe that active, timely, and continuous communication, training, technical assistance and quality management are essential components of contract compliance, access, and quality. Our implementation of ASO quality management processes in other states has taught us the importance of offering early and frequent provider orientation and training.

Consequently, we offer all providers multiple opportunities for training sessions to prepare for program participation. This ensures that they are continuously informed about our program and services, and they have opportunities to offer meaningful feedback.

Training Plan

Our goal is to provide proactive and comprehensive training; to help inform as many stakeholders as possible in a style conducive to learning and convenient for participation.

Our training strategies are vigorous, varied, and interactive in nature. Training plans are fluid and responsive to the changing needs of stakeholders. Training will be conducted in a variety of formats as deemed appropriate depending on the topic, audience and DBHDD approval, to include: face-to-face training, Web-based training, and formal and informal presentations, each with informational handouts as needed.

We will develop a training plan at least 60 days prior to the Go Live Date describing proposed initial and ongoing provider training. The plan will include time frames for delivering training sessions, content, target audience, locations, and topics. It is our intention to work collaboratively with DBHDD, Regional Offices, Georgia Mental Health Consumer Network, Georgia Council on Developmental Disabilities, the ADA and Olmstead ombudsman, and the Office of Learning and Development (OLAD) to develop education and training that is meaningful and relevant to current iniatives and subjects significant to stakeholders. Our familiarity with OLAD's and DBHDD's systems and successful training venues will enhance the planning and implementation of training sessions across the state.

We will assume responsibility for all costs related to training development, materials, handouts, equipment and locations. Prior to the training events and in collaboration with OLAD, DBHDD and the Regional Offices, announcement strategies will be implemented to ensure timely notifications to stakeholders, utilization of Web-based registration process and tracking attendance. An online calendar announcing upcoming educational sessions will be made available and e-bulletins will be sent to subscribers.

Orientation Training

Initial training provided as orientation sessions will be completed within thirty days of the Go Live Date. There will be up to four sessions in each region, two dedicated to orientation, with one each for behavioral health and HCBS-related topics. If necessary, we will accommodate more than two orientation sessions in regions with a large number of providers. Each orientation session will be divided into three distinct sessions that will include an overview and specific requirements for IDD, GCAL and behavioral health, in that order.

This will allow all providers to attend the GCAL session with the option to select the session that fits the population served. Each orientation session will be conducted in face-to-face, group settings and include:

- Overview of the mission, vision, goals and expectations of the ASO
- Overview of each key function of the ASO: Utilization Review, Quality Management, GCAL, and Management Information Systems
- General review of the onsite review processes

For two months after the initial orientation training, we will provide weekly conference calls for providers and other stakeholders statewide regarding these new processes and their implementation. This not only offers a venue for questions and answers, but a learning opportunity for providers who may have missed the training session.

Ongoing Training

We will conduct a minimum of 24 sessions for IDD providers with 12 of these covering HCBS-related topics. For behavioral health providers, we will conduct a minimum of 12 sessions ensuring each region receives at least two sessions. ValueOptions, with Delmarva and BHL, bring years of provider training experience. Specifically in Georgia, Delmarva has conducted similar training for IDD stakeholders, including HCBS and State-funded services, and linked topics directly to State regulations, person-centered philosophies, industry best practices and protocols. BHL experience includes training on accessing crisis services and ongoing care in DBHDD services through GCAL to school systems, DFCS, DJJ, probate courts, emergency departments, and law enforcement. BHL also provides suicide prevention and risk assessment training to the community on a regular basis. All provider training activities will be coordinated through the ASO's Provider Relations Manager.

We will collaborate with DBHDD to generate topics for two training sessions per region in each subsequent contract year. Sessions will be designed to address issues pertinent to support an optimal service delivery system that enhances outcomes and clinical practices important to individuals served. Ongoing training will be developed based upon input/discoveries from multiple sources, including:

- DBHDD
- Councils/Committees
- Utilization Management
- Regional Offices
- Key Stakeholders
- Incident Reports
- Review Activity Results
- Federal (CMS/DOJ)

All activities, including progress, feedback and development related to training will be reported quarterly and annually to DBHHD. We will deliver ongoing training to providers, drawing upon our training expertise incorporating best practices and national benchmarks in the areas of:

Behavioral Health	**Developmental Disabilities**	**Crisis**
• Evidence Based Practices	• Person-Centered Practices	• Crisis Systems
• Care Transitions	• Physical/Nutritional Management	• Suicide Prevention
• Utilization Management	• Continuous Quality Improvement	• Risk Assessment

This strong background in training will be complemented by the expertise provided by HSRI, with more than 30 years of experience providing evaluation, research, consultation, education, and training in the area of IDD and behavioral health.

Staff Training

Our strength comes from the dedication and commitment of our highly skilled employees, ensuring successful and timely completion of every task and dedication to the success of individuals with IDD and behavioral health issues. We will leverage the use of this

knowledgeable team, and thereby eliminate the "learning curve" and promote an effective, efficient, and transparent implementation of contract requirements and seamless transition to the new processes. Because our staff is already strategically located across the Regions, we have incorporated efficiencies in our ability to conduct trainings across a large geographic area.

Within one month of the contract award, we will develop and implement a staff training plan, with approval from DBHDD. Manadatory training will occur for all of our staff in the Quality Department to ensure cross pollination and integration of philosophy and focus. The training plan, at minimum, will encompass all aspects of the review processes (i.e., PCRs, QEPRs, FUTACs, behavioral health audits), policies and procedures and associated tools, including HCBS waiver requirements and the philosophy of person-centered services coupled with DBHDD's values of supporting recovery-oriented systems of care.

The curriculum will be designed to improve the skills, knowledge, and behavior of staff to achieve consistent, reliable outcome data and the ability to offer accurate and high-quality technical assistance to providers. Initial training will cover the new processes and tools, and will include competency-based testing, with refresher training on an ongoing basis. DBHDD will have input into training curricula that will include, at a minimum, requirements of the State and all programs in the quality management system.

Annual reliability testing will measure our consultant's consistency and knowledge on all review tools and procedures. Shadowing and coaching will take place periodically where managers accompany staff on reviews, offer feedback on all aspects of the review processes, and provide technical assistance if indicated.

STAFF TRAINING MANUAL

A manual consisting of all policies and procedures related to the implementation of the PCR, QEPR and FUTAC will be developed within three months of the Go Live Date and include specific instructions our QICs need to conduct all aspects of the review processes. They include but are not limited to:

- Tools used for interviews with individuals, support coordination, and direct support staff
- Observations of day and residential sites
- Record and data reviews for support coordination and providers
- Review of behavioral health services consistent with the behavioral health audits
- Review of the Individual Service Plan (ISP)
- NCI Surveys (i.e., adult, family guardian, and adult family)
- FUTAC process
- Administrative Review of staff/provider qualifications and training and policy and procedures

The manual will include instructions for QICs to conduct review processes starting with sampling, scheduling, interviewing techniques, collecting information from providers, conducting other onsite/desk review activities, evaluating the data to determine the quality of the service delivery system, and reporting of findings. This procedure manual will be written to

ensure all staff are trained and understand the consultative approach to these processes prior to conducting any type of review activity.

QUALITY MANAGEMENT REPORTING REQUIREMENTS

We have broad experience creating database systems that:

- Address specific State needs
- Offer the capacity for regular reporting on Performance Measures and Key Performance Indicators (i.e., CMS assurances)
- Provide flexible reporting capabilities across many different demographics
- Allow for linkages of information from various components of the review processes and data sources

Our CONNECTS database adapted to the QM system will house all information collected via Delmarva review applications. The systems are built with extensive security and error checks. The key to accurate, timely and informative reporting is not only ensuring valid and reliable data but the ability to utilize and link all aspects of the review processes. This provides a multitude of opportunities to compare outcome data from the individual interviews across different types of providers, regions, facility types and settings, or other demographics. With unique provider identifiers, our CONNECTS system will provide the additional capacity to link data from behavioral health audits and Medicaid claims to data from the QEPRs and PCRs.

Monthly Implementation Reports

We will work with DBHDD to design implementation and status reports that provide the information needed by the State.

Quarterly and Annual Reports

Reports summarizing results from PCRs, QEPRs and FUTACs will be completed on a quarterly basis, to include analysis of significant findings, KPI results, trends, results from NCI and Individual Interviews, graphic and tabular representation of data, discussion and interpretation of findings and recommendations to the State. The report will also include major accomplishments, contract activity, impact of the Quality Management program, and report of Quality Improvement Councils. Our scientist and quality team will work closely with DBHDD and the Division of Developmental Disabilities to revise and streamline the reports to meet evolving DBHDD needs.

Quality Improvement Study

Delmarva's scientist working with the Georgia program has written more than 30 quality improvement studies on various topics, often using statistical analysis to determine the best predictors of outcomes for individuals and/or provider systems relating to health and safety. Several studies were completed utilizing NCI data in combination with data from reviews. Numerous studies were also completed using high-risk profiles created with pharmacy data. The most recent study in Georgia explored medication use for individuals who recently transitioned from an institution. Our CONNECTS system will provide additional options for quality

improvement study topics that may explore the relationship between behavioral health and IDD service delivery systems.

Ad Hoc Reports

We have a long history of providing a variety of ad hoc reports to State agencies and stakeholder groups, such as: Quality of Life indicator results for legislative review; "At a Glance" reports to provide easy-to-access trends on provider performance and individuals' outcomes; background screening compliance for providers and their staff to help State remediation efforts; requests from QI Councils; and requests specific to the ADA population. We will provide up to 60 ad hoc reports at the request of DBHDD. Our IntelligenceConnect reporting system provides the capacity to create real-time data reports giving DBHDD the ability to download other reports as needed. Further, these reports can be downloaded onto mobile devises, ensuring our State partner information on the go, whenever needed.

Twice a year, the Quality Management Council will provide findings from behavioral health and IDD reviews to DBHDD's Executive Committee, including recommendations with actions to be taken that can improve services and outcomes for individuals served. Other presentations of review results, key findings, trends, and recommendations will be provided as requested.

STATEWIDE COLLABORATION

The current regional and statewide QI Councils are charged with developing regional and statewide QI initiatives based upon review of the data. Our RNMs and QICs will help inform the councils by sharing the data and expertise as they review progress on quality improvement initiatives and provider performance via our provider profiling initiatives. Over the past six years, our partner, Delmarva, has been instrumental in facilitating QI Council activities and influencing initiatives.

Through the QI Councils, we facilitate input from individuals, families and other stakeholders. We have fostered a collaborative relationship with Regional Offices, parent advocates, advocacy organizations, providers and provider advocacy groups through attendance at provider meetings, provider fairs, and other regional activities.

ATTACHMENT I.6

I.6 In Attachment I.6, **(two (2) page limit)**, propose a plan to administer and validate annual participant surveys regarding the quality of care. The plan will incorporate a partnered role with local peer-run agencies or organizations in the administration of the surveys. Plan should address details regarding sampling size, accessibility plan, survey methodologies, frequency, etc.

Through our years of experience in administering and validating surveys conducted with individuals with behavioral health disorders and intellectual and developmental disabilities, we realize there are various methods to solicit information, such as: peer-to-peer interviews, paper surveys and personal interviews. For Georgia, we have tailored a specific program that will create the most robust results.

SURVEYS FOR INDIVIDUALS WITH BEHAVIORAL HEALTH DISORDERS

In collaboration with the Georgia Mental Health Consumer Network (GMHCN) and the Georgia Council on Substance Abuse, regional Certified Peer Specialists and/or Certified Addiction Recovery Empowerment Specialists will be hired to conduct face-to-face surveys during the behavioral health audits with provider organizations. They will use the MHSIP survey to gather individuals' opinions regarding treatment and quality of behavioral health supports and services. The surveyors will help guide the individual through the survey process and provide necessary support to ensure all components are completed.

Regional surveyors will be trained by the GMHCN on the content of the survey, how to implement the survey, interviewing and communication techniques and how to effectively support someone in completing the survey. Competency-based testing will be used to help evaluate the effectiveness of the training and the surveyor's ability to apply lessons learned. Furthermore, internal checks and balances will be implemented to review the surveys for completeness and accuracy. Each surveyor will be observed periodically by the team leader to help ensure reliability and surveyor competency. If during the observations issues are identified, these will be addressed with the surveyor and appropriate action taken, such as re-training.

A random sample of individuals will be selected prior to the onsite behavioral health audit. At the time of the onsite audit, the surveyor will contact these individuals to request their participation. They will ensure the individual understands the survey is voluntary, confidential, and will not adversely affect their current services. If the individual declines to participate, another person will be chosen from an over-sample.

Parents who belong to the Georgia Parent Support Network will be asked to become surveyors to conduct the YSSF for children and adolescents receiving behavioral health services. Similar to the Peer Specialists, these parents will be asked to either meet with other parents face-to-face or via telephone to conduct these surveys. Because many parents work during the day or encounter

other scheduling challenges, the parent surveyors will offer fellow parent participants the option of conducting the survey at different times during the day, evening and week.

The YSSF surveyors will receive the same extensive training, testing and reliability as the surveyors for adults (MHSIP). They will be responsible for explaining the purpose of the survey, its voluntary and confidential nature, and the fact that their decision will not adversely affect current services. This helps dispel concerns from parents. These surveys will be conducted around the time of the onsite audit. The MHSIP survey and YSSF results will be used by the behavioral health audit team to help assess the quality of the supports and services received from the provider organization.

SURVEYS FOR IDD POPULATIONS

Individuals with IDD will also participate in a survey to solicit their perception of the quality of supports and services. Our partner, Delmarva Foundation, began conducting the NCI Consumer surveys in 2007 and has since conducted more than 6,000 interviews. HSRI will support Delmarva Foundation's activities, particularly as they relate to NCI rater reliability. HSRI takes a firm approach to its internal quality assurance systems, including standardized training for staff and contracted entities.

Prior to conducting the survey, each Delmarva consultant is trained by HSRI or an approved Delmarva trainer on the process to ensure reliability. For this contract, 480 individuals will be randomly selected, proportionate to the regional populations, to ensure a high degree of confidence in results statewide and within each region for comparative purposes. The consultant will contact the individual to determine his or her willingness to participate, and will then schedule the interview. NCI protocols include a feedback survey for the individual to complete to determine validity and reliability of the process. The individual is handed the survey with a stamped, self-addressed envelope, and asked to send it to HSRI. Results are reported to the State and included in the quarterly and annual reports, and have been consistently positive.

To ensure family members of individuals with IDD also have an opportunity to share their thoughts and opinions, the NCI Adult Family and Family Guardian surveys will be mailed annually to randomly selected family members with an individual with IDD age 18 or older living with the family member or living in another type of living arrangement. Since 2008, Delmarva Foundation has been collecting and entering the data from these surveys for the Georgia and Florida IDD QA programs. Approximately 1,500 to 1,700 surveys are mailed each year to ensure at least 400 are returned.

In the second year of this contract, we recommend focus groups be used in each region to enhance the information received from family members through the mail surveys. We intend to work with Parent to Parent of Georgia and have parents from the organization trained to conduct the focus groups.

ATTACHMENT I.7

I.7 In Attachment I.7, propose strategies **(two (2) pages)** to minimize administrative burden in the gathering of client-specific QM information needed to assess performance on the BH and IDD Performance Measures described in the Appendix 18, Performance Measures (hospitalization, employment status, housing status, national core indicators measures, national outcome measures, and treatment episode data set, etc.).

Recently, we met with some of the larger provider groups in Georgia to survey their concerns regarding the changes the new ASO contract would include. The providers were happy to shed some light on some of the administrative burdens and barriers they currently face.

The group unanimously agreed that although the current data collection tool (MICP) is Web-based and integrated into existing practice management systems, the process of completing the authorization is very time consuming. Additionally, obtaining the data collected and having the ability to analyze it to inform practice change decisions was high on their wish list.

As such, in addition to the redesign of the auditing process described above, the additional strategy we propose is to replace the MICP system with our CareConnect module. Our ASO care management application, CareConnect, is a feature-rich, secure, Web-based system designed to reduce the administrative burden imposed on providers and Clinical Care Managers by providing a single integrated platform to gather objective clinical data, track program specific KPIs, and perform efficient utilization management. We will work with Qualifacts to enhance the integration of their Treatment Planning functionality to improve performance measure tracking and reporting. Qualifacts has more than five years of supporting Georgia behavioral health providers with MICP processing. As we migrate the MICP data capture and related workflows to CareConnect, Qualifacts will make necessary changes to their existing functionality to seamlessly support the transition for providers currently using their services. Our system will be customized to be driven by the Georgia Service Class Grid and collect and track behavioral health and IDD performance measures. The result will be a system that will allow Clinical Care Managers and providers to concentrate on behavioral health, IDD and other needs of individuals rather than paperwork. The system is flexible and adjusts as provider types, individual eligibility and other business rules change.

CareConnect incorporates core clinical and demographic components, including data required for national core and outcome measures, treatment history, and highly configurable triage rules necessary to process incoming authorization requests. Required clinical elements are consistent for comparable services (e.g., inpatient and residential treatment center), but criteria for endorsement are specific to each level of care. When critical clinical information is missing, automated requests for additional information are forwarded to the provider for completion via ProviderConnect. Requests with complete clinical information are processed against triage guidelines and those that meet all required parameters receive automated approvals for specific

identified levels of care as approved by DBHDD. Requests indicating the need for additional clinical review are directed to the appropriate Clinical Care Manager for processing.

Because the entire process is housed within our fully integrated CONNECTS system, data entered into the system flow throughout the entire platform. Individual care/service plans with a summary of the individual's health history; a list of concerns, goals, and strengths; the plan for addressing those concerns or goals; the person(s) responsible for interventions; and the due date for the intervention are accessible in the system. This accessiblily of information provides providers and coordinators a holistic view of the individual enabling treatment providers to target interventions that have worked, and change those that have not. This roadmap improves the individual's ability to self-manage conditions and lifestyle behaviors. Once the care plan has been implemented, we will evaluate it on a regular basis. This process helps to ensure the care plan remains appropriate for the individual's needs and reflects progress, barriers, new priorities, and changing health status.

Significant amounts of data maintained in the CareConnects application will be used to monitor KPIs for the IDD systems. Data collected through the PCR process, which includes the National Core Indicators, will be used to measure specific KPIs that reflect the quality of life and supports and services, as indicated in many *Initial Performance Measures* in *Appendix 18* of the eRFP. These will include measures to address multiple non-clinical areas such as:

- ISP timeliness
- ISP Approval/Rejections
- Involvement in the development of ISP
- Support Coordination Monitoring reports
- Signed Consents
- Community Integration

Additional KPIs will be identified for specific populations as needed, including individuals with dual diagnoses and people who are part of the ADA Settlement Agreement.

ATTACHMENT J.1

J.1 In Attachment J.1, **(limit two (2) pages)**, describe the Offeror's experience with collecting encounter data and claims processing and reimbursement as applicable. Provide details related to each of the payment methodologies outlined in the RFP:

a. FFS claims
b. Expense Reimbursement (NCB) payments (e.g. paying nonstandard claims such as rent voucher, household furnishings, household goods and supplies, moving expenses, utility deposits reimbursement)
c. State funded encounters

ValueOptions offers DBHDD more than 30 years of experience managing accurate FFS claims, expense reimbursement (NCB) payments and State-funded encounters for behavioral health programs. We have a proven track record of processing claims and payments with 99 percent accuracy, and timely claims payments to providers.

ValueOptions processes more than 11 million behavioral health claims each year.

Our powerful claims payment system ensures payments are consistent with program participation requirements, including benefit design, eligibility, care management, and provider maintenance. Because all functions are performed within a single system, updates are immediately available to all service and functional areas.

FFS CLAIMS

For FFS claims, customized controls will be in place to suspend the submission of a claim or encounter that does not pass DBHDD-approved "pre-scrubbing" edits. These edits are intended to mimic DBHDD's adjudication edits, and result in our submission of files that meet DBHDD's processing and edit requirements. These pre-scrubbing edits are specific to the type of claim, and include but are not limited to the validation of the service code, the modifiers, the date of service, the place of service, and the providers' NPI number on file with DBHDD. We also ensure that claims already successfully accepted by the Medicaid GAMMIS vendor are not sent a second time. Our system automatically generates reports after each extract and notes the claim identifier and rejection reason for all claims not successfully extracted.

In addition to the tight controls in place to ensure compliance and the accuracy of data submission to the Medicaid GAMMIS vendor, we also have a robust reconciliation and management process for overseeing the response file application and process. We know the outcome of each claim extracted. Our system retains the date a claim/encounter is extracted, when a response is received, whether the claim is accepted or rejected, and if rejected, the reason why it is rejected. We evaluate the results at each potential failure point, and generate weekly reports to determine the current status of 100 percent of records. Metrics include paid, adjusted, and rejected claims, and reflect the disposition of newly submitted claims and encounters, the updated status of corrected claims and encounters, and summary-level data used to measure the overall success of submissions.

NCB PAYMENTS

NCB payments, such as rent, household furnishings, goods and supplies, moving expenses, and utility deposit reimbursement are provided through ClaimsConnect, our claims processing system described throughout this section. Payment information is keyed into ClaimsConnect for processing and adjudication against programmed edits to ensure accuracy of the information and timely payment to merchants.

As an example of managing NCB payments, under our current contract with the Maryland Department of Health and Mental Hygiene we provide data collection, voucher requirement validation and voucher payments for the Access to Recovery (ATR) grant. Through the ATR, providers such as halfway houses, recovery houses, family and couples counseling, and job readiness organizations input claim amounts into the Alcohol and Drug Abuse Administration's (ADAA) system based on services rendered. Once ADAA validates the data, ATR payments are processed and paid in the CONNECTS system. Once the payments are processed and posted within the system, payments are released by our Claims Disbursement Department (pending fund availability). As the cosignatory on the ATR bank account, we distribute payments weekly and address and resolve payment issues. We are currently making payments to 147 providers at a rate of approximately $60,000 per month under the ATR grant.

STATE FUNDED ENCOUNTERS

We will securely send required HIPAA-compliant 5010 version 837I and 837P transaction sets to the Medicaid GAMMIS vendor via FileConnect, ensuring all transactions follow the fiscal agent's companion guide. Throughout the country we have demonstrated experience working with Medicaid programs to develop and exchange the 837, 835, and 999 claims files. In 2013, we transmitted more than six million claims in outbound 837 files. Based on this experience, we have formulated comprehensive processes and controls to ensure that we meet all standards for accurate and timely submission of claims and encounter data to the Medicaid GAMMIS vendor.

We currently provide HIPAA-compliant 837 extract claims files on behalf of 14 clients, of which eight are on behalf of public behavioral health systems to meet Federal funds matching needs.

As an example, our claim encounter submission processes in our Texas program are similar to those followed for the state of Georgia. A claims payment extract is submitted to the State on a weekly basis for all claims processed during the previous week. As part of this submission process, the claims are validated against internal edits that mirror the State's edits, allowing us the opportunity to correct any errors prior to submitting the claims and encounters to the State. Claims that have errors are stored in an error recycle file that allows us to submit corrected claims during the next extract process. Claims that are submitted to the State and do not pass their edits are returned to ValueOptions, are corrected in accordance with the established error resolution policy and procedure, and resubmitted the following week.

ATTACHMENT J.2

J.2 In Attachment J.2, **(limit three (3) pages)**, describe the Offeror's expectation for staffing the Claims department.

CLAIMS DEPARTMENT STAFFING

Development of an administrative budget by a non-incumbent vendor typically initially includes an assessment and interpretation of eRFP requirements, deliverables and goals for every functional area and in aggregate. Staffing and non-staffing costs are then estimated to construct the infrastructure necessary to operationalize the program. For this contract, we have allocated 2.6 designated claims full-time equivalents for the administration of the Georgia behavioral health and IDD program. We have drawn from our national experience in staffing similar programs, and evaluated the data and eRFP requirements to best determine the appropriate staffing allocations needed to administer the DBHDD program.

Staffing for our Claims Department is based upon a thorough analysis of the volume, source, and variability of the claims we will be responsible for. The first step in the process is evaluation and analysis of all claims, membership, utilization, expense and any other data provided by the State as part of the eRFP and/or data book. This includes a review of the source data by service level and cohort, by month or other provided time period. The process includes a review to identify potential anomalies requiring further research, and potential adjustment in our staffing. Additional adjustments may be made to account for retrospective adjustments or other additional staffing resources.

ValueOptions' program management provides clear lines of communication and points of contact to ensure staff responsiveness for DBHDD. Our structure ensures that we provide DBHDD with the best qualified and experienced personnel to meet State and contract expectations. Our processes are flexible enough to control contract schedule, performance, and risk, and they are designed to maintain clear visibility into the program's overall performance.

We have established policies and procedures and management processes to support our employees' decision making and to guide our day-to-day service delivery. Using key metrics, such as quality data, telephone data, and other established service metrics, functional leads will work with staff and other key areas to identify trends and discuss potential service/program modifications through the program planning process.

ValueOptions' National Operations Center in Latham, New York, our Center of Excellence for claims administration, claims customer service and claims support functions is structured in two distinct units: one serving Medicaid programs and one serving commercial, health plan and government programs. The structure and staffing of the centralized Claims Department provides a staff base large enough and flexible enough to accommodate fail-over capacity. This ensures each claims team has sufficient backup to provide support in the event of the fluctuation in claims volume, and to absorb periods of illness, vacations and staff turnover.

Our Claims Department currently employs 150 professionals and serves approximately 250 commercial, health plan and Medicaid accounts. In addition to claims processing, our National Operations Center is responsible for customer service administration, eligibility, systems configuration, quality improvement, and training and claims support functions. The National Operations Center is managed by a team experienced in workflow and process management, as well as staff development. The Claims Department has exceeded industry standards consistently, and with the latest state-of-the-art technology, it has been operating efficiently and with perfect execution of performance standards. The Claims Center is audited regularly by independent external audit firms and consistently receives excellent results for claims adjudication.

Since 2004, ValueOptions has engaged these independent third-party auditors to complete SOC 1 audits validating our ability to comply with Section 404 of the Sarbanes-Oxley Act of 2002. Our 2013 SOC 1 report marks the 10th consecutive year that ValueOptions has received a "totally clean opinion."

Our Claims Department has a strong and well-seasoned management team. The Claims Managers each have more than 10 years of experience, and hold the necessary degrees and experience in health-related claims processing to lead a successful team. Claim Supervisors have multiple levels of tenure and possess the qualities that create an effective Claims Team. This team consistently exceeds industry standards through continuous process improvement and oversight by skilled professionals, which is demonstrated in our response to *Section J.3* below.

Lean Initiatives

As a strategic initiative to improve our operational processes, ValueOptions launched Lean to address waste and improve efficiency across our organization. Led by our Chief Process Improvement Officer, we embarked on our Lean journey in mid-2013. We engaged Lean consultants in a long-term partnership to help guide the strategic and tactical components of Lean, and we dedicated a significant amount of upfront time to training staff at all levels of the organization on Lean principles and methodologies. We launched Lean events to target specific areas of our workflow and remove waste from our processes, and leveraged process experts on the floor for "real-time" problem solving. One of the first operational areas we applied this initiative to is our claims processing operations. As a result, we have seen significant improvements in accuracy and processing speed. We see staff engaged and excited to be part of solutions to problems that they encounter in their everyday work, establishing themselves as the true "experts" in our work, and the ones who are critical to transforming the way we do business.

We understand that this new way of doing business represents not only an operational shift, but a significant cultural shift as well. From our most senior leaders down to our front line staff, we are committed to realizing the organizational transformation of Lean to deliver higher value to the customers we serve.

Training

Our claims training program consists of six weeks of formal classroom instruction combined with on-the-floor, practical experience. It also incorporates an eight week step-down program for quality initiatives. The training program includes orientation to our general business policies

and procedures, as well as technical instruction. This ensures staff learn the claims payment system, understands the behavioral health care business and is familiar with client-specific procedures and rules. During the classroom training, new employees actually begin processing claims so we can assess their knowledge and accuracy. We audit 100 percent of all trainee claims. We give trainees worksheets and examinations at various intervals to evaluate their progress in understanding and applying the material. The trainer reviews all processed claims and provides constructive feedback. We give each trainee several worksheets and examinations at various intervals throughout the classroom training to evaluate his or her progress in understanding and applying the material.

After completion of classroom instruction, we monitor the trainees very carefully. The trainer or a senior team member oversees their progress on the floor for at least two weeks. They work closely with trainees as they process claims, responding to their questions, helping them with difficult claims or inquiries, and reviewing their quality monitoring results.

Claims and Claims Research trainees are also subject to special audit and quality monitoring procedures until they have proven that they are fully proficient. A brief outline of the training topics covered in both claims and claims research training is provided below:

- Claims Data Entry
- Claims Processing Policies and Procedures
- Provider File Layout
- Inquiry Creation Process – Screens and Functionality
- Claims System Navigation
- Inquiry Tracking Screens – Use and Application
- Authorization Screens and Service Class Grid Interaction

Customer Service staff are provided with all of the basic claims processing policies and procedures and learn to use the claims system, but are not exposed to the same level of detail provided to new Claims Processors.

Once released from the classroom portion of the training, we monitor Claims Processors and Claims Customer Service trainees very carefully. The trainer oversees the progress of both types of trainees for at least two weeks after they have been released from classroom training. The trainer is located on the floor with the trainees and works closely with them as they process claims or handle inquiries, responds to their questions, helps them with difficult claims or inquiries, and reviews their quality monitoring results.

Ongoing Training

Our Claims Processors are trained to handle and resolve all types of claim edits related to behavioral health and IDD claims for our Medicaid clients. National training specialists provide our Claims Processors cross training for our different programs, as well as product-specific and client-specific training.

We provide experienced claims staff ongoing training on the adjustment process, reprocessing claims, and UB 04 claims processing. For supervisors and managers, we provide training on the process and workflow, as well as system enhancement training.

ATTACHMENT J.3

J.3 In Attachment J.3, **(limit three (3) pages)**, describe how the Offeror determines claims processing accuracy. Include examples. Provide claims accuracy statistics (i.e., percentage accurate), for the previous two (2) years.

Our completely customizable CONNECTS platform will be configured to meet DHBDD's behavioral health and IDD program requirements with speed and efficiency. Moreover, its flexible infrastructure ensures responsive implementation of any future customizations DBHDD may require.

A designated team of highly skilled professionals will handle all claims processing from our New York-based Claims Department. This team brings an average tenure of more than 20 years of experience working with our state Medicaid clients. Our management team brings more than 30 years of workflow administration, process administration and staff development expertise to DBHDD.

Our Claims Department currently employs 150 professionals and serves approximately 250 Medicaid, commercial, and health plan accounts.

DETERMINING CLAIMS PROCESSING ACCURACY

ValueOptions' CONNECTS system is capable of supporting complete managed behavior health and IDD programs from the eligibility process all the way through claims adjudication and payment. CONNECTS maintains benefit structures, provider reimbursement methodologies and adjudication rules for each program. It is fully integrated with eligibility, including data collected regarding other coverage, provider fee schedules, benefits, timely filing, and authorization requirements. All functions allow custom edits, which will be configured to meet the processing requirements of DBHDD. For virtually all of our large accounts, we coordinate closely with our clients' MMIS to ensure coordinated claims payment and benefits administration. Not only does this mean orchestrating a number of claims-related processes with providers, our clients and their intermediaries, it also requires technical flexibility and expertise.

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

- Verifies individual's enrollment
- Locates the servicing provider or on-call provider that matches the claim servicing provider and the claim service date
- Considers transitional authorizations based on the claim service date and number of visits accumulated
- Checks to see if an authorization is required
- Determine if the claim is a duplicate submission
- Applies benefit plan parameters, such as maximums and excluded charges
- Compatibility of third-party liability or coordination of benefits

- Identifies potential fraud and abuse
- Applies the approved amount from the appropriate fee schedule
- Determines if a valid authorization is on file. If adjudication edits and audits cannot be satisfied by information on ClaimsConnect directly, the claim is denied and a summary voucher is sent to the provider indicating the information needed to complete adjudication for payment. If the adjudication edits and audits are ultimately satisfied, the claim is approved for the payment cycle and the check and the summary voucher is sent to the appropriate provider.

The CONNECTS platform is fully integrated, taking all elements of the benefit plan and reference codes into account as the claim is adjudicated. Claims receive edits when limits are met or when specific combinations of codes are billed together. We also take other edits into consideration, such as duplicate claims submission, authorization edits, eligibility discrepancies, coordination of benefits, and specific diagnosis codes that are excluded entirely as eligible for reimbursement. The edits can be soft or hard, depending on the action that is to be taken. Hard and soft claim edits are accessed internally online by Claim Processors to ensure the proper handling of claims.

Hard Edits

Hard edits in ClaimsConnect allow claims to automatically adjudicate based on pre-determined system set-up of specific claim edits. For example, when a claim is entered into our claims system, the diagnosis code is validated against the diagnosis codes in the system reference file, as well as against the diagnosis codes covered by the client in the benefit set up. If the diagnosis code on the claim is not covered by the client the claim is automatically denied during batch adjudication. If the diagnosis code is not a valid code in the system reference file, a default value of ‘unk’ is entered in the diagnosis field and the claim is automatically denied with a request to resubmit it with a valid diagnosis code.

Soft Edits

With soft edits, Claims Processors receive an edit indicating there is a condition that needs to be manually reviewed before adjudication of the claim can be completed. Examples of review required include the possibility of a duplicate claim submission or an eligibility problem in the individual’s benefit plan. In these cases, the Claims Processors will determine if the service on the current claim can be paid on the same date as a previously paid service, or they determine if the correct group number is on the claim for eligibility purposes. If it is determined the claim should be paid, the edit is validated and the claim is adjudicated. If the claim should be denied, Claims Processors apply the appropriate denial code to the claim before completing adjudication. This information is available online to Claims Processors as well as the entire Claims Department.

ClaimsConnect has the capability to allow for hard and soft edits based on our clients’ requirements. For example, one client may request that we pay all claims received and not edit based on ‘multiple services on the same day. Other clients may have a limit on the number of services that can be paid on a specific service date. ValueOptions has the experience, expertise and flexibility to tailor our services to DBHDD’s specific needs.

CLAIMS ACCURACY STATISTICS

In 2013, ValueOptions processed approximately 11 million claims, including nearly three million claims representing Medicaid clients. Despite that volume, our claims team has consistently exceeded contract requirements, achieving excellent timeliness performance. Below are the performance statistics from our Claims Department:

Claims Processing	2012	2013
Financial Payment Accuracy (Dollars)	99.80%	99.85%
Payment Incidence Accuracy Rate	99.73%	99.69%
Overall Procedural Accuracy Rate	98.76%	98.71%

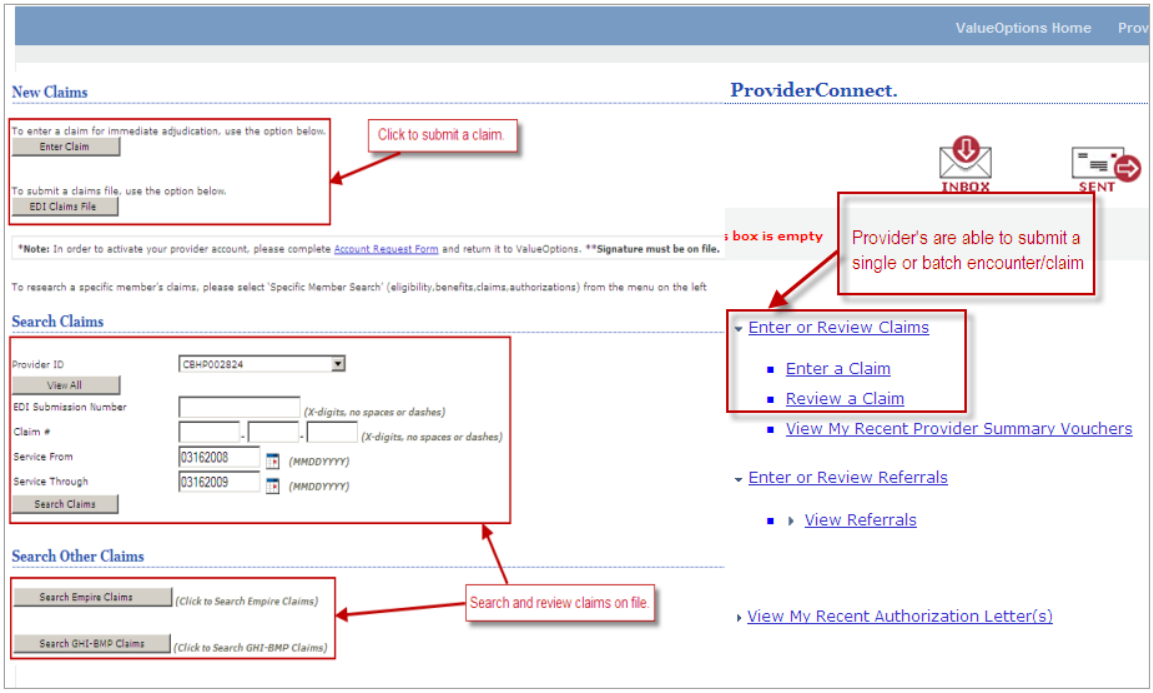
ATTACHMENT J.4

J.4 In Attachment J.4, **(limit two (2) pages)**, related to FFS Claim collection and reimbursement: describe the procedures, capability of a web portal and electronic data exchange for FFS claims, interaction with State and Provider staff, and payment processes of electronic funds transfer and paper checks.

FFS CLAIMS SUBMISSION

Our claims system can accommodate DBHDD's proposed Core Provider Redesign for Tier 1 and Tier 2 claims, interacting with other payment systems as necessary. Claims reporting and analysis can also support performance based contracting for core providers.

FFS claims can be submitted in both paper and electronic formats. Our no-cost electronic solutions for claims submission include HIPAA standard 837 formatted files from any provider's software application or third-party vendor. Alternatively, providers without electronic claims software can submit via our Web-based direct claims submission application. This application is easy to use and provides immediate validation results. Providers or their authorized provider staff can select from two submission methods: either direct data entry (single claim) or via an electronic 837 file transaction (batch claims). A screenshot of the claims submission options from ProviderConnect is provided below.



All electronic claims undergo various audits to satisfy all submission requirements. This includes verifying and validating data fields, such as identification number, date of birth, inclusive service dates and codes, number of units, service location, amount charged, and diagnosis code. Additional editing and validation requirements occur once the claim is uploaded into our claims processing system.

Paper claims are scanned, allowing ValueOptions to create a digital version. Claims that are submitted electronically and paper claims that are not manually keyed are converted into an electronic format during our scanning process and systematically loaded into our system. They are then processed automatically, applying all systematic edits, including any client-specific benefit requirements.

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

CLAIMS ENTRY/UPLOAD

All claims, regardless of the submission method, are processed against the same business rules. Claims that are uploaded into our system are processed automatically, subjecting them to industry-standard systematic edits, as well as customized, client-specific benefits or business requirements. Our proprietary system also enables us to apply client-specific settings for our edits. Once entered or uploaded, claim and encounter batches are reiteratively run through the adjudication cycle.

State and Provider Interaction

ValueOptions will provide DBHDD's GAMMIS with all claims and encounter data via an 837 file exchange. We have demonstrated experience in developing outbound 837 encounter and pre-priced claims extracts, as well as corresponding response files (i.e., 997, 277, 835 and client-specific formats). We currently provide 25 HIPAA-compliant 837 extract claims files, including 10 on behalf of Medicaid accounts for federal funds matching. In support of these clients, we submit files on a daily, weekly, and monthly basis. In most cases, we receive 997 and 277 response files; however, we also receive custom detail response files.

For questions or concerns related to use of ProviderConnect, our EDI Help Desk is available to assist and support system users. This includes training and other resources for new users or providers experiencing issues registering, navigating the system, and/or submitting electronic claims. During implementation, providers will have the opportunity to participate in training sessions and webinars, which include a demonstration of the ProviderConnect system. In addition, providers and State agencies can call our toll-free customer service number. Our Claims Customer Service Representatives will answer and resolve all claim related inquiries.

Payment Process

If adjudication edits and audits cannot be satisfied directly by information in our system, the claim is denied and a summary voucher is sent to the provider indicating the information needed to complete adjudication for payment. If the adjudication edits and audits are ultimately satisfied, the claim is approved for the payment cycle and payment is made to the appropriate provider through an electronic fund transfer (EFT). Providers have access to their summary vouchers online. Providers who have not yet elected EFT will receive a paper check and summary voucher.

ATTACHMENT J.5

J.5 In Attachment J.5, **(limit two (2) pages)**, related to State Funded Encounters: describe the procedures, capability of a web portal and electronic data exchange for encounters, assignment of rate-based value where applicable, interaction with State and Provider staff, and reporting system.

The CONNECTS information system has the capability to assign a rate-based value to the provider, or pre-pay providers if DBHDD advances the funds and specifies the providers to whom pre-payment is to be made. The system has the capability to accept and process State-funded encounters from those providers, offsetting reimbursement earned against the prepaid amount. In fact, in Medicaid contracts for which we are at full financial risk, we sometimes offer our "Ready Pay" option, which takes advantage of this functionality.

Under the Ready Pay option, each month for a designated period of time a provider will be paid a negotiated amount up-front that is equal to the provider's average reimbursement from State-funded, Medicaid, or other FFS funding streams. Reconciliations are done at the end of each month based on actual claims submitted. The Ready Pay option is designed to ensure economic stability for providers during a transition period.

EXPERIENCE WITH ADVANCE AND RECONCILIATION PROCESSES

As an example, we established a payment system for the child welfare portion of the state of New Mexico's contract whereby a provider who was contracted for up to a certain dollar amount of services in a given period (1/12th draw) would bill and receive payment up to the target amount for their specific contract. Claims above the target amount were tracked and processed as encounter claims transmitted to the State for validation via an 837I/837P transaction.

A similar process is in place for our Texas program. State providers receive a monthly block/prospective payment. Providers then bill claims against the monthly payment. No additional payment is made until the provider exceeds the monthly payment amount. Funds may be reallocated if a provider consistently fails to meet the established level of services contractually required to "earn" the block grant or prospective payment.

As noted above, Georgia providers will have the ability to submit claims and encounters via our secure, online provider portal. Providers or their authorized provider staff can select from two methods, either direct data entry (single claim) or via an electronic 837 file transaction (batch claims). Our powerful claims payment system ensures payments are consistent with program participation requirements, including benefit design, eligibility, care management, and provider maintenance. Because all functions are performed within a single system, updates are immediately available to all service and functional areas.

Once all encounter data is gathered, it is available for reporting and further analysis through IntelligenceConnect, our secure Web-based reporting platform. We separate our reporting

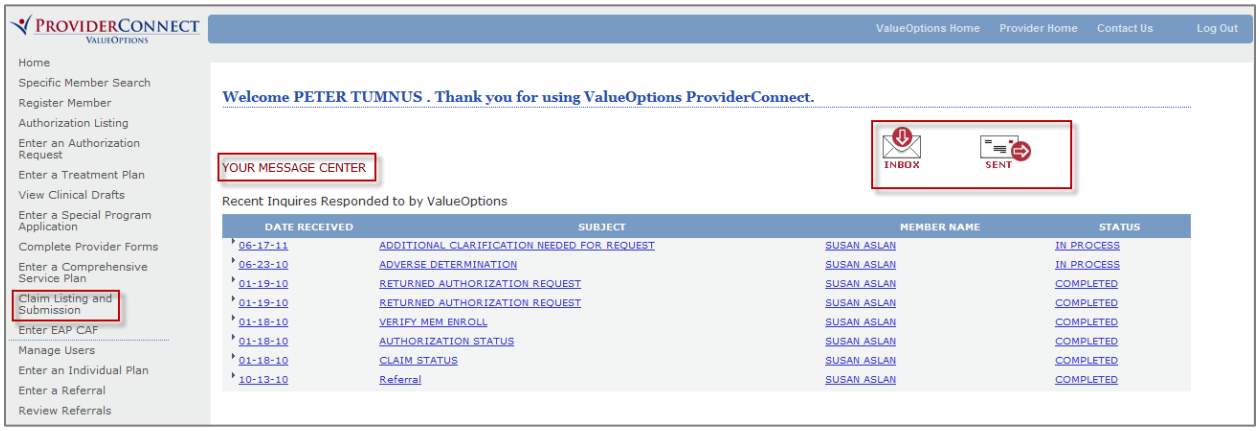
activity from operational activities by the use of a data warehouse and various data marts. The separation of these activities allows for reporting and analyzing work without impeding such operations as authorizing services, paying claims, and processing eligibility. This tool provides clients with an easy mechanism for accessing and viewing a variety of relevant data.

IntelligenceConnect will be available to DBHDD and other stakeholders (e.g., providers) for monitoring selected performance measures including: penetration rates, eligibility demographics, diagnostic information, utilization reports, and fiscal and statistical reports. In IntelligenceConnect, DBHDD will have access to dynamic reports that can be run on demand, as well as dashboards that present key performance metrics for easy analysis.

ATTACHMENT J.6

J.6 In Attachment J.6, **(limit two (2) pages)**, describe how the Offeror proposes to provide the Fiscal Intermediary Services described in this Section 14 for housing vouchers, transition funding and bridge funding. In particular, describe the procedures, capability of a web portal for collection of budgets, invoices and receipt information, interaction with State and Provider staff, and payment processes of electronic funds transfer and paper checks.

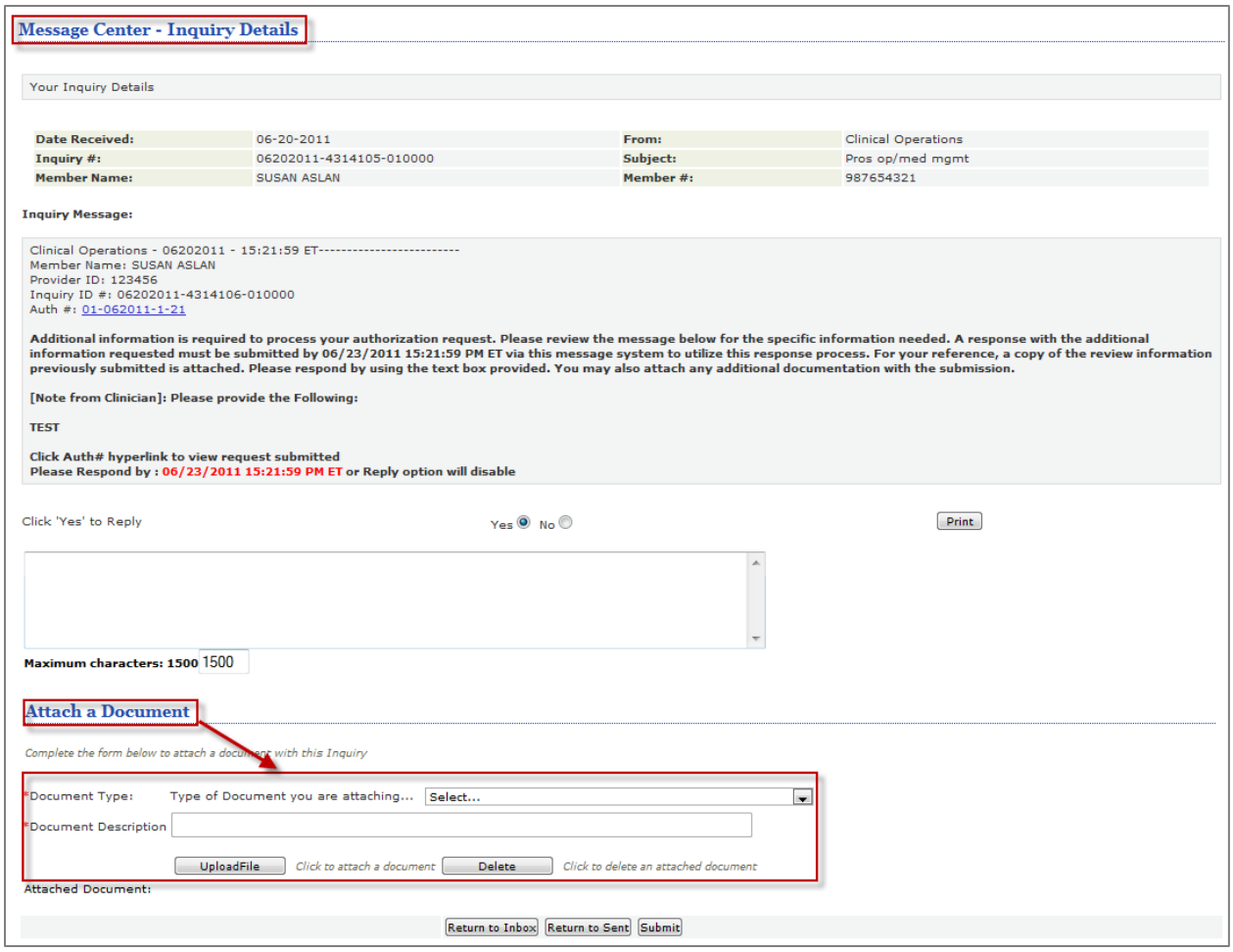
As mentioned previously, we are committed to helping providers manage their administrative functions more efficiently. We strive to make electronic claims submission a viable option for all providers and accept direct data entry of claims online and HIPAA-standard 837 formatted files from any provider's software application or third party vendor. All of these transactions can be performed via our secure provider portal, ProviderConnect, which is shown below.



Alternatively, NCB service payments (i.e., Georgia Housing Voucher Program, bridge funding, and transition funding) can be submitted via the personalized message center on ProviderConnect. DBHDD and providers will submit the necessary information and attach the documentation (e.g., receipts, invoices) required to request reimbursement for the eligible goods and services, including but not limited to rental assistance payments. Once the provider submits the NCB payment request, the message and the required documents and attachments are received by our staff to appropriately process the payment to the authorized provider. Much like the claims payment process described above, once the claim is approved for the payment cycle, a payment is made to the appropriate provider through an EFT. Providers have access to their summary vouchers online. Providers who have not yet elected EFT will receive a paper check and summary voucher.

We will work directly with DBHDD to ascertain the list of approved providers permitted to submit claims for bridge funding and transitional funding type payments, and follow all DBHDD processing guidelines.

The screenshot below demonstrates the system's ability to allow providers to submit (attach) receipts, invoices or other documentation required to process the non-claims-based service claims.



ATTACHMENT J.7

J.7 In Attachment J.7, **(limit four (4) pages)**, describe the Offeror's current capabilities for Fraud and Abuse detection including, but not limited to Claims system edits and processes to conduct pre- and post-payment reviews, data analytics to identify Provider outliers, and Provider compliance audit protocols.

ValueOptions has a fully developed fraud and abuse detection capability. Our proactive Fraud, Waste and Abuse program was designed to be in compliance with the Office of Inspector General (Medicaid and Medicare), Insurance Fraud Bureau, the U.S. Office of Personnel Management, and to protect individuals and providers. For accounts where we have responsibility for adjudication and payment of claims, we deploy a fraud and abuse process that includes pre- and post-payment reviews, data analytics and compliance audit protocols. Using this process, we have a successful track record in aggressive prevention, detection and recovery methods for our State clients. Our approach, with proven anti-fraud, waste, and abuse measures, mitigates improper payments, thus ensuring fiscal integrity of DBHDD's Medicaid program.

Spearheaded by our corporate-based Special Investigations Unit, our fraud, waste, and abuse program comprises four major functions: prevention, audit and detection, investigation, and resolution.

- **Prevention:** Our primary concern is awareness and communication of the program. This component includes technology tools, training, awareness, and communication. Specific examples of prevention mechanisms include, but are not limited to: training and education, claim edits, and an ethics and privacy hotline.
- **Audit and Detection:** We have numerous avenues that supply information about suspicious provider activity. The Special Investigations Unit reviews and monitors providers' claims and billing practices in response to questions raised, complaints filed, or issues identified and submitted to the unit.
- **Investigation:** Providers who are referred for alleged fraud and abuse are audited, targeting the specific issues identified. We rely on an array of tools to evaluate provider compliance programs, such as trend analyses and onsite reviews. We track all referrals submitted with a unique case number to include allegation specifics, referral source and actions taken.
- **Resolution:** Each provider is required to demonstrate his/her understanding of the errors identified in the Special Investigations Unit audit by creating a corrective action plan to address the steps he or she will take to ensure the errors are not repeated in the future. Every audit is followed up with a contact from our locally-based Provider Relations staff to reinforce the education given and to offer any support or further education the provider may need.

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

DETECTION OF POTENTIAL FRAUD, WASTE AND ABUSE

Our primary focus is the prevention of fraud, waste and abuse through awareness and communication of the program. Examples of prevention mechanisms include provider communication, training and education. Providers can find information relating to their roles and responsibilities in ensuring compliant practices in their Provider Handbook. Additionally, information in the handbook informs the provider of the reason and nature of audits done by the Special Investigations Unit and the ways that an audit can be triggered. We also conduct comprehensive anti-fraud training to deter fraudulent, abusive or wasteful practices and continue to expand our training and education resources available to individuals and providers. Our training program also includes examples of simple claims billing errors that may trigger a fraud investigation and provides an overview of the False Claims Act and other applicable laws, fraud reporting and referral processes, and whistleblower protection.

In addition to prevention measures, we have numerous avenues that detect and supply information about suspicious provider activity. These avenues include:

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

Claims Editing and Adjudication

All electronic claims submitted to ValueOptions are submitted through Electronic Transport System (ETS), our e-commerce application. ETS is programmed to receive and process electronic claims records automatically and seamlessly through ClaimsConnect, the claims processing system. Upon claims entry/upload, the ClaimsConnect system performs online automated edits that validate:

- Invalid procedure codes, diagnosis codes, and billing codes (i.e., CPT codes, HCPCS codes, revenue codes, ICD-9, and ICD-10 codes, when applicable)
- Eligibility and enrollment of the individual and/or dependents
- Excessive charges
- Benefit maximums, such as visit limitations, out-of-pocket expenses and lifetime maximums
- Unauthorized services
- Matches related to authorization
- Provider name, licensure, address, fee schedule, W-9 information, and network status
- Duplicate submissions, services and providers

- Compatibility of third-party liability, other health insurance and/or coordination of benefits
- Potential fraud and/or abuse

When any of the required information is missing or invalid (e.g., a procedure code is missing or an individual's number is invalid), a default value is assigned. An explanation of payment code is attached to the default value that instructs the provider to resubmit the claim with the required information.

If adjudication edits and audits cannot be satisfied by information on ClaimsConnect or through CONNECTS directly, the claim is denied and a summary voucher is sent to the provider indicating the information needed to complete adjudication for payment. Each line item is evaluated individually by calculating the difference between actual and allowable charges, allowing for coordination of benefits, and formulating a total amount to be paid.

Pre- and Post-Payment Review

As part of the claims authorization process, eligibility and services are verified prior to service delivery at the provider level. After services are rendered, a claim may be submitted to us either electronically or manually. When a claim is submitted, a second eligibility verification occurs in the scanning and auto-adjudication process. If there is a discrepancy, the claim is routed to an examiner. If eligibility differs, an electronic inquiry is sent to our Eligibility Department for research. Any disparity to the provider file would be routed to the examiner for validation. Our ClaimsConnect and ServiceConnect systems allow all staff that have involvement in claims resolution to see the claim online, track the history of the claim, and get all eligibility and clinical detail needed to process the claim. All services billed are validated in the adjudication process against the service authorized and services contracted for the billing provider.

Identification of Provider Outliers

Identification of outlier providers is done through ValueOptions' data mining, to include reviews of provider services such as number of individuals seen per day, number of episodes, numbers of sessions, and average sessions per episodes. We also review tips and complaints from Clinical Care Managers and individuals. Providers will be compared to other comparable practicing providers in their region. Based on the information, we will provide outreach for training on best practices and/or conduct chart audits. Our Medical Director performs onsite visits with Medical Directors and administrators of hospitals that have outlier lengths of stay and excessively high recidivism rates. Outlier outpatient providers with excessive utilization are pulled from the general authorization process and are subject to closer review by a Clinical Care Manager specializing in outpatient services.

