Acknowledgements

TAP International would like to thank the management and staff at Salt Lake County Division of Behavioral Health Services, OptumHealth of Salt Lake City, and Valley Behavioral Health for their assistance and contributions to this audit. We appreciate their efforts to submit information on a timely basis and to provide information about the issues addressed in this report.
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TAP International, Inc.
Final Report
Why Salt Lake County Sponsored This Review

Salt Lake County’s (SLCO) Medicaid program, a joint federal-state program that finances health insurance coverage of low-income individuals, is an important source of health care coverage for about 100,000 of its residents. SLCO contracted with TAP International, Inc. to address fiscal and other issues regarding the SLCO’s delivery of behavioral health services under a managed care model.

Behavioral health services are a covered benefit in SLCO. Presently, SLCO provides Medicaid-funded behavioral health services to about 14,144 Medicaid enrollees, and provides additional funding for the County’s 2,427 uninsured population. In FY 2013, SLCO’s expenditures on behavioral health services for its 16,571 Medicaid eligible and uninsured residents totaled about $56 million, or about $3,382 per eligible consumer.

As Medicaid enrollment and spending increased significantly over the past decade, so too has the use of managed care to provide services to Medicaid beneficiaries. Nearly all states and many counties enroll some Medicaid beneficiaries in various forms of managed care. The Centers for Medicare & Medicaid, the federal agency responsible for broad oversight of the Medicaid program, allows states and counties broad flexibility to implement Medicaid managed care programs. As a result, counties vary widely in terms of the scope of services they provide and the populations they enroll in managed care.

For 24 years, SLCO contracted the provision of all public behavioral health services to a local provider, Valley Behavioral Health (VBH), formerly known as Valley Mental Health. Until July 2011, VBH served as both the County’s primary provider of services and SLCO’s managed care organization (MCO), including having responsibility for decisions on appeals and grievances. The MCO supports the services and initiatives described in SLCO’s Behavioral Health Area Plan. The County’s Division of Behavioral Health Services (DBHS), within the SLCO’s Department of Human Services, oversees the provision of mental health services by the County’s MCO.

SLCO’s 2013 Area Plan calls for many initiatives, such as greater levels of recovery services and improved resiliency for consumers - youth and families - as well as identifying ways to improve service delivery through communication activities. The 2013 Area Plan includes the current MCO’s (OptumHealth) Quality Assessment and Performance Improvement (QAPI), which is a framework for continuous evaluation of all aspects of service delivery.

In 2010, SLCO initiated a competitive bid process to award a new MCO contract, under which the MCO would assume responsibility for managing behavioral health services. As illustrated in Figure A, DBHS selected a new MCO vendor, OptumHealth, and the transition began in July.
2011. OptumHealth received a one-year extension on the MCO contract, which expires on June 30, 2015.

SLCO contracted with TAP International, Inc. to evaluate and study the multiple issues affecting the delivery of behavioral health services under a managed care model. SLCO initiated the review because it is fully responsible for the $56 million Medicaid and uninsured funding for behavioral health services. Previously, VBH maintained full fiscal responsibility.

**Results in Brief**

SLCO’s contracted scope of work with TAP International, Inc. included nine key questions. This section provides a summary of our analysis and findings for each of the questions. Unless otherwise designated, year refers to Calendar Year (CY); and Fiscal Year (FY) refers to the 12-month period beginning July 1st.

1. **How do the County, OptumHealth, and VMH measure clinical improvement, network and client satisfaction, and continuity of care effectiveness?**

   - VBH, OptumHealth, and DBHS variously track over 30 industry accepted performance measures for clinic improvement, network and client satisfaction, and continuity of care effectiveness.
• An area of concern is that each entity generally relies on consumer reported information to assess whether clients are getting better rather than relying on evidence-based outcomes. Having evidence-based outcomes can help identify the types of services, programs, and providers that are effective at helping consumers lead productive lives. We describe in this report that OptumHealth and VBH are beginning to plan for and apply more evidence-based outcomes.

• OptumHealth would like to use technology to track provider performance, as well as, to strengthen efforts to monitor continuity of care among consumers. However, these activities are not yet included in OptumHealth’s contract with DBHS.

2. How is information technology affecting the system transition?

• After resolving information technology system configuration issues with both OptumHealth’s system and VBH’s 24-year-old DOS based IT system, one remaining IT technology issue is currently affecting system transition.
  
  • OptumHealth manually processes third party liability claims and will continue to do so until a system update occurs in late 2014 that will provide the capability to electronically process the claims.

  • Information technology issues could potentially re-occur if VBH configures its new system without integrating the IT requirements from OptumHealth to ensure the smooth electronic exchange of claim information.

3. How does OptumHealth facilitate interagency communication?

• OptumHealth conducts a wide range of outreach and other communication activities supporting substantial improvement in program transparency. OptumHealth facilitates interagency communication by:
  
  • Providing 24/7 access to the Program Director;
  • Holding quarterly provider network meetings (although inconsistently);
  • Providing top-level attention to consumer complaints and concerns;
  • Participating in monthly IT technology transition meetings;
PERFORMANCE AUDIT: EVALUATION OF BEHAVIORAL HEALTH SERVICES

- Facilitating monthly meetings with DBHS and VBH;
- Providing training to providers on claim preparation and processing;
- Providing training on clinical care strategies; and,
- Holding ad-hoc meetings with providers to discuss client care and access questions and issues.

- OptumHealth plans to facilitate meetings between providers to address long-standing communication issues regarding inpatient admission and discharge, and to hold provider network meetings to disseminate OptumHealth’s vision of its long-term goals and objectives for mental health services.

4. What services have been eliminated since the award of OptumHealth’s contract? Of those services, which have been eliminated, how many were decided by OptumHealth? What services have been added or grown since the award to OptumHealth?

- VBH and DBHS have each realigned services as follows:
  - VBH added and/or expanded five services, including school-based programs, wrap around services, and family oriented counselors for early intervention services, which was funded by the DBHS.
  - DBHS, through realignment of program revenue from reported cost savings, added five needed services to address consumers in crisis, which increased service delivery effectiveness and led to cost savings. University Hospital, who administers the new services, reported net savings of $3,110,027 for the first 3 months of 2014 stemming from diverting consumers from hospital inpatient stays to new programs: the crisis center, mobile crisis teams, the Wellness Recovery Center, and the Receiving Center;
  - VBH eliminated and/or reduced six programs with one program – respite services – that was transitioned to another provider per an agreement with DBHS.

- Service delivery changes by OptumHealth have accomplished DBHS’s goal to offer Medicaid enrollees a choice of providers, allowing DBHS to close the gap on services that would facilitate diversion from inpatient treatment.

5. Are VBH’s business practices consistent with a company with significant budget concerns? Are administrative costs minimized? Are travel, consulting, and other expenses appropriate, and within reasonable limits? Have all reasonable efforts been made by VMH to reduce costs and protect client services prior to cutting clients?
• VBH business practices are consistent with a company that recognizes the significance of budget deficits while providing needed behavioral health services. The actions VBH has taken to reduce costs prior to transferring clients to other providers include:
  • Selling of property to offset operating expenses;
  • Downsizing staffing levels, which have occurred as early as 2007 to reduce operating costs;
  • Implementing multiple layers of review and approval for hiring new personnel;
  • Monitoring of purchases;
  • Preparing and reviewing monthly revenue versus expenditure reports to identify further cost cutting strategies;
  • Reducing travel, consulting, and other operating expenses; between CY 2010 and CY 2012, VBH reduced operating costs by 20 percent ($16.7 million) to help offset declining revenues of 31 percent ($28.9 million); and,
  • Implementing an additional 39 initiatives across four operational functions - clinical improvement, regulatory compliance, financial management, and customer satisfaction. These initiatives address revenue collection, position consolidation, IT strategy planning, quality assurance, and pension cost reduction.

6. Is OptumHealth operating with appropriate business practices to achieve administrative savings without sacrificing the quality of care offered to clients?
   • OptumHealth operates with appropriate business practices to achieve administrative savings without sacrificing the quality of care offered to consumers.
     • DBHS structured its contract with OptumHealth that caps the MCO’s operating and profit margins to 14 percent of available Medicaid revenues, effectively preventing the MCO from sacrificing the quality of care to garner additional profits.
     • OptumHealth has the opportunity to receive performance incentives upon effective completion of goals and objectives set by DBHS. In FY 2013, OptumHealth forfeited $571,000 in payments because DBHS determined OptumHealth did not fully complete its performance expectations that lead to overall program deficits of $3.3 million, which OptumHealth absorbed.
     • DBHS receives few grievances and appeals against OptumHealth and a greater number of complaints from consumers against providers regarding access and quality of care activities.
7. **Is the County operating with appropriate oversight?**
   - DBHS exercised a new and appropriate level of oversight during the transition of a new vendor to serve as the managed care organization. The new oversight activities substantially increased the level of transparency and accountability over behavioral health services, which was generally absent when VBH administered the MCO contract.
   - Now that the transition of MCO vendors is in its third year and many operational issues have been resolved, DBHS can benefit from refining its oversight to provide an added focus on resolving complex issues, such as facilitating access to treatment for persistently and severely mentally ill (SPMI) consumers that have a criminal and/or violent backgrounds, addressing the shortage of beds available for mental health consumers, and rightsizing the level of the program and financial reports required of OptumHealth.

8. **What is the impact of budget reductions and funding cuts?**
   - Funding cuts have spurred the local market to offer and provide behavioral services at costs that VBH could no longer support, leveraging Medicaid funding.
   - VBH, after the award of the MCO contract to OptumHealth, experienced a large budget cut, creating a substantial revenue gap that added to its fiscal issues.
     - Without new revenue, VBH was not in a position to absorb a new 4.9 percent Medicaid rate cut without adversely affecting service delivery. The rate cut hastened the implementation of VBH’s plans to transfer consumers to other providers. Prior DBHS and OptumHealth initiatives to support VBH and VBH’s own efforts to cut costs, together were not sufficient to offset revenue cuts.
   - Medicaid cost reports prepared by DBHS reported FY 2013 budget deficits of $1.9 million for behavioral health services. OptumHealth absorbed the loss and is included in the overall $3.3 million deficit previously reported.

9. **What is the effectiveness of the current service delivery model when evaluating the staffing levels, service delivery efficiencies, provider/fee for service payment policies reserve fund levels, effectiveness of treatment policies, perceived savings, and performance measures?**
• Our analysis of seven components of DBHS’s behavioral health service model show important changes took place that suggest DBHS has improved current services and could enhance program effectiveness by addressing other opportunities for improvement.

• Service delivery changes have closed the gap on needed services for SLCO Medicaid enrollees.

• Staffing capability and capacity among mental health providers has allowed DBHS to reduce its reliance on one provider to deliver services, but most of the services provided to (SPMI) consumers continue to reside with one primary provider – VBH.

• Implementation of provider payment policies allow providers to receive reimbursement prior to delivery services, which help providers manage their cash flow. However, when providers do not spend all of their advance payments, it affects the ability of OptumHealth to spend available revenues on other services. Provider payment requirements also restrict the ability of providers that receive monthly payments to manage against their total budget.

• Increasing reserve fund levels to pay outstanding claims demonstrate increased accuracy in projecting the level of reserve funds, but the absence of historical and complete data stemming, in part, from technology issues influenced 2013 program deficits.

• The absence of a large number of consumer grievances regarding the quality of care supports the effectiveness of treatment policies.

• DBHS has a noteworthy practice to set aside unexpended funds for other priorities, but unexpended funds previously set aside were not likely “true” program savings because FY 2012 reconciliation between amounts paid and services provided among network providers were ongoing at the time of our review and are ongoing for FY 2012 among key providers within the network. Therefore, any apparent savings reported at that time may not have been fully accurate.

