

# **Behavioral Health Request for Information**

**The State of Connecticut**

July 2002

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Services  
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# Section 1 — Overview

## A. Background

The State of Connecticut (State) has contracted with Mercer Government Human Services Consulting (Mercer) to collect information about common practices, best practices, and pricing in public sector managed behavioral health (BH) administration. Under the proposed model, the State would integrate public sector BH funding and establish an administrative services agreement with an experienced BH managed care vendor to administer the program. In addition, the State may add child and/or adult rehabilitation services under the Medicaid state plan.

The purpose of this Request for Information (RFI) is to solicit information from established BH vendors with experience in public sector BH managed care regarding current practices and the typical range of administrative fees. The State may use the information in developing their managed BH program design and in estimating associated administrative fees. An electronic version of this RFI may be downloaded from the State's web site at <http://www.ctbhp.state.ct.us>.

Currently, there are separate programs for adults and children with multiple funding streams for both. Funding for children's BH services come from Medicaid, the State's Children's Health Insurance Program (S-CHIP), and the Department of Children and Families (DCF) grant services. In addition to the provision of BH services for children in its care and custody, DCF offers a Voluntary Services program for purposes of providing access to residential treatment<sup>1</sup>, group home, and community based services to Voluntary applicants meeting the program criteria.

Virtually all Medicaid and S-CHIP services for children are administered under a mandatory managed care program. The only exceptions to managed care in which children are covered under Medicaid Fee-For-Service (FFS) are:

1. when there is a gap in time between Medicaid eligibility determination and enrollment in managed care, which usually lasts less than 30 days;
2. when a child is inpatient on the day he/she is determined eligible, coverage remains under FFS until discharge; or
3. if a child is eligible under Supplemental Security Income (SSI) and/or is dually eligible for Medicaid and Medicare.

Under the mandatory managed care program there are currently four health plans<sup>2</sup>. These health plans currently subcontract their BH benefits out to Behavioral Health Managed Care

<sup>1</sup> Please note: Children in nonmedical Residential Treatment Centers (RTCs) are enrolled in managed Medicaid in virtually every case. However, RTC services have been paid for by DCF. As of January 1, 2002, nonmedical residential treatment was added as a covered service under Medicaid FFS.

<sup>2</sup> There were previously five plans and now there are four. The tables in Section III reflect data from all five of the prior plans.

Organizations (BHMCOs). Three of the BHMCOs have a full-risk capitated contract and one provides administrative services only (ASO). For psychiatric inpatient care, the health plan, and where applicable, the subcontracted BHMCO, are at risk for the first 15 days of treatment. The financial risk for inpatient stays over 15 days for children and adolescents, under 19 years of age, is covered under a State funded reinsurance program on a tiered basis. Please see the information below on the two types of reinsurance.

**Medically Necessary**

<u>Days</u>	<u>BHMCO pays</u>	<u>State pays (reinsurance)</u>
1– 15	100%	0%
16 – 45	25%	75%
46 – 60	10%	90%
61 +	0%	100%

**Administratively Necessary**

<u>Days</u>	<u>BHMCO pays</u>	<u>State pays (reinsurance)</u>
1	100%	0%
2+	0%	100%

Reinsurance is calculated on a per-admission basis.

The funding sources for adult services include Medicaid, the Department of Mental Health and Addiction Services’ (DMHAS) managed General Assistance Behavioral Health Program, and DMHAS grant services which could be covered under a Medicaid rehabilitation option, including group homes, supported housing, supervised housing, crisis services, inpatient, psychosocial rehabilitation, and assertive community treatment. In the adult population there are several different populations that would be covered under the Partnership including:

1. Temporary Assistance for Needy Families (TANF adults)
2. General Assistance Behavioral Health Program (GABHP)
3. Aged, Blind and Disabled (ABD) Medicaid recipients including those with Medicare coverage.

TANF adults are administered under the same mandatory managed care plans described above for children. The GABHP population is State funded and managed by DMHAS as a carve-out through a contract with a BHMCO. The contract is for administrative services, which include utilization review (UR) and claims payment. The ABD population is administered under Medicaid FFS.

