Independent Assessment of Idaho Behavioral Health Plan for Medicaid Members

Waiver Period: September 1, 2013 – March 31, 2015

Prepared for:
Idaho Department of Health & Welfare

Office of Mental Health & Substance Abuse

Division of Medicaid

Prepared by:

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Executive Summary

Background

The 2011 Idaho Legislature directed Idaho Medicaid, by 56-261 Idaho Code, to incorporate managed care systems for high-cost services as an effort to improve effectiveness and efficiency of services. Idaho Department of Health and Welfare designated the Division of Medicaid to oversee the new Idaho Behavioral Health Plan (IBHP) to ensure compliance with federal requirements. Optum Idaho was contracted to develop a statewide provider network of qualified behavioral health community providers. Through the implementation of a new managed care system under the 1915(b) waiver, beginning September 1, 2013, IDHW has worked to achieve specific goals with Optum Idaho as outlined in the initial waiver application. Peak View Performance Solutions, LLC (PVPS) has contracted with the Idaho Department of Health and Welfare to perform the Independent Assessment of the program operating under the Agency's 1915(b) waiver.

Assessment Focus

This assessment was completed in accordance with the Centers for Medicare & Medicaid Services, (CMS) *Independent Assessment Requirement for Section 1915(b) Waiver Programs: Guidance to States*, in order to comply with the Independent Assessment requirements of the 1915(b) waiver. This assessment's scope is to examine the State of Idaho's efforts to monitor the IBHP under the waiver. The timeframe used for this assessment is September 1, 2013 until March 31, 2015. PVPS reviewed existing data provided by IDHW and Optum Idaho, interviews with IDHW and Optum Idaho staff, scripted phone survey data collected from providers, CAHPS data provided by a third party, and CFR guidelines to assess the findings in this report. This report also includes recommendations noting areas in which IDHW could make improvements in processes.

Findings

Based on a review of contract requirements and reports submitted by both IDHW and Optum Idaho to the IDHW, PVPS found Optum Idaho is providing the same or

increased access and quality to Medicaid behavioral health members since the beginning of the waiver period. Areas for continuous improvement were noted in the sections of this assessment. IDHW and Optum Idaho contract standards described in this assessment should be addressed, including clarification of Geo Access standards.

As a result of the collaborative efforts from IDHW and Optum Idaho, the IBHP is structured to deliver quality health care to its members. The requirements set forth by the IDHW contract with Optum Idaho are comprehensive, which ensure quality care is provided to its members and fostering a comprehensive behavioral health system.

Strengths

During this assessment, a number of strengths have been identified. These strengths include:

- IDHW and Optum Idaho staff and management teams have worked collaboratively on issues found during the implementation phase and in the on-going contract monitoring process
- Optum Idaho has created and effectively implemented a 24-hour/365 day state-wide member and crisis hotline.
- Optum Idaho has implemented and maintained a statewide provider network of qualified behavioral health professionals.
- IDHW staff and administration have shown a dedication to preserving Member's rights during the implementation phase and moving forward.
- Approach to contract monitoring by OMHSA has been a systematic method to review all performance indicators in the first year of implementation and has continued to evolve since this assessment to continue monitoring the contract requirements and overall program.
- Optum Idaho has developed and implemented an extensive quality management system, where there was a very limited system in place before the waiver.
- Optum Idaho has provided IDHW annual plans for Network Development and Management, Quality Management and Utilization Management,

annual Cultural Competency Plan, and Provider Training Plan. These plans are all connected and reviewed by committees, IDHW and UBH national staff.

Recommendations

- Work in partnership with Optum Idaho to create an overall contract monitoring plan and review the contract for shared understandings of requirements.
- Create a governance policy, at a minimum to define control limits for the prioritization of contract monitoring compliance findings.
- Create a common language for terminology used by IDHW and Optum Idaho.
- Create a document control procedure for all policy documents sent from Optum Idaho.
- Use data collected in this assessment and from Optum Idaho's first eighteen months of implementation as baseline data for future assessments.

Background

The State of Idaho is unique with its small population, rural nature and geographic diversity. Idaho is a predominantly rural state with a population of approximately 1,600,000. About 40 percent of the population lives within the metropolitan area of Boise and the rest of the population lives in smaller cities and towns, or in rural areas. The Idaho Department of Health and Welfare, (IDHW), has structured the state into regions that serve Idaho citizens. Each region serves several counties as seen in figure 1.

Figure 1. Idaho State Regions

In addition to the geographical diversity of Idaho, the Idaho Office of Rural Health and Primary Care, has reported that all 44 counties in Idaho have been designated as Federal Mental Health Professional Shortage Areas (HPSA). According to the Health

Resources and Services Administration website, “Mental Health HPSAs are based on a psychiatrist to population ratio of 1:30,000.” This designation has created a challenge for the state to recruit and retain mental health professionals, especially in the rural areas of the state.

The State of Idaho initial waiver application provided the assessor essential information needed to understand the creation of the Idaho Behavioral Health Plan, (IBHP). The waiver application stated:

> The 2011 Idaho Legislature directed Idaho Medicaid, by 56-261 Idaho Code, to incorporate managed care systems for high-cost services as an effort to improve effectiveness and efficiency of services. To comply with this statute, Idaho Medicaid sought to implement a Prepaid Ambulatory Health Plan (PAHP) under a 1915(b) waiver, hereon referred to as waiver authority in order to move away from a fee-for-service reimbursement system for all of Idaho Medicaid’s behavioral health services for adults and children. Idaho Department of Health and Welfare designated the Division of Medicaid to oversee the new IBHP to ensure compliance with federal requirements. Medicaid provided for an IDHW Contract Manager to lead ongoing contract administration and contract performance monitoring with overall responsibility for the management of all aspects of the contract.

The IBHP went into effect on September 1, 2013, based on the contract established between the Idaho Department of Health & Welfare, Division of Medicaid, Office of Mental Health & Substance Abuse (OMHSA), and United Behavioral Health (dba Optum Idaho). Through the implementation of a new managed care system under the 1915(b) waiver, IDHW has worked to achieve goals with Optum Idaho as outlined in the initial waiver application. These goals included, but are not limited to;

- Implement and maintain a statewide provider network of qualified behavioral health professionals,
- Successful transition for both providers and Members,

- In the long term, have greater satisfaction with treatment and support services for Members and providers,
- Implementation of a quality assurance program and processes that would improve services and operations,
- Improved coordination with all treatment providers,
- Effective communication between IDHW, Optum Idaho and stakeholders within the state.

As part of the State of Idaho's 1915(b) waiver renewal process, the Centers for Medicare and Medicaid Services (CMS) requires that an independent assessment of the IBHP operating under the waiver be conducted to determine whether programs are meeting the requirements outlined in the approved waiver document in terms of access to care and quality of services. Peak View Performance Solutions, LLC (PVPS) has contracted with the Idaho Department of Health and Welfare to perform the Independent Assessment of the program operating under the Agency's 1915(b) waiver. The following sections analyze the degree of access and quality of care services available to IBHP members.

Assessment Methodology

This assessment was completed in accordance with the Centers for Medicare & Medicaid Services, (CMS) *Independent Assessment Requirement for Section 1915(b) Waiver Programs: Guidance to States*, in order to comply with the Independent Assessment requirements of the 1915(b) waiver. The scope of this assessment is to review the State of Idaho's efforts to monitor the program under the waiver. The IBHP waiver period began September 1, 2013. This assessment will include accessibility of care and the quality of care data from the beginning of the waiver period until March 31, 2015. Prior to the waiver period there was very little data collected in order to define, compare and determine program improvements. Therefore, in some areas this report will establish a data baseline and provide comparative data for future program assessments. The results of this analysis are provided in this report in narrative form, as well as visually displayed in tables, and figures.

The assessment was conducted as a summative evaluation, based on IDHW's need to focus on the impact of the IBHP. To conduct this assessment in a manner that would align with IDHW's goals and CMS guidelines, PVPS and IDHW created a statement of work to define the elements necessary in the independent assessment. For any evaluation, two elements are important to ensure credibility of the data, triangulation, which refers to the use of different types of data and multiple sources of information to increase the reliability of data, gathered during this evaluation. In order to eliminate a duplication of efforts PVPS used existing data, including Code of Federal Regulation (CFR), the contract agreement between IDHW and Optum Idaho, and data reports provided by IDHW and Optum Idaho. Scripted provider telephone survey data and independent CAPHS survey data results provided by IMS Government Solutions was also collected for use in this assessment. To increase the reliability of conclusions the assessor conducted open-ended, semi-structured interviews with Optum Idaho and IDHW staff to analyze and identify the state's efforts in monitoring the program. The assessor then determined processes that could be improved and offered recommendations for actions that can be completed in order to improve services to the members and providers.

Access to Care

Introduction

Federal and State regulations, and the contractual agreements between Optum Idaho and the State, spell out, in detail, the requirements for access to care. Systems and processes of Optum Idaho were assessed and performance results reviewed looking for suitable and sufficient accessibility and availability of providers and services. All parts of the contract have not been included in this assessment, specifically the RFP and Optum's proposal. Optum Idaho, along with the overall IBHP, was evaluated for how well it met its regulatory and contractual requirements.

Contract Requirements

The contract conforms to the federal standards in the 42 CFR 438 citations, and mandates that requirements are met regarding access of care to ensure services are provided in a well-organized service delivery system. The requirements set forth by the contract between IDHW and Optum Idaho are extensive. The contract includes a total of thirty-six performance indicators that are monitored by IDHW. In the contract classifications and thresholds have been identified for each indicator. The contract states,

> Each Performance Indicator has been assigned a classification of either "Critical" which must be performed at a level of 100%, "Essential" which must be performed at a level of 95% and "Important" which must be performed at a level of 90%. The thresholds have been determined by the relationship of the Performance Criteria to the Idaho Behavioral Health Plan critical, essential and important standards.
>
> Table 1 shows the performance indicators included in the contract, as well as the classifications and thresholds for each.

Performance Indicators	Classification	Threshold
General Requirements (Pre-Implementation and operations and deliverables)	Essential	95%
Administration and Operations	Essential	95%
Work Plan and Service Implementation	Essential	95%
Behavioral Health Services (Recovery oriented system of behavioral health care)	Essential	95%
Member Enrollment/Disenrollment	Essential	95%
Coverage and Payment for Post-Stabilization Services	Essential	95%
Access to Care	Critical	100%
Cultural Competency	Essential	95%
Customer Service System	Essential	95%
Provider Network Development and Management Plan	Essential	95%
Provider Network (Standards)	Critical	100%
Notification Requirements for Changes to the Network	Essential	95%
Provider Training and Technical Assistance	Critical	100%
Electronic Health Records	Important	90%
Management of Care (Care management and case management functions)	Critical	100%
Intake and Assessment	Essential	95%
Treatment Planning/Self-determination & Choice	Essential	95%
Primary Care Interface: PCCM and Health Homes	Essential	95%

Performance Indicators	Classification	Threshold
FQHC and RHC	Essential	95%
Indian Health Services	Essential	95%
Member Service Transitions	Essential	95%
EPSDT	Critical	100%
Complaint Resolution and Tracking System	Essential	95%
Member Grievances and Tracking System	Critical	100%
Electronic System and Data Security	Critical	100%
Website	Important	90%
Member Information and Member Handbook	Essential	95%
Member Protections/Liability for Payment	Critical	100%
Provider Manual	Essential	95%
Community Partnerships	Critical	100%
Outcomes, Quality Assessment and Performance Improvement Program	Essential	95%
Compliance and Monitoring (Utilization Management)	Essential	95%
Data Tracking and Utilization Information System	Critical	100%
Disaster Recovery Plan	Critical	100%
Reports/Records/Documentation	Critical	100%
Contract Transition Plan	Essential	95%

Table 1. Performance Indicators from IDHW and Optum Idaho Contract

Optum Idaho's contractual requirement includes providing access to care for eligible Members, including engaging high-risk Members, who may not seek assistance on their own. This assessment will review the following contract requirements related to access, as agreed upon by the assessor and IDHW:

- Implement and maintain a Provider Network per 42 CFR 438.206 to meet the Member's needs for behavioral health treatment in varied geographic locations throughout the state and composition. The contract has two Areas defined - Area 1 includes Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties and Area 2 includes all other counties in the state. The travel standards for Area 1 are thirty miles or thirty minutes, and the travel standards for Area 2 are forty-five miles or forty-five minutes. This includes using local providers whenever possible to minimize the need for travel and to promote local cultural proficiency.
- Develop and implement policies and procedures for the selection and retention of providers in the network per 42 CFR 438.214.
- Maintain a 24/7, 365 days a year, toll-free member line that is answered by a live voice at all times and provides Members and families access to clinical staff per 42 CFR 438.206,
- Participate in IDHW's efforts to promote service delivery in a culturally competent manner per 42 CFR 438.206 (2).
- Provide care and case management that is Member-centric and provides a multidisciplinary team approach. Optum Idaho is expected to cooperate with state facilities and community organizations, promote the coordination of the referral process, and implement policies that ensure providers coordinate with local primary care resources per contract section XV.
- Provide all Members with communication regarding behavioral health treatment services, educational opportunities and available network providers per 42 CFR 438.10.

The contract requires care coordination and collaboration with local community organizations, including a focus on Native American and Hispanic minorities, IDHW,

and other state boards and councils. Ultimately, these partnerships are intended to create a network in which behavioral health patients have increased access to care in the State of Idaho. Optum Idaho has created a care advocacy program that per the policy states the intention is to:

- Assist individual members and/or their parents or legal guardians with accessing services for the member as well as supporting the member's broader recovery and resiliency;
- Improve the experience of members with the system of care, human service agencies, and other resources; and
- To promote the use of appropriate clinical interventions to meet an individual's needs.
- Care advocacy program includes care advocates, discharge coordinators, and field care coordinators.

Optum Idaho identified there are four teams that work within the state's seven regions. The team's staff includes, field care coordinators, provider quality specialists, network managers and community liaisons. Each staff member on the team has a role to work with the local community. The field care coordinators consults with providers in the care of high risk or high need members. This team approach provides a collaborative process for meeting a member's behavioral health needs.

The contract requirements also address the need for minority populations to receive quality health services. The requirement to develop a comprehensive Cultural Competency Plan and work with regional organizations is vital for the diverse population of Idaho. The contract requirements state the contractor shall provide appropriate services with specific focus on Native American and Hispanic needs. These specific needs are addressed in the cultural competency plan.

The contract monitoring function is the responsibility of the OMHSA, a program unit of Medicaid. The office has eight total staff members working on contract monitoring, compliance, clinical work, and alternative care coordination. The structure of the office during this assessment period was; one manager, one supervisor, five contract monitors

and one support staff. The staff met regularly with Optum Idaho and IDHW stakeholders to discuss, monitor and report on the performance of Optum Idaho's performance.

Summary of Contract Requirements

During this assessment, the contract was found to be broad in necessary requirements, lacked quantifiable details in areas, and had inconsistencies within sections. For example, in Section VII, Access to Care, there are items in the contract that do not give detailed expectations. Specific examples are:

1) Section VII, C, 2 – Ensure services to Members are uninterrupted. This does not define any specifics or provide any details, although Optum Idaho's proposal includes a plan to ensure continuity of care is provided during the program implementation and on-going after implementation.

2) Section VII, C, 1(b) - Describes the provisions for access to care with one area being the location of providers. It states the providers should be located within thirty miles or thirty minutes for certain counties, and forty-five miles or forty-five minutes in all other counties. In another section of the contract, Section XI, L, 2(e), it requires the contractor to maintain an appropriate provider network and consider, "the geographic location of providers and Members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Members with disabilities." This statement suggests Optum Idaho should review the overall geography of provider locations, not just mileage or minutes. During this assessment the assessor asked, "The contract mentions mileage or travel, which measure does Optum use for determining the distance?" The response was,

> As noted in the Annual Network Management and Development Plan noted in the earlier review, Geo-access methods used to determine the above percentages are based on a proprietary algorithm used by GeoNetwork software to calculate the data. These calculations are based on industry standards and provide an estimate of the distance required to drive between a member location and a provider location. This method would not account for the obstacles in

frontier areas of the state, or inclimate weather that may impact a member's ability to arrive at a provider location.

When the assessor asked IDHW which standard was used to measure, the response was they thought Optum Idaho used a distance radius of "as the crow flies" and not a time to drive to the provider. The standard of measurement for provider locations from Members should be defined and documented in the contract.