Provider Compliance Audits

The Special Investigations Unit reviews and monitors claims and billing practices of providers in response to questions raised, complaints filed, or issues identified and submitted to the unit. Through data mining and trend analysis, the Special Investigations Unit conducts audits on random providers looking for any patterns that may suggest improper billing practices that may be part of fraud, waste or abuse. We re-audit providers who have had past errors to ensure that

education and corrective action plans have corrected past inaccuracies. If the same errors are present after education, this may indicate a clear intention of fraudulent behavior.

Noncompliance with Audit

To ensure the integrity of the network, if a provider is found to be in noncompliance with a Special Investigations Unit claims audit request, action plans taken by the Special Investigations Unit may include any or all of the following:

- Reversal of claims
- National Credentialing Committee review for a Special Investigations Unit recommendation for disenrollment and suspension of referrals
- State and/or Federal agency notification
- Provider and/or individual flags for monitoring claims activities

Audit findings are used to promote improvement via ongoing provider education.

We supply monthly, quarterly or annual fraud, waste and abuse reports, depending on the desired frequency. The reports log all referrals received and investigations conducted in relation to contracted providers.

The ASO will provide DBHDD with a fraud and abuse process that meets all the requirements detailed in *Attachment J, Section 3.3.5*. This will include providing a draft fraud and abuse action plan for DBHDD's approval no more than 60 days following the contract award date. The primary focus of this plan will be to implement mechanisms to prevent and detect fraud, waste, or abuse in the behavioral health and IDD program through effective communication, training, review, and investigation. Our provider education plan will ensure providers are fully informed on how to comply with applicable laws, regulations and standards, in addition to contractual obligations. The ASO staff will include a Compliance Officer to collaborate with the State regarding fraud, waste and abuse program requirements. This key position will have unrestricted access to our governing body for compliance reporting, including fraud, waste and abuse.

ATTACHMENT J.8

J.8 In Attachment J.8, **(limit two (2) pages)**, describe a time when the Offeror detected Fraud and Abuse for a similar Contract. Include how the Fraud and Abuse was discovered, the steps taken to report and address it, and the outcome of the actions taken.

VALUEOPTIONS' FWA REFERRAL TO MARYLAND OIG

On February 6, 2014, a parent of a Maryland member contacted ValueOptions requesting an authorization for outpatient therapy. The parent was informed that, before a new provider/new authorization could be authorized, previous authorizations needed to be "closed." The open authorizations were reviewed with the parent, who stated that she did not recognize one of the providers, "never brought her child to the provider," and "was not familiar with the provider's address." As a result, the matter was reported to the Maryland Engagement Center's Program Integrity/Compliance Department via the Fraud and Abuse Queue.

Upon review of the referral, Program Integrity staff identified that the member in question was part of a sibling group related to two previous referrals associated with this individual provider. Program Integrity staff contacted the provider and requested a sample of records for review, including records for this particular member. The provider complied with the request and submitted electronically scanned copies via e-mail.

While reviewing the provider's documents, staff noticed they were scanned using a scanner associated with the public school system. Incidentally, this provider had undergone a full audit by ValueOptions in May, 2012. A review of the audit report determined that the provider did not disclose her employment status with the school system. Rather, the report indicated the provider's work hours as an individual provider were Monday through Friday, 9 a.m. to 9 p.m., and Saturday and Sunday from 10 a.m. to 4 p.m.

A Google search was conducted of the provider and the public school system. The search yielded a number of results, including a link allowing school system employees to be searched by last name. The results from that link identified the provider, her hire date, and salary for fiscal year 2011. The Google search also identified the school where she was employed, and the school's website identified her as the school's social worker.

A re-review of the provider's supplied documentation identified five members who, based on the "Consent to Obtain/Release Information" forms, attended the same school where the provider was employed as the school's social worker.

Program Integrity staff subsequently conducted a claims review for a period of two years. Claims were separated into three distinct timeframes: two separate school years and one summer period in between the two school terms. The claims were then organized by date/day of the week (date of service) and the number of claims. The date/day of the week was cross-referenced with the school calendars, thus providing reference points. The claims review yielded that the

provider billed double-digit claims on 110 days, the majority being school days, and billed every day during the summer period, except July 4.

Outcome

Based on this information, Program Integrity staff identified a suspicion of fraud and/or abuse and referred the matter to the Maryland Office of Inspector General for review. The provider was a full-time employee of the public school system at the same time she billed double-digit claims for behavioral health services she provided to members. A school social worker, who is employed by the public school system to render therapeutic services, may not seek reimbursement from Maryland's Public Mental Health System for the same rendered services. Additionally, the documentation reviewed showed that five members attended the same school where the provider was employed.

The scenario above is currently an active case with the OIG. As such, we do not know the outcome of this case at this time. However, Program Integrity staff will make themselves available to the OIG, as requested, throughout its investigation into this provider.

ATTACHMENT K.1

K.1 In Attachment K.1, **(limit four (4) pages)**, describe any applications of new or innovative technologies the Offeror uses that would add value to this Contract.

Our information system, CONNECTS, comprises a suite of fully integrated applications (e.g., CareConnect, ProviderConnect and IntelligenceConnect) built on a single platform, representing more than 30 years of behavioral health and IDD experience and associated best practices. It supports complete managed behavioral health and IDD programs from initial individual contact through claims adjudication and payment, in conjunction with the full range of management and utilization reporting requirements. All integration occurs within our one platform—simply stated, everything communicates with everything else, and we own the source code, so a special request or urgent need can be accommodated with ease. Data can be organized at the account, individual, provider, regional, and population level, or any other level required by DBHDD. This means that our platform is truly an enabler of care coordination rather than a barrier that increases provider administrative burden. It will meet DBHDD's current and future demands for data and systems integration needs.

Recently, we met with some of the larger provider groups in Georgia to survey their concerns of the impending changes the new ASO contract would include. The providers were happy to shed some light on some of the administrative burdens and barriers they currently face. The group unanimously agreed that although the current data collection tool (MICP) is Web-based and integrated into existing practice management systems, the process of completing the authorization is very time consuming. Additionally, obtaining the data collected and having the ability to analyze it to inform practice change decisions was high on their wish list.

As a result of our meetings with Georgia providers, we determined the optimal solution to offer DBHDD was our CONNECTS platform in place of the MICP. We have invested extensively in our enabling technology. We will customize our system to fully integrate all the data fields currently collected by the MICP system to ensure all the data points requested by DBHDD are available for reporting purposes. Additionally, we recognized that some providers have invested substantial costs to integrate the MICP into their practice management systems. **With this in mind, we have partnered with Qualifacts to offer a no-cost transition from the MICP to ValueOptions' solution.** This solution will leverage data from their practice management system, eliminating duplicative data entry and offer the ability to submit batch registrations and authorizations via ProviderConnect.

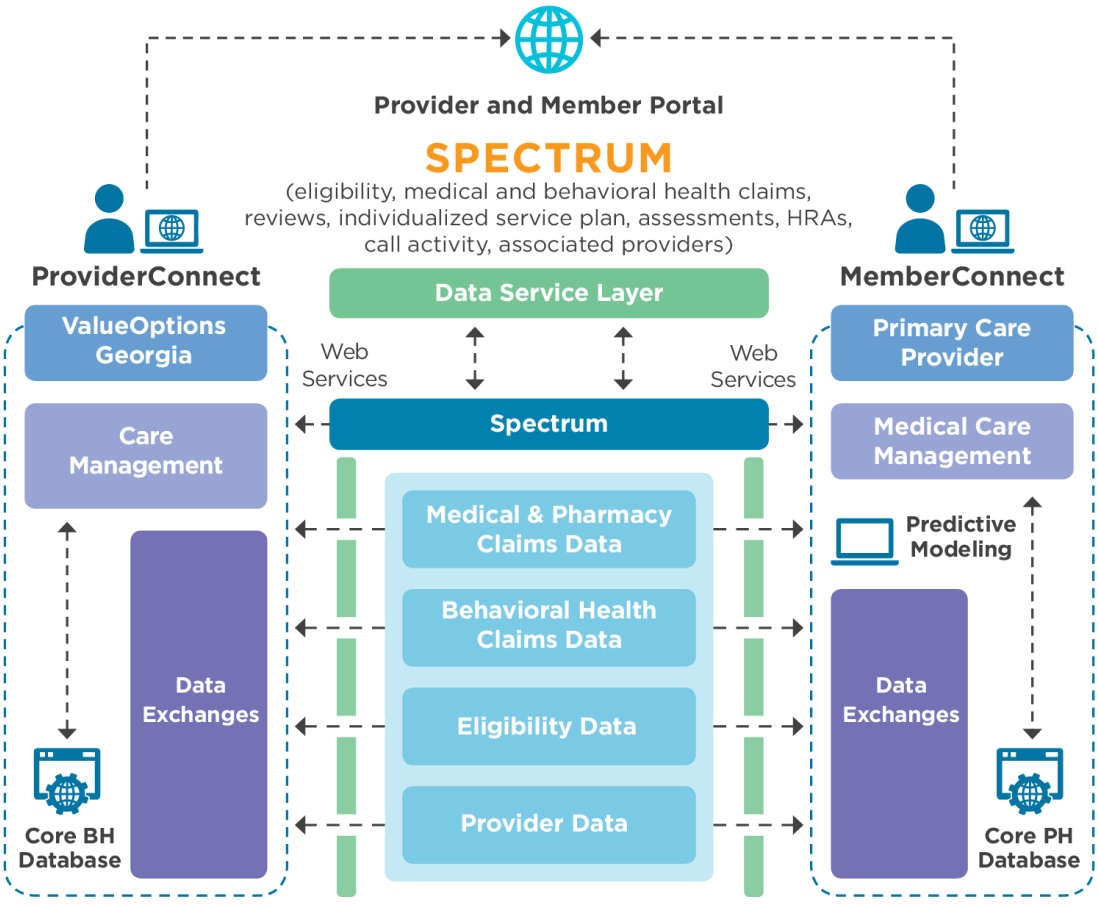
For those providers not using the Qualifacts practice management system, we offer our secure, provider portal, ProviderConnect, which will allow providers to submit batch registrations, authorizations and encounters electronically.

INNOVATIVE TECHNOLOGIES FOR GEORGIA

To further DBHDD's vision of a fully integrated behavioral health and IDD system, we detail several innovative technologies we have developed over the years and will implement in Georgia. We believe our technological capability will reduce administrative costs and diminish duplicative procedures, paperwork, and overhead for DBHDD and the provider networks while leading to better outcomes and containing costs.

Spectrum

Spectrum supports a Web-accessible, secure record that facilitates coordination by providing a state-of-the-art solution to provide role-based secure access to critical information related to the individual's plan of care or support plan and health services. Graphically depicted below, Spectrum is an easily accessible hub that supports information sharing among the individual, behavioral health, IDD and physical health providers, Support Coordinators, and care managers. It incorporates all information available to provide a holistic view of the individual, including relevant assessments and medication history. The person-centric record assists case managers with utilization review determinations, Support Coordinators with monitoring indiviudals' health and well being, and other providers in delivering the most effective care and services across the person's array of needs and desires.



Spectrum is a comprehensive, person-centric record consisting of integrated behavioral health, IDD, physical health, and pharmacy data all centrally stored on the CONNECTS platform.

ValueOptions has experience coordinating data from multiple sources. Key individual activity information from our care managers is readily available for all stakeholders involved in the individual's treatment plan through integration of systems and data exchanges without the need for additional logins, passwords, or delays. We accommodate a wide range of file formats for data exchanges and regularly provide data exchanges to our other health plan partners. Integrating our informational resources with those of DBHDD will pose no problem.

Clinical Care Alerts

Our Clinical Care Alerts application performs monthly medical and pharmacy claims screenings to identify additional care gaps (i.e., poor adherence, medication conflicts, sub-optimal therapy, treatment contraindications, and an absence of a recommended care intervention). The care alert provides clinical intervention via focused messaging to prescribers, direct outreach to treating providers, or Clinical Care Manager contact with the individual. These outreaches result in a reduction in inappropriate pharmacy utilization, the delivery of more comprehensive evidence-based treatment, and ultimately a reduction in inpatient admissions and emergency room visits as physicians help patients restore therapeutic adherence to recommended treatment protocols.

The Clinical Care Alerts Program analyzes paid medical, behavioral, and pharmacy claims to identify gaps in care and mail individual-specific alert notifications to physicians providing care related to the care gaps.

As the individual population is screened, we store clinical care alerts in our data warehouse. These flags enable us to automatically send a summary of each patient's alerts to their trusted advisors (e.g., primary care provider, behavioral health provider) for interpretation and inclusion in care plans. The platform increases our ability to help more patients and enhances provider collaboration by notifying all providers and enabling them to work together to coordinate care for the patient. The alerts are a highly-effective, low-cost way to identify and minimize care gaps and support more intensive care management.

Health Alert

Health Alert is an integrated component of our information management system that automates appointment and medication reminders to increase aftercare compliance in an effort to reduce unnecessary readmissions and cost of care.

With Health Alert, individuals can coordinate with their providers to set alerts for appointment dates and times for outpatient appointments, medications, and/or refill reminders. The dynamic notification program also captures the individual's contact preferences regarding time of day, phone or e-mail, and time zone preference. Appointment reminders can be set for:

Health Alert automatically reminds individuals of scheduled outpatient appointments and medication fills and refills thereby increasing utilization of community-based care and reducing unnecessary emergency room visits and inpatient admissions.

- Outpatient behavioral health appointments
- Outpatient prescriber appointments
- Medication refills
- Outpatient physical health appointments
- Daily/hourly medication reminders

Individuals are able to access Health Alert to set up and manage all of their appointment and medication reminders through our portal, MemberConnect, which will be accessible via the DBHDD dedicated website. GCAL and ValueOptions staff, as well as providers can access Health Alert to set up appointment or medication reminders for individuals. Individuals can view all reminders set by providers, our staff, or themselves.

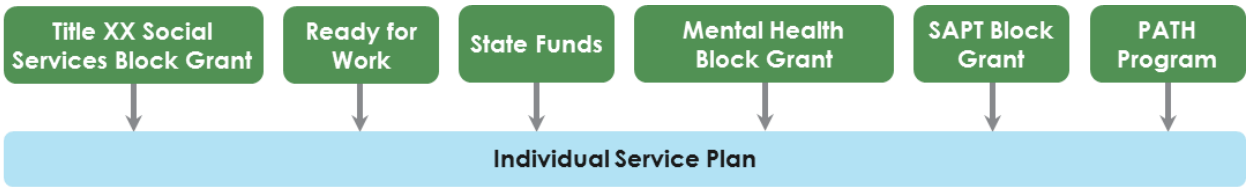
Below are examples of how we will enhance the Health Alert functionality for the purposes of supporting the IDD population:

- Notify providers when an individual's HRST is due for the annual update
- Notify individuals when they have a doctor appointment scheduled
- Notify providers when an individual is due for preventative health care (e.g. dental, annual physical, vision)
- Notify the State Support Coordinator/Planning List Administrator (or Support Coordinator) when the DMA-7 is about to expire

Braided Funding℠

Braided Funding is a collaborative approach to service planning and delivery that establishes the individual as the nexus for accessing multiple public funding sources. This process results in the most efficient use of funds when limited funding and budget restrictions might otherwise be barriers to care. Braided Funding also prevents unintended duplication of services for individuals who may be eligible for more than one program's funds and can also supplement services already being provided by other programs. While this process will be applied to the entire population, we believe it is especially relevant to individuals served by the program that have dual behavioral health/IDD diagnoses.

Braided Funding differs from 'blended funding' in that Braided Funding does not require a shared pool of money to be established for the combined needs of a set of predefined individuals. Rather, Braided Funding leverages all funding streams for which an individual may be eligible and provides a comprehensive service package that maximizes the resources available for that individual. The funds remain separate, but the services are braided together for the individual. This approach provides seamless and comprehensive care while maintaining accountability by funding, service, or agency. The control of funds is never ceded to another group for management and funds can be tracked at the individual level.



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

ATTACHMENT K.2

K.2 In Attachment K.2, **(no page limit)**, describe how the Offeror will meet the requirements for data capture and reporting for each critical function outlined in Section 15.3 of the RFP. Address the following in your response:

a. Describe the system components that will be implemented as a result of the Contract.
b. Describe the functionalities of the system including, but not limited to data capture, exchange, and integration.
c. Provide details regarding linkage between systems.
d. Identify which components are already built, partially built, or will be newly developed.
e. Indicate if the system is proprietary and maintained by the primary Offeror, proprietary and maintained by the Offeror's subcontractor, or owned by an external vendor. If an external vendor, identify which system and version number.
f. Identify when the next upgrade to the system is expected and if during implementation of this Contract; describe how system issues will be mitigated.

ValueOptions' CONNECTS platform is built specifically to manage behavioral health and IDD programs, and is the industry's only fully integrated IT platform. From initial eligibility through case management, claims administration, and reporting, all captured data can be fully integrated. It is designed to guide solid decision making and support utilization of providers, facilities, Regional Offices, and our ASO program staff.

ValueOptions has recently redesigned this management platform to provide a dedicated place for ValueOptions' clinicians to document and manage care plans in an efficient, standardized, and comprehensive manner. This upgraded module within our CONNECTS system will accommodate both behavioral health intensive case management (a detailed process for extensive treatment plans) and integrated care management (a less intensive process requiring fewer steps). The IDD support coordination services (including Individual Support Plan (ISP) processes and service oversight) support the following objectives:

- Promote national platform standardization while accommodating local customization
- Address accreditation and account specifications as required
- Streamline workflows and incorporate efficiencies, producing sequential and cohesive documentation/reports in line with the program work process
- Incorporate industry best practices; meet contract and market expectations for intensive case management, integrated care coordination programs, and IDD support coordination
- Include a case stratification process to inform resource allocation
- Support outcomes and operation management reporting

This significant investment in our technology infrastructure is designed to support highly integrated care expected in today's market. It will also provide DBHDD a high level of assurance that we will be able to successfully implement the ASO program and continue to improve its functionality over the life of the contract. The updated module incorporates standard industry best practice case management design with enhanced features for behavioral health specific condition management, as well as robust inclusion of physical health considerations for the management and support needs of the "whole person".

Specifically, the platform supports a wide range of administrative and clinical functions, including the following:

- Providers can submit authorizations and claims, preview clinical criteria, perform administrative procedures, access their demographic information, and submit appropriate changes online
- Data exchanges can be initiated in any format with the flexibility to meet DBHDD's needs
- Our Clinical Care Managers can track and report information, such as quality indicators and recidivism rates
- Online dashboard reporting offers DBHDD real-time access to detailed information including utilization metrics, Key Performance Indicators (KPIs), and financial and overall program performance
- Quality Management team members can utilize reporting functions to collect data at the individual and provider level

A. AND B. – SYSTEM COMPONENTS AND FUNCTIONALITY

Our highly adaptable information system, CONNECTS, manages complex ASO programs from initial enrollment and eligibility through claims adjudication and payment. It maintains benefit structures, provider reimbursement methodologies, and adjudication rules for each of our programs. Advanced capabilities have been designed throughout the system to incorporate multiple eligibility categories and service packages, and to further improve coordination of services. These will be customized specifically for the DBHDD program, addressing all the functions listed in *Attachment J, Section 15.3* of the eRFP. These system components and functionalities are described in greater detail in the following paragraphs.

CareConnect

Our service module, CareConnect, is the heart of our information management program, offering our program staff an enterprise-wide collaborative planning and behavioral health and IDD record environment. Accessible 24 hours a day, seven days a week by our teams, CareConnect enables users to identify, authorize, and manage the delivery of the most appropriate, high-quality behavioral health, substance use disorder, and IDD services for individuals—from the initial point of entry until services are no longer warranted.

The CareConnect application is used for the following processes:

- Creating referrals (i.e., routine, urgent, and emergency)
- Completing and tracking requests for service authorizations

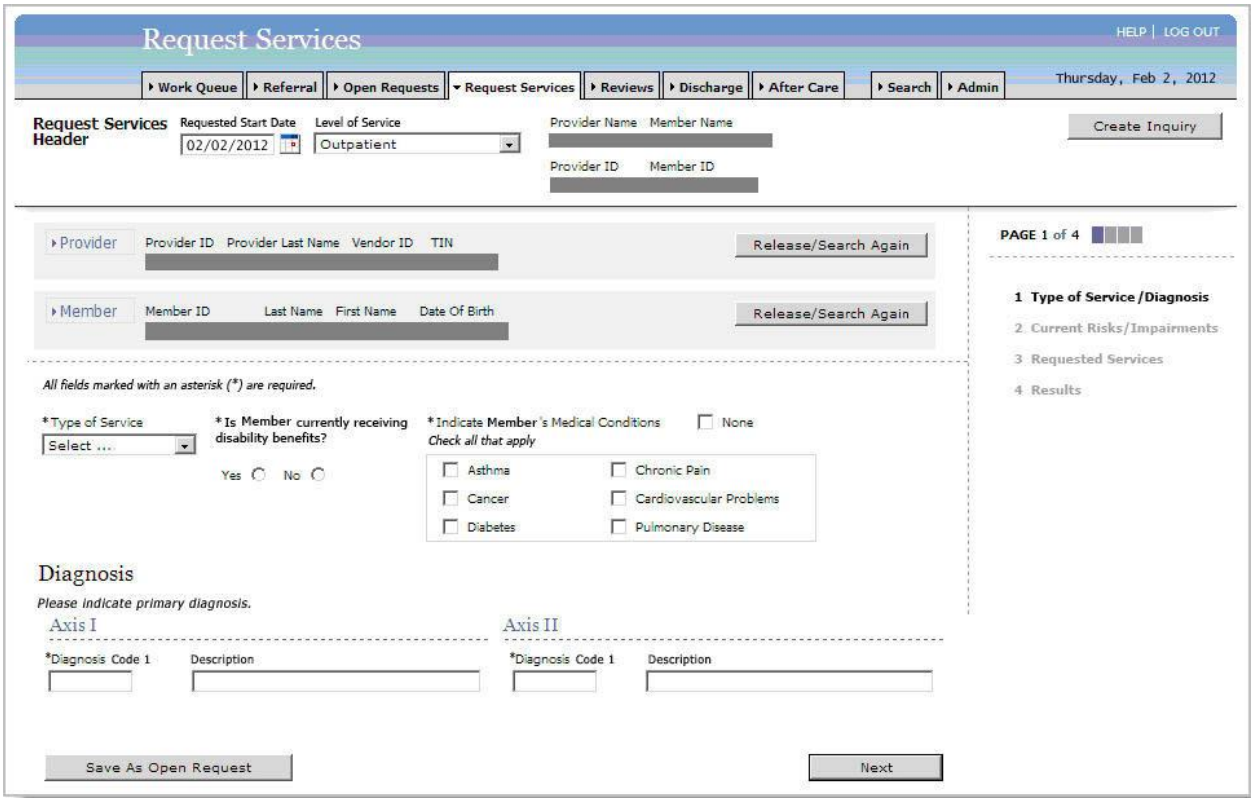
- Performing medication management, inpatient/higher levels of care reviews, and second level reviews
- Managing discharge information and reviews
- Coordinating aftercare and follow-up care

Whether information is submitted via the telephone, fax, interactive voice response system, or provider Web portal, our Clinical Care Managers review all authorization requests for authorization data. Any clinical data provided, as well as the rationale for decisions rendered, is recorded in CareConnect and becomes an integral part of the individual's record. Our case management system automates routine care management processes, which enables our staff to focus on the most pertinent clinical data for each individual and easily locate and view historical data summaries to efficiently formulate cases.

For indiviudals with IDD, the Regional Intake and Evaluation (I&E) staff will have access to CareConnect to establish records for individuals seeking services. It will track all steps of this process up through to denial or acceptance of services. CareConnect also houses and maintains all necessary documentation needed to determine eligibility, including assessments, ISPs, and evaluations. For those who are deemed eligible for services, the system will originate all of the necessary components to design and monitor the service delivery system for the person for as long as they are needed.

Functionality

CareConnect, shown on the following page, is a feature-rich suite of Web-enabled screens designed to reduce the administrative burden imposed on providers and our program staff by providing a platform to gather objective and pertinent data. The system is highly intuitive and functions are performed by simple point and click actions. It embeds best practice information as part of the framework to support care manager and support coordination decision making while reviewing cases for continued services. Information received from providers is contrasted against this information to guide discussions and decisions. For example, in a case involving a child participating in therapy for disruptive behavior with no evidence of participation by the parents based on clinical data, CareConnect would generate an alert to discuss this with the treating provider. As another example, if there is an individual with IDD and the Health Risk Screening Tool had not been updated or if Medicaid claims indicate new medications are being received but no update has been made, an alert will be sent to the provider to update this information.



CareConnect supports direct interchanges between providers and ValueOptions.

CareConnect collects and maintains all program data elements and enables us to successfully implement an electronic, enterprise-wide treatment and support planning and behavioral health and IDD record environment. With CareConnect, program staff can quickly focus on the most pertinent service or clinical data for each individual and easily locate and view historical data summaries to efficiently formulate cases and identify trends. The ability of the system to collect, monitor, and report program information provides stakeholders at all levels with the ability to assess program activities in near real-time and to conduct trend analysis to support an agile response to both positive and negative emerging issues and trends.

In addition, our system includes referral search screens for behavior health that allow Clinical Care Managers and clinical support staff to provide referrals for individuals seeking care. IDD support coordinators could look for service providers in the individual's local area according to services provided. The application enables standardized screening and the ability to search for the best matched providers for an individual member. The robust search engine can search by location, licensure, and specialty, as well as a variety of other factors that can be customized to each member's needs and desires for an optimal treatment experience.

ProviderConnect

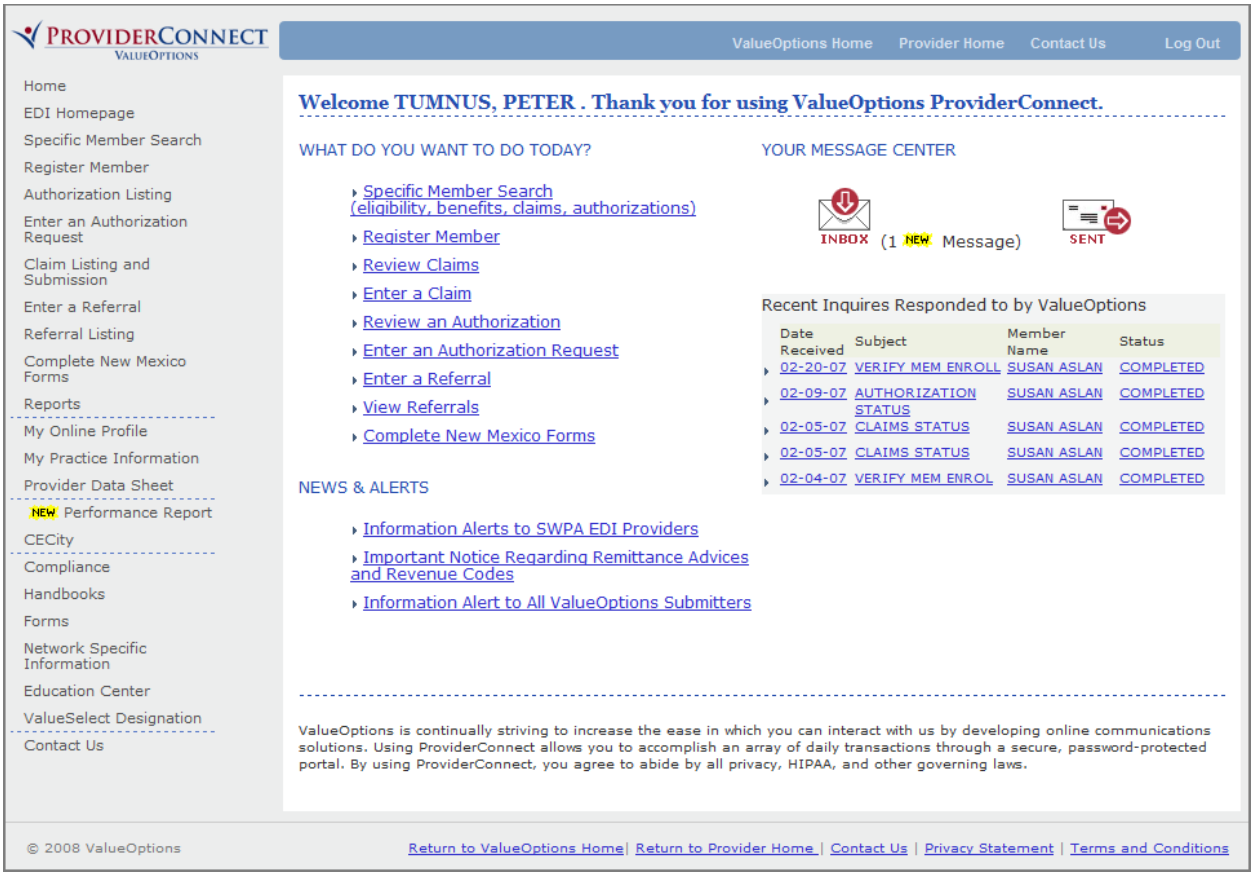
ProviderConnect is our exclusive Web portal for providers. It is very easy to use—even for novice users or those who may be uncomfortable in utilizing new technology platforms. As a

result, it boasts a very high rate of adoption by providers in our other ASO programs throughout the United States.

ValueOptions' user-friendly provider Web portal will significantly alleviate many of the concerns providers have with the existing system. Along with the support and educational tools we offer to providers, the system ensures optimal use of online systems, resulting in increased use of Web-based technology and a decrease in administrative burden for providers. For example, in our Maryland, Illinois, and Arkansas programs, the percent of providers electing to use the portal is well over 90 percent.

Our secure ProviderConnect Web portal allows providers to manage their interactions with us. It is an intuitive application that has achieved wide acceptance and usage throughout the United States.

Accessible 24 hours a day, seven days a week, providers can view, submit, and execute transactions online via a secure, scalable, and trusted Web portal. We have provided a screenshot of ProviderConnect below. This functionality will be especially crucial in the design and implementation of the new eISP process for individuals with IDD and the providers supporting them.



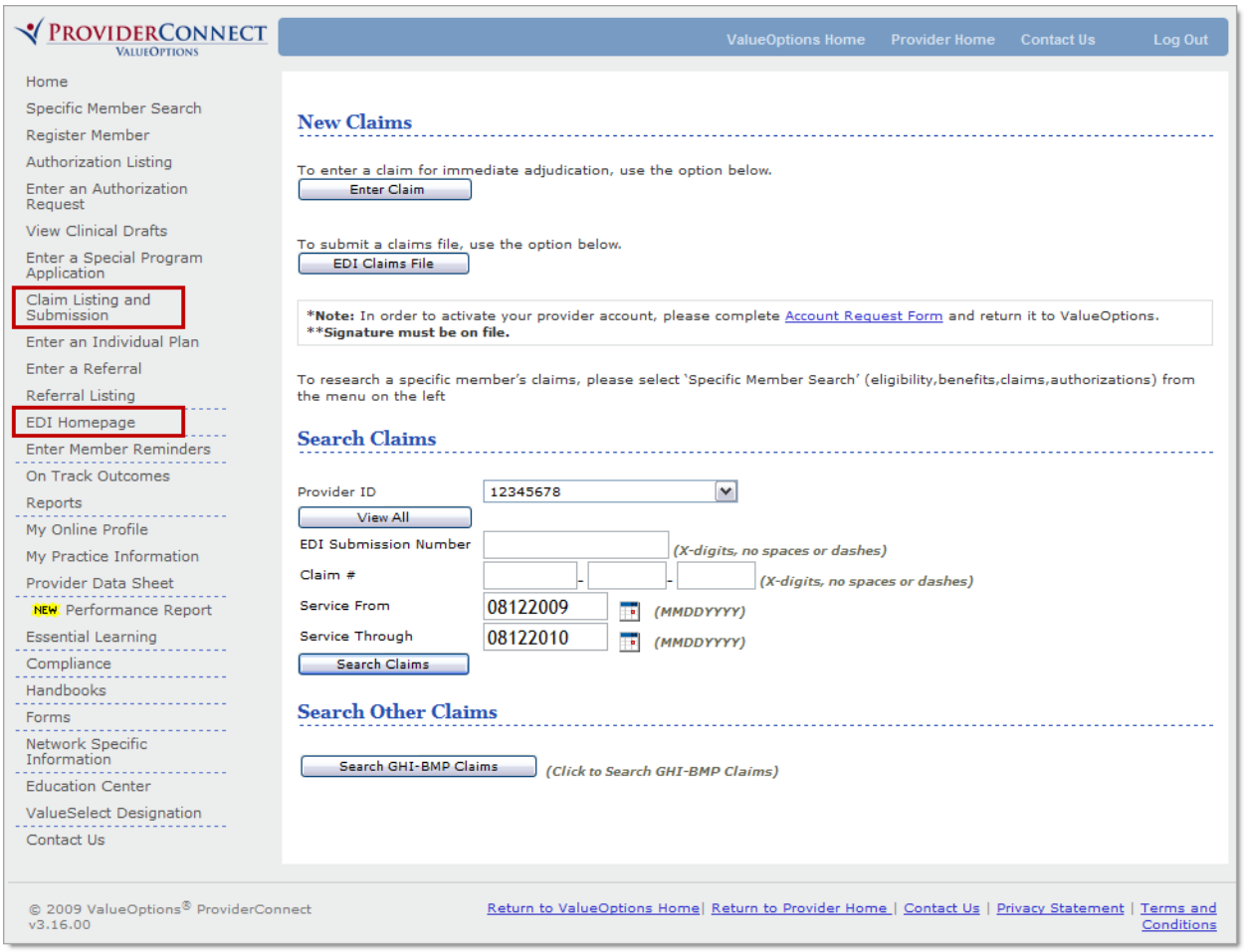
Our provider administration and service application enables network providers to conduct administrative transactions via a secure Internet portal, accessible from their office computers.

Functionality

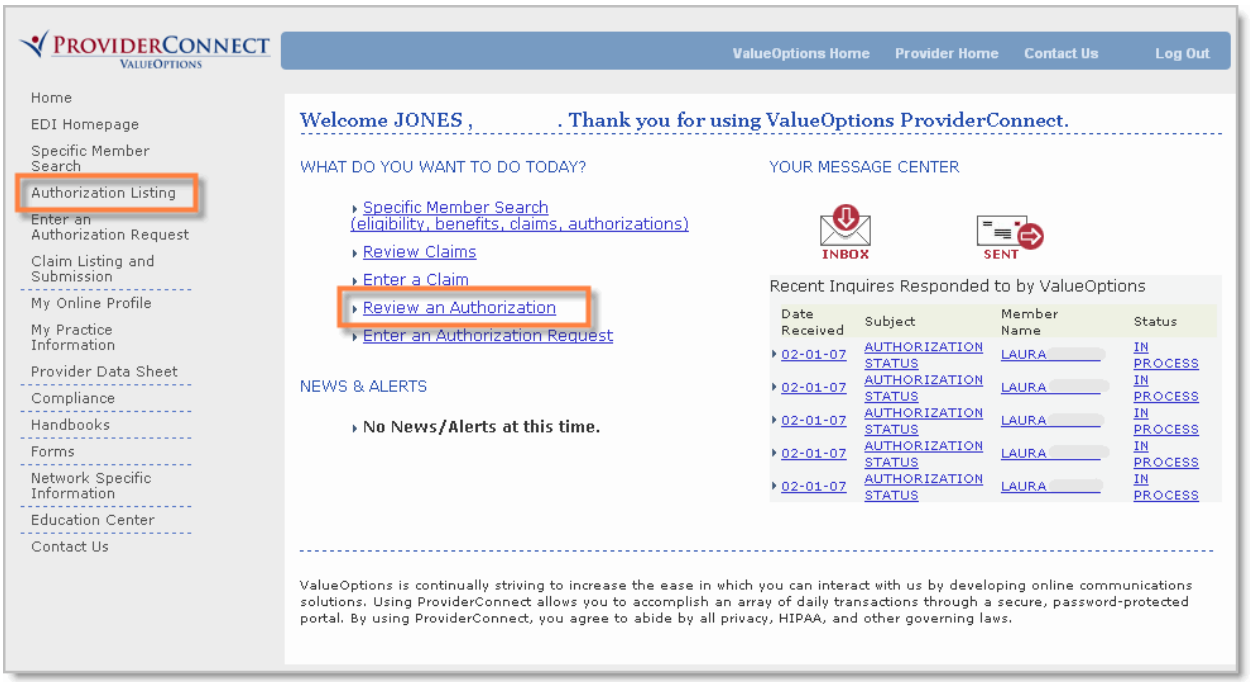
Through a Web interface, providers have real-time access to tools necessary for handling most administrative transactions as well as request services for members. ProviderConnect accelerates provider's workflows by delivering an interactive Web-based system for collaborative business processes. Depending on the function accessed within ProviderConnect, providers have read only or read/write capabilities. Key features of this website include the ability to:

- Access client specific network information
- Check an individual's benefit information
- Check status of an individual's enrollment
- Create and view other types of inquiries via a message center
- Directly enter and submit a claim or upload HIPAA-compliant claim files online
- Download and print standard forms
- Register an individual for services
- Review a detailed payment status of submitted claims
- Review and submit requests for authorization of care, as well as the ability to print these requests for their own records; some requests will receive immediate authorization based on benefit
- Submit/attach documents to all submissions
- View and print online correspondence, such as authorization letters and provider summary vouchers
- View and submit updates to demographic data for providers
- View authorization history and letter history
- View provider handbooks, obtain information on trainings, current clinical articles, and workshops

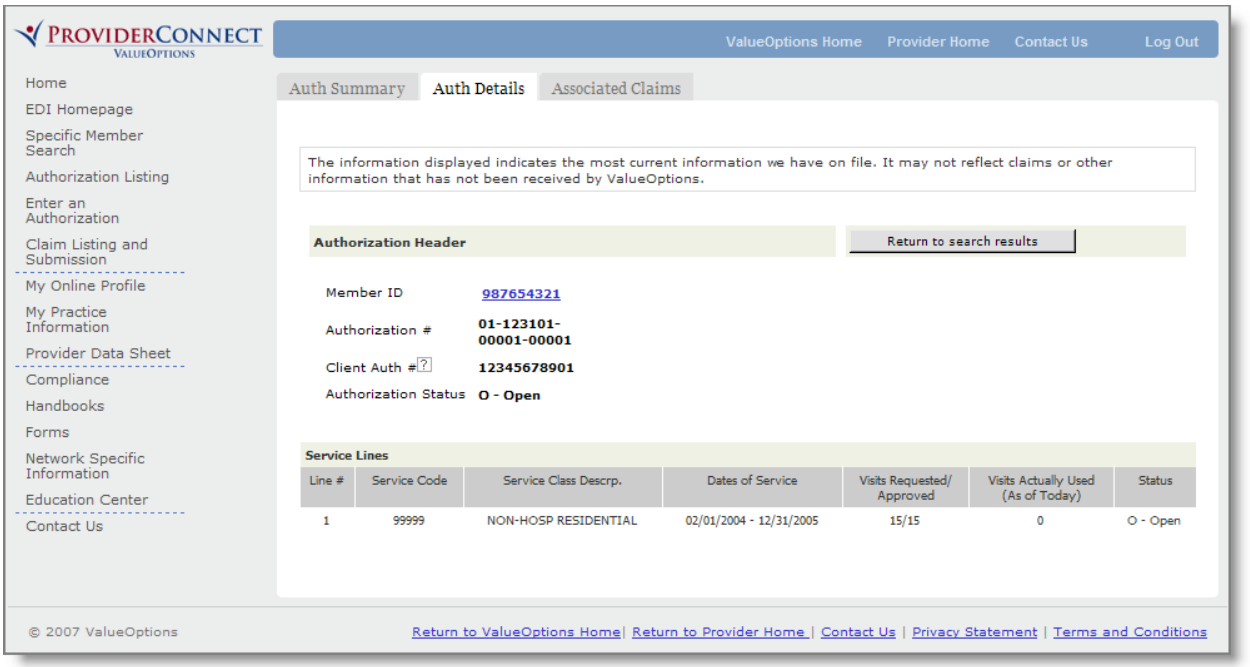
Presented on the following pages are screenshots of ProviderConnect illustrating how providers are able to enter and submit a new claim, view the status of current authorizations, and drill down to individual-specific authorization information. This function will allow for realtime access to current claims data and information used for the IDD and behavior health quality assurance reviews.



Providers can build and submit electronic claims files to ValueOptions or manually enter a claim into the ProviderConnect application utilizing data entry screens.



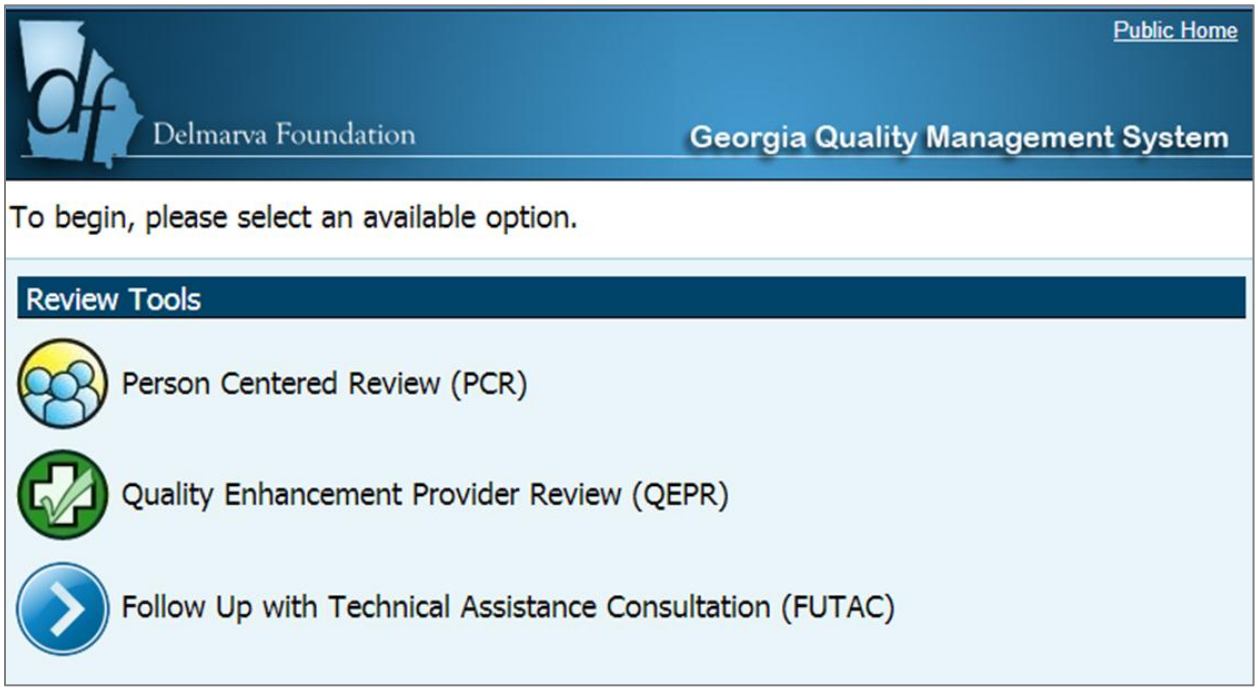
The system enables providers to perform many routine customer service transactions via a secure website, including requesting an authorization, and/or obtaining the status of an authorization.



ProviderConnect enables providers to obtain the status of an authorization right from their office computers.

Georgia Quality Management System

Delmarva will be responsible for the IDD and behavioral health onsite reviews. These reviews will be conducted in the Georgia Quality Management System (GQMS) designed and maintained by Delmarva. GQMS is a Web-based interface with a MS SQL Server 2012 backend database. All PCRs, QEPRs for IDD HCBS waivers and State-funded services and behavior health onsite audits, FUTACs, and Peer Interviews and Surveys will be conducted within this application. This application is also a custom built application that Delmarva will update as necessary to accommodate changes required by DBHDD. This means with proper requirements we can change the application faster than an off-the-shelf solution because we own it and know the code behind that application. PCR and QEPR reviewers will have access to CareConnect and batch files of specific data required to perform the reviews.

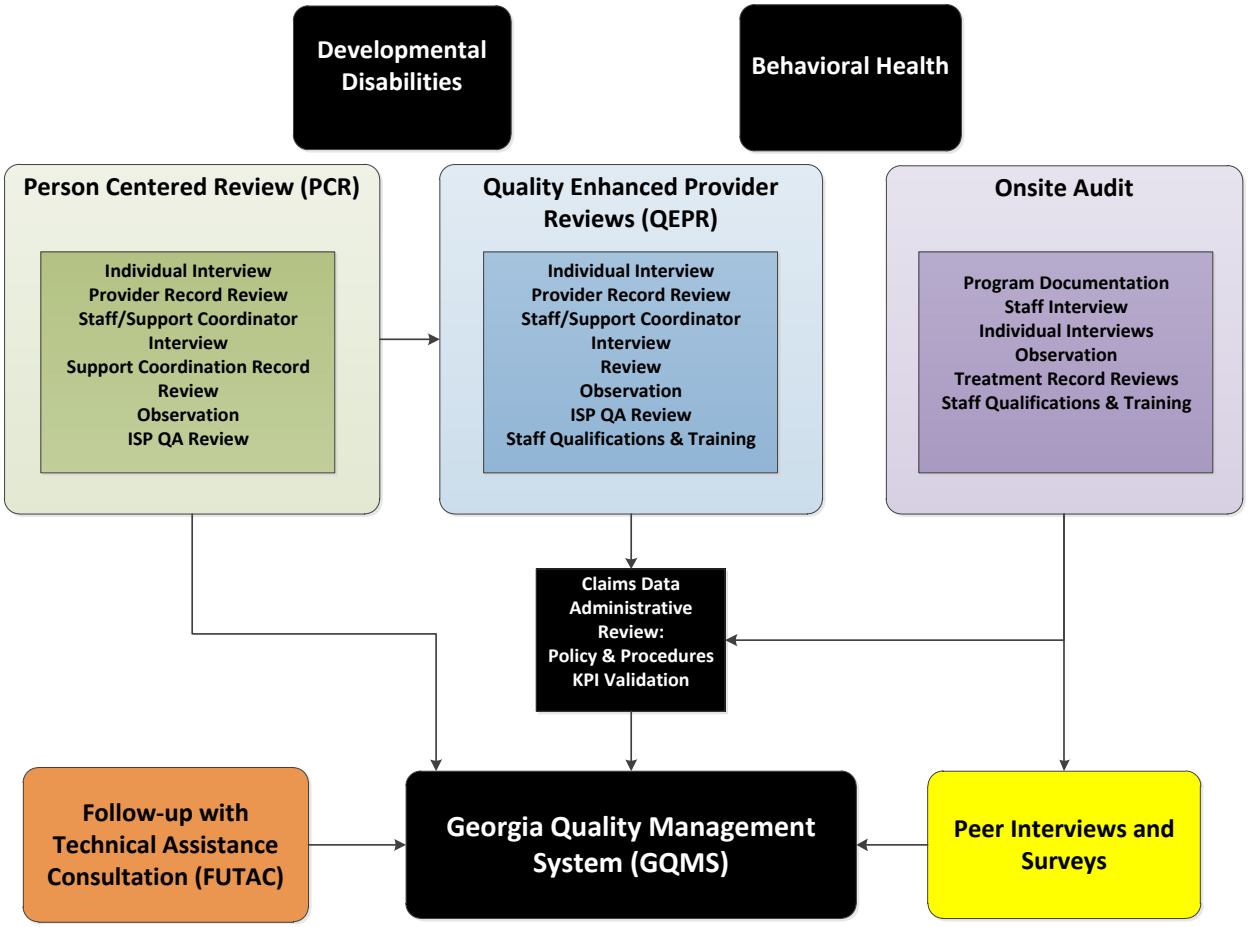


When applicable, GQMS will link to the CONNECTS database to provide current information about the individuals and providers under review. This linkage of systems will provide current data and reduce the amount of data entry that is required. Also, outcomes and reports will be provided from GQMS to the CONNECTS database so there is just one system for regional staff, providers, and other defined users to interact with the data from the IDD and behavioral health reviews. The integrated information will allow for performance measure monitoring and feed into the Provider Performance Profiles. Updates to and from each system will be conducted at a minimum of once per day but can be completed multiple times during the day if necessary.

Functionality

Through the Web interface, Delmarva consultants will be able to conduct interviews and audits real time onsite with individuals and providers. Depending on the characteristics of the

individuals in the sample or the type of provider selected for an audit, various instruments will automatically be active for consultants to enter data into.



All fields will require a response before a review can be completed. Once a review or audit is completed by a consultant it is forwarded to a queue for a Regional Network Manager to approve. Additional checks and balances will be put into place to ensure the integrity of the data and to help prevent human error. Upon approval by the manager, all data then becomes available for provider reports as well as any real time data functions and dashboards. This ensures the quality of the data collected is very high and that we have reproducible results.

Data Capture

Regardless of the system component, all information and data related to our care coordination and utilization management program is captured and stored in CONNECTS, our proprietary information system. CONNECTS provides our staff, providers, and other stakeholders with a dedicated place to document and manage care/support plans in an efficient, standardized, and comprehensive manner. The system accommodates both intensive case management (a detailed process for extensive treatment plans) and integrated care management (a less intensive process requiring fewer steps).

The table below provides a list of information captured in our system regarding specific case management data and activities.

Type of Data Captured	Purpose
Intensive Case Management Referral	Enables Clinical Care Managers to enter information pertaining to the individual's referral to the program
Acuity Assessment/Stratification	Enables Clinical Care Managers to complete, score, and save an acuity assessment for the individual
Intensive Case Management Engagement	Enables Clinical Care Managers to document information pertaining to an individual's engagement in the program
Clinical Assessments	Enables Clinical Care Managers to complete, score and save the following clinical assessments for the individual: • LOCUS • SF-12 • Mini MHSA • PHQ-9 • GAD-7 • AUDIT • CANS
Care Plan	Enables Clinical Care Managers to document care plan goals for the individual and monitor the progress of these goals
Medications	Enables Clinical Care Managers to view and modify information regarding the individual's current and historical medications, as well as add new medications and manage medication reminders
Clinical Profile	Assists Clinical Care Managers in determining whether or not the individual meets the criteria for intensive case management
Individual's Contacts	Enables Clinical Care Managers to view contact information for the individual
Intensive Case Management Contact Activity	Enables Clinical Care Managers to perform the following: • Document information pertaining to the individual's case • Create provider referrals • Document medication information and appointment adherence • Schedule appointment reminders • Specify and print follow-up contact plans
Discharge	Enables Clinical Care Managers to discharge individuals from the program

C. – SYSTEM LINKAGES

Data Exchange via FileConnect

Early in the implementation process, we will work with DBHDD, Alliant GMCF, the Georgia Department of Community Health's Division of Medicaid, GAMMIS, and providers to determine what infrastructure is necessary to support the required data exchange methods for

integration needs. This may include location, facility, network, telecommunications, equipment, security protocols, and transmission methods, among others.

ValueOptions processed 613,786 data exchanges (inbound and outbound) in 2013 with multiple trading partners and providers.

To facilitate efficient file exchange, ValueOptions developed FileConnect, our robust, secure infrastructure that has built-in interfaces allowing our clients, providers, and third-party trading partners to transfer data securely and accurately. Our FileConnect application is designed for the interchange of electronic data files, such as eligibility, claims, and encounters between network providers, state clients, business partners, or associates via secure Internet connections.

All of our data exchange procedures include development and support capabilities, such as error correction and reporting, data cleansing, tracking and performance metrics. Where applicable, we also support HIPAA transaction formats and have the ability to develop client-customized data exchanges.

This solution employs JBoss messaging for 'guaranteed delivery' of information exchanged with our clients and business partners. FileConnect also has the capability to send and retrieve (Push/Pull) files in a secure manner from our client and business partners' servers remotely. FileConnect offers different pathways to accommodate clients with diverse infrastructural needs. These include:

- File Transfer Protocol (FTP) over Virtual Private Network (VPN)
- FTP with Pretty Good Privacy (PGP) encryption
- Secure Shell Protocol (SSH) over FTP
- Secure Sockets Layer (SSL) over FTP
- Web Service call over Hypertext Transfer Protocol Secure (HTTPS)
- Secure website submission over HTTPS

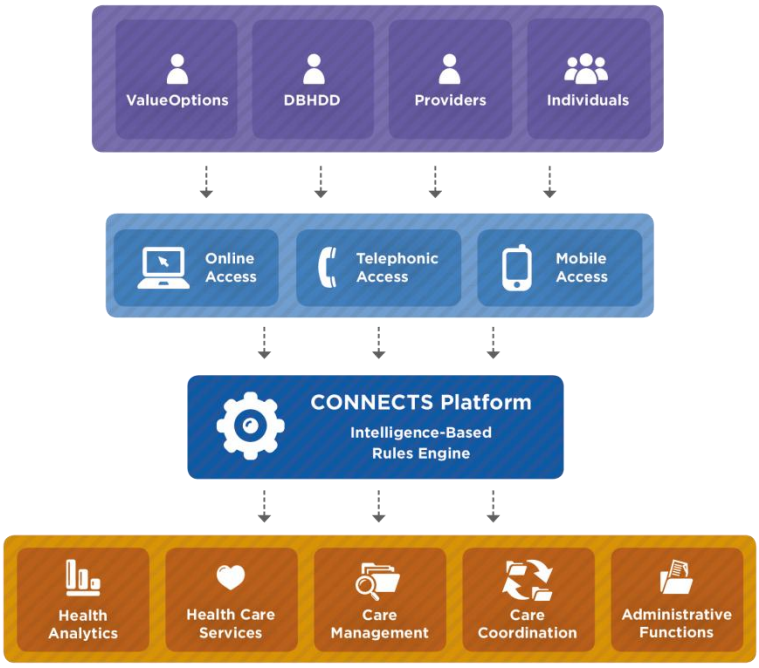
ValueOptions has the experience coordinating data from multiple sources, including a variety of state Medicaid, Federal, health plan, and commercial employer contract partners. Key individual activity information from our Clinical Care Managers and from support coordinators is readily available for all stakeholders involved in the individual's treatment/support plan through integration of systems and data exchanges without the need for additional logins, passwords, or delays. We accommodate a wide range of file formats for data exchanges and regularly provide data exchanges to our other health plan partners. Integrating our informational resources poses no problem.

Data Integration

CONNECTS comprises a suite of fully integrated applications built on a single platform. All integration occurs within our one platform—simply stated, everything communicates with everything else, and we own the source code, so a special request or urgent need can be accommodated with ease. Data can be organized at the account, individual, provider, and

population level, or any other level required by DBHDD. This means that our platform is truly an enabler of service coordination, rather than a barrier.

We recognize the population DBHDD serves is supported by multiple programs, each with their own set of eligibility status and resource eligibility rules. Our CONNECTS platform is capable of managing even the widest variety of benefit designs and structures. Each group added to the system has date sensitive tiers and benefit packages assigned to the contract period, and the system allows for the maintenance of contract history for each group. Within our eligibility module, we are able to store as many effective and term dates as needed to indicate changes in coverage, group assignment, benefit packages, or coordination of benefits data. CONNECTS displays eligibility history as well as current status for each individual to ensure services are approved or denied appropriately.



Our integrated platform collects all utilization, disease, and case management data, which becomes the person-centric record accessible via our Web-based solution, Spectrum.

Spectrum

As noted in our response to *Section K.1* above, providers and other stakeholders will have access to behavioral health, physical health, and pharmacy claims and encounter data through our person-centric record, Spectrum. Spectrum supports a Web accessible, secure person-centric record that facilitates coordination by providing access to critical information related to the participant's plan of care and health services.