• Analysis of many performance measures show improved results especially in network effectiveness, but unchanged performance for consumer outcomes.
Issues that Need SLCO Attention

- **Potential Year End Budget Deficit for Behavioral Health Services**: For FY 2013, DBHS reported a $1.9 million deficit in Medicaid and uninsured funding for behavioral services, and for FY 2014 (10 months) OptumHealth reported budget deficits of $2.0 million through April 2014. Budget deficits are fully absorbed by OptumHealth rather than by DBHS. DBHS contractually prevents OptumHealth from accomplishing administrative savings or additional profits at the expense of consumers’ quality of care.

- **Waiting Lists to Enter Treatment for Substance Abuse Services**: There are 126 uninsured SLCO residents waiting to enter alcohol and substance treatment at VBH. VBH also has seven Medicaid residents waiting for residential beds at the VBH’s Cottonwood facility. About half of the uninsured residents, or 57, waiting substance abuse services and five Medicaid enrollees waiting for residential beds have, to date, waited four months or longer. Both VBH and OptumHealth reported no waiting lists for Medicaid enrollees needing non-residential mental health services.

- **SPMI Consumers with Violent Histories**: OptumHealth has experienced some difficulty placing a few SPMI consumers with violent histories. While VBH has the capability to treat these types of consumers, VBH does not have, to date, all of the security equipment and monitoring equipment to ensure the safety of its employees. The absence of fully secure facilities may be an emerging issue for SLCO should the number of violent SPMI consumers increase.

- **Need for Better Information that Links Behavioral Health Spending and Consumer Progress**: In spite of the improvements made in the delivery and management of behavioral health services, DBHS does not have sufficient evidence to show whether consumers are actually getting better.

Conclusions

Despite the early challenges resulting from the change in MCOs vendors, DBHS’s decision to move to a managed care model has led to key accomplishments that include:

- Doubling the number of providers within the network, facilitating greater choice for consumers;
- Increasing the transparency and accountability of behavioral health service delivery through increased communication, reporting, and oversight;
• Allowing the marketplace to offer services at competitive pricing;
• Providing consistent structure and discipline in the implementation of level of care guidelines; and,
• Reducing the reliance on one primary provider to address the behavioral health needs of the community.

While the change in MCO vendors led to difficulties in processing provider payments, most have been successfully resolved through the focused efforts of OptumHealth and VBH. However, in spite of VBH’s considerable efforts to offset the funding gap that occurred when OptumHealth was awarded the contract, VBH could not overcome another Medicaid budget cut of 4.9 percent without hastening the previously planned transition of a large group of Medicaid consumers to other SLCO providers. Even without the budget cut, the transfer of consumers would have likely happened anyway because VBH was already rightsizing its organization to align services and its staffing levels with its new service delivery model. Ultimately, VBH transferred 733 consumers from a previously estimated level of 2,250.

Although the MCO transition process was awkward, no one single entity bears full responsibility for the issues, however, lessons learned are evident. The most important lesson is to provide a larger time period between the award of the managed care provider contract and the go-live date, so the existing MCO can better plan for the impact on its budget. DBHS, in its recognition of this need, has already established more lead time for IT implementation on future awards of the MCO contract.

Another lesson is the need for DBHS to maintain its own data and information systems for use by a new MCO to avoid similar technology transitions issues in the future. Further study is needed to determine whether DBHS should use its current information systems to store the data or purchase new systems that meet industry standards. In addition, DBHS, after three years of supporting VBH’s fiscal sustainability to the best of its ability and recognizing VBH’s past and current contributions to the SLCO community, should now allow the new managed care model to reach its full potential. With contractual protection in place that prevents the MCO from reducing services to increase profitability, OptumHealth could benefit from greater independence from DBHS in its administration of the managed care network. DBHS can ensure the MCO makes appropriate decisions through a refined oversight and performance-monitoring role.

All entities primarily involved in the transition – the DBHS, VBH, and OptumHealth – considered the best interest of the consumers during the transition.
Recommendations to SLCO and OptumHealth

1. To enhance its analysis of consumer outcomes, OptumHealth should incorporate additional evidence-based outcomes in its tracking of program operations by the provider network, or require providers to submit data annually on key outcomes metrics through its planned use of performance based contracting.

2. To enhance the effectiveness of financial oversight, DBHS should focus their monitoring efforts on MCO efficiency and effectiveness by conducting cost effectiveness studies to monitor specific program costs that link the data to consumer outcomes. DBHS can implement this recommendation through the acquisition of available software to conduct advanced business analytics.

3. DBHS, the providers with contracts with established budgets for Medicaid funded services, and OptumHealth should all agree on criteria allowing reimbursement when providers exceed budget allocations for individual services even though total spending has not exceeded the provider’s total budget allocation for services.

4. To determine the circumstances of recently made available reports on claims with missing authorizations, SLCO should conduct a performance audit of the claim authorization process.

5. To prevent the re-occurrence of technological transition issues, DBHS, in future procurements, should consider requiring the newly selected MCO vendor to use a County-owned system. However, should DBHS opt to require use of its existing system, SLCO should conduct a feasibility study to ensure it meets all industry claim processing and privacy standards, including having the capability to interface with newer systems without extensive reconfiguration.

6. To facilitate provider accountability for program requirements, OptumHealth should fully adhere to claim processing policies and requirements when VBH implements its new information system.

7. To enhance the effectiveness of communication activities, DBHS should require OptumHealth to hold monthly provider network meetings to allow providers to: (1) highlight their services, (2) provide updates on network changes, and (3) discuss and resolve issues and concerns presented by network providers.
PERFORMANCE AUDIT: EVALUATION OF BEHAVIORAL HEALTH SERVICES

8. To enhance program transparency, OptumHealth should redesign its website to facilitate the understanding of SLCO’s Medicaid enrollees and uninsured consumers on how behavioral health service delivery works, how to seek and become eligible for services, and to develop interactive features to help consumers make informed choices regarding provider selection. The website redesign should also serve as a comprehensive resource to existing and potential network subscribers by providing access to all related forms, tools, and instructions used to administer managed care requirements.

9. To facilitate communication regarding continuum of care, OptumHealth should include requirements in provider contracts to acknowledge receipt of step down information within 24 hours.

10. Now that DBHS is well into the transition, oversight activities should be refined by:
    a. Eliminating reports required of OptumHealth that DBHS no longer uses;
    b. Reducing the number of staff attending IT technology transition meetings;
    c. Enhancing audit tools by incorporating industry standard audit activities for MCOs, including conducting formal actuarial audits of IBNR, and performance audits of the referral processes;
    d. Formalizing guidance describing how communication shall occur among providers participating in County audits, and when DBHS should facilitate resolution of significant issues, such as access to treatment and service delivery.

11. To receive added assurance on whether SLCO’s Medicaid cost reports are reasonable, allocable, and allowable under Federal and State laws, SLCO should conduct its own independent and comprehensive program audit of its FY 2013 Medicaid cost report.

Matters for VBH Consideration

We encourage VBH to consider the following:

- Include OptumHealth Information Technology personnel in planning efforts for its new system implementation, and;
- Conduct an evaluation of its Intake Center business processes to verify prompt acknowledgement of admissions and discharge information.
Principal Results

Finding 1
DBHS, OptumHealth, and VBH All Monitor a Robust Set of Outcome Measures, but Could Benefit from Expanded Use of Evidence-based Consumer Outcomes

Measurements of behavioral health care should encompass clinical improvements, continuity of care, consumer and network satisfaction, and outcomes. Continuity of care refers to specific interventions performed by professionals that result in an outcome. Some examples of continuity of care are transfer of information, patient assessment, and development of a discharge plan. An “outcome” for mental health care is the effect on a consumer’s behavioral health status attributable to an intervention by a provider.

It is important to note that steps consumers take on their own behalf can influence outcomes, in addition to professional help, or even managed care. Clinical improvements are those numerous processes and linkages that affect the continuum of care, such as providing detailed instructions about follow-up visits or on medication utilization, following up on missed appointments, providing and preparing complete and up to date treatment records.

Generally, the type of measures tracked and monitored depends on the role and mission of the organization. For example, providers usually collect and analyze data on clinical improvement and continuity of care while managed care organizations track measures on network effectiveness. As shown in Table 1.0, VBH and OptumHealth track many of the same measures, but each collect and analyze more data than expected for their role, providing the County with an excellent opportunity to perform in-depth analysis about potential trends. The State of Utah requires monitoring of many of the measures, such as service delivery performance and customer satisfaction measures. We discuss later in this report the challenges of DBHS in analyzing the full range of data that it receives.

Table 1.0. Performance Measures Collected and/or Monitored

<table>
<thead>
<tr>
<th>Performance Category Measure</th>
<th>VBH</th>
<th>OptumHealth</th>
<th>SLCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer satisfaction *required consumer self-reporting</td>
<td>Monitor only</td>
<td>Monitors only</td>
<td>Monitors only</td>
</tr>
<tr>
<td>General satisfaction</td>
<td>✓</td>
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<td>✓</td>
</tr>
<tr>
<td>Positive service outcomes</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Social connections</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Improved functioning</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Wellness</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</table>
## Performance Audit: Evaluation of Behavioral Health Services

<table>
<thead>
<tr>
<th>Performance Category Measure</th>
<th>VBH</th>
<th>OptumHealth</th>
<th>SLCO</th>
<th>Monitors Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network Effectiveness</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals served</td>
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<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Claim processing satisfaction</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training quality</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Number of complaints</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Number of grievances and appeals</td>
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<td>✓</td>
<td></td>
<td>(collects)</td>
</tr>
<tr>
<td>Inpatient bed days</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Average length of stay</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Hospital inpatient days per 1,000 consumers</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Reductions in inpatient utilization</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Emergent services service delivery</td>
<td>✓</td>
<td>✓</td>
<td>(collects)</td>
<td></td>
</tr>
<tr>
<td>Urgent services service delivery</td>
<td>✓</td>
<td>✓</td>
<td>(collects)</td>
<td></td>
</tr>
<tr>
<td>Non urgent consults – service delivery</td>
<td>✓</td>
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<td>(collects)</td>
<td></td>
</tr>
<tr>
<td>Readmission rate</td>
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<td>✓</td>
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<td></td>
</tr>
<tr>
<td>Penetration Rate</td>
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<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Improvement</strong></td>
<td></td>
<td></td>
<td></td>
<td>Monitors Only</td>
</tr>
<tr>
<td>Quality and appropriateness of care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Timeliness of screening</td>
<td>✓</td>
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<td>✓</td>
<td></td>
</tr>
<tr>
<td>Audits (e.g. Medical Records/Documentation audits, compliance, contract, other special audit)</td>
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<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>MCOT program (consumer status outputs)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>FAST Program: Consumer status outputs (e.g. remained at home, went to foster care)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<tr>
<td>Reductions in inpatient utilization</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Broken Appointments (follow up tracking)</td>
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<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Continuity of Care</strong></td>
<td></td>
<td></td>
<td></td>
<td>Monitors Only</td>
</tr>
<tr>
<td>Participant in treatment planning</td>
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<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Treatment plan completion</td>
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<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Number of consumers waiting to enter treatment</td>
<td>✓</td>
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<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
PERFORMANCE AUDIT: EVALUATION OF BEHAVIORAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>Performance Category Measure</th>
<th>VBH</th>
<th>OptumHealth</th>
<th>SLCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions and discharges information</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Timely access to treatment</td>
<td>✓</td>
<td>✓</td>
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</tr>
</tbody>
</table>

Source of Data: TAP International analysis based on data collected and from interviews conducted at VBH, OptumHealth, and DBHS.

The most critical measurement for mental health services is whether a consumer receiving services is actually getting better. We evaluated the extent to which each of the entities - VBH, OptumHealth, and SLCO - measure consumer outcomes.