3) Section VII, C, 1 - The contract requirements do not always provide a standard for the contractor to follow. For example item (e) states that the contractor shall "ensure sufficient numbers of prescribers/psychiatrists are available in the state" and item (d) states, "Appropriate Member to provider ratios for all service in every region of the state, consistent with industry standards." When applicable, a standard should be included in the contract to provide the contractor a stated expectation.

4) Section IX – the contract has specific requirements for customer service calls answered if the contractor uses an IVR system, but there are limited requirements for live Member and Crisis call lines. For example, section VII, G, (2), the contract states, "the call shall be answered within thirty (30) seconds…" It does not give a standard for Member calls to be answered.

IDHW Administration and Optum Idaho leadership have collaborated on standards when the contract did not provide the details. During implementation, Optum Idaho worked with IDHW to review and approve reports required in the contract. The contract should be amended to reflect changes and mutually agreed upon standards.

Informational Access

Optum Idaho offers a variety of avenues for Members and providers to obtain culturally sensitive information for physical and behavioral needs of the Members. Information can be obtained through oral, written, and electronic formats, and meets the criteria set forth by 42 CFR 438.10. Each of these avenues can be accessed by the Member or a provider. These materials are to be updated yearly per the contractual agreement between the IDHW and Optum Idaho.

Customer Service Hotlines

Optum has established two distinct phone numbers; one for member access and crisis line and the second as a business line for providers and customer service. Optum Idaho has contracted with ProtoCall Services, Inc. to operate the toll-free IBHP Member Access and Crisis Line. The Member Access and Crisis Line provide the telephonic Member Services support outlined in the contract. The toll-free line is live-answered within 30 seconds by a Master's level behavioral health clinician 24 hours a day, 365 days a year. The business line for providers and customer service is available during regular business hours, weekdays from 8:00am to 6:00pm Mountain Time, and is answered by an automated Interactive Voice Response (IVR) system. A monthly report is generated and provided to IDHW that summarizes the telephonic data received each month by Optum. This report shows the volume and response metrics associated with each line. OMHSA monitors these reports and should be following up with Optum Idaho as abnormalities and contract deviations are identified.

The contract requirements established for Member Line is to answer the call within thirty seconds. In the absence of a contractual standard, Optum maintains an internal industry standard of 80% of all calls answered within thirty seconds. Figure 2 is a visual display of the member hotline call activity. According to Optum Idaho, the increase in calls during October 2014 was due to the Annual Member Mailing of Rights & Responsibilities being sent in September, and members calling with questions.

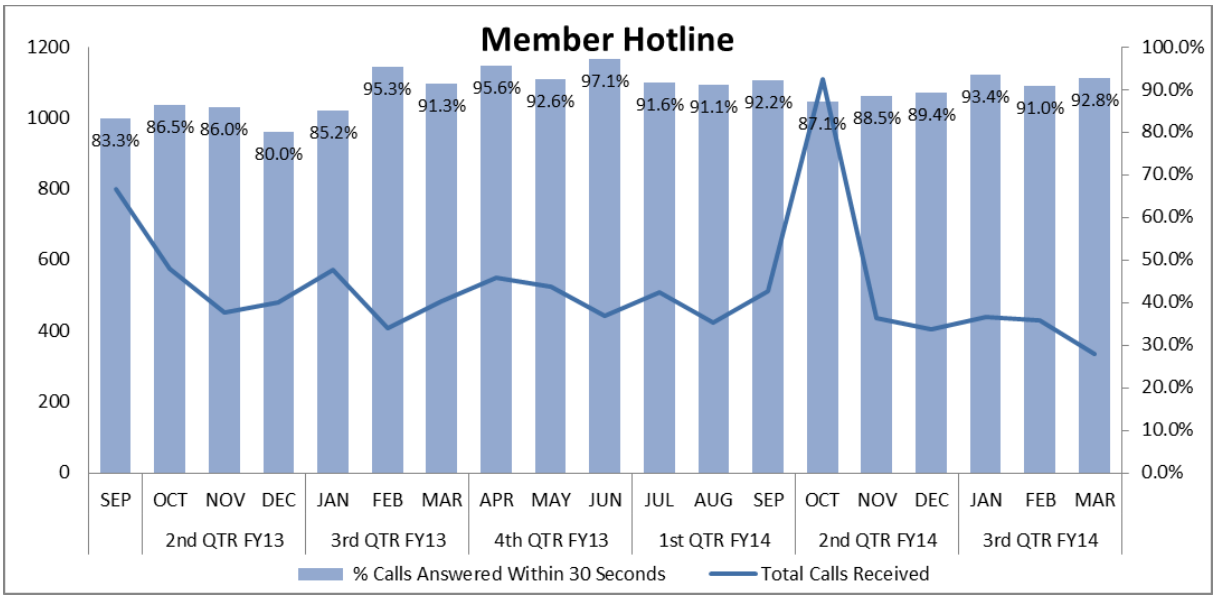


Figure 2. Member Hotline Call Answer Rate

Optum Idaho's provider hotline contract requirements are different from the Member line, because of the use of an automated IVR system. The established contract requirements for the business number and customer service line are outlined in the IDHW and Optum Idaho contract section IX: connection within three rings at least 99% of the time, receive a busy signal less than 5% of the time, calls are not dropped in excess of 0.5% of the total daily calls, average daily hold time less than 2 minutes, and an abandonment rate less than 7%. While not a contract requirement, Optum operates using the industry standard for average speed to answer 80% of all calls answered within 30 seconds. In the monthly reports, Optum Idaho has provided data to show the percent of calls answered within 30 seconds, daily average hold time and the abandonment rate. Optum Idaho has shown improvement in provider hotline statistics as seen in Figure 3 and 4. According to Optum Idaho, the increase in calls during July 2014 was due to certain changes in authorizations that went into effect July 1, 2014. Training was conducted in June, but the call volume still increased in July.

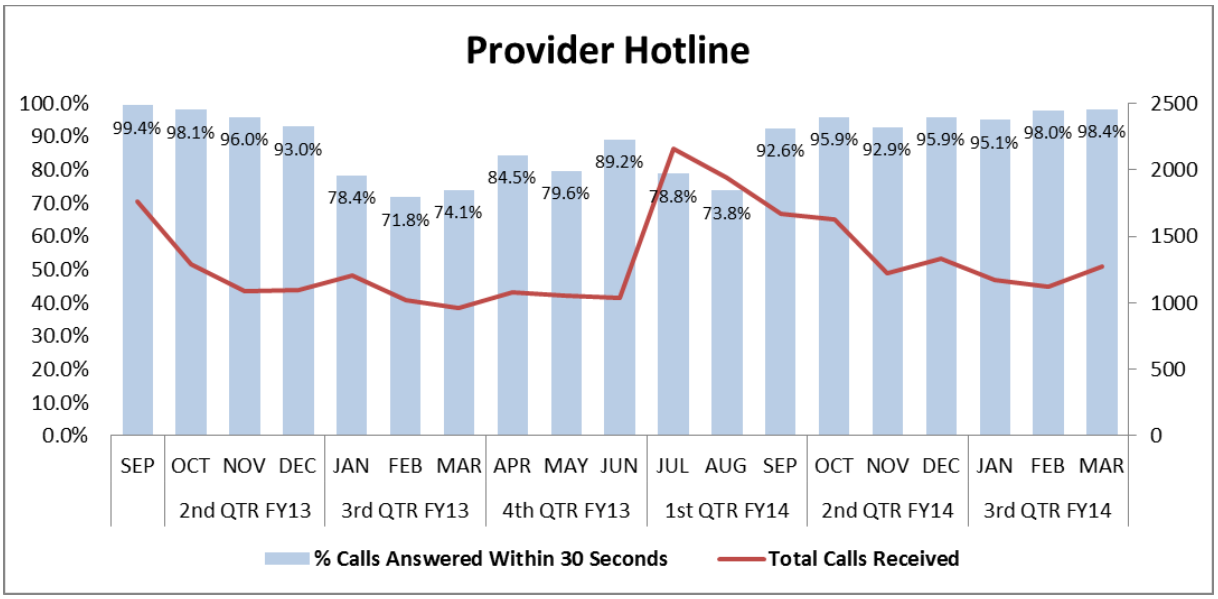


Figure 3. Provider Hotline Calls Answer Rate

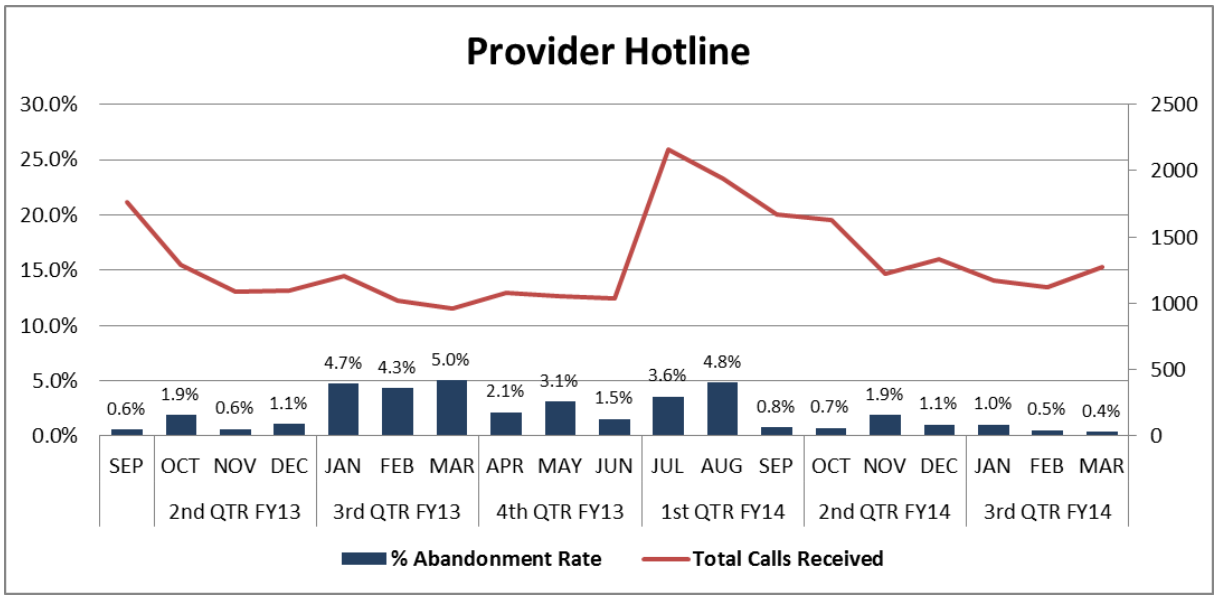


Figure 4. Provider Hotline Abandonment Rate

Summary of Informational Access

There was no provider and member hotline data pre-waiver, so the implementation of a member hotline and customer service line has been an improvement post-waiver. After reviewing the contract and the monthly customer service call response report, Optum Idaho has met the contract standards each month for the Member Line. It appears the

customer service line has improved, and OMHSA should continue to monitor the monthly reports for continued access standards.

Physical Access

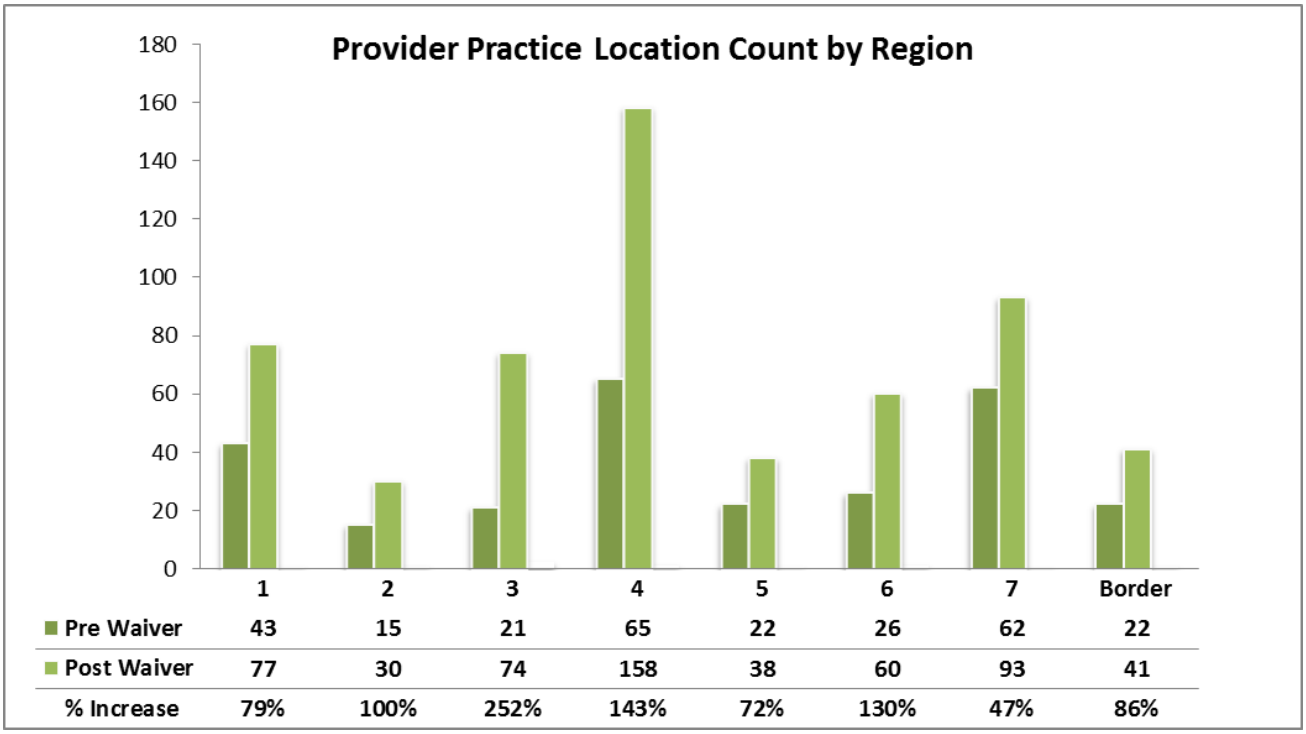
Provider Network

At the beginning of the waiver period, IDHW had the contractual expectation that Optum Idaho would implement and maintain a professional statewide provider network that would ensure adequate statewide access for eligible participants requiring necessary behavioral health service. According to the contract between IDHW and Optum Idaho, the initial provider network should be established from the existing providers enrolled in the Medicaid behavioral health program.

The way in which IDHW reported provider counts before the waiver period and how Optum Idaho reports provider counts after the waiver period was found to be different. For example, the counts pre-waiver were by practice and Optum Idaho reports counts each provider. When asked by the assessor to explain how provider counts are reported by Optum Idaho, the response was;

> Optum counts providers as they are credentialed. Individually contracted providers are counted and agency locations (who may host a roster of 5 practitioners) are counted. Agencies and individuals are only counted once per region, however if they have service locations in a separate region would be counted once in each region.

Figure 5 shows the provider location counts for both pre-waiver and post-waiver periods. These numbers were provided by IDHW, post waiver data was reported by pulling Optum Idaho report data and removing all duplicate practice locations. Pre-waiver data was provided by showing the number of practice locations, excluding SUDS locations. Each provider practice is counted once, even though there maybe more than one provider at that location.



