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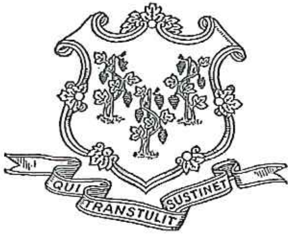


STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONTRACT AMENDMENT

Contractor:	VALUEOPTIONS, INC
Contractor Address:	240 CORPORATE BOULEVARD, NORFOLK, VA 23502
Contract Number:	999VOI-BHP-01 / 11DSS1206AL
Amendment Number:	A3
Amount as Amended:	$89,767,152
Contract Term as Amended:	01/01/11 - 12/31/15

The contract between **ValueOptions, Inc** (the Contractor) and the Department of Social Services (the Department), which was last executed by the parties and approved by the Office of the Attorney General on 1/5/14, is hereby further amended as follows:

1. The Year Three ASO Targets shall be as set forth in Exhibit A to this amendment.

2. The following changes are made to the Definitions section in Part I Section A on pages 11 through 28 of the original contract:

   a. A.1.9 "Behavioral Health Partnership" on pages 11 and 12 is deleted and replaced by the following definition:

      A.1.9 Behavioral Health Partnership ("Partnership" or "CT BHP"): An integrated behavioral health service system developed and managed by the Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services for HUSKY Part A,B, C, and D members, and children enrolled in the Voluntary Services Program operated by the Department of Children and Families.

   b. A.1.26 "Comprehensive Global Assessment" on page 14 is deleted in its entirety.

   c. A.1.29 "Connecticut Medical Assistance Program (CMAP) on page 14 is deleted and replaced by the following definition:

      A.1.29 Connecticut Medical Assistance Program (CMAP): The Connecticut Medical Assistance Program is comprised of several medical programs administered by the Department of Social Services and the provider network that serves these programs. The programs include: Medicaid (also known as Title XIX), Connecticut Behavioral Health Partnership (CTBHP), Health Insurance for Uninsured Kids and Youth (HUSKY) A & B, Connecticut AIDS Drug Assistance Program (CADAP), and the Connecticut Dental Health Partnership.

   d. A.1.42 "D02" on page 16 is deleted and replaced by the following definition:

A.1.42 D02: The Medicaid coverage group designation in DSS's eligibility management information system for DCF state funded Medicaid members nearly all of whom are eventually enrolled in the coverage group, HUSKY A.

e. A.1.45 "D05" on page 16 is deleted and replaced by the following definition:

A.1.45 D05: The Medicaid coverage group designation in DSS's eligibility management information system for DCF state funded Medicaid members nearly all of whom are eventually enrolled in the coverage group, HUSKY A.

f. A.1.52 "Eligible" on page 16: references to BHRP are deleted

g. A.1.53 "Eligibility Management System (EMS)" on page 16: phrase "including HUSKY A" is deleted

h. A.1.57 "Enrollment broker" on page 17 is deleted and replaced by the following definition:

A.1.57 Enrollment broker: An entity contracted by the Department of Social Services to perform certain administrative and operational functions for the HUSKY B program that may include HUSKY application processing, HUSKY B eligibility determinations, passive billing and enrollment brokering, or other functions as required by DSS.

i. A.1.67 "Fee for Service Member" on page 18 is deleted in its entirety.

j. A.1.67 "HUSKY, Part I or HUSKY A" on page 19: reference to SCHIP is changed to CHIP

k. A.1.78 "Implementation" on page 19 is deleted and replaced by the following definition:

A.1.78 Implementation: The date on which the Contractor assumes responsibility for the management of behavioral health benefits for Medicaid beneficiaries.

l. A.1.88 "Intermediate Duration Acute Psychiatric Care" on page 20: the phrase "documented DSM IV Axis I or Axis II" is deleted and replaced by "documented severe and persistent mental illness"

m. A.1.95 "Managed Care Organization (MCO)" on page 21 is deleted in its entirety.

n. A.1.98 "Medicaid Fee-for-Service (FFS) Member" on page 21 is deleted in its entirety.

o. A.1.100 "Medically Necessary or Medical Necessity" on page 22 is deleted and replaced by the following definition:

A.1.100 Medically Necessary or Medical Necessity:

(a) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than

an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

(b) Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.

p. A.1.104 "Network Manager" on page 24 is deleted in its entirety.

q. A.1.131 "Regional Network Manager" on page 25 is deleted and replaced by the following definition:

A.1.131 Regional Network Manager: An employee of the Contractor who works with contracted community behavioral health services providers; offering professional development, continuous quality management, quality improvement by way of developing provider performance analyses an enhance community relationships.

r. A.1.145 "Riverview" (Riverview Hospital for Children and Youth) on page 27 is deleted in its entirety.

s. A.1.163 "Warm Transfer" on page 28: the language at the end of the definition "…or if a HUSKY member calls the Contractor regarding pharmacy, it would be expected that the Contractor would contact the member's MCO and transfer the caller directly to the MCO." is deleted.

t. The following definitions shall be appended to the Definitions Section:

A.1.165 Albert J. Solnit Center South: Solnit Center South for Children and Youth is a psychiatric hospital/PRTF operated by the State of Connecticut that primarily serves children requiring extended acute stays, youth transferred from other hospital settings and youth who have been court ordered from detention centers.

A.1.167 HUSKY, Part C or HUSKY C: Connecticut's implementation of health insurance under the federal Medicaid program (Title XIX) for individuals who are aged, blind or disabled (ABD) and certain other groups such as refugees.

A.1.168 HUSKY, Part D or HUSKY D: Connecticut's implementation of health insurance under the federal Medicaid program (Title XIX) for low income adults age 19 to 64, also known as Medicaid for Low Income Adults (LIA).

A.1.170 HUSKY Health Program: Refers to the overall comprehensive health care benefit package, including preventive care, primary care and specialist visits, hospital care, behavioral health services, dental services, and prescription medications.

A1.171 Hour Observation Service: This level of care provides up to 23 hours of care in a secure and protected, medically staffed, psychiatrically supervised treatment environment that includes continuous nursing services and an on-site or on-call physician.

3. The first two paragraphs of Part I Section B, Populations to be Served and Roles of the Departments on pages 28 and 29 of the original contract, are deleted and replaced by the following section:

B. POPULATIONS TO BE SERVED AND ROLES OF THE DEPARTMENTS

The populations to be served by the Contractor through this contract are individuals with behavioral health disorders that are eligible for Medicaid or the HUSKY Health program and those children who are not otherwise enrolled in HUSKY A or HUSKY B but who may be involved with DCF through the Voluntary Services Program, child protective services, or juvenile justice. In addition, there are some children and adults in families who have recently qualified for Medicaid, as well as some children and adults who have been exempted from managed care because they are on Medicaid waivers (e.g., Katie Beckett, Acquired Brain Injury, Mental Health, Personal Care Assistance) or are designated to receive targeted case management services by either the Department of Developmental Services or the Department of Mental Health and Addiction Services.

DMHAS has the lead responsibility for the clinical management of publicly funded adult behavioral health services and DCF has the lead responsibility for the clinical management of publicly-funded behavioral health services to children, adolescents and families enrolled in the HUSKY Health program as well as children, adolescents and families served by DCF. The Departments will share three administrative functions including clinical management, claims processing and data management.

4. Part I Sections C.1 and C.2 in The Role of the Administrative Services Organization section pages 29 and 30 of the original contract are deleted and replaced by the following sections:

C.1 The Contractor shall be responsible for administering the behavioral health benefits for Medicaid Fee-for-Service members. In addition, if directed by DCF, the Contractor shall be responsible for administering the behavioral health benefits for children who are not otherwise enrolled in HUSKY Health program but who may be involved with DCF through the Voluntary Services program, child protective services, or juvenile justice. DCF will determine whether and to what extent these populations will be enrolled and have their benefits administered by the Contractor.

C.2 Utilization Management: The Contractor shall provide prospective, concurrent and retrospective utilization management (UM) services for eligible Members. Registration will be required for most behavioral health services. The quality of services provided is monitored and managed and frequent users/potential frequent users of services are identified through prospective, concurrent and retrospective processes. The Utilization Management Program (UM Program) shall support providers in delivering clinically necessary and effective care with minimal administrative barriers. The Contractor shall utilize separate child and adult specific level of care criteria approved by the Departments and provided to the Contractor. Denials of authorization must be based on the medical necessity definition as defined in A.1.100.

5. Part I Section D.4.5 in the Contract Administration section on page 33 of the original contract is deleted and replaced by the following section:

D.4.5 The Contractor shall coordinate directly with the appropriate Department representatives as directed by the individual Contract Manager when individual issues involving clinical care, quality of care, or safety for a specific member is in question.

6. Part I Sections D.5.1 through D.5.4 in the Deliverables – Submission and Acceptance Process section on page 33 of the original contract are deleted and replaced by the following sections:

D.5.1 For purposes of this section, any and all materials required to be submitted to the Departments for review and approval shall be considered a "Deliverable" and unless otherwise specified each "Deliverable" must be reviewed and approved by each Department.