The State of Utah requires consumers to complete satisfaction surveys when receiving behavioral health services. The survey asked consumers about their progress at accomplishing well-being and living productive lives. VBH and OptumHealth reported the data is collected to comply with state reporting requirements. Our analysis of the survey data identified discrepancies that argue for the expanded use of specific evidence-based outcomes. For example, the survey data show the same outcome results from year to year, including the identical number of consumers taking the survey. For reporting purposes, however, we show the data on page 47 of this report and discuss the disadvantages of relying on consumer reported information.

VBH has taken steps to use a checklist designed to collect, in a more formal way, clinical outcomes when consumers receive treatment. VBH plans to use the data contained in the completed checklists to conduct advanced analytics to identify risk factors for consumers in treatment.

In addition, OptumHealth uses some evidence-based data, especially for measuring the rate of consumers return to care because of relapses in illness and for evaluating the success of new programs. OptumHealth desires to develop additional evidence-based outcomes to rate service providers. Ratings of provider effectiveness would facilitate consumers’ informed choices about the providers they select to receive treatment.

Finally, a growing trend in performance measurement is the use of clinician surveys. Clinician surveys can help identify trends in the nature or complexities of consumer cases as well as identify other types of barriers to effective treatment, such as specific treatment policies, and authorization for care policies. OptumHealth does not yet require its network providers to collect clinician surveys to measure clinician satisfaction. OptumHealth collects provider satisfaction information on its managed care administration activities, such as claim processing,
training, and communication. OptumHealth also holds provider network meetings, which provides another mechanism for raising potential issues about managed care administration.

Finding 2
Manual Processing of Third Party Liability Claims by OptumHealth Continues to Affect System Transition

Among other activities, OptumHealth is responsible reporting on the number of and type of services provided to eligible Medicaid consumers (“encounters”) to state agencies, reimbursing providers for authorized services provided to consumers, maintaining data regarding provider utilization, financial management, and monitoring consumer outputs and outcomes. To perform these activities, robust information management systems are necessary that comply with state and federal requirements governing managed care operations. When DBHS awarded the new MCO contract to OptumHealth, OptumHealth brought with them an information management system it uses in other counties – Avatar. Other behavioral health organizations also use Avatar to manage behavioral health services. DBHS suggested to OptumHealth that it utilize DBHS’s behavioral health system to manage services, but OptumHealth, alternatively, elected to use its own system. The Avatar system is particularly useful for encounter reporting. OptumHealth needed to configure the Avatar system to process and reimburse fee for service claims, and to process them according to the State of Utah regulations.

OptumHealth had a very short time frame to configure its Avatar system before it went live on July 1, 2011. While DBHS informed OptumHealth of the award of the contract nine months earlier, ¹ OptumHealth followed common contracting procedures and opted against starting resource intensive system configuration activities until contract negotiations were completed with DBHS in May 2011. Recognizing the limitations with configuring its system within six weeks, OptumHealth requested providers to submit claims manually for processing until electronic interfaces could be configured between the Avatar system and the provider’s system. The electronic interfaces would allow the electronic processing of claims. All, but one provider, VBH, agreed to submit their claims manually. VBH opted against manually submitting the claims because it did not have the staffing resources to prepare claims for the thousands of individual services provided to their clients. In FY 2013, VBH submitted about 70 percent of about 684,300 services billed for reimbursement by network providers.

Prior to going live, VBH and OptumHealth worked together to build the required electronic interface. Despite the efforts, multiple information technology issues subsequently occurred

¹ SLCO management said it met with both OptumHealth and VBH during this several month time period to discuss the specifications needed for the new system (Avatar).
because VBH’s system was over 20 years old and therefore, building an electronic interface to VBH’s aged operating system to OptumHealth’s newer system was difficult. In addition, OptumHealth did not have enough time to effectively test and configure its system for the electronic processing of VBH’s claims prior to going live.

OptumHealth and VBH each identified configuration errors with their systems. For example, OptumHealth discovered that Avatar’s system tables suppressed information on certain claims. VBH’s explanation of benefits showed the initial charge for the service, but the paid amount was not evident on the claim. OptumHealth officials explained that if the services were ineligible for reimbursement, then the explanation of benefit would show only the charge amount by VBH, thereby creating confusion and difficulties in reconciling claim information at VBH. Alternatively, when VBH received authorization for services by OptumHealth, VBH’s system did not map authorization numbers to the correct consumer. Issues with information mapping occurred as recently as February 2014, which triggered the rejection of claims by OptumHealth because of missing, incorrect, or expired authorizations. Because of VBH’s logic errors, OptumHealth manually corrected up to 26.7 percent of 22,083 claim lines submitted for reimbursement, as shown in Figure 2.0. In January 2014, the same logic error was likely responsible for contributing to 11.2 percent of the 3,558 services billed for reimbursement, as shown in Figure 2.1. VBH reconfigured its system to correct the problem and reported in March 2014 that claims now submitted to OptumHealth for processing should be problem free. However, for May 2014, an OptumHealth to VBH MH Cap Summary report shows that the value of claims that need reconciliation on missing authorization is at an all-time high at about $91,000. Prior to the VBH MH Cap Summary becoming available, OptumHealth had previously confirmed that VBH made substantial improvement in the level of clean claims submitted by VBH.
Figure 2.0. VBH Claims Processing Activities of Claims by OptumHealth, February 2014 (22,082 services billed)

- Services paid after the correction of errors: 26.7%
- Service denied for payment: 1.35%
- No corrections or adjustments required for services billed: 1.13%

Source of Data: OptumHealth Explanation of Benefits, file 6940

Figure 2.1. VBH Claim Processing Activities of Claims by OptumHealth, January 2014 (3,558 services billed)

- Services paid after the correction of errors: 11.23%
- Services denied for payment: 0.97%
- No corrections or adjustments required prior to payment: 19.95%
- Adjustments needed prior to payment: 47.80%

Source of Data: OptumHealth Explanation of Benefits, File 6665
In comparison with VBH, other large network providers did not experience the same level of claim processing issues. University Hospital (UNI Hospital), who provides behavioral health services for consumers in crisis and those who need inpatient hospitalizations, reported general satisfaction with OptumHealth’s claim processing activities. In FY 2013, UNI Hospital billed OptumHealth for about 27,700 services provided to SLCO’s Medicaid consumers. UNI Hospital submitted claims manually until OptumHealth configured an electronic interface. Similarly, the results of OptumHealth’s April 2013 provider satisfaction survey echoed similar results. As shown in Figure 2.2, 85 percent of providers surveyed voiced satisfaction with claim payment accuracy.

Claim processing problems could potentially happen again if VBH configures its new information system (planned for early 2015) without considering the entire interface and processing requirements of OptumHealth. While DBHS staff participated in the evaluation of the bid process for the new VBH software, VBH did not yet contact DBHS or OptumHealth as of May 2014 for business requirements gatherings, although system implementation is underway. Industry standards for new system implementation process include the identification of business requirements among an organization’s key customers.

While many of the IT technology issues between VBH and OptumHealth have been resolved, one IT technology issue remained that continued to affect system transition. Third party claims include a secondary insurer on Medicaid claims, such as Medicare. For these claims, OptumHealth must adjust the third party charge amount prior to issuing the provider’s payment. The Avatar system did not have the necessary technology to perform the required claim adjustments, requiring manual processing by OptumHealth that led up to eight months to complete processing of 9,200 such claims submitted by VBH in September 2013.
At the time of our review, OptumHealth staff explained that manual processing of third party claims would continue until OptumHealth implemented an update to its system. According to DBHS staff, however, the new update does not allow for the electronic adjudication of the claims, but in late May 2014, OptumHealth reported that the new update, My Avatar, does have the requisite functionality for Third Party Liability claim processing, which will be available as soon as testing is completed.

DBHS’s Director, in her comments on the draft report (see page 54), reported that as DBHS prepares for its procurement process to contract with a MCO beginning in calendar year 2016, the RFP is being released at this time so that the new MCO has approximately a year to prepare its IT system. The DBHS Director also said it has included a requirement in the RFP that the County must approve the IT system chosen by the new MCO to ensure its needs are met.
Finding 3
OptumHealth Conducts a Myriad of Outreach and Other Communication Activities, but Opportunities are Present to Enhance Communication Strategies

Communication activities administered by managed care organizations are essential for ensuring efficient and effective management of services and the delivery of services by providers. Providers need up to date information on changes in business processes with Medicaid and other program changes, and about modifications or additions to the type of services provided within the network.

OptumHealth facilitates interagency communication, among many other activities, by:

• Ensuring 24/7 access to the Program Director;
• Holding quarterly provider meetings although its execution is inconsistent because of staff turnover;
• Providing top-level attention to consumer complaints and concerns;
• Participating in monthly IT technology transition meetings;
• Holding meetings with the County and with VBH;
• Providing training to providers on claim preparation and processing;
• Providing training on clinical care strategies;
• Setting up of ad-hoc meetings with providers to discuss client care and access questions and issues;
• Assigning care advocates to facilitate the exchange of information between the consumer and the provider referring the consumer for services (or those to be received) upon their discharge; and,
• Attending health fairs and conducting other outreach activities in the community.

OptumHealth participated in a summit meeting in July 2013 with DBHS management to present its vision for behavioral health service delivery. At the time of our review, OptumHealth had not yet communicated its vision to network providers. The presentation outlined potential future activities in the areas of technology, performance, and services that network providers find useful in their own planning. OptumHealth officials reported plans to conduct additional outreach, but did not yet establish a rollout date.

In another area, DBHS’s website linking to OptumHealth’s website could benefit from updating. Websites we evaluated in other counties that offer behavioral health services provided greater transparency about how to access services and how to make informed choices when selecting a provider. For providers, these websites contained detailed information on the forms, guidance, and processes for members to effectively work within the network, even information about how
to use information systems like Avatar. OptumHealth has plans to update its website, but no date was available for its completion at the time of our review.

Finally, a long-standing communication issue continues to persist regarding inpatient admission and discharges. When providers refer consumers for admissions to UNI Hospital’s Wellness Recovery Center or to the Hospital, OptumHealth submits daily information to VBH about the consumer’s admission and pending discharge, followed by notification to the provider of the consumer’s actual discharge from inpatient treatment. UNI Hospital also has its own protocols for sharing admission and discharge data to VBH. VBH has expressed concern about the absence and, in some cases, limited notification made available to them about its consumers prior to admissions or discharge even though it has set up email and liaison communication points. As a result, UNI Hospital began sending reports to VBH’s Intake Center in conjunction with its reporting to the consumer’s clinician. However, VBH continued to raise concern about the absence of information. UNI Hospital set up additional communication protocols by sending a summary of all consumer information on a monthly basis to VBH.

To determine the extent of the communication issues in this area, we asked OptumHealth to track when providers did not acknowledge communication to them about admissions and discharges of their clients. For a three-week period in April 2014, providers took three days or longer to acknowledge information received for 20 percent of 46 clients stepping down from inpatient treatment, as shown in Figure 3.0. VBH had comparable results.

**Figure 3.0: Provider Acknowledgement of Consumer Step Down Information**

<table>
<thead>
<tr>
<th>Total Number of clients: 04/01-11/2014</th>
<th>Turnaround time from outreach to provider to return response, 0-2 days</th>
<th>Turnaround time from outreach to provider to return response, 3-5 days</th>
<th>Turnaround time from outreach to provider to return response, 6+ days</th>
<th>Unable to determine due to incomplete data</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>67%</td>
<td>11%</td>
<td>9%</td>
<td>13%</td>
</tr>
<tr>
<td>Discharge date to first outpatient appt. w/in 7 days</td>
<td>Discharge date to first outpatient appt. w/in 30 days</td>
<td>Unable to determine due to incomplete data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>78%</td>
<td>15%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Total Number of VBH Clients</td>
<td>Turnaround time from outreach to provider to return response, 0-2 days</td>
<td>Turnaround time from outreach to provider to return response, 3-5 days</td>
<td>Turnaround time from outreach to provider to return response, 6+ days</td>
<td>Unable to determine due to incomplete data</td>
</tr>
<tr>
<td>27</td>
<td>63%</td>
<td>15%</td>
<td>7%</td>
<td>15%</td>
</tr>
<tr>
<td>Discharge date to first outpatient appt. w/in 7 days</td>
<td>Discharge date to first outpatient appt. w/in 30 days</td>
<td>Unable to determine due to incomplete data</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: OptumHealth, May 2014.
OptumHealth officials acknowledged the efforts made by their community partners to ensure VBH is receiving requested information as available, but have recognized the opportunity to improve this process. At the time of our review, OptumHealth officials reported organizing a stakeholder meeting to identify communication flow between agencies, as well as, internally for any of the organizations at the table.