	1	2	3	4	5	6	7	Border
Pre Waiver	43	15	21	65	22	26	62	22
Post Waiver	77	30	74	158	38	60	93	41
% Increase	79%	100%	252%	143%	72%	130%	47%	86%

Figure 5. Provider Practice Locations by region

Regional trend data

In the contract between IDHW and Optum Idaho providing Member's access to providers in each region is required. Optum Idaho provides a monthly provider suite of reports to OMSHA demonstrating the compliance of the access standards. These reports include Geo Access reports, provider additions and terminations, a full roster of providers, groups and agencies. The assessor asked how Optum Idaho takes the requirements of distance and time in to account for Idaho's rural and frontier areas, the Network Director responded with this explanation;

> Optum measures access against the contract requirements as outlined. These mileage and time travel markers were developed by the state for our contract. "Area 1" is only 7 counties within the state. Specifically, the single most populous county of each of the seven regions the State of Idaho hosts. "Area 2" which is the listing of all remaining counties in each of the 7 regions, as well as any neighboring state's border counties that serve our members and is defined by the State of Idaho as the rural and frontier

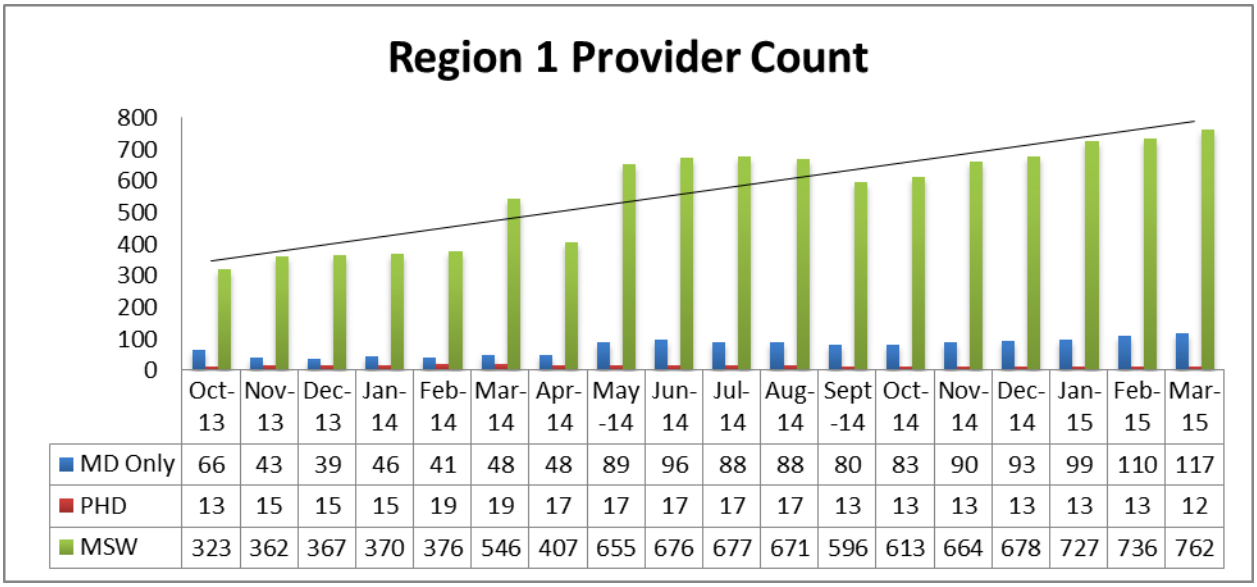
regions. Both Area 1 and Area 2 require full access and Optum is currently meeting access for both areas in the high 90th percentile, as noted in the Geo-Access reports. In all areas that show members without access, Optum attempts to recruit providers as well as minimize any additional mileage a member may need to drive in order to have a choice of provider. The monthly Geo-Access reports (OR54) does have a breakdown of the distance a member without access would have to travel to reach a provider and the Optum Network team monitors that routinely in an attempt to reduce required travel.

Optum Idaho describes the definitions of the credentialed providers included in the counts each month as;

> Master's level refers to all practitioners who hold an independent license to practice in the State of Idaho such as LPC, LPCP, LCSW, LMFT. The highest level of education required to work toward these license types is a Master's Degree, PhD would refer to those with a PhD degree in behavioral health such as psychologist, RNs would be those that are licensed/registered nurses and an Agency refers to those participating in our network under a single contract and tax ID number.

Provider count data was provided by Optum Idaho for each month beginning in October 2013 thru March 2015. The assessor reviewed each region and included the border counties from other states to review trends in provider counts. Each region was reviewed and statistically analyzed to reveal any irregularities. All regions, except the border counties, showed a significant increase in MSW providers. Each chart below shows the trends for MSW, PhD and MD providers by month.

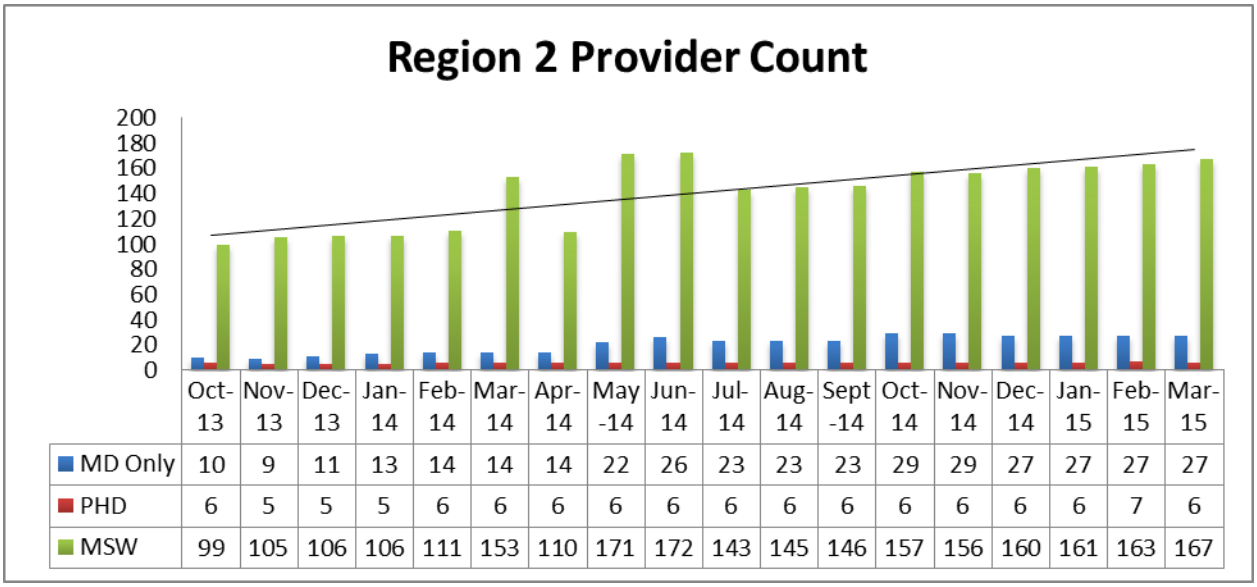
Region 1 trend, shown in figure 6, displays an increase in MSW and MD providers. It shows PhD providers increased in numbers throughout 2014, but declined to original numbers towards the end of the year.



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
MD Only	66	43	39	46	41	48	48	89	96	88	88	80	83	90	93	99	110	117
PHD	13	15	15	15	19	19	17	17	17	17	17	13	13	13	13	13	13	12
MSW	323	362	367	370	376	546	407	655	676	677	671	596	613	664	678	727	736	762

Figure 6. Region 1 Provider Count

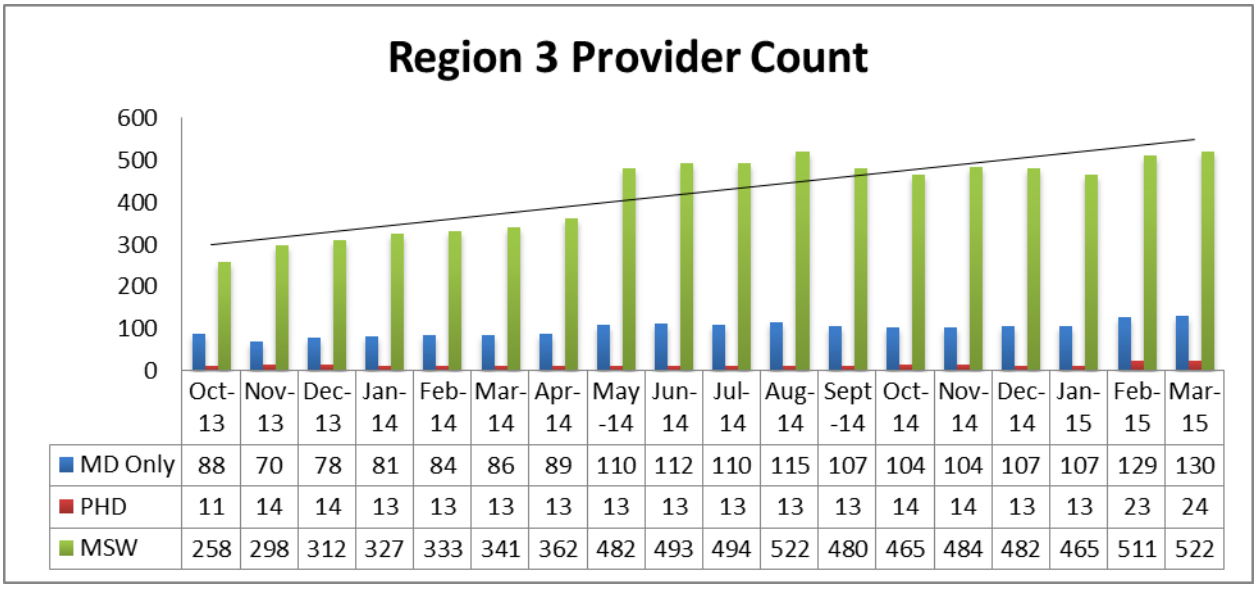
Region 2 trends shown in figure 7 illustrate an increase in MSW and MD providers and a stable number of PhD Providers.



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
MD Only	10	9	11	13	14	14	14	22	26	23	23	23	29	29	27	27	27	27
PHD	6	5	5	5	6	6	6	6	6	6	6	6	6	6	6	6	7	6
MSW	99	105	106	106	111	153	110	171	172	143	145	146	157	156	160	161	163	167

Figure 7. Region 2 Provider Count

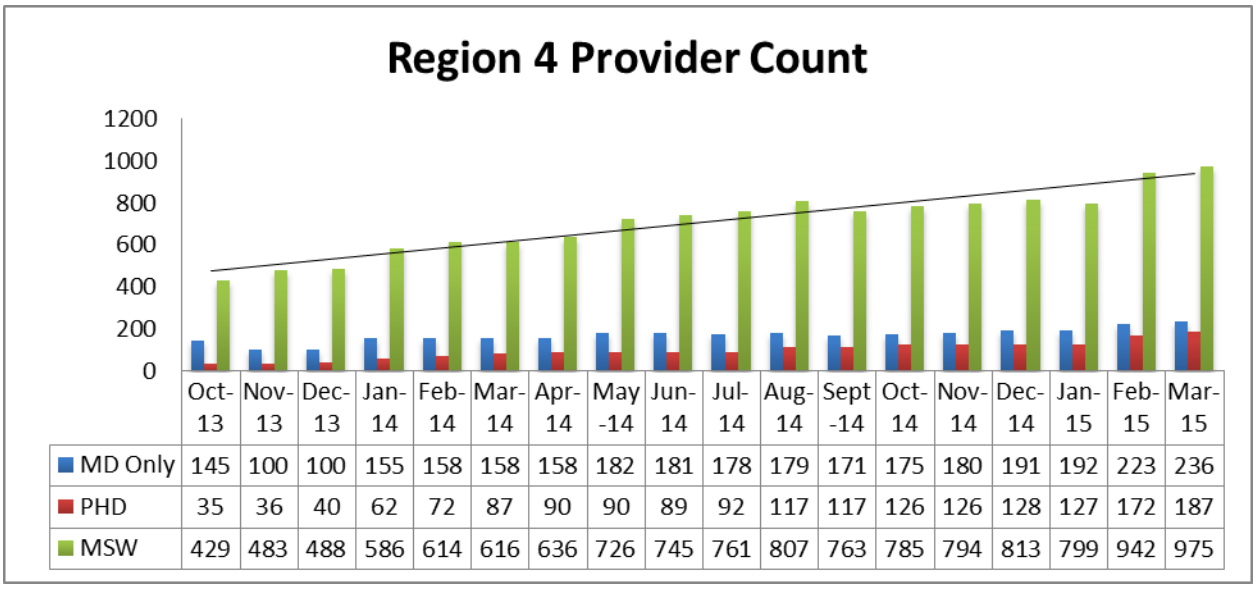
Figure 8 shows an increase in all provider types for region 3.



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
MD Only	88	70	78	81	84	86	89	110	112	110	115	107	104	104	107	107	129	130
PHD	11	14	14	13	13	13	13	13	13	13	13	13	14	14	13	13	23	24
MSW	258	298	312	327	333	341	362	482	493	494	522	480	465	484	482	465	511	522

Figure 8. Region 3 Provider Count

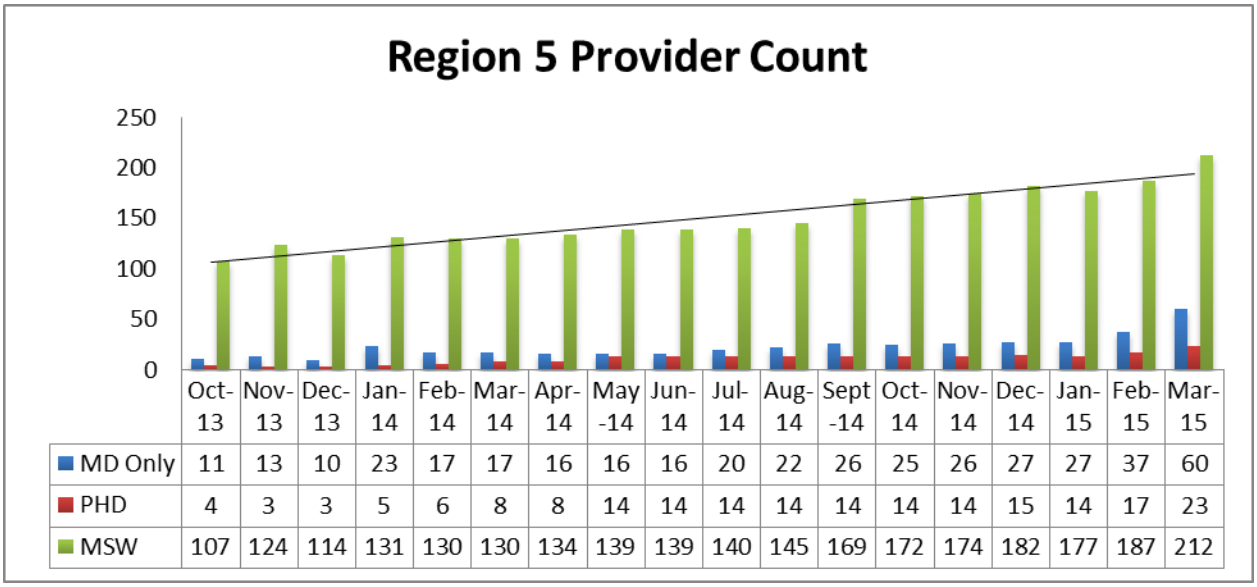
Figure 9 shows the increase in all provider types for region 4. The increase is significant in all types.



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
MD Only	145	100	100	155	158	158	158	182	181	178	179	171	175	180	191	192	223	236
PHD	35	36	40	62	72	87	90	90	89	92	117	117	126	126	128	127	172	187
MSW	429	483	488	586	614	616	636	726	745	761	807	763	785	794	813	799	942	975

Figure 9. Region 4 Provider Count

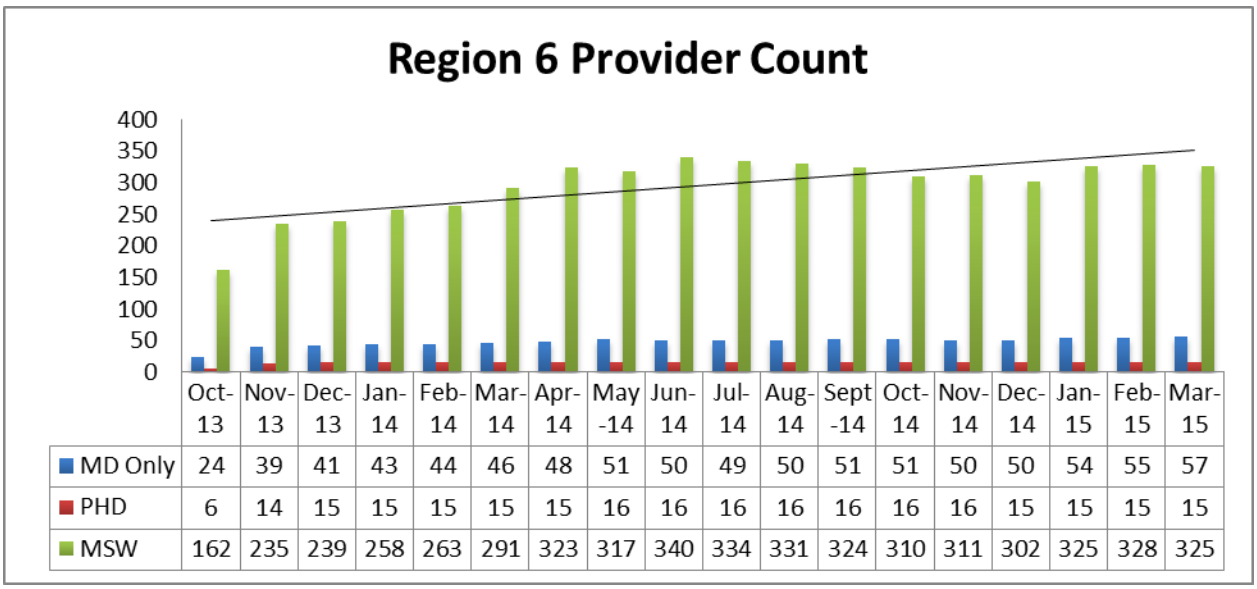
Region 5 trends shown in figure 10, shows an increase in MD, PhD, and MSW provider areas.