D.5.2 The Contractor shall submit Deliverables to each of the Departments' Contract Managers on or before the due date noted for each individual deliverable.

D.5.3 Upon receipt of the Deliverable the Departments' will respond in writing within 30 business days a notice of approval, conditional approval or outright disapproval. The notice of conditional approval or disapproval shall state the conditions necessary to meet the Deliverable for final approval.

D.5.4 If or when necessary the Contractor must submit a corrective action plan within 10 business days. The plan must include steps the Contractor will incorporate to fulfill the Deliverable and the date in which the Deliverable will be resubmitted.

7. Part I, Sections E.1.4.1 through E.1.8 of the Eligibility Section page 34 of the original contract, are deleted and replaced by the following sections:

E.1.4.1 One eligibility roster file generated by the DSS eligibility management system (EMS) at the end of each month that lists all HUSKY Health members and D05 members who are eligible for services for the following month and Members who have been added retroactively.

E.1.4.2 One eligibility roster file generated by the DSS enrollment broker at the end of each month that lists HUSKY B members who are eligible for services for the following month and Members who have been added retroactively

E.1.5 The Departments shall produce and supply to the Contractor on a daily basis, daily file updates (adds/deletes) for all behavioral health Medicaid members.

E.1.6 DSS shall train Contractor staff to use the data fields within EMS.

E.1.7 DSS shall place the Medicaid FFS, HUSKY B and D05 files on a secured FTP server from which the Contractor will download the file.

E.1.8 All eligibility files will be in HIPAA-compliant formats.

8. The title of Part I Section E.2 on page 36 of the original contract shall be changed from "Eligibility Verification" to "Eligibility Verification / Pending Eligibility."

9. In Part I, Section F.3.1 –Approval of the Contractor's UM Program on page 39 of the original contract, as amended on page 1 of Amendment 1, the phrase "…no later than April 1 of each year." is deleted.

10. In Part I, Section F.3.2 –Approval of the Contractor's UM Program on page 39 of the original contract, the phrase "Medicaid FFS and Charter Oak" is deleted and replaced by "HUSKY Health."

11. In Part I, Section F.5.9 – Clinical Review Process on pages 41 and 42 of the original contract, the phrase "…(including HUSKY A)…" is deleted.

12. Part I, Section F.6 – Clinical Review Availability and Timeliness Requirements on pages 42 and 43 of the original contract is deleted and replaced by the following section:

F.6 Clinical Review Availability and Timeliness Requirements

F.6.1 The Contractor shall perform admission reviews for inpatient services (psychiatric hospital, general hospital, inpatient detoxification, residential detoxification) 24 hours a day, seven days a week.

F.6.2 Acute inpatient services in a general hospital are payable under Medicaid as a per discharge case rate. Consequently, the Contractor shall be required to conduct admission authorizations, continued stay reviews and discharge reviews for acute inpatient services in general hospitals. Additional reviews may be necessary to facilitate timely discharge. Such reviews are also necessary for admissions to a DMHAS certified intermediate duration acute psychiatric care in a general hospital or inpatient admissions to a psychiatric hospital. In both cases, services are reimbursed by per diem and are not subject to per discharge cost settlement.

F.6.3 The Contractor shall perform admission reviews within the time parameters listed for the following levels of care. All times are measured from the time the Contractor receives all information deemed reasonably necessary and sufficient to render a decision, or, for cases referred for peer review, from the completion of the peer review:

F.6.3.1 The Contractor shall render a decision and communicate the decision to the provider by telephone within sixty (60) minutes for prospective prior authorization for inpatient level of care (including general hospital and inpatient psychiatric) Authorizations available electronically within 48 hours and denials in writing within three (3) business days from determination..

F.6.3.2 The Contractor shall render a decision and communicate the decision to the provider by telephone within sixty (60) minutes for prospective prior authorization for inpatient detoxification programs, and residential detoxification program. For cases referred for peer review, this is from the completion of the peer review, which must occur with (120) minutes. Authorizations shall be available electronically within 48 hours and denials in writing within three (3) business days from determination.

F.6.3.3 The Contractor shall render a decision and communicate the decision to the provider by telephone within sixty (60) minutes for prospective prior authorization for Partial Hospital Program (PHP), Intermediate Duration Acute Psychiatric Care, Psychiatric Residential Treatment Facility (PRTF ,Intensive Outpatient Program (IOP), and Extended Day Treatment (EDT)) For cases referred for peer review, this is from the completion of the peer review, which must occur within one (1) business day. For IOP and EDT determinations are made within tow (2) business days. Authorizations shall be available electronically within 48 hours and denials in writing within three (3) business days from determination.

F.6.4 The Contractor shall perform concurrent reviews within the time parameters listed for those levels of care that require concurrent review. All times are measured from the time the Contractor receives all information deemed reasonably necessary and sufficient to render a decision, or, for cases referred for peer review, from the completion of the peer review.

F.6.4.1 The Contractor shall render a decision within sixty (60) minutes for general hospital and inpatient psychiatric. If a provider submits a concurrent review request via the web before noon, a determination will be made before 5PM on the same business day. When pending before 7PM, a determination will be made before noon the following business day. When pending after 7PM, a determination will be made by 5PM the following business day. Authorizations shall be available electronically within 48 hours and denials in writing within three (3) business days from determination.

F.6.4.2 The Contractor shall render a decision within sixty (60) minutes for Inpatient or Residential detox. For cases referred for peer review, this is from the completion of the

peer review and must occur within (120) minutes. Authorizations available electronically within 48 hours and denials in writing within three (3) business days from determination.

F.6.4.3 The Contractor shall render a decision within sixty (60) minutes for Partial Hospital Program (PHP), Intermediate Duration Acute Psychiatric Care, Psychiatric Residential Treatment Facility (PRTF), Intensive Outpatient Program (IOP), and Extended Day Treatment (EDT)) For cases referred for peer review, this is from the completion of the peer review, which must occur within one (1) business day. For IOP and EDT determinations are made within tow (2) business days. Authorizations available electronically within 48 hours and denials in writing within three (3) business days from determination.

F.6.4.4 The Contractor shall render a decision within two (2) business days for Residential Treatment Centers (RTC), and GHMTPPRS. Authorizations available electronically within 48 hours and denials in writing within three (3) business days from determination.

F.6.4.5 The Contractor shall render a decision within sixty (60) minutes on the date that the authorization expires for psychiatric hospital inpatient, general hospital inpatient, inpatient detoxification, residential detoxification, PRTF, PHP, Intermediate Duration Acute Psychiatric Care, day treatment, IOP, or crisis stabilization program facilities.

F.6.4.6 For Home Health Services if the provider requests a concurrent review the Contractor shall render a decision within four (4) business days, Authorizations available electronically within 48 hours and denials in writing within three (3) business days from determination.

F.6.4.7 The Contractor shall render a decision for retrospective review if information is submitted within ninety (90) days of start of care when eligibility was determined prior to discharge. Decisions will be made within 30 calendar days of receipt. In instances where eligibility is determined following discharge, clinical information will be reviewed upon receipt. Authorizations shall be available electronically within 48 hours and denials in writing within three (3) business days from determination.

13. In Part I, Section F.10.1 – Written Notice on page 46 of the original contract, the stated time frame is changed from twenty-four (24) hours to forth-eight (48) hours.

14. Part I Section F.12.1.2 – Web-Based Automation on page 47 of the original contract is deleted and replaced by the following section:

    F.12.1.2 Issue an immediate on-screen notice that informs the requesting provider that a clinical review and authorization are required and that the provider must contact the Contractor to complete the review with a clinician if any of the following are true

15. In Part I Section G.5 – Peer and Family Specialists on page 56 of the original contract, "…HUSKY A, HUSKY B, and Charter Oak…" is deleted and replaced by "…HUSKY Health..."

16. In Part I Section H.1.3 – Access to EPSDT Exams under the Medicaid Program on page 58 of the original contract, all references to "HUSKY A and Medicaid FFS" are deleted and replaced by "HUSKY Health."

17. In Part I Section H.3.2.3 – Access to Services Recommended Pursuant to an EPSDT Exam on page 59 of the original contract, "HUSKY A" is deleted.

18. In Part I Section I under Coordination of Physical and Behavioral Health Care, sections I.1.1 through I.1.7 on pages 60 and 61 of the original contract are deleted and replaced by the following sections:

I.1.1 Under the Partnership, the medical ASO, or other entity under contract with DSS responsible for the care management of physical health services for HUSKY Health Members, shall be responsible for primary care based screening, diagnosis and treatment of behavioral health disorders and physical health related transportation, pharmacy, laboratory, and ED services of HUSKY Health Members.

I.1.2 Under the Partnership, the Contractor shall coordinate the behavioral health care needs of HUSKY Health Members directly with DSS, or its medical ASO, and the Members' physical health care providers.

I.1.3 Care management for physical health services for HUSKY Health members will be managed by DSS. The Contractor shall coordinate covered services with DSS and its medical ASO.