**Finding 4**

**VBH and SLCO have Realigned Services**

Behavioral health services provided among county programs generally include a wide range of services for adults, children, and families. Effective models provide services for a range of needs, including drug and alcohol abuse, assisted outpatient treatment, children and teenager mental health services, transportation services, consumer affairs, crisis and emergency services, supportive housing, mental health recovery services, early intervention services, inpatient services, consumer services, and medical management services. DBHS supports all of these services through OptumHealth’s contract and other vendor contracts.

Since the award of the MCO contract to OptumHealth in July 2011, VBH has eliminated and/or reduced six programs, as shown in Figure 4.0 below. One of these programs – respite services – was transitioned by VBH to another provider, per an agreement with the DBHS. Contracts used by OptumHealth and approved by DBHS require providers to provide mental health services, without specific provider requirements to guarantee service delivery during the contract period. While VBH eliminated and even reduced services, VBH added and expanded six services, mostly to address early intervention that would better align with its new consumer centric model of care.

DBHS, in coordination with OptumHealth, added and expanded eight services that address consumers in crisis, which closed a gap in services to SLCO Medicaid enrollees. UNI Hospital officials reported the new crisis programs led to savings of $3,110,027 for the first quarter of 2014 because of diversions from inpatient hospitalization and utilization of the Mobile Crisis Outreach teams, the Wellness Recovery Center, and the Receiving Center.
### Figure 4.0. Services Realigned by VBH and Salt Lake County

<table>
<thead>
<tr>
<th>VBH</th>
<th>Salt Lake County</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services added:</strong></td>
<td><strong>Services added</strong></td>
</tr>
<tr>
<td>• Assertive Community Treatment (ACT)</td>
<td>• Wellness Recovery Center, October 2012.</td>
</tr>
<tr>
<td>services for kids.</td>
<td>• Receiving Center, July 2012.</td>
</tr>
<tr>
<td>• School based services in nine schools.</td>
<td>• Mobile crisis teams, March 2012.</td>
</tr>
<tr>
<td>• Of a total of seven added to the</td>
<td>• Dedicated Warm Line, June 2012.</td>
</tr>
<tr>
<td>community, VBH added two family</td>
<td>• FAST Program - Afterschool program</td>
</tr>
<tr>
<td>resource facilitators to assist</td>
<td>administered by VBH to facilitate positive</td>
</tr>
<tr>
<td>families and youth in accessing</td>
<td>behavior among children.</td>
</tr>
<tr>
<td>appropriate mental health services,</td>
<td>• (ACT) for SPMI adults*.</td>
</tr>
<tr>
<td>which reduces use of emergency room</td>
<td></td>
</tr>
<tr>
<td>and inpatient mental health services.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Services expanded/modified</strong></th>
<th><strong>Services expanded/modified</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Wrap around services.</td>
<td>• Over 100 percent increase in number of providers.</td>
</tr>
<tr>
<td>• Increased capacity for Kids Intensive day</td>
<td>• Community Based Crisis Services for Latency Aged</td>
</tr>
<tr>
<td>services.</td>
<td>Children (planned for FY 2015).</td>
</tr>
<tr>
<td>• School based services in 31 schools.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Services reduced:</strong></th>
<th><strong>Service reduced:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduced 22 beds for day treatment.</td>
<td>• Facilities for inpatient treatment reduced from</td>
</tr>
<tr>
<td></td>
<td>three to two – University Hospital and</td>
</tr>
<tr>
<td></td>
<td>Pioneer Valley Hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Service eliminated:</strong></th>
<th><strong>Services eliminated:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• 12 Bed Transition for Alcohol and Drug</td>
<td>• 10 bed residential facility.</td>
</tr>
<tr>
<td>(integrated in 2011 to Day Treatment).</td>
<td>• 16 bed IPR residential facility.</td>
</tr>
<tr>
<td>• 10 bed residential facility.</td>
<td>• Therapeutic Foster Program (contract not extended).</td>
</tr>
<tr>
<td>• 16 bed IPR residential facility.</td>
<td>• Respite program (transferred to another provider).</td>
</tr>
<tr>
<td>• Therapeutic Foster Program (contract not</td>
<td>• Crisis line (transferred to another provider).</td>
</tr>
<tr>
<td>extended).</td>
<td></td>
</tr>
</tbody>
</table>

**Source of data:** TAP International analysis based on the QAPI plan for 2012 and 2013, and meetings with VBH and DBHS.

* OptumHealth staff reported a partnership with a provider to develop and implement an ACT Team as established by NAMI. The ACT Team will support those adults identified as high utilizers of inpatient and other services, and the Medicaid costs for these services has been substantial.
Positive impacts occurred because of the realignment of services. First, other providers within the Network experienced a substantial increase in their service delivery to Medicaid consumers served. As shown in Figure 4.1, about 7,400 consumers received services from providers other than VBH by FY 2013, a net increase of about 3,200 consumers.

**Figure 4.1. Medicaid Consumers Receiving Services by VBH and Other Providers, FY 2013 (not unique count)**

As shown in Figure 4.2, increases in services provided to SLCO’s uninsured population by other providers also occurred.

**Figure 4.2. Uninsured Consumers Receiving Services by VBH and Other Providers, FY 2013 (not unique count)**

Finding 5
VBH’s Business Practices are Consistent with a Company with Significant Budget Concerns

VBH, as a nonprofit behavioral healthcare provider specializing in mental health, substance abuse, and prevention services, serves adults, children, and seniors with locations across Salt Lake, Tooele, and Summit counties. VBH’s business practices are consistent with a company with significant budget concerns. The loss of funding at VBH after the award of SLCO’s MCO contract to OptumHealth had a significant impact at a time when the provider had on-going fiscal concerns. VBH’s fiscal strength continued to decline on all five fiscal indicators after the award of the MCO contract to OptumHealth.2

VBH recognized as early as CY 2008-09 that it needed to strengthen its fiscal health by changing operations. VBH had reduced residential treatment services to youth, offered early retirements to its employees, and curtailed new hires. VBH then took actions to implement large reductions in workforces that affected 260 VBH employees between CY 2010 and 2013, as shown in Figure 5.0.

Figure 5.0. VBH Staff Departures, CY 2010 to CY 2012.


Our fiscal analysis used VBH’s audited financial statements for CY 2010 and 2013 that consolidates financial data from VBH and all related entities. The fiscal ratios that were examined included profit margin levels, the amount of cash generated from rendering services, the ability to pay short-term liabilities, the level of short-term assets to pay liabilities, and the number of days cash is on hand to pay current bills.
Cost-cutting activities continued throughout the audit period for this review - FY 2010 through FY 2013, such as:

- Selling property to offset operating expenses;
- Implementing hiring freezes, and requiring multiple authorizations for new hires;
- Monitoring of purchases;
- Meeting monthly with agency staff to review and discuss budget versus actual expenditure reports, and to develop strategies to strengthen operating margins among individual programs;
- Reducing travel, consulting, and other expenses; and,
- Implementing an Action Plan calling for 39 initiatives across four operational functions—clinical improvement, regulatory compliance, financial management, and customer satisfaction—to strengthen revenue collection, consolidate positions, implement IT strategy planning, implement a quality assurance program to ensure compliance with regulatory and other contractual requirements, and address pension cost issues with State agencies.

VBH also initiated revenue generation activities that included setting productivity standards among employees and implementing a continuous process improvement program to ensure staff complete required information for claim submissions.

VBH initiatives to strengthen its fiscal health led to cost savings for the business entity in nine of the 12 key expenditures we analyzed. Expenditures declined from as low as 4 percent to as high as 42 percent between CY 2010 to CY 2012. In total, VBH reduced operating costs by $16.7 million to help offset the decline of revenues of about $28.9 million.

VBH sought additional assistance from DBHS and OptumHealth to provide further assistance in offsetting funding gaps prior to their transitioning of clients to other providers. Because DBHS was concerned about VBH’s fiscal strength, DBHS responded by offering supplemental assistance through a special reserve account and offered VBH opportunities to administer other services, some of which VBH declined because the contracted rate did not pay the anticipated cost of delivering services. DBHS also requested that OptumHealth minimize cutbacks in funding for VBH. Further, OptumHealth implemented initiatives to support VBH that a MCO would not otherwise perform. These initiatives include manually reviewing claims that would otherwise be denied for payment (due to discrepancies in claim information), and including VBH as one of three referral sources for consumers requesting services although the consumer may not exhibit the behaviors VBH is designed to treat – the severely and persistently mentally ill. OptumHealth also refers Medicaid consumers discharged from the Wellness Center to VBH. OptumHealth’s support continues presently.

Despite the efforts made by each of the three entities, VBH could not close its revenue and spending gap. Based on our analysis, VBH’s financial position could not sustain further funding
cuts without transitioning consumers to other providers. When SLCO requested an across the board 4.9 percent rate cut across the provider network to offset anticipated FY 2013 budget deficits, the loss in further revenue would have further eroded VBH’s fiscal health. Although VBH planned for the transition of consumers to other providers, the 4.9 percent rate cut hastened the execution of those plans.

By early Summer 2013, VBH publicly announced the transition of 2,250 consumers. Although OptumHealth and DBHS management were previously aware of VBH’s plan to transition consumers to other providers, as documented in the County’s 2012 QAPI plan, each entity reported surprise at the public announcement and on the number of consumers affected by the transition, especially when VBH management met with each entity just prior to the announcement. VBH identified the number of consumers potentially affected based on a quantitative projection considering the cost to treat consumers and the anticipated loss in funding.

VBH management explained the public announcement was in response to its frustration over the failure of a pilot program designed to transition selected consumers coupled with the absence of formal response on letters sent to the entities addressing VBH’s budget issues. VBH previously discussed with OptumHealth the development of a pilot program that would transfer 35 VBH consumers, who primarily needed medical management outpatient services, to other providers. OptumHealth’s clinical guidelines promote this process of step down to primary care once a person has demonstrated success in treatment. VBH clinic management explained that by transitioning consumers that need lower levels of care, VBH had a better ability to accept new consumers for treatment, providing a balancing effect on the number of consumers entering treatment and transitioning from treatment. After VBH worked directly with Pioneer Valley Hospital to develop a transition strategy, VBH contacted OptumHealth who provided assistance in preparing a letter to the affected group. The letter to consumers described the circumstances for the change and the procedures for the transfer. DBHS was notified of the plan, and subsequently notified the State’s Medicaid office. According to VBH, the State’s Medicaid Office raised concerns about the transition, explaining VBH could best serve the affected consumers. VBH officials opted against going forward with the pilot program in the absence of key stakeholder support. Therefore, VBH management explained the intent of the public announcement was to attract the attention needed to force the transition of consumers from its program so VBH could concentrate on what it believes it does best – serving the persistently and mentally ill population.

DBHS management, however, questioned VBH’s decision to transition consumers because at the time of the announcement, VBH was under spending on its Medicaid budget allocation. However, the spend levels at that time were not fully accurate. VBH management and staff reported not all services rendered were billed for reimbursement and our analysis of claims
identified services rendered in FY 2013 and even FY 2012 that were not submitted for reimbursement until January 2014, which would have affected spend levels reported during that time. VBH continues to strengthen its billing processes to ensure invoicing of services rendered.