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
MD Only	11	13	10	23	17	17	16	16	16	20	22	26	25	26	27	27	37	60
PHD	4	3	3	5	6	8	8	14	14	14	14	14	14	14	15	14	17	23
MSW	107	124	114	131	130	130	134	139	139	140	145	169	172	174	182	177	187	212

Figure 10. Region 5 Provider Count

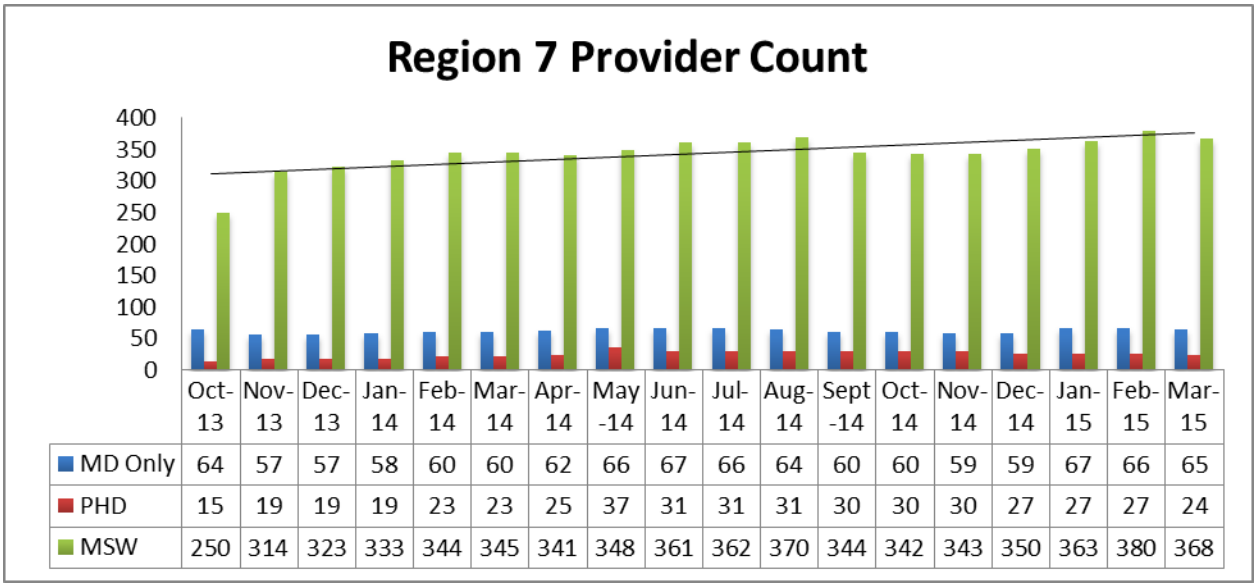
Region 6 trends shown in figure 11, shows an increase in MD, PhD, and MSW provider areas. It does indicate a small dip in MSW provider types, but has recovered and is still on a positive trend.



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
MD Only	24	39	41	43	44	46	48	51	50	49	50	51	51	50	50	54	55	57
PHD	6	14	15	15	15	15	15	16	16	16	16	16	16	16	15	15	15	15
MSW	162	235	239	258	263	291	323	317	340	334	331	324	310	311	302	325	328	325

Figure 11. Region 6 Provider Count

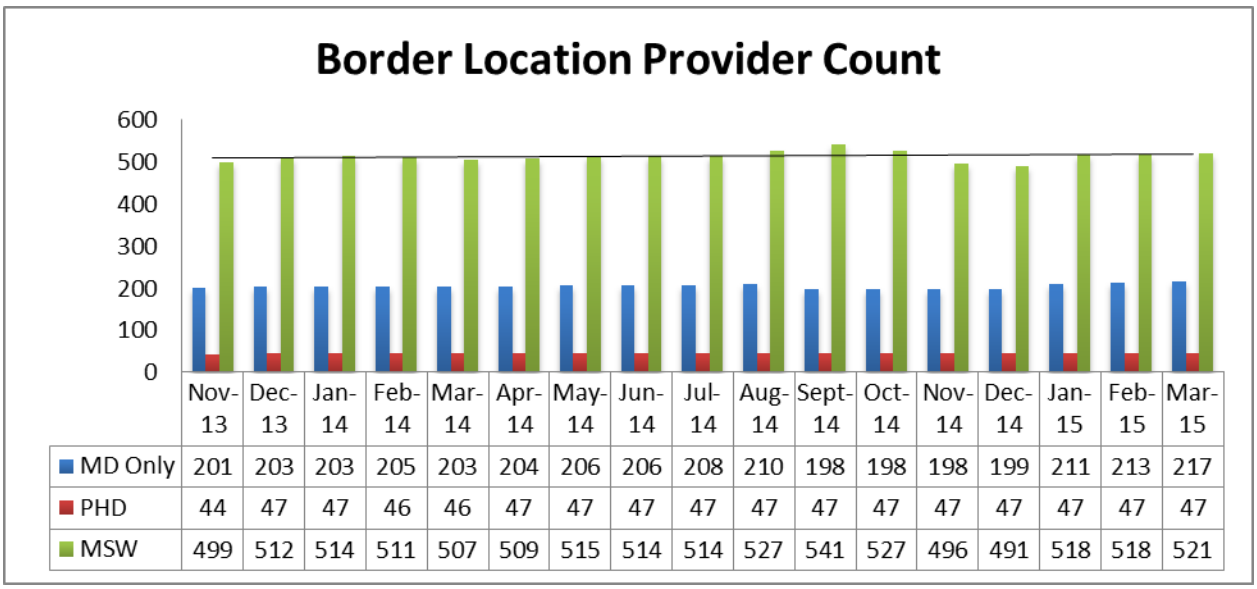
Region 7 trends shown in figure 12, shows an increase in PhD, and MSW provider areas. It additionally illustrates a steady number of MD providers in the region.



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
MD Only	64	57	57	58	60	60	62	66	67	66	64	60	60	59	59	67	66	65
PHD	15	19	19	19	23	23	25	37	31	31	31	30	30	30	27	27	27	24
MSW	250	314	323	333	344	345	341	348	361	362	370	344	342	343	350	363	380	368

Figure 12. Region 7 Provider Count

Border locations are providers outside the state of Idaho in neighboring communities. The trends in figure 13 show a slight increase in MSW providers, and a consistent number of PhD and MD providers.

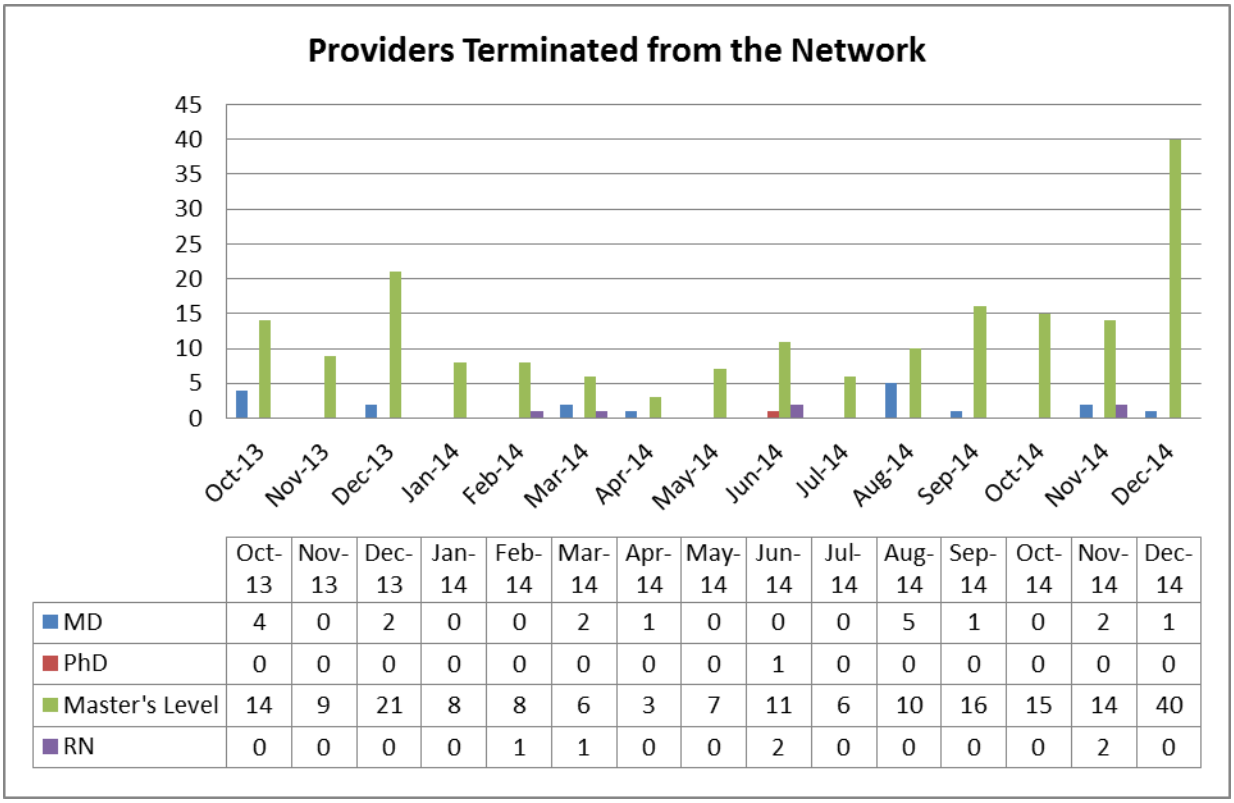


	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
MD Only	201	203	203	205	203	204	206	206	208	210	198	198	198	199	211	213	217
PHD	44	47	47	46	46	47	47	47	47	47	47	47	47	47	47	47	47
MSW	499	512	514	511	507	509	515	514	514	527	541	527	496	491	518	518	521

Figure 13. Border Location Provider Count

Provider Termination

In addition to adding providers to the network monthly, providers leave the network for various reasons. According to Optum Idaho's Network Director, "there are a number of reasons a provider may show as termed." Some of the reasons given are that providers may; (1) terminate by election, (2) transfer employment to another agency, (3) change careers, (4) not serving Medicaid members at the time of termination, or (4) dropped the Medicaid plan from their overall credentialing. Optum Idaho provided the assessor with provider termination data; figure 14 shows the number of providers that have terminated from the network during October 2013 – December 2014. When asked about the increase in Master's Level clinicians terminating in December, Optum Idaho shared the actual number was nineteen, but the providers were practicing in multiple regions, so they were counted more than once in the overall total.



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
MD	4	0	2	0	0	2	1	0	0	0	5	1	0	2	1
PhD	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Master's Level	14	9	21	8	8	6	3	7	11	6	10	16	15	14	40
RN	0	0	0	0	1	1	0	0	2	0	0	0	0	2	0

Figure 14. Providers Terminated from the Network

Network Development and Management Plan

The contract between IDHW and Optum Idaho required Optum to:

> Submit an annual Network Development and Management Plan, which contains specific action steps and measurable outcomes that are aligned with the IDHW provider network requirements. The Network Development and Management Plan shall take into account regional needs and incorporate region-wide, network-specific goals and objectives developed in collaboration with the IDHW.

In the Network Development and Management Plan, Optum outlined areas of needs in the various unique regions of Idaho. The plan also included targeted approaches for reaching goals and recruiting providers to fill the gaps in each area. One creative solution for increasing access is the use of telehealth services for medication management. The use of telehealth services allows regions of Idaho receive services that may not be available to them by a credentialed provider in a typical clinical delivery setting. Telehealth providers are included in the overall provider count based on location in Optum Idaho's monthly GeoAccess report sent to IDHW. According to Optum Idaho's Network Director, "An annual specialty report does offer a provider count by specialty types… At last delivery (July 2015) telehealth service capability was counted at 34 and telepsychiatry at 33, up from the 2014 count of 23 and 9 respectively."

Provider Credentialing

Since the beginning of the IBHP contract, Optum Idaho has followed the United Behavioral Health, (UBH) Clinician and Facility Credentialing Plan, which follows NCQA standards. The plan includes an overview of the UBH policies for credentialing, re-credentialing, ongoing monitoring and actions with clinicians and facilities that provide care and services to IBHP Members. The contract between IDHW and Optum Idaho states the establishment of the provider network should draw upon the existing pool of providers. The assessor asked Optum Idaho what the process was to credential new providers at the beginning of the waiver period. The response from an Optum Idaho representative was:

> Targeted our payor network and offered the opportunity to expand business to see Medicaid Members, we utilized documentation provided by the State to identify the existing network for Idaho Medicaid Members, additionally we reviewed claims utilization supplied by the State to identify additional recruitment opportunities.

Providers credentialed in the network prior to the waiver were given sixty days after the contract effective date of September 1, 2013 to join the Optum provider network. Optum worked with providers credential them in accordance to the credentialing plan standards.

Summary of Provider Network

In reviewing the data provided by IDHW from prior to the waiver and comparing it to the data provided by Optum Idaho, it appears the access to providers has increased for IBHP Members. At the beginning of the contract implementation period, there was discussion between IDHW and Optum Idaho, that 100% access would not be achievable due to the frontier and rural geography of the state. At the time of this assessment, access standards for Area 1 were 99.8% and Area 2 were 99.7%; the number of overall providers has increased, although there is still room for improvement in certain regions and counties. When asked about Member's access in areas Optum Idaho representative stated,

> In all areas that show members without access, Optum attempts to recruit providers as well as minimize any additional mileage a member may need to drive in order to have a choice of provider. The monthly Geo-Access reports (OR54) does have a breakdown of the distance a member without access would have to travel to reach a provider and the Optum Network team monitors that routinely in an attempt to reduce required travel.

Reporting methods by Optum Idaho to IDHW have been complex. The assessor had to ask numerous questions for the data to be interpreted. The suite of provider reports was agreed upon during implementation, but there are still questions by IDHW regarding how the data is reported.

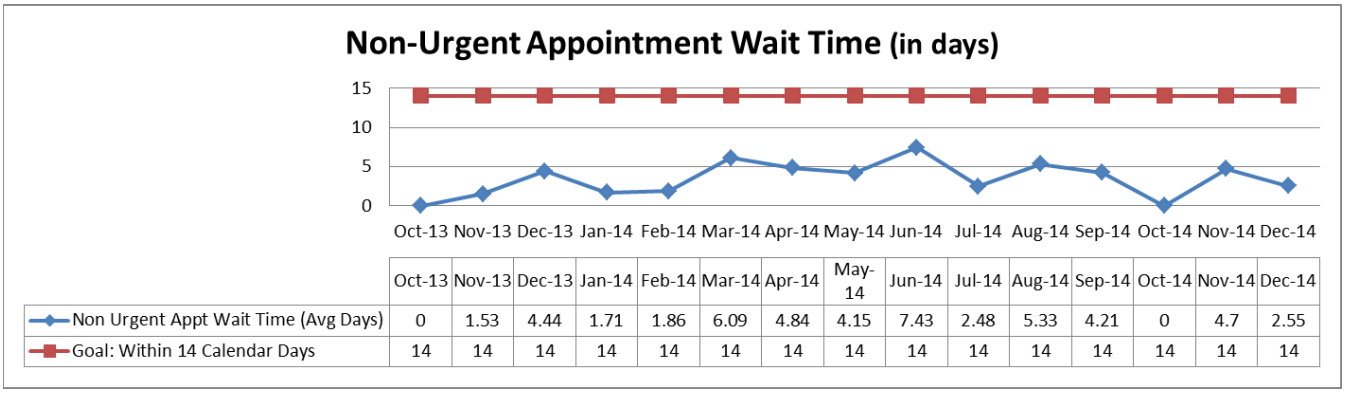
Optum Idaho has created a Network Development and Management plan to address gaps and to collaborate with IDHW to deliver Members the providers needed in their regions. In addition, Optum Idaho has introduced evidence-based practices for integrating delivery of behavioral health services.