## B. Request for Information (RFI) Process

The schedule for the RFI process is shown below:

Date	Activity
July 17, 2002	RFI sent to vendors
July 25, 2002	Deadline for all questions
August 9, 2002	Vendors' responses due
August 12, 2002, to August 31, 2002	Cost analysis and program design

Please submit a total of three (3) copies of your proposal as follows:

*One (1) hard copy to:*

Dr. Denise Podeschi  
3131 East Camelback Road, Suite 300  
Phoenix, Arizona 85016  
602 522 6552

*One (1) hard copy to:*

Ms. Mandie Hajek  
10 South Wacker Drive, Suite 1700  
Chicago, Illinois 60606  
312 575 8360

*One (1) electronic copy to:*

Mandie Hajek at [mandie.hajek@mercer.com](mailto:mandie.hajek@mercer.com)

All questions should be directed **via e-mail** to **Mandie Hajek** at [mandie.hajek@mercer.com](mailto:mandie.hajek@mercer.com).  
Questions and answers may be shared with all Respondents.

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## Section II — Program Specifications and Plan Design

### A. Future Managed Behavioral Health Program

The Department of Social Services (DSS), which administers Medicaid funding in the State, DCF, and DMHAS have formed the Connecticut Behavioral Health Partnership (CTBHP) to plan and implement an integrated public BH service system for children, adults, and families. The overall goal of the reform to the BH program is to provide adults and children seeking BH services with enhanced access to a broader and better coordinated system of community services and supports, and to reduce reliance on unnecessary institutional care. There are three primary objectives that will produce significant improvement in outcomes for adults and children, as well as greater administrative efficiency:

- 1. Administrative Integration** — Develop a common administrative infrastructure for the management of publicly funded BH services. Integrated administration would include clinical management, claims processing, and, to a lesser extent, data management functions. Administrative integration will enable the State to integrate funding streams. This will support comprehensive care planning, make it easier to avoid unnecessary institutional care, improve efficiency, reduce administrative costs to the State, improve administrative performance in key areas, and improve the State’s ability to design and manage performance-based clinical service contracts. It is important to note that two separate vendors will manage the clinical and claims components. While the plan is for a single administrative entity to oversee the operation of the CTBHP, the clinical and claims vendors can be expected to interface with each arm of the CTBHP from time to time.
- 2. Service Delivery Redesign** — Redesign of service delivery systems will emphasize children, families, and consumers as partners in care planning and improvements in the quality and availability of community-based services and supports. It is anticipated that these reforms will improve the ability of children and adults to remain in their homes and communities, to avoid unnecessary hospital admissions and extended institutional stays, and to improve client satisfaction and outcomes with respect to independent functioning and quality of life.
- 3. Revenue Maximization** — Service delivery redesign requires the enhancement of community services that provides an alternative to institutional care. Investing in a range of community services (e.g., crisis stabilization, psychosocial rehabilitation, mental health/substance abuse (MH/SA) residential treatment, home-based psychiatric services, assertive community treatment teams, mobile crisis (possible), case management, and respite), most of which would be eligible for Federal reimbursement under Medicaid if they were added to the Medicaid state plan under the rehabilitation option, is possible. This component of the program will most likely be phased in over time.

In both the adult and child systems, the BH benefit will have two tiers. The first tier will include most of the basic BH services currently covered under the existing Medicaid program (outpatient treatment, intensive outpatient treatment, partial hospitalization, extended day treatment, and inpatient psychiatric), as well as selected new community services, such as mobile crisis services and crisis stabilization services.

The second tier will include additional community and rehabilitation services, which will differ, to some extent, for children and adults. Additional child services may include care coordination (e.g., case management), comprehensive global assessments, home-based psychiatric services, behavior management services (i.e., paraprofessional aide support), behavioral consultation, and respite. Care coordination and mobile crisis services may continue to be grant funded. It is anticipated that approximately 1000 – 1500 children will have access to care coordination services and wrap-around care planning each year. Access to care coordination services will be managed by the BHMCO.