The transfer affected 733 consumers. VBH clinic directors identified the consumers by performing multiple reviews of case files using criteria established by the team, such as assessing the acuity needs of the consumer and past treatment history. Additionally, the consumers had to show some level of progress. Nearly all of affected consumers received medication management services at VBH, which other providers within the network offered.

To execute the large transfer of consumers, VBH initially prepared an original letter to send to the consumers, which provided explanation of the change and recognized their progress in recovery. However, DBHS staff expressed concerns about the content of the letter and sent the letter to the State Medicaid’s Office for review and comment. The State Medicaid’s Office reported the letter was too lengthy and required its issuance in plain language. Subsequent revisions between the State and DBHS inadvertently changed the tone of the letter, which suggested to the affected consumer that his/her recovery process was complete. OptumHealth and VBH staff each expressed their concerns about the stress caused among consumers from the revised letter. Some VBH staff reported receiving many complaints from their clients but other clinicians, including OptumHealth staff, reported receiving few complaints. To aid in the transition, OptumHealth issued a supplemental letter describing the next steps for the consumers and handled the transition of all of the affected consumers. Some of the affected consumers appealed the transfers and VBH allowed 15 consumers to return for services. However, OptumHealth documentation shows another 33 consumers who were not on the original list contacted OptumHealth after receiving word via an appointment or over the phone by VBH of the need to transition to other providers.

The awkward execution of the consumer transition appeared to have an adverse impact on VBH’s referral levels. The level of consumers contacting VBH for services and the number of referrals VBH received from other providers declined because, according to OptumHealth officials, the transition created the perception among the community at large that VBH was at full capacity and could no longer accept clients. OptumHealth officials explained that this perception remains today among SLCO’s Medicaid consumers.

VBH’s effort to improve their fiscal strength continues. VBH would like to receive additional referrals from UNI Hospital, but Hospital officials reported referrals of their patients to providers would continue to be to providers who can best address patient needs, which has been a long-standing policy. Hospital officials reported excellent relationships with all of their providers, including VBH, and that all deliver valuable services.
Finally, despite the impacts on VBH from budget reductions and other cuts, the cuts have prompted other network providers to offer services at reduced costs. OptumHealth and DBHS officials explained providers within the network in FY 2012 and FY 2013 expressed a willingness to take on additional services, with the market reducing gaps in services.

Finding 6
OptumHealth is Operating with Appropriate Business Practices to Achieve Administrative Savings without Sacrificing the Quality of Care Offered to Consumers

OptumHealth is operating with appropriate business practices to achieve administrative savings without sacrificing the quality of care it offers to consumers. OptumHealth administers DBHS’s mental health services program with 34.5 Full Time Equivalents (FTEs) variously comprised of professionals with prior managed care experience and specialized experience in other areas, such as clinical care and regulatory compliance. Some of the staff are former VBH employees. Other counties with similar size programs have twice the staffing levels to manage behavioral health services. With OptumHealth’s staffing level, optimal functioning and productivity among staff is required.

If OptumHealth’s staffing levels were insufficient and affected the effectiveness of network administration, it would be evident in the number of complaints, grievances, and appeals addressed by DBHS. However, OptumHealth received 47 general complaints in FY 2013 among about 16,500 consumers, but many of these complaints were related to network providers. When we examined the number of grievances filed against OptumHealth, there were even fewer grievances. For appeals, DBHS generally upheld decisions by OptumHealth concerning care, providing evidence OptumHealth is generally applying, in a consistent manner, Level of Care guidelines and other policies and procedures.

We examined whether OptumHealth had financial incentives to achieve administrative savings that would affect the quality of services authorized for consumers during the course of our review. Public stakeholders have raised concerns that consumers are not receiving all of the treatment afforded to them. However, DBHS’s contract with OptumHealth imposes a ceiling that caps the amount of revenue OptumHealth can spend on administration and imposes limits on profit margins. Specifically, DBHS retains 1 percent of available revenue and restricts funding to OptumHealth to an amount equal to 14 percent of the behavioral health services budget for administration and profit margins. DBHS requires OptumHealth to spend the remaining 85 percent of available revenue on consumer services. As a result, OptumHealth is contractually prevented from accomplishing administrative savings or additional profits at the expense of consumers’ quality of care. In FY 2013, OptumHealth suffered program losses of about $3.3 million. For FY 2014, OptumHealth has incurred about $2 million in program losses through
April 2014. DBHS’s contract with OptumHealth fully protects SCLO from absorbing cost overruns.

Finally, we assessed whether efforts by OptumHealth to gain performance incentives had adverse impacts on consumer services. SLCO allows OptumHealth to receive financial performance incentives for the delivery of key goals and expectations. In FY 2013, the County determined that OptumHealth did not qualify for some incentives that led OptumHealth to forfeit $571,000. The failure to accomplish the goals did have an adverse impact on achieving added efficiency and effectiveness in service delivery. For example, OptumHealth did not demonstrate further reductions in new arrest/recidivism during and post treatment, or a 25 percent increase in employment and permanent housing at discharge. In addition, OptumHealth did not fully accomplish all of the activities regarding the development of a billing model that captures all billable Medicaid encounters, clinical redirect costs for both the Mobile Crisis Outreach Team and the Receiving Center, or submit encounter data to the State that provides a 99 match to the State encounter data. OptumHealth had a 91.5 percent match because of system issues as well as factors outside of OptumHealth’s control.

Finding 7

DBHS is Operating with Appropriate Oversight, but Some Changes are Necessary

SLCO, serving as the Local Substance Abuse and Mental Health Authority, is legally required to perform a number of activities, including, but not limited to the following:

- Review and evaluate treatment needs and services;
- Annually prepare and submit to the State of Utah a funding and service delivery plan;
- Provide services;
- Establish and require contract providers to establish administrative, clinical, procurement, personnel, financial, and management policies; and
- Establish mechanisms allowing for direct citizen input.

OptumHealth fulfills these legal requirements with DBHS providing day-to-day oversight of OptumHealth to ensure contractual compliance.

Prior to the award of the MCO contract to OptumHealth, DBHS conducted limited oversight of VBH when it administered the MCO contract. Activities included attending VBH Board meetings, conducting an annual review, and requesting quarterly reports. DBHS began to increase its oversight activities when it consolidated mental health and substance abuse services, culminating in a new oversight role with the award of the new MCO contract. DBHS, among other activities, processes all appeals, reviews provider contracts, and prepares...
Medicaid cost reports. In addition, DBHS added requirements for OptumHealth to submit dozens of reports, participate in DBHS planning meetings, conduct community outreach, and provide some evidence-based measures of network effectiveness and consumer outcomes. All of the new oversight activities and contractual requirements imposed on OptumHealth substantially increased transparency and accountability of the mental health services program, which were noticeably absent when VBH administered the MCO contract.

In addition to overseeing contractual compliance, DBHS actively participated in resolving MCO transition issues regarding technology, communication, and referrals and authorization. DBHS officials explained close oversight was required given the lessons learned from other counties who underwent transitions to a formal managed care model. The close oversight continues three years into the contract award.

While the oversight provided by DBHS has substantially improved, the level of oversight and involvement could be refined in the following areas:

- Given that IT technology issues are nearly resolved, monthly IT meetings no longer require the current high levels of participation by DBHS management unless other IT technology issues emerge stemming from VBH’s new system implementation scheduled to go live by April 2015.

- DBHS has over formalized its oversight by requiring too many reports by OptumHealth that DBHS cannot fully analyze or utilize without assigning additional resources.

- There is no clear criteria established which would guide providers on when it can elevate issues to the County for resolution if efforts with OptumHealth are unsuccessful.

- While DBHS has borrowed audit guidelines from the State and OptumHealth’s parent company, United Health, to support its oversight activities, DBHS should better structure audit guidelines to test the accuracy of estimated reserves to pay outstanding claims, encounter reporting, evidence based outcomes, and information systems.

- OptumHealth and VBH both reported the need for DBHS to provide greater clarity in its communication regarding its audits. For example, in DBHS’ 2014 annual audit of OptumHealth, DBHS extended the scope of work to review data maintained by network providers, but VBH reported general confusion among the DBHS’s auditors visiting the provider to review records. VBH sought clarification with OptumHealth about whether the auditors were auditing VBH or OptumHealth.
Network providers report that DBHS needs to become more involved in resolving complex access issues with other state agencies. For example, UNI Hospital officials reported that one consumer had a stay of 100 days at the Hospital while waiting for a SLCO funded bed at the State operated mental health hospital, which led to the write-off of $277,000 in charges. OptumHealth payment policies limit reimbursement to 10 days. For that consumer and others, OptumHealth and UNI Hospital have worked to transfer the consumers, but Hospital officials reported DBHS could resolve issues quicker by facilitating interagency communication.

OptumHealth could also use the assistance of DBHS to resolve access to complex treatment issues whenever a consumer is too violent for a provider to serve. While VBH has expertise in addressing the needs of the severely and persistently mentally ill, it does not have the entire physical infrastructure necessary to address an extremely violent consumer. While at least two of VBH’s facilities have monitored parking lot surveillance and a security guard on duty, none of VBH’s facilities has emergency panic buttons, secured check-in and checkout, or the requisite video equipment necessary to provide a fully safe environment for its employees who treat consumers with violent and criminal pasts. At the time of our review, VBH was conducting facility security surveys to identify the extent of their needs.

We examined DBHS activities regarding preparing and submitting Medicaid cost reports, also known as Mental Health Substance Abuse Capitated Financial Reports (MHSACAP). DBHS relies on the State of Utah to implement agreed upon procedures reviews to verify the accuracy of the cost reports, and therefore, does not perform an independent program audit. Independent program audits of the cost reports are customary in other states because the results of the report drive Medicaid funding levels and matching funding requirements. DBHS has had to request extensions or submit revised reports to State agencies because of data accuracy issues stemming from provider information, or lack thereof.

Finally, we analyzed SLCO’s governing structures in comparison with three counties located in California to determine whether citizen engagement occurs as required by SLCO statute. SLCO’s Citizen Advisory’s Committee has a 16-member council comprised of care providers, consumers, professional behavior health associations, and representatives from the police department and county jail. Behavioral Health Commissions and/or Committees in the three comparison counties show expanded structural composition and size. Members of other county commissions and committees include representatives from legal aid societies, family members of consumers, community residents, and county behavioral services officials. Officials in the three counties, where up to 30 members are included on the committees, explained that because behavioral health needs are community wide issues, receiving input from as many
stakeholders as possible informs the decision-making on budget priorities while critically facilitating transparency and accountability. They also noted their committees provide a balanced perspective on service delivery needs. DBHS management shared a perspective that the current Committee structure is consistent with County statute.

**Finding 8**

**SLCO’s Current Behavioral Health Service Delivery Model Shows Positive Attributes and Opportunities for Continuous Improvement**

At the request of SLCO, we evaluated the strengths and weaknesses of the following seven key components of SLCO behavioral health service delivery model:

1. Staffing levels;
2. Provider payment policies;
3. Reserve fund levels;
4. Treatment policies;
5. Perceived cost savings;
6. Performance; and,
7. Service delivery.

**1. Staffing Levels**

New staffing capabilities provided by the network have allowed DBHS to reduce its reliance on one primary provider. As shown in Figure 5.0, VBH had 30.9 percent of the entire share of staffing capability throughout the network in 2011 among various positions that declined in current ranges of 11.7 percent and 55.3 percent by 2013.
Figure 5.0. VBH Share of Staffing Capability with SLCO’s Outpatient Provider Network, Pre OptumHealth Award (2011) and Post OptumHealth Award of the MCO contract (2013)

As shown in Figure 6.1, a key need in staffing capability is the use of peer advocates and peer support specialists throughout the provider network. A peer advocate is a person who has self-identified as having received or is presently receiving behavioral health services in personal recovery and has undergone certification training by the State of Utah on how to assist others in recovery and resiliency. Under general supervision, a certified peer specialist performs a wide range of tasks to assist individuals to regain control over their lives and their own recovery process. A peer specialist is a model for personal recovery and ongoing coping skills. While open recruitment activities take place, insufficient levels of peer advocates persist, according to VBH and OptumHealth officials. Upon recruiting potential candidates, delays occur in their certification because the State of Utah has not offered the training for over a year.