Optum Idaho worked during implementation to establish a provider network from existing providers. IDHW provided Optum a list of providers credentialed in the existing network. Optum routinely reported to IDHW the providers that were joining the network and those that were not.

Timely Access

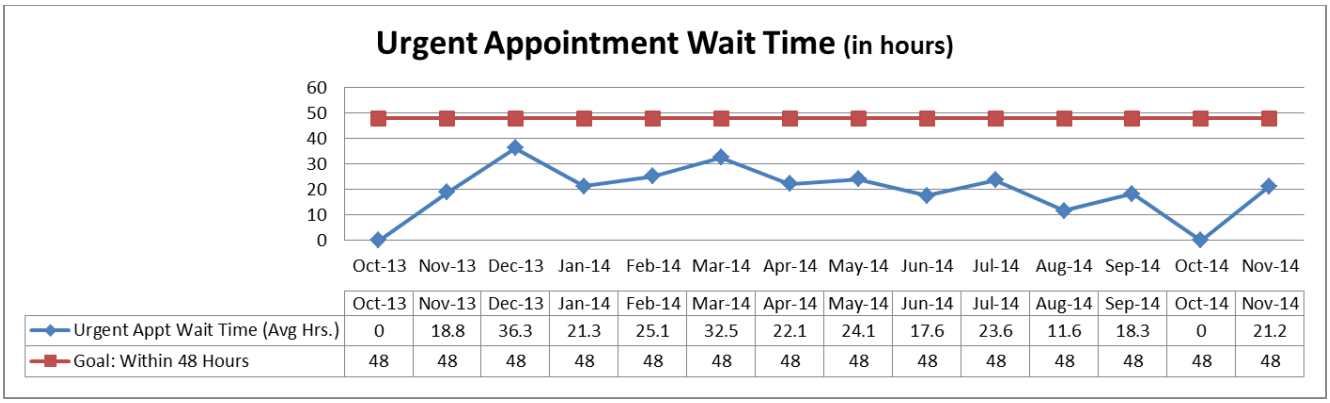
Appointment Wait Times

Optum Idaho provides the State of Idaho a monthly report that captures the data of existing Members and new Members receiving behavioral health services, the average time taken to receive authorization for services, and the average time it takes a member to get an appointment with a provider. The authorization count is provided by Optum Idaho reporting with a Linx based query counting all authorizations made in that month. The State monitors this report on a monthly basis and has not documented any concerns with the timeliness of access for Members. Optum Idaho provided figures 15 and 16 to illustrate the average appointment wait times for both urgent and non-urgent cases by month.



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Non Urgent Appt Wait Time (Avg Days)	0	1.53	4.44	1.71	1.86	6.09	4.84	4.15	7.43	2.48	5.33	4.21	0	4.7	2.55
Goal: Within 14 Calendar Days	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14

Figure 15. Optum Idaho Non-Urgent Appointment Wait Times



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14
Urgent Appt Wait Time (Avg Hrs.)	0	18.8	36.3	21.3	25.1	32.5	22.1	24.1	17.6	23.6	11.6	18.3	0	21.2
Goal: Within 48 Hours	48	48	48	48	48	48	48	48	48	48	48	48	48	48

Figure 16. Optum Idaho Urgent Appointment Wait Time

Medicaid versus Non-Medicaid Appointment Wait Times

Optum Idaho provided the assessor data showing the results of the randomly sampled providers surveyed for Medicaid data in each month's query. All providers are fully credentialed, participating in either a group or individual practitioners. The non-Medicaid data collected from a scripted phone survey conducted by the assessor. Providers were randomly selected from the Optum Idaho provider directory, and asked about appointment wait times for patients with private insurance. The number of providers called was based on a statistically significant amount of providers based on the number of unique providers in the network. The non-Medicaid survey sample represented providers from 91% of the counties in the state of Idaho. After conducting statistical testing on a sample of the Optum Idaho Medicaid report data and all non-Medicaid survey data, the appointment wait times were found to be significantly different. The Medicaid appointment wait time's mean was 3.7 days and the non-Medicaid appointment wait time mean was 6.3 days. Figure 17 represents providers from each region and the overall average of routine appointment wait times for all Medicaid and non-Medicaid patients.

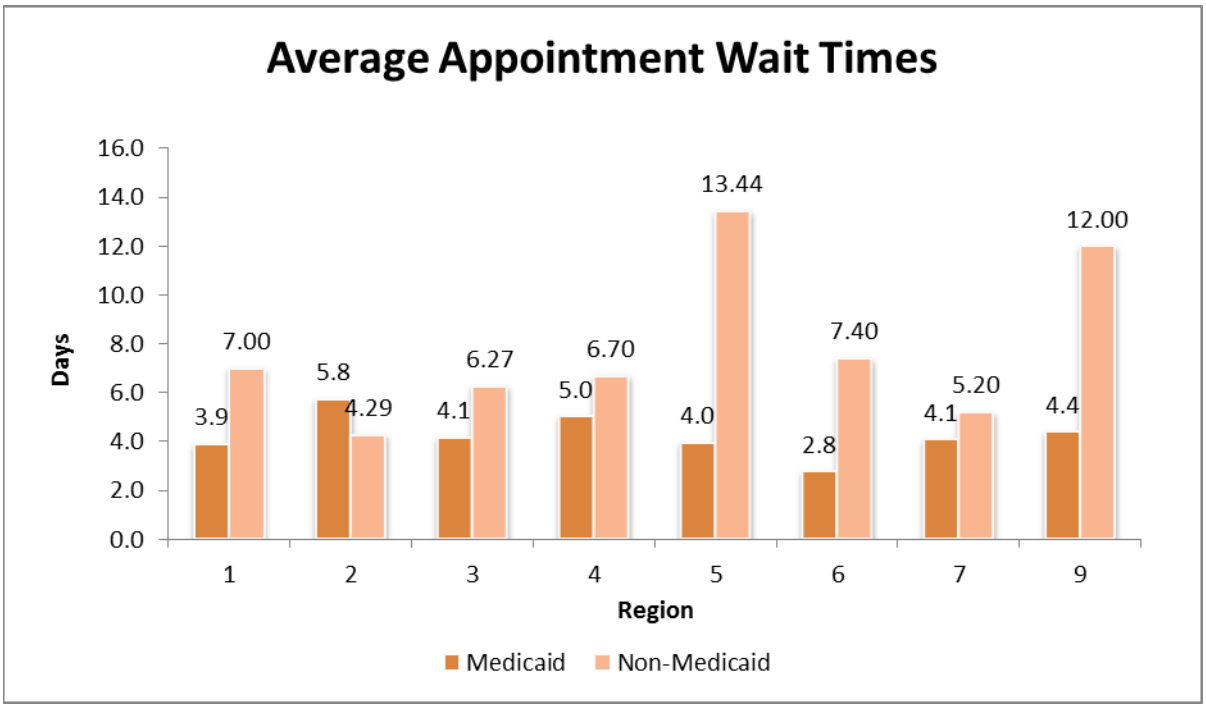


Figure 17. Average Appointment Wait Times for Medicaid and Non-Medicaid patients

The assessor also asked providers about medication management appointments. The data provided by Optum Idaho was divided into routine, urgent or crisis appointments. All providers are included in the monthly sample and are not broken into the provider type. For the assessor's survey, the appointments were divided into counseling or medication management appointments. The data collected is a representation of the average time a non-Medicaid patient would wait for a medication management appointment in Idaho. Additionally, while conducting the phone survey the assessor found approximately 20% of the providers did not offer medication management to patients. This did have an effect on the overall average wait times for medication management providers. Figure 18 shows the average days in each region.

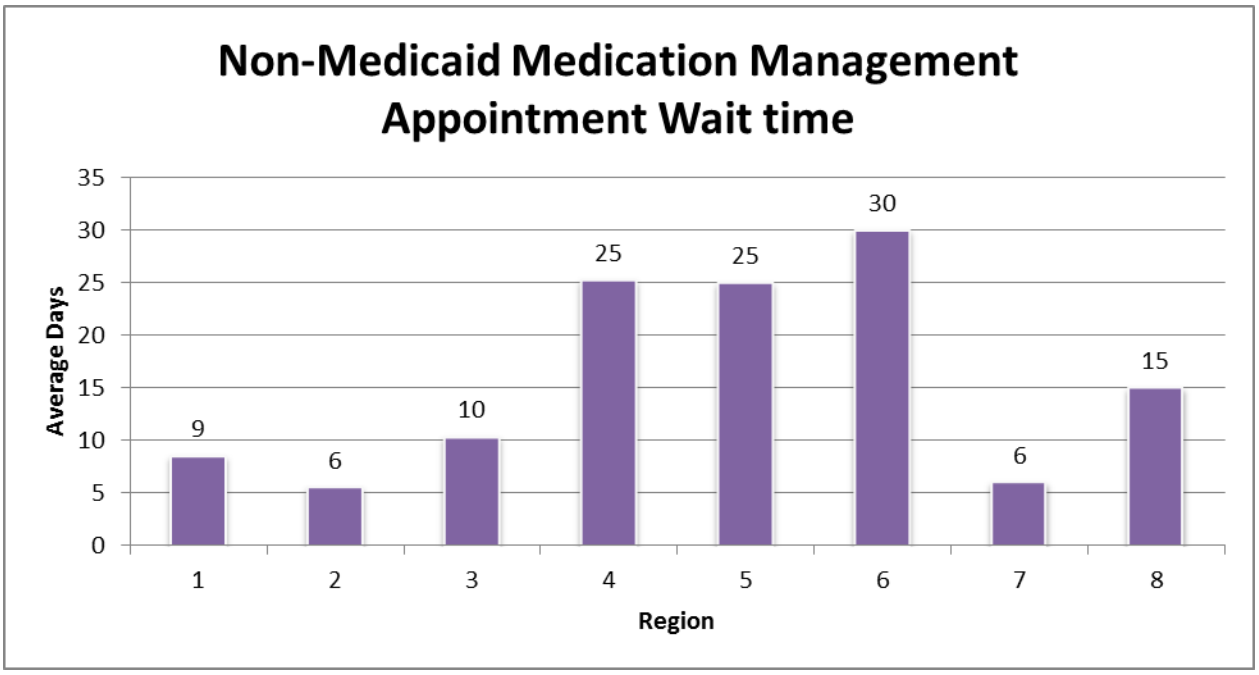


Figure 18. Medication Management Appointment Wait Times – Non-Medicaid Patients

Summary of Appointment Wait Times

Appointment wait times for Members have remained below the contract requirements for the duration of this assessment period. In reviewing the data comparing Medicaid and non-Medicaid members it shows the appointment wait times to be lower for Medicaid members. The higher average for region 5, non-Medicaid patients was due to a medication management provider that splits the time between five different clinics in different counties within the state. The provider is at one location for a limited amount of time, which has led to a three to four month wait for patients. Region 6 data for non-Medicaid patient wait time was also due to a long wait time for medication management provider. This outlies skewed the overall average. The longer, average wait time for Medicaid Members in region 2, was a result of the provider with a wait time of 21 days and another provider with a wait time of 10 days. These outliers skewed the average to be higher.

Summary of Overall Findings for Access of Care

Based on a review of contract requirements, compliance with CFR regulations, informational access, network adequacy, and reports submitted by Optum Idaho to IDHW, it is found that Optum Idaho is providing an increase in access to Medicaid behavioral health consumers.

Although the new behavioral health system is still fairly new, IDHW and Optum Idaho have taken significant steps to ensuring continuity of care through a strong provider network. During the assessment period, Optum Idaho has strengthened the network by providing more providers at all practitioner levels and the network has grown throughout the state of Idaho. At the time of this assessment, access standards for Area 1 are 99.8% and Area 2 is 99.7%. The state acknowledges that 100% is not achievable due to the frontier and rural nature of the state, and there are no specific standard requirements documented in the contract. Optum Idaho has demonstrated a focus on maintaining an extensive provider network by using creative solutions to provide care and recruit new providers to Idaho. The plans they have submitted to IDHW do show a commitment to continuing to build a provider network to meet the access needs of all Members.

Provider report methodology is complex and requires further investigation for numbers that are presented. For example, during this assessment Optum Idaho provided the assessor with report data on the number of provider terminated and added to the network. The numbers were not actual representations of the providers added to the network, instead the report required an explanation of the provider transactions for the month. The actual number of providers was much lower than reported; based on how the report was ran.

The new system emphasizes the involvement of local communities, minorities, families, and members. Optum Idaho is working with regional organizations, community interests, and Native American and Hispanic minority populations to increase member satisfaction and access to care. Both the contract between IDHW and Optum Idaho create high access standards for the new system.

Finally, reports show that Optum Idaho is serving a significant majority of the members, meeting performance standards for call centers and appointment wait time compliance, and provider network standards. As a result, it is clear that IDHW is making progress to monitor all contract standards. In all contract requirements reviewed in this assessment, Optum Idaho is meeting the standard.

Quality of Care

As part of Idaho's request for a Section 1915(b) Waiver, the State must demonstrate that the quality of care it delivers under the waiver is satisfactory. To assess the quality of care being provided to Members, the assessor analyzed compliance with the IDHW contract, Optum Idaho reports, compliance with state and federal regulations, and interviews with both Optum Idaho and IDHW staff. Prior to the waiver period, IDHW had a limited quality improvement program that consisted of provider monitoring.

Contract Monitoring

The contract between IDHW and Optum Idaho states, "IDHW will engage in ongoing contract monitoring… this may include review of documentation as well as onsite monitoring." Contract requirement for Optum Idaho include reporting on all aspects of programming, network functioning, service delivery, participant response to services, operations, and claims processing, as well as the specific performance indicators required in the contract. The contract ensures the creation of a comprehensive system of behavioral health. Furthermore, Optum Idaho is required by contract to provide IDHW reports on a monthly, quarterly, biannually and annual basis. The reported data from Optum Idaho is used by OMHSA to monitor the contractor's ongoing compliance with all contract terms and to analyze the data in order to identify and report the contractor's level of adherence to performance requirements. OMHSA staff has assigned the thirty-six key indicators from the contract to contract monitoring staff members for review. OMHSA contract monitors review each indicator and assess Optum Idaho's compliance within the framework of the contract, state and federal regulations. Each month a contract monitoring report is created and focuses on three to four indicators. However, if the contract monitor staff observes an abnormality in the

monthly data, they bring the issue forward for inclusion in the report. All thirty-six performance indicators were assessed during the first year of the waiver period. Using these indicators as a means to direct the research, the contract monitoring staff uses a Contract Monitoring Tool document to conduct their analysis and submit findings to the OMHSA manager. The contract monitoring program manager at the time of the assessment waiver period described the process as:

> An iterative process in which the Idaho Department of Health and Welfare (IDHW) will provide Optum Idaho with weekly opportunities to respond to IDHW's initial findings of contract compliance based on information obtained from Optum-generated data reports, IDHW-generated reports, audits, interviews, meetings, record reviews and any other valid source of information.

The manager would compile the data provided through the Contract Monitoring Tool, prioritize the concerns based on Health and Safety Issues, Policy and Procedures, and CFR citation and send the report to the Division of Medicaid's Administration for final determination of issues to present to Optum Idaho through a Point of Correction (POC), Corrective Action Plan (CAP) or for collaborative review. The final monthly report is presented to Optum Idaho for review. Optum Idaho responds to IDHW's CAP requests per contract, submitting either an appeal with evidence of compliance within 10 business days, or by submitting an Improvement Action Plan (IAP) for IDHW approval also within 10 business days. The CAP/IAP are reviewed and tracked by each individual contract monitoring staff member. Optum Idaho monitors IAPs, whether internally driven or driven by IDHW contract finding, through a process managed by the Quality Director. Optum initiates an IAP in response to OMHSA's request for POCs. During the initial implementation stage, the decision was made by new administration to work more collaboratively instead of requesting action plans with each monthly report. Weekly collaborative meetings with IDHW and Optum Idaho representatives are held to discuss contract monitoring activities outside of the quality committee structures.

Contract Monitoring Summary

Based on a review of OMHSA quality monitoring activities, the assessor examined the process to complete the contract monitoring tasks. It was found procedures for quality monitoring exist through varied inconsistent documentation practices, including research

tools and electronic communications. It appeared OMHSA staff members are using similar methods to fulfill their contract monitoring duties, but the process has not been standardized and documented. It has been determined that the internal process for completing monitoring activities is in the completion of the OMHSA Contract Monitoring Tool document. While this tool provides a template in which to deliver the data found, it is not a controlled document, and various versions exist. At the time of the assessment, for the assessment period, there has not been a centralized location to monitor the completion and closure of CAP/IAPs and monthly trends for performance indicators. Finally, when OMHSA staff was asked to explain how data received monthly from Optum Idaho is validated, they explained that they were unable to do so and relied on Optum and the State of Idaho DBH QA staff to validate the data provided by Optum Idaho. Since the assessment time frame, the contract monitoring function has evolved and improved to provide a cooperative approach to monitoring between IDHW administration, Optum Idaho leadership and the contract monitoring team.