Additional adult services will include case management, assertive community treatment, psychosocial rehabilitation, substance abuse residential services, mental health group homes, supervised independent living, and supported living. Case management and mobile crisis services may continue to be grant funded. Case management is expected to be provided to thousands of adults each year. Access to case management services will be managed by DMHAS.

Eligibility for tiers one and two will be based on demonstrated medical necessity and will be determined by the BHMCO using criteria established by the State. Only children with complex behavioral health needs and adults with serious and persistent psychiatric and addiction disorders will be eligible for the enhanced service package.

The goal is to begin implementation of the integrated administrative structure by July 1, 2003. It is anticipated that administrative integration will be phased-in over a six-month period. As part of the implementation, the State will seek a BHMCO to provide administrative services under an ASO arrangement. The State will require the BHMCO to provide those administrative services listed below. The location where these services are provided must be in the State of Connecticut.

### ***Member Services***

Required member services include a member service line that is staffed from 8 a.m. to 6 p.m., Monday through Friday. The BHMCO should expect that the majority of members would access services by directly contacting a network provider. The member service line will receive and manage member calls including responding to questions about benefits, complaints, and handbook requests, and helping direct members to providers within their region.

### ***Member Handbook and Communication Materials***

Member services will also create a member handbook. The handbook will be mailed to those recipients with more than eight visits or upon request. Additional member communications will be required from time to time to improve outreach and for other targeted initiatives.

## *Network Management*

The State will be responsible for establishing credentialing policies and will render all credentialing decisions. However, the BHMCO will provide the back-office functions including, but not limited to, verification of credentials, collection of applications, and direct provider contact when necessary. **The BHMCO will not be expected to do on-site reviews for credentialing purposes.** The BHMCO will be expected to work closely with the State to provide information in support of the credentialing process, including information regarding provider performance (e.g., over- and under-utilization, complaints, adverse incidents). The State will also sign and hold provider contracts. **Network directories will not be published.** The BHMCO's network management department will be expected to build a provider file and will be charged with assessment of network needs through annual geographic access analyses, provider recruitment, mailing provider applications, and tracking provider application status. It is anticipated that this will require two to three (2-3) FTEs.

The BHMCO will oversee and conduct network development in conjunction with the State. The BHMCO will be responsible for ensuring adequate network access, closing network gaps, and building network capacity. The network will need to be developed into a recovery/community-based model that includes both traditional and nontraditional services and supports. To that end, the BHMCO must employ management level professionals with managed care and/or behavioral health care service system knowledge and experience. These regional managers will collaborate with the local provider community and educate, recruit, and retain community-based providers. The BHMCO should employ a minimum of eight (8) FTEs to serve as regional managers for the child service system and a minimum of five (5) FTEs for the adult service system.

The regional managers will be responsible for the development and dissemination of a provider handbook and provider education as necessary. Provider education initiatives should include basic education geared toward assisting providers in successfully navigating the managed care system, as well as targeted education to address performance improvement issues. For example, as system capacity increases to address the psychosocial rehabilitation needs of members, monitoring of fidelity to accepted models of psychosocial rehabilitation, and technical assistance to improve fidelity will need to be provided.

The BHMCO will be expected to utilize reports from a centralized, State-contracted data warehouse for provider profiling in order to prioritize and implement network management and training initiatives. Audit priorities will need to be established and implemented with the network, including site visits of providers for quality management purposes (e.g., atypical utilization patterns, poor outcomes, complaints, etc.).

## *Claims, Eligibility, and Information Systems*

A separate third party Medicaid management information systems (MMIS) vendor will administer claims payment. Claims administration by the MMIS vendor will include handling provider complaints regarding claims issues. The BHMCO will be required to establish an

electronic interface with the MMIS/claims vendor to provide electronic feeds of authorizations on a daily basis.