I.1.4 The Contractor shall promote coordination of physical health and behavioral health care with the medical ASO under contract with DSS responsible for the care management of physical health services for HUSKY Health members. For HUSKY Health Members who access behavioral health services but who do not have special physical health care needs, the Contractor shall promote communication between behavioral health providers and the primary healthcare providers and shall support primary care based management of psychiatric medications as medically appropriate. For HUSKY Health Members who access behavioral health services and who also have special physical health care needs, the Contractor shall help ensure that services are coordinated, that duplication is eliminated, and that lead management is established in cases where medical and behavioral needs are serious or complex. Coordination of physical and behavioral health care shall be included in the Contractor's clinical management program. The Contractor shall coordinate as appropriate, with DCF Health Care Advocates in order to ensure the effective and timely provision of necessary care for DCF involved children.

I.1.5 If there is a conflict between the medical ASO under contract with DSS responsible for the care management of physical health services for HUSKY Health members and the Contractor regarding whether a HUSKY Health Member's medical or behavioral health condition is primary, the medical director for the entity under contract responsible for the care management of physical health services for HUSKY Health Members shall work with the Contractor to reach a timely and mutually agreeable resolution. If the Medical Director and the Contractor are not able to reach a resolution, the appropriate Departments will make a binding determination. Issues related to whether a Member's medical or behavioral health condition is primary must not delay timely medical necessity determinations. In these circumstances, the Contractor shall render a determination within the standard timeframe required under this Contract and its policies and procedures.

I.1.6 The medical ASO under contract with DSS responsible for the care management of physical health services for HUSKY Health Members shall be responsible for the Members' primary care and other services provided by primary care providers in independent practice and in hospitals regardless of diagnosis with the following exception. The medical ASO shall not be responsible for managing behavioral health evaluation and treatment services provided in these settings and billed under CPT codes 90791, 90792, 90832, 90833, 90834, 90846, 90847 and 90853, when the Member has a primary behavioral health diagnosis and the services are provided by a licensed behavioral health professional.

19. The Contractor shall maintain the Primary Care Behavioral Health Consultation Program developed pursuant to Part I, Section I.3.2 under Coordination with DSS and the CMAP Providers on pages 62 and 63 of the original contract.

20. The Contractor shall maintain the Behavioral and Physical Health Coordination Program developed pursuant to Part I, Section I.3.6 under Coordination with DSS and the CMAP Providers on page 64 of the original contract.

21. Part I, Sections I.4 through I.6 on pages 64 through 68 of the original contract are deleted and replaced by the following sections:

I.4 Coordination Requirements of DSS and the Medical ASO

I.4.1 DSS shall require that the entity(ies) responsible for the care management of physical health services for HUSKY Health members communicate and coordinate as necessary with the Contractor to ensure the effective coordination of medical and behavioral health benefits. DSS shall specifically require each entity (ies) responsible for the care management of physical health services for HUSKY Health members to:

I.4.1.1 Contact the Contractor when co-management of a member is indicated, such as for persons with special physical health and behavioral health care needs,

I.4.1.2 Respond to inquiries by the Contractor regarding the presence of medical co-morbidities,

I.4.1.3 Coordinate management activities and services with the Contractor when requested by the Contractor,

I.4.1.4 As appropriate, support coordination between behavioral health care providers and the contracted medical providers;

I.4.1.5 Develop quality improvement initiatives aimed at screening for psychiatric and substance related disorders in primary care settings, school based health centers, and for high-risk individuals, such as those with complex physical health needs;

I.4.1.6 When it is safe and appropriate to do so, support the contracted primary care providers of the entity(ies) responsible for the care management of physical health services for HUSKY Health members ability to provide behavioral health services in primary care settings and psychiatric medication management for persons with behavioral disorders,

I.4.1.7 Collaborate with the Contractor to coordinate other services that might be provided to behavioral health members by the medical ASO responsible for the care management of physical health services for HUSKY Health members including transportation, pharmacy, hospital ED services, laboratory services, and other services as required under their contracts with DSS,

I.4.1.8 Notify or coordinate the notification of behavioral health prescribing providers regarding pharmacy requirements (e.g., preferred drug list or formulary, prior authorization, generic substitution) that may be applicable to Medicaid enrollees, and

I.4.1.9 Provide the Contractor with quarterly pharmacy encounter extracts for the Contractor to use in its pharmacy analyses, pharmacy consultation with CMAP prescribing providers, and quality management.

I.5 Coordination Requirements of the Contractor with the Medical ASO

I.5.1 The Contractor shall communicate and coordinate with the medical ASO responsible for the care management of physical health services for HUSKY Health members as necessary to ensure the effective coordination of medical and behavioral health benefits.

I.5.2 The details of such coordination have been set forth by the Contractor in its Behavioral and Physical Health Coordination Program, approved by the Departments. Revisions to the

approved Behavioral and Physical Health Coordination Program must be submitted to the Departments for their review and approval prior to their implementation.

I.5.3 The Coordination Program shall provide for all necessary aspects of coordination between the medical ASO responsible for the care management of physical health services for HUSKY Members and the Contractor and specifically shall require that the Contractor:

I.5.3.1 Contact the medical ASO responsible for the care management of physical health services for HUSKY Members when co-management of a Member is indicated, such as for persons with special physical health and behavioral health care needs,

I.5.3.2 Respond to inquiries by the medical ASO responsible for the care management of physical health services for HUSKY Members regarding the presence of behavioral co-morbidities,

I.5.3.3 Coordinate management activities and services with the medical ASO responsible for the care management of physical health services for HUSKY Members when requested by the medical ASO responsible for the care management of physical health services for HUSKY Members, and

I.5.3.4 Promote and support coordination between behavioral health care providers and medical ASO contracted medical providers as appropriate.

I.6 Support for Primary Care Behavioral Health

I.6.1 The Contractor shall continue to operate the Primary Care Behavioral Health Consultation Program approved by the Departments, to support the psychiatric management of medication by PCPs enrolled and funded by the entity(ies) responsible for the care management of physical health services for HUSKY Health member. The program includes, but is not limited to:

I.6.1.1 Guidelines for primary care based screening and treatment of behavioral health disorders, indications for referral to a behavioral health specialist, and procedures for referring under the Partnership, developed in coordination with the entity(ies) responsible for the care management of physical health services for HUSKY Health members;

I.6.1.2 Plan for the provision of education and guidance to primary care providers with the participation of the entity(ies) responsible for the care management of physical health services for HUSKY Health members;

I.6.1.3 Identification by the Contractor of individuals receiving psychiatric medication management from the Partnership's behavioral health prescribing providers whose psychiatric medication management needs could be safely and appropriately provided through primary care providers and the transition of such individuals from the Partnership's behavioral health prescribing provider to a primary care provider;

I.6.1.4 Provisions for the continuation of therapy services by the Partnership's behavioral health providers (non-medical) in conjunction with the prescribing primary care provider;

I.6.1.5 Communication and coordination between the Partnership's behavioral health providers and primary care providers as necessary to support appropriate medication monitoring and management in primary care settings; and

I.6.1.6 Plan for the provision of telephonic pharmacy consultation services to primary care providers as provided for in the Pharmacy Consultation subsection below.

I.6.2 The Contractor shall adopt and implement similar measures for D05 members and those with commercial insurance, obtaining releases of information as necessary, to the extent permitted by state and federal law and to the extent that any given private insurer supports such collaboration.

I.6.3 The Contractor shall comply with the Health Insurance Portability and Accountability Act (HIPAA), privacy regulations promulgated there under, and Connecticut privacy and confidentiality statutes and regulations.

I.6.4 The Contractor shall participate with the entity(ies) responsible for the care management of physical health services for HUSKY Health members and the Departments in the development of policies pertaining to coordination between the Contractor and the entity(ies) responsible for the care management of physical health services for HUSKY Health members and shall adhere to such policies as approved by all parties, and as they may be revised from time to time.

22. In Part I Section I.7.1 under Pharmacy Consultation on page 68 of the original contract, "MCO" is deleted and replaced by "medical ASO."

23. The Contractor shall maintain the Family Service policies and procedures developed pursuant to Part I Section K.2.3 of the Family Oriented Management Processes on page 70 of the original contract.

24. In Part I, Section L.1, Introduction to Young Adult and Transitional Services on page 70 of the original contract, "...HUSKY A or B..." is deleted and replaced by "...Medicaid FFS..."

25. In Part I, Section L.2.2, DCF and Eligibility Information on page 71 "...HUSKY A, HUSKY B..." is deleted and replaced by "...Medicaid..."

26. In Part I, Section M.1.1.1 under Quality Management – Introduction on page 71 of the original contract, "...Medicaid FFS and Charter Oak..." is deleted and replaced by "...HUSKY Medicaid..."

27. In Part I, Section M.1.1.3 under Quality Management – Introduction on page 72 and 73 of the original contract, "...Medicaid FFS and Charter Oak..." is deleted and replaced by "...HUSKY Health..."