Provider Monitoring

Prior to the waiver IDHW conducted on-site provider reviews based on provider and Member complaints. Standard documentation was created and used in each region for conducting the on-site provider visits.

After providers are entered into the network, Optum Idaho conducts audits of provider records for both clinical and administrative compliance. The contract requires Optum Idaho to monitor and evaluate all providers, and conduct a formal review according to a periodic schedule that is consistent with industry standards and approved by IDHW. Optum Idaho has also included provider monitoring in the Annual Quality Improvement Plan. During the assessment interview, Optum Idaho representatives explained the quality standards used to monitor providers are NCQA compliant standards. Overall audit results are reported and monitored in the Provider Advisory Committee. Optum Idaho provided the assessor figure 19 to display the total number of audits conducted in each region from the third quarter of 2013 thru the fourth quarter of 2014.

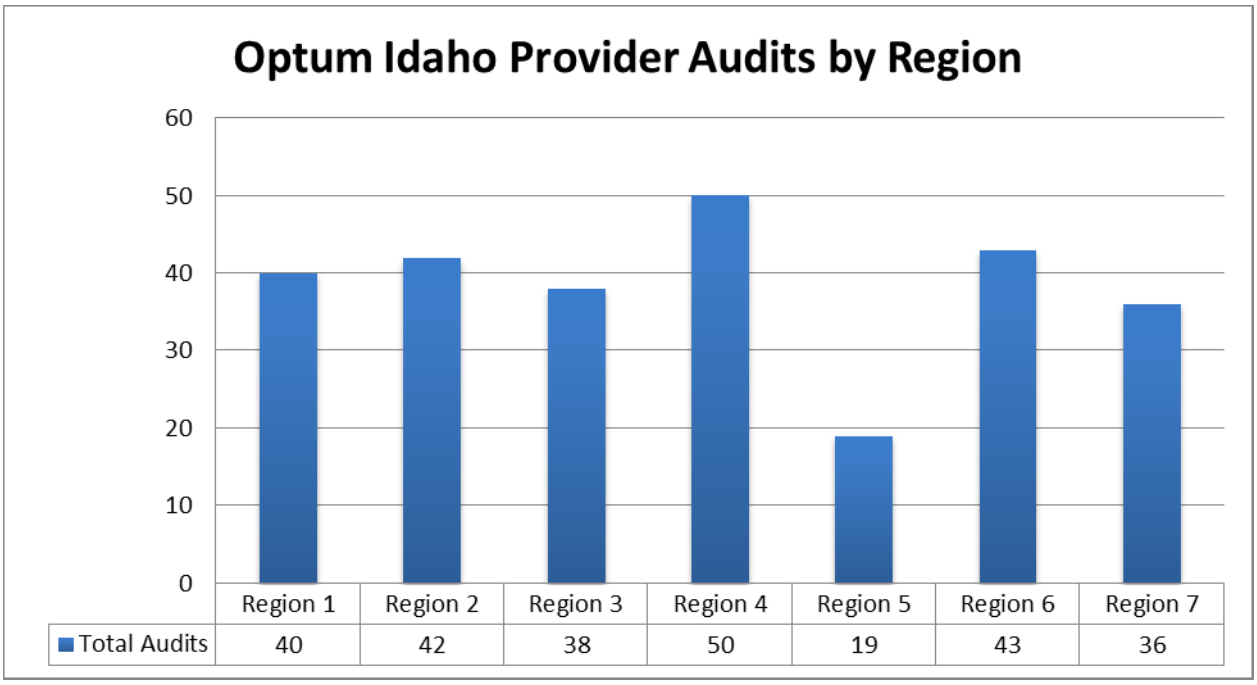


Figure 19. Optum Idaho Provider Audits by Regions

Optum Idaho provided figure 20 to represent the percentage of provider audits that resulted in a corrective action plan to be requested. Optum Idaho's Quality Director indicated that the providers effectively implemented necessary improvements when follow-up audits were conducted.

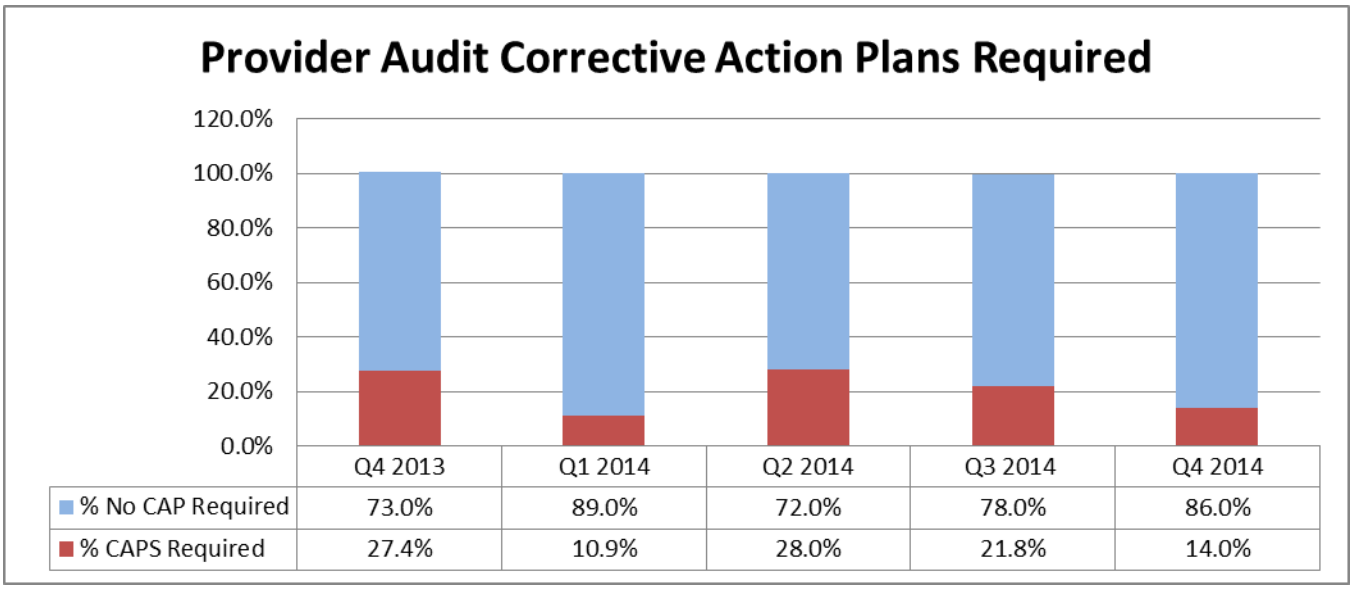


Figure 20. Provider Audit Corrective Action Plans Required Results

Provider Monitoring Summary

Optum Idaho has policies and procedures in place to conduct systematic provider monitoring activities. The use of NCQA compliant standards ensures an industry standard for on-going provider monitoring, which continues to be a priority for Optum's quality monitoring program.

Cultural Competency

Optum Idaho has submitted an annual Cultural Competency plan to IDHW and has formed a cultural competency committee that meets with members from IDHW, Optum Idaho staff, providers, Members and community stakeholders. OMHSA has monitored Optum Idaho's requirement related to cultural competency, through review of Optum Idaho's SR17 report, provider directory and SR07 member complaints. Per contract requirements, cultural competency trainings have been offered to providers, and the training materials are available to all providers on Optum Idaho's website. Based on available data, Optum Idaho was in compliance for serving members with alternative language and cultural sensitivity.

Quality Improvement Program

The contract requires Optum Idaho to implement a Quality Improvement program designed to facilitate a smooth transition of care for behavioral health patients and encourages continuous quality improvement.

Oversight of the Optum Idaho QI program is provided through a committee structure that is accountable to Optum Idaho Executive Leadership and to IDHW. The Executive Leadership of Optum Idaho delegates oversight of the QI program to the Optum Idaho Quality Assurance and Performance Improvement (QAPI) committee, co-chaired by the Chief Medical Officer and QI Director. This committee meets monthly, and reports up through the Optum Idaho governance structure to Senior Leadership. Optum Idaho describes the purpose of the QAPI committee in the QI plan as:

> The QAPI Committee's purpose is to oversee, organize, and evaluate all quality improvement activity. It is responsible for the implementation of the Outcomes Management & Quality Improvement Plan with the mission to

improve the behavioral health and well-being of the Membership it serves, promote high quality behavioral care, and a focus on recovery and resiliency for Members and families. The QAPI Committee is also responsible for reviewing measurements, outcomes, and reports that show progress toward system transformation. Areas that do not show progress toward desired outcomes are targeted for improvement efforts through the establishment of cross functional teams to address systems issues on a periodic and time-limited basis.

OMHSA has representatives on each committee to collaborate with Optum Idaho, Members, providers and stakeholders on items brought to each meeting. The committee structure created by Optum Idaho is a shadow of the UBH national committee structure. Table 2 shows the committees that provide reports each month for review by the QAPI.

Committee	**Role/Purpose**	**Chairperson**
Cultural Competency Committee	The purpose of the Cultural Competency Committee is to advance the goals of the IDHW and Regional Boards and to foster cultural competency, sensitivity, inclusion, and relevancy for recipients of care. The committee develops and monitors the system-wide cultural competency plan and identifies training needs, educational materials, and consultation services relevant to the needs of diverse populations in the regions of Idaho. Diversity includes, but is not limited, to: Ethnicity, race, sexual orientation, gender, age, socio-economic status, primary language, English proficiency, spirituality/religion, country of origin, literacy level, employment status, geographic location, disability/physical limitations, immigration status, and criminal justice involvement.	The Director of Member and Family Affairs or designee chairs the Cultural Competency Committee

Committee	Role/Purpose	Chairperson
PEER REVIEW COMMITTEE	The Peer Review Committee reviews quality of care concerns with specific providers and adverse incidents.	The Chief Medical Officer or designee
MEMBER ADVISORY COMMITTEE	The Member Advisory Committee shall serve to advise Optum Idaho on issues concerning service delivery and quality of service, Member rights and responsibilities, resolution of Member complaints and grievances and the needs of groups represented by board members as they pertain to Medicaid. The Committee is responsible for reviewing and providing input into Member information and educational material. The Committee also reviews and provides feedback and input into QI activities.	The Member and Family Affairs Director acts as liaison to the Committee. Committee members elect a Chair.
CLINICAL AND SERVICE ADVISORY COMMITTEE	The Clinical and Service Advisory Committee is responsible for reviewing inter-rater reliability, utilization and outcomes data for tracking and trending of quality of care and service. The Committee is also responsible for approving and modifying all utilization management criteria and practice guidelines tailored to the specific needs, regulatory requirements and policies of Optum Idaho.	Co-chaired by the Chief Medical Officer and the Clinical Director
PROVIDER ADVISORY COMMITTEE	The purpose of the Optum Idaho Provider Advisory Committee is to establish a forum for representatives from the qualified service providers to provide recommendations, input and prioritization of initiatives or issues impacting the provider community. The Committee is also a forum for providers to bring forth their recommendations for changes to procedures, enhancements to systems or to discuss/plan key initiatives to put forth to IDHW.	Optum Idaho Executive Director or designee, and provider representative
CROSS FUNCTIONAL TEAMS	Cross Functional Teams are established on a periodic and time limited basis to address blockages in progress toward system transformation	Chair of each Cross Functional Team is established when the team is formed.

Table 2. Committees that report to the QAPI

UBH has created policies and procedures at the national level and Optum Idaho has adapted these policies as needed for Idaho specifically. All policies created for the IBHP are reviewed by the committee, IDHW, Optum Idaho management, and the approval sign off is done at the national level of the organization. Once these policies are approved, there is a centralized location for all Optum Idaho employees to access the controlled document. If changes are made, employees are notified by a centralized workflow system.

Optum Idaho provided IDHW 2014 and 2015 Quality Improvement Plans. Optum Idaho's QI plan defines the strategy as:

> This Quality Improvement (QI) Plan represents Optum Idaho's blueprint for utilizing the Plan, Do, Study, Act (PDSA) model for continuous quality improvement (CQI) throughout the entire organization, as well as the provider network and in all our interactions with the community. The QI Plan establishes the groundwork that drives improvement for key measures identified in our *Outcomes Management and Quality Improvement Work Plan*.

Optum Idaho performs an annual evaluation of the quality improvement plan. During this evaluation analysis is done on the overall effectiveness of the program using relevant input from committees, staff, IDHW, providers, members and other stakeholders. The results of the annual evaluation are reviewed and approved in the QAPI committee and made available to IDHW, Members, provider and other stakeholders as requested.

Quality Improvement Program Summary

Optum has performed an Annual Program Evaluation of its Quality Management program for 2014. As a result, Optum has shown a commitment to improving quality through its Quality Management Program. The overall quality management program meets the contract standards defined in Section XXXII of the contract with IDHW and Optum Idaho.

Summary of Findings for Quality of Care

Based on contract requirements and federal regulations, IBHP is structured to promote and deliver quality health services. Prior to the waiver period, IDHW had a limited quality improvement program that consisted of provider credentialing and monitoring. Optum Idaho has created a robust quality management program. The program is comprehensive as it includes plans for establishing and driving improvement throughout the behavioral health system and a committee structure to hold the program accountable.

The state of Idaho has established a program monitoring group and has collaborated with Optum Idaho during the first eighteen months of the waiver program. OMHSA contract monitoring efforts continue to evolve and expand with the transition from an implementation to an operational phase of the new IBHP.

Independent State CAHPS Data Analysis

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. IDHW contracted with a third party vendor to develop and administer a customized CAHPS Health Plan Survey questionnaire. The vendor administered surveys targeted for IBHP adult members and for IBHP child members. The surveys were administered using a mixed methodology in an attempt to receive enough responses from an adequate representation of all IBHP members to be statistically significant. Since the surveys were modified from the CAHPS survey, to be behavioral health plan focused, this assessment did not compare the results of similar organizations or results in the CAHPS database. The survey was also independent of Optum Idaho CAPHS survey, and results do not include information from Optum Idaho's survey

Among adult members, a total of 442 surveys were completed. Out of the 442, 82% were returned by mail and 18% of the surveys were conducted over the phone. The overall adult survey response rate was 33%. Among the child member survey, a total of 621 surveys were completed. Out of the 621 surveys, 91% were returned by mail and

9% of the surveys were conducted over the phone. The overall response rate for the child's survey was 37.6%.

Adult Member Survey Results

Scores were grouped for the adult member survey in three categories; getting needed care, shared decision making, and provider communication. Composite scores were created for areas and scores were determined by calculating the percentage of group response values. Below are the contributory questions for each composite:

Getting needed care

- Q8 - In the last 12 months, how often was it easy to get Mental Health or Substance Abuse treatment through your health plan?
- Q20 - In the last 12 months, how often was it easy to get specialized treatment you needed for Mental Health or Substance Abuse through your health plan?

Shared decision making

- Q4 - In the last 12 months, how often was it easy to get health Mental Health/Substance Abuse provider to agree with you on the best way to manage your health conditions or problems?
- Q13 - In the last 12 months, how often were you involved as much as you wanted in these decisions about your health care?
- Q18 - In the last 12 months, how often did you and a Mental Health/Substance Abuse provider talk about specific things you could do to prevent worsening of symptoms?

Provider communication

- Q17 - In the last 12 months, when there was more than one choice for your treatment, did Mental Health or Substance Abuse provider ask which choice you thought was best for you?
- Q16 - In the last 12 months, did Mental Health or Substance Abuse provider talk with you about the pros and cons of each choice for your treatment?

Individual questions were also included in the final analysis.

Getting Needed Care Analysis

On figure 21, Members responded favorably when asked about the ease of scheduling an appointment with 66% responding “Always or Usually”.