Medicaid and GABHP eligibility will be administered by DSS. DSS has an eligibility management system for this purpose. A DSS agent will determine eligibility for S-CHIP services. This agent has its own S-CHIP eligibility system. The BHMCO will be expected to accept weekly eligibility feeds from DSS and its S-CHIP agent in order to administer the behavioral managed care program and to answer eligibility questions from members and providers.

DSS and DMHAS will each maintain a data warehouse. The DSS data warehouse will contain MMIS claims and authorization data and a provider database. The BHMCO will have access to this central data warehouse and be permitted to run reports for a variety of purposes. The BHMCO and claims vendor will provide direct feeds directly to the DMHAS and DSS data warehouses that will also include DCF data. The BHMCO may be requested to compile management reports as directed by the Departments. The Departments will establish parameters for data that they receive and share. This data will support the quality and contract management efforts. A common data dictionary will need to be created for the BHMCO and claims vendor. Data elements will be uniform and will comply with HIPAA standards.

### *Utilization and Care Management*

The BHMCO will be required to provide Utilization Management (UM) for the following **Mandatory** covered services:

- *Inpatient general hospital admissions for Medicaid recipients will only require prior authorization (PA) because these services are reimbursed on a case rate basis. Coordination will be required for planning aftercare.*
- *Inpatient general hospital admissions for all non-Medicaid coverage groups will require PA, concurrent and discharge reviews.*
- *Inpatient private psychiatric hospital admissions for all coverage groups will require PA, concurrent and discharge reviews.*
- *Outpatient treatment requires Outpatient Treatment Review after the twentieth visit. (Note: Providers will be required to notify the BHMCO after the initial visit for all outpatient episodes of care. It is expected that a substantial portion of outpatient episodes of care will end prior to the twentieth visit and never require Outpatient Treatment Review.)*
- *Home Health Agency services, including skilled nursing visits and home health aide visits, will require PA and concurrent review.*
- *Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), and other day program services will require PA and concurrent review.*

- *Child Residential Treatment Center (RTC) admissions will require PA and concurrent review. (Note: There are approximately 900 to 1,000 cases per year.)*
- *Adult Substance Abuse Residential Rehabilitation is currently a GABHP covered service, consequently, admissions for GABHP recipients will require PA and concurrent review.*
- *DCF funded care coordination services will require PA.*

The BHMCO may be required to provide UM for the following **Rehabilitation** services if the State implements a Medicaid rehabilitation option:

- *Adult and child rehabilitation services will require PA and concurrent review as these services are converted to FFS and added to the Medicaid plan as a rehabilitation option;*

The BHMCO will be expected to provide PA for acute care hospital services on a 24/7 basis. The medical necessity criteria for all services will be developed by the State. The UM process should address medical necessity, as well as care management issues, such as QM, coordination of care, and discharge planning. The BHMCO will be expected to conduct PA for individuals whose Medicaid eligibility is pending or who may be eligible for GABHP.

The BHMCO will be expected to provide medical management services to include oversight by board certified psychiatrists for all clinical services and UM decisions. All denials of service will require co-review by a board certified psychiatrist (inpatient), addiction medicine specialist (inpatient SA), or a doctoral level clinician (outpatient, day program, rehabilitation services). The BHMCO medical director shall direct a UM committee and provide oversight of the development and implementation of all clinical policies and procedures.

### *Intensive Care Management*

The BHMCO will provide prospective, concurrent, and retrospective UM services for children and adults as defined by the tiered benefit design and by the UM thresholds described under “Utilization and Care Management,” above. A subset of the population will receive intensive care management services when they meet criteria. The State and the BHMCO will work together to develop and adjust criteria for the provision of intensive care management. The quality of services provided would be monitored and frequent users/potential frequent users will be identified through a prospective, concurrent, and retrospective process.

### *Grievance and Appeals*

The BHMCO will also be responsible for administering all complaints, suspensions, grievances, and appeals. Appeals related to the denial, termination, or reduction of services provided through Medicaid will be subject to Federal notice of action requirements and will be subject to an administrative fair hearings process administered by DSS when unresolved by the BHMCO.