Figure 6.1. Summary of Staffing Issues

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Potential Areas for Continuous Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>OptumHealth utilizes corporate resources when necessary to support operations across nine business areas. For example, OptumHealth has provided a team of claim examiners to process third party liability claims.</td>
<td>The provider network needs additional peer specialists. Other than VBH, few providers have the teams necessary to serve the severely and persistently mentally ill.</td>
</tr>
</tbody>
</table>
OptumHealth has significant resources, 26 percent of 34.5 Full-Time Equivalents (FTEs), dedicated to clinical operations.

OptumHealth has a Resiliency and Recovery Manager to advocate that recovery is possible, providing examples of recovery and hope.

VBH has multidisciplinary personnel and expertise to address the severely and persistently mental ill population despite a lack of choice among providers that address high acuity needs.

Reductions in Force activities administered by VBH in 2012 and 2013 did not appear to affect consumer outcomes. Consumer reported levels of wellness and improved functioning remained about the same during the time period.

2. Provider payment policies

DBHS established requirements for OptumHealth to follow for the reimbursement of covered benefits. A notable feature includes the requirement to reimburse contracted providers of covered services within 20 days of receipt of clean claims (a “clean” claim is a form of an invoice without discrepancies). A special nuance in the requirement is that DBHS allows OptumHealth to issue monthly payments in advance of the services provided to County consumers. The monthly payments, spread across 12 months, equal the total budget allocated to the provider. Unlike capitation models, where providers can keep unexpended funds, SLCO’s providers must return fiscal surpluses for use on behavioral health services. If providers do not spend the full amount of funds allocated to them, the providers run the risk of budget cuts for the subsequent year. In addition, at year-end, when OptumHealth reconciles the amount paid to the providers against the services rendered by them, a one-time adjustment of monthly payments occurs so that OptumHealth can recoup the unspent Medicaid revenue.

DBHS wanted to implement a fee for service model whereby services are reimbursed as services are incurred, but when OptumHealth was awarded the MCO contract, DBHS applied lessons learned from counties located in other states that transitioned to managed care models. Those lessons called for providing payment advances to help mitigate the cash flow issues that could result from late reimbursement of services under a fee for service model. With the monthly payments, OptumHealth uses the claims submitted for services rendered to offset...
against amounts already paid, and to report on encounters. Encounter data covers Medicaid enrollees, including information on both their eligibility and their behavioral health care claims, providing detail, as previously described, about the consumer’s engagement with the provider network, such as clinic visits or drug prescriptions. One downside to the monthly payments is that it restricts the ability of OptumHealth to utilize unused funds to expand or develop new covered services. OptumHealth staff report that the MCO now performs more frequent payment reconciliation with the providers.

We examined the under spend/overspend status for VBH. As shown in Figure 7.0, OptumHealth reports VBH had unexpended funds of about $1.7 million through April 2014. This figure is without considering items requiring reconciliation. When factoring in reconciling items such as resolving claims with missing authorizations, processing of third party claims, and other items, the amount of unexpended funds is lower, to about $956,000.

While VBH had an underspend at the time of report issuance, it is important to note that under the VBH’s contract with OptumHealth, if the agency overspends on certain line items on their budget, such as psycho-educational services and mental health services providing personal care, VBH will not receive additional reimbursement. Through April 2014, VBH overspent on these line item budgets by about $344,000. VBH’s contract with OptumHealth does not allow the agency to manage against total budget allocations. When OptumHealth reported net savings in FY 2012 and had the revenue available, OptumHealth staff explained that DBHS relaxed the requirements to prohibit reimbursements when providers exceeded individual budget allocations.

DBHS, in its comments to this draft report, reported that because VBH will underspend on its budget for FY 2014, VBH would have its FY 2015 budget reduced. VBH management explained if further budget reductions occur stemming from the under-spend levels, it might affect again their ability to maintain its level of service. VBH management said OptumHealth should factor in the level of VBH encounters for the last quarter of FY 2014 when OptumHealth sets the provider’s budget for FY 2015. OptumHealth staff explained that VBH tends to have more encounters in the month of May with offsetting levels in June due to seasonality.
### Table 7.0. VBH Budget and Expenditure Variance through April, FY 2014

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Jul-13</th>
<th>Aug-13</th>
<th>Sep-13</th>
<th>Oct-13</th>
<th>Nov-13</th>
<th>Dec-13</th>
<th>Jan-14</th>
<th>Feb-14</th>
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<td>TPL (@ Optum Rates)</td>
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<td>1,925,526</td>
<td>19,255,260</td>
</tr>
</tbody>
</table>

Source of Data: Report received from VBH, OptumHealth VBH MH Cap Summary

Note: The data in the data is unaudited.

As shown in Figure 7.1, another key strength of provider payment policies is that DBHS retains the authority to resolve appeals raised by providers on the amount of charges paid or not paid by OptumHealth. While OptumHealth would like to administer the dispute process, DBHS officials explained they are in better position to evaluate the disputes fairly and independently. DBHS generally upholds most of the payment decisions made by OptumHealth, an indicator of the soundness of the MCO’s implementation of payment policies. DBHS’s role to resolve appeals is well within the type of oversight expected from SLCO.
Figure 7.1. Summary of Payment Policies and Activities

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Potential Areas for Continuous Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The County’s approach to require OptumHealth to provide progress payments to its primary providers before rendering services mitigated potential financial risks during the transition.</td>
<td>OptumHealth provides unused Medicaid dollars before they are actually needed, hampering the ability of OptumHealth to provide or expand services that are needed within the network.</td>
</tr>
<tr>
<td>When providers dispute payment decisions by the OptumHealth, the County administers an appeals/dispute process. Analyzing the rate at which the County overturns provider payment decisions by OptumHealth is one key indicator of the effectiveness of payment policies. In FY 2012 and FY 2013, the County upheld up to 90 percent of all units/days disputed regarding reimbursement.</td>
<td>While the use of progress payments ensures advance payment of Medicaid services provided to consumers and helps OptumHealth from overspending on the County’s budget, the reconciliation process for FY 2012 continues for key providers. There are no contractual requirements governing the timeliness for completing the reconciliation.</td>
</tr>
<tr>
<td>Fifty-eight percent of the disputes from last year are from providers outside of the network who may not fully understand the County’s payment policies for reimbursements.</td>
<td></td>
</tr>
</tbody>
</table>

3. Reserve fund policies

Managed care organizations generally use a reserve fund to pay fee for service providers on outstanding claims. The reserve fund, known as Incurred but Not Reported Reserves, or IBNR, serves as a critical financial management activity and reflects the amount expected to be paid on claims that have not yet been submitted for reimbursement by providers. IBNR methodologies are used as a tool in establishing IBNR reserve fund levels, with the calculations for anticipating the outstanding payments for inpatient, outpatient, and substance abuse services applied to fee for service network providers. Because OptumHealth cannot know in advance the precise number of claims to expect from network providers, the IBNR is an estimate.

As shown in Table 8.1, OptumHealth uses industry standard methodologies to estimate its IBNR reserves. OptumHealth considers up to 18 months of historical claim activity, excluding minimum and maximum amounts paid, and adjusts for seasonality. As shown in Figure 8.0 below, the IBNR estimates were lower for FY 2012 in comparison to FY 2013 because FY 2012 was the first year of the new MCO contract and OptumHealth could not consider a full 18-
months of claim activity. By FY 2013, OptumHealth had more claim activity to make IBNR projections, and thus the higher level of reserves set aside.

According to DBHS staff, IBNR estimates remained insufficient contributing to difficulties in preparing accurate Medicaid cost reports. IBNR estimates are heavily influenced by an analysis of a complete claim universe. If providers fail to bill for the services or submit claims more than six months after fiscal year end, these claims are not factored into the IBNR estimates, thus contributing to lower reserve levels. Also, the information technology sharing complications between OptumHealth and VBH likely influenced the IBNR estimates earlier in the transition because OptumHealth could not capture a full accounting of claim activity. By FY 2014, IBNR estimates were higher, as expected, because OptumHealth considered 18 months of historical claim activity in its estimate.

Having accurate IBNR estimates is important to avoid underfunding and overfunding of reserves and to ensure that funds are available when claims are submitted for reimbursement for fee for service providers. DBHS reviews OptumHealth’s IBNR estimates, but formal actuarial audits are not undertaken during its annual contract compliance review. Such audits, performed in accordance with all applicable Actuarial Standards of Practice, as issued by the Actuarial Standards Board, specifically standards for Incurred Health and Disability Claims are standard practice by oversight agencies of managed care organizations. DBHS management plans to support OptumHealth’s efforts to place more providers under contracts rather than administer services under a fee for service model, which will reduce the reliance on having accurate IBNR estimates.

Figure 8.0. OptumHealth’s Estimates to Pay Outstanding Claims

Source of Data: OptumHealth, April 2014.
Figure 8.1. Summary of Reserve Funds Issues

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Potential Areas for Continuous Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>OptumHealth uses industry standard methodologies (Completion Factor Method and PMPM Seasonality Method) for estimating reserve levels.</td>
<td>OptumHealth’s potential liability amounts for outstanding claims have increased, showing providers have been slow in submitting claims for reimbursement or encounter reporting.</td>
</tr>
<tr>
<td>Increasing reserve fund levels appears to demonstrate increased accuracy in their development of reserves as additional claim history becomes available.</td>
<td>Early IBNR estimates influenced Medicaid losses of up about $1.9 million in FY 2013.</td>
</tr>
</tbody>
</table>

4. Effectiveness of Treatment Policies

OptumHealth uses Level of Care Guidelines to facilitate the management of care provided to the County’s consumers. The Level of Care Guidelines identify the covered services that require pre-authorization, describe the process for authorizing treatment, and establish criteria for clinical operations of OptumHealth to follow when setting the parameters for the services to be delivered by the provider. For example, treatment policies govern whether the consumer should be authorized for 24-hour inpatient hospitalization or a three-day inpatient admission, depending on the consumer’s behavioral health needs. The Level of Care Guidelines incorporates leading practices in behavioral health treatment.