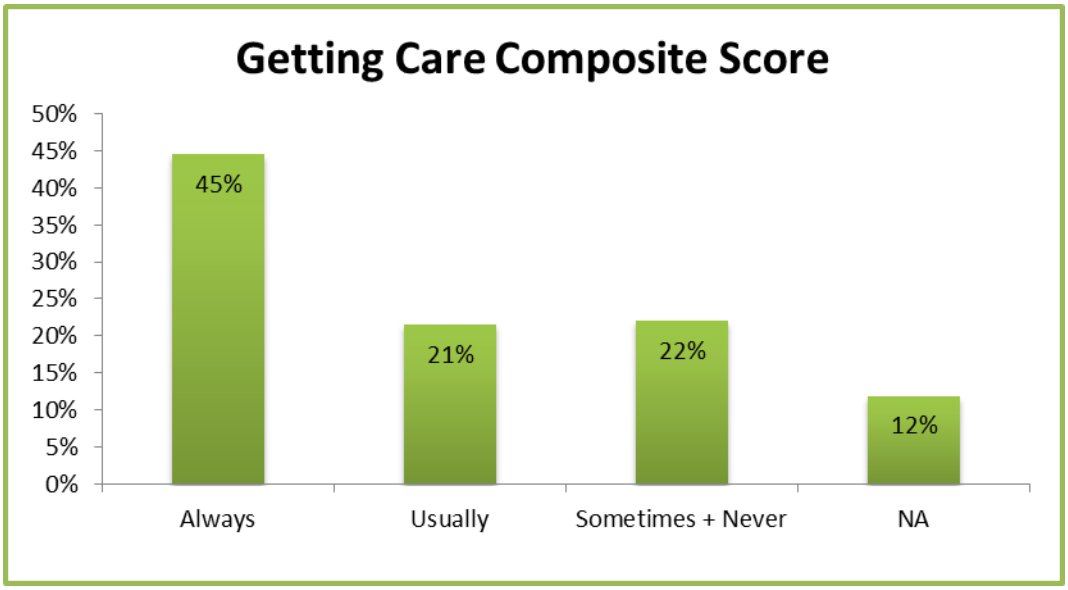


Figure 21. Getting Needed Care Composite Score – Adult Survey

An additional question, Q15, regarding the appointment wait time figure 22 illustrates that the majority of adult members, responding to the survey, are able to actually be seen by a provider within seven days of making the appointment.

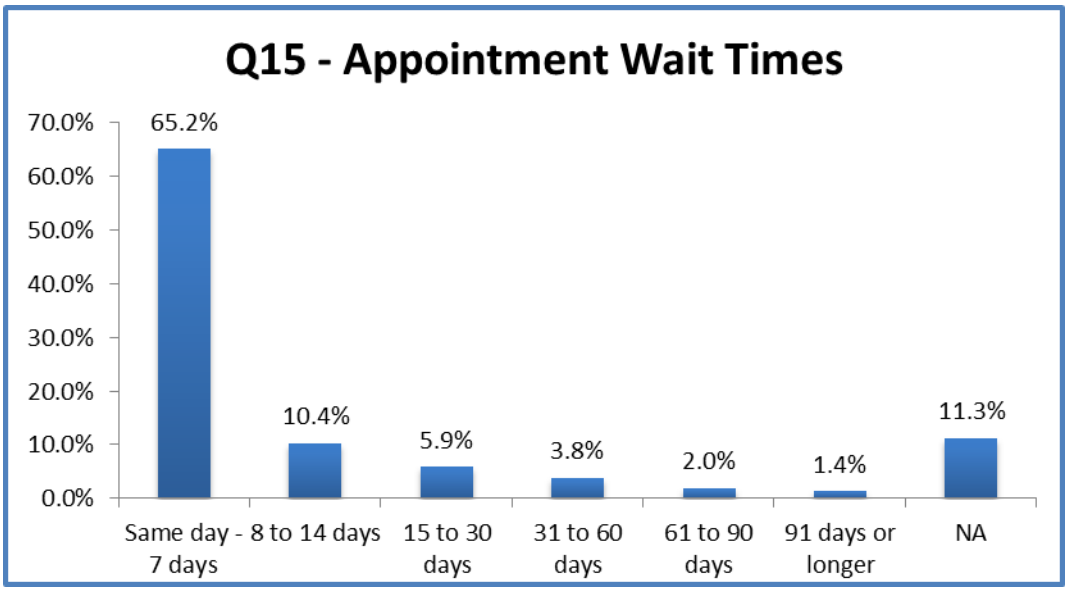


Figure 22. Appointment Wait Time – Adult Survey

Shared Decision Making

Figure 23 shows that less than 50% of the Members responded that the providers "always" included the member in the treatment decisions, although overall the responses were satisfactory.

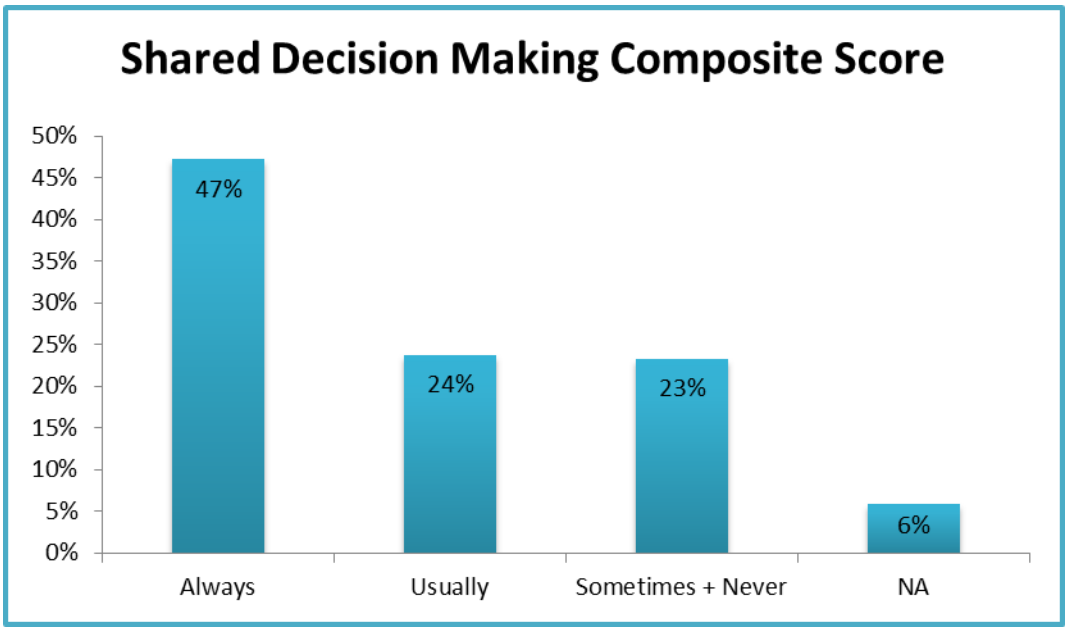


Figure 23. Shared Decision Making Composite Score – Adult Survey

Provider Communication

Figure 24 shows the response by Members to the provider's communication with the Member regarding the treatment choices.

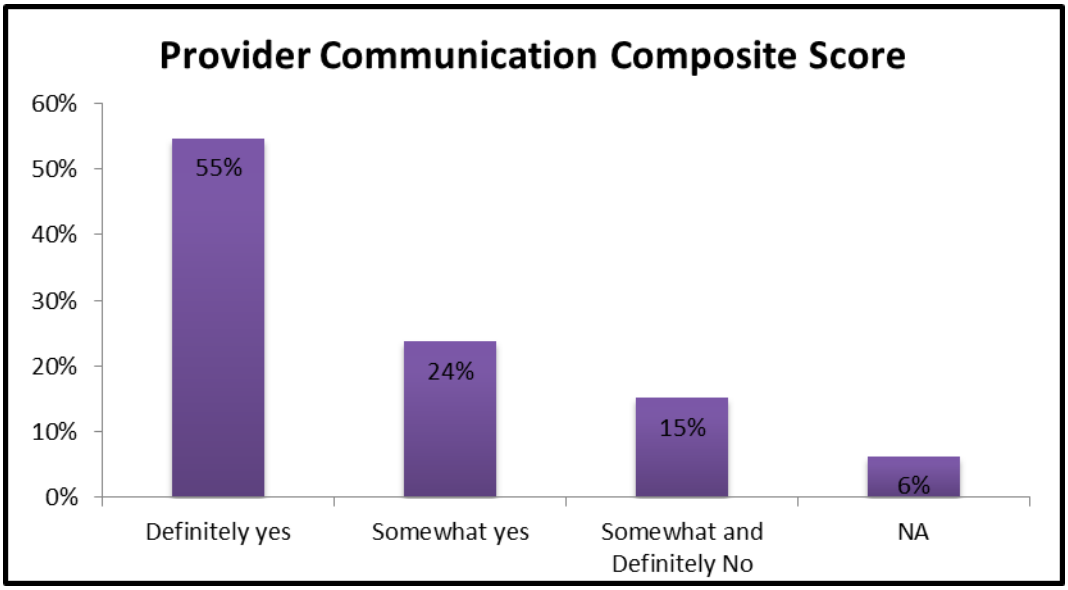


Figure 24. Provider Communication Composite Scores – Adult Survey

Coordination of Care

Figure 25 shows the responses to questions 20 asking Members, "In the last 12 months, how often did your Mental Health or Substance Abuse provider seem informed and up-to-date about the care you got from health providers?" Less than 50% of Members answered "always" to this question.

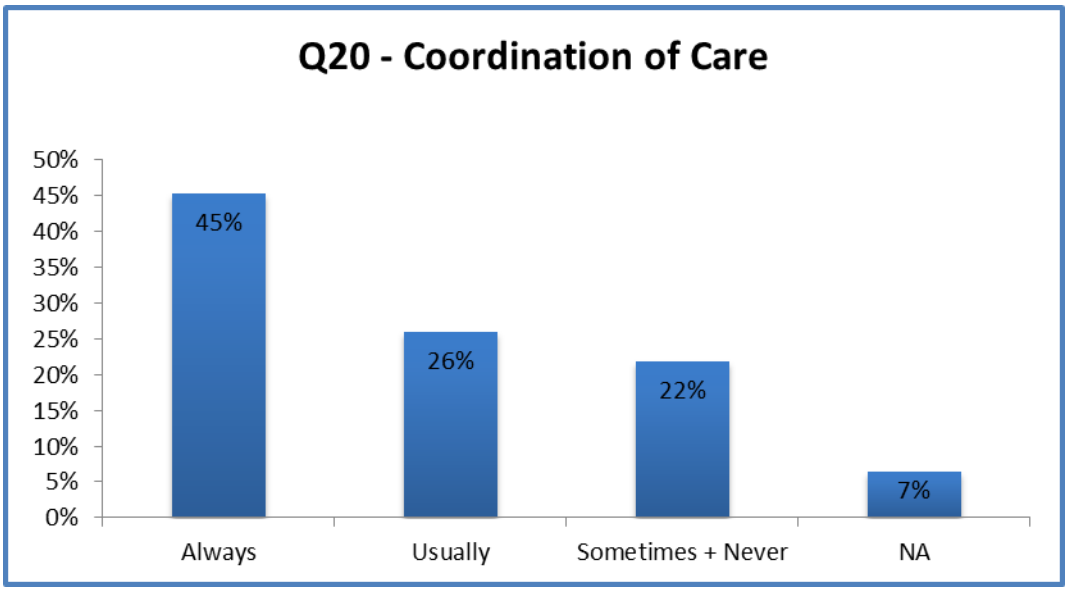


Figure 25. Question 20 Results – Adult Survey

Overall Treatment Rating

Figure 26 shows the Members' responses to question 10, asking the respondents to rate the Member's overall treatment or counseling in the last 12 months on a scale from where 0 is the worst treatment or counseling possible and 10 is the best treatment or counseling possible. In looking at this response, it is worth noting the increase in the number of Members that scored their overall treatment rating between four and zero from the number that rated their overall treatment between six and five.

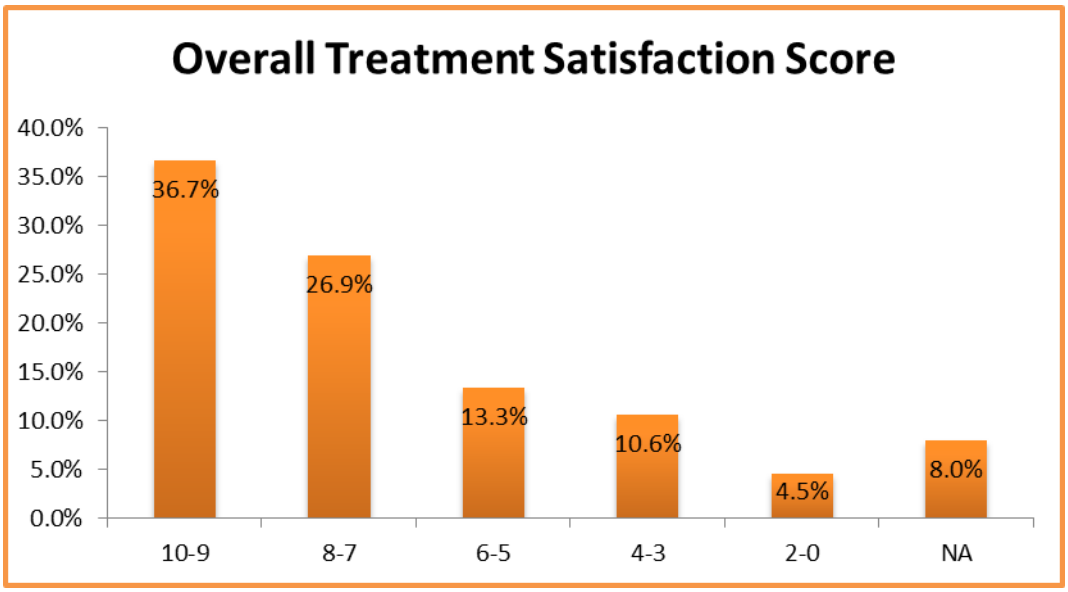


Figure 26. Overall Treatment Rating – Adult Survey

Child Member Survey Results

Composite scores were created for areas and scores were determined by calculating the score percentage of group response values. Below are the contributory questions for each composite:

Getting needed care

- Q6 - In the last 12 months, how often was it easy to get specialized treatment you needed for Mental Health or Substance Abuse through your health plan?
- Q16 - In the last 12 months, how often was it easy to get a referral to a Mental Health or Substance Abuse specialist that your child needed to see?
- Q8 - Since your child joined this health plan, how often was it easy to get a Mental Health or a Substance Abuse provider for him or her that you are happy with?

Shared decision making

- Q3 - In the last 12 months, how often did you get the specific information you needed from your child's Mental Health or Substance Abuse provider?
- Q4 - In the last 12 months, how often did you and your child's provider talk about specific things you could do to manage mental health/substance use disorder symptoms and behaviors in your child?
- Q12 - In the last 12 months, how often did your child's Mental Health or Substance Abuse provider make it easy for you to discuss your questions or concerns?

Individual questions were also included in the final analysis for each section.

Getting needed care

Figure 27 shows that 61.94% respondents could "Always or Usually" get the care needed for their child.

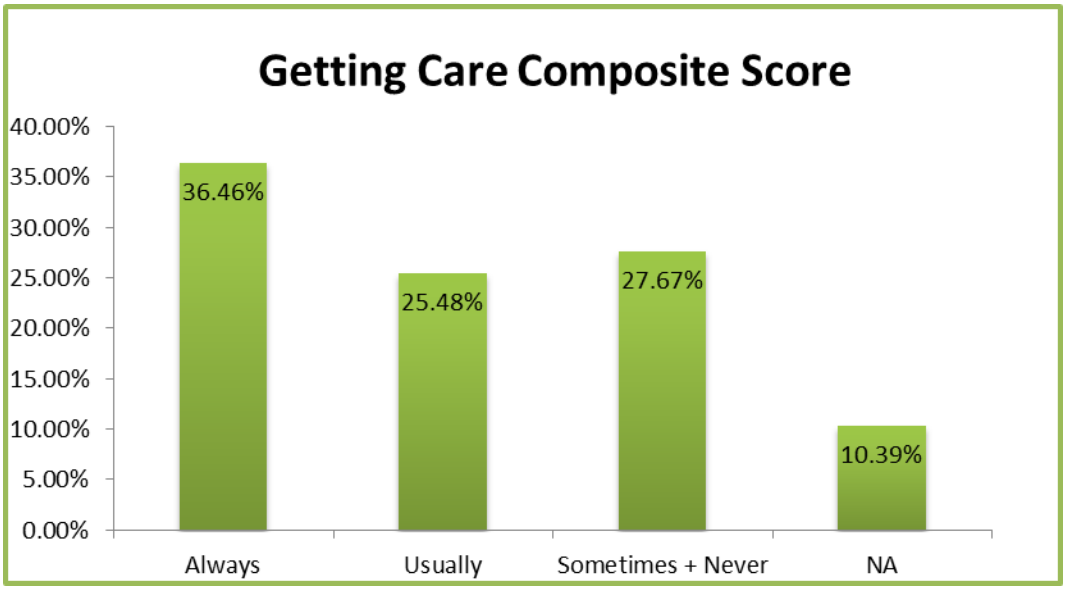


Figure 27. Getting Care Composite Score – Child Survey

Shared decision making

Figure 28 shows the respondents are split with the favorable and unfavorable responses to communicating with providers regarding treatment options and questions regarding their children. It is recommended that further research be conducted to review this area.