GABHP or Voluntary Services also will be subject to DCF and DMHAS administrative hearing processes.

### *Quality Management*

The BHMCO will be required to direct a QM program. This will include the development and administration of an annual QM plan to include a work plan that details specific quality improvement initiatives for the year. A minimum of two focused studies per year will be required. The BHMCO will be required to perform all the project administration, data analysis, and reporting necessary for implementation and oversight of these components of the QM program. The BHMCO will manage the implementation phase around several “key” quality indicators to be established by the Departments.

### *Account Management*

The BHMCO will be required to provide a single point of contact for account management issues. In addition, appropriate representatives from the BHMCO will be required to attend meetings and work on various initiatives from time to time to insure smooth administration and coordination of the program.

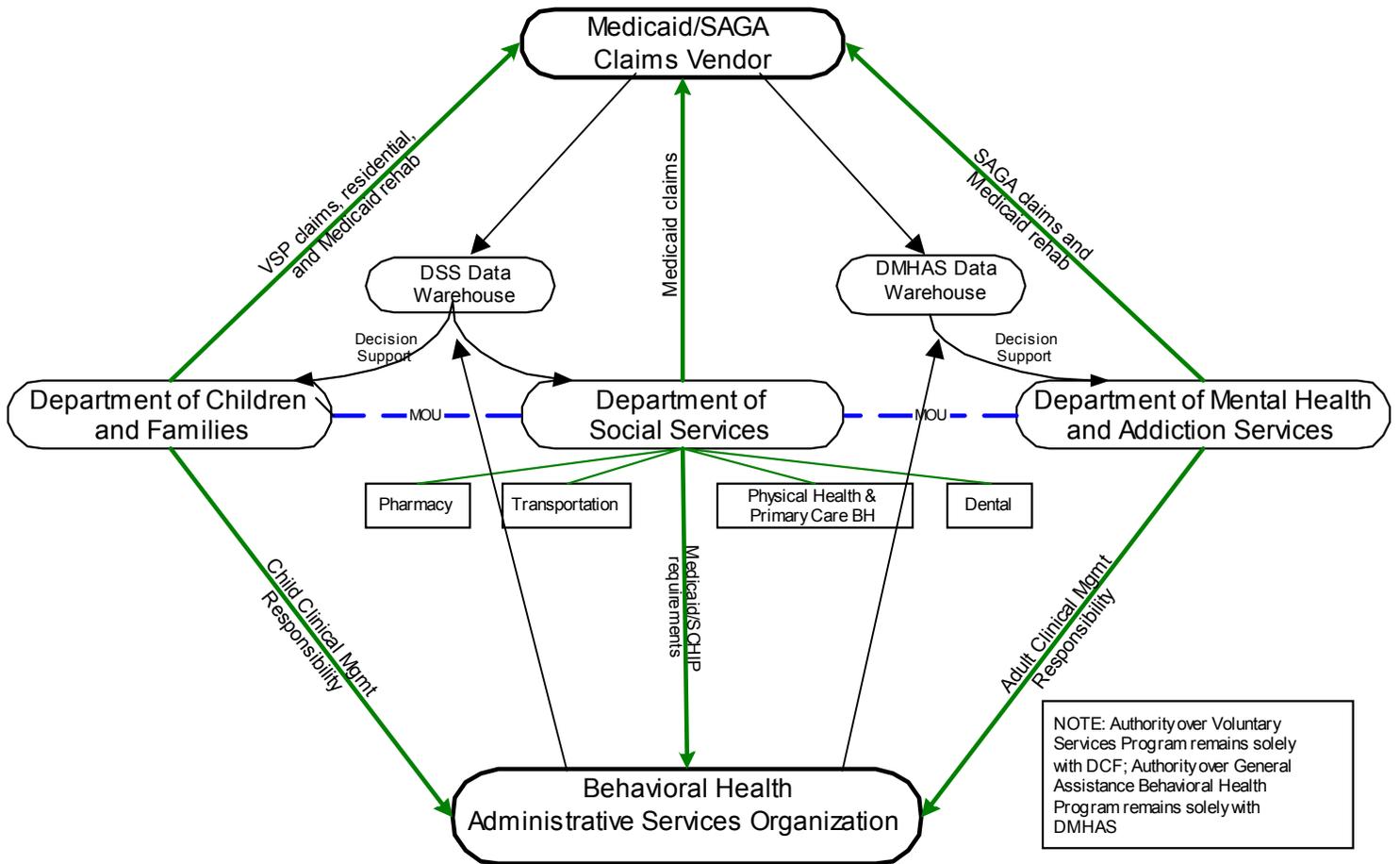
### *Other Services*

The State is interested in pricing for 24/7 crisis call management and claims processing. These two services are not currently requirements of the BHMCO. Pricing for these services, if available, should be separate from pricing of the basic suite of administrative services.

### *Summary*

The following graph depicts the relationship between the State agencies, the claims/MMIS vendor, and the BHMCO. A more complete description of the CTBHP can be found on the State’s web site at <http://www.ctbhp.state.ct.us>.

## Connecticut Behavioral Health Partnership Administrative Infrastructure



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## **Section III — Experience**

Summary Fiscal Year (FY) 2001 enrollment statistics for the State's population and Calendar Year (CY) 2000 expenditures for the program are identified in Appendix A.

Detailed claims information is not available for this RFI.

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## Section IV — Questionnaire

### A. Organization

Please respond to the following questions concisely and completely, without referencing separate materials unless specifically requested to do so. Repeat each question before responding. Answer every question, and state if a question is not applicable to your firm. Base your answers on current, not planned capabilities.

Please limit your response to each question that requires a narrative response to ONE page. Unless otherwise specified, any question where the response format is provided does not also require a narrative response.

For your convenience, a copy of this questionnaire can be downloaded from the State's web site at <http://www.ctbhp.state.ct.us>