28. Part I, Sections M.4.2 through M.4.4, Satisfaction Surveys, on page 73 of the original contract is deleted and replaced by the following subsections:

M.4.2 At the discretion of the Departments the Contractor shall contract with a specialized survey entity to conduct a survey of general service members including adults, parents or caregivers of children, and youth over twelve (12) years of age using a general satisfaction survey instrument approved by the Departments. Areas of assessment within the survey shall include but may not be limited to the following:

M.4.3 At the discretion of the Departments the Contractor shall conduct a survey of members or caregivers of members with complex behavioral health service needs using an instrument reviewed by members and caregivers, and approved by the Departments. The survey instrument shall include but may not be limited to the following:

M.4.4 At the discretion of the Departments the Contractor shall conduct a provider satisfaction survey using a provider survey instrument approved by the Departments. The survey shall, at a minimum, address the provider's satisfaction with the Contractor's services and other administrative services provided by the state or its agents including but not limited to authorization, courtesy and professionalism, network management services, provider appeals, provider education, referral assistance, coordination, claims processing (including those aspects of claims processing administered by the MMIS) and the perceived administrative burden experienced by providers providing behavioral health services in the Partnership.

29. Part I, Section M.5, Mystery Shopper Surveys, on page 74 of the original contract is deleted and replaced by the following subsection:

M.5 At the discretion of the Departments the Contractor shall implement mystery shopper surveys of a scope and frequency mutually agreeable to the Departments and the Contractor in order to assess the quality and responsiveness of network providers.

30. Part I, Section M.9.1, Training, on page 76 of the original contract is deleted and replaced by the following subsection:

M.9.1 The contractor will provide standard training and orientation to all new employees within the Connecticut Service Center, BHP and new providers to the partnership. Specialized training activities shall include but not be limited to:

31. Part I, Section N.7.1.1 , Provider Inquiries and Complaints, on page 84 of the original contract, is deleted and replaced by the following subsection:

N.7.1.1 Track and manage all provider inquiries and complaints related to clinical and administrative services covered under this Contract, except that the Contractor shall track transportation related complaints and forward such complaints to the entity (ies) responsible for transportation services for Medicaid members or to the DSS transportation vendor and the DSS the transportation contract manager for Medicaid members.

32. The first sentence of Part I, Section N.8.1, Web-Based Communication Solution, on page 85 of the original contract is deleted and replaced by: "The Contractor shall update the existing Partnership Web site at www.CTBHP.com as needed."

33. In Part I, Section O.4.1, Network Assessment, on page 88 of the original contract, the term "MCO" is deleted and replaced with "ASO".

34. In Part I, Section O.4.2.8, Network Assessment, on page 89 of the original contract, the term "MCOs" is deleted and replaced with "ASO".

35. The Contractor shall maintain the Member Inquiry Process developed pursuant to Part I, Section P.2.1 on page 92 of the original contract.

36. In Part I, Section P.3.1.3, Transportation, on page 93 of the original contract, the term "HUSKY A" is deleted and replaced by "Medicaid."

37. The Contractor shall update as needed the informational member brochure developed pursuant to Part I, Section P.5.1 on page 94 of the original contract.

38. Part I, Section 5.4, Member Brochure, on page 94 of the original contract is deleted and replaced by the following subsection:
    P.5.4 The Contractor will consider other means of communication including web based video feeds.

39. The Contractor shall maintain the Member Handbook developed pursuant to Part I, Section P.6 on page 95 of the original contract.

40. In Part I, Section R.3.1.8, Data Storage and Elements, on page 102 of the original contract, "(HUSKY A, HUSKY B Medicaid, MLIA, ABD & Charter Oak)" is deleted and replaced by "(HUSKY Health)."

41. In Part I, Section S.2.5.1, Information System – Eligibility Data on page 104 of the original contract, "HUSKY A, Medicaid FFS" is deleted and replaced by "HUSKY Health."

42. In Part I, Section T.1, Notices of Action, Denial Notices, Appeals and Administrative Hearings – General Requirements, on page 111 of the original contract, reference to "HUSKY Program, Medicaid FFS, and Charter Oak" is deleted and replaced by "HUSKY Health."

43. In Part I, Section T.2.3, Notices of Action, Denial Notices, Appeals and Administrative Hearings – Notices of Action and Denial Notices, on page 112 of the original contract, "Medicaid FFS" and "HUSKY A" are deleted and replaced by "HUSKY Health."

44. In Part I, Section T.2.4, Notices of Action, Denial Notices, Appeals and Administrative Hearings – Notices of Action and Denial Notices, on page 112 of the original contract, "For HUSKY A, D05, and Medicaid FFS…" is deleted and replaced by "For HUSKY Health and D05…"

45. In Part I, Section T.2.4, Notices of Action, Denial Notices, Appeals and Administrative Hearings – Notices of Action and Denial Notices, on page 112 of the original contract, references to "Charter Oak" are deleted and replaced with "Medicaid", and the Table on page 113 is deleted and replaced with the following table:

Program	Template
DO5	NOA for Denials/Partial Denials NOA for Termination, Suspension, Reduction Appeal/DCF Instructions
Medicaid	NOA for Denials/Partial Denials NOA for Termination, Suspension, Reduction Appeal/DSS Hearing Process Appeal Application Instruction / DOI Instructions
HUSKY B	Denial Notice

46. In Part I, Section T.3.1, Notices of Action, Denial Notices, Appeals and Administrative Hearings – Continuation of Benefits Pending Appeal, on page 114 of the original contract, reference to "HUSKY A" and "Medicaid FFS " are deleted and replaced by "Medicaid."

47. In Part I, Section T.4.1, T.4.3, T.4.4, T.4.8, T.4.9, Notices of Action, Denial Notices, Appeals and Administrative Hearings – Contractor Appeals Process - Routine, on page 114 of the original contract, reference to "HUSKY A," "Charter Oak," and "Medicaid FFS " are deleted and replaced by "Medicaid."

48. Part I, Section T72, External Review – HUSKY B on page 118 of the original contract is deleted in its entirety and replaced by the following section:

T.7 External Review – HUSKY B

T.7.1. The Department operates a program specific review process for an external review of appeals conducted by the Contractor. If a HUSKY B Member has exhausted the Contractor's internal appeals process and has received a final written determination from the Contractor upholding the Contractor's original denial of the service, the Member may file an external appeal with the Department of Social Services within thirty (30) days of the receipt of the final written appeal determination.

T.7.2 The Department will assign the appeal to the appropriate clinician within the agency who had no involvement in the underlying appeal or determination.

T.7.3 The Contractor will provide copies of its determination and all clinical documentation necessary to the Department's consideration of the External Appeal.

T.7.4 The Department will complete its External Appeal in no more than thirty (30) days from the date it was requested by the Member.

T.7.5 The Contractor shall comply with the Department's External Appeal determination and issue notification of the same to the Department.

T.7.6 Expedited Appeals. The Department shall conduct expedited External Appeals.

T.7.6.1 If the Contractor conducts the internal appeal on an expedited basis, the Contractor will scan and e-mail its final determination along with the supporting clinical information to the Department on the same day the Contractor makes its determination.

T.7.6.2 If the Contractor did not conduct an expedited internal appeal, but the Department determines that an expedited external appeal is warranted, or the client's provider certifies that an expedited external appeal is warranted, the Contractor shall provide the clinical/supporting information electronically on the same day that the Department requests this information.

49. The Contractor shall maintain to the Provider Appeals Process developed pursuant to Part I, Section U.1.2 on pages 118 and 119 of the original contract.

50. The Contractor shall maintain to the Security and Privacy Plan developed pursuant to Part I, Section V.3.2 on page 121 of the original contract.

51. The following terms are appended to Part I, Section X.1.1, Performance Targets and Withhold Allocations – General Provisions on page 126 of the original contract:

    For the contract year 2014, the Departments shall withhold 7% of each quarterly administrative payment; 5.5% of the withhold shall be paid to the Contractor, in whole or in part, contingent upon the Contractor's success in meeting established Performance Targets as set forth in Exhibit A for contract year 2014. The remaining 1.5% shall be guaranteed and invoiced quarterly. For contract year 2015, the Departments shall withhold 7.5% and shall guarantee 0% of the Performance Targets. The withhold shall be paid to the Contractor, in whole or in part contingent upon the Contractors' success in meeting established Performance Targets as set forth in Exhibit A for contract year 2015.

52. Effective January 1, 2014, Part I, Section, Part I, Section A.4.5.3 Staffing Levels – Ongoing Operations on page 137 of the original contract is deleted and replaced by the following subsection:

    AA.4.5.3 Total individuals served on an annual basis shall be no less than 2,200 individuals; and

53. Effective January 1, 2014, the staffing levels in Part I, Section AA.4.7.1, Staffing Levels – Ongoing Operations on page 138 of the original contract are revised to reflect staffing based on call volumes of 630,000-675,000 Members for calendar year 2014 and 675,000 – 725,000 Members for calendar year 2015.