Functionality

Spectrum supports a Web accessible secure record that facilitates coordination by providing a state-of-the-art solution to provide role-based secure access to critical information related to the individual's plan of care, IDD, and health services

Spectrum is an easily accessed hub to support information sharing among the individual, behavioral health and physical health providers, primary care providers and case managers/support coordinators. It incorporates all information available to provide a holistic view of the individual, including relevant assessments and medication history. The person-centric record assists both case managers and support coordinators in making utilization review

determinations and other providers in delivering the most effective supports and services throughout treatment. Key features of Spectrum include:

- A data driven and outcomes-based approach that informs identification and outreach activities, including:
  - Effective use of claims analysis and predictive modeling
  - Integration of health risk assessments and indiviudal care/support plans (through electronic provider portals) to inform management activities
  - Easy access to integrated, comprehensive clinical assessments completed with the individual and informed by the entire team (e.g., primary care, behavioral health specialists, IDD specialists, Regional Offices, rehabilitative providers)
- A clinical and multi-disciplinary approach supported by a primary Clinical Care Manager as the anchor and recognition that individuals have a myriad of needs beyond just their health care. This approach supports:
  - An integrated care delivery model through the use of multi-disciplinary teams consisting of medical, behavioral and pharmacy professionals, social workers, peer support workers, lay health educators, and community health specialists
  - Diverse and specialized teams, in collaboration with the primary Clinical Care Manager, comprehensively "wrap services around" the participant, addressing all participant needs with a designated Care Manager coordinating and directing the team

D. – EXISTING SYSTEM INFRASTRUCTURE

As mentioned above, we offer our fully integrated information management system, CONNECTS, for assimilating all eligibility, authorizations, claims, and other related data from disparate formats and sources. Our current integrated information system has significantly enhanced our ability to improve the coordination of care and service delivery for 32 million behavioral health members we serve throughout the country and is fully operational today. We recognize the need to conduct some customized programing to meet DBHDD's unique requirements. However, our existing infrastructure will allow us to implement all aspects of the requirements in *Attachment J, Section 15* in compliance with current and future Federal and State-specific laws, rules, regulations, requirements, and standards for system requirements, data exchange, privacy, security, and the timely collection, storage, and reporting of data. We will ensure that all our subcontractors comply with all such requirements for information systems involved in the work related to this contract.

E. – SYSTEM OWNERSHIP

ValueOptions has invested extensively in our enabling technology platform, and it is ours. We own the source code, so when DBHDD needs a modification or an enhancement of some kind, we can accommodate the request in a timely, cost-effective manner.

F. – SYSTEM UPGRADES

ValueOptions owns the source code for our core care management software and all the applications described above. Our National IT Department performs all upgrades and enhancements on a pre-defined quarterly schedule or as needed upon client implementations or when modifications are necessary due to contract requirements. As such, ValueOptions does not

need to wait for a third-party company to push any updates or patches to ValueOptions' systems. Changes are deployed into the production environment only after rigorous test procedures are completed successfully. DBHDD can be assured that any required modifications to our system due to the requirements of the ASO contract will be made efficiently and cost-effectively.

Our formal Change Management Process is designed on the basis of partnering with clients throughout the software development lifecycle to ensure change orders are prioritized and rapidly delivered. This process helps control, prioritize, and streamline the delivery of changes to our information technology products and services. The process also provides a standardized, effective, and efficient process to prioritize and fulfill changes for system enhancements and software upgrades.

ATTACHMENT K.3

K.3 In Attachment K.3, **(no page limit)**, describe how the Offeror will meet the requirements for a website and web-based system as outlined in Section 15.4 of the Attachment J, Detailed Contract Deliverables. Address the following in your response:

a. Describe the system components that will be implemented as a result of this solicitation.
b. Describe the functionalities of the system, including security features, web content, interfaces, etc.
c. Provide details regarding linkage between systems.
d. Identify which components are already built, partially built, or will be newly developed.
e. Indicate if the system vendor is owned and maintained by the Offeror or an external vendor. If a vendor, identify which system and version number.
f. Identify when the next upgrade to the system is expected and if during implementation of this Contract; describe how system issues will be mitigated.

A. AND B. – WEBSITE AND WEB-BASED SYSTEM COMPONENTS

In accordance with the content and functionality requirements outlined in *Attachment J, Section 15.4* of the eRFP, we will apply our extensive website development experience and knowledge to design and implement a customized stand-alone, publicly accessible website specifically engineered to serve individuals, providers, and DBHDD. We will develop, deploy, and manage a comprehensive website that leverages industry best practices and is customized to address the unique needs of the DBHDD program.

Our architecture and management approach will enable on-demand access to pertinent DBHDD information using intuitive menus and a three-click navigation scheme. Our websites are secure portals offering the following enhanced security features:

- Identification and authentication of users allowing multi-level user rights (e.g., providers, DBHDD staff/managers/executives, individuals, family members/caretakers)
- Verisign/Symantec SSL certificate with public key RSA 2048 bit to secure session with client browsers
- Creation of audit records whenever users inquire or update records
- Provision for access controls that are transaction-based, role-based, or user-based
- Verification controls to ensure that transmitted information has not been corrupted
- Authentication protocols to validate that a message is received unchanged
- Encryption or access controls, including audit trails, entity authentication and mechanisms for detecting and reporting unauthorized activity in the network

As described below, all DBHDD users will have a full array of information resources at their fingertips from the homepage level within the DBHDD dedicated website environment. We will work collaboratively with DBHDD, McGowen Associates (for the HRST), AAIDD (for SIS), and other State agencies to gather the necessary requirements to establish the necessary linkage to their respective websites and content as defined by DBHDD.

We propose to build a website that will, at the minimum, contain the following content and functionality:

Content	• GCAL information and telephone number
	• Approved educational materials, including practice guidelines, evidence-based practices, best practices, and national trends
	• Manuals
	• Handbooks
	• Provider resource directory
	• Provider applications
	• Data interface companion guides
	• Access to Web-based systems
	• Web-based provider training
	• Standard reports and ad hoc reporting tools
	• Frequently asked questions (FAQs)
	• Community forums schedule
	• Information on how to report fraud and abuse
	• DBHDD-specific information and forms, such as:
	  ○ DBHDD HIPAA complaint form
	  ○ DBHDD HIPAA violation report form
	  ○ Information on how to report abuse, neglect, or exploitation
	  ○ Searchable communications or notices section where communications from ValueOptions or the State are posted for provider or public viewing

Functionality	• Generation of unique identification number (CID)
	• Application for behavioral health State-funded services
	• Application for IDD services (i.e., HCBS and/or State-funded) as outlined in *Appendix 41, I&E Applicant Information*
	• Applicant Information
	• Provider applications
	• GCAL bed capacity dashboard
	• HCBS data management system
	• PASRR level of care referrals/reviews
	• NCB services authorization and payment system
	• Service authorization system
	• Claims payment and encounter submission system
	• Provider resource directory
	• Provider Performance Profiles
	• Reporting tools
	• IDD Quality Improvement Council portal
	• IDD Human Rights Council portal
	• Capacity to collect and store data related to IDD Intake and Evaluation
	• Assessment tools and results
	• ISP development, modification and tracking including, but not limited to:
	  ○ SIS
	  ○ Health risk screening tool

	○ Social work assessment ○ Nursing assessment ○ Psychological assessment • Collection and storage of documents such as Individual Support Plans, eligibility documents, medical, and psychological evaluations • Collect and support all IDD HCBS (e.g., COMP, NOW) and State-funded IDD Data Management Systems Web-based Components outlined in *Attachment J, Section 15.4.6* including, but not limited to: ○ Allowing I&E managers, regional and State office personnel, Support Coordinators, and associated IDD service providers throughout the State to input and review State and HCBS related data ○ Link and display all required historical data and documents from the existing IDD Consumer Information System ○ Allows Individuals and families to securely view his or her ISP ○ Supports DBHDD's planning list, ISPs, I&E assessments and updates, and Support Coordination monitoring ○ Hosts an electronic version of the HCBS Waiver application ○ Captures I&E data and documentation, including transition population information ○ Captures LOC Determination Data ○ Captures planning list case management activities including: contacts, enrollment in other services, Medicaid/SSI status, etc. ○ Accommodation of the draft and redesigned eISP tool ○ Captures initial and annual assessments and evaluations of Individuals receiving services, including LOC, HRST, and SIS capture case management functions for State-funded and Medicaid-funded services and supports ○ Interfaces with the HRST and SIS websites ○ Generates and houses individual budgets associated with ISPs ○ Captures program specific data, (e.g., Family Support, Supported Employment,Pre-Vocational) ○ Captures Support Coordination (State and Medicaid) activities ○ Tracks appeals to monitor findings (e.g. Support Coordination findings) and steps/status in the appeal process in accordance with Appendix 48 ○ PCRs, PRRs, QEPRs, FUTAC, and behavioral health audit processes, results and reporting ○ Performance monitoring relative to QIs, PMs, and PGs

As mentioned previously in *Section K.2*, our highly adaptable, Web-based system CONNECTS manages complex behavioral health programs from initial enrollment and eligibility through claims adjudication and payment. It maintains benefit structures, provider reimbursement methodologies, and adjudication rules for each of our programs. Advanced capabilities have been designed throughout the system to further improve coordination of care services, and will be customized specifically for the DBHDD program, addressing all the functions listed in *Attachment J, Section 15.4* of the eRFP. We provide a brief description of each Web-based component in the following paragraphs.

ProviderConnect

Requests for authorization will be available through our Web-enabled registration process. This Web-based registration is an integral part of the wide array of Web-enabled services available to

providers through our provider portal, ProviderConnect. By completing the registration, providers will be able to:

- Register individuals and enroll them for approved program services
- Receive a consumer identification number for the individual if one has not already been assigned
- Determine if eligible individuals are authorized for a particular benefit package, based on responses integrated into the registration process

ValueOptions is the only behavioral health care company in the nation that has successfully implemented an integrated electronic, collaborative authorization, treatment planning and behavioral health record environment. Our shared clinical record currently includes:

- Admissions and triage
- Centralized scheduling
- Complaint tracking
- Customized authorization/registration parameters
- Discharge planning
- Integrated utilization management
- Objective and standardized assessments
- Participant event tracking
- Treatment and service planning
- At-risk crisis plans
- Clinical progress notes
- Crisis tracking
- Drop down boxes to assist Clinical Care Managers' clinical decision making process
- Eligibility
- Medication tracking
- Participant demographics
- Referral tracking
- WRAP®

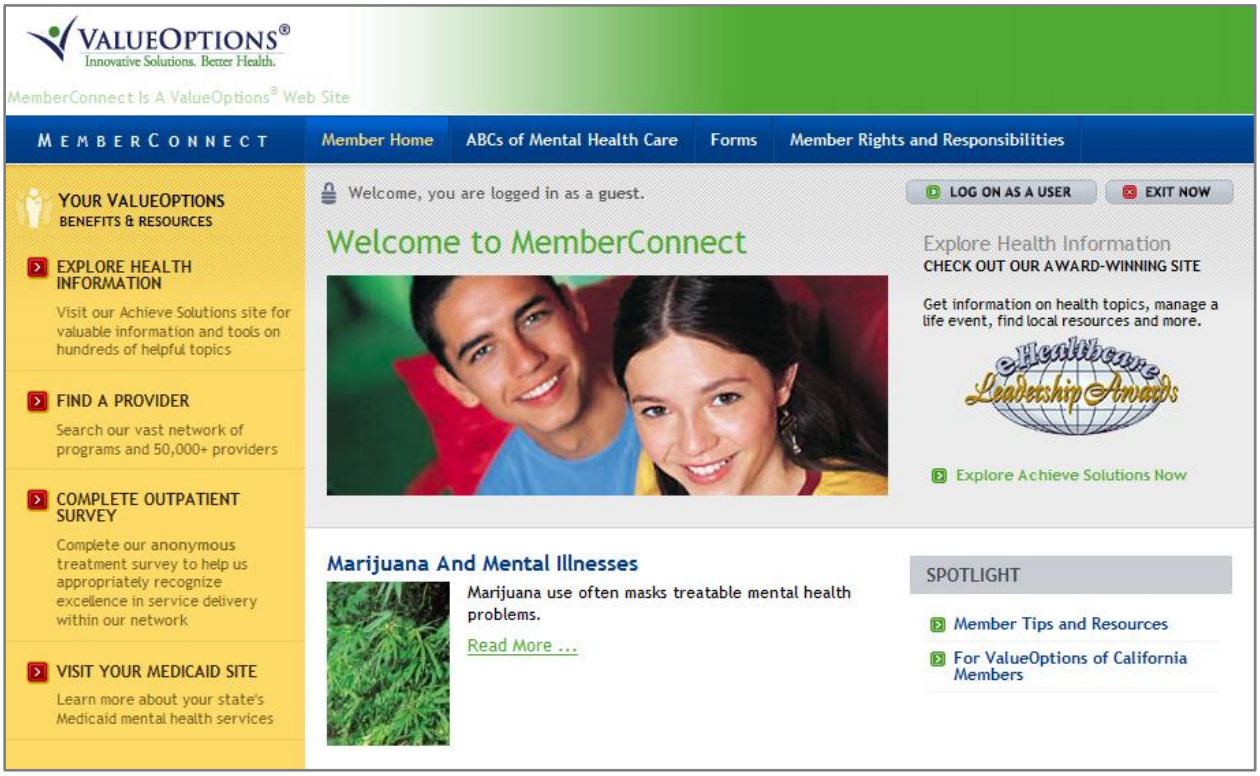
ProviderConnect incorporates core clinical components and highly configurable triage rules necessary to process incoming authorization requests. Required clinical elements are consistent for comparable services (e.g., inpatient and residential treatment center), but criteria for endorsement is specific to each level of care. When critical clinical information is missing, automated requests for additional information are forwarded to the provider for completion. Requests with complete clinical information are processed against triage guidelines and those that meet all required parameters receive automated approvals for specific identified levels of care as approved by DBHDD. Requests indicating the need for additional clinical review are directed to the appropriate Clinical Care Manager for processing.

Through ProviderConnect, providers have real-time access to the tools necessary to answer a myriad of administrative and care questions they might have as well as request services for participants. This provider portal supports efficient provider workflows by delivering an interactive Web-based system for collaborative business processes. All applicable data fields detailed in *Section 1.5* and *Appendix 17a-f* of this solicitation will be fully integrated into our information management system.

MemberConnect

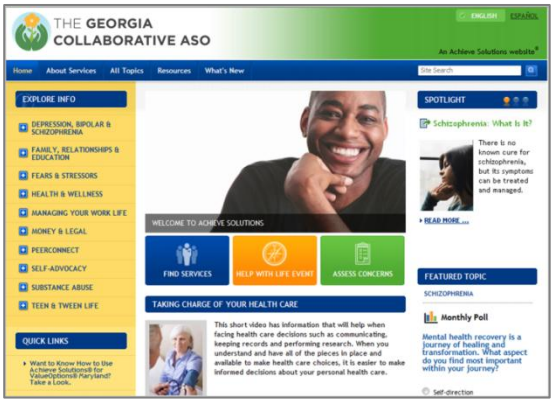
MemberConnect, displayed below, is a Web-based application maintained by our IT staff that serves as a 24/7 one-stop shop for individuals to complete everyday service requests online. Via a secured site, this portal allows users to conduct transactions such as eligibility inquiries, claims

inquiries, and claims submission via the Internet. It also enables users to view eligibility, check benefits, check authorization and claims status, check claims history, claims payment and view correspondence online. Individuals are presented with comprehensive and easy to read information within seconds.



Achieve Solutions

We offer our award-winning website, Achieve Solutions, customized specifically for Georgia that will support a recovery-based system of care. This robust site provides comprehensive information and practical recommendations related to confidential behavioral health and wellness resources focused on recovery, resilience, advocacy, medications, life events, and daily living skills and available to individuals and their families. It includes a broad range of content, such as interactive quizzes and online skill building modules.



In 2013, Achieve Solutions received a silver award for the Best Overall Internet Site for innovative excellence in design, ease of use, and meaningful content.

Providers and DBHDD staff will find Achieve Solutions is an excellent resource for their own professional reference and can print off articles to support their work with individuals and family members.

Features include:

- **Award-winning content:** The site has more than 3,000 content pieces housed under more than 130 mental health and wellness topics.
- **Exclusive content:** New content is continuously written for Medicaid populations at a 6th-grade reading level, and is often available in Spanish. Topics include recovery, resilience, co-occurring disorders, transitional youth, crisis planning, parenting a child with serious emotional disorders, and more. The "Real Stories of Recovery" series highlights actual personal or family stories of mental health recovery, written by our employees.
- **Convenient Access:** Users may access this site via Web browsers on personal computers and mobile devices.

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

- **Explore Info:** The center titles located in the navigation bar allow the user to review symptoms, rather than focus on a specific illness or diagnosis.
- **Spotlight:** This cycling content region on the upper right side can be client specific, and include quizzes, articles, audio and video clips, and/or engagement center news.
- **Find Services:** Users have quick access to self-search tools that help them locate a variety of services, including ValueOptions' mental health providers and localized community resources.
- **Help With Life Event:** Detailed information on mental health and wellness issues like bullying, caring for an older adult, and tobacco freedom. Each event has several resources available.
- **Access Concerns:** An interactive quiz-based "check-up" helps users identify areas of their life in distress, such as work/life balance, relationships, mood, stress, and substance abuse.

We will create a custom website navigation demonstration to allow users to find the information they are readily searching, and is available on the home page.

Awards for Achieve Solutions

Achieve Solutions has been awarded several awards since its launch in January 2000. In 2013, Achieve Solutions earned two prestigious awards, a silver eHealthcare Leadership award and a merit Web Health award.

Web Health Award
2013, 2011, 2010, 2008, 2007, 2002

eHealthcare Leadership Award
2013, 2012, 2011, 2009, 2008, 2007, 2005, 2004, 2002

eHealthcare Leadership Award

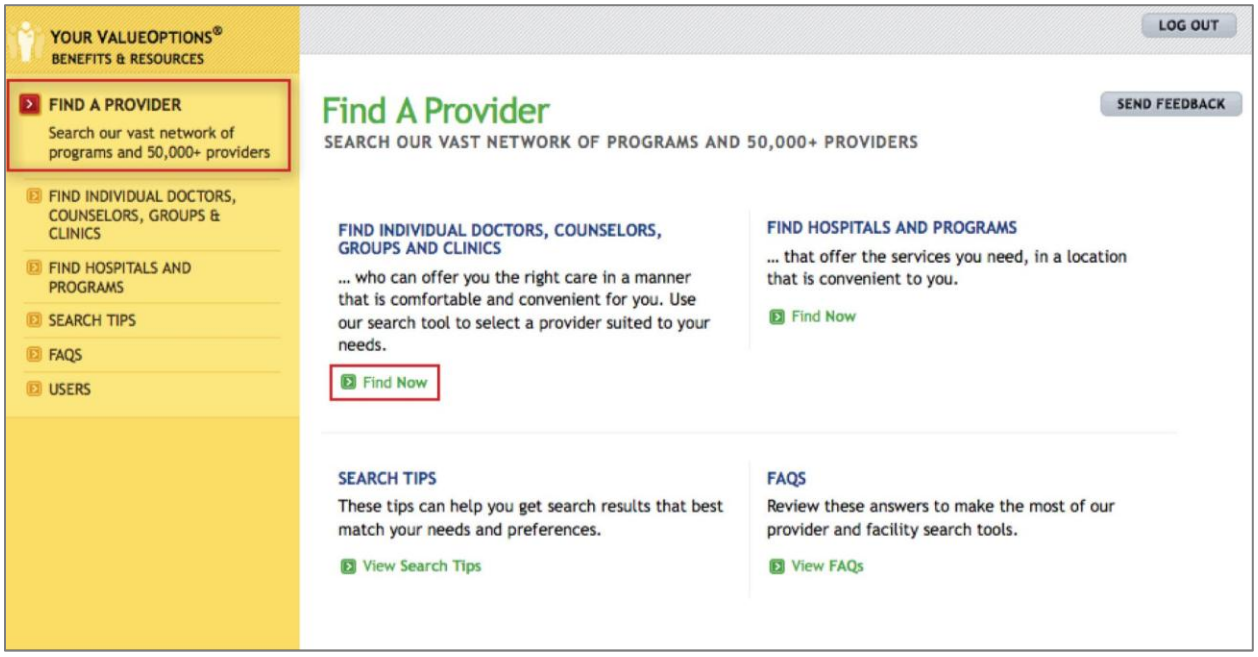
Maintaining its long winning streak, Achieve Solutions received a silver eHealthCareLeadership award for Best Overall Internet Site. For this category, judges considered how extensive, balanced, up-to-date, well-organized and readable the information is presented and can material be tailored to individual needs.

Web Health Award

Achieve Solutions won a Merit Award from Summer/Fall 2013 Web Health Awards. This is the 6th time that the site has received such recognition from this awards contest, which honors the nation's best digital health resources for individuals and health professionals. The competition, which is held twice yearly, featured 47 entry categories, including blog, e-newsletter, mobile application, mobile website, social media, video and website. A panel of experts in digital health media served as judges and selected gold, silver, bronze and merit winners from more than 300 entries. Entries were judged based on content, format and success in reaching the targeted health audience, as well as overall quality.

ReferralConnect

We offer an online provider directory, ReferralConnect (shown below), which is accessed by individuals, providers, or by our staff. The directory is directly linked to our information system, which houses the provider file. As changes are made to the provider file, the change is reflected in near real-time in our Web-based provider directory. This application also offers a "feedback" button that allows the user or provider to provide immediate feedback about changes needed (i.e., address, phone number).



Individuals have the convenient option through ReferralConnect to self-refer to a provider in the behavioral health system.

Individuals and providers simply enter their location, the distance they are willing to travel, and the type of provider they would like to locate. Based on search specifications, our Web-based provider resource directory supplies appropriate provider information and a map to help locate the provider's office. The provider list generated from the portal can be printed for easy

reference. This provider directory website is user-friendly and is equipped with a "help" function that provides a systematic guide to using the system.

ClientConnect

ValueOptions recognizes the increasing desire of many of our customers to have access to online reporting capabilities, administrative processes, and information. We have developed a unique password-protected Web portal, ClientConnect, which allows 'real-time' access to behavioral health program information. The ClientConnect application allows users to immediately access membership data, authorizations data, and reporting online. ClientConnect is a fully encrypted website that is completely HIPAA compliant.

ClientConnect provides DBHDD with real-time access to program data. Web access means that program data is far more accessible to DBHDD and authorized third parties than in a traditional model where reports are continually requested and provided with lag time lost for production. DBHDD is assured that although data is accessible, it is also secure on our encrypted HIPAA-secure site.

Within ClientConnect, users may view all DBHDD reporting via IntelligenceConnect our online reporting tool. If a report has been designed to include drill-down capabilities, the user can double-click one of the categories in the report to display the underlying records that made up that piece of the report, and then customize reporting based on specific needs. Users can store and print client reporting directly from this resource. To produce reports, clients simply navigate and click.

KnowledgeConnect (Business Intelligence)

With an ever increasing need to collect, store, and manage large quantities of data to support our client contracts, we have a developed a high-performance data warehouse platform. Our data warehouse, KnowledgeConnect, is a database that receives imports from CONNECTS (e.g., CareConnect and ProviderConnect) for reporting purposes. This data is formatted and stored as standard data into our Oracle® relational database system. An advantage of this data warehousing technique is the easy insertion of data from external sources, such as pharmacy, disease management, or medical data. The data from these external sources can be integrated into the data models to enhance reporting capabilities. These standard data models are used as the foundation for report generation, statistical analysis, decision support, and outcomes management.

We have adopted and employ throughout our operations a fully integrated approach to Business Intelligence (BI). This fully integrated approach is made possible by the strategic application of various products and services supplied by Business Objects™, a recognized leader in the BI realm. We have been successful in the practical application of their products and solutions for both internal and external customers for more than 10 years. IntelligenceConnect, our collective suite of Business Objects solutions, allows us to deliver best of breed, enterprise-wide solutions designed to meet all DBHDD's needs.

IntelligenceConnect

IntelligenceConnect is our Web-based reporting and analytics tool. It allows us to furnish standard reports in a format containing graphs, charts, or Dashboards. The tool consists of a suite of interactive report dashboards, Crystal Reports, and Web (Webi) intelligence reports, designed to transform client data into easy-to-read information. Crystal Reports' primary purpose within IntelligenceConnect is the production of reports designed to meet the ongoing continuous needs of our report consumers. Crystal Reports is also used to respond to some ad-hoc reporting requests.

Dashboards

ValueOptions' market-differentiating, real-time, online dashboard reporting ensures a transparent and collaborative partnership. The secure, password-protected online portal enables access to our Web-based reporting and analytics in real-time from your desktop. DBHDD, providers, and other stakeholders will be able to conduct a variety of analyses across a full range of inpatient and outpatient utilization features, including data on individual enrollment, care coordination, encounters, authorizations, and more. Drill downs on individual sub-group and clinical trends—including division, level of care and diagnosis—are also available. All reports can be printed on demand.

Security of System Components

ValueOptions Information Security Program sets priorities for management, control, and protection of our information assets; the following four formulated Security Strategic Concepts guides ValueOptions security initiatives:

- Implementation of safeguards to reduce risk
- Sustain heightened user security awareness
- Maintain compliance with Federal/State/ValueOptions policies and procedures
- Preserving continuity of IT Operations

These four strategic objectives are our foundation to efficiently and effectively address the management, control, and protection of ValueOption's information assets. These objectives are further articulated as 14 key activities within ValueOptions:

- Application Security
- Data Loss Prevention
- Identity and Access Management
- Network and host-based intrusion detection/prevention systems
- Secure Configurations
- Security Awareness and Training
- Vulnerability Management
- Business Continuity Management
- Endpoint Security
- Network Access Control
- Patch Management
- Physical and Environmental
- Secure Remote Access
- Security Information Management

These Security Strategic Concepts and key initiatives are the driver that propels ValueOptions' enterprise security initiatives to meet compliance requirements such as HIPAA, AICPA Trust Criteria, ISO 27002, and others. These four concepts give some responsibility to everyone;

every ValueOptions' staff member has a role to play in the implementation of our Plan. Our individual and collective compliance with these four Security Strategic Concepts protects the security of our IT assets and privacy of information entrusted to us.

Annual Security Controls Audit

ValueOptions engages KPMG and PricewaterhouseCoopers (PwC) to conduct an annual audit of our security controls. KPMG and PwC perform a SSAE 16 (SOC 1) audit of our controls and systems. Starting in 2013, KPMG also started performing a SSAE 16 (SOC 2 – Security and Availability principle) Audit. Our first SOC 2 Audit report was published in January 2014 and is provided as **Attachment 11**.

Since 2004, ValueOptions has engaged these independent third-party auditors to complete SSAE 16 (formerly, a SAS70 Type II) audits validating our ability to comply with Section 404 of the Sarbanes-Oxley Act of 2002. Our 2013 SSAE 16 report marks the 10th consecutive year that ValueOptions has received a "totally clean opinion".

In addition, ValueOptions also participates in the Verizon Business/Cybertrust Security Management Program. This program includes ongoing activities, such as:

- Internal Risk Assessment
- Desktop Risk Assessment
- Policy Review
- Wireless Assessment
- Penetration Testing
- External Risk Assessment
- E-mail Gateway Filter Check
- Policy and Procedure Validation
- War Dialing
- Physical Inspection

ValueOptions recently completed an independent HIPAA security assessment through Verizon Business/Cybertrust program in October 2013. The assessment resulted in a full HIPAA security assessment report that documented our system was in full compliance and that no mitigation actions were required.

C. – SYSTEM LINKAGES

As previously mentioned, ValueOptions has developed FileConnect, our robust, secure infrastructure that has built-in interfaces allowing our clients, providers and third-party trading partners to transfer data securely and accurately. Our FileConnect application is designed for the interchange of electronic data files, such as eligibility, claims, and encounters between network providers, clients, business partners, or associates via secure Internet connections.

All of our data exchange procedures include development and support capabilities, such as error correction and reporting, data cleansing, tracking and performance metrics. Where applicable, we also support HIPAA transaction formats and have the ability to develop client-customized data exchanges.

D. – EXISTING SYSTEM INFRASTRUCTURE

As mentioned above, we offer our fully integrated, Web-based information management system, CONNECTS, for assimilating all eligibility, authorizations, claims, and other related data from disparate formats and sources. Our integrated information system has significantly enhanced our

ability to improve the coordination of care and service delivery for 32 million behavioral health members we serve throughout the country and, and is fully operational today.

The Georgia Achieve Solutions website will be launched by the Go Live date of April 1, 2015. Launched in January 2000, Achieve Solutions was one of the first behavioral health care websites dedicated to supporting individuals by providing reliable tools and resources for overcoming barriers that may compromise satisfaction, productivity, or good health. Through the quality, depth, and presentation of content and services, we improve work and life satisfaction and encourage individuals to reach their personal goals.

Achieve Solutions currently has more than 250 client sites, including 15 Medicaid and one Accountable Care Organization sites, and more than five million page views in 2013.

The ASO program website will be developed after contract award notification. Functionality and content available via this site will conform to the specifications detailed in this eRFP. It will be maintained on a regular basis and updated to incorporate any new items required during the course of the contract.

E. – SYSTEM OWNERSHIP

ValueOptions has invested extensively in our enabling technology platform, and it is ours. We owns the source code, so when DBHDD needs a modification or an enhancement of some kind, we can accommodate the request in a timely, cost-effective manner.

F. – SYSTEM UPGRADES

ValueOptions owns the source code for our core care management software and all the applications described above. Our National IT Department performs all upgrades and enhancements on a pre-defined quarterly schedule or as needed upon client implementations or when modifications are necessary due to contract requirements. As such, ValueOptions does not need to wait for a third-party company to push any updates or patches to ValueOptions' systems. Changes are deployed into the production environment only after rigorous test procedures are completed successfully. DBHDD can be assured that any required modifications to our system due to the requirements of the ASO contract will be made efficiently and cost-effectively.

Our formal Change Management Process is designed on the basis of partnering with clients throughout the software development lifecycle to ensure change orders are prioritized and rapidly delivered. This process helps control, prioritize, and streamline the delivery of changes to our information technology products and services. The process also provides a standardized, effective, and efficient process to prioritize and fulfill changes for system enhancements and software upgrades.

ATTACHMENT K.4

K.4 In Attachment K.4, **(six (6) pages)**, describe how the Offeror will meet the telephone system requirements outlined in Section 15.5 of Attachment J, Detailed Contract Deliverables. Address the following in your response:

A. Describe the system components that will be implemented as a result of the contract.
B. Describe the functionalities of the system.
C. Provide details regarding linkage between systems.
D. Identify which components are already built, partially built, or will be newly developed.
E. Indicate if the system vendor is owned and maintained by the Offeror or an external vendor. If a vendor, identify which system and version number.
F. Identify when the next upgrade to the system is expected and if during implementation of this Contract; describe how system issues will be mitigated.

A. – SYSTEM COMPONENTS

We employ the latest advances in telephone technology. Leveraging an industry-leading telephonic platform that supports optimal call handling protocols, we easily accommodate large increases in telephone call volume, and widely varying peak call times. Supporting flexibility on call routing, handling, and full integration with system applications makes this platform unique within the industry. By integrating GCAL, we will create a blended multi-site telephony infrastructure connected via MPLS circuits enabling a seamless single network for all ASO telephony operations.

Our Engagement Center telephony architecture with defined automated call distributor call routing, call reporting, and call recording will be configured on our Avaya system and an Avaya Survivable Remote Gateway (SRG) located in our main Georgia data center. A pair of bonded CenturyLink T1s are located in our Engagement Center and will be configured to work with the SRG. The T1s are configured to continue to route calls if one would go down. Our designated circuit at our back-up Engagement Center will be setup to "Divert on Failure" to our T1s if communication is lost between the primary telephony system and the SRG. This configuration will provide a backup for inbound and outbound calls in the event the MPLS connection goes down.

Currently, BHL has 36 call stations at the primary location and eight call stations at the secondary site. Both locations have space to add stations if needed. Both sites use Avaya 9611G phones and Avaya POE switches to complement and flawlessly work with our back-up system. In addition, Nortel IP 1230 VOIP telephones are deployed for administrative staff and Polycom Sound Stations for each site's conference room.

B. – SYSTEM FUNCTIONALITY

The VOIP system has the ability to manage automated call distributor call routing, call recording and in-depth call reporting. The system allows an administrator the ability to create new call routings and queues on the fly. In addition, supervisors and quality management staff have the ability to monitor calls in whisper mode, which is the ability to talk to an agent while the caller cannot hear the supervisor, and the ability to take over the call if needed. The use of warm transfer allows the agent to keep the caller on the line while transferring the call to another agent or queue. This helps the agent keep the caller engaged while attempting to add another supervisor or third-party service. Numerous reporting tools are built in to the VOIP system with the ability to build out custom reports that can be saved for future use or for other staff to use.

Our telephone system functionality includes:

- Caller identification (caller ID) and routing technology
- Warm transfer and three-way calling capacity with phone patches as permitted by law
- HIPAA-compliant instant messaging and texting for internal and external purposes
- Silent monitoring and access

Telephone Crisis Functionality

Our system is currently configured to allow all GCAL and Engagement Center staff to remain on the line as long as necessary to assist and support calls warm transferred to 911 resources. In addition, any call that we transfer, we will remain on the line until the person receiving the call indications that our staff member may discount.

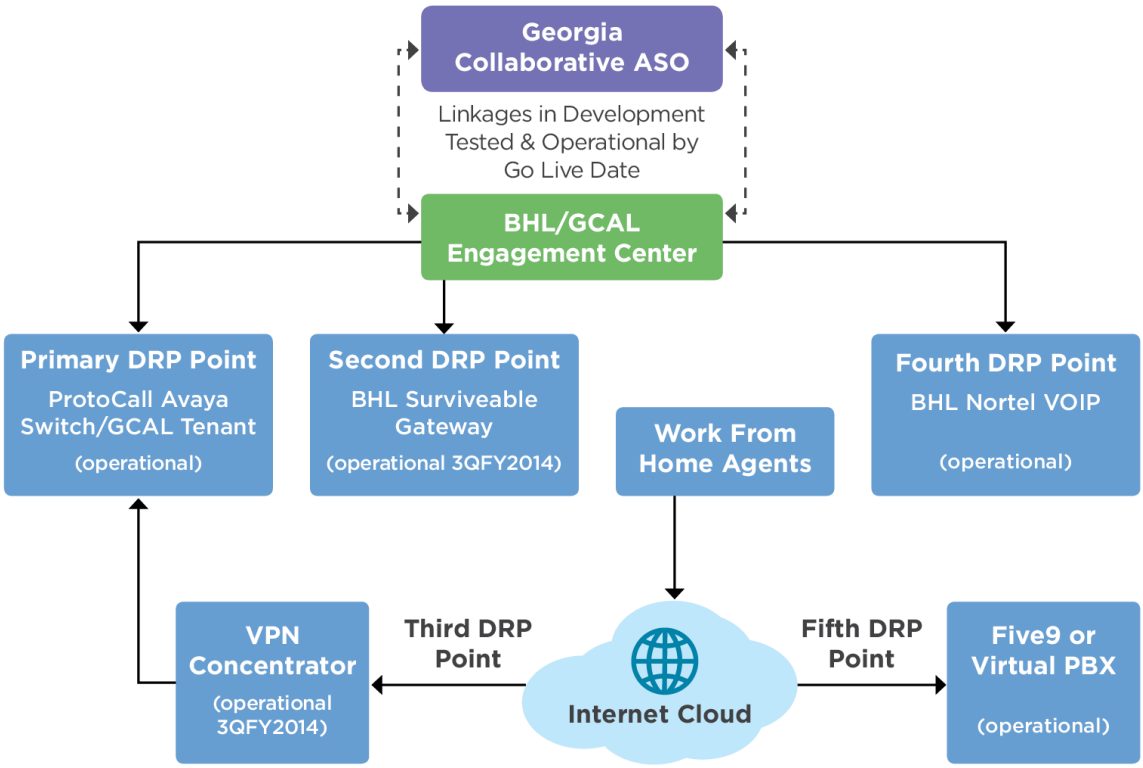
Throughout the contract, we will stay current on technology trends and functionality to create and maintain service efficiencies and attest that our applications are complaint with Georgia law.

C. – SYSTEM LINKAGES

All Enagement Centers will be connected through a CenturyLink MPLS network configured for QoS to support voice communications. Circuits will range from 3Mb to 10Mb and plans to add a second MPLS vendor is being planned to provide higher network throughput and network redundancy in the event of a circuit failure. Overall, there are five Engagement Centers being leveraged as a total backup solution; all connected through a MPLS network allowing agents to take calls at any Engagement Center. All inbound and outbound calls are routed through a G450 gateway with 85 percent of customer calls arriving on a pair of bonded Sprint T1s and the remaining 15 percent arriving on a CenturyLink T1. Two standby CenturyLink T1s will also be located in our Engagement Center in Atlanta.

D. – EXISTING AND DEVELOPING SYSTEM INFRASTRUCTURE

As depicted in the graphic on the following page, we house a Nortel CS1000E VOIP dual system with ACD call routing already configured that can be used in the event of an emergency. BHL also uses a third-party, cloud-based VOIP system, called Five9, that is available in the event of a total failure of all systems. This is a last resort disaster recovery solution and will only be used if all MPLS and T1 circuits are down.



We have five disaster recovery areas to help manage business continuity:

1. The primary system is located within our Portland back-up center and is currently operational
2. If the primary connection is lost, our secondary Survivable Remote Gateway is located at our Atlanta Call Center and will be operational in early third quarter, FY2014
3. Our third disaster recovery point is the use of VPN and softphones pointed to a dedicated VOIP VPN Concentrator for our call agents. This system will also be operational in early third quarter, FY2014.
4. Our forth disaster recovery point used, depending on the extent of accessibility, is our current and operational Nortel system.
5. The fifth disaster recovery point is our current, operational standby Virtual PBX/Five9 cloud-based system.

Telephone Conferencing

We use multiple Polycom Sound Stations for their telephone conferencing capabilities. We also use several conference services, including TeamViewer and GoToMeeting. Video and audio conferencing is done through the use of TeamViewer and GoToMeeting through personal computers and laptops, with added additional video conferencing hardware between our primary and secondary Engagement Center sites. In addition, we have confidentiality agreements in place with VSee, which provides video conferencing and tele-mental health services.

Automated Call Distributor Software

The Avaya Aura Enterprise Server provides skill-based call routing that is configured to allow call agents the ability to answer calls from any networked call center. The use of "Tenants"

provides the configuration of independent call groups on the main system that are separate from the other Engagement Centers. In the event of a spike in call volume or disaster, calls are answered by agents outside the Tenant. We will continue to use a Tenant off of the main system and independent of our back-up Engagement Centers. Routing of calls are DNIS or DN based. DNIS routing allows for cleaner reports. We use skillset routing that allows calls to reach the appropriate agents.

The Call Management System located in Portland, provides real-time and historical Engagement Center status reporting. An Optivity (Call Copy) call recording server is used to record calls and is configured to record varying percentages of inbound calls, ranging from 10 to 100 percent of calls. If DBHDD elects to record GCAL calls, we will have policies and procedures in place that address record retention and provide essential compliance with HIPAA regulations, 42 C.F.R. Part 2, and State law.

E. – TELEPHONY SYSTEM OWNERSHIP AND MAINTENANCE

The main telephony system is owned by ProtoCall Services. The Survivable Remote Gateway, IP phones, and licensing is owned by BHL. All telecommunications equipment is managed and monitored by Advantel Networks. Monitoring is done 24/7/365 and based on predefined Service Level Agreements (SLAs) requiring short response times, notification of key personnel on call and commitments to assist or resolve any problems that may occur. All MPLS and T1 service providers have similar SLAs in place for monitoring, notifying key on call staff and resolving issues. T1s that fail are configure to reroute automatically to specific locations based on our disaster recovery plan and can be routed manually via Web portal or through a telephone call.

The Avaya telephony system comprises an Avaya Aura Midsized Enterprise server solution in ProtoCall's Portland location. In addition, an Avaya S8300D server, Aura Foundation Suite R6 ASIPP, R6 MGMT SITE ADMIN, R6 SYSTEM MANAGER, and R6SM SIPCON is located at our site in Atlanta.

F. – EXPECTED SYSTEM UPGRADES

The next upgrade to the system will be the addition of the Softphone VPN concentrator. This will be completed prior to beginning of this contract. Software and system upgrades will be tested and implemented as new revisions are released. Upgrades occur every 18 to 24 months. During main system upgrades, calls will be transferred directly to our secondary location using the Avaya SRG. Main system downtime typically is less than 30 minutes with no foreseen loss of calls during these transitions.

Recorded Messages during System Downtime

We use Nortel Call Pilot which serves as the voicemail system and call messaging system. Call messaging are configured from a telephone, or done remotely by dialing in, to create single or multiple messages for inbound callers. These messages can be assigned to all inbound calls or setup to play on certain call treatments. Call treatments can be configured remotely and on the fly to accommodate spike in call volume to notify callers when a particular Engagement Center may be down.

ATTACHMENT K.5

K.5 In Attachment K.5, **(limit six (6) pages)**, describe the Offeror's experience in implementing a complex and multi-faceted information and associated data reporting system within 180 days or less. Include a summary description of the functional components of the information system implemented.

ValueOptions' strategy for **"High Assurance"** and achieving a successful implementation stresses close communication with DBHDD, the current ERO vendor and other vendors involved in implementation. We will work with DBHDD to develop a detailed implementation plan to integrate the new behavior health ASO program. Realizing that the implementation will be effecting some change within the state of Georgia, we will incorporate ongoing promotion and training to ensure the continued visibility and effectiveness of the program while addressing individuals, providers, and other stakeholder's questions and concerns.

Because of the number of clients we have implemented during our 30 years in the behavioral health field, we have vast experience from which to draw. This ensures that we are fully prepared to support DBHDD's implementation efforts and to ensure a smooth transition for individuals who are receiving treatment services. We have a proven track record of rapid implementations of large accounts and in designing implementation plans that are customized to meet the needs of our clients.

In the following paragraphs, we offer an example of a complex implementation we successfully implemented in less than 180 days that includes many of the same functional components we will implement for DBHDD's ASO program.

EXAMPLE IMPLEMENTATION

In late 2012, ValueOptions successfully completed the implementation a fully integrated physical health and behavioral health program with one of our State Medicaid partners. We worked closely with the State to ensure the implementation efforts aligned and supported their goals. The implementation effort took approximately 130 days, beginning with the award in early October 2012 until contract "go live" on January 1, 2013.

Our innovative and advanced technology used in support of this successful implementation and our skilled personnel served as the cornerstones and ensured continuity of operations, along with uninterrupted flow of our client's services throughout the implementation.

Within days from the announced award, we established an implementation team which comprised of dedicated IT Implementation leads, including but not limited to IT technical analysts and operational leads from different functional areas within the company. These designated individuals were responsible for coordinating and overseeing the implementation of all system or data integration activities relevant to the program.

Our dedicated IT technical analysts provided technical application support and coordinated the resolution of technical issues, new system development needs, and enhancements to data exchange and interface tools required to support the new account.

Example Milestones

Our IT resources worked closely with our client and our Project Management Organization (PMO) team to ensure that milestones were accurately documented and dependencies were mapped to the proper resources. In addition, the team worked closely with internal ValueOptions business leads to obtain the appropriate resources required to complete the scheduled tasks.

The key IT-related implementation milestones for this particular implementation included the following:

- Build-out of three new satellite offices
- Development of custom data collection forms
- Development of custom reports
- Development of our proprietary patient-centric record, Spectrum
- All required data exchanges

The IT team worked closely with the State and other trading partners to gather detailed requirements, write functional specifications, conduct testing, and coordinate the delivery of the application and data integration necessary to support the implementation. The team mitigated any unforeseen difficulties with interfacing with the client's information systems, by working closely and collaboratively with our client throughout the entire implementation. In addition, they supported the required connectivity, ensuring that all the necessary data circuits and communications lines were installed to support the expected data exchanges and system interfaces.

Implementations Lessons Learned

A robust, well-designed, and tested IT system is key to the success of any program. The IT component of program implementation covers a broad range of requirements and includes everything from determining system and platform integration to new application development. Because of the complexity of these tasks, and the impact any set back or disruption to the schedule can have on our overall success, we incorporated strategic steps into the plan that ensure a successful implementation. An important lesson learned is that without clear communication of IT requirements that include a well-defined scope of work, key implementation dates may be missed and unresolved issues may have a negative impact on our ability to provide service.

Defining IT Requirements

One of the challenges we have experienced is defining key IT requirements. IT plans are sometimes vague and require considerable discussion between ValueOptions and the customer to confirm a technological design that fully meets the client's or programs expectations. Ambiguous requirements can jeopardize the success of the entire project. All parties must

clearly understand the functional expectations and requirements of the program, and develop clearly defined plans to meet the expectations. A lack of understanding of the requirements can result in project delays and missed deadlines. To resolve the vague requirement dynamic, we found success in partnering with the customer's Subject Matter Expert (SME) for each particular IT implementation deliverable. Partnering the DBHDD and the current ERO vendor's SME with our SME from the onset of the project and throughout the entire lifecycle will ensure that expectations are defined. In addition, we invite and recommend that APS and DBHDD SMEs participate in the Level III (user acceptance) testing or beta periods to ensure the final product is satisfactory.

Additional Functional Components

We have also implemented a comprehensive data verification, validation, and accuracy program to ensure information integrity and reliability. Cutting-edge technology enforces data integrity rules through a series of field edits, validation rules, and run-to-run balancing routines. Measures range from parity algorithms, which confirm files' referential integrity, to verification checks against header/trailer information. We reduce threats to data integrity with regular backups, defined roles and privileges for data, security tools, and user interfaces that prevent invalid input and transmission error detection/correction tools. They also ensure the validity and completeness of all information. Examples include:

- **Encounter data receipt** – Our system performs a number of validation checks when data is received. First, it validates that the file meets the expected format. Next, it performs integrity checks on the file's header/trailer and the submitter's data (number of records). Finally, it checks required critical data elements. An automated message is sent to the submitter if the file fails any one of these validation routines.
- **Data warehouse** – Encounter information is imported daily into our data warehouse, KnowledgeConnect. It performs a number of checks to validate that loaded data accurately matches what was transmitted. First, it checks record counts to validate number consistency of records sent and loaded. Second, it runs parity checks to total dollar amounts, check member numbers, procedure codes, and other fields to ensure that all records are exactly the same.
- **Encounter submission** – We perform many of the same warehouse routines for encounter data, but add field level validation to ensure data integrity of each unit. When a record fails field-level validation, it alone is rejected and the rest of the batch processes. Rejected records are written to a report where Quality Analysts correct source system data and extract updated records from the subsequent load.
- **Controls for all data exchanges** – We customize controls to meet our clients' needs and ensure quality data. Controls, such as naming conventions, include client name, file creation date, headers and trailers, or record counters within each transmission, as well as IP address validation. We build additional data validations into our extract process.
- **Error resolution** – We generally create extracts as test files, correct any issues in our system, then generate a version that is sent to the client. We have custom error reports for each extract that identify any record that fails a specific client edit. We use the error report to correct data, which is included in the next file.

Our implementation structure is designed to facilitate a collaborative partnership while also providing the necessary oversight and accountability to ensure that deliverables are completed accurately and on time, and that any identified risks can be mitigated before negatively impacting the go-live date.

ValueOptions ensures that senior leadership is highly involved in implementation and beyond, with input into the ongoing operation of the program. Responsible for leading the implementation, our core team will be dedicated to the implementation, on the ground, and will remain in place to function as active participants throughout the pre- and post-implementation phases of this initiative. In addition to these process and technical experts, our account management team will be active participants in the process to ensure ongoing execution.

ATTACHMENT K.6

K.6 In Attachment K.6, **(limit three (3) pages)** describe strategies to ensure optimal performance of the information system during and after business hours and during periods of high usage (e.g., end/beginning of month, reporting and other functions which requires high system capacity).

ValueOptions employs industry-recognized best practices to routinely conduct systems capability and capacity assessments to analyze information on the utilization and effectiveness of our distributed IT infrastructure. We also use the resulting information to model and predict whether improvements such as upgrades or enhancements are required. We proactively identify necessary hardware and software system upgrades, which may be driven by utilization trends or enhanced application capabilities and data throughput. We utilize multiple prominent and reliable software tools to comprehensively collect, trend, and benchmark systems performance data.

We maintain a series of policies addressing the required maintenance of all operating and database systems, device firmware, productivity software (e.g., Microsoft Office®), monitoring software, and third-party commercial off the shelf software .

We established Service Level Standards which target 99.9 percent systems availability, with a .01 percent allotment for scheduled maintenance. We deploy major and minor patches of the software as needed and perform all maintenance and system updates during off-peak, non-business hours. All servers and associated applications are scheduled to be available for use Monday through Friday, 7:00 a.m. to 9:30 p.m. Eastern Time.

Below, we provide an overview of the primary automated tools we use to monitor and maintain our proprietary system:

- **UPTIME by Uptime Software**: UPTIME enables our technical staff access to trend analysis, automated operating system health checks, automated application health checks, and provides availability and problem alerts via SMTP mail.
- **Visual Performance Manager™:** Visual Performance Manager provides integrated views and unique data correlation for effective management of application availability and response time analytics.
- **IBM Performance Tools/400®:** This enables our technical staff to gather, analyze and maintain system summary and detailed trace information about our system performance to conduct ongoing capacity planning for on-going operational needs and conversion of historical records.

We externally validate our data and capabilities/capacity assessment methods by leveraging our partnership with IBM to ensure that we continue to apply industry-recognized best practices while monitoring and assessing our systems performance. These methods utilize:

- **IBM Performance Monitoring Infrastructure® (PMI):** PMI enables our technical staff the ability to analyze performance metrics from individual Java Virtual Machine (JVM) in the WebSphere environment. This tool also allows for staff to perform basic JVM problem determination.

- **IBM iDoctor®:** This software enables our technical staff to further diagnose and manage our hardware and software platform performance and consists of several utilities such as Job Watcher, which is used to collect, analyze, and model trace-level information about a job's behavior in real time. This information can be analyzed by us and/or shared with IBM for analysis in their performance team's labs.

- **IBM SQL Performance Monitor®:** This enables our technical staff to capture summary and/or detail level information about global or specific query executions through the entry of selection criteria. Summary data is written to hard disk when the monitor is paused or ended and can be analyzed. Detail data is written to hard disk in real time and does not need to be paused or ended to be analyzed. This information can also be analyzed by us and/or shared with IBM for analysis in their performance team's labs.

- **IBM Database Monitor®:** Database Monitor enables our technical staff to capture low level detail information about specific query executions. Detail data is written to hard disk in real time and does not need to be paused or ended to be analyzed. This information can also be analyzed by us and/or shared with IBM for analysis in their performance team's labs.

- **IBM Visual Explain®:** Visual Explain enables our technical staff to analyze specific queries to determine performance variables and query plan logic used to execute the query. The tool provides a graphical interface that provides statistical information about each step in the query plan, highlights areas of poor performance, and makes index and other recommendations to potentially enhance the performance of the query.

- **Big Brother™:** We use Big Brother to proactively monitor environmental statistics such as the temperature within the data racks, data centers, and network distribution closets. These tools facilitate proactive problem resolution and prevent critical outages.

- **CiscoWorks:** Our data network runs on Cisco® networking gears. We use the CiscoWorks suite of powerful management tools in the configuration, administration, monitoring, and troubleshooting of these gears. CiscoWorks is a centralized system for sharing and centrally managing device information across all LANs.

- **Converged Network Analyzer (CNA):** CNA allows ValueOptions to continuously and accurately monitor the quality and condition of service on all data telecommunication links, and to quickly and effectively switch and maintain and monitor traffic. We provision a minimum of two full-capacity WAN links for each service site and CNA allows technical staff to continuously monitor all links.

- **EventSentry:** EventSentry provides a suite of monitoring tools to monitor event logs, system health and uptime of Windows Systems including servers, desktops, and laptops.

- **NetFlow Tracker:** Netflow Tracker is used to see information on all network conversations passing through the WAN links. It provides detailed insight into how application traffic usage is impacting network performance.

- **HP OpenView:** HP OpenView provides the capability to monitor all of the nodes on the network that communicate using Simple Network Management Protocol (SNMP), and provides the capability to isolate and diagnose network anomalies as they occur.

- **Link Analyst:** Link Analyst allows us to monitor the up/down state of every link and device on the networking infrastructure through SNMP and Internet Control Messaging Protocol (ICMP) through the use of proactive real-time alerts and maintains historic data and statistics.

- **MRTG/CACTI:** This software provides graphical representations of our network's bandwidth and link usage patterns in real time to define baselines, trend information, identify anomalies, and optimize our network.

- **Observer Expert Suite and GigaStor:** Observer Expert speeds network troubleshooting by proactively identifying network issues and offering immediate solutions. Gigastor provides specialized computing capability with a 12TB drive capturing up to 4GB of real-time data for powerful network analysis.

ATTACHMENT K.7

K.7 In Attachment K.7, **(limit two (2) pages)**, Provide a high level description of the Offeror's system data capacity/storage and backup processes for the various information system functions to minimize (or prevent) the loss of data. Include details related to Offeror's data center(s) which will be utilized.

ValueOptions' National Data Processing Center provides the platform and support for the CONNECTS platform core software component, which is the major software platform providing managed care processing for our clients.

The ValueOptions JAVA-based CONNECTS applications are developed and deployed to the J2EE standard in a two tier configuration utilizing IBM's® WebSphere Application Server on pSeries® in a clustered configuration. Backend DB2 and Oracle® application databases reside on an iSeries i6 595® and two pSeries p7 740's® respectively. ValueOptions' i6 and p7s each consist of multiple logical partitions including dedicated production, development, staging, training and load test environments.

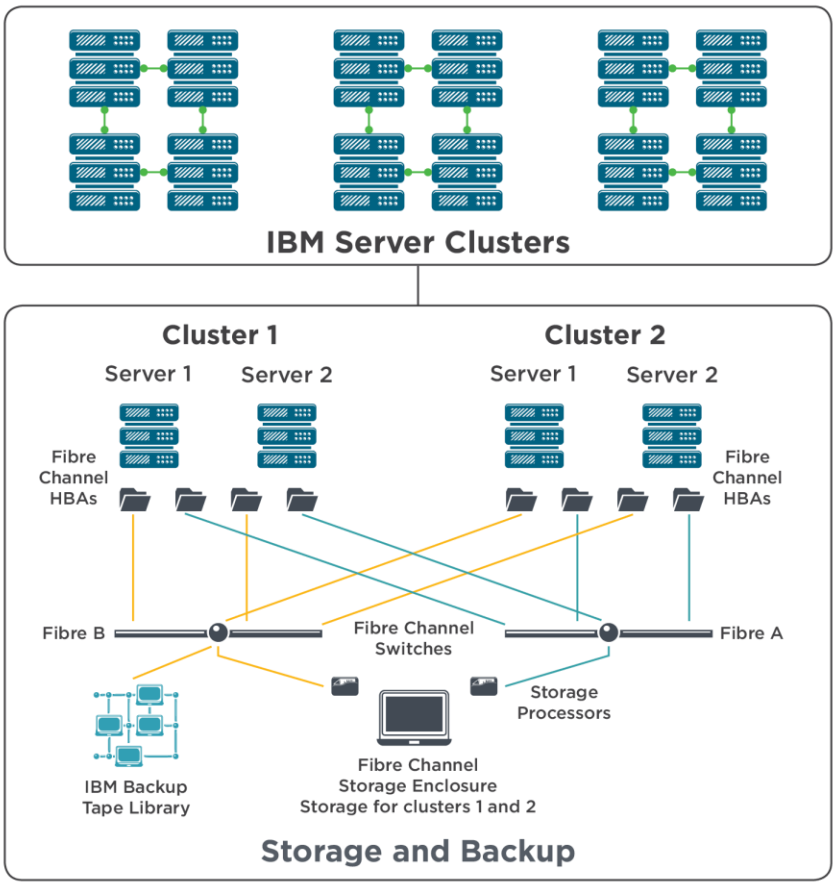
Our platform, graphically depicted on the following page, resides on an IBM® iSeries (AS/400) i6 595® application server running IBM's V7R1 i6/OS® operating system. ValueOptions' i6 595® consists of multiple logical partitions including production and development environments. It is configured with a 24-way POWER6 64bit CPU with 512GB of memory, 108,096 CPW Enterprise Edition® and over 50 Terabytes of mirrored disk storage. An IBM 3584 Automated Tape Library® containing 40 3592-E06 and 3592-E07 high-speed tape drives are attached for fully automated backups. Additional tape device support includes IBM 3590 and 3490E tape cartridge for client file compatibility. Host network communications includes four 1Gbps and seven 100Mbps Ethernet adapters.