- A1. When (yyyy) did your company become operational? \_\_\_\_\_
- A2. When (yyyy) did your company first begin providing public sector business? \_\_\_\_\_
- A3. Please indicate the total number of clients contracted with this company as of December 31, 2001, in the table below:

	<b>Public Sector Clients</b>	<b>Private Clients</b>
Number of clients		
Number of member* lives		
Percentage** ASO lives		
Percentage** Modified-Risk lives		
Percentage* Full-Risk lives		

\*for membership, list employees for commercial and enrollees for public sector

\*\*as a percentage of total lives

A4. Please list this company's five largest public sector accounts by covered lives. This information is requested for informational purposes only and will not be used for reference checking.

Account Name	Account Membership as of 1/1/2002	Percent of Total Company Membership	Client Implementation Date (mm/yyyy)
_____	_____	%	_____
_____	_____	%	_____
_____	_____	%	_____
_____	_____	%	_____
_____	_____	%	_____

A5. What factors influence a BHMCO's inclination to bid on an ASO public sector contract?

**B. Clinical Services**

B1. What experience do you have in managing care under a multi-party partnership similar to CTBHP? How would you anticipate managing care under the new Partnership for individuals with complex or multiple needs, including:

- adults with serious mental illness and addictive disorders;
- children and adolescents with serious emotional disturbances who are involved with children and youth services;
- children and adolescents with mental retardation and behavioral disorders; and
- persons with BH needs discharged from state and county correctional facilities?

B2. Have you authorized and/or managed grant-funded services for which no direct payment is made? How do you handle eligibility and encounters for members served under grant funded programs?

**C. Provider Network**

C1. Describe how performance requirements and/or financial mechanisms in BHMCO contracts with BH service providers have ensured service access for members with the most serious and chronic illnesses when the BHMCO is paid under an ASO basis.

C2. Describe alternative or creative reimbursement mechanisms that have been implemented in other states, which have encouraged and rewarded effective service delivery.

## **D. Information Systems**

- D1. Provide a copy of the standard reporting requirements that are provided to a public sector client. Include reporting on utilization, QM, member service, Complaints, Grievances and Appeals (CG&A), and provider network.
- D2. Describe any state-of-the-art technology you have available (e.g., IVR, web-based registration).