54. Part I, Section BB.3.1 – Contract Reimbursement – Operating Years on page 140 of the original contract is deleted and replaced by the following subsection:

    BB3.1 The maximum value of this contract for the performance of the administrative services required to meet the requirements of this contract during each year of full contract operations shall not exceed:

55. The following subsections are appended to Part I, Section BB.3.1 – Contractor Reimbursement – Operating Years on page 140 of the original contract:

    BB.3.1.5 for the period January 1, 2014 to December 31, 2014, $18,000,000
    BB.3.1.6 for the period January 1, 2015 to December 31, 2015, $18,500,000.

56. The following subsections are appended to Part I, Section BB.3.2 – Contractor Reimbursement – Operating Years on page 140 of the original contract:

    BB.3.2.4 for the period January 1, 2014 to December 31, 2014, monthly enrollment of at least 630,000 members but not to exceed 675,000 members;
    BB.3.2.5 for the period January 1, 2015 to December 31, 2015, monthly enrollment of at least 675,000 members but not to exceed 725,000 members;

57. The negotiated withhold cited in Part I, Section BB.3.9 on page 141 of the original contract is changed to 5.5% for calendar year 2014 and 7.5% for calendar year 2015.

58. The following payment information is appended to the table on page 142 of the original contract. Invoices for these amounts do not include the negotiated withhold of 5.5% for calendar year 2014 and 7.5% for calendar year 2015:

On or after this date the Contractor shall request a payment:	The maximum payment request shall be:	The payment request shall be for the operation of the program through the period:	Payments are contingent upon the DEPARTMENT'S receipt and approval of financial reports due on or before:
January 1, 2014	$4,268,691.50	January 1, 2014 – March 31, 2014	45 days after the close of the first quarter
April 1, 2014	$4,268,691.50	April 1, 2014 – June 30, 2014	45 days after the close of the second quarter
July 1, 2014	$4,268,691.50	July 1, 2014 – September 30, 2014	45 days after the close of the third quarter
October 1, 2014	$4,268,691.50	October 1, 2014 – December 31, 2014	2014 quarter 4 is due 5/31/15
January 1, 2015	$4,302,325.50.	January 1, 2015 – March 31, 2015	45 days after the close of the fifth quarter
April 1, 2015	$4, 302,325.50.	April 1, 2015 – June 30, 2015	45 days after the close of the sixth quarter
July 1, 2015	$4, 302,325.50	July 1, 2015 – September 30, 2015	45 days after the close of the seventh quarter
October 15, 2015	$4, 302,325.50	October 1, 2015 – December 31, 2015	2015 quarter 4 is due 5/31/2016

59. The following terms, effective January 1, 2014, shall be appended to Part I, Section BB.3.10 on page 143 of the original contract:

The 7.0% withhold in calendar year 2014 and 7.5% withhold in calendar year 2015 shall be paid to the Contractor, in whole or in part, at the end of each contract year contingent upon the Contractor's success in meeting established Performance Targets as set forth in Exhibit A. Of the 7.0%, 1.5% shall be guaranteed and shall be included in the quarterly invoices for CY 2014. Although a total of 5.5% & 7.5% respectively will be placed at risk as mutually agreed upon and set forth in Exhibit A, no more than 5.5% will be retained by the Departments in 2014. Failure to achieve a target associated with any of the percentage points, shall be applied against the 5.5% and 7.5% withhold.

60. The following terms, effective January 1, 2014, shall be appended to the table at the end of Part I, Section BB.3.15 on page 144 of the original contract:

For the Period	The reconciliation is due on or before:
January 1, 2014 – December 31, 2014	May 31, 2015
January 1, 2015 – December 31, 2015	May 31, 2016

This document constitutes an amendment to the above numbered contract. All provisions of that contract, except those explicitly changed above by this amendment, shall remain in full force and effect.

EXHIBIT A
2014 PERFORMANCE TARGETS

Performance Target #1
Identification of Emergency Department super users and Reduction of Adult Emergency Department (ED) Utilization and Recidivism at Select Hospitals

This Performance Target has two sections:

I. Definition, identification and analysis of ED "Super Users"
II. Intervention strategy at selected hospitals to reduce unnecessary ED utilization

Total Value of Performance Target: 2%

I. Reporting and Analysis (1%):

The purpose of this section is to develop a thorough understanding of ED utilization, both by analyzing the Medicaid members who have the highest levels of use of ED services and by comparing and contrasting the ED utilization at individual hospitals. The analyses will allow us to understand factors that contribute to the members' ED use, and also to determine if there are best practices and/or outliers among the hospitals. This information will assist the BHP in establishing outcomes based reporting, outlier management, utilization management techniques and specific provider interventions. This data in aggregate will provide the BHP a comprehensive summary of ED utilization by provider.

The state agency partners expect VO to analyze the reports on providers and populations and provide executive level analysis and recommendations. Claims from CY2013 will be used for this analysis. Items to be mutually agreed upon will be discussed in Data Warehouse and finalized in Core.

Elements of the PT will include:

1. Define and Identify Super Utilizers of ED & Hospital Inpatient Care for adults and youth
2. Define and Identify ED Super Users for adult and youth population
3. Identify Hospitals with the greatest numbers/highest percentage of ED super users for both adult and child populations
4. Develop and Implement methods of intervention for Adult ICMs to utilize with the ED Super Users
5. Reduce the rate of high end utilization of the Hospital ED for adults
6. Develop a methodology to evaluate rates of ambulatory primary care and behavioral health visits of ED super users for adults and youth.

A. Population and Member Profiling for Adults and Youth

1. Identify the top 10% of adults and youth who use ED and hospital inpatient services, based on ED and hospital inpatient service volume. There must be a

behavioral health diagnosis on the ED or inpatient claim. This becomes the Inpatient/ED high user report and should be separated by adults and youth.

2. By October 15, 2014, complete a further analysis of the adult and youth ED Super Users to determine the ongoing pattern of continued use of the ED, Medicaid eligibility, geographic mobility, and other factors that would be relevant to developing/refining an evaluation approach.

3. Review and evaluate best practices for evaluating adult and youth super users. By December 31, 2014, develop an evaluation methodology for an intervention to improve the connection and engagement in ambulatory primary and behavioral health care for high utilizers of the ED.

4. Identification of Adult Hospital ED Intervention Target (due June 1, 2014)
   a. Define a **baseline rate of ED Super User** based on the top 2% of ED utilization during the period of July 1, 2013 through December 31st 2013. Calculate this baseline rate for the five highest volume hospitals and the aggregate of the five hospitals. Determine the cutoff for the number of visits that defines the top 2% (for example 6 visits or greater). For example if hospital A had 2000 visits from 1500 members, the top 2% that had the highest number of visits would be equal to .02 X 1500 = 30. The number of visits that demarcates the 2% rate is 6.
   b. For the period July 1, 2014, through December 31, 2014, define a **comparison rate of ED Super User** based on the percentage of super users that meet or exceed the per visit cutoff set by the baseline. Again, for Hospital A, if they had 2100 visits by 1650 members during the comparison period, and 25 of those members met or exceeded the 6 visit threshold, the comparison rate would be 1.5%.
   c. Using claims data and the High user report, the contractor will develop reports to help the departments and the contractor identify the ED Super Users. The contractor will also identify the emergency departments most often utilized by ED super users.
      i. Identify the top 2% of ED Utilizers - those with the highest number of visits during the analysis period= ED super users
      ii. Using the results of previous regressions to inform the analysis – develop a profile (e.g. demographics, diagnosis, co morbid conditions, etc.) of ED Super users
      iii. Identify the top 10 utilized EDs by claims and utilization
      iv. Identify the top 10 EDs that have the highest recidivism rate (based on 7 day and 30 day re-admits)
      v. Identify the highest ED utilization and recidivism population with corresponding hospital EDs
      vi. Produce a geo-map of highest ED utilizers as a step in the direction towards "hot-spot" intervention
      vii. The Contractor and state agencies will mutually agree on the ED intervention cohort by June10, 2014.