The National Data Processing Center links the CONNECTS platform and ValueOptions' local and national personnel into a seamless and integrated information system. Centrally administered through ValueOptions' Reston National Data Center, the i595® is accessed by local and remote users via Local Area Networks (LAN) in a Wide Area Network (WAN) in an Verizon Business fully meshed MPLS network configuration.

From a software and database architectural view, our application software and database is configured to support over 999 million members, 99 million claims per day, 99 million authorizations per day, 450,000 clients, three million groups, and over 450,000 benefit plans.

The IT infrastructure is scalable to include ample disk storage, memory, and processing power to accommodate the anticipated membership. Our online screens utilize JAVA, COBOL and DB2 to provide a solution that simultaneously supports 1,000 interactive users and dynamically scalable to 2000. The response time is second or sub-second as a result of the above mentioned architecture. The engagement center staff access the CONNECTS system through our WANs

fully meshed MPLS network. Other online access is available through our toll-free number and access is available via a secure Internet connection.



Servers Platform

- IBM® iSeries (AS/400) i6 application servers running IBMs V7R0 i6/OS® operating system
- IBM i6 595® configured with multiple logical partitions including production and development environments
- 17-way POWER6 64bit CPU with 512GB of memory, 108,096 CPW Enterprise Edition®

Storage Platform

- Over 50 Terabytes of mirrored disk storage
- IBM 3584 Automated Tape Library® (ATL) containing 40 3592-E06 high-speed tape drives for fully automated backups
- IBM 3590 and 3490E tape cartridge for client file compatibility
- Host network communications includes four (4) 1Gbps and seven 100Mbps Ethernet adapters

Capacity

- Over 999 million mambers
- 99 million claims per day
- 99 million authorizations per day
- 450,000 clients, 3 million groups, and over 450,000 benefit plans
- 1000 simultaneous, interactive users (dynamically scalable to 2000) and,
- Sub-second response time

The Georgia Collaborative ASO, through ValueOptions, maintains multi-level system and data redundancy to prevent data loss and minimize interruptions to operations in case of power failures or disaster.

ATTACHMENT K.8

K.8 In Attachment K.8, **(limit two (2) pages)**, describe the Offeror's system capability to track enrollment for separate payor source and eligibility groups.

During the first year of the contract, we will apply DBHDD policy to determine eligibility for State-funded services. The Medicaid eligibility files received from the GAMMIS system can be loaded into our integrated system, CONNECTS. The system will be configured and programmed to determine the specific services a participant is eligible for based upon the Medicaid and DHMH medical necessity and clinical criteria. During the authorization process, eligibility and services are verified prior to service delivery at the provider and participant level. The eligibility data interacts with reference tables, benefits, contracts, participant group designations, claims, finance processes, providers, authorizations, and utilization throughout the adjudication process to ensure eligibility of all participants entering treatment.

The end result is complete, accurate membership data for Medicaid participants, linked to the appropriate participant group designation, funding stream, and appropriate benefit designs, registration, and authorization rules—all seamlessly within our integrated system.

After services are rendered and a claim is submitted, a second eligibility verification occurs in the scanning and auto-adjudication process. All services billed are validated in the adjudication process against the behavior health service authorized, dates of service, services contracted for the billing provider and other claims edits defined by DHMH.

The current Georgia system of public behavioral health and IDD care depends upon multiple sources of financing, including Medicaid and non-Medicaid behavioral health, HCBS and State-funded IDD, housing, bridge and transition funding. This complicated mix of funding streams creates challenges for coordination across providers, can lead to duplication of services and often results in a system that is extremely complex for individuals and providers to manage efficiently and effectively. To overcome these challenges and in preparation for complying with the requirement to systematically validate an individual's financial eligibility for State-funded services in year two, we will use our comprehensive "Braided Funding^{SM}" approach to support multiple funding streams that is specifically designed to identify, track, and manage unique funding streams across disparate health care delivery systems.

VALUEOPTIONS' BRAIDED FUNDING APPROACH

Braided Funding combines multiple sources of funds to pay for services, while maintaining administrative ability to track and account for the unique funds. In our Braided Funding module, providers are guided through an intuitive registration process that identifies all available funding sources. Using state-approved fund hierarchy (priority) and system logic, the module assigns individuals to all appropriate and allowable funding sources. It also tracks dollars spent by funding stream to provide accountability for each funding source. Braiding the multiple funding sources increases opportunities for service coordination and continuity of care, and creates

administrative and economic efficiencies. More importantly, individual outcomes are improved as the effects of financing silos are removed.

The Registration Process

To register an individual, the provider enters the individual's specific demographic and clinical information within the online Consumer Registration Module. This automatically generates a list of appropriate, approved DBHDD and/or DCH programs for which the individual may be registered (i.e., Medicaid and State-funded programs). The online Consumer Registration Module includes a provider authentication process that filters the list of available programs down to only those for which the provider is contracted. The provider can then select the programs in which he or she wants to register the individual.

Selecting Funds

The registration process also requires the selection of the funds the individual should be registered for. Once all funds have been selected, they are automatically verified against the eligibility and business rules as defined by the State. Once a provider has completed the initial steps of assigning fund types, the Consumer Registration Module then prompts the provider to complete specific forms within the module in order to complete the registration process. The forms to be completed will vary based on the funding streams selected for each individual and include the required clinical and functional information needed to assign the individual to the appropriate benefits package. When all required information has been submitted, our registration system automatically reviews the submitted information against the State defined criteria and parameters. If approved, the provider automatically receives a registration confirmation and is allowed to seek authorization of care if needed. If an individual is found not to meet eligibility, fund type, or clinical criteria as specific by DBHDD/DCH, the confirmation page will display the registration status of ineligible.

Providers are prompted to enter the individual's specific demographic and eligibility information, and once the "uninsured" criteria are met, the provider will be prompted to complete the registration process.

Once the provider completes the online registration form, eligibility is instantaneously determined and the provider will be presented with either an approval or denial of coverage. If approved, the coverage is updated real time in our integrated information system, the member is automatically assigned a unique identification number and all operations areas have access to that information. The provider can then seamlessly and instantaneously move from an eligibility request to a request for services. If the participant has not applied for health insurance, providers can access our online provider handbook, which contains step-by-step instructions on how to apply for Medicaid, MCHP, or coverage through a qualified health plan.

Additionally, the provider has the option to register an uninsured individual by phone as well through our customer service line during regular business hours.

ATTACHMENT K.9

K.9 In Attachment K.9, **(limit two (2) pages)**, describe the Offeror's experience in exchanging the following data:

a. Eligibility information with the States' Medicaid management information systems.

b. Hospital, outpatient, emergency room, or pharmacy claims to support care coordination.

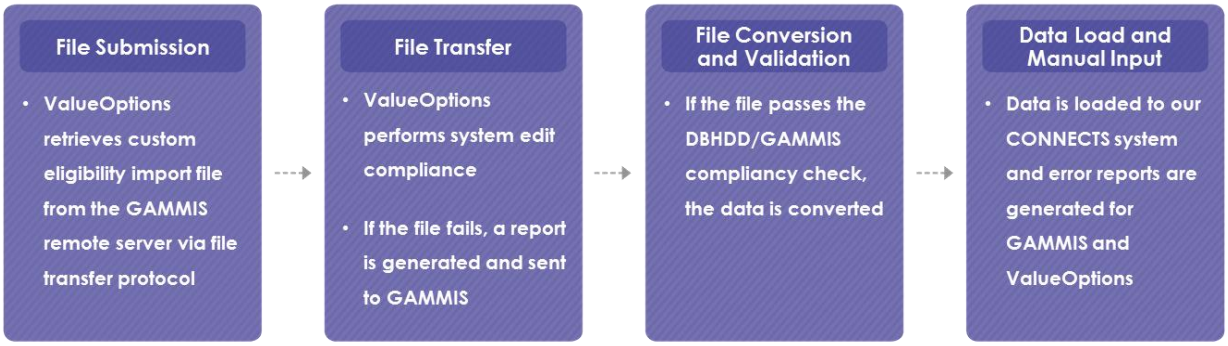
As the ASO for 15 Medicaid state clients, ValueOptions has gained significant experience exchanging daily prior authorization data, eligibility, claims and many other industry standard data exchanges with our clients. All data is exchanged via a secure Web-based FTP protocol and supports the required data interfaces with DBHDD, its fiscal agent (HP), the incumbent (APS), Alliant GMCF, and other State agencies or external sources in order to securely transfer accurate data for the DBHDD ASO program.

Because the type, volume, and exchange requirements vary from each trading partner, we have developed a core set of standard programs to select and format the outbound data and to import response files. Data is tracked throughout the transmission process, including submission and response status. We have the ability to check compliance of file formatting and data content using nationally accredited compliance checking tools.

All of our data exchange procedures include development and support capabilities, such as error correction and reporting, data cleansing, tracking, and performance metrics. Where applicable, we also support HIPAA transaction formats and have the ability to develop customized data exchanges with DBHDD.

A. – ELIGIBILITY/ENROLLMENT DATA

Our ability to customize our programs to meet the specific needs of our clients differentiates us within the industry. This customization extends to how we address eligibility tracking and receipt.



Our eligibility load process has been designed with state Medicaid programs in mind, giving us a proven record of exceeding performance requirements.

Our fully integrated eligibility application, EligibilityConnect, uses key demographic information from the eligibility file provided by the client's MMIS and select the appropriate individual record for inquiry tracking, clinical notes, authorizations, and claims. This integration eliminates the need for Customer Service Representatives to enter demographic information and provides up-to-date eligibility information when a caller is anxious to begin addressing their particular issue.

B. – CLAIMS DATA

Additionally, ValueOptions has demonstrated experience in the development of outbound 837 encounter extracts as well as corresponding response files (997, 277, 835) and client-specific formats in order to conduct Federal Funds matching. In most cases, we receive 997 and 277 response files; however we also receive custom detail response files.

Customized controls are in place to suspend the submission of a claim or encounter that does not pass "pre-scrubbing" edits. These edits are intended to mimic the DBHDD's adjudication edits, and result in our submission of files that meet the State's MMIS processing and edit requirements. These pre-scrubbing edits are specific to the type of claim, and include but are not limited to the validation of the service code, the modifiers, the date of service, the place of service, and the providers' NPI number on file with the client. We also ensure that claims already successfully accepted by the client are not sent a second time. Our system automatically generates reports after each extract with the claim identifier and the rejection reason for all claims not successfully extracted. Error records identified on the response file are formatted into a report which is distributed to the Claims Operations team for resolution. Once resolved, the original claim is voided and replaced by the corrected record and then transmitted back on the next file transaction.

In addition to the tight controls we would put in place to ensure compliance and the accuracy of data submitted to the MMIS, we also have a robust reconciliation and management process for oversight of the response file application and process. We know the outcome of each claim extracted. Our system retains the date a claim/encounter is extracted, when a response is received, whether the claim is accepted or rejected, and if rejected the reason why it is rejected. We evaluate the results at each potential failure point and generate weekly reports to determine the current status of 100 percent of records. Metrics include paid, adjusted, and rejected claims, and reflect the disposition of newly submitted claims and encounters, the updated status of corrected claims and encounters, and summary level data used to measure the overall success of submissions.

Our IT Implementation and clinical team will work collaboratively with DBHDD, its fiscal agent (HP) and other data trading partners upon award of the contract to provide technical application support and coordinate the identification of all required data elements and required data exchanges required in this eRFP.

ATTACHMENT K.10

K.10 In Attachment K.10, **(limit four (4) pages)**, describe the Offeror's experience with data migration and conversion from prior external systems.

In early 2009, the Mental Hygiene Administration (MHA), a unit of the Department of Health and Mental Hygiene (DHMH) for the state of Maryland, awarded ValueOptions the ASO contract to provide MHA with administrative support services to operate Maryland's Public Mental Health System (PMHS).

ValueOptions successfully migrated data from the previous incumbent, APS Healthcare, without operational interruption and has significantly enhanced the system functionality over the past five years of the contract. As the ASO, ValueOptions assisted MHA and the Core Service Agencies in implementing and managing the PMHS by providing the following support services:

- Access to services, including provider enrollment, access telephone line with live answer, information and referral, and eligibility related services
- Utilization management, including authorizations, concurrent and retrospective reviews, audits, complaints, grievances, and appeals
- Claims processing and payment
- Data collection and reporting (e.g., eligibility determination and enrollment, assessment and clinical date, service authorization, provider network, service utilization and expenditures, claims processing, payment and federal funds reimbursement, quality and outcomes reporting)
- Public information: ValueOptions developed a state-of-the-art communication system via telephone, electronic transmission, mail, and the Internet for information exchange between the ASO, providers, consumers, State agencies, Core Service Agencies, and the general public.
- Consultative, training and evaluation services (e.g., consumer and provider satisfaction/ outcomes surveys)
- Special projects/new initiatives, including: OMS enhancements, DORS Integration, Ticket to Work, Legal History Data Integration, PRTF, 1915(c) management and reporting

In support of the new contract, ValueOptions warehoused historical authorization, claims, case management records, eligibility, FFP, and pharmacy data dating from 2001. Additionally, we imported APS' open authorizations to ensure continuity and minimal disruption of Maryland consumers.

ValueOptions worked closely with MHA and APS to implement the contract. Listed below is a non-exclusive list of customizations made to CONNECTS that were developed with MHA to support the existing PMHS contract:

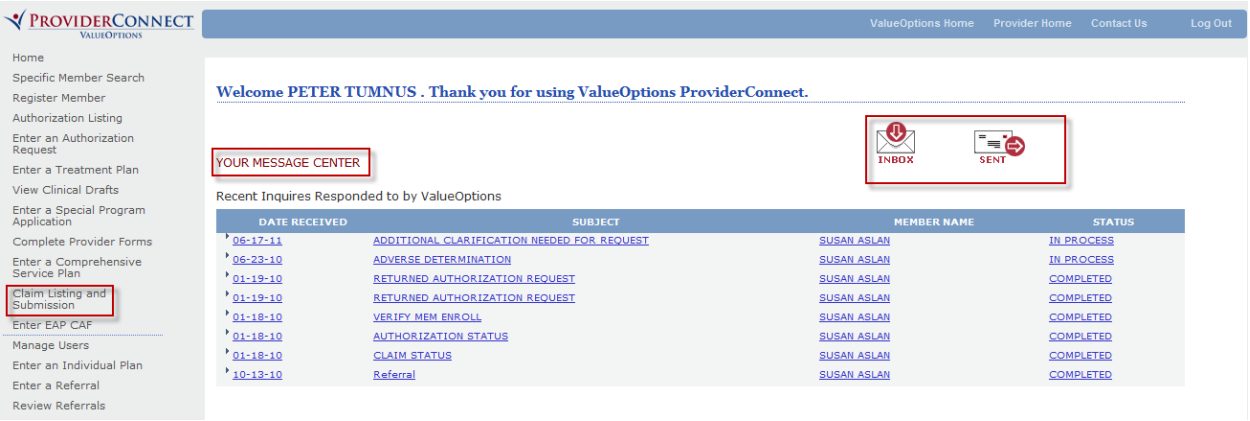
- Accepted and converted ten years of historical claims to support claims run-off, clinical, and reporting needs
- Migrated authorization data from the incumbent's system

- Developed a custom Web-based Outcomes Measurement System (OMS) tied to authorization for outpatient services for OMS involved populations and providers that enables providers, Core Service Agencies and the public at-large to access analyses comparing selected OMS results
- Developed a custom participant registration process within the CONNECTS platform that automatically directs select providers to enter responses to specific questions based upon certain participant eligibility characteristics that trigger authorization for a bundled set of services
- Developed a customized, online, uninsured eligibility registration application that assigns real-time, instantaneous uninsured eligibility for participants who meet DHMH criteria
- Developed a tracking application within the CONNECTS platform that combines administrative procedures between MHA and the Division of Rehabilitation Services (DORS), for the approval of supported employment services (e.g., Ticket to Work)
- Enhanced the CONNECTS platform to include DHMH-identified data elements that provide a greater level of detail in reporting on the participant population (e.g., race, ethnicity, veteran status, highest level of schooling completed)
- Developed customized workflows through the CONNECTS platform for OMS, traumatic brain injury, and Supported Employment (Ticket to Work)

ATTACHMENT K.11

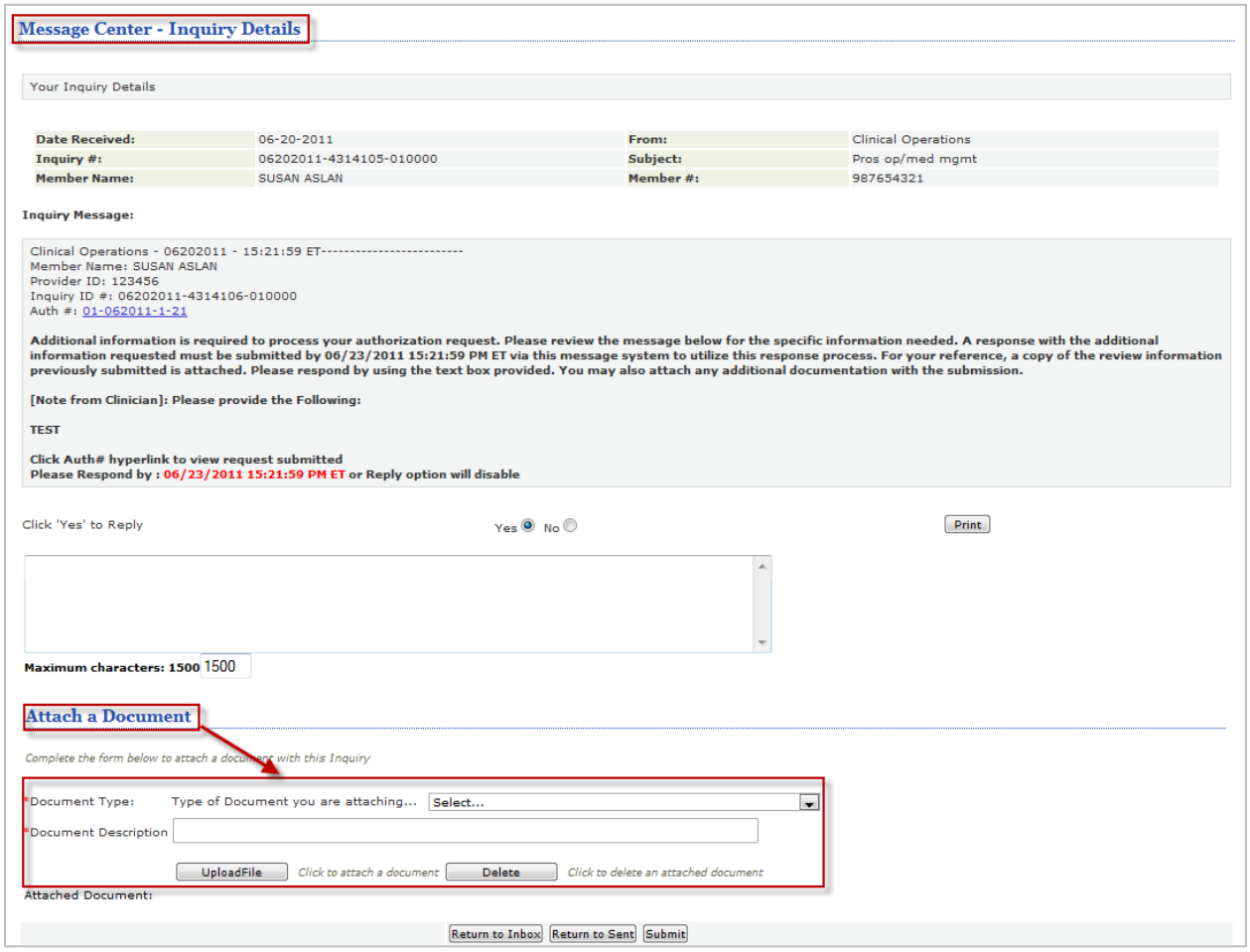
K.11 In Attachment K.11, **(limit two (2) pages)**, describe the process of linking the web-interfaces with the system to reimburse for housing vouchers, bridge funding, and transition funding.

As mentioned previously, we are committed to helping providers manage their administrative functions more efficiently. We strive to make electronic claims submission a viable option for all providers and accept direct data entry of claims online. Alternatively, for non-claims based service payments (i.e., Georgia Housing Voucher Program, Bridge-funding, Transition funding) can be submitted via the personalized message center on ProviderConnect. DBHDD and providers will submit the necessary information and attach the documentation (e.g., receipts, invoices) required to request reimbursement for the eligible goods and services, including but not limited to rental assistance payments. All of these transactions can be performed via our secure provider portal, ProviderConnect, shown in the screenshot below.



We will work directly with DBHDD to ascertain the list of approved providers permitted to submit claims for bridge funding and transitional funding type payments and follow all DBHDD processing guidelines.

The screenshot on the following page illustrates the system's ability to allow providers to submit (attach) receipts, invoices, or other documentation required to process the non-claims based service claims.


Message Center - Inquiry Details
Your Inquiry Details
Date Received: 06-20-2011
From: Clinical Operations
Inquiry #: 06202011-4314105-010000
Subject: Pros op/med mgmt
Member Name: SUSAN ASLAN
Member #: 987654321
Inquiry Message:
Clinical Operations - 06202011 - 15:21:59 ET----------
Member Name: SUSAN ASLAN
Provider ID: 123456
Inquiry ID #: 06202011-4314106-010000
Auth #: 01-062011-1-21
Additional information is required to process your authorization request. Please review the message below for the specific information needed. A response with the additional information requested must be submitted by 06/23/2011 15:21:59 PM ET via this message system to utilize this response process. For your reference, a copy of the review information previously submitted is attached. Please respond by using the text box provided. You may also attach any additional documentation with the submission.
[Note from Clinician]: Please provide the Following:
TEST
Click Auth# hyperlink to view request submitted
Please Respond by : 06/23/2011 15:21:59 PM ET or Reply option will disable
Click 'Yes' to Reply
Yes
No
Print
Maximum characters: 1500
1500
Attach a Document
Complete the form below to attach a document with this Inquiry
*Document Type:
Type of Document you are attaching...
Select...
*Document Description
UploadFile
Click to attach a document
Delete
Click to delete an attached document
Attached Document:
Return to Inbox
Return to Sent
Submit

ATTACHMENT K.12

K.12 In Attachment K.12, **(limit (2) pages)**, provide the Offer's system security strategy and how the Offeror will utilize role based security and access privileges to the various components of the information system. Describe how the Offeror will ensure that internal DBHDD staff and external provider staff only have access to the systems, screens, data, and reports approved for the user.

As a behavioral health and IDD provider, we are extremely sensitive to the need to ensure and maintain confidentiality, integrity, and availability of data in accordance with all applicable laws, regulation, and best practice guidelines developed by IBM for data protection within a DB2 environment. Our system architecture includes security controls and protections features to ensure the confidentiality, integrity, and availability of data at multiple levels within our system environment. We have implemented discretionary access controls at the operating system level to prevent unauthorized users from accessing our systems, application layer security controls to restrict user access to their job-related functions and data within specific applications, and database and records level controls to restrict access to certain database and records within databases from unauthorized disclosure or access.

Our operational security policies, protocols, and technical solutions stress our commitment and demonstrated our belief that confidentiality and security are paramount to our ability to meet the operational requirements of our clients. Our secure, integrated computing platform enforces ValueOptions' confidentiality protocol by storing all client information in a trusted database environment. Our system unifies all administrative functions, from invoice to clinical and intake data to referral data and benefits, and is accessible via secure sign-on. Our system security protocols maintain all data related to individual system users and defines the level of access they are permitted across all applications based on their job functions. Our National Security Team maintains all protocols surrounding system access to support member privacy and confidentiality, such as:

- Maintaining clear procedures for requesting and authorizing system access requests
- Maintaining role-based security, restricting employee access based on their job responsibilities
- Establishing system security protocols to detect, prevent, and report any virus, network intrusion as well as support efforts related to disaster recovery and contingency planning
- Archiving system/data information and record destruction
- Securing transmissions between ValueOptions internal systems and external constituencies
- Managing a secure e-mail product for communications with clients, customers, and providers

We have the ability to configure role-based security profiles exclusively for DBHDD and other authorized entities/agencies (e.g., Regional Offices) to log into our information management system to authorize care and coordinate services as requested by DBHDD, access the OMS and the online reporting tool, IntelligenceConnect. With the role-based profile, the authorized users

are able to request and review authorizations, view previous claims, and view participant history in real time in the exact same manner as our Clinical Care Managers and have access to online DBHDD reports and dashboards.

ValueOptions Information Security Program sets priorities for management, control, and protection of the ValueOptions' information assets; the following four formulated Security Strategic Concepts guides ValueOptions security initiatives:

- Implementation of safeguards to reduce risk
- Sustain heightened user security awareness
- Maintain compliance with Federal/State/ValueOptions policies and procedures
- Preserving continuity of IT Operations

These four strategic objectives are our foundation to efficiently and effectively address the management, control, and protection of ValueOption's information assets. These objectives are further articulated as 14 key activities within ValueOptions:

- Application Security
- Data Loss Prevention
- Identity and Access Management
- Physical and Environmental
- Secure Remote Access
- Security Information Management
- Network and host-based intrusion detection/prevention systems
- Business Continuity Management
- Endpoint Security
- Network Access Control
- Patch Management
- Secure Configurations
- Security Awareness and Training
- Vulnerability Management

These Security Strategic Concepts and key initiatives are the driver that propels ValueOptions' enterprise security initiatives to meet compliance requirements such as HIPAA, AICPA Trust Criteria, ISO 27002, and others. These four concepts give some responsibility to everyone; every ValueOptions' staff member has a role to play in the implementation of our Plan. Our individual and collective compliance with these four Security Strategic Concepts protects the security of our IT assets and privacy of information entrusted to us.

ANNUAL SECURITY CONTROLS AUDIT

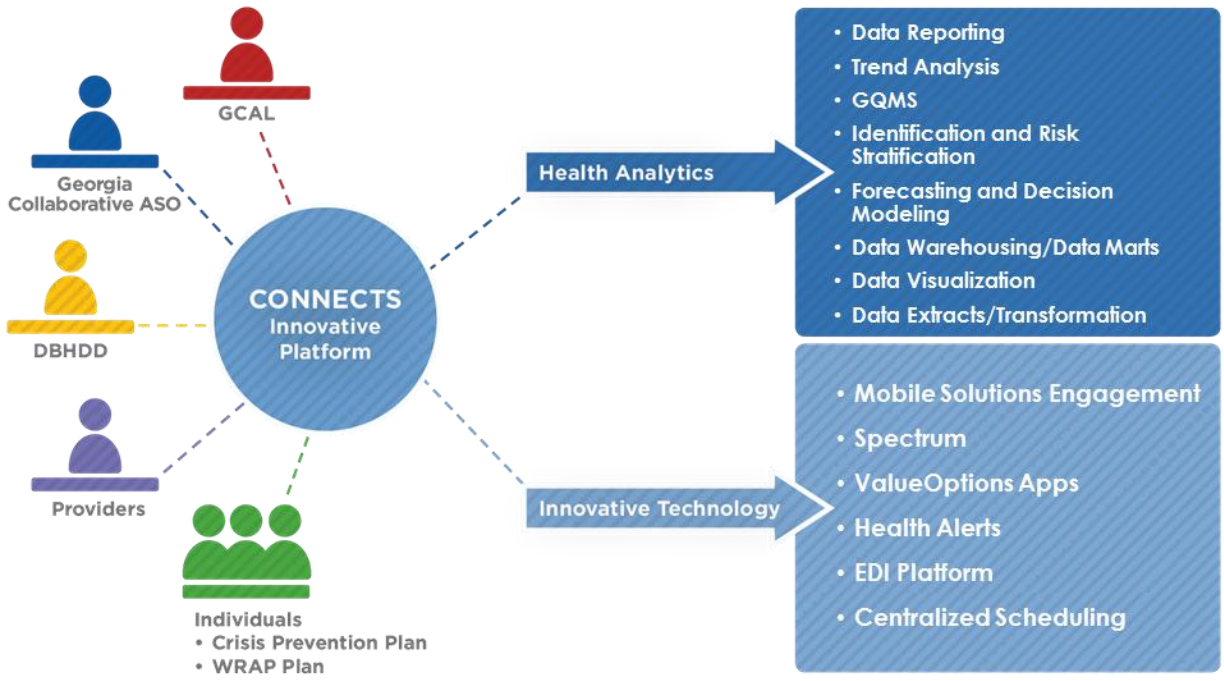
ValueOptions engages KPMG and PricewaterhouseCoopers (PwC) to conduct an annual audit of our security controls. KPMG and PwC perform a SSAE 16 (SOC 1) audit of our controls and systems. Starting in 2013, KPMG also started performing a SSAE 16 (SOC 2 – Security and Availability principle) Audit. Our first SOC 2 Audit report was published in January 2014 and is provided as **Attachment 11**.

ATTACHMENT L.1

L.1 In Attachment L.1, **(four (4) pages)** describe the specific software products, tools, or other state-of-the art technologies used in support of the data management functions.

During our background outreach efforts in preparation for the release of DBHDD's eRFP, a common theme among providers was that data and information from the provider community were put into the system but they received little or no informative analysis in return. One of the primary goals of the suite of software products we will offer DBHDD is to deliver information to providers and DBHDD that will drive overall system quality improvement. Our data management system will serve as an "information hub" capable of interfacing with DBHDD's data warehouse, GCAL, and the behavioral health and IDD quality management and utilization management functions for the purpose of creating informative reports. This information hub will include data on demographics, authorizations, claims and encounters, assessments, and all other programmatic information.

To support our **"High Assurance"** model, we created a suite of software products, which we own and update on a regular basis, specifically designed to meet program data management and reporting goals similar to those identified by DBHDD. Our comprehensive management information platform, CONNECTS is a suite of fully integrated applications designed to provide innovative data management and reporting capabilities. In particular, the CONNECTS platform represents more than 20 years of behavioral health and IDD experience and associated best practices in supporting Medicaid health care programs and facilitating ease of use while adhering to State and Federal requirements.



The system was specifically designed to ease the administrative burden of the provider requesting approval of services, to allow our Clinical Care Managers to quickly access information to respond and document a request for service, and provide program directors with key measures to monitor overall program performance. Working from a shared database, the platform consists of highly sophisticated, scalable Web-based components designed for:

- Individual enrollment
- Research
- Electronic data exchanges
- Care management
- Appeals, complaints and grievances
- Care coordination
- Inquiry tracking
- Financial operations
- Clinical notes
- Claims processing and payment
- Authorizations
- Customer service
- Reporting functions
- Provider communication
- Provider network management

This integrated computing environment significantly enhances our ability to improve the coordination of care and service delivery for the 32 million individuals with behavioral health and IDD challenges we serve throughout the country. Its flexibility allows us to customize the system to support the varying requirements of our partnerships across the nation. Since its inception, we continually enhance the CONNECTS platform to specifically meet the current and future needs of the behavioral health programs that we manage. Advanced capabilities are designed throughout the system to further improve coordination of care services, and will be customized specifically for the DBHDD contract. Furthermore, we will be able to quickly meet DBHDD's requirement to make modifications to the system during the term of the contract to reflect changes in DBHDD, DCH, State and/or Federal requirements, including those changes required by the ADA Settlement Agreement. DBHDD will be getting a mature system that will continue to evolve and improve during the life of the contract.

KNOWLEDGECONNECT

Our National Data Warehouse, KnowledgeConnect, receives imports from the CONNECTS platform and other external data sources for reporting purposes. These data are formatted and stored as standard data in our Oracle relational database system. KnowledgeConnect was created to provide the ability to combine data from internal and external sources into data models that provide enhanced reporting capabilities. These data models are used as the foundation for report generation, statistical analysis, decision support, and outcomes management.

KnowledgeConnect currently resides on a p740 AIX® 7 operating system and an Oracle 11g® database. It is specifically configured to support our full line of business and the unique reporting needs of each reporting area and each client. It was designed by and is maintained by ValueOptions' National IT, Database Administration Services Department.

During implementation, we will work closely and collaboratively with DBHDD to support required connectivity and confirm that all the necessary data circuits and communications lines are installed to support the expected data exchanges and any online access required to our system.

INTELLIGENCECONNECT

We recognize that measuring and managing health outcomes is an essential part of delivering high quality, cost-effective services. Our business intelligence philosophy is that on a day-to-day basis, every decision maker needs direct access to the data and information that allows him or her to make informed decisions. We leverage our substantial investment in data warehousing technology, as well as our information systems platform to provide better, more meaningful reporting to DBHDD.

Once data are gathered, analyzed and integrated into our systems, they are available for reporting and further analysis through IntelligenceConnect, our secure Web-based reporting platform. The IntelligenceConnect application runs on SAP BusinessObjects BI Platform 4.1 software, one of the business intelligence industry's leading BI applications. The platform runs in a highly scalable, fault-tolerant VMware virtual environment based on Dell and EMC hardware. It employs advanced strategies such as Dynamic Resource Scheduling and High Availability to maintain maximum uptime and performance. We separate reporting activity from operational activities by the use of KnowledgeConnect and various data marts. The separation of these activities allows for reporting and analyzing work without impeding such operations as authorizing services, paying claims, and processing eligibility. This tool, shown below, provides DBHDD with an easy mechanism for accessing and viewing a variety of relevant data.

IntelligenceConnect will be available to DBHDD for monitoring of selected performance measures and includes penetration rates, eligibility demographics, diagnostic information, utilization reports, and fiscal and statistical reports. In IntelligenceConnect, DBHDD will access dynamic reports that can be run on demand, as well as dashboards that present key performance metrics for easy analysis.

IntelligenceConnect complements and enriches our standard reporting package by providing a suite of interactive dashboards and ad hoc reporting capabilities are available online or using our

mobile application for Apple, Blackberry and Android-powered smartphones. IntelligenceConnect's secure dashboard reports render fully customizable data and performance statistics to meet DBHDD's needs. The dashboards and statistics can be used for ongoing trending analyses and can serve as a compliance benchmark.

Our market-differentiating, real-time, online dashboard reporting ensures a transparent and collaborative partnership. The secure, password-protected online portal enables access to our Web-based reporting and analytics in real time. DBHDD can conduct a variety of analyses across a full range of utilization features for both behavior health and IDD populations, including data on enrollment, care coordination, encounters, authorizations and more. Drill-downs on individual sub-groups, demongraphics and trends, including level of care and diagnosis, home type, and services are also available. All reports can be printed on demand.

We recognize there are many different consumers of data and information, from DBHDD to providers and individuals. IntelligenceConnect's secure dashboard reports render fully customizable data and performance statistics to meet all of our stakeholder's needs. The dashboards and statistics can be used for ongoing trending analyses.

With meticulous validation and close coordination with DBHDD, we will successfully implement essential reports required for this contract. All necessary data to accommodate these reports will be collected, maintained and continually updated to ensure the most current logic is applied to yield the most accurate and relevant information available. We will work with DBHDD to identify other data sources (e.g., State agencies, MCOs) and gather data from these additional entities to develop integrated reports. For example, for our Maryland program, we made changes to our system to support data collections for the Uniform Reporting System (URS), Client Level Data (CLD), Outcomes Measures (OMS), Treatment Episode Data Sets (TEDS), and other customized Federal reporting elements.

Key Metric Indicators

IntelligenceConnect presents each Key Metric Indicator in clear, uncomplicated graphics. By pointing and clicking on the Key Metric Indicators, the user is allowed to conduct a variety of analyses and monitoring of selected performance measures and includes penetration rates, eligibility demographics, diagnostic information, trending by month, utilization by specific location or population, and fiscal and statistical reports.

Drill Down Function

The various menus at the top allow the user to render all gauges and pie charts dynamically, based on their selections in level of care, DBHDD-specific divisions, diagnosis type and timeframe. Clicking on any pie slice will also present the user with a drill-down report showing more detailed data specific to their selection. Selecting the trending option will present the user with a utilization trending dashboard that allows the user to select the time interval of the trend and the measure.

We are confident DBHDD will appreciate the content and functionality in this easily-navigated system. IntelligenceConnect is not only the reporting platform we offer our clients, but is also the platform utilized internally by our executive decision makers.

ATTACHMENT L.2

L.2 In Attachment L.2, **(text response limited to one (1) page per report; report examples limited to five (5) pages each)**, provide excerpts from your five (5) best reports (other than the UM/UR report already provided in response to A.8) that would be relevant to this Contract. Describe how the reports are generated, how the integrity of data is assured, how the report is used, and describe why they are considered to be the best reports.

REPORT EXAMPLE ONE

Illinois Mental Health Collaborative for Access and Choice Annual Return on Investment Report	
Background	In 2007, the Illinois Department of Human Services/Division of Mental Health (DHS/DMH) partnered with ValueOptions to form the Illinois Mental Health Collaborative for Access and Choice. They created the Collaborative in compliance with the state legislature's mandate to ensure the appropriateness of community mental health services for nearly 170,000 adults and children enrolled in Illinois' Medicaid program. Statewide, ValueOptions provides utilization management services for several levels of care: Assertive Community Treatment, Community Support Teams, Community Support Groups, Psychosocial Rehabilitation and Therapy/Counseling. In 2012, we added inpatient care to our utilization management services for the greater Chicago and Northwest Illinois areas. To better demonstrate the value of the program, we developed an analytical report to calculate the return of investment (ROI) our UM activities generate for the State on an annual basis.
Value of the Report	The studies can be used to determine what policy titrations may be necessary to achieve system of care goals. The benefits to these studies are that they are able to evidence goal attainment or deficiency from both macro and micro levels of administrative review. The Collaborative continues to achieve significant cost savings for the State. Analyzed claims data from DHS/DMH fiscal years 2010-2012 indicate savings over $37.1 Million – approximately 11 percent of the total Medicaid spend for the set of analyzed claims. During this timeframe, the program experienced a 15 percent increase in the target population served suggesting that we are serving more Illinois consumers while simultaneously lowering costs.
Analytical Process and Data Integrity Verification	Our analytical team extracted Medicaid paid claims data for over 15 services. The services include those where Utilization Management does and does not occur. Within the studies, the metrics for Number of Consumers Served, Total Program Costs, Average Cost per Consumer, Maximum Cost per Consumer, Percent of Target Consumer, and Age demographics are analyzed. The analysis looks at what is occurring over time with respect to each category. This is completed for individual services, UM versus non-UM services, and cost savings. Each of the analyses has their own stand-alone fact sheet. Comprehensive Overall Savings are determined with respect to annualized Cost Savings less the client's spend on their ValueOptions contract. Extracted Medicaid paid claims are analyzed internally at the local Engagement Center and then reviewed by a ValueOptions medical economist for validation. The studies are then distributed to the client.
Report usage	The primary use of the report is to inform DHS/DMH of the impact of program services. We also use the reports to inform key Illinois legislators and stakeholders about the value of the program.

Excerpts from this report are provided on the following pages.

Service Discussion Points based on MCD data

Aggregate Services – All MCD

- Aggregates all services in which the Collaborative has MCD data.
- Total Service Costs increased by approximately $400K.
- Maximum Cost per Consumer decreased by approximately $5700.
- Percent of Target Consumers raised by 4%.
- Consumer age distributions remained relatively static during the measured period.

Cost Savings – All MCD

- Compares the differences in Total Costs in services where Utilization Management (UM) was implemented versus where it was not implemented.
- Where UM was implemented, the aggregated net Total Cost Savings from FY 10 to FY 11 was approximately $3,615,658.50.
- Services where UM was not implemented display a cost increase of approximately $4.0M
- All services where UM had been implemented was compared to the US Dept. of Labor's Consumer Price Index (CPI) (http://www.bls.gov/news.release/cpi.nr0.htm) – which indicated a 3.7% cost increase between 2010 and 2011. Extrapolations were prepared to indicate the additional cost savings to the DHS/DMH where UM occurred as compared to federal standards. The net cost savings were $6,575,164.75.
- Coupling the operational cost savings between the fiscal years with the CPI extrapolation, suggests a net cost savings of $10,190,823.25.

UM Services – All MCD

- Aggregate report detailing services where UM is implemented.
- Total Service Costs decreased by approximately $3.6M.
- The Average Cost per Consumer had a slight reduction.
- Maximum Cost per Consumer was reduced by $6,700
- Percent of Target Consumer rose by 2%.
- The Consumer Age breakouts appear to remain static.

Non UM Services – All MCD

- Aggregate report detailing services where UM is not implemented.
- Total Service Costs rose by approximately $4.0M.
- Average Cost per Consumer had an increase of $42.
- Maximum Cost per Consumer reduced by approximately $12K
- Percent of Target Consumers increased by 4%.
- The Consumer Age Breakouts appear to remain static.

Target Consumers – All MCD

- This fact sheet compares the averaged Percent of Target Consumers between three (3) sets of data: Services where UM was implemented, Services where UM was not implemented, and the compilation of all services.
- Percentage of Target Consumers for services where UM is implemented is highest for both years.

ACT = Assertive Community Treatment

- ACT services were utilized by 63 more consumers in FY 11 than FY 10.
    - Although there is a rise in the number of consumers served in this time period, the number of consumers served in ACT has shown a significant decrease since the Collaborative's involvement in FY 08. When the Collaborative started working with DMH, there were 1,751 consumers of ACT services. By FY 11, the number of consumers in ACT was 683 (historical data can be provided upon request). This is a positive development as it indicates that the consumers currently being served are indeed the consumers who are clinically appropriate for this level of service. ACT is intended to be a service for the "sickest of the sick" and thus should see a smaller percentage of overall consumers.
- Total Service Costs increased by $567K from FY 10 to FY 11.
    - There has been a noticeable cost decrease since the Collaborative became involved in this service. This illustrates the Collaborative's commitment to ensure that dollars go to provider agency programs and consumers who meet the eligibility criteria and fidelity requirements for this service. This is consistent with EBP treatment standards as published in the research literature.
- Average Cost per Consumer increased by $25.
    - With decreasing numbers of consumers comes an overall increase in average cost per consumer has occurred. This is consistent with this level of service serving the "sickest of the sick;" those that meet the criteria for this service have high needs and thus we would anticipate that cost per consumer would increase after those who did not fully meet criteria (i.e., those who did not truly need this high intensity service) are removed from the pool.
    - The cost per consumer has stabilized over the past two fiscal years as the number of consumers utilizing this service has come to more natural levels and has also stabilized.
- Maximum Cost per Consumer was reduced in FY 11 by approximately $6,700.
    - This can be attributed to the Collaborative's attention to outliers and ultra-outliers along with close monitoring of high utilizing consumers and providers in order to ensure provision of practicing within Evidence Based Practices (EBP) parameters.
- Percent of Target Consumers increased by 8% to 96% in FY 11.
    - This upward trend in the percentage of target consumers being served is significant for this time period. It is even more dramatic if the figures going back to FY 08 are included. The percentage of target consumers being serviced jumped from 77% to 95% (data can be provided upon request) in just the years since the Collaborative's involvement. This is important and quite positive in that ACT is a service geared toward the "sickest of the sick", which corresponds with DMH's Target Consumer Diagnosis population. It is also positive that the rate of increase has been gradual. This allowed providers the time to transition those consumers not needing ACT to the necessary supports during the implementation of the Collaborative's authorization program (from education to soft-landing period to current full criteria application).

CSG = Community Support Group

- The Number of Consumers Served in this time period indicates an increase of 744 consumers.
    - Suggests that consumers from higher levels of service have been appropriately transitioned into CSG. This is backed by the decrease in the number of consumers receiving PSR and demonstrates that those consumers who have mastered the skills

necessary to graduate to community tracks that teach operationalization of skills in the natural environment are indeed occurring.

- Although there was a triple digit increase in the number of Consumers Served, there was a decrease in the Total Service Costs by approximately $140K.
    - Indicates that dollars are being spent more effectively and providers are using resources in more cost-efficient manner.
- The Average Cost per Consumer also decreased by approximately $106.
    - Indicates that available dollars are being spent more efficiently and providers are using resources in a more cost-effective fashion.
- A reduction in the Maximum Cost per Consumer was realized. This reduction was approximately $8,500.
    - This can be attributed to the Collaborative's attention to ultra-outliers and outliers along with monitoring those high utilizing consumer-provider combinations to ensure provision of practicing within EBP parameters for best use of limited resources/$ for those consumers who meet the DMH Medical Necessity Criteria.
- There was an increase of 2% in the Percent of Target Population.
    - The Collaborative fully anticipates that the % target consumers will demonstrate continued positive upward trending with continued education, outreach, and shaping of providers related to this service through the ongoing Collaborative staff efforts.

CST = Community Support Team

- An increase in the Number of Consumers Served is indicated. This increase was by 262 consumers.
    - Historically, there was a drop in the number of consumers served, which has been followed by a relative stabilization in the number of consumers being served. This indicating that "loading" of CST services from ACT did not occur once UM had begun.
- There was also an increase in the Total Service Costs. The increase was just over $1M.
- Similarly, there was a slight increase in the Average Cost per Consumer. $114 was the increase for this average.
    - In looking at this data compared to historic data, there has been an overall reduction in the average cost per consumer. This indicates that funds are being used more efficiently and cost-effectively in serving this population of consumers.
- The Maximum Cost per Consumer also realized an increase of approximately $2,800.
    - Although ultra-outliers have been realized in preceding fiscal years, the trending has shown a decrease over the time period. This can be attributed to the Collaborative's attention to ultra-outliers and outliers, along with monitoring high utilizing consumers and providers in order to ensure EBP practices are being followed in the provision of services to those consumers who meet the DMH Medical Necessity Criteria (MNC) for this service.
- The Percent of Target Consumers also increased by 1%.
    - The percent of target consumers has steadily increased since the inception of UM. In this period, a 1% increase is realized (93% - to 94%). This suggests that the consumers who are receiving this service are in fact those who meet the criteria for participation. Those who do not meet those criteria are not receiving the service.

PSR = Psychosocial Rehabilitation

- The Number of Consumers Served had a decrease by over 300 consumers.
    - The decrease in the number of consumers receiving this "inside of a facility building" based training program, demonstrates that those consumers who have mastered the skills taught in this service program, graduate to community tracks (as clinically appropriate) that teach operationalization of the classroom taught skills in the natural community environment. Correspondingly, the increase in the number of consumers receiving CSG corroborates this.
    - For those persons, who in the past (prior to Collaborative involvement) needed to repeat remedially PSR classes over and over with little clinical gains, the Collaborative staff partners with provider agencies to identify potential additional or other services and supports to help the consumer be successful and/or graduate from PSR.
- There was also a significant reduction in spend. The reduction was approximately $2.4M.
    - The Collaborative's shaping outreach efforts and attention to ensuring provision of practicing within EBP parameters for the most efficient use of limited resources/$ for those consumers who meet the DMH Medical Necessity Criteria for this service has been a major factor associated with in the savings realized here.
- The Average Cost per Consumer also saw a reduction of $278.
    - Indicates that available dollars are being spent more efficiently and providers are using resources in a more cost-effective fashion.
- There was a reduction in the Maximum Cost per Consumer of nearly $4,600.
    - This can be attributed to Collaborative's attention to ultra-outliers & outliers along with monitoring those high utilizing consumer-provider combinations to ensure provision of practicing within EBP parameters for best use of limited resources/$ for those consumers who meet the DMH Medical Necessity Criteria.
- There was an increase of 1% in the Percent of Target Population.
    - As PSR is a relatively high intensity service generally geared toward the population that corresponds to DMH's Target Consumer Diagnosis population (which = a sub-set of the DMH full Eligible population universe), the Collaborative staff is working closely with provider agencies to ensure that the right people are getting the right services in the right amounts. Thus this positive, albeit small, % increase is reassuring to see.
    - It is equally reassuring that this increase has been small, in that it demonstrates that the Collaborative is partnering with provider agencies to allow for clinically appropriate transition times to link those consumers to the necessary supports needed during the implementation of the Collaborative's authorization program.
    - The Collaborative fully anticipates that the % target consumers will demonstrate continued upward trending with continued education, outreach, and shaping of providers related to this service.

TC = Therapy/Counseling

- A reduction in the Number of Consumers Served was realized by over 700 consumers.
    - This indicates that consumers not needing this service are being referred to more clinically appropriate services, or transitioned out from this service when clinically indicated.
- The Total Service Costs were reduced by over $2.6M.
    - Those consumers served are being treated with modalities consistent with EBPs which have been demonstrated to improve the quality of care and clinical outcomes which in turn result in decreased costs.
    - Also, a result of fewer consumers being in this service.
- The Average Cost per Consumer was reduced by $53.
    - This is consistent with the Collaborative staff's efforts associated with reviewing care to ensure that those consumers receiving this service are being provided EBP treatment modalities which have been demonstrated to improve the quality of care & clinical outcomes which in turn result in decreased costs.
- Maximum Cost per Consumer was also reduced by nearly $7,300.
    - This can be attributed to the Collaborative's attention to ultra-outliers & outliers along with monitoring those high utilizing consumer-provider combinations to ensure provision of practicing within EBP parameters for best use of limited resources/$ for those consumers who meet the DMH Medical Necessity Criteria.
- The Percent of Target Consumers was also on the increase. This increase was 3%.
    - Demonstrates that this service is being increasingly provided to those with the greatest target clinical needs.

CI = Crisis Intervention

- Nearly 300 fewer Consumers received Crisis Intervention Services.
- The Total Services Cost was also reduced by over $77K.
- The Average Cost per Consumer was essentially flat.
- The Maximum Cost per Consumer was also reduced by over $900.
- The Percent of Target Consumer was elevated to 71%, an increase of 3%.

CM = Case Management

- An additional 7,725 consumers received services in FY 11 compared to FY 10.
- The Total Service Costs increased by $1.9M.
- The Average Cost per Consumer was nearly without change.
- The Maximum Cost per Consumer grew over $11K during this period.
- The Percent of Target Consumer was increased by 2% to 70%.

CSI = Community Support Individual

- Almost 2,000 more consumers received CSI services in FY 11 compared to FY 10.
- Total Service Costs increased in this time period by more than $1.75M.
- The Maximum Cost per Consumer saw a reduction by more than $20K.
- The Percent of Target Consumers had a 2% increase taking FY 11 to 76%.

REPORT EXAMPLE TWO

Developing Performance-Based Payment Models that Test the Feasibility of Linking the Payment for Outpatient Services to Improved Community-Tenure Outcomes for Adult Covered Individuals with High Rates of Acute Psychiatric and/or Substance Abuse Hospitalization – Phase II	
Background	Traditional payment models associated with the provision of behavioral health care do not necessarily support the application of best practices nor do they serve as an incentive to encourage service providers to strive for improved behavioral health outcomes. For example, the correlation between service utilization and revenue, which is inherent in fee for service models, tends to promote service utilization without addressing outcomes. The purpose of this report was to analyze the impact of payment models that align reimbursement incentives with quality of care and desired outcomes, rather than quantity of outpatient behavioral health services. The desired outcome is to increase a Member's community tenure. It is expected that the community tenure goal should allow for a cost-neutral model in that the incentive payments to outpatient providers for meeting or exceeding community tenure goals are associated with the cost reduction attributed to reduced behavioral health inpatient days.
Value of the Report	The report validated the cost savings of the performance-based payment model and provided insight to explore additional strategies for identifying and effecting increased community tenure for a cohort of Members, who experience mental health and substance use 24-hour acute levels of care, but who do not yet utilize outpatient/community-based behavioral health services.
Analytical Process and Data Integrity Verification	This project was based on behavioral health claims data from the ValueOptions claims system. The new payment model was developed by selecting members discharged from 24-hour settings and following their treatment trajectory for six months post-discharge in order to calculate community tenure scores. The model was developed in an exploratory analysis in FY2011 and was verified by conducting the identical analysis on a separate cohort of members to ensure that the results of the initial analysis could be replicated. Subsequent analyses confirmed the validity of the initial exploratory research. Community tenure scores were calculated in the data analytic dataset and verified by manually calculating the community tenure scores for a subset of members in the dataset in order to verify the accuracy of the calculations. A similar verification process was used after each phase of the study. The final community tenure scores and the accompanying financial incentives paid to the participating providers were also verified independently by the project manager and by the project's Senior Sponsor, Massachusetts Behavioral Health Partnership's (MBHP) Chief Financial Officer.
Report usage	This report was used to make several recommendations regarding the sustainability and feasibility of further expanding the performance-based payment model. • Sustainability – the overall cost savings was greater than originally projected and the results encouraged MBHP to facilitate additional opportunities for these providers to implement the performance-based payment model. • Feasibility – the evaluation of the ability of providers to implement the performance-based payment model was encouraging of continued implementation of the model.

Excerpts from this report are provided on the following pages.

