ADULT UTILIZATION MANAGEMENT

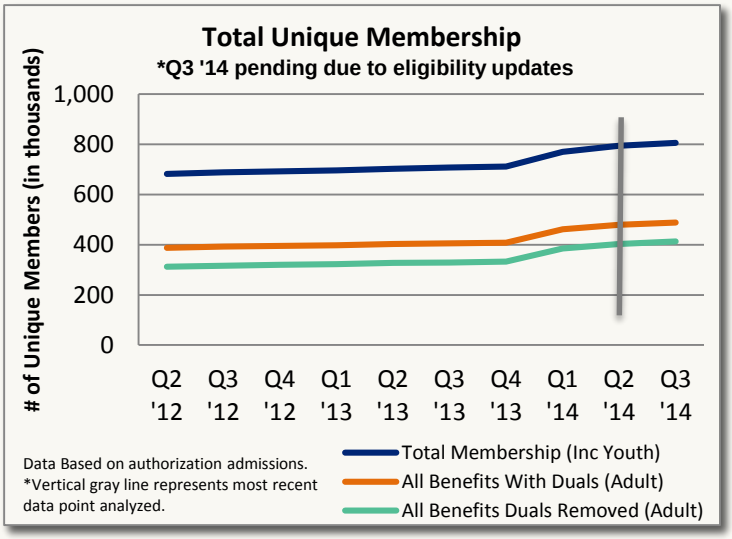
Highlights from Quarter 3, 2014

On at least a quarterly basis, the reports mutually agreed upon in Exhibit E of the CT BHP contract are submitted to the state for review. This Quarterly Report focuses on the utilization management portion of these reports, evidenced in the 4A series which reviews utilization statistics such as average length of stay (ALOS) and admissions per 1,000 members (Admits/1,000).

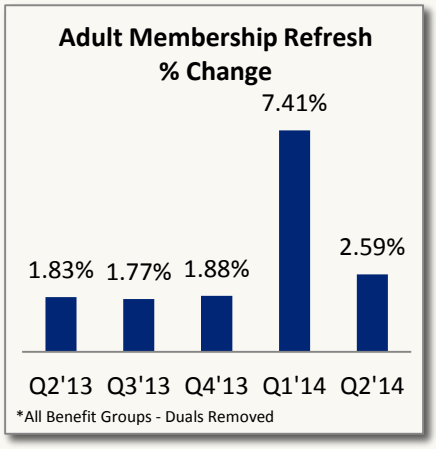
Connecticut BHP
Supporting Health and Recovery

Continued Growth in Membership

The total population (Youth and Adult) increased by 23,462 members, a 3.0% increase from Q1 '14 (770,252 members) to Q2 '14 (793,714 members). The adult population, including dual eligible members, increased by 18,061 members, a 3.9% increase from Q1 '14 (461,344 members) to Q2 '14 (479,405 members). The adult population, excluding dual eligible members, increased by 18,216 members, a 4.7% increase from Q1 '14 (384,950 members) to Q2 '13 (403,166 members).

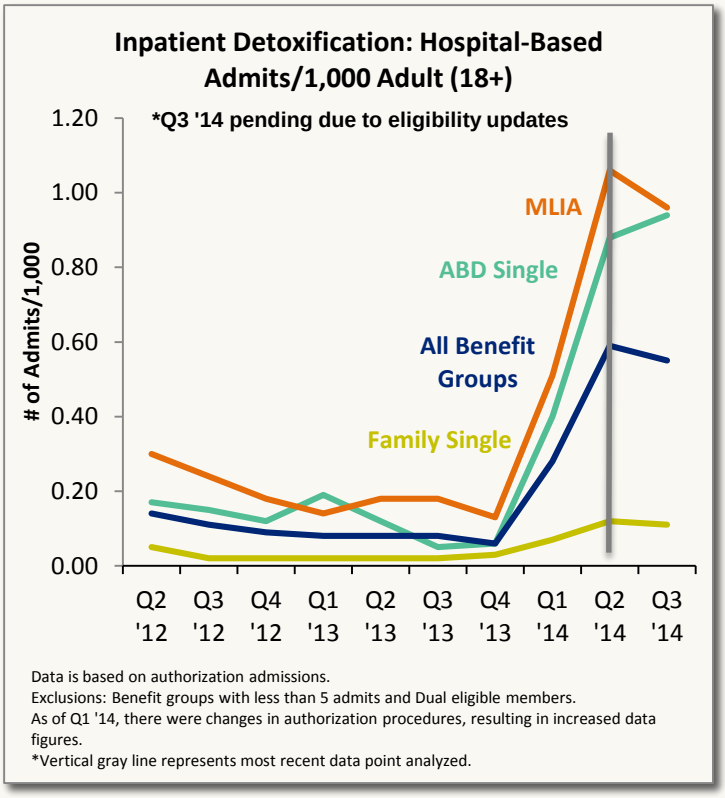


The refresh rate dropped from 7.41% in Q1 '14 to 2.59% in Q2 '14, suggesting that the influx of new membership due to the Affordable Care Act has peaked for this time period, and the processing delay may return to more historical levels.



Hospital Based Inpatient Detoxification

ValueOptions assumed responsibility for authorizing hospital-based detox services on March 1, 2014. Previously, CHN (Community Health Network) authorized most hospital-based detoxes. The average length of stay for hospital-based detox increased from Q4 '13 to Q1 '14 and again from Q1 '14 to Q2 '14. The increase in ALOS is expected because members with medical co-morbidities typically stay longer in the hospital than those without such conditions. As expected, the Admits/1,000 for All Benefit Groups has increased dramatically since ValueOptions assumed responsibility for authorizing hospital-based detox. HUSKY D (MLIA) members continue to utilize this level of care at the highest rate, followed by HUSKY C (ABD Single), and HUSKY A (Family Single).