II. Intervention Strategies for Adult Super Users and Hospitals (1%)

1. Assign staff and deploy when necessary to select hospital EDs'.(Value = .5%)

a. Assign an adult ICM and/or Peer Specialist to each of the five (5) selected hospitals (from the top 10 noted above) and select the ED intervention target at each hospital.
b. The intervention target will be defined and prioritized according to the following criteria;
    i. the ED super users identified in the period July 1, 2013 to December 31, 2013
    ii. members presenting at the ED that match the profile of high utilizers
    iii. members identified by the ED as recent/current high utilizers
c. Perform the following interventions/analyses to assist in reducing the rate of members in the ED super use group:
    i. Determine baseline rates of connect to care and hospital re-admissions for the comparison group by July 1, 2014.
    ii. Begin interventions with ED's and Super Users by July 1, 2014.
    iii. Intervention group will connect to care at a mutually agreed upon rate higher than the comparison group at 7 and 30 days when comparing October 1, 2014 through December 31, 2014. The rate will be mutually agreed upon by August 1, 2014.
    iv. Intervention group will re-admit to any hospital for any reason at a mutually agreed upon rate lower than the comparison group at 7 and 30 days when comparing October 1, 2014 through December 31, 2014. The rate will be mutually agreed upon by August 1, 2014.
    v. VO will refresh the baseline data regarding connect to care and readmission rates by August 31, 2014. State partners and VO will review updated baseline information by 9/15/2014 to confirm that the mutually agreed upon target rates are acceptable. If the new analysis shows results that are significantly different from the initial results, the target rates will be renegotiated.
d. Utilize RNM's to support an ED focused educational campaign (brochures/posters) regarding prescription medication abuse/overdose;

2. Develop or enhance Community Care Teams or their equivalent at Select Hospitals (Value = .5% of PT)
    a. Implement or enhance community provider meetings that address the needs of the highest utilizers/recidivists within the five selected hospitals.
        i. Meet with ED staff to identify the highest ED utilizers based on Medicaid claims as described above
        ii. Explore the feasibility of replicating the ROI processes utilized by other community hospitals that have implemented successful pilot projects in this area of practice
        iii. Work with Hospital Staff and local providers to facilitate the development of Wraparound Plans for the ED intervention cohort
        iv. Collaborate with care managers from CHN and/or ABH when appropriate

Performance Target #2
Inpatient Hospitalization – Activities to be performed in CY 2014

This Performance Target has two sections:

I. Standardized Reporting and Analysis: Provider & Population Profiles
II. Intervention Strategy for Specialized Target Population

Total Value of Performance Target: 2.0%

I. Reporting and Analysis (1%):

The purpose of this section is to continue the analysis from 2013 and develop standardized reports to better understand individual hospital utilization and activity related to inpatient services. It is important to understand the existing utilization of inpatient services by hospital to determine if there are best practices and/or outliers among the hospitals. This information will assist the BHP in establishing outcomes based reporting, outlier management, utilization management techniques (e.g. by-pass) and specific provider interventions. This data in aggregate will provide the BHP a comprehensive summary of inpatient utilization by provider.

The purpose of the population profile analysis is to continue the analysis from 2013 and develop standardized reports that will assist the BHP in examining who is using inpatient services by specific target population established by the state agencies and ValueOptions (VO). Claims from CY2013 will be used for this analysis.

The state agency partners expect VO to analyze the reports on providers and populations and provide executive level analysis and recommendations. Items to be mutually agreed upon will be discussed in Data Warehouse and finalized in Core.

A. Provider Profiling:

a. Establish standardized provider report cards that compare like hospitals by relevant factors that may include: DCF identifiers, HUSKY cohort, demographics, behavioral and medical diagnoses using integrated data from the agencies and Medicaid claims for items i. -v. below. VO will use available hospital characteristics to create a single set of hospital taxonomy that will be used to compare outcomes for similar hospitals.

i. admission rate, from the ED and non-ED admits as possible,
ii. observation admits
iii. inpatient length of stay (median and average),
iv. connect to care at 7 and 30 days for ambulatory services, including residential rehab.
v. re-admission rate to same or higher level of care 7 and 30 days post-inpatient stay. Differentiate between re-admits for the same category of diagnoses or for different diagnostic categories at 7 and 30 days. This analysis will follow the same methodology as 2013 to determine if a readmit occurred, but will compare discharge diagnoses between episodes. The focus will be primarily on behavioral health diagnoses but the general category definitions will be mutually agreed upon by VO and the State Partners.

vi. Provide an executive level summary of key findings and recommended outlier management protocols based on the data above.

B. Population Profile and Predictive Modeling/Risk Stratification:

a. For items "a" through "e", which were components of the 2013 Inpatient Performance Target, establish standardized population profile reports for youth and adults to be produced annually as follows: Describe the characteristics of the people using inpatient services using an integrated data base which includes Medicaid claims and DMHAS and DCF data. The analysis and synthesis of findings will be structured around four main population groups: adult, youth, Medicaid eligible, DMHAS-involved and substance abuse involved. For the purposes of the youth population, eligibility category will be defined by DCF identifiers (Voluntary, Juvenile Justice, Protective Supervision, FWSSN, and Dually Committed) and non- DCF youth rather than HUSKY eligibility category as well as age cohorts of 3-12 and 13-<18. Users of inpatient services will be compared to mutually agreed upon comparison groups identified during discussions in Data Warehouse meetings and agreed upon in the CORE contract meeting. Additionally, before reports are finalized, the definitions of the classifications, such as diagnostic categories, will be reviewed and mutually agreed upon in the Data Warehouse and Core meeting. All comparisons will be evaluated statistically to determine if differences between the target population and the comparison group are significant.

b. Using Medicaid claims data, the Contractor will profile IP utilizers' Medicaid/ DCF eligibility group, gender, race, ethnicity, and age for youth, adults and DMHAS Medicaid eligible.

c. Using Medicaid claims data, the Contractor will profile IP utilizers using mutually agreed upon behavioral health diagnosis classification including mental illness type, substance abuse category and co-occurring mental health and substance abuse categories. Specification of these categories will be mutually agreed upon in the data warehouse and Core meetings.

d. Using Medicaid claims data, the Contractor will profile IP utilizers' number and type of co-morbid chronic physical conditions in these populations.

e. Using Medicaid claims data, the Contractor will profile IP utilizers' medication adherence by examining medication possession rate (MPR) and further profiling population characteristics and ED / IP utilization related to medication non-adherence.

f. DMHAS and DCF data will be integrated with Medicaid claims data to enhance and produce further population profile characteristics including timing of other service use, discharge type, living situation, employment, social connectedness, abstinence and drug of choice.

g. The Contractor will develop a Predictive Modeling Program ultimately designed to understand the behavioral health care service system better and to identify which services should be targeted to which populations. Based on the deliverables listed above predictive models should be developed, using multivariate statistical and other techniques, for the following:

i. Factors that are likely to decrease follow-up care for ambulatory and other services.

Based on the Predictive Modeling Program, the Contractor will develop a risk stratification system that assigns a statistically developed and clinically informed risk score to individuals with behavioral health disorders. Risk scores will be developed based on mutually agreed upon criteria such as the following descriptions:

i. Low Risk- unlikely to need any acute, residential or intermediate levels of care in the next 12 months
ii. Low/Moderate Risk – unlikely to need acute services in the next 12 months
iii. Moderate Risk – likely to need one acute episode of care in the next 12 months
iv. Moderate/High Risk – likely to need more than one, but less than three acute episode of care in the next 12 months
v. High Risk- likely to three or more acute episodes of care in the next 12 months.

II. Intervention Strategy for Special Target Population (1%):

a. Based on the 2011-2012 inpatient data: Select the top 5 hospitals with the highest rates of adults that receive detoxification services on a medical unit or a psychiatric unit. Based on this data and the willingness of the hospitals to participate, select 2 of the top 5 hospitals with the highest utilization, select a mutually agreed upon number of individuals at these hospitals that meet a mutually defined definition of "super users". This will be defined as the "comparison" group.
b. Starting July 1, 2014, VO ICM staff will initiate intervention strategies at the two mutually agreed upon hospitals and work directly with the members who meet the definition of super users, as mutually agreed upon. Individuals who receive intervention services starting on July 1, 2014 from the VO ICM staff will be known as the intervention group.
c. VO, through their ICM/peer support models and other systems coordination with housing providers, as applicable, will do the following for the intervention group:
   i. Determine baseline rates of connect to care and hospital re-admissions for the comparison group by July 1, 2014.
   ii. Intervention group will connect to care at a mutually agreed upon rate higher than the comparison group at 7 and 30 days when comparing October 1, 2014 through December 31, 2014. The rate will be mutually agreed upon by August 1, 2014.
   iii. Intervention group will re-admit to any hospital for any reason at a mutually agreed upon rate lower than the comparison group at 7 and 30 days when comparing October 1, 2014 through December 31, 2014. The rate will be mutually agreed upon by August 1, 2014.
   iv. VO will refresh the baseline data regarding connect to care and readmission rates by August 31, 2014. State partners and VO will review updated baseline information by 9/15/2014 to confirm that the

mutually agreed upon target rates are acceptable. If the new analysis shows results that are significantly different from the initial results, the target rates will be renegotiated.

d. VO will develop a formal feedback process to the BHP and VO for the ICMs that are assigned to the two hospitals in order to learn from their experience with this population within the hospital systems. A formal report of their qualitative findings and a description of the intervention will be submitted as part of the deliverable.
e. VO will compare mutually agreed upon intervention group outcomes with a concurrent comparison group of those individuals who meet the mutually agreed upon "super user" definition at three similar hospitals that did not receive intervention services.

Performance Target #3: Maintaining the Reduction of Discharge Delay for Children and Adolescents Receiving Inpatient Behavioral Health Treatment

Total Value of Performance Target: .5%

Over the next calendar year, the Contractor will maintain discharge delay days, at 10% or less of total inpatient days. Specifically, "Percent of Inpatient Days in Delay Status for All Members", as reported on the 10B Part 7 report (All Members, IPF & IPM, and excluding Riverview) shall total no more than 10% in CY 2014. Acute average length of stay shall increase by no more than 3% in CY 2014 from a revised baseline of 11.38 days. The new baseline represents the acute average length of stay for all child inpatient cases for CY 2013.
For the purposes of this project, acute average length of stay will be computed via the use of the Contractor's Discharge-based Acute/Discharge Delay Average Length of Stay utilization reports (#8066 and #8076).