A key indicator about the effectiveness of treatment policies is evaluating the level of grievances filed against OptumHealth by consumers. In FY 2012, DBHS received a low level of consumer grievances regarding the quality of care received. Of the 12,031 consumers served in that year, .001 percent of the grievances filed were against OptumHealth. Our scope of work did not include an evaluation of whether consumers were aware of the SLCO’s grievance process, but we noted that VBH, when it administered the MCO contract, received a higher number of consumer grievances concerning the quality of care.
Figure 9.0. Summary of Treatment Policies Issues

<table>
<thead>
<tr>
<th>Key Strengths</th>
<th>Potential Areas for Continuous Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>OptumHealth follows <em>Level of Care Guidelines</em> established by the County when authorizing treatment, which was not always consistent prior to the awarding of the new MCO contract.</td>
<td>Network providers have expressed concerns about “after hours” services provided by OptumHealth.</td>
</tr>
<tr>
<td>Analysis of consumer grievances filed in 2012 - the first year of the transition- showed few complaints about the quality of treatment. Consumers filed 20 grievances of the 12,031 consumers served.</td>
<td>OptumHealth has a current practice of utilizing staff working in locations outside of Utah to provide referral and authorization services. Noting local clinical operations staff has a better understanding of its enrollees’ needs, providers offered the suggestion for OptumHealth to return to its prior practice of providing “after hours” services at its SLCO office.</td>
</tr>
<tr>
<td>SLCO closely monitors effectiveness of treatment policies.</td>
<td>A separate review would be needed to determine the level of disparities in providing authorization services outside of SLCO, but given the low levels of provider and consumer complaints within the network, there does not appear to be high probability that significant problems would be found.</td>
</tr>
<tr>
<td></td>
<td>In DBHS’s annual review of OptumHealth, DBHS found that OptumHealth had inconsistent interpretation and understanding of the definition for “medically necessary”, which can lead to denials in authorizing care. There was insufficient evidence available to determine the extent of the impact on the quality of care, but DBHS has received few provider grievances against OptumHealth on this issue.</td>
</tr>
</tbody>
</table>

5. Perceived Cost Savings
In FY 2013, OptumHealth contracted with its provider network to provide $56 million in services for Medicaid enrollees and uninsured residents, an increase from the prior year level of about $6 million. To determine whether surpluses occurred, we examined MHSACAP (Medicaid) cost reports for gains and losses reported to the State of Utah. For FY 2012, SLCO reported about $5.3 million in Medicaid gains (unexpended revenue). Because OptumHealth forecasted surplus in FY 2012, SLCO used the available revenue through the County Offender Reform Act (CORA) account to fund crisis services. According to DBHS management, DBHS has the option to transfer surpluses to this fund account. The CORA account, a notable feature in comparison to other public agencies, provides a dedicated funding stream for facilitating the movement of consumers from jail to community treatment providers, and allows DBHS flexibility to support and/or expand behavioral health services. In FY 2012, DBHS did not expend CORA funds for behavioral health services. However, DBHS paid to VBH and UNI Hospital over $2.2 million in FY 2013 to support existing and new services, as shown in Figure 10.0. The payments provided to VBH by DBHS shows how DBHS has worked with VBH to help sustain its operations since the award of the MCO contract to OptumHealth.

The surpluses reported for FY 2012 might not be fully accurate because OptumHealth continues to reconcile services administered by providers against amounts paid to them. In addition, during FY 2012, VBH was in the process of strengthening its billing processes and acknowledges that all of the services were not billed, leading to additional uncertainty about the level of actual savings reported for that year. However, because the new crisis services offered led to program cost savings by diverting consumers from more expensive inpatient treatment, the overall savings level could be insignificant, but more study in this area is needed after all FY 2012 reconciliations with providers are complete.

We examined the potential for savings in FY 2013 and FY 2014 savings. For FY 2013, SLCO reported a $1.9 million deficit in Medicaid funding for behavioral health services. As of May 1, 2014, OptumHealth reported a $2 million program deficit. OptumHealth must absorb the program losses, as required by its contract with DBHS.

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**Figure 10.0. CORA Payments for Behavioral Health Services, FY 2012, and FY 2013.**

<table>
<thead>
<tr>
<th></th>
<th>FY 2012</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORA Funding for University Hospital Programs</td>
<td>$0</td>
<td>$1,972,976</td>
</tr>
<tr>
<td>CORA Funding for VBH Programs*</td>
<td>$0</td>
<td>$259,047</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$2,232.023</td>
</tr>
</tbody>
</table>

Source of Data: Salt Lake County Behavioral Health Services, April 2014.

*OptumHealth MH Cap Summary reports show net cash payments of about $759,000 to VBH from the CORA account for FY 2013.
PERFORMANCE AUDIT: EVALUATION OF BEHAVIORAL HEALTH SERVICES

Figure 10.1. Summary of “Perceived Savings” Issues

<table>
<thead>
<tr>
<th>Key Strengths</th>
<th>Potential Areas for Continuous Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The County has a noteworthy practice in establishing the CORA account to place unexpended funds to address network and provider needs. SLCO uses unexpended Medicaid funds to develop new mental health programs to provide more cost effective services for County consumers, closing the gap on unmet needs.</td>
<td>The unexpended funds transferred to the CORA account were not likely “true” program savings because reconciliation between amounts paid and services provided are ongoing for FY 2012 among key providers within the network. Therefore, any perceived savings reported may not be accurate. Further analysis is needed upon completion of all provider reconciliations.</td>
</tr>
</tbody>
</table>

6. Performance measurement

The National Alliance on Mental Health (NAMI) reports a major concern of the behavioral health treatment community is absence of coordination in implementing measures, as well as a process that frequently excludes critical measurement components. NAMI advocates any set of performance measures should be able to address, at a minimum:

- Whether or not consumers are receiving the services they need;
- That the services provided meet the consumer’s needs;
- Whether consumers are actually getting better; and,
- Whether resources are used efficiently.

We previously described in this report that OptumHealth, VBH, and DBHS are all collecting key data, primarily outputs, regarding behavioral health services. Our analysis of actual performance among 18 measures shows improvement among nine areas, especially among network effectiveness, as shown in Table 11.0.

Since 2010, there was no change in performance in four areas, especially among three areas that show whether consumers are actually getting better. It is important to note the results are based on consumer reported information. The State of Utah requires consumer reported information on eight key mental health outcomes that include general satisfaction, good service access, quality and appropriateness of services, participation in treatment, treatment planning, positive service outcomes, social connectiveness, improved functioning, and wellness. However, primarily relying on consumer reported information presents a set of complexities for program administrators because the information does not control for self-help activities of the
consumers and treatment strategies could include a mixture of provider interventions, managed care services, or other types of services. Without the use of other advanced data analysis to assess consumer outcomes, decisions on where to make program improvements become difficult.

OptumHealth, VBH, and DBHS all implement limited use of advanced data analysis to measure consumer outcomes. Presently, OptumHealth monitors provider performance on the number of consumers re-entering inpatient treatment within 30 days of the initial treatment. For those providers with high re-admission rates, OptumHealth has provided treatment protocol training which has led to improved providers. In addition, OptumHealth, as part of its ongoing management of the ACT program, said it prepares a High Utilizer list for DBHS review.

Nevertheless, the use of advanced data analysis needs to expand, allowing for data driven results to informed decision-making by program administrators. One area that could benefit from advanced analytics is to identify the programs that are helping consumers get better and those programs that do not help consumers. DBHS offers dozens of services for SLCO Medicaid across a network of providers without having the evidence-based knowledge on the types of programs and services that substantially influence consumer progress. Another need is to identify the strengths of individual providers in affecting various positive consumer behaviors. Having this information will allow OptumHealth to better align the needs of the consumers to the provider with the best capability to address them.

The performance analysis shows two areas with declining performance: (1) the percentage of consumers reporting incompletion of planned goals and, (2) the level of Medicaid gains/loss as reported on DBHS’s Medicaid cost reports.

Finally, one important indicator for government performance is the capacity to deliver services. For behavioral health services, one measure of assessment is the number of consumers waiting to enter into treatment. As of May 1, 2014, VBH’s waiting list showed 126 uninsured consumers awaiting entry into alcohol and drug treatment with about 45 percent of them waiting at least three months or longer. Only one person waited at least six months.

The number of consumers on the waiting list does not reflect those consumers who contacted VBH for services, but opted against placement on the waiting list. VBH Directors explained funding availability drives access to substance abuse treatment services. In FY 2013, SLCO provided about $2.4 million in funding for the uninsured, which represents a decline of about $707,000 from FY 2012.
VBH does not have a waiting list for Medicaid consumers in need of mental health services, except those in need of residential services. As of May 1, 2014, VBH has seven Medicaid consumers awaiting residential treatment.

Table 11.0. Performance of SLCO’s Behavioral Health Services

<table>
<thead>
<tr>
<th>Behavioral Health Service Delivery Performance Level Changes, Pre to Post OptumHealth Award</th>
<th>% Change 2010 to 2013</th>
<th>Improvement</th>
<th>No Change</th>
<th>Decline in Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLINICAL IMPROVEMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caseload levels (VBH only)</td>
<td>-10.2</td>
<td>Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical staff survey</td>
<td>na</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NETWORK EFFECTIVENESS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of consumer complaints</td>
<td>-33.8</td>
<td>Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of provider complaints</td>
<td>0.0</td>
<td>Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of individuals served</td>
<td>24.8</td>
<td>Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Gain/Loss</td>
<td>-210</td>
<td>Red</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average cost per individual served</td>
<td>-14</td>
<td>Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient admissions per 100 individuals served</td>
<td>0.1</td>
<td>Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONTINUITY OF CARE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant in treatment planning (Mental Health adults only)</td>
<td>6.4</td>
<td>Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of plan goal completion (VBH only – Mental Health adults only)</td>
<td>-23.0</td>
<td>Red</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting time from assessment to the first appointment</td>
<td>-13.0</td>
<td>Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of consumers linked to primary care</td>
<td>na</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of individuals served with an assessment</td>
<td>-7.7</td>
<td>Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of network partners making referrals</td>
<td>na</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONSUMER OUTCOMES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social connectiveness</td>
<td>-3</td>
<td>Red</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellness</td>
<td>0</td>
<td>Red</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved Functioning</td>
<td>0</td>
<td>Red</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmission Rate</td>
<td>3</td>
<td>Green</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: TAP International analysis using SLCO financial and program reports, OptumHealth financial and program reports, and State required consumer reported information.

Note: Readmission rate is the change in performance from 2010 to 2013 based on the number of readmissions to total inpatient admission using data reported by OptumHealth.
PERFORMANCE AUDIT: EVALUATION OF BEHAVIORAL HEALTH SERVICES

Figure 10.1. Summary of Performance Measurement Issues

<table>
<thead>
<tr>
<th>Key Strengths</th>
<th>Potential Areas for Continuous Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>OptumHealth tracks and monitors the nationally recommended metrics to monitor the efficiency of service delivery and has some data on clinical outcomes for selected programs.</td>
<td>OptumHealth and VBH could more fully utilize evidence-based practices to assess consumer outcomes, relying on consumer reported information.</td>
</tr>
<tr>
<td>VBH assesses efficiency and effectiveness in the areas of financial performance, regulatory compliance, clinical operations, and customer satisfaction.</td>
<td>VBH could develop mechanisms to share consumer outcomes with case managers. Case managers reported the information could help improve how they serve consumers.</td>
</tr>
<tr>
<td>Analysis of 18 metrics show improved performance in nine areas, no change in four other areas, and reduce performance in the remaining two areas.</td>
<td>Data could be developed and tracked that was not available to assess three indicators that we examined – clinical staff satisfaction, the percent of consumers linked to primary care, and the level of referrals between providers. Data was not tracked, as collecting data is not a requirement.</td>
</tr>
<tr>
<td>VBH is beginning to utilize advanced analytics to help identify risk factors among consumers. OptumHealth has plans to use analytics to rank providers and monitor consumer follow up on appointments.</td>
<td>VBH’s waiting list for uninsured consumers awaiting treatment needs review for ways to reduce the wait.</td>
</tr>
<tr>
<td>SLCO’s Medicaid consumers are not waiting for mental health services although a few of them are waiting for residential treatment.</td>
<td></td>
</tr>
</tbody>
</table>

7. **Service Delivery Efficiencies**

Service delivery in a managed care model is provided through a community of providers who offer a range of services that address the full range of primary and supportive needs required to facilitate consumer recovery. Key attributes of service delivery that we examined to determine the efficiencies of service delivery are network capacity and use of the provider network. Other service delivery components, such as communication, information technology, covered services offered, and payment policies are discussed throughout this report.

As shown in Figure 11.1, a key strength of OptumHealth’s provider network shows a substantial increase in the number of providers ready to deliver care to eligible consumers. The capacity of the provider network grew from 77 in 2010 (pre MCO award to OptumHealth) to about 180 providers by 2013 (post MCO award to OptumHealth), creating greater choice for SLCO’s Medicaid enrollees. Allowing choice increases the potential for consumers to fully partner in
their treatment by selecting providers who consumers can best connect, especially with seeking understanding of issues and deliberating treatment decisions.