BOSTON

Aftercare Arranged Prior to Discharge Compliance Rates in 2012 & 2013 YTD (Jan-Sep)

PROVNAM	2012 Numerator	2012 Denominator	2012 Compliance Rate	2013 YTD Numerator	2013 YTD Denominator	2013 YTD Compliance Rate
[redacted]	40	53	75.5%	38	56	67.9%
	43	62	69.4%	40	53	75.5%
				1	1	100.0%
	4	7	57.1%			
	7	8	87.5%	6	7	85.7%
	3	4	75.0%			
	0	3	0.0%	3	4	75.0%
	6	13	46.2%	0	1	0.0%

Drill Down of Non-Compliant Discharges in 2013 YTD (Jan-Sep)

PROVNAM	# of non-compliant discharges in 2013 YTD	Documented 'Name of BH service covered'	Documented 'Name of Provider'	Documented 'Date of appointment'	Documented 'Time of appointment'	Documented 'Mbr/family involvement & agreement'
[redacted]	18	18	17	7	0	18
	13	10	11	4	0	11
	0					
	1	1	1	1	0	1
	1	0	0	0	0	1
	1	1	1	0	0	1

- Aftercare arranged prior to discharge compliance is based on, as evidenced in Member's medical record, documentation of:
  - Name of BH service covered
  - Name of Provider
  - Date of appointment (if open-access or walk-in, document the earliest date available)
  - Time of appointment (if open-access or walk-in, document the earliest time available)
  - Member/family involvement & agreement
- Aftercare appointments should be made within seven days post discharge
- Discharge forms should be entered via ProviderConnect within seven days post discharge (refer to the PC Inpatient Discharge Review Guide)

METRO

Aftercare Arranged Prior to Discharge Compliance Rates in 2012 & 2013 YTD (Jan-Sep)

PROVNAM	2012 Numerator	2012 Denominator	2012 Compliance Rate	2013 YTD Numerator	2013 YTD Denominator	2013 YTD Compliance Rate
[redacted]	53	66	80.3%	17	48	35.4%
	10	18	55.6%	5	7	71.4%
	6	8	75.0%			
	16	24	66.7%	16	20	80.0%
	4	6	66.7%			
	0	3	0.0%	6	7	85.7%
	11	16	68.8%	3	3	100.0%
	1	1	100.0%			

Drill Down of Non-Compliant Discharges in 2013 YTD (Jan-Sep)

PROVNAM	# of non-compliant discharges in 2013 YTD	Documented 'Name of BH service covered'	Documented 'Name of Provider'	Documented 'Date of appointment'	Documented 'Time of appointment'	Documented 'Mbr/family involvement & agreement'
[redacted]	31	9	9	2	0	31
	2	2	2	0	0	2
	4	4	4	0	0	4
	1	1	1	0	0	1
	0					

- Aftercare arranged prior to discharge compliance is based on, as evidenced in Member's medical record, documentation of:
  - Name of BH service covered
  - Name of Provider
  - Date of appointment (if open-access or walk-in, document the earliest date available)
  - Time of appointment (if open-access or walk-in, document the earliest time available)
  - Member/family involvement & agreement
- Aftercare appointments should be made within seven days post discharge
- Discharge forms should be entered via ProviderConnect within seven days post discharge (refer to the PC Inpatient Discharge Review Guide)

NORTHEAST

Aftercare Arranged Prior to Discharge Compliance Rates in 2012 & 2013 YTD (Jan-Sep)

PROVNAM	2012 Numerator	2012 Denominator	2012 Compliance Rate	2013 YTD Numerator	2013 YTD Denominator	2013 YTD Compliance Rate
[redacted]	18	24	75.0%	18	20	90.0%
	4	7	57.1%	0	4	0.0%
	1	13	7.7%	2	4	50.0%
	23	32	71.9%	21	22	95.5%
	67	86	77.9%	39	45	86.7%
	6	18	33.3%	28	45	62.2%

Drill Down of Non-Compliant Discharges in 2013 YTD (Jan-Sep)

PROVNAM	# of non-compliant discharges in 2013 YTD	Documented 'Name of BH service covered'	Documented 'Name of Provider'	Documented 'Date of appointment'	Documented 'Time of appointment'	Documented 'Mbr/family involvement & agreement'
[redacted]	2	2	2	0	0	2
	4	3	3	0	0	3
	2	2	2	0	0	2
	1	1	1	0	0	1
	6	5	5	1	0	6
	17	14	5	2	0	17

- Aftercare arranged prior to discharge compliance is based on, as evidenced in Member's medical record, documentation of:
  - Name of BH service covered
  - Name of Provider
  - Date of appointment (if open-access or walk-in, document the earliest date available)
  - Time of appointment (if open-access or walk-in, document the earliest time available)
  - Member/family involvement & agreement
- Aftercare appointments should be made within seven days post discharge
- Discharge forms should be entered via ProviderConnect within seven days post discharge (refer to the PC Inpatient Discharge Review Guide)

SOUTHEAST

Aftercare Arranged Prior to Discharge Compliance Rates in 2012 & 2013 YTD (Jan-Sep)

PROVNAM	2012 Numerator	2012 Denominator	2012 Compliance Rate	2013 YTD Numerator	2013 YTD Denominator	2013 YTD Compliance Rate
[redacted]	5	5	100.0%	3	3	100.0%
	3	5	60.0%	2	3	66.7%
	29	36	80.6%	41	41	100.0%
	10	15	66.7%	9	10	90.0%
	12	19	63.2%	1	2	50.0%

Drill Down of Non-Compliant Discharges in 2013 YTD (Jan-Sep)

PROVNAM	# of non-compliant discharges in 2013 YTD	Documented 'Name of BH service covered'	Documented 'Name of Provider'	Documented 'Date of appointment'	Documented 'Time of appointment'	Documented 'Mbr/family involvement & agreement'
[redacted]	0					
	1	1	1	1	0	1
	0					
	1	1	0	0	0	1
	1	1	1	0	0	1

- Aftercare arranged prior to discharge compliance is based on, as evidenced in Member's medical record, documentation of:
  - Name of BH service covered
  - Name of Provider
  - Date of appointment (if open-access or walk-in, document the earliest date available)
  - Time of appointment (if open-access or walk-in, document the earliest time available)
  - Member/family involvement & agreement
- Aftercare appointments should be made within seven days post discharge
- Discharge forms should be entered via ProviderConnect within seven days post discharge (refer to the PC Inpatient Discharge Review Guide)

PROVNAM	REGION	1/6/13 - 2/2/13		2/3/13 - 3/2/13		3/3/13 - 3/30/13		3/31/13 - 4/27/13		4/28/13 - 5/25/13		5/26/13 - 6/22/13		6/23/13 - 7/20/13		7/21/13 - 8/17/13		8/1/13 - 9/14/13		9/15/13 - 10/12/13		10/13/13 - 11/9/13		11/10/13 - 12/7/13		12/8/13 - 1/4/14	
		Total # of D/C	Avg # of days entered after D/C	Total # of D/C	Avg # of days entered after D/C	Total # of D/C	Avg # of days entered after D/C	Total # of D/C	Avg # of days entered after D/C	Total # of D/C	Avg # of days entered after D/C	Total # of D/C	Avg # of days entered after D/C	Total # of D/C	Avg # of days entered after D/C	Total # of D/C	Avg # of days entered after D/C	Total # of D/C	Avg # of days entered after D/C	Total # of D/C	Avg # of days entered after D/C	Total # of D/C	Avg # of days entered after D/C	Total # of D/C	Avg # of days entered after D/C	Total # of D/C	Avg # of days entered after D/C
[redacted]	NE	15	0.2 days	13	0 days	12	0.2 days	8	0.1 days	13	0.3 days	8	0 days	8	0 days	13	0.3 days	25	0.6 days	16	0.9 days	11	0.6 days	15	0.2 days	10	0.1 days
	BOS	102	0.5 days	130	0.8 days	141	0.5 days	135	0.4 days	142	0.3 days	126	0.7 days	136	0.6 days	139	0.3 days	142	0.4 days	144	0.4 days	123	0.3 days	142	0.8 days	97	0.5 days
	NE			7	1 days	1	3 days	2	1.5 days			6	0.8 days	2	2.5 days	2	3.5 days	2	4.5 days	3	2.3 days	3	2.7 days	19	2.4 days	6	1.7 days
	W	3	0 days	2	0 days	9	0.4 days	2	1 days	3	4 days	4	0 days	4	0.3 days	4	2.3 days	10	0.4 days	5	0.6 days	5	0.4 days	5	1.4 days	4	0.5 days
	W	1	0 days	18	0.2 days	17	0.1 days	17	1.5 days	13	0.7 days	6	0.2 days	15	0.1 days	10	0.2 days	15	0.5 days	15	0.8 days	12	0.7 days	13	0.2 days	7	0.6 days
	W	8	0.3 days	5	0.4 days	5	0 days	5	0 days	9	1.3 days	7	0.3 days	9	0.4 days	11	0.2 days	12	0.3 days	9	0.1 days	21	0 days	14	0.2 days	7	0.1 days
	BOS	5	12.6 days	4	2 days	9	0.8 days	2	1 days	2	17.5 days	1	0 days			19	20.9 days	9	9.9 days	7	10.6 days			6	23.7 days	4	18 days
	BOS									6	0.3 days	22	1.1 days	35	2.8 days	57	0.6 days	27	1.1 days	39	0.7 days	46	0.7 days	46	0.5 days	35	0.5 days
	BOS															1	0 days	9	0.9 days	5	1 days	7	4 days	4	2 days	5	0.6 days
	METRO	8	0.4 days	9	1.6 days	9	0 days	12	0.1 days	13	0.1 days	17	0 days	6	0.3 days	10	0.2 days	18	0.8 days	24	0.5 days	33	0.6 days	30	1.7 days	32	3.8 days
	NE			1	7 days					1	0 days			1	0 days	1	0 days	1	0 days	5	2.2 days	12	2.3 days	17	1.3 days	16	0.9 days
	SE																					6	0.2 days	4	2.3 days	7	1.1 days
	BOS	4	0.5 days	3	0.7 days	3	0.7 days	4	0.8 days			1	0 days	5	0.4 days	4	0.5 days	3	1 days	2	4.5 days			6	0.8 days		
	W			2	0 days	3	0.7 days	1	0 days	2	1 days	1	1 days	2	0 days	5	0.8 days	7	0.3 days	8	0.4 days	5	0.4 days	7	0.4 days	10	0.5 days
	BOS																	1	2 days	11	7.5 days	7	8 days	7	6.6 days	13	9.4 days
	NE	5	1.8 days	3	5.3 days	9	8.8 days	2	8.5 days	1	2 days	3	4.7 days	3	36.3 days	3	19.7 days			4	1.5 days						
	NH			10	4.1 days	15	4.6 days	23	2.4 days	17	4.9 days	9	2.1 days	15	10.1 days	17	5.7 days	21	1.5 days	23	2.2 days	19	1.6 days	10	3.1 days	13	2.6 days
	C			4	19 days					22	35.4 days	21	112 days	11	24.5 days	4	1.3 days	2	10 days	7	3.7 days	5	3.6 days	6	6 days	11	6.2 days
	C	1	1 days	7	2 days	10	1.5 days	9	2.1 days	12	1.1 days	6	4 days	4	1 days	7	2.6 days	3	1 days	9	2.3 days	4	2.5 days	5	0.6 days	1	0 days
	SE	18	0.3 days	21	0 days	23	0.1 days	21	0.5 days	24	0.7 days	17	0.2 days	16	0.7 days	25	0.4 days	27	7 days	21	0.4 days	21	0.7 days	21	0.1 days	20	0.1 days
	W	15	0 days	10	0.4 days	11	0.2 days	4	0 days	10	0 days	7	0.3 days	11	0.1 days	8	0 days	6	0 days	7	0 days	10	0 days	7	1 days	10	0.6 days
	METRO																							18	11.9 days	14	1.3 days
	BOS	6	0.2 days	3	0 days	8	1.4 days	8	0 days	11	0.2 days	10	4.1 days	8	0.6 days	8	1.9 days	9	1.6 days	3	0 days	9	4.2 days	6	0.5 days	9	0 days
	METRO									3	0 days			2	0 days			2	0 days	6	0.7 days	6	11.3 days	1	0 days	6	0.8 days
	METRO	17	0.4 days	19	1.5 days	12	0.6 days	24	0.3 days	26	0.4 days	13	0.3 days	12	0.4 days	14	0.8 days	14	0.5 days	20	0.3 days	12	0.2 days	18	0.4 days	17	0.5 days
	METRO	8	1.1 days	7	6.3 days	2	2.5 days	4	4.5 days	7	1.6 days	15	2.9 days	9	2.3 days	12	3.3 days	8	0.6 days	9	1 days	8	2.5 days	9	1.4 days	3	0.7 days
	W	3	0 days	3	0.7 days	4	0.5 days	3	1.3 days	2	0 days	6	1 days	4	1.3 days	5	0.2 days	2	0 days	5	0.8 days	5	0.4 days	2	0 days		
	NE	8	0.5 days	6	1.2 days	9	1.1 days	8	0.4 days	8	1.1 days	2	2 days	17	1.1 days	11	0.4 days	9	0.4 days	13	0.7 days	9	4.8 days	8	2.3 days	6	2.3 days
	NE			5	0.4 days	2	0 days	1	11 days			2	11 days														
	NE			6	1.7 days	11	9 days	7	3.1 days	14	2.5 days	9	1.4 days	15	3.8 days	9	3 days	3	0.7 days	6	14.5 days	7	5.4 days	3	4.7 days	10	17.8 days
	NE	37	0.3 days	48	0.1 days	1	4 days	45	0.1 days	45	0.1 days	54	0.2 days	48	0.1 days	48	0.2 days	47	0.3 days	47	0.1 days	47	0.1 days	33	0.1 days	31	0.2 days
	NE	1	0 days	8	0.5 days	47	0.1 days	7	0.9 days	7	0.4 days	4	0.3 days	5	0 days	5	0 days	9	0.1 days	2	0.5 days	4	0.5 days	7	1.1 days	9	0.2 days
	W	32	36.3 days	54	30.1 days	25	8.3 days	30	9.6 days	14	17 days	26	17.8 days	17	15.7 days	19	13.1 days	42	27.5 days	12	19.9 days	34	20.1 days	19	23.5 days	8	15.8 days
	SE					1	0 days	12	0.6 days	10	0.7 days	8	0.5 days	10	1.4 days	10	1.4 days	16	0.9 days	15	1.7 days	11	1.7 days	1	0 days	6	11.3 days
	BOS									4	6 days	25	8.4 days														
	NE	25	0.1 days	29	0.4 days	27	0.1 days	32	0.1 days	25	0.4 days	32	0.1 days	29	0.1 days	21	0.1 days	30	0.1 days	37	0.2 days	29	0 days	23	0.7 days	25	0.2 days
	BOS	10	1.2 days	12	1.5 days	14	4.1 days	13	1.5 days	12	0.7 days	17	1.1 days	11	0.9 days	11	1.2 days	8	1 days	6	0.5 days	5	2.8 days	17	2.1 days	17	4.5 days
	BOS			1	1 days	14	4.1 days	10	1.7 days	9	1.7 days	12	3.2 days	7	2.9 days	10	2.5 days	7	2.1 days	5	5.8 days	3	1.7 days	12	1.8 days	8	1 days
	SE																			14	0.1 days	45	0.4 days	36	0.2 days	29	0.8 days
	NE			1	1 days	2	0.5 days			1	0 days					3	1.3 days	1	1 days	5	0.2 days	2	0 days	11	0.7 days	13	1 days
	METRO	5	2 days	8	2.1 days	60	16.3 days	16	1.4 days	20	5.3 days	34	12.3 days	48	41.7 days			6	1.7 days	32	33.7 days	56	15.8 days			28	61.6 days
	METRO					1	3 days	1	5 days	14	5.4 days	13	4 days	7	4 days	2	4 days							5	0.6 days	6	4.8 days
	C	18	0.3 days	7	0.6 days	9	0.3 days	16	0.3 days	15	0.3 days	19	0.1 days	22	0.4 days	13	0.8 days	14	0.3 days	12	0.3 days	16	0.2 days	17	0.6 days	13	0.2 days
	METRO																	1	0 days	1	0 days	5	1.2 days	3	0.3 days	4	0.8 days

- Discharge forms should be entered via ProviderConnect within **seven days** post discharge (refer to the PC Inpatient Discharge Review Guide)
- Completely document arrangement of aftercare appointment in **medical record** and **electronic discharge form** via ProviderConnect
- Aftercare arranged prior to discharge compliance is based on the documentation of:
  - ✓ Name of BH service covered
  - ✓ Name of Provider
  - ✓ Date of appointment (if open-access or walk-in, document the earliest date available)
  - ✓ Time of appointment (if open-access or walk-in, document the earliest time available)
  - ✓ Member/family involvement & agreement
- Aftercare appointments should be made within seven days post discharge
- Average # of days entered after discharge > 7 days are in red

REPORT EXAMPLE THREE

Analysis of Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)	
Background	IICAPS is one of the intensive, home-based services provided in Connecticut. Developed at Yale University over the last 15 years, IICAPS serves youth that are often at imminent risk of hospitalization or placement out of their home due to the seriousness of their mental health issues. A primary purpose of IICAPS is to assist children to improve functioning so they can remain at home, in their community, and with a reduced reliance on care provided in a hospital inpatient unit or emergency department. The Yale child study center has been collecting data on IICAPS for many years and has provided data supporting improvement in functioning, reductions in problem severity, and reductions in use of the emergency department and hospital care during an IICAPS episode. Yale conducted a randomized control trial to obtain more information on effectiveness. This evaluation aimed to examine who uses IICAPS, how the service is delivered, and whether there is evidence that it produces lasting change.
Value of the Report	Yale promotes IICAPS provider performance through standardized training, data reviews, site visits, and other performance improvement activities. This study looked at consistency of service delivery and the nature of services accessed after families have completed IICAPS. Results showed that outpatient treatment and medication management are the two most frequently accessed services following an IICAPS episode. More intensive community services are also utilized but at relatively low rates. The results also revealed the pattern of episode duration across providers. There is some variation but there is also a degree of consistency across providers
Analytical Process and Data Integrity Verification	To be accepted into the IICAPS program, a child/adolescent must be between the ages of five and 17. He or she will have a mental health diagnosis, and be at imminent risk of psychiatric hospitalization or residential placement or just coming out of a psychiatric hospital or other residential treatment. IICAPS works with children who have been diagnosed with disorders, such as depression, anxiety, psychosis, bipolar, among others. The program works with the child/adolescent in all areas of their life, including their own personal challenges, school, home, and their community. IICAPS focuses on the child and family's strengths and helps identify areas that need improvement. Utilization costs of children/adolescents accepted into the program were compared to a similar cohort of children/adolescents not participating in the program that were matched on the basis of pre-program acuity and demographics. The utilization patterns of the two groups were tracked over time.
Report usage	This report is used to inform key stakeholders regarding the performance of this service and forms the basis for updates in the performance improvement system and measures.

Excerpts from this report are provided on the following pages.

6/20/2013

Sample

The sample includes all Husky A and B members (n=1961) discharged from IICAPS treatment during 2011. The following cases (participants) and/or episodes (treatment *without* a gap in services of 21 day or more) were removed from the originally provided sample (CTBH13036_IICAPS_WITH_ADDRESS): a) cases that received IICAPS services only in 2010, only in 2012, or only in 2010 and 2012 (with no 2011 service date); b) episodes within individual that ended in 2010 or 2012. The final sample includes all clients and each of their individual episodes ending in 2011.

The 1961 cases in the 2011 IICAPS cohort ranged in age from 3 to 18 years (median=12.0 years, mode=15.0 years, mean=11.5 years, s.d. 3.53 years).

AGE	Frequency	Percent	Cumulative Frequency	Cumulative Percent
3	15	0.76	15	0.76
4	37	1.89	52	2.65
5	60	3.06	112	5.71
6	99	5.05	211	10.76
7	107	5.46	318	16.22
8	118	6.02	436	22.23
9	151	7.70	587	29.93
10	143	7.29	730	37.23
11	153	7.80	883	45.03
12	174	8.87	1057	53.90
13	207	10.56	1264	64.46
14	201	10.25	1465	74.71
15	241	12.29	1706	87.00
16	164	8.36	1870	95.36
17	87	4.44	1957	99.80
18	4	0.20	1961	100.00

61.3% (n=1202) of the sample are male. Race/Ethnicities with the highest rates included Caucasian (49.5%, n=970), Hispanic (33.2%, n=651); and Black (16.1%, n=316).

RACE	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Asian	14	0.71	14	0.71
Black	316	16.11	330	16.83
Caucasian	970	49.46	1300	66.29
Hispanic	651	33.20	1951	99.49
Multi	1	0.05	1952	99.54
Native American	3	0.15	1955	99.69
Pacific Islander	1	0.05	1956	99.75
Unknown	5	0.25	1961	100.00

Rates of mental health disorders according to codes available for up to 5 diagnoses for each IICAPS client included the following: 2397 cases with ADHD (58%); 685 with mood disorders (34.9%); 297 with anxiety (15.2%); 106 with adjustment disorders (5.4%); 50 with schizophrenia (2.6%); 13 with autism (0.7%) and 12 with miscellaneous mental health disorders (0.6%) (based on IICAPS claims data)

In addition, 26.7% (n=523) were diagnosed with asthma, 11.8% (n=231) diabetes, 3.6% (n=72) mental retardation and 10.3% any substance related disorder (n=201) (based on all medicaid MH and physical health claims). When examining IICAPS claims diagnoses, 5 clients received a primary diagnosis of a substance use disorder (i.e. the first diagnosis listed out of a possible 5 diagnoses.

Fully 31.4% (n=615) of the sample were DCF affiliated during at least one IICAPS episode (i.e. ongoing treatment *without* a gap in services of 21 days or more and ending in 2011).

DCFTYPE	Frequency	Percent	Cumulative Frequency	Cumulative Percent
D=All others	397	64.55	397	64.55
F=Families with Special Needs	3	0.49	400	65.04
J=Juvenile Justice	6	0.98	406	66.02
T=Title XIX	2	0.33	408	66.34
V=Voluntary	207	33.66	615	100.00
Frequency Missing = 1346				

I. How much do we do? IICAPS utilization patterns.

Amount of Services Billed/Received

Based on claims dates, the average number of days that each client received IICAPS services was **40.2 days** (s.d. 22.3) for episodes ending in 2011. 70.1% of the sample (n=1375) had only one IICAPS episode ending in 2011, 17.3% had 2 episodes (n=340) and the remaining 12.6% of the sample has 3 or more episodes (maximum of 7). Clients received an average of 333.35 (s.d. 188.80) service units (15 minute increments) or **83.3 hours of services per client** (s.d. 47.2 hours) across episodes.

episode_counter	Frequency	Percent	Cumulative Frequency	Cumulative Percent
1	1375	70.12	1375	70.12
2	340	17.34	1715	87.46
3	56	2.86	1771	90.31
4	158	8.06	1929	98.37
5	27	1.38	1956	99.75
6	3	0.15	1959	99.90
7	2	0.10	1961	100.00

Variable	N	Mean	Std Dev	Minimum	Maximum
hoursbilled	1961	83.3377104	47.1995474	0.5000000	316.7500000
svcdaycount	1961	40.2483427	22.3142909	1.0000000	171.0000000
episode_counter	1961	1.5410505	1.0078633	1.0000000	7.0000000
hoursperday	1961	2.1422162	0.6864130	0.3333333	6.5000000
daysperepisode	1961	34.1048894	22.9242019	0.1666667	111.0000000
hoursperepisode	1961	70.1668798	47.2636205	0.1250000	268.0000000

Amount Paid

The total amount paid for IICAPS episodes ending in 2011 was $20,019,321.60. An average of **$10,208.73 was paid per client** (s.d. $5812.02).

Brief IICAPS Encounters

Of the 1375 participants with only one 2011 episode, the following table shows the number of service days characterizing different percentiles of the sample. For example, the lowest 5% in terms of days of service, received IICAPS services on 5 or fewer days. The highest 5% (95th percentile) received IICAPS services on 77 or more days.

svcdaycount	
Quantile	Estimate
100% Max	111
99%	93
95%	77
90%	70
75% Q3	58
50% Median	44
25% Q1	27
10%	11
5%	5
1%	1
0% Min	1

A total of 75 clients (among those with only one IICAPS episode) received 5 or fewer days of IICAPS services, all of whom had 18 or fewer hours of IICAPS billed (mean 6.1, s.d. 4.49, median 4.5, mode 1.5). Six of these clients (8.0%), had at least 1 emergency department visit in 2011 *following* the start of their IICAPS service episode. This rate is significantly lower than the rate of an emergency department visit for those with 1 episode, but greater than 5 days of service (21.2%) (X^2=7.6, df=1, p=.0051)

II. How well do we do it? IICAPS provider performance.

There are **14 IICAPS** providers represented in this data including 1) Boys and Girls Village; 2) Bridges; 3) Catholic Charities; 4) Child and Family Agency of SE CT; 5) Community Child Guidance Clinic; 6) Community Health Resources, Inc.; 7) Family and Children's Agency; 8)

Family and Children's Aid, Inc.; 9) Middlesex Hospital; 10) Natchaug Hospital; 11) Village for Families and Children; 12) Wellmore Behavioral Health; 13) Wheeler Clinic; 14) Yale Child Study.

Number of IICAPS clients by provider

U_PROVNAM	Frequency	Percent	Cumulative Frequency	Cumulative Percent
BOYS & GIRLS VILLAGEINC	128	6.53	128	6.53
BRIDGES A COMMUNITYSUPPORT	113	5.76	241	12.29
CATHOLIC CHARITIESINC	37	1.89	278	14.18
CHILD & FAMILYAGENCY OF SE CT	79	4.03	357	18.20
COMMUNITY CHILDGUIDANCE CLINIC	36	1.84	393	20.04
COMMUNITY HEALTHRESOURCES INC	111	5.66	504	25.70
FAMILY & CHILDREN'SAGENCY	70	3.57	574	29.27
FAMILY & CHILDRENSAID INC	589	30.04	1163	59.31
MIDDLESEX HOSPITAL	69	3.52	1232	62.83
NATCHAUG HOSPITALINC	62	3.16	1294	65.99
VILLAGE FOR FAMILIES& CHILDREN	110	5.61	1404	71.60
WELLMORE BEHAVIORALHEALTH	259	13.21	1663	84.80
WHEELER CLINIC INC	115	5.86	1778	90.67
YALE CHILD STUDY	183	9.33	1961	100.00

Demographics by Provider

Provider	Age mean(s.d.)	Female n (%)	DCF affil. n (%)
Boys and Girls Village	11.3 (3.51)	43 (33.6%)	40 (31.3%)
Bridges	11.7 (3.80)	44 (39.0%)	22 (19.5%)
Catholic Charities	12.5 (3.37)	16 (43.2%)	15 (40.5%)
Child and Family Agency of SE CT	10.6 (3.61)	33 (41.8%)	17 (21.5%)
Community Child Guidance Clinic	9.5 (3.78)	10 (27.8%)	14 (38.9%)
Community Health Resources, Inc.	12.0 (3.33)	50 (45.1%)	47 (42.3%)
Family and Children's Agency	12.4 (3.16)	25 (35.7%)	28 (40.0%)
Family and Children's Aid, Inc.	11.4 (3.49)	241 (40.9%)	205 (34.8%)
Middlesex Hospital	11.7 (3.30)	27 (39.1%)	28 (40.6%)
Natchaug Hospital	11.4 (3.54)	20 (32.3%)	12 (19.4%)
Village for Families and Children	11.1 (3.24)	37 (33.6%)	31 (28.2%)
Wellmore Behavioral Health	11.2 (3.69)	106 (40.9%)	43 (16.6%)
Wheeler Clinic	12.7 (3.19)	36 (31.3%)	28 (24.4%)
Yale Child Study	12.2 (3.56)	71 (38.8%)	49 (26.8%)

REPORT EXAMPLE FOUR

Psychotropic Medication Use Among Individuals who Recently Transitioned to the Community (IRTC)	
Background	As part of the Department of Justice (DOJ) Americans with Disabilities Act (ADA) Settlement in Georgia (2010), individuals with IDD must be provided opportunity to live in the least restrictive environment. Therefore, many individuals who had been living in an institution are transitioning to a community setting and are utilizing supports and services, as appropriate, to help them successfully live in their communities. However, National Core Indicator Consumer Surveys, conducted in Georgia, demonstrated an overall increase in the proportion of individuals with IDD who used psychotropic medications; from 36.2 percent in fiscal year 2005-2006 to 51.0 percent in fiscal year 2010-2011 (NCI Consumer Survey Georgia State Report, 2005-2011). Because people transitioning into the community from institutions often present with significant health and mental health challenges, the transition process is critical in managing medication use for them and for the community providers who support them. Therefore, a study was designed to examine psychotropic medication use among individuals recently transitioned into the community.
Value of the Report	Results of this study suggest some of the challenges of transitioning individuals to the community are being addressed through chemical controls. These challenges may be reduced through an effective transition process that helps ensure the continued health and safety of individuals striving to maintain an every day life in the community. Because people all over the country are transitioning from institutions to less restrictive environments, the findings in this study have broad implications. In Georgia, DBHDD implemented a revision to the transition process to allow for greater and earlier involvement of the person's Support Coordinator. This new process included an increase in training for provider staff and an increase in regional oversight through the development of Regional Review Teams post transition. One of the Regional Quality Improvement Councils developed a quality improvement project providing education to medical professionals and the medical community.
Analytical Process and Data Integrity Verification	The study population consisted of adults, age 18 or older, with IDD and receiving services through the Georgia Medicaid HCBS waivers or state funding. Adult medication use in the ADA Settlement Group (n=325) was compared to all other individuals receiving HCBS waiver or state-funded services (n=12,722), individuals already residing in the community (July 2010 – December 2012). Medication information was obtained from the Health Risk Screening Tool (HRST). Medication types and prescription names were reviewed and categorized by Delmarva Foundation's Registered Nurse, a Certified Developmental Disabilities Nurse with a Master's degree in Public Health, and a Pharmacist. The average number of medications taken and the prevalence rates were calculated and compared between the groups, across time and pre vs. post transition into the community.
Report usage	The primary use of the report was to assist DBHDD's ongoing effort to assess the appropriateness and effectiveness of the transition process and the health of individuals in the IRTC population, with a focus on how this may impact psychotropic medication use.

Excerpts from this report are provided on the following pages.

Psychotropic & Anticonvulsant Medication: Individuals with Intellectual and Developmental Disabilities Who Transitioned to the Community from an Institution

Susan Kelly, PhD and Yani Su, MPH

Introduction

As part of the Department of Justice (DOJ) Americans with Disabilities Act (ADA) Settlement in Georgia (2010), individuals with intellectual and developmental disabilities (I/DD) must be provided opportunity to live in the least restrictive environment. Therefore, many individuals who had been living in an institution are transitioning to a community setting and are utilizing supports and services, as appropriate, to help them successfully live in their communities. Because people transitioning into the community from institutions often present with significant health and mental health challenges, the transition process is critical in managing medication use for them and for the community providers who support them.[1]

The Georgia Department of Behavior Health and Developmental Disabilities (DBHDD), in an ongoing effort to assess the appropriateness and effectiveness of the transition process and the health of individuals, requested a closer analysis of medication use for this group: before, during and after transition from the institution. The research questions are:

- Does the average medication use increase after individuals transition from an institution into a community setting? Does it differ for the general I/DD population?
- Is there an increase in the percent (prevalence) of individuals prescribed medication as they transition to the community? Does it differ for the general I/DD population?
- Does the prevalence rate vary by demographics; residential setting, gender, race/ethnicity, age or disability?[2]

Data and Methods

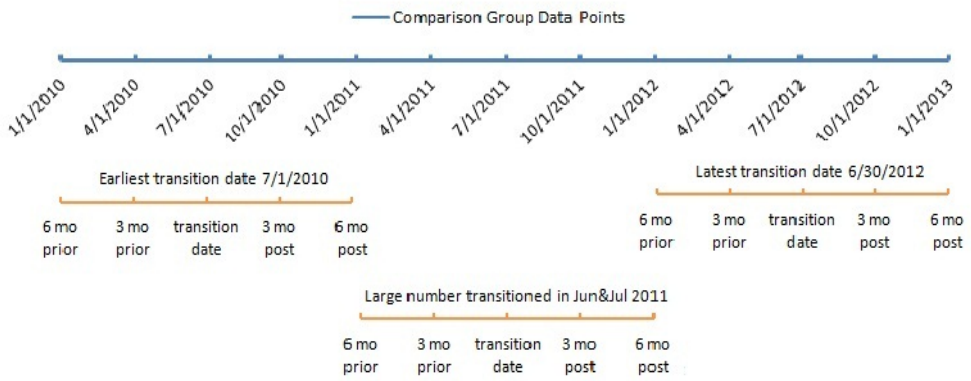
The study population consists of adults, age 18 or older on 1/1/2010, with I/DD and receiving services through the Georgia Medicaid Home and Community-Based Services (HCBS) waivers or state funding. Adults in the IRTC Group (N=325) transitioned from state hospitals into the community between July 2010 and June 2012. All other individuals receiving HCBS waiver or state funded services were included as the comparison group (N=12,722), individuals already residing in a community-based residence.

[1] Unless otherwise noted medication refers to psychotropic or anticonvulsant medication.

[2] In this truncated version of the paper we do not include results of findings by demographics, and some larger tables, but include discussion of significant demographic results. Please follow the link for the paper submitted to DBHDD for further details:
http://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/document/Attachment%205-Psychotropic%20medication%20QI%20study.pdf

The transition date for each individual was provided by DBHDD, and is used as an anchor point to identify before and after transition rates when analyzing medication utilization in the IRTC population. Since the greatest number of transitions occurred in June and July 2011, July 1, 2011, was used as the anchor date to analyze comparison group results. Figure 1 shows how the time spans for the two groups overlap.

Figure 1. Time Spans for the IRTC group and the Comparison Group



The analytic periods were defined as follows:

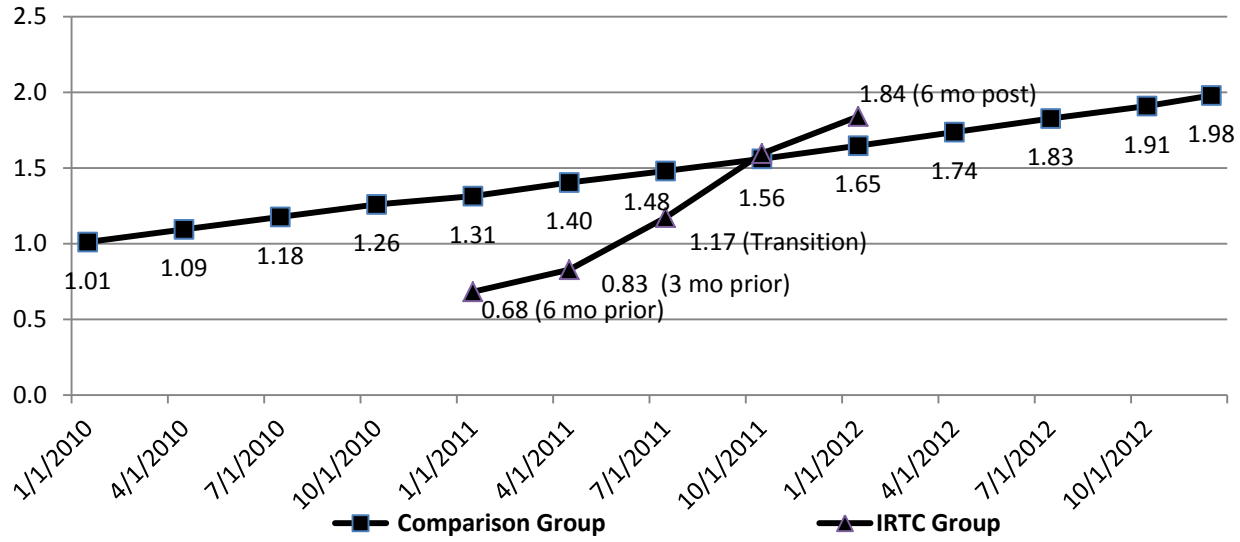
- IRTC Group: rates were calculated six and three months prior to transition, on the transition day, and three and six months post transition. The earliest pre transition date was in January 2010 and the latest post transition date was December 2012.
- Comparison Group: Analysis was completed from January 2010 to December 2012, representing the same span of time as for the IRTC group. Rates were calculated at three-month intervals, consistent with the IRTC Group.

Average Medication Utilization

The average number of medications was calculated for the IRTC group at the specified times and for the comparison group at three-month intervals. The number of medications per individual ranged from one to six. The "shorter" line in Figure 2 shows results for individuals who transitioned, anchored around the transition date and positioned mid point on the comparison group "longer" line. However, there is not a one to one correspondence with the dates representing the comparison group rates.

Results in Figure 2 show an increase for the IRTC group, from 0.68 to 1.84, while average utilization for the comparison group increased from 1.01 to 1.98. Results from the 95 percent confidence intervals indicate the increases for both groups were statistically significant. However, the increase as individuals transitioned into the community was greater and faster. Prior to the transition date, the average utilization rate was significantly lower than in the comparison group on 1/1/2010. After transitioning to the community, there was no significant difference between the two groups.

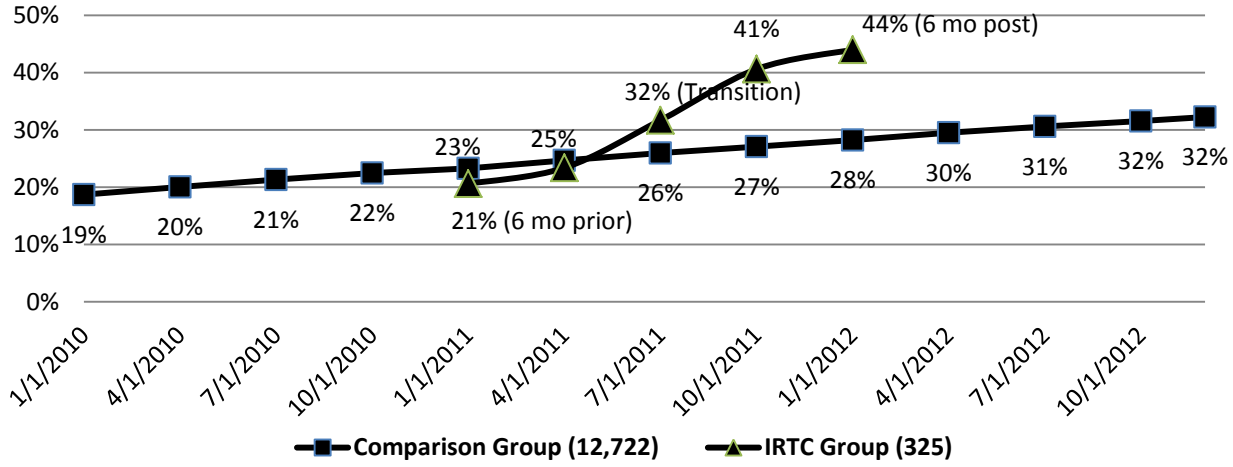
Figure 2. Average Number of Medications Prescribed
IRTC (N=151) v Comparison (N=4,371)



Prevalence Rates

Prevalence rates show the percent of adults prescribed one or more psychotropic medication and were calculated for the same time periods as indicated in Figure 2. The IRTC rate increased over 20 percentage points from 23 percent six months prior to transition to 44 percent six months post transition. There was a slower increase in the comparison group, 13 percentage points over the time period (from 19% to 32%). While the prevalence rates were approximately the same for the two groups at the start of the time period (1/1/2010 and six months pre-transition), by the end of the time period (12/31/2012 and six months post-transition), individuals who transitioned to the community were significantly more likely to be taking one or more medication (difference between 44% and 32%: Z-score=4.22, p < .000).

Figure 3. Psychotropic Medication Prevalence Rates (>=1 Medication)



Results for the IRTC group also indicate an increase in both the average use and prevalence rates from six months prior to transitioning up to the transition day. Overall, the average increased from 0.68 to 1.17 over this time period. The confidence intervals do not overlap indicating this trend may be a significant factor for individuals preparing to move into the community. Prevalence rates also increased as individuals prepared to transition from the institution, from approximately 21 percent to 32 percent. This increase is also shown to be statistically significant, with a Z-score of 3.2 ($p < .001$).

Discussion

As of December 31, 2012, 32 percent of Georgia adults with I/DD were prescribed at least one psychotropic medication. This is similar to the prevalence reported by the cross-sectional study from Australia (Doan, Lennox, et. al., 2013), which was conducted between 2000 and 2002 among adults with I/DD living in the community of Brisbane, Australia. Of the 117 participants, 35 percent was prescribed psychotropic medications. In addition, similar to trends noted in the NCI data (NCI Consumer Survey Georgia State Report, 2005-2011), findings in this study indicate that psychotropic medication use has increased significantly among all individuals with I/DD who are receiving services through the Georgia Home and Community-Based Services Waivers or through state funding.

Key findings indicate that psychotropic medication use and prevalence have significantly increased in this population in Georgia, and for individuals who have recently moved from an institutional setting to the community the increase has been significant and dramatic. Findings suggest that individuals are not only taking more psychotropic medications (increased average number) as they move through the transition process, but individuals are significantly more likely to take at least one of these types of medications as well (increased prevalence). These results appear to be independent of the overall trend in the population, indicating something about the transition process may be impacting medication use and the management of new and/or additional behavioral challenges. In institutions, services may be provided by the same providers and psychologist for many years, providing consistency for the person and a reduced need for medication therapies. While in the community, individuals may be medicated to compensate for the less restrictive environment with inconsistent provider supports.

Data in this study also indicate medication use in the IRTC group began to increase prior to the actual transition day. The reason for this is not clear. It is clear, however, that as individuals begin discussing and learning about transitioning, they may become frustrated or fearful of the change and this may manifest in challenging behaviors and increased medication use. Whatever the reason, the increased use of psychotropic medications prior to leaving the institution reinforces the importance of utilizing a thorough and effective transition process where the person has adequate time to work with a support coordinator/case manager and learn about new providers and the new environment.

Increases in the prevalence and average medication use during the transition process were significant across all the different demographic categories over time; and appear to indicate no

demographic group was impacted more than others. While the sample sizes were relatively small, some relationships were robust enough to be statistically significant at this level of analysis (without controlling for other factors). Older individuals who transitioned were much less likely to be taking a psychotropic medication than their younger counterparts, the opposite true for individuals already living in the community. Furthermore, individuals with profound ID who transitioned were much less likely to take a psychotropic medication than individuals with mild to moderate ID, also opposite to what was found among individuals already living in the community.

Each state should consider conducting an analysis of the current transition process to ensure specific, competency based training is occurring with direct service providers to help them adequately assess and manage the use of psychotropic medication and challenging behaviors; particularly for providers who may not be familiar with the more complex behavioral and medical issues of individuals coming to them from institutions. Demographic characteristics should be included as mitigating factors, particularly age, disability, and residence. The transition process should begin early and include all relevant staff, providers and family members; and include, at a minimum, a pharmacy review and medication reduction plan for people prescribed psychotropic or similar types of medications.

The medical community could benefit from educational programs on behaviors typically associated with I/DD psychiatric or behavioral disorders that are actually medical issues, such as a Urinary Tract Infection or dental issue that could exhibit as unusual or challenging behaviors not resultant of a mental illness. Results in this study suggest some of the challenges of transitioning individuals to the community are being addressed through chemical controls, challenges that may be reduced through an effective transition process that helps ensure the continued health and safety of individuals striving to maintain an every day life in the community.

It is important to monitor and control the use of psychotropic medication among people with I/DD who are more vulnerable than individuals in the general population. They may be subject to overmedication and the use of physical and/or chemical restraints to address challenging behaviors. There are often ethical concerns in prescribing such medications if individuals are unable to give consent to their own treatment. Findings point to a steady increase in the use of psychotropic medications in the state, as well as a more pronounced and rapid increase among individuals who are transitioning to communities from state institutions. Because people all over the country are transitioning from institutions to less restrictive environments, the findings in this study have broad implications.

REPORT EXAMPLE FIVE

Denials Report	
Background	GCAL has been submitting the denials report to DBHDD for several years. This report captures how many times each Crisis Stabilization Unit (CSU), Behavioral Health Crisis Center (BHCC) and State Contracted Bed Facility (SCB) denies individuals referred for their services and what reason was given for each denial.
Value of the Report	Used in conjunction with CSU Beds Inventory Status and Census reports, this report assists DBHDD and Regional Office staff in identifying trends in over-utilization of the state hospital in some regions and under-utilization of CSUs in some regions that may be contributing to the state hospital over-utilization. In some regions, particularly SPOE regions, these denials are tracked by the Regional Office and mapped to beds inventory and census data for discussions about inappropriate denial of individuals meeting level of care guidelines. Facilities denying for acuity milieu and high acuity receive technical assistance from the Regional Offices on contract expectations and, at times, offered training related to caring for individuals with high acuity. This report will also allow the ASO to monitor performance expectations for these contracts.
Analytical Process and Data Integrity Verification	All referrals to CSUs, BHCCs and SCBs that are made through GCAL are tracked. Denials are time stamped upon receipt by the CSUs in SPOE regions and by GCAL staff in non-SPOE regions. Each month, the report is meticulously analyzed to ensure that there are no duplications and that cancelled referrals are not included.
Report usage	This report is used to inform key stakeholders regarding the performance of these services and forms the basis for updates in the performance improvement system and measures.

Excerpts from this report are provided on the following pages.

Age Group	(Multiple Items)
Crisis Region	(Multiple Items)

GCAL Outcomes Report April 2	Referral Outcomes		
Provider Region, Provider Type, Provider	*Acceptance - Referral Acceptance	Denial - Acuity Milieu	Denial - Acuity To High
Region 1	**425**	**79**	**12**
CSU	**378**	**64**	**0**
Avita CSU, Avita Commu	54	5	0
Cobb/Douglas Crisis Sta	57	20	0
Rome Adult CSP, Highla	60	7	0
RTU / Residential Treatı	104	18	0
Treatment Services, Hig	103	14	0
Private IP	**13**	**9**	**8**
Floyd Behavioral Health	2	1	3
Laurelwood, Northeast	3	2	2
New Vision, Wellstar Co	0	0	0
Ridgeview Institute, Rid	2	0	0
Wellstar Behavioral Hea	3	4	1
Westcott Center, Hamil	3	2	2
SCB	**34**	**6**	**4**
APS Wellstar Behaviora	20	4	3
APS Laurelwood, North	11	0	1
APS Floyd Behavioral He	3	2	0
Region 2	**75**	**7**	**8**
CSU	**56**	**2**	**5**
River Edge C&A CSP (14	21	0	0
Serenity CSU, Serenity I	16	1	4
The Recovery Center, R	7	0	1
Vantage Point CSP, Adv	12	1	0
Private IP	**12**	**3**	**3**
Behavioral Health Cente	1	0	0
Center for Behavioral H	4	0	1
East Central Regional H	0	2	0
Lake Bridge Behavioral	7	0	1
Lighthouse Care Center	0	0	0
Medical College of Geo	0	1	1
State IP	**7**	**2**	**0**
East Central Regional H	7	2	0
Region 3	**479**	**26**	**61**
CSU	**79**	**7**	**11**
DeKalb Regional Crisis C	24	0	0
Summit Ridge, Universa	0	0	0

View Point Health - GR	42	3	0
View Point Health Adul	13	4	11
Detox	**18**	**0**	**0**
Newport Detox, Newpo	17	0	0
St Jude's Detox, St Jude	1	0	0
Private IP	**64**	**17**	**40**
Anchor Hospital, Southe	19	0	1
Atlanta Medical Center	3	5	10
Atlanta Medical Center,	10	8	11
DeKalb Medical Center,	0	0	1
Eastside Heritage, Easts	4	3	12
Emory Medical Center,	2	1	1
Georgia Regional Hospi	0	0	0
Grady Health Care, Gra	0	0	0
Lakeview Behavioral He	3	0	1
Peachford Hospital, Uni	15	0	1
Riverwoods, Accadia	4	0	2
Summit Ridge, Universa	4	0	0
Wesley Woods - Geriat	0	0	0
SCB	**168**	**1**	**10**
APS Summit Ridge, Univ	24	0	0
APS Peachford Hospital	87	0	5
APS Anchor Hospital R6	19	0	2
APS Anchor Hospital R1	38	1	3
State IP	**150**	**1**	**0**
Georgia Regional Hospi	143	1	0
APS Georgia Region Ho:	7	0	0
Region 4	**258**	**51**	**17**
BHCC	**144**	**0**	**1**
Albany Area BHCC, Alba	46	0	0
Thomasville BHCC, Geo	62	0	1
Valdosta Area BHCC, BH	36	0	0
CSU	**75**	**42**	**0**
Albany Area CSU, Alban	15	7	0
Thomasville CSU, Georg	25	13	0
Valdosta CSU, BHS of Sc	35	22	0
Private IP	**37**	**7**	**11**
Archbold Northside Cer	7	1	5
Greenleaf Center, Acca	10	0	1
Phoebe Behavioral Hea	18	5	5
Turning Point, Universa	2	1	0
SCB	**2**	**2**	**5**
APS Greenleaf Center, A	1	1	3
APS Archbold Northside	0	1	2
APS Behavioral Health C	1	0	0
Region 5	**115**	**25**	**31**
CSU	**43**	**22**	**26**

Gateway BHS Glynn CSU	1	0	0
John's Place CSU, Pinel	11	0	13
Lakeside C&A CSU, Geo	8	19	0
Quentin's Place CSP, CS	9	0	9
St Illa CSU, Satilla Comn	14	3	4
Private IP	**47**	**2**	**5**
Center for Behavioral H	4	1	2
Coastal Behavioral Heal	27	1	3
Coastal Harbor C&A Tre	9	0	0
Georgia Regional Hospi	1	0	0
Saint Simons By The Sea	6	0	0
State IP	**25**	**1**	**0**
Georgia Regional Hospi	25	1	0
APS Georgia Regional H	0	0	0
Region 6	**316**	**129**	**41**
BHCC	**20**	**0**	**0**
The Bradley Center BHC	20	0	0
CSU	**167**	**120**	**0**
Hope Corner C&A CSU,	19	21	0
Phoenix Pointe CSU, Ph	19	57	0
Pine Woods Crisis Stabi	56	18	0
Second Season, Pathwa	59	16	0
The Bradley Center Cris	14	8	0
Private IP	**81**	**9**	**34**
Bradley Center, St. Fran	19	2	16
Crescent Pines Hospital	5	1	0
Riverside Treatment Ce	34	2	11
Willowbrooke, Tanner I	23	4	7
SCB	**47**	**0**	**7**
APS Crescent Pines Hos	14	0	2
APS Willowbrooke at Ta	15	0	3
APS Willowbrooke at Ta	18	0	2
APS Bradley Center, St.	0	0	0
State IP	**1**	**0**	**0**
APS West Central Georg	0	0	0
APS West Central Georg	1	0	0
OOS	**0**	**0**	**0**
Private IP	**0**	**0**	**0**
Aurora Pavilion, Univer:	0	0	0
Grand Total	**1668**	**317**	**170**

Age Group	(Multiple Items)

GCAL Unique Crisis Episodes	
Crisis Region	Count of Episode
Region 1	809
Region 2	150
Region 3	490
Region 4	339
Region 5	189
Region 6	375
Grand Total	2352

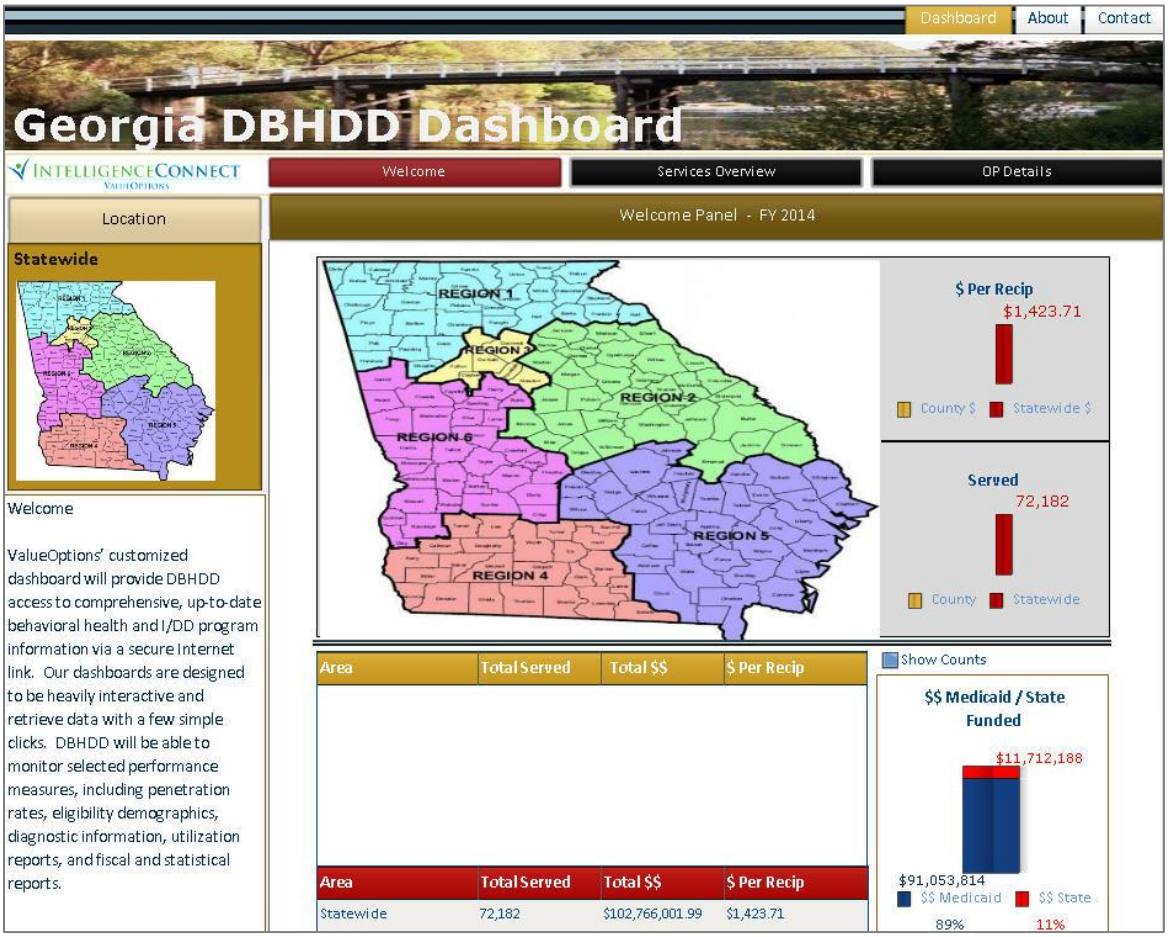
Average Referrals before Final	2.18

Denial - Acuity To Low	Denial - Beds Full	Denial - Clinical Acuity	Denial - Distance/Transportation	Denial - Do Not Admit List
4	669	4	4	4
0	236	4	0	0
0	26	1	0	0
0	12	0	0	0
0	139	0	0	0
0	2	0	0	0
0	57	3	0	0
3	213	0	4	4
0	2	0	2	1
0	114	0	0	1
0	1	0	1	0
0	16	0	0	0
3	76	0	0	0
0	4	0	1	2
1	220	0	0	0
1	116	0	0	0
0	104	0	0	0
0	0	0	0	0
16	196	0	5	0
1	187	0	3	0
0	31	0	0	0
0	43	0	0	0
1	55	0	2	0
0	58	0	1	0
3	9	0	1	0
0	1	0	0	0
1	1	0	0	0
1	0	0	0	0
1	3	0	0	0
0	1	0	0	0
0	3	0	1	0
12	0	0	1	0
12	0	0	1	0
5	494	1	11	6
1	338	1	7	0
0	152	0	5	0
0	1	0	0	0

ATTACHMENT L.3

L.3 In Attachment L.3, **(text response limited to one (1) page per dashboard)**, provide up to three examples of Dashboards. Describe your Dashboard functionality and security features.

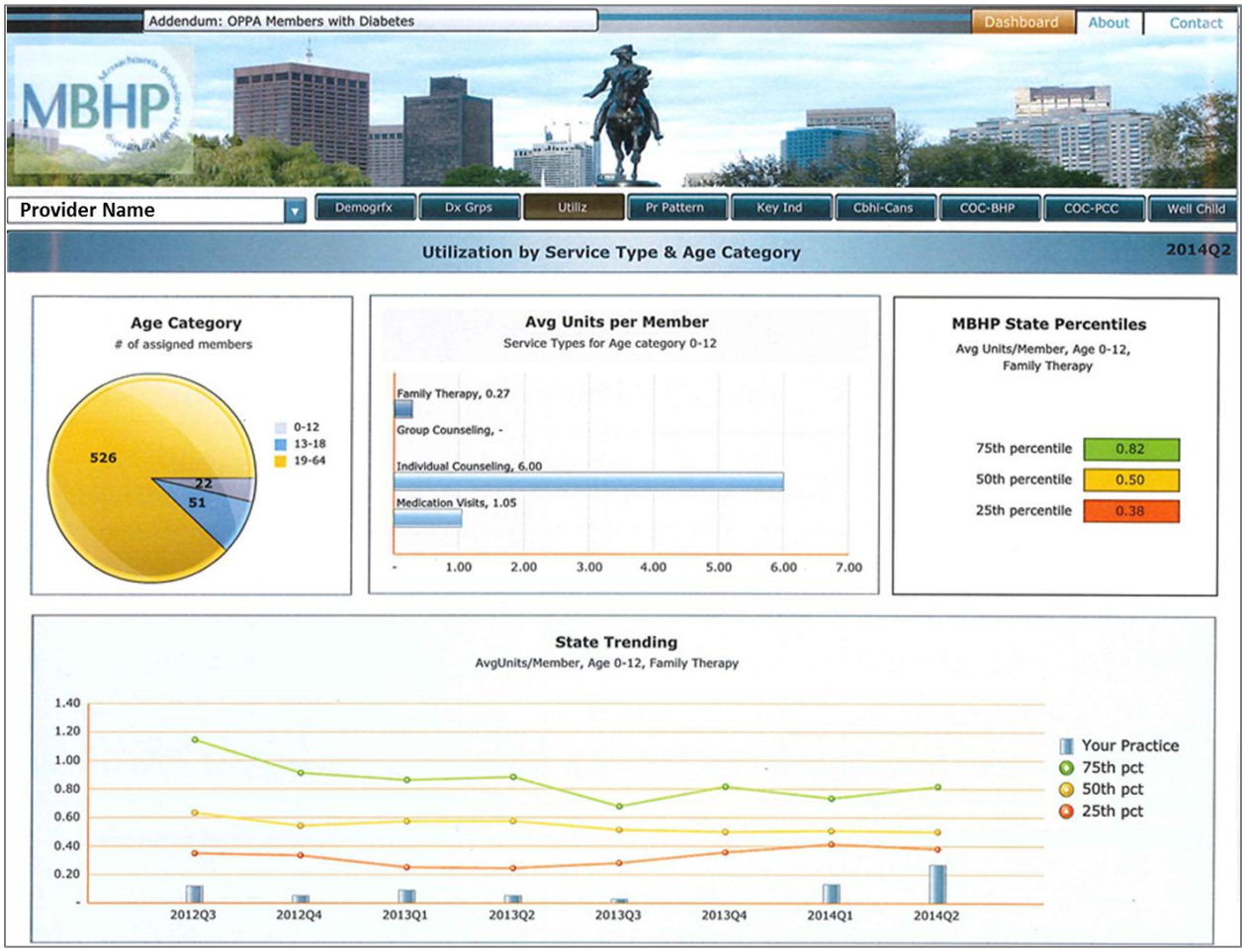
InfoView is the IntelligenceConnect user interface that simplifies information access and helps users to be more productive. It provides a single Web interface to access and interact with any type of Business Intelligence application—including reports, queries, analytics, and dashboards. Our online portal also leverages the Business Objects security configuration allowing content and features to be customized based on login. This functionality facilitates ValueOptions ability to restrict or grant individual users rights to specific folders, report objects, dashboards, or limit functionality within WebI. The single sign-on feature of IntelligenceConnect streamlines user credentialing while enforcing password and security standards. DBHDD and provider level security will be in place with the flexibility to scale to additional levels as needed. We will work with DBHDD to develop the DBHDD "home page" and the custom suite of reports that will meet the program's needs. We provide an example of the IntelligenceConnect dashboard that we will develop specifically for this program in the screenshot below:



OUTPATIENT PROVIDER PRACTICE ANALYSIS (OPPA) DASHBOARD

For our program in Massachusetts, we converted the static OPPA paper reports into a dashboard presentation. These reports, which are updated quarterly, allow our Regional Network Managers to present and manipulate data in real time during provider meetings. This dashboard allows the data to become a dynamic part of the conversations held with outpatient providers. The data in the report is benchmarked against similar size providers. All categories of contracted outpatient providers receive this profiling data who have had a minimum of 50 "assigned" members, including outpatient clinics, hospital based outpatient clinics, group practices, and individual practitioners.