One hundred percent (100%) of the amount of the withhold shall be returned if the Contractor achieves a total of no more than 10% of inpatient discharge delay days in CY 2014.

Seventy five percent (75%) of the amount of the withhold shall be returned if the Contractor achieves a total of no more than 12% of inpatient discharge delay days.

The State shall have discretion regarding the value of the withhold awarded by taking other key environmental factors which impact discharge delay into consideration.

If the Department's resources dedicated and necessary to this performance target are impacted such that the Contractor is not able to successfully complete this performance target, and all requirements of this performance target under the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of the withhold.

If DCF experiences significant changes (i.e. Voluntary Service restrictions, reduced access to DCF funded services or constraints in access attributable to closure of State facilities, lack of access to GH 2 or a decrease in Flex Fund availability, changes in Department policy regarding level of care determinations etc.) that negatively impact total length of stay for the Discharge Delay population and all requirements of this performance target under the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full return of the withhold.

If the Contractor's resources dedicated and necessary to this performance target are impacted directly due to additional contract reductions by the Departments, such that precludes the successful completion of the performance target as determined by the Departments, this performance target may be deemed by the Departments as having met the required target for full or partial return of withhold.

Performance Target #4
IICAPS

This Performance Target has two sections:

I. Standardized Reporting and Analysis: Provider Profiles
II. Standardized Reporting and Analysis: Non-Completer Analysis

Total Value of Performance Target: 1.0%

It is recommended that the performance target for IICAPS utilize the findings from the 2013 PT. The priorities for process oriented data elements to be tracked, monitored, and reported to providers are as follows;

- An empirically demonstrated or likely relationship to IICAPS outcomes
- Available to be accessed and analyzed in a relatively short time frame so as to be relevant to current practice OR, alternatively, designed to be assessed once per year
- Already collected within the Yale/DCF data system OR available from claims data

I. Standardized Reporting and Analysis: Provider Profiles (produced twice annually in the first year and then quarterly thereafter) (Value .5%)

   1. Process Measures
      a. Rate of treatment completion*
      b. Duration of Care*
      c. Rate of gaps in service within an episode of care **
      d. Number of visits/hours of service (intensity)
      e. Connect to Care
         i. Rate of behavioral health outpatient treatment within 30 days of discharge from IICAPS episode of care (claims based and produced once per year)
         ii. Rate of behavioral health outpatient medication management within 30 days for those clients receiving at least one psychotropic

medication at the time of discharge (claims based and produced once per year)

2. Outcome Measures
    a. Rate of hospitalization during IICAPS episode of care*
    b. Rate of hospitalization within 60 days of discharge from IICAPS episode of care (claims based and produced once per year)

3. Engagement with providers to review and refine the profiles in preparation for a PARS program to be implemented calendar year 2015.

II. Non-Completer Analysis (Value = .5%)

There are various reasons for children to not complete an IICAPS episode of care. The state agencies are interested in learning more about the "non-completers" as a cohort. The contractor will consult with and provide technical assistance to the model developer to create a report that helps the BHP understand who is not completing services. The proposed time period for evaluation is calendar years 2010- 2013. Variables should include, but are not limited to the following;

1. Age (3-12, 13-18)
2. Gender*
3. DCF status
4. Ethnicity
5. Race
6. Diagnosis*
7. Co-morbid medical conditions of Diabetes and Asthma
8. Relationship to primary caregiver*
9. Status of parents regarding their behavioral health service needs*
10. School Participation/Attendance*
11. Legal History*
12. Psychiatric Admissions prior and during IICAPS*
13. Psychiatric days prior and during IICAPS*
14. ED Visits prior and during*
15. Alcohol or drug problem Lifetime/last six months*

If Yale does not complete and deliver the non-completer analysis to VO by August 15th, 2014 then a non-completer analysis will be completed by VO to include the following variables:

1. Age (3-12, 13-18)*
2. Gender*
3. DCF status*
4. Ethnicity*
5. Race*
6. Diagnosis*
7. Co-morbid Medical Conditions of Diabetes and Asthma

* All items are collected as part of the YALE/DCF data system

** The data is collected in the YALE/DCF data system. The model developer would need to produce this measure and provide the analysis as it is not already included in the IICAPS monitoring system.

In the event that data and/or resources necessary to this performance target are delayed or unavailable such that the Contractor is not able to complete this performance target successfully, this performance target may be deemed by the Departments as having met the required target for full or partial return of the withhold. This condition would include, but not be limited to, the delay or absence of relevant, usable data received from the Yale/DCF data set, the model developer, or IICAPs providers.

Performance Target #5
Licensed Home Health Care Agency Services CY 2014

Total Value of Performance Target: 1.5%

A key goal for the CT BHP is to support the member's movement towards recovery while ensuring the right level of care at the right time. This Performance Target aims to increase member independence and self-reliance. Some of the actions to achieve this goal include continued work with HH agencies to identify members who are clinically appropriate to increase autonomy via skills transfer, to transfer Med Admin services from nurses to home health aides, and/or increase use of medication assisted technology.

On a quarterly basis the Contractor will do presentations to State Partners regarding progress on this Performance Target.

A final report is due no later than December 31, 2014 summarizing status of the Provider Analysis and Reporting (PAR) Program and how it might evolve, key findings and recommended actions related to HH ED and Inpatient super-users, as well as other recommended actions that the Contractor might implement related to increasing the use of nurse delegation and medication assisted technology.

A. Enhancement of the Provider Analysis and Reporting (PAR) Program and Provider Training and Education

Value: 1.0%

The Contractor will:

1. At least semi-annually, organize and facilitate HH Agency PAR meetings as well as individual provider agency meetings with the 15 identified high-volume agencies throughout CY 2014. The meetings will serve to share data, explore best practices* and to collaborate in overcoming barriers identified by the Contractor and/or the agencies regarding implementing/increasing use of nurse delegation and medication assisted technology, among other issues. (Items marked with * are described in a Glossary of Terms at the end of this document.)

2. When necessary, the Contractor will engage smaller workgroups with providers and/or prescribers to address and resolve specific barriers and provide educational/training sessions to implement and/or promote increased use of nurse delegation and medication assisted technology for members who are clinically appropriate for these services.

3. Continue to collect and trend data by provider regarding the rate of ED, hospital inpatient (medical and behavioral health) and use of observation bed for all home health recipients as part of the PAR Profile. This data will also serve as the basis for comparison of the hospitalization rate from the study period of the previous PT and will be reported semi-annually as a PAR program quality indicator. Based on this data, the State agencies and VO will determine the criteria that defines "Super Users". Please note, the Dual members will be included in this section of the analysis.

4. Using the data to determine the top 10% utilizers*, the state agencies and the Contractor will agree on a sub-cohort of super users. Using the agreed upon super user cohort, determine the following within 180 days of the receipt of the data described below:

   a. Diagnostic, demographic, and living situation, if available, to determine if there are common characteristics of the cohort.

   b. Please note: For this section of the performance target, the Dual members will be removed from the analysis. After receiving the applicable provider type/specialty designations and applicable procedure codes from DSS by May15, 2014, determine the rate of primary care utilization in the last 12 months of super users by total cohort and by provider. If the rate of primary care utilization is determined by the state agencies and contractor to be a contributing factor to Inpatient and ED utilization, the contractor will work with home health providers to increase the use of primary care utilization. This determination will be informed by baseline primary care utilization of the entire Medicaid program provided to the Contractor by DSS by June 15, 2014.

   c. The Contractor will send the super user file to DMHAS for DMHAS to determine if any super users are receiving services from a local mental health authority (LMHA) provider and if so, the Contractor will facilitate the coordination of care* between the LMHA and home health providers in order to develop a plan of care that includes concrete actions that decrease the use of the emergency department. The goal is for the home health provider and the applicable LMHA to develop jointly a crisis prevention plan that reduces unnecessary emergency department utilization.

5. Continue to provide quarterly ED, ED OBS, and hospital admission, including the frequency distributions indicating the number of members with 1, 2, 3, etc., hospital admissions. Report these rates separately for individuals who have reduced their medication administration, to examine if the decrease in medication administration services corresponds to an increase in these rates.

(Note: The data will be calculated quarterly and presented as part of the semi-annual PARs profiles.)

6. Repeat the statistical analysis completed in 2013 using 2013 claims data to determine the key factors that are likely to contribute to or predict ED, observation bed, and hospital inpatient utilization for all home health recipients and provide recommended actions to State Partners.

7. In 2014, we will enhance the PAR profile as follows:

   a. By April 30th, 2014 addition of the rate of use of observation beds; and

   b. By April 30th, 2014, the concurrent utilization of ED services

   c. By October 31st, 2014 integration of the utilization of Nurse delegation and medication assisted technology, provided those services have begun by June 1, 2014 (to allow for claims lag in recording the services).