## **E. Quality Management/Satisfaction**

- E1. Describe your experience in developing outcome measures to assess program quality and effectiveness.

## **F. Financial**

- F1. Describe savings you have achieved with other states as a result of effective care management, increased service capacity, increased capacity of community-based and alternative services for priority populations. A narrative or case study format is acceptable as a response. What factors influence these savings?
- F2. What factors impact ASO pricing?
- F3. What type of shared risk, modified risk, or alternative funding arrangements would your organization consider?
- F4. Provide the number of public sector clients with whom you currently have performance-based contracts with financial incentives or penalties. What is the average percentage of fees at risk? Please specify which portions of your fees are at risk for ASO versus risk accounts.
- F5. How do you handle start-up costs? Do you build them into your per member per month (PMPM)? If so, over what period of time will you amortize these costs into the ASO rate?
- F6. The GABHP and/or Voluntary Services coverage groups may be phased-in October 1, 2003 or January 1, 2004. Please describe how this would impact pricing.
- F7. In Connecticut, home health agency behavioral health services represent a disproportionate share (35%) of overall non-inpatient behavioral health expenditures for adult behavioral health. Currently, these services are unmanaged. Please indicate whether and to what extent utilization management might be expected to affect utilization of these services.

F8. Please estimate your ASO fee for your basic service package, but **without** claims administration. Please provide an estimate for each of the coverage groups listed as well as a blended rate.

Please note that we are asking you to provide two estimates. One is for managing current covered levels of care, referred to as “Mandatory Covered Services” in Appendix A. The other estimate is for the additional responsibility of managing child and adult “Rehabilitation” option services if these become covered services under a rehabilitation option. The two estimates would be added to yield the combined fee in Column III.

The coverage group specific bid should be adjusted to reflect the unique administrative demands of each coverage group.

*Please consider the requirements outlined in Section II-A in providing these estimates, specifically the following:*

- *Inpatient stays for Medicaid recipients in general hospitals are reimbursed under a (Tax Equity and Fiscal Responsibility Act (TEFRA) case rate arrangement; only preadmission reviews are necessary.*
- *Outpatient concurrent reviews will only be required after the twentieth visit.*
- *Medicaid/Medicare dual eligibles require minimum management. Medicare covered services are exempt from management. Expenditures for services that would be subject to management are included in Appendix A.*

<b>Typical Fees on a Per Member Per Month Basis</b>			
<b>In Column I, estimate the fees for mandatory covered services; in Column II estimate the additional ASO fee for including management of child and adult rehabilitation services referenced above. In column III, present the combined rate.</b>			
<b>Coverage Groups</b>	<b>I. Mandatory Service Package</b>	<b>II. Rehabilitation Services</b>	<b>III. Combined</b>
Medicaid — ABD – Adult and Child			
Medicaid — non-ABD - Child			
Medicaid — non-ABD - Adult			
Medicaid/Medicare			
Medicaid — Child Welfare			
GABHP			
S-CHIP			
<b>Blended Across All Categories of Aid</b>			

F9. If the bid that you provided needed to be reduced by 5%, 10%, or 15%, what areas would you recommend reducing or eliminating to meet the required bid reduction?

F10. Please confirm which services are included in fee estimates in the following grid. If a service is not a part of your basic package, indicate the additional fees associated with this service in comparable programs.

Services Included in Basic ASO Agreement	<i>If no, list additional fee</i>
Member Services <input type="checkbox"/> YES <input type="checkbox"/> NO	\$
Member Handbooks/Communications Materials <input type="checkbox"/> YES <input type="checkbox"/> NO	\$
Network Management <input type="checkbox"/> YES <input type="checkbox"/> NO	\$
Utilization, Care, and Medical Management <input type="checkbox"/> YES <input type="checkbox"/> NO	\$
Grievance and Appeals <input type="checkbox"/> YES <input type="checkbox"/> NO	\$
Quality Management <input type="checkbox"/> YES <input type="checkbox"/> NO	\$
Reporting and Account Management <input type="checkbox"/> YES <input type="checkbox"/> NO	\$
<b>List Any Other Services Included in Basic Services Pricing</b>	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

F11. What additional services, if any, can be purchased a la carte, and what is the typical pricing? The State is particularly interested in pricing for crisis call management and claims administration. These services are not currently requirements of the BHMCO. The State, however, would be interested in pricing information for these services if they are offered by your organization.