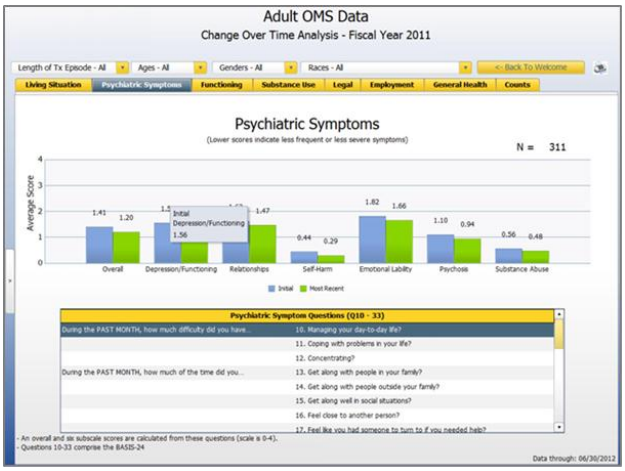
Many of the indicators on the OPPA reports address access. For example and shown below, the utilization data about number of units billed for outpatient services. MBHP assesses the provider to see if the provider offers adequate resources to members for therapy, medication management, groups, and family treatment. There is also data about the number of MBHP members who are receiving medication visits with no other billed services. This indicator can be used to discuss whether a provider has enough clinicians to access therapy.

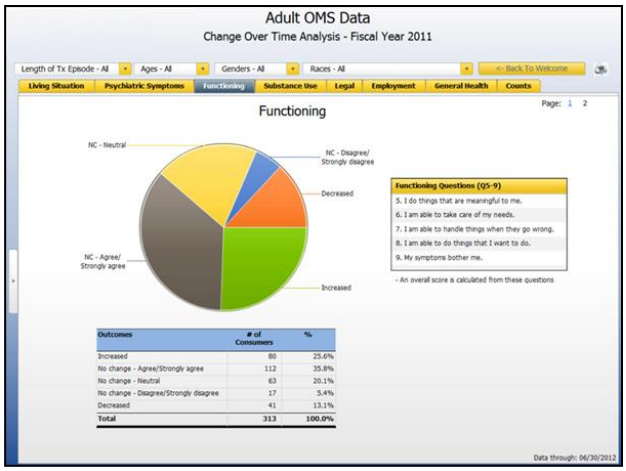


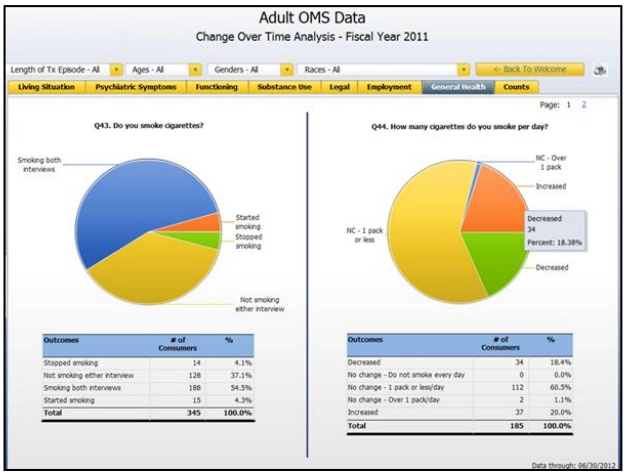
OUTCOMES MANAGEMENT SYSTEM (OMS)

Another example of our dashboard capabilities is our OMS dashboard. We collaborated with the Maryland Mental Health Authority (MHA) to develop this highly custom solution to meet the needs of the MHA contract. This dashboard tracks outcomes of services delivered at outpatient mental health centers throughout the state of Maryland. With OMS, state and county administrators and providers can log into a Web-based dashboard that tracks how individuals' in outpatient services progress in various aspects of their lives, such as housing, employment or school, psychiatric symptoms, substance use, overall functioning, legal involvement and physical health. Users are able to select a variety of analyses, such as time period, geographic region and individual demographics.

For our Maryland program specifically, data is grouped by eight life domains and enables filtering on dimensions such as county, age category, gender, or race. An outward facing dashboard is available to individuals, providers and state and county agencies. We also provide an ad hoc query environment for key state stakeholders to further analyze data. The system then enables the end user to filter the data on data dimensions such as county, age category, gender, or race. Screenshots of the OMS dashboard are provided below.







ATTACHMENT L.4

L.4 In Attachment L.4, **(limit three (3) pages)**, propose outcome measures for mental health, addictive disease, and IDD Target Populations under this Contract. Describe how data will be collected, analyzed, and reported. Describe how these measures would assist DBHDD in meeting it's goals for the service delivery system.

OUTCOME MEASURES

In collaboration with DBHDD's Quality Committee, we will utilize nationally recognized outcomes tools, such as:

- **Standard applicable HEDIS measures:** HEDIS measures provide nationally comparable outcomes information to gauge program effectiveness, including:
  - Anti-depressant medication management
  - Initiation and Engagement of Alcohol and Other Drug
  - ADHD Follow-up
  - Anti-psychotics and Metabolic Syndrome Management
  - Follow-up after Mental Health Hospitalization

- **Clinical outcomes measures:** These measures provide nationally validated measures for improvement with individuals focusing on condition specific symptoms/functioning and with population health measures. These also help distinguish providers of excellence for inclusion in our ValueSelect tiered network process and include:
  - Clinical outcomes symptom impairment measures, such as:
    - PHQ-9 for depression
    - SF-12 for functional assessment
    - GAD-7 for anxiety
    - AUDIT for alcohol use
    - WHO-DAS for global level of impairment
  - Georgia specific treatment improvement instruments, such as:
    - LOCUS
    - National Outcome Measure (NOMS)
    - On Track
    - PCR and QEPR record review

- **Non-clinical Outcome Measures**: These measures provide outcome-focused data to track and trend the quality of critical aspects of each individuals's life, such as health, safety, provision of rights, person-centered planning, informed choice, and community integration. They include measures appropriate to all populations and measures to address CMS's new HCBS residential setting requirements, such as the number and percent of individuals:
  - With a plan that includes advance directives regarding preferences in times of crisis
  - Who participate in community activities when they want to
  - Who have informed choice
  - Given the option to self-direct
  - In provider owned/controlled HCBS residential settings who can have visitors at any time
  - In provider owned/controlled HCBS residential settings who chose and have their own bedroom

- **Process measures:** These measures focus on process steps and service related outcomes that inform the overall effectiveness of the QM system. They also help distinguish providers of excellence for inclusion in our ValueSelect tiered network process and include:
  - Hospital readmission
  - Documentation of coordination of care between providers
  - Annual physicals
  - HRST annual updates
  - Provider capacity and qualifications
  - Development of social roles
  - Inappropriate use of emergency room
  - Days in the community
  - Routine screening for substance use disorder
  - Annaul ISP updates and as needs change
  - Tracking progress on goals

- **Utilization measures:** These measures focus on the effective use of resources to inform re-balancing of programmatic efforts and include:
  - Inpatient and higher LOC admission rates
  - Intermediate LOC units per 1,000
  - Mobile crisis dispatched
  - Residential crisis placements
  - Authorized IDD State-funded services used
  - Inpatient and higher LOC days per 1,000
  - OutpatientLOC units per 1,000

DATA COLLECTION, ANALYSIS AND REPORTING

ValueOptions recognizes that measuring and managing individuals' health outcomes is an essential part of delivering high-quality, cost effective services. Monitoring care processes is certainly a critical element of an effective behavioral health program, but ultimately health care providers and managed care organizations are accountable for the outcomes they deliver. **We will customize our powerful CONNECTS platform and reporting capabilities to develop broad-based outcome measurements and reports.**

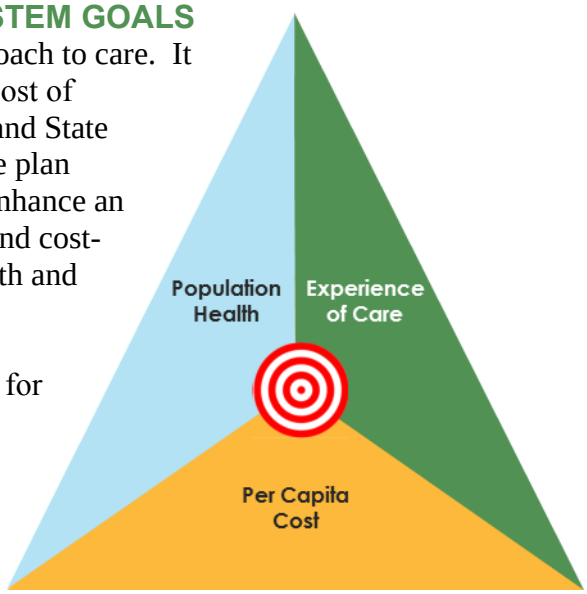
We will put our experience to work, creating flexible, custom capabilities to measure and reflect outcomes. Our advanced, state-of-the-art CONNECTS system provides broad Web-based reporting. To address specific measures, we will customize the following reports to meet DBHDD's needs:

- **Readmissions (claims)**
  - 30-, 60-, and 90-day readmission rates
- **Customer satisfaction (client, individual, provider)**
  - Overall percent satisfaction with services
  - Percent reporting improvement (if this is a question)
- **Network development and provider relations management**
  - Number of credentialed and recredentialed providers
  - Number of quality of care and/or service complaints
  - Outcomes of Provider Performance Reports

We will work collaboratively with DBHDD to identify other outcomes measures and targeted populations that will continue to enhance the behavioral health and IDD program.

MEETING DBHDD'S SERVICE DELIVERY SYSTEM GOALS

Our entire program is guided by a whole-person approach to care. It focuses on an individual's goals and needs, the total cost of individualized care and collaboration with providers and State stakeholders to manage and support an integrated care plan model. This strategy aligns with DBHDD's goal to enhance an individual's access to a more complete, coordinated and cost-effective system of community-based behavioral health and IDD services and supports. It also adheres to our commitment to the Institute for Health Care Improvement's "Triple Aim" of achieving better care for individuals, improving health of all populations and reducing the per capita cost of care.



By providing a fully integrated system by seamlessly linking GCAL, streamlining the registration and authorization process, promoting holistic, person-centered care coordination throughout the provider community and Regional Offices, and providing actionable data via our technology solutions, such as ProviderConnect, CareConnect, and Spectrum we demonstrate that we are committed to advancing values and principles that:

- Improve the quality of behavioral health and IDD services received through the Medicaid and state funded system by applying evidence-based strategies, data monitoring and management, and utilization and outcomes management
- Support an individual's rights and preferences through supportive home- and community-based services and resources
- Promote rapid access to qualified providers and community-based resources offering effective services and supports (i.e., "no wrong door")
- Focus on the whole health of individuals and improve the coordination of services received, especially for those with co-occurring behavioral health conditions and IDD
- Employ meaningful involvement of individuals, family members, peer-run organizations, and other stakeholders in decision-making and oversight
- Promote recovery, resilience and wellness for all individuals
- Deliver person-centered services and supports that promote independence, health and safety
- Incorporate state-of-the-art information systems and technologies that streamline administrative burdens, promote transparency and improve efficiency
- Utilize State resources in a cost-effective manner that improves treatment outcomes and the overall health and quality of life for individuals while reducing unnecessary expenditures

We are committed to furthering the development of an independence- and recovery-oriented system of care that is fully integrates the principles, practices and values of sustained support to each person in the system. Our **"High Assurance"** approach to administration and comprehensive systems of care will help realize DBHDD's vision of effective treatment, reduced costs and improved overall health for individuals in the program.

ATTACHMENT L.5

L.5 In Attachment L.5, **(limit two (2) pages)**, provide examples of other performance measures that you would recommend for Contract implementation.

We recommend tracking many of the outcome measures identified in DBHDD's quality management plan. In keeping with the plan, we will collaborate with the Quality Committee to obtain and utilize measures that will increase the overall system effectiveness leading to an improved the quality of life for all individuals served by DBHDD providers. In the table below, we provide other recommended performance measures that we are willing to negotiate with DBHDD for consideration and contract implementation.

Key Performance Indicators, Target Population and Reporting Method	DBHDD Goals and Collection Method
Housing Stability: Percent of Georgia Housing Voucher Program (GHVP) adult mental health individuals in stable housing for greater than six months. Denominator = all consumers enrolled in the GHVP during the month.	**Goal:** Independence and integration (stability) **Collection Method:** Provider monthly report, onsite audits or authorization tool
Housing Stability: Percent of GHVP adult mental health individuals who have left stable housing under unfavorable circumstances and have been re-engaged and re-assigned vouchers. Denominator = all consumers who are and were enrolled in the GHVP during the calendar month	**Goal:** Independence and integration (reengagement) **Collection Method:** Provider monthly report, onsite audits or authorization tool
Supported Employment: Percent of adult mental health supported employment providers that meet a caseload average of employment specialist staff to consumer ratio of 1:20. Denominator = number of contracts DBHDD Community Mental Health holds for support employment.	**Goal:** Efficiency (caseload size) **Collection Method:** Provider monthly report, onsite audits or authorization tool
Supported Employment: Percent of unduplicated adult mental health individuals who had first contact with a competitive employer within 30 days of enrollment. Denominator = number of settlement criteria consumers who started supported employment services during the quarter.	**Goal:** Effectiveness **Collection Method:** Provider monthly report, onsite audits or authorization tool
Assertive Community Treatment, Intensive Case Management, Community Support Teams, and Case Management: The percent of adult mental health ACT, ICM, CST, and CM consumers who are enrolled within three days of referral. Denominator = total number of consumer enrollments (consumers who started services) during the month.	**Goal:** Accessibility (enrollment) **Collection Method:** Provider monthly report, onsite audits or authorization tool
Assertive Community , Intensive Case Management, Community Support Teams, and Case Management: The percent of adult mental health ACT, ICM, CST, and CM consumers admitted to a psychiatric hospital within the past month. Denominator = census on the last day of month minus the number of enrollments during month.	**Goal:** Treatment effectiveness (admissions) **Collection Method:** Provider monthly report, onsite audits or authorization tool

Key Performance Indicators, Target Population and Reporting Method	DBHDD Goals and Collection Method
Assertive Community, Intensive Case Management, Community Support Teams, and Case Management: Average number of jail/prison days utilized per enrolled adult mental health consumer. Denominator = number of discharges during the month plus the census on the last day of the month.	**Goal:** Treatment effectiveness (incarceration) **Collection Method:** Provider monthly report, onsite audits or authorization tool
Assertive Community , Intensive Case Management, Community Support Teams, and Case Management: The percent of adult mental health ACT, ICM, CST, and CM consumers housed (non-homeless) within the past month. Denominator = number of consumers by living arrangement on the last day of the month.	**Goal:** Housing **Collection Method:** Provider monthly report, onsite audits or authorization tool
Addictive Disease: Percent of adult addictive disease consumers discharged from crisis/detoxification who receive follow-up services. • Follow up is defined as an authorization for a behavioral health service that demonstrates a connection.	**Goal:** Treatment/program effectiveness **Collection Method:** Provider monthly report, onsite audits or authorization tool
Addictive Disease: Percent of adult addictive disease consumers remaining active in treatment for 90 days after beginning non-crisis stabilization services. • Non crisis is defined as a service that is not a CSU admission.	**Goal:** Treatment/program effectiveness **Collection Method:** Provider monthly report, onsite audits or authorization tool
IDD: The percent of ISPs written to support either a Service Life, Good but Paid Life, or Community Life. Denominator = the number of waiver supported individuals who completed an ISP QA Checklist form. • Service Life means the individuals uses paid supports and services and has little to no connection with the community. • Good but Paid Life means the plan supports life in the community, but real community connections are lacking. The individual has both paid and unpaid supports. • Community Life means the ISP is written to move people toward a community life as the person chooses.	**Goal:** Individual Support Plan **Collection Method:** Provider monthly report and onsite reviews
IDD: The percent of crisis incidents that resulted in intensive home supports. Denominator = number of Mobile Crisis Team dispatches	**Goal:** Crisis Response System **Collection Method:** Provider monthly report, onsite reviews or GCAL data
IDD: The percent of Crisis incidents that resulted in placement of the individual in a crisis home. Denominator = number of Mobile Crisis Team dispatches	**Goal:** Crisis Response System **Collection Method:** Provider monthly report, onsite reviews or GCAL data
IDD: Number and percent of individual support plans that include informed consent on individualized plan of supports, are revised to address changing needs, and have proper oversight to ensure needed services are delivered and outcomes are achieved. Denominator = number PCR record reviews with documentation	**Goal:** Improved IDD transitions **Collection Method:** Collected during Person-Centered Review

ATTACHMENT M.1

M.1 In Attachment M.1, **(limit two (2) pages)**, provide a description of the Offeror's financial management system and the Offeror's ability to implement changes in reporting requirements or provide ad-hoc data requests as required by DBHDD, Department of Community Health, and CMS.

FINANCIAL MANAGEMENT SYSTEM

ValueOptions' financial system FinanceConnect, serves as our overall information management system to track, execute and report on all our financial transactions. It is comprised of an Oracle software supported Accounts Payable, Accounts Receivable and General Ledger functions and Hyperion software supported budgeting and forecasting functions. The General Ledger and related suite applications provide the ability to manage contracts, like the Georgia Collaborative ASO, in an efficient and effective manner.

The Oracle General Ledger system is a comprehensive financial management solution that provides advanced financial controls and data collection for ValueOptions' entire enterprise. The General Ledger system provides a robust account structure that supports full cost accounting including appropriate capture and reporting of direct, indirect and general and administrative costs. The system supports cost-plus, firm fixed price and time and material type contracts. It enables the detail accumulation of contract-level detail as well as the overall aggregate data.

The Oracle Accounts Payable Subsystem supports the related processes involving invoices, adjustments, and payments for supplied services and products. The basic components of the accounts payable system are the entry, inquiry, and reporting aspects typically found in an accounts payable system, along with the ability to receive the generated invoices from other system components. The Oracle Accounts Receivable Subsystem module provides the necessary functions to support the related processes involving invoicing, adjustments, and payments for supplied services and/or products.

Within FinanceConnect, we have the ability to track utilization and report financial results by funding stream through the use of the general ledger system and the finance reporting engines. Our Braided Funding^{SM} solution provides advanced financial controls and data collection of the Medicaid and non-Medicaid funds. We maintain separate general ledgers and payment accounts to represent each funding stream. We then leverage our data warehouse to segregate authorization/utilization information by funding stream and generate a weekly reimbursement request and detailed claims report. We have extensive experience providing this type of reporting for our State partners and will provide this in a format specified by DBHDD.

ValueOptions maintains a robust internal control system to ensure reporting by funding stream is accurate. Our National Revenue Reconciliation teams analyze the payment received from our client and split the payment into key data sets, such as distinct funding streams. Once completed, the payment and funding stream information accompanying the payment is compared

and reconciled with the eligibility data for which the payment is to be based, this information is provided to ValueOptions by the State's MMIS via a Payment Order/Remittance Advice – 835 electronic transactions. If any discrepancies are discovered, our Revenue Reconciliation team will work directly with DBHDD to make the necessary corrections. In addition, we will work with external auditors to complete additional analysis of the data for audits DBHDD requests to verify reporting at the funding stream level annually, or as needed.

AD HOC REPORTING CAPACITY

As stated in our response to *Section L, Data Management & Performance Measures*, our reporting platform, IntelligenceConnect allows ValueOptions to deliver a customized reporting solution to support DBHDD and State stakeholders. IntelligenceConnect offers DBHDD the ability to monitor selected performance measures and includes penetration rates, eligibility demographics, diagnostic information, utilization reports, and fiscal and statistical reports. In IntelligenceConnect, clients have access to dynamic reports that can be run on demand, as well as dashboards that present key performance metrics for easy analysis. This system allows us to develop very specific reports and conduct analysis as requested by DBHDD.

Within IntelligenceConnect, we utilize Crystal Reports for all production reports. Crystal Reports is the world's de facto standard in enterprise reporting solutions. It incorporates an intuitive report development tool that facilitates developers' and IT professionals' ability to rapidly create flexible, feature rich reports. Its primary purpose within IntelligenceConnect is the production of reports designed to meet the ongoing continuous needs of report consumers. We have used this tool to automate the production of many contractually required reports currently being produced for our State clients. Crystal Reports is also used currently to respond too many of the ad hoc reporting requests.

In addition, we utilize WebI, a Web-based query and analysis product that enables users to interact with business information, answer ad hoc questions, and perform deep dive/root cause analysis themselves with minimal knowledge of the underlying data sources and structures. Recognizing the varying degrees of technical aptitude within the user community, there are two levels of WebI offered to IntelligenceConnect users, Interactive WebI and Full Query WebI.

Interactive WebI was specifically designed for business users who need powerful analytical capabilities and whose focus is analysis not report development. Interactive WebI provides for integrated analysis of preformatted WebI reports allowing the user to "slice and dice" information using a menu of available data dimensions. Full Query WebI was developed for "power users" who are interested in developing their own sophisticated reports from scratch. Full Query WebI supports free-form query generation and basic report authoring with a full universe of possible data elements.

The power and flexibility of the Crystal Reporting tool coupled with the extensive scheduling and distribution features of the IntelligenceConnect interface allow for the generation and provision of the key reports prescribed in this eRFP. Additionally, the on-demand capabilities of parameterized Crystal Reports and the Interactive WebI Reports will help facilitate the rapid and efficient response to any ad hoc reporting request.

ATTACHMENT M.2

M.2 In Attachment M.2, **(limit one (1) page)**, describe the Offeror's process for certifying financial records submitted as reports.

We will certify provider payment information and annual financial audit and submit the required certifications to DBHDD by the timeframes outlined in *Appendix 26* of this eRFP. As required in the eRFP, ValueOptions' Chief Financial Officer will certify all provider payment information that will be used for rate setting purposes as part of this program by the 15th of each month. Additionally, we will certify and submit an annual financial audit of our program to DBHDD within 180 days of the end of our fiscal year.

We validate all electronic data transactions received by providers to ensure they meet the expected and defined file format. We perform integrity checks for data inside the file (header/trailer) and from data supplied from the submitter (number of records), verifying all critical data elements. If a file fails any one of these validation routines, an automated message is sent to the submitter.

ATTACHMENT N.1

N.1 In Attachment N.1, **(no page limit)**, provide a detailed start-up/implementation plan for this Contract. The implementation plan will include the following components:

a. The names of each implementation team member.
b. For each team member listed:
   i. Their credentials and relevant experience.
   ii. Their role and/or function.
   iii. The percent of time (as a percent of full-time equivalent) that they will be dedicated to the implementation of this Contract.
c. An implementation schedule that addresses all implementation requirements in Section 19 of Attachment J, Detailed Contract Deliverables. For each task, the schedule shall include the following components:
   i. The person or any named subcontractor(s) responsible for completing the task.
   ii. The date by which the task will be completed.
   iii. Progress measures, including milestones, risks, and constraints.

ValueOptions' highest priority is to ensure that the transition/implementation process safeguards the continuity and quality of care that participants receive, avoids client disruption and/or transition noise, and mitigates transition risk throughout the State.

PRE-CONTRACT TRANSITION PLAN

ValueOptions has a dedicated, core team of implementation experts that is led by Mr. Matthew Grenier, Senior Vice President of National Implementations. Mr. Grenier will be supported by a dedicated team of subject matter experts, staff, and project management professionals who are trained specifically in the unique processes and requirements necessary to successfully manage large and complex implementations. We will participate in initial implementation planning sessions with DBHDD and APS to coordinate and oversee the transition activities required in our respective areas of expertise.

ValueOptions' national leadership team will be available throughout the life of the contract. Mr. Grenier will be accountable for the implementation process for the DBHDD program; working under him will be Trish Raines, Implementation Project Director. Our implementation team will include oversight from our Executive Leadership Team, account management, and departmental leads from 20 different functional areas that are key to ensuring a successful, error-free implementation. These designated individuals are responsible for coordinating and overseeing the implementation activities relevant to their functional area or department (e.g., Claims, Customer Service, IT, Provider Relations, Quality Management). This structure ensures that the highest level of our organization is kept attuned to the implementation's progress, and ensures that any potential roadblocks and resource issues identified by the implementation team are immediately remedied.

A. AND B – IMPLEMENTATION TEAM

Detailed in the list below are short biographies of the experienced professionals who will provide implementation and ongoing support for DBHDD program. During implementation, the availability of our national resources may fluctuate and necessitate an alternative resource to be assigned; however, the level of commitment would remain the same.

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
Proprietary and Confidential		
Matthew Grenier: Senior Vice President, National Implementations	As Senior Vice President of National Implementations and Enterprise Projects at ValueOptions, Mr. Grenier is responsible for ensuring client implementations are seamlessly delivered. Mr. Grenier and his team use project management processes and controls to guarantee the implementations are well organized and executed on time. Additional responsibilities include ensuring enterprise projects are delivered on time with high quality. Prior to his employment with ValueOptions, Mr. Grenier was responsible for the project management office at Monster.com. Previously, Mr. Grenier led the Technical Writing team, Proposal Team, and Information Technology Project Management activity at Lodestar Corporation, an energy deregulation software company. Mr. Grenier earned a Master of Public Administration from the Sawyer School of Management at Suffolk University, and a Bachelor of Science degree in Administration from Salem State University.	10%
Trish Raines: Director, National Implementations	As Director of National Implementation for ValueOptions, Ms. Raines directly manages overall client implementations and operational projects. She is also responsible for establishing, organizing, and directing staff resources within National Implementations and other functional departments to support client implementation and operational project requirements and deliverables. She is accountable for performing capacity planning to ensure projects are properly resourced. Prior to her current position, Ms. Raines served as Director of Business Operations for ValueOptions where she was responsible for directing and managing business operations for public sector contracts. She also partnered with client, vendor, and state contacts to implement policy-driven operational changes and related technical interface. Ms. Raines received a Bachelor of Science degree in Health Services Management from East Carolina University.	80%
Mary Mastrandrea: Senior Vice President, Public Sector Division	Ms. Mastrandrea is Senior Vice President of the Public Sector Division for ValueOptions and is responsible for planning, organizing, and coordinating multiple Public Sector Division engagement center operations and overall performance. She establishes organizational structure, roles, and responsibilities, and ensures processes and procedures meet all contract requirements. Additionally, Ms. Mastrandrea oversees	20%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
Proprietary and Confidential		
	development of annual administrative and medical spending budgets, and monitors spending and variances to ensure financial and budgetary targets are on track. Ms. Mastrandrea has been with ValueOptions since 2007 and first joined the company as Chief of Operations at the ValueOptions' New Mexico Engagement Center, where was responsible for the day-to-day operations and overall management of the engagement center. She then became the Chief Executive Officer of the ValueOptions' Maryland Engagement Center. She has vast experience in the behavioral health care industry in different managerial positions. Ms. Mastrandrea received a Master of Social Work from Adelphi University, and a Bachelor of Arts in Social Work from the State University of New York at Stony Brook. She is a Clinical Licensed Certified Social Worker in the State of Maryland.	
Robert Flowe: Chief Financial Officer and Interim President of the Public Sector Division	Mr. Flowe is the Senior Vice President, Chief Financial Officer for all product markets, and Interim President of the Public Sector Division at ValueOptions. He is responsible for fiscal operations and holds profit and loss responsibility for all product lines. Prior to his promotion to this current position, Mr. Flowe was Chief Financial Officer and Chief Operating Officer for the company's public sector division, responsible not only for the financial operations of ValueOptions' largest division, but also for managing and ensuring continuity of the operational aspects of the division. His skill in understanding and balancing the priorities and needs of clients and their members with those of ValueOptions has made him a valued and respected client-facing financial representative. With more than 25 years with the company, Mr. Flowe has a broad range of experience in a variety of financial roles to support both provider and managed care operations. Mr. Flowe holds a Bachelor of Science in Accounting from Old Dominion University. He is also a Certified Public Accountant in the Commonwealth of Virginia.	20%
Deborah Hirschfelder, MS: Senior Vice President, National Quality Services	As Senior Vice President of National Quality Services at ValueOptions, Ms. Hirschfelder oversees all engagement center quality initiatives and directs all regulatory compliance. Ms. Hirschfelder has 28 years of experience within the health care industry. Before joining ValueOptions, she served as Principal of Hirschfelder HealthCare Consultants. She was also a health care consultant at PricewaterhouseCoopers. Ms. Hirschfelder received a Master of Science degree in Psychology from Southern Illinois University, and a Bachelor of	20%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
Proprietary and Confidential		
	Science in Psychology and Sociology from Washington University.	
Cindy Troxler: Senior Vice President, National Claims Operations	Ms. Troxler is the Senior Vice President of National Claims Operations for ValueOptions. Ms. Troxler has more than 25 years of experience in claims and service operations. Prior to joining ValueOptions, she was with Blue Cross Blue Shield of North Carolina as Vice President of Claim Operations. While there, she improved their claim accuracy and analytic capabilities, including creating a "Claims Command Center" that captured customer-facing metrics and developed staffing models that improved productivity and accountability for results. Prior to that, she worked for Health Net, Inc. as Vice President of Call and Claim Operations for its Northeast region and Arizona. She has also held leadership positions at CIGNA Healthcare and Jefferson-Pilot Life. Ms. Troxler received her degree from Franklin Pierce University.	5%
Lisa LaPlante: Senior Director, National Clams Operations	As Senior Director of National Claims for ValueOptions, Ms. LaPlante is responsible for claims operations for all lines of business across multiple engagement and operations centers. She directs claims implementations for new clients and programs, and oversees a management team to ensure all corporate and client goals are met. Prior to joining ValueOptions in 2002, Ms. LaPlante worked at Univera Healthcare for six years as a Compliance Director, and as a Senior Manager of Systems Configuration. Ms. LaPlante received a Bachelor of Science degree in Public Health Administration from The State University of New York.	10%
Karen Vendetti: Director, National Eligibility	In her role as the Director of Eligibility for ValueOptions, Ms. Vendetti has overseen more than 100 implementations, including Medicaid programs in Arkansas, Florida, Illinois, and Maryland. Annually, her department is responsible for loading more than 22,000 eligibility files containing more than 1 billion eligibility records. With over nine years of experience in the eligibility department at ValueOptions and more than 25 years of experience in the health care field, Ms. Vendetti is a Subject Matter Expert and has extensive experience managing professional-level teams consisting of business analysts, testers, and production staff, with low employee turnover. She demonstrates proficiency for implementing and improving business processes and workflows with a strong focus on staff development. She is committed to excellence and maintaining customer and client satisfaction and is skilled in problem solving and analysis, project management, and quality assurance. Before joining ValueOptions, Ms. Vendetti worked for Blue Cross Blue Shield of New Hampshire.	10%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
Proprietary and Confidential		
Amy Daversa: Director, National Systems Configuration	As Director of Corporate Systems Configurations with ValueOptions, Ms. Daversa oversees the management of plan design and administration for new and existing clients. Her primary responsibilities include managing and facilitating implementations of new plan designs and regulatory requirements, as well as providing ongoing contract performance compliance and stakeholder satisfaction. Her responsibilities span across all divisions, including Employer Group, Health Plan, Public Sector, and Federal Agencies. Ms. Daversa has more than 19 years of combined management and operational experience in the health care industry. Her areas of expertise include project management, strategic planning, and business process improvements. Ms. Daversa holds a bachelor's degree in Business Administration from the College of Saint Rose.	10%
Janice Maurizio, MSW: Senior Vice President, National Clinical Services	As Senior Vice President of National Clinical Services, Ms. Maurizio oversees all clinical operations within ValueOptions. She is responsible for implementations, managing clinical requests, and ensuring clinical departments meet all regulatory and contract-specific standards. She works with all ValueOptions' operational areas including claims, system configuration, and customer services, ensuring departmental processes and systems are aligned to provide quality services for all clients. Ms. Maurizio has more than 20 years of experience in the mental health industry. She was previously employed at Oneida County Mental Health Adult Mental Clinic and Day Treatment Program in New York. While on staff at the mental health clinic, Ms. Maurizio assisted in developing a program to serve the chronically mentally ill population in Oneida County. She also held a position at Project Strive—a preventive service program for children—and conducted medical social work at St. Clare's Hospital. She received a Master of Social Work from State University of New York.	5%
Robert Foley: Vice President, Disability Related Programs	Mr. Foley has more than 12 years of direct experience developing, implementing, and managing QA programs for service delivery systems supporting individuals with intellectual and developmental disabilities. In addition, he has over 15 years of direct experience relating to the management of support coordination, supported employment, and residential programs for individuals with intellectual and developmental disabilities living and interacting within their communities. Mr. Foley oversees Delmarva Foundation's quality assurance/improvement contracts in Florida, Georgia, and California. He has been involved in each program since inception, and has taken an active role in development,	5%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
Proprietary and Confidential		
	implementation, and operation activities. His responsibilities include liaison activities with provider groups and state personnel at both local and statewide levels, oversight of production activities, management of contractual obligations, and development of new initiatives. Mr. Foley earned a Bachelor of Arts in Psychology from Miami University in Oxford, Ohio.	
Susan Kelly, Ph.D.: Senior Scientist	Dr. Kelly joined Delmarva in 2004 as a Social Research and Evaluation Scientist. Her role has grown over the years to encompass activities in the South Carolina, Georgia, and Florida Quality Assurance Programs. Her responsibilities include overseeing all aspects of data analysis and research/sample designs for ongoing and new project initiatives, overseeing two senior analysts, writing Quality Improvement Studies along with quarterly and annual reports, and providing ongoing analytical support. She has worked closely with subcontractors, directing them in the review and analysis of data for quarterly and annual reports, and for Pharmaceutical Drug Use studies. Dr. Kelly performs complex statistical analyses including multiple regression, logistic regression, spatial analysis (adjusting for spatial autocorrelation), principle component analysis, cost function analysis, and some work with path analysis. She has extensive experience working with large and complex data sets. Dr. Kelly received master's and doctorate degrees in Sociology from Florida State University. She has recently provided instruction in social research methods and statistics as an adjunct professor at Florida State University and Tallahassee Community College.	15%
Dan Edris: Director, Data Management	Mr. Edris has been with Delmarva for over 20 years. His role as Director of Data Management is to provide databases for capturing review and interview data, manage more than 20 database servers that contain many terabytes of data used across the organization, and maintain the appropriate level of security so all of the data is protected appropriately. He has extensive experience working with large and complex data sets. For the last four years he has been the IT Lead for the current Georgia Developmental Disabilities contract and the Florida Developmental Disabilities contract. Mr. Edris has significant experience providing database support for Delmarva's review activities, writing necessary extract, transform, and loading (ETL) procedures to incorporate external data into our systems, export data for our partners to use, and monitor access for all users of the contract data. Mr. Edris received a Bachelor of Science in Statistics from Virginia Polytechnic Institute and State University.	15%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
Proprietary and Confidential		
Marion Olivier, MSW: Project Director, GQMS	Ms. Olivier has been the Director of the Georgia Quality Management System since its inception in July 2008, and has been supporting efforts of continuous quality improvement to the service delivery system for citizens with intellectual/ developmental disabilities receiving services in Georgia. Ms. Olivier has been involved in conducing quality assurance and improvement activities in behavioral health and intellectual/developmental disabilities since 1995. Her field experience includes case management, counseling, quality assurance monitoring, quality assurance and improvement program management and development, technical assistance/consultation, and training. She has been with Delmarva Foundation since 2001 working on IDD state contracts for Florida, and is currently in Georgia. Ms. Olivier is also a monitor supporting quality improvement of ICF/MR facilities in California. Her accomplishments include policy development, design and implementation of quality assurance instruments, quality management program design, and curriculum development for statewide training. She has facilitated numerous statewide stakeholder workgroups to assist in quality improvement initiatives and public reporting of quality review results. Ms. Olivier received her Master of Social Work from Florida State University. She is the current Chair for the Georgia Chapter for the American Association on Intellectual and Developmental Disabilities (AAIDD).	25%
Gregg Graham, MBA: President and BHL Chief Executive Officer/ Managing Partner of Crisis Access Holdings, LLC.	As the President and Chief Executive Officer for Behavioral Health Link, Mr. Graham has more than 30 years of experience serving the behavioral health community in multiple capacities. Starting his career in community behavioral health, Mr. Graham served on a very early mobile crisis team. He has worked as a hospital administrator and is a member of the American College of Mental Health Administrators. Mr. Graham has also served on the national board of Mental Health America and on numerous local and statewide boards to advocate for suicide prevention. He has worked diligently throughout his career to ensure individuals have access to services they need. Mr. Graham holds a Master of Arts in Clinical Psychology from Appalachian State University, and a Masters in Business Administration from East Tennessee State University.	80%
Wendy Martinez Schneider, LPC: GCAL Director	Ms. Martinez Schneider has more than 16 years of professional experience in direct service and administration within both the public and private sectors. Currently, she works to ensure that Behavioral Health Link's Mobile Crisis and Crisis Call Center's clinical services are provided in accordance with clinical policies, procedures and protocols. She has significant	80%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
Proprietary and Confidential		
	experience with implementing mobile crisis programs in wide geographic areas, has run a 24-hour call center and mobile crisis program in a private psychiatric hospital system, and has significant experience in utilization management for specialty and inpatient programs. With many years of experience in community mental health programs in Georgia and Texas, Ms. Martinez Schneider has worked with some of the most seriously and persistently mentally ill individuals and has a strong commitment to ensure that individuals have access to appropriate services around the clock. Ms. Martinez Schneider holds a master's degree in Clinical Psychology from Marquette University, and is a Licensed Professional Counselor and Certified NAMI Family to Family Educator.	
Joe Cordero, MBA: Chief of Information Technology	Mr. Cordero is an IT professional with over 15 years' experience in IT support and management. Coming to Behavioral Health Link after serving as the Senior LAN Administrator for Grady Health Systems in Atlanta, Mr. Cordero has designed, participated and led many IT/telephony and construction projects. His expertise includes IT Management, IT Operations, IT Strategy, Project Management/Delivery Strategic Planning, Corporate Security, HIPAA Compliance, System Architecture, ITIL Standards, Risk Management, Disaster Recovery, Business Continuity, High Availability, SaaS, Web Applications Virtualization, VMWare, Hyper-V, Citrix, Cloud Technologies, Lync, Office 365, Server, Terminal Server, RDS, Active Directory, Networking, Cisco, SonicWall, VLAN, VPN, MPLS, VOIP, Avaya, and Nortel systems. Mr. Cordero holds a Master of Business Administration with an emphasis in Information Security Management from St. Leo University.	50%
D. Mark Livingston, LPC: Chief Innovation Officer	As the Chief Innovation Officer for Behavioral Health Link, Mark Livingston has more than 20 years of experience in behavioral health, both in the public and private sectors. A seasoned clinician with a strong background in child and adolescent services, Mr. Livingston's significant technology and clinical skills enable him to work diligently to apply technology to clinical practices. Mr. Livingston is the primary designer of BHL's website and its applications, including dashboards, the Mobile Crisis Dispatch System, and Referral Status Boards. He also has expertise in SQl Reports Builder, data management and reporting.	50%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
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	Mr. Livingston holds a master's degree in Community Agency Counseling and is a Georgia Licensed Professional Counselor, a Certified Professional Counselor Supervisor, and a Certified CPI Nonviolent Crisis Intervention Instructor.	
Gina Gibson, MPA, PHR: Chief Operating Officer	As the Chief Operating Officer, Ms. Gibson ensures that Behavioral Health Link's Call Center and Mobile Crisis Services operate smoothly. She first joined Behavioral Health Link as the Human Resources Director after serving the Georgia State Road and Tollway Authority as their Human Resources Manager. A U.S. Army Veteran with nine years of active service, Ms. Gibson is a results-oriented leader with strategic and tactical experience, skilled at identifying and leveraging resources to achieve business objectives. She has proven her ability to guide change and develop collaborative partnerships at all levels of an organization, both internally and externally. Ms. Gibson received her Master of Public Administration from Troy University, and she is a Certified Professional in Human Resources.	75%
Allison Trammell, MSW: Chief of Quality Management and Utilization Management	As the Chief of Quality Management and Utilization Management for Behavioral Health Link, Ms. Trammell ensures quality management processes are in place for both the Behavioral Health Link crisis call center and mobile crisis services. With more than 20 years of experience in public and private sector behavioral health, she has a strong background in staff development and has been instrumental in authoring the training curriculum for Call Center Clinicians. She has also served as a Behavioral Health Link liaison to the National Suicide Prevention Lifeline, the Veterans Crisis Line, and the Disaster Distress Helpline. Ms. Trammell received her Master of Social Work from Clark Atlanta University, and is a certified Applied Suicide Intervention Skills Trainer (ASIST).	50%
Holli Woods, MPA: Developmental Disability Outcomes Manager	As the Developmental Disability Outcomes Manager for Behavioral Health Link, Ms. Woods is responsible for ensuring that GCAL staff follow appropriate protocols related to the Georgia Crisis Response System for Developmental Disabilities. Ms. Woods works with DD Mobile Crisis providers, crisis homes, and regional and State officials to broker appropriate crisis care. Ms. Woods has more than 15 years of experience working with individuals with IDD. She worked at Northwest Georgia Regional Hospital in Rome, Georgia, in both direct care and as a planning list administrator assisting individuals to access needed waiver services. She also has a strong background in child protective services work and advocacy work for victims of domestic violence. Ms. Woods received her Master of Public	50%

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	Administration and is currently a second-year law student at John Marshall School of Law in Atlanta, Georgia.	
Bari Blake, LPC: Behavioral Health Outcomes Manager	As Behavioral Health Outcomes Manager for Behavioral Health Link, Ms. Blake is responsible for ensuring that protocols and processes related to mobile crisis dispatch and single point of entry services are successfully implemented. She reports daily compliance with performance metrics to call center staff. Prior to joining the Behavioral Health Link team in 2013, Ms. Blake worked in a private psychiatric facility for more than 20 years in several capacities, including Director of Utilization Management and Partial Hospital Manager. Her expertise lies in utilization management, case management, crisis intervention, and de-escalation/debriefing critical incidents. Ms. Blake holds a Master of Arts in Community Counseling from the University of Alabama, and has been a Licensed Professional Counselor in Georgia since 1994.	50%
Laura Beaver, LCSW: Director, National Clinical Services	Ms. Beaver is Director of National Clinical Services for ValueOptions, responsible for developing operating policies and procedures for the clinical management department, and monitoring utilization management in accordance with targets set by senior management. She uses specific reports to identify patterns and trends to ensure appropriate levels of care guidelines are followed by care management staff. Prior to joining ValueOptions in 2003, Ms. Beaver worked for Rocky Mount Academy as a Guidance Counselor, where she provided consultation to teachers and parents, and brief counseling to students, promoting student optimal academic functioning, and emotional well-being. Before that, she worked as a Clinical Social Worker for the Developmental Evaluation Center for the State of North Carolina. Ms. Beaver is a Licensed Clinical Social Worker in the State of North Carolina. She received a Master of Social Work from the University of North Carolina at Chapel Hill, and a Bachelor of Arts degree in Psychology from Trinity University.	20%
Josephine Hargis: Senior Vice President, National Customer Service	As ValueOptions' Senior Vice President of National Customer Service, Ms. Hargis has nearly 30 years of experience in health care, with the majority of that experience in a managed care setting. As a recognized leader in operations management, she has responsibility for the executive oversight and strategic direction of ValueOptions' Customer Service Operations, providing service to members of the Employer Solution and Health Plan Divisions' membership. In this role, she ensures that the development and implementation of strategies,	20%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
Proprietary and Confidential		
	systems, and methods to achieve operational efficiencies are in place to provide exceptional service to internal and external customers. Prior to joining ValueOptions, Ms. Hargis served as Assistant Vice President for Empire Blue Cross Blue Shield, New York's largest health insurer. She oversaw the dedicated operation serving more than one million members of the New York State Empire Plan, Empire's largest employer group. The dedicated operation included claims, customer service, benefits configuration, data management, and facilitating and responding to external audits conducted by New York's Civil Service Department. Prior to that, Ms. Hargis served as Director of Strategic Planning and Implementation, and Director of Customer Service with Kaiser Permanente, a leader in the managed care industry. In that role, she oversaw the implementation of new accounts, account management of strategic business partners, and the overall success of a multi-state customer service operation.	
Mary Golden: Senior Director, National Customer Service	Ms. Golden is a Senior Director of Clinical Customer Service at ValueOptions and is responsible for the oversight and strategic direction of the Health Plan Clinical Customer Service department. She has been with the company since 2003 and has more than 26 years of health care industry experience, encompassing both behavioral health and medical/surgical managed care organizations. Previous positions she has held at ValueOptions include Director of National Claims, Director of Service Operations and Project Manager in the Implementations and Operations Support team. Prior to joining ValueOptions, Ms. Golden was a Senior Manager and Director for Empire Blue Cross Blue Shield, where she was responsible for the overall operational success for claims, customer service and membership functions. Ms. Golden received a Bachelor of Science in Business Administration from Southern Vermont College.	30%
Sue Healey: Senior Director, National Claims Customer Service	Ms. Healey is Senior Director of National Claims Customer Service at ValueOptions, and is responsible for claims customer service, the provider service line, the electronic data interchange helpdesk, administrative appeals and complaints, and customer service quality development. Ms. Healey began her career at ValueOptions as the Manager of Claims Customer Service and Appeals and has gained additional responsibility throughout the years. Before joining ValueOptions, she held several positions at WellPoint, Inc. (formerly Empire Blue Cross Blue Shield), including Business Analyst and Supervisor of Appeals and Customer Service.	10%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
Proprietary and Confidential		
Kathy Burdick, RN: Director, National Clinical Customer Service	As Director of National Clinical Customer Service at ValueOptions, Ms. Burdick provides oversight of Engagement Centers to ensure quality, productivity, and telephone standards are met. She collaborates with Clinical Directors on all clinical matters and ensures that all calls are answered within established departmental and client-specific time standards. Additionally, Ms. Burdick ensures operational performance and budgetary targets are effectively monitored and achieved. Before working as Director of National Clinical Customer Service, she served as a Manager and Clinical Supervisor for ValueOptions. Ms. Burdick has been with ValueOptions since 1993. She received an Associate's degree from Maria College and is a Registered Nurse.	10%
Nancy Martin, MBA: Senior Vice President, National Network Services and Medicare Advantage Operations	As Senior Vice President of National Network Services and Medicare Advantage Operations at ValueOptions, Ms. Martin is responsible for overseeing national network strategy and services, including provider relations, contracting and credentialing. She also manages overall operation of the Medicare Advantage program for ValueOptions' clients. Prior to joining the company, Ms. Martin held a series of managerial roles at various health care companies, including Health Dialog, Coventry Health Care of Georgia, and CIGNA Healthcare. Ms. Martin has a Master of Business Administration from the American Graduate School of International Management, and a Bachelor of Arts from the University of Kansas.	5%
Cathleen Gilbert, PAHM: Vice President, National Provider Relations	Ms. Gilbert serves as Vice President of National Provider Relations for ValueOptions and has been with the company since 2002. She is responsible for the Provider Relations units in all Commercial and Public Sector Division Engagement Centers. Within this role, she is a part of the National Network Services Leadership Team and serves as the Provider Relations lead on company initiatives. Her prior positions during her tenure with ValueOptions included Director of National Provider Relations over the Commercial Division overseeing the New York, North Carolina, Texas, Michigan and California Provider Relations units, and Regional Director of Provider Relations for the Great Lakes Region. Ms. Gilbert came to ValueOptions from Great Lakes Health Plan (GLHP) where, as the Manager of Contracting, she was responsible for network development and maintenance, contract negotiations, and provider relations for all practitioners and facilities in Michigan. Ms. Gilbert earned a Master of Health Care Administration from Central Michigan University and a Bachelor of Arts in Social Work from Eastern Michigan	5%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
Proprietary and Confidential		
	University. She has also completed her certification as a Professional from the Academy for Healthcare Management.	
Josh Holte, MBA: Senior Director, National Provider Network Services Operations	Mr. Holte is the Senior Director of National Provider Network Services Operations at ValueOptions. Prior to joining ValueOptions, Mr. Holte worked for Aetna as Head of Medicare Claim Operations, where he was responsible for developing and directing long-range execution of the business area's strategic and operational business plans, and programs for member claims functions. He also directed establishment and implementation of service standards to ensure delivery of quality-focused, consistent, and cost-effective claims processing service and administration. Mr. Holte has over eight years of experience in the health care industry and management positions. Mr. Holte received a Master of Business Administration from Regis University, and a Bachelor of Science degree in Public Health Administration from Rutgers University.	5%
Rhonda Hernandez: Manager, Credentialing Quality and Committee Support	Ms. Hernandez is the Manager of Credentialing Quality and Committee Support for ValueOptions, and is responsible for managing credentialing projects, including development and implementation of policies and procedures to ensure compliance with NCQA, URAC and various state, federal, and client standards. Ms. Hernandez develops and manages workflows and work instructions for various processes to ensure quality and efficiency, and also analyzes and tracks data to ensure compliance with multiple client requirements. Ms. Hernandez worked for ValueOptions from 2005 through 2013 as a Networks Operations Manager and as Director of Credentialing. She went to Sentara Medical Group in 2013 as a Credentialing Manager, where she was responsible for managing the credentialing process for a large, multispecialty practice, and developing training documentation and a quality control process. In 2014, she returned to ValueOptions to assume her current position. Ms. Hernandez received a Bachelor of Arts degree in Organizational Management from Eastern University.	5%
Shaun Costello: Senior Vice President and Chief Information Officer, National Information Technology	As Senior Vice President and Chief Information Officer of National Information Technology of ValueOptions, Mr. Costello is responsible for core IT functions, including data center operations, telecommunications, technology planning and deployment, IT business support, and application development for all business-critical systems. Additional responsibilities include leveraging new technologies to improve business operations and competitive positioning, and developing strategic alliances with leading technology vendors.	5%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
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	Mr. Costello has served at ValueOptions for 15 years and has a total of 25 years of experience in progressively expanding responsibilities in IT operations and management. At ValueOptions, he has successfully established and directed multi-million dollar technology programs and carried out numerous large client implementations. Prior to his appointment as Chief Information Officer, Mr. Costello held the position of Vice President of Information Technology Hosting Services. He managed service delivery responsibility in the areas of corporate security, database management and data warehousing, systems administration and computer operations, document and production control, and facilities management. Before ValueOptions, he spent time at Charles E. Smith Companies, Sato Travel, and Intelligent Electronics. Prior to his civilian career, he served in the United States Marine Corps.	
Alicia Williams: Vice President, Regional Support Services, National Information Technology	As Vice President of Regional Support Services and National Information Technology (IT) for ValueOptions, Ms. Williams promotes the strategic direction, philosophy, IT standards, and principles of the organization. She participates in client and vendor presentations and meetings, and assists sales and proposal staff with technical reviews and responses to requests for proposals and requests for information. Additionally, Ms. Williams manages client and business unit expectations regarding IT services and performance. Prior to her appointment as Vice President, Ms. Williams served as Director of Business Systems Support for ValueOptions, directing a team of programmers, analysts, and consultants on gathering business requirements and creating functional design and technical specifications. She also served as Coordinator of Member and Provider Services. Ms. Williams is pursuing a Bachelor of Arts degree in Business Administration from Strayer University.	20%
Maria Hester, CFM: Vice President, Facilities & Purchasing, National Information Technology	Ms. Hester is the Vice President of Regional Support Services, National Information Technology for ValueOptions. She leads several key organizational initiatives, including the development of a Facilities Strategy, various client implementation infrastructure build-outs, strategic leasehold improvements and implementation of various rent reduction strategies. Prior to joining ValueOptions, Ms. Hester worked for L-3 Services, Inc. where she held operational support and budgetary responsibility for more than 1.2 million square feet of L-3 real estate in the United States and Asia. She was also responsible for managing and executing day-to-day operations, including accounting, job costing, contracts, and requisitions related to all corporate facilities. Before joining L-3, Ms. Hester	20%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
Proprietary and Confidential		
	served as a Facilities Manager for Equinix, Inc. where she directed and coordinated all aspects of corporate headquarters' facilities, regional offices and all office administration issues, including build-outs, renovations, drawings, and project management. Ms. Hester received a Master's Level Certification in Facilities Management from Michigan State University.	
Chad Rajpal: Vice President, IT Operations, National Information Technology	Mr. Rajpal is the Vice President of IT Operations and National IT for ValueOptions. Within this role, his responsibilities include managing all facets of IT operations in a large, growing infrastructure. He has established and led the corporate IT department, and managed a team of 138 individuals. His experience includes strategic and operational planning, team recruitment, leadership and resources allocation. Prior to joining ValueOptions, Mr. Rajpal served as Vice President of Network Operations for Comtech Mobile DataCom Corporation, where he provided executive leadership as the head of Operations and Technology. Before that, he served as Director of IT at TechTeam Global Government Solutions. Mr. Rajpal is currently pursuing a Master of Business Administration from George Washington University. He received a Bachelor of Arts degree in Information Technology from the Rochester Institute of Technology.	2%
Izhar Mujaddidi, MBA: Vice President, IT Security, National Information Technology	ValueOptions' Vice President of Information Technology Security and National Information Technology, Mr. Mujaddidi, is responsible for providing innovation, integration, and maintenance for a comprehensive information security program, encompassing overall budgeting, profit and loss, governance, and risk and compliance efforts. Prior to joining the company in 2011, Mr. Mujaddidi served as Senior Vice President and Chief Security Officer at TCAssociates where he directed operations, contributed to proposal development, and built and maintained business partnerships. Before that, he worked as an Information Assurance Program Manager in the Netstar-1 Government Solutions Office for the Air Force Surgeon General. Mr. Mujaddidi received a Master of Business Administration from Brenau University, and a Bachelor of Science degree from the American College of Greece in Athens, Greece.	2%
Keith Roberts, MS: Vice President, Data Services, National Information Technology	As Vice President of National IT Data Services for ValueOptions, Mr. Roberts assumes operational leadership responsibilities for the Database Services, Data Warehousing, and Electronic Data Interchange (EDI) teams. He is also responsible for crafting tactical plans to improve operational effectiveness, developing strategic plans around business and	10%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
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	technological trends in data, such as big data, data governance, enterprise data architecture standards, and real-time interoperability. Mr. Roberts has been with ValueOptions for more than 17 years and has served in a variety of progressively responsible roles within IT. During that time he has distinguished himself as an innovative leader who willingly takes on new challenges and develops customer-centric solutions. In his most recent role as Web Development Director, Mr. Roberts led the EDI area in introducing standard but flexible architectural frameworks that reduce time to market for new data exchanges. Prior to that, he was a key member of the core technology team that architected and developed the organization's flagship suite of applications that became the CONNECTS platform, and transformed ValueOptions' core business processes. Mr. Roberts earned a Master of Science in Computational Science from George Mason University, a Master of Science in Computer Science from Marymount University, and a Bachelor of Science in Mathematics from Tennessee Temple University.	
Dan Santmyer, FSA: Senior Vice President, National Data Analytics	Mr. Santmyer is Senior Vice President of National Data Analytics at ValueOptions. His client activities include analyzing provider reimbursement arrangements and provider contracts, communicating network performance to current and potential purchasers of health plan products, and cost and utilization reporting. Mr. Santmyer has worked in the health care industry since 1993. Prior to joining ValueOptions, he served as a principal and consulting actuary for Milliman. He also worked as Vice President of National Account Pricing, client reporting, and client consulting for WellPoint, Inc. Before joining WellPoint, Mr. Santmyer served as Senior Director of Group Pricing at Blue Cross Blue Shield of North Carolina. Mr. Santmyer received a Bachelor of Science degree in Mathematics from Loyola College, Maryland. He is a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries.	3%
Anthony Ritter, MPA: Director, Business Intelligence, National Data Analytics	Mr. Ritter is the technical owner of ValueOptions' Business Intelligence (BI) platform, IntelligenceConnect. He oversees all facets of hardware, software, and application configuration required to provide a highly available BI system to more than 7,000 internal and external BI users. Additionally, Mr. Ritter provides direct leadership to the BI development staff and project management. The BI development team leverages SAP Business Objects products to deploy standard reporting,	3%

Staff/Position	Credentials, Relevant Experience and Role	Percent of Direct Support
Proprietary and Confidential		
	ad hoc reporting, and dashboard solutions to IntelligenceConnect users. In addition to directing the BI solutions for ValueOptions, Mr. Ritter oversees the Data Integration team responsible for integrating physical, behavioral, and pharmacy claims, and performing analysis on the combined dataset. Mr. Ritter received a Master of Public Administration from Old Dominion University.	
Mark Irvine: Director, National Data Analytics	Mr. Irvine is the Director of National Data Analytics for ValueOptions. He is responsible for all internal and external client reporting for two Engagement Centers in New York, as well as Engagement Centers in Michigan, Tennessee and Maryland. Mr. Irvine has extensive experience in a variety of reporting tools, including Crystal Reports, Statistical Analysis Systems, Sequential Query Language, Impromptu, Microsoft Access and Microsoft Excel. Prior to his appointment as Director, Mr. Irvine worked as a Quality Improvement Analyst, Programmer, Analyst and Business Systems Manager. Before joining ValueOptions, Mr. Irvine worked in Empire Blue Cross Blue Shield's Customer Service Department. Mr. Irvine received a Bachelor of Science degree from Regents College.	7%

IMPLEMENTATION PROCESSES AND METHODOLOGIES

We employ a suite of proven project management methodologies to develop our implementation plan. Our approach follows a well-defined, detailed process based on best practices we have developed over years of implementing similar programs and informed by relevant principles from the Project Management Institute and Six Sigma. Our process for implementation management has seven distinct phases:

1. **Pre-Implementation Activity**
2. **Requirement and Transition Process**
3. **Implementation Plan Finalization**
4. **Implementation Activity**
5. **Readiness Testing and DBHDD Review and Acceptance**
6. **Implementation Transition**
7. **Operations Validation/Lessons Learned**

We provide a brief summary of key aspects for each phase below.