8. Incorporate 2013 member feedback into home health provider training through:

   a. Conduct at least 5 webinar trainings in 2014 that include, but are not limited to the following topics:
      i. Nursing role in Med Admin and recovery training
      ii. Member rights and responsibilities
      iii. Developing client centered care plans
      iv. Nontraditional resources

   b. Expand target audience to include prescribers of HH services.

9. Continue to gather member feedback:

   a. Utilize the existing phone survey tools and techniques developed in CY 2013 to solicit feedback from members who had their medication administration services decreased. These surveys will incorporate questions related to assistive technologies and nurse delegation, provided such services have begun by April 15th, 2014. That date will allow for inclusion in the survey tool. The survey will expand to include a sampling of all members, and compare findings for those who reduced services. A summary of the feedback/findings and recommended follow up actions from these surveys will be delivered to the State Partners no later than October 1, 2014; and

   b. If applicable, provide member feedback to providers and/or prescribers during provider/prescriber forums

10. Analyze use of home health services in RCHs

    a. Using the same methodology developed in 2013, assess changes in expenditures and the use of multiple medication administration home health providers following the certification of RCH staff in med admin.

Identify utilization of home health med admin services by those RCHs that have certified staff and those RCHs that do not have certified staff.

Medication Administration Training, Nurse Delegation and Medication Administration Assistive Technology

The Department of Social Services implemented two initiatives within the home health industry that have been included in the updated 2014 Level of Care Guidelines for Home Health Care Agencies. Nurse delegation is an initiative that will allow certified home health aides to administer certain medications under the non-direct supervision of a nurse. The second initiative is electronic medication dispensing assistive technology. The electronic "med boxes" can be used to pre-pour several medications for a clinically appropriate duration for individuals who are deemed medically competent to take and adhere to their own medications with minimal prompts.

11. Educate the home health industry regarding the revised Level of Care Guidelines by:

    a. By May 31, 2014 the Contractor will meet with and educate, at a minimum, 5 high volume medication administration prescribers regarding the revised Level of Care Guidelines

    b. By May 31, 2014 the Contractor will meet with and educate, at a minimum, the top 5 high volume Home Health agencies providing medication administration services regarding the revised Level of Care Guidelines.

B. Reduce Per Utilizer Per Month (PUPM) Cost of Home Health Services

Value: 0.5%

The Contractor will reduce the PUPM cost of Home Health services to Medicaid Members. The PUPM equation is based on unduplicated Medicaid Members who have had home health services, rather than the total Medicaid Population.

Utilizing claims data the Contractor will analyze the test period of 2014 to the baseline PUPM of 2013. The baseline period of time is July 1, 2013 to December 31, 2013.

The six-month period test period of 2014 is July 1, 2014 to December 31, 2014.

The PUPM is as follows:

$$\frac{\text{Average Monthly Claims for Husky C Users}}{\text{Average Monthly Husky C Users}} = \text{PUPM}$$

- 100%*- The contractor will receive 100% of the with-hold if they decrease the per user per month amount by 2.5%from the final, 2013 PUPM baseline per user per month amount.

- 75%*- The Contractor will receive 75% of the with-hold if they decrease the per user per month by 2.0% from the final, 2013 PUPM baseline per user per month amount.

April 15th 2015 will be considered the cut-off date for the July-Dec 2014 final claims data run (allowance for 90 days to pass following 12/31/14). Final submission of the CY2014 PUPM for this performance target will be completed by April 30th 2015.

PUPM numerator will be the average monthly HH expenditures for all members utilizing HH services that are derived from the HH claims query for CY '13 and CY '14 and for Medicaid C population only (ABD single/ABD/dual).

PUPM denominator will be the average monthly unique Medicaid HUSKY C users (ABD/single ABD/dual) of home health services. Users will be identified per month based on any billed home health services derived from the HH claims query for CY '13 and CY '14. Home health services include skilled nursing, medication administration, home health aide, occupational therapy, physical therapy, and speech therapy.

If the Department's resources dedicated and necessary to this performance target are impacted such that the Contractor is not able to successfully complete this performance target, and all requirements of this performance target under the control of the Contractor are successfully met as determined by the Departments, this performance target may be deemed as having met the required target for full or partial return of the withhold.

*If the Department institutes a rate change during the performance period in 2014 for any of the home health services included in this analysis, as identified above, the Contractor and State mutually agree to conduct a re-analysis of the performance period PUPM results to adjust the expenditure data to reflect the reimbursement rate under which this performance target was developed.

GLOSSARY OF TERMS for HOME HEALTH PERFORMANCE TARGET #3

Best practices (Item A.1) – Best practices for nurse delegation and medication dispensing machinery have not been developed. It is understood that this term refers to information that will be discovered via working with providers who implement these activities, exploring their successes and complications, and determining the elements that how such activities might work most effectively for other provider agencies.

Top 10% utilizers (Item A.4) – This group is defined as follows: Of Home Health service recipients who have also utilized Inpatient facilities and the ED, the 10% that have the highest rate of Inpatient and ED use are defined as "top 10% utilizers".

Facilitate the coordination of care (Item A.4.c) – When the determination is made that a "super user" is receiving services from both a Home Health provider and a Local Mental Health Authority (LMHA), ValueOptions staff will notify the two agencies of their mutual involvement and will provide contact information for each organization to assist with developing a Wellness and Recovery Action Plan (WRAP) that incorporates goals and interventions from each entity. Part of that WRAP will include how those entities will coordinate activities to prevent unnecessary Inpatient and ED utilization in the future.

SIGNATURES AND APPROVALS

999VOI-BHP-01 / 11DSS1206AL A1

The Contractor IS a Business Associate under the Health Insurance Portability and Accountability Act of 1996 as amended.

Documentation necessary to demonstrate the authorization to sign must be attached.

This amendment may be executed in counterparts.

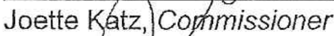
CONTRACTOR - VALUEOPTIONS, INC

Douglas Thompson, *CFO* — Date

DEPARTMENT OF SOCIAL SERVICES

Roderick L. Bremby, *Commissioner* — Date

DEPARTMENT OF CHILDREN AND FAMLIES



Joette Katz, *Commissioner* — Date 5/21/14

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Patricia Rehmer, *Commissioner* — Date

OFFICE OF THE ATTORNEY GENERAL

ASST. / Assoc. Attorney General (Approved as to form & legal sufficiency) — ___/___/___ Date

SIGNATURES AND APPROVALS

999VOI-BHP-01 / 11DSS1206AL A1

The Contractor IS a Business Associate under the Health Insurance Portability and Accountability Act of 1996 as amended.

Documentation necessary to demonstrate the authorization to sign must be attached.

This amendment may be executed in counterparts.

CONTRACTOR - VALUEOPTIONS, INC

E. Paul Dunn, Jr., *CFO* Date

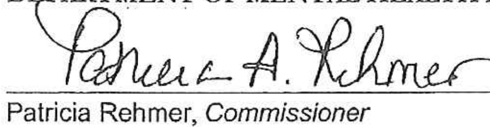
DEPARTMENT OF SOCIAL SERVICES

Roderick L. Bremby, *Commissioner* Date

DEPARTMENT OF CHILDREN AND FAMLIIES

Joette Katz, *Commissioner* Date

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES



4/7/2014

Patricia Rehmer, *Commissioner* Date

OFFICE OF THE ATTORNEY GENERAL

ASST. / Assoc. Attorney General (Approved as to form & legal sufficiency) ___/___/___ Date

SIGNATURES AND APPROVALS

999VOI-BHP-01 / 11DSS1206AL A4

The Contractor IS a Business Associate under the Health Insurance Portability and Accountability Act of 1996 as amended.

Documentation necessary to demonstrate the authorization to sign must be attached.

This amendment may be executed in counterparts.

CONTRACTOR - VALUEOPTIONS, INC

Douglas Thompson, *CFO* — 5/15/14 Date

DEPARTMENT OF SOCIAL SERVICES

Roderick L. Bremby, *Commissioner* — 6/3/14 Date

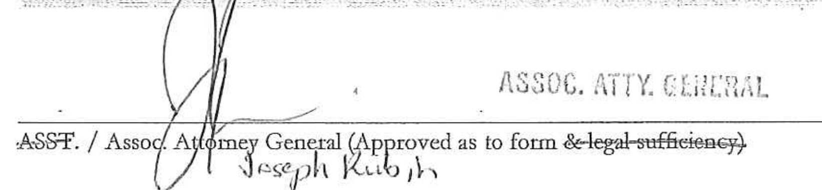
DEPARTMENT OF CHILDREN AND FAMLIIES

Joette Katz, *Commissioner* — Date

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Patricia Rehmer, *Commissioner* — Date

OFFICE OF THE ATTORNEY GENERAL



ASSOC. ATTY. GENERAL

~~ASST.~~ / Assoc. Attorney General (Approved as to form ~~& legal sufficiency)~~ — 7/31/14 Date

Joseph Rubin