In contrast, uninsured consumers seeking substance abuse services continue to rely on one primary provider for services (VBH) and do not have same level of choice afforded to Medicaid consumers. SPMI Adult consumers also have limited choice in providers. OptumHealth identified at least four providers at the time of our review that could address this population. For SPMI youth, five providers could address are flexible regarding intensity of services. However, for the first six months of FY 2014, OptumHealth counted 1,499 SPMIs who sought services among 80 providers, raising questions about OptumHealth’s referral process. The referral and authorization process was not a component of this audit.

Our analysis of the use of the network utilization statistics from July through December 2013 show consumers received assessment services from 67 providers, or 37 percent of the available providers in the network, providing evidence that consumers are utilizing the network available to them and consumers who need services can find an available provider.

OptumHealth presented its plan for the future of behavioral health services to DBHS in July 2013. The vision, as illustrated in Figure 12.0 below, describes OptumHealth’s desire to enhance its use of analytics, and provide other mechanisms for service delivery through information technology, use of peer whole health specialist, and telepsychiatry to benefit the consumer.
Figure 12.0. OptumHealth’s Desired Key Goals for Behavioral Health Services in SLCO.

- Provider ratings to facilitate consumer choice
- Population Health Monitoring
- Real time point of service information
- Mobile applications to support behavior changes

- Use of peer whole health specialist
- Continued training on recovery and resiliency activities
- Improve existing peer specialist support services

Source of Data: OptumHealth Summit Meeting Presentation, July 2013

Figure 11.1. Summary of Service Delivery Issues

<table>
<thead>
<tr>
<th>Key Strengths</th>
<th>Potential Opportunities for Continuous Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider network within SLCO has grown from 77 to about 180 between 2011 and 2013, creating greater choice for County mental health and substance abuse consumers. OptumHealth has outlined a notable vision for the County’s behavioral health programs with innovative technology goals to enhance peer specialist services, add other provider training, use performance-based contracting with providers to incentive them financially to meet established performance targets, and the use of smart phones to facilitate service delivery.</td>
<td>The County’s uninsured consumers for substance abuse services do not have the same level of choice as other consumers because OptumHealth contracts directly with VBH.</td>
</tr>
</tbody>
</table>
Appendix A: Scope and Methodology

The scope of review evaluated the activities of three organizations:
- SLCO’s Division of Behavioral Health Services,
- Valley Behavioral Health – provider of behavioral health services for SLCO,
- OptumHealth – SLCO’s new managed care organization.

To address the objectives of the review, we conducted both qualitative and quantitative methods of analysis. First, we met with 24 County, OptumHealth, and VBH management and staff to discuss service delivery models, activities prior to the award of the MCO contract to OptumHealth, and activities post-award of the contract. The discussions focused on financial management, communications, Information technology, claim processing performance, service delivery, business processes, quality assurance activities, reporting, oversight, performance monitoring, access to treatment, provider payment policies, and treatment policies.

Second, we analyzed data for years 2010 to 2013 to identify changes in performance across 18 areas to determine the overall program impact of the transition to a new MCO. The contract award to OptumHealth took effect on July 1, 2011. We collected and analyzed state and county reports, consumer satisfaction surveys, newsletters, quarterly reports, financial statements, claim processing reports, oversight reports, policies and procedures, provider presentation, minutes of stakeholder meetings, utilization reports, enrollment reports, Medicaid cost reports, disputes and grievances reports, VBH Board meeting minutes, waiting lists, and strategic plans. We also reviewed OptumHealth’s website and BHSD’s website for how it conveyed information about behavioral health services to consumers and to providers.

Third, we conducted a review of three other counties to gather information on how other counties shared information and conducted oversight. For this review, we selected California counties in Yolo, San Mateo, and Santa Clara because of their use of the same similar claim processing systems, their comparable size of their provider network and/or shared vision on the use of managed care models.

Fourth, we contacted other providers within the SLCO’s network to discuss technology and communication activities.

We conducted this performance audit from February 2014 through April 2014 in accordance with the formal guidelines of generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and
conclusions based on our audit objectives.

**Limitations of Our Analysis**

Our analysis captures information with respect to the selected areas described above; however, several other factors that could affect the results of this review were not included in our analysis. For example, the scope of our review did not include an evaluation of the eligibility procedures. Such a review measures the extent to which the County might have provided services to those ineligible for care. In addition, our scope of review did not include an evaluation of business processes for preparing, submitting, and adjudicating claims, although we did analyze a snapshot of claims submitted to verify information reported by the entities. The results of an extensive claims processing review would analyze actual level claims submission accuracy among all providers and payment accuracy by the MCO. In addition, our contracted scope of services did not include an examination of the sufficiency of referral and authorization processes.

We attempted data analysis on whether consumers were actually getting better, but found these to be either difficult to quantify or the data not readily available. We ultimately excluded these factors, except for hospital re-admissions, from our analysis. We relied on self-reported consumer data for evaluating on consumer outcomes.

**Data Reliability**

To determine the reliability of the data sources, we reviewed IT audit reports, system edit checks and controls, and interviewed experts most knowledgeable in the collection and validation of the specific data. For large data sets, such as the February claims processing files, we conducted electronic testing for outliers and other discrepancies. We also compared the data in the reports received, when possible, to similar data presented in other reports. For any identified differences, we worked with the DBHS staff to obtain formal source records.

For the data reported in this report, the data sources analyzed were sufficiently reliable for the purposes of our engagement. In those instances where data was not available, we indicated the unavailability.
Agency Comments

We provided a draft of this report to DBHS, OptumHealth, and Valley Behavioral Health for comment. All three entities provided written comments on the draft. Where applicable and relevant to the findings, we incorporated verified comments into the report. DBHS and VBH also provided a formal letter for inclusion in this report. (See pages 54 and 56).

DBHS’s letter asserted that this report concludes that the IT systems are working effectively and accurately. This report discusses the IT technology issues that have been resolved as of March 2014 and the manual processing of third party claims. While we describe the general satisfaction among other providers of OptumHealth’s claim processing activities, we did not make any conclusions on the effectiveness or the accuracy of the systems. Instead, we recommended that DBHS conduct IT system audits as part of its annual oversight of OptumHealth.

We show in this report several charts where claims processing issues occurred stemming from VBH’s system as late of February 2014, and newly released reports incorporated into this report suggest that missing authorizations on claims continue although OptumHealth and VBH both implemented technological fixes to resolve the problem. Based on the most recent data, we provide a recommendation to SCLO to conduct a performance audit of VBH’s and OptumHealth’s claim authorization and submittal processes, which was not included in our contracted scope of work, to identify the cause to the problem.

DBHS’s letter asserts that the IT issues have directly affected the underspend issue by VBH. However, our analysis shows that the underspend issue is not solely an IT issue. As we previously explained, claims with missing authorization numbers continue to occur which may be due to the business processes established rather than by IT configuration issues given that both OptumHealth and VBH provided assurances of their resolution. In addition, we describe in this report that VBH had not been submitting claims for all services rendered (a business process issue) which directly affects the level of underspend amounts reported.

DBHS states that while VBH was under spending on its budget in FY 2014, it was sending clients to other programs as well as closing programs. Our report describes VBH’s fiscal condition through FY 2012, but in that analysis, we determined that despite substantial cost cutting efforts by VBH, it was not enough to close the gap between total expenditures and total costs without taking other action. We explain in this report that VBH is implementing a comprehensive Action Plan to close the gap between their total revenues and total expenditures. For some programs, it cost VBH more to render services in comparison to the revenue received under Medicaid reimbursement rates.
Finally, DBHS suggests that OptumHealth had up to nine months to configure its claim processing process. We explain in this report that DBHS allowed OptumHealth to begin configuring its system when the contract was awarded, but OptumHealth opted against doing so. A common business practice is not to invest substantial time and resources into a project until the contract is fully executed. Because of lengthy contract negotiations, OptumHealth’s contract for MCO services was not executed until six weeks before the go-live date. We commend DBHS’s initiatives in its latest request for proposal for the MCO contract to avoid comparable problems in the next competitive bid process for managing mental health services.
June 13, 2014

Denise Callahan
Tap International, Inc.
1364 Brickwell Way
Carmichael, CA 95608

Dear Ms. Callahan:

As my Behavioral Health Services Division and I have reviewed this report, though we do not agree with every detail and recognizing that it would be near impossible in such a short timeframe to get every detail right, we generally believe the message of this report is accurate and the recommendations are helpful.

There are two assertions that I do believe I need to point out and dispute.

First, the report states multiple times that, apart from a minor TPL challenge, the IT system is now working very effectively. That same IT system undeniably shows, and VBH agrees, that in the first 6 months of SFY14, while VBH was sending clients to other programs and closing programs, they underspent their cap by at least $1.1 million. There is absolutely no pre-authorization required for admission to VBH outpatient services and all stakeholders in the community that refer clients for mental health services have done so directly to VBH for 20+ years. Optum has done nothing to change this open referral structure to VBH and additionally, Optum reports that they did not change their own referral practices.

As we close out SFY14, this VBH underspend that all parties (VBH, Optum and County) agree occurred will require Optum to reduce the SFY15 VBH cap as the benefit expense is being used by other providers to serve clients who have chosen to go to them for services. We believe it is inconsistent to state that the systems are running accurately, which show significant under expend but then in the same report state that VBH may still spend its contractual funding cap.

The second assertion I feel needs to be disputed is that Optum only had 6 weeks to prepare its IT systems for the implementation. Yes, we acknowledge that there were delays that led to the contract being formally signed 6 weeks before the July 1, 2011 go-live date, but Optum was notified that they were awarded the contract over 9 months before that in Sept of 2010. Shortly after learning it had been awarded the contract, Optum began meeting with the County to discuss the specifics of the IT system(s) it would need. The State Department of Health requested that the County maintain the contract with VBH an additional 6 months through June 30, 2011 to give it time to adjust its systems for the change. To support DOH and to give both VBH and Optum additional time to prepare
for the systems change, Salt Lake County extended the VBH contract as requested an additional 6 months. Both parties therefore had 9 months to prepare. Salt Lake County asked Optum to look at using our existing IT system, UWITS. Optum evaluated it and declined. Over a several month period Optum was meeting with both County and VBH IT folks to develop system specs to be ready for the July 1, 2011 go-live date. As Salt Lake County prepares for its procurement process to contract with an MCO beginning SFY16, the RFP is being released now with the intent to give the chosen agency approximately 1 year to prepare and Salt Lake County has made it clear in the RFP that it must approve the IT system chosen by the new MCO.

Regards,

Lori Bays, Director
Human Services Department
To Mayor McAdams and Salt Lake County Council:

Thank you for providing Valley Behavioral Health with the opportunity to respond and fully participate in the County Behavioral Health Systems audit performed by TAP International. Valley management appreciates the work of Denise Callahan for her high level of professionalism, attention to detail and for the quality of the report.

Valley appreciates the recommendations and suggestions for system improvement contained in the report. We see this process as an opportunity to continually improve our service delivery and partnership with OptumHealth and Salt Lake County.

Specifically we would like to highlight a couple of key parts of the report that we feel are significant.

- Our clients are our number one priority. Valley has strived to and we believe as the report suggests, has achieved a high level of client satisfaction, despite the financial difficulties and cost-cutting measures we had to take. Going forward, we will continue these efforts to provide effective services.

- Valley fully supports the audit recommendation to implement evidence based practices and outcome measures. We have in the past, and will continue to advocate for, a comprehensive process to measure client outcomes throughout the provider network and are willing to partner with Optum and Salt Lake County in this endeavor.

- Valley is proactive in striving for optimal clinical outcomes, financial stability, regulatory adherence and client and stakeholder satisfaction. This is our business model and has been an effective way to operate through difficult times.

In closing, I would like to again thank Ms. Callahan for undertaking this important work. Our company sees this report as a step forward in working on providing the best quality system of care for Salt Lake County residents.

Sincerely,

Dave Justice
Director, Regulatory Oversight and Compliance
Valley Behavioral Health