Pre-Implementation Activity

This phase includes identifying the activities that will begin immediately upon contract award. Pre-implementation activities, many of which are already underway for this program, include initiating additional staff recruitment, formulating our utilization management/special projects

strategy, and other activities. Within the first 10 days of contract award, we will meet with DBHDD to:

- Define the project management team, the communication paths and reporting protocols
- Schedule the implementation kick-off meeting
- Align resource interfaces for the implementation teams
- Establish ongoing oversight and weekly status meetings

Requirements and Transition Process

This phase includes gathering the specific and detailed information necessary to support the overall implementation effort. We will work with DBHDD prior to any information requests to ensure that these requests do not pose unnecessary burdens on DBHDD or your staff. Information gathered during this phase informs the development of a number of tasks that are key to the success of the implementation, such as:

- Validating key assumptions
- Finalizing operational and developmental deliverables
- Confirming network strategies
- Defining benefit configuration, eligibility, accumulators and other key data exchanges
- Agreeing on continuity of care plan strategies

Implementation Plan Finalization

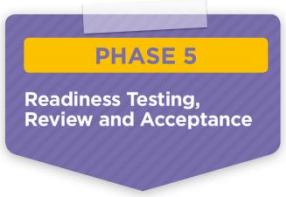
The goal of this phase is to gain approval of the detailed implementation plan. The deliverable from this phase is a jointly developed, extremely detailed implementation plan that gives both parties a high degree of confidence in a successful transition and problem-free effective date. It also creates a clear record of performance accountability for each major area and specific task.

Implementation Activity

Once the final implementation plan is approved, this phase includes actively managing the outlined tasks and timelines toward full program implementation, such as:

- Developing detailed products by functional-area work groups
- Designing, developing, testing and deploying benefit configuration, eligibility, data exchanges, and interfaces
- Refining workflows, policies and procedures
- Deploying claims transition activities

Readiness Testing and DBHDD Review and Acceptance



The purpose of this phase is to ensure we are on track for a seamless transition, and we have enough time to troubleshoot potentially

problematic areas prior to Go-Live. This includes effective readiness testing and ensures that we are on track for a seamless transition through:

- Full auditing of all contract requirements to ensure we meet DBHDD's expectations
- Joint, end-to-end testing to ensure that all process throughputs designed for the program are operating in the expected manner

Implementation Transition

This phase includes transitioning activities from the implementation team to the permanent staff that will be responsible for the ongoing ASO operations of Georgia's behavioral health and IDD program. After the successful Go-Live, we will:

- Facilitate a thoughtful transition to full ownership by Engagement Center personnel
- Ratify operational hand-off documents for each department
- Hold ad hoc meetings with DBHDD to review operational progress

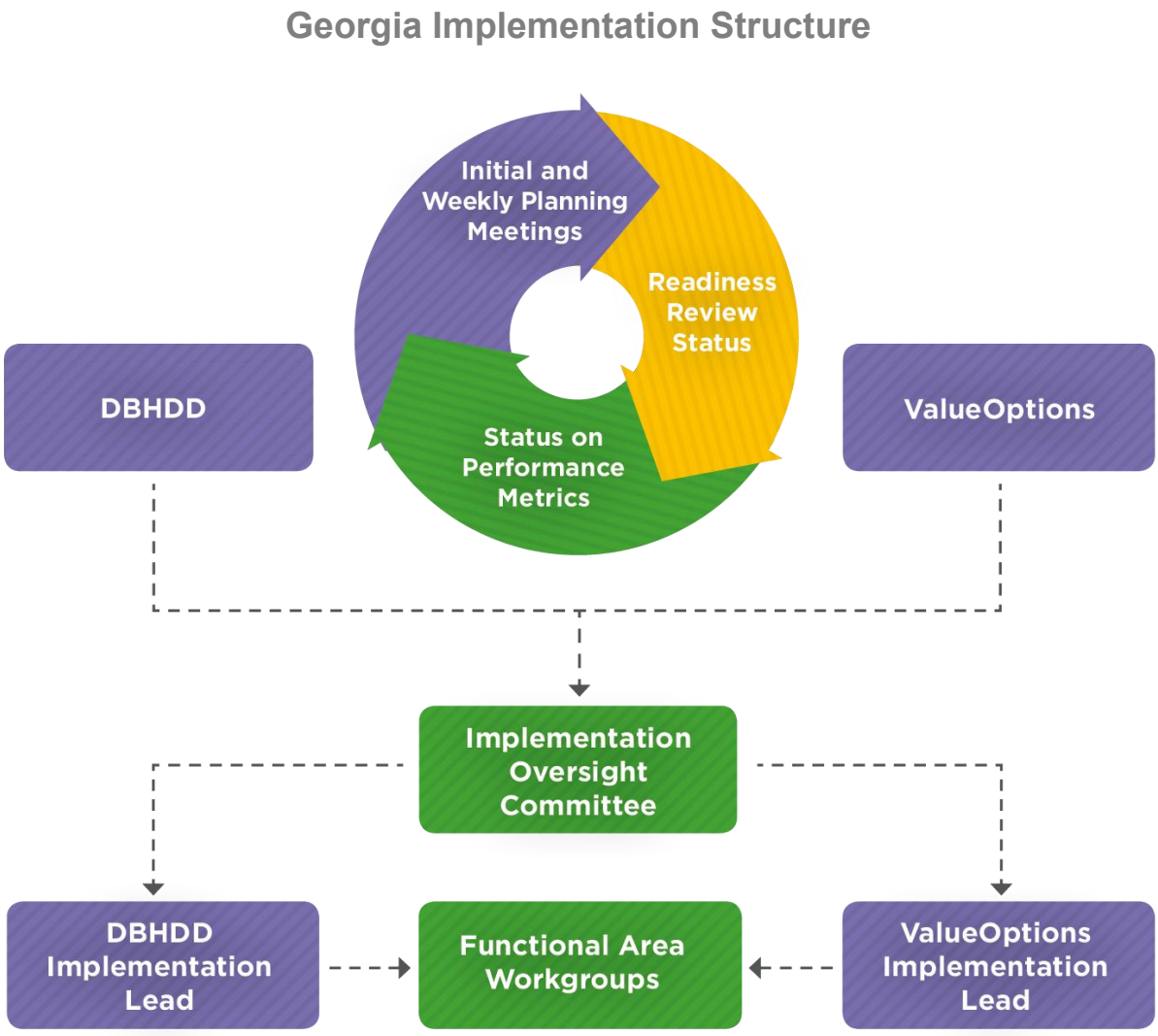
Implementation will be considered complete only with DBHDD's formal approval.

Operations Validation/Lessons Learned

Post-implementation, we will monitor all aspects of the new operation to ensure success. Once the implementation is complete, we will offer DBHDD the opportunity to participate in a formal "lessons learned" process to gather input and feedback, both positive and negative, on areas where expectations were exceeded and where improvement can be made.

IMPLEMENTATION STRUCTURE

Based on our experience, we know that a successful implementation will be predicated on a strong partnership and continuous dialogue with DBHDD. ValueOptions strives for a high degree of responsiveness and will ensure continuous communication throughout the implementation structure. As the diagram on the following page depicts, weekly reports will be generated and provided to DBHDD based on implementation metrics and controls. The metrics and controls will include overall and functional area completion percentages, as well as an itemization of delinquent activities, if any, with a remediation corrective action plan.



Our implementation process stresses close communication between our organization and DBHDD throughout all phases of the implementation.

C. – PROJECT WORK PLAN

We have included our project work plan for the implementation and execution of this contract on the following pages.

Georgia Department of Behavioral Health and Developmental Disabilities ASO
ValueOptions DRAFT - Implementation Plan

ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1	**DBHDD Implementation Plan**	**150 days**	**Mon 9/1/14**	**Fri 3/27/15**		**DBHDD, ValueOptions, BHL and Delmarva**
2	**Project Setup**	**30 days**	**Mon 9/1/14**	**Fri 10/10/14**		**M. Grenier**
3	Notification of Award/CIG Received					M. Mastreandrea
4	Identify Account Mgmt Team					M. Mastreandrea
5	Identify Implementation Leads (Functional Areas)	5 days	Mon 9/1/14	Fri 9/5/14		Functional Area Leads
6	Obtain Contract					M. Mastreandrea
7	Obtain and review budget					T. Raines
8	Obtain Finance Code					T. Raines
9	**Review Staffing**	**5 days**	**Mon 9/1/14**	**Fri 9/5/14**		**Functional Area Leads**
10	Setup SharePoint					T. Raines
11	Obtain reference files from Proposals					T. Raines
12	Create SP site and Load					T. Raines
13	Obtain and distribute CIG					M. Mastreandrea
14	**Review Underwriting**	**5 days**	**Mon 9/1/14**	**Fri 9/5/14**		**Functional Area Leads**
15	Obtain Final UW					T. Raines
16	Review with Functional Area Leads					T. Raines
17	Identify Impacts / Issues / Constraints					Functional Area Leads
18	Meet to Finalize					Functional Area Leads
19	Resolve Issues					Functional Area Leads
20	Lessons Learned Scrub					T. Raines
21	**Develop Project Schedule**	**10 days**	**Mon 9/1/14**	**Fri 9/12/14**		**T. Raines**
22	Draft Schedule					T. Raines
23	Distribute to Functional Area Leads					T. Raines
24	Review Schedule: compare to CRTG					Functional Area Leads
25	Receive Updates					T. Raines
26	Distribute v.2 to Team and DBHDD					T. Raines
27	DBHDD Review: Milestones and Project Schedule					DBHDD
28	Approval: DBHDD: Milestones and Schedule					DBHDD
29	**Performance Guarantees**	**30 days**	**Mon 9/1/14**	**Fri 10/10/14**		**T. Raines**
30	Assemble and Format					T. Raines
31	Distribute to Functional Area and Subcontractors Leads					T. Raines

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32	Review & Q/A PGs					Functional Area Leads
33	Latham Planning Meeting					T. Raines
34	Obtain understanding sign-off from Functional and Subcontractor Leads					T. Raines
35	**Complete CRTG - 1st Attestation**	**30 days**	**Mon 9/1/14**	**Fri 10/10/14**		**T. Raines**
36	Update CRTG from RFP, Proposal and Other docs					T. Raines
37	Distribute to Functional Area Leads					T. Raines
38	Review and Identify Issues if any					Functional Area Leads
39	Provide 1st Attestation					Functional Area Leads
40	**KickOffs Meetings**	**10 days**	**Mon 9/1/14**	**Fri 9/12/14**		**M. Grenier**
41	**Internal KO**	**1 day**	**Mon 9/1/14**	**Mon 9/1/14**		**T. Raines**
42	Draft Presentation					T. Raines
43	Review and Approve					M. Mastreandrea
44	Conduct Internal KO					T. Raines
45	Determine Status Meeting Schedule					T. Raines
46	**External KO**	**5 days**	**Mon 9/1/14**	**Fri 9/5/14**		**M. Grenier/M. Mastreandrea**
47	Draft Agenda/Presentation					M. Mastreandrea
48	Review and Approve Agenda					M. Mastreandrea
49	Prep for Pre-Brief					T. Raines
50	Conduct Pre-Brief					M. Mastreandrea
51	Conduct External KO					M. Mastreandrea
52	Determine DBHDD/ValueOptions Weekly Status Meeting schedule					T. Raines
53	Provide POC list to DBHDD					T. Raines
54	**Establish Governance (Project Communication Plan)**	**5 days**	**Mon 9/1/14**	**Fri 9/5/14**		**T. Raines**
55	Decision Making Process: Sign-offs, Change Control, Escalations					T. Raines
56	Communications Flows					T. Raines
57	Submit written Project Communication Plan to DBHDD	5 days	Mon 9/1/14	Fri 9/5/14		T. Raines
58	**Detailed Business Requirements Gathering (Discovery)**	**10 days**	**Mon 9/1/14**	**Fri 9/12/14**		**DBHDD/ValueOptions**
59	Distribute Detailed Bus Rqmts Track Grid					T. Raines

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60	Populate Grid with Questions					Functional Area Leads
61	Submit to DBHDD					T. Raines
62	DBHDD Review: DBRs					DBHDD
63	DBHDD Initial Response: DBRs					DBHDD
64	Resolve Gaps					T. Raines
65	DBR Gathering Complete					T. Raines
66	DBHDD: Final DBR Review					DBHDD
67	DBHDD: Final DBR Sign-off					DBHDD
68	Coordinate, Develop and submit comprehensive set of diagrams of proposed Operations	10 days	Mon 9/1/14	Fri 9/12/14		ValueOptions, BHL and Delmarva
69	**Sales Development**	**1 day**	**Mon 9/1/14**	**Mon 9/1/14**		**J. O'Leary**
70	Complete and post Client Implementation Guide (CIG)					J. O'Leary
71	Complete Contract Action Form and submit to Finance					J. O'Leary
72	Provide Point of Contact list for Client and VO					J. O'Leary
73	Confirm Pre and Post-implementation Audit needs					J. O'Leary
74	Identify performance guarantees					J. O'Leary
75	**Legal**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**D. Risku**
76	**Perform contract review**	**10 days**	**Mon 9/1/14**	**Fri 9/12/14**		**D.Risku**
77	Perform contract review					D.Risku
78	Ensure compliance with applicable State and Federal requirements					D.Risku
79	Receive input from internal stakeholders					D.Risku
80	Present questions to DBHDD					D.Risku
81	Negotiate new language in contract					D.Risku
82	Present revised contract to DBHDD for review					D.Risku
83	Review DBHDD edits					D.Risku
84	Incorporate all edits					D.Risku
85	Finalize contract					D.Risku
86	DBHDD execute contract					DBHDD
87	VO execute contract					D.Risku
88	Contract fully executed					D.Risku
89	Send executed contract to Legal for filing					D.Risku
90	**Licensures**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**D. Risku**

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91	Apply for licensure (if applicable)					D.Risku
92	Receive State License					D.Risku
93	**Compliance**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**S. Marzka/I. Mujaddidi**
94	Submit independent Security/Privacy audit report		Mon 9/1/14			S. Marzka/I. Mujaddidi
95	Develop State by State grid claims Rules					S. Marzka
96	Develop State by State Grid Um Rules					S. Marzka
97	Develop State by State Grid Appeal Language					S. Marzka
98	Confirm EOB, PSV Messaging					S. Marzka
99	Confirm Denial Letter language					S. Marzka
100	Confirm Auths Letter language					S. Marzka
101	Confirm partial Denial Letter language					S. Marzka
102	Confirm alternate language requirements					S. Marzka
103	**Compliance action plan**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**S. Marzka**
104	Identify compliance plan requirements					S. Marzka
105	Clarify national/local roles in compliance monitoring					S. Marzka
106	Develop compliance action plan	130 days	Mon 9/1/14	Fri 2/27/15		S. Marzka
107	Submit to DBHDD					S. Marzka
108	DBHDD Review: Compliance Action Plan					DBHDD
109	DBHDD Initial Response: Compliance Action Plar					DBHDD
110	Implement into production					S. Marzka
111	**Fraud Waste and Abuse**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**J. Martin**
112	Identify Requirements					J. Martin
113	Develop/modify Fraud & Abuse P&Ps for GA ASO					J. Martin
114	Develop Fraud and Abuse Prevention Plan					J. Martin
115	Submit to DBHDD	1 day	Mon 11/24/14	Mon 11/24/14	300	J. Martin
116	DBHDD Review: Fraud & Abuse Plan					DBHDD
117	DBHDD Initial Response: Fraud & Abuse Plan					DBHDD
118	Implement into production					J. Martin
119	**Human Resources/Staffing**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**Delmarva, Claims, Customer Service, etc.**
120	**Preparation for Recruitment**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**B. McNeil**
121	Review and confirm staffing plan					B. McNeil

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
122	Review proposal staffing and job descriptions					B. McNeil
123	Prepare ads					B. McNeil
124	Post jobs internally/externally					B. McNeil
125	**Recruitment**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**B. McNeil**
126	Interview candidates (and complete background checks)					B. McNeil
127	Offer positions					B. McNeil
128	**Training/Employee setup**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**B. McNeil**
129	Coordinate new hire training with operational departments					B. McNeil
130	Develop and implement P&Ps for on-boarding and off-boarding of staff					B. McNeil
131	Ensure employees complete training program					B. McNeil
132	Confirm staff licensure					B. McNeil
133	**Internal Training**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**B. McNeil**
134	Identify internal training needs					B. McNeil
135	Establish internal training plan and schedule	30 days	Mon 9/1/14	Fri 10/10/14		B. McNeil
136	Confirm internal training location/set up					B. McNeil
137	Prepare internal project specific training materials					B. McNeil
138	Conduct internal training					B. McNeil
139	**Client Training (if applicable)**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**B. McNeil**
140	Identify Client training needs					B. McNeil
141	Establish internal training plan and schedule	30 days	Mon 9/1/14	Fri 10/10/14		B. McNeil
142	Establish Client training plan and schedule					B. McNeil
143	Prepare Client training materials					B. McNeil
144	Conduct Client training					B. McNeil
145	**Local HR setup (GA Engagement Center)**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**B. McNeil**
146	Train staff on HR tasks					B. McNeil
147	Display state, federal, contractual posters					B. McNeil
148	**Staffing Reports**	**10 days**	**Mon 9/1/14**	**Fri 9/12/14**		**B. McNeil**
149	Sumbit list of Key personnel to DBHDD					B. McNeil
150	Obtain DBHDD sign off for key roles as applicable					B. McNeil
151	Key personnel change notification plan					B. McNeil

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152	Develop Open Position Reports					B. McNeil
153	**GCAL**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**Behavioral Health Link/ValueOptions**
154	Prepare and submit a comprehensive set of diagrams of GCAL Operations	10 days	Mon 9/1/14	Fri 9/12/14		Gregg Graham, Wendy Martinez Schneider,Mark Livingston, Gina Gibson,
155	Transition and assume operations of GCAL phone line	0 days	Mon 9/1/14	Mon 9/1/14		GCAL Implementation Team
156	Establish Communication between CCID , BHL Web, and CONNECTS	130 days	Mon 9/1/14	Fri 2/27/15		Mark Livingston, Joe Cordero, Wendy Martinez Schneider, and Gregg Graham
157	Provide "MyGCAL" link to ValueOptions to include a link on GA ASO site					Mark Livingston, Joe Cordero, Wendy Martinez Schneider, and Gregg Graham
158	**Staffing**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**Sivi Bobbit, Gina Gibson, Allison Trammell and Wendy Martinez Schneider**
159	Review of staff credentials and plan for transition if associate licensed Clinicians					Sivi Bobbit, Gina Gibson, Allison Trammell and Wendy Martinez Schneider
160	Hiring complete and training of new staff	130 days	Mon 9/1/14	Fri 2/27/15		Sivi Bobbit, Gina Gibson, Allison Trammell and Wendy Martinez Schneider
161	**GCAL Marketing Plan**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**Gregg Graham and Wendy Martinez Schneider**
162	Systematic development of MOUS with 911 and GCAL by Region beginning in SPOE Regions 1, 4 & 6 with later expansion to 2, 3, and 5.					Gregg Graham and Wendy Martinez Schneider
163	Systematic education to community about GCAL services including 911 call centers, law enforcement/CIT, Georgia Hospital Association Membership					Gregg Graham and Wendy Martinez Schneider
164	Draft GCAL Marketing Materials for approval by ValueOptions, DBHDD and the DBHDD Office of Deaf Services all in Spanish	129 days	Mon 9/1/14	Thu 2/26/15		Gregg Graham and Wendy Martinez Schneider
165	Submit Draft GCAL Marketing materials to DBHDD and the DBHDD Office of Deaf Services	130 days	Mon 9/1/14	Fri 2/27/15	164	Gregg Graham and Wendy Martinez Schneider
166	DBHDD Review: Draft GCAL Marketing materials					DBHDD
167	DBHDD Approval: Draft GCAL Marketing materials					DBHDD
168	Targeted Marketing Plan Complete	63 days	Fri 1/2/15	Tue 3/31/15	167	Gregg Graham and Wendy Martinez Schneid
169	**General and Claims Customer Service**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**M. Golden**
170	Confirm program hours					M. Golden
171	Identfy all existing Toll Free Numbers					M. Golden
172	Determine ownership of TFN					M. Golden

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173	Order Toll Free Number or work with DBHDD and TeleCom to port exising TFN					M. Golden
174	Publish Toll Free Number					M. Golden
175	Confirmed procedure in place for Telephonic translator					M. Golden
176	Develop TDD for hearing-impaired callers					M. Golden
177	Develop Phone scripting with DBHDD					M. Golden
178	Complete Call Center Design Document					M. Golden
179	DBHDD reviews and approves Call Center Design Docu				178	M. Golden
180	DBHDD and ValueOptions perform testing of phone scr					M. Golden
181	DBHDD signs off (approves) results of phone scripting t				180	M. Golden
182	Complete setup to support Call Center general information and transition cases pre-go live					M. Golden
183	Define after hour call flow					M. Golden
184	Design interdepartmental call flow					M. Golden
185	Complete trunking evaluation of switch					M. Golden
186	Complete switch programming in Georgia					M. Golden
187	Queue Assignment/SetUp					M. Golden
188	Set up/train BRP and CNS					M. Golden
189	Design Business Recovery Plan					M. Golden
190	Define Customer service performance guarantees					M. Golden
191	Communicate performance guarantees to necessary st					M. Golden
192	Confirm exceptions to standard Customer Service Workflows					M. Golden
193	Update Customer Service Routing Grid with work queue					M. Golden
194	Readiness Review-Pre implementation audit (if applicab	110 days	Mon 9/1/14	Fri 1/30/15		M. Golden
195	**ACD_Customer Service Reporting**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**M. Golden**
196	Identify reporting requirements - internal/external					M. Golden
197	Coordinate report development/approval with Reporti					M. Golden
198	Implement reports into production					M. Golden
199	**Review/refine current Policies and Procedures to meet needs of the program with DBHDD**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**M. Golden**
200	Transfer protocols					M. Golden
201	Crisis calls					M. Golden

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
202	Routine/urgent calls					M. Golden
203	Greetings					M. Golden
204	Conferencing					M. Golden
205	Voicemail protocols					M. Golden
206	Set up language line protocols					M. Golden
207	TDD/TTY protocols					M. Golden
208	**Member Inquiry Process**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**M. Golden**
209	Review current inquiry processes					M. Golden
210	Establish processes and systems to document and monitor the st					M. Golden
211	DBHDD reviews and approves member inquiry proce					M. Golden
212	**Provider Inquiry Process**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**M. Golden**
213	Review current inquiry processes					M. Golden
214	Establish processes and systems to document and monitor the status and outcome of all provider inquiries and develop appropriate reporting mechanisms to track progress and evaluate trends					M. Golden
215	DBHDD reviews and approves provider inquiry proce					M. Golden
216	**Appeals/Grievances**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**M. Golden**
217	Design, develop and implement necessary procedure					M. Golden
218	Order letterhead					M. Golden
219	Develop grievance interface protocols					M. Golden
220	Review and finalize Appeal letters (Acknowledgemer					M. Golden
221	Define appeal letter language					M. Golden
222	Define process for handling misdirected corresponde					M. Golden
223	Develop point of contact list of DBHDD and ValueOp					M. Golden
224	**Call Center Staffing**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**M. Golden**
225	Access staffing needs					M. Golden
226	Recruit and hire Claims Customer Service					M. Golden
227	Recruit and hire Generall Customer Service					M. Golden
228	Assess floor space requirement					M. Golden
229	Request workstation configurations					M. Golden
230	**Call Center Training**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**M. Golden**
231	Assess Training needs and timelines					M. Golden

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232	Identify Training Resource					M. Golden
233	Develop General/Claims Customer Service Trainir	30 days	Mon 9/1/14	Fri 10/10/14		M. Golden
234	Schedule weekly training workgroup sessions					M. Golden
235	Establish Train the Trainer sessions					M. Golden
236	Conduct General/ Claims Customer Service Traini					M. Golden
237	Identify go live floor support for Latham and Servic					M. Golden
238	**Finance**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**B. Flowe/B. Marshall**
239	Set up/communicate implementation charge code					B. Flowe/B. Marshall
240	Performance bonds					B. Flowe/B. Marshall
241	Set up invoicing					B. Flowe/B. Marshall
242	Determine primary Finance contact for DBHDD					B. Flowe/B. Marshall
243	Determine state revenue/funding setup					B. Flowe/B. Marshall
244	Set up ACH/EFT if applicable					B. Flowe/B. Marshall
245	Payroll setup					B. Flowe/B. Marshall
246	Identify special requirements for positive pay					B. Flowe/B. Marshall
247	Determine requirement with regards to bank account					B. Flowe/B. Marshall
248	Establish bank accounts as needed (ASO)					B. Flowe/B. Marshall
249	Coordinate Client billing and membership reconciliation processes					B. Flowe/B. Marshall
250	Develop reconcilliation reports (820 vs encounters)					B. Flowe/B. Marshall
251	Establish Claims Funding Account					B. Flowe/B. Marshall
252	Determine check signing/mailing process (claims funds					B. Flowe/B. Marshall
253	Order check stock, if applicable					B. Flowe/B. Marshall
254	Establish check run dates					B. Flowe/B. Marshall
255	Establish process for issuance of provider and or member payments					B. Flowe/B. Marshall
256	Finance system configuration					B. Flowe/B. Marshall
257	Support for revenue and payment					B. Flowe/B. Marshall
258	Determine 1099 reporting requirements					B. Flowe/B. Marshall
259	Finalize EOB-RA processing requirements					B. Flowe/B. Marshall
260	**NCB Invoice tracking (Housing Vouchers, Bridge and Transition Funding)**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**B. Flowe/B. Marshall**
261	Identify requirements					B. Flowe/B. Marshall

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262	Set up inquiry queue to respond to ProviderConnect messages					B. Flowe/B. Marshall
263	Develop process for tracking monthly invoices					B. Flowe/B. Marshall
264	Implement process					B. Flowe/B. Marshall
265	**Set up Annual expense allocation (1/12th draw Provider Accumulator Tables- CAS)**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**B. Flowe/B. Marshall**
266	Gather requirements					B. Flowe/B. Marshall
267	Configure system					B. Flowe/B. Marshall
268	Test Provider Encounters					B. Flowe/B. Marshall
269	**Clinical Operations**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**J. Maurizio/L. Beaver**
270	**Initial DBHDD meetings**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**J. Maurizio/L. Beaver**
271	Clinical interface with DBHDD for decision making					J. Maurizio/L. Beaver
272	Request member utilization					J. Maurizio/L. Beaver
273	Confirm utilization review and customer service workflows currently being utilized					J. Maurizio/L. Beaver
274	Establish transition plan					J. Maurizio/L. Beaver
275	Develop interface protocols with previous ERO vend					J. Maurizio/L. Beaver
276	Request active case data from former ERO vendor for transition process					J. Maurizio/L. Beaver
277	Coordinate discharge process with former vendors					J. Maurizio/L. Beaver
278	ID all plans that will be managed					J. Maurizio/L. Beaver
279	Determine appeal and grievance process to be followed					J. Maurizio/L. Beaver
280	Obtain BH Clinical and I/DD Criteria from DBHDD					J. Maurizio/L. Beaver
281	Provide DBHDD with sample Service Class Grid					J. Maurizio/L. Beaver
282	Provide DBHDD with proposed Mixed Services protocols					J. Maurizio/L. Beaver
283	Provide DBHDD with Proposed Substitution Rules inpt, PHP, Rehab, etc					J. Maurizio/L. Beaver
284	**BH and I/DD Benefits (Medicaid and Non-Medicaid)**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**J. Maurizio/L. Beaver**
285	Discuss DBHDD benefit plan nuances					J. Maurizio/L. Beaver
286	ID benefit design Registration or pass thrus					J. Maurizio/L. Beaver
287	Confirm transition process with Client					J. Maurizio/L. Beaver
288	ID workflow for on OON members					J. Maurizio/L. Beaver

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289	ID workflow for specialty networks					J. Maurizio/L. Beaver
290	ID workflow for providers going through credentialing process					J. Maurizio/L. Beaver
291	Revise Mixed Services document					J. Maurizio/L. Beaver
292	DBHDD Sign off on Mixed Services Doc					J. Maurizio/L. Beaver
293	Review Clinical Criteria with DBHDD					J. Maurizio/L. Beaver
294	DBHDD Sign off on Clinical Criteria					J. Maurizio/L. Beaver
295	Coordinate with CS and establish trainings for CS sta					J. Maurizio/L. Beaver
296	**Clinical Processes**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**J. Maurizio/L. Beaver**
297	Finalize authorization, registration processes					J. Maurizio/L. Beaver
298	Finalize level of care clinical criteria and policies and procedures					J. Maurizio/L. Beaver
299	Determine ratios for ALOCs					J. Maurizio/L. Beaver
300	Develop and submit Medicaid UM/UR plan and guidelines to DBHDD	88 days	Mon 9/1/14	Wed 12/31/14		J. Maurizio/L. Beaver
301	Finalize Peer Advisor protocols					J. Maurizio/L. Beaver
302	Finalize access timeframes					J. Maurizio/L. Beaver
303	Finalize clinical/administrative appeals process					J. Maurizio/L. Beaver
304	Finalize crisis intervention/critical incident process					J. Maurizio/L. Beaver
305	Handling various types of calls including need for immediate clinical involvement					J. Maurizio/L. Beaver
306	Tailor clinical workflows as necessary					J. Maurizio/L. Beaver
307	Refine coordination processes with PCPs (e.g. if medical consultation is needed)					J. Maurizio/L. Beaver
308	**Letters**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**J. Maurizio/L. Beaver**
309	Review Copies of DBHDD letters					J. Maurizio/L. Beaver
310	Determine letter format(CC's etc)					J. Maurizio/L. Beaver
311	Develop letter matrix					J. Maurizio/L. Beaver
312	Approval by VO legal					J. Maurizio/L. Beaver
313	Approval by DBHDD					DBHDD
314	Testing of letters					J. Maurizio/L. Beaver
315	Letters sent to IT for production load					J. Maurizio/L. Beaver
316	Establish letter error resolution process					J. Maurizio/L. Beaver
317	**Staffing**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**J. Maurizio/L. Beaver**

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
318	Access staffing needs	130 days	Mon 9/1/14	Fri 2/27/15		J. Maurizio/L. Beaver
319	Recruit and hire Clinical Staff	130 days	Mon 9/1/14	Fri 2/27/15		J. Maurizio/L. Beaver
320	Assess floor space requirement					J. Maurizio/L. Beaver
321	Request workstation configurations					J. Maurizio/L. Beaver
322	**Training**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**J. Maurizio/L. Beaver**
323	Assess Training needs and timelines					J. Maurizio/L. Beaver
324	Identify Training Resource					J. Maurizio/L. Beaver
325	Develop Clinical (client-specific)Training material	30 days	Mon 9/1/14	Fri 10/10/14		J. Maurizio/L. Beaver
326	Schedule weekly training workgroup sessions					J. Maurizio/L. Beaver
327	Establish Train the Trainer sessions					J. Maurizio/L. Beaver
328	Conduct Clinical Training					J. Maurizio/L. Beaver
329	Identify go live floor support forDBHDDService Ce					J. Maurizio/L. Beaver
330	**Communication**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**ValueOptions Marketing and Functinal Le**
331	Develop program logo					ValueOptions Marketing and Functinal Leads
332	Submit to DBHDD for approval					ValueOptions Marketing and Functinal Leads
333	DBHDD approves logo					ValueOptions Marketing and Functinal Leads
334	Update logo					ValueOptions Marketing and Functinal Leads
335	**Member Communication**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**ValueOptions Marketing and Functinal Le**
336	Review required member materials and establish schedule for material distribution with Client					ValueOptions Marketing and Functinal Leads
337	Refine materials as needed					ValueOptions Marketing and Functinal Leads
338	Material distribution					ValueOptions Marketing and Functinal Leads
339	**Provider Communication**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**ValueOptions Marketing and Functinal Le**
340	Determine appropriate materials					ValueOptions Marketing and Functinal Leads
341	Establish notification and timeframe					ValueOptions Marketing and Functinal Leads
342	Develop Provider Handbook					ValueOptions Marketing and Functinal Leads
343	**Quality Management**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**D. Hirschfelder**
344	**Quality Management**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**D. Hirschfelder**
345	Identify delegation arrangements					D. Hirschfelder
346	Identify satisfaction surveys requirements and methodology to DBHDD					D. Hirschfelder
347	Review and obtain DBHDD performance standards/indicators					D. Hirschfelder

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348	Confirm complaint/grievance requirements and identify process for collection and reporting					D. Hirschfelder
349	Review adverse incident process					D. Hirschfelder
350	Submit ValueOptions QM program description and work plan to DBHDD	88 days	Mon 9/1/14	Wed 12/31/14		D. Hirschfelder
351	QM interface with key departments (i.e. clinical, networks, etc.)					D. Hirschfelder
352	**Provider appeals**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**D. Hirschfelder**
353	**Review current practices to ensure Medical Necessity Appeals meet contract requirements**			**Mon 9/1/14**		**D. Hirschfelder**
354	Level 1					D. Hirschfelder
355	Level 2					D. Hirschfelder
356	Review current practices					D. Hirschfelder
357	Submit toDBHDD for review/approval					D. Hirschfelder
358	Update policies and procedures					D. Hirschfelder
359	**Member appeals**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**D. Hirschfelder**
360	Develop member appeal policies and procedures					D. Hirschfelder
361	Submit to DBHDD for review/approval					D. Hirschfelder
362	Obtain approval on Member Appeals process from DBHDD					D. Hirschfelder
363	Update policies and procedures					D. Hirschfelder
364	**Security and Privacy Plan**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**D. Hirschfelder**
365	Review current Security and Privacy Plan to ensure contract requirements are met					D. Hirschfelder
366	Submit plan to DBHDD for approval					D. Hirschfelder
367	Obtain approval on Security and Privacy Plan from DBHDD					D. Hirschfelder
368	**Notice of Action & Denial Process Requirements**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**D. Hirschfelder**
369	Review current process to ensure contract requirements are met					D. Hirschfelder
370	Submit to DBHDD for approval					D. Hirschfelder
371	Obtain approval on Notice of Action & Denial Process requriements					D. Hirschfelder
372	Implement content modifications					D. Hirschfelder
373	**Quality Management Reporting**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**D. Hirschfelder**

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374	Clarify QM role in state reporting					D. Hirschfelder
375	Identify reporting requirements - internal/external					D. Hirschfelder
376	Coordinate report development/approval with Reporti					D. Hirschfelder
377	Implement reports into production					D. Hirschfelder
378	**QM committee setup**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**D. Hirschfelder**
379	Identify committee requirements					D. Hirschfelder
380	Identify committee members					D. Hirschfelder
381	Develop committee charters					D. Hirschfelder
382	Implement committee meetings					D. Hirschfelder
383	**DD Provider Monitoring**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**Delmarva Foundation**
384	Identify requirements	30 days	Mon 9/1/14	Fri 10/10/14		Delmarva Foundation
385	Develop tool	30 days	Mon 9/1/14	Fri 10/10/14		Delmarva Foundation
386	Develop Training Manual	88 days	Mon 9/1/14	Wed 12/31/14		Delmarva Foundation
387	**Schedule**	**60 days**	**Mon 9/1/14**	**Fri 11/21/14**		**Delmarva Foundation**
388	Develop schedule	60 days	Mon 9/1/14	Fri 11/21/14		Delmarva Foundation
389	Sumbit schedule to DBHDD	32 days	Tue 11/18/14	Wed 12/31/14		Delmarva Foundation
390	Initiate audits - (On-going)		Wed 4/1/15			Delmarva Foundation
391	**Outcome Measures Reporting**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**Delmarva Foundation**
392	Identify Reporting Requirments for DBHDD	130 days	Mon 9/1/14	Fri 2/27/15		Delmarva Foundation
393	Identify Data Elements Required	130 days	Mon 9/1/14	Fri 2/27/15		Delmarva Foundation
394	Training of I/DD staff	10 days	Wed 3/11/15	Tue 3/24/15		Delmarva Foundation
395	Inter-rater reliability	88 days	Wed 4/1/15	Fri 7/31/15		Delmarva Foundation
396	**Provider Training - Pre Implementation**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**ValueOptions/Delmarva Foundation/BHL**
397	Develop training presentation on QM System	66 days	Mon 9/1/14	Mon 12/1/14		ValueOptions/Delmarva Foundation/BHL
398	Train Providers around the State on the QM System	42 days	Thu 1/1/15	Fri 2/27/15		ValueOptions/Delmarva Foundation/BHL
399	**Provider Training - Ongoing**		**Wed 4/1/15**			**ValueOptions/Delmarva Foundation/BHL**
400	Develop Training Plan	23 days	Thu 1/1/15	Sat 1/31/15		ValueOptions/Delmarva Foundation/BHL
401	**Delmarva Foundation Implementation**	**283 days**	**Tue 9/2/14**	**Thu 10/1/15**		
402	**DBHDD Portal Set Up**	**19 days**	**Tue 9/2/14**	**Fri 9/26/14**		**Delmarva**
403	Gather Requirements	2 days	Tue 9/2/14	Wed 9/3/14		Delmarva
404	Gather list of users that need access	1 day	Thu 9/4/14	Thu 9/4/14		Delmarva

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405	Build Portal Site	12 days	Thu 9/4/14	Fri 9/19/14	403	Delmarva
406	Test Portal Access and Functionality	5 days	Mon 9/22/14	Fri 9/26/14	405	Delmarva
407	**Gather Review Requirements**	**35 days**	**Mon 9/8/14**	**Fri 10/24/14**		**Delmarva**
408	**Develop Required Report Formats**	**10 days**	**Mon 9/8/14**	**Fri 9/19/14**		**Delmarva**
409	PCR Reports	5 days	Mon 9/8/14	Fri 9/12/14		Delmarva
410	QEPR Reports	5 days	Mon 9/8/14	Fri 9/12/14		Delmarva
411	FUTAC Reports	5 days	Mon 9/8/14	Fri 9/12/14		Delmarva
412	Behavioral Health Reports	5 days	Mon 9/15/14	Fri 9/19/14		Delmarva
413	**Identify Required Review Tools/Elements**	**25 days**	**Mon 9/22/14**	**Fri 10/24/14**		**Delmarva**
414	PCR Tools/Elements	5 days	Mon 9/22/14	Fri 9/26/14		Delmarva
415	QEPR Tools/Elements	5 days	Mon 9/29/14	Fri 10/3/14		Delmarva
416	FUTAC Tools/Elements	5 days	Mon 10/6/14	Fri 10/10/14		Delmarva
417	**Behavioral Health Tools/Elements**	**9 days**	**Tue 10/14/14**	**Fri 10/24/14**		**Delmarva**
418	**Identify Required Functionality and Workflow for Application**	**25 days**	**Mon 9/22/14**	**Fri 10/24/14**		**Delmarva**
419	PCR Workflow	5 days	Mon 9/22/14	Fri 9/26/14		Delmarva
420	QEPR Workflow	5 days	Mon 9/29/14	Fri 10/3/14		Delmarva
421	FUTAC Workflow	5 days	Mon 10/6/14	Fri 10/10/14		Delmarva
422	Behavioral Health Workflow	9 days	Tue 10/14/14	Fri 10/24/14		Delmarva
423	**Application Development**	**120 days**	**Mon 9/15/14**	**Fri 2/27/15**		**Delmarva**
424	Create login page, default page, style sheet	10 days	Mon 9/15/14	Fri 9/26/14		Delmarva
425	**PCR Review**	**30 days**	**Mon 9/29/14**	**Fri 11/7/14**	**419**	**Delmarva**
426	Create PCR Wireframes	5 days	Mon 9/29/14	Fri 10/3/14		Delmarva
427	Develop PCR Web Pages	15 days	Mon 10/6/14	Fri 10/24/14	426	Delmarva
428	Test PCR Web Pages	5 days	Mon 10/27/...	Fri 10/31/14	427	Delmarva
429	Revise PCR Web Pages (as needed)	5 days	Mon 11/3/14	Fri 11/7/14	428	Delmarva
430	**QEPR Review**	**30 days**	**Mon 10/27...**	**Fri 12/5/14**	**427**	**Delmarva**
431	Create QEPR Wireframes	5 days	Mon 10/27/...	Fri 10/31/14	427	Delmarva
432	Develop QEPR Web Pages	15 days	Mon 11/3/14	Fri 11/21/14	431	Delmarva
433	Test QEPR Web Pages	7 days	Mon 11/24/...	Tue 12/2/14	432	Delmarva
434	Revise QEPR Web Pages (as needed)	3 days	Wed 12/3/14	Fri 12/5/14	433	Delmarva

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435	**Behavioral Health Review**	**50 days**	**Mon 11/24/...**	**Fri 1/30/15**	**422**	**Delmarva**
436	Create Behavioral Health Wireframes	5 days	Mon 11/24/...	Fri 11/28/14	432	Delmarva
437	Develop Behavioral Health Web Pages	30 days	Mon 12/1/14	Fri 1/9/15	436	Delmarva
438	Test Behavioral Health Web Pages	8 days	Mon 1/12/15	Wed 1/21/15	437	Delmarva
439	Revise Behavioral Health Web Pages (as needed)	7 days	Thu 1/22/15	Fri 1/30/15	438	Delmarva
440	**FUTAC Review**	**30 days**	**Mon 1/12/15**	**Fri 2/20/15**	**421**	**Delmarva**
441	Create FUTAC Wireframes	5 days	Mon 1/12/15	Fri 1/16/15	437	Delmarva
442	Develop FUTAC Web Pages	15 days	Mon 1/19/15	Fri 2/6/15	441	Delmarva
443	Test FUTAC Web Pages	5 days	Mon 2/9/15	Fri 2/13/15	442	Delmarva
444	Revise FUTAC Web Pages (as needed)	5 days	Mon 2/16/15	Fri 2/20/15	443	Delmarva
445	Link all review types into default page	5 days	Mon 2/23/15	Fri 2/27/15	444	Delmarva
446	**Application Training**	**22 days**	**Mon 3/2/15**	**Tue 3/31/15**	**445**	**Delmarva**
447	Create user Manuals	5 days	Mon 3/2/15	Fri 3/6/15		Delmarva
448	Conduct Training Sessions with Staff	10 days	Mon 3/9/15	Fri 3/20/15	447	Delmarva
449	**Generate Required Report Templates**	**35 days**	**Mon 2/9/15**	**Fri 3/27/15**	**442**	**Delmarva**
450	Generate PCR Report Templates	5 days	Mon 2/9/15	Fri 2/13/15	442	Delmarva
451	Generate QEPR Report Templates	8 days	Mon 2/16/15	Wed 2/25/15	450	Delmarva
452	Generate FUTAC Report Templates	8 days	Thu 2/26/15	Mon 3/9/15	451	Delmarva
453	Generate Behavioral Health Report Templates	9 days	Tue 3/10/15	Fri 3/20/15	452	Delmarva
454	Report Template Review	30 days	Mon 2/16/15	Fri 3/27/15	450	Delmarva
455	**Create Portal Sites**	**33 days**	**Mon 1/12/15**	**Wed 2/25/15**		**Delmarva**
456	**Quality Improvement Council (QIC)**	**25 days**	**Mon 1/12/15**	**Fri 2/13/15**		**Delmarva**
457	Gather QIC Portal Requirements	15 days	Mon 1/12/15	Fri 1/30/15		Delmarva
458	Create QIC Portal Site	8 days	Mon 2/2/15	Wed 2/11/15	457	Delmarva
459	Provide User Access to QIC Portal	2 days	Thu 2/12/15	Fri 2/13/15	458	Delmarva
460	**Human Rights Council (HRC)**	**33 days**	**Mon 1/12/15**	**Wed 2/25/15**		**Delmarva**
461	Gather HRC Portal Requirements	15 days	Mon 1/12/15	Fri 1/30/15		Delmarva
462	Create HRC Portal Site	8 days	Thu 2/12/15	Mon 2/23/15	458	Delmarva
463	Provide User Access to HRC Portal	2 days	Tue 2/24/15	Wed 2/25/15	462	Delmarva

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464	**Connecting to Value Options Systems**	**87 days**	**Mon 12/1/14**	**Tue 3/31/15**		**Delmarva,Value Options**
465	Gather Requirements (Data, Type of Connection, Frequency)	15 days	Mon 12/1/14	Fri 12/19/14		Delmarva,Value Options
466	Develop Connection between Company Servers	15 days	Mon 1/5/15	Fri 1/23/15		Delmarva,Value Options
467	Automate Transfer Procedures	20 days	Mon 2/2/15	Fri 2/27/15		Delmarva,Value Options
468	Test Transfer Procedures	22 days	Mon 3/2/15	Tue 3/31/15		Delmarva,Value Options
469	**Georgia Provider Public Reporting Website**	**132 days**	**Wed 4/1/15**	**Thu 10/1/15**		**Delmarva**
470	Gather Public Reporting Requirements	43 days	Wed 4/1/15	Fri 5/29/15		Delmarva
471	Create Public Reporting Site	55 days	Mon 6/1/15	Fri 8/14/15	470	Delmarva
472	Test Public Reporting Site	10 days	Mon 8/17/15	Fri 8/28/15	471	Delmarva
473	Revise Public Report Site	10 days	Mon 8/31/15	Fri 9/11/15	472	Delmarva
474	Migrate Data (if applicable)	10 days	Mon 9/14/15	Fri 9/25/15	473	Delmarva
475	Public Reporting Go-Live Date	1 day	Mon 9/28/15	Mon 9/28/15	474	Delmarva
476	**Real Time Data Reporting (RTDR) Website**	**132 days**	**Wed 4/1/15**	**Thu 10/1/15**		**Delmarva**
477	Gather RTDR Requirements	43 days	Wed 4/1/15	Fri 5/29/15		Delmarva
478	Create RTDR Site	65 days	Mon 6/1/15	Fri 8/28/15	477	Delmarva
479	Test RTDR Site	10 days	Mon 8/31/15	Fri 9/11/15	478	Delmarva
480	Revise RTDR Site	10 days	Mon 9/14/15	Fri 9/25/15	479	Delmarva
481	RTDR Go-Live Date	1 day	Mon 9/28/15	Mon 9/28/15	480	Delmarva
482	**Data Analytics (Appendix 26 and Dashboard Reporting)**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**D. Santmyer**
483	Identify required reports					D. Santmyer
484	Identify performance guarantees					D. Santmyer
485	Identify/prioritize day 1 reports					D. Santmyer
486	Identify/prioritize non-day 1 reports (Monthly, Quarterly, etc.)					D. Santmyer
487	Create report mock-ups					D. Santmyer
488	Meetings with DBHDD to review reporting requirements/formats/mock-ups					D. Santmyer
489	DBHDD approves reporting requirements/formats/mockups					D. Santmyer
490	Create technical specifications for DBHDD required reports					D. Santmyer

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491	Determine data mart requirements					D. Santmyer
492	Program Day 1 reports					D. Santmyer
493	Program, Validate, and implement non-day 1 Monthly Reports					D. Santmyer
494	Program, Validate, and implement Quarterly Reports in 2014					D. Santmyer
495	Validate Day 1 Reports					D. Santmyer
496	Submit reports for review and sign-off by the VO Functional Areas					D. Santmyer
497	Set up Day 1 reports on IntelligenceConnect to begin running					D. Santmyer
498	Set up process for ad hoc reporting requests from DBHDD					D. Santmyer
499	**Internal reporting requirements**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**D. Santmyer**
500	Identify required reports					D. Santmyer
501	Identify performance guarantees					D. Santmyer
502	Meet with teams to define report specifications/mock-ups					D. Santmyer
503	Create technical specifications for reports					D. Santmyer
504	Identify/prioritize day 1 reports					D. Santmyer
505	Identify/prioritize non-day 1 reports					D. Santmyer
506	Determine data mart requirements					D. Santmyer
507	Program Day 1 reports					D. Santmyer
508	Program, Validate, and implement non-day 1 Monthly Reports					D. Santmyer
509	Program, Validate, and implement Quarterly Reports in 2014					D. Santmyer
510	Validate Day 1 Reports					D. Santmyer
511	**National Provider Network Services**	**152 days**	**Mon 9/1/14**	**Tue 3/31/15**		**N. Martin/C. Gilbert**
512	**Provider Relations**	**152 days**	**Mon 9/1/14**	**Tue 3/31/15**		**N. Martin/C. Gilbert**
513	Set Up Provider Relations Work Group					N. Martin/C. Gilbert
514	Set internal weekly meeting schedule with team mem					N. Martin/C. Gilbert
515	Set up workgroup with DBHDD and VO PR and Cont					N. Martin/C. Gilbert
516	Set weekly meeting schedule with team members					N. Martin/C. Gilbert
517	**Identify DBHDD Network**	**30 days**	**Mon 9/1/14**	**Fri 10/10/14**		**N. Martin/C. Gilbert**

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518	Secure listing of all current vendor's network provi					N. Martin/C. Gilbert
519	Secure listing of all current vendor's high volume p					N. Martin/C. Gilbert
520	**Perform and Analyze Network Comparison**	**30 days**	**Mon 9/1/14**	**Fri 10/10/14**		**N. Martin/C. Gilbert**
521	Perform disruption analysis to determine who is in					N. Martin/C. Gilbert
522	Identify current vendor's " high volume " providers					N. Martin/C. Gilbert
523	Provide comparison data to DBHDD					N. Martin/C. Gilbert
524	**Identify Recruitment Needs and Recommendatio**					**N. Martin/C. Gilbert**
525	Conduct initial geo-access study					N. Martin/C. Gilbert
526	Review results of GEO access to ensure Performa					N. Martin/C. Gilbert
527	Provider recruitment recommendations to DBHDD					N. Martin/C. Gilbert
528	**Provider Communication**	**152 days**	**Mon 9/1/14**	**Tue 3/31/15**		**N. Martin/C. Gilbert**
529	**E-mail Account**					**N. Martin/C. Gilbert**
530	Submit THC to request unique e-mail account for GA ASO Provider Network Communications					N. Martin/C. Gilbert
531	**Approval letters**					**N. Martin/C. Gilbert**
532	DBHDD review/approve					N. Martin/C. Gilbert
533	**Denial letters**					**N. Martin/C. Gilbert**
534	DBHDD review/approve					N. Martin/C. Gilbert
535	**Provider and HCBS Orientation Forums/Trainings**	**152 days**	**Mon 9/1/14**	**Tue 3/31/15**		**N. Martin/C. Gilbert**
536	Develop and submit an initial/on-going Provider Training Plan	93 days	Mon 9/1/14	Wed 1/7/15		N. Martin/C. Gilbert
537	DBHDD Review: Provider Training Plan					DBHDD
538	Approval: DBHDD: Provider Training Plan	3 days	Thu 1/8/15	Mon 1/12/15	536	DBHDD
539	Identify locations (hotel meeting rooms, conferenc					N. Martin/C. Gilbert
540	Book dates					N. Martin/C. Gilbert
541	Make payment arrangements with hotel/conferenc					N. Martin/C. Gilbert
542	Create agenda					N. Martin/C. Gilbert
543	Identify resources/VO attendees					N. Martin/C. Gilbert
544	Create invitations					N. Martin/C. Gilbert
545	Obtain management approval of invitations					N. Martin/C. Gilbert
546	Request mailing labels					N. Martin/C. Gilbert
547	Ensure photocopying of invitations					N. Martin/C. Gilbert
548	Mail invitations					N. Martin/C. Gilbert