Typical Fees on a Per Member Per Month Basis		
Optional Services	Available?	Associated Costs
1. <i>Crisis Call Management: A single statewide BH crisis line. The BHMCO would be expected to manage the crisis line 24 hours a day, seven days a week. BHMCO Masters level clinicians would be required to triage calls and provide a warm transfer to the DCF and DMHAS grant-funded local mobile crisis service for members in crisis. In addition, DMHAS will maintain its local crisis lines</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$
2. <i>Claims administration</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$
3.		\$
4.		\$
5.		\$
6.		\$
7.		\$
8.		\$
9.		\$
10.		\$

## Section V—Appendix A

COVERAGE GROUP MATRIX*												
Coverage band	Enrollment	Experience (Dollars in 1000's)										
		Mandatory Services								Subtotal	Optional Rehab Services	Total
		OP	MM	PHP, IOP & EDT	MH, RTC, SA RTC	IP-GH	IP-PH & IP-SO	HH				
Medicaid – ABD - Adult and Child	28,000	\$ 2,398	\$ 1,714	\$ 1,382	\$ -	\$ 6,699	\$ 2,464	\$ 4,797	\$ 19,454	\$ 10,281	\$ 29,735	
Medicaid – non-ABD – Child	158,000	\$ 12,942	\$ -	\$ 1,854	\$ 27,145	\$ 10,213	\$ 32,795	\$ 1,083	\$ 86,032	\$ 4,636	\$ 90,668	
Medicaid – non-ABD - Adult	80,000	\$ 6,835	\$ 4,887	\$ 3,939	\$ -	\$ 19,095	\$ 7,025	\$ 13,676	\$ 55,457	\$ 29,307	\$ 84,764	
Medicaid/Medicare	121,000	\$ 10,320	\$ 7,360	\$ 5,937	\$ -	\$ -	\$ -	\$ 20,599	\$ 44,216	\$ 44,139	\$ 88,355	
Medicaid – child welfare	9,000	\$ 1,508	\$ -	\$ 110	\$ 51,682	\$ 650	\$ 5,041	\$ 64	\$ 59,055	\$ 4,245	\$ 63,300	
GABHP	22,000	\$ 1,752	\$ 6,033	\$ 7,355	\$ 14,866	\$ 5,470	\$ 9,877	\$ -	\$ 45,353	\$ -	\$ 45,353	
SCHIP	9,000	\$ 95	\$ -	\$ 8	\$ -	\$ 189	\$ 374	\$ 6	\$ 672	\$ -	\$ 672	
<b>Total</b>	<b>427,000</b>	<b>\$ 35,850</b>	<b>\$ 19,994</b>	<b>\$ 20,585</b>	<b>\$ 93,693</b>	<b>\$ 42,316</b>	<b>\$ 57,576</b>	<b>\$ 40,225</b>	<b>\$ 310,239</b>	<b>\$ 92,608</b>	<b>\$ 402,847</b>	

\* These are hypothetical enrollment and expenditure values. They represent only the services that are expected to be managed by the ASO. It is not intended to reflect the entire expenditure base for any program.

Child = birth to age 18

Adult = 18+

OP = outpatient

MM = methadone maintenance

PHP = partial hospitalization program

IOP = intensive outpatient program

EDT = extended day treatment

MH = mental health

SA = substance abuse

RTC = residential treatment center

IP-GH = inpatient general hospital

IP-PH = inpatient free standing psychiatric hospital

IP-SO = inpatient state operated hospital

HH = home health