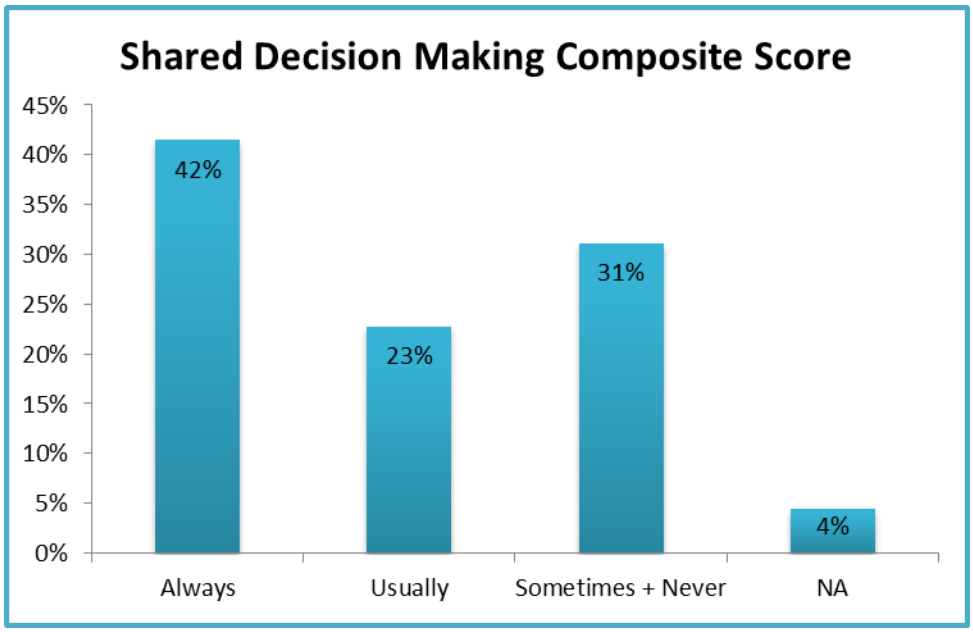


Figure 28. Shared Decision Making Composite Score – Child Survey

Additionally, Q17 asked respondents if the child's provider asked which choice they thought was best for the child. Figure 29 shows that the majority of respondents answered "definitely or somewhat yes".

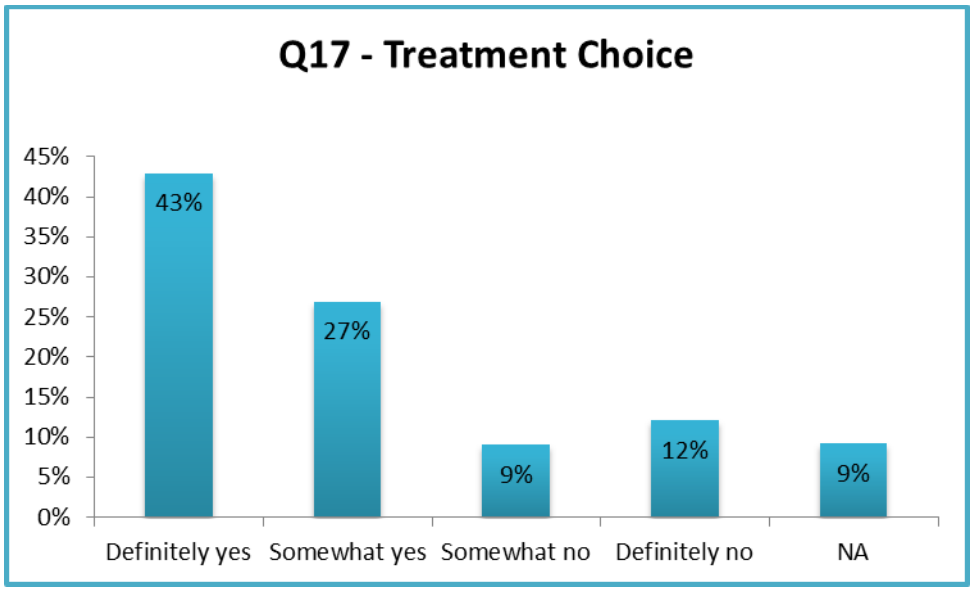


Figure 29. Q17 Treatment Choice – Child Survey

Coordination of Care

Question 18 asked respondents, "In the last 12 months, how often did your child's Mental Health or Substance Abuse provider seem informed and up-to-date about the care your child got from other providers?" Figure 30 shows the responses to this question. It should be noted the responses for sometimes and never are almost equal to the responses of always. This is an area that further investigation by OMHSA should be done.

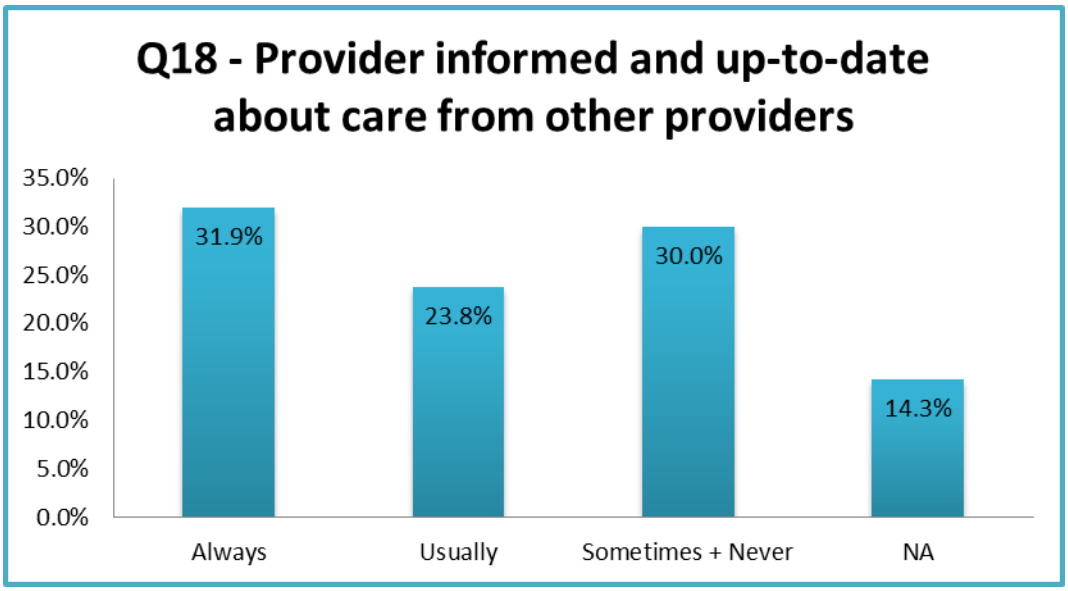


Figure 30. Question 18 Responses – Child Survey

Health Plan Communication

Figure 31 shows the response to Q15, asking respondents, "In the last 12 months, how often did the written materials on the Internet provide the information you needed about how your child's health plan works?" This is an area that further investigation by OMHSA should be done.

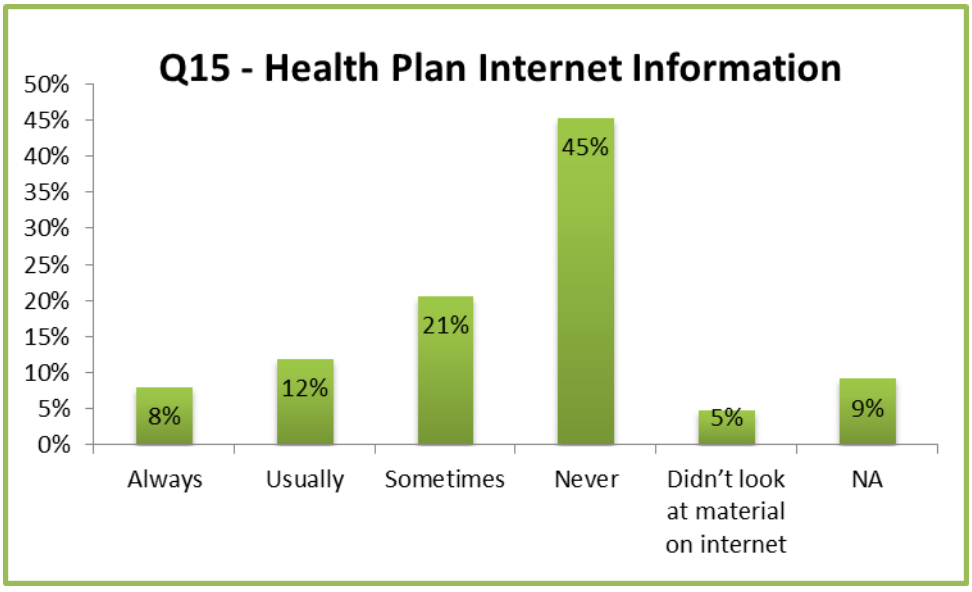


Figure 31. Health Plan Internet Information – Child Survey

Overall Treatment Rating

Figure 32 shows the responses from respondents to Q10, asking them to rate their child's overall treatment or counseling in the last 12 months. This shows most respondents rated their treatment in the 8-7 rating. The overall rating is favorable, with over 75% of respondents rating the overall treatment a seven or higher.

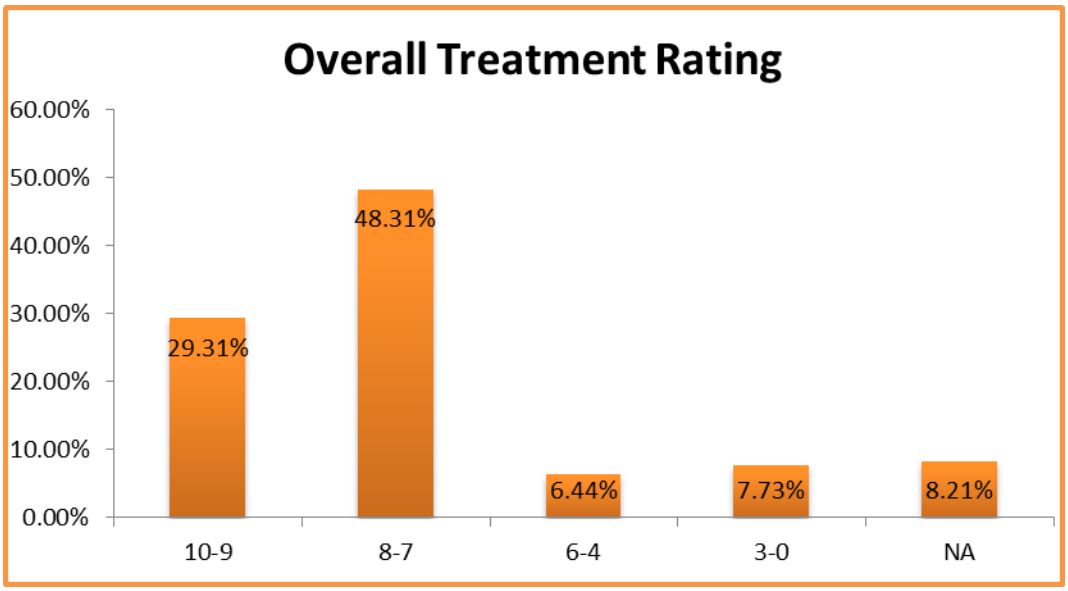


Figure 32. Overall Treatment Rating – Child Survey

Summary of Independent State CAHPS Data Analysis

The assessor's analysis has allowed for the identification of specific areas such as the rating of the adult overall treatment and health plan information, where Member satisfaction could be improved. Further analysis of this data is needed by IDHW, including a "drill down" to identify root causes for overall treatment satisfaction and barriers where improvement is needed. Actions need to be designed and implemented to impact the root causes of satisfaction and mitigate barriers to Member satisfaction. These findings would give IDHW the information necessary to develop targeted interventions and thus improve the satisfaction in this area. Furthermore, improvements on these areas will likely increase IBHP's overall chance of obtaining higher satisfaction ratings and composite scores.

Additionally, the CAHPS data collected for 2014 should be used as a baseline for future CAHPS results. Further investigation is needed in some areas to review results and

comparisons could be made to data collected by Optum Idaho's member satisfaction survey results or Optum Idaho CAHPS data.

Strengths of Idaho Behavioral Health Plan

The assessor identified the following strengths of IDHW to be beneficial in the implementation of the IBHP during this waiver period.

- Optum Idaho has created and effectively implemented 24 hour/365 day a state-wide member and crisis hotline, which was not available to Medicaid members prior to the waiver.
- Optum Idaho has strengthened the network by providing more providers at all practitioner levels and the network has grown throughout the state of Idaho. The use of telehealth services allows regions of Idaho receive services that may not be available to them by a credentialed provider in a typical clinical delivery setting.
- IDHW and Optum Idaho have worked collaboratively on issues found during the implementation phase and on-going contract monitoring process.
- IDHW staff and administration have shown a dedication to preserving Member's rights during the implementation phase and moving forward.
- Approach to contract monitoring by OMHSA has been a systematic method to review all performance indicators in the first year of implementation.
- Optum Idaho has extensive quality management documentation for policies, procedures and plans. The various documents all use a common language between Optum Idaho and United Behavioral Health.
- Optum Idaho has provided IDHW annual plans for Network Development and Management, Quality Management and Utilization Management, annual Cultural Competency Plan, and Provider Training Plan. These plans are all connected and reviewed by committees, IDHW and UBH national staff.

Recommendations

Contract Monitoring Plan

It is a recommendation that IDHW work in partnership with Optum Idaho to create an overall contract monitoring plan and review the contract for shared understandings of requirements. It was found in reading various meeting minutes and reports, there is a gap in IDHW and Optum Idaho's full understanding of the contract requirements. For example, the mileage requirements from Members to providers are measured in miles or minutes. This may require a complete review of the contract. Once the contract requirements have a mutual understanding, a shared Contract Monitoring Tracking tool should be created and implemented. Contract monitors should implement a standardized process to track and monitor all indicators and issues that are found.

Governance

It is a recommendation that IDHW creates a governance policy, at a minimum to define control limits for the prioritization of contract monitoring compliance findings. During data collection and analysis the assessors did not find a rationale that explained when OMHSA contract monitoring findings were determined to become a POC or to be done collaboratively. The only explanation given was the decision is made based on health and safety of the member. In a behavioral health system, all findings could be labeled as urgent for a Member's health and safety, and without a governance plan it is difficult to determine the indicators and issues that require corrective action plans.

Common Language

It is recommended that a common language is created for terminology used by IDHW and Optum Idaho. Throughout data collection and analysis the assessor found disputing terminology. While there are many examples the following are focused on terminology regarding grievance and appeals, meeting minutes and CAP/CAR/IAP. For example the differences in terminology between CFR criteria, the contract between IDHW and Optum Idaho, committee meeting minutes, and member and provider handbooks create confusion due to the differences between the federal definitions vs. the State and Optum definitions. These differences create inconsistent understanding of

guidelines for member rights. Nomenclature across venues needs to be the same in order to ensure accuracy and reporting capabilities.

Document Management System

During this assessment, inconsistencies had been identified in documentation provided by OMHSA and Optum Idaho. The premise of using a document management system is that it provides the most basic functionality to content management, imposing controls and management capabilities. The SharePoint site OMHSA is using to store documentation is a first step in creating a document management system. Our recommendation would be to create a version control procedure for all policy documents sent from Optum Idaho.

Baseline Data

Information provided in this report should be used as a baseline for future assessments and for continued program monitoring. Specifically, the state of Idaho's independent CAHPS data should be reviewed and investigation by IDHW to review results for areas of improvement. Optum Idaho data should be used for performance tracking of the program where pre-waiver data does not exist. As more data is collected each month, trends can be identified and performance improvement efforts can be targeted. Quality systems should continue to be monitored for effectiveness and Optum Idaho's implementation from the plans submitted to IDHW.