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549	Identify materials to be distributed/mailed					N. Martin/C. Gilbert
550	Identify mandatory training requirements (claims, C					N. Martin/C. Gilbert
551	Identify presentation training materials					N. Martin/C. Gilbert
552	Ensure presentation materials are photocopied as nee					N. Martin/C. Gilbert
553	Coordinate delivery of information packets to forun					N. Martin/C. Gilbert
554	Ensure photocopying of information/training materials					N. Martin/C. Gilbert
555	Advise VO attendees of need to make travel arrangements with Corporate Travel (as					N. Martin/C. Gilbert
556	Coordinate session audio-visual equipment					N. Martin/C. Gilbert
557	Coordinate refreshments delivery and set-up					N. Martin/C. Gilbert
558	Re-verify forum locations) availability and times to set up/tear down					N. Martin/C. Gilbert
559	Engage in Mock Presentation with all participants					N. Martin/C. Gilbert
560	Gather feedback questionnaires and prepare summary of results					N. Martin/C. Gilbert
561	Conduct Provider Trainings	35 days	Mon 1/12/15	Fri 2/27/15	538	N. Martin/C. Gilbert
562	**Provider Relations Performance Standards**					**N. Martin/C. Gilbert**
563	**Identify all Performance Standards and assign owners**					**N. Martin/C. Gilbert**
564	Geo Access Standard					N. Martin/C. Gilbert
565	Network Availability Standard					N. Martin/C. Gilbert
566	Network Discount Standards					N. Martin/C. Gilbert
567	Provider Satisfaction Standard					N. Martin/C. Gilbert
568	**Provider Qualification Verification**	**152 days**	**Mon 9/1/14**	**Tue 3/31/15**		**N. Martin/J. Holte**
569	**Medicaid and State-Funded BH and IDD Provider**					**N. Martin/J. Holte**
570	Track receipt of applications					N. Martin/J. Holte
571	Track missing/incomplete credentialing elements					N. Martin/J. Holte
572	Request missing elements from provider via e-mail, fax/phone/written notification					N. Martin/J. Holte
573	Follow-up with providers who are non-responsive to missing/incomplete requests via fax/phone/written notification					N. Martin/J. Holte
574	Assemble complete files and forward to Network Operations					N. Martin/J. Holte

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
575	Review weekly status reports of qualification verification process					N. Martin/J. Holte
576	Review files for DBHDD Policy and Medicaid State Plan qualifications					N. Martin/J. Holte
577	Complete Primary Source Verification (PSV)					N. Martin/J. Holte
578	Submit files to Quality Control for credentialing review					N. Martin/J. Holte
579	Forward recommendations to DBHDD/DCH					N. Martin/J. Holte
580	**Medicaid and State-Funded BH and IDD Provider Data Entry**	**152 days**	**Mon 9/1/14**	**Tue 3/31/15**		**N. Martin/D. Ellis**
581	Approved files are data entered into provider management system					N. Martin/D. Ellis
582	Welcome packets are generated/mailed					N. Martin/D. Ellis
583	Denied providers are notified					N. Martin/D. Ellis
584	**HCBS Provider and State-Funded IDD Provider**	**152 days**	**Mon 9/1/14**	**Tue 3/31/15**		**N. Martin/J. Holte**
585	Track receipt of applications					N. Martin/J. Holte
586	Track missing/inc omplete credentialing elements					N. Martin/J. Holte
587	Request missing elements from provider via e-mail/fax/phone/written notification					N. Martin/J. Holte
588	Follow-up with providers who are non-responsive to missing/incomplete requests via fax/phone/written notification					N. Martin/J. Holte
589	Assemble complete file and forward to Network Operations					N. Martin/J. Holte
590	Review daily status reports of credentialing proces					N. Martin/J. Holte
591	Review file for DBHDD Policy and Medicaid State Plan qualifications					N. Martin/J. Holte
592	Identify non-accredited organizational providers					N. Martin/J. Holte
593	Schedule site visits for non-accredited organizations					N. Martin/J. Holte
594	Conduct site visits to non-accredited organizations					N. Martin/J. Holte
595	Forward site visit results for scoring					N. Martin/J. Holte
596	Include site visit outcome in provider file for DBHDD/DCH recommendation					N. Martin/D. Ellis
597	Validate facility sanctions					N. Martin/J. Holte
598	Submit recommendation to DBHDD/DCH for approval or denial					N. Martin/J. Holte

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599	**HCBS Provider and State-Funded IDD Provider Data Entry**	**152 days**	**Mon 9/1/14**	**Tue 3/31/15**		**N. Martin/D. Ellis**
600	Determine system set Up					N. Martin/D. Ellis
601	Approved files are data entered into provider management system					N. Martin/D. Ellis
602	Welcome packets are generated/mailed					N. Martin/D. Ellis
603	Denied providers are notified					N. Martin/D. Ellis
604	**Reporting**					**N. Martin/J. Holte**
605	Design application and process tracking report					N. Martin/J. Holte
606	Add request for weekly production of status/progress report					N. Martin/J. Holte
607	**Network Operations**					**N. Martin/D. Ellis**
608	**Set Up Network Operations Work Group**					**N. Martin/D. Ellis**
609	Set internal weekly meeting schedule with team members					N. Martin/D. Ellis
610	Set up call-in numbers for internal and external calls					N. Martin/D. Ellis
611	**Network Operations Resources**					**N. Martin/D. Ellis**
612	Determine resources required to develop/recruit network including toll free telephone line					N. Martin/D. Ellis
613	Determine resources required to credential/contract network					N. Martin/D. Ellis
614	Determine resources required for data entry/file maintenance					N. Martin/D. Ellis
615	Determine resources required for Data Management/ Reporting					N. Martin/D. Ellis
616	**System Set-up (NetworkConnect)**					**N. Martin/D. Ellis**
617	Confirm all system set-up codes for provider file					N. Martin/D. Ellis
618	Determine number and assignment of P-Org					N. Martin/D. Ellis
619	Determine number and assignment of Contract Code					N. Martin/D. Ellis
620	Determine number and assignment of Association Code					N. Martin/D. Ellis
621	**Claims Administration**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Troxler/L. Laplante**
622	**Implementation Planning**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Troxler/L. Laplante**
623	Review Program Requirements					C. Troxler/L. Laplante

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624	Determine claims contact and interface protocols with Client					C. Troxler/L. Laplante
625	Determine claims receipt volume					C. Troxler/L. Laplante
626	Develop discovery questions					C. Troxler/L. Laplante
627	Determine whether new PO Box is required	1 day	Wed 10/1/14	Wed 10/1/14		C. Troxler/L. Laplante
628	Determine which CAS environment client is being implemented (e.g. O, M)					C. Troxler/L. Laplante
629	Confirm requirements for tracking/maintaining applicable deductibles					C. Troxler/L. Laplante
630	Review EOP and EOB remarks codes					C. Troxler/L. Laplante
631	Identify and create client specific preferences (e.g hold codes, claims payment edits)					C. Troxler/L. Laplante
632	Complete System Config Checklist					C. Troxler/L. Laplante
633	Interest Setup					C. Troxler/L. Laplante
634	Queue Setup					C. Troxler/L. Laplante
635	Identify new reports					C. Troxler/L. Laplante
636	Same Day/Same Service protocol					C. Troxler/L. Laplante
637	Create workflows to ensure all required data is collected on claims for extract requirements					C. Troxler/L. Laplante
638	Timely Filing					C. Troxler/L. Laplante
639	**Update Policies and Procedures to reflect DBHDD claims payment rules**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Troxler/L. Laplante**
640	Review/refine workflow for tracking applicable co-payments, maximums					C. Troxler/L. Laplante
641	Review/refine process to administer exclusions, exceptions, limitations					C. Troxler/L. Laplante
642	Refine guidelines for split claims payments					C. Troxler/L. Laplante
643	Refine out-of-state, out-of-country and out-of-network claim procedures					C. Troxler/L. Laplante
644	**TPL/COB**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Troxler/L. Laplante**
645	Clarify responsibility for TPL					C. Troxler/L. Laplante
646	Review and clarify COB methodology					C. Troxler/L. Laplante
647	Develop any special process and policy and procedures					C. Troxler/L. Laplante
648	Develop any special letter templates					C. Troxler/L. Laplante
649	Review TPL data with customer					C. Troxler/L. Laplante

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650	Revise letter formats as needed					C. Troxler/L. Laplante
651	Adapt applicable P & Ps/materials to meet requirements of program: mixed services,					C. Troxler/L. Laplante
652	Adapt mixed services and transition protocols to comply with requirements					C. Troxler/L. Laplante
653	**Scanning/Mailroom**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Troxler/A. Daversa**
654	Secure New PO Box					C. Troxler/A. Daversa
655	Notify AE of New PO Box					C. Troxler/A. Daversa
656	**Confirm CAS environment**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Troxler/A. Daversa**
657	**RRI Custom Configuration**					**C. Troxler/A. Daversa**
658	Complete Consultant Agreement Form (CARF) to secure RRI resources					C. Troxler/A. Daversa
659	Vendor to sign NDA and BAA					C. Troxler/A. Daversa
660	Gather Requirements					C. Troxler/A. Daversa
661	Functional Specs					C. Troxler/A. Daversa
662	Sign Off					C. Troxler/A. Daversa
663	Programming					C. Troxler/A. Daversa
664	Level 1 Testing					C. Troxler/A. Daversa
665	Level 2 Testing					C. Troxler/A. Daversa
666	Sign Off					C. Troxler/A. Daversa
667	Operationalize					C. Troxler/A. Daversa
668	**Staffing**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Troxler/L. Laplante**
669	Confirm Staffing in underwriting					C. Troxler/L. Laplante
670	Coordinate with HR to post postions (internal and external)					C. Troxler/L. Laplante
671	Conduct interviews					C. Troxler/L. Laplante
672	Hire positions					C. Troxler/L. Laplante
673	**Training**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Troxler/L. Laplante**
674	Develop staff training curriculum	30 days	Mon 9/1/14	Fri 10/10/14		C. Troxler/L. Laplante
675	Distribute DBHDD claims payment rules and P & P					C. Troxler/L. Laplante
676	Schedule trainings					C. Troxler/L. Laplante
677	Implement training					C. Troxler/L. Laplante
678	**Information Technology**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**S. Costello/K. Roberts/C. Rajpal**

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679	**Information Technology**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**S. Costello/K. Roberts/C. Rajpal**
680	**Implementation Process**	**5 days**	**Mon 9/1/14**	**Fri 9/5/14**		**S. Costello/K. Roberts/C. Rajpal**
681	Notification of Award/CIG Received					S. Costello/K. Roberts/C. Rajpal
682	Identify Implementation Leads (Functional Areas)					S. Costello/K. Roberts/C. Rajpal
683	Obtain Finance Code					S. Costello/K. Roberts/C. Rajpal
684	Submit request for Implementation Project to be created in JIRA					S. Costello/K. Roberts/C. Rajpal
685	Document system information (Data dictionary, Release notes…)	30 days	Fri 1/30/15	Thu 3/12/15		S. Costello/K. Roberts/C. Rajpal
686	**IT Operations**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Rajpal/M. Hester**
687	**Facility Management Tasks**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**M. Hester**
688	**New Contract Award Notification**			**Mon 9/1/14**		**M. Hester**
689	Obtain copy UW budget; determine go live date; verify staffing requirements; determine facility location if one required; estimate square					M. Hester
690	Work with underwriting & implementation leader to obtain information					M. Hester
691	**Perform Search for Required Property**			**Mon 9/1/14**		**M. Hester**
692	Tenant broker perform search based upon information provided from above requirements					M. Hester
693	**Daily IT/Facility Mtgs**					**M. Hester**
694	Participate with preparation of facility / IT project plan and provide progress updates					M. Hester
695	**Data Voice Circuits**					**M. Hester**
696	IT order required circuits					M. Hester
697	**Select Preferred Properties**					**M. Hester**
698	Request proposals					M. Hester
699	Complete Nat'l Facility Site Survey					M. Hester
700	Forward to IT					M. Hester
701	Receive/evaluate proposals					M. Hester
702	Schedule IT site visits					M. Hester
703	Solicit IT property preference					M. Hester
704	Obtain IT drawing/ environmental requirements for computer room - Data Center					M. Hester
705	Submit counter-proposal					M. Hester

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706	**Receive/evaluate LL counter proposal response**					**M. Hester**
707	Compare LL responses					M. Hester
708	Execute recommendation					M. Hester
709	Request real estate lease					M. Hester
710	**Facility Floor Plan**					**M. Hester**
711	Obtain CAD File					M. Hester
712	Complete space/furniture design					M. Hester
713	Submit plans for approval					M. Hester
714	**Plans Approved**					**M. Hester**
715	LL request permits					M. Hester
716	Submits plans for bids					M. Hester
717	IT forwards to cable vendor					M. Hester
718	Facility orders furniture					M. Hester
719	**Real Estate Lease**					**M. Hester**
720	Review/compare lease w/approved LL proposal					M. Hester
721	Negotiate any issues					M. Hester
722	Finalize lease					M. Hester
723	**Construction build-out schedule**					**M. Hester**
724	Obtain construction build out schedule					M. Hester
725	Communicate to IT, cable, furniture and security vendors					M. Hester
726	**Office Equipment**					**M. Hester**
727	Order copiers					M. Hester
728	Order fax					M. Hester
729	Order postage machines					M. Hester
730	Set up UPS & eWay accounts					M. Hester
731	Establish local PO Box/courier required					M. Hester
732	**Office Signage & Business Licenses**					**M. Hester**
733	Submit & obtain office signage					M. Hester
734	Local business licenses					M. Hester
735	**Schedule Construction Mtgs**					**M. Hester**

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736	Weekly mtgs w/construction project mgr					M. Hester
737	Mtgs w/trade vendors, as necessary					M. Hester
738	**Cubicle/Furniture Install**					**M. Hester**
739	Schedule cubicle/furniture installations w/cable vendor & GC					M. Hester
740	**Build out Completion**					**M. Hester**
741	Perform final walk thru w.construction project mgr/GC					M. Hester
742	Identify/document all issues					M. Hester
743	Receive timeline for correction					M. Hester
744	**Final Build out cost reconciliation**					**M. Hester**
745	Work w/GC & construction project mgr for completion of build out reconciliation					M. Hester
746	Obtain approval and submit to finance					M. Hester
747	**IT Information Gathering for Data Center**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Rajpal**
748	**Building Security**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Rajpal**
749	**Select Vendor**					**C. Rajpal**
750	Identify locations for building security card readers					C. Rajpal
751	Provide AutoCAD of card reader locations					C. Rajpal
752	Contact Security Vendor with target move in date					C. Rajpal
753	Provide Security Vendor soft copy of electrical drawings					C. Rajpal
754	Provide pricing for purchase order for cabling new location					C. Rajpal
755	Create Purchase Order for security cabling					C. Rajpal
756	Cabling new location					C. Rajpal
757	**Data Center Leases, Contracts & Accounts**					**C. Rajpal**
758	Establish Vendor Contract for HVAC					C. Rajpal
759	Establish Vendor Contract for Security					C. Rajpal
760	**Network Services LAN/WAN IT Implementation Template**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Rajpal**
761	**Identify LAN/WAN equipment for data center**					**C. Rajpal/R. Alesio**
762	**Power/UPS/Generator**					**C. Rajpal/R. Alesio**

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763	Calculate power requirements for data center equipment - LAN					C. Rajpal/R. Alesio
764	Calculate power requirements for data center equipment - WAN					C. Rajpal/R. Alesio
765	Prepare Server Room Diagram					C. Rajpal/R. Alesio
766	**LAN Tasks**					**C. Rajpal/R. Alesio**
767	**Determine Needed LAN Hardware/Software**					**C. Rajpal/R. Alesio**
768	**Obtain Staffing Information**					**C. Rajpal/R. Alesio**
769	On-Site					C. Rajpal/R. Alesio
770	Off-Site					C. Rajpal/R. Alesio
771	Determine the number of servers					C. Rajpal/R. Alesio
772	Determine Set Up Date					C. Rajpal/R. Alesio
773	Determine shipping plan					C. Rajpal/R. Alesio
774	**Order LAN Equipment**					**C. Rajpal/R. Alesio**
775	Create and submit Purchase Requests (PR) for all LAN equipment					C. Rajpal/R. Alesio
776	Obtain VP management approval for PR and Purchase Order (PO)					C. Rajpal/R. Alesio
777	Document Equipment Ordered into LAN Services Inventory					C. Rajpal/R. Alesio
778	Order hardware (Server, Rack, Cable, Video, Mouse)					C. Rajpal/R. Alesio
779	**Receive LAN Equipment**					**C. Rajpal/R. Alesio**
780	Servers					C. Rajpal/R. Alesio
781	Software					C. Rajpal/R. Alesio
782	Racks to include: Cable, Video, Mouse					C. Rajpal/R. Alesio
783	**Install/Setup LAN Equipment**					**C. Rajpal/R. Alesio**
784	Configure Servers					C. Rajpal/R. Alesio
785	Install Software					C. Rajpal/R. Alesio
786	Setup Racks to include: Cable, Video, Mouse					C. Rajpal/R. Alesio
787	Test Servers					C. Rajpal/R. Alesio
788	**WAN Tasks**					**C. Rajpal/R. Alesio**
789	**Determine Method of connectivity**					**C. Rajpal/R. Alesio**

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790	Determine WAN Equipment Needed for connectivity					C. Rajpal/R. Alesio
791	Determine File Transfer Needs/ Method and Resources Assigned					C. Rajpal/R. Alesio
792	**Determine Circuit Size**					**C. Rajpal/R. Alesio**
793	Data					C. Rajpal/R. Alesio
794	Voice					C. Rajpal/R. Alesio
795	**Obtain Location Information**					**C. Rajpal/R. Alesio**
796	**Obtain Location Description**					**C. Rajpal/R. Alesio**
797	Obtain Site Address					C. Rajpal/R. Alesio
798	Obtain Site Layout					C. Rajpal/R. Alesio
799	Obtain Local Contact Information (e.g. Building/Property Management)					C. Rajpal/R. Alesio
800	Obtain IT Contact Information					C. Rajpal/R. Alesio
801	**Obtain Staffing Information**					**C. Rajpal/R. Alesio**
802	On-Site					C. Rajpal/R. Alesio
803	Off-Site					C. Rajpal/R. Alesio
804	**Order WAN Equipment**					**C. Rajpal/R. Alesio**
805	**Hardware**					**C. Rajpal/R. Alesio**
806	Determine hardware needs					C. Rajpal/R. Alesio
807	Generate PR					C. Rajpal/R. Alesio
808	Obtain VP management approval for PR					C. Rajpal/R. Alesio
809	Order hardware					C. Rajpal/R. Alesio
810	Receive Hardware					C. Rajpal/R. Alesio
811	Configure Hardware					C. Rajpal/R. Alesio
812	Install Hardware					C. Rajpal/R. Alesio
813	Test Hardware					C. Rajpal/R. Alesio
814	**Cabling**					**C. Rajpal/R. Alesio**
815	Determine cabling needs					C. Rajpal/R. Alesio
816	Identify vendor					C. Rajpal/R. Alesio
817	Design cable					C. Rajpal/R. Alesio
818	Confirm Construction Completion Before Cable Installation					C. Rajpal/R. Alesio

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819	Lay Cable(s)					C. Rajpal/R. Alesio
820	Test Cable(s)					C. Rajpal/R. Alesio
821	**Data Circuits & CPE**					**C. Rajpal/R. Alesio**
822	Determine Data Circuit & CPE needs					C. Rajpal/R. Alesio
823	Determine size					C. Rajpal/R. Alesio
824	Place Data Circuit & CPE order					C. Rajpal/R. Alesio
825	Obtain Data Circuits & CPE					C. Rajpal/R. Alesio
826	Install Data Circuit & CPE					C. Rajpal/R. Alesio
827	Network Planning and Engineering (NPE) Testing					C. Rajpal/R. Alesio
828	**Client Site**					**C. Rajpal/R. Alesio**
829	**Method of connectivity**					**C. Rajpal/R. Alesio**
830	**Router(s)**					**C. Rajpal/R. Alesio**
831	Order Router(s) for Client Site					C. Rajpal/R. Alesio
832	Receive Router(s) for Client Site					C. Rajpal/R. Alesio
833	Configure Router(s) for Client Site					C. Rajpal/R. Alesio
834	Ship Router(s) to Client Site					C. Rajpal/R. Alesio
835	**Switch(es)**					**C. Rajpal/R. Alesio**
836	Determine Switch/Hub Requirements					C. Rajpal/R. Alesio
837	Order Switch(es) for Client Site					C. Rajpal/R. Alesio
838	Receive Switch(es) for Client Site					C. Rajpal/R. Alesio
839	Configure Switch(es) for Client Site					C. Rajpal/R. Alesio
840	Ship Switch(es) to Client Site					C. Rajpal/R. Alesio
841	**Site to Site VPN**					**C. Rajpal/R. Alesio**
842	Determine need for Site to Site VPN					C. Rajpal/R. Alesio
843	Distribute VPN form to Client					C. Rajpal/R. Alesio
844	Obtain completed form and sign off from Client (VPN form)					C. Rajpal/R. Alesio
845	Configure Site to Site VPN					C. Rajpal/R. Alesio
846	Test Site to Site connectivity					C. Rajpal/R. Alesio
847	**Desktop Services Tasks**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Rajpal**
848	Determine the number of Desktops / Laptops					C. Rajpal/R. Alesio

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849	Determine number of desktops/laptops for the MD/PA staff					C. Rajpal/R. Alesio
850	Determine the number of Printers, Copiers, and Fax Machines					C. Rajpal/R. Alesio
851	Determine Fax Purposes to be setup on the Fax server					C. Rajpal/R. Alesio
852	Order equipment					C. Rajpal/R. Alesio
853	Setup Desktops and Monitors for staff functional 5/1					C. Rajpal/R. Alesio
854	Setup Printers					C. Rajpal/R. Alesio
855	Test Setup					C. Rajpal/R. Alesio
856	Determine equipment count for expansion space					C. Rajpal/R. Alesio
857	Place Equipment Order					C. Rajpal/R. Alesio
858	Complete Desktop/Monitors setup as additional staff join					C. Rajpal/R. Alesio
859	Test Setup					C. Rajpal/R. Alesio
860	**Telecom Tasks**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Rajpal/R. Corduck**
861	**Telecom Tasks**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**C. Rajpal/R. Corduck**
862	**Define TFN and ACD Programming**					**C. Rajpal/R. Corduck**
863	Provide 800#s for publications to Business					C. Rajpal/R. Corduck
864	**Gather Requirements**					**C. Rajpal/R. Corduck**
865	Business to provide scripts for the TFN					C. Rajpal/R. Corduck
866	Define BRP site					C. Rajpal/R. Corduck
867	Define Agent Groups					C. Rajpal/R. Corduck
868	Define Service Levels on VDN's					C. Rajpal/R. Corduck
869	Define Service Levels on Skills					C. Rajpal/R. Corduck
870	D efine VDN Names					C. Rajpal/R. Corduck
871	Define Announcements					C. Rajpal/R. Corduck
872	Define AUX Reason Codes					C. Rajpal/R. Corduck
873	Provide Holiday Schedule					C. Rajpal/R. Corduck
874	Confirm Zip Tone					C. Rajpal/R. Corduck
875	Provide Vector's for the VDN's					C. Rajpal/R. Corduck
876	Provide Aux Reason Code Description					C. Rajpal/R. Corduck
877	Provide Skill Level for Agents					C. Rajpal/R. Corduck

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
878	Provide Vu Stat Formats					C. Rajpal/R. Corduck
879	**Complete Design**					**C. Rajpal/R. Corduck**
880	Prepare Call Center Design Documents					C. Rajpal/R. Corduck
881	Review Design with business team					C. Rajpal/R. Corduck
882	Update design document if needed					C. Rajpal/R. Corduck
883	**Setup Other Applications**					**C. Rajpal/R. Corduck**
884	Order Language Line Services					C. Rajpal/R. Corduck
885	Setup service center on E911					C. Rajpal/R. Corduck
886	**Test Plan**					**C. Rajpal/R. Corduck**
887	Prepare Test Plan, Execution, Executive Summary and Analysis Package					C. Rajpal/R. Corduck
888	**Define CMS Programming**					**C. Rajpal/R. Corduck**
889	CMS Dictionary (agent names, trunk group names)					C. Rajpal/R. Corduck
890	The Service Levels on VDN's for the Call Profile Reports					C. Rajpal/R. Corduck
891	The Service Levels on Skills for the Call Profile Reports					C. Rajpal/R. Corduck
892	Agent Groups					C. Rajpal/R. Corduck
893	**System Set Up**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K.Roberts/R. Lisseveld/A. Daversa**
894	**CAS Set Up**			**Mon 9/1/14**		**A. Daversa**
895	**System/Benefits Configuration**					**A. Daversa**
896	Requirements					A. Daversa
897	Gather requirements for benefit information/benefit rules					A. Daversa
898	Obtain final BDD from Acct Manager or < Client					A. Daversa
899	Obtain list of covered services					A. Daversa
900	Obtain listing of covered diagnosis codes by state					A. Daversa
901	Obtain authorization requirements/auths types					A. Daversa
902	Create draft of Service Class Grid{s}					A. Daversa
903	**CAS Claims Configuration/Reference File Setup/CC & Service Connect**					**A. Daversa**

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
904	Assign Parent Code{s}					A. Daversa
905	Develop Benefit Shells					A. Daversa
906	Load Service Class Grid{s} into CAS					A. Daversa
907	Configure CareConnect/Service Connect					A. Daversa
908	**Configure MemberConnect SSO Admin**					**A. Daversa**
909	Load Parent code					A. Daversa
910	Obtain ReferralConnect information {username, Pswd, URL} from Software Development					A. Daversa
911	Obtain Achieve Solutions information {client user ID, URL} from Software Development					A. Daversa
912	Obtain Medicaid Website {URL specific website} from Software Development					A. Daversa
913	**Benefit Configuration**					**A. Daversa**
914	Configure Benefits					A. Daversa
915	Peer-to-peer audit					A. Daversa
916	Test Benefits					A. Daversa
917	**BenefitConnect**					**A. Daversa**
918	Load Client {s}					A. Daversa
919	Load Benefit Packages					A. Daversa
920	Load Benefit Information					A. Daversa
921	Activate Client					A. Daversa
922	**References and Tables**					**A. Daversa**
923	Establish ELGPAR					A. Daversa
924	Define Groups					A. Daversa
925	Set Up Unknown Member					A. Daversa
926	Set Up Groups					A. Daversa
927	Parent/Reason Code Cross Reference (RF1321)					A. Daversa
928	**CONNECTIONS Set Up**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K.Roberts/R. Lisseveld**
929	**JIRA Set Up**					**K.Roberts/R. Lisseveld**
930	Add Implementation Deliverables to JIRA					K.Roberts/R. Lisseveld
931	**ServiceConnect/CareConnect Set Up**					**K.Roberts/R. Lisseveld**

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
932	Determine Client Auto Routing Set Up for Clinical services					K.Roberts/R. Lisseveld
933	Complete WARMAS/SECFLA set up					K.Roberts/R. Lisseveld
934	Determine Client Auths Parameter Set Up					K.Roberts/R. Lisseveld
935	Submit THC ticket to update WARMAS					K.Roberts/R. Lisseveld
936	Set Up Service Center & Market Segments Codes on Group Record (ME1031) to support auths auto-routing					K.Roberts/R. Lisseveld
937	Confirm Service/CareConnect Set Up					K.Roberts/R. Lisseveld
938	**NetworkConnect (Provider System) set-up**					**K. Roberts/D. Ellis**
939	**NetworkConnect (Provider System) set-up**					**K. Roberts/D. Ellis**
940	Review CIG					K. Roberts/D. Ellis
941	Identify Provider File Configuration needs					K. Roberts/D. Ellis
942	Create Client Contract Code (cc)					K. Roberts/D. Ellis
943	Create Network Association Code					K. Roberts/D. Ellis
944	Create Parent Organization Code (PORG)					K. Roberts/D. Ellis
945	Data Entry of Files (If Applicable)					K. Roberts/D. Ellis
946	Work with IT to develop Provider File Import (If applicable)					K. Roberts/D. Ellis
947	Create fee codes					K. Roberts/D. Ellis
948	Create any additional REFMAS elements					K. Roberts/D. Ellis
949	Load rates into FEEMAS					K. Roberts/D. Ellis
950	Map Parent Code to assigned Network (RF1015					K. Roberts/D. Ellis
951	**NetworkConnect (Provider System) set-up**					**K. Roberts/D. Ellis**
952	Notify NetOps, Eligibility and Implementation Team of Provider Configuration					K. Roberts/D. Ellis
953	**ReferralConnect Set Up**					**K. Roberts**
954	Gather Requirements					K. Roberts
955	Communicate Network Configuration Information To IT					K. Roberts
956	Set Up Access					K. Roberts
957	Test Access					K. Roberts
958	Sign Off					K. Roberts
959	**ClientConnect Set Up**					**K. Roberts**

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
960	Gather Requirements					K. Roberts
961	Set Up Access					K. Roberts
962	Test Access					K. Roberts
963	Sign Off					K. Roberts
964	**ProviderConnect Setup**					**K. Roberts**
965	Determine Inquiry routing needs					K. Roberts
966	Submit THC ticket to initiate inquiry routing set-up					K. Roberts
967	Set up inquiry routing					K. Roberts
968	**TeleConnect Set Up**					**K. Roberts**
969	Gather Requirements					K. Roberts
970	Verify ECR set up					K. Roberts
971	Provider Opt out numbers for Claims and Customer Service					K. Roberts
972	Enter opt out data and Parent codes in TeleConnect					K. Roberts
973	Set Up Access					K. Roberts
974	Test Access					K. Roberts
975	**MemberConnect Setup**					**K. Roberts**
976	Determine Inquiry routing needs					K. Roberts
977	Submit THC ticket to initiate inquiry routing set-up					K. Roberts
978	Set up inquiry routing					K. Roberts
979	Provide ReferralConnect set up to Systems Configuration					K. Roberts
980	**Achieve Solutions Setup**					**K. Roberts**
981	Submit AS Implementation Form Obtain set up form					K. Roberts
982	Retrieve and Review Implementation Form					K. Roberts
983	Provide link to AchieveSolutions to Systems Configuration					K. Roberts
984	Enter Client Configuration into MemberConnect Admin					K. Roberts
985	**FileConnect Set Up**					**K. Roberts**
986	Assign Grid Owner					K. Roberts

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
987	Determine File Transfer Method and Resources Assigned					K. Roberts
988	Complete Grid					K. Roberts
989	Assign User ID's and Passwords					K. Roberts
990	Test connectivity					K. Roberts
991	**Correspondence**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Roberts**
992	**EOB - Explanation of Benefits Set Up**					**K. Roberts**
993	Business Requirements					K. Roberts
994	Send Group Rules to ABF					K. Roberts
995	Confirm ABF Set Up					K. Roberts
996	Confirm CAS Set Up					K. Roberts
997	Send Test File to ABF					K. Roberts
998	Validate ABF Results					K. Roberts
999	Sign Off					DBHDD
1000	Implement into production					K. Roberts
1001	**PSV - Provider Vouchers**					**K. Roberts**
1002	Notify vendor of the new client PSV (include go live date)					K. Roberts
1003	Distribute group rules form to AE for completion					K. Roberts
1004	Business Requirements					K. Roberts
1005	Obtain Business Requirements Signoff					K. Roberts
1006	Send Group Rules to Payformance					K. Roberts
1007	Confirm Payformance Set Up					K. Roberts
1008	Confirm CAS Set Up					K. Roberts
1009	Create test temp member records					K. Roberts
1010	Create test authorizations					K. Roberts
1011	Create test claims					K. Roberts
1012	Send Test File to Payformance					K. Roberts
1013	Validate Payformance Results					K. Roberts
1014	Sign Off					DBHDD
1015	Implement into production					K. Roberts

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1016	**KnowledgeConnect (Data Warehouse) Set Up and Data Loads**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Roberts**
1017	**Data Warehouse External Loads (DBHDD Historical Loads, ISP, Medicaid Paid Claims, etc.**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**J. Park**
1018	Define requirements					J. Park
1019	Create new DWH tables					J. Park
1020	Create new DWH control files					J. Park
1021	Create and test new DWH load processes					J. Park
1022	Request and validate ETS setup					J. Park
1023	Create scheduled job					J. Park
1024	Perform Initial load					J. Park
1025	**Production Internal Loads**					**K. Roberts**
1026	Define requirements					K. Roberts
1027	Create and test new AS/400 extract processes					K. Roberts
1028	Create new DWH tables					K. Roberts
1029	Create new DWH control files					K. Roberts
1030	Create and test new DWH load processes					K. Roberts
1031	Perform Initial extract					K. Roberts
1032	Perform Initial Load					K. Roberts
1033	**CONNECTIONS - CAS Systems Development**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Roberts**
1034	**Data Exchanges**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Roberts**
1035	**Data Imports**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Roberts**
1036	**Eligibility Import - Custom File Layout**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Vendetti**
1037	Gather Requirements					K. Vendetti
1038	Functional Specs					K. Vendetti
1039	Sign Off					DBHDD/K. Vendetti
1040	Programming					ValueOptions Programmer
1041	Send Eligibility Test File					DBHDD
1042	Level 1 Testing					ValueOptions Programmer
1043	Level 2A Testing					K. Vendetti
1044	Level 2B Testing					K. Vendetti

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1045	Sign Off					DBHDD
1046	Operationalize				1045	K. Vendetti
1047	**Third Party Liability (TPL)**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Vendetti**
1048	Gather Requirements					K. Vendetti
1049	Functional Specs					K. Vendetti
1050	Sign Off					DBHDD/K. Vendetti
1051	Programming					ValueOptions Programmer
1052	Send TPL Test File					DBHDD
1053	Level 1 Testing					ValueOptions Programmer
1054	Level 2A Testing					K. Vendetti
1055	Level 2B Testing					K. Vendetti
1056	Sign Off					DBHDD
1057	Operationalize					K. Vendetti
1058	**Existing CIDs Import - Custom File Layout**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Vendetti**
1059	Gather Requirements					K. Vendetti
1060	Functional Specs					K. Vendetti
1061	Sign Off					DBHDD/K. Vendetti
1062	Programming					ValueOptions Programmer
1063	Send CIDs Test File					DBHDD
1064	Level 1 Testing					ValueOptions Programmer
1065	Level 2A Testing					K. Vendetti
1066	Level 2B Testing					K. Vendetti
1067	Sign Off					DBHDD
1068	Operationalize					K. Vendetti
1069	**Authorization Import (Batch Files from Providers, Qualifacts)**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Roberts**
1070	Gather Requirements					K. Roberts
1071	Functional Specs					K. Roberts
1072	Sign Off					J. Maurizio/Qualifacts
1073	Programming					ValueOptions Programmer
1074	Send Batch Auth Test File					Qualifacts/Providers
1075	Level 1 Testing					ValueOptions Programmer

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1076	Level 2 Testing					K. Roberts
1077	Level 3 Testing					J. Maurizio
1078	Sign Off					J. Maurizio/Qualifacts
1079	Operationalize					K. Roberts
1080	**PASRR LOC (ALLIANT/GMCF) Import**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Roberts**
1081	Gather Requirements					K. Roberts
1082	Functional Specs					K. Roberts
1083	Sign Off					Alliant/GMCF
1084	Programming					ValueOptions Programmer
1085	Send PASRR LOC Test File					ValueOptions EDI
1086	Level 1 Testing					ValueOptions Programmer
1087	Level 2 Testing					K. Roberts
1088	Level 3 Testing					Alliant/GMCF
1089	Sign Off					Alliant/GMCF
1090	Operationalize					K. Roberts
1091	**DBHDD Provider Import**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Roberts**
1092	Gather Requirements					K. Roberts
1093	Functional Specs					K. Roberts
1094	Sign Off					DBHDD/D. Ellis
1095	Programming					ValueOptions Programmer
1096	Send Provider Test File					DBHDD
1097	Level 1 Testing					ValueOptions Programmer
1098	Level 2 Testing					K. Roberts
1099	Level 3 Testing					D. Ellis
1100	Sign Off					DBHDD/D. Ellis
1101	Operationalize					K. Roberts
1102	**820 Premium Payment from DBHDD**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Roberts**
1103	Gather Requirements					K. Roberts
1104	Functional Specs					K. Roberts
1105	Sign Off					B. Flowe/B. Marshall
1106	Programming					ValueOptions Programmer
1107	Send Test 820 File					DBHDD

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1108	Level 1 Testing					ValueOptions Programmer
1109	Level 2 Testing					K. Roberts
1110	Level 3 Testing					B. Flowe/B. Marshall
1111	Sign Off					B. Flowe/B. Marshall
1112	Operationalize					K. Roberts
1113	**Medicaid Paid Claims File**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Roberts**
1114	Gather Requirements					K. Roberts
1115	Functional Specs					K. Roberts
1116	Sign Off					DBHDD/C. Troxler
1117	Programming					ValueOptions Programmer
1118	Send Paid Claims Test File					DBHDD
1119	Level 1 Testing					ValueOptions Programmer
1120	Level 2 Testing					K. Roberts
1121	Level 3 Testing					C. Troxler/ L. Laplante
1122	Sign Off					DBHDD/C. Troxler
1123	Operationalize					K. Roberts
1124	**Authorization Response File from DBHDD/GAMMIS**					**K. Roberts**
1125	Gather Requirements					K. Roberts
1126	Functional Specs					K. Roberts
1127	Sign Off					K. Roberts
1128	Programming					ValueOptions Programmer
1129	Send Test Auth Response File					DBHDD
1130	Level 1 Testing					ValueOptions Programmer
1131	Level 2 Testing					K. Roberts
1132	Level 3 Testing					K. Roberts
1133	Sign Off					K. Roberts
1134	Operationalize					K. Roberts
1135	**Encounters/NCB Claims Response File from DBHDD/GAMMIS**					**K. Roberts**
1136	Gather Requirements					K. Roberts
1137	Functional Specs					K. Roberts

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1138	Sign Off					K. Roberts
1139	Programming					ValueOptions Programmer
1140	Send Test Response File					DBHDD
1141	Level 1 Testing					ValueOptions Programmer
1142	Level 2 Testing					K. Roberts
1143	Level 3 Testing					K. Roberts
1144	Sign Off					K. Roberts
1145	Operationalize					K. Roberts
1146	**Data Extracts**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Roberts**
1147	**Encounter Extract**					**K. Roberts**
1148	Gather Requirements					K. Roberts
1149	Functional Specs					K. Roberts
1150	Sign Off					DBHDD/C. Troxler
1151	Programming					ValueOptions Programmer
1152	Send Test Encounter File					ValueOptions EDI
1153	Level 1 Testing					ValueOptions Programmer
1154	Level 2 Testing					K. Roberts
1155	Level 3 Testing					DBHDD/C. Troxler
1156	Sign Off					DBHDD/C. Troxler
1157	Operationalize					K. Roberts
1158	**Authorization Extract**					**K. Roberts**
1159	Gather Requirements					K. Roberts
1160	Functional Specs					K. Roberts
1161	Sign Off					DBHDD/J. Maurizio
1162	Programming					ValueOptions Programmer
1163	Send Test Auth File					ValueOptions EDI
1164	Level 1 Testing					ValueOptions Programmer
1165	Level 2 Testing					K. Roberts
1166	Level 3 Testing					DBHDD/J. Maurizio
1167	Sign Off					DBHDD/J. Maurizio
1168	Operationalize					K. Roberts
1169	**PASRR LOC (ALLIANT/GMCF) Extract**					**K. Roberts**

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Georgia Department of Behavioral Health and Developmental Disabilities ASO
ValueOptions DRAFT - Implementation Plan

ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1170	Gather Requirements					K. Roberts
1171	Functional Specs					K. Roberts
1172	Sign Off					Alliant/GMCF
1173	Programming					ValueOptions Programmer
1174	Send Test PASRR LOC File					ValueOptions EDI
1175	Level 1 Testing					ValueOptions Programmer
1176	Level 2 Testing					K. Roberts
1177	Level 3 Testing					Alliant/GMCF
1178	Sign Off					Alliant/GMCF
1179	Operationalize					K. Roberts
1180	**Web Development**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**K. Roberts**
1181	**Design/Develop Custom GA ASO Website**					**K. Roberts**
1182	Gather Requirements					K. Roberts
1183	Functional Specs					K. Roberts
1184	Sign Off					DBHDD
1185	Programming					K. Roberts
1186	Level 1 Testing					K. Roberts
1187	Level 2 Testing					K. Roberts
1188	Level 3 Testing					DBHDD
1189	Sign Off					DBHDD
1190	Operationalize					K. Roberts
1191	**IDD on-line capabilities**					**K. Roberts**
1192	Gather Requirements					K. Roberts
1193	Functional Specs					K. Roberts
1194	Sign Off					K. Roberts/J. Maurizio
1195	Programming					ValueOptions Programmer
1196	Level 1 Testing					K. Roberts
1197	Level 2 Testing					K. Roberts
1198	Level 3 Testing					K. Roberts
1199	Sign Off					J. Maurizio
1200	Operationalize					K. Roberts
1201	**ServiceConnect Customizations**					**K. Roberts**

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1202	Gather Requirements					K. Roberts
1203	Functional Specs					K. Roberts
1204	Sign Off					K. Roberts/M. Golden
1205	Programming					K. Roberts
1206	Level 1 Testing					K. Roberts
1207	Level 2 Testing					K. Roberts
1208	Level 3 Testing					K. Roberts
1209	Sign Off					M. Golden
1210	Operationalize					K. Roberts
1211	**CareConnect Customizations**					**K. Roberts**
1212	**Individual (Consumer) Registration**					**K. Roberts**
1213	Gather Requirements					K. Roberts
1214	Functional Specs					K. Roberts
1215	Sign Off					J. Maurizio
1216	Programming					ValueOptions Programmer
1217	Level 1 Testing					ValueOptions Programmer
1218	Level 2 Testing					K. Roberts
1219	Level 3 Testing					J. Maurizio
1220	Sign Off					J. Maurizio
1221	Operationalize					K. Roberts
1222	**Custom Authorization Parameters/Triage Guidelines**					**K. Roberts**
1223	Gather Requirements					K. Roberts
1224	Functional Specs					K. Roberts/J. Maurizio
1225	Sign Off					J. Maurizio
1226	Programming					ValueOptions Programmer
1227	Level 1 Testing					ValueOptions Programmer
1228	Level 2 Testing					K. Roberts
1229	Level 3 Testing					J. Maurizio
1230	Sign Off					J. Maurizio
1231	Operationalize					K. Roberts
1232	**Custom Forms (ITR/ORF)**					**K. Roberts**

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1233	Gather Requirements					K. Roberts
1234	Functional Specs					K. Roberts/J. Maurizio
1235	Sign Off					J. Maurizio
1236	Programming					ValueOptions Programmer
1237	Level 1 Testing					ValueOptions Programmer
1238	Level 2 Testing					K. Roberts
1239	Level 3 Testing					J. Maurizio
1240	Sign Off					J. Maurizio
1241	Operationalize					K. Roberts
1242	**Batch Authorizations**					**K. Roberts**
1243	Gather Requirements					K. Roberts
1244	Functional Specs					K. Roberts/J. Maurizio
1245	Sign Off					J. Maurizio
1246	Programming					ValueOptions Programmer
1247	Level 1 Testing					ValueOptions Programmer
1248	Level 2 Testing					K. Roberts
1249	Level 3 Testing					J. Maurizio
1250	Sign Off					J. Maurizio
1251	Operationalize					K. Roberts
1252	**Custom Assesments (HCBS, PASRR, BH and IDD)**					**K. Roberts**
1253	Gather Requirements					K. Roberts
1254	Functional Specs					K. Roberts/J. Maurizio
1255	Sign Off					J. Maurizio
1256	Programming					ValueOptions Programmer
1257	Level 1 Testing					ValueOptions Programmer
1258	Level 2 Testing					K. Roberts
1259	Level 3 Testing					J. Maurizio
1260	Sign Off					J. Maurizio
1261	Operationalize					K. Roberts
1262	**ProviderConnect Customizations**					**K. Roberts**
1263	**Individual (Consumer) Registration**					**K. Roberts**

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1264	Gather Requirements					K. Roberts
1265	Functional Specs					K. Roberts/J. Maurizio
1266	Sign Off					J. Maurizio
1267	Programming					ValueOptions Programmer
1268	Level 1 Testing					ValueOptions Programmer
1269	Level 2 Testing					K. Roberts
1270	Level 3 Testing					J. Maurizio
1271	Sign Off					J. Maurizio
1272	Operationalize					K. Roberts
1273	**Batch Authorizations**					**K. Roberts**
1274	Gather Requirements					K. Roberts
1275	Functional Specs					K. Roberts/J. Maurizio
1276	Sign Off					J. Maurizio
1277	Programming					ValueOptions Programmer
1278	Level 1 Testing					ValueOptions Programmer
1279	Level 2 Testing					K. Roberts
1280	Level 3 Testing					J. Maurizio
1281	Sign Off					J. Maurizio
1282	Operationalize					K. Roberts
1283	**Custom Forms (ITR/ORF)**					**K. Roberts**
1284	Gather Requirements					K. Roberts
1285	Functional Specs					K. Roberts/J. Maurizio
1286	Sign Off					J. Maurizio
1287	Programming					ValueOptions Programmer
1288	Level 1 Testing					ValueOptions Programmer
1289	Level 2 Testing					K. Roberts
1290	Level 3 Testing					J. Maurizio
1291	Sign Off					J. Maurizio
1292	Operationalize					K. Roberts
1293	**Custom Authorization Parameters/Triage Guidelines**					**K. Roberts**
1294	Gather Requirements					K. Roberts

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1295	Functional Specs					K. Roberts/J. Maurizio
1296	Sign Off					J. Maurizio
1297	Programming					ValueOptions Programmer
1298	Level 1 Testing					ValueOptions Programmer
1299	Level 2 Testing					K. Roberts
1300	Level 3 Testing					J. Maurizio
1301	Sign Off					J. Maurizio
1302	Operationalize					K. Roberts
1303	**Custom Assesments (HCBS, PASRR, BH and IDD)**					**K. Roberts**
1304	Gather Requirements					K. Roberts
1305	Functional Specs					K. Roberts/J. Maurizio
1306	Sign Off					J. Maurizio
1307	Programming					ValueOptions Programmer
1308	Level 1 Testing					ValueOptions Programmer
1309	Level 2 Testing					K. Roberts
1310	Level 3 Testing					J. Maurizio
1311	Sign Off					J. Maurizio
1312	Operationalize					K. Roberts
1313	**ReferralConnect Customizations**					**K. Roberts**
1314	**Filter by population served and display days/hours of service**					**K. Roberts**
1315	Gather Requirements					K. Roberts
1316	Functional Specs					K. Roberts
1317	Sign Off					D. Ellis
1318	Programming					ValueOptions Programmer
1319	Level 1 Testing					ValueOptions Programmer
1320	Level 2 Testing					K. Roberts
1321	Level 3 Testing					D. Ellis
1322	Sign Off					K. Roberts
1323	Operationalize					K. Roberts
1324	**Clinical Care Alerts**					**K. Roberts**

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1325	Identify DBHDD Rx PBM					K. Roberts
1326	Obtain DBHDD PBMs Pharmacy Data and File Layout					K. Roberts
1327	Build Data Import for Rx data (to data warehouse)					K. Roberts
1328	Load Rx Data to Clinical Care Alerts DB (From Data Warehouse). Connect to existing Eligibility data					K. Roberts
1329	Link date into Clinical Care Alerts. Make data conversions as needed.					K. Roberts
1330	Add client name into Clinical Care Alerts, modify data rules.					K. Roberts
1331	Run Care Alerts					K. Roberts
1332	Clinical Review					K. Roberts
1333	Level 1 Testing					K. Roberts
1334	Level 2 Testing					K. Roberts
1335	UAT					J. Maurizio
1336	Submit data to letter vendor					K. Roberts
1337	Letters in production					K. Roberts
1338	Sign Off on Clinical Care Alerts Implementation					J. Maurizio
1339	**Spectrum (Patient-centric record)**					**K. Roberts**
1340	Business Requirements Defined					K. Roberts
1341	Design Specifications					K. Roberts
1342	Internal Sign Off					K. Roberts
1343	Specifications Review Meeting with Client					K. Roberts
1344	Client Offline Review					DBHDD
1345	Specification Review Follow Up/Modifications					K. Roberts
1346	Client Sign Off					DBHDD
1347	Programming					ValueOptions Programmer
1348	Level 1 Testing					ValueOptions Programmer
1349	Level 2 Testing					K. Roberts
1350	UAT sign-off					DBHDD/ J. Maurizio
1351	Production Release					K. Roberts

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1352	Post-production testing					DBHDD/ J. Maurizio
1353	**Training**	**130 days**	**Mon 9/1/14**	**Fri 2/27/15**		**C. Rajpal**
1354	**Preparation**					**C. Rajpal**
1355	Determine System security group access profiles					C. Rajpal
1356	Obtain Covered Services Grid from Benefit Configuration team					C. Rajpal
1357	Obtain workflows from functional work groups					C. Rajpal
1358	Modify training curriculum for client specific enhancements					C. Rajpal
1359	**BHL**					**C. Rajpal**
1360	Determine training schedule					C. Rajpal
1361	Coordinate creation of System log-ons (eSars)					C. Rajpal
1362	Confirm students have received and tested their appropriate System log-ons					C. Rajpal
1363	Assign students to individual classes and schedule training					C. Rajpal
1364	Conduct Training					C. Rajpal
1365	**Delmarva**					**C. Rajpal**
1366	Determine training schedule					C. Rajpal
1367	Coordinate creation of System log-ons (eSars)					C. Rajpal
1368	Confirm students have received and tested their appropriate System log-ons					C. Rajpal
1369	Assign students to individual classes and schedule training					C. Rajpal
1370	Conduct Training					C. Rajpal
1371	**DBHDD, Regional Offices and other authorized external users of SCC**					**C. Rajpal**
1372	Determine training schedule					C. Rajpal
1373	Coordinate creation of System log-ons (eSars)					C. Rajpal
1374	Confirm students have received and tested their appropriate System log-ons					C. Rajpal
1375	Assign students to individual classes and schedule training					C. Rajpal
1376	Conduct Training					C. Rajpal
1377	**Call Center**					**C. Rajpal**

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1378	Determine training schedule					C. Rajpal
1379	Coordinate creation of System log-ons (eSars)					C. Rajpal
1380	Confirm students have received and tested their appropriate System log-ons					C. Rajpal
1381	Assign students to individual classes and schedule training					C. Rajpal
1382	Conduct Training					C. Rajpal
1383	**Clinical**					**C. Rajpal**
1384	Determine training schedule					C. Rajpal
1385	Coordinate creation of System log-ons (eSars)					C. Rajpal
1386	Confirm students have received and tested their appropriate System log-ons					C. Rajpal
1387	Assign students to individual classes and schedule training					C. Rajpal
1388	Conduct Training					C. Rajpal
1389	Confirm students have received and tested their appropriate System log-ons					C. Rajpal
1390	**Claims**					**C. Rajpal**
1391	Determine training schedule					C. Rajpal
1392	Coordinate creation of System log-ons (eSars)					C. Rajpal
1393	Confirm students have received and tested their appropriate System log-ons					C. Rajpal
1394	Assign students to individual classes and schedule training					C. Rajpal
1395	Conduct Training					C. Rajpal
1396	**Provider Network Services (Development, Contracting and Credentialing)**					**C. Rajpal**
1397	Determine training schedule					C. Rajpal
1398	Coordinate creation of System log-ons (eSars)					C. Rajpal
1399	Confirm students have received and tested their appropriate System log-ons					C. Rajpal
1400	Assign students to individual classes and schedule training					C. Rajpal
1401	Conduct Training					C. Rajpal
1402	**Provider Network Operations**					**C. Rajpal**
1403	Determine training schedule					C. Rajpal

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1404	Coordinate creation of System log-ons (eSars)					C. Rajpal
1405	Confirm students have received and tested their appropriate System log-ons					C. Rajpal
1406	Assign students to individual classes and schedule training					C. Rajpal
1407	Conduct Training					C. Rajpal
1408	**Model Office/System Readiness**	**110 days**	**Mon 9/1/14**	**Fri 1/30/15**		**T. Raines**
1409	**Model Office Planning**					**T. Raines**
1410	Complete Model Office Checklist/System Validation					T. Raines
1411	Schedule Model Office Meetings					T. Raines
1412	Confirmed Development Environment is Refreshed					T. Raines
1413	Confirm Data Required in MO					T. Raines
1414	Confirm Model Office Testing Environment					T. Raines
1415	Confirm Model Office Data Warehouse Environment					T. Raines
1416	**Operations**					**T. Raines**
1417	Confirm Location/Office Space					T. Raines
1418	Confirm Connectivity					T. Raines
1419	Confirm phone availability					T. Raines
1420	Confirm PC availability					T. Raines
1421	**Coordination of Test Scripts**					**T. Raines**
1422	Document Members and Scenarios					T. Raines
1423	Document Dates of Service					T. Raines
1424	Document Providers, Service Codes, and Diagnosis					T. Raines
1425	Circulate Completed Test Scripts					T. Raines
1426	Review Test Scripts					T. Raines
1427	**Eligibility**					**K. Vendetti**
1428	Generate Initial Eligibility Import					K. Vendetti
1429	Validate Initial Eligibility Import					K. Vendetti
1430	**Claims/Finance**					**L. Laplante**
1431	Enter test claims					L. Laplante

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ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1432	Adjudicate Claims					L. Laplante
1433	Generate Check Run					L. Laplante
1434	Produce/validate PSV					L. Laplante
1435	**Provider**					**D. Ellis**
1436	Validate Provider File Configuration / Set-up					D. Ellis
1437	Test Provider File Scenarios /SCC					D. Ellis
1438	Validate / Test CareConnect SCA Workflows					D. Ellis
1439	**Customer Service**					**M. Golden**
1440	Create test inquiries (PC, MC and SC)					M. Golden
1441	Test Provider File Scenarios / Customer Service					M. Golden
1442	Validate / Test Servi ceConnect Workflows					M. Golden
1443	**Clinical**					**J. Maurizio**
1444	Create Test Authorizations					J. Maurizio
1445	Generate Auth Letters					J. Maurizio
1446	Validate Authorization Letters					J. Maurizio
1447	**Data Exchanges**					**K. Roberts**
1448	Run Provider File Import					K. Roberts
1449	Batch Authorizations Import					K. Roberts
1450	Run Authorization Response Import					K. Roberts
1451	Run Authorization File Extract					K. Roberts
1452	Run NCB Claims File Extract					K. Roberts
1453	Run Provider File Extract					K. Roberts
1454	**DWH/Data Management**					**K. Roberts**
1455	Load test data to DWH					K. Roberts
1456	Validate DWH load					K. Roberts
1457	Generate test/sample client reports					D. Santmyer
1458	Validate test reports					D. Santmyer
1459	**Model Office Sign-off**	**1 day**	**Fri 3/13/15**	**Fri 3/13/15**		**T. Raines**
1460	IT Leads (System Development, DWH…)					K. Roberts
1461	Eligibility					K. Vendetti
1462	Network Operations					D. Ellis
1463	Customer Service					M. Golden

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1464	Clinical					J. Maurizio
1465	DM & A					D. Santmyer
1466	DBHDD Sign-off					DBHDD
1467	**Go Live**	**1 day**	**Wed 4/1/15**	**Wed 4/1/15**		**T. Raines**
1468	Go Live					

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ATTACHMENT O.1

O.1 For vendors who are selected to participate in the demonstration:

1. The Offeror will demonstrate current information systems or provide a demo of proposed information systems to include:
   a. Eligibility verification system
   b. System which captures clinical data and determines authorization status when applicable
   c. Provider Directory
   d. Claims submission system to include claims payment for non-Medicaid benefits, authorization submission to a 3rd party administrator/MMIS who pays Medicaid claims and data exchange with the state and/or its designated MMIS to send and receive claims data
   e. Client information system for HCBS waiver services
   f. Proposed reporting capabilities e.g. dashboards, reporting tools, etc.

2. Offeror will demonstrate current system or provide demo of proposed GCAL processes and systems to support a crisis and access line.

If selected to participate in a demonstration, ValueOptions will showcase our current information management systems as well as Behavioral Health Link's GCAL processes and systems at a time and location determined by DBHDD. These demonstrations will include:

- Eligibility verification
- Clinical care information capture and management
- Authorizations
- Provider directory
- Claims submission and payment
- Data exchange
- Information management for HCBS waiver services
- Proposed reporting capabilities
- GCAL processes, and crisis and access line capabilities

ValueOptions underpins clinical excellence with cutting edge technology. This system is in place now and continuously refined for other Medicaid contracts across the country. In fact, our GCAL system is in use today in Georgia. We built our information technology platform, CONNECTS, from the ground up and seamlessly serve the specialized needs of the behavioral health and IDD management business. The platform integrates all core business functions—crisis and routine care management and coordination, network management, claims processing, and data analytics—and bridges the gap between care management, service delivery and treatment success.