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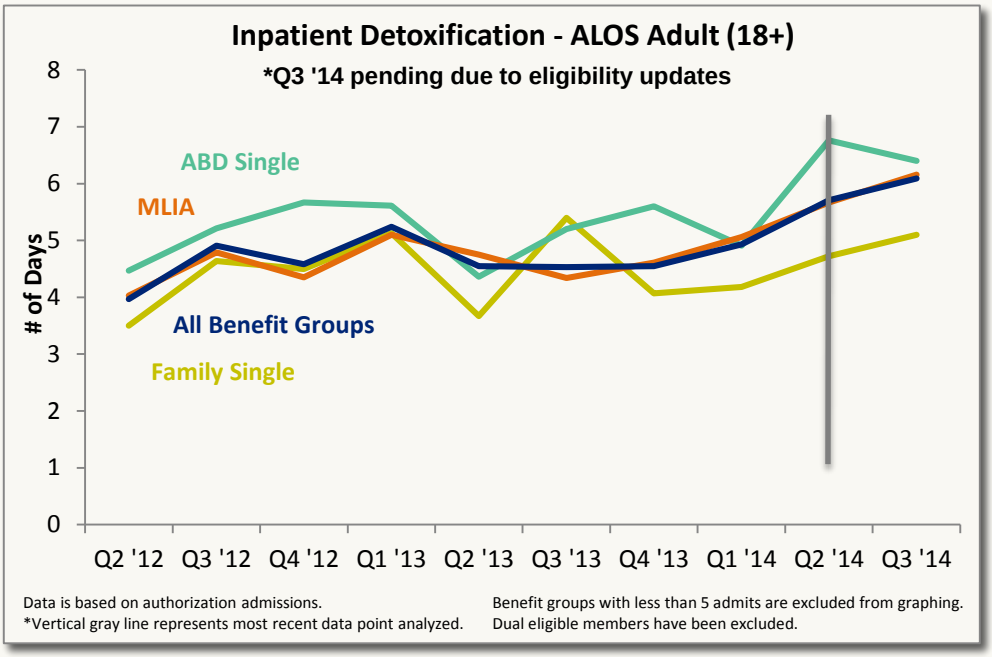
Hospital Based Inpatient Detoxification, Continued

The increase in ALOS in HUSKY C (ABD Single), HUSKY D (MLIA), and All Benefit Groups were statistically significant from Q1 '14 to Q2 '14. There was also a statistically significant increase in HUSKY D (MLIA) and All Benefit Groups since Q2 '13. The ALOS for this level of care has been variable in the past, but there is a steady increase in ALOS for All Benefit groups over the past year. This change was expected due to the increase in authorizations for medically-complex cases to this level of care. There is potential for the ALOS to increase further because the less complex cases will be diverted to free-standing detox programs, keeping the more complex cases in hospital-based detox.



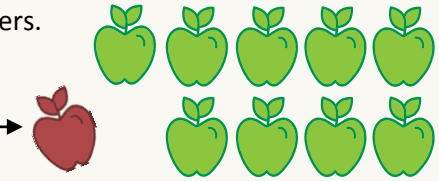
Data is based on authorization admissions.
*Vertical gray line represents most recent data point analyzed.

Benefit groups with less than 5 admits are excluded from graphing.
Dual eligible members have been excluded.

Treatment for Eating Disorders

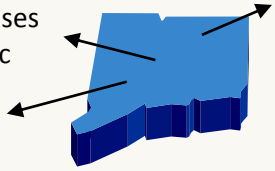
"Members with eating disorders need access to a variety of services within the state to ensure that care is comprehensive and well-coordinated."

Only 1 in 10 men and women with eating disorders receive treatment. Only 35% of people that receive treatment for eating disorders get treatment at a specialized facility for eating disorders.



(Source Characteristics and Treatment of Patients with Chronic Eating Disorders, by Dr. Greta Noordenbox, International Journal of Eating Disorders, Volume 10: 15-29, 2002.)

Based on information gleaned from data and care manager's experience, VO recognizes a need to develop a comprehensive in-state continuum of care for members with Eating Disorders. There are two intermediate care providers in-state and several outpatient providers, but inpatient care that specifically focuses on both the medical and psychiatric effects/symptoms of the eating disorder remain out of state.



The Development of Community Care Teams

Regional Network Managers are making progress implementing and enhancing Community Care Teams (CCTs) across the state. CCTs are a systems based strategy for improving connections to care and reducing ED readmissions for frequent visitors to the ED. CCTs by Region:

- Region 1 - Norwalk Hospital has an existing CCT that has been operational for over one year. The Region 1 RNM has worked with Saint Vincent's to establish a CCT.
- Region 2 - RNM has been instrumental in establishing a CCT at Yale New Haven Hospital.
- Region 3 - RNM has been working with William Backus Hospital to enhance their existing case conference meeting to resemble a CCT more closely, and has been exploring the possibility of establishing a CCT at Lawrence and Memorial.
- Region 4 - RNM has worked extensively with Hartford and Saint Francis hospitals to establish a joint CCT. In addition, he is working with Manchester Hospital to establish a CCT east of the river.
- Region 5 – Danbury Hospital is hosting their 1st CCT in December and the RNM has been supporting the development of one at Charlotte Hungerford.
- Region 6 - RNM has been instrumental in establishing a CCT at Bristol Hospital and will consult with the Hospital of Central CT to establish a CCT at that location as well.

This summary is an extraction of the key points from a more extensive quarterly report submitted to the State of Connecticut by ValueOptions Connecticut.